



# Medicaid Expenditure Report

 SFY 2022

RHODE  
ISLAND

# Purposes of this Report

This Medicaid Expenditure Report contains all components indicated in statute at R.I.G.L. 42-7.2-5, in order to provide a comprehensive overview of all Medicaid expenditures, outcomes, and utilization rates during State Fiscal Year (SFY) 2022.

The goals of this report are to:

- 01

Provide state policymakers with a comprehensive overview of state Medicaid expenditures to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process.
- 02

Summarize Medicaid expenditures for eligible individuals and families covered by the relevant Rhode Island departments.
- 03

Show enrollment and expenditure trends for Medicaid coverage groups by service type, care setting, and delivery mechanism.
- 04

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

# Reporting Methodology & Data Notes

This report is generally based on: (a) Rhode Island’s Medicaid Management Information System (MMIS) extracts that include capitation and other payments to health plans, fee-for-service claims, and provider payouts; (b) summary reports from the State’s accounting system (RIFANS); and (c) financial reporting to CMS.

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

Other data notes:

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

## Definitions

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

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# Summary and Key Findings

## Overview

During SFY 2022, Rhode Island’s Medicaid program provided full medical coverage to **371,000 Rhode Islanders** at some point during the year, with an average monthly enrollment of 347,000 members. Another 15,000 Rhode Islanders received limited benefits from Medicaid.

Overall, Medicaid expenditures **totaled \$3.8 billion** (at a state cost of \$1.3 billion), with nearly **\$3.2 billion in spending on benefits for members receiving full Medicaid benefits** in the state fiscal year.

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

- \$2.8 billion – Executive Office of Health and Human Services (EOHHS)
- \$301 million – Behavioral Healthcare, Developmental Disability, and Hospitals (BHDDH)
- \$59 million – Department of Children, Youth and Families (DCYF)

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

Expenditures in this Report are inclusive of federal funds, general revenues, and restricted receipts. The effective federal share was 65% across the entire Medicaid program.

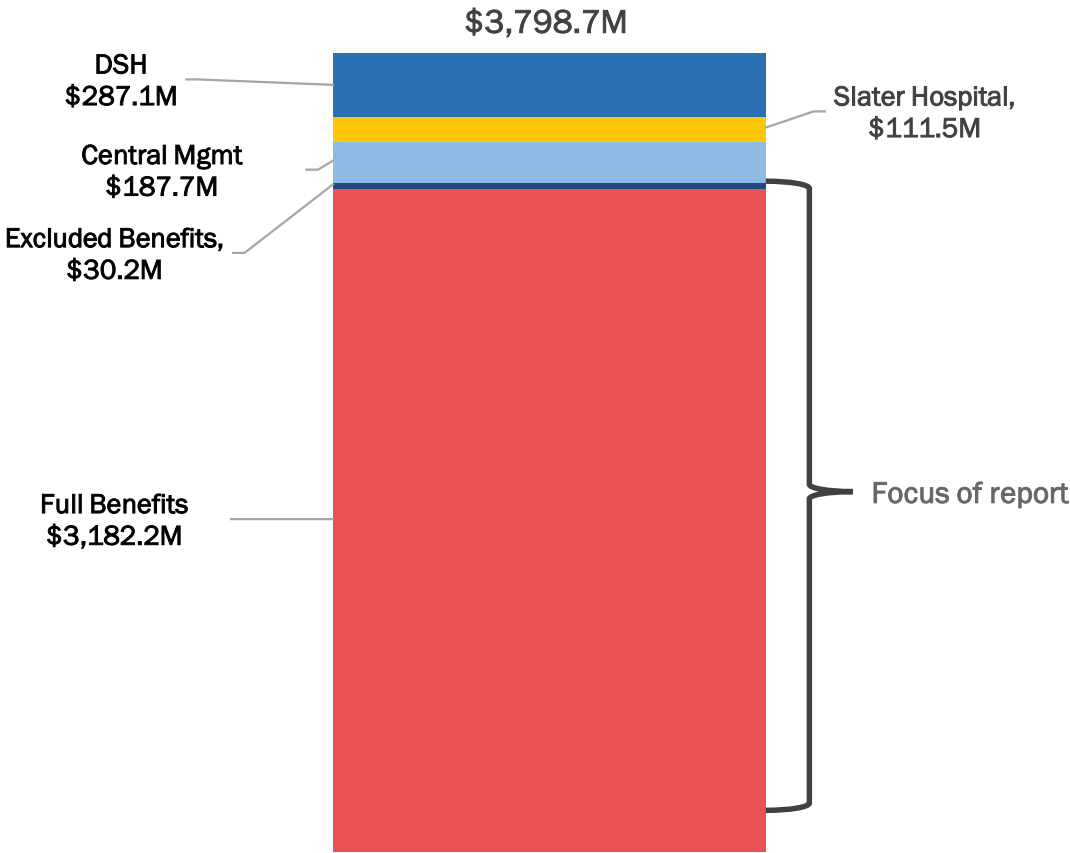
## Key Findings

- Average full benefits’ enrollment increased 6.6% in SFY 2022 over SFY 2021, from 326,000 to 347,000.
- Children and Families comprised 51% of enrollees, followed by Expansion (30%), Adults with Disabilities (9%), Elders (7%) and Children with Special Healthcare Needs (4%).
- 88% of enrollees were in managed care; and three-fifths (60%) of all Medicaid enrollees were in the Accountable Entity (AE) program.
- SFY 2022 per member per month (PMPM) costs increased by 5.2% over SFY 2021 to \$764 PMPM. This is higher than the five-year compounded annual growth rate (CAGR) of 3.3% since SFY 2018.
- The cost of caring for certain populations varies significantly, with Elders and Adults with Disabilities costing two times the average beneficiary and Children and Families costing less than half.
  - Overall, costs are highly skewed: 16% of Medicaid enrollees incurred almost half of claims in SFY 2022.
- Acute services accounted for 56% of SFY 2022 full benefit expenditures, while expenditures on LTSS represented 29%.
- Central management spending of \$188 million accounted for 5.6% of spending on full benefits and 4.9% of overall Medicaid spending.
- COVID-19 began to significantly impact expenditures and enrollment in March 2020, impacting trends and general observations for fiscal year 2022 and when compared to prior fiscal years.

# Overall Medicaid Expenditures

Medicaid expenditures in SFY 2022 totaled \$3.8 billion. Expenditures on fully covered populations totaled approximately \$3.2 billion.

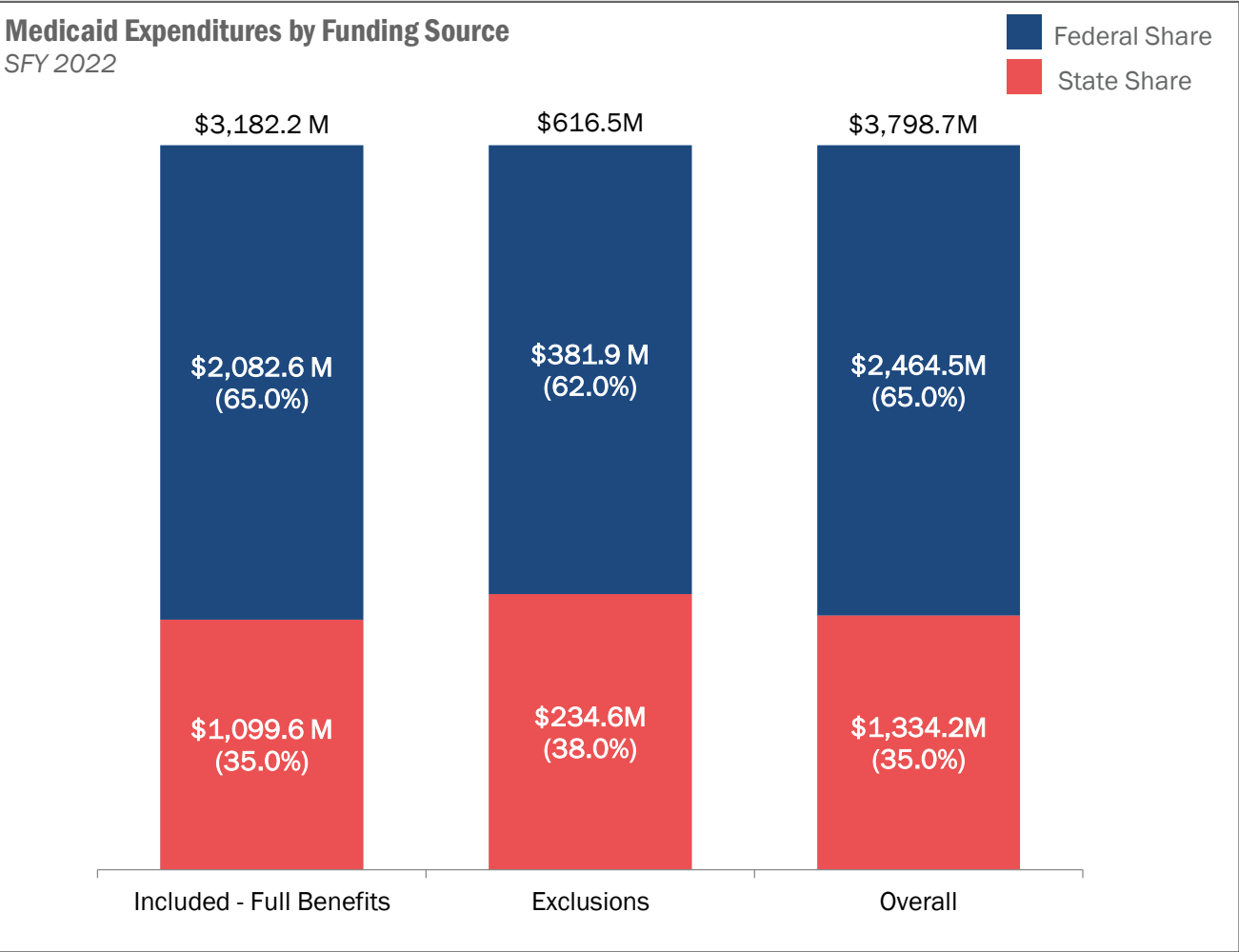
Overall Medicaid Expenditures SFY 2022	Members:	Full Benefits	347,167
		Limited Benefits	12,488



- Services for Members with Full Benefits cost \$3,182.2 million and are expenditures for services delivered to enrollees who received comprehensive medical coverage through Medicaid and are the primary focus of this report.
- Central Management Costs of \$187.7 million are expenditures related to managing the Medicaid program, such as paying for technology infrastructure, processing claims, and state personnel services for staff that oversee the program. These expenses are **excluded** from this report. Lastly, Managed Care Organization (MCO) *administrative costs/taxes are not reflected in Central Management, but instead reflected in the total costs for members with full benefits and are included in this Report.*
- Other notable exclusions totaling, \$429.3 million, include :
  - Disproportionate Share Hospitals (DSH):** Statutorily required payments to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety net hospitals.
  - Costs Not Otherwise Matchable (CNOM) and Partial Emergency Services:** Limited benefits not traditionally eligible for federal Medicaid funding match, that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible. This includes services covered by OHA. Additionally, emergency services for low-income Rhode Islander’s who would be eligible for Medicaid but for their immigration status are included here.
  - Partial Duals:** Medicare premium payments for certain qualifying members with limited incomes who are not otherwise eligible for Medicaid services.
  - Recoveries** are collections (usually against the estates of members who had received long term care services and supports) and are partial offsets to cost incurred by the State on these clients behalf.

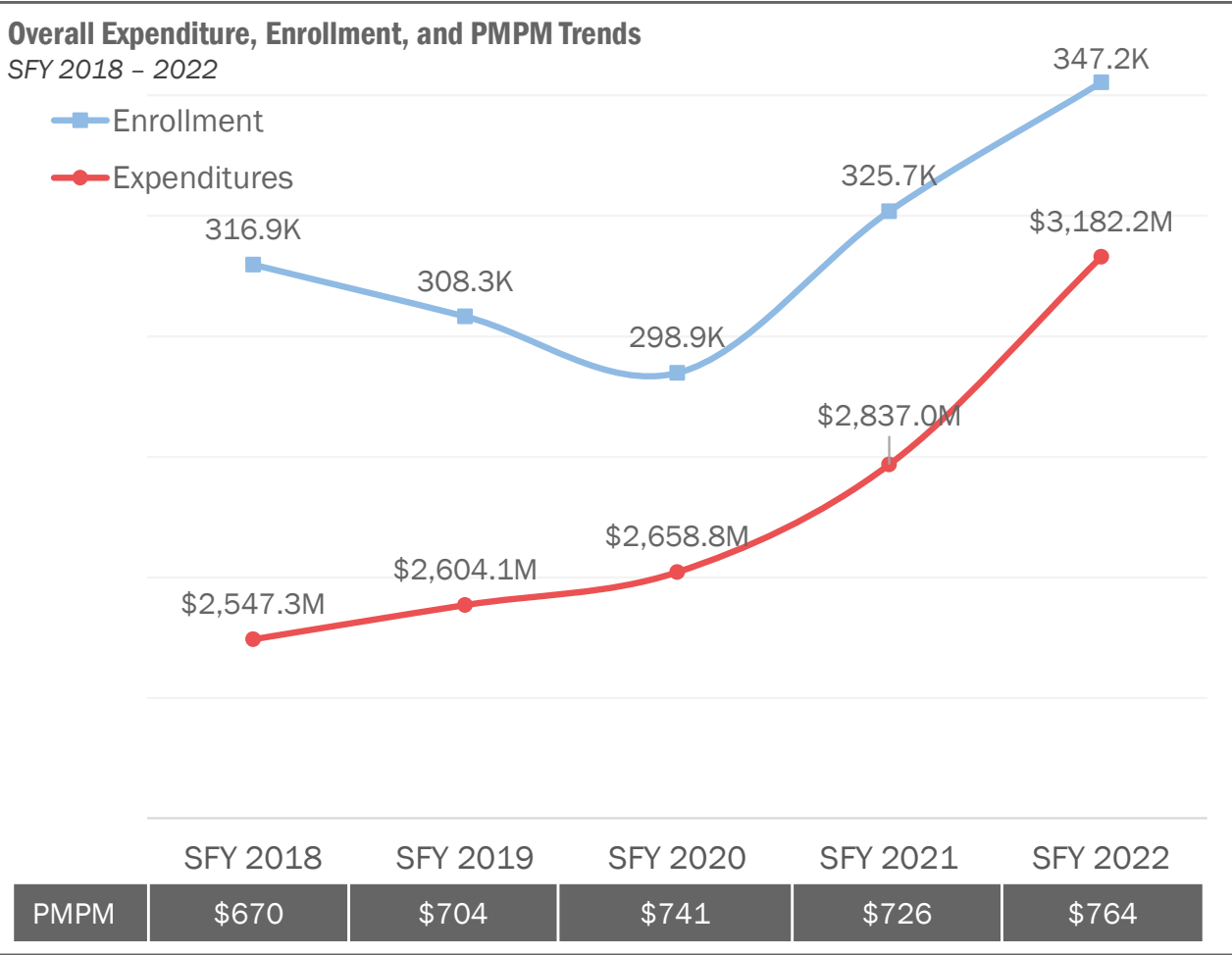
# Expenditures by Funding Source

Medicaid expenditures on full benefits totaled \$3.2 billion at a direct cost of \$1.1 billion to state taxpayers in SFY 2022.



- The largest source of funding for the state share is general revenue appropriations to agencies. Other sources of state share include:
  - Local Education Agencies’ Certified Public Expenditures.
  - Restricted Receipt spending, including Health System Transformation Project (HSTP) and Children’s Health Account.
  - In March 2021, EOHHS began to claim additional revenues against certain home and community-based services (HCBS) and behavioral health expenditures. These revenues were deposited into a Restricted Receipt account for future investments into HCBS and behavioral health services.
- Note that in SFY 2022, not all expenditures for Eleanor Slater Hospital were submitted as claims or matched with federal funding due to concerns about complying with federal regulations on Institutes of Mental Disease. Technically these expenditures are not Medicaid; however, for comparison with prior years this spending remains in this report and are treated as State only costs and included in the “Exclusions.”
- As a result of the declaration by the federal government of a Public Health Emergency related to COVID-19, beginning on January 1, 2020, Rhode Island became eligible for a temporary increase to the Federal Medical Assistance Percentage (FMAP): an increase of 6.20% for Regular Medicaid and increase of 4.34% for CHIP.
  - Medicaid Expansion and Central Management expenditures—the former already eligible for 90% federal financing—were not eligible for this increased FMAP.

# Five-Year Trends: Expenditures, Enrollment, and PMPM



Expenditures

- In SFY 2022, expenditures increased by \$345.2 million or 12.2% over SFY 2021; more than the five-year compounded annual growth rate of 5.7%.

Enrollment

- Average enrollment increased in SFY 2022 by 6.6% over the SFY 2021 average, more than the five-year compounded annual growth rate of 2.3%.
- This increase in the average monthly enrollment over the fiscal year reflects the sharp increase that started in March 2020, following the declaration by the federal government of a Public Health Emergency for COVID-19, which included a moratorium on most regular termination activities.
- Most of the growth in SFY 2022 over SFY 2021 was in Expansion Adults and Children and Families that grew in their average monthly enrollment by 12,131 (13%) and 7,713 (5%), respectively, over FY 2021.

PMPM

- Overall PMPM costs increased by an average of 3% in SFY 2022 over SFY 2021, ranging from than 0% for Expansion Adults and to 5% for Children and Families and Elders.



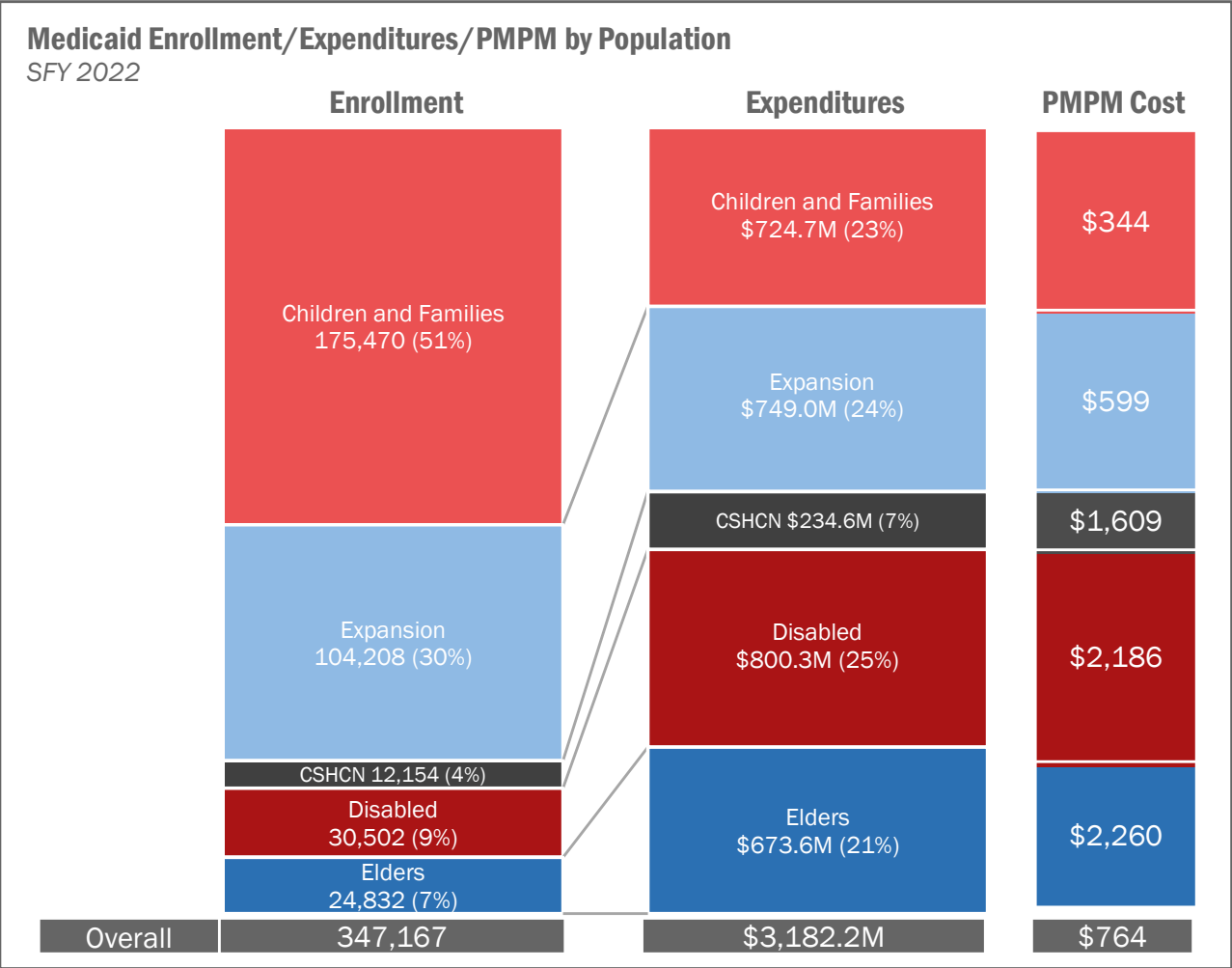
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# Expenditures by Population Group

Medicaid expenditures in SFY 2022 totaled \$3.1 billion. Expenditures for fully covered populations totaled approximately \$3.1 billion.



Medicaid serves five primary populations:

- **Elders** are enrollees over age 65. 94% of this population are also covered by Medicare. Their average SFY 2022 PMPM cost was \$2,260. Nursing facilities account for 49% of their expenditures.
- **Adults with Disabilities** are enrollees under age 65 with identified disabilities and 48% are also covered by Medicare. Their average cost was \$2,186 PMPM. I/DD providers account for 26% of their expenditures.
- **CSHCN** are enrollees under age 21 who have higher needs physically, developmentally, behaviorally or emotionally. Their average PMPM costs were \$1,609 with professional services accounting for 38% of expenditures.
- **Expansion** enrollees are low-income adults without dependent children. These members cost \$599 PMPM. Hospital services account for 44% and 26% of this population.
- **Children and Families** enrollees are qualified children, parents and pregnant women. They have average costs of \$344 PMPM. Hospital and professional services account for 43% and 27% of their expenditures, respectively.

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

Overall, Rhode Island provided Medicare assistance to 51,388 Rhode Islanders, including 43,244 Dual-eligible clients with full Medicaid benefits.

# Expenditures by Population Group, Continued

Between SFY 2018 and SFY 2022, annual expenditures, enrollment, and PMPM increased modestly: expenditures by 5.7%, enrollment by 2.3%, and PMPM by 3.3%.

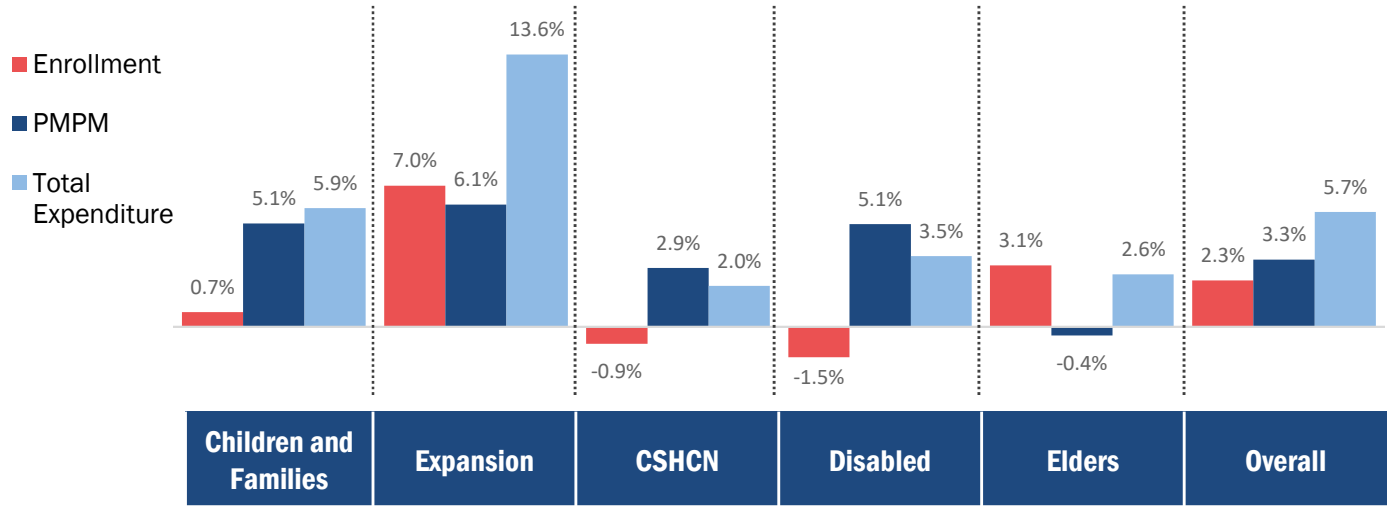
## Current Expenditures

SFY 2022

	Children and Families	Expansion	CSHCN	Disabled	Elders	Overall
Members	175,470	104,208	12,154	30,502	24,832	347,166
PMPM	\$344	\$599	\$1,609	\$2,186	\$2,260	\$764
Expenditure	\$724.7M	\$749.0M	\$234.6M	\$7800.3M	\$673.6M	\$3,182.2M

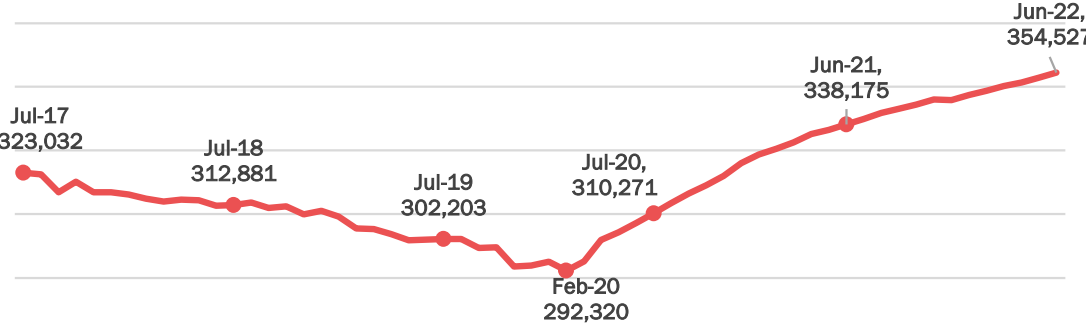
## Expenditures - 5-Year Compounded Annual Growth Rate

SFY 2018-2022



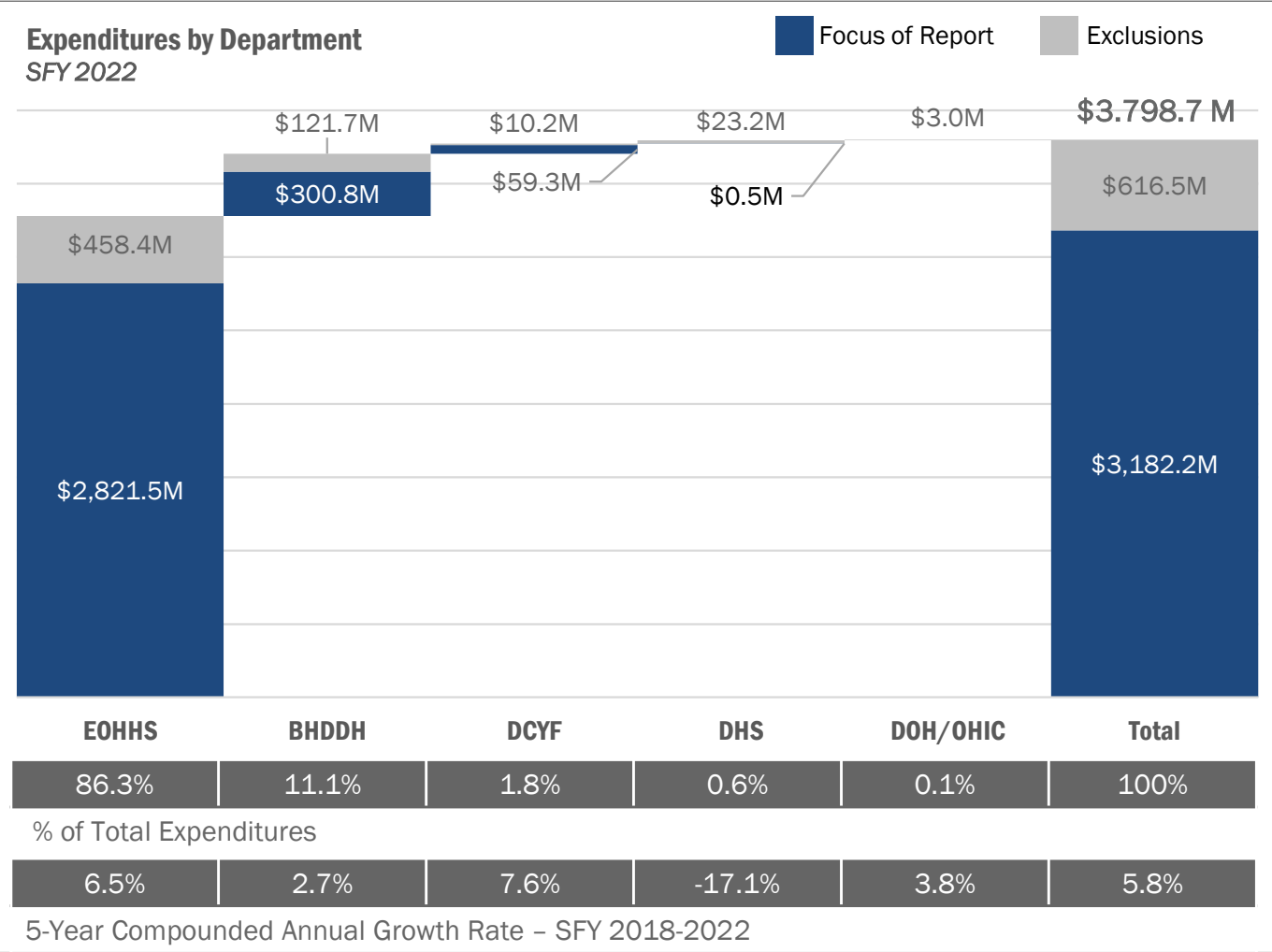
- Between SFY 2018 – 2022, the population groups experienced the following:
  - Expansion enrollment** experienced the largest increases with enrollments and expenditures increasing by 7% and 13.6% annually.
  - Elder** enrollment increased 3.1% annually and overall costs by 2.6% annually. **Disabled** enrollment decreased by 1.5% annually, while expenditures increased 3.5% annually.
  - Children and Families** spending increased 5.9% annually, driven primarily by price factors as average enrollment increased very modestly (<1 %) over the five-year period.
  - CSHCN** enrollment declined modestly (–1%) and the group’s price trends remained below the average across all population groups besides Elders.
- It remains noteworthy that these moderate five-year trends hide the more recent impact of COVID-19 and the nation’s Public Health Emergency on Medicaid caseload. Since February 2020, Rhode Island has seen a net 15.6% increase in members, reversing what had been a steady decline in overall caseload. Below is a summary of Medicaid enrollment with full benefits over the past four fiscal years:

### Medicaid Enrollment – Full Benefits



# Expenditures by Department

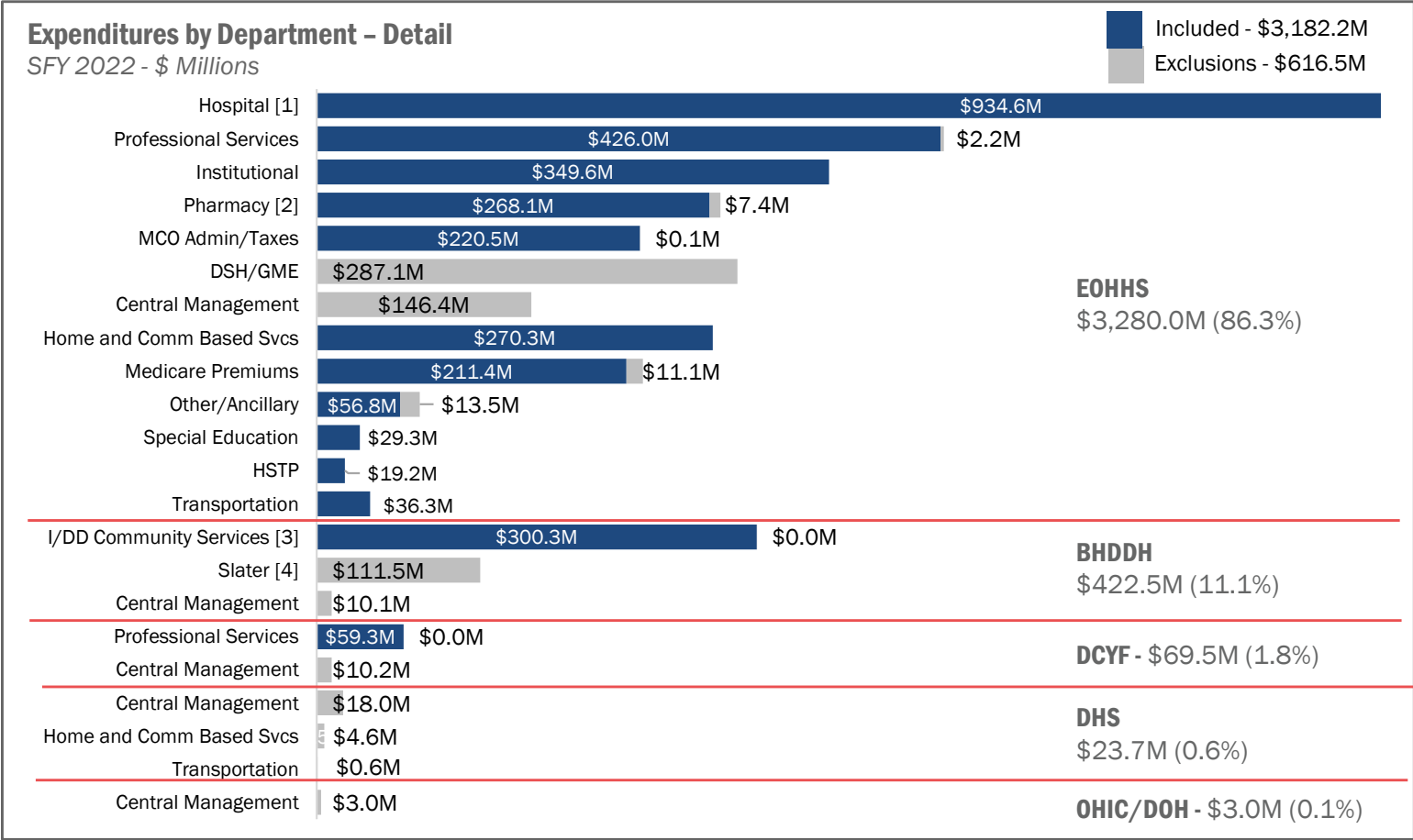
Four departments in Rhode Island are appropriated funding for the Medicaid program. Over 85% of funds are appropriated directly to EOHHS.



