Rhode Island
Medicaid Expenditure Report

SFY 2019

Publication Date: May 6, 2021

Purposes of this Report

This Medicaid Expenditure Report contains all components indicated in statute at R.I.G.L.42-7.2-5, in order to provide a comprehensive overview of all Medicaid expenditures, outcomes, and utilization rates during State Fiscal Year (SFY) 2019.

The goals of this report are to:

- Provide state policymakers with a comprehensive overview of state Medicaid expenditures to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process.
- Summarize Medicaid expenditures for eligible individuals and families covered by the relevant Rhode Island departments.
- Show enrollment and expenditure trends for Medicaid coverage groups by service type, care setting, and delivery mechanism.
- Maintain a standard format for tracking and evaluating trends in annual Medicaid expenditures within and across departments.

- **Several enhancements have been included compared to previous reports:**
  - New cost per service type reporting
  - New condition-specific reporting
  - Reporting on central administrative costs and spending on mandatory and optional services and populations, as required by 2019 statutory changes
- **Other Notes:**
  - Methodology used to classify expenditures, enrollment and utilization differed from prior reports, thus historical data may differ in prior versions.
  - Other reasons for variance include accrual vs. paid amounts, provider payouts, capitation vs. claim amounts, and rounding.

Reporting Methodology & Data Notes

- This report is based on Medicaid systems extracts that include claims, capitation payments, premiums, and provider payouts.
  - Capitation payments, premiums, and payouts are proportionately allocated to Medicaid coverage groups, service types and care settings based on respective claims, encounter, and payout information.
  - Due to the proportional allocation method used here, other reports based directly on claims data may differ from the expenditure amounts in this report.
- The primary basis for identifying expenditures in this report is the actual date of service, 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.
  - Data from the Elders and dual eligible (i.e. eligible for both Medicare and Medicaid) population are excluded from reporting on prevalence of diagnosis, and utilization and expenditure by acute care service type.
  - Claims were assigned to diagnostic categories using the Clinical Classification Software maintained by the Agency for Healthcare Research and Quality.
  - Pharmacy, Long-Term Services and Supports (LTSS), and dental claims data are excluded from reporting on diagnosis-related data and figures due to limited diagnostic data on these claim types.
  - Enrollment for the diagnoses represented in the report will vary slightly from enrollment in the rest of the report. This enrollment is a unique count of full benefit enrollees with at least six months of Medicaid enrollment in a single year.
  - Totals in pages displaying diagnosis data do not add to 100% because conditions may overlap and other conditions exist which are excluded from the analysis.
  - Expenditure amounts used in this report may vary from expenditure amounts reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion, accrual vs. paid amounts, provider payouts, capitation vs. claim amounts, and rounding.
  - Pharmacy expenditures are shown as net of rebates.

Definitions

- **Average annual rates methodology** - This report shows trends in terms of an average annual trend rate based on historical data in order to present longer term trends rather than year to year variation.
- **Rounding** - The values presented in this report are rounded; the totals illustrated in the report may not equal the sum of the component parts.
- Acronyms are defined at the end of this report.

Table of Contents

Overview and Key Findings

Overview

During SFY 2019, Rhode Island's Medicaid program provided full medical coverage to approximately 356,000 Rhode Islanders, with an average of 308,000 members enrolled at any one time.

Medical benefits expenditures totaled $2.6 billion for Medicaid covered services for recipients receiving full benefits in SFY 2019. This $2.6 billion expenditure is inclusive of federal funds, general revenues, and restricted receipts. The effective Federal Medicaid Assistance Percentage (FMAP) was approximately 60% across the Medicaid program, with the remaining 40% paid with State dollars. An additional $367 million was spent on populations and services not fully covered (e.g., Medicare Savings Program), as well as program administrative costs.

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

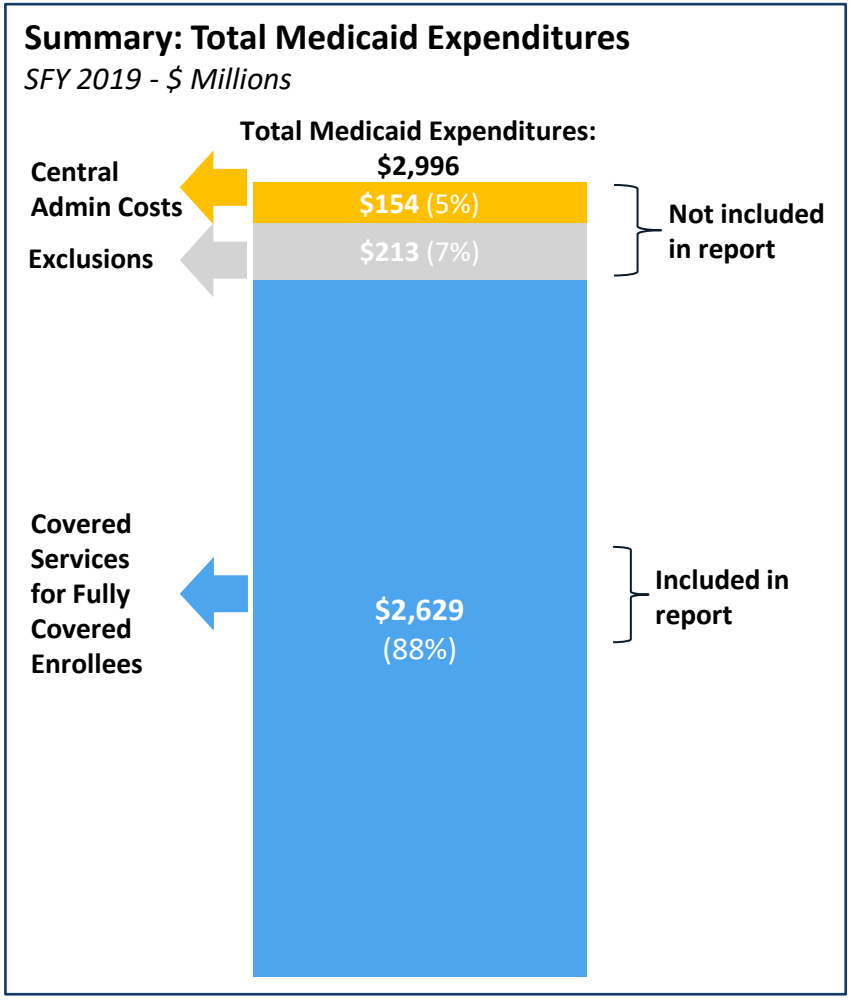
- $2.2 billion – Executive Office of Health and Human Services (EOHHS)
- $351 million – Behavioral Healthcare, Developmental Disability, and Hospitals (BHDDH)
- $45 million – Department of Children, Youth and Families (DCYF)
- $10 million – Department of Human Services (DHS) and Department of Corrections (DOC)

Key Findings

- Average enrollment decreased in SFY 2019 to 308,000 from 316,000 in SFY 2018.
- Children and Families comprise 53% of enrollees, followed by Expansion (25%), Adults with Disabilities (10%), Elders (7%) and CSHCN (4%).
- 89% of enrollees are in some form of managed care, and a majority (58%) Medicaid enrollees are now in the Accountable Entity (AE) program.
- SFY 2019 PMPM costs increased by approximately 4% compared to less than 1% in SFY 2018.
- 9% of Medicaid enrollees incurred 73% of claims in SFY 2019.
- Acute services account for 55% of SFY 2019 expenditures, while expenditures on LTSS represent 33%. Remaining expenditures were for Managed Care Organization (MCO) administration, premiums and taxes.
- The cost of caring for certain populations varies significantly, with Elders and Adults with Disabilities costing more than twice the average beneficiary and Children and Families costing less than half.
- State-by-state comparisons of Medicaid quality from CMS and NCQA show Rhode Island's quality to be better than average on most measures.

Total Expenditures

Medicaid expenditures in SFY 2019 totaled approximately $3.0 billion. Expenditures for covered services for fully covered populations are the focus of this report and totaled approximately $2.6 billion.

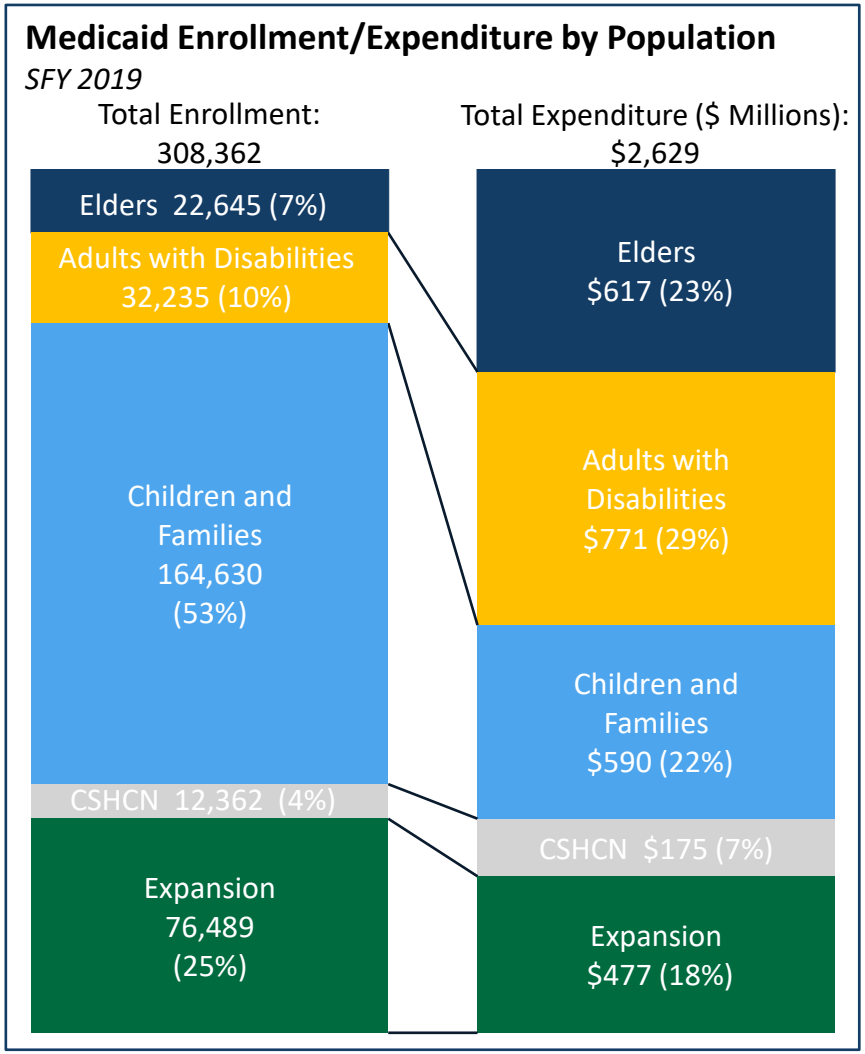


- **Central Administrative Costs** are expenditures related to managing the Medicaid program, such as paying for technology infrastructure and processing claims. MCO administrative costs are included in the covered services for fully covered enrollees.
- **Exclusions** are expenditures for populations and services which are not fully covered by Medicaid. They 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.
  - **Local Education Authorities (LEAs):** Payments for certain Medicaid services provided to students with special needs.
  - **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.
  - **Health System Transformation Project (HSTP) funding:** MCO and AE payments to help with the transition to value-based care.
  - **Medicare Prime:** Payments for Medicare premiums for qualifying individuals based on income.
  - **Other:** Payments for graduate medical education and services covered by DOC and DHS.
- **Covered Services for Fully Covered Enrollees** are expenditures for services delivered to enrollees who receive comprehensive medical coverage through Medicaid.

Populations

Medicaid serves five primary populations:

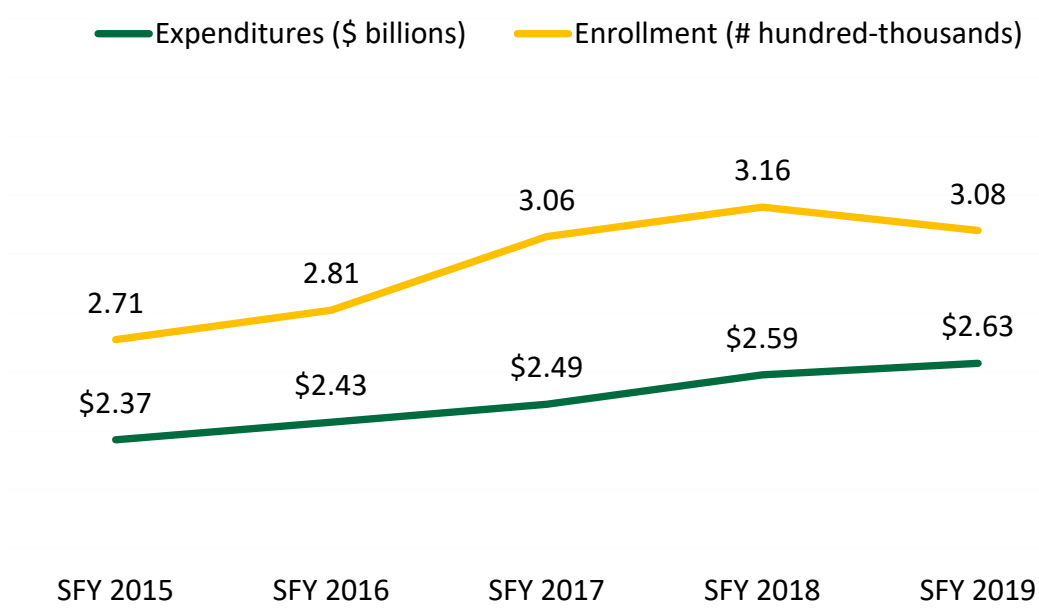
- **Elders** are enrollees over age 65. 92% of this population are also covered by Medicare. Their average SFY 2019 PMPM cost was $2,270. Nursing facilities account for 59% of elder expenditures.
- **Adults with Disabilities** are enrollees under age 65 with identified disabilities and 48% are also covered by Medicare. Their average SFY 2019 PMPM cost was $1,993, with residential and rehabilitative services accounting for 28% of their expenditures.
- **Children and Families** enrollees are qualified children, parents and pregnant women. They have SFY 2019 PMPM average costs of $298. Professional services and hospital care account for 41% and 40% of expenditures for this population, respectively.
- **CSHCN** are enrollees under age 21 who need more care for the physical, developmental, behavioral or emotional differences than their peers. Their average SFY 2019 PMPM costs were $1,176. Professional services account for 54% of expenditures for this population.
- **Expansion** enrollees are qualified adults without dependent children. This population, who became eligible under the Affordable Care Act (ACA), have SFY 2019 PMPM costs of $520. Hospital and professional services account for 44% and 26% of expenditures for this population, respectively.



Expenditure, Enrollment and PMPM Trends

Expenditure, Enrollment and PMPM Trends

SFY 2015 - 2019



	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
PMPM	$729	$719	$678	$683	$710

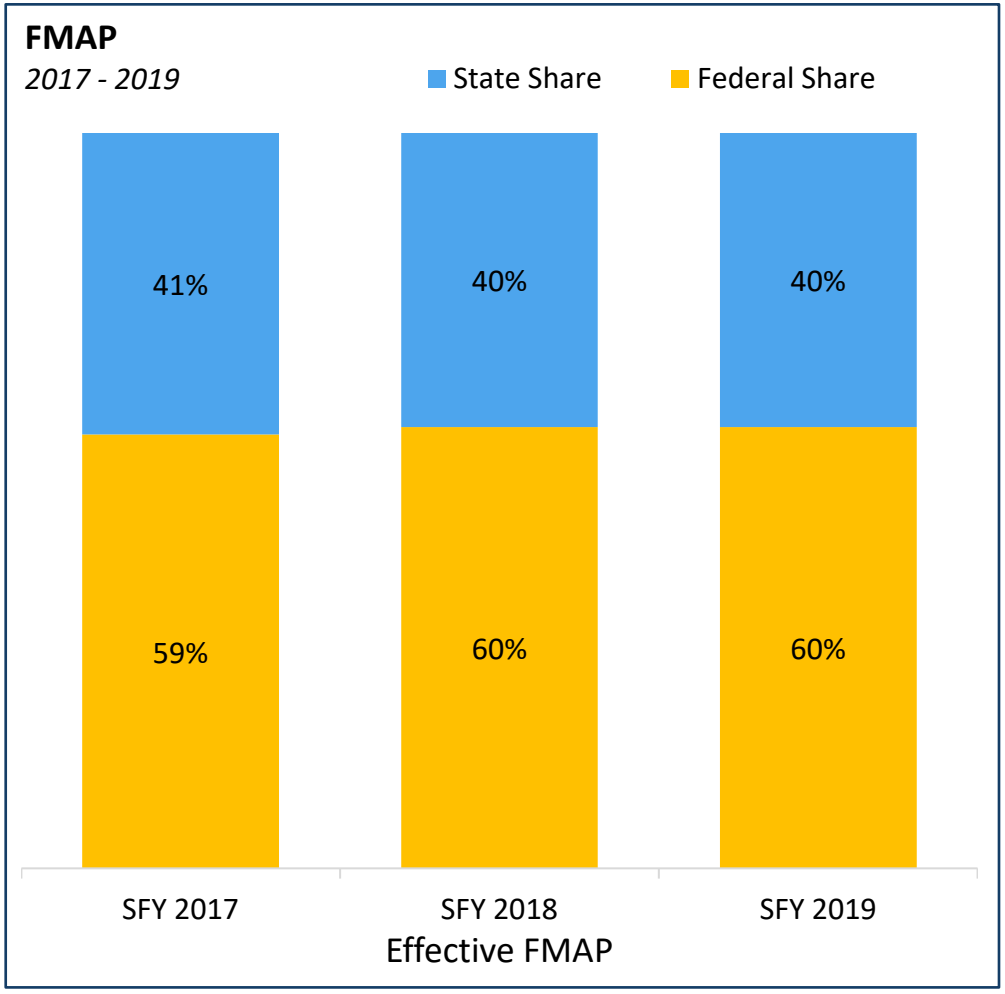
- Expenditure
  - In SFY 2019, expenditures increased by $39 million (1.5%).
  - A key contributing factor for the expenditure increase was increased Elders enrollment, who have the highest PMPM of any population and significant nursing facility expenditures.
  - Additional factors include growth of utilization of inpatient (IP) services among all populations, and increasing PMPM costs for the non-Elder populations.
- Enrollment
  - Enrollment increased from SFY 2013 (not shown), the year before Rhode Island expanded Medicaid, through SFY 2019 by 58%, or 113,000. Most (68%) of the overall increase since Medicaid expansion is attributable to the newly-covered population, but enrollment in other populations grew as well.
  - Enrollment dropped in SFY 2019 by approximately 7,500 (2.4%). Every population except Elders experienced an enrollment decrease.
- PMPM
  - Overall, PMPM costs increased by an average of 2.7% annually from SFY 2016 to SFY 2019. Additional information can be found on page 64.
  - From SFY 2017 to SFY 2019, PMPM costs for Elders decreased by an average of 2.4%, while PMPM of other populations increased by averages ranging from 1.9% to 3.4%.

Expenditure and Enrollment: Overview

The following sections provide a variety of breakdown analysis for the $2.6 billion in Medicaid expenditures in SFY 2019.

Federal and State Share of Expenditures

Medicaid programs are funded by state and federal dollars. In SFY 2019, Rhode Island paid approximately $1.0 billion or 40% of expenditures with state dollars, while approximately $1.6 billion or 60% were paid using federal matching dollars.



- Rhode Island receives different federal matching percentages for the Expansion population and non-Expansion population. The effective FMAP is the weighted average of these federal contributions.
- Federal matching dollars differ based on the population.
  - The FMAP for the Elders, Adults With Disabilities, Children and Families and CSHCN populations is calculated based on average state income.
  - 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 Refugee Assistance Program and HSTP funded expenditures are matched at 100%.

Mandatory vs. Optional Expenditures

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

Enrollment and Expenditures by Mandatory vs. Optional Populations and Benefits

SFY 2019 - $ Millions

	Mandatory Populations	Optional Populations	Total
ENROLLMENT	207,126 67% of total population	101,236 33% of total population	308,362
Expenditures on Mandatory Benefits	$1,099 42% of total expenditures	$846 32% of total expenditures	$1,945 74% of total expenditures
Expenditures on Optional Benefits	$388 15% of total expenditures	$296 11% of total expenditures	$684 26% of total expenditures
TOTAL EXPENDITURES	$1,487 57% of total expenditures	$1,142 43% of total expenditures	$2,629

Assignment of mandatory versus optional eligibility populations and services is subject to further refinement in future reporting.

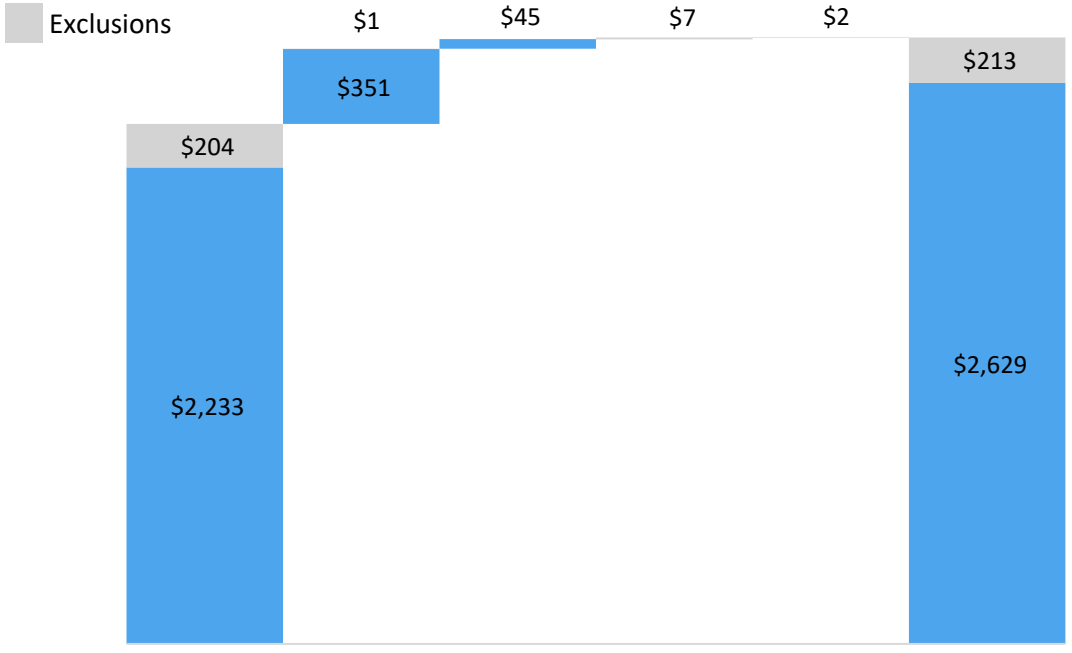
- **Mandatory Medicaid populations** include groups like low-income families, qualified pregnant women and children, and individuals receiving SSI.
- **Optional populations** can be covered at the discretion of the state and include groups like:
  - Low-income children, pregnant women, and parents above federal minimum standards
  - Elderly and disabled individuals with incomes above federal minimum standards or who receive LTSS in the community Medically needy
  - Adults without dependent children
  - Enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services
- **Mandatory benefits** include services like inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and home health services, among others. **Optional benefits** include services like prescription drugs, case management, physical therapy, and occupational therapy.
- In Rhode Island the top five optional benefits, in terms of total expenditures, are:
  - IDD Residential/Rehab, Group Home ($250 million)
  - Pharmacy ($240 million)
  - Personal Care Services ($53 million)
  - Hospice ($32 million)
  - Licensed behavioral health therapists, physical therapy, and occupational therapy ($17 million)
- Optional benefits may reduce beneficiaries' health care costs overall; for example, access to prescription drugs helps individuals avoid preventable and more expensive emergency room visits.

Expenditures by Department

Five departments in the state of Rhode Island are responsible for administering Medicaid funds. Over 85% of funds are administered by EOHHS.

