Rhode Island Annual Medicaid Expenditure Report SFY 2018

Executive Office of Health and Human Services

September 2019

Purposes of this Report

The purposes of this report include the following:

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

Variance to Other Reports:

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

The primary basis for identifying expenditures in this report is the actual date of service, 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.

Provider type definitions changed from the SFY 2017 version of this report, and therefore year-over-year growth rates by provider type are generally not illustrated.

Other reasons for variance might include factors such as accrual vs. paid amounts, provider payouts, capitation vs. claim amounts, and rounding.

Additionally, capitation expenditures were allocated based on the MCO submitted encounter data. No adjustment was made for potential encounter data incompleteness.

Definition of 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.*

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Executive Summary: Overview and Key Findings

Overview

During SFY 2018 Rhode Island's Medicaid program provided full medical coverage to approximately 364,000 distinct Rhode Islanders, with an average of 316,000 members enrolled at any one time.

Medical benefits expenditures totaled $2.6 billion for Medicaid covered services for fully covered populations in SFY 2018. This $2.6 billion expenditure is inclusive of federal funds, general revenues, and restricted receipts, with approximately 40% of spending coming from State sources. The effective Federal Medical Assistance Percentage (FMAP) was 60% on average across the Medicaid program.

Medicaid expenditures for fully covered populations are divided among several state agencies, with $2.2 billion of expenditures managed by the Executive Office of Health and Human Services (EOHHS), $356 million managed by the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH), and $44 million managed by the Department of Children, Youth, and Families (DCYF).

Key Findings:

- During SFY 2018 Rhode Island's Medicaid program served an average of **316,000 enrollees** with full Medicaid benefits. Another 19,400 average enrollees received partial benefits.
- **Total expenditures were $2.6 billion** in SFY 2018 for Medicaid covered services for the fully covered populations. The State spent another $0.2 billion on items eligible for Medicaid financing beyond services for the fully covered population.
- The state share of these expenditures was approximately 40% of total spend.

With respect to the fully covered enrollees and their benefits' expenditures:

- Between SFY 2015 and 2018, total Medicaid expenditures increased an average of 3.3% per year.
- Enrollment has increased 5.3% per year on average over the last four years.
- Per member per month (PMPM) costs have decreased 1.8% per year, from $729 in SFY 2015 to $691 in SFY 2018.
- These expenditure trends compare quite favorably to both national Medicaid total expenditures and state commercial PMPM cost trends.
- Adults with disabilities account for 29% of expenditures. Elders account for another 23%.
- Hospitals and nursing facilities account for 40% of Medicaid expenditures.
- Ninety-one percent of Medicaid recipients are enrolled in managed care programs. Two out of three of Rhode Island's Medicaid managed care organizations were rated 4.5 out of 5 by the National Committee for Quality Assurance (NCQA), and the remaining MCO was unrated.
- Claims expenditures are highly concentrated – the top 5% of users account for 63% of claims expenditures.

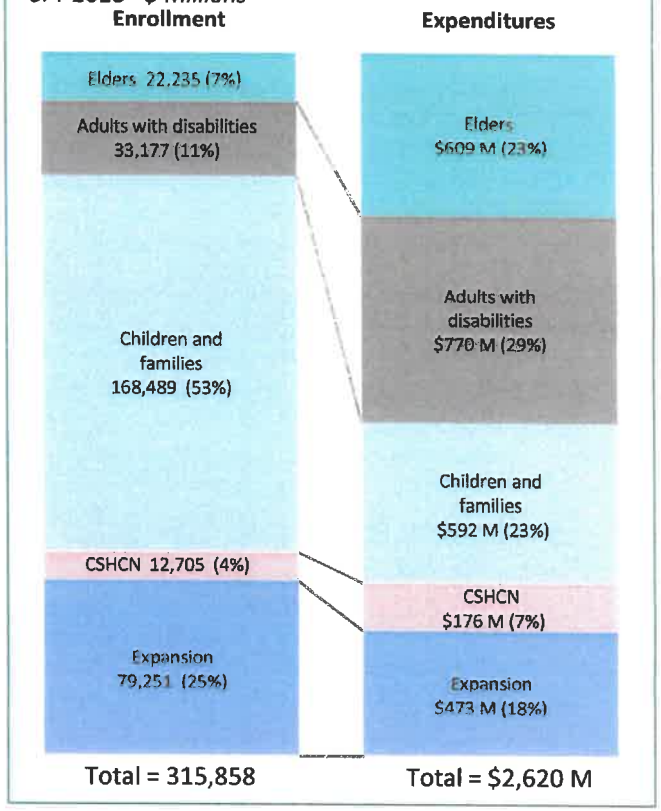
Executive Summary: Populations

Medicaid serves five different primary populations:

- **Elders** includes 22,235 adults over age 65, 93% of whom are also covered by Medicare.[1] Elders account for $609 million in SFY 2018 Medicaid expenditures with an average PMPM cost of $2,284, the highest of the five populations. Nursing facilities account for 53% of expenditures on Elders.
- **Adults with disabilities** includes 33,177 adults under age 65 who have identified disabilities. Almost half (48%) of this population is also covered by Medicare. Adults with disabilities account for the largest share of SFY 2018 expenditures, $770 million, and an average PMPM cost of $1,934. The largest components of expenditures for this population are for residential and rehabilitation services for persons with intellectual and developmental disabilities and for hospital care.
- **Children and families** includes 168,489 low income children, parents and pregnant women who meet specific income requirements. Children and families account for 53% of total enrollment and 23% of total expenditures, with total SFY 2018 expenditures of $592 million and an average PMPM of under $300. Most expenditures on this population are for hospital care and professional services. Ninety-six percent of this population is enrolled in managed care.
- **Children with special health care needs (CSHCN)** includes 12,705 individuals under 21 who are eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. These children account for 4% of enrollment and 7% of total Medicaid expenditures, with SFY 2018 expenditures of $176 million. Eighty-four percent of this population is enrolled in managed care.
- **Expansion** includes 79,251 low income adults without dependent children. The Expansion population, newly eligible under the ACA in 2014, account for 25% of SFY 2018 enrollment and 18% of total expenditures, or $473 million. This population mainly uses hospital and professional services. Nearly all (93%) were enrolled in managed care.

Medicaid Enrollment/Expenditures by Population

SFY 2018 - $ Millions



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

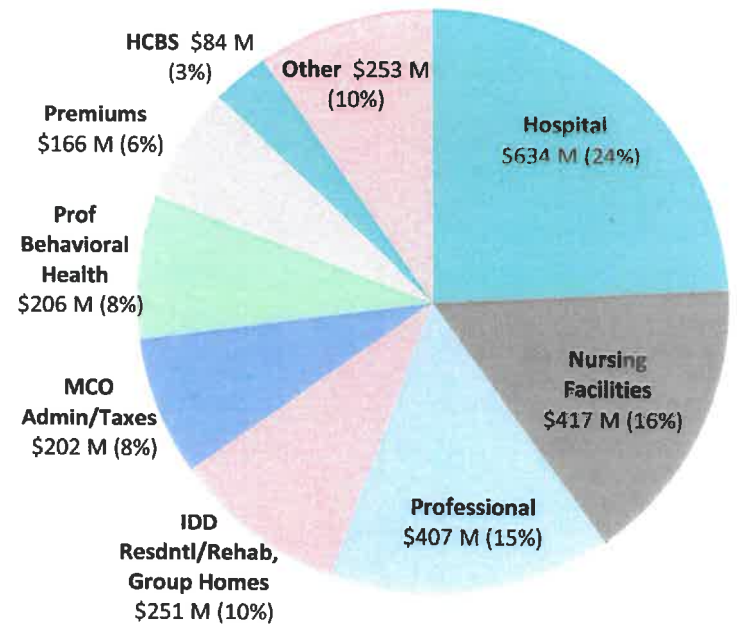
Executive Summary: Medicaid Providers

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

- Hospitals were the largest provider type, accounting for 24% of expenditures for fully covered Medicaid recipients in SFY 2018.
- Nursing facilities (including both nursing homes and hospice) were the next largest provider type, accounting for 16% of expenditures.
- MCO admin fees and taxes accounted for 8% of expenditures in SFY 2018.
- The IDD provider type includes residential and rehabilitation services and group homes for persons with intellectual and developmental disabilities.
- Other provider type includes pharmacy, and Slater Hospital, Tavares and Zambarano.

Medicaid Expenditures by Provider Type

SFY 2018 - $ Millions – Total $2.6 B



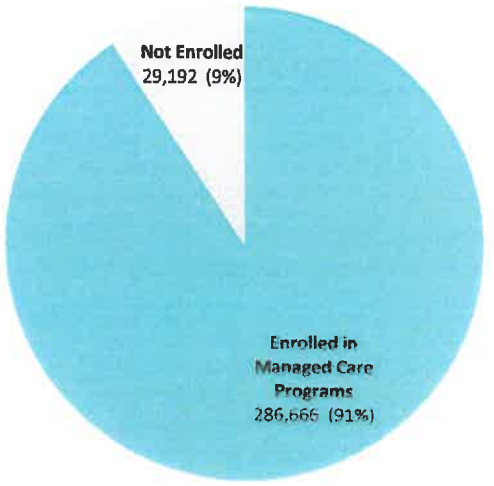
Executive Summary: Managed Care

For the 91% of Medicaid eligibles enrolled in managed care in SFY 2018, payments are made by Medicaid to the managed care plans rather than directly to service providers. These enrolled populations account for 78% of Medicaid expenditures.

- Fifty percent of Medicaid eligibles are enrolled in managed care through RIte Care, which is a Medicaid managed care program for children and parents. Another 23% of eligibles are enrolled in managed care through Medicaid Expansion.
- Four percent of eligibles make up the Children with Special Health Care Needs population, of which 84% are enrolled in managed care.
- Five percent of eligibles are enrolled in Rhody Health Partners (RHP), a managed care program for adults with disabilities.
- Four percent are enrolled in Rhody Health Options (RHO) Phase 1 and four percent are enrolled in RHO Phase 2, or the Integrated Care Initiative (ICI), which are fully capitated managed care programs for long term care, long term services and supports, and other Medicaid-funded services designed primarily for eligibles with both Medicaid and Medicare eligibility. RHO Phase 1 ended September 30, 2018 and members were either transitioned into ICI or the fee-for-service delivery system.
- Enrollment in Medicaid managed care programs is divided between Neighborhood Health Plan, United Healthcare and Tufts Health Plan. Neighborhood Health Plan and United Healthcare were rated 4.5 out of 5.0 by the National Committee for Quality Assurance (NCQA), and Tufts Health Plan, which began enrolling Medicaid members in SFY 2018, does not have a current rating available from NCQA.
- Two percent of Medicaid eligibles are enrolled in RIte Share, a premium assistance program for Medicaid eligibles with access to commercial insurance. This minimizes Medicaid expenditures by leveraging the employers' contributions.

Medicaid Eligibles by Enrollment

SFY 2018 – Total 315,858 Eligibles

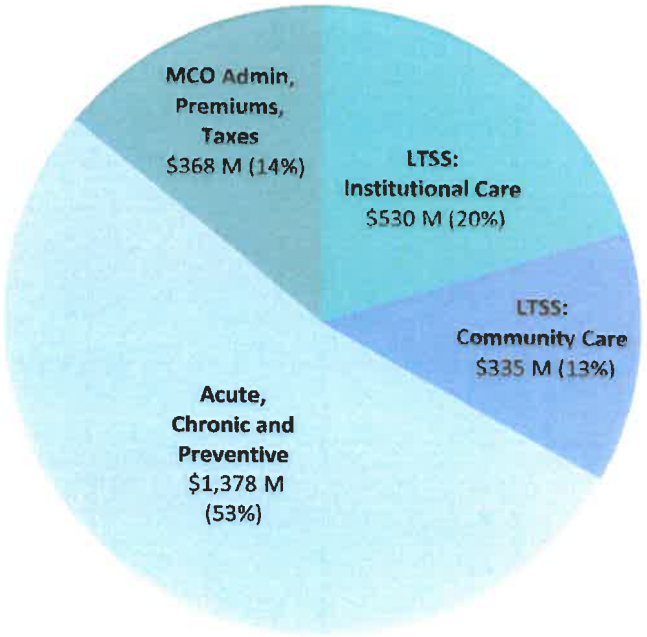


Executive Summary: Long Term Services and Supports

Long term services and supports (LTSS) include institutional care and community care. These services are mainly focused on the Elders and Adults with disabilities populations. Expenditures on LTSS account for $865 million in total Medicaid expenditures in SFY 2018, 33% of total.

- Community care services are provided to at-risk populations as alternatives to more costly nursing home/institutional options and account for $335 million, 39% of the LTSS expenditures. Community care includes home and community-based services (HCBS), residential and rehabilitation services for the intellectually and developmentally disabled, and group homes.
- Institutional care services account for the remaining $530 million of LTSS expenditures. The largest category is nursing home services, accounting for 46% of LTSS expenditures overall. Other institutional care expenditures are for hospice and care in the Slater Hospital, and the Tavares and Zambarano facilities.
- Nursing home expenditures have been growing at 5.6% per year on average over the last four years.
- Acute, chronic and preventive services and MCO admin, premiums and taxes account for the remaining 67% of Medicaid expenditures.

Medicaid Expenditures by Provider Type Category
SFY 2018 -- $ Millions – Total $2.6 B



Executive Summary: High Cost Users

- The top five percent of Medicaid users, those with over $25,000 in claims expenditures per year, account for nearly two-thirds (63%) of claims expenditures.
- In order to better examine the characteristics of this population, this report defines "high cost" users as those with over $15,000 of claims expenditures per year, adding another 3 percent of users to the top 5%. Therefore, 8% of Medicaid users are "high cost" users and account for 71% of claims expenditures.
- High cost users typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- High cost users can be divided into three categories: those who reside in institutions or residential facilities; those receiving maternity/delivery services; and the remainder who presumably reside "in the community."
- Community high cost users account for $740 million of claims-specific payments in SFY 2018.
- Over half (60%) of community high cost user expenditures are for adults with disabilities and the Expansion population.
- Hospital inpatient and outpatient claims expenditures together account for 42% of community high cost user expenditures.
- An estimated 34% of community high cost user claims expenditures are related to mental health and substance use disorders.

Medicaid User Claims Expenditures

*SFY 2018 -- $ Millions – Total $2.2 B**

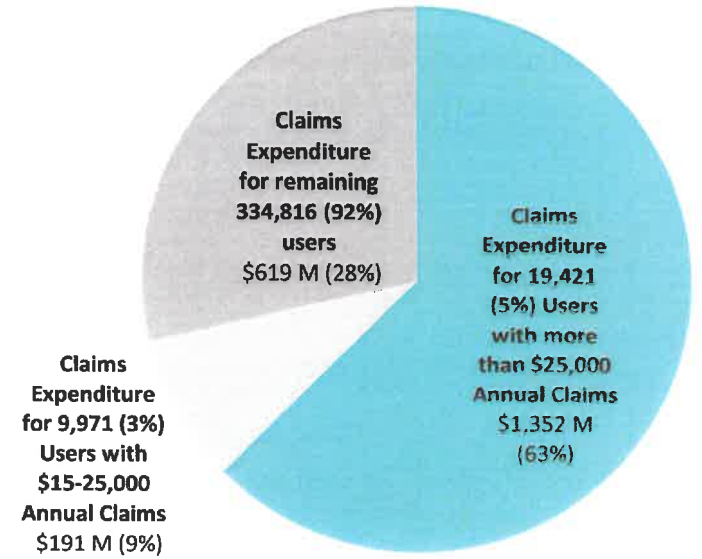


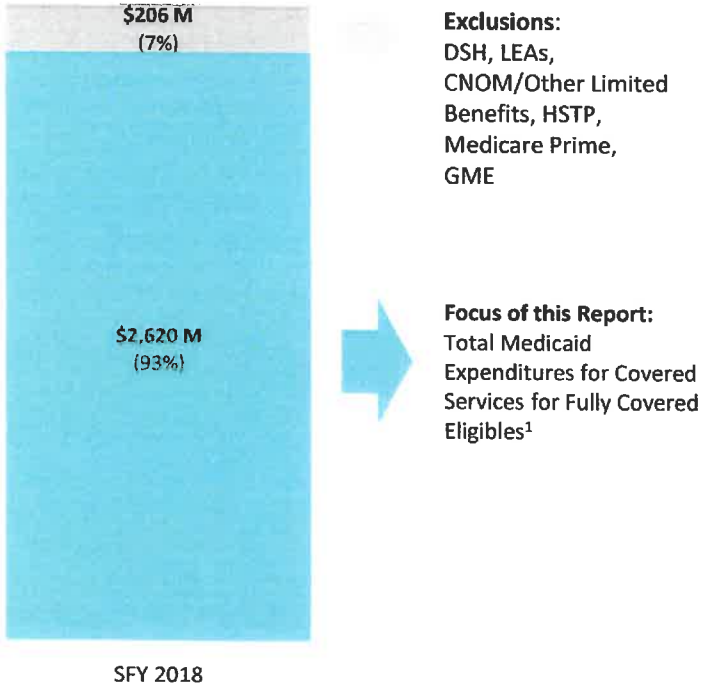
*Chart shows claims-specific payments only. Certain expenditures are not attributable to specific users.

Total Expenditures: Definitions and Exclusions

Medicaid expenditures in SFY 2018 totaled approximately $2.8 billion. Expenditures for covered services for fully covered populations, the focus of this report, totaled $2.6 billion.

Summary: Total Medicaid Expenditures
SFY 2018 - $ Millions

Total Medicaid Expenditures: $2,826 M



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

- Medicaid expenditures are split between state and federal funds. This report includes both state and federal funds.
- The focus of this report is expenditures for covered services for fully covered populations. Certain expenditures and populations are excluded from the following pages of detailed analyses, including:
  - $140 million in Disproportionate Share Hospital (DSH) statutorily required payments intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety-net hospitals
  - $19 million in payments to Local Education Authorities (LEAs) for certain Medicaid services provided to students with special needs.
  - $23 million in CNOM (costs not otherwise matchable) and other limited benefits for certain state programs not traditionally allowable under Medicaid fund matching rules that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible.
  - $14 million in Health System Transformation Project funding, which is paid out to managed care organizations and accountable entities to help with the transition to value-based care.
  - $10 million in Medicare Prime payments for individuals at qualifying income levels who only receive assistance with their Medicare premium payments.
  - $1 million in payments made for GME.
- More detail on excluded payments is provided in the Appendix.

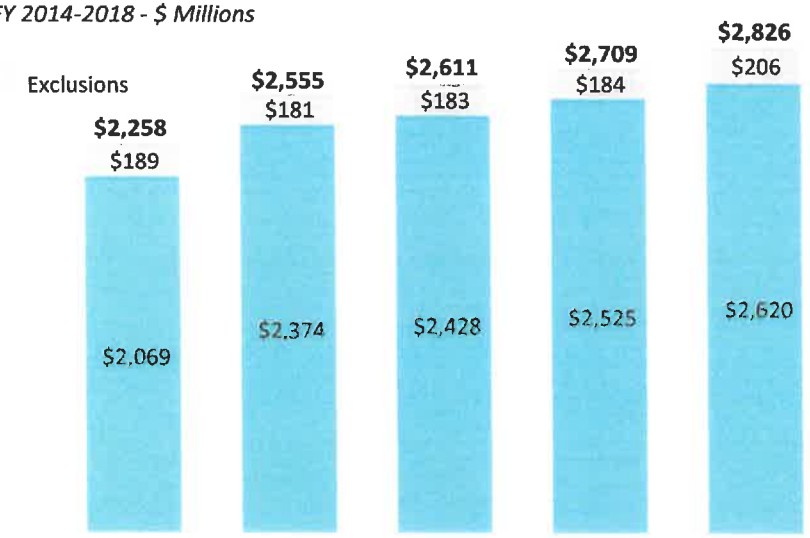
Note: This report looks at Medicaid expenditures for covered services and does not include state overhead and administrative costs related to managing the Medicaid program.

Medicaid Expenditure Trends

Following stabilization of ACA implementation in SFY 2015, Rhode Island Medicaid expenditures **increased 3.4% per year** from SFY 2015 through SFY 2018.

