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July 20, 2018

ADDENDUM #3

RFP #: 7594609

Title: Actuarial and Financial Analysis Support

Submission Deadline: August 1, 2018 at 10:30 AM

Notice to Vendors

Attached are vendor questions with state response. No further questions will be answered.

David J. Francis
Interdepartmental Project Manager

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted

Vendor Questions for RFP #7594609 Actuarial and Financial Analysis Support

Question 1: In Appendix B: Sample Budget Worksheet and the accompanying guide on pages 21 and 22 of the RFP document, a cost-based pricing model is described for vendors to follow. This model starts with salaries, and builds cost up allowing for a 10% administrative load at the end of the process. We have concerns with this process and the disclosure of employee salary and cost data, in addition the 10% indirect/administrative costs load would not meet our requirements. We have not seen this type of cost proposal to procure actuarial services. It is more common to bid hourly rates by staffing level for a fixed bank of hours. If this approach is not acceptable, would the state extend the use of a federally approved indirect rate to also permit the use of a federally approved all-inclusive rate by staffing level (for example, an approved General Services Administration (GSA) rate)? We would appreciate clarification on your cost proposal process to assess whether or not we will be able to bid.

Answer to question 1:

The form attached to the RFP at Appendix B has been updated based on bidder questions. Bidders are to use this updated form to provide cost estimates for actuary services based on an estimated 1500 billable hours distributed by staffing level.

Question 2: Regarding the tasks, Section 3. Task 1 and Task 2, please provide a schedule of timing specific to the various requirements, including:

a. a reporting calendar that the bidder is responsible for

b. frequency and volume of rate development, i.e. the specific programs/products/rating populations, their rating periods (including initial rating period)

c. risk share/stop loss/FQHC reconciliation

Answer to question 2:

a. A calendar of the major financial reports and analyses referenced in Task 2 are below; additional reports may be requested. The due dates listed are external. Internal deadlines would be clearly established with potential bidder accordingly to allow time for State input and review as needed. The State may add reports upon request.

Frequency	Due Date(s)	Task
Annually	7/30/18	Medicaid Budget Survey
Annually	2/1/18	Children's Health Account Analysis, see response to question 10.
Annually	3/15/18	RI Annual Medicaid Expenditure Report
Semi Annual	4/30/18	Caseload Testimony
Semi Annual	10/31/18	Caseload Testimony
Quarterly	1/15/18	Financial Report to State Budget Office and General Assembly
Quarterly	4/15/18	Financial Report to State Budget Office and General Assembly
Quarterly	10/15/18	Financial Report
Monthly		RI Medicaid Monthly Managed Care Report

b. Rate Development:
The State requires all rate setting services to be carried out in compliance with Centers for Medicare and Medicaid Services requirements where applicable including but not limited to actuarial soundness requirements and timelines. Currently, the rating period is a state fiscal year, beginning July 1, and the rates are updated at least annually. The State needs to review the vendor's rate analysis and submit the proposed rates to CMS at least 90 days prior to the start of the fiscal year for approved rates to be in effect on July 1, or 90 days prior to the start of a contract amendment effective date.
Where MCOs submit encounter data that is not supported by accepted claims in MMIS, the vendor will review the rejected or not submitted claims to determine the extent they would affect rate setting and make adjustments as necessary.

In addition, re-rating may be required when budget initiatives are enacted by the General Assembly after the passage of the State budget. Such re-rating may be required on a short timeline.

Finally, the vendor will also need to model budget implications of various rate change scenarios in developing savings initiatives for the agency's budget.

The potential vendor will be involved in:
Contracted / capitated rate development including:

- Managed Care Organization rate development, including rates for Rite Smiles, Rite Care, Rhody Health Partners, Expansion, and Children with Special Health Care Needs, Rhody Health Options/Integrated Care Initiative
- Non-emergency medical transportation rate development
- Program of All-Inclusive Care for the Elderly rate development

Provider / Medicaid FFS Rate Development

- Durable Medical Equipment
- Federally Qualified Health Center rate development
- Hospital rate development
- Nursing Home Rate
- Other Medicaid FFS products as needed

c. Risk share/Stop loss: Timelines will vary depending on the contractual terms established by the State with the MCOs. Currently, review of risk share and stop loss with the three health plans involves monthly receipt of reports from MCOs and review for completeness, reasonableness and accuracy. At the end of a contract year, the vendor prepares an interim payment before final settlement; after a 12- month allowed claims run out for claims incurred during the associated contract period. After the 12-month run out, the vendor reviews MCO's reported member months, medical premium, and claims payment dollars to the membership, premium, and claims payment data derived from the EOHHS' MMIS and works to reconcile any differences before making a final settlement payment or recoupment.

   The FQHC reconciliation process has monthly and annual components as outlined in our FQHC Principles of Reimbursement, now attached.

Question 3: Please provide a sample of required/desired reporting as listed in the task requirements.

Answer to question 3:

As an illustrative example of the work required, the list of following documents are attached:

1. Rhode Island Annual Medicaid Expenditure Report 2017
2. May 2018 Caseload Documents
   a. May 2018 CEC Testimony Revised v20180427

b. May 2018 CEC Attachments 1-8 with embedded documents
c. May 2018 CEC Attachment 8b
d. May 2018 CEC Attachment 8c
e. May 2018 CEC Attachment 6c-Revised
f. May 2018 CEC Attachment 6d-Revised

3. RI Medicaid Monthly Managed Care Enrollment Report
4. FQHC Principles of Reimbursement
5. RI Budget Survey 2017
6. Current rate cells for managed care organization rates
7. Quarterly CHIP Report
8. 2018 Caseload meeting example

Question 4: Section 4.A3.Work Plan, page 10. It is unclear whether this section is meant as a subset of or meant to fully embrace Section 3, Tasks 1 and 2. For example, Section 4.A3, **Work Plan** seems to focus on the annual rate certification, the semi-annual caseload support, and support for the annual Rhode Island Medicaid Expenditure Report. Meanwhile, Section 3, **Scope of Work and Requirements**, outlines numerous tasks and activities. Moreover, the Medicaid Expenditure Report is seemingly not listed as a component of Section 4.A3. Please clarify.

Answer to question 4:

The three tasks (annual rate certification, the semi-annual caseload support, and support for the annual Rhode Island Medicaid Expenditure Report) in Section 4.A.3 are a subset of tasks in the Scope of Work and is meant to provide 3 specific sub-tasks within the Scope of Work for the workplan submission of the response. These three specific sub-tasks are critical to the overall success of the Medicaid program on an annual basis, and are meant to be illustrative and not an exhaustive list of support requirements. The Medicaid Expenditure Report is part of our annual Financial Reporting support listed under Task 2. Other reports include the quarterly and annual CHIP reports and Quarterly Financial Reports for the Office of Management and Budget. The State reserves the right to add additional tasks with consultation with the vendor.

Question 5: In Section 4.A.2., regarding the requirement for 4 actuaries, for which tasks and/or subtasks will they be needed/required?

Answer to question 5:

The State requires all rate setting services to be carried out in compliance with Centers for Medicare and Medicaid Services requirements where applicable including but not limited to actuarial soundness requirements and timelines; for example, CMS requires that our managed care organization rates and our non-emergency medical transportation rates are actuarily certified. See response to question 2.

Question 6: What should the vendor expect with respect to initial and subsequent frequency of revision to hospital, nursing home, FQHC, and alternative payment methodologies rate development?

Answer to question 6:

See response to question 2.

Question 7: Please provide a sample data extract and associated reference files that will be needed for the various tasks including but not limited to rating, semi-annual caseload, and the annual Rhode Island Medicaid Expenditure Report, etc., i.e. claims, eligibility, enrollment segments, long term care segments, Medicare/TPL segments, capitation, other premium arrangements, sub-capitated arrangements, provider files, and enrollment segments specific to any rating cohort and/or rate cell. What is the periodicity, the size, and the system requirements for the data extracts?

Answer to question 7:

Periodicity, size and system requirements may be variable depending on the task, but the state will work with the selected vendor to ensure that the data extracts are appropriate and usable for the vendor. Examples added in document library in response to bidder questions.

Question 8: Please list all rating populations and respective rating cohorts/rate cells, including special populations and/or bundled payments.

Answer to question 8:

For managed care organization rates, the State has provided its current rate information. In the future, the state may take an alternative approach based in part upon expert advice of the vendor, although the State requires all rate setting services to be carried out in compliance with Centers for Medicare and Medicaid Services requirements where applicable. In addition to MCO rates, additional rate setting is required as outlined in question 2 and the RFP.

Question 9: Please describe the nature of the work with respect to the reconciliations listed in Task 1 and specific to FQHCs, risk-sharing arrangements, and stop-loss arrangements. For example, on page 6 of RFP, it reads, "Determination of gain share opportunities or risk share obligations is based on review of reported plan experience." Please explain what is meant by review.

Answer to question 9:

See response to question 2.

Question 10: Please explain what is meant by Children's Health Account analysis? What would be the relationship of the selected vendor and KidsVax who appears to administer the program on behalf of the State (http://cha-ri.org/).

Answer to question 10:

The Children's Health Account (CHA) analysis is required by Rhode Island General Law: http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-12/42-12-29.HTM ; EOHHS reviews claims for specific services paid by Medicaid on behalf of children with third party coverage to determine the assessment on commercial insurers. We provide this analysis and work with KidsVax, the state's fiscal intermediary.

Question 11: Although not listed as a task, to ensure accuracy and reasonableness of MCO data for development of actuarial products and/or other financial analyses, is the State or vendor responsible for performing the MCO health plan reconciliations? If the vendor is responsible, what are the expectations when the underlying data is not within an acceptable threshold of completeness?

a. What are the specifics regarding the tasks of reconciling? For example, is it to simply quantify the difference, i.e. 2.4%, or is to achieve an acceptable difference, i.e. within 0.5% difference?

b. What will be the source file of the information, e.g. MMIS claims or health plan data or both?

c. Does reconciliation occur at the level of the MCO; or at the product level; or at the detailed level (i.e. inpatient, sub-capitated services, etc.)?

d. What is the ratio of incurred claims to MMIS accepted claims in the underlying years used for rating experience? What is the acceptable ratio for MCOs and/or sub-capitated arrangements in order to commence the rating process?

Answer to question 11:

All actuarial analysis and rate setting services provided will be carried out in compliance with Centers for Medicare and Medicaid Services requirements related to actuarial soundness and all other applicable requirements. The MCO rate development noted in Task 1 encompasses assessing accuracy and reasonability of MCO data at a threshold to be specified by the State based in part on the expert advice of the selected vendor.

Question 12: Please provide a sample of semi-annual Caseload and explain what is meant by "support". i.e. project management, subject matter expertise, data collection and aggregation, financial modeling, preparation of written and/or public testimony.

Answer to question 12:

Caseload support will include project management, data extraction and analysis including financial modeling, drafting of written testimony. May be needed for public testimony support upon request, but it is not anticipated. Caseload example provided.

Question 13: With respect to financial analysis (including semi-annual Caseload and the annual Rhode Island Medicaid Expenditure Report), please describe EOHHS' reporting and accounting systems. i.e. cash-basis or accrual-basis, and the nature of the data that the selected vendor will be reviewing and compiling. Will the selected vendor be receiving reports and/or data from the State or be responsible for accessing information from the various reporting and accounting systems? If the latter, what is the nature of the data, e.g. transactional level, aggregated by cost center and period? Please explain the expectation and system requirements.

Answer to question 13:

The state's accounting system is cash-basis. Vendors will have access to RIBridge and MMIS data and reporting. Vendor must have appropriate BAA and DUA's in place with the State.

Question 14: How many years of historical data is required for conducting budget neutrality analysis? In what format will this data be provided to the vendor?

Answer to question 14:

This will be variable depending on the budget neutrality analysis calculation required to support a specific 1115 waiver request. The data format may be variable depending on the task, but the state will work with the selected vendor to ensure that the data extracts are appropriate and usable for the vendor.

Question 15: Will HIPAA-compliant hardware be provided by the State or be the responsibility of vendor?

Answer to question 15:

The State will provide HIPAA compliant computer hardware for all on-site financial analysis support staff. All off-site IT systems will be the responsibility of the vendor and must meet current federal HIPAA, SSA, and state IT security standards.

Question 16: Please clarify Requirement 14 under **Section I. Instructions and Notifications to Offers** (listed on page 6 of RFP) and relationship of HealthSourceRI to the contract.

Answer to question 16:

EOHHS and the Medicaid Program are partners with the Department of Administration / HSRI in delivering health services support to the people of Rhode Island. HSRI administers services for the Medicaid expansion population under the Affordable Care Act. This provision is in place in the event a request for actuary or financial analysis support for an interagency project is made from the Department of Administration / HSRI during the period of the awarded contract.

Question 17: What is the impact of the issues surrounding RI Bridges, Medicaid Eligibility and the Nursing Home lawsuit? How will any of this affect the work listed in this RFP? Please specify which tasks this may affect.

Answer to question 17:

The is no impact to tasks requested in this RFP from the Nursing Home Lawsuit. The State continues to make progress on improving the functionality of the RI Bridges system and processing Medicaid Eligibility. The vendor will be responsible for reporting identified or suspected anomalies in caseload or other financial analysis tasks to the State as possible indicators of system functionality issues.

Question 18: What are the skill sets and system requirements that the State is requesting?

Answer to question 18:

The skills and systems required are those necessary to complete the tasks outlined in the RFP. Please see the RFP for specific qualifications related to actuarial staff. For data sharing, vendor needs appropriate security systems in place in order for the State to provide data for analysis purposes. Additional info is in the response to question 15.

Question 19: The RFP indicates on-site and off-site work efforts; as such, how many FTEs is the State asking the vendor to supply for on-site work?

Answer to question 19:

The State will require close collaboration with potential vendor, including availability for on-site meetings as State determines necessary, and availability during standard working hours.

Question 20: Page 1, Appendix B. For the current actuarial (sub)contractor, would the State please provide separately for Task 1, Task 2, and Task 3, or in Total if separation by Task is unavailable: Total Billable Hours and Total Payments, for each of Calendar Year 2016 and 2017 (or for any more current complete two annual periods)?

Answer to question 20:

The following estimate may not be indicative of future resource needs. However, the State estimates an average of 7500 billable hours (of which 1,500 are billable hours for actuarial services) in SFY17 and SFY18 in support of similar tasks outlined in this RFP. All service levels are subject to availability of State funding and State requirements for support.

Question 21: Page 3, Section 1, Instructions and Notifications to Offerors, Item 5. What does, "… unless otherwise indicated in the proposal." mean?

Answer to question 21:

Rates for services identified in the response are firm-fixed and not subject to risk adjustment unless the bidder identifies in the proposal an area requesting cost adjustments to mitigate risk for loss.

Question 22: Page 8, Section 3, Task 1. For each rate development project submitted to the Centers for Medicare and Medicaid Services (CMS) for approval (Managed Care Organization, Program of All-Inclusive Care for the Elderly, any other), would the State please provide a copy of the certification/methodology document(s)?

Answer to question 22:

See response to question 8.

Question 23: Page 8, Section 3, Task 1. Are all capitation rates on a July 1 to June 30 contract period? If not, what are the time periods?

Answer to question 23:

Currently, all managed care organization (MCO) rates are on a July 1 to June 30 contract period. Except the ICI contract, which is on a calendar year basis.

Question 24: Page 10, Section 4, Technical Proposal, Item 4 and Page 13, Section 7, D. Does the Work Plan qualify as an appendices, or should it be included within the six page limit?

Answer to question 24:

The overview of the work plan should be contained in the base technical proposal document limited to 6 pages. The work plan section of the technical proposal may utilize appendices as required to complete the submission.

Question 25: Page 10, Section 4, Technical Proposal, Item 4. What percentage of the current actuarial (sub)contractor's staff are "onsite" versus "off-site"?

Answer to question 25:

Currently all Actuary staff support is off-site.

Question 26: General Question. Is the State willing to negotiate the terms and conditions of the contract? Specifically, is the State willing to consider a limitation of liability? Where should vendors include exceptions, e.g. attachment to cover letter, appendix of RFP response, etc.? Does the submission of exceptions have any impact on the scoring of the vendor's proposal?

Answer to question 26:

The general terms and conditions are non-negotiable.

Question 27: Can the State provide sample work product for each of the deliverables outlined in the RFP to assist the vendor in understanding the scope of the required work?

Answer to question 27:

See response to question 3.

Question 28: Can the State provide a rough timeline for the calendar year or frequency for the expected delivery of services described in the RFP?

Answer to question 28:

See response to question 2. A timeline of the formally scheduled meetings for the most recent caseload testimony preparations is attached. Meetings frequency may change this is provided for illustrative purposes.

Question 29: The Cost Proposal in Section 4, B. indicates that the form presented in Appendix B should be used to prepare the proposal of costs for the staff and subcontractors assigned to the project. With regard to Appendix B:

a. Is the cost allocation (between salary, fringe benefits, direct and indirect) required or may the vendor choose to submit its total hourly rate?
b. If the detail is required, please confirm that the load for Indirect/Administrative Costs has a maximum of 10% and the 10% is inclusive of profit and all other indirect costs (assuming a federally approved indirect rate is not applicable)?
c. The cost proposal worksheet develops the proposal cost based on the anticipated number of hours. If the vendor is awarded the work, do the quoted fee estimates become the contract amount (i.e. treated as a fixed fee) which would then be billed monthly or will the vendor invoice the State based on actual hours each month irrespective of the estimated budget?
d. Are the direct costs anticipated to be converted to an hourly rate? If not, how are these costs submitted to the State for reimbursement?
e. Is there a required format for preparing the bid for each of the four potential 12-month extensions?

Answer to question 29:

The form attached to the RFP at Appendix B has been updated based on bidder questions. Bidders are to use this updated form to provide cost estimates for actuary services based on an estimated 1500 billable hours distributed by staffing level. Other tasks are by rate and hours the bidder estimates are required to complete the tasks.

The vendor will invoice that State based on actual hours each month required to complete requested tasks by staff rates identified on the purchase order. Budgets are subject to the availability of State funds. Vendors will utilize a similar format for hourly rates submission by staff level for potential extensions.

Question 30: Section 3, Scope of Work and Requirements, includes Task 3 for additional tasks that may be identified during the course of the engagement and references the "hourly rates established in the award". Appendix B calculates the proposed project fees for Tasks 1 and 2 based on the hourly pay rate for the assigned staff with adjustments for benefits, subcontractors and other costs. Does the State anticipate that a new Appendix B worksheet would be prepared for any additional work defined under Task 3? If not, please describe what is meant by "hourly rates established in the award".

Answer to question 30:

During the course of the contract, should the state elect to authorize the use of Task 3, the vendor must prepare their response using the current rates that where established within the PO for similar scoped positions.

Question 31: Please describe the requirements, if any, for on-site support.

Answer to question 31:

The state has no requirement for on-site support, but will require close collaboration with the potential vendor, including availability for on-site meetings as State determines necessary, and availability during standard working hours.

Question 32: Section 7, Proposal Contents, provides the specifications for the proposal submission. The last bullet in Section 7 indicates that the printed copies are to be bound with removable binder clips only. Does this apply to the cost proposal only? Is a three-ring binder acceptable for the technical proposal?

Answer to question 32:

This requirement applies to the cost and technical proposals. Three ring binders are acceptable.

Question 33: Can the State provide an estimate of the current number of hours and associated fees it is currently paying for this scope of work (and/or indicate the number of full time equivalent staff by job level)?

Answer to question 33:

The following estimate may not be indicative of future resource needs. However, the State estimates an average of 7500 billable hours (of which 1,500 are billable hours for actuarial services) in SFY17 and SFY18 in support of similar tasks outlined in this RFP. All service levels are subject to availability of State funding and State requirements for support.

Question 34: Our firm typically provides consulting services based on hourly rates on a fee-for-service basis. Are vendors permitted to prepare the Cost Proposal on this basis?

Answer to question 34:

The form attached to the RFP at Appendix B has been updated based on bidder questions. Bidders are to use this updated form to provide cost estimates for actuary services based on an estimated 1500 billable hours distributed by staffing level. Other tasks are by rate and hours the bidder estimates are required to complete the tasks.

Question 35: Please describe the current approach used for risk adjustment with the plans. Will the State require a specific risk scoring methodology to be used?

Answer to question 35:

Currently, managed care organization (MCOs) rates are not risk adjusted.

Question 36: What factors have led to the State's decision to re-procure this work?

Answer to question 36:

The State's current contract ends on December 31, 2018.

Question 37: What is the current annual budget for services described in the RFP that are currently being provided to the State by consultants?

Answer to question 37:

The State's budget is subject to the availability of State funds which are appropriated on an annual basis for the State Fiscal year beginning on July 1st.

Question 38: Please indicate which services described in the RFP, if any, are not currently provided to the State by consultants.

Answer to question 38:

Completion of these tasks requires close collaboration with State and contract staff.

Question 39: How many actuarial certifications are required each year, and for which programs?

Answer to question 39:

See response to question 2.

Appendix B: Sample Budget Worksheet – revised 7.20.18

Use this format to submit your budget. All items included in this Budget Form must be fully explained in the Budget Narrative.

Task 1: Actuary Support: For budget analysis, use a total of 1500 hours of actuary service			
Personnel (Name, Title or Staffing Level)	Total Hourly Rate	Total # of Hours	Total
Task 2: Financial Analysis: Number of hours are estimated by the bidder to accomplish the tasks listed in the RFP.			
Personnel (Name, Title)	Total Hourly Rate	Total # of Hours	Total
Subcontracts (Name and Description of Service, Cost)			$
Other: (if your expense does not fit into a category above please list and specify below)			$
			$
Total Request			

A. Justification of Budget Expenses

PERSONNEL **$6,534.00**

Sally Smith, Director $2,132.00
$24.79 per hour for 86 hours
Ms. Smith will work with community partners to achieve the goals and objectives of this proposal. She will attend monthly trainings/meetings as required by the RFP.

John Jones, Assistant Systems Development $2,178.00
$33.76 per hour for 64.50 hours
Mr. Jones will specifically review operating protocols related to systems development, implementation and operation performance.

John Doe, RN, C. MS, Project Coordinator $2,224.00
$51.72 per hour for 43 hours
Mr. Doe will assume responsibility for oversight of the project and all project-reporting requirements.

FRINGE BENEFITS **$1,960.00**

Taxes and fringe @ 30% are calculated as follows: Social Security 6.20%, Medicare 2.45%, Workmen's Comp 4.54%, Unemployment Insurance 4.46%, Dental Insurance 1.00%, Life Insurance .68%, Pension 10.67%.

SUBCONTRACTS **$4,000.00**

John Hope Settlement House and the Center for Hispanic Policy & Advocacy will conduct a community assessment on tobacco use.

John Hope Settlement House $2,000.00
$25 per hour x 80 hours

Center for Hispanic Policy & Advocacy $2,000.00
$25 per hour x 80 hours

SUB-TOTAL **$43,694.00**

ADMINISTRATIVE COST **$4,369.00**
10% of all direct expenses less equipment and subcontracts

TOTAL **$48,063.00**

Rhode Island Annual Medicaid Expenditure Report SFY 2016

Executive Office of Health and Human Services

May 2017

Purpose of this Report

The purposes of this report include the following:

- Comply with the requirements of Statutory Mandate R.I.G.L.42-7.2-5(d), the authorizing statute for the Executive Office of Health and Human Services (EOHHS), to provide a comprehensive overview of all Medicaid expenditures, outcomes, and utilization rates.
- 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.
- Summarize Medicaid expenditures for eligible individuals and families covered by the health and human services departments.
- Show enrollment and expenditure trends for Medicaid coverage groups by service type, care setting, and delivery mechanism.
- Establish a standard format for tracking and evaluating trends in annual Medicaid expenditures within and across departments.

Variance to Other Reports:

This report is based on Medicaid systems extracts that include claims, capitation payments, premiums and provider payouts. Capitations, premiums and payouts are proportionately allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information. Due to the proportional allocation method used here, other reports based directly on claims data may differ from the expenditure amounts in this report.

The primary basis for identifying expenditures in this report is the actual date of service with an adjustment for incurred but not reported (IBNR) claims, 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 reasons for variance might include factors such as claim completion and rounding.

Definition of average annual rates methodology: *This report shows trends in terms of an average annual trend rate based on five years of historical data in order to present longer term trends rather than year to year variation. An average annual increase of 1.0% per year from 2011 to 2015 is equivalent to an increase of 4.1% in total from 2011 to 2015.*

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Executive Summary: Overview and Key Findings

Overview

During SFY 2016 Rhode Island's Medicaid program served approximately 325,000 Rhode Islanders, with an average of 282,000 enrolled at any one time. This includes 86,000 individuals enrolled in Medicaid Expansion, the program started January 1, 2014 to expand Medicaid eligibility to adults without dependent children with incomes less than 138% of the federal poverty level.

Program expenditures on Medicaid covered services for SFY 2016 totaled $2.4 billion. Medicaid expenditures are divided among several state agencies, with $2 billion of expenditure managed in SFY 2016 by the Executive Office of Health and Human Services (EOHHS), and $340 million managed by the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH).

Under the Medicaid program, the federal government is typically responsible for approximately half of total expenditure. In SFY 2016 the Federal Medical Assistance Percentage (FMAP) was 50.32% for the bulk of Medicaid expenditure. For certain programs the FMAP is higher, including Expansion population, Children's Health Insurance Program (CHIP), and others.

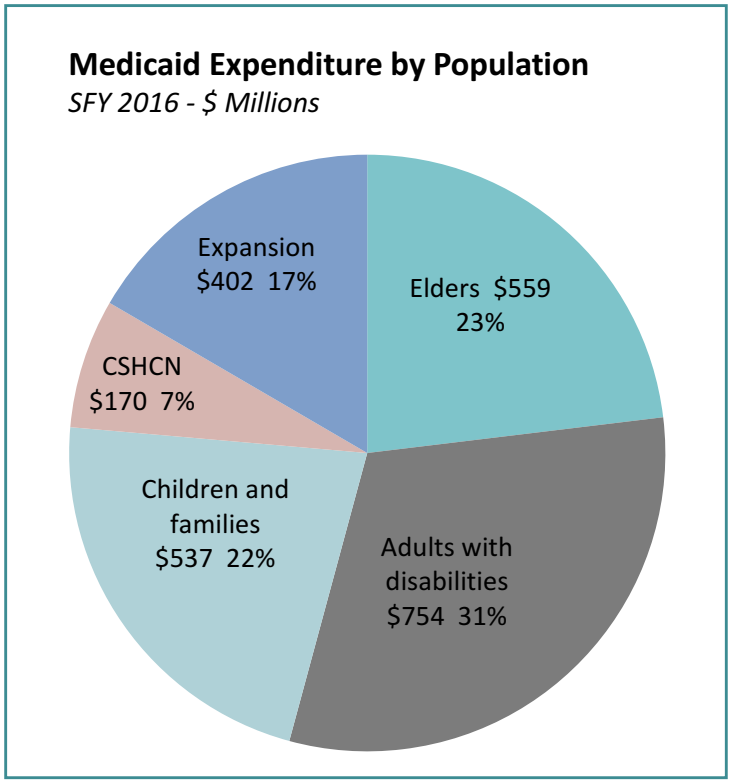
Key Findings:

- During SFY 2016 Rhode Island's Medicaid program served an average of **282,000 enrollees** at any one time during the year.
- Total expenditures for Medicaid covered services for SFY 2016 were **$2.4 billion**.
- Between SFY 2012 and 2016, total Medicaid expenditures have increased an average of 2.3% per year, excluding growth from the Expansion population.
- Enrollment has increased 2.9% per year on average over the last five years, excluding growth from the Expansion population.
- Per member per month (PMPM) costs have decreased 0.5% per year, from $794 in SFY 2012 to $777 in SFY 2016, excluding the Expansion population. When including the Expansion population, overall Medicaid PMPM for SFY 2016 is $717.
- These expenditure trends compare quite favorably to both national Medicaid total expenditures and state commercial PMPM cost trends.
- Adults with disabilities account for 31% of expenditure. Elders account for another 23%.
- Hospitals and nursing facilities account for nearly half (45%) of Medicaid expenditure.
- Ninety percent of Medicaid recipients are enrolled in managed care programs. Both of Rhode Island's Medicaid managed care organizations were rated 4.5 out of 5 by the National Committee for Quality Assurance (NCQA).
- Claims expenditures are highly concentrated – the top 6% of users account for 62% of claims expenditure.

Executive Summary: Populations

Medicaid serves five different primary populations:

- **Elders** include 19,198 adults over age 65, 96% of whom are also covered by Medicare.[1] Elders account for $559 million in total SFY 2016 Medicaid expenditure, and have the highest average PMPM cost of $2,427. Nursing facilities account for sixty percent of expenditures for this population.
- **Adults with disabilities** include 32,080 adults under age 65 who have identified disabilities. Almost half (48%) of this population is also covered by Medicare. Adults with disabilities account for the largest share of expenditure, with SFY 2016 expenditure of $754 million, and an average PMPM cost of $1,958. The largest components of expenditure for this population are residential and rehabilitation services for persons with intellectual and developmental disabilities and hospital care.
- **Children and families** include 153,342 low income children, parents and pregnant women who meet specific income requirements. Children and families account for 54% of total enrollment and 22% of total expenditure, with total SFY 2016 expenditure of $537 million and an average PMPM of under $300. Most expenditure on this population is for hospital care and professional services. Ninety-five percent of this population is enrolled in managed care. The federal match is increased to 82.47% for qualifying low income children and pregnant women under the Children's Health Insurance Program (CHIP).



- **Children with special health care needs (CSHCN)** include 12,025 individuals under 21 who are eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. These children account for 7% of total Medicaid expenditures and 4% of enrollees, with SFY 2016 expenditures of $170 million. Eighty-two percent of this population is enrolled in managed care.
- **Expansion** includes 64,989 low income adults without dependent children, newly eligible under the ACA on January 1, 2014. The Expansion population accounted for 23% of SFY 2016 enrollment and 17% of total SFY 2016 expenditure, or $402 million. Expenditure for this population is 100% federally funded through the end of calendar year 2016. This population mainly used hospital and professional services, accounting for 77% of expenditures on this population. Nearly all (95%) were enrolled in managed care.

[1]Enrollment figures represent average monthly enrollment unless otherwise specified.

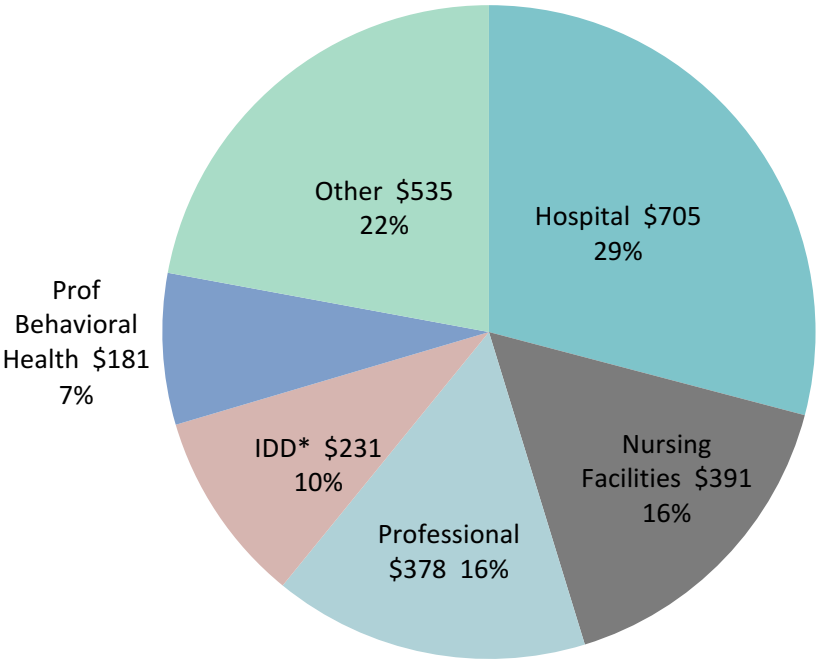
Executive Summary: Medicaid Providers

Medicaid pays for services offered by a variety of provider types. Hospitals and nursing facilities together account for nearly half of program expenditure.

- Hospitals were the largest provider type, accounting for 29% of Medicaid expenditure in SFY 2016.
- Hospital expenditures increasing at 1.1% annually over the last five years, not including expenditure on the Expansion population.
- Nursing facilities (including both nursing homes and hospice) were the next largest provider type, accounting for 16% of expenditure in SFY 2016.
- Total Medicaid payments to nursing facilities have been increasing on average 2.7% per year between SFY 2012-2016 (trend rates do not include the Expansion population).
- The provider type categories with the highest average annual growth trends were professional services, home and community based services, and premiums.
- Other provider types detailed in the report include premiums; pharmacy; home and community-based services; and care provided in the Slater Hospital, Tavares and Zambarao facilities.

Medicaid Expenditure by Provider Type

SFY 2016 - $ Millions

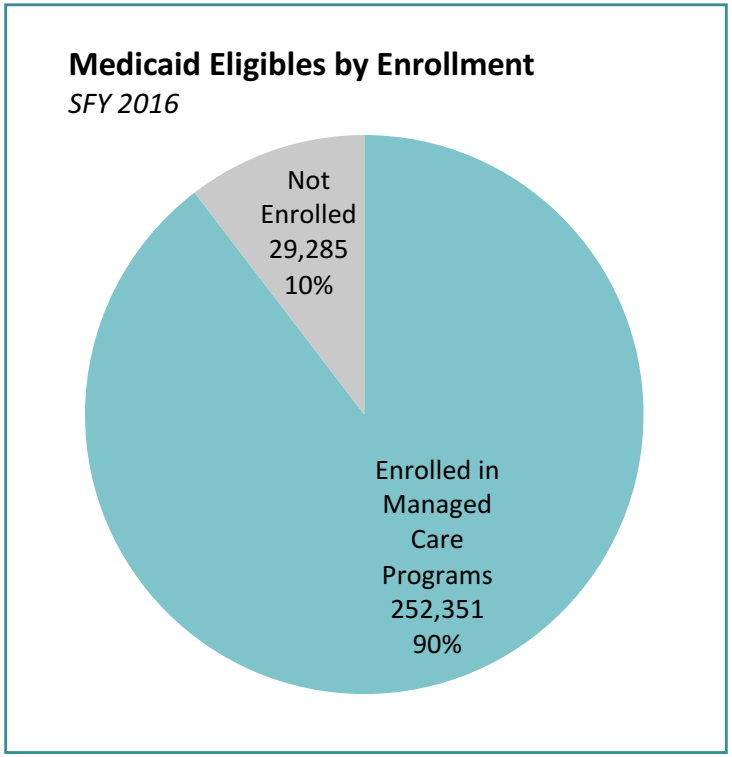


*The IDD provider type includes residential and rehabilitation services and group homes for persons with intellectual and developmental disabilities.

Executive Summary: Managed Care

Not all payments are made directly by Medicaid to service providers. In SFY 2016, 90% of Medicaid eligibles are enrolled in risk-based managed care plans. These enrolled populations accounted for 76% of Medicaid expenditure.

- Forty-nine percent of Medicaid eligibles are enrolled in managed care through RIte Care, which is a Medicaid managed care program for children and parents.
- Another 3% of managed care enrolled eligibles are the Children with Special Health Care Needs population.
- Five percent of eligibles are enrolled in Rhody Health Partners (RHP), a managed care program for adults with disabilities.
- The Expansion population is mainly enrolled in managed care.
- Enrollment in Medicaid managed care programs is divided between Neighborhood Health Plan and United Healthcare. Both of these Medicaid managed care organizations were rated 4.5 out of 5 by the National Committee for Quality Assurance (NCQA).
- Rhody Health Options (RHO) is a managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term services and supports and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility. In SFY 2016 7% of Medicaid eligibles are enrolled in RHO.
- Three percent of Medicaid eligibles are enrolled in RIte Share, a premium assistance program for Medicaid eligibles with access to commercial insurance. This minimizes Medicaid expenditure by leveraging the employers' contributions.



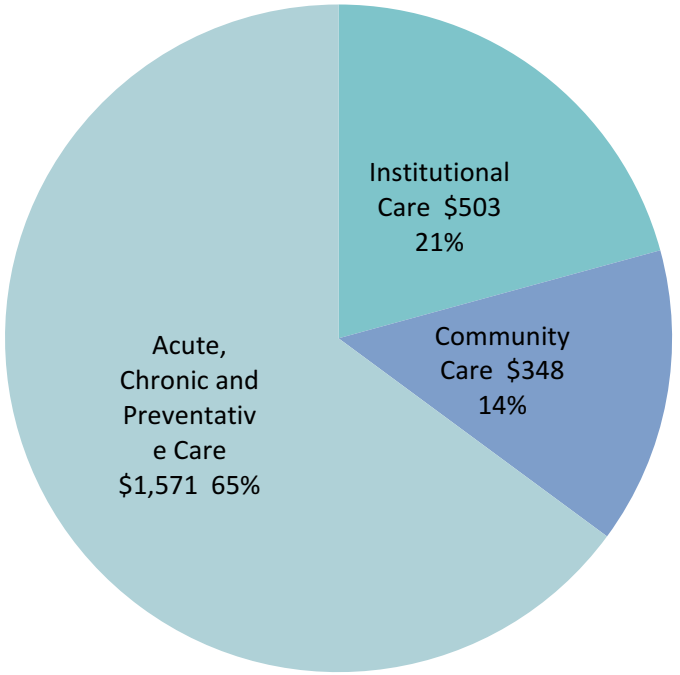
Executive Summary: Long Term Services and Supports

Long term services and supports (LTSS) include institutional care and community care. These services are mainly focused on the elders and adults with disabilities populations. Expenditures on LTSS account for $850 million in total Medicaid expenditure in SFY 2016, 35% of total.

- Community care services are provided to at-risk populations as alternatives to more costly nursing home/institutional options and account for $348 million, 41% of the LTSS expenditure.
- Institutional care services account for the remaining $503 million of LTSS expenditure. The largest category is nursing home services, accounting for 43% of LTSS expenditure overall. Other institutional care expenditure is for hospice and care in the Slater Hospital, Tavares and Zamabarano facilities.
- The balance of expenditure between nursing facilities and home and community based care (HCBS, a subset of Community Care) has been shifting over the last 5 years. In SFY 2016 HCBS accounted for 23% of the combined expenditure on both nursing facilities and HCBS compared to 20% in SFY 2012.
- Expenditure on HCBS has been growing at 7.2% per year on average over the last 5 years. Nursing home expenditure has been growing at 3.0% per year on average.
- Acute, chronic and preventive services account for the remaining 65% of Medicaid expenditure.

Medicaid Expenditure by Provider Type Category

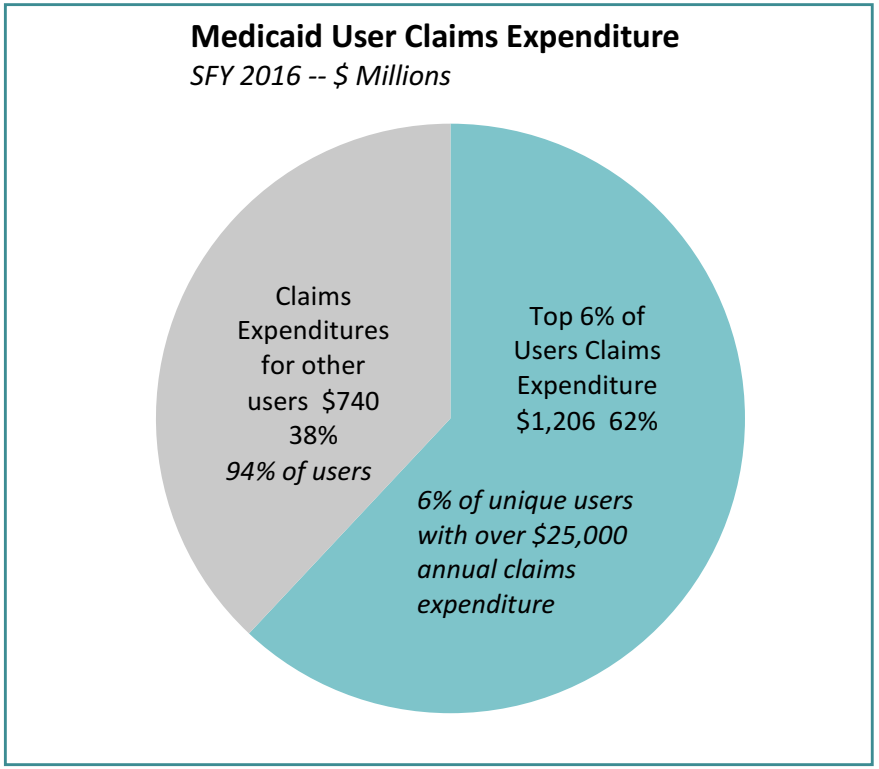
SFY 2016 -- $ Millions



Executive Summary: High Cost Users

The top six percent of Medicaid users, those with over $25,000 in claims expenditure per year, account for nearly two-thirds (62%) of claims expenditures.

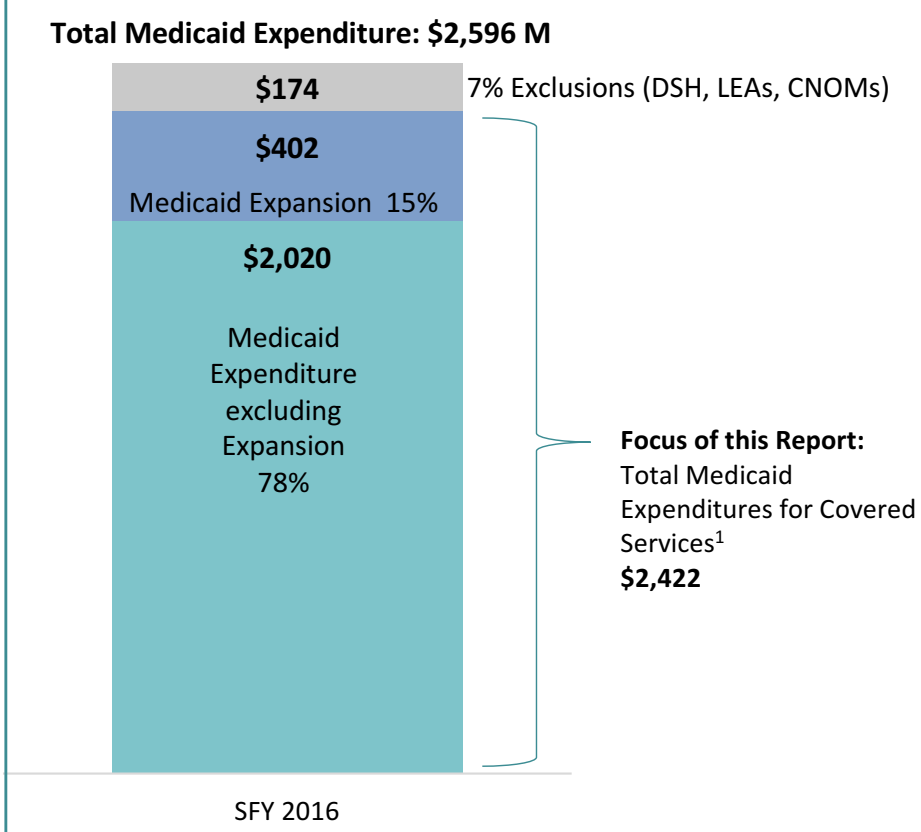
- This analysis examines the characteristics of "high cost" users, those with over $15,000 of claims expenditure of per year.
- Nine percent of Medicaid users are "high cost" users and account for 71% of claims expenditure.
- High Cost users typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- Forty-one percent of claims expenditure for high cost users is for nursing facilities and residential and rehabilitation services for persons with intellectual and developmental disabilities. Hospital services account for another 24% of high cost user claims expenditure.
- Together, elders and adults with disabilities account for 71% of claims expenditure for high cost users. For both of these populations, about three-quarters of total population expenditure is attributable to high cost user claims.



Total Expenditures: Definitions and Exclusions

Medicaid expenditures in SFY 2016 totaled approximately $2.6 billion. Expenditures for covered services totaled $2.4 billion, including $402 million for Medicaid Expansion.

Summary: Total Medicaid Expenditures
SFY 2016 - $ Millions



- Medicaid expenditure was split between state and federal funds. This report includes all Medicaid expenditures, including both state and federal funds.
- Starting January 1, 2014, Rhode Island expanded Medicaid coverage to adults without dependent children under 138% FPL. Expenditure on this population during SFY 2016 was $402 million and the state received 100% federal matching funds for this population.
- The analyses in this report exclude $141 million in Disproportionate Share Hospital (DSH) payments, $16 million in costs not otherwise matchable (CNOM), payments of $18 million to Local Education Authorities (LEAs), and EOHHS administrative expenditure. More detail on excluded payments is provided in the Appendix.
- In previous years, this report has excluded Medicare "clawback" payments. Officially known as the "phased-down state contribution", the clawback is a monthly payment made by each state to the federal Medicare program to help finance the Medicare drug benefit. This report includes $53 million in clawback payments, and all historical data shown has been updated to include clawback payments as well.

Note: This report looks at Medicaid expenditures for covered services and does not include state overhead and administrative costs related to managing the Medicaid program.

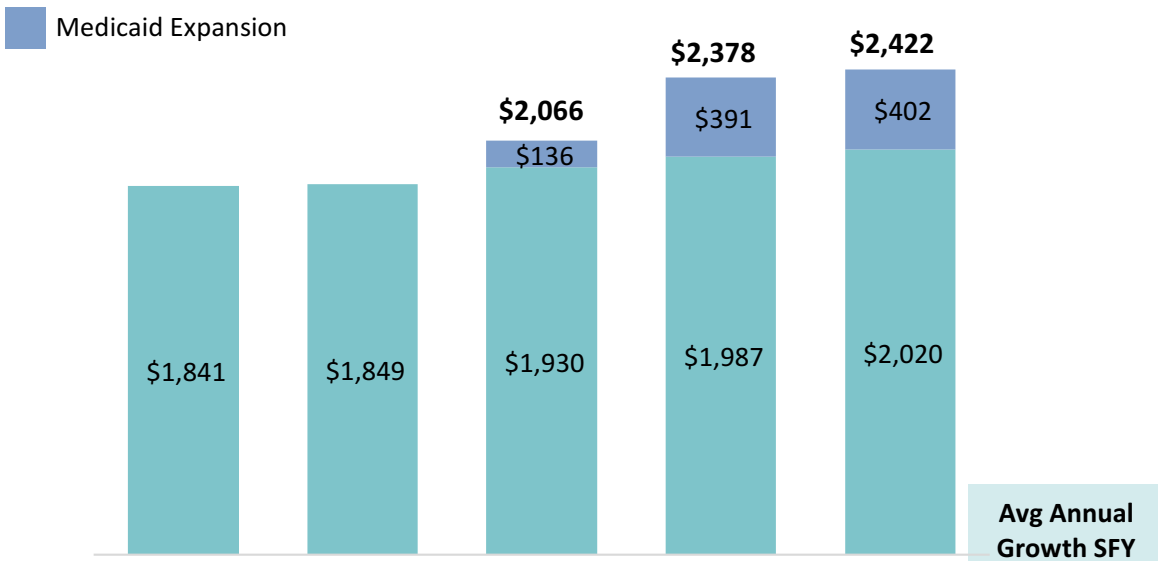
[1]Expenditures reflect medical benefits only and do not include EOHHS central management expenditures.

Medicaid Expenditure Trends

Over the past five years, Rhode Island Medicaid expenditures have **increased 2.3% per year on average**, excluding the Medicaid expansion population.

Total Medicaid Expenditure for Covered Services[1]

SFY 2012-2016 - $ Millions



		SFY 2013	SFY 2014	SFY 2015	SFY 2016	Avg Annual Growth SFY 2012-2016[2]
Annual Exp Growth	Excluding Expansion	0.4%	4.4%	2.9%	1.7%	**2.3%**
	With Expansion		11.7%	15.1%	1.8%	**7.1%**

- Including the Expansion population, expenditure increases for SFY13-14 and SFY14-15 were 11.7% and 15.1% respectively. However total expenditure growth including Expansion for SFY 15-16 has slowed to 1.8%.
- The state receives federal matching funds to cover 100% of the Expansion population expenditures for SFY 2016. For SFY 2017, FMAP for this population will be 97.5% and for SFY 2018 it is expected to be 94.5%.
- One contributing factor to the increase in expenditure in SFY 2013-15 was the ACA-mandated primary care physician rate increase in effect for calendar years 2013 and 2014.
  - This resulted in increased payments to primary care physicians for certain services to match the Medicare Physician Fee Schedule.
  - This rate increase, which was 100% federally funded, added approximately $24 million in spending for calendar years 2013 and 2014.
  - Roughly half of the total increased amount occurred in SFY 2014.

[1]Annual expenditure includes the spending for Medicare clawback payments that were excluded in previous year versions of this Report.

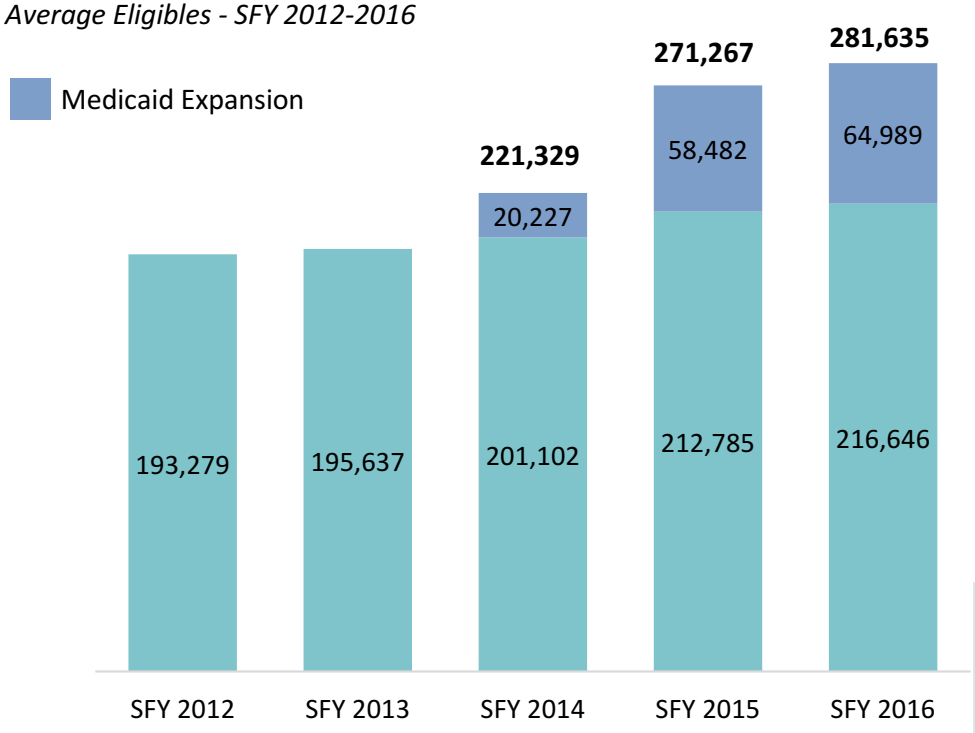
[2]Calculated as compounded annual growth rate (CAGR) over period SFY 2012-2016 as shown.

Medicaid Expenditure Trends: Enrollment

Average annual Medicaid enrollment has **increased 2.9% per year on average**, excluding Medicaid Expansion.

Total Medicaid Enrollment

Average Eligibles - SFY 2012-2016



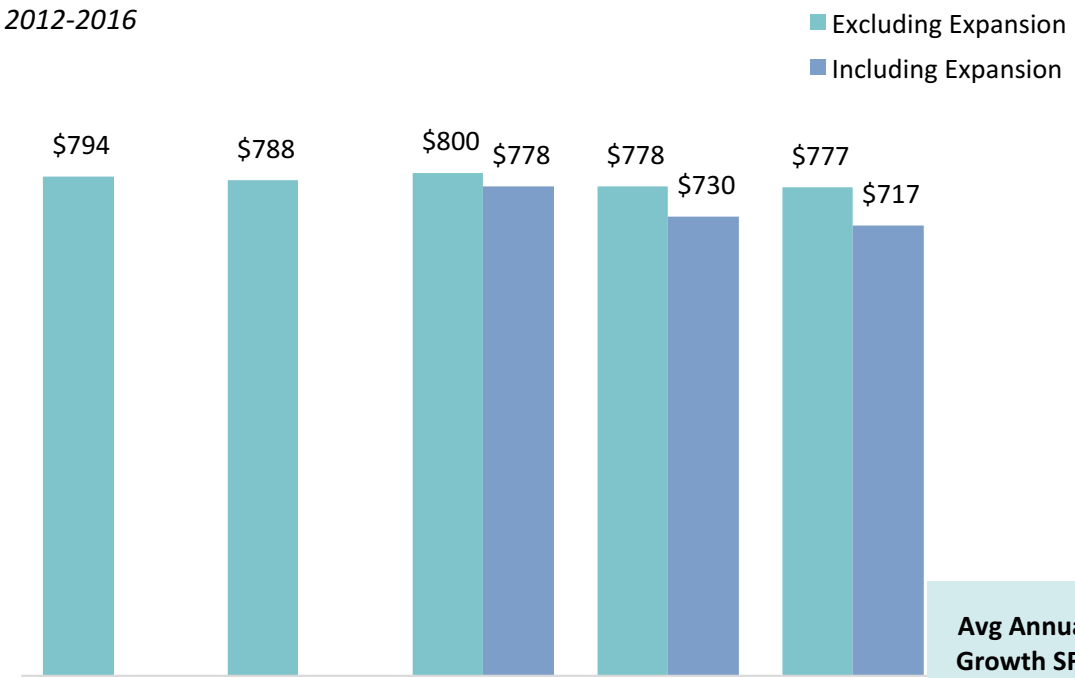
		SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	Avg Annual Growth SFY 2012-2016
Annual Enrollment Growth	Excluding Expansion		1.2%	2.8%	5.8%	1.8%	**2.9%**
	With Expansion			13.1%	22.6%	3.8%	**9.9%**

- ACA implementation on January 1, 2014, resulted in enrollment increases for both Expansion and non-Expansion populations, as eligibility rules changed and outreach increased.
- Including the Expansion population, total Medicaid enrollment increased 3.8% from SFY 2015 to SFY 2016.
- There was a surge in non-Expansion enrollment of 5.8% from SFY 2014 to SFY 2015, but the rate of increase slowed to historical levels from SFY 2015 to SFY 2016.
- Overall, including Expansion, Medicaid enrollment increased from 193,279 average eligibles in SFY 2012 to 281,635 average eligibles in SFY 2016, an average annual increase of 9.9%, with the bulk of the increase coming during the Expansion period.
- Eligibility counts reflect members eligible for full Medicaid benefits and does not include Partial Duals who receive assistance only with their Medicare premium payments.

Medicaid Expenditure Trends: PMPM

Average annual Medicaid PMPM has **decreased 0.5% per year on average**, excluding Medicaid Expansion.

Total Medicaid PMPM
SFY 2012-2016



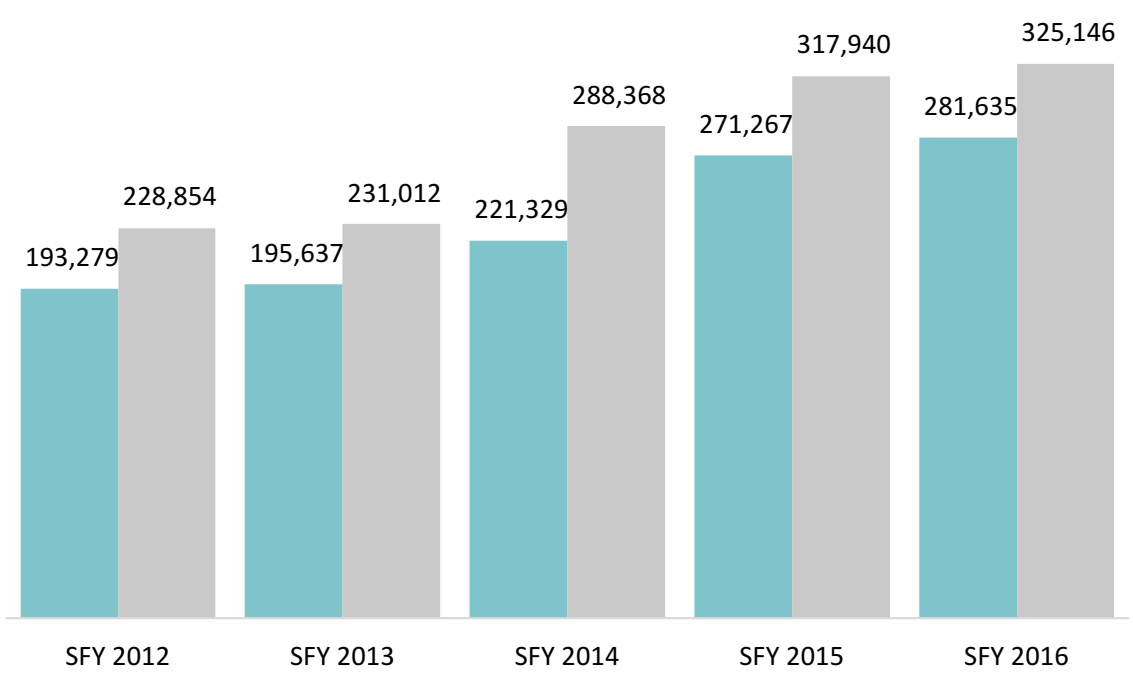
		SFY 2013	SFY 2014	SFY 2015	SFY 2016	Avg Annual Growth SFY 2012-2016
Annual PMPM Growth	Excluding Expansion	-0.8%	1.6%	-2.8%	-0.1%	**-0.5%**
	With Expansion		-1.2%	-6.1%	-1.9%	**-2.5%**

- Excluding Expansion, PMPM costs have decreased 0.5% per year on average since SFY 2012. The PMPM cost for SFY 2016 excluding Expansion is lower than any of the last 5 years.
- Including the Medicaid Expansion population, the average PMPM for Medicaid overall is $717, a decrease of 1.9% from SFY 2015.
- Overall average Medicaid PMPM, including Expansion, has decreased 2.5% on average over the last 5 years, from $794 in SFY 2012 to $717 in SFY 2016.
- SFY 2016 reduction in PMPM reflects implementation of Governor Gina Raimondo's Reinventing Medicaid savings initiatives that included certain programmatic changes, such as a 2.5% cut to hospital reimbursement rates and a 2.0% cut to nursing home reimbursement rates.

Medicaid Expenditure Trends: Unique Recipients

Including the Expansion population, **about 31% of Rhode Island's population were enrolled** in Medicaid for some part of SFY 2016.

Average Eligibles and Unique Recipients
SFY 2012-2016



	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Turnover Ratio	1.18	1.18	1.30	1.17	1.15
Unique Recipients % of RI Pop[1]	22%	22%	27%	30%	31%

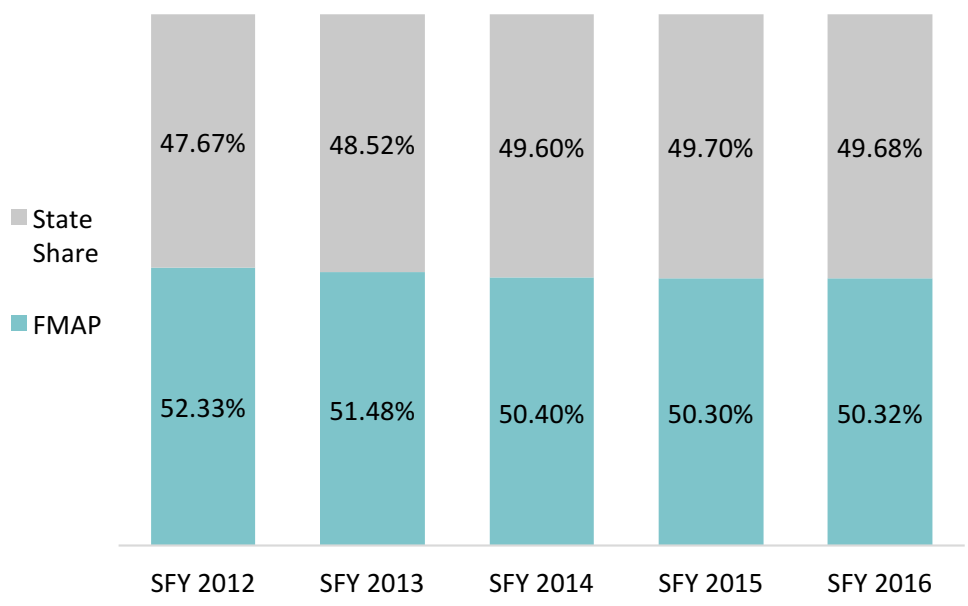
[1]Source: Population Division, US Census Bureau.

- Unique recipients is a measure of the number of individuals enrolled in Medicaid at any time during the fiscal year. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- The turnover ratio compares unique recipients to average eligibles. If the number of unique recipients is equal to the average eligibles, that indicates that there is a steady population of eligibles that remain on the program for the full year. If the number of unique recipients is above the average eligibles (a turnover ratio of >1), this indicates that some Rhode Islanders are using Medicaid for shorter periods of time.
- The higher turnover ratio for SFY 2014 is due to the fact that the Expansion population was enrolled for at most 6 months of the year and many were enrolled for less than that. In SFY 2015-6, the turnover ratio is much closer to the typical annual turnover ratio.

Federal and State Share of Expenditures

Funding for Medicaid expenditures is split between state and federal dollars, with Rhode Island typically responsible for just under half of program expenditures.

Federal Medicaid Assistance Percentage (FMAP)
SFY 2012-2016



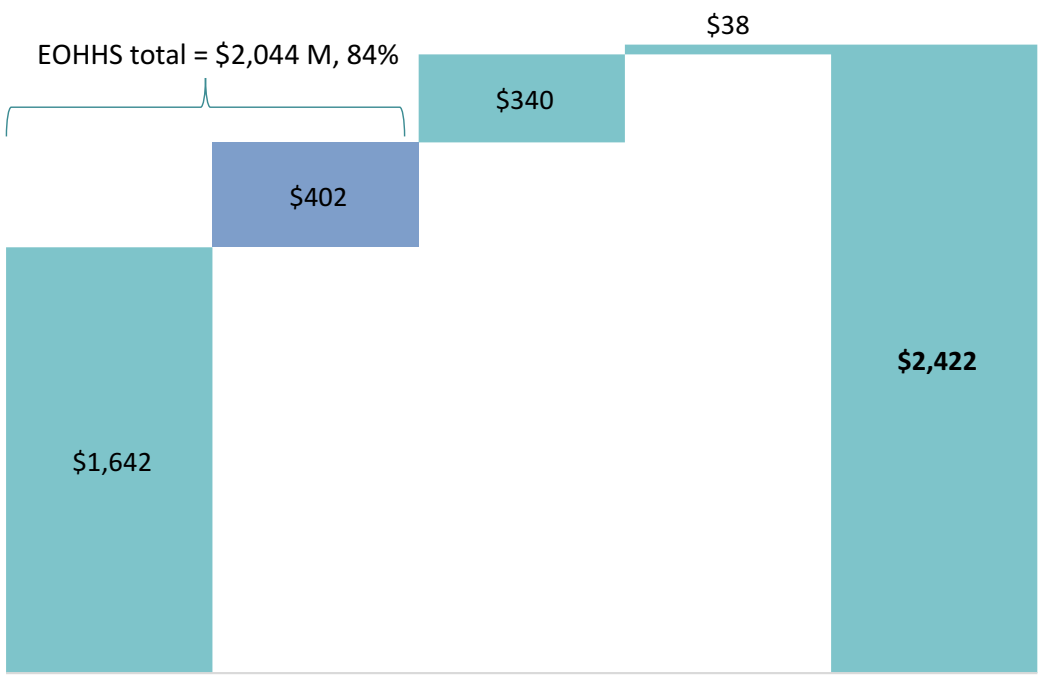
FMAPs shown reflect average during state fiscal year period and do not apply to Expansion, primary care rate increase, CHIP, and selected other programs.

- While this report will review trends in total Medicaid medical expenditure, it is important to recognize that less than half of this expenditure falls to the Rhode Island budget.
- There are several instances of variation from the FMAP levels shown on the chart at left:
  - The FMAP for the Medicaid Expansion population is 100% for SFY 2016. For SFY 2017, FMAP for this population will be 97.5% and for SFY 2018 it is expected to be 94.5%.
  - During CY 2013-2014, the State was required to increase payments to primary care physicians for certain services to match the Medicare Physician Fee Schedule. The additional cost of this requirement was funded with 100% federal matching funds.
  - The federal match is enhanced for 24,571 enrollees in the CHIP program, which provides insurance coverage to uninsured children and pregnant women from families with incomes up to 250% of the federal poverty level who are not otherwise eligible for Medicaid. In SFY 2016, Rhode Island received a 82.47% combined CHIP/FMAP federal match on CHIP children and pregnant women.
  - There are also a few small programs with a 90% match, including Breast & Cervical Cancer Prevention & Treatment (BCCPT) and Extended Family Planning (EFP).

Expenditure by Department

The majority of expenditure (84%) is administered by EOHHS, including all expenditure for the Expansion population.

Expenditure by Department
SFY 2016 - $ Millions

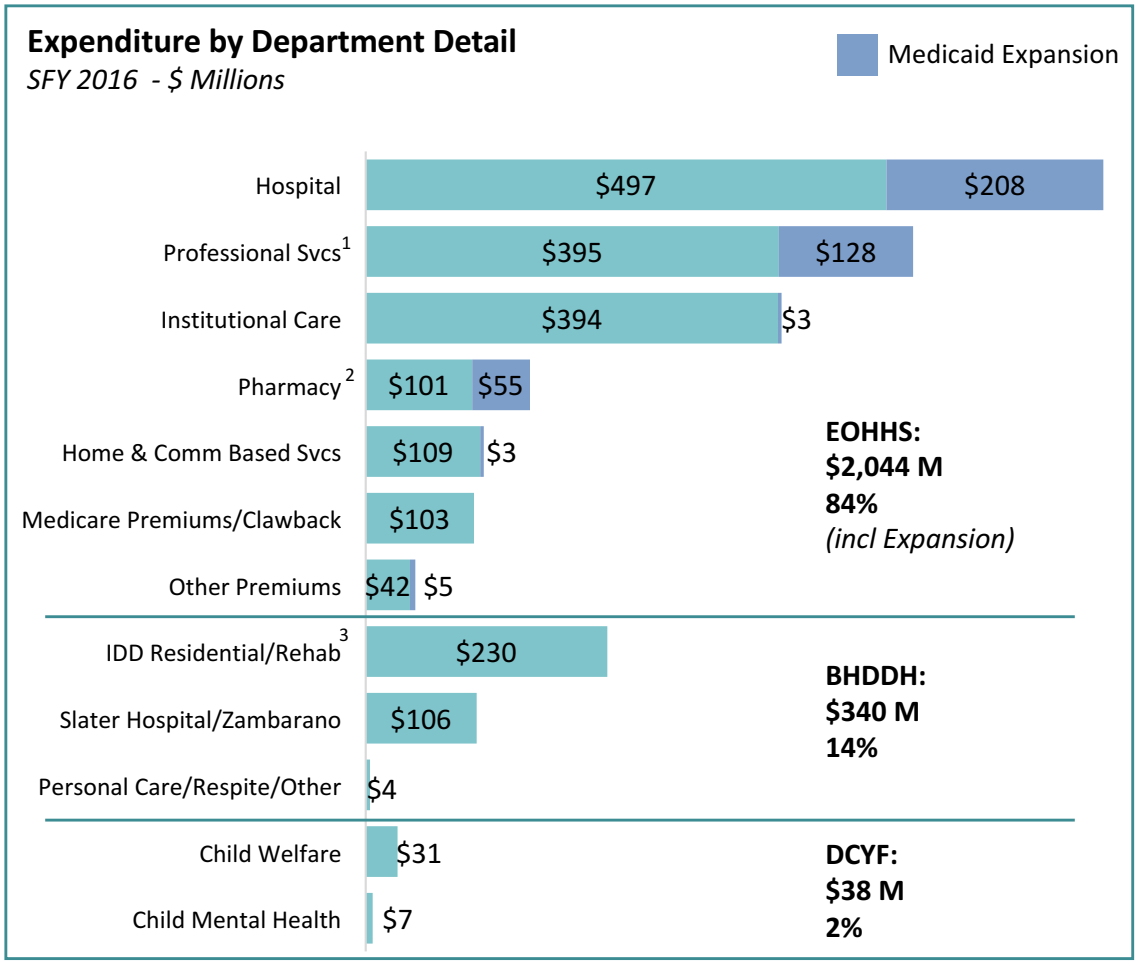


	EOHHS	EOHHS- Medicaid Expansion	BHDDH	DCYF	Total
% of Total	68%	17%	14%	2%	100%
Avg Ann Exp Growth 2012-6	3.5%		-2.2%	0.1%	

- In SFY 2016, the state departments responsible for administering components of the Medicaid program were: the Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH); and the Department of Children, Youth and Families (DCYF).
- EOHHS is the lead administrator for the Medicaid contract with CMS. The Single State Medicaid Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
- The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers the second largest share of Medicaid expenditure (14%). Note that funding for intensive behavioral health services was transferred from BHDDH to EOHHS as of July 1, 2014.
- Detail for each department is shown on the next page.

Expenditure by Department: State Agency Detail

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



- EOHHS overall accounts for 84% of Medicaid expenditure. The biggest portion of that is for hospital-based services, accounting for 34% of EOHHS expenditure. Professional services account for 26% of EOHHS expenditure, and institutional care is another 19%.
- BHDDH expenditures include three primary areas: the management of Slater Hospital, residential facilities for persons with intellectual and developmental disabilities, and community based services.
- DCYF accounts for $38 Million (2%) of Medicaid expenditure. DCYF administers programs serving children in the child welfare system, children in substitute care and children with behavioral health conditions.

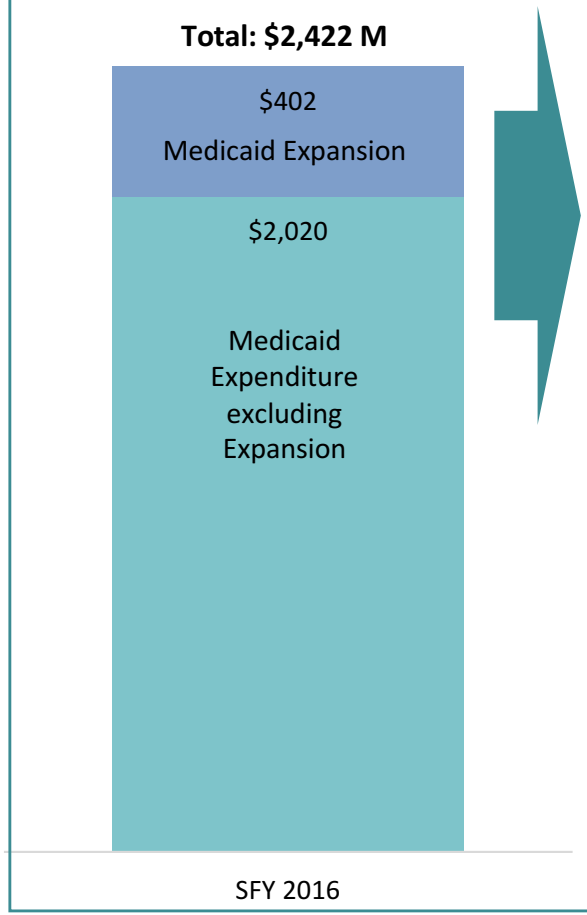
Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion and rounding.

[1]Includes professional services for behavioral health.
[2]Total expenditure shown is net of pharmacy rebates.
[3]IDDD Residential/Rehab is Residential and Rehabilitation Services for persons with intellectual and developmental disabilities, including group homes.

Expenditure Distributions

Medicaid expenditures can be broken down in several ways.

Medicaid Expenditures for Covered Services
SFY 2016 - $ Millions



Expenditure Distributions include:

Breakdown by population:
- Elders
- Adults with Disabilities
- Children and Families
- Children with Special Health Care Needs
- Medicaid Expansion

Breakdown by population shows expenditure by Medicaid recipient age and category of need

Breakdown by provider type:
- Hospital
- Nursing Facility
- IDD Residential/Rehab, Group Homes
- Behavioral Health
- Home & Community Based Services
- Long Term Services & Supports
- Professional Services
- Premiums

Breakdown by provider type shows expenditure by the institution or the type of professional performing the services

LTSS Details:
- Types of LTSS Providers
- LTSS Trends

Further details on Long Term Services & Supports expenditures

Breakdown by program:
- Managed Care
- Fee-for-service (FFS)

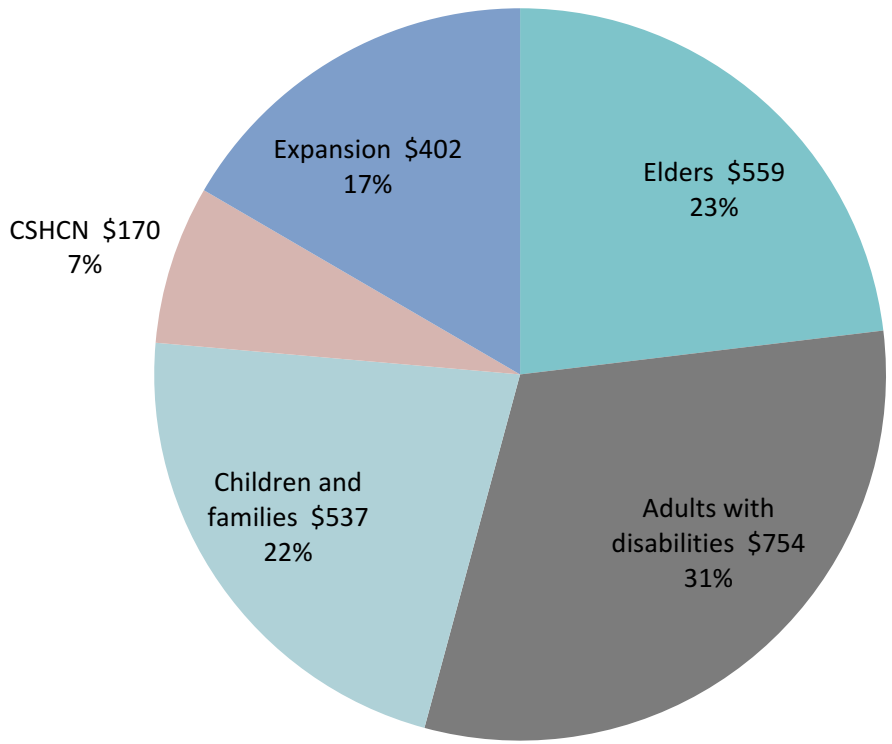
Breakdown by program shows expenditure by type of managed care program and amount of fee-for-service spending

Expenditure by Population

Over half of Medicaid expenditure (54%) is for Elders and Adults with Disabilities.

Medicaid Expenditure by Population
SFY 2016 - $ Millions

Total: $2,422 M



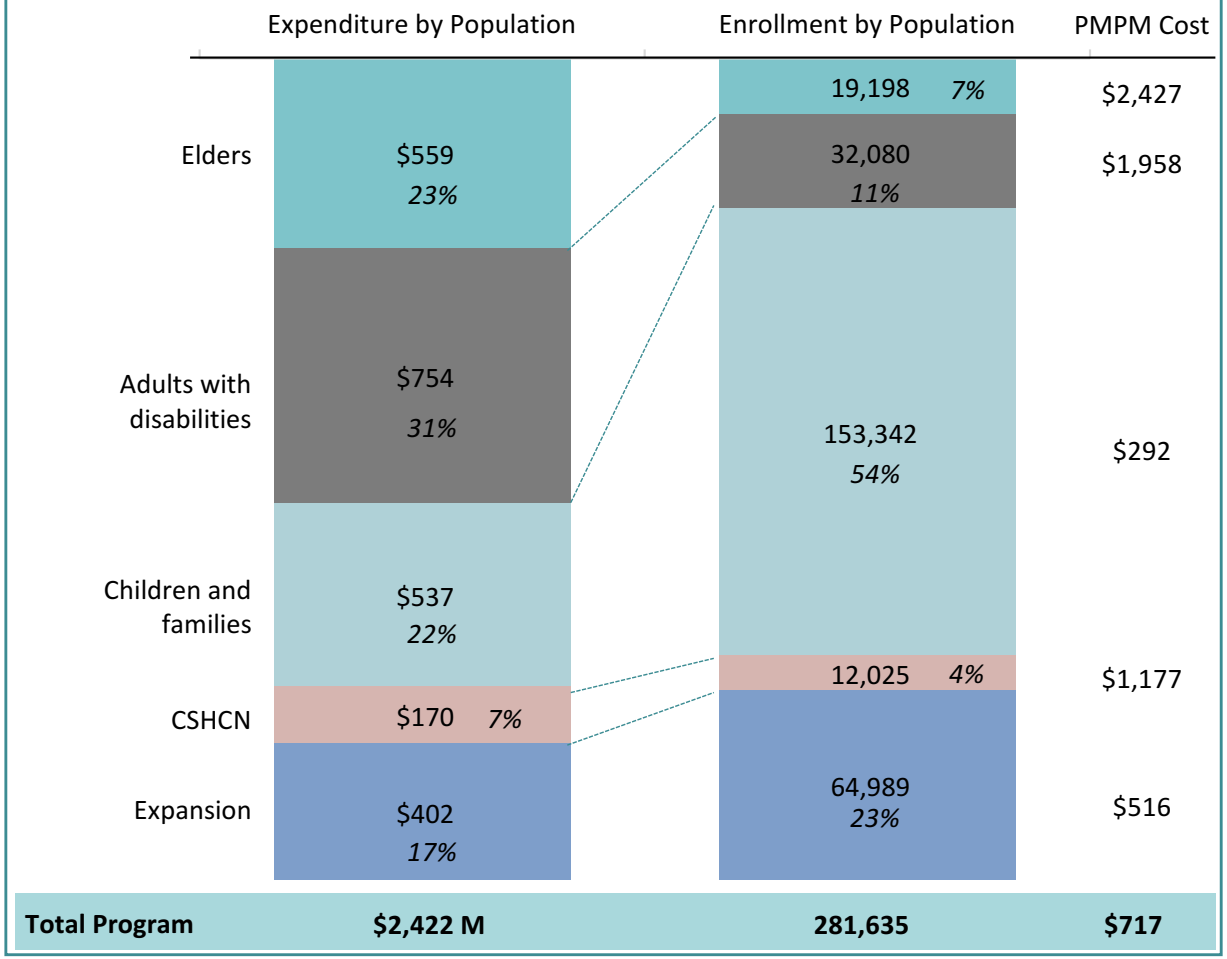
- **Elders** are adults over age 65, including those also eligible for Medicare. This population accounts for 23% of Medicaid expenditure, or $559 million.
- **Adults with Disabilities** are adults under age 65 who have identified disabilities (does not include RIte Care enrolled adults). This population accounts for $754 million in Medicaid expenditure, the largest portion of expenditure at 31% of total.
- **Children and Families** are low income children, parents and pregnant women who meet specific income requirements. This population accounts for another 22% of Medicaid expenditure, $537 million.
- **Children with Special Health Care Needs (CSHCN)** are individuals under 21 eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. This population accounts for 7% of Medicaid expenditure.
- **Medicaid Expansion** are adults without dependent children with incomes under 138% FPL who were newly eligible for Medicaid as of January 1st 2014 under ACA expansion rules. This population accounts for 17% of Medicaid expenditure.

Expenditure by Population

The Medicaid program served an average of 281,635 eligibles in SFY 2016, at an average cost per member per month of $717. However, PMPM costs vary considerably by population.

Medicaid Expenditure by Population

SFY 2016 - $ Millions



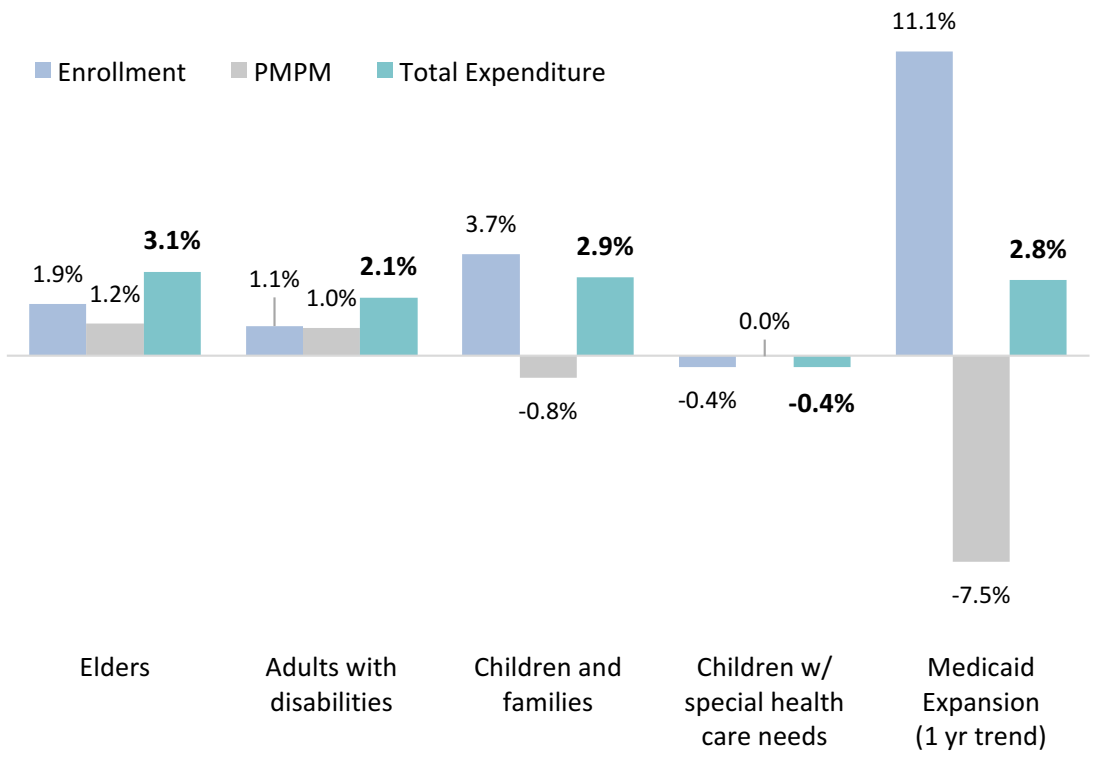
- **Elders** account for 23% of expenditure and 7% of enrollment, with a PMPM cost of $2,427. This population has the highest PMPM of the population groups shown in this report.
- **Adults with Disabilities** account for 31% of expenditure and 11% of enrollment, with a PMPM cost of $1,958.
- Together, elders and adults with disabilities account for 54% of expenditure and 18% of total eligibles.
- **Children and families** account for over half of total enrollment (54%) and 22% of total expenditure with a PMPM cost of $292.
- **CSHCN** account for 7% of expenditure and 4% of eligibles at a PMPM of $1,177.
- **Medicaid Expansion** accounts for 23% of eligibles and 17% of overall expenditure, with a PMPM of $516.

Expenditure by Population: Trends

Expenditure trends between SFY 2012 and SFY 2016 differed for the various population groups.

Average Annual Trends

SFY 2012-2016 – Medicaid Expansion Trends for SFY 2015-2016



2016 Expenditure by Population

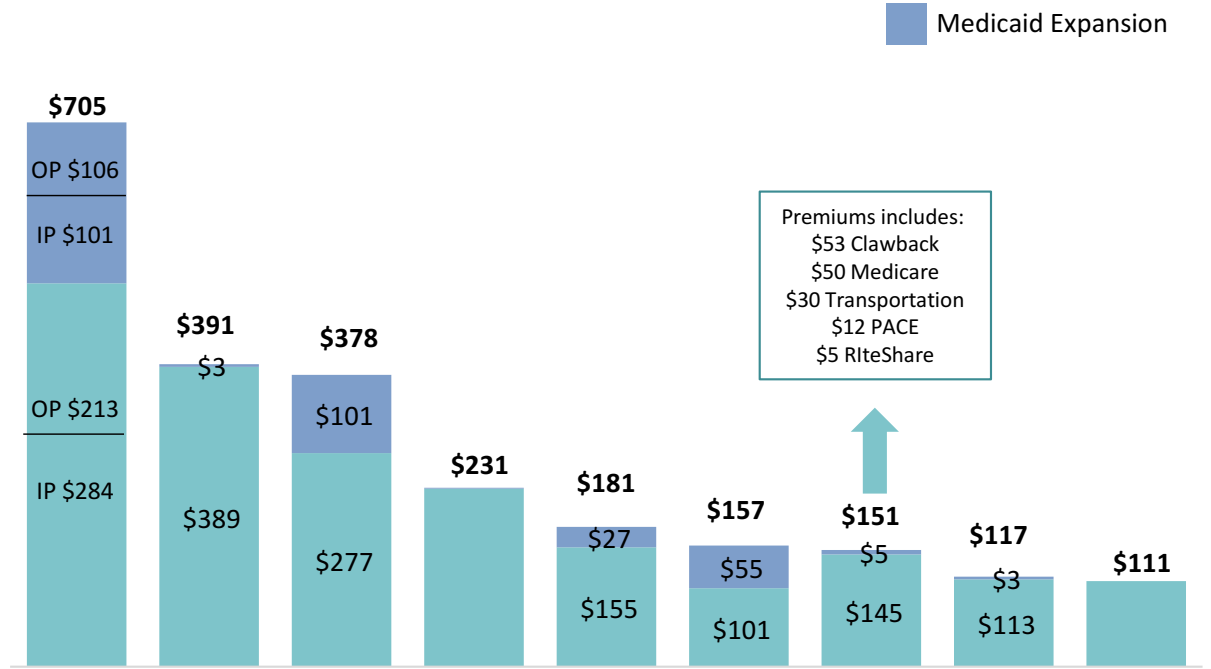
- The total expenditure trend can be broken into two composite pieces - the per member per month (PMPM) cost trend and the enrollment trend.
- Elders have experienced a 3.1% average annual increase in expenditure since SFY 2012. This increase is about 2/3 due to an increase in enrollment and 1/3 due to an increase in PMPM.
- Adults with disabilities expenditure has increased 2.1% per year on average over the last 5 years.
- Children and families experienced a 2.9% average expenditure growth over the past 5 years and an average enrollment growth of 3.7%. This population had an average annual PMPM decrease of 0.8% .
- Children with special health care needs have experienced a decrease in PMPM and overall expenditure since SFY 2012.
- The Medicaid Expansion population has experienced a 2.8% increase in expenditure since SFY 2015 even though enrollment has grown 11.1% in the same one year period.

Expenditure by Provider Type

Medicaid program funds are used to reimburse a variety of providers. Together, hospitals and nursing facilities account for nearly half (45%) of program expenditure in SFY 2016.

Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Total: $2,422 M



	Hospital	Nursing Home /Hospice	Professional	IDD Resdntl/ Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
% of 2016 Expenditure	29%	16%	16%	10%	7%	6%	6%	5%	5%
Avg Ann Growth 2012-16 (excluding Expansion)	1.1%	2.7%	4.9%	3.0%	-3.8%	1.6%	6.9%	7.2%	0.7%

- Hospitals were the largest provider type, accounting for 29% of Medicaid expenditures in SFY 2016.
- Including Expansion, hospital payments have increased 4.9% in the one year from SFY 2015 to SFY 2016.
- Not including expenditures on the Expansion population, hospital payments have been increasing at an average of 1.1% per year over the last 5 years,.
- Nursing facilities and professional services each accounted for 16% of expenditure.
- Expansion population expenditure was concentrated in hospital, professional, and pharmacy services.
- Two-thirds of the Premiums expenditure is for Medicare clawback payments and Medicare premiums. The remainder is for transportation, PACE, and RIteShare premiums.
- Detailed definitions of each provider type is included on the next page.

Expenditure by Provider Type: Definitions

Medicaid providers can be grouped into three categories – acute care, institutional care, and community-based services.

Acute, Chronic and Preventive Care	Hospital	Hospital includes inpatient and outpatient services.
	Professional	Professional includes Physician, Dental, DME/Supplies, X-Ray/Lab/Tests, Ambulance, etc.
	Professional BH	Professional Behavioral Health includes DHS, BHDDH and DCYF expense including, but not limited to, Professional Mental Health/Substance Abuse, Cedar services (Comprehensive, evaluation, diagnosis, assessment, referral, re-evaluation services), CMHC, and Residential DCYF.
	Pharmacy	Prescription and over-the-counter medications, net of pharmacy rebates
	Premiums	Premiums includes Medicare premiums paid for qualifying individuals, Medicare clawback payments, transportation premiums, premiums for PACE (Program of All-Inclusive Care of the Elderly) 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.
Institutional Care	Nursing Home/Hospice	Nursing home 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	IDD Resdntl/ Rehab, Group Homes	Residential and Rehabilitation Services for persons with intellectual and developmental disabilities, including public and private IDD group homes, IDD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).
	HCBS	Home and Community Based Services (HCBS) are services provided as an alternative to nursing home/institutional options, such as personal care, assisted living, and case management.

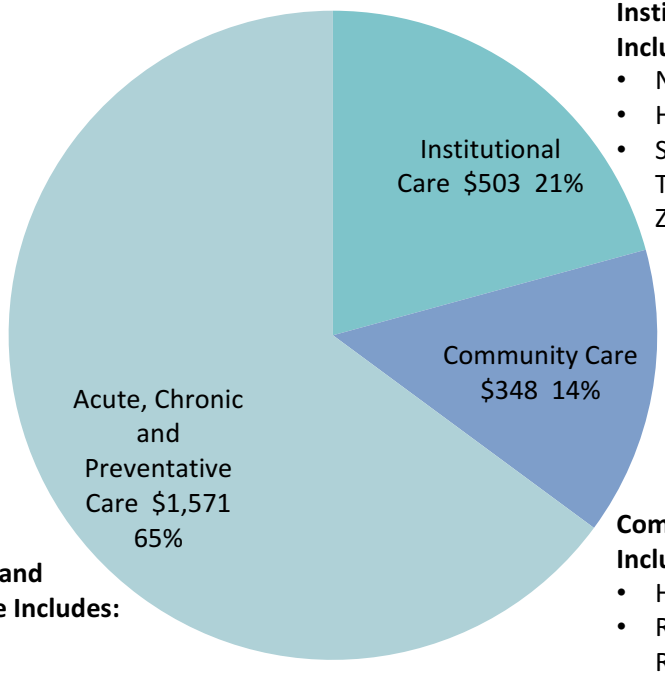
Please note that administrative dollars paid to health plans are allocated across provider types based on distribution of claims for purposes of this report.

Expenditure by Provider Type Summary

Overall, 35% of Medicaid expenditure is for Institutional Care and Community Care, together referred to as Long Term Services and Supports (LTSS).