Expenditures by Department

SFY 2019 – $ Millions



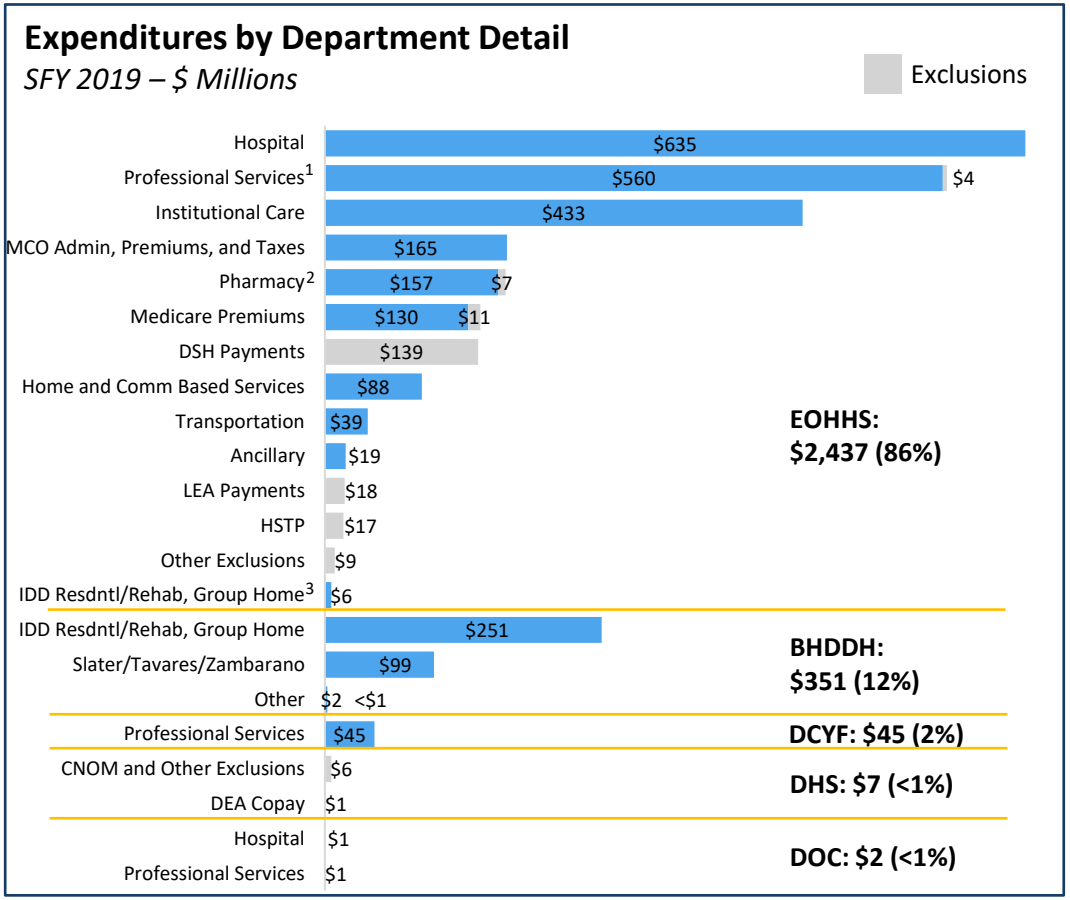
	EOHHS	BHDDH	DCYF	DHS	DOC	Total
% of Total	85.7%	12.4%	1.6%	0.2%	0.1%	100%
	3.1%	0.3%	2.8%	6.3%	7.8%	2.8%

Avg Annual Expenditure Change SFY 2017 - 2019 (full + partial populations/services)

- EOHHS is the lead administrator for the Medicaid contract with CMS. The Single State Medicaid Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
- In SFY 2019, EOHHS relied on several state departments to administer components of the Medicaid program: EOHHS, BHDDH, DCYF, DHS, and DOC.
- All expenditures by the DHS and DOC and some expenditures by EOHHS and BHDDH did not go towards covered services for fully covered populations (totaling $213 million), and thus are excluded from analyses in this report.
- Overall Medicaid expenditures increased from SFY 2017 to 2019 by 2.8%, with EOHHS spending increasing by 3.1%.

Expenditures by Department: Detail

Five agencies in Rhode Island are responsible for the expenditure of Medicaid funds. EOHHS spends the most, with over $2 billion in expenditures, and DHS and DOC spend the least, with less than $10 million each.



- **EOHHS** is responsible for $2.4 billion in Medicaid expenditure, which is 86% of total Medicaid spending in Rhode Island. The agency's goal is to assure access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders.
- **BHDDH** serves Rhode Islanders who live with mental illness, Substance Use Disorder (SUD) and/or developmental disabilities.
- **DCYF** works with families and communities to promote safe and healthy child and youth development.
- **DHS** runs programs that promote health, nutrition, education, employment and quality of life.
- **DOC** maintains a balanced correctional system of institutional and community programs that provide a range of custodial options, supervision and rehabilitative services.

[1]Includes professional services for behavioral health.
[2]Total expenditure shown are net of pharmacy rebates.
[3]Intellectually and Developmentally Disabled (IDD) Residential/Rehab is Residential and Rehabilitation Services for persons with IDD, including group homes.

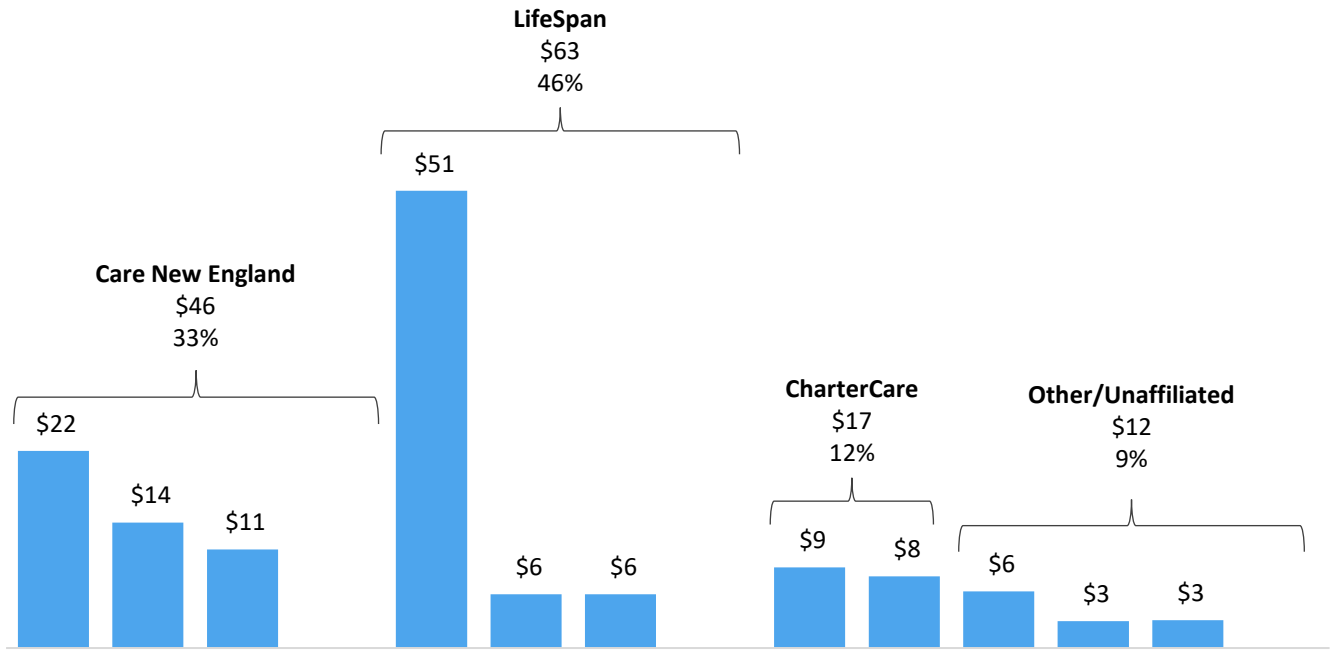
Exclusions: DSH Payments

Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.

DSH Distribution by Hospital

SFY 2019 – $ Millions

Total SFY 2019 DSH Expenditure = $139 M



Women & Infants	Memorial	Kent	Butler	Rhode Island	Miriam	Newport	Bradley	St.Joseph	Roger Williams	Landmark	South County	Westerly	Slater
15.7%	10.1%	7.6%	0.0%	37.1%	4.6%	4.0%	0.0%	6.2%	5.7%	4.3%	2.5%	2.2%	0.0%

% of SFY 2019 DSH Payments

- DSH payments make up most of the excluded expenditures in the report, accounting for $139 million of the $213 million in total SFY 2019.
- Care New England, LifeSpan and CharterCare are multi-hospital health systems in Rhode Island
- More than half of the year's DSH payments went to two facilities:
  - Rhode Island Hospital in Providence
  - Women & Infants Hospital in Providence

DSH payments are one of four types of excluded expenditures in this report. The other three are LEAs, CNOMs and the HSTP AE Incentive Program.

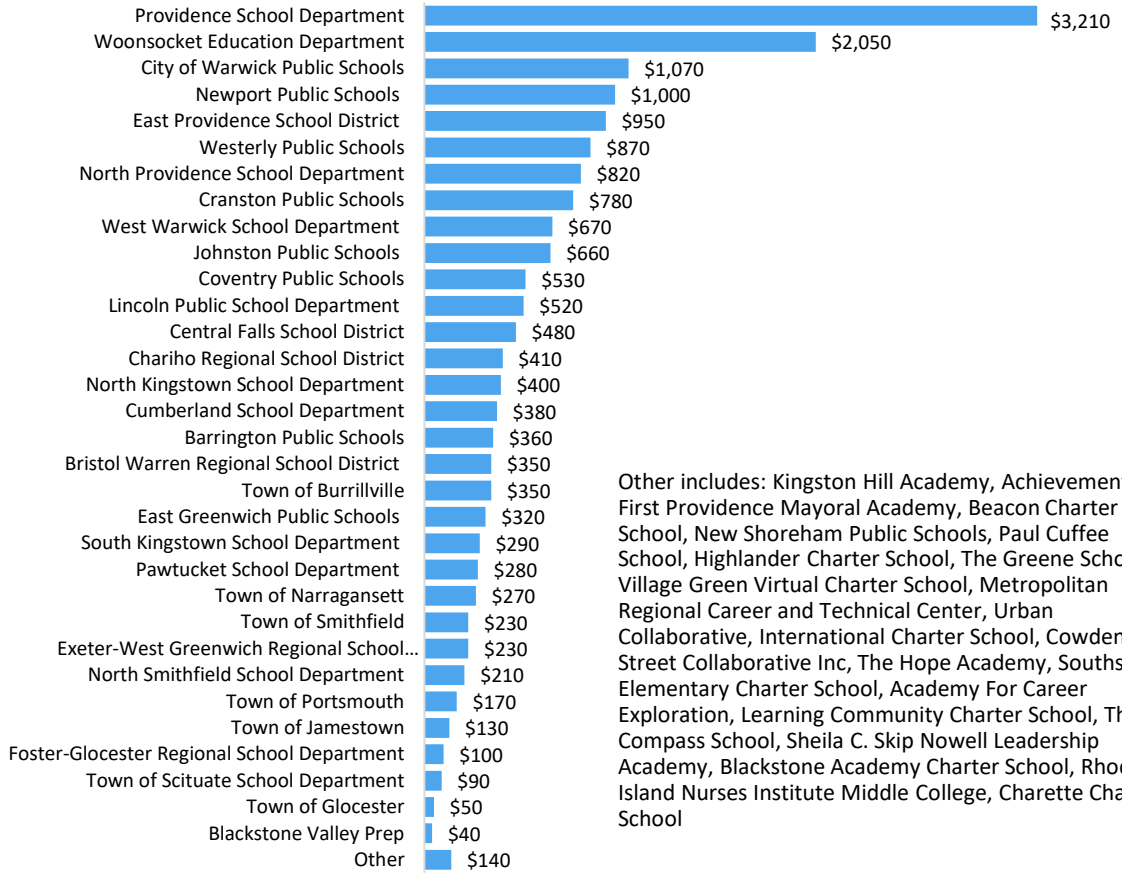
Exclusions: Local Education Agencies (LEAs)

LEAs may receive federal matching funds for a variety of services provided to Medicaid-eligible children.

Medicaid Funding to LEAs

SFY 2019 - $ Thousands

Total SFY 2019 LEA Expenditure = $18 M



Other includes: Kingston Hill Academy, Achievement First Providence Mayoral Academy, Beacon Charter School, New Shoreham Public Schools, Paul Cuffee School, Highlander Charter School, The Greene School, Village Green Virtual Charter School, Metropolitan Regional Career and Technical Center, Urban Collaborative, International Charter School, Cowden Street Collaborative Inc, The Hope Academy, Southside Elementary Charter School, Academy For Career Exploration, Learning Community Charter School, The Compass School, Sheila C. Skip Nowell Leadership Academy, Blackstone Academy Charter School, Rhode Island Nurses Institute Middle College, Charette Charter School

These 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.

- LEA expenditures totaled $18 million in SFY 2019.
- 53 school districts/ departments received LEA payments in SFY 2019.
- LEA expenditures make up less than a tenth of excluded expenditures.

Payments to LEAs are one of four types of excluded expenditures in this report. The other three are DSH, CNOM and the HSTP AE Incentive Program.

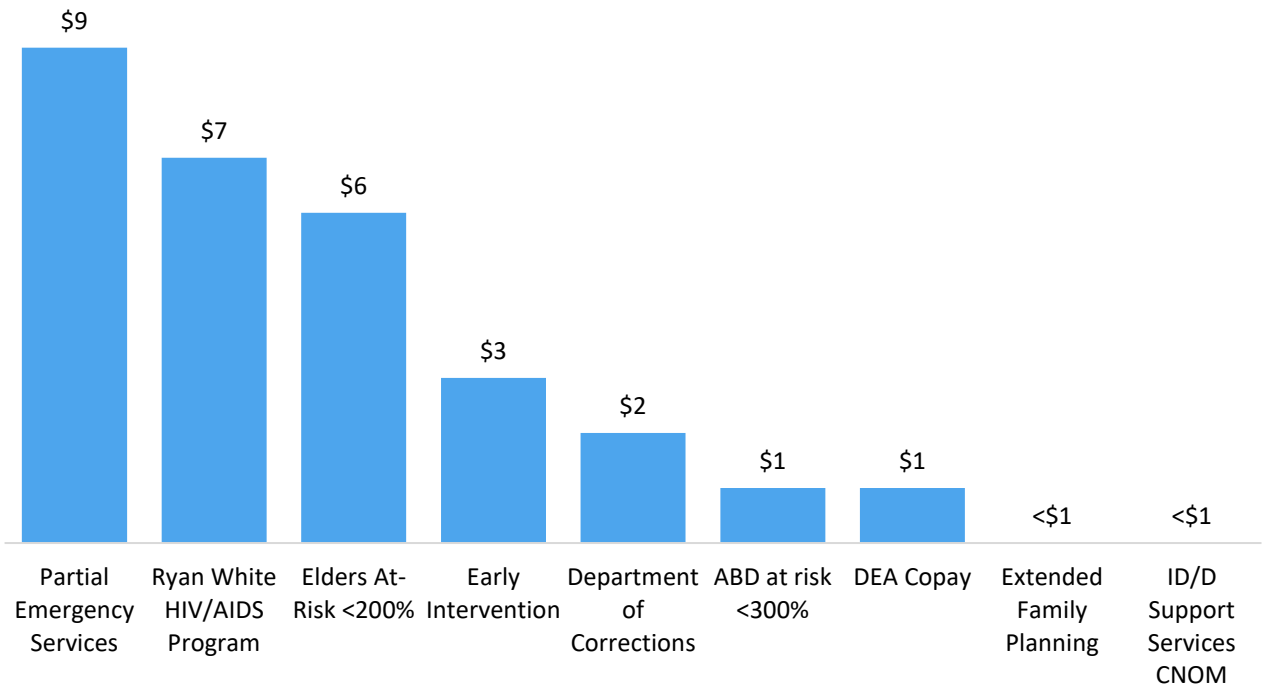
Exclusions: CNOM and Other Limited Benefit Programs

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

CNOMs and Other Limited Benefit Programs

SFY 2019 – $ Millions

Total SFY 2019 CNOM and Other Limited Benefit Program Expenditure = $27 M



- CNOM and other limited benefit program expenditures totaled $27 million in SFY 2019.
- CNOM and other limited benefit program expenditures constitute 13% of excluded expenditures, which totaled $213 million in SFY 2019.
- Note:
  - Most CNOM and other limited benefit program expenditures go towards partial emergency services, the Ryan White HIV/AIDS program and Elders at risk of becoming Medicaid eligible.

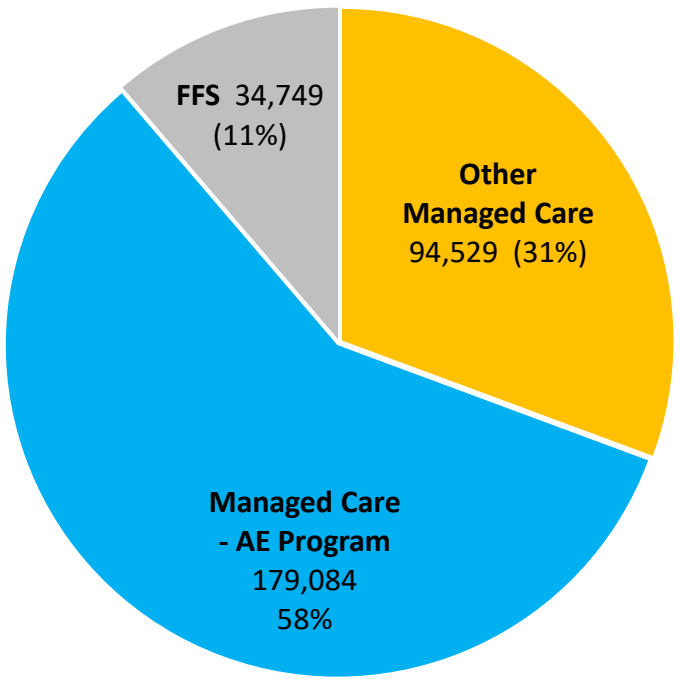
CNOM are one of four types of excluded expenditures in this report. The other three are DSHs, LEAs and the HSTP AE Incentive Program.

Programs

This section provides enrollment and expenditure information on Rhode Island Medicaid's Managed Care and Accountable Entity program.

Enrollment by Program

Medicaid Enrollment by Program
SFY 2019
Total Enrollment 308,362



- **Managed Care – AE Program:** The AE Program is Rhode Island Medicaid's version of an Accountable Care Organization (ACO) in which a provider organization is accountable for quality health care, outcomes and the total cost of care for enrollees. Children and Families and the Expansion population account for a large number of AE enrollees, through the RIte Care and Medicaid Expansion managed care programs. All members in the AE program are also enrolled in an MCO.
- **Other Managed Care:** In these managed care arrangements, Rhode Island pays a private insurer to provide coverage for Medicaid enrollees. This includes members enrolled in RIte Share, Program of All-Inclusive Care for the Elderly (PACE), or members enrolled with an MCO but not assigned to an AE.
- **Fee-For-Service (FFS):** In FFS, the state reimburses providers directly for covered services provided. Elders are the only population for whom most are not enrolled in managed care.

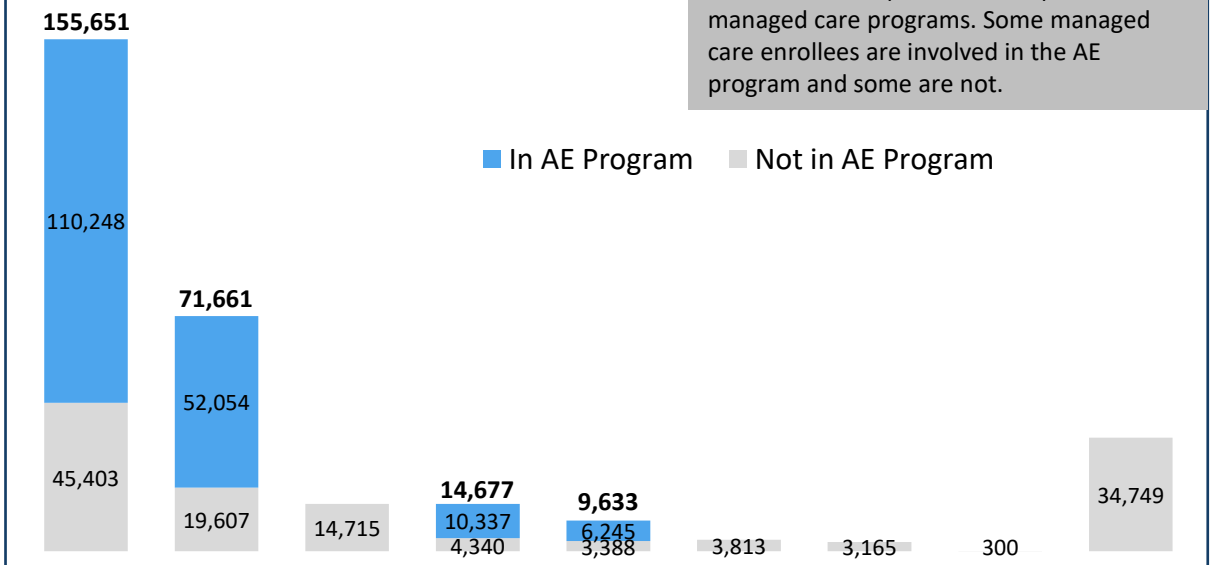
Managed Care Enrollment

89% of Rhode Island Medicaid enrollees are in managed care programs. Most enrollees are in the RIte Care and Medicaid Expansion programs, but enrollees with specific health needs are often treated in smaller, more specialized programs.

Program Enrollment
SFY 2019

308,362 Total Average Monthly Enrollees

All columns except for "FFS" represent managed care programs. Some managed care enrollees are involved in the AE program and some are not.



RIte Care	Medicaid Expansion	RHO Integrity	RHP	CSHCN	RIte Share	RHO Phase I	PACE	FFS
50.5%	23.2%	4.8%	4.8%	3.1%	1.2%	1.0%	0.1%	11.3%
% of SFY 2019 Enrollment								
2.0%	0.9%	43.5%	-1.0%	2.3%	-26.5%	-55.5%	4.7%	4.5%
Avg Annual Growth – SFY 2017 - 2019								

- Managed care enrollment is divided between Rhode Island's three MCOs, Neighborhood Health Plan, United Healthcare and Tufts Health Plan. Neighborhood Health Plan has the majority of enrollees, with 63%, followed by United (33%) and Tufts (3%).
- Rhody Health Options (RHO) Phase I terminated in SFY 2019, which accounts for the move of enrollment from this program to RHO Integrity.
- Notes:
  - RIte Care mainly serves children and parents. The majority of RIte Care enrollees are in the AE program.
  - RHO is a fully capitated managed care program for LTSS and other Medicaid-funded services designed primarily for enrollees with both Medicaid and Medicare coverage.
  - Rhody Health Partners (RHP) is a managed care program for Adults with Disabilities.
  - RIte Share is a program designed to allow Medicaid enrollees with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditure by leveraging the employer's contribution.

Expenditures by Managed Care Enrollment

Most (57%) program expenditures are made through managed care programs, which cover 89% of Medicaid enrollees. The rest (43%) are non-managed care expenditures, which primarily go toward FFS enrollees but can also be spent on carve-out services for managed care enrollees in certain circumstances.

Expenditures by Managed Care Program Enrollment

SFY 2019

$ Millions

Managed Care – Non-AE and AE Enrolled
Enrollment: *273,613 (89%)*
Expenditures: *$1,884 (72%)*

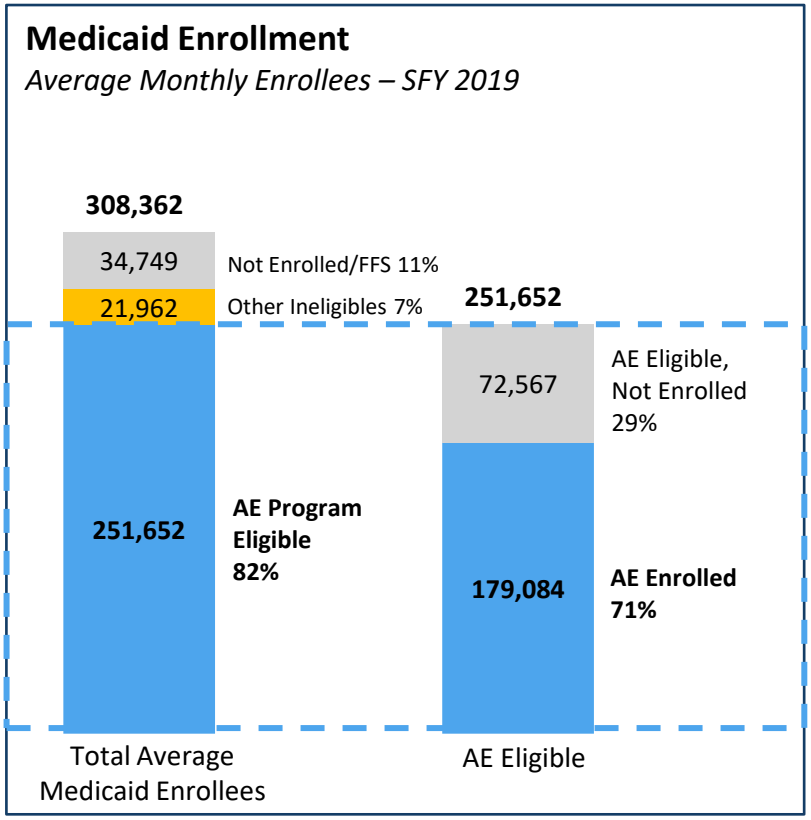
	Managed Care Non-AE Enrolled *94,529 (31%)*	Managed Care AE Enrolled *179,084 (58%)*	Non-Managed Care Enrolled *34,749 (11%)*
Managed Care Expenditures *$1,491* *57%*	**$595** **23%**	**$895** **34%**	
Other Expenditures *$1,138* *43%*	**$252** **10%**	**$142** **5%**	**$745** **28%**
Total Expenditures	**$847** **32%**	**$1,037** **39%**	**$745** **28%**

- 89% of Medicaid's 308,000 enrollees are enrolled in managed care programs, including RIte Care, RIte Share, RHP, RHO I, RHO II, Medicaid Expansion Managed Care, and PACE. These enrolled populations accounted for 72% of Medicaid expenditures in SFY 2019.
- 57% of Medicaid expenditures are managed care expenditures. Most of the remaining 43% are FFS payments for populations not in managed care.
- Notes:
  - Some "Other Expenditures" are also used for the managed care populations to fund carve-out services not paid by managed care plans, such as Neonatal Intensive Care Unit (NICU), adult dental care, and wrap payments for federally qualified health centers, as well as LTSS payments for the IDD population administered by BHDDH.

