Medicaid Expenditure Report

SFY 2021

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) 2021.

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; (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 on 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 2021, Rhode Island's Medicaid program provided full medical coverage to at least **350,000 Rhode Islanders** at some point during the year, with an average monthly enrollment of 325,000 members.

Overall, medical expenditures **totaled $3.2 billion** (at a state cost of $1.1 billion), with nearly $2.9 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:

- $2.5 billion – Executive Office of Health and Human Services (EOHHS)
- $363 million – Behavioral Healthcare, Developmental Disability, and Hospitals (BHDDH)
- $47.6 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 66% across the entire Medicaid program.

Key Findings

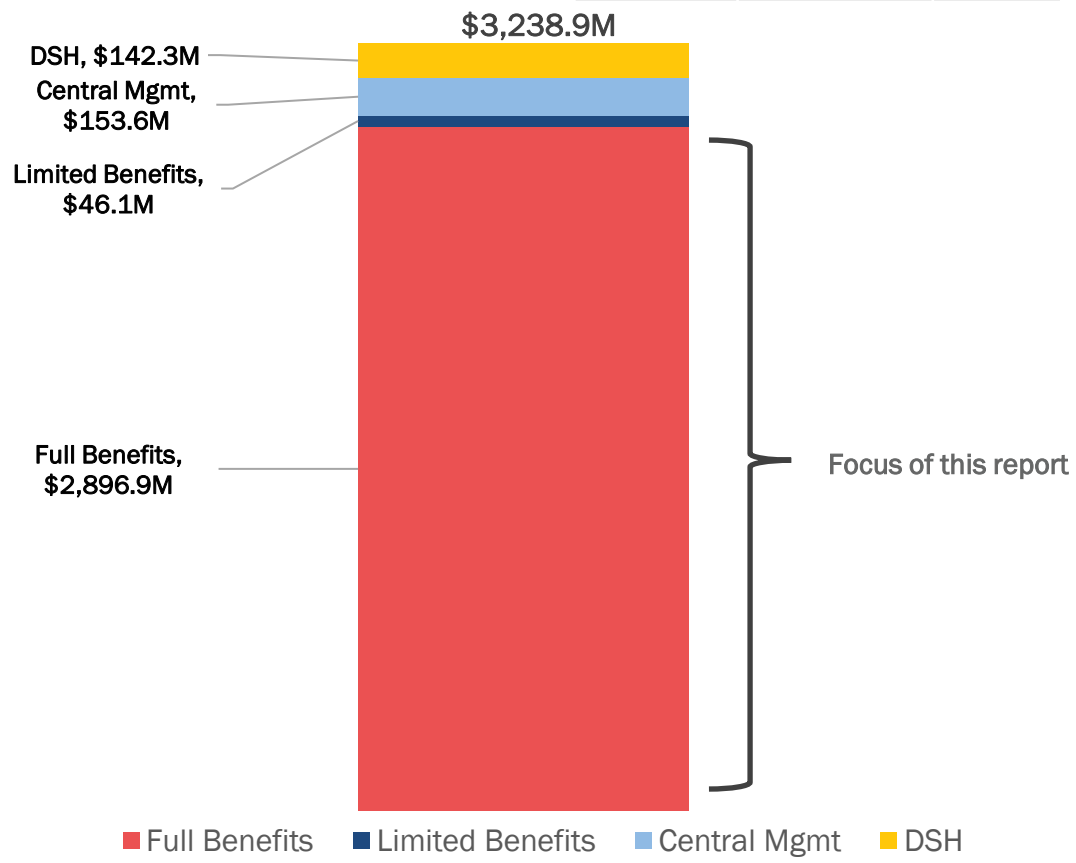
- Average enrollment increased 8.9% in SFY 2021 over SFY 2020, from 298,000 to 325,000.
- Children and Families comprise 51.5% of enrollees, followed by Expansion (28.3%), Adults with Disabilities (9.6%), Elders (6.8%) and Children with Special Healthcare Needs (3.8%).
- 87 % of enrollees are in managed care; and just under three-fifths (59.1%) of all Medicaid enrollees are now in the Accountable Entity (AE) program.
- SFY 2021 per member per month (PMPM) costs decreased by 1.2% over SFY 2020 to $742 PMPM. This is lower than the five-year compounded annual growth rate (CAGR) of 2.0% since SFY 2017.
- 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 more than half of claims in SFY 2021.
- Acute services account for 58% of SFY 2021 expenditures, while expenditures on LTSS represent 30%.
- COVID-19 began to significantly impact expenditures and enrollment in March 2020, impacting trends and general observations for fiscal year 2021 and when compared to prior fiscal years.

Overall Medicaid Expenditures

Medicaid expenditures in SFY 2021 totaled $3.2 billion. Expenditures on fully covered populations totaled approximately $2.9 billion.

Overall Medicaid Expenditures
SFY 2021

Members:		
	Full Benefits	325,442
	Limited Benefits	13,826



- **Services for Members with Full Benefits cost $2,896.9 million** and are expenditures for services delivered to enrollees who received comprehensive medical coverage through Medicaid and are the primary focus of this report.
- **Central Management Costs** of **$153.6 million** are expenditures related to managing the Medicaid program, such as paying for technology infrastructure, processing claims, and state personnel services for staff that oversee the program. These expenses are **excluded** from this report. Lastly, Managed Care Organization (*MCO) administrative costs/taxes are not reflected here, but instead reflected in the total costs for members with full benefits.*
- **Other notable exclusions** totaling, **$188.4 million,** include :

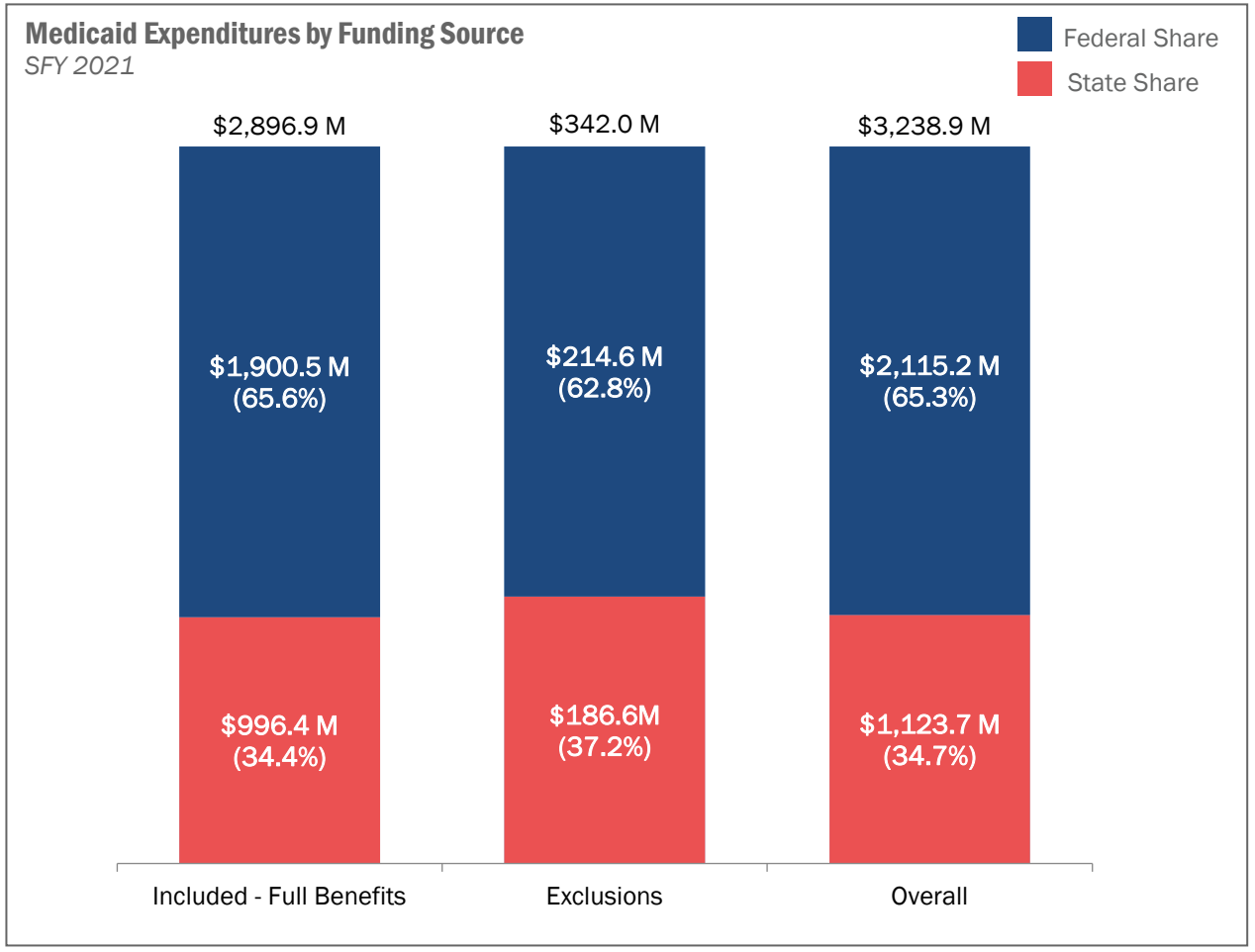
  Disproportionate Share Hospitals (DSH): Statutorily required payments to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety net hospitals.

  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. This includes services covered by OHA. Additionally, emergency services for low-income Rhode Islander's who would be eligible for Medicaid but for their immigration status are included here.

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

Expenditures by Funding Source

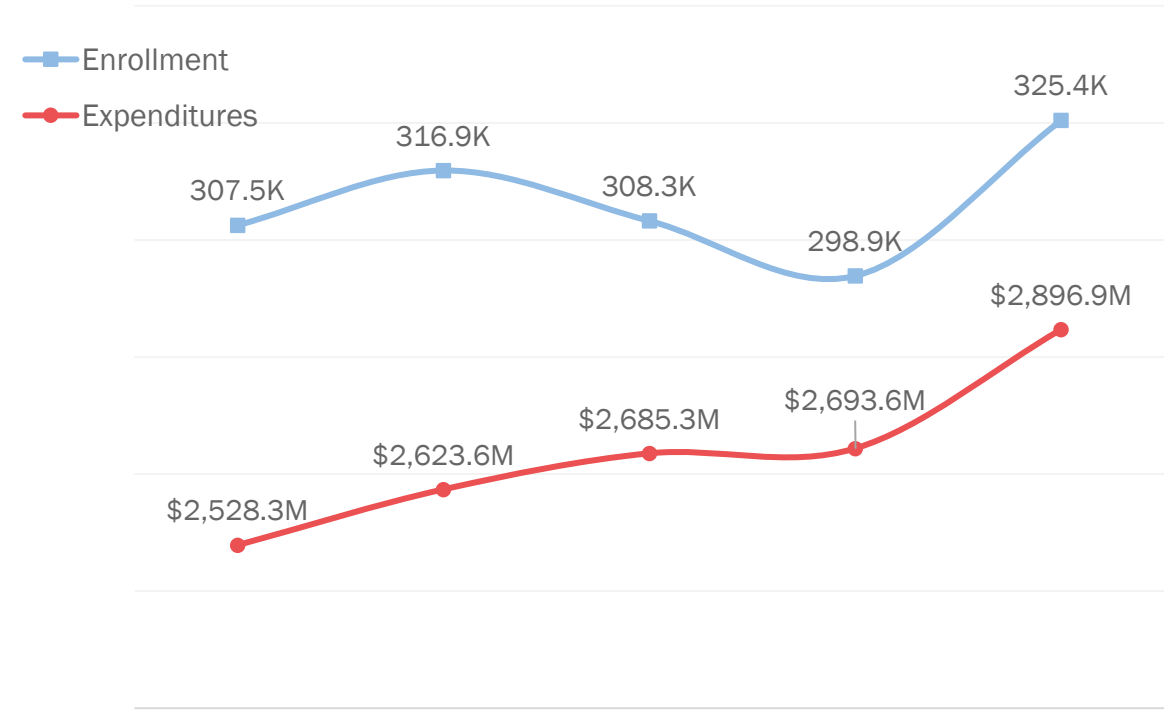
Medicaid expenditures in SFY 2021 totaled $3.2 billion at a direct cost of $1.1 billion to state taxpayers.



- 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 Health System Transformation Project (HSTP) and Children's Health Account.
  - In March 2021, EOHHS began to claim additional revenues against certain home and community-based services (HCBS) and behavioral health expenditures. These revenues were deposited into a Restricted Receipt account for future investments into HCBS and behavioral health services.
- Note that in SFY 2021, 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. Technically these expenditures are not Medicaid; however, for comparison with prior years this spending remains 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 2017 – 2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
PMPM	$685	$690	$726	$751	$742

Expenditures

- In SFY 2021, expenditures increased by $203.3 million or 7.0% over SFY 2020; more than the five-year compounded annual growth rate of 3.5%.

Enrollment

- Average enrollment increased in SFY 2021 by 8.1% over the SFY 2020 average, more than the five-year compounded annual growth rate of 1.4%.
- This increase in the average monthly enrollment over the fiscal year reflects 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.
- Most of the growth in SFY 2021 over SFY 2020 was in Expansion Adults and Children and Families that grew in their average monthly enrollment by 16,440 (21.7%) and 10.038 (6.4%), respectively, over FY 2021

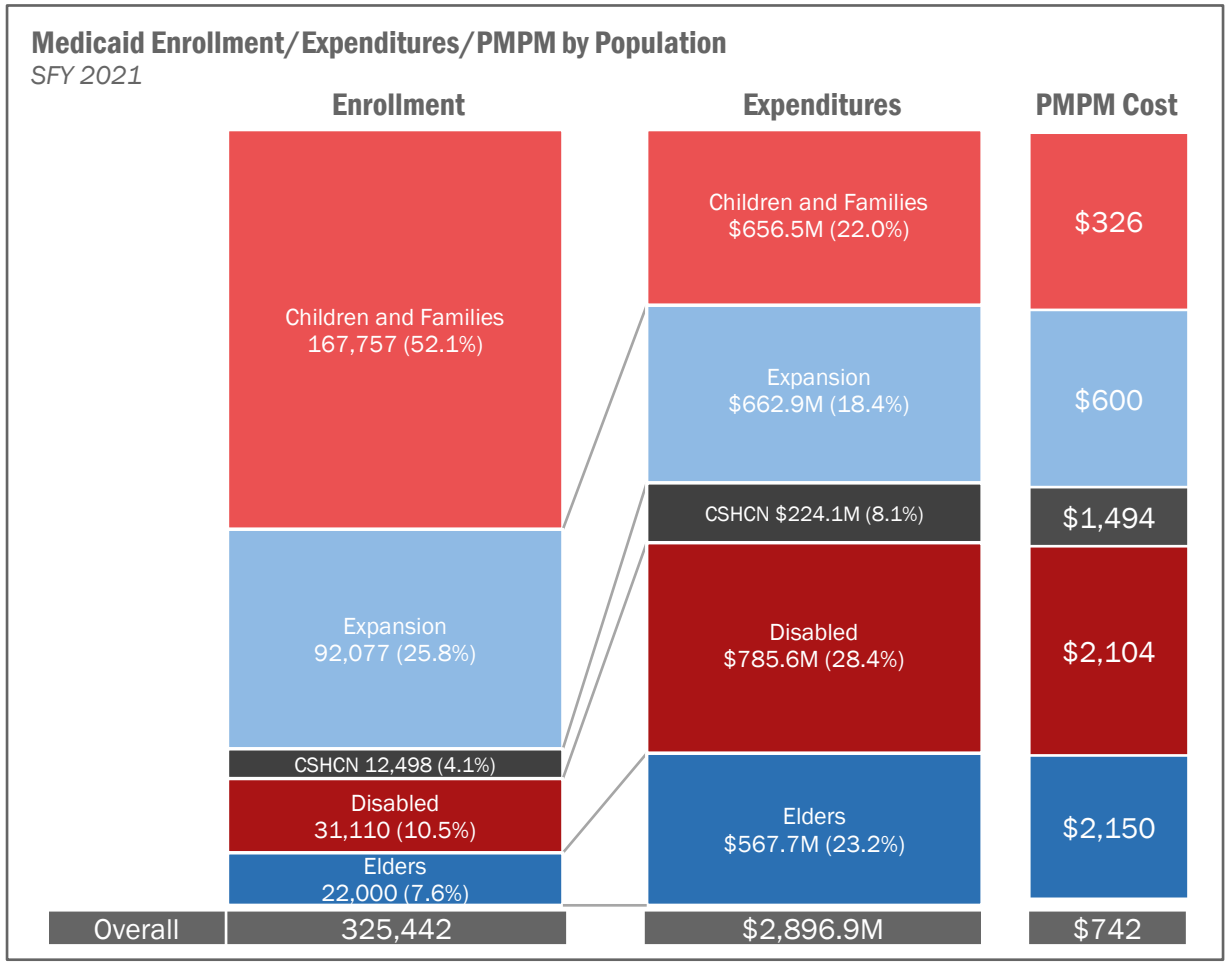
PMPM

- Overall PMPM costs decreased by an average of 1.2% in SFY 2021 over SFY 2020, ranging from than -7.7% for Elders and to 10.8% for Expansion Adults.
- A key contributing factor for the expenditure decrease and lower PMPM costs across all populations was reduced acuity (i.e., healthcare needs) of members that resulted in gain share recoupments from the health plans as well as lower nursing facility costs of the elder and disabled populations.

Overview & Trends

Expenditures by Population Group

Medicaid expenditures in SFY 2021 totaled $3.1 billion. Expenditures for fully covered populations totaled approximately $2.9 billion.



Medicaid serves five primary populations:

- **Elders** are enrollees over age 65. 94.9% of this population are also covered by Medicare. Their average SFY 2021 PMPM cost was $2,150. Nursing facilities account for 48.6% 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 $2,104 PMPM. I/DD providers account for 26% of their expenditures.
- **Children and Families** enrollees are qualified children, parents and pregnant women. They have average costs of $326 PMPM. Hospital and professional services account for 43% and 27% of their expenditures, respectively.
- **CSHCN** are enrollees under age 21 who have higher needs physically, developmentally, behaviorally or emotionally. Their average PMPM costs were $1,494 with professional services accounting for 38% of expenditures.
- **Expansion** enrollees are low-income adults without dependent children. These members cost $600 PMPM. Hospital services account for 44% and 26% of this population.

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

Between SFY 2017 and SFY 2021, annual expenditures, enrollment, and PMPM increased modestly: expenditures by 3.5%, enrollment by 1.4%, and PMPM by 2.0%.

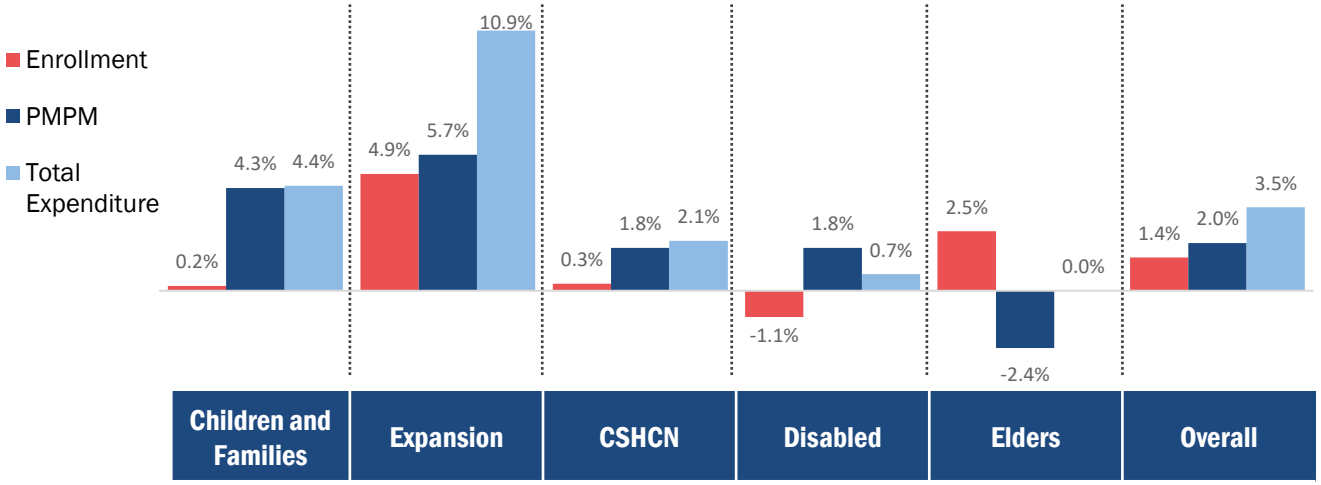
Current Expenditures

SFY 2021

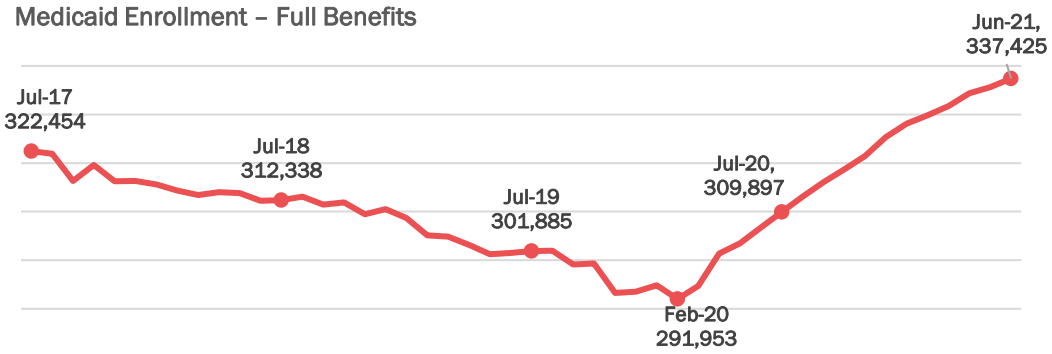
	Children and Families	Expansion	CSHCN	Disabled	Elders	Overall
Members	167,757	92,077	12,498	31,110	22,000	325,442
PMPM	$326	$600	$1,494	$2,104	$2,150	$742
Expenditure	$656.5M	$662.9M	$224.1M	$785.6M	$567.7M	$2,896.9M

