



Medicaid Expenditure Report

State Fiscal Year (SFY) 2024

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 to provide a comprehensive overview of all Medicaid expenditures, outcomes, and utilization rates during State Fiscal Year (SFY) 2024.

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

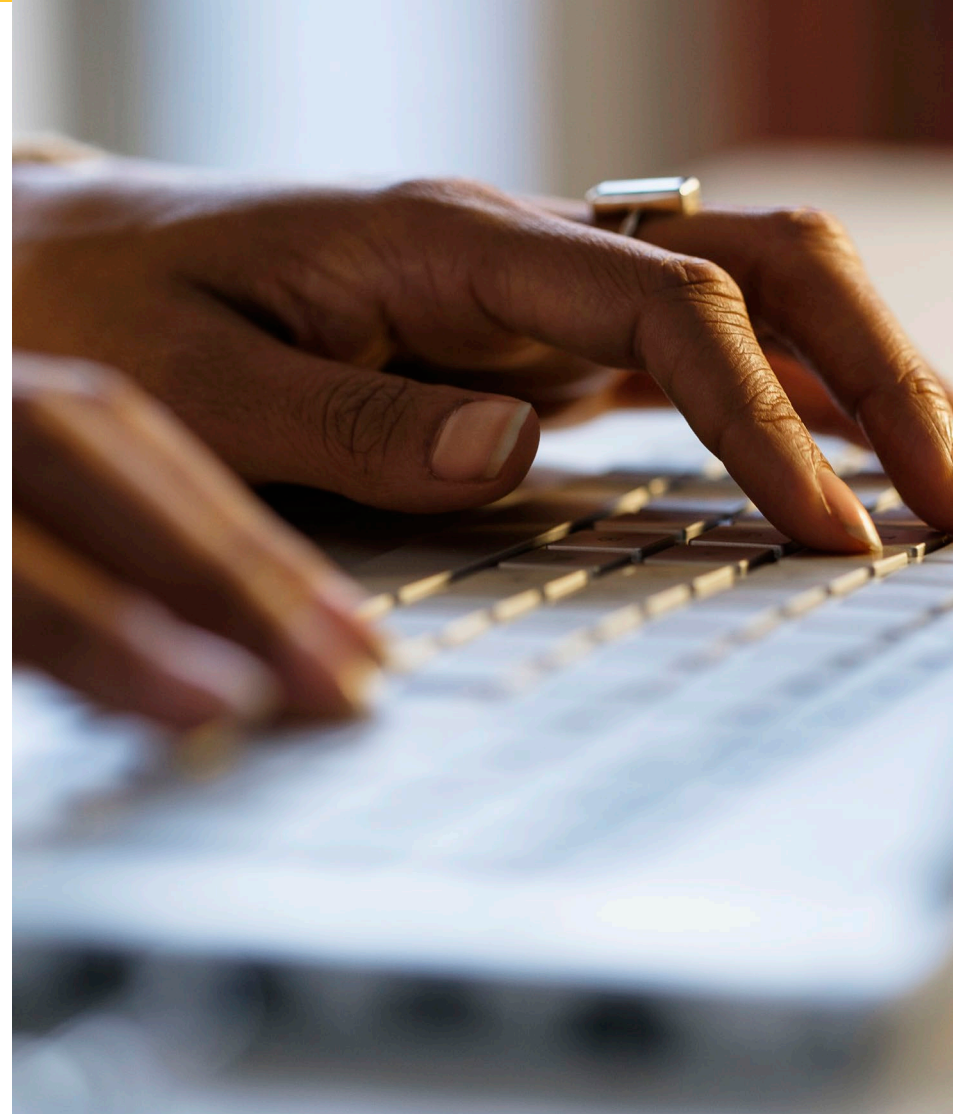
Summarize Medicaid expenditures for eligible individuals and families covered by the relevant Rhode Island departments.

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 beneficiaries, if a beneficiary crosses programs within the year, the beneficiary is assigned to their last eligibility group and program (e.g., a beneficiary who shifted from Rlte 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 beneficiaries with at least six months of Medicaid enrollment in a single year.

Definitions

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

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Summary and Key Findings



Executive Summary

Overview

During SFY 2024, Rhode Island's Medicaid program provided full medical coverage to **408,000 Rhode Islanders** at some point during the year, with an average monthly enrollment of 348,000 beneficiaries. Another 13,000 Rhode Islanders received limited benefits from Medicaid.

Overall, Medicaid expenditures **totaled \$4.3 billion** (at a state cost of \$1.7 billion), with nearly **\$3.9 billion in spending on benefits for beneficiaries receiving full Medicaid benefits** in the state fiscal year.

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

- \$3.4 billion – Executive Office of Health and Human Services (EOHHS)
- \$434 million – Behavioral Healthcare, Developmental Disability, and Hospitals (BHDDH)
- \$59 million – Department of Children, Youth and Families (DCYF)

The Office of Healthy Aging (OHA) within Department of Human Services (DHS) and Ryan White Program within EOHHS as well as other programs in EOHHS also provide limited services to beneficiaries with limited benefits.

Expenditures in this Report are inclusive of federal funds, general revenues, and restricted receipts. Overall, the effective federal share was 58% across the entire Medicaid program.

Key Findings

- Average full benefits' enrollment decreased 4.9% in SFY 2024 from SFY 2023, from 366,000 to 348,000.
- Children and Families comprised 52% of beneficiaries, followed by Expansion (28%), Adults with Disabilities (8%), Elders (8%) and Children with Special Healthcare Needs (4%).
- 88% of beneficiaries were in managed care; and three-fifths (60%) of all Medicaid beneficiaries were in the Accountable Entity (AE) program.
- SFY 2024 per beneficiary per month (PMPM) costs increased to \$926 PMPM, a 17.4% increase over SFY 2023. This is higher than the five-year compounded annual growth rate (CAGR) of 5.7% since SFY 2020.
- The 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.
 - Costs are highly skewed: 4% of Medicaid beneficiaries incurred almost half of expenditures in SFY 2024.
- Acute services accounted for 56% of SFY 2024 full benefit expenditures, while expenditures on LTSS represented 30%.
- Central management spending of \$216 million accounted for 5.6% 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 2024 and when compared to prior fiscal years.

Overall Medicaid Expenditures

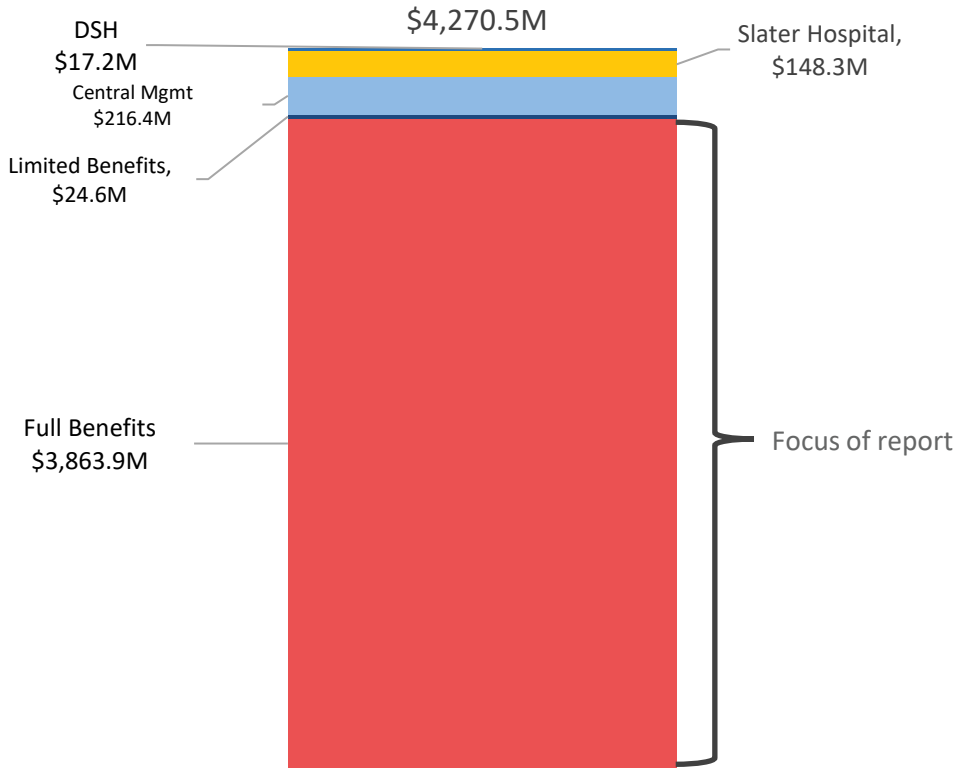


Executive Summary

Medicaid expenditures in SFY 2024 totaled \$4.3 billion. Expenditures on those with full Medicaid benefits totaled approaching \$3.9 billion.

Overall Medicaid Expenditures SFY 2024

Beneficiaries:	Full Benefits	347,851
	Limited Benefits	12,910



- Services for beneficiaries with Full Benefits cost \$3,863.9 million.** These are beneficiaries with comprehensive medical coverage through Medicaid and/or comprehensive third-party coverage (usually Medicare) whose cost sharing and any payment for any wrap-around services are incurred by Medicaid. These beneficiaries are the primary focus of this report.
- Central Management costs of \$216.4 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 beneficiaries with full benefits and are included in this Report.
- Other notable exclusions** totaling, **\$190.2 million**, include:

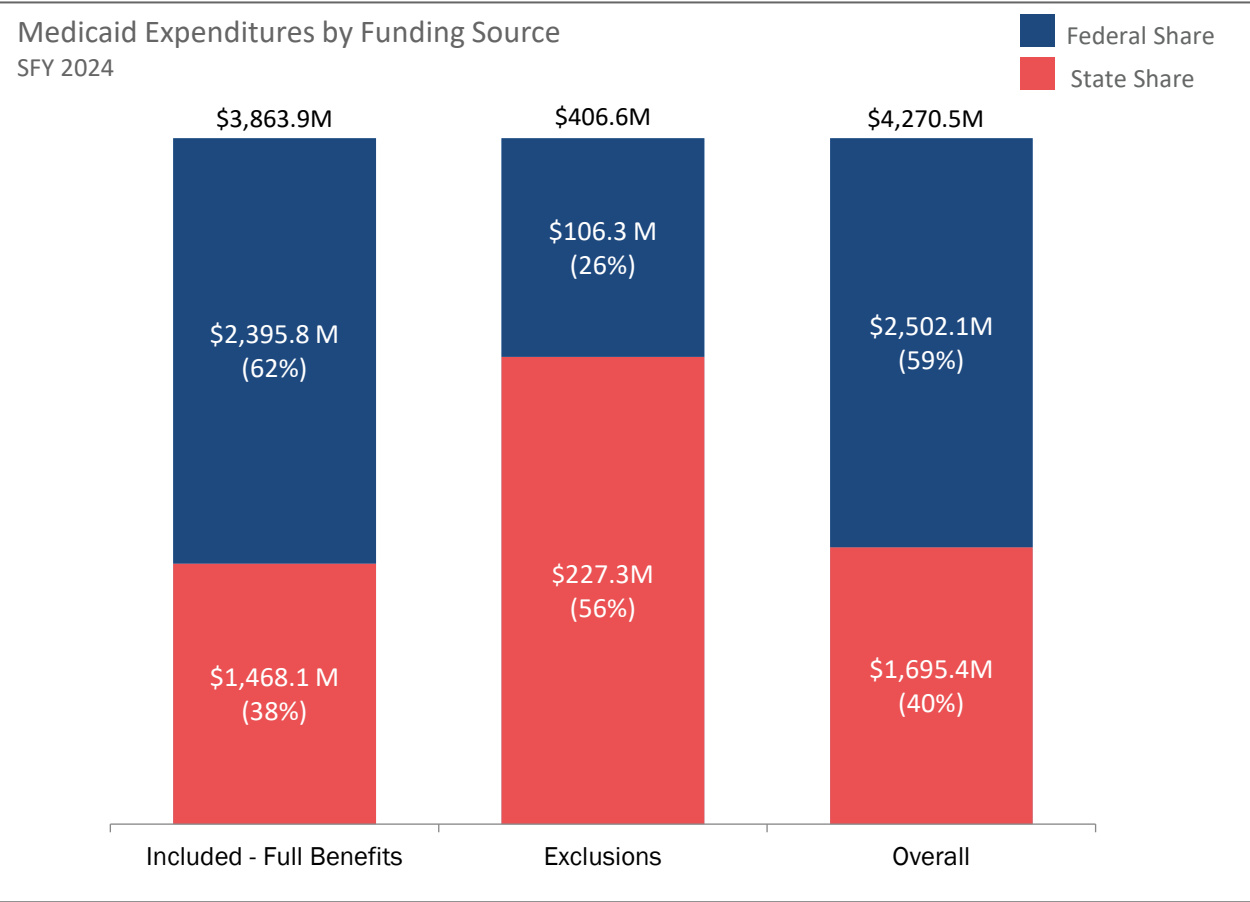
 - Disproportionate Share Hospitals (DSH):** Statutorily required payments to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety net hospitals.
 - Costs Not Otherwise Matchable (CNOM) and Partial Emergency Services:** 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 beneficiaries with limited incomes who are not otherwise eligible for Medicaid services.
 - Recoveries** are collections (usually against the estates of beneficiaries 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



Executive Summary

Medicaid expenditures on full benefits totaled \$3.9 billion at a direct cost of \$1.5 billion to state taxpayers in SFY 2024.

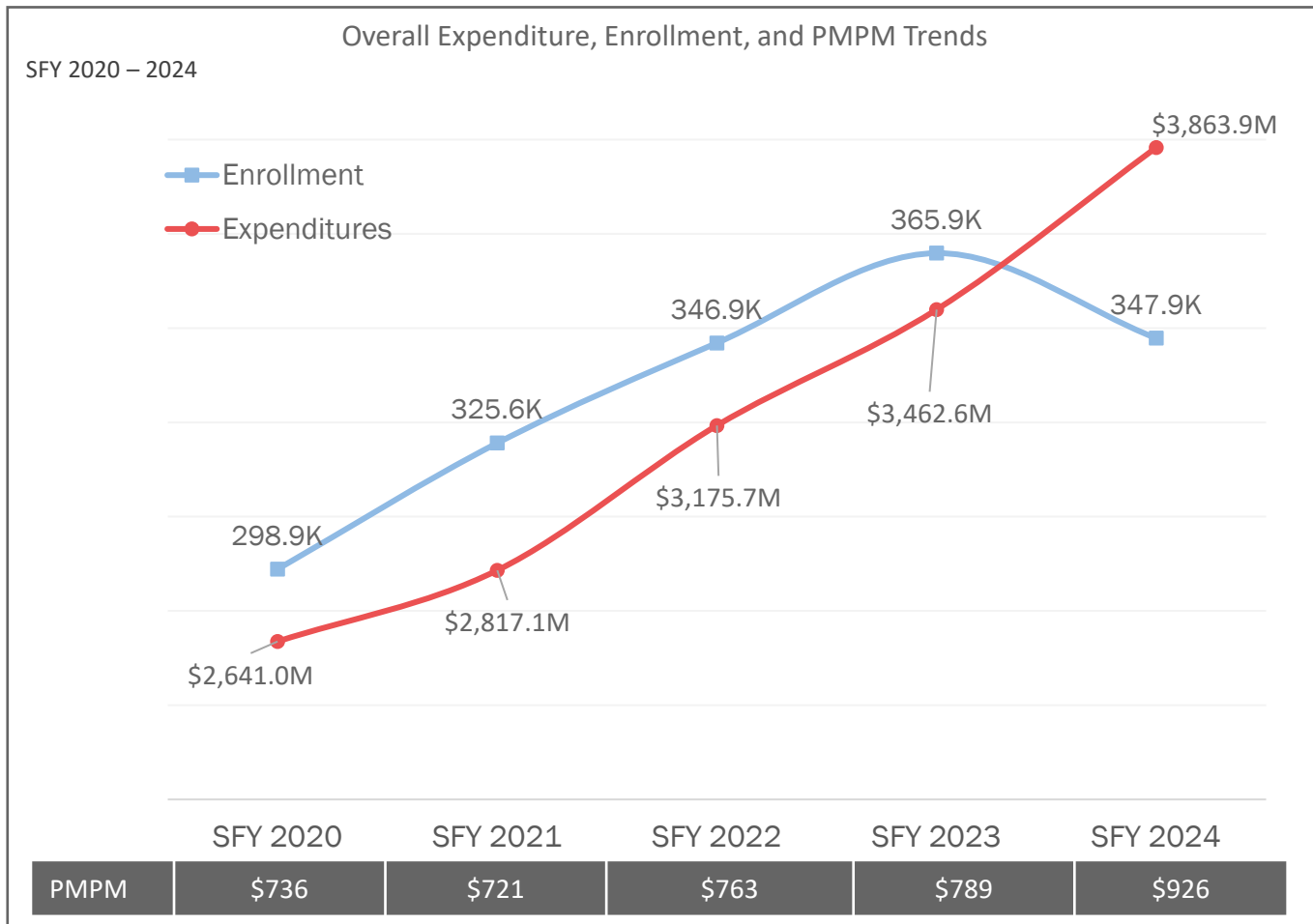


- The largest source of funding for the state share is general revenue appropriations to agencies. Other sources of state share include:
 - Local Education Agencies’ Certified Public Expenditures.
 - Restricted Receipt spending, including Health System Transformation Project (HSTP) and Children’s Health 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. Some of these 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, the federal government implemented a phased reduction to this enhanced funding, eliminating the temporary increase to Regular Medicaid and CHIP as of January 1, 2024.
 - 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



Executive Summary



Expenditures

- In SFY 2024, expenditures increased by \$380.3 million or 11% over SFY 2023; more than the five-year compounded annual growth rate of 9.8%.

Enrollment

- Average enrollment decreased in SFY 2024 by 4.9% from the SFY 2023 average, less than the five-year compounded annual growth rate of 3.9%.
- Most of the growth in SFY 2024 over SFY 2023 was in Elders, which grew in average monthly enrollment by 596 (2%). All other categories saw declines in their average monthly enrollment, most significantly the Expansion group, by 15,751 (14%).

PMPM

- Overall PMPM costs increased by an average of 16.7% in SFY 2024 over SFY 2023.

Expenditures

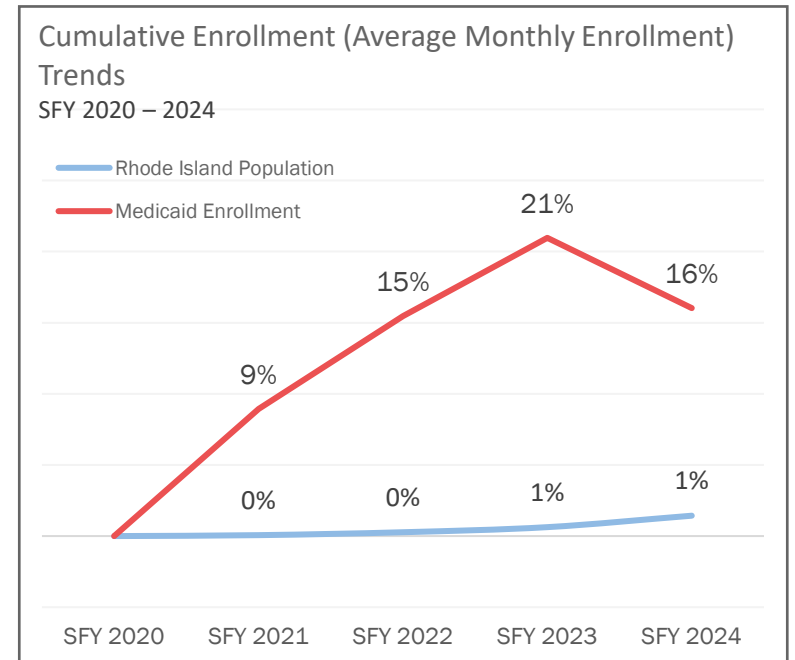
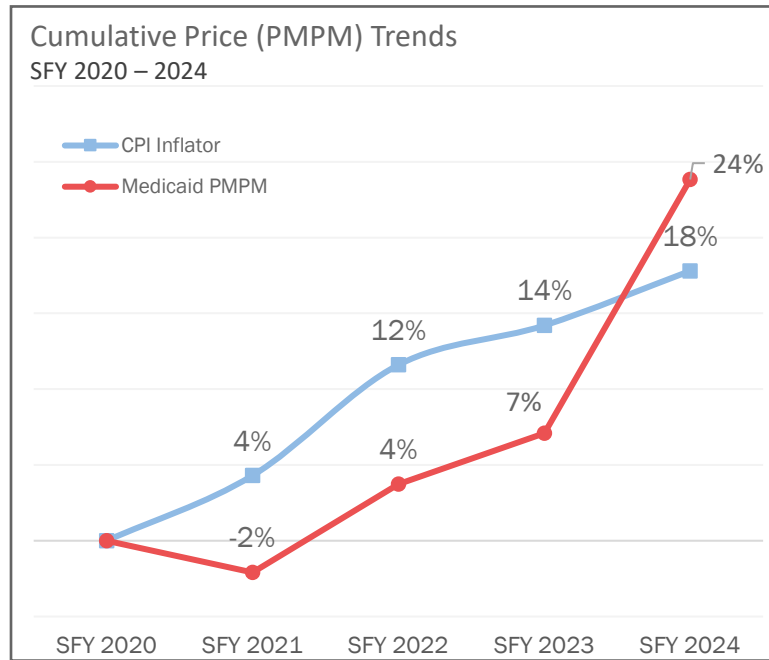
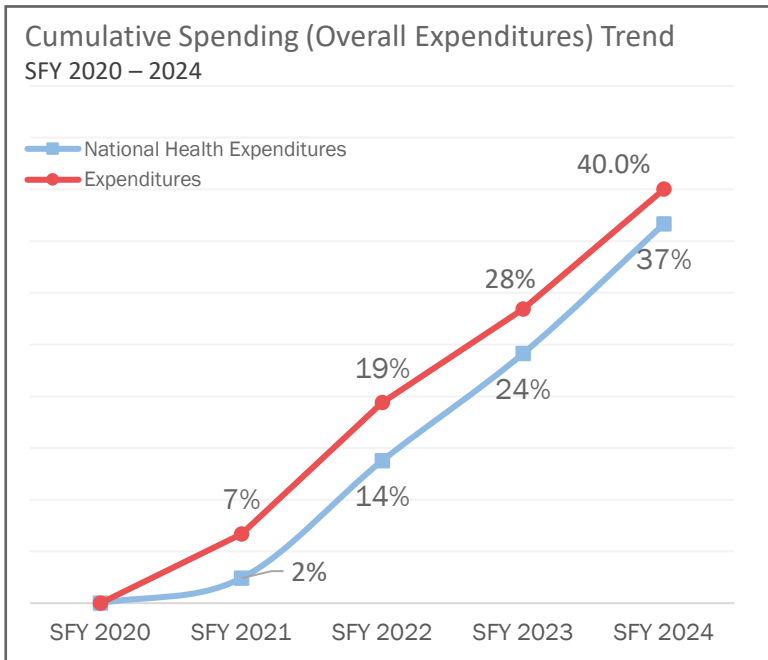
- Since 2020, cumulative annual change for expenditures was 39 percent; this growth outpaced National Health Expenditure by 2% in the same period.
- Medicaid expenditures have steadily grown in the past 5 years while National Health Expenditures took a dip in 2020 with gradual increase from SFY 2021 on.

Price - PMPM

- Annual PMPM change grew to 24% cumulative since 2020, outpacing general inflation by 6% as measured by Northeast CPI.
- CPI grew at a faster pace than PMPM each year except SFY 2020 and SFY 2024, with PMPM seeing a sharp increase of 17% between SFYs 2023 and 2024.

Caseload - Enrollment

- Cumulative annual enrollment change increased by 16% over the last five years; compared to net increase of 1.0% for Rhode Island's population.
- This increased enrollment came during the continuation of the Public Health Emergency, which included a moratorium on terminations that became effective March 2020.
- Termination activities did not resume until towards the second half of SFY 2023, which is reflected in the declining enrollment between SFYs 2023 and 2024.



¹ Cumulative CPI was calculated using Northeast Consumer Price Index percent change from 12 months ago for all urban consumers from 2020-2024, using July as the comparison.

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Full Benefit Populations

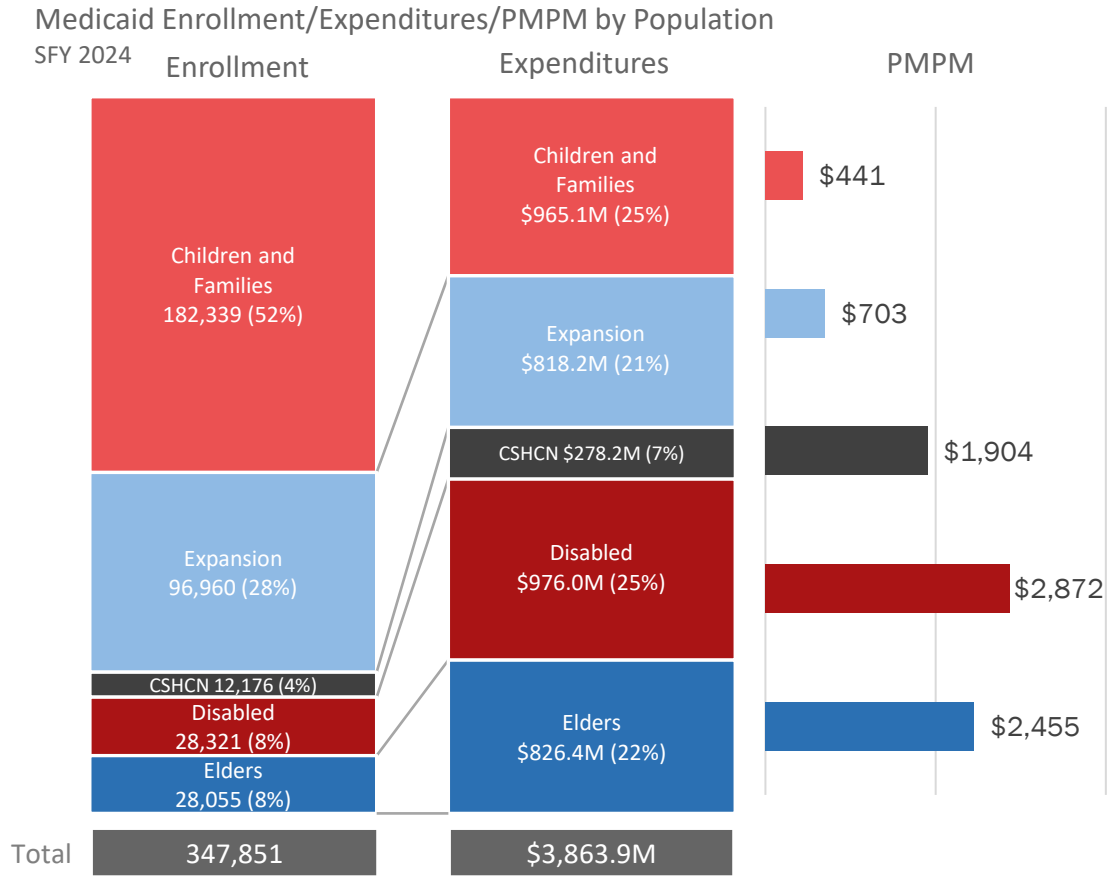
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Five Year Enrollment Trends

Unique Recipients

Expenditures by Population Group

Medicaid expenditures in SFY 2024 totaled \$4.3 billion. Expenditures for fully covered populations totaled approximately \$3.9 billion.



Medicaid serves five primary populations:

- Elders** are beneficiaries over age 65 and 93% of this population are also covered by Medicare. Their average SFY 2024 PMPM cost was \$2,455. Nursing facilities account for 45% of their expenditures.
- Adults with Disabilities** are beneficiaries under age 65 with identified disabilities and 48% are also covered by Medicare. Their average cost was \$2,872 PMPM. I/DD providers account for 18% of their expenditures.
- CSHCN** are beneficiaries under age 21 who have higher needs physically, developmentally, behaviorally or emotionally. Their average PMPM costs were \$1,904, with professional services accounting for 34% of expenditures.
- Expansion** beneficiaries are low-income adults without dependent children. These beneficiaries cost \$703 PMPM. Hospital services account for 49% of expenditures for Expansion adults.
- Children and Families** beneficiaries are qualified children, parents, and pregnant women. They have average costs of \$441 PMPM. Hospital and professional services account for 46% and 27% of their expenditures, respectively.

Beneficiaries with **Limited Benefits** are excluded from the report, but include populations covered by Medicare with limited Medicaid benefits (Partial Duals), beneficiaries 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 53,721 Rhode Islanders, including 44,837 Dual-eligible clients with full Medicaid benefits.

Expenditures by Population Group, Continued



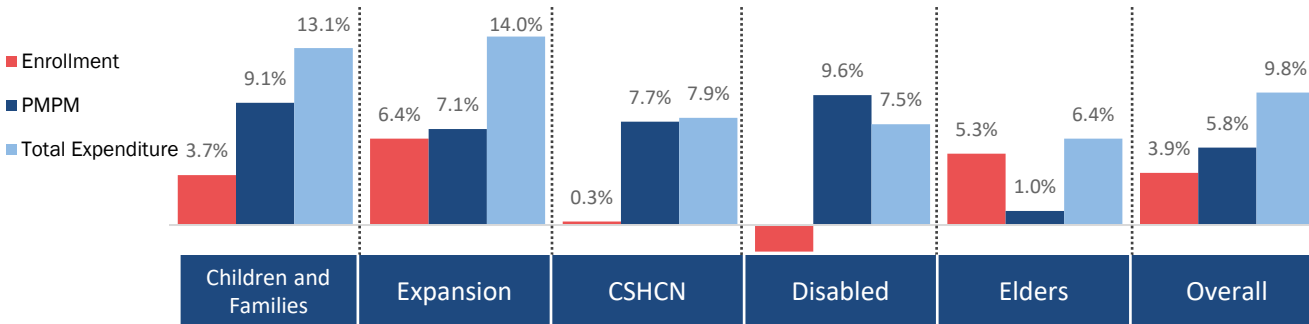
Overview and Trends

Between SFY 2020 and SFY 2024, annual expenditures, enrollment, and PMPM increased: expenditures by 9.8%, enrollment by 3.9%, and PMPM by 5.7%.