Medicaid Expenditure by Provider Type Category
SFY 2016 -- $ Millions

Total: $2,422 M



Institutional Care Includes:
- Nursing Home
- Hospice
- Slater Hospital, Tavares, and Zambarano

Community Care Includes:
- HCBS
- Residential and Rehab Services for the Intellectually and Developmentally Disabled
- Assisted Living
- Public and Private IDD Group Homes

Acute, Chronic and Preventive Care Includes:
- Hospital
- Professional
- Professional BH
- Pharmacy
- Premiums

Nearly all Expansion expenditure in this category

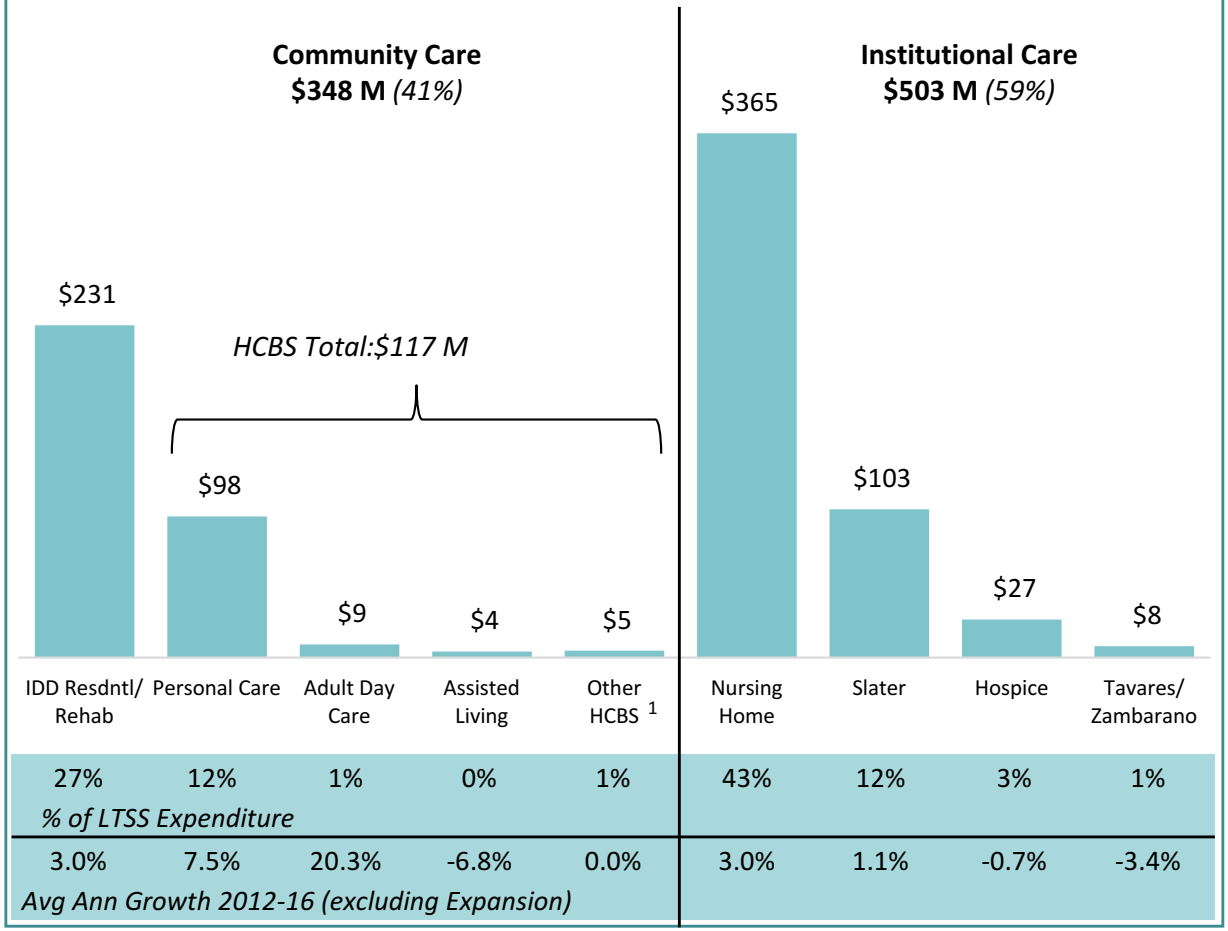
- Over one-third (35%) of Medicaid expenditure is for Long Term Services and Supports (LTSS), including institutional care and community care.
  - Institutional care includes nursing facilities and care in the Slater Hospital and Tavares and Zambarano facilities.
  - Community Care includes home and community-based services, residential and rehabilitation services for the intellectually and developmentally disabled, and group homes.
- The other 65% of Medicaid expenditure is for acute, chronic and preventive care services such as hospital, professional services, and pharmacy.
- Nearly all (98%) of the expenditure for the Expansion population falls into the Acute, Chronic, and Preventative Care category.
- There are several ways to categorize Medicaid-provided services. Other reports may group together services in different ways for different needs.

Provider Type Detail: LTSS Detail

Long term services and supports, including both institutional care and community care, accounted for $850 million in SFY 2016, about 35% of Medicaid expenditure.

LTSS Expenditure by Provider Type
SFY 2016 -- $ Millions

Total LTSS Expenditure: $850 M



- The 1115 Medicaid Waiver granted Rhode Island the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide home and community based services to at-risk populations as alternatives to more costly nursing home/institutional options.
- Institutional care services account for 59% of LTSS expenditure. The largest category of institutional care is nursing homes, accounting for 43% of LTSS spending and 73% of spending on institutional care.
- Forty-one percent of long term services and support expenditure ($348 million) is for Community Care services, including services for the IDD population and HCBS.
- One driver of the growth in Community Care expenditures is for HCBS for the non-intellectually/developmentally disabled population. These services, such as personal care and assisted living, are less expensive alternatives to nursing home or institutional options.

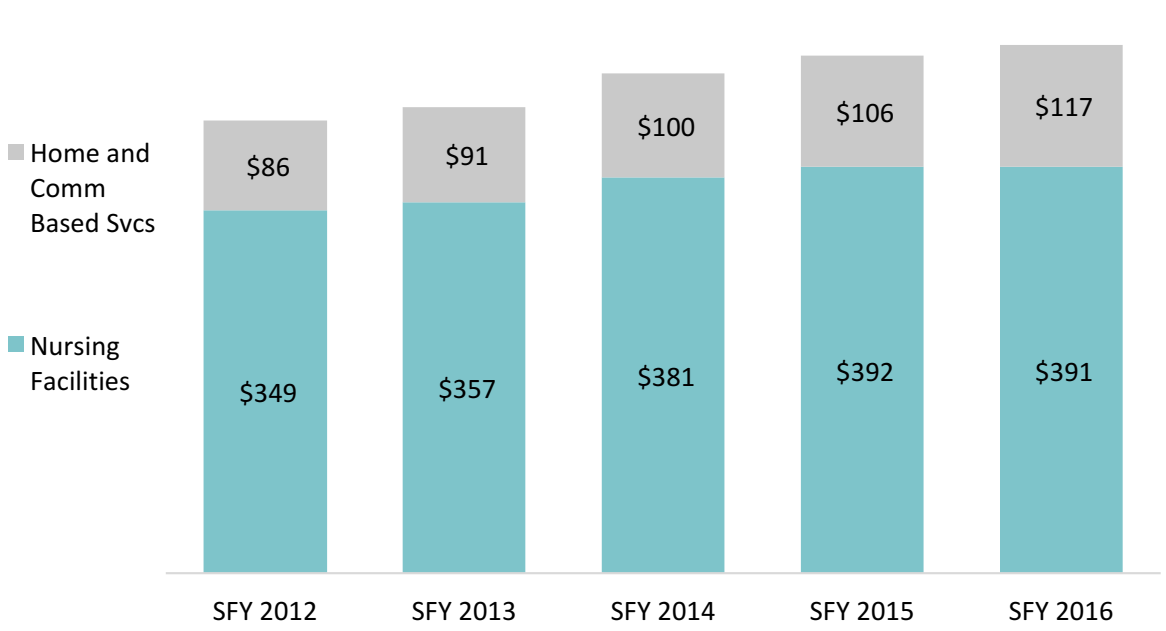
[1]Other HCBS includes DME (e.g. Home Modifications), Case Management, Meals, Shared Living and other.

Expenditure by Provider Type: LTSS Rebalancing

Over the last 5 years, the ratio of nursing facility expenditure to HCBS expenditure has decreased.

Balance of Nursing Facility and HCBS Expenditure

SFY 2012-2016 -- $ Millions



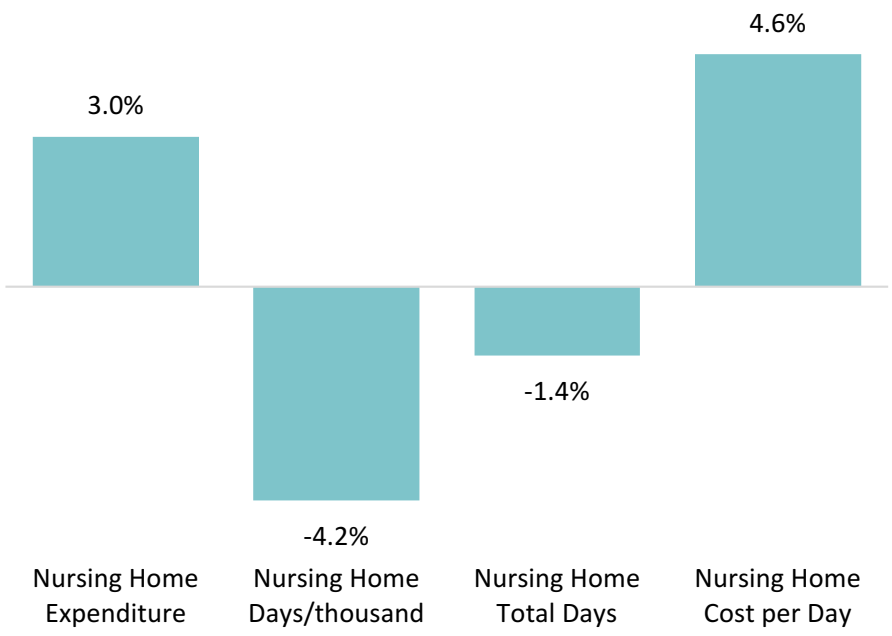
	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% HCBS	20%	20%	21%	21%	23%
% Nursing Facilities	80%	80%	79%	79%	77%

- A key consideration for LTSS services is the transition away from nursing facilities and into home and community based services (HCBS).
- One way to measure the rebalancing trend is to examine the ratio of expenditure between nursing facility services (part of Institutional Care) and HCBS (part of Community Care).
- The balance of expenditure between nursing facilities and HCBS has been shifting over the last 5 years. In SFY 2016 HCBS accounted for 23% of the total expenditure on both nursing facilities and HCBS compared to 20% in SFY 2012.

Provider Type Detail: Nursing Home Trends

Nursing home total days and days per thousand have decreased over the last five years, while total nursing home expenditure has increased.

Nursing Home Services Average Annual Trend Rates
SFY 2012-2016



	Nursing Home Expenditure	Nursing Home Days/thousand	Nursing Home Total Days	Nursing Home Cost per Day
SFY 2016 Expenditure	$365 M		1,910,645	$191/day

- Nursing home expenditure accounted for $365 million in SFY 2016, with an average annual increase of 3.0% per year on average since SFY 2012.
- Over the same period, days per thousand for nursing homes decreased by 4.2% per year on average.
- Nursing home days in total decreased 1.4% per year on average between SFY 2012 and SFY 2016.
- Nursing home cost per day (calculated as total expenditure divided by total days) has increased from $160 to $191 between SFY 2012 and SFY 2016, about 4.6% on average per year.
- Total expenditure for nursing homes includes allocated capitation and premium payments, so the calculated cost per day shown here may differ from the actual payment rates.

Expenditure by Managed Care Enrolled and Not Enrolled

Overall, 61% of total Medicaid expenditure is paid through managed care programs.

Expenditure for Enrolled Populations
SFY 2016

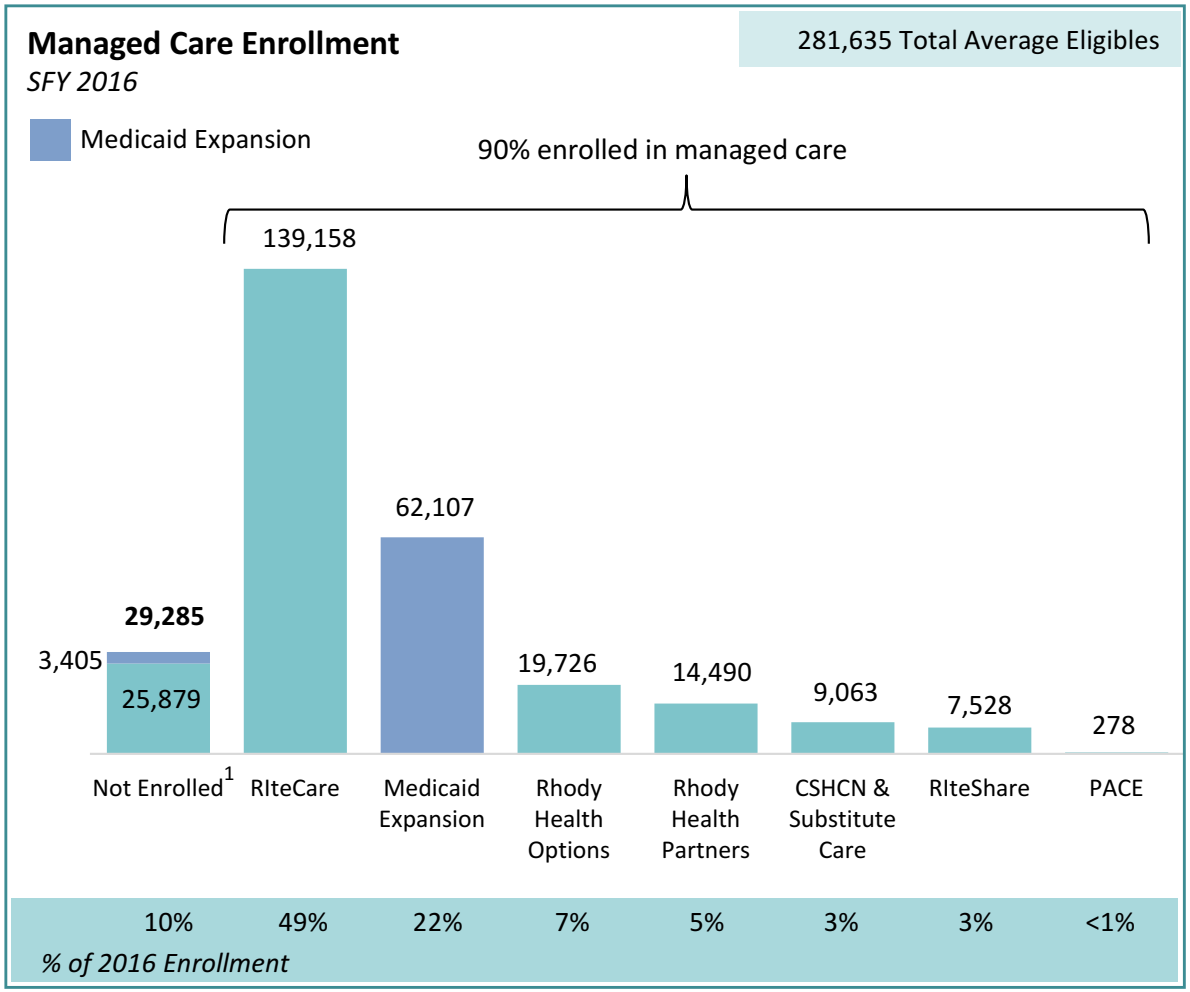
	Managed Care Enrolled *252,351 Eligibles (90%)*	Not Enrolled[1] *29,285 Eligibles (10%)*	Total Expenditure
Managed Care Expenditure	**$1,488 M** **61%** Managed Care Expenditure for Managed Care Enrolled Eligibles		**$1,488 M** **61%**
Other Expenditure	**$346 M** **14%** Other Expenditure for Managed Care Enrolled Eligibles (*for services not covered by Managed Care)*	**$588 M** **24%** Expenditure for Eligibles Not Enrolled in Managed Care	**$934 M** **39%**
Total Expenditure	**$1,834 M** **76%**	**$588 M** **24%**	**$2,422 M**

[1]Unenrolled populations include 2,357 Medicaid eligibles enrolled in Connect Care Choice and Connect Care Choice Community Partners, which are primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

- Ninety percent of Medicaid eligibles are enrolled in managed care programs, including RIte Care, RIteShare, Rhody Health Partners, Rhody Health Options, and PACE. These enrolled populations account for about three-quarters (76%) of Medicaid expenditure in SFY 2016.
- Of the $1,834 million in expenditure on managed care enrolled populations, $1,488 million was paid through managed care programs, accounting for 61% of total Medicaid expenditure.
- The remaining $346 million in expenditure on managed care enrolled populations was paid for FFS claims and premiums for managed care enrolled eligibles.
  - FFS claims include services such as Neonatal Intensive Care Unit (NICU), certain behavioral health services, specialized services for children with special healthcare needs, and dental care
  - Premiums for managed care enrollees include Medicare premiums and transportation.
- On January 1, 2016, EOHHS moved the expenditures for certain behavioral health services for children and adults enrolled in managed care into the payments made to the health plans, reducing FFS expenditures for the managed care enrolled population.

Managed Care Enrollment

Medicaid enrollees who do not have other insurance are enrolled in Medicaid managed care plans. About 90% of Medicaid average eligibles are enrolled in some sort of managed care programs.



[1]The Not Enrolled category includes persons in periods of eligibility prior to managed care enrollment, as well as certain persons with other insurance, such as Medicare.

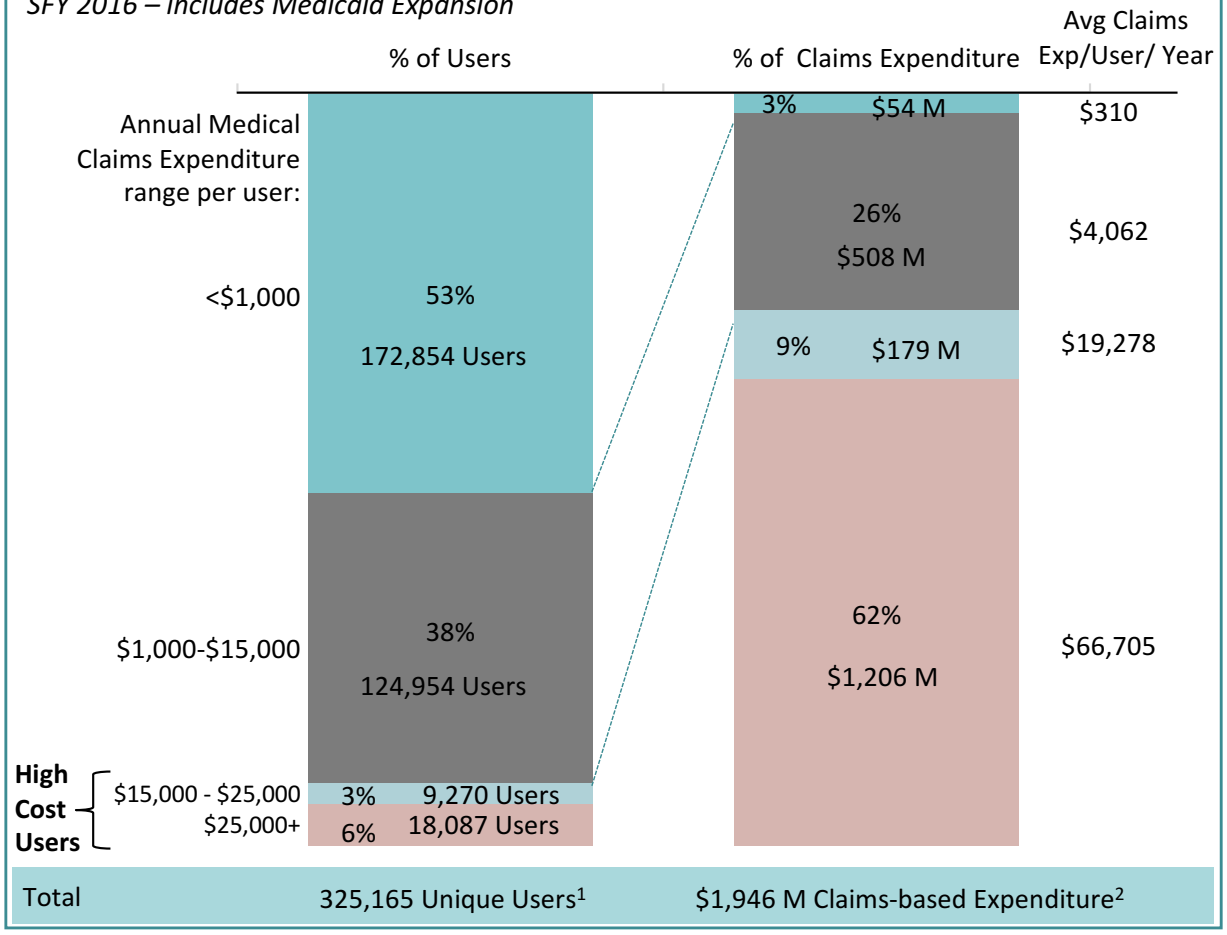
- Managed care enrollment is divided between Rhode Island's two Medicaid Managed Care Organizations (MCOs), Neighborhood Health Plan (NHP) and United Healthcare (UHC).
- **RIte Care** mainly serves children and parents. **Rhody Health Partners** is is a managed care program for adults with disabilities.
- The Medicaid Expansion and CSHCN populations are also enrolled in managed care programs.
- **RIte Share** is a program designed to allow Medicaid eligibles with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditure by leveraging the employer's contribution.
- **Rhody Health Options** is a fully capitated managed care program for long term care, long term services and supports, and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility.

High Cost Users: By Expenditure Level

Medicaid claims expenditures are highly concentrated. The top 6% of Medicaid users account for almost two thirds (62%) of Medicaid claims expenditure.

Medicaid User Claims Expenditure Distribution

SFY 2016 – includes Medicaid Expansion



- In order to look at spending by user, it is necessary to look at "unique users" rather than average eligibles. A unique user is an individual associated with a medical claim or capitation payment. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- This analysis examines the characteristics of "high cost" users, those with over $15,000 of claims expenditure of per year. There are 27,357 of these "high cost" users (9%) who account for $1,385 million (71%) in claims expenditure.
- High Cost users typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- On the other end of the spectrum, 53% of Medicaid users access services at a cost of less than $1,000 per year and account for 3% of claims expenditure, averaging $310 in annual claims expenditure per user.

[1]Includes overlap in users across cost categories.

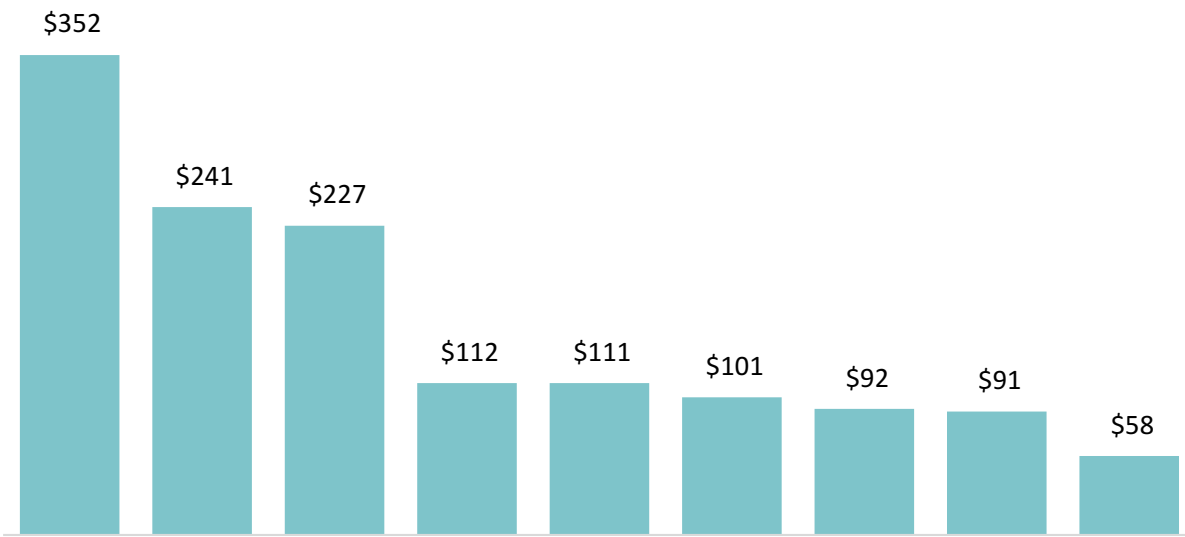
[2]Total of claims-specific payments. Certain expenditures (e.g. UPL, Medicare and PACE Premiums) not attributable to specific users.

High Cost Users: By Provider Type

About 41% of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with intellectual and developmental disabilities.

High Cost User Claims Expenditure by Provider
Users with Annual Medicaid Claims Expenditure over $15,000
SFY 2016 -- $ Millions – includes Medicaid Expansion

Total High Cost User Claims Expenditure[1]: $1,385 M



Nursing Home/ Hospice	Hospital Inpatient	IDD Resdntl/ Rehab, Group Homes	Slater Hospital/ Zambarano/ Tavares	Other Professional	Hospital Outpatient	Professional BH	Home and Comm Based Svcs	Pharmacy
25%	17%	16%	8%	8%	7%	7%	7%	4%
% of Total High Cost User Claims Expenditure								
90%	63%	98%	100%	29%	32%	51%	78%	37%
% of Provider Type Total Expenditure attributable to High Cost User Claims								

- Nursing facilities account for 25% of the claims expenditure for high cost users, and residential and rehabilitation services for persons with intellectual and developmental disabilities account for another 16%.
- Hospital services account for 24% of high cost user claims expenditure, including 17% for inpatient and 7% for outpatient. Inpatient includes Neonatal Intensive Care Unit (NICU) services.
- 90% of the total expenditure for nursing facilities and 100% of the total expenditure for Slater Hospital, Zambarano and Tavares is for claims expense for high cost users. This is due to extended stays in institutions for users of those services.

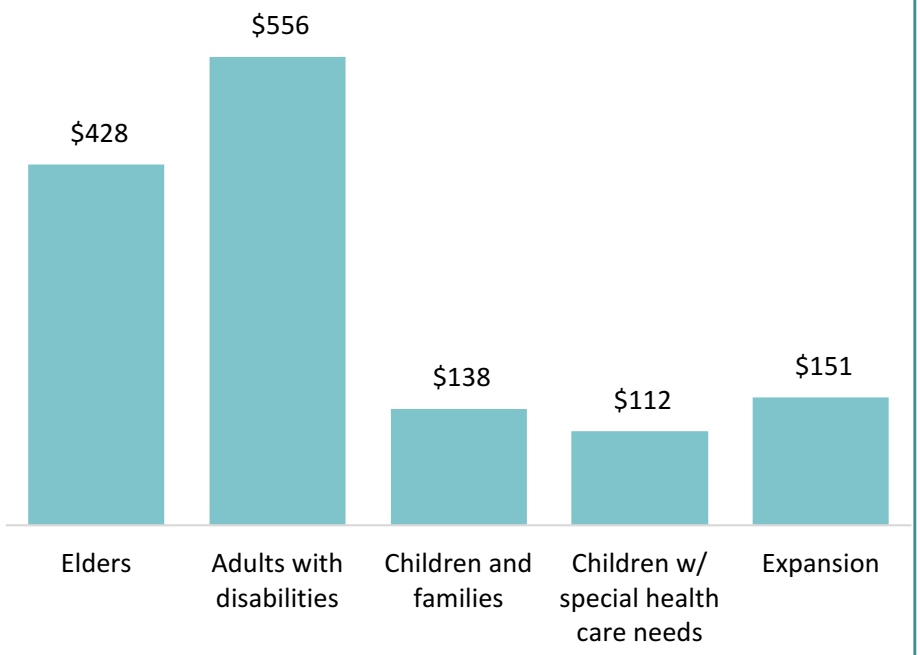
[1]Based on claims-specific payments only.

High Cost Users: By Population

Elders and adults with disabilities account for 71% of claims expenditure for high cost users.

High Cost User Claims Expenditure by Population
Users with Annual Medicaid Claims Expenditure over $15,000
SFY 2016 -- $ Millions – includes Medicaid Expansion

Total High Cost User Claims Expenditure: $1,385 M



	Elders	Adults with disabilities	Children and families	Children w/ special health care needs	Expansion
% of High Cost User Claims Expenditure	31%	40%	10%	8%	11%
# High Cost Unique Users[1]	8,219	9,251	4,140	2,477	4,748
% of Population Group Total Expenditure attributable to High Cost User Claims	77%	74%	26%	66%	38%

[1]Total high cost unique users by population does not equal overall total due to overlap between eligibility groups.

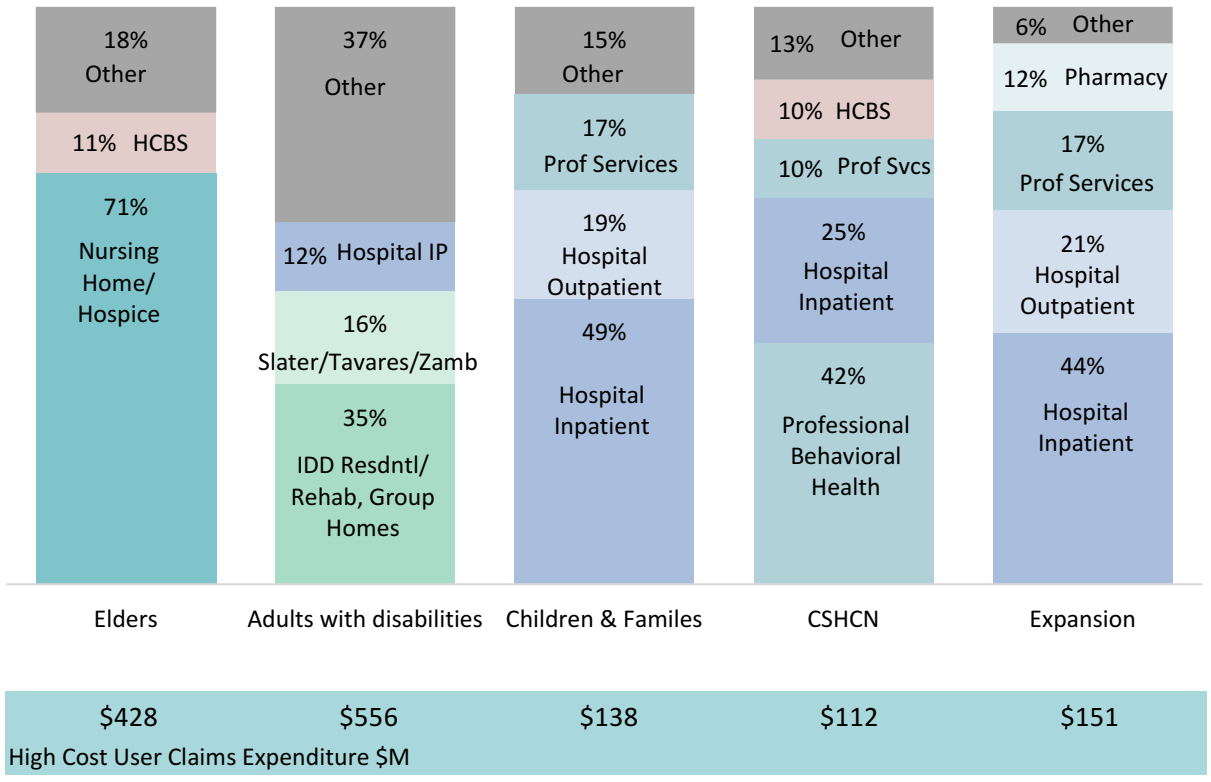
- Elders account for 31% of claims expenditure for high cost users and have the highest proportion of total expenditure for high cost user claims, with 77% of total expenditure attributable to high cost user claims expenditure.
- Adults with disabilities account for 40% of high cost user claims expenditure, and 74% of adults with disabilities total expenditure is attributable to high cost user claims expenditure.
- Children and families account for 10% of high cost user claims expenditure with 26% of total expenditure attributable to high cost users claims. Children with special health care needs account for another 8% of claims expenditure.
- The Expansion population accounted for 11% of high cost user claims expenditure.

High Cost Users: By Population Detail

The services used by high cost users varies by population.

High Cost User Claims Expenditure
Users with Annual Medicaid Claims Expenditure over $15,000
SFY 2016

Total High Cost User Claims Expenditure: $1,385 M



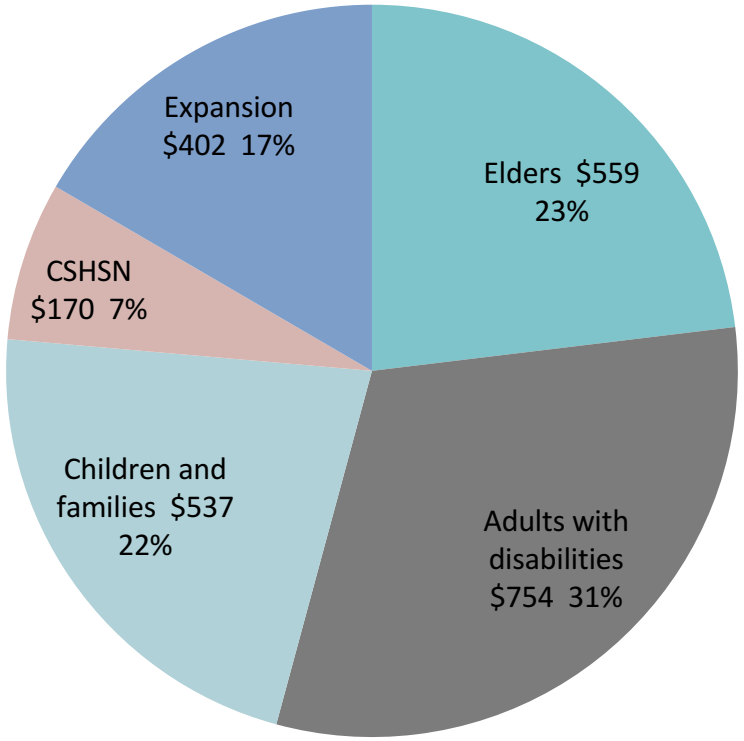
- The largest category of claims expenditure for high cost elders is nursing facilities, accounting for 71% of claims expenditure on high cost elders.
- The largest category of expenditure for high cost adults with disabilities is residential and rehabilitation services for the intellectually and developmentally disabled, accounting for 35% of claims expenditure.
- 68% of high cost claims expenditure for children and families and 65% of high cost claims expenditure for the Expansion population is hospital-related, including both inpatient and outpatient services.
- Professional behavioral health services account for 42% of high cost user claims expenditure for the high cost users in the children with special healthcare needs population.

Expenditure Detail by Population

In order to get a clearer picture of the characteristics of each population, it is useful to look at expenditures, enrollment, and utilization for each group separately. This section contains details on expenditures for each population group as follows:

Medicaid Expenditure by Population
SFY 2016 - $ Millions

Total: $2,422 M



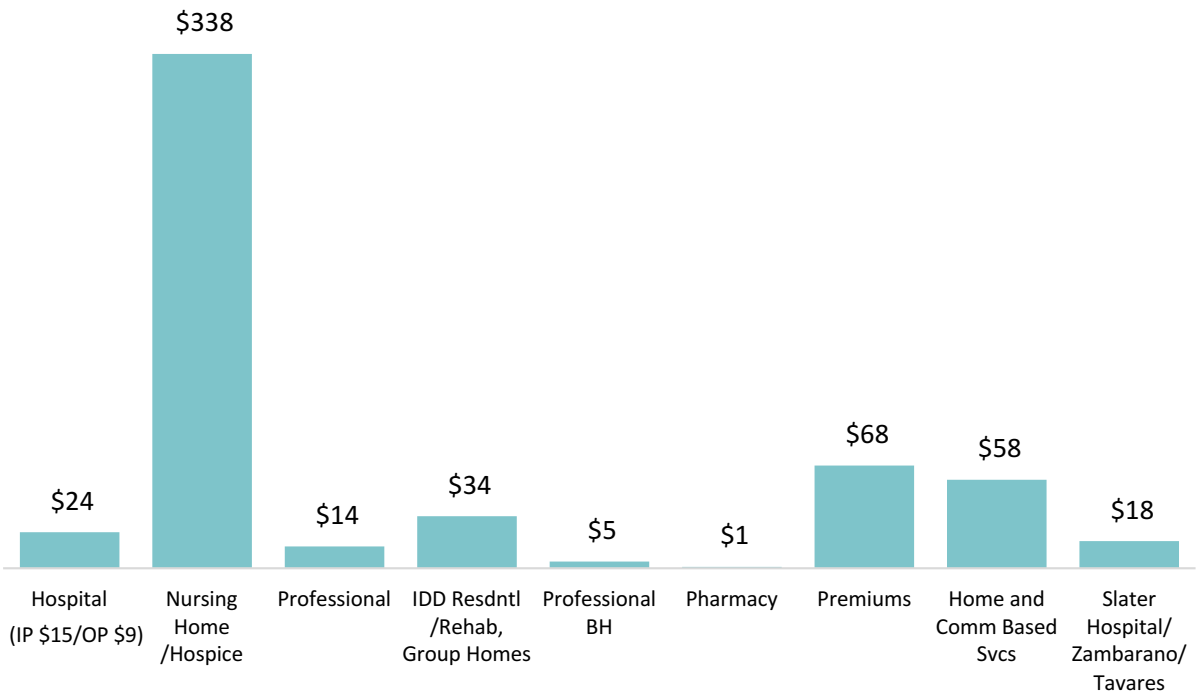
- **Elders**:
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in Medicare
  - Nursing facility and HCBS utilization
- **Adults with Disabilities**:
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in Medicare
  - Acute care services utilization – hospital days and admissions, office visits, pharmacy claims
  - Nursing facility and HCBS utilization
- **Children and Families**:
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization
- **Children with Special Healthcare Needs (CSHCN):**
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization
- **Expansion:**
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization

Elders: Expenditure by Provider Type

Nursing facilities (including nursing homes and hospice) account for sixty percent of total Medicaid expenditure on elders.

Elders: Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Elders Expenditure =	$559 M
% of 2016 Expenditure =	23%
Avg Annual Growth =	3.1%



Hospital (IP $15/OP $9)	Nursing Home /Hospice	Professional	IDD Resdntl /Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
4%	60%	3%	6%	1%	<1%	12%	10%	3%
% of 2016 Expenditure								
0.0%	2.0%	16.0%	3.0%	-0.3%	1.0%	7.8%	5.3%	-0.4%
Avg Ann Growth 2012-16								

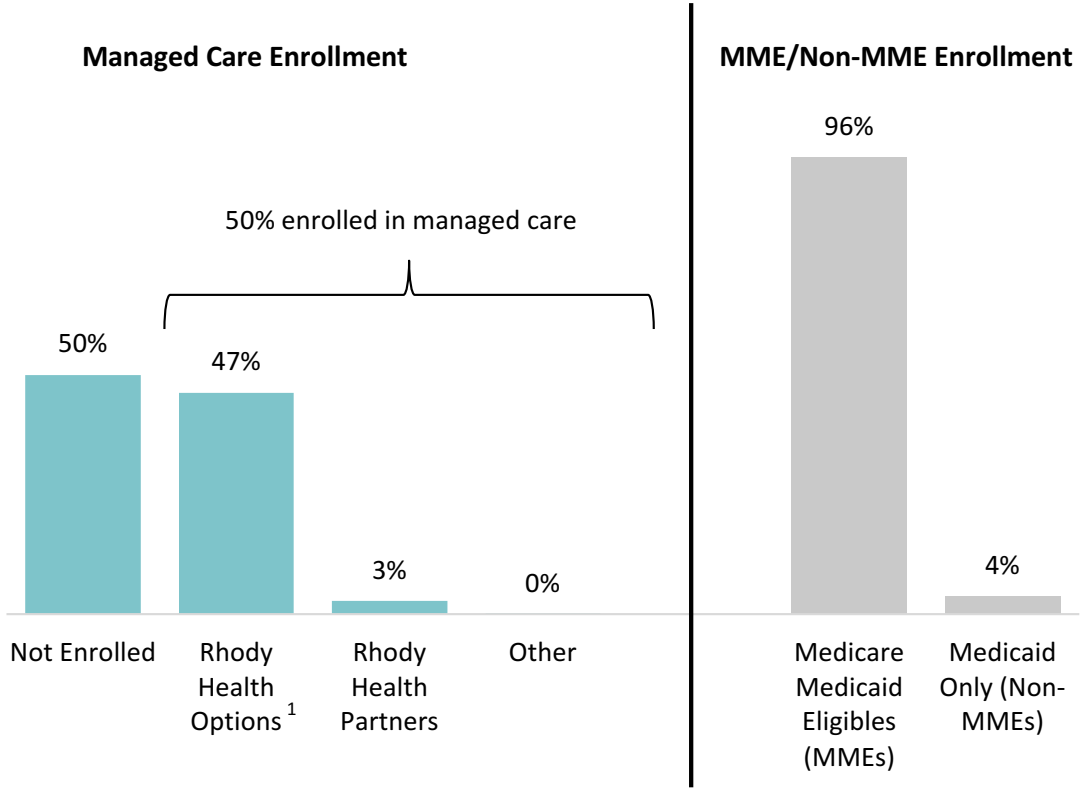
- Medicaid expenditures on elders totaled $559 million in SFY 2016 and has been increasing at 3.1% per year over the past 5 years.
- The large majority of elders are also eligible for Medicare, which was the primary payer for most medical services (e.g. hospital, professional). Consequently those expenditures were not paid by Medicaid and are not included here.
- The increase in nursing facility expenditure has been lower than the increase in overall expenditure for this population - an average annual increase of 2.0 percent per year.
- Most of the growth in Medicaid expenditure for elders has been in nursing facility services and home and community based services. The increase in home and community based services is due in part to an effort to invest in alternatives to institutional/nursing home care

Elders: Managed Care and Dual Enrollment

Rhody Health Options rolled out in 2013 and has enrolled nearly 20,000 eligibles, about 9,000 of whom are elders, in a managed care program for duals and/or members needing long term services and supports.

Elders: Managed Care and MME (Dual) Enrollment
SFY 2016

Elders Expenditure = $559 M
Elders Average Eligibles = 19,198



	Not Enrolled	Rhody Health Options [1]	Rhody Health Partners	Other	Medicare Medicaid Eligibles (MMEs)	Medicaid Only (Non-MMEs)
Average Eligibles	9,691	8,957	539	11	18,473	725

- Ninety-six percent of elders are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- For the elders who are dually enrolled, Medicare is the primary payer for most acute and and primary care services (e.g., hospital, professional, pharmacy).
- Rhody Health Options is a fully capitated managed care program for long term care, long term services and supports (LTSS), and other Medicaid-funded services designed to more fully meet the needs of people with both Medicaid and Medicare eligibility.
- The Not Enrolled category includes 935 elders enrolled in Connect Care Choice and Connect Care Choice Community Partners (CCC/CP), which are primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

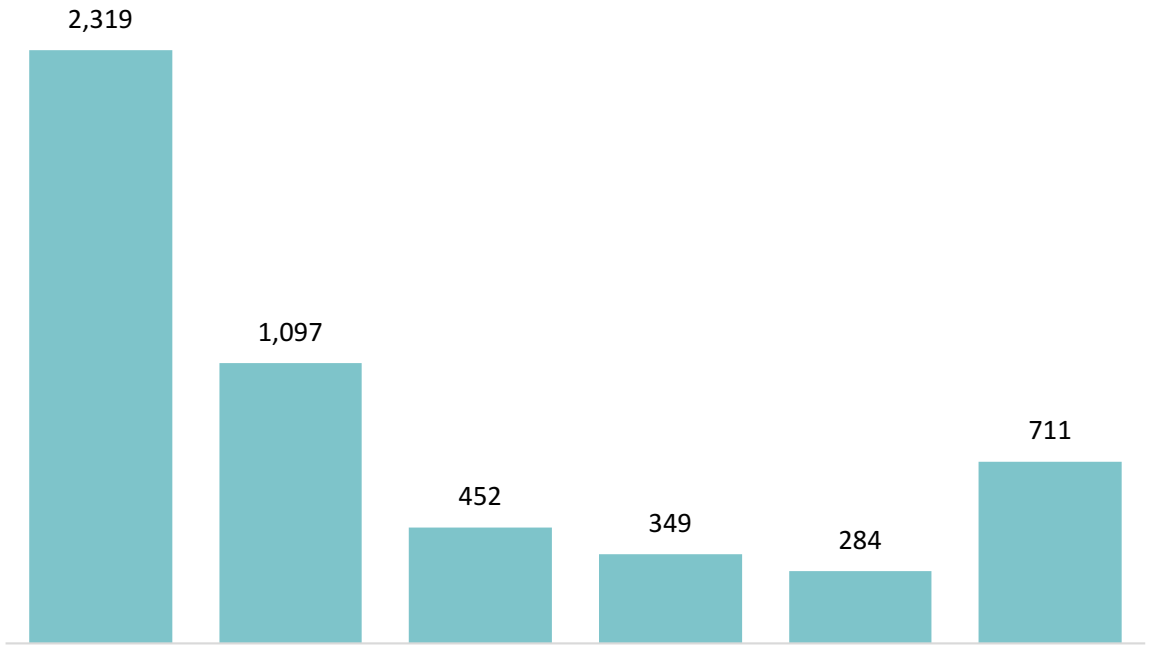
[1]Chart does not include approx. 10,000 adults with disabilities population enrolled in Rhody Health Options.

Elders: HCBS Utilization

Home and community based services enable some elders to remain in a community setting rather than be admitted to or remain in a nursing home.

Elders: Home and Community Based Services
Average Monthly Census
SFY 2016

Elders Average Eligibles = 19,198



	Personal Care	DME	Adult Day Care	IDD Resdtl/Rehab	Assisted Living	Other HCBS
Avg Ann Growth 2012-2016	4.1%	1.0%	15.6%	0.7%	-6.9%	-6.0%

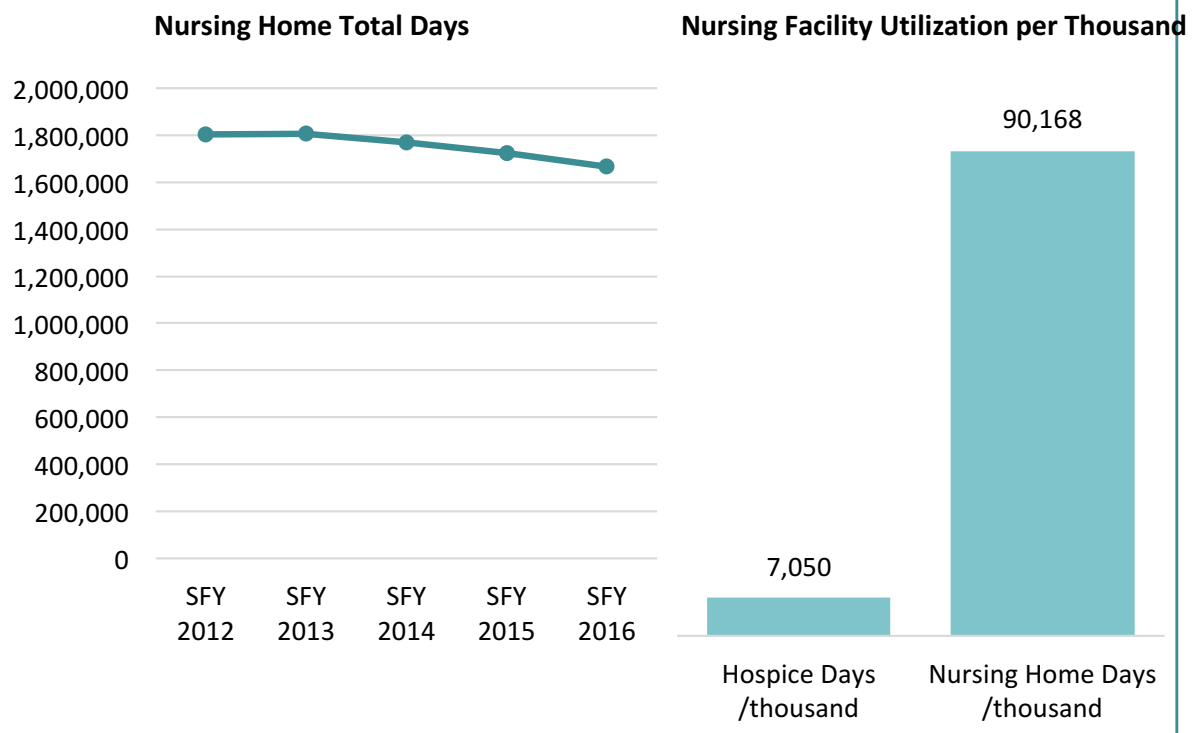
- The largest category of home and community based services (HCBS) is personal care services, with an average monthly census for elders of 2,319 recipients in SFY 2016. The monthly census for elders for this category has increased at 4.1% per year since SFY 2012.
- The category with the highest increase in average monthly census is adult day care, with an average annual increase of 15.6% per year.
- Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.

Elders: Nursing Facility Utilization (MME only)

For MME Elders, nursing home days per thousand eligibles decreased 3.7% per year from SFY 2012 to 2016.

MME Elders: Nursing Facility Utilization
SFY 2016

MME Elders: 18,473
96% of Elders



Avg Ann Growth 2012-2016	-1.9%	-7.3%	-3.7%

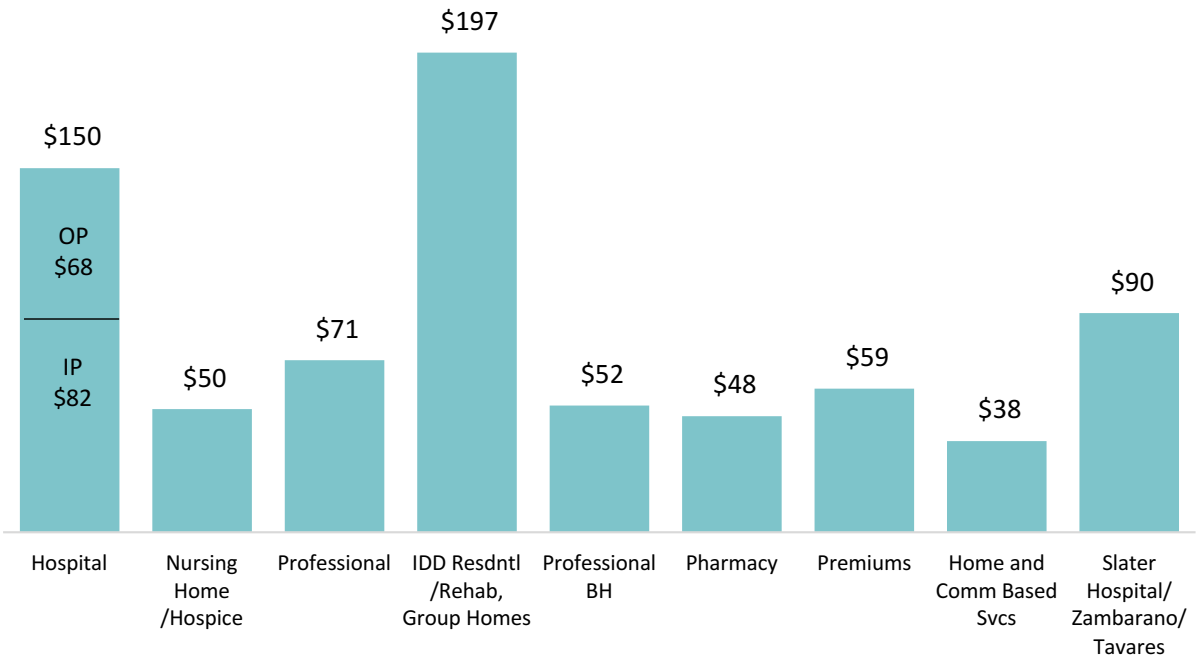
- Ninety-six percent of elders are Medicaid Medicare eligibles (MMEs, also called duals). For these elders covered by both Medicare and Medicaid, Medicare is the primary payer for the majority of acute and primary care services while Medicaid covers long term services and supports.
- The total nursing home days for this population has decreased by 1.9% per year on average over the last 5 years.
- Nursing home days per thousand for MME elders were 90,168 in SFY 2016. This measure has decreased by an average annual rate of 3.7% since SFY 2012.
- Hospice days per thousand for MME elders have decreased at a rate of 7.3% on average per year over the last 5 years to 7,050 per thousand in SFY 2016.

Adults with Disabilities: Expenditure by Provider Type

For adults with disabilities, hospital services and residential and rehabilitation services for persons with intellectual and developmental disabilities account for just under half of expenditures.

Adults with Disabilities:
Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Adults with Disabilities Expenditure = $754 M
% of 2016 Expenditure = 31%
Avg Annual Growth = 2.1%



20%	7%	9%	26%	7%	6%	8%	5%	12%
% of 2016 Expenditure								
-2.4%	8.1%	6.5%	3.1%	-4.2%	3.9%	9.1%	5.5%	0.8%
Avg Ann Growth 2012-16								

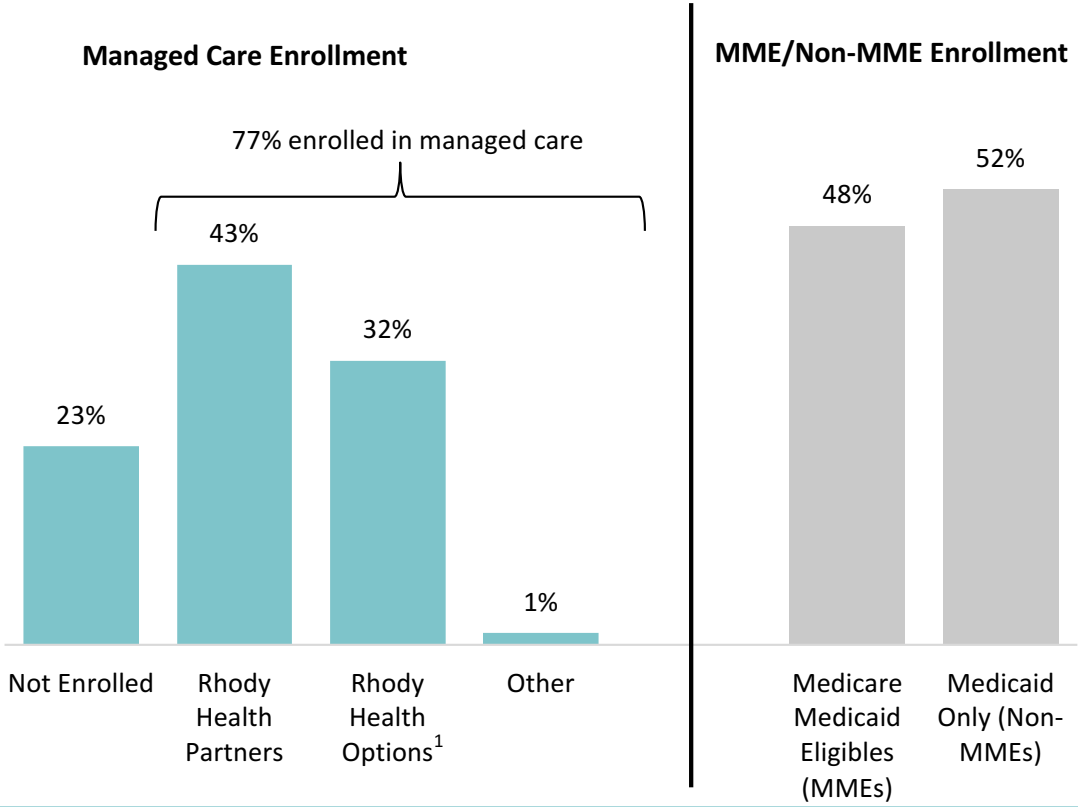
- Adults with disabilities account for the largest share of Medicaid expenditures, with total SFY 2016 expenditure of $754 million. Expenditure for this population has increased by approximately 2.1% per year over the past 5 years.
- Hospital and residential and rehabilitation services for persons with intellectual and developmental disabilities account for 20% and 26% of expenditure, respectively.
- However, expenditure for hospital services has been decreasing 2.4% per year on average over the last 5 years.
- Similar to the elders population, both nursing facility services and home and community based services have experienced high growth rates for the adults with disabilities population.

Adults with Disabilities: Managed Care Enrollment

More than three-quarters (77%) of adults with disabilities are enrolled in managed care.

Adults with Disabilities: Managed Care and MME (Dual) Enrollment
SFY 2016

Adults with Disabilities Expenditure = $754 M
Average Eligibles = 32,080



	Not Enrolled	Rhody Health Partners	Rhody Health Options[1]	Other	Medicare Medicaid Eligibles (MMEs)	Medicaid Only (Non-MMEs)
Average Eligibles	7,292	13,938	10,424	426	15,369	16,711

[1]Chart does not include approx. 9,000 elders population enrolled in Rhody Health Options.

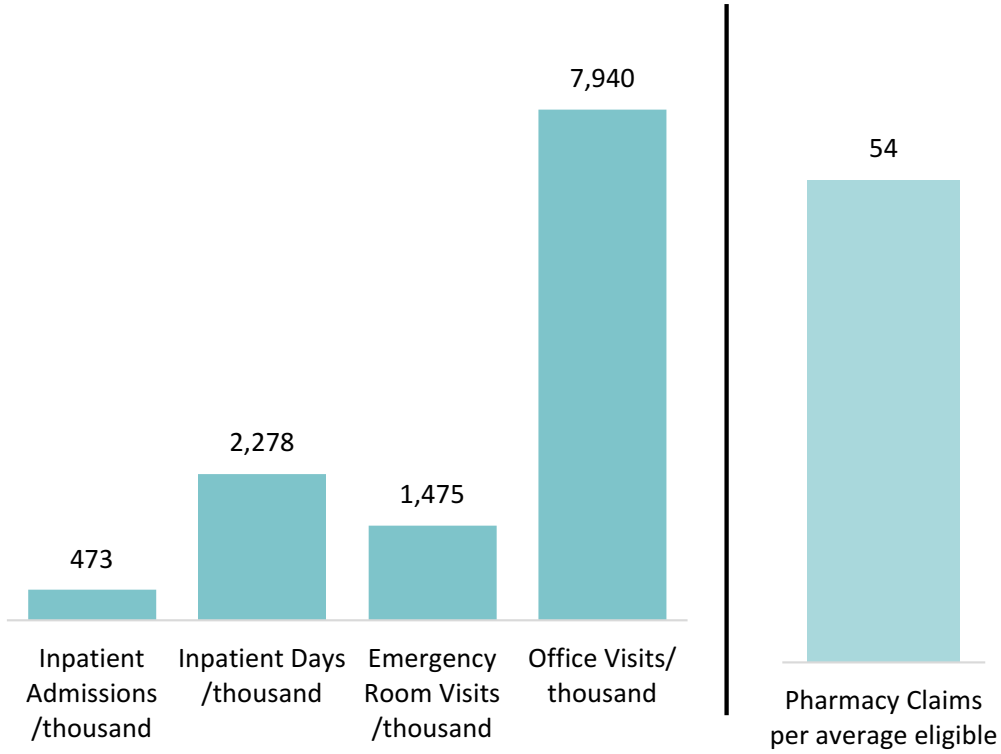
- Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- For the adults with disabilities who are dually enrolled, Medicare is the primary payer for most acute and and primary care services (e.g., hospital, physician, pharmacy).
- Adult populations had historically been served in fee-for-service Medicaid but have been transitioned to managed care over the last several years. In SFY 2016 77% of this population was enrolled in managed care.
- In addition, 1,413 adults with disabilities in the Not Enrolled category were enrolled in SFY 2016 in Connect Care Choice and Connect Care Choice Community Partners, PCCM programs where Medicaid pays providers for enhanced care management within the fee-for-service structure.

Adults with Disabilities: Acute Care Utilization

Both inpatient admissions and days per thousand have declined over the last 5 years for adults with disabilities with Medicaid-only coverage (non-MMEs).

Adults with Disabilities:
Non-MMEs: Acute Care Utilization
SFY 2016

Non-MME Adults with Disabilities = 16,711
52% of Adults with Disabilities



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2012-2016	-1.8%	-8.1%	-1.3%	3.7%	0.2%

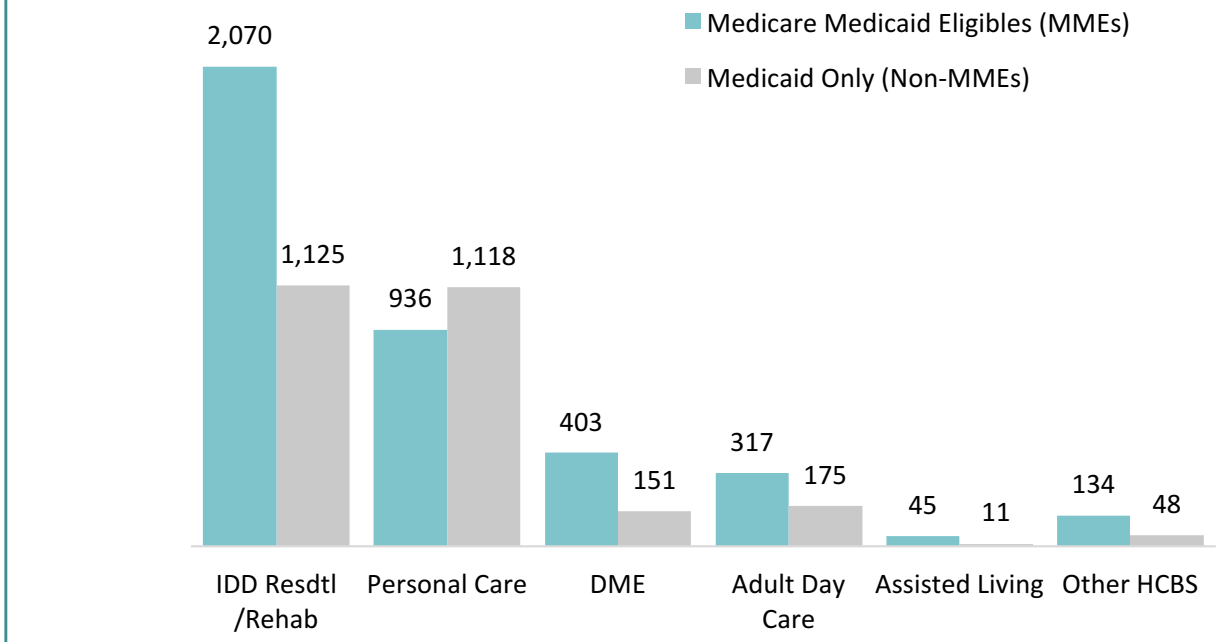
- Fifty-two percent of adults with disabilities are covered by only Medicaid. Utilization shown here is for the adults with disabilities without Medicare coverage (Non-MMEs).
- Acute care utilization is not shown for dual enrolled adults with disabilities (MMEs) because Medicare is the primary payer for most acute care services.
- Non-MME adults with disabilities averaged 7,940 office visits per thousand eligibles per year in SFY 2016, an increase of 3.7% per year on average in the last 5 years.
- Over the same period, inpatient admissions/thousand and inpatient days/thousand for this population have decreased at an annual rate of 1.8% and 8.1% respectively.
- Pharmacy claims for non-MME adults with disabilities average 54 claims per average eligible per year, and have been increasing at a rate of 0.2% per year on average over the last 5 years.

Adults with Disabilities: HCBS Utilization

The largest categories of home and community based services for adults with disabilities are residential and rehabilitation services for the intellectually and developmentally disabled and personal care services.

Adults with Disabilities:
Home and Community Based Services
Average Monthly Census
SFY 2016

Non-MME Adults with Disabilities = 16,711
MME Adults with Disabilities = 15,369



Avg Ann Growth 2012-2016	IDD Resdtl /Rehab	Personal Care	DME	Adult Day Care	Assisted Living	Other HCBS
MMEs	0.2%	5.4%	7.9%	18.6%	-4.4%	-7.7%
Non-MMEs	3.4%	19.8%	-2.7%	15.4%	-10.4%	-20.2%

- Residential and rehabilitation services for intellectually and developmentally disabled individuals had an average monthly census in SFY 2016 of 2,070 recipients for MME adults with disabilities and 1,125 recipients for Non-MME adults with disabilities.
- The second largest category of HCBS for this population is personal care services, with an average monthly census of 936 recipients in SFY 2016 for MME adults with disabilities and 1,118 recipients for Non-MME adults with disabilities.
- The monthly census for personal care services is growing at 5.4% per year on average for MME adults with disabilities and at 19.8% per year on average for Non-MME adults with disabilities.

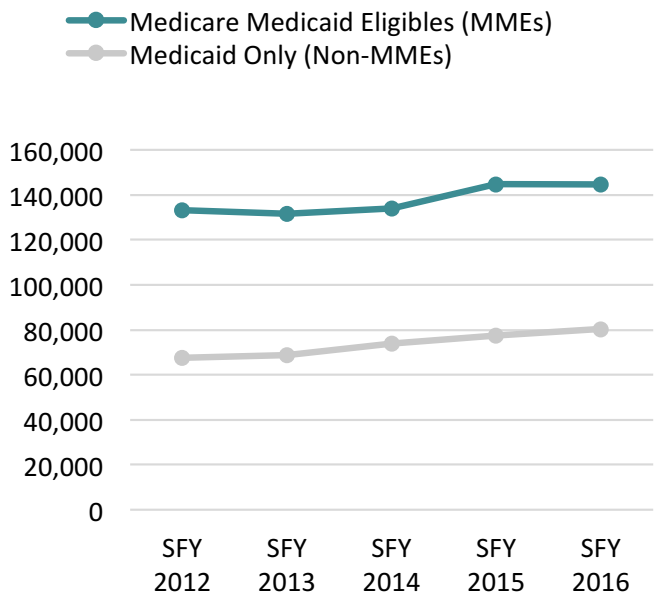
Adults with Disabilities: Nursing Facility Utilization

Nursing home days per thousand have increased 4.6% per year since SFY 2012 for non-MME adults with disabilities and decreased 0.4% per year for MME adults with disabilities.

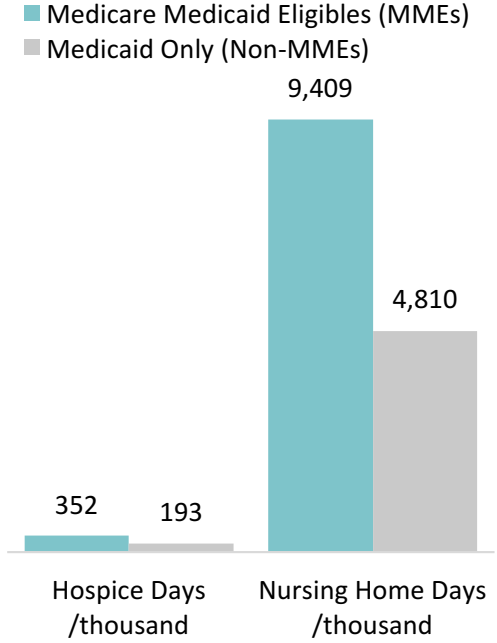
Adults with Disabilities:
Nursing Facility Utilization
SFY 2016

Non-MME Adults with Disabilities = 16,711
MME Adults with Disabilities = 15,369

Nursing Home Total Days



Nursing Facility Utilization per Thousand



Avg Ann Growth 2012-2016			Hospice Days /thousand		Nursing Home Days /thousand	
MMEs	2.1%		-2.9%		-0.4%	
Non-MMEs		4.4%		-13.9%		4.6%

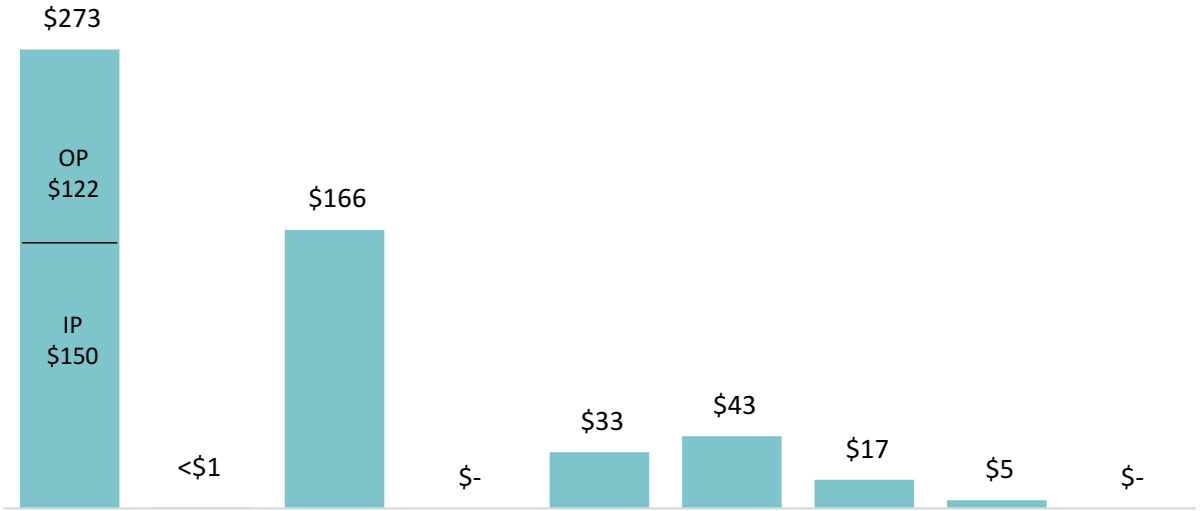
- Long term services supports are primarily covered through Medicaid for both MME and Non-MME adults with disabilities.
- For MME adults with disabilities, hospice days decreased 2.9% per year and nursing home days per thousand decreased 0.4% per year on average since SFY 2012.
- Nursing home days were 9,409 per thousand for MME adults with disabilities and 4,810 per thousand for Non-MME adults with disabilities in SFY 2016.
- Note that nursing home days for this population represent 12% of total Medicaid nursing home days since elders account for the majority of nursing home days overall.

Children and Families: Expenditure by Provider Type

In the children and families population, hospital and professional services are the largest contributors to expenditure increases.

Children and Families:
Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Children and Families Expenditure = $537 M
% of 2016 Expenditure = 22%
Avg Annual Growth = 2.9%



Hospital	Nursing Home /Hospice	Professional	IDD Resdntl /Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
51%	0%	31%	0%	6%	8%	3%	1%	0%
% of 2016 Expenditure								
3.2%	6.9%	4.6%	N/A	-3.3%	0.2%	-1.9%	N/A	N/A
Avg Ann Growth 2012-16								

N/A indicates expenditure in this category too small to calculate a meaningful trend rate.
[1]Rate based on currently available data for 2008 – 2012. Source: http://www.health.ri.gov/data/birth/

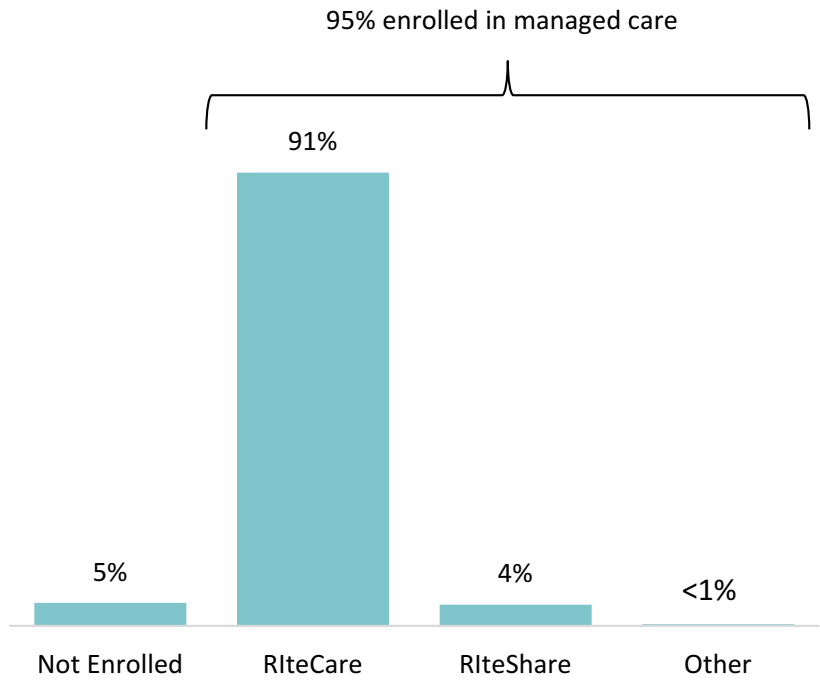
- Children and families account for about one-fourth (22%) of total Medicaid expenditures, with SFY 2016 expenditure of $537 million. Expenditure for this population has increased by 2.9% per year over the past 5 years.
- Most expenditure on children and families is divided between professional and hospital care, with hospital care accounting for more than half (51%) of expenditure.
- A major component of expenditure relates to prenatal care and births. Annually, approximately 47% of Rhode Island's births are covered through RIte Care.[1]
- Federal match is enhanced for 24,571 qualifying low income children and pregnant women under the CHIP program. In SFY 2016, Rhode Island received an 82.47% federal match on CHIP enrollees.

Children and Families: Managed Care Enrollment

Nearly all children and families are enrolled in managed care.

Children and Families: Managed Care Enrollment
SFY 2016

Children and Families Expenditure = $537 M
Average Eligibles = 153,342



	Not Enrolled	RIteCare	RIteShare	Other
Average Eligibles	7,028	139,158	6,630	526

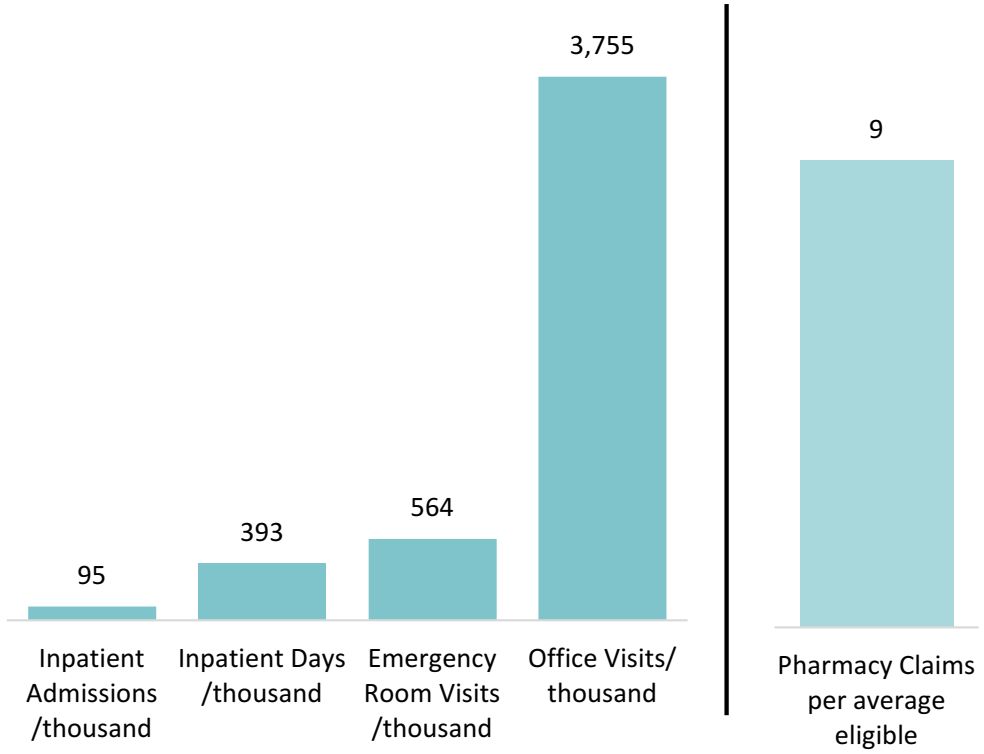
- Ninety-one percent of children and families are enrolled in a Medicaid managed care program through RIte Care. These enrollees are divided between Neighborhood Health Plan (NHP) and United Healthcare (UHC).
- RIte Share is a program designed to allow Medicaid eligibles with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditure by leveraging the employer's contribution. In SFY 2016 there were 6,630 Medicaid eligible children and parents enrolled in the RIte Share program.
- The unenrolled children and families include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

Children and Families: Acute Care Utilization

For children and families, inpatient admissions and inpatient days per thousand have decreased on average since SFY 2012.

Children and Families: Acute Care Utilization
SFY 2016

Children and Families Average Eligibles = 153,342



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2012-2016	-6.3%	-5.1%	-1.2%	0.0%	-1.9%

- For children and families, hospital-based acute care utilization measures have decreased since SFY 2012. Inpatient admissions per thousand and emergency room visits per thousand have decreased 6.3% per year and 1.2% per year, respectively, since SFY 2012.
- Office visits per thousand have stayed essentially flat over the same period.
- Pharmacy claims for children and families average 9 claims per average eligible person per year and have decreased 1.9% per year on average over the last 5 years.
- About 41% of inpatient admissions and 42% of inpatient days are maternity related (including maternity, nursery and NICU). Annually, approximately 47% of all RI births are covered through RIte Care.[1]

[1]Rate based on currently available data for 2008 – 2012. Source: http://www.health.ri.gov/data/birth/

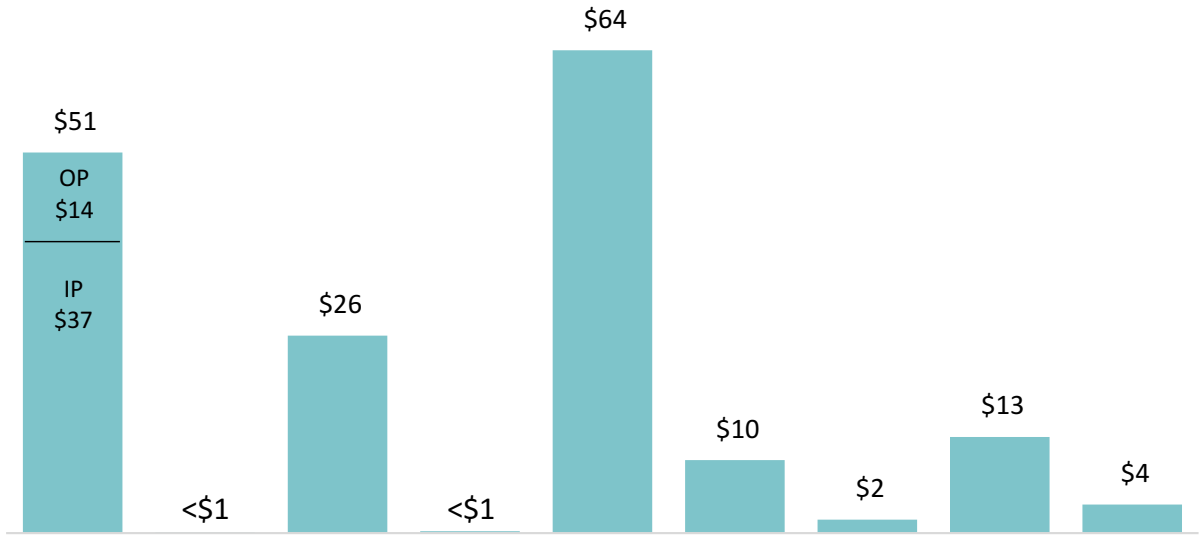
Children with Special Health Care Needs (CSHCN): Expenditure by Provider Type

In the population of children with special health care needs, professional behavioral health accounts for 38% of all expenditure.

CSHCN: Medicaid Expenditure by Provider Type

SFY 2016 -- $ Millions

CSHCN Expenditure = $170 M
% of 2016 Expenditure = 7%
Avg Annual Growth = -0.4%



Hospital	Nursing Home /Hospice	Professional	IDD Resdntl /Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
30%	<1%	15%	<1%	38%	6%	1%	8%	2%
% of 2016 Expenditure								
2.0%	N/A	-1.1%	N/A	-3.8%	-2.3%	6.9%	14.5%	4.0%
Avg Ann Growth 2012-16								

N/A indicates expenditure in this category too small to calculate a meaningful trend rate.

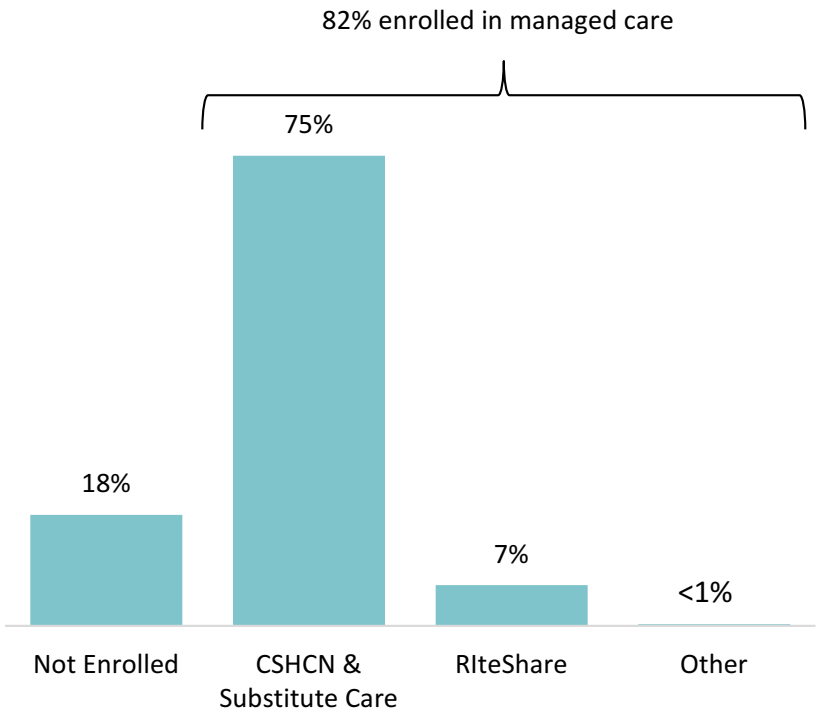
- Children with Special Health Care Needs (CSHCN) comprise a relatively small population, accounting for seven percent of total Medicaid expenditures and four percent of enrollees.
- Expenditure for this population is dominated by professional behavioral health services, which account for $64 million in CSHCN expenditures (38%). Professional behavioral health services include Cedar (Comprehensive, evaluation, Diagnosis, assessment, referral, re-evaluation) and Cedar Direct services, residential DCYF services, and professional mental health, substance abuse, and other services.

Children with Special Health Care Needs: Managed Care Enrollment

Over 80% of children with special healthcare needs are enrolled in managed care.

CSHCN: Managed Care Enrollment
SFY 2016

CSHCN Expenditure = $170 M
Average Eligibles = 12,025



	Not Enrolled	CSHCN & Substitute Care	RIteShare	Other
Average Eligibles	2,146	9,063	787	29

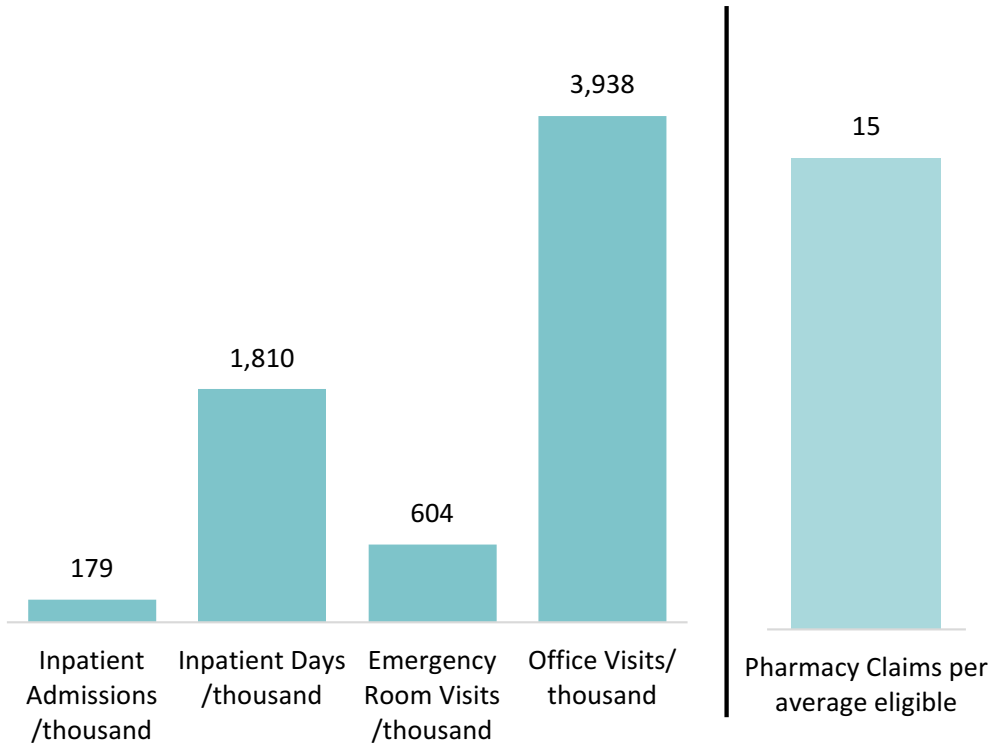
- In 2008, enrollment in Medicaid managed care became mandatory for children with special health care needs (CSHCN) without other insurance. In SFY 2016 82% were enrolled in managed care.
- The unenrolled children with special healthcare needs include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

Children with Special Health Care Needs: Acute Care Utilization

For children with special health care needs, emergency room visits per thousand have decreased by 1.3% per year on average since SFY 2012.

CSHCN: Acute Care Utilization
SFY 2016

CSHCN Average Eligibles = 12,025



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2012-2016	3.6%	4.2%	-1.3%	5.3%	0.1%

- Inpatient admissions per thousand have increased over the last 5 years at an average rate of 3.6% per year to 179 per thousand in SFY 2016.
- Office visits per thousand have increased at an average rate of 5.3% per year since SFY 2012 to 3,938 visits per thousand in SFY 2016.
- Almost half (45%) of inpatient admissions per thousand are for behavioral health. In terms of inpatient days, 52% are related to behavioral health.[1]
- Pharmacy claims per average eligible have increased at 0.1% per year over the last 5 years.

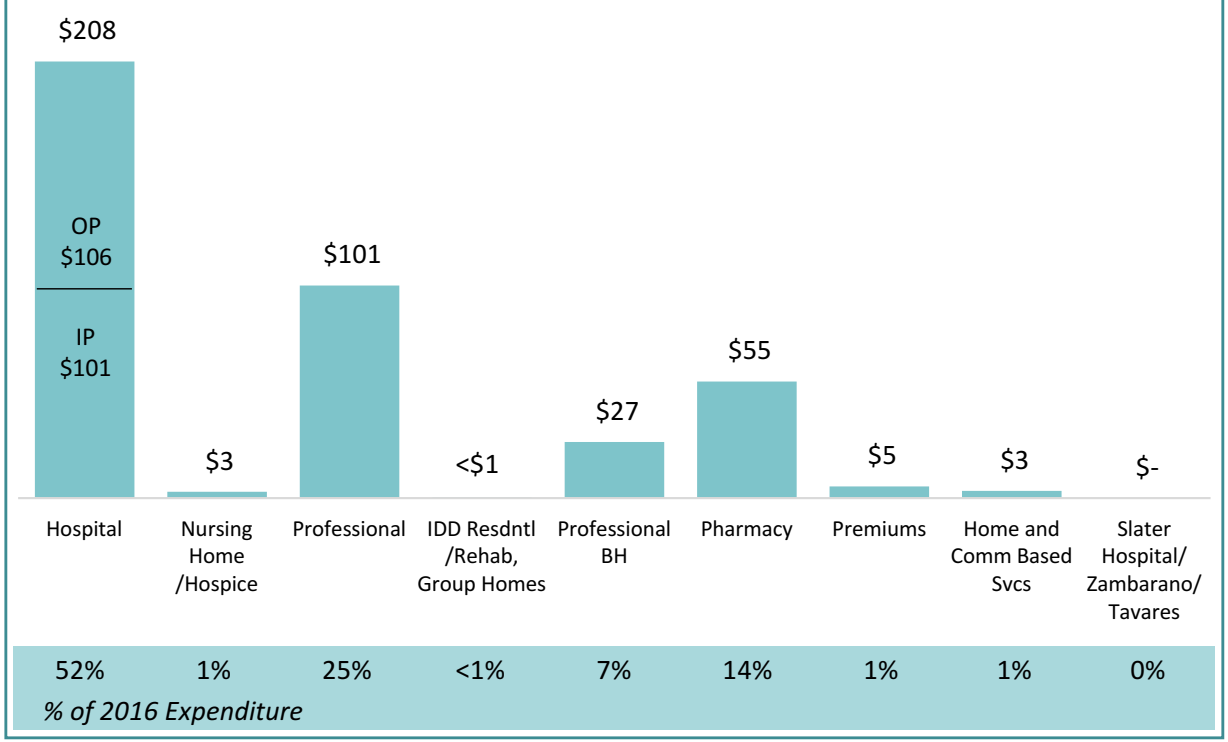
[1]Includes days in the Children's Residential and Family Treatment (CRAFT) program at Bradley Hospital.

Expansion: Expenditure by Provider Type

The Expansion population mainly uses hospital and professional services.

Expansion: Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Expansion Expenditure = $402 M
% of 2016 Expenditure = 17%



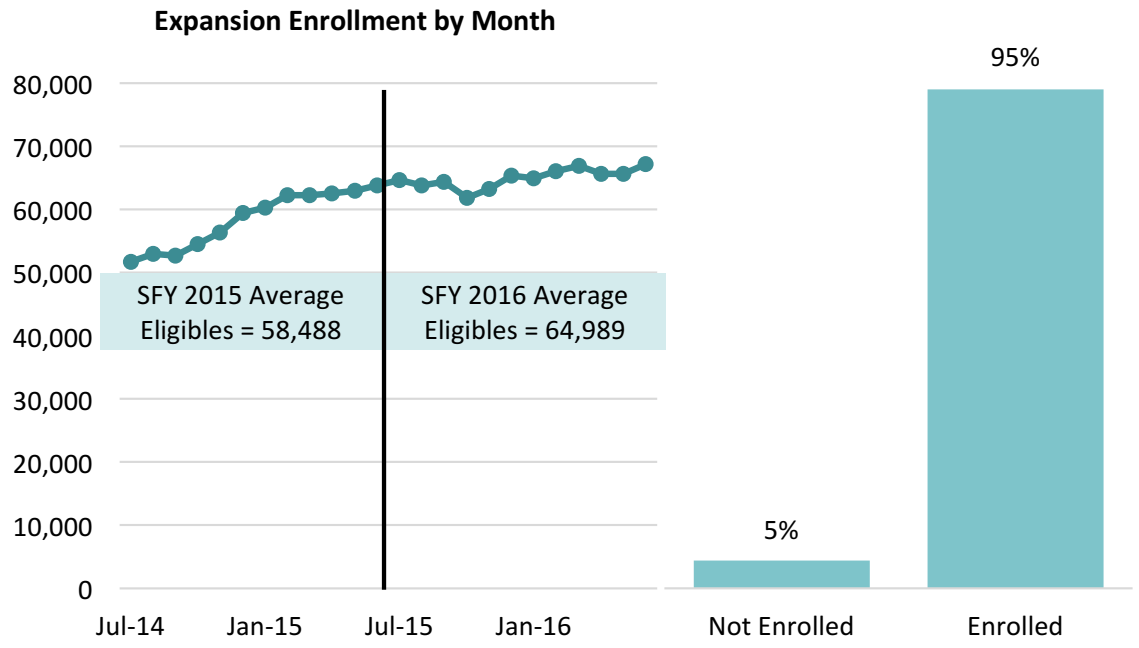
- The Expansion population became eligible for Medicaid starting January 1, 2014.
- This population accounted for $402 million in expenditure in SFY 2016, 17% of total Medicaid expenditure.
- The two largest provider types for the Expansion population are hospital and professional services, accounting for 77% of expenditure.
- The Expansion population used almost no long term services and supports.

Expansion: Managed Care Enrollment

The Expansion population is mainly enrolled in managed care programs

Expansion: Managed Care Enrollment
SFY 2016

Expansion Average Eligibles = 64,989



Average Eligibles	3,405	61,584

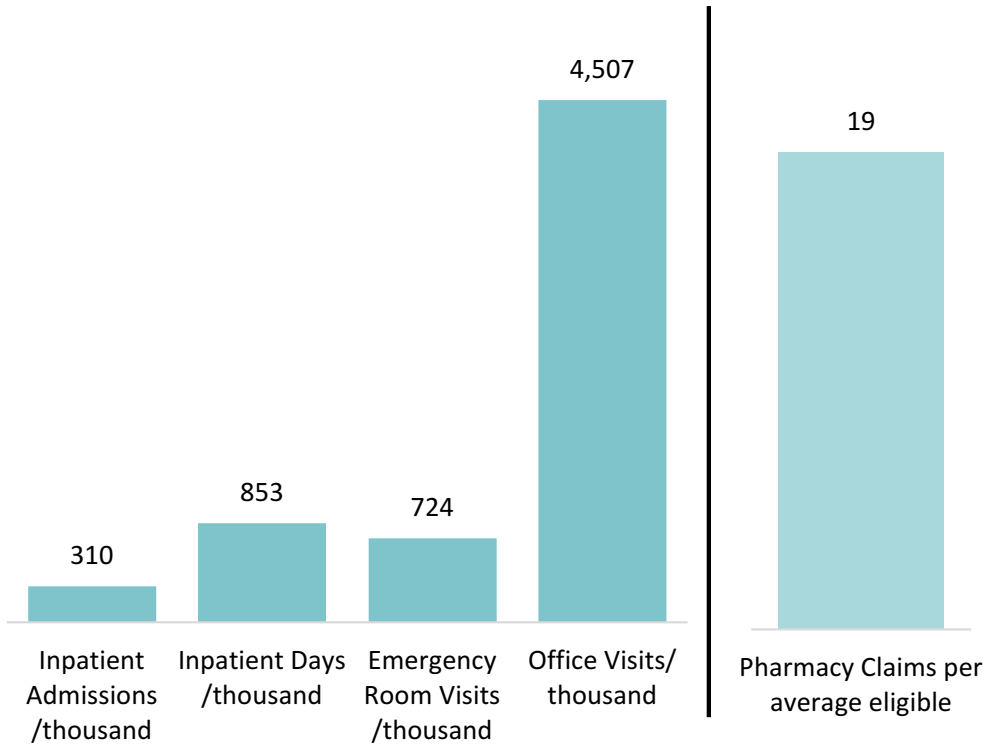
- The Medicaid Expansion population is expected to entirely enroll in managed care. However new enrollees experience an initial period in fee-for-service prior to enrollment in a health plan.
- Expansion eligibility commenced in January 2014 and was still phasing in during SFY 2015. Enrollment has mainly stabilized for SFY 2016, increasing by 2,505 eligibles between July 2015 and June 2016.

