Medicaid Expenditure Report

SFY 2020

RHODE ISLAND

Purposes of this Report

This Medicaid Expenditure Report contains all components indicated in statute at R.I.G.L. 42-7.2-5, in order to provide a comprehensive overview of all Medicaid expenditures, outcomes, and utilization rates during State Fiscal Year (SFY) 2020.

The goals of this report are to:

01 Provide state policymakers with a comprehensive overview of state Medicaid expenditures to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process.

02 Summarize Medicaid expenditures for eligible individuals and families covered by the relevant Rhode Island departments.

03 Show enrollment and expenditure trends for Medicaid coverage groups by service type, care setting, and delivery mechanism.

04 Maintain a standard format for tracking and evaluating trends in annual Medicaid expenditures within and across departments.

Reporting Methodology & Data Notes

This report is generally based on: (a) Rhode Island's Medicaid Management Information System (MMIS) extracts that include capitation and other payments to health plans, fee-for-service claims, and provider payouts, as well as; (b) RIFANS summaries, and; (c) financial reporting to CMS.

- Capitation payments and plan payouts are proportionately allocated to Medicaid coverage groups, service types and care settings based on respective claims information.
  - Due to the proportional allocation method, other reports and analyses based exclusively on claims data may differ from the expenditure amounts in this report.
- The primary basis for identifying expenditures in this report is the incurred date of service, rather than paid date.
  - Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes due to differences in timing.

Other data notes:

- Enrollment figures represent average monthly enrollment unless otherwise stated. If a member crosses programs within the year, the member is assigned to their last program (e.g., a member who shifted from RIte Care to Expansion within the year would be assigned to Expansion).
- Expenditure amounts used in this report may vary from those reported for financial reconciliation or other purposes. Reasons for variance might include factors such as claim completion, accruals, provider payouts, capitation vs. claim amounts, and program assignment.
- Pharmacy expenditures are shown as net of rebates.
- For reporting on prevalence of diagnoses:
  - Claims were assigned to diagnosis categories using the Clinical Classification Software maintained by the Agency for Healthcare Research and Quality.
  - Data from the Dual Eligible (i.e., eligible for both Medicare and Medicaid) population are excluded from reporting on prevalence of diagnosis, and utilization and expenditure by acute care service type.
  - Pharmacy, Long-Term Services and Supports (LTSS), and dental claims data are excluded from reporting on diagnosis-related analyses.
  - Enrollment for the diagnoses represented in the report will vary from the rest of the report. This enrollment is a unique count of full benefit enrollees with at least six months of Medicaid enrollment in a single year.

Definitions

- **Trending methodology** - This report shows 5-year trends in terms of a compounded annual growth rate (CAGR) based on historical data in order to present longer term trends rather than year to year variation.
- **Rounding** - The values presented in this report are rounded; the totals illustrated in the report may not equal the sum of the component parts.
- Acronyms are defined at the end of this report.

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Summary and Key Findings

Overview

During SFY 2020, Rhode Island's Medicaid program provided full medical coverage to nearly **350,000 Rhode Islanders** at some point during the year, with an average monthly enrollment of 298,000 members.

Overall, medical expenditures **totaled $3.1 billion** (at a state cost of $1.2 billion), with nearly $2.7 billion in spending on benefits for members receiving full benefits in the state fiscal year.

Medicaid expenditures for fully covered populations are divided among several state agencies:

- $2.3 billion – Executive Office of Health and Human Services (EOHHS)
- $366 million – Behavioral Healthcare, Developmental Disability, and Hospitals (BHDDH)
- $59 million – Department of Children, Youth and Families (DCYF)

The Office of Healthy Aging (OHA) within Department of Human Services (DHS) and Ryan White Program within EOHHS also provide benefits to members with limited benefits.

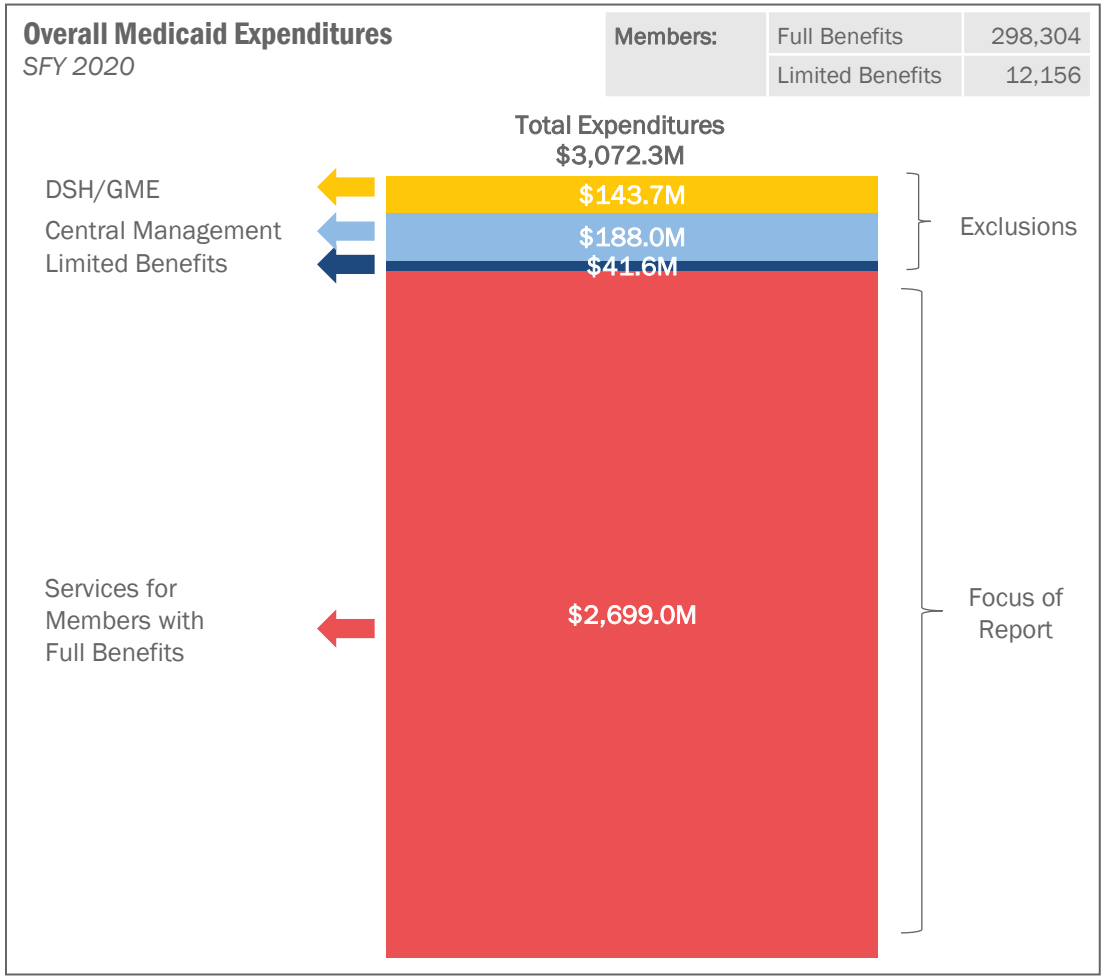
Expenditures in this Report are inclusive of federal funds, general revenues, and restricted receipts. The effective Federal Medicaid Assistance Percentage (FMAP) was 61% across the entire Medicaid program.

Key Findings

- Average enrollment decreased 3.1% in SFY 2020 over SFY 2019, from 308,000 to 298,000.
- Children and Families comprise 52.1% of enrollees, followed by Expansion (25.8%), Adults with Disabilities (10.5%), Elders (7.6%) and Children with Special Healthcare Needs (4.1%).
- 87.3% of enrollees are in managed care; and over three-fifths (62.2%) of all Medicaid enrollees are now in the Accountable Entity (AE) program.
- SFY 2020 per member per month (PMPM) costs increased by 4.9% over SFY 2019 to $754 PMPM. This is higher than the five-year compounded annual growth rate (CAGR) of 1.0% since SFY 2016.
- The cost of caring for certain populations varies significantly, with Elders and Adults with Disabilities costing nearly three times the average beneficiary and Children and Families costing less than half.
    - Overall, costs are highly skewed: 20% of Medicaid enrollees incurred nearly 90% of claims in SFY 2020.
- Acute services account for 54% of SFY 2020 expenditures, while expenditures on LTSS represent 34%.
- COVID-19 began to significantly impact expenditures and enrollment in March 2020, partially impacting trends and general observations for fiscal year 2020 and when compared to prior fiscal years.

Overall Medicaid Expenditures

Medicaid expenditures in SFY 2020 totaled $3.1 billion. Expenditures on fully covered populations totaled approximately $2.7 billion.



- **Services for Members with Full Benefits cost $2,699 million** and are expenditures for services delivered to enrollees who received comprehensive medical coverage through Medicaid and are the primary focus of the report.
- **Central Management Costs** of **$188 million** are expenditures related to managing the Medicaid program, such as paying for technology infrastructure and processing claims. These expenses are excluded from this report. Some of the State's investments in its **Health System Transformation Project (HSTP)** are within Central Management (HSTP incentive payments are within benefits expense). *Note, however, that MCO administrative costs/taxes are included in the services for members with full benefits.*
- **Other exclusions** totaling **$185.3 million** include supplemental payments to hospitals and benefits for members with limited benefits as well Medicare premium payments for certain dual eligible members without comprehensive Medicaid. These expenditures include:

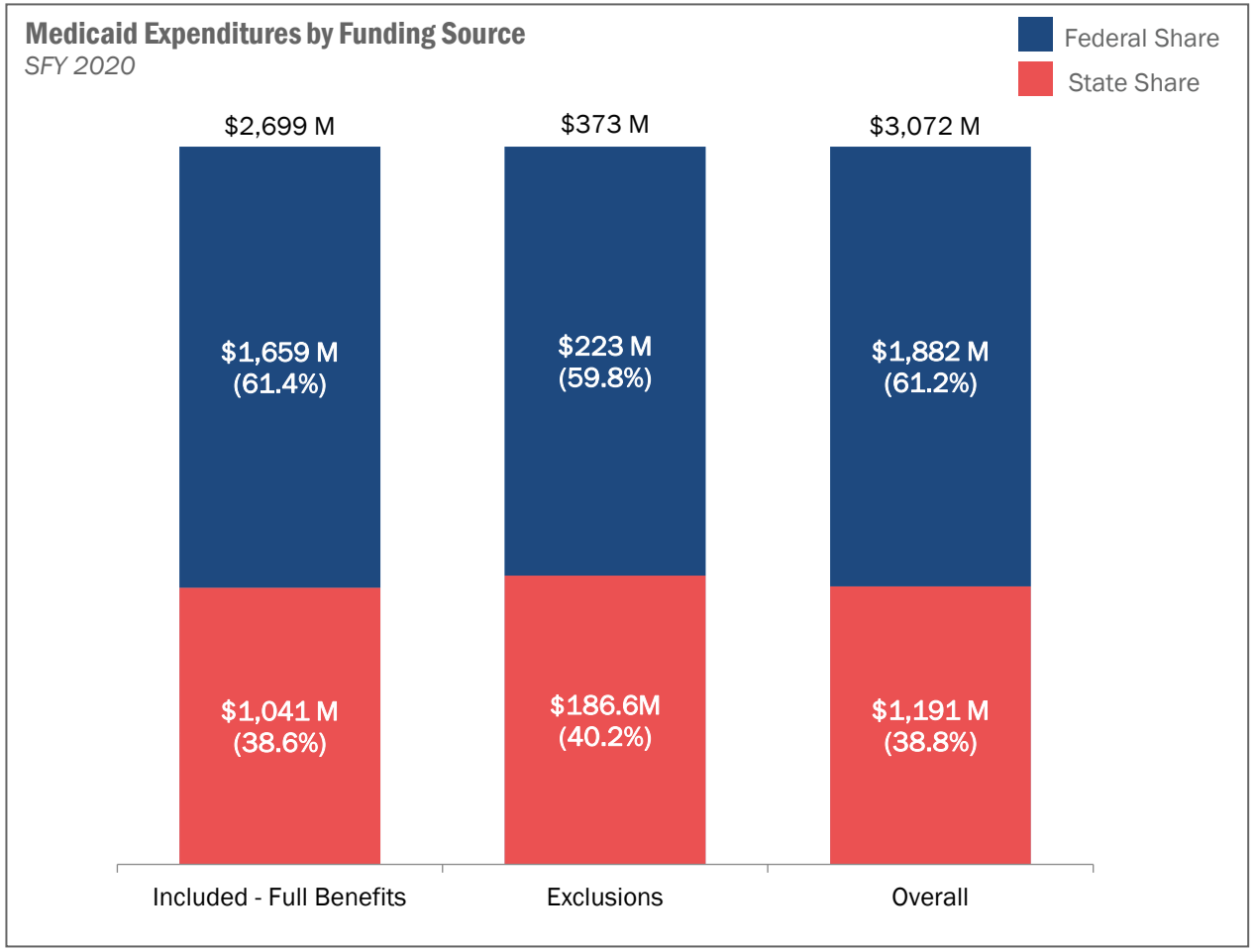
  Disproportionate Share Hospitals (DSH) and Graduate Medical Education (GME): Statutorily required payments to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety net hospitals.

  Costs Not Otherwise Matchable (CNOM) and Partial Emergency Services: Limited benefits not traditionally eligible for federal Medicaid funding match, that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible. Includes services covered by the Office of Healthy Aging.

  Partial Duals: Medicare premium payments for certain qualifying members with limited incomes who are not otherwise eligible for Medicaid services.

Expenditures by Funding Source

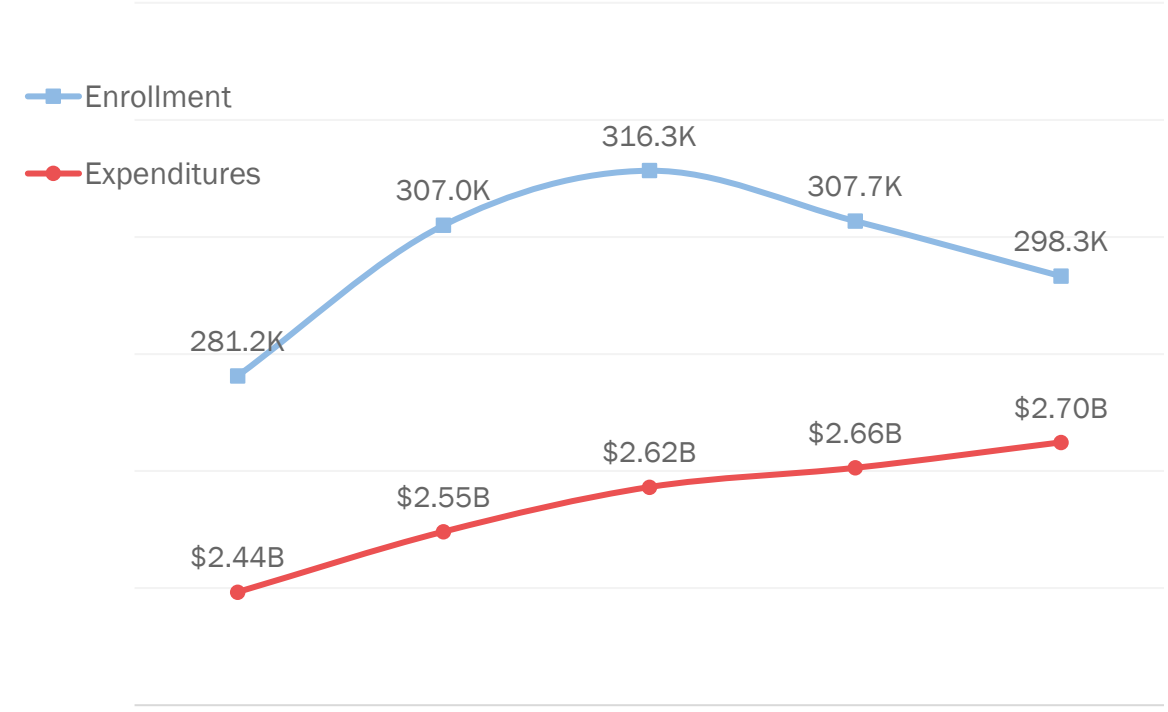
Medicaid expenditures in SFY 2020 totaled $3.1 billion at a direct cost of $1.2 billion to state taxpayers.



- The largest source of funding for the state share is general revenue appropriations to agencies. Other sources of state share include:
  - Local Education Agencies' Certified Public Expenditures
  - Restricted Receipt spending, including HSTP and Children's Health Account
- Note that in SFY 2020, not all expenditures for Eleanor Slater Hospital were submitted as claims or matched with federal funding due to concerns about complying with federal regulations on Institutes of Mental Disease. The State-only expenditures are included in this report.
- As a result of the declaration by the federal government of a Public Health Emergency related to COVID-19, beginning on January 1, 2020, Rhode Island became eligible for a temporary increase to the Federal Medical Assistance Percentage (FMAP): an increase of 6.20% for Regular Medicaid and increase of 4.34% for CHIP.
  - Medicaid Expansion and Central Management expenditures—the former already eligible for 90% federal financing—were not eligible for this increased FMAP

Five-Year Trends: Expenditures, Enrollment, and PMPM

Overall Expenditure, Enrollment, and PMPM Trends
SFY 2016 – 2020



	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
PMPM	$724	$691	$691	$719	$754

Expenditures

- In SFY 2020, expenditures increased by $43.6 million or 1.6% over SFY 2019; less than the five-year compounded annual growth rate of 2.5%

Enrollment

- Average enrollment fell again in SFY 2020, by 3.1% over the SFY 2019 average, further moderating the five-year compounded annual growth rate to 1.5% since SFY 2016.
- This reduction in the average monthly enrollment over the fiscal year hides the sharp increase that started in March 2020, following the declaration by the federal government of a Public Health Emergency for COVID-19, which included a moratorium on most regular termination activities.

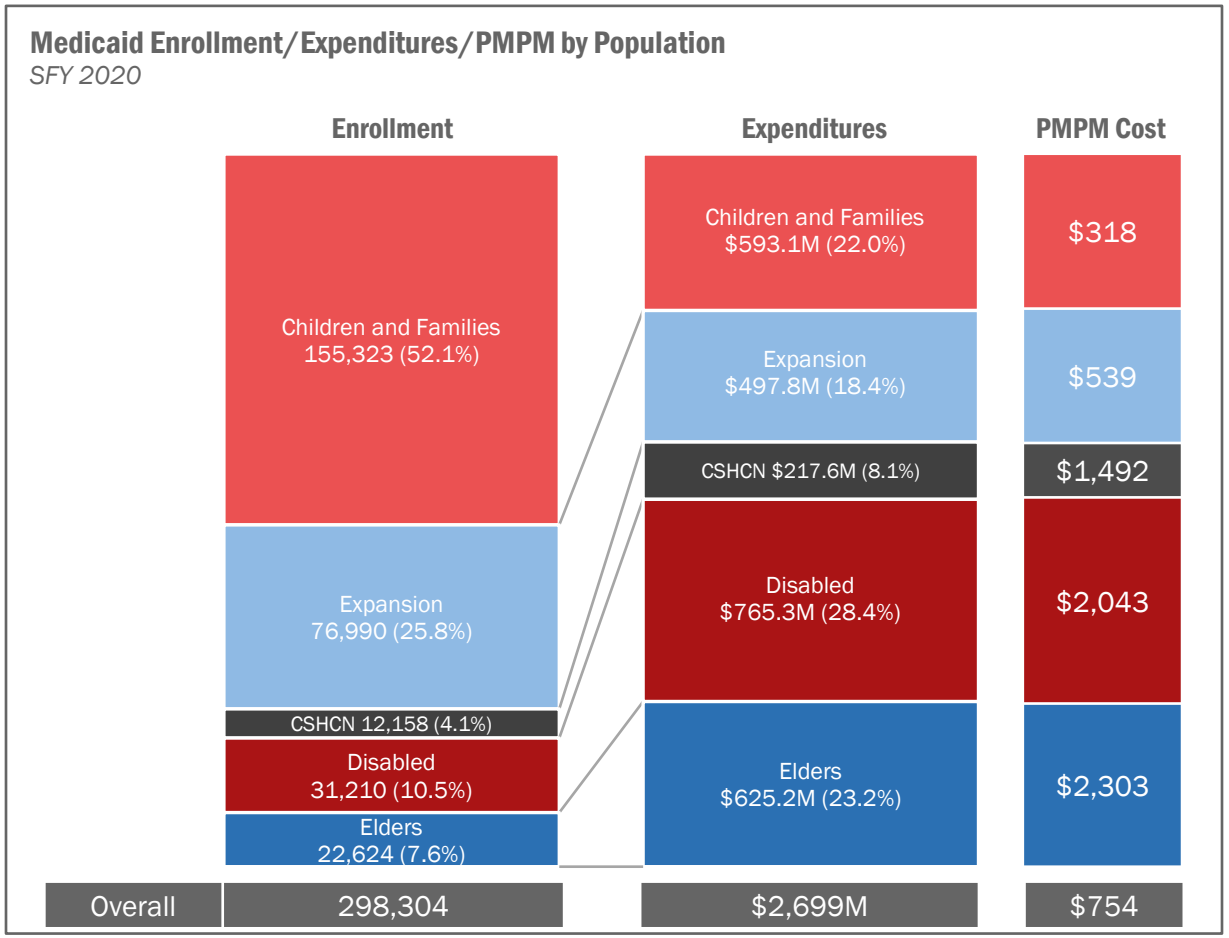
PMPM

- After several years of stability in the PMPM, overall PMPM costs increased by an average of 4.9% in SFY 2020 over SFY 2019, ranging from less than 0.5% for Elders and nearly 9.5% for Expansion Adults.
  - It is worth noting that the reduction to Clawback expenditures (due to the COVID-19 Enhanced FMAP) reduced the trend for Elders by approximately 1 percentage point.
- A key contributing factor for the expenditure increase and higher PMPM costs across all populations were certain legislatively mandated price increases to hospital and nursing home rates as well as an increase in the average acuity as members following the disenrollment of comparatively healthier members.

Overview & Trends

Expenditures by Population Group

Medicaid expenditures in SFY 2020 totaled $3.1 billion. Expenditures for fully covered populations totaled approximately $2.7 billion.



Medicaid serves five primary populations:

- **Elders** are enrollees over age 65. 92% of this population are also covered by Medicare. Their average SFY 2020 PMPM cost was $2,303. Nursing facilities account for 59% of their expenditures.
- **Adults with Disabilities** are enrollees under age 65 with identified disabilities and 48% are also covered by Medicare. Their average cost was $2,043 PMPM. Home and Community Based Services, including I/DD providers, account for 28% of their expenditures.
- **Children and Families** enrollees are qualified children, parents and pregnant women. They have average costs of $318 PMPM. Professional services and hospital care account for 41% and 40% of their expenditures, respectively.
- **CSHCN** are enrollees under age 21 who have higher needs physically, developmentally, behaviorally or emotionally. Their average PMPM costs were $1,492 with professional services accounting for 54% of expenditures.
- **Expansion** enrollees are low-income adults without dependent children. These members cost $539 PMPM. Hospital and professional services account for 44% and 26% of expenditures for this population, respectively.

Members with **Limited Benefits** are excluded from the report, but include populations covered by Medicare with limited Medicaid benefits (so-called Partial Duals), members who receive limited support with paying for Home and Community Based Services, and those getting Emergency Medical coverage only or support for paying for prescription drugs.

Expenditures by Population Group, Continued

From SFY 2016 to 2020, overall expenditures, enrollment, and PMPM increased modestly: expenditures by 2.5% annually, enrollment by 1.5% annually, and PMPM by 1.0% annually.