Total Medicaid Expenditures for Covered Services[1]

SFY 2014-2018 - $ Millions



	SFY14	SFY15	SFY16	SFY17	SFY18	**Avg Annual Growth SFY 2015-2018**
Annual Expenditures Growth (net of exclusions)		13.7%	2.3%	4.0%	3.8%	**3.4%**

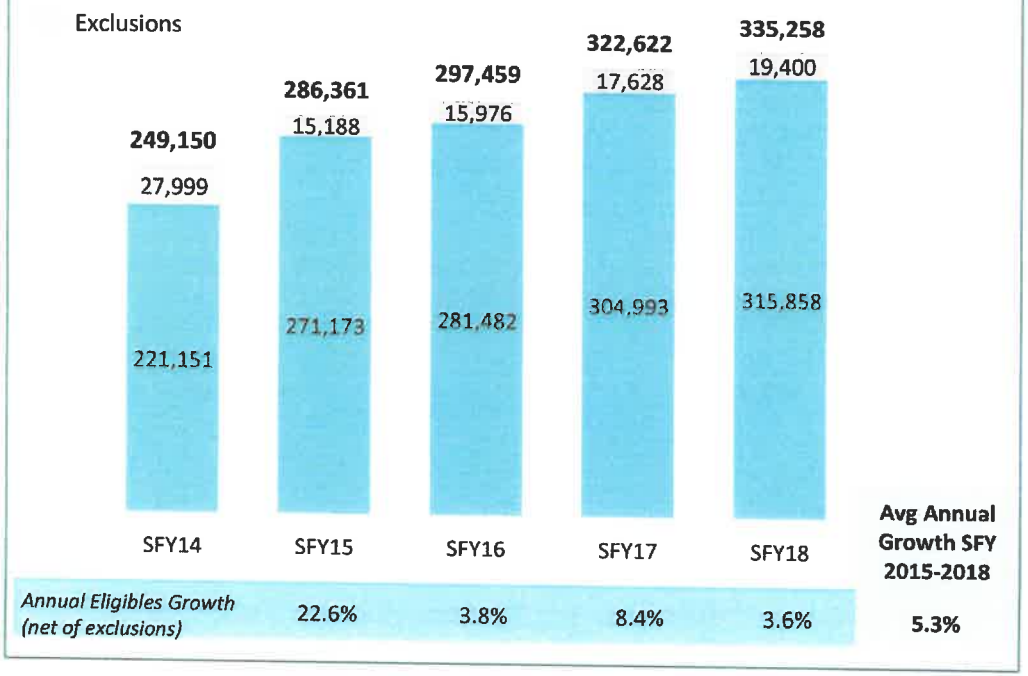
- Total expenditures, net of exclusions, were $2.6B for SFY 2018. This represents a 3.8% increase from SFY 2017, which is slightly less than the prior year's growth.
- Expenditure trends in this year's report focus on the four years since implementation of the ACA stabilized in SFY 2015. Therefore average annual trends shown here and on subsequent pages are based on trends since SFY 2015.
- Net of exclusions, expenditures increases for SFY 2015-2016, SFY 2016-2017 and SFY 2017-2018 were 2.3%, 4.0% and 3.8% respectively.

[1]Annual expenditures include the spending for both fully covered and partially covered enrollees.

Medicaid Expenditure Trends: Enrollment

Average annual Medicaid enrollment of fully covered populations has **increased 5.3% per year on average** over the last 4 years.

Total Medicaid Enrollment
Average Eligibles - SFY 2014-2018



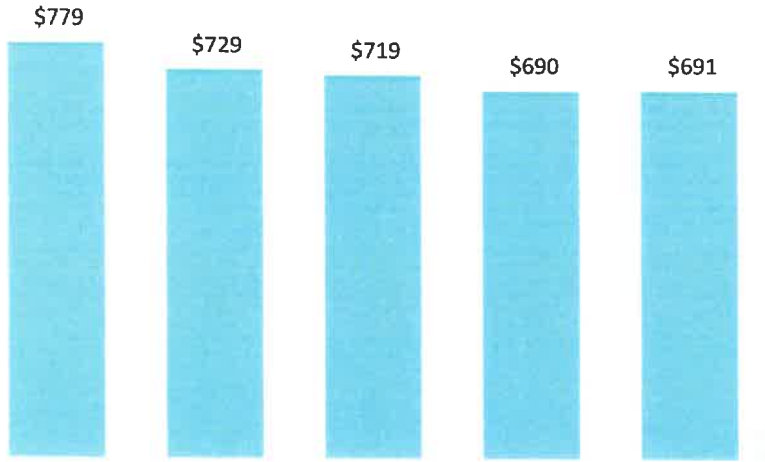
	SFY15	SFY16	SFY17	SFY18	Avg Annual Growth SFY 2015-2018
Annual Eligibles Growth (net of exclusions)	22.6%	3.8%	8.4%	3.6%	**5.3%**

- Total Medicaid enrollment increased 3.9% from SFY 2017 to SFY 2018. This includes the Expansion population.
- Excluded populations are members eligible for partial benefits such as individuals who receive assistance only with their Medicare premium payments and populations receiving services under a CNOM or other limited benefits program.
- ACA implementation on January 1, 2014, resulted in enrollment increases for both Expansion and non-Expansion populations, as eligibility rules changed and outreach increased.

Medicaid Expenditure Trends: PMPM

Average annual Medicaid PMPM has **decreased 1.8% per year on average** over the last 4 years.

Total Medicaid PMPM – Fully Covered Populations/Services
SFY 2014-2018



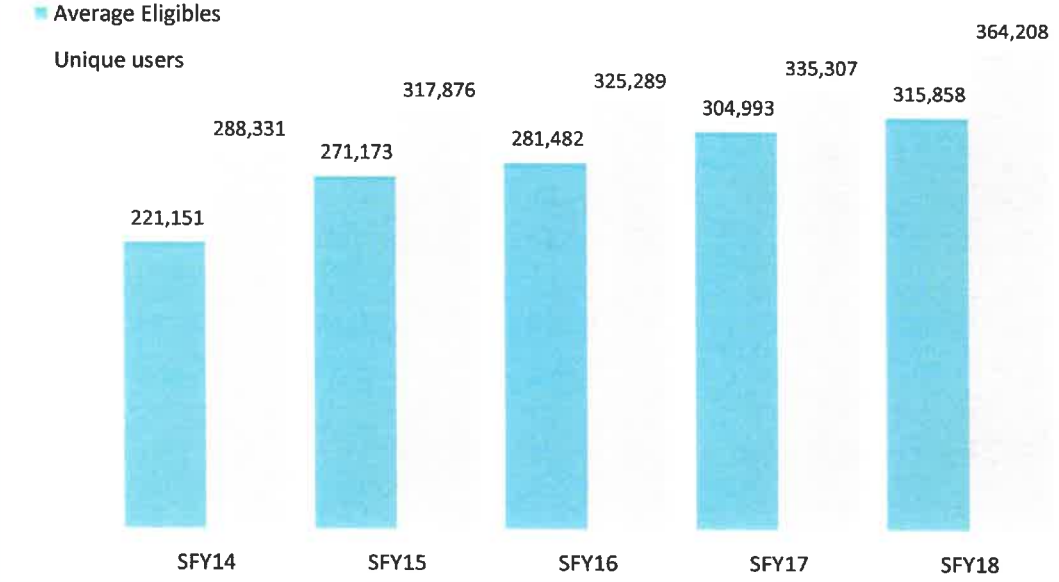
	SFY15	SFY16	SFY17	SFY18	Avg Annual Growth SFY 2015-2018
Annual PMPM Change (net of exclusions)	-6.4%	-1.4%	-4.0%	0.1%	**-1.8%**

- The average PMPM for fully covered populations is $691 in SFY 2018, remaining virtually unchanged from SFY 2017 when the PMPM was $690.
- The decline in the average PMPM since SFY 2014 is reflective of the change in the overall nature of the State's enrolled Medicaid population, with growth being heavily concentrated among the non-disabled children and adults who have comparatively low costs.
- The consistent PMPM over the last two years is reflective of a maturing program and relatively stable membership.

Medicaid Expenditure Trends: Unique Recipients

About one-third of Rhode Island's population was enrolled in Medicaid for some part of SFY 2018.

Average Eligibles and Unique Recipients - Fully Covered Populations/Services
SFY 2014-2018



	SFY14	SFY15	SFY16	SFY17	SFY18
Turnover Ratio	1.30	1.17	1.16	1.10	1.15
Unique Recipients % of RI Pop[1]	27%	30%	31%	32%	34%

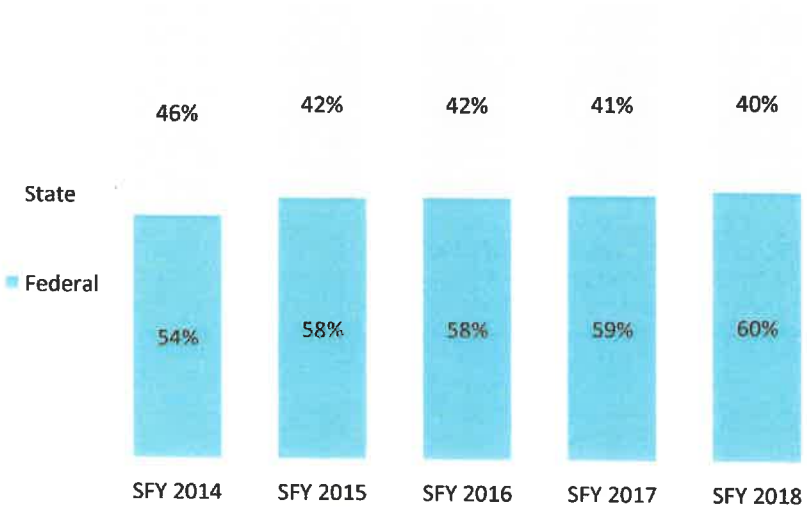
[1]Source: Population Division, US Census Bureau.

- Unique recipients is a measure of the number of individuals enrolled in Medicaid at any time during the fiscal year. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- The turnover ratio compares unique recipients to average eligibles. If the number of unique recipients is equal to the average eligibles, that indicates that there is a steady population of eligibles who remain on the program for the full year. If the number of unique recipients is above the average eligibles (a turnover ratio of >1), this indicates that some Rhode Islanders are using Medicaid for shorter periods of time.
- The higher turnover ratio for SFY 2014 is due to the fact that the Expansion population was enrolled for at most 6 months of the year and many were enrolled for less than that. In SFY 2015-2018, the turnover ratio is much closer to the typical annual turnover ratio.

Federal and State Share of Expenditures

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

Effective Federal Medicaid Assistance Percentage (FMAP)
SFY 2014-2018

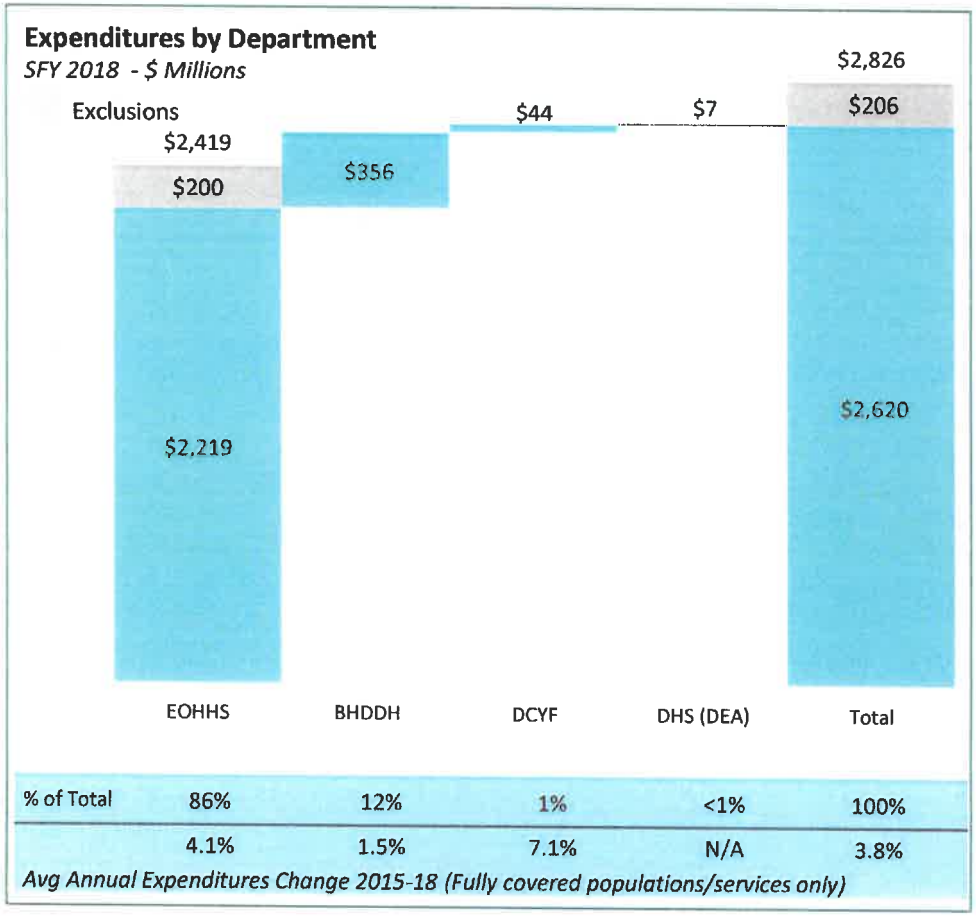


FMAPs shown reflect average effective state share during state fiscal year period across all programs, inclusive of excluded expenditures.

- While this report will review trends in total Medicaid medical expenditures, it is important to recognize that less than half of these expenditures fall to the Rhode Island budget.
- The chart at left shows effective state share across the Medicaid program, taking into account several variations from the basic FMAP levels, including:
  - The FMAP for the Medicaid Expansion population is 94.5% for SFY 2018.
  - The enhanced FMAP for the CHIP program was 88.9% in SFY 2018. The CHIP program provides full Medicaid benefits to uninsured children and pregnant women from families with incomes up to 250% of the federal poverty level. In SFY 2018, there were 28,783 average CHIP enrollees.
  - There are also a few small programs with a 90% match, including Breast & Cervical Cancer Prevention & Treatment (BCCPT), Extended Family Planning (EFP). The Refugee Assistance Program and Health System Transformation Project-funded expenditures are matched at 100%.

Expenditures by Department

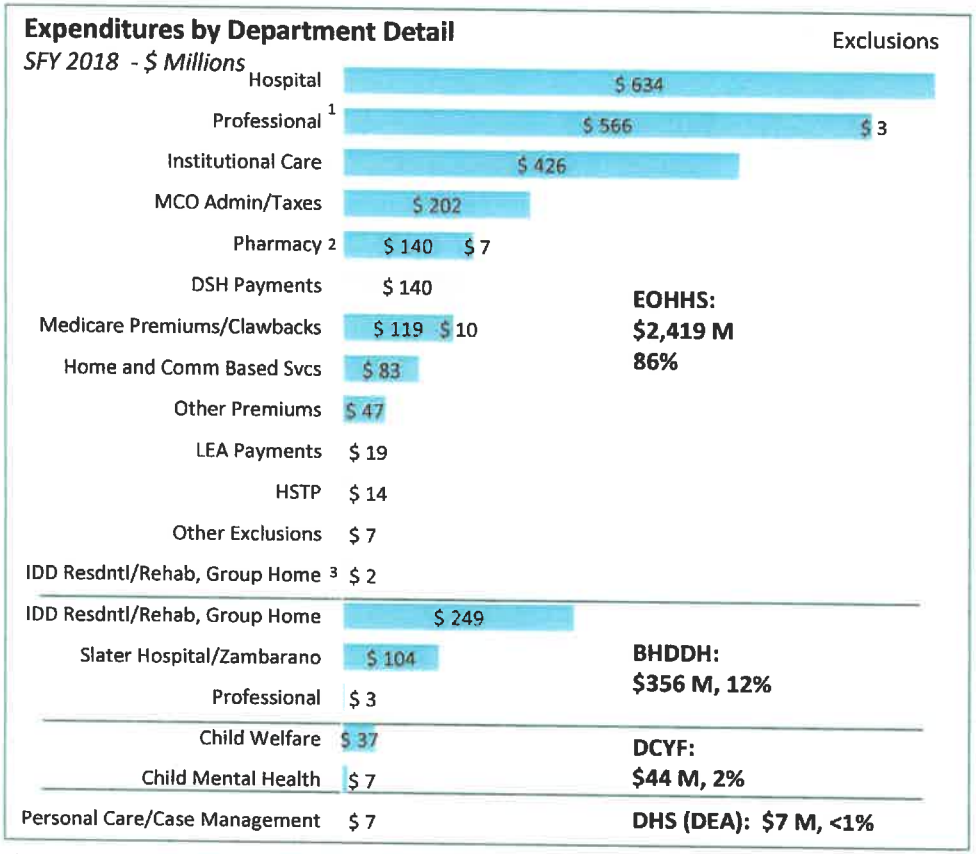
The majority of expenditures (86%) are administered by EOHHS.



- In SFY 2018, the state departments responsible for administering components of the Medicaid program were: the Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH); and the Department of Children, Youth and Families (DCYF).
- EOHHS is the lead administrator for the Medicaid contract with CMS. The Single State Medicaid Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
- The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers the second largest share of Medicaid expenditures (13%). Note that funding for intensive behavioral health services was transferred from BHDDH to EOHHS as of July 1, 2014.
- Detail for each department is shown on the next page.

Expenditures by Department: State Agency Detail

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



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

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- EOHHS overall accounts for 86% of Medicaid expenditures. The biggest portion of that is for hospital-based services, accounting for 26% of EOHHS expenditures. Professional services accounts for 24% of EOHHS expenditures, and institutional care is another 18%.
- BHDDH expenditures include residential facilities for persons with intellectual and developmental disabilities and the management of Slater and Zambarano Hospitals.
- DCYF accounts for $44 million (2%) of Medicaid expenditures. DCYF administers programs serving children in the child welfare system, children in substitute care and children with behavioral health conditions.
- DHS accounts for $7 million of Medicaid expenditures. These are mainly CNOM expenditures designed to forestall the need for persons served to become fully Medicaid eligible.

Expenditures amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion, accrual vs. paid amounts, provider payouts, capitation vs. claim amounts, and rounding.

Expenditure Distributions

Medicaid expenditures can be broken down in several ways.

Medicaid Expenditures for Covered Services
SFY 2018 - $ Millions

SFY 2018

Expenditure Distributions include:

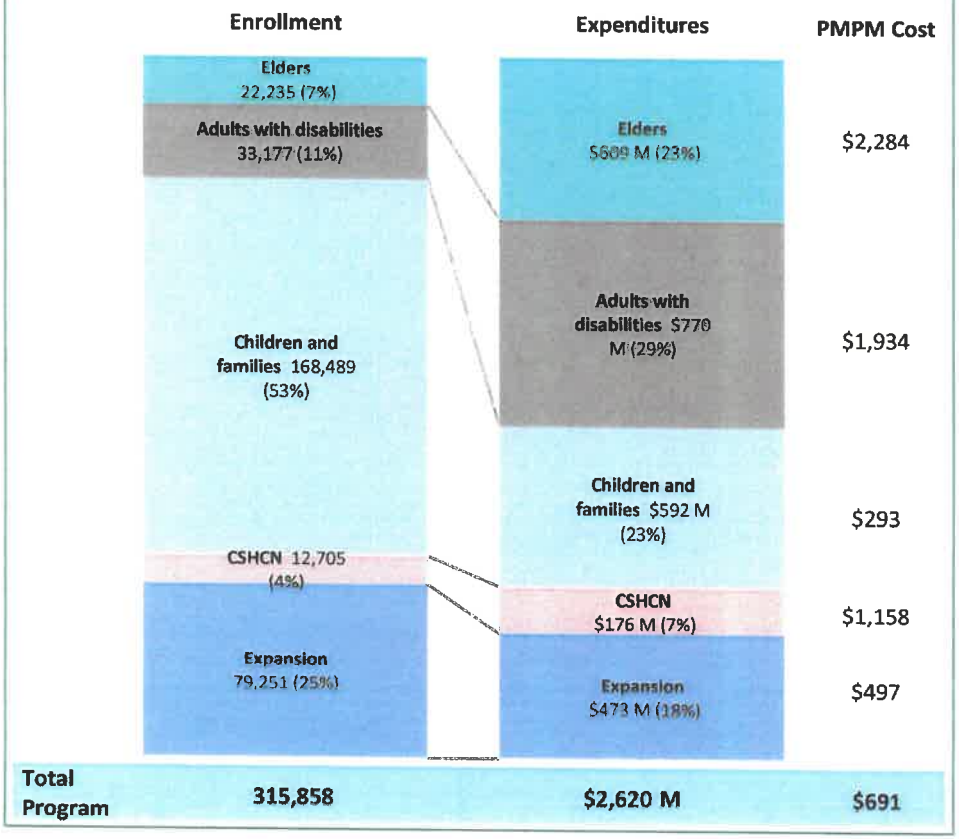
Breakdown by population: ▪ Elders ▪ Adults with disabilities ▪ Children and families ▪ Children with Special Health Care Needs ▪ Medicaid Expansion	*Breakdown by population shows expenditures by Medicaid recipient age and category of need.*
Breakdown by provider type: ▪ Hospital ▪ Nursing Facility ▪ IDD Residential/Rehab, Group Homes ▪ Behavioral Health ▪ Home & Community Based Services ▪ Long Term Services & Supports ▪ Professional Services ▪ Premiums ▪ MCO Admin/Taxes	*Breakdown by provider type shows expenditures by the institution or the type of professional performing the services.*
LTSS Details: ▪ Types of LTSS Providers ▪ LTSS Trends	*Further details on Long Term Services & Supports expenditures.*
Breakdown by program: ▪ Managed Care ▪ Fee-for-Service (FFS)	*Breakdown by program shows expenditures by type of managed care program and amount of fee-for-service spending.*

Expenditures by Population

The Medicaid program served an average of 315,865 eligibles in SFY 2018 at an average cost per member per month of $691. However, PMPM costs vary considerably by population.