Expansion: Acute Care Utilization

The Expansion population had an average of 19 pharmacy claims per 12 months of eligibility.

Expansion: Acute Care Utilization
SFY 2016

Expansion Average Eligibles = 64,989



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Growth **SFY 2015-2016**	12.5%	-2.4%	-2.6%	-0.9%	4.3%

Note: Growth rate on this chart is for one year, not the average annual rate for five years.

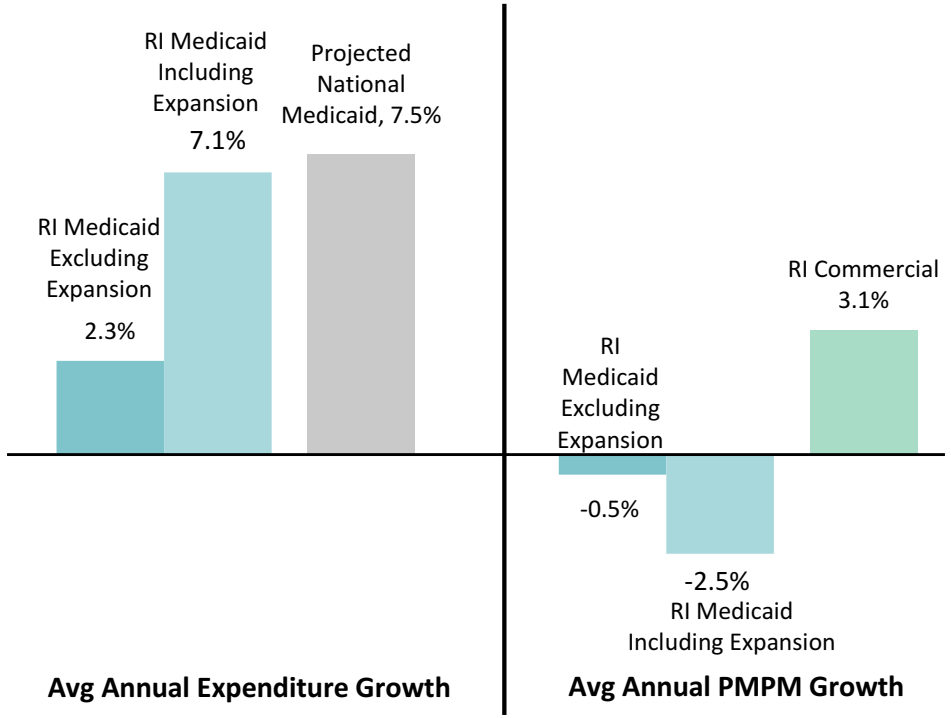
- The Medicaid Expansion population had 310 inpatient admissions per thousand and 853 inpatient days per thousand during SFY 2016.
- The Expansion population used about 4.5 office visits per average eligible.
- The Expansion population was newly eligible during SFY 2014, so data is not available to calculate a five-year average growth rate. However, trend rates from SFY 2015 to 2016 show a decrease in utilization for the Expansion population for inpatient days, ER visits, and office visits per thousand.

Medicaid Trends: National Medicaid and State Commercial

RI Medicaid trends were comparable to national Medicaid trends including the expenditure on the Expansion population. RI Medicaid trends were notably lower than regional Commercial experience over a similar period.

Rhode Island Medicaid vs. National and Commercial Trends

SFY 2012-2016[1], see below for sources



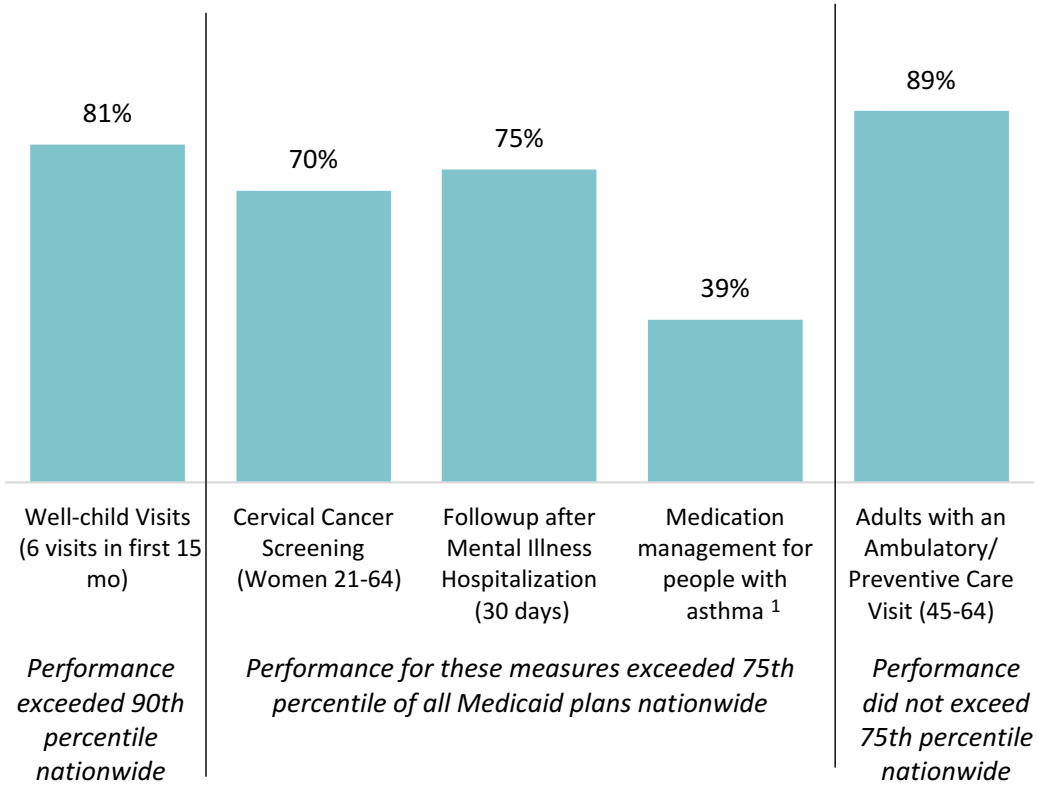
- Overall expenditure growth over the years 2012-2016 was similar to the national Medicaid expenditure trend. According to Centers for Medicare & Medicaid Services (CMS), Medicaid national expenditure trend over this time period increased an average 7.5% per year, vs. Rhode Island Medicaid's trend of 7.1%.
- The national measure included projections that not all states would expand Medicaid and would presumably have been higher if all states nationwide had expanded Medicaid eligibility under ACA.
- Rhode Island Medicaid PMPM (per member per month) cost trends compare favorably to local commercial benchmarks. Between SFY 2012 and 2016, the state Medicaid program experienced a decrease in average annual PMPM cost of 2.5% per year, including Expansion. The average annual medical PMPM cost for RI commercial health plans over a similar period increased 3.1% per year.[1]
- The RI commercial benchmark may underestimate PMPM growth because it only includes total incurred claims reported by the carriers, not any out of pocket costs borne by members. Medicaid plans generally have very low, if any, out of pocket costs for members.

[1]RI Commercial trend for CY2011-2015. National trend for FFY 2012-2016.
Sources: National Medicaid Trend from 2016 CMS National Health Expenditure Report. RI Commercial trend from Office of the Health Insurance Commissioner (OHIC), 2016 carrier rate filings, Incurred claims per member per month, includes both small group and large group claims from Blue Cross Blue Shield RI, United Healthcare of New England and Tufts Health Plan.

Managed Care: Quality Indicators

Both of Rhode Island's participating Medicaid Managed Care Organizations (MCOs) received an overall plan rating of 4.5 out of 5 from the National Committee for Quality Assurance (NCQA) for 2016.

Combined Performance of RI Medicaid Managed Care Plans on Selected HEDIS Quality Measures
CY 2015



- NCQA ratings consists of three types of quality measure domains: clinical quality, consumer satisfaction, and results from NCQA's review of the Health Plan's health quality processes.
- Selected HEDIS® quality measures are shown at left demonstrating the combined performance of RI Medicaid Managed Care Organizations.
- On the HEDIS® measures assessing the percentage of enrollees who had six or more well-child visits during their first 15 months of life, both of Rhode Island's Medicaid Health Plans ranked above the 90th percentile compared with Medicaid health plans nationally.
- On the HEDIS® measures of cervical cancer screening, follow-up after mental illness hospitalization, and medication management for people with asthma, Rhode Island's Medicaid Health Plans ranked above the 75th percentile compared with other plans nationwide.

[1]HEDIS 2016 retired the *Use of Appropriate Mediations for People with Asthma* and replaced with *Medication Management for People with Asthma.*
Sources: NCQA data from Kaiser Family Foundaiton report: Medicaid MCO Quality Ratings, based on NCQA 2016-2017 ratings.
HEDIS data from Monitoring Quality and Access in RIte Care and Rhody Health Partners, RI EOHHS, October 2016. Results are reported in aggregate, not by health plan.

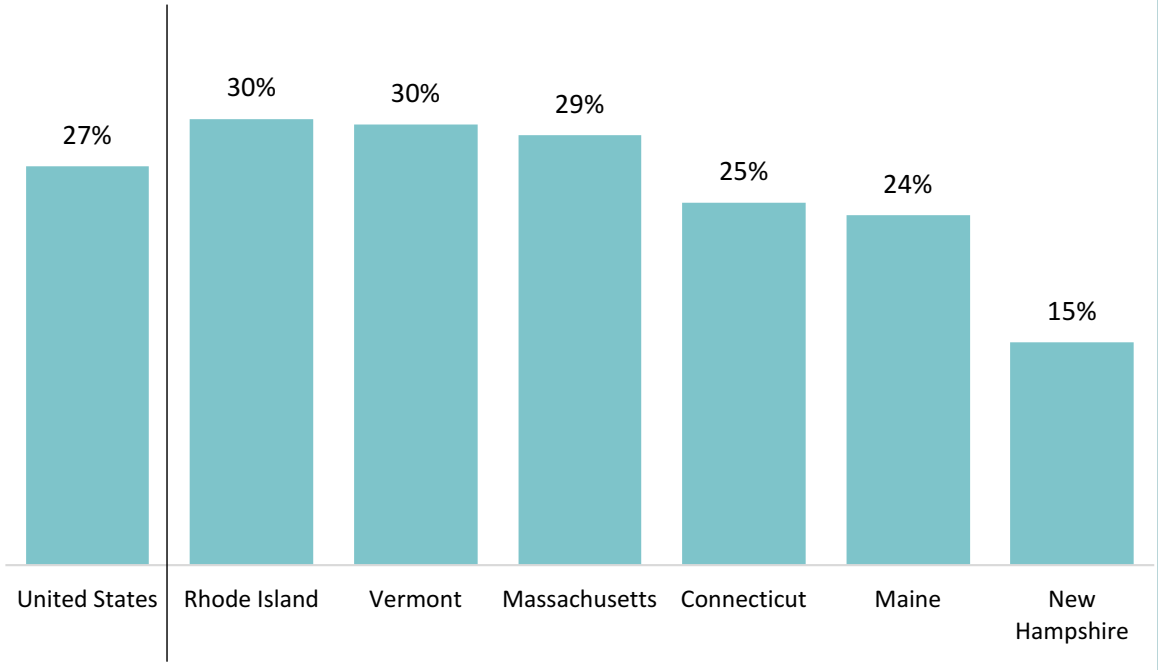
Medicaid Trends: Medicaid Enrolled Population

According to November 2016 enrollment data, Rhode Island's Medicaid enrollment is 30% of its population under 65, the highest percentage of the New England states.

Medicaid Enrollment as Percent of Under 65 Population

November 2016

Source: Manatt analysis of CMS Medicaid/CHIP enrollment data and Census Bureau Population Data



72,395,517	290,809	166,794	1,665,877	750,009	269,051	186,377

Medicaid Enrollment, Nov 2016

- CMS compiles Medicaid enrollment data for all states monthly. This enrollment data was converted for the purposes of this chart to percent of population under 65 for each state using data from the US Census Bureau.
- After Rhode Island, Vermont had the second highest percentage Medicaid enrollment of the New England states.
- Nationally 27% of the population under 65 is enrolled in Medicaid.

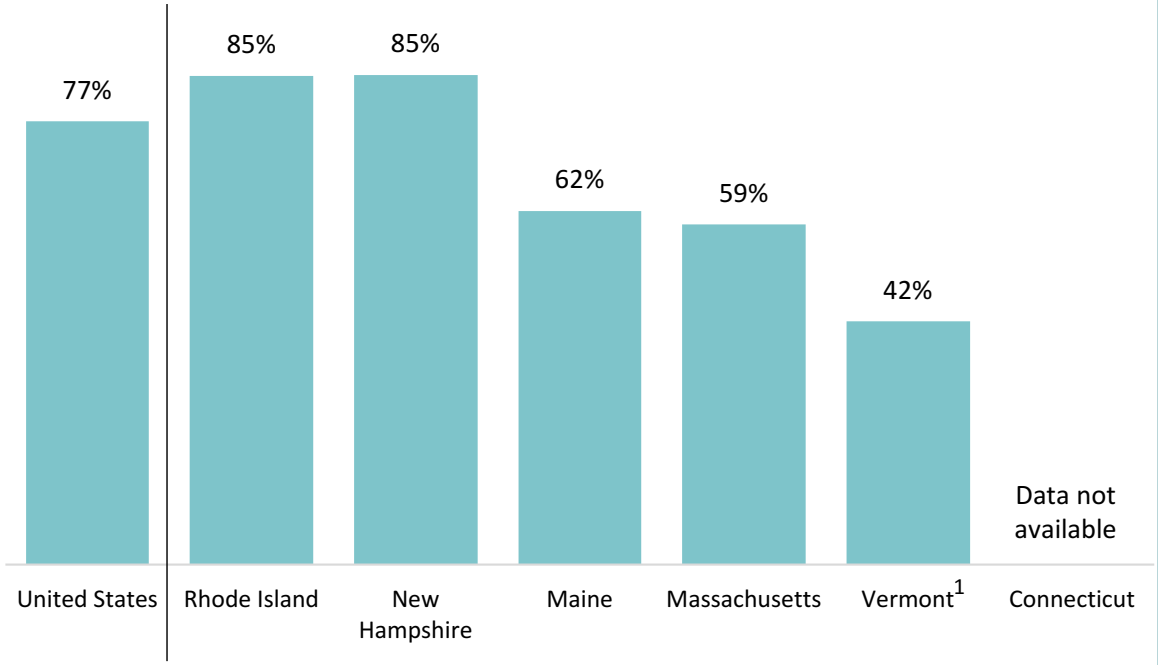
Medicaid Trends: Managed Care Enrollment

Rhode Island and New Hampshire have the highest rates of managed care enrollment compared to the other New England states.

Managed Care Enrollment as Percent of Medicaid Enrollment

January 2014

Source: Kaiser Family Foundation report, based on CMS enrollment data



- Total Medicaid enrollment for this chart is defined as beneficiaries enrolled in any Medicaid managed care program, including comprehensive MCOs, limited benefit MCOs, and PCCMs.
- Nationally the average percent of Medicaid managed care enrollment is 77%.
- This data differs from the managed care enrollment data shown earlier in this report because it is based on data from 2014 in order to allow comparison to national and regional data.
- For SFY 2016, Rhode Island managed care enrollment is 90% of eligibles, an increase from the 85% shown in this Kaiser report.

[1]The Department of Vermont Health Access, a state agency, acts as Vermont's single MCO entity.

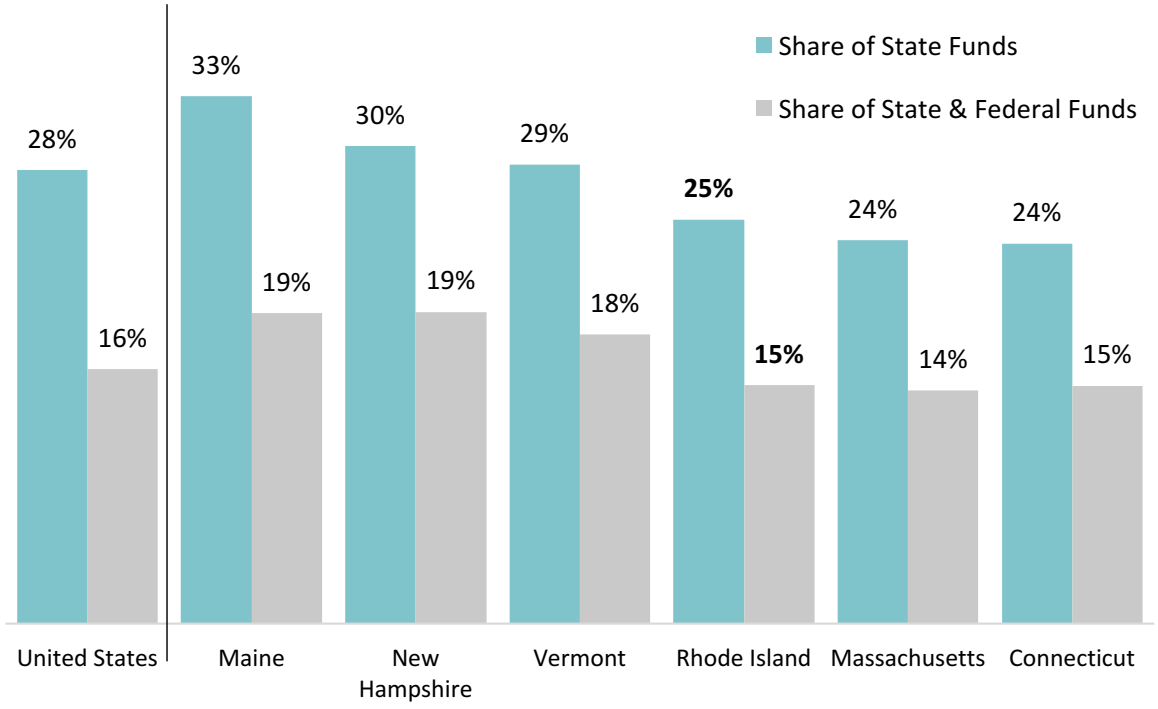
Medicaid Trends: Share of State/Federal Spending

Medicaid spending in Rhode Island accounted for about 25% of state funds in the state budget for SFY 2015.

Medicaid Spending as a Share of State and Federal Funds in State Budgets

SFY 2015

Source: Manatt analysis of National Association of State Budget Officers (NASBO) data



- Across all states, the average share of state funds dedicated to Medicaid spending is about 28%, and the average share of both state and federal funds dedicated to Medicaid spending is about 16%.
- In Maine, New Hampshire and Vermont , Medicaid spending represents a higher share of state and federal funds than in Rhode Island.

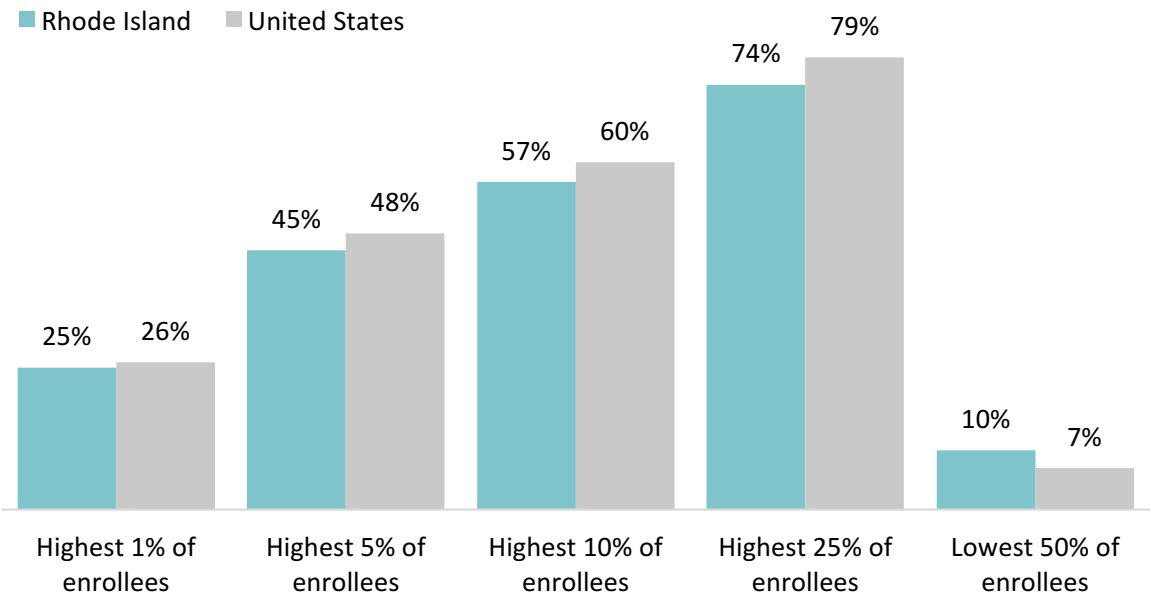
Medicaid Trends: Cost/Utilization Benchmarks

According to a US Government Accountability Office report, Rhode Island is fairly consistent with national benchmarks in terms of the amount of Medicaid expenditure attributable to the highest cost enrollees.

Distribution of Expenditures among Medicaid-only Enrollees FFY 2011

(excludes MMEs – Medicare dual eligibles)

Source: US Government Accountability Office Report

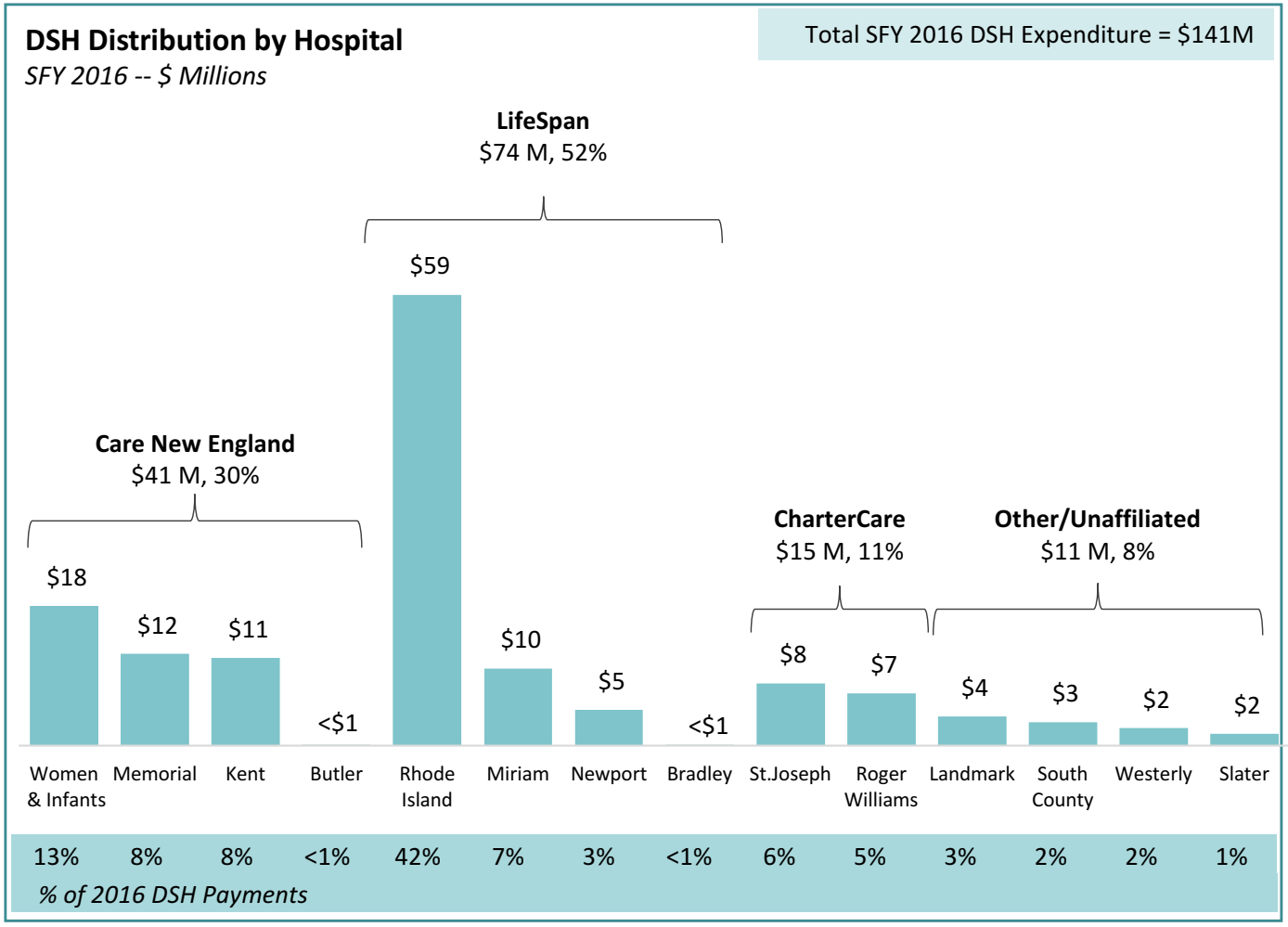


Percentage of expenditures for Medicaid-only enrollees attributable to selected portions of enrollees

- The GAO report from 2011 showed that both nationwide and in Rhode Island, the top 1% of Medicaid enrollees account for about one-quarter of total Medicaid expenditure. The top 5% of enrollees account for nearly half.
- On the other end of the spectrum, the lowest 50% of enrollees account for 10% of Medicaid expenditure in Rhode Island and 7% nationally.
- This data differs from the high cost user statistics shown earlier in this report because it excludes dual eligibles in Medicare and is based on data from 2011 in order to allow comparison to available national data.

Exclusions: (1) Disproportionate Share Hospitals (DSH)

Disproportionate share hospital (DSH) payments are intended to subsidize the cost of providing care to indigent and very low income people.



- A total of $141 million in DSH funds was paid out to hospitals in SFY 2016.
- The state's two largest hospitals – Rhode Island and Women and Infants – together accounted for 55% of total DSH payments
- DSH payments are not included in the Medicaid expenditure analysis in this report.

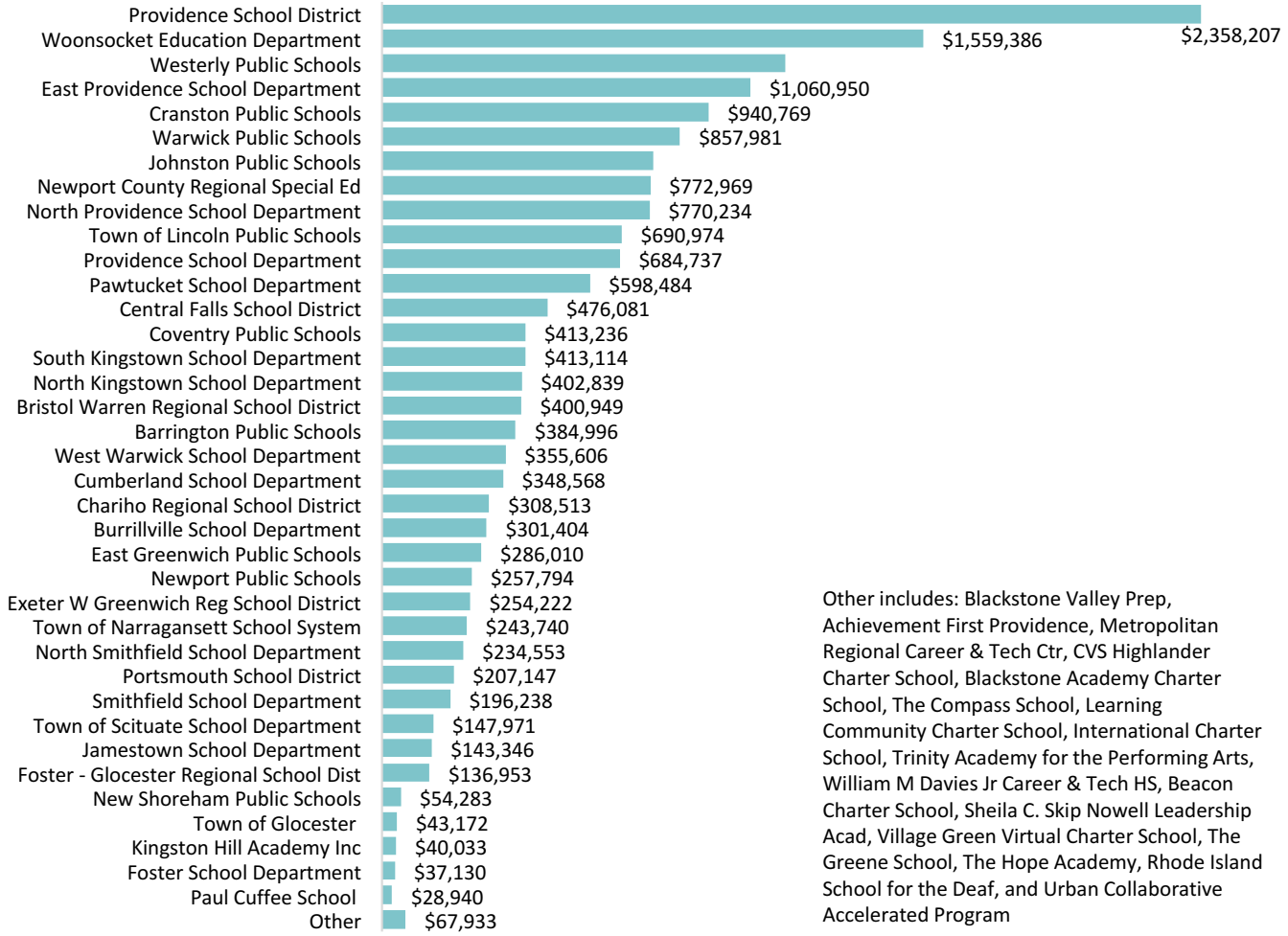
Exclusions: (2) Local Education Authorities (LEA)

Local Education Authorities (LEAs) account for $18 million in total expenditures in 54 school districts.

Medicaid Funding to Local Education Authorities (LEAs)

SFY 2016

Total SFY 2016 LEA Expenditure = $18 M



Other includes: Blackstone Valley Prep, Achievement First Providence, Metropolitan Regional Career & Tech Ctr, CVS Highlander Charter School, Blackstone Academy Charter School, The Compass School, Learning Community Charter School, International Charter School, Trinity Academy for the Performing Arts, William M Davies Jr Career & Tech HS, Beacon Charter School, Sheila C. Skip Nowell Leadership Acad, Village Green Virtual Charter School, The Greene School, The Hope Academy, Rhode Island School for the Deaf, and Urban Collaborative Accelerated Program

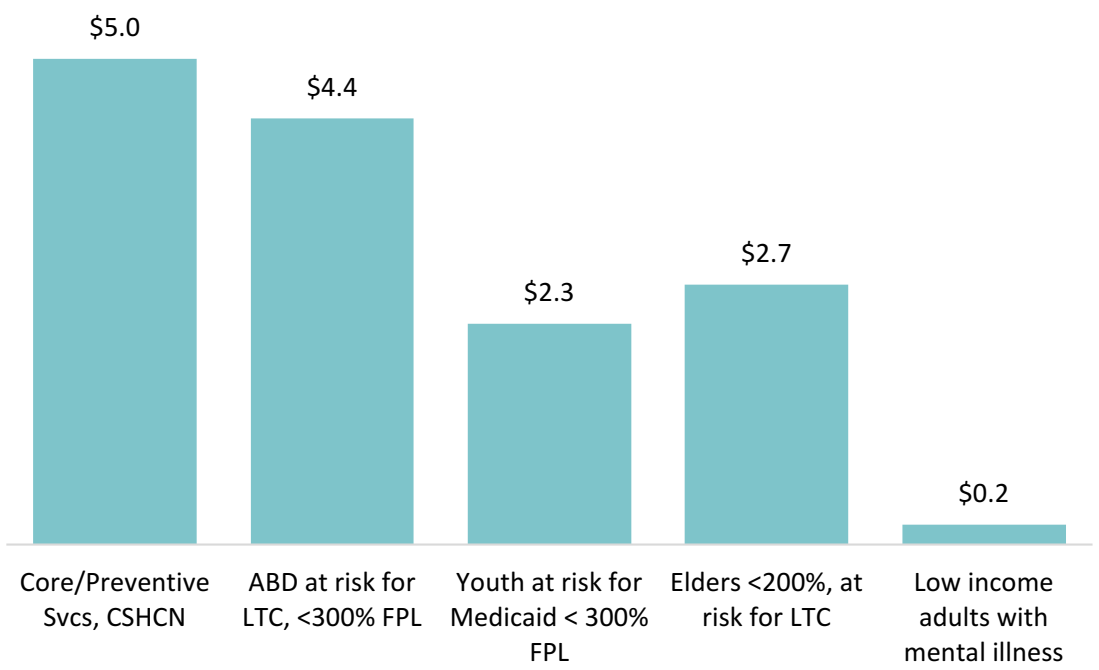
- LEAs provide special education services in their districts.
- For LEA expenditures, the match to the federal share is paid with LEA funds.
- LEA payments are not included in the Medicaid expenditure analysis in this report.

Exclusions: (3) Costs Not Otherwise Matchable (CNOM)

Costs Not Otherwise Matchable (CNOMs) account for $15 million in total expenditures.

Costs Not Otherwise Matchable (CNOMs)
SFY 2016 -- $ Millions

Total SFY 2016 CNOM Expenditure = $15M



- Under the terms of Rhode Island's 1115 Waiver Demonstration agreement with the federal government, 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.
- These CNOM expenditures are not part of the core Medicaid program and as such are not included in the Medicaid expenditure analysis in this report.

Acronyms and Abbreviations

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

ACA: Affordable Care Act
BCBSRI : Blue Cross Blue Shield of Rhode Island
BHDDH: Behavioral Healthcare, Developmental Disability, and Hospitals
CHIP: Children's Health Insurance Program
CMHC: Community Mental Health Center
CMS: Centers for Medicare and Medicaid Services
CNOM: Costs Not Otherwise Matchable
CSHCN: Children with Special Health Care Needs
DCYF: Department of Children, Youth and Families
IDD: Intellectually and Developmentally Disabled
DEA: Department of Elderly Affairs
DSH: Disproportionate Share Hospitals
DHS: Department of Human Services
DME: Durable Medical Equipment
DOH: Department of Health
EOHHS: Executive Office of Health and Human Services
ER: Emergency Room
FFY: Federal Fiscal Year
FMAP: Federal Medicaid Assistance Percentage
HCBS: Home and Community-Based Services
HEDIS: Healthcare Effectiveness Data and Information Set
IP: Hospital Inpatient
LEA: Local Education Agencies
LTSS: Long Term Services and Supports
MCO: Medicaid Managed Care Organization
MME: Medicaid Medicare Eligibles
NHPRI : Neighborhood Health Plan of Rhode Island
NICU: Neonatal Intensive Care Unit
OP: Hospital Outpatient
PACE: Program of All-Inclusive Care of the Elderly
PCCM: Primary Care Case Management
PMPM: Per member per month
RIPTA: Rhode Island Public Transit Authority
SA: Substance Abuse
SFY: State Fiscal Year
SSI: Supplemental Security Income
UHCNE: UnitedHealth Care of New England
UPL: Upper Payment Limit

Sources and Notes

Source Data and Analytic Method

This report is based on SFY 2016 and a five year historical Rhode Island Medicaid systems extracts:

- Including claims, capitation payments, premiums and provider payouts.
- Reflecting data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through November 2016
- Capitations, premiums and payouts are proportionately allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information with IBNR.

Variance to Other Reports

The purpose of this report is to provide 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. Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion, rounding and allocation of non-claims based expenditures.

APRIL 24, 2018

REVISIONS TO APRIL 23, 2018 TESTIMONY

MAY 2018

CASELOAD ESTIMATING CONFERENCE

TESTIMONY OF THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

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b. FY 2019 Projection – Medical Benefits
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7. Miscellaneous Reports

8. Responses to Conferees' Questions for RI EOHHS – Medical Assistance

General Considerations

For Fiscal Year 2018, Rhode Island's Executive Office of Health and Human Services (EOHHS) anticipates its expenditures on medical benefits to be **$2,451,561,688 All Funds**. This reflects a **$17.3 million deficit** compared to the FY 2018 November CEC Adopted (Nov CEC).

EOHHS anticipates FY 2018 General Revenue (GR) expenditures of **$960,280,062**. This reflects a $5.5 million GR surplus against the Nov CEC. However, after correcting the Nov CEC estimate to reflect the shift in funding from state to federal sources as it relates to the conferees' original estimate of the impact of CHIP reauthorization, EOHHS forecasts a **$1.4 million GR deficit**. **Table 1** compares EOHHS' current FY 2018 forecast to Nov CEC and a revised Nov CEC with CHIP.

Table 1. Summary of Rhode Island Medicaid – Medical Benefits, SFY 2018

	SFY 2017:	SFY 2018:			
	Final	Nov CEC	Nov CEC w CHIP	Current	Surplus/(Deficit) over Nov CEC w CHIP
Summary by Funding Source:					
General Revenue	$ 919,322,206	$ 965,886,157 →	$ 958,868,945	$ 960,280,062	($1.4) M
Federal Funds	$ 1,388,566,147	$ 1,457,062,545 →	$ 1,464,079,757	$ 1,479,992,357	($15.9) M
Restricted Receipts	$ 10,973,508	$ 11,289,268	$ 11,289,268	$ 11,289,268	$0.0 M
All Funds	**$ 2,318,861,860**	**$ 2,434,237,970**	**$ 2,434,237,970**	**$ 2,451,561,688**	($17.3) M
Trend Over Prior SFY	*6.1%*			*5.7%*	

For FY 2019, EOHHS currently projects **$2,523,693,914 All Funds** expenditures on medical benefits, of which **$979,239,904** are expected to be financed with **General Revenues**. The latter number reflects a $24.4 million GR surplus over FY 2019 Nov CEC. As with FY 2018, however, the reauthorization of CHIP provides immediate General Revenue savings to Medicaid; therefore, after restating Nov CEC for the shift from state to federal spending that was assumed by the conferees in November, EOHHS forecasts a **$4.1 million GR deficit**.[1,2] **Table 2** compares EOHHS' current FY 2019 forecast to Nov CEC and a revised Nov CEC with CHIP.

Table 2. Summary of Rhode Island Medicaid – Medical Benefits, SFY 2019

	SFY 2018:	SFY 2019:			
	Nov CEC	Nov CEC	Nov CEC w CHIP	Current	Surplus/(Deficit) over Nov CEC w CHIP
Summary by Funding Source:					
General Revenue	$ 965,886,157	$ 1,003,666,781 →	$ 975,150,257	$ 979,239,904	($4.1) M
Federal Funds	$ 1,457,062,545	$ 1,487,621,522 →	$ 1,516,138,046	$ 1,535,429,805	($19.3) M
Restricted Receipts	$ 11,289,268	$ 11,289,268	$ 11,289,268	$ 9,024,205	$2.3 M
All Funds	**$ 2,434,237,970**	**$ 2,502,577,571**	**$ 2,502,577,571**	**$ 2,523,693,914**	($21.1) M
Trend Over Prior SFY				*2.9%*	

[1] Consistent with Governor's FY 2018 Revised and FY 2019 Recommend, EOHHS recommends additional savings that are not reflected in this document; these reductions include elimination of state-only funded contracts (i.e., Cortical Integrated Therapy, Community Health Teams Rhode Island, and Housing Stabilization Program), Graduate Medical Education, and the Perry-Sullivan Appropriation, which has been reallocated to fund the home care wage increase. To be consistent with current law, these savings are not included in this document.

[2] As noted in **Major Developments** and **Hospitals** section, EOHHS recommends—consistent with the conferees memorandum following the November CEC—funding DSH to the maximum amount allowed by State law: $138.6 million. This would change EOHHS' fiscal position to **$19.8 million GR deficit** compared to Nov CEC with CHIP.

Attachment 1a and ***Attachment 1b*** provide summaries of RI EOHHS' current forecast by budget program/category.

EOHHS' revised forecast for FY 2018 and FY 2019 is summarized in **Table 3**.

With respect to FY 2018, EOHHS assumes an average eligibility base of **311,367 members** with full Medicaid benefits, an increase of 6,428 members over that assumed in the Nov CEC. Nearly three-quarters of the net caseload growth is within Medicaid Expansion.

For FY 2019, EOHHS currently forecasts an average caseload of **316,440 members**, reflecting an increase of 1.6% composite trend over revised monthly forecast for current fiscal year. This forecast is 16,152 members over Nov CEC, with over half of unanticipated growth attributed to Medicaid Expansion.

EOHHS' revised caseload forecast for FY 2018 and its preliminary monthly caseload forecast for FY 2019 are included in ***Attachment 5a*** and ***Attachment 5b****, respectively.*

Table 3. Summary of Rhode Island Medicaid Caseload (Full Medical Assistance Only)

	SFY 2017:	SFY 2018:			SFY 2019:		
	Final	Nov CEC	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)
Enrolled in Managed Care:							
RIte Care Core (exc. EFP)	149,690	156,121	157,340	1,219	153,955	160,211	6,256
RIte Care CSHCN	9,216	10,196	10,165	(31)	10,149	10,254	105
Expansion	70,352	70,385	74,045	3,660	68,099	76,291	8,192
Rhody Health Partners	14,977	15,406	15,171	(235)	15,399	15,315	(84)
Rhody Health Options	23,150	24,743	25,038	295	24,813	25,975	1,162
PACE	278	293	298	5	305	307	2
Subtotal Enrolled	267,663	277,144	282,058	4,914	272,720	288,353	15,633
RIte Share	8,034	6,564	6,476	(88)	6,255	6,099	(156)
Remaining in FFS:							
Children and Families	4,708	4,341	4,894	553	4,456	4,373	(83)
CSHCN	1,933	1,824	1,766	(58)	1,832	1,897	65
Expansion	1,842	1,990	3,001	1,011	1,910	2,448	538
Aged, Blind and Disabled	12,633	13,076	13,170	94	13,115	13,270	155
Total Full Medical Assistance	**296,812**	**304,939**	**311,367**	**6,428**	**300,288**	**316,440**	**16,152**
Trend Over Prior SFY	*5.3%*		*4.9%*	*2.1%*		*1.6%*	*5.4%*

I. Major Developments

EOHHS' revised caseload and consequent medical benefits budget forecast deviate from November CEC Adopted (Nov CEC) in several areas, with the net impact of such changes resulting in an overall anticipated $18.3 million deficit in FY 2018 and a $17.9 million deficit in FY 2019. (*Please note that unless otherwise noted all expenditures are presented in All Funds.*)

The rest of this section highlights major developments that contribute to the drivers listed above and/or represent a meaningful change from prior fiscal years. Additional details, including variances against the Nov CEC within the medical budget programs, are provided in the subsequent sections and attachments.

A. Summary of Changes in Forecast

A summary of the favorable and unfavorable changes in EOHHS' current fiscal outlook compared to Nov CEC estimates for FY 2018 and FY 2019 are summarized in **Table I-1** and **Table I-2**, respectively.

These impactful changes as well as additional factors contributing to any variances in EOHHS' revised caseload forecast and overall financial position will be described in the following sections of **Major Developments**, within the subsequent account summaries, and/or as part of the responses to specific conferee questions.

Table I-1. FY 2018 - Variations between Nov CEC Adopted and Current Forecast

	All Funds	General Revenue
Unfavorable:		
Capitation - Price and Volume	($21.75) M	($1.71) M
Capitation - Hospital Pricing	($2.61) M	($1.27) M
FFS Activity - Nursing Facilities	($6.66) M	($6.06) M
FQHC PPS Wrap	($4.69) M	($1.86) M
Medicare Premium Payment	($2.23) M	($1.13) M
DRE/J-Code	$1.19 M	($2.22) M
Recoveries	($1.96) M	($0.95) M
All Other Activity	($0.90) M	($0.80) M
Favorable:		
Capitation - HIF Moratorium	$8.28 M	$2.69 M
Risk Share/Stop Loss	$15.06 M	$3.31 M
FFS Activity - All Other FFS	($1.06) M	$3.90 M
CHIP - Increased Claiming	$12.54 M	$4.71 M
Subtotal	($17.32) M	($1.38) M
CHIP - Reauthorization	$18.66 M	$7.02 M
Total after CHIP Reauthorization	($17.32) M	$5.64 M

Table I-2. FY 2019 - Variations between Nov CEC Adopted and Current Forecast

	All Funds	General Revenue
Unfavorable:		
Capitation - Price and Volume	($39.10) M	($10.19) M
FFS Activity - Nursing Facilities	($8.08) M	($3.85) M
Medicare Premium Payment	($3.62) M	($2.62) M
DRE/J-Code	$5.32 M	($0.71) M
Recoveries	($1.32) M	($0.90) M
Children's Health Account	($2.27) M	($2.27) M
All Other Activity	($1.32) M	($0.90) M
Favorable:		
Capitation - HIF Moratorium	$17.16 M	$5.64 M
Risk Share/Stop Loss/Incentives	$2.38 M	$1.50 M
FFS Activity - All Other	$2.31 M	$5.56 M
FQHC PPS Wrap	$0.98 M	$0.27 M
DSH/UPL/GME	$4.81 M	$2.39 M
CHIP - Increased Claiming	$5.41 M	$2.02 M
Subtotal	($20.47) M	($4.05) M
CHIP - Reauthorization	$76.41 M	$28.52 M
Total after CHIP Reauthorization	($20.47) M	$24.47 M

B. Recommended Adjustment to DSH Limit

EOHHS recommends increasing Rhode Island's FY 2019 DSH appropriation to $138.6 million, the maximum amount allowed under current state law. All conferees agreed after the November Caseload Estimating Conference that "the expectation is that any federal action to delay the [then planned Federal funding] reduction…would result in a restoration of the state match that goes with it."[3]

That federal action occurred in February 2018 when Congress passed a short-term continuing resolution that included the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, eliminating the reduction to DSH payments for FFY 2018 and FFY 2019. In light of the federal government's recognition of the continued importance of this subsidy for the uncompensated care underwritten by the nation's hospitals, EOHHS supports a restoration of the state match as consistent with state law. The fiscal implications of such a change are addressed in **Hospitals – Disproportionate Share Hospital (DSH)** section.

C. CHIP Reauthorization and Enhanced Claiming

EOHHS' current forecast reflects the federal reauthorization of CHIP.

As part of the same continuing resolution that placed a moratorium on the HIF, Congress passed a six-year reauthorization of CHIP funding. That reauthorization was extended to a full decade as part of the subsequent continuing budget resolution that Congress passed in February. These federal laws maintain the 23 percentage points CHIP enhanced federal match rate for FFY 2018 and FFY 2019, decreases it to 11.5 percentage points in FFY 2020, and returns to the regular CHIP match rate for FFY 2021 through FFY 2027. The reauthorization also continues the qualifying states' option that allows states that expanded Medicaid before CHIP was created in 1997

[3] Whitney, Mullaney and Reynolds Ferland. November 16, 2018. Rhode Island Caseload Estimating Conference Memorandum re: November 2017 Caseload Estimating Conference.

to receive CHIP matching funds for some children enrolled in Medicaid. Rhode Island is a qualifying state and uses this provision to maximize its federal financial participation.

Consistent with the conferees' Report following the November Caseload Estimating Conference, the CHIP reauthorization shifts $7.0 million and $28.0 million in state spending to federal spending for FY 2018 and FY 2019, respectively. These amounts are reflected in Governor's FY 2018 Revised and FY 2019 Recommend.

While CHIP reauthorization was a necessary pre-requisite, EOHHS has increased its overall CHIP claiming relative to Nov CEC to provide an additional $4.7 million General Revenue savings in FY 2018 and $2.0 million General Revenue savings in FY 2019 compared to Nov CEC. Please refer to **Managed Care** section for further discussion.

D. Caseload Growth and Trend Development

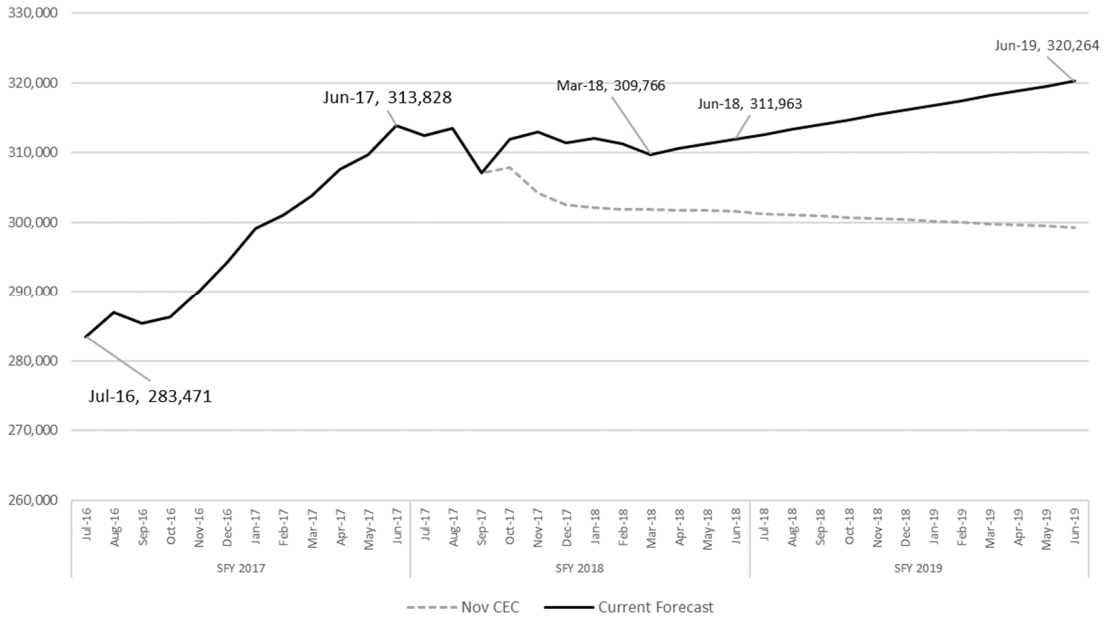
Despite terminating 33,253 members with full Medicaid benefits during the first half of the current fiscal year (compared to 23,747 members termed through the entirety of FY 2017) and seeing a moderation to the subsequent trend over the most recent quarter, Medicaid's revised forecast exceeds its prior caseload estimates from November. Specifically, although EOHHS anticipates a net reduction of 1,865 members between the June 2017 snapshot and June 2018, EOHHS' revised forecasts for FY 2018 and FY 2019 remain 6,428 and 16,152 members higher than the forecasts adopted by the conferees in the Nov CEC.[4] **Figure I-1** compares EOHHS' revised forecast to the Nov CEC forecast.

Overall, the net reduction over FY 2018, even if less than originally anticipated, compares favorably to the net increase of 30,000+ members in FY 2017. Further, the higher than anticipated caseload for Medicaid is consistent with the enrollment success of Rhode Island's health insurance exchange, HealthSource RI, that experienced a 5% increase in enrollments during its 2018 open enrollment period. According to preliminary enrollment data reported by National Academy for State Health Policy, this increase figures as the biggest gain among state-run insurance exchanges comparing 2018 to 2017 enrollment activity.

EOHHS' revised forecast does not incorporate any significant one-time reductions (or additions) that would bring caseload in closer alignment with the prior November estimates. That is, terminations have stabilized and the State believes that RI Bridges functionality is no longer a driver of caseload. While deficiencies remain, most are being mitigated by business process. Fixing these deficiencies will allow more efficiency, but are not anticipated to impact caseload. Responses to specific questions related to RI Bridges operations are provided in **Attachment 8**.

[4] The November CEC forecast is a proxy of the conferees' estimate based on a comparison of EOHHS' testimony and final budget adopted by November CEC. To recalibrate its original caseload assumptions, EOHHS assumed that any additional dollars appropriated to Medicaid, by budget line, impacted capitation payments, and EOHHS calculated the number of additional member months funded by dividing marginal change by the composite PMPM assumed in EOHHS' original testimony. For example, the conferees provided an additional $3.5 million compared to EOHHS' testimony for Managed Care. With a composite PMPM in RIte Care Core of $234, these additional revenues supported 14,950 member-months in FY 2018. These member months were then distributed through the second half of the fiscal year. A similar calculation was done for FY 2019, with distribution of any additional member months evenly across the entire fiscal year.

Figure I-1. November CEC Adopted Compared to Current Forecast, FY 2017 – FY 2019



Distribution of Growth as a Mitigating Factor on the Fiscal Impact of Caseload Growth

Given the unanticipated caseload growth, the relatively modest change to Medicaid's overall financial position may be surprising, particularly the minimal General Revenue deficit even after incorporating the favorable fiscal impact of CHIP reauthorization (i.e., a 0.2% increase in expenditures over Nov CEC compared to a 2.1% increase in caseload). This incongruity is due, in part, to the fact that the increased capitation payments are offset by various favorable changes to EOHHS' Medical Benefits budget, including: reduced expenditures associated with the moratorium on the Health Insurer Fee; a general improvement in the health plans' Risk Share performance, and; General Revenue relief provided by increased CHIP claiming and further maximizing of expenditures attributed to Expansion.

Most importantly, however, is the nature of the caseload increases across the different eligibility groups. Specifically, the direct fiscal impact of the caseload increase on the State is significantly mitigated by the fact that most growth occurred among the Medicaid Expansion eligible group followed by growth among Children and Families enrolled in RIte Care Core. With respect to the former eligibility group, Rhode Island benefits from generous federal financial participation, averaging 94.5% in FY 2018, that limits the State's share of the composite capitation rate to $28 PMPM (see **Table V-4** in **Medicaid Expansion** section). And among RIte Care Core membership, the composite PMPM is comparatively low at $259 PMPM in FY 2018 (see **Table II-7** in **Managed Care** section), with an effective state cost of $126 PMPM after federal claiming. Further, if the caseload growth occurred among the CHIP population—which coincidentally experienced significant growth—the marginal state cost could be as little as $25 PMPM after application of the enhanced FMAP rate of 88.94%.

Furthermore yet, offsetting the caseload increases within these two groups was a slight reduction among Children with Special Healthcare Needs and Aged, Blind and Disabled enrolled in Rhody Health Partners. Compared to the low general revenue outlays for Expansion and RIte Care Core, RIte Care CSHCN and Rhody Health Partners are comparatively expensive. For example, after federal financial participation, CSHCN and RHP cost an average of $473 and $686 PMPM, respectively. Therefore, for every 1-person reduction in CSHCN or RHP, the State could alternatively finance coverage for between 16 and 25 newly enrolled Expansion members or between 4 and 28 Core members (the latter being the case if the newly eligible Core members were CHIP-eligible) without a significant change in overall state spending.

Table I-3 quantifies the distribution of the caseload change compared to Nov CEC. The caseload impact is further generalized in Price-Volume comparisons included in the subsequent sections for **Managed Care**, **Rhody Health Partners**, **Rhody Health Options**, and **Expansion.**

Table I-3. Distribution of Caseload Changes Compared to November CEC, FY 2018 and FY 2019

	FY 2018:				FY 2019:			
	Nov CEC	Current	Change	% of Overall Increase	Nov CEC	Current	Change	% of Overall Increase
Expansion	72,708	77,465	4,757	74.0%	70,329	79,191	8,862	54.9%
Children and Families	165,888	167,482	1,594	24.8%	163,574	169,438	5,864	36.3%
Children with Special Healthcare Needs	12,716	12,630	(86)	-1.3%	12,647	12,835	187	1.2%
Aged, Blind and Disabled	53,627	53,789	162	2.5%	53,738	54,977	1,239	7.7%
Rhody Health Options	24,743	25,038	295	4.6%	24,813	25,975	1,162	7.2%
Rhody Health Partners	15,406	15,171	(235)	-3.7%	15,399	15,315	(84)	-0.5%
PACE	293	298	5	0.1%	305	307	2	0.0%
Remaining in FFS	13,185	13,281	96	1.5%	13,221	13,380	159	1.0%
Total	304,939	311,367	6,428	100.0%	300,288	316,440	16,152	100.0%

SFY 2019 Trend Development

The caseload growth is attributed to higher than anticipated enrollments through March 2018 and an application of EOHHS' revised trend through remainder of current fiscal year and entirety of FY 2019. Compared to the flat or negative trends assumed in EOHHS' November testimony, EOHHS' current estimate reflects a composite trend of approximately 2.7% annualized.

Rhode Island does not have sufficiently reliable and consistent experience to support the application of a regression analysis or cyclical time series to develop caseload trends from actual experience. Instead, EOHHS has derived its trends by examining and averaging EOHHS' experience during four discrete moments over the past three fiscal years.

Figure I-2 presents overall Medicaid enrollment from January 2013 through March 2018 and imposes natural breaks on the data that represent exogenous shocks to Medicaid eligibility. For example, prior to the implementation of the Affordable Care Act, Rhode Island experienced remarkably stable trends month-over-month. The growth during the first 18 months following implementation can be largely, but not exclusively, attributed to the newly eligible Medicaid Expansion population as well as the Welcome Mat effect among our Children and Families. Then, beginning in FY 2016, as Phase I of RI Bridges stabilized and EOHHS resumed redeterminations for MAGI-based membership, overall caseload stabilized, even as RHP and RHO continued to increase as a result of the elimination of Connect Care Choice and apparent transition of members from fee-for-service into managed care. This stability was subsequently disrupted in June 2016 with the implementation of the second phase of Rhode Island's integrated eligibility system. More recently, through the concerted effort by EOHHS operational staff and EOHHS' subcontractors, and improvements within RI Bridges, that growth was reversed in the first half of the current fiscal year, finally reaching a new potential level of stability over the latest quarter.

EOHHS trends are derived by averaging the annualized trends of the four discrete periods identified in **Figure I-2**: the period of stability with RI Bridges Phase I; the period of instability and growth following implementation of RI Bridges Phase II; the period of focused efforts on resolving terminations backlog; and the current period.

Although the figure presents Medicaid caseload in the aggregate, the trends were developed for each of our major eligibility groups based on the trend amongst the members enrolled in managed care. The exceptions to this selection criteria were for Rhody Health Partners and Rhody Health Options that used the overall trend exhibited by all Aged, Blind and Disabled eligible members.

Table I-4 summarizes the historical annualized trends by group and period as well as the selected trend calculated by averaging the most recent four periods. These selected trends are applied linearly from April 2018 forward. For example, with respect to its RIte Care Core enrolled forecast, EOHHS' current forecast assumes linear growth equivalent to 2.6% annualized. Compared to no growth in SFY 2019, this trend will increase total enrolled by 4,183 members between June 2018 and June 2019 and result in 27,082 additional member months of paid coverage. With a composite PMPM of $272.68, the cost associated with the caseload increase is anticipated to be $7.4 million holding all else constant.

The overall consequence of these trends is that, by June 2019, EOHHS forecasts total Medicaid caseload of 320,264, a 2.7% increase or 10,613-member increase over June 2018.

Figure I-2. Historical Month-End Caseload (Full Medical Assistance Only), January 2013 through March 2018

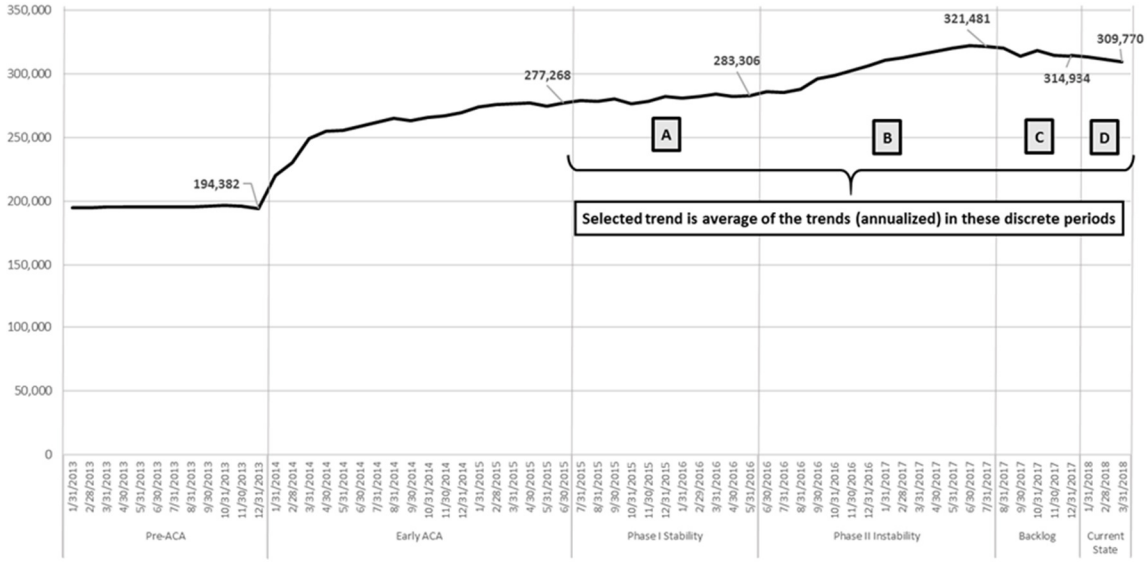


Table I-4. Historical Caseload Trends and Selected Caseload Assumptions

Period	Core	CSHCN	Expansion	RHP	RHO	ABD Eligible
Pre-ACA	0.2%	0.8%	n/a	2.1%	n/a	0.2%
Early ACA	11.3%	2.6%	n/a	1.1%	103.9%	-4.7%
UHIP Phase I Stable	3.1%	-2.1%	-0.5%	6.7%	23.5%	-0.1%
UHIP Phase II Implementation	11.0%	11.6%	19.1%	-0.9%	9.5%	5.0%
Backlog Terminations	-2.8%	-0.1%	-10.4%	7.1%	8.8%	4.7%
Current State	-0.8%	-0.8%	5.8%	-2.5%	11.1%	-1.6%
Selected Trend[1]	**2.6%**	**2.2%**	**3.5%**	**2.6%**	**13.2%**	**2.0%**

Note:

1. Selected trend based on average Phase I through Current State trends (annualized).

Sensitivity Analysis Applied to Selected FY 2019 Trends

To assist the conferees in revising EOHHS' assumptions if desired, EOHHS has calculated the marginal impact of a change to its underlying trend assumptions by budget line.

The impact of a one percentage point change to EOHHS' selected trends is quantified in **Table I-5**. For example, if the conferees retain the assumption of linear growth, then each percentage point change to the FY 2019 trend assumption for RIte Care Core will contribute a +/- 854 change in the number of average enrollees. If these

members reflect a similar distribution across pay levels to the status quo, the fiscal impact would be $2.6 million All Funds or $1.22 million General Revenue in FY 2019.

However, please note that the calculated fiscal impact reflects only the change to capitation payments paid to the health plans. Were a lower or higher caseload trend to be realized, the true fiscal impact would be determined by the mix of the affected population as well as the corollary impact that a change in caseload would have upon risk share, stop loss, DRE, and other dependent expenditures. However, none of these other identified expenditures are likely to be as sensitive to caseload changes as are EOHHS' monthly capitation payments to the health plans, and so their fiscal impact is ignored.

Table I-5. Impact of a One Percentage Point Change in Caseload, SFY 2019, by Enrolled Group

Enrolled Members:	Additional Members	Increase in Average Enrollment	All Funds Impact	General Revenue Impact
Core	4,183	2,257	$2.56 M	$1.22 M
Children with Special Healthcare Needs	119	119	$0.65 M	$0.31 M
Expansion	1,415	1,415	$2.39 M	$0.16 M
Rhody Health Partners	161	161	$1.43 M	$0.68 M
Rhody Health Options	274	274	$2.08 M	$0.99 M
Total	2,260	1,535	$9.13 M	$3.37 M

E. HIF Moratorium

On January 22, 2018 Congress passed (and the President signed) a law that continued funding federal government activity and addressed certain taxes and fees established under the Affordable Care Act, including a new moratorium on the collection of the Health Insurer Fee (HIF) imposed under Section 9010 of the ACA that will be applied to 2019.

The 2019 moratorium has no effect on the filing obligation and fee amounts for the 2018 fee year. However, as EOHHS funded this liability in CY 2017 it will be recouping against the health plans for any funding of this fee in the second half of FY 2018. Additionally, no HIF will be included in the rate development for FY 2019.

The savings attributed to HIF moratorium are summarized, by fiscal year, in **Table I-6**.

Table I-6. Fiscal Impact of Moratorium on Federal Health Insurer Fee

	FY 2018	FY 2019
RIte Care Core	$2.52 M	$5.44 M
RIte Care CSHCN	$0.37 M	$0.76 M
RIte Smiles	$0.35 M	$0.74 M
Rhody Health Partners	$1.95 M	$4.04 M
Expansion	$3.10 M	$6.18 M
Total Savings	$8.28 M	$17.16 M
General Revenue Savings	*$2.69 M*	*$5.64 M*

These savings are fully reflected in EOHHS' revised estimate and the calculation of total capitation payments for FY 2018 and FY 2019, including the necessary accrual for the anticipated recoupment against actual payments made in January through March 2018.

Consistent with generally accepted actuarial guidelines, EOHHS intends to continue to recognize the liability that the HIF imposes on our health plans. This is consistent with EOHHS' funding of Rhode Island's broad-based premium tax. However, as part of the simplification of its financial arrangements with the Health Plans, EOHHS is

planning to transition from the prospective payment of our Health Plan's estimated HIF liability to a retroactive settlement of their actual payment. Both approaches are consistent with CMS guidance. However, the interaction of the one-year federal moratorium on the collection of the HIF and this latter change to EOHHS' payment methodology will provide budgetary relief from the HIF until at least FY 2021, as the next possible payment is expected to be due in September 2020 based on CY 2019 premiums.

F. Higher Drug Rebate and J-Code Collections

Total drug rebate for FY 2018 are up over November CEC: $132.8 million (net of the quarterly rebate offsets) compared to $131.8 million. However, the General Revenue savings associated with these rebates are down by $2.2 million. This discordant change is because much of the growth being driven by increased prescriptions costs has been seen among the Medicaid Expansion eligible population. A similar pattern is demonstrated in FY 2019.

With respect to its current estimates, EOHHS continues to calculate its pharmacy rebates by examining historical rebates in relation to concurrent enrollment and calculating a PMPM rebate value by budget line. In the past this PMPM was discounted by 2% and then multiplied against EOHHS' enrollment forecast to derive a fiscal year estimate; however, consistent with the Nov CEC methodology, EOHHS has not discounted the figure for its revised forecast.

Table I-7 summarizes EOHHS' current pharmacy and J-Code estimates for FY 2018 and FY 2019. These expenditure offsets are reflected in the appropriate budget lines. Despite increasing rebates across both fiscal years, the proportion of rebates for Expansion- and CHIP-eligible contributes to deficits of $2.2 million GR and $0.7 million GR over Nov CEC targets for SFY 2018 and SFY 2019, respectively.

Table I-7. Summary of Drug Rebate Collections

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
DRE								
Managed Care	$ (35,670,511)	$ (35,242,657)	($0.4) M	$ (35,040,564)	$ (36,197,648)	$1.2 M	($1.0) M	2.7%
Rhody Health Partners	$ (36,021,024)	$ (36,456,662)	$0.4 M	$ (36,101,900)	$ (36,920,163)	$0.8 M	($0.5) M	1.3%
Rhody Health Options	$ (2,480,818)	$ (2,443,429)	($0.0) M	$ (2,487,140)	$ (2,469,834)	($0.0) M	($0.0) M	1.1%
Expansion	$ (39,527,971)	$ (45,487,399)	$6.0 M	$ (38,164,692)	$ (45,187,789)	$7.0 M	$0.3 M	-0.7%
Fee-for Service	$ (7,954,444)	$ (7,807,145)	($0.1) M	$ (8,182,643)	$ (7,855,888)	($0.3) M	($0.0) M	0.6%
Subtotal DRE	$ (121,654,768)	$ (127,437,292)	$5.8 M	$ (119,976,939)	$ (128,631,323)	$8.7 M	($1.2) M	0.9%
J-Code								
Managed Care	$ (3,938,571)	$ (1,745,457)	($2.2) M	$ (3,869,015)	$ (2,395,778)	($1.5) M	($0.7) M	37.3%
Rhody Health Partners	$ (1,739,027)	$ (1,623,479)	($0.1) M	$ (1,742,932)	$ (1,634,275)	($0.1) M	($0.0) M	0.7%
Rhody Health Options	$ (1,835,259)	$ (549,019)	($1.3) M	$ (1,839,936)	$ (869,818)	($1.0) M	($0.3) M	58.4%
Expansion	$ (2,746,272)	$ (2,313,061)	($0.4) M	$ (2,651,556)	$ (2,438,332)	($0.2) M	($0.1) M	5.4%
Fee-for Service	$ (1,740,000)	$ (1,175,000)	($0.6) M	$ (1,740,000)	$ (1,175,000)	($0.6) M	$0.0 M	0.0%
Subtotal J-Code	$ (11,999,129)	$ (7,406,017)	($4.6) M	$ (11,843,439)	$ (8,513,203)	($3.3) M	($1.1) M	14.9%
Total Rebates	$ (133,653,897)	$ (134,843,309)	$1.2 M	$ (131,820,378)	$ (137,144,527)	$5.3 M	($2.3) M	1.7%
Quarterly Rebate Offset Amount (QROA) - 100% State Only								
Subtotal QROA	$ 1,864,532	$ 1,978,036	($0.1) M	$ 1,864,532	$ 2,076,938	($0.2) M	$0.1 M	5.0%
Total Rebates net of QROA	$ (131,789,365)	$ (132,865,273)	$1.1 M	$ (129,955,846)	$ (135,067,589)	$5.1 M	($2.2) M	1.7%
General Revenue	***$ (43,346,085)***	***$ (41,168,675)***	($2.2) M	***$ (42,678,035)***	***$ (41,957,495)***	($0.7) M	($0.8) M	1.9%

G. FY 2018 Budget Initiatives and Undistributed Savings

EOHHS has achieved most of Medicaid's FY 2018 budget initiatives as well as the initiatives undertaken by EOHHS as a part of Department of Administration's undistributed savings target. A summary of the agency's performance against each initiative's respective target is presented in **Table I-8**.

Of note, EOHHS received federal approval to support the Recovery Navigation Program effective April 2018. This program funds a community-based, non-residential, short-term, recovery-oriented environment, that connects Medicaid beneficiaries with a chronic/severe alcohol use disorder with resources such as detox, treatment, and recovery services. After being eliminated as a state-only program in mid-October 2017, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) found alternative (non-state) funding to continue supporting this program through March 2018. Because these expenditures will be eligible for regular federal financial participation, EOHHS will resume payment for the service and has allocated new expenditures of $105,500 and $422,000 in FY 2018 and FY 2019 within Other Services. See responses to conferee questions in **Attachment 8** for more information.

Consistent with Governor's FY 2018 Revised and FY 2019 Recommend, EOHHS recommends additional savings that are not reflected in this document; these reductions include elimination of state-only funded contracts (i.e., Cortical Integrated Therapy, Community Health Teams Rhode Island, and Housing Stabilization Program), Graduate Medical Education, and the Perry-Sullivan Appropriation, which has been reallocated to fund the home care wage increase. Except for the costs attributed to the elimination of certain state-only Medical programs that were similarly included in Nov CEC, these savings are not included in this document because EOHHS' caseload testimony accords to current law, but they are summarized in **Table I-9**.

Table I-8. Summary of FY 2018 Budget Initiatives

	FY 2018:			FY2019:		
	Nov CEC	Current	Surplus/ (Decifit) from Nov	Nov CEC	Current	Surplus/ (Decifit) from Nov
FY 2018 Medicaid Budget Initiatives:						
Home Health Care Workers	$ 1,879,539	$ 1,879,539	$0.0 M GR	$ 2,506,052	$ 2,506,052	$0.0 M GR
Enhanced Recoveries	$ (250,000)	$ (250,000)	$0.0 M GR	$ (250,000)	$ (250,000)	$0.0 M GR
FQHC payments	$ (988,807)	$ -	($1.0) M GR	$ (983,507)	$ -	($1.0) M GR
Performance Goal Program	$ (1,489,603)	$ (1,489,603)	$0.0 M GR	$ (1,452,400)	$ (1,452,400)	$0.0 M GR
Managed Care Provider Incentive Program	$ (1,467,857)	$ (1,467,857)	$0.0 M GR	$ (1,467,857)	$ (1,467,857)	$0.0 M GR
Improve Program Integrity	$ (492,100)	$ (492,100)	$0.0 M GR	$ (492,100)	$ (492,100)	$0.0 M GR
Increased CHIP Claiming	$ (3,616,650)	$ (8,316,650)	$4.7 M GR	$ -	$ -	$0.0 M GR
Managed Care Rate Reduction	$ (2,675,393)	$ (2,675,393)	$0.0 M GR	$ (2,623,161)	$ (2,623,161)	$0.0 M GR
Nursing Home Rate Freeze	$ (5,276,737)	$ (5,276,737)	$0.0 M GR	$ (5,173,719)	$ (5,173,719)	$0.0 M GR
Children's Health Account Threshold	$ (3,059,268)	$ (3,059,268)	$0.0 M GR	$ (3,059,268)	$ (3,059,268)	$0.0 M GR
Transportation Funding Initiative	$ (437,940)	$ (437,940)	$0.0 M GR	$ (314,886)	$ (314,886)	$0.0 M GR
Subtotal	$ (17,874,817)	$ (21,586,009)	$3.7 M GR	$ (13,310,845)	$ (12,327,339)	($1.0) M GR

Table I-9. Summary of FY 2018 Undistributed Savings and Carry-Forward Impact on FY 2019

	FY 2018:			FY2019:		
	Nov CEC	Current	Surplus/ (Decifit) from Nov	Nov CEC	Current	Surplus/ (Decifit) from Nov
FY 2018 Undistributed Savings						
CHIP federal extension		$ (7,017,212)	$7.0 M		$ (28,516,524)	$28.5 M
Perry Sullivan Appropriation		$ (3,016,920)	$3.0 M		$ (2,958,020)	$3.0 M
State-Only: Cortical Integrated Therapy		$ (765,000)	$0.8 M		$ (1,000,000)	$1.0 M
State-Only: Other Reductions[1]	$ 142,483	$ (116,452)	$0.3 M	$ (641,120)	$ (439,784)	($0.2) M
Eliminate GME[2]		$ (4,000,000)	$4.0 M		$ (2,500,000)	$2.5 M
Subtotal		$ (14,915,584)	$15.1 M		$ (35,414,328)	$34.8 M

Note

1. Nov CEC already incorporated costs/savings associated with elimination of certain State Only programs.
2. FY 2018 undistributed savings target assumes elimination of GME. The FY 2019 Gov Recommend includes $1.5 million GR funding toward GME.

H. Accountable Entities and Health Systems Transformation Project

In October 2016, CMS approved an amendment to RI Medicaid's 1115 Waiver, bringing up to $129.8 million in federal participation to Rhode Island from November 2016 to December 2020. The Health System Transformation Project's source of funding is based on the establishment of a Health Workforce Partnership with our three public higher education institutions. The project's uses of funding are restricted to the establishment of new ways of paying for and delivering healthcare through newly-formed provider networks called Accountable Entities (AE).

Accountable Entities will substantially transition payment for Medicaid services away from fee-for-service models to models that incentivize providers and insurers to deliver coordinated, accountable care for all, with targeted support for high-cost/high need populations. They are designed to better address the population health needs of Medicaid recipients, with special consideration given to behavioral health services and to the social determinants of health.

To date and in alignment with the State Innovation Model (SIM), we have received CMS approval for the HSTP Roadmap, which includes guidelines for assessing AEs' performance on established metrics. We are currently reviewing applications and certifying six entities that have applied to become AEs. These AEs are expected to amend contracts with the State's MCOs starting in July 2018. The FY 2019 budget includes $22.6 million in incentive-based funding for the infrastructure that is required to transition MCOs and provider networks to this new model of care. Medicaid managed care plans can receive incentive payments for deliverables such as contracting with AEs and for reporting to EOHHS on AE enrollment, operations, quality and finance. AEs can receive incentive payments for performance against milestones such as contracting with MCOs, achieving specific project milestones, and for reporting on outcome metrics.[5]

I. Medicaid Expenditures by Type of Service

A breakdown of all Medicaid expenditures by type of service for FY 2018 and FY 2019 will be provided to conferees in the Excel Workbook.[6] This analysis proxies claims experience by allocating all managed care expenditures to

[5] While not part of the Medical Benefits budget of Medicaid, EOHHS has awarded $1.3 million to the institutions of higher education for 11 projects focusing on Health Workforce Transformation in FY18. EOHHS FY 2019 administrative budget includes an additional $2.9 million for the institutes of higher education, including $1.6 million to University of Rhode Island, $700,000 to Rhode Island College, and $600,000 to Community College of Rhode Island.

[6] The Rhode Island Medicaid Annual Expenditure Report is a statutory-required report that reflects Medicaid's benefit expenditures in the prior fiscal year across EOHHS. The Report is not generally published until April or May of each year because of the reconciliation work associated with its underlying data sources that are generally not available until late March.

specific types of service based on the actuarially certified rates for FY 2018 and preliminary rates for FY 2019. This information is used for rebasing certain FY 2019 budget initiatives included in the FY 2019 Governor's Recommend. **Figure I-3** and **Figure I-4** present breakdowns of all forecast expenditures by various types of service for FY 2018 and FY 2019, respectively.

Figure I-3. FY 2018 Medical Benefits Expenditures by Type of Service, excluding HSTP/Special Education

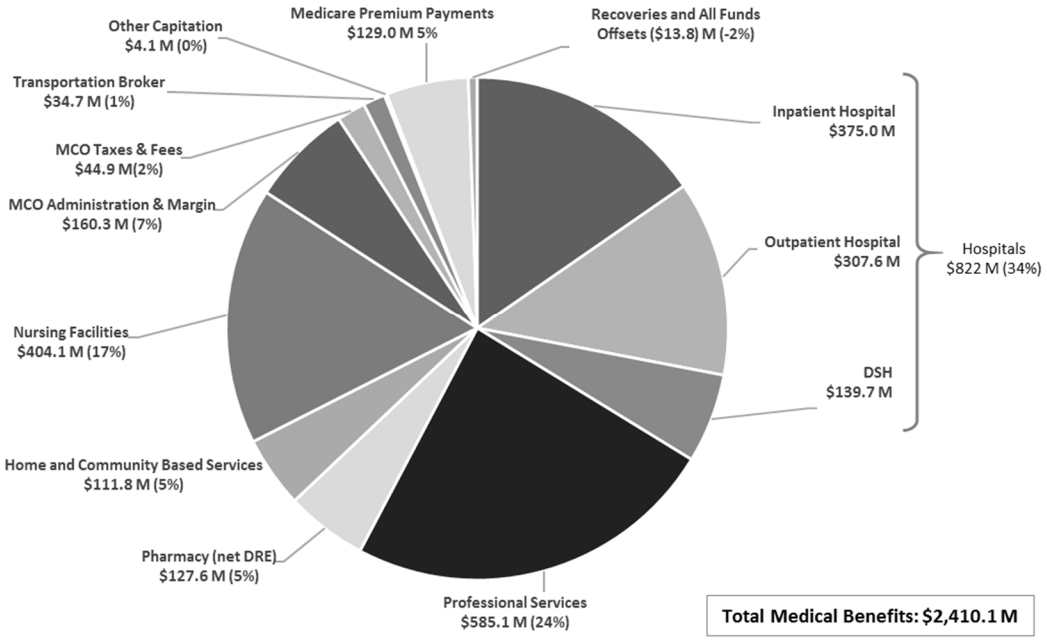
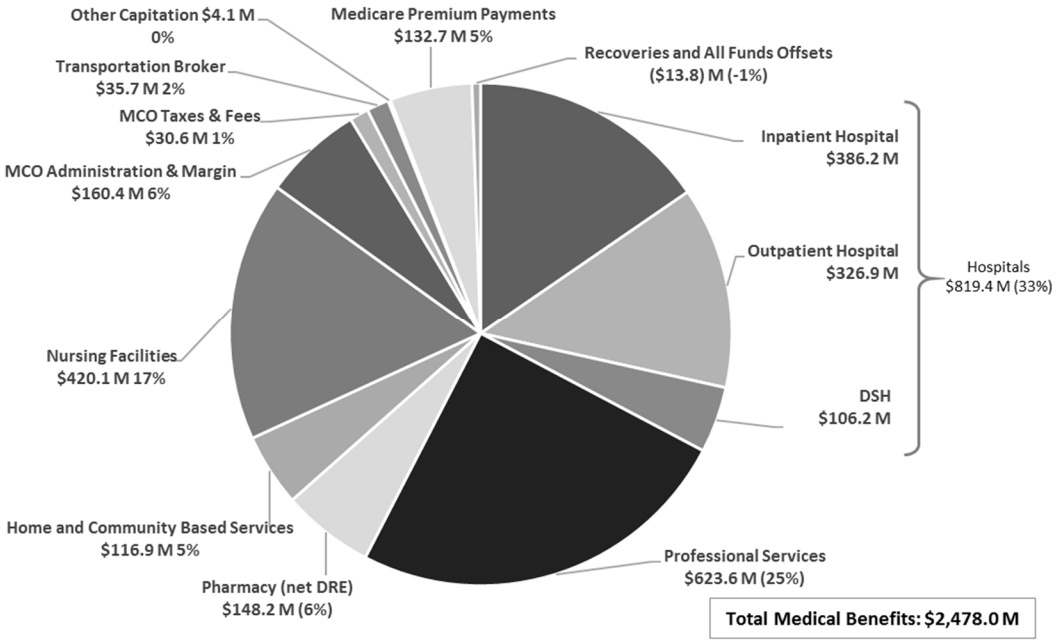


Figure I-4. FY 2019 Medical Benefits Expenditures by Type of Service, excluding HSTP/Special Education



At the request of the conferees, additional information is provided in **Attachment 8** with respect to aggregate expenditures by various eligibility populations and treatment groups that spans EOHHS' separate budget lines. This reflects medical expenditures for FY 2017 based on actual claims experience or total capitation payments where applicable, but is not allocated by type of service (with exception of payments for various health home programs); for example, the total costs for SSI or SSI-like individuals could appear in Rhody Health Partners or Rhody Health Options or the various fee-for-service budget accounts. These costs are not adjusted for DRE/J-Code or Risk Share offsets.

II. Managed Care

Managed Care			
FY 2017	Final	$	681,026,614
FY 2018	Enacted	$	690,512,594
	November CEC Adopted	$	713,000,000
	May CEC Testimony	**$**	**717,201,235**
	Deficit over Nov CEC	*$*	*(4,201,235)*
FY 2019	November CEC Adopted	$	753,000,001
	May CEC Testimony	**$**	**760,820,544**
	Deficit over Nov CEC	*$*	*(7,820,543)*

The following tables summarize EOHHS' revised forecasts for Managed Care for FY 2018 and FY 2019:

Table II-1 summarizes all expenditures by capitated payments by product line to the health plans as well as various fee-for-service payments. **Table II-2** and **Table II-3** identify total CHIP and EFP claiming and changes against Nov CEC that provide general revenue savings through enhanced federal claiming.

EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized in **Table II-4** and the forecast for the number of births and NICU stays are presented in **Table II-5**. Additional month-by-month detail is provided in **Attachment 5a** and **Attachment 5b**.

Table II-6 calculates the price and volume related changes between EOHHS' current forecast and the enacted budget for FY 2018 as well as for FY 2019 over FY 2018.

For comparative purposes, the average monthly RIte Care and RIte Smiles capitation rate paid to the Health Plans are summarized in **Table II-7** and **Table II-8**.

Managed Care Highlights – FY 2018

- Overall, the managed care forecast reflects a $4.5 million deficit compared to Nov CEC.
- The primary drivers for the deficit are:
  - a significant increase of 1,219 RIte Care Core enrollees and 3,054 RIte Smiles enrollees
    - after controlling for savings from the federal moratorium on the Health Insurer Fee, this enrollment increase contributes $4.3 million in additional capitation payments to the Health Plans;
  - an upward revision to outstanding liability for FQHC wrap payments in FY 2018 and a $1.6 million under-accrual for prior fiscal year's PPS reconciliation; and
  - lower than anticipated J-Code collections, based on results of the first two quarters of the current fiscal year.
- The increased costs are offset by:
  - a slight reduction in enrollment and significant reduction in the composite costs of RIte Care CSHCN that contribute to $1.1 million surplus, prior to additional savings from HIF moratorium;
  - $2.9 million reduction in liability associated with financing the federal HIF; and
  - a further shift of births paid under Medicaid Expansion and reduction in average cost of a NICU stay reduced SOBRA and NICU expenditures by $2.2 million combined.
- Despite the All Funds deficit, EOHHS forecasts a $9.6 million GR surplus against Nov CEC resulting from the additional General Revenue savings afforded by the reauthorization of CHIP and the higher than anticipated CHIP claiming. Please see the ***CHIP Reauthorization*** section and **Table** II-2 below.

Managed Care Highlights – FY 2019

- Overall, the managed care forecast reflects a $7.8 million deficit.
- However, CHIP reauthorization and further increase in CHIP claiming contribute to an overall surplus of $29.7 million GR (after rebasing for the CHIP reduction assumed in Nov CEC the surplus reduces to $2.7 million GR).
- From an All Funds perspective, and compared to the Nov CEC forecast, the primary driver for the FY 2019 deficit is caseload-driven, with increased enrollment of 6,256 average monthly enrollees in RIte Care Core and 8,244 average monthly enrollees in RIte Smiles.
- While the moratorium on collection of HIF provided $6.9 million relief in FY 2019 against RIte Care Core/CSHCN and RIte Smiles total capitation payments remain $19.5 million higher over Nov CEC.

CHIP Reauthorization

The CHIP reauthorization shifts back to federal funds $7.0 million and $28.0 million in state spending for FY 2018 and FY 2019, respectively. These amounts are reflected in Governor's FY 2018 Revised and FY 2019 Recommend and represented total CHIP claiming of $74.9 million and $76.4 million, respectively.

When measured against these adjusted targets, EOHHS' current forecast further improves CHIP claiming by $12.5 million in FY 2018 and $5.4 million in FY 2019, providing an additional $4.7 million General Revenue and $2.0 million General Revenue relief.

Contributing to the increased CHIP activity was EOHHS' implementation of a change to its eligibility criteria that extends CHIP eligibility down to children aged 1 through 18 in households with incomes as low as 133% of FPL. As a result, EOHHS estimates approximately $800,000 in additional CHIP claiming (equivalent to $300,000 General Revenue relief). Until RI Bridges is updated to prospectively identify these individuals at the time of application, EOHHS staff and consultants will make quarterly adjustments to its federal claiming in accordance with methodology approved by CMS.

Please note that EOHHS' FY 2018 forecast benefits from a one-time savings related to this expanded CHIP eligibility as applied to prior period activity that remains within the two-year CMS filing deadline that overstates the amount that can be carried forward. **Table II-2** details the different factors contributing EOHHS overall CHIP claiming against Medical Benefits. A repurposing of the Performance Goal Program to specifically target the health plan's performance in serving their enrolled children and families reflects a FY 2018 initiative to maximize federal financial participation by leveraging Rhode Island's CHIP administrative allotment to fund activities targeting children and families.

Table II-1. Summary of Managed Care Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC Adopted	Current Forecast	Surplus/ (Deficit)	Nov CEC Adopted	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Payments to Health Plans:								
RIte Care Core	$ 438,740,253	$ 439,959,513	($1.2) M	$ 456,709,303	$ 474,942,602	($18.2) M	$35.0 M	8.0%
RIte Care CSHCN	$ 120,124,848	$ 118,650,028	$1.5 M	$ 126,070,434	$ 120,640,230	$5.4 M	$2.0 M	1.7%
RIte Care SOBRA	$ 48,836,987	$ 48,165,939	$0.7 M	$ 52,022,552	$ 49,290,633	$2.7 M	$1.1 M	2.3%
RIte Smiles	$ 24,368,298	$ 24,971,444	($0.6) M	$ 25,928,060	$ 27,222,351	($1.3) M	$2.3 M	9.0%
Performance Goal Program	$ 3,961,711	$ 3,236,292	$0.7 M	$ 3,891,747	$ 3,295,401	$0.6 M	$0.1 M	1.8%
Risk Share/Stop Loss	$ 9,641,753	$ 10,408,465	($0.8) M	$ 11,810,714	$ 11,848,636	($0.0) M	$1.4 M	13.8%
Subtotal Health Plan Payments	$ 645,673,849	$ 645,391,681	$0.3 M	$ 676,432,811	$ 687,239,853	($10.8) M	$40.4 M	6.5%
Other Payments:								
RIte Share	$ 7,333,408	$ 7,162,804	$0.2 M	$ 6,929,249	$ 6,755,613	$0.2 M	($0.4) M	-5.7%
Premium Assistance Program	$ 225,215	$ 174,505	$0.1 M	$ 286,227	$ 187,251	$0.1 M	$0.0 M	7.3%
Transportation Broker	$ 15,001,489	$ 15,191,678	($0.2) M	$ 14,723,845	$ 15,443,362	($0.7) M	$0.3 M	1.7%
TANF Charge Back	$ (1,969,800)	$ (1,949,280)	($0.0) M	$ (1,969,800)	$ (1,949,280)	($0.0) M	$0.0 M	0.0%
NICU FFS	$ 26,974,092	$ 25,505,096	$1.5 M	$ 27,885,017	$ 26,462,220	$1.4 M	$1.0 M	3.8%
Other FFS	$ 32,343,406	$ 32,129,703	$0.2 M	$ 34,929,847	$ 33,066,397	$1.9 M	$0.9 M	2.9%
EI CNOM	$ 3,413,599	$ 3,324,416	$0.1 M	$ 3,408,473	$ 3,323,424	$0.1 M	($0.0) M	0.0%
FQHC Wrap Payments	$ 24,253,312	$ 27,974,315	($3.7) M	$ 29,825,869	$ 29,319,249	$0.5 M	$1.3 M	4.8%
DRE/J-Code	$ (41,100,636)	$ (38,555,749)	($2.5) M	$ (40,474,092)	$ (40,050,099)	($0.4) M	($1.5) M	3.9%
Overdose Prevention Taskforce	$ 1,030,208	$ 1,030,208	$0.0 M	$ 1,545,312	$ 1,545,312	$0.0 M	$0.5 M	50.0%
BHDDH State Only Transfer	$ 344,615	$ 344,615	$0.0 M	$ -	$ -	$0.0 M	($0.3) M	-100.0%
Miscellaneous	$ (522,758)	$ (522,758)	$0.0 M	$ (522,758)	$ (522,758)	$0.0 M	$0.0 M	0.0%
Subtotal Other Payments	$ 67,326,150	$ 71,809,554	($4.5) M	$ 76,567,189	$ 73,580,691	$3.0 M	$1.8 M	2.5%
Total	$ 713,000,000	$ 717,201,235	($4.2) M	$ 753,000,000	$ 760,820,544	($7.8) M	$43.6 M	6.1%
General Revenue	***$ 323,717,485***	***$ 314,136,719***	***$9.6 M***	***$ 359,787,738***	***$ 330,069,482***	***$29.7 M***	***$15.9 M***	***5.1%***

Table II-2. CHIP Claiming

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC with CHIP[1]	Current Forecast	Increase/ (Decrease)	Nov CEC with CHIP[1]	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Under 8	$ 16,252,989	$ 18,688,544	$2.4 M	$ 17,474,849	$ 18,688,544	$1.2 M	$0.0 M	0.0%
Aged 8+	$ 54,293,089	$ 58,440,117	$4.1 M	$ 53,818,302	$ 59,241,425	$5.4 M	$0.8 M	1.4%
Performance Goal Program	$ 3,961,711	$ 3,236,292	($0.7) M	$ 3,891,747	$ 3,295,401	($0.6) M	$0.1 M	1.8%
Other Adjustments[2]	$ 3,282,114	$ 3,534,840	$0.3 M	$ 4,052,443	$ 3,444,214	($0.6) M	($0.1) M	-2.6%
Prior Period Adjustment[3]		$ 6,236,075	$6.2 M			$0.0 M	($6.2) M	-100.0%
DRE/J-Code	$ (2,877,320)	$ (2,768,938)	$0.1 M	$ (2,826,506)	$ (2,851,131)	($0.0) M	($0.1) M	3.0%
Total CHIP Claiming	$ 74,912,584	$ 87,366,930	$12.5 M	$ 76,410,835	$ 81,818,454	$5.4 M	($5.5) M	-6.4%
Federal Share	$ 66,627,252	$ 77,704,147	$11.1 M	$ 68,471,750	$ 73,317,516	$4.8 M	($4.4) M	-5.6%
State Share	$ 8,285,332	$ 9,662,782	$1.4 M	$ 7,939,086	$ 8,500,937	$0.6 M	($1.2) M	-12.0%
General Revenue Relief	***$ 28,167,131***	***$ 32,849,966***	**$4.7 M**	***$ 28,516,524***	***$ 30,534,647***	**$2.0 M**	**($2.3) M**	**-7.0%**

Notes:

1. November CEC Adopted amount rebased to add dollars associated with reauthorization of CHIP.
2. Adjustments allocate a proportion of Managed Care Risk Share and FQHC Wrap Payments associated with CHIP-eligible members.
3. Reflects adjustment for children in households with incomes between 138 and 155% of FPL. This is a one-time savings associated with prior SFY activity.

