
Rhode Island Annual Medicaid Expenditure Report

Executive Office of Health and Human Services

July 2014

Medicaid Annual Expenditure Report

Statutory Mandate

R.I.G.L.42-7.2-5(d), the authorizing statute for the Executive Office of Health and Human Services (EOHHS), requests the Secretary to:

“Beginning in 2006, prepare and submit to the governor, the chairpersons of the house and senate finance committees, the caseload estimating conference, and to the joint legislative committee for health care oversight, by no later than March 15 of each year, a comprehensive overview of all Medicaid expenditures, outcomes, and utilization rates.

The overview shall include, but not be limited to, the following information:

- (i) Expenditures under Titles XIX and XXI of the Social Security Act, as amended;*
- (ii) Expenditures, outcomes and utilization rates by population and sub-population served (e.g. families with children, children with disabilities, children in foster care, children receiving adoption assistance, adults with disabilities, and the elderly);*
- (iii) Expenditures, outcomes and utilization rates by each state department or other municipal or public entity receiving federal reimbursement under Titles XIX and XXI of the Social Security Act, as amended; and*
- (iv) Expenditures, outcomes and utilization rates by type of service and/or service provider.*

The directors of the departments, as well as local governments and school departments, shall assist and cooperate with the secretary in fulfilling this responsibility by providing whatever resources, information and support shall be necessary.”

Purposes of the Expenditure Report

The purposes of this report include the following:

- ❖ 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.
- ❖ Identify areas in the Medicaid program where the state has flexibility and control over the scope, amount and duration of coverage and services.
- ❖ Establish a standard format for tracking and evaluating trends in annual Medicaid expenditures within and across departments.

Executive Summary (page 1 of 4)

Overview

During SFY 2013 Rhode Island's Medicaid program served approximately 230,000 Rhode Islanders, with an average of 195,000 enrolled at any one time. Twenty-two percent of Rhode Island's population were enrolled in Medicaid for some part of SFY 2013. Program expenditures for SFY 2013 totaled approximately \$1,785 million.

Medicaid expenditures are divided among several state agencies, with \$1,370 million of expenditure managed in SFY 2013 by the Rhode Island Executive Office of Health and Human Services (EOHHS), and \$370 million managed by the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH). Under the Medicaid program, the federal government is typically responsible for approximately half of total expenditure. In SFY 2013 the Federal Medical Assistance Percentage (FMAP) was 51.48%.

Key Findings:

- ❖ Enrollment has increased 2.8% per year on average over the last five years, from 175,000 average eligibles in SFY 2009 to 195,000 average eligibles in SFY 2013.
- ❖ Per member per month (PMPM) costs have decreased 1.5% per year over the same period, from \$808 to \$762.
- ❖ Hospitals and nursing facilities account for nearly half (47%) of Medicaid expenditure.
- ❖ Adults with disabilities account for 37% of expenditure. Elders account for another 27%.
- ❖ Over three-quarters of Medicaid recipients are enrolled in managed care programs.
- ❖ Claims expenditures are highly concentrated – the top 7% of users account for 66% of claims expenditure

Between SFY 2009 and 2013, total Rhode Island Medicaid medical expenditures based on date of service have increased an average of 1.3 percent per year. This overall expenditure increase is associated with a 2.8 percent average annual increase in enrollment combined with a 1.5 percent overall average decrease in per member per month (PMPM) costs. The increase in enrollment and the decrease in PMPM can be added together to determine average annual expenditure growth.

Enrollment has been steadily increasing since SFY 2009. PMPM costs have decreased each year since SFY 2010, resulting in SFY 2013 PMPM costs that are lower than they were 5 years ago. These expenditure trends compare quite favorably to both national Medicaid expenditures and state commercial per member per month cost trends.

Definition of average annual rates methodology: This report shows trends in terms of an average annual trend rate based on five years of historical data in order to emphasize longer term trends rather than year to year variation. An average annual increase of 1.0% per year from 2009 to 2013 is equivalent to an increase of 4.1% in total from 2009 to 2013.

Executive Summary (page 2 of 4)

Populations Served

Medicaid serves four different primary populations, each with very different service needs and PMPM cost experience.