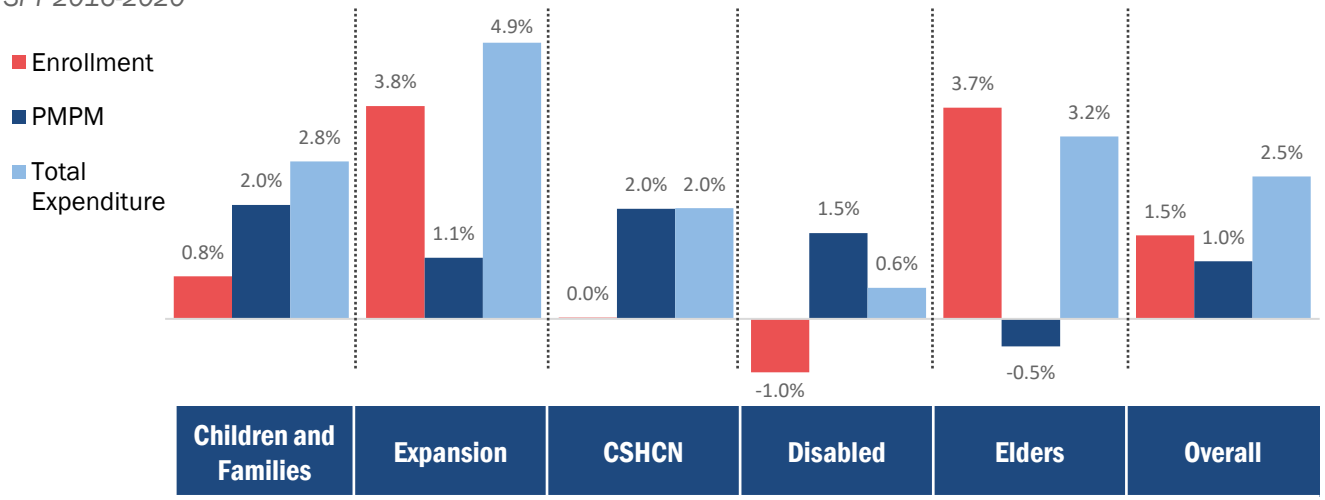
Current Expenditures

SFY 2020

	Children and Families	Expansion	CSHCN	Disabled	Elders	Overall
Members	155,323	76,990	12,158	31,210	22,624	298,304
PMPM	$318	$539	$1,492	$2,043	$2,303	$754
Expenditure	$593.1M	$497.8M	$217.6M	$765.3M	$625.2M	$2,699.0M

Expenditures - 5-Year Compounded Annual Growth Rate

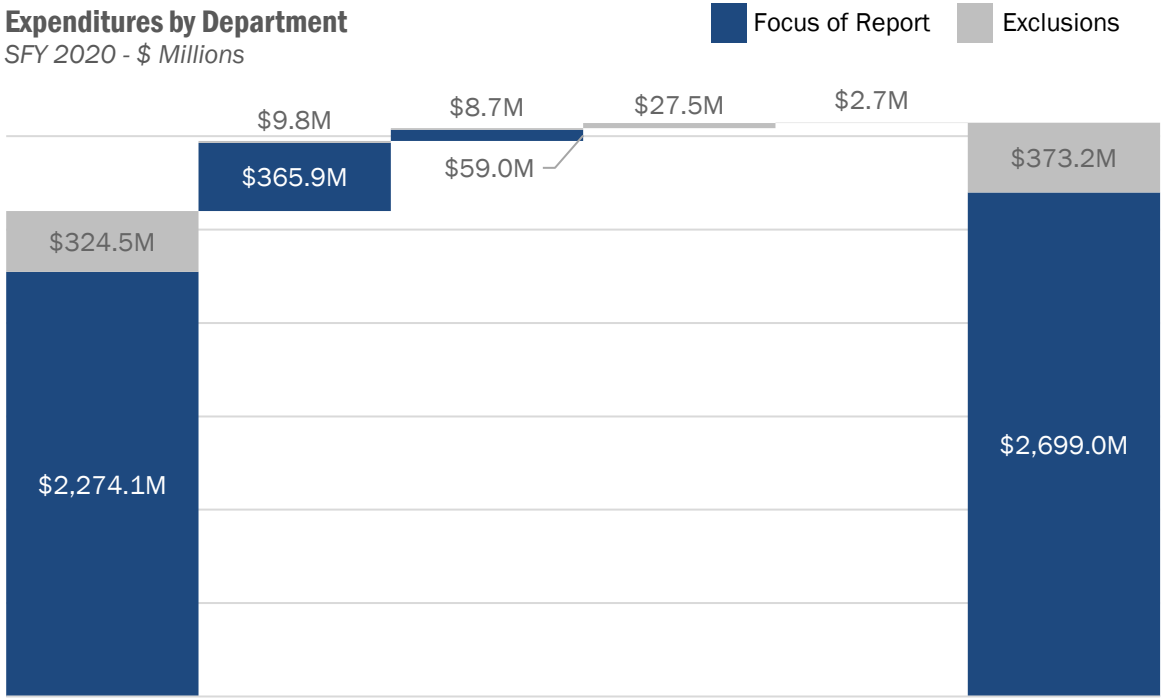
SFY 2016-2020



- Between SFY 2016 – 2020, the population groups experienced the following:
  - **Expansion** enrollment experienced the largest growth: net increase of 10,583 members over the past five years or 3.8% annually. Overall costs increased significantly as well, from $411 M in SFY 2016 to $498 M in SFY 2020. Over that time period, the state share also increased from 0% in the first half of SFY 2016 to 10% in SFY 2020.
  - **Children and Families** had a slight increase in enrollment and modest price trends; the latter, however, was lower than the general medical inflation index over the same time period.
  - **Elder** and **Adults with Disabilities** enrollment decreased slightly, although spending in each of their largest service category, Nursing Facility and IDD Residential/Rehab, respectively, grew by 2% compounded average.
  - **CSHCN** enrollment is effectively flat. The increases to their overall expenditures and PMPM can be attributed to average annual increases in their two largest spending categories: professional (2.2%) and inpatient services (5.2%).

Expenditures by Department

Four departments in Rhode Island are appropriated funding for the Medicaid program. Nearly 85% of funds are appropriated directly to EOHHS.

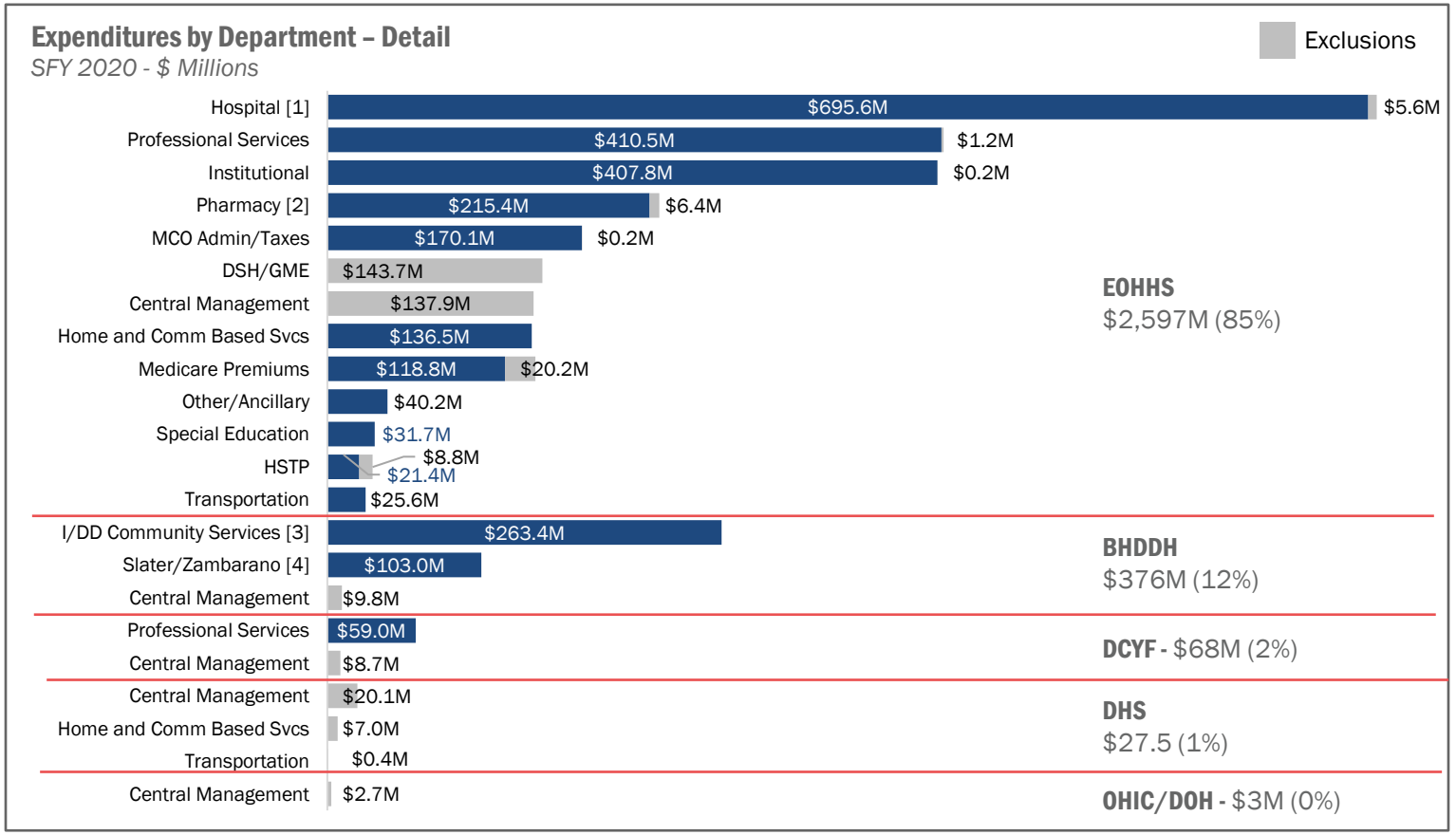


EOHHS	BHDDH	DCYF	DHS	DOH/OHIC	Total
84.6%	12.2%	2.2%	0.9%	<0.1%	100%
% of Total Expenditures					
1.8%	2.5%	10.4%	-1.5%	1.6%	2.0%
5-Year Compounded Annual Growth Rate – SFY 2016-2020					

- EOHHS is the administrator for the Medicaid program, known as the Single State Agency. The Single State Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
  - Overall Medicaid expenditures increased from SFY 2016 to 2020 by 2.0% per annum, with EOHHS spending increasing by 1.8% per annum.
- In SFY 2020, other departments were overseen by EOHHS in administering the Medicaid program, including at BHDDH, DCYF, and DHS.
  - Additionally, certain administrative functions performed by the Office of Health Insurance Commissioner and Department of Health are charged to Medicaid.
- Central management supporting the Medicaid program (i.e., were eligible for federal reimbursement from Medicaid) totaled $188.0 million across all agencies.
- Grey expenditures in the chart at the left are excluded; note that all benefit expenditures by the DHS and some expenditures by EOHHS do not go toward benefits for fully covered populations, and thus are excluded from benefit analyses in this report. Other exclusions are detailed on the next slide.

Expenditures by Department - Detail

EOHHS funds most traditional medical services, including hospital-based services, professional services, institutional care, and pharmacy.

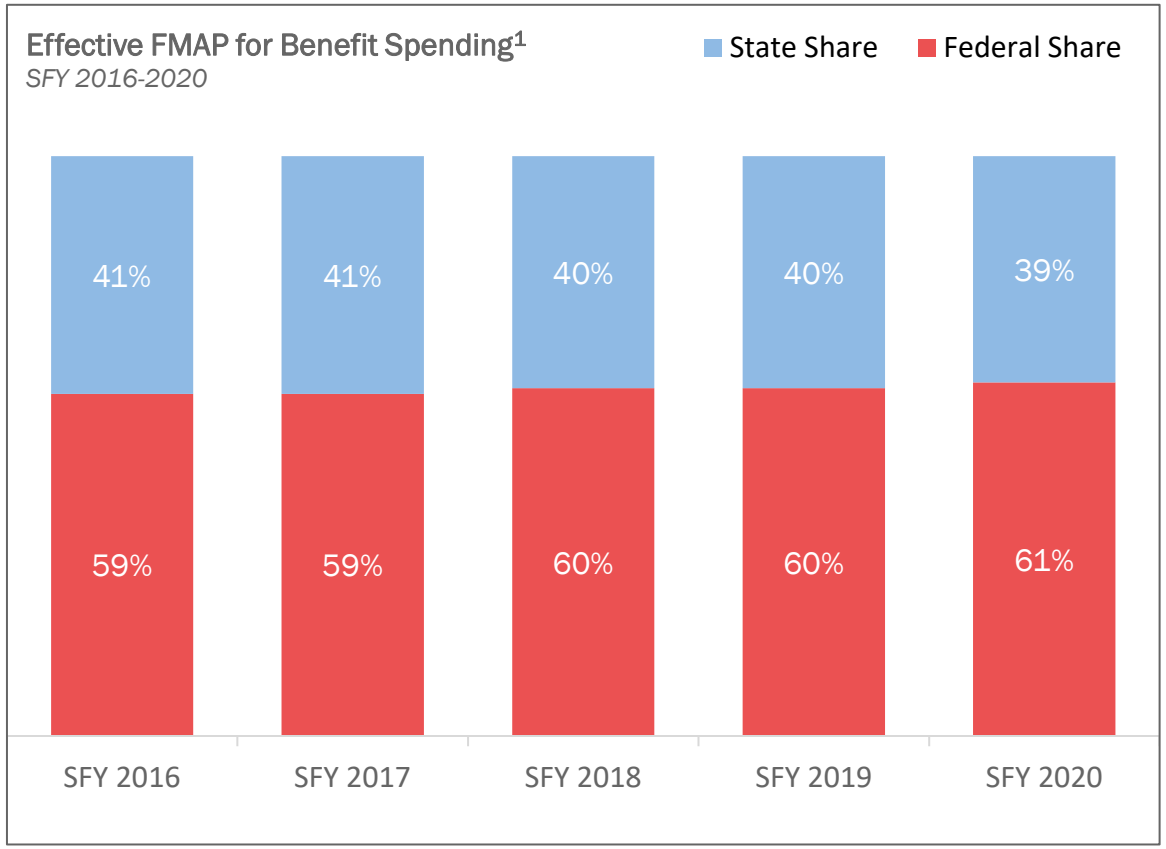


- Overall, with total spending of $2.6 billion, **EOHHS** appropriations account for 85% of Medicaid expenditures. The biggest portion (27%) of that is for hospital-based services. Professional services and institutional care (inclusive of Nursing Facilities and Hospice) each account for 16% of EOHHS benefit expenditures.
- **BHDDH** appropriations account for 12% of state Medicaid spending and include three primary areas: both residential services and community-based services for persons with intellectual and developmental disabilities, as well as Eleanor Slater Hospital.
  - In SFY 2020, not all expenditures for Eleanor Slater Hospital (ESH) were Medicaid-eligible due to concerns with federal regulations on Institutes of Mental Disease. Nonetheless this report includes these expenditures.
- **DCYF** accounts for $68 million (2%) of Medicaid expenditures. DCYF supports programs serving children in the child welfare system, children in substitute care and children with behavioral health conditions.
- **DHS** accounts for $27.5 million of Medicaid expenditures. Benefit spending of $7.4 million is largely for CNOM programs managed by the Office of Healthy Aging designed to forestall the need for persons served to become fully Medicaid eligible.

[1] EOHHS Hospital spending includes acute spending on Inpatient and Outpatient Hospitals, UPL Payments and spending at Tavares.
[2] Total Pharmacy includes retail pharmacy, office-administered drugs, and outpatient pharmacy. Costs are net of pharmacy rebates.
[3] I/DD Community includes all residential and rehabilitation services for persons with intellectual and developmental disabilities, including group homes.
[4] Slater expenditures include State-only spending not matchable by CMS in SFY 2020.

Benefit Spending by Funding Source

Medicaid programs are funded by state and federal dollars. In SFY 2020, Rhode Island paid approximately 39% of all benefit expenditures (i.e., full and limited benefits, excluding Central Management) using state funds.

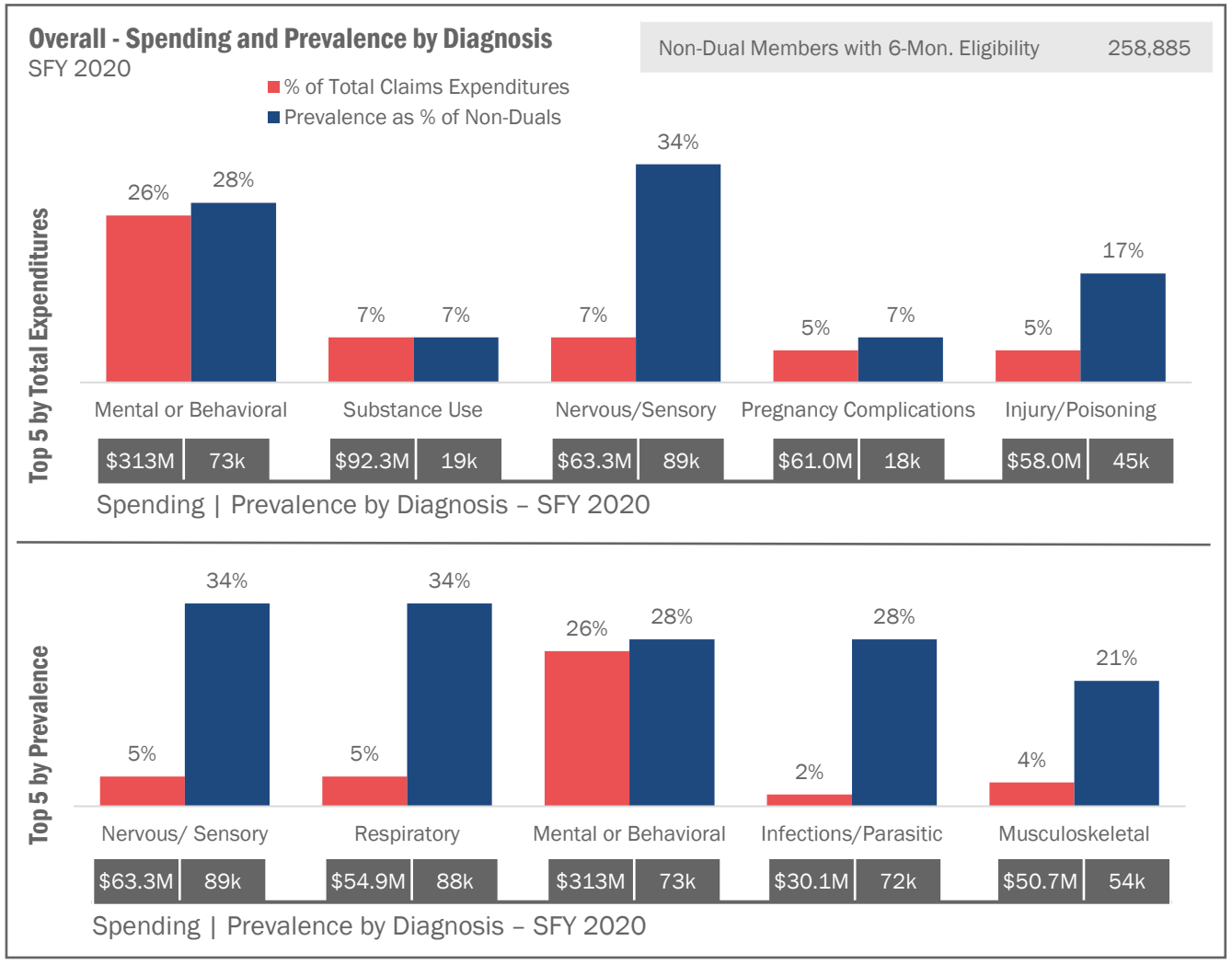


[1] Benefit Spending includes members with full and limited benefits. Does not include Central Management expenditures.

- Rhode Island receives different federal matching rates for the Expansion population and non-Expansion population. The effective Federal Medical Assistance Percentage (FMAP) is the weighted average of these federal contributions.
- Federal matching dollars differ based on the population:
  - The Regular FMAP for the Elders, Adults With Disabilities, Children and Families and CSHCN populations is published prospectively by the Department of Health and Human Services and is based on formula that compares the state's average income to the national average. The Enhanced FMAP for the Children's Health Insurance Program reflects an adjustment to the state's Regular FMAP.
  - The Expansion population's FMAP is consistent across all states and is determined by the ACA.
  - A few small programs receive a 90% match, including the Breast and Cervical Cancer Prevention and Treatment and Extended Family Planning programs.
- HSTP-funded items use restricted revenues to finance what would otherwise be the state's share of the expenditure. HSTP incentive payments are included as benefit expense.
- The state share for the Special Education program is financed by the local education agencies.

COVID-19 Enhanced FMAP: In January 2021 Rhode Island began to receive a 6.20% increase to its Regular FMAP and 4.20% increase to its Enhanced FMAP (for CHIP). The Secretary of Health and Human Services (federal) communicated that this increase would last for the duration of the COVID-19 Public Health Emergency. This change did not impact the match rate for Central Management and expansion-eligible benefits.

Expenditures by Diagnoses



- The only diagnosis category that exceeds 10% of Medicaid expenditures is mental or behavioral health, which accounts for at least 25% of expenditures.
  - Prevalence data does not include the Dual population and may understate cost of treating certain conditions.
- Two diagnoses are in the top five in terms of both expenditure and prevalence:
  - Mental or behavioral health, and
  - Diseases of the nervous system and sense organs.
- Notes:
  - Prevalence is presented in this report as both a percentage of the CSHCN, Children and Families, Expansion and Disabled Adults populations with the diagnoses, and as the number of enrollees with the diagnoses.

An example of how to interpret the chart to the left:

- 28% "prevalence as a % of non-duals" means that among members within the overall population that have at least 6 months of eligibility during the year and do not have Medicare, 28% had claims where "Mental or Behavioral Health" was the primary diagnosis.
- Of the total claims for this population, 26% of their costs were for claims where "Mental or Behavioral Health" was the primary diagnosis.

Optional vs. Mandatory Expenditures

Federal law requires states participating in the Medicaid program to cover certain groups of individuals and provide certain mandatory benefits but allows states the choice of covering other optional populations and benefits

Enrollment and Expenditures by Mandatory vs. Optional Populations and Benefits[1]
SFY 2020

	Mandatory Populations	Optional Populations	Total
ENROLLMENT	199,660 (67%)	98,644 (33%)	298,304
Expenditures on Mandatory Benefits	$1,003 M (37%)	$797 M (30%)	$1,800 M (67%)
Expenditures on Optional Benefits	$520 M (19%)	$379 M (14%)	$899 M (33%)
TOTAL EXPENDITURES	$1,523 M (56%)	$1,176 M (44%)	$2,699 M

[1] Proportional allocation of expenditures identified as "optional" or "mandatory" based on share of actual claim amounts for members with full Medicaid benefits identified as being for an "optional" or "mandatory" service category.

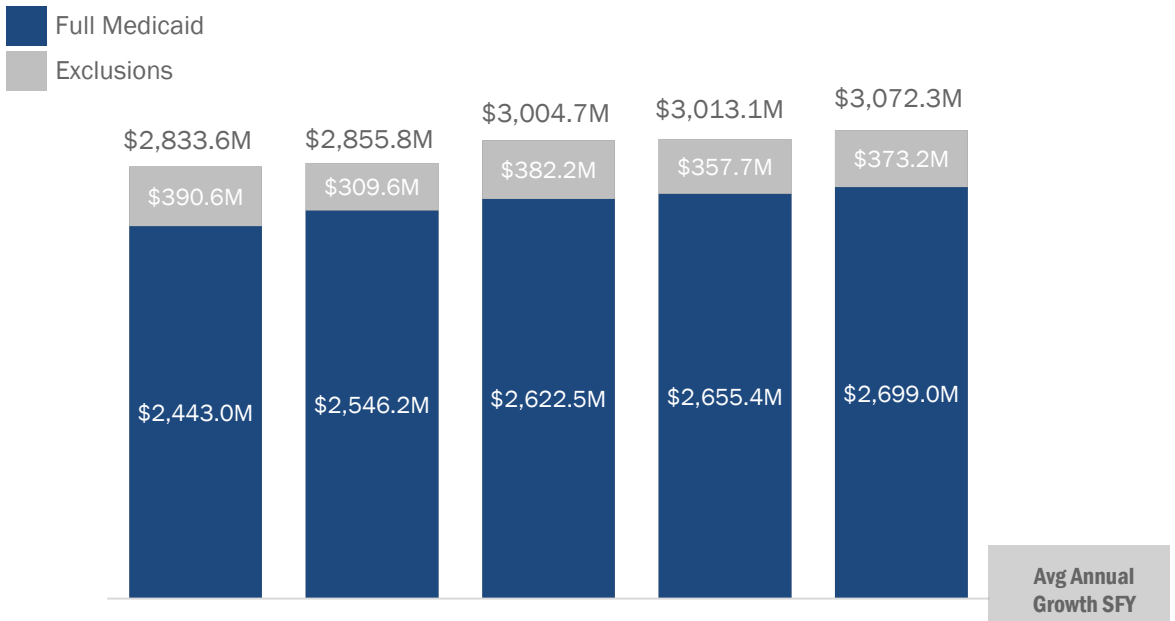
- Mandatory Medicaid populations include groups like low-income families, qualified pregnant women and children, and individuals receiving SSI.
- Optional populations can be covered at the discretion of the state and include adults without dependent children, low-income pregnant women and parents above federal minimum standards, elderly and disabled individuals with incomes above federal minimum standards or who receive LTSS in the community, and enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services.
- In Rhode Island, Expansion members make up most optional members.
- For purposes of this exhibit, CHIP is considered mandatory due to the maintenance of effort (MOE) provisions contained in the HEALTHY KIDS and ACCESS Acts, which extended federal funding for CHIP through FY 2027. As a condition of receiving federal funding for Medicaid, states must maintain Medicaid and CHIP "eligibility standards, methodologies, and procedures" for children that are no more restrictive than those in effect on March 23, 2010. See: https://www.medicaid.gov/federal-policy-guidance/downloads/sho18010.pdf
- The list of optional and mandatory Medicaid benefits are available from CMS at the following link: https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html
- In Rhode Island, the top optional benefits, in terms of total expenditures, are:
  - I/DD Community Services ($262 million)
  - Pharmacy ($147 million net of rebates)
  - Home and Community Based Services for LTSS members ($128 million)
  - Hospice ($31 million)
- However, consistent with Medicaid's Early and Periodic Screening, Diagnostic Testing (EPSDT) benefit requirement, all services for children under 21 are treated as "mandatory."

Note: If optional eligibility pathways are eliminated, members may shift to mandatory eligibility pathways. Correspondingly, expenditures for mandatory services may increase in response to the elimination of optional services.

Trends: Expenditures

Overall Medicaid expenditures have overall cost trends of 1.6% in SFY 2020 and average 2.5% over the past five fiscal years.

Total and Full Benefits Only Medicaid Expenditures
SFY 2016-2020



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	Avg Annual Growth SFY 2016-2020[1]
Annual Enrollment Growth (Full Benefits only)	4.2%	3.0%	1.3%	1.6%	2.5%

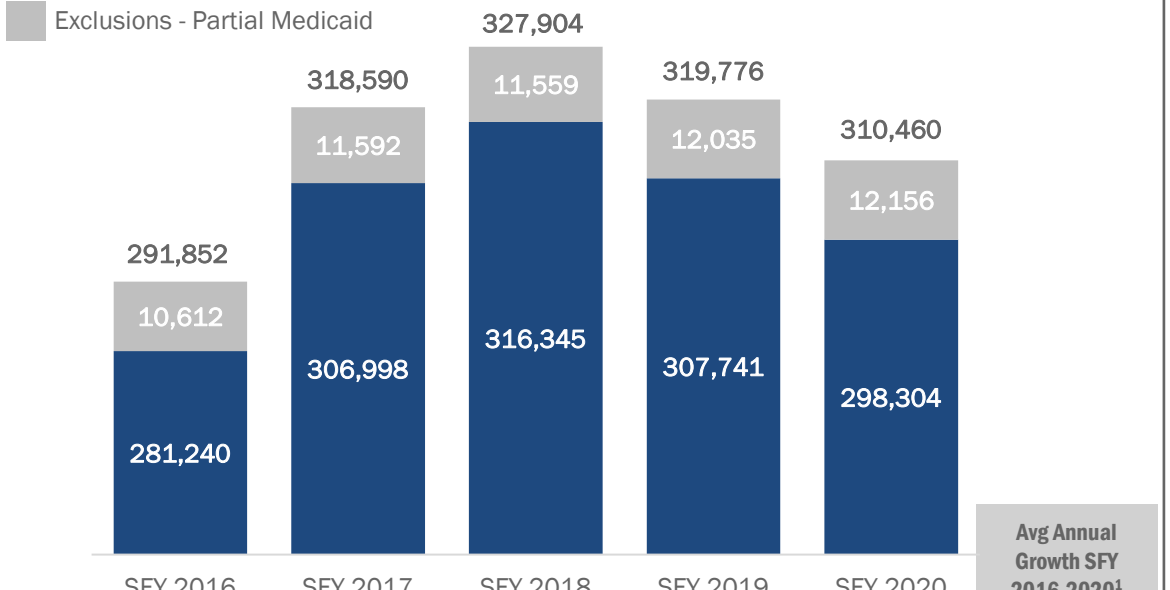
- Overall spending on benefits for fully-covered members increased by 1.6% in SFY 2020 to $2,699 million.
  - The low increase in overall spending was attributed to a 4.9 percent increase in per member costs offset by a 3.1 percent decline in average monthly enrollment over the current fiscal year.
- Compared to SFY 2019, spending on nursing and hospice fell by nearly 2.9%. Despite a temporary 10% increase to nursing home rates to offset the fiscal impact of COVID-19, expenditures decreased due to a census decline attributable to the onset of COVID-19.