Table II-3. EFP Claiming

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
State - General Revenue	$ 730,012	$ 733,120	$0.0 M	$ 755,171	$ 814,946	$0.1 M	$0.1 M	11.2%
Federal - Enhanced	$ 6,570,105	$ 6,598,078	$0.0 M	$ 6,796,542	$ 7,334,513	$0.5 M	$0.7 M	11.2%
All Funds	$ 7,300,117	$ 7,331,198	$0.0 M	$ 7,551,713	$ 8,149,459	$0.6 M	$0.8 M	11.2%
Effective Federal %	90%	90%		90%	90%			
General Revenue Relief	***$ 2,822,066***	***$ 2,834,241***	**$0.0 M**	***$ 2,847,721***	***$ 3,073,161***	**$0.2 M**	**$0.2 M**	**8.4%**

Table II-4. Average Managed Care Caseload

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Enrollment by Delivery System:								
RIte Care Core	156,121	157,340	1,219	153,955	160,211	6,256	2,871	1.8%
RIte Care CSHCN	10,196	10,165	(31)	10,149	10,254	105	89	0.9%
RIte Share	6,564	6,476	(88)	6,255	6,099	(156)	(377)	-5.8%
Remaining in FFS	6,165	6,660	495	6,288	6,270	(18)	(390)	-5.9%
Core	4,341	4,894	553	4,456	4,373	(83)	(521)	-10.7%
CSHCN	1,824	1,766	(58)	1,832	1,897	65	131	7.4%
RIte Smiles	104,299	107,353	3,054	104,299	112,543	8,244	5,190	4.8%
Total[1]	178,604	180,112	1,508	176,221	182,273	6,051	2,160	1.2%

Note:

1. Total excludes RIte Smiles and RIte Share enrolled children or parents whose underlying eligiblity is under Expansion or Aged, Blind and Disabled.

Table II-5. Medicaid Births and NICU Stays

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Births:								
Births	4,794	4,899	105	4,842	4,941	99	42	0.9%
RIte Care	4,332	4,287	(45)	4,374	4,347	(27)	60	1.4%
Expansion	462	612	150	468	594	126	(18)	-2.9%
NICU Stays	540	550	10	543	555	12	5	0.9%
Cost per Birth (SOBRA)	$ 11,275	$ 11,236	*$ (38)*	$ 11,895	$ 11,339	*$ (556)*	$ 103	0.9%
% Expansion	*9.6%*	*12.5%*		*9.7%*	*12.0%*			
Cost per NICU Stay	*$ 49,952*	*$ 46,373*	$ (3,579)	$ 51,354	*$ 47,680*	*$ (3,674)*	$ 1,307	2.8%

Table II-6. Managed Care Price-Volume Comparison

SFY 2018: Current compared to Nov CEC Adopted

	Nov CEC Adopted	Current	Change	% Change	Increase/ (Decrease)
Children and Families					
Price	$ 295.35	$ 296.95	$ 1.60	0.5%	$3.2 M
Volume	165,888	167,482	1,594	1.0%	$5.7 M
Children with Special Healthcare Needs					
Price	$ 819.62	$ 794.39	$ (25.23)	-3.1%	($3.8) M
Volume	12,716	12,630	(86)	-0.7%	($0.8) M

SFY 2019: Current compared to Nov CEC Adopted

	Nov CEC Adopted	Current	Change	% Change	Increase/ (Decrease)
Children and Families					
Price	$ 316.58	$ 312.19	$ (4.39)	-1.4%	($8.6) M
Volume	163,574	169,438	5,864	3.6%	$22.0 M
Children with Special Healthcare Needs					
Price	$ 867.03	$ 818.50	$ (48.52)	-5.6%	($7.4) M
Volume	12,647	12,835	187	1.5%	$1.8 M

May CEC: SFY 2018 compared to SFY 2019

	SFY 2018	SFY 2019	Change	% Change	Increase/ (Decrease)
Children and Families					
Price	$ 296.95	$ 312.19	$ 15.24	5.1%	$31.0 M
Volume	167,482	169,438	1,956	1.2%	$7.0 M
Children with Special Healthcare Needs					
Price	$ 794.39	$ 818.50	$ 24.11	3.0%	$3.7 M
Volume	12,630	12,835	205	1.6%	$2.0 M

Table II-7. Summary of RIte Care Core and CSHCN Monthly Premiums

	SFY 2016[1]	SFY 2017[1]	SFY 2018[1]	SFY 2019[2]	Annualized Trends: FY16 → FY19	FY17 → FY19	FY18 → FY19
RIte Care Core							
MF < 1 y.o.	$ 469.73	$ 463.79	$ 472.85	$ 499.09	2.0%	3.7%	4.7%
MF 1-4 y.o.	$ 151.21	$ 146.23	$ 150.35	$ 151.88	0.1%	1.9%	0.9%
MF 5-14 y.o.	$ 147.19	$ 145.33	$ 149.14	$ 154.72	1.7%	3.2%	3.2%
M 15-44 y.o.	$ 222.89	$ 205.93	$ 208.33	$ 229.57	1.0%	5.6%	8.7%
F 15-44 y.o.	$ 304.13	$ 307.05	$ 309.21	$ 335.58	3.3%	4.5%	7.3%
MF 45+ y.o.	$ 450.35	$ 428.73	$ 431.10	$ 481.09	2.2%	5.9%	9.9%
EFP Only	$ 16.27	$ 10.09	$ 10.11	$ 21.91	10.4%	47.4%	94.0%
SOBRA	$ 10,016	$ 10,984	$ 11,179	$ 11,339	4.2%	1.6%	1.2%
Composite	$ 255.04	$ 253.59	$ 258.53	$ 272.68	2.3%	3.7%	4.7%
RIte Care CSHCN							
Substitute Care	$ 695.46	$ 736.83	$ 770.77	$ 813.79	5.4%	5.1%	4.8%
SSI <15	$ 1,192.75	$ 1,174.54	$ 1,230.48	$ 1,352.50	4.3%	7.3%	8.4%
SSI 15-20	$ 1,010.73	$ 1,030.94	$ 1,083.51	$ 974.02	-1.2%	-2.8%	-8.7%
Katie Beckett	$ 2,577.29	$ 2,568.85	$ 2,775.81	$ 2,970.60	4.8%	7.5%	6.0%
Adoption Subsidy	$ 540.76	$ 528.49	$ 561.83	$ 528.82	-0.7%	0.0%	-5.1%
Composite	$ 941.07	$ 937.57	$ 972.69	$ 980.40	1.4%	2.3%	0.7%

Notes:

1. For comparative purposes, rates reflect non-profit rates to exclude impact of Health Insurer Fee.
   To minimize change to benefits package, the SFY 2016 rates reflect rates effective January 1, 2018.
   The SFY 2017 were in effect from July 1, 2016 through February 28, 2017.
   The SFY 2018 rates for these products were in effect from March 1, 2017 through June 30, 2018.
2. SFY 2019 rates are preliminary.

Table II-8. Summary of RIte Smiles Monthly Premiums

	SFY 2016	SFY 2017	SFY 2018	SFY 2019[1]	Annualized Trends: FY16 → FY19	FY17 → FY19	FY18 → FY19
Rite Smiles							
MF 0-2 y.o.	$ 3.38	$ 3.63	$ 4.11	$ 4.82	12.5%	15.2%	14.6%
MF 3-5 y.o.	$ 15.84	$ 16.75	$ 17.53	$ 17.47	3.3%	2.1%	-0.3%
MF 6-10 y.o.	$ 21.40	$ 21.80	$ 23.72	$ 23.58	3.3%	4.0%	-0.5%
MF 11-14 y.o.	$ 28.61	$ 27.15	$ 27.01	$ 25.90	-3.3%	-2.3%	-3.5%
MF 15 y.o.	$ 28.61	$ 27.15	$ 20.83	$ 25.90	-3.3%	-2.3%	20.5%
MF 16+ y.o.	$ 28.61	$ 27.15	$ 20.83	$ 21.70	-8.8%	-10.6%	3.6%
MF 17	$ -	$ -	$ 20.83	$ 21.70	*n/a*	*n/a*	4.2%
MF 18	$ -	$ -	$ 20.83	$ 21.70	*n/a*	*n/a*	4.2%
Composite	$ 18.83	$ 19.14	$ 19.38	$ 20.16	2.3%	2.6%	3.4%

Notes:

1. SFY 2019 rates are preliminary.

III. Rhody Health Partners

Rhody Health Partners			
FY 2017	Final	$	237,877,888
	Adjusted Final [1]	$	228,428,496
FY 2018	Enacted	$	236,298,335
	November CEC Adopted	$	243,900,000
	May CEC Testimony	**$**	**233,374,687**
	Surplus over Nov CEC	*$*	*10,525,313*
FY 2019	November CEC Adopted	$	259,200,000
	May CEC Testimony	**$**	**249,096,870**
	Surplus over Nov CEC	*$*	*10,103,130*

Note:

[1] "Adjusted Final" for FY 2017 reflects the transfer of $13.6M from RHP to Other Services (for BH-related expenditures for members remaining in FFS) and $4.1M from Other Services to RHP (for transportation expenditures for members enrolled in RHP)

The following tables summarize EOHHS' revised forecasts for Rhody Health Partners for FY 2018 and FY 2019. **Table III-1** summarizes all expenditures by capitated payments by product line to the health plans as well as various fee-for-service payments, and **Table III-3** calculates the price and volume related changes between EOHHS' current forecast and the enacted budget for FY 2018 as well as for FY 2019 over FY 2018.

The average monthly RHP capitation rate, by pay level, is summarized in **Table III-4** and can be found in **Attachment 7a**.

EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized **Table III-2**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**.

Rhody Health Partners Highlights – FY 2018

A reduction in both volume and average price contribute to a $10.5 million surplus against Nov CEC.

- A decrease in capitation payments of $5.1 million is due primarily to enrollment of 235 fewer members compared to Nov CEC, but also to the $2.0 million savings in the second half of FY 2018 for the HIF moratorium.
    - For example, with a monthly premium of $1,319 PMPM for SSI-eligible members aged 45 or older, the 141-member reduction provides $2.2 million in reduced capitation. This is equivalent to the cost of insuring nearly 1,000 children under 19 in RIte Care.
- The unanticipated performance of the Health Plans has led to a decrease in Risk Share expenses—Regular and Separate Behavioral Health—totaling $5.2 million, including the effect of a favorable accrual from FY 2017.

Rhody Health Partners Highlights – FY 2019

This favorable position carries forward into FY 2019, with price and volume reductions providing a $10.1 million surplus.

- A decrease in capitation payments of $11.9 million due to reduced enrollments and a modest price decrease when compared to Nov CEC estimates; the moratorium on HIF contributes $4.0 million of the latter savings.
- EOHHS is offsetting the modest PMPM increase in capitation with a significant increase in anticipated payments for Risk Share and Hepatitis C, both compared to FY 2018 and the Nov CEC estimate for FY 2019

Table III-1. Summary of RHP Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Capitation Payments	$ 261,865,875	$ 256,775,911	$5.1 M	$ 276,113,600	$ 264,226,018	$11.9 M	$7.5 M	2.9%
Performance Goal Program	$ 420,398	$ 364,107	$0.1 M	$ 421,342	$ 367,559	$0.1 M	$0.0 M	0.9%
Risk Share/Stop Loss	$ 14,933,883	$ 9,726,042	$5.2 M	$ 16,067,172	$ 18,392,544	($2.3) M	$8.7 M	89.1%
Transportation Broker	$ 4,245,241	$ 4,180,708	$0.1 M	$ 4,254,345	$ 4,201,781	$0.1 M	$0.0 M	0.5%
DRE/J-Code	$ (37,760,051)	$ (38,080,140)	$0.3 M	$ (37,844,832)	$ (38,554,438)	$0.7 M	($0.5) M	1.2%
RHP FFS	$ 194,654	$ 408,059	($0.2) M	$ 188,374	$ 463,406	($0.3) M	$0.1 M	13.6%
Total	$ 243,900,000	$ 233,374,687	$10.5 M	$ 259,200,000	$ 249,096,870	$10.1 M	$15.7 M	6.7%
General Revenue	***$ 119,373,375***	***$ 114,301,972***	$5.1 M	***$ 124,390,537***	***$ 119,623,058***	$4.8 M	$5.3 M	4.7%

Table III-2. RHP Average Enrollment

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Enrolled Caseload								
SSI 21-44 y.o.	3,902	3,838	(64)	3,898	3,865	(33)	27	0.7%
SSI 45+ y.o.	7,668	7,527	(141)	7,671	7,572	(99)	45	0.6%
SPMI	2,889	2,853	(36)	2,887	2,895	9	43	1.5%
ID/DD	947	954	7	944	983	39	29	3.0%
Total	15,406	15,171	(235)	15,399	15,315	(84)	144	0.9%

Table III-3. RHP Price-Volume Comparison to November CEC

SFY 2018: Current compared to Nov CEC Adopted

	Nov CEC	Current	Change	% Change	Increase/ (Decrease)
Price	$ 1,319.29	$ 1,285.90	$ (33.39)	-2.5%	($6.2) M
Volume	15,406	15,171	(235)	-1.5%	($3.6) M

SFY 2019: Current compared to Nov CEC Adopted

	Nov CEC	Current	Change	% Change	Increase/ (Decrease)
Price	$ 1,402.69	$ 1,355.41	$ (47.28)	-3.4%	($8.7) M
Volume	15,399	15,315	(84)	-0.5%	($1.4) M

May CEC: SFY 2018 compared to SFY 2019

	SFY 2018	SFY 2019	Change	% Change	Increase/ (Decrease)
Price	$ 1,285.90	$ 1,355.41	$ 69.51	5.4%	$12.8 M
Volume	15,171	15,315	144	0.9%	$2.2 M

Table III-4. RHP Monthly Premiums

	SFY 2016[1]	SFY 2017[1]	SFY 2018[1]	SFY 2019[2]	Annualized Trends: FY16 → FY19	FY17 → FY19	FY18 → FY19
Rhody Health Partners							
SSI 21-44 y.o.	$ 895.02	$ 902.49	$ 920.36	$ 920.76	0.9%	1.0%	0.0%
SSI 45+ y.o.	$ 1,298.13	$ 1,291.10	$ 1,319.20	$ 1,408.38	2.8%	4.4%	5.8%
SPMI	$ 2,306.66	$ 2,282.97	$ 2,331.43	$ 2,339.40	0.5%	1.2%	0.3%
ID/DD	$ 992.37	$ 1,090.93	$ 1,120.07	$ 1,040.45	1.6%	-2.3%	-6.1%
Composite	$ 1,373.71	$ 1,390.40	$ 1,410.44	$ 1,437.73	1.5%	1.7%	1.7%

Notes:

1. For comparative purposes, rates reflect non-profit rates to exclude impact of Health Insurer Fee.
   To minimize change to benefits package, the SFY 2016 rates reflect rates effective January 1, 2018.
   The SFY 2017 were in effect from July 1, 2016 through February 28, 2017.
   The SFY 2018 rates for these products were in effect from March 1, 2017 through June 30, 2018.
2. SFY 2019 rates are preliminary.

IV. Rhody Health Options

Rhody Health Options			
FY 2017	Final	$	345,803,444
	Adjusted Final [1]	$	352,215,263
FY 2018	Enacted	$	355,304,108
	November CEC Adopted	$	367,600,000
	May CEC Testimony	**$**	**373,029,835**
	Deficit over Nov CEC	*$*	*(5,429,835)*
FY 2019	November CEC Adopted	$	386,000,000
	May CEC Testimony	**$**	**396,795,140**
	Deficit over Nov CEC	*$*	*(10,795,140)*

Note:
[1] "Adjusted Final" for FY 2017 reflects the transfer of $6.4M from Other Services RHO (for transportation expenditures for members enrolled in RHP)

The following tables summarize EOHHS' revised forecasts for Rhody Health Options for FY 2018 and FY 2019. **Table IV-1** summarizes all expenditures by capitated payments by product line to the health plans as well as various fee-for-service payments and **Table IV-3** calculates the price and volume related changes between EOHHS' current forecast and the enacted budget for FY 2018 as well as for FY 2019 over FY 2018.

The average monthly Rhody Health Option capitation rates, by pay level, are summarized in **Table IV-4.** Per the conferees' request, additional payments to the health plans in the form of Risk Share are presented in **Table IV-5.**

EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized in **Table IV-2**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**.

Rhody Health Options Highlights – FY 2018

The overall Rhody Health Options estimate shows a net increase in expenses of $5.4 million in FY 2018, driven by $4.4 million due to increased caseload of 295 average enrollees over Nov CEC and $1.0 million attributed to a $3.48 increase in net average monthly cost per member.

The primary drivers of these increases are:

- An increase in capitation payments of $4.5 million, due primarily to increase in the number of Community Non-LTSS membership following the elimination of the Community Health Team program and transition of members in fee-for-service.
    - $0.8 million of this increase is due to a recognition by EOHHS of its outstanding liability for a Quality Withhold accrual that was inadvertently not included in Nov CEC.
- A decrease in J-Code rebates of $1.3 million.

Rhody Health Options Highlights – FY 2019

The overall Rhody Health Options forecast reflects an increase in expenses of $10.8 million, primarily attributed to the 1,162 additional enrollees associated with the growth experienced in the second half of FY 2018. Change in caseload volume contribute $17.7 million in additional costs compared to a $6.9 million reduction for reduced per-member price.

The primary drivers of this increase are:

- An increase in capitation payments of $12.3 million primarily due to an increase in volume in Community Non-LTSS membership.
- This caseload increase is offset by a decrease in composite price of $6.9 million that results from a change in the expected mix of the enrolled membership.
- EOHHS has recently just started rate development for Rhody Health Options I/II and so the rates reflect a 4.0% composite price increase compared to existing rates, albeit with increasing savings taken against the RHO Phase II payments per CMS requirements of the Integrated Care Initiative.

Table IV-1. Summary of Rhody Health Options Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Rhody Health Options I/II	$ 350,575,337	$ 354,386,222	($3.8) M	$ 369,471,266	$ 381,733,497	($12.3) M	$27.3 M	7.7%
RHO Phase I	$ 238,132,858	$ 241,433,209	($3.3) M	$ 251,654,211	$ 264,285,724	($12.6) M	$22.9 M	9.5%
RHO Phase II	$ 112,442,479	$ 112,953,014	($0.5) M	$ 117,817,055	$ 117,447,772	$0.4 M	$4.5 M	4.0%
Quality Withhold	$ -	$ 847,148	($0.8) M	$ -	$ 2,348,955	($2.3) M	$1.5 M	177.3%
Risk Share/Stop Loss	$ 11,249,969	$ 10,713,276	$0.5 M	$ 10,683,776	$ 5,700,656	$5.0 M	($5.0) M	-46.8%
Transportation Broker	$ 6,832,070	$ 6,948,648	($0.1) M	$ 6,851,265	$ 7,186,130	($0.3) M	$0.2 M	3.4%
DRE/J-Code	$ (4,316,077)	$ (2,992,448)	($1.3) M	$ (4,327,076)	$ (3,339,652)	($1.0) M	($0.3) M	11.6%
DRE	$ (2,480,818)	$ (2,443,429)	($0.0) M	$ (2,487,140)	$ (2,469,834)	($0.0) M	($0.0) M	1.1%
J-Code	$ (1,835,259)	$ (549,019)	($1.3) M	$ (1,839,936)	$ (869,818)	($1.0) M	($0.3) M	58.4%
RHO FFS	$ 158,701	$ 26,989	$0.1 M	$ 220,770	$ 65,553	$0.2 M	$0.0 M	142.9%
Perry Sullivan Appropriation	$ 3,100,000	$3,100,000	$0.0 M	$ 3,100,000	$3,100,000	$0.0 M	$0.0 M	0.0%
Total	$ 367,600,000	$ 373,029,835	($5.4) M	$ 386,000,000	$ 396,795,140	($10.8) M	$23.8 M	6.4%
General Revenue	***$ 178,974,656***	***$ 181,609,038***	($2.6) M	***$ 184,266,121***	***$ 189,408,318***	($5.1) M	$7.8 M	4.3%

Table IV-2. RHO Average Enrollment

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Enrolled Caseload								
RHO Phase I	11,175	11,219	44	11,257	12,126	869	907	8.1%
SPMI	532	488	(44)	536	504	(32)	16	3.3%
ID/DD	838	822	(16)	842	854	12	32	3.9%
Community LTSS	862	853	(9)	869	948	79	95	11.2%
NH > 90 days	2,170	2,150	(20)	2,168	2,280	112	130	6.0%
Community Non-LTSS	6,203	6,313	110	6,271	6,924	653	611	9.7%
MA Only LTSS	570	592	22	571	615	44	23	3.9%
RHO Phase II	13,568	13,820	252	13,556	13,849	293	29	0.2%
MMP SPMI	1,398	1,409	11	1,392	1,385	(7)	(24)	-1.7%
MMP ID/DD	1,272	1,250	(22)	1,272	1,243	(29)	(7)	-0.6%
MMP Community LTSS	1,238	1,244	6	1,243	1,282	39	38	3.1%
MMP NH > 90 days	481	469	(12)	477	454	(23)	(15)	-3.1%
MMP Community Non-LTSS	9,179	9,448	269	9,172	9,485	313	37	0.4%
Total RHO I/II	24,743	25,038	295	24,813	25,975	1,162	936	3.7%

Table IV-3. RHO Price-Volume Comparison to November CEC Adopted

SFY 2018: Current compared to Nov CEC Adopted

	Nov CEC	Current	Change	% Change	Increase/ (Decrease)
Price	$ 1,238.06	$ 1,241.54	$ 3.48	0.3%	$1.0 M
Volume	24,743	25,038	295	1.2%	$4.4 M

SFY 2019: Current compared to Nov CEC Adopted

	Nov CEC	Current	Change	% Change	Increase/ (Decrease)
Price	$ 1,296.36	$ 1,273.02	$ (23.34)	-1.8%	($6.9) M
Volume	24,813	25,975	1,162	4.7%	$17.7 M

May CEC: SFY 2018 compared to SFY 2019

	SFY 2018	SFY 2019	Change	% Change	Increase/ (Decrease)
Price	$ 1,241.54	$ 1,273.02	$ 31.49	2.5%	$9.8 M
Volume	25,038	25,975	936	3.7%	$14.0 M

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

	SFY 2016	SFY 2017	SFY 2018	SFY 2019[1]	Annualized Trends: FY16 → FY19	FY17 → FY19	FY18 → FY19
Rhody Health Options							
Phase I							
SPMI	$ 152.50	$ 1,252.65	$ 1,131.52	$ 1,176.78	97.6%	-3.1%	3.4%
ID/DD	$ 126.84	$ 246.07	$ 161.11	$ 167.55	9.7%	-17.5%	3.4%
Community LTSS NH > 90 days	$ 3,540.15	$ 4,211.05	$ 4,629.57	$ 4,814.75	10.8%	6.9%	4.0%
Community Non-LTSS	$ 1,944.20	$ 225.57	$ 216.04	$ 224.68	-51.3%	-0.2%	3.4%
MA Only LTSS	$ 6,126.22	$ 5,931.76	$ 6,549.40	$ 6,811.38	3.6%	7.2%	3.4%
Phase II							
MMP SPMI		$ 1,227.72	$ 1,109.00	$ 1,138.83		-3.7%	2.7%
MMP ID/DD		$ 241.17	$ 157.90	$ 162.16		-18.0%	2.7%
MMP Community LTSS MMP NH > 90 days		$ 3,374.26	$ 3,335.92	$ 3,425.66		0.8%	2.7%
MMP Community Non-LTSS		$ 221.09	$ 211.74	$ 217.43		-0.8%	2.7%
Composite	$ 1,236.36	$ 1,213.67	$ 1,179.49	$ 1,224.70	-0.3%	0.5%	3.3%

Notes:

1. SFY 2019 rates are preliminary.

Table IV-5. Historical Risk Share Payments

	Total Risk Share	PMPM Risk	% of Capitation
FY 2014[1]	$ 6,661,530	$ 75.04	6.0%
FY 2015	$ 11,706,536	$ 56.59	4.5%
FY 2016	$ 12,535,243	$ 52.73	4.2%
FY 2017	$ 14,479,884	$ 52.13	4.3%
FY 2018[2] *Est.*	$ 10,713,276	$ 35.66	3.0%
FY 2019 *Est.*	$ 5,700,656	$ 18.29	1.5%

Note:

1. Partial Year - program started in November 2013.
2. FY 2018 risk share based on reporting through Jan-18.

V. Medicaid Expansion

Medicaid Expansion			
FY 2017	Final	$	438,607,824
FY 2018	Enacted	$	478,512,635
	November CEC Adopted	$	457,000,000
	May CEC Testimony	**$**	**469,077,209**
	Deficit over Nov CEC	*$*	*(12,077,209)*
FY 2019	November CEC Adopted	$	472,000,000
	May CEC Testimony	**$**	**480,551,819**
	Deficit over Nov CEC	*$*	*(8,551,819)*

The following tables summarize EOHHS' revised forecasts for Expansion for FY 2018 and FY 2019. **Table V-1** summarizes all expenditures by capitated payments by product line to the health plans as well as various fee-for-service payments, and **Table V-3** calculates the price and volume related changes between EOHHS' current forecast and the enacted budget for FY 2018 as well as for FY 2019 over FY 2018.

The average monthly Expansion capitation rates, by pay level, is summarized in **Table V-2** and can be found in **Attachment 7a**.

EOHHS' revised average caseload forecast and a comparison to prior estimates is summarized in **Table V-4**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**.

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

Medicaid Expansion Highlights – FY 2018

The overall Medicaid Expansion estimate indicates an increase in expenses of $13.5 million, driven primarily by caseload increases totaling $28.8 million offset by reduction in price-per-member that contributes $16.7 million in savings.

The drivers of this net change are:

- An increase in capitation payment of $15.4 million due to membership increases of 5,285 average enrollees. SOBRA payments also show an increase of $1.7 million, albeit with a partial offset in SOBRA payments made in RIte Care.
    - These premiums reflect $3.1 million savings from HIF moratorium and its recoupment effective January 1, 2018.
- Overall payments to the health plans were partially offset by a $9.4 reduction to EOHHS' estimated Risk Share liability.
- An Increase of $6.2 million in DRE/J-Code rebates offset by an increase in Expansion FFS expenses of $9.2 million.

Medicaid Expansion Highlights – FY 2019

Caseload changes contribute $53.4 million in additional costs; however, a reduction to the average price provide $44.8 million in expenditure relief. Overall, the Medicaid Expansion forecast shows an increase in expenses of $8.6 million over Nov CEC and $11.5 million over current FY 2018.

The primary drivers of this increase relative to Nov CEC are:

- A net increase in capitation payment of $5.5 million due to membership increases totaling 9,495 monthly enrollees over Nov CEC. SOBRA payments also increased $1.7 million.
- This increase is largely offset by a decrease, based on preliminary rates that support a slight decline in composite PMPM compared to the 3.5% rate increase assumed in Nov CEC.
- Factored into the price change is $6.2 million in savings associated with the federal moratorium on the collection of the Health Insurer Fee in 2019.
- An increase in Expansion FFS expenses of $8.0 million over Nov CEC is consistent with EOHHS' revised FFS figure for FY 2018; as is the favorable increase in DRE/J-Code collections of $7.4 million.
- The 21 percent increase in General Revenue outlays for this population in FY 2019 over FY 2018 is attributed to the 18 percent increase in the State's share of funding, increasing from a blended matching rate of 5.5% in FY 2018 to 6.5% FY 2019.

Table V-1. Summary of Medicaid Expansion Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Payments to Health Plans:								
Expansion	$ 429,997,299	$ 445,396,758	($15.4) M	$ 439,397,577	$ 444,902,639	($5.5) M	($0.5) M	-0.1%
Expansion SOBRA	$ 5,213,050	$ 6,879,364	($1.7) M	$ 5,571,193	$ 6,735,366	($1.2) M	($0.1) M	-2.1%
Performance Goal Program	$ 1,701,932	$ 1,777,079	($0.1) M	$ 1,643,234	$ 1,830,972	($0.2) M	$0.1 M	3.0%
Risk Share/Stop Loss	$ 19,744,811	$ 10,369,707	$9.4 M	$ 20,684,536	$ 21,387,544	($0.7) M	$11.0 M	106.3%
Subtotal Health Plan Payments	$ 456,657,092	$ 464,422,908	($7.8) M	$ 467,296,540	$ 474,856,521	($7.6) M	$7.5 M	2.2%
Other Payments:								
Expansion FFS	$ 26,894,075	$ 36,044,178	($9.2) M	$ 27,284,112	$ 35,323,832	($8.0) M	($0.7) M	-2.0%
Overdose Taskforce	$ 1,545,312	$ 1,545,312	$0.0 M	$ 2,317,968	$ 2,317,968	$0.0 M	$0.8 M	50.0%
Transportation Broker	$ 5,999,572	$ 6,404,481	($0.4) M	$ 5,790,061	$ 6,591,295	($0.8) M	$0.2 M	2.9%
FQHC Wrap Payments	$ 9,331,885	$ 10,305,656	($1.0) M	$ 11,277,063	$ 10,802,603	$0.5 M	$0.5 M	4.8%
DRE/J-Code	$ (43,427,936)	$ (49,645,326)	$6.2 M	$ (41,965,744)	$ (49,340,401)	$7.4 M	$0.3 M	-0.6%
Subtotal Other Payments	$ 342,908	$ 4,654,301	($4.3) M	$ 4,703,460	$ 5,695,298	($1.0) M	$1.0 M	22.4%
Total	$ 457,000,000	$ 469,077,209	($12.1) M	$ 472,000,000	$ 480,551,819	($8.6) M	$11.5 M	2.4%
General Revenue	***$ 25,223,555***	***$ 25,896,386***	($0.7) M	***$ 30,772,982***	***$ 31,337,865***	($0.6) M	$5.4 M	21.0%

Table V-2. Summary Medicaid Expansion Average Enrollment

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Enrollment by Delivery System:								
Expansion	70,385	74,045	4,217	68,099	76,291	8,902	2,246	3.0%
RIte Share	333	419	86	320	452	132	34	8.0%
Remaining in FFS	1,990	3,001	1,011	1,910	2,448	538	(553)	-18.4%
Total	72,708	77,465	5,314	70,329	79,191	9,572	1,726	2.2%

Table V-3. Expansion Price-Volume Comparison

SFY 2018: Current compared to Nov CEC Adopted

	Nov CEC	Current	Change	% Change	Increase/ (Decrease)
Price	$ 523.78	$ 504.61	$ (19.17)	-3.7%	($16.7) M
Volume	72,708	77,465	4,757	6.5%	$28.8 M

SFY 2019: Current compared to Nov CEC Adopted

	Nov CEC	Current	Change	% Change	Increase/ (Decrease)
Price	$ 559.28	$ 505.69	$ (53.59)	-9.6%	($45.2) M
Volume	70,329	79,191	8,862	12.6%	$53.8 M

May CEC: SFY 2018 compared to SFY 2019

	SFY 2018	SFY 2019	Change	% Change	Increase/ (Decrease)
Price	$ 504.61	$ 505.69	$ 1.08	0.2%	$1.0 M
Volume	77,465	79,191	1,726	2.2%	$10.5 M

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

	SFY 2016[1]	SFY 2017[1]	SFY 2018[1]	SFY 2019[2]	Annualized Trends: FY16 → FY19	FY17 → FY19	FY18 → FY19
Expansion							
F 19-24 y.o.	$ 359.25	$ 333.74	$ 309.55	$ 259.52	-10.3%	-11.8%	-14.0%
F 25-29 y.o.	$ 498.57	$ 393.92	$ 377.47	$ 361.14	-10.2%	-4.3%	-3.7%
F 30-39 y.o.	$ 586.61	$ 547.49	$ 562.69	$ 562.20	-1.4%	1.3%	-0.1%
F 40-49 y.o.	$ 707.75	$ 696.16	$ 653.39	$ 642.67	-3.2%	-3.9%	-1.4%
F 50-64 y.o.	$ 722.43	$ 721.75	$ 672.30	$ 630.94	-4.4%	-6.5%	-5.3%
M 19-24 y.o.	$ 264.01	$ 226.08	$ 204.51	$ 196.44	-9.4%	-6.8%	-3.4%
M 25-29 y.o.	$ 288.63	$ 317.87	$ 322.54	$ 333.22	4.9%	2.4%	2.8%
M 30-39 y.o.	$ 431.04	$ 411.00	$ 415.24	$ 475.40	3.3%	7.5%	12.3%
M 40-49 y.o.	$ 587.50	$ 609.59	$ 603.05	$ 643.09	3.1%	2.7%	5.7%
M 50-64 y.o.	$ 807.14	$ 814.03	$ 755.02	$ 703.26	-4.5%	-7.1%	-5.9%
SOBRA	$10,016.00	$10,984.00	$11,179.00	$11,339.00	4.2%	1.6%	1.2%
Composite	$ 553.19	$ 503.75	$ 509.01	$ 493.33	-3.7%	-1.0%	-2.6%

Notes:

1. For comparative purposes, rates reflect non-profit rates to exclude impact of Health Insurer Fee.
   To minimize change to benefits package, the SFY 2016 rates reflect rates effective January 1, 2018.
   The SFY 2017 were in effect from July 1, 2016 through February 28, 2017.
   The SFY 2018 rates for these products were in effect from March 1, 2017 through June 30, 2018.
2. SFY 2019 rates are preliminary.

5-Year Extended Forecast

- For FY 2020 and onward, EOHHS' extended five-year forecast assumes a 1.0 percent caseload increase and 3.5 percent price increase.
- By FY 2021 when the FMAP rate has fully transitioned to 90 percent for this population, Rhode Island's General Revenue fiscal liability for this population will exceed $50 million, double the anticipated $24.9 million anticipated General Revenue cost for FY 2018.

Table V-5. Medicaid Expansion FY 2017 + Extended 5-Year Fiscal Year Forecast

Fiscal Year	Average Eligible	PMPM	All Funds	General Revenue	State Share
FY 2017 Final	72,510	$504.08	$438.6 M	$11.0 M	2.5%
FY 2018 May CEC	77,436	$506.37	$470.5 M	$26.0 M	5.5%
FY 2019 May CEC	79,114	$506.18	$480.6 M	$31.3 M	6.5%
FY 2020 Estimate	79,905	$523.90	$502.3 M	$42.7 M	8.5%
FY 2021 Estimate	80,704	$542.23	$525.1 M	$52.5 M	10.0%
FY 2022 Estimate	81,511	$547.66	$535.7 M	$53.6 M	10.0%

VI. Hospitals

Hospitals - Regular			
FY 2017	Final	$	48,816,259
FY 2018	Enacted	$	58,279,523
	November CEC Adopted	$	54,500,000
	May CEC Testimony	**$**	**54,635,085**
	Deficit over Nov CEC	*$*	*(135,085)*
FY 2019	November CEC Adopted	$	55,000,000
	May CEC Testimony	**$**	**51,281,156**
	Surplus over Nov CEC	*$*	*3,718,844*

Hospitals - DSH Payments			
FY 2017	Final	$	138,131,872
FY 2018	Final	**$**	**139,703,581**
FY 2019	November CEC Adopted	$	106,239,320
	May CEC Testimony	**$**	**106,239,320**
	Deficit over Nov CEC	*$*	-

A summary of the FY 2018 and FY 2019 hospital expenditure forecasts are shown in **Table VI-1**. EOHHS' estimate of $54,635,085 for FY 2018 reflects a $0.1 million deficit against Nov CEC.

The price and caseload factors assumed in the calculation of the FY 2019 forecast are presented in **Table VI-4**. Projected FY 2019 hospital claims expenditures are forecast to total $51,281,156, a $3.7 million savings against Nov CEC.

Table VI-1. Summary of Hospital – Regular Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Supplemental Payments to Hospitals:								
Upper Payment Limit (UPL)	$ 20,478,475	$ 20,478,475	$0.0 M	$ 20,478,475	$ 15,671,754	$4.8 M	($4.8) M	-23.5%
Inpatient UPL	$ 14,064,189	$ 14,064,189	$0.0 M	$ 14,064,189	$ 9,350,481	$4.7 M	($4.7) M	-33.5%
Outpatient UPL	$ 6,414,286	$ 6,414,286	$0.0 M	$ 6,414,286	$ 6,321,273	$0.1 M	($0.1) M	-1.5%
Graduate Medical Education (GME)	$ 4,000,000	$ 4,000,000	$0.0 M	$ 4,000,000	$ 4,000,000	$0.0 M	$0.0 M	0.0%
Subtotal Supplemental Payments	$ 24,478,475	$ 24,478,475	$0.0 M	$ 24,478,475	$ 19,671,754	$4.8 M	($4.8) M	-19.6%
Fee-for-Service Claims Paid to Hospitals:								
Inpatient Claims	$ 25,933,726	$ 26,382,491	($0.4) M	$ 26,402,364	$ 27,699,033	($1.3) M	$1.3 M	5.0%
Outpatient Claims	$ 4,087,799	$ 3,774,119	$0.3 M	$ 4,119,161	$ 3,910,369	$0.2 M	$0.1 M	3.6%
Subtotal Claims:	$ 30,021,525	$ 30,156,610	($0.1) M	$ 30,521,525	$ 31,609,402	($1.1) M	$1.5 M	4.8%
Total	$ 54,500,000	$ 54,635,085	($0.1) M	$ 55,000,000	$ 51,281,156	$3.7 M	($3.4) M	-6.1%
General Revenue	***$ 26,973,530***	***$ 27,039,262***	($0.1) M	***$ 26,804,609***	***$ 24,932,618***	$1.9 M	($2.1) M	-7.8%

Table VI-2. Summary of Hospital – DSH Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Disproportionate Share Hospital	$ 139,703,581	$ 139,703,581	$0.0 M	$ 106,239,320	$ 106,239,320	$0.0 M	($33.5) M	-24.0%
General Revenue	***$ 68,426,814***	***$ 68,426,814***	$0.0 M	***$ 51,579,190***	***$ 51,579,190***	$0.0 M	($16.8) M	-24.6%

Hospital Supplemental Payments – Upper Payment Limit (UPL)

Total UPL payments in FY 2018 are $20.5 million with 18.1% of these payments being eligible for enhanced federal claiming because of the associated activity being for members determined eligible under the new Expansion eligibility criteria.

FY 2019, UPL payments have been revised downward to $15.7 million. This 23.5% decline is attributed to a reduction in FFS hospital activity and is calculated in accordance with Rhode Island's CMS-approved methodology for determining maximum allowable UPL payments.[7]

Based on EOHHS' updated analysis of the proportion of hospital fee-for-service expenditures attributed to Expansion-eligible members, 21.5% of inpatient UPL and 30.6% of outpatient UPL payments are assumed eligible for enhanced federal financial participation.

Please refer to **Attachment 3c** for additional information on UPL payments.

Hospital Supplemental Payments – Graduate Medical Education (GME)

A Graduate Medical Education (GME) payment of $4.0 million is included in both the FY 2018 and FY 2019 forecasts. These payments are not eligible for federal match and are made entirely from General Revenue funds.

However, the payment for FY 2018 has not yet been made and is included in the Department of Administration's undistributed savings target included as part of the FY 2018 Enacted. These undistributed savings were carried forward into the FY 2019 Level A Target and partially assumed in Governor's FY 2019 Recommend.

Hospitals – Disproportionate Share Hospital (DSH)

DSH payments totaling $139.7 million for FY 2018 are consistent with FY 2018 Enacted. EOHHS' current FY 2019 forecast, like the Nov CEC, reduces the FY 2019 DSH forecast by 24.0% to $106.2 million. This reduction reflected the long-planned reductions in these federal payments.

However, the short-term continuing resolution passed by Congress in February 2018 included the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act that eliminated the payment reduction to DSH payments for FFY 2018 and 2019. Echoing the federal government's recognition of the continued importance of this subsidy for the uncompensated care underwritten by the nation's hospitals, EOHHS recommends an increase to its current DSH appropriation. This aligns with conferees' November CEC report and their "expectation that any federal action to delay the reduction … would result in a restoration of the state match that goes with it."[8]

The additional All Funds and General Revenue fiscal impact of a change is accounted in **Table VI-3**.

See **Attachment 3b** for additional detail of DSH payments by hospital.

[7] Please note that the UPL amounts are calculated based upon the assumption of a market basket increase to Rhode Island Medicaid's fee-for-service hospital reimbursement rates. A rate freeze or reduction over current rates would increase the allowable UPL payment. This potentially offsetting impact is reflected in **Attachment 2** and the rebasing of FY 2019 budget initiatives.

[8] Whitney, Mullaney and Reynolds Ferland. November 16, 2018. Rhode Island Caseload Estimating Conference Memorandum re: November 2017 Caseload Estimating Conference.

Table VI-3. SFY 2019 – Alternative DSH Limits

	DSH Amount	Additional All Funds	Additional GR
Nov CEC Adopted	$106,239,320		
Current limit per RI §40-8.3-3(c)(1)	$138,600,000	$ 32,360,680	$ 15,711,110
FFY 2018 Federal Allocation	$142,000,618	$ 35,761,298	$ 17,362,110

Table VI-4. FY 2018 Hospital Trend Assumptions

	Percent[1]	Dollar Impact	Source
Price			
Inpatient	2.7%	$ 728,212	Healthcare Cost Review: CMS Hospital PPS Market Basket
Outpatient	1.4%	$ 52,087	CMS 2018 Outpatient PPS Increase
		$ 780,299	
Caseload			
Inpatient	2.2%	$ 588,329	EOHHS
Outpatient	2.2%	$ 84,163	EOHHS
		$ 672,492	

Note:

1. Caseload percent change reflects change in average caseload for SFY 2019 compared to SFY 2018.
   All caseload forecasts reflect an annualized 2.0% trend over March 2018 actual baseline.

VII. Nursing and Hospice Care

Nursing and Hospice Care			
FY 2017	Final	$	195,584,724
FY 2018	Enacted	$	178,843,933
	November CEC Adopted	$	188,500,000
	May CEC Testimony	**$**	**195,158,388**
	Deficit over Nov CEC	*$*	*(6,658,388)*
FY 2019	November CEC Adopted	$	195,700,000
	May CEC Testimony	**$**	**200,094,252**
	Deficit over Nov CEC	*$*	*(4,394,252)*

A delineation of the FY 2018 and FY 2019 nursing home and hospice expenditure forecasts, patient days, and the trend assumptions used for these forecasts are presented in **Table VII-1**, **Table VII-2**, **Table VII-3,** and **Table VII-4**. Additional information on patient days is presented in **Attachments 4a**, **4b,** and **4c**.

The revised FY 2018 forecast is based on an analysis for claims payments and interim payments through the first nine months of fiscal year. EOHHS' General Revenue estimate assumes that 10% of estimated advances made within current fiscal year will be ineligible for federal financial participation.

Additional information on EOHHS' advances and reconciliation process is provided in **Attachment 8**.

Effective October 1, 2017, the Gain/Loss Policy Adjustor rate component was fully phased out. Additionally, the Direct Care Policy Adjustor was reduced to 75% as part of a plan enacted in statute to phase it out over four years. This policy adjustor will be reduced to 50% effective October 1, 2018.

The $4.94 million increase in fee-for-service FY 2019 nursing home and hospice expenditures over FY 2018 is comprised of the following components:

- Carryover of 10/1/18 rate changes: $0.40 million
- FY 2019 Caseload increase of 0.32%: $0.62 million
- 10/1/18 Nursing Home rate increase: $4.12 million
- 10/1/18 Hospice rate increase: $0.24 million
- 10/1/18 Rate Methodology Phase-in: ($0.50) million
- 1/1/19 Medicare Co-pay rate increase: $0.06 million

With respect to the revised forecast for FY 2019, EOHHS assumes that all payments will be eligible for federal claiming.

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

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Nursing Facilities	$ 173,836,776	$ 183,927,533	($10.1) M	$ 180,510,811	$ 188,587,341	($8.1) M	$4.7 M	2.5%
Medicaid Days	$ 171,918,688	$ 182,904,548	($11.0) M	$ 178,366,859	$ 187,501,854	($9.1) M	$4.6 M	2.5%
Medicare Days	$ 1,918,088	$ 1,022,985	$0.9 M	$ 2,143,952	$ 1,085,486	$1.1 M	$0.1 M	6.1%
Hospice	$ 14,663,224	$ 11,230,855	$3.4 M	$ 15,189,189	$ 11,506,911	$3.7 M	$0.3 M	2.5%
Total	$ 188,500,000	$ 195,158,388	($6.7) M	$ 195,700,000	$ 200,094,252	($4.4) M	$4.9 M	2.5%
General Revenue	***$ 91,724,100***	***$ 97,787,772***	($6.1) M	***$ 93,368,470***	***$ 95,464,968***	($2.1) M	($2.3) M	-2.4%

Table VII-2. Nursing Home Medicaid Per Diem before Patient Share (Average)

Rate Effective	Per Diem[1]
1-Oct-16	$221.34
1-Oct-17	$221.88
1-Oct-18	$226.93

Note:

1. Rate prior to Patient Share.

Table VII-3. Nursing Home and Hospice Days

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Nursing Home Days:								
Medicaid	950,930	994,857	43,927	973,280	998,040	24,760	3,183	0.3%
Medicare	36,321	15,140	(21,181)	31,831	15,188	(16,643)	48	0.3%
Subtotal Nursing Home	987,251	1,009,997	22,746	1,005,111	1,013,228	8,117	3,231	0.3%
Hospice	88,889	59,652	(29,237)	80,935	59,843	(21,092)	191	0.3%
Total	1,076,140	1,069,649	(6,491)	1,086,046	1,073,071	(12,975)	3,422	0.3%

Table VII-4. Nursing and Hospice Care Trend Assumptions

	Percent[1]	Dollar Impact	Source
Price			
Medicaid			
Market Basket	2.8%	$ 4,252,128	Healthcare Cost Review: CMS SNF Market w/o Capital Costs
Capital Cost	1.1%		Healthcare Cost Review: CMS SNF Market Basket : Capital Costs
Medicare		$ 59,227	Healthcare Cost Review: CMS SNF Market Basket
		$ 4,311,356	
Caseload			
Nursing Homes	0.3%	$ 585,295	EOHHS
Medicare	0.3%	$ 3,274	EOHHS
Hospice	0.3%	$ 35,939	EOHHS
		$ 624,508	

VIII. Home and Community Care

Home and Community Care			
FY 2017	Final	$	53,184,119
FY 2018	Enacted	$	59,870,895
	November CEC Adopted	$	58,500,000
	May CEC Testimony	**$**	**53,989,886**
	Surplus over Nov CEC	*$*	*4,510,114*
FY 2019	November CEC Adopted	$	60,000,000
	May CEC Testimony	**$**	**57,327,752**
	Surplus over Nov CEC	*$*	*2,672,248*

Table VIII-1 provides a delineation of the FY 2018 and FY 2019 Home and Community Based Service (HCBS) forecast expenditures compared to historical data. Enrollment projections are presented in **Table VIII-3**.

The projected $4.5 million favorable variance across Assisted Living and Other HCBS is attributable to lower costs due to reduced utilization or a change in the mix of services.

The number of members with a long-term care determination who are eligible for HCBS remains stable. The precipitous decline in HCBS-eligible members compared to November CEC is grossly overstated and due to incorrect reporting included in EOHHS' prior estimate.

The trend assumptions are shown in **Table VIII-2**. EOHHS' ongoing efforts to rebalance long term care services is a contributing factor to this increase.

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

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC Adopted	Current Forecast	Surplus/ (Deficit)	Nov CEC Adopted	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
PACE	$ 12,780,889	$ 12,785,491	($0.0) M	$ 13,292,125	$ 13,840,089	($0.5) M	$1.1 M	8.2%
Assisted Living	$ 4,328,740	$ 3,623,776	$0.7 M	$ 4,703,592	$ 4,209,889	$0.5 M	$0.6 M	16.2%
Other HCBS	$ 38,040,371	$ 34,230,619	$3.8 M	$ 38,654,284	$ 35,927,774	$2.7 M	$1.7 M	5.0%
Home Modification Grant	$ 250,000	$ 250,000	$0.0 M	$ 250,000	$ 250,000	$0.0 M	$0.0 M	0.0%
Perry-Sullivan Appropriation	$ 3,100,000	$ 3,100,000	$0.0 M	$ 3,100,000	$ 3,100,000	$0.0 M	$0.0 M	0.0%
Total	$ 58,500,000	$ 53,989,886	$4.5 M	$ 60,000,000	$ 57,327,752	$2.7 M	$3.3 M	6.2%
General Revenue	***$ 28,594,450***	***$ 26,399,828***	$2.2 M	***$ 28,756,725***	***$ 27,481,795***	$1.3 M	$1.1 M	4.1%

Table VIII-2. Home and Community Care Trend Assumptions

	Percent[1]	Dollar Impact	Source
Price			
PACE	5.3%	$ 696,605	EOHHS Rate Setting
Assisted Living	2.9%	$ 118,646	Healthcare Cost Review: CMS Home Health Market Basket
Other HCBS	2.9%	$ 1,012,542	Healthcare Cost Review: CMS Home Health Market Basket
		$ 1,827,793	
Caseload			
PACE	2.8%	$ 357,994	EOHHS
Assisted Living	12.9%	$ 467,467	EOHHS
Other HCBS	2.0%	$ 684,612	EOHHS
		$ 1,510,073	

Note:

1. Caseload percent change reflects change in average caseload for SFY 2019 compared to SFY 2018.
   All caseload forecasts reflect an annualized 2.0% trend over March 2018 actual baseline.

Table VIII-3. Home and Community Based Services Enrollment

		SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	SFY 2017	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
FFS HCBS									
PACE	278	293	298	5	305	307	2	9	3.0%
Assisted Living	229	455	258	(197)	481	289	(192)	30	11.8%
Other HCBS	1,890	2,806	1,913	(893)	2,873	1,933	(940)	20	1.1%
Total FFS HCBS	2,397	3,554	2,470	(1,084)	3,659	2,529	(1,130)	60	2.4%

Table VIII-4. Summary of PACE Monthly Premiums

					Annualized Trends:		
	SFY 2016	SFY 2017	SFY 2018	SFY 2019[1]	FY16 → FY19	FY17 → FY19	FY18 → FY19
Premium:							
Dual 55-64 y.o.	$ 2,938.00	$ 2,938.00	$ 2,938.00	$ 3,094.00	1.7%	2.6%	4.5%
Dual 65+ y.o.	$ 3,534.00	$ 3,534.00	$ 3,534.00	$ 3,721.00	1.7%	2.6%	4.5%
MA Only	$ 5,162.00	$ 5,162.00	$ 5,162.00	$ 5,436.00	1.7%	2.6%	4.5%
Composite	$ 3,650.23	$ 3,653.21	$ 3,665.90	$ 3,860.00	1.9%	2.8%	4.5%
Premium after Patient Share:							
Dual 55-64 y.o.	$ 2,765.00	$ 2,783.00	$ 2,811.00	$ 2,967.00	2.4%	3.3%	4.7%
Dual 65+ y.o.	$ 3,471.00	$ 3,476.00	$ 3,477.00	$ 3,664.00	1.8%	2.7%	4.6%
MA Only	$ 5,142.00	$ 5,143.00	$ 5,149.00	$ 5,423.00	1.8%	2.7%	4.5%
Composite	$ 3,576.00	$ 3,588.00	$ 3,603.00	$ 3,794.00	2.0%	2.8%	4.5%

Notes:

1. SFY 2019 rates are preliminary.

IX. Pharmacy

Pharmacy			
FY 2017	Final	$	(4,891,997)
FY 2018	Enacted	$	(1,359,290)
	November CEC Adopted	$	(1,454,975)
	May CEC Testimony	**$**	**(766,754)**
	Deficit over Nov CEC	*$*	*(688,221)*
FY 2019	November CEC Adopted	$	(1,446,583)
	May CEC Testimony	**$**	**(739,787)**
	Deficit over Nov CEC	*$*	*(706,796)*

FY 2018 and FY 2019 Pharmacy expenditures and rebates are presented in **Table IX-1** as well as in **Major Developments**. The trend assumptions used for these forecasts are shown in **Table IX-2**.

Beginning in FY 2018, the Enacted and current forecasts properly allocate to the respective budget lines the drug rebates collected against fee-for-service Pharmacy claims paid on behalf of members prior to enrollment in RIte Care or Expansion. The Pharmacy expenditures included in the Pharmacy budget line generally include only those paid for people remaining in fee-for-service who are Aged, Blind or Disabled.

Compared to November, EOHHS is forecasting a reduction in both Pharmacy claims paid on behalf of Aged, Blind and Disabled as well as rebates, netting overall deficits of $0.7 million for the fiscal year.

As previously explained, the continued net "savings" on our Pharmacy expenditures is due to: (1) CMS' rebate formula, which, for certain drugs, can compensate for significant price increases; (2) Medicaid being entitled to the full rebate amount even if it only pays a portion of a drug claim; and (3) the fact that the Pharmacy budget reflects J-Code rebates collected against pharmaceuticals delivered in an Inpatient Hospital setting.

Please note that the General Revenue proportion of net expenditure associated with Pharmacy is affected by the Quarterly Rebate Offset Amount that is a 100% reduction to general revenue savings from rebate collections

Table IX-1. Summary of Pharmacy Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Pharmacy Claims	$ 5,594,222	$ 4,802,890	$0.8 M	$ 5,762,050	$ 5,120,149	$0.6 M	$0.3 M	6.6%
Rebates[1]	$ (7,049,197)	$ (5,569,644)	($1.5) M	$ (7,208,633)	$ (5,859,937)	($1.3) M	($0.3) M	5.2%
DRE	$ (5,309,197)	$ (4,394,644)	($0.9) M	$ (5,468,633)	$ (4,684,937)	($0.8) M	($0.3) M	6.6%
J-Code/Supplemental[2]	$ (1,740,000)	$ (1,175,000)	($0.6) M	$ (1,740,000)	$ (1,175,000)	($0.6) M	$0.0 M	0.0%
Total	$ (1,454,975)	$ (766,754)	($0.7) M	$ (1,446,583)	$ (739,787)	($0.7) M	$0.0 M	-3.5%
General Revenue	***$ (393,752)***	***$ (83,337)***	($0.3) M	***$ (360,214)***	***$ (48,699)***	($0.3) M	$0.0 M	-41.6%

Note:

1. Historical DRE reflect all rebates collected against FFS pharmacy claims; including for expenditures falling under Managed Care or Expansion FFS. For SFY 2018 and SFY 2019 those DRE are under included in the appropriate budget line.
2. J-Code rebates are offset costs for pharmaceuticals delivered in an Inpatient setting. These costs are included in the Hospitals budget line.

Table IX-2. Pharmacy Trend Assumptions

	Percent[1]	Dollar Impact	Source
Price			
Claims	3.3%	$ 163,567	Healthcare Cost Review: PPI-Drugs
Rebates			
Regular		$ (149,664)	EOHHS Experience: 91.5% of claims
Supplemental & J-Code Rebates		$ -	
		$ 13,903	
Caseload			
Claims	3.2%	$ 153,692	EOHHS
Rebates			
Regular		$ (140,629)	EOHHS Experience: 91.5% of claims
Supplemental & J-Code Rebates		$ -	
		$ 13,063	

Note:

1. Caseload percent change reflects change in average caseload for SFY 2019 compared to SFY 2018.
   All caseload forecasts reflect an annualized 2.0% trend over March 2018 actual baseline.

X. Pharmacy Claw Back (Medicare Part D)

Pharmacy Claw Back (Medicare Part D)			
FY 2017	Final	$	59,123,022
FY 2018	Enacted	$	63,427,823
	November CEC Adopted	$	63,489,364
	May CEC Testimony	**$**	**64,027,205**
	Deficit over Nov CEC	*$*	*(537,841)*
FY 2019	November CEC Adopted	$	63,846,253
	May CEC Testimony	**$**	**65,990,101**
	Deficit over Nov CEC	*$*	*(2,143,848)*

EOHHS' FY 2018 revised estimate for Pharmacy Claw Back is $0.5 million higher than Nov CEC. This revised forecast is based on actual caseload and Part D payments made through April 2018.

The FY 2019 forecast is based on the currently available PMPM multiplier information and the actual caseloads through April 2018, as reflected in the monthly receipts from CMS to Rhode Island, trended at 2.0% annually through FY 2019.

Table X-1. Summary of Pharmacy Claw Back Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Clawback Payment	$ 63,489,364	$ 64,027,205	($0.5) M	$ 63,846,253	$ 65,990,101	($2.1) M	$2.0 M	3.1%
General Revenue	***$ 63,489,364***	***$ 64,027,205***	($0.5) M	***$ 63,846,253***	***$ 65,990,101***	($2.1) M	$2.0 M	3.1%
Multiplier								
July - September	$ 155.64	$ 155.64	$ -	$ 156.16	$ 156.16	$ -	$ 0.52	0.3%
October - December	$ 154.27	$ 154.27	$ -	$ 152.56	$ 152.56	$ -	$ (1.71)	-1.1%
January - June	$ 156.16	$ 156.16	$ -	$ 157.14	$ 155.52	$ (1.62)	$ (0.64)	-0.4%
Blended Multiplier	$ 157.34	$ 155.42	$ (1.92)	$ 155.75	$ 155.75	$ -	$ 0.33	0.2%
Average Caseload	33,626	34,330	(704)	34,161	35,307	(1,146)	977	2.8%

XI. Other Medical Services

Other Medical Services			
FY 2017	Final	$	99,980,379
	Adjusted Final [1]	$	103,017,952
FY 2018	Enacted	$	107,072,462
	November CEC Adopted	$	107,000,000
	May CEC Testimony	**$**	**109,631,333**
	Deficit over Nov CEC	*$*	*(2,631,333)*
FY 2019	November CEC Adopted	$	110,000,000
	May CEC Testimony	**$**	**113,198,168**
	Deficit over Nov CEC	*$*	*(3,198,168)*

Note:

[1] "Adjusted Final" for FY 2017 reflects the transfer of $13.6M from RHP to Other Services (for BH-related expenditures for members remaining in FFS) and $10.5M from Other Services to RHP and RHO (for transportation expenditures for members enrolled

The revised FY 2018 forecast for Other Medical Services is $2.8 million above FY 2018 Nov CEC. As shown in **Table XI-1** and **Table XI-3,** this variance is due to higher expenditures for Medicare premium payments (explained below) and lower than anticipated Recoveries. All other expenditure categories, in the aggregate, have a favorable variance of $0.6 million.

Table XI-2 summarizes all Other Services expenditures subject to a non-regular matching rate.

The pricing and caseload assumptions used for the FY 2018 and FY 2019 forecasts are shown in **Table XI-4** below.

Medicare Part A/B Premium Payments

Expenditures for FY 2018 are based on current enrollment numbers and amounts invoiced to the State by CMS. The $1.7 million unfavorable variance over the FY 2018 November adopted estimate is due to a $1.3 million retroactive payment of Part B premiums for approximately 1,000 individuals. It was determined that these individuals had been improperly terminated.

FY 2019 forecast is based on a 4.7% caseload increase. The Part A and Part B premium rates used are those contained in the July 2017 Medicare Trustees Report.

Recoveries

FY 2018, the recoveries forecast of $11.3 million is nearly $2.0 million less than what was projected last November. EOHHS is forecasting the same the level of recoveries for FY 2019. Estate recoveries account for $2.9 million of the total.

Table XI-1. Summary of Other Medical Services Expenditures

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Medicare Part A/B Premiums	$ 63,291,615	$ 64,983,598	($1.7) M	$ 65,253,804	$ 66,731,396	($1.5) M	$1.7 M	2.7%
Non-Emergency Transportation	$ 3,386,369	$ 2,920,852	$0.5 M	$ 3,399,807	$ 2,983,731	$0.4 M	$0.1 M	2.2%
Recoveries	$ (900,000)	$ (900,000)	$0.0 M	$ (660,000)	$ (660,000)	$0.0 M	$0.2 M	-26.7%
Other Medical Services								
Tavares	$ 6,425,708	$ 6,170,488	$0.3 M	$ 6,597,820	$ 6,323,114	$0.3 M	$0.2 M	2.5%
Physician Services	$ 9,497,731	$ 9,876,955	($0.4) M	$ 9,782,978	$ 10,030,106	($0.2) M	$0.2 M	1.6%
Durable Medical Equipment	$ 2,440,240	$ 2,537,674	($0.1) M	$ 2,513,529	$ 2,577,023	($0.1) M	$0.0 M	1.6%
Laboratory	$ 105,153	$ 109,352	($0.0) M	$ 108,312	$ 111,048	($0.0) M	$0.0 M	1.6%
Optometry	$ 196,425	$ 204,268	($0.0) M	$ 202,325	$ 207,436	($0.0) M	$0.0 M	1.6%
Podiatry	$ 53,136	$ 55,258	($0.0) M	$ 54,732	$ 56,115	($0.0) M	$0.0 M	1.6%
Dialysis	$ 472,750	$ 491,626	($0.0) M	$ 486,948	$ 499,249	($0.0) M	$0.0 M	1.6%
Ambulance	$ 86,544	$ 90,000	($0.0) M	$ 87,783	$ 90,000	($0.0) M	$0.0 M	0.0%
Other Practitoners	$ 1,598,019	$ 1,661,825	($0.1) M	$ 1,640,074	$ 1,681,504	($0.0) M	$0.0 M	1.2%
Rehabilitation Services	$ 17,662,830	$ 16,758,209	$0.9 M	$ 18,102,845	$ 17,859,233	$0.2 M	$1.1 M	6.6%
Targeted Case Management	$ 549,020	$ 429,698	$0.1 M	$ 476,996	$ 457,929	$0.0 M	$0.0 M	6.6%
BHDDH Medical Program	$ 13,150,224	$ 13,422,686	($0.3) M	$ 13,694,378	$ 13,630,817	$0.1 M	$0.2 M	1.6%
Recovery Navigation Program	$ 375,000	$ 337,956	$0.0 M	$ -	$ 422,000	($0.4) M	$0.1 M	24.9%
Cortical Integrated Therapy	$ 1,000,000	$ 1,000,000	$0.0 M	$ 1,000,000	$ 1,000,000	$0.0 M	$0.0 M	0.0%
Community Health Team RI	$ 387,745	$ 292,212	$0.1 M	$ -	$ -	$0.0 M	($0.3) M	-100.0%
Refugee Program	$ 480,608	$ 488,362	($0.0) M	$ 516,787	$ 497,153	$0.0 M	$0.0 M	1.8%
Subtotal	$ 54,481,135	$ 53,926,569	$0.6 M	$ 55,265,507	$ 55,442,727	($0.2) M	$1.5 M	2.8%
Recoveries	$ (13,259,119)	$ (11,299,686)	($2.0) M	$ (13,259,119)	$ (11,299,686)	($2.0) M	$0.0 M	0.0%
Total	$ 107,000,000	$ 109,631,333	($2.6) M	$ 110,000,000	$ 113,198,168	($3.2) M	$3.6 M	3.3%
General Revenue	***$ 39,782,580***	***$ 40,738,402***	($1.0) M	***$ 40,454,370***	***$ 43,401,207***	($2.9) M	$2.7 M	6.5%

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

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Favorable/ (Unfavorable)	% Change
Restricted Receipts - Children's Health Account	$ (11,274,268)	$ (11,274,268)	$0.0 M	$ (11,274,268)	$ (9,009,205)	($2.3) M	($2.3) M	-20.1%
Restricted Recipts - Organ Transpant Fund	$ (15,000)	$ (15,000)	$0.0 M	$ (15,000)	$ (15,000)	$0.0 M	$0.0 M	0.0%
100% Federal - Q1 Medicare	$ (1,386,137)	$ (1,617,142)	$0.2 M	$ (1,288,170)	$ (1,617,142)	$0.3 M	$0.0 M	0.0%
100% Federal - Refugee Program	$ 480,608	$ 488,362	($0.0) M	$ 516,787	$ 497,153	$0.0 M	($0.0) M	1.8%
State Only	$ 1,012,745	$ 473,452	$0.5 M	$ -	$ -	$0.0 M	$0.5 M	-100.0%

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

CY	Part A	Part B
2017	$413.00	$134.00
2018	$422.00	$134.00
2019 *Est.*	$436.00	$134.00

Table XI-4. Other Medical Services Trend Assumptions

	Percent[1]	Dollar Impact	Source
Price			
Medical Services[2]	1.8%	$ 509,115	Healthcare Cost Review: Medical Economic Index
Rehabilative Services / TCM	1.8%	$ 323,879	Healthcare Cost Review: Medical Economic Index
Tavaras	2.5%	$ 152,626	Healthcare Cost Review: CMS SNF Market Basket : Capital Costs
		$ 985,620	
Caseload			
Medical Services[2]	-0.2%	$ (69,466)	EOHHS
Rehabilative Services / TCM	4.7%	$ 805,376	EOHHS
Tavaras	0.0%	$ -	EOHHS
		$ 735,910	

Note:

1. Caseload percent change reflects change in average caseload for SFY 2019 compared to SFY 2018.
   All caseload forecasts reflect an annualized 2.0% trend over March 2018 actual baseline.
2. Medical Services includes Behavioral Health expenditures

XII. Attachments

Attachment 1a

MAY 2018 CEC TESTIMONY

FY 2018 Revised Projection - Medical Benefits

	FY 2017 Spent Actual	FY 2018 Enacted	FY 2018 Nov CEC Adopted	FY 2018 EOHHS May CEC Revised	Surplus/(Deficit) Nov CEC - May CEC	FY 2018 Enacted	FY 2018 * Nov CEC Adopted	FY 2018 EOHHS May CEC Revised	Surplus/(Deficit) * Nov CEC - May CEC
	All Funds	All Funds	All Funds	All Funds	All Funds	Gen Revenue	Gen Revenue	Gen Revenue	Gen Revenue
Hospital - Regular	50,316,259	58,279,523	54,500,000	**54,635,085**	**(135,085)**	28,777,661	26,973,530	27,039,262	**(65,732)**
Hospital - Disprop. Share	138,131,872	139,703,581	139,703,581	**139,703,581**	**-**	68,426,813	68,426,814	68,426,814	**-**
Long Term Care:									
Nursing Homes / Hospice	195,918,135	178,843,933	188,500,000	**195,158,388**	**(6,658,388)**	87,025,458	91,724,100	97,787,772	**(6,063,672)**
Home and Community Based Svs	53,184,119	59,870,895	58,500,000	**54,989,886**	**3,510,114**	29,133,178	28,594,450	26,886,428	**1,708,022**
Managed Care	681,026,614	690,512,594	713,000,000	**717,201,235**	**(4,201,235)**	305,669,199	323,717,485	314,136,719	**9,580,766**
Rhody Health Partners	224,209,001	236,298,335	243,900,000	**233,374,687**	**10,525,313**	115,685,063	119,373,375	114,301,972	**5,071,403**
Behavioral Health Program	14,522,807	-	-	**-**	**-**	-	-	-	**-**
Rhody Health Options	345,803,445	355,304,108	367,600,000	**373,029,835**	**(5,429,835)**	172,986,465	178,974,656	181,609,038	**(2,634,382)**
Medicaid Expansion	437,906,572	478,512,635	457,000,000	**469,077,209**	**(12,077,209)**	26,399,321	25,223,555	25,896,386	**(672,831)**
Pharmacy	(4,891,998)	(1,359,290)	(1,454,975)	**(766,755)**	**(688,220)**	(298,607)	(393,752)	(83,336)	**(310,416)**
Pharmacy Clawback	59,123,022	63,427,823	63,489,364	**64,027,205**	**(537,841)**	63,427,823	63,489,364	64,027,205	**(537,841)**
Other Services	99,454,777	107,072,462	107,000,000	**109,631,332**	**(2,631,332)**	40,075,432	39,782,580	40,738,402	**(955,822)**
Total - CEC Medical Benefits	**2,294,704,625**	**2,366,466,599**	**2,391,737,970**	**2,410,061,688**	**(18,323,718)**	**937,307,806**	**965,886,157**	**960,766,662**	**5,119,495**
Special Education	17,157,235	19,000,000	19,000,000	**19,000,000**	**-**	-	-	**-**	**-**
Health System Transformation	7,000,000	23,500,000	23,500,000	**23,500,000**	**-**	-	-	**-**	**-**
Total Medical Benefits Program	**2,318,861,860**	**2,408,966,599**	**2,434,237,970**	**2,452,561,688**	**(18,323,718)**	**937,307,806**	**965,886,157**	**960,766,662**	**5,119,495**

* Before impact of CHIP reauthorization

Attachment 1b

MAY 2018 CEC TESTIMONY

FY 2019 Revised Projection - Medical Benefits

	FY 2018 EOHHS Current	FY 2019 Nov CEC Adopted	FY 2019 EOHHS May CEC Revised	Surplus/(Deficit) Nov CEC - May CEC	FY 2018 EOHHS Current	FY 2019 * Nov CEC Adopted	FY 2019 EOHHS May CEC Revised	Surplus/(Deficit) * Nov CEC - May CEC
	All Funds	All Funds	All Funds	All Funds	Gen Revenue	Gen Revenue	Gen Revenue	Gen Revenue
Hospital - Regular	54,635,085	55,000,000	**51,281,156**	**3,718,844**	27,039,262	26,804,609	24,932,618	**1,871,991**
Hospital - Disprop. Share	139,703,581	106,239,320	**106,239,320**	**-**	68,426,814	51,579,190	51,579,190	**-**
Long Term Care:		-						
Nursing Homes / Hospice	195,158,388	195,700,000	**200,094,252**	**(4,394,252)**	97,787,772	93,368,470	95,464,968	**(2,096,498)**
Home and Community Based Svs	54,989,886	60,000,000	**54,660,751**	**5,339,249**	26,886,428	28,756,725	26,209,369	**2,547,356**
Managed Care	717,201,235	753,000,000	**760,820,544**	**(7,820,544)**	314,136,719	359,787,738	330,069,482	**29,718,256**
Rhody Health Partners	233,374,687	259,200,000	**249,096,870**	**10,103,130**	114,301,972	124,390,537	119,623,058	**4,767,479**
Behavior Health Program	-	-			-	-		
Rhody Health Options	373,029,835	386,000,000	**396,795,140**	**(10,795,140)**	181,609,038	184,266,121	189,408,318	**(5,142,197)**
Medicaid Expansion	469,077,209	472,000,000	**480,551,819**	**(8,551,819)**	25,896,386	30,772,982	31,337,865	**(564,883)**
Pharmacy	(766,755)	(1,446,583)	**(739,787)**	**(706,796)**	(83,336)	(360,214)	(48,699)	**(311,515)**
Pharmacy Clawback	64,027,205	63,846,253	**65,990,101**	**(2,143,848)**	64,027,205	63,846,253	65,990,101	**(2,143,848)**
Other Services	109,631,332	110,000,000	**113,198,168**	**(3,198,168)**	40,738,402	40,454,370	43,401,207	**(2,946,837)**
Total - CEC Medical Benefits	**2,410,061,688**	**2,459,538,990**	**2,477,988,334**	**(18,449,344)**	**960,766,662**	**1,003,666,781**	**977,967,477**	**25,699,304**
Special Education	19,000,000	19,538,580	**19,538,580**	**-**	-	-	**-**	**-**
Health System Transformation	23,500,000	23,500,000	**23,500,000**	**-**	-	-	**-**	**-**
Total Medical Benefits Program	**2,452,561,688**	**2,502,577,570**	**2,521,026,914**	**(18,449,344)**	**960,766,662**	**1,003,666,781**	**977,967,477**	**25,699,304**

* Before impact of CHIP reauthorization

Attachment 1c
MAY 2018 CEC TESTIMONY

Summary of Federal Financial Participation

FMAP Rates

	Federal FY		State FY		
	Federal	**State**	**Federal**	**State**	**Source**
2018	51.45%	48.55%	51.34%	48.66%	FFIS
2019	52.57%	47.43%	52.29%	47.71%	FFIS

Enhanced (CHIP) FMAP Rates

	Federal FY		State FY		
	Federal	**State**	**Federal**	**State**	**Source**
2018	89.02%	10.98%	88.94%	11.06%	FFIS
2019	89.80%	10.20%	89.61%	10.39%	FFIS

Money Follows the Person

Benefits

	State FY	
	Federal	**State**
2018	51.34%	48.66%
2019	52.29%	47.71%

Reinvestment Fund

	State FY
	Federal
2018	24.33%
2019	23.86%

Estimate DRE - Drug Rebate Equalization Rates for Managed Care, RHP, Pharmacy

Percentage of Total All Funds rebate estimate that is 100% federal.

	State FY
	Federal
2018	8.00%
2019	8.00%

Medicaid Expansion

Federal share gradually reduced to 90% by 2020, starting in Federal FY 2017 (eff. 1/1/2017)

	State FY	
	Federal	**State**
2018	94.50%	5.50%
2019	93.50%	6.50%

Attachment 1d

MAY 2018 CEC TESTIMONY

MAY 2018 CEC TESTIMONY

2018 Federal Poverty Level (FPL) Guidelines, By Family Size

Annual Household Income											
Size of Family	**100%**	**109%** *[Note 1]*	**133%**	**142%** *[Note 2]*	**150%**	**157%** *[Note 3]*	**175%**	**185%**	**190%** *[Note 4]*	**200%**	**250%**
1	$ 12,140	$ 13,233	$ 16,146	$ 17,239	$ 18,210	$ 19,060	$ 21,245	$ 22,459	$ 23,066	$ 24,280	$ 30,350
2	$ 16,460	$ 17,941	$ 21,892	$ 23,373	$ 24,690	$ 25,842	$ 28,805	$ 30,451	$ 31,274	$ 32,920	$ 41,150
3	$ 20,780	$ 22,650	$ 27,637	$ 29,508	$ 31,170	$ 32,625	$ 36,365	$ 38,443	$ 39,482	$ 41,560	$ 51,950
4	$ 25,100	$ 27,359	$ 33,383	$ 35,642	$ 37,650	$ 39,407	$ 43,925	$ 46,435	$ 47,690	$ 50,200	$ 62,750
5	$ 29,420	$ 32,068	$ 39,129	$ 41,776	$ 44,130	$ 46,189	$ 51,485	$ 54,427	$ 55,898	$ 58,840	$ 73,550
6	$ 33,740	$ 36,777	$ 44,874	$ 47,911	$ 50,610	$ 52,972	$ 59,045	$ 62,419	$ 64,106	$ 67,480	$ 84,350
7	$ 38,060	$ 41,485	$ 50,620	$ 54,045	$ 57,090	$ 59,754	$ 66,605	$ 70,411	$ 72,314	$ 76,120	$ 95,150
8	$ 42,380	$ 46,194	$ 56,365	$ 60,180	$ 63,570	$ 66,537	$ 74,165	$ 78,403	$ 80,522	$ 84,760	$ 105,950

Notes:

1 MAGI floor for CHIP children

2 MAGI Equivalent for 133% for children

3 MAGI Equivalent for 150% for children

4 MAGI Equivalent for 185% for children

Attachment 2a
May 2018 CEC

Executive Office and Health and Human Services

SFY 2018 Medicaid Budget Initiatives and Undistributed Savings

General Revenue Only

	FY2018: Enacted	FY 2018: Nov CEC	FY 2018: Current	Surplus/ (Decifit) from Nov	FY2019: Nov CEC	FY2019: Current	Surplus/ (Decifit) from Nov
FY 2018 Medicaid Budget Initiatives:							
Home Health Care Workers	$ 1,879,539	$ 1,879,539	$ 1,879,539	$0.0 M GR	$ 2,506,052	$ 2,506,052	$0.0 M GR
Enhanced Recoveries	$ (250,000)	$ (250,000)	$ (250,000)	$0.0 M GR	$ (250,000)	$ (250,000)	$0.0 M GR
FQHC payments[1]	$ (1,317,125)	$ (988,807)	$ -	($1.0) M GR	$ (983,507)	$ -	($1.0) M GR
Performance Goal Program	$ (1,356,428)	$ (1,489,603)	$ (1,489,603)	$0.0 M GR	$ (1,452,400)	$ (1,452,400)	$0.0 M GR
Managed Care Provider Incentive Program	$ (1,467,857)	$ (1,467,857)	$ (1,467,857)	$0.0 M GR	$ (1,467,857)	$ (1,467,857)	$0.0 M GR
Improve Program Integrity	$ (492,100)	$ (492,100)	$ (492,100)	$0.0 M GR	$ (492,100)	$ (492,100)	$0.0 M GR
Increased CHIP Claiming	$ (3,616,650)	$ (3,616,650)	$ (8,316,650)	$4.7 M GR	$ -	$ -	$0.0 M GR
Managed Care Rate Reduction	$ (3,500,000)	$ (2,675,393)	$ (2,675,393)	$0.0 M GR	$ (2,623,161)	$ (2,623,161)	$0.0 M GR
Nursing Home Rate Freeze	$ (5,276,737)	$ (5,276,737)	$ (5,276,737)	$0.0 M GR	$ (5,173,719)	$ (5,173,719)	$0.0 M GR
Children's Health Account Threshold	$ (3,059,268)	$ (3,059,268)	$ (3,059,268)	$0.0 M GR	$ (3,059,268)	$ (3,059,268)	$0.0 M GR
Transportation Funding Initiative	$ (371,364)	$ (437,940)	$ (437,940)	$0.0 M GR	$ (314,886)	$ (314,886)	$0.0 M GR
Nursing Home Census Reduction	$ (2,493,538)	$ -	$ -	$0.0 M GR	$ -		$0.0 M GR
Automation of Patient Share	$ (2,449,922)	$ -	$ -	$0.0 M GR	$ -		$0.0 M GR
Coordination of Benefits with Medicare/VA	$ (250,000)	$ -	$ -	$0.0 M GR	$ -		$0.0 M GR
Subtotal	$ (24,021,450)	$ (17,874,817)	$ (21,586,009)	$3.7 M GR	$ (13,310,845)	$ (12,327,339)	($1.0) M GR

	FY2018: Enacted	FY 2018: Nov CEC	FY 2018: Current	Surplus/ (Decifit) from Nov	FY2019: Nov CEC	FY2019: Current	Surplus/ (Decifit) from Nov
FY 2018 Undistributed Savings							
although not reflected in this document, EOHHS recommends savings for these items as consistent with Governor's FY 2018 Revised and FY 2019 Recommend							
CHIP Reauthorization			$ (7,017,212)	$7.0 M GR		$ (28,516,524)	$28.5 M GR
Perry Sullivan Appropriation			$ (3,016,920)	$3.0 M GR		$ (2,958,020)	$3.0 M GR
State-Only: Cortical Integrated Therapy			$ (765,000)	$0.8 M GR		$ (1,000,000)	$1.0 M GR
State-Only: Other Reductions[2]		$ 142,483	$ (116,452)	$0.3 M GR	$ (641,120)	$ (439,784)	($0.2) M GR
Eliminate GME[3]			$ (4,000,000)	$4.0 M GR		$ (2,500,000)	$2.5 M GR
Subtotal		$ 142,483	$ (14,915,584)	$15.1 M GR	$ (641,120)	$ (35,414,328)	$34.8 M GR
Total:	$ (24,021,450)	$ (17,732,334)	$ (36,501,593)	$18.8 M GR	$ (13,951,965)	$ (47,741,666)	$33.8 M GR

Note

1. EOHHS has reached an agreement in principle with the FQHCs that will have savings relative to status quo.
2. Nov CEC already incorporated costs/savings associated with elimination of certain State Only programs.
3. FY 2018 undistributed savings target assumes elimination of GME. The FY 2019 Gov Recommend includes $1.5 million GR funding toward GME.

Attachment 3a

Hospital Discharges
Inpatient Hospital Only
Excluding Crossovers
Based on Date of Service

CY 2016

Month	Discharges
Jan-16	332
Feb-16	367
Mar-16	556
Apr-16	406
May-16	292
Jun-16	621
Jul-16	342
Aug-16	246
Sep-16	553
Oct-16	268
Nov-16	186
Dec-16	362
	4,531

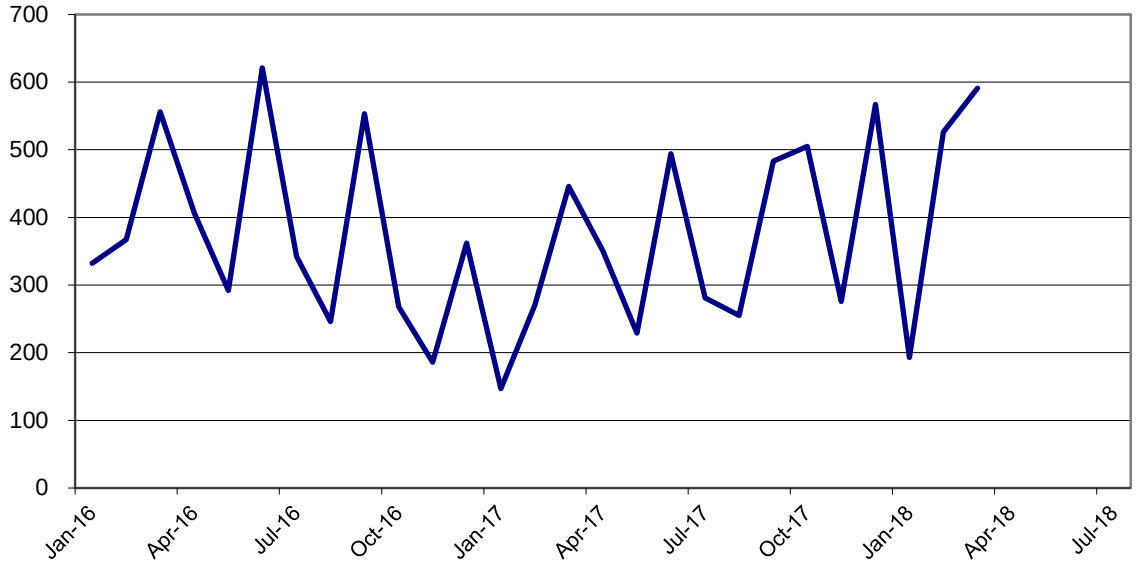
CY 2017

Month	Discharges
Jan-17	147
Feb-17	270
Mar-17	446
Apr-17	350
May-17	229
Jun-17	494
Jul-17	281
Aug-17	255
Sep-17	483
Oct-17	505
Nov-17	276
Dec-17	567
	4,303

CY 2018

Month	Discharges
Jan-18	193
Feb-18	526
Mar-18	591
Apr-18	
May-18	
Jun-18	
Jul-18	
Aug-18	
Sep-18	
Oct-18	
Nov-18	
Dec-18	
	1,310

Total Discharges



Attachment 3b

Disproportionate Share Hospitals
Plan Year 2017 and Plan Year 2018

	DSH Plan Year 2017[1]		DSH Plan Year 2018[2]	
Rehab Hospital	$ -			
Bradley Hospital	$ -			
Butler Hospital	$ -			
Kent Hospital	$ 6,804,513			
Landmark Hospital	$ 6,334,020			
Memorial Hospital	$ 15,021,720			
Miriam Hospital	$ 6,601,403			
Newport Hospital	$ 5,377,656			
Rhode Island Hospital	$ 54,332,441			
Roger Williams Medical Center	$ 8,446,060			
St Joseph Hospital	$ 9,935,021			
South County Hospital	$ 3,596,615			
Westerly Hospital	$ 3,099,782			
Women & Infants Hospital	$ 20,137,136			
Eleanor Slater Hospital	$ -			
Total Plan Year DSH Payment	$ 139,686,367	*Pay 7-2017 (SFY 2018)*	$ 138,600,000	*Pay 7-2018 (SFY 2019)*
DSH Cap Budget:	$ 139,703,581		$ 142,000,618 [3]	
Over/(Under) Cap	$ (17,214)		$ (3,400,618)	

	SFY 2018 Budget		SFY 2019 Budget
Total SFY DSH Payment	$ 139,703,581		$ 138,600,000

Notes:

1. Final hospital distribution
2. Individual hospital distribution not final
3. CMS DSH Allotment for DSH Plan Year 2018

Attachment 3c

UPL Supplemental Payments
FY 2018 and FY 2019

	FY 2018 UPL			EST. FY 2019 UPL		
	Outpatient	Inpatient	Total	Outpatient	Inpatient	Total
Rehab Hospital	$24,744	$0	$24,744			
Bradley Hospital	$0	$0	$0			
Butler Hospital	$0	$0	$0			
Kent Hospital	$623,625	$965,243	$1,588,868			
Landmark Hospital	$309,231	$424,487	$733,718			
Memorial Hospital	$491,453	$263,733	$755,186			
Miriam Hospital	$613,591	$779,268	$1,392,859			
Newport Hospital	$195,282	$278,763	$474,045			
Rhode Island Hospital	$2,455,148	$4,047,209	$6,502,357			
Roger Williams Medical Ctr.	$299,002	$645,602	$944,604			
St Joseph Hospital	$345,216	$921,944	$1,267,160			
South County Hospital	$144,975	$125,508	$270,483			
Westerly Hospital	$73,426	$59,274	$132,700			
Women & Infants Hospital	$838,591	$5,553,158	$6,391,749			
Total	**$6,414,284**	**$14,064,189**	**$20,478,473**	**$6,321,273**	**$9,350,481**	**$15,671,754**

1. Payments made quarterly: July 20, October 20, January 20, & April 20.

2. FY 2019 UPL Estimate. Final number and distribution will be available when hospital cost report information is available.