AE Program Enrollment

Beginning in late 2015, the Rhode Island EOHHS began pursuing Medicaid waiver financing to create a pool of funds primarily focused on assisting in the design, development and implementation of the infrastructure needed to enable AEs to succeed under value-based payments and improve quality of care and population health outcomes. EOHHS submitted an application for such funding in early 2016 as an amendment to RI's current Global Medicaid 1115 Waiver. In October 2016, CMS approved this waiver amendment, bringing $129.8 million in Federal Financial Participation (FFP) to Rhode Island.[1]

Expenditures for the AE transformation have grown significantly as the program has moved out of the pilot phase.



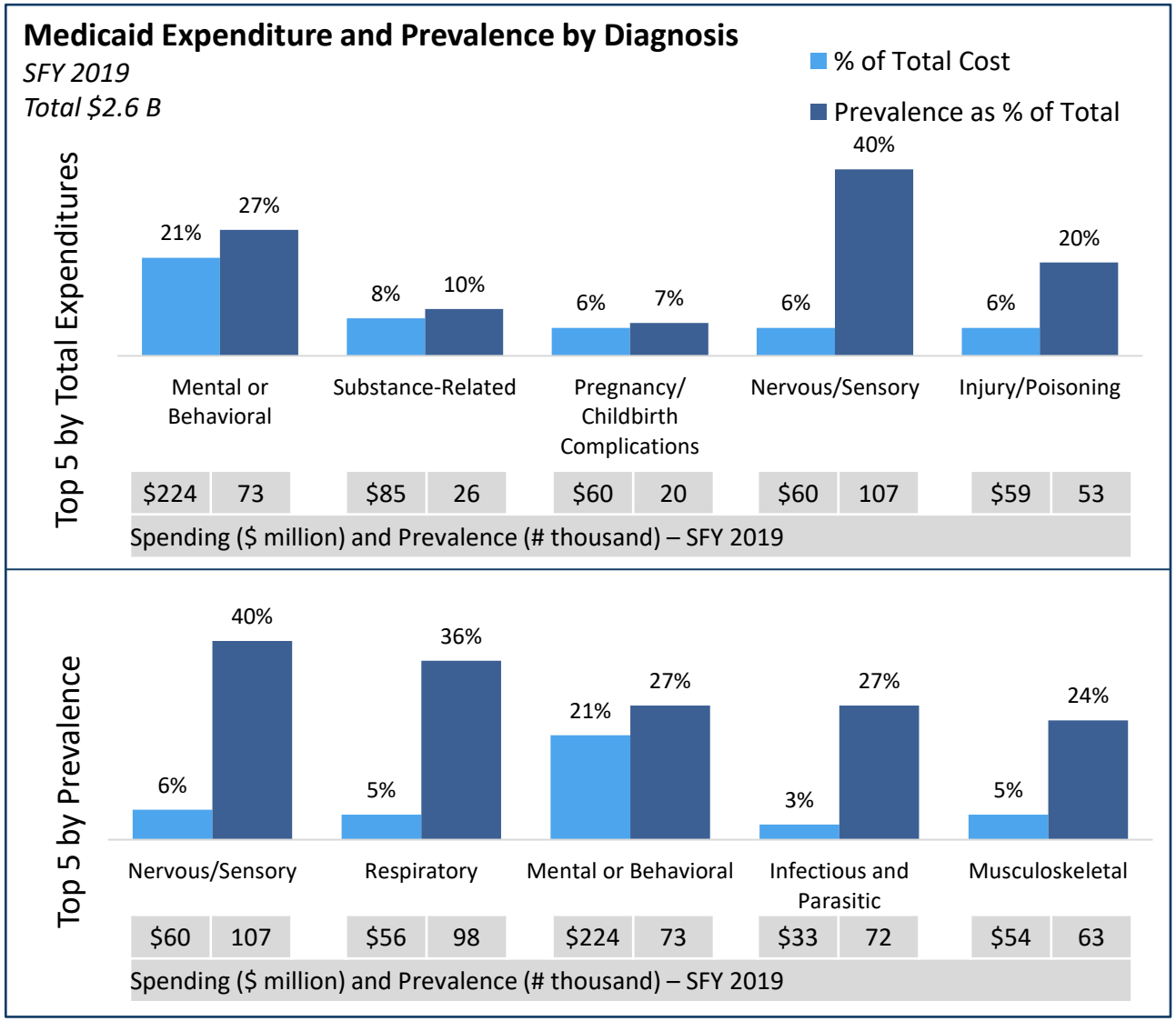
- SFY 2017 and SFY 2018 were the pilot years for Rhode Island's AE program. AE program Incentive payments, which began in SFY 2019, are time limited payments and will be distributed for the duration of the program, which is expected to last until SFY 2024.
- Five AEs participated in the AE Program during year one (SFY 2019):
  - Blackstone Valley Community Health Center
  - Integra Community Care Network
  - Integrated Healthcare Partners (CHC ACO)
  - Prospect Health Services RI
  - Providence Community Health Center
- Future planned payments will support enhancements of capabilities of participating health care providers in the areas of data and analytics, population health, workforce planning and programming, care management, member engagement and access, quality, interdisciplinary partnerships, and leadership and management.

[1]The current Rhode Island 1115 Waiver is a 5-year demonstration, ending 12/31/2023.

Diagnoses

Certain diagnoses are more prevalent and higher cost than others within Rhode Island Medicaid's populations, as described in this section.

Expenditure and Prevalence by Diagnosis



- The only diagnosis category that exceeds 10% of Medicaid expenditures is mental or behavioral health, which accounts for 21% of expenditures.
- Two diagnoses are in the top 5 in terms of both expenditure and prevalence: mental or behavioral health, and diseases of the nervous system and sense organs.
- Notes
  - For these charts, prevalence is calculated using a unique count of full benefit enrollees with at least six months of Medicaid enrollment in a single year.
  - Prevalence is presented in this report as both a percentage of the population with the diagnoses, and as the number of enrollees with the diagnoses.
  - Common diagnoses within these categories are outlined in the Key Terms and Notes section on page 70.

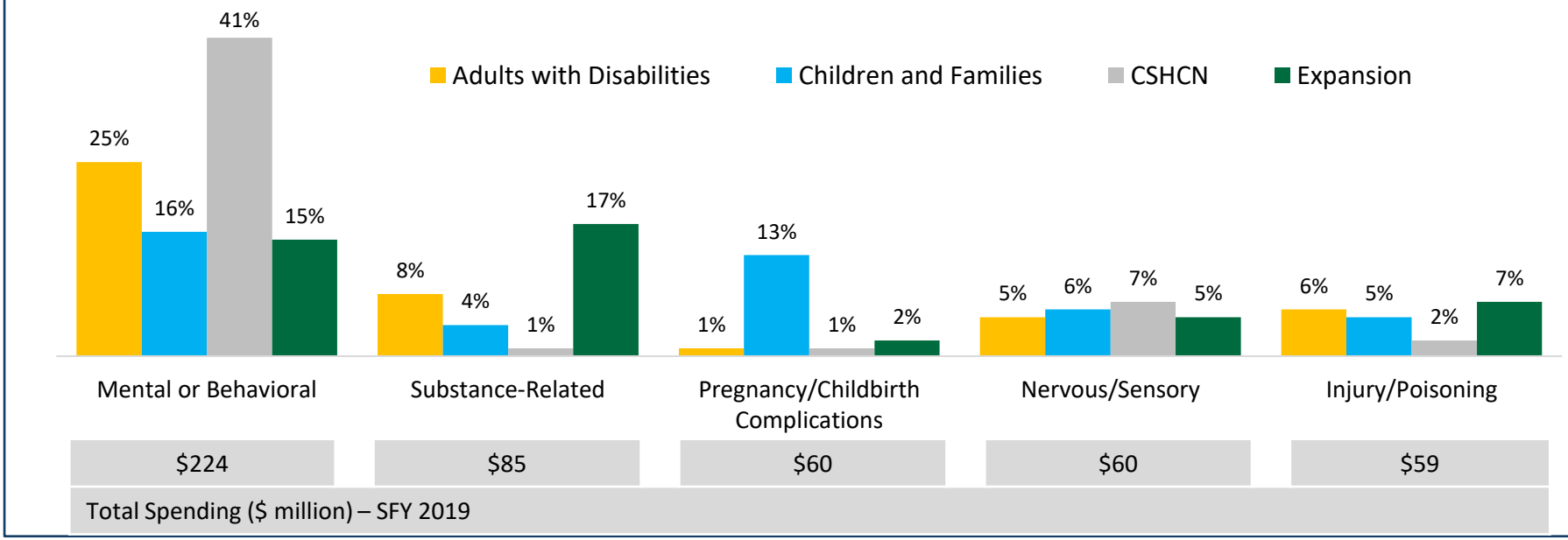
Expenditures and prevalence statistics exclude Elders and dual eligible populations. Pharmacy, LTSS, and dental expenditures are also excluded.

Top 5 High-Expenditure Diagnoses

- Mental or behavioral health diagnoses account for a high proportion of spending for all population categories, but this spending is particularly high for the Adults with Disabilities and CSHCN populations.
- Substance-related disorders account for a larger proportion of the Expansion population spending compared to other populations.
- Expenditures on complications of pregnancy, childbirth, and the postpartum period represent a much higher percentage of total expenditure in the Children and Families population.

Expenditure on Top 5 Diagnoses as a Percentage of Total Spend Among Medicaid Enrollee Categories

SFY 2019 – Total $2.6 B



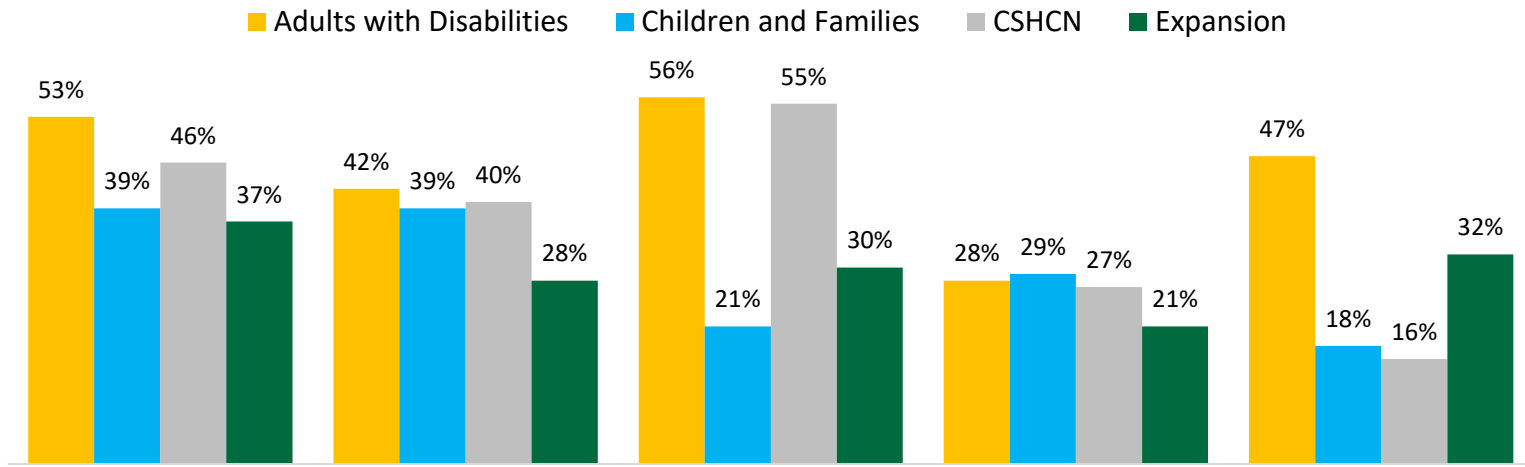
Expenditures and prevalence statistics exclude Elders and dual eligible populations. Pharmacy, LTSS, and dental expenditures are also excluded.

Top 5 High-Prevalence Diagnoses

Looking at prevalence of diagnoses by population may help guide program development for various groups. For instance, mental or behavioral health diagnoses are more prevalent among Adults with Disabilities and CSHCN than other populations.

Prevalence of 5 Most Prevalent Diagnoses by Population

SFY 2019 – Total 308,362 Enrollees



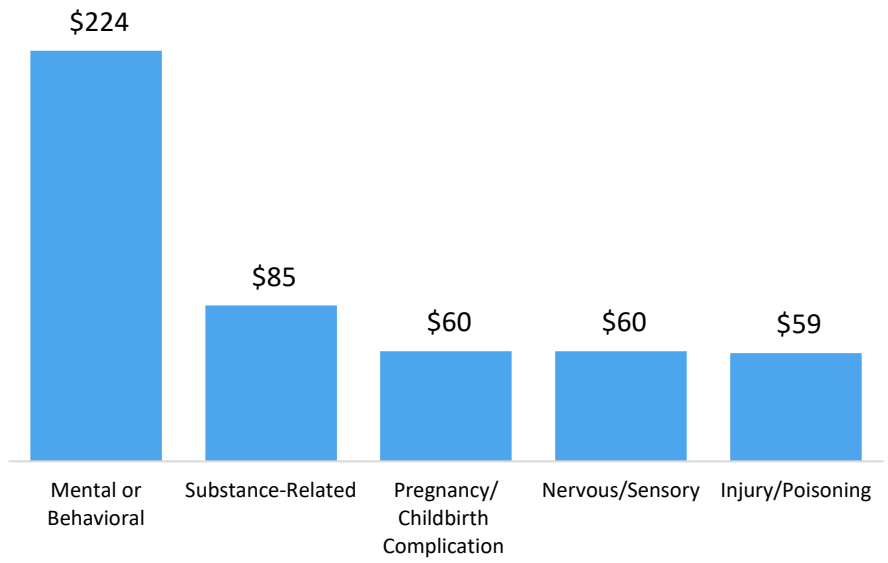
Expenditures and prevalence statistics exclude Elders and dual eligible populations. Pharmacy, LTSS, and dental expenditures are also excluded.

Expenditures by High-Expenditure Diagnosis

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

Expenditures by Diagnosis

SFY 2019 – $ Millions



	Mental or Behavioral	Substance-Related	Pregnancy/ Childbirth Complication	Nervous/Sensory	Injury/Poisoning
Avg 2-Year Growth	7.6%	11.2%	4.9%	4.5%	1.6%
% of Total Spend	21%	8%	6%	6%	6%
Prevalence (# per thousand)	73	26	20	107	53
Prevalence (%)	27%	10%	7%	40%	20%

- Mental or Behavioral Health was the diagnosis associated with the highest level of expenditure, more than double any other diagnosis.
- Mental or Behavioral Health and Substance-Related Disorders were the fastest growing diagnosis-related expenditures over the last two fiscal years.
- Diseases of the Nervous System and Sense Organs were the most prevalent conditions, but were associated with the third-highest expenditures.

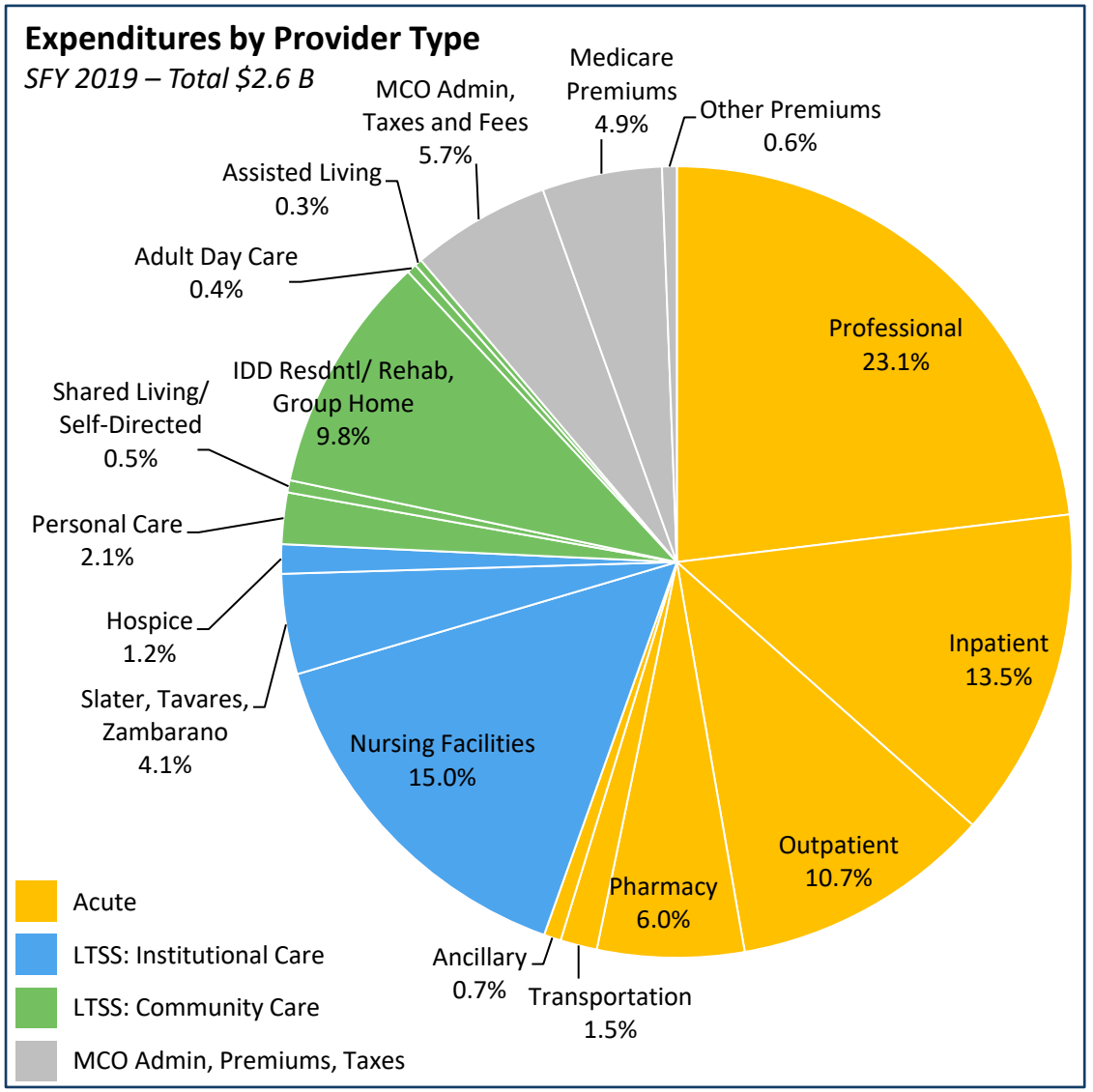
Expenditures and prevalence statistics exclude Elders and dual eligible populations. Pharmacy, LTSS, and dental expenditures are also excluded.

Provider Type

This section provides a breakdown of Rhode Island Medicaid's SFY 2019 expenditures by provider type.

Expenditures by Provider Type

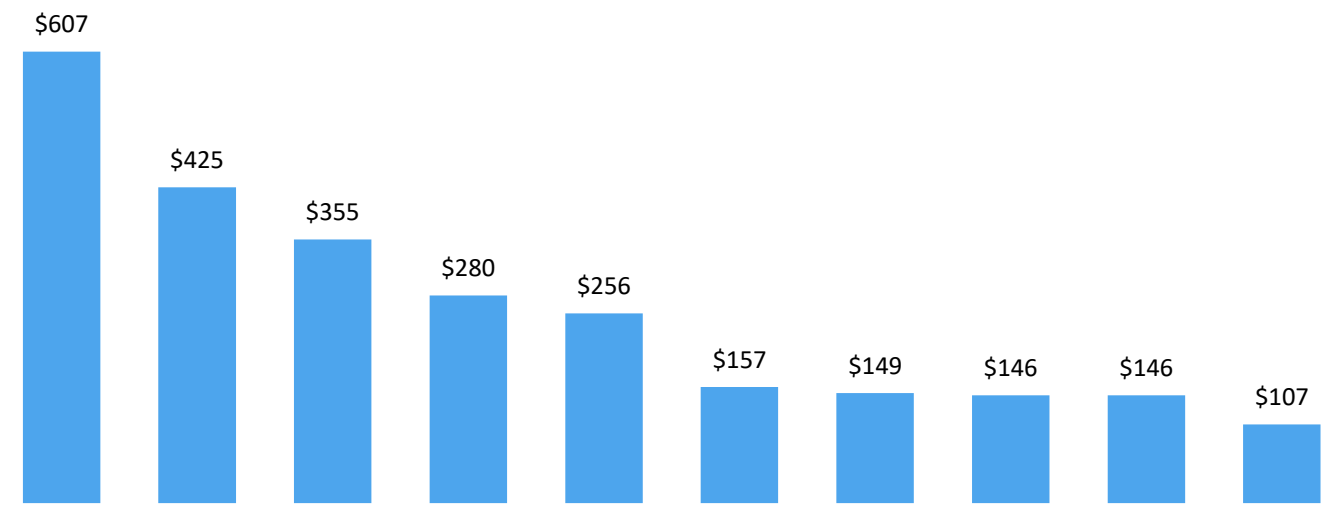
- **Acute services** had $1,458 million in Medicaid expenditures in SFY 2019, constituting 55% of all expenditures.
- **LTSS** had $876 million in Medicaid expenditures, constituting 33% of all expenditures. LTSS expenditures primarily serve the Elders and Adults with Disabilities populations. They can be placed into two categories:
  - **Institutional Care** services are provided to populations who stay in an institution. These services account for 61% of LTSS expenditures and 20% of all expenditures.
  - **Community Care** services are provided to at-risk populations as alternatives to more costly nursing facility/institutional options. These services account for 39% of LTSS expenditures and 13% of all expenditures.
- **MCO Administration, Premiums and Taxes** include the non-claims expenditures of Medicaid MCOs and other premiums paid by EOHHS on behalf of covered enrollees.



Expenditures by Provider Type (cont'd)

Expenditures by Provider Type
SFY 2019 – $ Millions

Total Expenditure = $2,629 M
Avg Annual Growth SFY 2017 - 2019 = 2.7%



Professional	Nursing Facilities/ Hospice	Inpatient*	Outpatient*	IDD Resdntl/ Rehab, Group Home	Pharmacy*	MCO admin, Taxes and Fees	HCBS, Transportation and Ancillary	Premiums	Slater/ Tavares/ Zambarano
23.1%	16.2%	13.5%	10.7%	9.8%	6.0%	5.7%	5.6%	5.5%	4.1%
% of Total Expenditure									
3.6%	4.9%	6.9%	3.0%	2.3%	9.0%	-13.7%	-2.3%	8.4%	-1.3%
Avg Annual Growth – SFY 2017 - 2019									

*Utilization metrics on the following page

- Pharmacy expenditures nationwide and among all insurance types have grown quickly in recent years; this trend also appeared in Rhode Island Medicaid.
- Inpatient services expenditure growth can be mostly attributed to per-person utilization, which increased by 8.1% in SFY 2019.
- Nursing facility/hospice expenditure growth can be mostly attributed growth in the Elders population.
- MCO admin, taxes and fees decreased by 13.7% ($51 million) over the last two fiscal years, in part due to the termination of the RHO Phase I program and changes in the MCO capitation rates.

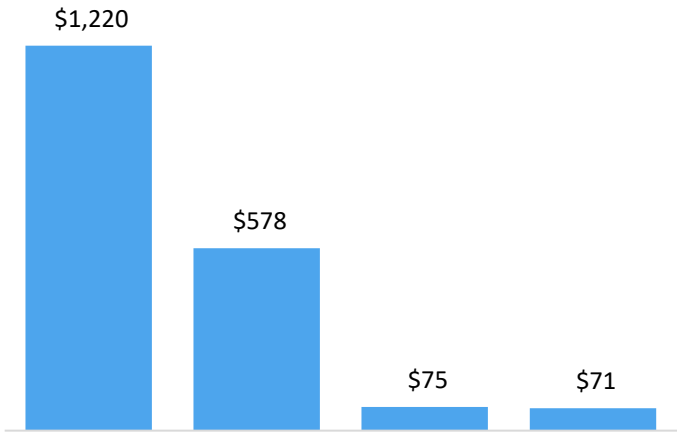
Expenditures by Acute Care Service Type

Acute care services comprise $1.5 billion of total spending in SFY 2019. Acute care includes inpatient, outpatient, professional, pharmacy, transportation and ancillary services. Select average cost and utilization metrics are shown below. Note that the average cost per script does not include offsetting drug rebates.

