

# Data Book

Rhode Island Long Term Care

Data Graphs

September, 2009



## **FOREWARD**

This is a draft of a potential Periodic Data Book for EOHHS/DHS management. This book will hopefully be prepared each three to six months. It will expand over time to include additional reports as desired by management. This first mock-up is produced for general comment and suggestions for future editions.

## **EXECUTIVE SUMMARY**

This first Data book contains three sections. First, Home and Community based Service Trends, second, Long-term care indicators for Rhode Island and third, Medicare Utilization of Long-term care services for Post-acute Care.

Each graph consists of a title (in yellow) and explanation of the displayed graph. The main graph itself is centered in the middle of each page followed by the source of the data. Lastly to the left of each graph (in green) are the author's observations, inferences, and potential next steps based on the information presented. It is believed this format will assist management in determining follow up questions or future actions.



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***(TAB #1) RI-LTC Indicators***



## GENERAL OVERVIEW

The purpose of the Long Term Care Indicator Data Book is to assess, design, monitor and evaluate long term care health and social services and program interventions for Rhode Islanders on Medicaid using existing public health data sets. The trend data in this report is designed to determine unmet health needs, measure access to care, and evaluate health outcomes of Medicaid enrollees in long term care compared to Rhode Islanders on Medicare or the Privately Insured.

## METHODS

### Health Indicator Selection Criteria:

RI population based data set that:

- Contains Long Term Care Measures
- Is collected annually, so trend comparisons can be made
- Collects insurance coverage, so comparisons can be made between Medicare, Medicaid, and Privately Insured.

### Two Data Sets that meet these criteria:

1. Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health
2. Hospital Discharge Data Set (HD) 2002-2007, RI Department of Health

## SUMMARY OF FINDINGS/TRENDS

- Approximately 1 in 3 hospitalizations for Rhode Islanders ages 18-64 on fee for service Medicaid is for a mental disorder (See Figure 1-1).
- Elderly on Medicaid (>= 65 years old) have almost twice the percentage of hospitalizations for ambulatory care sensitive conditions (e.g., asthma, diabetes, hypertension) (See Figures 1-2, 1-3).
- The percent of Medicaid beneficiaries who are discharged from the hospital to home with home health agency services has increased from 2002-2007. For working-aged the percent has increased from 11% to 12% and for elderly the percent increased from 24% to 28% (See Figures 1-4, 1-5).
- The rate of “avoidable” hospitalizations (PQIs) is decreasing for the publically insured. In 2005 the PQI rate for Rhode Islanders on FFS Medicaid was 2,313 per 100,000 and in 2007 this PQI rate declined to 2,088.3 per 100,000 (See Figure 2-1).

## SUMMARY OF FINDINGS/TRENDS

- Rates of PQIs for diabetes hospitalizations and bacterial pneumonia have dropped significantly from 2005-2007 for Rhode Islanders on FFS Medicaid (See Figures 2-2, 2-3).
- Receipt of flu shot and pneumonia vaccine has increased from 2002-2007 for working-aged adults on FFS Medicaid. Receipt of the flu shot went from 32% to 39% and for pneumonia vaccine went from 20% to 30% (See Figures 3-3, 3-4).
- Rates of chronic disease are high among FFS Medicaid beneficiaries. 12% have diabetes, 28% have asthma, 42% have arthritis, and 33% are obese (See Figures 3-5 – 3-8).
- 43% of FFS Medicaid beneficiaries rate their healthcare as fair/poor. In addition on average 17 days a month their physical health is not good and 17 days a month their mental health is not good.
- Medicaid beneficiaries have the highest rate of cigarette smoking. 43% of working age Rhode Islanders on Medicaid smoke whereas 26% of Medicare beneficiaries smoke and only 17% for the privately insured.

***(TAB #2) Section 1: Hospital Discharge Data***

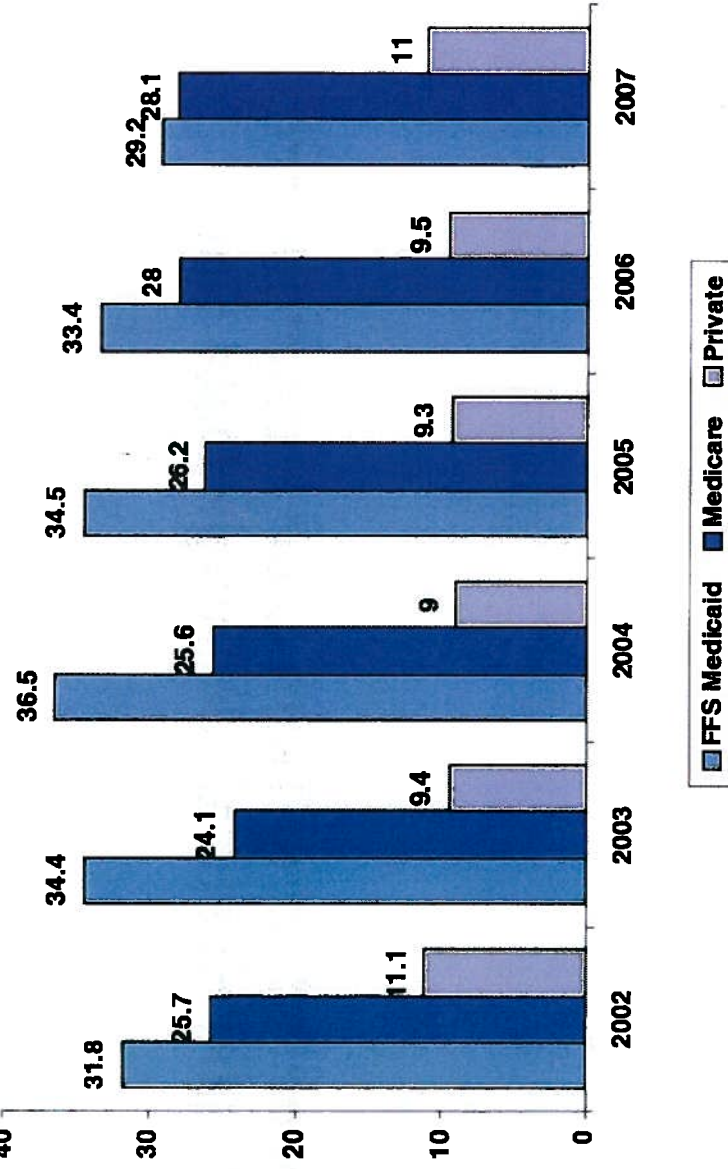




# **Section 1: Selected Long Term Care Indicators from Rhode Island Hospital Discharge Data Set**

**Figure 1-1**  
**Percent of Hospitalizations with Primary Diagnosis of Mental Disorder**  
**Ages 18-64 by Health Insurance Coverage**

Approximately 1 in 3 hospitalizations for Rhode Islanders ages 18-64 on FFS Medicaid is for a mental disorder



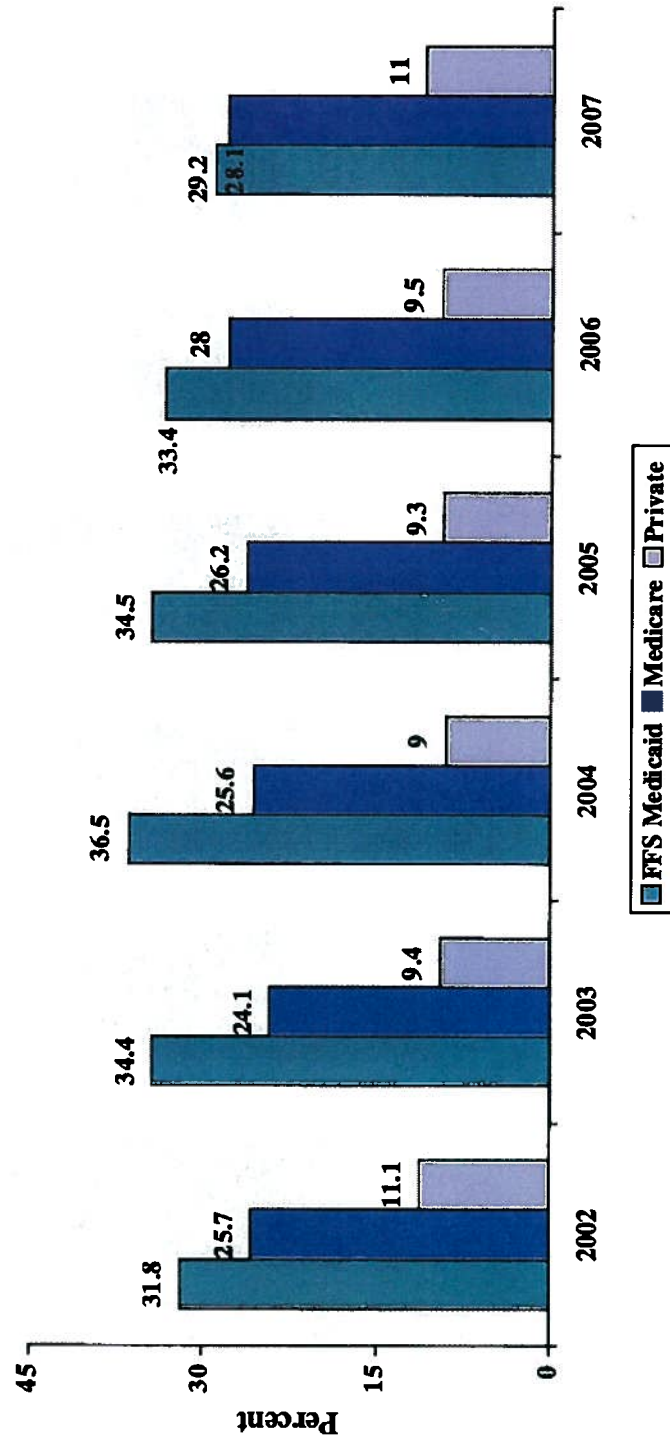
Hospitalization rates for mental disorders are highest among Rhode Islanders on FFS Medicaid. This higher rate may indicate a lack of access to community mental health services.

Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007,  
 RI Department of Health

**Figure 1-2  
Percent of Hospitalizations for Ambulatory Care Sensitive Conditions  
Ages 18-64 by Health Insurance Coverage**

Working Aged Adults on FFS Medicaid have the highest rate of hospitalizations for ambulatory care sensitive conditions (e.g., asthma, diabetes, hypertension).

High rates of Hospitalization for ACS conditions indicate lack of access to primary care. Rhode Islanders on FFS Medicaid have the highest percent of hospitalizations that are considered preventable.

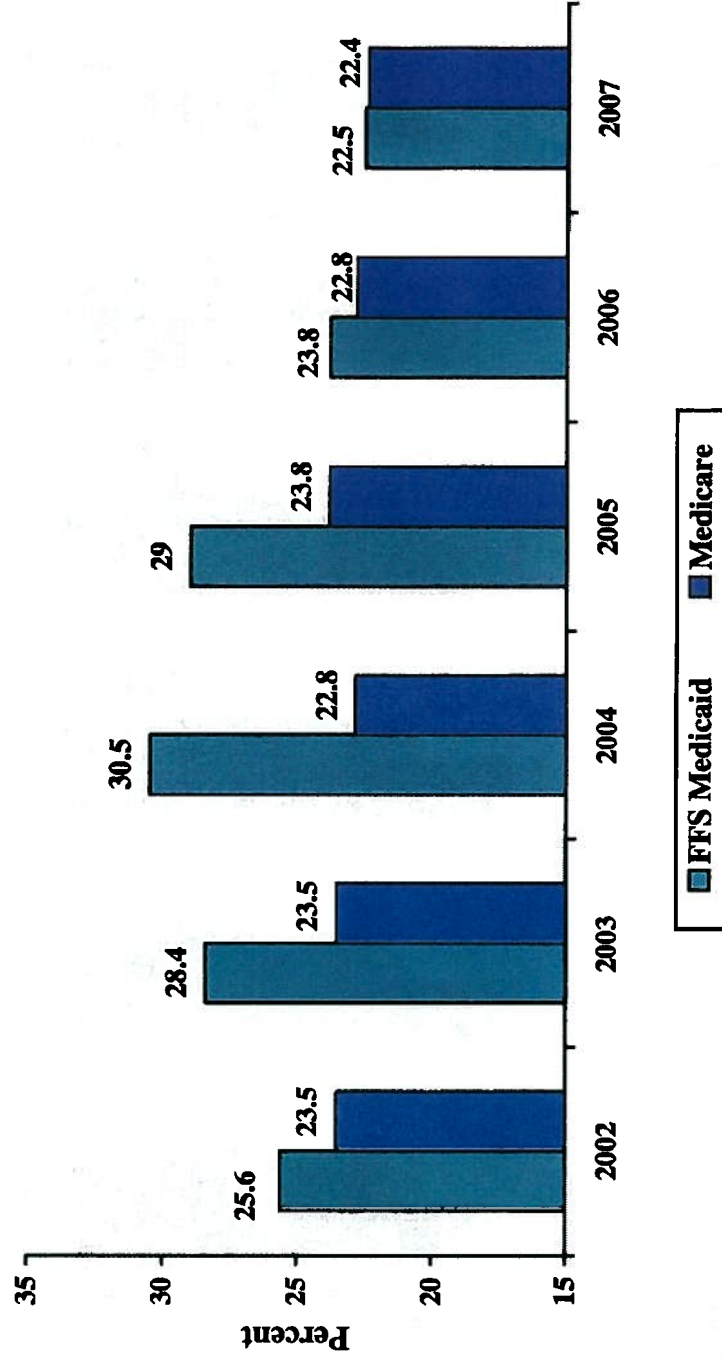


Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007, RI Department of Health

**Figure 1-3**

**Percent of Hospitalizations for Ambulatory Care Sensitive Conditions  
Ages >= 65 by Health Insurance Coverage**

Elderly on Medicaid (>= 65 years old) have the highest percentage of hospitalizations for ambulatory care sensitive conditions, however the rate is declining



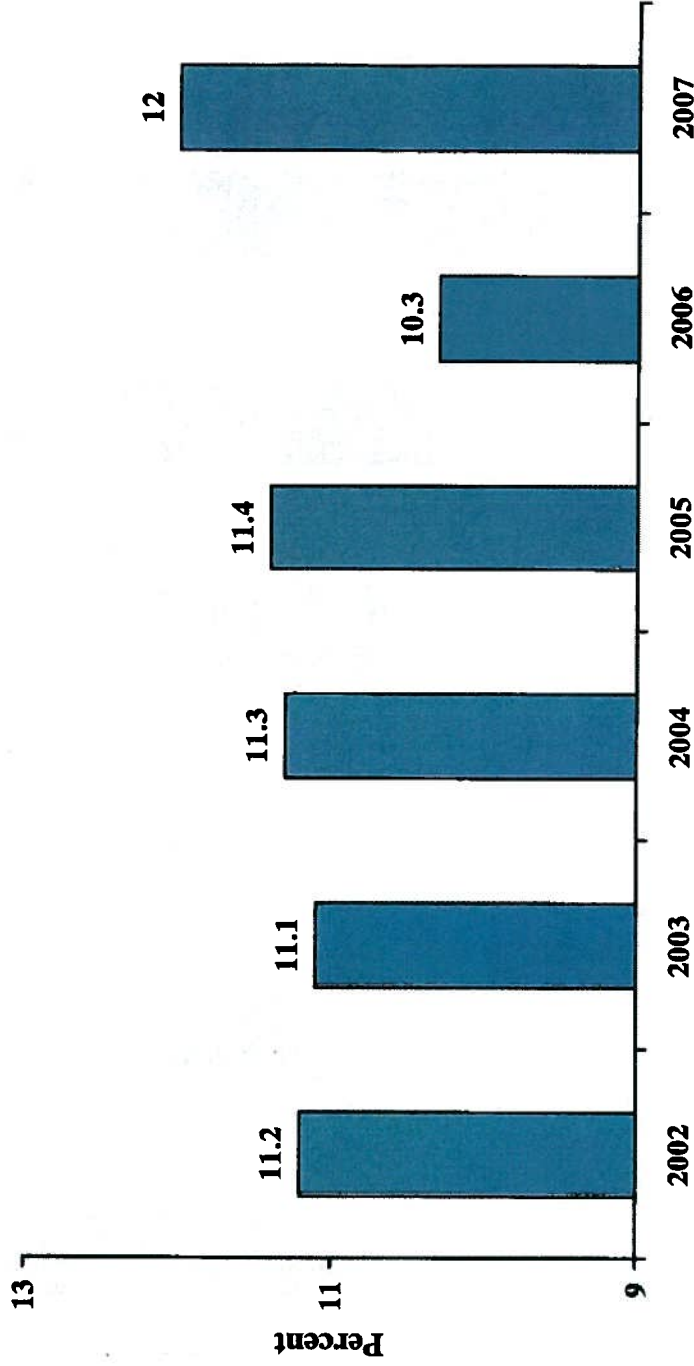
Access to primary care for elderly on Medicaid is improving.

Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007, RI Department of Health

**Figure 1-4**

**Percent of Medicaid Hospitalizations Ages 18-64 Discharged Home with Home Health Agency Services**

The percent of Medicaid beneficiaries who are discharged from the hospital to home with home health agency services has increased from 2002-2007.



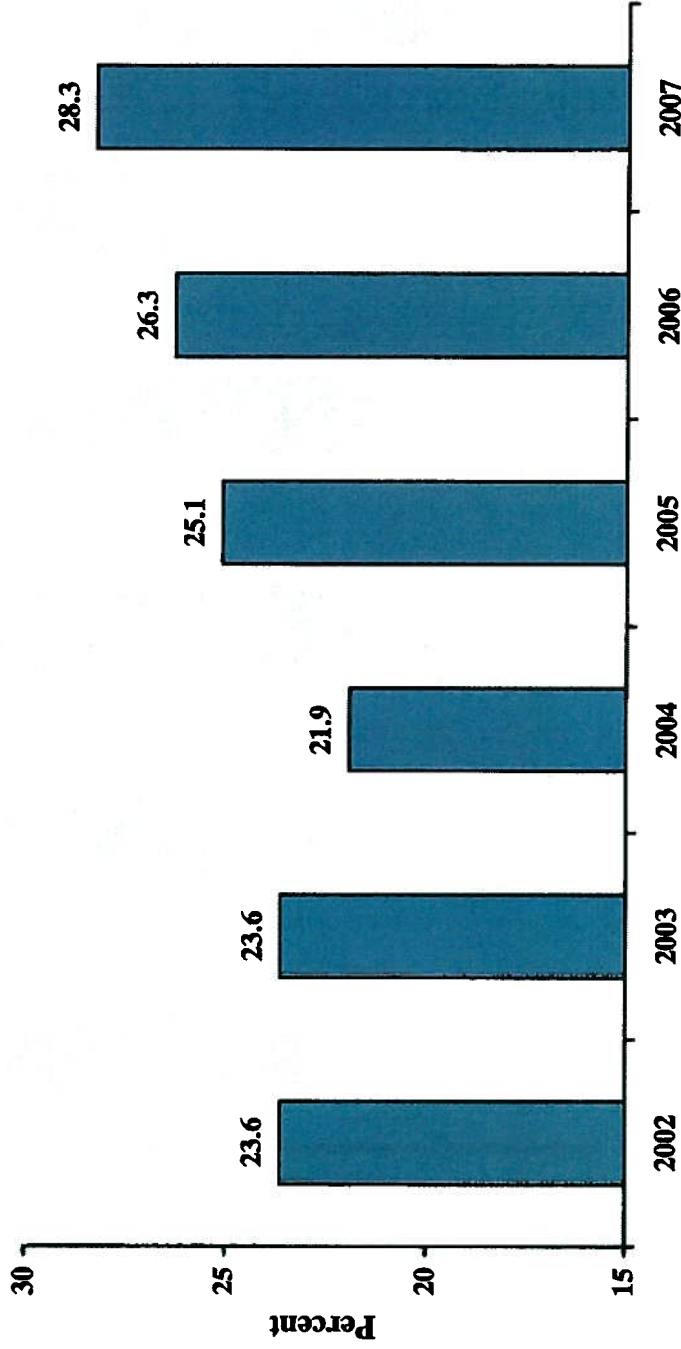
This Long Term Care Indicator will be interesting to track to see if nursing home admissions are decreasing while hospital discharges to home with support services are increasing.

Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007, RI Department of Health

**Figure 1-5**

**Percent of Medicaid Hospitalizations Ages >=65 Discharged Home with Home Health Agency Services**

The percent of Medicaid beneficiaries who are discharged from the hospital to home with home health agency services has increased from 2002-2007.



This Long Term Care Indicator will be interesting to track to see if nursing home admissions are decreasing while hospital discharges to home with support services are increasing.

Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007, RI Department of Health

***(TAB #3) Section 2: QI Discharge Data***



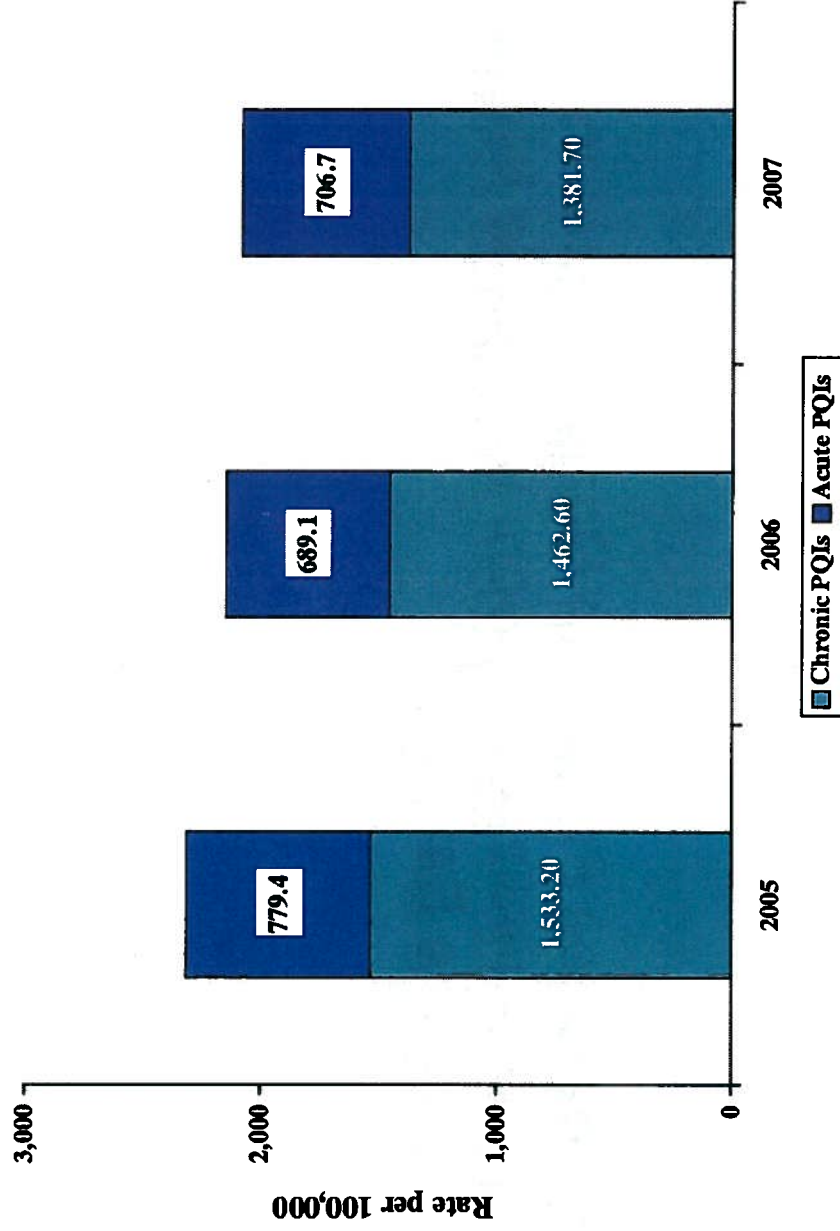


**Section 2: Selected Prevention Quality Indicators  
("Avoidable" Hospitalizations) from the Rhode Island  
Hospital Discharge Data Set**

**Figure 2-1**  
**Rate of PQI Hospitalizations**  
**for Rhode Islanders Age >18 on FFS Medicaid**

The rate of “avoidable” hospitalizations (PQIs) is decreasing for FFS Medicaid. In 2005 the PQI rate for Rhode Islanders on FFS Medicaid was 2,313 per 100,000 and in 2007 this PQI rate declined to 2,088 per 100,000

Prevention Quality Indicators (PQIs) are a set of measures designed by the Agency for Health Care Research and Quality (AHRQ) that can be used with hospital inpatient discharge data to identify “ambulatory care sensitive conditions (ACSCs)” or “avoidable” hospitalizations. ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complication or more severe disease.