Attachment 4a

Fee-for-Service Nursing Facility Medicaid Days

CY 2016

Month	Days
Jan-16	74,932
Feb-16	78,563
Mar-16	67,667
Apr-16	78,308
May-16	79,771
Jun-16	74,157
Jul-16	69,630
Aug-16	78,104
Sep-16	73,457
Oct-16	58,453
Nov-16	61,329
Dec-16	54,517
	848,888

CY 2017

Month	Days
Jan-17	56,322
Feb-17	55,424
Mar-17	54,904
Apr-17	51,379
May-17	51,540
Jun-17	49,903
Jul-17	45,275
Aug-17	50,030
Sep-17	51,759
Oct-17	57,141
Nov-17	81,802
Dec-17	59,556
	665,035

CY 2018

Month	Days
Jan-18	55,198
Feb-18	71,027
Mar-18	54,558
Apr-18	
May-18	
Jun-18	
Jul-18	
Aug-18	
Sep-18	
Oct-18	
Nov-18	
Dec-18	
	180,783

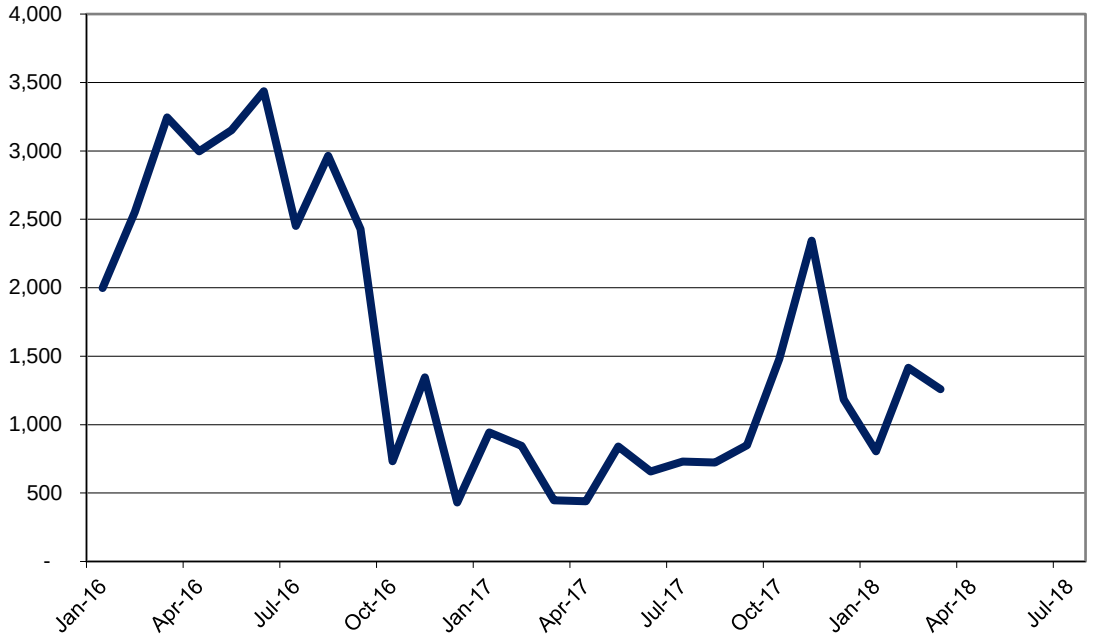
Attachment 4b

Fee-for-Service Nursing Facility Medicare Days

CY 2016	
Month	**Days**
Jan-16	1,997
Feb-16	2,552
Mar-16	3,245
Apr-16	2,997
May-16	3,151
Jun-16	3,436
Jul-16	2,451
Aug-16	2,963
Sep-16	2,428
Oct-16	732
Nov-16	1,345
Dec-16	431
	27,728

CY 2017	
Month	**Days**
Jan-17	942
Feb-17	845
Mar-17	447
Apr-17	440
May-17	839
Jun-17	658
Jul-17	730
Aug-17	722
Sep-17	850
Oct-17	1,482
Nov-17	2,344
Dec-17	1,183
	11,482

CY 2018	
Month	**Days**
Jan-18	805
Feb-18	1,416
Mar-18	1,258
Apr-18	
May-18	
Jun-18	
Jul-18	
Aug-18	
Sep-18	
Oct-18	
Nov-18	
Dec-18	
	3,479



Attachment 4c

Fee-for-Service Hospice Days
Days Paid within the Month

CY 2016

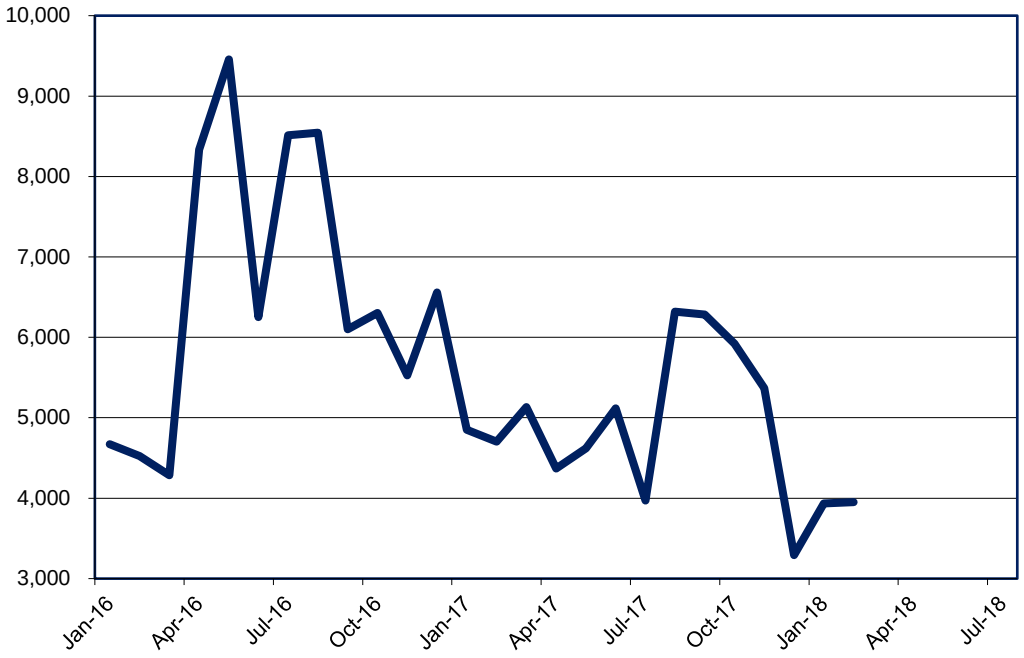
Month	Days
Jan-16	4,673
Feb-16	4,525
Mar-16	4,287
Apr-16	8,335
May-16	9,456
Jun-16	6,250
Jul-16	8,513
Aug-16	8,546
Sep-16	6,101
Oct-16	6,303
Nov-16	5,528
Dec-16	6,560
	79,077

CY 2017

Month	Days
Jan-17	4,850
Feb-17	4,705
Mar-17	5,134
Apr-17	4,370
May-17	4,619
Jun-17	5,116
Jul-17	3,971
Aug-17	6,321
Sep-17	6,283
Oct-17	5,920
Nov-17	5,369
Dec-17	3,292
	59,950

CY 2018

Month	Days
Jan-18	3,933
Feb-18	3,949
Mar-18	4,654
Apr-18	
May-18	
Jun-18	
Jul-18	
Aug-18	
Sep-18	
Oct-18	
Nov-18	
Dec-18	
	12,536



Executive Office and Health and Human Services

Medical Caseload Forecast Report

Actuals through: 31-Mar-18

	FISCAL YEAR 2018															
	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Nov-17 Actual	Dec-17 Adjusted	Jan-18 Adjusted	Feb-18 Adjusted	**Mar-18 Current**	Apr-18 *Forecast*	May-18 *Forecast*	Jun-18 *Forecast*	**Δ Mar'18 to Feb'18**	**FY18 Current**	FY18 Nov CEC	**Δ Current to Nov CEC**
Children and Families																
RIte Care	159,121	158,406	156,172	156,567	155,895	156,777	157,676	157,787	156,849	157,268	157,611	157,955	(938)	157,340	154,875	2,466
MF < 1 y.o. [1]	5,452	5,488	5,486	5,650	5,470	6,051	6,199	6,300	6,282	6,296	6,309	6,323	(18)	5,942	5,800	142
MF 1-4 y.o.	30,022	30,080	29,727	30,001	30,109	30,150	30,337	30,257	30,108	30,189	30,255	30,321	(149)	30,130	29,427	703
MF 5-14 y.o.	48,022	48,084	47,525	48,093	48,159	48,491	48,762	48,951	48,921	49,053	49,160	49,267	(30)	48,541	46,948	1,593
M 15-44 y.o.	19,774	19,561	19,278	18,818	18,671	18,497	18,602	18,598	18,287	18,336	18,376	18,416	(311)	18,768	19,051	(283)
F 15-44 y.o.	45,719	45,333	44,453	44,344	43,975	43,971	44,134	44,095	43,779	43,896	43,992	44,088	(316)	44,315	44,008	307
MF 45+	10,132	9,860	9,703	9,661	9,511	9,617	9,642	9,586	9,473	9,498	9,519	9,540	(113)	9,645	9,641	4
RIte Share	6,048	5,886	5,624	5,547	5,522	5,242	5,093	4,932	4,754	4,764	4,775	4,785	(178)	5,248	5,426	(179)
Remaining in FFS	3,395	5,017	5,067	5,682	8,209	5,151	4,654	4,124	4,354	4,357	4,359	4,360	230	4,894	4,341	554
Eligibility Base	168,564	169,309	166,863	167,796	169,626	167,170	167,423	166,843	165,957	166,389	166,744	167,100	(886)	167,482	164,642	2,840
Children with Special Health Care Needs																
RIte Care	10,194	10,216	10,163	10,212	10,220	10,143	10,136	10,144	10,172	10,118	10,127	10,136	28	10,165	10,197	(32)
Substitute Care	2,474	2,465	2,520	2,622	2,674	2,755	2,784	2,836	2,896	2,863	2,868	2,873	60	2,719	2,562	157
SSI < 15 y.o.	3,390	3,410	3,362	3,313	3,278	3,258	3,248	3,203	3,168	3,146	3,146	3,146	(35)	3,256	3,370	(114)
SSI 15-20 y.o.	2,302	2,326	2,275	2,261	2,226	2,081	2,037	2,033	2,010	1,999	1,999	1,999	(23)	2,129	2,270	(141)
Katie Beckett	116	113	113	111	107	109	109	110	112	113	113	113	2	112	111	0
Adoption Subsidy	1,912	1,902	1,893	1,905	1,935	1,940	1,958	1,962	1,986	1,997	2,000	2,004	24	1,950	1,883	66
RIte Share	745	741	726	719	710	695	687	679	669	670	672	673	(10)	699	696	3
Remaining in FFS	1,571	1,653	1,684	1,675	1,731	1,777	1,845	1,839	1,803	1,869	1,872	1,876	(36)	1,766	1,824	(58)
Eligibility Base	12,510	12,610	12,573	12,606	12,661	12,615	12,668	12,662	12,644	12,658	12,671	12,685	(18)	12,630	12,717	(87)
Expansion																
Enrolled	76,730	75,293	70,972	73,739	71,395	73,277	74,168	74,750	74,233	74,446	74,661	74,875	(517)	74,045	69,827	4,218
F 19-24 y.o.	7,499	7,182	6,842	7,878	7,614	7,989	8,057	8,035	7,982	8,005	8,028	8,051	(53)	7,763	6,734	1,030
F 25-29 y.o.	4,991	4,895	4,436	4,559	4,463	4,540	4,623	4,709	4,654	4,667	4,681	4,694	(55)	4,659	4,397	263
F 30-39 y.o.	4,346	4,288	4,026	4,128	3,987	4,047	4,116	4,205	4,195	4,207	4,219	4,232	(10)	4,166	3,962	205
F 40-49 y.o.	4,664	4,579	4,324	4,581	4,453	4,580	4,603	4,654	4,641	4,655	4,668	4,681	(13)	4,590	4,250	340
F 50-64 y.o.	12,432	12,279	11,929	12,235	11,777	12,081	12,285	12,339	12,152	12,187	12,222	12,257	(187)	12,181	11,669	512
M 19-24 y.o.	8,195	7,917	7,523	8,401	8,102	8,546	8,553	8,517	8,507	8,532	8,556	8,581	(10)	8,327	7,404	924
M 25-29 y.o.	7,528	7,380	6,684	6,699	6,491	6,582	6,714	6,827	6,825	6,845	6,865	6,885	(2)	6,860	6,627	233
M 30-39 y.o.	9,642	9,541	8,785	8,726	8,504	8,632	8,752	8,964	8,929	8,955	8,981	9,006	(35)	8,951	8,672	279
M 40-49 y.o.	6,732	6,634	6,209	6,189	6,051	6,094	6,132	6,193	6,183	6,201	6,219	6,236	(10)	6,256	6,107	149
M 50-64 y.o.	10,701	10,598	10,214	10,343	9,953	10,186	10,333	10,307	10,164	10,193	10,222	10,252	(143)	10,289	10,006	283
RIte Share	349	341	349	434	436	459	440	439	443	444	445	446	4	419	333	86
Remaining in FFS	1,261	2,620	2,870	3,990	5,192	4,198	3,493	2,607	2,446	2,446	2,447	2,447	(161)	3,001	1,990	1,011
Eligibility Base	78,340	78,254	74,191	78,163	77,023	77,934	78,101	77,796	77,122	77,337	77,552	77,768	(674)	77,465	72,150	5,315

Attachment 5a
May 2018 CEC

	FISCAL YEAR 2018															
	Jul-17 Actual	Aug-17 Actual	Sep-17 Actual	Oct-17 Actual	Nov-17 Actual	Dec-17 Adjusted	Jan-18 Adjusted	Feb-18 Adjusted	**Mar-18 Current**	Apr-18 *Forecast*	May-18 *Forecast*	Jun-18 *Forecast*	**Δ Mar'18 to Feb'18**	**FY18 Current**	FY18 Nov CEC	**Δ Current to Nov CEC**
Aged, Blind and Disabled																
Rhody Health Partners	14,799	15,460	15,399	15,179	15,045	15,231	15,283	15,191	15,080	15,104	15,129	15,154	(111)	15,171	15,375	(203)
SSI 21-44 y.o.	3,764	3,926	3,899	3,805	3,772	3,897	3,896	3,837	3,805	3,812	3,818	3,824	(32)	3,838	3,894	(57)
SSI 45+ y.o.	7,305	7,687	7,665	7,595	7,520	7,560	7,567	7,526	7,455	7,468	7,480	7,492	(71)	7,527	7,652	(126)
SPMI	2,791	2,904	2,889	2,832	2,826	2,832	2,860	2,867	2,851	2,856	2,860	2,865	(16)	2,853	2,883	(31)
ID/DD	939	943	946	947	927	942	960	961	968	969	971	973	7	954	945	9
Rhody Health Options	24,295	24,441	24,467	24,406	24,209	25,094	25,381	25,612	25,576	25,617	25,659	25,701	(36)	25,038	24,743	295
SPMI	1,954	1,951	1,940	1,934	1,914	1,877	1,861	1,873	1,860	1,863	1,866	1,869	(13)	1,897	1,930	(33)
ID/DD	2,092	2,097	2,091	2,076	2,061	2,052	2,067	2,056	2,065	2,069	2,072	2,075	9	2,073	2,110	(37)
Community LTSS	2,007	2,010	2,007	2,001	2,003	2,045	2,115	2,167	2,196	2,199	2,203	2,207	29	2,097	2,100	(3)
NH > 90 days	2,630	2,608	2,565	2,475	2,459	2,599	2,608	2,689	2,692	2,697	2,701	2,706	3	2,619	2,651	(32)
Community Non-LTSS	15,032	15,201	15,293	15,348	15,203	15,937	16,101	16,234	16,157	16,183	16,210	16,236	(77)	15,761	15,382	379
MA Only LTSS	580	574	571	572	569	584	629	593	605	606	607	608	12	592	570	21
RHO Phase I	10,514	10,815	10,987	10,061	10,083	10,989	11,493	11,805	11,940	11,959	11,979	11,998	135	11,219	11,175	44
RHO Phase II	13,781	13,626	13,480	14,345	14,126	14,105	13,888	13,807	13,636	13,658	13,680	13,703	(171)	13,820	13,568	251
PACE	299	300	296	298	297	298	299	298	298	299	300	301	(0)	298	295	4
Dual 55-64 y.o.	44	43	40	40	39	38	40	40	41	41	41	41	1	41	39	2
Dual 65+ y.o.	215	217	216	218	216	217	214	213	214	215	216	216	1	216	219	(3)
MA Only	40	40	40	40	42	43	45	45	43	43	43	43	(2)	42	37	5
RIte Share	110	113	115	115	113	114	110	109	108	108	108	109	(1)	111	109	2
CHT-RI	2,723	2,711	2,658	2,613	2,568	-	-	-	-	-	-	-	-	1,106	2,667	(1,561)
Remaining in FFS [2]	13,500	13,059	13,185	13,415	14,029	12,890	12,790	12,813	12,982	13,109	13,128	13,146	169	13,170	13,076	94
MA Only	2,438	1,945	1,999	2,220	2,414	2,474	2,141	2,248	2,255	2,366	2,370	2,374	7	2,270	2,089	181
Part A Only	735	735	733	744	754	722	742	751	767	768	768	769	16	749	735	14
Part B Only	2,429	2,442	2,404	2,409	2,403	2,381	2,407	2,421	2,391	2,393	2,395	2,397	(30)	2,406	2,416	(10)
Dual	7,898	7,937	8,049	8,042	8,458	7,313	7,500	7,393	7,569	7,582	7,594	7,606	176	7,745	7,837	(91)
Eligibility Base	53,003	53,373	53,462	53,413	53,693	53,627	53,863	54,023	54,043	54,237	54,324	54,410	20	53,789	53,598	191
RIte Smiles																
RIte Smiles	104,201	104,614	103,736	104,966	105,519	106,969	108,110	108,897	109,524	110,027	110,717	110,958	627	107,353	104,299	3,054
Transportation Broker																
Enrolled	309,319	305,982	299,651	302,193	299,154	302,407	304,570	306,238	304,110	304,818	305,515	306,212	(2,128)	304,181	296,998	7,183
Full Medicaid Summary																
Enrolled in Managed Care [3]	285,438	284,116	277,469	280,401	277,061	280,820	282,943	283,782	282,207	282,853	283,486	284,121	(1,575)	282,058	275,311	6,747
RIte Share	7,252	7,081	6,814	6,815	6,781	6,510	6,330	6,159	5,974	5,987	6,000	6,013	(185)	6,476	6,564	(88)
Remaining in FFS	19,727	22,349	22,806	24,762	29,161	24,016	22,782	21,383	21,585	21,781	21,805	21,829	202	22,832	21,232	1,601
Eligibility Base	312,417	313,546	307,089	311,978	313,003	311,346	312,055	311,324	309,766	310,621	311,291	311,963	(1,558)	311,367	303,107	8,260
excluding Expansion	*234,077*	*235,292*	*232,898*	*233,815*	*235,980*	*233,412*	*233,954*	*233,528*	232,644	*233,284*	*233,739*	*234,195*	*(884)*	*233,902*	*230,957*	*2,945*

Notes:

Please note that the forecast is based on a month-end snapshot taken in first week of subsequent month. This data is updated to reflect retroactive enrollment/eligibility changes as well as an estimate of any unrealized adjustments for most recent three months.

[1] As a consequence of enrollment delays common to newborns, the six months prior to the current period reflect actual enrollments adjusted by a fulltime equivalency factor and estimate of outstanding capitation payments owed back to date of birth.

[2] The Aged, Bind, and Disabled "Remaining in FFS" figure includes members enrolled in Community Health Team Rhode Island (CHT-RI)

[3] Total enrolled does not include RIte Smiles or Transportation Broker. The division between Health Plans is a proxy based historical experience.

Executive Office and Health and Human Services

Medical Caseload Forecast Report

Actuals through: 31-Mar-18

	FISCAL YEAR 2019														
	Jul-18 *Forecast*	Aug-18 *Forecast*	Sep-18 *Forecast*	Oct-18 *Forecast*	Nov-18 *Forecast*	Dec-18 *Forecast*	Jan-19 *Forecast*	Feb-19 *Forecast*	Mar-19 *Forecast*	Apr-19 *Forecast*	May-19 *Forecast*	Jun-19 *Forecast*	**FY19 Current**	FY19 Nov CEC	**Δ Current to Nov CEC**
Children and Families															
RIte Care	158,299	158,644	158,990	159,337	159,684	160,032	160,381	160,731	161,082	161,433	161,785	162,138	160,211	153,955	6,256
MF < 1 y.o. [1]	6,337	6,351	6,365	6,378	6,392	6,406	6,420	6,434	6,448	6,462	6,476	6,491	6,413	5,877	536
MF 1-4 y.o.	30,387	30,453	30,519	30,586	30,653	30,720	30,787	30,854	30,921	30,988	31,056	31,124	30,754	29,259	1,495
MF 5-14 y.o.	49,374	49,482	49,590	49,698	49,806	49,915	50,024	50,133	50,242	50,352	50,461	50,571	49,971	46,650	3,320
M 15-44 y.o.	18,457	18,497	18,537	18,578	18,618	18,659	18,699	18,740	18,781	18,822	18,863	18,904	18,680	18,931	(251)
F 15-44 y.o.	44,184	44,281	44,377	44,474	44,571	44,668	44,765	44,863	44,961	45,059	45,157	45,256	44,718	43,637	1,081
MF 45+	9,560	9,581	9,602	9,623	9,644	9,665	9,686	9,707	9,728	9,750	9,771	9,792	9,676	9,600	75
RIte Share	4,796	4,806	4,817	4,827	4,838	4,848	4,859	4,869	4,880	4,891	4,901	4,912	4,854	5,163	(309)
Remaining in FFS	4,362	4,364	4,366	4,368	4,370	4,372	4,374	4,376	4,378	4,380	4,381	4,383	4,373	4,456	(83)
Eligibility Base	167,457	167,814	168,173	168,532	168,892	169,252	169,614	169,976	170,339	170,703	171,068	171,433	169,438	163,574	5,864
Children with Special Health Care Needs															
RIte Care	10,154	10,172	10,190	10,209	10,227	10,245	10,263	10,282	10,300	10,318	10,337	10,355	10,254	10,149	105
Substitute Care	2,878	2,883	2,889	2,894	2,899	2,904	2,909	2,915	2,920	2,925	2,930	2,935	2,907	2,566	341
SSI < 15 y.o.	3,152	3,158	3,163	3,169	3,175	3,180	3,186	3,192	3,197	3,203	3,209	3,214	3,183	3,349	(166)
SSI 15-20 y.o.	2,003	2,006	2,010	2,013	2,017	2,021	2,024	2,028	2,031	2,035	2,039	2,042	2,022	2,252	(230)
Katie Beckett	114	114	114	114	114	115	115	115	115	115	116	116	115	111	4
Adoption Subsidy	2,008	2,011	2,015	2,018	2,022	2,026	2,029	2,033	2,036	2,040	2,044	2,047	2,027	1,871	156
RIte Share	675	676	678	679	681	682	684	685	687	688	690	691	683	666	17
Remaining in FFS	1,879	1,882	1,886	1,889	1,892	1,896	1,899	1,903	1,906	1,909	1,913	1,916	1,897	1,832	65
Eligibility Base	12,708	12,731	12,754	12,777	12,800	12,823	12,846	12,869	12,893	12,916	12,939	12,963	12,835	12,647	187
Expansion															
Enrolled	75,091	75,307	75,524	75,741	75,959	76,177	76,396	76,616	76,837	77,058	77,279	77,502	76,291	69,827	6,463
F 19-24 y.o.	8,074	8,097	8,120	8,144	8,167	8,191	8,214	8,238	8,262	8,285	8,309	8,333	8,203	6,565	1,637
F 25-29 y.o.	4,708	4,721	4,735	4,749	4,762	4,776	4,790	4,804	4,817	4,831	4,845	4,859	4,783	4,256	527
F 30-39 y.o.	4,244	4,256	4,268	4,280	4,293	4,305	4,318	4,330	4,342	4,355	4,367	4,380	4,312	3,863	448
F 40-49 y.o.	4,695	4,708	4,722	4,736	4,749	4,763	4,777	4,790	4,804	4,818	4,832	4,846	4,770	4,146	624
F 50-64 y.o.	12,293	12,328	12,363	12,399	12,435	12,471	12,506	12,542	12,578	12,615	12,651	12,687	12,489	11,449	1,040
M 19-24 y.o.	8,605	8,630	8,655	8,680	8,705	8,730	8,755	8,780	8,806	8,831	8,856	8,882	8,743	7,221	1,522
M 25-29 y.o.	6,904	6,924	6,944	6,964	6,984	7,004	7,024	7,045	7,065	7,085	7,106	7,126	7,015	6,416	599
M 30-39 y.o.	9,032	9,058	9,084	9,110	9,137	9,163	9,189	9,216	9,242	9,269	9,295	9,322	9,177	8,427	750
M 40-49 y.o.	6,254	6,272	6,290	6,308	6,327	6,345	6,363	6,381	6,400	6,418	6,437	6,455	6,354	5,948	406
M 50-64 y.o.	10,281	10,311	10,341	10,370	10,400	10,430	10,460	10,490	10,520	10,551	10,581	10,611	10,446	9,806	639
RIte Share	447	448	449	450	451	452	453	454	455	456	457	458	452	320	132
Remaining in FFS	2,447	2,447	2,447	2,448	2,448	2,448	2,448	2,448	2,449	2,449	2,449	2,449	2,448	1,910	538
Eligibility Base	77,985	78,202	78,420	78,638	78,857	79,077	79,297	79,518	79,740	79,962	80,185	80,409	79,191	72,057	7,134

Attachment 5b
May 2018 CEC

	FISCAL YEAR 2019														
	Jul-18 *Forecast*	Aug-18 *Forecast*	Sep-18 *Forecast*	Oct-18 *Forecast*	Nov-18 *Forecast*	Dec-18 *Forecast*	Jan-19 *Forecast*	Feb-19 *Forecast*	Mar-19 *Forecast*	Apr-19 *Forecast*	May-19 *Forecast*	Jun-19 *Forecast*	**FY19 Current**	FY19 Nov CEC	**Δ Current to Nov CEC**
Aged, Blind and Disabled															
Rhody Health Partners	15,178	15,203	15,228	15,253	15,277	15,302	15,327	15,352	15,377	15,402	15,427	15,452	15,315	15,399	(84)
SSI 21-44 y.o.	3,830	3,837	3,843	3,849	3,855	3,862	3,868	3,874	3,881	3,887	3,893	3,900	3,865	3,898	(33)
SSI 45+ y.o.	7,504	7,516	7,529	7,541	7,553	7,565	7,578	7,590	7,602	7,615	7,627	7,640	7,572	7,671	(99)
SPMI	2,870	2,874	2,879	2,884	2,888	2,893	2,898	2,903	2,907	2,912	2,917	2,921	2,895	2,887	9
ID/DD	974	976	977	979	980	982	984	985	987	988	990	992	983	944	39
Rhody Health Options	25,743	25,785	25,827	25,869	25,911	25,953	25,995	26,038	26,080	26,123	26,165	26,208	25,975	24,743	1,231
SPMI	1,872	1,875	1,878	1,881	1,884	1,887	1,890	1,893	1,897	1,900	1,903	1,906	1,889	1,928	(39)
ID/DD	2,079	2,082	2,086	2,089	2,092	2,096	2,099	2,103	2,106	2,109	2,113	2,116	2,097	2,114	(17)
Community LTSS	2,210	2,214	2,217	2,221	2,225	2,228	2,232	2,235	2,239	2,243	2,246	2,250	2,230	2,112	118
NH > 90 days	2,710	2,714	2,719	2,723	2,728	2,732	2,737	2,741	2,746	2,750	2,754	2,759	2,734	2,645	89
Community Non-LTSS	16,263	16,289	16,316	16,342	16,369	16,396	16,422	16,449	16,476	16,503	16,529	16,556	16,409	15,443	966
MA Only LTSS	609	610	611	612	613	614	615	616	617	618	619	620	615	571	44
RHO Phase I	12,018	12,037	12,057	12,077	12,096	12,116	12,136	12,155	12,175	12,195	12,215	12,235	12,126	11,257	869
RHO Phase II	13,725	13,747	13,770	13,792	13,815	13,837	13,860	13,882	13,905	13,928	13,950	13,973	13,849	13,556	293
PACE	302	303	304	305	306	307	308	309	310	311	312	313	307	305	2
Dual 55-64 y.o.	41	42	42	42	42	42	42	42	43	43	43	43	42	41	1
Dual 65+ y.o.	217	218	219	219	220	221	222	222	223	224	225	225	221	225	(4)
MA Only	43	43	43	44	44	44	44	44	44	44	45	45	44	39	5
RIte Share	109	109	109	110	110	110	110	111	111	111	111	112	110	106	4
CHT-RI	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Remaining in FFS [2]	13,165	13,184	13,203	13,222	13,241	13,260	13,279	13,298	13,317	13,336	13,356	13,375	13,270	13,115	155
MA Only	2,378	2,382	2,386	2,390	2,393	2,397	2,401	2,405	2,409	2,413	2,417	2,421	2,399	2,089	310
Part A Only	770	770	771	771	772	773	773	774	775	775	776	777	773	736	37
Part B Only	2,399	2,401	2,403	2,405	2,407	2,409	2,411	2,413	2,415	2,417	2,419	2,421	2,410	2,415	(5)
Dual	7,619	7,631	7,644	7,656	7,669	7,681	7,694	7,706	7,719	7,731	7,744	7,756	7,687	7,874	(187)
Eligibility Base	54,497	54,584	54,671	54,758	54,845	54,932	55,020	55,107	55,195	55,283	55,371	55,459	54,977	53,751	1,226
RIte Smiles															
RIte Smiles	111,200	111,442	111,685	111,929	112,173	112,418	112,663	112,908	113,155	113,401	113,649	113,897	112,543	104,299	8,244
Transportation Broker															
Enrolled	306,921	307,633	308,344	309,059	309,773	310,491	311,210	311,927	312,649	313,372	314,097	314,823	310,858	296,998	13,860
Full Medicaid Summary															
Enrolled in Managed Care [3]	284,766	285,414	286,062	286,712	287,364	288,017	288,671	289,328	289,985	290,645	291,305	291,968	288,353	275,311	13,042
RIte Share	6,026	6,039	6,053	6,066	6,079	6,092	6,106	6,119	6,132	6,146	6,159	6,172	6,099		6,099
Remaining in FFS	21,853	21,878	21,902	21,927	21,951	21,976	22,000	22,025	22,050	22,074	22,099	22,124	21,988	21,232	757
Eligibility Base	312,646	313,331	314,017	314,705	315,394	316,085	316,777	317,471	318,167	318,864	319,563	320,264	316,440	303,107	13,334
excluding Expansion	*234,661*	*235,129*	*235,597*	*236,066*	*236,537*	*237,008*	*237,480*	*237,953*	*238,427*	*238,902*	*239,378*	*239,855*	*237,249*	*230,957*	*6,200*

Notes:

Please note that the forecast is based on a month-end snapshot taken in first week of subsequent month. This data is updated to reflect retroactive enrollment/eligibility changes as well as an estimate of any unrealized adjustments for most recent three months.

[1] As a consequence of enrollment delays common to newborns, the six months prior to the current period reflect actual enrollments adjusted by a fulltime equivalency factor and estimate of outstanding capitation payments owed back to date of birth.

[2] The Aged, Bind, and Disabled "Remaining in FFS" figure includes members enrolled in Community Health Team Rhode Island (CHT-RI)

[3] Total enrolled does not include RIte Smiles or Transportation Broker. The division between Health Plans is a proxy based historical experience.

Attachment 6a
MAY 2018 CEC TESTIMONY

MONTHLY MEDICAID POPULATION REPORT

FY 2018	Elderly	Adults with Disability	Children and Families	Medicaid Expansion	TOTAL
Jul-17	24,452	32,267	183,555	77,547	317,821
Aug-17	24,618	32,369	184,218	77,278	318,483
Sep-17	24,792	32,306	182,002	73,271	312,371
Oct-17	24,833	32,575	182,896	77,499	317,803
Nov-17	24,901	32,552	182,434	76,094	315,981
Dec-17	24,962	32,746	182,176	77,755	317,639
Jan-18	25,102	32,748	181,978	77,468	317,296
Feb-18	25,274	32,737	181,475	77,341	316,827
Mar-18	25,417	32,659	180,713	76,713	315,502
Apr-18					-
May-18					-
Jun-18					-
AVG. FY 2018	24,928	32,551	182,383	76,774	316,636

FY 2017	Elderly	Adults with Disability	Children and Families	Medicaid Expansion	TOTAL
Jul-16	22,824	31,292	169,304	66,656	290,076
Aug-16	22,987	31,327	171,537	67,902	293,753
Sep-16	22,816	31,065	170,207	68,072	292,160
Oct-16	22,819	30,944	170,338	68,492	292,593
Nov-16	22,996	30,998	172,144	69,661	295,799
Dec-16	23,230	31,099	174,400	71,524	300,253
Jan-17	23,618	31,080	176,742	72,969	304,409
Feb-17	23,752	31,038	177,704	73,806	306,300
Mar-17	23,989	31,034	179,725	74,637	309,385
Apr-17	24,054	31,331	181,800	75,976	313,161
May-17	24,247	31,625	183,021	76,749	315,642
Jun-17	24,422	32,099	184,473	77,879	318,873
AVG. FY 2017	23,480	31,244	175,950	72,027	302,700

FY 2016	Elderly	Adults with Disability	Children and Families	Medicaid Expansion	TOTAL
Jul-15	22,345	31,296	162,871	64,627	281,139
Aug-15	22,428	31,299	163,020	63,504	280,251
Sep-15	22,572	31,307	164,577	64,294	282,750
Oct-15	22,626	31,067	163,603	61,554	278,850
Nov-15	22,616	30,981	164,496	62,868	280,961
Dec-15	22,648	30,966	166,198	65,235	285,047
Jan-16	22,497	30,930	165,484	64,516	283,427
Feb-16	22,613	31,024	165,736	65,883	285,256
Mar-16	22,774	31,313	167,251	66,877	288,215
Apr-16	22,781	31,273	166,813	65,554	286,421
May-16	22,824	31,295	167,334	65,482	286,935
Jun-16	22,835	31,321	169,437	67,052	290,645
AVG. FY 2016	22,630	31,173	165,568	64,787	284,158

FY 2015	Elderly	Adults with Disability	Children and Families	Medicaid Expansion	TOTAL
Jul-14	21,901	30,569	161,000	47,452	260,922
Aug-14	22,027	30,599	162,442	48,659	263,727
Sep-14	22,071	30,660	159,802	48,287	260,820
Oct-14	22,189	30,782	160,383	50,081	263,435
Nov-14	22,365	30,937	158,215	51,575	263,092
Dec-14	22,341	30,990	157,733	54,782	265,846
Jan-15	22,181	30,749	160,891	55,529	269,350
Feb-15	22,289	30,924	160,727	57,482	271,422
Mar-15	22,371	31,128	161,312	57,389	272,200
Apr-15	22,254	31,305	162,944	62,177	278,680
May-15	22,272	31,114	159,951	62,576	275,913
Jun-15	22,365	31,311	159,011	63,430	276,117
AVG. FY 2015	22,219	30,922	160,368	54,952	268,460

Attachment 6b

MAY 2018 CEC TESTIMONY

FY 2018 Monthly Medicaid Expenditure Report
March 2018

	FY 2017 Spent	FY 2018 Enacted	FY 2017 Accruals [2]	July	August	September	October	November	December	January	February	March	April	May	June	FY 2018 YTD
28 Scheduled HP Cash Disbursement Cycles[1]	30	28		2	2	3	2	2	3	2	2	3	2	2	3	28
Capitation Payments Schedule				2	1	1	1	1	1	1	1	1	1	1	0	12
Hospital - Regular	50,316,259	58,279,523	6,968,522	462,272	3,713,069	3,236,207	7,703,393	1,479,127	1,154,641	6,181,975	2,447,273	4,092,293	-	-	-	37,438,773
Hospital - Disproportionate Share	138,131,872	139,703,581	-	139,722,001	(35,634)	-	-	-	-	-	-	-	-	-	-	139,686,367
Long Term Care																
Nursing Homes	195,918,135	178,843,933	19,889,311	(4,665,798)	14,057,202	16,389,136	16,933,615	17,259,056	23,814,842	14,732,092	14,179,654	16,413,400	-	-	-	149,002,510
Home and Community Based Services	53,184,119	59,870,895	4,165,757	291,412	3,081,238	5,119,074	4,201,624	3,026,991	5,328,839	3,820,582	3,806,428	5,130,370	-	-	-	37,972,315
Managed Care	681,026,614	690,512,594	50,677,905	66,510,071	7,082,783	123,710,153	49,554,338	8,212,411	126,493,529	1,524,428	58,222,782	118,345,593	-	-	-	610,333,993
Rhody Health Partners	238,731,808	236,298,335	(2,781,288)	47,295,722	21,594,736	23,167,760	17,542,288	20,303,283	24,486,414	20,487,803	16,640,511	22,357,961	-	-	-	211,095,190
Rhody Health Options	345,803,445	355,304,108	15,647,400	41,761,256	29,235,737	33,859,200	28,878,975	26,352,097	35,057,248	30,323,945	29,270,498	29,065,628	-	-	-	299,451,985
Medicaid Expansion	437,906,572	478,512,635	(7,655,968)	107,284,083	38,247,282	22,724,792	34,513,961	36,874,799	40,434,906	37,221,248	34,599,396	42,134,084	0	0	0	386,378,584
Other	99,454,777	130,572,462	4,585,257	9,255,445	8,120,424	10,038,333	9,411,990	8,114,185	10,797,539	7,645,077	10,037,215	9,921,458	-	-	-	87,926,923
Pharmacy	(4,891,998)	(1,359,290)	(2,241,887)	2,528,483	(258,082)	(1,103,932)	46,411	232,462	(1,804,260)	(171,852)	259,594	(840,039)	-	-	-	(3,353,102)
Pharmacy Clawback	59,123,022	63,427,823	5,245,379	0	5,267,325	5,288,958	5,275,418	5,255,510	5,290,025	5,253,976	5,395,681	5,421,618	-	-	-	47,693,890
Total Medicaid Benefits	**2,294,704,625**	**2,389,966,599**	**94,500,388**	**410,444,945**	**130,106,082**	**242,429,681**	**174,062,011**	**127,109,922**	**271,053,723**	**127,019,274**	**174,859,033**	**252,042,368**	**-**	**-**	**-**	**2,003,627,427**
General Revenue	919,322,206	937,307,806	34,268,930	151,333,341	71,130,363	109,925,538	72,642,107	48,619,930	118,756,409	49,412,719	65,872,584	102,441,839	-	-	-	824,403,760
Federal Funds	1,364,408,911	1,441,384,525	60,231,458	259,111,605	58,975,718	132,453,343	101,401,619	78,453,993	152,279,398	77,542,595	103,790,248	149,581,709	-	-	-	1,173,821,686
Restricted Receipts	10,973,508	11,274,268	-	-	-	50,800	18,285	35,999	17,916	63,960	5,196,201	18,820	-	-	-	5,401,981
Total Medicaid	**2,294,704,625**	**2,389,966,599**	**94,500,388**	**410,444,945**	**130,106,082**	**242,429,681**	**174,062,011**	**127,109,922**	**271,053,723**	**127,019,274**	**174,859,033**	**252,042,368**	**-**	**-**	**-**	**2,003,627,427**
Special Education	17,157,235	19,000,000	1,500,000	(422,074)	527,954	979,563	1,211,026	1,019,496	2,079,693	1,014,355	1,333,994	1,943,194	-	-	-	11,187,200
Health System Transformation Project	7,000,000	23,500,000		-	-	13,500,000	-	-	-	-	-	-	-	-	-	13,500,000
		-														
Total Medical Benefits	**2,318,861,860**	**2,432,466,599**	**96,000,388**	**410,022,871**	**130,634,036**	**256,909,244**	**175,273,037**	**128,129,418**	**273,133,415**	**128,033,629**	**176,193,027**	**253,985,562**	**-**	**-**	**-**	**2,028,314,626**

[1]FY 2018 includes 28 cycle disbursements with four one-week cycles

[2]Note: Final Accrual Reversals posted in RIFANS in July and September; audit adjustments posted in Dec.

Attachment 6c
MAY 2018 CEC TESTIMONY

FY 2018 EXPANDED MONTHLY MEDICAID EXPENDITURE REPORT - MMIS

	July	August	September	October	November	December	January	February	March	April	May	June	Total
Hospitals													
Inpatient Expenditures	$2,502,221	$1,701,232	$2,797,058	$2,011,256	$1,258,223	$2,253,512	$886,579	$2,164,379	$3,658,244				$19,232,703
Outpatient Expenditures	$302,978	$273,793	$439,259	$314,521	$222,931	$401,000	$174,529	$284,028	$433,626				$2,846,665
Supplemental Payments (UPL)	$4,863,639	$0	$0	$5,375,600	$0	$0	$5,119,618	$0	$0				$15,358,857
Subtotal	**$7,668,837**	**$1,975,026**	**$3,236,317**	**$7,701,378**	**$1,481,154**	**$2,654,512**	**$6,180,725**	**$2,448,406**	**$4,091,870**				**$37,438,225**
DSH Payments	$139,703,581	$0	$0	$0	$0	$0	$0	$0	$0				$139,703,581
Total Hospital Expenditures	**$147,372,418**	**$1,975,026**	**$3,236,317**	**$7,701,378**	**$1,481,154**	**$2,654,512**	**$6,180,725**	**$2,448,406**	**$4,091,870**				**$177,141,806**
Long Term Care													
Nursing Home													
Hospice	$688,272	$1,099,723	$1,141,022	$1,065,136	$1,211,569	$908,834	$751,344	$672,550	$825,605				$8,364,056
Nursing Home Claims	$8,401,550	$8,998,846	$9,098,801	$10,518,064	$15,059,937	$11,036,577	$10,004,452	$13,541,815	$10,091,357				$96,751,400
Nursing Home Off-Cycle Pymts	$1,785,040	$3,423,125	$10,687,792	$5,349,979	$986,441	$12,250,720	$3,976,575	$0	$5,479,791				$43,939,462
Total Nursing Home	**$10,874,862**	**$13,521,694**	**$20,927,616**	**$16,933,179**	**$17,257,947**	**$24,196,131**	**$14,732,370**	**$14,214,366**	**$16,396,754**				**$149,054,919**
Home and Community Based Services													
All Other HCBS	$2,532,922	$1,860,607	$3,206,811	$2,303,734	$1,421,483	$3,171,550	$2,315,803	$2,311,446	$3,328,836				$22,453,191
Assisted Living Claims	$38,654	$37,705	$82,682	$166,942	$79,951	$57,029	$51,919	$49,718	$62,200				$626,800
Assisted Living Off-Cycle Pymts	$157,200	$136,894	$37,185	$185,572	$78,671	$260,380	$52,869	$0	$102,913				$1,011,682
PACE	$1,133,186	$778,328	$1,079,175	$1,094,874	$1,077,068	$1,096,368	$1,074,108	$1,095,854	$1,048,712				$9,477,674
Total HCBS	**$3,861,962**	**$2,813,533**	**$4,405,853**	**$3,751,122**	**$2,657,173**	**$4,585,328**	**$3,494,698**	**$3,457,018**	**$4,542,661**				**$33,569,348**
Total LTC Expenditures	**$14,736,823**	**$16,335,227**	**$25,333,470**	**$20,684,302**	**$19,915,120**	**$28,781,458**	**$18,227,069**	**$17,671,383**	**$20,939,414**				**$182,624,266**
Managed Care													
Capitation													
RIte Care Core	$37,239,607	$36,530,725	$36,617,914	$36,331,840	$36,939,354	$37,073,119	$38,116,488	$37,755,451	$37,780,526				$334,385,023
CSHCNs	$7,106,222	$6,984,983	$6,890,815	$6,797,873	$6,650,786	$6,519,723	$6,493,029	$6,463,363	$6,251,070				$60,157,864
Foster	$1,898,560	$1,906,551	$2,017,618	$2,112,206	$2,161,417	$2,158,849	$2,174,558	$2,240,142	$2,254,799				$18,924,700
Total Capitation	**$46,244,389**	**$45,422,260**	**$45,526,347**	**$45,241,918**	**$45,751,557**	**$45,751,690**	**$46,784,075**	**$46,458,956**	**$46,286,395**				**$413,467,587**
RIteSmiles Capitation	$2,028,442	$0	$4,044,997	$2,044,379	$0	$4,210,028	$0	$2,111,295	$4,257,392				$18,696,533
RIteShare Premiums	$319,092	$310,228	$306,386	$301,025	$295,430	$297,743	$293,867	$282,236	$276,746				$2,682,754
SOBRA	$5,103,501	$3,664,410	$5,393,902	$3,464,557	$3,087,099	$5,268,439	$3,870,856	$1,980,639	$3,410,112				$35,243,515
NICU	$2,481,343	$976,317	$2,990,158	$2,270,515	$1,242,199	$2,658,122	($22,242)	$4,386,254	$3,497,785				$20,480,451
RIteCare/RIteShare FFS Payments	$3,778,267	$1,543,816	$6,174,985	$3,801,377	$1,701,300	$14,634,613	$1,266,083	$5,399,385	$9,458,809				$47,758,635
Other Managed Care Services	$563,569	$784,612	$9,508,612	($98,616)	$2,140,761	$3,054,118	($152,898)	($152,092)	$1,364,850				$17,012,916
Managed Care Encounter Drug Rebates	($1,594,447)	($945,973)	($7,086,822)	($2,560,745)	($215,074)	($3,439,765)	($5,300,068)	($455,996)	($6,467,297)				($28,066,188)
Total Managed Care Expenditures	**$58,924,156**	**$51,755,669**	**$66,858,565**	**$54,464,410**	**$54,003,273**	**$72,434,988**	**$46,739,673**	**$60,010,676**	**$62,084,793**				**$527,276,204**
Note: Other MC Services include Stop Loss, Risk Share, P4P, DRE, EI CNOM, FQHC Transition Pymts, Premium Collections and Tax Intercept.													
Rhody Health													
Rhody FFS	$31,192	$22,971	$11,963	$52,907	$72,076	$21,904	$29,654	$53,001	$10,744				$306,411
Rhody Health Options	$19,702,359	$18,980,469	$24,303,468	$18,487,329	$17,830,359	$21,206,102	$19,136,485	$19,904,390	$21,094,999				$180,645,960
Rhody Health Partners	$22,162,510	$22,078,224	$22,952,014	$21,794,729	$22,109,161	$24,289,700	$21,643,874	$21,058,283	$21,377,520				$199,466,014
Other Services and Financial Transactic	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
CMS Demonstration	$9,618,380	$9,263,176	$10,197,234	$9,857,298	$9,351,323	$10,814,804	$9,762,942	$9,776,501	$8,025,912				$86,667,568
RHO - Drug Rebates	($183,960)	($81,636)	($599,596)	($269,369)	($18,171)	($283,493)	($431,615)	($37,337)	($429,337)				($2,334,514)
RHP - Drug Rebates	($1,371,901)	($812,831)	($6,074,934)	($2,603,797)	($184,331)	($3,427,013)	($5,396,980)	($461,357)	($4,899,257)				($25,232,401)
Rhody Other Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Rhody Expenditures	**$49,958,578**	**$49,450,374**	**$50,790,149**	**$47,319,099**	**$49,160,417**	**$52,622,003**	**$44,744,360**	**$50,293,481**	**$45,180,579**				**$439,519,039**
Note: Other Rhody Services include Risk Share, P4P, DRE.													
Pharmacy													
Pharmacy	$417,558	$300,275	$631,347	$344,035	$280,254	$464,078	$211,912	$371,749	$552,466				$3,573,674
Pharmacy Rebates	($26,219)	($39,103)	($2,908,921)	($44,600)	$0	($2,779,737)	($40,752)	($43,763)	($1,875,582)				($7,758,678)
Clawback	$5,245,379	$5,267,325	$5,288,958	$5,275,418	$5,255,510	$5,290,025	$5,253,976	$5,396,364	$5,421,618				$47,694,573
Total Pharmacy Expenditures	**$5,636,719**	**$5,528,496**	**$3,011,384**	**$5,574,852**	**$5,535,764**	**$2,974,366**	**$5,425,135**	**$5,724,350**	**$4,098,502**				**$43,509,569**
Note: Rebates reflect the amount received regardless of the time period to which they apply.													
Other Services													
Medicare Premiums	$5,084,245	$5,302,356	$5,142,517	$5,239,638	$10,681,791	$5,267,412	$5,297,586	$5,297,586	$6,670,446				$53,983,575
Recoveries	($1,508,343)	($565,376)	($1,458,098)	($695,508)	($453,386)	($593,919)	($819,638)	($916,665)	($1,738,662)				($8,749,595)
Transportation	$9,842	$5,316	$7,436	$5,102	$5,533	$8,051	$4,785	$9,939	$9,299				$65,303
Durable Medical Equipment	$198,175	$127,551	$253,838	$167,748	$141,151	$240,633	$165,785	$204,783	$283,259				$1,782,924
Rehabilitation	$1,134,080	$898,842	$2,274,373	$1,264,418	$691,727	$1,939,635	$591,809	$1,273,486	$2,005,276				$12,073,647
Tavares	$521,306	$538,876	$538,876	$506,601	$497,609	$522,466	$476,736	$498,451	$607,000				$4,707,921
Health System Transportation Project		$0	$13,500,000	$0	$0	$0	$0	$0	$0				$13,500,000
All Other	$2,471,006	$2,012,177	$3,259,384	$2,565,217	$2,144,375	$3,128,807	$1,828,244	$2,315,379	$2,887,181				$22,611,771
Total Other Services Expenditures	**$7,910,312**	**$8,319,743**	**$23,518,324**	**$9,053,215**	**$13,708,800**	**$10,513,086**	**$7,545,308**	**$8,682,959**	**$10,723,800**				**$99,975,546**
CNOM													
Transportation Broker	$36,760	$37,544	$39,360	$42,023	$40,083	$38,948	$41,197	$35,253	$43,365				$354,533
GPA	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
ORS	$16,034	$25,896	$73,759	$38,278	$36,964	$67,132	$34,453	$47,966	$56,285				$396,766
FQHC	($2,006)	($205)	($2,000)	($1,339)	($417)	($913)	($500)	$0	$0				($7,379)
Transportation for the Elderly	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
Total CNOM Expenditures	**$50,788**	**$63,236**	**$111,119**	**$78,962**	**$76,630**	**$105,167**	**$75,150**	**$83,219**	**$99,650**				**$743,919**
Special Education													
Special Education	**$1,077,387**	**$528,493**	**$988,155**	**$1,211,331**	**$1,021,163**	**$2,080,716**	**$1,015,969**	**$1,336,468**	**$1,947,340**				**$11,207,023**
Miscellaneous													
Adolescent Pregnancy	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
Bus Pass (TANF)	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
EHR payments	$327,250	$517,084	$682,632	$0	$34,000	$0	$34,000	$17,000	$167,168				$1,779,134
Quality Institute	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458				$2,254,122
Title XX	$0	$767,542	$0	$0	$0	$0	$0	$0	$0				$767,542
Total Miscellaneous	**$577,708**	**$1,535,084**	**$933,090**	**$250,458**	**$284,458**	**$250,458**	**$284,458**	**$267,458**	**$417,626**				**$4,800,798**
Medicaid Expansion													
Claims	$1,672,975	$218,719	($261,860)	$2,667,162	$681,412	$2,250,263	$1,977,601	$1,566,964	$2,779,794				$13,553,029
Financial Transactions	$0	($452,126)	($15,801,711)	($287,840)	$0	($3,967,098)	$0	$0	($343,157)				($20,851,932)
Premiums	$39,712,925	$39,005,387	$38,667,653	$39,079,765	$37,036,074	$40,077,326	$38,506,191	$39,121,999	$39,080,087				$350,287,406
Drug Rebates	($1,731,999)	($1,070,655)	($8,056,720)	($3,064,414)	($243,341)	($4,624,716)	($7,175,361)	($623,911)	($7,378,838)				($33,969,956)
Transportation Broker	$557,492	$531,874	$477,601	$544,420	$485,477	$538,135	$535,608	$539,028	$532,140				$4,741,774
Sobra Claims	$874,545	$509,682	$732,177	$568,193	$543,043	$1,086,876	$833,345	$582,286	$720,346				$6,450,493
Total Medicaid Expansion	**$41,085,938**	**$38,742,881**	**$15,757,139**	**$39,507,285**	**$38,502,664**	**$35,360,786**	**$34,677,383**	**$41,186,366**	**$35,390,372**				**$320,210,814**
Grand Total	**$327,330,827**	**$174,234,228**	**$190,537,712**	**$185,845,291**	**$183,689,443**	**$207,777,540**	**$164,915,230**	**$187,704,766**	**$184,973,947**	**$0**	**$0**	**$0**	**$1,807,008,984**

Attachment 6d
MAY 2018 CEC TESTIMONY

FY 2018 ADDITIONAL MONTHLY MEDICAID CASELOAD INDICATORS - MMIS

Hospitals	July	August	September	October	November	December	January	February	March	April	May	June
Inpatient Days (Incl Psych)	2,970	2,715	3,482	3,126	3,014	2,509	2,016	824	130	0	0	0
Inpatient DRG Discharges	46	73	75	87	26	38	17	30	208	0	0	0
Inpatient Non-DRG Discharges	1	0	1	0	0	0	0	0	1	0	0	0
Long Term Care												
NH Medicaid Days	47,482	51,104	51,872	62,203	83,785	61,089	56,622	72,965	55,526	0	0	0
NH Medicare Days	730	722	850	1,482	2,344	1,183	805	1,416	1,258	0	0	0
Hospice Days	3,971	6,321	6,283	5,920	5,369	3,292	3,933	3,949	4,654	0	0	0
Home and Community Based Services												
HCBS Eligibles												
Assisted Living	144	144	121	129	127	130	132	146	150	0	0	0
PACE	292	299	297	302	300	296	300	299	301	0	0	0
A&D Waiver, Personal	2	2	2	3	3	3	3	3	3	0	0	0
Choice/HAB Waiver	517	518	524	518	516	516	511	509	507	0	0	0
Habilitation Community Svc	20	20	23	22	21	21	21	20	21	0	0	0
Habilitation Group Home	24	26	25	25	26	26	27	26	25	0	0	0
Preventive Community Svc	1,001	1,007	984	987	987	991	999	1,004	1,003	0	0	0
Core Community Svc	2,396	2,373	2,386	2,369	2,375	2,429	2,441	2,432	2,540	0	0	0
Total Eligibles	4,396	4,389	4,362	4,355	4,355	4,412	4,434	4,439	4,550	0	0	0
Managed Care Enrollment												
RIte Care												
RIte Care Core	160,478	159,540	157,556	158,387	157,590	158,054	158,530	158,490	157,708	0	0	0
CSHCN's	7,760	7,788	7,662	7,624	7,558	7,417	7,373	7,323	7,298	0	0	0
Foster	2,486	2,504	2,585	2,689	2,725	2,785	2,796	2,865	2,911	0	0	0
Total RIte Care	170,724	169,832	167,803	168,700	167,873	168,256	168,699	168,678	167,917	0	0	0
RIteShare	7,268	7,109	6,843	6,846	6,661	6,541	6,363	6,186	6,005	0	0	0
RiteSmiles	104,671	105,059	104,181	105,433	105,969	107,377	108,533	109,312	109,879	0	0	0
Shared Living	136	145	151	153	160	161	165	164	169	0	0	0
Rhody Health												
Total Enrollment	14,831	15,498	15,277	14,993	14,765	15,260	15,319	15,241	15,109	0	0	0
Rhody Health Options												
Total Enrollment	10,726	10,999	11,173	10,188	10,186	11,068	11,539	11,855	12,109	0	0	0
Medicaid Expansion												
Total Enrollment	77,547	77,278	73,271	77,499	76,094	77,755	77,468	77,341	76,713	0	0	0
Pharmacy												
Scripts	9,995	6,908	11,127	8,853	6,767	12,002	6,272	8,667	11,970	0	0	0
Other												
Estates and Casualty Recoveries	$563,502	$480,083	$432,416	$265,376	$133,245	$153,843	$331,640	$388,335	$735,586	$0	$0	$0

May 2018 Caseload Conference

Questions for the Executive Office of Health and Human Services and

Department of Human Services

The members of the Caseload Estimating Conference request that the Executive Office of Health and Human Services and the Department of Human Services provide written answers to the following questions in addition to the presentation of their estimates on April 23, 2018. Please submit the answers no later than close of business April 19 so that staff can have the opportunity to review the material prior to the meeting.

In addition to the caseload and expenditure estimates, the testimony should include background information supporting each estimate, including (but not limited to) caseload and unit cost trends and key assumptions underlying the projections, as has been provided in the past.

Please also include enrollment/utilization projections for all Medical Assistance programs (including hospitals, nursing homes, pharmacy, in addition to the capitated programs). Please submit a hard copy of any information that is provided as an excel sheet embedded in the documents.

Unified Health Infrastructure Project

Please provide a "punch list" of what is left to do to have a fully functioning system including start and end dates as appropriate.

Please see attached the additional work required for RI Bridges Functionality:

May 2018 CEC - UHIP Addl Work.doc

Please fill out the following table to show the current functionality of the UHIP system to electronically: accept applications, process eligibility, determine eligibility and process monthly payments. Please indicate if any actions are done manually and what is the timeline to eliminate that.

RI Bridges - Electronic Processing					
Program	Benefits	Eligibility	Approval	Monthly Payments	Manual Actions Taken?
	RIte Share				
	Rhody Health Partners				
	Rhody Health Options				
	LTC				
	LTC- Patient Liability				
Medicaid	All Other Fee for Service				
	RI Works				
	RI Works - Sanctions				
	Child Care Subsidies				
	Child Care- Co-pay				
	SSI				
Cash Assistance	SNAP				

Please see the updated RI Bridges Functionality Chart attached:

RI Bridges
Functionality Chart

The Cash Assistance portion of the chart will be addressed during the Department of Human Services' presentation.

Fraud, Waste & Abuse

1) Please indicate the amount of recoveries received through waste, fraud and abuse efforts that has been undertaken by the Bureau of Audits, over and above usual levels. How does this compare to the November caseload estimate for FY 2018 and FY 2019?

The Office of Internal Audit (DOA) initiative enabled Medicaid to recoup funds from capitation payments made for certain deceased individuals. These are not recoveries, but reduced capitation payments. In February and March 2018, Medicaid recouped $5.0 M All Funds in gross capitation payments for SFYs 2017 and 2018. After adjusting for risk share and returning the federal portion to CMS, these recoupments amount to $400 K General Revenues savings.

2) Please provide the backup information on the caseload related components of the $8.5 million assumed in the Department of Administration's budget for the fraud, waste and abuse initiative. Because the general revenues savings are included in DOA and cannot be double counted as part of the May caseload estimate, we will also need to account for the Medicaid match distinct from the baseline estimate.

Any savings realized from the DOA initiatives will be realized in Medicaid. A journal entry will be made to credit the savings to DOA or an amendment will be made to adjust the DOA budget line. To date, only the savings addressed above have been operationalized. Medicaid will continue to work with the Office of Internal Audit to discuss an operational plan for the remaining savings.

3) How are any recoveries through the BAE contract accounted for in the caseload estimate? What are the total recoveries from this contract in FY 2018 and FY 2019?

The BAE contract enabled Medicaid with the Office of Program Integrity to identify and terminate certain persons residing Out of State. For SFY 2018, Medicaid sent out 1,751 additional documentation request forms for these individuals and completed 1,007 terminations; therefore, the budget initiative called "Improve Program Integrity," is marked as achieved. These savings are included in the caseload numbers.

Long Term Care Offline Payments & Reconciliation

1) Please include updated monthly medical assistance data that reflects in which month the "offline" payments would have been paid if UHIP were fully functional.

The month the "offline" payments would have been paid if UHIP were fully functional is not available.

2) Please include the information for nursing facilities, assisted living facilities, and home care providers by month, payment and provider.

Please see updated interim payment reports for nursing facilities, assisted living facilities, and home care providers attached.

May 2018 CEC -
Interim Payments 4-

3) Please provide a detailed description of the reconciliation process being used for the offline payments. This should include steps, entities involved, documents generated and timeline.

Documents generated and timeline are attached below.

Please see a copy of the update general Provider Letter that was sent out to Nursing Homes and Assisted Living Providers. An updated Provider Letter to Home Care providers is pending:

May 2018 CEC -
Letter - Assisted Livi

May 2018 CEC -
Letter - Nursing Hon

Please see a copy of the updated recoupment Provider Letters for Group One. These letters are populated with provider specific information, a generic copy has been provided herein.

May 2018 CEC -
Letter - Recon with I

May 2018 CEC -
Letter - Recon witho

Please see a copy of the Reconciliation process and timeline attached.

May 2018 CEC -
Payment Reconciliat

Entities involved: DXC, Medicaid, DHS, providers, Deloitte and state contract staff.

4) As of April 2018, what is the total that has been paid out in FY 2017 and FY 2018. How much has been reconciled and recouped? Have any further payments been made to a nursing facility resulting from the reconciliation?

To date, 27 nursing homes and 4 assisted living facilities have been contacted to begin the reconciliation. The initial reconciliation for a group of nine (9) nursing homes is complete. Reconciliation and recoupment from this group as of 4/11/18 totals $1,983,470.79. In addition to interim payments, the only payments to nursing homes are for claims paid through MMIS.

5) How many providers are impacted by this process and how are disputes handled? What is the responsibility of the facility in this process?

Interim payments have been made to 85 nursing homes, 24 assisted living, 18 home health, and 2 different hospice providers. The facilities must provide detailed information to support interim payments made between 9/16/16 and 1/17/17. Facilities are responsible for reviewing the state's findings and submitting reimbursement to the state for cases that have a paid claim in MMIS.

An attempt will be made to resolve disputes internally. If that process fails, providers have the Administrative Appeals process as an available next step, which is the state's process for dispute resolution.

6) What is the process to reconcile the applied income calculation? How is EOHHS tracking patient liability?

We are working with each provider on a case by case basis to ensure a full reconciliation of an accurate claims payment. Some providers estimated patient liability in their contingency payment request for each client, while others did not calculate a liability into their request.

At the end of each month, MMIS adjusts claims when there is an adjustment to applied income. MMIS will adjust the claim paid up or down depending on the updated calculation for the provider. EOHHS is recouping the contingency amount provided to the facility.

MEDICAL ASSISTANCE

Please provide, where possible, excel spreadsheets/tables with details/explanation for your narrative testimony related to expenditures, eligibility, growth factors and methodology for projections. Please include notes/comments within on any related adjustments or factors that are relevant to the estimate. *See supporting documentation in testimony and attachments.*

1) Please provide any limitation in the data used for estimates related to UHIP challenges.

The data provided includes data from RI Bridges. Any anomalies in this data would be included in these estimates.

2) Please provide the schedule for verifying and purging enrollment data. How many were deemed ineligible as a result of SWICA data? Identify the number of enrollees by month for those who are were deemed ineligible due to verification. How many have then deemed eligible and returned?

The State runs a process called "Post Eligibility Verification or PEV" every month. SWICA is updated refreshed quarterly by design.

In the PEV processing, a case is checked against external data. If the client reported data on a case matches the external data source, the case is considered a pass and no client action or state action is needed. If the client reported data on a case does not match the external data source and the difference between the two data sources is over the threshold for reasonable compatibility, the client receives an Additional Documentation Request (ADR). The client has 15 days to return the required documents to the State to verify their application information. If it is determined that the client no longer meets the eligibility requirements, the case is terminated.

Please see attachment below, "Monitoring PEV Batch Statistics" for additional information and statistics on ADRS and terminations.

May 2018 CEC - PEV Batch Processing.pd

3) Please provide an update on how the $0.9 million in savings as part of the agreement with Logisticare to reduce the contract is reflected in the caseload estimate.

Logisticare has agreed to provide a rebate to the State of Rhode Island of $900,000 in FY 2018 and $660,000 for the first 6-months of FY 2019. Logisticare intends to recover these savings through program and technological efficiencies while not adversely impacting delivery of services to members.

This savings is reflected as a recovery against Other Services.

FY 2019 Budget Initiatives

1) Attached is the spreadsheet that lists items included in the Governor's recommended budget that should be included in the Executive Office's testimony. There is also a spreadsheet that was included in the November conference estimate for current initiatives and the action taken in the November estimate for FY 2018 and FY 2019 please update the sheet for the May estimate.

*See **Attachment 2a**.*

2) Please provide an update on the negotiations with the community health centers for the change made in Article 12 of 2017-H 5175.

EOHHS has reached an agreement in principle with FQHCs to amend the payment methodology that will lead to savings compared to the status quo. We are also planning to move these payments in-plan in FY 2020.

3) Also include a reconciliation of which FY 2019 initiatives are included in caseload and which initiatives not included that require legislative change. Further, we ask that EOHHS testimony include updated information regarding the necessity of Category II or III changes, State Plan Amendments, or changes to State rules and regulations governing the Medicaid program for each item. If any or all of these actions are required, please include information regarding the anticipated timeframe for approval and the steps taken thus far to initiate the process.

Please see reconciliation chart attached.

Governor Initiatives - May 2018 CEC.doc

The normal rule promulgation process takes anywhere from 4 to 6 months. In general, SPAs require a 30-day public notice period and then CMS has 90 days to approve/deny the SPA. This timeframe can be extended. If at day 45,

CMS does not have enough information to make a decision, they will "freeze the clock." Under the new CMS administration, the time from SPA submission to SPA approval has decreased. The initiatives that are in bold font are more complicated SPAs that may require additional time. SPAs for those initiatives that require a July 1, 2018, effective date will be prioritized first, but EOHHS intends to submit draft SPAs to CMS well in advance of submission deadline to initiate the review process.

Long Term Care (including the Integrated Care Initiative)

1) Please provide an update on enrollment in the Integrated Care Initiative for dual eligible and certain Medicaid-only populations, consisting of the following:

***Attachment 5a** and **Attachment 5b** include revised forecast with actuals through March 2018 for Rhody Health Phase II (i.e. Integrated Care Initiative or ICI). There are no Medicaid-Only members enrolled in the ICI. Summary data is provided in the **Rhody Health Options** section of EOHHS' testimony.*

   a) Please provide a project plan or details on the process of reconciliation of offline nursing home payments.

The response to Question #3 under the Long-Term Care Offline Payments and Reconciliation section above identifies the steps in the reconciliation process. A more formal project plan is under development.

   b) Please identify the payments that have been made to nursing facilities that are "offline" in each month.

Please refer to the response provided for Question #2 under the section, Long Term Care Offline Payments and Reconciliation above.

2) Please provide distinguish between pre UHIP backlog and post UHIP backlog.

   a) Provide # of pending applications

In June 2016, OMB performance management data indicated that the State had 719 pending LTSS applications. As of April 13, 2018, the State has 842 LTSS applications pending for over 90 days.

   b) Please identify the payments that have been made offline to nursing homes, assisted living facilities and home care provider.

Please refer to the response provided for Question #2 under the section, Long Term Care Offline Payments and Reconciliation above.

   c) How many applications are being processed manually

The State is using RI Bridges to process all applications but various manual workaround or Interim Business Processes (IBPs) are being used to complete cases processing when necessary. For example, an IBP is used to correct transactions from RI Bridges and MMIS that have failed.

3) Current and anticipated caseload trends for both Rhody Health Options.

***Attachment 5a** and **Attachment 5b** include revised forecast with actuals through March 2018 for Rhody Health Phase. Summary data is provided in the **Rhody Health Options** section of EOHHS' testimony.*

a) A table of FY 2018 and FY 2019 Neighborhood capitation rates for Rhody Health Options (per member per month payments from the state to NHP).

*Please see **Rhody Health Options** section of testimony.*

b) Please provide an update on the opt-out/not returned mail rate for Rhody Health Options.

Please see RHO and ICI opt-out numbers below:

Total RHO Ever Enrolled and Opt Outs

November 2013 through April 2018

Program	Medicare Status	Pay Level	Total Clients Ever Enrolled	Total Clients Ever Opted Out	% Opted Out
RHO	Full Dual	SPMI	3,050	271	8.9%
		Developmentally Delayed	2,551	291	11.4%
		Community with LTSS	3,880	1,391	35.9%
		Nursing Home > 90 days	7,314	1,397	19.1%
		Community no LTSS	23,763	2,489	10.5%
	Medicaid Only	Nursing Home or Community LTSS	1,339	161	12.0%
		Partial Duals		25	
		Total RHO	37,344	6,523	17.5%

Total ICI Ever Enrolled and Opt Outs

November 2013 through April 2018

Program	Medicare Status	Pay Level	Total Clients Ever Enrolled	Total Clients Ever Voluntarily Disenrolled	Total Clients Ever Opted Out After Enrollment	% Disenrolled/Opted Out
ICI	Full Dual	SPMI	1,797	55	10	3.6%
		Developmentally Delayed	1,437	67	3	4.9%
		Community with LTSS	1,719	112	48	9.3%
		Nursing Home > 90 days	938	93	50	15.2%
		Community no LTSS	11,834	494	132	5.3%
		Total ICI	16,803	796	231	6.1%

The percentage of returned mail rate for Rhody Health Options for the last six months of 2017 was 6.3%.

4) Please provide description of the Rhody Health Redesign that is included in the Governor's recommended budget. What is the updated plan, steps or process of implementation, and anticipated outcomes.

Please see the draft description for the Dual-Eligible and Long-Term Services and Support Redesign attached.

May 2018 CEC -
RHO Redesign.docx

5) Please provide the enrollment and capitation rate information for the PACE program.

*Please refer to the **HCBS Section** of the testimony.*

Long Term Care

1) Please provide a breakdown of type of service for home and community care expenses identified as "All Other HCBS" in the monthly Medicaid Expenditure report.

Please see the attached file for the home and community care expenses.

May 2018 CEC -
HCBS Expense Delin

2) Please provide current and trended enrollment data of those dually eligible for Medicaid and Medicare.

Attachment 5a *and* ***Attachment 5b*** *include a break down enrollment data for all Aged, Blind and Disabled individuals, including those dually eligible for Medicaid and Medicare. These members are identified as either enrolled in Rhody Health Options or remaining in Fee-for-Service. (Please note that Rhody Health Partners is the mandatory managed care plan for ABD members not yet dually eligible for Medicaid and Medicare).*

Additionally, Rhode Island Medicaid provides limited assistance in the form of Medicare Premium Payment subsidies to an average of approximately 7,500 members each month.

Integrated Care Initiative

Please provide an update on the Integrated Care Initiative for dual eligibles and certain Medicaid-only populations, consisting of the following:

1) Current and anticipated caseload trends for both Rhody Health Options.

Attachment 5a *and* ***Attachment 5b*** *include revised forecast with actuals through March 2018 for Rhody Health Phase. Summary data is provided in the* ***Rhody Health Options*** *section of EOHHS' testimony.*

2) A table of FY 2018 and FY 2019 NHPRI capitation rates for Rhody Health Options PMPM payments from the EOHHS MA program to NHPRI. RHO

   a) Please provide PMPM for eligibility category

Current and prior fiscal year premium rates are included in ***Rhody Health Options*** *section. The FY 2019 premiums reflect a 4.0% price increase over existing FY 2018 rates.*

   b) Please provide risk share payments for the last five years and areas of expenditures they are related to.

A five-year history of risk share payments to NHPRI for Rhody Health Options Phase I and Phase II are included in the ***Rhody Health Options*** *section. Risk Share payments are made in the aggregate against under performance by the Health Plan against the medical baseline included in the premium. At this time, a precise breakdown of driving factors for health plan's overspending against the medical component is not known.*

However, prior rate setting work demonstrated that part of Risk Share was associated with overpayments by NHPRI for services where Medicare was primary payer. In current fiscal year, a proportion of losses are related to the enrollment in incorrect pay levels.

With respect to ICI, a majority of overall losses incurred are related to the underfunding of administrative functions by CMS in the Medicare component of the rate.

c) Please provide the PMPM payments NHP receives from Medicare.

This information is not available at this time.

d) Include spending categories we estimate in FFS

***Subsection I. Medicaid Expenditures by Type of Service** in **Major Developments** summarizes all spending (capitation payments and otherwise) by broad type of service based on distribution of expenditures reflected in development of prior period rates. This is intended as a proxy of actual expenditures by service type.*

Details by Budget Line and Capitation versus Fee-for-Service expenditures are included in accompany Excel Workbook.

e) Include nursing home and HCBS days as well and the average spend per person

EOHHS does not yet receive claims data from NHPRI for its ICI and so this data is not readily available.

However, EOHHS has received offline information related to nursing home expenditures through December 2018 that we will summarize and provide for conferees.

Managed Care

1) Please include the enrollment information by month in FY 2018 for Rite Care to include the number of recipients who were no longer eligible because of redetermination. Or is there still deferral of redeterminations that is currently impacting program enrollment? Is there still a backlog?

***Attachment 5a** and **Attachment 5b** provide monthly enrollment (with actuals through March 2018) across all pay levels in Managed Care and those remaining in fee-for-service.*

Additional information on monthly terminations will be provided in accompany Excel Workbook.

The State has been processing Passive MAGI renewals since August of 2017 (known as "exparte renewals"). The State is also processing non-MAGI renewals to a limited extent (known as "modified renewals)". The State does still have a backlog of historic renewals that need to be completed (due to the delays in implementing the renewals process). The State is currently working on a re-distribution plan to work the remaining backlog of historic renewals.

The majority of persons on RiteCare are included in the Passive MAGI renewals ("exparte") process. Please see attachment for some additional data on the renewals process. There are some categories of RiteCare recipients that are excluded from renewals such as DCYF subcare youth. In addition, some categories of RiteCare

recipients receive a modified renewal based on their aid category, such as parent/caretakers with Long Term Services and Supports.

May 2018 CEC -
Passive Renewal Bat

2) Please provide estimates for Managed Care, broken down by RIte Care, RIte Share and fee-for-service for FY 2018 and FY 2019. Please delineate those aspects of managed care programs not covered under a payment capitation system.

*Please see **Managed Care Section** for a detailed breakdown of Managed Care expenditures and membership.*

3) For the Managed Care Line Expenditure Detail sheet provided in previous testimony, please include the FY 2017 actual expenditures for each item (RIte Care, RIte Share, RIte Smiles, NICU) so estimators can compare current estimate to prior year spending.

Please see accompany Excel Workbook for comparison of expenditures to prior fiscal year (forthcoming).

Please note that certain expenditures may be allocated based on year-end close and impact of accruals.

4) Please provide the monthly capitation rate(s) for RIte Care. If different from cap rate assumed in the November 2017 estimate for FY 2018, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions and administrative costs. Also, where the testimony cites a percent based caseload or cost inflator, please ensure that the specific cost impacts are also provided.

*Please see **Managed Care Section** for a detailed breakdown of Managed Care expenditures and membership.*

Please note that Managed Care, Rhody Health Partners, Rhody Health Options, and Expansion each include a Price-Volume comparison that differentiates contributing factors to variance against Nov CEC Adopted for FY 2018 and FY 2019 and change between current FY 2018 estimate to current FY 2019 estimate.

5) Please provide transportation costs (by category) including those attributable to RIte Care families and disabled populations.

Logisticare assumed transportation broker responsibility for EOHHS's Medicaid non-emergency transportation program in May 2014. Logisticare's contract has been extended through December 31, 2018. EOHHS has released a Request for Proposals (RFP) and received more than 100 questions from potential bidders. EOHHS is responding to the questions by Monday, April 23rd, and bids are currently due from bidders by May 4th.

The following table forecasts the total EOHHS' non-emergency transportation budget and PMPM by budget line. These costs are included in the budgets of the respective lines of business:

Summary of Non-Emergency Transportation Expenditures, by Budget Line

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Surplus/ (Deficit)	Nov CEC	Current Forecast	Surplus/ (Deficit)	Increase/ (Decrease)	% Change
Capitation by Population Group:								
Managed Care	$ 15,001,489	$ 15,191,678	($0.2) M	$ 14,723,845	$ 15,443,362	($0.7) M	$0.3 M	1.7%
RHP	$ 4,245,241	$ 4,180,708	$0.1 M	$ 5,790,061	$ 4,201,781	$1.6 M	$0.0 M	0.5%
Rhody Health Options	$ 6,832,070	$ 6,948,648	($0.1) M	$ 4,254,345	$ 7,186,130	($2.9) M	$0.2 M	3.4%
Expansion	$ 5,999,572	$ 6,404,481	($0.4) M	$ 6,851,265	$ 6,591,295	$0.3 M	$0.2 M	2.9%
ABD Remaining in FFS	$ 2,928,945	$ 2,920,852	$0.0 M	$ 2,934,094	$ 2,983,731	($0.0) M	$0.1 M	2.2%
DEA CNOM[1]	$ 457,425	$ 481,578	($0.0) M	$ 465,713	$ 583,111	($0.1) M	$0.1 M	21.1%
Subtotal Capitation	$ 35,464,741	$ 36,127,945	($0.7) M	$ 35,019,323	$ 36,989,411	($2.0) M	$0.9 M	2.4%
Medicaid Offsets:								
TANF Charge Back	$ (1,969,800)	$ (1,949,280)	($0.0) M	$ (1,969,800)	$ (1,949,280)	($0.0) M	$0.0 M	0.0%
Logisticare Rebate	$ (900,000)	$ (900,000)	$0.0 M	$ (660,000)	$ (660,000)	$0.0 M	$0.2 M	-26.7%
Total Medicaid	$ 32,594,941	$ 32,797,087	($0.2) M	$ 32,389,523	$ 33,797,020	($1.4) M	$1.0 M	3.0%
General Revenue	***$ 13,271,283***	***$ 13,194,889***	$0.1 M	***$ 12,629,635***	***$ 13,408,285***	($0.8) M	$0.2 M	1.6%

Summary of Non-Emergency Transportation Enrollment, by Budget Line

	SFY 2018:			SFY 2019:			SFY19 over SFY18:	
	Nov CEC	Current Forecast	Increase/ (Decrease)	Nov CEC	Current Forecast	Increase/ (Decrease)	Increase/ (Decrease)	% Change
Enrollment by Population Group:								
Managed Care	174,598	176,812	2,214	171,367	179,741	8,374	2,929	1.7%
Expansion	69,827	74,540	4,713	67,389	76,714	9,325	2,174	2.9%
Rhody Health Partners	15,375	15,141	(234)	15,408	15,217	(190)	76	0.5%
Rhody Health Options	24,743	25,165	422	24,813	26,025	1,213	860	3.4%
ABD Fee-for-Service	10,608	10,578	(29)	10,626	10,806	180	228	2.2%
DEA CNOM[1]	1,847	1,944	98	1,880	2,354	474	410	21.1%
Total Enrolled	296,998	304,181	7,183	291,483	310,858	19,376	6,678	2.2%

Non-Emergency Transportation Rates, SFY 2016 – SFY 2019

	SFY 2016	SFY 2017	SFY 2018	SFY 2019[1]
Managed Care	$ 7.07	$ 7.07	$ 7.16	$ 7.16
Expansion	$ 7.07	$ 7.07	$ 7.16	$ 7.16
Rhody Health Partners	$ 22.99	$ 22.99	$ 23.01	$ 23.01
Rhody Health Options	$ 22.99	$ 22.99	$ 23.01	$ 23.01
ABD Fee-for-Service	$ 22.99	$ 23.06	$ 23.01	$ 23.01
DEA CNOM	$ 20.64	$ 20.64	$ 20.64	$ 20.64
Composite	$ 9.93	$ 9.80	$ 9.65	$ 9.74

Note:

1. FY 2019 rates do not reflect rates released as part of Transportation RFP.
EOHHS rebasing of Governor's FY 2019 Budget Initiatives will reflect the proposed rates.

a) Please provide a breakdown of types of usage of transportation.

During FY 2018 through February 2018, Logisticare provided the Rite Care, Children with Special Healthcare Needs, and the Medicaid Expansion populations 504,222 one-way trips, of which 383,365 were for mass transit rides; the Aged, Blind, and Disabled populations were provided 547,080 one-way trips, which included 115,410 mass transit rides, and the CNOM population were provided 26,214 one-way trips, which included 501 mass transit trips.

Rides for the Non-Medicaid Elderly population totaled 89,383 one-way trips, which included 361 mass transit rides. Transportation assistance is available for Rhode Island residents at age 60 or older when they have no other means of transportation to/from appointments for five specific priority categories that include dialysis/cancer treatments, general medical, IN-SIGHT services, adult day care, and meal sites.

Please see Trips by Treatment Type for the Medicaid and the Non-Medicaid Populations for CYs 2016 and 2017 attached. For the Medicaid populations, 48.4% of the total trips taken in CY 2016 and 53.5% of the total trips taken in CY 2017 were for substance abuse treatment services (not specifically Methadone), and 23.7% of the total trips taken in CY 2016 and 22.3% of the total trips taken in CY 2017 were for adult daycare.

For the Non-Medicaid Elderly populations, 30.3% of the total trips taken in CY 2016 and 32.3% of the total trips taken in CY 2017 were for dialysis treatments, 23.9% of the total trips taken in CY 2016 and 22.5% of the total trips taken in CY 2017 were for adult daycare, and 11.7% of the total trips taken in CY 2016 and 13.9% of the total trips taken in CY 2017 were for elderly meal sites.

Logisticare -
Treatment Type Repo

b) Please include transportation usage specific to methadone treatment.

Please see above for trips for substance abuse treatment services.

c) Please provide most recent performance/complaint report.

EOHHS also monitors Logisticare's monthly call statistics reports and customer and facility complaint reports. Attached are Logisticare's monthly call statistic report and complaint summary report for FY 2018, through February 2018:

Logisticare - Call
Statistics Report - Fe

Logisticare -
Complaint Report -

6) Please provide the projected SCHIP funding for FY 2018 and FY 2019 as well as a breakdown of any state-only expenditures and CNOM-funded expenditures in the estimates. If the estimate has changed from November, please provide an explanation for the change.

*Please see Table II-2 CHIP Claiming and Table II-3 EFP Claiming in **Managed Care** section.*

The accompany Excel Workbook provides detailed breakdown of all expenditure items with corresponding FMAP applied. In addition to CHIP and EFP with enhanced claiming, the Managed Care budget lines includes $200,000 of Early Intervention federal grant support

Rhody Health Partners

1) How many clients are enrolled in Rhody Health Partners?

    a) Please provide the monthly capitated payment for the different groups enrolled in Rhody Health Partners.

    b) If different from prior cap rate, please document the change according to: contributing factors such as medical expense trends, risk/claims adjustment assumptions and administrative costs.

*Please see **Rhody Health Partners** section for summary and variance information related to RHP enrollment and detailed explanation of variances in expenditures.*

***Attachment 5a** and **Attachment 5b** provide monthly enrollment (with actuals through March 2018) across all pay levels in Rhody Health Partners.*

Additional information on monthly terminations will be provided in accompany Excel Workbook.

2) Please include the disenrollment information by month in FY 2018 for Rhody Health Partners.

    a) When was the last time there was a recertification process to limited enrollment to those eligible for the program?

The State does not track or complete renewals based on program enrollment categories, such as "Rhody Health Partners." However, based on the aid categories/ base line eligibility of persons enrolled in Rhody Health partners, most of those persons should receive a Passive MAGI renewal ("exparte renewals"). These renewals occur monthly. Please see additional information as outlined in question No. 1.

The State continues to hold Deloitte accountable to fixing RI Bridges. Deloitte, at its own expense, has committed to ensuring RI Bridge works and is the best technology it can be for Rhode Island.

Hospitals

1) Please provide separate inpatient and outpatient estimates of hospitals for FY 2018 and FY 2018.

*Please refer to the **Hospital** section of the Testimony.*

Pharmacy

1) Please provide separate estimates of pharmacy expenditures and rebates for FY 2018 and FY 2018.

*Please refer to the **Pharmacy** section of the Testimony.*

Other Medical Services

1) Please provide an updated estimate of receipts for the Children's Health Account and expenditures for all Other Medical Services by service.

In August 2017, the Rhode Island Legislature passed a provision to increase the funds needed for the Children's Health Account. This legislation raised the threshold maximum, by types of service, from $7,500 to $12,500 per service. The total collection for SFY 2018 is $11,229,973.

The collections for the Children's Health Account for FY 2019 is expected to be $9,009,205. This dollar decrease is due primarily to the FY 2016 Reinvent Medicaid savings program that reduced the number of utilizers for these care management services. Going forward, EOHHS does not anticipate any further reductions in these services.

Please see Summary of Other Expenditures in the Other Medical Services section of RI EOHHS's medical benefits testimony.

2) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2018 and FY 2019.

Please see the attached file for the projected Medicare Part A and B premium costs.

May 2018 CEC -
Medicare Part A & B

3) What are the state-only costs in FY 2018 and FY 2019?

*Please refer to **Table XI-2** in the **Other Medical Services Section** of the testimony.*

Medicaid Expansion

1) Please provide updated caseload and expenditure estimates (with associated methodology) for FY 2018 and FY 2019 for the ACA-based Medicaid expansion population.

*Please see **Medicaid Expansion** section of testimony and **Attachment 5a** and **Attachment 5b**.*

2) What are the five-year projections for the Medicaid expansion program?

    a) What is the updated number of potential individuals who are eligible to enroll?

*A five-year forecast is included in **Medicaid Expansion** section of testimony.*

FY 2019 assumes a 3.5% trend for Medicaid Expansion. Subsequent years incorporate a 1.0% caseload trend.

3) Please provide a current estimate of the cost and number of participants of the Exchange premium support program (the "Affordability Assistance Program"). Please s*ee below.*

   a) Has the program now been automated through HSRI? If not, when is this expected?

The RI Affordable Health Care Coverage Assistance Program started in February 2014 for parents of Medicaid eligible children with annual household incomes under 175% of the federal poverty level (FPL). These parents are eligible for assistance to pay a portion of their monthly premium if they choose an appropriate Cost Sharing Reduction Silver qualified health plan (QHP) from HealthSource RI.

EOHHS revised budget reflects $225,215 All Funds and $286,227 All Funds for FY 2018 and FY 2019, respectively.

This funding will provide Premium Assistance Program coverage to 395 and 476 individuals in FY 2018 and FY 2019, respectively

The amount of assistance from the State to help pay the monthly premium is shown below:

Premium Assistance for Families with Income between 138 and 175% of FPL

	138% FPL to 150% FPL		***151% FPL to 175% FPL***	
Family Size	*Monthly Reimbursement for income less than this amount:*		*Monthly Reimbursement for income between this amount:*	
2	*$39*	*$22,715*	*$28*	*$22,715 - $28,805*
3	*$49*	*$28,676*	*$43*	*$28,676 - $36,365*
4	*$59*	*$34,638*	*$58*	*$34,638 - $43,925*
5	*$69*	*$40,600*	*$73*	*$40,600 - $51,485*
6	*$79*	*$46,561*	*$88*	*$46,561 - $59,045*

The current assistance program requires that individuals complete a one-page application and submit it to EOHHS. EOHHS verifies information provided by families through the UHIP system. The information verified includes the following:

- *family/individual has chosen a Silver plan through HSRI*
- *family/individual has made payment for the insurance coverage*
- *family/individual has a child actively eligible in RIte Care*
- *FPL as identified in UHIP*

Once verified, EOHHS issues a reimbursement to the family. The family needs to apply only once and each month a data file from UHIP identifies whether the family remains eligible for Affordability Assistance or not, based on the information noted above.

Automation of the assistance program has not yet been determined due to other system work priorities.

Behavioral Health

1) Please provide an estimate for FY 2018 and FY 2019 of Medicaid expenditures for behavioral health services.

Breakdown of historical behavioral health expenditures is provided in accompany Excel Workbook.

a) How many individuals receiving specialized, intensive services, such as ACT, are enrolled as "medically needy"?

There are on average of 6,336 members in IHH, 958 members in ACT, and 2,703 members in Opioid Treatment program in FY 2018. An estimate of the total annual costs by eligibility group (including Medically Needy) that are associated with the health home payments to the Community Mental Health Organizations and/or Opioid Treatment centers are presented below.

Estimate of SFY 2018 Behavioral Health Home Expenditures, by Eligibility Group

SFY	2017

	Average Monthly Eligibility:			Estimate Annual Cost:		
	IHH	ACT	OTP	IHH	ACT	OTP
Children and Families	**463**	**18**	**567**	**$ 2,336,423**	**$ 269,871**	**$ 1,456,270**
Expansion	**989**	**95**	**1,336**	**$ 4,986,751**	**$ 1,446,914**	**$ 3,431,704**
Children with Special Healthcare Needs	**13**	**1**	**2**	**$ 67,655**	**$ 11,403**	**$ 5,564**
Aged, Blind and Disabled						
SSI	3,330	600	635	$ 16,791,571	$ 9,121,133	$ 1,629,824
Elders and Adults with Disabilities (SSI-like)	1,116	165	143	$ 5,628,847	$ 2,501,058	$ 367,866
217-waiver	181	37	7	$ 913,138	$ 558,747	$ 16,692
Medically Needy	208	42	12	$ 1,046,348	$ 633,500	$ 30,816
Sherlock	26	1		$ 129,848	$ 16,471	
BCCTP			1			$ 3,638
Aged, Blind and Disabled Total	**4,861**	**844**	**798**	**$ 24,509,752**	**$ 12,830,909**	**$ 2,048,836**
Grand Total	**6,326**	**958**	**2,703**	**$ 31,900,581**	**$ 14,559,097**	**$ 6,942,374**

Note:

1. OTP expenditures do not include the additional $85 weekly charge for methodone costs.

Definitions:

IHH - Integrated Health Home
ACT - Assertive Community Treatment
OTP - Opioid Treatment Program

b) What costs are projected for the opioid treatment health home program in FY 2018 and FY 2019? How many individuals receiving the service are part of the medically needy coverage group?

Please see response to 1(a) above.

2) Please include the impact to the managed care estimate, by program, for the recent consolidation of East Bay Community Action Program and East Bay Mental Health. Are the services provided through the mental health center now subject to the same reconciliation process that reimburses for encounter data because it is now part of an agency that is a licensed federally qualified health center.

Yes, the services provided by the mental health center are now subject to the same reconciliation process as those services provided by the medical health services center.

The merger occurred in January 2016. The impact of the merger and increasing the number of encounters and total payments made to East Bay Community Action Program are reflected below. It is noteworthy that plan payments to EBCAP increased by $600,00 over the two fiscal years, but EOHHS wrap payments increased by $2.5 million raise the share of total revenues paid through the PPS from 52% to 65%.

	FY 2015	***FY 2016***	***FY 2017 Prelim.***
Encounters	*10,180*	*14,732*	*21,929*

MCO Payments	*$999,678*	*$1,198,741*	*$1,591,447*
PPS Wrap	*$1,063,403*	*$1,786,846*	*$2,935,101*
Total PPS	*$2,063,081*	*$2,985,587*	*$4,526,548*
% EOHHS	*51.5%*	*59.8%*	*64.8%*

3) Please provide costs expected to be incurred in FY 2019 and if applicable FY 2018, for the following programs. Please indicate the costs to programs individually.

   a) Recovery Navigation (STOP) program

For FY2019, the State has provided a bundled rate of $422.50 for the Recovery Navigation program. Beginning in April 2018, the State anticipates that 80 units a month will be provided to Medicaid eligible individuals, and these expenses are reflected in our caseload testimony. Although the State will pay for this program with State only dollars until the methodology is approved, we anticipate that the State can retro claim for this program.

   b) Peer Support Programs

EOHHS just received approval for peer support services in April of 2018. EOHHS is now working on a process to implement a peer support service code and rate for Medicaid Fee for Service billing. This code and rate is not currently operational.

An estimate of total expenditures for Peer Support Program for FY 2018 and FY 2019 and has not changed since Nov CEC. These expenditures appear in the Managed Care and Expansion budget lines.

   c) Centers of Excellence

Average monthly census in Centers of Excellence is approximately 100 members. This number is expected to increase as additional centers open and access expands.

Because of difficulties that the COEs have with submitting claims, our cash payments grossly understated EOHHS' anticipated liability. As such, our estimate for COE for FY 2018 and FY 2019 and has not changed since Nov CEC. These expenditures appear in the Managed Care and Expansion budget lines.

   d) Behavioral Health Link Program

FY 2019 assumes a 5/1/18 Implementation Date for BH Health Link with total provider payments budgeted at $600,000. The bundled payment rate has yet to be finalized.

This estimate is reflected in EOHHS' overall investment for overdose treatment currently budgeted to Managed Care and Expansion.

Governor's FY 2019 Savings Proposals

1) Please update the savings included in the Governor's FY 2019 recommended budget for the May caseload estimate.

*Please see **Attachment 2b** and accompany Excel Workbook. (forthcoming)*

2) Please update the savings to tie to the appropriate program. For example, Rhody Health Redesign is a net savings shown in the Rhody Health Options program instead of adjustments to the fee for service programs and significant decrease to the managed care plan.

*Please see **Attachment 2b** and accompany Excel Workbook. (forthcoming)*

3) Please identify which new authorities contained in the pending 1115 Waiver (Extension) request are necessary to achieve savings targets/initiatives contained in the current Governor's recommendation.

Please see the attached file for an overview of requests within the 1115 Waiver Extension Request.

Map of
Waivers.Appropriati

General Questions

Medically Needy Coverage Group

1) What are the eligibility requirements to receive Medicaid coverage as "medically needy"?

A Medically Needy (MN) spenddown, previously referred to as the "Flexible Test of Income", is a cost-sharing approach that provides a Medicaid eligibility pathway for certain people who have income above the limit for their applicable coverage group if they have high health expenses. Under the State's Medicaid State Plan, members of these populations become eligible for Medicaid by "spending down" their income to a limit established by the state (currently about $980 per month) - - known as the MN income limit or MNIL by deducting certain health care expenses. The following populations may be MN eligible under this section:

a) Elders and adults with disabilities with income above 100 percent of the FPL;

b) Children with income above the MACC limit of 266% of the FPL (includes the 5% disregard);

c) Pregnant women with income above the MACC limit of 258% of the FPL (includes the 5% disregard);

d) Parents/caretakers with income above the MACC limit of 138% of the FPL (includes the 5% disregard);

e) Non-qualified non-citizens seeking coverage for emergency Medicaid if ineligible under all other pathways. (See § 1.7.5 of this Subchapter); and

f) Certain refugees, as defined in § 1.7.3 of this Subchapter, who do not otherwise qualify for Medicaid health coverage or commercial insurance with financial help through HSRI.

2) How many individuals are deemed medically needy? What are the projected costs?

Please see accompany Excel Workbook for distribution of expenditures by Eligibility Group and Service Type. Costs reflect historical expenditures on a paid basis for FY 2016 and FY 2017.

3) What is the process for requalification and how often does requalification occur?

The MN cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility for Medicaid health coverage as MN is not established, however, until the applicant has presented proof of health expenses incurred and paid or that remain outstanding for the eligibility period. Any health expenses for which a beneficiary continues to be liable dating back to the retroactive period are also considered. The six (6) month renewal period includes the spenddown calculation of allowable health care expenses.

a) Please provide a list by month of those who have flexed on and off Medicaid for FY 2017 and FY 2018.

This data is not available at this time. EOHHS is working to develop query to analyze eligibility patterns among its Medically Needy population. Additional information will be forthcoming.

SSI Like Coverage Group

1) What are the eligibility requirements to receive Medicaid coverage through the SSI-like eligibility pathway for those receiving community Medicaid benefits?

"SSI-like" is a reference to the Low-Income Elders and Adults with Disabilities (EAD) eligibility group. In addition to meeting general eligibility requirements (e.g., residency, immigration/citizenship, etc.) an individual must meet the following criteria to be eligible:

For EAD:

a) Characteristic requirements:
- *Age: 65 or older; or*
- *Disability: Determined by the State's Medicaid Assessment and Review Team to meet the applicable SSI disability standards; or*
- *Blindness: Federal regulations preclude states that have expanded SSI-based eligibility to income above the SSI standard (at or below 75%) to treat blindness as a distinct eligibility characteristic. Accordingly, applicants who are blind and are ineligible for SSI or an SSI Protected Status are subject to a MART disability determination.*

b) Financial requirements:
- *Income: Total countable income must be at or below 100% of the FPL; and*
- *Resources: Total countable resources must not exceed $4,000 for an individual and $6,000 for a couple.*

For SSI and SSI-Protected Status groups:

a) SSI – There is no distinct state-based eligibility pathway for SSI recipients. Medicaid eligibility is automatic upon approval of SSI. The SSA determines eligibility for SSI and notifies the State of the SSI recipient's eligibility through an electronic data exchange.

b) SSI-Protected Status – There are certain circumstances in which SSI recipients who lose or otherwise no longer qualify for full cash assistance benefits are afforded "protected status" which allows them to retain their Medicaid eligibility. In such instances, the person is treated as if he or she is an SSI recipient for Medicaid eligibility purposes.t

2) How many individuals are deemed SSI-like for community Medicaid benefits? What are the projected costs?