Medicaid Enrollment/Expenditures/PMPM by Population

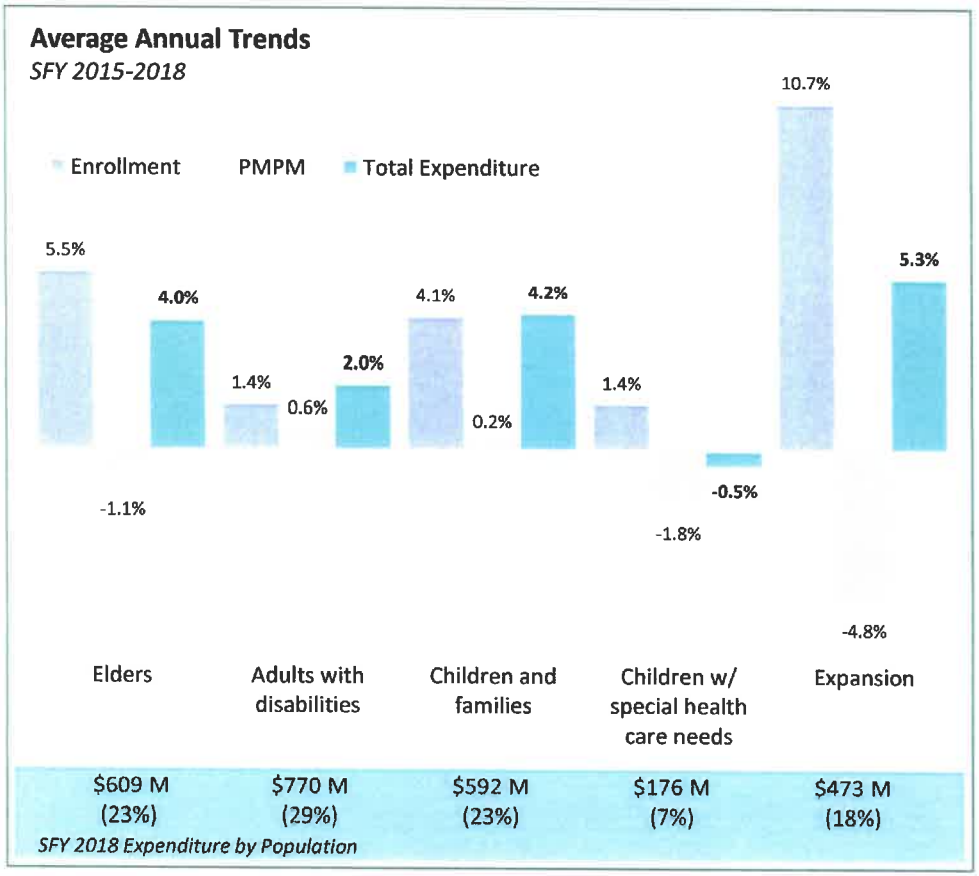
SFY 2018 - $ Millions



- **Elders** are adults over age 65, including those also eligible for Medicare. Elders account for 7% of enrollment and 23% of expenditures, with a PMPM cost of $2,284.
- **Adults with disabilities** are adults under age 65 who have identified disabilities. They account for 11% of enrollment and 29% of expenditures, with a PMPM cost of $1,934.
- **Children and families** are low income children, parents and pregnant women who meet specific income requirements. This population accounts for over half of total enrollment (53%) and 23% of total expenditures, with a PMPM cost of $293.
- **Children with Special Health Care Needs (CSHCN)** are individuals under 21 eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. CSHCN account for 4% of eligibles and 7% of expenditures at a PMPM of $1,158.
- **Medicaid Expansion** are adults without dependent children and with incomes under 138% FPL who were newly eligible for Medicaid as of January 1st 2014 under ACA expansion rules. Medicaid Expansion accounts for 25% of eligibles and 18% of overall expenditures, with a PMPM of $497.

Expenditures by Population: Trends

Expenditure trends between SFY 2015 and SFY 2018 differed for the various population groups.

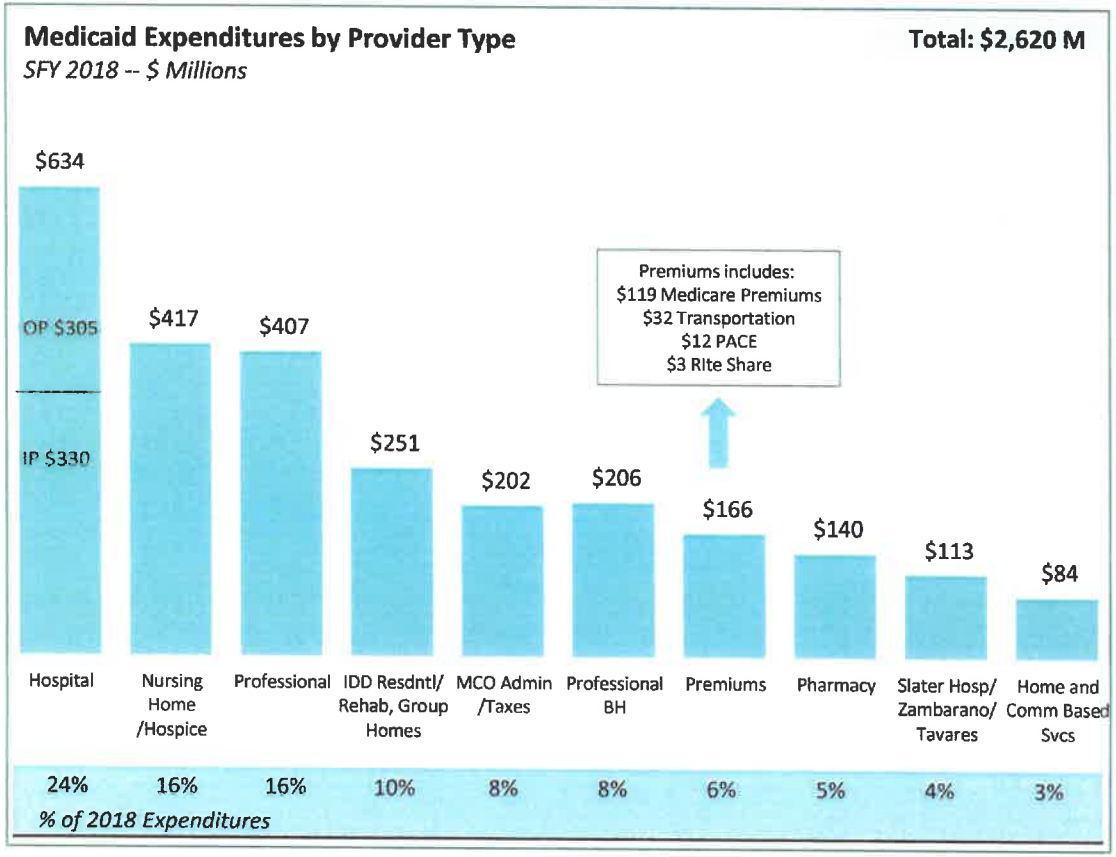


The total expenditure trend can be broken into two composite pieces - the per member per month (PMPM) **cost** trend and the enrollment, or **volume**, trend. Over the last four years, between SFY 2015 and SFY 2018:

- Elders experienced a 4.0% average annual increase in expenditures. This was despite a 1.1% PMPM cost decrease, and was driven by enrollment growth of 5.5%.
- Adults with Disabilities expenditures increased 2.0% on average, with PMPM cost contributing 0.6% and annual enrollment growing by 1.4%.
- Children and Families experienced a 4.2% average annual expenditures growth rate due mostly to the contribution of a 4.1% average annual enrollment increase, with PMPM costs increasing slightly as well.
- Children with Special Healthcare Needs experienced an overall negative expenditures growth rate of 0.5%. This was despite a 1.4% enrollment increase, and was driven by a PMPM cost decrease of 1.8% annually.
- Total Expansion population expenditures increased 5.3% annually, driven by a 10.7% average annual increase in enrollment offset by a 4.8% average reduction in PMPM cost.

Expenditures by Provider Type

Medicaid program funds are used to reimburse a variety of providers. Together, hospitals and nursing facilities account for forty percent of program expenditures in SFY 2018.



- Hospitals were the largest provider type, accounting for 24% of Medicaid expenditures in SFY 2018.
- Nursing facilities and professional services each accounted for 16% of expenditures.
- Eight percent of expenditures went to MCO administration and state and federal taxes and fees assessed against MCOs, consistent with SFY 2017.
- Detailed definitions of each provider type are included on the next page.

Note: Child welfare and Child Mental Health expenditures are included in the professional and professional BH categories.

Expenditure by Provider Type: Definitions

Medicaid provider types can be grouped into four categories – acute care, institutional care, community care, and administrative costs.

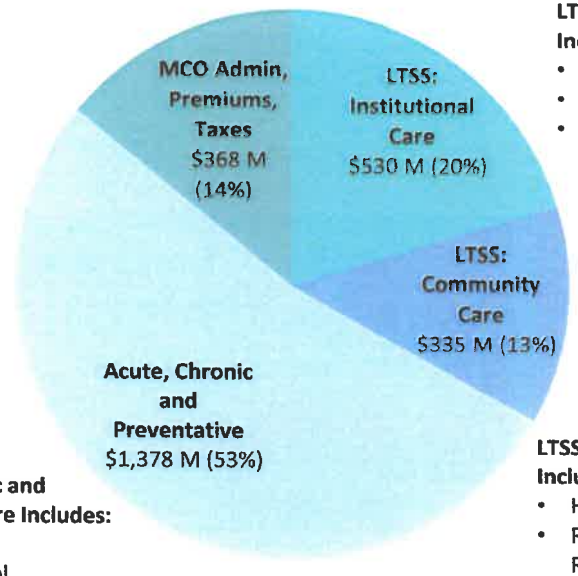
Acute, Chronic and Preventive Care	Hospital	Hospital includes inpatient and outpatient services.
	Professional	Professional includes physician, dental, DME/supplies, x-ray/lab/tests, ambulance, etc.
	Professional BH	Professional Behavioral Health includes DHS, BHDDH and DCYF services including, but not limited to, Professional Mental Health/Substance Use Disorder, Cedar (Comprehensive, evaluation, diagnosis, assessment, referral, re-evaluation services), CMHC, and Residential DCYF.
	Pharmacy	Pharmacy includes prescription and over-the-counter medications, net of pharmacy rebates.
Institutional Care	Nursing Home/Hospice	Nursing home includes skilled nursing facilities. Hospice includes home-based, inpatient, and nursing facility-based hospice care.
	Slater Hospital, Tavares, and Zambarano	Slater Hospital, Tavares and Zambarano are specialized facilities for severely disabled adults or children.
Community Care	IDD Resdntl/ Rehab, Group Homes	Residential and Rehabilitation Services for persons with intellectual and developmental disabilities, including public and private IDD group homes, IDD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications, and supported employment).
	HCBS	Home and Community Based Services (HCBS) are services provided as an alternative to nursing home/institutional options, such as adult day care, assisted living, community services, and shared living/personal care.
Other	Premiums	Premiums includes Medicare premiums paid for qualifying individuals, Medicare clawback payments, transportation premiums, premiums for PACE (Program of All-Inclusive Care for the Elderly) and RIte Share premiums, which are the employee share of private insurance premiums paid on behalf of Medicaid eligibles who have access to private insurance.
	MCO Admin/Taxes	MCO admin/taxes includes administrative costs paid to the managed care organizations and state/federal taxes paid by the MCOs.

Expenditures by Provider Type Summary

Overall, 33% of Medicaid expenditures are for Institutional Care and Community Care, together referred to as Long Term Services and Supports (LTSS).

Medicaid Expenditures by Provider Type Category
SFY 2018 -- $ Millions

Total: $2,620 M



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

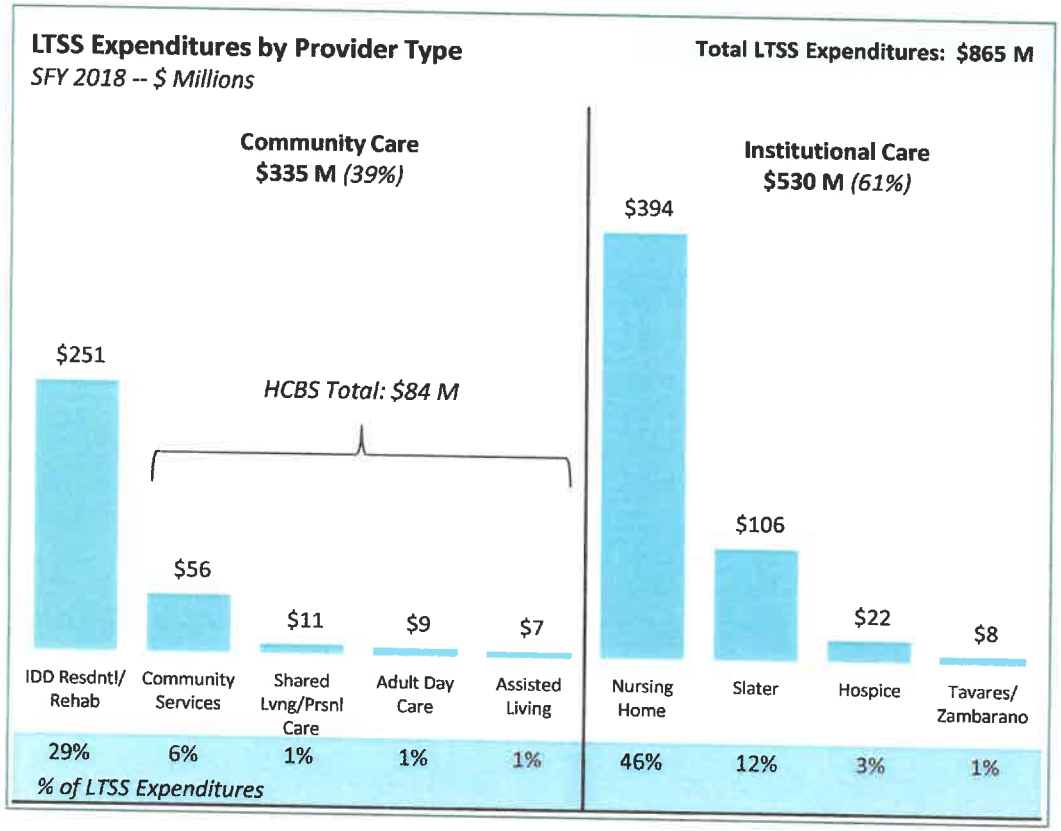
LTSS Community Care Includes:
- HCBS
- Residential and Rehab Services for the Intellectually and Developmentally Disabled
- Assisted Living
- Public and Private IDD Group Homes

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

- Approximately one-third (33%) of Medicaid expenditures are for Long Term Services and Supports (LTSS), including institutional care and community care.
  - Institutional care includes nursing facilities and care in the Slater Hospital and Tavares and Zambarano facilities.
  - Community Care includes home and community-based services (HCBS), residential and rehabilitation services for the intellectually and developmentally disabled, and group homes.
- Another 53% of Medicaid expenditures are for acute, chronic, and preventive care services such as hospital, professional services, and pharmacy.
- The remaining 14% of expenditures are for MCO administrative costs, premiums and taxes.
- There are several ways to categorize Medicaid-provided services. Other reports may group together services in different ways for different needs.

Provider Type Detail: LTSS Detail

Long term services and supports, including both institutional care and community care, accounted for $865 million in SFY 2018, about 33% of Medicaid expenditures.

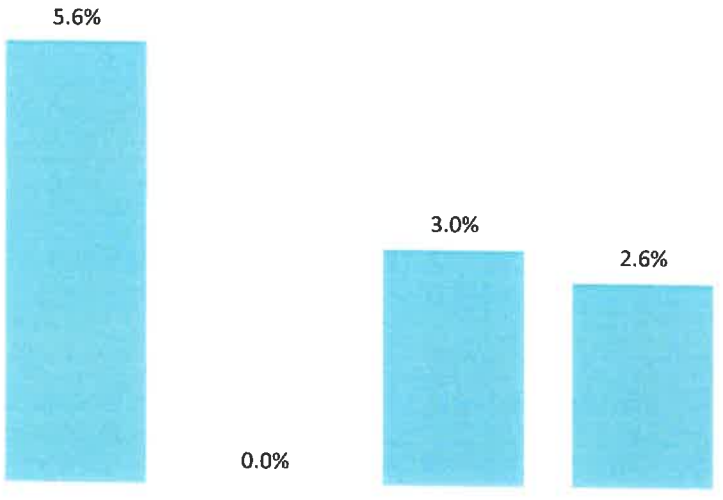


- The 1115 Medicaid Waiver granted Rhode Island the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide home and community based services to at-risk populations as alternatives to more costly nursing home/institutional options.
- Institutional care services account for 61% of LTSS expenditures. The largest category of institutional care is nursing homes, accounting for 46% of LTSS spending and 74% of spending on institutional care.
- Thirty-nine percent of long term services and support expenditures ($335 million) are for Community Care services, including services for the IDD population and HCBS.

LTSS Detail: Nursing Home Trends

Nursing home expenditures have increased 5.6% per year on average since SFY 2015.

Nursing Home Services Average Annual Trend Rates
SFY 2015-2018



	Nursing Home Expenditures	Nursing Home Days/thousand (Elders and adults with disabilities)	Nursing Home Total Days	Nursing Home Cost per Day
SFY 2018 Value	$394 M[1]	37,418	2,073,459	$190/day

[1]Total spending on Nursing Home and Hospice care was $417 million.

