
# Medicaid Expenditure Report

SFY 2023

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) 2023.**

**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.

# Table of Contents

# Summary and Key Findings

## Overview

During SFY 2023, Rhode Island's Medicaid program provided full medical coverage to **389,000 Rhode Islanders** at some point during the year, with an average monthly enrollment of 366,000 members. Another 12,000 Rhode Islanders received limited benefits from Medicaid.

Overall, Medicaid expenditures **totaled $3.9 billion** (at a state cost of $1.3 billion), with nearly **$3.4 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:

- $2.9 billion – Executive Office of Health and Human Services (EOHHS)
- $364 million – Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
- $55 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. Overall, the effective federal share was 65% across the entire Medicaid program.

### Key Findings

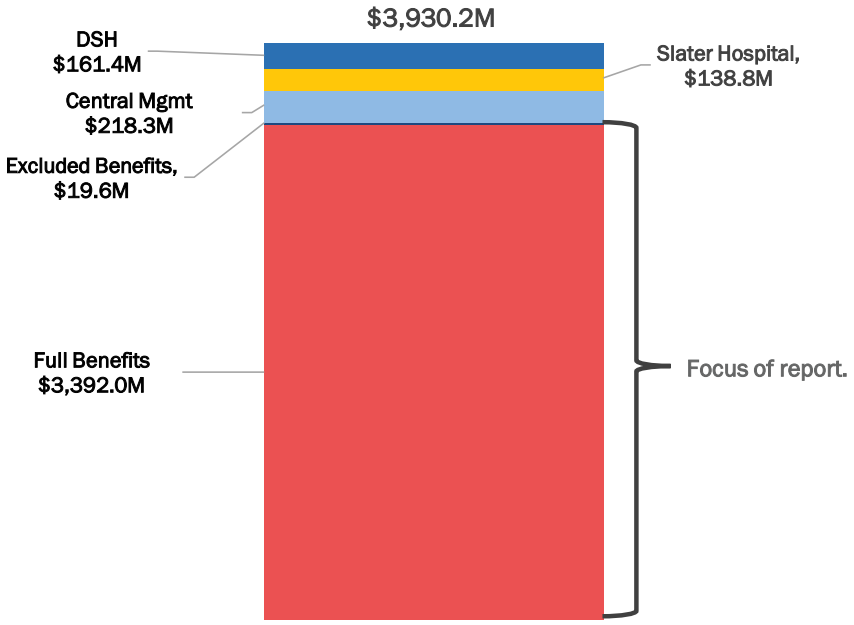
- Average full benefits enrollment increased 5.5% in SFY 2023 over SFY 2022, from 347,000 to 366,000.
- Children and Families comprised 50% of enrollees, followed by Expansion (31%), Adults with Disabilities (8%), Elders (8%) and Children with Special Healthcare Needs (3%).
- 88% of enrollees were in managed care; and three-fifths (60%) of all Medicaid enrollees were in the Accountable Entity (AE) program.
- SFY 2023 per member per month (PMPM) costs increased by 4.7% over SFY 2022 to $776 PMPM. This is higher than the five-year compounded annual growth rate (CAGR) of 2.9% since SFY 2019.
- The per member cost of caring for certain populations varies significantly, with Elders and Adults with Disabilities costing two times the composite average across all Medicaid beneficiaries and Children and Families costing less than half.
    - Overall, costs are highly skewed: 16% of Medicaid enrollees incurred almost half of claims in SFY 2023.
- Acute services accounted for 53% of SFY 2023 full benefit expenditures, while expenditures on LTSS represented 30%.
- Central management spending of $209 million accounted for 6.2% of spending on full benefits and 5.3% of overall Medicaid spending.
- COVID-19 began to significantly impact expenditures and enrollment in March 2020, impacting trends and general observations for fiscal year 2023 and when compared to prior fiscal years.

# Overall Medicaid Expenditures

**Medicaid expenditures in SFY 2023 totaled $3.9 billion. Expenditures on those with full Medicaid benefits totaled approximately $3.4 billion.**

Overall Medicaid Expenditures
*SFY 2023*

| | | |
|---|---|---|
| Members: | Full Benefits | 366,082 |
| | Limited Benefits | 11,513 |




- **Services for members with Full Benefits cost $3,392 million.** These are members with comprehensive medical coverage through Medicaid and/or members having comprehensive third-party coverage (usually Medicare) whose cost sharing and any payment for any wrap-around services are incurred by Medicaid. These clients are the primary focus of this report.
- **Central Management costs** of **$209.2 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. However, administrative costs/taxes incurred by Managed Care Organization (MCO) 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, **$319.8 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.

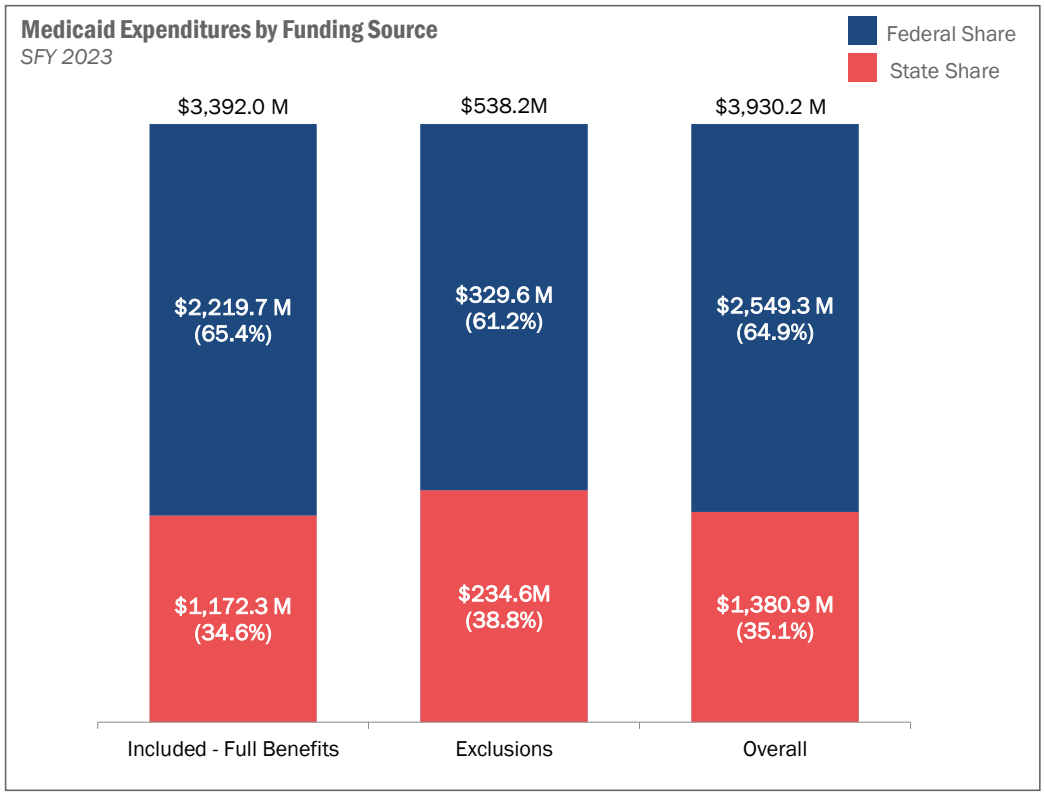
  **Costs Not Otherwise Matchable (CNOM) and Partial Emergency Services:** Limited benefits not traditionally eligible for federal Medicaid funding match, that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible. This includes services covered by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

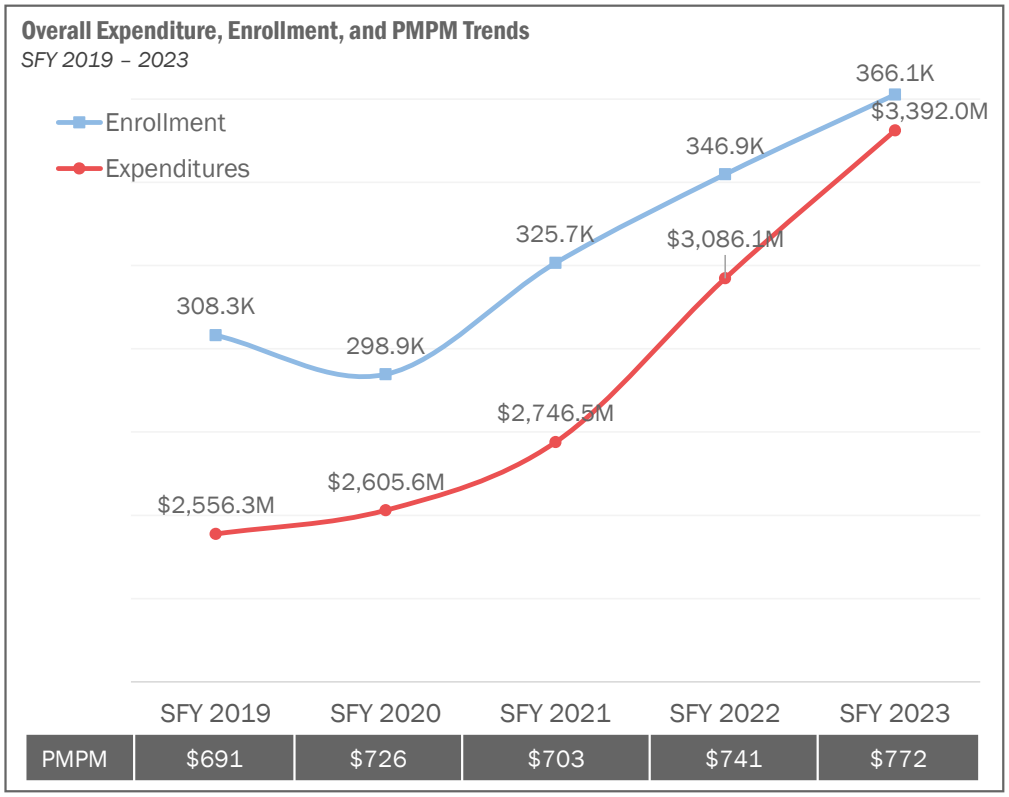
# Expenditures by Funding Source

**Medicaid expenditures on full benefits totaled $3.39 billion at a direct cost of $1.2 billion to state taxpayers in SFY 2023.**




- 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 October 2022, the RI Department of Health approved a license for the RI State Psychiatric Hospital (RISPH). Previously, a subset of expenditures incurred at this new facility may have been labeled as Eleanor Slater Hospital. 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. Beginning in April 2023 (i.e., last quarter of SFY 2023), the enhanced rate decreased to 5.0% for Regular Medicaid and 3.5% 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 2023, expenditures increased by $305.9 million or 9.9% over SFY 2022; more than the five-year compounded annual growth rate of 7.3%.

## Enrollment

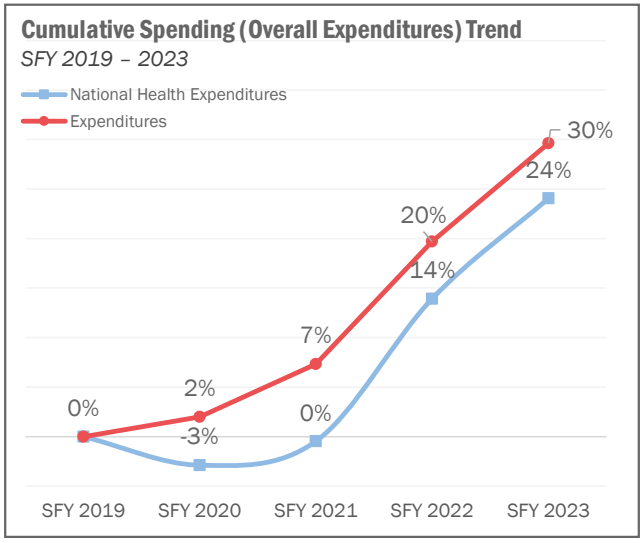
- Average enrollment increased in SFY 2023 by 5.5% over the SFY 2022 average, more than the five-year compounded annual growth rate of 4.2%.
- This increase in the average monthly enrollment over the fiscal year reflects the sharp increase that started in March 2020, following the declaration by the 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 2023 over SFY 2022 was in Expansion Adults and Children and Families that grew in their average monthly enrollment by 8,592 (8%) and 5,733 (3%), respectively, over FY 2022.

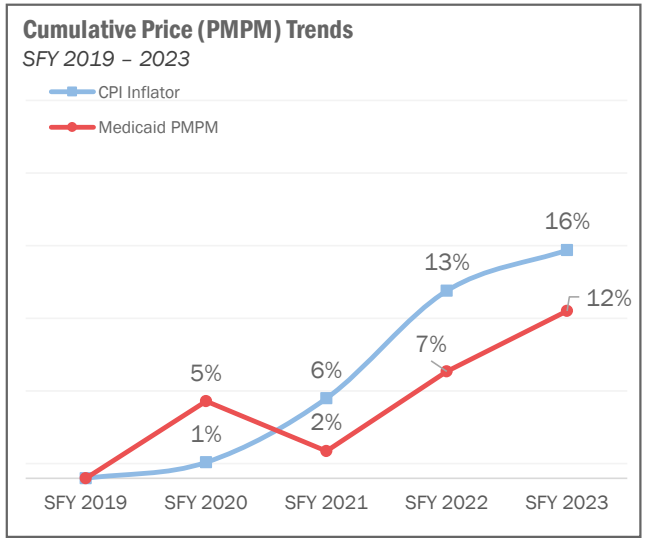
## PMPM

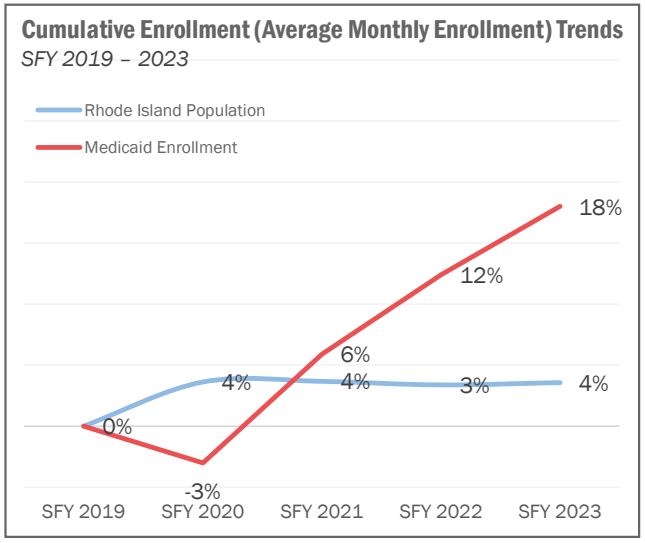
- Overall PMPM costs increased by an average of 4.% in SFY 2023 over SFY 2022.

# Five-Year Trends

| | |
|---|---|
| **Expenditures** | ▪ Since 2019, cumulative annual change for expenditures was 30%; this growth outpaced National Health Expenditure by 6% in the same period.<br>▪ Medicaid expenditures have steadily grown in the past 5 years while National Health Expenditures took a dip in 2020 with gradual increase from SFY 2021 on. |
| **Price - PMPM** | ▪ Annual PMPM change grew to 12% cumulative since 2019; lower than general inflation as measured by Northeast CPI.<br>▪ CPI grew at a faster pace then PMPM each year except SFY 2020, outpacing PMPM by 4% in SFY 2023. |
| **Caseload - Enrollment** | ▪ Cumulative annual enrollment change increased by 18% over the last five years; compared to net increase of 4.0% for Rhode Island's population.<br>▪ This increased enrollment came during the continuation of the Public Health Emergency which included a moratorium on terminations that became effective March 2020.<br>▪ Termination activities did not resume until towards the second half of SFY 2023. |





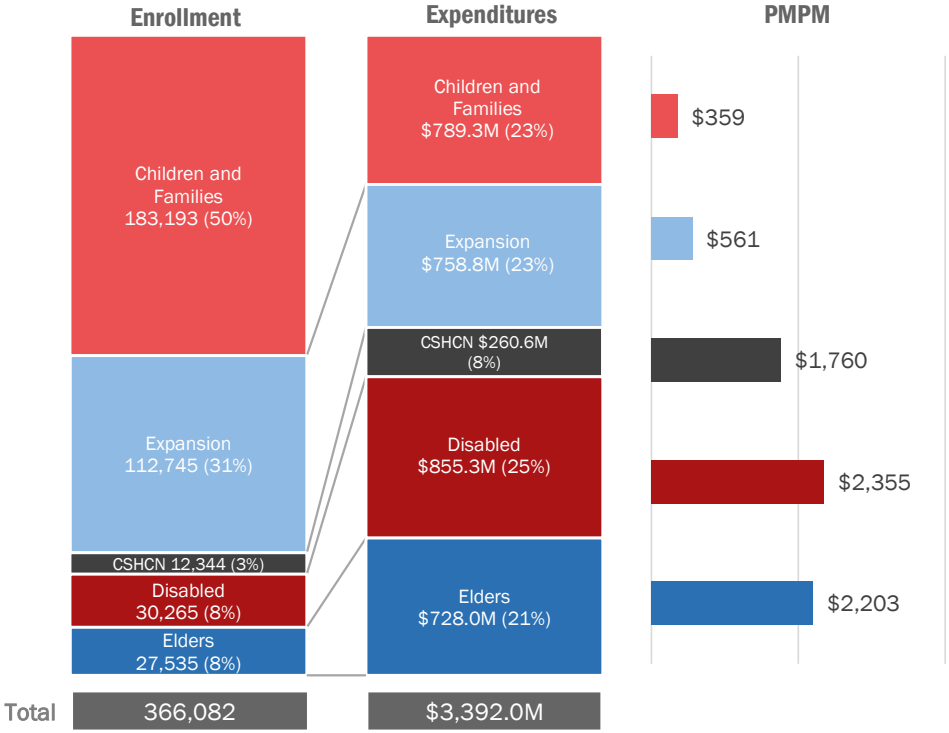

[1] Cumulative NHE was calculated using National Health Expenditures from the 2020-2030 NHE projections Percent Change Year/Year (SFY Basis)
[2] Cumulative CPI was calculated using Northeast Consumer Price Index percent change from 12 months ago for all urban consumers from 2019-2023, using July as the comparison.

# Overview & Trends

# Expenditures by Population Group

**Medicaid expenditures in SFY 2023 totaled $3.4 billion. Expenditures for fully covered populations totaled approximately $3.4 billion.**

**Medicaid Enrollment/Expenditures/PMPM by Population**
*SFY 2023*




Medicaid serves five primary populations:

- **Elders** are enrollees over age 65. 93% of this population are also covered by Medicare. Their average SFY 2023 PMPM cost was $2,203. Nursing facilities account for 43% of their expenditures.
- **Adults with Disabilities** are enrollees under age 65 with identified disabilities and 49% are also covered by Medicare. Their average cost was $2,355 PMPM. I/DD providers account for 33% of their expenditures.
- **CSHCN** are enrollees under age 21 who have higher needs physically, developmentally, behaviorally or emotionally. Their average PMPM costs were $1,760 with professional services accounting for 34% of expenditures.
- **Expansion** enrollees are low-income adults without dependent children. These members cost $561 PMPM. Hospital services account for 44% of this population.
- **Children and Families** enrollees are qualified children, parents and pregnant women. They have average costs of $359 PMPM. Hospital and professional services account for 45% 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 54,677 Rhode Islanders, including 46,697 Dual-eligible clients with full Medicaid benefits.