Current Expenditures
SFY 2024

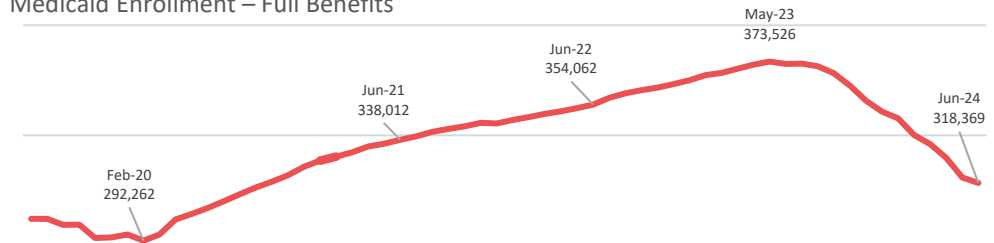
	Children and Families	Expansion	CSHCN	Disabled	Elders	Overall
Beneficiaries	182,339	96,960	12,176	28,321	28,055	347,851
PMPM	\$441	\$703	\$1,904	\$2,872	\$2,455	\$921
Expenditure	\$965.1M	\$818.2M	\$278.2M	\$976.0M	\$826.4M	\$3,863.9M

Expenditures - 5-Year Compounded Annual Growth Rate
SFY 2020-2024



- Between SFY 2020 – 2024, the population groups experienced the following:
 - Expansion enrollment experienced the largest increases with enrollments and expenditures increasing by 6.4% and 14.0% annually.
 - Elder enrollment increased 5.3% annually and overall costs by 6.4% annually. Disabled enrollment decreased by 2.0% annually, while expenditures increased 7.5% annually.
 - Children and Families spending increased 13.1% annually, driven primarily by price factors as average enrollment increased by 3.7% over the five-year period.
 - CSHCN enrollment increased modestly (0.3%) and the group’s expenditures increased by 7.9%.
- 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. Between February 2020 and May 2023, Rhode Island saw a net 27.8% increase in beneficiaries, reversing what had been a steady decline in overall caseload prior to COVID. Below is a summary of Medicaid enrollment over the past five fiscal years:

Medicaid Enrollment – Full Benefits

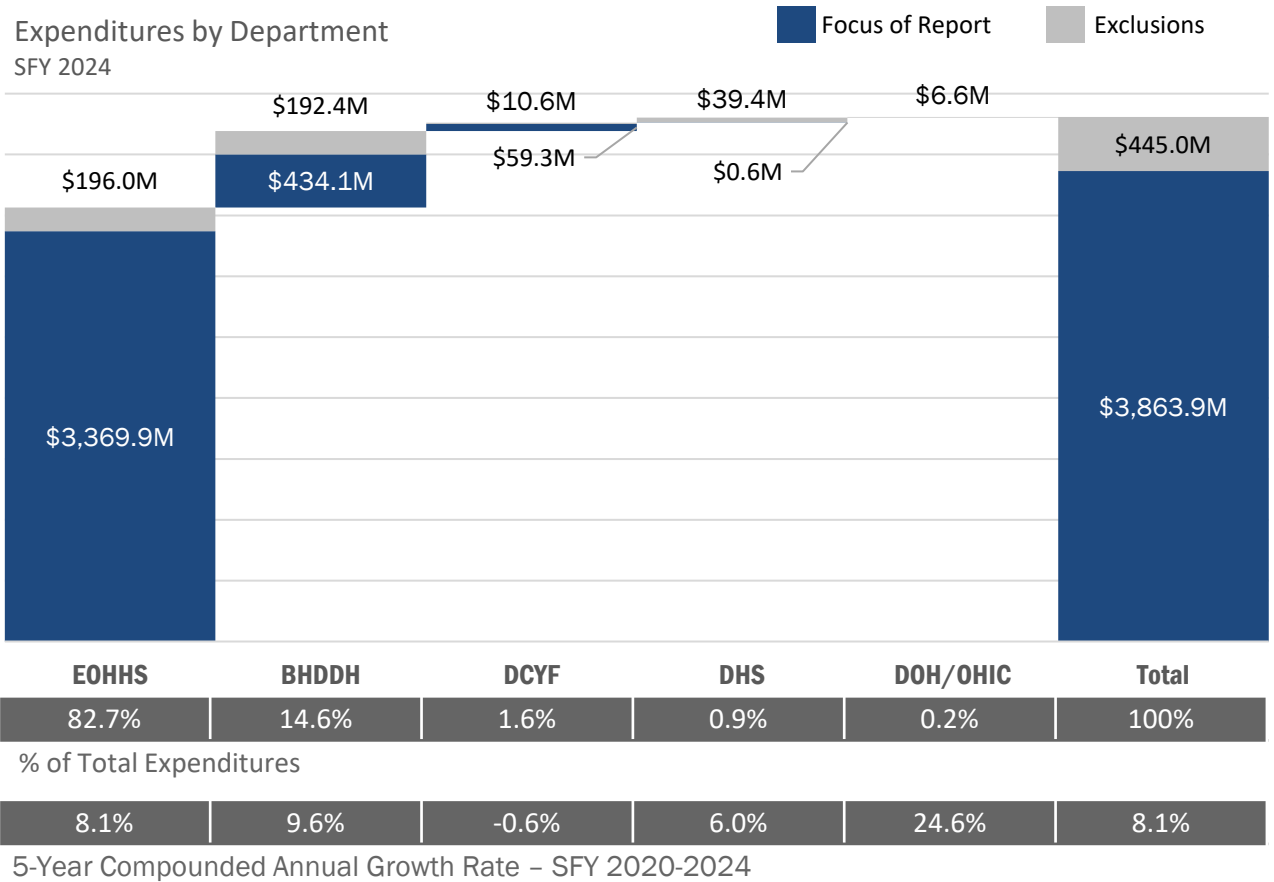


Expenditures by Department



Overview and Trends

Four departments in Rhode Island are appropriated funding for the Medicaid program. About 83% of funds are appropriated directly to EOHHS.



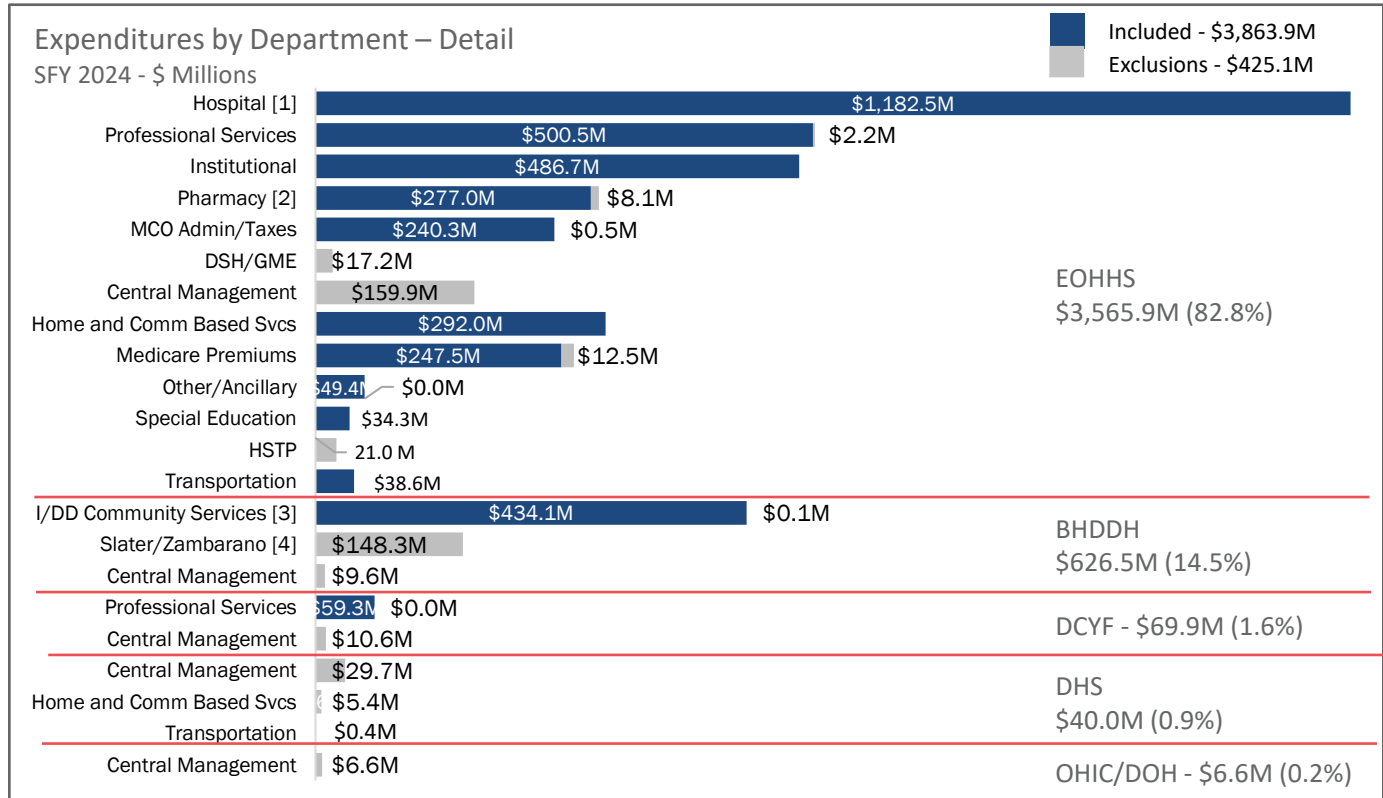
- EOHHS is the administrator for the Medicaid program and is known as the Single State Agency (SSA) for purposes of drawing down federal funds.
 - Overall Medicaid expenditures increased from SFY 2020 to 2024 by 8.1% per annum, with EOHHS spending also increasing by 8.1% per annum.
- In SFY 2024, the other departments overseen by EOHHS in administering the Medicaid program included BHHDDH, DCYF, and DHS.
 - Additionally, certain administrative functions performed by the Office of Health Insurance Commissioner and the Department of Health are charged to Medicaid.
- Central management expenses supporting the Medicaid program (i.e., were eligible for federal reimbursement from Medicaid) totaled \$216.4 million across all agencies.
- Please note that the “grey” expenditures in the chart at the left are excluded; this includes all benefit expenditures by 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



Overview and Trends

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



- Overall, with total spending of \$3.5 billion, **EOHHS** spending accounts for 82.8% of Medicaid expenditures. The biggest portion (35%) of that is for hospital-based services. Professional services accounts for 14% and institutional care (inclusive of Nursing Facilities and Hospice) accounts for 15% 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 \$626.5 million account for 14.6% 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 2024, not all expenditures for Eleanor Slater Hospital (ESH) were Medicaid-eligible due to federal regulations pertaining to Institutes of Mental Disease. Nonetheless, this report recognizes these expenditures, albeit as “exclusions” to the majority of the Report.
- DCYF** accounts for \$69.9 million (1.6%) 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 \$40.0 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.

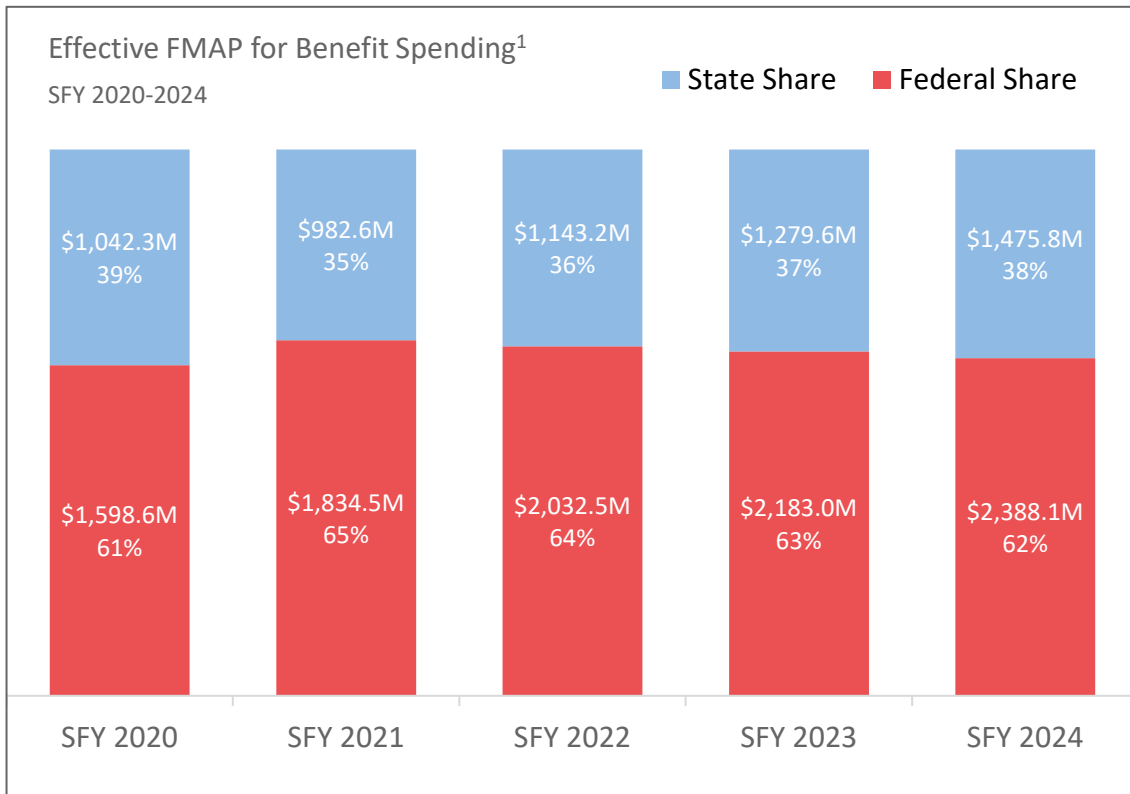
¹ EOHHS Hospital spending includes acute spending on Inpatient and Outpatient Hospitals, UPL Payments and \$7.5 M in spending at Tavares.
² Total Pharmacy includes retail pharmacy, office-administered drugs, and outpatient pharmacy. Costs are net of pharmacy rebates.
³ I/DD Community includes all residential and rehabilitation services for persons with intellectual and developmental disabilities, including group homes.
⁴ Slater expenditures include \$34.4 million at RI Psychiatric Hospital that is state-only spending and not matchable by CMS in SFY 2024.

Benefit Spending by Funding Source



Overview and Trends

Medicaid programs are funded by state and federal dollars. In SFY 2024, Rhode Island paid approximately 38% of all full benefit expenditures (i.e., excluding Limited Benefits and Central Management) using state funds.



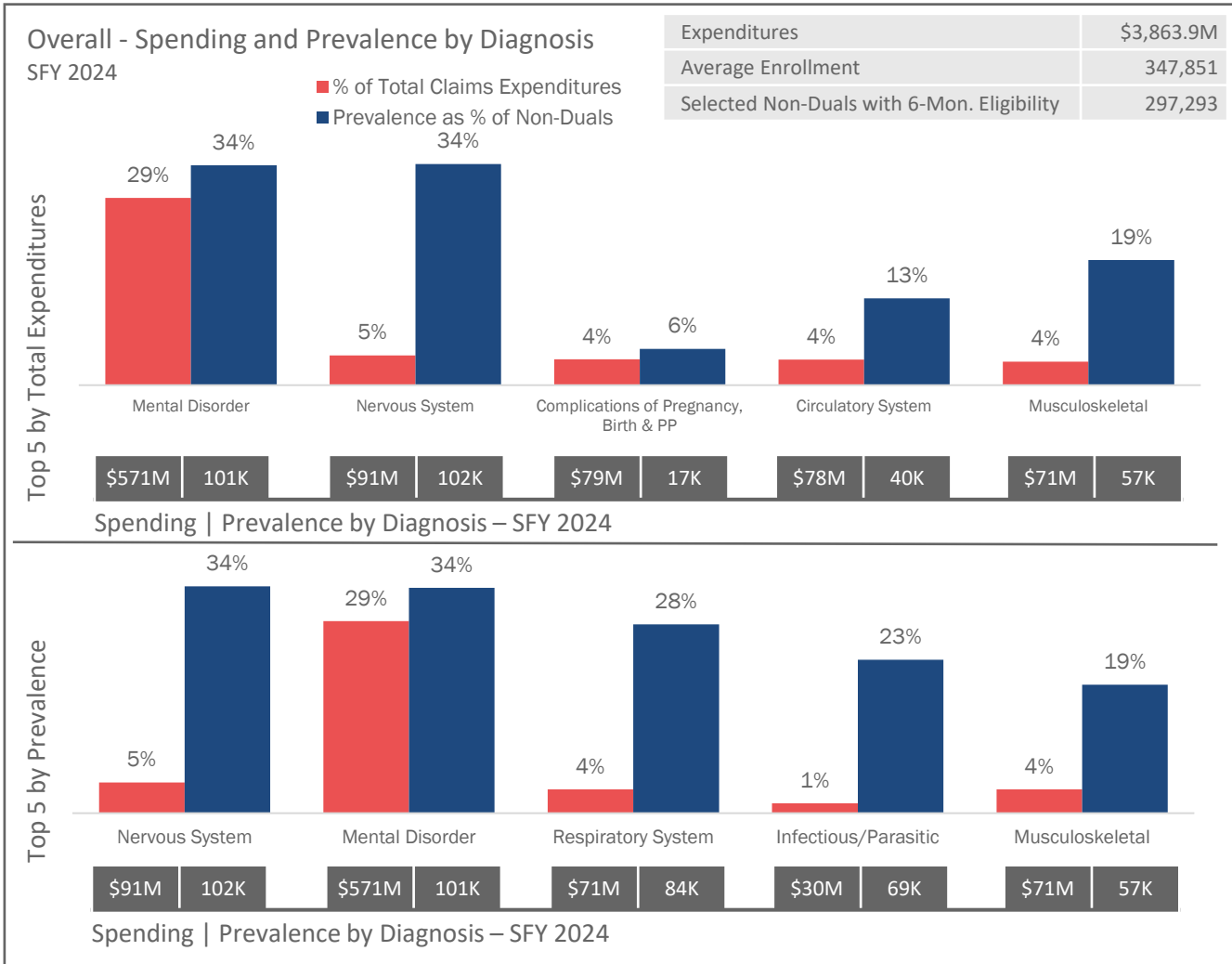
¹ Benefit Spending includes beneficiaries with full benefits. Does not include Central Management or Limited Benefits expenditures.

- 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.

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, and it was phased out in December 2023.

Expenditures by Diagnoses

Overview and Trends



- The only diagnosis category that exceeds 10% of Medicaid expenditures is mental or behavioral health, which accounts for at least 29% of expenditures.
 - Prevalence data does not include the dual population and may understate cost of treating certain conditions.
- Three diagnoses are in the top five in terms of both expenditure and prevalence:
 - Mental or behavioral health
 - Diseases of the nervous system and sense organs, and
 - Musculoskeletal.
- Complications of pregnancy, childbirth, and the puerperium supplanted diagnoses of the respiratory system in the top five by expenditures between SFYs 2023 and 2024.

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 beneficiaries with the diagnoses.

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

- 34% "prevalence as a % of non-duals" means that among beneficiaries 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.

Optional vs. Mandatory Expenditures



Overview and Trends

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 Benefits¹
SFY 2024

	Mandatory Populations	Optional Populations	Total
ENROLLMENT	222,625 (64%)	125,226 (36%)	347,851 (100%)
Expenditures on Mandatory Benefits	\$1,460.3 M (38%)	\$1,191.3 M (31%)	\$2,651.6 M (69%)
Expenditures on Optional Benefits	\$674.3 M (17%)	\$538.0 M (14%)	\$1,191.3 M (31%)
TOTAL EXPENDITURES	\$2,134.6 M (55%)	\$1,729.3 M (45%)	\$3,863.9 M (100%)

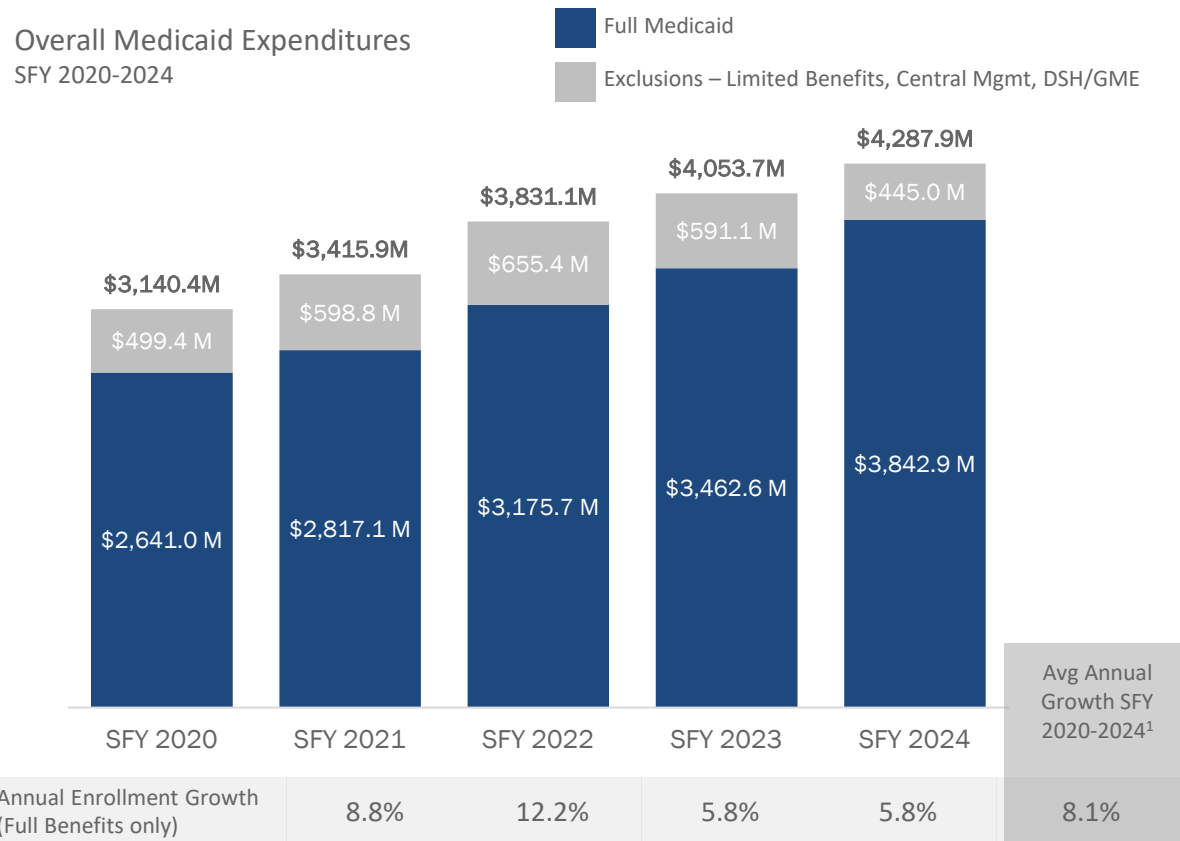
¹ Exhibit is prepared using a proportional allocation from SFY 2024. Allocation based upon expenditures identified as “optional” or “mandatory” based on share of actual claim amounts for beneficiaries with full Medicaid benefits identified as being for an “optional” or “mandatory” service category or “optional” or “mandatory” eligibility group.

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 beneficiaries covered only for specific diseases or services, such as breast and cervical cancer or family planning services.
- In Rhode Island, Expansion beneficiaries make up most optional beneficiaries.
- 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 2024 claims include:
 - I/DD Community Services (\$434 million)
 - Pharmacy (\$405 million, excluding rebates)
 - Home and Community Based Services (HCBS) for LTSS beneficiaries (\$293 million)
 - Hospice (\$29 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, beneficiaries may shift to mandatory eligibility pathways. Correspondingly, expenditures for mandatory services may increase in response to the elimination of optional services.

Overall Medicaid expenditures have overall cost trend increases of 6% in SFY 2024 and average 8.1% over the past five fiscal years.



¹ Calculated as compounded annual growth rate (CAGR) over period SFY 2020-2024 as shown.

- Overall spending on benefits for fully-covered beneficiaries increased by 6% in SFY 2024 to \$4,288 million. The increases in spending may be attributed to:
 - Continued increases in enrollment and member months due to the declaration by the federal government of a Public Health Emergency (PHE) for COVID-19 and a moratorium on most regular termination activities, which continued through SFY 2023. Although Rhode Island began closing eligibility for clients beginning in May 2023, overall average enrollment throughout SFY 2024 remained elevated.
 - High medical inflation attributed to both higher per unit costs and higher utilization [Due to increased acuity of clients and pent up demand following COVID-19 PHE].

Spending Comparison by Eligibility Group, SFY 2020 to SFY 2024

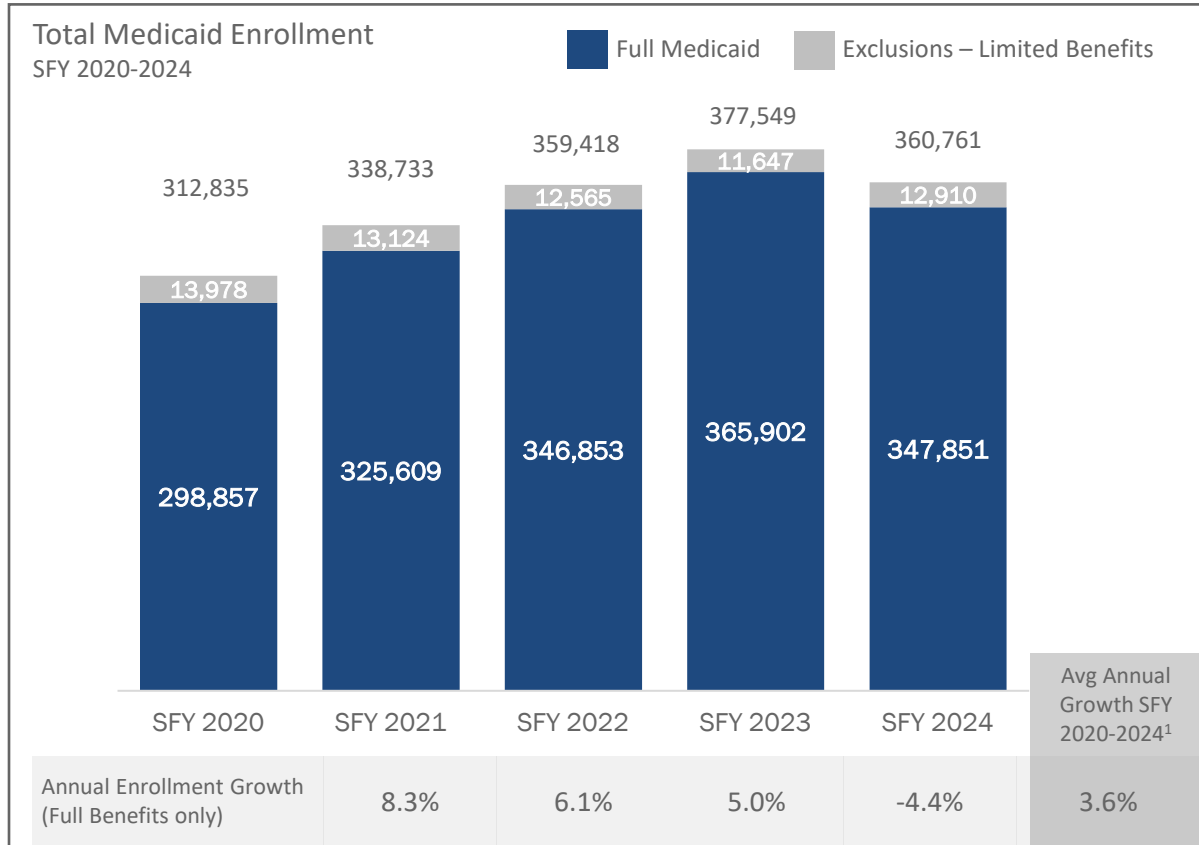
Eligibility Group	SFY 2020	SFY 2024	Annual Growth Rate SFY 2020-2024
Children and Families	\$584.2M	\$956.9M	13.1%
CSHCN	\$203.8M	\$276.7M	7.9%
Expansion	\$480.1M	\$810.7M	14.0%
Disabled Adults	\$728.5M	\$972.4M	7.5%
Elders	\$644.4M	\$826.3M	6.4%
Overall	\$2,641.0M	\$3,863.9M	9.8%

Trends: Average Monthly Enrollment



Overview and Trends

After years of increases, average enrollment decreased in SFY 2024. This decline aligns with the termination of the Public Health Emergency in May 2023, following cessation of renewals and most closures since March 2020.