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2016-2020 as shown.

Trends: Enrollment

After years of growth, average enrollment declined for the second consecutive year in SFY 2020. This decline began reversing in March 2020.

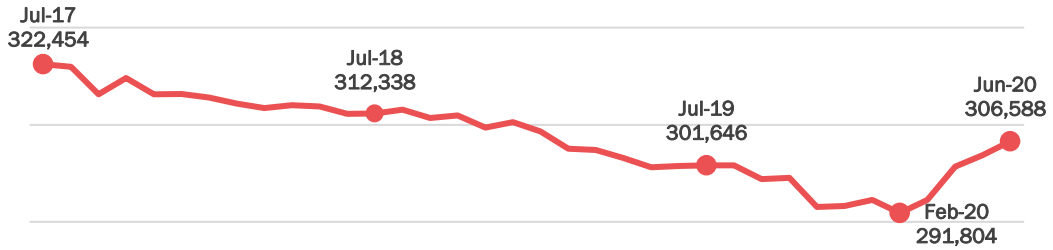
Total Medicaid Enrollment
SFY 2016-2020



					Avg Annual Growth SFY 2016-2020[1]
Annual Enrollment Growth (Full Benefits only)	9.2%	3.0%	-2.7%	-3.1%	1.5%

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2016-2020 as shown.

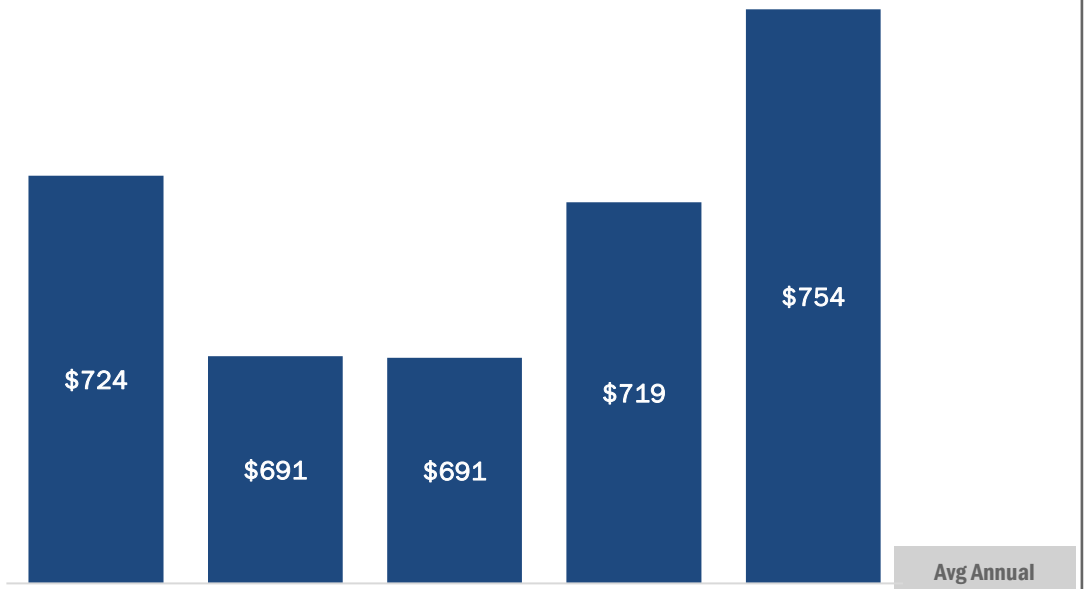
- Average monthly enrollment declined 3.1% in SFY 2020: the second consecutive year of declining caseload.
- However, the average enrollment figures understate both the pre-COVID-19 reductions and the subsequent gains that came after the declaration of a Public Health Emergency which included a moratorium on terminations that became effective March 2020:
  - As of February 2020, enrollment of Rhode Islanders with full Medicaid benefits had declined to 291,804, a reduction of 9.6% from Rhode Island's peak enrollment of 322,853 in June 2017.
  - By June 2020, enrollment of fully-covered Medicaid beneficiaries had rebounded to 306,588.
- Below is a summary of the month-over-month change in enrollment of Medicaid members with full benefits over the past three fiscal years:



Trends: PMPM

Average PMPM increased nearly 5.0% in 2020; however, average costs remained stable over the past five years.

Total Medicaid PMPM - Full Medicaid Enrollment Only
SFY 2016-2020



	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	Avg Annual Growth SFY 2016-2020[1]
Annual PMPM Change (Full Benefits only)		-4.5%	0.0%	4.1%	4.9%	1.0%

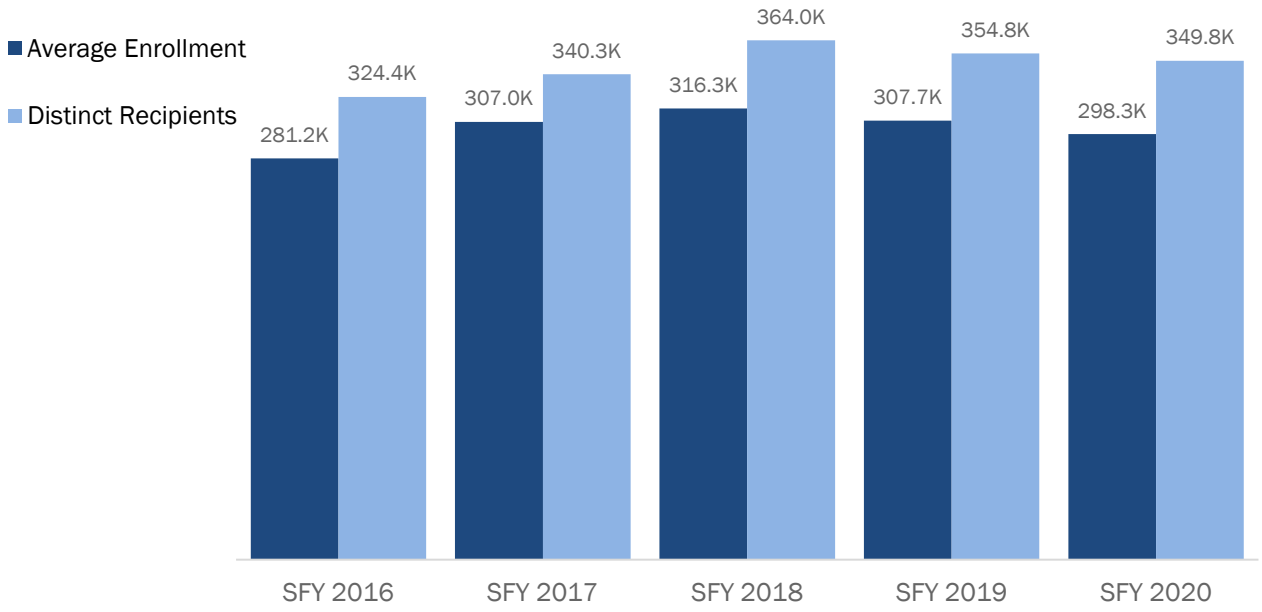
[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2016-2020 as shown.

- After declining 4.5% in SFY 2017 and experiencing no meaningful change in SFY 2018, the Medicaid PMPM trend increased to 4.1% and 4.9% in SFY 2019 and SFY 2020, respectively.
- The overall five-year PMPM trend of just 1.0% is attributed, in part, to a change in the mix of the population groups:
  - PMPMs vary significantly across populations, from $318 for Children and Families to $2,303 for Elders.
  - The average annual compounded PMPM growth rate varies over the past five years, from -1.0% for Adults with Disabilities to 2.0% for Children and Families.

Trends: Unique Recipients

Nearly one-third of Rhode Island's population was enrolled in Medicaid with full benefits for some part of SFY 2020.

Total Medicaid Enrollment, including Full Medicaid Only
SFY 2016-2020



	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Turnover Ratio	1.15	1.11	1.15	1.15	1.17
Unique Members as % of RI Population[1]	31%	32%	34%	34%	32%

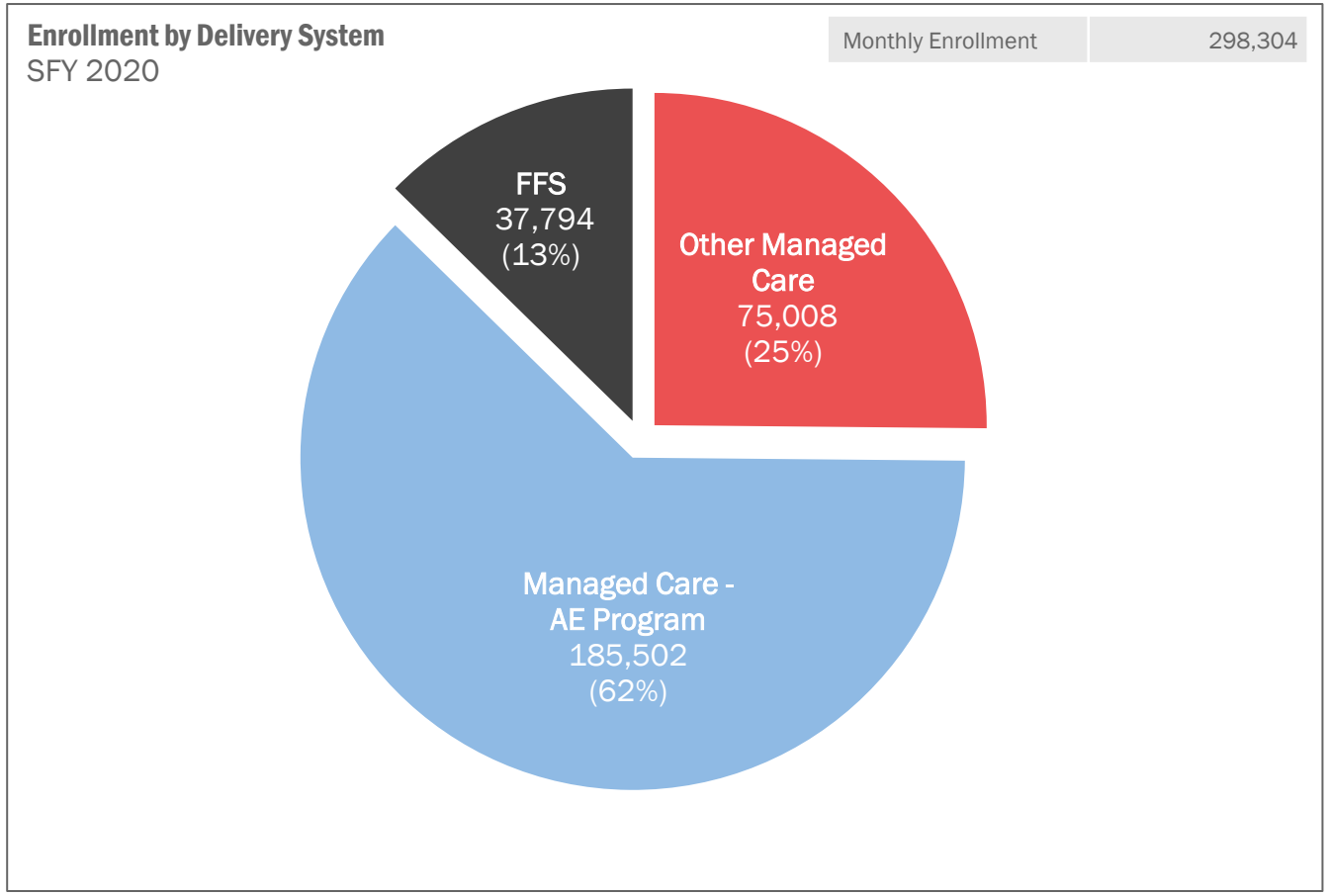
[1]Source: Population Division, US Census Bureau.

- Unique recipients is a measure of the number of individuals enrolled in Medicaid at any time during the fiscal year. Average enrollment is annual full-time equivalents or 12 months of eligibility.
- The turnover ratio compares unique recipients to average enrollment. If the number of unique recipients is equal to the average enrollment, that indicates that there is a steady population of members who remain on the program for the full year. If the number of unique recipients is above the average enrollment (i.e., a turnover ratio greater than 1), this indicates that some Rhode Islanders are using Medicaid for shorter periods of time.
- The higher turnover ratio for SFY 2020 is due to a high level of termination activity in the first half of the fiscal year associated with cleanup of outstanding termination that could not be completed previously for administrative reasons.
- In March 2020, CMS initiated a federal moratorium on termination activity that reduced this turnover ratio from what it otherwise would have been and will result in a lower turnover ratio in SFY 2021.

Programs and Provider Type

Enrollment by Program

Nearly 90% of members with full Medicaid benefits are enrolled in managed care and 60% are attributed to the Accountable Entity Program.



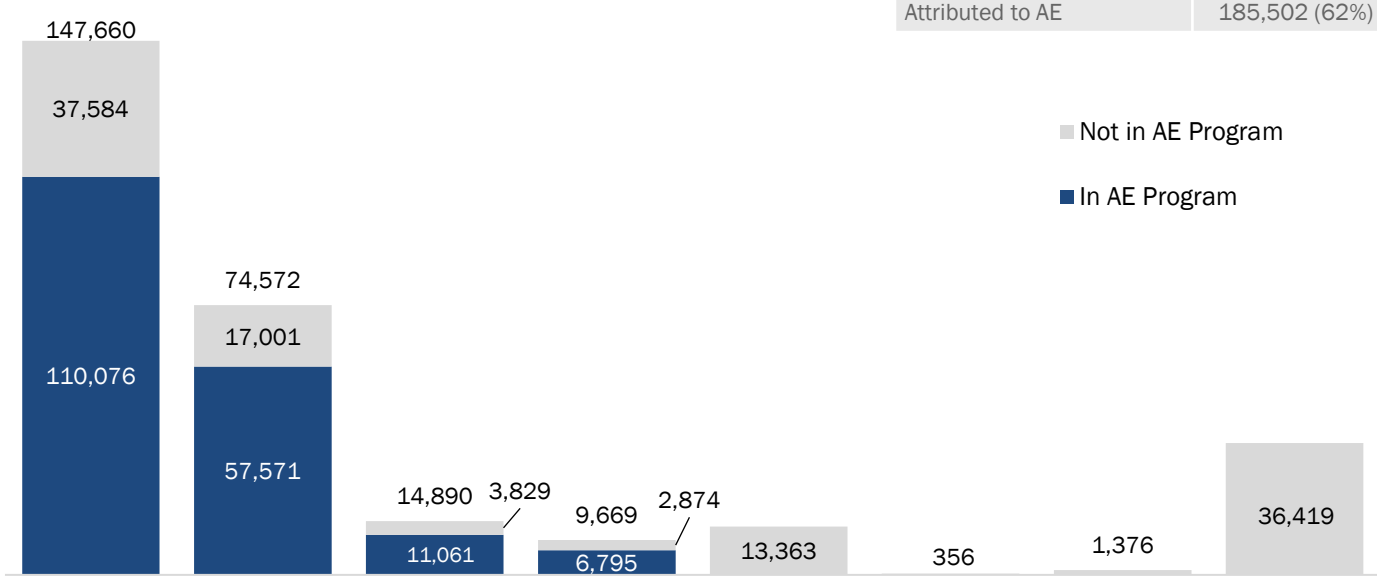
- Managed Care – AE Program: The AE Program is Rhode Island Medicaid's version of an Accountable Care Organization (ACO) in which a provider organization is accountable for quality health care, outcomes and the total cost of care for enrollees. All members in the AE program are also enrolled in an MCO. RIte Care Core and the Expansion are the two managed care programs that account for the most AE enrollees.
- Other Managed Care: In these managed care arrangements, Rhode Island pays a private insurer to provide coverage for Medicaid enrollees. This includes members enrolled in RIte Share, Program of All-Inclusive Care for the Elderly (PACE), or members enrolled with an MCO but not assigned to an AE.
- Fee-For-Service (FFS): In FFS, the state reimburses providers directly for covered services provided. Most members in FFS are in a "pre-MCO enrollment period," and later transition into Managed Care (in or out of an AE). Dual eligible Elders are the only population who do not enroll in an MCO.

Managed Care Enrollment

87% of Rhode Island Medicaid enrollees are in managed care programs. Most enrollees are in the RIte Care and Medicaid Expansion programs, but enrollees with specific health needs are treated in different programs.

Program Enrollment
SFY 2020

Total Monthly Enrollment	298,304
Enrolled in Managed Care	260,510 (87%)
Attributed to AE	185,502 (62%)



RC Core	Expansion	RHP	RC CSHCN	RHO	PACE	RIte Share	FFS
49.5%	25.0%	5.0%	3.2%	4.5%	0.1%	0.5%	12.2%

% of Enrollment – SFY 2020

1.4%	3.4%	-0.3%	1.0%	-12.3%	5.2%	-22.4%	9.2%

5-Year Compounded Annual Growth Rate – SFY 2016 - 2020

- Medicaid managed care enrollment is divided between three MCOs: Neighborhood Health Plan of RI (NHPRI), United Healthcare (UHC) and Tufts Health Plan.
- RIte Care Core (RC Core) serves children and parents. The majority of RC Core are attributed to an AE.
- Expansion is a managed care program for childless adults. The majority of Expansion are attributed to an AE. Aside from PACE, Expansion is the managed care program that has seen the most significant year-over-year growth over the past five years.
- FFS increased over this time period due to the elimination of one component of the Rhody Health Options (RHO) program. RHO Phase I was eliminated in October 2018, contributing to the increase in members in FFS over this time period.
- RHO declined over this time period because of the elimination of RHO Phase I. RHO Phase II, the CMS Demonstration, remains. it is a fully capitated managed care program for enrollees with both Medicaid and Medicare coverage.
- Rhody Health Partners (RHP) is a managed care program for Adults with Disabilities.
- RIte Share is a program designed to allow Medicaid enrollees with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium.

Expenditures by Delivery System

Most program expenditures are made through managed care programs. The remaining expenditures are for limited managed care programs, Medicare premiums, and members remaining in FFS.

Expenditures by Delivery System
SFY 2020

Total Monthly Enrollment	298,304
Total Expenditures	$2,699 M

AE-Eligible Managed Care
Enrollment: 246,790 (83%)
Expenditures: $1,574M (58%)

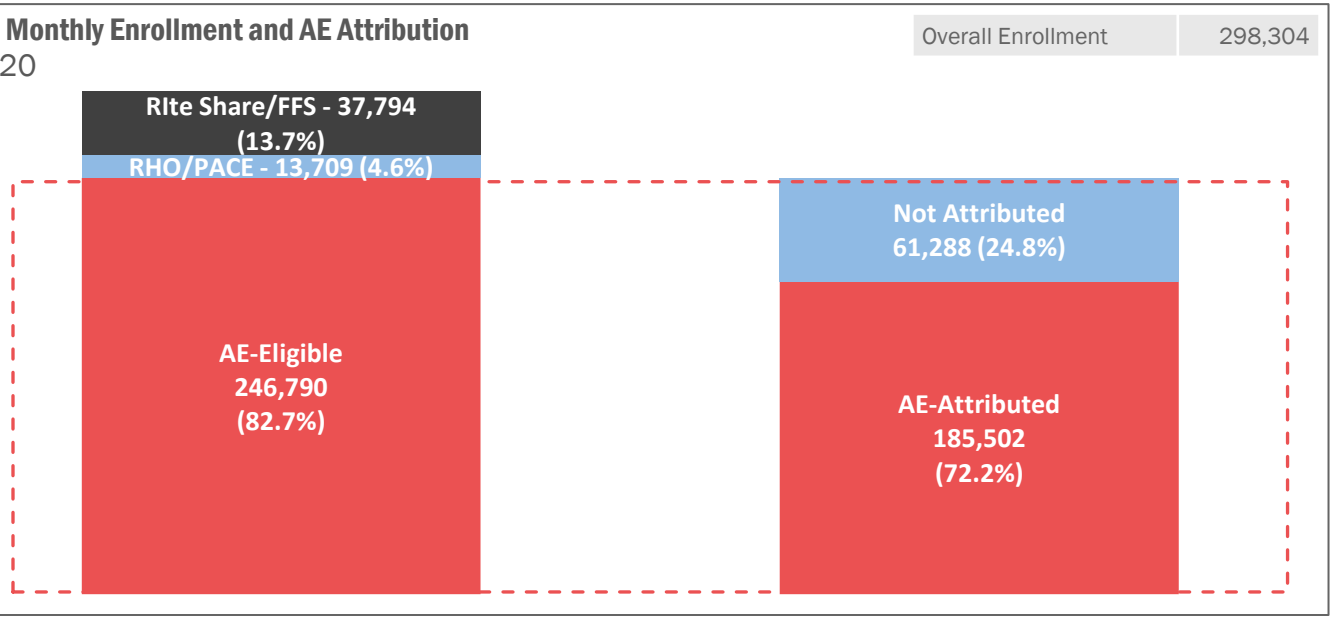
	Managed Care AE-Attributed *185,502 (62%)*	Managed Care Not Enrolled in AE *61,288 (21%)*	Managed Care RHO & PACE *13,719 (5%)*	Remaining in FFS/Rite Share *37,794 (13%)*
Major Medical Capitation *$1,464M (54%)*	$971.7M 36%	$319.5M 12%	$146.5M 5%	$26.7M 1%
Other Capitation *$170M (6%)*	$33M 1%	$11M <1%	$44M 2%	$81M 3%
FFS Expenditures *$1,065M (39%)*	$174M 6%	$64M 2%	$115M 4%	$712M 26%
Total Expenditures	$1,178.8M 44%	$394.9M 15%	$305.7M 11%	$819.6M 30%

- 88% of Medicaid's 298,304 members are enrolled in managed care programs, including RIte Care, RHP, Expansion, RHO, and PACE. Members enrolled in RIte Care, RHP and Expansion may be attributed to an Accountable Entity.
- Overall, monthly capitation (major medical and other) payments of $1.6 billion account for 59% of Medicaid expenditures. Note: Assignment to a delivery system is based on the member's last status within the year, so, some members classified as "remaining in FFS" were previously enrolled in a managed care plan and may have had capitation paid on their behalf:
  - $1.5 billion (54%) of expenditures go toward capitated medical services provided by NHPRI, UHC, and Tufts, excluding dental, non-emergency transportation, and certain carved-out benefits.
  - Other capitation payments of $170 million include Medicare Premium Payments, RIte Smiles, and Non-Emergency Transportation.
- FFS spending of $1.1 billion is primarily for members not in managed care, but also includes spending on carved out benefits such as services delivered in a Neonatal Intensive Care Unit (NICU), adult dental care, any pre-enrollment activity, as well as community-based LTSS and professional services, for BHDDH and DCYF clients

Managed Care Enrollment and AE Attribution

EOHHS' "Health System Transformation Program (HSTP)" aims to transform the Medicaid delivery system and a shift toward value-based purchasing through the Accountable Entity program.

Average Monthly Enrollment and AE Attribution
SFY 2020



Trend: AE Attribution
SFY 2016-2020

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	Avg Annual Growth SFY 2016-2020[1]
Annual Attribution Change		11.5%	12.5%	5.7%	-1.4%	6.9%

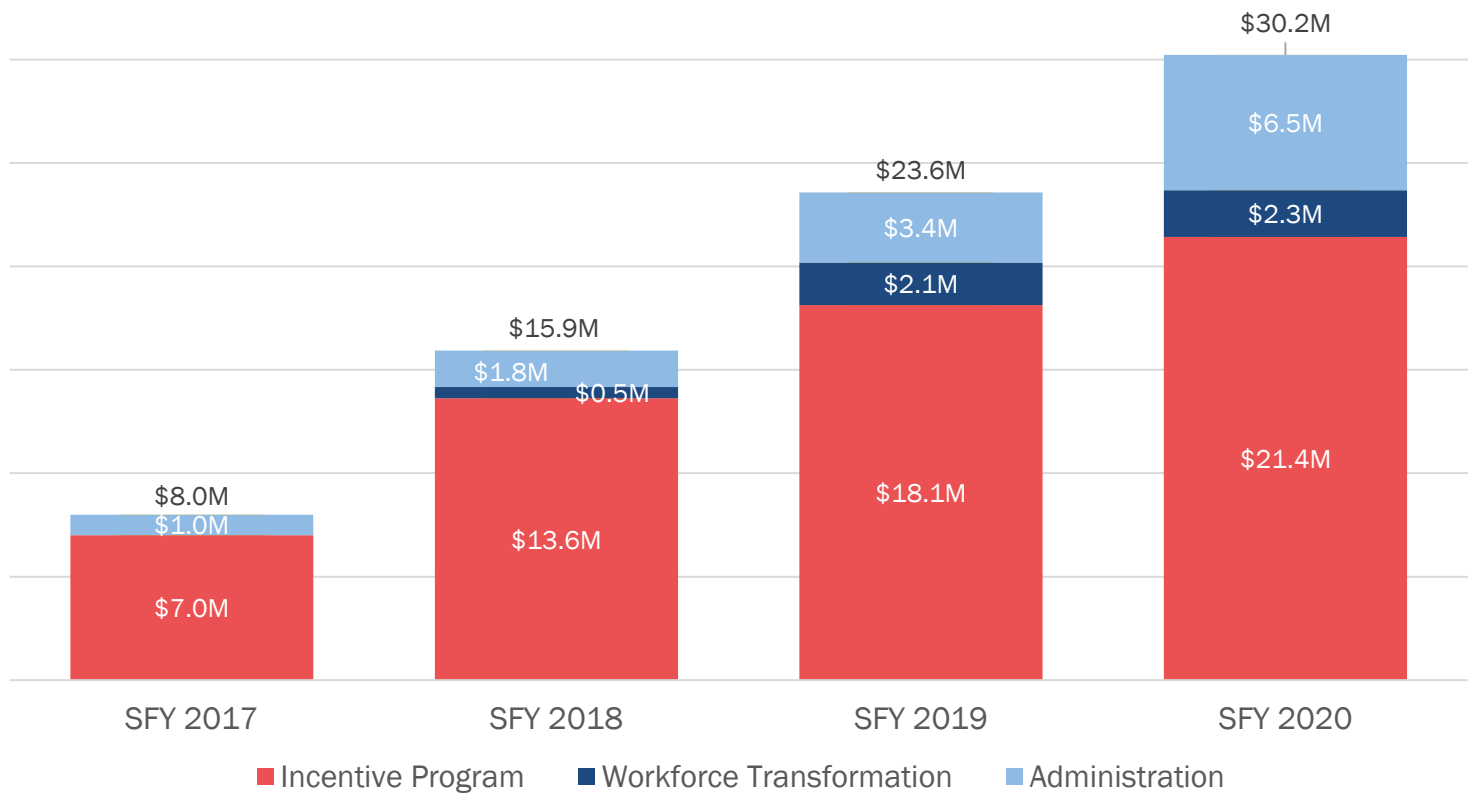
- Six AEs participated in the AE Program during the year:
  - Blackstone Valley Community Health Center
  - Coastal Medical
  - Integra Community Care Network
  - Integrated Healthcare Partners (CHC ACO)
  - Prospect Health Services RI
  - Providence Community Health Center
- AE program Incentive payments, which began in SFY 2019, are time limited payments and will be distributed for the duration of the program, which is expected to last until SFY 2024. This spending is reflected in the overall benefits expenditures on fully-covered Medicaid members.
- Incentive payments support enhancements of capabilities of participating health care providers in the areas of data and analytics, population health including a focus on social determinants, workforce planning and programming, care management, member engagement and access, quality, interdisciplinary partnerships, and leadership and management.