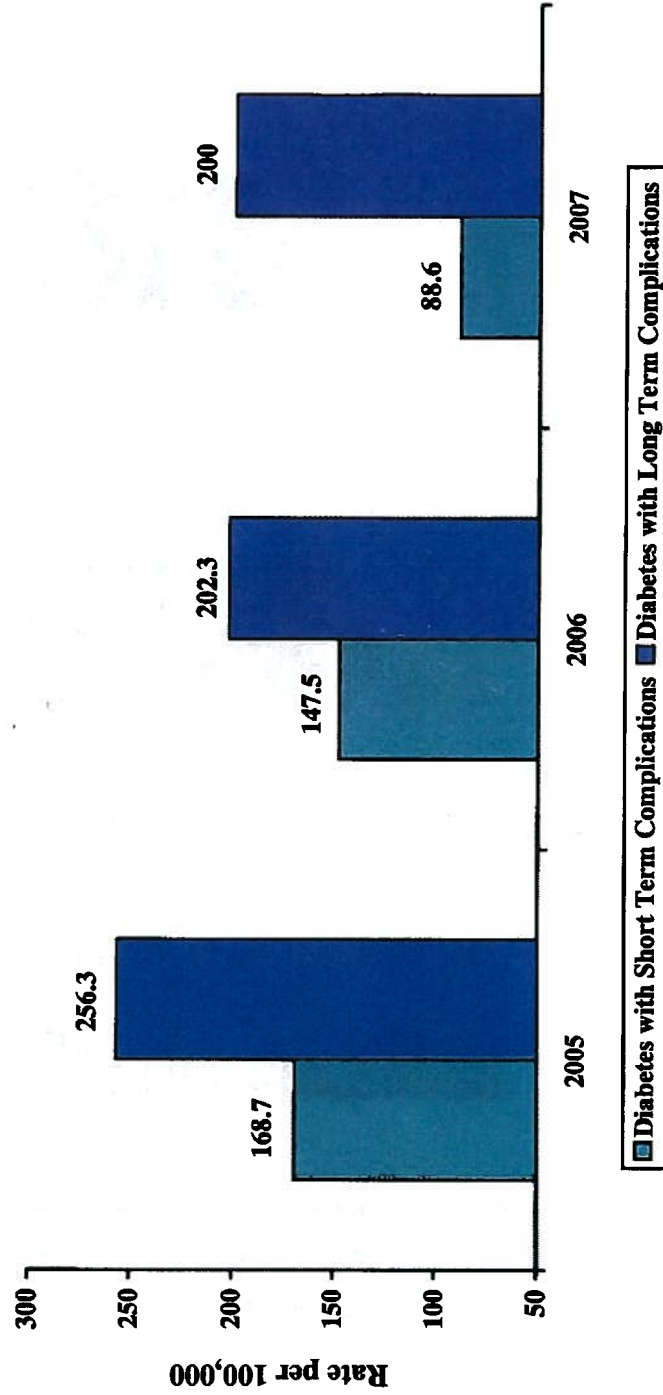


**Figure 2-2**

**Rate of PQI Diabetes Hospitalizations for Rhode Islanders Age >18 on FFS Medicaid**

Rates of PQIs for diabetes hospitalizations have dropped significantly from 2005-2007

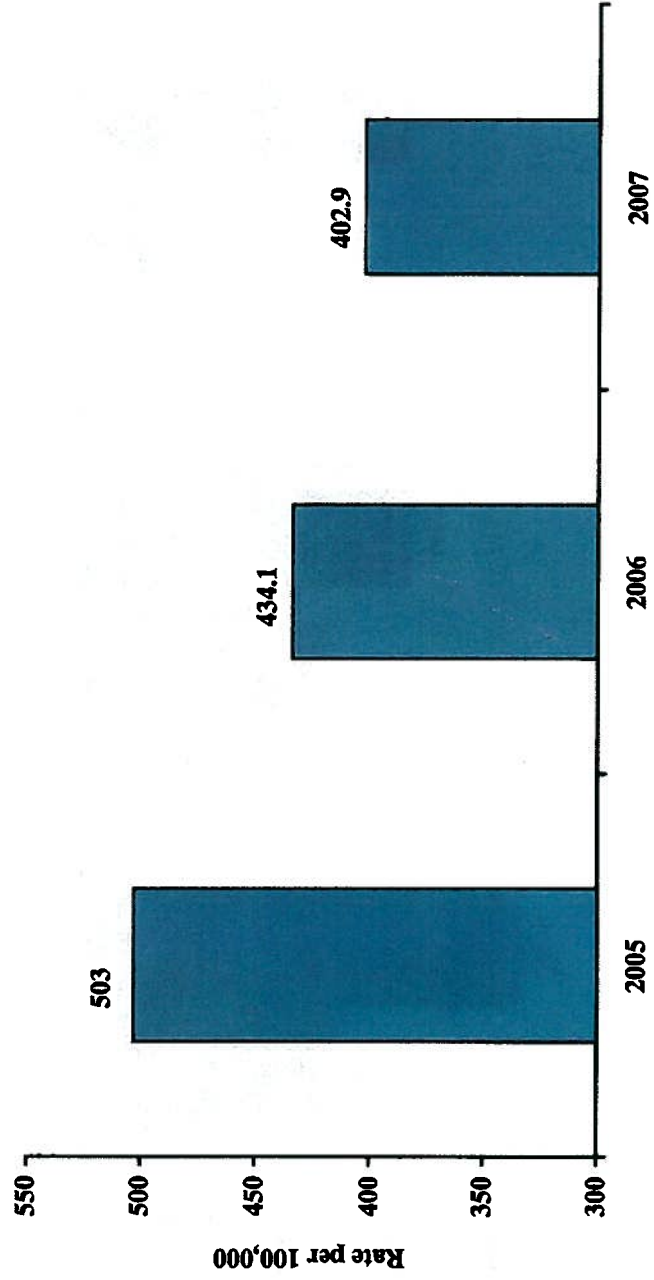
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Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007, RI Department of Health

**Figure 2-3**  
**Rate of PQI Bacterial Pneumonia Hospitalizations for Rhode Islanders Age >18 on FFS Medicaid**  
 Rates of PQIs for and bacterial pneumonia have dropped significantly from 2005-2007 for Rhode Islanders on FFS Medicaid

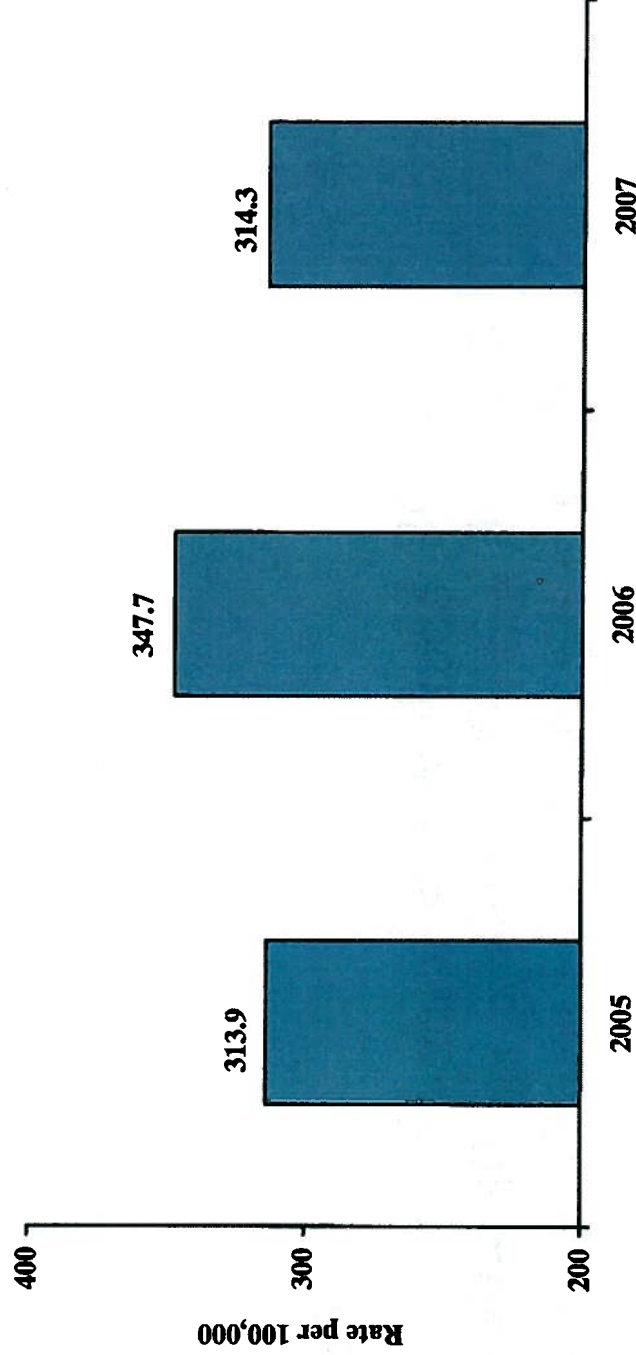
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Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007, RI Department of Health

Prevention Quality Indicators (PQIs) are a set of measures designed by the Agency for Health Care Research and Quality (AHRQ) that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions (ACSCs)" or "avoidable" hospitalizations. ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complication or more severe disease.

**Figure 2-4**  
**Rate of PQI Asthma Hospitalizations**  
**for Rhode Islanders Age >18 on FFS Medicaid**  
**Asthma hospitalization rates have remained the same**



Data Source: Medicaid Data Archive, RI Hospital Discharge Data Set 2002-2007, RI Department of Health

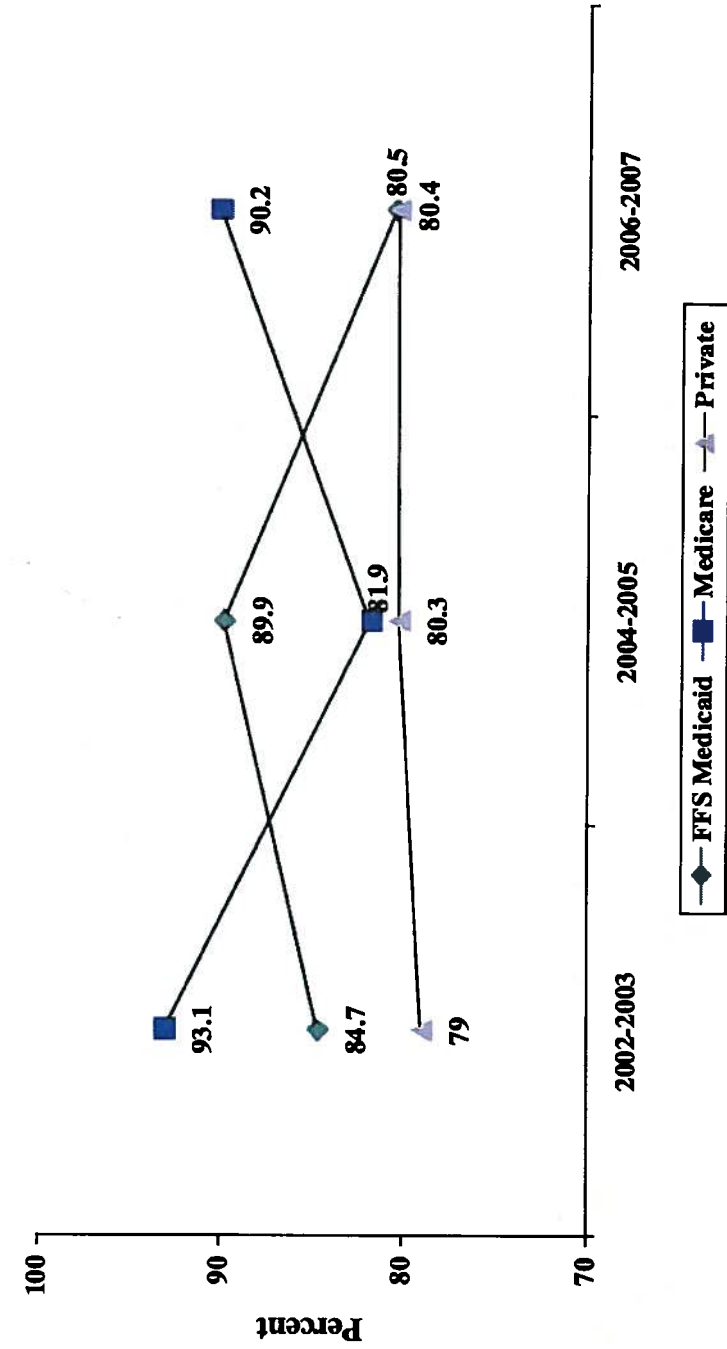
**Section 3: Selected Long Term Care Access,  
Quality and Health Status Indicators from the  
Behavioral Risk Factor Surveillance System  
(BRFSS)**

***(TAB #4) Section 3: Access, Quality, Health Status***





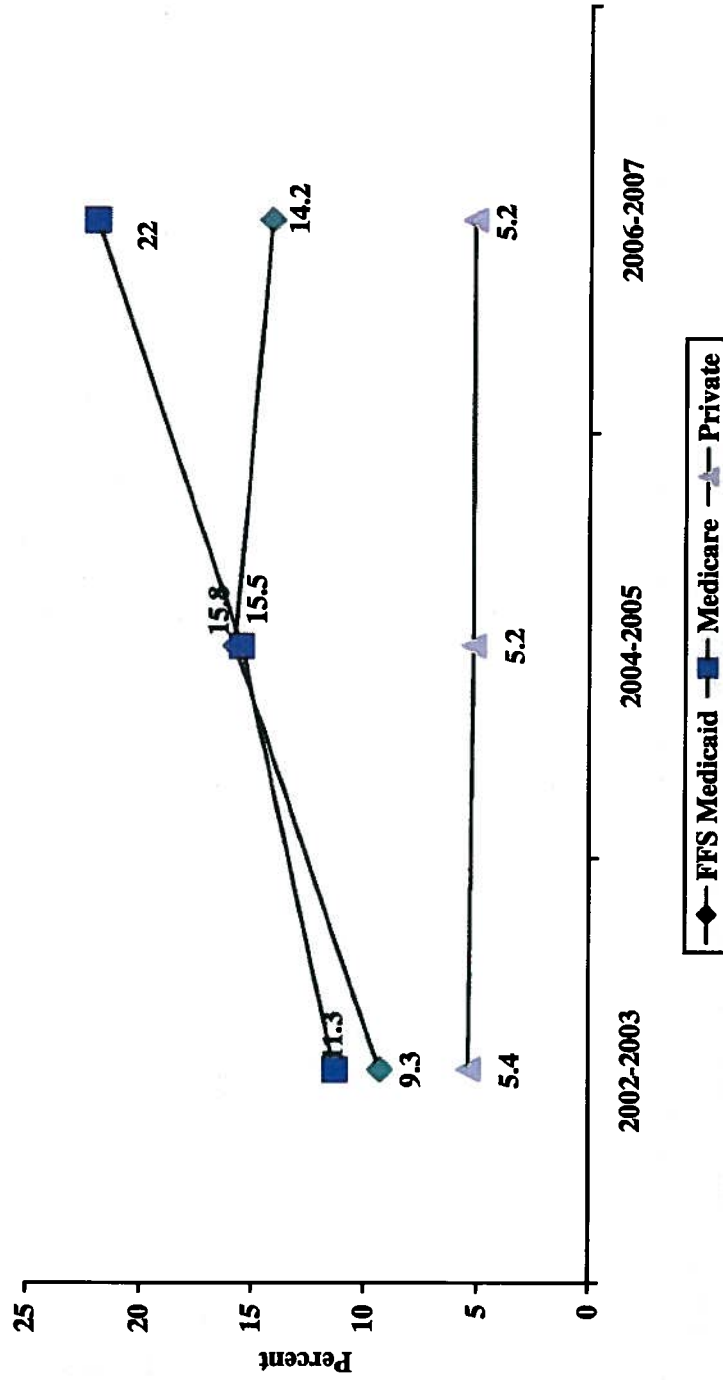
**Figure 3-1**  
**Percent Had Medical Check-up in Past Year**  
**Ages 18-64 by Health Insurance Coverage**



Publically insured Rhode Islanders are more likely than privately insured Rhode Islanders to have had an annual check-up.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

**Figure 3-2**  
**Percent Couldn't See a Doctor Due to Cost in Past Year**  
**Ages 18-64 by Health Insurance Coverage**

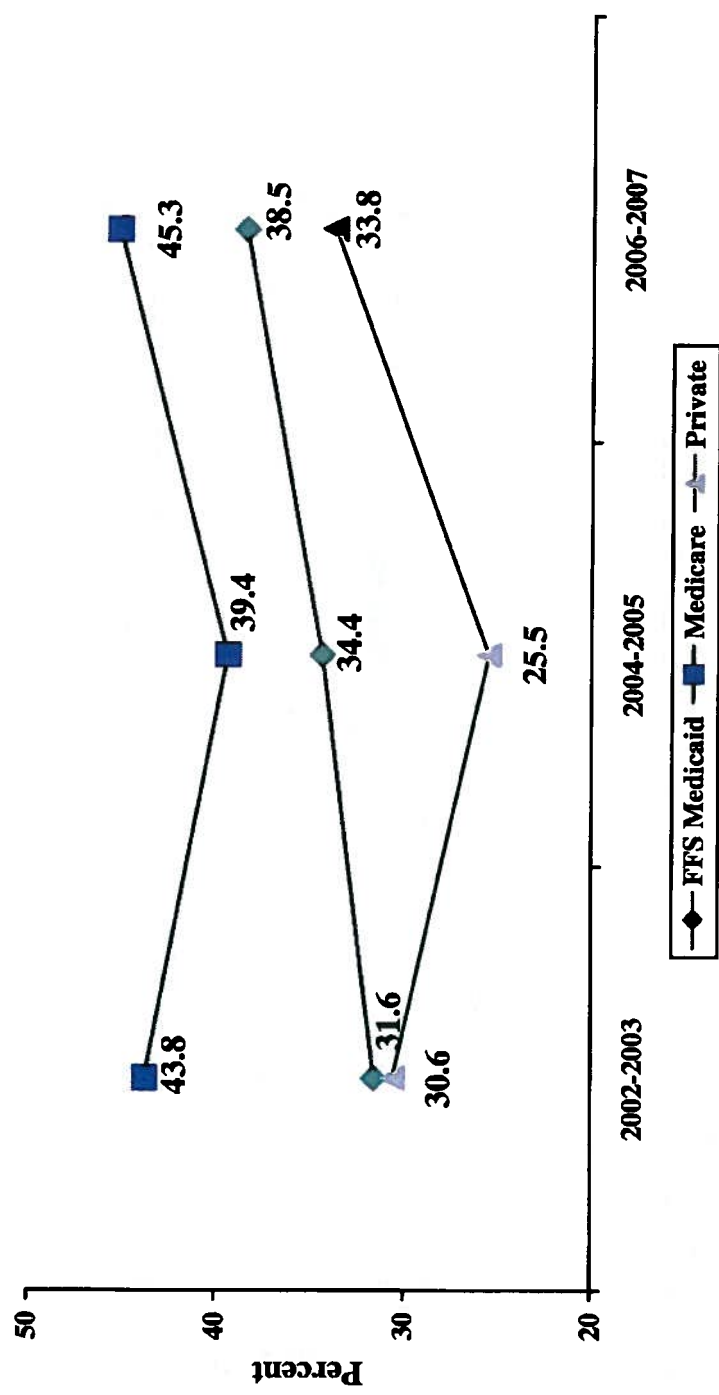


Publically insured Rhode Islanders are more likely than privately insured Rhode Islanders to not see a doctor due to cost. Access to care has improved the most for Medicare beneficiaries.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

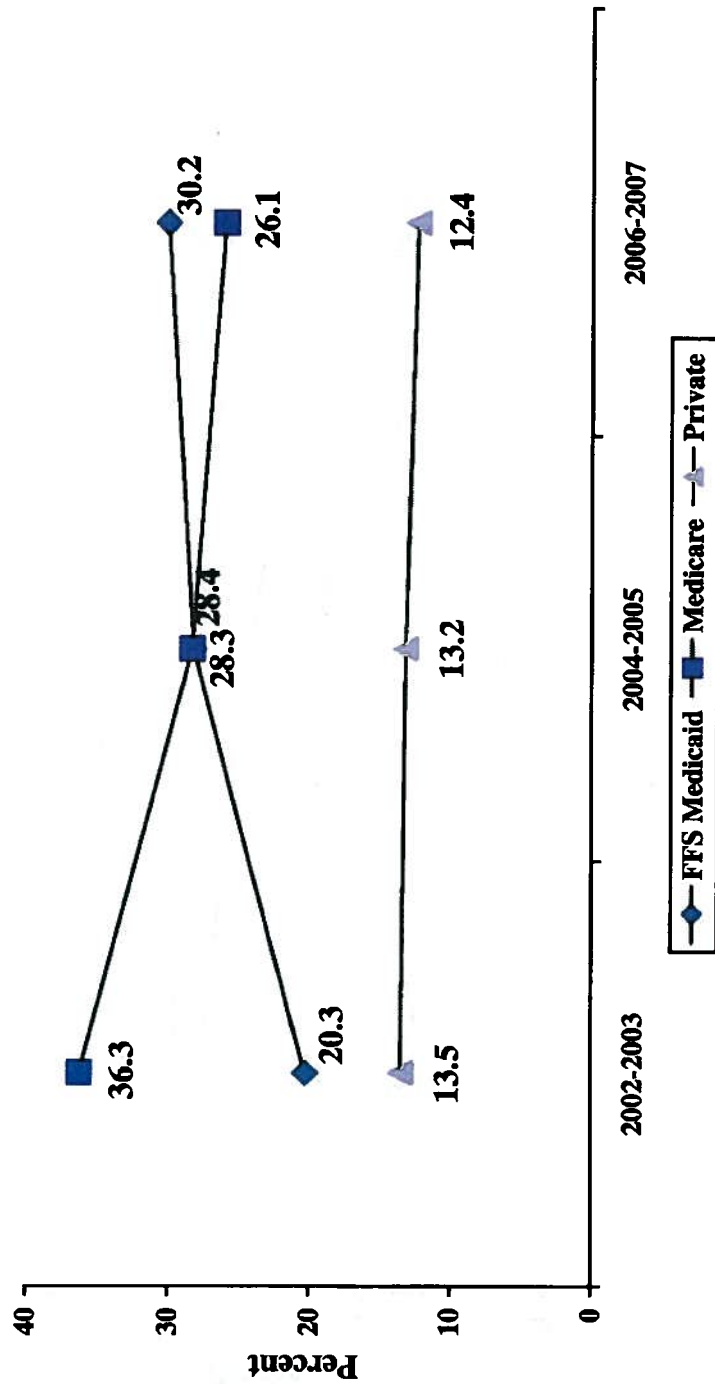
**Figure 3-3**  
**Percent Had Flu Shot in Past Year**  
**Ages 18-64 by Health Insurance Coverage**

Receipt of a flu shot is a nationally recognized quality measure. The percent of working-aged Rhode Islanders on FFS Medicaid who received a flu shot has improved significantly from 32% in 2002-3 to 39% in 2006-7.



Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

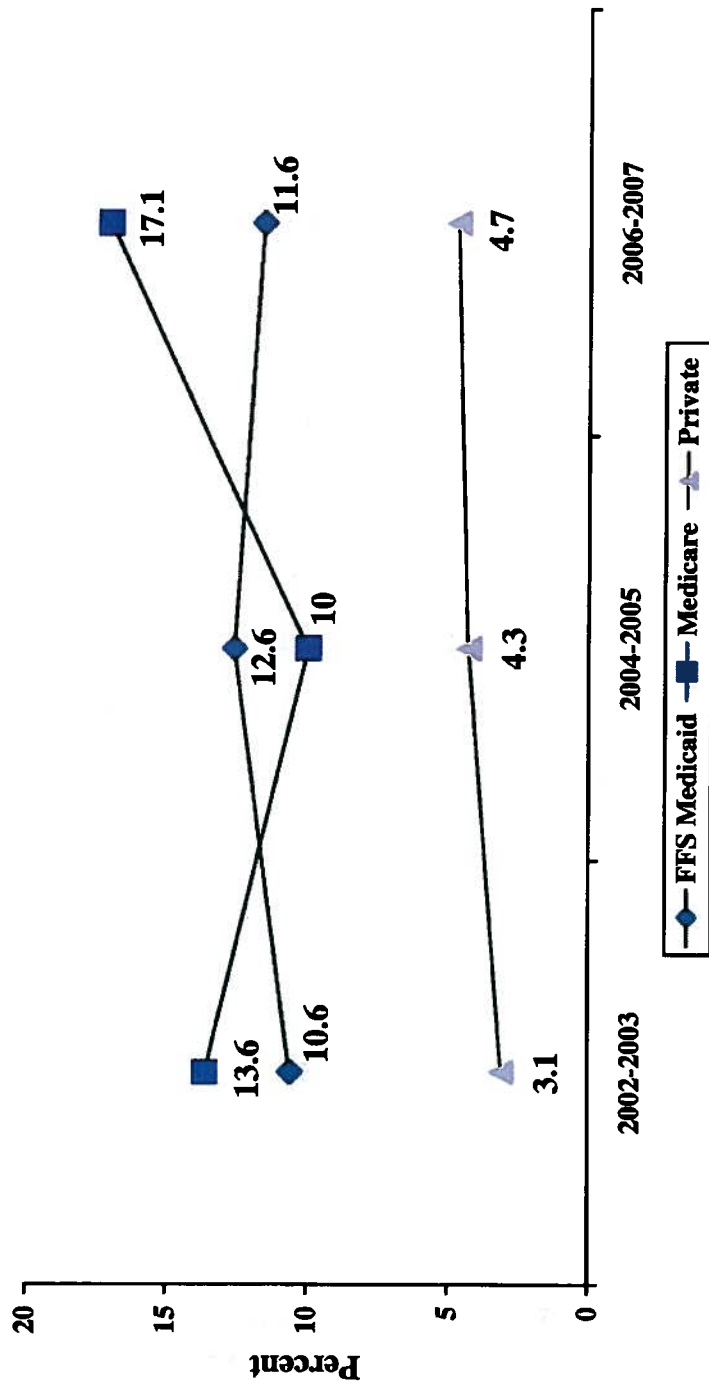
**Figure 3-4**  
**Percent Ever Had Pneumonia Vaccine**  
**Ages 18-64 by Health Insurance Coverage**



Receipt of a pneumonia shot is a nationally recognized quality measure. The percent of working-aged Rhode Islanders on FFS Medicaid who received a pneumonia shot has improved significantly from 20% in 2003 to 30% in 2006-7.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

**Figure 3-5**  
**Percent Who Have Diabetes**  
**Ages 18-64 by Health Insurance Coverage**

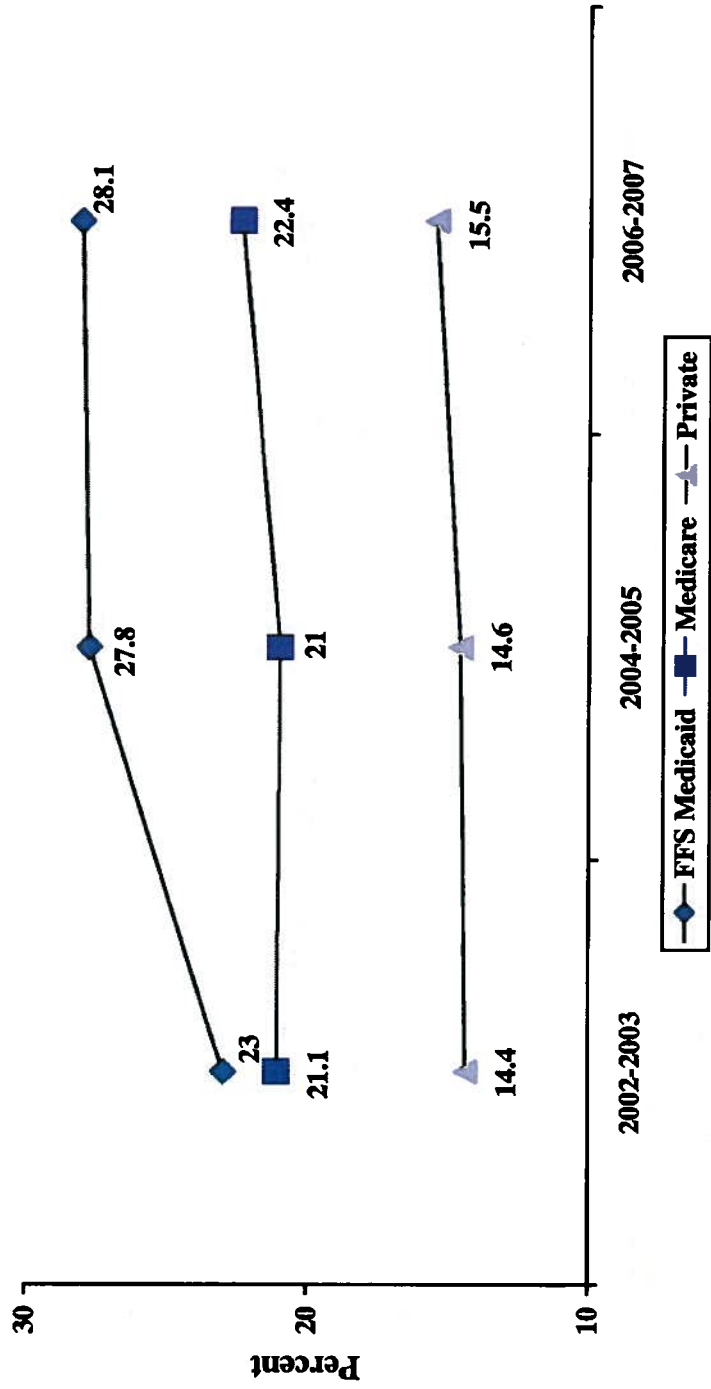


Rates of Diabetes are three times higher for Rhode Islanders on FFS Medicaid. In 2006-7 12% on FFS Medicaid had diabetes compared to only 5% for privately insured. This high prevalence rate for diabetes explains why hospitalization rates for ACS and PQI conditions were so high for this population.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

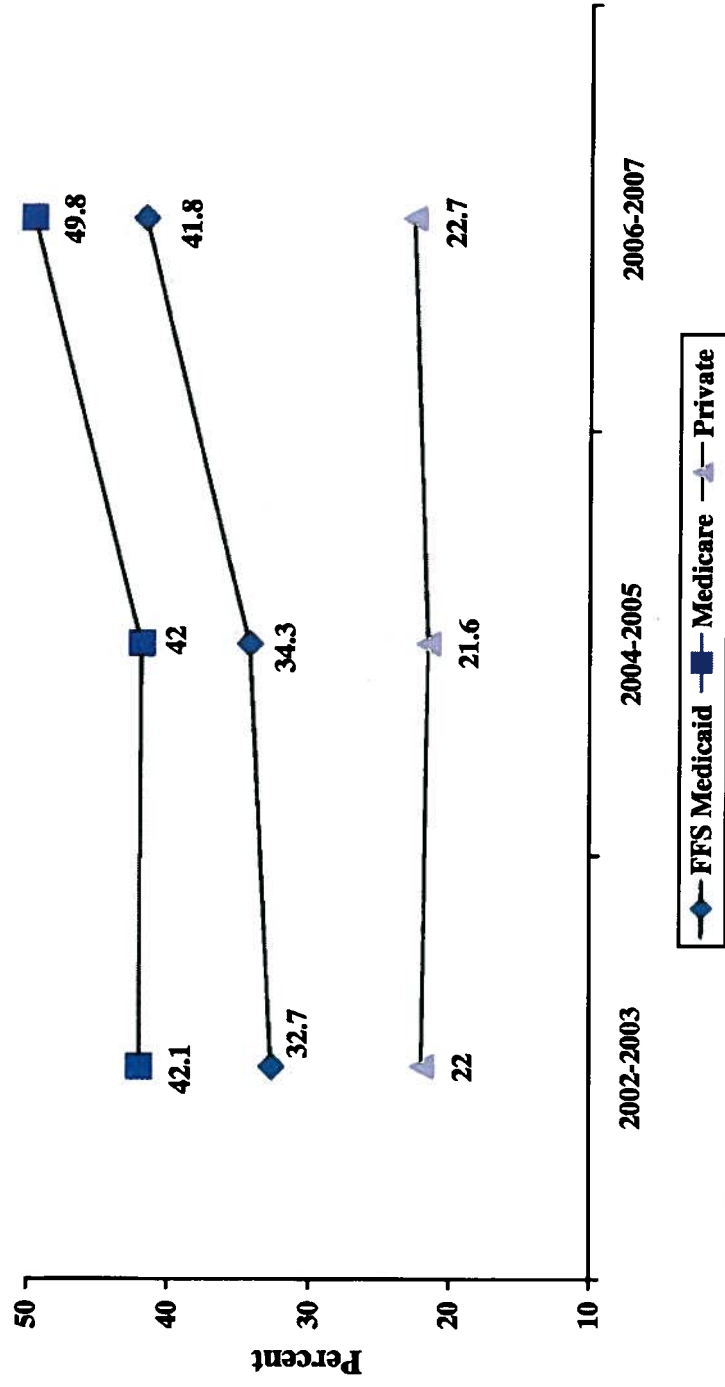
**Figure 3-6**  
**Percent Who Have Asthma**  
**Ages 18-64 by Health Insurance Coverage**

Rates of asthma are highest for Rhode Islanders on FFS Medicaid and the rates have been rising since 2002. These high prevalence rates for asthma explain why hospitalization rates for ACS and PQI conditions are so high for this population.



Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

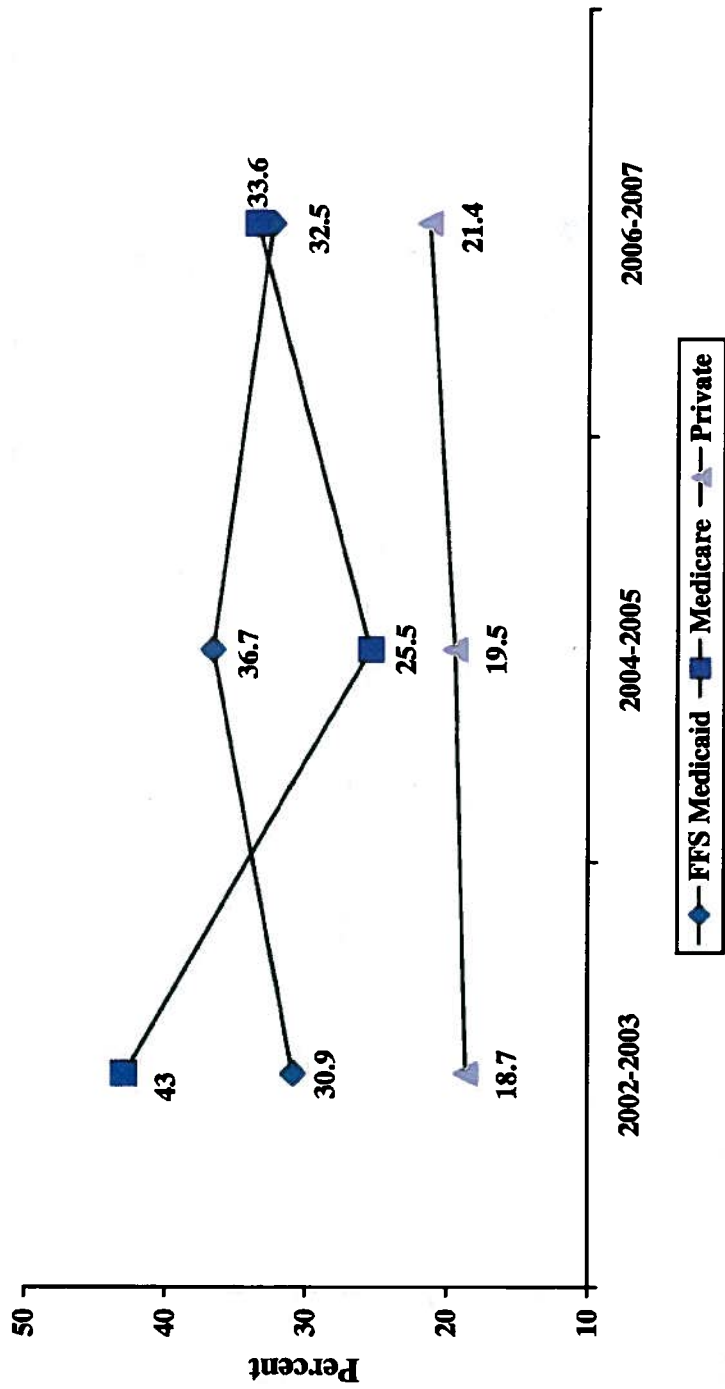
**Figure 3-7**  
**Percent Who Have Arthritis**  
**Ages 18-64 by Health Insurance Coverage**



Rates of arthritis are twice as high for Rhode Islanders on public insurance than the privately insured.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

**Figure 3-8**  
**Percent Who Are Obese**  
**Ages 18-64 by Health Insurance Coverage**

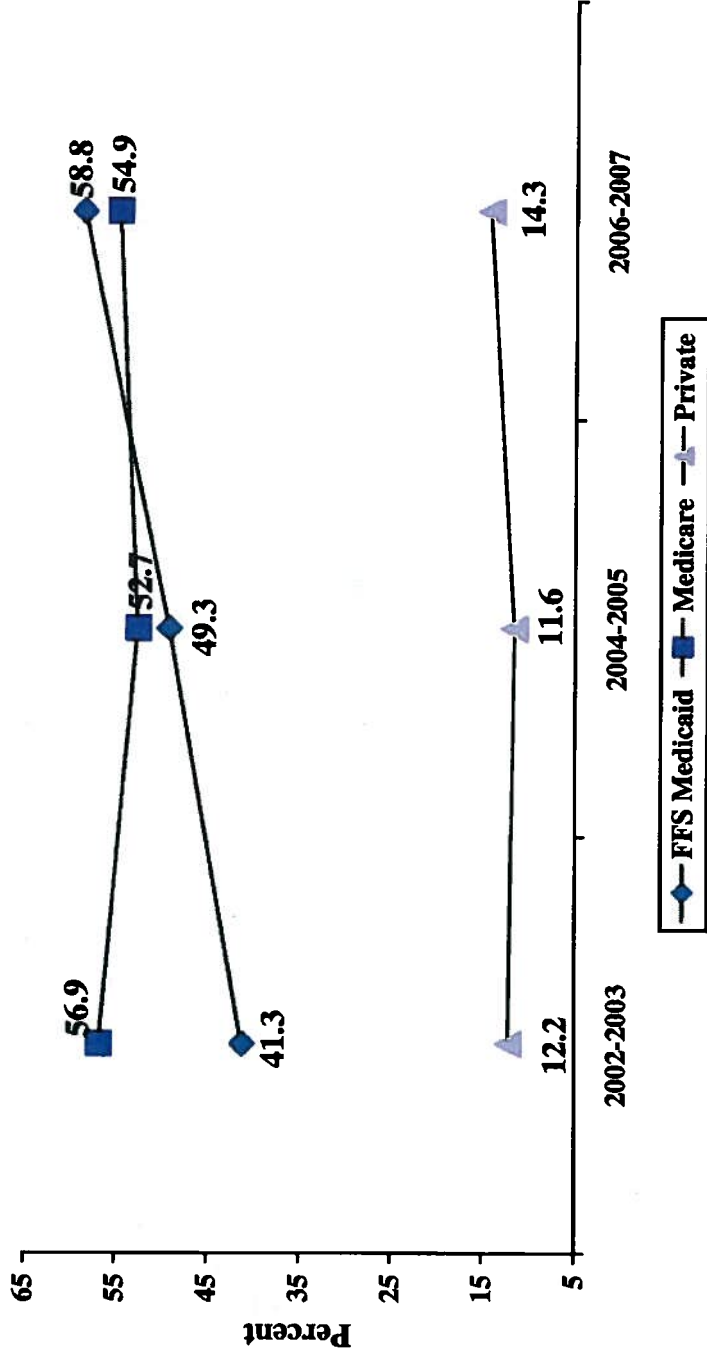


Obesity is associated with high rates of chronic disease. Approximately 1 in 3 Rhode Islanders on FFS Medicaid is obese.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health



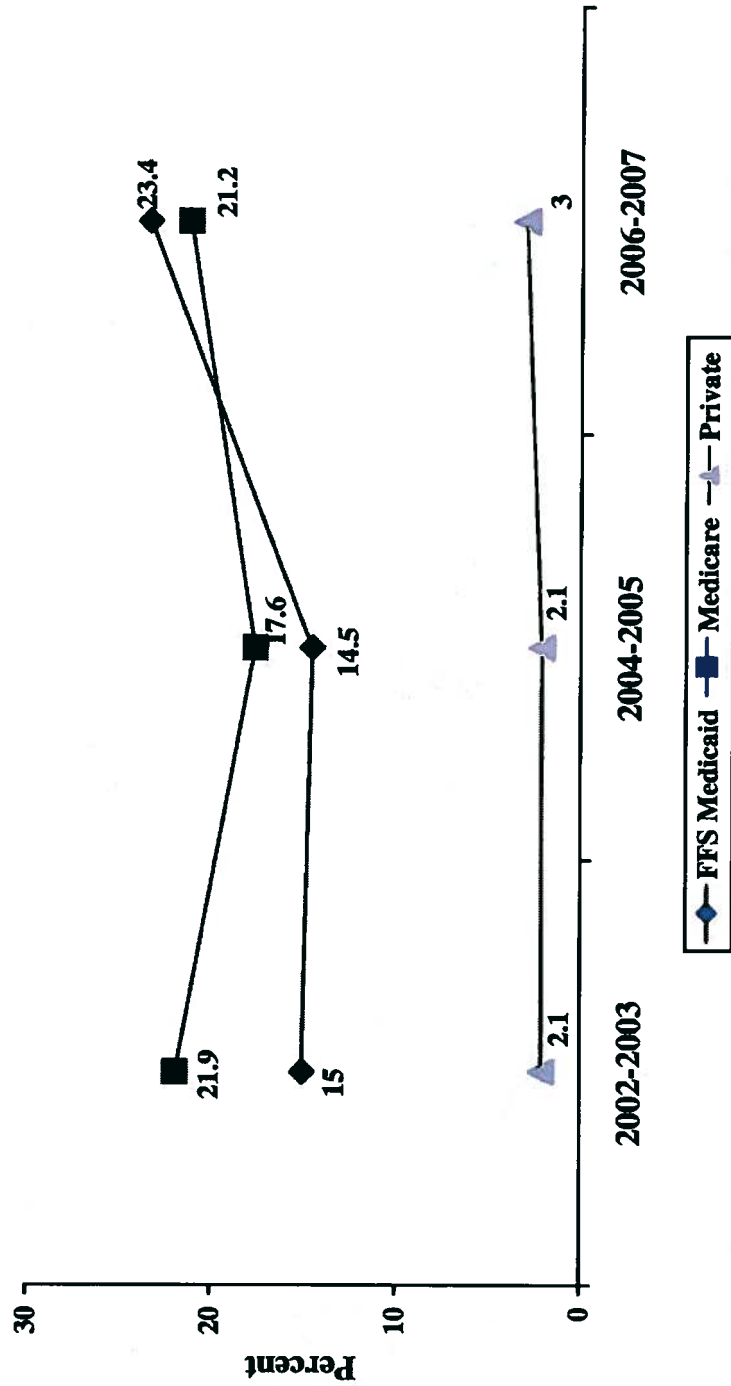
**Figure 3-9**  
**Percent Limited in Any Way Due to Physical or Emotional Problems**  
**Ages 18-64 by Health Insurance Coverage**



Over half of Rhode Islanders on public insurance experience limitations due to physical or emotional problems.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

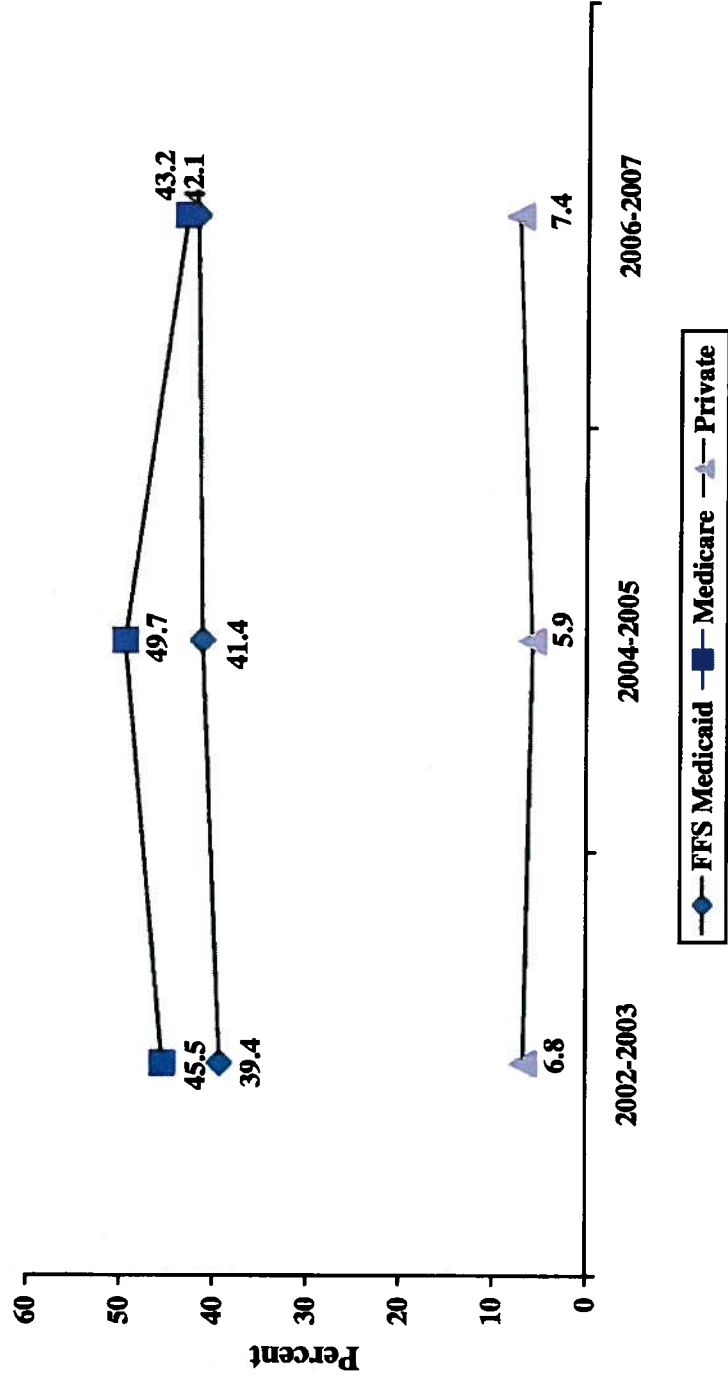
**Figure 3-10**  
**Percent Have Health Problem That Requires Special Equipment**  
**Ages 18-64 by Health Insurance Coverage**



Almost 1 in 4 Rhode Islanders on FFS Medicaid require special equipment due to a health problem.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

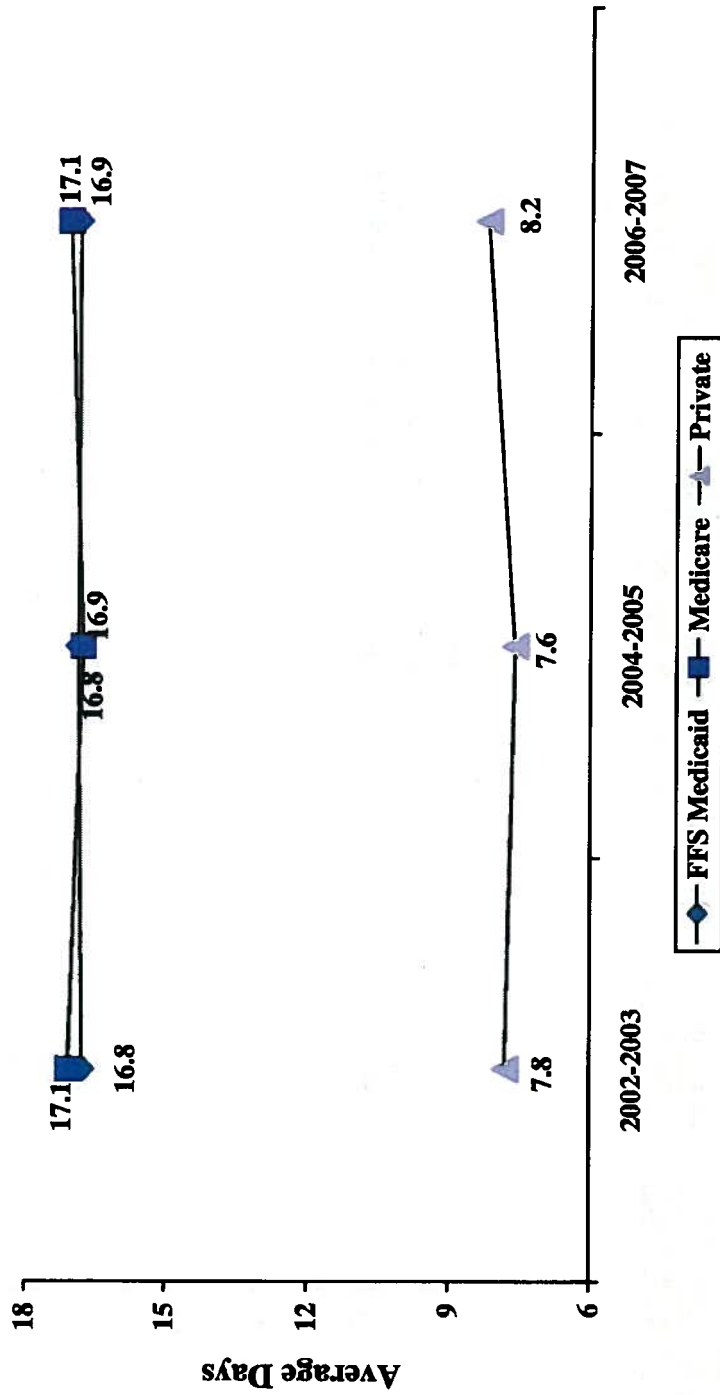
**Figure 3-11**  
**Percent With Fair/Poor Health**  
**Ages 18-64 by Health Insurance Coverage**