# Expenditures by Population Group, Continued

**Between SFY 2019 and SFY 2023, annual expenditures, enrollment, and PMPM increased modestly: expenditures by 7.3%, enrollment by 4.4%, and PMPM by 2.8%.**

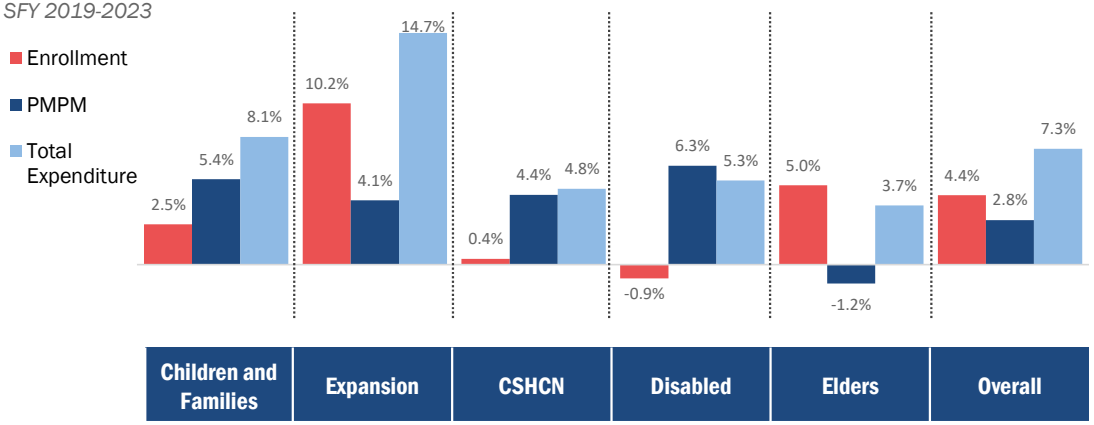
**Current Expenditures**

*SFY 2023*

| | Children and Families | Expansion | CSHCN | Disabled | Elders | Overall |
|---|---|---|---|---|---|---|
| Members | 183,193 | 112,745 | 12,344 | 30,265 | 27,535 | 366,082 |
| PMPM | $359 | $561 | $1,760 | $2,355 | $2,203 | $772 |
| Expenditure | $789.3M | $758.8M | $260.6M | $855.3M | $728.0M | $3,392.0M |

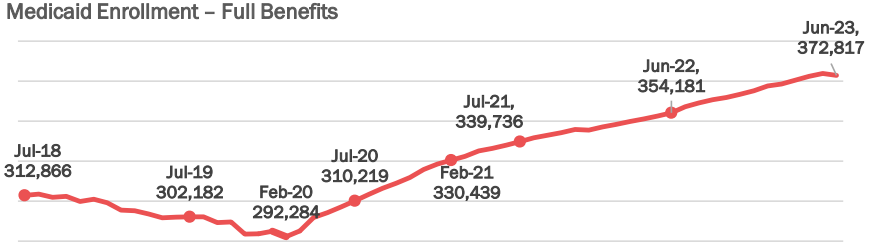
**Expenditures - 5-Year Compounded Annual Growth Rate**

*SFY 2019-2023*

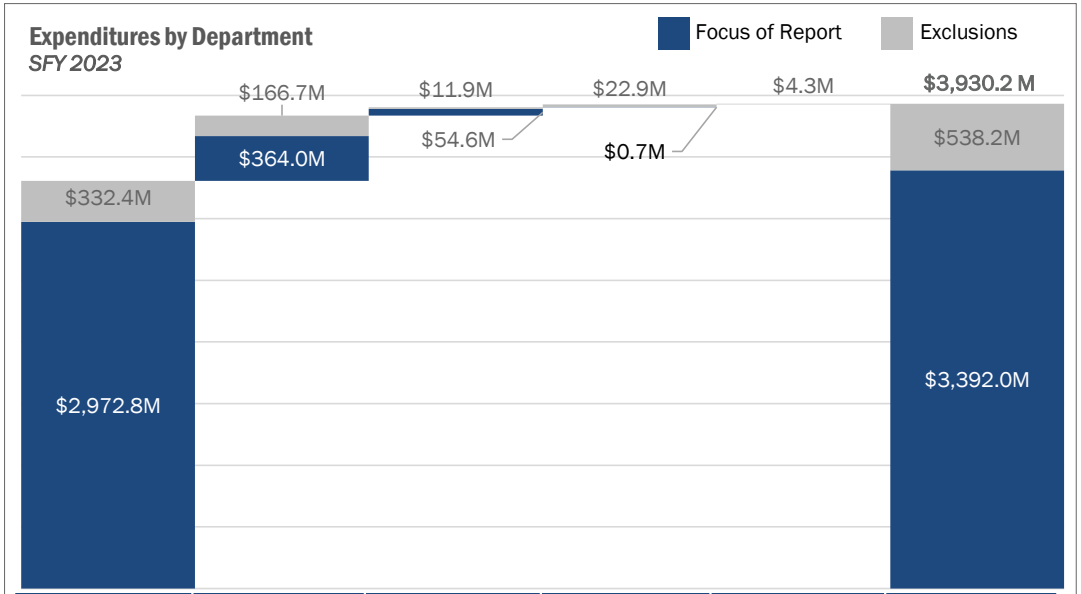



- Between SFY 2019 – 2023, the population groups experienced the following:
  - **Expansion enrollment** experienced the largest increases with enrollments and expenditures increasing by 10.2% and 14.7% annually.
  - **Elder** enrollment increased 5% annually and overall costs by 3.7% annually. **Disabled** enrollment decreased by 0.9% annually, while expenditures increased 5.3% annually.
  - **Children and Families** spending increased 8.1% annually, driven primarily by price factors as average enrollment increased very modestly (2.5%) over the five-year period.
  - **CSHCN** enrollment increased modestly (0.4%) 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




| EOHHS | BHDDH | DCYF | DHS | DOH/OHIC | Overall |
|---|---|---|---|---|---|
| 84.1% | 13.5% | 1.7% | 0.6% | 0.1% | 100% |

% of Total Expenditures

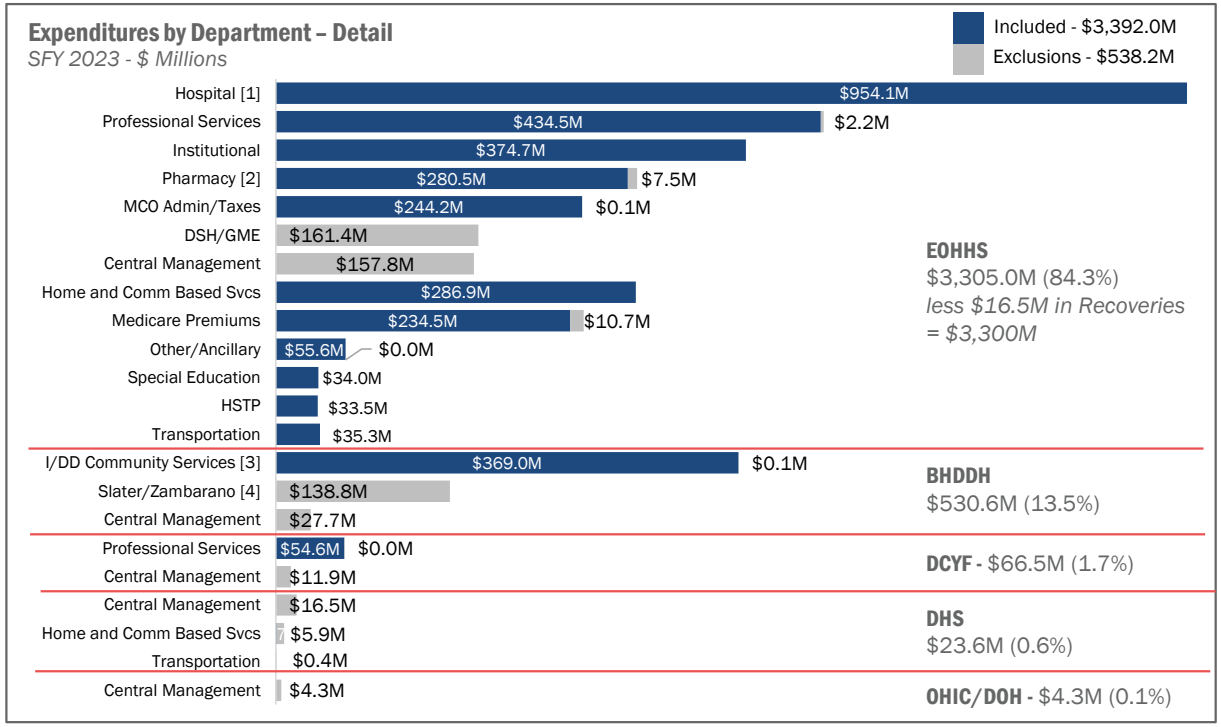
| 6.3% | 8.6% | 6.6% | -5.4% | 11.5% | 6.5% |
|---|---|---|---|---|---|

5-Year Compounded Annual Growth Rate – SFY 2019-2023

- 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 2019 to 2023 by 6.5% per annum, with EOHHS spending increasing by 6.3% per annum.
- In SFY 2023, 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 $218.3 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.**

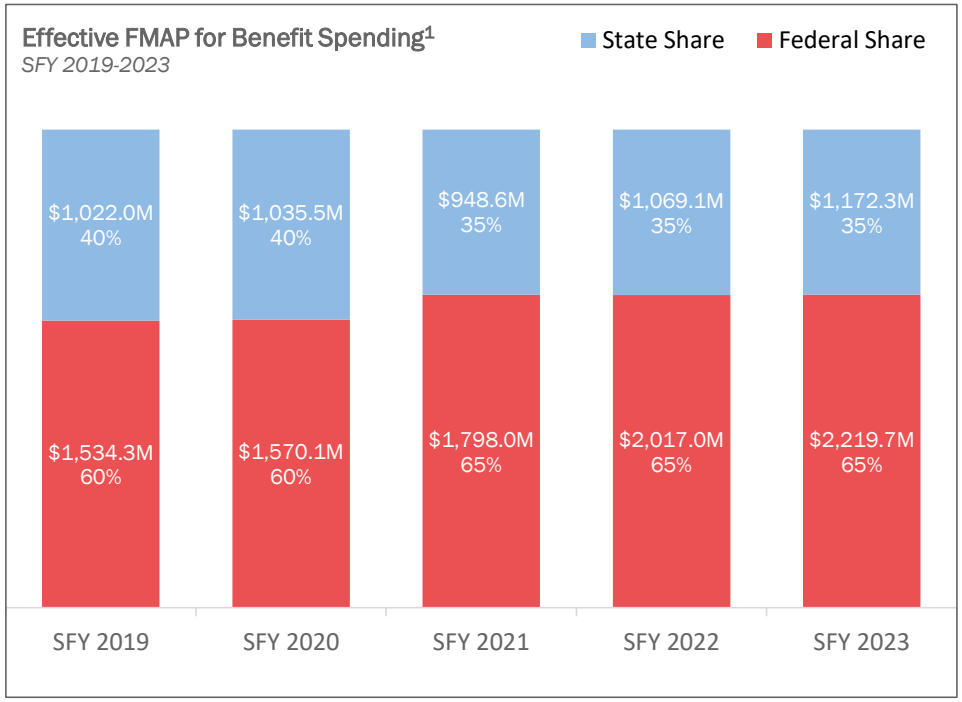



[1] EOHHS Hospital spending includes acute spending on Inpatient and Outpatient Hospitals, UPL Payments and $7.1M in spending at Tavares.
[2] Total Pharmacy includes retail pharmacy, office-administered drugs, and outpatient pharmacy. Costs are net of pharmacy rebates.
[3] I/DD Community includes all residential and rehabilitation services for persons with intellectual and developmental disabilities, including group homes.
[4] Slater expenditures include State-only spending not matchable by CMS in SFY 2023.

- Overall, with total spending of $3.3 billion, **EOHHS** spending accounts for 84.1% of Medicaid expenditures. The biggest portion (29%) of that is for hospital-based services. Professional services accounts for 13% and institutional care (inclusive of Nursing Facilities and Hospice) accounts for 11% 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 $530.6 million account for 13.5% of state Medicaid spending and include three primary areas: both residential services and community-based services for persons with intellectual and developmental disabilities, as well as Eleanor Slater Hospital.
  - In SFY 2023, 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 $66.5 million (1.7%) 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 $23.6 million of Medicaid expenditures (<1%). Benefit spending is largely for CNOM programs managed by the Office of Healthy Aging designed to forestall the need for persons served to become fully Medicaid eligible.

# Benefit Spending by Funding Source

**Medicaid programs are funded by state and federal dollars. In SFY 2023, Rhode Island paid approximately 35% of all full benefit expenditures (i.e., excluding Limited Benefits and Central Management) using state funds.**

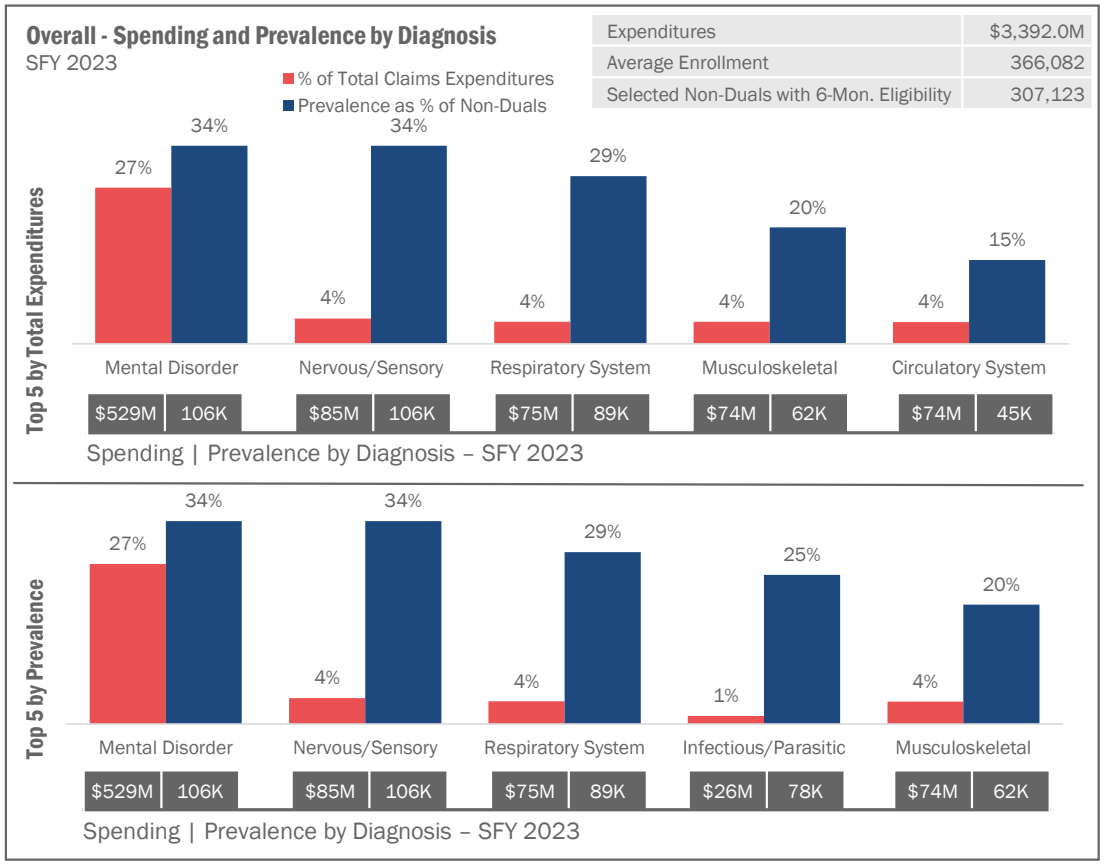



[1] Benefit Spending includes members with full benefits. Does not include Central Management or Limited Benefits expenditures.

- Rhode Island receives different federal matching rates for the Expansion population and non-Expansion population. The effective Federal Medical Assistance Percentage (FMAP) is the weighted average of these federal contributions.
- Federal matching dollars differ based on the population:
  - The Regular FMAP for the Elders, Adults With Disabilities, Children and Families and CSHCN populations is published prospectively by the Department of Health and Human Services and is based on formula that compares the state's average income to the national average. The Enhanced FMAP for the Children's Health Insurance Program reflects an adjustment to the state's Regular FMAP.
  - The Expansion population's FMAP is consistent across all states and is determined by the ACA.
  - A few small programs receive a 90% match, including the Breast and Cervical Cancer Prevention and Treatment and Extended Family Planning programs.
- 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 $136.60 million (3%), whereas the Federal Share has increased by $717.19 million (9%).

**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.
- Four 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
  - Respiratory System, 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:**

- 34% "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, 34% 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[1]**
*SFY 2023*

| | Mandatory Populations | Optional Populations | Total |
|---|---|---|---|
| ENROLLMENT | 234,292 (64%) | 131,790 (36%) | 366,082 |
| Expenditures on Mandatory Benefits | $1,289.0 M (38%) | $1,051.5 M (31%) | $2,340.5 M (69%) |
| Expenditures on Optional Benefits | $576.6 M (17%) | $474.9 M (14%) | $1,051.5 M (31%) |
| TOTAL EXPENDITURES | $1,865.6 M (55%) | $1,526.4 M (45%) | $3,392.0 M |

[1] Exhibit uses % from SFY 2022 Expenditure Report. These were 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.*

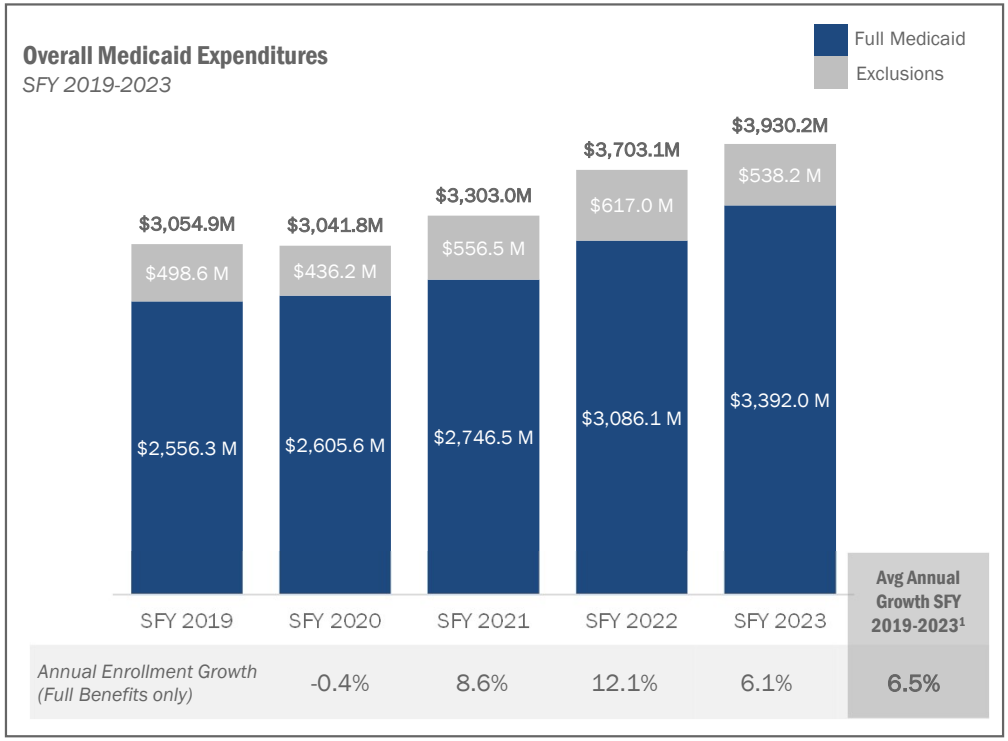
Mandatory Medicaid populations include groups like low-income families, qualified pregnant women and children, and individuals receiving SSI.

- 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 6% in SFY 2023 and average 6.4% over the past five fiscal years.**




[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2019-2023 as shown.

- Overall spending on benefits for fully-covered members increased by 6% in SFY 2023 to $3,930 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 2023.
  - Also related to COVID-19, a significant shift in LTSS spending occurred in the last quarter of SFY 2020 that carried into SFY 2023:
    - Compared to SFY 2019, spending at institutional settings (i.e., nursing facilities, hospice, and at Tavares Pediatric Center) fell by $11.6 million in SFY 2023, from $386.3 million to $374.7 million. This, however, was offset with a significant increase of $215.0 million in community LTSS spending, from $441.6 million in SFY 2019 to $656.5 million in SFY 2023.

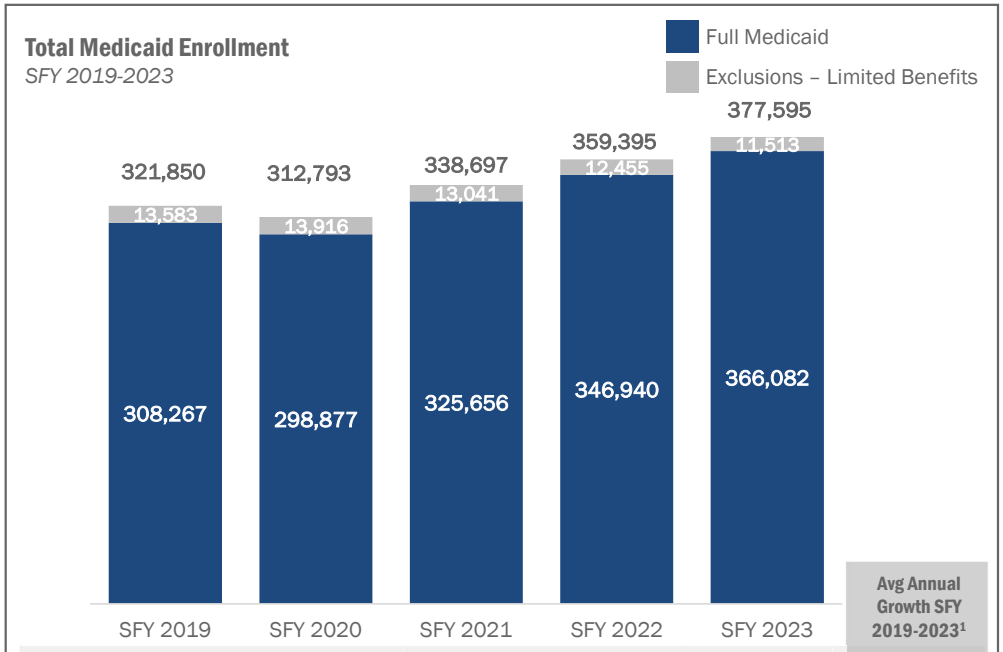
**Spending Comparison by Eligibility Group, SFY 2019 to SFY 2023**

| | SFY 2019 | SFY 2023 | Annual Growth Rate SFY 2019-2023 |
|---|---|---|---|
| Children and Families | $578.1M | $789.3 | 8.0% |
| CSHCN | $216.1M | $260.7M | 4.8% |
| Expansion | $438.7M | $758.8M | 14.7% |
| Disabled Adults | $695.0M | $855.3M | 5.3% |
| Elders | $628.4M | $728.0M | 3.7% |
| **Overall** | **$2,556.3M** | **$3,392.0M** | **7.3%** |

# Trends: Average Monthly Enrollment

**After years of decline, average enrollment continued to increased in SFY 2023. This decline began reversing in March 2020.**

**Total Medicaid Enrollment**
*SFY 2019-2023*




| | SFY 2020 | SFY 2021 | SFY 2022 | SFY 2023 | Avg Annual Growth SFY 2019-2023[1] |
|---|---|---|---|---|---|
| *Annual Enrollment Growth (Full Benefits only)* | -2.8% | 8.3% | 6.1% | 5.1% | 4.1% |

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2019-2023 as shown.