- From SFY 2017 to SFY 2019, costs per Emergency Department (ED) visit, outpatient visit, and pharmacy claim experienced yearly average increases of 8.5%, 3.7% and 7.7%, respectively. However, cost per inpatient day stayed approximately the same.
- During this time span, inpatient utilization increased significantly (8.1% annually), while ED visits dropped (8.0%, annually). Office visits and pharmacy utilization per person grew modestly.

Cost of Services

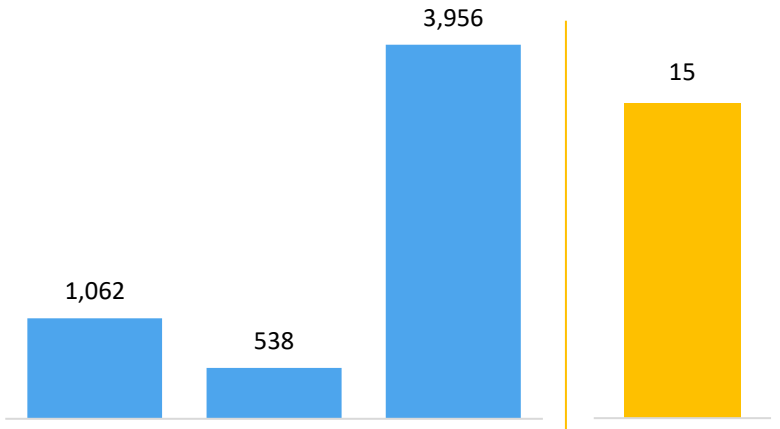
Average Cost - SFY 2019



-0.1%	8.5%	3.7%	7.7%
Average Annual Growth – SFY 2017 - 2019			

Acute Care Utilization

SFY 2019



8.1%	-8.0%	0.2%	1.3%
Average Annual Growth – SFY 2017 - 2019			

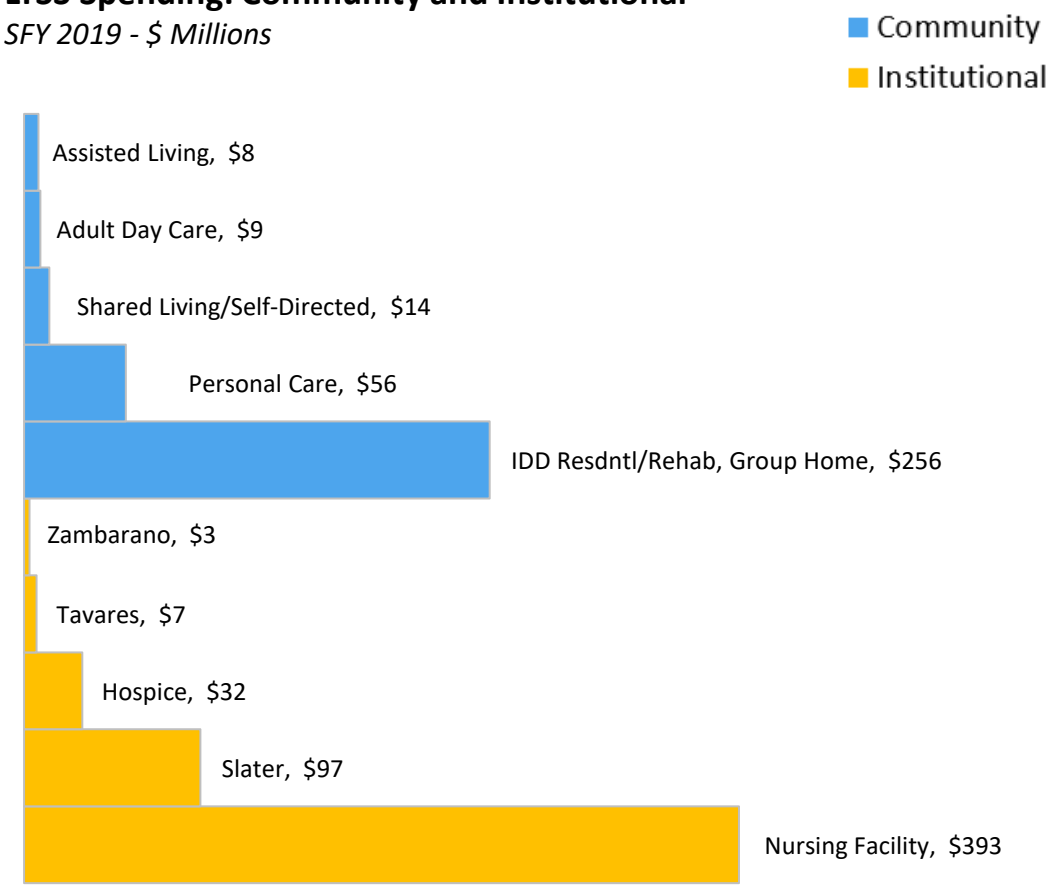
Note: The utilization and cost per unit metrics on this page are based on detailed claims data and do not include gross-level adjustments.

LTSS Spending: Community and Institutional

LTSS include institutional care and community care. These services are mainly focused on the Elders and Adults with Disabilities populations. Expenditures on LTSS accounted for $876 million in Medicaid expenditures in SFY 2019, which was 33% of total Medicaid expenditures. A breakdown of how LTSS dollars were spent is shown below.

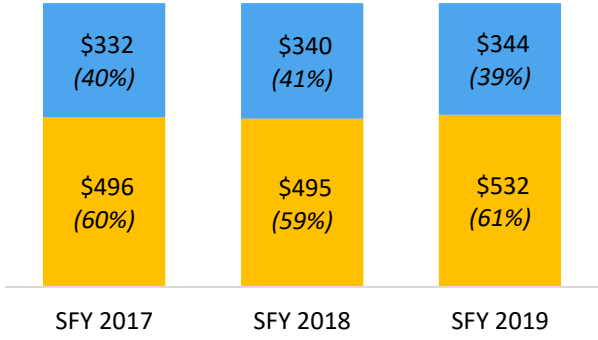
LTSS Spending: Community and Institutional

SFY 2019 - $ Millions



- Community care services are provided to at-risk populations as alternatives to more costly nursing facility/institutional options. Community care includes residential and rehabilitation services for persons with Intellectually and Developmentally Disabled (IDD), which account for 75% of spending in this category, as well as Home and Community-Based Services (HCBS) and group homes.
- Institutional care services include nursing facility services, which account for 74% of spending in this category, as well as hospice care and care in the Slater Hospital, and the Tavares and Zambarano facilities.

SFY 2017 - 2019 - $ Millions



Populations

All of Rhode Island's Medicaid enrollees are classified into one of five population categories.

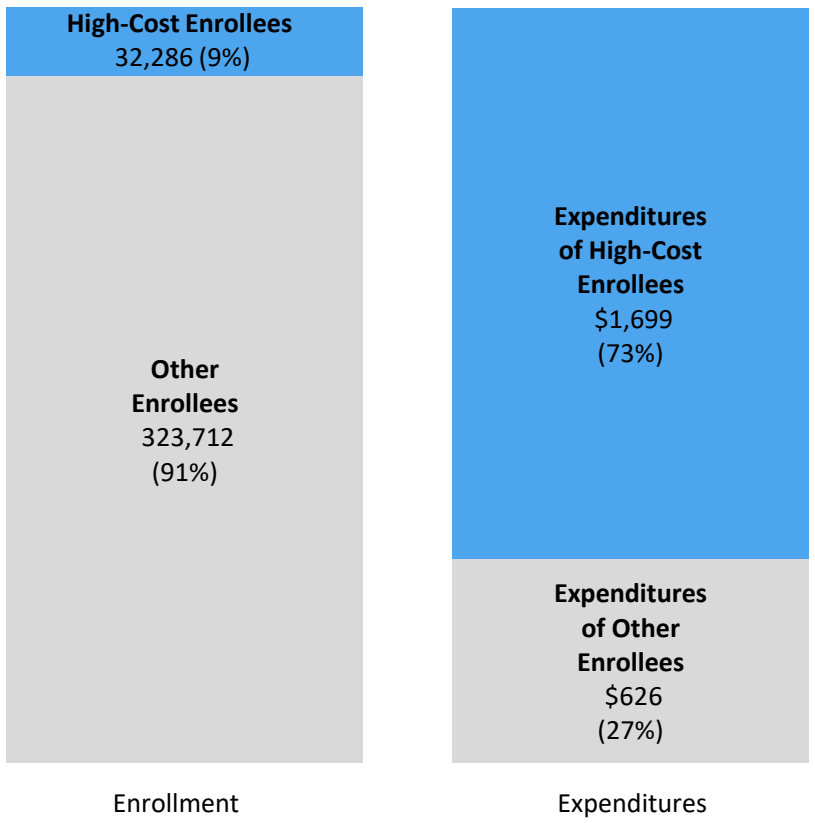
High-Cost Enrollees

Medicaid Enrollee Claims Expenditures

SFY 2019 - $ Millions

Total $2.3 B

355,998 Total Unique Enrollees

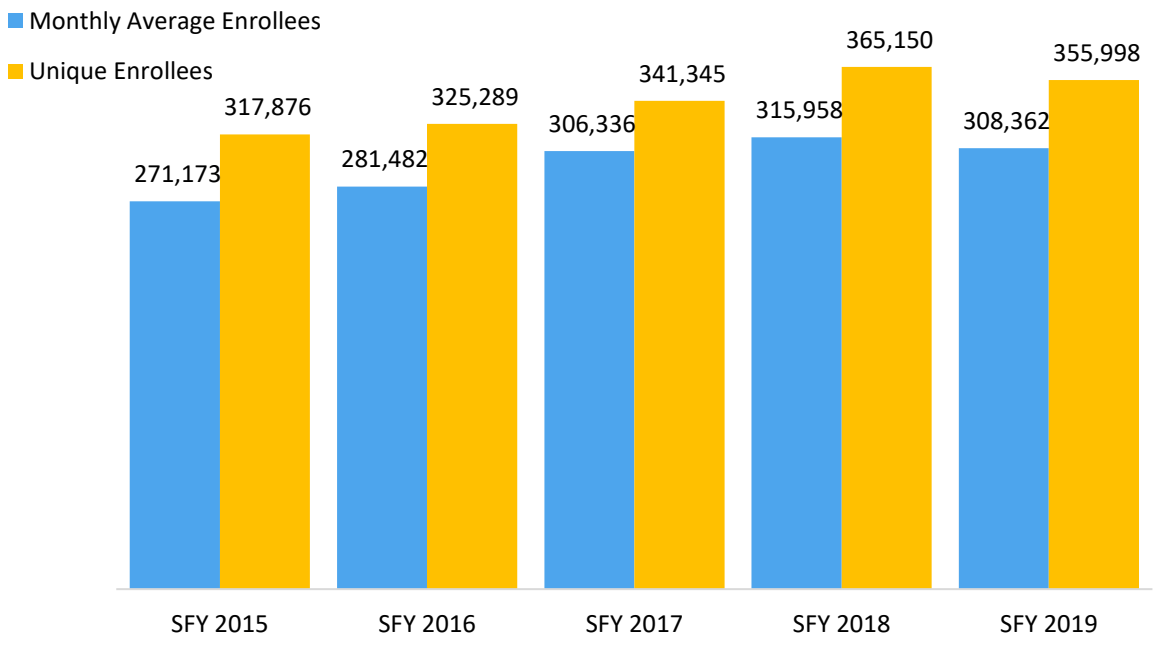


- High-cost enrollees are enrollees who incur more than $15,000 of total claims expenditures over the course of a fiscal year.
- Medicaid claims expenditures are highly concentrated. The top 9% of Medicaid enrollees account for almost three quarters (73%) of Medicaid claims expenditures.
- High cost enrollees typically have multiple, complex conditions, requiring care coordination across a variety of provider types.
- Most high-cost enrollees residing within the community belong to the Adults with Disabilities or Expansion populations.
- Nearly all nursing facility residents, individuals residing in institutions such as rehabilitation hospitals, and those in group homes and facilities for the intellectually and developmentally disabled are high-cost enrollees.
- Notes:
  - Chart shows claims-specific payments only.
  - Certain expenditures are not attributable to specific users.

Unique Enrollees

Approximately three in ten Rhode Islanders were enrolled in Medicaid at any point in time in SFY 2019. This represents a slight increase over a five-year period.

Average and Unique Enrollees - Fully Covered Populations/Services
SFY 2019



	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Turnover Ratio	1.17	1.16	1.11	1.16	1.15
Average Enrollees: % of RI Pop[1]	26%	27%	29%	30%	29%

- Unique enrollees is a measure of the number of individuals enrolled in Medicaid at any time during the fiscal year.
- Monthly average eligible enrollment is annual full time equivalents, or 12 months of eligibility.

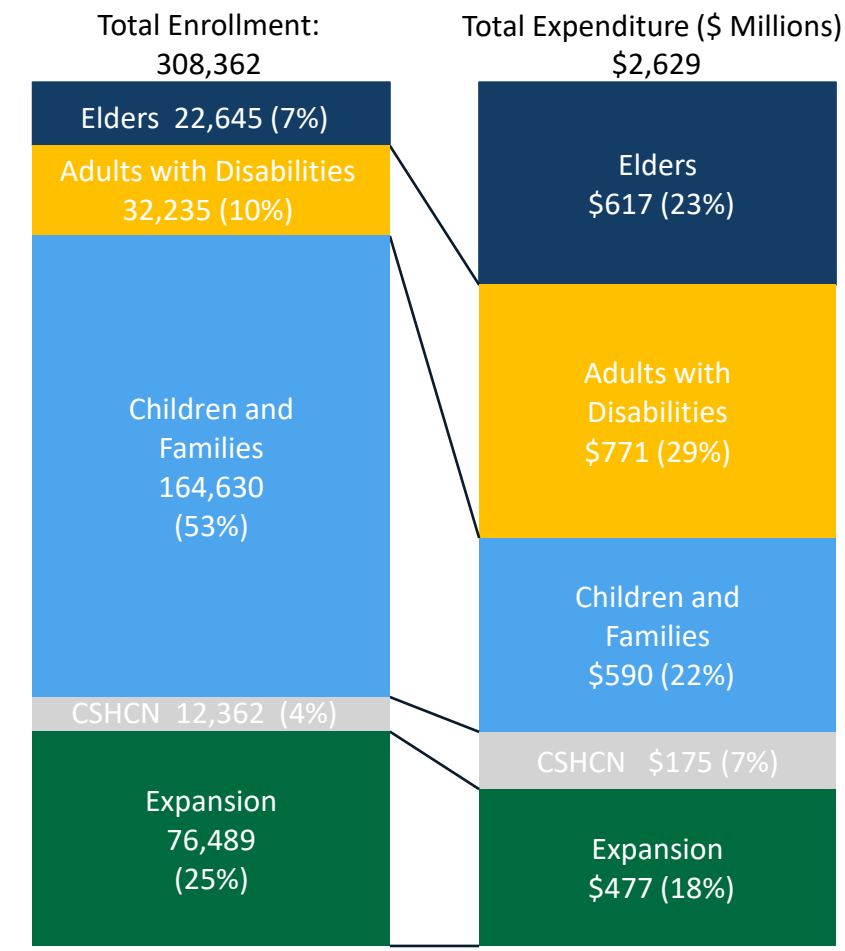
[1]Source: Population Division, US Census Bureau. According to the US Census, Rhode Island's population was 1,059,361 in CY 2019, 1,058,287 in CY 2018, 1,055,673 in CY 2017, 1,056,770 in CY 2016, and 1,056,065 in CY 2015.

Expenditures by Population

- **Elders** are over age 65. They have an average PMPM cost of $2,270, which is the highest of the five populations. 92% of them are also covered by Medicare. Nursing facilities and hospice account for 59% of expenditures on Elders.
- **Adults with Disabilities** are under age 65 and have identified disabilities. They have the second-highest PMPM of any population, at $1,993. About half (48%) of this population is also covered by Medicare. Residential and rehabilitative services account for 28% of expenditures for this population.
- **Children and Families** are children, parents and pregnant women. They have PMPM costs of $298, which is the lowest of the five populations. Professional services and hospital care account for 41% and 40% of expenditures for this population, respectively.
- **CSHCN** require more care for their physical, development, behavioral or emotional differences than their typically developing peers, and consist of enrollees under 21 who are eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. They have PMPM costs of $1,176. Professional services account for 54% of expenditures for this population.
- **Expansion** are adults newly eligible under the Affordable Care Act in 2014, have a PMPM of $520. Hospital and professional services account for 44% and 26% of expenditures for this population, respectively.

Medicaid Enrollment/Expenditure by Population

SFY 2019 - $ Millions



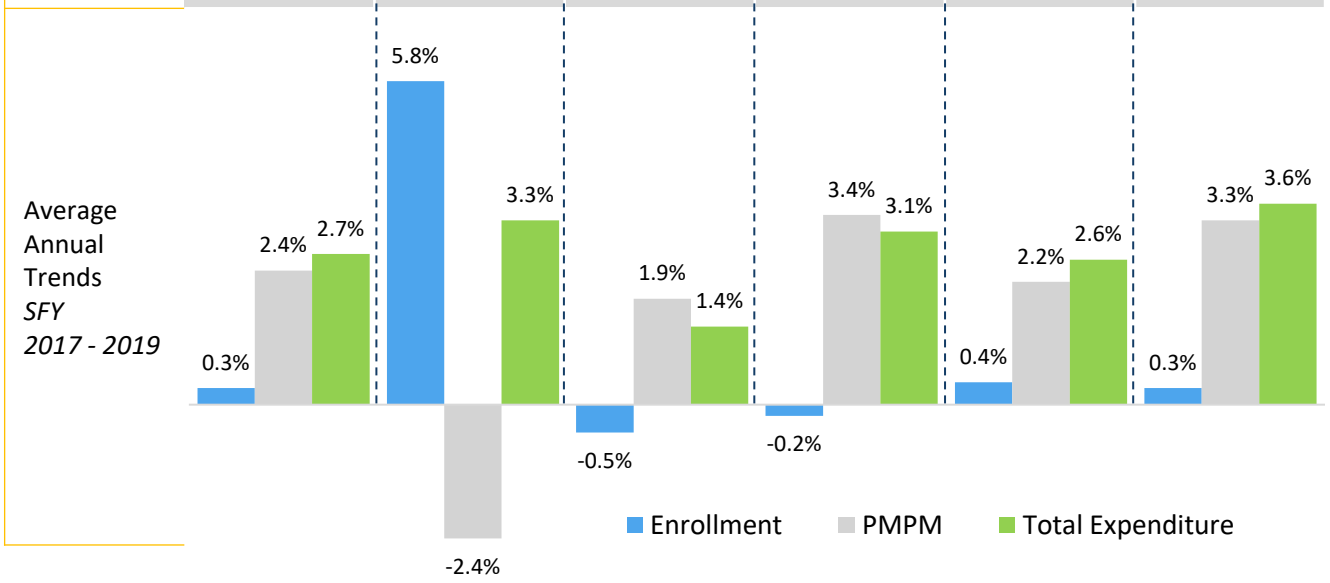
Expenditures by Population: Trends

From SFY 2017 to 2019, overall expenditures, enrollment, and PMPM all increased: expenditures by 2.7% ($138 M), enrollment by 0.3% (2,026) and PMPM by 2.4% ($33). Growth or decline in each of these areas varied by population.

Current Expenditures and Trends

SFY 2017 - 2019

SFY 2019	Overall	Elders	Adults with Disabilities	Children and Families	CSHCN	Expansion
Enroll-ment	308,362	22,645	32,235	164,630	12,362	76,489
PMPM	$710	$2,270	$1,993	$298	$1,176	$520
Expen-diture	$2,629 M (100%)	$617 M (23%)	$771 M (29%)	$590 M (22%)	$175 M (7%)	$477 M (18%)



From SFY 2017 - 2019 population groups experienced the following average annual trends:

- **Elders** had the largest increase in enrollment, of approximately 2,400. Nursing facility expenditures for Elders, which is their largest spending category, grew with enrollment, at an average annual rate of 4%.
- **Adults with Disabilities** enrollment decreased slightly, although their largest spending category, IDD Residential/Rehab, grew by a 2% average over this time span.
- **Children and Families** also had a slight decrease in enrollment. However, their largest spending categories: professional, inpatient and outpatient (OP), all grew by 5% or more.
- **CSHCN** expenditure and PMPM increases can be mostly attributed to average annual increases in their two largest spending categories: professional (2.2%) and inpatient (5.2%).
- **Medicaid Expansion** expenditure and PMPM increases can mostly be attributed to an 8.6% average annual increase in inpatient expenditures, which is their second-largest spending category.

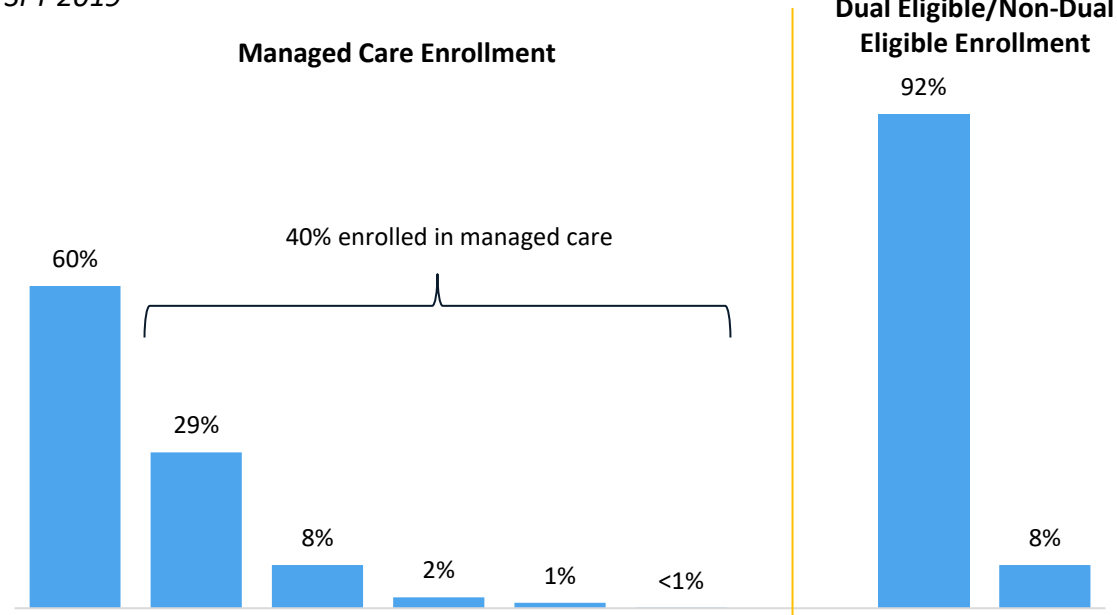
Elders: Managed Care and Dual Enrollment

Elders are the only population for which most enrollees are not enrolled in managed care. They are also one of two populations (the other being Adults With Disabilities) which can also be enrolled in Medicare, and the only population for which a majority are also enrolled in Medicare.

Elders: Managed Care and Dual Eligible Enrollment

SFY 2019

Elders Expenditure = $617 M
Elders Average Monthly Enrollees = 22,645



Not Enrolled	RHO Integrity	RHO Phase I	RHP	PACE	Other	Dual Eligible	Non-Dual Eligible
13,523	6,523	1,812	498	259	30	20,823	1,823
Average Monthly Enrollees – SFY 2019							
24.3%	45.5%	-51.0%	-7.2%	4.4%	-6.2%	5.5%	10.2%
Avg Annual Growth – SFY 2017 - 2019							

- Only 40% of Elders have their Medicaid coverage administered by a private MCO (the remainder are in FFS).
- 29% of Elders are enrolled in RHO Integrity and another 8% were enrolled in RHO Phase I, which are managed care programs for LTSS and other Medicaid-funded services designed primarily for individuals who are dually eligible for Medicaid and Medicare.
- 92% of Elders are covered by both Medicare and Medicaid (called “dual eligible”).
- Notes:
  - The RHO Phase I program ended on September 30, 2018.
  - For the Elders who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, professional, pharmacy).