Health status is more likely to be rated fair/poor for Rhode Islanders on public insurance

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

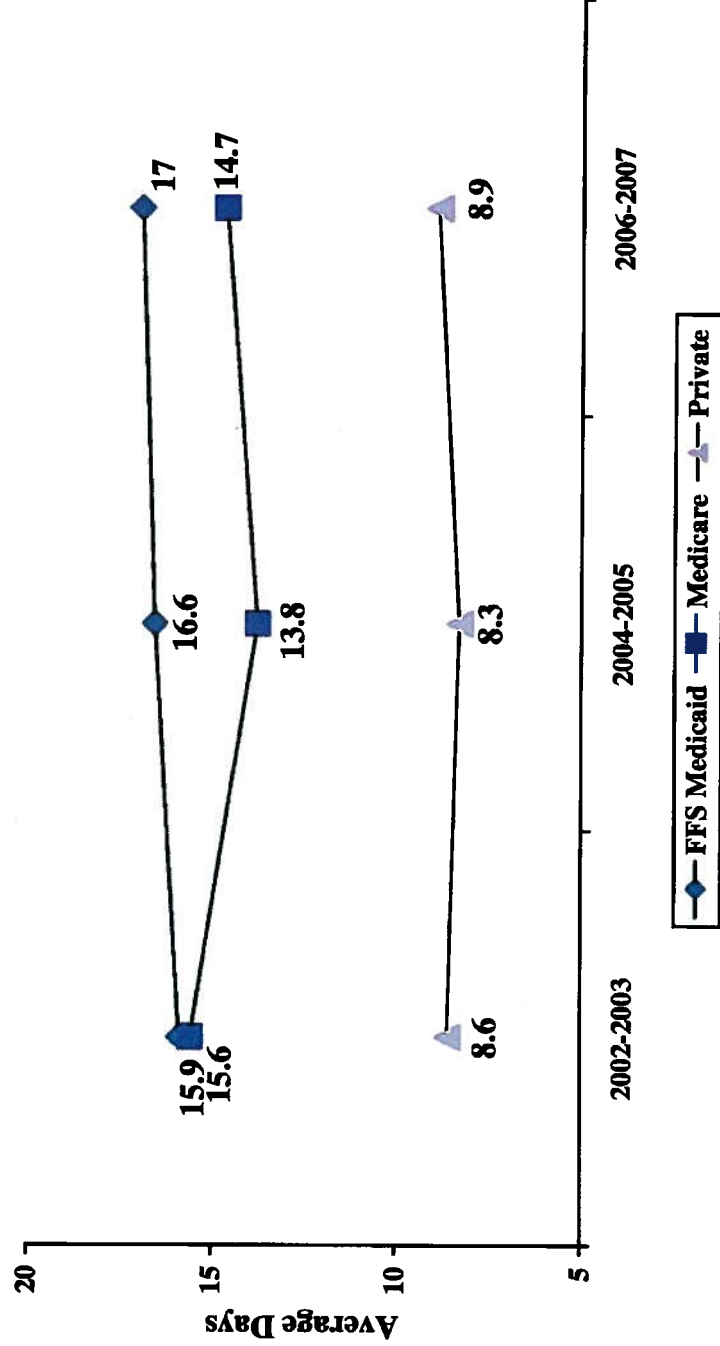
**Figure 3-12**  
**Average Days Per Month Physical Health Not Good Ages 18-64**  
**by Health Insurance Coverage**



The physical health for Rhode Islanders on FFS Medicaid is not good on average 17 days per month. This compares to 8 days a month for the privately insured.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

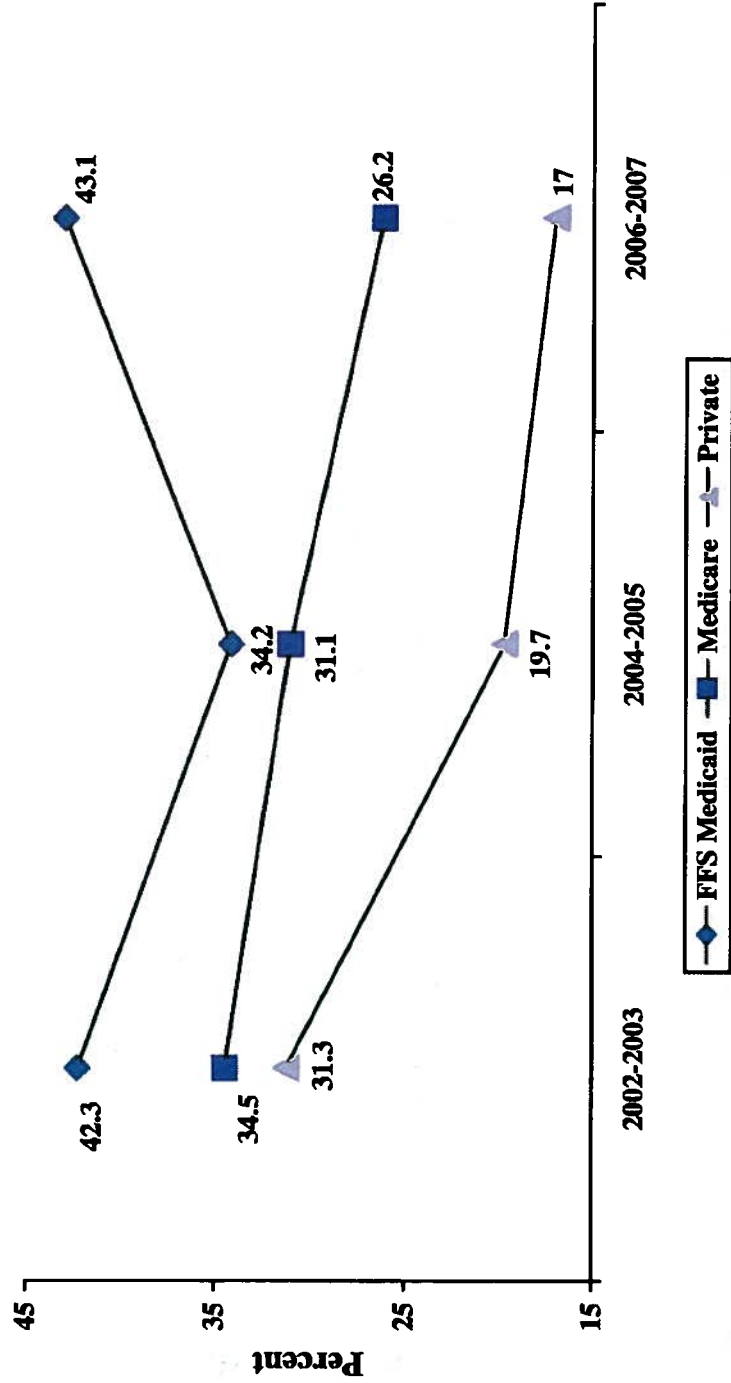
**Figure 3-13**  
**Average Days Per Month Mental Health Not Good**  
**Ages 18-64 by Health Insurance Coverage**



The mental health for Rhode Islanders on FFS Medicaid is not good an average 17 days per month. This compares to 9 days a month for the privately insured.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

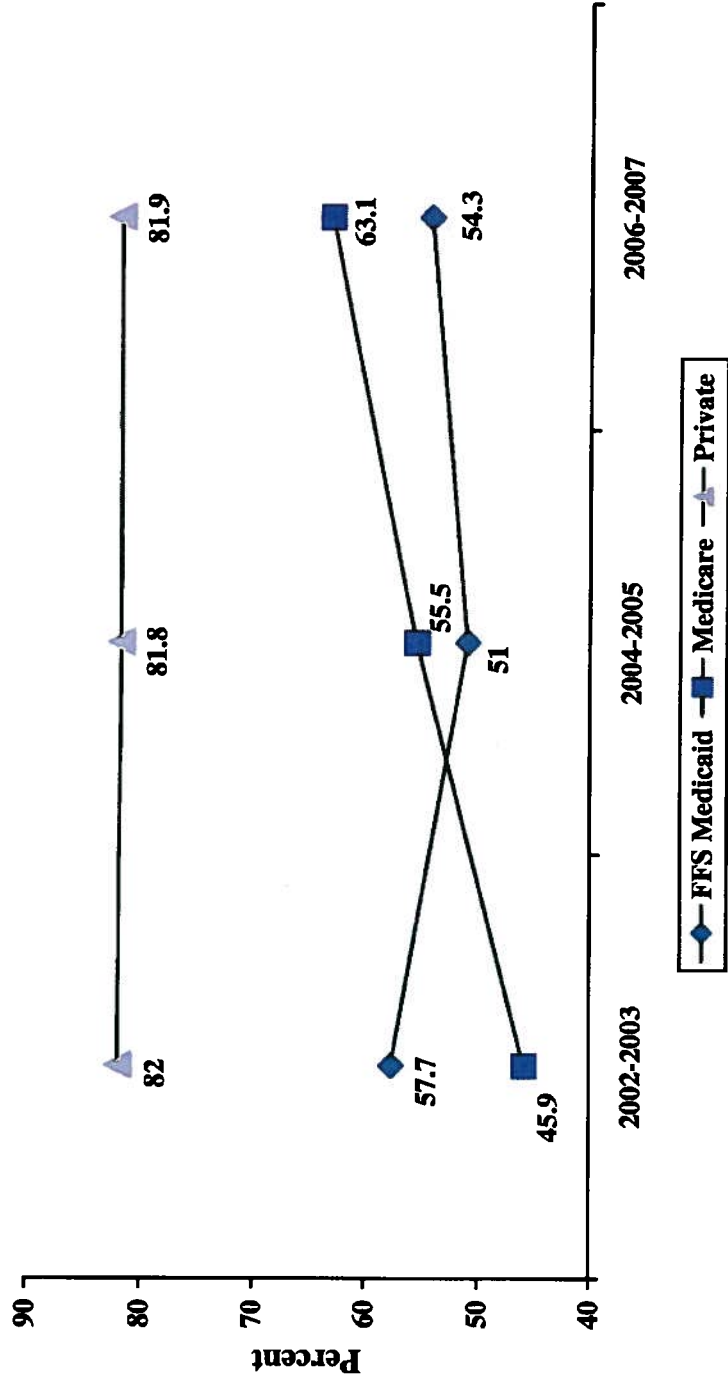
**Figure 3-14**  
**Percent Who Smoke Cigarettes**  
**Ages 18-64 by Health Insurance Coverage**



Smoking rates for Rhode Islanders on FFS Medicaid are significantly higher than any other insurance group. 43% of FFS Medicaid beneficiaries smoke. Smoking is associated with high rates of chronic disease.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health

**Figure 3-15**  
**Percent Who Exercised in Past Month**  
**Ages 18-64 by Health Insurance Coverage**



Exercise has been shown to prevent nursing home stays. Rhode Islanders on FFS Medicaid have the lowest percent of 'exercised in past month' compared to the other insurance groups.

Data Source: Medicaid Data Archive, Behavioral Risk Factor Surveillance System (BRFSS) 2002-2007, RI Department of Health



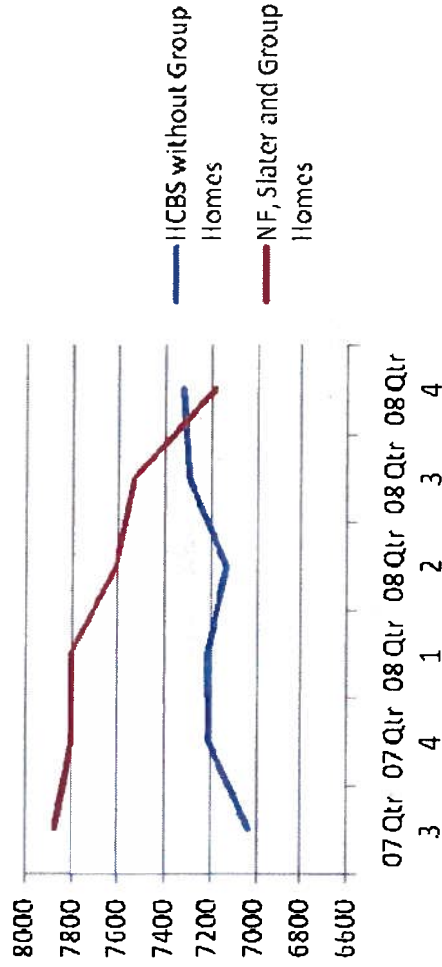


**(TAB #5) HCBS-Trends**

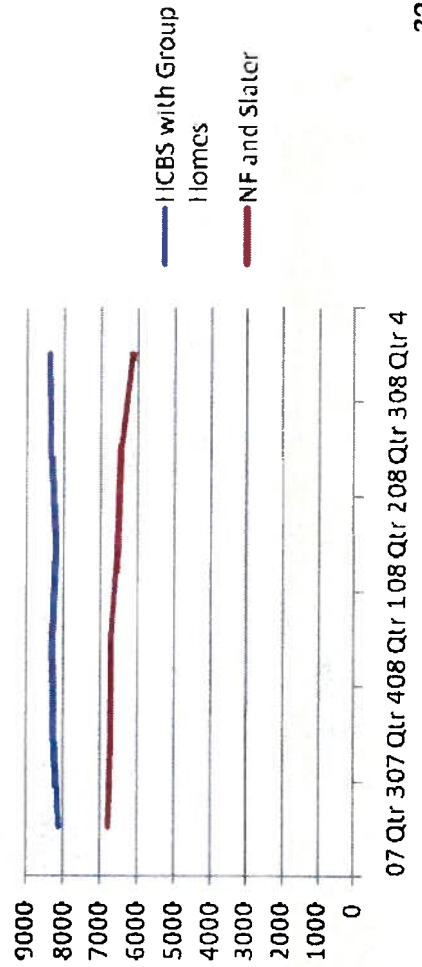


## Recipient Trends

**Recipient Trends, Group Homes as Institution**



**Recipient Trends, Group Homes as HCBS**



**Program Note**  
 Recipients are clearly trending more toward community based services whether group homes are considered to be institutional or HCBS. The trend is most dramatic where group homes are considered to be institutional due to the decline in use of group homes.

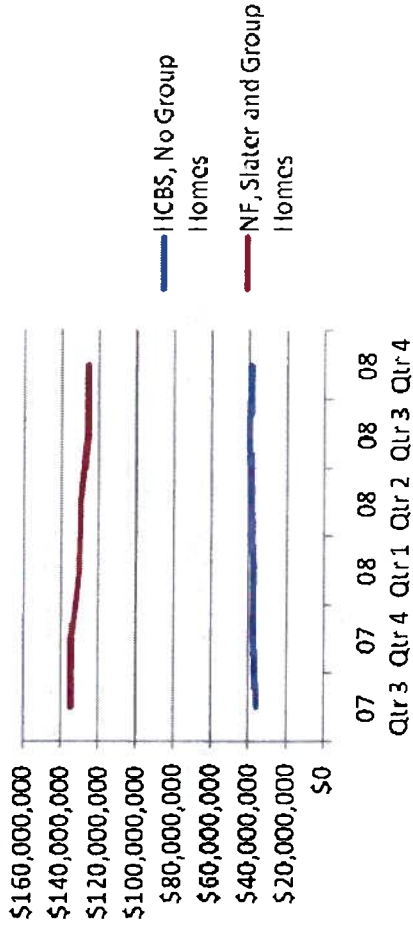
Data Source: MMIS unduplicated recipients with payment >\$0 for at least one claim in the respective category

# Cost Trends

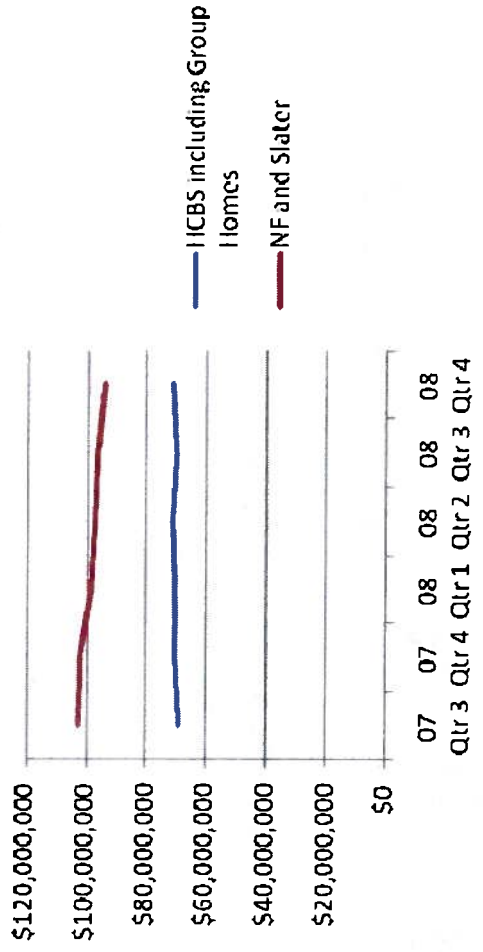
## Program Note

Inferences - Institutional costs are declining, and HCBS are showing slight increases in cost. The per person costs (by comparing recipient and cost trends) appear to be rising for institutional services and declining for HCBS. This needs closer examination to be sure that HCBS payments are sufficient to sustain needed capacity.

### Cost Trends, Group Home as Institution



### Cost Trends, Group Home as HCBS

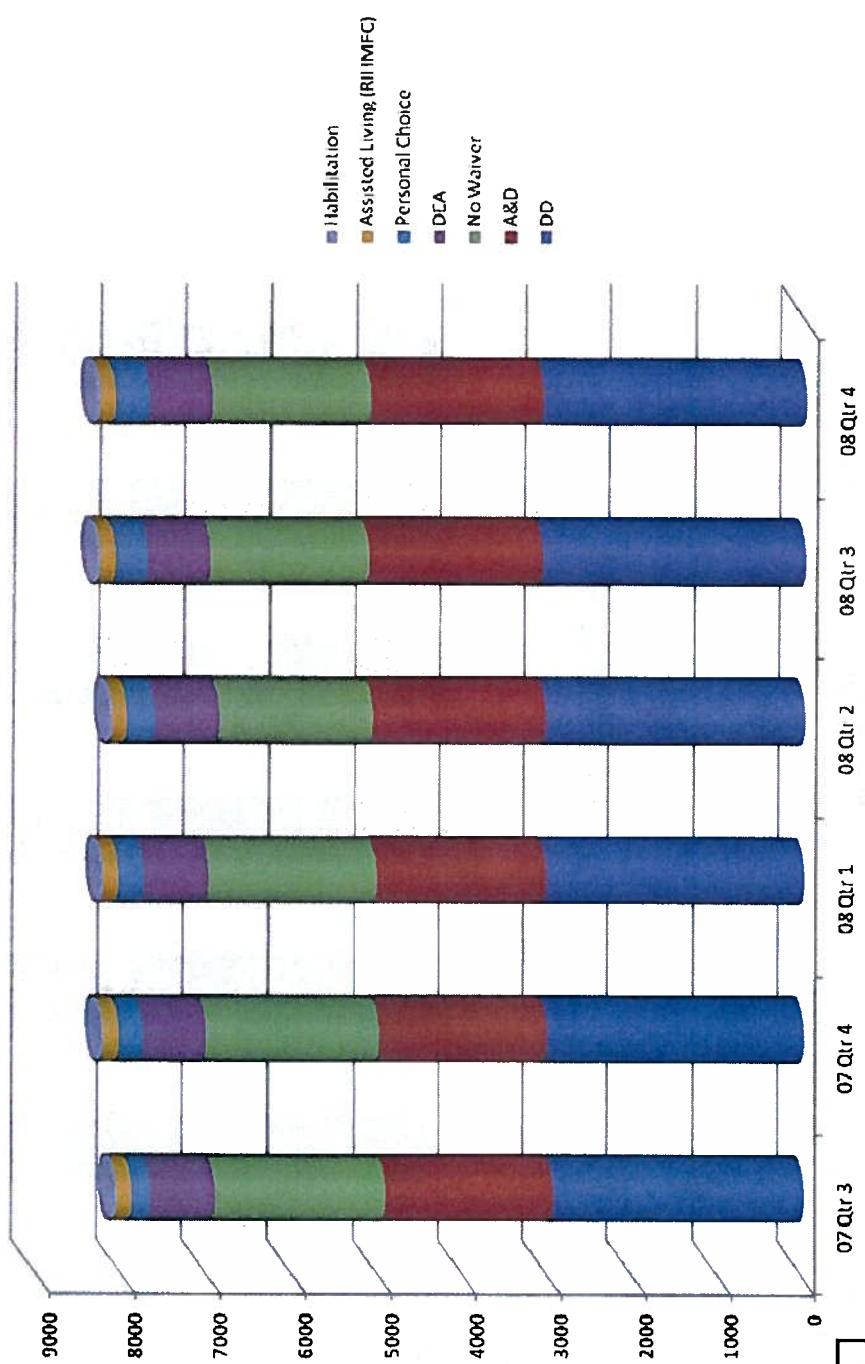


Data Source: MMIS, Offline Claims  
 Habilitation and PersonalChoice  
 Waivers

# Recipients by Program

**Program Note**  
 Inferences -  
 The 3 largest program groupings are those in the Developmental Disability Waiver, The Aged and Disabled Waiver, and those not in any waiver but who receive a state plan HCBS (DME, Supplies such as incontinence products, and Adult Day Care).