- Average monthly enrollment increased 5.1% in SFY 2023 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 292,284, a reduction of 9.5% from Rhode Island's peak enrollment of 322,853 in June 2017.
  - By June 2023, enrollment of fully-covered Medicaid beneficiaries had rebounded to 372,817, an increase of 27.6% from February 2020.

**Enrollment Comparison, by Eligibility Group, SFY 2019 to SFY 2023**

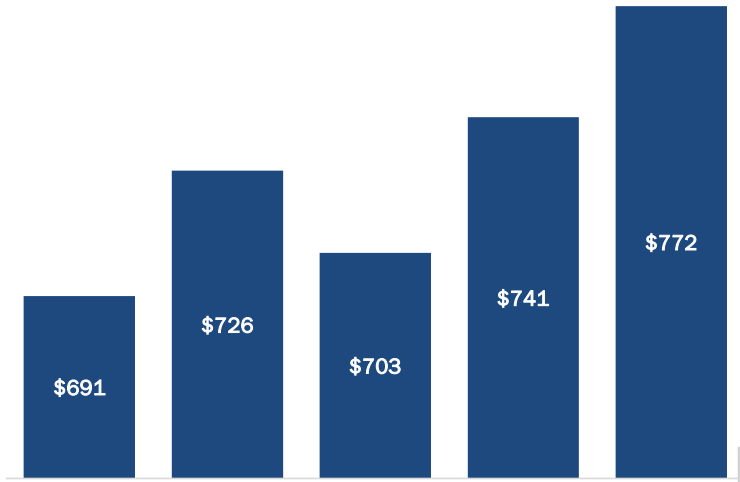
| | SFY 2019 | SFY 2023 | Annual Growth Rate SFY 2019-2023 |
|---|---|---|---|
| Children and Families | 165,683 | 183,193 | 2.5% |
| CSHCN | 12,171 | 12,345 | 0.4% |
| Expansion | 76,415 | 112,745 | 10.2% |
| Disabled Adults | 31,360 | 30,265 | -0.9% |
| Elders | 22,639 | 27,535 | 5.0% |
| **Overall** | **308,267** | **366,083** | **4.4%** |

# Trends: PMPM

**Average PMPM increased over 4% in SFY 2023; and had an average annual growth of 3% since SFY 2019.**

**Total Medicaid PMPM - Full Medicaid Only**
*SFY 2019-2023*

| | |
|---|---|
| Expenditures – Full Benefits | $3,392.0M |
| Average Enrollment | 366,083 |




| | SFY 2020 | SFY 2021 | SFY 2022 | SFY 2023 | Avg Annual Growth SFY 2019-2023[1] |
|---|---|---|---|---|---|
| *Annual PMPM Change (Full Benefits only)* | 5.1% | -3.2% | 5.4% | 4.2% | 2.8% |

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2019-2023 as shown.

- After a decrease in SFY 2021, the Medicaid PMPM trend increased by 4.2% in SFY 2023.
- The overall five-year PMPM trend of 2.8% 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 $361 for Children and Families to $2,355 for Elders.
  - The average annual compounded PMPM growth rate varies over the past five years, from –1.2% for Elders to 6.3% for Disabled Adults.

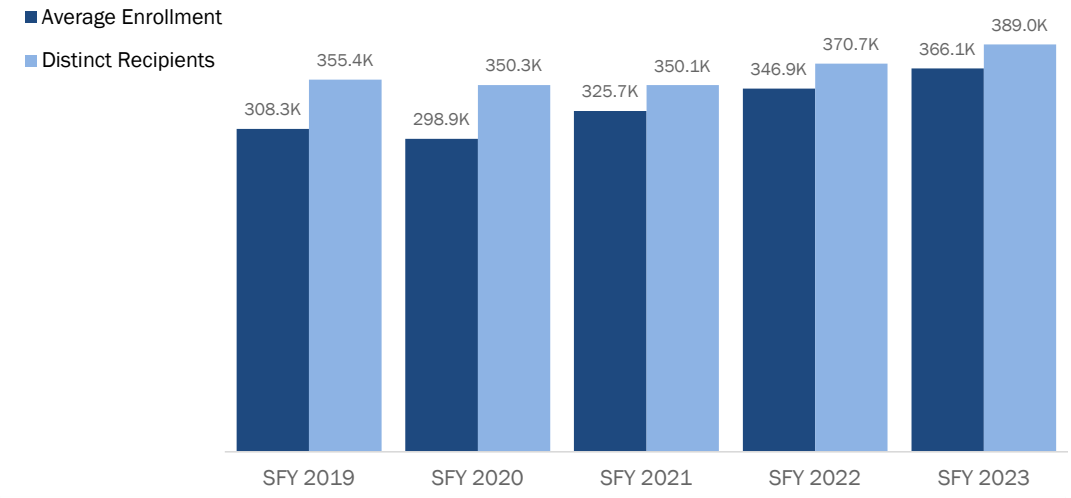
**PMPM Comparison by Eligibility Group, SFY 2019 to SFY 2023**

| | SFY 2019 | SFY 2023 | Annual Growth Rate SFY 2019-2023 |
|---|---|---|---|
| Children and Families | $291 | $359 | 5.2% |
| CSHCN | $1,480 | $1,760 | 4.4% |
| Expansion | $478 | $561 | 4.1% |
| Disabled Adults | $1,847 | $2,355 | 6.3% |
| Elders | $2,313 | $2,203 | -1.2% |
| **Overall** | **$691** | **$772** | **2.8%** |

# Trends: Unique Recipients

**One-third of Rhode Island's population was enrolled in Medicaid with full benefits for some part of SFY 2023.**

**Medicaid Enrollment, including Full Medicaid Only**
*SFY 2019-2023*




| | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 | SFY 2023 |
|---|---|---|---|---|---|
| Turnover Ratio | 1.15 | 1.17 | 1.08 | 1.07 | 1.06 |
| Unique Members as % of RI Population[1] | 33.5% | 33.1% | 31.9% | 33.8% | 35.6% |

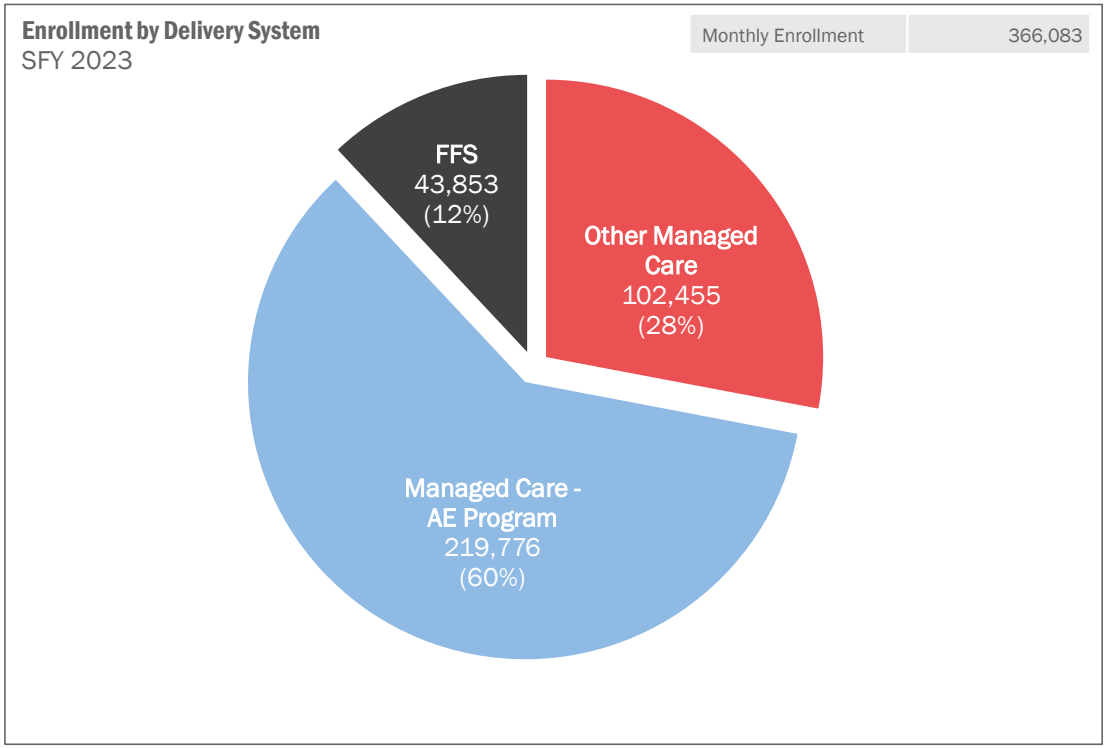
[1]Source: U.S. Census Bureau - Population Estimates

- 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 ended in March 2023. This moratorium on terminations reduced the turnover ratio compared to prior state fiscal years. Terminations began in the final quarter of SFY 2023.

# Programs and Provider Type

# Enrollment by Program

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




- **Managed Care – 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. RIte 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 RIte Share, Program of All-Inclusive Care for the Elderly (PACE), or members enrolled with an MCO but not assigned to an AE.
- Fee-For-Service (FFS):
  - In FFS, the state reimburses providers directly for covered services provided. Most members in FFS are in a "pre-MCO enrollment period," and later transitioned into Managed Care (in or out of an AE). Dual eligible Elders are the only population who do not enroll in an MCO.

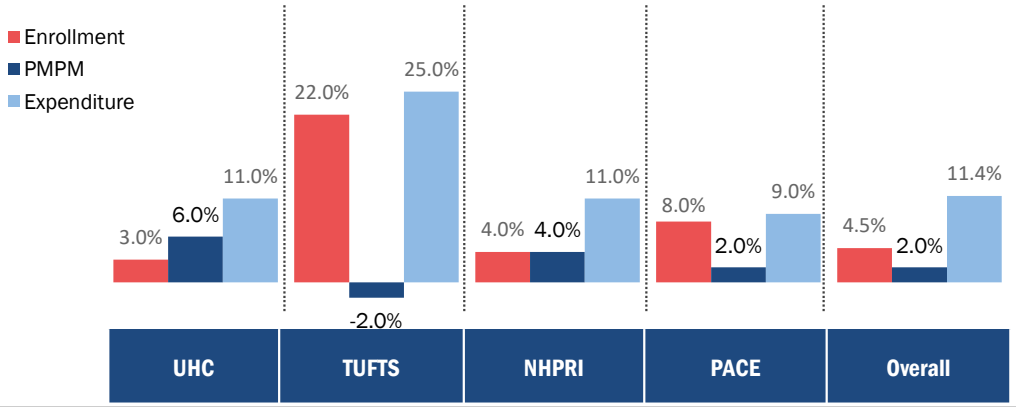
# Enrollment, PMPM, and Expenditure by MCO

**Between SFY 2019 and SFY 2023, annual expenditures and enrollment increased across all MCOs: expenditures by 11.3% and enrollment by 4.5%.**

**Current Expenditures**
*SFY 2023*

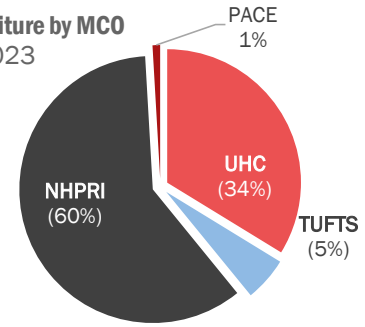
| | UHC | TUFTS | NHPRI | PACE | Overall |
|---|---|---|---|---|---|
| Enrollment | 100,619 | 20,115 | 201,091 | 405 | 322,230 |
| PMPM | $595 | $437 | $693 | $4,496 | $1,555 |
| Expenditure | $733.5M | $116.3M | $1,303.0M | $19.9M | $2,172.6M |

**Expenditures - 5-Year Compounded Annual Growth Rates**
*SFY 2019-2023*

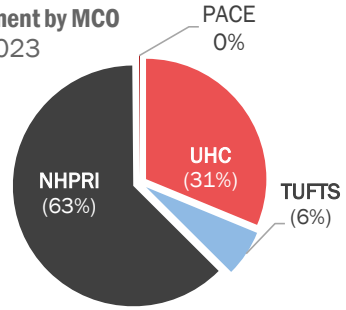



- Between SFY 2019 – 2023, the MCOs experienced the following:
  - **United Healthcare** experienced the smallest annual increases with enrollments (3%) while growing at a similar annual rate of expenditures as the other MCOs (11%). UHC also had the largest PMPM increase (6%)
  - **Tufts** had the largest annual growth for both enrollment and expenditure with 22% and 25% respectively, while simultaneously seeing a 2% decrease in its average PMPM.
  - **Neighborhood Health Plan of Rhode Island** had the both the largest portion of enrollment (62% of MCO members) and the largest portion of expenditure (60% of MCO expenditures).
  - Although **PACE** is the smallest payer in terms of both enrollment and expenditures, it has experienced meaningful annual increases of 8% and 9% increases in both areas.

**Expenditure by MCO**
SFY 2023




**Enrollment by MCO**
SFY 2023

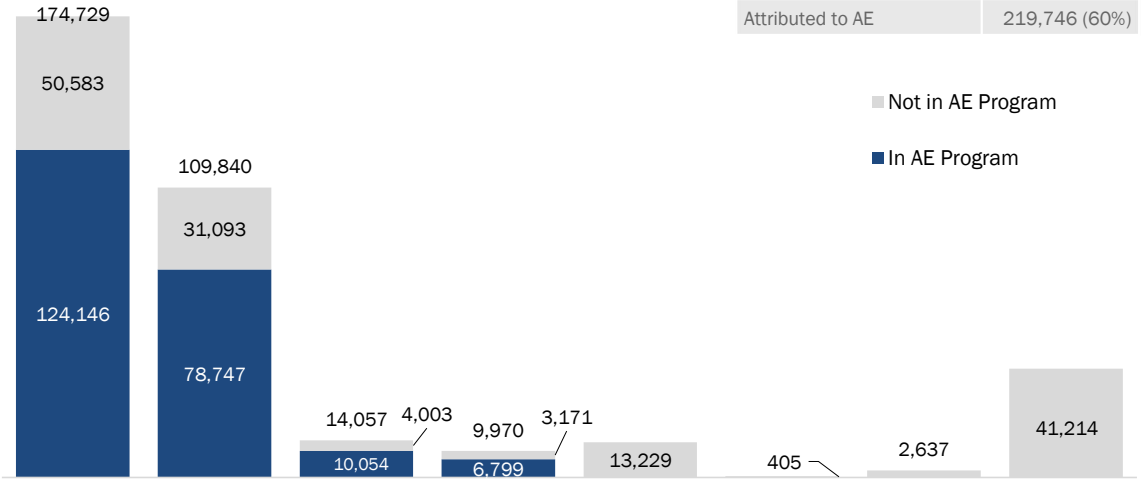


# Managed Care Enrollment

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

**Program Enrollment**
*SFY 2023*

| | |
|---|---|
| Total Monthly Enrollment | 366,083 |
| Enrolled in Managed Care | 322,231 (88%) |
| Attributed to AE | 219,746 (60%) |




| RC Core | Expansion | RHP | RC CSHCN | RHO | PACE | RIte Share | FFS |
|---|---|---|---|---|---|---|---|
| 47.7% | 30.0% | 3.8% | 2.7% | 3.6% | 0.1% | 0.7% | 11.3% |

% of Enrollment – SFY 2023

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2.8% | 11.3% | -1.0% | 0.8% | -6.8% | 7.7% | -8.0% | 4.6% |

5-Year Compounded Annual Growth Rate – SFY 2019 – 2023

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

# Expenditures by Delivery System

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

**Expenditures by Delivery System**
*SFY 2023*

| | |
|---|---|
| Total Monthly Enrollment | 366,083 |
| Total Expenditures | $3,392.0M |

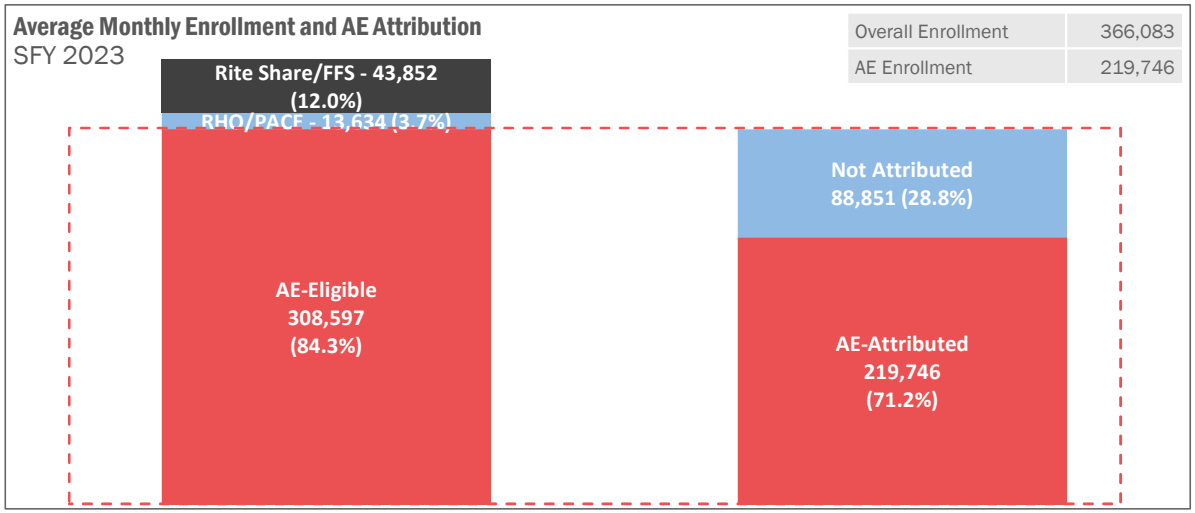
***AE-Eligible Managed Care***
*Enrollment: 308,597 (84.3%)*
*Expenditures: $2,140.6M (63.1%)*

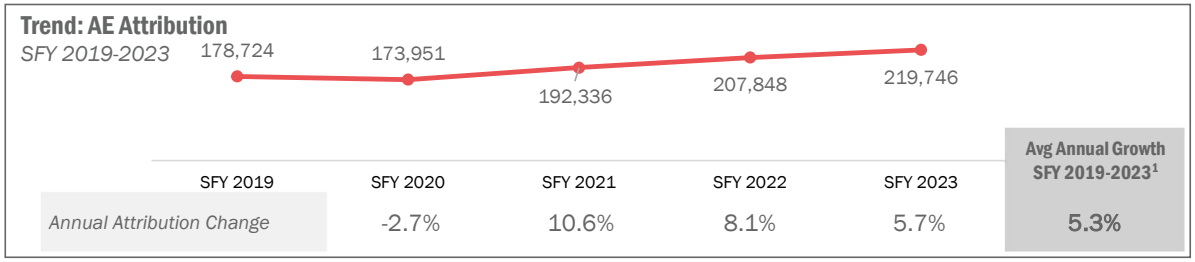
| | Managed Care AE-Attributed *219,746 (60.0%)* | Managed Care Not Enrolled in AE *88,851 (24.3%)* | Managed Care RHO & PACE *13,634 (3.7%)* | Remaining in FFS/Rite Share *43,852 (12.0%)* |
|---|---|---|---|---|
| **Major Medical Capitation** *$2,002.3M (59.0%)* | $1,376.4M 40.6% | $437.6M 12.9% | $185.9M 5.5% | $2.4M 0.1% |
| **Other Capitation** *$301.1M (8.9%)* | $51.8M 1.5% | $22.1M 0.7% | $76.2M 2.2% | $151.1M 4.5% |
| **FFS Expenditures** *$1,068.1M (31.5%)* | $161.2M 4.8% | $76.3M 2.3% | $157.9M 4.7% | $672.6M 19.8% |
| **Total Expenditures** | $1,599.5M 47.2% | $541.1M 16.0% | $420.0M 12.4% | $831.4M 24.5% |

- 88% of Medicaid's 366,082 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, 219,746 member (60% of all Medicaid members and 84.4% of AE-eligible members) are attributed to an AE.
- Monthly capitation payments of $2.3 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:
  - $2.0 billion (59%) of expenditures go toward capitated medical services provided by NHPRI, UHC, and Tufts, excluding dental, non-emergency transportation, and certain carved-out benefits.
  - Other capitation payments of $301.1 million (8.9%) include Medicare Premium Payments, RIte Smiles, and Non-Emergency Transportation.
- FFS spending of $1.1 billion is primarily for members not in managed care, but also includes spending on carved out benefits such as services delivered in a Neonatal Intensive Care Unit (NICU), adult dental care, any pre-enrollment activity, as well as community-based LTSS and professional services, for BHDDH and DCYF clients.

# Managed Care Enrollment and AE Attribution

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




| | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 | SFY 2023 | Avg Annual Growth SFY 2019-2023[1] |
|---|---|---|---|---|---|---|
| *Annual Attribution Change* | | -2.7% | 10.6% | 8.1% | 5.7% | 5.3% |

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2019-2023 as shown.