- ❖ **Elders** includes adults over age 65, 96% of whom are also covered by Medicare. Elders account for \$484 million in total SFY 2013 Medicaid expenditure, and the highest average cost per member per month (PMPM) of \$2,230. For this population, nursing facilities account for nearly two-thirds (66%) of expenditures. For elders covered by both Medicaid and Medicare, Medicare is the primary payer for most acute and primary care services while Medicaid pays for services not paid for by Medicare (e.g., extended nursing home stays, home and community supports).
- ❖ **Adults with disabilities** includes adults under age 65 who have identified disabilities. Adults with disabilities account for the largest share of expenditure, with SFY 2013 expenditure of \$667 million, and an average PMPM cost of \$1,793. The largest components of expenditure for this population are residential and rehabilitation services for persons with developmental disabilities (27%) and hospital care (24%). Almost half (48%) of this population is also covered by Medicare.
- ❖ **Children and families** includes low income children, parents and pregnant women who meet specific income requirements. Children and families account for 69% of total enrollment and 26% of total expenditure, with total SFY 2013 expenditure of \$464 million. Additionally, the federal match is increased to 66.03% for qualifying “optional” low income children and pregnant women under the Children’s Health Insurance Program (CHIP).
- ❖ **Children with special health care needs (CSHCN)** includes individuals under 21 who are eligible for SSI (Supplemental Security Income), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. These children account for 10 percent of total Medicaid expenditures and 6 percent of enrollees, with SFY 2013 expenditures of \$171 million. Expenditures on this population are dominated by professional behavioral health services, which account for just under half (44%) of total expenditures.

Medicaid Providers

Medicaid pays for services offered by a variety of providers. Hospitals and nursing facilities together account for nearly half of program expenditure. Key contributors to expenditure growth were nursing facilities and professional providers.

- ❖ Hospitals were the largest provider type, accounting for 27% of Medicaid expenditure in SFY 2013. Hospital payments have been a key driver of Medicaid expenditure growth, however hospital payments have decreased since SFY 2011, resulting in an average growth rate of 1.5% per year over the last 5 years.
- ❖ Nursing facilities were the next largest provider type, accounting for 20% of expenditure in SFY 2013. Expenditure on these providers has been increasing on average 3.2% per year between SFY 2009-2013. Over the same period, nursing facility admissions per thousand for the Elders population have decreased by 2.5% per year.

Executive Summary (page 3 of 4)

Managed Care

It is important to note that not all payments are made directly by Medicaid to service providers. In SFY 2013, 77% of Medicaid eligibles were enrolled in managed care plans. These enrolled populations accounted for 49% of Medicaid expenditure.

- ❖ Children and families who are not eligible for employer sponsored or Medicare coverage are nearly all enrolled in managed care plans.
- ❖ Starting in 2008, children with special health care needs without other insurance coverage were required to enroll in managed care plans, resulting in 80% of this population now enrolled in managed care. In addition, new managed care programs were established in 2008 to transition Medicaid eligible adults with disabilities to managed care. In SFY 2013, 47% of Medicaid-eligible adults with disabilities were enrolled in managed care.
- ❖ In September 2013 the National Committee for Quality Assurance (NCQA) recognized the performance of both of Rhode Island's participating Medicaid Managed Care Health Plans within the "Medicaid Top Ten" ranking of Medicaid Health Plans nationwide.

Long Term Services and Supports

Long term services and supports (LTSS) includes both institutional care and home and community based services (HCBS). Expenditures on LTSS account for about 41% of total Medicaid expenditure (\$741 million) in SFY 2013. HCBS are services provided to at-risk populations as alternatives to more costly nursing home/institutional options.

Optional Services

Under federal guidelines, there are "mandatory" populations and services that all state Medicaid programs must cover to receive federal matching payments. States may obtain federal matching funds for covering "optional" groups of individuals and services. Most of the expenditure on optional services is designed to reduce expenditure for mandatory services.

- ❖ Optional services accounted for \$529 million of Medicaid expenditures in SFY 2013, about 30% of total. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services.
- ❖ The largest component of optional services is residential and rehabilitation services for persons with developmental disabilities, including group homes, accounting for \$209 million (40%) of optional services spending.
- ❖ Other optional services include home and community based services, professional behavioral health services, hospice, dental, and transportation services.