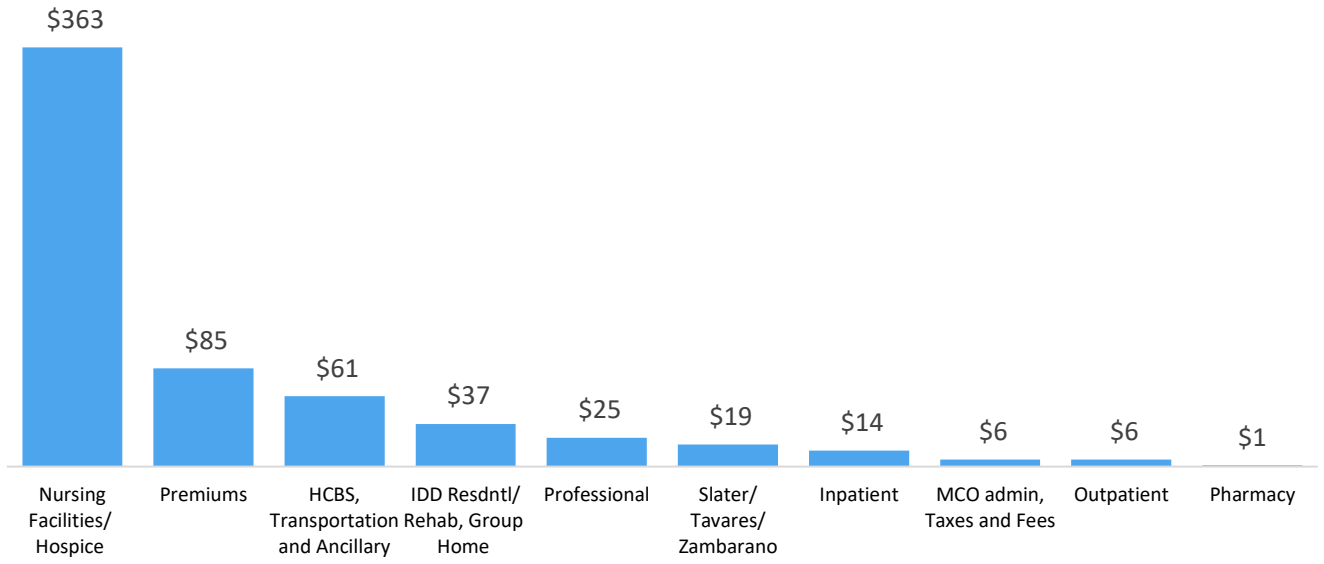
Elders: Expenditures by Provider Type

Most expenditures for Elders go towards long-term stays in nursing facilities, which are covered by Medicaid but not Medicare.

Elders: Medicaid Expenditures by Provider Type

SFY 2019 – $ Millions

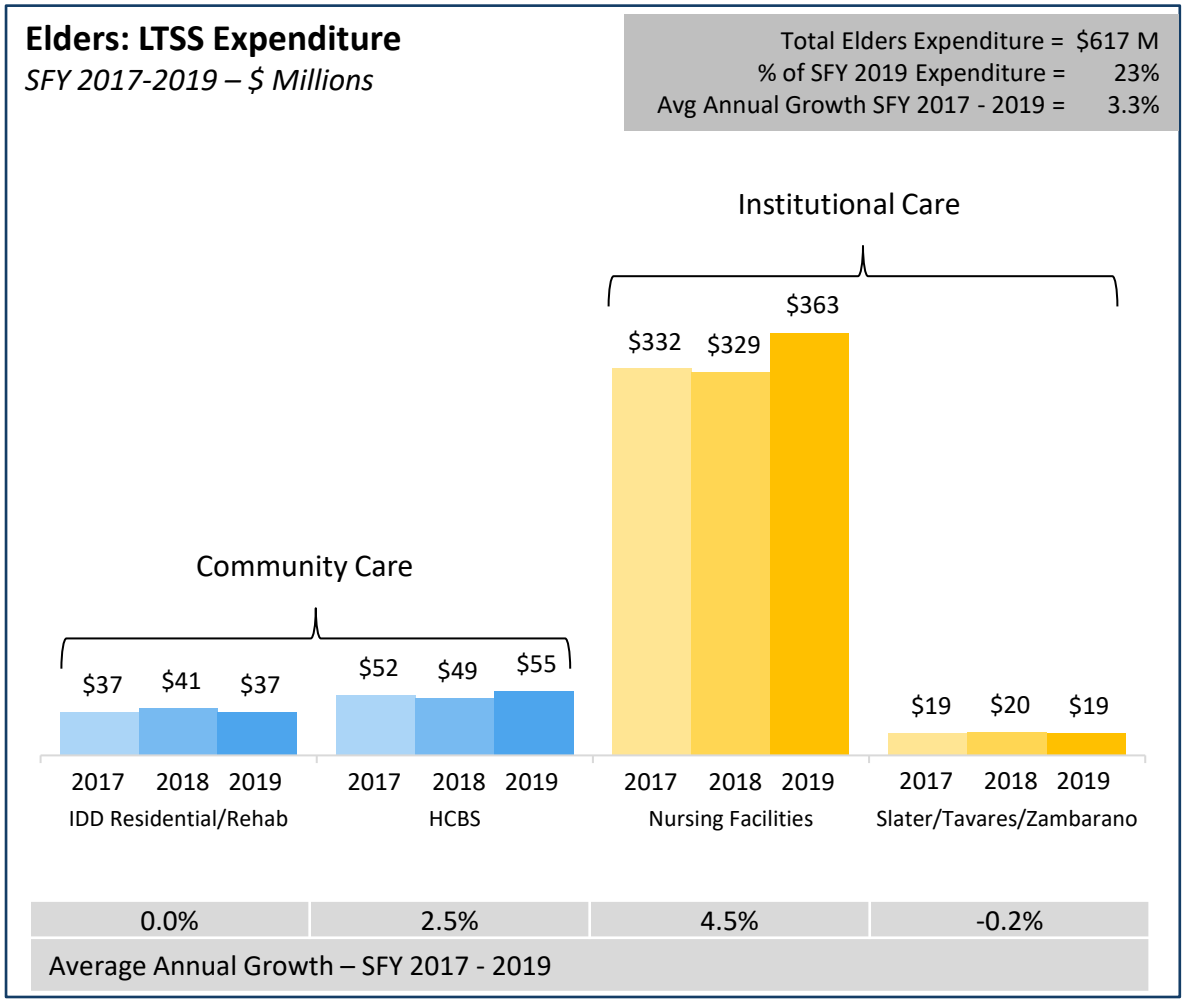
Total Elders Expenditure =	$617 M
% of SFY 2019 Expenditure =	23%
Avg Annual Growth SFY 2017 - 2019 =	3.3%



Nursing Facilities/ Hospice	Premiums	HCBS, Transportation and Ancillary	IDD Resdntl/ Rehab, Group Home	Professional	Slater/ Tavares/ Zambarano	Inpatient	MCO admin, Taxes and Fees	Outpatient	Pharmacy
4.5%	11.1%	1.3%	0.0%	6.9%	-0.2%	9.3%	-45.8%	-2.6%	7.7%
Avg Annual Growth – SFY 2017 - 2019									
58.8%	13.9%	9.9%	6.0%	4.0%	3.0%	2.3%	1.0%	0.9%	0.1%
% of Total Elders Expenditures – SFY 2019									
16.2%	5.5%	5.6%	9.8%	23.1%	4.1%	13.5%	5.7%	10.7%	6.0%
All Populations Provider Type Spend as % All Populations Expenditures – SFY 2019*									

- Medicaid expenditures on Elders totaled $617 million in SFY 2019, an increase of 5.9% since SFY 2018.
- Nursing facility expenditures totaled $333 million for this population, and hospice expenditures totaled $29 million.
- Notes:
  - The large majority of Elders are also eligible for Medicare, which was the primary payer for most medical services (e.g. hospital, professional). Consequently, those expenditures were not paid by Medicaid and are not included here.
  - Most premiums for this population are Medicare premiums, which Medicaid pays for those who are dual eligible.
  - All populations include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Elders: LTSS Expenditure Trends



- There is currently a state initiative to "rebalance" LTSS expenditures back into the community instead of institutions. Providing services in this setting can integrate efforts with communities and enable LTSS enrollees to thrive in them, but in many instances an institutional setting is required to fulfill patient needs.
- Overall, expenditures on institutional care for Elders rose by $32 million from SFY 2018 to 2019, while expenditures for community care rose by $3 million. This trend goes against the rebalancing initiative; it is largely driven by the increase in enrollment of Elders, who live in nursing facilities.
- In SFY 2019, institutional spending for Elders was more than four times that of community spending; this is in contrast to Adults with Disabilities, the other population who frequently uses LTSS services, for whom more is spent on community care and institutional care.
- Nursing facility expenditures for Elders increased by $34 million from SFY 2018 to 2019, a 10% increase.
- HCBS expenditure for Elders increased $6 million from SFY 2018 to 2019, a 13% increase.

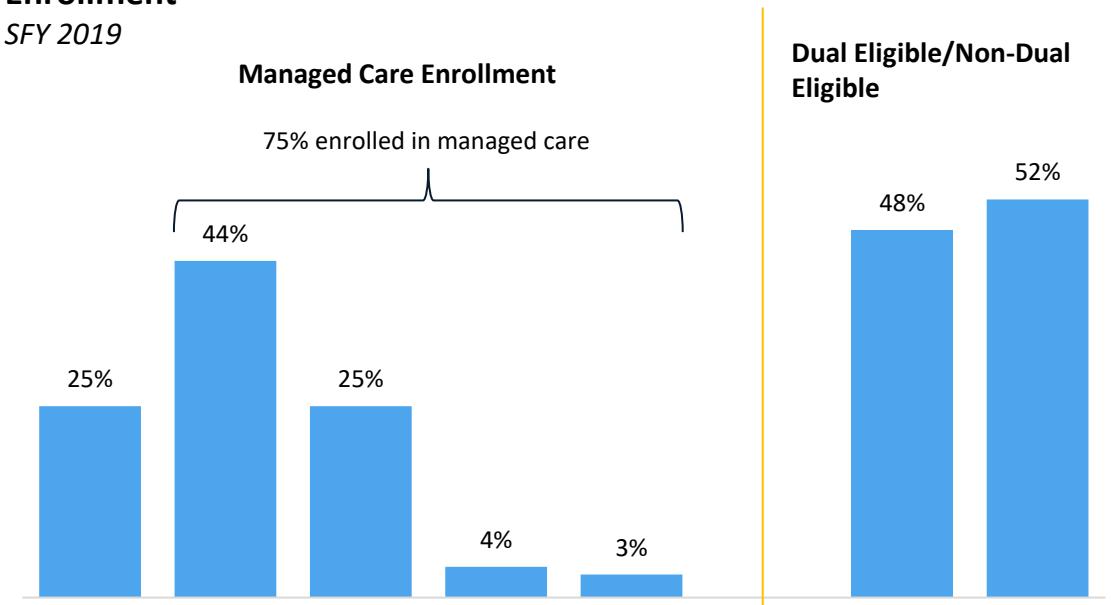
Adults with Disabilities: Managed Care Enrollment

Most Adults with Disabilities are enrolled in managed care programs, but this population is enrolled at lower rates than all other populations except Elders. Adults with Disabilities are also one of two populations (the other being Elders) who can also be enrolled in Medicare, and approximately half of this population is enrolled in Medicare.

Adults with Disabilities: Managed Care and Dual Eligible Enrollment

SFY 2019

Adults w/ Disab Expenditure = $771 M
Adults w/ Disab Average Monthly Enrollees = 32,235



Not Enrolled	RHP	RHO Integrity	RHO Phase I	Other	Dual Eligible	Non-Dual Eligible
8,083	14,134	7,913	1,252	854	15,483	16,752
Average Monthly Enrollees – SFY 2019						
23.7%	-0.8%	40.7%	-60.4%	-4.1%	-0.1%	-0.8%
Avg Annual Growth – SFY 2017 - 2019						

- 44% percent of Adults with Disabilities are enrolled in RHP, a comprehensive managed care program for Adults with Disabilities.
- 25% of Adults with Disabilities are enrolled in RHO Integrity and another 4% are enrolled in RHO Phase I.
- 25% of Adults with Disabilities are not enrolled in managed care, and have their Medicaid coverage administered by the state of Rhode Island instead of an MCO.
- 48% of Adults with Disabilities are dual eligible.
- Notes:
  - RHO Integrity and RHO Phase I are managed care programs for LTSS and other Medicaid-funded services designed primarily for individuals with both Medicaid and Medicare eligibility. RHO Phase I ended on September 30, 2018. Phase II, or "RHO Integrity", began in July 2016 and remains in effect.
  - For the Adults with Disabilities who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, professional, pharmacy).

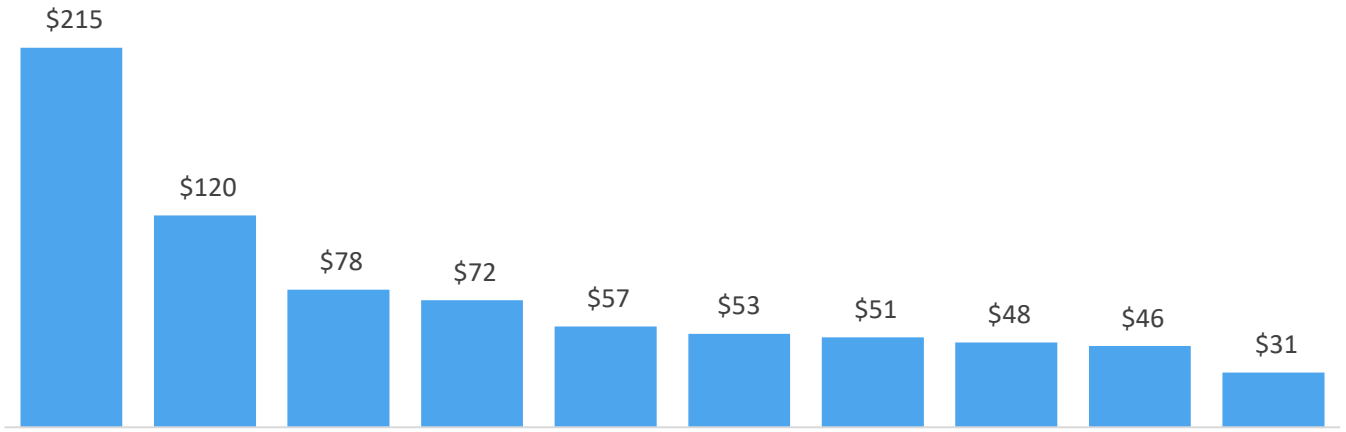
Adults with Disabilities: Expenditures by Provider Type

Most expenditures on Adults with Disabilities go towards residential/rehabilitation services or group homes for Intellectually and Developmentally Disabled enrollees.

Adults with Disabilities: Expenditures by Provider Type

SFY 2019 – $ Millions

Total Adults with Disabilities Expenditure =	$771 M
% of SFY 2019 Expenditure =	29%
Avg Annual Growth SFY 2017 - 2019 =	1.4%

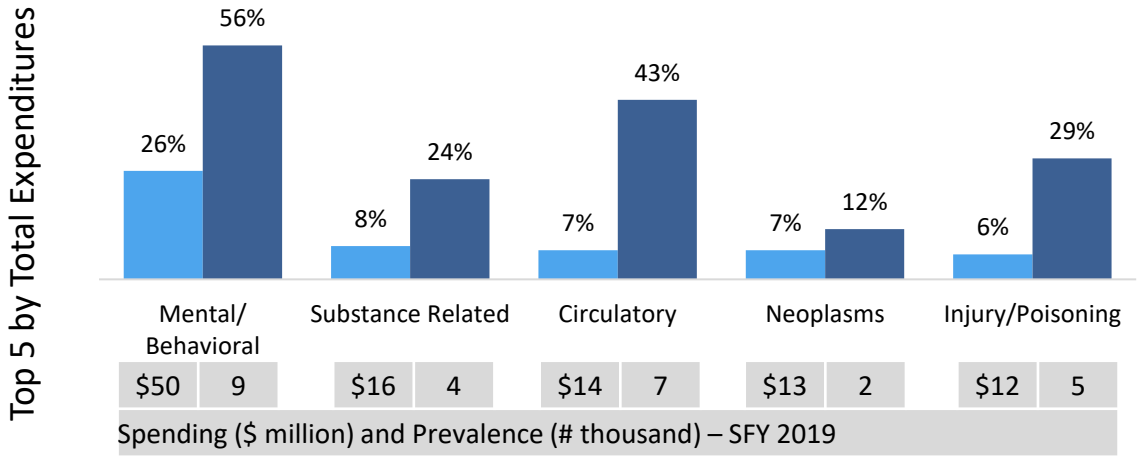


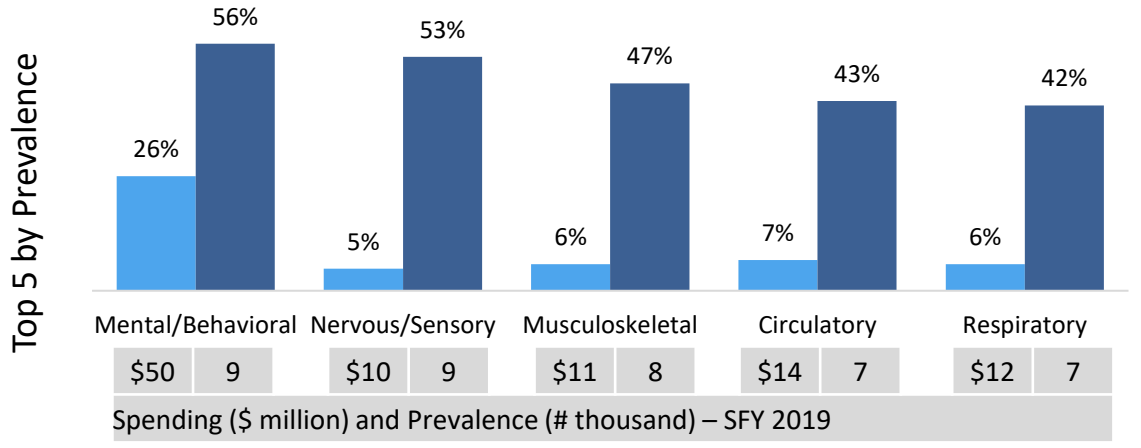
1.9%	3.5%	-3.9%	5.9%	6.8%	4.9%	-5.1%	1.9%	7.7%	-12.8%
Avg Annual Growth – SFY 2017 - 2019									
27.9%	15.5%	10.1%	9.3%	7.5%	7.0%	6.5%	6.2%	5.9%	4.1%
% of Total Adults with Disabilities Expenditure – SFY 2019									
9.8%	23.1%	4.1%	13.5%	5.5%	16.2%	5.6%	10.7%	6.0%	5.7%
All Populations Provider Type Spend as % all Populations Expenditures – SFY 2019									

- Over the past two years, Adults with Disabilities have had the lowest overall expenditure and PMPM growth rates of any population.
- The highest trend rates for Adults with Disabilities are pharmacy, premiums, inpatient and nursing facility/hospice; growth rates for these services are similar to the overall population.
- Total expenditures for Adults with Disabilities have grown at 1.4% over the last two years, the lowest trend rate of any of the populations.
- Notes:
  - All populations include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Adults with Disabilities: Diagnoses

Adults with Disabilities:
Medicaid Spending and Prevalence by Diagnosis
SFY 2019 – Total $771 M





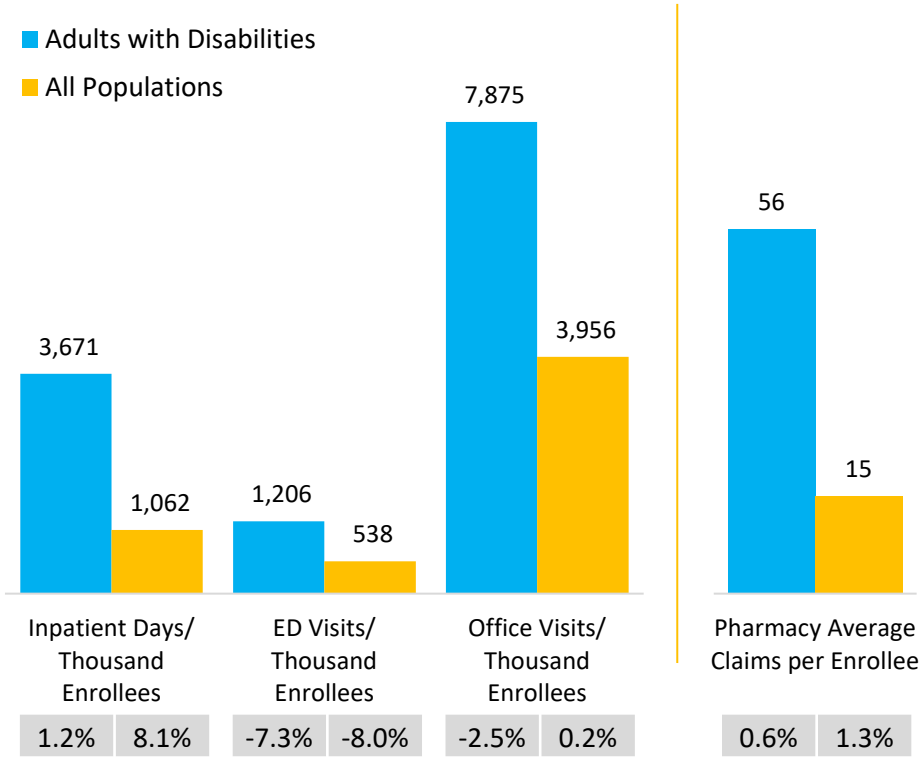
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental and behavioral conditions are both the highest cost and most prevalent conditions among Adults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

Adults with Disabilities: Acute Care Service Utilization

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

Adults with Disabilities:
Non-Dual Eligible: Acute Care Utilization
SFY 2019

Non-Dual Eligible Adults with Disabilities = 16,752



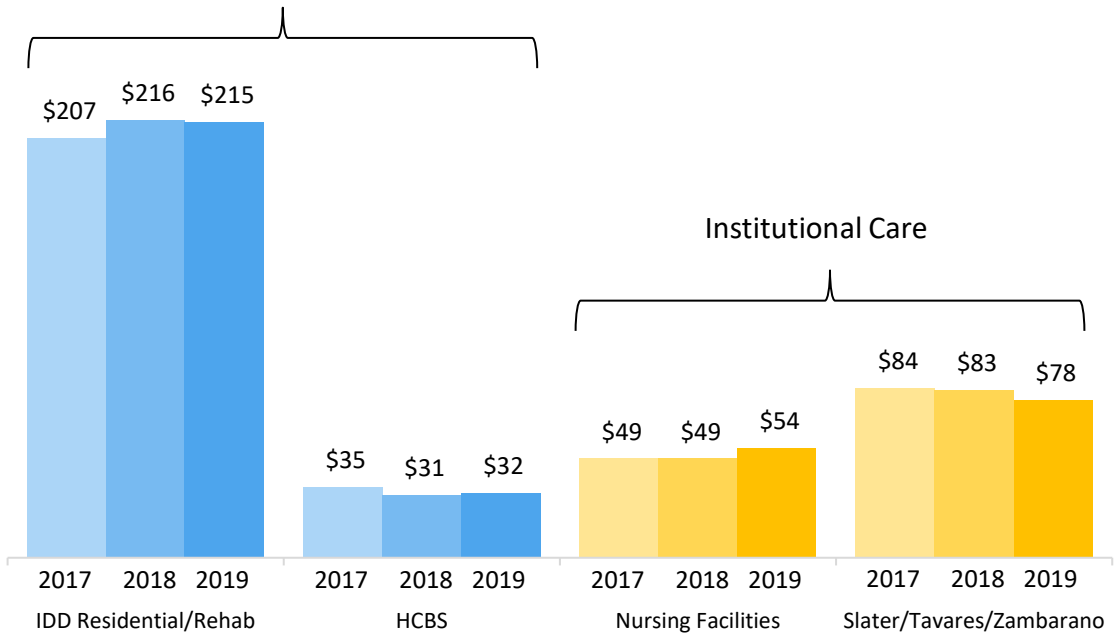
- Although per-person utilization levels are higher for Adults with Disabilities than the overall population, their growth trends are lower than the overall population.
- Adults with Disabilities spent an average of 3.7 days in the hospital in SFY 2019, whereas the average Medicaid enrollee spent only 1.1 days.
- Per-person inpatient utilization increased 1.2% for Adults with Disabilities from SFY 2017 to SFY 2019, but increased 8.1% for the overall population.
- The average Adults with Disabilities had 56 pharmacy claims per year, whereas the average enrollee has 15 pharmacy claims per year.
- Notes:
  - All populations include Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Adults with Disabilities: LTSS Expenditure Trends

Adults with Disabilities: LTSS Expenditure

SFY 2017 - 2019 – $ Millions

Total Adults w/ Disab Expenditure =	$771 M
% of SFY 2019 Expenditure =	29%
Avg Annual Growth SFY 2017 - 2019 =	1.4%



1.9%	-3.9%	4.9%	-4.1%

Average Annual Growth – SFY 2017 - 2019

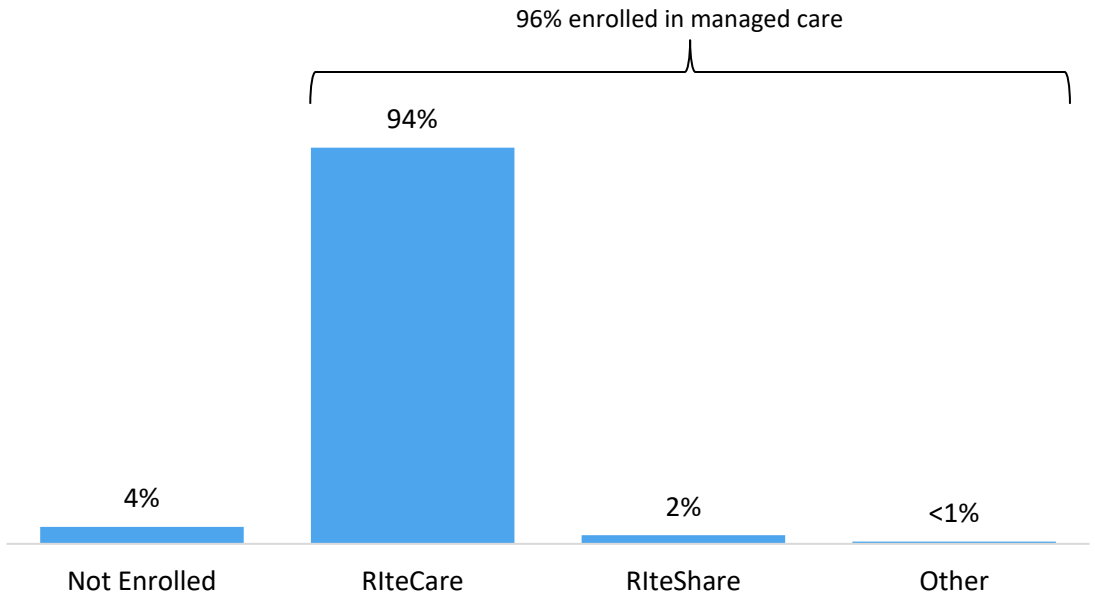
- There is currently a state initiative to "rebalance" LTSS expenditures back into the community instead of institutions. Providing services in this setting can integrate efforts with communities and enable LTSS enrollees to thrive in them, but in many instances an institutional setting is required to fulfill patient needs.
- Adults with Disabilities have more expenditures in the community care category than the institutional care category. This is in contrast to Elders, the other population who frequently uses LTSS services, for whom more than four times as much is spent on institutional care.
- Residential and rehabilitation services for those with IDD are the highest LTSS expenditures for Adults with Disabilities.