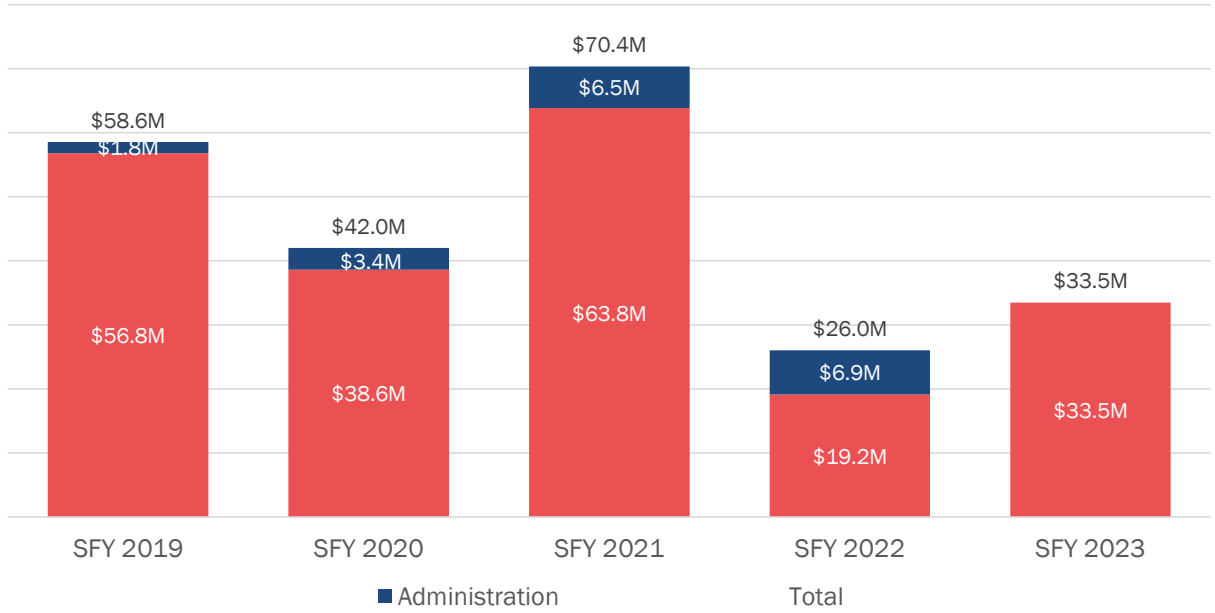
- Seven AEs participated in the AE Program during the year:
  - Blackstone Valley Community Health Center
  - Coastal Medical
  - Integra Community Care Network
  - Integrated Healthcare Partners (CHC ACO)
  - Prospect Health Services RI
  - Providence Community Health Center
  - Thundermist Health Center
- 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.

# 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.**

**Health System Transformation Program Expenditures**
SFY 2019-2023

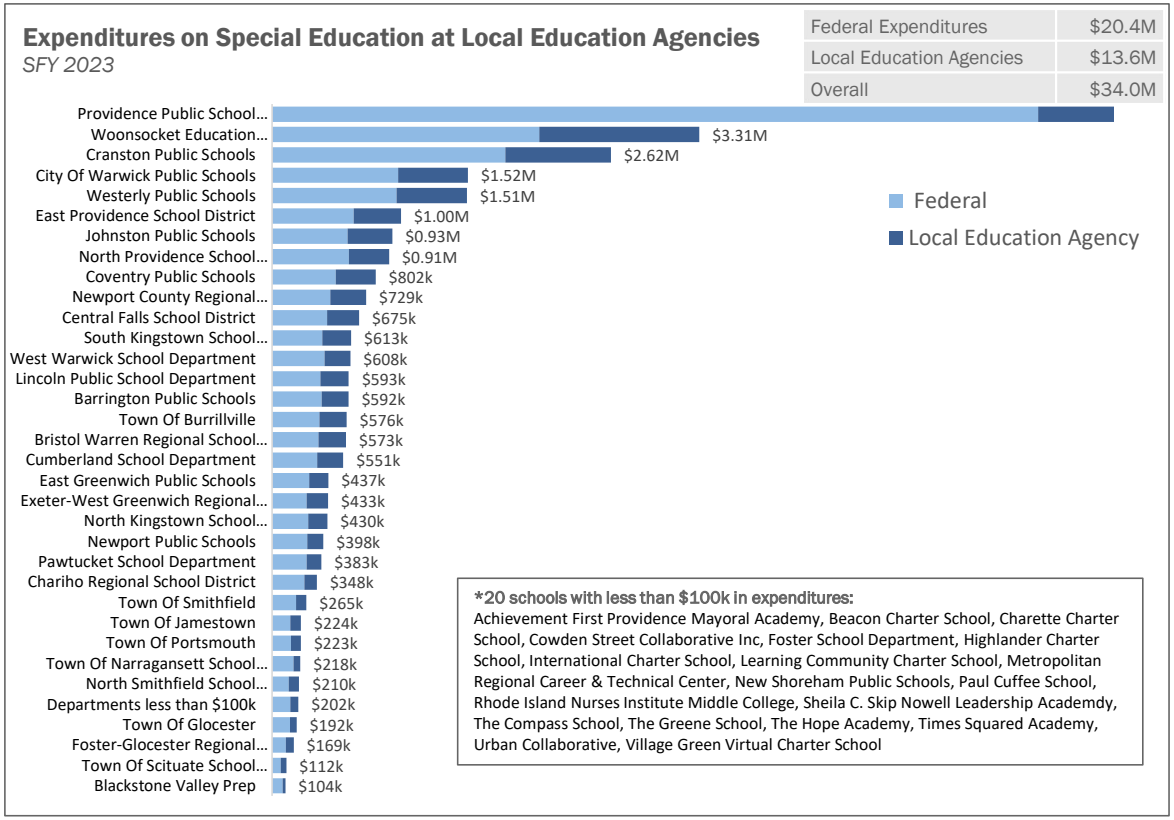
| | |
|---|---|
| Included with Benefits (SFY 2023) | $33.5M |
| Exclusions (in Central Management) | $9.7M |




- In SFY 2023, EOHHS continued to make incentive payments to its Accountable Entity partners and invest in the 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.

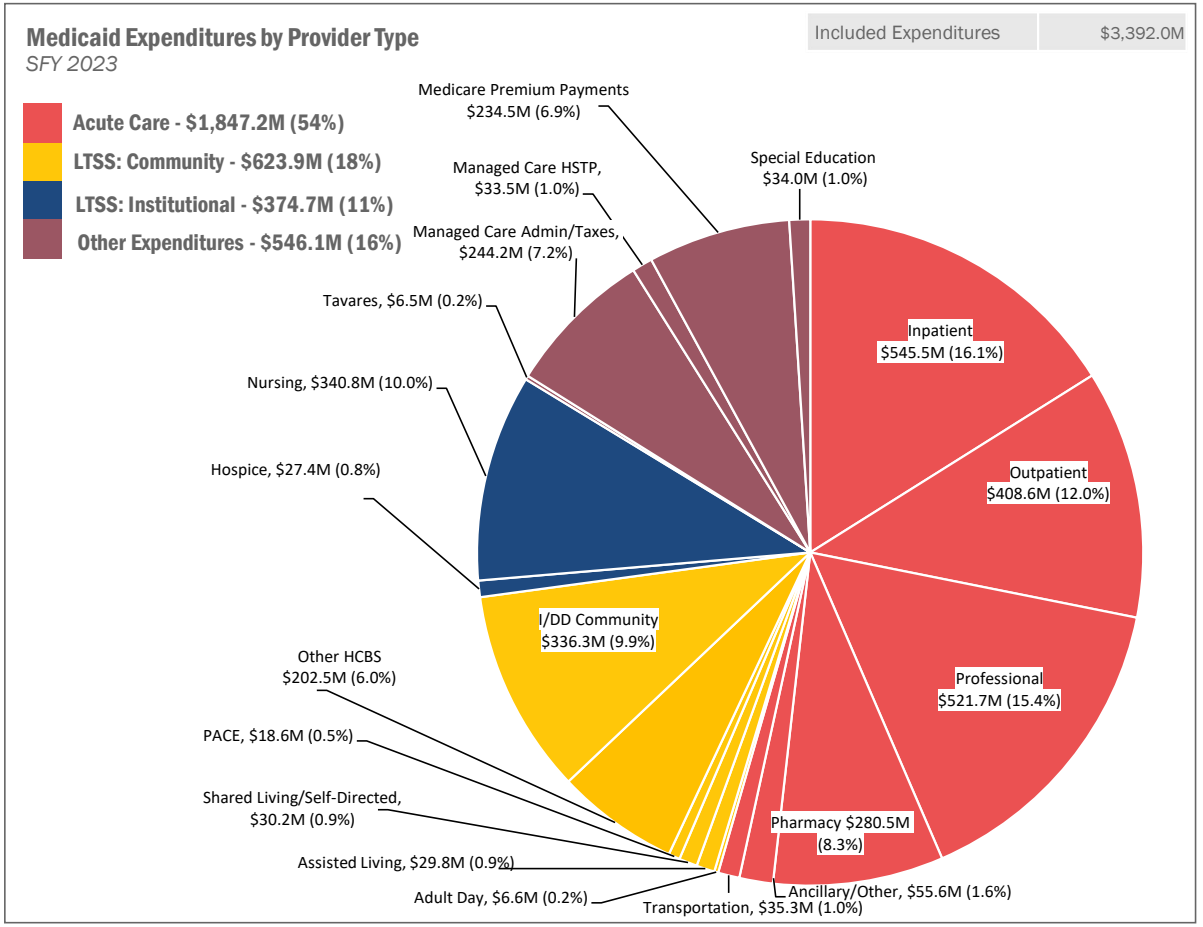
- Expenditures for Medicaid-eligible special education services include the federal share funded in the EOHHS budget and the matching funds for those services, which are financed by each local education agency.
- 34 school districts/departments received LEA payments in SFY 2023.

**Note:**

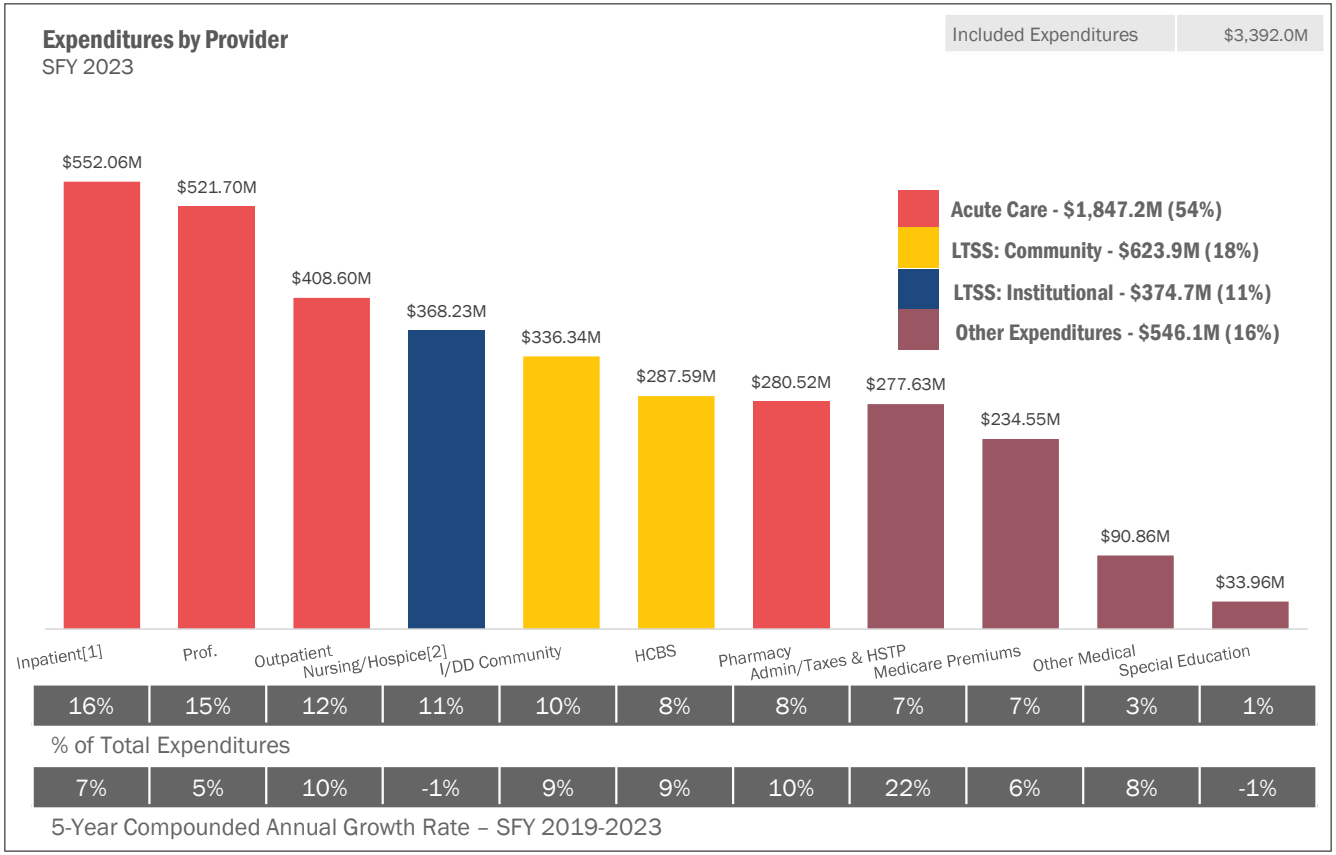
- In prior Expenditure Reports, LEA expenditures had been excluded from further analyses. However, as these expenditures are for individuals with Full Medicaid eligibility they have been included herein.
- Additionally, the LEA share of the expenditure is imputed based on the effective FMAP rate for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

# Expenditures by Provider Type

- **Acute services** had $1,847.22 million in Medicaid expenditures in SFY 2023, constituting 54% of all expenditures.
  - Pharmacy spend is net of rebates.
- **LTSS** had $998.66 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 $374.7 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 $623.93 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.



# Expenditures by Provider Type (cont'd)

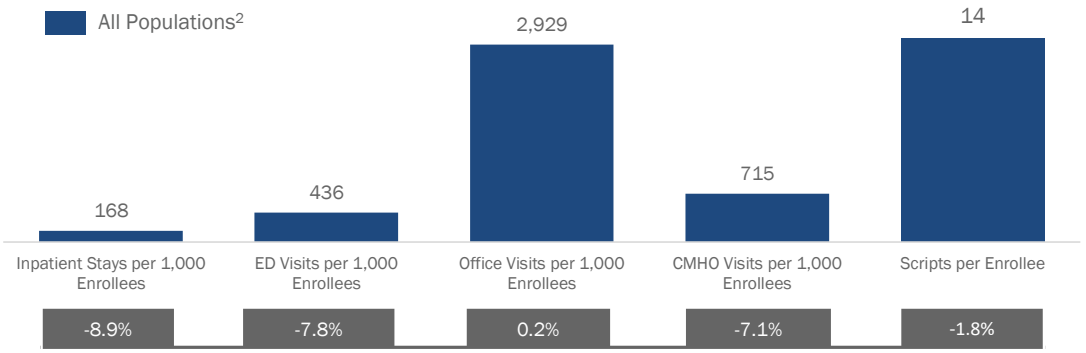



- This spending is net of rebates. In terms of growth rates over the past five years:
  - Pharmacy services expenditures have grown faster than all other service types because of increasing costs across the populations.
  - Medicare expenses have increased 7% annually, but Medicaid does not control these 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 2024 and beyond.
  - Nursing/Hospice spending decreased 1% from FY 2019 to FY 2023, 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: Select Acute Care Utilization**
SFY 2023

| Non-Dual Members with 6-Mon. Eligibility[1] | 299,743 |
|---|---|




5-Year Compounded Annual Change in Utilization SFY 2019-2023

**Overall: Average Cost per Acute Care Service**
SFY 2023

| Inpatient Stay | ED Visit | Office Visit | CMHO | Prescription |
|---|---|---|---|---|
| $7,590 | $689 | $94 | $266 | $92 |
| 10.3% | 7.0% | 5.1% | 5.1% | 6.9% |

5-Year Compounded Annual Change in Unit Cost SFY 2019-2023

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

Acute care services comprise $2.0 billion, or 60 percent, of total Medicaid benefit spending in SFY 2023. 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. Continuing in SFY 2023, 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 2019 experience may be only artificially depressed.

- From SFY 2019 to SFY 2023, utilization fell for inpatient stays, ED visits, and prescriptions, with inpatient stays/ED visits/scripts per enrollees falling –8.9%, -7.8%, and -1.8%, respectively.
- During this time span, costs per inpatient stays increased by 10.3%, cost per ED visits increased by 7%, and costs per prescription increased by 6.9%.

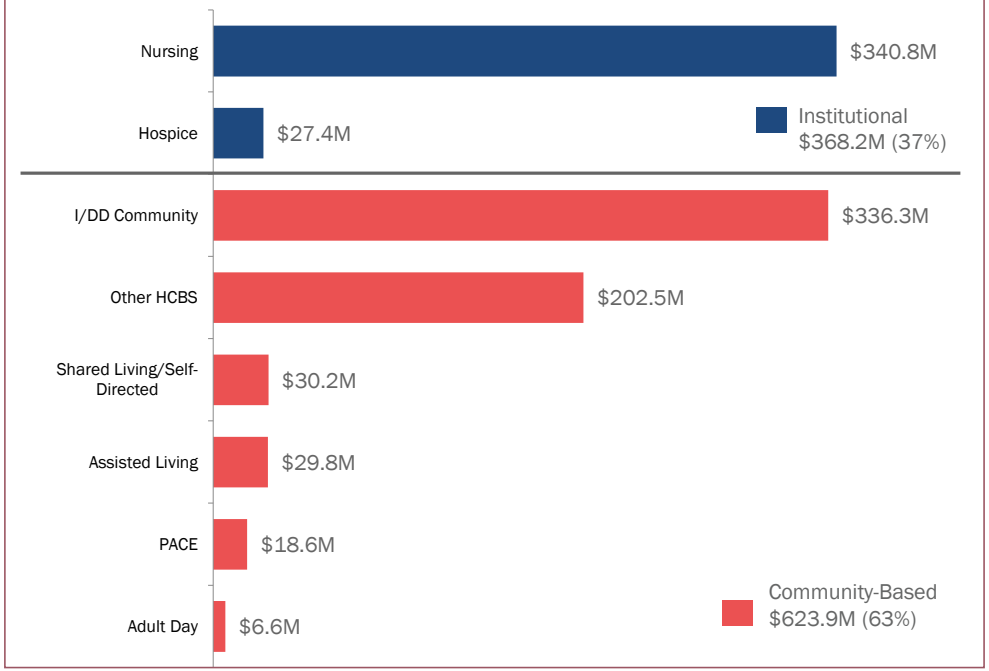
**Data Clarification:**

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

# LTSS Spending: Community vs Institutional

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

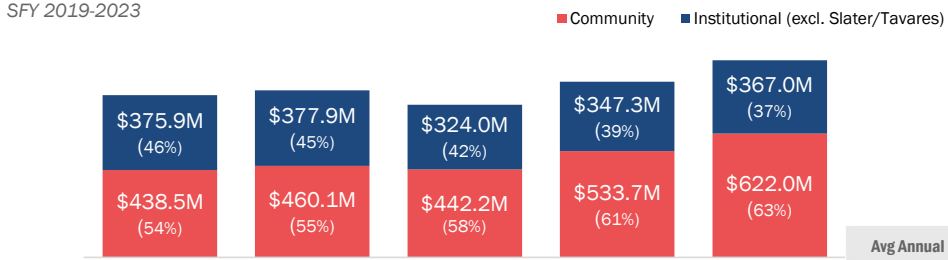
**Medicaid Long Term Care Spending**
*SFY 2023*




[1] "Self-Directed" includes the Self-Directed Personal Choice and Independent Provider programs.
[2] "Other HCBS" includes personal care and severely disabled nursing homecare services.

- 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 2023 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..

**LTC Spending: Institutional vs. Community Spending, excl. Slater/Tavares [1]**
*SFY 2019-2023*




| | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 | SFY 2023 | Avg Annual Growth SFY 2019-2023 |
|---|---|---|---|---|---|---|
| *Annual % Change – Inst.* | | 5% | -4% | 21% | 17% | 9% |
| *Annual % Change – Comm.* | | 1% | -14% | 7% | 6% | -1% |

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

# Populations

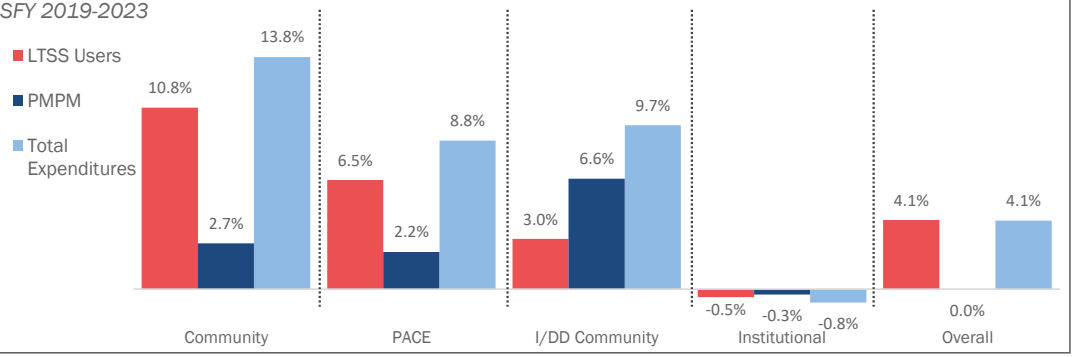
# Elders: LTSS Users and Spending on LTSS

**Current LTSS Expenditures**
*SFY 2023*

| | |
|---|---|
| Elders Enrollment | 27,535 |
| Overall Elders PMPM | $2,203 |
| Total Elders Expenditures | $728.0M |

| | Community | PACE | I/DD Community | Institutional[4] | Overall LTSS |
|---|---|---|---|---|---|
| LTSS Users[1] | 4,447 | 341 | 453 | 5,016 | 10,256 |
| LTSS PMPM[2] | $3,412 | $4,415 | $11,545 | $5,469 | $4,810 |
| LTSS Spend[2] | $182.1M | $18.0M | $62.7M | $329.2M | $592.0M |

**Expenditures - 5-Year Trends (Compound Annual Growth Rates)**
*SFY 2019-2023*




- Providing LTSS services in the community setting allows enrollees to thrive in the lowest setting of care possible, however in many instances an institutional setting is required to fulfill patient needs.
- Overall, expenditures increased by $87.3 million, or nearly 4.1%, over the 5-year period. This change is driven by Community expenses, which increased by $73.5 million.
- The overall PMPM for this population decreased by $6, or an average of less than 1% per annum over the 5-year period. This was comprised of the following average annual PMPM trends:
  - The institutional (Nursing facility/hospice) PMPM decreased by $72 (-0.3%).
  - The PACE PMPM increased by $369 (2.2%).
  - The Community PMPM increased by $346 (2.7%).
  - The I/DD Community PMPM increased by $2,594 (6.6%).