- EOHHS is the administrator for the Medicaid program and is known as the Single State Agency for purposes of drawing down federal funds. The Single State Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
  - Overall Medicaid expenditures increased from SFY 2018 to 2022 by 5.8% per annum, with EOHHS spending increasing by 6.5% per annum.
- In SFY 2022, the other departments overseen by EOHHS in administering the Medicaid program, included BHDDH, DCYF, and DHS.
  - Additionally, certain administrative functions performed by the Office of Health Insurance Commissioner and Department of Health are charged to Medicaid.
- Central management expenses supporting the Medicaid program (i.e., were eligible for federal reimbursement from Medicaid) totaled \$187.7 million across all agencies.
- Please note that the “grey” expenditures in the chart at the left are excluded; this includes all benefit expenditures by the DHS and some expenditures by EOHHS that do not go toward benefits for fully covered populations, and thus are excluded from benefit analyses in this report. Other exclusions are detailed on the next slide.

# Expenditures by Department - Detail

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



- Overall, with total spending of \$3.2 billion, EOHHS spending accounts for 86.3% of Medicaid expenditures. The biggest portion (25%) of that is for hospital-based services. Professional services accounts for 11% and institutional care (inclusive of Nursing Facilities and Hospice) accounts for 9% of EOHHS benefit expenditures.
  - Expenditures for Medicaid-eligible special education services include the federal share funded in the EOHHS budget and the matching funds for those services, which are financed by each local education agency.
- BHDDH expenditures of \$422.5 million account for 11.1% of state Medicaid spending and include three primary areas: both residential services and community-based services for persons with intellectual and developmental disabilities, as well as Eleanor Slater Hospital.
  - In SFY 2022, not all expenditures for Eleanor Slater Hospital (ESH) were Medicaid-eligible due to federal regulations pertaining to Institutes of Mental Disease. Nonetheless this report recognizes these expenditures, albeit as “exclusions” to the majority of the Report.
- DCYF accounts for \$69.5 million (1.8%) of Medicaid expenditures. DCYF supports programs serving children in the child welfare system, children in substitute care and children with behavioral health conditions.
- DHS accounts for \$23.7 million of Medicaid expenditures (<1%). Benefit spending is largely for CNOM programs managed by the Office of Healthy Aging designed to forestall the need for persons served to become fully Medicaid eligible.

<sup>1</sup> EOHHS Hospital spending includes acute spending on Inpatient and Outpatient Hospitals, UPL Payments and \$7.1M in spending at Tavares.

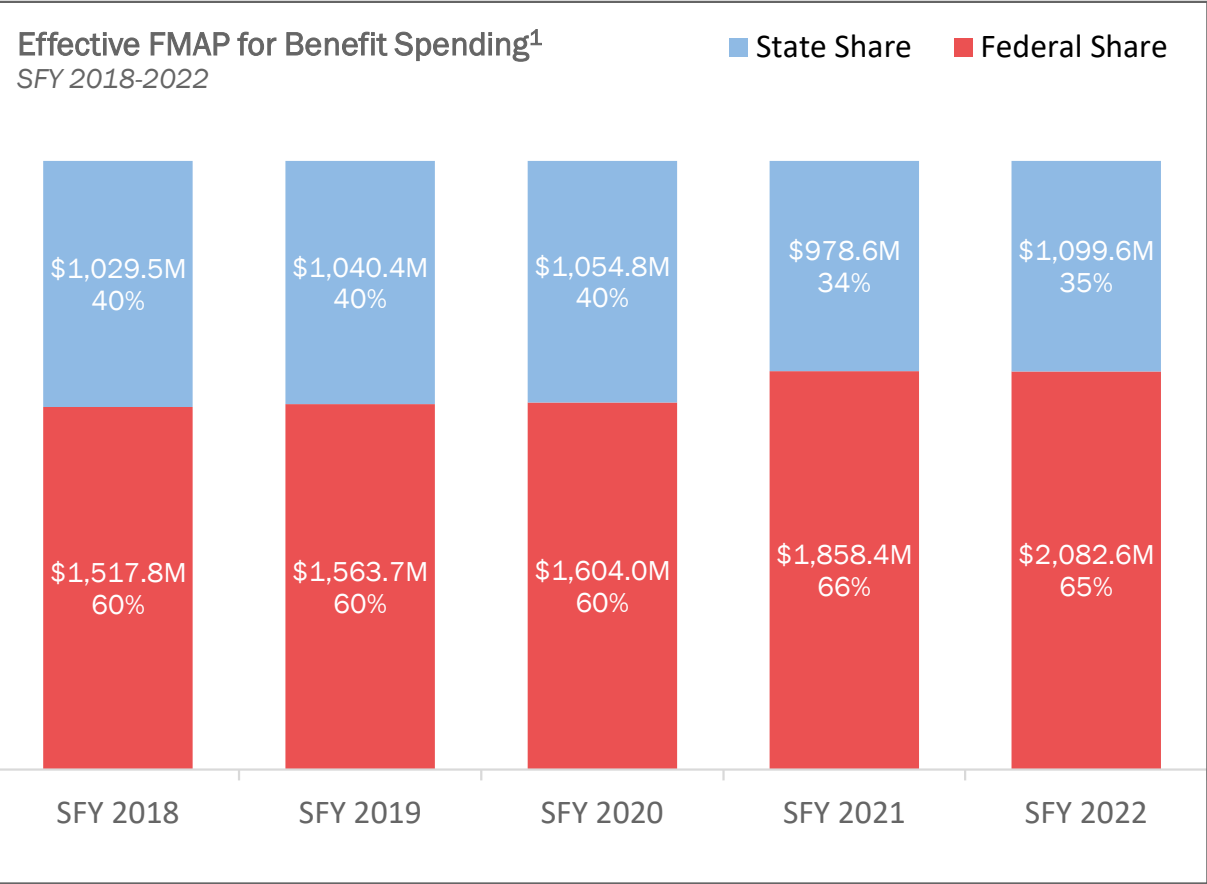
<sup>2</sup> Total Pharmacy includes retail pharmacy, office-administered drugs, and outpatient pharmacy. Costs are net of pharmacy rebates.

<sup>3</sup> I/DD Community includes all residential and rehabilitation services for persons with intellectual and developmental disabilities, including group homes.

<sup>4</sup> Slater expenditures include State-only spending not matchable by CMS in SFY 2022.

# Benefit Spending by Funding Source

Medicaid programs are funded by state and federal dollars. In SFY 2022, Rhode Island paid approximately 35% of all full benefit expenditures (i.e., excluding Limited Benefits and Central Management) using state funds.

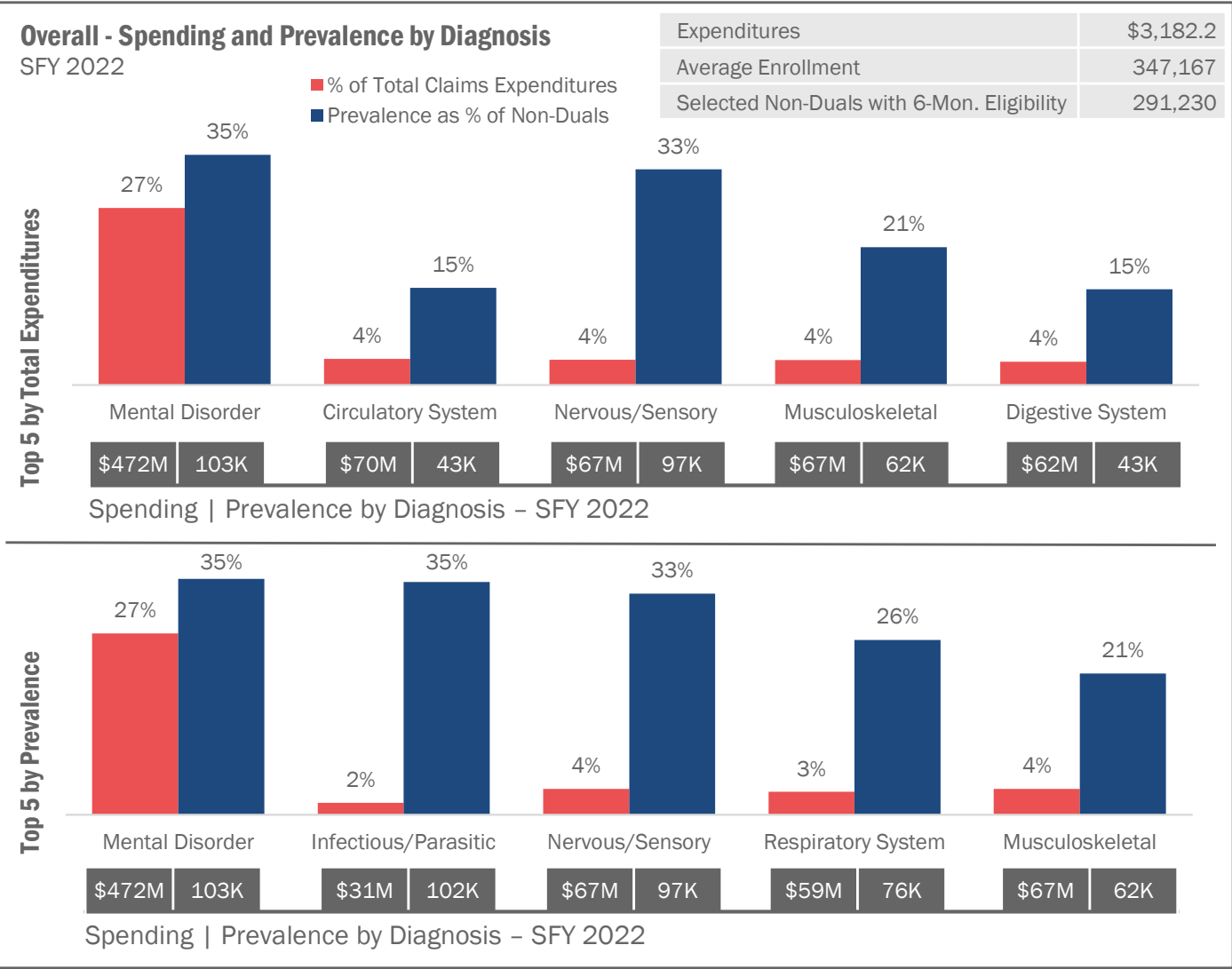


<sup>1</sup> Benefit Spending includes members with full benefits. Does not include Central Management or Limited Benefits expenditures.

- Rhode Island receives different federal matching rates for the Expansion population and non-Expansion population. The effective Federal Medical Assistance Percentage (FMAP) is the weighted average of these federal contributions.
- Federal matching dollars differ based on the population:
  - The Regular FMAP for the Elders, Adults With Disabilities, Children and Families and CSHCN populations is published prospectively by the Department of Health and Human Services and is based on formula that compares the state’s average income to the national average. The Enhanced FMAP for the Children’s Health Insurance Program reflects an adjustment to the state’s Regular FMAP.
  - The Expansion population’s FMAP is consistent across all states and is determined by the ACA.
  - A few small programs receive a 90% match, including the Breast and Cervical Cancer Prevention and Treatment and Extended Family Planning programs.
- The state share for the Special Education program is financed by the local education agencies.
- The Covid-19 Enhanced FMAP has provided significant fiscal relief to Rhode Island:
  - The State Share since pre-pandemic has increased by \$99.1 million (2%), whereas the Federal Share has increased by \$640.59 million (8%).

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

# Expenditures by Diagnoses



- The only diagnosis category that exceeds 10% of Medicaid expenditures is mental or behavioral health, which accounts for at least 27% of expenditures.
  - Prevalence data does not include the Dual population and may understate cost of treating certain conditions.
- Three diagnoses are in the top five in terms of both expenditure and prevalence:
  - Mental or behavioral health
  - Diseases of the nervous system and sense organs, and
  - Musculoskeletal.
- Notes:
  - Prevalence is presented in this report as both a percentage of the CSHCN, Children and Families, Expansion, and Disabled Adults populations with the diagnoses, and as the number of enrollees with the diagnoses.

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

- 35% "prevalence as a % of non-duals" means that among members within the overall population that have at least 6 months of eligibility during the year and do not have Medicare, 35% had claims where "Mental or Behavioral Health" was the primary diagnosis.
- Of the total claims for this population, 27% of their costs were for claims where "Mental or Behavioral Health" was the primary diagnosis.



# Optional vs. Mandatory Expenditures

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

Enrollment and Expenditures by Mandatory vs. Optional Populations and Benefits<sup>1</sup>  
SFY 2022

	Mandatory Populations	Optional Populations	Total
ENROLLMENT	222,186 (64%)	124,981 (36%)	347,167
Expenditures on Mandatory Benefits	\$1,209.2 M (38%)	\$986.5 M (31%)	\$2,195.7 M (69%)
Expenditures on Optional Benefits	\$541.0 M (17%)	\$445.5 M (14%)	\$986.5 M (31%)
TOTAL EXPENDITURES	\$1,750.2 M (55%)	\$1,432.0 M (45%)	\$3,182.2 M

<sup>1</sup> Exhibit is prepared using a proportional allocation of expenditures identified as “optional” or “mandatory” based on share of actual claim amounts for members with full Medicaid benefits identified as being for an “optional” or “mandatory” service category or “optional” or “mandatory” eligibility group.

Pursuant to 42 CFR § 433.400 Continued enrollment for temporary FMAP increase, states are generally **prohibited from reducing any benefit (including imposition of cost shares or elimination of optional benefits)** for Medicaid members prior to the end of the Public Health Emergency without risking loss of federal matching funds. Additionally, due to the maintenance of effort (MOE) provisions contained in the American Rescue Plan Act (ARPA), states may not reduce coverage or eligibility levels for HCBS below those in effect as of April 1, 2021 without risking loss of federal matching funds.

Mandatory Medicaid populations include groups like low-income families, qualified pregnant women and children, and individuals receiving SSI.

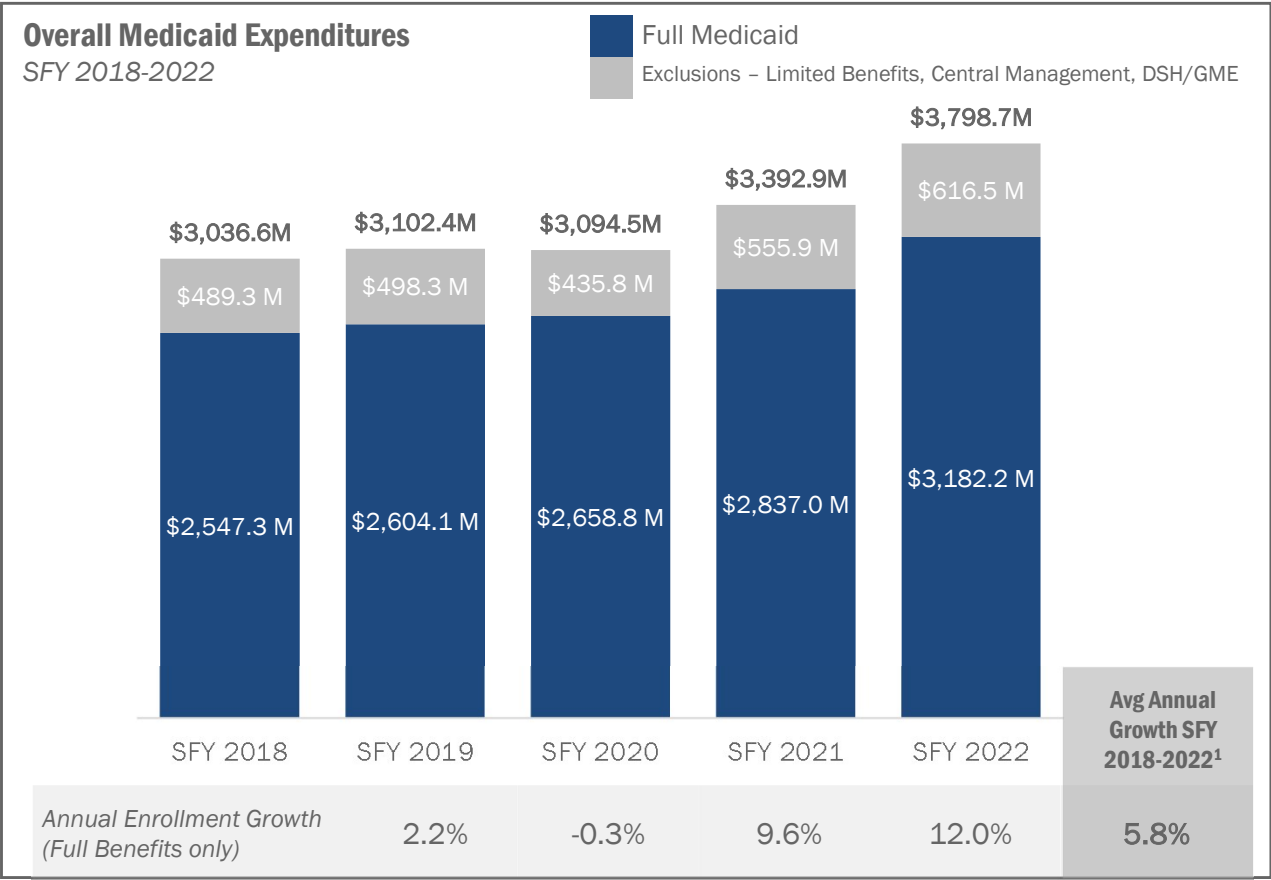
- Optional populations can be covered at the state’s discretion and include adults without dependent children, low-income pregnant women and parents above federal minimum standards, elderly and disabled individuals with incomes above federal minimum standards or who receive LTSS in the community, and enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services.
- In Rhode Island, Expansion members make up most optional members.
- For purposes of this exhibit, CHIP is considered mandatory due to the MOE provisions contained in the HEALTHY KIDS and ACCESS Acts, which extended federal funding for CHIP through FY 2027.
- The list of optional and mandatory Medicaid eligibility pathways is available from CMS at the following link: <https://www.medicaid.gov/sites/default/files/2019-12/list-of-eligibility-groups.pdf>
- The list of optional and mandatory Medicaid benefits is available from CMS at the following link: <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html>
- In Rhode Island, the top optional benefits based on FY 2022 claims include:
  - I/DD Community Services (\$300.3 million)
  - Pharmacy (\$268 net of rebates)
  - Home and Community Based Services (HCBS) for LTSS members (\$270.3 million)
  - Hospice (\$26.3 million)
- Consistent with Medicaid’s Early and Periodic Screening, Diagnostic Testing (EPSDT) benefit requirement, all services for children under 21 are treated as “mandatory.”

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



# Trends: Expenditures

Overall Medicaid expenditures have overall cost trend increases of 12% in SFY 2022 and average 5.8% over the past five fiscal years.



<sup>1</sup> Calculated as compounded annual growth rate (CAGR) over period SFY 2018-2022 as shown.

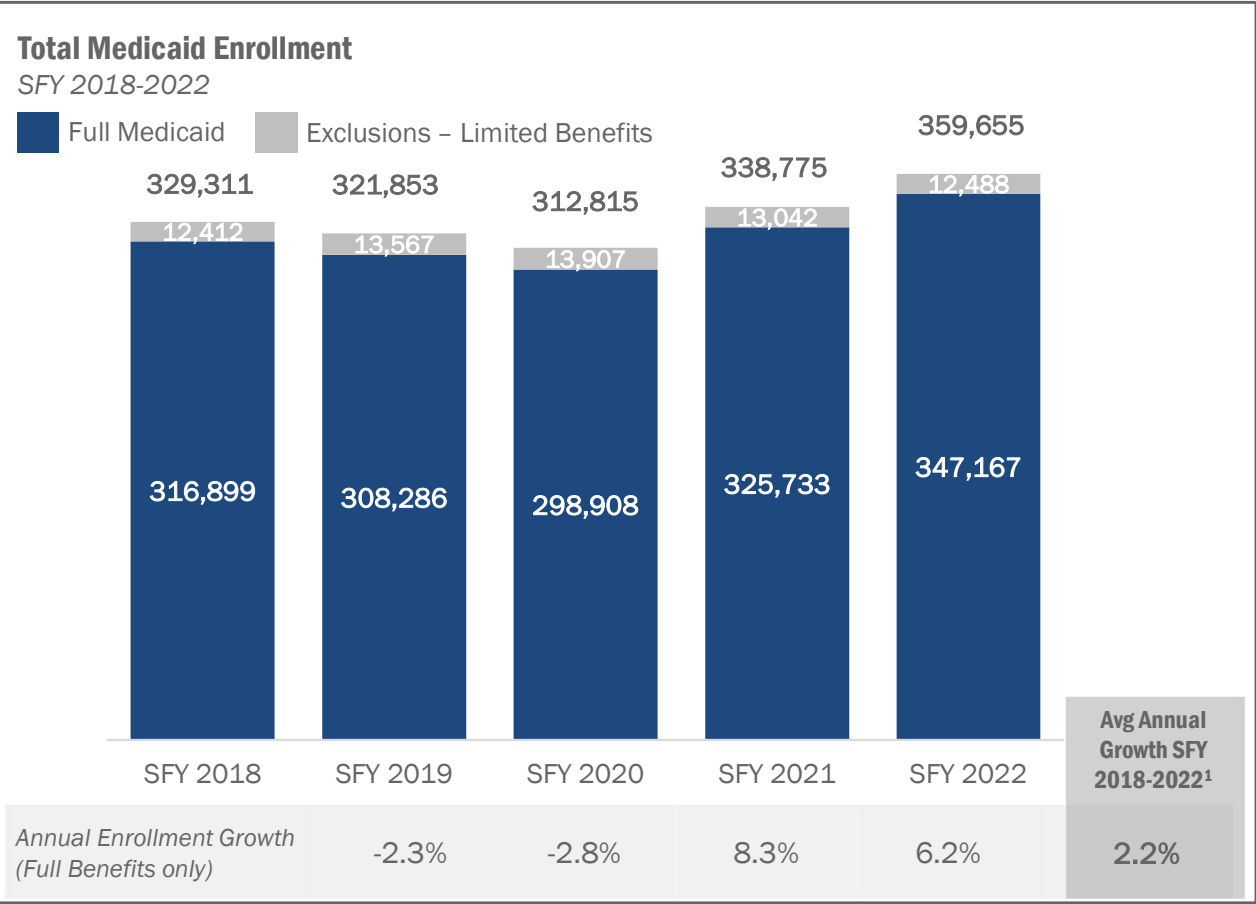
- Overall spending on benefits for fully-covered members increased by 12% in SFY 2022 to \$3,798.7 million.
  - The increase in spending is attributable to a sharp increase in enrollment in March 2020, following the declaration by the federal government of a Public Health Emergency for COVID-19 and a moratorium on most regular termination activities. The PHE continued through SFY 2022.
  - Also related to COVID-19, a significant shift in LTSS spending occurred in the last quarter of SFY 2020 that carried into SFY 2022:
    - Compared to SFY 2018, spending at institutional settings (i.e., nursing facilities, hospice, and at Tavares Pediatric Center) fell by \$21.0 million in SFY 2022, from \$377.7 million to \$356.7 million. This, however, was offset with a significant increase of \$146.2 million in community LTSS spending, from \$425.0 million in SFY 2018 to \$571.2 million in SFY 2022.

### Spending Comparison by Eligibility Group, SFY 2018 to SFY 2022

	SFY 2018	SFY 2022	Annual Growth Rate SFY 2018-2022
Children and Families	\$575.7M	\$724.7M	5.9%
CSHCN	\$216.5M	\$234.6M	2.0%
Expansion	\$450.3M	749.0M	13.6%
Disabled Adults	\$697.0M	\$7800.3M	3.5%
Elders	\$607.8M	\$673.6M	2.6%
Overall	\$2,547.3M	\$3,182.2M	5.8%

# Trends: Average Monthly Enrollment

After years of decline, average enrollment continued to increased in SFY 2022. This decline began reversing in March 2020.



<sup>1</sup> Calculated as compounded annual growth rate (CAGR) over period SFY 2018-2022 as shown.

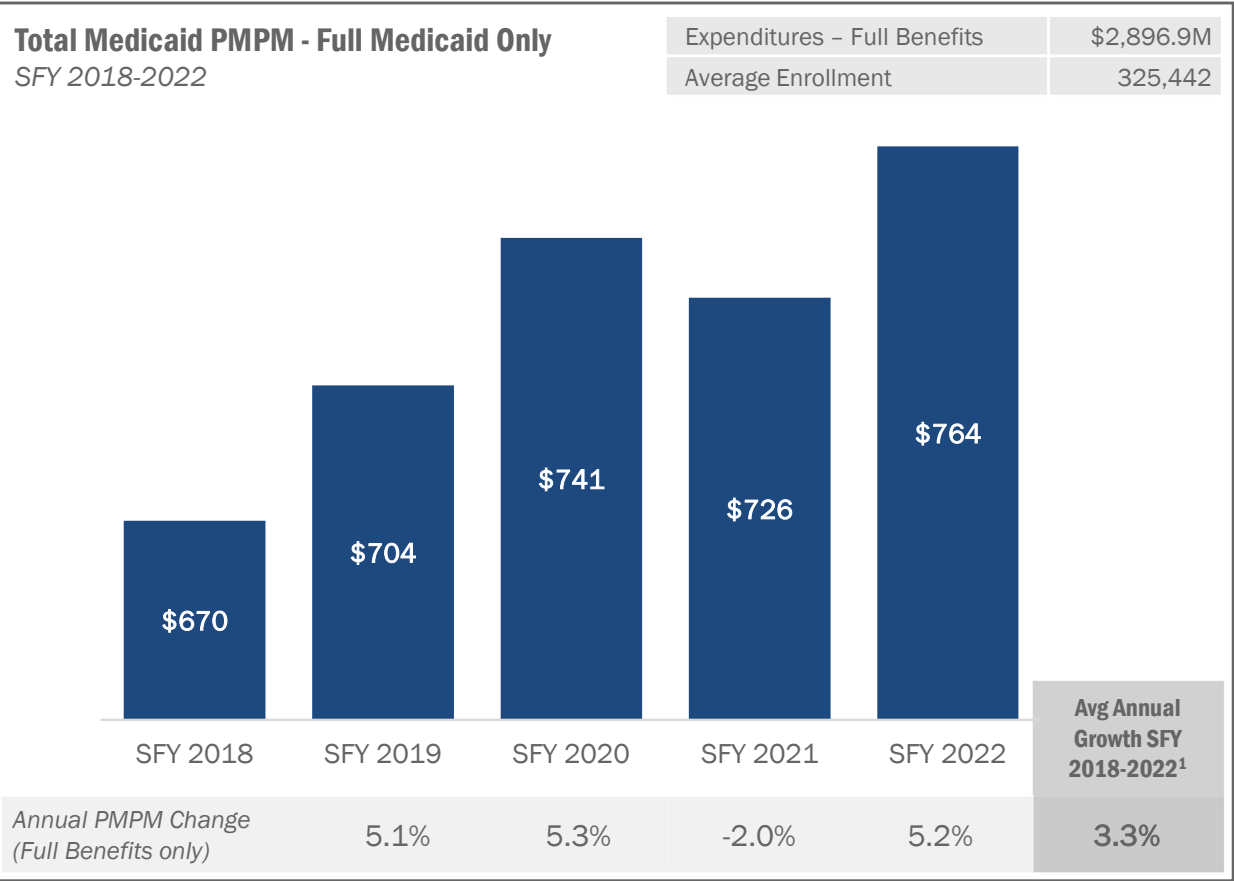
- Average monthly enrollment increased 6.2% in SFY 2022 after the increase seen in SFY 2021.
- The increased enrollment came during the continuation of the Public Health Emergency which included a moratorium on terminations that became effective March 2020:
  - As of February 2020, enrollment of Rhode Islanders with full Medicaid benefits had declined to 292,320, a reduction of 9.5% from Rhode Island’s peak enrollment of 322,853 in June 2017.
  - By June 2022, enrollment of fully-covered Medicaid beneficiaries had rebounded to 354,527, an increase of 21.3% from February 2020.