Children and Families: Managed Care Enrollment

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

Children and Families: Managed Care Enrollment
SFY 2019

Children and Families Expenditure = $590 M
Average Monthly Enrollees = 164,630



5,867	154,752	3,246	765
Average Monthly Enrollees – SFY 2019			
-21.9%	2.0%	-27.6%	0.3%
Avg Annual Growth – SFY 2017 - 2019			

- 94% of the Children and Families population is enrolled in RIte Care, a managed care program for families with children, pregnant women and children under age 19.
- RIte Care enrollees are divided between Neighborhood Health Plan, United Healthcare, and Tufts Health Plan. 64% are covered by Neighborhood Health Plan, 33% are covered by United Healthcare and 3% are covered by Tufts Health Plan.
- Notes:
  - RIte Share is a program designed to allow Medicaid enrollees with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditures by leveraging the employer's contribution.
  - The unenrolled Children and Families include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

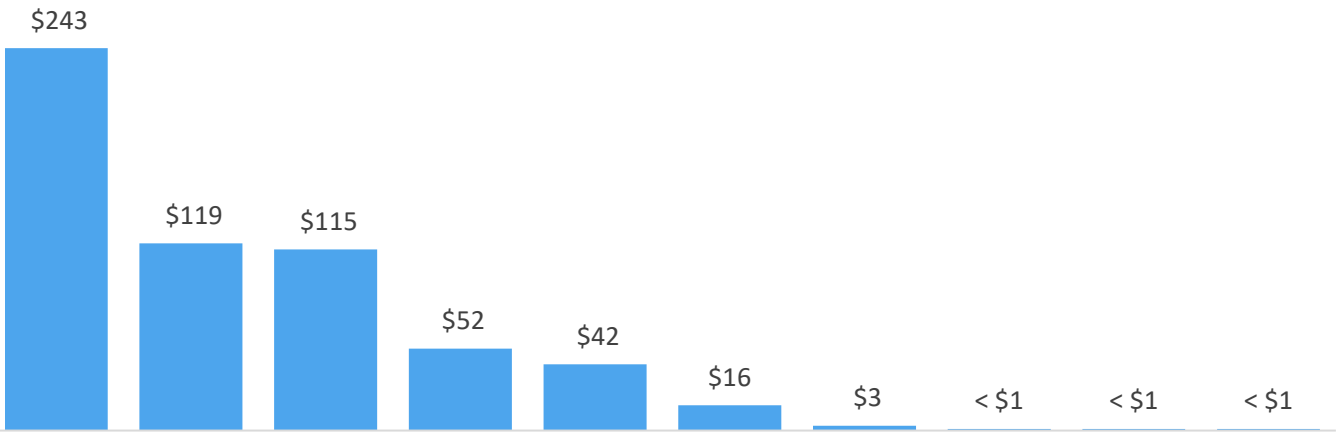
Children and Families: Expenditures by Provider Type

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

Children and Families: Expenditures by Provider Type

SFY 2019 – $ Millions

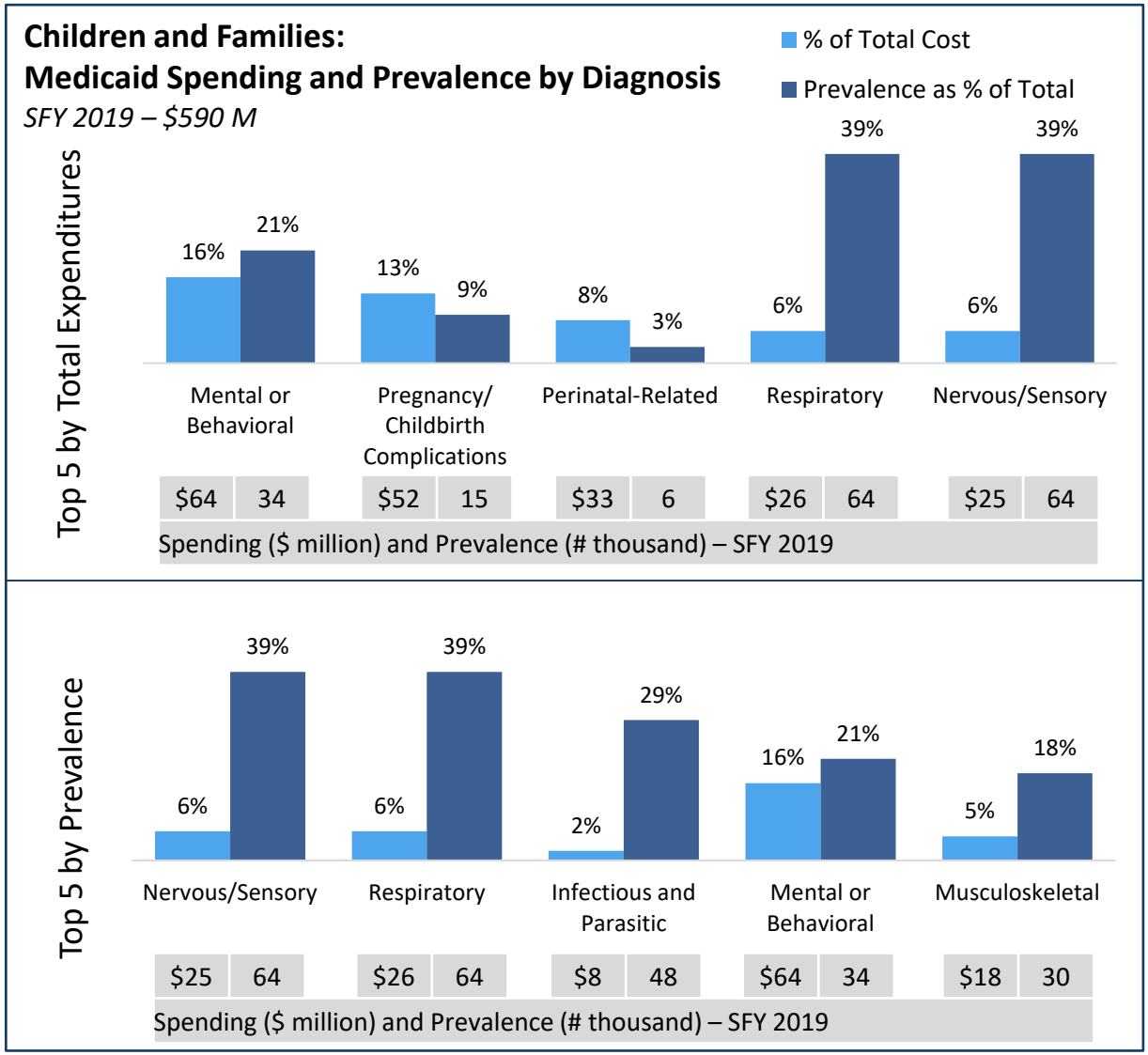
Total Children and Families Expenditure =	$590 M
% of SFY 2019 Expenditure =	22%
Avg Annual Growth SFY 2017 - 2019 =	3.1%



Professional	Outpatient	Inpatient	MCO Admin/ Taxes	Pharmacy	HCBS, Transportation and Ancillary	Premiums	Nursing Home/ Hospice	Slater/ Tavares/ Zambarano	IDD Redntl/ Rehab, Group Home
4.9%	5.4%	6.3%	-11.8%	10.6%	-9.0%	-20.7%	-14.9%	n/a	n/a
Avg Annual Growth – SFY 2017 - 2019									
41.1%	20.2%	19.5%	8.9%	7.1%	2.6%	0.4%	0.1%	0.0%	0.0%
% of Total Children and Families Expenditure – SFY 2019									
23.1%	10.7%	13.5%	5.7%	6.0%	5.6%	5.5%	16.2%	4.1%	9.8%
All Populations Provider Type Spend as % all Populations Expenditures – SFY 2019*									

- Children and Families is the largest population group in Rhode Island Medicaid, with 53% of all Medicaid enrollees falling into this category.
- Children and Families have the lowest per-person expenditures of any of the populations.
- The fastest-growing expenditure category for Children and Families is pharmacy, which grew at a yearly average of 10.6% from SFY 2017 to 2019; this growth outpaced overall pharmacy spending growth, which was 9.0%.
- Notes:
  - All populations include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Children and Families: Diagnoses



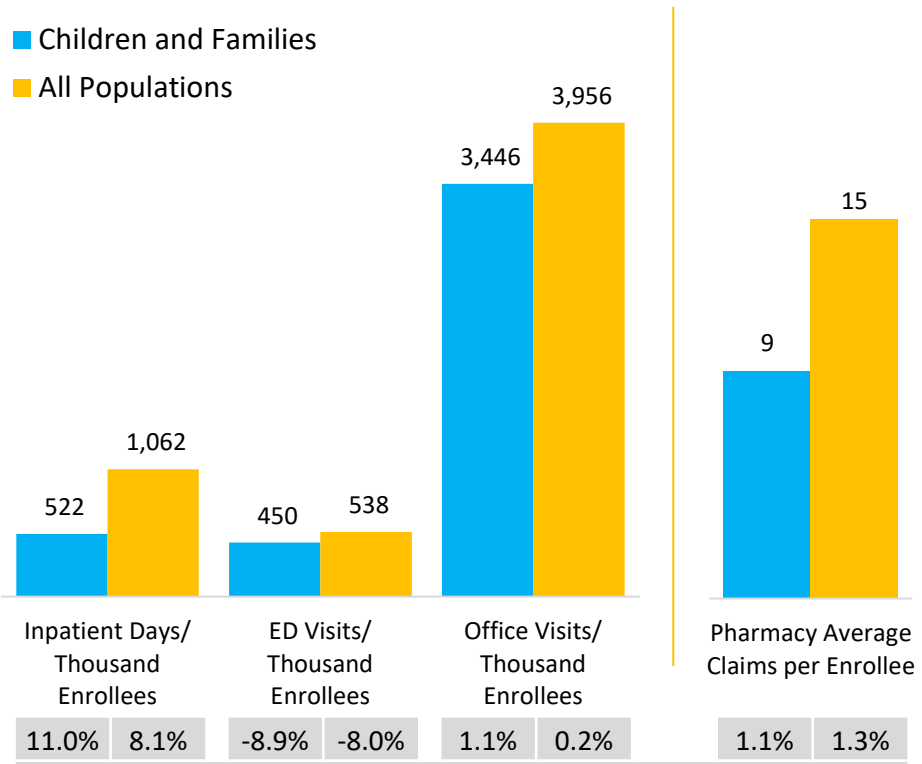
- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Similarly to other populations, mental or behavioral health has high prevalence and high cost for Children and Families.
- Complications of pregnancy, childbirth and postpartum, and certain conditions originating in the perinatal period account for 21% of expenditures for Children and Families.
- Diseases of the nervous system and sense organs, respiratory system, infectious and parasitic diseases, and musculoskeletal diagnoses are also prevalent among Children and Families.

Children and Families: Acute Care Service Utilization

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

Children and Families: Acute Care Utilization
SFY 2019

Children and Families Enrollment = 164,630



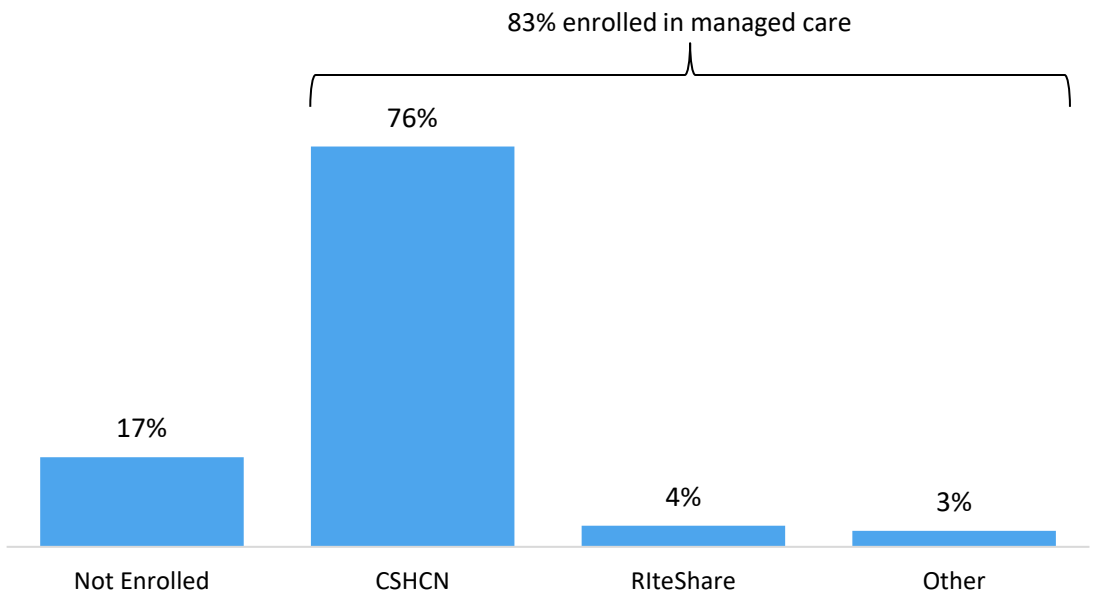
- Children and Families use, on average, fewer than half as many inpatient days per person as the overall Medicaid population.
- Children and Families use the ED and have office visits at levels approximately 15% lower than the overall population.
- Per person utilization for Children and Families have lower growth trends than the overall population for all services.
- Notes:
  - All populations include Adults with Disabilities, Children and Families, CSHCN, and Expansion.

CSHCN: Managed Care Enrollment

CSHCN are primarily enrolled in managed care, in the CSHCN managed care program.

CSHCN: Managed Care Enrollment
SFY 2019

CSHCN Expenditure = $175 M
Average Monthly Enrollees = 12,362



Not Enrolled	CSHCN	RIteShare	Other
2,163	9,341	537	321
Average Monthly Enrollees – SFY 2019			
0.9%	1.7%	-15.9%	-4.6%
Avg Annual Growth – SFY 2017 - 2019			

- 76% of CSHCN are covered through the CSHCN managed care program designed specifically for that population.
- CSHCN who live in institutions have their Medicaid coverage administered by the state of Rhode Island and are not enrolled in managed care.
- Enrollees in the CSHCN managed care program are divided between Neighborhood Health Plan, United Healthcare, and Tufts Health Plan.
- CSHCN RIte Share enrollees are eligible or have parents who are eligible for assistance paying for existing employer-based coverage. Wraparound services are provided on an FFS-basis.

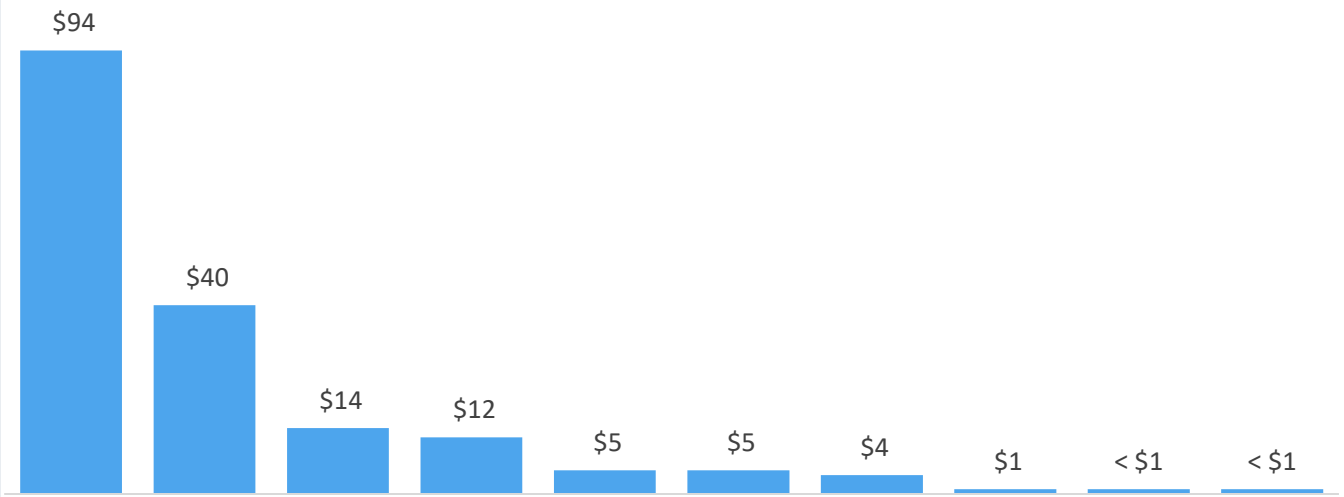
CSHCN: Expenditures by Provider Type

CSHCN expenditures are largely concentrated in professional and inpatient services.

CSHCN: Expenditures by Provider Type

SFY 2019 – $ Millions

Total CSHCN Expenditure =	$175 M
% of SFY 2019 Expenditure =	7%
Avg Annual Growth SFY 2017 - 2019 =	2.6%



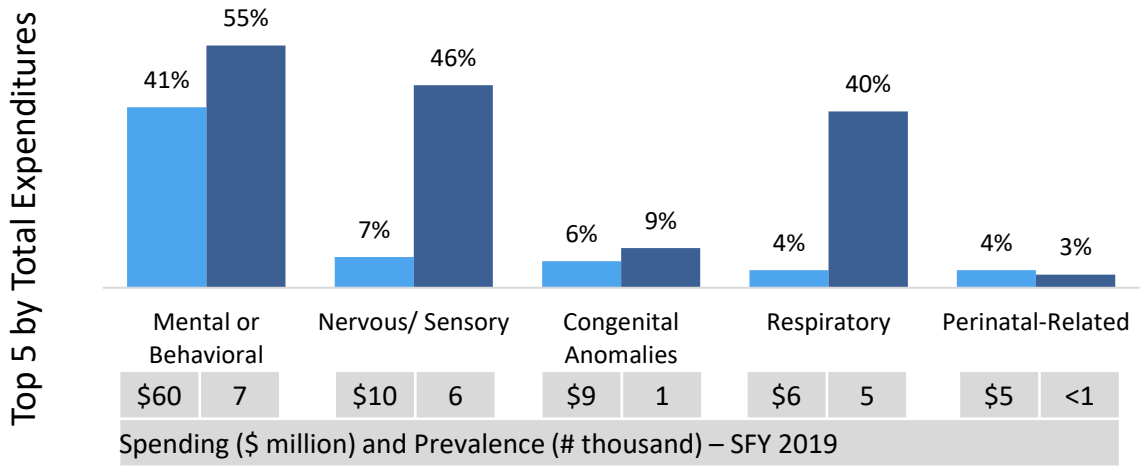
Professional	Inpatient	MCO Admin/ Taxes	Outpatient	HCBS, Transportation and Ancillary	Pharmacy	Slater/ Tavares/ Zambarano	IDD Resdntl/Rehab, Group Homes	Premiums	Nursing Facility/ Hospice
2.2%	5.2%	-3.6%	5.5%	-4.9%	9.1%	2.3%	53.7%	n/a	n/a
Avg Annual Growth – SFY 2017 - 2019									
53.7%	23.0%	7.7%	6.9%	2.9%	2.7%	2.4%	0.5%	0.1%	0.0%
% of Total CSHCN expenditure – SFY 2019									
23.1%	13.5%	5.7%	10.7%	5.6%	6.0%	4.1%	9.8%	5.5%	16.2%
All Populations Provider Type Spend as % all Populations Expenditures – SFY 2019*									

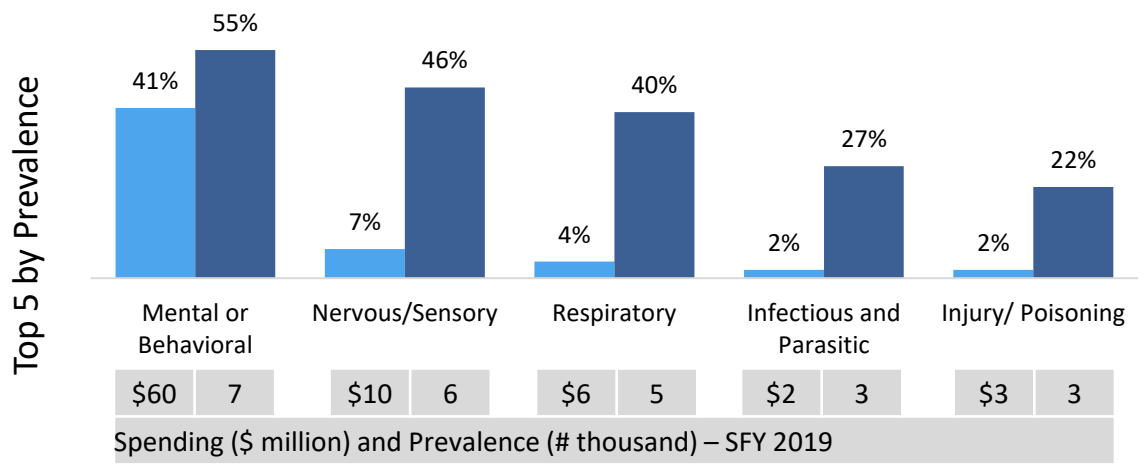
- 77% of CSHCN expenditures go towards professional services and inpatient hospital services.
- A significantly smaller percentage of CSHCN expenditures go towards pharmacy, residential and rehabilitation services for persons with IDD, premiums, and nursing facilities and hospice than for the overall population.
- Average annual growth of professional and inpatient expenditures from SFY 2017 to 2019 was lower than the overall population.
- Average annual growth of outpatient services (5.5%) was higher than that of the overall population (3.0%).
- Notes:
  - All populations include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

CSHCN: Diagnoses

Medicaid Spending and Prevalence by Diagnosis

SFY 2019 – Total $175 M





- A comparison of total cost and prevalence by diagnosis can show the relative cost of treating these diagnoses and help identify potential program areas that will impact the highest areas of need.
- Mental or behavioral health diagnoses have high prevalence and cost among all populations, but are higher among CSHCN than any other population.
- Diagnoses of congenital anomalies are associated with the third-highest expenditures for CSHCN; this diagnosis is not in the top 10 for any other population.
- Mental or behavioral diagnoses, diseases of the nervous system and sense organs, and respiratory system diagnoses are prevalent among the CSHCN population, each affecting at least 40% of the population.