Expenditures - 5-Year Compounded Annual Growth Rate

SFY 2017-2021

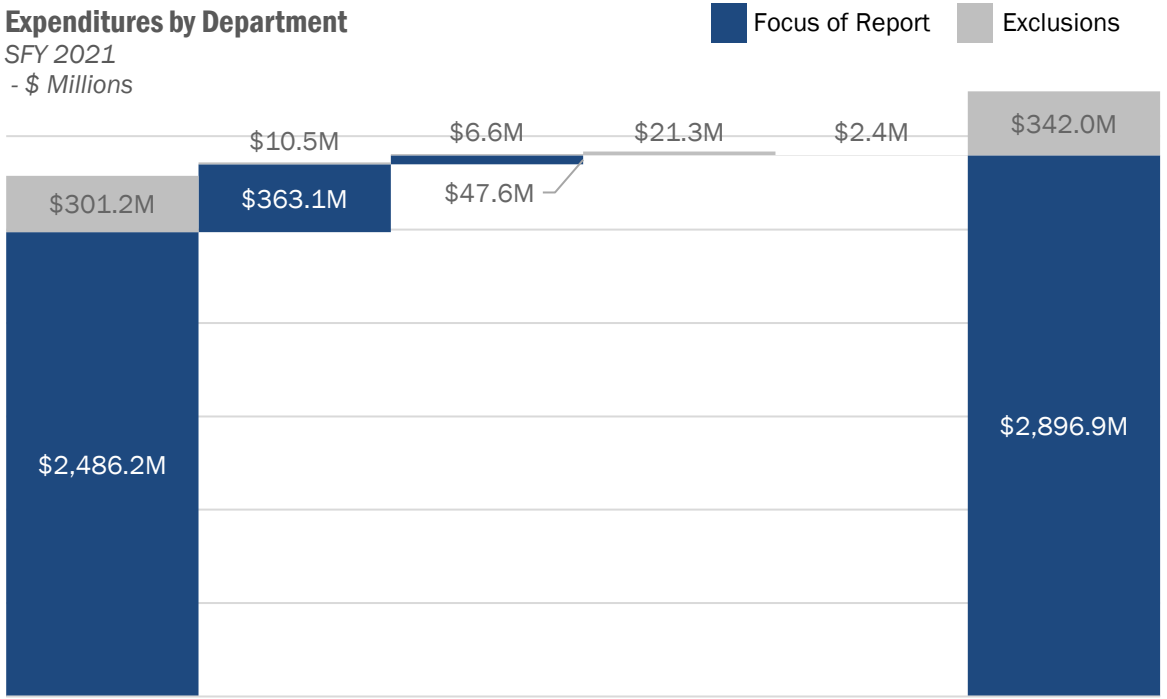


- Between SFY 2017 – 2021, the population groups experienced the following:
  - **Expansion** enrollment experienced the largest increases, with enrollments increasing 4.9% annually and overall costs increasing by 10.9% annually.
  - **Children and Families** spending was up 4.4% annually, driven primarily by price factors as enrollment was effectively flat over that period.
  - Overall, **Elder** and **Adults with Disabilities** experienced moderate spending growth as overall caseload growth was low and reduced institutional spending in SFY 2021 depressed PMPM growth.
  - Similarly, **CSHCN** enrollment was effectively flat, and the group's price trends remained below the average across all population groups.
- However, it remains noteworthy that these moderate five-year trends hide the more recent impact of COVID-19 and the nation's Public Health Emergency on Medicaid caseload. Since February 2020, Rhode Island has seen a net 15.6% increase in members, reversing what had been a steady decline in overall caseload. Below is a summary of Medicaid enrollment with full benefits over the past four fiscal years:



Expenditures by Department

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

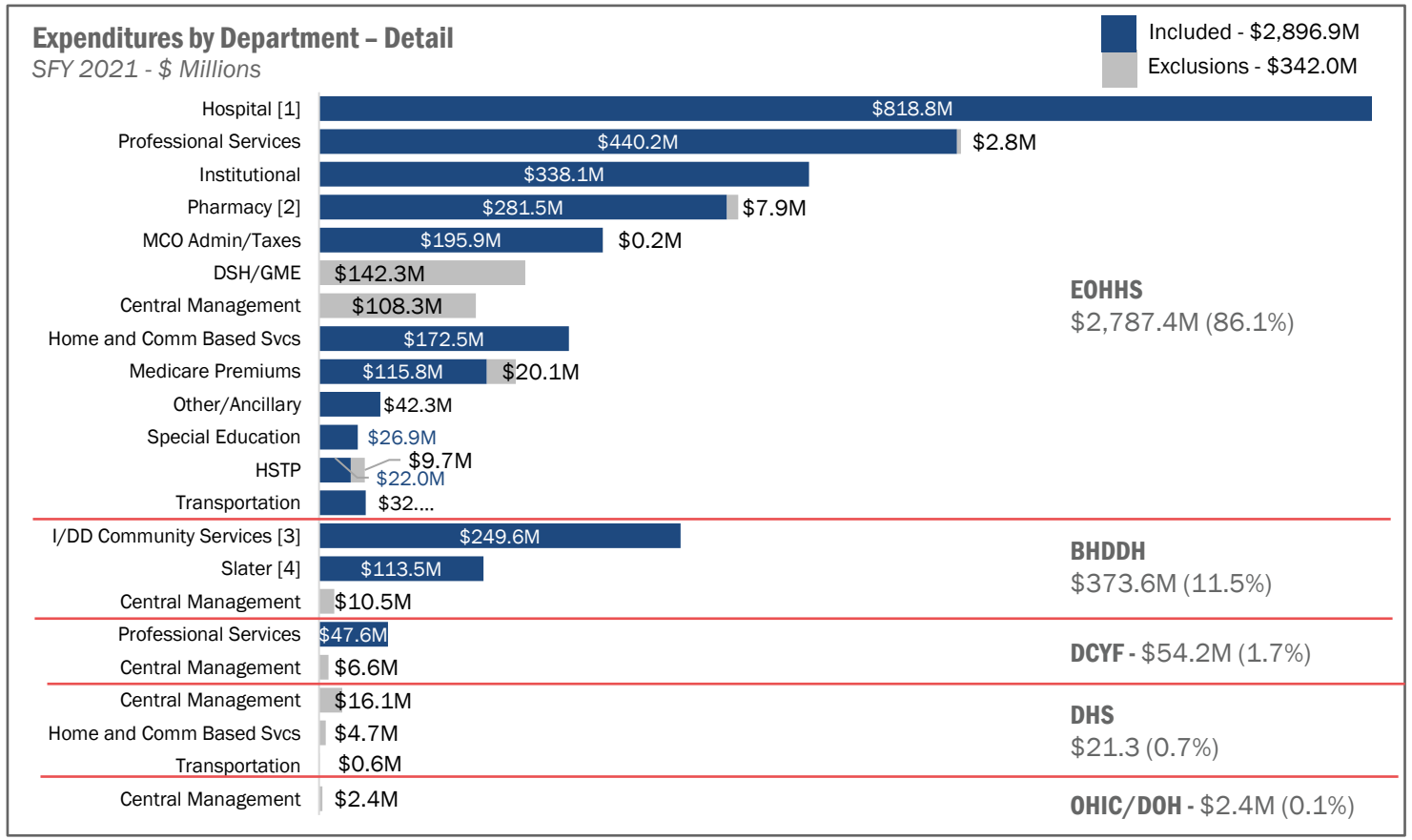


EOHHS	BHDDH	DCYF	DHS	DOH/OHIC	Total
86.1%	11.5%	1.7%	0.7%	0.1%	100%
% of Total Expenditures					
2.5%	-0.4%	1.1%	-20.5%	-0.7%	-18.0%
5-Year Compounded Annual Growth Rate – SFY 2017-2021					

- 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 2017 to 2021 by 18% per annum, with EOHHS spending increasing by 2.5% per annum.
- In SFY 2021, 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 $153.6 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.

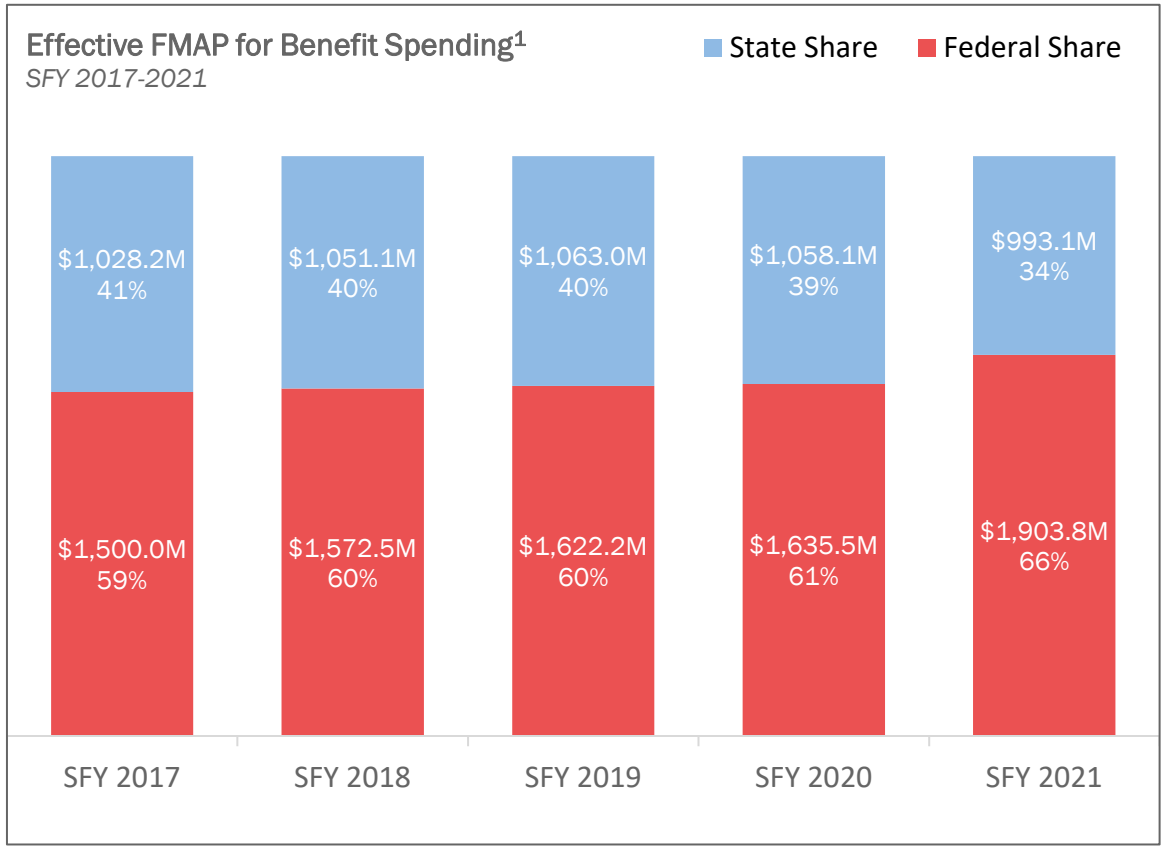


[1] EOHHS Hospital spending includes acute spending on Inpatient and Outpatient Hospitals, UPL Payments and spending at Tavares.
[2] Total Pharmacy includes retail pharmacy, office-administered drugs, and outpatient pharmacy. Costs are net of pharmacy rebates.
[3] I/DD Community includes all residential 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 2021.

- Overall, with total spending of $2.9 billion, **EOHHS** spending account for 86.1% of Medicaid expenditures. The biggest portion (29.7%) of that is for hospital-based services. Professional services accounts for 16% and institutional care (inclusive of Nursing Facilities and Hospice) accounts for 12% of EOHHS benefit expenditures.
  - Expenditures for Medicaid-eligible special education services include the federal share funded in the EOHHS budget and the matching funds for those services, which are financed by each local education agency.
- **BHDDH** expenditures of $373.6 million account for 11.5% 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 2021, 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 $54.2million (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 $21.3 million of Medicaid expenditures (<1%). Benefit spending 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.

Benefit Spending by Funding Source

Medicaid programs are funded by state and federal dollars. In SFY 2021, Rhode Island paid approximately 34% of all full benefit expenditures (i.e., excluding Limited Benefits and Central Management) using state funds.

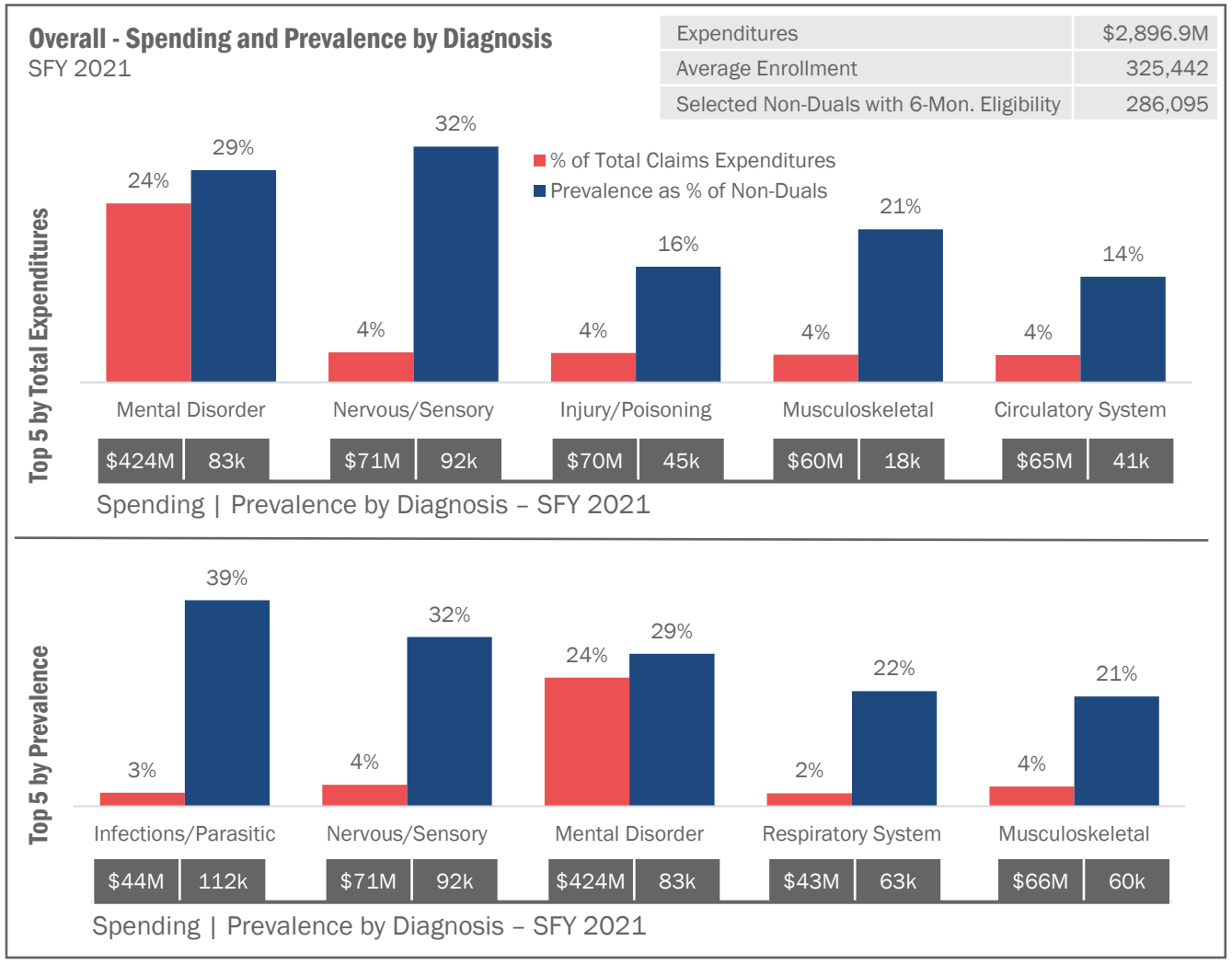


[1] Benefit Spending includes members with full benefits. Does not include Central Management or Limited Benefits expenditures.

- 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 24% 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:

- 29% "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, 29% had claims where "Mental or Behavioral Health" was the primary diagnosis.
- Of the total claims for this population, 24% 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 2021

	Mandatory Populations	Optional Populations	Total
ENROLLMENT	209,191 (64%)	116,251 (36%)	325,442
Expenditures on Mandatory Benefits	$1,102.9 M (38%)	$902.7 M (31%)	$2,005.6 M (69%)
Expenditures on Optional Benefits	$504.5 M (17%)	$386.7 M (13%)	$891.3 M (31%)
TOTAL EXPENDITURES	$1,607.5 M (55%)	$1,289.4 M (45%)	$2,896.9 M

[1] Exhibit is prepared using a 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 or "optional" or "mandatory" eligibility group.

*Due to the maintenance of effort (MOE) provisions contained in the American Rescue Plan Act (ARPA), states may not reduce coverage or eligibility levels for HCBS below those in effect as of April 1, 2021 without risking loss of federal matching funds. Additionally, as of the writing, CMS has re-opened its November 2020 Interim Final Rule and is actively considering reinstating its original interpretation of the continuous coverage requirement contained at Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) which **prohibited states from reducing any benefit (including imposition of cost shares or elimination of optional benefits)** for Medicaid members prior to the end of the Public Health Emergency without risking loss of federal matching funds.*

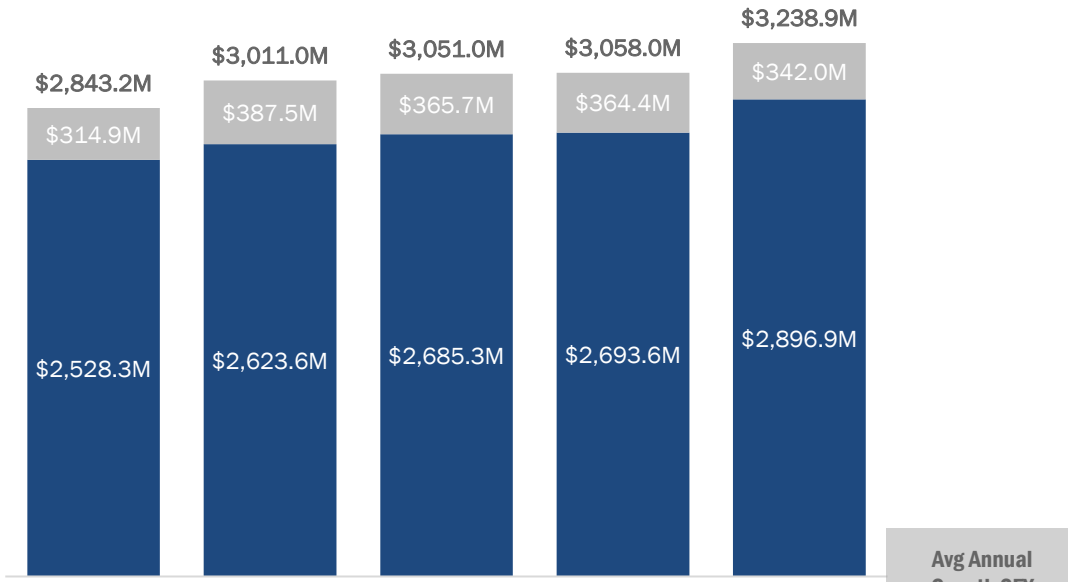
- Mandatory Medicaid populations include groups like low-income families, qualified pregnant women and children, and individuals receiving SSI.
- Optional populations can be covered at the state's discretion and include adults without dependent children, low-income pregnant women and parents above federal 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 MOE provisions contained in the HEALTHY KIDS and ACCESS Acts, which extended federal funding for CHIP through FY 2027.
- 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 based on FY 2021 claims include:
  - I/DD Community Services ($249.6 million)
  - Pharmacy ($169 million net of rebates)
  - Home and Community Based Services (HCBS) for LTSS members ($144 million)
  - Hospice ($25.6 million)
- 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 7.5% in SFY 2021 and average 3.5% over the past five fiscal years.

Overall Medicaid Expenditures
SFY 2017-2021



	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Avg Annual Growth SFY 2017-2021[1]
Annual Enrollment Growth (Full Benefits only)	3.8%	2.4%	0.3%	7.5%	3.5%

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2017-2021 as shown.

- Overall spending on benefits for fully-covered members increased by 7.5% in SFY 2021 to $2,896.9 million.
  - The increase in spending is largely attributable to the sharp increase in enrollment that started in March 2020, following the declaration by the federal government of a Public Health Emergency for COVID-19 and a moratorium on most regular termination activities.
  - Also related to COVID-19, a significant shift in LTSS spending occurred in the last quarter of SFY 2020 that carried into SFY 2021:
    - Compared to SFY 2017, spending at institutional settings (i.e., nursing facilities, hospice, and at Tavares Pediatric Center) fell by $46 million in SFY 2021, from $384 million to $338 million. This, however, was offset with a significant increase of $31 million in community LTSS spending, from $381 million in SFY 2017 to $422 million in SFY 2021.

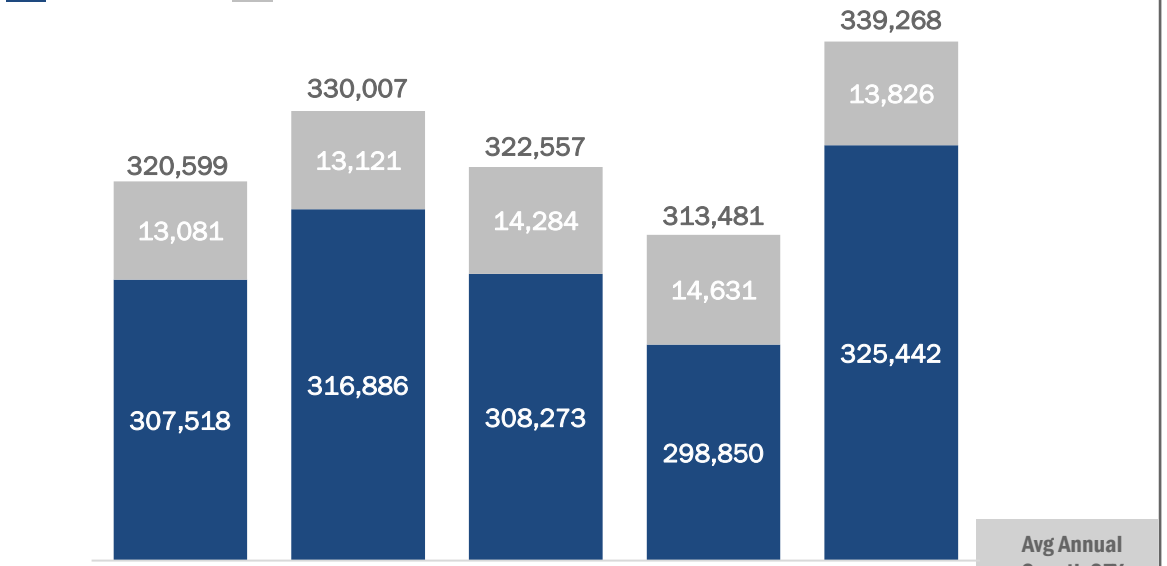
Spending Comparison, by Eligibility Group, SFY 2017 to SFY 2021

	SFY 2017	SFY 2021	Annual Growth Rate SFY 2017-2021
Children and Families	$551.6M	$656.5M	4.4%
CSHCN	$206.3M	$224.1M	2.1%
Expansion	$438.6M	$663.0M	10.9%
Disabled Adults	$764.0M	$785.6M	0.7%
Elders	$567.8M	$567.7M	0.0%
Overall	**$2,528.3M**	**$2,896.9M**	**3.5%**

Trends: Average Monthly Enrollment

After years of decline, average enrollment increased in SFY 2021. This decline began reversing in March 2020.

Total Medicaid Enrollment
SFY 2017-2021



					Avg Annual Growth SFY 2017-2021[1]
Annual Enrollment Growth (Full Benefits only)	3.0%	-2.7%	-3.1%	8.9%	1.4%

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2017-2021 as shown.