Enrollment Comparison, by Eligibility Group, SFY 2018 to SFY 2022

	SFY 2018	SFY 2022	Annual Growth Rate SFY 2018-2022
Children and Families	170,477	175,470	0.7%
CSHCN	12,581	12,154	-0.9%
Expansion	79,381	104,208	7.0%
Disabled Adults	32,447	30,502	-1.5%
Elders	22,014	24,832	3.1%
Overall	316,899	347,167	2.2%

# Trends: PMPM

Average PMPM increased over 5% in SFY 2022; and had an average annual growth of 3.3% since SFY 2018.



<sup>1</sup> Calculated as compounded annual growth rate (CAGR) over period SFY 2018-2022 as shown.

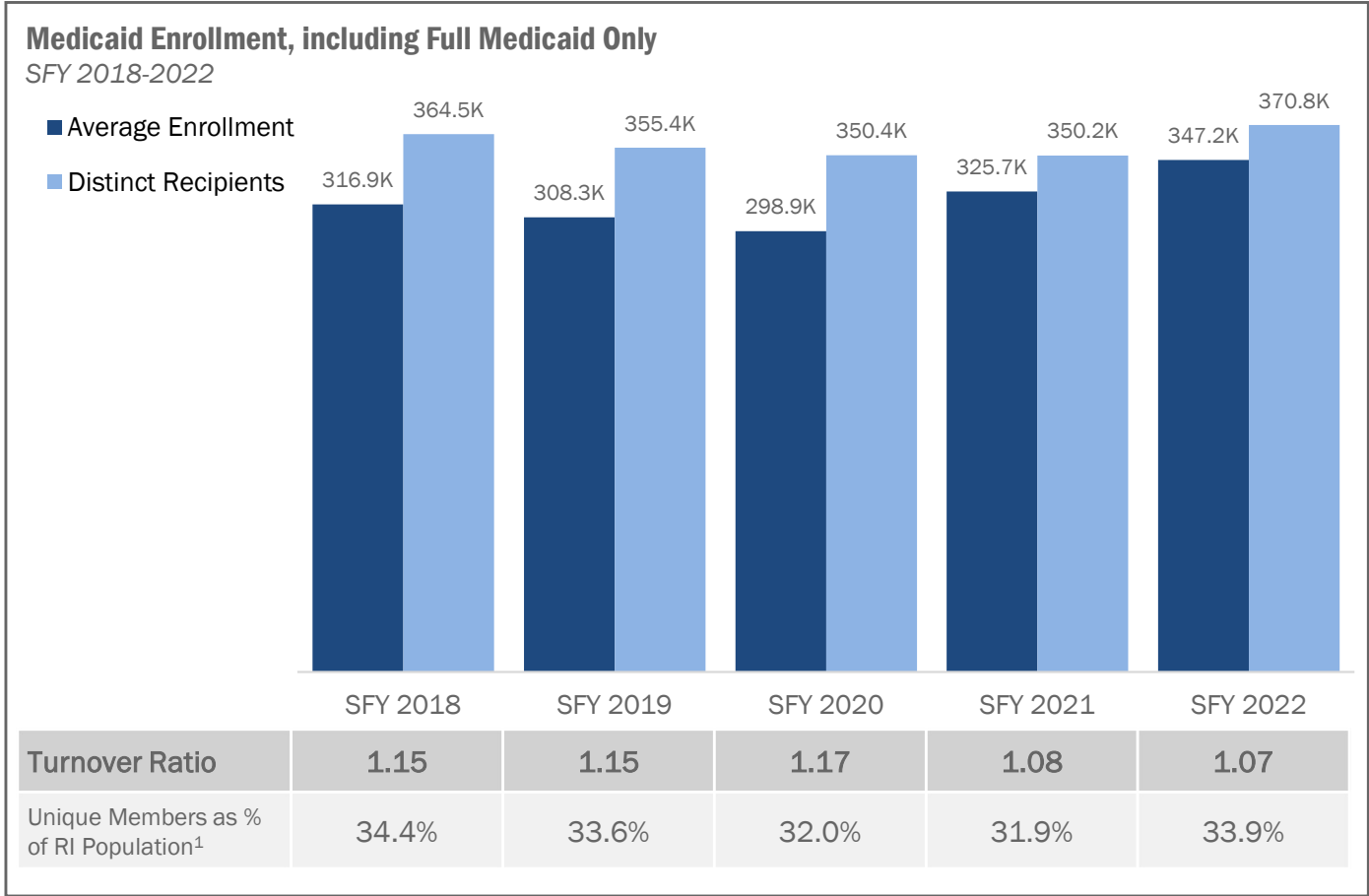
- After a decrease in SFY 2021, the Medicaid PMPM trend increased by 5.2% in % SFY 2022.
- The overall five-year PMPM trend of 3.3% is attributed, in part, to a change in the mix of the population groups, with most of the enrollment growth concentrated within the Children and Families and Expansion eligibility groups:
  - PMPMs vary significantly across populations, from \$281 for Children and Families to \$2,301 for Elders.
  - The average annual compounded PMPM growth rate varies over the past five years, from -0.4% for Elders to 6.1% for Expansion adults.

PMPM Comparison by Eligibility Group, SFY 2018 to SFY 2022

	SFY 2018	SFY 2022	Annual Growth Rate SFY 2018-2022
Children and Families	\$281	\$344	5.2%
CSHCN	\$1,434	\$1,608	2.9%
Expansion	\$473	\$599	6.1%
Disabled Adults	\$1,1790	\$2186	5.1%
Elders	\$2,301	\$2,260	-0.4%
Overall	\$670	\$764	3.3%

# Trends: Unique Recipients

One-third of Rhode Island’s population was enrolled in Medicaid with full benefits for some part of SFY 2022.



- Unique recipients is a measure of the number of individuals enrolled in Medicaid at any time during the fiscal year. Average enrollment is annual full-time equivalents or 12 months of eligibility.
- The turnover ratio compares unique recipients to average enrollment. If the number of unique recipients is equal to the average enrollment, that indicates that there is a steady population of members who remain on the program for the full year. If the number of unique recipients is above the average enrollment (i.e., a turnover ratio greater than 1), this indicates that some Rhode Islanders are using Medicaid for shorter periods of time.
- In March 2020, CMS initiated a federal moratorium on termination activity that persisted throughout SFY 2022. This moratorium on terminations reduced the turnover ratio compared to prior state fiscal years.

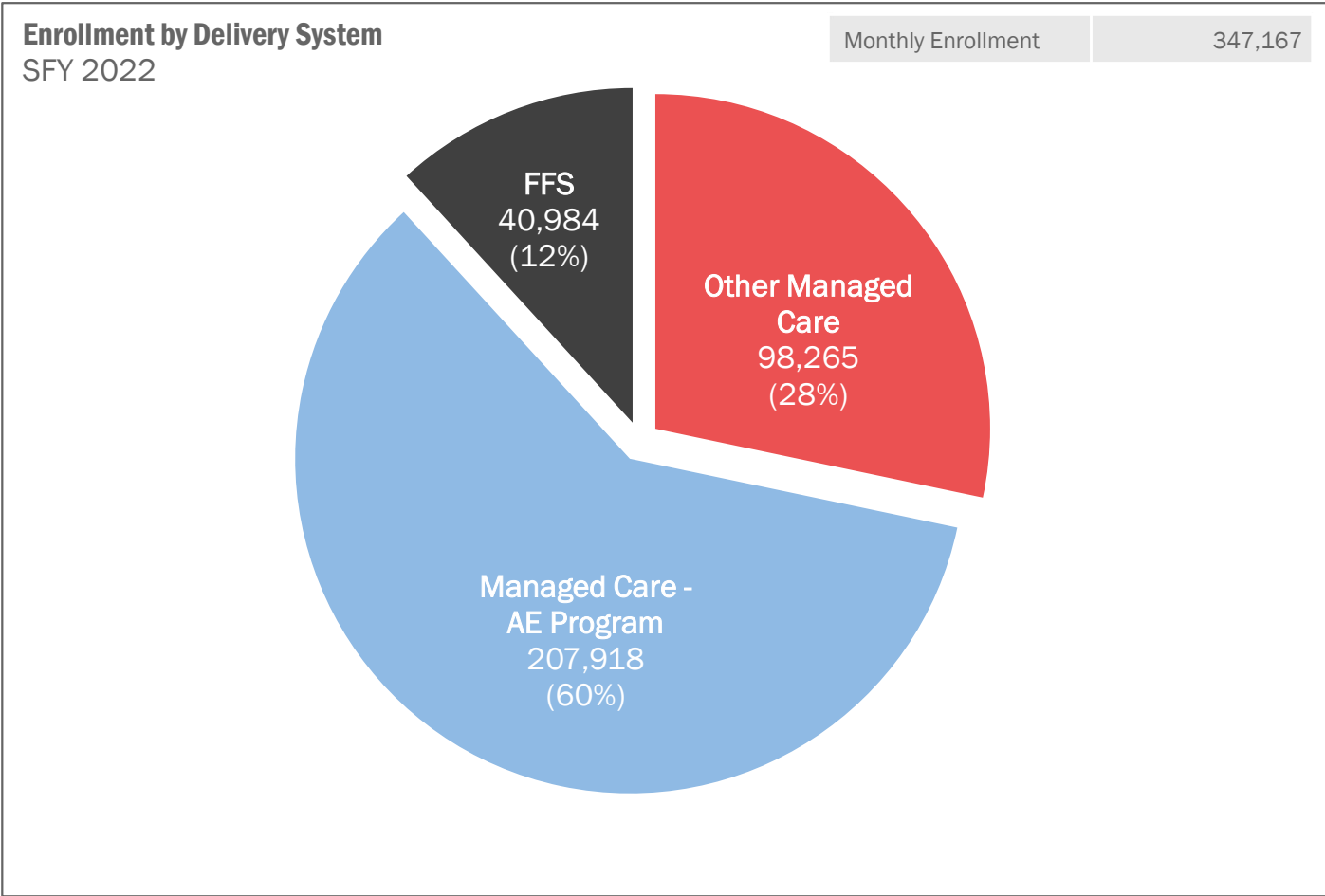
<sup>1</sup>Source: U.S. Census Bureau - Population Estimates

# Programs and Provider Type

22	<b>Enrollment By Program</b> Managed Care vs. FFS Accountable Entity Attribution	27	<b>Special Education Medicaid Expenditures</b> By Local Education Agencies (LEAs)
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24	<b>Expenditures By Delivery System</b> Managed Care and Fee For Service AE Attribution	30	<b>Acute Care Utilization and Costs</b> Inpatient, Outpatient Emergency Department, Prescriptions
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# Enrollment by Program

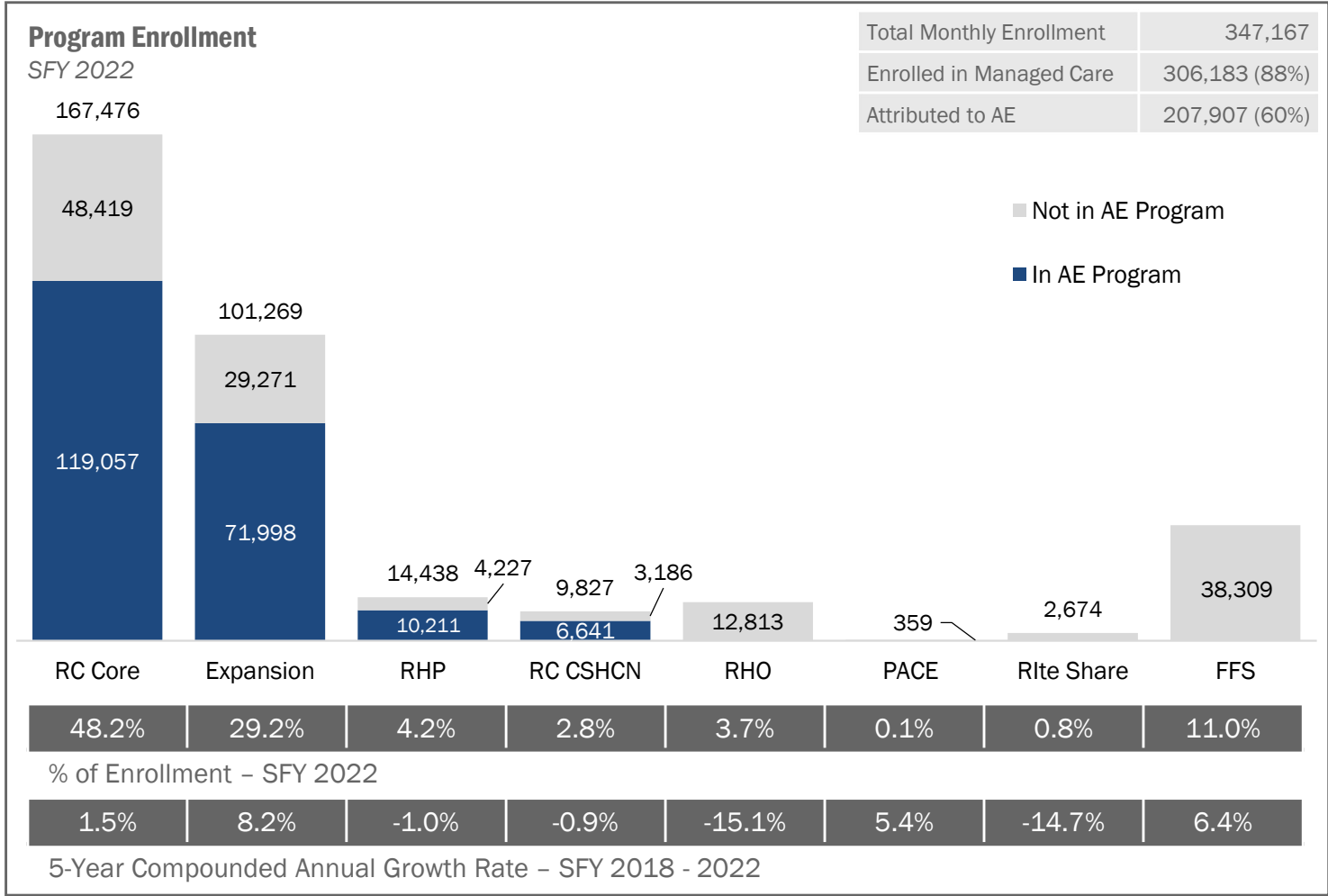
Nearly 90% of members with full Medicaid benefits are enrolled in managed care and nearly 60% are attributed to the Accountable Entity Program.



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

# Managed Care Enrollment

88% of Rhode Island Medicaid enrollees are in managed care programs. Most enrollees are in the Rlte Care and Medicaid Expansion programs, but enrollees with specific health needs are treated in different programs.



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

# Expenditures by Delivery System

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

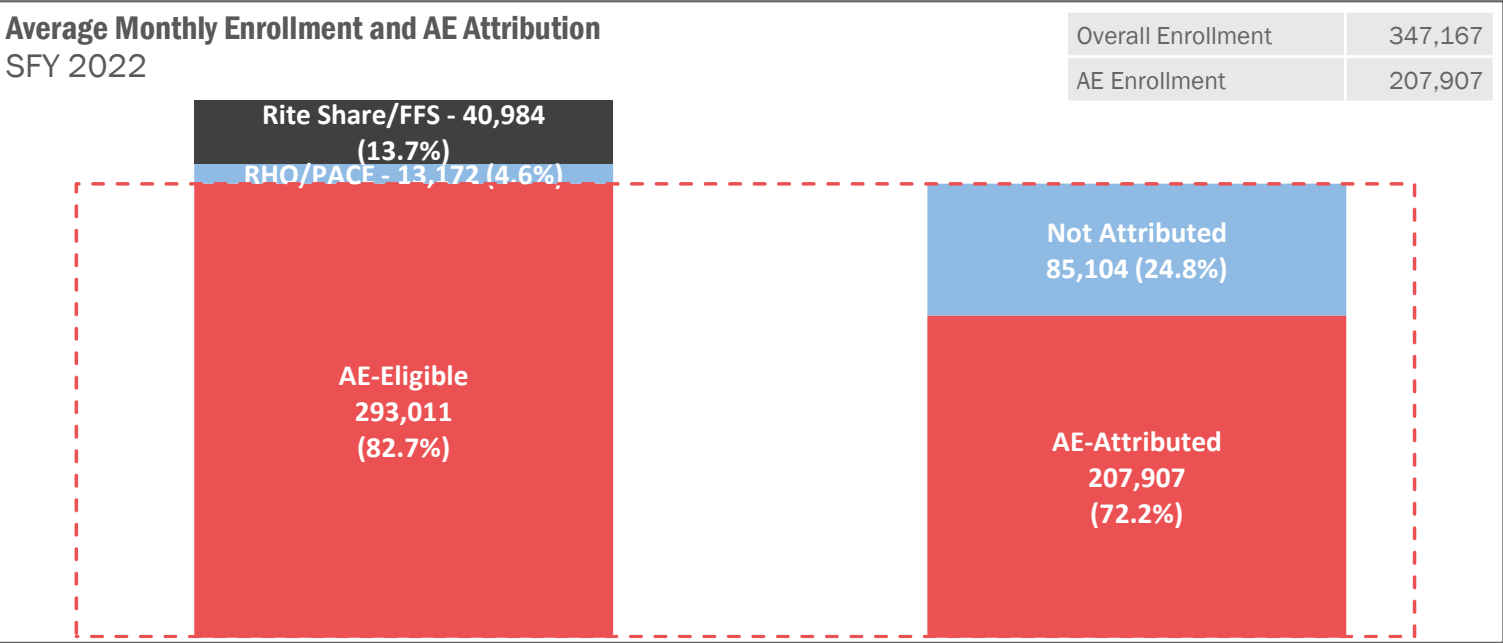
Expenditures by Delivery System SFY 2022					Total Monthly Enrollment	347,167
					Total Expenditures	\$3,182.2 M
<i>AE-Eligible Managed Care</i> Enrollment: 293,011 (84.4%) Expenditures: \$2,012.7 M (63.1%)						
	Managed Care AE-Attributed 207,907 (59.9%)	Managed Care Not Enrolled in AE 85,104 (24.5%)	Managed Care RHO & PACE 13,172 (3.8%)	Remaining in FFS/Rite Share 40,984 (11.8%)		
Major Medical Capitation \$1,881.5M (59.1%)	\$1,219.4M 38.3%	\$508.2M 16.0%	\$151.3M 4.8%	\$2.6M 0.1%		
Other Capitation \$274.5M (8.6%)	\$45.6M 1.4%	\$20.0M 0.6%	\$71.7M 2.3%	\$137.1M 4.3%		
FFS Expenditures \$1,008.3M (31.7%)	\$141.4M 4.4%	\$65.6M 2.1%	\$132.1M 4.2%	\$669.1M 21.0%		
Total Expenditures	\$1,414.7M 44.5%	\$598.1M 18.8%	\$355.3M 11.2%	\$814.2M 25.6%		

- 88% of Medicaid’s 347,167 members are enrolled in managed care programs, including Rite Care, RHP, Expansion, RHO, and PACE.
  - Members enrolled in Rite Care, RHP, and Expansion may be attributed to an Accountable Entity (AE). Overall, 207,907 member (60% of all Medicaid members and 84.4% of AE-eligible members) are attributed to an AE.
- Monthly capitation payments of \$2.16 billion account for 68% of Medicaid expenditures. Note: Assignment to a delivery system is based on the member’s last status within the year, so, some members classified as “remaining in FFS” were previously enrolled in a managed care plan and may have had capitation paid on their behalf:
  - \$1.9 billion (59.1%) of expenditures go toward capitated medical services provided by NHPRI, UHC, and Tufts, excluding dental, non-emergency transportation, and certain carved-out benefits.
  - Other capitation payments of \$274.5 million (8.6%) include Medicare Premium Payments, Rite Smiles, and Non-Emergency Transportation.
- FFS spending of \$1 billion is primarily for members not in managed care, but also includes spending on carved out benefits such as services delivered in a Neonatal Intensive Care Unit (NICU), adult dental care, any pre-enrollment activity, as well as community-based LTSS and professional services, for BHDDH and DCYF clients.

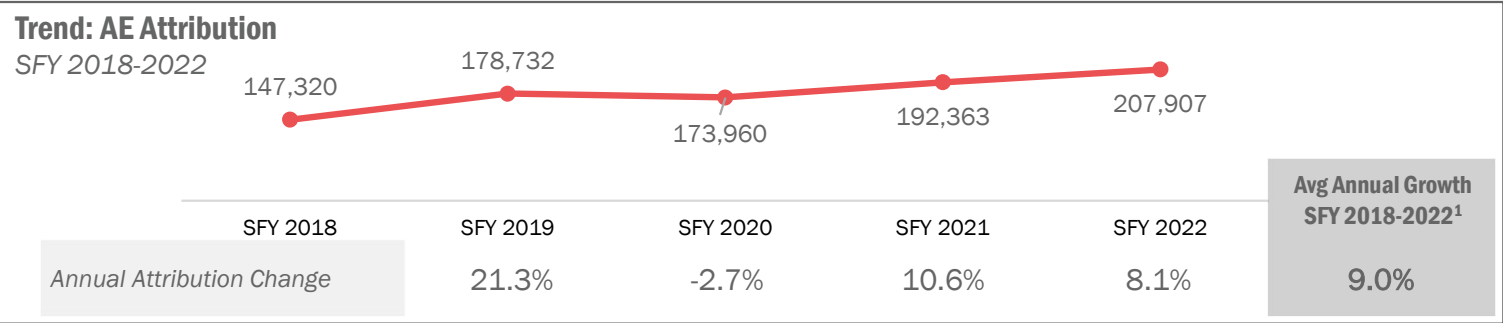


# Managed Care Enrollment and AE Attribution

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



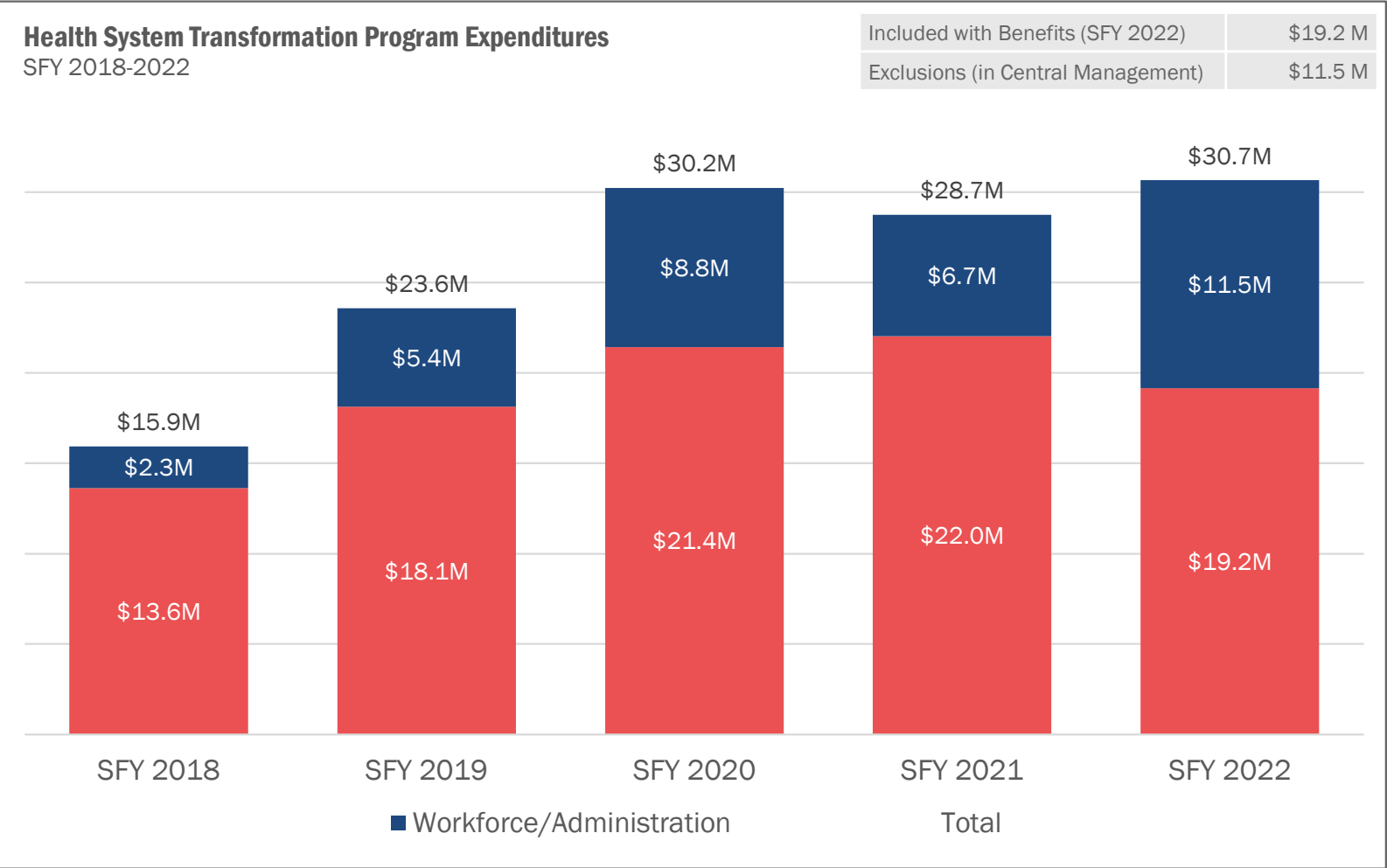
- Seven AEs participated in the AE Program during the year:
  - Blackstone Valley Community Health Center
  - Coastal Medical
  - Integra Community Care Network
  - Integrated Healthcare Partners (CHC ACO)
  - Prospect Health Services RI
  - Providence Community Health Center
  - Thundermist Health Center
- AE program Incentive payments, which began in SFY 2019, are time limited payments and will be distributed through SFY 2024 (limited funds may be remaining for payment in SFY 2025). This spending is reflected in the overall benefits expenditures on fully-covered Medicaid members.
- Incentive payments support enhancements of capabilities of participating health care providers in the areas of data and analytics, population health including a focus on social determinants, workforce planning and programming, care management, member engagement and access, quality, interdisciplinary partnerships, and leadership and management.



<sup>1</sup> Calculated as compounded annual growth rate (CAGR) over period SFY 2018-2022 as shown.

# Health System Transformation Program (HSTP)

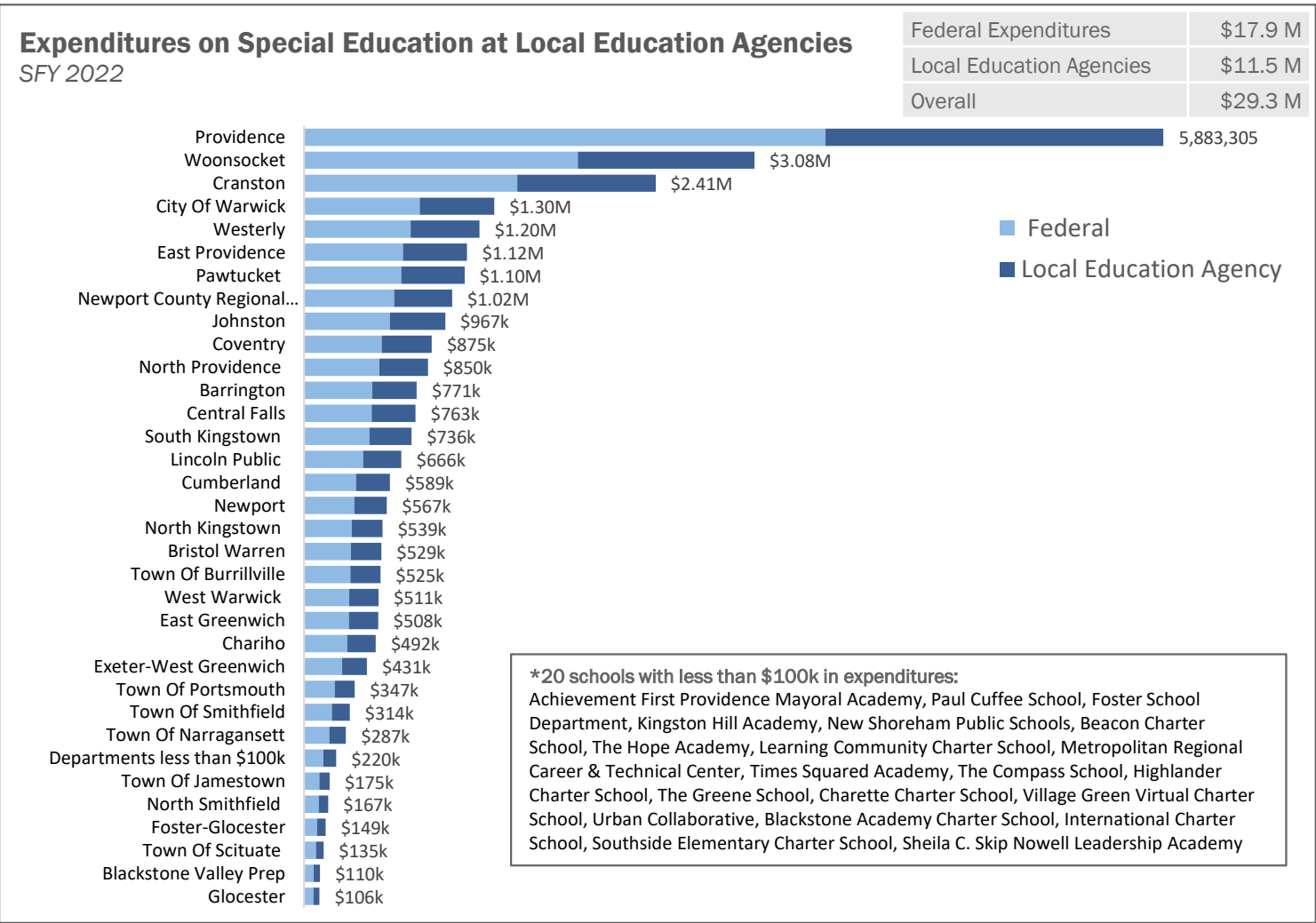
In October 2016, CMS approved Rhode Island’s HSTP waiver amendment, bringing in restricted revenues to the State for use as the state share on new investments towards the establishment of Accountable Entities.