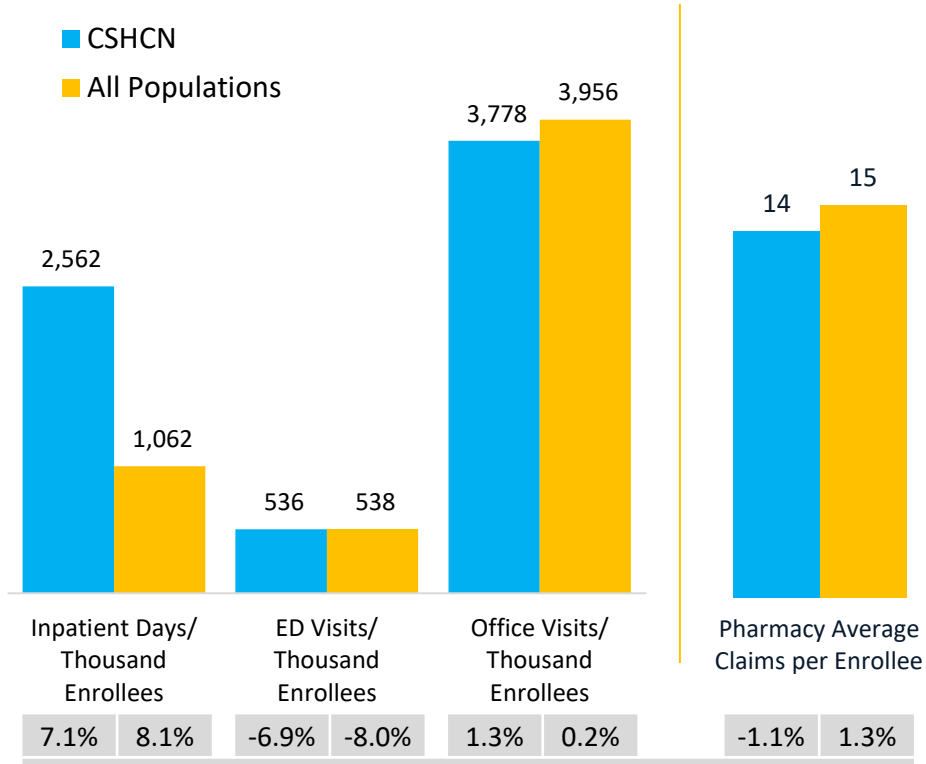
CSHCN: Acute Care Service Utilization

CSHCN use most services at the same approximate rate as the overall population, with the exception of inpatient services.

CSHCN: Acute Care Utilization

SFY 2019

CSHCN enrollment = 12,362



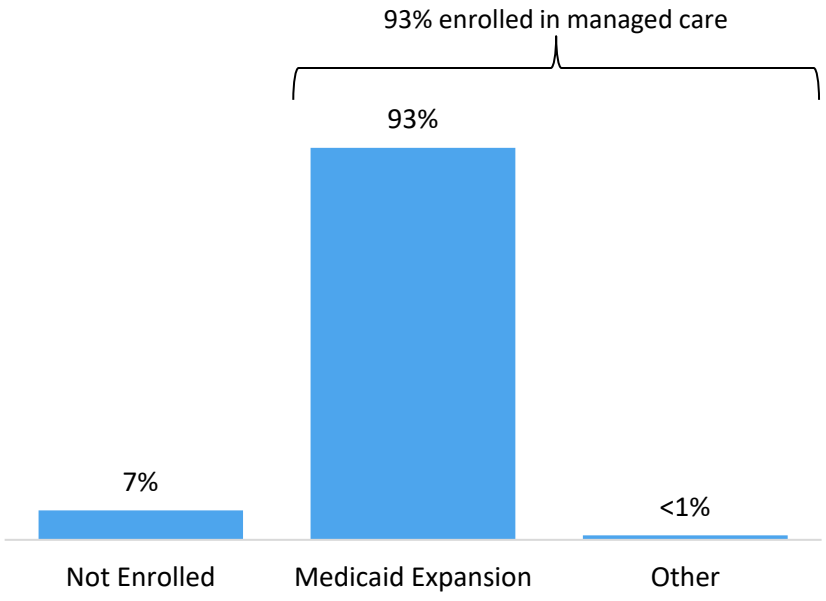
- CSHCN had over twice the number of inpatient days per person than the overall Medicaid population.
- CSHCN rates of utilization for ED, office, and pharmacy utilization are similar to those for the overall population.
- CSHCN expenditure growth has been slower than that of other populations for all acute care service types.
- Notes:
  - All populations include Adults with Disabilities, Children and Families, CSHCN, and Expansion

Expansion: Managed Care Enrollment

The Expansion population is primarily enrolled in managed care.

Expansion: Managed Care Enrollment
SFY 2019

Expansion Expenditure =	$477 M
Average Monthly Enrollees =	76,489



Not Enrolled	Medicaid Expansion	Other
5,113	70,812	564
Average Monthly Enrollees – SFY 2019		
-7.9%	0.9%	7.5%
Avg Annual Growth – SFY 2017 - 2019		

- 93% of the Expansion population is covered through Medicaid Expansion, a managed care program that covers Medicaid enrollees who became eligible for the program when the state expanded Medicaid under ACA in 2014.
- Enrollees in the Medicaid Expansion managed care program are divided between Neighborhood Health Plan, United Healthcare, and Tufts Health Plan.
- The Medicaid Expansion population is almost entirely enrolled in managed care. However, new enrollees experience an initial period in FFS prior to enrollment in a health plan.

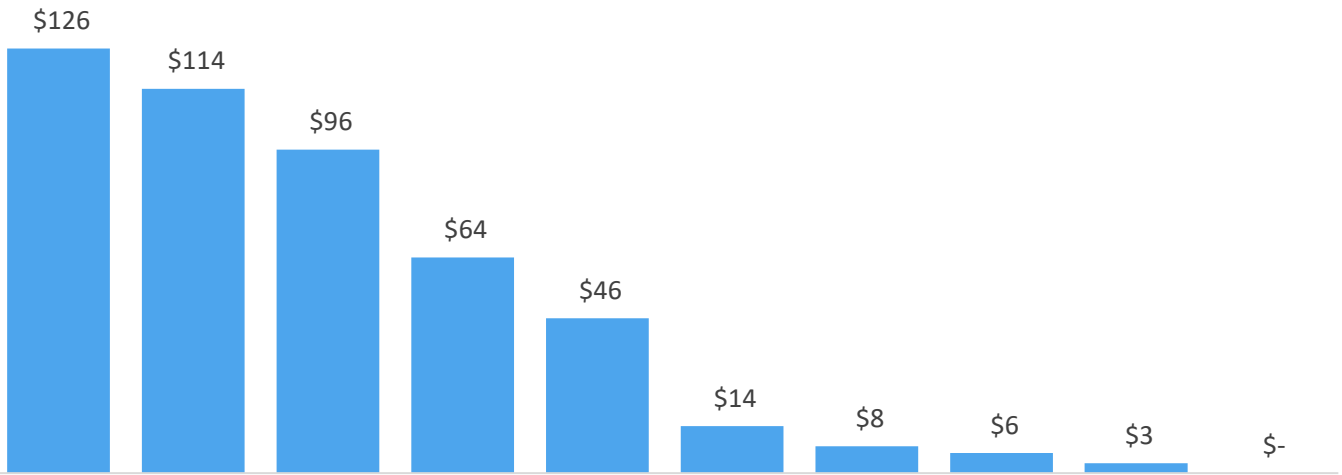
Expansion: Expenditures by Provider Type

The Expansion population's spending is concentrated in acute care services like professional, inpatient, outpatient, and pharmacy services, with smaller amounts spent on LTSS.

Expansion: Expenditures by Provider Type

SFY 2019 – $ Millions

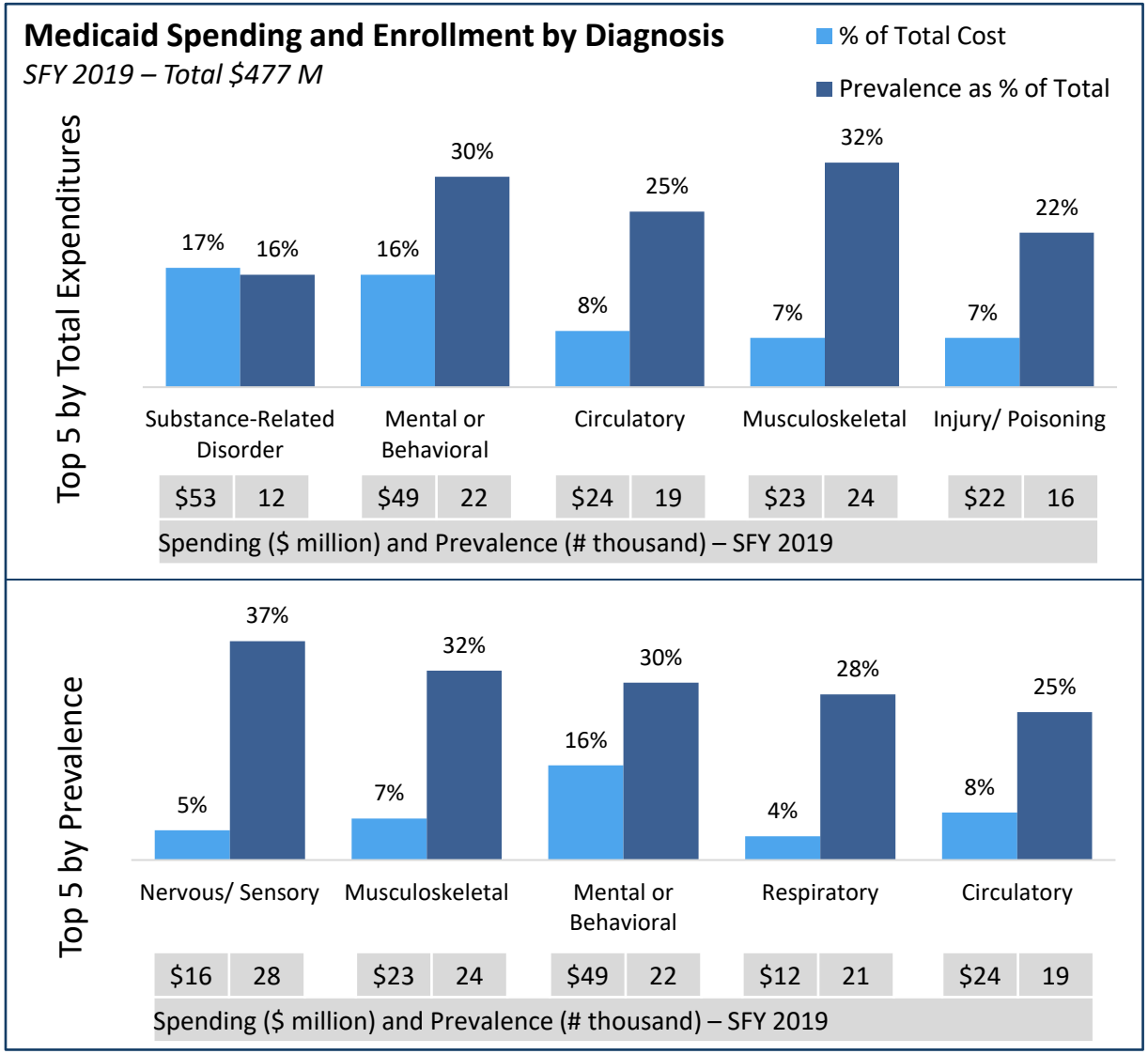
Total Expansion Expenditure =	$477 M
% of SFY 2019 Expenditure =	18%
Avg Annual Growth SFY 2017 - 2019 =	3.6%



Professional	Inpatient	Outpatient	Pharmacy	MCO Admin/ Taxes	HCBS, Transport and Ancillary	Nursing Home/ Hospice	Slater/ Tavares/ Zambarano	IDD Resdntl/Rehab, Group Homes	Premiums
1.6%	8.6%	0.9%	7.8%	-9.3%	3.3%	35.9%	52.3%	202.9%	n/a
Avg Annual Growth – SFY 2017 - 2019									
26.5%	23.9%	20.1%	13.3%	9.6%	3.0%	1.8%	1.3%	0.6%	0.0%
% of Total Expansion Expenditure – SFY 2019									
23.1%	13.5%	10.7%	6.0%	5.7%	5.6%	16.2%	4.1%	9.8%	5.5%
All Populations Provider Type Spend as % all Populations Expenditures – SFY 2019*									

- Expenditure growth for the Expansion population is slightly higher (3.6%) than the overall population (2.7%).
- The Expansion population utilizes inpatient, outpatient and pharmacy services at a higher rate than other populations.
- Expenditures on LTSS services are relatively low for the Expansion population.
- Note:
  - All populations include Elders, Adults with Disabilities, Children and Families, CSHCN, and Expansion.

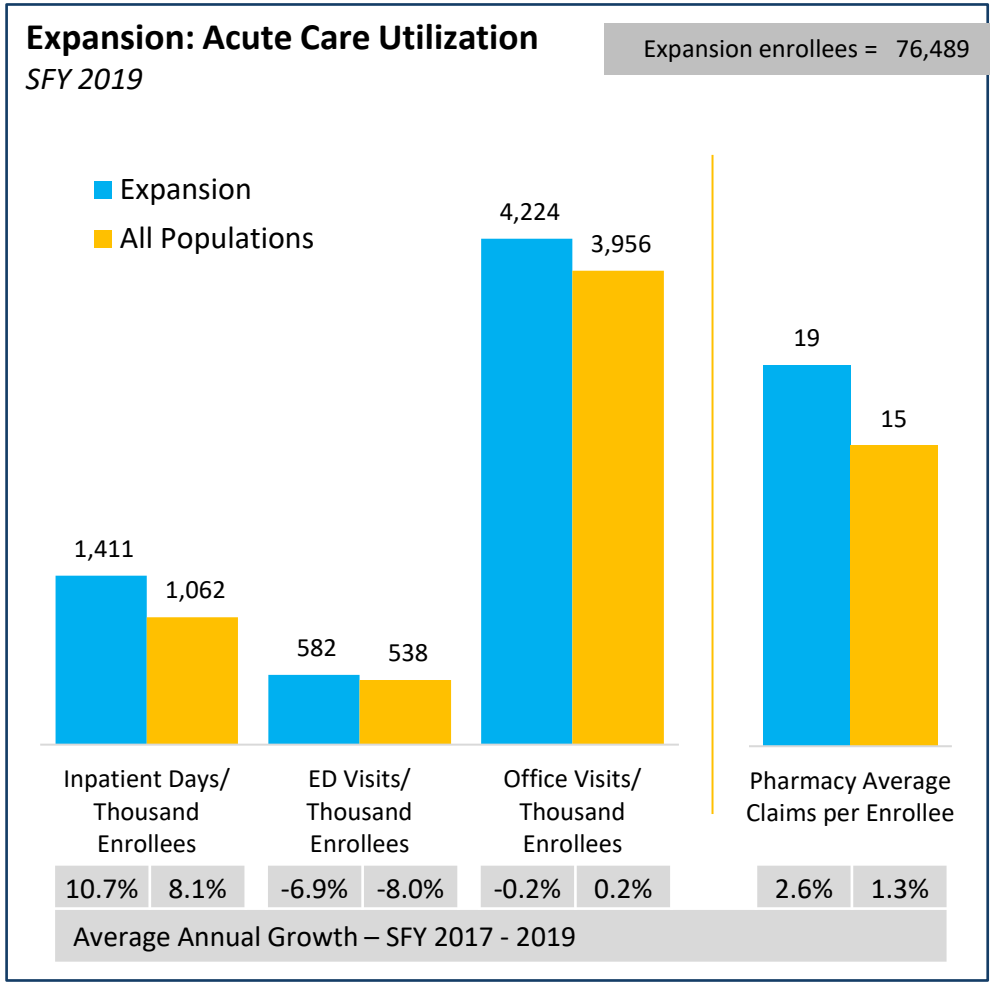
Expansion: Diagnoses



- Substance-related disorders are nearly twice as prevalent among the Expansion population compared to the overall population.
- Prevalent diagnoses in the Expansion population (diseases of the nervous system and sense organs, musculoskeletal diagnoses, mental or behavioral health, respiratory system diagnoses, and circulatory system) are similar to prevalent diagnoses in the overall population.

Expansion: Acute Care Service Utilization

The Expansion population utilizes acute care services at similar rates to the overall population.



- The per person utilization rates of the Expansion population are higher than the overall population, varying from 7% (office visits) to 28% (inpatient days).
- Benefits for the Expansion population vary from the benefits offered to traditional Medicaid populations, with less emphasis on long-term care.
- Notes:
  - All populations include Adults with Disabilities, Children and Families, CSHCN, and Expansion.

Quality

The quality of Rhode Island's Medicaid program is evaluated by third-party organizations who provide assessments of Medicaid programs across the country.

Quality Overview

The goal of the Rhode Island EOHHS and of the Rhode Island Medicaid program is to be a catalyst for the Triple Aim* and the Department of Health and Human Services National Quality Strategy by providing eligible beneficiaries with services that are accessible, of high quality, and promote positive health outcomes in a cost efficient and effective manner.

Rhode Island's MCOs are subject to quality provisions and oversight activities. They are also required to undergo four performance improvement projects and must submit an annual quality plan to the state. The four guiding principles for the Medicaid Managed Care Quality Strategy are:

1. Pay for value, not volume
2. Coordinate physical, behavioral, and long-term health care
3. Rebalance the delivery system away from high-cost settings
4. Promote efficiency, transparency and flexibility

The following pages provide an overview of Rhode Island's statewide performance on certain key measures, using the most recent CMS Medicaid Scorecard and NCQA Health Insurance Plan Ratings.

Key Takeaways:

- CMS Medicaid Scorecard measures for Rhode Island show better-than-average performance on most measures in child and adult measure sets, compared to performance across all states
- NCQA scores of Rhode Island's MCOs show better-than-average performance compared to performance of MCOs across all states

* The term "Triple Aim" refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

The CMS Medicaid Scorecard

CMS developed its Medicaid and Children's Health Insurance Program (CHIP) Scorecard to increase public transparency about the programs' administration and outcomes.

The CMS Medicaid Scorecard includes two measure sets: The Child Core Set and the Adult Core Set.

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.

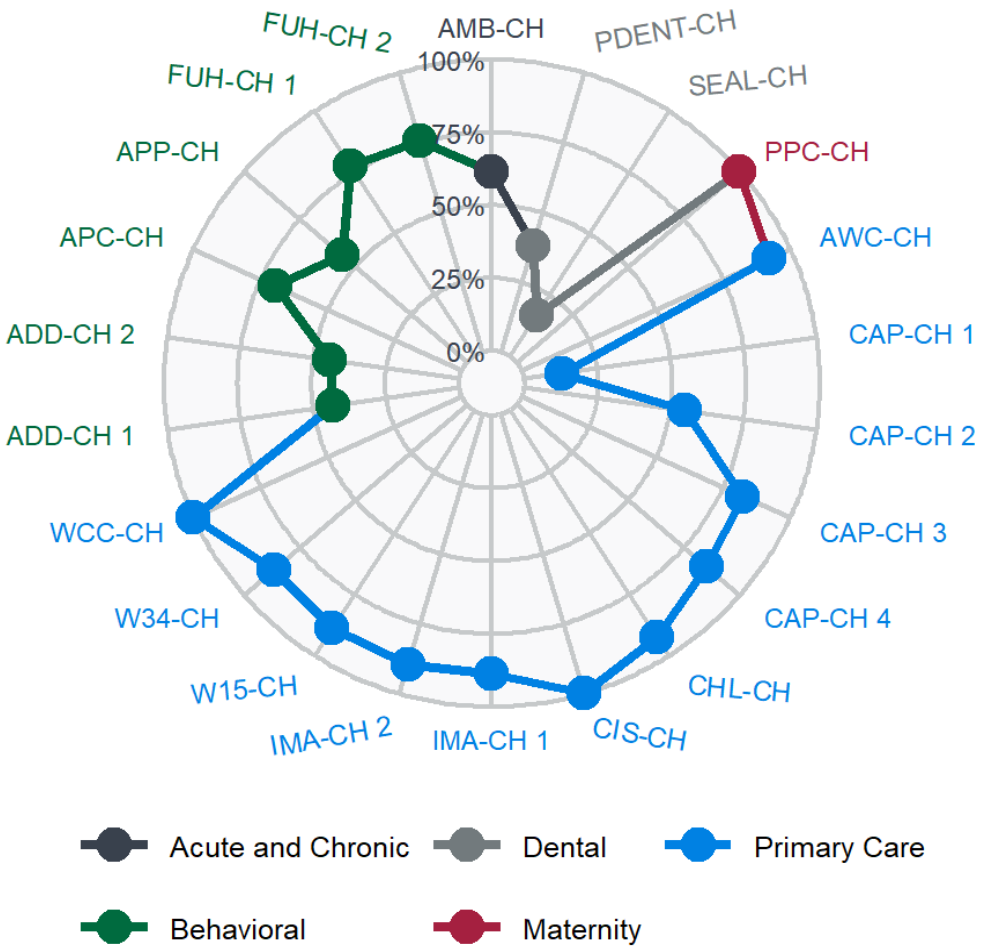
In recognition of reporting differences across states reflected in the CMS Medicaid and CHIP Scorecard, this report summarizes information in a format that provides the ability to compare states that use similar logic for reporting. Comparisons are only made of states that use the same population and reporting methodology for each rate, allowing for a more accurate comparison between states.

Contents of Medicaid Scorecard:

- Both the Child and Adult Core Sets are organized into the following categories:
  - Care of Acute and Chronic Conditions
  - Maternal and Perinatal Health
  - Primary Care Access and Preventive Care
  - Behavioral Healthcare
  - Dental and Oral Health Services (Child Core Set only)

*For information about measures, see Key Terms and Notes section

CMS Medicaid Scorecard – Child Core Set Measures



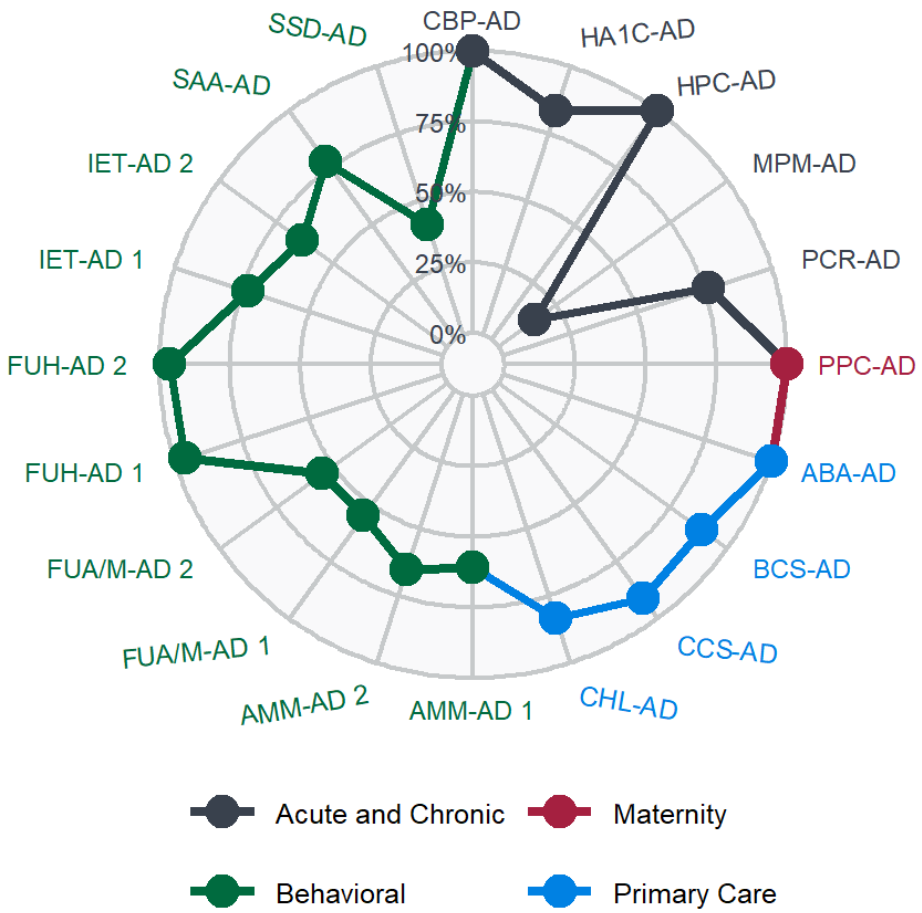
- Rhode Island's Child Core Set measures were above the 50th percentile for 17 out of 22 measures nationally, and above the 75th percentile for 13 out of 22 measures.
- For information about measures, see Key Terms and Notes section.

How to interpret the radar charts

- The state charts measure a rate on each axis (or "spoke").
- Rates are only included when there are at least 10 states using the same population and reporting methodology.
- 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.
- Rates are grouped and color-coded by domain to facilitate the understanding of broad, domain-level trends.