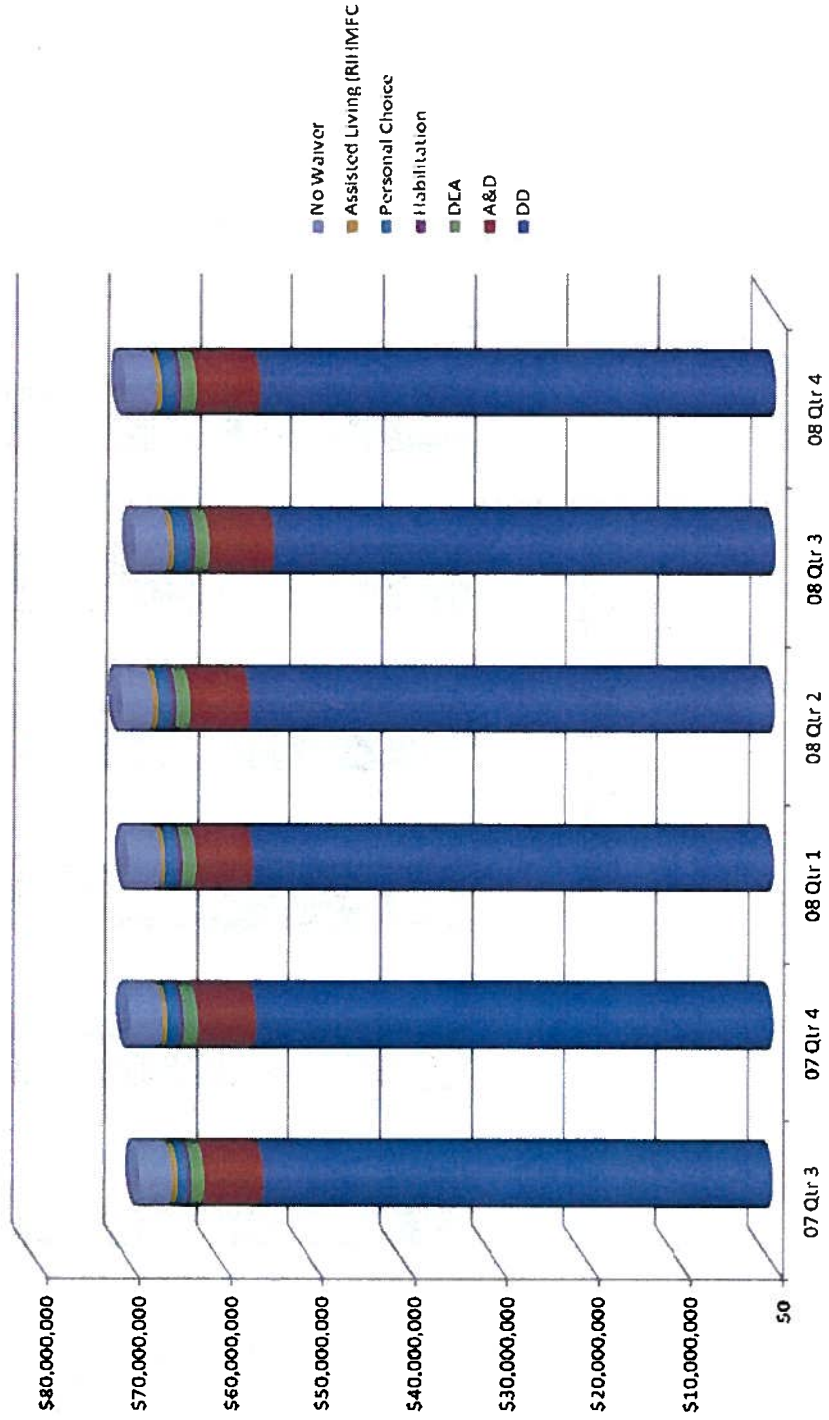
**Recipients by Program**



Data Source: MMIS unduplicated recipients with payment >\$0 for at least one claim in the respective category

# Cost by Program

Cost By Program

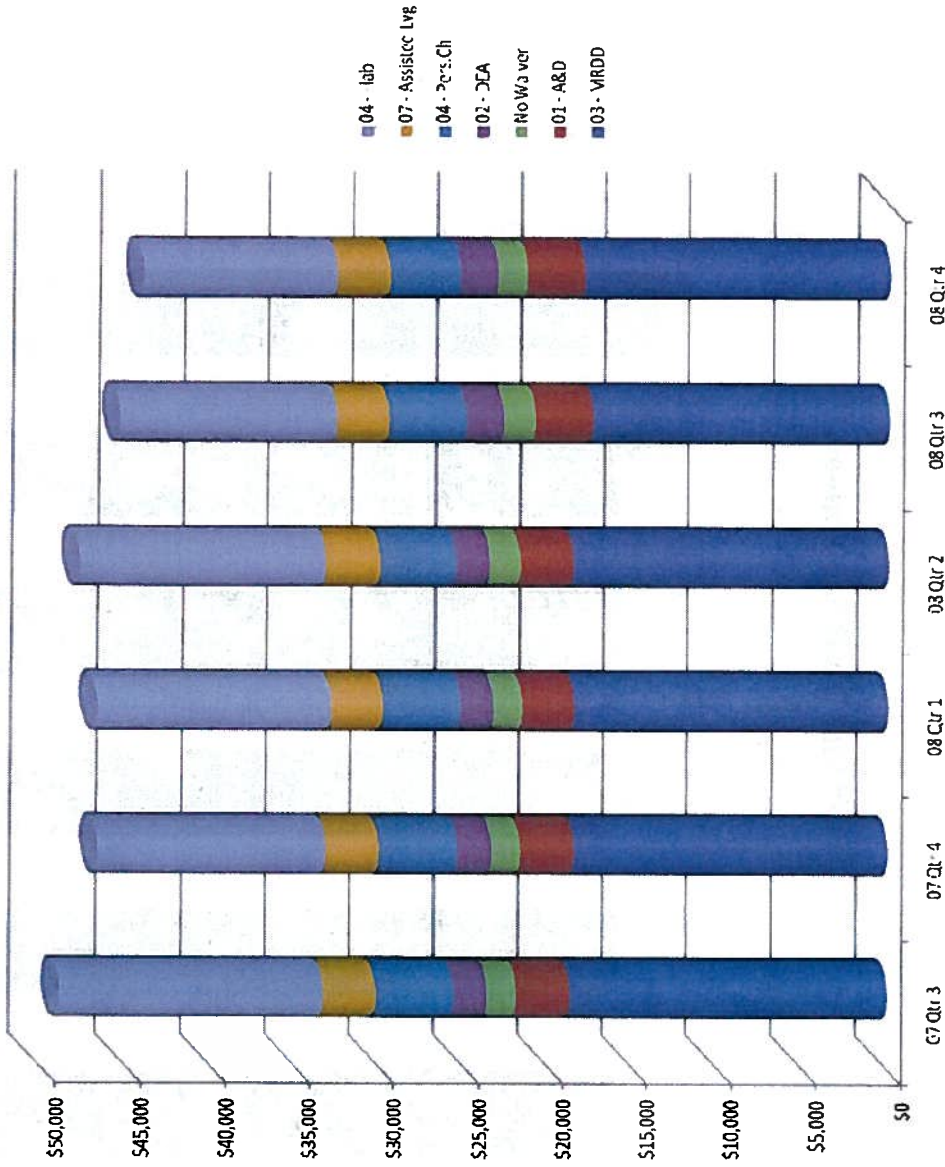


**Program Note**  
 Inferences - As would be expected, the vast majority of dollars are expended within the Developmental Disability Program (this program has both the highest number of recipients and highest cost services including group homes).

Data Source: MMIS, and Hab and PersonalChoice offline claims

## Rhode Island HCBS per Member per Quarter Costs

Rhode Island HCBS Per Member Per Quarter Costs



### Program Note

Inferences - The Hab and DD programs show, as expected, the highest per person costs. Both of these programs include group homes and persons needing intensive support services. The DEA waiver does NOT include case management and assisted living claims, so is higher than what is shown here.

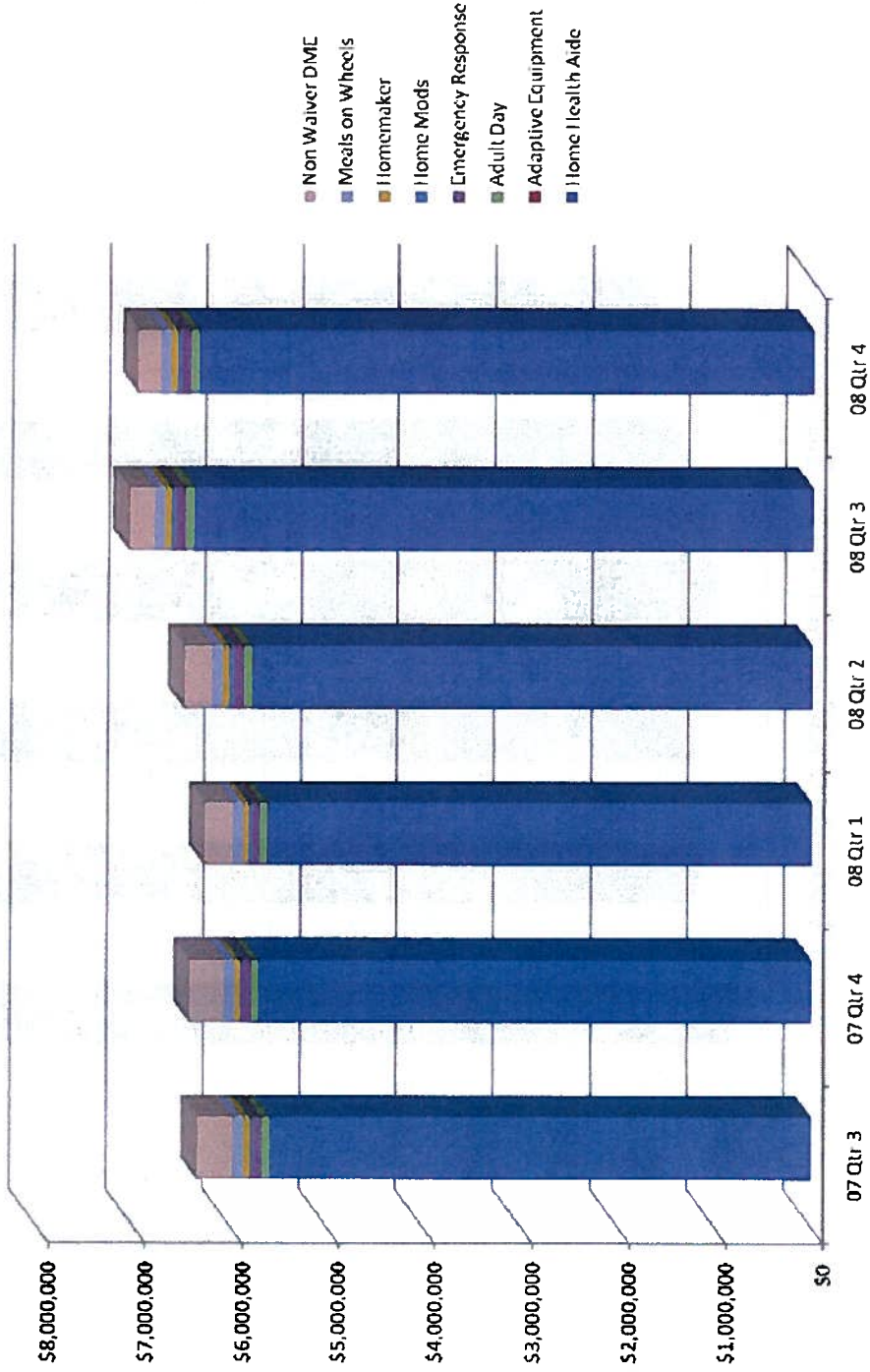
Data Source: Data Source: MMIS, and Hab and PersonalChoice offline claims

# Aged and Disabled Waiver

## Program Note

Inferences - This chart clearly demonstrates that home health aide services are the significant driver of A&D waiver costs. Case management is an administrative cost so does not show in this chart.

### Aged and Disabled Waiver



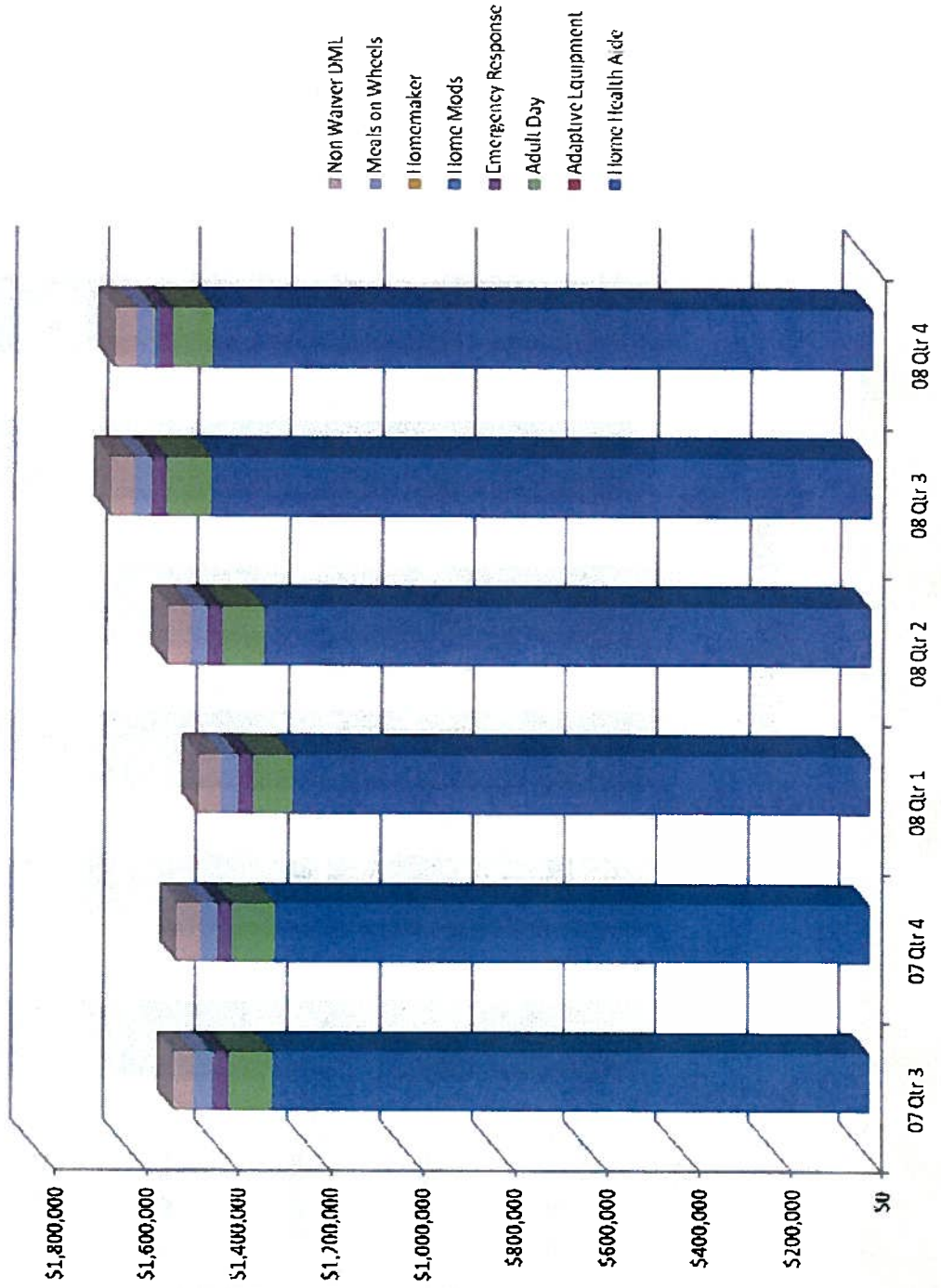
Data Source: MMIS Claims



# DEA Waiver

**Program Note**  
 Inferences -  
 When the offline assisted living and case management claims are added to this chart, it should present a different picture,

**DEA Waiver Minus Assisted Living and Case Management**



**Data Source: MMIS (Note: NEED offline DEA assisted living and case management claims)**

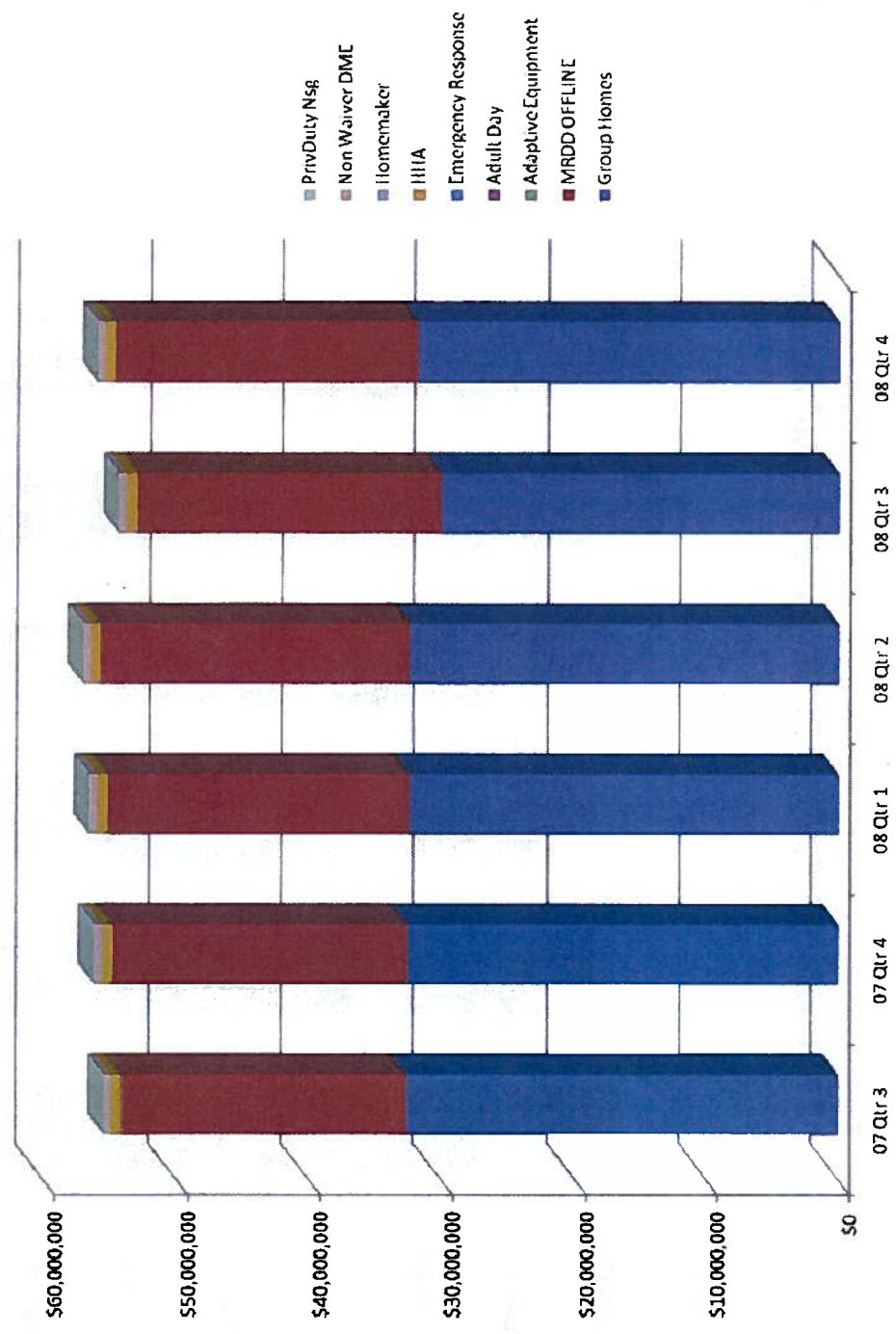
# Developmental Disability

**Program Note**

**Inferences -**  
 A very large part of claims are in the undifferentiated "Offline" category. To fully understand the service distribution, this information is needed.

Group home costs are very clearly a major driver of cost.

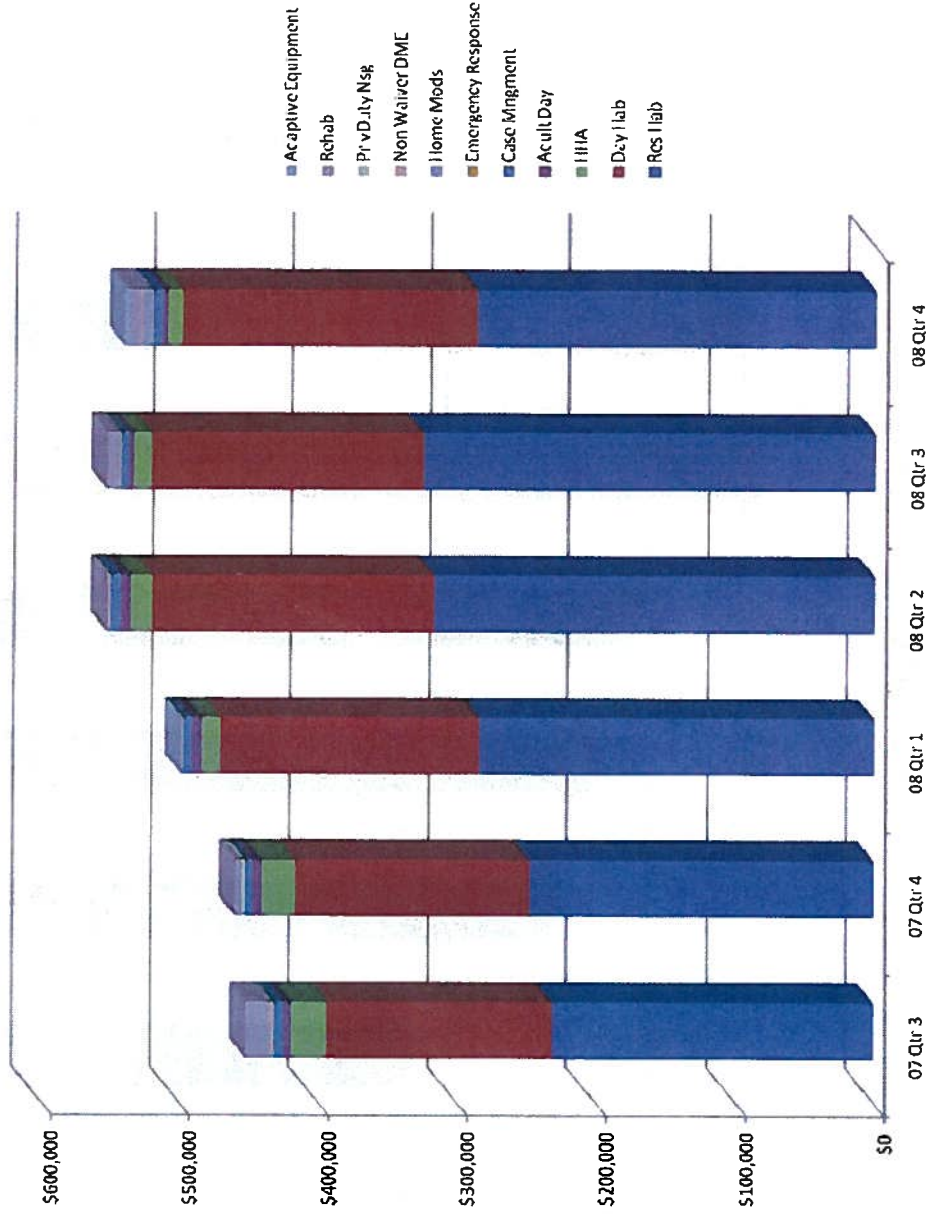
**Developmental Disability**



Data Source:MMIS

# Habilitation Disability

## Habilitation Waiver



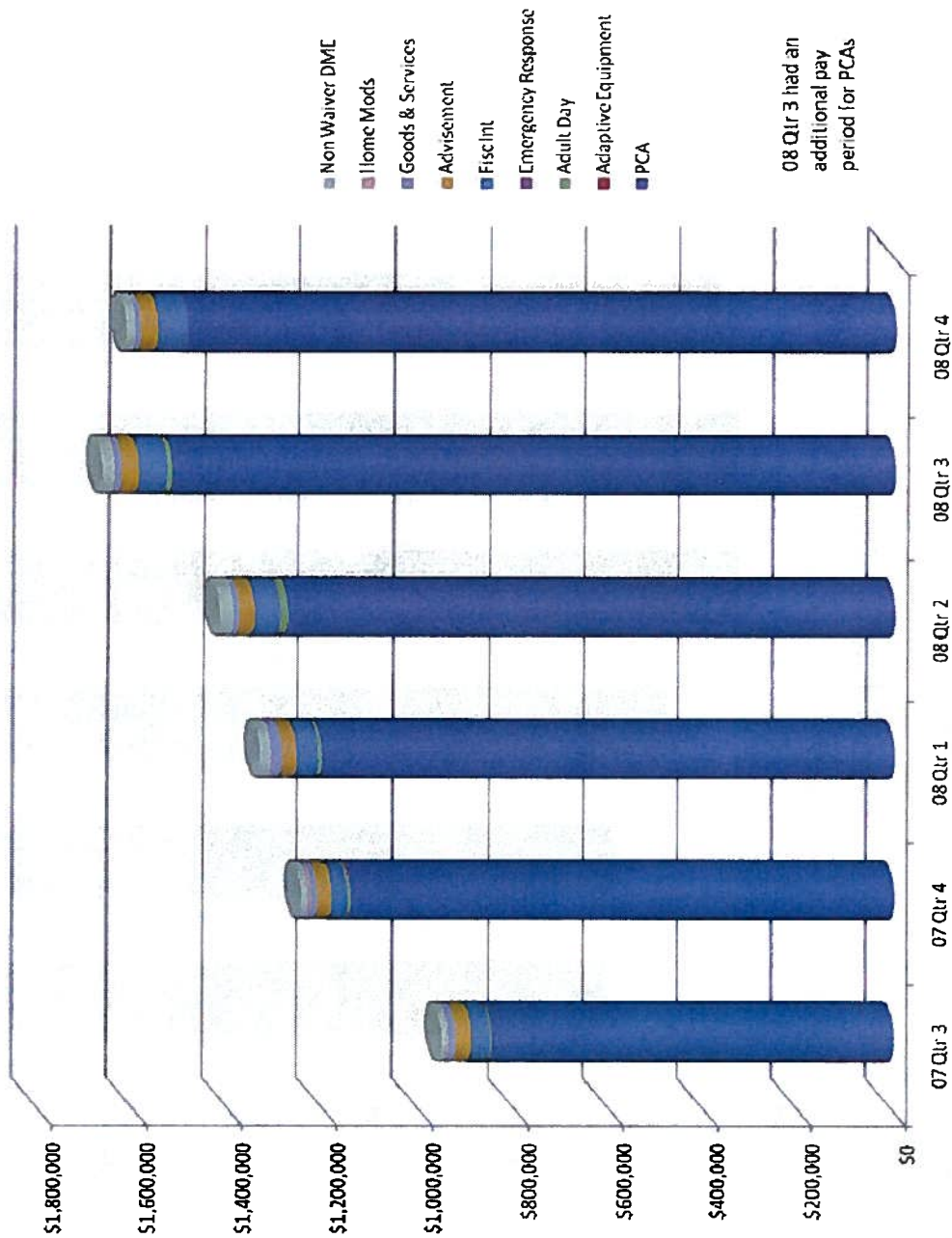
### Program Note

Inferences - This program made up primarily of people with brain injuries has the two primary categories of residential and day habilitation. Residential hab includes both group home and in-home support. The overall costs are low due to the 50 person restriction. However, there is a waiting list and costs in this high need population are likely to rise.