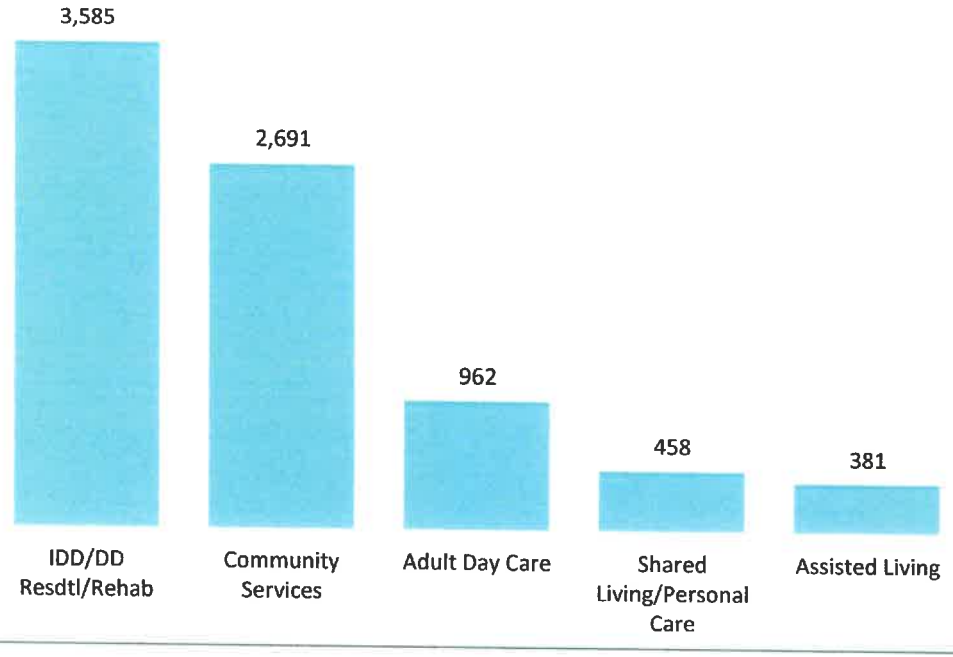
- Nursing home expenditures accounted for $394 million[1] in SFY 2018. SFY 2018 expenditures are consistent with EOHHS' year-end accrual for nursing home payments net of anticipated recoupments against advances paid within the fiscal year. This amount may be revised in subsequent Medicaid Expenditure Reports.
- Over the last four years, nursing home days per thousand for elders and adults with disabilities averaged 0.0% growth per year. Nursing home days in total increased 3.0% per year on average.
- Nursing home cost per day (calculated as total expenditures divided by total days) has increased from $174 to $190 between SFY 2015 and SFY 2018, about 2.6% on average per year. Cost per day reflects payment by EOHHS after deducting member patient share.
- Total expenditures for nursing homes includes allocated premium payments and advances, so the calculated cost per day shown here may differ from the actual payment rates and rates shown in other reports.

LTSS Detail: HCBS Utilization

Home and community based services enable some members to remain in community settings rather than be admitted to or remain in nursing homes.

Home and Community Based Services
Average Monthly Census[1]
SFY 2018

Elders and Adults with Disabilities
Average Eligibles = 55,413



- Residential and rehabilitation services for intellectually and developmentally disabled individuals is the largest category of home and community based services (HCBS) and had an average monthly census in SFY 2018 of 3,585 recipients.
- Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.
- Utilization data for members receiving services under the ICI program is not available in a form to be included in this chart. Due to this missing data, these census totals may be understated.

[1]HCBS categories have changed compared to SFY17 report, thus do not have trend values illustrated.

Expenditures by Managed Care Enrollment Status

Overall, 66% of total Medicaid expenditures are paid through managed care programs.

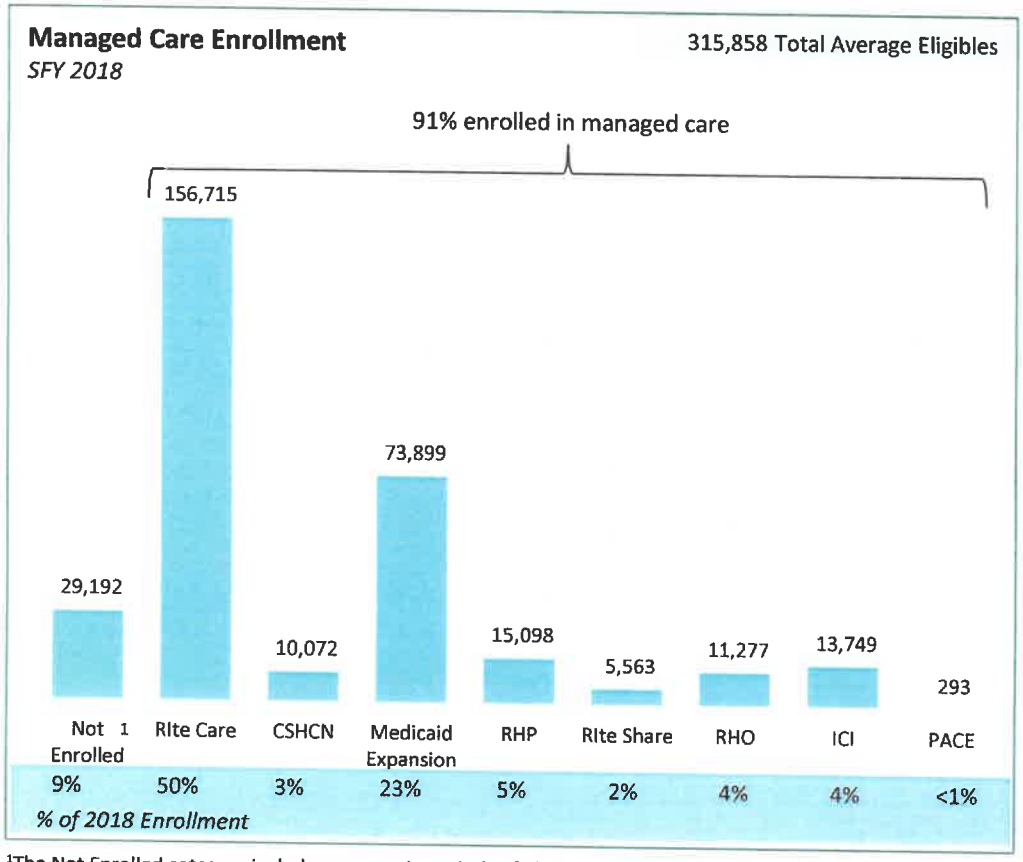
Expenditures by Managed Care Enrollment Status
SFY 2018

	Managed Care Enrolled *286,666 Eligibles (91%)*	Not Enrolled *29,192 Eligibles (9%)*	Total Expenditures
Managed Care Expenditures	**$1,738 M** **66%** Managed Care Expenditures for Managed Care Enrolled Eligibles		**$1,738 M** **66%**
Other Expenditures	**$300 M** **12%** Other Expenditures for Managed Care Enrolled Eligibles *(for services not covered by Managed Care)*	**$582 M** **22%** Expenditures for Eligibles Not Enrolled in Managed Care	**$882 M** **34%**
Total Expenditures	**$2,038 M** **78%**	**$582 M** **22%**	**$2,620 M**

- Ninety-one percent of Medicaid eligibles are enrolled in managed care programs, including RIte Care, RIte Share, Rhody Health Partners, Rhody Health Options, Integrated Care Initiative, Medicaid Expansion Managed Care, and PACE. These enrolled populations account for about three-quarters (78%) of Medicaid expenditures in SFY 2018.
- Of the $2,038 million in expenditures on managed care enrolled populations, $1,738 million was paid through managed care programs, accounting for 66% of total Medicaid expenditures.
- The remaining $300 million in expenditures on managed care enrolled populations was paid for FFS claims and Medicare/transportation premiums for managed care enrolled eligibles.
- FFS claims for managed care enrolled populations include services such as NICU, adult dental care, and wrap payments for federally qualified health centers (FQHC), as well as the long-term care services and supports for the ID/DD population administered by BHDDH.

Managed Care Enrollment

Medicaid enrollees who do not have other insurance are enrolled in Medicaid managed care plans. About 91% of Medicaid average eligibles are enrolled in some sort of managed care programs.



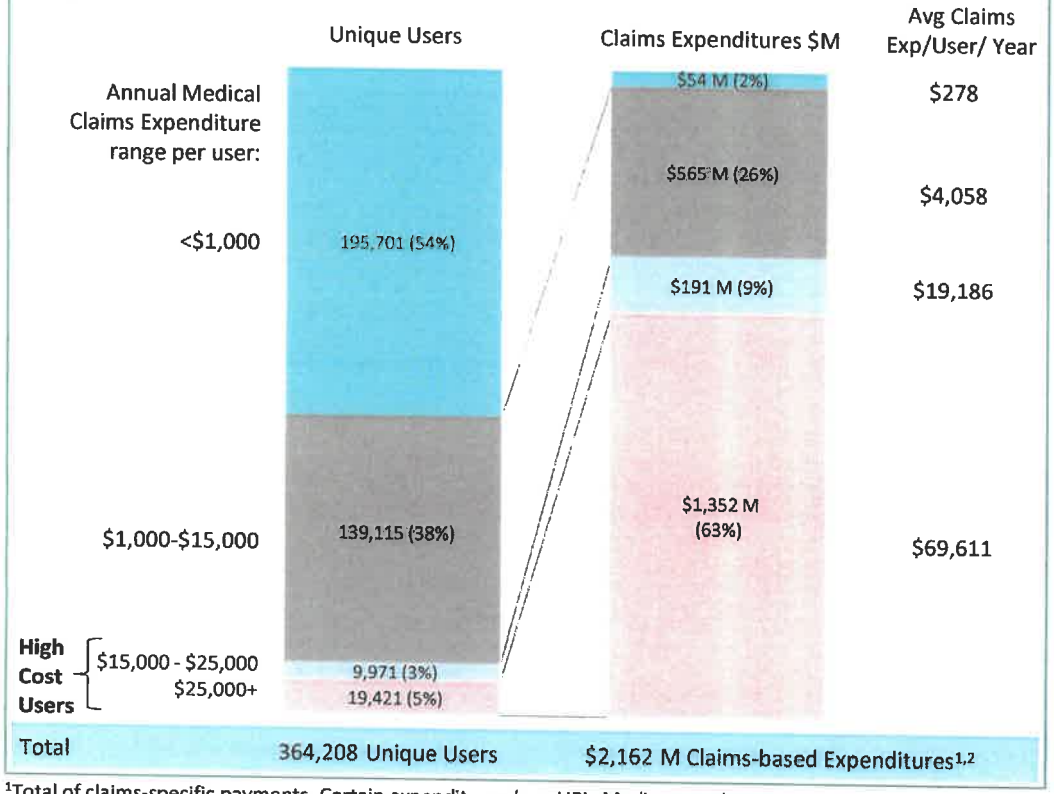
[1]The Not Enrolled category includes persons in periods of eligibility prior to managed care enrollment, as well as certain persons with other insurance, such as Medicare.

- Managed care enrollment is divided between Rhode Island's three Medicaid Managed Care Organizations (MCOs), Neighborhood Health Plan (NHP), United Healthcare (UHC) and Tufts Health Plan (THP), who began enrolling Medicaid members in SFY 2018.
- **RIte Care** mainly serves children and parents. **Rhody Health Partners** is a managed care program for adults with disabilities.
- **RIte Share** is a program designed to allow Medicaid eligibles with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditures by leveraging the employer's contribution.
- The **Integrated Care Initiative (ICI)** and **Rhody Health Options (RHO)** are fully capitated managed care programs for long term care, long term services and supports, and other Medicaid-funded services designed primarily for eligibles with both Medicaid and Medicare eligibility.

High Cost Users: By Expenditures Level

Medicaid claims expenditures are highly concentrated. The top 5% of Medicaid users account for almost two thirds (63%) of Medicaid claims expenditures.

Medicaid User Claims Expenditures Distributions
SFY 2018



- In order to look at spending by user, it is necessary to look at "unique users" rather than average eligibles. A unique user is a unique individual with associated Medicaid eligibility. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- In order to better examine the characteristics of this population, this report defines "high cost" users as those with over $15,000 of claims expenditures per year, adding another 3 percent of users to the top 5%. There are 29,392 "high cost" users (8%) who account for $1,543 million (71%) in claims expenditures.
- High cost users typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- On the other end of the spectrum, 54% of Medicaid users access services at a cost of less than $1,000 per year and account for 3% of claims expenditures, averaging $278 in annual claims expenditures per user.

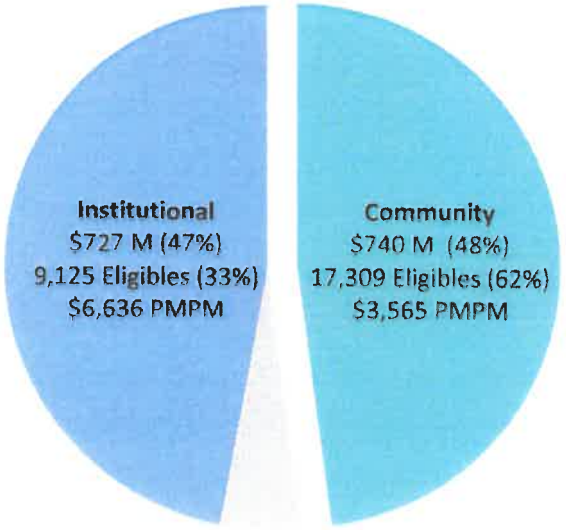
[1]Total of claims-specific payments. Certain expenditures (e.g. UPL, Medicare and PACE Premiums) not attributable to specific users.
[2]No adjustment was made for claims paid by the MCOs but not submitted and accepted into the EOHHS MMIS.

High Cost Users: By Cohort

High cost users can be divided into three categories: those who reside in institutions or residential facilities; those receiving maternity/delivery services; and the remainder who presumably reside "in the community."

High Cost User Claims Expenditures by Cohort
Users with Annual Medicaid Claims Expenditures over $15,000
SFY 2018 -- $ Millions

Total High Cost User Claims Expenditures[1,2]: $1,543 M
Average Eligibles[3]: 27,981



Maternity
$76 M (5%)
1,547 Eligibles (6%)
$4,099 PMPM

Focus of this section: High cost users "in the community"
- By population
- By provider type
- By diagnosis

- Developing approaches to impact the costs and reduce the spending for high cost users requires an understanding of their circumstances and characteristics, the programs and services they are accessing, and their health care needs.
- Institutional high cost users account for 47% of high cost user expenditures and include nursing home residents, individuals residing in rehabilitation hospitals, and those in group homes and facilities for the intellectually and developmentally disabled. Nearly all the individuals residing in one of these settings are high cost users.
- High cost users receiving maternity and delivery services are mainly infants receiving NICU services and other high cost mothers and newborns.
- This remainder of this section will focus on the characteristics of high cost users who do not fall into the institutional or maternity categories, those presumably living in the community.

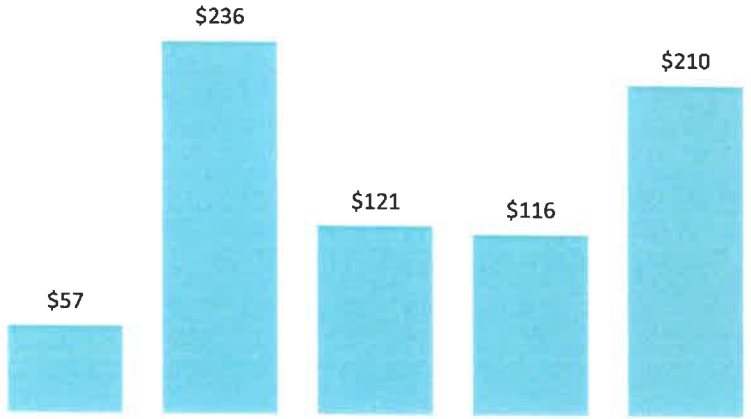
[1]Based on claims-specific payments only. Does not include pharmacy rebates.
[2]No adjustment was made for claims paid by the MCOs but not submitted and accepted into the EOHHS MMIS.
[3]In order to look at spending by user, it is necessary to look at "unique users", as on previous slide, however an analysis of PMPM costs requires looking at average eligibles. Thus the rest of the high cost user analysis considers average eligibles as based on those unique users who are determined as "high cost".

High Cost Users in the Community: By Population

Adults with disabilities and the Expansion population account for 60% of claims expenditures for high cost users in the community.

Community High Cost User Claims Expenditures by Population
Users "in the Community" with Annual Medicaid Claims Expenditures over $15,000
SFY 2018 -- $ Millions

Total Community High Cost User Claims Expenditures[1,2]: $740 M
Eligibles: 17,309



	Elders	Adults with disabilities	Children and families	Children w/ special health care needs	Expansion
% of Community High Cost User Claims Expenditures	8%	32%	16%	16%	28%
# Comm High Cost Eligibles	1,740	5,232	3,140	2,091	5,106

- Elders account for 8% of claims expenditures for high cost users in the community. High cost elders are more typically in institutions such as nursing homes and therefore do not fall into the community subset of high cost users.
- Adults with disabilities account for 32% of community high cost user claims expenditures, and 31% of adults with disabilities total expenditures are attributable to community high cost user claims expenditures.
- The Expansion population accounts for 5,106 community high cost user eligibles and 28% of community high cost user expenditures.

[1]Based on claims-specific payments only. Does not include pharmacy rebates.
[2]No adjustment was made for claims paid by the MCOs but not submitted and accepted into the EOHHS MMIS.

High Cost Users in the Community: By Provider Type

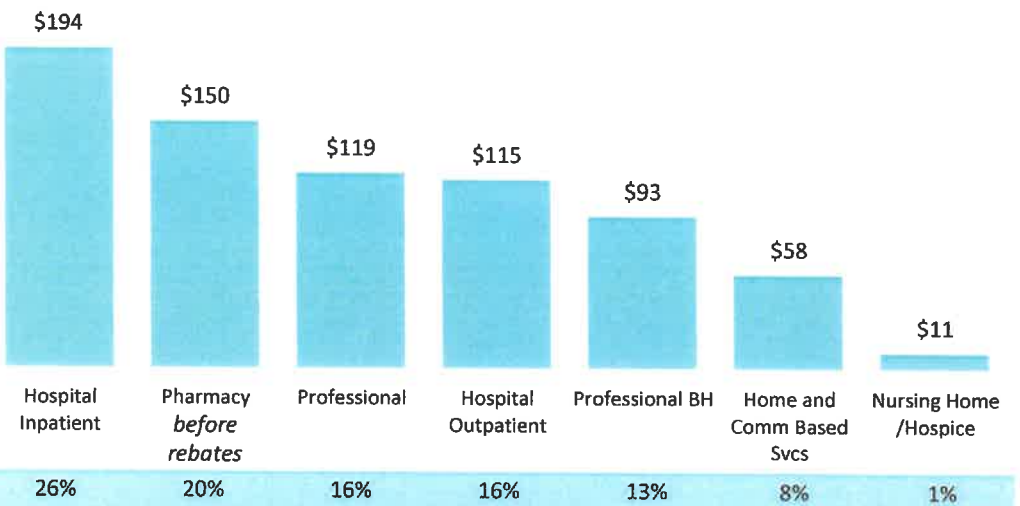
Over one-quarter of community high cost user claims expenditures are for hospital inpatient services.

Community High Cost User Claims Expenditures by Provider

Users "in the Community" with Annual Medicaid Claims Expenditures over $15,000

SFY 2018 -- $ Millions

Total Community High Cost User Claims Expenditures[1,2]: $740 M



- Hospital inpatient and outpatient claims expenditures together account for 41% of community high cost user expenditures.
- Community high cost users' claims account for over half (59%) of hospital inpatient expenditures.
- Twenty percent of community high cost user claims expense is for pharmacy claims. This expense is before accounting for pharmacy rebates.

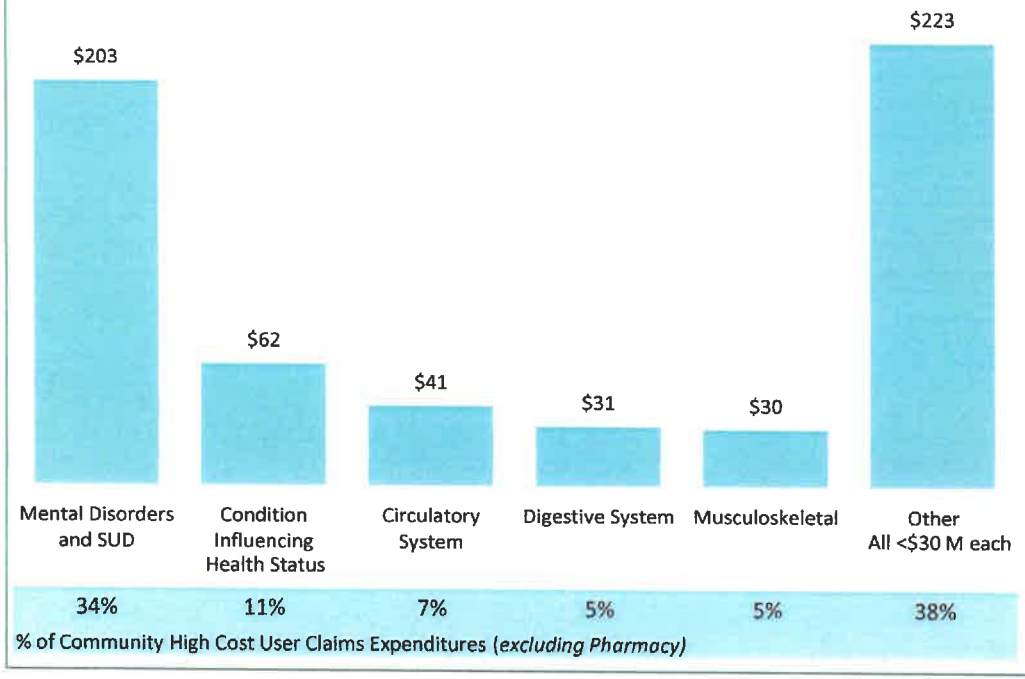
[1]Based on claims-specific payments only. Does not include pharmacy rebates.
[2]No adjustment was made for claims paid by the MCOs but not submitted and accepted into the EOHHS MMIS.