■ In SFY 2022, EOHHS continued to make incentive payments to its Accountable Entity partners and invest it’s the State’s health care workforce.

# Special Education

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



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

- Expenditures for Medicaid-eligible special education services include the federal share funded in the EOHHS budget and the matching funds for those services, which are financed by each local education agency.
- 54 school districts/departments received LEA payments in SFY 2022.

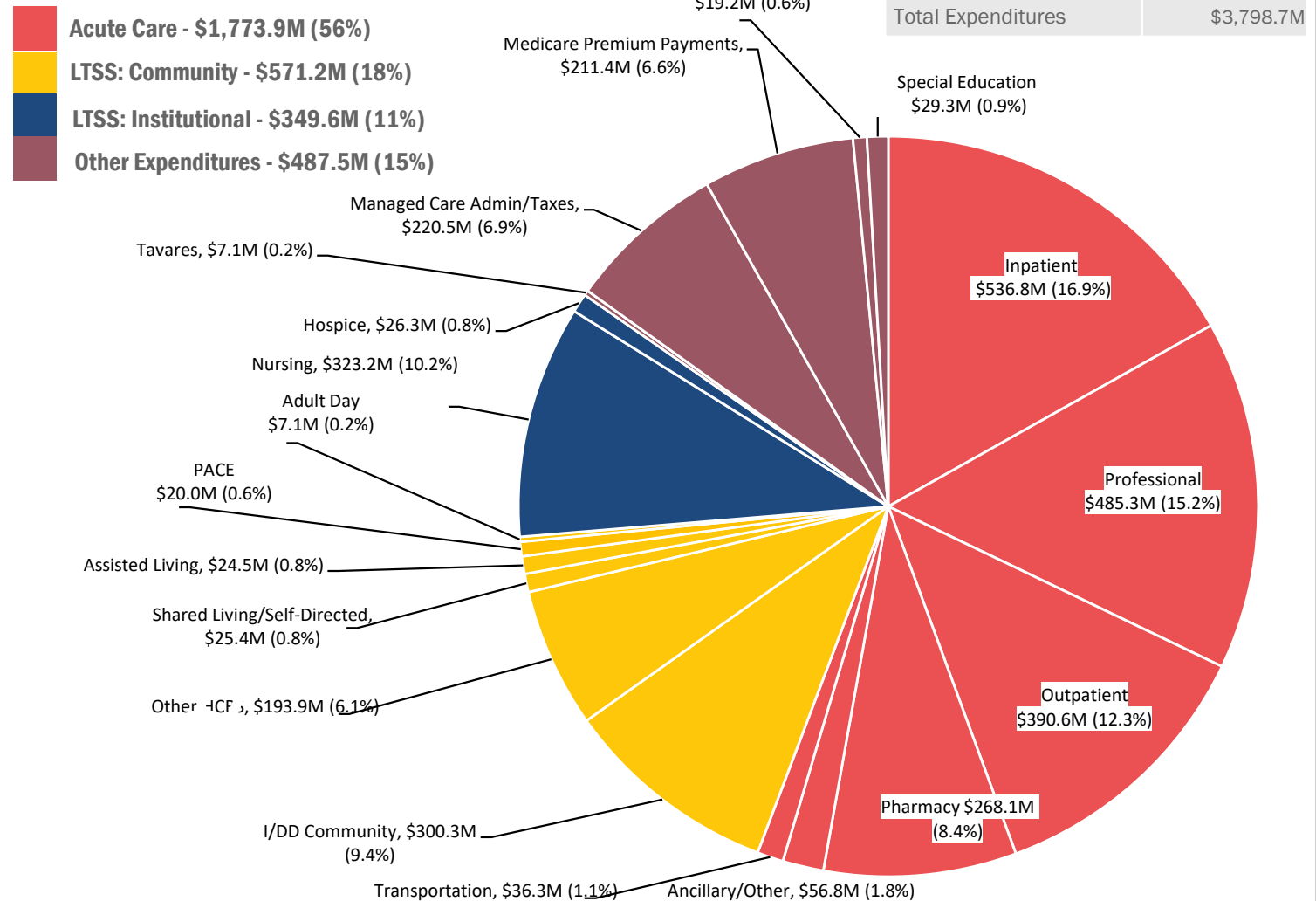
**Note:**

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

# Expenditures by Provider Type

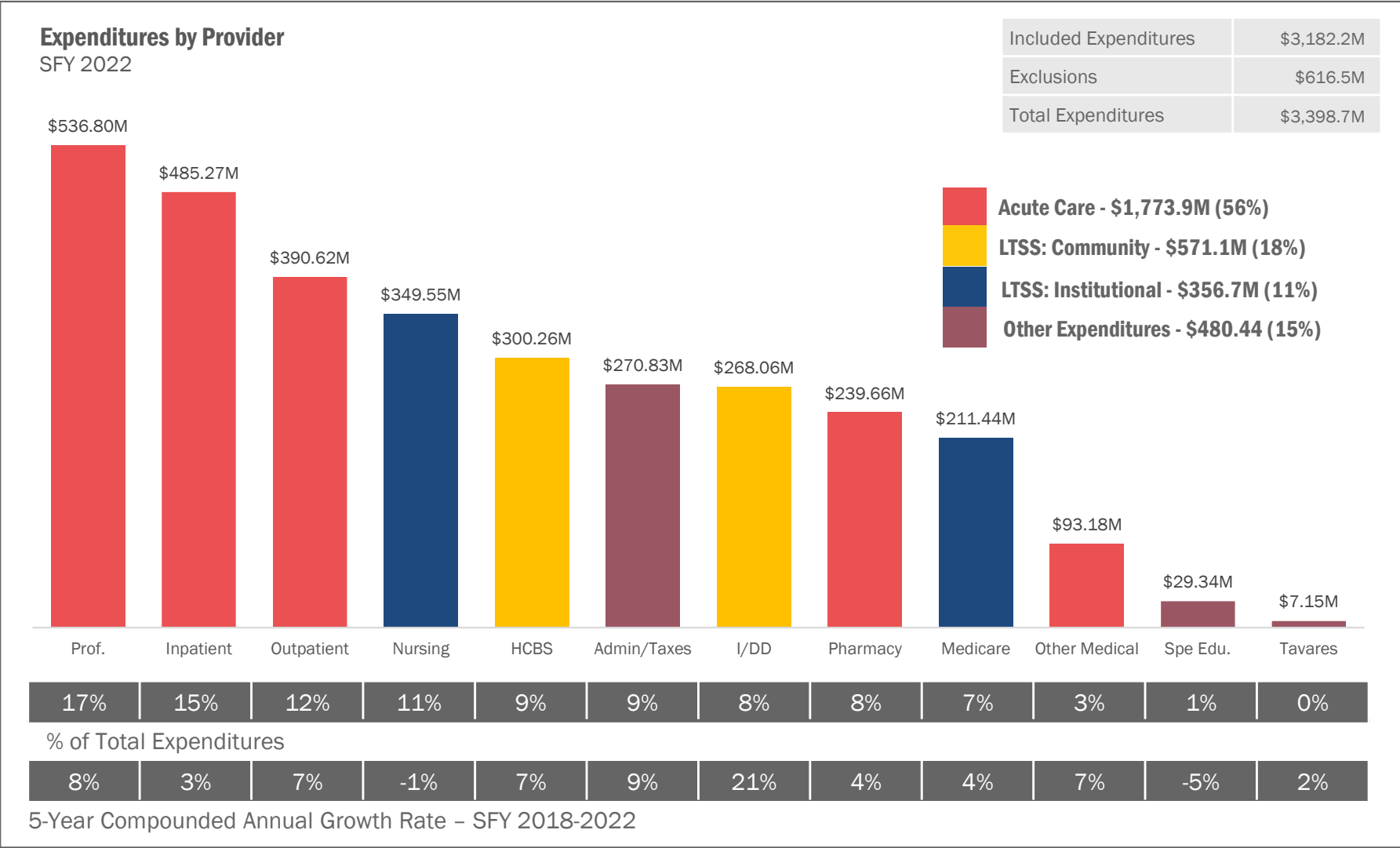
- **Acute services** had \$1,773.93 million in Medicaid expenditures in SFY 2022, constituting 56% of all expenditures.
  - Pharmacy spend is net of rebates.
- **LTSS** had \$920.7 million in Medicaid expenditures, constituting 29% of all expenditures. LTSS expenditures primarily serve the Elders and Adults with Disabilities populations. They are grouped into two categories:
  - **Institutional Care** services are provided to populations who stay in an institution. These services account for \$349.6 million, including 38% of all LTSS expenditures and 11% of overall expenditures.
  - **Community Care** services are provided to at-risk populations as alternatives to more costly nursing facility/institutional options. These services totaling \$480.4 million account for 62% of LTSS expenditures and 18% of all expenditures.
- **Other Expenditures** include the non-claims expenditures of Medicaid MCOs (e.g., administrative expenses and taxes) and Medicare premiums paid by EOHHS on behalf of covered enrollees. EOHHS has also classified Special Education and Tavares expenditures under this category this fiscal year.

Medicaid Expenditures by Provider Type  
SFY 2022



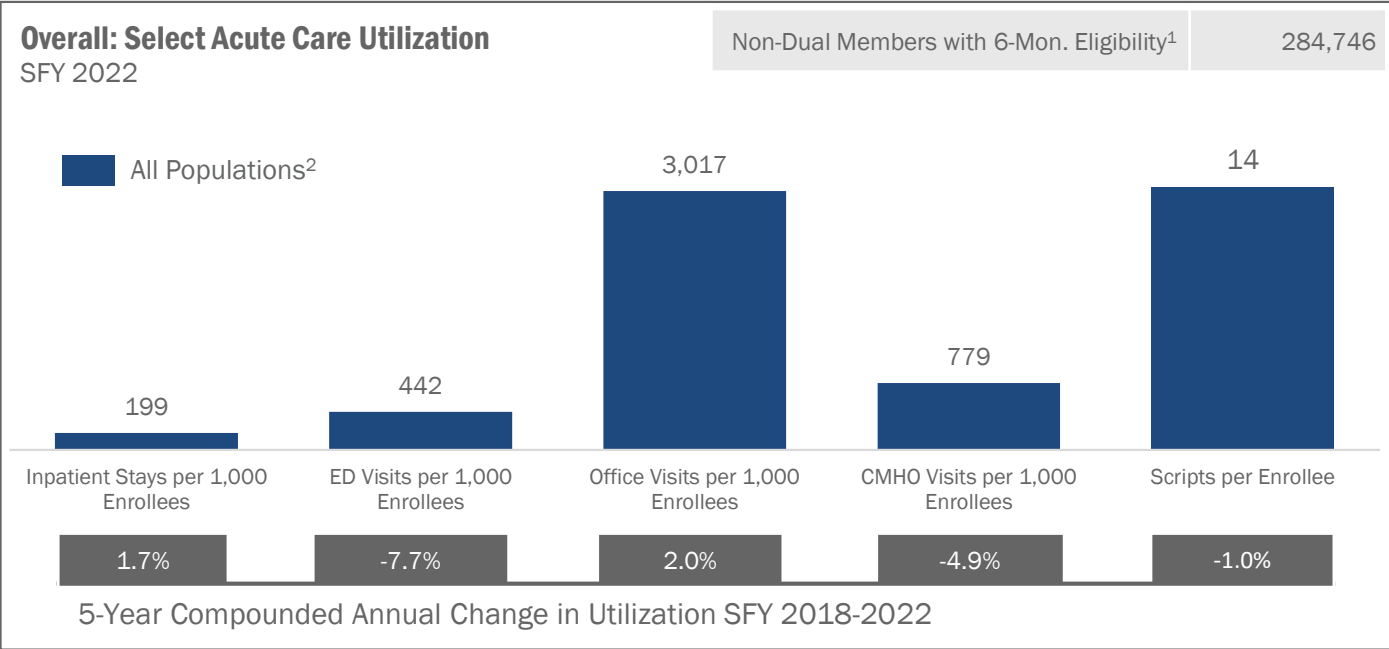
Included Expenditures	\$3,182.2M
Exclusions	\$616.5M
Total Expenditures	\$3,798.7M

# Expenditures by Provider Type (cont'd)



- This spending is net of rebates. In terms of growth rates over the past five years:
  - Pharmacy expenditures, net of rebates, has grown faster than all other service types as a result of both increasing costs and increasing utilization among the Expansion population. However, a January 2022 report by Congressional Budget Office (“Prescription Drugs: Spending, Use, and Prices”) suggest Rhode Island Medicaid’s experience is consistent with national trends.
  - Medicare expenses have increased 3.7% annually, but Medicaid does not control these rates, and this rate was moderated during the Public Health Emergency due to the temporary increase to Rhode Island’s FMAP rate that significantly reduced the cost of providing Medicare Part D coverage. EOHHS anticipates continued growth in these costs in SFY 2023 and beyond.
  - Nursing/Hospice spending increased in FY 2022 over FY 2021, but the long term reduction is attributed to the impact of COVID-19 on nursing facility census and the decline in facility census experienced since March 2020. .

# Acute Care: Select Utilization & Costs



Overall: Average Cost per Acute Care Service

SFY 2022

Inpatient Stay	ED Visit	Office Visit	CMHO	Prescription
\$6,148	\$665	\$79	\$256	\$85
1.7%	6.9%	1.3%	5.4%	8.0%

5-Year Compounded Annual Change in Unit Cost SFY 2018-2022

Acute care services comprise \$1.9 billion, or 60 percent, of total Medicaid benefit spending in SFY 2022. Acute care includes inpatient, outpatient, professional, pharmacy, transportation, and ancillary services (e.g., DME, prosthetics, and pathology/lab).

Select average cost and utilization metrics are presented here. Beginning in SFY 2022, these trends are affected by the onset of the COVID-19 public health emergency which depressed utilization of certain service. As a result, the derivation of the compound annual growth rate when compared to SFY 2018 experience may be only artificially depressed.

- From SFY 2018 to SFY 2022, utilization fell for Emergency Department (ED) visits and prescriptions, with ED visits/scripts per enrollees falling – 7.7%, and -1.0%, respectively. Inpatient stays experienced a slight increase in utilization (1.7%).
- During this time span, costs per ED visits increased by 6.9%, costs per prescription increased by 8.0%, and costs per office visit increased by 1.3%.

Data Clarification:

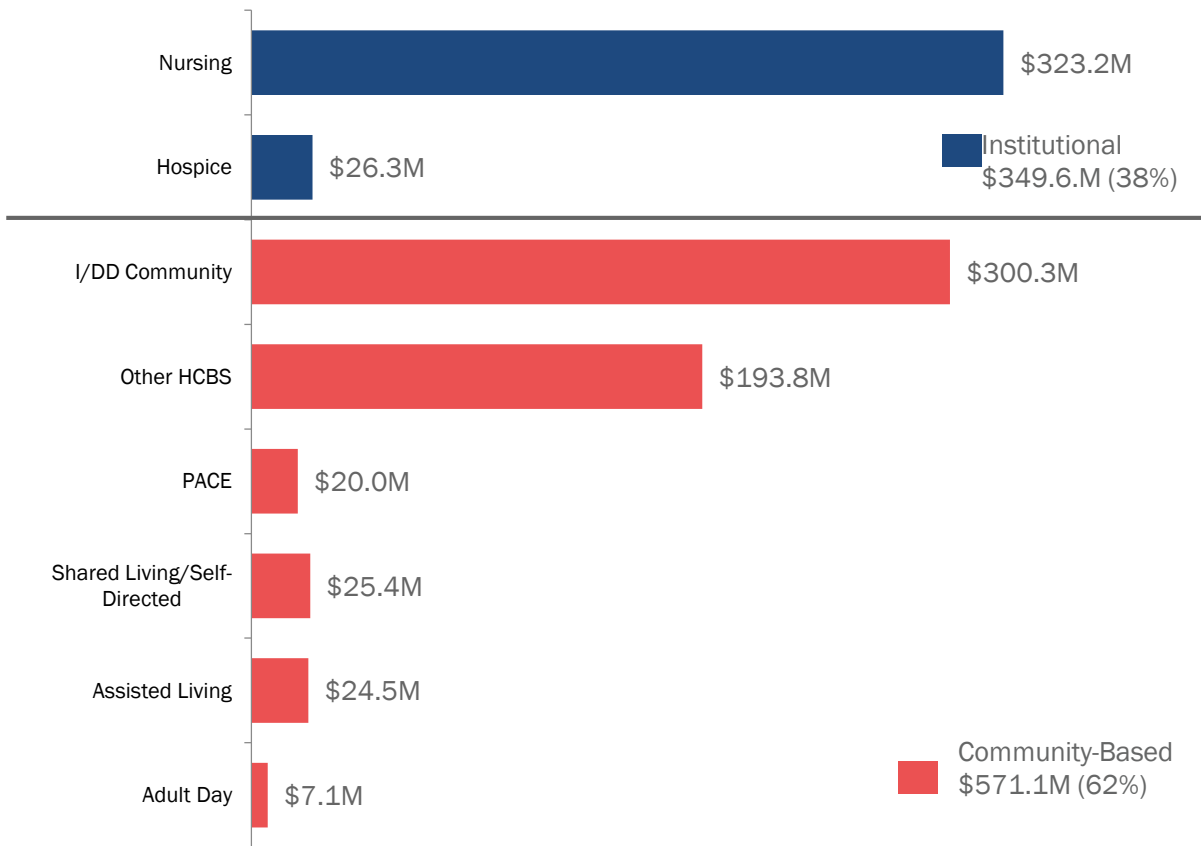
- The utilization and cost per unit metrics on this page are based on detailed claims data and do not include non-claims adjustments (e.g., missing data from MCOs and IBNR).
- The average cost per prescription does not include offsetting drug rebates.

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

# LTSS Spending: Community vs Institutional

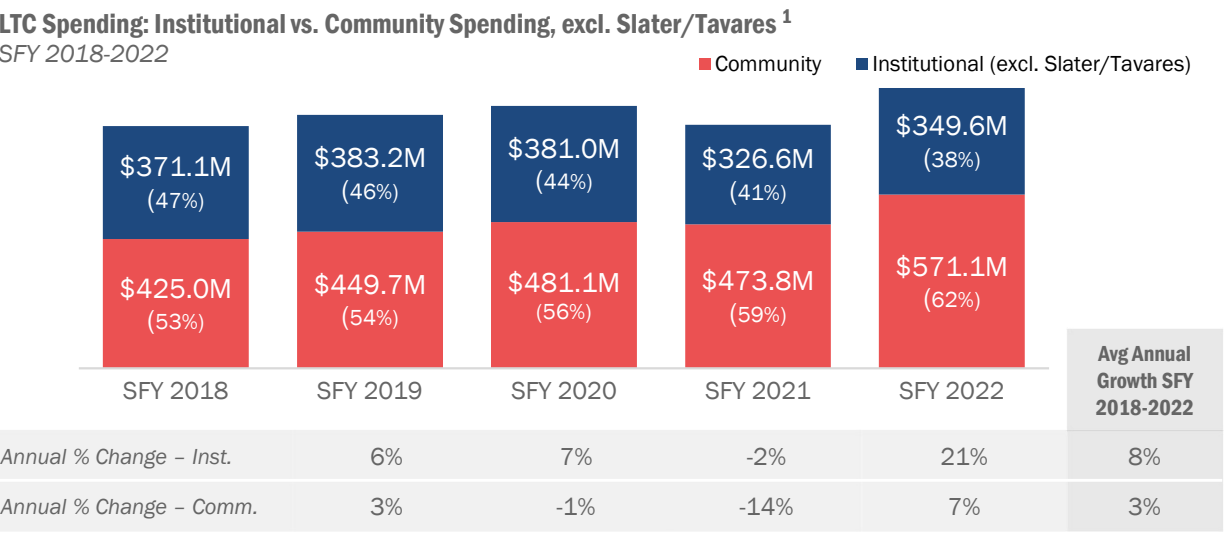
LTSS includes community care and institutional care. These services are mainly focused on the Elders and Adults with Disabilities populations.

Medicaid Long Term Care Spending  
SFY 2022



<sup>1</sup> “Self-Directed” includes the Self-Directed Personal Choice and Independent Provider programs.  
<sup>2</sup> “Other HCBS” includes personal care and severely disabled nursing homecare services; approx. \$22M is for children.

- Community care services are provided to at-risk populations as alternatives to more costly institutional options. Such services include residential and rehabilitation services, including group homes and transportation costs for persons with Intellectual and Developmental Disabilities.
- Institutional care services include nursing facility services, as well as hospice care. For purposes of the FY 2022 expenditure report, spending at Slater Hospital (including Zambarano) is not included in the full report. Tavares Pediatric Center is not treated as a LTSS institutional provider for purposes of this report..



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

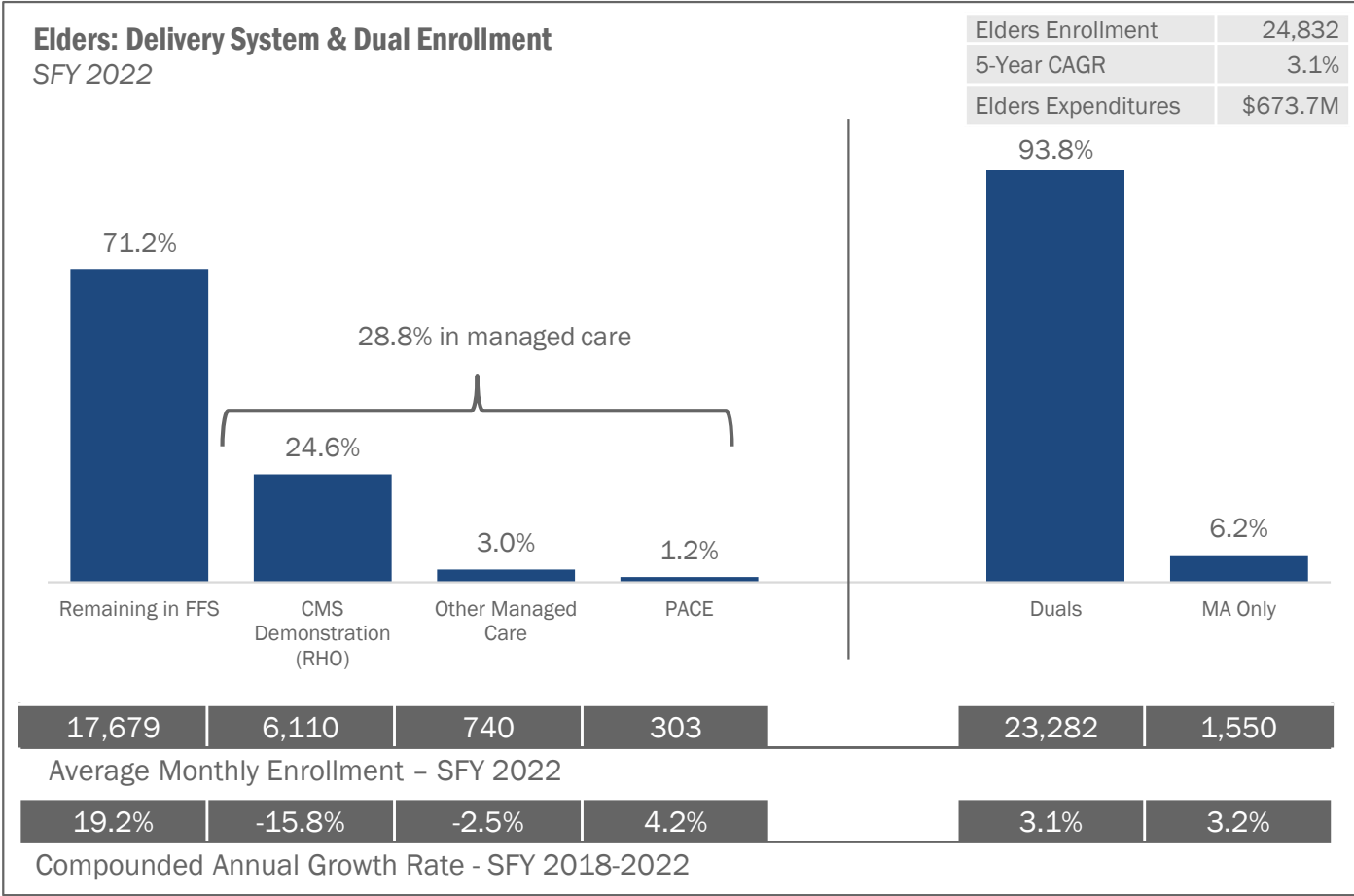
# Populations

33	<b>Elders</b> By Delivery System, Provider Type, and Dual Status LTSS Users and Expenditures
36	<b>Adults with Disabilities</b> By Delivery System, Provider Type, and Dual Status Diagnosis, Acute Care Utilization, and LTSS Users and Expenditures
41	<b>Children and Families</b> By Delivery System and Provider Type Diagnosis and Acute Care Utilization
45	<b>Children with Special Healthcare Needs</b> By Delivery System and Provider Type Diagnosis and Acute Care Utilization
49	<b>Expansion Adults</b> By Delivery System and Provider Type Diagnosis and Acute Care Utilization



# Elders: Managed Care and Dual Enrollment

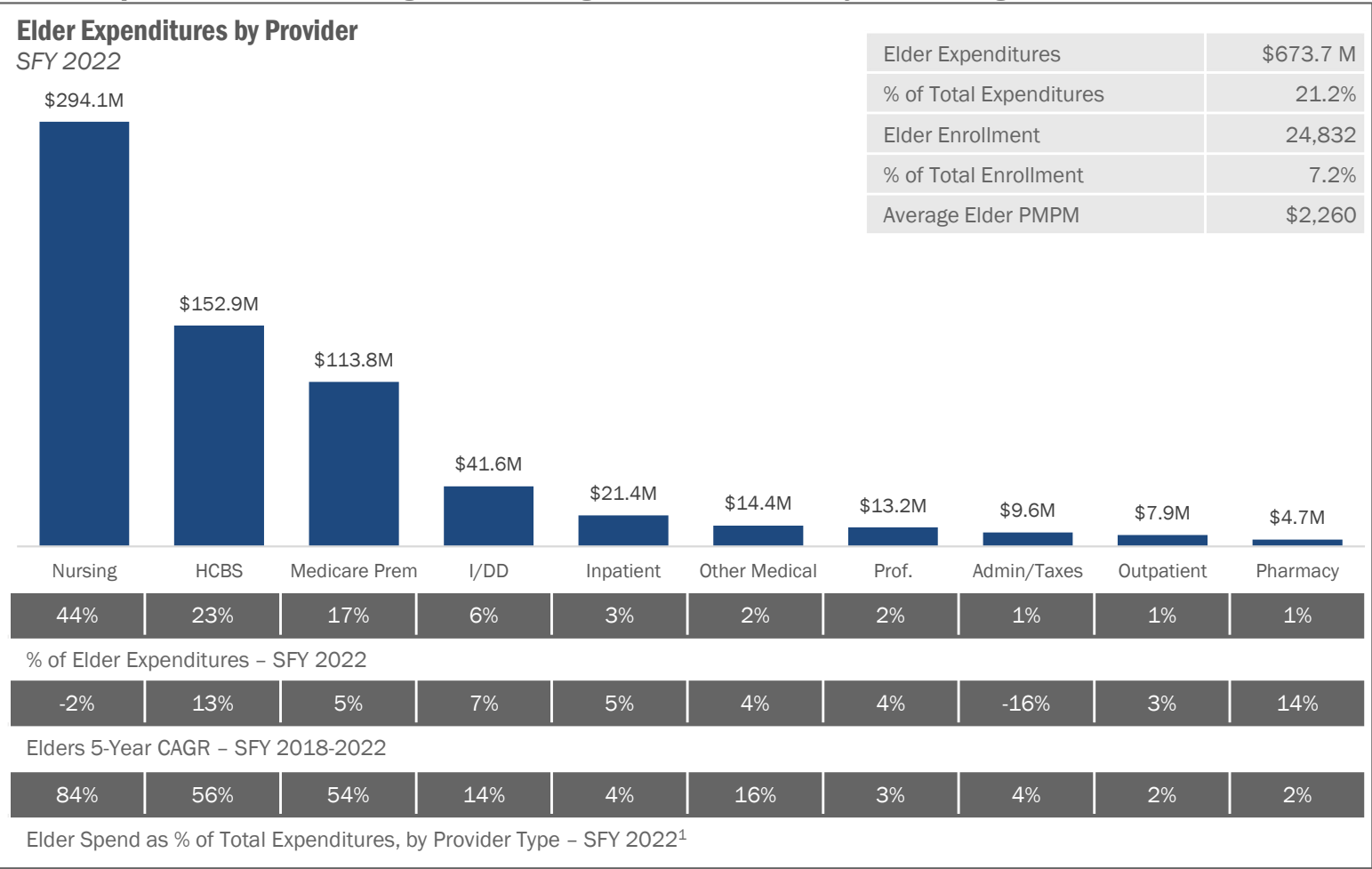
Elders are the only population for which most enrollees are not enrolled in managed care. They are also one of two populations (the other being Adults With Disabilities) which may have a significant portion enrolled in Medicare.



- Compared to other population groups, elders are predominantly in FFS:
  - 71.2% of elders receive their Medicaid services delivered through EOHHS’ FFS program.
  - 28.8% of elders receive their Medicaid services via managed care.
    - Approximately 24.6% are enrolled in the CMS Demonstration (RHO Phase II)
    - Less than 1.5% are enrolled in PACE.
- 93.8% of Elders are covered by both Medicare and Medicaid (so-called “Dual Eligible” or “Duals”).
  - For the Elders who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, professional, pharmacy).
  - Medicaid pays for the Medicare premiums and, in most cases, Medicare coinsurance charges on behalf of these Duals.