Please see accompany Excel Workbook for distribution of expenditures by Eligibility Group and Service Type. Costs reflect historical expenditures on a paid basis for FY 2016 and FY 2017.

3) What is the process for requalification and how often does requalification occur?

Individuals are eligible for a 12-month period. Eligibility is renewed using a modified passive renewal process. Individuals must review and update a pre-populated form containing information obtained in their accounts and updated through electronic data matches about eligibility factors that are subject to change.

Medical Assistance Review Team (MART)

1) For FY 2018, please provide a list, by month, that includes how many individuals have applied for Medicaid through the MART and how many have been approved for coverage and how many have been denied and at what step the denial occurred, if the information is available. Please provide the information for FY 2017 if it is available.

Medical Assistance Review Team Statistics, January 2017 through March 2018

CY 2017:													
	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Total
New Applications	6	59	49	45	44	43	36	49	38	29	41	41	**480**
Approvals	**1**	**4**	**6**	**5**	**19**	**15**	**11**	**9**	**13**	**1**	**5**	**8**	**97**
Denials	**4**	**23**	**30**	**40**	**36**	**35**	**31**	**24**	**39**	**48**	**34**	**39**	**383**
CY 2018:													
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Total
New appl	26	33	16										**75**
Approved	**2**	**7**	**4**										**13**
Denied	**24**	**37**	**27**										**88**

a) How many as medically needy and how many as SSI like?

All members who applied thru MART had MAGI MA coverage with SSI or SSI hearings pending. Per the attached, in CY 2017, 480 members applied for SSI status, 383 members were denied, and 97 were approved.

Additional Work Relating to UHIP/ RI Bridges

This is a complex system. We are making considerable progress in addressing the deficiencies but work remains. The State and Deloitte have developed a robust plan through July to bring the system close to substantial federal compliance. Through this release planning effort, the State and Deloitte have identified deficiencies across 38 program and functional areas that must be addressed. These 38 "themes" – defined as collections of fixes required to deliver a business capability – are reviewed weekly by joint State and Deloitte teams. In this way, we know that specific business functionality will be delivered in to the system at specific release dates. This will allow for better business planning and clear dates by which we expect certain pieces of functionality to be operating with a minimal number of defects.

At the same time, Deloitte has utilized new tools and dedicated additional resources to the triage of any defects in the system. This effort would confirm that that there are no additional incidents to be addressed. An incident accounts for any concern experienced in the system that needs to be investigated and, as needed, resolved. IT systems generally require updates and enhancements during their useful life, so an incident number will never hit zero. However, the incident count in RI Bridges should gradually decline over time as the system is stabilized. The number of new and existing incidents logged into RI Bridges has been declining steadily over the last several months. As of the beginning of April, open incidents totaled 2,557 – dropping 67 percent since December 2017. Deloitte anticipates fully completing this triage by early May.

Given the need to continue incident triage, The State and Deloitte recognize that there will likely be defects to fix after July and while we believe that we will have addressed critical business functionality by July, additional releases in to the fall will be necessary. Planning for these releases is ongoing but deficiencies fixed in this timeframe should have little overall impact on caseload.

While the State and Deloitte continue to work on all 38 themes, we have included details on the 5 most relevant to conferees below. All told, we expect that 31% of the deficiencies will be addressed by the end of April, 50% by the beginning of July, and the remaining 18% after July. The exact defects being fixed are subject to change.

1) *Termination Quality*

   While terminations have stabilized and the State believes that RI Bridges functionality is no longer a driver of caseload, deficiencies remain in termination functionality to be addressed. Most of these deficiencies are currently mitigated by business process, but the fixing of these deficiencies will allow more efficient and accurate processing of terminations. These deficiencies include notice triggers, address accuracy, and disposal dates. Currently 15 defects are scheduled to be addressed in April, with 8 remaining for early July and 8 for after July.

2) *MMIS Stabilization*

This theme exists to ensure that RI Bridges and MMIS accurately reflect one another without excessive manual intervention. Examples of deficiencies to be addressed include avoiding demographic discrepancies and reducing manual intervention. 8 defects are expected to be addressed by the end of April with an additional 6 to follow in early July.

3) *RIteShare Eligibility Accuracy*

This theme exists to ensure that eligibility, enrollment and notices are accurate and meet required regulation for the RIteShare program. Examples of deficiencies to be addressed included enrollment and employer screen updates, task improvement and updating addresses. 8 defects are scheduled for the end of April, 8 for early July and 10 longer term changes to RIteShare screens are proposed for after July.

4) *MAGI & QHP Eligibility*

When policy or field staff identify eligibility errors, incidents are logged and the root cause fixes are tracked in this theme. The State is currently tracking 11 defects for resolution by early July.

5) *CMS Eligibility PERM Audit*

As part of CMS's regular PERM audit, CMS identified eligibility incidents that must be addressed. These include issues with verification results and household composition. The State is currently tracking 17 defects for resolution by early July, and 4 for a post-July release.

We will consider the system complete when it complies with all federal rules and regulations and is working for Rhode Islanders. That means:

- *Benefits are being delivered accurately and in a timely manner;*
- *Workers can process applications without system defects;*
- *Provider payments are being paid consistently and accurately;*
- *Notices are sent in a timely and accurate manner*

We are making strides every day. And we will not let up until this vision is realized.

RI Bridges Functionality

updated for May 2018 CEC by EOHHS

Instructions. Please fill out of the following table to show the current functionality of Rhode Island Bridges system to electronically: accept applications, process eligibility, determine eligibility and process monthly payments. Please indicate if any actions are done manually and what is the timeline to eliminate that.

Medicaid:

Benefits	Eligibility & Approvals	Monthly Payments	Manual Actions Taken?
RIte Care	Eligibility accomplished through the MAGI hierarchy logic. Some eligibility issues (Ex. Newborns)/ issues with notices exist (ex. Terminations). Expect to alleviate problems in CY 2018. *Issues are being tracked through various themes including: Termination Quality, Eligibility, and MMIS Stabilization.*	Some problems with transmission of eligibility/approval data to the MMIS claims processing system. Largely, transactions for this group are processed successfully.	Some IBP to correct transcations, if needed. System/notices issues cause termination postponements until problems are corrected. Some system & data discrepancies exist between Bridges and MMIS.
RIte Share	OHHS continues to work with Deloitte on developing full functionality in Bridges. Currently staff is operating under a manual Interim Business Process which involves using an Access Database and the MMIS almost completely bypassing Bridges. EOHHS continues working with Deloitte staging different levels for functionality. Full migration to Bridges targeted for possibly late CY 2018/early 2019.	Using the prior system (Access Database) to transfer eligibility to the MMIS claims payment system. Involves manual work to get eligibility to MMIS.	Anticipate to migrate the Rite Share data to Bridges in late CY 2018/ early 2019 to work with the needed Rite Share app functionality due to be available then.
Expansion	Eligibility accomplished through the MAGI hierarchy logic. Some issues with notices exist (ex. Terminaitons). Expect to alleviate problems in CY 2018. *Issues are being tracked through various themes including: Termination Quality, Eligibility, and MMIS Stabilization.*	Some problems with transmission of eligibility/approval data to the MMIS claims processing system. Largely, transactions for this group are processed successfully.	Some IBP to correct transcations, if needed. System/notices issues cause termination postponements until problems are corrected. Some system & data discrepancies exist between Bridges and MMIS.
Rhody Health Partners (RHP)	RHP moved to Bridges using the hierarchy logic for eligibility. Some issues with notices (ex. Terminaitons) exist. Expect to alleviate problems in CY 2018. *Issues are being tracked through various themes including: Termination Quality, Eligibility, and MMIS Stabilization.*	Some problems with transmission of eligibility/approval data to the MMIS claims processing system. Largely, transactions for this group are processed successfully.	Some IBP to correct transcations, if needed. System/notices issues cause termination postponements until problems are corrected. Some system & data discrepancies exist between Bridges and MMIS.
Rhody Health Options (RHO)	RHO migrated to Bridges using the hierarchy logic. Some eligibility issues - identification of Medicare data -) and issues with notices exist. Expect to alleviate problems in CY 2018.	Problems with transmission of eligibility/approval data to the MMIS claims processing system. In eligibility determination, Bridges may not have the proper Medicare data to support this eligibility determination, recipient ends up improperly in Expansion. System still needs improvements as manual actions are used to resolve situations in the MMIS and at the HMO's as IBP, as well as for client notices.	Some IBP to correct transcations, if needed. System/notices issues cause termination postponements until problems are corrected. Some system & data discrepancies exist between Bridges and MMIS.

Medicaid:

Benefits	Eligibility & Approvals	Monthly Payments	Manual Actions Taken?
LTC - Patient Liability	Complex Medicaid (LTC) newly migrated to Bridges using the Medicaid hierarchy logic. System can now easily identify applicants who are not MAGI eligible and streamlines components of the MAGI flow. Some eligibility issues exist. Backlog is currently about 920 cases pending over 90 days. Expect to alleviate system and backlog problems by July 2018. Most system problems related to calculating cost of care have been resolved or are scheduled for a system fix by June. Challenges continue with transmitting the correct cost of care calculation from Bridges to the MMIS system and from the MMIS system to the Neighborhood enrollment file. Issues expected to be alleviated before the end of the year. *Issues are being tracked in the LTSS Cost of Care/ CSRA Calculation.*	Eligibility transmitted from Bridges to MMIS claims payment system nightly. System still needs improvements. The current transaction success rate is 70% on average, with waiver transactions being the most problematic.	Problems are being troubleshot and addressed routinely either through Bridges updates, code changes, manual actions in the system and/or through other types of payments and processing. **Specifically, all segments of eligibility over 11 months old are being manually submitted to MMIS on a weekly basis. Manual interventions are still needed to address MMIS transactions that fail on first supmission**. Interim payments are still being made to facilities outside of the MMIS system due to the backlog of cases pending over 90 days. **Additionally, supervisors are regularly using a manual override to correct patient cost share and spousal allowances and to correct case closure dates when a case closes due to death.**
All Other Fee for Service	Fee for Service clients/cases migrated to Bridges using the MAGI hierarchy logic. Some eligibility (ex. Terminaitons) issues exist. Expect to alleviate problems in CY 2018. *Issues are being tracked through various themes including: Termination Quality, Eligibility, and MMIS Stabilization.*	Some problems with transmission of eligibility/approval data to the MMIS claims processing system. Largely, transactions for this group are processed successfully.	Some IBP to correct transcations, if needed. System/notices issues cause termination postponements until problems are corrected. Some system & data discrepancies exist between Bridges and MMIS.

Benefits	Eligibility & Approvals	Monthly Payments	Manual Actions Taken?
RIWorks	Rhode Island Works is the State program that distributes the cash assistance portion of the Temporary Assistance for Needy Families (TANF) block grant, which serves about 10,000 low income Rhode Islanders per month. With TANF, most recipients are required to work with an Employment Career Advisor (ECA) to develop an employment plan that specifies work activities with particular providers, and providers are required to log participant attendance that is regularly checked by ECAs who then issue sanctions or closures for non-compliance. Some eligibility issues/ issues with notices exist. Expect to alleviate problems in CY 2018. Issues are being tracked through various themes including: RI EARR, RIW Hardships, RIW Sanctions, and RIW Timeclocks.	System is predominately stable for current monthly benefits issued to customers EBT (cash account) card timely.	Problems being troubleshot within the system and fixed (via code changes and database queries if needed) as they occur.
RIWorks - Sanctions	A sanction is a temporary reduction in cash benefits that is applied to a TANF case when a customer does not meet work participation requirements or cooperation with child support. Initial errors in RIBridges led to incorrect benefit calculations and a lack of appropriate tracking and curing of non-compliance. Some eligibility issues/ issues with notices exist. Expect to alleviate problems in CY 2018. Issues are being tracked through various themes including: RIW Sanctions.	Sanctions are applied to cases and lifted through RIBridges. On the grounds business processes and communications between eligibility, service and child support workers has streamlined the timely processing of sanctions.	Problems being troubleshot within the system and fixed (via code changes and database queries if needed) as they occur.

Medicaid:

Benefits	Eligibility & Approvals	Monthly Payments	Manual Actions Taken?
Child Care	RIBridges childcare provider portal has been redeployed and is functioning with greater stability. DHS has focused efforts on improving functionality related to providing consistency across Child Care Provider Portal and payments, improving provider usability, increasing the accuracy and timeliness of payments, SEIU collective bargaining agreement compliance, recoupment and over payment to child care provider, consistently and accurately enrolling CCAP providers, consistently and accurately allow for CCAP providers to enroll children in the provider portal, ability for DCYF to enroll foster care children in portal, ability to export accurate data for CCAP reports, send appropriate notices to families and letter to CCAP providers, implement direct deposit process, clean up language on provider portal. CCAP eligibility is now running through RIBridges. Some eligibility issues and notices issues exist. Expect to alleviate problems in CY 2018 as well as address any additional functionality needed. Issues are being tracked through various themes including: CCAP Eligibility, and CCAP Enrollment/ Financial.	There were problems with payments to providers since implementation. System is now predominantly stable for payment issuance, though limitied issues remain with co-payment calculation, which can impact payment accuracy. Off cycle payments continue to take place to immediately correct any underpayments to providers.	Problems being troubleshot within the system and, when possible, fixed (via code changes and database queries if needed) as they occur. Manual workarounds continue to be used when additional time is needed to address issues.
SSI	SSI eligibility occurs through the Social Security Administration (SSA). Data extracts enter RIBridges through interfaces with the SSA where eligibility for Medicaid and State Supplemental Payments are displayed. Some eligibility issues/ issues with notices exist. Expect to alleviate problems in CY 2018. Issues are being tracked through various themes including: SSP Benefit Issuance, and SSP Eligibility.	There were problems with payments during the first few months. System is predominantly stable for payments.	Problems being troubleshot within the system and fixed (via code changes and database queries if needed) as they occur.
GPA	GPA Bridge, Hardship and Burial eligibility is running through RIBridges. Some eligibility issues/ issues with notices exist. Expect to alleviate problems in CY 2018. Issues are being tracked through various themes including: GPA Eligibility and GPA Issuance.	There were problems with payments during the first few month. System is predominantly stable for payments.	Problems being troubleshot within the system and fixed (via code changes and database queries if needed) as they occur.

Medicaid:

Benefits	Eligibility & Approvals	Monthly Payments	Manual Actions Taken?
SNAP	SNAP, previously known as food stamps, provides approximately $300 million annually in federally funded benefits to low-income individuals and families to purchase unprepared foods. The program serves approximately 170,000 Rhode Islanders each year. To be eligible for SNAP a household must have a combined income below 130% of the federal poverty line (FPL) — about $26,200 a year for a three-person family. SNAP eligibility is now running through RIBridges, the department's new integrated eligibility system. While technical issues in the system persist, most households are able to receive benefits in a timely manner. Any technical issues that block application processing or prevent SNAP benefits from being issued, are prioritized for fixes with the system vendor and are addressed as quickly as possible to minimize impact on individuals and families. Issues are being tracked through various themes including: SNAP ABAWD, SNAP Eligibility Expenses, SNAP Eligibility Results, SNAP Household Composition, SNAP Quality Control Sanctions, SNAP Re-certifications, SNAP Reports, and SNAP Timeliness.	The system is predominantly stable for monthly benefit issuances. Households deemed eligible for continued participation in SNAP receive their benefits on the first day of each month.	The need for manual workaround and actions continue to decrease. Whenever there is a system issue affecting a case, a ticket is written to track it from solutioning to fix.

Notes:

1. Eligibility results in approvals, so the two columns are combined into one.
2. Manual work can be performed in the system OR via external work-arounds used prior to the 9-13-2016 rollout.

Nursing Facility Interim Payments Made in SFY 2018

Nursing Facility Name	July '17	August '17	September '17	October '17	November '17	December '17	January '18	March '18	April '18	YTD
ALPINE NURSING HOME INC	$88,121		$49,055			$57,579	$47,208	$14,919	$14,763	$271,645
ATHENA ORCHARD VIEW LLC	$120,579	$183,125	$88,157	$142,400		$159,835	$127,506	$84,478	$109,380	$1,015,460
AVALON NURSING HOME		$68,816				$68,816				$137,632
BALLOU HOME FOR THE AGED	$29,559	$77,880	$38,409			$69,915		$63,543		$279,306
BANNISTER OPERATIONS ASSOC LLC	$51,456	$26,304	$82,400	$24,400		$145,400	$136,000	$62,000	$82,200	$610,160
BERKSHIRE PLACE	$134,076.97	$127,429.90	$183,542.92	$147,303.14		$214,035	$69,756	$176,537	$105,513	$1,158,194
BETHANY HOME OF RHODE ISLAND	$83,552.00	$104,608.00				$20,608.00		$78,176		$286,944
BRENTWOOD NURSING HOME	$49,984.00	$38,368.00	$45,232.00							$133,584
BRIARCLIFFE MANOR	$141,280.61	$99,936.35		$308,740.89		$195,592			$198,653	$944,203
BROOKDALE SMITHFIELD										$0
BURRILLVILLE HEALTH CENTER						$602,774			$211,574	$814,348
BURRILLVILLE NURSING HOME								$16,104		$16,104
CEDAR CREST NURSING CENTRE INC										$0
CHARLESGATE NURSING CENTER	$79,170.00	$57,246.00	$37,149.00	$36,540.00		$30,450.00	$31,465.00	$37,758	$34,104	$343,882
CHERRY HILL MANOR	$117,831.00	$127,786.00	$127,786.00	$131,949.00		$244,350	$187,697	$207,064	$105,342	$1,249,805
CLIPPER HOME, THE										$0
CORTLAND PLACE	$82,146.98	$98,644.94	$60,737.86	$37,768.03		$57,233	$39,568	$23,717	$13,339	$413,154
COVENTRY HEALTHCARE AND REHAB. CENTER			$489,533.00		$122,954.34	$260,524.00		$373,214		$1,246,225
CRA-MAR MEADOWS	$37,884.00	$26,404.00	$30,504.00	$29,520.00		$35,096	$10,168			$169,576
CRESTWOOD NURSING & CONV HOME INC										$0
EASTGATE NURSING & RECOVERY CENTER	$27,900			$153,450		$79,236			$193,998	$454,584
ELDERWOOD AT RIVERSIDE			$107,853.05	$13,739.08		$348,163.41		$204,678		$674,434
ELMHURST OPERATORS, LLC.	$230,312.12	$166,151.92	$240,802.27	$110,311.10		$292,712	$185,931	$122,592	$333,005	$1,681,818
ELMWOOD HEALTH CENTER	$16,920.00	$17,484.00	$40,608.00	$22,560.00		$68,056.00			$103,588	$269,216
EVERGREEN HOUSE HEALTH CENTER	$181,498	$72,335	$163,159.66	$48,915.94		$520,039.02	$203,712	$75,330	$155,480	$1,420,470
FRIENDLY HOME	$121,400.39	$80,095.95	$95,984.97	$79,714.82		$215,304	$117,113	$55,405	$51,653	$816,670
GOLDEN CREST NURSING CENTRE										$0
GRACE BARKER NURSING CENTER INC.		$210,857				$240,334				$451,191
GRAND ISLANDER CENTER			$301,124		$265,964.11	$119,354.00		$189,074		$875,516
GRANDVIEW CENTER			$436,348.00		$143,460.66	$71,064.00		$76,892		$727,765
GREENE ACRES HEALTHCENTER, LLC		$223,916				$148,610		$101,332	$8,624	$482,482
GREENVILLE HEALTHCARE AND REHAB. CTR.			$394,362.00		$56,388.20	$222,708.00		$316,173		$989,631
GREENWOOD NURSING & REHAB. CENTER			$313,280.00		$59,897.46	$121,574.00		$176,398		$671,149
HALLWORTH HOUSE (Episcopal Housing Foundation)	$33,935.38	$9,995.00	$74,329.07			$52,711	$43,359	$64,759	$71,355	$350,444
HARRIS HEALTH CARE CENTER-NORTH (Quality Gerontological Services)	$20,020.22	$15,387.22	$22,114.41	$9,519.25		$16,765	$6,053	$1,412		$91,271

Nursing Facility Interim Payments Made in SFY 2018

Nursing Facility Name	July '17	August '17	September '17	October '17	November '17	December '17	January '18	March '18	April '18	YTD
HARRIS HEALTH CENTER, LLC		$21,519.97	$19,478.72	$22,686.55		$8,803	$10,396	$4,065		$86,949
HATTIE IDE CHAFFEE HOME										$0
HEATHERWOOD RI, LLC	$130,055.28	$137,663.59	$99,832.73	$88,509.41		$161,296	$72,559	$44,031	$58,163	$792,110
HEBERT NURSING HOME INC	$129,752.92	$38,358.99	$156,550.54	$70,958.44		$68,601	$45,330	$41,466		$551,019
HERITAGE HILLS NURSING CENTRE	$104,650		$233,142.00	$129,584.00					$367,640	$835,016
HOLIDAY RETIREMENT HOME INC	$163,177.62	$125,883.30	$168,732.75	$150,880.89		$457,297	$274,950	$166,234	$133,977	$1,641,133
HOPKINS MANOR LTD	$15,040.00	$159,048.00	$116,372.00	$98,700.00		$177,848		$78,208		$645,216
JEANNE JUGAN RESIDENCE		$59,153.00	$18,476.00	$13,410.00		$46,786	$18,476			$156,301
JOHN CLARKE RETIREMENT CTR, THE	$204,678			$56,977.00		$217,188.87	$178,267.01	$40,989	$31,051	$729,151
KENT REGENCY CENTER			$324,862.00		$175,024.28	$156,870.00		$92,130		$748,886
LINN HEALTH CARE CENTER (United Methodist)	$96,707						$342,620			$439,327
MANSION NURSING HOME	$16,576.00	$29,117.18	$24,725.73	$26,315.07		$45,152.12	$27,212.98	$9,539	$7,205	$185,842
MORGAN HEALTH CENTER			$389,480					$338,884		$728,364
MOUNT ST RITA HEALTH CENTRE	$313,956			$73,530			$317,205		$132,696	$837,387
OAK HILL NURSING AND REHABILITATION CENTER		$129,635	$69,472	$58,951		$225,951	$127,363	$214,762	$145,624	$971,758
OAKLAND GROVE HEALTH CARE CENTER	$292,596.70	$230,032.54	$214,942.64	$241,632.06		$210,045	$172,511	$129,736	$94,174	$1,585,670
OVERLOOK NURSING & REHAB. CENTER	$96,619.10	$132,770.00	$142,040.05	$150,236.00		$252,247	$107,220	$70,334	$48,208	$999,675
PARK VIEW OPERATIONS ASSOCIATES LLC	$30,645.00	$69,235.00	$86,714.00	$27,240.00		$129,390	$32,007	$14,074	$12,712	$402,017
PAWTUCKET HEALTHCARE AND REHAB. CTR.			$499,648.00		$107,954.26	$438,036.00		$192,643		$1,238,281
RIVERVIEW HEALTHCARE COMMUNITY						$1,108,520		$332,630		$1,441,150
ROBERTS HEALTH CENTRE INC	$94,881			$125,766		$28,635	$64,535	$16,982		$330,799
ROYAL MIDDLETOWN (Forest Farm)	$184,731.09	$24,671.30				$72,024.10	$33,599.55			$315,026
ROYAL WESTERLY (Westerly Nursing Home)	$118,550	$70,187	$25,781	$18,712		$65,937	$19,099	$44,211		$362,476
SAINT ELIZABETH HOME, EAST GREENWICH		$48,487	$31,410	$39,212		$111,250	$65,295	$31,847	$31,811	$359,312
SAINT ELIZABETH MANOR, EAST BAY	$57,441	$59,132	$24,101	$46,631		$78,119	$38,176	$22,369	$20,937	$346,907
SCALABRINI VILLA	$45,090	$46,593	$41,416	$59,285		$108,383	$44,756	$78,490	$63,460	$487,473
SCALLOP SHELL NURSING & REHAB. CENTER										$0
SCANDINAVIAN HOME INC						$305,350				$305,350
SHADY ACRES INC	$26,100	$70,470	$48,285	$63,655		$143,840	$60,610	$24,215	$16,675	$453,850
SILVER CREEK MANOR	$93,143.43	$80,402.28	$154,467.48	$103,934.93		$229,782	$107,127	$85,595	$93,346	$947,798
SOUTH COUNTY NURSING & SUBACUTE CTR.			$283,023		$27,814	$162,840		$135,936		$609,613
SOUTH KINGSTOWN NURSING REHAB. CENTER	$400,064					$369,816			$181,640	$951,520
ST ANTOINE RESIDENCE										$0
ST CLARE HOME								$75,982		$75,982
STEERE HOUSE										$0
SUMMIT COMMONS	$148,529	$283,222	$221,948	$213,770		$264,913	$187,879	$112,761	$180,921	$1,613,944

Nursing Facility Interim Payments Made in SFY 2018

Nursing Facility Name	July '17	August '17	September '17	October '17	November '17	December '17	January '18	March '18	April '18	YTD
SUNNY VIEW NURSING HOME	$25,740	$51,774	$45,092							$122,606
TOCKWOTTON HOME										$0
TRINITY HEALTH CARE	$203,194.75	$288,336.05	$225,137.10	$141,964.15		$321,308	$146,683	$99,412		$1,426,036
VILLAGE HOUSE CONVALESCENT HOME INC			$192,399			$90,624		$68,499		$351,522
WARREN HEALTHCARE AND REHAB. CENTER	$204,417				$26,984	$107,334		$92,259		$430,994
WATCH HILL CARE AND REHAB	$32,400	$40,176	$46,872			$23,760	$31,104		$12,744	$187,056
WATERVIEW VILLA INC	$185,587	$242,559	$146,111	$203,815		$300,635	$158,671	$118,507	$102,274	$1,458,160
WEST SHORE HEALTH CENTER (Warwick Health Center)						$615,276			$309,258	$924,534
WEST VIEW HEALTH CARE CENTER	$63,617	$108,126	$115,396	$48,092		$162,984	$87,386	$45,292		$630,893
WESTERLY HEALTH CENTER	$273,792					$305,040		$136,152		$714,984
WOONSOCKET HEALTH CENTRE (CON-V-CARE))										$0
TOTAL	**$5,399,358**	**$4,379,322**	**$7,588,379**	**$3,571,278**	**$986,441**	**$12,250,720**	**$3,976,575**	**$5,479,791**	**$3,837,087**	**$47,468,951**

Assisted Living Facility Imnterim payments Made in SFY 2018

Assisted Living Facility Name	July '17	August '17	September '17	October '17	November '17	December '17	January '18	March '18	April '18	YTD
ARBOR HILL ASSISTED LIVING		$38,449.92				$27,362				$65,812
AUTUMN VILLA										$0
BLACKSTONE VALLEY ASST. LIVING										$0
BRISTOL ASSISTED LIVING LP (Franklin Court)										$0
BROOKDALE GREENWICH BAY										$0
BROOKDALE POCASSET BAY			$3,879	$8,980		$9,064	$5,059	$3,921		$30,903
BROOKDALE SOUTH BAY MANOR		$18,044.48	$6,239.68	$5,059.20		$7,546.64	$3,920.88	$3,921		$44,732
BROOKDALE WEST BAY										$0
CAPITOL RIDGE										$0
COURTLAND PLACE HEALTH CENTER	$5,059	$5,228	$10,371	$20,532		$6,450	$2,614	$20,321	$5,902	$76,478
DARLINGTON ASSISTED LIVING	$37,438	$2,530				$39,673		$30,988		$110,628
DARLINGTON MEMORY LANE	$76,562.56	$2,866.88				$44,352		$25,633		$149,415
ETHAN PLACE										$0
FOUR SEASONS ASSISTED LIVING			$16,021	$6,240		$11,172	$7,757	$3,921		$45,111
GOLDEN YEARS ASST LIVING			$9,739	$6,450		$2,277	$8,179			$26,645
HIGHLANDS ON THE EAST SIDE	$1,264.80	$1,306.96						$11,594	$1,054	$15,220
ROYAL MIDDLETOWN ASST. LIVING				$30,735						$30,735
SPRING VILLA INC					$78,670.56	$39,756.88	$18,888		$27,741	$165,056
ST GERMAINE (Woonsocket Housing Auth.)		$27,235				$41,064				$68,299
ST. ELIZABETH COURT		$12,901		$14,419						$27,320
SUMMER VILLA										$0
THE WILLOWS										$0
TWENTY-ONE OPCO VENTURES (BROOKDALE)										$0
UNITED METHODDIST (WINSLOW GARDENS)		$25,760				$29,090				$54,850
WYNDEMERE WOODS		$2,572	$1,307	$1,265		$2,572	$6,450	$2,614	$2,361	$19,141
TOTAL	**$120,325**	**$136,894**	**$47,556**	**$93,680**	**$78,671**	**$260,380**	**$52,869**	**$102,913**	**$37,059**	**$930,345**

Home Care Provider Name	July '17	August '17	September '17	October '17	November '17	December '17	January '18	March '18	April '18	YTD
A Caring Experience			$34,314.00							$34,314
Nursing Placement			$38,443.00	$19,297						$57,740
Haigh Ventures			$21,356							$21,356
TOTAL	**$0**	**$0**	**$94,113**	**$19,297**	**$0**	**$0**	**$0**	**$0**	**$0**	**$113,410**

Executive Office of Health and Human Services
3 West Road, Virks Building, Cranston, RI 02920

Office of the Medicaid Program Director
Patrick Tigue

January 31, 2018

RE: Update Regarding Interim Payments and Reconciliation/Recoupment of Payments - Assisted Living

Dear Provider:

We appreciate your continued cooperation and commitment to the care of our customers. As we continue to work through the backlog of long term services and supports applications, I am writing to provide an update to our interim payment request and reconciliation processes. These process updates have been informed by feedback from several of you, and I look forward to your continued feedback as we move forward.

Below, please find updated information regarding two related processes - the first is designed to allow providers to request interim payments for pending completed Long Term Care applications, and the second is designed to address the reconciliation and recoupment of payments made pursuant to this statute.

Regarding interim payments for services rendered:

To receive payment for services rendered to applicants while a completed Long-Term Care Application has been pending for greater than 90 days, please submit the forms specified below via secure e-mail to lawrence.ross@ohhs.ri.gov and cc sharon.previte@dhs.ri.gov. This will enable EOHHS to process your request while providing DHS the data necessary to review applicants against RI Bridges. The required forms and the submission time frames are enclosed. Please submit a cover letter that includes the provider's NPI number, and the name, phone number and e-mail address for an individual at the provider group for the State to contact with questions.

All providers should submit Enclosure A: *RI Communication Tool Nov. 2017 Update. Please note, Tab 1 is not required to be completed for payment but it is requested to be completed for research and review purposes.*

All interim payment requests will continue be reviewed and approved prior to processing the payment. In line with statutory expectations, the following cases will not be included in interim payments:

- Individuals for whom the provider can bill and receive payment for (through MMIS);
- Individuals that do not have a Medicaid application on file. The State will contact the provider if this occurs for follow up purposes;
- Individuals that have been issued a denial for Medicaid eligibility.

Due to the detailed nature of the review, it may take two to three weeks to process interim payments. Payments will be processed via a manual check. If there is a hardship or a concern with this timeframe, please reach out to the specified contacts listed at the end of the document.

Important Reminders:

- Providers must submit a first name, last name, SSN, DOB for all clients on the interim payment file. The State will check this information prior to issuing any payment.

- Providers are asked to continue to submit claims in MMIS for all persons. The State will continue to review all requests for interim payment to ensure requests are for applications that have been pending for at least 90 days and include a complete application with DHS.

- DHS is making progress on the backlog of applications. As such, providers are reminded to check their Remittance Advices after every billing cycle. Please remove any clients for whom you can receive payment for in MMIS from future interim payment requests.

- Providers are expected to collect patient share for all applicable claims that include a patient share receivable.

- The State will waive timely filing requirements for any impacted claims related to RI Bridges issues. Please contact the DXC Provider Representative for questions.

Regarding Recoupment and Reconciliation of Payments:

All interim payments made will be subject to reconciliation and recoupment after eligibility and billing information is finalized and claims have been processed. The Medicaid division will commence a interim payment reconciliation process. This process will occur over the course of several months in multiple phases. Each phase will address the reconciliation of a distinct group of payments.

These payments were made to providers during this time due to delays in processing long term care applications and other delays related to the launch of the new integrated eligibility system. As you are aware, R. I. Gen. Laws §40-8-6.1 requires the State to make payments to providers for the care provided to an applicant during the pendency of an application as though the application were approved, beginning the date of such request. In addition, for applications that are approved, state law allows the state to offset payments for the period between the date of the application and the determination by any amounts paid as per the statute.

Therefore, the reconciliation process must balance payments during the interim period with actual claims for approved patients.

Providers will receive a separate letter with provider specific information relating to each payment in the applicable groups below. The Medicaid division will start with Group 1 and then move to the subsequent Groups.

Group 1:
Payments in this group were issued between 9/1/16 and 1/1/17. Providers who received any interim payment in this period will receive a letter requesting a response within thirty (30) calendar days for claims that could not be reconciled.

Group 2:
Payments in this group were issued between 1/18/17 and 2/20/2017. Group 2 reconciliation will begin when Group 1 is complete.

Group 3: Group 3 includes any payments made subsequent to 2/20/2017, as well as cases from the first two groups that have other case issues. Group 3 reconciliation will begin when Group 2 is complete.

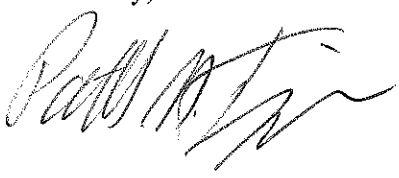
All payments can be remitted to the following:
DXC Technologies
Attn: Recon Unit
PO Box 2010
Warwick, RI 02886

For questions and concerns related to nursing home reconciliation /other provider/ general questions, please contact:
Ralph Racca, Medicaid Division, EOHHS
401-462-1879
Ralph.Racca@ohhs.ri.gov

For questions and concerns related to assisted living reconciliation, please contact:
Karen Young, Medicaid Division, EOHHS
401-462-6319
Karen.Young@ohhs.ri.gov

Thank you again for your consideration and anticipated cooperation.

Sincerely,



Patrick Tigue
Medicaid Program Director
Executive Office of Health and Human Services

Enclosures (2):
RI Communication Tool November 2017 Update
Interim Payment Submission Time Frames

Cc:
Virginia Burke, Esq.
Jim Nyberg
Kathleen Kelly

Rhode Island Medicaid Interim Payment Request Form

Provider Name: ______________________________

Provider NPI #: ______________________________ Date Submitted: __________

Patient Information*

Last Name	First Name	Date of Birth (MM/DD/YY)	SSN	From Date (MM/DD/YY)	To Date (MM/DD/YY)	# of Days
Total Days						0
Facility Rate						
Total Due Facility						$ -

Interim Payment Submission Time Frames

November:	20th - 29th at noon
December:	18th - 22nd at noon
January:	22nd – 26th at noon
February:	19th – 23rd at noon
March:	19th – 23rd at noon
April:	23rd – 27th at noon
May:	21st – 25th at noon
June:	18th – 22nd at noon
July:	23rd – 27th at noon

Executive Office of Health and Human Services
3 West Road, Virks Building, Cranston, RI 02920

Office of the Medicaid Program Director
Patrick Tigue

January 31, 2018

RE: Update Regarding Interim Payments and Reconciliation/Recoupment of Payments

Dear Provider:

We appreciate your continued cooperation and commitment to the care of our customers. As we continue to work through the backlog of long term services and supports applications, I am writing to provide an update to our interim payment request and reconciliation processes. These process updates have been informed by feedback from several of you, and I look forward to your continued feedback as we move forward.

Below, please find updated information regarding two related processes - the first is designed to allow providers to request interim payments for pending completed Long Term Care applications, and the second is designed to address the reconciliation and recoupment of payments made pursuant to this statute.

Regarding interim payments for services rendered:

To receive payment for services rendered to applicants while a completed Long-Term Care Application has been pending for greater than 90 days, please submit the forms specified below via secure e-mail to lawrence.ross@ohhs.ri.gov and cc sharon.previte@dhs.ri.gov. This will enable EOHHS to process your request while providing DHS the data necessary to review applicants against RI Bridges. The required forms and the submission time frames are enclosed. Please submit a cover letter that includes: the provider's NPI number, and the name, phone number and e-mail address for an individual at the provider group for the State to contact with questions.

To request and receive interim payments, nursing home providers can continue to use either of the two options described below:

1. The Average Payment method calculation reflecting an average per diem rate for the individual facility that considers the facility's average patient share and average acuity level. To request payments under this methodology, please submit Enclosure A: RI Communication Tool Nov. 2017 Update using the Average Payment Method tab to request payment.

2. Resource Utilization Groups (RUG) based payment adjusted for estimated patient share. To request an interim payment for clients using this methodology, please submit Enclosure A: RI Communication Tool Nov. 2017 Update using the RUG Based Payment Method tab along with Enclosure B: NH Turnaround Document (TAD) to request payment.

All providers should submit Enclosure A: *RI Communication Tool Nov. 2017 Update. Please note, Tab 1 is not required to be completed for payment but it is requested to be completed for research and review purposes*

All interim payment requests will continue be reviewed and approved prior to processing the payment. In line with statutory expectations, the following cases will not be included in interim payments:

- Individuals for which specific information is not included in the pended cases tab of the Communication tool, (nursing homes only);
- Individuals for whom the provider can bill and receive payment for (through MMIS);
- Individuals that do not have a Medicaid application on file. The State will contact the provider if this occurs for follow up purposes;
- Individuals that have been issued a denial for Medicaid eligibility.

Due to the detailed nature of the review, it may take two to three weeks to process interim payments. Payments will be processed via a manual check. If there is a hardship or a concern with this timeframe, please reach out to the specified contacts listed at the end of the document.

Important Reminders:

- Providers must submit a first name, last name, SSN, DOB for all clients on the interim payment file. The State will check this information prior to issuing any payment.

- Providers are asked to continue to submit claims in MMIS for all persons. The State will continue to review all requests for interim payment to ensure requests are for applications that have been pending for at least 90 days and include a complete application with DHS.

- DHS is making progress on the backlog of applications. As such, providers are reminded to check their Remittance Advices after every billing cycle. Please remove any clients for whom are able to receive payment for in MMIS from future interim payment requests.

- The PASSAR process is a condition of payment. A provider may not seek payment either by a claim or on the interim request process unless a PASSAR has been completed.

- Providers are expected to collect patient share for all applicable claims that include a patient share receivable.

- The State will waive timely filing requirements for any impacted claims related to RI Bridges issues. Please contact the DXC Provider Representative for questions.

Regarding Recoupment and Reconciliation of Payments:

All interim payments made to all facilities will be subject to reconciliation and recoupment after eligibility and billing information is finalized and claims have been processed. The Medicaid division will commence an interim payment reconciliation process. This process will occur over the course of several months in multiple phases. Each phase will address the reconciliation of a distinct group of payments.

These payments were made to providers during this time due to delays in processing long term care applications and other delays related to the launch of the new integrated eligibility system. As you are aware, R. I. Gen. Laws §40-8-6.1 requires the State to make payments to providers for the care provided to an applicant during the pendency of an application as though the application were approved, beginning the date of such request. In addition, for applications that are approved, state law allows the state to offset payments for the period between the date of the application and the determination by any amounts paid as per the statute.

RI. Gen. Laws §40-8-6.1 (b)(2) states that for approved applications, the state may offset payments due for the period between the date of the application and the determination by any amounts paid hereunder.-Therefore, the reconciliation process must balance payments during the interim period with actual claims for approved patients.

Providers will receive a separate letter with provider specific information relating to each payment in the applicable groups below. The Medicaid division will start with Group 1 and then move to the subsequent Groups.

Group 1:
Payments in this group were issued between 9/1/16 and 1/1/17. Providers who received any interim payment in this period will receive a letter requesting a response within thirty (30) calendar days for claims that could not be reconciled.

Group 2:
Payments in this group were issued between 1/18/17 and 2/20/2017. Group 2 reconciliation will begin when Group 1 is complete.

Group 3: Group 3 includes any payments made subsequent to 2/20/2017, as well as cases from the first two groups that have other case issues. Group 3 reconciliation will begin when Group 2 is complete.

All payments can be remitted to the following:
DXC Technologies
Attn: Recon Unit
PO Box 2010
Warwick, RI 02886

For questions and concerns related to nursing home reconciliation /other provider/ general questions, please contact:
Ralph Racca, Medicaid Division, EOHHS
401-462-1879
Ralph.Racca@ohhs.ri.gov

For questions and concerns related to assisted living reconciliation, please contact:
Karen Young, Medicaid Division, EOHHS
401-462-6319
Karen.Young@ohhs.ri.gov

Thank you again for your consideration and anticipated cooperation.

Sincerely,

Patrick Tigue
Medicaid Program Director
Executive Office of Health and Human Services

Enclosures (2):
RI Communication Tool November 2017 Update
Interim Payment Submission Time Frames

Cc:
Virginia Burke, Esq.
Jim Nyberg
Kathleen Kelly

Rhode Island Medicaid Interim Payment Request Form

Provider Name: ______________________________

Provider NPI #: ______________________________ Date Submitted: __________

Patient Information*

Last Name	First Name	Date of Birth (MM/DD/YY)	SSN	From Date (MM/DD/YY)	To Date (MM/DD/YY)	# of Days

Total Days	0
Facility Rate	42.16
Total Due Facility	$ -

Interim Payment Submission Time Frames

November:	20th - 29th at noon
December:	18th - 22nd at noon
January:	22nd – 26th at noon
February:	19th – 23rd at noon
March:	19th – 23rd at noon
April:	23rd – 27th at noon
May:	21st – 25th at noon
June:	18th – 22nd at noon
July:	23rd – 27th at noon

3 West Road | Virks Bldg. | Cranston, RI 02920

March 1, 2018

Facility Name
Street
City and State

NPI ID#: XXXXX
Prov. ID#: XXXXX

Re: Interim Payment Reconciliation

Dear Provider,

As previously announced, the EOHHS Medicaid Division is implementing a phased Interim payment reconciliation process. The first reconciliation phase will focus on "Group 1" payments. Group 1 payments were made between 9/1/17 and 1/17/17, to qualifying LTSS providers, at the request of providers. Group 1 payments are subject to reconciliation/recoupment consistent with the provisions of R. I. Gen. Laws §40-8-6.1(b)(2).

On the following dates, you received the following interim payments:

- 12/07/16 Check #: xxxxxx Amount: $ XXXXX
- 01/30/17 Check #: xxxxxx Amount: $ XXXXX
- 02/03/17 Check #: xxxxxx Amount: $ XXXXXX
- **TOTAL:** Amount: **$ XXXXXX**

These amounts have been reconciled with claims paid in MMIS for the members and dates of service associated with these payments. Based on the results of this reconciliation, EOHHS requests a partial repayment of the interim payments.

The attached spreadsheet provides the detail to support the amount of the repayment requested. If you agree with the amount of repayment, please mail a check in the amount of **$XXXXXX**, made payable to **"State of Rhode Island, Executive Office of Health and Human Services** to:

- DXC Technologies
  Attn: Recon Unit
  PO Box 2010
  Warwick, RI, 02886.

If you disagree with the amount of repayment, or if you have any other questions or concerns, please contact me to further discuss this matter. I look forward to working with you to address any questions or discrepancies.

Sincerely,

Ralph Racca
Administrator, EOHHS Medicaid Division

Enclosure:
Reconciliation Spreadsheet

Contact Information:
For questions and concerns related to nursing home reconciliation /other provider/ general questions, please contact:

Ralph Racca, Medicaid Division, EOHHS
401-462-1879
ralph.racca@ohhs.ri.gov

For questions and concerns related to assisted living reconciliation, please contact:

Karen Young, Medicaid Division, EOHHS
401-462-6319
karen.young@ohhs.ri.gov

3 West Road | Virks Bldg. | Cranston, RI 02920

March 1, 2018

Facility Name
Street Address
City, State

Provider ID #: XXXXX
NPI ID#: XXXXX

RE: Group 1 Interim Payments

Dear Provider:

The Executive Office of Health and Human Services (EOHHS), in response to provider concerns over delayed eligibility determinations, instituted and interim/contingency payment program to ensure that providers received payment for services rendered pending a final eligibility determination and that EOHHS is compliant with R. I. Gen. Laws §40-8-6.1.

EOHHS is beginning the interim/contingency payment reconciliation process for payments made from 9/1/16 to current. Consistent with our correspondence dated 1/31/18, the reconciliation process is divided into three (3) groups. This letter is for **Group 1** payments only. These payments were not associated with specific residents or dates of service but rather, were made to qualifying LTC providers at their request from 9/1/16 to 1/17/17.

Group 1 payments were made to LTC providers, in the amount requested by the provider. Interim payments that were made during this time are subject to reconciliation/recoupment consistent with the provisions of R. I. Gen. Laws §40-8-6.1(b)(2) as the payments must be ultimately for approved long-term care services rendered to patients.

On [DATE] you received an interim payment, check #: XXXXXX, in the amount of $XXXXXX. As this amount was not associated with specific residents or dates of service, EOHHS is requesting repayment of this amount within 30 calendar days from the date of this letter.

Please send in a check in the amount of $XXXXXX is made payable to **"State of Rhode Island, Executive Office of Health and Human Services."** The check must be mailed to:

DXC Technologies
Attn: Recon Unit
PO Box 2010
Warwick, RI 02886

Please feel free to contact me, if you have any questions.

Sincerely,

Ralph Racca
Administrator, EOHHS Medicaid Division

Enclosure:
Reconciliation Spreadsheet

Contact Information:

For questions and concerns related to nursing home reconciliation /other provider/ general questions, please contact:

Ralph Racca, Medicaid Division, EOHHS
401-462-1879
ralph.racca@ohhs.ri.gov

For questions and concerns related to assisted living reconciliation, please contact:

Karen Young, Medicaid Division, EOHHS
401-462-6319
karen.young@ohhs.ri.gov

Interim Payment Reconciliation Process- Updated

Revised, as of 4/17/2018

The State of Rhode Island/ Executive Office of Health and Human Services (EOHHS) issued interim/ contingency payments to Nursing Homes, Assisted Living, Hospice providers and Home Care providers due to delays with application processing resulting in delayed claims payment.

EOHHS has commenced a reconcialtion process, with the purpose of reconciling and recouping interium payments. This process will occur over the course of several months in multiple phases.

EOHHS has grouped interim payments into three categories:

Group 1: Payments in this group were issued between 9/1/16 and 1/1/17.
Group 2: Payments in this group were issued between 1/18/17 and 2/20/17.
Group 3: Payments in this group were issued after 2/20/2017. This will also contain cases in other groups that have other reconciliation issues.

EOHHS will begin this process, by reconciling claims with providers by verifying payments made from the MMIS to interim payment advance lists. If a provider requested an interim payment for a client, and subsequently the case was processed in MMIS and a claim was paid, the State will request that the provider return the interim payment amount back to EOHHS.

Phase 1: During Phase 1 (Group 1), the State will produce a letter for each provider, that has claims paid on the MMIS for persons on the interim payment lists. The State will also request payment or request additional information for cases that the State cannot reconcile. The letter will contain the following information:

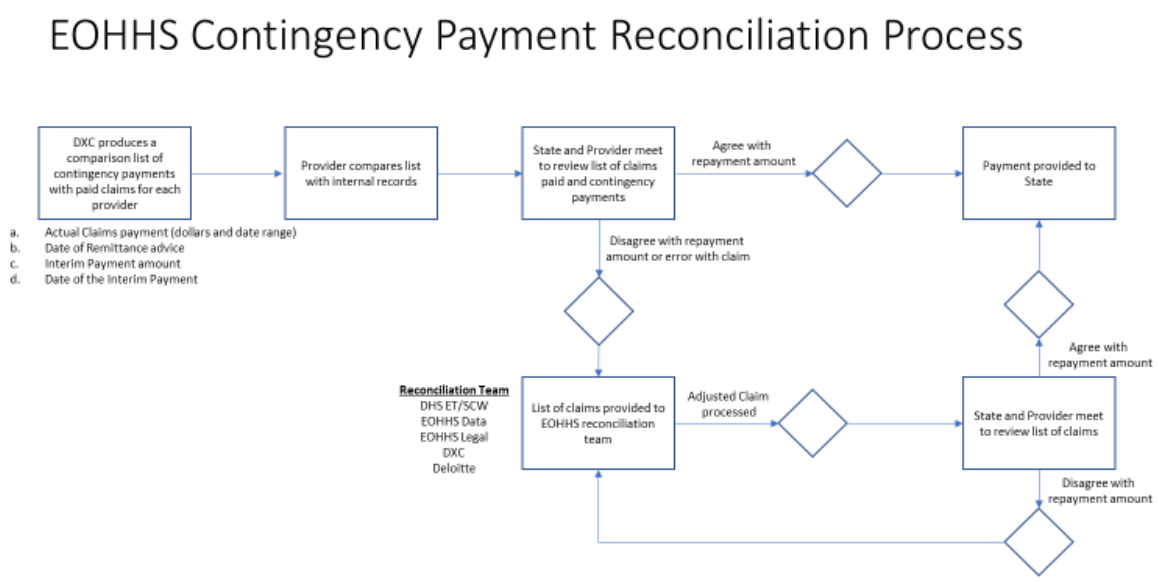
a. Actual claims payment (dollars and date range)
b. Date of Remittance advice
c. Interim Payment amount
d. Date of the Interim payment
e. Case level information

The State will then mail this letter to the provider, and request that the check be returned to the State within 30 calendar days. If the provider has any concerns or disputes with any information contained on this letter, they may call the provided contact person to set up an individual meeting to review the case information contained on the letter.

Please note that providers may receive a series of these letters over the course of the next several months as cases/ claims are resolved, this will be an ongoing process. If a provider has any questions about any information presented on the letters, they may contact the State at any time to request a meeting.

Update: As of April 2017, the State is actively in this Phase of the Recoupment Process. The State has sent out 27 letters in group 1.

Process Diagram of EOHHS Contingency Payment Reconciliation Process:

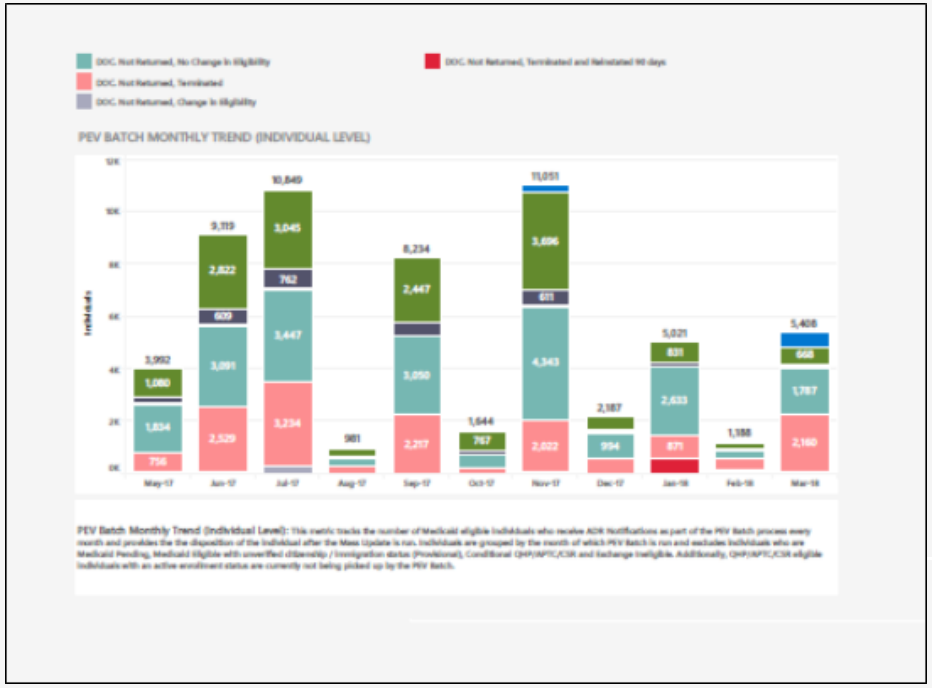


Future Interim Payment Process Updates and Reminders:

Please see updated provider letter for additional information.

Data refreshed as of : 04/11/2018

MONITORING PEV BATCH STATUS



Governor's initiatives			
	SPA	**1115**	**State Rules**
1. ***Adult Co-Payments for Select Services - ($3,246,719)***	X Began internal draft of SPA		X
2. CHIP Reauthorization – ($28,516,524)			
3. Dual Eligible and Long-Term Services and Supports (LTSS) Redesign – ($10,297,970)	Possible	Possible	X
4. Reallocate GME - ($3,284,350)	X Began internal draft of SPA		
5. Eliminate State-Only Funded Contracts and Services – ($1,641,120)			
6. Freeze Hospital Rates – ($5,360,808)	X Began internal draft of SPA		
7. Inpatient Upper Payment Limit (UPL) Funding Elimination – ($5,588,454)	X Began internal draft of SPA		
8. Modernize LTSS Eligibility Integrity – ($5,312,501)	X		X
9. MCO Administrative Rate Reduction – ($1,892,496)			
10. MCO Medical Rate Reduction – ($14,853,957)			
11. MCO Profit Margin Rate Reduction – ($6,912,796)			
12. Non-Emergency Medical Transportation Reform – ($3,844,021)	X Began internal draft of SPA		X
13. Increase Nursing Home Rates by 1.0% – ($2,574,599)	X Began internal draft of SPA		
14. Perry-Sullivan – ($2,958,020)			
15. ***Revenue Maximization – ($1,586,085)***	X Began internal draft of RIte Share SPA		X
16. ***Community First Choice Option***	X		X
17. BHDDH's BH Link		X (Cat III) Included request in 1115 Waiver Extension	

18. ***BHDDH's Conflict-Free Case Management Health Home***	X BHDDH has begun discussions w/providers; EOHHS has shared expectations for SPA w/BHDDH		
19. ***BHDDH's Alternative Payment Methodology***	X BHDDH has begun discussions w/providers; EOHHS has shared expectations for SPA w/BHDDH		

Dual-Eligible and Long-Term Services and Supports Redesign Budget Initiative

In the Governor's budget for SFY 2019, EOHHS has proposed to restructure the delivery system for individuals who have Medicare and Medicaid coverage (i.e., dual-eligible beneficiaries) or Medicaid-only coverage and receive long-term services and supports (LTSS). The budget initiative proposes to transition dual-eligibles who are enrolled in Rhody Health Options (RHO) (capitated managed LTSS arrangement) to a managed fee-for-service (FFS) arrangement. EOHHS will take responsibility for claims payment and financial risk for the population and enhance the services available (e.g., care management, a beneficiary call center, ombudsman services) to support the FFS population; these enhanced services will be available to dual-eligibles, as well as to other adult populations who are not eligible for managed care (e.g., people in the Sherlock plan, dual-eligibles with partial Medicare coverage). Qualified dual-eligible beneficiaries will continue to also have the option to enroll in either the Medicare-Medicaid plan operated by Neighborhood Health Plan of Rhode Island or the Program of All-Inclusive Care for the Elderly (PACE). Medicaid-only adults who are eligible for LTSS will be mandatorily enrolled in the Rhody Health Partners (RHP) program (capitated managed care arrangement for adults with disabilities) with a choice of three health plans. LTSS benefits will be carved out of RHP and provided through Medicaid FFS. The transition of RHO members to either managed FFS or RHP will be effective as of October 1, 2018.

Key implementation steps include:

- Engaging stakeholders in the design and implementation of the budget initiative, particularly related to the enhanced services in FFS
- Amending existing state contracts and/or procuring new services to support FFS beneficiaries
- Assessing changes to Medicaid FFS payment rates or benefits to improve access to care
- Amending the RHP contract to carve-out LTSS services for adults with disabilities and setting capitation rates for people transitioning from RHO to RHP
- Assessing and implementing systems changes in MMIS and Bridges
- Disenrolling beneficiaries from RHO and enrolling them in either managed FFS or RHP
- Amending the Medicaid Code of Administrative Rules to reflect the redesigned delivery system options for the affected populations

This initiative is expected to result in a more cost-effective delivery system for dual-eligibles. The net budget savings, which will be achieved through reductions in administrative costs, medical expenses, and health plan taxes, are projected to be $7.0M (general revenue). Further, through investments in targeted care management services and other supports in Medicaid FFS, the redesigned system is expected to improve coordination of care and outcomes for dual-eligibles currently enrolled in RHO and other populations that are not eligible for managed care enrollment. In addition, mandatory RHP enrollment of Medicaid only beneficiaries who are receiving LTSS will reduce enrollment churn, increase continuity of coverage, and provide them with a choice of three managed care plans (as opposed to one in RHO).

Delineation of "All Other HCBS" Expenses

Type of Service	YTD FY '18	Est. FY '18	Est. FY '19
Home-Based Care	$22,041,539	$32,812,396	$34,285,537
Adult Day Care	$1,894,259	$2,508,114	$2,632,467
Shared Living	$907,355	$1,204,871	$1,264,609
DME	$163,544	$210,719	$221,158
Other (incl. Rehab. & Case Mgmt.)	$451,429	$594,526	$624,002
	$25,458,126	**$37,330,626**	**$39,027,773**

Unified Health Infrastructure Project

MEDICAID BATCH METRICS

RIBridges

Data refreshed as of : 04/10/2018

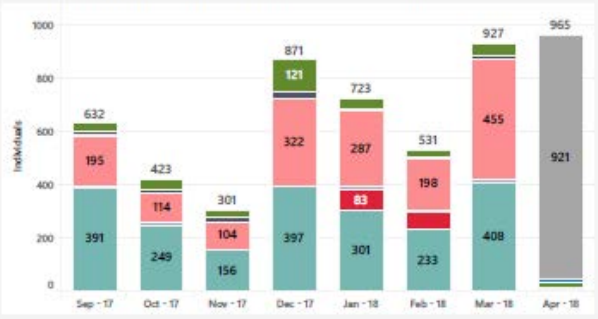
MONITORING MEDICAID PASSIVE RENEWAL BATCH STATUS

PASSIVE RENEWAL POPULATION MONTHLY TREND (CASE LEVEL)

Passive Renewal Population Monthly Trend (Case Level): This metric tracks the number cases which are up for renewal each month and consists of the following categories for each month: Modified (Complex Medicaid), the count of Complex Medicaid (LTSS, SSI Lookalikes, Community Medicaid, Katie Beckett, Sherlock, MPP); Ex Parte Unverified, the count of MA Category Medicaid (MAGI Medicaid, Chafee Kids, Extended Family Planning, and Extended Medicaid) for which eligibility data is unverified and; Ex Parte Verified, the count of MA Category Medicaid (MAGI Medicaid, Chafee Kids, Extended Family Planning, and Extended Medicaid) for which eligibility data is verified (please note that no other metrics will be provided for this population as an ADR will not be mailed). The cases are grouped by the month in which the Passive Renewal batch is run.

ADR Sent, Pending Client
DOC. Returned, No Change in Eligibility
DOC. Not Returned, No Change in Eligibility
DOC. Not Returned, Terminated & Reinstated 90 Days
DOC. Returned, Processed
DOC. Returned, Terminated
DOC. Not Returned, Terminated
DOC. Returned, Pending State
DOC. Returned, Change in Eligibility
DOC. Not Returned, Change in Eligibility

EX PARTE : UNVERIFIED MONTHLY TREND (INDIVIDUAL LEVEL)



Ex Parte: Unverified Monthly Trend (Individual Level): This metric tracks the monthly count of Medicaid individuals (MAGI Medicaid, Chafee Kids, Extended Family Planning, Extended Medicaid) who are subjected to the Ex Parte Passive Renewal process and for which data was unverified. All measures are calculated at the individual level and individuals are grouped by the month in which their case is picked up by the Passive Renewal Batch. This metric excludes QHP, LTSS, SSI Lookalikes, Community Medicaid, Katie Beckett, Sherlock, MPP cases.

MODIFIED MONTHLY TREND (INDIVIDUAL LEVEL)

Modified Monthly Trend (Individual Level): This metric tracks the monthly count of Complex Medicaid individuals (LTSS, SSI Lookalikes, Community Medicaid, Katie Beckett, Sherlock, MPP) who are subjected to the Modified Passive Renewal process. All measures are calculated at the case level and the cases are grouped by the month in which the case is picked up by the Passive Renewal Batch. This metric excludes QHP, MAGI Medicaid, Chafee Kids, Extended Family Planning, Extended Medicaid cases.

Trips by Treatment Types for the Medicaid and the Non-Medicaid Population:

Medicaid Population - Trips by Treatment Types	CY 2016	
Treatment Type	Total	Percent
Substance Use Disorder	784,066	48.4%
Adult Daycare	383,220	23.7%
Dialysis	75,898	4.7%
Specialist Visit	47,809	3.0%
Follow Up Visits	44,422	2.7%
Mental Health	40,703	2.5%
Clinic Visits	31,994	2.0%
TANF Specialized Transportation for Medical Appointment	24,747	1.5%
Physical Therapy	22,236	1.4%
Physician Services	20,698	1.3%
Psychiatry	20,626	1.3%
Dental	13,951	0.9%
Social Care Counseling	11,308	0.7%
Eye Doctor	9,857	0.6%
All Other	88,556	5.5%
Total	1,620,091	100.0%

Medicaid Population - Trips by Treatment Types	CY 2017	
Treatment Type	Total	Percent
Substance Use Disorder	909,622	53.5%
Adult Daycare	378,939	22.3%
Dialysis	79,701	4.7%
Specialist Visit	37,380	2.2%
Follow Up Visits	40,918	2.4%
Mental Health	16,387	1.0%
Clinic Visits	9,297	0.5%
TANF Specialized Transportation for Medical Appointment	27,662	1.6%
Physical Therapy	23,702	1.4%
Physician Services	40,279	2.4%
Psychiatry	21,165	1.2%
Dental	12,536	0.7%
Social Care Counseling	12,208	0.7%
Eye Doctor	9,641	0.6%
All Other	81,323	4.8%
Total	1,700,760	100.0%

Non-Medicaid Elderly Population - Trips by Treatment Types	CY 2016	
Treatment Type	Total	Percent
Dialysis	54,878	30.3%
Adult Daycare	43,226	23.9%
Elderly Meal Site	21,192	11.7%
Specialist Visit	20,169	11.1%
Follow Up Visits	9,230	5.1%
Physician Services	4,289	2.4%
Clinic Visit	4,220	2.3%
Eye Doctor	3,398	1.9%
Radiation Treatment	3,187	1.8%
Wound Care	2,088	1.2%
Doctor Appointment	1,937	1.1%
Substance Use Disorder	1,841	1.0%
Cardiac Rehab	1,555	0.9%
Routine Services	1,087	0.6%
All Other	8,716	4.8%
Total	181,013	100.0%

Non-Medicaid Elderly Population - Trips by Treatment Types	CY 2017	
Treatment Type	Total	Percent
Dialysis	52,638	32.3%
Adult Daycare	36,733	22.5%
Elderly Meal Site	22,672	13.9%
Specialist Visit	11,561	7.1%
Follow Up Visits	5,135	3.2%
Physician Services	8,571	5.3%
Clinic Visit	1,055	0.6%
Eye Doctor	2,699	1.7%
Radiation Treatment	1,836	1.1%
Wound Care	1,221	0.7%
Doctor Appointment	4,646	2.9%
Substance Use Disorder	1,845	1.1%
Cardiac Rehab	715	0.4%
Routine Services	2,106	1.3%
All Other	9,520	5.8%
Total	162,953	100.0%

RI EOHHS Monthly Call Stat Report																								
Month	Year	Reservation English							Reservation Spanish							Facility Queue								
Month	Year	Total Calls Received	Total Calls Abandoned	Call Answered	% of Calls Abandoned	Average Speed of Answer	Average Talk Time	Avg. Abandon Time	Total Calls Received	Total Calls Abandoned	Call Answered	% of Calls Abandoned	Average Speed of Answer	Average Talk Time	Avg. Abandon Time	Total Calls Received	Total Calls Abandoned	Call Answered	% of Calls Abandoned	Average Speed of Answer	Average Talk Time	Avg. Abandon Time		
May	2016	16,706	488	16,218	2.8%	00:56	05:50	00:58	1,328	48	1,280	3.2%	01:12	06:33	00:57	3,415	33	3382	1.0%	00:20	04:27	00:30		
June	2016	16,962	480	16,482	3.8%	01:16	05:34	01:04	1,528	47	1,481	3.1%	01:23	06:12	01:14	3,543	38	3505	1.1%	00:24	04:15	00:27		
July	2016	15,372	619	14,753	3.5%	01:19	05:10	00:59	1,490	60	1,430	3.8%	01:17	06:11	01:29	3,194	42	3152	1.0%	00:25	04:05	00:32		
August	2016	17,838	893	16,945	5.0%	01:44	05:31	01:16	1,570	43	1,527	2.6%	01:27	06:12	01:03	3,628	88	3540	2.4%	00:40	04:12	00:52		
September	2016	17,943	1,453	16,490	7.4%	02:30	05:35	01:36	1,601	86	1,515	5.1%	02:02	06:09	01:37	3,631	118	3513	3.2%	00:51	04:33	00:57		
October	2016	16,887	1,191	15,696	6.3%	02:11	05:22	01:38	1,533	71	1,462	4.4%	01:38	06:14	01:43	3,496	127	3369	3.1%	00:52	04:08	01:07		
November	2016	16,188	697	15,491	3.9%	01:24	05:12	01:18	1,399	38	1,361	2.5%	01:08	05:55	01:18	3,841	79	3762	2.1%	00:44	04:18	00:48		
December	2016	15,899	1,163	14,736	6.4%	02:22	04:56	01:46	1,344	59	1,285	4.1%	01:38	05:52	01:22	3,943	82	3861	2.0%	00:52	04:13	01:15		
January	2017	18,490	1,196	17,294	6.7%	02:30	05:10	01:46	1,403	68	1,335	3.4%	01:57	05:59	01:30	3,712	136	3576	6.1%	01:17	04:13	01:39		
February	2017	16,607	447	16,020	2.6%	01:02	04:45	00:55	1,437	47	1,382	3.2%	01:18	05:54	01:32	3,316	133	3151	3.8%	01:23	04:21	01:39		
March	2017	18,524	723	17,425	3.8%	01:20	04:45	01:16	1,771	45	1,680	2.5%	01:09	05:54	01:12	3,690	90	3,554	2.3%	00:47	03:58	01:07		
April	2017	16,647	1,174	15,229	7.2%	02:24	04:43	02:18	1,541	53	1,477	3.4%	01:24	05:24	02:00	3,097	118	2,938	3.6%	01:23	04:16	02:00		
May	2017	18,786	1,738	16,828	8.7%	02:37	04:51	02:20	1,557	52	1,481	3.2%	01:25	05:40	01:26	3,387	157	3,191	4.5%	01:37	04:16	01:58		
June	2017	17,911	1,272	16,468	7.2%	02:10	05:13	02:11	1,480	35	1,432	2.5%	01:16	05:21	01:08	3,448	72	3,348	2.0%	00:54	04:18	01:31		
July	2017	15,785	1,167	14,448	7.5%	02:19	05:14	02:03	1,147	68	1,070	6.1%	02:17	05:47	01:52	3,328	91	3215	2.8%	00:59	03:47	01:39		
August	2017	15,771	641	15,012	4.0%	01:15	05:00	01:28	1,092	36	1,045	3.3%	01:54	05:44	01:24	3,514	52	3434	1.4%	00:35	03:59	00:53		
September	2017	15,724	909	14,671	5.8%	01:50	05:08	01:42	1,102	54	1,041	4.9%	02:08	05:36	02:04	3,755	106	3610	2.8%	00:54	04:00	01:25		
October	2017	16,327	939	15,221	5.6%	01:42	05:13	01:54	1,269	2	1,257	0.1%	00:10	06:26	00:05	4,279	160	4076	3.4%	01:03	04:28	01:37		
November	2017	15,652	1,199	14,282	7.6%	02:17	05:01	02:07	1,236	2	1,231	0.1%	00:09	05:49	00:06	4,377	220	4120	4.8%	01:30	03:51	02:12		
December	2017	13,651	656	12,852	4.7%	01:32	04:46	01:32	1,072	2	1,066	0.2%	00:10	05:29	00:04	3,754	109	3610	2.7%	01:08	04:07	01:35		
January	2018	17,839	942	16,616	5.0%	01:49	04:45	01:52	1,382	3	1,375	0.2%	00:10	05:32	00:06	4,535	168	4292	3.2%	01:18	03:53	01:31		
February	2018	15,611	854	14,614	5.5%	01:50	05:07	01:42	1,242	5	1,229	0.4%	00:16	05:53	00:07	4,092	200	3818	4.7%	01:42	04:18	02:17		
March	2018																							
April	2018																							
May	2018																							
June	2018																							
July	2018																							
August	2018																							
September	2018																							
October	2018																							
November	2018																							
December	2018																							

Complaint Summary Report by Complaint Type and Month: FY '17-18														
	Month	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Total
Shorthand	Description													
LEI	LogistiCare Employee Issue	1	1	2	2	3	3	5	1	0	1			**19**
LI	LogistiCare Issue	8	4	2	3	1	6	6	5	1	2			**38**
INJ	Injury	3	2	7	10	7	17	5	3	4	2			**60**
LI	Issue with a Facility	2	3	6	12	5	2	1	1	7	6			**45**
NVA	No Vehicle Available (NVA)	0	0	3	2	0	2	0	1	3	3			**14**
OT	Unknown / Other	2	1	1	5	1	5	10	3	11	9			**48**
RR	Rerouted out of time	0	0	0	0	0	0	0	0	1	0			**1**
RFA	Rider Fraud & Abuse	10	8	12	17	27	14	5	2	16	12			**123**
RIDR	Rider Issue (Complaint about Rider)	27	19	28	35	36	30	21	17	32	43			**288**
RNS	Rider No Show	**8**	**7**	10	15	47	47	11	23	31	30			**229**
TPE	Transportation Provider Early	12	12	11	9	11	9	7	10	9	9			**99**
PL	Transportation Provider Late	213	155	132	135	207	155	175	129	166	135			**1,602**
PNS	Transportation Provider No Show	46	43	42	24	29	35	51	31	69	53			**423**
FFA	Tran. Provider (possible) Fraud & Abuse	4	13	10	11	19	9	10	6	16	5			**103**
TP	Transportation Provider	65	51	53	89	90	91	87	61	98	98			**783**
VI	Vehicle Issue (e.g., AC, heat, etc.)	3	6	4	2	3	1	4	5	2	3			**33**
WTDI	Wheelchair tie down issue	2	2	2	2	1	2	4	1	2	3			**21**
Total		**406**	**327**	**325**	**373**	**487**	**428**	**402**	**299**	**468**	**414**	**0**	**0**	**3,929**

May '18 Caseload Conference

Medicare Premium Calculation

SFY 2018 **$64,983,598**
SFY 2019 **$66,731,396**

	May '18 CEC FY '18 Forecast				
FY'18	Premiums	Part A	Part B	A & B	$/Eligible
Jul-17	$5,084,245	947	34,335	35,282	$144.10
Aug-17	$5,302,357	957	34,716	35,673	$148.64
Sep-17	$5,142,517	958	34,820	35,778	$143.73
Oct-17	$5,239,638	973	34,917	35,890	$145.99
Nov-17	$5,444,878	985	35,178	36,163	$150.56
Dec-17	$5,236,913	993	35,264	36,257	$144.44
Jan-18	$5,267,412	1,001	35,377	36,378	$144.80
Feb-18	$5,297,586	1,004	35,554	36,558	$144.91
Mar-18	$6,670,446	999	36,530	37,529	$177.74
Apr-18	$5,496,299	1,004	36,531	37,535	$146.43
May-18	$5,332,644	1,004	36,556	37,560	$141.98
Jun-18	$5,468,663	1,009	36,641	37,650	$145.25
FY'18	**$64,983,598**	**986**	**35,535**	**36,521**	**$148.28**
		plus 5/mo.	**plus 85/mo.**		

Medicare Premiums

CY	Pt. A	Pt. B
2,017	$413	$121.80
2,018	$422	$134.00
Incr.	**$9.00**	**$12.20**

	May '18 CEC - FY '19 Forecast				
FY'19	Premiums	Part A	Part B	A & B	$/Eligible
Jul-18	$5,481,735	1,014	36,726	37,740	$145.25
Aug-18	$5,494,808	1,019	36,811	37,830	$145.25
Sep-18	$5,507,880	1,024	36,896	37,920	$145.25
Oct-18	$5,520,953	1,029	36,981	38,010	$145.25
Nov-18	$5,534,025	1,034	37,066	38,100	$145.25
Dec-18	$5,547,098	1,039	37,151	38,190	$145.25
Jan-19	$5,574,716	1,044	37,236	38,280	$145.63 **
Feb-19	$5,587,823	1,049	37,321	38,370	$145.63
Mar-19	$5,600,930	1,054	37,406	38,460	$145.63
Apr-19	$5,614,037	1,059	37,491	38,550	$145.63
May-19	$5,627,143	1,064	37,576	38,640	$145.63
Jun-19	$5,640,250	1,069	37,661	38,730	$145.63
FY'19	**$66,731,396**	**1,042**	**37,194**	**38,235**	**$145.44**
		plus 5/mo.	**plus 85/mo.**		

Medicare Premiums

CY	Pt. A	Pt. B
2,018	$422	$134.00
2,019	$436	$134.00
Incr.	**$14.00**	**$0.00**

2017 Medicare Trustees Rpt. Pg. 199-202

	Part A	Part B	A & B	PMPM Incr.
Jan-19	$14,616	$0	$14,616	$0.38
Feb-19	$14,686	$0	$14,686	$0.38
Mar-19	$14,756	$0	$14,756	$0.38
Apr-19	$14,826	$0	$14,826	$0.38
May-19	$14,896	$0	$14,896	$0.39
Jun-19	$14,966	$0	$14,966	$0.39
			Avg. Decr.	**$0.38**

** reflects avg. increase of **$0.38** / mo.

Overview of Requests Within the 1115 Waiver Extension Request

Title	FY19 Funds	Description	Source of Request	Alignment with Principles			
				Pay for value, not for volume	Coordinate physical, behavioral, & long-term health care	Rebalance the delivery system away from high-cost settings	Promote efficiency, transparency, and flexibility
Eligibility							
Streamlining the Process for Collecting Patient Liability to Decrease Provider Burden and Improve Program Integrity	No addtl funds needed	· EOHHS proposes a new approach to the collection of beneficiary liability; the State will collect the beneficiary liability directly from the Medicaid eligible individuals rather than having providers collect them. · This change would solely address the process of collection; methodology for determining the application of beneficiary income to the cost of care will remain the same.	External stakeholders Internal EOHHS staff		X		X
Medicaid LTSS for Adults with Developmental and Intellectual Disabilities Group Homes	No addtl funds needed	· Request to strengthen eligibility criteria for group home services for the developmentally disabled (DD) population receiving HCBS; designed to ensure that the services provided are in the most integrated, least restrictive setting, that the services are appropriate for the needs of the population, and to reduce an over reliance on the most restrictive and highest cost community living option. · Criteria will not be applied to those individuals that are already residing in a group home	BHDDH staff		X	X	X
Facilitating Medicaid Eligibility for Children with Special Needs	No addtl funds needed	· Establish an eligibility category for children who meet the SSI disability criteria, but whose household income and assets exceed the SSI resource limits. · Allows children who meet the SSI disability criteria and require care in a residential treatment facility to become Medicaid eligible and receive residential care without parents needing to voluntarily relinquish custody to DCYF.				X	X
Benefits							
Covering Family Home Visiting Programs to Improve Birth and Early Childhood Outcomes	__	· Seeking authority to receive federal matching funds for evidence-based home visiting services for Medicaid-eligible pregnant women and children up to age four who are at-risk for adverse health, behavioral, and educational outcomes are the target population · Aimed at improving maternal and child health outcomes, encourage positive parenting, and promote child development and school readiness	RIDOH		X	X	X
Supporting Home- and Community-Based Therapeutic Services for the Adult Population	___	· Expansion of current in-home/community-based skill building and therapeutic/clinical services for children to adults. · Services may include but are not limited to: evidence based practices; home-based specialized treatment; home-based treatment support; individual-specific orientation; transitional services; lead therapy; life skill building; specialized treatment consultation by a behavioral health clinician; and treatment coordination.	External stakeholders BHDDH staff (Coordinated Specialty Care/transition services)		X	X	
Enhancing Peer Support Services for Parents and Youth Navigating Behavioral Health Challenges	In DCYF budget	· Request to offer peer mentoring services to children, youth, and young adults, and their families, who have complex behavioral health needs and are at risk of removal from the home due to child welfare or juvenile justice involvement, or who may need extended residential psychiatric treatment. · Peer support providers who struggled with and successfully overcame behavioral health challenges as youth may work directly with current youth deemed in need of the service, or parent support providers who have parented youth involved in the behavioral health, child welfare, juvenile justice or other youth serving systems may support parents or caregivers directly to enhance the parent/caregivers' ability to address their child's behavioral health. · To be claimed under Budget Services 4 for at risk youth	DCYF staff		X	X	
Improving Access to Care for Homebound Individuals	__	· Request to cover home-based primary care services only for Medicaid-eligible individuals who are homebound, have functional limitations that make it difficult to access primary care, or for whom routine office-based primary care is not effective because of complex medical, social, and/or behavioral health conditions.	Internal EOHHS staff		X	X	X
Building Supports for Individuals in a Mental Health or Substance Use Crisis	Will pursue an amendment if necessary and also address in the caseload process.	· Behavioral Health Link (BH Link) triage center to support crisis stabilization and short-term treatment for individuals experiencing a behavioral health or substance use crisis. · Number of providers allowed to provide this service will be limited based on need.	BHDDH staff	X	X	X	
Providing Clinical Expertise to Primary Care through Telephonic Psychiatric Consultation	__	· Authority to cover child, adolescent and adult telephonic psychiatric consultation services for primary care practitioners; this is an expansion of the SIM initiative Pediatric Psychiatry Resource Network or "PediPRN" to adults	BHDDH staff		X	X	X

Overview of Requests Within the 1115 Waiver Extension Request

Title	FY19 Funds	Description	Source of Request	Alignment with Principles			
				Pay for value, not for volume	Coordinate physical, behavioral, & long-term health care	Rebalance the delivery system away from high-cost settings	Promote efficiency, transparency, and flexibility
Facilitating Successful Transitions to Community Living	___	· Seeking to revise the current authority for Community Transition Services by: 1. Characterizing the services as a Preventive service, rather than a Core service; and 2. Expanding the allowable expenses that can be covered under this authority to include: - Storage fees; - Weather appropriate clothing; - Assistance with obtaining needed items for housing applications (e.g., assistance with obtaining and paying for a birth certificate or a state identification card, transportation to the local Social Security office); - Short-term assistance with rental costs for people who are at imminent risk of homelessness and are likely to be institutionalized in the absence of safe housing or who are in an institution and are unable to secure new housing without financial assistance (e.g., past due rent with housing agencies); - A short-term supply of food when people transition from the nursing facility or the hospital to the community; and - Transportation from a nursing facility to a new community-based living arrangement.	Internal EOHHS staff External stakeholders		X	X	X
Ensuring the Effectiveness of Long-Term Services and Supports	No addtl funds necessary	· Request to modify the LTSS expedited eligibility authority by: 1. Using a more efficient, clinical/functional expedited eligibility review process that employs a shortened, concise application that will capture the information (from medical providers) needed to identify individuals who qualify for LTSS; 2. Expanding the benefit package to include Preventive HCBS; 3. Increasing the number of days that adult day care services may be covered from three (3) to five (5) days per week; and 4. Including an option to provide additional hours of personal care/homemaker services above the twenty (20) hours currently allowed for beneficiaries with the highest clinical/functional need for an institutional level of care.	External stakeholders		X	X	X
Modernizing the Preventive and Core Home- and Community-Based Services Benefit Package	___	· EOHHS seeks to modernize the Preventive and Core Home and Community Based Service (HCBS) package for beneficiaries who meet the applicable clinical/functional criteria by: · Eliminating select HCBS that are no longer needed as they are now State Plan benefits; · Broadening the range of needs-based Preventive and Core HCBS (see list below); · Updating the definitions of the benefits; and · Instituting authority to cap the amount or duration of Preventive HCBS based on need and mandate cost-sharing for Preventive HCBS · New Preventive HCBS include: - Assistive technology - Chore - Community Transition Services - Home stabilization - Limited non-emergency transportation/home visits - Medication management/administration - Peer Supports - Skilled-nursing, when pre-authorized based on need · New Core HCBS include: - Bereavement Counseling - Career Planning - Consultative Clinical and Therapeutic Services - Prevocational Services - Psychosocial Rehabilitation Services - Training and Counseling Services for Unpaid Caregivers	External stakeholders EOHHS staff		X	X	X
Delivery System							
DSHP Claiming and Expenditure Authority for a Full Five Years	This authority allows for the HSTP spending requested in the FY19 budget: As per the Technical Appendix: $9,350,000 Admin $23,500,000 in benefits For $32,850,000 in total	· Extension of the Designated State Health Program (DSHP) authority through December 31, 2020, allowing continued work on AEs and Healthcare Workforce Development activities through 2022	Internal EOHHS staff	X	X	X	X
Piloting Dental Case Management	Afforded within EOHHS budget request	· Pilot four new dental case management CPT codes in select group of approximately six trained dental practices across the state · Monitored via claims data from MMIS and a customized data collection form to determine effectiveness prior to full implementation	Internal EOHHS/DOH staff (Dr. Zwetchkenbaum)		X	X	X
Promoting Access to Appropriate, High-Quality Mental Health and Substance Use Treatment by Waiving the IMD Exclusion	No addtl funds needed	· Waiver of IMD exclusion in section 1905(a)(29)(B) of the Social Security Act and 42 CFR 435.1009 to allow Medicaid coverage and federal financial participation for residential treatment services for Medicaid-eligible people who have mental health or substance use disorders and are participating in residential treatment programs with a census of 16 or more beds that are considered IMDs	Internal EOHHS staff BHDDH staff		X		X
Finance							

Overview of Requests Within the 1115 Waiver Extension Request

Title	FY19 Funds	Description	Source of Request	Alignment with Principles			
				Pay for value, not for volume	Coordinate physical, behavioral, & long-term health care	Rebalance the delivery system away from high-cost settings	Promote efficiency, transparency, and flexibility
Testing New Personal Care and Homemaker Services Payment Methodologies Aimed at Increasing Provider Accountability	No addtl funds needed	· Pilot an Alternative Payment Methodology (such as bundled payments, per member per month payments, episodic payments, and quality-adjusted payments) for personal care and homemaker services · Pilot first, then full implementation if evaluation proves successful	Internal EOHHS staff	X	X	X	X

Attachment 8b

May 2018 Caseload Estimating Conference

Reponses to Conferee Questions – April 23, 2018 CEC Meeting

1. **Please provide what will happen to HCBS dollars in April – June 2018 versus what was presented. Please provide year-to-date dollars versus dollar projections for full year.**

Anticipated expenditures and caseload for the last quarter of the FY 2018 are presented below.

Forecast Expenditures	April	May	June
All Other HCBS *	$2,086,369	$2,784,470	$4,187,885
Assisted Living **	$302,710	$303,210	$303,952
PACE	$1,098,893	$1,102,606	$1,106,318
Total HCBS	**$3,487,972**	**$4,190,286**	**$5,598,155**

Forecast Caseload	April	May	June
All Other HCBS *	1,926	1,928	1,932
Assisted Living **	287	288	288
PACE	300	301	302
Total	**2,513**	**2,517**	**2,522**

* includes DEA waiver & case management

** includes off-cycle payments and DEA Asst. Living

2. **Please correct for adjustment to the Home and Community Care Expenditures.**

*EOHHS incorrectly reported its "Other HCBS" expenditures within its **Home and Community Care Expenditures** account. With respect to FY 2018, we overstated our expenditures by $1,000,000. The problem was identified as a double-counting of the partial impact associated with the 7% rate increase for home care workers included in FY 2018 Enacted and effective as of October 1, 2017.*

With respect to FY 2019, we understated our anticipated expenditures by $2,667,000 which reflects an oversight of not including the costs attributed to the home care wage increase in FY 2019 not yet reflected in experience.

EOHHS regrets this error and has revised its fiscal positions in FY 2018 and FY 2019 to reflect these corrections.

Corrected pages are attached and will be provided to the conferees.

May 2018 CEC - Testimony REVISED

*Related, please note that **Attachment 6c** have been updated to include expenditures that are omitted from the Monthly Medicaid Expenditures Report provided to House and Finance committees.*

3. Please provide reconciliation between number of terminations reported in Nov 2017 CEC and May 2018 CEC.

*In October, EOHHS testified to 26,304 terminations processed by RI Bridges between May 2017 and September 2017. This data was presented in Table II-2 on page 8 of the October 31, 2017 testimony and summarized in **Table 1** below.*[1]

Comparatively, on April 23, 2018, EOHHS reported a total of 33,253 terminations in MMIS for first half of FY 2018 (June 2017 through Dec 2017 below).[2] *These full Medicaid terminations are associated with a different period than that reported in October.*

EOHHS' current number that is comparable to its previously reported figure is the 21,322 terminations between June 2017 and October 2017. (From a date perspective, any terminations that RI Bridges processes in a month is realized in the next month's caseload.) The variation is associated with the two figures originating from different reporting environments (RI Bridges and MMIS) and representing related but distinct metrics (raw terminations and terminations net of churn, respectively). EOHHS has provided a workbook detailing historical churn of members, by eligibility group, between SFY 2014 through March 2018 with its May CEC Testimony of April 23, 2018.

The reduction in the number of effective terminations between RI Bridges and MMIS is due, in part, to the fact that any member that regains eligibility in the following month would have their new eligibility segment go back to the first of that month and would therefore not appear to have any gap in Medicaid coverage. For example, the 3,484 terminations processed by RI Bridges in September resulted in 2,482 actual terminations of members no longer eligible in MMIS.

Table 1. Comparison of RI Bridges Terminations (Nov CEC) and MMIS Churn (May CEC)

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
May CEC - Terminations Realized in MMIS											
Full Medicaid	1,802	1,705	2,957	4,317	9,861	2,482	8,303	5,355	5,393	5,178	5,557
Partial Medicaid	513	494	541	509	529	486	587	587	485	497	478
Total	2,315	2,199	3,498	4,826	10,390	2,968	8,890	5,942	5,878	5,675	6,035
Nov CEC - Terminations Processed in RI Bridges											
Full Medicaid	1,678	3,236	5,128	12,032	3,484	11,140	8,068	3,652			
Partial Medicaid	984	983	985	1,050	960	731	1,252	567			
Total	2,662	4,219	6,113	13,082	4,444	11,871	9,320	4,219			

May CEC (MMIS)
Full MA Terminations: 21,322

Nov CEC (RI Bridges)
Full MA Terminations: 25,558

[1] Although, after a review of the actual terminations, presented in **Table II-2** for the period May through September total 25,558, not 26,304 as written in text which had been based on earlier communications with Deloitte.

[2] Through the first three-quarters of FY 2018 there have been 49,403 effective terminations. This number could change, however, at the margin, as a result of retroactive determinations.

Much of the difference between Nov CEC and May CEC forecasts is driven by the increase in the number newly eligible in October 2017 that were not adequately anticipated in EOHHS' prior forecast. As communicated in a memorandum to the conferees on November 7, 2017, the month-end actuals for October 2017 were 3,057 higher than expected and incorporated into November CEC. This increase to the and the replacement of the 1.1% trend for the second half of FY 2018 with a 2.6% annual trend explains much of the deviation between the Nov CEC and May CEC forecasts.

4. **Please update the Rhody Health Options risk share to properly account for losses against the medical premium.**

*The original number of $14.5 million for FY 2017 included in **Table IV-5** on page 31 of **Testimony** incorrectly included risk share payments paid by CMS against losses on the Medicare premium*

Table IV-5. Historical Risk Share Payments

	Total Risk Share	PMPM Risk	% of Capitation
FY 2014[1]	$ 6,661,530	$ 75.04	6.0%
FY 2015	$ 11,706,536	$ 56.59	4.5%
FY 2016	$ 12,535,243	$ 52.73	4.2%
FY 2017	$ 11,045,629	$ 39.76	3.3%
FY 2018[2] *Est.*	$ 10,713,276	$ 35.66	3.0%
FY 2019 *Est.*	$ 5,700,656	$ 18.29	1.5%

Note:

1. Partial Year - program started in November 2013.
2. FY 2018 risk share based on reporting through Jan-18.

5. **Please provide the timeline for DXC to resolve the billing issue for J-Codes, that is, billings based on claims incurred date versus paid date?**

The state is currently working with DXC to assess the scope and prioritization of this project.

EOHHS' current Medical Benefits estimate for FY 2018 and FY 2019 do not presume a fix to be implemented prior to end of FY 2019 nor does it include any accrual for potential reductions in J-Code collections related to the change in CMS regulations around invoicing for J-Code rebates.

6. **What is the fiscal impact of the hospital rate cut on the UPL?**

Information on the offsetting fiscal impact that the Governor's proposed rate freeze would have on the maximum allowable Inpatient and Outpatient UPL payments for FY 2019 will be included in the rebasing of the FY 2019 initiatives. In general, when the State imposes a cut or freeze to the hospital rates there will be a corresponding increase in UPL payments compared to what the UPL amount would have been absent the cut or freeze to hospital rates.

Please note that because the Governor's FY 2019 Recommend included the elimination of the Inpatient UPL there would be no interaction between the proposed hospital rate freeze and Inpatient UPL

payments. The Governor's Recommend, however, overstated the savings of the Outpatient rate cut by not accounting for the offsetting increase of $115,000 All Funds (approx. $40,000 GR) to the Outpatient UPL.

7. **Please provide the Increased CHIP claiming due to growth for FY 2019.**

The CHIP forecast is based on average claiming over the past 12 months trended forward at 2.5% annualized. Additional CHIP claiming is then added related to allocation of FQHC, Risk Share, and Performance Goal Program expenditures. In May CEC, EOHHS added additional claiming associated with the newly identified group that is not yet reflected in experience.

8. **Given the FQHC agreement, please the estimated savings compared to what would otherwise have been status quo expenditures for FQHCs.**

Compared to what FQHC rates would otherwise have been, the savings of the agreement is estimated to be $694,826 All Funds in FY18.

9. **Please provide additional details on the LTSS redesign expenditures.**

Summary of proposed partial reinvestment MCO administrative payment savings:

Proposed Enhanced Services and Supports for Medicaid FFS Beneficiaries	**Annual Cost (all funds)**
Call center	$0.35 M
Care management, case management, and care coordination	$2.98 M
Community transition services	$1.25 M
Interpreter services	$0.2 M
Grievances and appeals	$0.15 M
Provider network management	$0.2 M plus $1.25 M for FFS provider rate increases
Utilization management	$0.25 M
LTSS options counseling, care planning, and authorizations	$0.35 M
Ombudsman	$0.05 M
Total Cost	**$7.03 M**

10. **Please provide the last time that Rhody Health Options and ICI members could opt-in/opt-out.**

Members are currently able to opt-in and/or opt-out of RHO or ICI. New members are currently passively enrolled into RHO but not into ICI.

11. Please explain the timeline for federal approval of the Recovery Navigation Program?

BHDDH used federal funds to fund the program through the end of March. In April, Medicaid submitted a rating methodology to CMS for approval and began using this rate to pay for RNP. Once CMS approves this rate, we expect to claim federal match retrospectively.

12. Please provide the total recoveries to date for the BAE contract. What is this in terms of dollars? It should be more than the budget initiative. What is the expectation going forward for this contract?

In Medicaid, the BAE contract has resulted in 1,007 terminations which resulted in approximately $5.8 M All Funds/ $430 K General Revenue savings.

It is anticipated that BAE will generate additional savings through its contract period, ending October, 2018.

13. Please indicate why in FY 2018 RiteSmiles enrollment increased 3,054 while RiteCare Core enrollment only increased 1,219.

We don't have a definitive explanation, but a possible explanation, consistent with the variable aged-related change in caseload noted above, is that a greater proportion of the termination activity in the first half of the fiscal year impacted parents who were already ineligible for RIte Smiles and/or a greater proportion of new determinations was among children who were also RIte Smiles eligible.

Please note that RIte Smiles enrollment also includes members enrolled in CSHCN.