- Average monthly enrollment increased 8.9% in SFY 2021 after two consecutive years of declining enrollment growth.
- The increased enrollment 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 291,953, a reduction of 9.6% from Rhode Island's peak enrollment of 322,853 in June 2017.
  - By June 2021, enrollment of fully-covered Medicaid beneficiaries had rebounded to 337,425, an increase of 15.6% from February 2020.

Enrollment Comparison, by Eligibility Group, SFY 2017 to SFY 2021

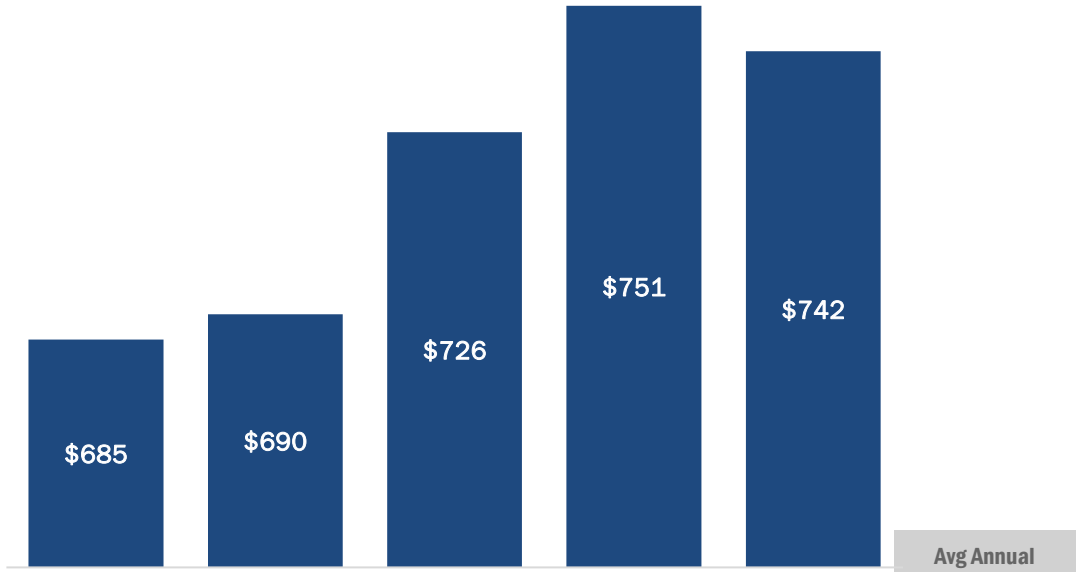
	SFY 2017	SFY 2021	Annual Growth Rate SFY 2017-2021
Children and Families	166,690	167,757	0.2%
CSHCN	12,363	12,498	0.3%
Expansion	76,050	92,077	4.9%
Disabled Adults	32,481	31,110	-1.1%
Elders	19,934	22,000	2.5%
Overall	**307,518**	**325,442**	**1.4%**

Trends: PMPM

Average PMPM declined just over 1% in SFY 2021; and had an average annual growth of 2% since SFY 2017.

Total Medicaid PMPM - Full Medicaid Only
SFY 2017-2021

Expenditures	$2,896.9M
Average Enrollment	325,442



	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Avg Annual Growth SFY 2017-2021[1]
Annual PMPM Change (Full Benefits only)	-0.7%	5.2%	3.5%	-1.2%	2.0%

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2017-2021 as shown.

- After experiencing no meaningful change in SFY 2018, the Medicaid PMPM trend increased to 5.2% and 3.5% in SFY 2019 and SFY 2020, respectively.
- The overall five-year PMPM trend of 2.0% is attributed, in part, to a change in the mix of the population groups, with most of the enrollment growth concentrated within the Children and Families and Expansion eligibility groups:
  - PMPMs vary significantly across populations, from $326 for Children and Families to $2,151 for Elders
  - The average annual compounded PMPM growth rate varies over the past five years, from –2.4% for Elders to 5.7% for Expansion adults.

PMPM Comparison, by Eligibility Group, SFY 2017 to SFY 2021

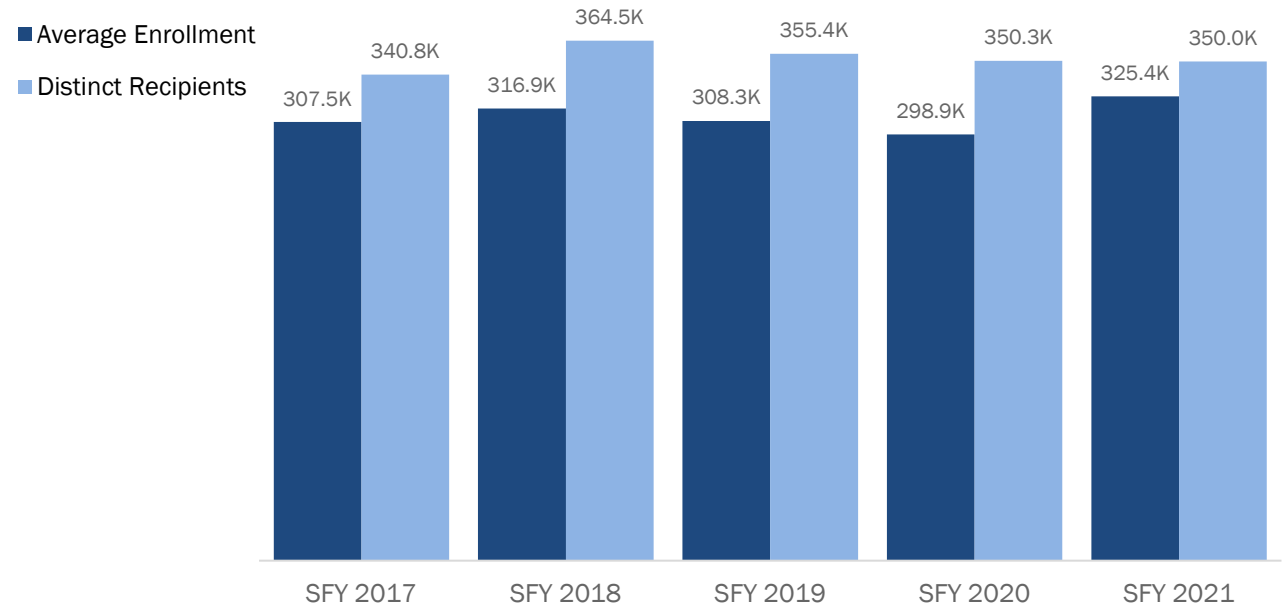
	SFY 2017	SFY 2021	Annual Growth Rate SFY 2017-2021
Children and Families	$276	$326	4.3%
CSHCN	$1,391	$1,495	1.8%
Expansion	$481	$600	5.7%
Disabled Adults	$1,966	$2,106	1.7%
Elders	$2,374	$2,151	-2.4%
Overall	**$685**	**$742**	**2.0%**

Trends: Unique Recipients

Nearly one-third of Rhode Island's population was enrolled in Medicaid with full benefits for some part of SFY 2021.

Medicaid Enrollment, including Full Medicaid Only

SFY 2017-2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Turnover Ratio	1.11	1.15	1.15	1.17	1.08
Unique Members as % of RI Population[1]	32.3%	34.5%	33.6%	33.2%	31.9%

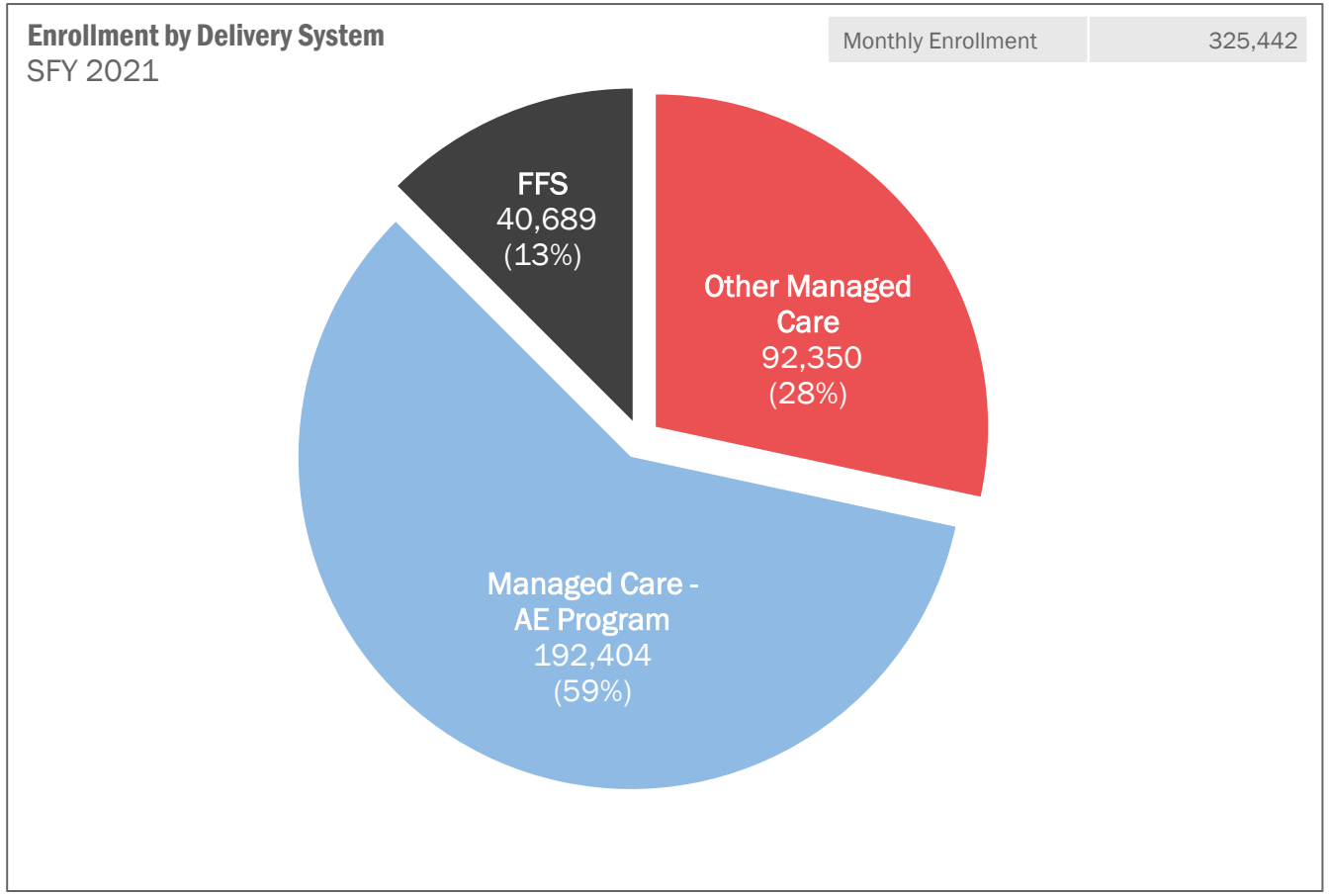
[1]Source: Population Division, US Census Bureau.

- 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.
- In March 2020, CMS initiated a federal moratorium on termination activity that reduced this 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 nearly 60% are attributed to the Accountable Entity Program.



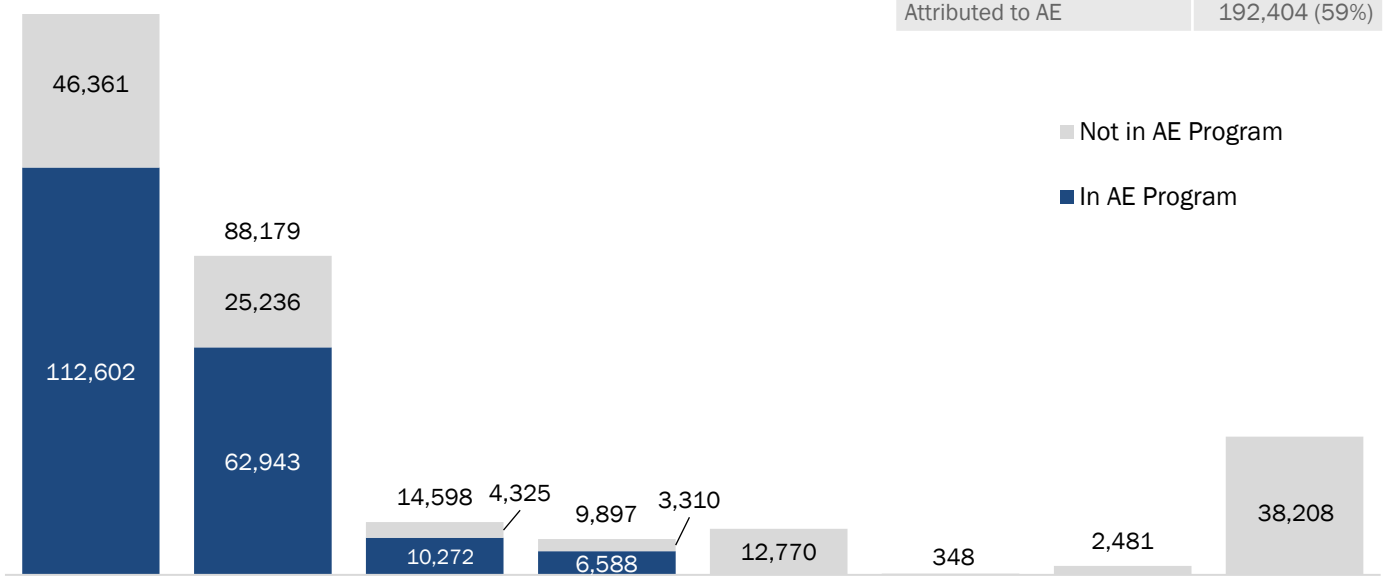
- Managed Care – AE Program: The AE Program is Rhode Island Medicaid's version of an Accountable Care Organization (ACO) in which a provider organization is accountable for quality health care, outcomes, and the total cost of care for enrollees. All members in the AE program are also enrolled in an MCO. 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 transitioned 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 2021

Total Monthly Enrollment	325,442
Enrolled in Managed Care	284,754 (87%)
Attributed to AE	192,404 (59%)



RC Core	Expansion	RHP	RC CSHCN	RHO	PACE	RIte Share	FFS
48.8%	27.1%	4.5%	3.0%	3.9%	0.1%	0.8%	11.7%

% of Enrollment – SFY 2020

1.3%	5.8%	-0.6%	1.5%	-13.6%	5.7%	-21.8%	4.4%

5-Year Compounded Annual Growth Rate – SFY 2017 - 2021

- 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 2021

Total Monthly Enrollment	325,442
Total Expenditures	$2,896 M

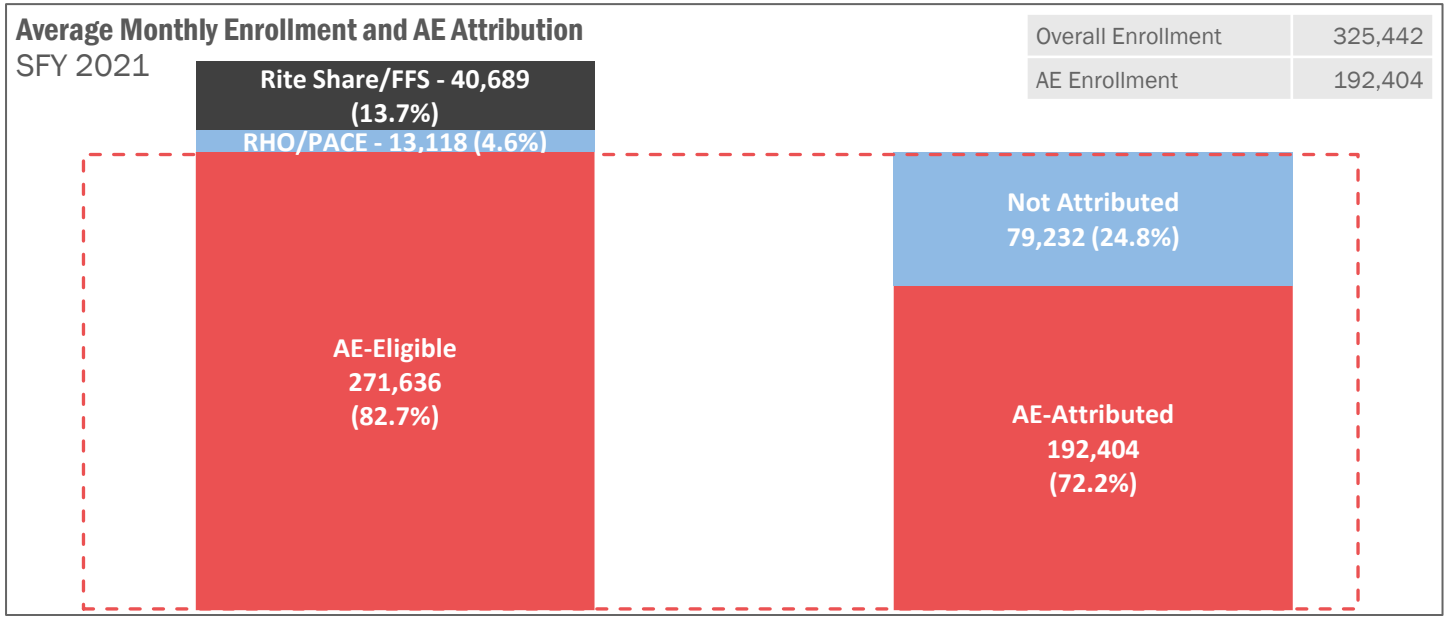
AE-Eligible Managed Care
Enrollment: 271,636 (83.4%)
Expenditures: $1,811 M (62.9%)

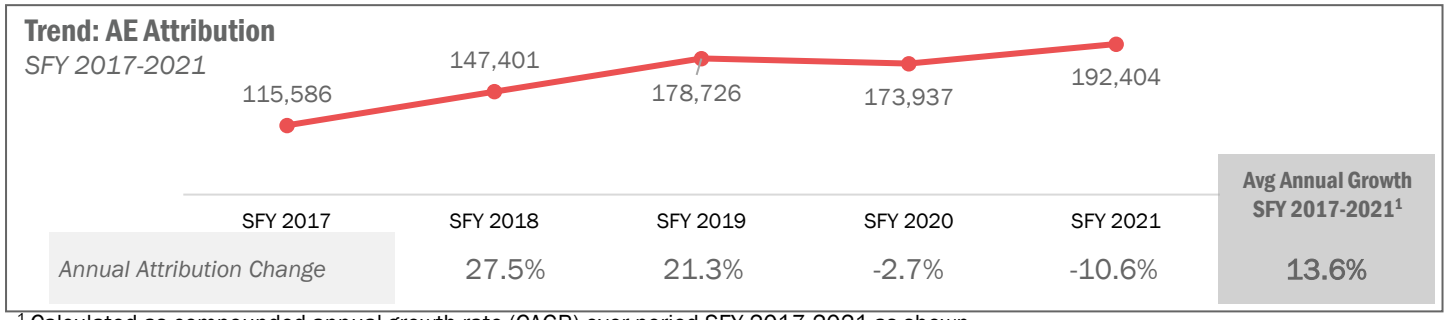
	Managed Care AE-Attributed *192,404 (59.1%)*	Managed Care Not Enrolled in AE *79,232 (24.3%)*	Managed Care RHO & PACE *13,118 (4.0%)*	Remaining in FFS/Rite Share *40,689 (12.5%)*
Major Medical Capitation *$1,715.5M (59.2%)*	$1,114.6M 38.5%	$476.2M 16.4%	$124.9M 4.3%	($0.3M) 0.0%
Other Capitation *$72.6M (2.5%)*	$35.0M 1.2%	$15.2M 0.5%	$60.6M 2.1%	$77.6M 2.7%
FFS Expenditures *$993.0M (34.3%)*	$121.0M 4.2%	$59.1M 2.0%	$109.0M 3.8%	$703.9M 24.3%
Total Expenditures	$1,270.8M 43.9%	$550.5M 19%	$294.7M 10.2%	$781.5M 27%

- 87% of Medicaid's 325,442 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 (AE). Overall, 192,404 member (59% of all Medicaid members and 71% of AE-eligible members) are attributed to an AE.
- Monthly capitation payments of $1.788 billion account for 62% 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:
  - $1.7 billion (59%) 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 $72.6 million (3%) include Medicare Premium Payments, RIte Smiles, and Non-Emergency Transportation.
- FFS spending of $993 million 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.



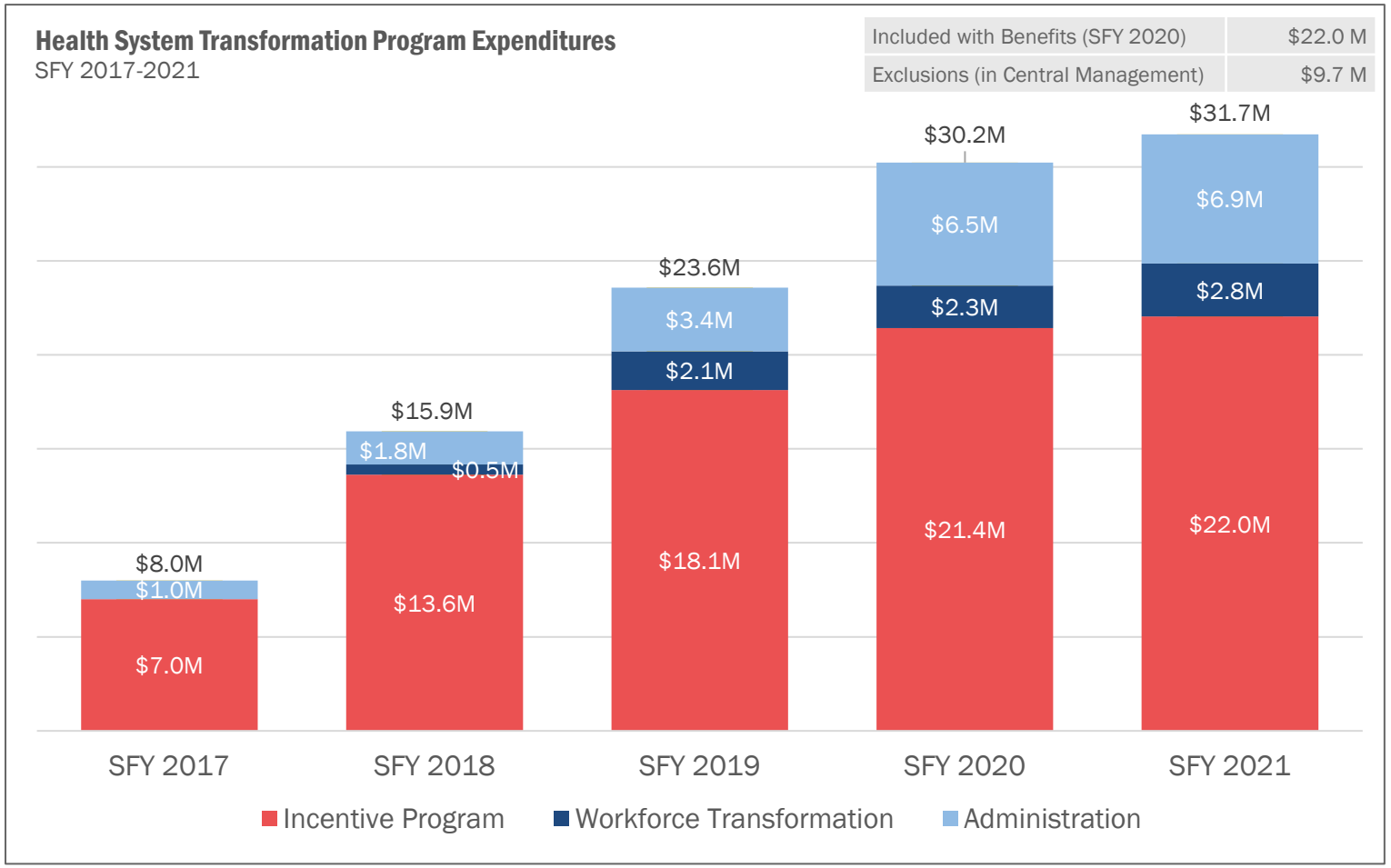


[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2017-2021 as shown.