# Elders: Expenditures by Provider Type

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



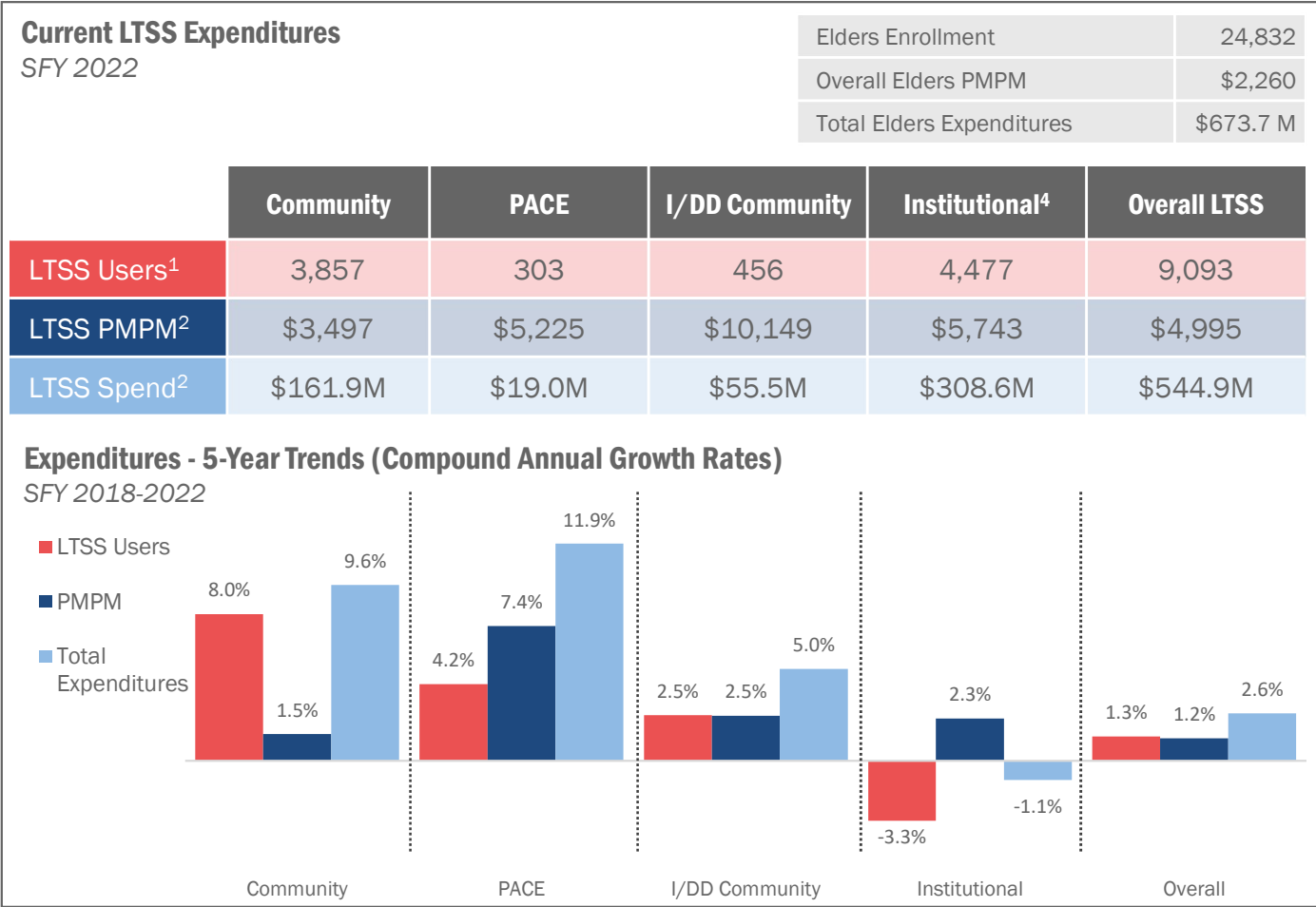
- Medicaid expenditures on Elders totaled \$673.7 million in SFY 2022, an amount roughly equivalent to total expenditures in SFY 2018.
- Beginning in SFY 2021, these trends are materially affected by the onset of the COVID-19 public health emergency which significantly depressed utilization of nursing facility services in SFY 2021 compared to prior periods (in SFY 2020 this report included \$343.3 million in nursing /hospice expenditures).
- Prior to the PHE, nursing facility expenditures had been steadily rising year/year.

Notes:

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

<sup>1</sup> Nursing includes Nursing & Hospice. Table shows Elder's spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

# Elders: LTSS Users and Spending on LTSS



<sup>1</sup> LTSS users reflects members with an LTSS authorization in the fiscal year.

<sup>2</sup> Spending represents LTSS services costs only. except for PACE that includes full capitation.

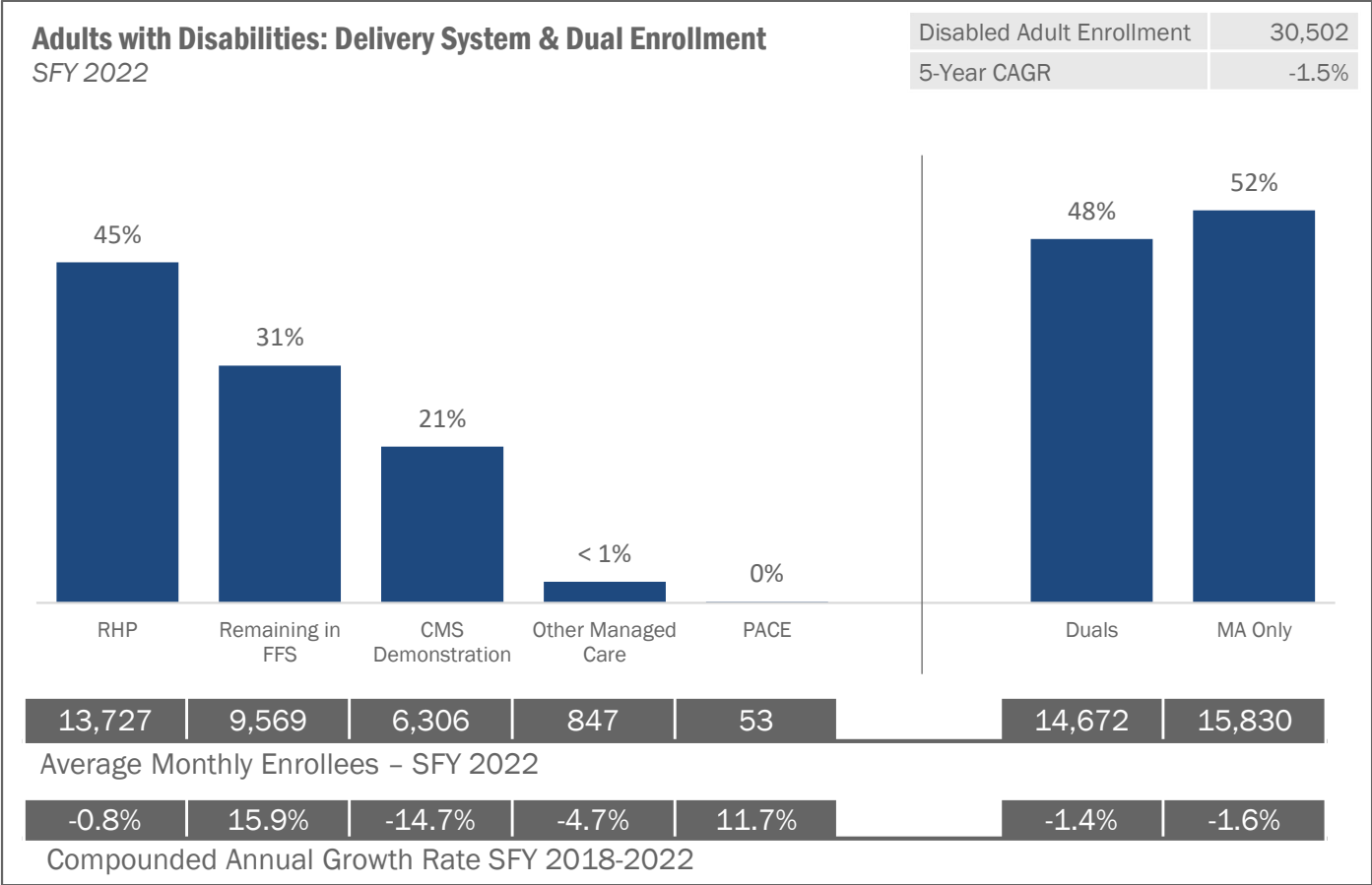
<sup>3</sup> Community authorizations include those with Preventive Only coverage that have lower LTSS utilization.

<sup>3</sup> Institutional includes nursing facilities and hospice users only. Does not include Slater Hospital users.

- There is currently a state initiative to “rebalance” LTSS expenditures back into the community instead of institutions. Providing services in this setting can integrate efforts with communities and enable LTSS enrollees to thrive in them, but in many instances an institutional setting is required to fulfill patient needs.
- Overall, expenditures increased by \$52.9 million, or nearly 2.6%, over the 5-year period. This change is driven by Community expenses, which increased by \$49.7 million.
- The overall PMPM for this population rose by \$239, or an average of 1.2% per annum over the 5-year period. This was comprised of the following average annual PMPM trends:
  - The institutional (Nursing facility/hospice) PMPM increased by \$501 (2.3%).
  - The PACE PMPM increased by \$1,292 (7.4%).
  - The Community PMPM increased by \$198 (1.5%).
  - The I/DD Community PMPM increased by \$939 (2.5%).

# Adults with Disabilities: Managed Care and Dual Enrollment

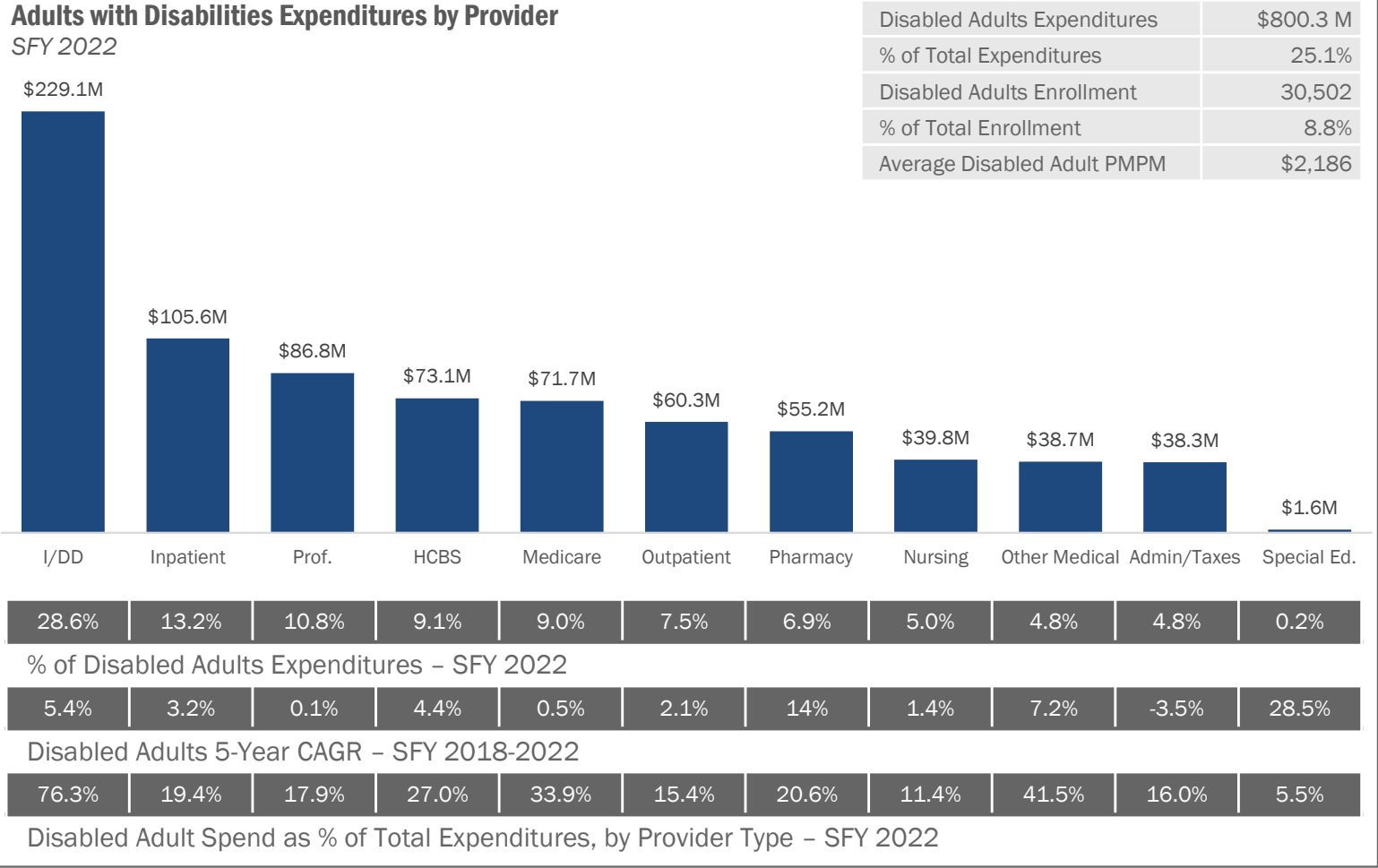
Most Adults with Disabilities are enrolled in managed care programs, but a lower proportion are enrolled than all other populations except Elders. Adults with Disabilities are also one of two populations who have a significant number of Duals; approximately half of this population is enrolled in Medicare.



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

# Adults with Disabilities: Expenditures by Provider Type

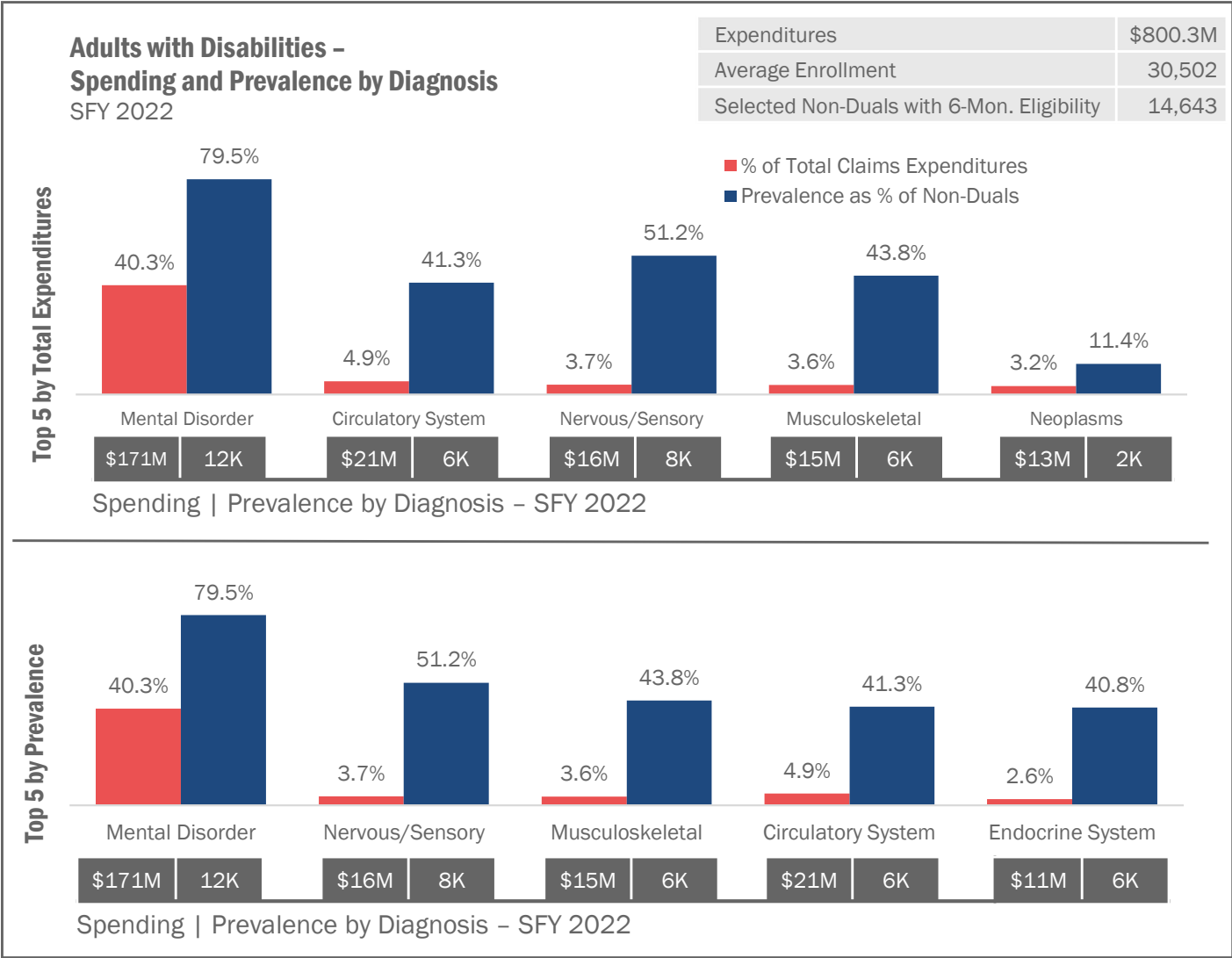
Most expenditures on behalf of Adults with Disabilities are for I/DD community services, including public and private group homes, funded by BHDDH appropriations.



<sup>1</sup> Inpatient spending includes \$3.5 million spending at Tavares Pediatric Center that is an Intermediate Care Facility.

- Adults with Disabilities have the highest PMPM among Medicaid members with full benefits, with those expenditures dominated by I/DD community services.
  - I/DD community services make up 29% of expenditures for this population.
- Over the past five years, expenditures on a per member basis for Adults with Disabilities have grown at approximately 4% per year. The only population with a lower per member growth rate is Elders.
- Many costs for Adults with Disabilities grew at lower rates than the overall population.
  - Pharmacy costs grew by 14% vs. 21%
  - Inpatient costs grew by 3% vs. 17%
  - Outpatient costs grew by 2% vs. 7%

# Adults with Disabilities: Diagnoses



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

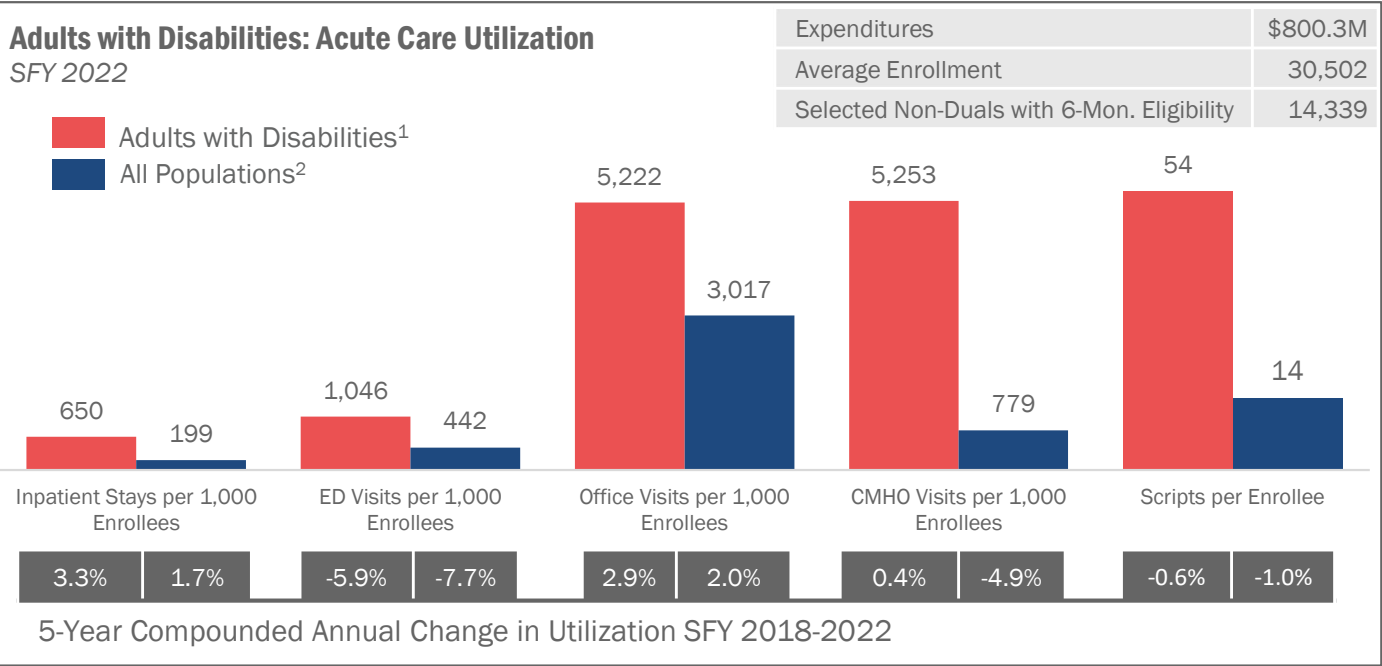
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental and behavioral conditions are both the highest cost and most prevalent conditions among Adults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

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

- 79.5% "prevalence as a % of non-duals" means that among members within the Adults with Disabilities population that have at least 6 months of enrollment during the year, 79.5% of the non-duals had claims where "mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 40.3% of costs were for claims where "mental or behavioral health" was the primary diagnosis.

# Adults with Disabilities: Acute Care Utilization

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



- Per-person inpatient utilization increased 3.3% per year for Adults with Disabilities from SFY 2018 to SFY 2022; but increased 1.7% for the overall population.
- Adults with Disabilities have significantly higher utilization at hospitals than all other groups, with 3.3 times more inpatient stays per 1,000 (at a 18% higher cost per stay) and 2.4 more ED visits per 1,000 (at a 16% higher cost per visit)
- The average Adult with Disabilities had 54 pharmacy claims per year, whereas the average enrollee had 14 pharmacy claims per year.

Adults with Disabilities: Average Cost per Acute Care Service

SFY 2022

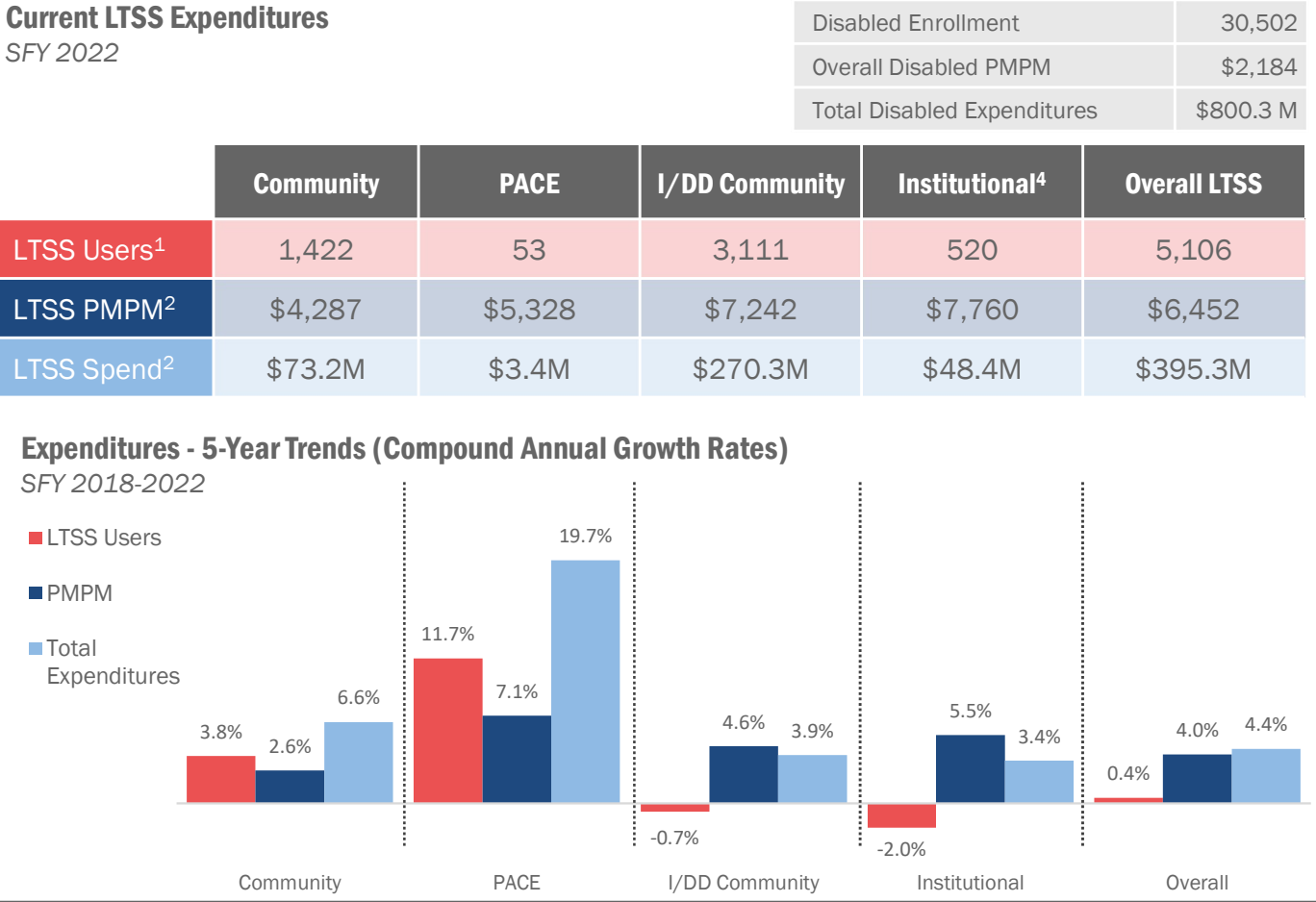
	IP Stay	ED Visit	Office Visit	CMHO Visit	Script
Adults with Disabilities	\$7,262	\$774	\$74	\$339	\$100
Overall	\$6,148	\$665	\$79	\$256	\$85

<sup>1</sup> Unduplicated enrollees includes count of Medicaid Only members with a minimum of six months of eligibility.

<sup>2</sup> All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.



# Adults with Disabilities: LTSS Users and Spending



- There is currently a state initiative to “rebalance” LTSS expenditures towards the community instead of institutions with a focus on person-centered choice. Providing services in the community can enable LTSS enrollees to thrive. However, in many instances an institutional setting is required to fulfill patient needs.
- Aligned with this initiative, enrollment for adults with disabilities in institutional care decreased by 2.0% on average per year between SFY 2018 and SFY 2022.
- Enrollment in community LTSS increased by 3.8% annually.
- Overall LTSS expenditures for Disabled Adults increased by \$62.9 million from SFY 2018 to 2022: with widespread increases in expenditures across all methods of care.
- The overall PMPM for Adults with Disabilities increased by \$931 over the 5-year period, by 4.0% per year on average.
  - Over this same time period, the Community PMPM increased by \$425 or 2.6%.
  - The PACE and Institutional PMPM rates increased by \$1,280 and \$1,507, or 7.1% and 5.5%, respectively.

<sup>1</sup> LTSS users reflects members with an LTSS authorization in the fiscal year.

<sup>2</sup> Spending represents LTSS service costs only. Costs not adjusted for allocations of missing data/admin; except PACE that includes full capitation.

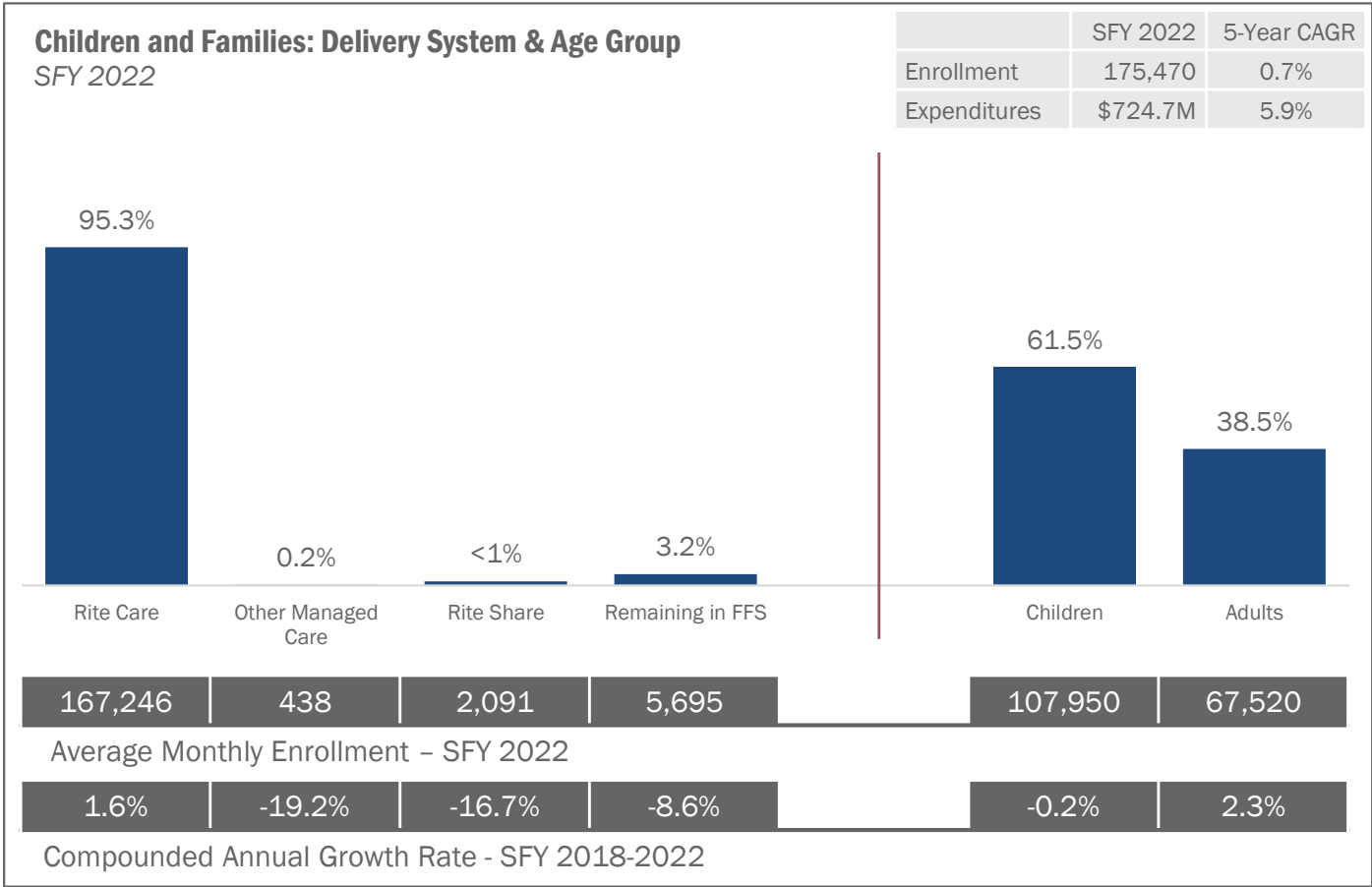
<sup>3</sup> Community authorizations includes those with Preventive Only coverage that have lower LTSS utilization.