Health System Transformation Program (HSTP)

In October 2016, CMS approved Rhode Island's HSTP waiver amendment, bringing $115.4 million to the State for use as the state share on new investments towards the establishment of Accountable Entities

Health System Transformation Program Expenditures
SFY 2017-2020

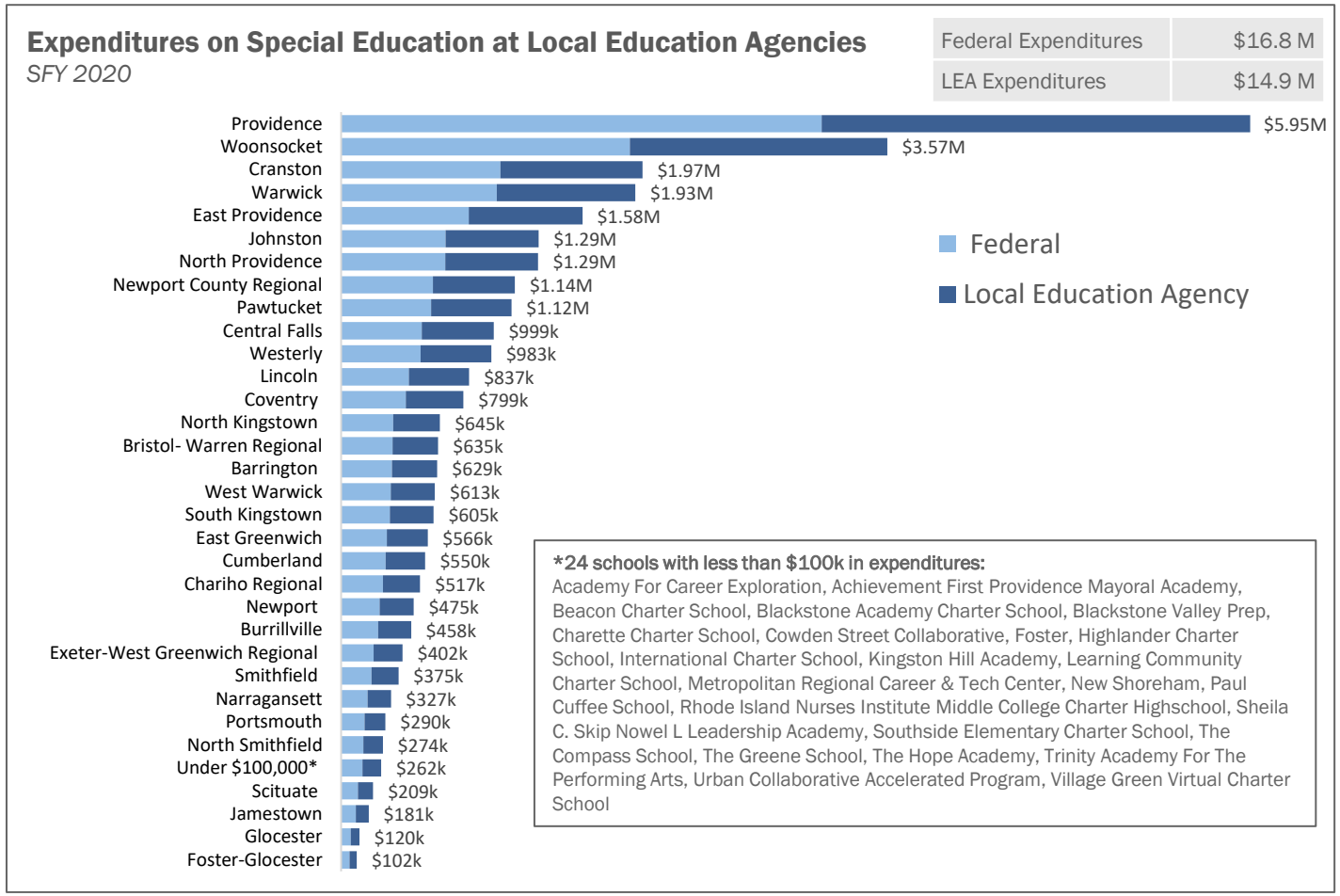
Included with Benefits (SFY 2020)	$21.4 M
Exclusions (in Central Management)	$8.8 M



- In SFY 2020, EOHHS invested $30.2 million in Rhode Island's health delivery system. Of this:
  - $21.4 million was distributed as incentive payments through the Medicaid health plans. This spending is reflected in the overall benefits expenditures on fully-covered Medicaid members.
  - $8.8 million was spent within EOHHS' central management budget for workforce development and administrative-related expenditures.
- Through SFY 2020, EOHHS has invested $77.7 million All Funds using a combination of restricted revenues accumulated by the claiming opportunities afforded by Rhode Island's HSTP waiver amendment and additional federal funds.

Special Education

Expenditures on Special Education at Local Education Agencies (LEA) receive federal matching funds for a variety of services provided to Medicaid-eligible children.



Special Education services include conducting medical assessments; providing personal aide services, speech, occupational, and physical therapies; administering first aid or prescribed injections or medication, including immunizations; and providing direct clinical/treatment services, developmental assessments, and behavioral health counseling services; among others in accordance with the Medicaid State Plan.

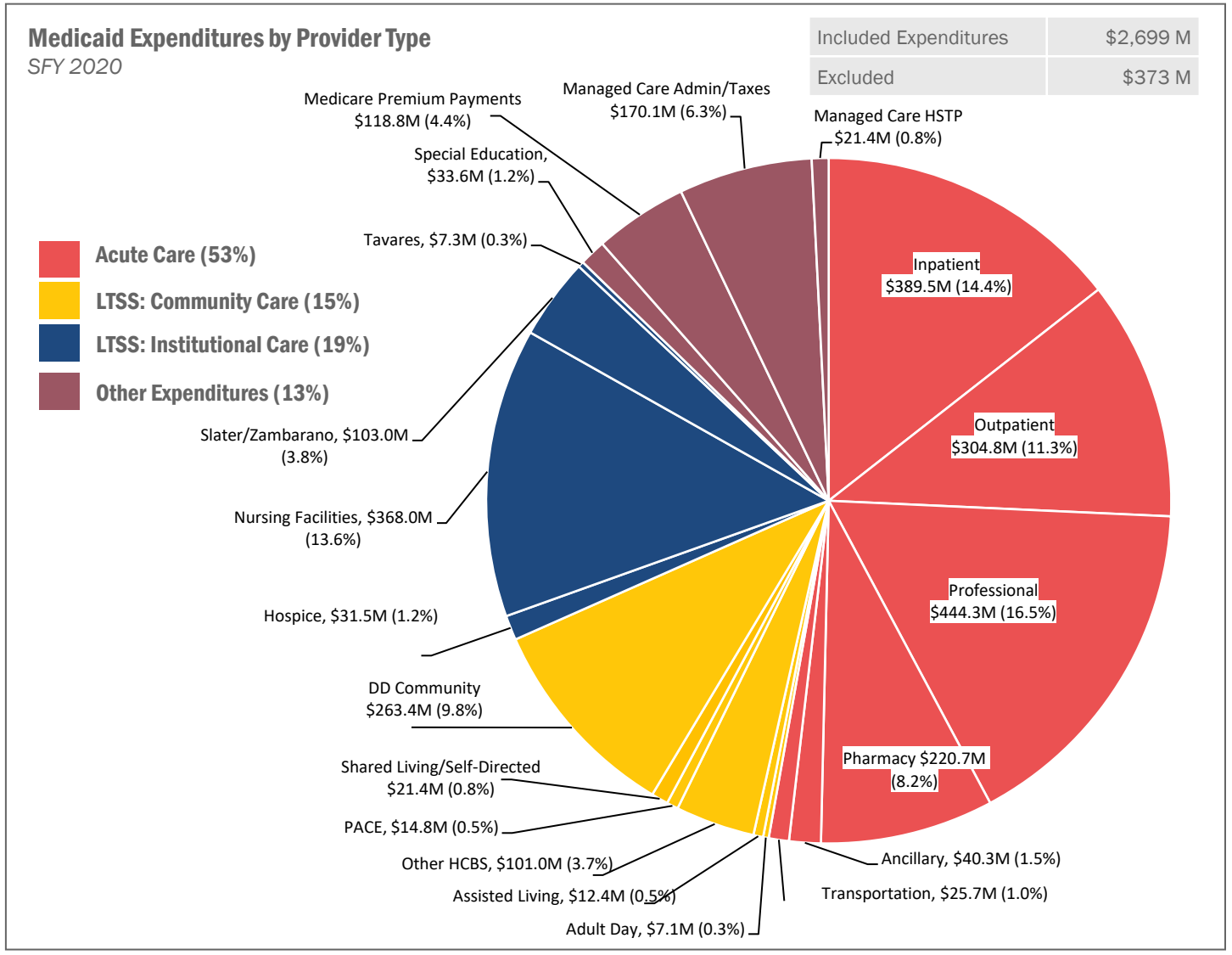
- The local education agencies finance the state share of the expenditures. Only the federal share is reflected in EOHHS' Medicaid budget.
- 56 school districts/departments received LEA payments in SFY 2019.
- LEA expenditures make up less than a tenth of excluded expenditures.

Note:

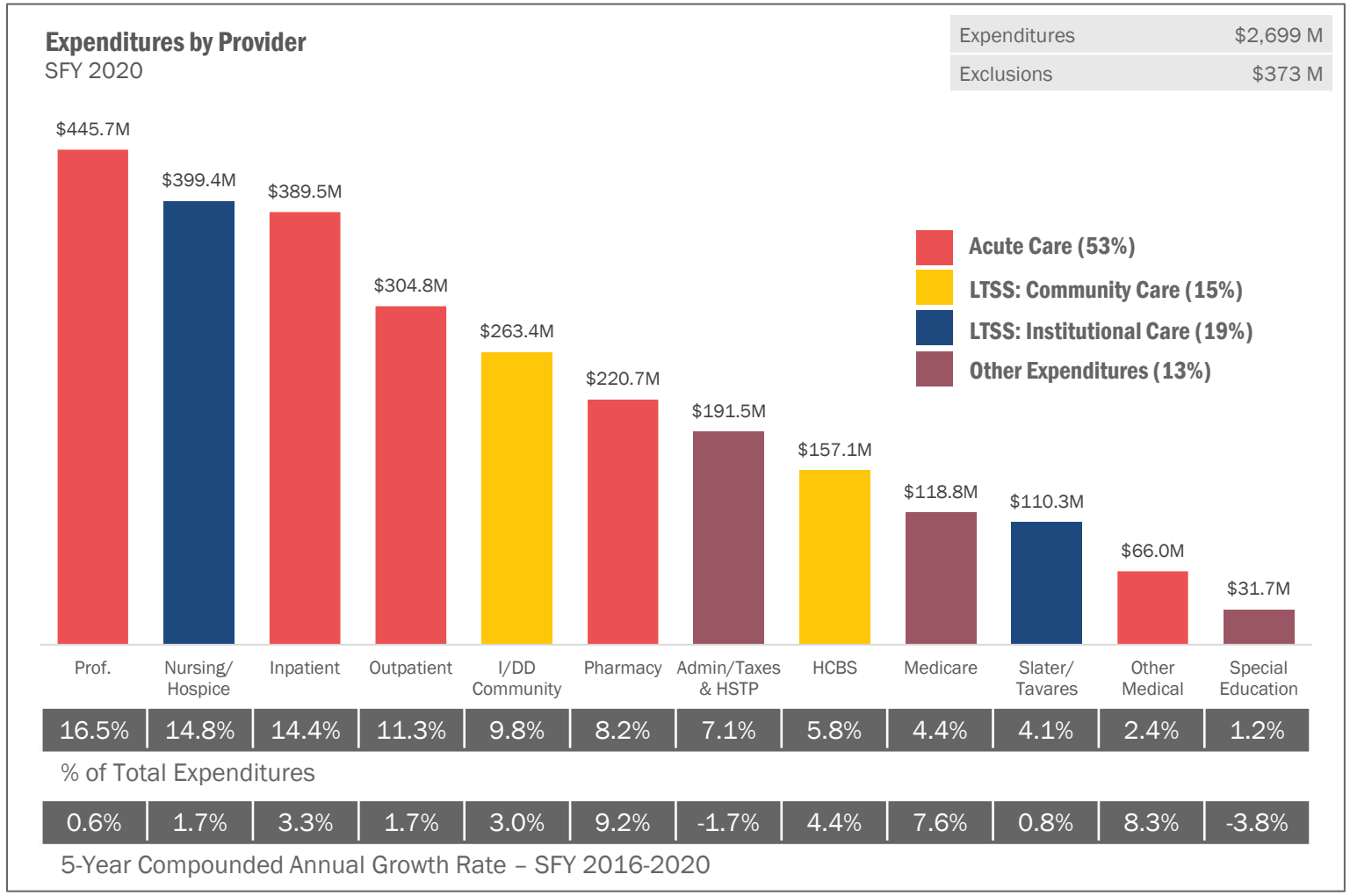
- In prior Expenditure Reports, LEA expenditures had been excluded from further analyses. However, as these expenditures are for individuals with Full Medicaid eligibility they have been included herein.
- Additionally, the local education authority share of the expenditure is imputed based on the effective FMAP rate for the fiscal year.

Expenditures by Provider Type

- **Acute services** had $1,427 million in Medicaid expenditures in SFY 2020, constituting 53% of all expenditures.
  - Pharmacy spend is net of rebates.
- **LTSS** had $930 million in Medicaid expenditures, constituting 34% of all expenditures. LTSS expenditures primarily serve the Elders and Adults with Disabilities populations. They can be placed into two categories:
  - **Institutional Care** services are provided to populations who stay in an institution. These services account for $510 million, including 55% of all LTSS expenditures and 19% of overall expenditures.
  - **Community Care** services are provided to at-risk populations as alternatives to more costly nursing facility/institutional options. These services totaling $421 million account for 45% of LTSS expenditures and 15% of all expenditures.
- **Other Expenditures** include the non-claims expenditures of Medicaid MCOs (e.g., administrative expenses and taxes) and Medicare premiums paid by EOHHS on behalf of covered enrollees. EOHHS has classified Special Education expenditures under this category.

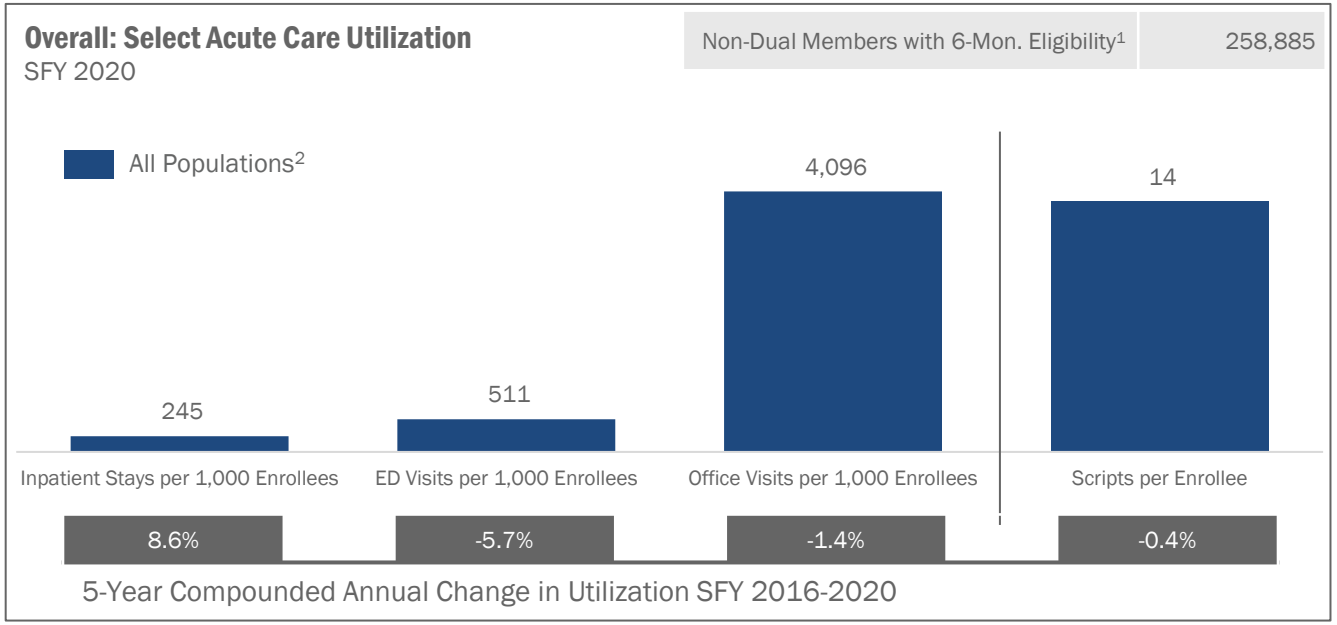


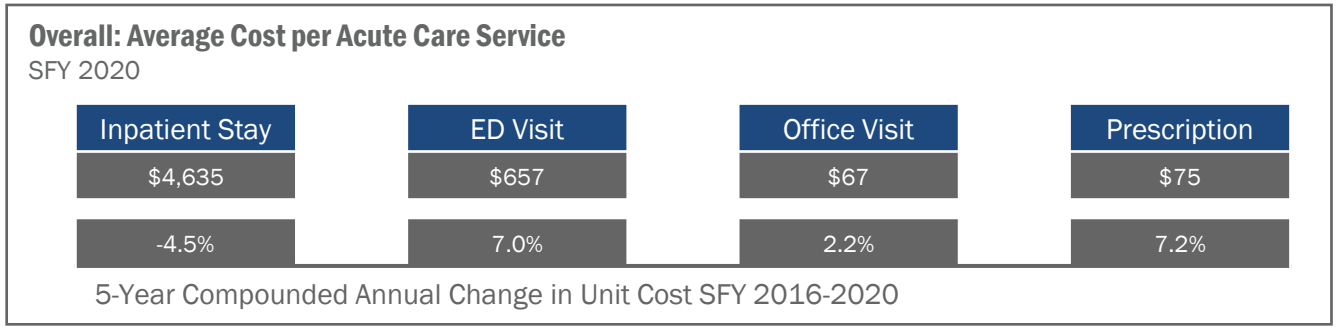
Expenditures by Provider Type (cont'd)



- This spending is net of rebates. In terms of growth rates:
  - Pharmacy expenditures over the 5-year period have grown faster than other service types as a result of both increasing costs and increasing utilization among the Expansion population.
  - A January 2022 report by Congressional Budget Office ("Prescription Drugs: Spending, Use, and Prices") suggest Rhode Island Medicaid's experience is consistent with national trends.
  - Medicare expenses have increased 7.6% over the 5-year period, but Medicaid does not control these rates.
  - Nursing facility/hospice expenditure growth can be mostly attributed growth in the Elders population.
  - MCO admin, taxes and fees have decreased by a combined $52 million since FY 2018 in part due to the termination of the RHO Phase I program.

Acute Care: Select Utilization & Costs





[1] Unduplicated enrollees includes count of Medicaid Only members with full benefits and a minimum of 6 months of eligibility.
[2] All populations include Medicaid Only members: Adults with Disabilities, Children and Families, CHSCN, and Expansion.

Acute care services comprise $1.4 billion, or 53 percent, of total Medicaid benefit spending in SFY 2020. Acute care includes inpatient, outpatient, professional, pharmacy, transportation and ancillary services (e.g., DME, prosthetics, and pathology/lab).

Select average cost and utilization metrics are presented here:

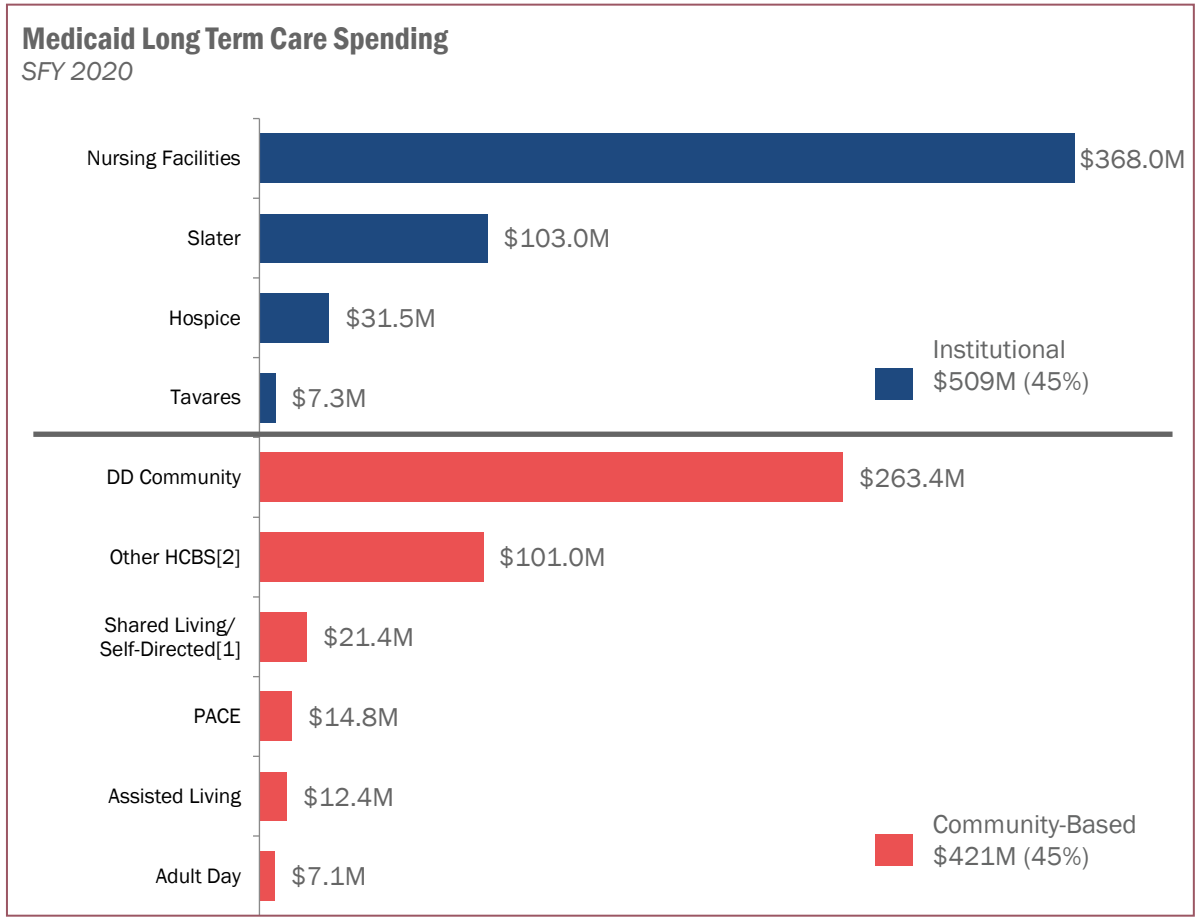
- From SFY 2016 to SFY 2020, utilization fell for ED visits, office visits, and prescriptions, with visits/scripts per enrollees falling -5.7%, -1.4%, and -0.4%, respectively.
- During this time span, costs per Emergency Department (ED) visit, office visits, and pharmacy claims experienced yearly average increases of 7.0%, 2.2% and 7.2%, respectively.
- The exception to these trends between are inpatient stays, that experienced significant increase in utilization (+8.6% annually) and a reduction in average cost per stay (-4.5%).

Data Clarification:

- The utilization and cost per unit metrics on this page are based on detailed claims data and do not include non-claims adjustments (e.g., missing data from MCOs and IBNR).
- The average cost per prescription does not include offsetting drug rebates.

LTSS Spending: Community vs Institutional

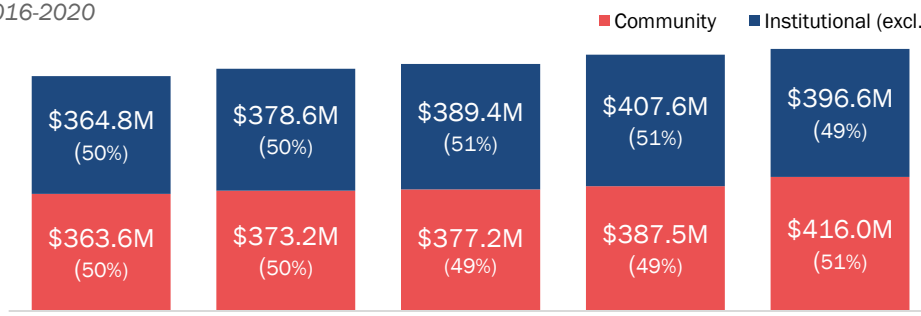
LTSS includes community care and institutional care. These services are mainly focused on the Elders and Adults with Disabilities populations.



[1] "Self-Directed" includes the Self-Directed Personal Choice and Independent Provider programs.
[2] "Other HCBS" includes personal care and severely disabled nursing homecare services; approx. $22M is for children.

- Community care services are provided to at-risk populations as alternatives to more costly institutional options. Such services include residential and rehabilitation services, including group homes and transportation costs for persons with Intellectual and Developmental Disabilities.
- Institutional care services include nursing facility services, as well as hospice care and care in the Slater Hospital (including Zambarano) as well as Tavares Pediatric Center.