High Cost Users in the Community: By Diagnosis

Over one-third of the claim specific payments for community high cost users are related to a mental health or substance use disorder.

Community High Cost User Claims Expenditures by Diagnosis
Users "in the Community" with
Annual Medicaid Claims Expenditures over $15,000
SFY 2018 -- $ Millions

Total Community High Cost User Claims Expenditures[1,2]: $590 M *(excludes pharmacy)*



- Within mental disorders, $162 million of claims expenditures are for a diagnosis related to mental health while the remaining $41 million is for diagnosis related to substance use disorder.
- The next most common diagnosis for community high users, accounting for 11% of claims expenditures, is "condition influencing health status", which is mainly related to bed confinement.
- Pharmacy claims expenditures are excluded from this analysis because pharmacy claims are not associated with a diagnosis code.

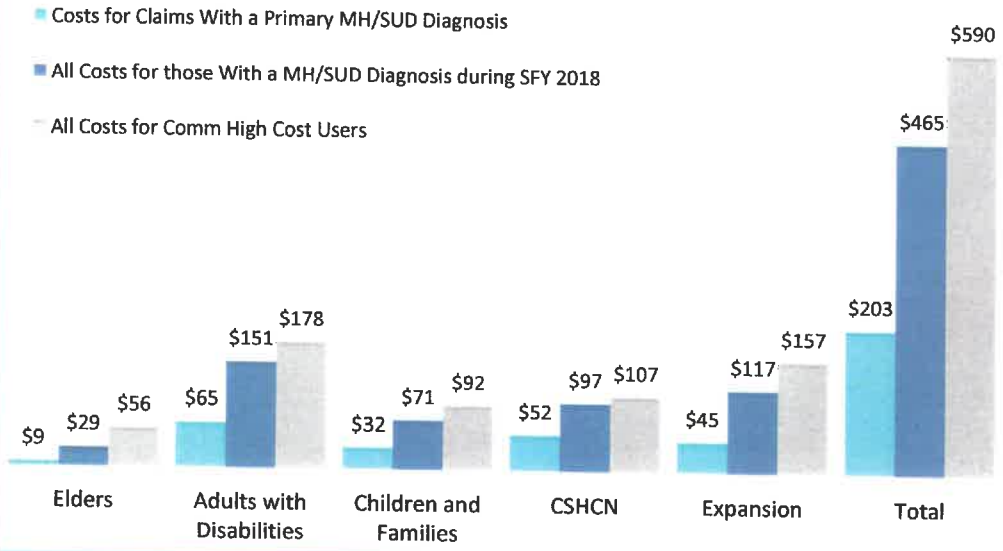
[1]Based on claims-specific payments only. Does not include pharmacy rebates.
[2]No adjustment was made for claims paid by the MCOs but not submitted and accepted into the EOHHS MMIS.

High Cost Users in the Community: Diagnosis Details

Seventy-nine percent of the expenditures on community high cost users was for individuals for whom there was a mental health (MH) or substance use disorder (SUD) diagnosis during the year.

Community High Cost User Claims Expenditures by Diagnosis
Users "in the Community" with Annual Medicaid Claims Expenditures over $15,000
SFY 2018 -- $ Millions

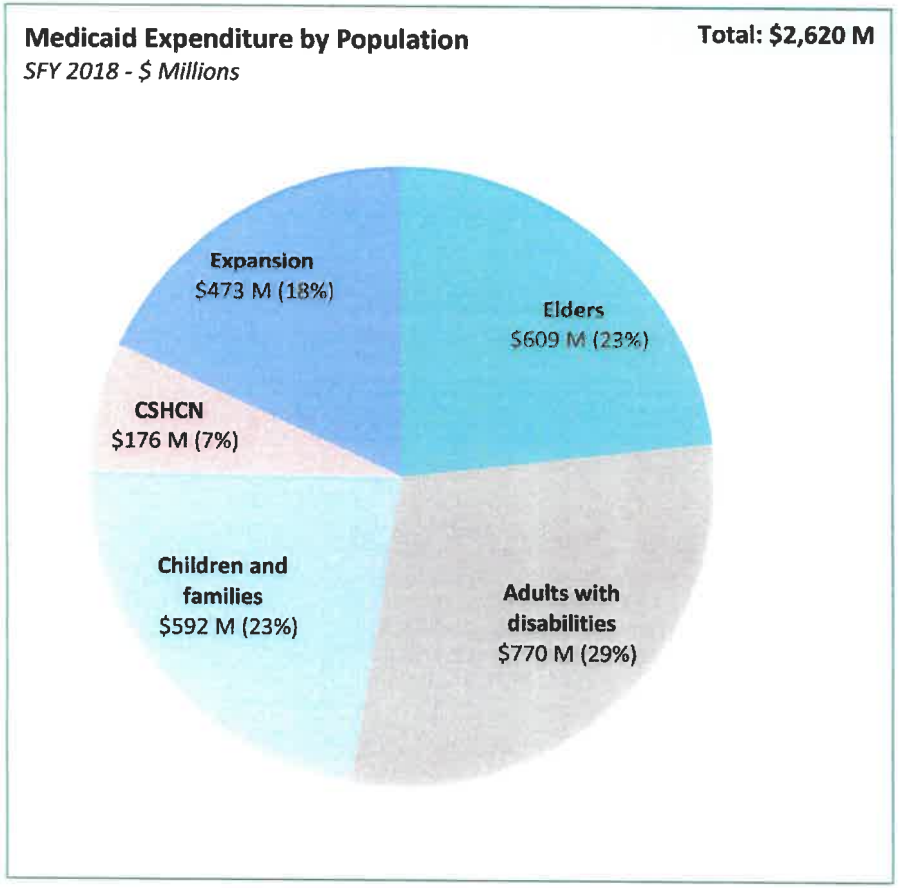
Total Community High Cost User Claims Expenditures: $590 M *(excludes pharmacy)*



- Of the $590 million spent on community high cost users, $465 million (79%) was for individuals for whom there was a mental health or substance use disorder claim at some point during the fiscal year.
- However, the spending was NOT concentrated in mental health/substance use services, as the specific MH/SUD claims only accounted for about $203 million, or 34% of the claims costs.
- These findings are relatively consistent across all populations of community high cost users.

Expenditures Detail by Population

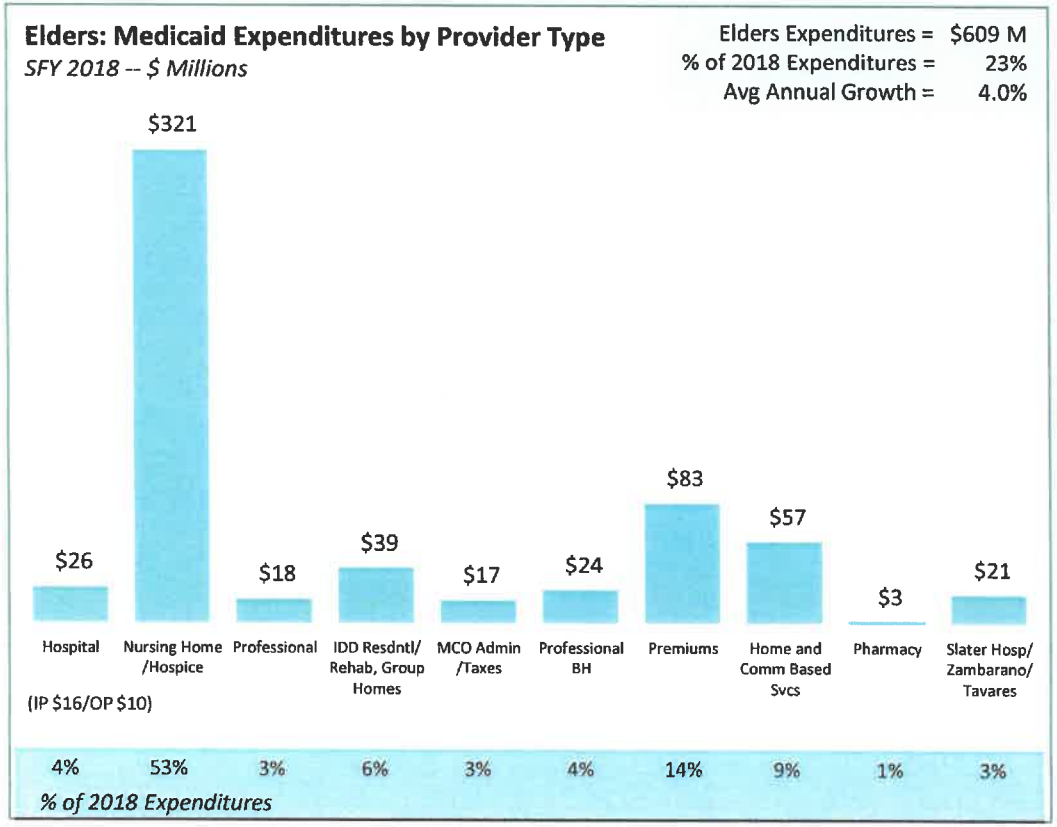
In order to get a clearer picture of the characteristics of each population, it is useful to look at expenditures, enrollment, and utilization for each group separately. This section contains details on expenditures for each population group as follows:



- **Elders:**
  - Expenditures by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in Medicare and Medicaid
- **Adults with Disabilities:**
  - Expenditures by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in Medicare and Medicaid
  - Acute care services utilization – inpatient days, emergency room visits, office visits, and pharmacy claims
- **Children and Families:**
  - Expenditures by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization
- **Children with Special Healthcare Needs (CSHCN):**
  - Expenditures by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization
- **Expansion:**
  - Expenditures by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization

Elders: Expenditures by Provider Type

Nursing facilities (including nursing homes and hospice) account for 53% of total Medicaid expenditures on elders.



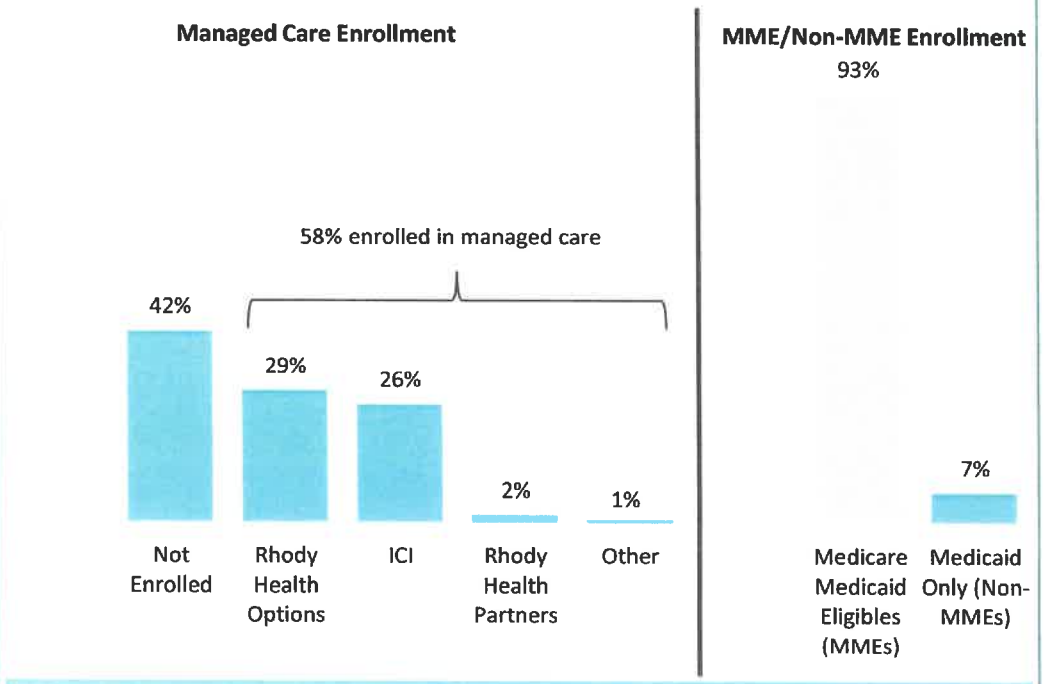
- Medicaid expenditures on elders totaled $609 million in SFY 2018, a decrease of 1.0% relative to SFY 2017. The annual growth over the past 4 years, however, has averaged to 4.0%.
- The large majority of elders are also eligible for Medicare, which was the primary payer for most medical services (e.g. hospital, professional). Consequently those expenditures were not paid by Medicaid and are not included here.
- Nursing home and hospice services account for 53% of expenditures for this population, with home and community based services contributing another 9%.

Elders: Managed Care and Dual Enrollment

Overall 58% of elders are enrolled in managed care programs.

Elders: Managed Care and MME (Dual) Enrollment
SFY 2018

Elders Expenditures = $609 M
Elders Average Eligibles = 22,235

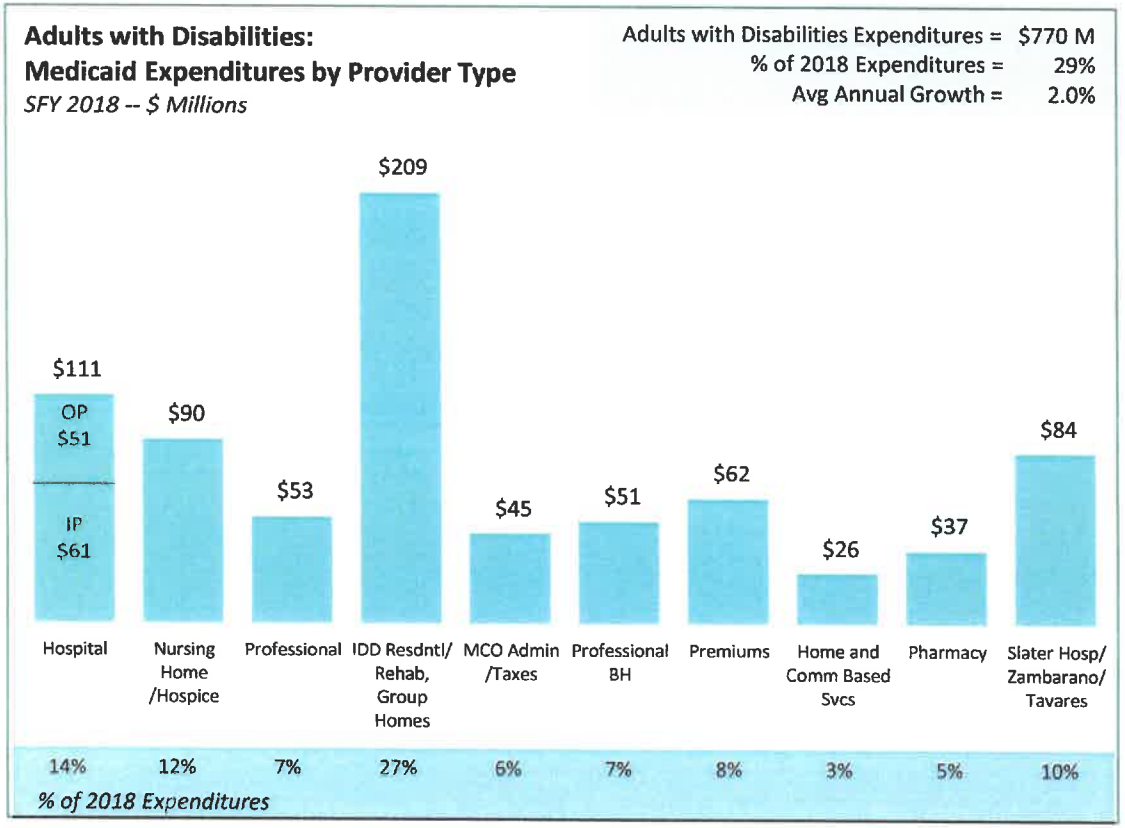


	Not Enrolled	Rhody Health Options	ICI	Rhody Health Partners	Other	Medicare Medicaid Eligibles (MMEs)	Medicaid Only (Non-MMEs)
Average Eligibles	9,280	6,456	5,658	533	307	20,620	1,615

- Ninety-three percent of elders are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- For the elders who are dually enrolled, Medicare is the primary payer for most acute and and primary care services (e.g., hospital, professional, pharmacy).
- Twenty-nine percent of elders are enrolled in Rhody Health Options (RHO) and another 26% are enrolled in the Integrated Care Initiative (ICI), both of which are fully capitated managed care programs for long term care, long term services and supports (LTSS), and other Medicaid-funded services designed primarily for individuals with both Medicaid and Medicare eligibility.

Adults with Disabilities: Expenditures by Provider Type

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



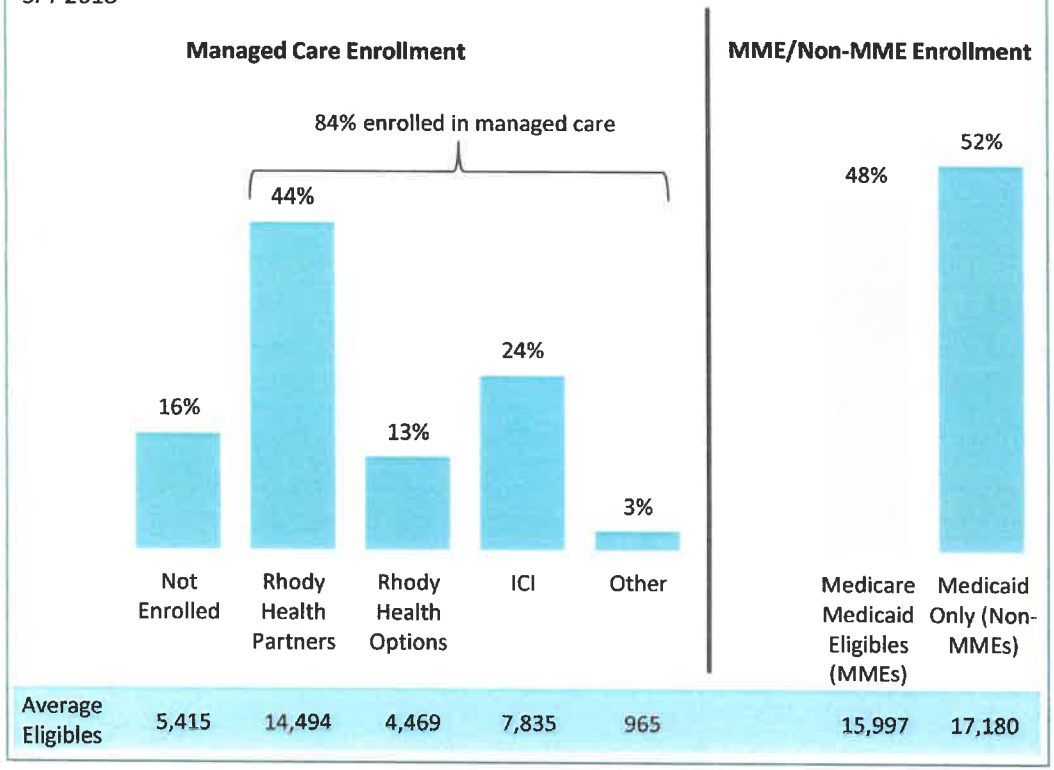
- Adults with disabilities account for the largest share of Medicaid expenditures, with total SFY 2018 expenditures of $770 million. Expenditure for this population has increased by approximately 2.0% per year over the past 4 years.
- Hospital and residential and rehabilitation services for persons with intellectual and developmental disabilities account for 14% and 27% of expenditures, respectively.