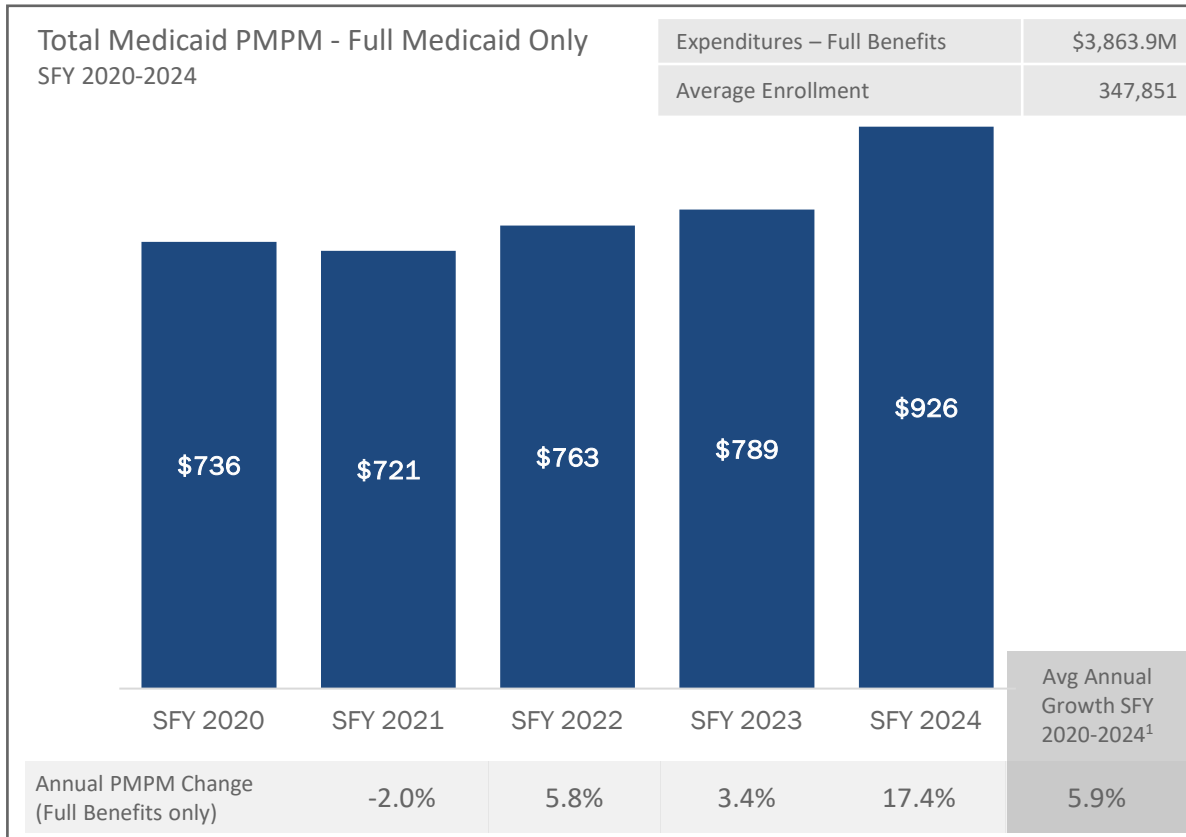
- Average monthly enrollment decreased 4.4% in SFY 2024.
- The increased enrollment came during the prolonged Public Health Emergency, which included a moratorium on terminations that became effective March 2020:
 - As of February 2020, enrollment of Rhode Islanders with full Medicaid benefits had declined 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 2020 to SFY 2024

Eligibility Group	SFY 2020	SFY 2024	Annual Growth Rate SFY 2020-2024
Children and Families	157,707	182,339	3.7%
CSHCN	12,054	12,176	0.3%
Expansion	75,616	96,960	6.4%
Disabled Adults	30,668	28,321	-2.0%
Elders	22,813	28,055	5.3%
Overall	298,857	347,851	3.9%

¹ Calculated as compounded annual growth rate (CAGR) over period SFY 2020-2024 as shown.

Average PMPM increased over 16% in SFY 2024; and had an average annual growth of 6% since SFY 2020.



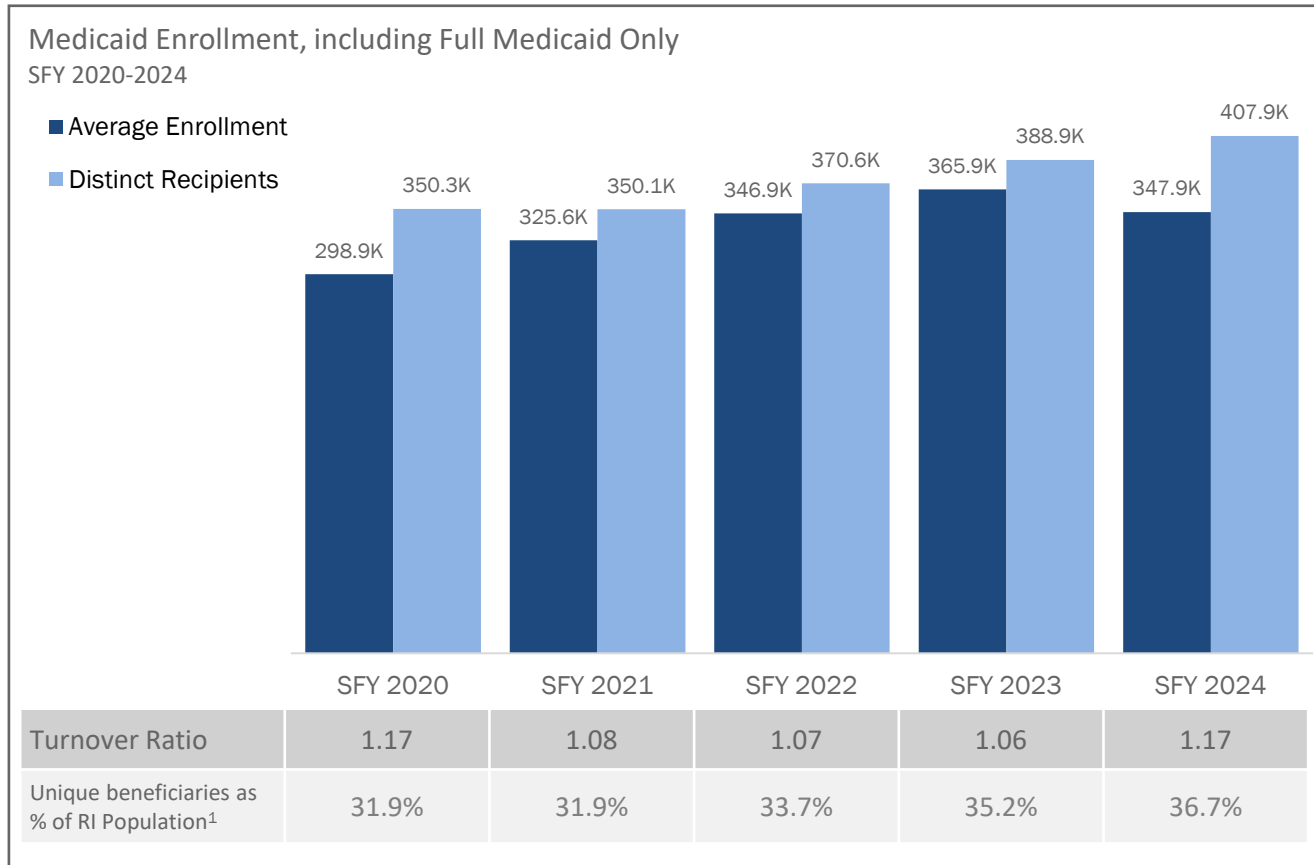
- After a decrease in SFY 2021, the Medicaid PMPM trend increased by 16.7% in SFY 2024.
- The overall five-year PMPM trend of 5.9% is attributed, in part, to a change in the mix of the population groups, with most of the enrollment growth concentrated within the Children and Families and Expansion eligibility groups:
 - PMPMs vary significantly across populations, from \$441 for Children and Families to \$2,455 for Elders.
 - The average annual compounded PMPM growth rate varies over the past five years, from 1.1% for Elders to 9.7% for Disabled Adults.

PMPM Comparison by Eligibility Group, SFY 2019 to SFY 2023

	SFY 2020	SFY 2024	Annual Growth Rate SFY 2020-2024
Children and Families	\$309	\$441	9.3%
CSHCN	\$1,409	\$1,904	7.8%
Expansion	\$529	\$703	7.4%
Disabled Adults	\$1,980	\$2,872	9.7%
Elders	\$2,354	\$2,455	1.1%
Overall	\$736	\$926	5.9%

¹ Calculated as compounded annual growth rate (CAGR) over period SFY 2020-2024 as shown.

One-third of Rhode Island's population was enrolled in Medicaid with full benefits for some part of SFY 2024.



- 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 beneficiaries 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.

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

Programs and Provider Type



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LTSS Expenditures

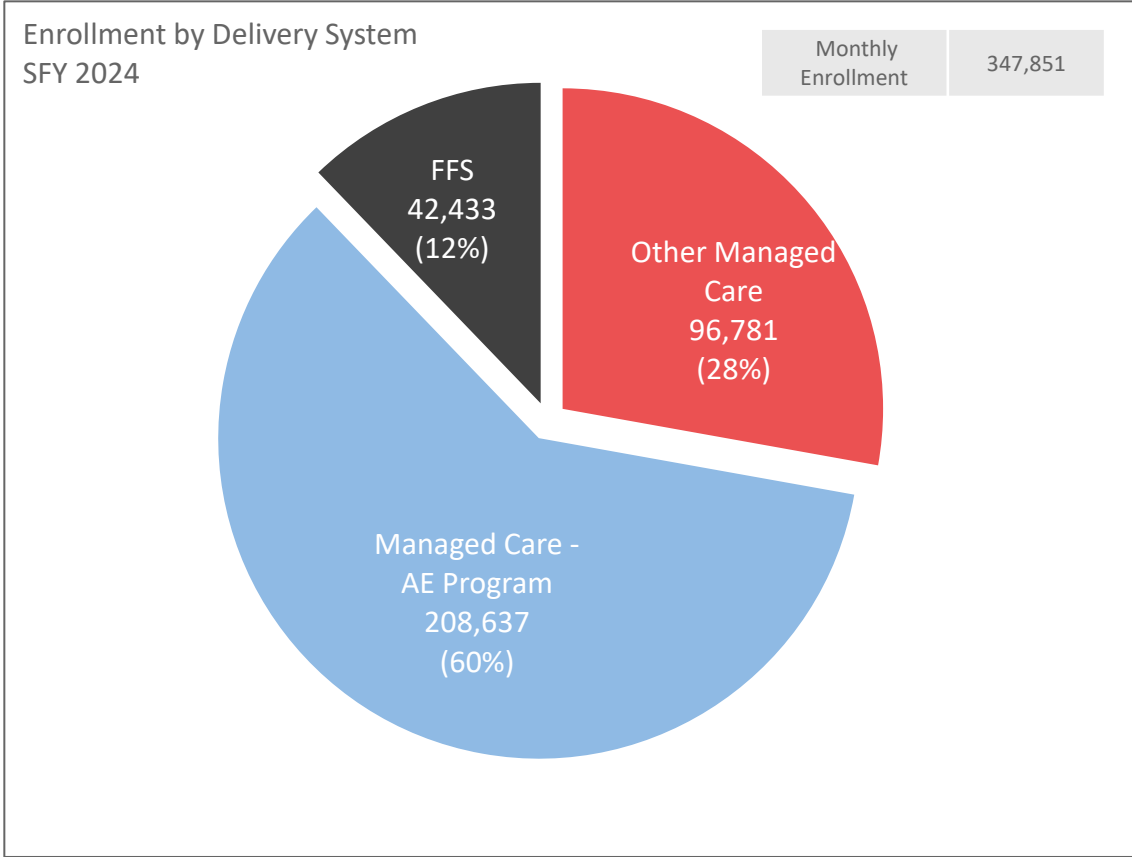
FY 2024 Snapshot
Expenditures by Delivery System
Five Year History: Community vs. Institutional

Enrollment by Program



Programs

Nearly 90% of beneficiaries with full Medicaid benefits are enrolled in managed care and 60% of those 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 beneficiaries. All beneficiaries 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 beneficiaries.
- **Other Managed Care:**
 - In these managed care arrangements, Rhode Island pays a private insurer to provide coverage for Medicaid beneficiaries. This includes beneficiaries enrolled in Rite Share, Program of All-Inclusive Care for the Elderly (PACE), or beneficiaries 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 beneficiaries 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



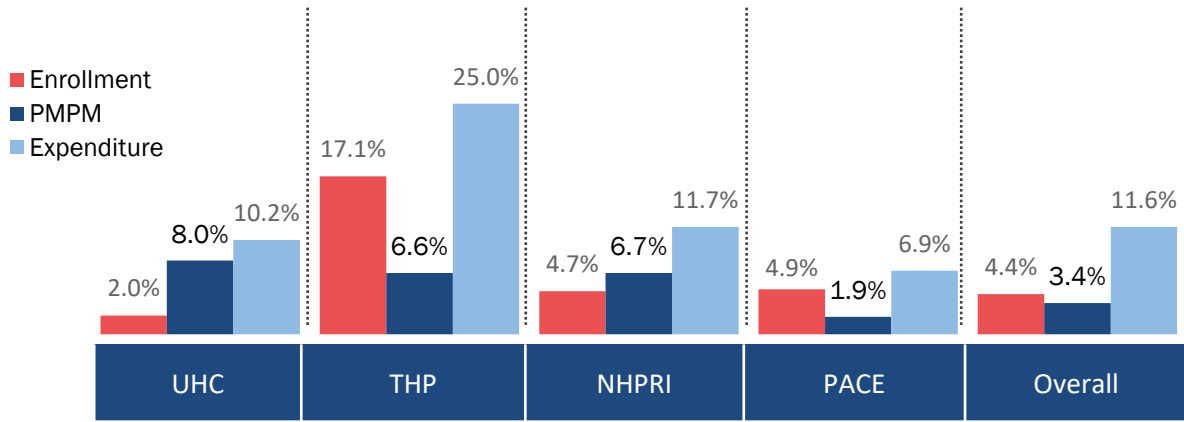
Programs

Between SFY 2020 and SFY 2024, annual expenditures and enrollment increased across all MCOs: expenditures by 11.6% and enrollment by 4.4%.

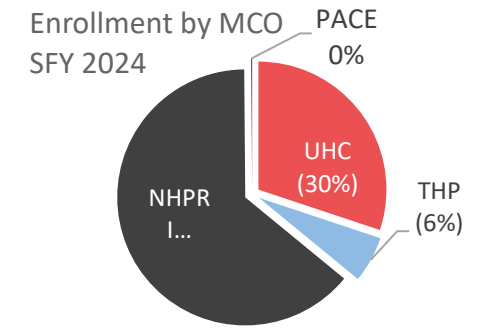
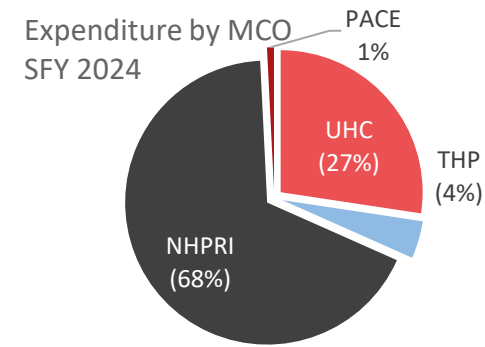
Current Expenditures
SFY 2024

	UHC	THP	NHPRI	PACE	Overall
Enrollment	92,499	17,902	196,372	408	307,181
PMPM	\$717	\$577	\$836	\$4,676	\$1,702
Expenditure	\$793.8M	\$123.7M	\$1,958.3M	\$22.9M	\$2,898.6M

Expenditures - 5-Year Compounded Annual Growth Rates
SFY 2020-2024



- Between SFY 2020 – 2024, the MCOs experienced the following:
 - United Healthcare (UHC)** experienced the smallest annual increases with enrollments (2%) while growing at a similar annual rate of expenditures as the other MCOs (10%). UHC also had the largest PMPM increase (8%)
 - Tufts Health Plan (THP)** had the largest annual growth for both enrollment and expenditure with 17% and 25% respectively, while simultaneously seeing a 7% increase in its average PMPM.
 - Neighborhood Health Plan of Rhode Island (NHPRI)** had the both the largest portion of enrollment (64% of MCO beneficiaries) and the largest portion of expenditure (68% of MCO expenditures).
 - Although **PACE** is the smallest payer in terms of both enrollment and expenditures, it has experienced meaningful annual increases of 5% and 7% increases in both areas.

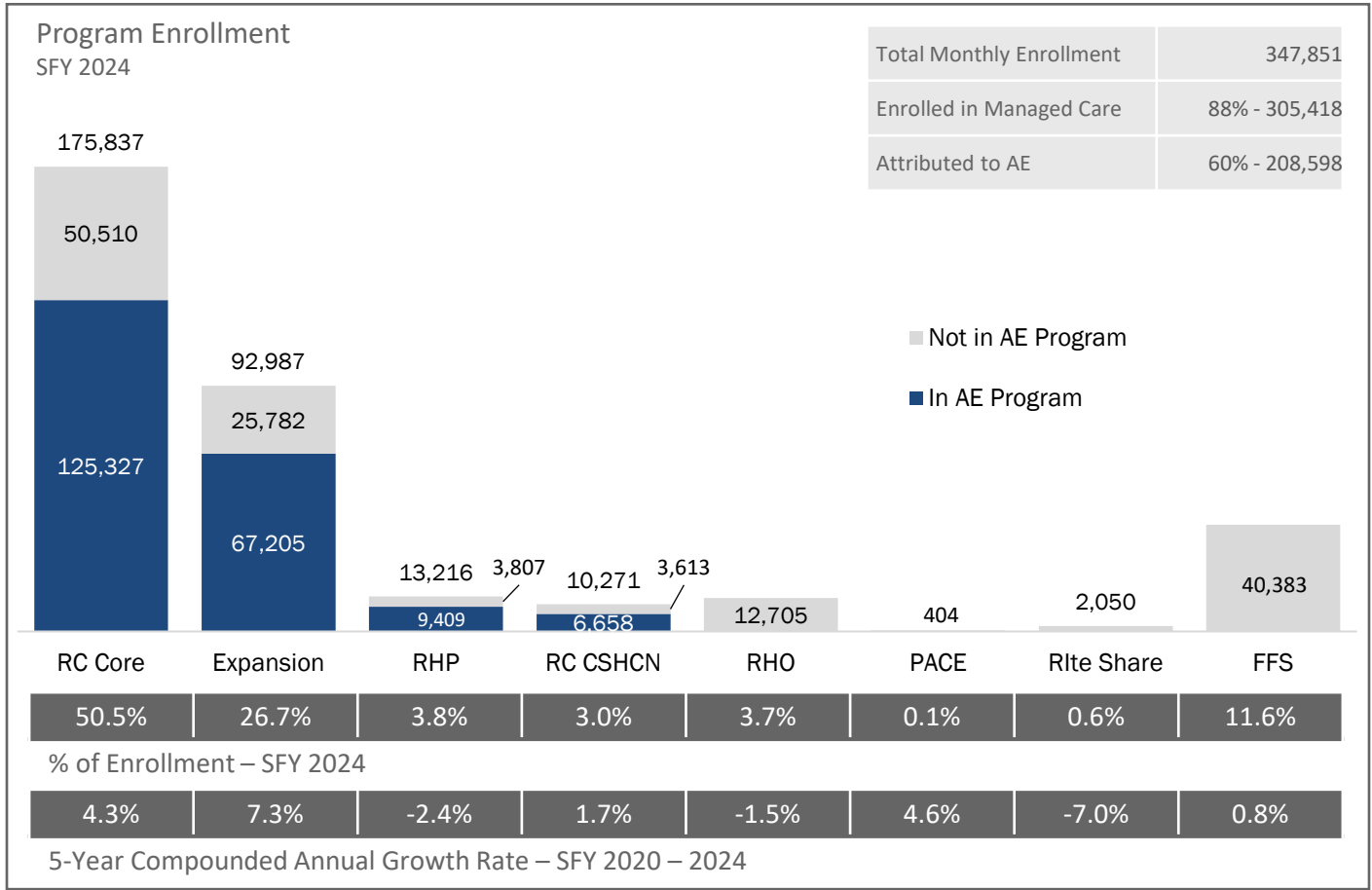


Managed Care Enrollment by Delivery System



Programs

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



- Medicaid managed care enrollment is divided between the three MCOs: NHPRI, UHC, and THP.
- 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 adults without children. Most 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.
- Beneficiaries remaining in fee-for-service increased from 2020 to 2024 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 beneficiaries in FFS over this time period.
- RHO declined over this time-period because of EOHHS eliminated RHO Phase I that did not integrate the client’s Medicaid and Medicare coverage. RHO Phase II, the CMS Demonstration, remains. it is a fully capitated managed care program for beneficiaries 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 beneficiaries 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



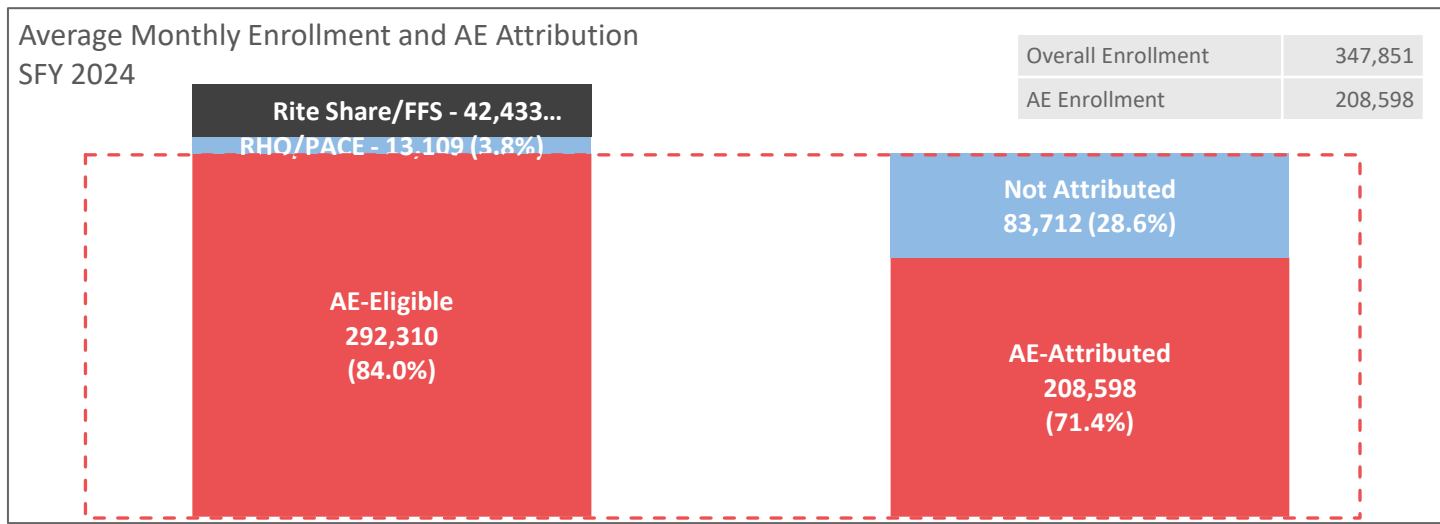
Programs

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

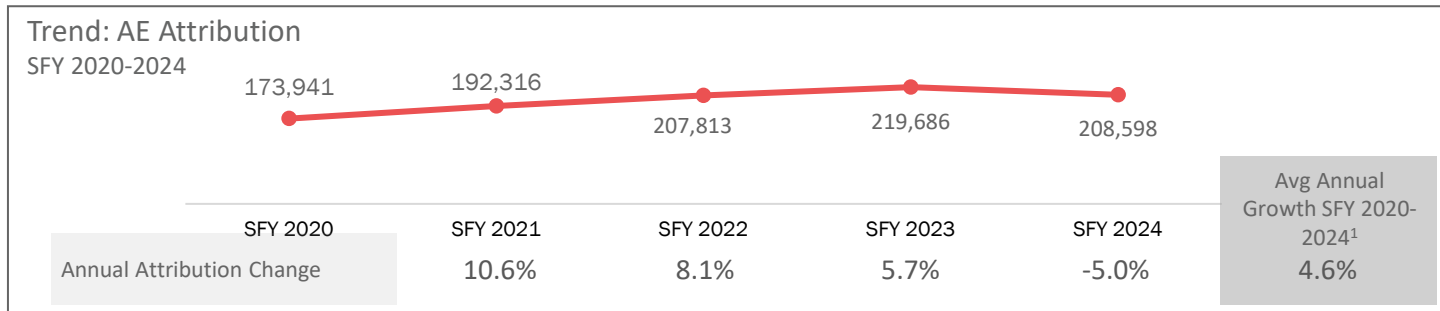
Expenditures by Delivery System SFY 2024				
	AE-Eligible Managed Care Enrollment: 292,310 (84.0%) Expenditures: \$2,449.9M (63.8%)		Total Monthly Enrollment	347,851
			Total Expenditures	\$3,863.9M
	Managed Care AE-Attributed 208,598 (60.0%)	Managed Care Not Enrolled in AE 83,712 (24.1%)	Managed Care RHO & PACE 13,109 (3.8%)	Remaining in FFS/Rite Share 42,433 (12.2%)
Major Medical Capitation \$2,275.3M (59.2%)	\$1,490.4M 38.2%	\$606.8M 15.8%	\$196.9M 5.1%	\$2.2M 0.1%
Other Capitation \$314.4M (8.2%)	\$49.6M 1.3%	\$20.7M 0.5%	\$79.9M 2.1%	\$164.2M 4.3%
FFS Expenditures \$1,234.1M (32.1%)	\$192.9M 5.0%	\$93.8M 2.4%	\$168.1M 4.4%	\$779.3M 20.3%
Total Expenditures	\$1,742.9M 44.8%	\$728.0M 18.9%	\$444.9M 11.6%	\$948.1M 24.7%

- 84% of Medicaid’s 347,851 beneficiaries are enrolled in managed care programs, including Rite Care, RHP, Expansion, RHO, and PACE.
 - Beneficiaries enrolled in Rite Care, RHP, and Expansion may be attributed to an Accountable Entity (AE). Overall, 292,310 beneficiary (60% of all Medicaid beneficiaries and 71.4% of AE-eligible beneficiaries) are attributed to an AE.
- Monthly capitation payments of \$2.6 billion account for 68% of Medicaid expenditures. Note: Assignment to a delivery system is based on the beneficiary’s last status within the year, so, some beneficiaries classified as “remaining in FFS” were previously enrolled in a managed care plan and may have had capitation paid on their behalf:
 - \$2.3 billion (59.2%) of expenditures go toward capitated medical services provided by NHPRI, UHC, and THP, excluding dental, non-emergency transportation, and certain carved-out benefits.
 - Other capitation payments of \$314.4 million (8.2%) include Medicare Premium Payments, Rite Smiles, and Non-Emergency Transportation.
- FFS spending of \$1.2 billion is primarily for beneficiaries 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.

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



- Seven AEs participated in the AE Program during the year:
 - Blackstone Valley Community Health Center
 - Coastal Medical
 - Integra Community Care Network
 - Integrated Healthcare Partners (CHC ACO)
 - Prospect Health Services RI
 - Providence Community Health Center
 - Thundermist Health Center
- AE program Incentive payments, which began in SFY 2019, are time limited payments and will be distributed through SFY 2024 (limited funds remaining for payment in SFY 2025). This spending is reflected in the overall benefits expenditures on fully-covered Medicaid beneficiaries.
- 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, beneficiary engagement and access, quality, interdisciplinary partnerships, and leadership and management.



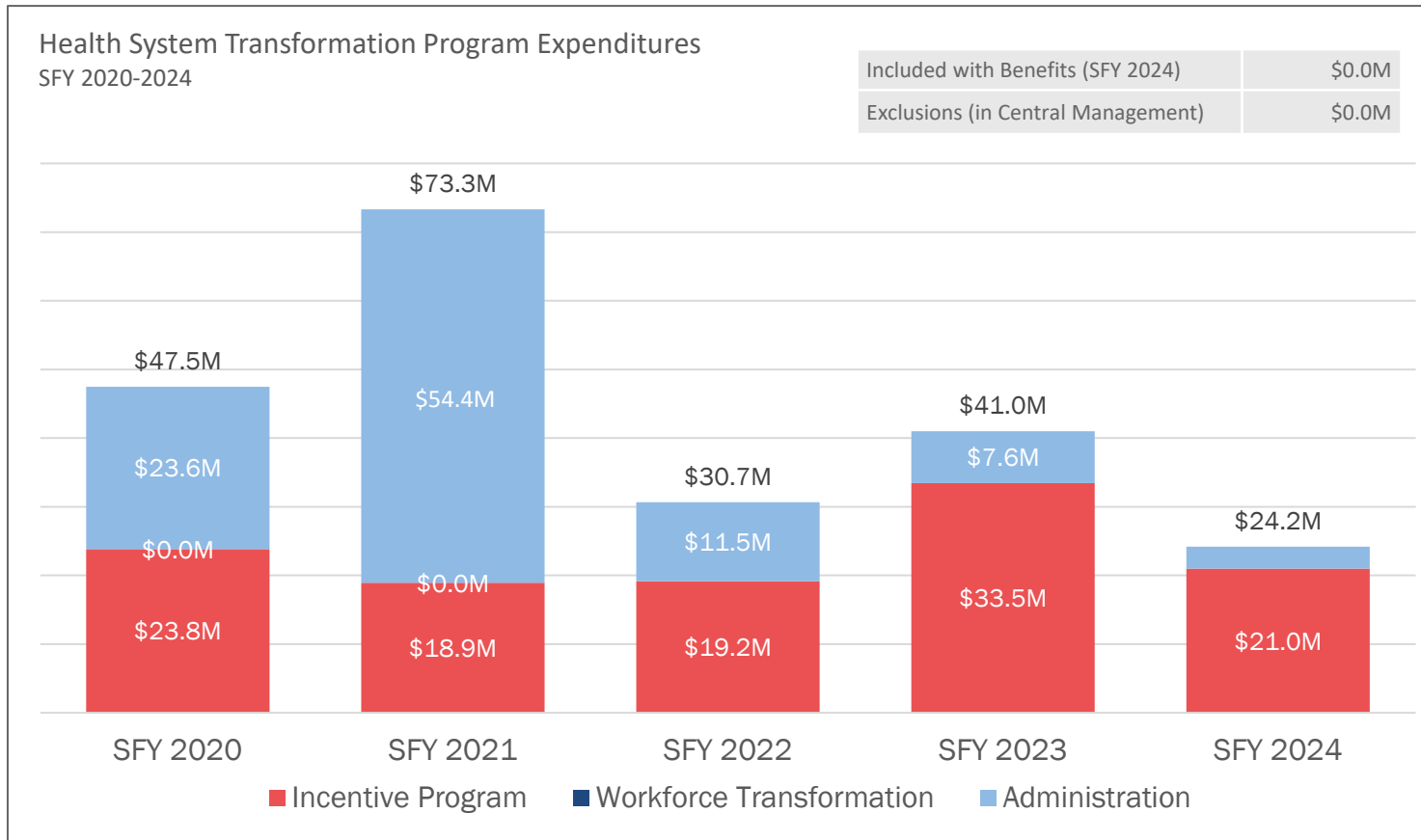
¹ Calculated as compounded annual growth rate (CAGR) over period SFY 2020-2024 as shown.