Data Source: MMIS and Offline Claims data

# Personal Choice Waiver

## PersonalChoice Waiver



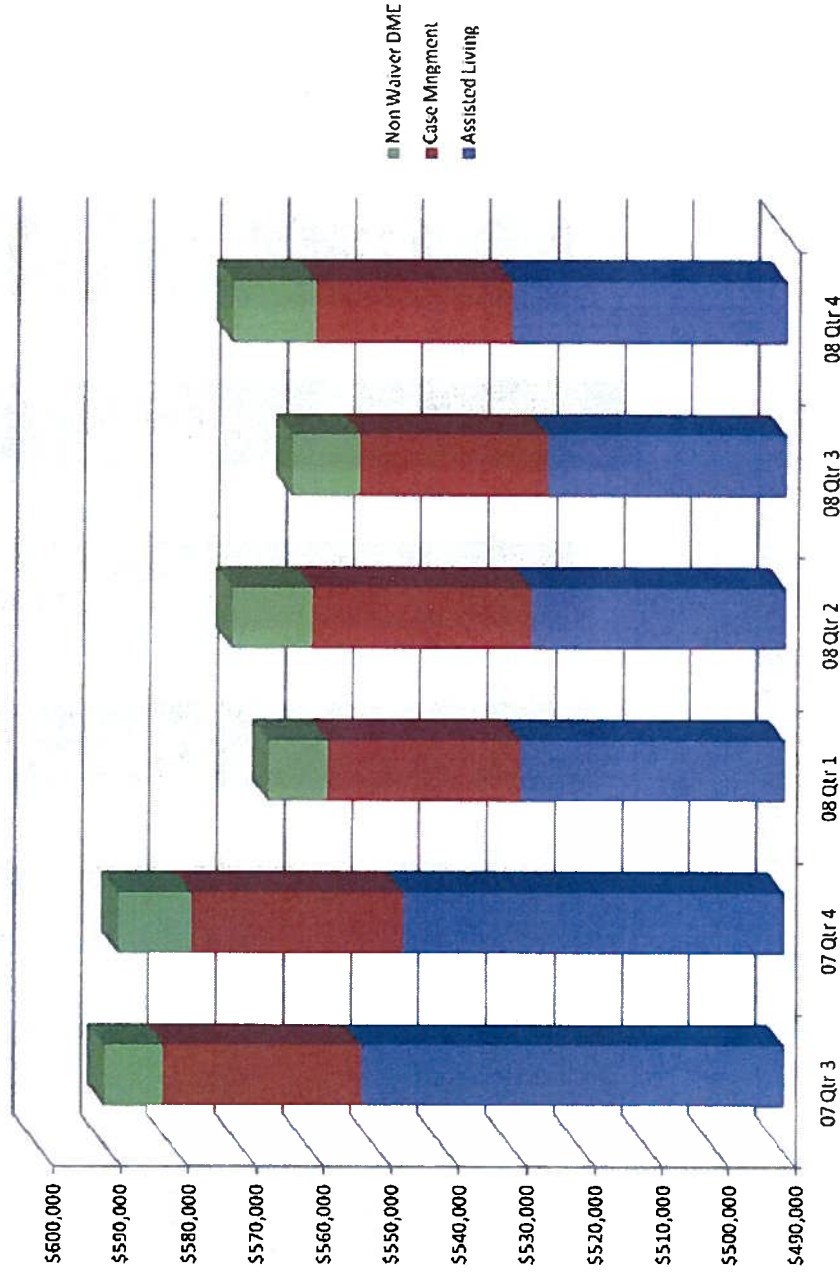
### Program Note

Inferences - This participant-directed cash and counseling program cost driver is clearly the self hired personal care attendants. This program comprises people with quad- and hemiplegia, other physical disabilities, and increasing numbers of elders. The program grew from less than 100 persons in 2007 to almost 400 at the end of 2008.

Data Source: Offline  
PersonalChoice claims

## Assisted Living Waiver

Assisted Living Waiver



### Program Note

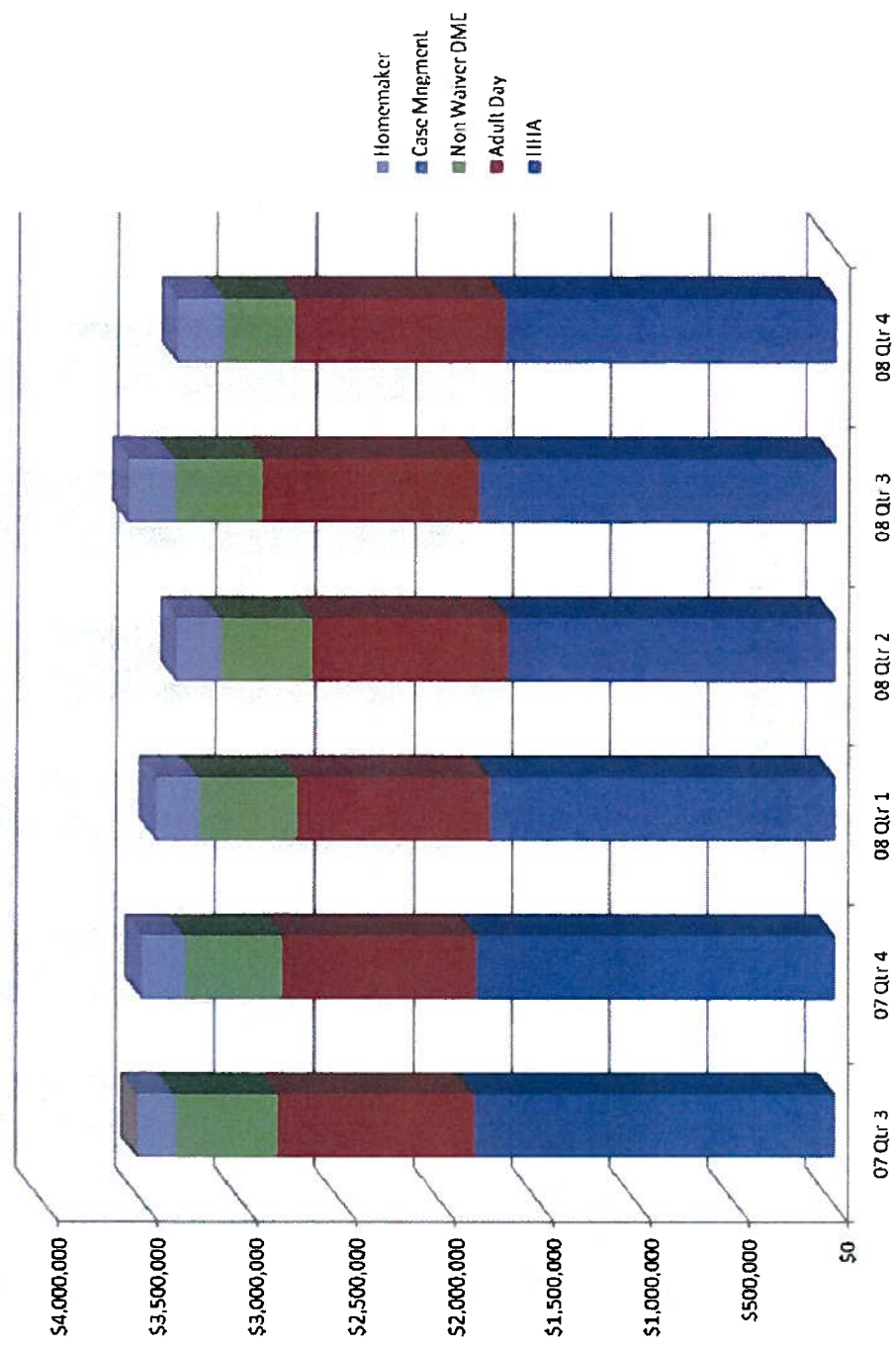
Inferences - This is the "RI Housing" waiver that was significantly altered by a court decision in 2007 that restricted certain slots to certain residences. That (possibly in addition to level funding) has resulted in lower usage

Data Source: MMIS

# Non Waiver Recipients of HCBS

**Program Note**  
 Inferences - These are the people not in any waiver eligibility group who received at least one of the services listed. This would be Title XX, Targeted Case Management and/or other state plan services.

**Non Waiver Recipients of HCBS**

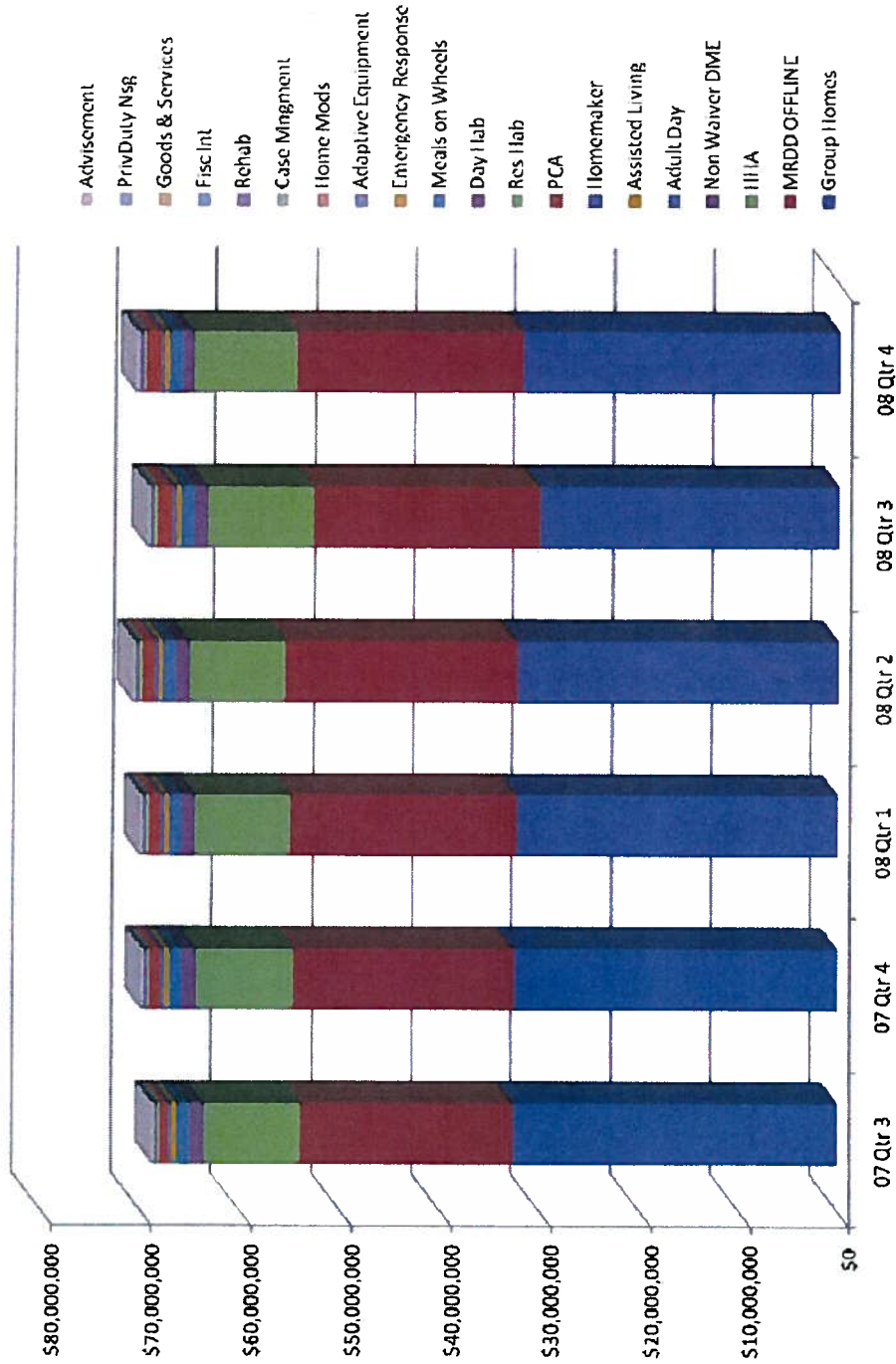


**Data Source: MMIS**

## Expenditures by Services All HCBS

**Program Note**  
 Inferences - This chart combines all previous program chart expenditures, again showing the effect of group homes on HCBS costs.

**Expenditures by Services All HCBS**



Data Source: Data Source:  
 MMIS, Offline Claims  
 Habilitation and PersonalChoice  
 Waivers





***(TAB #6) Medicare-LTC Trends***

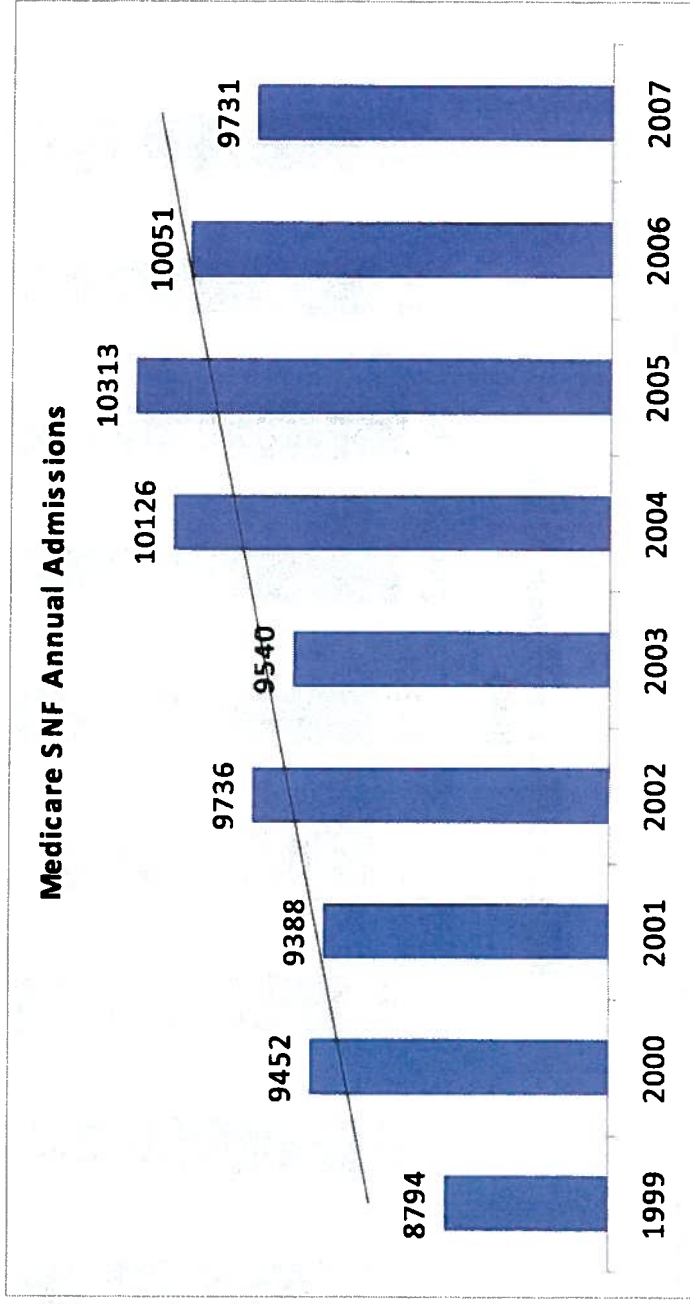


**Medicare use of SNF is trending higher**

- SNF use is up 11% since 1999
- From the peak in 2005 SNF use would be up by 17%
- Medicare enrollment by contrast has only grown 2% (see page 12)

**Program Note**

- Monitor Medicare SNF capacity utilization particularly if bundled payments come to fruition



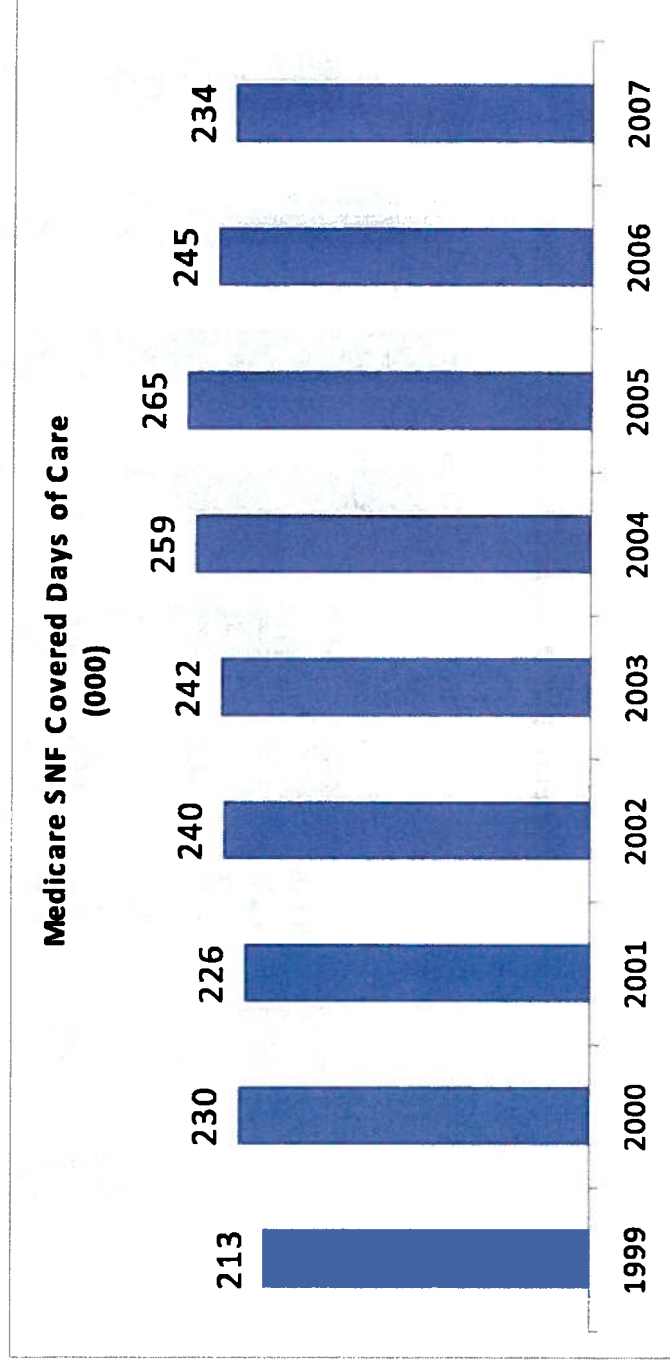
Data Source: Medicare Statistical Supplements various years; NP calculations

## Total covered days have fluctuated significantly since 1999

- From 1999 to 2007 covered days are up 9.9%

### Program Note

- Fluctuations in SNF admissions could strain SNF system if beds are "taken down"

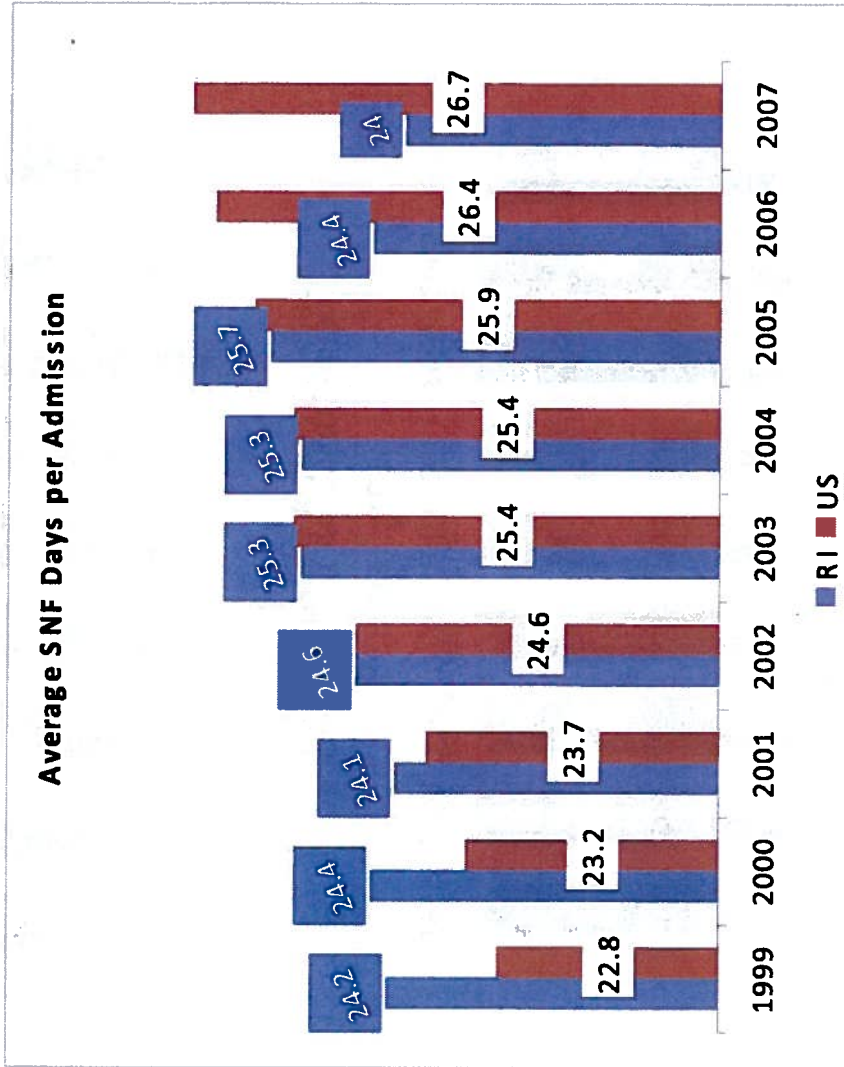


Data Source: Medicare Statistical Supplements various years; NP calculations

**RI Medicare SNF average days has stayed within a range around 24 days whereas nationally average days have been steadily increasing**

**Program Note**

- Monitor Medicare SNF capacity utilization particularly if bundled payments come to fruition



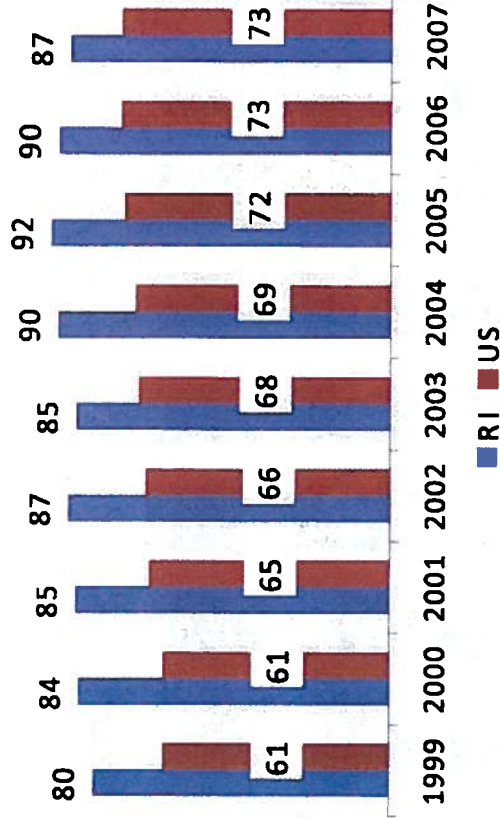
Data Source: Medicare Statistical Supplements various years; NP calculations

## Utilization rates of skilled nursing facilities by medicare enrollees

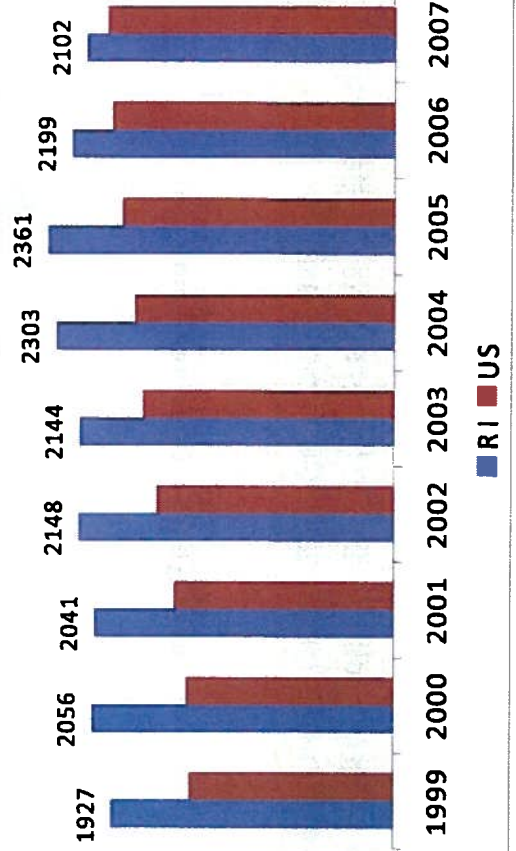
### Program Note

- Monitor Medicare SNF capacity utilization particularly if bundled payments come to fruition

SNF Utilization Rate per 1000 Medicare Beneficiaries



Covered Days per 1000 Enrollees



Data Source: Medicare Statistical Supplements various years; NP calculations

## Despite indications of higher utilization and comparable lengths of stay – Medicare occupies a smaller percentage of the state's SNF capacity than nationally

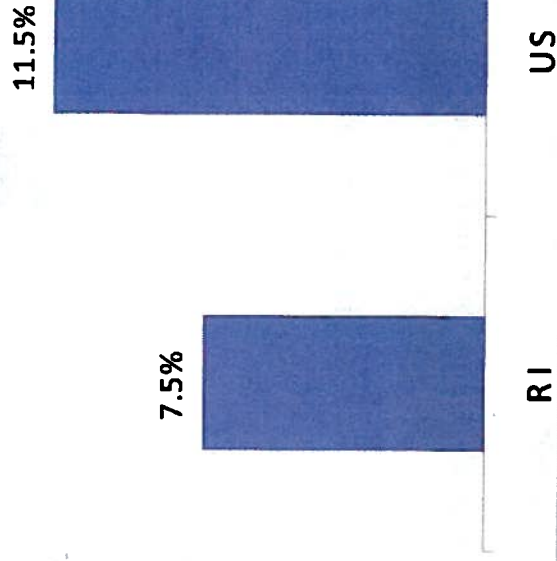
- RI Total certified beds: 8581
- RI Total Bed Days: 3,132,065
- RI Occupancy rate: 92.2%
- RI Total Occupied Bed Days: 2,887,764
- RI Medicare Bed Days: 234,000
- RI Medicaid Bed Days: 2,029,597
- RI Other Paid Bed Days: 624,167
- RI Available Bed Days: 244,301

Note: In most health care planning environments 85% of capacity is considered full to provide for surge emergency capacity or down time. Accordingly RI nursing home beds for all practical purposes are “full” with little slack capacity.