- 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 through 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)

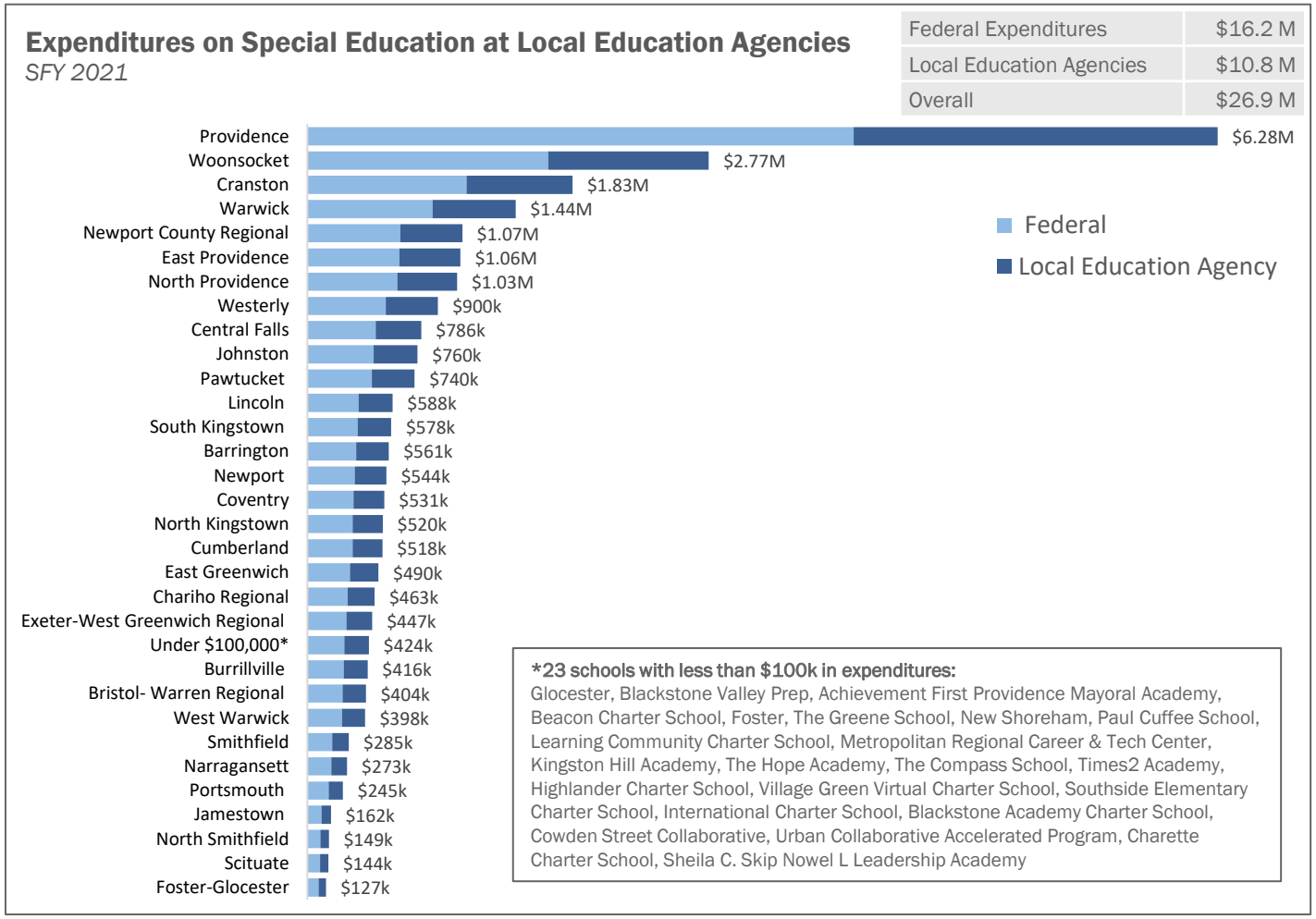
In October 2016, CMS approved Rhode Island's HSTP waiver amendment, bringing in restricted revenues to the State for use as the state share on new investments towards the establishment of Accountable Entities.



- In SFY 2021, EOHHS invested $31.7 million in Rhode Island's health delivery system. Of this:
  - $22 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.
  - $9.7 million was spent within EOHHS' central management budget for workforce development and administrative-related expenditures.
- Through SFY 2021, EOHHS has invested $109.5 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.

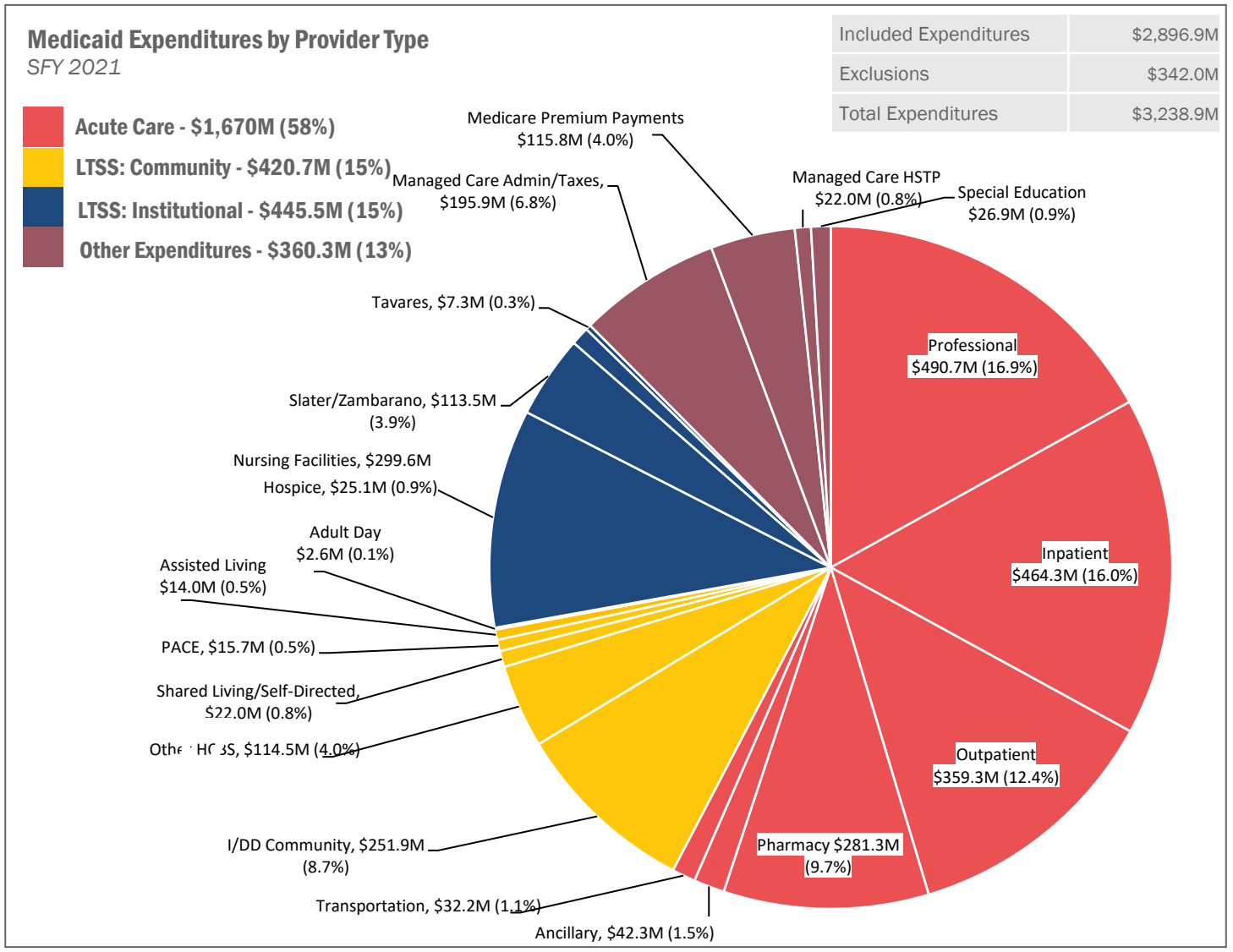
- Expenditures for Medicaid-eligible special education services include the federal share funded in the EOHHS budget and the matching funds for those services, which are financed by each local education agency.
- 54 school districts/departments received LEA payments in SFY 2021.

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 LEA share of the expenditure is imputed based on the effective FMAP rate for the fiscal year.

Expenditures by Provider Type

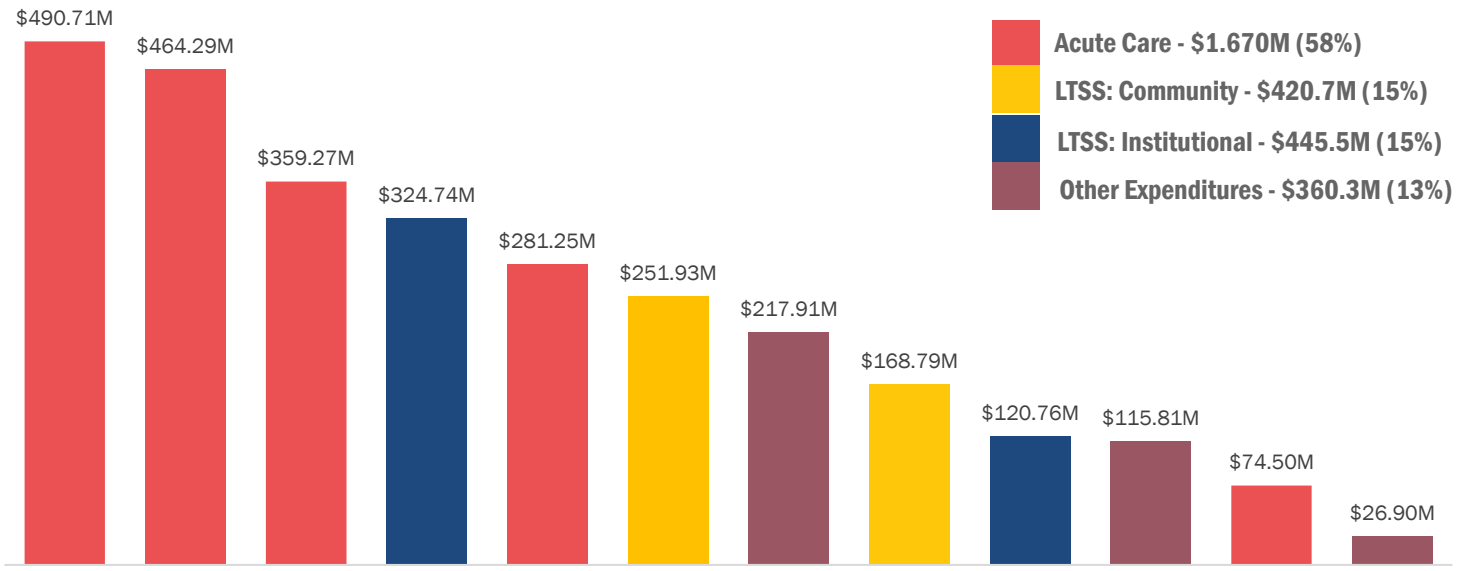
- **Acute services** had $1,670 million in Medicaid expenditures in SFY 2021, constituting 58% of all expenditures.
  - Pharmacy spend is net of rebates.
- **LTSS** had $866 million in Medicaid expenditures, constituting 30% of all expenditures. LTSS expenditures primarily serve the Elders and Adults with Disabilities populations. They are grouped into two categories:
  - **Institutional Care** services are provided to populations who stay in an institution. These services account for $446 million, including 51% of all LTSS expenditures and 15% 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 49% 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 also classified Special Education expenditures under this category.



Expenditures by Provider Type (cont'd)

Expenditures by Provider
SFY 2021

Included Expenditures	$2,896.9M
Exclusions	$342.0M



Prof.	Inpatient	Outpatient	Nursing/ Hospice	Pharmacy	I/DD Community	Admin/Taxes & HSTP	HCBS	Slater/ Tavares	Medicare Premiums	Other Medical	Special Education
16.9%	16.0%	12.4%	11.2%	9.7%	8.7%	7.5%	5.8%	4.2%	4.0%	2.6%	0.9%

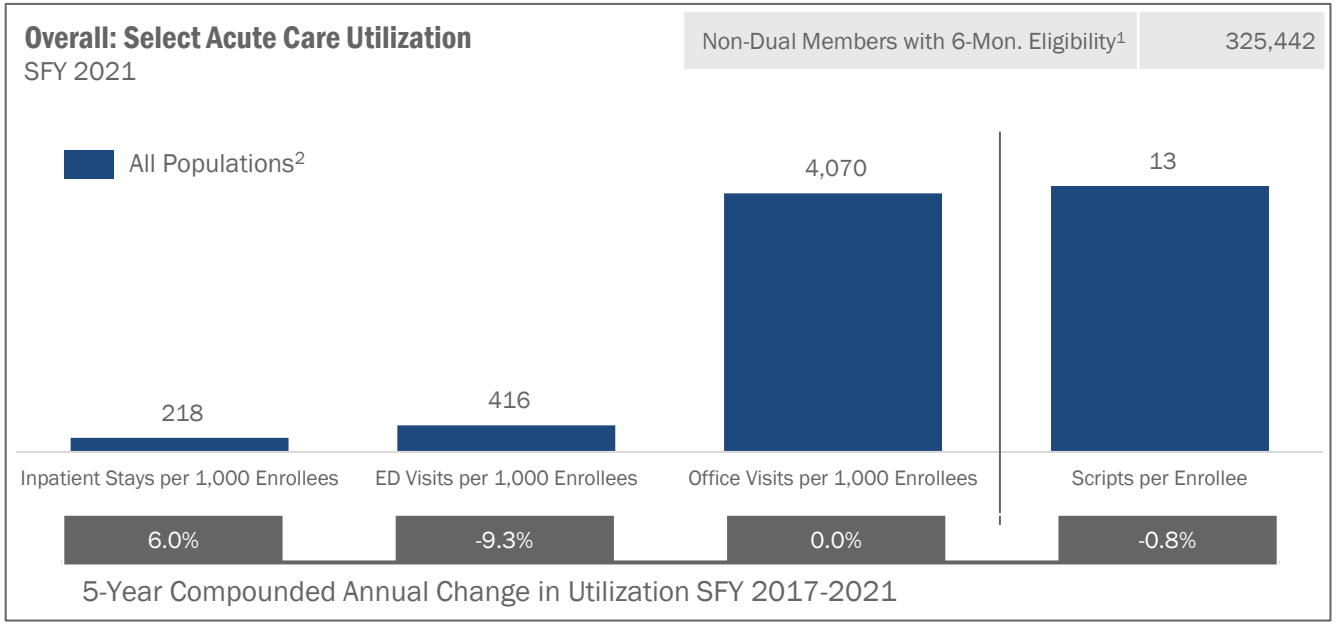
% of Total Expenditures

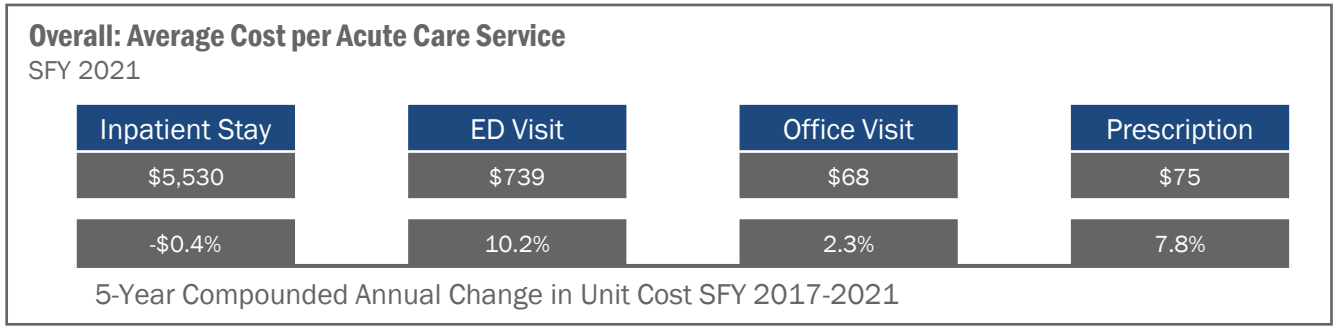
3.1%	6.3%	5.0%	-3.1%	15.1%	0.2%	0.7%	6.9%	2.6%	3.8%	1.7%	-7.5%

5-Year Compounded Annual Growth Rate – SFY 2017-2021

- 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 3.8% over the 5-year period, but Medicaid does not control these rates, and this rate was moderated in SFY 2021 due to the PHE and a temporary increase to Rhode Island's FMAP rate that reduced the cost of providing Medicare Part D coverage.
  - The reduction in Nursing/Hospice spending is attributed to the impact of COVID-19 on nursing facility census and the decline in facility census experienced since March 2020. A similarly precipitous decline was experienced across all payers.
- Please note for discussion purposes, in some exhibits, Slater and/or Tavares Hospital, are treated separately from long-term institutional spending in a nursing facility.

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 $1.7 billion, or 58 percent, of total Medicaid benefit spending in SFY 2021. 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. Beginning in SFY 2021, these trends are affected by the onset of the COVID-19 public health emergency which depressed utilization of certain service. As a result, the derivation of the compound annual growth rate when compared to SFY 2017 experience may be only artificially depressed.

- From SFY 2017 to SFY 2021, utilization fell for Emergency Department (ED) visits and prescriptions, with ED visits/scripts per enrollees falling –9.3%, and -0.8%, respectively. Inpatient stays experienced significant increase in utilization (+6.0% annually).
- During this time span, costs per ED visits increased by 10.2%, costs per prescription increased by 7.8%, and costs per office visit increased by 2.3%.

Data Clarification:

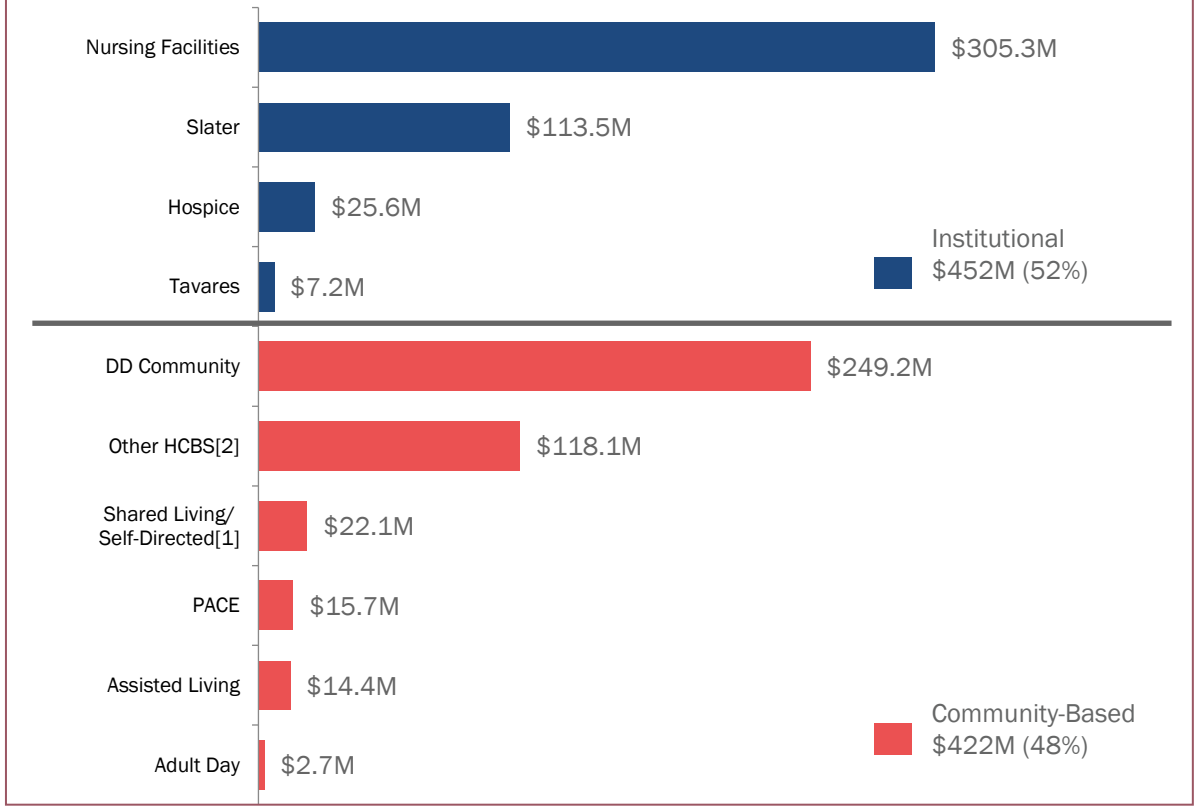
- The utilization and cost per unit metrics on this page are based on detailed claims data and do not include non-claims adjustments (e.g., missing data from MCOs and IBNR).
- The average cost per prescription does not include offsetting drug rebates.

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.

Medicaid Long Term Care Spending

SFY 2021

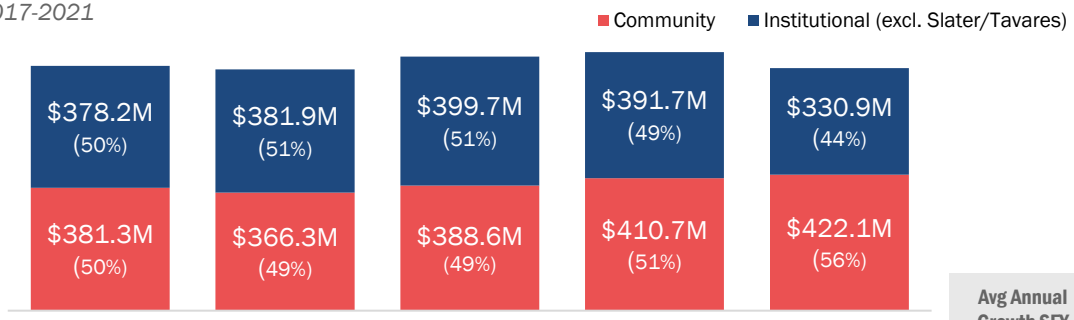


[1] "Self-Directed" includes the Self-Directed Personal Choice and Independent Provider programs.
[2] "Other HCBS" includes personal care and severely disabled nursing homecare services; approx. $22M is for children.