Health System Transformation Program (HSTP)



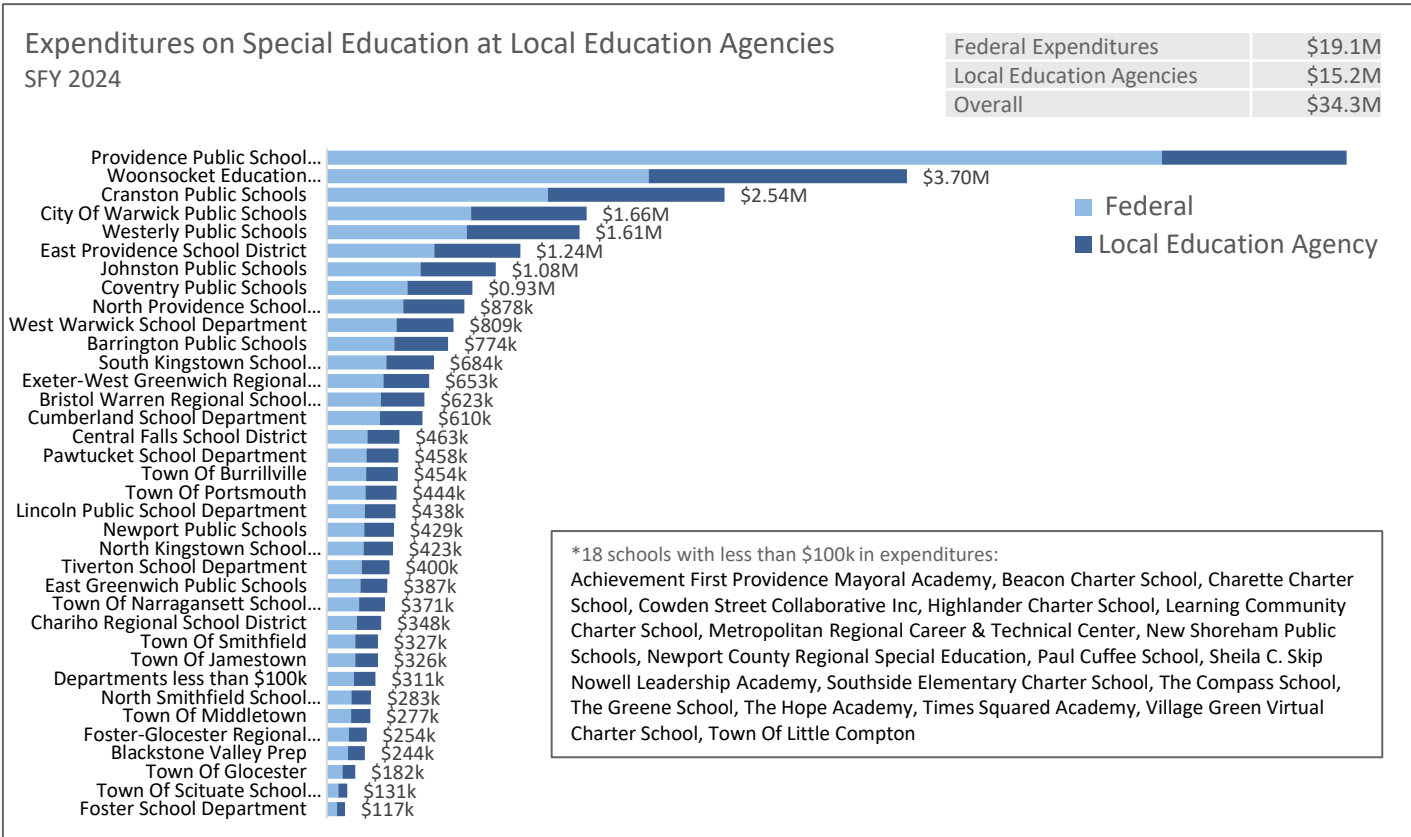
Programs

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



- In SFY 2024, EOHHS continued incentive payments to its Accountable Entity partners.
- Note, Administration expenses also includes payments for workforce transformation initiatives.

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.
- 36 school districts/departments received LEA payments in SFY 2024.

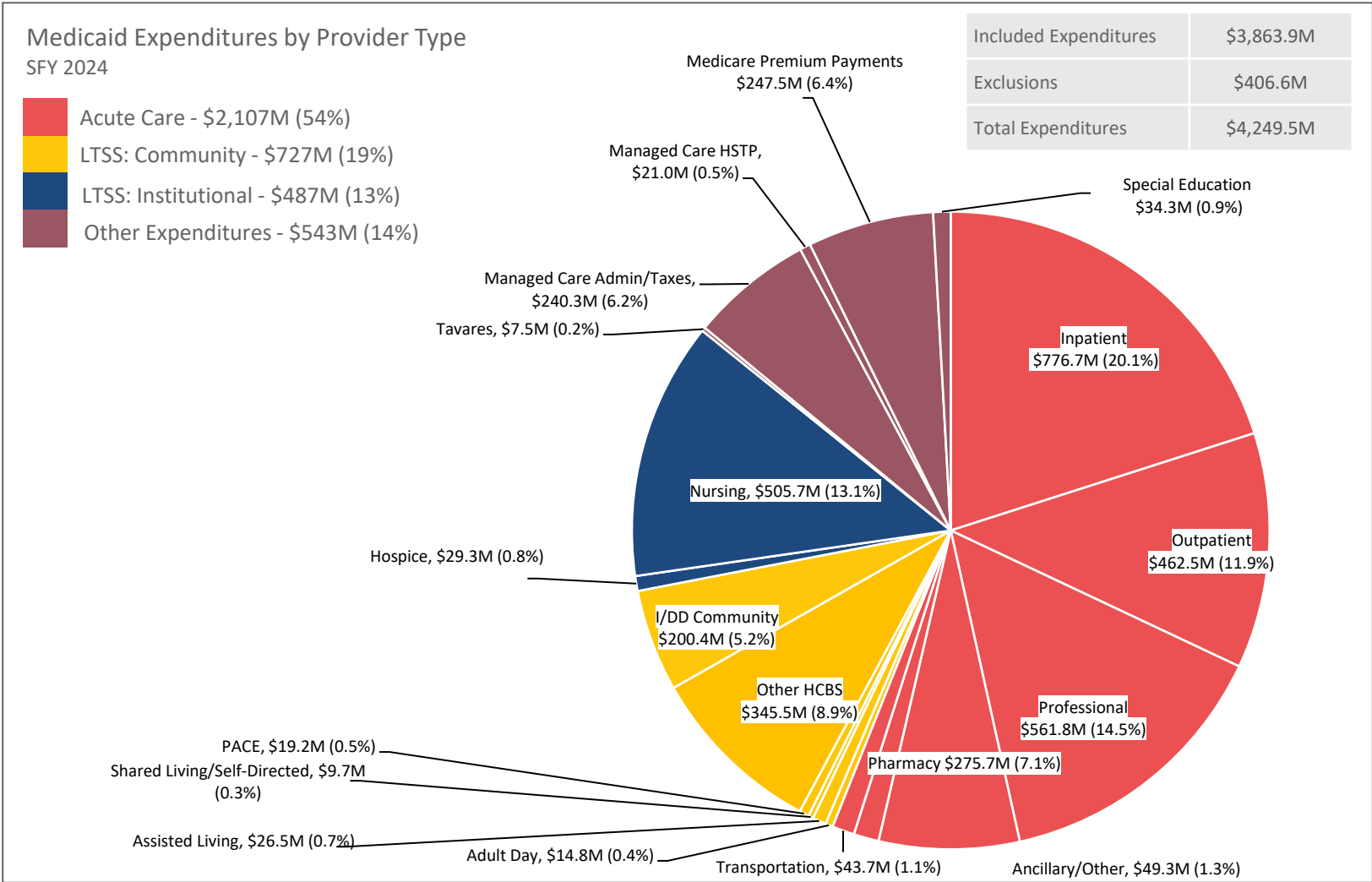
Note:

- 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

Provider Type

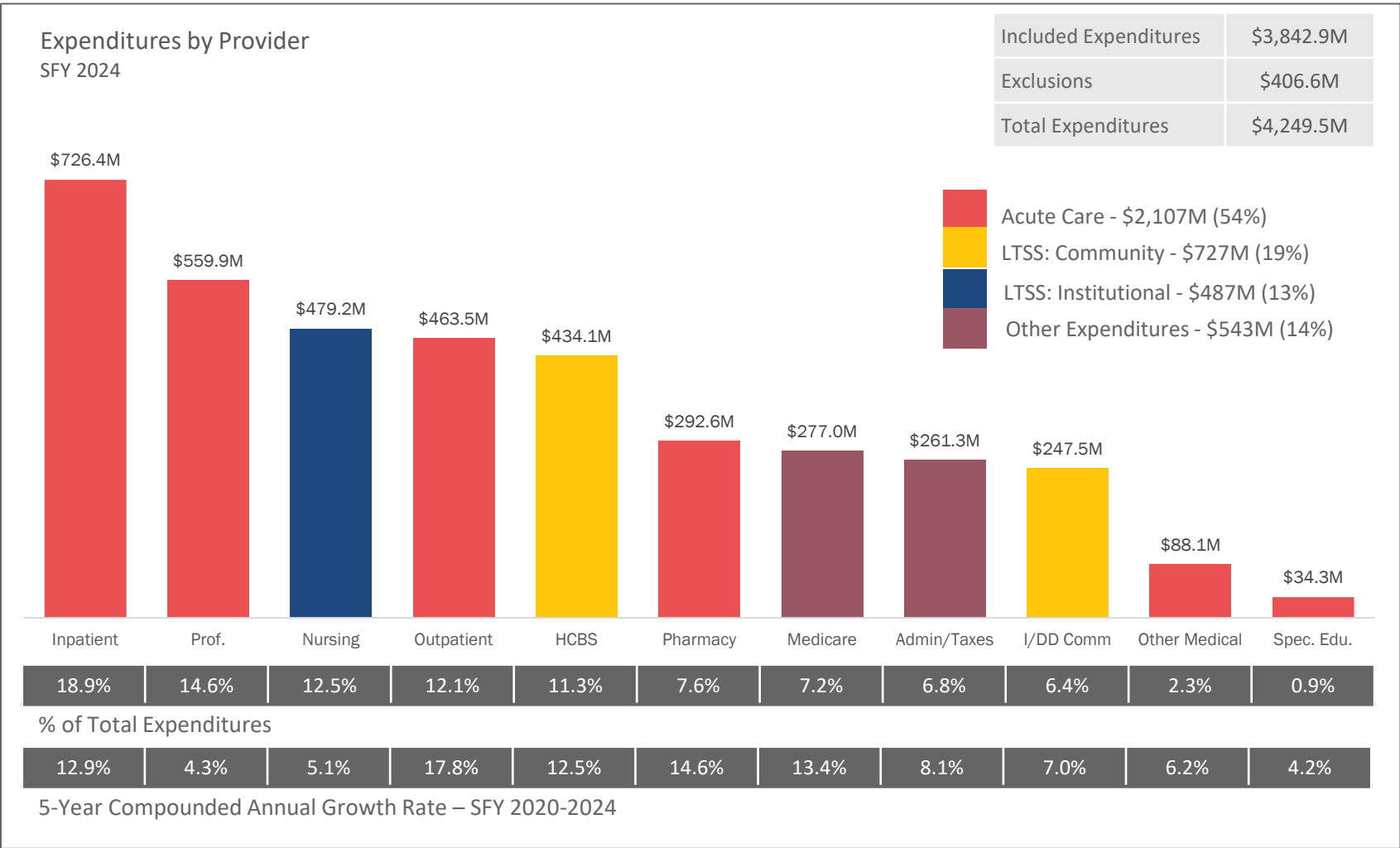
- Acute care services** had \$2,169.6 million in Medicaid expenditures in SFY 2024, constituting 56% of all expenditures.
 - Pharmacy spend is net of rebates.**
- LTSS** had \$1,151.17 million in Medicaid expenditures, constituting 30% of all expenditures. LTSS expenditures primarily serve the Elders and Adults with Disabilities populations. They are grouped into two categories:
 - Institutional Care** services are provided to populations who stay in an institution. These services account for \$535.1 million, including 46% of all LTSS expenditures and 14% of overall expenditures.
 - Community Care** services are provided to at-risk populations as alternatives to more costly nursing facility/institutional options. These services totaling \$616.1 million account for 54% of LTSS expenditures and 16% 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 beneficiaries. EOHHS has also classified Special Education and Tavares expenditures under this category this fiscal year.



Expenditures by Provider Type (cont'd)



Provider Type

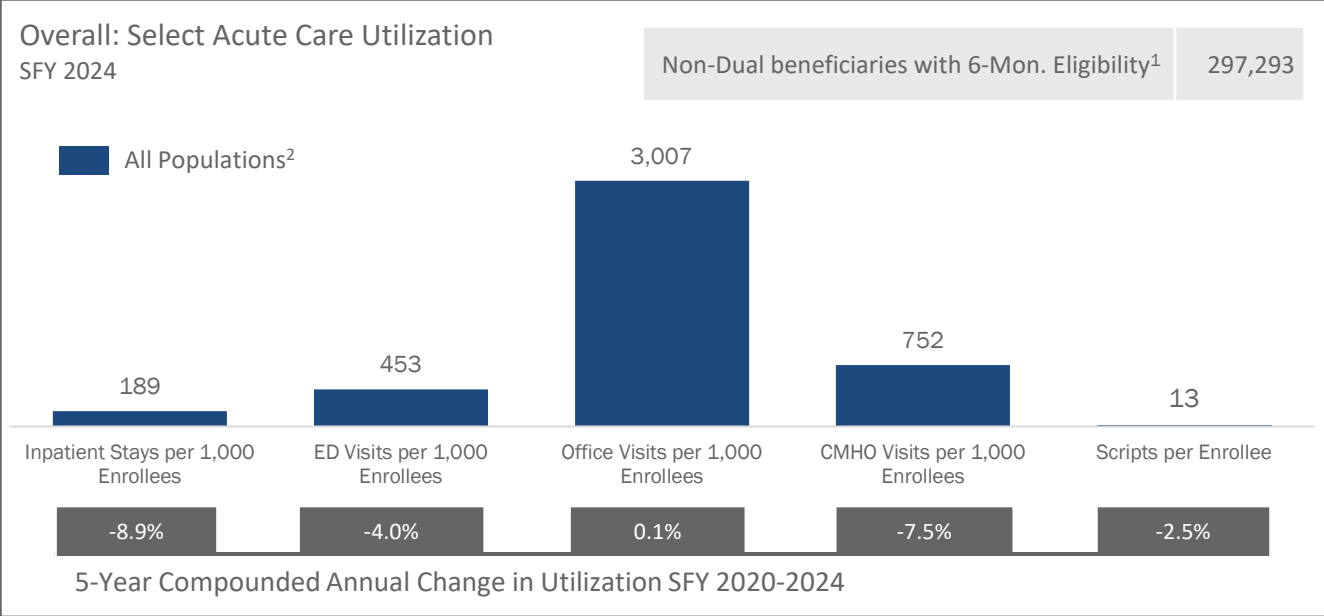


- In terms of growth rates over the past five years:
 - HCBS expenditures have grown faster than all other service types as a result of increasing investment into HCBS models in the state.
 - Medicare expenses have increased 7.0% annually, but Medicaid does not control these rates, and this rate was 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 2025 and beyond.
 - Nursing/Hospice spending increased 4% from FY 2020 to FY 2024, indicating growth following a long-term reduction attributed to the impact of COVID-19 on nursing facility census and the decline in facility census experienced since March 2020.
 - Note that Pharmacy is net of rebates. Gross spending on pharmacy in SFY 2024 was \$405 million.

Acute Care: Select Utilization & Costs



Provider Type



Acute care services comprise \$2.1 billion, or 55 percent, of total Medicaid benefit spending in SFY 2024. 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 2024, 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 2020 experience may be only artificially depressed.

- From SFY 2020 to SFY 2024, utilization fell for inpatient stays, ED visits, CMHO visits, and prescriptions, with inpatient stays/ED visits/scripts per beneficiaries falling -8.9%, -4.0%, -7.5%, and -2.5%, respectively.
- During this time span, costs per inpatient stays increased by 10.9%, cost per ED visits increased by 5.1%, costs per CMHO visit increased by 3.6%, and costs per prescription increased by 5.8%.

Overall: Average Cost per Acute Care Service SFY 2024

Service	Average Cost (SFY 2024)	5-Year Compounded Annual Change (%)
Inpatient Stay	\$7,262	10.9%
ED Visit	\$720	5.1%
Office Visit	\$96	6.3%
CMHO	\$264	3.6%
Prescription	\$94	5.8%

5-Year Compounded Annual Change in Unit Cost SFY 2020-2024

Data Clarification:

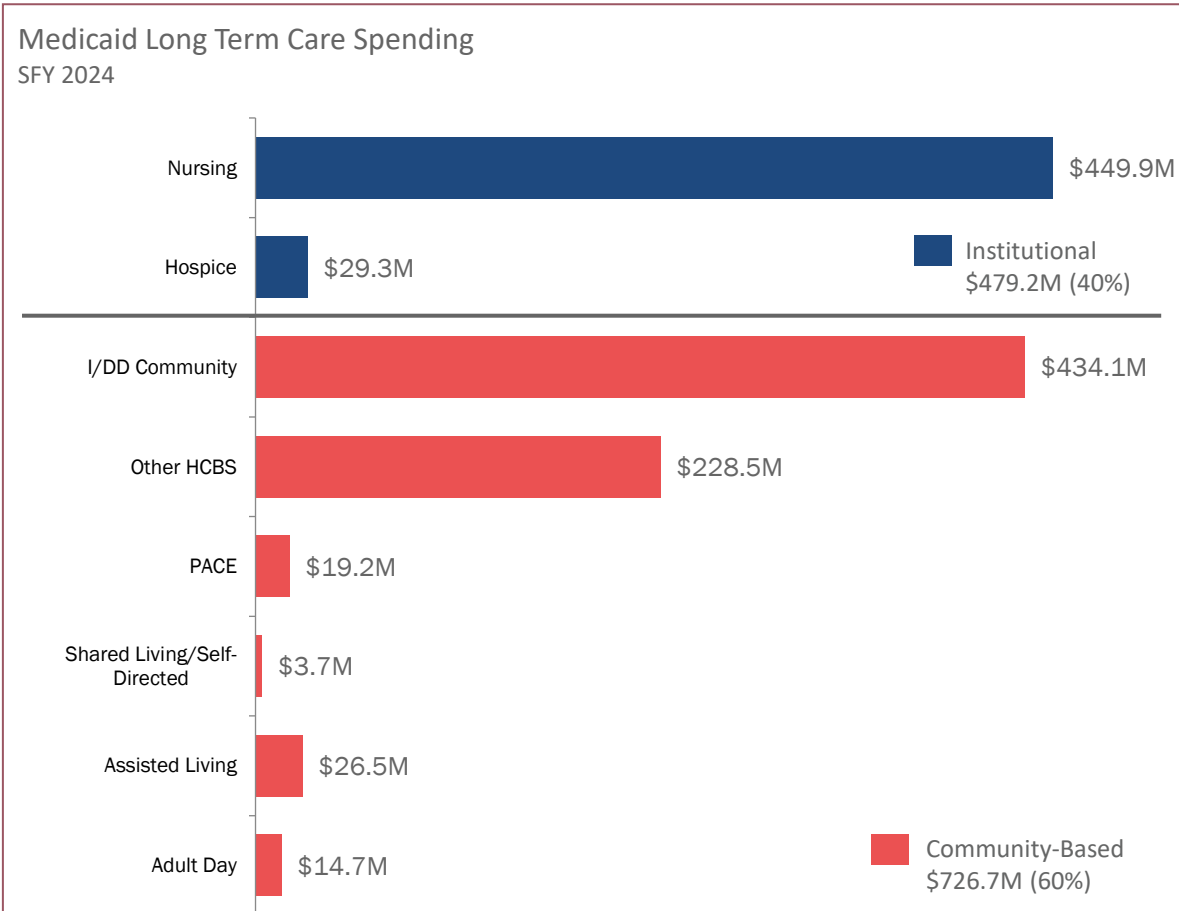
- The utilization and cost per unit metrics on this page are based on detailed claims data and do not include non-claims adjustments (e.g., missing data from MCOs and IBNR).
- The average cost per prescription does not include offsetting drug rebates.

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

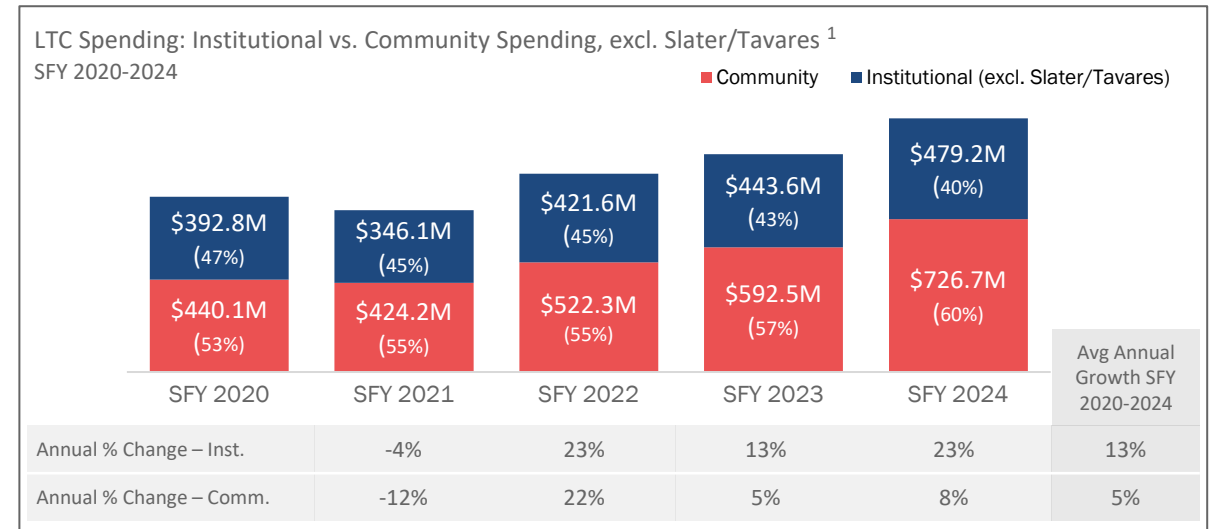
LTSS Spending: Community vs Institutional

Provider Type

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



- 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 2024 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.



¹ "Self-Directed" includes the Self-Directed Personal Choice and Independent Provider programs.

² "Other HCBS" includes personal care and severely disabled nursing home care services.

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

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Elders

By Delivery System, Provider Type, and Dual Status
LTSS Users and Expenditures

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Adults with Disabilities

By Delivery System, Provider Type, and Dual Status
Diagnosis, Acute Care Utilization, and LTSS Users

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Children and Families

By Delivery System and Provider Type
Diagnosis, and Acute Care Utilization

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Children with Special Healthcare Needs

By Delivery System and Provider Type
Diagnosis, and Acute Care Utilization

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Expansion Adults

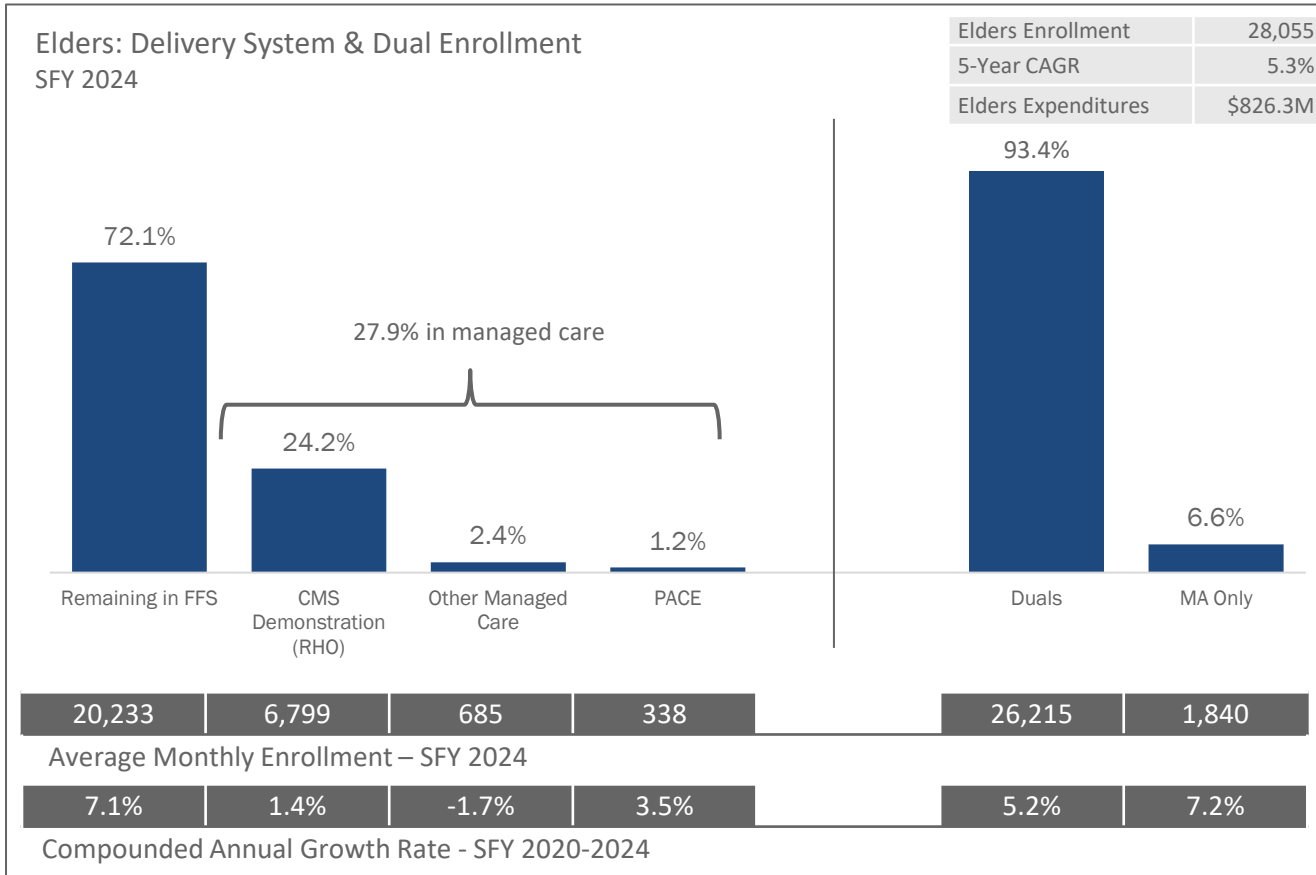
By Delivery System and Provider Type
Diagnosis and Acute Care Utilization

Elders: Managed Care and Dual Enrollment



Populations: Elders

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



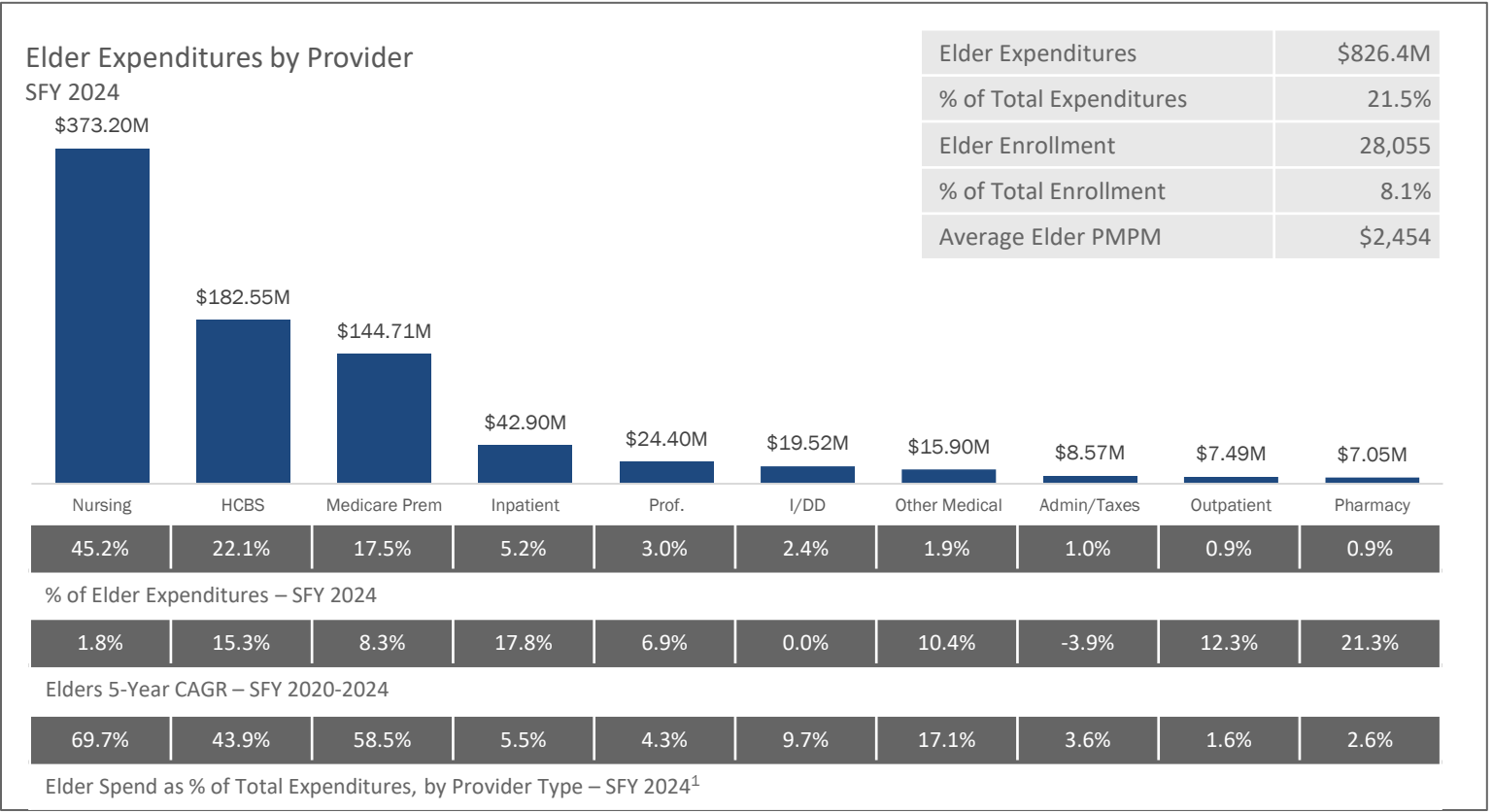
- Compared to other population groups, elders are predominantly in FFS:
 - 72.1% of elders receive their Medicaid services delivered through EOHHS’ FFS program.
 - 27.9% of elders receive their Medicaid services via managed care.
 - Approximately 24.2% are enrolled in the CMS Demonstration (RHO Phase II)
 - Less than 1.5% are enrolled in PACE.
- 93.4% of Elders are covered by both Medicare and Medicaid (so-called “Dual Eligible” or “Duals”).
 - For the Elders who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, professional, pharmacy).
 - Medicaid pays for the Medicare premiums and, in most cases, Medicare coinsurance charges on behalf of these Duals.