LTC Spending: Institutional (excl. Slater/Tavares) vs. Community Spending [1]
SFY 2016-2020



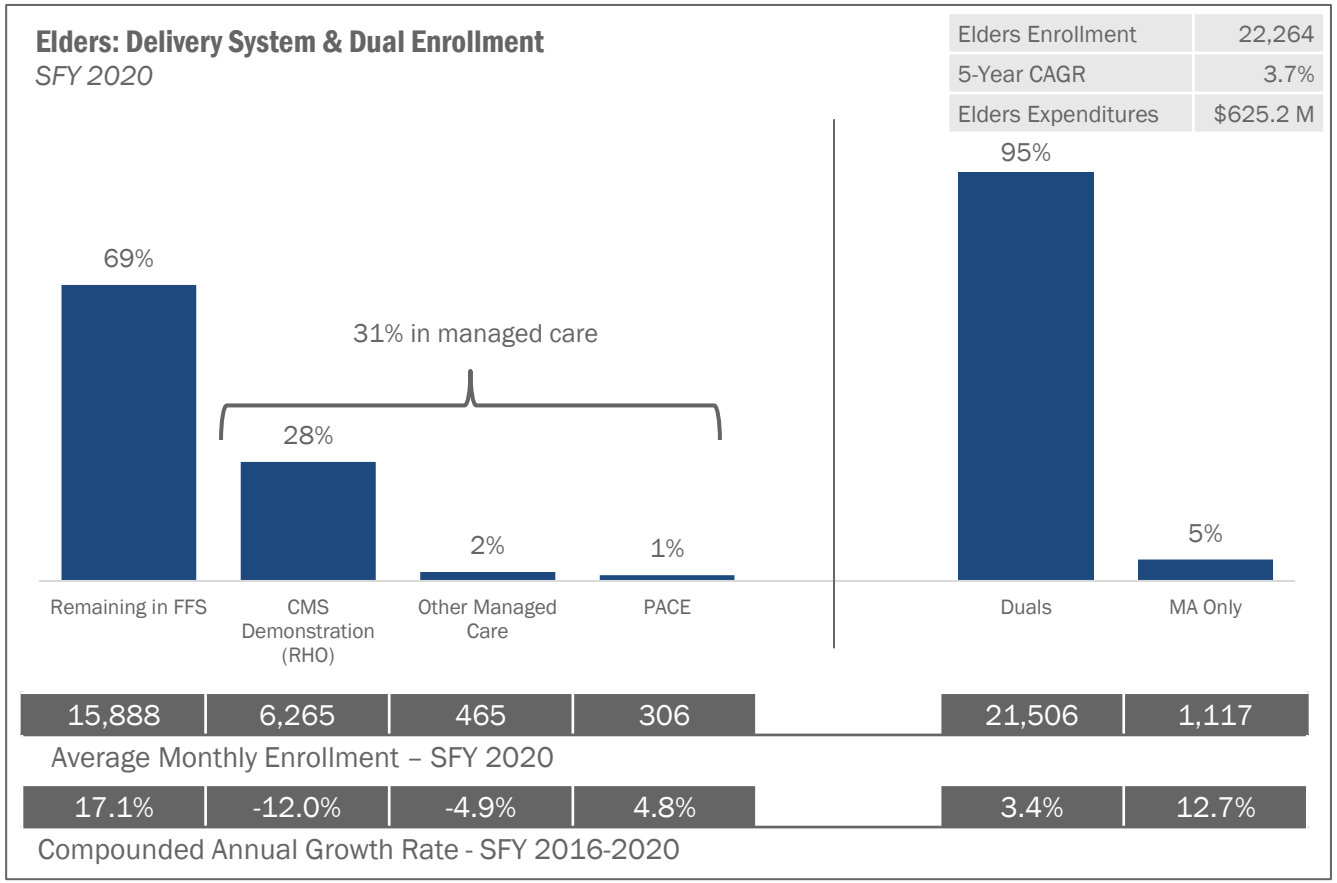
	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	Avg Annual Growth SFY 2016-2020
Annual % Change – Inst.		2.9%	2.9%	4.7%	-3.5%	**1.7%**
Annual % Change – Comm.		2.8%	1.1%	2.7%	7.5%	**3.5%**

[1] Other reporting on LTSS spending may differ based on classification of Slater/Tavares and DD Community expenditures as well as age and/or eligibility criteria

Populations

Elders: Managed Care and Dual Enrollment

Elders are the only population for which most enrollees are not enrolled in managed care. They are also one of two populations (the other being Adults With Disabilities) which may have a significant portion enrolled in Medicare.



- Compared to other population groups, elders are predominantly in FFS:
  - 69% of elders receive their Medicaid services delivered through EOHHS' fee-for-service program.
  - 28% of Elders are enrolled in the CMS Demonstration (RHO Phase II) and less than 1.5% are enrolled in PACE.
    - *Rhody Health Options Phase I ceased operation in October 2018. In SFY 2018, 60% of all Elders were enrolled in either RHO Phase I or Phase II.*
- 95% of Elders are covered by both Medicare and Medicaid (so-called "Dual Eligible" or "Duals").
  - For the Elders who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, professional, pharmacy).
  - Medicaid pays for the Medicare premiums and, in most cases, Medicare coinsurance charges on behalf of these Duals.
- 5,035 of the elders are aged 85 or older.

Elders: Expenditures by Provider Type

Most expenditures for Elders go toward long-term custodial stays in nursing facilities that are covered by Medicaid but not Medicare.

Elder Expenditures by Provider

SFY 2020

Elder Expenditures	$625.2 M
% of Total Expenditures	23.2%
Elder Enrollment	22,624
% of Total Enrollment	7.6%
Average Elder PMPM	$2,303

Nursing/ Hospice	HCBS	Medicare	I/DD Community	Slater/ Tavares	Prof.	Inpatient	Admin/Taxes & HSTP	Other Medical	Outpatient	Pharmacy	Special Education
54.9%	14.4%	10.4%	6.7%	3.3%	3.1%	2.5%	1.5%	1.5%	1.3%	0.5%	-
% of Elder Expenditures – SFY 2020											
2.2%	4.9%	9.3%	4.0%	4.2%	7.4%	1.6%	-17.3%	28.5%	1.0%	13.5%	-
Elders 5-Year CAGR – SFY 2016-2020											
85.9%	57.4%	54.6%	15.8%	18.9%	4.3%	4.0%	5.0%	14.0%	2.6%	1.3%	

Elder Spend as % of Total Expenditures, by Provider Type – SFY 2020[1]

- Medicaid expenditures on Elders totaled $625.2 million in SFY 2020, an increase of 3.2% since SFY 2016.
- Nursing facility expenditures totaled $315.4 million for this population and hospice expenditures totaled $27.9 million.

Notes:

- Most Elders are eligible for Medicare, which is the primary payer for most of their acute medical services (e.g., hospital, professional). Such acute care expenditures are not paid by Medicaid and are therefore not included here.
- Most premiums for this population are Medicare premiums, which Medicaid pays for those who are dual eligible.

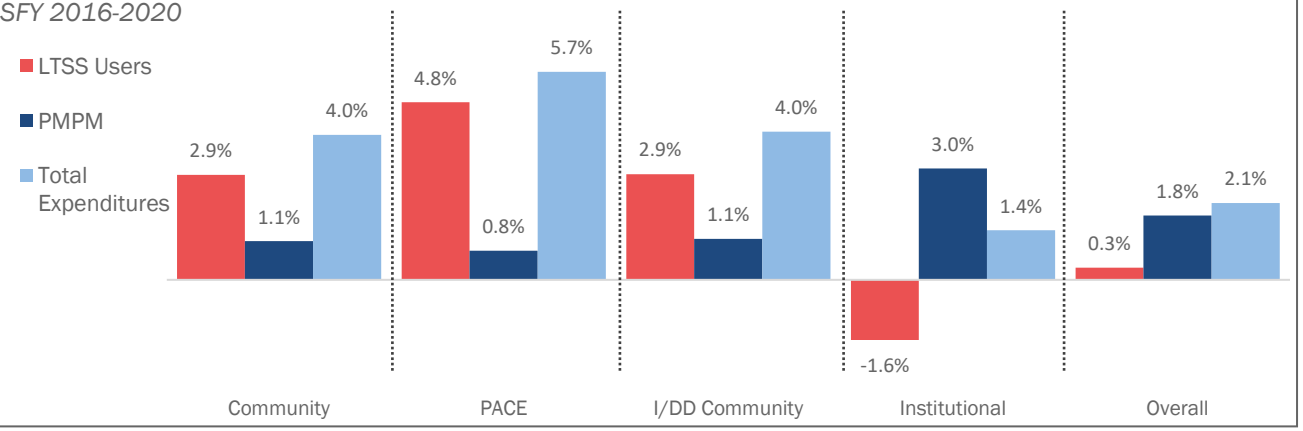
[1] Table shows this population's spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Elders: LTSS Users and Spending on LTSS

Current LTSS Expenditures
SFY 2020

	Community	PACE	I/DD Community	Institutional[4]	Overall LTSS
LTSS Users[1]	3,432	306	411	4,997	9,146
LTSS PMPM[2]	$1,845	$3,593	$8,449	$5,578	$4,241
LTSS Spend[2]	$76.0M	$13.2M	$41.7M	$334.5M	$465.4M

Expenditures - 5-Year Trends
SFY 2016-2020



[1] LTSS users reflects members with an LTSS authorization and at least $1,000 in claims in the fiscal year
[2] Spending represents LTSS services costs only. except for PACE that includes full capitation.
[3] Community authorizations include those with Preventive Only coverage that have lower LTSS utilization.
[3] Institutional includes nursing facilities and hospice users only. Does not include Slater Hospital users.

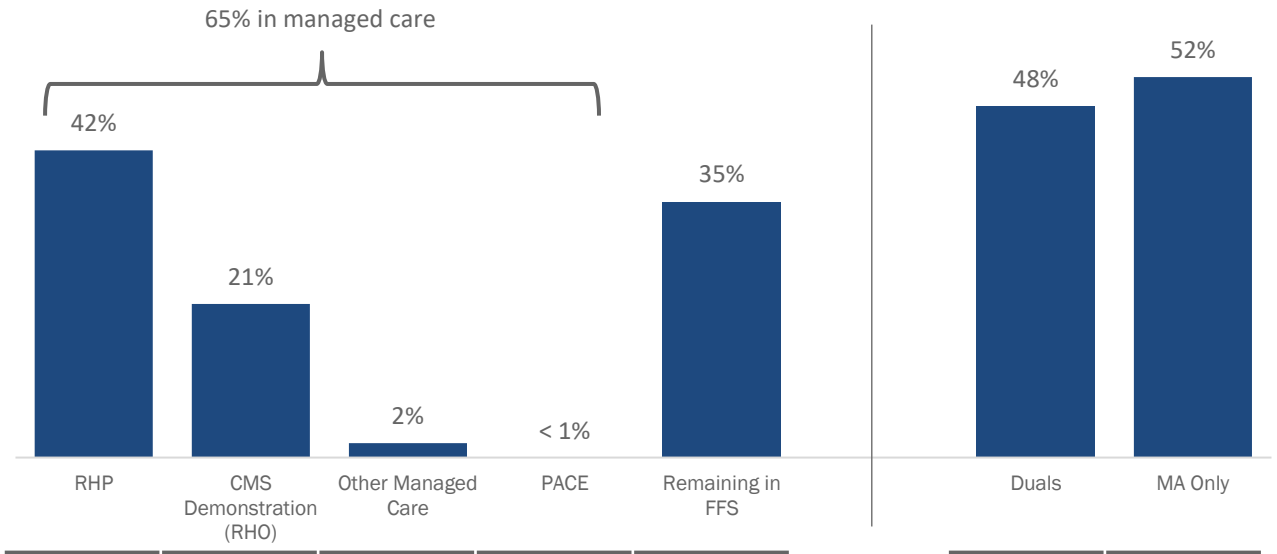
- There is currently a state initiative to "rebalance" LTSS expenditures back into the community instead of institutions. Providing services in this setting can integrate efforts with communities and enable LTSS enrollees to thrive in them, but in many instances an institutional setting is required to fulfill patient needs.
- Overall, expenditures rose by $37.1 million over the 5-year period. This increase is driven by Institutional expenses, which increased by $17.5 million over the 5-year span.
  - Overall expenditures are driven by 54.9% of elders in Nursing/Hospice, 14.4% in HCBS and 10.4% in a dual Medicaid-Medicare setting.
- Enrollment for elders in nursing home decreased by 7.9%, while enrollment for elders in HCBS increased by 16% from SFY 2016 to SFY 2020.
- Overall PMPM increased by $286 over the 5-year period. The Institutional PMPM increased by $630 or 11%, while the PACE and Community PMPM rates increased by $112 and $76, or 3% and 4%, respectively.

Adults with Disabilities: Managed Care and Dual Enrollment

Most Adults with Disabilities are enrolled in managed care programs, but a lower proportion are enrolled than all other populations except Elders. Adults with Disabilities are also one of two populations who have a significant number of Duals; approximately half of this population is enrolled in Medicare.

Adults with Disabilities: Delivery System & Dual Enrollment
SFY 2020

Disabled Adult Enrollment	31,210
5-Year CAGR	-1.0%



RHP	CMS Demonstration (RHO)	Other Managed Care	PACE	Remaining in FFS	Duals	MA Only
8,083	14,134	7,913	1,252	854	15,483	16,752

Average Monthly Enrollees – SFY 2020

-0.1%	-12.8%	30.6%	5.3%	12.0%	-1.3%	-0.7%

Compounded Annual Growth Rate SFY 2016-2020

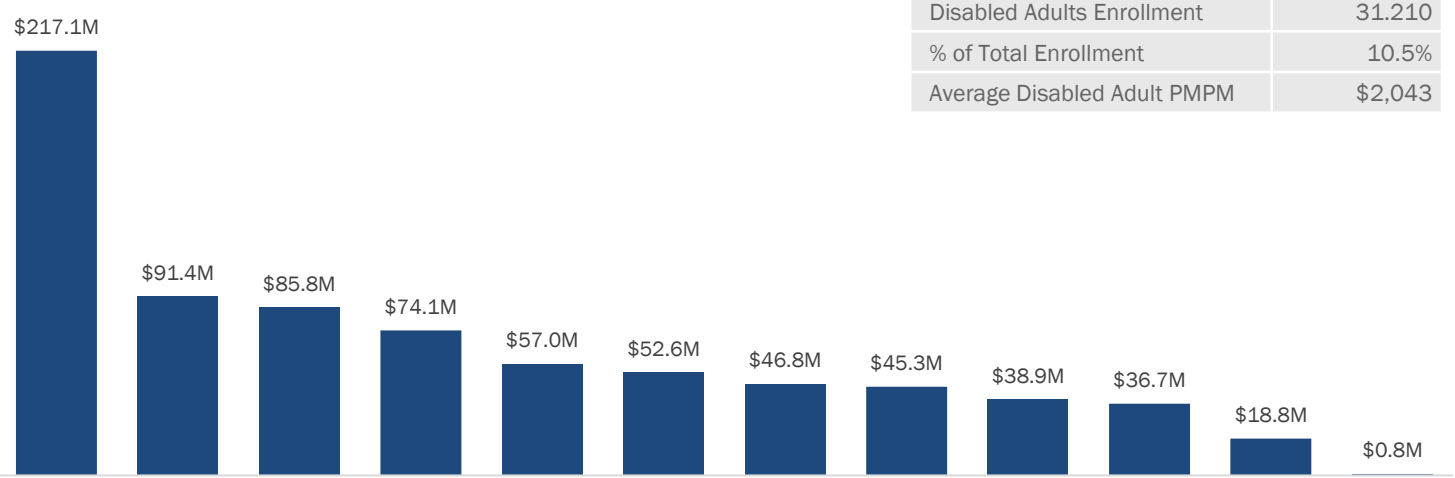
- 42% percent of Adults with Disabilities are enrolled in RHP, a comprehensive managed care program for Adults with Disabilities.
- 48% of Adults with Disabilities are dual eligible.
  - 21% of Adults with Disabilities are enrolled in CMS Dual Demonstration (RHO II).
  - 35% of Adults with Disabilities are not enrolled in managed care and are instead in FFS.
    - Most of the FFS members are dual eligible and are not subject to mandatory enrollment.
    - Medicaid-only members will remain in FFS for only an interim period prior to enrollment in RHP.
- FFS increased over this time period due to the elimination of one component of the Rhody Health Options (RHO) program. RHO Phase I was eliminated in October 2018, contributing to the increase in members in FFS over this time period. CMS Demonstration (RHO II) is a managed care programs for LTSS and other Medicaid-funded services designed for individuals with both Medicaid and Medicare eligibility. RHO II, also known as “RHO Integrity”, began in July 2016 and remains in effect.

Adults with Disabilities: Expenditures by Provider Type

Most expenditures on behalf of Adults with Disabilities are for I/DD community services, including public and private group homes, funded by BHDDH appropriations.

Adults with Disabilities Expenditures by Provider
SFY 2020

Disabled Adults Expenditures	$765.3 M
% of Total Expenditures	28.4%
Disabled Adults Enrollment	31.210
% of Total Enrollment	10.5%
Average Disabled Adult PMPM	$2,043



I/DD Community	Prof.	Inpatient	Slater/ Tavares	Pharmacy	Outpatient	Nursing/ Hospice	Medicare	HCBS	Admin/Taxes & HSTP	Other Medical	Special Education
28.4%	11.9%	11.2%	9.7%	7.4%	6.9%	6.1%	5.9%	5.1%	4.8%	2.5%	0.1%
% of Disabled Adults Expenditures – SFY 2020											
2.2%	0.1%	0.0%	-3.4%	4.4%	-1.9%	1.2%	4.4%	0.1%	-6.3%	9.4%	-
Disabled Adults 5-Year CAGR – SFY 2016-2020											
82.5%	20.5%	22.0%	67.2%	25.8%	17.3%	11.7%	38.1%	24.8%	19.1%	28.5%	2.5%
Disabled Adult Spend as % of Total Expenditures, by Provider Type – SFY 2020											

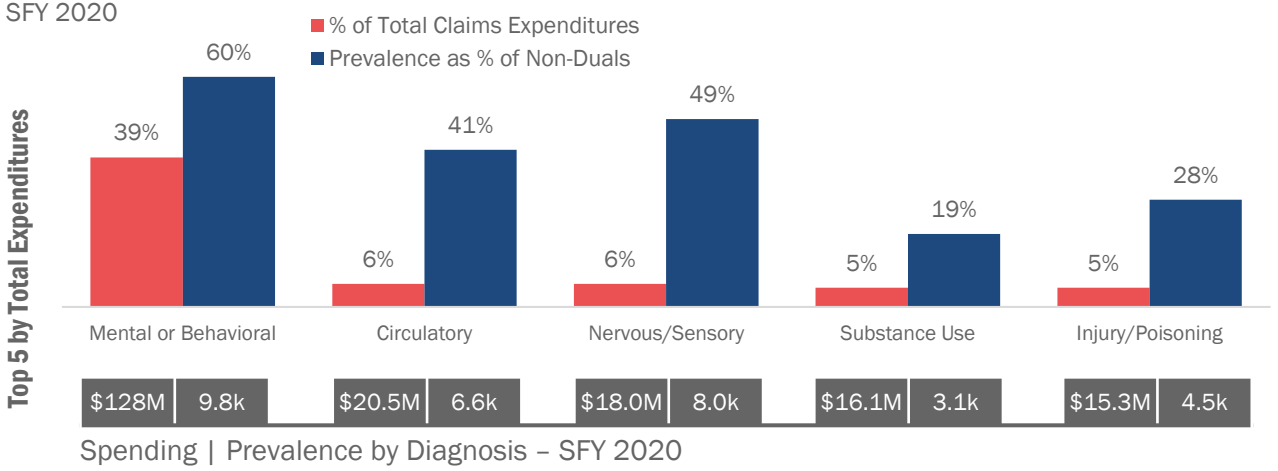
- Over the past two years, Adults with Disabilities have had the lowest overall expenditure and PMPM growth rates of any population.
- The highest trend rates for Adults with Disabilities are pharmacy, premiums, inpatient and nursing facility/hospice; growth rates for these services are similar to the overall population.
- Total expenditures for Adults with Disabilities have grown at 1.4% over the last two years, the lowest trend rate of any of our populations.

[1] Table shows this population's spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

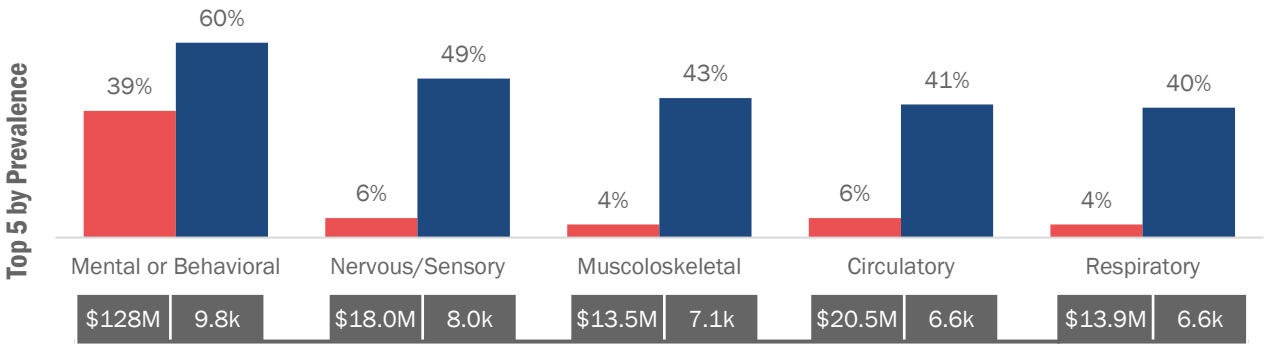
Adults with Disabilities: Diagnoses

Adults with Disabilities – Spending and Prevalence by Diagnosis
SFY 2020

Non-Dual Adults with Disabilities with 6-Mon.	16,333



Spending | Prevalence by Diagnosis – SFY 2020



Spending | Prevalence by Diagnosis – SFY 2020

Most expenditures on Adults with Disabilities go toward services for Intellectually and Developmentally Disabled enrollees.

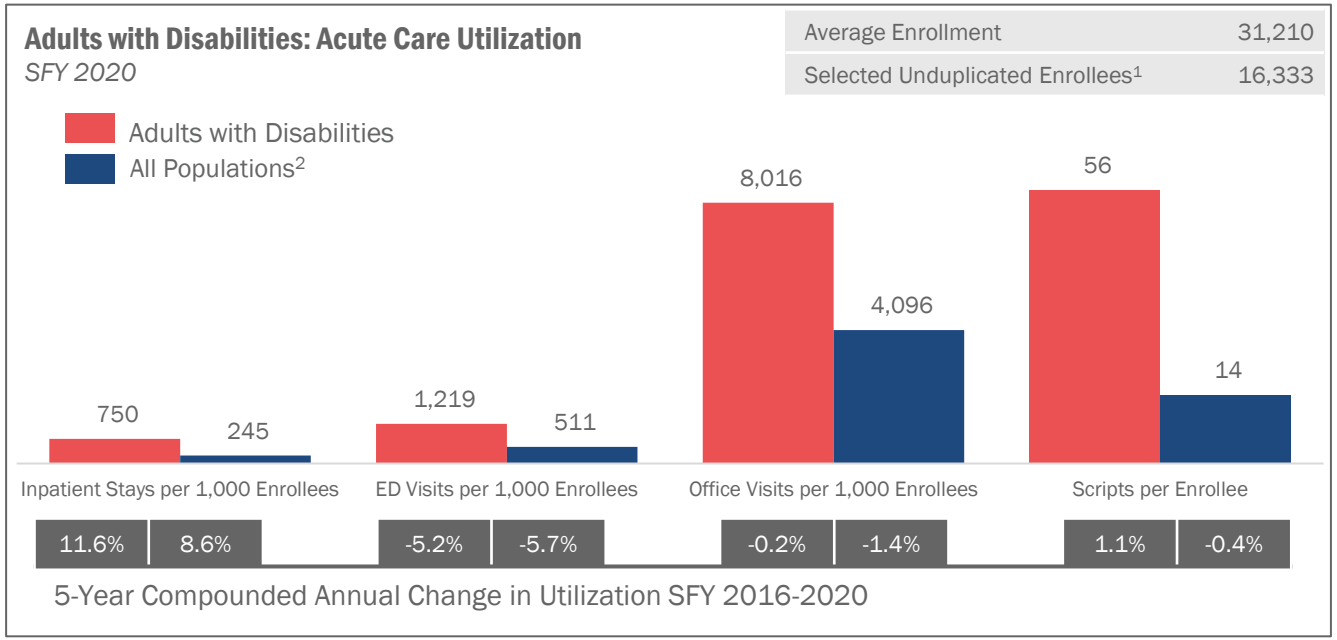
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental and behavioral conditions are both the highest cost and most prevalent conditions among Adults with Disabilities. As with the overall population, this is the only diagnosis which exceeds 10% of both total cost and prevalence.
- Diseases of the nervous system and sense organs, musculoskeletal system, circulatory system, and endocrine, nutrition, and metabolic diseases and immunity disorders are most prevalent among this population, like the general Medicaid population.

An example of how to interpret the chart to the left:

- 60% "prevalence as a % of non-duals" means that among members within the Adults with Disabilities population that have at least 6 months of enrollment during the year, 60% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 39% of costs were for claims where “mental or behavioral health" was the primary diagnosis.

Adults with Disabilities: Acute Care Utilization

Adults with Disabilities on average utilize all service types more frequently than average enrollees.



- Although per-person utilization levels are higher for Adults with Disabilities than the overall population, their growth trends are lower than the overall population.
- Adults with Disabilities spent an average of 3.7 days in the hospital in SFY 2019, whereas the average Medicaid enrollee spent only 1.1 days.
- Per-person inpatient utilization increased 1.2% for Adults with Disabilities from SFY 2017 to SFY 2019; but increased 8.1% for the overall population.
- The average Adult with Disabilities had 56 pharmacy claims per year, whereas the average enrollee had 15 pharmacy claims per year.

Adults with Disabilities: Average Cost per Acute Care Service
SFY 2020

	Inpatient Stay	ED Visit	Office Visit	Script
Adults with Disabilities	$6,034	$770	$66	$92
Overall	$4,635	$657	$67	$75

[1] Unduplicated enrollees includes count of Medicaid Only members with a minimum of six months of eligibility.
[2] All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.