### Program Note

- Monitor Medicare SNF capacity utilization particularly if bundled payments come to fruition
- Review emergency medical planning and role of nursing homes in that emergency planning
- Analyze nursing homes to determine “Medicaid dependent” homes versus homes that specialize in sub acute care as part of “take down” strategy

**% of Nursing Home Bed Capacity Used by Medicare  
Percentage of Total Bed Days (2007)**



Data Source: Medicare Statistical Supplements various years; Kaiser State Health Facts; RI Medicaid Office; PAS Center; NP calculations

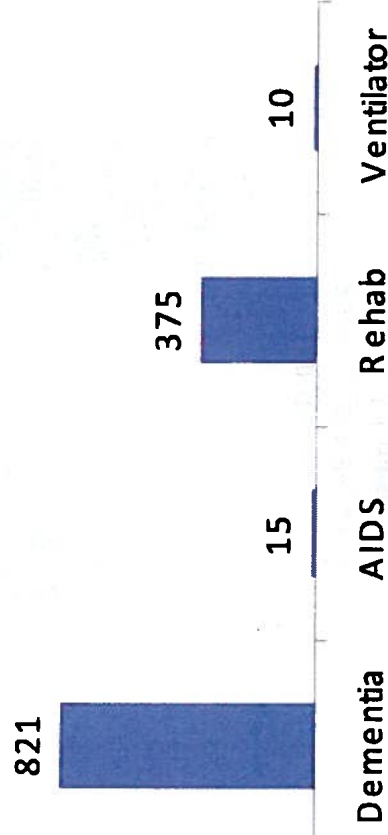
## Rhode Island may be under-resourced in some key special care beds

- Medicaid reimbursement policy may be a factor
- It should be noted that annually approximately 470 medicare patients require special care beds

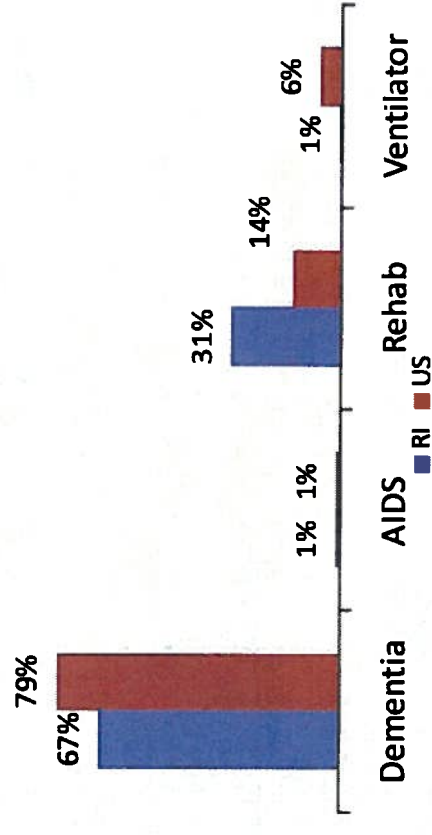
### Program Note

- Consider implications of payment structures on developing or overdeveloping specific specialty bed capacity

RIS Special Care Beds



SNF Bed Distribution



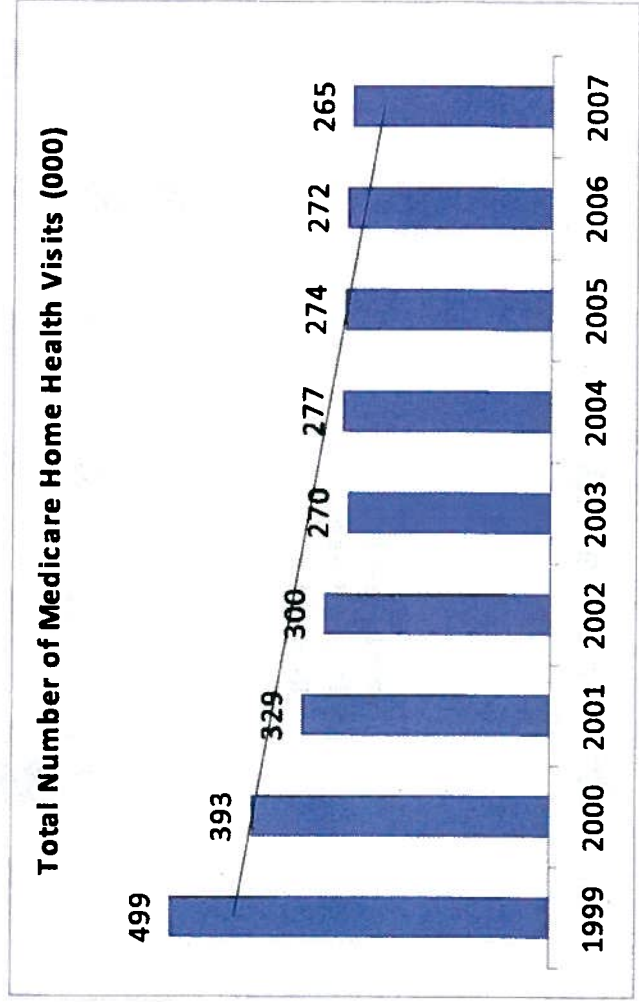
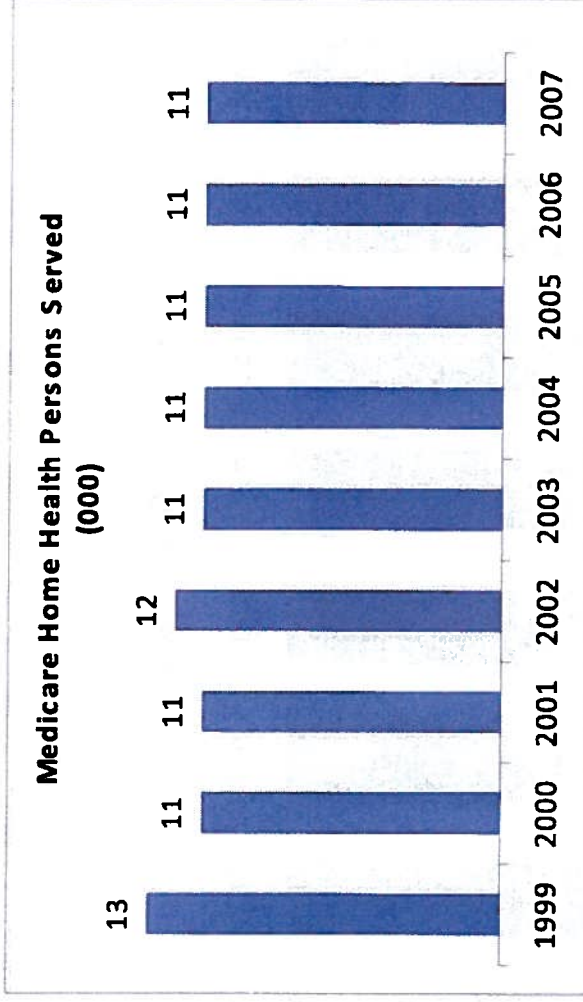
Data Source: PAS Center; Medicare Nursing Home data



## Medicare home health utilization is essentially flat since 2002 (cont)

### Program Note

- This is an indication that medicare payment levels are not attractive to drive additional capacity
- Medicaid payment structures may need to be sufficient to build net new capacity rather than absorbing existing marginal capacity
- Medicare payment bundling may have an impact on utilization
- A concern raised during interviews is that certain types of capacity such as respiratory/pulmonary home health capacity is severely limited or lacking

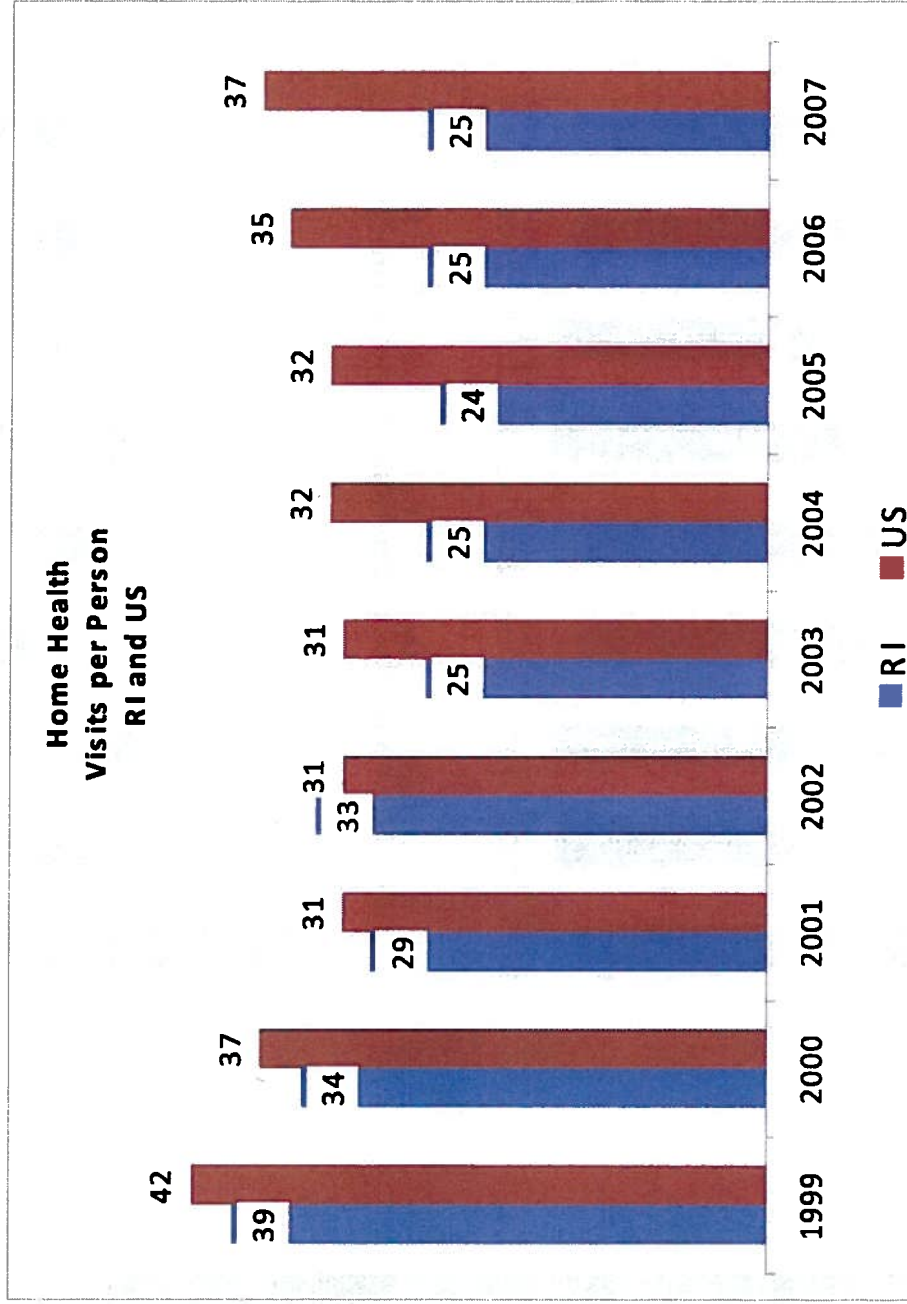


Data Source: Medicare Statistical Supplements various years; NP calculations

**Medicare home health utilization is essentially flat since 2002 (cont)**

**Program Note**

- This is an indication that medicare payment levels are not attractive to drive additional capacity
- Medicaid payment structures may need to be sufficient to build net new capacity rather than absorbing existing marginal capacity
- Medicare payment bundling may have an impact on utilization

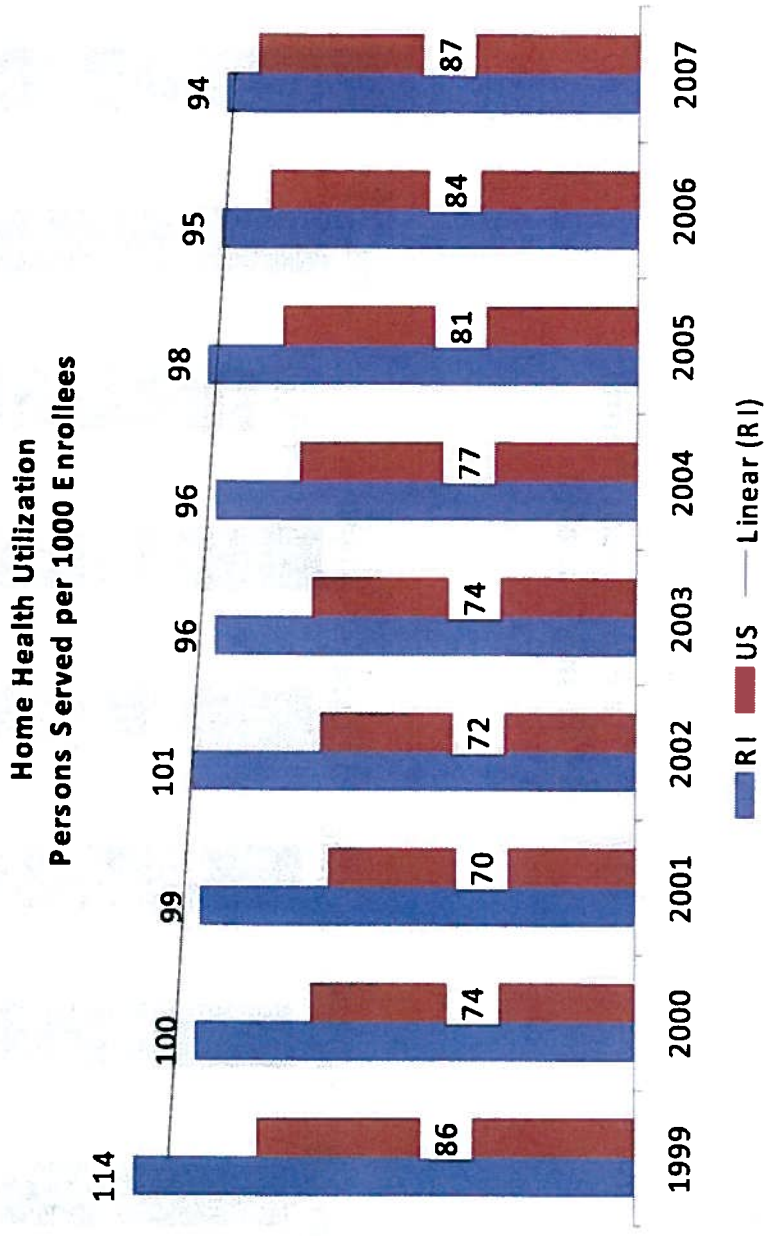


Data Source: Medicare Statistical Supplements various years; NP calculations

**Medicare home health utilization in RI has had a continual downward trend since its peak in 1999**

**Program Note**

- This is an indication that medicare payment levels are not attractive to drive additional capacity
- Medicaid payment structures may need to be sufficient to build net new capacity rather than absorbing existing marginal capacity
- Medicare payment bundling may have an impact on utilization



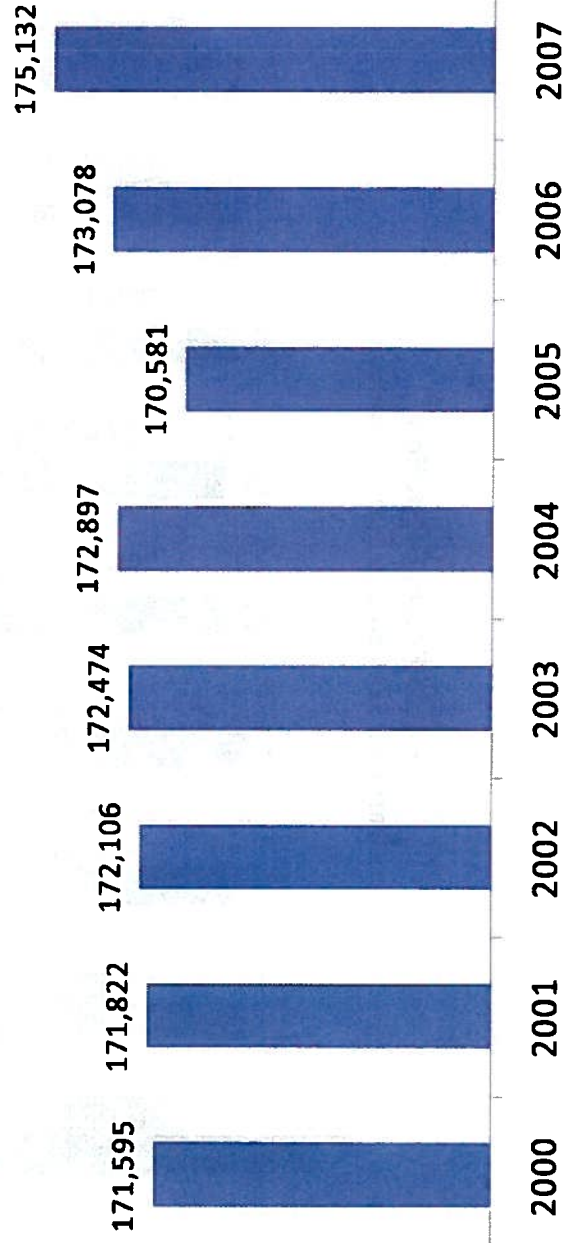
## Medicare enrollment has grown by 2%

Data Source: Medicare Statistical Supplements various years; NP calculations

### Program Note

- Track population trends

### RI Medicare Enrollment Trends Aged and Disabled



Data Source: Medicare Statistical Supplements various years; NP calculations

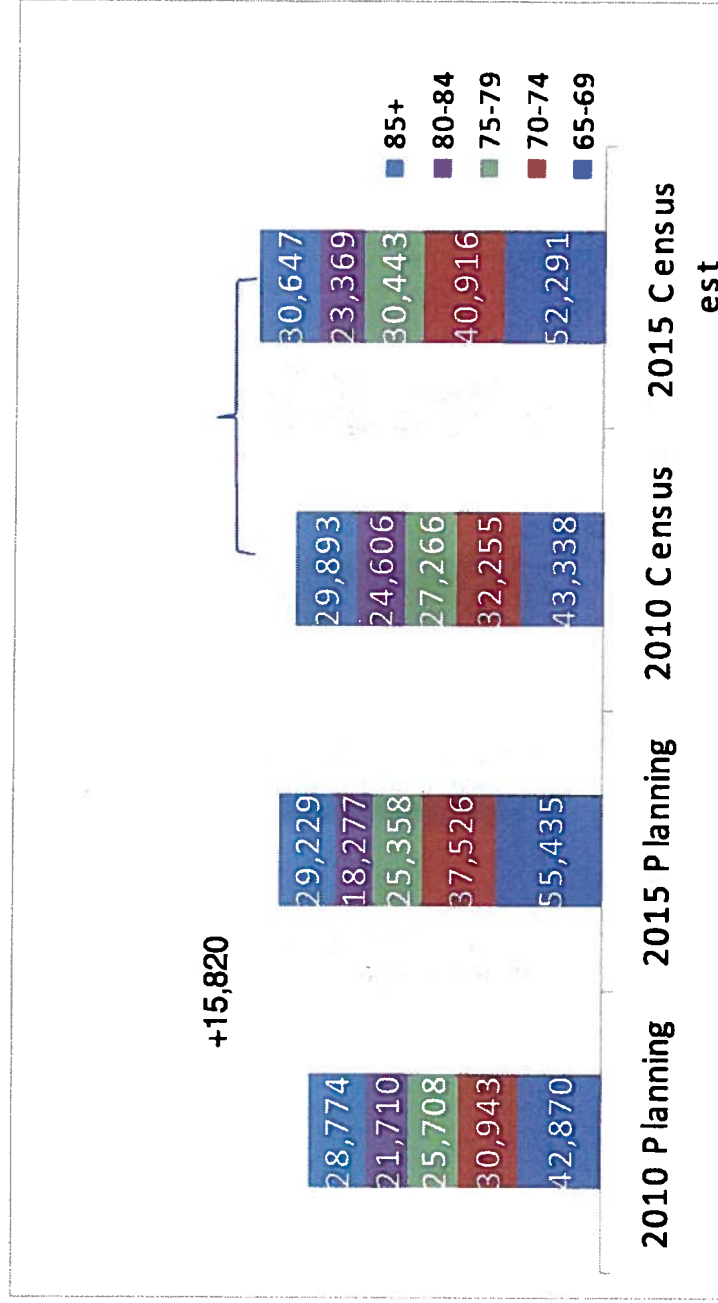
## Population forecasts – medicare eligible by age to 2015

Note: this excludes medicare eligibles due to an SSI determination

- SSI represents approximately 30,000 people in the medicare program in RI
- RI Division of Planning forecast projects an increase of 15,820 in the age cohort 65 +
- Census Bureau forecasts projects 20,307 in this same cohort

### Program Note

- "Oldest old" population could increase 1.5% to 2.4% or from approximately 450 to over 730
- Could trigger demand for SNF facilities