Compared to Nov CEC, enrollment among RIte Care Core children under 15 increased by 1,776; whereas enrollment children and adults aged 15+ decreased by 557 over Nov CEC.

14. Please provide the timeline for completing the reconciliation process for interim payments. Please include the number of individuals involved.

The goal is to finalize most of the reconciliation process by the end of SFY 2019. Per each group of payments, EOHHS's goal is to complete the reconciliation no later than two years following the issue date of a contingency payment. This will occur in a stepwise fashion per each group.

The number of patients (unduplicated count) for whom EOHHS has made an interim payment to a nursing facility is approximately 4,000. Reconciliation and recoupment as of 4/11/18 totals $1,983,470.79.

15. Please provide additional detail on Post Eligibility Verification (PEV) processing.

The State has been processing cases through post eligibility verification (PEV) since 2017. The first production run was between April and May of 2017, with the first cases terminating from PEV on May 30, 2017.

PEV verifies income and death data. Incarceration status is being verified in the MMIS. The processing runs monthly, but SWICA data is refreshed quarterly by design.

Please see the following summary statistics for PEV:

Since July of 2017, 14,489 individuals have been terminated because of PEV.
Since July of 2017, 45,117 individuals have been sent Additional Document Request Forms (ADRs) for PEV.
Please be advised that only individuals who do not meet reasonable compatibility standards receive ADRs.

16. Renewal Redistribution Plan.

The State has been working with CMS and Deliotte on a renewal re-distribution plan on the backlog of histroical renewals that are oustanding. To date, the State has idenfitied 223,268 indivudals who renewal date has already been updated or does not need correction. In addition, the State has identified, 52, 499 indivudals whose renewal date needs to be re-distributed. Please be advised that the renewal re-distribution plan does not take into consideration popualtions that are automatically renewed such as DCYF sub-care youth and SSI indivudals. The renewal re-distibution plan re-aligns and distributes the historical backlog of cases over the next 12 months.

17. Please provide more detail about the one-time adjustment for the estimated 1,000 individuals who were reinstated in Medicare Part B program due to being terminated.

There were approximately 1,000 persons that were incorrectly terminated from the Medicare Premium Payment program (Medicare Part B supplement program). The State has since re-instated these cases back to their incorrect termination date. The cases will be re-evaluated for redetermination during the next redetermination period, or if a change of status/ circumstance occurs.

Attachment 8c

May 2018 Caseload Estimating Conference

Reponses to Conferee Questions – April 23, 2018 CEC Meeting

1. **Please provide enrollment numbers for Rhody Health Options and ICI members who opted-in and -out of the programs.**

Please see Rhody Health Options/ICI Enrollment and Call Center Reports for December 2017 and March 2018 attached.


May 2018 CEC - RHO Enrollment Rep


May 2018 CEC - RHO Enrollment Rep

2. **For the nursing facility payment reconciliation program, please provide the number of cases that equate to the $1,983,471 collected.**

The recovered interim payment amount received to date is associated with 62 unique Medicaid members with 314 months of nursing home services.

3. **Please provide a more legible copy of the Post Eligibility Verification (PEV) process table.**

Please see attached.


RI Bridges PEV (Individuals).pdf

4. **Please provide a description of the State's interfaces for Date of Death processing.**

Death verification in RI Bridges occurs from a composite of two sources of data to confirm accuracy; generally, a State data source (RI DOH) and a Federal Source (SSA). Instead of using SSA data, RI Bridges currently relies on RI DOH data and triggers an Addition Documentation Request (ADR) to the estate of the deceased individual for additional confirmation. This was done while the SSA data sources were being corrected. We are working to implement SSA data in production and are completing test reviews now.

5. **Based on the 52,499 individuals whose renewal date needs to be re-distributed, please provide the oldest recertification dates for these individuals.**

Please see the renewals re-distribution breakout attached. This data will change as additional analysis is completed.

May 2018 CEC -
Renewal Distributio

The response provided in Attachment 8b, Question #17, has been revised as follows:

6. Please provide more detail about the one-time adjustment for the estimated 1,000 individuals who were reinstated in Medicare Part B program due to being terminated.

There were approximately 1,000 persons that were inadvertently discontinued from or not appropriately accreted to the Medicare Premium Payment program (Medicare Part B supplement program). The State has since re-instated these cases back to the date of discontinuation or accretion. The cases will be re-evaluated for redetermination during the next redetermination period, or if a change of status/ circumstance occurs.

6a. Please explain when the 1,000 individuals came off of or should have been added to the caseload of Medicare Part B.

These cases were impacted during the period of time between October 2016 – December 2017. We currently do not have data broken down for any other time period. We only have data for the overall time period cited above.

7. Please provide the eligibility processing process for the Medically-Needy. Is this process the same for the SSI-Like population?

The RI Bridges system evaluates clients for Aged/ Blind/ Disabled (ABD) – Medically Needy or Long-Term Services and Supports (LTSS) – Medically Needy when they are above the categorically-needy income limits. At this point, for community Medicaid, they can either fall into the Medically Needy limits or go into Medicaid Flex (Spend Down). In either case, they would need to provide medical bills to show that they spent down their excess income to meet the categorically-needy standards.

Persons have six months in which to reach the categorically needy standards.

Attachment 6c
MAY 2018 CEC TESTIMONY

FY 2018 EXPANDED MONTHLY MEDICAID EXPENDITURE REPORT - MMIS

	July	August	September	October	November	December	January	February	March	April	May	June	Total
Hospitals													
Inpatient Expenditures	$2,502,221	$1,701,232	$2,797,058	$2,011,256	$1,258,223	$2,253,512	$886,579	$2,164,379	$3,658,244				$19,232,703
Outpatient Expenditures	$302,978	$273,793	$439,259	$314,521	$222,931	$401,000	$174,529	$284,028	$433,626				$2,846,665
Supplemental Payments (UPL)	$4,863,639	$0	$0	$5,375,600	$0	$0	$5,119,618	$0	$0				$15,358,857
Subtotal	**$7,668,837**	**$1,975,026**	**$3,236,317**	**$7,701,378**	**$1,481,154**	**$2,654,512**	**$6,180,725**	**$2,448,406**	**$4,091,870**				**$37,438,225**
DSH Payments	$139,703,581	$0	$0	$0	$0	$0	$0	$0	$0				$139,703,581
Total Hospital Expenditures	**$147,372,418**	**$1,975,026**	**$3,236,317**	**$7,701,378**	**$1,481,154**	**$2,654,512**	**$6,180,725**	**$2,448,406**	**$4,091,870**				**$177,141,806**
Long Term Care													
Nursing Home													
Hospice	$688,272	$1,099,723	$1,141,022	$1,065,136	$1,211,569	$908,834	$751,344	$672,550	$825,605				$8,364,056
Nursing Home Claims	$8,401,550	$8,998,846	$9,098,801	$10,518,064	$15,059,937	$11,036,577	$10,004,452	$13,541,815	$10,091,357				$96,751,400
Nursing Home Off-Cycle Pymts	$1,785,040	$3,423,125	$10,687,792	$5,349,979	$986,441	$12,250,720	$3,976,575	$0	$5,479,791				$43,939,462
Total Nursing Home	**$10,874,862**	**$13,521,694**	**$20,927,616**	**$16,933,179**	**$17,257,947**	**$24,196,131**	**$14,732,370**	**$14,214,366**	**$16,396,754**				**$149,054,919**
Home and Community Based Services													
All Other HCBS	$2,532,922	$1,860,607	$3,206,811	$2,303,734	$1,421,483	$3,171,550	$2,315,803	$2,311,446	$3,328,836				$22,453,191
DEA Personal Care & Case Mgmt.	$311,167	$203,364	$456,957	$276,013	$225,066	$339,871	$234,572	$250,500	$421,195				$2,718,705
Assisted Living Claims	$38,654	$37,705	$82,682	$166,942	$79,951	$57,029	$51,919	$49,718	$62,200				$626,800
DEA Assisted Living	$74,966	$74,447	$119,636	$156,803	$95,146	$208,833	$92,846	$117,109	$135,636				$1,075,421
Assisted Living Off-Cycle Pymts	$157,200	$136,894	$37,185	$185,572	$78,671	$260,380	$52,869	$0	$102,913				$1,011,682
PACE	$1,133,186	$778,328	$1,079,175	$1,094,874	$1,077,068	$1,096,368	$1,074,108	$1,095,854	$1,048,712				$9,477,674
Total HCBS	**$4,248,095**	**$3,091,344**	**$4,982,446**	**$4,183,939**	**$2,977,385**	**$5,134,031**	**$3,822,117**	**$3,824,627**	**$5,099,492**				**$37,363,474**
Total LTC Expenditures	**$15,122,956**	**$16,613,038**	**$25,910,062**	**$21,117,118**	**$20,235,332**	**$29,330,162**	**$18,554,487**	**$18,038,992**	**$21,496,245**				**$186,418,393**
Managed Care													
Capitation													
RIte Care Core	$37,239,607	$36,530,725	$36,617,914	$36,331,840	$36,939,354	$37,073,119	$38,116,488	$37,755,451	$37,780,526				$334,385,023
CSHCNs	$7,106,222	$6,984,983	$6,890,815	$6,797,873	$6,650,786	$6,519,723	$6,493,029	$6,463,363	$6,251,070				$60,157,864
Foster	$1,898,560	$1,906,551	$2,017,618	$2,112,206	$2,161,417	$2,158,849	$2,174,558	$2,240,142	$2,254,799				$18,924,700
Total Capitation	**$46,244,389**	**$45,422,260**	**$45,526,347**	**$45,241,918**	**$45,751,557**	**$45,751,690**	**$46,784,075**	**$46,458,956**	**$46,286,395**				**$413,467,587**
RIteSmiles Capitation	$2,028,442	$0	$4,044,997	$2,044,379	$0	$4,210,028	$0	$2,111,295	$4,257,392				$18,696,533
RIteShare Premiums	$319,092	$310,228	$306,386	$301,025	$295,430	$297,743	$293,867	$282,236	$276,746				$2,682,754
SOBRA	$5,103,501	$3,664,410	$5,393,902	$3,464,557	$3,087,099	$5,268,439	$3,870,856	$1,980,639	$3,410,112				$35,243,515
NICU	$2,481,343	$976,317	$2,990,158	$2,270,515	$1,242,199	$2,658,122	($22,242)	$4,386,254	$3,497,785				$20,480,451
RIteCare/RIteShare FFS Payments	$3,778,267	$1,543,816	$6,174,985	$3,801,377	$1,701,300	$14,634,613	$1,266,083	$5,399,385	$9,458,809				$47,758,635
Other Managed Care Services	$563,569	$784,612	$9,508,612	($98,616)	$2,140,761	$3,054,118	($152,898)	($152,092)	$1,364,850				$17,012,916
Managed Care Encounter Drug Rebates	($1,594,447)	($945,973)	($7,086,822)	($2,560,745)	($215,074)	($3,439,765)	($5,300,068)	($455,996)	($6,467,297)				($28,066,188)
Total Managed Care Expenditures	**$58,924,156**	**$51,755,669**	**$66,858,565**	**$54,464,410**	**$54,003,273**	**$72,434,988**	**$46,739,673**	**$60,010,676**	**$62,084,793**				**$527,276,204**
Note: Other MC Services include Stop Loss, Risk Share, P4P, DRE, EI CNOM, FQHC Transition Pymts, Premium Collections and Tax Intercept.													
Rhody Health													
Rhody FFS	$31,192	$22,971	$11,963	$52,907	$72,076	$21,904	$29,654	$53,001	$10,744				$306,411
Rhody Health Options	$19,702,359	$18,980,469	$24,303,468	$18,487,329	$17,830,359	$21,206,102	$19,136,485	$19,904,390	$21,094,999				$180,645,960
Rhody Health Partners	$22,162,510	$22,078,224	$22,952,014	$21,794,729	$22,109,161	$24,289,700	$21,643,874	$21,058,283	$21,377,520				$199,466,014
Other Services and Financial Transacti	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
CMS Demonstration	$9,618,380	$9,263,176	$10,197,234	$9,857,298	$9,351,323	$10,814,804	$9,762,942	$9,776,501	$8,025,912				$86,667,568
RHO - Drug Rebates	($183,960)	($81,636)	($599,596)	($269,369)	($18,171)	($283,493)	($431,615)	($37,337)	($429,337)				($2,334,514)
RHP - Drug Rebates	($1,371,901)	($812,831)	($6,074,934)	($2,603,797)	($184,331)	($3,427,013)	($5,396,980)	($461,357)	($4,899,257)				($25,232,401)
Rhody Other Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Rhody Expenditures	**$49,958,578**	**$49,450,374**	**$50,790,149**	**$47,319,099**	**$49,160,417**	**$52,622,003**	**$44,744,360**	**$50,293,481**	**$45,180,579**				**$439,519,039**
Note: Other Rhody Services include Risk Share, P4P, DRE.													
Pharmacy													
Pharmacy	$417,558	$300,275	$631,347	$344,035	$280,254	$464,078	$211,912	$371,749	$552,466				$3,573,674
Pharmacy Rebates	($26,219)	($39,103)	($2,908,921)	($44,600)	$0	($2,779,737)	($40,752)	($43,763)	($1,875,582)				($7,758,678)
Clawback	$5,245,379	$5,267,325	$5,288,958	$5,275,418	$5,255,510	$5,290,025	$5,253,976	$5,396,364	$5,421,618				$47,694,573
Total Pharmacy Expenditures	**$5,636,719**	**$5,528,496**	**$3,011,384**	**$5,574,852**	**$5,535,764**	**$2,974,366**	**$5,425,135**	**$5,724,350**	**$4,098,502**				**$43,509,569**
Note: Rebates reflect the amount received regardless of the time period to which they apply.													
Other Services													
Medicare Premiums	$5,084,245	$5,302,356	$5,142,517	$5,239,638	$5,444,878	$5,236,913	$5,267,412	$5,297,586	$6,670,446				$48,685,990
Recoveries	($1,508,343)	($565,376)	($1,458,098)	($695,508)	($453,386)	($593,919)	($819,638)	($916,665)	($1,738,662)				($8,749,595)
Transportation	$9,842	$5,316	$7,436	$5,102	$5,533	$8,051	$4,785	$9,939	$9,299				$65,303
Durable Medical Equipment	$198,175	$127,551	$253,838	$167,748	$141,151	$240,633	$165,785	$204,783	$283,259				$1,782,924
Rehabilitation	$1,134,080	$898,842	$2,274,373	$1,264,418	$691,727	$1,939,635	$591,809	$1,273,486	$2,005,276				$12,073,647
Tavares	$521,306	$538,876	$538,876	$506,601	$497,609	$522,466	$476,736	$498,451	$607,000				$4,707,921
Health System Transportation Project		$0	$13,500,000	$0	$0	$0	$0	$0	$0				$13,500,000
All Other	$2,471,006	$2,012,177	$3,259,384	$2,565,217	$2,144,375	$3,128,807	$1,828,244	$2,315,379	$2,887,181				$22,611,771
Total Other Services Expenditures	**$7,910,312**	**$8,319,743**	**$23,518,324**	**$9,053,215**	**$8,471,888**	**$10,482,587**	**$7,515,134**	**$8,682,959**	**$10,723,800**				**$94,677,961**
CNOM													
Transportation Broker	$36,760	$37,544	$39,360	$42,023	$40,083	$38,948	$41,197	$35,253	$43,365				$354,533
GPA	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
ORS	$16,034	$25,896	$73,759	$38,278	$36,964	$67,132	$34,453	$47,966	$56,285				$396,766
FQHC	($2,006)	($205)	($2,000)	($1,339)	($417)	($913)	($500)	$0	$0				($7,379)
Transportation for the Elderly	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
Total CNOM Expenditures	**$50,788**	**$63,236**	**$111,119**	**$78,962**	**$76,630**	**$105,167**	**$75,150**	**$83,219**	**$99,650**				**$743,919**
Special Education													
Special Education	**$1,077,387**	**$528,493**	**$988,155**	**$1,211,331**	**$1,021,163**	**$2,080,716**	**$1,015,969**	**$1,336,468**	**$1,947,340**				**$11,207,023**
Miscellaneous													
Adolescent Pregnancy	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
Bus Pass (TANF)	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
EHR payments	$327,250	$517,084	$682,632	$0	$34,000	$0	$34,000	$17,000	$167,168				$1,779,134
Quality Institute	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458	$250,458				$2,254,122
Title XX	$0	$767,542	$0	$0	$0	$0	$0	$0	$0				$767,542
Total Miscellaneous	**$577,708**	**$1,535,084**	**$933,090**	**$250,458**	**$284,458**	**$250,458**	**$284,458**	**$267,458**	**$417,626**				**$4,800,798**
Medicaid Expansion													
Claims	$1,672,975	$218,719	($261,860)	$2,667,162	$681,412	$2,250,263	$1,977,601	$1,566,964	$2,779,794				$13,553,029
Financial Transactions	$0	($452,126)	($15,801,711)	($287,840)	$0	($3,967,098)	$0	$0	($343,157)				($20,851,932)
Premiums	$39,712,925	$39,005,387	$38,667,653	$39,079,765	$37,036,074	$40,077,326	$38,506,191	$39,121,999	$39,080,087				$350,287,406
Drug Rebates	($1,731,999)	($1,070,655)	($8,056,720)	($3,064,414)	($243,341)	($4,624,716)	($7,175,361)	($623,911)	($7,378,838)				($33,969,956)
Transportation Broker	$557,492	$531,874	$477,601	$544,420	$485,477	$538,135	$535,608	$539,028	$532,140				$4,741,774
Sobra Claims	$874,545	$509,682	$732,177	$568,193	$543,043	$1,086,876	$833,345	$582,286	$720,346				$6,450,493
Total Medicaid Expansion	**$41,085,938**	**$38,742,881**	**$15,757,139**	**$39,507,285**	**$38,502,664**	**$35,360,786**	**$34,677,383**	**$41,186,366**	**$35,390,372**				**$320,210,814**
Grand Total	**$327,716,961**	**$174,512,039**	**$191,114,304**	**$186,278,108**	**$178,772,742**	**$208,295,745**	**$165,212,475**	**$188,072,375**	**$185,530,778**	**$0**	**$0**	**$0**	**$1,805,505,526**

Attachment 6d
MAY 2018 CEC TESTIMONY

FY 2018 ADDITIONAL MONTHLY MEDICAID CASELOAD INDICATORS - MMIS

Hospitals	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
Inpatient Days (Incl Psych)	2,970	2,715	3,482	3,126	3,014	2,509	2,016	824	130	0	0	0
Inpatient DRG Discharges	46	73	75	87	26	38	17	30	208	0	0	0
Inpatient Non-DRG Discharges	1	0	1	0	0	0	0	0	1	0	0	0
Long Term Care												
NH Medicaid Days	47,482	51,104	51,872	62,203	83,785	61,089	56,622	72,965	55,526	0	0	0
NH Medicare Days	730	722	850	1,482	2,344	1,183	805	1,416	1,258	0	0	0
Hospice Days	3,971	6,321	6,283	5,920	5,369	3,292	3,933	3,949	4,654	0	0	0
Home and Community Based Services												
HCBS Eligibles												
Assisted Living	213	223	233	243	258	256	253	270	287	0	0	0
PACE	292	299	297	302	300	296	300	299	301	0	0	0
DEA Waiver	287	294	290	277	286	311	302	298	305			
A&D Waiver, Personal	0	0	0	1	1	1	1	1	1	0	0	0
Choice/HAB Waiver	219	231	233	226	226	217	215	212	206	0	0	0
Habilitation Community Svc	8	8	8	9	9	9	9	9	8	0	0	0
Habilitation Group Home	8	8	8	8	8	9	9	8	9	0	0	0
Preventive Community Svc	381	387	383	375	383	369	375	376	372	0	0	0
Core Community Svc	950	944	937	948	969	963	956	948	979	0	0	0
Total Eligibles	2,358	2,394	2,389	2,389	2,440	2,431	2,420	2,421	2,468	0	0	0
Managed Care Enrollment												
RIte Care												
RIte Care Core	160,478	159,540	157,556	158,387	157,590	158,054	158,530	158,490	157,708	0	0	0
CSHCN's	7,760	7,788	7,662	7,624	7,558	7,417	7,373	7,323	7,298	0	0	0
Foster	2,486	2,504	2,585	2,689	2,725	2,785	2,796	2,865	2,911	0	0	0
Total RIte Care	170,724	169,832	167,803	168,700	167,873	168,256	168,699	168,678	167,917	0	0	0
RIteShare	7,268	7,109	6,843	6,846	6,661	6,541	6,363	6,186	6,005	0	0	0
RiteSmiles	104,671	105,059	104,181	105,433	105,969	107,377	108,533	109,312	109,879	0	0	0
Shared Living	136	145	151	153	160	161	165	164	169	0	0	0
Rhody Health												
Total Enrollment	14,831	15,498	15,277	14,993	14,765	15,260	15,319	15,241	15,109	0	0	0
Rhody Health Options												
Total Enrollment	10,726	10,999	11,173	10,188	10,186	11,068	11,539	11,855	12,109	0	0	0
Medicaid Expansion												
Total Enrollment	77,547	77,278	73,271	77,499	76,094	77,755	77,468	77,341	76,713	0	0	0
Pharmacy												
Scripts	9,995	6,908	11,127	8,853	6,767	12,002	6,272	8,667	11,970	0	0	0
Other												
Estates and Casualty Recoveries	$563,502	$480,083	$432,416	$265,376	$133,245	$153,843	$331,640	$388,335	$735,586	$0	$0	$0

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services

Medical Assistance Program

Date Generated: July 2, 2018

June 30, 2018 Month-End Snapshot and June 2018 Churn Analysis

	May-18	No Longer Enrolled	Newly Enrolled	Jun-18	Jun-over-May Net Change	Jun-over-May Net Change %	% of Total
1. Children and Families:							
Neighborhood Health Plan of RI	102,236	(2,142)	1,887	101,981	(255)	(0.2%)	61.6%
UnitedHealthcare	53,420	(1,314)	1,135	53,241	(179)	(0.3%)	32.1%
Tufts Health Plan	2,666	(283)	548	2,931	265	9.9%	1.8%
Subtotal Rite Care Core Enrolled	158,323	(3,740)	3,571	158,154	(169)	(0.1%)	95.5%
RIte Share/Fee-for-Service	8,305	(1,756)	973	7,522	(783)	(9.4%)	4.5%
Total	**166,606**	**(3,370)**	**2,440**	**165,676**	**(930)**	**(0.6%)**	**100.0%**
2. Extended Family Planning Only:							
Neighborhood Health Plan of RI	721	(46)	33	708	(13)	(1.8%)	68.7%
UnitedHealthcare	276	(18)	13	271	(5)	(1.8%)	26.3%
Tufts Health Plan	19	(2)	2	19	0	0.0%	1.8%
Subtotal Rite Care EFP Enrolled	1,016	(66)	48	998	(18)	(1.8%)	96.8%
RIte Share/Fee-for-Service	42	(12)	3	33	(9)	(21.4%)	3.2%
Total	**1,058**	**(71)**	**44**	**1,031**	**(27)**	**(2.6%)**	**100.0%**
3. Substitute Care:							
Neighborhood Health Plan of RI	2,913	(114)	115	2,914	1	0.0%	90.0%
Subtotal Rite Care Substitute Care Enrolled	2,913	(114)	115	2,914	1	0.0%	90.0%
RIte Share/Fee-for-Service	328	(42)	38	324	(4)	(1.2%)	10.0%
Total	**3,241**	**(118)**	**115**	**3,238**	**(3)**	**(0.1%)**	**100.0%**
4. Children with Special Healthcare Needs:							
Neighborhood Health Plan of RI	5,267	(141)	62	5,188	(79)	(1.5%)	55.2%
UnitedHealthcare	1,914	(45)	21	1,890	(24)	(1.3%)	20.1%
Tufts Health Plan	32	(4)	4	32	0	0.0%	0.3%
Subtotal Rite Care CSHCN Enrolled	7,213	(190)	87	7,110	(103)	(1.4%)	75.6%
RIte Share/Fee-for-Service	2,329	(73)	37	2,293	(36)	(1.5%)	24.4%
Total	**9,542**	**(225)**	**86**	**9,403**	**(139)**	**(1.5%)**	**100.0%**
5. Expansion:							
Neighborhood Health Plan of RI	39,305	(1,914)	1,180	38,571	(734)	(1.9%)	50.3%
UnitedHealthcare	31,533	(1,479)	868	30,922	(611)	(1.9%)	40.3%
Tufts Health Plan	3,637	(383)	682	3,936	299	8.2%	5.1%
Subtotal Expansion Enrolled	74,475	(3,776)	2,730	73,429	(1,046)	(1.4%)	95.7%
RIte Share/Fee-for-Service	3,434	(2,034)	1,922	3,322	(112)	(3.3%)	4.3%
Total	**77,908**	**(3,063)**	**1,905**	**76,750**	**(1,158)**	**(1.5%)**	**100.0%**
6. Aged, Blind, and Disabled:							
Rhody Health Partners:							
Neighborhood Health Plan of RI	7,245	(169)	144	7,220	(25)	(0.3%)	13.1%
UnitedHealthcare	7,214	(151)	105	7,168	(46)	(0.6%)	13.0%
Tufts Health Plan	507	(68)	62	501	(6)	(1.2%)	0.9%
Subtotal RHP Enrolled	14,966	(388)	311	14,889	(77)	(0.5%)	27.0%
Rhody Health Options:							
Phase I - Neighborhood Health Plan of RI	12,749	(201)	582	13,130	381	3.0%	23.8%
Phase II - Neighborhood Health Plan of RI	13,482	(179)	93	13,396	(86)	(0.6%)	24.3%
Subtotal RHO Enrolled	26,227	(223)	517	26,521	294	1.1%	48.0%
PACE Organization of RI	286	(3)	2	285	(1)	(0.3%)	0.5%
Subtotal ABD Enrolled	41,478	(548)	763	41,693	215	0.5%	75.5%
RIte Share/Fee-for-Service	13,800	(829)	542	13,513	(287)	(2.1%)	24.5%
Total	**55,277**	**(460)**	**389**	**55,206**	**(71)**	**(0.1%)**	**100.0%**
7. Grand Total[1]	**312,489**	**(6,037)**	**3,695**	**310,147**	**(2,342)**	**(0.7%)**	**100.0%**

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services

Medical Assistance Program

Date Generated: July 2, 2018

June 30, 2018 Month-End Snapshot and June 2018 Churn Analysis

	May-18	No Longer Enrolled	Newly Enrolled	Jun-18	Jun-over-May Net Change	Jun-over-May Net Change %	% of Total
8. RIte Smiles	**111,054**	**(1,618)**	**1,595**	**111,031**	**(23)**	**(0.0%)**	**100.0%**
9. Medicaid Eligibility, by Population:							
Core	166,606	(3,370)	2,440	165,676	(930)	(0.6%)	53.4%
Substitute Care	3,241	(118)	115	3,238	(3)	(0.1%)	1.0%
Children with Special Healthcare Needs	9,542	(225)	86	9,403	(139)	(1.5%)	3.0%
Expansion	77,908	(3,063)	1,905	76,750	(1,158)	(1.5%)	24.7%
Aged, Blind, and Disabled	55,277	(460)	389	55,206	(71)	(0.1%)	17.8%
Total	**312,489**	**(6,037)**	**3,695**	**310,147**	**(2,342)**	**(0.7%)**	**100.0%**
10.a. Medicaid Enrollment in Managed Care, by Population:[2]							
Core	158,323	(3,297)	3,128	158,154	(169)	(0.1%)	55.9%
Substitute Care	2,913	(114)	115	2,914	1	0.0%	1.0%
Children with Special Healthcare Needs	7,213	(179)	76	7,110	(103)	(1.4%)	2.5%
Expansion	74,474	(3,515)	2,469	73,428	(1,046)	(1.4%)	25.9%
Aged, Blind, and Disabled	41,478	(548)	763	41,693	215	0.5%	14.7%
Total	**284,296**	**(6,920)**	**5,793**	**283,169**	**(1,127)**	**(0.4%)**	**100.0%**
10.b. Medicaid Enrollment in Managed Care, by Payer:[2]							
Neighborhood Health Plan of RI	183,155	(4,246)	3,422	182,331	(824)	(0.4%)	64.4%
UnitedHealthcare	94,059	(2,790)	1,935	93,204	(855)	(0.9%)	32.9%
Tufts Health Plan	6,842	(719)	1,277	7,400	558	8.2%	2.6%
PACE Organization of RI	286	(3)	2	285	(1)	(0.3%)	0.1%
Total	**284,296**	**(6,920)**	**5,793**	**283,169**	**(1,127)**	**(0.4%)**	**100.0%**
11. Medicaid Enrollment in RIte Share, by Population:							
Core	4,488	(174)	55	4,369	(119)	(2.7%)	78.8%
Substitute Care	34	(2)	2	34	0	0.0%	0.6%
Children with Special Healthcare Needs	622	(19)	1	604	(18)	(2.9%)	10.9%
Expansion	444	(30)	12	426	(18)	(4.1%)	7.7%
Aged, Blind, and Disabled	108	(2)	7	113	5	4.6%	2.0%
Total	**5,696**	**(211)**	**61**	**5,546**	**(150)**	**(2.6%)**	**100.0%**
12. Medicaid Remaining in Fee-for-Service (excl. RIte Share), by Population:							
Core	3,862	(1,595)	935	3,202	(660)	(17.1%)	14.6%
Substitute Care	303	(41)	36	298	(5)	(1.7%)	1.4%
Children with Special Healthcare Needs	1,713	(54)	36	1,695	(18)	(1.1%)	7.7%
Expansion	3,413	(2,017)	1,916	3,312	(101)	(3.0%)	15.1%
Aged, Blind, and Disabled	13,696	(827)	535	13,404	(292)	(2.1%)	61.2%
Total	**22,987**	**(4,497)**	**3,421**	**21,911**	**(1,076)**	**(4.7%)**	**100.0%**

Note:

1. Grand Total and RIte Share/Remaining in FFS do not include members with partial Medicaid, including Extended Family Planning (EFP) Only benefits, Emergency Medicaid, or Medicare Premium Payment only (i.e. QMB/SLMB/QI-I)
2. Enrollment by Managed Care does not include enrollment in Rite Share or Extended Family Planning (EFP) Only or Rite Smiles

Please note that Totals may not equal sum of constituent parts as members may be enrolled in multiple products or payers and enrollment does not yet reflect retroactive adjustments to premium payments.

Overview: Full Medicaid Eligibility and Enrollment through June 2018, by Population Group and Delivery System

Date Generated: July 2, 2018

	Eligible by Population:						Medicaid Managed Care Enrollment, by Program:						RIte Share, by Population[1]:				Remaining in Fee-for-Service:			
Month End	RIte Care[2]	Expansion	Aged, Blind and Disabled	Total	Net Change	Net Change %	RIte Care[2]	Expansion	Rhody Health Partners	Rhody Health Options	PACE	Subtotal Managed Care	RIte Care[2]	Expansion	Aged, Blind and Disabled	Subtotal RIte Share	RIte Care[2]	Expansion	Aged, Blind and Disabled	Subtotal Remaining in FFS
Jun-18	178,384	77,165	55,215	310,764	(2,325)	(0.7%)	168,179	73,429	14,889	26,527	285	283,309	5,004	424	113	5,541	5,201	3,312	13,401	21,914
				100.0%								*91.2%*				*1.8%*				*7.1%*
May-18	179,478	78,327	55,284	313,089	(596)	(0.2%)	168,450	74,475	14,966	26,231	286	284,408	5,144	439	108	5,691	5,884	3,413	13,693	22,990
Apr-18	179,848	78,836	55,001	313,685	803	0.3%	168,001	74,530	14,966	25,930	288	283,715	5,243	444	107	5,794	6,604	3,862	13,710	24,176
Mar-18	179,617	78,134	55,131	312,882	(1,529)	(0.5%)	167,568	74,263	15,072	25,705	287	282,895	5,289	432	107	5,828	6,760	3,439	13,960	24,159
Feb-18	180,524	78,818	55,069	314,411	(1,553)	(0.5%)	168,263	74,704	15,170	25,457	287	283,881	5,419	430	107	5,956	6,842	3,684	14,048	24,574
Jan-18	181,553	79,391	55,020	315,964	(981)	(0.3%)	168,308	74,116	15,234	25,298	288	283,244	5,550	426	106	6,082	7,695	4,849	14,094	26,638
Dec-17	182,099	79,933	54,913	316,945	33	0.0%	167,879	73,229	15,180	25,060	293	281,641	5,693	442	109	6,244	8,527	6,262	14,271	29,060
Nov-17	183,242	78,942	54,728	316,912	(3,400)	(1.1%)	167,839	71,353	15,005	24,203	290	278,690	5,828	417	110	6,355	9,575	7,172	15,120	31,867
Oct-17	184,414	81,204	54,694	320,312	4,245	1.3%	168,492	73,700	15,157	24,399	289	282,037	5,989	429	109	6,527	9,933	7,075	14,740	31,748
Sep-17	184,042	77,603	54,422	316,067	(6,075)	(1.9%)	167,539	70,915	15,361	24,370	288	278,473	6,113	351	108	6,572	10,390	6,337	14,295	31,022
Aug-17	186,271	81,501	54,370	322,142	(494)	(0.2%)	169,199	75,234	15,419	24,365	286	284,503	6,347	343	107	6,797	10,725	5,924	14,193	30,842
Jul-17	186,570	82,111	53,955	322,636	(333)	(0.1%)	169,921	76,648	14,771	24,191	289	285,820	6,500	347	103	6,950	10,149	5,116	14,601	29,866
Jun-17	186,976	82,511	53,482	322,969	1,607	0.5%	169,398	76,374	14,751	23,946	286	284,755	6,629	337	103	7,069	10,949	5,800	14,396	31,145
May-17	186,177	82,234	52,951	321,362	2,606	0.8%	168,011	75,148	14,848	23,817	281	282,105	6,718	336	102	7,156	11,448	6,750	13,903	32,101
Apr-17	184,911	81,134	52,711	318,756	2,951	0.9%	166,324	74,098	14,949	23,763	272	279,406	6,744	332	101	7,177	11,843	6,704	13,626	32,173
Mar-17	183,263	80,169	52,373	315,805			164,133	73,319	14,930	23,450	275	276,107	6,842	332	99	7,273	12,288	6,518	13,619	32,425

Fiscal Year Average:

	Eligible by Population:						Medicaid Managed Care Enrollment, by Program:						RIte Share, by Population[1]:				Remaining in Fee-for-Service:			
Month End	RIte Care[2]	Expansion	Aged, Blind and Disabled	Total	Net Change	Net Change %	RIte Care[2]	Expansion	Rhody Health Partners	Rhody Health Options	PACE	Subtotal Managed Care	RIte Care[2]	Expansion	Aged, Blind and Disabled	Subtotal RIte Share	RIte Care[2]	Expansion	Aged, Blind and Disabled	Subtotal Remaining in FFS
2018 YTD	182,170	79,330	54,817	316,317	9,325	3.0%	168,303	73,883	15,099	25,145	288	282,718	5,677	410	108	6,195	8,190	5,037	14,177	27,405
2017	178,424	76,447	52,122	306,992	25,506	9.1%	159,921	70,331	14,947	23,034	276	268,509	7,044	311	98	7,454	11,458	5,804	13,767	31,030
2016	164,715	65,682	51,089	281,486	10,801	4.0%	149,772	62,111	14,426	19,661	276	246,245	7,379	197	92	7,668	7,564	3,374	16,635	27,573
2015	160,824	58,989	50,872	270,685	50,361	22.9%	143,711	54,866	13,837	17,128	281	229,822	8,424	95	126	8,645	8,689	4,028	19,502	32,219
2014	149,267	20,228	50,431	220,324	25,744	13.2%	131,501	15,079	13,829	7,339	269	168,017	9,612	23	152	9,787	8,154	5,125	28,843	42,122
2013	144,839	0	49,326	194,581	2,351	1.2%	125,472	0	13,501	0	236	139,208	10,525	0	138	10,662	8,843	0	35,451	44,294
2012	143,226	0	48,553	192,230	4,108	2.2%	123,787	0	13,240	0	211	137,238	10,763	0	127	10,890	8,676	0	34,975	43,651
2011	135,285	0	52,837	188,122			121,017	0	12,514	0	210	133,531	10,573	0	65	10,638	3,695	0	40,048	43,744

Notes:

[1] RIte Share includes RIte Care eligibles, Expansion, and Age & Disabled adults. Does not include others such as EFP who may be incidentally rolled into RIte Share as part of family with RIte Share eligible children.

[2] RIte Care includes RIte Care Core, Children with Special Healthcare Needs, SubCare; does not include EFP

Rhode Island EOHHS (Medicaid)

Rite Care Eligible through June 2018, by Enrollment Status and Population Group

Date Generated: July 2, 2018

	Eligible by Population:						Enrolled in RIte Care:				Enrolled in RIte Share:				Remaining in Fee-for-Service:			
		Substitute				Net Change		Substitute				Substitute				Substitute		
Month End	Core	Care	CSHCN	Total	Net Change	%	Core	Care	CSHCN	Subtotal	Core	Care	CSHCN	Subtotal	Core	Care	CSHCN	Subtotal
Jun-18	165,729	3,246	9,409	**178,384**	(1,094)	(0.6%)	158,155	2,914	7,110	**168,179**	4,366	34	604	**5,004**	3,208	298	1,695	**5,201**
				100.0%						*94.3%*				*2.8%*				*2.9%*
May-18	166,679	3,251	9,548	179,478	(370)	(0.2%)	158,324	2,913	7,213	168,450	4,487	35	622	5,144	3,868	303	1,713	5,884
Apr-18	167,099	3,254	9,495	179,848	231	0.1%	157,931	2,913	7,157	168,001	4,584	40	619	5,243	4,584	301	1,719	6,604
Mar-18	166,696	3,279	9,642	179,617	(907)	(0.5%)	157,361	2,914	7,293	167,568	4,619	35	635	5,289	4,716	330	1,714	6,760
Feb-18	167,615	3,232	9,677	180,524	(1,029)	(0.6%)	158,088	2,859	7,316	168,263	4,745	34	640	5,419	4,782	339	1,721	6,842
Jan-18	168,637	3,164	9,752	181,553	(546)	(0.3%)	158,126	2,798	7,384	168,308	4,871	33	646	5,550	5,640	333	1,722	7,695
Dec-17	169,160	3,131	9,808	182,099	(1,143)	(0.6%)	157,655	2,787	7,437	167,879	5,008	30	655	5,693	6,497	314	1,716	8,527
Nov-17	170,225	3,066	9,951	183,242	(1,172)	(0.6%)	157,548	2,724	7,567	167,839	5,136	30	662	5,828	7,541	312	1,722	9,575
Oct-17	171,385	3,025	10,004	184,414	372	0.2%	158,183	2,684	7,625	168,492	5,287	32	670	5,989	7,915	309	1,709	9,933
Sep-17	171,087	2,902	10,053	184,042	(2,229)	(1.2%)	157,295	2,580	7,664	167,539	5,405	31	677	6,113	8,387	291	1,712	10,390
Aug-17	173,290	2,796	10,185	186,271	(299)	(0.2%)	158,911	2,506	7,782	169,199	5,627	29	691	6,347	8,752	261	1,712	10,725
Jul-17	173,649	2,746	10,175	186,570	(406)	(0.2%)	159,677	2,491	7,753	169,921	5,775	28	697	6,500	8,197	227	1,725	10,149
Jun-17	174,082	2,724	10,170	186,976	799	0.4%	159,264	2,457	7,677	169,398	5,898	28	703	6,629	8,920	239	1,790	10,949
May-17	173,461	2,700	10,016	186,177	1,266	0.7%	158,138	2,413	7,460	168,011	5,970	32	716	6,718	9,353	255	1,840	11,448
Apr-17	172,326	2,664	9,921	184,911	1,648	0.9%	156,592	2,393	7,339	166,324	5,989	35	720	6,744	9,745	236	1,862	11,843
Mar-17	170,951	2,570	9,742	183,263			154,781	2,260	7,092	164,133	6,090	27	725	6,842	10,080	283	1,925	12,288

Fiscal Year Average:

	Eligible by Population:						Enrolled in RIte Care:				Enrolled in RIte Share:				Remaining in Fee-for-Service:			
		Substitute				Net Change		Substitute				Substitute				Substitute		
Month End	Core	Care	CSHCN	Total	Net Change	%	Core	Care	CSHCN	Subtotal	Core	Care	CSHCN	Subtotal	Core	Care	CSHCN	Subtotal
2018 YTD	169,271	3,091	9,808	**182,170**	17,455	10.6%	158,105	2,757	7,442	**168,303**	4,993	33	652	**5,677**	6,174	302	1,715	**8,190**
2017	166,242	2,394	9,788	178,424	17,600	10.9%	150,654	2,143	7,124	159,921	6,281	23	740	7,044	9,306	229	1,924	11,458
2016	152,763	2,313	9,639	164,715	19,395	13.3%	140,679	2,113	6,980	149,772	6,596	23	760	7,379	5,488	177	1,899	7,564
2015	148,670	2,392	9,761	160,824	15,504	10.7%	134,582	2,166	6,962	143,711	7,647	20	758	8,424	6,441	206	2,042	8,689
2014	137,371	2,262	9,633	145,320	5,563	4.8%	122,706	2,046	6,749	131,506	8,811	23	778	9,666	5,854	194	2,106	4,148
2013	132,932	2,221	9,687	139,757	1,588	1.4%	116,708	2,017	6,747	125,474	9,710	26	789	10,554	6,514	178	2,151	3,729
2012	131,064	2,225	9,937	138,169	2,882	2.3%	114,882	2,022	6,883	123,789	9,999	26	738	10,783	6,183	177	2,316	3,597
2011	123,053	2,558	9,676	135,287			112,019	2,241	6,759	121,019	9,911	24	638	10,587	1,109	293	2,279	3,681

Rhode Island EOHHS (Medicaid)

RIte Care Managed Care Enrollment through June 2018, by Health Plan, Population Group, Age Group, and Gender

Date Generated: July 2, 2018

				By Health Plan:			By Population:			By Age:		By Gender:	
Month End	Total	Net Change	Net Change %	NHPRI	UHC	Tufts	Core	Substitute Care	CSHCN	Children (Under 19)	Adults (19+)	Male	Female
Jun-18	168,179	(271)	(0.2%)	110,083	55,132	2,963	158,155	2,914	7,110	114,073	54,106	71,506	96,673
	100.0%			*65.5%*	*32.8%*	*1.8%*	*94.0%*	*1.7%*	*4.2%*	*67.8%*	*32.2%*	*42.5%*	*57.5%*
May-18	168,450	449	0.3%	110,417	55,334	2,698	158,324	2,913	7,213	114,225	54,225	71,747	96,703
Apr-18	168,001	433	0.3%	110,297	55,364	2,339	157,931	2,913	7,157	113,701	54,300	71,551	96,450
Mar-18	167,568	(695)	(0.4%)	109,993	55,454	2,120	157,361	2,914	7,293	113,314	54,254	71,460	96,108
Feb-18	168,263	(45)	(0.0%)	110,398	55,824	2,040	158,088	2,859	7,316	113,316	54,947	71,762	96,501
Jan-18	168,308	429	0.3%	110,474	55,977	1,856	158,126	2,798	7,384	113,188	55,120	71,792	96,516
Dec-17	167,879	40	0.0%	110,342	55,927	1,610	157,655	2,787	7,437	112,733	55,146	71,517	96,362
Nov-17	167,839	(653)	(0.4%)	110,440	56,078	1,321	157,548	2,724	7,567	112,318	55,521	71,594	96,245
Oct-17	168,492	953	0.6%	111,176	56,353	963	158,183	2,684	7,625	112,244	56,248	71,822	96,670
Sep-17	167,539	(1,660)	(1.0%)	110,675	56,268	596	157,295	2,580	7,664	110,727	56,812	71,483	96,056
Aug-17	169,199	(722)	(0.4%)	112,049	56,903	247	158,911	2,506	7,782	111,474	57,725	72,141	97,058
Jul-17	169,921	523	0.3%	112,608	57,313	0	159,677	2,491	7,753	111,322	58,599	72,387	97,534
Jun-17	169,398	1,387	0.8%	112,404	56,994	0	159,264	2,457	7,677	110,755	58,643	72,072	97,326
May-17	168,011	1,687	1.0%	111,623	56,388	0	158,138	2,413	7,460	110,161	57,850	71,483	96,528
Apr-17	166,324	2,191	1.3%	110,723	55,601	0	156,592	2,393	7,339	109,399	56,925	70,866	95,458
Mar-17	164,133			109,518	54,615	0	154,781	2,260	7,092	108,351	55,782	69,918	94,215

Fiscal Year Average:

				By Health Plan:			By Population:			By Age:		By Gender:	
SFY	Total	Net Change	Net Change %	NHPRI	UHC	Tufts	Core	Substitute Care	CSHCN	Children (Under 19)	Adults (19+)	Male	Female
2018 YTD	168,303	18,531	12.4%	110,746	55,994	1,563	158,105	2,757	7,442	112,720	55,584	71,730	96,573
2017	159,921	16,210	11.3%	107,672	52,249	0	150,654	2,143	7,124	106,543	53,378	68,209	91,712
2016	149,772	6,061	4.2%	101,576	48,196	0	140,679	2,113	6,980	101,154	48,618	64,166	85,606
2015	143,711	12,209	9.3%	96,782	46,929	0	134,582	2,166	6,962	95,663	48,048	61,556	82,155
2014	131,501	6,030	4.8%	89,071	42,430	0	122,706	2,046	6,749	88,410	43,092	56,618	74,884
2013	125,472	1,684	1.4%	84,920	40,552	0	116,708	2,017	6,747	83,865	41,607	54,005	71,467
2012	123,787	2,771	2.3%	84,551	39,236	0	114,882	2,022	6,883	82,773	41,014	53,252	70,535
2011	121,017			81,009	35,217	0	112,019	2,240	6,758	81,142	39,875	81,142	39,875

Rhode Island EOHHS (Medicaid)

RIte Share Month-End Snapshot through June 2018, by Population Group

Date Generated: July 2, 2018

				By Population Group:					
Month End	Total	Net Change	Net Change %	Core	Substitute Care	CSHCN	Expansion	ABD	Other
Jun-18	5,562	(155)	(2.7%)	4,366	34	604	424	113	21
	100.0%			*78.5%*	*0.6%*	*10.9%*	*7.6%*	*2.0%*	*0.4%*
May-18	5,717	(105)	(1.8%)	4,487	35	622	439	108	26
Apr-18	5,822	(37)	(0.6%)	4,584	40	619	444	107	28
Mar-18	5,859	(123)	(2.1%)	4,619	35	635	432	107	31
Feb-18	5,982	(133)	(2.2%)	4,745	34	640	430	107	26
Jan-18	6,115	(160)	(2.5%)	4,871	33	646	426	106	33
Dec-17	6,275	(109)	(1.7%)	5,008	30	655	442	109	31
Nov-17	6,384	(173)	(2.6%)	5,136	30	662	417	110	29
Oct-17	6,557	(47)	(0.7%)	5,287	32	670	429	109	30
Sep-17	6,604	(224)	(3.3%)	5,405	31	677	351	108	32
Aug-17	6,828	(153)	(2.2%)	5,627	29	691	343	107	31
Jul-17	6,981	(118)	(1.7%)	5,775	28	697	347	103	31
Jun-17	7,099	(90)	(1.3%)	5,898	28	703	337	103	30
May-17	7,189	(22)	(0.3%)	5,970	32	716	336	102	33
Apr-17	7,211	(96)	(1.3%)	5,989	35	720	332	101	34
Mar-17	7,307			6,090	27	725	332	99	34

Fiscal Year Average:

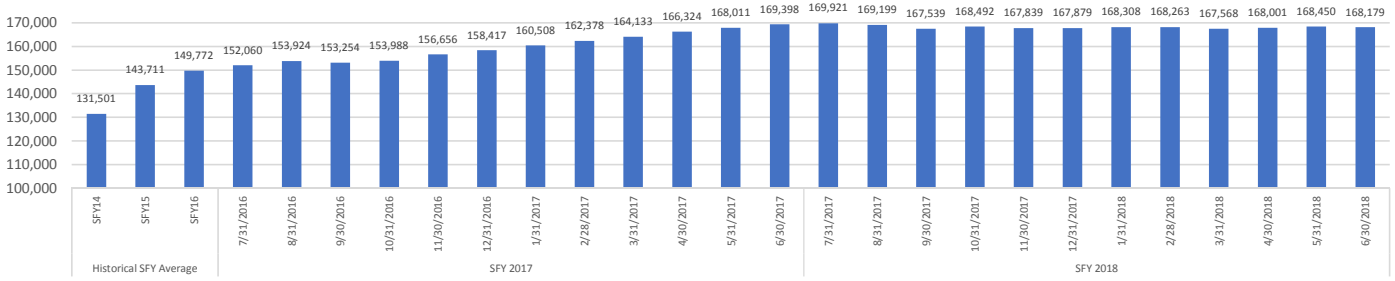
				By Population Group:					
Month End	Total	Net Change	Net Change %	Core	Substitute Care	CSHCN	Expansion	ABD	Other
2018 YTD	6,224	(1,268)	(16.9%)	4,993	33	652	410	108	29
2017	7,492	(1,178)	(13.6%)	6,281	23	740	311	98	39
2016	7,708	(962)	(11.1%)	6,596	23	760	197	92	40
2015	8,671	(1,143)	(11.6%)	7,647	20	758	95	126	26
2014	9,814	(845)	(7.9%)	8,811	23	778	23	152	27
2013	10,680	(218)	(2.0%)	9,710	26	789	0	138	17
2012	10,906	262	2.5%	9,999	26	738	0	127	16
2011	10,650			9,911	24	638	0	65	13

Rhode Island EOHHS (Medicaid)

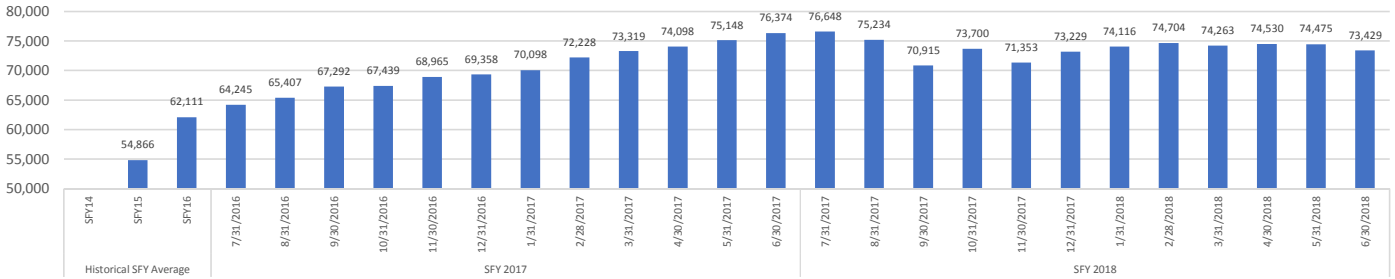
Managed Care Enrollment through June 2018, by Product

Date Generated: July 2, 2018

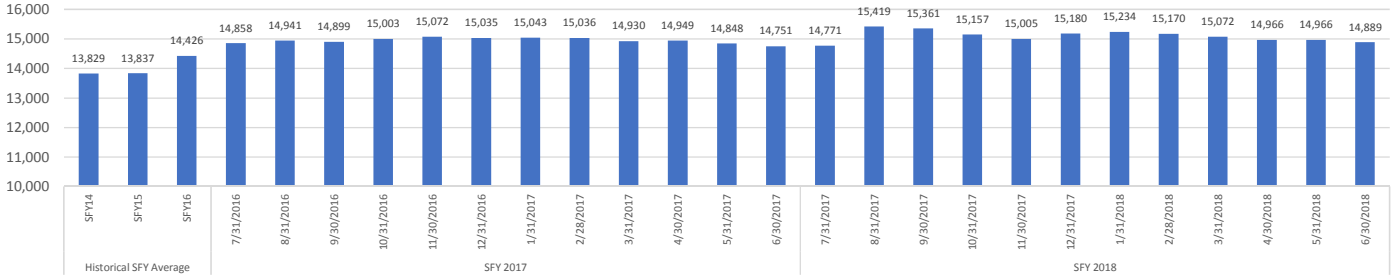
RIte Care (inc. Core/CSHCN) Managed Care Enrollment



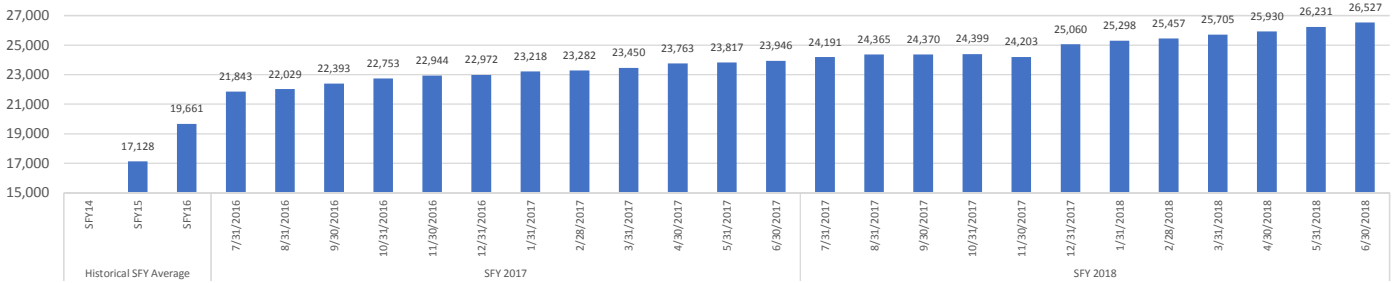
Expansion Managed Care Enrollment



Rhody Health Partners Enrollment



Rhody Health Options (Combined Phase I & Phase II) Enrollment



Rhode Island EOHHS (Medicaid)

Full Medicaid Eligibility as of June 30, 2018, by County/City and Enrollment Status [1]

Date Generated: July 2, 2018

	Enrolled in Managed Care, by Population Group:					
	RIte Care	Expansion	Aged, Blind and Disabled	Total	Remaining in FFS/RIte Share	Total
Bristol	**3,724**	**2,205**	**1,082**	**7,011**	**858**	**7,869**
Barrington	767	445	206	1,418	204	1,622
Bristol	1,633	1,043	477	3,153	383	3,536
Warren	1,324	717	399	2,440	271	2,711
Kent	**17,853**	**9,147**	**5,182**	**32,182**	**3,449**	**35,631**
Warwick	8,376	4,545	2,670	15,591	1,722	17,313
Coventry	3,264	1,601	868	5,733	640	6,373
East Greenwich	755	546	280	1,581	213	1,794
West Greenwich	378	244	70	692	98	790
West Warwick	5,080	2,211	1,294	8,585	776	9,361
Newport	**8,069**	**4,083**	**1,893**	**14,045**	**1,400**	**15,445**
Newport	3,287	1,478	823	5,588	487	6,075
Jamestown	214	213	121	548	68	616
Little Compton	244	143	37	424	40	464
Middletown	1,682	786	368	2,836	324	3,160
Portsmouth	1,142	709	238	2,089	236	2,325
Tiverton	1,500	754	306	2,560	245	2,805
Providence	**127,371**	**51,058**	**30,186**	**208,615**	**18,769**	**227,384**
Central Falls	7,677	2,176	1,530	11,383	699	12,082
Cranston	11,061	5,121	2,678	18,860	2,321	21,181
East Providence	6,236	3,036	1,716	10,988	1,175	12,163
Pawtucket	18,370	6,781	4,328	29,479	2,626	32,105
Providence	53,153	19,849	11,809	84,811	6,488	91,299
Woonsocket	11,974	4,344	3,139	19,457	1,576	21,033
Burrillville	1,801	754	407	2,962	338	3,300
Cumberland	2,819	1,356	769	4,944	640	5,584
Foster	479	246	74	799	76	875
Glocester	714	446	169	1,329	101	1,430
Johnston	3,735	1,903	1,074	6,712	758	7,470
Lincoln	2,231	999	451	3,681	335	4,016
North Providence	4,100	2,207	1,289	7,596	882	8,478
North Smithfield	939	451	199	1,589	206	1,795
Scituate	834	544	180	1,558	179	1,737
Smithfield	1,248	845	374	2,467	369	2,836
Washington	**10,676**	**6,210**	**2,339**	**19,225**	**1,978**	**21,203**
Charlestown	705	482	125	1,312	122	1,434
Exeter	431	371	92	894	74	968
Hopkinton	904	495	165	1,564	122	1,686
Narragansett	728	593	167	1,488	168	1,656
New Shoreham	93	77	13	183	7	190
North Kingstown	2,415	1,193	668	4,276	511	4,787
Richmond	401	259	61	721	60	781
South Kingstown	2,016	1,287	497	3,800	407	4,207
Westerly	2,983	1,453	551	4,987	507	5,494
Unknown In-State	13	13	-	26	-	26
Unknown Out-of-State	823	553	677	2,053	506	2,559
Grand Total	**168,546**	**73,277**	**41,362**	**283,185**	**26,963**	**310,148**

Note:

[1] Full medicaid does not include individuals eligible for limited benefits, such as EFP or SLMB/QMB/QI-1 or Emergency Medical Only.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

PRINCIPLES OF REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS

July 2018

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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

PRINCIPLES OF REIMBURSEMENT
FOR
FEDERALLY QUALIFIED HEALTH CENTERS

Revised: July 2018

1.0 Legal Basis for Program:

The Rhode Island Medical Assistance program was established on July 1 1965 under the provision of Title XIX of the Social Security Act as amended by Public Law 89-97, enacted by Congress on July 30, 1965. The enabling State Legislation is to be found in Title 40 of the Rhode Island General Laws (RIGL).

2.0 Payment to Community Health Centers:

Rhode Island General Laws §40-8-26 govern the payment methodologies for community health centers. These principles of reimbursement reflect those provisions.

3.0 Medicaid Prospective Payment System for Federally Qualified Health Centers

3.1 Rate Setting Overview

The Medicaid prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) became effective January 1, 2001 under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. PPS established a methodology assuring FQHCs a minimum per visit reimbursement rate when providing care to Medicaid beneficiaries. The FQHC rate was to be set based on the average of each health center's reasonable costs per visit in 1999 and 2000. The FQHC rate was then to be adjusted annually for inflation using the Medicare Economic Index (MEI). Payments may also be adjusted based on a recognized change in the scope of services provided.

States have the option of using an alternative payment methodology, if the medical payment rate is not lower than what would be paid under PPS. To be eligible for payment under the alternative payment methodology, the FQHC must agree to participate.

These Principles of Reimbursement set forth the Alternative Payment Methodology (APM) to be used for establishing rates for participating FQHCs. This includes rate setting for medical services and dental services. For these purposes medical services shall include behavioral health services and the established rate applies to both medical and behavioral health services. This document outlines the obligations of both the FQHC and EOHHS to provide timely reporting and rate determination.

4.0 PPS and Alternative Payment Methodology

4.1 Visit/Encounter Definition

The APM is designed to reflect the cost for all the services associated with a comprehensive primary care, behavioral health or dental visit, even if not all the services occur on the same day. Stand-alone billable visits are typically evaluation and management type of services or screenings for certain preventive services. The professional component of a procedure is usually a covered service, but is not a stand-alone billable visit, even when furnished by an FQHC practitioner.

As such, some services do not count as encounters eligible for the PPS or APM rate. These include, but are not limited to the following, as outlined in the Uniform Data System (UDS) Manual for the UDS report filed annually by the FQHCs with the Bureau of Primary Health Care (BPHC) under the Health Resources and Services Administration (HRSA), part of the US Department of Health and Human Services:

Health screenings

- Screenings frequently occur as part of community meetings or group sessions that involve conducting outreach or group education, but do not provide clinical services
- Examples include information sessions for prospective patients; health presentations to community groups, information presentations about available health services at the center; services conducted at health fairs or at schools; immunization drives; services provided to groups or similar public health efforts

Group visits

- Visits conducted in a group setting, except for behavioral health group visits
- The most common non-behavioral health group visits are patient education or health education classes (e.g., people with diabetes learning about nutrition)

Tests and other ancillary services

- Tests support the services of the clinical programs
- Examples of tests include laboratory (including purified protein derivatives (PPD tests), pregnancy tests, Hemoglobin A1c tests, blood pressure tests) and imaging (including sonography, radiology, mammography, retinography, or computerized axial tomography)
- Services required to perform such tests, such as drawing blood or collecting urine

Dispensing or administering medications

- Dispensing medications, including dispensing, from a pharmacy (whether by a clinical pharmacologist or a pharmacist) or administering medications (such as buprenorphine or Coumadin) unless an evaluation and management (office visit) code is also assigned to the visit in accordance with CPT guidelines and the visit is provided by a physician, physician assistant or nurse practitioner (i.e. nursing visits are not eligible regardless of CPT codes assigned to visit).
- Giving any injection (including vaccines, allergy shots, and family planning methods) regardless of education provided at the same time unless an evaluation and management (office visit) code is also assigned to the visit in accordance with CPT guidelines and the visit is provided by a physician, physician assistant or nurse practitioner (i.e. nursing visits are not eligible regardless of CPT codes assigned to visit).

Telemedicine

- Telemedicine/telehealth, except for behavioral health telemedicine – While primary medical telehealth visits are not presently eligible encounters, EOHHS and the FQHCs agree to reconsider the eligibility of telehealth primary care visits as the delivery of telemedicine evolves and Rhode Island and federal regulations governing the provision and eligibility of telehealth services evolve.

Health status checks

- Follow-up tests or checks (such as patients returning for HbA1c tests or blood pressure checks)
- Wound care (which are following up to the original primary care visit)

- Taking health histories
- Making referrals for or following up on external referrals

An encounter must include a face-to-face visit with a physician (including optometrists and psychiatrists), physician assistant, nurse practitioner (advanced practice registered nurses), clinical social worker, clinical psychologist, certified nurse midwife, clinical nurse specialist, licensed mental health counselor, licensed marriage and family therapist, dentist or registered dental hygienist.

Visits with more than one professional on the same day will be deemed as one encounter unless one visit is medical, one is behavioral health, or one is dental, or the patient suffers an additional or different illness requiring another visit. The visit must be documented in the patient's chart and must meet commonly accepted standards for medical record documentation.

An encounter must involve a patient who is Medicaid eligible on the date of service.

The terms "visit" and "encounter" may be used interchangeably.

4.2 Rate Determination

FQHC APM rates through July 1, 2017 were determined in accordance with the "Principles of Reimbursement for Federally Qualified Health Centers Revised: July 2012". Such rates will remain in effect through June 30, 2018.

For FQHCs electing the Alternative Payment Method (APM), effective July 1, 2018 and on each July 1st thereafter, each FQHC's medical and dental rate shall be increased by the amount of the FQHC Market Basket Index net productivity adjustment as published by CMS for that same calendar year. These adjusted rates will also become the respective FQHC's Fee For Service (FFS) rates for that same rate year.

EOHHS will determine the Medicaid prospective payment system (PPS) rate for each FQHC according to the methodology defined in federal law by March 31, 2019, to be able to notify each FQHC of their PPS rate as outlined below. Should any party elect not to use the APM, the PPS rate will become the effective rate.

Under this APM methodology, the PPS rate and the APM rate will likely be different in future years.

4.3 Notification of Rates

Each FQHC will be notified in writing of its adjusted medical and dental APM rates by no later than 61 days prior to July 1st of each year (i.e. May 1st). Any FQHC may request its adjusted PPS rate after January 1st of each year but, absent a request, EOHHS will not provide the adjusted PPS rate.

4.4 FQHC Submission Requirements

Each FQHC will submit the following materials annually, five months after the close of each FQHC's fiscal year, to EOHHS' Deputy Director of Finance and Budget:

1. Medicare/Medicaid Cost Report Crosswalk, according to the template in Appendix C
2. Medicare cost report filed with CMS for the same fiscal year
3. Audited financial statements for the same fiscal year (normally submitted to EOHHS five months after the close of the fiscal year but will be submitted immediately upon receipt from the FQHC's independent auditors if issued thereafter)
4. An attestation of the CEO and CFO as per Appendix C

4.5 New FQHC or FQHC merging with another entity

Should there be a new FQHC operating in Rhode Island, EOHHS shall set an interim prospective APM rate for the new FQHC based either on a pro forma cost report in the case of a new entity or actual cost data for the past two fiscal years in the case of merging organizations that have been in operation for at least two years. The interim prospective rate will be utilized until the new or merged FQHC has been in operation for one full fiscal year and has audited financial data for that year that can be used in a cost report as provided for in Appendix B.

5.0 Changes in Scope of Services: Special Circumstances and Adjustments to Rate Determination

Under certain circumstances, based on verifiable data provided by the FQHC, including a pro forma cost report and on favorable review by EOHHS/Medicaid, Medicaid can make adjustments to FQHC's APM encounter rates due to a change in the scope of Medicaid covered services provided by the FQHC.

Rate adjustment requests by FQHCs outside the normal rate setting process are limited to one request per year. Rate adjustment request submissions shall include but are not limited to addressing the Evaluation Criteria identified in Appendix A. Upon receipt of a request for a rate adjustment, EOHHS/Medicaid will review the request and make a determination within sixty (60) calendar days of receipt. If EOHHS/Medicaid does not make a formal determination within sixty (60) calendar days, the rate adjustment as requested will go into effect 60 calendar days after the date of submission. Notwithstanding the above, EOHHS/Medicaid may request additional information from the FQHC pertinent to the analysis of the FQHC's submission. In such case the EOHHS/Medicaid request for additional information shall be in written form. This written request for information will stop the sixty-day clock based on the date of the request. Upon receipt of the additional information from the FQHC a new sixty-day clock will resume. In this case, EOHHS/Medicaid will make a final determination within sixty (60) days of receipt of additional information received from the FQHC in response to a formal request.

The reference below to a 5% or more change in the cost per visit shall be calculated by using the FQHC's current APM rate (e.g., if the cost per visit is less than 95% or greater than 105% of the current APM rate, the 5% requirement is satisfied). If a change in scope is made prior to a rate adjustment request, EOHHS may use a 10% threshold instead of the 5% threshold as outlined

below.

Rate adjustments where approved may be temporary in nature but only if the rate is adjusted pursuant to 5.1, Extraordinary Circumstances. The criteria for change in scope rate adjustments will include the following:

5.1 Extraordinary Circumstances

A rate adjustment will be considered where there is a material change in the FQHC operations that results in a long- term (six months or more) change in the FQHC's cost per visit of 5% or more (compared to the one year prior to the change in operations) that EOHHS/Medicaid deems to be significant based on verifiable data provided by the FQHC. Such extraordinary situations will be reviewed on a case by case basis.

5.2 Other Changes in Scope

A rate adjustment will be considered where there is a demonstrable change in the FQHC scope of services that will result in a long-term (six months or more) change in the FQHCs cost per visit of 5% or more. Such changes will include, but are not limited to: (1) A change in organizational structure (e.g. merger, acquisition or a change in corporate structure); (2) A change in practice by the FQHC; (3) Addition or elimination of a core FQHC service, which is defined as primary care, dental, behavioral health, pharmacy and enabling services; (4) Or addition or deletion of specialty care services.

5.2.1 Pay for Performance Programs

EOHHS/Medicaid may consider an adjustment to a rate if a FQHC can, in concert with EOHHS, define a performance-based program, which provides clear added value (e.g. health outcomes, cost efficiencies).

5.2.2 Capital improvements

EOHHS will review a rate adjustment request if a FQHC has expended funds for capital improvements that will result in a long-term (six months or more) increase in the FQHCs cost per visit of 5% or more. The review request could apply to either the medical or dental rate as assigned. To be eligible for review, costs must be incurred for a one-month period before a rate change will be initiated. EOHHS will be responsible to determine the materiality of the improvement and the effect on the rate assigned. A basic minimum of $50,000 for an individual improvement would have to be expended before consideration of the review. Capital improvements shall include but shall not be limited to the opening of a new location, facility expansion/renovation and the acquisition and implementation of health information technology.

6.0 Appeals Process

An FQHC may request an adjustment to the EOHHS calculated Medical or Dental rate by written appeal to the rate setting department within the EOHHS/Medicaid Program. As a result of the

review, the rate setting department will provide the FQHC a written decision of the appeal within 30 business days from the receipt of the appeal. Appeals beyond the rate setting department or designee appointed by the Secretary of EOHHS will be in accordance with the Administrative Procedures Act.

7.0 Demonstrated Error

If an FQHC can verify an error was made in the rate determination process, a rate adjustment due to error would be retroactively effective to the 1st day of the year for which the rate was effective. EOHHS shall also correct the rate(s) of any other FQHCs whose computed rates were adversely impacted by 2% or more prior to the discovery of the error. Such corrections shall be applied retroactively to the 1st day of the year for which the rate(s) was effective.

8.0 Record Keeping

FQHCs providing services under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable of substantiating the reasonableness of the FQHC cost report. Records include all ledgers, books, and source documents. All records must be physically available on site during the course of a field audit examination. All documents must be retained for at least seven (7) years following the month in which the materials apply.

EOHHS/Medicaid will maintain all cost reports submitted by FQHCs and all written reports prepared by the Agency and sent to the FQHCs for at least seven (7) years after the month in which the cost report was filed or at least seven (7) years after the month in which the report was sent.

9.0 Penalties

9.1 Penalties for Late Submissions

A cost report filing will be deemed late either due to an incomplete submission to EOHHS, or due to a complete submission received by OHHS/Medicaid after five months from the end of the FQHC's fiscal year. The next APM rate increase due will be delayed by sixty (60) business days when an FQHC's submission is delayed.

9.2 Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act, and Rhode Island General Laws 11-41-3, 40-8.2-3, 40-8.2-4, 40-8.2-7, and 40-8.2-1 and any other applicable statues. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of Rhode Island General Laws Chapter 40-8.2, as well as suspension from participation in the program by state or federal authorities.

10.0 Reconciliation Arrangements for Managed Care Enrollees

FQHCs are entitled to overall reimbursement equivalent to the total number of medical or dental encounters provided to persons enrolled in Medicaid managed care programs on the day of the encounter multiplied by the applicable FQHC rate ("attributable revenue"). The applicable FQHC rate is established by the process established through these Principles of Reimbursement.

In the event that, for Medicaid beneficiaries enrolled in managed care plans, the managed care plans do not cover the full applicable FQHC rate for eligible encounters for Medicaid beneficiates enrolled in managed care plans, Medicaid will follow the prospective payment/ reconciliation process set forth in Attachment I: (Annual Submission Guidelines for Prospective Payment System (PPS) Reconciliation Reports).

11.0 Signatures and FQHC Statement of Participation

FQHC STATEMENT OF PARTICIPATION
PPS ALTERNATIVE PAYMENT METHODOLOGY

As an authorized agent for _____, I have fully reviewed these "July 2018 Principles of Reimbursement for Federally Qualified Health Centers" (FQHCs) as published by the State of Rhode Island's Executive Office of Health and Human Services (EOHHS). Subject to the conditions outlined below, this health center agrees to participate in the Alternative Payment Methodology described herein with an effective date of July 1, 2018.

In accordance with CMS guidelines and related regulations, Rhode Island's FQHCs have requested to carve Medicaid managed care (MCO) pharmacy claims into their respective 340(B) contract pharmacy programs. In response to this request, contingent upon each FQHC that is participating in the 340(B) program submitting their respective, 340(B) data as outlined herein, EOHHS has agreed to complete a financial impact and compliance analysis of the FQHCs' request and to share results of such analyses by December 31, 2018. Specifically, _____ agrees to submit to EOHHS if possible by August 15 , 2018, but no later than August 31, 2018, the available data elements that are necessary to inform such analyses in a format established by EOHHS and the FQHCs including but not limited to: 1) for Medicaid MCO 340(B) pharmacy claims, for the 6-month period ending 3/31/18, at claim level detail, the prescriber NPI, prescription number, date of prescription (a/k/a date of service), patient ID (as issued by RI Medicaid), actual acquisition cost of the drug, third party administrator fee, dispensing fee, and any other component costs associated with the 340(B) program; 2) a detailed description of the entire 340(B) process including the timing and process of determining eligibility, submitting a claim to MCO/Medicaid, and purchasing the drug at the discounted 340(B) price; 3) a description of the oversight activities and relationship with the third party administrators and contracted pharmacies; and 4) a complete list of all contracted pharmacies.[1]

[1] EOHHS acknowledges and understands that the requested claims data elements can only be provided for Medicaid MCO pharmacy claims written by FQHC prescribers that are presently carved-into the FQHC's 340(b) pharmacy program. EOHHS and the FQHCs will work collaboratively to quantify and evaluate the impact of a carve-in of the FQHCs' Medicaid MCO pharmacy claims that are presently excluded from the FQHCs' 340(b) pharmacy programs.

EOHHS has committed to providing such analyses in writing by December 31, 2018. Such analyses shall include the value of the rebates that EOHHS would forego in the event of the carve-in of the FQHC Medicaid MCO claims into the FQHCs' 340(B) pharmacy programs. Thereafter, EOHHS will engage in good faith discussions to develop a mutually-agreeable, compliant resolution that adheres to CMS guidelines and 340(B) program regulations, including the prohibition against duplicate discounts. Nothing contained in this paragraph requires EOHHS and the FQHCS to achieve a mutually-agreeable resolution.

In the event that EOHHS does not provide such analyses by December 31, 2018, or if EOHHS ceases to operate in good faith to develop a mutually-agreeable, compliant resolution, _____'s participation in the July 1 2018 Alternative Payment Methodology can be withdrawn upon the submission of a notice withdrawing this election. In the event of a withdrawal, EOHHS shall recalculate this FQHC's medical and dental payment rates in accordance with the July 24, 2012 Principles of Reimbursement retroactive to July 1, 2017. Such recalculations and corresponding retroactive payment adjustments shall be completed by March 31, 2019.

Acting as an authorized agent of _____, I hereby affirm our participation subject to the terms and conditions outlined above:

Name of FQHC's Authorized Agent: _____
Title: _____
Signature: _____
Date signed: _____

_____
Patrick Tigue
Medicaid Director

APPENDIX A

FQHC APM and Rate Adjustments Evaluation Criteria for Mergers and Changes of Scope of Services

1. Describe the organizational change/project that has resulted in a request for a rate adjustment (e.g. mergers, expanded hours, Electronic Health Records, new operations (ACO), or other as provided for in these Principles).

2. A Medicaid cost report, which quantifies the request, including an identification and explanation of key underlying assumptions must be submitted. Such cost report shall be prepared in accordance with the provisions of Appendix B.

3. Why is the change in operations/scope needed? Please include specific information on the changes in capacity and projected volume as well as a description and quantification of any cost efficiencies.

4. Please identify any HRSA mandates and/or program expectations that the change/project is intending to address.

5. What were alternatives considered and what key factors led to the organization's decision to proceed with this particular change/project?

6. Please explain how the FQHC's changes address the needs of the Medicaid population served. Please highlight how the changes align with CMS' goals to improve to access and quality and to decrease the overall cost of providing healthcare to Medicaid beneficiaries.

7. Please provide a project timeline.

8. Please identify three to five measurable project goals pertaining to access, quality and cost. Baseline data should be provided for these metrics.

9. What actions or alternative solutions will the origination employ if the request is not approved?

10. Identify all other funding, if any, that is being utilized in the initiative (e.g., foundation grants, federal grants)

APPENDIX B

Cost Report Submission Requirements

New and merging FQHCs will submit a cost report using the template included as Attachment II. Additionally, each FQHC when requesting a rate adjustment in accordance with the provisions of APPENDIX A will submit a cost report using the template included as Attachment II. The cost report template consists of:

1. Worksheet A - Reclassification and Adjustment of Trial Balance Expenses,
2. Worksheet A-1 Reclassifications,
3. Worksheet A-2 Adjustments to Expenses,
4. Worksheet A-2-1 Part I and Part II - Acknowledgment and costs due to transactions with related parties,
5. Worksheet B-Part I-Encounters and Productivity Medical,
6. Worksheet B-Part H Encounters and Productivity Dental,
7. Worksheet B-Part III -Determination of Total Allowable Cost,
8. Worksheet C Part I - Determination of Cost for Medical Services,
9. Worksheet C -Part II - Determination of Cost for Dental Services, Attestation

Instructions for completing the FQHC Cost Report

Worksheets A - C in the cost report are to be completed in conformance with CMS 224-14 using the instructions as published by CMS.

Use of Classification Guide of FQHC Accounts by Cost Center

Rate determination will be based on five specific cost centers as set forth below. In order to ensure that costs are linked to cost centers uniformly for all FQHC, the CMS 224-14 will be modified using the classification guide (Attachment III):

1. Direct Productivity	Lines 1 - 3	Medical Section
	Lines 28-30	Dental Section
2. Direct Other	Lines 5-16	Medical Section
	Lines 32-37	Dental Section
3. Other Medical	Lines 19-25	Medical Section
	Lines 40-46	Dental Section
4. Facility	Lines 50-59	Combined Sections
5. Administration	Lines 61-71	Combined Sections

Instructions for Completing Worksheets B and C

Instructions for completion of Worksheets B and C of the FQHC cost report will deviate from CMS guidelines by using the following definitions of encounters and productivity.

Encounters

See definition in Section 4.1.

Productivity

In determining the number of minimum encounters, the productivity screens will be determined by EOHHS using the most recent available UDS Rhode Island Rollup published by the US Department of Health and Human Services, Health Resources and Services Administration. The productivity screens will be determined annually upon availability of updated UDS data and input to the FQHC cost report template made available for use by the FQHCs.

APPENDIX C

Medicare/Medicaid Cost Report Crosswalk and Attestations

TEMPLATE UNDER DEVELOPMENT

ATTESTATION:

Misrepresentation or falsification of any information contained in this crosswalk may be punishable by criminal, civil and administrative action, fine and/or imprisonment under Federal and State law. Furthermore, if services identified in this crosswalk were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

CERTIFICATION BY OFFICERS

I HEREBY CERTIFY that I have read the above statement and that I have examined this crosswalk prepared by _____ (Provider) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this crosswalk were provided in compliance with such laws and regulations.

(Signed)

_____

CEO or Administrator of Facility

_____

Date

_____

CFO or Finance Director of Facility

_____

Date

Attachment I.

RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Annual Submission Guidelines
For
Prospective Payment System (PPS) Reconciliation Reports Submitted by Federally Qualified Health Centers for Services Provided to Managed Care Enrollees

July 2018

I. Introduction

The reconciliation provisions contained herein are directly a part of the July 2018 Principles of Reimbursement. The purpose of these Submission Guidelines is to set forth the process for PPS/APM reconciliation for services provided by FQHCs to persons enrolled in any managed care program in the event that the managed care plan does not cover the applicable FQHC rate for eligible encounters. These reconciliation provisions apply annually to the state fiscal year (July 1 – June 30). Reconciliation Reports as described herein are due annually beginning July 1, 2006 and constitute the whole of such reconciliation provisions for participating FQHCs. To accomplish the reconciliation, FQHCs are to follow the submission requirements described herein.

Ia. Definitions

The *Activity Year* is the State fiscal year during which the encounters provided by the FQHCs take place and during which monthly, prospective payments are made by Medicaid to the FQHCs.

The *Reconciliation Year* is the State fiscal year during which Medicaid and the FQHCs reconcile the number of encounters provided by the FQHCs and the amount of payments received for these encounters by the FQHCs from the State and the managed care organizations during the previous Activity Year.

Each State fiscal year serves as both an Activity Year in itself and as the Reconciliation Year for the previous Activity Year.

For each twelve month Activity Year (July 1 – June 30), FQHCs are entitled to overall reimbursement equivalent to the total number of medical encounters provided to persons enrolled in managed care on the day of the encounter times the applicable FQHC rate ("attributable revenue"). The applicable FQHC rates are established by the processes presented in these Principles of Reimbursement.

The annual reconciliation encompasses three phases, elaborated below: prospective payments; supplemental payment/recoupment; and final settlement.

II. Reconciliation Phase 1: Prospective Payments

In the event that Medicaid anticipates that managed care plans will not reimburse FQHCs at the full, applicable PPS/APM rates, Medicaid will make prospective payments to the FQHCs during the Activity Year. These prospective payments are designed to minimize the gaps between what the FQHCs are owed for eligible encounters and reimbursed for eligible encounters. The prospective payments are calculated by modifying ongoing payments according to the data provided by the FQHCs on their submitted Prospective Payment Reconciliation Schedules. See Section VIII below for additional details.

If Medicaid and the FQHCs determine that managed care organizations are reimbursing FQHCs at the full, applicable PPS/APM rates, Medicaid will cease making monthly, prospective payments.

III. Reconciliation Phase 2: Supplemental Payment/Recoupment

By October 15 of the Reconciliation Year, each FQHC will submit to Medicaid a Prospective Payment Reconciliation Schedule (see the template below), along with a claims-level data file supporting the numbers provided in the Schedule. This Reconciliation Schedule will include the amount the FQHC believes it is owed by Medicaid or owes to Medicaid, after considering the number of encounters provided, along with payments received from the managed care organizations and the monthly, prospective payments made by Medicaid during the Activity Year. By December 1 of the Reconciliation Year, Medicaid will pay to each FQHC 80% of the amount the FQHC believes it is owed by Medicaid or recoup 80% of the amount the FQHC believes it owes Medicaid, as appropriate. This supplemental payment or recoupment is made in advance of further reconciliation and a final settlement.

IV. Reconciliation Phase 3: Settlement Payment/Recoupment

Using the supporting claims-level data files provided by the FQHCs and claims-level data files provided by the managed care plans, Medicaid will review the information submitted by the FQHCs in the Reconciliation Schedule. This review will include an effort to determine the eligibility of the encounters as per the definition of encounters elaborated in Section 4.1 of these Principles of Reimbursement.

Where Medicaid's review determines that its count of eligible encounters and its summing of total dollars paid for these encounters falls within 3% of the encounter count and payment total reported by the FQHC in its Reconciliation Schedule, the State will accept the number of encounters and sum of received payments reported by the FQHC and make the corresponding settlement payment or recoupment.

Where Medicaid's review determines that its count of eligible encounters and its summing of total dollars paid for these encounters exceeds 3% of the encounter count and payment total reported by the FQHC in its Reconciliation Schedule, Medicaid will seek to clarify with the FQHC and resolve any discrepancies.

Once Medicaid and the FQHC agree to a final settlement, by the end of the third quarter of the Reconciliation Year, Medicaid will, as appropriate, make a final payment to the FQHC or final recoupment from the FQHC.

V. Requirement of Submission of Prospective Payment Reconciliation Schedule and Supporting Data File

FQHCs must submit the annual Prospective Payment Reconciliation Schedule and supporting data file on a timely basis. This supporting file will provide claims-level data to confirm the numbers reported on the Prospective Payment Reconciliation Schedule.

The supporting data file must include the following pieces of information:

- recipient name;
- recipient date of birth;

- recipient SSN;
- date of encounter;
- encounter identification number;
- amount of payment received from managed care organization;
- indication of type of service (Medical, Behavioral Health);
- indication of whether or not encounter was covered by a managed care capitation arrangement; and
- all procedure codes billed for each encounter.

If the recipient SSN is unavailable, the FQHC should provide another marker of identification, such as Managed Care Plan ID, or Medicaid or Medicare ID number.

The PPS reconciliation process requires confirmation of *both* the number of eligible encounters provided and the amounts of payments received by the FQHCs. The supporting data must provide enough information, including all procedure codes, to facilitate both of these confirmation processes.

VI. Timeline for Submission of Reconciliation Report

On an annual basis, each FQHC must file the Prospective Payment Reconciliation Schedule and supporting documentation to Medicaid within 107 days following the close of the state fiscal year (June 30th), that is, by October 15.

In the event that a completed Prospective Payment Reconciliation Schedule is not filed timely, monthly prospective payments will be suspended for that FQHC until the filing is received.

VII. Instructions for Submission of Prospective Payment Reconciliation Schedule

The electronic submission should be sent to:
katie.alijewicz@ohhs.ri.gov

The signed paper submission shall be mailed to:

Katie Alijewicz
EOHHS/Medicaid Program
5 West Road
Cranston, RI 02920

VIII. Instructions for Completion of Prospective Payment Reconciliation Schedule

a. Part I: Attributable Revenue for Period

This section is used to recognize all revenue to the FQHC for services provided during the Activity Period to persons enrolled in RIte Care or other EOHHS authorized managed care programs on the dates of service. The line definitions below include the language "payments received." In some instances, services will have been provided but actual payments are pending and have not yet been received. Such receivables are to be included in the "payments received" calculation. Medicaid's intention is that the payments reported

in Part I of the Reconciliation Schedule correspond directly and fully to the encounters reported in Part II of the Schedule, that is, for dates of service between July 1 and June 30. Furthermore, any receivable dollars should be reported NET of any contractually obligated write-offs or reduction from charges.

The various sources of this reimbursement are to be itemized as follows:

Line I.1: NHPRI Capitation – Payments received by FQHC on a monthly basis from Neighborhood Health Plan of Rhode Island for primary health care services to individuals for whom the FQHC serves as the primary care provider. Payments to be included are those made for the periods July through June of the Activity Year.

Line I.2: NHPRI Reimbursement – Payments received by FQHC from Neighborhood Health Plan of Rhode Island for non-capitated health care services to its RIte Care members or other contracted managed care enrollees. Payments to be included are those FFS payments made for the periods July through June of the Activity Year.

Line I.3: Tufts Reimbursement-RIte Care – Payments received by FQHC from Tufts Health Plan for health care services to its RIte Care members or other contracted managed care enrollees.

Line I.4: UHC Reimbursement-RIte Care – Payments received by FQHC from United Health Care of New England for health care services to its RIte Care members or other contracted managed care enrollees.

Line I.5: Other Net Patient Revenue – Any other revenue received, from any source (please specify source), for health care services provided to RIte Care eligible individuals or enrollees of any other EOHHS contracted managed care program.

Line I.6: Subtotal of Health Plan Payments to FQHC – This line is the subtotal of all capitation and fee-for-service based payments made to the FQHC by health plans.

Line I.7: EOHHS PPS Monthly Payments – Monthly payments for managed care enrollees received from EOHHS or its fiscal agent,

Line I.8: Total Amounts Received/Receivable – The sum of lines I.6 and I.7 identifies total payments to the FQHC for RIte Care enrollees or other contracted managed care enrollees.

Note: Revenue associated with OB deliveries and GYN surgical procedures (i.e. colposcopy and loop electrosurgical excision procedure) is excluded from the above totals. Revenue associated with prenatal visits is included in the above totals.

b. Part II: Allowable Encounters for Persons Enrolled with a RIte Care Health plan or other EOHHS contracted managed care program on Date of Service.

This section of the Reconciliation Schedule will identify all encounters with managed care enrollees on dates of service within the specified period. This includes all Medicaid enrollees covered by a Medicaid managed care plan, including Children with Special Needs, children in Subsidized Care, and adults covered under the Rhody Health Partners program. All payments (both received and receivable) associated with these encounters should be reported in Part I. Encounters should be reported as follows:

Line II.1: NHPRI Capitated Encounters – - Allowable encounters for Medicaid recipients enrolled in Neighborhood Health Plan of Rhode Island (NHPRI) on the date of service, and whose reimbursement for primary care is paid on a capitated basis by NHPRI to the FQHC.

Line II.2: NHPRI Encounters (Other) – Allowable encounters for Medicaid recipients enrolled in Neighborhood Health Plan of Rhode Island (NHPRI) on the date of service, and whose reimbursement is paid on a fee-for-service basis by NHPRI to the FQHC.

Line II.3: Tufts Encounters –Allowable encounters for Medicaid recipients enrolled in Tufts Health Plan on the date of service, and whose reimbursement is paid on a fee-for-service basis by Tufts to the FQHC.

Line II.4: UHC Encounters –Allowable encounters for Medicaid recipients enrolled in United Health Care (UHC) on the date of service, and whose reimbursement is paid on a fee-for-service basis by UHC to the FQHC.

Line II.5: Other Allowable Encounters – Any other allowable Encounters for Medicaid recipients enrolled with a RIte Care Plan or other EOHHS contracted managed care program on the Date of Service (please specify).

Line II.6: Total Encounters – The sum total of lines II.1 through II.5.

Note: Visits for OB deliveries and GYN surgical procedures (i.e. colposcopy and loop electrosurgical excision procedure) are excluded from the above totals. Prenatal visits are included in the above totals.

c. Part III: Payment Calculation.

Part III of this schedule is used to calculate the imputed revenue the FQHC would have received had reimbursement been paid on a fee for service basis at the applicable FQHC rates for recipients eligible for Medicaid managed care. Amounts received or receivable are factored to arrive at the balance due to the FQHC or the amount of overpayment to the FQHC. The results of the reconciliation will be used to (a) identify an estimate of the monthly payment due to the FQHC and (b) make any adjustment to that amount for reconciliation.

Line III.1: Applicable FQHC Reimbursement Rate – This is the encounter rate as established by EOHHS and in effect during the Activity Year.

Line III.2: Imputed PPS Revenue Total – The product of lines III.1 and II.6 (encounter rate multiplied by total encounters).

Line III.3: Total Amount Required in EOHHS Payments (Line III.2 minus I.6) – This line is the difference between line III.2, total imputed PPS revenue, and Line I.6, total health plan payments to FQHC. This result represents the amount due from EOHHS to meet PPS requirements.

Line III.4: Actual EOHHS Payments – This line shows the actual amount received by the FQHC for the period, based on EOHHS payments.

Line III.5: Balance Due/(Recoupment) – This line equals Line III.3 minus Line III.4 – It represents the amount either owed to the FQHC or due to EOHHS to reconcile the PPS. This reconciliation relates to services provided only to managed care recipients who are enrolled in a qualified RIte Care health plan or other EOHHS contracted managed care program on the dates of service.

While the Prospective Payment Reconciliation Schedule is formatted for submission of information in monthly increments, it is acceptable for individual FQHCs to report this information on an annual basis only.

IX. Method for Payment

Under the prospective payment system, the monthly payment to each health center will be based (a) on the estimated amount that would come as close as possible to making Line III.5 equal zero for the next reconciliation period and (b) any adjustment to that amount based on the results of the current reconciliation.

To achieve this, payment will occur as follows:

- The result for the year from Line III.3 represents a best estimate of EOHHS payment obligations for the next year. This amount will be used to establish base EOHHS monthly payments.
- Results from Line III.5 show the results for the reconciliation period. This 12-month total divided by the number of months remaining in the then current fiscal year will be taken as an adjustment (+ or -) to the EOHHS monthly payment to the FQHC.

X. Assurance

Each annual submission must be (a) accompanied by a letter of assurance as to the accuracy of the information, and (b) signed by the Chief Executive Officer and Chief Financial Officer of the FQHC.

It is the understanding of EOHHS that all participating FQHCs are subject to an annual audit in accordance with the provisions described in the U.S. Office of Management and Budget's Uniform Guidance. Such audit is conducted by a firm of independent certified public accountants.

Since payments under the PPS will be considered material to the financial operations of the FQHC, each FQHC's independent auditor shall review any data submitted to EOHHS for PPS reconciliation during the fiscal year as part of the scope of their annual audit of the financial statements.

XI. Other Data Submission Requirements

Together with the PPS Reconciliation and supporting claims detail, each FQHC shall submit to EOHHS the following:

a) A copy of its most recent desk audited Medicare Cost Report; and

b) A copy of its UDS (Uniform Data System) Report as submitted to the Bureau of Primary Health Care for the previous calendar year.

By no later than 45 days following the end of each quarter, each FQHC shall submit to EOHHS, its total number of Medicaid managed care medical and behavioral health encounters for the quarter.