- 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 vs. Community Spending, excl. Slater/Tavares [1]

SFY 2017-2021



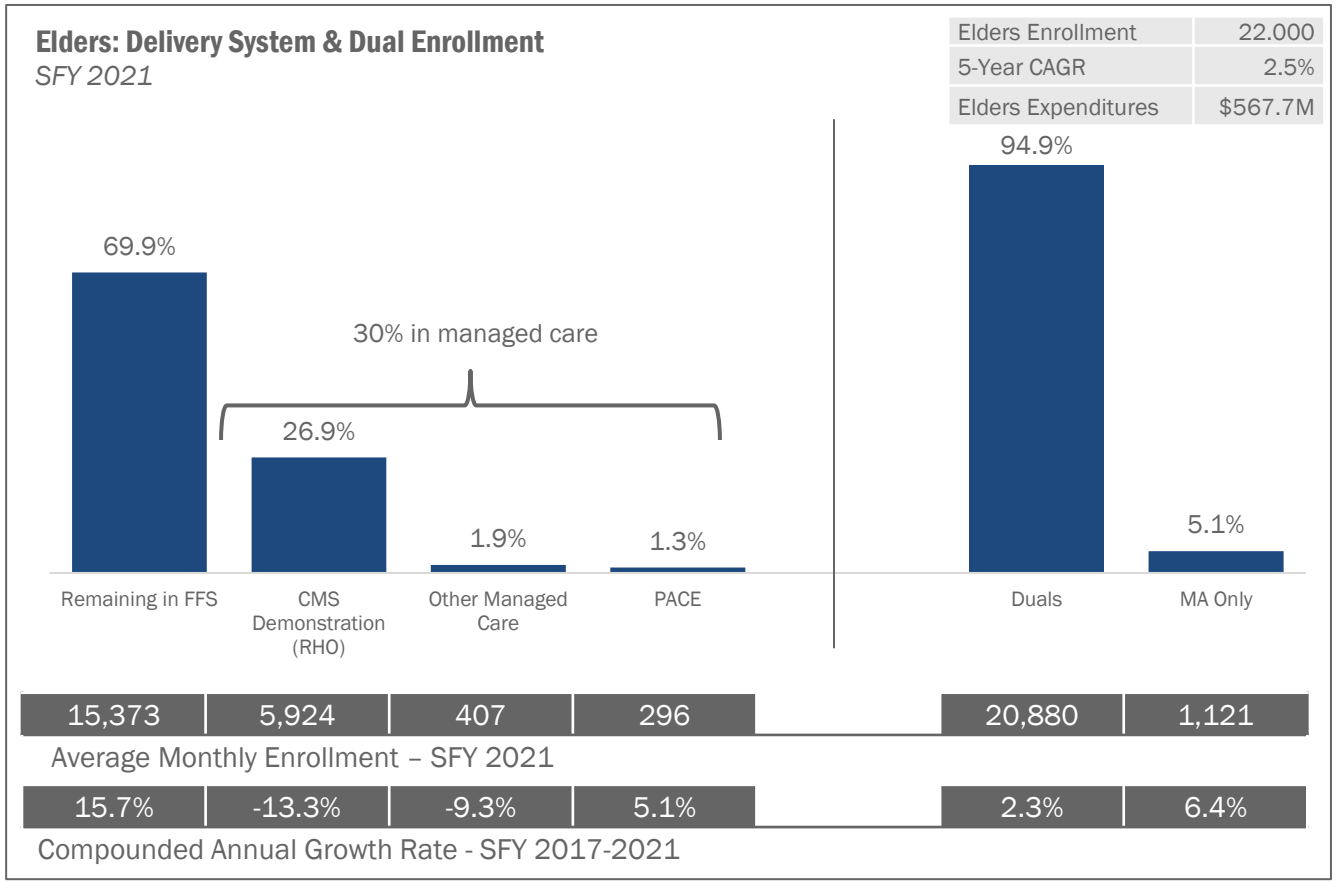
					Avg Annual Growth SFY 2017-2021
Annual % Change – Inst.	1%	5%	-2%	-16%	-3%
Annual % Change – Comm.	-4%	6%	6%	3%	3%

[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.



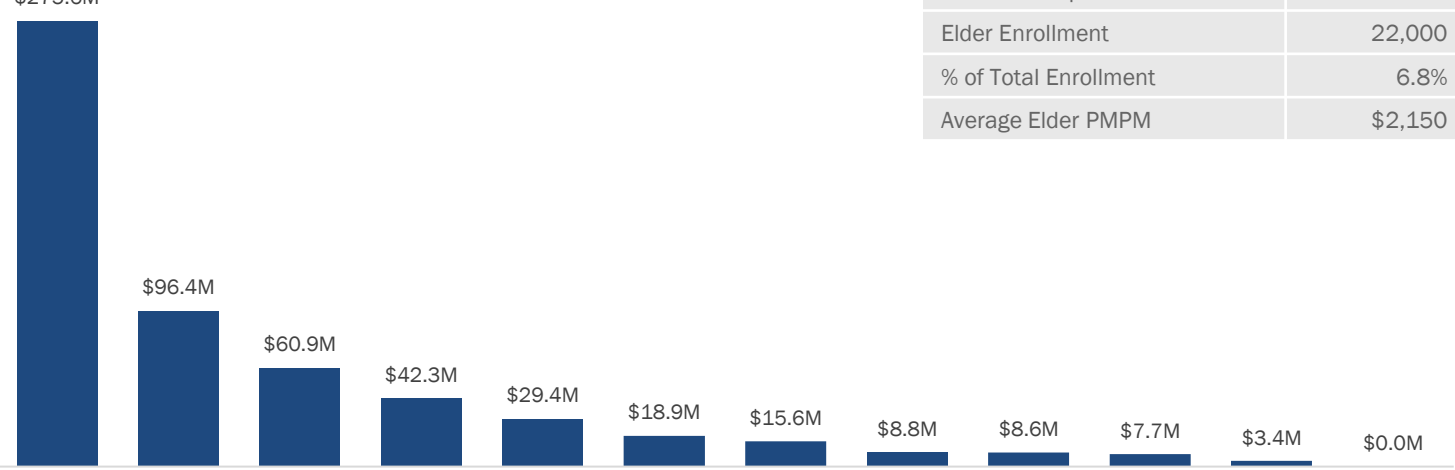
- Compared to other population groups, elders are predominantly in FFS:
  - 70% of elders receive their Medicaid services delivered through EOHHS' FFS program.
  - 30% of elders receive their Medicaid services via managed care.
    - Approximately 27% are enrolled in the CMS Demonstration (RHO Phase II)
    - Less than 1.5% are enrolled in PACE.
- 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.

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 2021



Elder Expenditures	$567.7 M
% of Total Expenditures	19.6%
Elder Enrollment	22,000
% of Total Enrollment	6.8%
Average Elder PMPM	$2,150

	Nursing/ Hospice	HCBS	Medicare Premiums	I/DD Community	Slater/ Tavares	Prof.	Inpatient	Other Medical	Admin/Taxes & HSTP	Outpatient	Pharmacy	Special Education
% of Elder Expenditures – SFY 2021	48.6%	17.0%	10.7%	7.4%	5.2%	3.3%	2.7%	1.6%	1.5%	1.3%	0.6%	-
Elders 5-Year CAGR – SFY 2017-2021	-3.6%	8.0%	4.4%	2.4%	12.2%	5.9%	1.9%	-2.7%	-19.0%	1.5%	10.9%	0.0%
Elder Spend as % of Total Expenditures, by Provider Type – SFY 2021[1]	77.9%	34.7%	52.6%	16.8%	24.4%	3.9%	3.4%	8.4%	4.0%	2.1%	1.2%	0.0%

- Medicaid expenditures on Elders totaled $567.7million in SFY 2021, an amount roughly equivalent to total expenditures in SFY 2017.
- Beginning in SFY 2021, these trends are materially affected by the onset of the COVID-19 public health emergency which significantly depressed utilization of nursing facility services in SFY 2021 compared to prior periods (in SFY 2020 this report included $343.3 million in nursing /hospice expenditures).
- Prior to the PHE, nursing facility expenditures had been steadily rising year/year.

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.

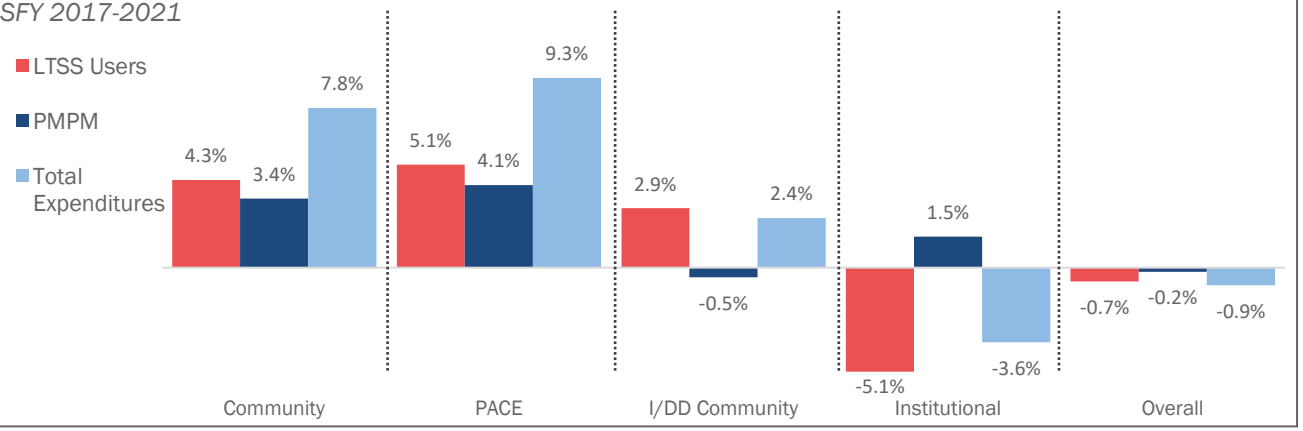
[1] Table shows Elder's spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Elders: LTSS Users and Spending on LTSS

Current LTSS Expenditures
SFY 2021

	Community	PACE	I/DD Community	Institutional[4]	Overall LTSS
LTSS Users[1]	3,706	296	404	3,852	8,258
LTSS PMPM[2]	$1,883	$3,570	$8,719	$5,963	$4,181
LTSS Spend[2]	$83.7M	$12.7M	$42.3M	$276.5M	$414.3M

Expenditures - 5-Year Trends (Compound Annual Growth Rates)
SFY 2017-2021



[1] LTSS users reflects members with an LTSS authorization 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.

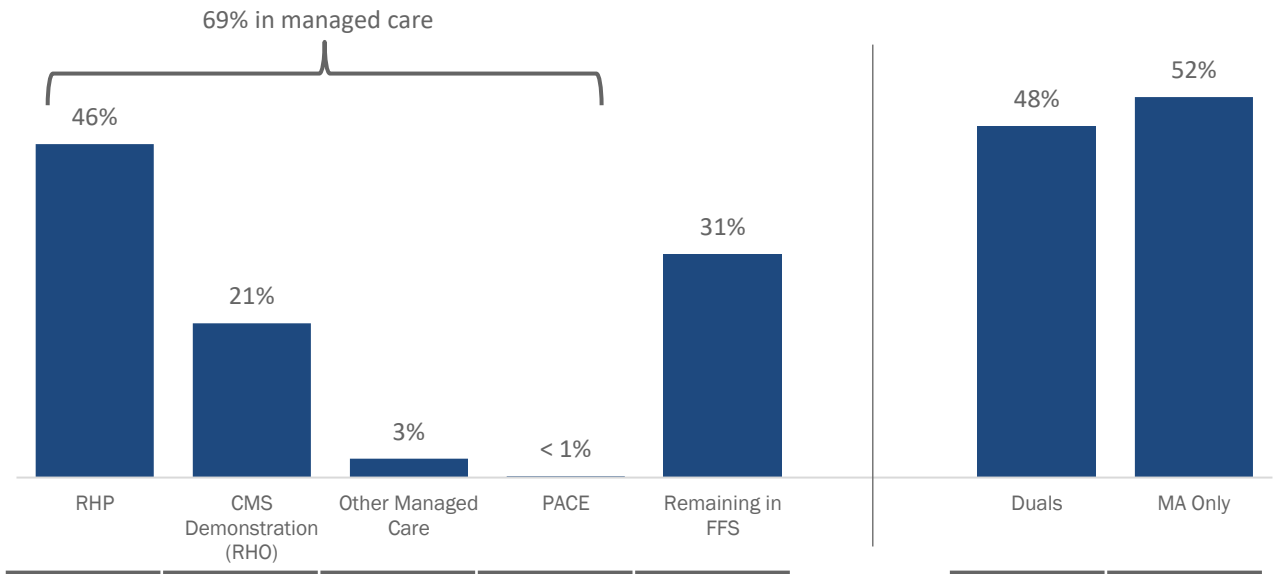
- There is currently a state initiative to "rebalance" LTSS expenditures back into the community instead of institutions. Providing services in this setting can integrate efforts with communities and enable LTSS enrollees to thrive in them, but in many instances an institutional setting is required to fulfill patient needs.
- Overall, expenditures fell by $14.7 million, or nearly -1.0%, over the 5-year period. This change is driven by Institutional expenses, which decreased by $44 million, which more than offset sizeable increases in HCBS services of $29 million over the 5-year span.
  - As noted in earlier sections of this report, the reduction in nursing home expenditures in SFY 2021 was materially affected by the onset of the COVID-19 public health emergency, which significantly depressed these expenditures compared to prior periods.
- The overall PMPM for this population fell by $33, or an average of 0.7% per annum over the 5-year period. (Although most of the decline can be attributed to a decline in nursing home census since March 2020.) This was comprised of the following average annual PMPM trends:
  - The institutional (Nursing facility/hospice) PMPM declined by $351 (1.5%).
  - The PACE PMPM increased by $525 (4.1%).
  - The Community PMPM increased by $160 (3.4%).
  - The I/DD Community PMPM decreased $167 (-0.5%).

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 2021

Disabled Adult Enrollment	31,110
5-Year CAGR	-1.1%



RHP	CMS Demonstration (RHO)	Other Managed Care	PACE	Remaining in FFS	Duals	MA Only
14,191	6,55	801	49	9,514	14,946	16,164

Average Monthly Enrollees – SFY 2021

-0.2%	-13.9%	-2.7%	8.0%	15.9%	-1.1%	-1.1%

Compounded Annual Growth Rate SFY 2017-2021

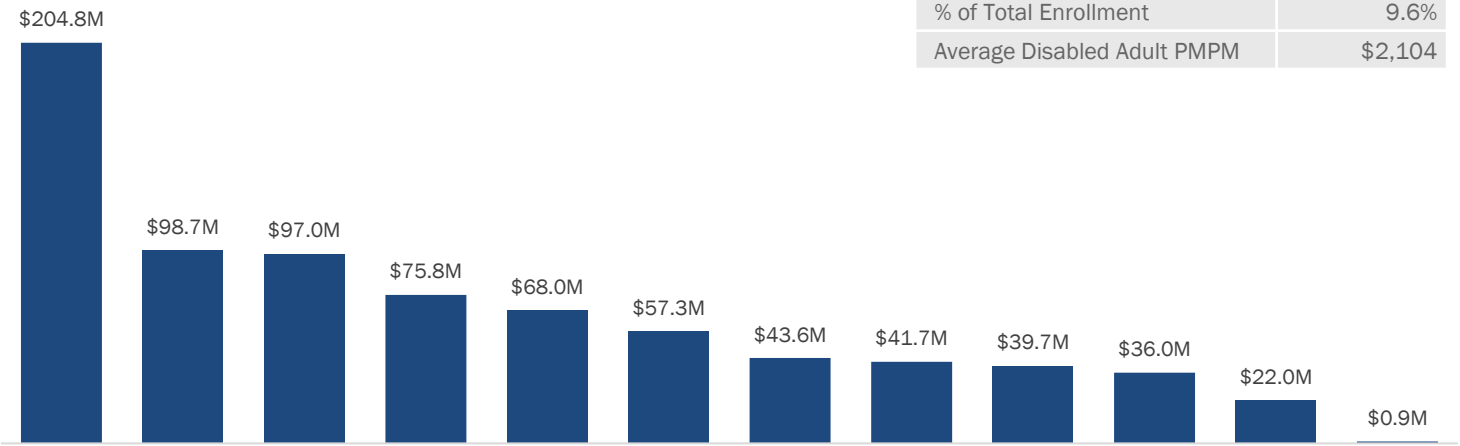
- 46% percent of Adults with Disabilities are enrolled in RHP, a comprehensive managed care program for Adults with Disabilities.
- 48% of Adults with Disabilities are dual eligible.
  - 21% of Adults with Disabilities are enrolled in CMS Dual Demonstration (RHO II).
  - 31% of Adults with Disabilities are not enrolled in managed care and are instead in FFS.
    - Most of these 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 is the only population group that has seen a decline over the past five years. This decline, however, is illusionary as these members are gaining eligibility under Medicaid Expansion as previously-eligible Adults.

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 2021

Disabled Adults Expenditures	$785.6 M
% of Total Expenditures	27.1%
Disabled Adults Enrollment	31.110
% of Total Enrollment	9.6%
Average Disabled Adult PMPM	$2,104



I/DD Community	Prof.	Inpatient	Slater/ Tavares	Pharmacy	Outpatient	Medicare Premiums	HCBS	Nursing/ Hospice	Admin/Taxes & HSTP	Other Medical	Special Education
26.1	12.6%	12.3%	9.7%	8.7%	7.3%	5.6%	5.3%	5.1%	4.6%	2.8%	0.1%

% of Disabled Adults Expenditures – SFY 2021

-0.8%	2.9%	4.0%	-2.5%	9.2%	0.9%	0.9%	2.4%	-2.2%	-7.4%	-0.3%	40.7%

Disabled Adults 5-Year CAGR – SFY 2017-2021

26.1%	12.6%	12.3%	9.7%	8.7%	7.3%	5.6%	5.3%	5.1%	4.6%	2.8%	0.1%

Disabled Adult Spend as % of Total Expenditures, by Provider Type – SFY 2021

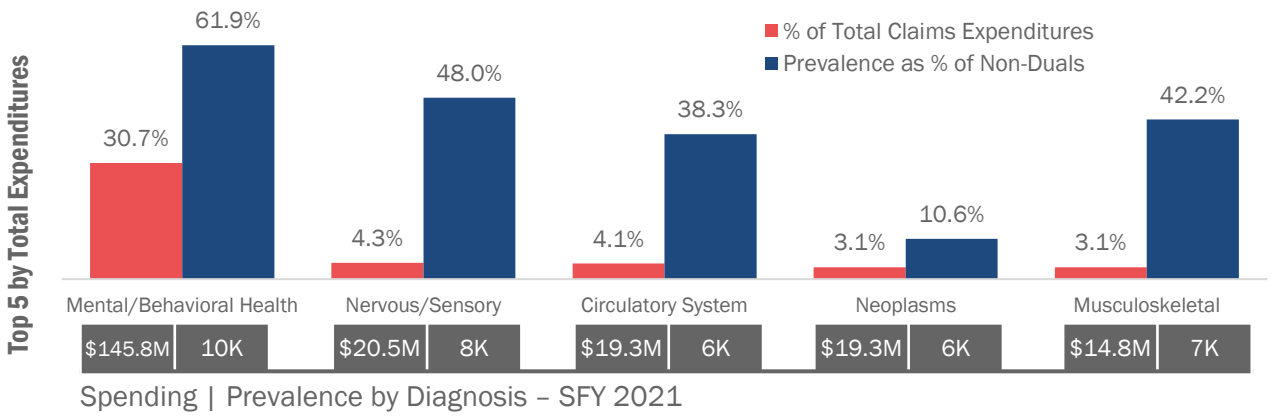
- Adults with Disabilities have the highest PMPM among Medicaid members with full benefits, with those expenditures dominated by I/DD community services.
  - I/DD community services make up 26.1% of expenditures for this population.
- Over the past five years, expenditures on a per member basis for Adults with Disabilities have grown at approximately 1.7% per year. The only population with a lower per member growth rate is Elders.
- Many costs for Adults with Disabilities grew at lower rates than the overall population.
  - Pharmacy costs grew by 9.2% vs. 15.6%
  - Inpatient costs grew by 4.0% vs. 6.5%
  - Outpatient costs grew by 0.9% vs. 5.1%

[1] Table shows Adults with Disabilities 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.

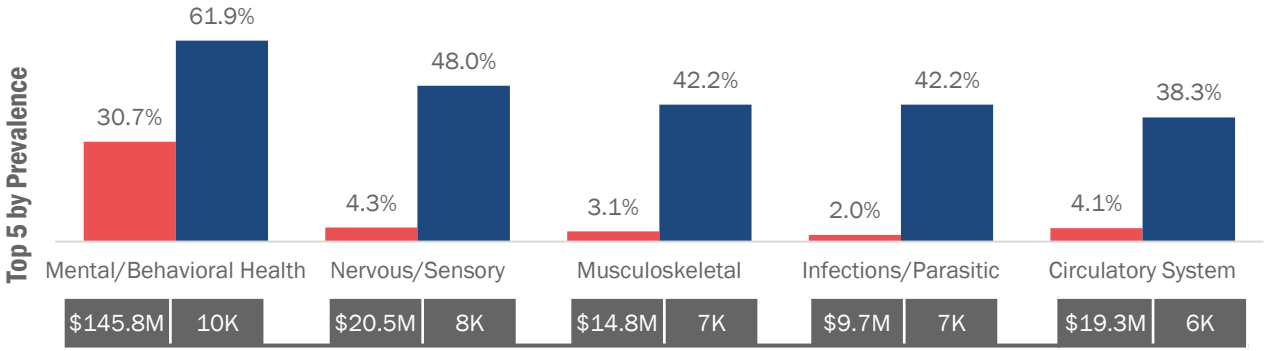
Adults with Disabilities: Diagnoses

Adults with Disabilities – Spending and Prevalence by Diagnosis
SFY 2021

Expenditures	$785.6M
Average Enrollment	31,110
Selected Non-Duals with 6-Mon. Eligibility	16,186



Spending | Prevalence by Diagnosis – SFY 2021



Spending | Prevalence by Diagnosis – SFY 2021

Most expenditures on Adults with Disabilities go toward services for members with Intellectually and Developmental Disabilities.