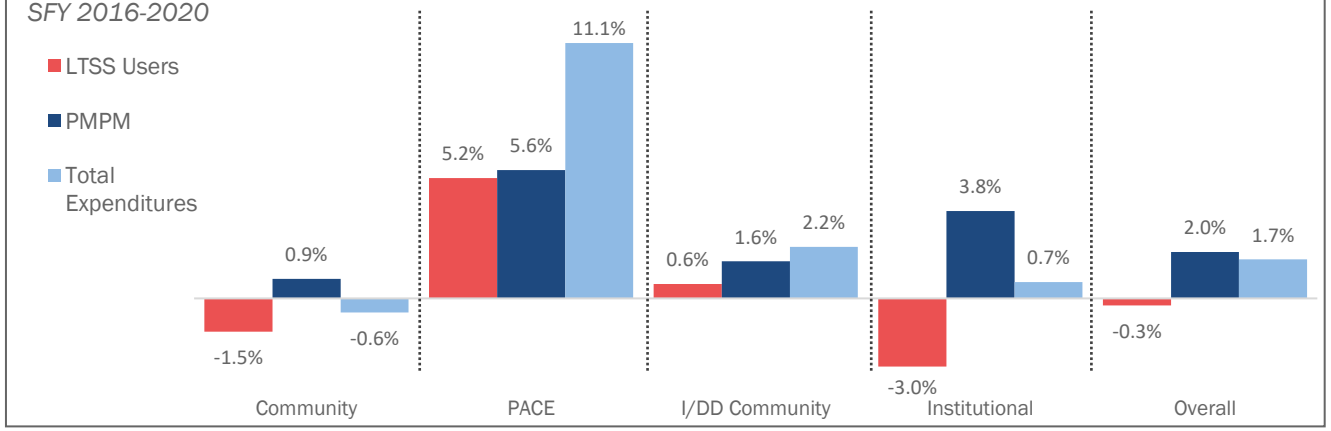
Adults with Disabilities: LTSS Users and Spending

Current LTSS Expenditures
SFY 2020

Disabled Enrollment	31,210
Overall Disabled PMPM	$2,043
Total Disabled Expenditures	$765.3 M

	Community	PACE	I/DD Community	Institutional[4]	Overall LTSS
LTSS Users[1]	1,575	47	3,523	571	5,716
LTSS PMPM[2]	$1,949	$4,265	$5,137	$6,777	$4,415
LTSS Spend[2]	$36.8M	$2.4M	$217.1M	$46.4M	$302.8M

Expenditures - 5-Year Trends
SFY 2016-2020

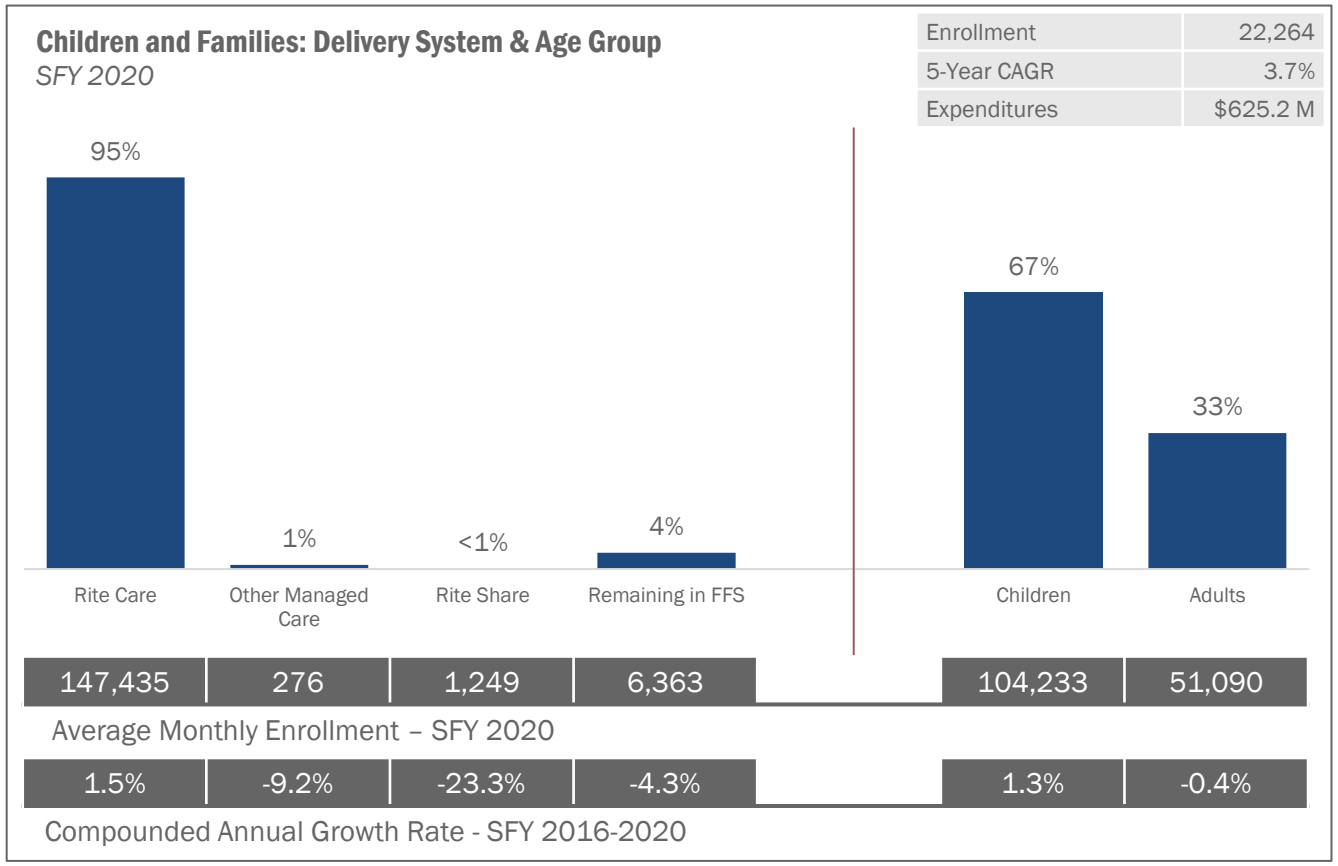


- There is currently a state initiative to "rebalance" LTSS expenditures towards the community instead of institutions with a focus on person-centered choice. Providing services in the community can enable LTSS enrollees to thrive. In many instances an institutional setting is required to fulfill patient needs.
- Aligned with this initiative, enrollment for adults with disabilities in institutional care decreased by 3% from SFY 2016 to SFY 2020, while enrollment for I/DD Community users increased 0.6%.
- Overall expenditures rose by $19.6 million from SFY 2016 to 2020: with most of this increase in I/DD Community care (which rose by $18.5 million while institutional care rose by only $1.3 million).
- Overall PMPM increased by $339 over the 5-year period. The Community PMPM increased by $65 or 3%, while the PACE and Institutional PMPM rates increased by $835 and $939, or 24% and 16%, respectively.

[1] LTSS users reflects members with an LTSS authorization and at least $1,000 in claims in the fiscal year.
[2] Spending represents LTSS service costs only. Costs not adjusted for allocations of missing data/admin; except PACE that includes full capitation.
[3] Community authorizations includes those with Preventive Only coverage that have lower LTSS utilization.
[3] Institutional includes nursing facilities and hospice users only. Does not include Slater Hospital users.

Children and Families: Managed Care Enrollment

The Children and Families population is primarily enrolled in the RIte Care managed care program.



- 95% of the Children and Families population is enrolled in RIte Care Core, a managed care program for families with children, pregnant women and children under age 19.
- RIte Care enrollees are divided between Neighborhood Health Plan of RI, United Healthcare of New England, and Tufts Health Plan.
  - 64% are covered by NHPRI, 33% are covered by UHC, and 3% are covered by Tufts.
- RIte Share is a program designed to allow Medicaid enrollees with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium and any out-of-pocket expenditures. This minimizes Medicaid expenditures by leveraging the employer's contribution.
- The members remaining in FFS are those with access to other insurance and/or newly enrolled members during the period prior to enrollment in RIte Care.
- "Other Managed Care" includes members who for a portion of the year were enrolled in RHP or Expansion.

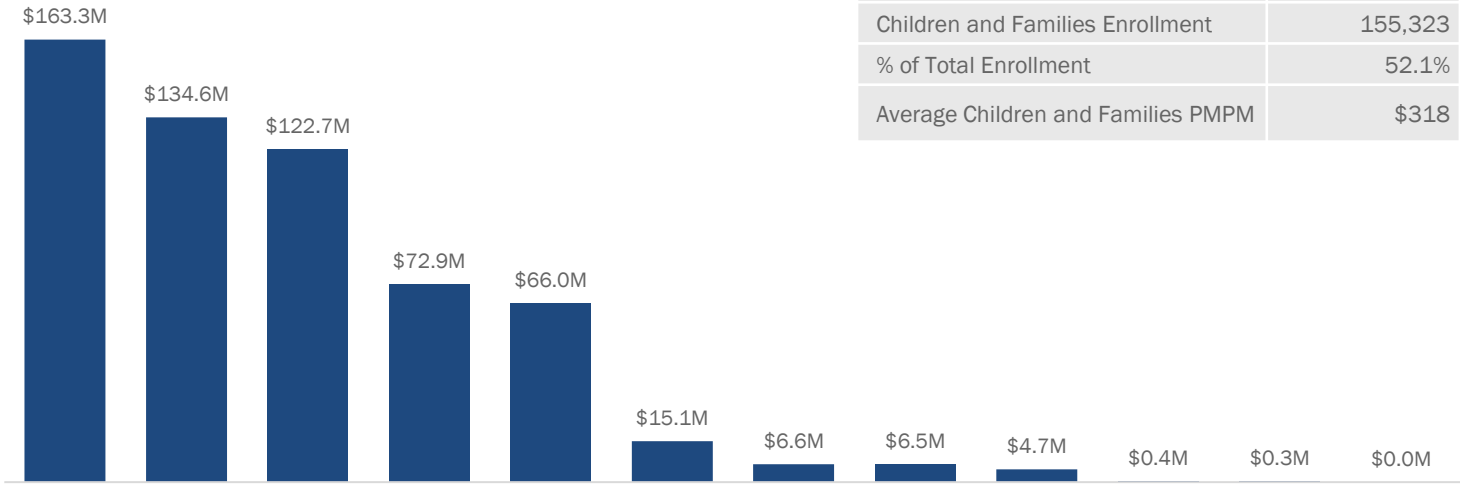
Children and Families: Expenditures by Provider Type

Most expenditures for the Children and Families population go toward professional services and hospital services.

Children and Families Expenditures by Provider

SFY 2020

Children and Families Expenditures	$593.1 M
% of Total Expenditures	22.0%
Children and Families Enrollment	155,323
% of Total Enrollment	52.1%
Average Children and Families PMPM	$318



Prof.	Outpatient	Inpatient	Admin/Taxes & HSTP	Pharmacy	Other Medical	HCBS	Special Education	Medicare	Slater/ Tavares	Nursing/ Hospice	I/DD Community
28%	23%	21%	12%	11%	3%	1%	1%	1%	<1%	<1%	-

% of Children and Families Expenditures – SFY 2020

Prof.	Outpatient	Inpatient	Admin/Taxes & HSTP	Pharmacy	Other Medical	HCBS	Special Education	Medicare	Slater/ Tavares	Nursing/ Hospice	I/DD Community
-0.3%	3.4%	2.8%	1.4%	11.0%	3.6%	17.8%	-2.4%	26.6%	-	-6.3%	-

Children and Families 5-Year CAGR – SFY 2016-2020

Prof.	Outpatient	Inpatient	Admin/Taxes & HSTP	Pharmacy	Other Medical	HCBS	Special Education	Medicare	Slater/ Tavares	Nursing/ Hospice	I/DD Community
37%	44%	32%	38%	30%	23%	4%	21%	4%	<1%	<1%	-

Children and Families Spend as % of Total Expenditures, by Provider Type – SFY 2020

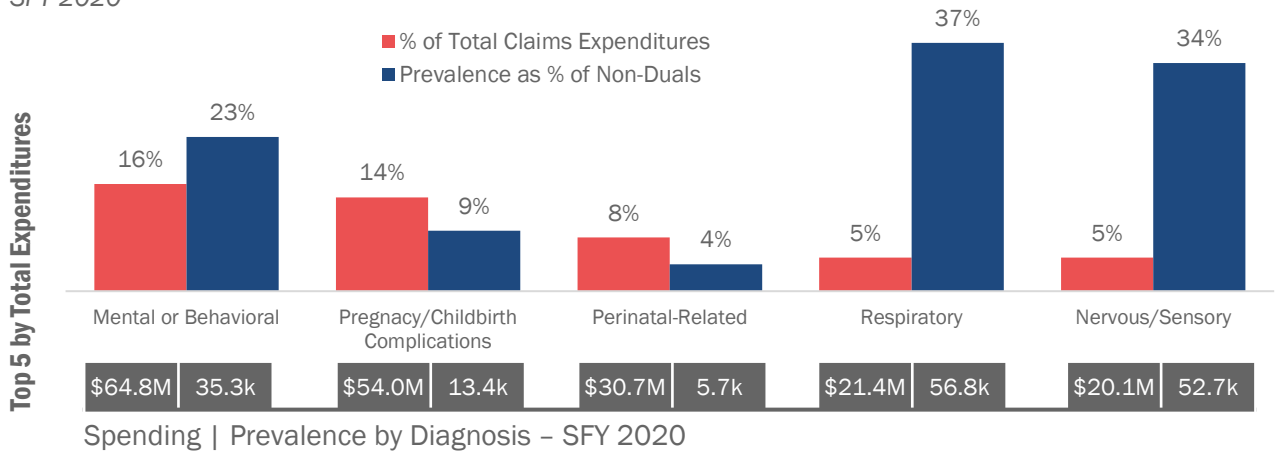
- Children and Families is the largest population group in Rhode Island Medicaid, with 52.1% of all Medicaid enrollees falling into this category.
- Children and Families have the lowest per-person expenditures of any of the populations.
- Professional services and hospital services (outpatient and inpatient) account for 72% ($420.4M) of the expenditures for the Children and Families population in SFY 2020.
- The fastest-growing expenditures for Children and Families are Medicare, HCBS, and Pharmacy, which grew at a yearly average of 26.6%, 17.8% and 11.0%, respectively, from SFY 2016 to 2020.
  - This growth outpaced overall Medicare, HCBS, and Pharmacy spending growth, which was 7.6%, 4.4%, and 9.2%, respectively.

[1] Table shows this population's spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

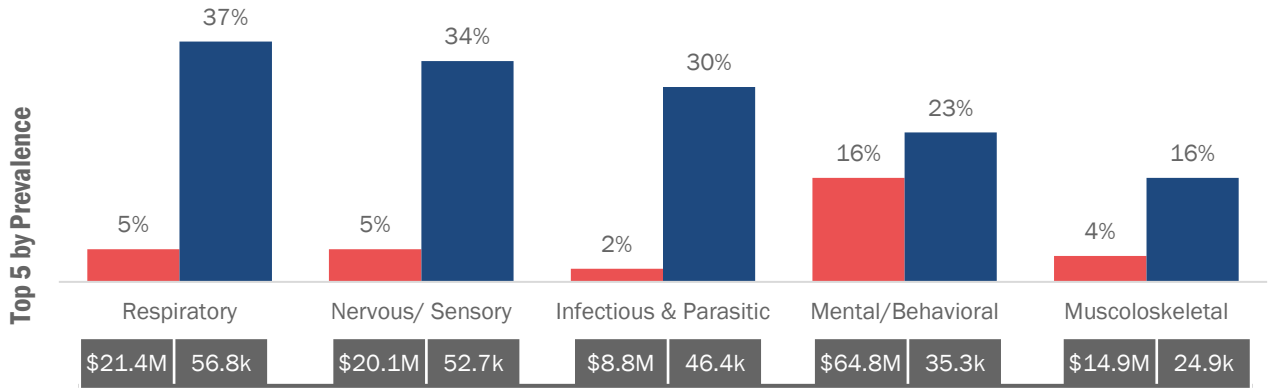
Children and Families: Diagnoses

Children and Families – Spending and Prevalence by Diagnosis
SFY 2020

Non-Dual Children with Families with 6-Mon. 154,640



Spending | Prevalence by Diagnosis – SFY 2020



Spending | Prevalence by Diagnosis – SFY 2020

Most expenditures for the Children and Families population go towards professional services and outpatient and inpatient hospital services.

- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Similarly, to other populations, mental or behavioral health has high prevalence and high cost for Children and Families.
- Complications of pregnancy, childbirth and postpartum, and certain conditions originating in the perinatal period account for 21% of expenditures for Children and Families.
- Diseases of the nervous system and sense organs, respiratory system, infectious and parasitic diseases, and musculoskeletal diagnoses are also prevalent among Children and Families.

An example of how to interpret the chart to the left:

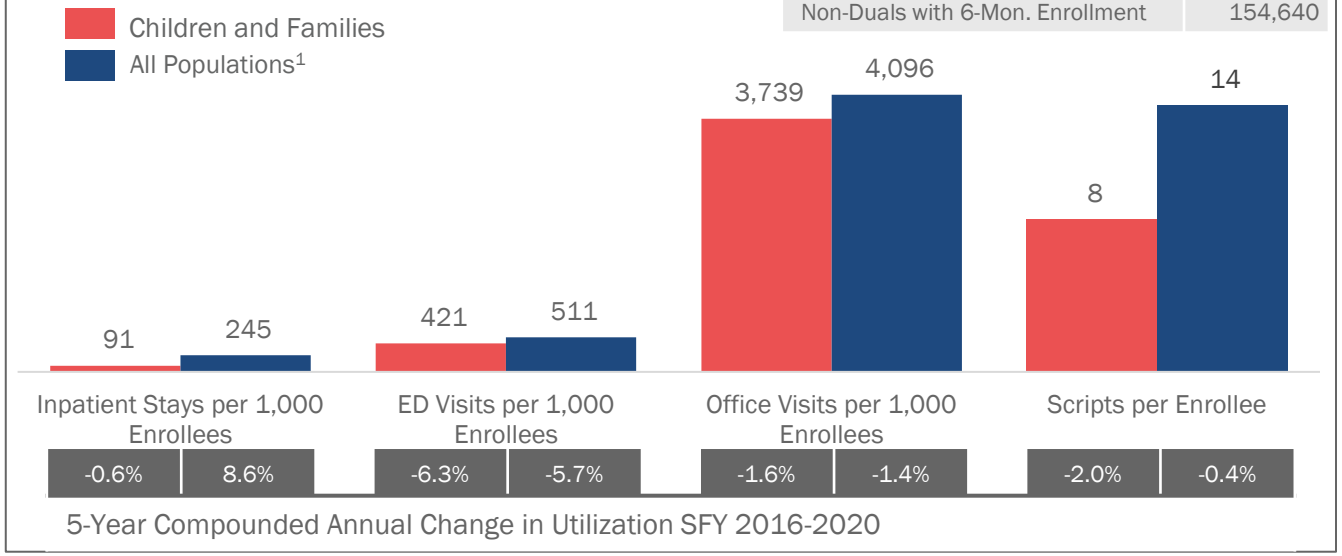
- 23% "prevalence as a % of non-duals" means that among members within the Children and Families population that have at least 6 months of enrollment during the year, 23% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 16% of costs were for claims where “mental or behavioral health" was the primary diagnosis.

Children and Families: Acute Care Services

Children and Families use fewer services per person than the overall population.

Children and Families: Acute Care Utilization
SFY 2020

Expenditures	$593.1 M
Average Enrollment	155,323
Non-Duals with 6-Mon. Enrollment	154,640



Children and Families: Average Cost per Acute Care Service
SFY 2020

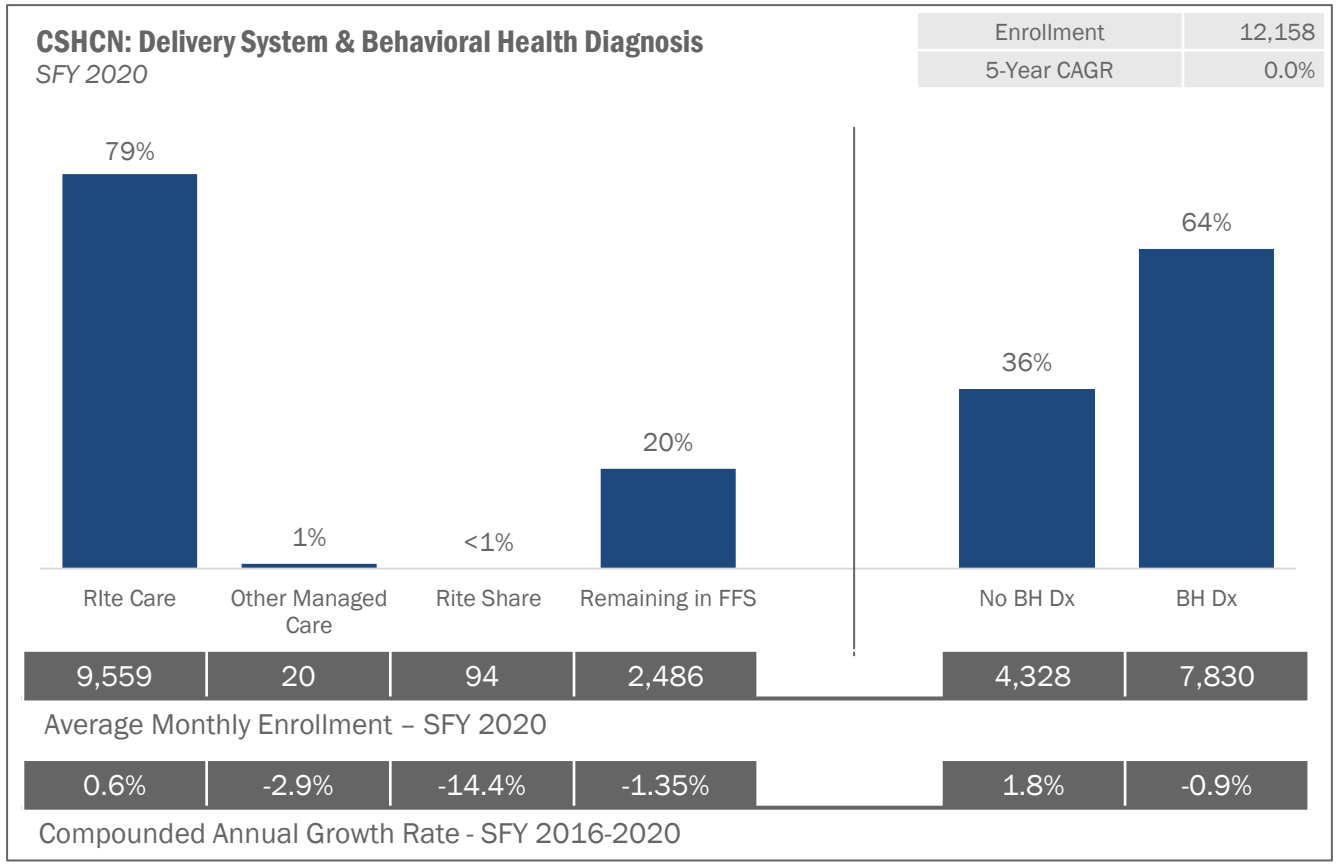
	Inpatient Stay	ED Visit	Office Visit	Script
Children and Families	$5,989	$595	$67	$56
Overall	$4,635	$657	$67	$75

- Children and Families use, on average, fewer than half as many inpatient days per person as the overall Medicaid population.
- Children and Families use the ED and have office visits at levels approximately 18% and 8% lower than the overall population, respectively.
- Per person utilization for Children and Families have lower growth trends than the overall population for all services.

[1] All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.

CSHCN: Managed Care Enrollment

CSHCN are primarily enrolled in managed care, in the RIte Care program. However, a significantly greater proportion (20%), compared to youth in the Children and Families population group, remain in fee-for-service as they have access to other third-party coverage for their acute care needs.



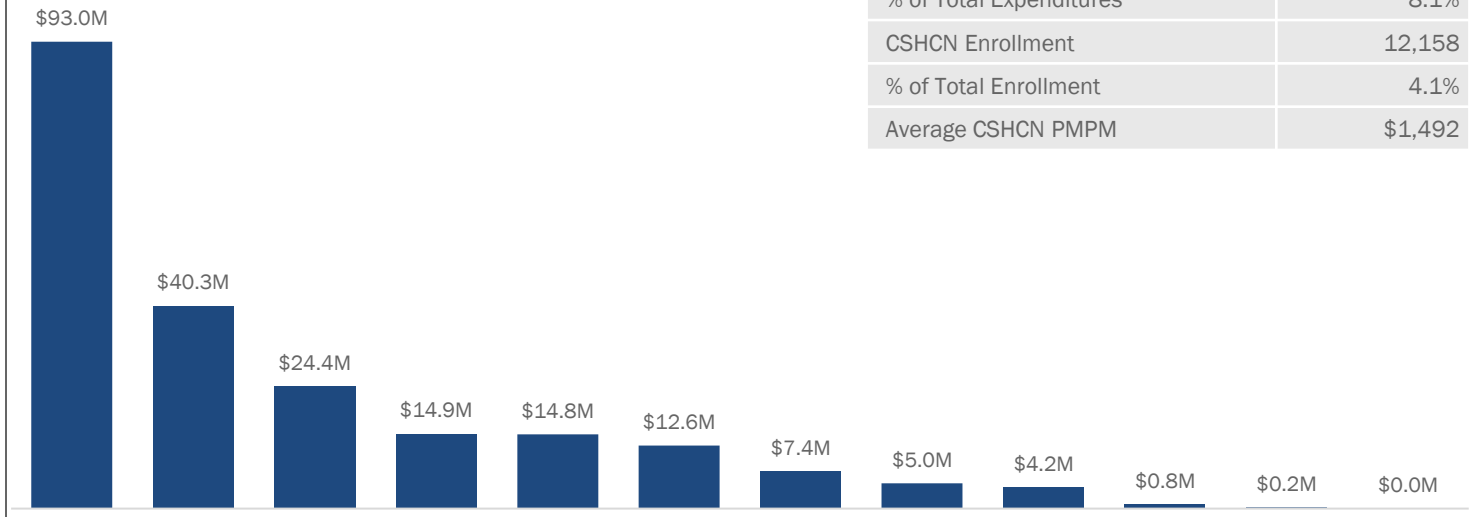
- 79% of Children with Special Health Care Needs are enrolled in RIte Care.
  - Enrollees in the RIte Care are divided between Neighborhood Health Plan, United Healthcare, and Tufts Health Plan.
  - Children in substitute care administered by DCYF are exclusively enrolled in Neighborhood.
- CSHCN who live in institutions have their Medicaid coverage administered by the state of Rhode Island in FFS and are not enrolled in managed care.
- A greater proportion of CSHCN are remaining in FFS compared to Children and Families or Expansion because many of the families of these children have comprehensive third-party coverage for their families, including:
  - approximately 90% of Katie Beckett children, and
  - 30% of Adoption Subsidy
- "Other Managed Care" includes members who for a portion of the year were enrolled in RHP or Expansion

CSHCN: Expenditures by Provider Type

CSHCN expenditures are largely concentrated in professional and inpatient services.