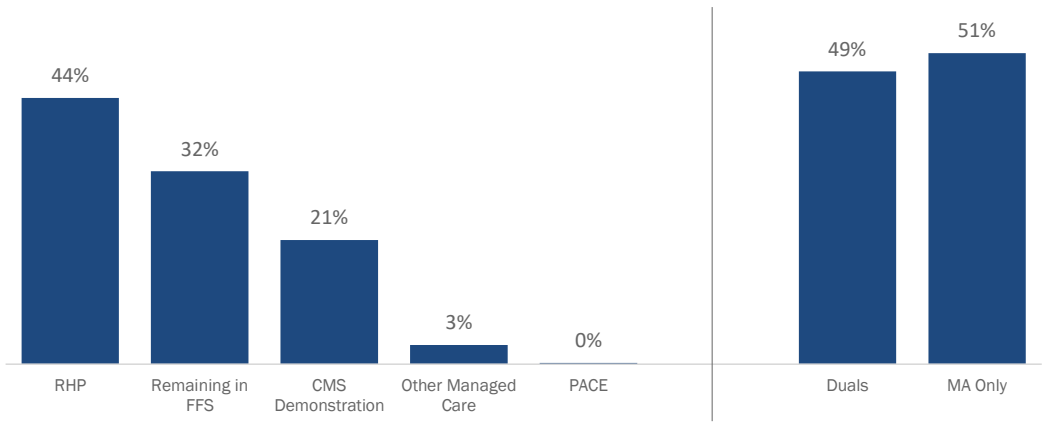
[1] LTSS users reflects members with an LTSS authorization in the fiscal year.
[2] Spending represents LTSS services costs only. except for PACE that includes full capitation.
[3] Community authorizations include those with Preventive Only coverage that have lower LTSS utilization.
[3] Institutional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

# Adults with Disabilities: Managed Care and Dual Enrollment

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

**Adults with Disabilities: Delivery System & Dual Enrollment**
*SFY 2023*

| | |
|---|---|
| Disabled Adult Enrollment | 30,265 |
| 5-Year CAGR | -0.9% |




| RHP | Remaining in FFS | CMS Demonstration | Other Managed Care | PACE | Duals | MA Only |
|---|---|---|---|---|---|---|
| 13,342 | 9,670 | 6,230 | 965 | 59 | 14,680 | 15,585 |

Average Monthly Enrollees – SFY 2023

| RHP | Remaining in FFS | CMS Demonstration | Other Managed Care | PACE | Duals | MA Only |
|---|---|---|---|---|---|---|
| -0.9% | 5.4% | -8.0% | 0.2% | 13.9% | -0.7% | -1.1% |

Compounded Annual Growth Rate SFY 2019-2023

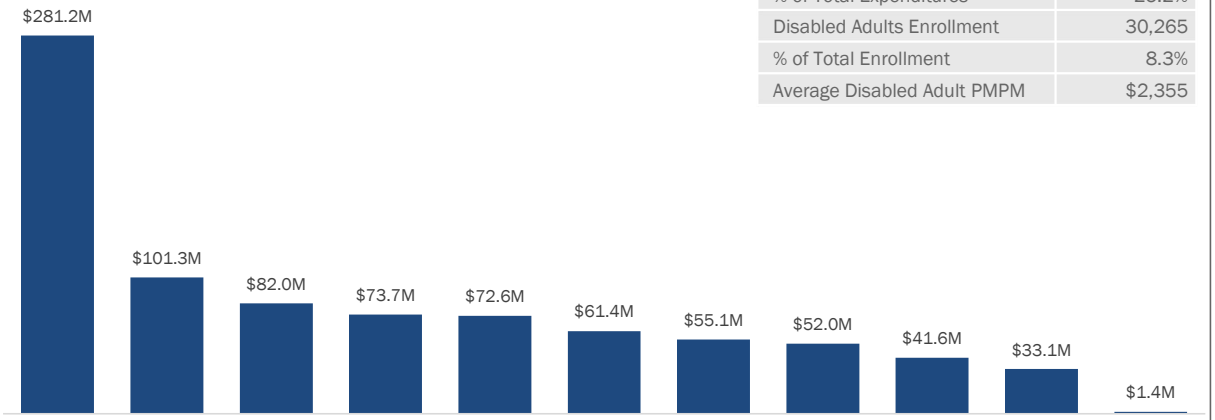
- 44% percent of Adults with Disabilities are enrolled in RHP, a comprehensive managed care program for Adults with Disabilities.
- 49% of Adults with Disabilities are dual eligible.
  - 21% of Adults with Disabilities are enrolled in CMS Dual Demonstration (RHO II).
  - 32% of Adults with Disabilities 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 illusionary as these members are gaining eligibility under Medicaid Expansion as previously-eligible Adults.

# Adults with Disabilities: Expenditures by Provider Type

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

**Adults with Disabilities Expenditures by Provider**
*SFY 2023*

| | |
|---|---|
| Disabled Adults Expenditures | $855.3M |
| % of Total Expenditures | 25.2% |
| Disabled Adults Enrollment | 30,265 |
| % of Total Enrollment | 8.3% |
| Average Disabled Adult PMPM | $2,355 |




| I/DD | Inpatient | Prof. | Medicare | HCBS | Outpatient | Pharmacy | Admin/Taxes | Nursing | Other Medical | Special Ed. |
|---|---|---|---|---|---|---|---|---|---|---|
| 32.9% | 11.8% | 9.6% | 8.6% | 8.5% | 7.2% | 6.4% | 6.1% | 4.9% | 3.9% | 0.2% |

% of Disabled Adults Expenditures – SFY 2023

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 8.8% | 2.9% | 2.2% | 0.6% | 4.5% | 5.3% | 11.1% | 5.1% | 1.8% | 4.6% | 18.7% |

Disabled Adults 5-Year CAGR – SFY 2019-2023

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 83.6% | 18.3% | 15.7% | 31.4% | 25.2% | 15.0% | 19.6% | 18.7% | 11.3% | 36.4% | 4.1% |

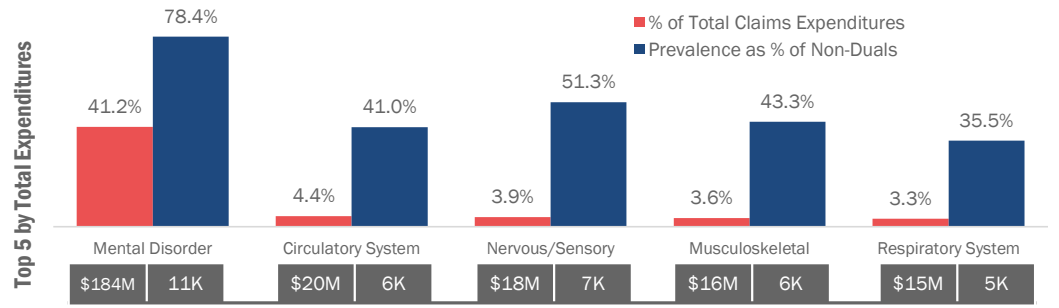
Disabled Adult Spend as % of Total Expenditures, by Provider Type – SFY 2023

- Adults with Disabilities have the highest PMPM among Medicaid members with full benefits, with those expenditures dominated by I/DD services.
  - I/DD services make up 32.9% of expenditures for this population.
- Over the past five years, expenditures on a per member basis for Adults with Disabilities have grown at approximately 6% per year. Children and Families had the same growth rate of 6%.

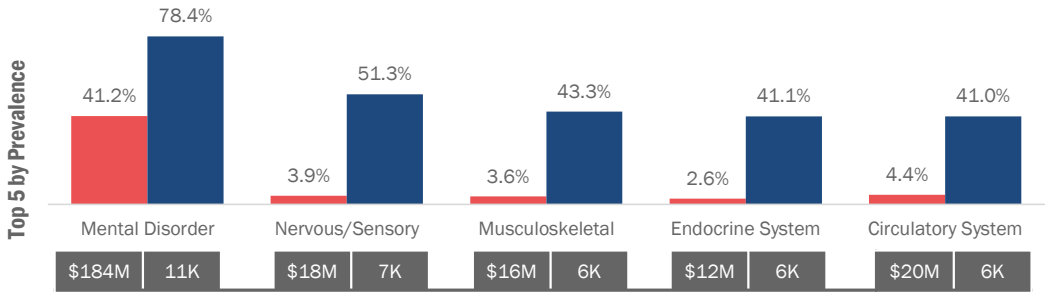
# Adults with Disabilities: Diagnoses

**Adults with Disabilities – Spending and Prevalence by Diagnosis**
SFY 2023

| | |
|---|---|
| Expenditures | $855.3M |
| Average Enrollment | 30,265 |
| Selected Non-Duals with 6-Mon. Eligibility | 14,346 |




Spending | Prevalence by Diagnosis – SFY 2023




Spending | Prevalence by Diagnosis – SFY 2023

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

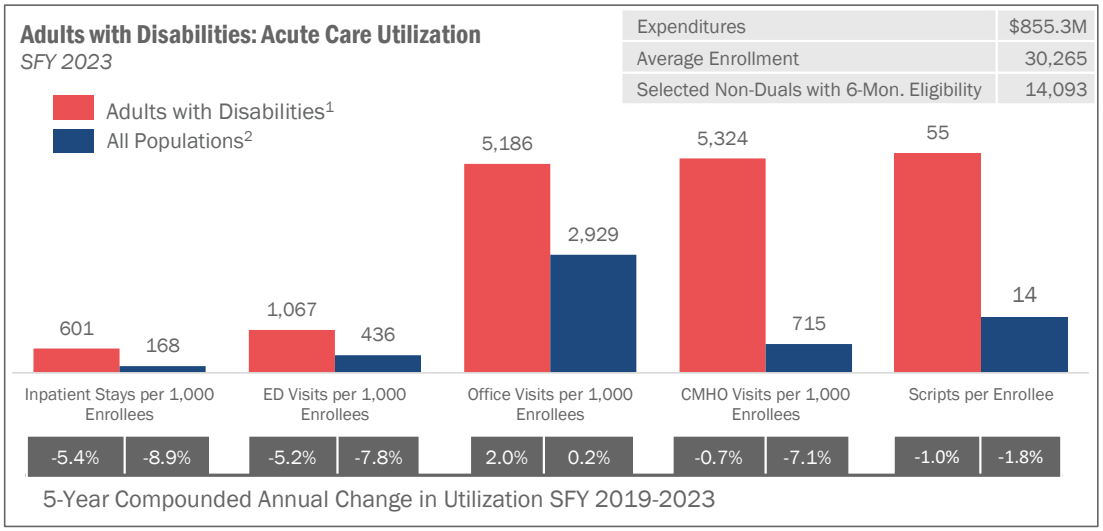
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental and behavioral conditions are both the highest cost and most prevalent conditions among Adults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

- 78.4% "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, 78.4% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 41.2% 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 decreased for both Adults with Disabilities (-5.4%) and the overall population (-8.9%) from SFY 2019 to SFY 2023 per year.
- Adults with Disabilities have significantly higher utilization at hospitals than all other groups, with 3.6 times more inpatient stays per 1,000 (at a 7% higher cost per stay) and 2.4 more ED visits per 1,000 (at a 15% higher cost per visit)
- The average Adult with Disabilities had 55 pharmacy claims per year, whereas the average enrollee had 14 pharmacy claims per year.

**Adults with Disabilities: Average Cost per Acute Care Service**
SFY 2023

| | IP Stay | ED Visit | Office Visit | CMHO Visit | Script |
|---|---|---|---|---|---|
| Adults with Disabilities | $8,154 | $795 | $77 | $327 | $105 |
| Overall | $7,590 | $689 | $94 | $266 | $92 |

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

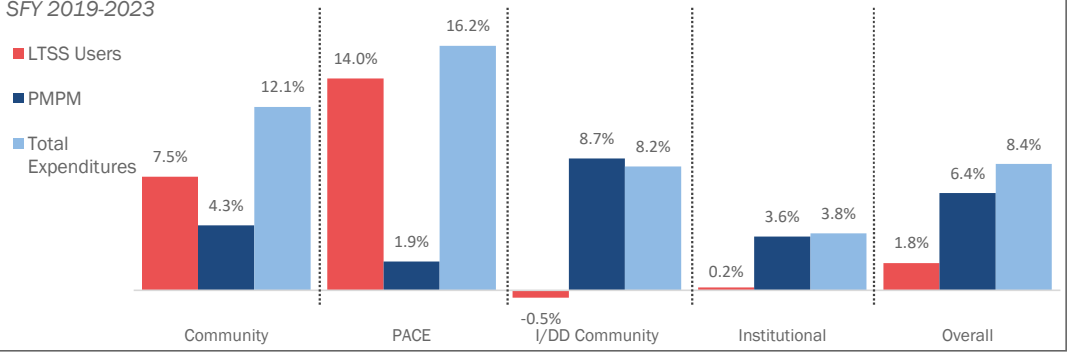
# Adults with Disabilities: LTSS Users and Spending

**Current LTSS Expenditures**
*SFY 2023*

| | |
|---|---|
| Disabled Enrollment | 30,265 |
| Overall Disabled PMPM | $2,355 |
| Total Disabled Expenditures | $855.3M |

| | Community | PACE | I/DD Community | Institutional[4] | Overall LTSS |
|---|---|---|---|---|---|
| LTSS Users[1] | 1,601 | 59 | 3,121 | 571 | 5,352 |
| LTSS PMPM[2] | $4,413 | $4,889 | $8,624 | $7,539 | $7,207 |
| LTSS Spend[2] | $84.8M | $3.5M | $323.0M | $51.6M | $462.9M |

**Expenditures - 5-Year Trends (Compound Annual Growth Rates)**
*SFY 2019-2023*




- Enrollment for adults with disabilities in institutional care slightly increased by 0.2% on average per year between SFY 2019 and SFY 2023.
- Enrollment in community LTSS increased by 7.5% annually.
- Overall LTSS expenditures for Disabled Adults increased by $127 million from SFY 2019 to 2023: with widespread increases in expenditures across all methods of care.
- The overall PMPM for Adults with Disabilities increased by $1,589 over the 5-year period, by 6.4% per year on average.
  - Over this same time period, the Community PMPM increased by $684 or 4.3%.
  - The I/DD Community and Institutional PMPM rates increased by $2,449 and $985, or 8.7% and 3.6%, respectively.

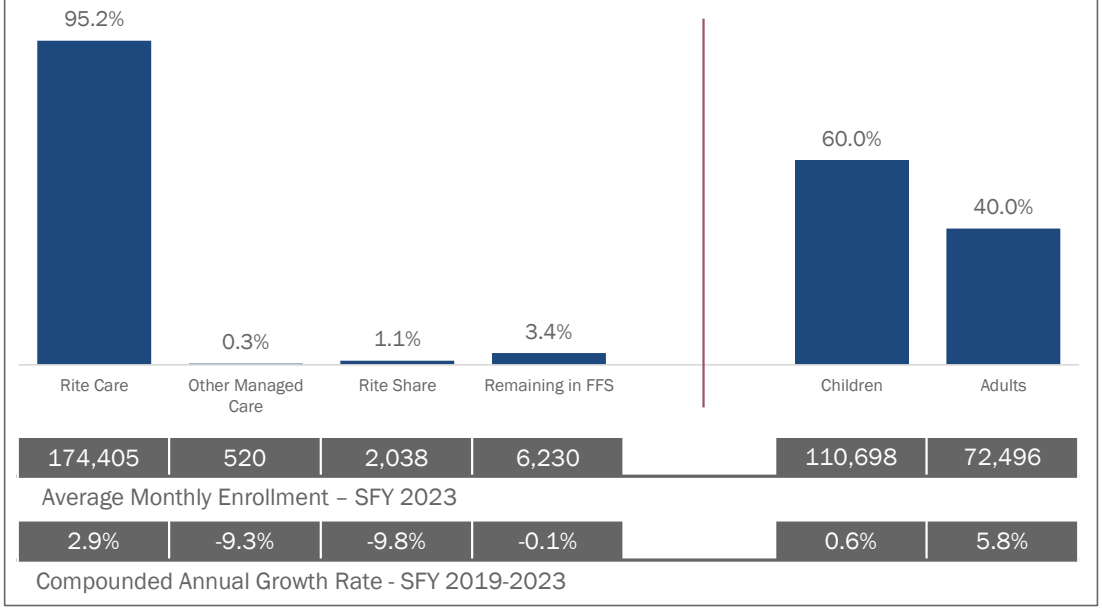
[1] LTSS users reflects members with an LTSS authorization in the fiscal year.
[2] Spending represents LTSS service costs only. Costs not adjusted for allocations of missing data/admin; except PACE that includes full capitation.
[3] Community authorizations includes those with Preventive Only coverage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

# Children and Families: Managed Care Enrollment

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

**Children and Families: Delivery System & Age Group**
*SFY 2023*

| | SFY 2023 | 5-Year CAGR |
|---|---|---|
| Enrollment | 183,193 | 2.3% |
| Expenditures | $789.3M | 8.1% |

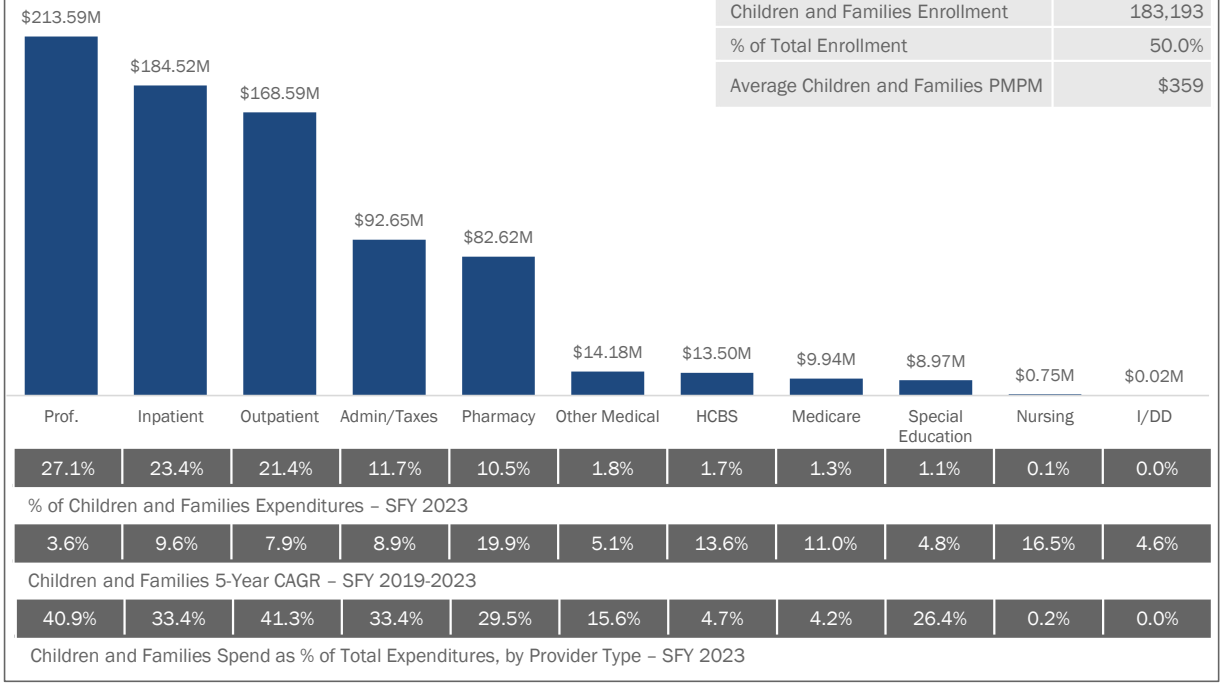



- 96% of the Children and Families population is enrolled in RIte Care, a managed care program for families with children, pregnant women, and children under age 19.
- RIte Care enrollees are divided between Neighborhood Health Plan of RI, United Healthcare of New England, and Tufts Health Plan.
- RIte Share is a program designed to allow Medicaid enrollees with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium and any out-of-pocket expenditures. This minimizes Medicaid expenditures by leveraging the employer's contribution.
- The members remaining in FFS are those with access to other insurance and/or newly enrolled members during the period prior to enrollment in RIte Care.
- "Other Managed Care" includes members who for a portion of the year were enrolled in RHP or Expansion.