Elders: Expenditures by Provider Type



Populations: Elders

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



- Medicaid expenditures on Elders totaled \$826.3 million in SFY 2024.
- Beginning in SFY 2021, these trends are materially affected by the onset of the COVID-19 public health emergency which significantly depressed utilization of nursing facility services in SFY 2021 compared to prior periods (in SFY 2020 this report included \$343.3 million in nursing /hospice expenditures).
- Prior to the PHE, nursing facility expenditures had been steadily rising year/year.

Notes:

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

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

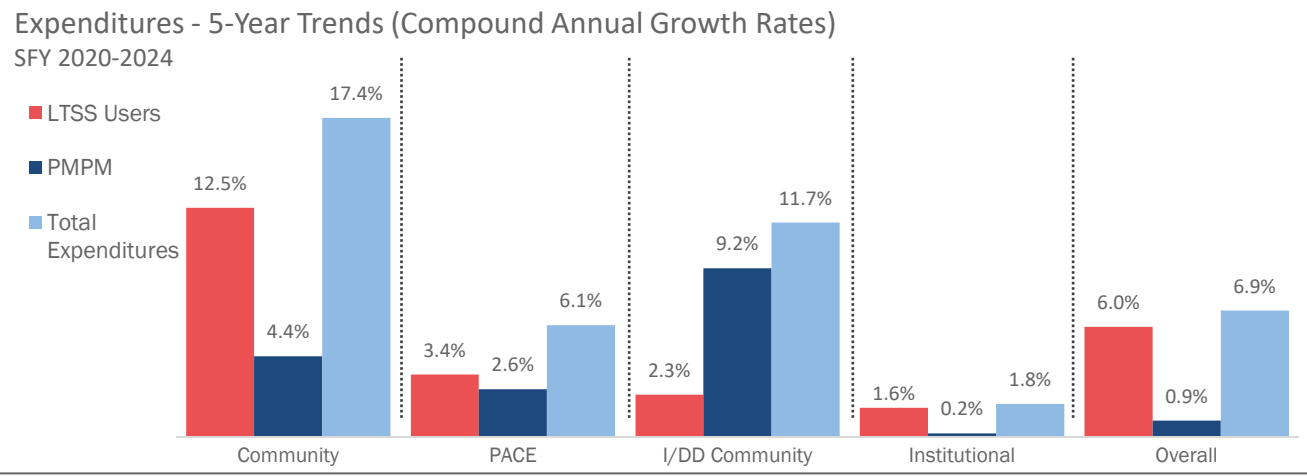
Elders: LTSS Users and Spending on LTSS



Populations: Elders

Current LTSS Expenditures SFY 2024	
Elders Enrollment	28,055
Overall Elders PMPM	\$2,455
Total Elders Expenditures	\$826.4M

	Community	PACE	I/DD Community	Institutional ⁴	Overall LTSS
LTSS Users ¹	5,126	338	455	5,302	11,221
LTSS PMPM ²	\$3,621	\$4,632	\$13,474	\$5,827	\$5,094
LTSS Spend ²	\$222.8M	\$18.8M	\$73.6M	\$370.7M	\$685.9M



- Overall, expenditures increased by \$161.5 million, or nearly 6.9%, over the 5-year period. This change is driven by Community expenses, which increased by \$105.5 million.
- The overall PMPM for this population increased by \$178, 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 increased by \$48 (0.2%).
 - The PACE PMPM increased by \$447 (2.6%).
 - The Community PMPM increased by \$573 (4.4%).
 - The I/DD Community PMPM increased by \$3,984 (9.2%).

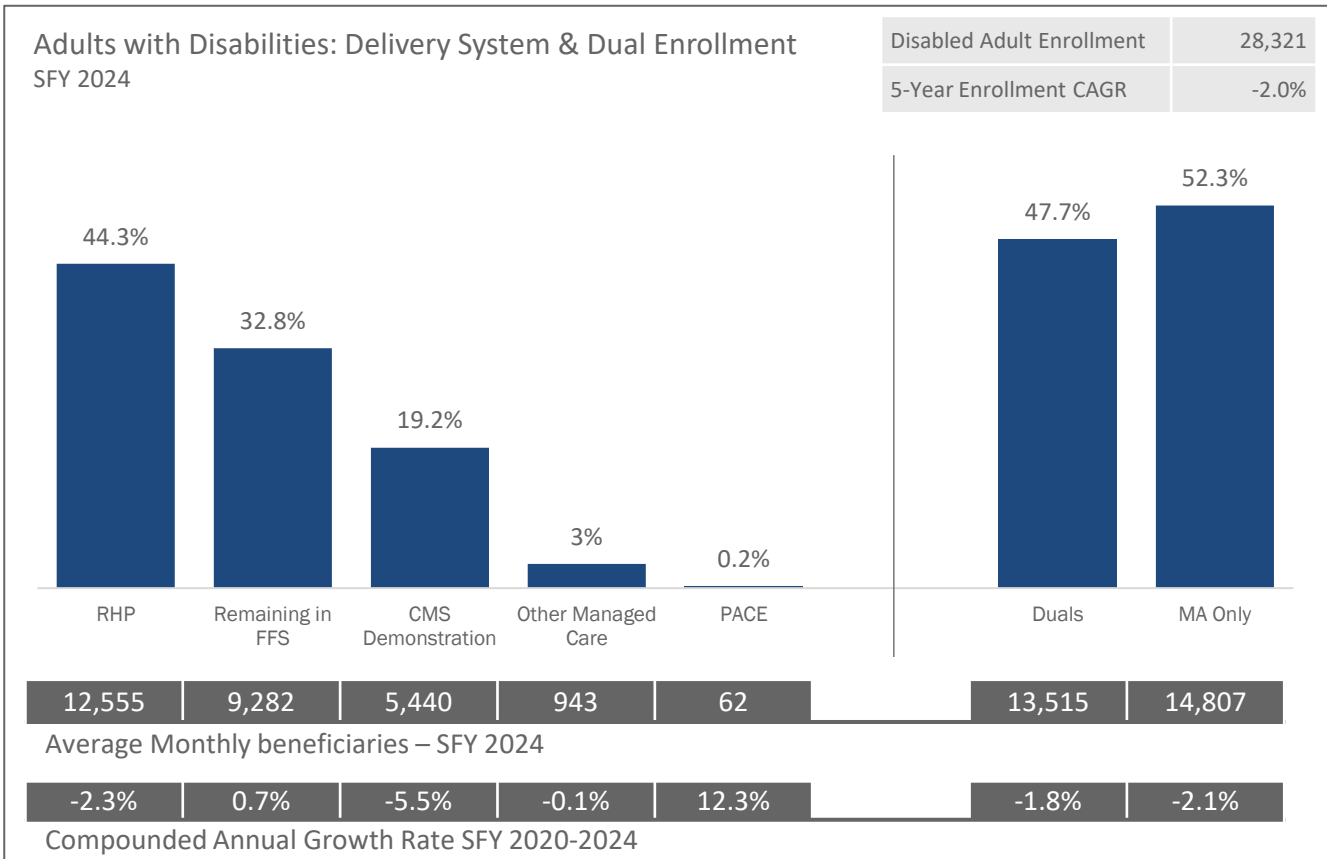
¹ LTSS users reflects beneficiaries with an LTSS authorization in the fiscal year.
² Spending represents LTSS services costs only, except for PACE that includes full capitation.
³ Community authorizations include those with Preventive Only coverage that have lower LTSS utilization.
⁴ Institutional includes nursing facilities and hospice users only. Does not include Slater Hospital users.

Adults with Disabilities: Managed Care and Dual Enrollment



Populations: Adults with Disabilities

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.



- 44% percent of Adults with Disabilities are enrolled in RHP, a comprehensive managed care program for Adults with Disabilities.
- 48% of Adults with Disabilities are dual eligible.
 - 19% of Adults with Disabilities are enrolled in CMS Dual Demonstration (RHO II).
 - 33% of Adults with Disabilities are not enrolled in managed care and are instead in FFS.
 - Most of these FFS beneficiaries are dual eligible and are not subject to mandatory enrollment.
 - Medicaid-only beneficiaries will remain in FFS for only an interim period prior to enrollment in RHP.
- Adults with Disabilities is the only population group that has seen a decline over the past five years. This decline, however, is illusory as these beneficiaries are gaining eligibility under Medicaid Expansion as previously-eligible Adults.

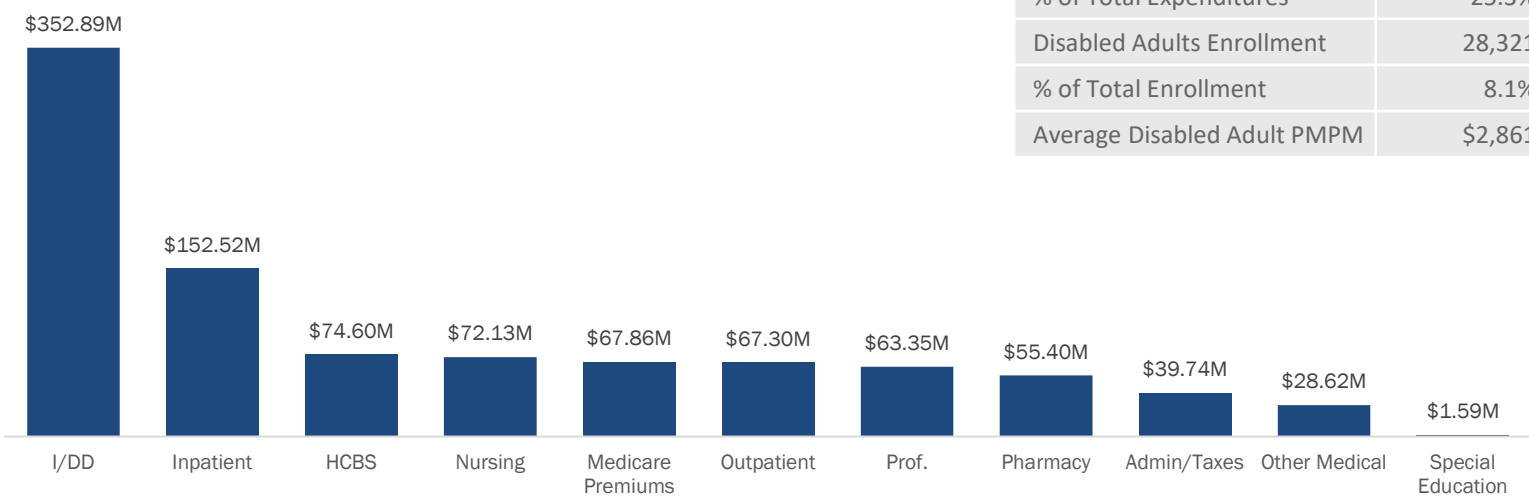
Adults with Disabilities: Expenditures by Provider Type



Populations: Adults with Disabilities

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 2024



Disabled Adults Expenditures	\$976.0M
% of Total Expenditures	25.3%
Disabled Adults Enrollment	28,321
% of Total Enrollment	8.1%
Average Disabled Adult PMPM	\$2,861

- Adults with Disabilities have the highest PMPM among Medicaid beneficiaries with full benefits, with those expenditures dominated by I/DD services.
- I/DD services make up 18.4% of expenditures for this population.
- Over the past five years, expenditures on a per beneficiary basis for Adults with Disabilities have grown at approximately 7.5% per year.

36.3%	15.7%	7.7%	7.4%	7.0%	6.9%	6.5%	5.7%	4.1%	2.9%	0.2%
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% of Disabled Adults Expenditures – SFY 2024

12.2%	8.9%	1.1%	12.2%	13.1%	9.8%	-5.1%	4.8%	0.1%	0.3%	16.1%
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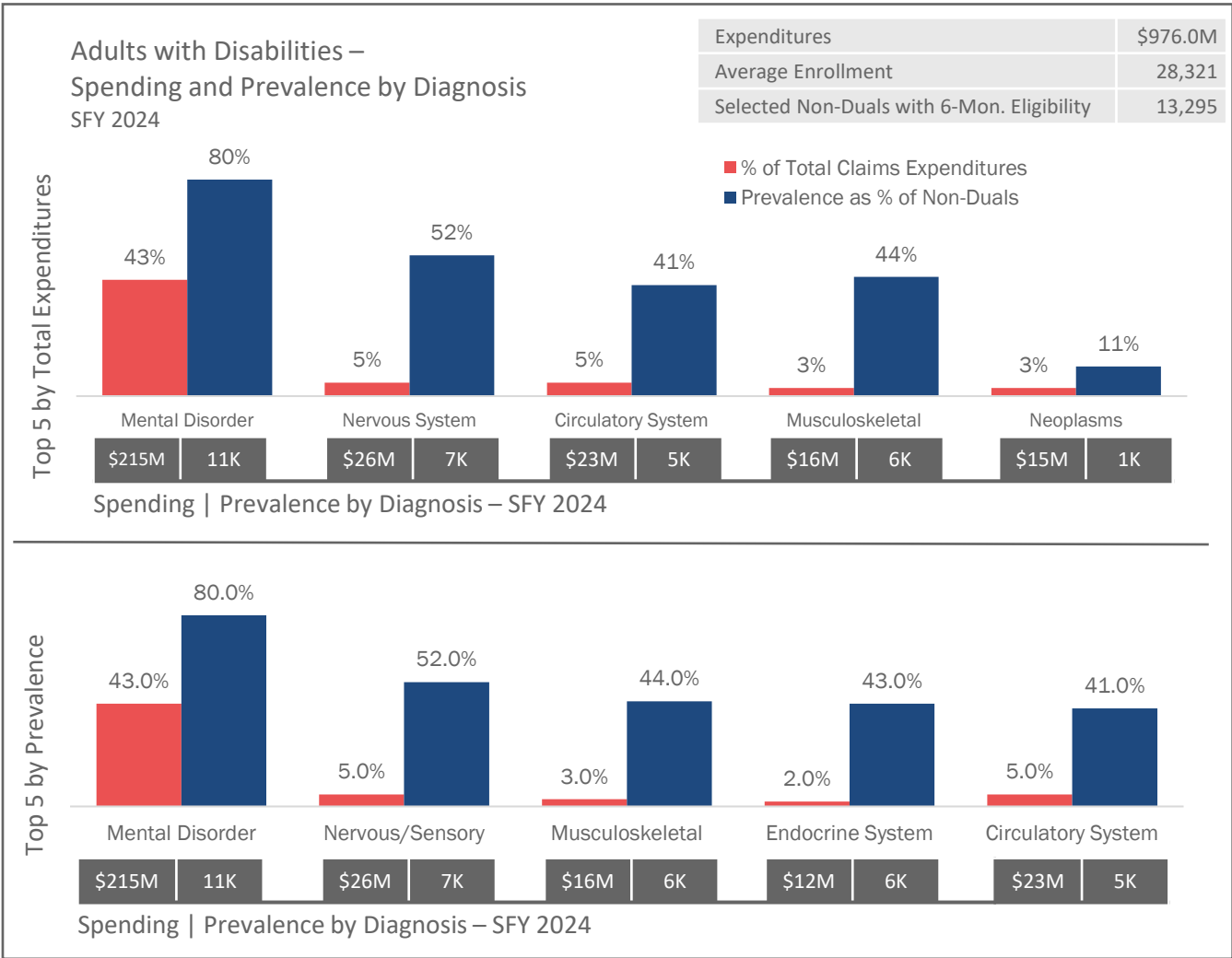
Disabled Adults 5-Year CAGR – SFY 2020-2024

81.3%	21.0%	30.1%	15.6%	23.2%	14.0%	11.3%	20.0%	15.2%	32.5%	4.6%
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Disabled Adult Spend as % of Total Expenditures, by Provider Type – SFY 2024

Adults with Disabilities: Diagnoses

Populations: Adults with Disabilities



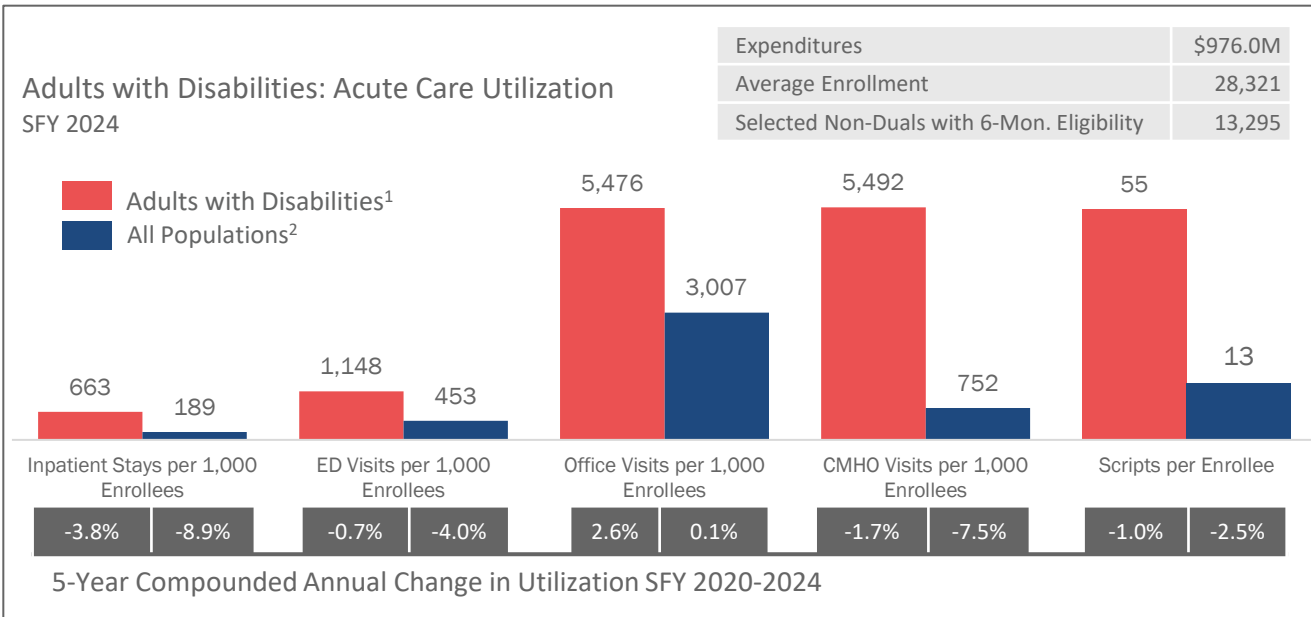
Most expenditures on Adults with Disabilities go toward services for beneficiaries with Intellectually and Developmental Disabilities.

- 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, endocrine system, and the circulatory system are most prevalent among this population, like the general Medicaid population.

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

- 80% "prevalence as a % of non-duals" means that among beneficiaries within the Adults with Disabilities population that have at least 6 months of enrollment during the year, 80% of the non-duals had claims where "mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 43% of costs were for claims where "mental or behavioral health" was the primary diagnosis.

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



- Per-person inpatient utilization decreased for both Adults with Disabilities (-3.8%) and the overall population (-8.9%) from SFY 2020 to SFY 2024 per year.
- Adults with Disabilities have significantly higher utilization at hospitals than all other groups, with 3.5 times more inpatient stays per 1,000 (at a 13% higher cost per stay) and 2.5 more ED visits per 1,000 (at a 11% higher cost per visit)
- The average Adult with Disabilities had 55 pharmacy claims per year, whereas the average beneficiary had 13 pharmacy claims per year.

Adults with Disabilities: Average Cost per Acute Care Service SFY 2024

	IP Stay	ED Visit	Office Visit	CMHO Visit	Script
Adults with Disabilities	\$8,218	\$802	\$77	\$326	\$108
Overall	\$7,262	\$720	\$96	\$264	\$94

¹ Unduplicated beneficiaries includes count of Medicaid Only beneficiaries with a minimum of six months of eligibility.

² All populations include Medicaid Only beneficiaries Adults with Disabilities, Children and Families, CHSCN, and Expansion beneficiaries with a minimum of 6 months of eligibility.

Adults with Disabilities: LTSS Users and Spending



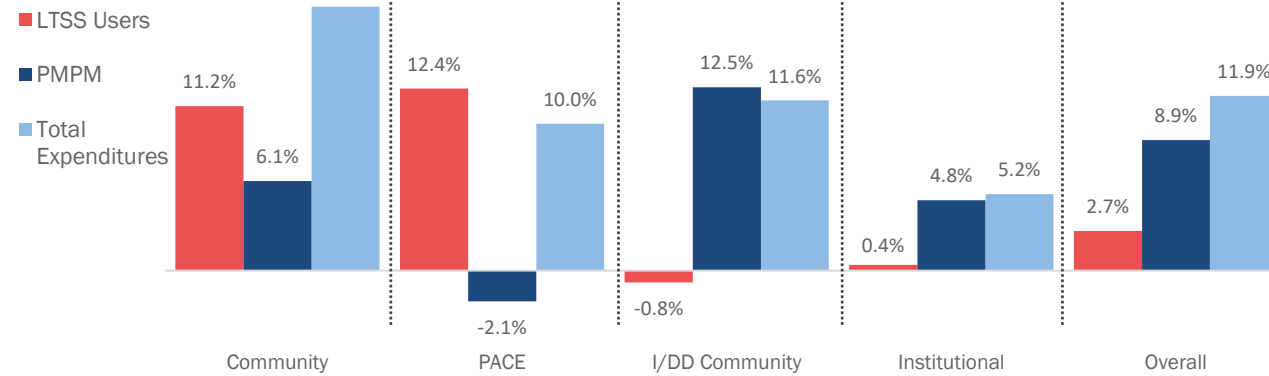
Populations: Adults with Disabilities

Current LTSS Expenditures SFY 2024

Disabled Enrollment	28,321
Overall Disabled PMPM	\$2,872
Total Disabled Expenditures	\$976.0M

	Community	PACE	I/DD Community	Institutional ⁴	Overall LTSS
LTSS Users ¹	1,898	62	3,155	580	5,695
LTSS PMPM ²	\$4,788	\$4,869	\$10,116	\$8,305	\$8,099
LTSS Spend ²	\$109.0M	\$3.6M	\$383.0M	\$57.8M	\$553.5M

Expenditures - 5-Year Trends (Compound Annual Growth Rates) SFY 2020-2024



- Overall LTSS expenditures for Disabled Adults increased by \$201 million from SFY 2020 to 2024: with widespread increases in expenditures across all methods of care.
- The overall PMPM for Adults with Disabilities increased by \$2,348 over the 5-year period, by 8.9% per year on average.
 - Over this same time period, the Community PMPM increased by \$1,009 or 6.1%.
 - The I/DD Community and Institutional PMPM rates increased by \$3,809 and \$1,414, or 12.5% and 4.8%, respectively.

¹ LTSS users reflects beneficiaries 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.

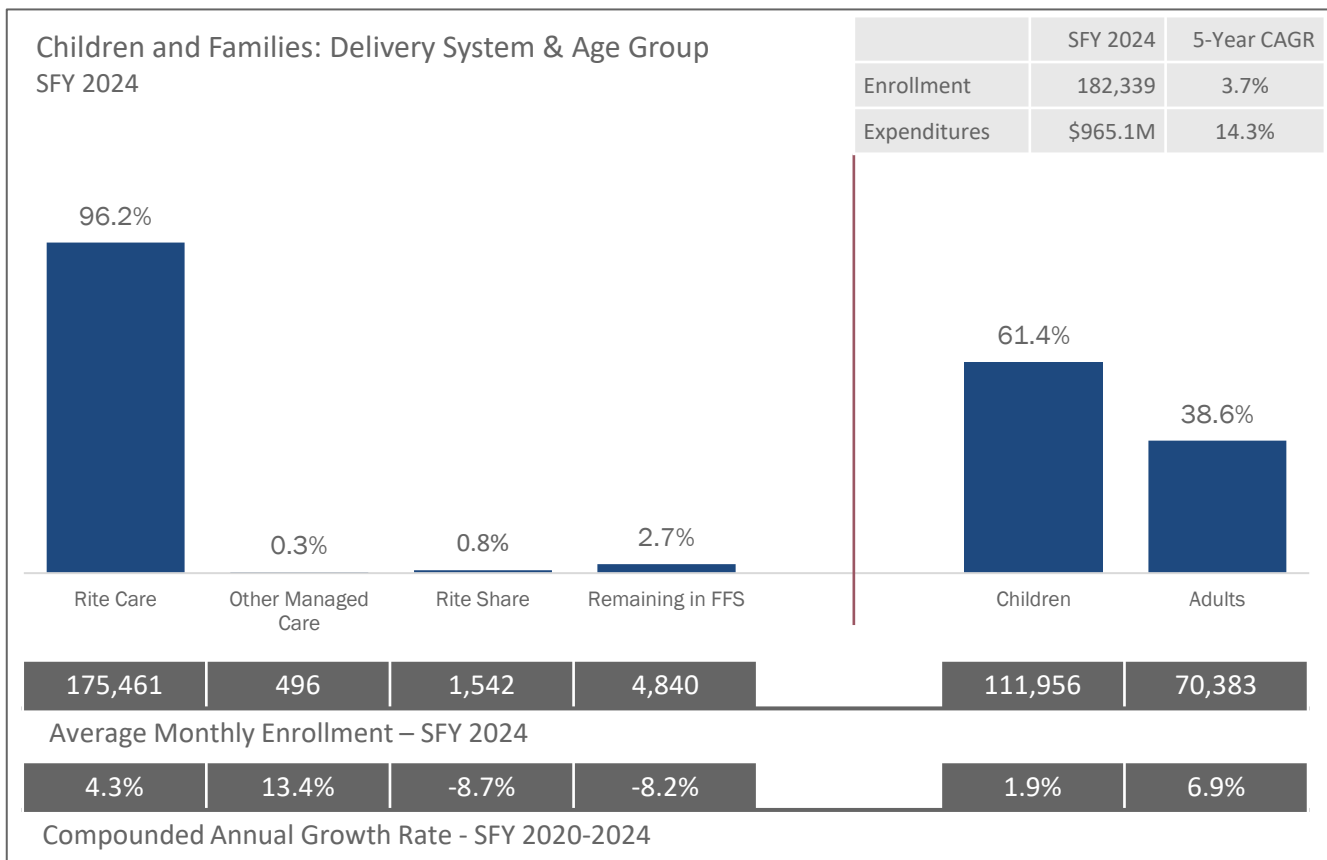
⁴ Institutional includes nursing facilities and hospice residents only. Does not include Slater Hospital admits.