CSHCN Expenditures by Provider
SFY 2020

CSHCN Expenditures	$217.6 M
% of Total Expenditures	8.1%
CSHCN Enrollment	12,158
% of Total Enrollment	4.1%
Average CSHCN PMPM	$1,492

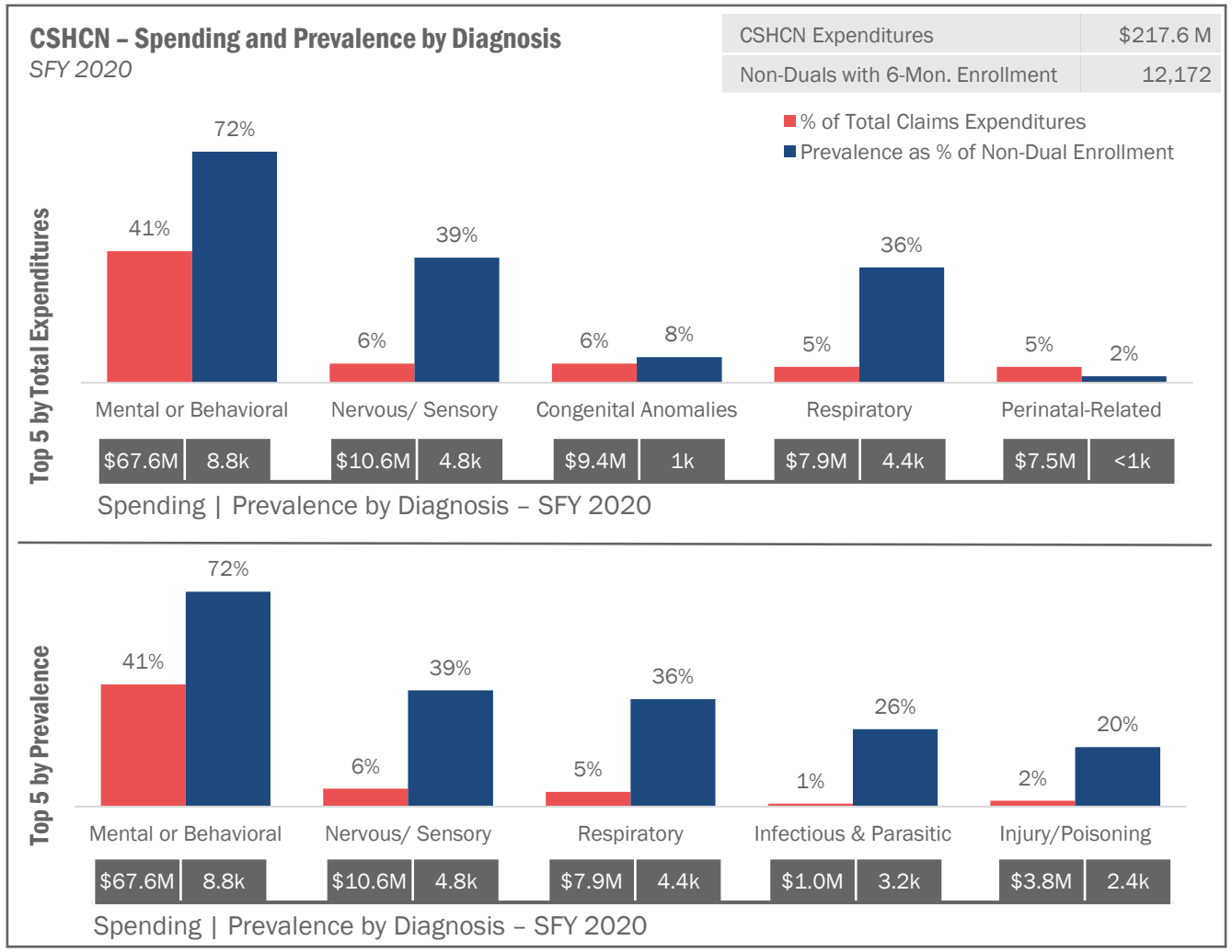


	Prof.	Inpatient	Special Education	Admin/Taxes & HSTP	HCBS	Outpatient	Pharmacy	Other Medical	Slater/ Tavares	I/DD Community	Medicare	Nursing/ Hospice
% of Children with Special Healthcare Needs Expenditures – SFY 2020	43%	19%	11%	7%	7%	6%	3%	2%	2%	<1%	<1%	-
CSHCN 5-Year CAGR – SFY 2016-2020	2.0%	2.5%	-4.4%	0.7%	11.5%	1.6%	6.5%	5.3%	3.7%	77.7%	4.7%	-
CSHCN Spend as % of Total Expenditures, by Provider Type – SFY 2020	21%	10%	77%	8%	9%	4%	3%	8%	4$	<1%	<1%	-

- 77% of CSHCN expenditures go towards professional services and inpatient hospital services.
- A significantly smaller percentage of CSHCN expenditures go toward pharmacy, residential and rehabilitation services for persons with IDD, premiums, and nursing facilities and hospice than for the overall population.
- Average annual growth of professional expenditures (2.0%) from SFY 2016 to 2020 was lower than the overall population (2.5%).
- CSHCN Special education expenditures ($24.5M) accounted for 77% of the overall population ($33.6M) in SFY 2020.

[1] Table shows this population's spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

CSHCN: Diagnoses



CSHCN expenditures are largely concentrated in professional and inpatient services.

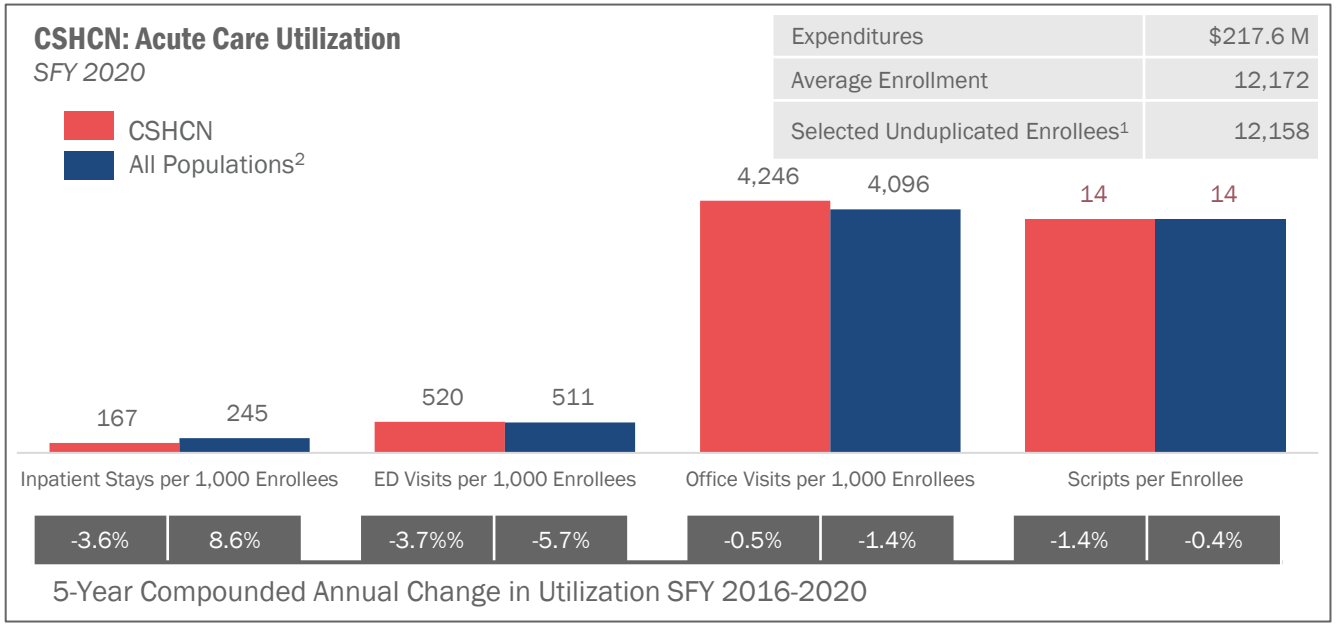
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental or behavioral health diagnoses have high prevalence and cost among all populations but are higher among CSHCN than any other population.
- Diagnoses of congenital anomalies are associated with the third-highest expenditures for CSHCN; this diagnosis is not in the top 10 for any other population.
- Mental or behavioral diagnoses, diseases of the nervous system and sense organs, and respiratory system diagnoses are prevalent among the CSHCN population, each affecting at least 40% of the population.
- Perinatal-Related diagnoses includes data on members with less than 6-months of eligibility.

An example of how to interpret the chart to the left:

- 72% "prevalence as a % of non-duals" means that among members within the CSHCN population that have at least 6 months of enrollment during the year, 72% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 41% of costs were for claims where “mental or behavioral health" was the primary diagnosis.

CSHCN: Acute Care Utilization

CSHCN use most services at the same approximate rate as the overall population; however, on average the duration of their inpatient stays is longer.



- The CSHCN population experiences fewer inpatient stays than the overall Medicaid population. However, each stay is more expensive, with an average cost per stay of $17,972 for CSHCN compared to $4,193 for the rest of the Medicaid-only population.
- CSHCN rates of utilization for ED, office, and pharmacy utilization are like those for the overall population.
- CSHCN expenditure growth has been slower than that of other populations for all acute care service types.

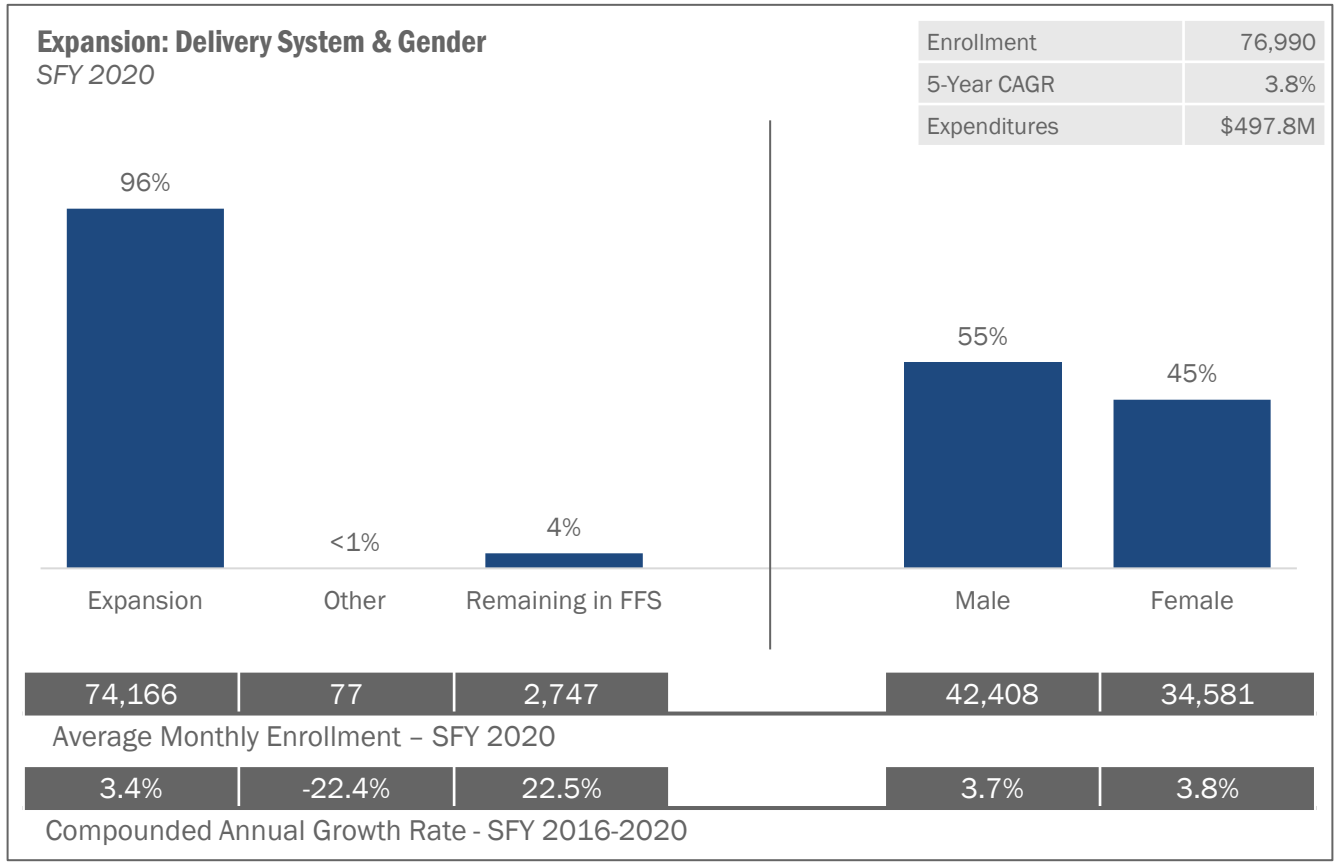
CSHCN: Average Cost per Acute Care Service
SFY 2020

	Inpatient Stay	ED Visit	Office Visit	Script
Children with Special Health Needs	$17,972	$631	$78	$87
Overall	$4,635	$657	$67	$75

[1] Unduplicated enrollees includes count of Medicaid Only members with a minimum of 6 months of eligibility.
[2] All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.

Expansion: Managed Care Enrollment

The Expansion population is primarily enrolled in managed care.



- Expansion includes childless adults who are eligible under the income-based eligibility standards set when the state expanded Medicaid under ACA in 2014. This population also includes people who are classified as previously eligible under criteria for "Adults with Disabilities."
- Spending on the Expansion population totaled $497.8 million in SFY 2020.
- 96% of the Expansion population enrolled in managed care
  - Newly eligible members experience an initial period of up to 45 days in FFS prior to their mandatory enrollment in a health plan.
- Unlike overall Medicaid enrollment, males make up a disproportionate share of the total Medicaid Expansion population.
- Enrollees in the Medicaid Expansion managed care program are divided between NHPRI (55%), UHC (33%), and Tufts (4%).
- "Other" includes members who transitioned to Expansion after being enrolled in another managed care program for portion of the year (e.g., RIte Care or RHP).

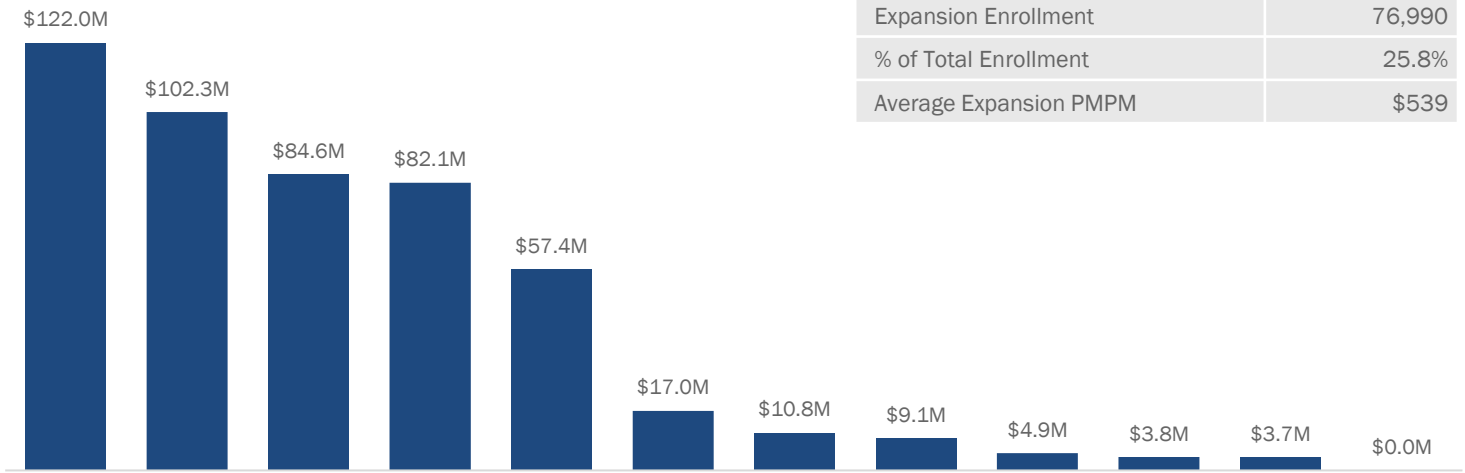
Expansion: Expenditures by Provider Type

The Expansion population's spending is concentrated in acute care services like professional, inpatient, outpatient, and pharmacy services.

Expansion Expenditures by Provider

SFY 2020

Expansion Expenditures	$497.8 M
% of Total Expenditures	18.4%
Expansion Enrollment	76,990
% of Total Enrollment	25.8%
Average Expansion PMPM	$539



Inpatient	Outpatient	Pharmacy	Prof.	Admin/Taxes & HSTP	Other Medical	Slater/ Tavares	Nursing/ Hospice	HCBS	Medicare	I/DD Community	Special Education
25%	21%	17%	16%	12%	3%	2%	2%	1%	1%	1%	-

% of Expansion Expenditures – SFY 2020

6.0%	1.2%	9.1%	0.4%	1.8%	3.9%	-	38.3%	15.0%	7.1%	-	-

5-Year Compounded Annual Growth Rate – SFY 2016-2020

31%	24%	38%	18%	30%	26%	10%	2%	3%	3%	1%	-

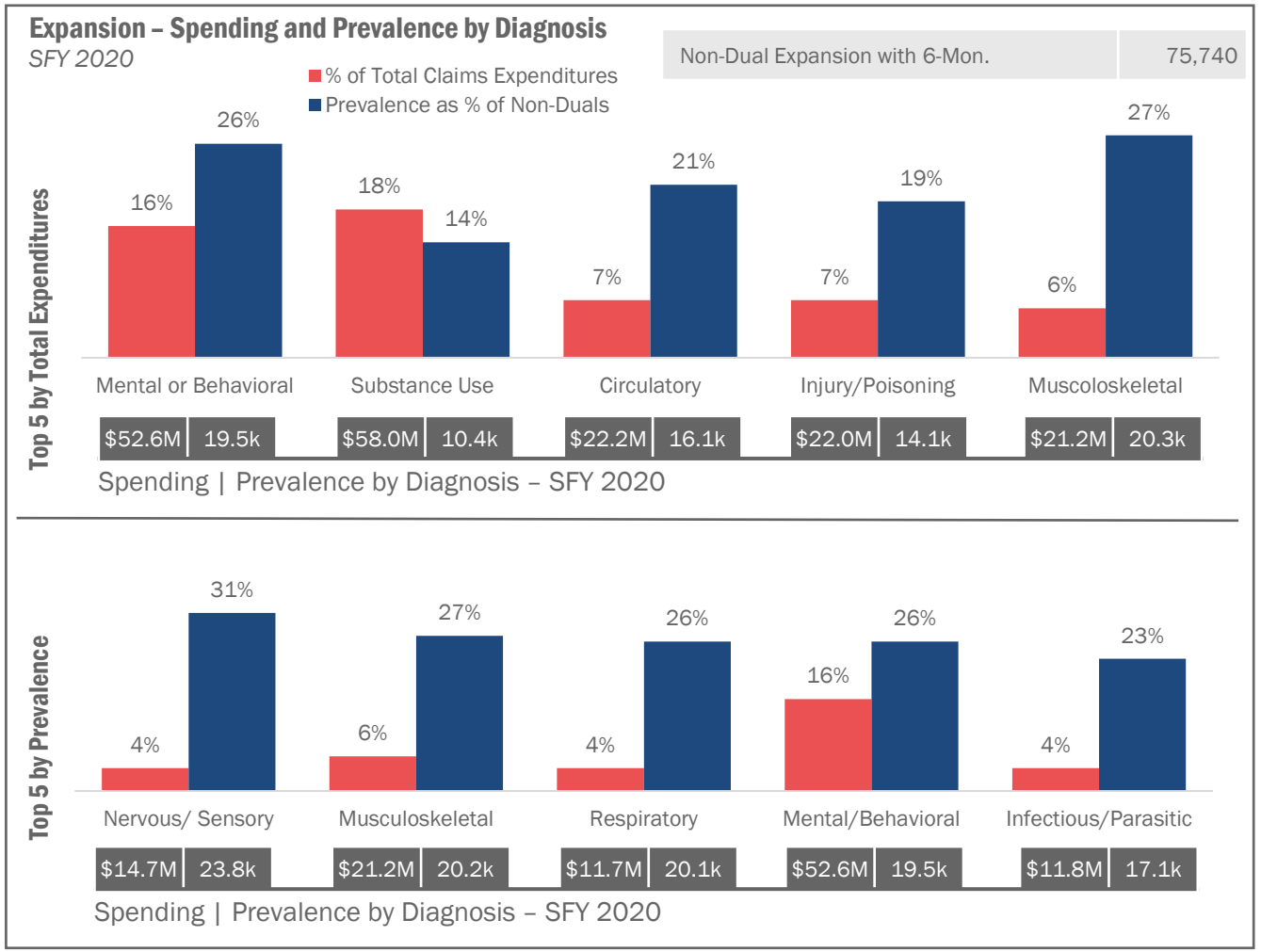
Expansion Spend as % of Total Expenditures, by Provider Type – SFY 2020

- Expenditure growth for the Expansion population is slightly higher (3.6%) than the overall population (2.7%).
- The Expansion population utilizes inpatient, outpatient and pharmacy services at a higher rate than other populations.
- Expenditures on LTSS services are relatively low for the Expansion population.

[1] Table shows this population's spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Expansion: Diagnoses

The top 5 highest-expenditure diagnoses, pictured below, account for varying levels of growth, total spend, and prevalence.

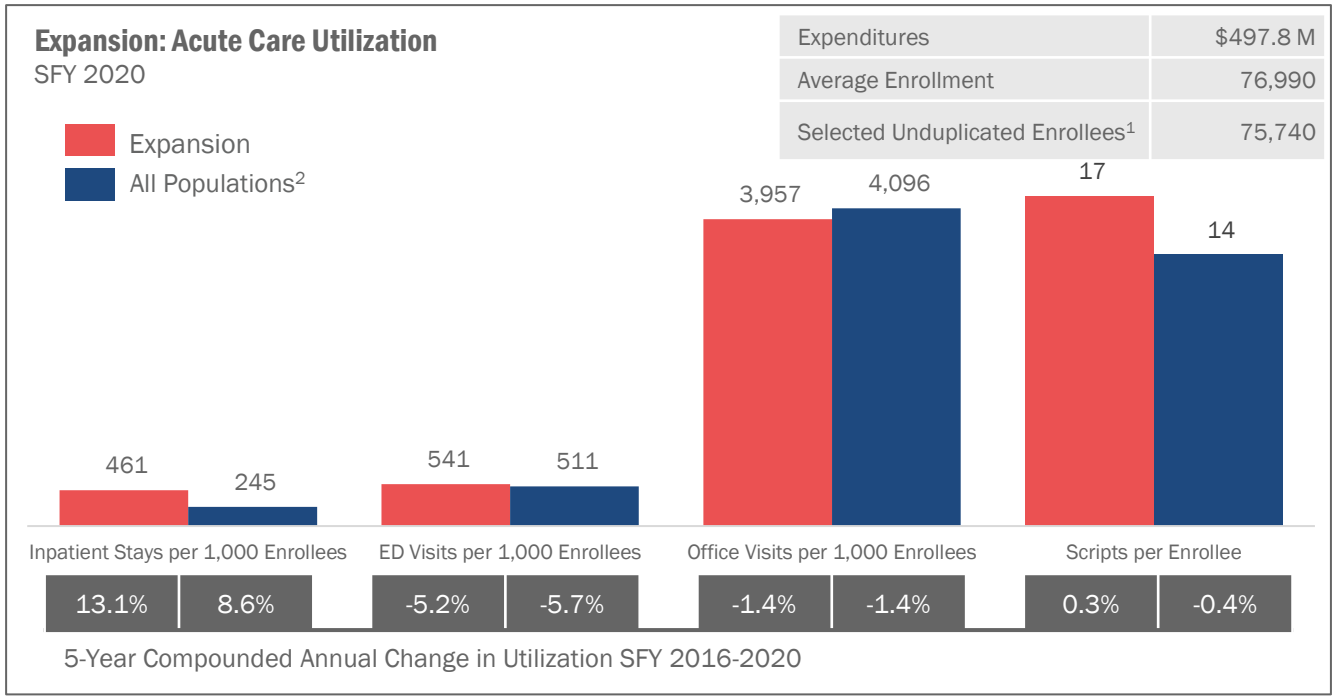


- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Substance-related disorders are nearly twice as prevalent among the Expansion population compared to the overall population.
- Prevalence of diagnoses in the Expansion population are like the prevalent diagnoses in the overall population.

An example of how to interpret the chart to the left:

- 26% "prevalence as a % of non-duals" means that among members within the Expansion population that have at least 6 months of enrollment during the year, 26% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 16% of costs were for claims where “mental or behavioral health" was the primary diagnosis.

Expansion: Acute Care Utilization



- The per person utilization rates of the Expansion population are higher than the overall population, varying from 7% (office visits) to 28% (inpatient days) greater utilization for certain common acute care services.
- Average cost per service is comparable to the overall population except for Inpatient Stays that are significantly less.