	Attachment I a. - PPS Reconciliation Report														
	Health Center Name:	**(Please input name here)**					**State Fiscal Year**								
	Medicaid - Medical Only	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Accrual for Unpaid Encounters	Total
I.	**Actual PPS Attributable revenue for Period (based on dates of service)**														
I.1	NHP Capitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.2	NHP Reimbursement (other)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.3	Tufts Reimbursement - RIte Care	$ -	$ -	$ -	$	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.4	UHC Reimbursement - RIte Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
I.5	Other Net Patient Revenue (if applicable)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
	EDS														$ -
I.6	**Subtotal**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		$ -
I.7	DHS PPS PMPM Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
															$ -
I.8	**Total Amounts Received/Receivable:**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**
II.	**Allowable Encounters for Persons Enrolled with a RIte Care Plan on the Date of Service**														
II.1	NHP Capitated Encounters				-										
II.2	NHP Encounters (other)														
II.3	Tufts Encounters - RIte Care				-										
II.4	UHC Encounters - RIte Care				-										
II.5	Other allowable Encounters (EDS)				-										
II.6	**Total Encounters**	-	-	-	-	-	-	-	-	-	-	-	-		-
III.	**Payment Calculation**														
III.1	Applicable FQHC Reimbursement Rate	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
III.2	**Imputed PPS Revenue total**	$	$	$	$	$	$	$	$ -	$	$	$	$		$ -
III.3	Total Amount Required in DHS Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
III.4	Actual DHS Amounts Paid on Interim Basis	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
III.5	**Balance due (credit)**	$	$	$	$	$	$	$	$ -	$	$	$	$		$ -

Attachment II

Rhode Island EOHHS/FQHC Cost Report Format

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet A

Reclassification and Adjustment of Trial Balance of Expenses

	Cost Center	Compensation	Other	Total	Reclassi-factions	Reclassified Trial Balance	Adjustments	Net Expenses
		1	2	3	4	5	6	7
	MEDICAL CARE STAFF COSTS							
1	Physician		-	-	-		-	
2	Physician Assistant			-	-			-
3	Nurse Practitioner			-	-			-
4	Subtotal - Direct Productivity	-	-	-	-	-	-	-
5	Visiting Nurse		-		-		-	
6	Other Nurse		-		-		-	
7	Clinical Psychologist			-		-		-
8	Clinical Social Worker			-		-		-
9	Laboratory Technician			-		-		-
10	Medical Assistants			-	-			-
11	Front Desk		-		-		-	
12	Medical Records		-		-		-	
13	Subtotal-Medical Care Staff Cost	-	-	-	-	-	-	-
	COSTS UNDER AGREEMENT							
14	Physician Services Under Agreement			-		-		-
15	Physician Supervision Under Agreement			-		-		-
16	Other Costs Under Agreement			-		-		-
				-		-		-
17	Subtotal Under Agreement	-	-	-	-	-	-	-
18	**Subtotal Direct Other**	-	-	-	-	-	-	-
	OTHER HEALTH CARE COSTS							
19	Medical Supplies		-		-		-	
20	Transportation (Health Care Staff)			-		-		-
21	Depreciation-Medical Equipment			-		-		-
22	Professional Liability Insurance			-		-		-
23	Other Direct Medical			-		-		-
24	Medical waste		-		-		-	
25	Medical record supplies			-		-	-	-
26	Subtotal-Other Medical Care	-	-	-	-	-	-	-
27	Subtotal - Medical Costs	-	-	-	-	-	-	-
	DENTAL CARE STAFF COSTS							
28	Dentist		-		-		-	
29	Dental Hygienist			-		-		-
30	Dental Assistant			-		-		-
31	Subtotal Direct Productivity	-	-	-	-	-	-	-
32	Front Desk		-		-		-	
33	Dental Records	-	-	-		-		-
34	Subtotal- Dental Care Staff Cost	-	-	-	-	-	-	-
	COSTS UNDER AGREEMENT							
35	Dentist Services Under Agreement			-		-		-
36	Dentist Supervision Under Agreement			-		-		-
37	Other Costs Under Agreement			-		-		-
				-		-		-
38	Subtotal Under Agreement	-	-	-	-	-	-	-
39	**Subtotal Direct Other**	-	-	-	-	-	-	-
	OTHER DENTAL CARE COSTS							
40	Dental Supplies		-		-		-	
41	Transportation (Dental Care Staff)			-		-		-
42	Depreciation-Dental Equipment			-		-		-
43	Professional Liability Insurance			-		-		-
44	Other Direct Dental			-		-		-
45	Dental record supplies			-		-		-
46	Equipment maintenance			-		-		-
47	Subtotal-Other Dental Care	-	-	-	-	-	-	-
48	Subtotal - Dental Costs	-	-	-	-	-	-	-
49	Total Cost of Health Care Services	-	-	-	-	-	-	-

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet A

Reclassification and Adjustment of Trial Balance of Expenses

	Cost Center	Compensation 1	Other 2	Total 3	Reclassi-factions 4	Reclassified Trial Balance 5	Adjustments 6	Net Expenses 7
	FACILITY OVERHEAD - FACILITY COST							
50	Rent		-	-			-	
51	Insurance		-		-		-	
52	Interest on Mortgage or Loans			-		-	-	-
53	Utilities		-		-		-	
54	Depreciation-Building and Fixtures			-		-	-	-
55	Housekeeping and Maintenance			-		-		-
56	Property Tax		-		-		-	
57	Other Facility Cost (contracted security)			-		-		-
58		-		-		-		
59		-		-		-		
60	Subtotal-Facility Costs	-	-	-	-	-	-	-
	FACILITY OVERHEAD - ADMINISTRATIVE COSTS							
61	Office Salaries		-	-	-		-	
62	Depreciation-Office Equipment			-		-		-
63	Office Supplies		-		-		-	
64	Legal		-	-			-	
65	Accounting		-		-		-	
66	Insurance		-		-		-	
67	Telephone		-		-		-	
68	Fringe Benefits and Payroll Taxes			-		-		-
69	Other Admin Costs (Conferences & Meetings)			-		-		-
70	Contracted Admin Svcs.			-		-		-
71.01	Bad Debt Expense			-	-		-	-
71.02	Interest Expense		-					-
71.03	Dues and Licenses			-	-			-
71.04	Equipment maintenance			-		-		-
71.05	Miscellaneous Admin. Costs			-		-	-	-
71.06	Postage & Delivery			-	-			-
71.07		-		-		-		
72	Subtotal-Administrative Costs	-	-	-	-	-	-	-
73	Total Overhead	-	-	-	-	-	-	-
	COST OTHER THAN RHC/FQHC SERVICES							
74	Pharmacy							
75			-		-	-	-	
76	Other Cost (Specify) radiology		-		-		-	
77	Enabling services			-		-		-
78	Subtotal-Cost Other Than RHC/FQHC			-		-		-
		-	-	-	-	-	-	-
	NON-REIMBURSABLE COSTS							
79	Non-Reimbursable Cost (Specify)			-		-		-
80	Subtotal Non-Reimbursable Cost			-		-		-
		-	-	-	-	-	-	-
81	Total Costs	-	-	-	-	-	-	-

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet A-1

Reclassifications

	Explanation of Entry	Code	Increase Cost Center	Increase Line No	Increase Amount	Decrease Cost Center	Decrease Line No	Decrease Amount
		1	2	3	4	5	6	7
1	Physician Admin Time	A	Office Salaries			Physician		
2								
3								
4								
5								
	TOTAL RECLASSIFICATIONS				-			-

Worksheet A-2

Adjustments to Expenses

	Description	Basis	Amount	Cost Center	Line No
		1	2	3	4
1	Investment income on commingled restricted and unrest funds				
2	Trade, quantity and time discounts on purchases	B			
3	Rebates and refunds of expenses	B			
4	Rental of building or office space to others	B			
5	Home office costs				
6	Adjustment resulting from transactions with related orgs.	A-2-1	-		
7	Vending machines				
8	Practitioner Assigned by National Health Service Corps				
9	Depreciation - Building and Fixtures	A	-	Depreciation	
10	Depreciation - Equipment	A	-	Depreciation	
11	Meals & Entertainment	A	-	Office Supplies	
11.01	Telephone-Cellular	A	-	Office Supplies	
11.02	In Kind Donations	A	-	Physician Services under Agree	-
11.03	Pharmacy costs not requiring allocation of oh	A	-	Pharmacy	-
11.04	Bad debt expense	A	-	Other administrative costs	-
11.05	Advertising/fundraising Costs	A	-	Other administrative costs	-
11.06	Medical records revenue	B	-	Medical records supplies	-
11.07	Miscellaneous income	B	-	Other administrative costs	-
11.08	DCYF grant revenue for reimbursement of salary	B	-	Enabling services	-
12	Total	-			

Worksheet A-2-1

Part I

Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part 1, chapter 10?

Yes [ ] No [ ]

Part II - Cost incurred and adjustments required as result of transactions with related organizations

Line No	Cost Center	Expense Items	Amount	Amount Allowable In Cost	Net Adjustment
1	2	3	4	5	6
1					
2					
3					
4					
5	TOTALS		-	-	-

Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the provider;
B. Corporation, partnership, or other organization has financial interest in the provider;
C. Provider has financial interest in corporation, partnership, or other organization(s);
D. Director, officer, administrator, or key person of the provider or relative of such person has financial interest in related organization;
E. Individual is director, officer, administrator, or key person of the provider and related organization;
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the provider;
G. Other (financial or non-financial)

(Provider Name)
Template of DHS/FQHC Cost Report
YEAR ENDED JUNE 30, _____

Worksheet B

Part I - ENCOUNTERS AND PRODUCTIVITY-MEDICAL

	Positions	Number of FTE Personnel 1	Total Encounters 2	Productivity Standard 3	Minimum Encounters 4	Greater of Col.2 or Col. 4 5
1	Physicians		-			
2	Physician Assistants			-		
3	Nurse Practitioners			-		
4	Subtotal	-	-		-	-
5	Visiting Nurse		-			
6	Clinical Psychologist			-		
7	Clinical Social Worker			-		
8	Total Staff	-	-			-
9	Physician Services Under Agreement				-	

Part II - ENCOUNTERS AND PRODUCTIVITY-DENTAL

	Positions	Number of FTE Personnel 1	Total Encounters 2	Productivity Standard 3	Minimum Encounters 4	Greater of Col.2 or Col. 4 5
10						
11						
12	Dentists		-			
13	Hygienists Subtotal Dental Assistants		-			
		-	-		-	-
14	Dental Services Under Agreement					

Part III - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC

		Amount	Overhead	
				Screen
				Not applicable
15	Cost of Medical Service - excluding overhead	-		
16	Cost of Dental Service - excluding overhead	-		
17	Cost of Other Than RHC/FQHC Service - excluding overhead		-	
18	Cost of Connect Care Choices - excluding overhead		-	
19	Cost of All Services	-		
20	Ratio of Medical Services			
21	Ratio of Dental Services			
22	Total Overhead	Facility		Admin Total
23	Overhead Applicable to Medical Services	-	-	-
24	Overhead Applicable to Dental Services	-	-	-
25	Total Overhead Applicable to Medical and Dental Services:			
26	Not applicable			
27	Not applicable			
28	28 Total Allowable Cost of Medical Services			
29	Total Allowable Cost of Dental Services			

(Provider Name)
Template of FQHC Medical/Dental Cost Report
YEAR ENDED JUNE 30, _____

Worksheet C

Part I - DETERMINATION OF COST FOR MEDICAL SERVICES

		Amount
1	Total Allowable Costs	-
2	Greater of Minimum or Actual Encounters By Health Care Staff	-
3	Physicians Encounters Under Agreements	-
4	Total Adjusted Encounters	-
5	Adjusted Cost Per Encounter	
6	Adjusted Cost per Encounter - Dir Prod. Medical	
7	Adjusted Cost per Encounter - Dir Other Medical	
8	Adjusted Cost per Encounter - Other Medical	
9	Adjusted Cost per Encounter - Medical Facility	
10	Adjusted Cost per Encounter - Medical Admin.	

Part II - DETERMINATION OF COST FOR DENTAL SERVICES

		Amount
11	Total Allowable Costs	-
12	Greater of Minimum or Actual Encounters By Health Care Staff	-
13	Dental Encounters Under Agreements	-
14	Total Adjusted Encounters	-
15	Adjusted Cost Per Encounter	
16	Adjusted Cost per Encounter - Dir Prod. Dental	
17	Adjusted Cost per Encounter - Dir Other Dental	
18	Adjusted Cost per Encounter - Other Dental	
19	Adjusted Cost per Encounter - Dental Facility	
20	Adjusted Cost per Encounter - Dental Admin.	

Template of FQHC Medical/Dental Cost Report

Worksheet D

Part I - DETERMINATION OF NET EXPENSE RELATED TO CONNECT CARE CHOICES

1	Nurse Case Manager	-
2	Fringe Benefits & Payroll Taxes	-
3	Equipment	-
4	Other Direct Expenses related to Connect Care Choices	-
5	Expense of Connect Care Choices - Excluding Overhead	-
6	Overhead Applicable to Connect Care Choices	-
7	Total Expense Applicable to Connect Care Choices	-
8	Revenue Received	-
9	Net Expense Applicable to Connect Care Choices	-

(Provider Name)
Template of FQHC Medical/Dental Cost Report
YEAR ENDED JUNE 30, _____

ATTESTATION:

Misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under Federal and State law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

CERTIFICATION BY OFFICERS

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by _____ (Provider) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
CEO or Administrator of Facility

_____
Date

_____
CFO or Finance Director of Facility

_____
Date

Attachment III

Classification of FQHC Accounts by Cost Center

			Attachment III
	CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER		
LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
1	Physician	Salary, fees and benefits.	Direct Productivity
2	Physician Assistant	Salary, fees and benefits.	Direct Productivity
3	Nurse Practitioner	Salary, fees and benefits.	Direct Productivity
5	Visiting Nurse	Salary, fees and benefits.	Direct Other
6	Other Nurse	Salary, fees and benefits.	Direct Other
7	Clinical Psychologist	Salary, fees and benefits.	Direct Other
8	Clinical Social Worker	Salary, fees and benefits.	Direct Other
9	Laboratory Technician	Salary, fees and benefits.	Direct Other
10	Medical Assistants	Salary, fees and benefits.	Direct Other
11	Front Desk/Reception	Salary, fees and benefits.	Direct Other
12	Medical Records	Salary, fees and benefits.	Direct Other
14	Physician Services Under Agreement	Salary, fees and benefits.	Direct Other
15	Physicians Supervision Under Agreement	Salary, fees and benefits.	Direct Other
16	Other Costs Under Agreement	Salary, fees and benefits.	Direct Other
19	Medical/Lab Supplies		Other Medical
20	Transportation (Health Care Staff)		Other Medical
21	Depreciation-Medical Equipment		Other Medical

	CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER		
LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
22	Professional Liability Insurance		Other Medical
23-25	Other Direct Medical (CME/license, direct staff		Other Medical
	repairs of med. Equip., uniforms, beepers)		
28	Dentist	Salary, fees and benefits.	Direct Productivity
29	Dental Hygienist	Salary, fees and benefits.	Direct Productivity
30	Dental Assistant	Salary, fees and benefits.	Direct Productivity
32	Front Desk	Salary, fees and benefits.	Direct Other
33	Dental Records	Salary, fees and benefits.	Direct Other
35	Dentist Services Under Agreement	Salary, fees and benefits.	Direct Other
36	Dentist Supervision Under Agreement	Salary, fees and benefits.	Direct Other
37	Other Costs Under Agreement	Salary, fees and benefits.	Direct Other
40	Dental Supplies		Other Dental
41	Transportation (Dental Care Staff)		Other Dental
42	Depreciation-Dental Equipment		Other Dental

	CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER		
LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
43	Professional Liability Insurance		Other Dental
44-46	Other Direct Dental (CME/license, direct repairs of med. Equip., uniforms, beepers)		Other Dental
50	Rent		Facility
51	Insurance		Facility
52	Interest on Mortgage or Loans		Facility
53	Utilities		Facility
54	Depreciation- Building & Fixtures		Facility
55	Housekeeping and Maintenance		Facility
56	Property Tax		Facility
57-59	Other Facility Cost (Specify)		Facility
61	Office Salaries (CEO, CFO, HR, Billing, IT, (admin asst., QI Mgr., Med Dir,)		Administration
62	Depreciation- Office Equipment		Administration
63	Office Supplies		Administration
64	Legal		Administration
65	Accounting		Administration
66	Insurance		Administration
67	Telephone		Administration
68	Fringe Benefits & Payroll Taxes		Administration
69-71	Other Administrative Costs (travel,		Administration

	CLASSIFICATION OF FQHC ACCOUNTS BY COST CENTER		
LINE	ACCOUNT NAME	ACCOUNT DESCRIPTION	COST CENTER
74	Pharmacy		
76-77	Other Costs (Specify - Enabling)		

MEDICAID BUDGET SURVEY
FOR STATE FISCAL YEARS 2017 AND 2018

State	RI	**Name**	Melody Lawrence		
Phone	401-46206348	**Email**	melody.lawrence@ohhs.ri.gov	**Date**	September 1, 2017

SECTION 1: MEDICAID EXPENDITURES & ENROLLMENT

1. Medicaid Expenditure Growth: SFYs 2016-2018. For each year, indicate the annual percentage change in total Medicaid expenditures for each source of funds. ***(Exclude admin. and Medicare Part D Clawback payments.)***

Fiscal Year (generally, July 1 to June 30)	Percentage Change of Each Fund Source		
	Non-Federal Share*	Federal	Total: All Sources
a. FY 2016 over FY 2015	-1.39%	-0.70%	-0.98%
b. FY 2017 over FY 2016	4.76%	6.90%	6.03%
c. FY 2018 over FY 2017 (proj.)	2.15%	2.15%	2.15%

**Non-federal share includes state general revenues/ state general funds and local or other funds.*

2. Non-Federal Share. For FY 2018, about what percentage of the non-federal share is state general revenues/ general funds? **98.8%** If less than 100%, indicate in the table below other sources for the non-federal share in FY 2018.

Local or Other Funds *(Check all that apply)*		
i. [ ] IGTs and/or CPEs	**ii.** [ ] Provider taxes	**iii.** [ ] Tobacco taxes
iv. [ ] Other fees	**v.** [ ] County matching funds	**vi.** [X] Other

Comments on non-federal share (Question 2):
Funds are restricted receipted collected against private insurers for Medicaid-eligible children with TPL who are using certain home and community based services paid by Medicaid

3. Shortfall. How likely is a FY 2018 Medicaid budget shortfall given the funding authorized? **Not likely**

Comments on Medicaid expenditures (Questions 1-3):

4. Factors Driving Total Expenditure Changes. What were the most significant factors that affected growth or decline in *total* Medicaid spending (all funds) in FY 2017 and projected for FY 2018?

Total Medicaid Spending		FY 2017	FY 2018 (projected)
a. Upward Pressures	**i.** Most significant factor?	caseload growth	csaeload growth
	ii. Other significant factors?	- provider reimbursement (FQHC, Hepatitis C drug) - ltc expenditures	provider reimbursement
b. Downward Pressures	**i.** Most significant factor?	rebate collections	implementation of full functionality of eligiblity system
	ii. Other significant factors?	lower costs than expected for Expansion population	

Comments on factors (Question 4):

5. Enrollment and Spending Change. Indicate percentage changes in total Medicaid (Title XIX - funded) enrollment and per enrollee spending. *(Exclude CHIP-funded enrollees and family planning only enrollees).*

Fiscal Year	Percentage Change in Enrollment and Per Enrollee Spending				
	All Enrollees	Children	Expansion Adults	Aged/Disabled	All other Adults
Enrollment					
a. 2017 over 2016	8.1%	5.4%	14.9%	2.4%	11.4%
b. 2018 over 2017 (proj.)	-0.7%	3.0%	-3.9%	-1.0%	-4.0%
Per Enrollee Spending					
c. 2017 over 2016	-2.0%	-0.6%%	-2.0%	2.1%	-0.6%
d. 2018 over 2017 (proj.)	4.8%	0.8%	13.5%	4.9%	0.8%

Comments on enrollment changes and per enrollee spending by eligibility group (Question 5): **All percentages approximate based on month end snapshot and allocation of expenditures to group that is most relevant despite not all expenses being mutually exclusive.**

For enrollment purposes, 'Other Adults' are all MAGI-eligible individuals 19+; ABD includes Children with Special Healthcare Needs who are 19+; For per enrollee expenditures, RI cannot differentiate between children and other adults as both are enrolled in RIte care managed care program and a lot of costs are not differentiated; underaccrual of Gain Share for Medicaid Expansion overstates pmpm decline in FY17 and growth in FY18

6. Key Factors Driving Change in Enrollment. In the table below, please identify what you believe were the key factors that were upward and downward pressures on total enrollment in FY 2017, and expected to be in FY 2018.

	FY 2017	FY 2018 (projected)
a. Upward Pressures	continued delay in functionality of new eligiblity system	continued delays in eligibility system
b. Downward Pressures		- implementation of full functionality of eligiblity system - reaching full enrollment of Medicaid eligible residents

Comments on factors driving enrollment changes (Question 6):

7. DSH Payment and CHIP Budget Assumptions. Does your state budget for FY 2018 assume:

a. The continuation of federal CHIP funding? **Yes**

b. A decrease in your state's federal disproportionate share hospital (DSH) allotment?**No**

Comments on budget assumptions (including fiscal/coverage impact of CHIP funding expiration) (Question 7)
current appropriation level assumes continuation of enhanced FMAP (approx. 88% for RI) beyond September 2017 sunset date (kg): Current allotment expected to run out in February 2018. No contingency plans.

8. ACA Medicaid Expansion Population Non-Federal Share Financing (*Non-expansion states may skip*)
a. Use the drop-down to identify the source of financing for the state share:**State General Fund**
b. If answered "other" for 8a, please briefly describe:

Comments on expansion financing (Question 8):

SECTION 2: MEDICAID ELIGIBILITY STANDARDS, APPLICATION AND RENEWAL PROCESSES

1. Changes in Medicaid Eligibility Standards. Describe changes in Medicaid eligibility standards* implemented in FY 2017 or adopted for FY 2018. *(Exclude federally mandated changes and CHIP-funded changes.)* Use the drop-down boxes to indicate the Year, Eligibility Group Affected ("Children," "Expansion Adults," "Aged & Disabled," or "All Other Adults,") and the "Nature of Impact" ("Expansion," "Restriction," or "Neutral" effect from the beneficiary's perspective). If no changes, check the box on line "d."

Nature of Eligibility Standards Change	Fiscal Year	Group Affected	Est. # of People Affected	Nature of Impact	Waiver or SPA
a.					
b.					
c.					
d. **[X]** No changes in either FY 2017 or FY 2018					

* "Eligibility standards" include income standards, asset tests, retroactivity, continuous eligibility, treatment of asset transfers or income, or implementing buy-in options (including Ticket to Work and Work Incentive Improvement Act or the DRA Family Opportunity Act).

Comments on change in eligibility standards (Question 1):
no eligibility changes

2. Corrections-Related Enrollment Policies. Please indicate if your state's Medicaid program had the following policies in place for jails, prisons, and/or parolees in FY 2017 and if these policies will be adopted or expanded in FY 2018.

Select Corrections-Related Medicaid Policies	Jails		Prisons		Parolees	
	In Place FY17	FY18 Changes	In Place FY17	FY18 Changes	In Place FY17	FY18 Changes
a. Medicaid outreach/assistance strategies to facilitate enrollment prior to release	X	No Change	X	No Change		
b. Medicaid coverage for inpatient care provided to incarcerated individuals	X	No Change	X	No Change	*N/A*	*N/A*
c. Medicaid eligibility suspended for enrollees who become incarcerated	X	No Change	X	No Change	*N/A*	*N/A*
d. Other:						

Please briefly describe corrections-related Medicaid actions listed above (Question 2):
kg: RI operates a combined jail/prison system.

SECTION 3: MONTHLY CONTRIBUTIONS / PREMIUMS AND COST-SHARING CHANGES

1. Changes in Monthly Contributions / Premiums. In the table below, please describe any monthly contribution / premium policy changes made in FY 2017 or planned for FY 2018. Use the drop-down boxes to indicate Year, Nature of Impact, and Waiver or SPA Authority. Also indicate Effective Date and Eligibility Group(s) Affected. If there are no monthly contribution/premium changes to report for either year, check the box on line "d."

Monthly Contribution/Premium Action	Fiscal Year	Eff. Date	Elig. Group(s) Affected	Nature of Impact	Waiver or SPA
a.					
b.					
c.					
d. **[X]** No changes in either FY 2017 or FY 2018					

Comments on premiums (Question 1):

2. Changes in Cost-Sharing. In the table below, please describe any cost-sharing policy changes in FY 2017 or planned for FY 2018. Use the drop-down boxes to indicate Year, Nature of Impact, and Waiver or SPA Authority. Also indicate Effective Date and Eligibility Group(s) Affected. If there are no cost-sharing changes to report for either year, check the box on line "d."

Cost-Sharing Action	Fiscal Year	Eff. Date	Elig. Group(s) Affected	Nature of Impact	Waiver or SPA
a.					
b.					
c.					
d. **[X]** No changes in either FY 2017 or FY 2018					

Comments on cost-sharing (Question 2):

SECTION 4: PROVIDER PAYMENT RATES AND PROVIDER TAXES / ASSESSMENTS

1. **Fee-For-Service (FFS) Provider/MCO Payment Rates.** Compared to the prior year, indicate by provider type any FFS rate changes implemented in FY 2017 or planned for FY 2018. Use "+" to denote an increase, "-" to denote a decrease, or "0" to denote "no change." ***(Include COLA or inflationary changes as "+".)***

Provider Type/MCO	FY 2017	FY 2018
a. Inpatient hospital	+	+
b. Outpatient hospital	+	+
c. Doctors – primary care	0	0
d. Doctors – specialists	0	0
e. Dentists	0	0
f. Managed care organizations *(put N/A if there are no Medicaid MCOs)*	+	+
g. Nursing Facilities	+	0
h. HCBS	+	+

Comments on provider/MCO payment rates (Question 1):

2. **Managed Care Organization (MCO) Payment Rates** ***(Skip if your state does not have Medicaid MCOs)***
   a. Does your state require MCOs to implement provider payment changes in accordance with changes made to FFS payment rates? **Yes - for some provider types**

      Please describe:
      For rate cuts, must be eliminated. New statute in FY18 stipulates that MCOs must give hospitals the CMS market basket price increase

   b. Do MCO contracts mandate a minimum provider reimbursement rate floor?**Yes - for some provider types**
      i. If "yes for some," please identify which provider types: **hospitals, nursing home**

3. **Supplemental Payments**
   a. What share of your total FY 2016 FFS inpatient hospital payments were supplemental payments (such as UPL payments, but excluding DSH) not tied to a specific service for a specific beneficiary?**40%-49%**
   b. Do you make payments to hospitals and other providers through your MCOs that count as non-DSH supplemental payments subject to phase-down or elimination under the 2016 Medicaid Managed Care Final Rule?**No**
      i. If yes, what share of your MCO capitation do supplemental payments comprise?
      ii. How will your Medicaid program be affected by the phase-out requirements?

4. **Provider Taxes / Assessments.** Use the drop-downs to indicate provider taxes in place in FY 2017 and new taxes or changes for FY 2018. Also indicate whether the tax exceeds 3.5% or 5.5% of net patient revenues.

Provider Group Subject to Tax	In place in FY 2017	Provider Tax Changes (New, Increased, Decreased, Eliminated, No Change, or N/A) in FY 2018	Does tax exceed specified percentage of Net Patient Revenues (as of July 1, 2017)	
			Exceeds 3.5%	Exceeds 5.5%
a. Hospitals	X	No Change	Yes	Yes
b. ICF/ID		No Change		
c. Nursing Facilities	X	No Change	Yes	No
d. Other: **MCO**	X	No Change	No	No
e. Other:				

Comments on provider taxes/assessments (Question 4):

[LA/KG]: MCO tax is a broad based premium tax imposed on all plans (Medicaid and commercial). Not dedicated to Medicaid.

5. **Non-Federal Share Funded by Provider Taxes.** For FY 2017, please estimate the proportion (%) of the non-federal share of your state's Medicaid expenditures that are funded through provider tax revenue. If unknown, please indicate "don't know".**Don't know**

6. Does your state have a tax on MCOs, health insurance premiums, or health care claims that does not apply to other goods and services?**Yes**
   a. If yes, is this tax dedicated to funding the Medicaid program?**No**

SECTION 5A: BENEFIT AND PHARMACY CHANGES

1. **Benefit Actions.** Describe below any benefits changes implemented during FY 2017 or planned for FY 2018. (Exclude HCBS and pharmacy benefit changes, which are covered later.) Use drop-downs to indicate Year and Nature of Impact (i.e., from beneficiary's perspective, is it an "Expansion," a "Limitation," an "Elimination," or a change with a "Neutral Effect"?). If there are no benefit changes for either year, check the box on line "d."

Benefit Change	Fiscal Year	Eff. Date	Elig. Group(s) Affected	Nature of Impact
a. **Home Stabilizaton services**	**FY 2017**		**All**	**Expansion**
b. **Sobering Treatment Opportunity Program (STOP)**	**FY 2017**		**chronic inebriates**	**Expansion**
c. **Telehealth**	**FY 2017**		**All**	**Expansion**
d. **[ ]** No changes in either FY 2017 or FY 2018				

Comments on benefit actions (Question 1):
b: STOP is an ER diversion pilot in Providence that wll cover an overnight stay and referral to appropriate counseling for homeless chronic inebriates; c: initiation of telehealth coverage will occur through the new MCO contracts [AL - pulled from 16 survey]

2. **Top Pharmacy Cost Drivers.** Please list the biggest cost drivers that affected growth in total pharmacy spending (all funds) in FY 2017
HepC and specialty Rx

and projected for FY 2018
HepC and specialty Rx.

3. **Medicaid Covered Outpatient Drug Final Rule ("Rx Rule").** The Rx Rule requires states to come into compliance with new requirements for drug ingredient cost reimbursement and professional dispensing fees by April 1, 2017. Please use the drop down to indicate the expected budget impact of these changes. **Greater costs expected**

4. **Managed Care's Role in Delivering Pharmacy Benefits.** ***(Skip if your state does not have Medicaid MCOs)***
   a. If your state uses MCOs to deliver acute care benefits, were pharmacy benefits covered under your managed care contracts as of July 1, 2017? **Generally carved in (with possible exceptions)**

If "other," please briefly describe:

   b. If pharmacy benefits are carved-in, please indicate if the policies listed in the table below were in place in MCO contracts in FY 2017 and if changes were made in FY 2018. Use the comment section to provide additional details or clarification (e.g., if these requirements were implemented in some but not all contracts).

Managed Care Pharmacy Policies	In Place in FY 2017	Changes in FY 2018	Comments
i. Uniform clinical protocols, one or more drugs	X	No Change	HepC; generics first policy
ii. Uniform PDL			
iii. Risk-sharing for one or more drugs (e.g., risk corridors/pool, reinsurance, etc.)	X	No Change	Stop loss for HepC
iv. Other:			

5. **Pharmacy Cost Containment.** Please indicate in the table below any new or expanded pharmacy cost containment strategies implemented in FY 2017 or planned for FY 2018. *Please exclude changes reported under questions 3 and 4 above or routine updates (e.g., to PDLs or State Maximum Allowable Cost programs).*

Pharmacy Cost Containment Actions Implemented or Enhanced	FY 2017	FY 2018	Pharmacy Cost Containment Actions Implemented or Enhanced	FY 2017	FY 2018
a. Rebate enhancement initiative			b. New utilization controls applied		
c. Enrollee Rx cost sharing increased			d. Rx fraud/waste/abuse initiative		
e. Ingredient cost reimbursement reduced			f. Provider education / profiling initiative		
g. Dispensing fees reduced			h. Other		
i. Medication Therapy Management program			j. Other		

Comments on pharmacy actions (Questions 2-5):
kg: No changes to report in 5.5.

SECTION 5B: OPIOID USE DISORDER PREVENTION, HARM REDUCTION, AND TREATMENT

1. **CDC Guidelines.** Has your Medicaid program adopted or is it planning to adopt the:
   a. For FFS? **Not Sure/Still Evaluating**
   b. As a requirement for **MCOs** to adopt? **Not Sure/Still Evaluating**
   c. Please briefly describe any implementation challenges:
   Implement changes supporting State Legislation on opioid limitations.

2. **Pharmacy Benefit Management (PBM) Strategies**. A 2016 highlighted Medicaid PBM strategies for preventing opioid-related harms. In the table below, please indicate whether your state had one or more of the listed strategies in place in FFS in FY 2017 or will make changes to any of these strategies in FY 2018.

Medicaid FFS PBM Strategies to Address Opioid Misuse & Addiction	In place in FY 2017	FY 2018 Changes (New, Expand, Restrict, Eliminate, No Change)	Comments (briefly describe changes)
a. Clinical criteria claim system edits for opioids (subject to Prior Authorization (PA) override)	X	Expand	support legislation
b. Step therapy PA criteria for opioids	X	Expand	expanding to more LA opioids
c. Quantity limits on opioids		New	support legislation
d. Other PA requirements for opioids	X	New	support legislation
e. Naloxone:			
i. Available in at least one formulation without PA	X	No Change	
ii. Nasal spray covered without PA	X	No Change	

iii. Nasal spray atomizer covered without PA	X	No Change	
iv. Auto-injectors covered without PA		No Change	
v. Coverage provided for family members or friends obtaining prescriptions on enrollee's behalf		No Change	
f. Medicaid prescribers must check Prescription Drug Monitoring Program before prescribing opioids		New	support legislation
g. Other:			

3. **Managed Care PBM Opioid Policies.** ***(Skip if your state does not have Medicaid MCOs)***
   - **a.** If your state uses MCOs to deliver pharmacy benefits, please indicate whether, *as of July 1, 2017*, MCOs are required to follow the FFS PBM strategies described in Question 2 above: **No**
   - **b.** If "Yes, in part", please briefly describe the notable FFS/managed care policy differences:

Comments on PBM strategies (Questions 2 and 3):

4. **Medication Assisted Treatment.** Please use the dropdowns in the table below to indicate whether your state covers or has plans to add coverage for the medications listed below ***when used to treat opioid use disorders***. (If only covered for pain management, please select "Not covered.")

Coverage of Opioid Use Disorder Medications			
a. Buprenorphine	Covered as of FY 2017	b. Oral naltrexone	Covered as of FY 2017
c. Injectable naltrexone	Covered as of FY 2017	d. Methadone	Covered as of FY 2017

Comments on Section 5B:

SECTION 6A: MEDICAID DELIVERY SYSTEM

1. **Medicaid Managed Care Overview.** What types of managed care systems were in place in your state's Medicaid program as of July 1, 2017? *(check all that apply)*:

[X] MCO **[ ] PCCM-** Primary Care Case Management **[X] PHP -** PIHP or PAHP **[ ] Other**:

[ ] No managed care programs operating in your state Medicaid program as of July 1, 2017

2. **Managed Care Changes**. Has your state changed its managed care systems in FY 2017 or does it have plans to make changes in FY 2018 (e.g., eliminating PCCM, adding a new PHP, implementing MCO contracts when there were none the previous year)? **no changes**

3. **Population.** Please indicate the approximate share of your total Medicaid population served by **each acute care delivery system** model listed in the table below, **as of July 1, 2017**. If possible, please also indicate the share of each eligibility group served by each delivery system model. *Include full-benefit beneficiaries only; exclude partial-benefit dual eligibles and family planning-only enrollees.*

Delivery System	Distribution of Medicaid population as of July 1, 2017 *(Each column should sum to 100%)*				
	Total Population	Children	Expansion Adults	Aged & Disabled	All other Adults
a. MCOs	90.4%	96.7%	97.5%	74.3%	97.4%
b. PCCM (managed FFS)	%	%	%	%	%
c. Traditional FFS	9.6%	3.3%	2.5%	25.7%	2.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Comments on populations served (Question 3):
MCOs proportions include those enrolled in Rhode Island's RIte Share program (Medicaid assistance for those with TPL).
Percentages based on Enrollment forecast as of June 30, 2016.
"All Other Adults" percentage is a proxy derived from (a) Children and Families population group; whereas "Children" percentages derived from (a) Children and Families and (b) CSHCN groups.

If your state does not have Medicaid MCOs, please skip Sections 6B-6C.

SECTION 6B: GEOGRAPHIC SCOPE, ENROLLMENT, & BENEFITS – ACUTE CARE MCOS

1. **Geographic scope**
   - **a.** Were acute care MCOs operating statewide as of July 1, 2017? **Yes**
   - **b.** If not, does your state have plans to expand to new regions in FY 2018? **N/A**

2. **Enrollment Requirements.** For geographic areas where MCOs operate, use the drop-downs in the table below to indicate for each group whether enrollment in MCOs is "always mandatory," "always voluntary," "varies," or the group is "always excluded" from MCOs ***as of July 1, 2017***. You may provide additional detail under "Comments" (below the table).

MCO Enrollment Policies for Specified Populations			
a. Pregnant women	Always mandatory	b. Children with special health care needs	Always mandatory
c. Foster children	Always mandatory	d. Persons with a Serious Mental Illness (SMI) or SED?	Varies
e. Persons with ID/DD	Varies	f. Adults with physical disabilities	Varies

Comments on acute care MCO enrollment requirements (Question 2):

For Duals, enrollment is not mandatory. For Non-Duals, enrollment is mandatory for all population groups.

3. New Populations
- **a.** Did (or will) you enroll previously excluded populations in acute care MCOs in FY 2017 or FY 2018? **No**
- **b.** If yes, please identify the new populations and which year they were added:
- **c.** If yes, please indicate whether enrollment is (or will be) mandatory:

4. Changes to MCO Enrollment Requirements

- **a.** Did (or will) your state shift from voluntary to mandatory MCO enrollment for any Medicaid population in FY 2017 or FY 2018? **No**
- **b.** If yes, please identify the populations shifted and the year the change was made:

5. Reducing Acute Care MCO Enrollment. Did (or will) your state implement policy changes designed to reduce acute care MCO enrollment in FY 2017 or FY 2018? **No**

If so, briefly describe the changes in each year:

6. MCO Coverage of Behavioral Health (BH) Benefits as of July 1, 2017. *For beneficiaries enrolled in an MCO for acute care benefits,* please indicate whether the following BH benefits are always carved-in (i.e., virtually all services are provided directly by the MCO or through MCO sub-contracts), always carved-out (i.e., services are provided by a PHP or via FFS, not by the MCO), or whether carve-in policies vary by geography or other factors.

Services	Always Carved-in	Always Carved-out	Varies by:			Comments
			Geography	Other (describe)		
a. Specialty outpatient mental health*	X					
b. Inpatient mental health	X					stays cannot exceed 15 days
c. Inpatient SUD	X					
d. Outpatient SUD	X					

*"Specialty outpatient mental health" refers to services utilized by adults with Serious Mental Illness (SMI) and/or youth with serious emotional disturbance (SED), often provided by specialty providers such as community mental health centers.

7. Did (or will) your state make any changes to how BH benefits were *delivered under MCO contracts* (i.e., carve in/out) in FY 2017 or in FY 2018? **No**

If so, briefly describe the changes:

8. IMD Services. The 2016 Medicaid Managed Care Final Rule allows states to make a monthly capitation payment to an MCO or PIHP for an enrollee ages 21-64 receiving inpatient treatment in an IMD if the length of stay in the IMD is no more than 15 days during the period of the monthly capitation payment.
- **a.** Did (or will) your state use this authority in FY 2017 or in FY 2018? **Yes -- in both FY 2017 and FY 2018**
- **b.** In your opinion, does the Final Rule allow MCOs sufficient flexibility to provide cost-effective "in lieu of" IMD services to meet acute inpatient or residential treatment needs for members with:
  - **i. SMI Yes** ii. **SUD Yes**

Comments on IMD Services (Question 8):

SECTION 6C: QUALITY & CONTRACT ADMIN FOR MCOS (INCLUDING MLTSS)

1. HEDIS Measures in Contracting. Does your state include or plan to include MCO HEDIS© scores among its criteria for selecting plans to contract with? **Yes**

Comments:

2. MLR. As of July 1, 2017, does your state have a minimum MLR requirement for Medicaid MCOs? **No**

- **a.** If so, what is the minimum MLR for acute care MCOs?
- **b.** If so, what is the minimum MLR for MLTSS (if applicable)?
- **c.** Does your state require MCOs that do not meet the minimum MLR to pay remittances?

Comments on MLR (Question 2)**:**
RI has a risk/gain share that limits potential loss/profit on medical component of rate (kg: Only for non-Medicaid Exchange plans)

3. Auto Enrollment: Does your state include quality performance in its auto enrollment algorithm? **No**

If yes, please describe.

4. MCO Program Initiatives to Improve Quality of Care. While all states track certain quality measures (e.g., HEDIS©), we are also interested in states' use of contractual mechanisms to improve MCO quality performance. In the table below, please indicate whether your state included any of the following strategies in its MCO contracts in FY 2017 or added or significantly expanded such strategies in FY 2018.

Quality Initiatives in MCO Contracts		FY 2018	Comments:

	In Place FY 2017	New	Expanded	
a. Pay-for-performance/performance bonus	X			
b. Capitation withhold or penalty	X			
c. Required data collection and reporting	X			
d. Other:				

Comments on quality initiatives in MCO contracts (Question 4):

5. **Managed Care Capitation Withhold.** If your state uses MCO capitation withholds, what share of MCO capitation payments was withheld:
   a. For acute care services in FY 2017? **0**% and in FY 2018 **0**%
   b. For LTSS (if applicable) in FY 2017? **1**% and in FY 2018 **1.5**%

6. **Alternative Provider Payment Models.**
   a. In your MCO contracts, does your state set a target percentage of MCO provider payments that MCOs must make through alternative provider payment models? **Yes, in place in FY 2017**

   If so, please briefly describe.
   60% by last quarter of FY 2018, including 35% for total cost of care

   b. In your MCO contracts, does your state encourage or require MCOs to implement specific alternative provider payment models (e.g., episode-based payment, shared savings/shared risk)? **Plan to require in FY 2018**

   If so, please briefly describe.
   establish total Cost of Care with shared savings arrangements with ACOs

7. **Social Determinants of Health.** Does your state encourage or require MCOs to screen enrollees for social needs and/or provide enrollees with referrals to social services (e.g., housing services, SNAP)? **Plan to encourage in FY 2018**

   If so, please briefly describe (including whether requirement differs for screening vs. referrals):

8. **Corrections-Related Populations.** Does your state encourage or require MCOs to provide care coordination services to enrollees prior to release from incarceration? **No, no current plan to adopt**

   If so, please briefly describe.

9. **Additional Services.** Medicaid MCOs may have flexibility to use administrative savings within their capitation rates to provide services beyond Medicaid benefits required under their contracts.
   a. Do any MCOs in your state provide additional services to Medicaid enrollees? **Don't know**

   b. If yes, please provide examples of the most commonly provided additional services:

SECTION 6D: PRIMARY CARE CASE MANAGEMENT (PCCM)

1. **PCCM Policy Changes.** Did your state implement, or does it plan to implement, policy changes designed to ***increase*** or ***decrease*** the number of enrollees served through your PCCM program in:
   a. FY 2017? **No change** **b.** FY 2018? **No change**

   c. If yes in either FY 2017 or FY 2018, please briefly describe the change(s):

SECTION 6E: LIMITED-BENEFIT PREPAID HEALTH PLANS (PHP)

1. **PHP Services.** If your state contracted with at least one PHP as of July 1, 2017, please indicate in the table below the services provided under PHP contracts:

PHP Services *(Check all that apply)*		
a. Outpatient mental health	**b.** Inpatient mental health	**c.** Outpatient SUD treatment
d. Inpatient SUD treatment	**e.** X Dental care	**f.** Vision care
g. X NEMT	**h.** LTSS	

2. **PHP Policy Changes.** Did your state implement, or does it plan to implement, policy changes designed to ***increase*** or ***decrease*** the number of enrollees served through a PHP in:
   a. FY 2017? **No change** **b.** FY 2018? **No change**

   c. If yes in either FY 2017 or FY 2018, please briefly describe the change(s):

SECTION 7A: LONG-TERM SERVICES AND SUPPORTS (LTSS) REBALANCING

1. Did (or will) your state increase the number of persons receiving LTSS in home and community- based settings in FY 2017 or 2018? **Yes in both FY 2017 and FY 2018** If "yes," please check below all rebalancing tools used to accomplish the increase:

LTSS Rebalancing Tools/Methods	**FY 17**	**FY 18**
a. Section 1915(c) or Section 1115 HCBS Waiver (new waiver adopted, more slots added and filled, or more slots filled)		
b. Section 1915(i) HCBS State Plan Option (new SPA or more enrollees served)		
c. Section 1915(k) Community First Choice Option (new SPA or more enrollees served)		

d. Rebalancing incentives built into managed care contracts covering LTSS	X	X
e. PACE (new provider added and/or number of persons served increased)		
f. Close/down-size a state institution and transition residents into community settings		
g. Implement/ tighten Certificate of Need program or impose a new or extended moratorium on construction of new nursing facility beds or ICF/IDD beds		
h. Other:		

Comments on rebalancing tools/methods including type of incentives built into managed care contracts if applicable (e.g., blended NF/HCBS rate, etc.) (Question 1):

2. **Restrict Number Served in the Community.** If your state adopted, or plans to adopt, new restrictions on the number of people served in the community (e.g., eliminating a PACE site, reducing or newly capping HCBS waiver enrollment) **OR** if your state removed restrictions, or plans to do so, on institutional LTSS development (e.g., lift or liberalize a CON program or moratorium) in FY 2017 or FY 2018, briefly describe the changes in each year:

3. **HCBS Benefit Actions.** Describe below any HCBS benefits changes (including those required in MLTSS contracts) implemented during FY 2017 or planned for FY 2018. (Include and specify in the table below 1915(c) or 1115 HCBS waivers; 1915(i), 1915(k), and State Plan personal care, home health private duty nursing; and new PACE sites.) Use drop-downs to indicate Year, Nature of Impact (i.e., from beneficiary's perspective, is it an "Expansion," a "Limitation," an "Elimination," or a change with a "Neutral Effect"?).

HCBS Benefit Change	Year	Effective Date	Nature of Impact	Specify Authority (e.g., 1915(c), SPA)
a.				
b.				
c.				

Comments on HCBS benefit changes (Question 3):

4. **LTSS Direct Care Workforce.** Please briefly describe if your state has or will implement a Medicaid initiative in FY 2017 or FY 2018 to address LTSS direct care workforce shortages and/or turnover.
Yes - approx. 7.5% homecare wage increase included in each of FY17 and FY18 budgets

5. **Housing Supports.** A 2015 clarified housing-related activities that may be eligible for Medicaid reimbursement (i.e., Individual Housing Transition services, Individual Housing & Tenancy Sustaining services, State-level Housing Related Collaboration Activities).
   a. Did (or will) your state implement/expand any strategy outlined in the CMCS Bulletin in FYs 2017 or 2018?
   Yes -- in FY 2017
      i. If "yes," please briefly describe and indicate the target populations:
      (kg): Housing stabilization services available to all populations
   b. Does your state currently offer housing-related services under a State Plan, 1915(c) HCBS waiver, or Section 1115 waiver that will continue after the Money Follows the Person (MFP) program expires? **Don't know**
      i. If "yes," please briefly describe and indicate the target populations (e.g., individuals with physical disabilities, SMI, or chronically homeless):

   c. If your state participated in the MFP program, when does grant funding expire? **(kg): Per CMS website, 12/31/2018**
   d. Please also list any services your state will discontinue due to the expiration of the MFP program:
   (kg): No decisions yet

SECTION 7B: CAPITATED MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)

1. As of July 1, 2017, does your state cover long-term services supports through any of the following managed care (capitated) arrangements? *(Check all that apply)*
   [X] Medicaid MCO (MCO covers Medicaid acute + Medicaid LTSS)
   [ ] PHP (PHP covers only Medicaid LTSS)
   [X] MCO Arrangement for dual eligibles (MCO covers Medicaid and Medicare acute + Medicaid LTSS in a single contract, under the Financial Alignment Demonstration)
   [ ] No MLTSS

2. **Geographic Scope**
   a. Were MLTSS plans operating in all regions of your state as of July 1, 2017? **Yes**
   b. If not, did your state expand to new regions in FY 2017 or plan to do so in FY 2018? **N/A**

Comments on arrangements or geographic scope of MLTSS (Questions 1 and 2):

3. **Populations Covered.** For geographic areas where MLTSS plans operate, please use the drop-downs in the table below to indicate if enrollment into MLTSS plans for each of the groups listed is "always mandatory," "always voluntary," "varies," or is "always excluded." You may provide additional detail under "Comments" (below the table). If the program is *not* statewide but is mandatory in the counties where the program operates, please record as "mandatory."

MLTSS Enrollment Policies for Specified Populations *(As of July 1, 2017)*			
a. Seniors	**Varies**	b. Persons with physical disabilities < age 65	**Varies**
c. Persons with ID/DD	**Varies**	d. Full benefit dual eligibles	**Varies**

Comments on populations covered under MLTSS (Question 3):

4. **New Populations**
   a. Did (or will) you enroll previously excluded populations in MLTSS in FY 2017 or FY 2018? **No**

   b. If yes, please identify the new populations and which year they were added:

   c. If yes, please indicate whether enrollment is (or will be) mandatory:

5. **MLTSS Benefits/Medicare Alignment**
   a. As of July 1, 2017, were both institutional and HCBS services covered under an MLTSS contract?
   Yes - Covered both Institutional and HCBS
   b. Did (or will) your state make MLTSS benefits changes in FY 2017 or FY 2018? **No**
   If so, please briefly describe:

   c. Does your state require or encourage MCOs to be dual eligible special needs plans (D-SNPs) or Fully Integrated Dual Eligible (FIDE) plans? **No**
   d. If known, please indicate the approximate percentage of your dual eligible MLTSS enrollees that are enrolled in an aligned D-SNP or FIDE plan (and the time period for this percentage):

   Comments on MLTSS benefits/Medicare alignment (Question 5):

6. **Decrease Enrollees Served**. If your state implemented, or plans to implement, policy changes designed to ***decrease*** the number of enrollees served in MLTSS plans in FY 2017 or FY 2018, please briefly describe the changes:

SECTION 8: MEDICAID DELIVERY SYSTEM OR PAYMENT REFORMS

1. Please indicate in the table below all delivery system and payment reform initiatives (including multi-payer initiatives that Medicaid is a part of) in place in your state in FY 2017. Use the drop-downs to indicate changes to these initiatives in FY 2018. Use the "Additional Information" column to describe or **provide a web link** where such information can be found.

Delivery System or Payment Reform Initiatives	In Place FY 2017	Changes in FY 2018:	Additional Information: (specify if part of multi-payer initiative)
a. Patient-Centered Medical Home	X	No Change	
b. Health Home (under ACA Section 2703)	X	No Change	
c. Accountable Care Organization	X	Expanded	
d. Dual Eligible Initiative (Outside the FAD)			
e. Episode of Care Payments			
f. Delivery System Reform Incentive Payment (DSRIP) waiver		N/A	
g. All-Payer Claims Database	X		
h. Other: **Designated State Health Program (DSHP)**	X	Expanded	

Comments on delivery system and payment reforms (Question 1):

2. **Other Medicaid Initiatives.** If your state has or will implement an initiative in either of the areas listed below in FY 2017 or FY 2018, please briefly describe.

   a. Initiative(s) to increase access to dental care or improve oral health outcomes
   kg: nothing new

   b. Initiative(s) to increase access to telehealth:
   covered benefit since FY 2016

Comments on dental or telehealth initiatives (including any challenges or opportunities experienced so far):

3. **Social Determinants of Health.** If your state has or will implement an initiative to address one or more social determinants of health (SDHs) in FY 2017 or FY 2018 (other than housing supports already reported), please briefly describe the types SDHs addressed (e.g., employment, education, food access, etc.) and the delivery system(s) being used:

SECTION 9: ADMINISTRATION AND FUTURE OUTLOOK FOR THE MEDICAID PROGRAM

1. **Planned Future Section 1115 Medicaid Waiver Activity**
   a. Has your state submitted or is it planning to submit a Section 1115 waiver to CMS that will not be implemented until *after* FY 2018? **Yes - Still under development at state level**
   b. If yes, please identify in the table below the key components and/or topics addressed in the waiver.

Section 1115 Waiver Provisions *(Check all that apply)*		
i. [ ] Premiums	ii. [ ] Premium assistance (QHP or ESI)	iii. [ ] Health Savings Accounts
iv. [ ] Healthy Behavior Incentives	v. [ ] Copayments above statutory limits	vi. [ ] Work requirement
vii. [ ] Retroactive coverage waiver	viii. [ ] Reasonable promptness waiver	ix. [ ] Time limit on coverage
x. [ ] NEMT waiver	xi. [ ] DSRIP	xii. [ ] MLTSS
xiii. [ ] Behavioral health	xiv. [ ] Other:	xv. [ ] Other: **Full text moved to comments, just below (DR):**

Comments (including populations impacted):

Program additions and revisions to exisiting Comprehensive 1115 Waiver Demonstration under which RI operates its entire Medicaid program, with the exception of DSH payments, admin expenses, phased-Part D contributions, and payments to local education agencies for services in school-based settings.

2. **ACA Repeal/Medicaid Expansion** ***(Expansion States Only)***
   a. Describe the top two or three potential implications of ending the enhanced FMAP for the ACA Medicaid expansion in your state (e.g., fiscal/coverage impacts, implications for access to MH/addiction services).
   The loss of federal financial assistance could destabilize the market, result in coverage losses, and increase uncompensated care. TrumpCare could put as many as 8,000 Rhode Island jobs at risk. Over 70,000 Rhode Islanders who receive coverage through the Medicaid expansion could lose coverage.?????

   b. Has your state calculated or estimated the fiscal impact on Medicaid and/or the overall state budget of ending the enhanced FMAP for the ACA Medicaid expansion? **Yes**

   Comments:
   More than ~$200M in General Revenue or other funds would be needed to maintain the Medicaid expansion.

3. **ACA Medicaid Expansion** ***(Non-Expansion States Only)*****.** If there has been activity in your state around potential adoption of the ACA Medicaid expansion, how have federal health reform negotiations impacted this activity?

4. **Financing Changes.** What do you see as the top two or three challenges or opportunities for your state of capping federal Medicaid financing under a per capita cap or block grant system?
   Governor Raimondo's innovative package of Reinventing Medicaid reforms are 'bending the cost curve' in Medicaid and have resulted in Rhode Island's per-capita Medicaid expenses growing more slowly than the cap (rate of medical inflation), but the cap could limit state flexibility and cause significant hits to the state budget in future. The state's liability would increase substantially more under a block grant – by upwards of half a billion by 2028 under a block grant according to the Urban Institute. The change in the Medicaid financing scheme would increase state investment by upwards of $400 million to maintain program at current level

5. **Conclusions/Outlook**. Is there anything else that we have not discussed that you would like to highlight about your state's current program or changes under consideration for the future?

(kg):
-- Full implementation of new eligibility system; huge undertaking
-- Accountable Care Entity program implementation

Program	Current Rate Cells
Rite Care	< 1 yr. < = 185% FPL
Rite Care	1- 5 yr. < = 185% FPL
Rite Care	6 – 14 yr. < = 185% FPL
Rite Care	M 15 – 44 yr. < = 185% FPL
Rite Care	F 15 – 44 yr. < = 185% FPL
Rite Care	M & F > 44 yr. < = 185% FPL
Rite Care	Extended Family Planning (EFP)
Rite Care	EFP > 250% FPL
Rite Care	SOBRA
CSN and Sub Care	DCYF Rite Care < 1 yr.
CSN and Sub Care	DCYF Rite Care 1- 5 yr.
CSN and Sub Care	DCYF Rite Care 6 – 14 yr.
CSN and Sub Care	DCYF Rite Care M 15 – 21 yr.
CSN and Sub Care	DCYF Rite Care F 15 – 21 yr.
CSN and Sub Care	SSI Child < 1 yr.
CSN and Sub Care	SSI Child 1 – 5 yr.
CSN and Sub Care	SSI Child 6 – 14 yr.
CSN and Sub Care	SSI M 15 – 44 yr.
CSN and Sub Care	SSI F 15 – 44 yr.
CSN and Sub Care	Katie Beckett < 1 yr.
CSN and Sub Care	Katie Beckett 1 – 5 yr.
CSN and Sub Care	Katie Beckett 6 – 14 yr.
CSN and Sub Care	Katie Beckett M 15 – 44 yr.
CSN and Sub Care	Katie Beckett F 15 – 44 yr.
CSN and Sub Care	Sub. Adopt Child < 1 yr.
CSN and Sub Care	Sub. Adopt Child 1 – 5 yr.
CSN and Sub Care	Sub. Adopt Child 6 – 14 yr.
CSN and Sub Care	Sub. Adopt M 15 – 44 yr.
CSN and Sub Care	Sub. Adopt F 15 – 44 yr.
Rhody Health Partners	Disabled 21 – 44 yr.
Rhody Health Partners	Disabled > 44 yr.
Rhody Health Partners	Severe Persistant Mental Illness (SPMI)
Rhody Health Partners	MRDD
Medicaid Expansion	Female 19 – 24 yr.
Medicaid Expansion	Female 25 – 29 yr.
Medicaid Expansion	Female 30 – 39 yr.
Medicaid Expansion	Female 40 – 49 yr.
Medicaid Expansion	Female 50 – 64 yr.
Medicaid Expansion	Male 19 – 24 yr.
Medicaid Expansion	Male 25 – 29 yr.
Medicaid Expansion	Male 30 – 39 yr.
Medicaid Expansion	Male 40 – 49 yr.
Medicaid Expansion	Male 50 – 64 yr.
Medicaid Expansion	SOBRA
Rhody Health Options	Medicaid/Medicare ID
Rhody Health Options	Medicaid/Medicare SPMI

Rhody Health Options	Medicaid/Medicare Community-based (not long-term service and support)
Rhody Health Options	Medicaid/Medicare Long Term Care (NH > 90 dys)
Rhody Health Options	Medicaid/Medicare Waiver (Community-based LTSS)
Rhody Health Options	Medicaid/Medicare Long Term Care/ Waiver (LTSS Community Blended Rate)
Rhody Health Options	Medicaid Only, LTSS
Rite Smiles	0-2
Rite Smiles	3 to 5
Rite Smiles	6 to 10
Rite Smiles	11 to 14
Rite Smiles	15
Rite Smiles	16
Rite Smiles	17
Rite Smiles	18

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program

State: Rhode Island **Quarter:2/2018**

Age Range: Under 0

Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	19	0	0	0	0	19
1B - Man Care Arngmt	780	2	0	0	0	782
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	799	2	0	0	0	801
2. Unduplicated # New Enrollees						
2A - Fee For Service	8	0	0	0	0	8
2B - Man Care Arngmt	138	2	0	0	0	140
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	146	2	0	0	0	148
3. Unduplicated # Disenrollees						
3A - Fee For Service	10	0	0	0	0	10
3B - Man Care Arngmt	169	1	0	0	0	170
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	179	1	0	0	0	180
4. # Member Months Enrollment						
4A - Fee For Service	41	0	0	0	0	41
4B - Man Care Arngmt	2,028	3	0	0	0	2,031
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	2,069	3	0	0	0	2,072
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.2	0.0	0.0	0.0	0.0	2.2
5B - Man Care Arngmt	2.6	1.5	0.0	0.0	0.0	2.6
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.6	1.5	0.0	0.0	0.0	2.6
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	11	0	0	0	0	11
6B - Man Care Arngmt	652	1	0	0	0	653
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	663	1	0	0	0	664

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program

State: Rhode Island **Quarter:2/2018**

Age Range: 0 - 1						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program

State: Rhode Island **Quarter:2/2018**

Age Range: 1 - 5						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program

State: Rhode Island **Quarter:2/2018**

Age Range: 6 - 12						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program

State: Rhode Island **Quarter:2/2018**

Age Range: 13 - 18						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Summary)

State: Rhode Island **Quarter:2/2018**

	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	19					19
1B - Man Care Arngmt	780	2				782
1C - Pri Care CA Mgt						0
Total	799	2	0	0	0	801
2. Unduplicated # New Enrollees						
2A - Fee For Service	8					8
2B - Man Care Arngmt	138	2				140
2C - Pri Care CA Mgt						0
Total	146	2	0	0	0	148
3. Unduplicated # Disenrollees						
3A - Fee For Service	10					10
3B - Man Care Arngmt	169	1				170
3C - Pri Care CA Mgt						0
Total	179	1	0	0	0	180
4. # Member Months Enrollment						
4A - Fee For Service	41					41
4B - Man Care Arngmt	2,028	3				2,031
4C - Pri Care CA Mgt						0
Total	2,069	3	0	0	0	2,072
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.2	0.0	0.0	0.0	0.0	2.2
5B - Man Care Arngmt	2.6	1.5	0.0	0.0	0.0	2.6
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.6	1.5	0.0	0.0	0.0	2.6
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	11					11
6B - Man Care Arngmt	652	1				653
6C - Pri Care CA Mgt						0
Total	663	1	0	0	0	664

DISCLAIMER: In Order for this form to be meaningful, the same income ranges should be used on each CMS-21E Form heading

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: Under 0						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 0 - 1						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 1 - 5						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 6 - 12						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 13 - 18						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: Under 0						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	1	0	0	0	0	1
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1	0	0	0	0	1
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	3	0	0	0	0	3
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	3	0	0	0	0	3
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	0.0	0.0	0.0	0.0	3.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	0.0	0.0	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	1	0	0	0	0	1
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1	0	0	0	0	1

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 0 - 1						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 1 - 5						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 6 - 12						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 13 - 18						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: Under 0						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	19	0	0	0	0	19
1B - Man Care Arngmt	780	2	0	0	0	782
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	799	2	0	0	0	801
2. Unduplicated # New Enrollees						
2A - Fee For Service	8	0	0	0	0	8
2B - Man Care Arngmt	138	2	0	0	0	140
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	146	2	0	0	0	148
3. Unduplicated # Disenrollees						
3A - Fee For Service	10	0	0	0	0	10
3B - Man Care Arngmt	169	1	0	0	0	170
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	179	1	0	0	0	180
4. # Member Months Enrollment						
4A - Fee For Service	41	0	0	0	0	41
4B - Man Care Arngmt	2,028	3	0	0	0	2,031
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	2,069	3	0	0	0	2,072
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.2	0.0	0.0	0.0	0.0	2.2
5B - Man Care Arngmt	2.6	1.5	0.0	0.0	0.0	2.6
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.6	1.5	0.0	0.0	0.0	2.6
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	11	0	0	0	0	11
6B - Man Care Arngmt	652	1	0	0	0	653
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	663	1	0	0	0	664

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 0 - 1						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 1 - 5						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 6 - 12						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served, Separate Child Health Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 13 - 18						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Pregnant Women served

State: Rhode Island **Quarter:2/2018**

Age Range: 19 - 64						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	18	29	14	0	0	61
1B - Man Care Arngmt	62	437	99	0	0	598
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	80	466	113	0	0	659
2. Unduplicated # New Enrollees						
2A - Fee For Service	1	3	0	0	0	4
2B - Man Care Arngmt	6	67	0	0	0	73
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	7	70	0	0	0	77
3. Unduplicated # Disenrollees						
3A - Fee For Service	2	17	7	0	0	26
3B - Man Care Arngmt	27	162	53	0	0	242
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	29	179	60	0	0	268
4. # Member Months Enrollment						
4A - Fee For Service	52	68	33	0	0	153
4B - Man Care Arngmt	143	1,057	243	0	0	1,443
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	195	1,125	276	0	0	1,596
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	2.3	2.4	0.0	0.0	2.5
5B - Man Care Arngmt	2.3	2.4	2.5	0.0	0.0	2.4
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.4	2.4	2.4	0.0	0.0	2.4
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	16	16	7	0	0	39
6B - Man Care Arngmt	39	312	61	0	0	412
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	55	328	68	0	0	451

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Pregnant Women served (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 19 - 64						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Pregnant Women served (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 19 - 64						
Program Code: RI	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	1	18	9	0	0	28
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1	18	9	0	0	28
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	11	6	0	0	17
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	11	6	0	0	17
4. # Member Months Enrollment						
4A - Fee For Service	3	43	19	0	0	65
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	3	43	19	0	0	65
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	2.4	2.1	0.0	0.0	2.3
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	2.4	2.1	0.0	0.0	2.3
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	1	9	3	0	0	13
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1	9	3	0	0	13

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Pregnant Women served (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 19 - 64						
Program Code: RI	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program

State: Rhode Island **Quarter:2/2018**

Age Range: 0 - 1						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	4	10	48	0	0	62
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	4	10	48	0	0	62
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	1	7	0	0	8
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	1	7	0	0	8
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	3	0	0	3
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	3	0	0	3
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	10	30	139	0	0	179
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	10	30	139	0	0	179
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	2.5	3.0	2.9	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.5	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	4	10	46	0	0	60
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	4	10	46	0	0	60

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program

State: Rhode Island **Quarter:2/2018**

Age Range: 1 - 5						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	13	142	79	0	0	234
1B - Man Care Arngmt	315	3,381	1,778	0	0	5,474
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	328	3,523	1,857	0	0	5,708
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	1	0	0	0	1
2B - Man Care Arngmt	3	66	43	0	0	112
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	3	67	43	0	0	113
3. Unduplicated # Disenrollees						
3A - Fee For Service	1	14	10	0	0	25
3B - Man Care Arngmt	7	96	102	0	0	205
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	8	110	112	0	0	230
4. # Member Months Enrollment						
4A - Fee For Service	38	419	227	0	0	684
4B - Man Care Arngmt	935	9,978	5,176	0	0	16,089
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	973	10,397	5,403	0	0	16,773
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	3.0	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	12	138	72	0	0	222
6B - Man Care Arngmt	331	3,310	1,691	0	0	5,332
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	343	3,448	1,763	0	0	5,554

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program

State: Rhode Island **Quarter:2/2018**

Age Range: 6 - 12						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	35	698	266	0	0	999
1B - Man Care Arngmt	543	8,785	2,713	0	0	12,041
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	578	9,483	2,979	0	0	13,040
2. Unduplicated # New Enrollees						
2A - Fee For Service	2	6	2	0	0	10
2B - Man Care Arngmt	6	110	40	0	0	156
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	8	116	42	0	0	166
3. Unduplicated # Disenrollees						
3A - Fee For Service	1	30	9	0	0	40
3B - Man Care Arngmt	7	207	157	0	0	371
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	8	237	166	0	0	411
4. # Member Months Enrollment						
4A - Fee For Service	103	2,054	779	0	0	2,936
4B - Man Care Arngmt	1,616	25,985	7,918	0	0	35,519
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1,719	28,039	8,697	0	0	38,455
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	2.9	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	34	670	257	0	0	961
6B - Man Care Arngmt	538	8,613	2,583	0	0	11,734
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	572	9,283	2,840	0	0	12,695

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program

State: Rhode Island **Quarter:2/2018**

Age Range: 13 - 18						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	39	598	218	0	0	855
1B - Man Care Arngmt	460	7,323	2,378	0	0	10,161
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	499	7,921	2,596	0	0	11,016
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	5	2	0	0	7
2B - Man Care Arngmt	4	94	47	0	0	145
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	4	99	49	0	0	152
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	18	17	0	0	35
3B - Man Care Arngmt	7	174	161	0	0	342
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	7	192	178	0	0	377
4. # Member Months Enrollment						
4A - Fee For Service	117	1,766	631	0	0	2,514
4B - Man Care Arngmt	1,361	21,685	6,886	0	0	29,932
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1,478	23,451	7,517	0	0	32,446
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	3.0	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	39	584	202	0	0	825
6B - Man Care Arngmt	454	7,185	2,241	0	0	9,880
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	493	7,769	2,443	0	0	10,705

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Summary)

State: Rhode Island **Quarter:2/2018**

	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	87	1,438	563			2,088
1B - Man Care Arngmt	1,322	19,499	6,917			27,738
1C - Pri Care CA Mgt						0
Total	1,409	20,937	7,480	0	0	29,826
2. Unduplicated # New Enrollees						
2A - Fee For Service	2	12	4			18
2B - Man Care Arngmt	13	271	137			421
2C - Pri Care CA Mgt						0
Total	15	283	141	0	0	439
3. Unduplicated # Disenrollees						
3A - Fee For Service	2	62	36			100
3B - Man Care Arngmt	21	477	423			921
3C - Pri Care CA Mgt						0
Total	23	539	459	0	0	1,021
4. # Member Months Enrollment						
4A - Fee For Service	258	4,239	1,637			6,134
4B - Man Care Arngmt	3,922	57,678	20,119			81,719
4C - Pri Care CA Mgt						0
Total	4,180	61,917	21,756	0	0	87,853
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	2.9	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	85	1,392	531			2,008
6B - Man Care Arngmt	1,327	19,118	6,561			27,006
6C - Pri Care CA Mgt						0
Total	1,412	20,510	7,092	0	0	29,014

DISCLAIMER: In Order for this form to be meaningful, the same income ranges should be used on each CMS-64.21E Form heading

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 0 - 1						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	4	10	47	0	0	61
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	4	10	47	0	0	61
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	1	6	0	0	7
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	1	6	0	0	7
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	3	0	0	3
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	3	0	0	3
4. # Member Months Enrollment						
4A - Fee For Service	10	30	137	0	0	177
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	10	30	137	0	0	177
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.5	3.0	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.5	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	4	10	45	0	0	59
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	4	10	45	0	0	59

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program

Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 1 - 5						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	11	132	69	0	0	212
1B - Man Care Arngmt	309	3,303	1,724	0	0	5,336
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	320	3,435	1,793	0	0	5,548
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	1	0	0	0	1
2B - Man Care Arngmt	3	55	35	0	0	93
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	3	56	35	0	0	94
3. Unduplicated # Disenrollees						
3A - Fee For Service	1	14	10	0	0	25
3B - Man Care Arngmt	6	92	98	0	0	196
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	7	106	108	0	0	221
4. # Member Months Enrollment						
4A - Fee For Service	32	389	197	0	0	618
4B - Man Care Arngmt	919	9,776	5,034	0	0	15,729
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	951	10,165	5,231	0	0	16,347
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	2.9	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	10	128	62	0	0	200
6B - Man Care Arngmt	306	3,235	1,640	0	0	5,181
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	316	3,363	1,702	0	0	5,381

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program

Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 6 - 12						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	28	593	218	0	0	839
1B - Man Care Arngmt	526	8,580	2,613	0	0	11,719
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	554	9,173	2,831	0	0	12,558
2. Unduplicated # New Enrollees						
2A - Fee For Service	2	4	2	0	0	8
2B - Man Care Arngmt	5	100	36	0	0	141
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	7	104	38	0	0	149
3. Unduplicated # Disenrollees						
3A - Fee For Service	1	26	9	0	0	36
3B - Man Care Arngmt	7	195	154	0	0	356
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	8	221	163	0	0	392
4. # Member Months Enrollment						
4A - Fee For Service	82	1,746	635	0	0	2,463
4B - Man Care Arngmt	1,567	25,417	7,632	0	0	34,616
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1,649	27,163	8,267	0	0	37,079
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	2.9	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	27	569	209	0	0	805
6B - Man Care Arngmt	521	8,420	2,485	0	0	11,426
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	548	8,989	2,694	0	0	12,231

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program

Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 13 - 18						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	25	402	145	0	0	572
1B - Man Care Arngmt	341	5,898	1,893	0	0	8,132
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	366	6,300	2,038	0	0	8,704
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	4	2	0	0	6
2B - Man Care Arngmt	2	71	32	0	0	105
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	2	75	34	0	0	111
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	12	11	0	0	23
3B - Man Care Arngmt	5	126	134	0	0	265
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	5	138	145	0	0	288
4. # Member Months Enrollment						
4A - Fee For Service	75	1,185	421	0	0	1,681
4B - Man Care Arngmt	1,013	17,495	5,492	0	0	24,000
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1,088	18,680	5,913	0	0	25,681
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	2.9	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	25	392	135	0	0	552
6B - Man Care Arngmt	337	5,801	1,782	0	0	7,920
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	362	6,193	1,917	0	0	8,472

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 0 - 1						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 1 - 5						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	8	98	50	0	0	156
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	8	98	50	0	0	156
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	1	0	0	0	1
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	1	0	0	0	1
3. Unduplicated # Disenrollees						
3A - Fee For Service	1	2	4	0	0	7
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1	2	4	0	0	7
4. # Member Months Enrollment						
4A - Fee For Service	23	290	145	0	0	458
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	23	290	145	0	0	458
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	3.0	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.9	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	7	97	47	0	0	151
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	7	97	47	0	0	151

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 6 - 12						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	26	592	221	0	0	839
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	26	592	221	0	0	839
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	1	2	0	0	3
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	1	2	0	0	3
3. Unduplicated # Disenrollees						
3A - Fee For Service	1	18	9	0	0	28
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1	18	9	0	0	28
4. # Member Months Enrollment						
4A - Fee For Service	76	1,748	644	0	0	2,468
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	76	1,748	644	0	0	2,468
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	3.0	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.9	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	25	574	212	0	0	811
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	25	574	212	0	0	811

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 13 - 18						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	32	479	163	0	0	674
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	32	479	163	0	0	674
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	4	0	0	0	4
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	4	0	0	0	4
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	10	13	0	0	23
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	10	13	0	0	23
4. # Member Months Enrollment						
4A - Fee For Service	96	1,418	473	0	0	1,987
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	96	1,418	473	0	0	1,987
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	3.0	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	32	470	151	0	0	653
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	32	470	151	0	0	653

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 0 - 1						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 1 - 5						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 6 - 12						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of CHIP Children Served in Medicaid Expansion Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: Unborn Children						
Age Range: 13 - 18						
Type of Eligible: U2	**Percentage of FPL**					
	0-133	**134-200**	**201-250**	**251-300**	**301**	**Total**
	(A)	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program

State: Rhode Island **Quarter:2/2018**

Age Range: 0 - 1						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	233	1	3	0	0	237
1B - Man Care Arngmt	5,791	0	1	0	0	5,792
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	6,024	1	4	0	0	6,029
2. Unduplicated # New Enrollees						
2A - Fee For Service	117	1	1	0	0	119
2B - Man Care Arngmt	1,399	0	0	0	0	1,399
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1,516	1	1	0	0	1,518
3. Unduplicated # Disenrollees						
3A - Fee For Service	35	0	0	0	0	35
3B - Man Care Arngmt	129	0	0	0	0	129
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	164	0	0	0	0	164
4. # Member Months Enrollment						
4A - Fee For Service	492	3	7	0	0	502
4B - Man Care Arngmt	15,968	0	3	0	0	15,971
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	16,460	3	10	0	0	16,473
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.1	3.0	2.3	0.0	0.0	2.1
5B - Man Care Arngmt	2.8	0.0	3.0	0.0	0.0	2.8
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.7	3.0	2.5	0.0	0.0	2.7
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	205	1	3	0	0	209
6B - Man Care Arngmt	5,713	0	1	0	0	5,714
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	5,918	1	4	0	0	5,923

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program

State: Rhode Island **Quarter:2/2018**

Age Range: 1 - 5						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	1,441	54	26	0	0	1,521
1B - Man Care Arngmt	26,745	158	81	0	0	26,984
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	28,186	212	107	0	0	28,505
2. Unduplicated # New Enrollees						
2A - Fee For Service	151	14	8	0	0	173
2B - Man Care Arngmt	420	1	3	0	0	424
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	571	15	11	0	0	597
3. Unduplicated # Disenrollees						
3A - Fee For Service	213	1	2	0	0	216
3B - Man Care Arngmt	604	1	4	0	0	609
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	817	2	6	0	0	825
4. # Member Months Enrollment						
4A - Fee For Service	3,883	133	58	0	0	4,074
4B - Man Care Arngmt	79,237	472	238	0	0	79,947
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	83,120	605	296	0	0	84,021
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.7	2.5	2.2	0.0	0.0	2.7
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.9	2.9	2.8	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	1,293	53	25	0	0	1,371
6B - Man Care Arngmt	26,335	157	77	0	0	26,569
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	27,628	210	102	0	0	27,940

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program

State: Rhode Island **Quarter:2/2018**

Age Range: 6 - 12						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	1,870	156	54	0	0	2,080
1B - Man Care Arngmt	30,687	284	75	0	0	31,046
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	32,557	440	129	0	0	33,126
2. Unduplicated # New Enrollees						
2A - Fee For Service	115	26	9	0	0	150
2B - Man Care Arngmt	362	2	0	0	0	364
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	477	28	9	0	0	514
3. Unduplicated # Disenrollees						
3A - Fee For Service	42	5	1	0	0	48
3B - Man Care Arngmt	469	7	7	0	0	483
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	511	12	8	0	0	531
4. # Member Months Enrollment						
4A - Fee For Service	5,380	414	142	0	0	5,936
4B - Man Care Arngmt	91,828	840	220	0	0	92,888
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	97,208	1,254	362	0	0	98,824
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	2.7	2.6	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	2.9	2.8	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	1,845	151	53	0	0	2,049
6B - Man Care Arngmt	30,452	277	70	0	0	30,799
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	32,297	428	123	0	0	32,848

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program

State: Rhode Island **Quarter:2/2018**

Age Range: 13 - 18						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	2,060	193	58	0	0	2,311
1B - Man Care Arngmt	22,795	236	71	0	0	23,102
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	24,855	429	129	0	0	25,413
2. Unduplicated # New Enrollees						
2A - Fee For Service	129	23	12	0	0	164
2B - Man Care Arngmt	308	1	2	0	0	311
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	437	24	14	0	0	475
3. Unduplicated # Disenrollees						
3A - Fee For Service	48	4	4	0	0	56
3B - Man Care Arngmt	413	7	1	0	0	421
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	461	11	5	0	0	477
4. # Member Months Enrollment						
4A - Fee For Service	5,934	529	142	0	0	6,605
4B - Man Care Arngmt	67,730	696	212	0	0	68,638
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	73,664	1,225	354	0	0	75,243
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	2.7	2.4	0.0	0.0	2.9
5B - Man Care Arngmt	3.0	2.9	3.0	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	2.9	2.7	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	2,025	189	54	0	0	2,268
6B - Man Care Arngmt	22,529	230	70	0	0	22,829
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	24,554	419	124	0	0	25,097

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program

State: Rhode Island **Quarter:2/2018**

Age Range: 19 - 20						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	654	42	21	2	0	719
1B - Man Care Arngmt	9,408	323	109	0	0	9,840
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	10,062	365	130	2	0	10,559
2. Unduplicated # New Enrollees						
2A - Fee For Service	91	1	1	0	0	93
2B - Man Care Arngmt	241	1	0	0	0	242
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	332	2	1	0	0	335
3. Unduplicated # Disenrollees						
3A - Fee For Service	98	27	12	1	0	138
3B - Man Care Arngmt	1,409	162	60	0	0	1,631
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	1,507	189	72	1	0	1,769
4. # Member Months Enrollment						
4A - Fee For Service	1,669	97	45	4	0	1,815
4B - Man Care Arngmt	26,275	781	267	0	0	27,323
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	27,944	878	312	4	0	29,138
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.6	2.3	2.1	2.0	0.0	2.5
5B - Man Care Arngmt	2.8	2.4	2.4	0.0	0.0	2.8
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.8	2.4	2.4	2.0	0.0	2.8
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	567	20	10	1	0	598
6B - Man Care Arngmt	8,204	200	65	0	0	8,469
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	8,771	220	75	1	0	9,067

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Summary)

State: Rhode Island **Quarter:2/2018**

	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	6,258	446	162	2		6,868
1B - Man Care Arngmt	95,426	1,001	337			96,764
1C - Pri Care CA Mgt						0
Total	101,684	1,447	499	2	0	103,632
2. Unduplicated # New Enrollees						
2A - Fee For Service	603	65	31			699
2B - Man Care Arngmt	2,730	5	5			2,740
2C - Pri Care CA Mgt						0
Total	3,333	70	36	0	0	3,439
3. Unduplicated # Disenrollees						
3A - Fee For Service	436	37	19	1		493
3B - Man Care Arngmt	3,024	177	72			3,273
3C - Pri Care CA Mgt						0
Total	3,460	214	91	1	0	3,766
4. # Member Months Enrollment						
4A - Fee For Service	17,358	1,176	394	4		18,932
4B - Man Care Arngmt	281,038	2,789	940			284,767
4C - Pri Care CA Mgt						0
Total	298,396	3,965	1,334	4	0	303,699
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.8	2.6	2.4	2.0	0.0	2.8
5B - Man Care Arngmt	2.9	2.8	2.8	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.9	2.7	2.7	2.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	5,935	414	145	1		6,495
6B - Man Care Arngmt	93,233	864	283			94,380
6C - Pri Care CA Mgt						0
Total	99,168	1,278	428	1	0	100,875

DISCLAIMER: In Order for this form to be meaningful, the same income ranges should be used on each CMS-64.EC Form heading

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 0 - 1						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	113	0	0	0	0	113
1B - Man Care Arngmt	5,188	1	0	0	0	5,189
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	5,301	1	0	0	0	5,302
2. Unduplicated # New Enrollees						
2A - Fee For Service	18	0	0	0	0	18
2B - Man Care Arngmt	841	0	0	0	0	841
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	859	0	0	0	0	859
3. Unduplicated # Disenrollees						
3A - Fee For Service	32	0	0	0	0	32
3B - Man Care Arngmt	118	0	0	0	0	118
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	150	0	0	0	0	150
4. # Member Months Enrollment						
4A - Fee For Service	297	0	0	0	0	297
4B - Man Care Arngmt	15,124	0	0	0	0	15,124
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	15,421	0	0	0	0	15,421
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.6	0.0	0.0	0.0	0.0	2.6
5B - Man Care Arngmt	2.9	0.0	0.0	0.0	0.0	2.9
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.9	0.0	0.0	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	87	0	0	0	0	87
6B - Man Care Arngmt	5,118	0	0	0	0	5,118
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	5,205	0	0	0	0	5,205

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 1 - 5						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	1,114	25	8	0	0	1,147
1B - Man Care Arngmt	26,324	155	77	0	0	26,556
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	27,438	180	85	0	0	27,703
2. Unduplicated # New Enrollees						
2A - Fee For Service	19	0	0	0	0	19
2B - Man Care Arngmt	338	1	3	0	0	342
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	357	1	3	0	0	361
3. Unduplicated # Disenrollees						
3A - Fee For Service	204	0	2	0	0	206
3B - Man Care Arngmt	539	1	4	0	0	544
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	743	1	6	0	0	750
4. # Member Months Enrollment						
4A - Fee For Service	3,143	75	23	0	0	3,241
4B - Man Care Arngmt	78,199	463	226	0	0	78,888
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	81,342	538	249	0	0	82,129
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.8	3.0	2.9	0.0	0.0	2.8
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	973	25	7	0	0	1,005
6B - Man Care Arngmt	25,960	154	73	0	0	26,187
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	26,933	179	80	0	0	27,192

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 6 - 12						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	1,146	82	30	0	0	1,258
1B - Man Care Arngmt	30,300	268	66	0	0	30,634
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	31,446	350	96	0	0	31,892
2. Unduplicated # New Enrollees						
2A - Fee For Service	13	0	0	0	0	13
2B - Man Care Arngmt	298	2	0	0	0	300
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	311	2	0	0	0	313
3. Unduplicated # Disenrollees						
3A - Fee For Service	27	1	1	0	0	29
3B - Man Care Arngmt	402	7	5	0	0	414
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	429	8	6	0	0	443
4. # Member Months Enrollment						
4A - Fee For Service	3,401	244	89	0	0	3,734
4B - Man Care Arngmt	90,324	792	193	0	0	91,309
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	93,725	1,036	282	0	0	95,043
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	3.0	3.0	0.0	0.0	3.0
5B - Man Care Arngmt	3.0	3.0	2.9	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	1,128	81	29	0	0	1,238
6B - Man Care Arngmt	30,026	261	61	0	0	30,348
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	31,154	342	90	0	0	31,586

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 13 - 18						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	913	99	22	0	0	1,034
1B - Man Care Arngmt	18,686	176	50	0	0	18,912
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	19,599	275	72	0	0	19,946
2. Unduplicated # New Enrollees						
2A - Fee For Service	15	0	0	0	0	15
2B - Man Care Arngmt	199	1	1	0	0	201
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	214	1	1	0	0	216
3. Unduplicated # Disenrollees						
3A - Fee For Service	24	0	3	0	0	27
3B - Man Care Arngmt	272	3	0	0	0	275
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	296	3	3	0	0	302
4. # Member Months Enrollment						
4A - Fee For Service	2,698	297	62	0	0	3,057
4B - Man Care Arngmt	55,671	525	150	0	0	56,346
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	58,369	822	212	0	0	59,403
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	3.0	2.8	0.0	0.0	3.0
5B - Man Care Arngmt	3.0	3.0	3.0	0.0	0.0	3.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	894	99	19	0	0	1,012
6B - Man Care Arngmt	18,512	174	50	0	0	18,736
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	19,406	273	69	0	0	19,748

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: DS (Dental-only Supplmental Coverage)						
Age Range: 19 - 20						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	0	0	0	0	0	0
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	0	0	0	0	0	0
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
5. Average # Months (Line 4/1)						
5A - Fee For Service	0.0	0.0	0.0	0.0	0.0	0.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	0	0	0	0	0	0
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 0 - 1						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	14	0	0	0	0	14
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	14	0	0	0	0	14
2. Unduplicated # New Enrollees						
2A - Fee For Service	0	0	0	0	0	0
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
3. Unduplicated # Disenrollees						
3A - Fee For Service	0	0	0	0	0	0
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	0	0	0	0	0	0
4. # Member Months Enrollment						
4A - Fee For Service	42	0	0	0	0	42
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	42	0	0	0	0	42
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	0.0	0.0	0.0	0.0	3.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	0.0	0.0	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	14	0	0	0	0	14
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	14	0	0	0	0	14

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 1 - 5						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	314	31	9	0	0	354
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	314	31	9	0	0	354
2. Unduplicated # New Enrollees						
2A - Fee For Service	2	0	0	0	0	2
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	2	0	0	0	0	2
3. Unduplicated # Disenrollees						
3A - Fee For Service	10	1	2	0	0	13
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	10	1	2	0	0	13
4. # Member Months Enrollment						
4A - Fee For Service	923	91	26	0	0	1,040
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	923	91	26	0	0	1,040
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.9	2.9	2.9	0.0	0.0	2.9
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.9	2.9	2.9	0.0	0.0	2.9
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	304	30	8	0	0	342
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	304	30	8	0	0	342

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 6 - 12						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	975	101	33	0	0	1,109
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	975	101	33	0	0	1,109
2. Unduplicated # New Enrollees						
2A - Fee For Service	8	0	0	0	0	8
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	8	0	0	0	0	8
3. Unduplicated # Disenrollees						
3A - Fee For Service	17	3	1	0	0	21
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	17	3	1	0	0	21
4. # Member Months Enrollment						
4A - Fee For Service	2,894	297	98	0	0	3,289
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	2,894	297	98	0	0	3,289
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	2.9	3.0	0.0	0.0	3.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	2.9	3.0	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	963	98	32	0	0	1,093
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	963	98	32	0	0	1,093

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 13 - 18						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	870	154	29	0	0	1,053
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	870	154	29	0	0	1,053
2. Unduplicated # New Enrollees						
2A - Fee For Service	10	0	0	0	0	10
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	10	0	0	0	0	10
3. Unduplicated # Disenrollees						
3A - Fee For Service	22	2	3	0	0	27
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	22	2	3	0	0	27
4. # Member Months Enrollment						
4A - Fee For Service	2,572	459	84	0	0	3,115
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	2,572	459	84	0	0	3,115
5. Average # Months (Line 4/1)						
5A - Fee For Service	3.0	3.0	2.9	0.0	0.0	3.0
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	3.0	3.0	2.9	0.0	0.0	3.0
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	854	152	26	0	0	1,032
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	854	152	26	0	0	1,032

Department of Health and Human Services
Centers for Medicare & Medicaid Services **Transaction File**

Children's Health Insurance Program
Number of Children Served in Medicaid Program (Informational)

State: Rhode Island **Quarter:2/2018**

Information Category: ESI (Employer Sponsored Insurance)						
Age Range: 19 - 20						
	Percentage of FPL					
	0-133	134-200	201-250	251-300	301	Total
	(A)	(B)	(C)	(D)	(E)	(F)
1. Unduplicatd # Ever Enrolled						
1A - Fee For Service	112	34	14	0	0	160
1B - Man Care Arngmt	0	0	0	0	0	0
1C - Pri Care CA Mgt	0	0	0	0	0	0
Total	112	34	14	0	0	160
2. Unduplicated # New Enrollees						
2A - Fee For Service	7	0	0	0	0	7
2B - Man Care Arngmt	0	0	0	0	0	0
2C - Pri Care CA Mgt	0	0	0	0	0	0
Total	7	0	0	0	0	7
3. Unduplicated # Disenrollees						
3A - Fee For Service	25	20	9	0	0	54
3B - Man Care Arngmt	0	0	0	0	0	0
3C - Pri Care CA Mgt	0	0	0	0	0	0
Total	25	20	9	0	0	54
4. # Member Months Enrollment						
4A - Fee For Service	296	81	29	0	0	406
4B - Man Care Arngmt	0	0	0	0	0	0
4C - Pri Care CA Mgt	0	0	0	0	0	0
Total	296	81	29	0	0	406
5. Average # Months (Line 4/1)						
5A - Fee For Service	2.6	2.4	2.1	0.0	0.0	2.5
5B - Man Care Arngmt	0.0	0.0	0.0	0.0	0.0	0.0
5C - Pri Care CA Mgt	0.0	0.0	0.0	0.0	0.0	0.0
Total	2.6	2.4	2.1	0.0	0.0	2.5
6. # of Children Enrolled at Last Day of Quarter						
6A - Fee For Service	90	17	6	0	0	113
6B - Man Care Arngmt	0	0	0	0	0	0
6C - Pri Care CA Mgt	0	0	0	0	0	0
Total	90	17	6	0	0	113

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Transaction file

CHIP Statistical Enrollment Data System

State: Rhode Island

Quarter: 2/2018

Gender, Race, Ethnicity	21E Enrolled	64.21E Enrolled	Total CHIP Enrolled	64.EC Enrolled	21PW Enrolled
Gender					
1 - Female	801	14867	15668	50472	659
2 - Male	0	14,959	14,959	53,340	0
3 - Unspecified Gender	0	0	0	0	0
Race					
1 - White	62	9,981	10,043	25,402	224
2 - Black or African American	40	2,126	2,166	7,475	48
3 - American Indian or Alaska Native	1	171	172	721	6
4 - Asian Indian	6	56	62	514	3
5 - Chinese	0	114	114	506	4
6 - Filipino	0	0	0	0	0
7 - Japanese	0	0	0	1	0
8 - Korean	0	0	0	0	0
9 - Vietnamese	0	0	0	0	0
10 - Other Asian	0	0	0	0	0
11 - Asian Unknown	0	0	0	0	0
12 - Native Hawaiian	0	0	0	0	0
13 - Guamanian or Chamorro	0	0	0	0	0
14 - Samoan	0	0	0	0	0
15 - Other Pacific Islander	0	0	0	0	0
16 - Native Hawaiian or Other Pacific Islander Unknown	0	0	0	0	0
17 - Some other race	601	14,605	15,206	52,946	298
18 - Two or more races (regardless of ethnicity)	0	0	0	0	0
19 - Unspecified Race	91	2,773	2,864	16,247	76
Ethnicity					
1 - Not of Hispanic, Latino/a, or Spanish origin	0	0	0	0	0
2 - Mexican, Mexican American, Chicano/a	0	0	0	0	0
3 - Puerto Rican	0	0	0	0	0
4 - Cuban	0	0	0	0	0
5 - Another Hispanic, Latino, or Spanish Origin	0	0	0	0	0
6 - Hispanic or Latino Unknown	0	0	0	0	0
7 - Unspecified Ethnicity	801	29,826	30,627	103,812	659

3/20/2018

2018 – Caseload Estimating Conference Meeting Schedule for April testimony

Date	Time
February 20	9:00 – 10:00
February 27	9:00 – 10:00
March 1	2:00 – 3:00
March 6	9:00 – 10:00
March 13	9:00 – 10:00
March 19	3:00 – 4:00
March 20	9:00 – 10:00
March 26	9:00 – 10:00
March 27	12:15 – 1:15
April 3	9:00 – 10:00
April 4	9:00 – 10:00
April 5	10:00 – 11:00
April 6	9:00 – 10:00
April 10	9:00 – 10:00
April 11	9:00 – 10:00
April 12	12:45 – 1:45
April 16	9:00 – 10:00
April 18	9:00 – 10:00
April 19	9:00 – 10:00
April 20 Actual testimony	9:00 – 12:00
April 24	9:00 – 10:00
April 26	9:00 – 10:00
April 27 Follow up testimony	9:00 – 12:00