Executive Summary (page 4 of 4)

High Cost Users

Medicaid claims expenditures are highly concentrated, as the top seven percent of users account for nearly two-thirds (66%) of claims expenditures.

- ❖ High cost users are defined as those who incur \$25,000 or more per year in Medicaid claims expenditure. These high utilizers typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- ❖ Eighty-three percent of claims expenditure for high cost users is for Elders and Adults with Disabilities. The largest categories of claims expenditure for high cost users are nursing facilities and residential and rehabilitation facilities for persons with developmental disabilities.

Utilization

Individuals covered by both Medicare and Medicaid are known as MMEs (Medicaid Medicare Eligibles – also referred to as “duals”). Medicare is the primary payer for most medical services (e.g. hospital, physician, pharmacy) for 96% of elders and for 48% of adults with disabilities. Medicaid pays for services not paid for by Medicare (e.g. extended nursing home stays, home and community based services). For non-MMEs (persons covered only by Medicaid), Medicaid pays for all covered services.

- ❖ For MME elders, nursing home admissions decreased 2.5% per year on average between SFY 2009-13 while hospice admissions per thousand increased by 1.6% per year on average. Nursing home admissions are five times higher than hospice admissions per thousand.
- ❖ For Non-MME adults with disabilities, emergency room visits per thousand have decreased 3.3% per year and inpatient admissions per thousand have decreased 0.6% per year on average over the last 5 years. Over the same period office visits per thousand have increased 9.3% per year on average.
- ❖ For children and families and for children with special healthcare needs, inpatient admissions and emergency room (ER) admissions have decreased or remained flat over the last 5 years while office visits per thousand have increased.

Variance to Other Reports: 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. Reasons for variance might include factors such as claim completion and rounding.

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends
- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population
- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Long Term Services and Supports
- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail
- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

1a. Total Medicaid Expenditures, SFY 2013

Medicaid expenditures total approximately \$1,785 million.

Summary: Total Medicaid Expenditures for Covered Services SFY 2013 - \$ Millions

Total SFY 2013
Medicaid Expenditure:
\$1,785 M

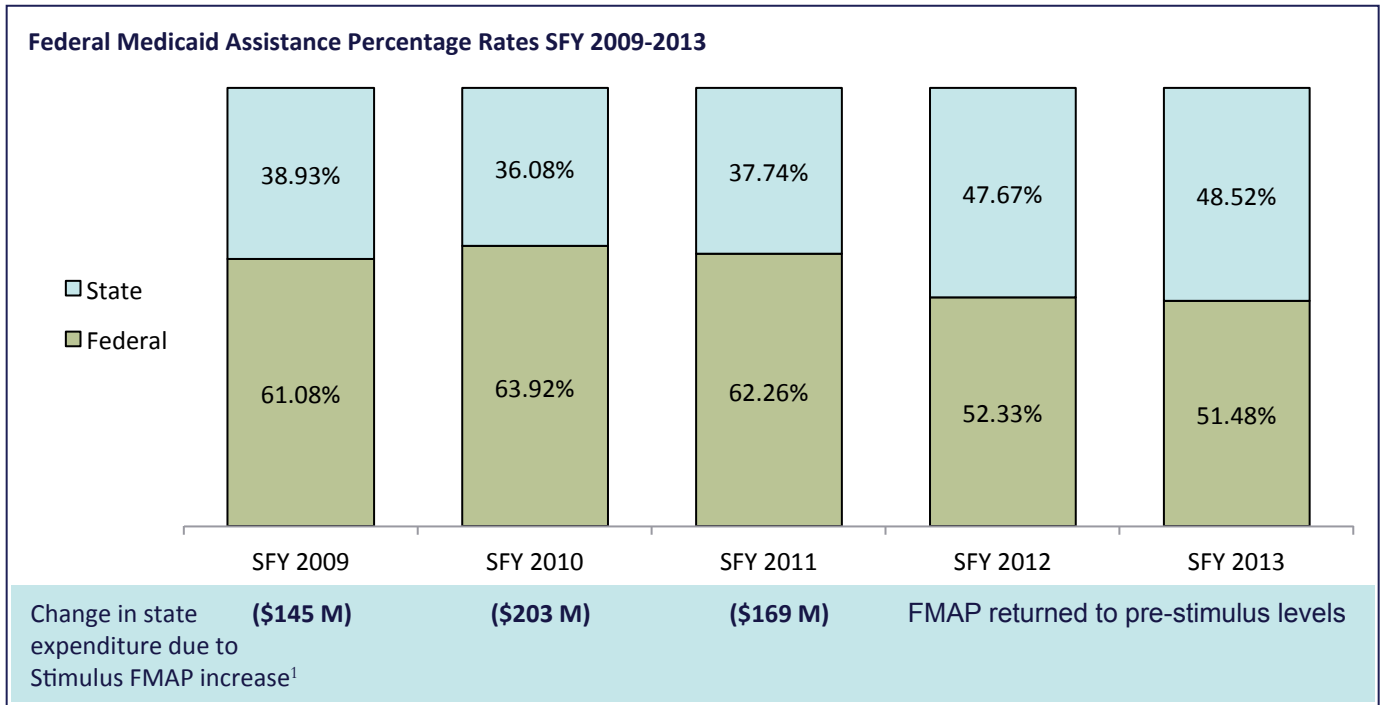
Excluded from this Analysis:

\$128 M Disproportionate Share Hospital payments (DSH)
\$40 M Costs Not Otherwise Matchable (CNOM)
\$20 M Local Education Authorities (LEAs)
(see Appendix for more detail on DSH, CNOM and LEAs)

- ❖ In state fiscal year 2013, Rhode Island incurred approximately \$1,785 million in Medicaid expenditures. This expenditure was split between state and federal funds. This report includes all Medicaid expenditures, including both state and federal funds.
- ❖ The analysis in this report excludes \$128 million in DSH (Disproportionate Share Hospital) payments, \$40 million in costs not otherwise matchable (CNOM), and payments of \$20 million to LEAs (Local Education Authorities). More detail on the DSH, LEA, and CNOM payments is provided in the Appendix.
- ❖ The following report contains a variety of analyses describing the different elements of Rhode Island's Medicaid program in order to provide a common understanding of the key elements of Medicaid expenditure and areas of expenditure growth.

1b. Federal Medicaid Assistance Percentage (FMAP) Trends

The State of Rhode Island is typically responsible for just under half of Medicaid expenditures. State share was reduced due to stimulus funding for SFY 2009-2011, but returned to base levels in SFY 2012-13.

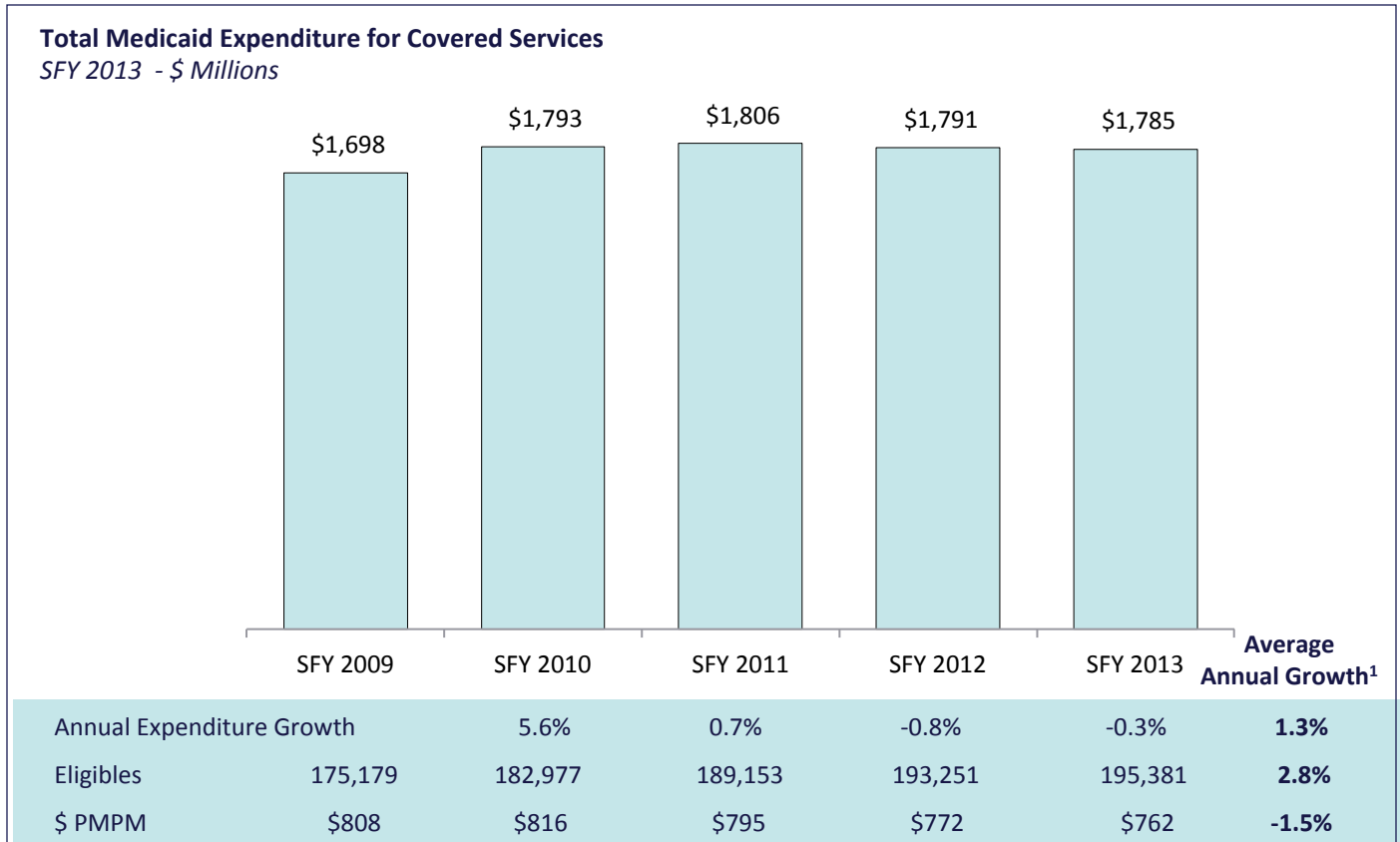


- ❖ While this report will review trends in total Medicaid medical expenditure, it is important to recognize that less than half of this expenditure falls to the Rhode Island budget. Funding is split between state and federal dollars, with Rhode Island typically responsible for just under half of all program expenditures.