Adults with Disabilities: Managed Care Enrollment

Eighty-four percent of adults with disabilities are enrolled in managed care.

Adults with Disabilities: Managed Care and MME (Dual) Enrollment
SFY 2018

Adults with Disabilities Expenditures = $770 M
Average Eligibles = 33,177



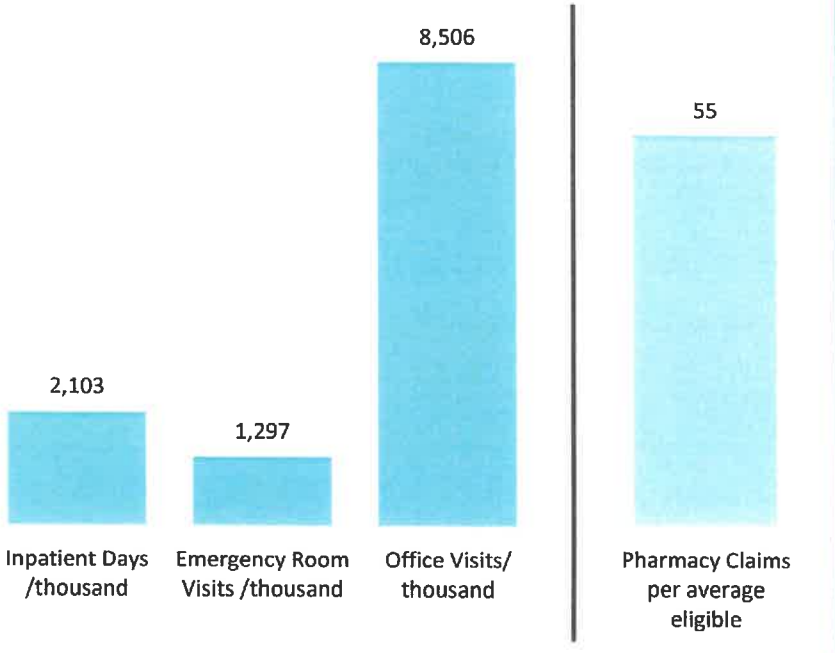
- Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- For the adults with disabilities who are dually enrolled, Medicare is the primary payer for most acute and and primary care services (e.g., hospital, physician, pharmacy).
- Adult populations had historically been served in fee-for-service Medicaid but have been transitioned to managed care over the last several years. In SFY 2018 84% of this population was enrolled in managed care.

Adults with Disabilities: Acute Care Utilization

All acute care utilization measures have decreased over the last 2 years for adults with disabilities with Medicaid-only coverage (non-MMEs) except for pharmacy claims.

Adults with Disabilities:
Non-MMEs: Acute Care Utilization
SFY 2018

Non-MME Adults with Disabilities = 17,180
52% of Adults with Disabilities

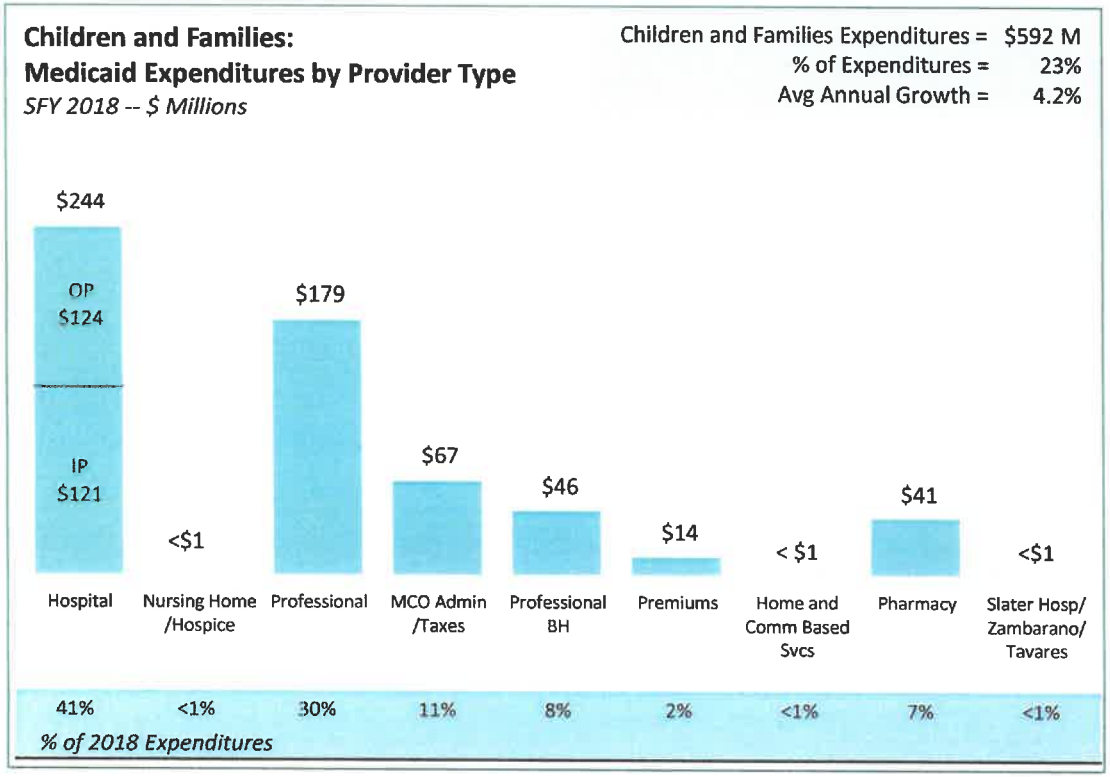


	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2016-2018	-2.3%	-6.0%	-1.5%	0.7%

- Fifty-two percent of adults with disabilities are covered by only Medicaid. Utilization shown here is for the adults with disabilities without Medicare coverage (Non-MMEs).
- Acute care utilization is not shown for dual enrolled adults with disabilities (MMEs) because Medicare is the primary payer for most acute care services.
- Non-MME adults with disabilities averaged 8,506 office visits per thousand eligibles per year in SFY 2018, a decrease of 1.5% per year on average in the last 3 years.
- Over the same period, inpatient days/thousand for this population have decreased at an annual rate of 2.3%.
- Pharmacy claims for non-MME adults with disabilities average 55 claims per average eligible per year, and have been increasing at a rate of 0.7% per year on average over the last 3 years.

Children and Families: Expenditures by Provider Type

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



- Children and families account for about one-fourth (23%) of total Medicaid expenditures, with SFY 2018 expenditure of $592 million. Expenditures for this population have increased by 4.2% per year over the past 4 years.
- Most expenditures on children and families are divided between professional and hospital care, with hospital care accounting for 41% of expenditures.
- A major component of expenditures relates to prenatal care and births. Annually, approximately 49% of Rhode Island's births are covered through RIte Care.[1]
- The enhanced federal match for the CHIP program was 88.94% in SFY 2018. The CHIP program provides full Medicaid benefits to uninsured children and pregnant women from families with incomes up to 250% of the federal poverty level. In SFY 2018, there were 28,783 average CHIP enrollees.

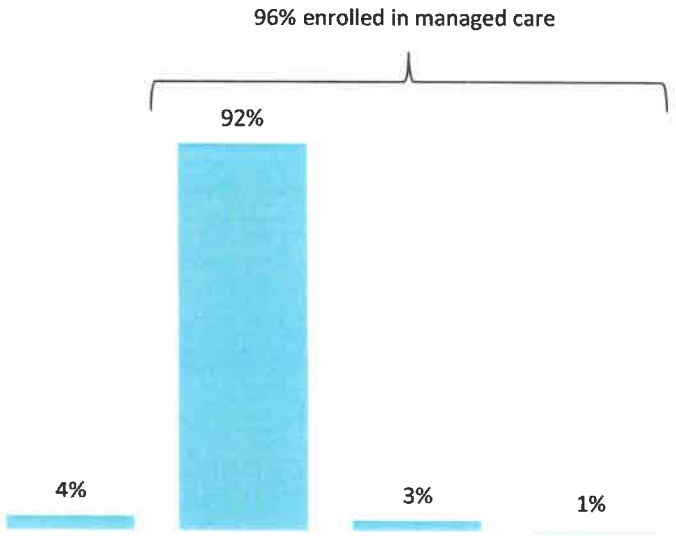
[1]Rate based on currently available data for 2008 – 2012. Source: http://www.health.ri.gov/data/birth/

Children and Families: Managed Care Enrollment

Nearly all children and families are enrolled in managed care.

Children and Families: Managed Care Enrollment
SFY 2018

Children and Families Expenditures = $592 M
Average Eligibles = 168,489

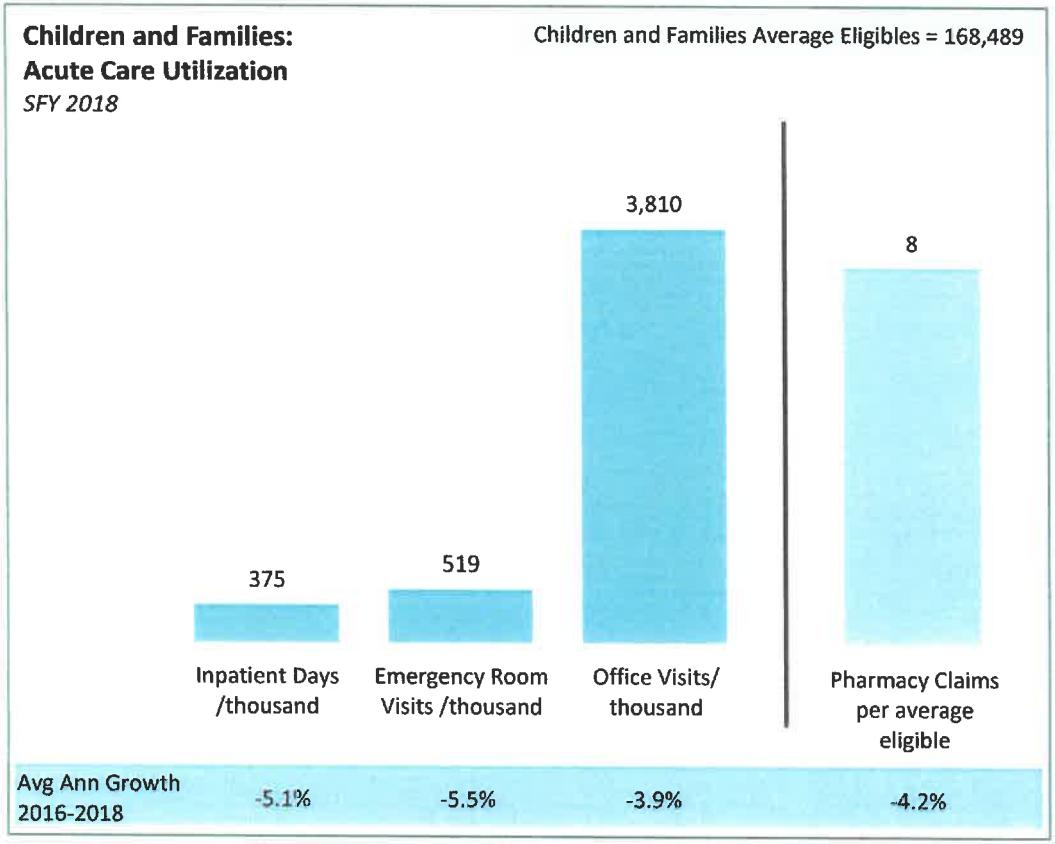


	Not Enrolled	RIteCare	RIteShare	Other
Average Eligibles	6,986	155,736	4,773	993

- Ninety-two percent of children and families are enrolled in a Medicaid managed care program through RIte Care. These enrollees are divided between Neighborhood Health Plan (NHP), United Healthcare (UHC), and Tufts Health Plan (THP).
- RIte Share is a program designed to allow Medicaid eligibles with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditures by leveraging the employer's contribution. In SFY 2018 there were 4,773 Medicaid eligible children and parents enrolled in the RIte Share program.
- The unenrolled children and families include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

Children and Families: Acute Care Utilization

For children and families, inpatient days per thousand have decreased by 5% per year on average since SFY 2016.

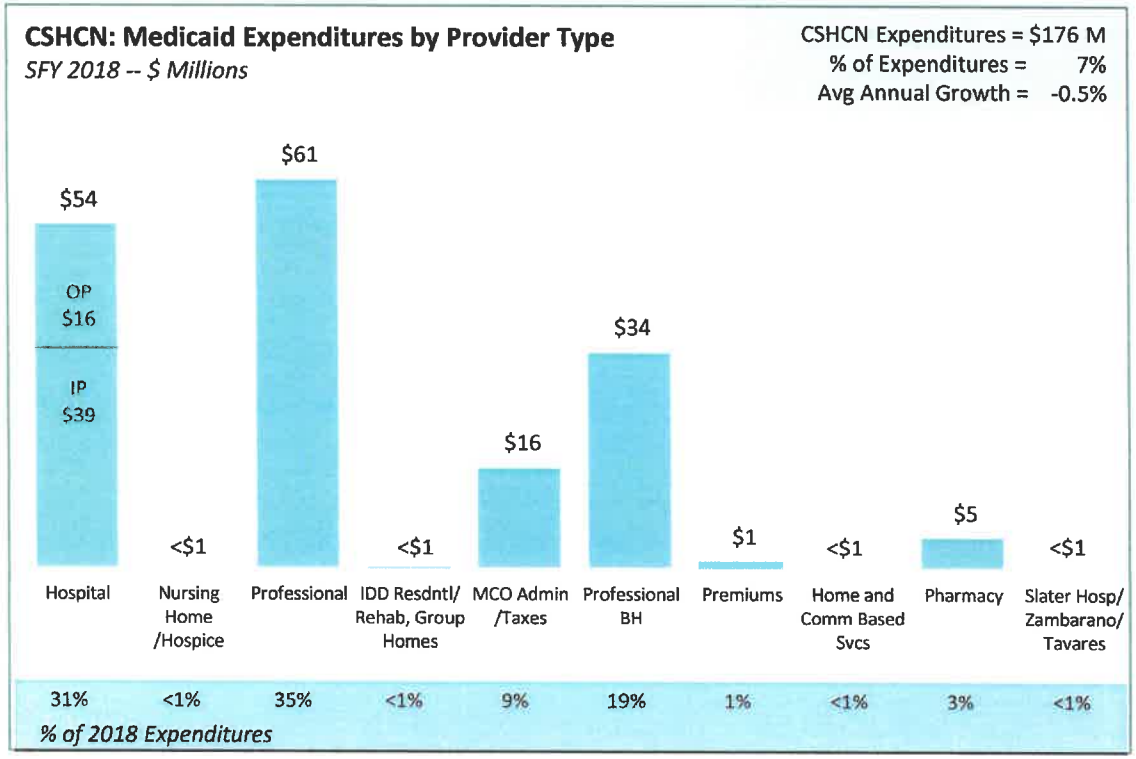


- For children and families, emergency room visits per thousand have decreased at 5.5% per year since SFY 2016.
- Office visits per thousand have decreased at 3.9% per year over the same period.
- Pharmacy claims for children and families average 8 claims per average eligible person per year and have decreased by 4.2% per year on average over the last 3 years.
- About 40% of inpatient days are maternity related (including maternity, nursery and NICU). Annually, approximately 49% of all RI births are covered through RIte Care.[1]

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

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

In the population of children with special health care needs, professional services account for 35% of all expenditures.



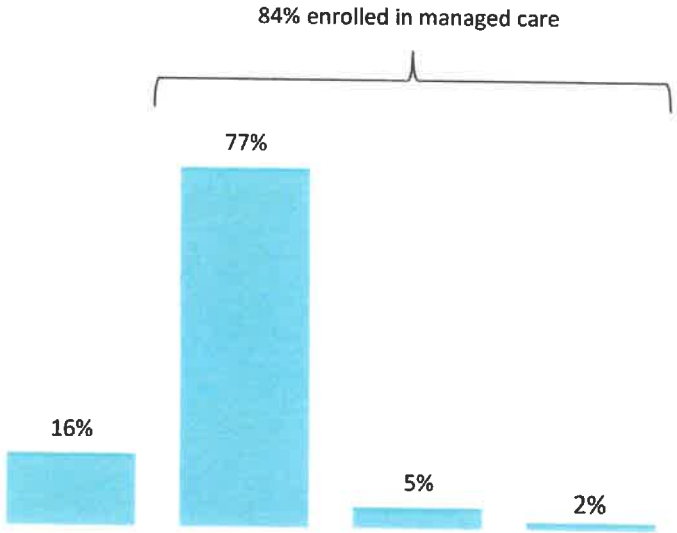
- Children with Special Health Care Needs (CSHCN) comprise a relatively small population, accounting for 7% percent of total Medicaid expenditures and 4% of enrollees.
- Expenditures for this population are dominated by hospital, professional, and professional behavioral health services, which together account for $149 million in CSHCN expenditures (85%). Professional behavioral health services include Cedar (Comprehensive, evaluation, Diagnosis, assessment, referral, re-evaluation) and Cedar Direct services, residential DCYF services, and professional mental health, substance use disorder, and other services.

Children with Special Health Care Needs: Managed Care Enrollment

Over 84% of children with special healthcare needs are enrolled in managed care.

CSHCN: Managed Care Enrollment
SFY 2018

CSHCN Expenditures = $176 M
Average Eligibles = 12,705



Average Eligibles	2,032	9,747	655	271

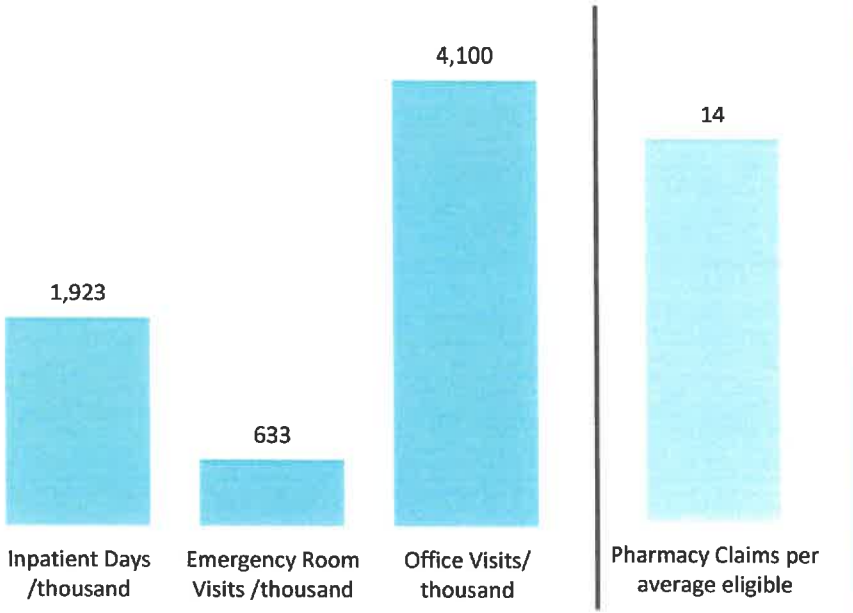
- In SFY 2018, 84% of children with special health care needs (CSHCN) without other insurance were enrolled in managed care. This is an increase from 82% in SFY 2017.
- The unenrolled children with special healthcare needs include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

Children with Special Health Care Needs: Acute Care Utilization

Inpatient days per thousand have increased over the last 2 years at an average rate of 9.3% per year.