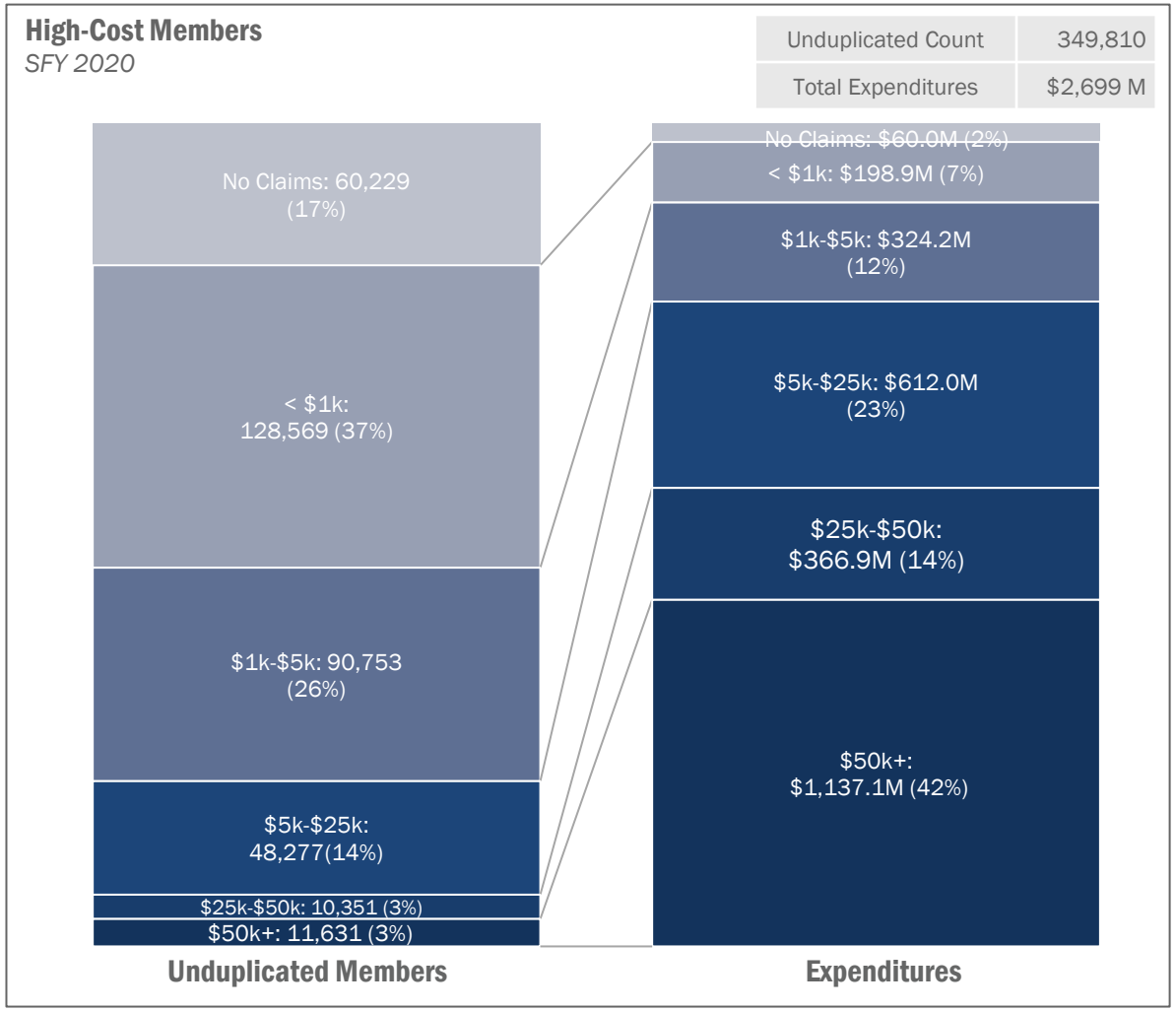
Expansion: Average Cost per Acute Care Service
SFY 2020

	Inpatient Stay	ED Visit	Office Visit	Script
Expansion	$2,821	$704	$65	$79
Overall	$4,635	$657	$67	$75

[1] Unduplicated enrollees includes count of Medicaid Only members with a minimum of six months of eligibility.
[2] All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of six months of eligibility.

Miscellany & Exclusions

High-Cost Enrollees: Summary



- Medicaid claims expenditures are highly concentrated:
  - Approximately 80% of expenditures are associated with 20% of members.
  - 22,000 Rhode Islanders, just 6% of all Medicaid enrollees, incurred costs that exceeded $25,000 in SFY 2020 and accounted for 56% of all Medicaid benefits expenditures on members with full benefits
- Members with no claims' activity account for nearly 17% of distinct enrollees within the fiscal year. Although they do not have claims activity, EOHHS still pays a capitation payment to the MCOs on their behalf which includes an administrative component reflected herein.
  - *Note: Expenditures are primarily allocated based on claims payments; however, MCO administrative costs, NEMT broker capitation, and RIte Smiles, are allocated on a PMPM basis across relevant membership regardless of claims utilization.*
- High-cost enrollees typically have multiple complex conditions, requiring care coordination across a variety of provider types.
- Most high-cost enrollees residing within the community belong to the Adults with Disabilities or Expansion populations.
- Nearly all nursing facility residents, individuals residing in institutions such as rehabilitation hospitals, and those in group homes and facilities for the intellectually and developmentally disabled, are high-cost enrollees.

High Cost Enrollees: Behavioral Health Diagnoses and Expenditures

Members with a diagnoses for a behavioral or mental health condition account for 75% of all high-cost users and have a PMPM that is, on average, more than three times greater than a member without such a condition.

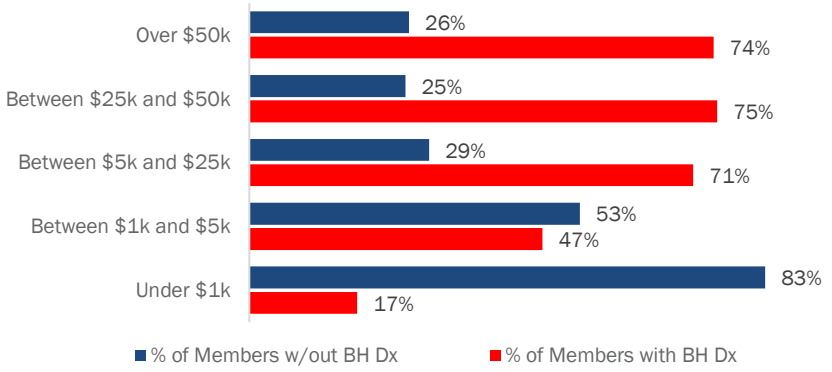
Enrollment and Expenditures among Members with a Behavioral Health Diagnosis
SFY 2020

Primary Payer and Diagnosis[1]	Average Enrollment	% of Enrollment	Overall PMPM	% of Expenditures
Medicaid Only				
I/DD Community (BHDDH)	1,190	<1%	$5,890	5%
Other Developmental Disability	12,417	5%	$1,069	9%
Substance Use Disorder	15,196	6%	$1,628	17%
Other Behavorial/Mental Health	60,269	23%	$869	37%
Subtotal - Any BH-Related Diagnoses	89,112	34%	$1,093	69%
No BH-Related Diagnosis	169,922	66%	$263	31%
Overall - Medicaid Only	259,034	100%	$548	100%
Duals				
I/DD Community (BHDDH)	2,532	6%	$6,561	20%
Other Developmental Disability	241	1%	$3,065	1%
Substance Use Disorder	2,163	6%	$1,304	3%
Other Behavorial/Mental Health	11,855	30%	$2,469	35%
Subtotal – Any BH-Related Diagnoses	16,908	43%	$2,928	60%
No BH-Related Diagnosis	22,362	57%	$1,492	40%
Overall - Duals	39,270	100%	$2,110	100%

[1] Members had a claim with an I/DD community provider or a primary diagnoses indicating specified behavioral health condition. If multiple BH categories applicable, member assignment based on prioritization: I/DD (BHDDH), Other DD, SUD, Other BH/MH.

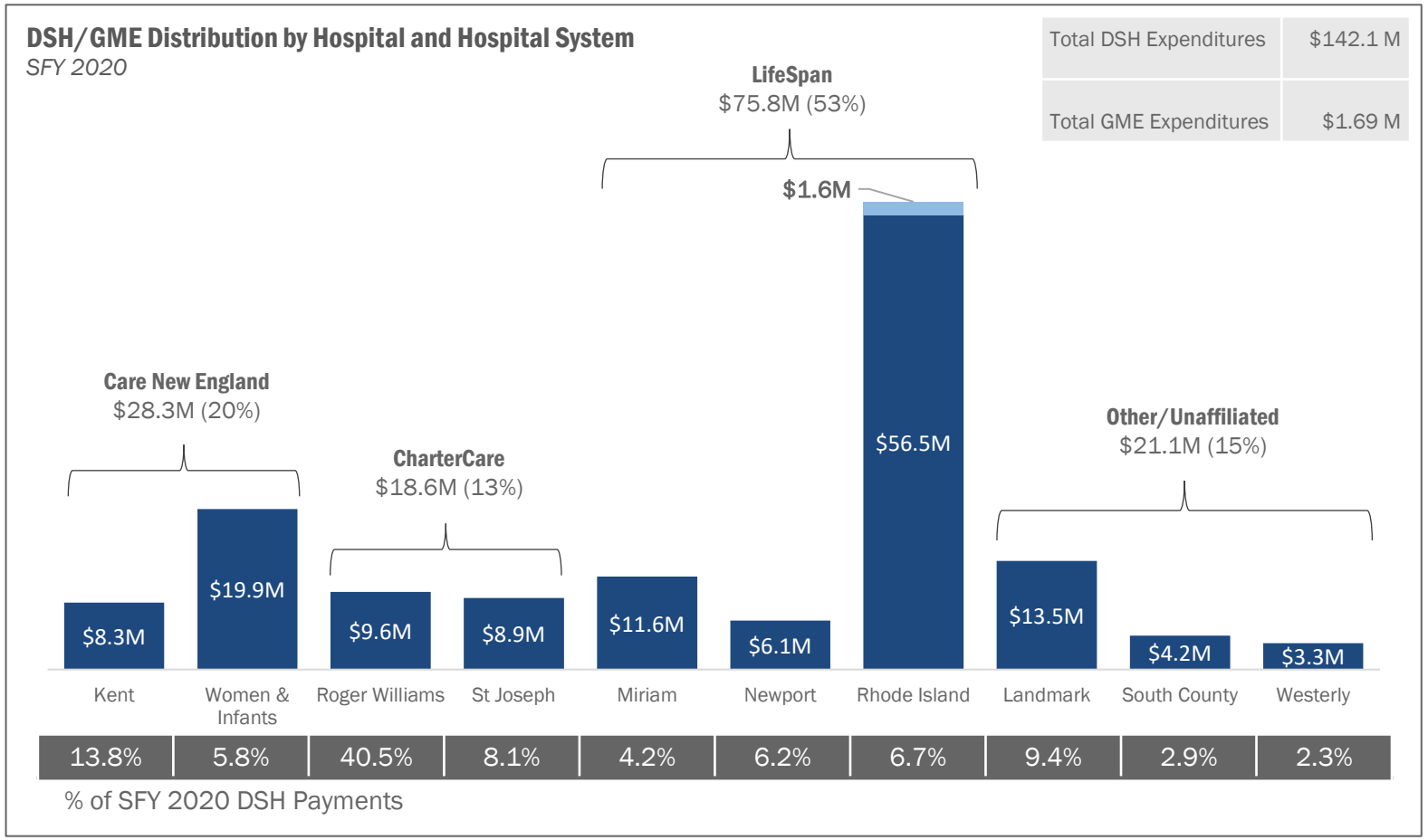
- Among both the Dual and Medicaid Only populations, members with a BH diagnosis account for a disproportionate share of expenditures:
  - One-third of Medicaid Only members have a BH-related diagnosis and account for over two-thirds of expenditures
  - 40% of Duals have a BH diagnosis and account for 60% of expenditures
- Approximately three-quarters of members with $5,000 or more in claims per year had a BH-related diagnoses

Total Cost of Care and Indication of Behavioral Health Diagnoses



Exclusions: DSH/GME

Federal law allows state Medicaid programs to make Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME) payments to qualifying hospitals that serve Medicaid and uninsured individuals.



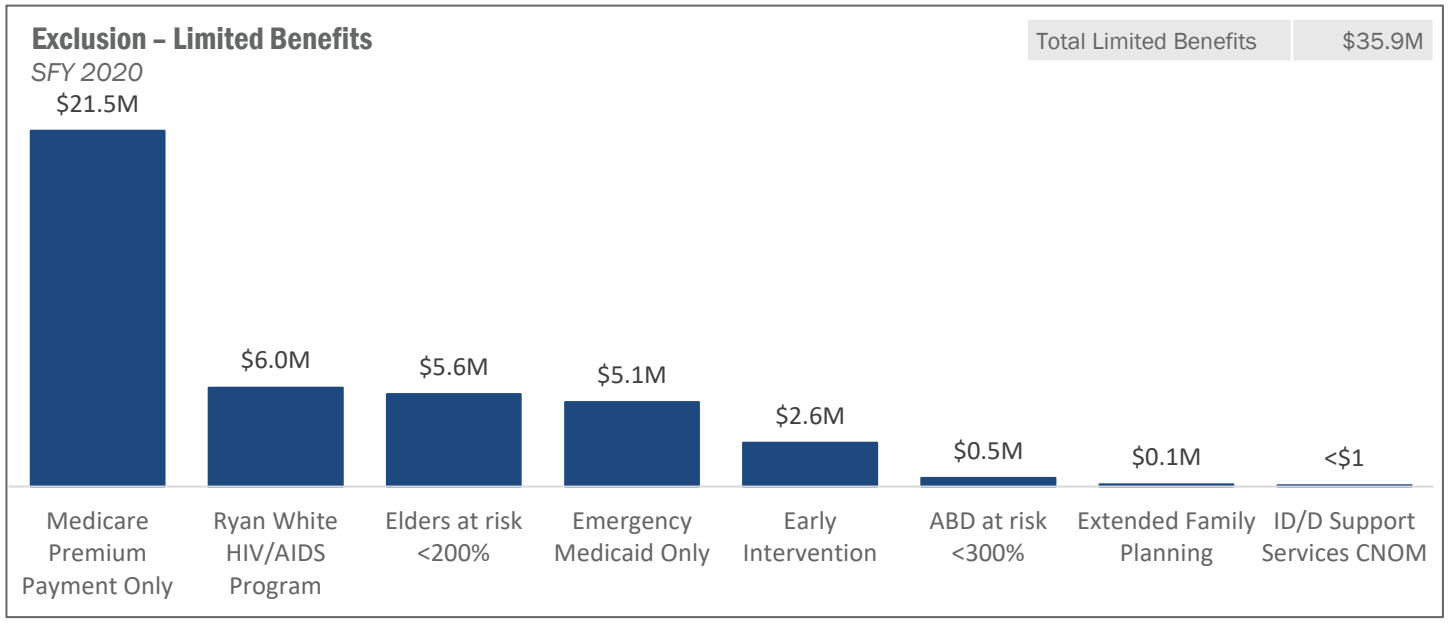
- Total DSH payments eligible for Medicaid financing is determined by federal regulation that establishes each State's maximum DSH allotment.
- In SFY 2020, Rhode Island DSH payments totaled **$142.1 million.**
- EOHHS also made a **$1.6 million** GME payment to Rhode Island Hospital.
- More than half of the year's DSH payments went to two facilities:
  - Rhode Island Hospital in Providence
  - Women & Infants Hospital in Providence
- Care New England, LifeSpan and CharterCare are multi-hospital health systems in Rhode Island.

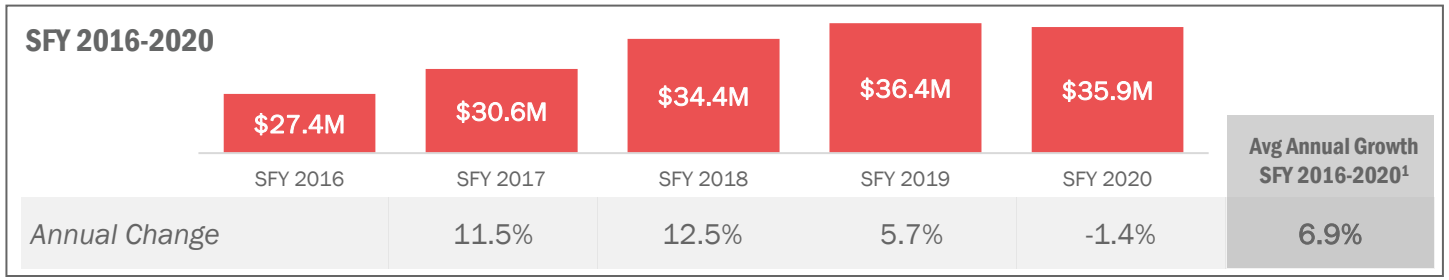
Rhode Island EOHHS also makes supplemental Upper Payment Limit (UPL) expenditures to hospitals. These supplemental payments are tied directly to FFS expenditures for Medicaid-eligible members and are included in hospital spending within the general Expenditure Report.

In SFY 2020, EOHHS made $4.6 million in Outpatient UPL payments.

Exclusions: Limited Benefits

Under the terms of Rhode Island's 1115 Waiver Demonstration agreement, certain state programs not traditionally allowable under Medicaid fund matching rules can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible.





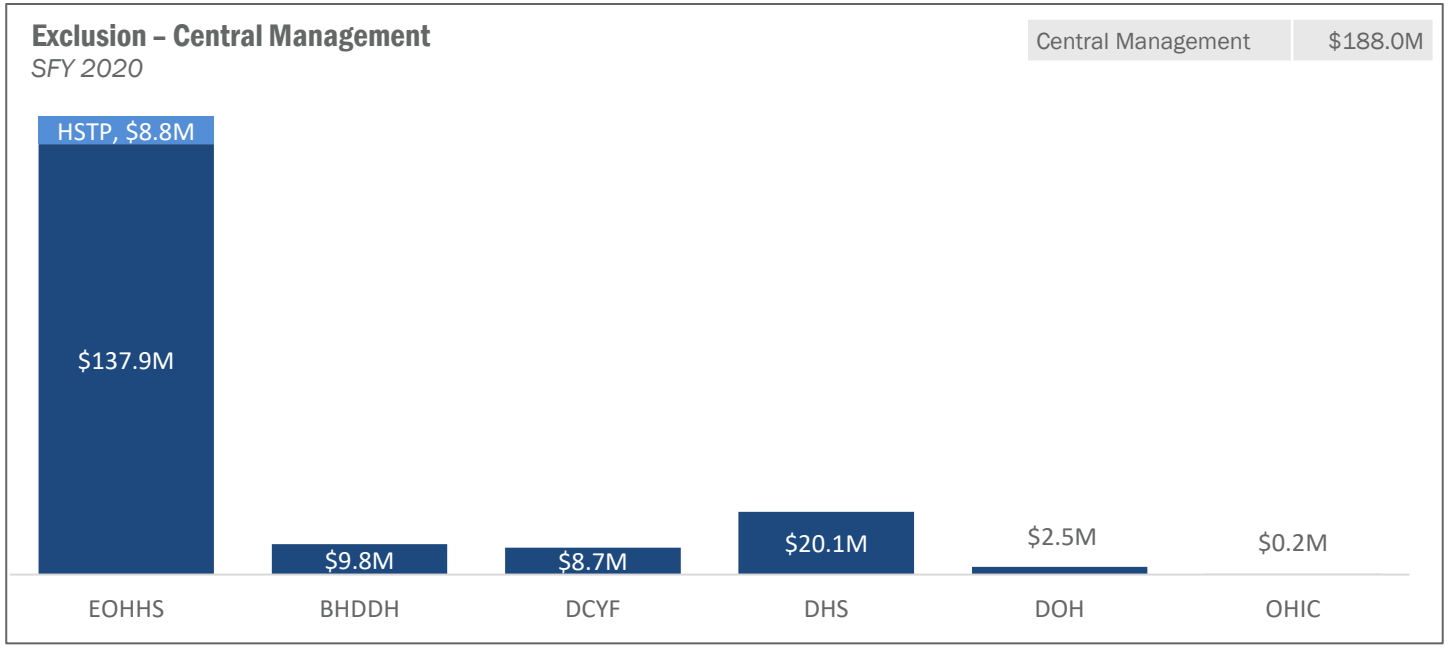
- Expenditures for members with limited benefits totaled $35.9 million in SFY 2020.
- **Partial Duals:** Payments for Medicare premiums for qualifying individuals account for $21.5 million. In SFY 2020, EOHHS subsidized the Medicare premiums for an average of 6,800 low-income elders each month with limited Medicaid.
- **Costs Not Otherwise Matchable (CNOM) and Partial Emergency Services:** Limited benefits not traditionally eligible for federal Medicaid funding match, that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible. Includes services covered by the Office of Healthy Aging and the Ryan White HIV/AIDS program.
- Note prior years' Expenditure Reports have reported spending at the Department of Corrections (RIDOC) among the CNOM and Limited Benefits exclusions. These expenditures are not Medicaid-eligible. Rather, RIDOC simply uses the State's fiscal intermediary to process medical claims and so they appear within the MMIS transactions.

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2016-2020 as shown.

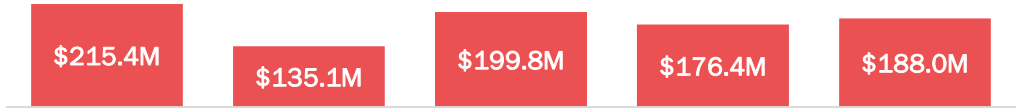
Exclusions: Central Management

EOHHS is the Single State Agency for Administering the Medicaid Program and accounts for 78% of all central management expenditures in SFY 2020.

Exclusion – Central Management
SFY 2020



SFY 2016-2020



					Avg Annual Growth SFY 2016-2020[1]
Annual Change	-37.3%	47.9%	-11.7%	6.6%	-3.4%

- Central Management expenditures can vary significantly year-over-year.
- In SFY 2020 EOHHS central management expenditures included $8.8 million for HSTP workforce development and administration.
- HSTP expenditures leverage restricted receipts and therefore cost the state no general revenues.

Note Regarding Methodology

- In the FY 2019 version of this report, Central Management expenditures were based upon total expenditures made by the EOHHS Central Management budgetary program. In the FY 2020 version of the report, this definition has been modified to Medicaid administrative expenditures made by all departments, consistent with the requirement contained at RIGL 42-7.2-5.
- Totals are based upon CMS-64 reporting, inclusive of prior period adjustments, so may not align with other financial reporting.

Acronyms

The following acronyms and abbreviations have been used in this report.

ACA:	Affordable Care Act
ACO:	Accountable Care Organization
AE:	Accountable Entity
BH:	Behavioral Health
BHDDH:	Behavioral Healthcare, Developmental Disability, and Hospitals
CAGR:	Compound Annual Growth Rate. The average annual rate of change over a period.
CHIP:	Children's Health Insurance Program
CMS:	Centers for Medicare and Medicaid Services
CNOM:	Costs Not Otherwise Matchable
COPD:	Chronic Obstructive Pulmonary Disease
CSHCN:	Children with Special Health Care Needs
DCYF:	Department of Children, Youth and Families
DHS:	Department of Human Services
DME:	Durable Medical Equipment
DOC:	Department of Corrections
DSH:	Disproportionate Share Hospitals
EOHHS:	Executive Office of Health and Human Services
ED:	Emergency Department
FFP:	Federal Financial Participation
FFS:	Fee-For-Service
FFY:	Federal Fiscal Year
FMAP:	Federal Medicaid Assistance Percentage
FPL:	Federal Poverty Level
HCBS:	Home and Community-Based Services
HSTP:	Health System Transformation Project
IDD:	Intellectually and Developmentally Disabled
IP:	Hospital Inpatient
LEA:	Local Education Agencies
LTSS:	Long-Term Services and Supports
MCO:	Managed Care Organization
NCQA:	National Committee for Quality Assurance
NICU:	Neonatal Intensive Care Unit
OP:	Hospital Outpatient
PACE:	Program of All-Inclusive Care of the Elderly
PCCM:	Primary Care Case Management
PCP:	Primary Care Physician
PMPM:	Per member per month
RHO:	Rhody Health Options
RHP:	Rhody Health Partners
SFY:	State Fiscal Year
SSI:	Supplemental Security Income
SUD:	Substance Use Disorder

Diagnosis Definition

The following conditions are mentioned in this Report.

Circulatory	Conditions affecting the circulatory system, such as hypertension and acute myocardial infarction
Congenital Anomalies	Congenital anomalies affecting the cardiac and circulatory, digestive, genitourinary, nervous system, or other systems
Endocrine/Metabolic/Immunity	Endocrine, nutritional, and metabolic diseases and immunity disorders
Genitourinary	Conditions affecting the genitourinary system, such as chronic kidney disease, endometriosis, and female infertility
Infectious and Parasitic	Infectious and parasitic diseases, such as tuberculosis, HIV and hepatitis
Injury/Poisoning	Injury and poisoning, such as bone fractures, wounds, burns, and poisoning by medications or nonmedicinal substances
Mental or Behavioral	Conditions affecting mental health, excluding substance-related disorders, which are classified into the "substance-related" category
Musculoskeletal	Conditions affecting the muscles and bones, such as arthritis, osteoporosis, and certain deformities
Neoplasms	Forms of cancer, including benign cancer
Nervous/Sensory	Diseases of the nervous system and sense organs, such as Parkinson's disease, multiple sclerosis and cataracts
Perinatal-Related	Certain conditions originating in the perinatal period, such as birth trauma and low birth weight
Pregnancy/Childbirth Complications	Complications of pregnancy, childbirth and the puerperium
Respiratory	Conditions affecting the respiratory system, such as pneumonia, asthma and Chronic Obstructive Pulmonary Disease (COPD)
Substance-Related	Conditions related to the abuse of substances

Provider Type Definition

Acute Care	Hospital	Hospital includes inpatient and outpatient services.
	Professional	Professional includes physician, dental, x-ray/lab/tests, ambulance, etc.
	Professional BH	Professional Behavioral Health includes DHS, BHDDH and DCYF services including, but not limited to, Professional Mental Health/SUD, CEDAR (Comprehensive, evaluation, diagnosis, assessment, referral, re-evaluation services), Community Mental Health Centers, and Residential DCYF.
	Pharmacy	Pharmacy includes prescription and over-the-counter medications, net of pharmacy rebates.
	Ancillary	Ancillary includes Durable Medical Equipment (DME)/supplies and Transportation.
Institutional Care	Nursing Facility/ Hospice	Nursing facility includes skilled nursing facilities. Hospice includes home-based, inpatient, and nursing facility-based hospice care.
	Slater Hospital, Tavares, and Zambarano	Slater Hospital, Tavares and Zambarano are specialized facilities for severely disabled adults or children.
Community Care	I/DD Community	I/DD Community includes public and private IDD group homes, IDD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications, supported employment and transportation).
	HCBS	HCBS are provided as an alternative to nursing facility/institutional options, such as adult day care, assisted living, personal care, and shared living/self-directed services.
Other	Premiums	Premiums includes Medicare premiums paid for qualifying individuals, Medicare clawback payments, transportation premiums, premiums for PACE and RIte Share premiums, which are the employee share of private insurance premiums paid on behalf of Medicaid eligibles who have access to private insurance.
	MCO Admin/Taxes	MCO admin/taxes includes administrative costs paid to the MCO and state/federal taxes paid by the MCOs.