<sup>4</sup> Institutional includes nursing facilities and hospice residents only. Does not include Slater Hospital admits.



# Children and Families: Managed Care Enrollment

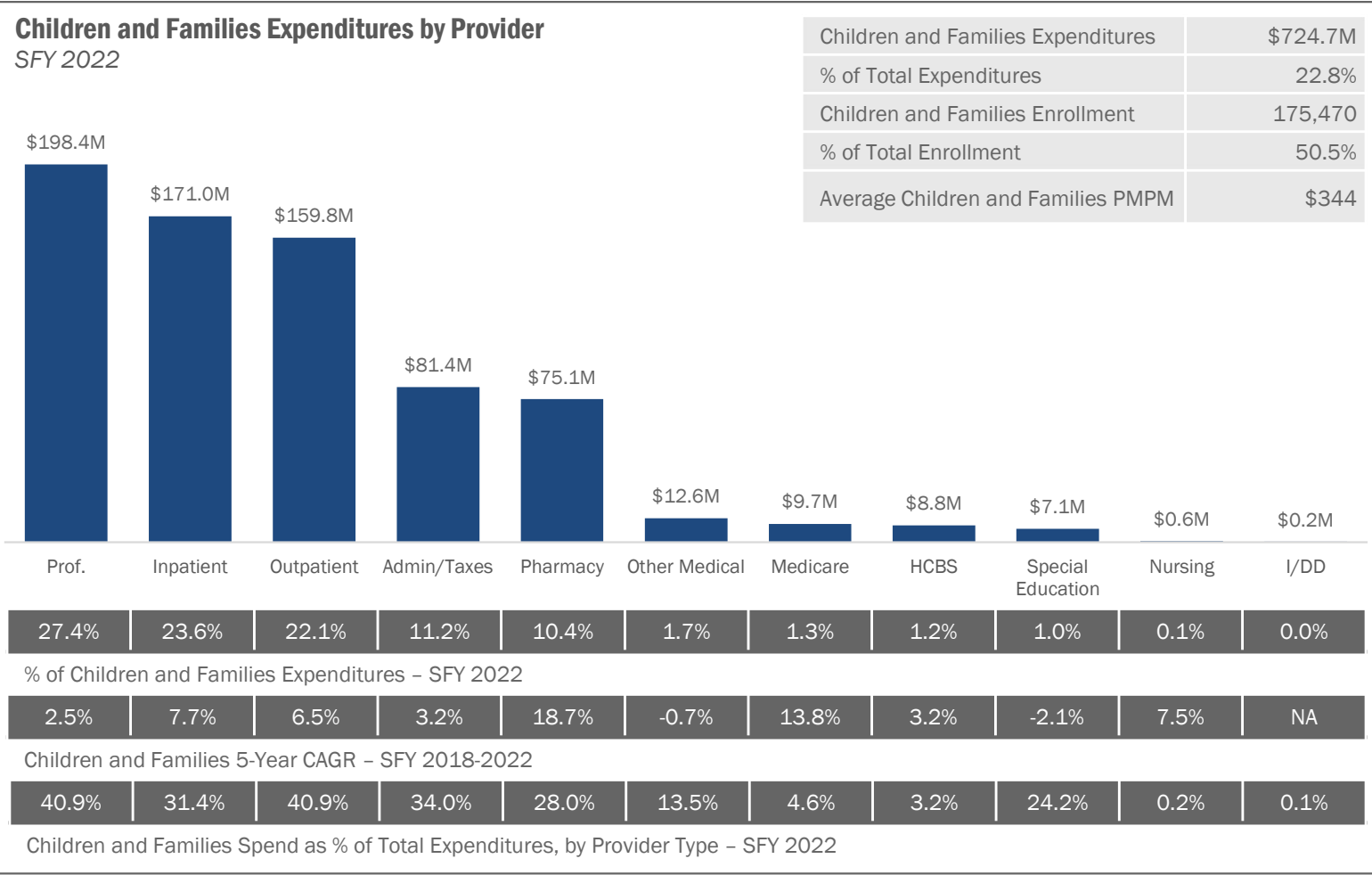
The Children and Families population is primarily enrolled in the Rlte Care managed care program.



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

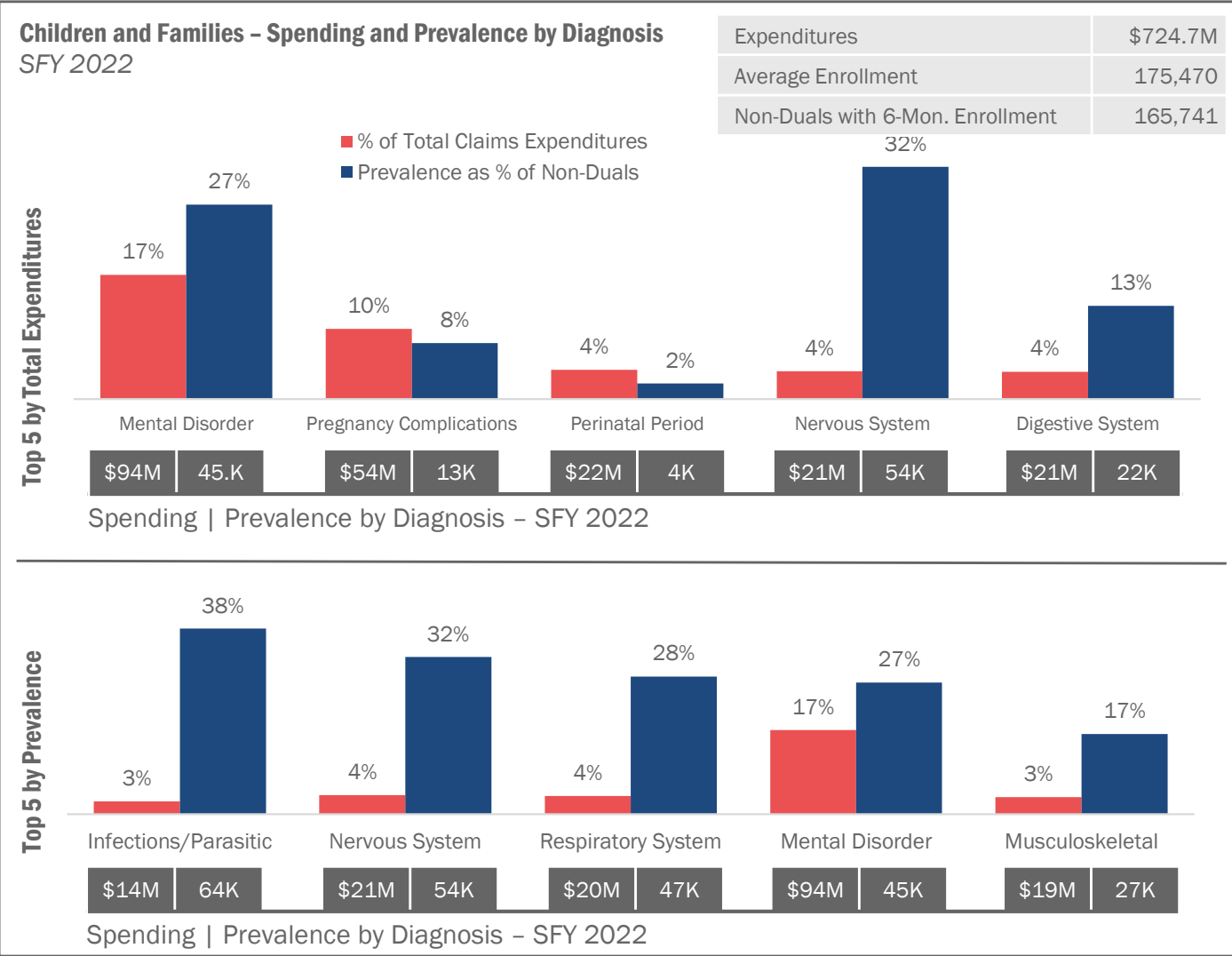
# Children and Families: Expenditures by Provider Type

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



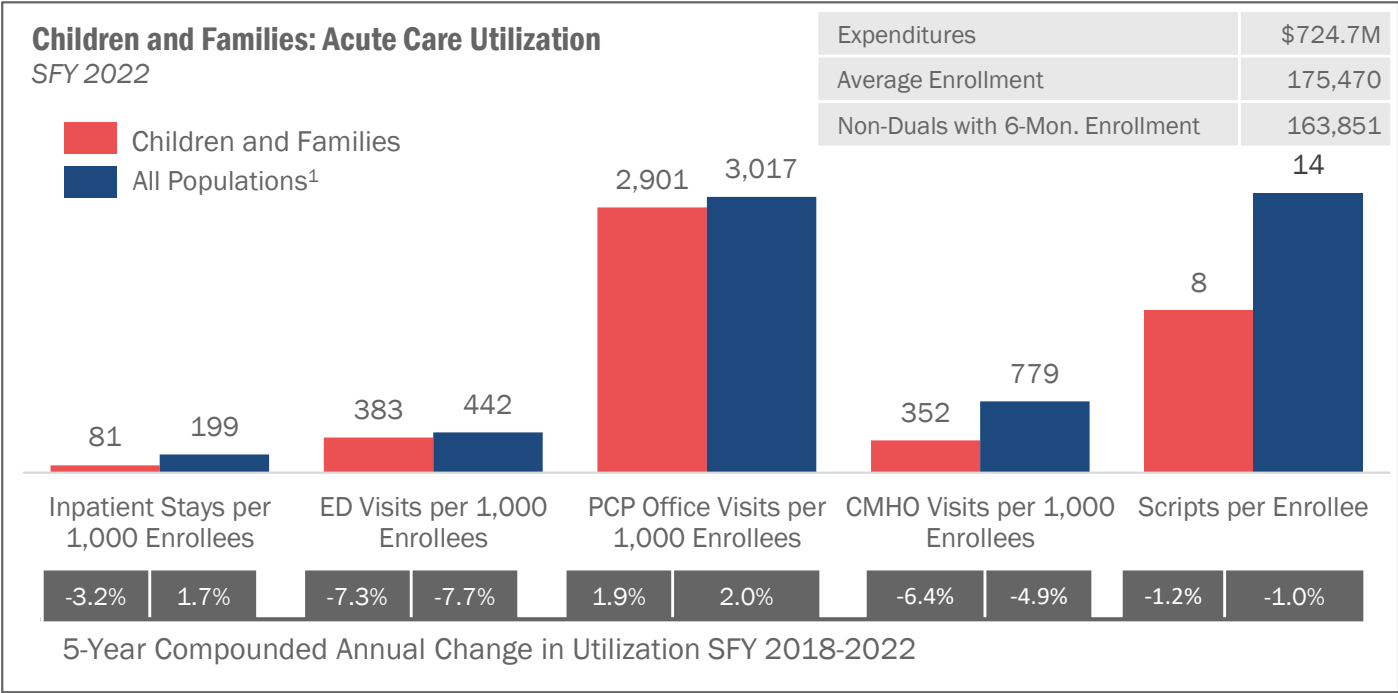
- Children and Families is the largest population group in Rhode Island Medicaid, with 50.5% of all Medicaid enrollees falling into this category.
- Children and Families have the lowest per-person expenditures of any of the populations.
- Professional services and hospital services (outpatient and inpatient) account for 73% (\$529.2M) of the expenditures for the Children and Families population in SFY 2022.
- The fastest-growing expenditures for Children and Families are Pharmacy, Medicare Premium Payments, and Inpatient Services, which grew at a yearly average of 18.7%, 13.8%, and 7.7%, respectively, from SFY 2018 to 2022.

# Children and Families: Diagnoses



# Children and Families: Acute Care Services

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



- Children and Families use, on average, fewer than half as many inpatient days per person as the overall Medicaid population.
- In SFY 2022, Children and Families used the ED and had office visits at levels approximately 6% and 4% lower than the overall population, respectively.
- Per person utilization for Children and Families have lower growth trends than the overall population for most services.
- Costs per script in FY 2022 were approximately 21% lower for the Child and Families population than for the overall population.

Children and Families: Average Cost per Acute Care Service

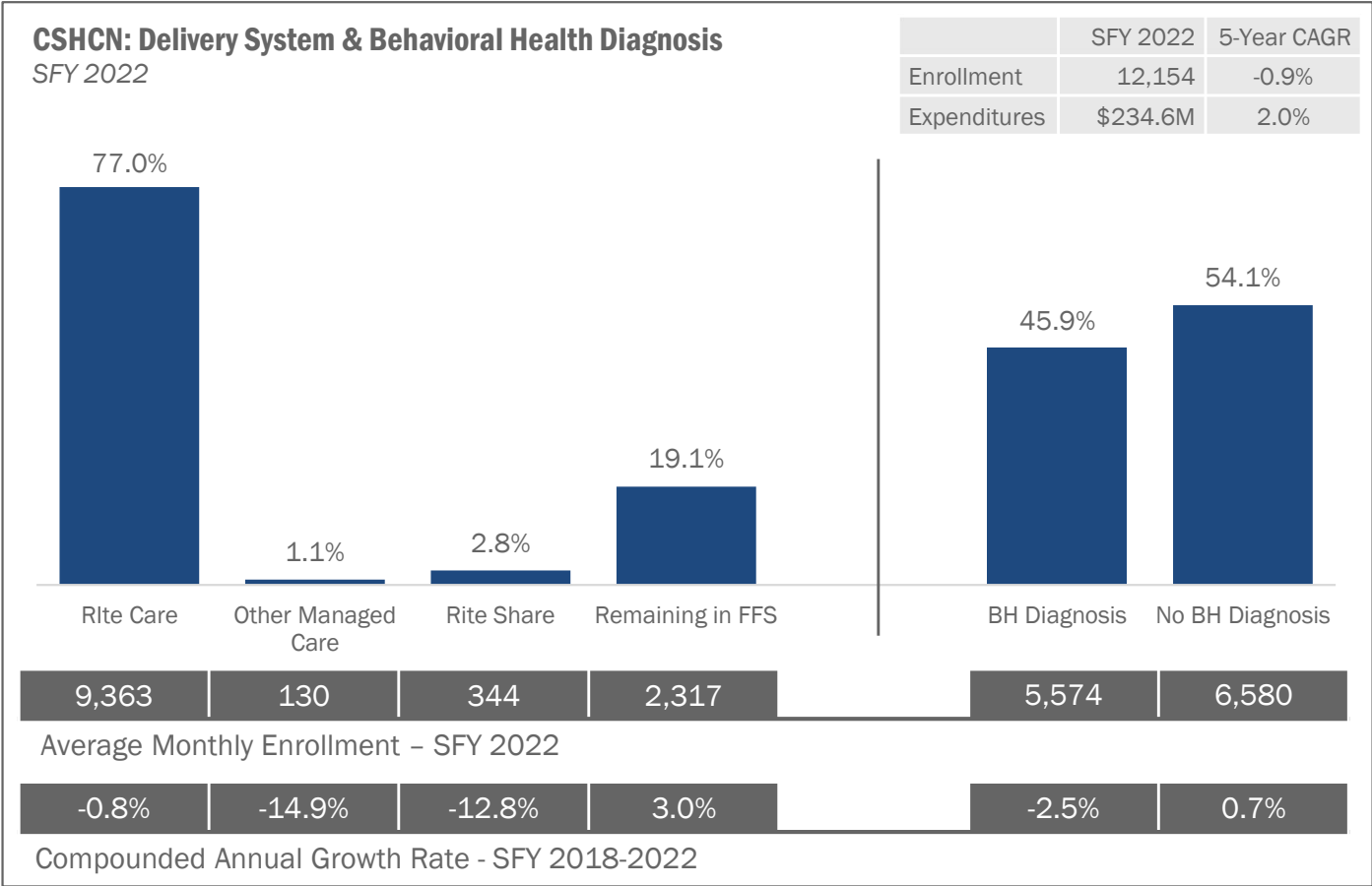
SFY 2022

	Inpatient Stay	ED Visit	Office Visit	CMHO Visit	Script
Children and Families	\$8,126	\$616	\$81	\$152	\$67
Overall	\$6,148	\$665	\$79	\$256	\$85

<sup>1</sup> All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.

# CSHCN: Managed Care Enrollment

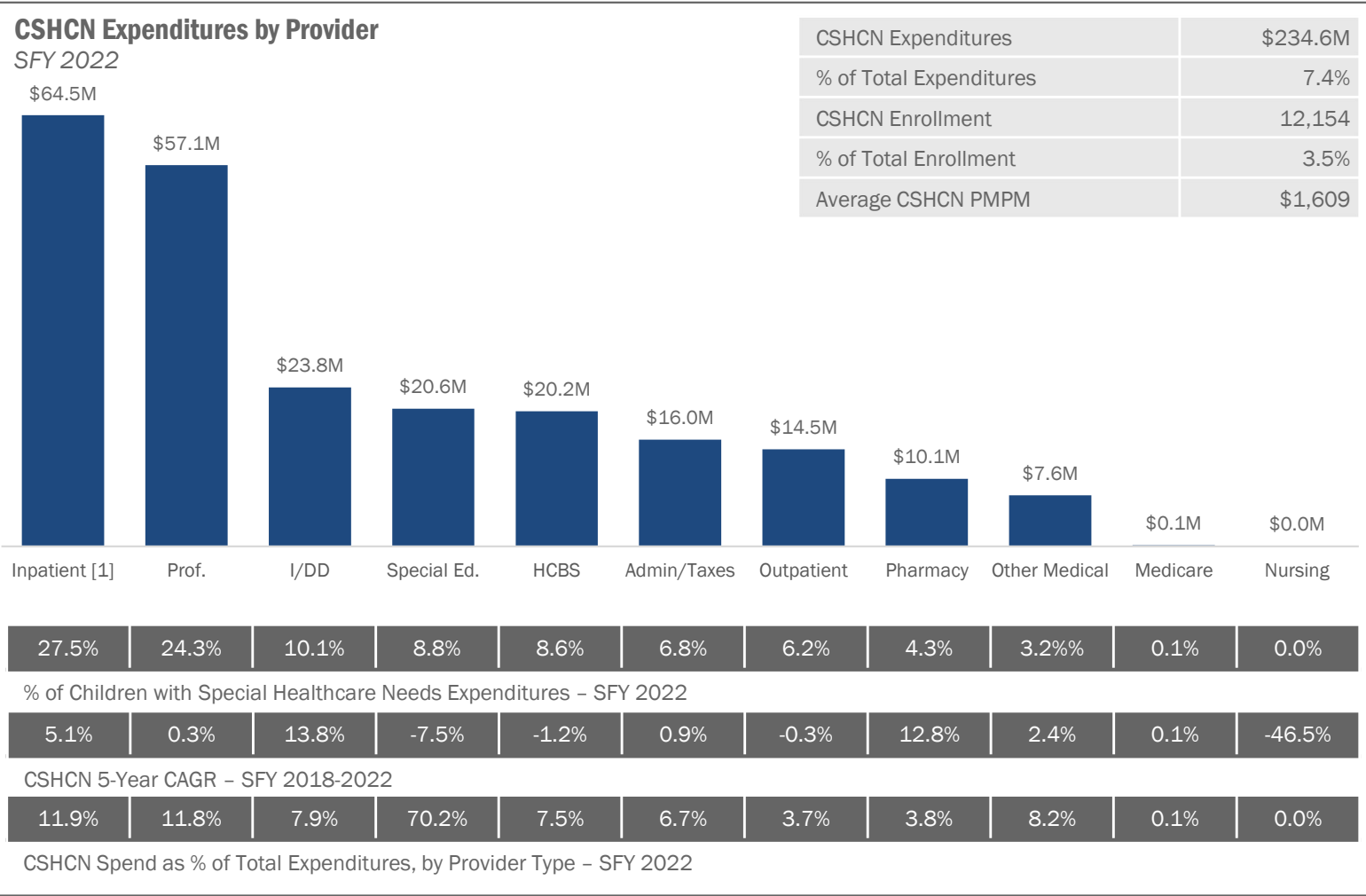
CSHCN are primarily enrolled in managed care, in the Rite Care program. However, a significantly greater proportion (19.1%), compared to youth in the Children and Families population group, remain in fee-for-service as they have access to other third-party coverage for their acute care needs.



- 77.0% of Children with Special Health Care Needs are enrolled in Rite Care.
  - Enrollees in the Rite Care are divided between Neighborhood Health Plan, United Healthcare, and Tufts Health Plan.
  - Children in substitute care administered by DCYF are exclusively enrolled in Neighborhood.
- CSHCN who live in institutions have their Medicaid coverage administered by the state of Rhode Island in FFS and are not enrolled in managed care.
- A greater proportion of CSHCN are in Rite Share or remaining in FFS compared to Children and Families or Expansion because many of the families of these children have comprehensive third-party coverage for their families, including:
  - approximately 90% of Katie Beckett children, and
  - 30% of Adoption Subsidy.
- "Other Managed Care" includes members who for a portion of the year were enrolled in RHP or Expansion.

# CSHCN: Expenditures by Provider Type

CSHCN expenditures are largely concentrated in professional and inpatient services.

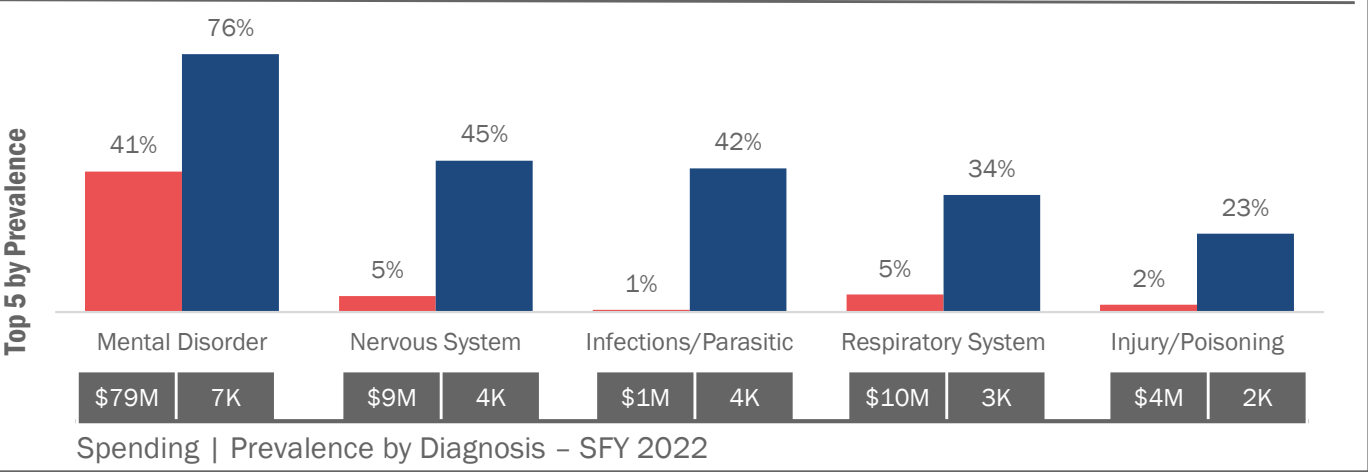
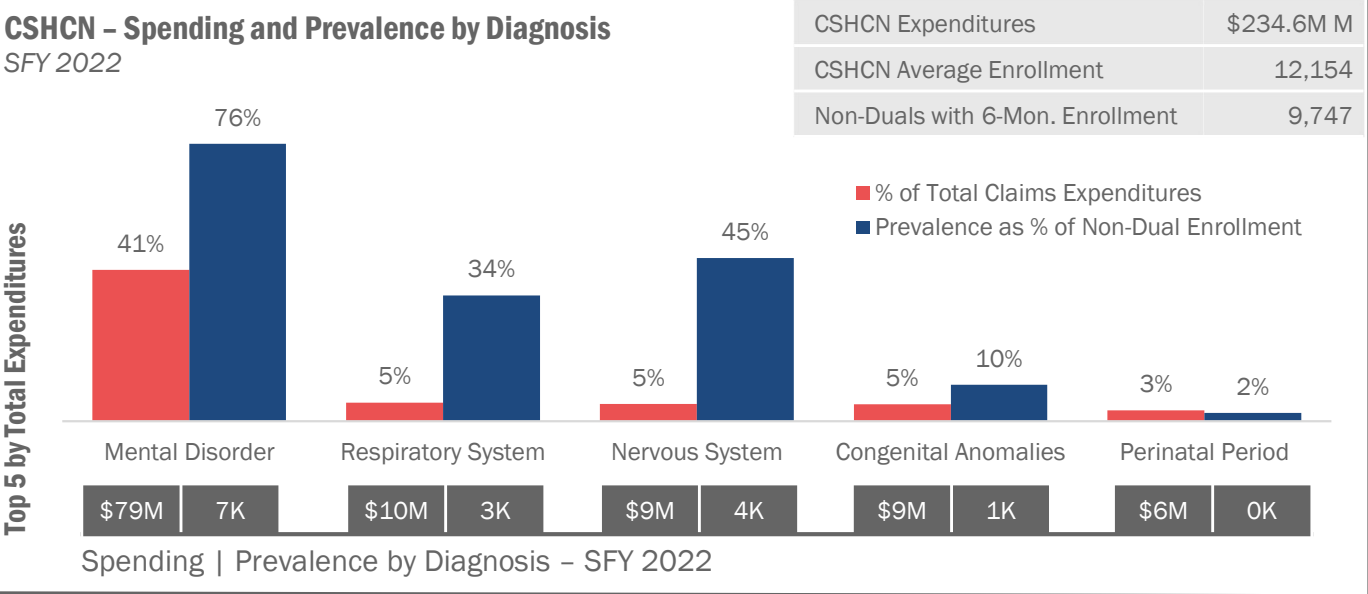


<sup>1</sup> Inpatient spending includes \$3.6 million spending at Tavares Pediatric Center that is an Intermediate Care Facility.

- 52% of CSHCN expenditures go towards professional services and inpatient hospital services.
- A significantly smaller percentage of CSHCN expenditures go toward pharmacy, residential and rehabilitation services for persons with IDD, premiums, and nursing facilities and hospice than for the overall population.
- Average annual growth of professional expenditures (0.3%) from SFY 2018 to 2022 was lower than the overall population (3.0%).
- CSHCN Special Education expenditures (\$20.6 M) accounted for 70% of the overall population (\$29.3M) in SFY 2022.

# CSHCN: Diagnoses

CSHCN – Spending and Prevalence by Diagnosis  
SFY 2022



CSHCN expenditures are largely concentrated in professional and inpatient services.

- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental or behavioral health diagnoses have high cost among all populations but are higher among CSHCN than any other population.
- Diagnoses of the respiratory system are associated with the second-highest expenditures for CSHCN.
- Mental or behavioral diagnoses, diseases of the nervous system and sense organs, infections, respiratory system, and injury/poisoning diagnoses are prevalent among the CSHCN population.

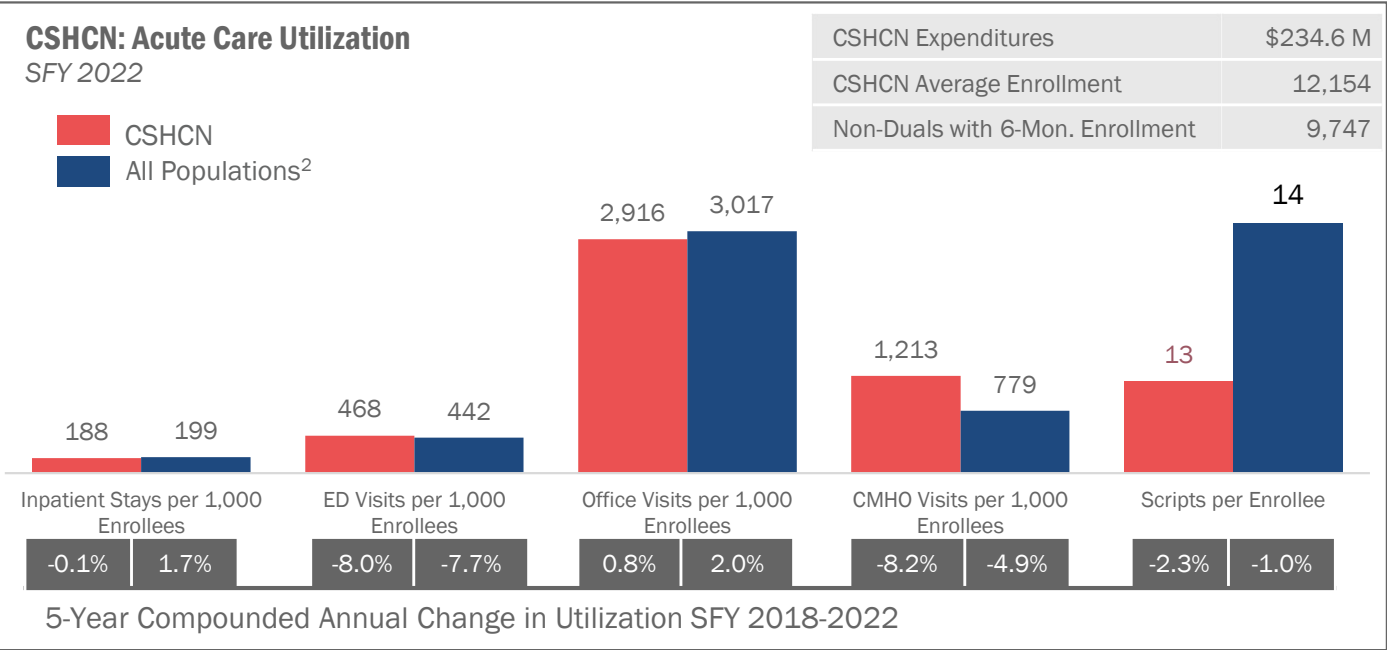
An example of how to interpret the chart to the left:

- Of the total claims for this population, 41% of costs were for claims where “mental or behavioral health” was the primary diagnosis.
- 76% “prevalence as a % of non-duals” means that among members within the CSHCN population that have at least 6 months of enrollment during the year, 76% of the non-duals had claims where “mental or behavioral health” was the primary diagnosis.