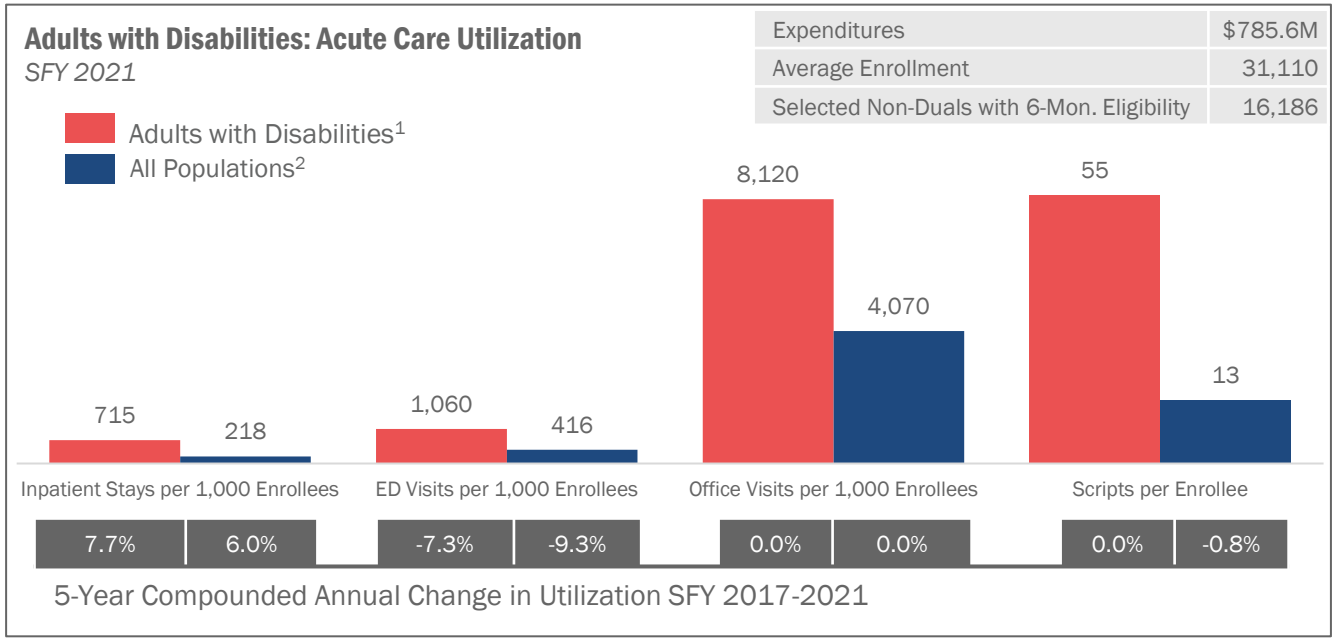
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental and behavioral conditions are both the highest cost and most prevalent conditions among Adults 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:

- 61.9% "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, 61.9% 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.



- Per-person inpatient utilization increased 7.7% per year for Adults with Disabilities from SFY 2017 to SFY 2021; but increased 6% for the overall population.
- Adults with Disabilities have significantly higher utilization at hospitals than all other groups, with 3.3 times more inpatient stays per 1,000 (at a 26% higher cost per stay) and 2.5 more ED visits per 1,000 (at a 14% higher cost per visit)
- The average Adult with Disabilities had 55 pharmacy claims per year, whereas the average enrollee had 13 pharmacy claims per year.

Adults with Disabilities: Average Cost per Acute Care Service
SFY 2021

	Inpatient Stay	ED Visit	Office Visit	Script
Adults with Disabilities	$6,972	$844	$67	$95
Overall	$5,530	$739	$68	$81

[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.

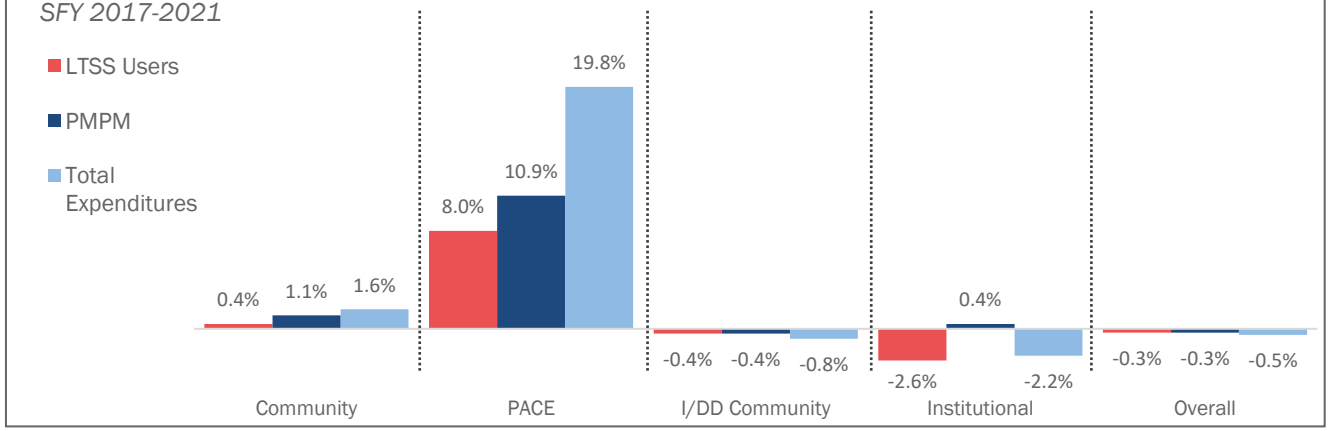
Adults with Disabilities: LTSS Users and Spending

Current LTSS Expenditures
SFY 2021

Disabled Enrollment	31,110
Overall Disabled PMPM	$2,104
Total Disabled Expenditures	$785.6 M

	Community	PACE	I/DD Community	Institutional[4]	Overall LTSS
LTSS Users[1]	1,704	49	3,215	523	5,491
LTSS PMPM[2]	$1,903	$4,788	$5,309	$6,323	$4,344
LTSS Spend[2]	$38.9M	$2.8M	$204.8M	$39.7M	$386.2M

Expenditures - 5-Year Trends (Compound Annual Growth Rates)
SFY 2017-2021

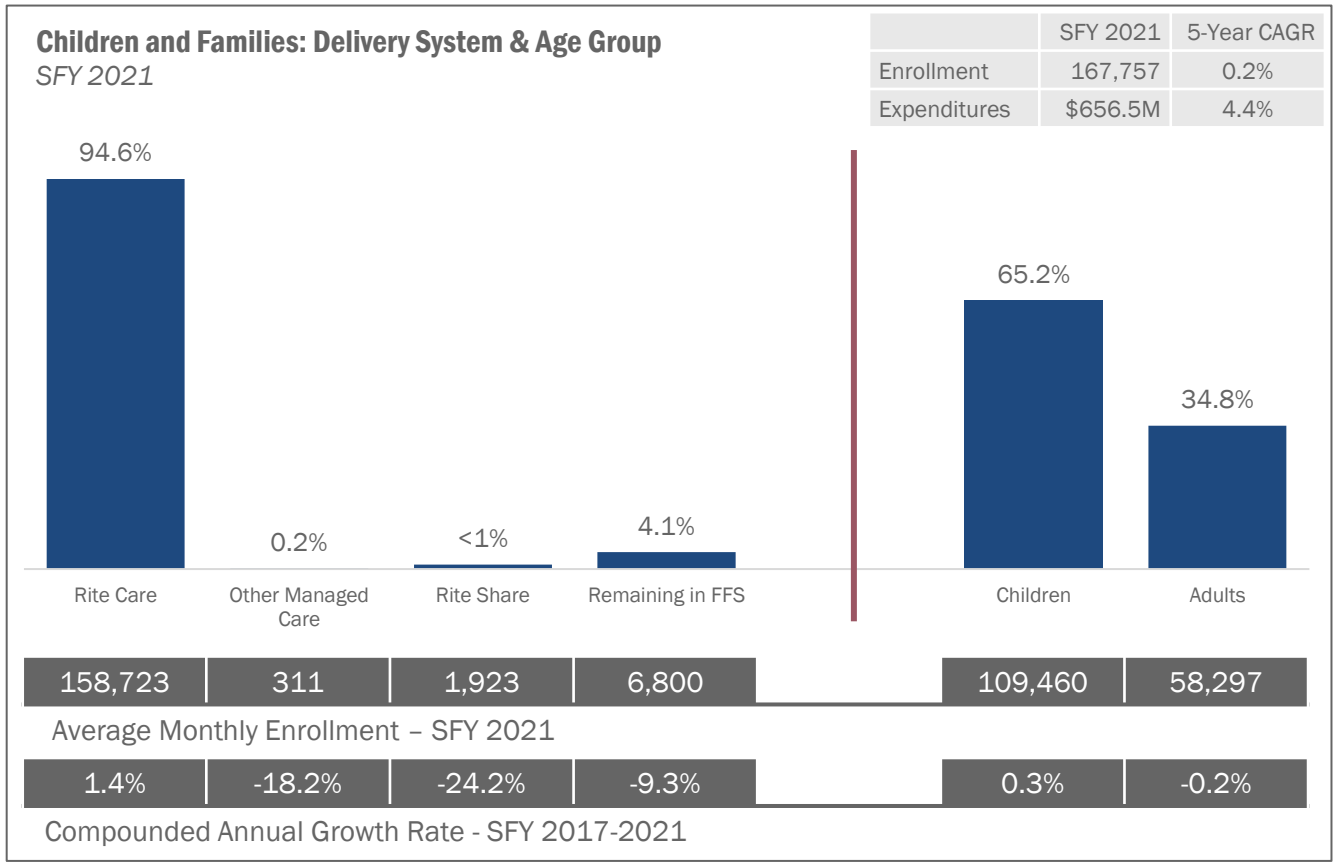


- There is currently a state initiative to "rebalance" LTSS expenditures towards the community instead of institutions with a focus on person-centered choice. Providing services in the community can enable LTSS enrollees to thrive. However, in many instances an institutional setting is required to fulfill patient needs.
- Aligned with this initiative, enrollment for adults with disabilities in institutional care decreased by 2.6% on average per year between SFY 2017 and SFY 2021
- Enrollment in community LTSS decreased by 0.4% annually.
- Overall LTSS expenditures for Disabled Adults decreased by $6.4 million from SFY 2017 to 2021: a decrease in expenditures in I/DD Community care and institutional care is partially offset by an increase in community and PACE services.
- The overall PMPM for Adults with Disabilities decreased by $44 over the 5-year period, by -0.3% per year on average.
  - Over this same time period, the Community PMPM increased by $82 or 1.1%
  - The PACE and Institutional PMPM rates increased by $1,625 and $96, or 10.9% and 0.4%, respectively.

[1] LTSS users reflects members with an LTSS authorization 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.
[4] Institutional includes nursing facilities and hospice residents only. Does not include Slater Hospital admits.

Children and Families: Managed Care Enrollment

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



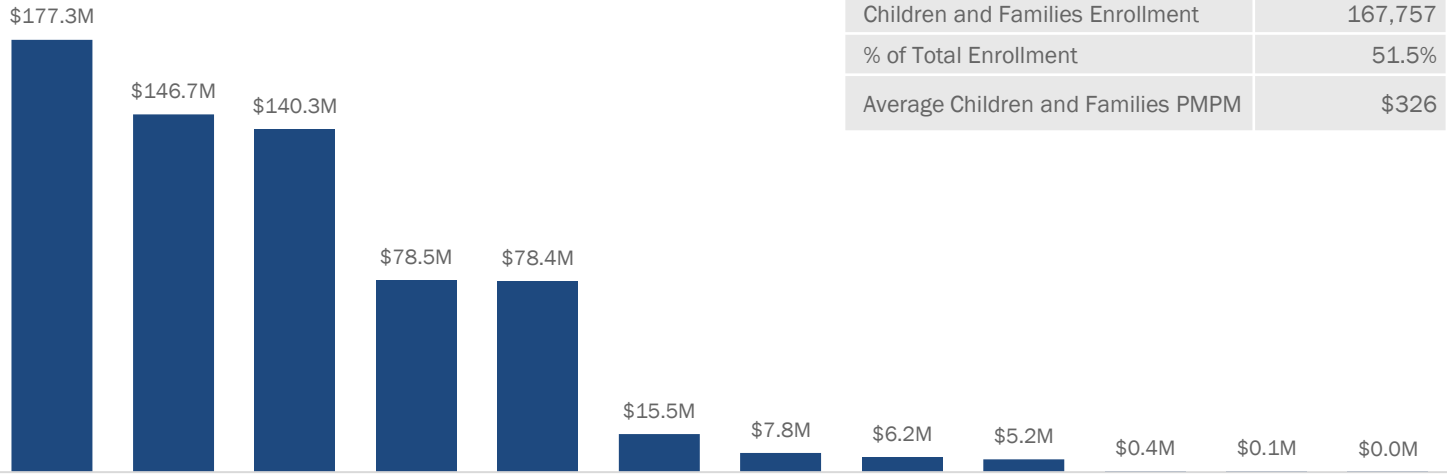
- 95% of the Children and Families population is enrolled in RIte Care Core, a managed care program for families with children, pregnant women, and children under age 19.
- RIte Care enrollees are divided between Neighborhood Health Plan of RI, United Healthcare of New England, and Tufts Health Plan.
- 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 2021

Children and Families Expenditures	$656.5M
% of Total Expenditures	22.7%
Children and Families Enrollment	167,757
% of Total Enrollment	51.5%
Average Children and Families PMPM	$326



Prof.	Outpatient	Inpatient	Admin/Taxes & HSTP	Pharmacy	Other Medical	HCBS	Special Education	Medicare	Slater/ Tavares	Nursing/ Hospice	I/DD Community
27.0%	22.3%	21.4%	12.0%	11.9%	2.4%	1.2%	0.9%	0.8%	<1%	0.1%	<1%

% of Children and Families Expenditures – SFY 2021

1.2%	5.0%	4.5%	2.8%	16.4%	-0.8%	15.6%	-5.8%	17.7%%	-	-3.0	-

Children and Families 5-Year CAGR – SFY 2017-2021

36.1%	40.8%	30.2%	30.1%	27.9%	17.1%	4.6%	23.1%	4.5%	0.1%	0.1%	<0.1%

Children and Families Spend as % of Total Expenditures, by Provider Type – SFY 2021

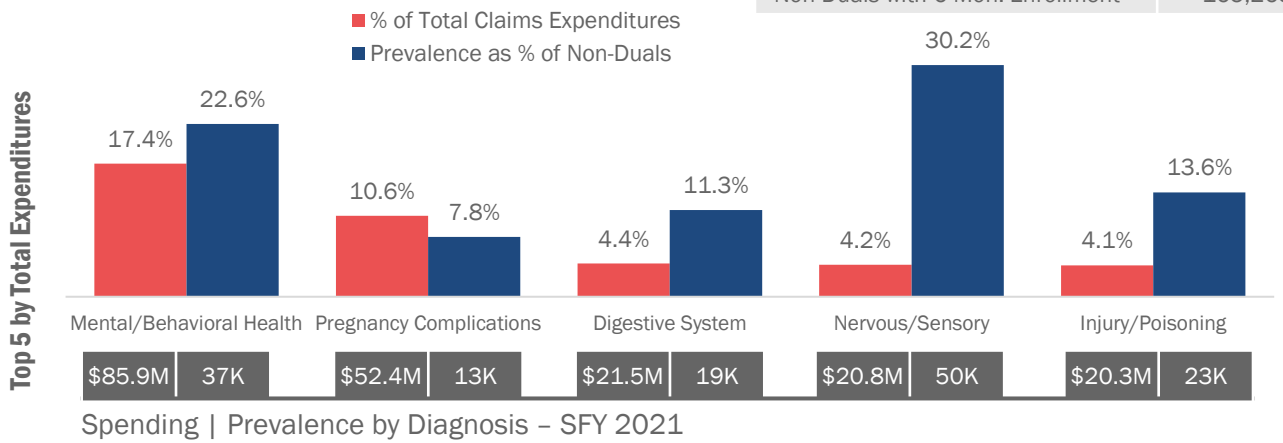
- Children and Families is the largest population group in Rhode Island Medicaid, with 51.5% of all Medicaid enrollees falling into this category.
- Children and Families have the lowest per-person expenditures of any of the populations.
- Professional services and hospital services (outpatient and inpatient) account for 71% ($464.3M) of the expenditures for the Children and Families population in SFY 2021.
- The fastest-growing expenditures for Children and Families are HCBS, Pharmacy, and Medicare Premium Payments, which grew at a yearly average of 15.6%, 16.4%, and 17.7%, respectively, from SFY 2017 to 2021.

[1] Table shows Children and Families 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.

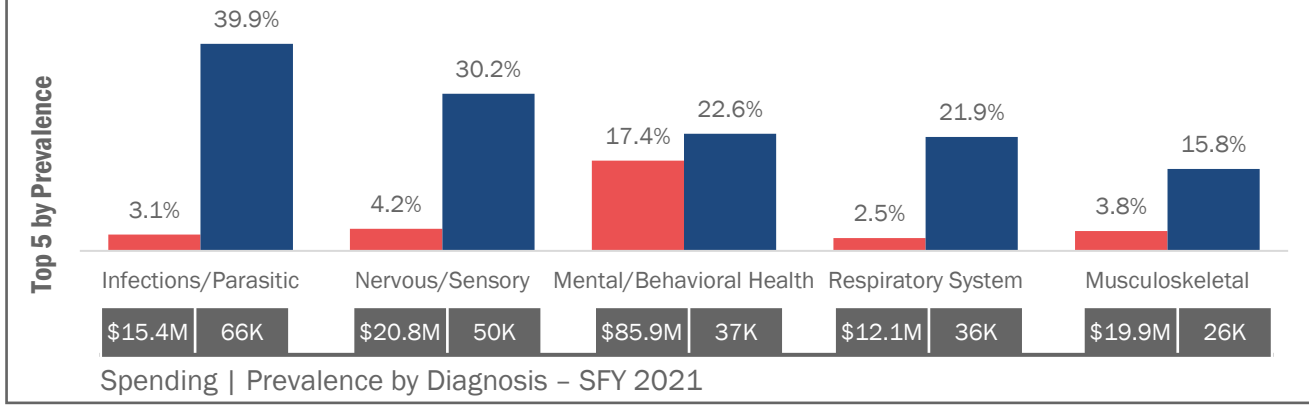
Children and Families: Diagnoses

Children and Families – Spending and Prevalence by Diagnosis
SFY 2021

Expenditures	$656.5M
Average Enrollment	167,757
Non-Duals with 6-Mon. Enrollment	165,265



Spending | Prevalence by Diagnosis – SFY 2021



Spending | Prevalence by Diagnosis – SFY 2021

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 11% 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:

- 22.6% "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, 22.6% 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.

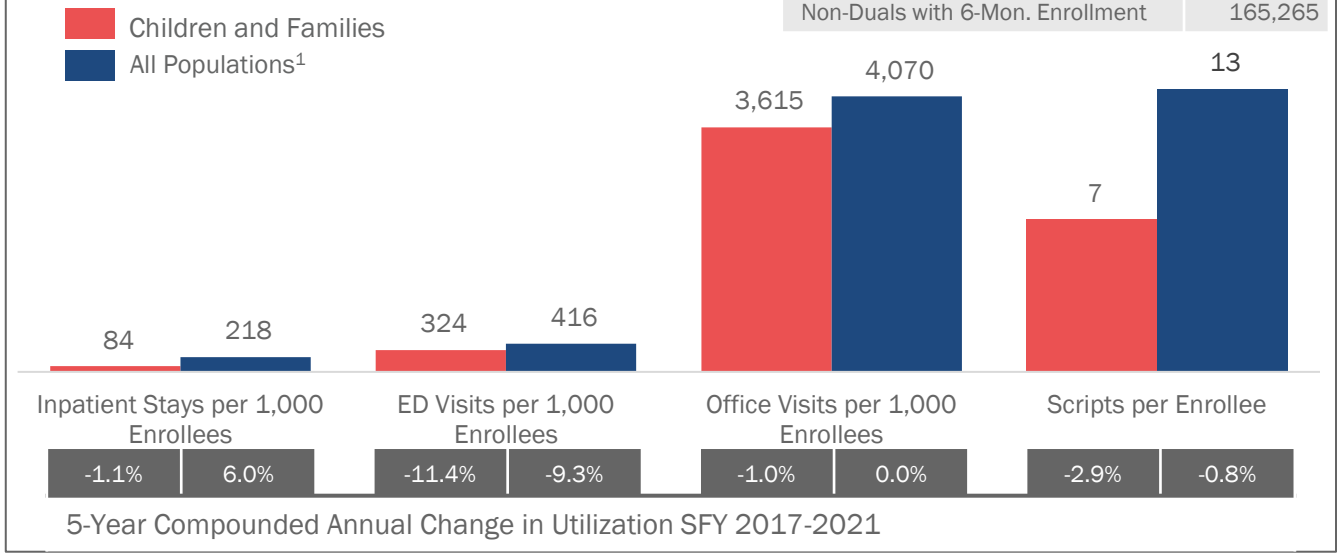
Children and Families: Acute Care Services

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

Children and Families: Acute Care Utilization

SFY 2021

Expenditures	$656.5M
Average Enrollment	167,757
Non-Duals with 6-Mon. Enrollment	165,265



Children and Families: Average Cost per Acute Care Service

SFY 2021

	Inpatient Stay	ED Visit	Office Visit	Script
Children and Families	$6,927	$691	$68	$64
Overall	$5,530	$739	$68	$81

[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.

- Children and Families use, on average, fewer than half as many inpatient days per person as the overall Medicaid population.
- In SFY 2021, Children and Families used the ED and have office visits at levels approximately 22% and 11% lower than the overall population, respectively.
- Per person utilization for Children and Families have lower growth trends than the overall population for all services.
- Costs per script in FY 2021 were approximately 21% lower for the Child and Families population than for the overall population.

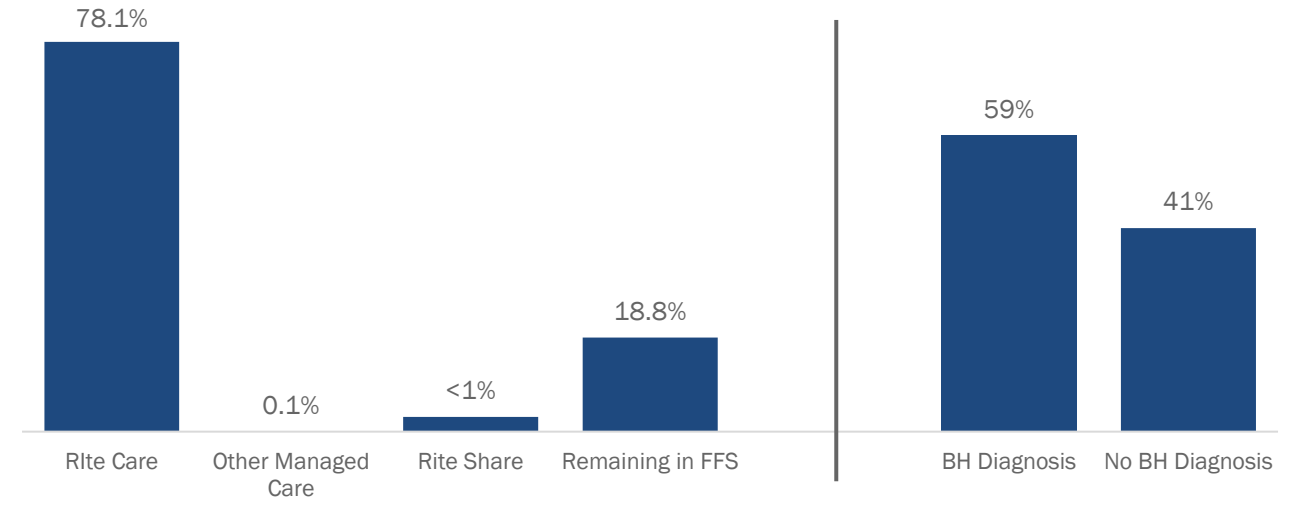
CSHCN: Managed Care Enrollment

CSHCN are primarily enrolled in managed care, in the Rite Care program. However, a significantly greater proportion (18.8%), 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.