# Children and Families: Expenditures by Provider Type

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

**Children and Families Expenditures by Provider**
*SFY 2023*




| | |
|---|---|
| Children and Families Expenditures | $789.3M |
| % of Total Expenditures | 23.3% |
| Children and Families Enrollment | 183,193 |
| % of Total Enrollment | 50.0% |
| Average Children and Families PMPM | $359 |

| Prof. | Inpatient | Outpatient | Admin/Taxes | Pharmacy | Other Medical | HCBS | Medicare | Special Education | Nursing | I/DD |
|---|---|---|---|---|---|---|---|---|---|---|
| 27.1% | 23.4% | 21.4% | 11.7% | 10.5% | 1.8% | 1.7% | 1.3% | 1.1% | 0.1% | 0.0% |

% of Children and Families Expenditures – SFY 2023

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 3.6% | 9.6% | 7.9% | 8.9% | 19.9% | 5.1% | 13.6% | 11.0% | 4.8% | 16.5% | 4.6% |

Children and Families 5-Year CAGR – SFY 2019-2023

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 40.9% | 33.4% | 41.3% | 33.4% | 29.5% | 15.6% | 4.7% | 4.2% | 26.4% | 0.2% | 0.0% |

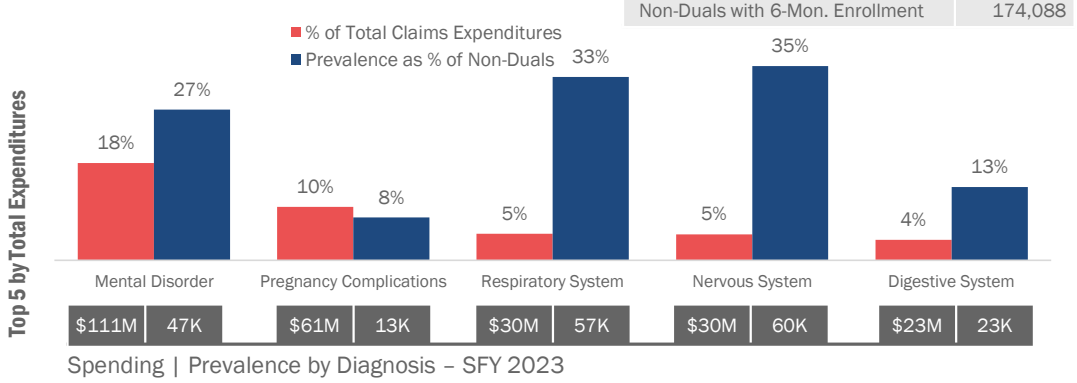
Children and Families Spend as % of Total Expenditures, by Provider Type – SFY 2023

- Children and Families is the largest population group in Rhode Island Medicaid, with 50% of all Medicaid enrollees falling into this category.
- Children and Families have the lowest per-person expenditures of any of the populations with a PMPM $200 less than the Expansion population.
- Professional services and hospital services (outpatient and inpatient) account for 72% ($563.88M) of the expenditures for the Children and Families population in SFY 2023.
- The fastest-growing expenditures for Children and Families are Pharmacy, Nursing, and HCBS Services which grew at a yearly average of 19.8%, 16.5%, and 13.6%, respectively, from SFY 2019 to 2023.

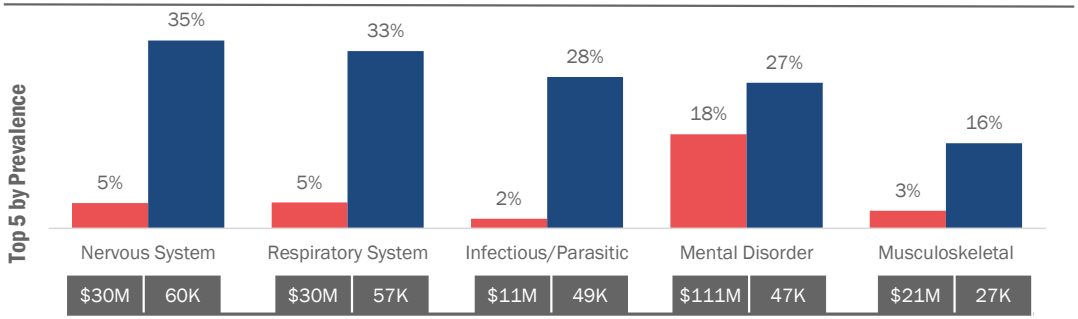
# Children and Families: Diagnoses

**Children and Families – Spending and Prevalence by Diagnosis**
*SFY 2023*

| | |
|---|---|
| Expenditures | $789.3M |
| Average Enrollment | 183,193 |
| Non-Duals with 6-Mon. Enrollment | 174,088 |




Spending | Prevalence by Diagnosis – SFY 2023




Spending | Prevalence by Diagnosis – SFY 2023

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

- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Similarly, to other populations, mental or behavioral health has high prevalence and high cost for Children and Families.
- Complications of pregnancy, childbirth and postpartum, and certain conditions originating in the perinatal period account for 10% of expenditures for Children and Families.
- Diseases of the nervous system and sense organs, respiratory system, infectious and parasitic diseases, and musculoskeletal diagnoses are also prevalent among Children and Families.

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

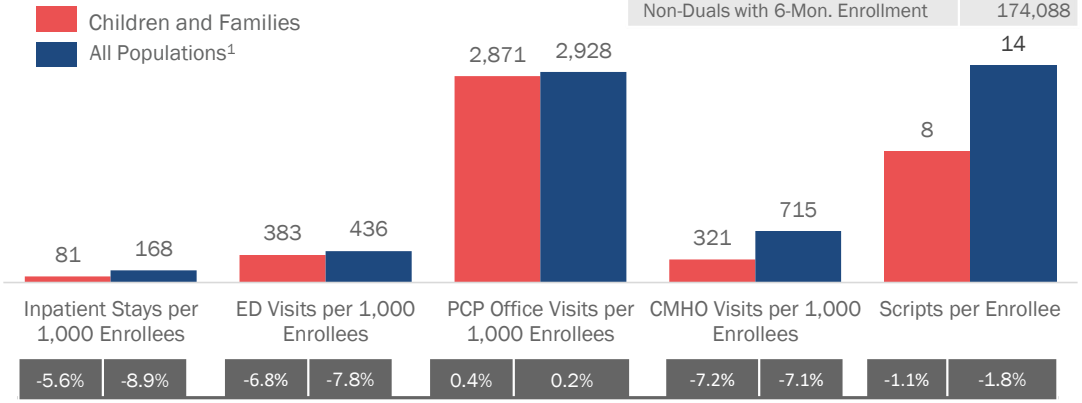
- 27% "prevalence as a % of non-duals" means that among members within the Children and Families population that have at least 6 months of enrollment during the year, 27% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 18% of costs were for claims where “mental or behavioral health" was the primary diagnosis.

# Children and Families: Acute Care Services

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

**Children and Families: Acute Care Utilization**
*SFY 2023*

| | |
|---|---|
| Expenditures | $789.3M |
| Average Enrollment | 183,193 |
| Non-Duals with 6-Mon. Enrollment | 174,088 |




5-Year Compounded Annual Change in Utilization SFY 2019-2023

- Children and Families use, on average, fewer than half as many inpatient stays per person as the overall Medicaid population.
- Per person utilization for Children and Families have lower growth trends than the overall population for most services.
- Costs per script in FY 2023 were approximately 18% lower for the Children and Families population than for the overall population.

**Children and Families: Average Cost per Acute Care Service**
*SFY 2023*

| | Inpatient Stay | ED Visit | Office Visit | CMHO Visit | Script |
|---|---|---|---|---|---|
| Children and Families | $9,247 | $654 | $102 | $176 | $75 |
| Overall | $7,590 | $689 | $94 | $266 | $92 |

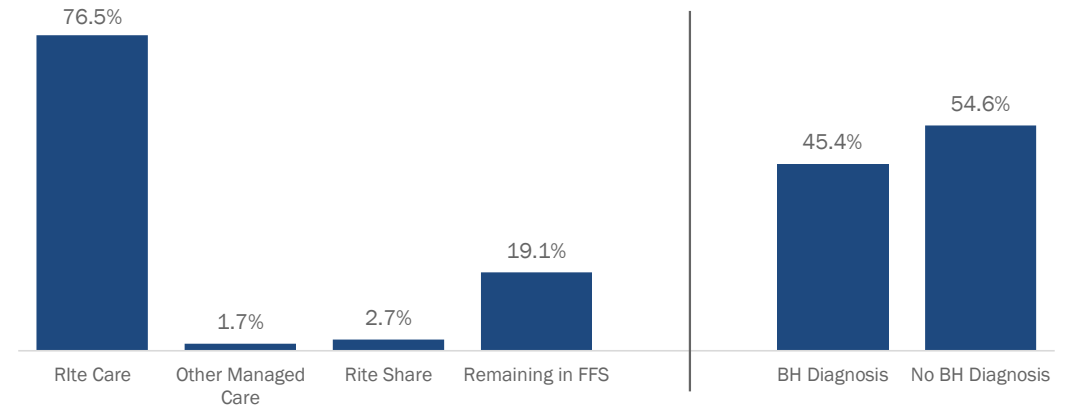
[1] All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.

# CSHCN: Managed Care Enrollment

**Children with Special Health Care Needs (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.**

**CSHCN: Delivery System & Behavioral Health Diagnosis**
*SFY 2023*

| | SFY 2023 | 5-Year CAGR |
|---|---|---|
| Enrollment | 12,345 | 0.4% |
| Expenditures | $260.7M | 4.8% |




| RIte Care | Other Managed Care | Rite Share | Remaining in FFS | BH Diagnosis | No BH Diagnosis |
|---|---|---|---|---|---|
| 9,445 | 212 | 336 | 2,352 | 5,602 | 6,743 |

Average Monthly Enrollment – SFY 2023

| RIte Care | Other Managed Care | Rite Share | Remaining in FFS | BH Diagnosis | No BH Diagnosis |
|---|---|---|---|---|---|
| 0.6% | -7.2% | -9.1% | 2.2% | -1.8% | 2.3% |

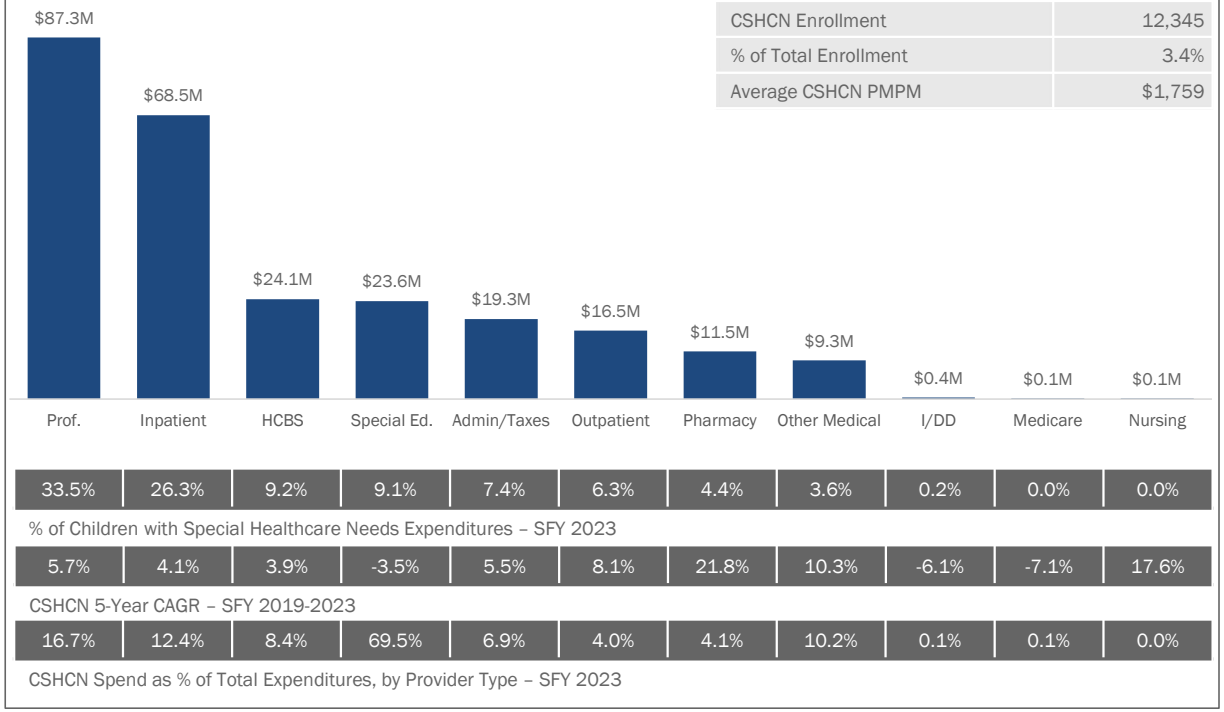
Compounded Annual Growth Rate - SFY 2019-2023

- 76.5% of CSHCN are enrolled in RIte Care.
  - Enrollees in the RIte Care are divided between Neighborhood Health Plan, United Healthcare, and Tufts Health Plan.
  - Children in substitute care administered by DCYF are exclusively enrolled in Neighborhood.
- CSHCN who live in institutions have their Medicaid coverage administered by the state of Rhode Island in FFS and are not enrolled in managed care.
- A greater proportion of CSHCN are in Rite Share or remaining in FFS compared to Children and Families or Expansion because many of the families of these children have comprehensive third-party coverage for their families, including:
  - approximately 90% of Katie Beckett children, and
  - 30% of Adoption Subsidy.
- "Other Managed Care" includes members who for a portion of the year were enrolled in RHP or Expansion.

# CSHCN: Expenditures by Provider Type

**CSHCN expenditures are largely concentrated in professional and inpatient services.**

**CSHCN Expenditures by Provider**
*SFY 2023*




| | |
|---|---|
| CSHCN Expenditures | $260.7M |
| % of Total Expenditures | 7.7% |
| CSHCN Enrollment | 12,345 |
| % of Total Enrollment | 3.4% |
| Average CSHCN PMPM | $1,759 |

| Prof. | Inpatient | HCBS | Special Ed. | Admin/Taxes | Outpatient | Pharmacy | Other Medical | I/DD | Medicare | Nursing |
|---|---|---|---|---|---|---|---|---|---|---|
| 33.5% | 26.3% | 9.2% | 9.1% | 7.4% | 6.3% | 4.4% | 3.6% | 0.2% | 0.0% | 0.0% |

% of Children with Special Healthcare Needs Expenditures – SFY 2023

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 5.7% | 4.1% | 3.9% | -3.5% | 5.5% | 8.1% | 21.8% | 10.3% | -6.1% | -7.1% | 17.6% |

CSHCN 5-Year CAGR – SFY 2019-2023

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 16.7% | 12.4% | 8.4% | 69.5% | 6.9% | 4.0% | 4.1% | 10.2% | 0.1% | 0.1% | 0.0% |

CSHCN Spend as % of Total Expenditures, by Provider Type – SFY 2023

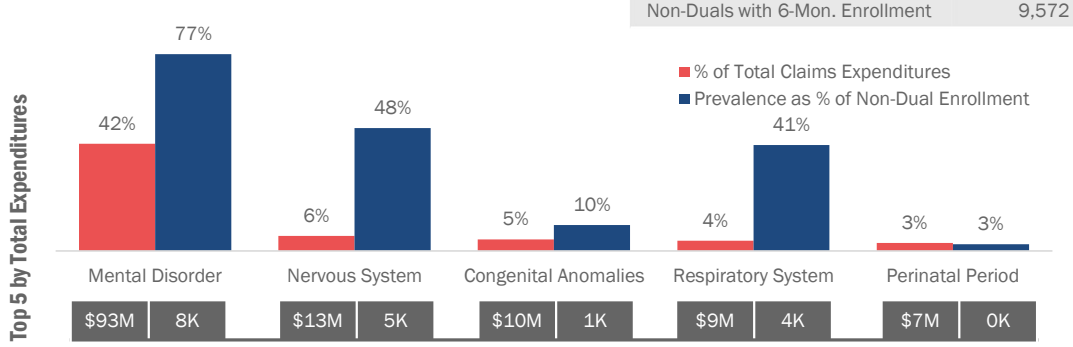
- 60% of CSHCN expenditures go towards professional services and inpatient hospital services.
- A significantly smaller percentage of CSHCN expenditures go toward pharmacy, residential and rehabilitation services for persons with IDD, premiums, and nursing facilities and hospice than for the overall population.
- Average annual growth of professional expenditures (5.7%) from SFY 2019 to 2023 was slightly higher than the overall population (5.0%).

[1] Inpatient spending includes $3.6 million spending at Tavares Pediatric Center that is an Intermediate Care Facility.

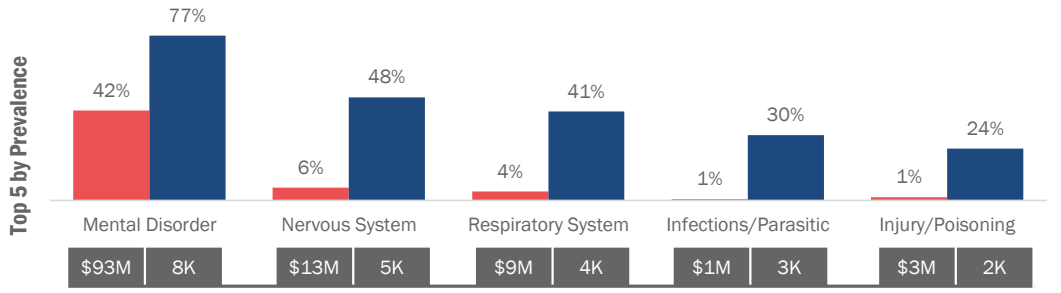
# CSHCN: Diagnoses

**CSHCN – Spending and Prevalence by Diagnosis**
*SFY 2023*

| | |
|---|---|
| CSHCN Expenditures | $260.7M |
| CSHCN Average Enrollment | 12,345 |
| Non-Duals with 6-Mon. Enrollment | 9,572 |




Spending | Prevalence by Diagnosis – SFY 2023




Spending | Prevalence by Diagnosis – SFY 2023

**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 nervous system and sense organs are associated with the second-highest expenditures for CSHCN.
- Mental or behavioral diagnoses, diseases of the nervous system and sense organs, respiratory system, infections, and injury/poisoning diagnoses are prevalent among the CSHCN population.

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

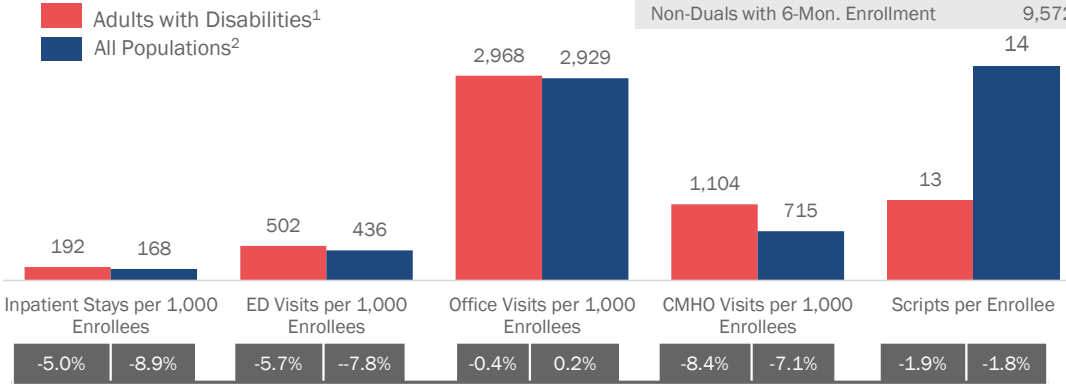
- Of the total claims for this population, 42% of costs were for claims where “mental or behavioral health" was the primary diagnosis.
- 77% "prevalence as a % of non-duals" means that among members within the CSHCN population that have at least 6 months of enrollment during the year, 77% of the non-duals 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.**

**Adults with Disabilities: Acute Care Utilization**
*SFY 2023*

| | |
|---|---|
| CSHCN Expenditures | $260.7 M |
| CSHCN Average Enrollment | 12,345 |
| Non-Duals with 6-Mon. Enrollment | 9,572 |




5-Year Compounded Annual Change in Utilization SFY 2019-2023

- The CSHCN population experiences more inpatient stays than the overall Medicaid population.
  - Additionally, each stay is more expensive, with an average cost per stay of $22,634 for CSHCN compared to $7,590 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 26%, respectively).