Time Period: Federal Fiscal Year (FFY) 2018 (October 1, 2017 – September 30, 2018)
Source: Milliman Evaluation of Medicaid Scorecard Data

CMS Medicaid Scorecard – Adult Core Set Measures



- Rhode Island's Adult Core Set measures were above the 50th percentile for 18 out of 20 measures nationally, and above the 75th percentile for 12 out of 20 measures.
- For information about measures, see Key Terms and Notes section.

How to interpret the radar charts

- The state charts measure a rate on each axis (or "spoke").
- Rates are only included when there are at least 10 states using the same population and reporting methodology.
- 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.
- Rates are grouped and color-coded by domain to facilitate the understanding of broad, domain-level trends.

Time Period: FFY 2018 (October 1, 2017 – September 30, 2018)
Source: Milliman Evaluation of Medicaid Scorecard Data

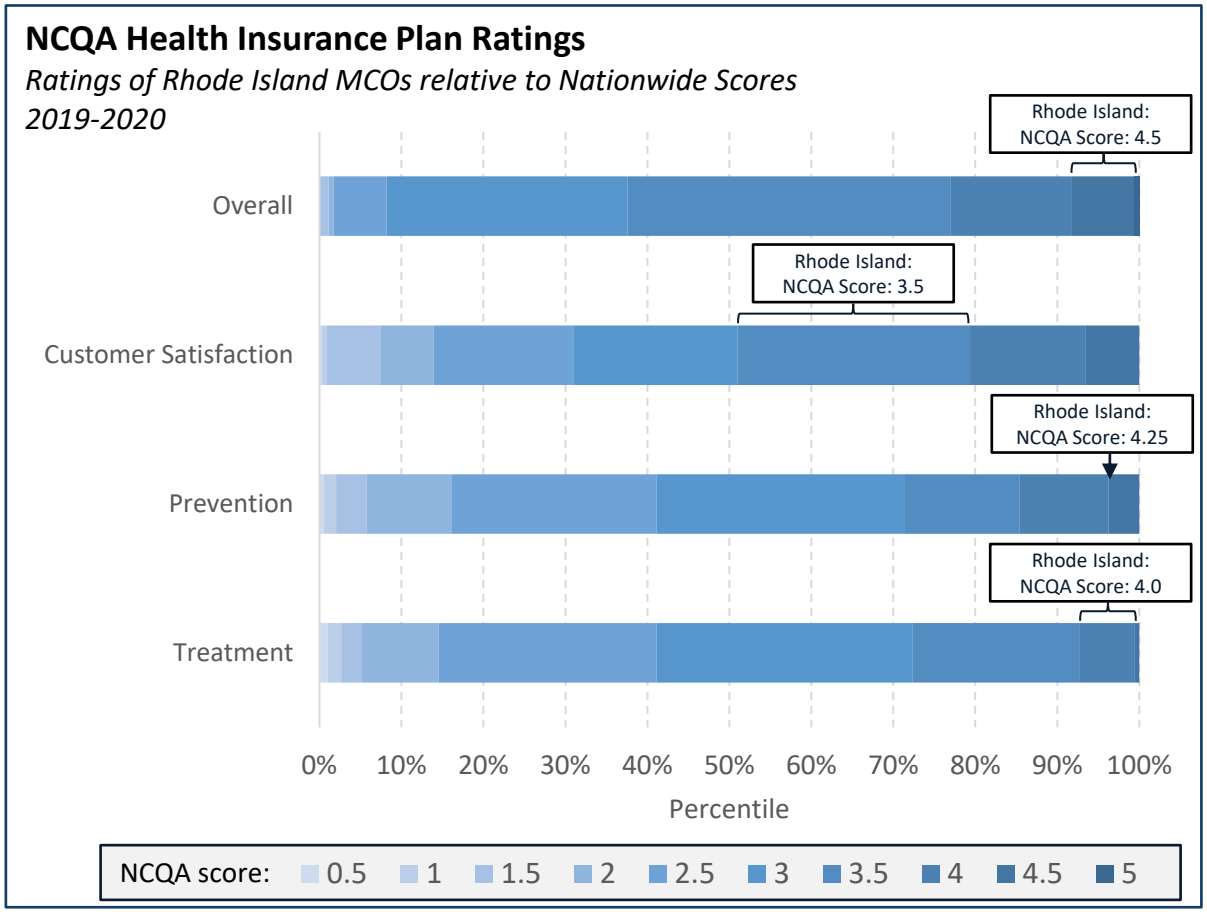
NCQA Quality

Rhode Island currently contracts with three MCOs (Neighborhood Health Plan, United Healthcare and Tufts Health Plan) who collectively provide coverage for 89% of the state's Medicaid beneficiaries. Tufts Health Plan began enrolling Rhode Island Medicaid members in SFY 2018 and is not scored by NCQA, thus the data presented below excludes them.

The NCQA scores Medicaid MCOs based on clinical quality, member satisfaction and NCQA Accreditation Survey Results. Ratings are out of 5 total points, with 5 being the highest score. Rhode Island's Medicaid MCO NCQA scores are displayed below.

NCQA Health Insurance Plan Ratings

Ratings of Rhode Island MCOs relative to Nationwide Scores 2019-2020



- **Overall Satisfaction Score**
  - Rhode Island's MCOs scored an average of 4.5/5 in the overall category, and only 1% of MCOs nationwide had a higher score.
- **Consumer Satisfaction** (indicates members' opinions of their plan's care, services, and physicians)
  - Rhode Island's MCOs scored an average of 3.5/5 on consumer satisfaction; 21% of MCOs nationwide had a higher score.
- **Prevention** (indicates how well plans provide screenings, immunizations, and other preventative services)
  - Rhode Island's MCOs scored an average of 4.25/5 score on prevention; only 4% of MCOs nationwide had a higher score.
- **Treatment** (indicates a plan's performance in treating chronic and acute conditions)
  - Rhode Island's MCOs scored a 4/5 on treatment; only 1% of MCOs nationwide had a higher score.

Benchmarks

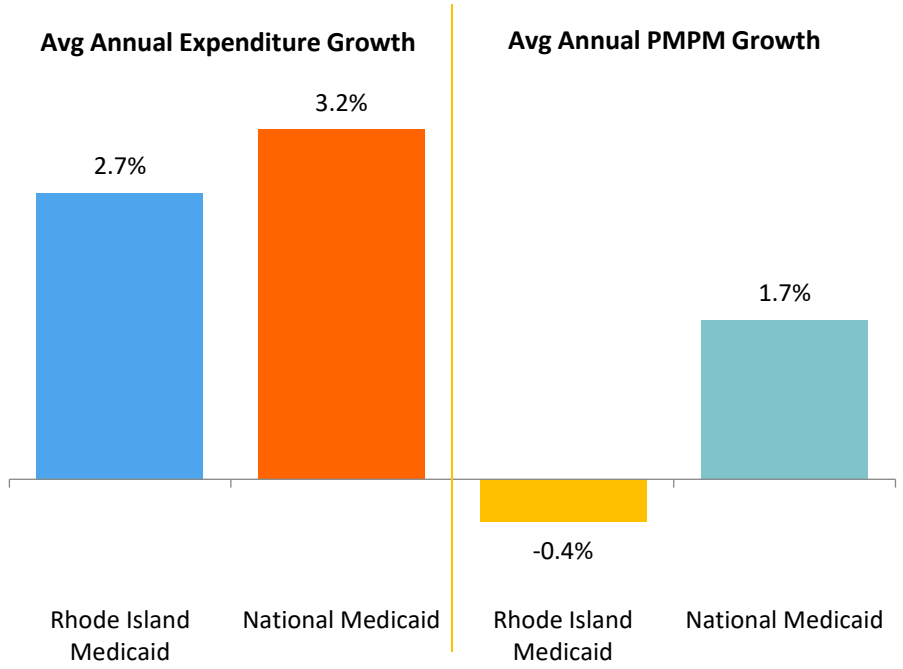
This section explores how Medicaid expenditure trends and enrollment in Rhode Island differ from other states.

Medicaid Expenditure Growth Trends

Comparison to National Medicaid Trends

RI: SFY 2016 - 2019

National: CY 2015 - 2018



Sources: National Medicaid Trend from 2018 CMS National Health Expenditure Report.

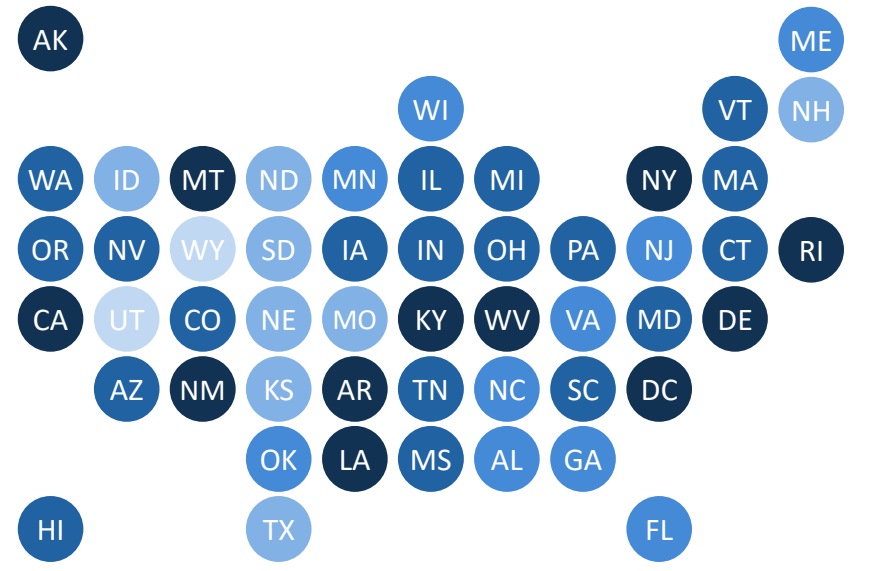
- Rhode Island's expenditures grew over the last three years despite a lowering PMPM because enrollment grew by approximately 27,000 (9.6%) during this time period.
- Over the last three years, Rhode Island's average annual expenditure growth has been approximately 20% lower than national Medicaid trends.
- Over the last three years, Rhode Island's PMPM expenditures have dropped, while nationally these expenditures grew by 1.5%.
- Note:
  - Rhode Island's SFY runs from July 1st of the prior calendar year thru the following June 30th, and national Medicaid rates are shown in calendar years, thus in this chart the national data lags behind the Rhode Island data by 6 months.

Medicaid Trends: Medicaid Enrolled Population by State

Rhode Island has a higher percentage of its population enrolled in Medicaid or CHIP than most other states, and has the highest percentage of its population enrolled of the New England states.

Percentage of Population Enrolled in Medicaid or CHIP

Data Published July 2019



Source: Medicaid/CHIP enrollment from Kaiser Family Foundation, Population from Census Bureau

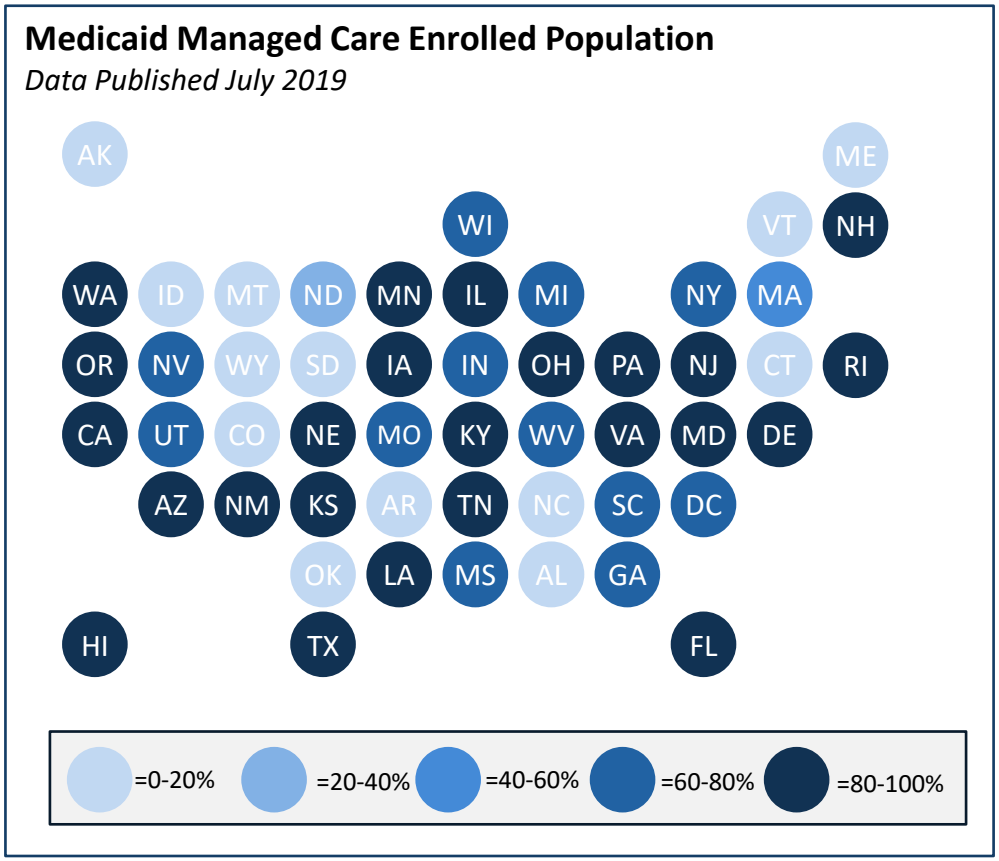
- 28% of Rhode Islanders are enrolled in Medicaid or CHIP, compared to 22% nationally and 22% in New England.
- Notes:
  - Rhode Island's CHIP eligibility (calculated as a percentage of Federal Poverty Level (FPL) is more inclusive than that of most other states.
  - CMS compiles Medicaid enrollment data for all states monthly. For the purpose of this chart, this enrollment data was converted to percent of population enrolled in Medicaid or CHIP for each state using data from the US Census Bureau.
  - Percentage presented in this nationwide comparison varies slightly from the value presented on page 34 (29%) due to differences in data sources.

Medicaid Trends: Managed Care Enrollment by State

States take a wide variety of approaches to providing Medicaid services, with some operating exclusively with a state-run FFS model and others providing all services through private MCOs. Most states use both approaches simultaneously.

Medicaid Managed Care Enrolled Population

Data Published July 2019



Source: Kaiser Family Foundation

- Nationwide, approximately two-thirds of Medicaid beneficiaries are enrolled in managed care.
- Rhode Island has the second-highest MCO enrollment for its Medicaid population in New England, second to New Hampshire.
- For SFY 2019, 88.7% of Rhode Island Medicaid enrollees were covered through MCOs.
- Note:
  - The methodology used to determine these numbers differs from that used in the rest of the report; it is used here in order to show comparison across states.
  - Managed Care as represented in above visual does not include enrollment in Primary Care Case Management (PCCM), in which Medicaid agencies contract with primary care providers to provide, locate, coordinate, and monitor primary care services for Medicaid beneficiaries.

Key Terms and Notes

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

Acronyms

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

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

Provider Type Definitions

Acute Care	Hospital	Hospital includes inpatient and outpatient services.
	Professional	Professional includes physician, dental, Durable Medical Equipment (DME)/supplies, 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.
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	IDD Resdntl/ Rehab, Group Homes	Residential and Rehabilitation Services for persons with IDD, including public and private IDD group homes, IDD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications, and supported employment).
	HCBS	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.

Diagnosis Definitions

The following conditions are mentioned in the 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

CMS Medicaid Scorecard – Child Core Set Measures Definitions

	ID	Definition
Care of Acute & Chronic Conditions	AMB-CH[1,2]	Emergency Department Visits per 1,000 Beneficiary Months: Ages 0-19
	AMR-CH 1[5]	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5-11
	AMR-CH 2[5]	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 12-18
	AMR-CH 3[5]	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5-18
Dental & Oral	PDENT-CH	Percentage with at Least 1 Preventive Dental Service: Ages 1-20
	SEAL-CH	Percentage at Elevated Risk of Dental Caries (Moderate or High Risk) who Received a Sealant on a Permanent First Molar Tooth: Ages 6-9
Maternal & Perinatal Health	CCP-CH 1[4,5]	Percentage of Postpartum Women Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery: Ages 15-20
	CCP-CH 2[4,5]	Percentage of Postpartum Women Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery: Ages 15-20
	CCP-CH 3[4,5]	Percentage of Postpartum Women Provided a Most Effective or Moderately Effective Method of Contraception Within 3 Days of Delivery: Ages 15-20
	CCP-CH 4[4,5]	Percentage of Postpartum Women Provided a Most Effective or Moderately Effective Method of Contraception Within 60 Days of Delivery: Ages 15-20
	CCW-CH 1[4,5]	Percentage of Women at Risk for Unintended Pregnancy Provided a Long-Acting Reversible Method of Contraception: Ages 15-20
	CCW-CH 2[4,5]	Percentage of Women at Risk for Unintended Pregnancy Provided a Most Effective or Moderately Effective Method of Contraception: Ages 15-20
	LBW-CH[1,4]	Percentage of Live Births that Weighed Less than 2,500 Grams
	PPC-CH[4]	Percentage of Women Delivering a Live Birth with a Prenatal Care Visit in the First Trimester or within 42 Days of Enrollment in Medicaid or CHIP

1. Lower rates are better for these measures.
2. These measures are not expressed as percentages.
3. These measures are part of the Behavioral Health Core Set.
4. These measures are part of the Maternity Core Set.
5. These measures are newly available in the 2018 Core Set. They could be either new measures entirely, or did not previously meet reporting thresholds.

CMS Medicaid Scorecard – Child Core Set Measures Definitions (cont'd)

	ID	Definition
Primary Care Access and Preventive Care	AWC-CH	Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or an Obstetrical/Gynecological Practitioner: Ages 12-21
	CAP-CH 1	Percentage with a Primary Care Physician (PCP) Visit in the Past Year: Ages 12-24 Months
	CAP-CH 2	Percentage with a PCP Visit in the Past Year: Ages 25 Months-6 Years
	CAP-CH 3	Percentage with a PCP Visit in the Past Two Years: Ages 7-11 Years
	CAP-CH 4	Percentage with a PCP Visit in the Past Two Years: Ages 12-19 Years
	CHL-CH	Percentage of Sexually Active Women Screened for Chlamydia: Ages 16-20
	CIS-CH	Percentage Up-to-Date on Immunizations (Combination 3) by their Second Birthday
	DEV-CH	Percentage Screened for Risk of Developmental, Behavioral, and Social Delays Using a Standardized Screening Tool: Ages 0-3
	IMA-CH 1	Percentage Receiving Meningococcal Conjugate and Tdap Vaccines (Combination 1) by their 13th Birthday
	IMA-CH 2	Percentage Completing the Human Papillomavirus (HPV) Vaccine Series by Their 13th Birthday
	W15-CH[4]	Percentage of Children who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life
	W34-CH	Percentage who had 1 or More Well-Child Visits with a Primary Care Practitioner: Ages 3-6
	WCC-CH	Percentage who had an Outpatient Visit with a Primary Care Practitioner or Obstetrical/Gynecological Practitioner who had Body Mass Index Percentile Documented in the Medical Record: Ages 3-17
Behavioral Healthcare	ADD-CH 1[3]	Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase: Ages 6-12
	ADD-CH 2[3]	Percentage Newly Prescribed ADHD Medication with at Least 2 Follow-Up Visits in the 9 Months Following the Initiation Phase: Ages 6-12
	APC-CH[1,3]	Percentage on Two or More Concurrent Antipsychotic Medications: Ages 1-17
	APP-CH[3,5]	Percentage who had a New Prescription for an Antipsychotic Medication and had Documentation of Psychosocial Care as First-Line Treatment: Ages 1-17
	FUH-CH 1[3]	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 30 Days of Discharge: Ages 6-20
	FUH-CH 2[3]	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 7 Days of Discharge: Ages 6-20

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CMS Medicaid Scorecard – Adult Core Set Measures Definitions

	ID	Definition
Care of Acute & Chronic Conditions	AMR-AD 1[5]	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 19-50
	AMR-AD 2[5]	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 19-64
	AMR-AD 3[5]	Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 51-64
	CBP-AD	Percentage who had a Diagnosis of Hypertension and Whose Blood Pressure was Adequately Controlled During the Measurement Year: Ages 18-64
	HA1C-AD	Percentage with Diabetes (Type 1 or Type 2) who had a Hemoglobin A1c (HbA1c) Test: Ages 18-64
	HPC-AD[1]	Percentage with Diabetes (Type 1 or Type 2) who had Hemoglobin A1c in Poor Control (>9.0%): Ages 18-64
	MPM-AD	Percentage who Received at Least 180 Treatment Days of Ambulatory Medication Therapy for Select Therapeutic Agent and Annual Monitoring: Ages 18-64
	PCR-AD[2,5]	Ratio of Observed All-Cause Readmissions to Expected Readmissions: Ages 18-64
	PQI01-AD[1,2]	Inpatient Hospital Admissions for Diabetes Short-Term Complications per 100,000 Beneficiary Months: Ages 18-64
	PQI05-AD[1,2]	Inpatient Hospital Admissions for Chronic Obstructive Pulmonary Disease (COPD) or Asthma per 100,000 Beneficiary Months: Ages 40-64
	PQI08-AD[1,2]	Inpatient Hospital Admissions for Heart Failure per 100,000 Beneficiary Months: Ages 18-64
	PQI15-AD[1,2]	Inpatient Hospital Admissions for Asthma per 100,000 Beneficiary Months: Ages 18-39

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4. These measures are part of the Maternity Core Set.
5. These measures are newly available in the 2018 Core Set. They could be either new measures entirely, or did not previously meet reporting thresholds.

CMS Medicaid Scorecard – Adult Core Set Measures Definitions (cont'd)

	ID	Definition
Maternal & Perinatal Health	CCP-AD 1[4,5]	Percentage of Postpartum Women Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery: Ages 21-44
	CCP-AD 2[4,5]	Percentage of Postpartum Women Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery: Ages 21-44
	CCP-AD 3[4,5]	Percentage of Postpartum Women Provided a Most Effective or Moderately Effective Method of Contraception Within 3 Days of Delivery: Ages 21-44
	CCP-AD 4[4,5]	Percentage of Postpartum Women Provided a Most Effective or Moderately Effective Method of Contraception Within 60 Days of Delivery: Ages 21-44
	PPC-AD[4]	Percentage of Women Delivering a Live Birth who had a Postpartum Care Visit on or Between 21 and 56 Days after Delivery
Primary Care Access & Preventive Care	ABA-AD	Percentage who had an Outpatient Visit with a BMI Documented in the Medical Record: Ages 18-64 Years
	BCS-AD	Percentage of Women who had a Mammogram to Screen for Breast Cancer: Ages 50-64
	CCS-AD	Percentage of Women Screened for Cervical Cancer: Ages 21-64
	CHL-AD	Percentage of Sexually Active Women Screened for Chlamydia: Ages 21-24
Behavioral Healthcare (1/2)	AMM-AD 1[3]	Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 12 Weeks: Ages 18-64
	AMM-AD 2[3]	Percentage Diagnosed with Major Depression who were Treated with and Remained on Antidepressant Medication for 6 Months: Ages 18-64
	FUA/M-AD 1[3,5]	Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18-64
	FUA/M-AD 2[3,5]	Percentage of Emergency Department (ED) Visits for Alcohol and Other Drug Abuse or Dependence with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18-64
	FUA/M-AD 3[3,5]	Percentage of ED Visits for Mental Illness with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18-64

1. Lower rates are better for these measures.
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3. These measures are part of the Behavioral Health Core Set.
4. These measures are part of the Maternity Core Set.
5. These measures are newly available in the 2018 Core Set. They could be either new measures entirely, or did not previously meet reporting thresholds.

CMS Medicaid Scorecard – Adult Core Set Measures Definitions (cont'd)

	ID	Definition
Behavioral Healthcare (2/2)	FUA/M-AD 4[3,5]	Percentage of Emergency Department (ED) Visits for Mental Illness with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18-64
	FUH-AD 1[3]	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 30 Days of Discharge: Ages 21-64
	FUH-AD 2[3]	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit Within 7 Days of Discharge: Ages 21-64
	IET-AD 1[3,5]	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18-64
	IET-AD 2[3,5]	Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18-64
	IET-AD 3[3,5]	Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18-64
	IET-AD 4[3,5]	Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18-64
	IET-AD 5[3,5]	Percentage with a New Episode of Opioid Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18-64
	IET-AD 6[3,5]	Percentage with a New Episode of Opioid Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18-64
	IET-AD 7[3,5]	Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18-64
	IET-AD 8[3,5]	Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18-64
	SAA-AD[3]	Percentage with Schizophrenia who were Dispensed and Remained on Antipsychotic Medication for at Least 80 Percent of their Treatment Period: Ages 19-64
	SSD-AD[3]	Percentage with Schizophrenia or Bipolar Disorder who were Dispensed an Antipsychotic Medication and had a Diabetes Screening Test: Ages 18-64

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