CSHCN: Delivery System & Behavioral Health Diagnosis

SFY 2021

	SFY 2021	5-Year CAGR
Enrollment	12,498	0.3%
Expenditures	$224.1M	2.1%



RIte Care	Other Managed Care	Rite Share	Remaining in FFS	BH Diagnosis	No BH Diagnosis
9,757	12	374	2,355	7,406	5,092

Average Monthly Enrollment – SFY 2021

RIte Care	Other Managed Care	Rite Share	Remaining in FFS	BH Diagnosis	No BH Diagnosis
0.8%	-26.4%	-14.8%	2.0%	-1.2%	2.6%

Compounded Annual Growth Rate - SFY 2017-2021

- 78.1% 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 in Rite Share or 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.

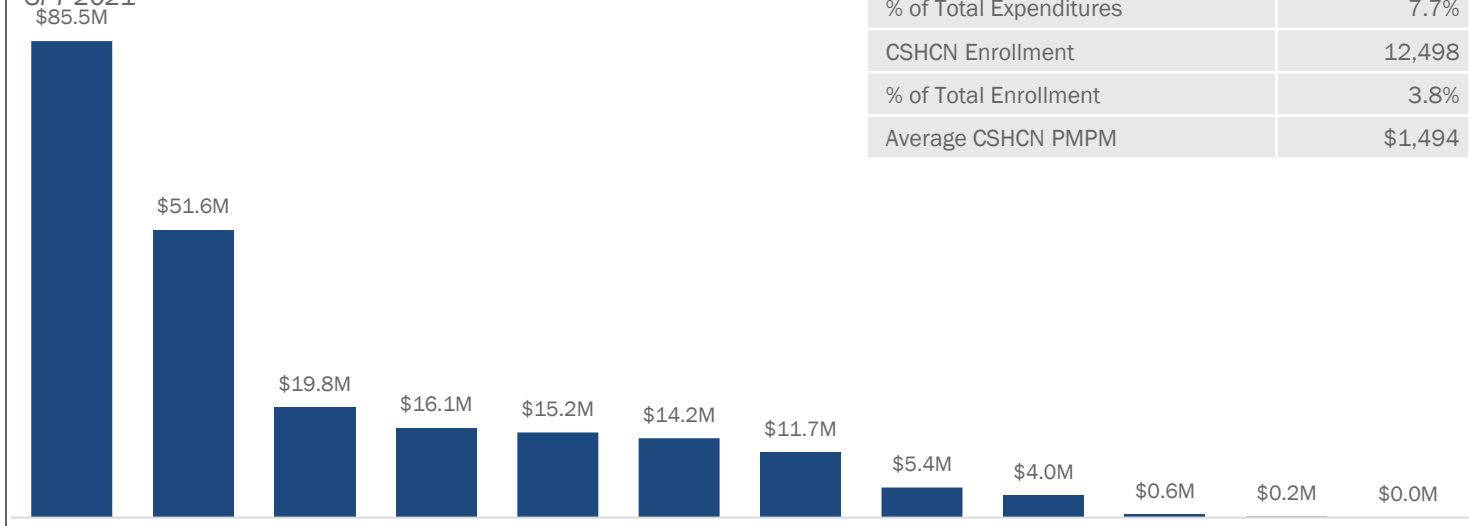
CSHCN: Expenditures by Provider Type

CSHCN expenditures are largely concentrated in professional and inpatient services.

CSHCN Expenditures by Provider

SFY 2021

CSHCN Expenditures	$224.1M
% of Total Expenditures	7.7%
CSHCN Enrollment	12,498
% of Total Enrollment	3.8%
Average CSHCN PMPM	$1,494



38.1%	23.0%	8.8%	7.2%	6.8%	6.3%	5.2%	2.4%	1.8%	0,3%	0.1%	<0.1%

% of Children with Special Healthcare Needs Expenditures – SFY 2021

2.5%	3.6%	-8.9%	7.7%	0.7%	2.4%	14.8%	4.0%	1.3%	22.8%	-0.6%	-

CSHCN 5-Year CAGR – SFY 2017-2021

17.4%	11.1%	73.4%	9.5%	6.7%	3.9%	4.1%	6.7%	3.3%	0.2%	0.1%	<0.1%

CSHCN Spend as % of Total Expenditures, by Provider Type – SFY 2021

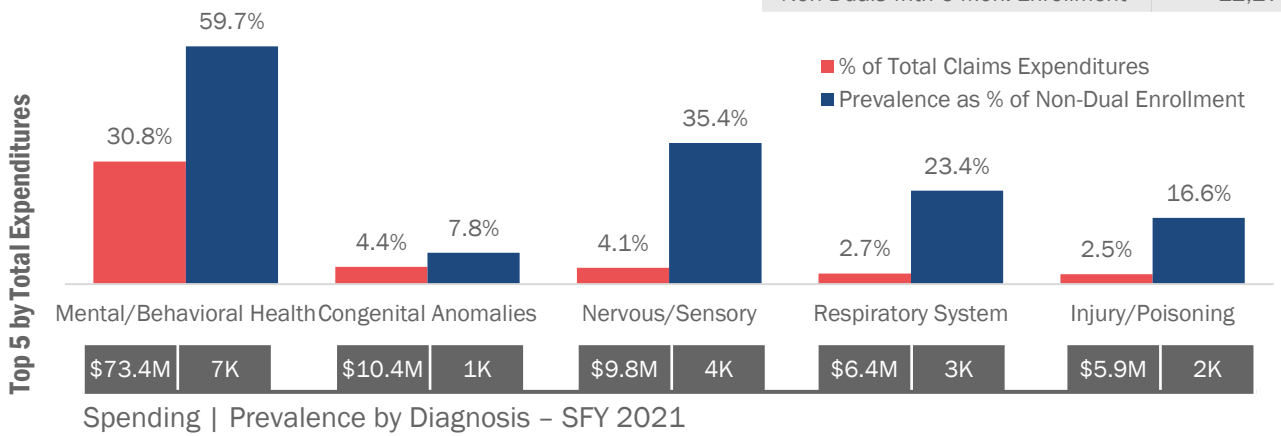
- 61% of CSHCN expenditures go towards professional services and inpatient hospital services.
- A significantly smaller percentage of CSHCN expenditures go toward pharmacy, residential and rehabilitation services for persons with IDD, premiums, and nursing facilities and hospice than for the overall population.
- Average annual growth of professional expenditures (2.5%) from SFY 2017 to 2021 was lower than the overall population (3.1%).
- CSHCN Special Education expenditures ($19.8 M) accounted for 73.4% of the overall population ($26.9M) in SFY 2021.

[1] Table shows CSHCN 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.

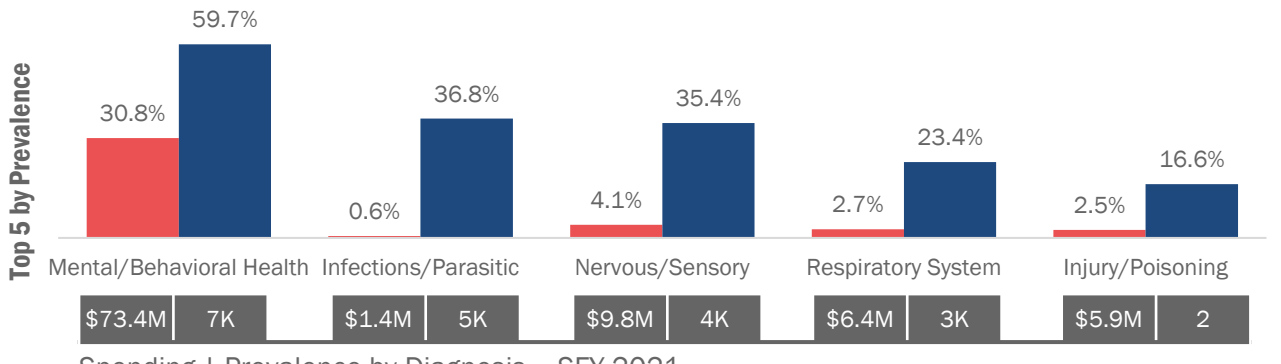
CSHCN: Diagnoses

CSHCN – Spending and Prevalence by Diagnosis
SFY 2021

CSHCN Expenditures	$224.1 M
CSHCN Average Enrollment	12,498
Non-Duals with 6-Mon. Enrollment	12,274



Spending | Prevalence by Diagnosis – SFY 2021



Spending | Prevalence by Diagnosis – SFY 2021

CSHCN expenditures are largely concentrated in professional and inpatient services.

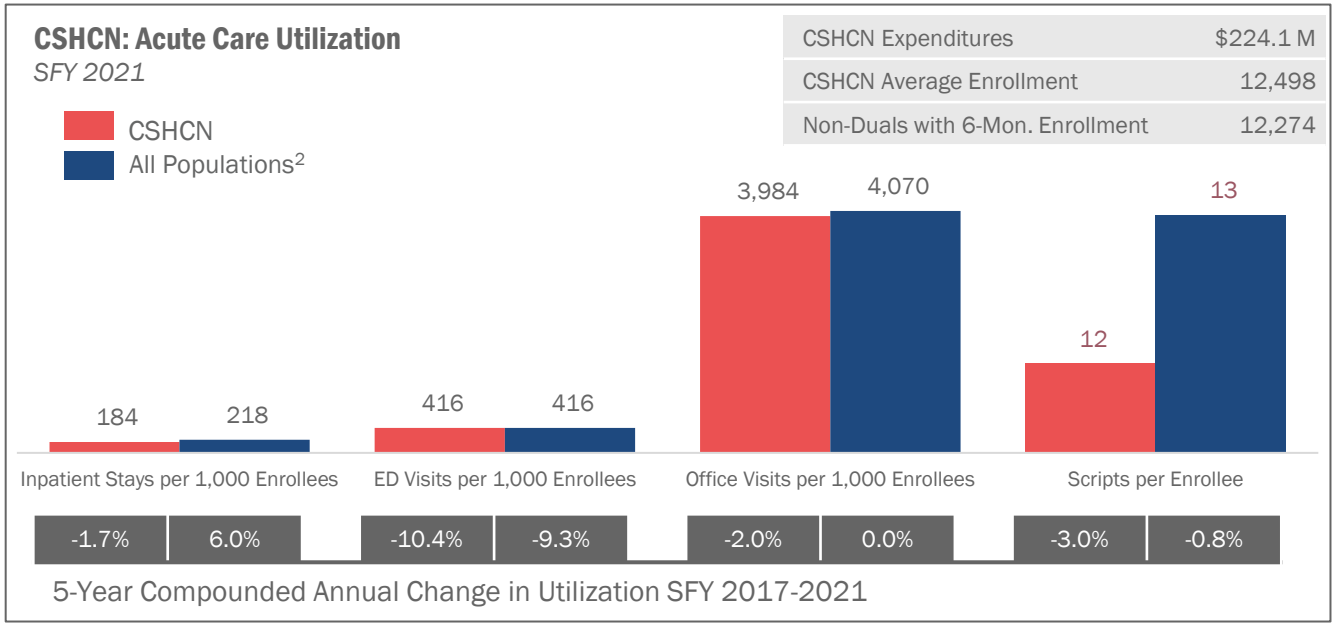
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental or behavioral health diagnoses have high prevalence and cost among all populations but are higher among CSHCN than any other population.
- Diagnoses of congenital anomalies are associated with the second-highest expenditures for CSHCN; this diagnosis is not in the top 10 for any other population.
- Mental or behavioral diagnoses, infections, diseases of the nervous system and sense organs, and respiratory system diagnoses are prevalent among the CSHCN population.

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

- Of the total claims for this population, 30.8% of costs were for claims where “mental or behavioral health" was the primary diagnosis.
- 59.7% "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, 59.7% of the non-duals had 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 $19,705 for CSHCN compared to $5,530 for the rest of the Medicaid-only population suggesting a longer average length of stay.
- 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.
- Both costs per script and costs per office visit are greater for the CSHCN population than for the overall population (20% and 27%, respectively).

CSHCN: Average Cost per Acute Care Service
SFY 2021

	Inpatient Stay	ED Visit	Office Visit	Script
Children with Special Health Needs	$19,705	$662	$82	$103
Overall	$5,530	$739	$68	$81

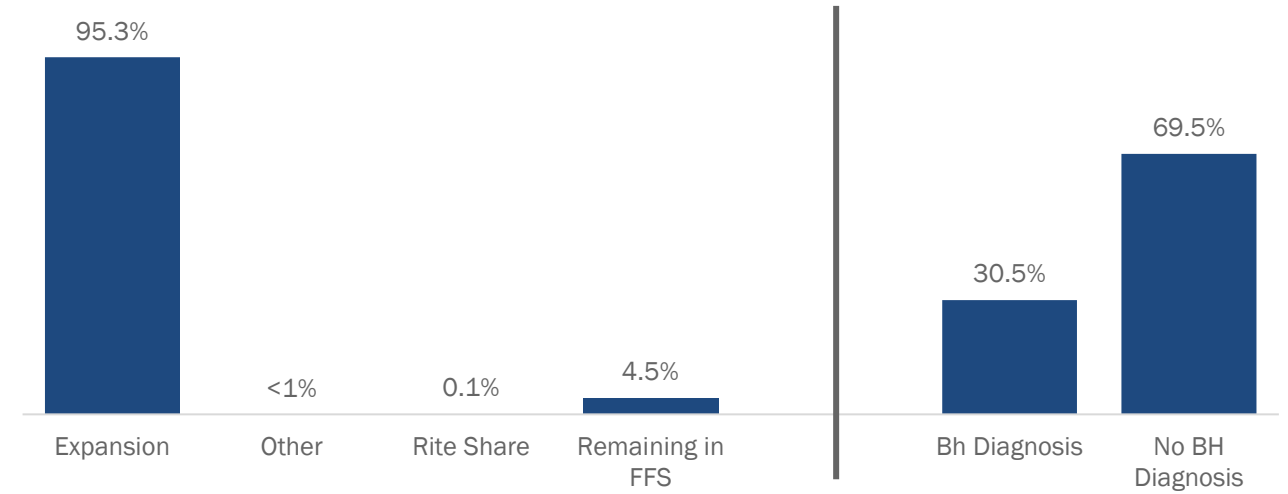
[1] Unduplicated enrollees includes count of Medicaid Only members with a minimum of 6 months of eligibility.
[2] All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.

Expansion: Managed Care Enrollment

The Expansion population is primarily enrolled in managed care.

Expansion: Delivery System & BH Diagnosis
SFY 2021

	SFY 2021	5-Year CAGR
Enrollment	92,077	4.9%
Expenditures	$622.9M	10.9%



- 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 $622.9 million in SFY 2021.
- 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.
- "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).

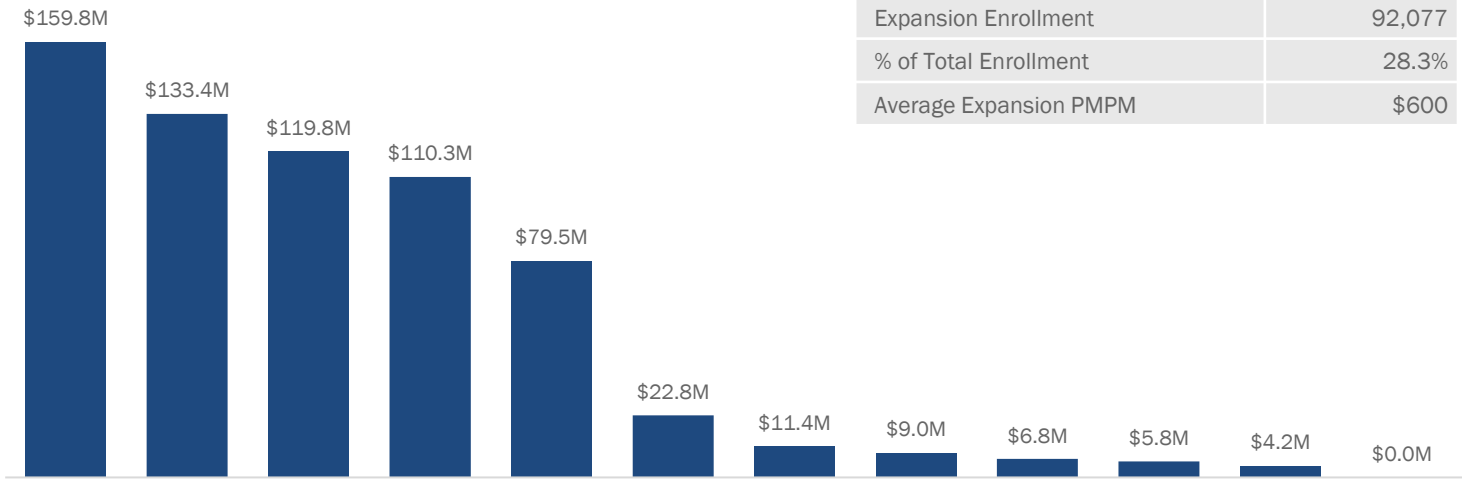
Expansion: Expenditures by Provider Type

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

Expansion Expenditures by Provider

SFY 2021

Expansion Expenditures	$662.9M
% of Total Expenditures	22.9%
Expansion Enrollment	92,077
% of Total Enrollment	28.3%
Average Expansion PMPM	$600



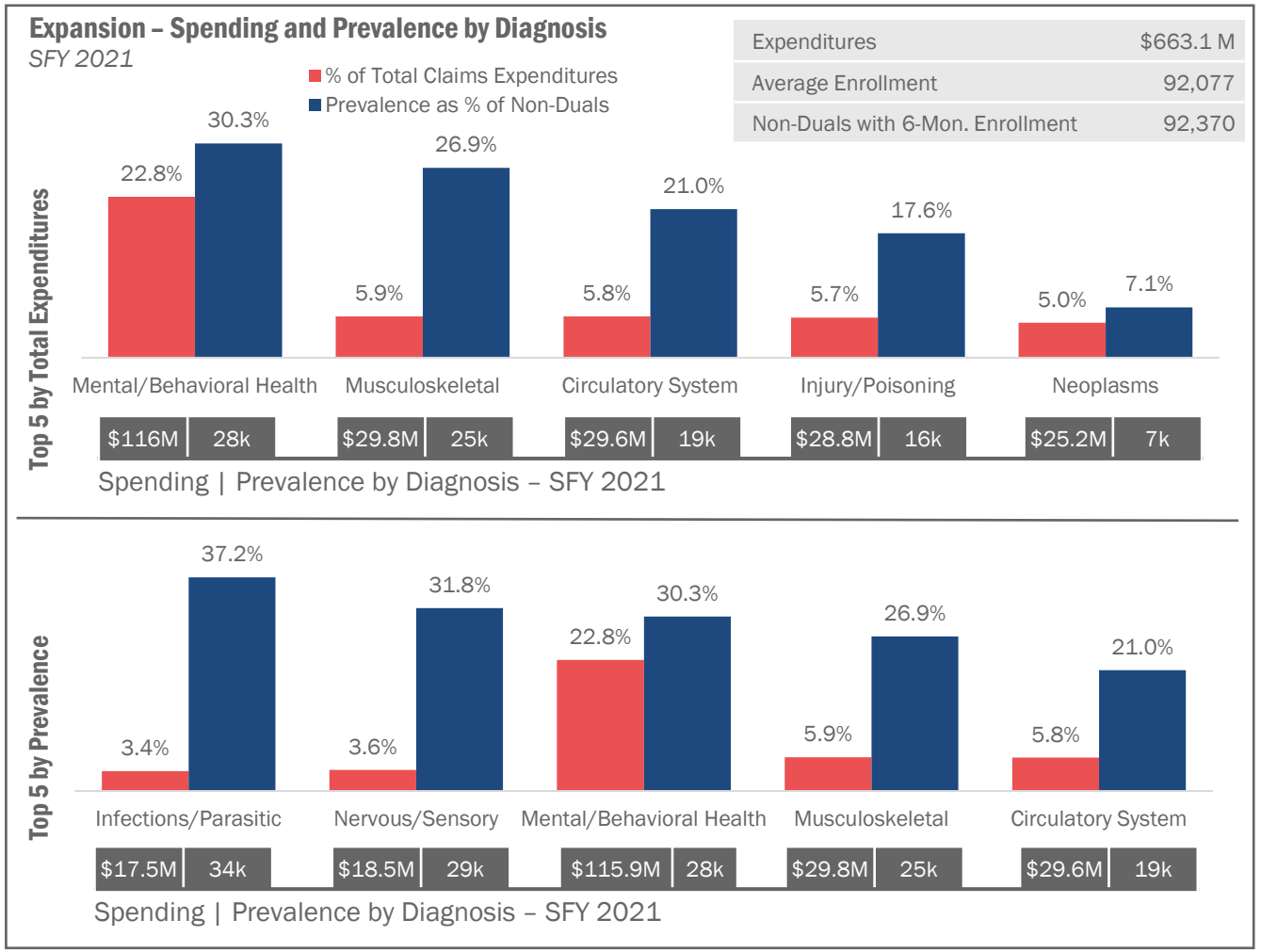
	Inpatient	Outpatient	Pharmacy	Prof.	Admin/ Taxes &	Other Medical	Slater/ Tavares	Nursing/ Hospice	HCBS	Medicare Premiums	I/DD Community	Special Education
% of Expansion Expenditures – SFY 2021	24.1%	20.1%	18.1%	16.6%	12.0%	3.4%	1.7%	1.4%	1.0%	0.9%	0.6%	<0.1%
5-Year Compounded Annual Growth Rate – SFY 2017-2021	11.3%	7.7%	18.4%	6.9%	8.3%	7.9%	45.5%	19.1%	14.4%	12.2%	70.5%	-
Expansion Spend as % of Total Expenditures, by Provider Type – SFY 2021	34.4%	37.1%	42.6%	22.5%	33.2%	18.4%	9.4%	2.6%	3.6%	5.0%	1.7%	0.1%

[1] Table shows Expansion 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.

- Expenditure growth for the Expansion population was significantly higher (10.9%) than the overall population (3.5%), driven primarily by higher enrollment growth (4.9% per annum for Expansion compared to 1.4% overall)
- 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.

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.
- Among all mental health diagnoses, substance-related disorders are nearly twice as prevalent among the Expansion population compared to the overall population.