Data Source: Medicare Statistical Supplements various years; NP calculations

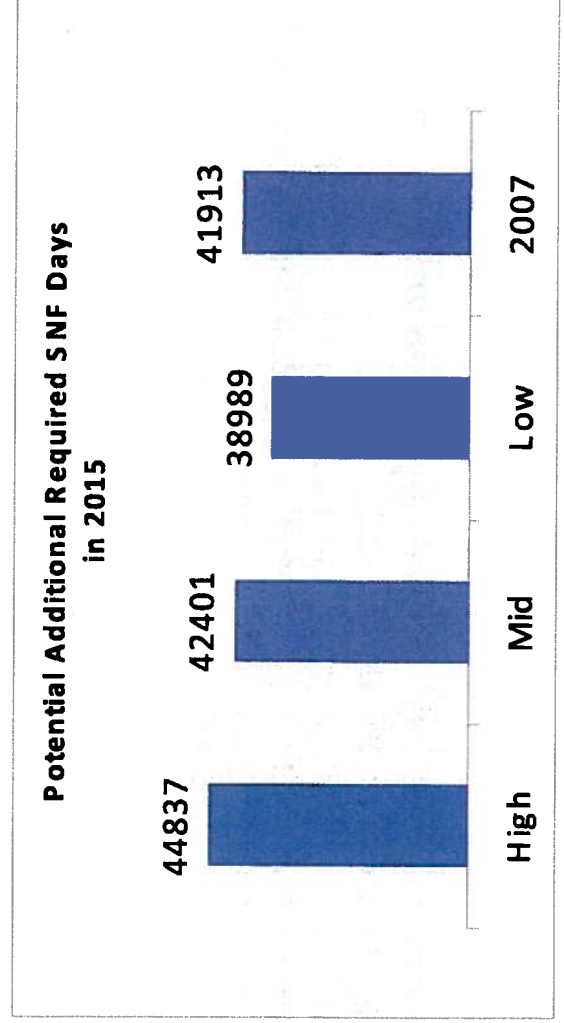
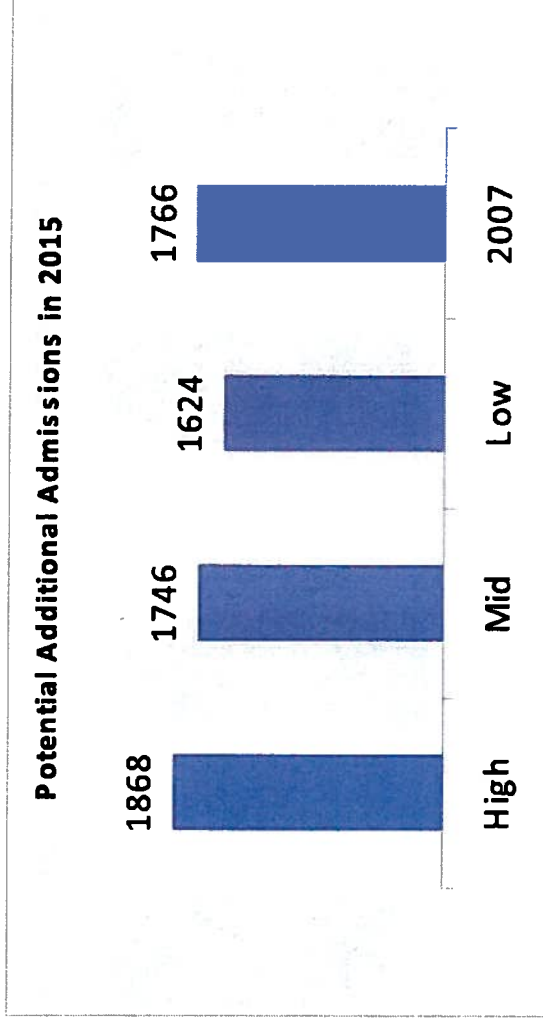
## Potential demand implications for Medicare SNF

- SSI is excluded because the annual additions vary between 1000 to 2000 additions per year and is not material to the forecast
- Forecast is based on 2007 and high/low /midpoint utilization rates

### Program Note

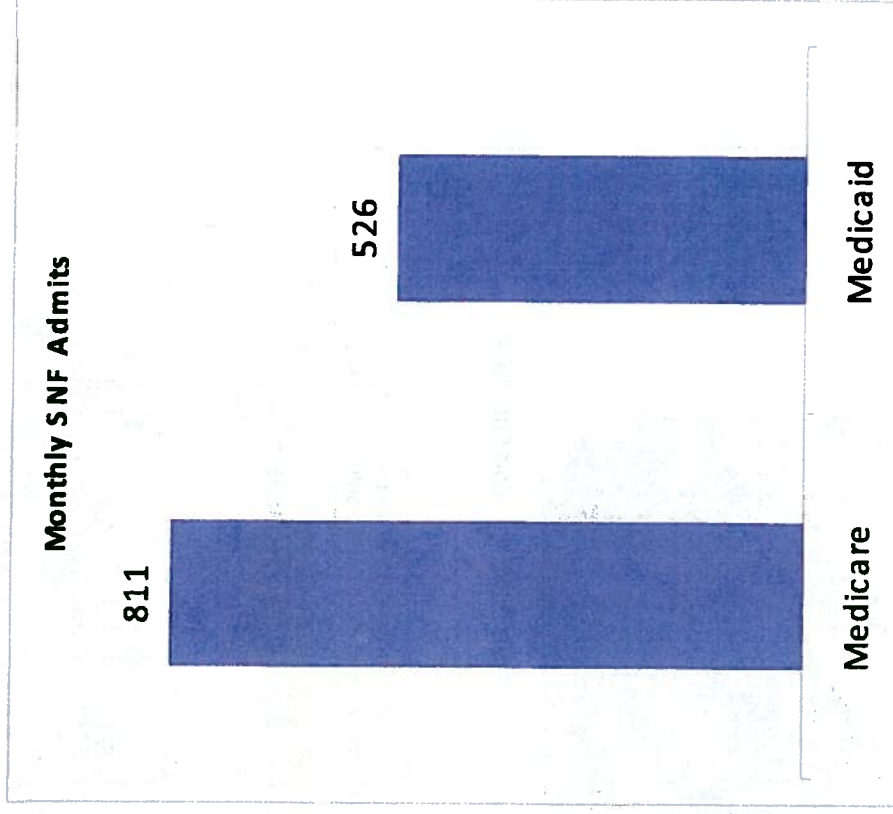
- Monitor SNF utilization across all payers particularly considering growth in "oldest old" population described earlier
- Pay particular attention to critical care beds

Data Source: Medicare Statistical Supplements various years; NP calculations



## Key comments and issues for consideration regarding SNFs

- RI has higher utilization rates than the nation so it is unlikely that there will be an increase in utilization by Medicare
- Increases are the result of the increase in the medicare eligible population – depending on the forecast between 11% and 13% in the next 5 years
- Important factors to consider
  - How medicare NH beds are “taken down”
    - 8581 beds in the system - nearly all are dually certified
    - Distribution of critical care beds across nursing homes
    - Distribution of medicare across nursing facilities and relationship to critical care beds
  - How critical care beds are supported through some type of case mix adjustment rate setting
  - Determination of adequate post-acute discharge capacity to serve both the medicare and private pay markets on a monthly admit basis



Data Source: Medicare Statistical Supplements various years; NP calculations

## Program Notes

### Potential demand implications for Medicare home health services

- Unless there is a dramatic shift in reimbursement policy and staff availability there is little reason to believe that actual home health utilization by medicare will increase
- A key implication for the Medicaid program is going to be the reimbursement approach and level sufficient to support the development of additional capacity
- And whether that capacity gets shifted to serve medicare to meet a potential unmet demand of about 2000 more patients and approximately 47000 more visits

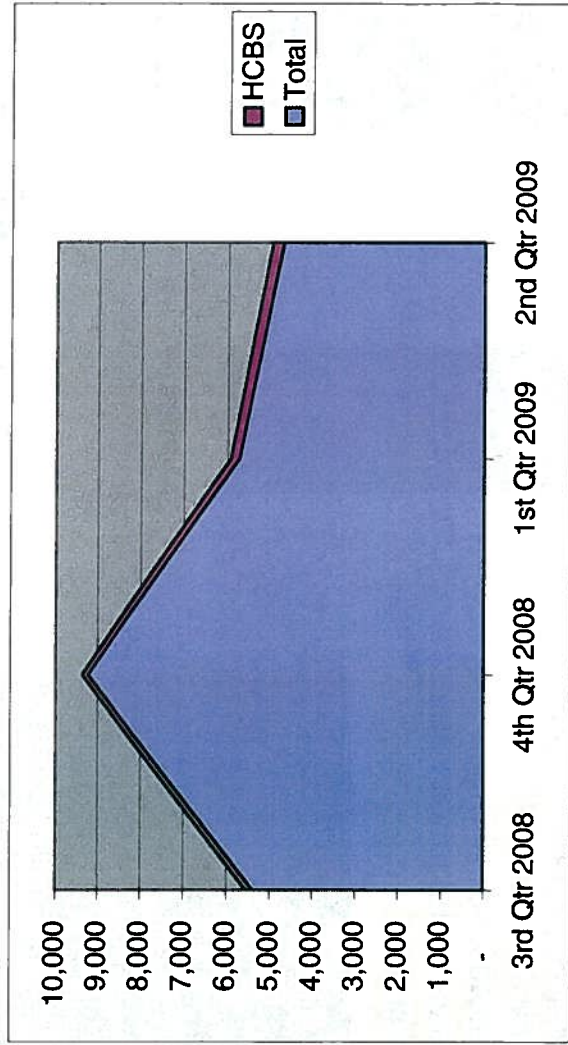
**Program Note**

Inferences: Point inquiries for HCBS as a % of total calls increased from 2.79% for the QE 9/30/08 to 5.19% for the QE 6/30/09 (includes: Adult Day Care, Care support, In-home Care, and Respite)

**Ask Rhody:**

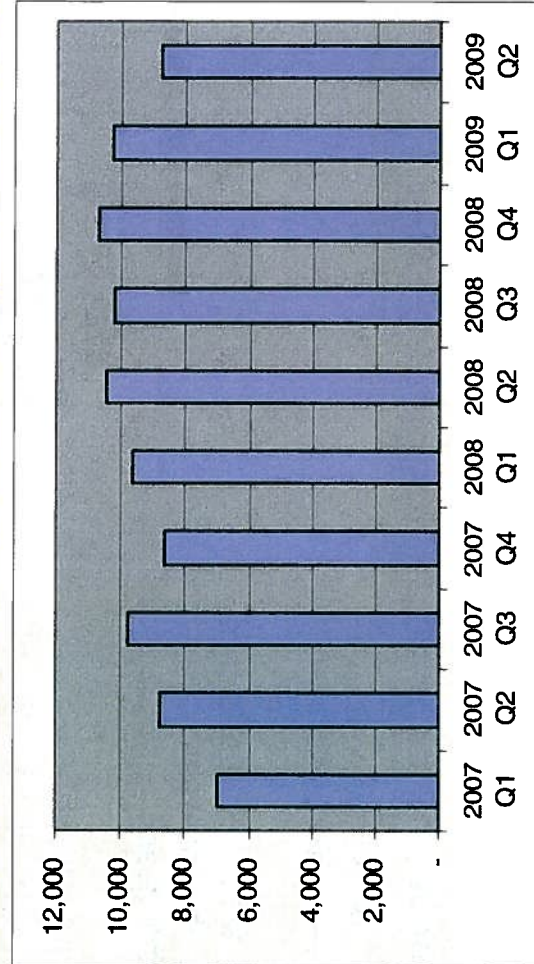
Inferences: Dip in Q2-2009 due largely to Ask Rhody being Off Line the first two weeks in June

**Total Calls to The POINT compared with the number of calls relating to HCBS**



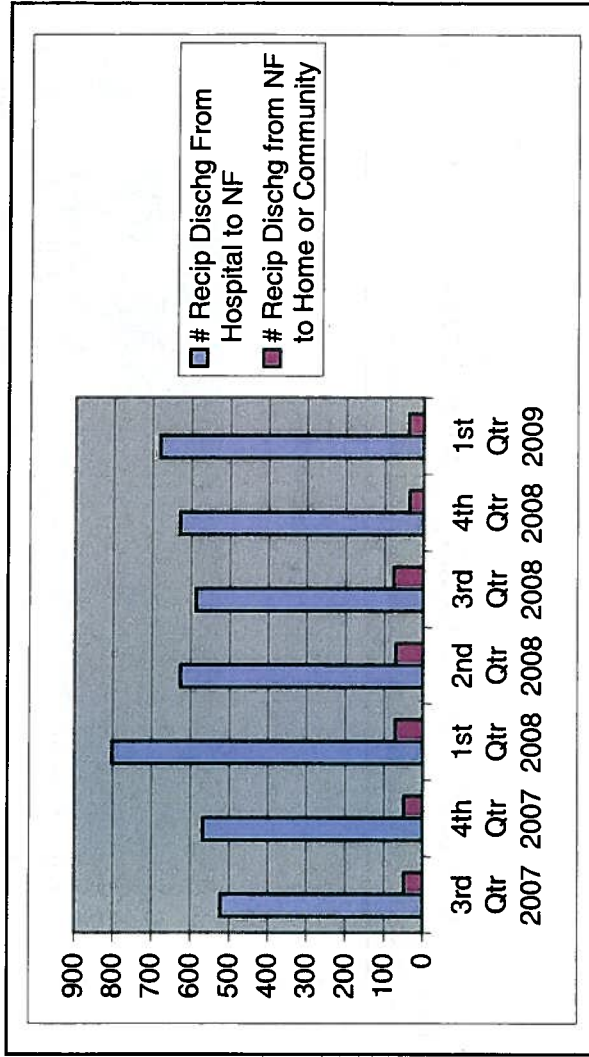
**Data Source-The Point:** Call counts from EDS Avaya Telephone system ; Nature of call from Avaya qualified codes - as entered for each call by operator. NOTE: only one topic can be entered

**DHS's www.AskRhody.org Website Visits**





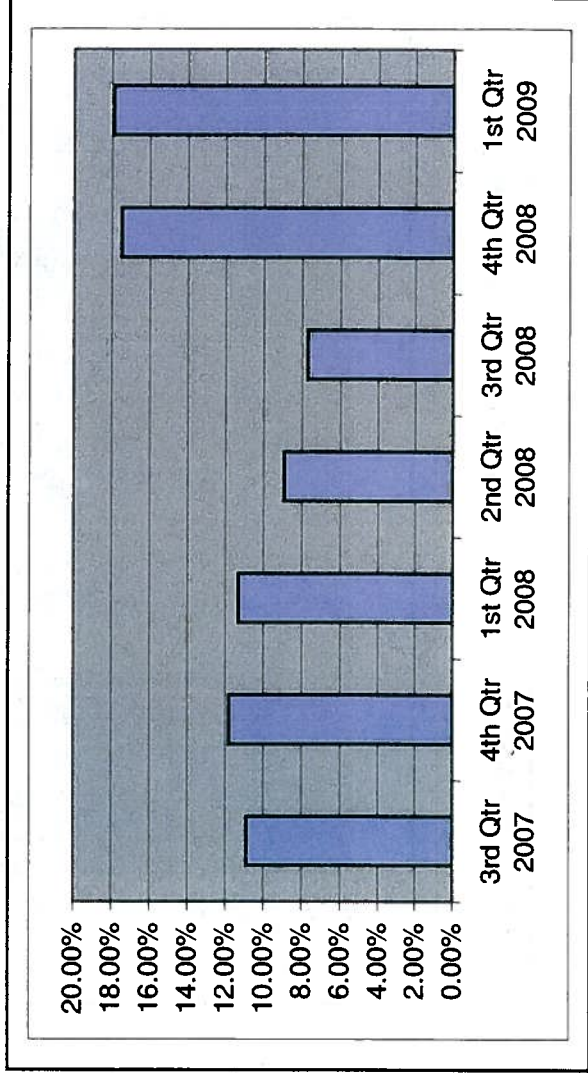
## Recipients Discharged from a Hospital to a Nursing Facility then to the Home or Community



### Program Note

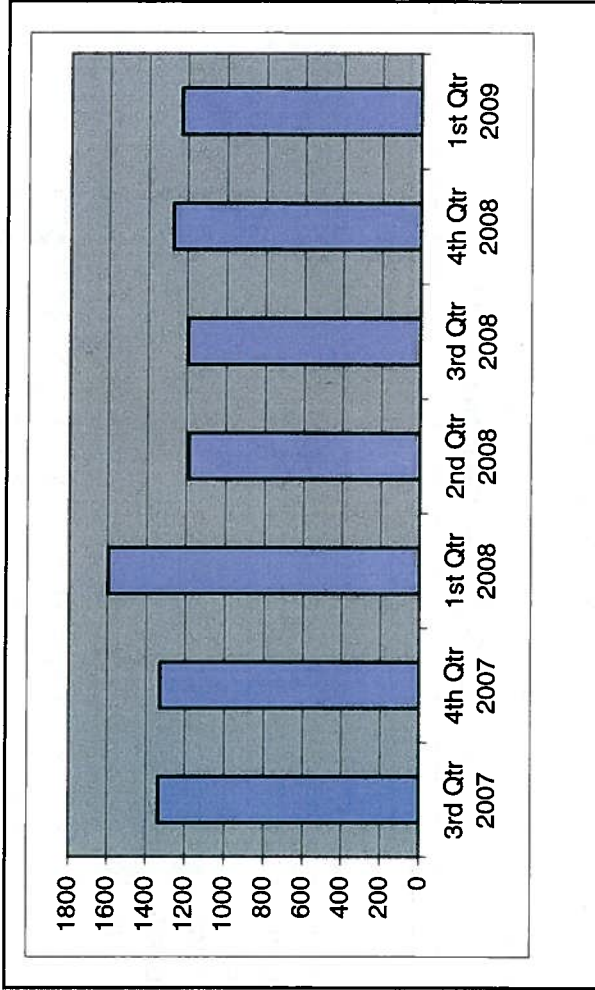
Inferences: Ave hospital discharge rate is 12.28% for seven quarters

## Hospital Discharge Rate

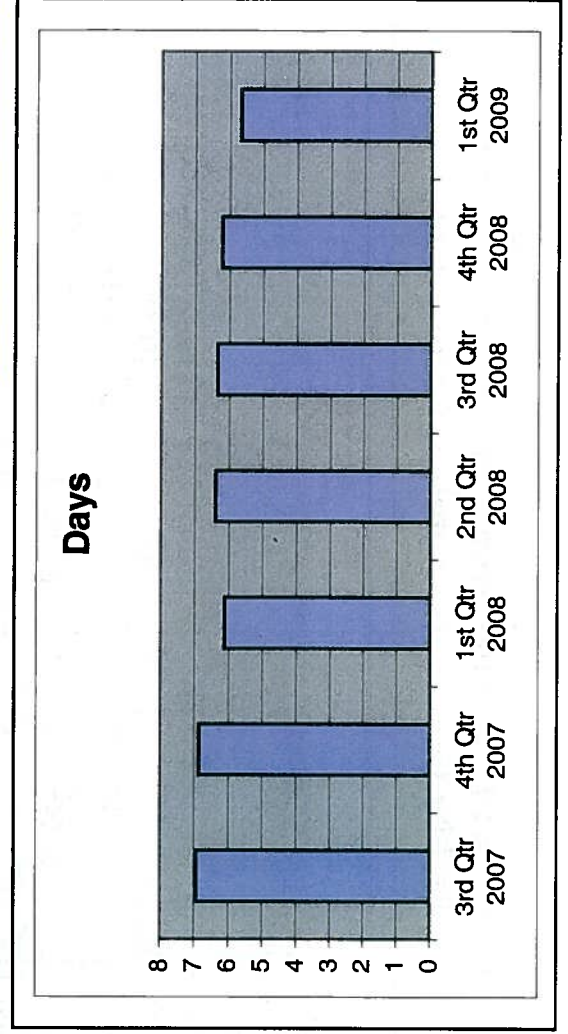


Data Source: MMIS

## LTC and HCBS Recipients Admitted to a Hospital



## LTC and HCBS Hospitalization-Average Length of Stay



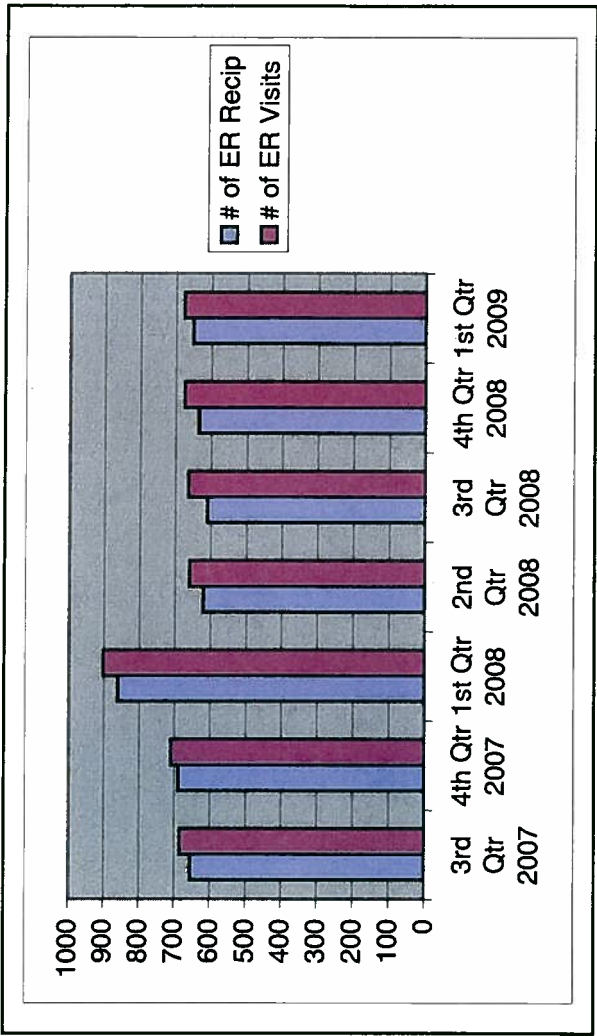
### Program Note

Inferences: An average of 1306 LTC and HCBS Recipients were Admitted to a Hospital over a period of seven quarters. LTC recipients include all categories that bill as a NF to include group homes & Eleanor Slater Hospital

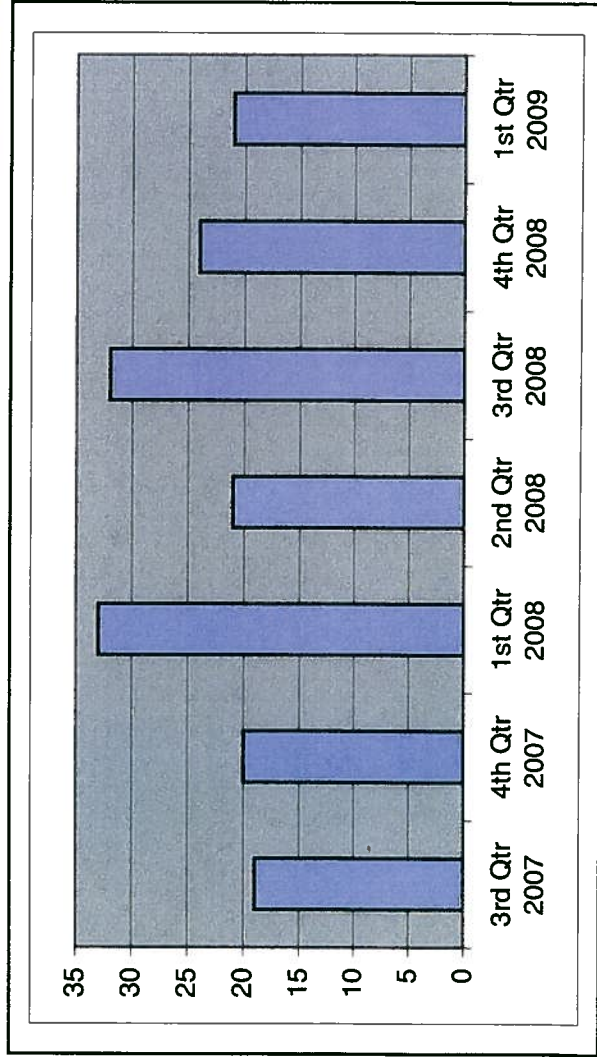
The average length of stay in a hospital for seven quarters for LTC and HCBS Hospitalization is 6.36 days.

Data Source: MMIS

**LTC and HCBS Recipients Emergency Room Data**



**LTC and HCBS Hospitalization- Number of Recipients Admitted with Depression**



**Program Note**  
 Inferences:  
 Repeat emergency room visits are 5.24% for seven quarters

An average of 24.3 people were admitted for depression for seven quarters. This represents 1.86% of admissions

Data Source: MMIS