**CSHCN: Average Cost per Acute Care Service**
*SFY 2023*

| | Inpatient Stay | ED Visit | Office Visit | CMHO Visit | Script |
|---|---|---|---|---|---|
| CSHCN | $22,634 | $641 | $118 | $164 | $120 |
| Overall | $7,590 | $689 | $94 | $266 | $92 |

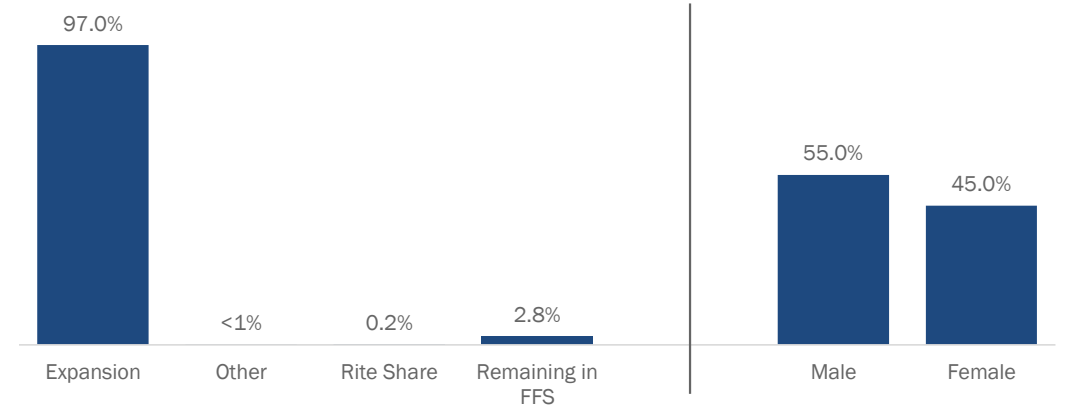
[1] Unduplicated enrollees includes count of Medicaid Only members with a minimum of 6 months of eligibility.
[2] All populations include Medicaid Only members Adults with Disabilities, Children and Families, CHSCN, and Expansion members with a minimum of 6 months of eligibility.

# Expansion: Managed Care Enrollment

**The Expansion population is primarily enrolled in managed care.**

**Expansion: Delivery System & BH Diagnosis**
*SFY 2023*

| | SFY 2023 | 5-Year CAGR |
|---|---|---|
| Enrollment | 112,745 | 10.2% |
| Expenditures | $758.8M | 14.7% |




| Expansion | Other | Rite Share | Remaining in FFS | Male | Female |
|---|---|---|---|---|---|
| 109,372 | 64 | 208 | 3,101 | 62,001 | 50,745 |

Average Monthly Enrollment – SFY 2023

| Expansion | Other | Rite Share | Remaining in FFS | Male | Female |
|---|---|---|---|---|---|
| 11.6% | -43.7% | 69.8% | -11.8% | 10.1% | 10.4% |

Compounded Annual Growth Rate - SFY 2019-2023

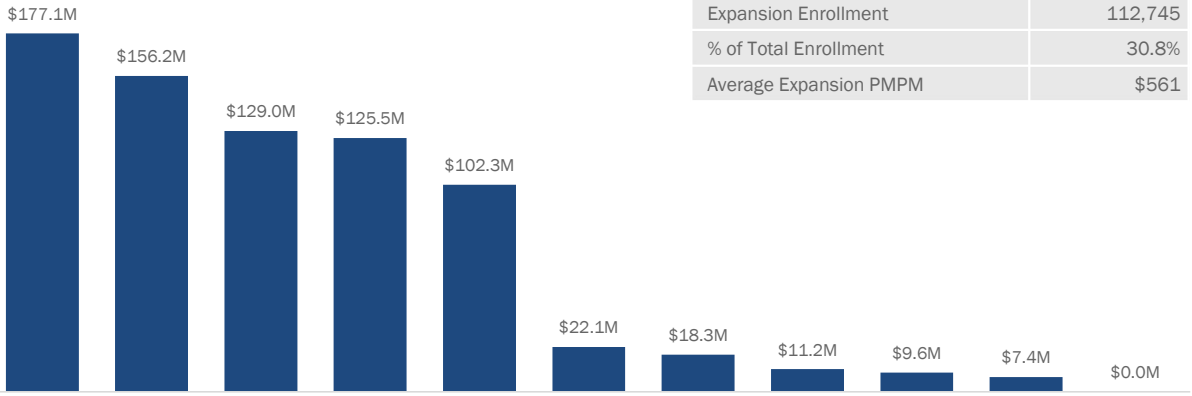
- Expansion includes childless adults who are eligible under the income-based eligibility standards set when the state expanded Medicaid under the Affordable Care Act (ACA) in 2014. This population also includes people who are classified as previously eligible under criteria for "Adults with Disabilities."
- Spending on the Expansion population totaled $758.5 million in SFY 2023.
- 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.**

**Expansion Expenditures by Provider**
*SFY 2023*

| | |
|---|---|
| Expansion Expenditures | $758.8M |
| % of Total Expenditures | 22.4% |
| Expansion Enrollment | 112,745 |
| % of Total Enrollment | 30.8% |
| Average Expansion PMPM | $561 |



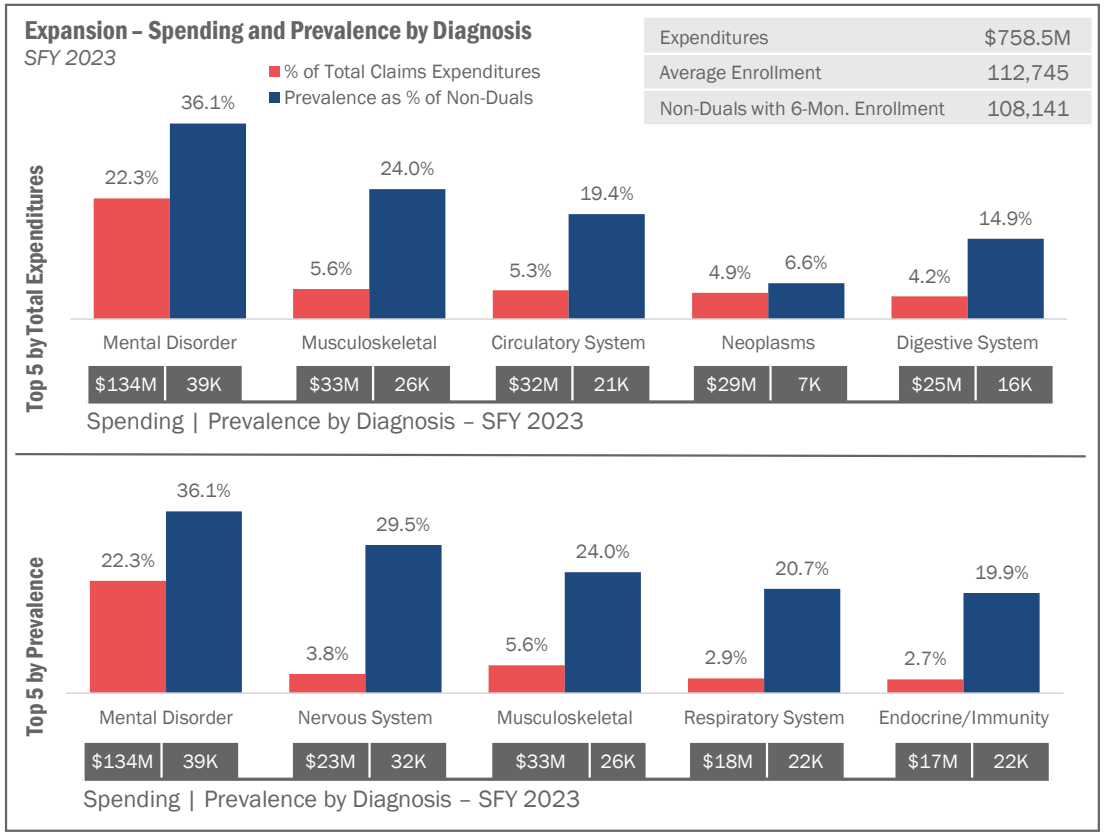

| Expansion Spend as % of Total Expenditures, by Provider Type – SFY 2023 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Inpatient | Outpatient | Pharmacy | Prof. | Admin/Taxes | Medicare | Other Medical | HCBS | Nursing | I/DD | Special Ed. |
| % of Expansion Expenditures – SFY 2023 | 23.3% | 20.6% | 17.0% | 16.5% | 13.5% | 2.9% | 2.4% | 1.5% | 1.3% | 1.0% | 0.0% |
| 5-Year Compounded Annual Growth Rate – SFY 2019-2023 | 9.6% | 14.0% | 29.5% | 7.9% | 18.0% | 38.8% | 15.4% | 26.7% | 4.0% | 19.2% | -100.0% |
| | 32.1% | 38.2% | 46.0% | 24.1% | 36.9% | 9.4% | 20.2% | 3.9% | 2.6% | 2.2% | 0.0% |

- Expenditure growth for the Expansion population was significantly higher (15%) than the overall population (7%), driven primarily by higher enrollment growth (8% per annum for Expansion compared to 5% 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.

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

# Expansion: Diagnoses

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

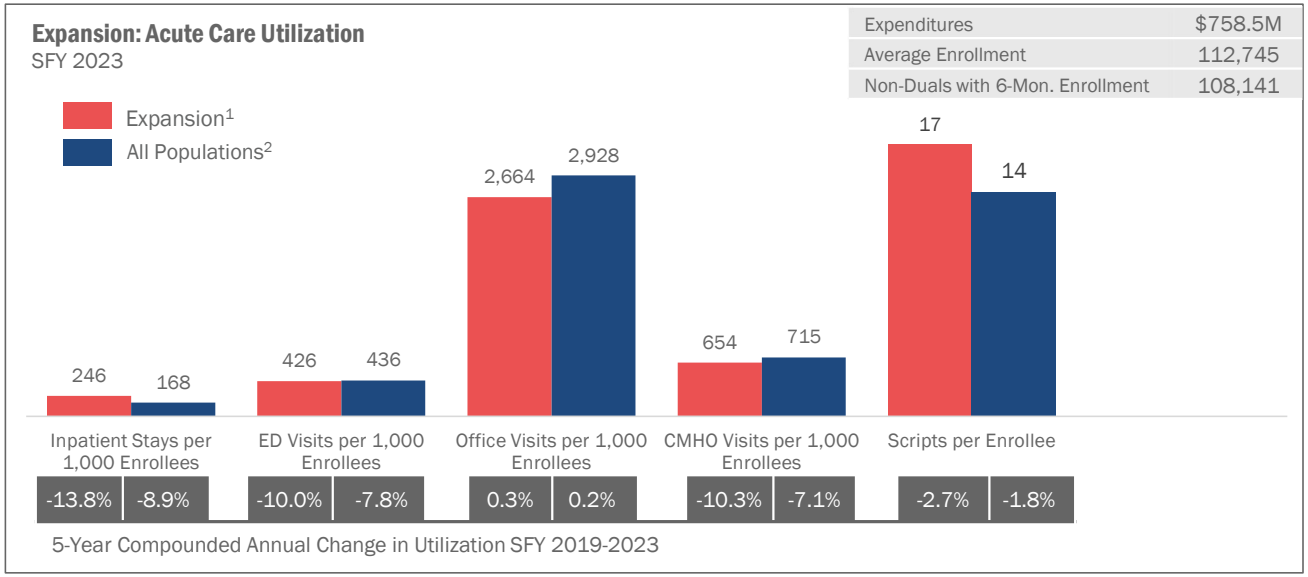



- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Among all mental health diagnoses, substance-related disorders are nearly twice as prevalent among the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

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

- 36% "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, 36% of the non-duals had claims where “mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 22.3% of costs were for claims where “mental or behavioral health" was the primary diagnosis.

# Expansion: Acute Care Utilization




- The per person utilization rates of the Expansion population are consistent with the overall population generally, while growth rates in utilization are mixed.
  - Utilization of inpatient stays declined at a faster rate on average over the five-year period than the overall populations.
- Emergency department visits declined by -10% per year on average over the five-year period.
- 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.

**Expansion: Average Cost per Acute Care Service**

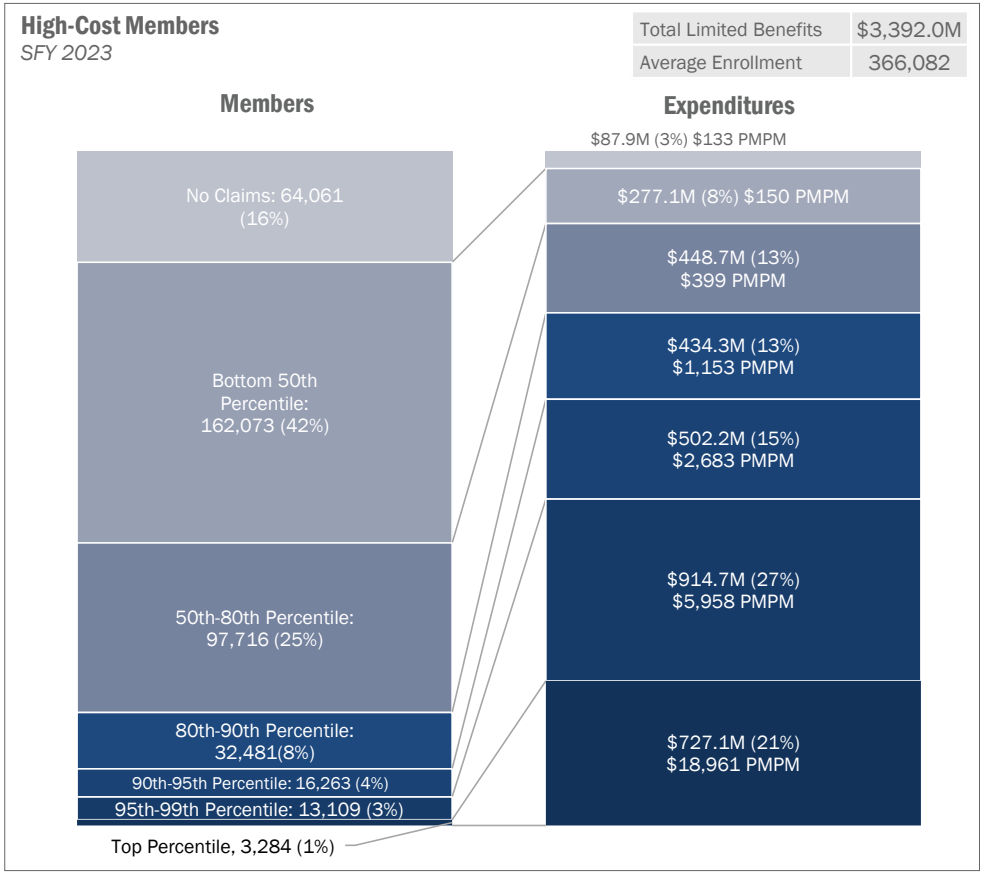
*SFY 2023*

| | Inpatient Stay | ED Visit | Office Visit | CMHO Visits | Script |
|---|---|---|---|---|---|
| Expansion | $4,997 | $705 | $80 | $287 | $97 |
| Overall | $7,590 | $689 | $94 | $266 | $92 |

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

# Miscellany & Exclusions

# High-Cost Enrollees: Summary




- Medicaid claims expenditures are highly concentrated:
  - The top 1% of users account for 21% of all benefit expenditures with an average PMPM of $18,961 or over $200,000 in spending per year.
  - And the top 20th percentile of Medicaid users account for 76% of all expenditures with an average PMPM of $7,189.
  - The bottom 50th percentile of Medicaid users with any claims activity have an average PMPM of $150.
- Members with no claims activity account for 16% 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 2023

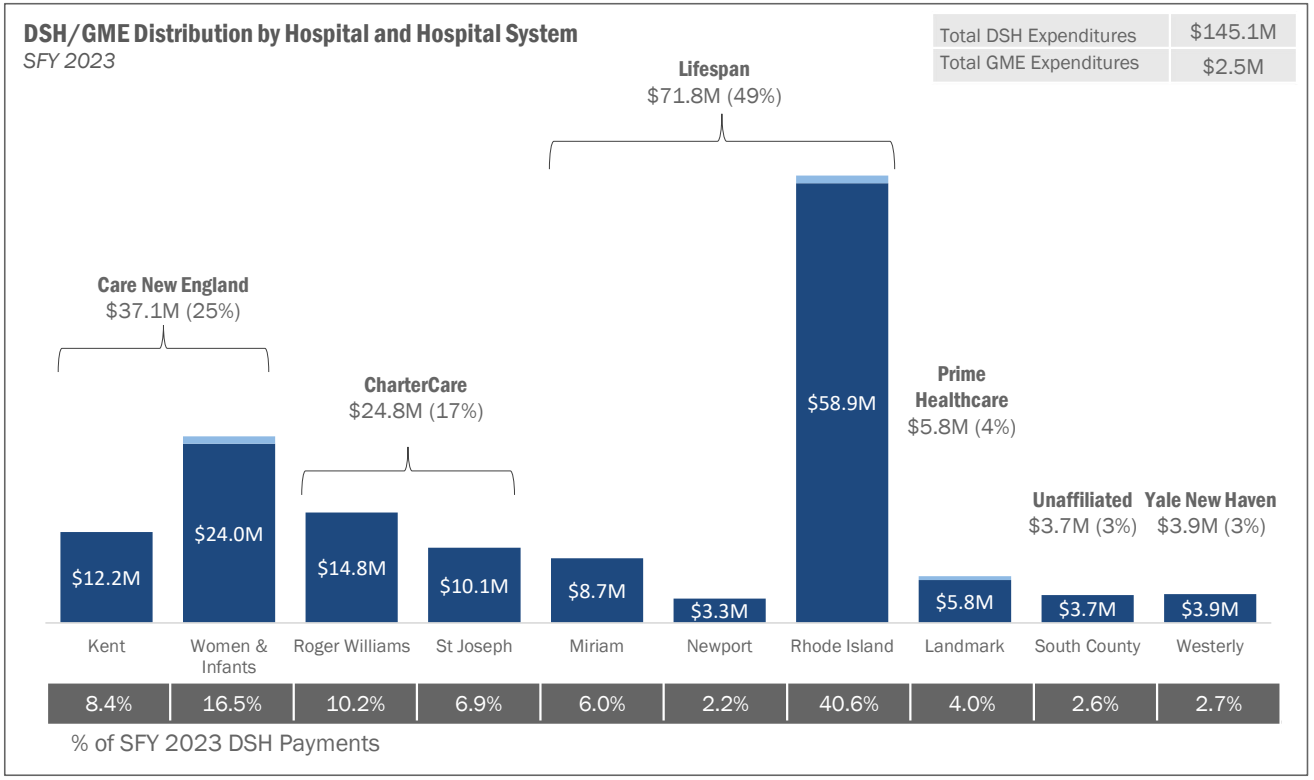
| Primary Payer and Diagnosis[1] | Average Enrollment | % of Enrollment | Overall PMPM | % of Expenditures |
|---|---|---|---|---|
| Medicaid Only | | | | |
| I/DD Community (BHDDH) | 1,233 | 0.4% | $8,548 | 5.8% |
| Other Developmental Disability | 10,302 | 3.3% | $1,526 | 8.6% |
| Substance Use Disorder | 9,949 | 3.2% | $2,360 | 12.8% |
| Other Behavorial/Mental Health | 36,728 | 11.7% | $1,252 | 25.1% |
| Subtotal - Any BH-Related Diagnoses | 58,157 | 18.5% | $1,638 | 52.0% |
| No BH-Related Diagnosis | 256,450 | 81.5% | $341 | 47.9% |
| Overall - Medicaid Only | 314,662 | 100.0% | $582 | 100.0% |
| Duals | | | | |
| I/DD Community (BHDDH) | 2,442 | 5.3% | $9,083 | 23.7% |
| Other Developmental Disability | 159 | 0.3% | $3,691 | 0.6% |
| Substance Use Disorder | 1,001 | 2.2% | $1,583 | 1.7% |
| Other Behavorial/Mental Health | 7,551 | 16.3% | $2,656 | 21.7% |
| Subtotal – Any BH-Related Diagnoses | 11,153 | 24.1% | $3,873 | 46.1% |
| No BH-Related Diagnosis | 35,093 | 75.9% | $1,406 | 52.6% |
| Overall - Duals | 46,246 | 100.0% | $2,027 | 100.0% |

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

- Among both the Dual and Medicaid Only populations, members with a BH diagnosis account for a disproportionate share of expenditures:
  - 18.5% of Medicaid Only members have a BH-related diagnosis and account for over half of expenditures.
  - 24.1% of Duals have a BH diagnosis and account for 46.1% of expenditures.
- Overall, the PMPM for a non-dual member with a BH diagnosis was $1,638 compared to $341 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.**

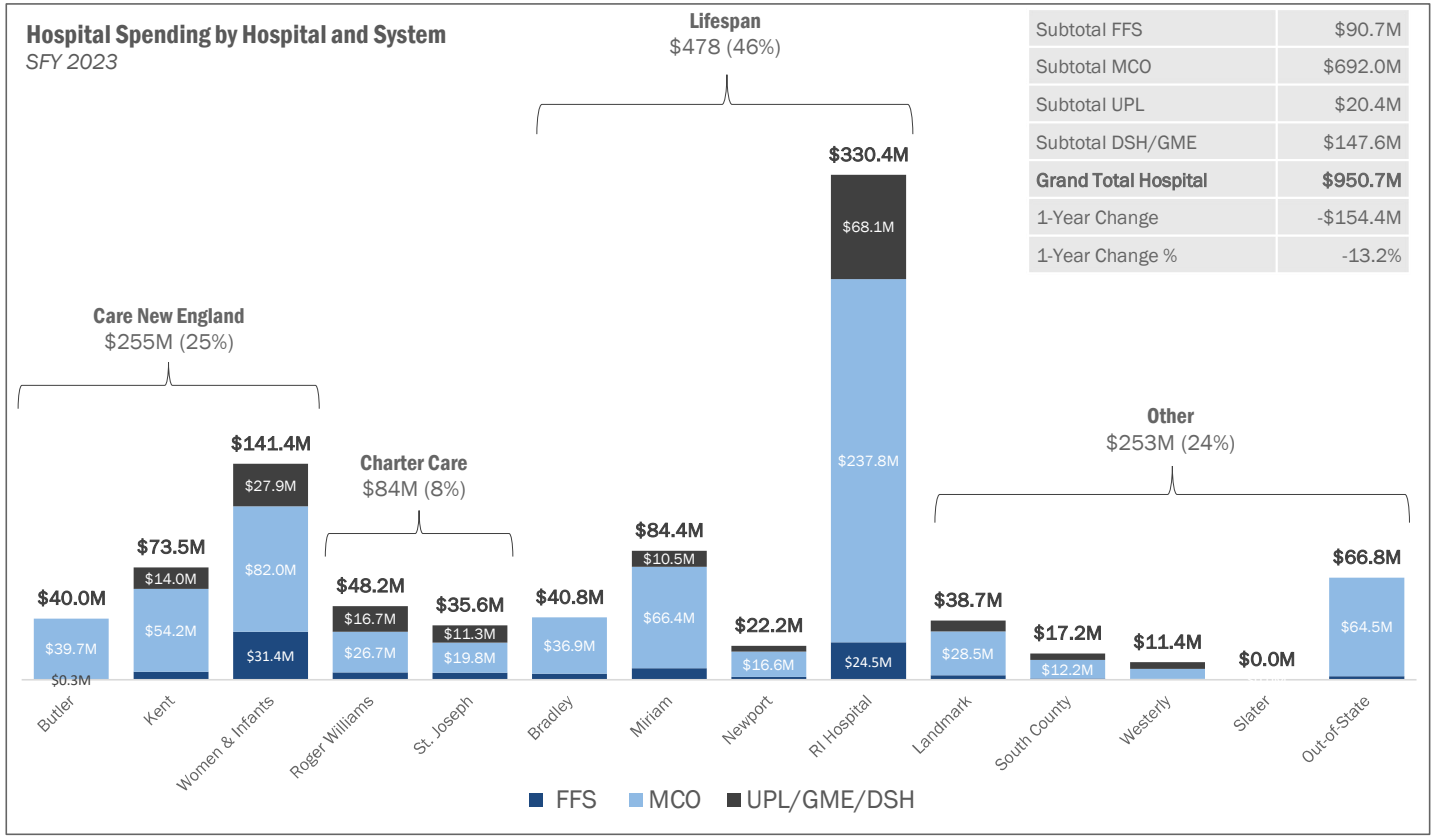



- Total DSH payments eligible for Medicaid financing is determined by federal regulation that establishes each State's maximum DSH allotment.
- In SFY 2023, Rhode Island DSH payments totaled **$145.1 million,** near halving payments made in SFY 2022.
- EOHHS paid $2.5 million in GME payments in SFY 2023.
- Over 40% of the year's DSH payments went to Rhode Island 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 2023, EOHHS made $20.4 million in UPL payments.