Children and Families: Managed Care Enrollment



Populations: Children and Families

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



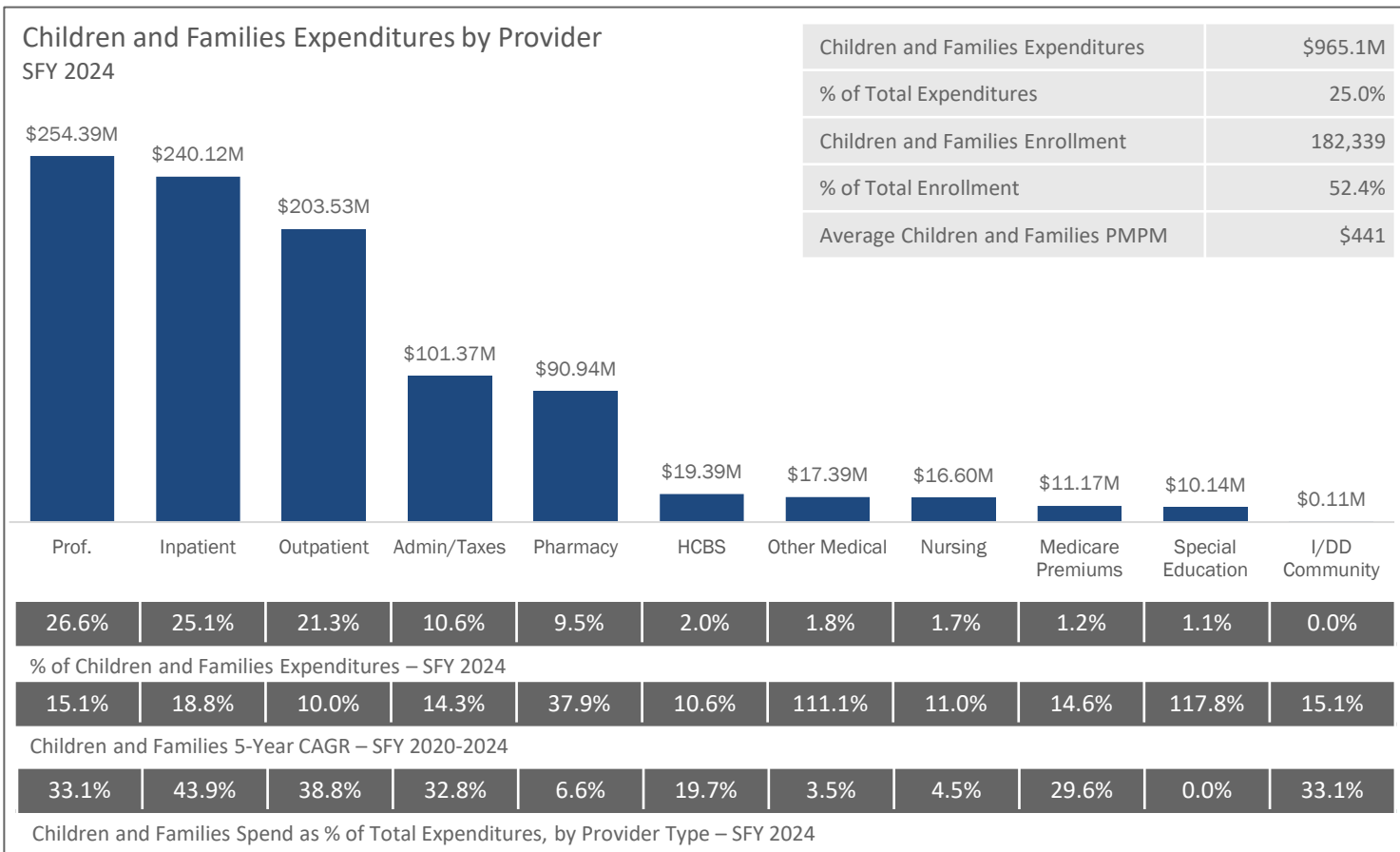
- 96% of the Children and Families population is enrolled in Rite Care Core, a managed care program for families with children, pregnant women, and children under age 19.
- Rite Care beneficiaries are divided between NHPRI, UHC, and THP.
- Rite Share is a program designed to allow Medicaid beneficiaries 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 beneficiaries remaining in FFS are those with access to other insurance and/or newly enrolled beneficiaries during the period prior to enrollment in Rite Care.
- "Other Managed Care" includes beneficiaries who for a portion of the year were enrolled in RHP or Expansion.

Children and Families: Expenditures by Provider Type



Populations: Children and Families

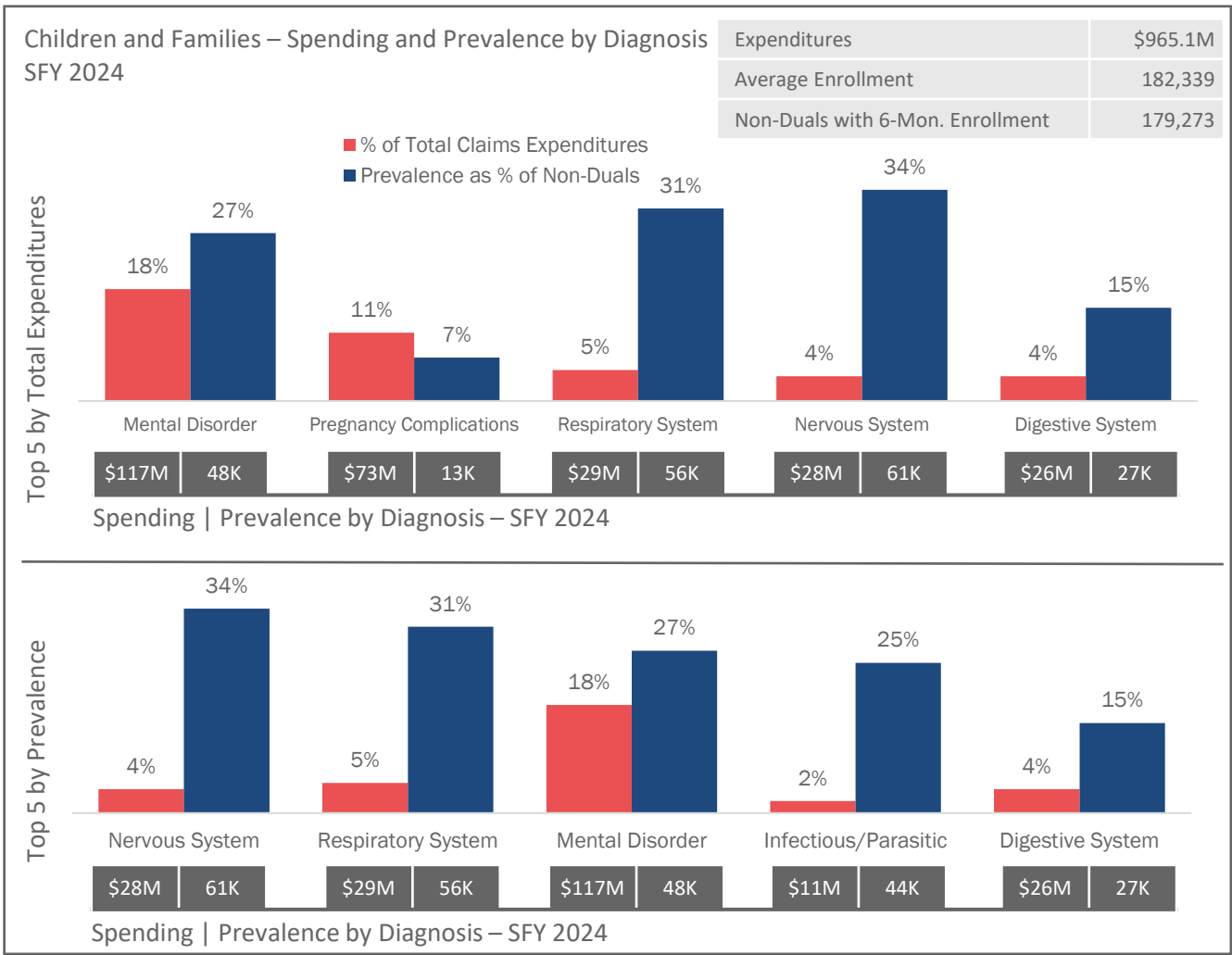
Most expenditures for the Children and Families population go toward professional services and hospital services.



- Children and Families is the largest population group in Rhode Island Medicaid, with 52% of all Medicaid beneficiaries falling into this category.
- Children and Families have the lowest per-person expenditures of any of the populations with a PMPM \$260 less than the Expansion population.
- Professional services and hospital services (outpatient and inpatient) account for 73% (\$698.03M) of the expenditures for the Children and Families population in SFY 2024.
- The fastest-growing expenditures for Children and Families are Nursing, HCBS, and Outpatient services which grew at a yearly average of 108.2%, 38.0%, and 18.8%, respectively, from SFY 2020 to 2024.

Children and Families: Diagnoses

Populations: Children and Families



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

- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Similarly, to other populations, mental or behavioral health has high prevalence and high cost for Children and Families.
- Complications of pregnancy, childbirth and postpartum, and certain conditions originating in the perinatal period account for 11% of expenditures for Children and Families.
- Diseases of the nervous system and sense organs, respiratory system, infectious and parasitic diseases, and digestive system diagnoses are also prevalent among Children and Families.

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

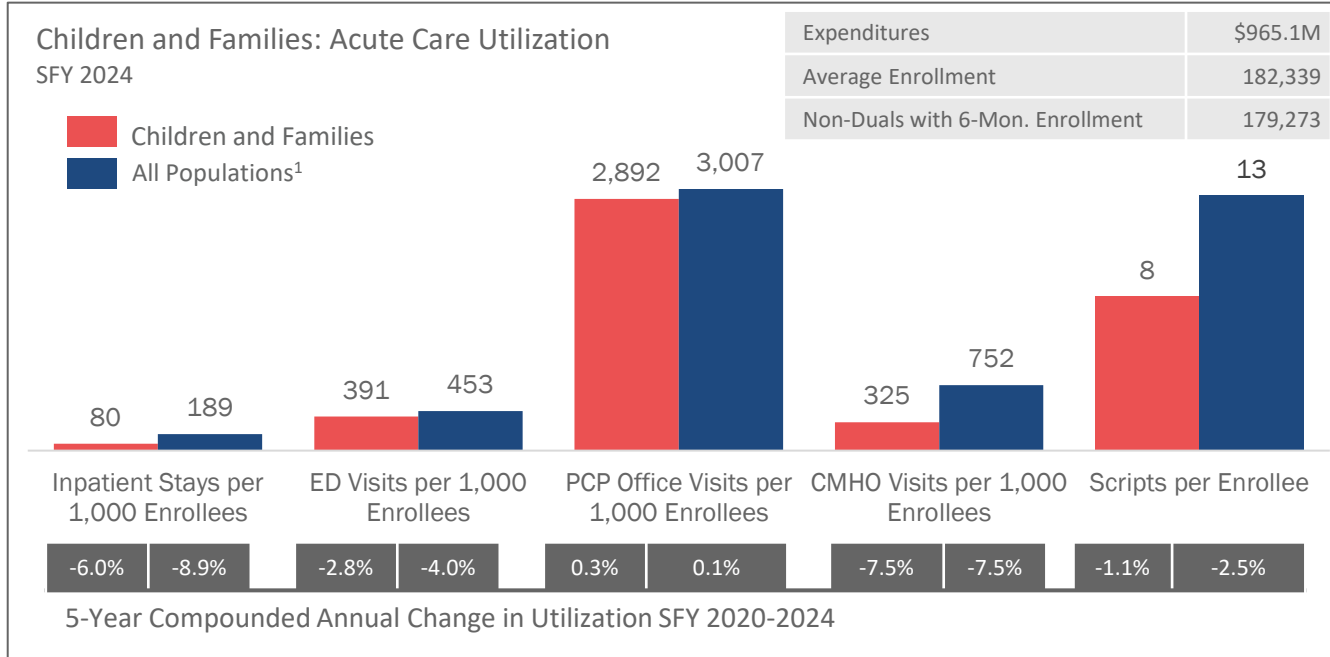
- 27% "prevalence as a % of non-duals" means that among beneficiaries within the Children and Families population that have at least 6 months of enrollment during the year, 27% of the non-duals had claims where "mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population,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

Children and Families: Acute Care Services



Populations: Children and Families

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



- 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 higher growth trends than the overall population for most services.
- Costs per script in FY 2024 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 2024

	Inpatient Stay	ED Visit	Office Visit	CMHO Visit	Script
Children and Families	\$9,326	\$687	\$104	\$173	\$76
Overall	\$7,262	\$720	\$96	\$264	\$94

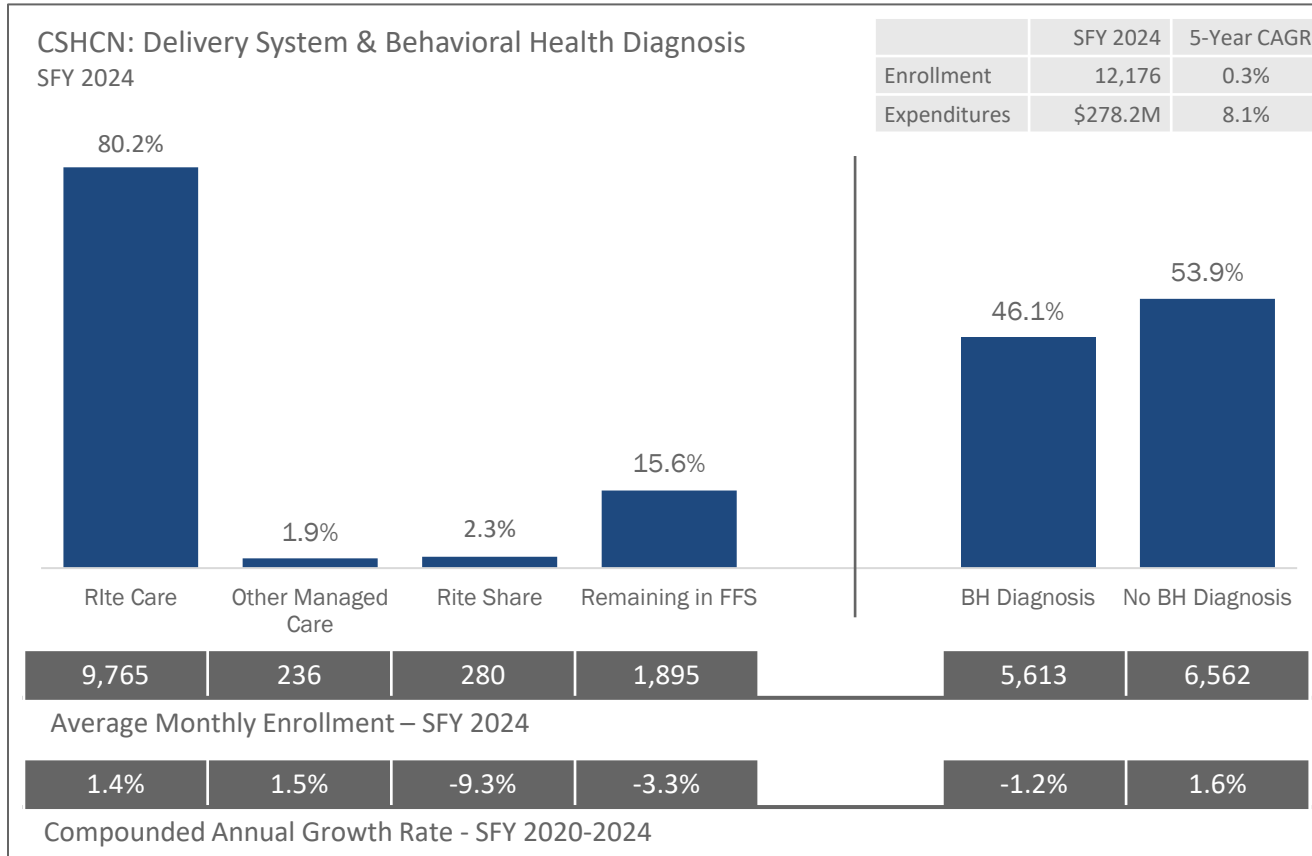
¹ All populations include Medicaid Only beneficiaries Adults with Disabilities, Children and Families, CHSCN, and Expansion beneficiaries with a minimum of 6 months of eligibility.

CSHCN: Managed Care Enrollment



Populations: Children with Special Healthcare 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.



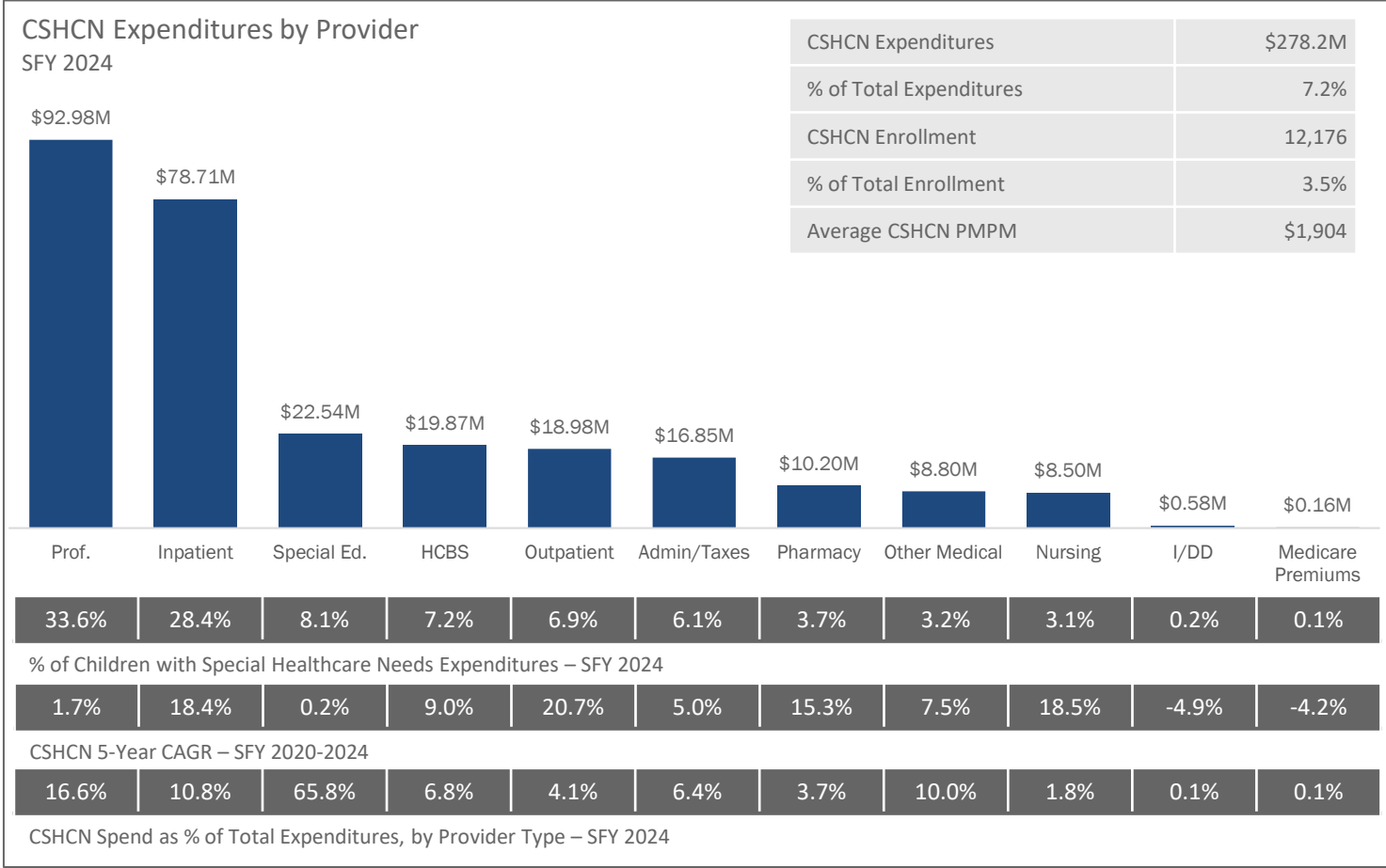
- 80.2% of Children with Special Health Care Needs are enrolled in Rite Care.
 - Beneficiaries in the Rite Care are divided between NHPRI, UHC, and THP.
 - Children in substitute care administered by DCYF are exclusively enrolled in Neighborhood.
- CSHCN who live in institutions have their Medicaid coverage 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
 - 30% of Adoption Subsidy.
- "Other Managed Care" includes beneficiaries who for a portion of the year were enrolled in RHP or Expansion.
- Starting in SFY 2024, EOHHS began providing case management services to all Katie Beckett children through Managed Care.

CSHCN: Expenditures by Provider Type



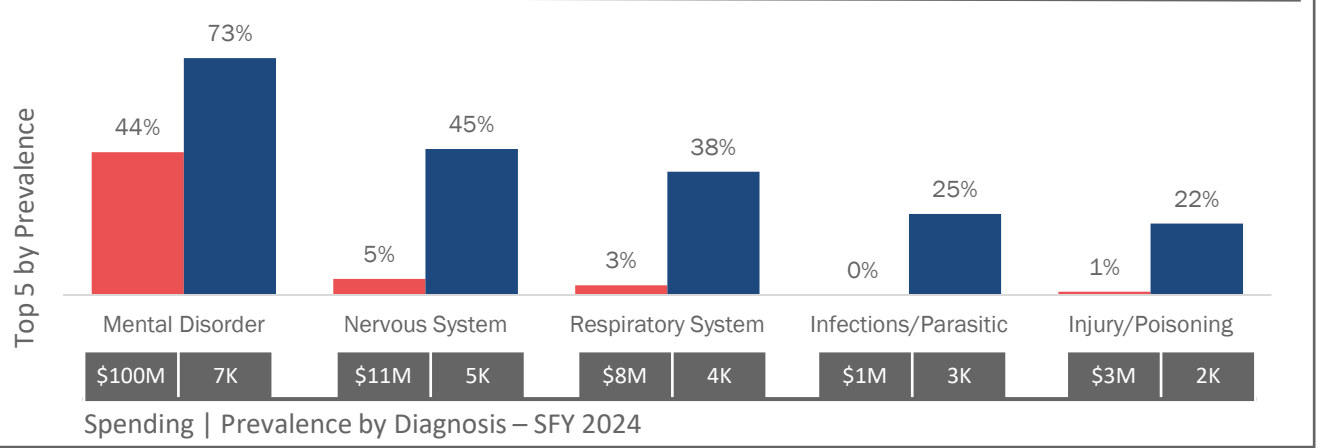
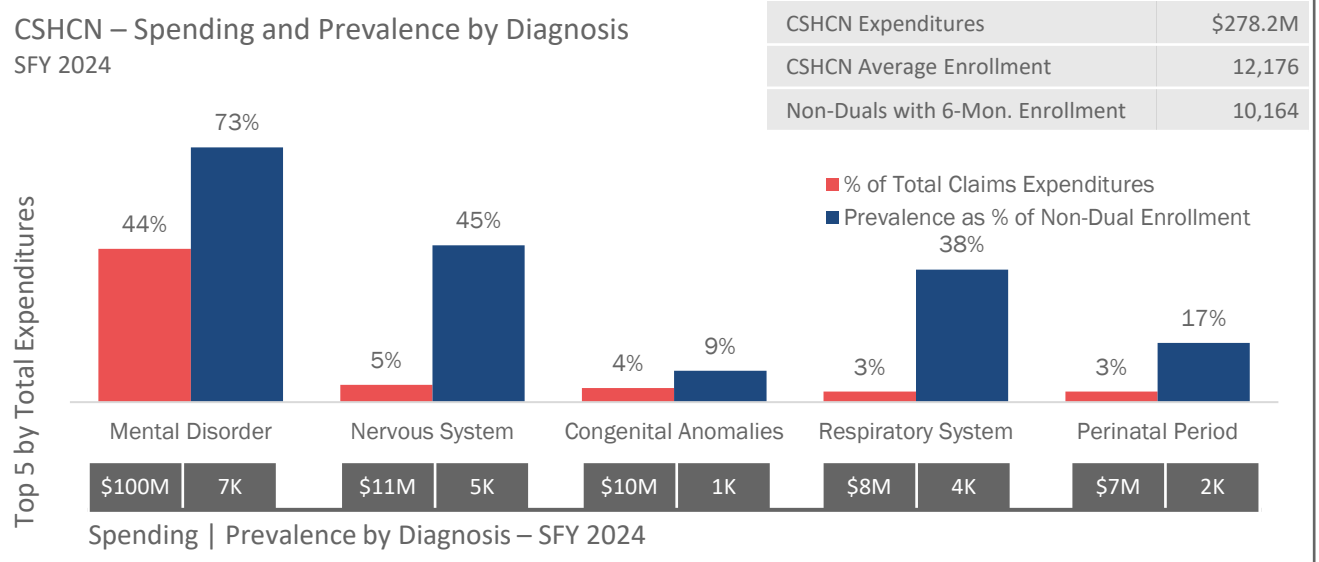
Populations: Children with Special Healthcare Needs

CSHCN expenditures are largely concentrated in professional and inpatient services.



- 62% 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 I/DD, premiums, and nursing facilities and hospice than for the overall population.
- Average annual growth of professional expenditures (1.7%) from SFY 2020 to 2024 was lower than the overall population (4.4%).
- CSHCN Special Education expenditures (\$22.5 M) accounted for 66% of the overall population (\$34.2M) in SFY 2024.

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



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.
- Diagnoses of the nervous system and sense organs are associated with the second-highest expenditures and prevalence 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:

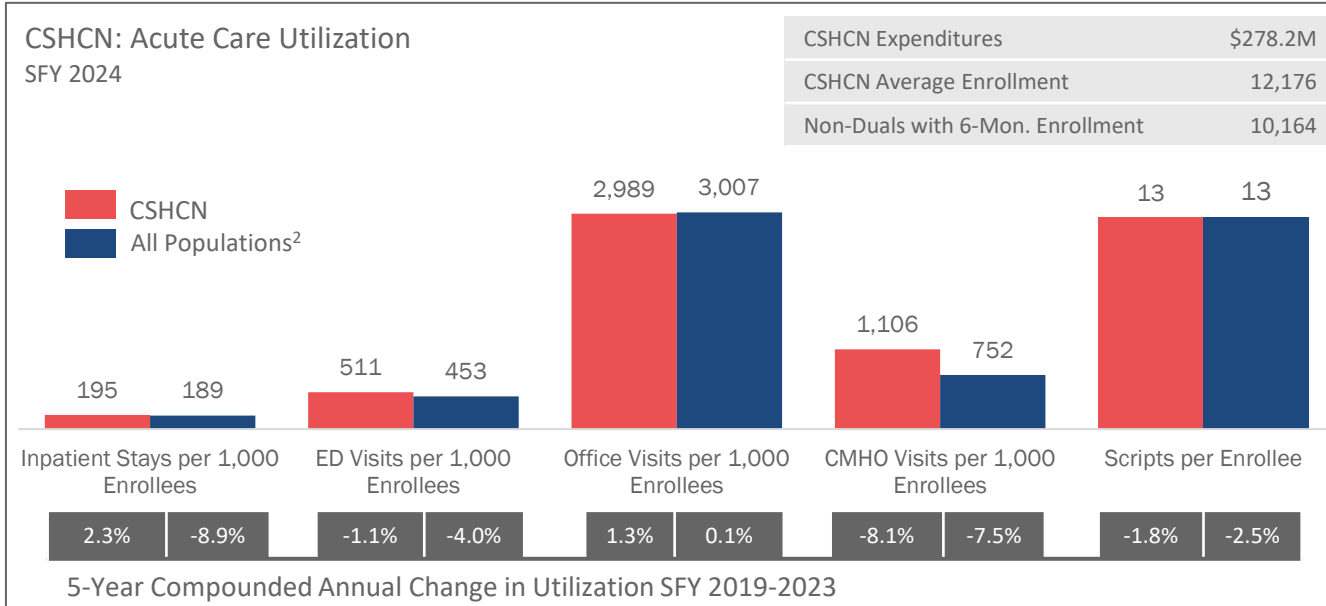
- Of the total claims for this population, 44% of costs were for claims where “mental or behavioral health” was the primary diagnosis.
- 73% "prevalence as a % of non-duals" means that among beneficiaries within the CSHCN population that have at least 6 months of enrollment during the year, 77% of the non-duals had claims where “mental or behavioral health” was the primary diagnosis.

CSHCN: Acute Care Utilization



Populations: Children with Special Healthcare Needs

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



- The CSHCN population experiences more inpatient stays than the overall Medicaid population.
 - Additionally, each stay is more expensive, with an average cost per stay of \$22,948 for CSHCN compared to \$7,262 for the rest of the Medicaid-only population suggesting a longer average length of stay.
- CSHCN rate of utilization for ED is higher than the utilization rates for the overall population.
- CSHCN expenditure growth has been faster than the overall population for all acute care service types except CMHO visits.
- Costs per script and costs per office visit are greater for the CSHCN population than for the overall population (40% and 24%, respectively).

CSHCN: Average Cost per Acute Care Service
SFY 2024

	Inpatient Stay	ED Visit	Office Visit	CMHO Visit	Script
CSHCN	\$22,948	\$711	\$119	\$163	\$132
Overall	\$7,262	\$720	\$96	\$264	\$94

¹ Unduplicated beneficiaries includes count of Medicaid Only beneficiaries with a minimum of 6 months of eligibility.

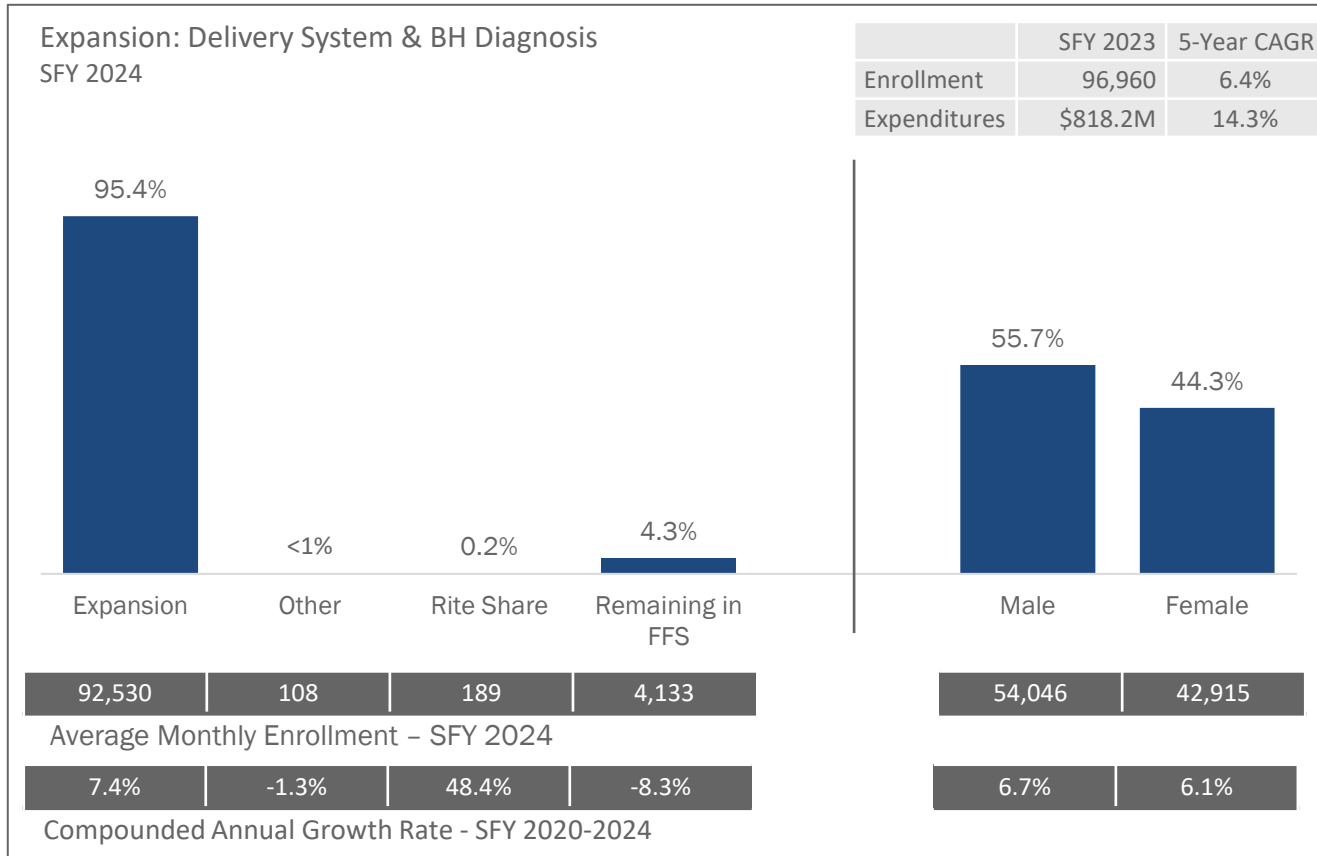
² All populations include Medicaid Only beneficiaries Adults with Disabilities, Children and Families, CHSCN, and Expansion beneficiaries with a minimum of 6 months of eligibility.