CSHCN: Acute Care Utilization
SFY 2018

CSHCN Average Eligibles = 12,705

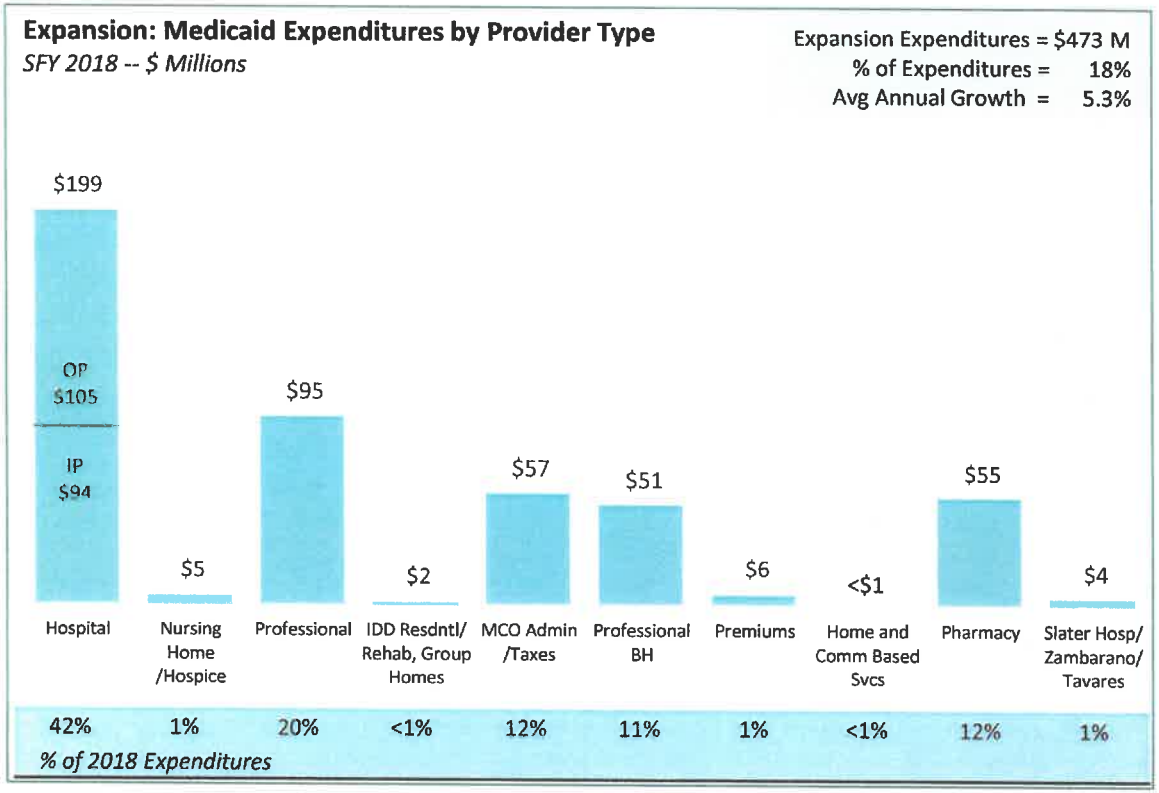


	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2016-2018	9.3%	2.4%	-2.3%	-3.8%

- For children with special health care needs, emergency room visits per thousand have increased by 2.4% per year on average since SFY 2016.
- Office visits per thousand have decreased at an average rate of 2.3% per year since SFY 2016 to 4,100 visits per thousand in SFY 2018.
- Eighty percent of inpatient days are related to behavioral health admissions.
- Pharmacy claims per average eligible have decreased at 3.8% per year over the last 3 years.

Expansion: Expenditures by Provider Type

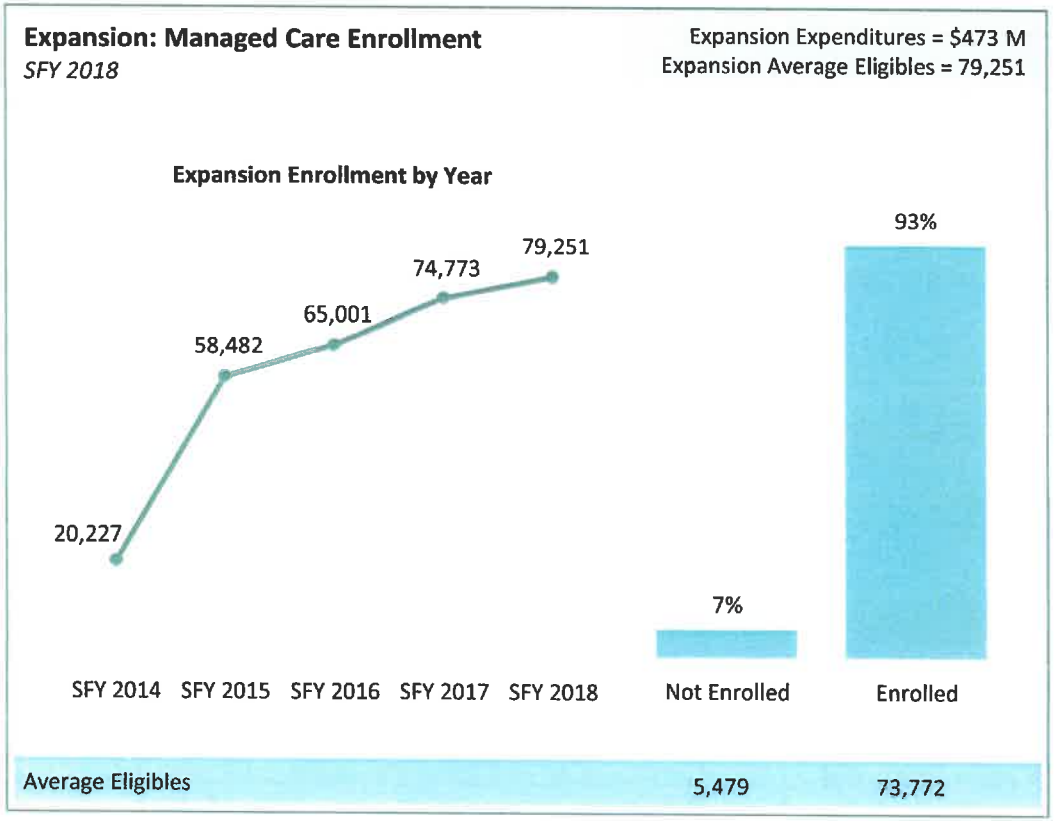
The Expansion population mainly uses hospital and professional services.



- The Expansion population became eligible for Medicaid starting January 1, 2014.
- This population accounted for $473 million in expenditures in SFY 2018, 18% of total Medicaid expenditures.
- The two largest provider types for the Expansion population are hospital and professional services, accounting for 62% of expenditures.
- The Expansion population used almost no long term services and supports.

Expansion: Managed Care Enrollment

The Expansion population is mainly enrolled in managed care programs



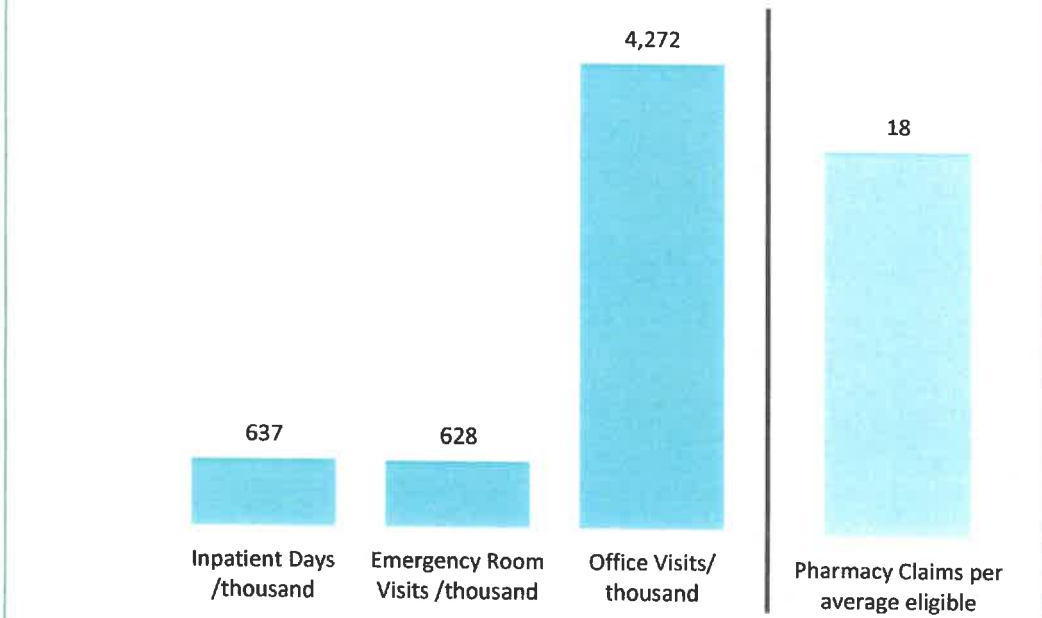
- The Medicaid Expansion population is almost entirely enrolled in managed care. However new enrollees experience an initial period in fee-for-service prior to enrollment in a health plan.
- Expansion eligibility commenced in January 2014 and was mainly stabilized by the end of SFY 2015.

Expansion: Acute Care Utilization

All acute care utilization measures for the Expansion population have decreased over the last 3 years.

Expansion: Acute Care Utilization
SFY 2018

Expansion Average Eligibles = 74,773



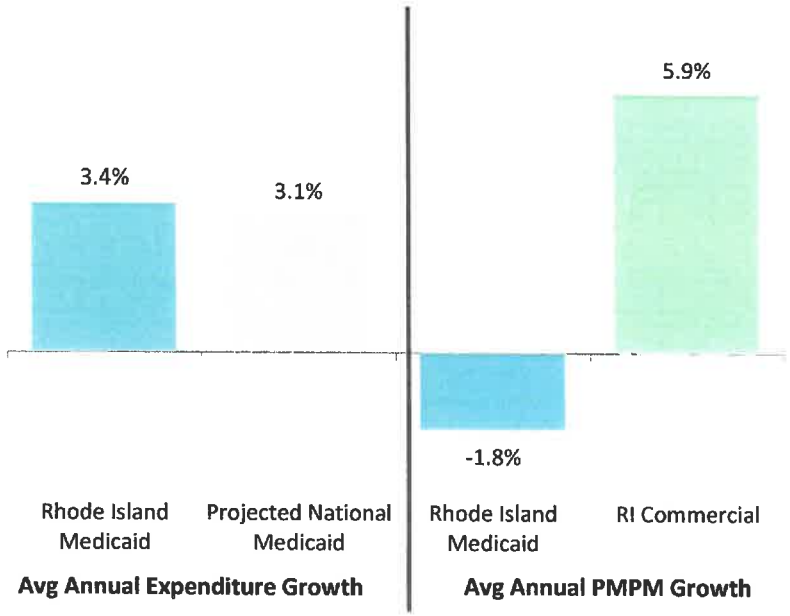
	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2016-2018	-4.9%	-8.0%	-6.4%	-2.0%

- The Medicaid Expansion population had 637 inpatient days per thousand during SFY 2018.
- The Expansion population used about 4.3 office visits per average eligible.
- The Expansion population had an average of 18 pharmacy claims per 12 months of eligibility.

Medicaid Trends: National Medicaid and State Commercial

RI Medicaid trends were comparable to national Medicaid trends over the past three years. RI Medicaid trends were notably lower than Commercial experience over a similar period.

Rhode Island Medicaid vs. National and Commercial Trends
SFY 2015-2018[1], see below for sources



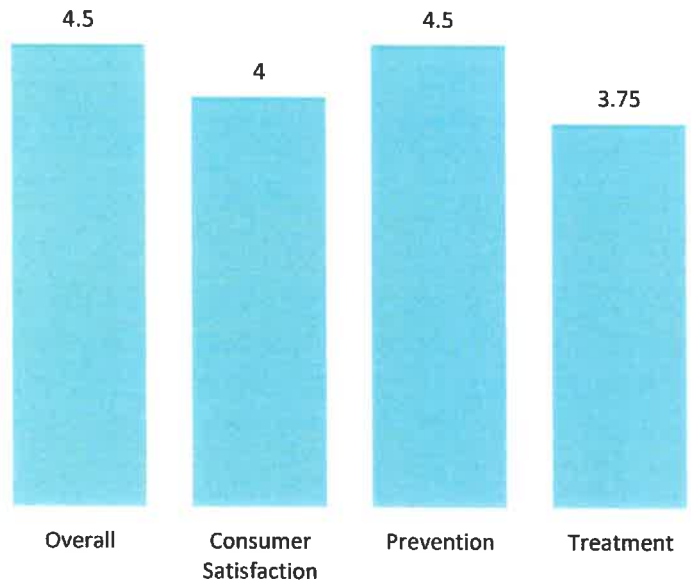
- Overall expenditures growth over the years SFY 2015-2018 was similar to the national Medicaid expenditure trend. According to Centers for Medicare & Medicaid Services (CMS), Medicaid national expenditure trend over this time period increased an average 3.1% per year, vs. Rhode Island Medicaid's trend of 3.4%.
- Rhode Island Medicaid PMPM (per member per month) cost trends compare favorably to local commercial benchmarks. From SFY 2015 through SFY 2018, the state Medicaid program experienced a decrease in average annual PMPM cost of 1.8% per year. The average annual medical PMPM cost for RI commercial health plans over a similar period increased 5.9% per year.[1]

[1]RI Commercial trend for CY 2015-2018. National trend for FFY 2015-2018.
Sources: National Medicaid Trend from 2018 CMS National Health Expenditure Report.
RI Commercial trend from Office of the Health Insurance Commissioner (OHIC), 2018 carrier rate filings, Allowed claims per member per month, includes small group and large group claims from Blue Cross Blue Shield RI, United Healthcare of New England, Neighborhood Health Plan and Tufts Health Plan.

Managed Care: Quality Indicators

Both of Rhode Island's participating Medicaid Managed Care Organizations (MCOs) received an overall plan rating of 4.5 out of 5.0 from the National Committee for Quality Assurance (NCQA) for 2018-19.

NCQA Health Insurance Plan Ratings
Average for Rhode Island MCOs, 2018-2019



- Only 13 MCOs across the country received an overall rating of 4.5 or above.
- NCQA ratings consists of three types of quality measure domains: clinical quality, consumer satisfaction, and results from NCQA's review of the Health Plan's health quality processes.
- Ratings of 4.0 and above are considered "high performance." Both Rhode Island MCOs scored in the high performance range for consumer satisfaction and prevention domains.
- Consumer satisfaction indicates members' opinions of their plan's care, services, and physicians.
- Prevention indicates how well plans provide screenings, immunizations, and other preventative services.
- Treatment indicates a plan's performance in treating chronic and acute conditions.
- Enrollment in Medicaid managed care programs is divided between Neighborhood Health Plan, United Healthcare and Tufts Health Plan. Tufts Health Plan, which began enrolling Medicaid members in SFY 2018, does not have current ratings available from NCQA.

Source: NCQA health insurance plan ratings, Summary Report (Medicaid) for Rhode Island plans. www.healthinsuranceratings.ncqa.org

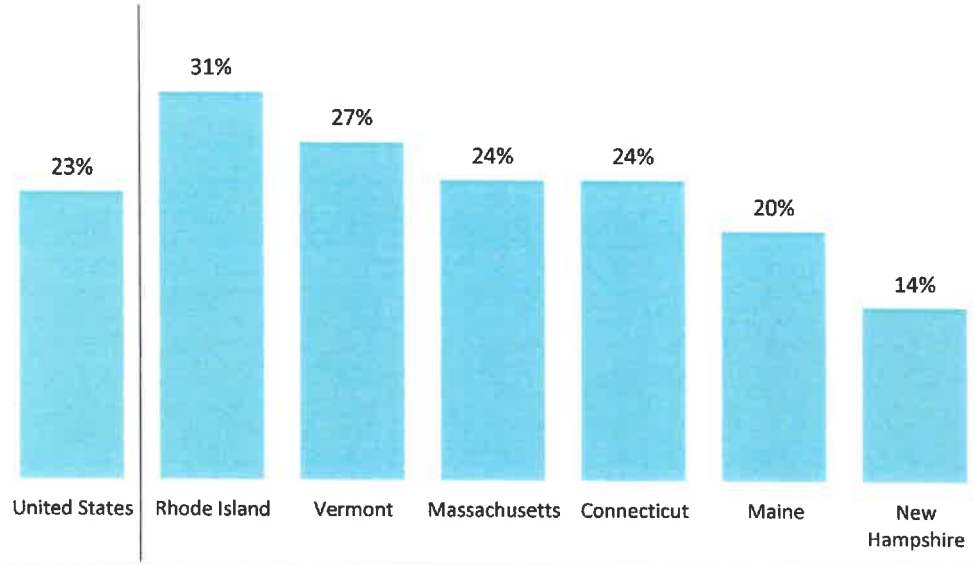
Medicaid Trends: Medicaid Enrolled Population

According to enrollment data as of the end of SFY 2018, Rhode Island's Medicaid enrollment is 31% of population, the highest percentage of the New England states.

Medicaid Enrollment as Percent of Population

July 2018

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



United States	Rhode Island	Vermont	Massachusetts	Connecticut	Maine	New Hampshire
73,732,636	311,231	162,726	1,609,281	845,276	266,526	185,233

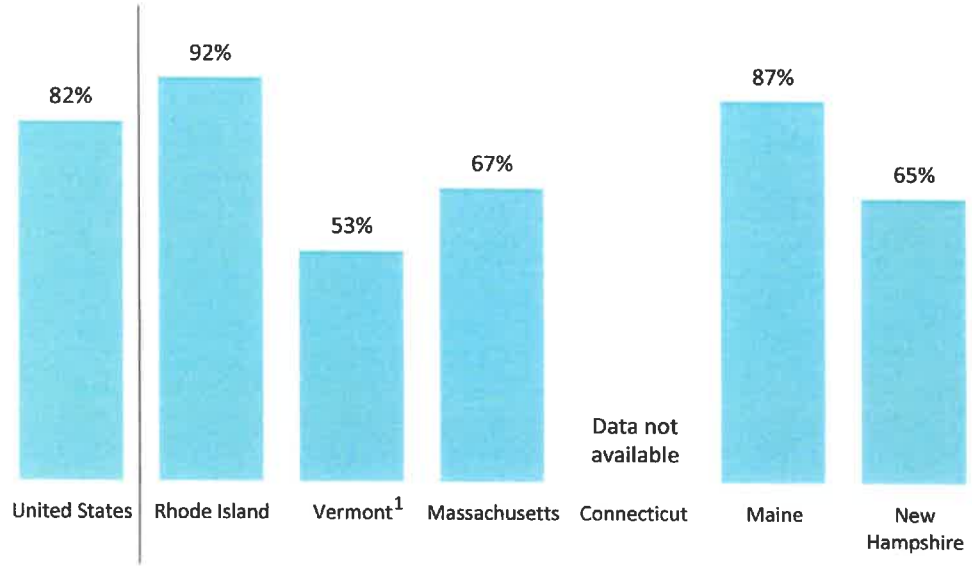
Medicaid Enrollment, July 2018

- CMS compiles Medicaid enrollment data for all states monthly. This enrollment data was converted for the purposes of this chart to percent of population for each state using data from the US Census Bureau.
- After Rhode Island, Vermont had the second highest percentage Medicaid enrollment of the New England states.
- Nationally 23% of the population is enrolled in Medicaid.