# All Hospital Spending




| | |
|---|---|
| Subtotal FFS | $90.7M |
| Subtotal MCO | $692.0M |
| Subtotal UPL | $20.4M |
| Subtotal DSH/GME | $147.6M |
| **Grand Total Hospital** | **$950.7M** |
| 1-Year Change | -$154.4M |
| 1-Year Change % | -13.2% |

- Medicaid made total payments of $1,131 million, including:
  - Rhode Island DSH/GME payments totaled **$147.6 million**.
  - UPL payments totaled **$20.4 million**.
  - **$702 million** for claims activity
- MCO payments account for 71% of all hospital spending.
- 75% of the year's hospital payments went to two hospital systems:
  - Care New England
  - Lifespan
- Rhode Island Hospital alone accounted for $330.4 million (38%) of the public's spending on hospitals.

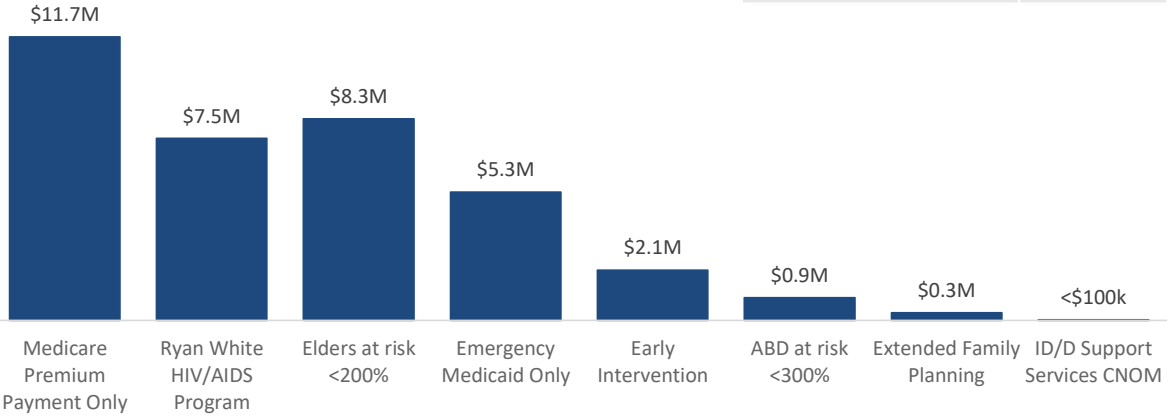
| | Total Hospital Spending |
|---|---|
| SFY 2019 | $1,003.3M |
| SFY 2020 | $908.5M |
| SFY 2021 | $1,022.5M |
| SFY 2022 | $1,167.5M |
| SFY 2023 | $1,013.0M |
| 5-Year CAGR % | 0.2% |

# 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.**

**Exclusion – Limited Benefits**
*SFY 2023*

| | |
|---|---|
| Total Limited Benefits | $36.1M |
| Members with Limited Benefits | 11,513 |




**SFY 2019-2023**


| | | | | | Avg Annual Growth SFY 2019-2023 |
|---|---|---|---|---|---|
| *Annual Change* | -2.8% | -6.2% | -7.5% | 6.0% | -2.6% |

[1] Calculated as compounded annual growth rate (CAGR) over period SFY 2019-2023 as shown.

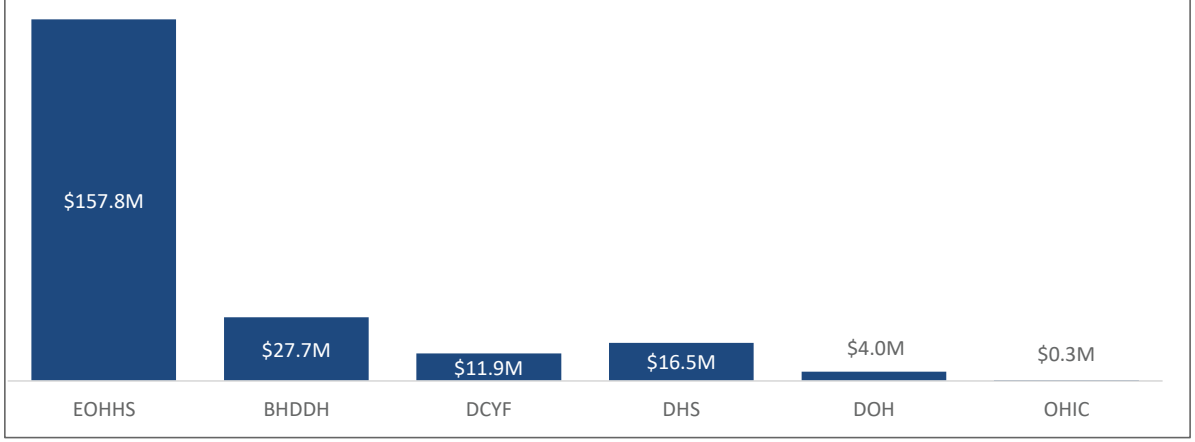
- Expenditures for members with limited benefits totaled $36.1 million in SFY 2023.
- **Partial Duals:** Payments for Medicare premiums for qualifying individuals account for $11.7 million. In SFY 2023, EOHHS subsidized the Medicare premiums for an average of 7,025 low-income elders each month with limited 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.

# Exclusions: Central Management

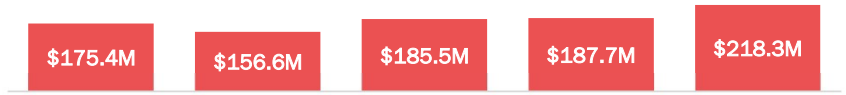
**EOHHS is the Single State Agency for Administering the Medicaid Program and accounts for 75% of all central management expenditures in SFY 2023.**

**Exclusion – Central Management**
*SFY 2023*

| Central Management | $209.2M |
|---|---|




**SFY 2019-2023**



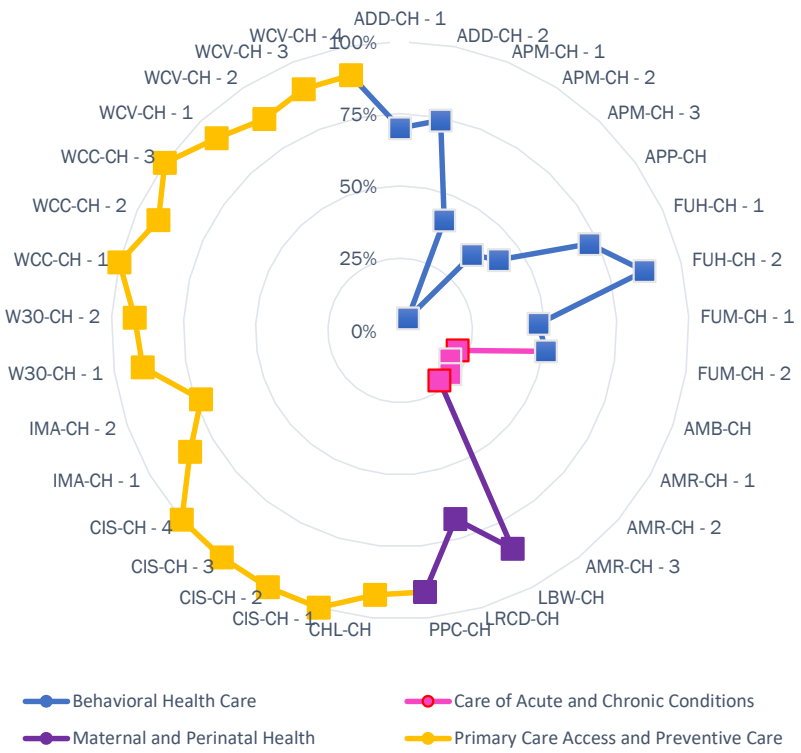

| | | | | | Avg Annual Growth SFY 2019-2023 |
|---|---|---|---|---|---|
| *Annual Change* | -10.7% | 18.5% | 1.2% | 16.3% | 5.6% |

- Central Management expenditures can vary significantly year-over-year due to investments in capital projects or availability of federal funds.

**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




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

- 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 50th percentile and 17 measured exceeded 75th percentile.
- As of date of publication, the FFY 2023 report was not available.

### 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

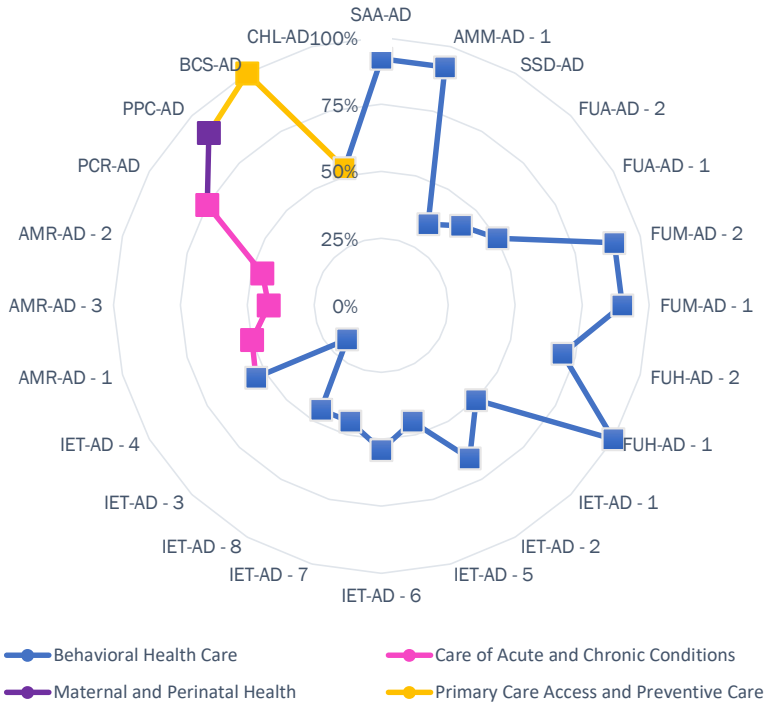
# Core Set Measure Definitions - Children

| Domain<br>Measure | Measure Description | RI Rate | National Median | RI 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 | 43.4 | **70%** |
| ADD-CH - 2 | ADHD Med Follow-Up (9 Months) - % Newly Prescribed ADHD Med with ≥2 Follow-Ups (Ages 6-12) | 57.8 | 54.0 | **74%** |
| APM-CH - 1 | Metabolic Monitoring - % on Antipsychotics with Glucose & Cholesterol Testing (Ages 1-17) | 30.3 | 33.5 | 41% |
| APM-CH - 2 | Metabolic Monitoring - % on Antipsychotics with Glucose Testing (Ages 1-17) | 43.6 | 53.3 | 5% |
| APM-CH - 3 | Metabolic Monitoring - % on Antipsychotics with Cholesterol Testing (Ages 1-17) | 32.8 | 35.3 | 36% |
| APP-CH | Psychosocial Care (Antipsychotic New Rx) - % with Psychosocial Care (1st-Line Tx) (Ages 1-17) | 62.6 | 63.0 | 42% |
| FUH-CH - 1 | Follow-Up After Mental Illness Hospitalization (30 Days) - % w/ Follow-Up (Ages 6-17) | 79.8 | 72.1 | **72%** |
| FUH-CH - 2 | Follow-Up After Mental Illness Hospitalization (7 Days) - % w/ Follow-Up (Ages 6-17) | 65.4 | 51.7 | **87%** |
| FUM-CH - 1 | Follow-Up After ED Visit (30 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 6-17) | 73.5 | 73.7 | 48% |
| FUM-CH - 2 | Follow-Up After ED Visit (7 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 6-17) | 59.2 | 58.1 | **51%** |
| **Care of Acute and Chronic Conditions** | | | | |
| AMB-CH | ED Visits - Emergency Department Visits per 1,000 Beneficiary Months (Ages 0-19) | 25.4 | 31.3 | 21% |
| AMR-CH - 1 | Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 12-18) | 62.9 | 68.9 | 20% |
| AMR-CH - 2 | Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 5-11) | 72.4 | 77.2 | 23% |
| AMR-CH - 3 | Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 5-18) | 67.6 | 73.1 | 22% |
| **Maternal and Perinatal Health** | | | | |
| LBW-CH | Low Birth Weight - % Live Births <2,500g | 8.8 | 10.1 | 15% |
| LRCD-CH | Low-Risk Cesarean Delivery - % C-Section (Nulliparous, Term, Cephalic Presentation) | 26.5 | 24.7 | **68%** |
| PPC-CH | Prenatal Care Timeliness - % Prenatal Care in 1st Trimester (or within 42 Days) | 89.2 | 84.0 | **91%** |

# Core Set Measure Definitions - Children, cont.

| Domain<br>Measure | Measure Description | RI<br>Rate | National<br>Median | RI<br>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 | 54.6 | **90%** |
| WCV-CH - 1 | Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 12-17) | 62.8 | 49.9 | **92%** |
| WCV-CH - 2 | Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 18-21) | 38.6 | 24.3 | **87%** |
| WCV-CH - 4 | Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 3-21) | 60.4 | 47.7 | **90%** |
| CIS-CH - 3 | Immunization (MMR) - % with MMR Vaccination by Age 2 | 90 | 83.9 | **100%** |
| CIS-CH - 4 | Immunization (Flu) - % with 2 Flu Vaccinations by Age 2 | 72.4 | 48.1 | **100%** |
| CIS-CH - 2 | Immunization (Combo 3) - % Up to Date on Immunizations (Combo 3) by Age 2 | 76.3 | 64.8 | **100%** |
| CIS-CH - 1 | Immunization (Combo 10) - % Up to Date on Immunizations (Combo 10) by Age 2 | 61.5 | 34.4 | **100%** |
| CHL-CH | Chlamydia Screening (Ages 16-20) - % Screened for Chlamydia | 62.8 | 47.9 | **92%** |
| IMA-CH - 1 | HPV Vaccine - % Completing HPV Vaccine Series by Age 13 | 46.1 | 35.0 | **84%** |
| IMA-CH - 2 | Meningococcal & Tdap Vaccines - % Receiving Meningococcal & Tdap by Age 13 | 83.6 | 78.8 | **73%** |
| WCC-CH - 1 | Weight Assessment & Counseling (BMI) - BMI Percentile Documentation (Ages 3-17) | 88.3 | 75.9 | **100%** |
| WCC-CH - 2 | Weight Assessment & Counseling (Nutrition) - Counseling for Nutrition (Ages 3-17) | 82.7 | 70.4 | **92%** |
| WCC-CH - 3 | Weight Assessment & Counseling (Physical Activity) - Counseling for Physical Activity (Ages 3-17) | 80.3 | 67.2 | **100%** |
| W30-CH - 2 | Well-Child Visits - % w/ 6+ Well-Child Visits (0-15 Months) | 68.9 | 57.7 | **92%** |
| W30-CH - 1 | Well-Child Visits - % w/ 2+ Well-Child Visits (15-30 Months) | 77.5 | 65.1 | **90%** |

# CMS Medicaid Scorecard – Adult Core Set




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

- 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$^{th}$ percentile. 9 out of 25 measures exceeded the 75$^{th}$ percentile.
- As of date of publication, the FFY 2023 report was not available.

### 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

# Core Set Measure Definitions - Adults

| Domain<br>Measure | Measure Description | RI Ra | RI Media | RI Percenti |
|---|---|---|---|---|
| **Behavioral Health Care** | | | | |
| SAA-AD | Percentage with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on Antipsychotic Medication for at Least 80 Percent of their Treatment Period: Age 18 and older | 92% | 62.7 | **75.0** |
| AMM-AD - 1 | Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 12 Weeks: Ages 18 to 64 | 76% | 55.1 | **64.0** |
| AMM-AD - 1 | Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 6 Months: Ages 18 to 64 | 92% | 55.1 | **64.0** |
| SSD-AD | Percentage with Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder who were Dispensed an Antipsychotic Medication and had a Diabetes Screening Test: Ages 18 to 64 | 35% | 75.8 | **74.9** |
| FUA-AD - 2 | Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18 to 64 | 42% | 17.4 | 14.9 |
| FUA-AD - 1 | Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18 to 64 | 50% | 25.8 | 25.8 |
| FUM-AD - 2 | Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18 to 64 | 90% | 45.6 | **59.9** |
| FUM-AD - 1 | Percentage of Emergency Department (ED) Visits for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18 to 64 | 90% | 58.9 | **72.4** |
| FUH-AD - 2 | Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days after Discharge: Ages 18 to 64 | 70% | 35.1 | **51.8** |
| FUH-AD - 1 | Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Ages 18 to 64 | 100% | 59.2 | **73.4** |
| IET-AD - 1 | Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64 | 50% | 40.6 | 40.6 |
| IET-AD - 2 | Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64 | 66% | 12.5 | 15.1 |
| IET-AD - 5 | Percentage with a New Episode of Opioid Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64 | 45% | 61.2 | **60.9** |
| IET-AD - 6 | Percentage with a New Episode of Opioid Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64 | 54% | 34.6 | 35.3 |
| IET-AD - 7 | Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64 | 45% | 37.6 | 36.9 |
| IET-AD - 8 | Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64 | 45% | 12.2 | 10.5 |
| IET-AD - 3 | Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64 | 18% | 42.4 | 40.8 |
| IET-AD - 4 | Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64 | 54% | 16.2 | 16.4 |

# Core Set Measure Definitions - Adults

| Domain<br>Measure | Measure Description | RI Ra | Media | RI Percenti |
|---|---|---|---|---|
| **Care of Acute and Chronic Conditions** | | | | |
| AMR-AD - 1 | Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 19 to 50 | 50% | 58.6 | **58.6** |
| AMR-AD - 3 | Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 51 to 64 | 42% | 61.2 | **58.6** |
| AMR-AD - 2 | Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 19 to 64 | 46% | 59.4 | **58.6** |
| PCR-AD | Ratio of Observed All-Cause Readmissions to Expected Readmissions: Ages 18 to 64 | 75% | 1.0 | 1.1 |
| **Maternal and Perinatal Health** | | | | |
| PPC-AD | Percentage of Women Delivering a Live Birth who had a Postpartum Care Visit on or Between 7 and 84 Days after Delivery | 91% | 79.3 | **85.6** |
| **Primary Care Access and Preventive Care** | | | | |
| BCS-AD | Percentage of Women who had a Mammogram to Screen for Breast Cancer: Ages 50 to 64 | 100% | 53.8 | **61.0** |
| CHL-AD | Percentage of Sexually Active Women Screened for Chlamydia: Ages 21 to 24 | 53% | 63.9 | **63.9** |

# Acronyms

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

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

# Diagnosis Definition

**The following conditions are mentioned in this Report.**

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

# Provider Type Definition

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