# CSHCN: Acute Care Utilization

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



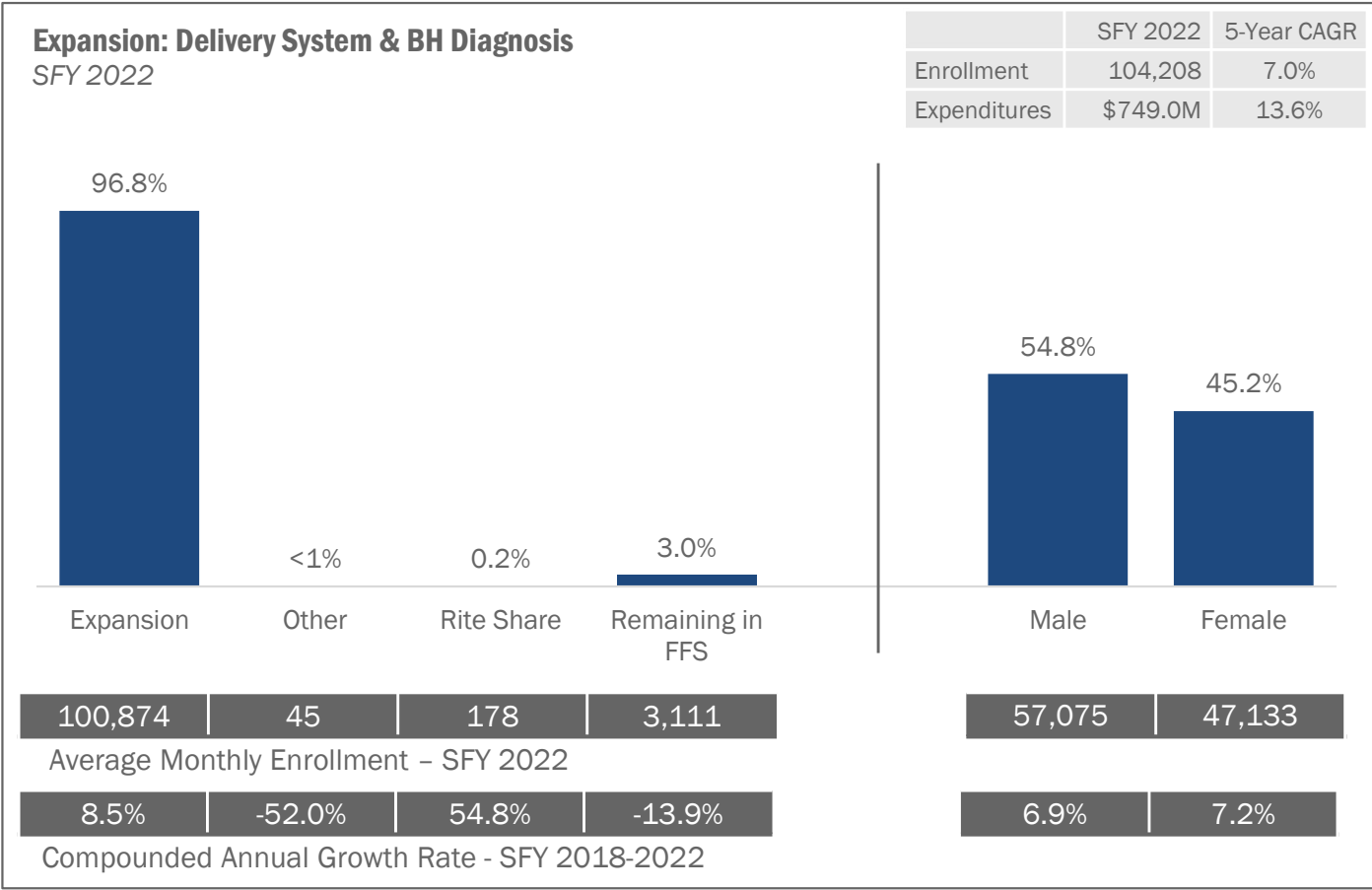
- The CSHCN population experiences fewer inpatient stays than the overall Medicaid population.
  - However, each stay is more expensive, with an average cost per stay of \$21,477 for CSHCN compared to \$6,148 for the rest of the Medicaid-only population suggesting a longer average length of stay.
- CSHCN rates of utilization for ED and CMHO visits are higher than the utilization rates for the overall population.
- CSHCN expenditure growth has been slower than that of other populations for all acute care service types.
- Both costs per script and costs per office visit are greater for the CSHCN population than for the overall population (31% and 19%, respectively).

CSHCN: Average Cost per Acute Care Service					
SFY 2022					
	Inpatient Stay	ED Visit	Office Visit	CMHO Visit	Script
CSHCN	\$21,477	\$609	\$94	\$139	\$112
Overall	\$6,148	\$665	\$79	\$256	\$85

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

# Expansion: Managed Care Enrollment

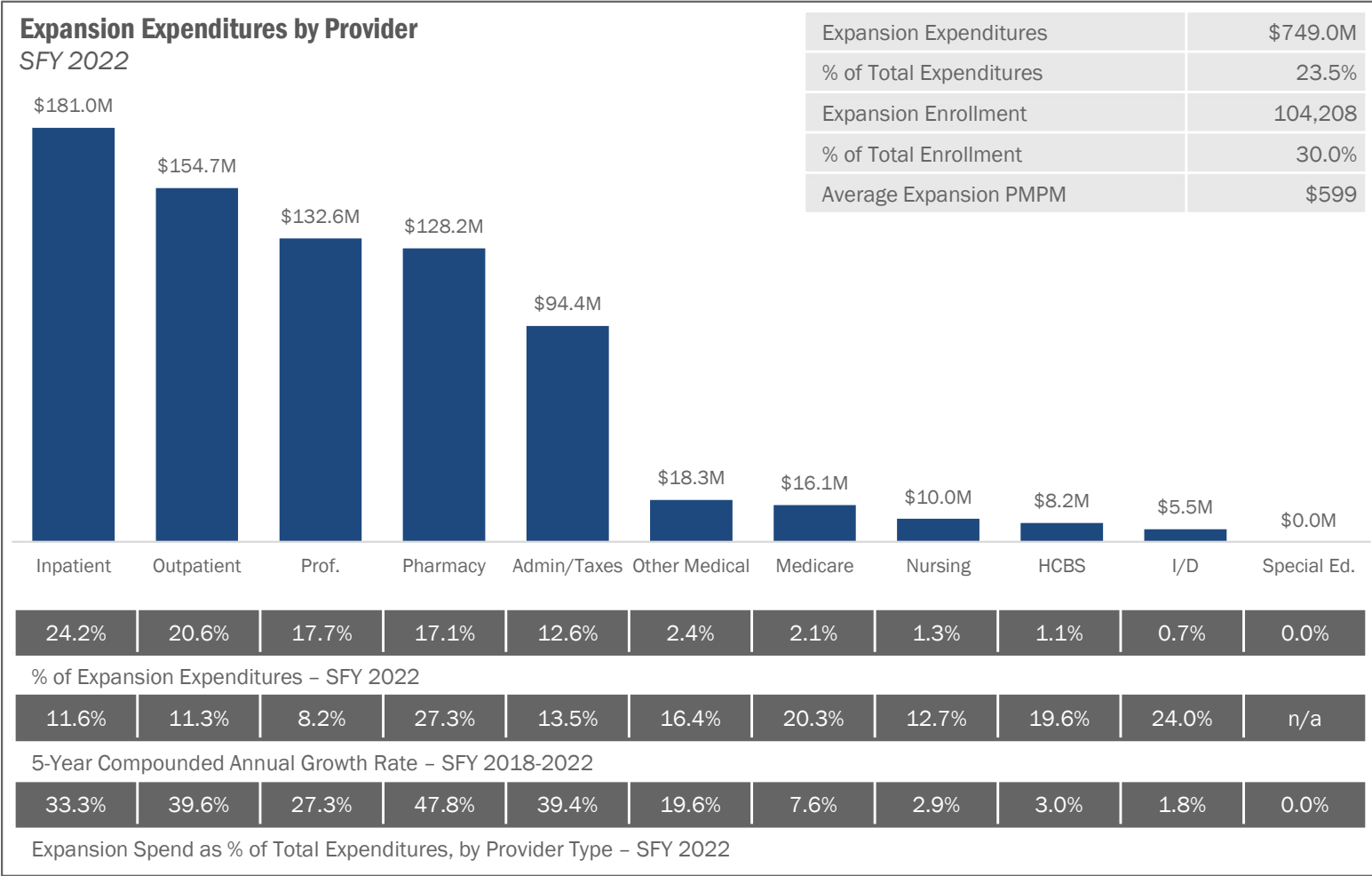
The Expansion population is primarily enrolled in managed care.



- Expansion includes childless adults who are eligible under the income-based eligibility standards set when the state expanded Medicaid under ACA in 2014. This population also includes people who are classified as previously eligible under criteria for "Adults with Disabilities."
- Spending on the Expansion population totaled \$749 million in SFY 2022.
- 97% of the Expansion population enrolled in managed care.
  - Newly eligible members experience an initial period of up to 45 days in FFS prior to their mandatory enrollment in a health plan.
- Unlike overall Medicaid enrollment, males make up a disproportionate share of the total Medicaid Expansion population.
- "Other" includes members who transitioned to Expansion after being enrolled in another managed care program for portion of the year (e.g., Rite Care or RHP).

# Expansion: Expenditures by Provider Type

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

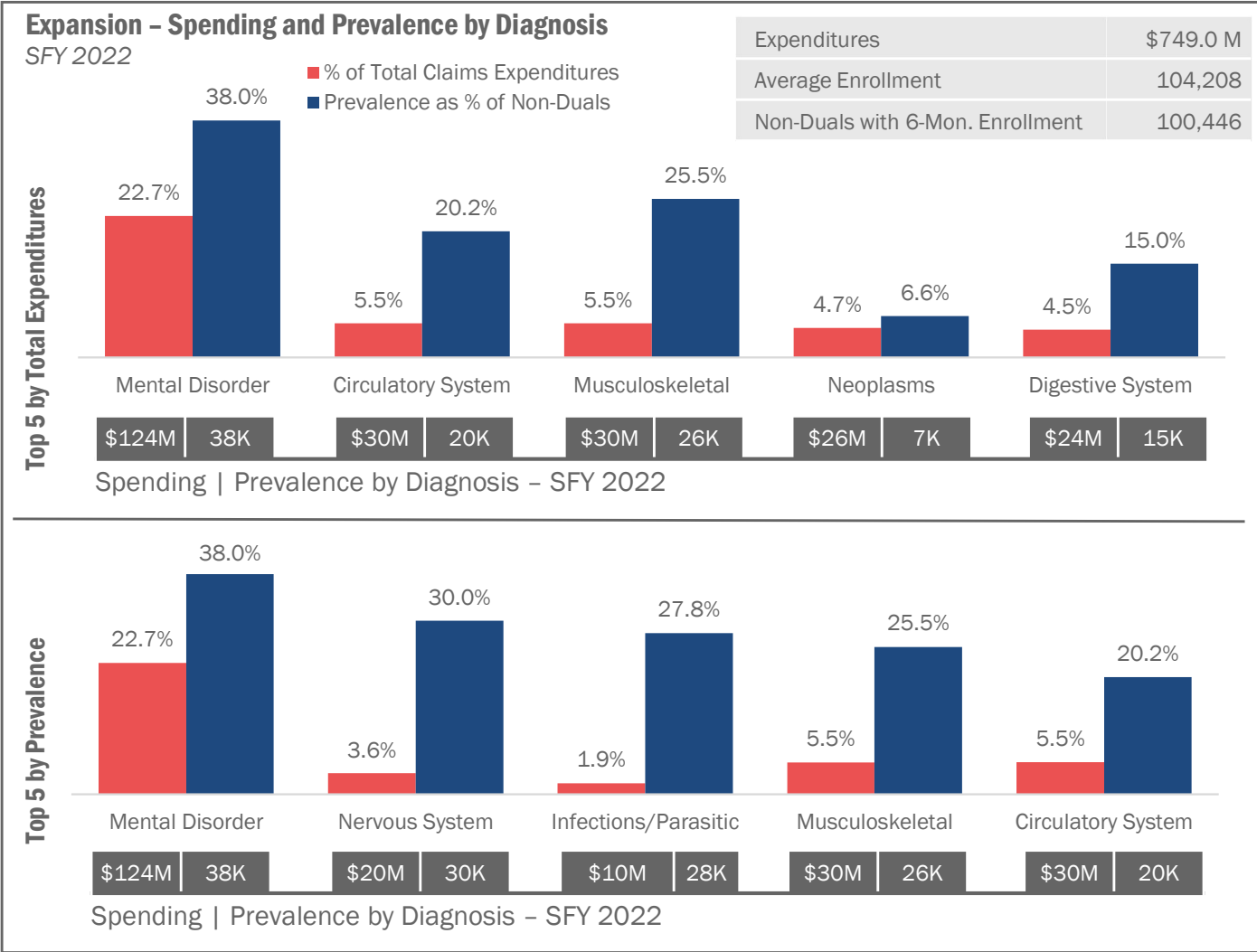


- Expenditure growth for the Expansion population was significantly higher (14%) than the overall population (6%), driven primarily by higher enrollment growth (7.0% per annum for Expansion compared to 2.3% overall).
- The Expansion population utilizes inpatient, outpatient and pharmacy services at a higher rate than other populations.
- Expenditures on LTSS services are relatively low for the Expansion population.

<sup>1</sup> Table shows Expansion spend as a percentage of total expenditures of the overall population. The overall population include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

# Expansion: Diagnoses

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



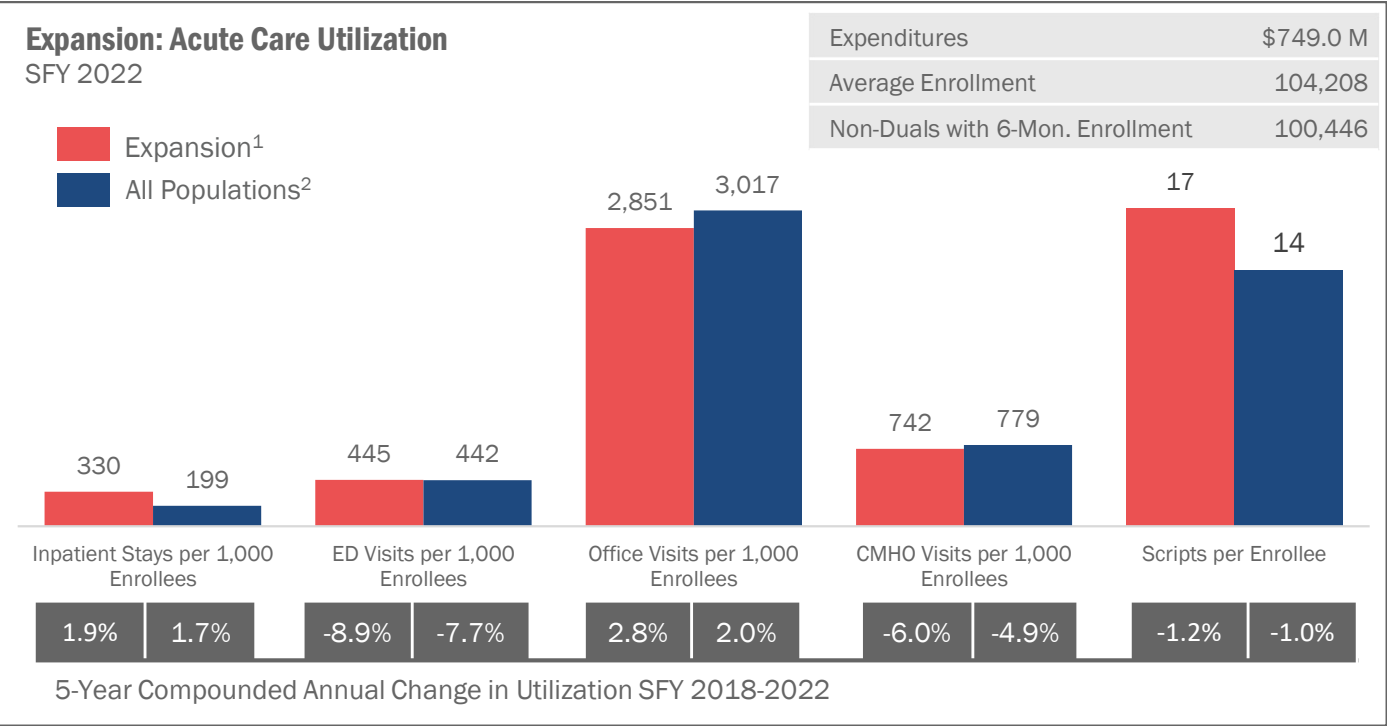
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Among all mental health diagnoses, substance-related disorders are nearly twice as prevalent among the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

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

■ 38% "prevalence as a % of non-duals" means that among members within the Expansion population that have at least 6 months of enrollment during the year, 38% of the non-duals had claims where "mental or behavioral health" was the primary diagnosis.

■ Of the total claims for this population, 22.7% of costs were for claims where "mental or behavioral health" was the primary diagnosis.

# Expansion: Acute Care Utilization



Expansion: Average Cost per Acute Care Service					
SFY 2022					
	Inpatient Stay	ED Visit	Office Visit	CMHO Visits	Script
Expansion	\$3,381	\$702	\$75	\$268	\$89
Overall	\$6,148	\$665	\$79	\$256	\$85

<sup>1</sup> Unduplicated enrollees includes count of Medicaid Only members with a minimum of six months of eligibility.

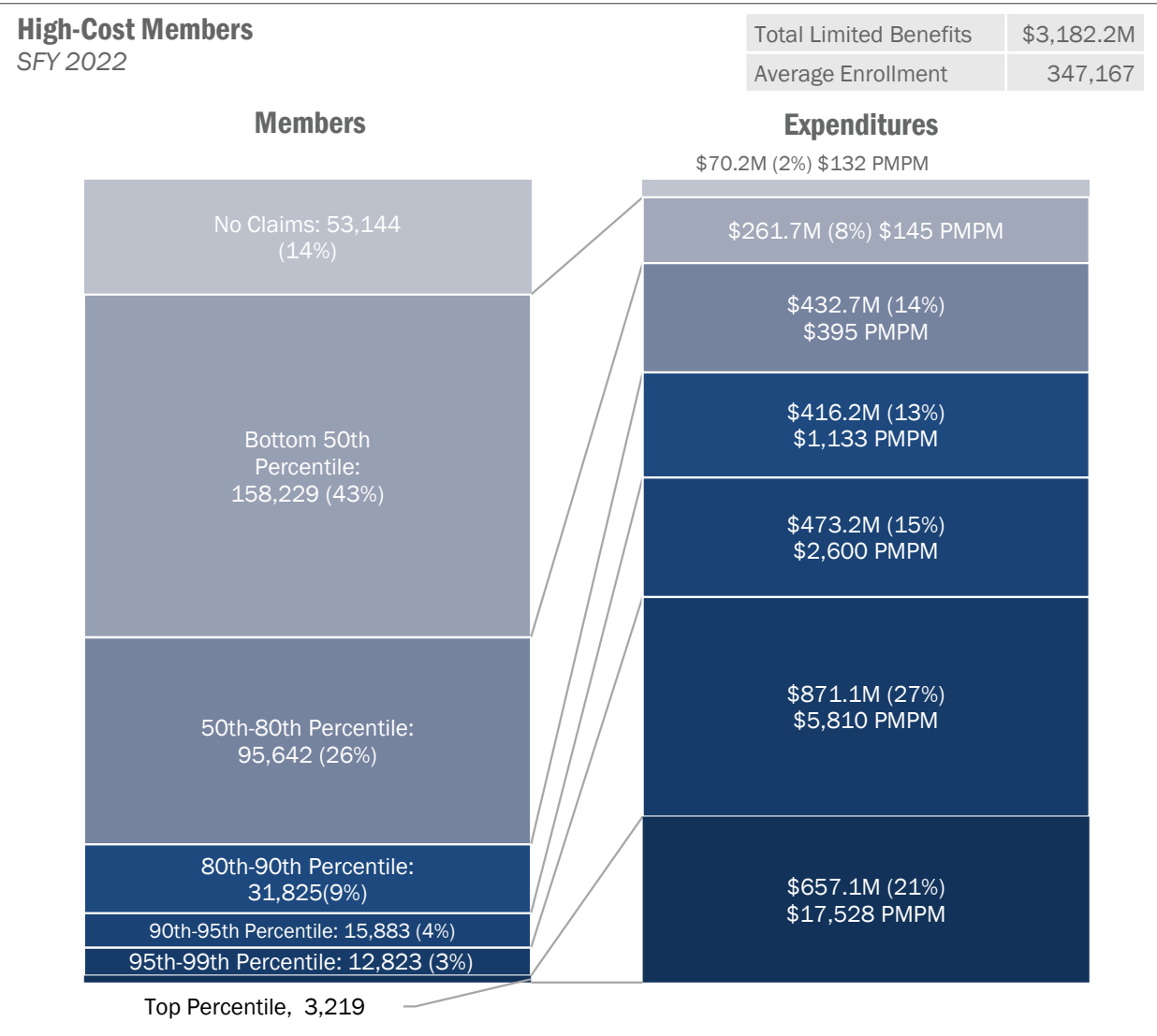
<sup>2</sup> All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of six months of eligibility.

- The per person utilization rates of the Expansion population are consistent with the overall population generally, while growth rates in utilization are mixed.
  - Utilization of inpatient stays grew at a faster rate on average over the five-year period than the overall populations.
- Emergency department visits declined by -8.9% per year on average over the five-year period, which is slightly more than the declining utilization among the overall population.
- The overall cost per script (excluding rebates) is consistent with the overall population. The Expansion and overall population saw a modest decline in utilization on an annual basis over the five-year period.
- The average cost for most services is comparable to the overall population except for Inpatient Stays that are significantly less.

# Miscellany & Exclusions

54	<b>High-Cost Enrollees</b> FY 2022 Snapshot Behavioral Health Diagnosis
56	<b>Hospital Spending</b> Disproportionate Share Hospital/Graduate Medical Education All Hospital Spending, by Hospital and Type of Expenditure
58	<b>Limited Benefits</b> FY 2022 Snapshot Five Year History
59	<b>Medicaid Central Management Costs</b> FY 2022 Snapshot: By Department Five Year History
60	<b>CMS Core Measures</b> Children and Adult CMS Scorecard Benchmarking
66	<b>Acronyms and Definitions</b> General Acronyms, Diagnosis, and Provider Types

# High-Cost Enrollees: Summary



- Medicaid claims expenditures are highly concentrated:
  - The top 1% of users account for 21% of all benefit expenditures with an average PMPM of \$17,528 or over \$200,000 in spending per year.
  - And the top 20<sup>th</sup> percentile of Medicaid users account for 63% of all expenditures with an average PMPM of \$6,741.
  - The bottom 50<sup>th</sup> percentile of Medicaid users with any claims activity have an average PMPM of \$145.
- Members with no claims’ activity account for nearly 14% of enrollment within the fiscal year. Although they do not have claims activity, EOHHS still pays a capitation payment to the MCOs on their behalf which includes an administrative component reflected herein.
  - Note: Expenditures are primarily allocated based on claims payments; however, MCO administrative costs are allocated on a PMPM basis across relevant membership regardless of claims utilization.*
- High-cost enrollees typically have multiple complex conditions, requiring care coordination across a variety of provider types.
- Most high-cost enrollees residing within the community belong to the Adults with Disabilities or Expansion populations.



# High-Cost Enrollees: Behavioral Health Diagnoses and Expenditures

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

Enrollment and Expenditures among Members with a Behavioral Health Diagnosis  
SFY 2022

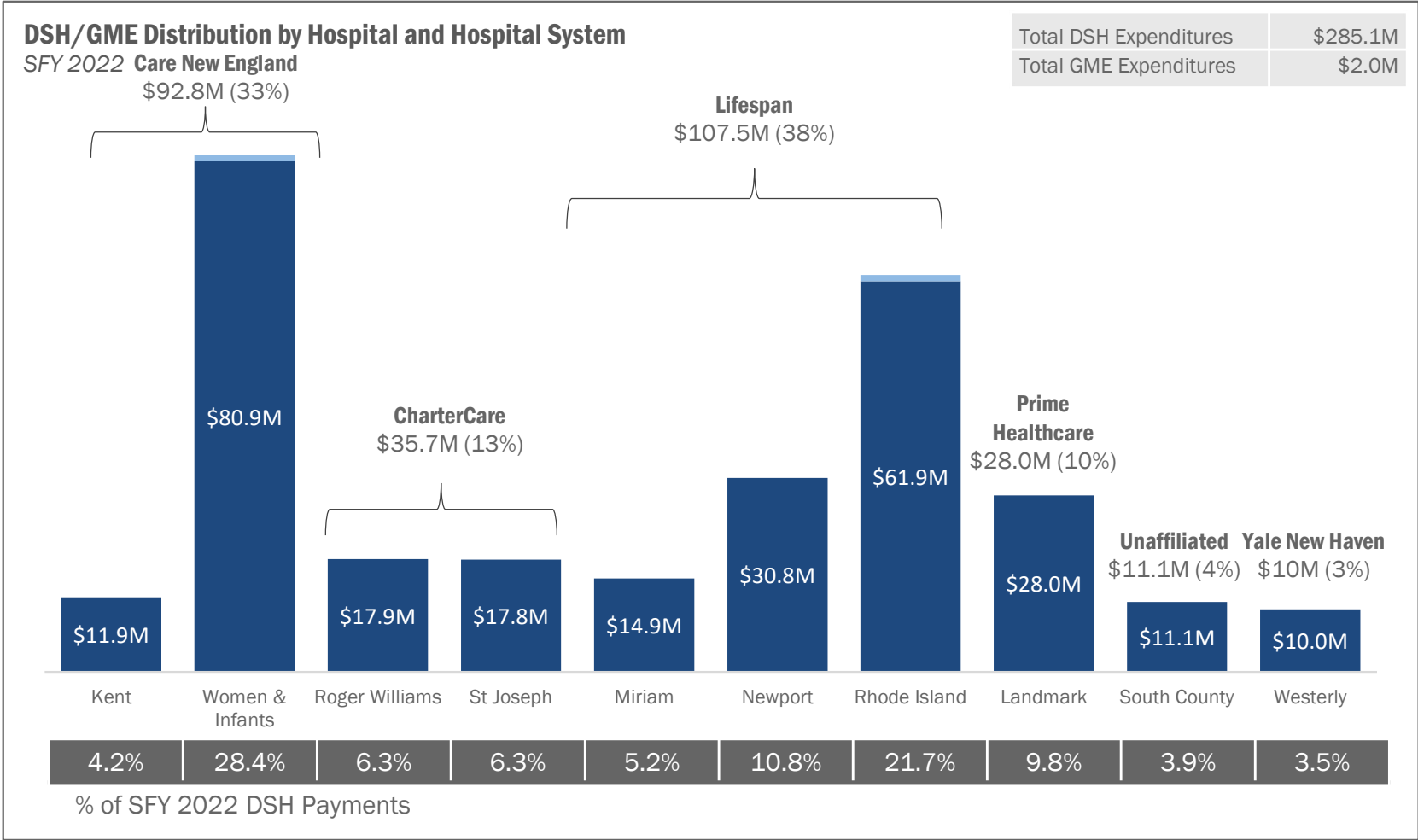
Primary Payer and Diagnosis <sup>1</sup>	Average Enrollment	% of Enrollment	Overall PMPM	% of Expenditures
Medicaid Only				
I/DD Community (BHDDH)	1,176	0.4%	\$7,256	5%
Other Developmental Disability	9,860	3.3%	\$1,224	7%
Substance Use Disorder	10,237	3.4%	\$2,302	13.7%
Other Behavioral/Mental Health	35,900	12.0%	\$1,211	25.3%
Subtotal - Any BH-Related Diagnoses	57,109	19.1%	\$1,527	50.7%
No BH-Related Diagnosis	241,722	80.9%	\$349	49.0%
Overall - Medicaid Only	298,896	100%	\$576	100%
Duals				
I/DD Community (BHDDH)	2,482	5.8%	\$7,704	22.0%
Other Developmental Disability	156	0.4%	\$3,790	0.7%
Substance Use Disorder	1,205	2.8%	\$1,542	2.1%
Other Behavioral/Mental Health	8,239	19.4%	\$2,594	24.6%
Subtotal - Any BH-Related Diagnoses	12,082	28.4%	\$3,477	48.4%
No BH-Related Diagnosis	30,481	71.6%	\$1,438	50.5%
Overall - Duals	42,562	100%	\$2,039	100%

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

- Among both the Dual and Medicaid Only populations, members with a BH diagnosis account for a disproportionate share of expenditures:
  - 19.1% of Medicaid Only members have a BH-related diagnosis and account for over two-thirds of expenditures.
  - 28.4% of Duals have a BH diagnosis and account for 48.4% of expenditures.
- Approximately half of all members with \$6,000 or more in claims per year had a BH-related diagnosis.
- Overall, the PMPM for a non-dual member with a BH diagnosis was \$1,527 compared to \$349 PMPM for members without any BH diagnoses.

# Exclusions: Hospital Spending DSH/GME

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

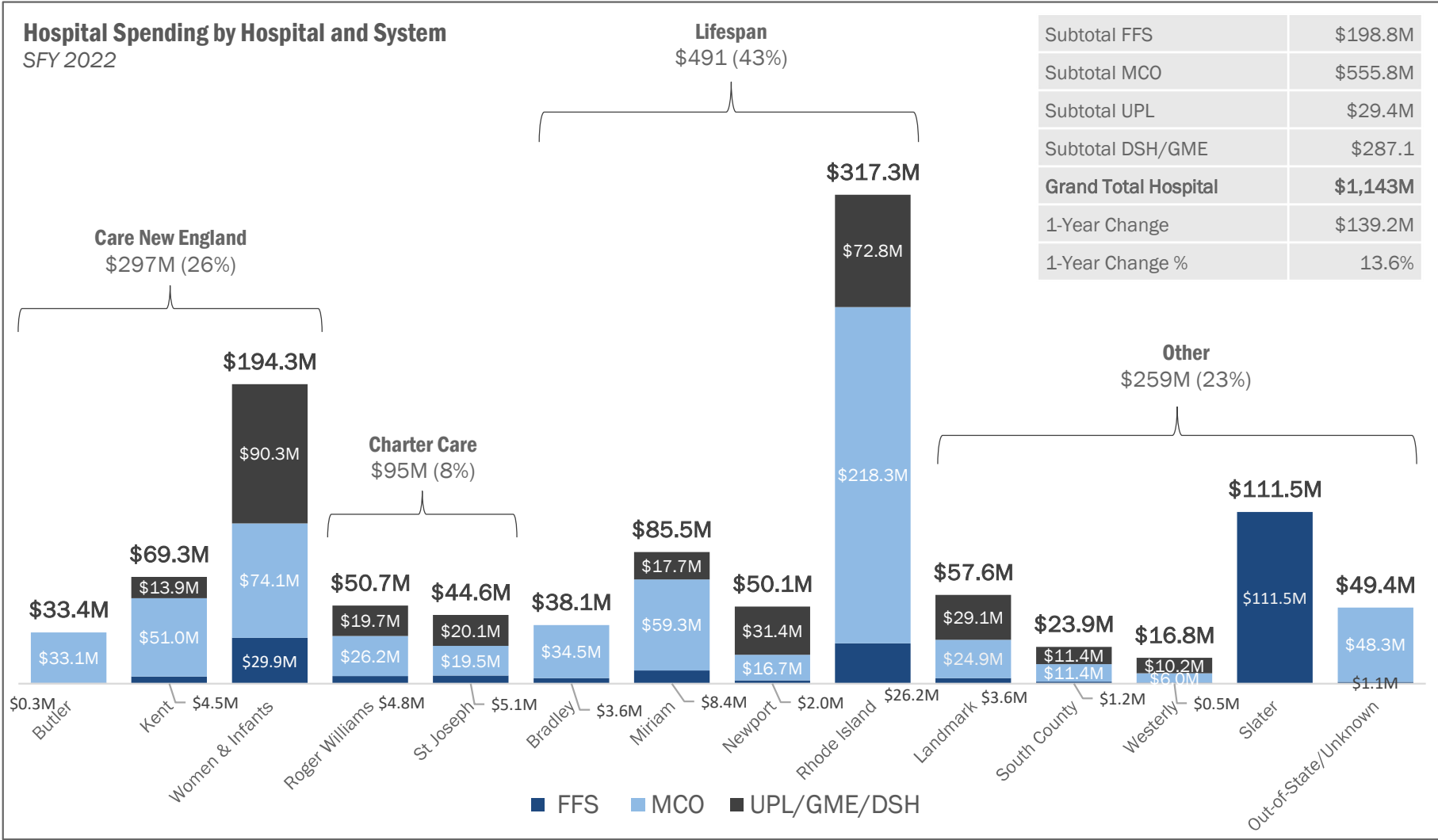


- Total DSH payments eligible for Medicaid financing is determined by federal regulation that establishes each State’s maximum DSH allotment.
- In SFY 2022, Rhode Island DSH payments totaled **\$285.1 million** near doubling of payments made in SFY 2021.
- EOHHS paid \$2.0 million in GME payments in SFY 2022.
- Half of the year’s DSH payments went to two facilities:
  - Rhode Island Hospital in Providence
  - Women & Infants Hospital in Providence
- Care New England, Lifespan, and CharterCare are multi-hospital health systems in Rhode Island.