Expansion: Managed Care Enrollment



Populations: Expansion Adults

The Expansion population is primarily enrolled in managed care.



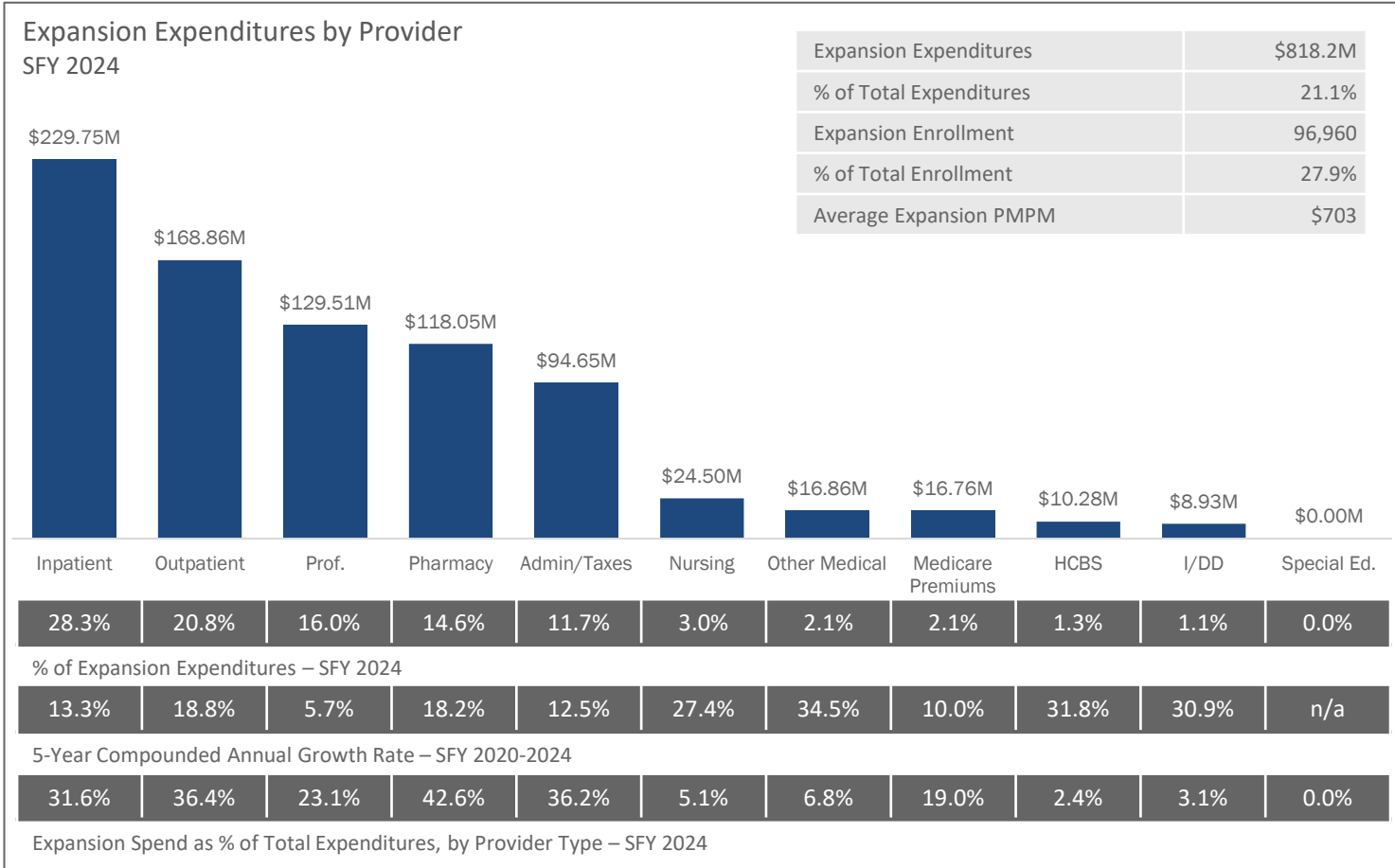
- Expansion includes childless adults who are eligible under the income-based eligibility standards set when the state expanded Medicaid under ACA in 2014. This population also includes people who are classified as previously eligible under criteria for "Adults with Disabilities."
- Spending on the Expansion population totaled \$810.7 million in SFY 2024.
- 96% of the Expansion population enrolled in managed care.
 - Newly eligible beneficiaries 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 beneficiaries 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



Populations: Expansion Adults

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



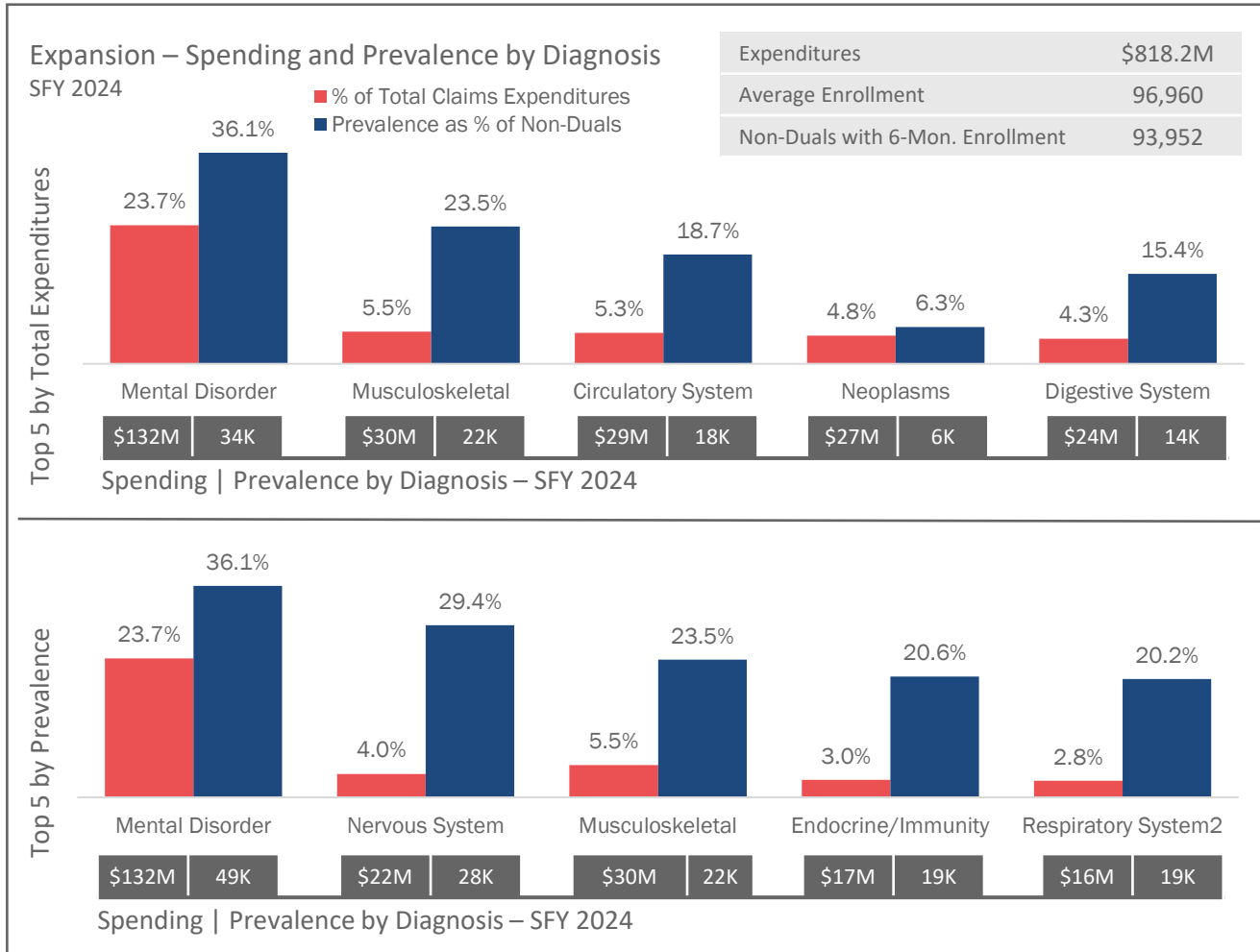
- Expenditure growth for the Expansion population was significantly higher (14%) than the overall population (10%), driven primarily by higher enrollment growth (6% per annum for Expansion compared to 4% overall).
- 64% of the Expansion population expenditures is from inpatient, outpatient and pharmacy services.
- 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

Populations: Expansion Adults

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



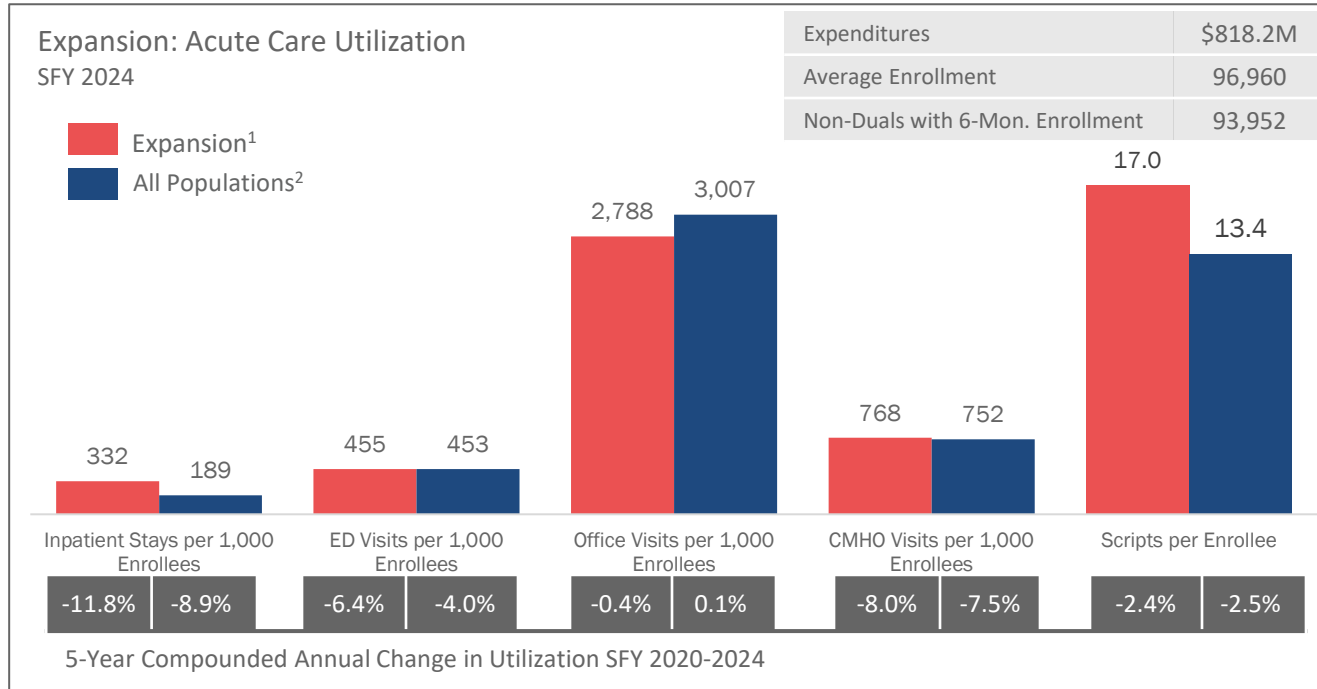
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Among all mental health diagnoses, substance-related disorders are nearly twice as prevalent among the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

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

- 36.1% "prevalence as a % of non-duals" means that among beneficiaries within the Expansion population that have at least 6 months of enrollment during the year, 36.1% of the non-duals had claims where "mental or behavioral health" was the primary diagnosis.
- Of the total claims for this population, 23.7% of costs were for claims where "mental or behavioral health" was the primary diagnosis.

Expansion: Acute Care Utilization

Populations: Expansion Adults



- 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 -6.4% per year on average over the five-year period.
- The overall cost per script (excluding rebates) is slightly higher compared 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 2024

	Inpatient Stay	ED Visit	Office Visit	CMHO Visits	Script
Expansion	\$4,491	\$742	\$82	\$287	\$99
Overall	\$7,262	\$720	\$96	\$264	\$94

¹ Unduplicated beneficiaries includes count of Medicaid Only beneficiaries with a minimum of six months of eligibility.

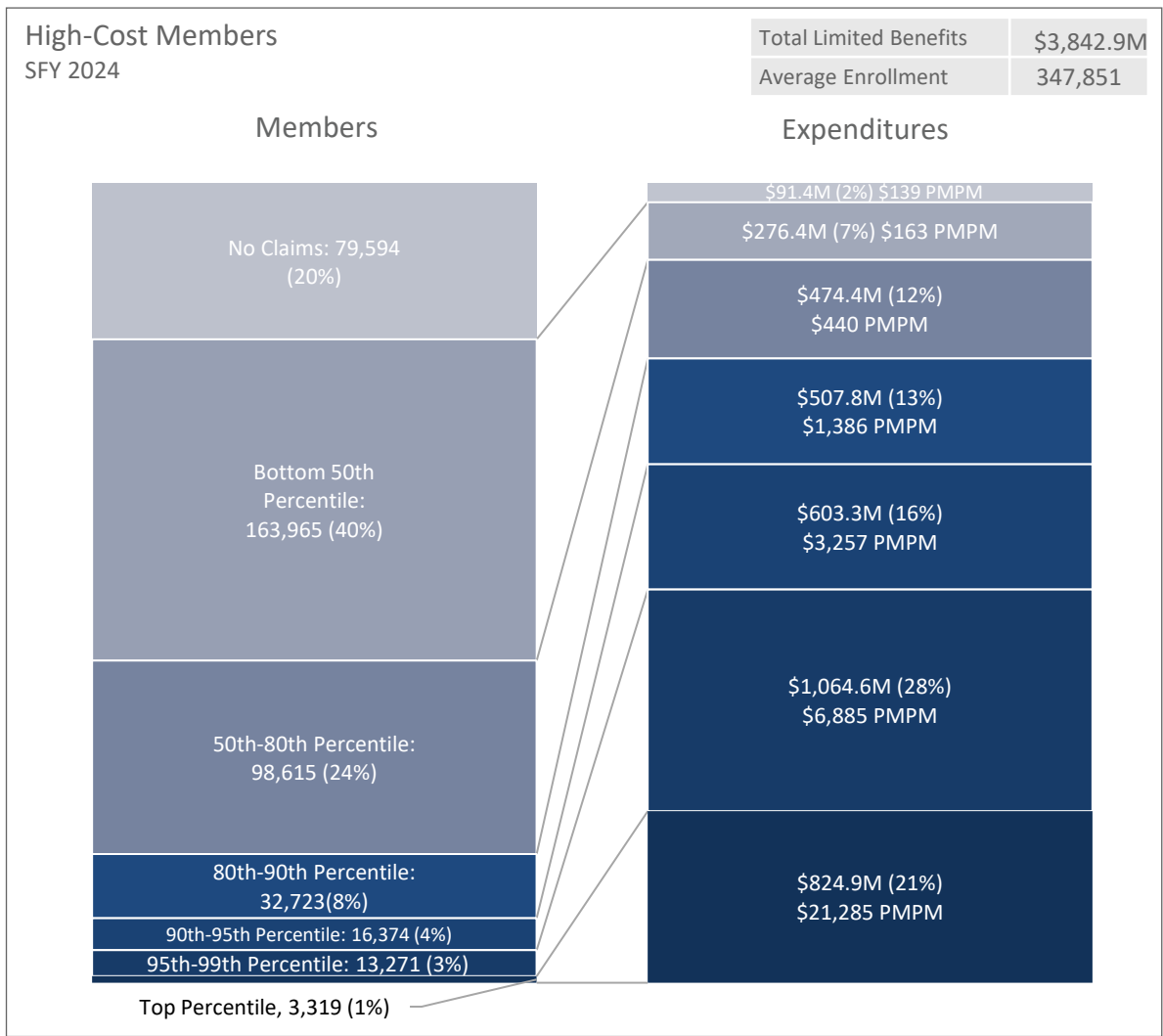
² All populations include Medicaid Only beneficiaries Adults with Disabilities, Children and Families, CHSCN, and Expansion beneficiaries with a minimum of six months of eligibility.

Miscellany & Exclusions



56	High-Cost Beneficiaries FY 2024 Snapshot Behavioral Health Diagnosis
58	Hospital Spending Disproportionate Share Hospital/Graduate Medical Education All Hospital Spending, by Hospital and Type of Expenditure
60	Limited Benefits FY 2024 Snapshot Five Year History
61	Medicaid Central Management Costs FY 2024 Snapshot: By Department Five Year History
62	CMS Core Measures Children and Adult CMS Scorecard Benchmarking
68	Acronyms and Definitions General Acronyms, Diagnosis, and Provider Types

High-Cost Beneficiaries: Summary



- Medicaid claims expenditures are highly concentrated:
 - The top 1% of users account for 21% of all benefit expenditures with an average PMPM of \$21,285, or over \$250,000 in spending per year.
 - The top 20th percentile of Medicaid users account for 78% of all expenditures, with an average PMPM of \$8,203.
 - The bottom 50th percentile of Medicaid users with any claims activity have an average PMPM of \$163.
- Beneficiaries with no claims activity account for 20% of enrollment within fiscal year 2024. 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 beneficiaries typically have multiple complex conditions, requiring care coordination across a variety of provider types.
- Most high-cost beneficiaries residing within the community belong to the Adults with Disabilities or Expansion populations.

High-Cost Beneficiaries: Behavioral Health Diagnoses and Expenditures



Miscellaneous

Beneficiaries 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 beneficiary without such a condition.

Enrollment and Expenditures among beneficiaries with a Behavioral Health Diagnosis
SFY 2024

Primary Payer and Diagnosis ¹	Average Enrollment	% of Enrollment	Overall PMPM	% of Expenditures
Medicaid Only				
I/DD Community (BHDDH)	1,268	0.4%	\$9,868	6.1%
Other Developmental Disability	11,252	3.9%	\$1,591	8.7%
Substance Use Disorder	8,993	3.1%	\$3,075	13.4%
Other Behavioral/Mental Health	34,567	11.9%	\$1,475	24.7%
Subtotal - Any BH-Related Diagnoses	56,029	19.2%	\$1,937	52.6%
No BH-Related Diagnosis	235,290	80.8%	\$413	47.1%
Overall - Medicaid Only	291,369	100.0%	\$708	100.0%
Duals				
I/DD Community (BHDDH)	2,471	5.8%	\$10,726	25.5%
Other Developmental Disability	160	0.4%	\$4,103	0.6%
Substance Use Disorder	884	2.1%	\$1,737	1.5%
Other Behavioral/Mental Health	7,367	17.3%	\$3,003	21.3%
Subtotal - Any BH-Related Diagnoses	10,882	25.5%	\$4,543	47.5%
No BH-Related Diagnosis	31,735	74.5%	\$1,677	51.2%
Overall - Duals	42,617	100.0%	\$2,441	100.0%

- Among both the Dual and Medicaid Only populations, beneficiaries with a BH diagnosis account for a disproportionate share of expenditures:
 - 19.2% of Medicaid Only beneficiaries have a BH-related diagnosis and account for over half of expenditures.
 - 25.5% of Duals have a BH diagnosis and account for 47.5% of expenditures.
- Overall, the PMPM for a non-dual beneficiary with a BH diagnosis was \$1,937 compared to \$413 PMPM for beneficiaries without any BH diagnoses.

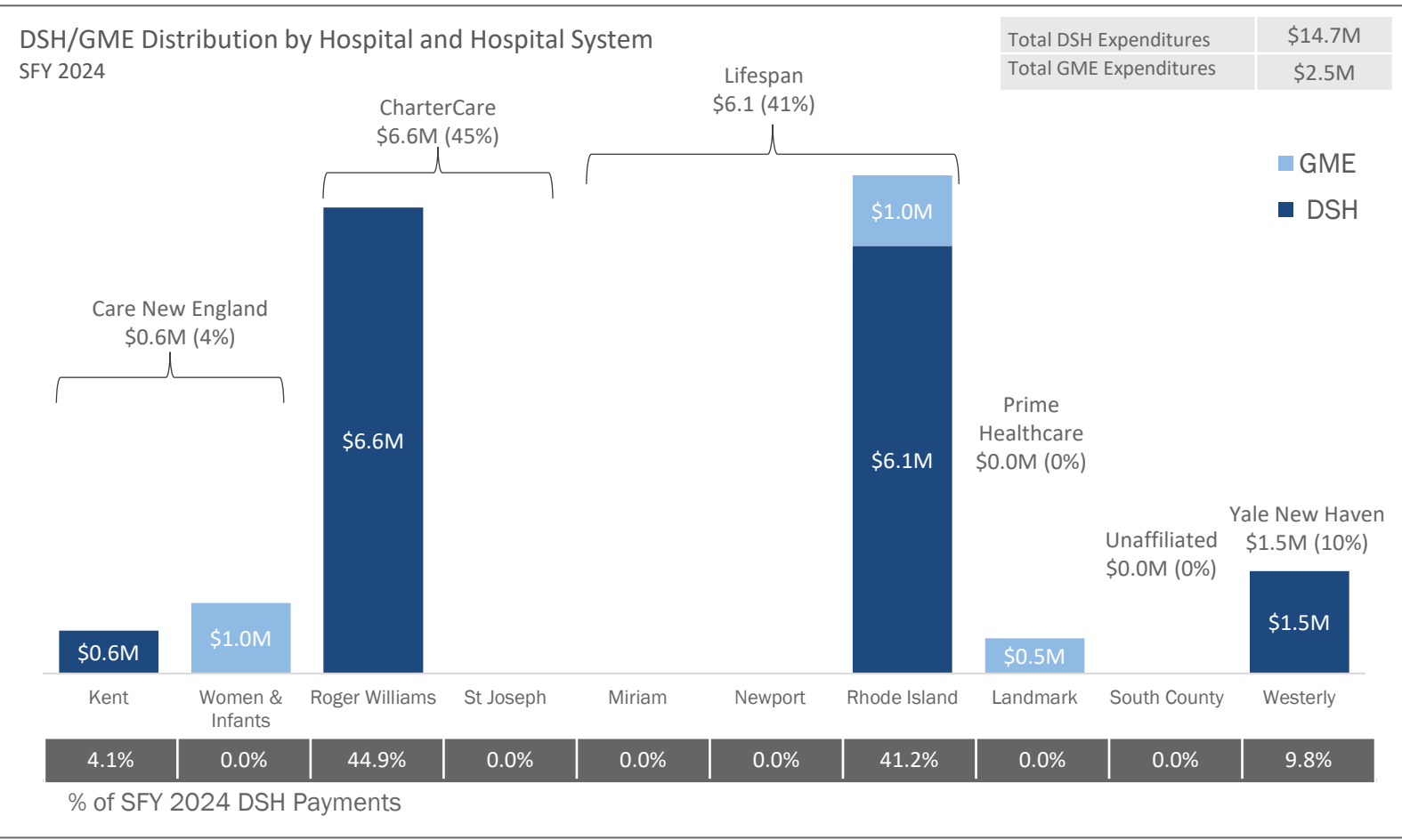
¹ Beneficiaries had a claim with an I/DD community provider or a primary diagnoses indicating specified behavioral health condition. If multiple BH categories applicable, beneficiary assignment based on prioritization: I/DD (BHDDH), Other DD, SUD, Other BH/MH.

Exclusions: Hospital Spending DSH/GME



Miscellaneous

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. DSH payments are to hospitals that serve a large number of low-income patients and receive additional payments from Medicare and Medicaid to help cover the costs of providing care to uninsured individuals.
- In SFY 2024, Rhode Island DSH payments totaled **\$14.7 million**, roughly ten percent of SFY 2023’s DSH payments.
- EOHHS paid \$2.5 million in GME payments in SFY 2024. GME are state-only payments in SFY 2024.
- Over 40% of the year’s DSH payments went to Rhode Island Hospital, and nearly 45% went to Roger Williams Hospital. Both of these are in Providence.
- Care New England, Lifespan, and CharterCare are multi-hospital health systems in Rhode Island.

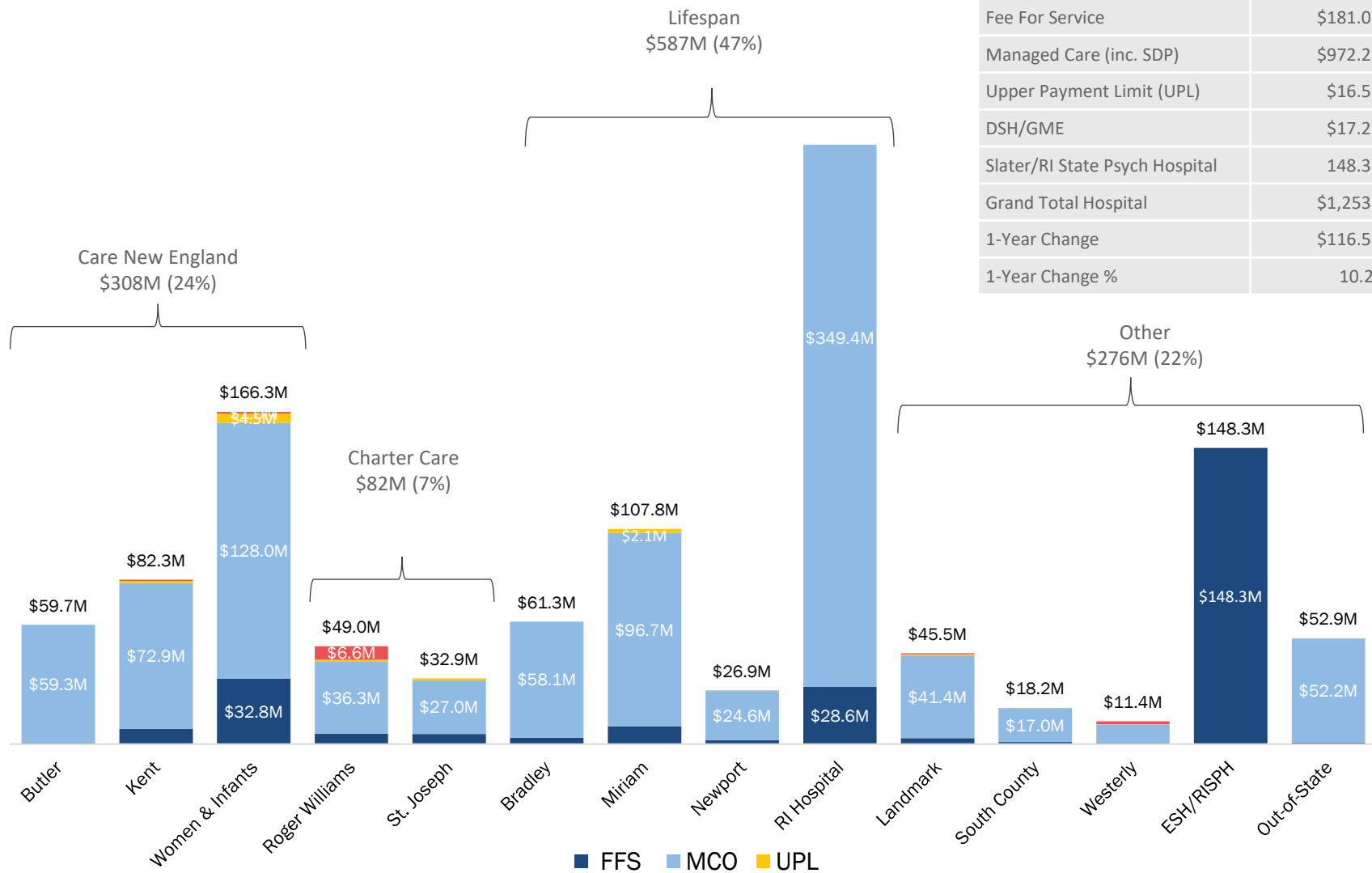
Rhode Island EOHHS also makes supplemental Upper Payment Limit (UPL) expenditures to hospitals. These supplemental payments are tied directly to FFS expenditures for Medicaid-eligible beneficiaries and are included in hospital spending within the general Expenditure Report.

In SFY 2024, EOHHS made \$16.5 million in UPL payments.