Mental Health Diagnoses, SFY 2021:

	Members (Prevalence %)	Service Costs (PMPM)
Substance Use Disorder	9.7K (10.6%)	$54.8M ($469 PMPM)
Other Behavioral Health	23.3K (25.3%)	$59.7M ($213 PMPM)
Developmental Disability	0.1K (0.1%)	$1.4M ($885 PMPM)
Any BH Diagnosis	**28.0K (30.3%)**	**$115.9M ($344 PMPM)**

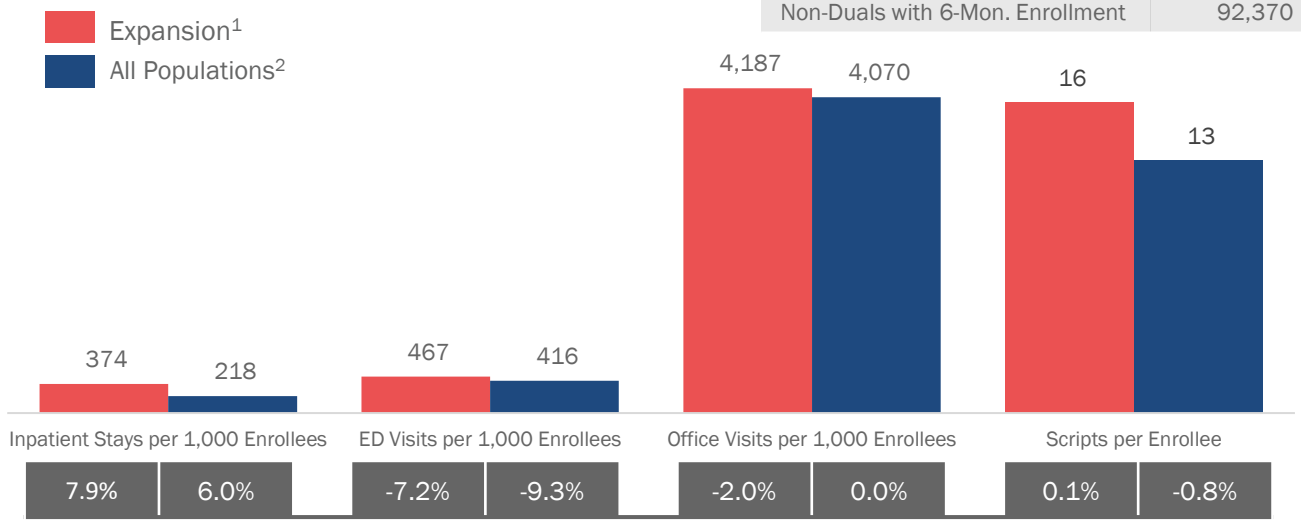
An example of how to interpret the chart to the left:

- 30.3% "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, 30.3% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 22.8% of costs were for claims where “mental or behavioral health" was the primary diagnosis.

Expansion: Acute Care Utilization

Expansion: Acute Care Utilization
SFY 2021

Expenditures	$663.1 M
Average Enrollment	92,077
Non-Duals with 6-Mon. Enrollment	92,370



5-Year Compounded Annual Change in Utilization SFY 2017-2021

Expansion: Average Cost per Acute Care Service
SFY 2021

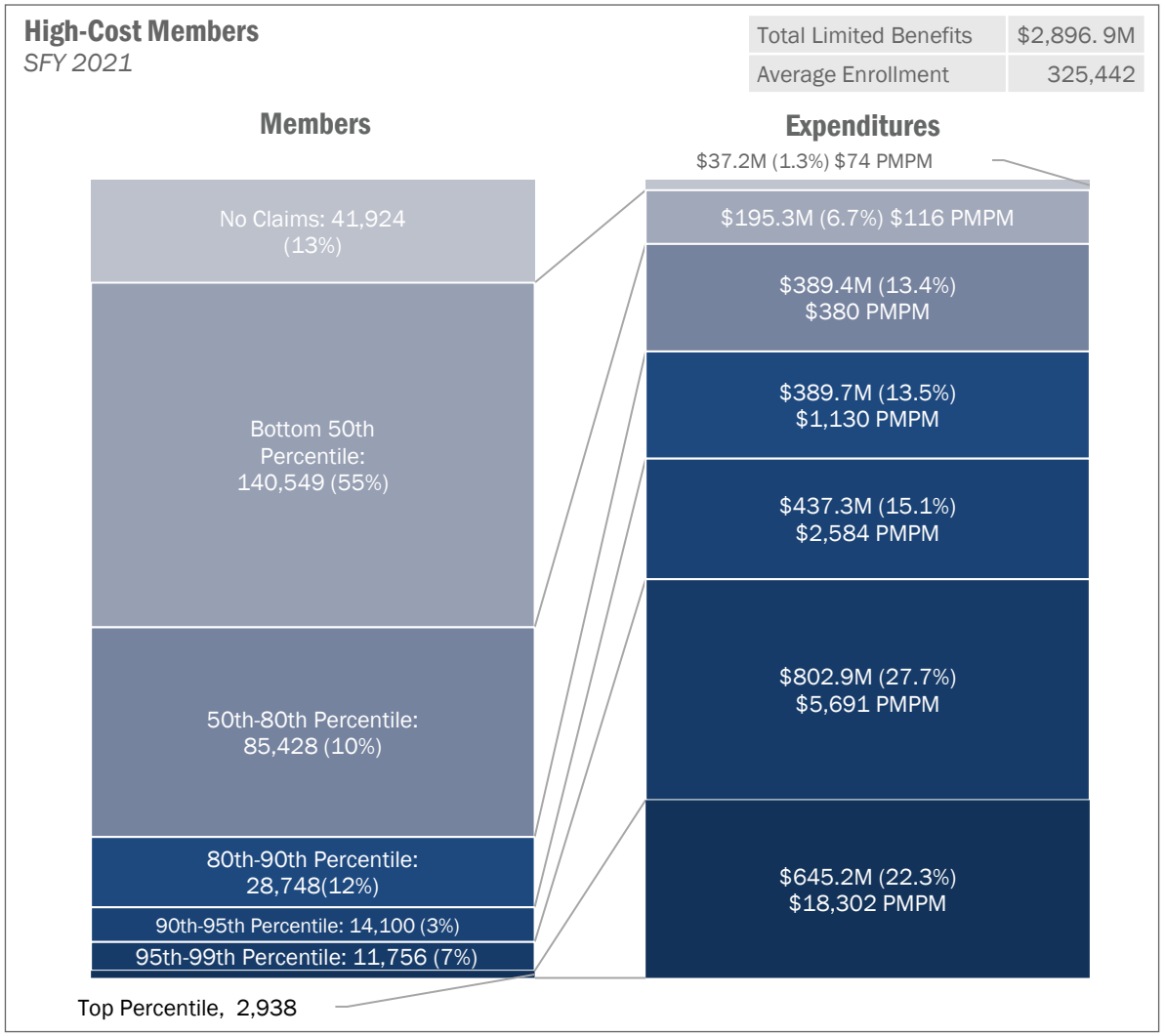
	Inpatient Stay	ED Visit	Office Visit	Script
Expansion	$3,559	$765	$65	$83
Overall	$5,530	$739	$68	$81

- The per person utilization rates of the Expansion population are higher than the overall population generally, while growth rates in utilization are mixed.
  - Utilization of inpatient stays grew at a faster rate on average over the five-year period than the overall populations.
- Emergency department visits declined by -2.0% per year on average over the five-year period, compared to flat utilization among the overall population.
- The overall cost per script (excluding rebates) is consistent with the overall population, though utilization remained flat in the Expansion population. The overall population saw a modest decline in utilization on an annual basis over the five-year period.
- The average cost for most services is comparable to the overall population except for Inpatient Stays that are significantly less.

[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:
  - The top 1% of users account for 22% of all benefit expenditures with an average PMPM of $18,302 or over $200,000 in spending per year.
  - And the top 20th percentile of Medicaid users account for 78.5% of all expenditures with an average PMPM of $3,295.
  - The bottom 50th percentile of Medicaid users have an average PMPM of $116.
- Members with no claims' activity account for nearly 13% of enrollment 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 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. For example, the average cost among members with an I/DD is $6,077 PMPM and among members residing in a nursing facility is $6,153 PMPM.

High-Cost Enrollees: Behavioral Health Diagnoses and Expenditures

Members with a diagnoses for a behavioral or mental health condition account for two-thirds 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.

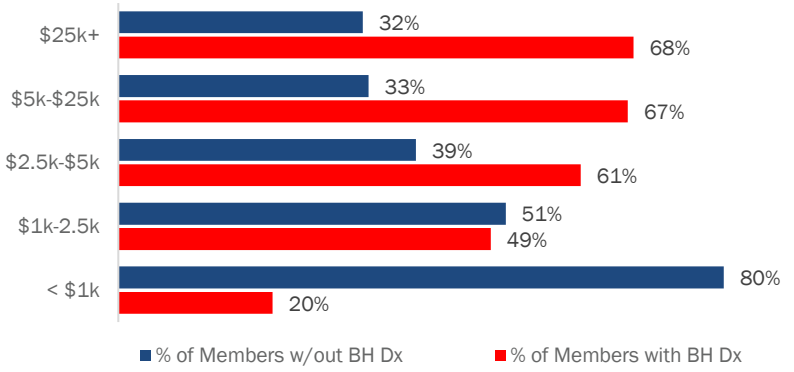
Enrollment and Expenditures among Members with a Behavioral Health Diagnosis
SFY 2021

Primary Payer and Diagnosis[1]	Average Enrollment	% of Enrollment	Overall PMPM	% of Expenditures
Medicaid Only				
I/DD Community (BHDDH)	1,213	<1%	$5,704	5%
Other Developmental Disability	13,280	5%	$5,704	9%
Substance Use Disorder	16,185	6%	$5,704	17%
Other Behavorial/Mental Health	51,747	20%	$938	37%
Subtotal - Any BH-Related Diagnoses	82,425	32%	$1,198	69%
No BH-Related Diagnosis	203,331	78%	$319	31%
Overall - Medicaid Only	285,756	100%	$573	100%
Duals				
I/DD Community (BHDDH)	2,510	6%	$6,257	20%
Other Developmental Disability	281	1%	$6,257	1%
Substance Use Disorder	2,164	5%	$6,257	4%
Other Behavorial/Mental Health	11,011	28%	$6,257	36%
Subtotal – Any BH-Related Diagnoses	15,966	40%	$2,971	61%
No BH-Related Diagnosis	23,720	60%	$1,279	39%
Overall - Duals	39,686	100%	$1,959	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.

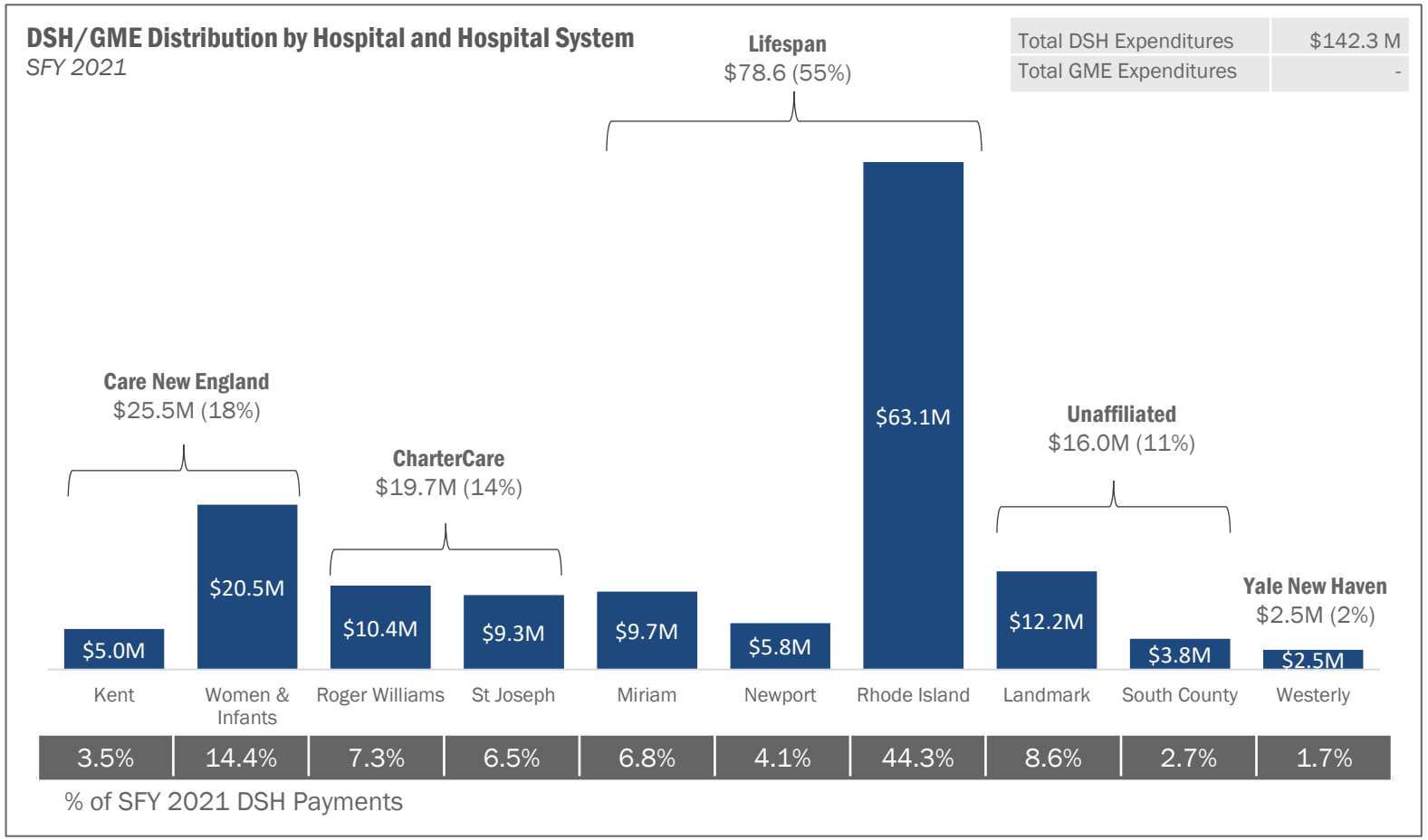
- Among both the Dual and Medicaid Only populations, members with a BH diagnosis account for a disproportionate share of expenditures:
  - One-third of Medicaid Only members have a BH-related diagnosis and account for over two-thirds of expenditures.
  - 40% of Duals have a BH diagnosis and account for 61% of expenditures.
- Approximately two-thirds of all members with $5,000 or more in claims per year had a BH-related diagnosis.
- Overall, the PMPM for a member with a BH diagnosis was $1,488 compared to $497 PMPM for members without any BH 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 2021, Rhode Island DSH payments totaled **$142.3 million.**
- Please note that EOHHS made no GME payments in SFY 2021. The amount originally appropriated in SFY 2021 was paid in SFY 2022.
- 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.

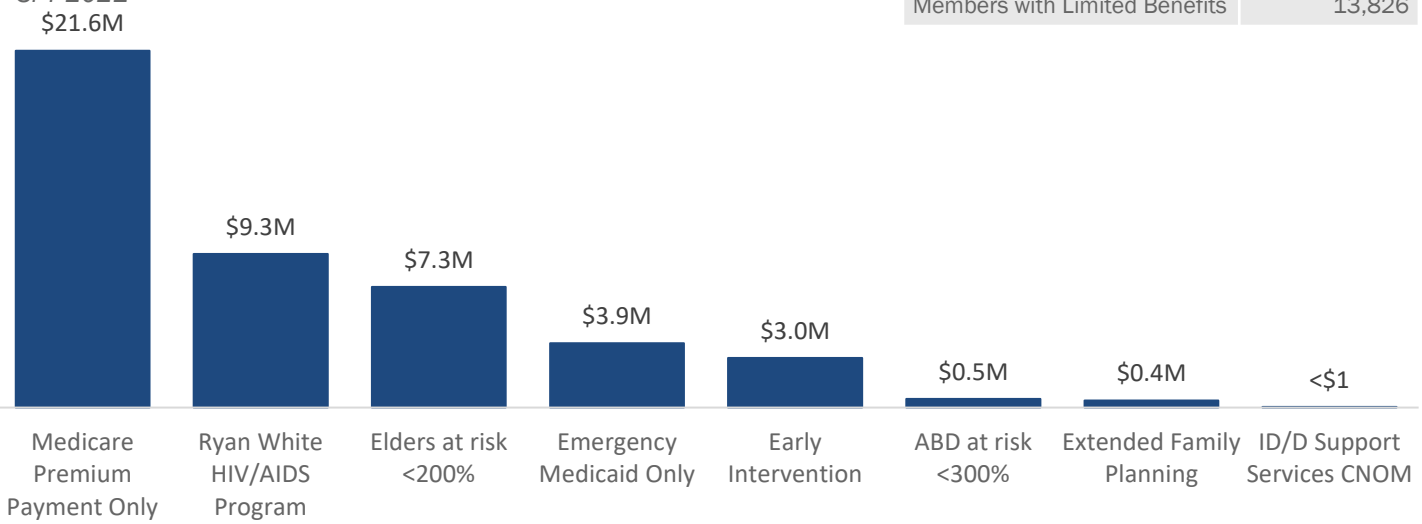
In SFY 2021, EOHHS made $7.9 million in Outpatient UPL payments.

Exclusions: Limited Benefits

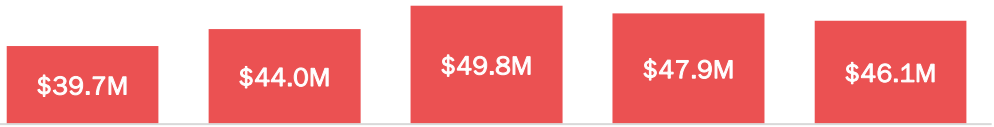
Under the terms of Rhode Island's 1115 Waiver Demonstration agreement, certain state programs not traditionally allowable under Medicaid fund matching rules can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible.

Exclusion – Limited Benefits
SFY 2021

Total Limited Benefits	$46.1M
Members with Limited Benefits	13,826



SFY 2017-2021



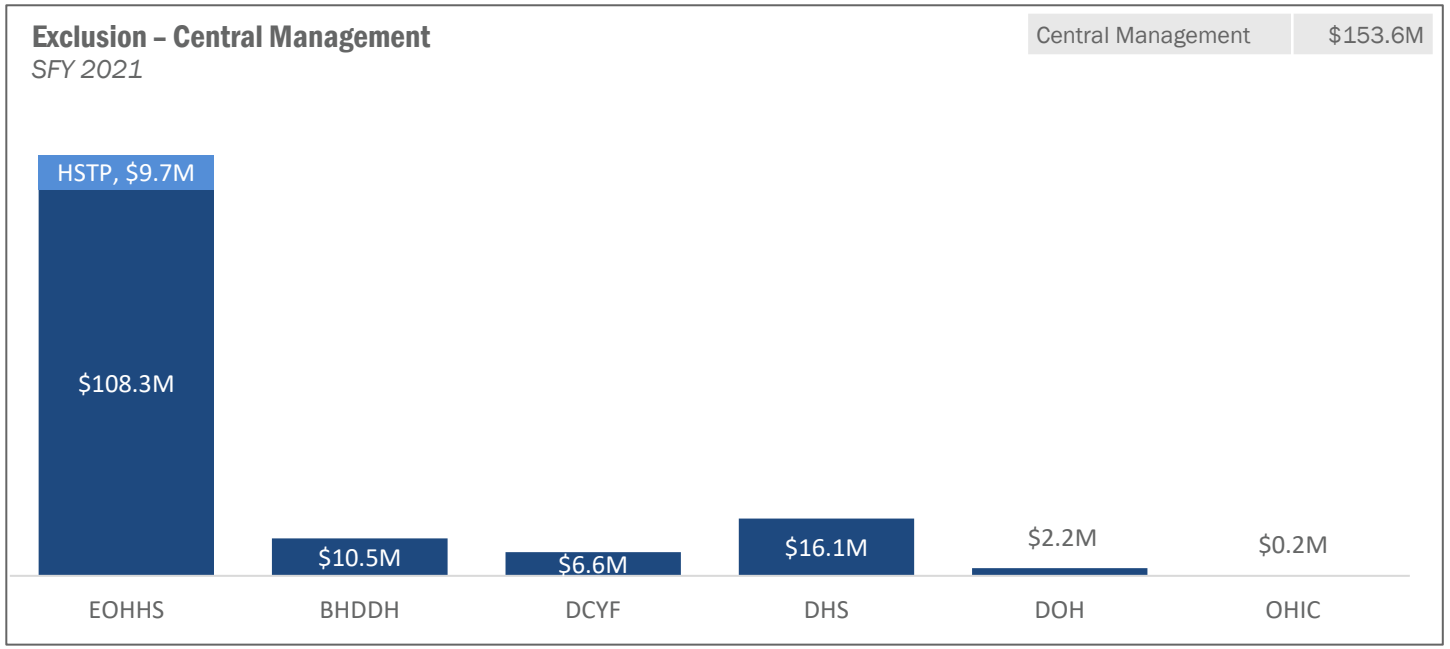
	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Avg Annual Growth SFY 2017-2021
Annual Change		10.7%	13.4%	-3.8%	-3.9%	3.3%

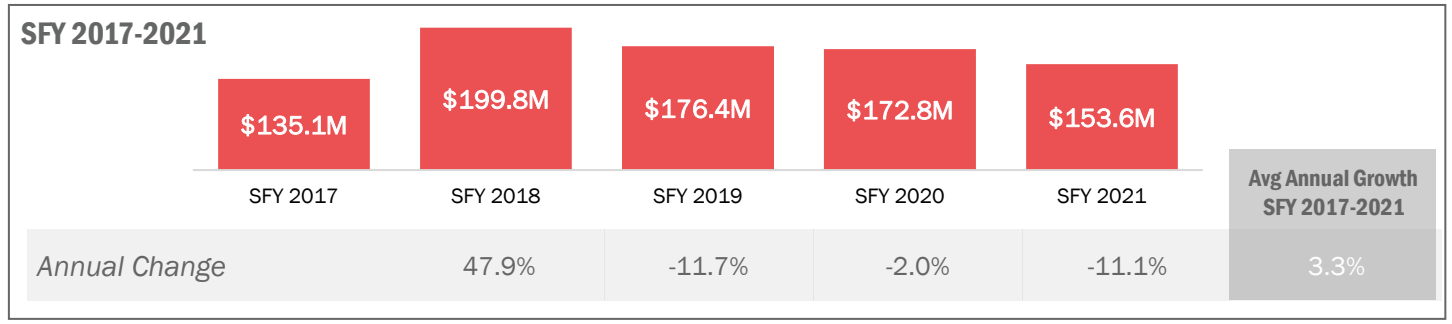
- Expenditures for members with limited benefits totaled $46.1 million in SFY 2021.
- **Partial Duals:** Payments for Medicare premiums for qualifying individuals account for $21.6 million. In SFY 2021, EOHHS subsidized the Medicare premiums for an average of 7,679 low-income elders each month with limited 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 2017-2021 as shown.

Exclusions: Central Management

EOHHS is the Single State Agency for Administering the Medicaid Program and accounts for 77% of all central management expenditures in SFY 2021.





	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Avg Annual Growth SFY 2017-2021
Annual Change	47.9%	-11.7%	-2.0%	-11.1%	3.3%

- Central Management expenditures can vary significantly year-over-year.
- In SFY 2021 EOHHS central management expenditures included $9.7 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. Starting with 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
PHE: Public Health Emergency
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.