Medicaid Trends: Managed Care Enrollment

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

Managed Care Enrollment as Percent of Medicaid Enrollment
2017
Source: Kaiser Family Foundation report, based on 2017 CMS enrollment data

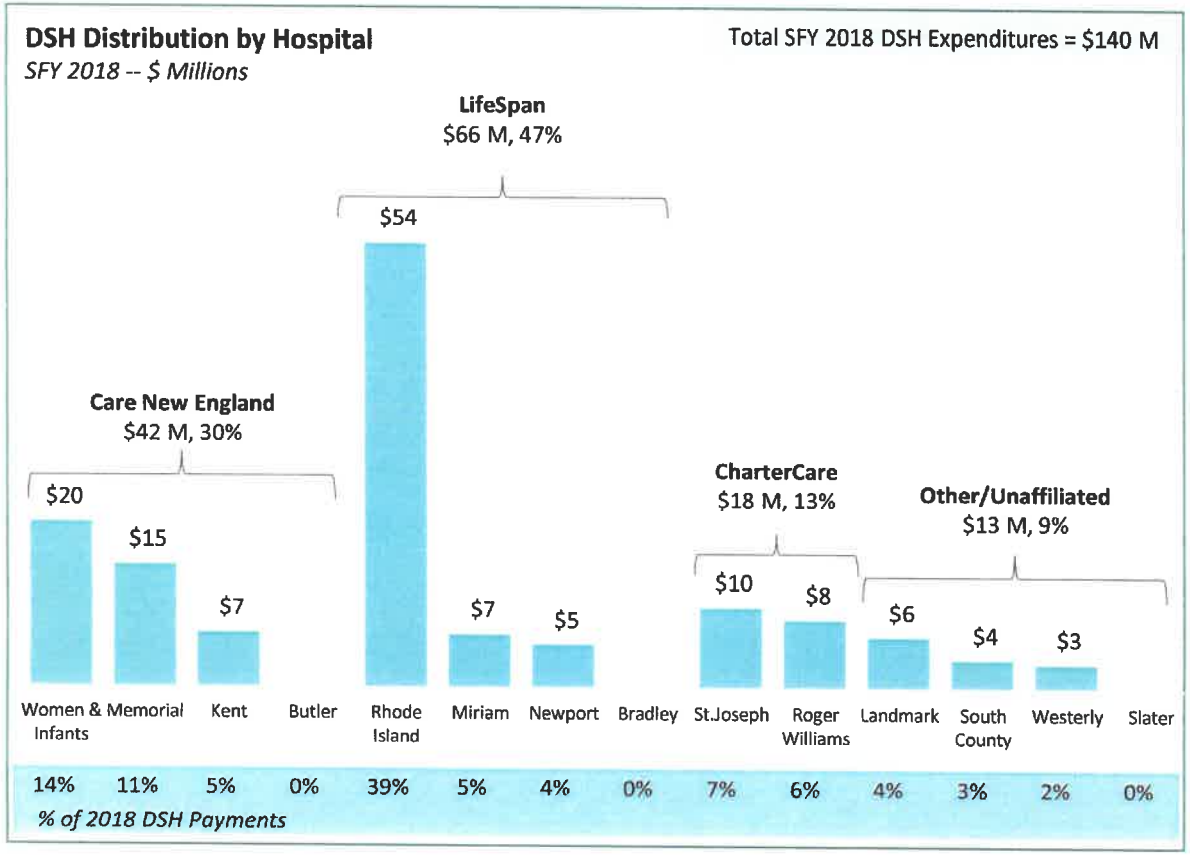


[1]The Department of Vermont Health Access, a state agency, acts as Vermont's single MCO entity.

- Total Medicaid enrollment for this chart is defined as beneficiaries enrolled in any Medicaid managed care program, including comprehensive MCOs, limited benefit MCOs, and PCCMs.
- Nationally the average percent of Medicaid managed care enrollment is 82%.
- This data differs from the managed care enrollment data shown earlier in this report because it is based on data from 2017 in order to allow comparison to national and regional data.
- For SFY 2018, Rhode Island managed care enrollment is 91% of eligibles, consistent with the 92% shown in this Kaiser report.

Exclusions: (1) Disproportionate Share Hospitals (DSH)

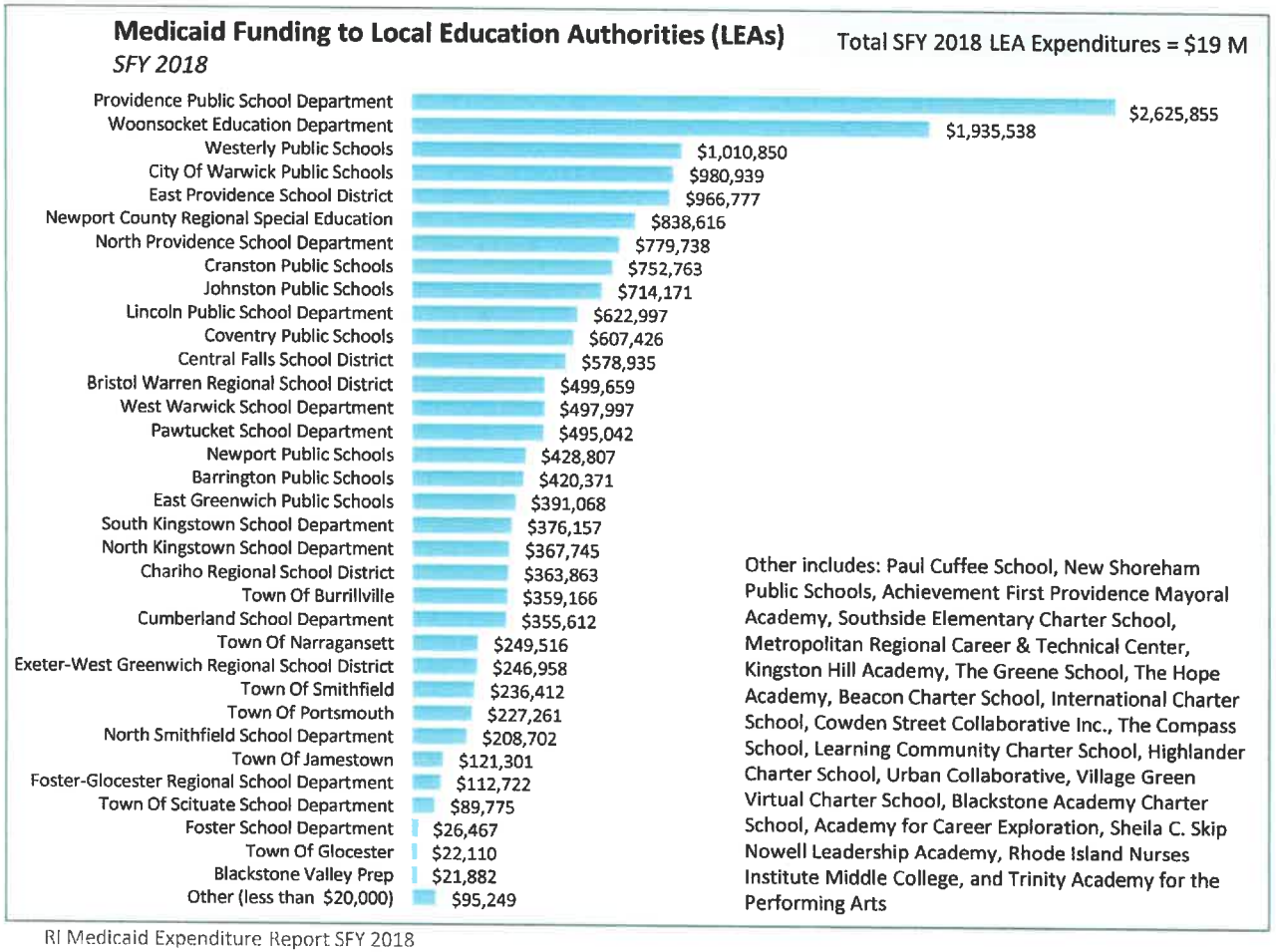
Disproportionate share hospital (DSH) payments are intended to subsidize the cost of providing care to indigent and very low income people.



- A total of $140 million in DSH funds was paid out to hospitals in SFY 2018.
- The state's two largest hospitals – Rhode Island and Women and Infants – together accounted for 53% of total DSH payments.
- DSH payments are not included in the Medicaid expenditure analysis in this report.

Exclusions: (2) Local Education Authorities (LEA)

Local Education Authorities (LEAs) account for $19 million in total expenditures in 55 school districts.



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

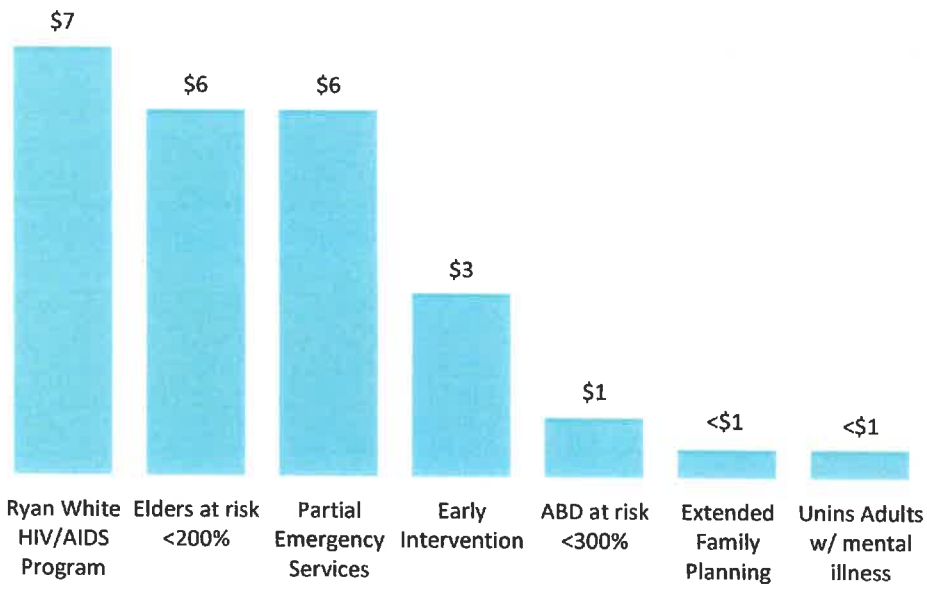
RI Medicaid Expenditure Report SFY 2018

Exclusions: (3) Costs Not Otherwise Matchable (CNOM) and Other Limited Benefit Programs

Costs Not Otherwise Matchable (CNOMs) and other limited benefit programs account for $23 million in total expenditures.

CNOMs and other limited benefit programs
SFY 2018 -- $ Millions

Total SFY 2018 CNOM and Other Limited Benefit Program Expenditures = $23 M



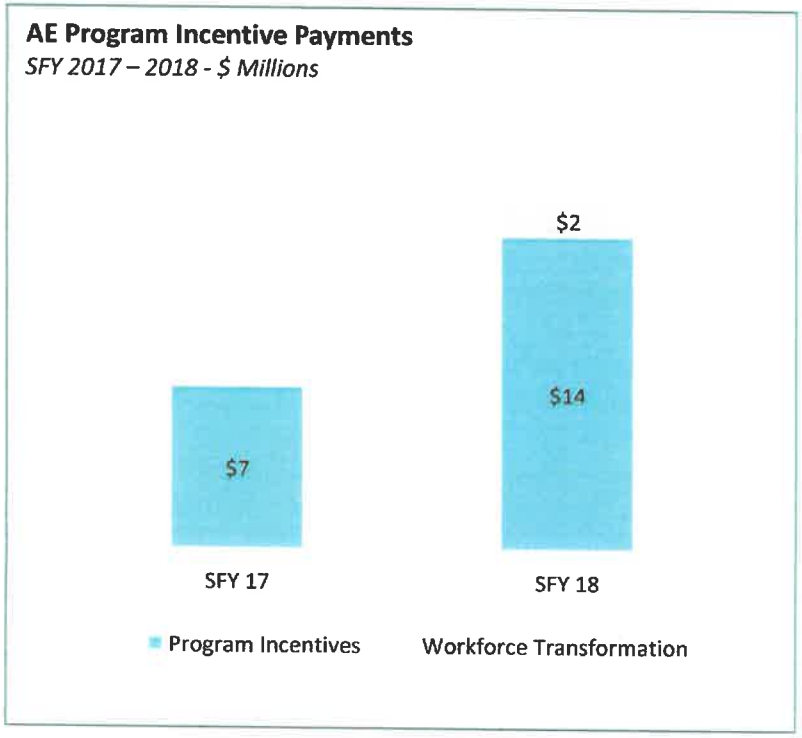
- Under the terms of Rhode Island's 1115 Waiver Demonstration agreement with the federal government, certain state programs not traditionally allowable under Medicaid fund matching rules can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible.
- These CNOM and other limited benefit program expenditures are not part of the core Medicaid program and as such are not included in the Medicaid expenditure analysis in this report.

Exclusions: (4) HSTP AE Incentive Program Expenditures

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 support AEs. EOHHS submitted an application for such funding in early 2016 as an amendment to RI's current Global Medicaid 1115 Waiver. In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved this waiver amendment, bringing $129.8 million in Federal Financial Participation (FFP) to RI.[1]

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

AE Program Incentive Payments
SFY 2017 – 2018 - $ Millions



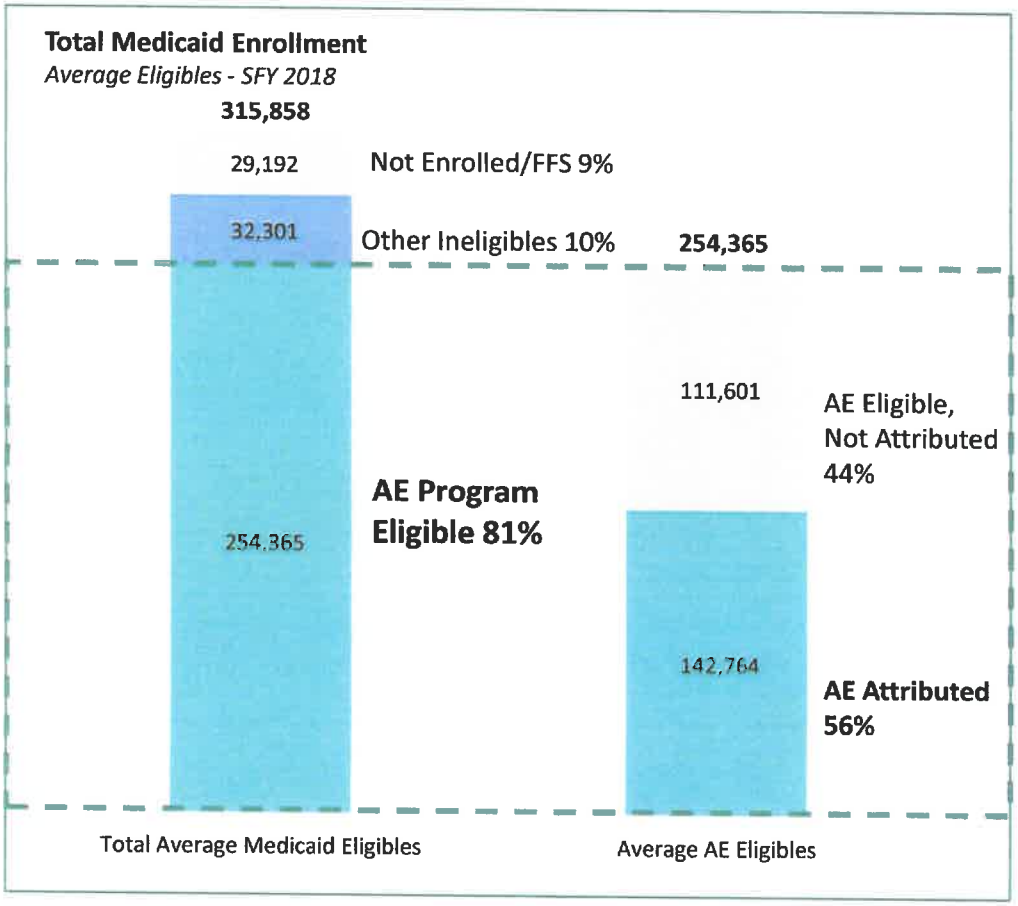
- Program Incentives in SFY 2017 and SFY 2018 were paid to nursing homes and hospitals to support the transition of Rhode Island's Medicaid program to value-based care.
- SFY 2017 and SFY 2018 were the pilot years for Rhode Island's Accountable Entity program. AE Program Incentive payments are time-limited payments and will be distributed for the duration of the program, which is expected to last until SFY 2023. Future 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.
- Workforce Transformation funds are spent through public universities to build the healthcare workforce to meet the needs of Rhode Island's Medicaid program. These funds were spent to build career pathways to develop skills that matter for jobs that pay, expand home and community-based care, and teach core concepts of health system and practice transformation.

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

Accountable Entity (AE) Enrollment – SFY 2018

81% of Medicaid enrollment is eligible to be attributed to Accountable Entities (AEs).

56% of the AE eligible population is attributed to an AE.



Definitions and Notes

AE Program Eligible

- This is the population eligible for the AE Program.
- Includes all NonDuals enrolled in managed care programs, including RIte Care, Medicaid Expansion, Rhody Health Partners, and Rhody Health Options.

Other Ineligibles

- Includes managed care Duals, RIte Share, and PACE enrollees who are not eligible for the AE Program.

Not Enrolled/FFS

- Includes all FFS recipients, not enrolled in managed care and therefore not eligible for AE attribution.

Source: MMIS Claims and Eligibility Data, Package 20181115, Table II.

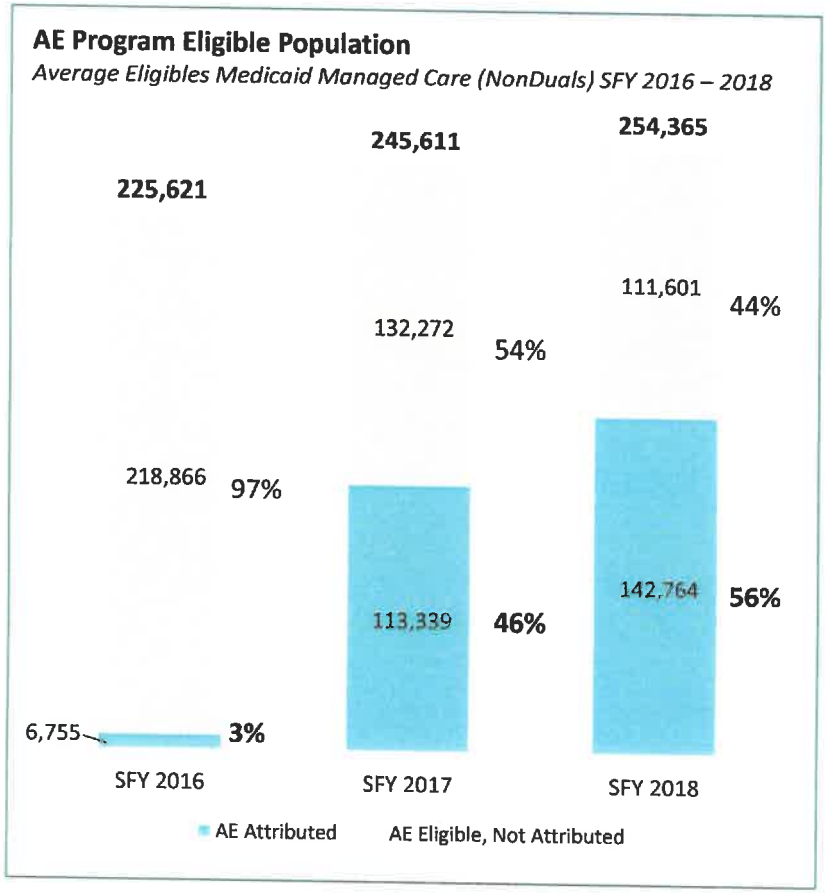
AE Attributed Enrollment Over Time

The share of AE Eligibles attributed to an AE has increased substantially since the start of the program.

An AE Pilot Program ran from SFY 2016 – 2018; SFY 2019 will be the first full program year of the AE Program.

AE Program Eligible Population

Average Eligibles Medicaid Managed Care (NonDuals) SFY 2016 – 2018



- AE enrollment accounts for a large share of members enrolled in managed care
- There has been significant growth in AE-attributed members since the program rolled out in SFY 2016
- 5 AEs participated in the AE Pilot Program (SFY 16-18):
  - Blackstone Valley Community Health Center
  - Integra
  - Integrated Health Partners (CHC ACO)
  - Prospect
  - Providence Community Health Center

Source: MMIS Claims and Eligibility Data, Package 20181115, Table V.

Acronyms and Abbreviations

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

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

Sources and Notes

Source Data and Analytic Method

This report is based on SFY 2018 and five year historical Rhode Island Medicaid systems extracts, including claims, capitation payments, premiums, and provider payouts.

- Claims data is based on claims paid and encounters submitted through December 2018. Claims incurred in SFY 2018 but not reported by December 2018 were estimated to be immaterial for purposes of this report. Non-claim based payments were included based on SFY 2018 accruals.
- Capitations, premiums and payouts are proportionately allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information.
- Capitation expenditures were allocated based on the MCO submitted encounter data. No adjustment was made for potential encounter data incompleteness.

Variance to Other Reports

The purpose of this report is to provide a comprehensive overview of state Medicaid expenditures to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process. Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion, rounding, and allocation of non-claims based expenditures.