All Hospital Spending, SFY 2024



Miscellaneous



Fee For Service	\$181.0M
Managed Care (inc. SDP)	\$972.2M
Upper Payment Limit (UPL)	\$16.5M
DSH/GME	\$17.2M
Slater/RI State Psych Hospital	148.3M
Grand Total Hospital	\$1,253M
1-Year Change	\$116.5M
1-Year Change %	10.2%

- Medicaid paid \$1,254 million to hospitals, including:
 - Rhode Island DSH/GME payments totaled **\$17.2 million**.
 - UPL payments totaled **\$16.5 million**.
 - State Directed Payments (SDP) to Hospitals (via the health plans) totaled **\$287.7 M**
 - \$782.4 million** for claims activity
- 70% of the year's hospital payments went to two hospital systems:
 - Care New England
 - Lifespan
- Rhode Island Hospital alone accounted for \$283.4 million (35%) in the public's spending.

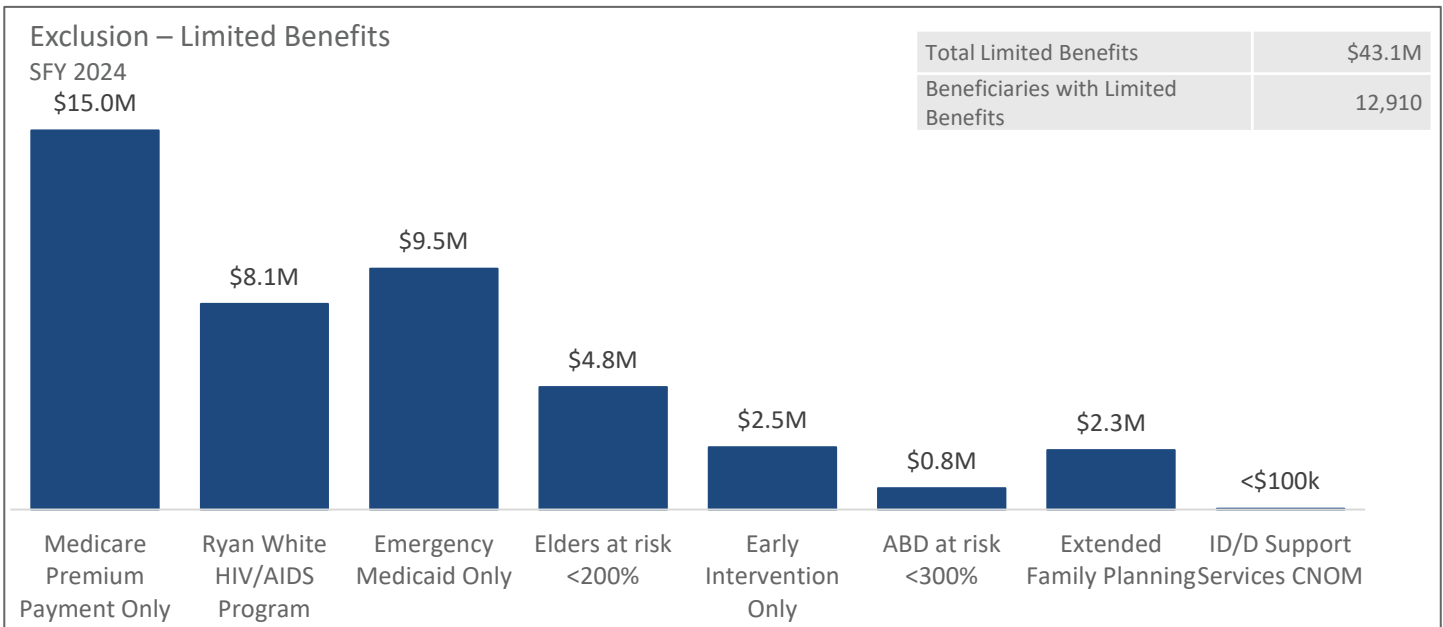
	Total Hospital Spending
SFY 2020	\$880.6M
SFY 2021	\$961.9M
SFY 2022	\$1,149M
SFY 2023	\$1,137M
SFY 2024	\$1,254M
5-Year CAGR %	9.2%

Exclusions: Limited Benefits

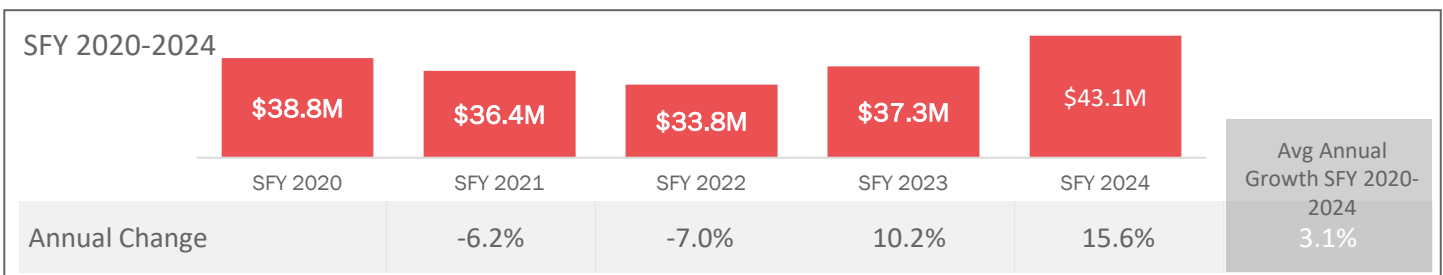


Miscellaneous

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



- Expenditures for beneficiaries with limited benefits totaled \$43.1 million in SFY 2024.
- Partial Duals: Payments for Medicare premiums for qualifying individuals account for \$15.0 million. In SFY 2024, EOHHS subsidized the Medicare premiums for an average of 7,826 low-income elders each month with limited Medicaid.
- Costs Not Otherwise Matchable (CNOM) and Partial Emergency Services: Limited benefits not traditionally eligible for federal Medicaid funding match, that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible. Includes services covered by the Office of Healthy Aging and the Ryan White HIV/AIDS program.
- Note: prior years' Expenditure Reports have reported spending at the Department of Corrections (RIDOC) among the CNOM and Limited Benefits exclusions. These expenditures are not Medicaid-eligible. Rather, RIDOC simply uses the State's fiscal intermediary to process medical claims and so they appear within the MMIS transactions.



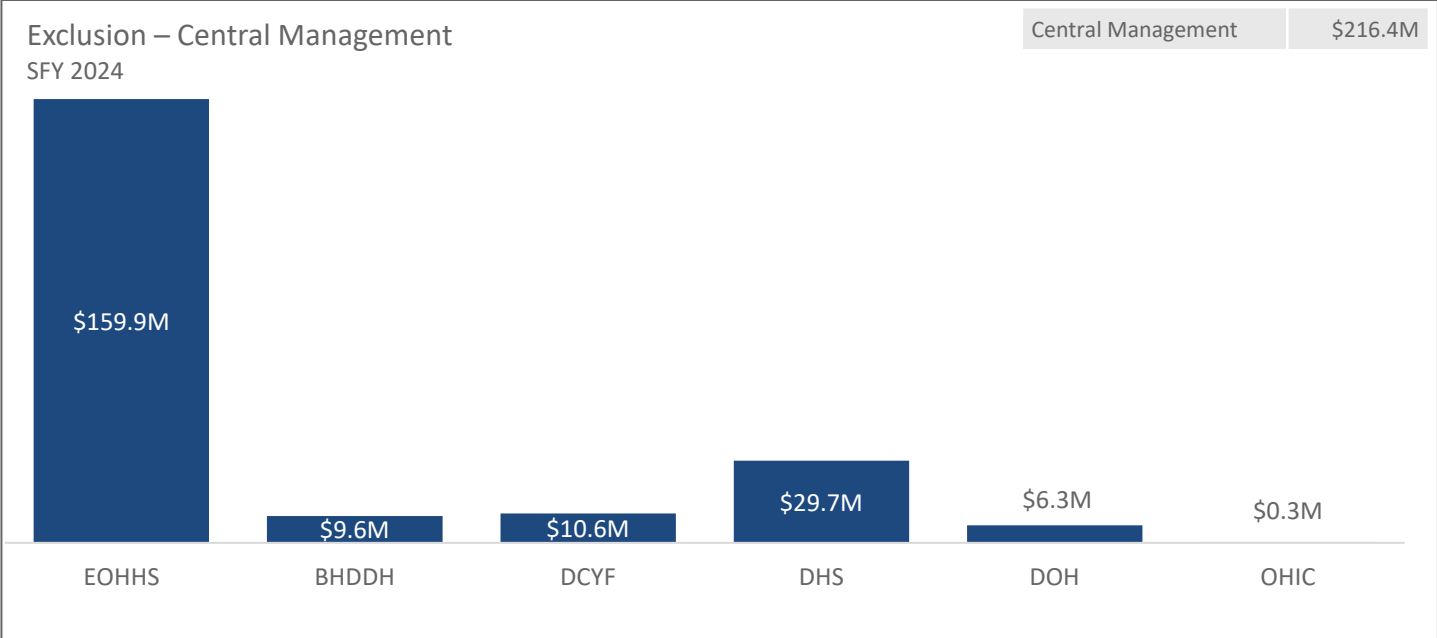
¹ Calculated as compounded annual growth rate (CAGR) over period SFY 2020-2024 as shown.

Exclusions: Central Management

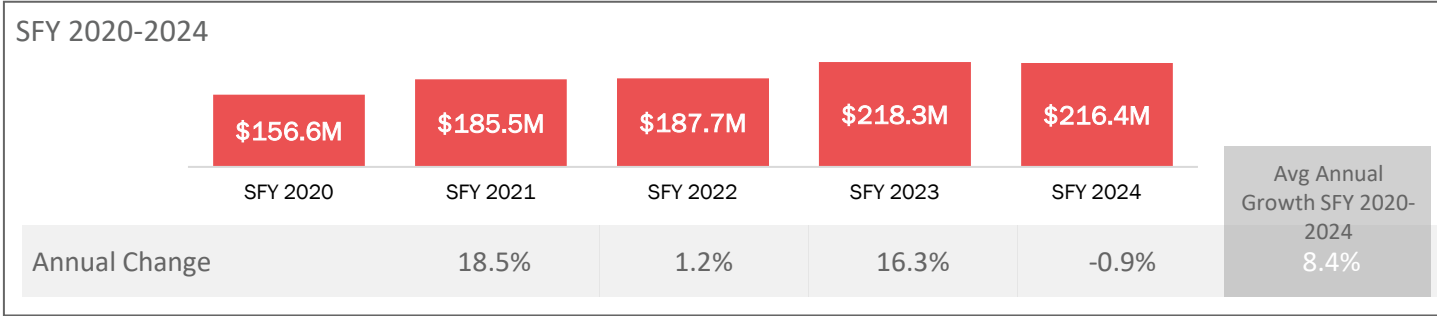


Miscellaneous

EOHHS is the Single State Agency for Administering the Medicaid Program and accounts for 74% of all central management expenditures in SFY 2024.



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



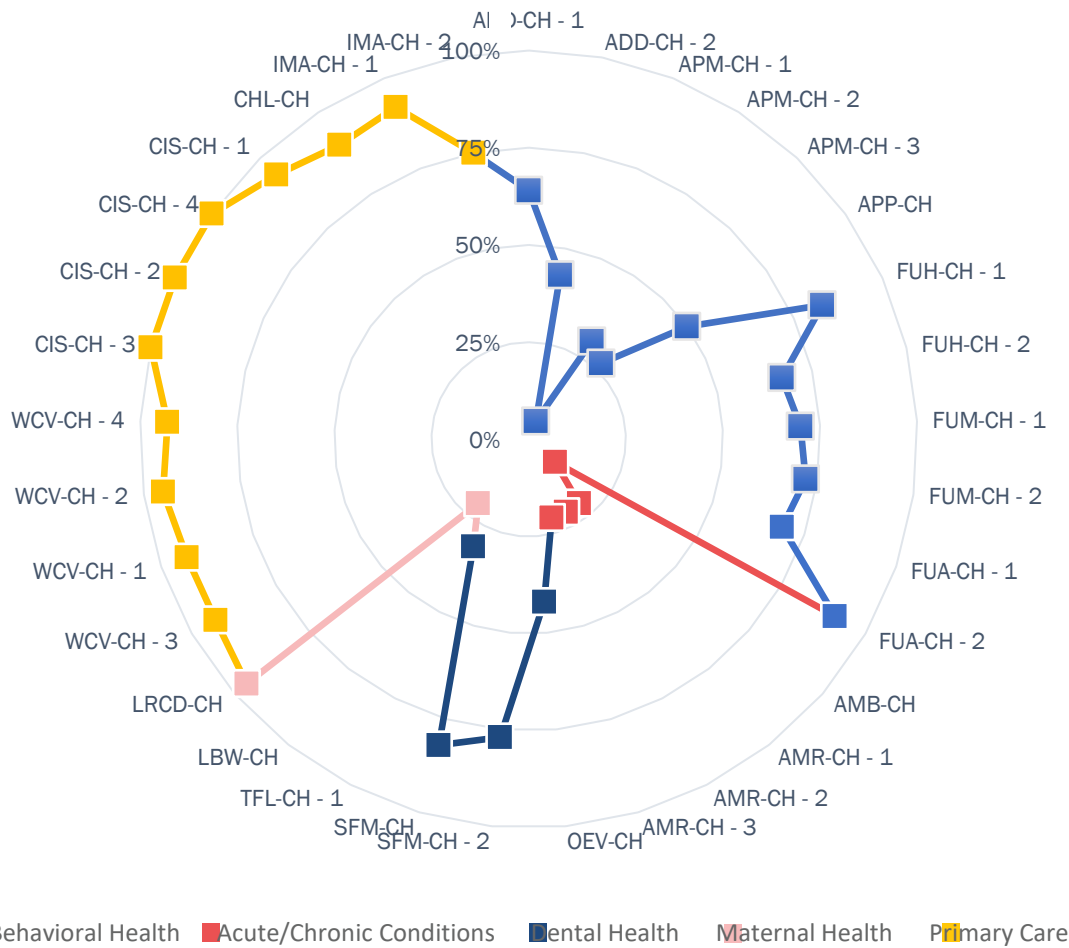
Note Regarding Methodology

- Starting with the FY 2020 version of the report, Central Management expenditures has been composed of Medicaid administrative expenditures made by all departments, consistent with the requirement of 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



Miscellaneous



- 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 2023**, Rhode Island’s performance exceeded the 50th percentile in 27 out of the 39 measures included in this analysis and exceeded the 75th percentile in 20. (Note: Some of these measures’ success is indicated by a lower rate of incidence, e.g., LBW-CH: Low Birth Weight).
- As of date of publication, the FFY 2024 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 2023 Child and Adult Health Care Quality Measures available at: <https://data.medicaid.gov/dataset/e85033c7-367e-467e-9e81-8e85048102b8>

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

Core Set Measure Definitions - Children



Miscellaneous

Domain Measure	Measure Description	RI Rate	1st Quartile	Median	3rd Quartile	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)	48.1	42.3	45.8	50.4	64%
ADD-CH - 2	ADHD Med Follow-Up (9 Months) - % Newly Prescribed ADHD Med with ≥2 Follow-Ups (Ages 6-12)	52.6	48.9	53.5	59.9	43%
APM-CH - 1	Metabolic Monitoring - % on Antipsychotics with Glucose Testing (Ages 1-17)	43	49.5	54.7	59.0	5%
APM-CH - 2	Metabolic Monitoring - % on Antipsychotics with Cholesterol Testing (Ages 1-17)	31	28.8	35.1	43.0	30%
APM-CH - 3	Metabolic Monitoring - % on Antipsychotics with Glucose & Cholesterol Testing (Ages 1-17)	28.1	27.1	33.3	41.6	27%
APP-CH	Psychosocial Care (Antipsychotic New Rx) - % with Psychosocial Care (1st-Line Tx) (Ages 1-17)	62.2	57.8	62.2	68.1	50%
FUH-CH - 1	Follow-Up After Mental Illness Hospitalization (7 Days) - % w/ Follow-Up (Ages 6-17)	60.4	39.8	49.1	57.6	83%
FUH-CH - 2	Follow-Up After Mental Illness Hospitalization (30 Days) - % w/ Follow-Up (Ages 6-17)	77.5	64.0	74.1	80.5	67%
FUM-CH - 1	Follow-Up After ED Visit (30 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 6-17)	60.6	42.7	51.5	61.2	70%
FUM-CH - 2	Follow-Up After ED Visit (7 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 6-17)	75	61.0	70.2	77.0	72%
FUA-CH - 1	Follow-Up After ED Visit (7 Days) - % w/ Follow-Up (ED Visits for SUD or Overdose) (Ages 6-17)	28.3	19.7	23.6	31.4	69%
FUA-CH - 2	Follow-Up After ED Visit (30 Days) - % w/ Follow-Up (ED Visits for SUD or Overdose) (Ages 6-17)	51.7	30.8	33.8	46.6	91%
Care of Acute and Chronic Conditions						
AMB-CH	ED Visits - Emergency Department Visits per 1,000 Beneficiary Months (Ages 0-19)	29.3	33.3	36.4	40.8	9%
AMR-CH - 1	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 12-18)	65.1	65.5	69.0	73.1	21%
AMR-CH - 2	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 5-11)	68.7	71.4	76.0	81.3	21%
AMR-CH - 3	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 5-18)	66.9	68.4	71.8	77.1	21%
Dental and Oral Health Services						
OEV-CH	Oral Exams - % w/ Comprehensive or Periodic Oral Evaluation (Ages <1-20)	42.3	39.0	42.8	47.6	42%
SFM-CH - 2	Sealant on Molars - % w/ Sealant on at Least One Permanent First Molar Tooth by Age 10	57.4	40.1	48.1	56.1	77%
SFM-CH	Sealant on Molars - % w/ Sealant on at All Four Permanent First Molar Tooth by Age 10	42.8	29.7	35.0	41.6	82%
TFL-CH - 1	Fluoride Treatments - % w/ at Least 2 Topical Fluoride Applications (Ages 1-20)	17.5	16.7	19.0	22.7	31%
Maternal and Perinatal Health						
LBW-CH	Low Birth Weight - % Live Births <2,500g	9.1	9.2	10.4	11.3	21%
LRCD-CH	Low-Risk Cesarean Delivery - % C-Section (Nulliparous, Term, Cephalic Presentation)	29.2	22.4	24.2	26.5	96%

Core Set Measure Definitions - Children, cont.



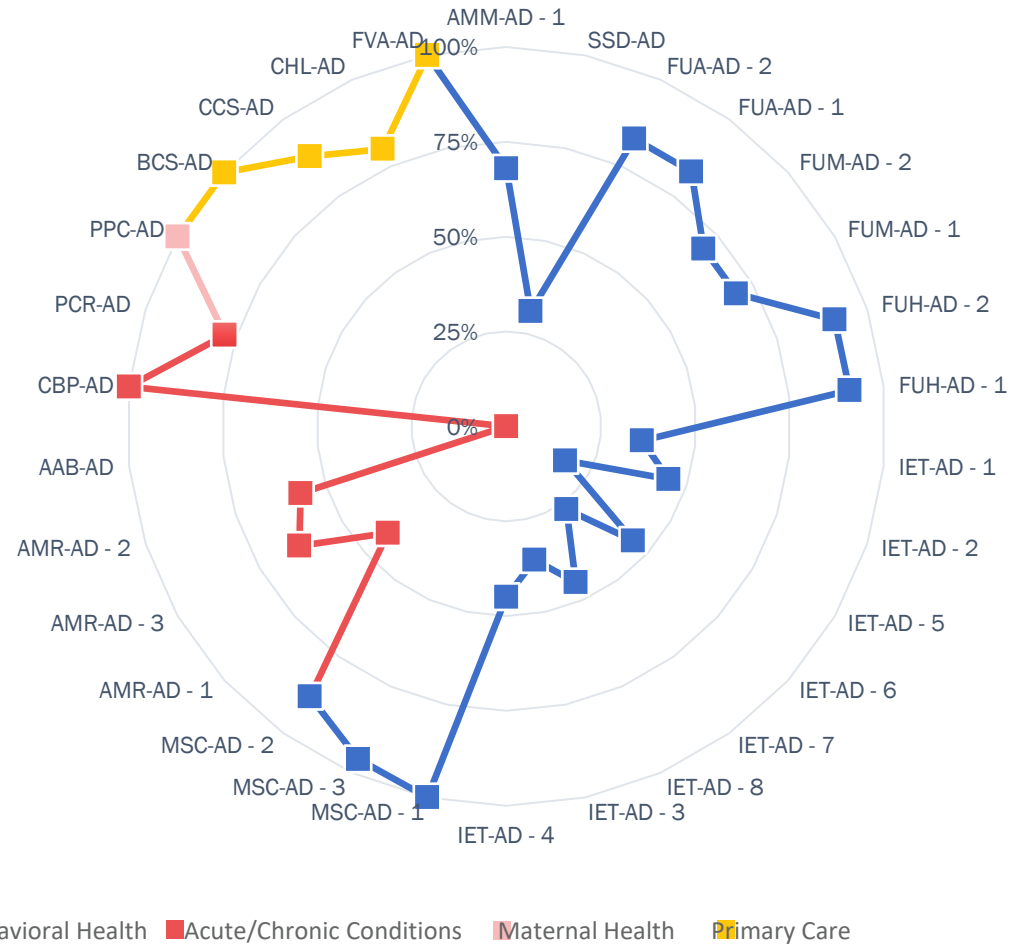
Miscellaneous

Domain Measure	Measure Description	RI Rate	1st Quartile	Median	3rd Quartile	RI 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)	68.4	50.5	53.6	60.5	93%
WCV-CH - 1	Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 12-17)	63	42.3	48.9	54.8	93%
WCV-CH - 2	Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 18-21)	39.7	19.8	22.9	29.2	95%
WCV-CH - 4	Well-Care Visits - % w/ 1 Well-Care Visit (Primary Care/OB-GYN) (Ages 3-21)	61	43.2	46.7	53.3	93%
CIS-CH - 3	Immunization (Combo 3) - % Up to Date on Immunizations (Combo 3) by Age 2	79.5	61.4	68.2	71.3	100%
CIS-CH - 2	Immunization (Flu) - % with 2 Flu Vaccinations by Age 2	66.4	36.8	46.9	52.2	100%
CIS-CH - 4	Immunization (Combo 10) - % Up to Date on Immunizations (Combo 10) by Age 2	57.9	28.5	35.6	41.1	100%
CIS-CH - 1	Immunization (MMR) - % with MMR Vaccination by Age 2	90.9	83.8	85.9	87.6	94%
CHL-CH	Chlamydia Screening (Ages 16-20) - % Screened for Chlamydia	61.9	42.5	45.9	59.0	90%
IMA-CH - 1	HPV Vaccine - % Completing HPV Vaccine Series by Age 13	47.4	30.9	36.0	40.3	92%
IMA-CH - 2	Meningococcal & Tdap Vaccines - % Receiving Meningococcal & Tdap by Age 13	83.9	75.7	80.2	83.9	75%
WCC-CH - 1	Weight Assessment & Counseling (BMI) - BMI Percentile Documentation (Ages 3-17)	90.2	72.3	77.1	83.2	100%
WCC-CH - 2	Weight Assessment & Counseling (Nutrition) - Counseling for Nutrition (Ages 3-17)	84	62.7	71.1	76.1	100%
WCC-CH - 3	Weight Assessment & Counseling (Physical Activity) - Counseling for Physical Activity (Ages 3-17)	82.7	58.3	66.4	71.3	100%
W30-CH - 2	Well-Child Visits - % w/ 6+ Well-Child Visits (0-15 Months)	73.8	54.3	59.6	62.9	97%
W30-CH - 1	Well-Child Visits - % w/ 2+ Well-Child Visits (15-30 Months)	79.2	60.9	65.6	71.4	93%
LSC-CH	Lead Screening - % with Blood Test for Lead Poisoning by Age 2	75.7	62.6	71.8	75.7	75%

CMS Medicaid Scorecard – Adult Core Set



Miscellaneous



■ Behavioral Health ■ Acute/Chronic Conditions ■ Maternal Health ■ Primary Care

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

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- 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 2023**, Rhode Island’s performance exceeded the 50th percentile in 19 out of the 30 measures included in this analysis and exceeded the 75th percentile in 14. (Note: Some of these measures’ success is indicated by a lower rate of incidence, e.g., LBW-CH: Low Birth Weight).
- As of date of publication, the FFY 2024 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 2023 Child and Adult Health Care Quality Measures available at: <https://data.medicare.gov/dataset/e85033c7-367e-467e-9e81-8e85048102b8>

Core Set Measure Definitions - Adults



Miscellaneous

Domain Measure	Measure Description	RI Rate	1st Quartile	Median	3rd Quartile	RI Percentile
Behavioral Health Care						
AMM-AD - 1	MDD Meds (12 Wks) - % Diagnosed with MDD who Remained on an Antidepressant > 12 Wks (Ages 18-64)	63.0	56.3	60.9	64.0	68%
SSD-AD	Metabolic Monitoring - % on Antipsychotics with Diabetes Testing (Ages 18-65)	75.8	75.6	76.8	78.8	31%
FUA-AD - 2	Follow-Up After ED Visit (30 Days) - % w/ Follow-Up (ED Visits for SUD or Overdose) (Ages 18-64)	49.2	29.1	37.5	42.6	83%
FUA-AD - 1	Follow-Up After ED Visit (7 Days) - % w/ Follow-Up (ED Visits for SUD or Overdose) (Ages 18-64)	34.1	18.9	24.8	28.4	83%
FUM-AD - 2	Follow-Up After ED Visit (30 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 18-64)	70.8	47.7	57.2	72.5	70%
FUM-AD - 1	Follow-Up After ED Visit (7 Days) - % w/ Follow-Up (ED Visits for Mental Illness) (Ages 18-64)	58.6	32.9	35.6	60.6	70%
FUH-AD - 2	Follow-Up After Mental Illness Hospitalization (30 Days) - % w/ Follow-Up (Ages 18-64)	70.3	46.3	62.7	63.6	91%
FUH-AD - 1	Follow-Up After Mental Illness Hospitalization (7 Days) - % w/ Follow-Up (Ages 18-64)	50.9	27.0	33.1	40.3	91%
IET-AD - 1	Alcohol Use Disorder (14 Days) - % of New Episodes within 14 Days of Initiation of SUD Treatment (Ages 18-64)	40.5	39.9	43.9	46.3	36%
IET-AD - 2	Alcohol Use Disorder (34 Days) - % of New Episodes within 34 Days of Engagement w/ SUD Treatment (Ages 18-64)	14.5	11.9	14.6	15.4	45%
IET-AD - 5	Other SUD (14 Days) - % of New Episodes within 14 Days of Initiation of SUD Treatment (Ages 18-64)	35.7	35.7	43.2	47.6	18%
IET-AD - 6	Other SUD (34 Days) - % of New Episodes within 34 Days of Engagement w/ SUD Treatment (Ages 18-64)	11.4	9.2	11.5	14.1	45%
IET-AD - 7	Total SUD (14 Days) - % of New Episodes within 14 Days of Initiation of SUD Treatment (Ages 18-64)	40.5	40.0	48.8	54.4	27%
IET-AD - 8	Total SUD (34 Days) - % of New Episodes within 34 Days of Engagement w/ SUD Treatment (Ages 18-64)	15.0	11.5	16.0	19.3	45%
IET-AD - 3	Opioid Use Disorder (14 Days) - % of New Episodes within 14 Days of Initiation of SUD Treatment (Ages 18-64)	57.5	54.0	63.1	66.0	36%
IET-AD - 4	Opioid Use Disorder (34 Days) - % of New Episodes within 34 Days of Engagement w/ SUD Treatment (Ages 18-64)	30.2	16.7	31.4	37.9	45%
MSC-AD - 1	Smoking and Tobacco Use - % Advised to Quit (Ages 18-64)	83.6	69.3	73.0	75.8	100%
MSC-AD - 3	Smoking and Tobacco Use - % Discussed or Provided Cessation Methods or Strategies (Ages 18-64)	56.4	41.7	43.6	48.5	96%
MSC-AD - 2	Smoking and Tobacco Use - % Discussed or Recommended Cessation Medications (Ages 18-64)	59.7	46.3	51.5	54.5	88%

Core Set Measure Definitions - Adults



Miscellaneous

Domain Measure	Measure Description	RI Rate	1st Quartile	Median	3rd Quartile	RI Percentile
Care of Acute and Chronic Conditions						
AMR-AD - 1	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 19-50)	57.2	55.1	57.9	62.2	42%
AMR-AD - 3	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 51-64)	62.5	56.3	59.8	63.3	63%
AMR-AD - 2	Asthma Medication Ratio (0.50+) - % Persistent Asthma, Controller Meds/Total Meds (Ages 19-64)	58.8	56.0	57.7	61.9	57%
AAB-AD	Bronchitis - % of Episodes that did not Result in an Antibiotic Dispensing Event (Ages 18-64)	32.7	43.2	53.5	57.1	0%
CBP-AD	Hypertension - % Whose Blood Pressure was Adequately Controlled (Ages 18-64)	70.6	56.0	61.5	63.5	100%
PCR-AD	Readmission - Ratio of Observed All-Cause Readmissions to Expected Readmissions (Ages 18-64)	1.1	0.9	1.0	1.1	78%
Maternal and Perinatal Health						
PPC-AD	Postpartum Follow-Up (7-84 Days) - % Women who had a Postpartum Care Visit on or Between 7 and 84 Days :	86.9	72.7	75.6	80.6	100%
Primary Care Access and Preventive Care						
BCS-AD	Mammograms - % of Women who had a Mammogram to Screen for Breast Cancer (Ages 50-64)	63.9	46.2	49.6	53.9	100%
CCS-AD	Cervical Cancer Screening - % of Women Screened for Cervical Cancer (Ages 21-64)	65.5	52.8	56.4	60.2	88%
CHL-AD	Chlamydia Screening (Ages 21-24) - % Women Screened for Chlamydia	64.3	55.7	61.4	63.5	80%
FVA-AD	Immunization (Flu) - % Received a Flu Vaccination (Ages 18-64)	50.8	34.2	38.5	41.8	100%

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

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

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



Miscellaneous

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.