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

In SFY 2022, EOHHS made \$29.4 million in UPL payments.

# All Hospital Spending

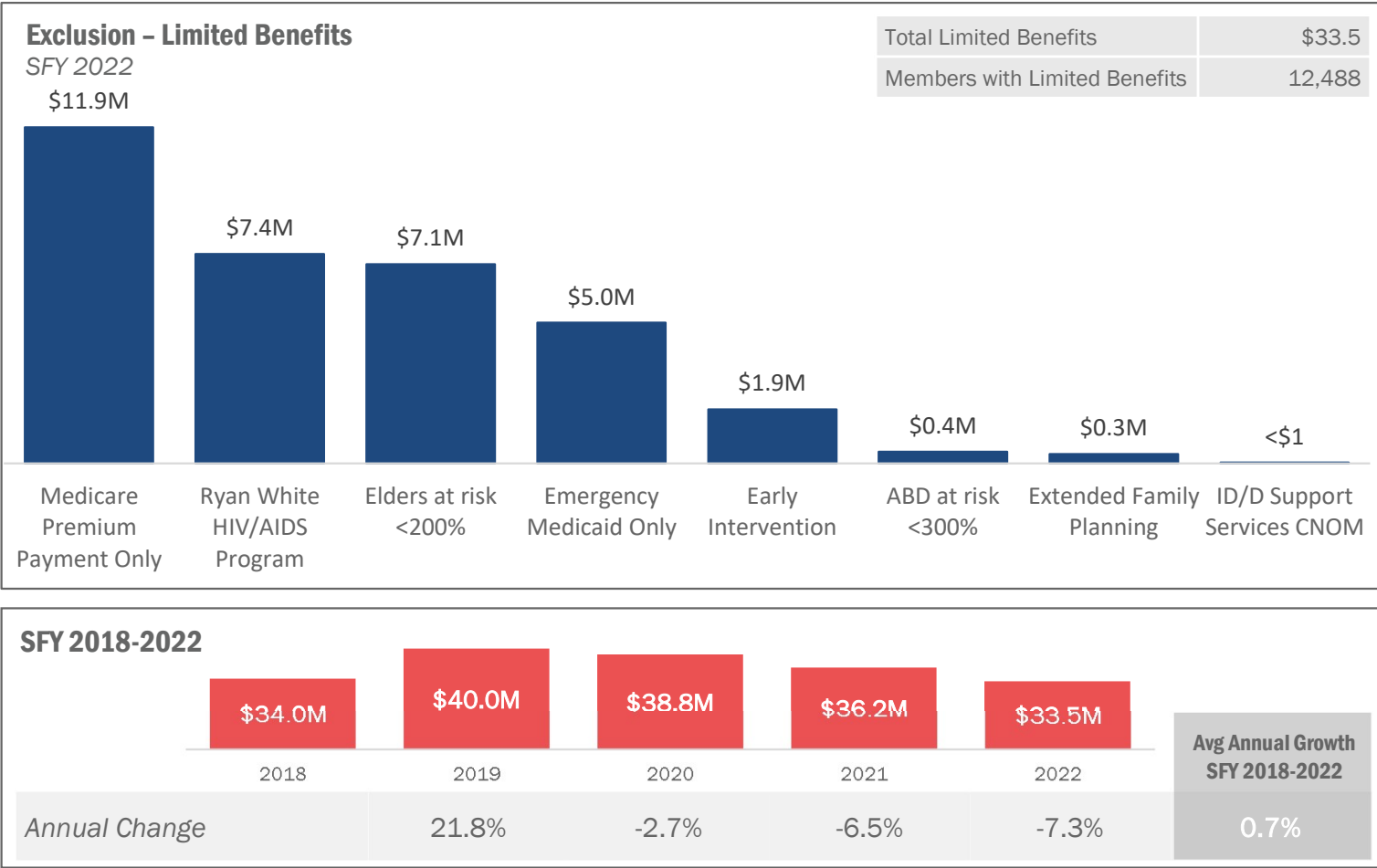


- Medicaid made total payments of \$1,143 million, including:
  - Rhode Island DSH/GME payments totaled **\$287.1 million**.
  - UPL payments totaled **\$29.4 million**.
  - \$827 million** for claims activity
- MCO payments account for 52% of all hospital spending.
- More than 60% of the year’s hospital payments went to two hospital systems:
  - Care New England
  - Lifespan
- Rhode Island Hospital alone accounted for \$317.3 million (30%) in the public’s spending.

	Total Hospital Spending
SFY 2018	\$864M
SFY 2019	\$890M
SFY 2020	\$873M
SFY 2021	\$962M
SFY 2022	\$1,143M
5-Year CAGR %	7.2%

# Exclusions: Limited Benefits

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

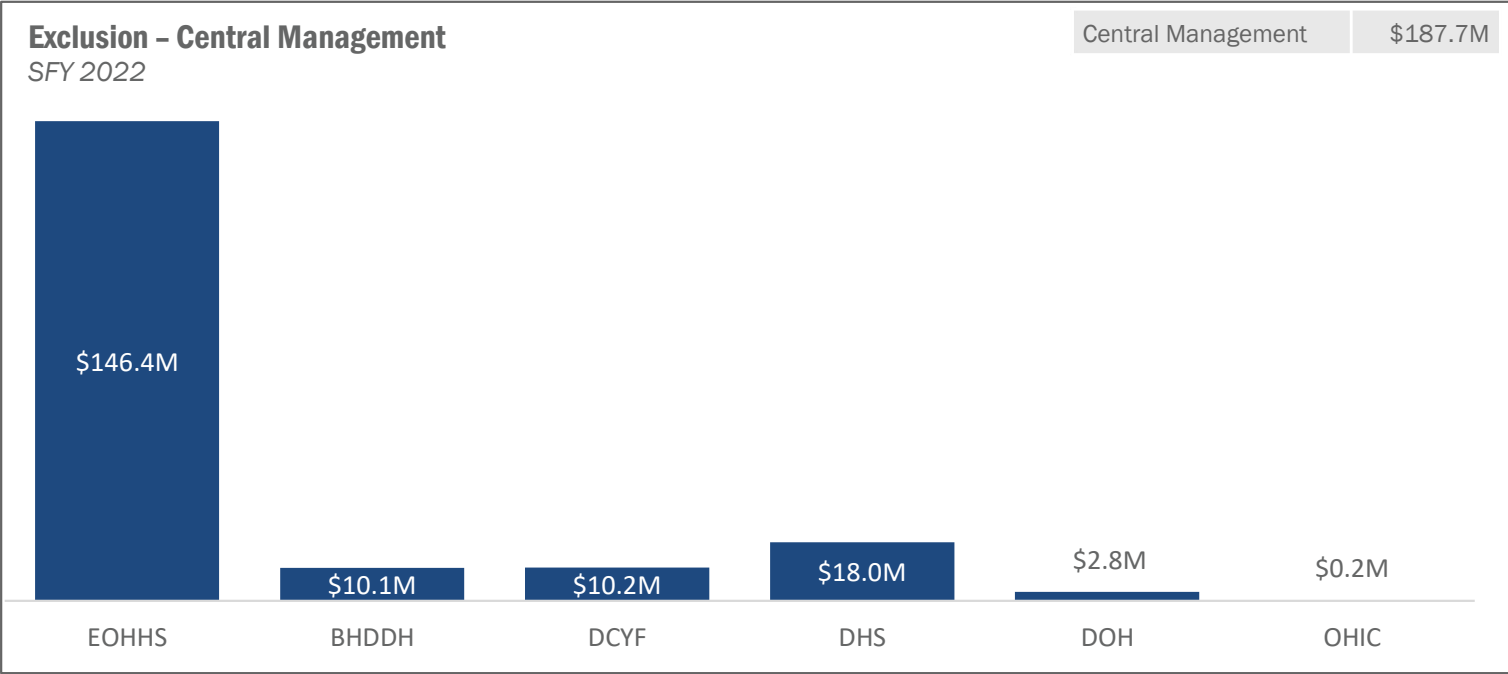


- Expenditures for members with limited benefits totaled \$33.5 million in SFY 2022.
- Partial Duals:** Payments for Medicare premiums for qualifying individuals account for \$11.9 million. In SFY 2022, EOHHS subsidized the Medicare premiums for an average of 7,319 low-income elders each month with limited Medicaid.
- Costs Not Otherwise Matchable (CNOM) and Partial Emergency Services:** Limited benefits not traditionally eligible for federal Medicaid funding match, that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible. Includes services covered by the Office of Healthy Aging and the Ryan White HIV/AIDS program.
- Note prior years’ Expenditure Reports have reported spending at the Department of Corrections (RIDOC) among the CNOM and Limited Benefits exclusions. These expenditures are not Medicaid-eligible. Rather, RIDOC simply uses the State’s fiscal intermediary to process medical claims and so they appear within the MMIS transactions.

<sup>1</sup> Calculated as compounded annual growth rate (CAGR) over period SFY 2018-2022 as shown.

# Exclusions: Central Management

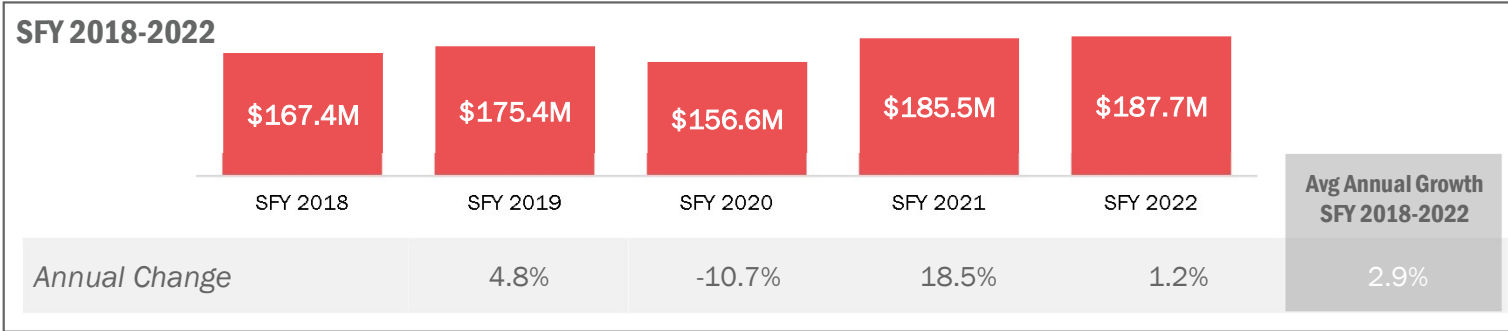
EOHHS is the Single State Agency for Administering the Medicaid Program and accounts for 78% of all central management expenditures in SFY 2022.



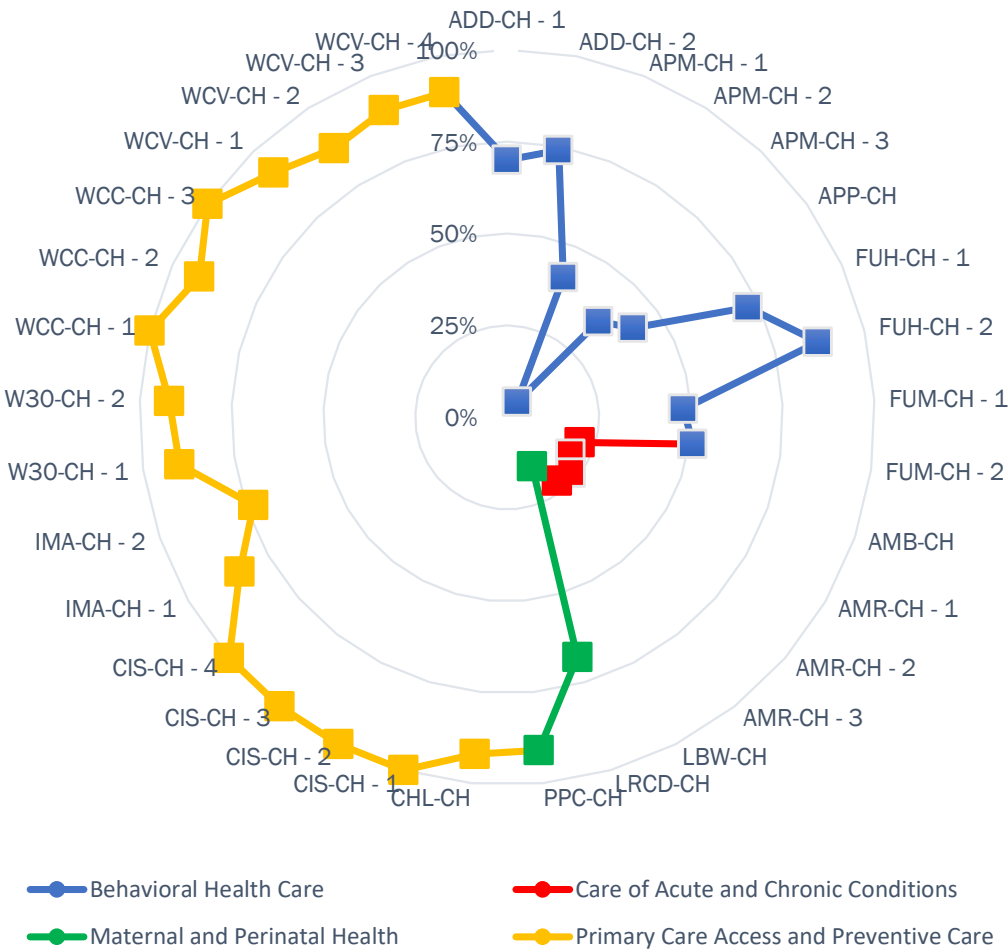
- Central Management expenditures can vary significantly year-over-year.

### Note Regarding Methodology

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



# CMS Medicaid Scorecard – Child Core Set



- CMS developed its Medicaid and Children’s Health Insurance Program (CHIP) Scorecard to increase public transparency about the programs’ outcomes.
- The Child and Adult Core Sets support federal and state efforts to collect, report, and use a standardized set of measures to drive improvement in the quality of care provided to Medicaid and CHIP beneficiaries.
- In recognition of reporting differences across states reflected in the CMS Medicaid and CHIP Scorecard, this report summarizes information in a format that provides the ability to compare states that use similar logic for reporting. Comparisons are only made of states that use the same population and reporting methodology for each rate, allowing for a more accurate comparison between states.
- In FFY 2022, 23 out of the 33 measures included in this analysis Rhode Island’s performance exceeded the 50<sup>th</sup> percentile and 17 measured exceeded 75<sup>th</sup> percentile.

### How to interpret the radar chart

Each measure included in the analysis is represented as an axis, or “spoke”.

Rates are displayed on a percentile basis (compared to those states using the same population and reporting methodology for that rate).

Points near the outside of the circle reflect better relative performance.

Source: EOHHS analysis of 2022 Child and Adult Health Care Quality Measures available at: <https://data.medicaid.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6>

[1] Limited to measures with at least 10 states using the same population and reporting methodology.

# Core Set Measure Definitions - Children

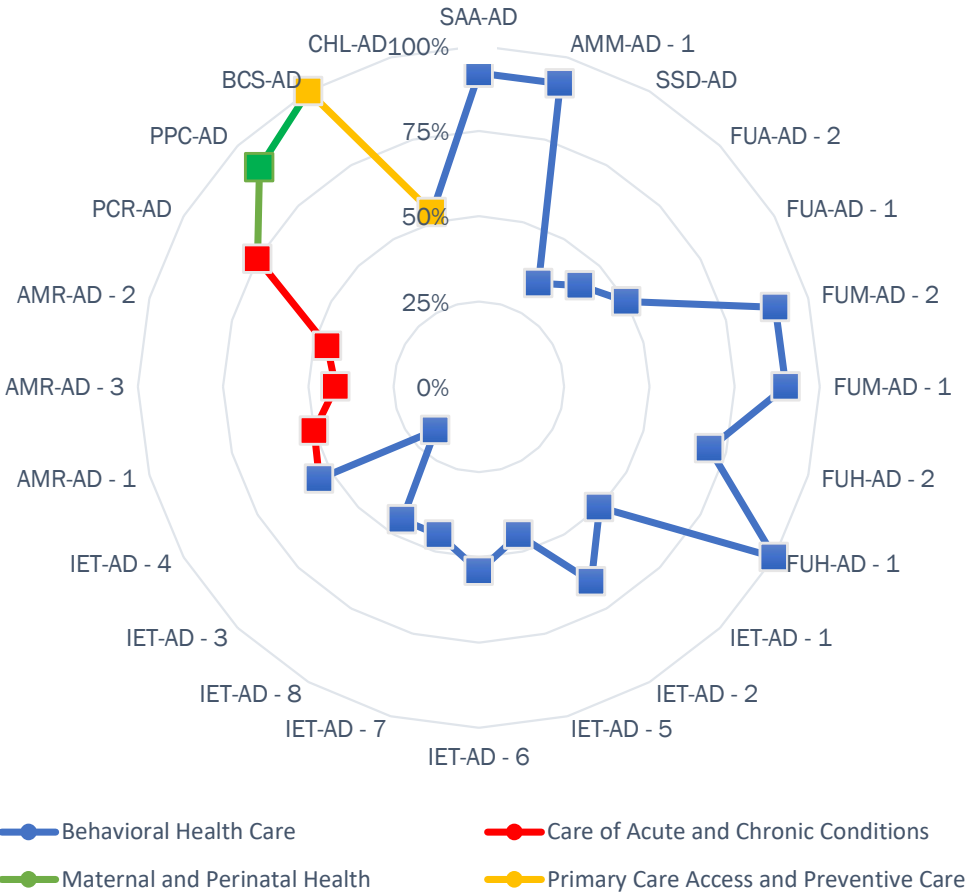
Domain		RI				RI
Measure	Measure Description	Rate	1st Quartile	Median	3rd Quartile	Percentile
Behavioral Health Care						
ADD-CH - 1	ADHD Med Follow-Up (30 Days) - % Newly Prescribed ADHD Med with 1 Follow-Up (Ages 6-12)	48.3	39.6	43.4	49.4	70%
ADD-CH - 2	ADHD Med Follow-Up (9 Months) - % Newly Prescribed ADHD Med with ≥2 Follow-Ups (Ages 6-12)	57.8	47.1	54.0	58.2	74%
APM-CH - 1	Metabolic Monitoring - % on Antipsychotics with Glucose & Cholesterol Testing (Ages 1-17)	30.3	27.3	33.5	41.6	41%
APM-CH - 2	Metabolic Monitoring - % on Antipsychotics with Glucose Testing (Ages 1-17)	43.6	47.7	53.3	58.3	5%
APM-CH - 3	Metabolic Monitoring - % on Antipsychotics with Cholesterol Testing (Ages 1-17)	32.8	29.2	35.3	42.9	36%
APP-CH	Psychosocial Care (Antipsychotic New Rx) - % with Psychosocial Care (1st-Line Tx) (Ages 1-17)	62.6	59.5	63.0	67.4	42%
FUH-CH - 1	Follow-Up After Mental Illness Hospitalization (30 Days) - % w/ Follow-Up (Ages 6-17)	79.8	65.6	72.1	80.0	72%
FUH-CH - 2	Follow-Up After Mental Illness Hospitalization (7 Days) - % w/ Follow-Up (Ages 6-17)	65.4	42.7	51.7	59.0	87%
FUM-CH - 1	Follow-Up After ED Visit (30 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 6-17)	73.5	64.7	73.7	79.1	48%
FUM-CH - 2	Follow-Up After ED Visit (7 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 6-17)	59.2	47.3	58.1	67.2	51%
Care of Acute and Chronic Conditions						
AMB-CH	ED Visits - Emergency Department Visits per 1,000 Beneficiary Months (Ages 0-19)	25.4	26.3	31.3	35.8	21%
AMR-CH - 1	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 12-18)	62.9	64.8	68.9	72.2	20%
AMR-CH - 2	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 5-11)	72.4	73.0	77.2	80.9	23%
AMR-CH - 3	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 5-18)	67.6	67.6	73.1	76.8	22%
Maternal and Perinatal Health						
LBW-CH	Low Birth Weight - % Live Births <2,500g	8.8	9.2	10.1	11.1	15%
LRCD-CH	Low-Risk Cesarean Delivery - % C-Section (Nulliparous, Term, Cephalic Presentation)	26.5	22.6	24.7	26.8	68%
PPC-CH	Prenatal Care Timeliness - % Prenatal Care in 1st Trimester (or within 42 Days)	89.2	81.1	84.0	87.8	91%



# Core Set Measure Definitions - Children, cont.

Domain		RI				RI
Measure	Measure Description	Rate	1st Quartile	Median	3rd Quartile	Percentile
Primary Care Access and Preventive Care						
WCV-CH - 3	Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 3-11)	67.2	51.2	54.6	62.1	90%
WCV-CH - 1	Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 12-17)	62.8	44.3	49.9	57.4	92%
WCV-CH - 2	Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 18-21)	38.6	20.2	24.3	31.4	87%
WCV-CH - 4	Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 3-21)	60.4	43.4	47.7	55.6	90%
CIS-CH - 3	Immunization (MMR) - % with MMR Vaccination by Age 2	90	82.1	83.9	86.7	100%
CIS-CH - 4	Immunization (Flu) - % with 2 Flu Vaccinations by Age 2	72.4	38.2	48.1	53.9	100%
CIS-CH - 2	Immunization (Combo 3) - % Up to Date on Immunizations (Combo 3) by Age 2	76.3	59.5	64.8	69.7	100%
CIS-CH - 1	Immunization (Combo 10) - % Up to Date on Immunizations (Combo 10) by Age 2	61.5	28.2	34.4	41.8	100%
CHL-CH	Chlamydia Screening (Ages 16-20) - % Screened for Chlamydia	62.8	43.4	47.9	59.2	92%
IMA-CH - 1	HPV Vaccine - % Completing HPV Vaccine Series by Age 13	46.1	33.1	35.0	40.9	84%
IMA-CH - 2	Meningococcal & Tdap Vaccines - % Receiving Meningococcal & Tdap by Age 13	83.6	73.6	78.8	83.9	73%
WCC-CH - 1	Weight Assessment & Counseling (BMI) - BMI Percentile Documentation (Ages 3-17)	88.3	70.7	75.9	81.6	100%
WCC-CH - 2	Weight Assessment & Counseling (Nutrition) - Counseling for Nutrition (Ages 3-17)	82.7	62.0	70.4	77.9	92%
WCC-CH - 3	Weight Assessment & Counseling (Physical Activity) - Counseling for Physical Activity (Ages 3-17)	80.3	57.0	67.2	74.5	100%
W30-CH - 2	Well-Child Visits - % w/ 6+ Well-Child Visits (0-15 Months)	68.9	51.2	57.7	61.0	92%
W30-CH - 1	Well-Child Visits - % w/ 2+ Well-Child Visits (15-30 Months)	77.5	60.5	65.1	72.1	90%

# CMS Medicaid Scorecard – Adult Core Set



- CMS developed its Medicaid and Children’s Health Insurance Program (CHIP) Scorecard to increase public transparency about the programs’ outcomes.
- The Child and Adult Core Sets support federal and state efforts to collect, report, and use a standardized set of measures to drive improvement in the quality of care provided to Medicaid and CHIP beneficiaries.
- In recognition of reporting differences across states reflected in the CMS Medicaid and CHIP Scorecard, this report summarizes information in a format that provides the ability to compare states that use similar logic for reporting. Comparisons are only made of states that use the same population and reporting methodology for each rate, allowing for a more accurate comparison between states.
- In FFY 2022, 16 out of the 25 measures included in this analysis Rhode Island’s performance exceeded the 50<sup>th</sup> percentile. 9 out of 25 measures exceeded the 75<sup>th</sup> percentile.

### How to interpret the radar chart

Each measure included in the analysis is represented as an axis, or “spoke”.

Rates are displayed on a percentile basis (compared to those states using the same population and reporting methodology for that rate).

Points near the outside of the circle reflect better relative performance.

Source: EOHHS analysis of 2022 Child and Adult Health Care Quality Measures available at: <https://data.medicare.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6>

[1] Limited to measures with at least 10 states using the same population and reporting methodology.

# Core Set Measure Definitions - Adults

Domain Measure	Measure Description	RI Rate	1st Quartile	Median	3rd Quartile	RI Percentile
Behavioral Health Care						
SAA-AD	Antipsychotic Med Adherence (Schizophrenia 18+): % Dispensed & Remained on Med (80%+ Treatment)	75.0	58.0	62.7	65.5	92%
AMM-AD - 1	Antidepressant Med Management (Depression 18-64, 12 Weeks): % Diagnosed & Treated (12 Wks)	64.0	53.1	55.1	63.8	76%
AMM-AD - 2	Antidepressant Med Management (Depression 18-64, 6 Months): % Diagnosed & Treated (6 Mos)	64.0	53.1	55.1	63.8	92%
SSD-AD	Diabetes Screening (Schizophrenia/Bipolar 18-64): % Dispensed Med & Diabetes Screening	74.9	71.9	75.8	77.8	35%
FUA-AD - 2	Follow-Up After ED Visit (Alcohol/Drug Abuse 18-64, 7 Days): % Follow-Up (7 Days)	14.9	11.3	17.4	19.4	42%
FUA-AD - 1	Follow-Up After ED Visit (Alcohol/Drug Abuse 18-64, 30 Days): % Follow-Up (30 Days)	25.8	18.4	25.8	30.9	50%
FUM-AD - 2	Follow-Up After ED Visit (Mental Illness 18-64, 7 Days): % Follow-Up (7 Days)	59.9	33.5	45.6	54.3	90%
FUM-AD - 1	Follow-Up After ED Visit (Mental Illness 18-64, 30 Days): % Follow-Up (30 Days)	72.4	50.6	58.9	65.4	90%
FUH-AD - 2	Follow-Up After Hosp (Mental Illness 18-64, 7 Days): % Follow-Up (7 Days)	51.8	31.5	35.1	53.0	70%
FUH-AD - 1	Follow-Up After Hosp (Mental Illness 18-64, 30 Days): % Follow-Up (30 Days)	73.4	50.5	59.2	70.2	100%
IET-AD - 1	Initiation & Engagement (Alcohol/Drug Abuse 18-64, 14 Days): % Initiated & Engaged (14 Days)	40.6	35.5	40.6	46.0	50%
IET-AD - 2	Initiation & Engagement (Alcohol/Drug Abuse 18-64, 34 Days): % Initiated & Engaged (34 Days)	15.1	10.8	12.5	15.9	66%
IET-AD - 5	Initiation & Engagement (Opioid Abuse/Dependence 18-64, 14 Days): % Initiated & Engaged (14 Days)	60.9	51.9	61.2	65.5	45%
IET-AD - 6	Initiation & Engagement (Opioid Abuse/Dependence 18-64, 34 Days): % Initiated & Engaged (34 Days)	35.3	30.9	34.6	38.1	54%
IET-AD - 7	Initiation & Engagement (Other Drug Abuse/Dependence 18-64, 14 Days): % Initiated & Engaged (14 Days)	36.9	35.8	37.6	45.2	45%
IET-AD - 8	Initiation & Engagement (Other Drug Abuse/Dependence 18-64, 34 Days): % Initiated & Engaged (34 Days)	10.5	9.3	12.2	14.8	45%
IET-AD - 3	Initiation & Engagement (Alcohol/Drug Abuse 18-64, 14 Days): % Initiated & Engaged (14 Days)	40.8	41.0	42.4	46.1	18%
IET-AD - 4	Initiation & Engagement (Alcohol/Drug Abuse 18-64, 34 Days): % Initiated & Engaged (34 Days)	16.4	14.0	16.2	20.9	54%

# Core Set Measure Definitions - Adults

Domain		RI				RI
Measure	Measure Description	Rate	1st Quartile	Median	3rd Quartile	Percentile
Care of Acute and Chronic Conditions						
AMR-AD - 1	Asthma Med Ratio (Persistent Asthma 19-50): % Controller Med Ratio (0.50+)	58.6	54.3	58.6	61.0	50%
AMR-AD - 3	Asthma Med Ratio (Persistent Asthma 51-64): % Controller Med Ratio (0.50+)	58.6	52.5	61.2	64.8	42%
AMR-AD - 2	Asthma Med Ratio (Persistent Asthma 19-64): % Controller Med Ratio (0.50+)	58.6	54.2	59.4	62.8	46%
PCR-AD	Plan All-Cause Readmissions (18-64): Observed/Expected Readmissions Ratio	1.1	1.0	1.0	1.1	75%
Maternal and Perinatal Health						
PPC-AD	Prenatal & Postpartum Care: % Postpartum Care (7-84 Days)	85.6	74.3	79.3	82.7	91%
Primary Care Access and Preventive Care						
BCS-AD	Breast Cancer Screening (50-64): % Mammogram	61.0	48.8	53.8	56.7	100%
CHL-AD	Chlamydia Screening (21-24): % Chlamydia Screening	63.9	52.8	63.9	66.8	53%

# Acronyms

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

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

# Diagnosis Definition

The following conditions are mentioned in this Report.

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

# Provider Type Definition

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