- ❖ Stimulus funding increased FMAP by 11.42% percentage points between October 1, 2008, and December 31, 2010. The stimulus increase resulted in a substantial reduction in the state share of Medicaid expenditure for SFY 2009-11. In SFY 2012, FMAP returned to pre-stimulus levels of 52.33%. The slight decrease in FMAP from SFY 2012-2013 is due to a reduction in federal matching levels.
- ❖ There are two instances of variation from the FMAP levels shown above:
 - The federal match is enhanced for qualifying low income children and pregnant women under the CHIP program. CHIP is designed to provide insurance coverage to "targeted low-income children and pregnant women" from families with incomes up to 250% of the federal poverty level who are uninsured and not otherwise eligible for Medicaid. In SFY 2013, Rhode Island received a 66.03% combined CHIP/FMAP federal match on 21,144 "optional" children and pregnant women who are in families with incomes above mandatory coverage levels.
 - In October 2011, Rhode Island received federal authority for Health Home services. This authority established two Health Home providers in RI - CEDARR Family Centers and Community Mental Health Organizations. Health Home services are matched at ninety percent (90%) for eight (8) quarters by the federal government. This only affected the first quarter of SFY 2013.

¹Analysis based on FMAP only – does not include CHIP match. Increase calculated as the difference between actual state expenditure and the amount the state would have spent without the federal stimulus increase to FMAP.

1c. Medicaid Expenditure Trends, SFY 2009-2013

Over the past five years, Rhode Island Medicaid per member per month (PMPM) costs have been decreasing an average 1.5 percent per year.

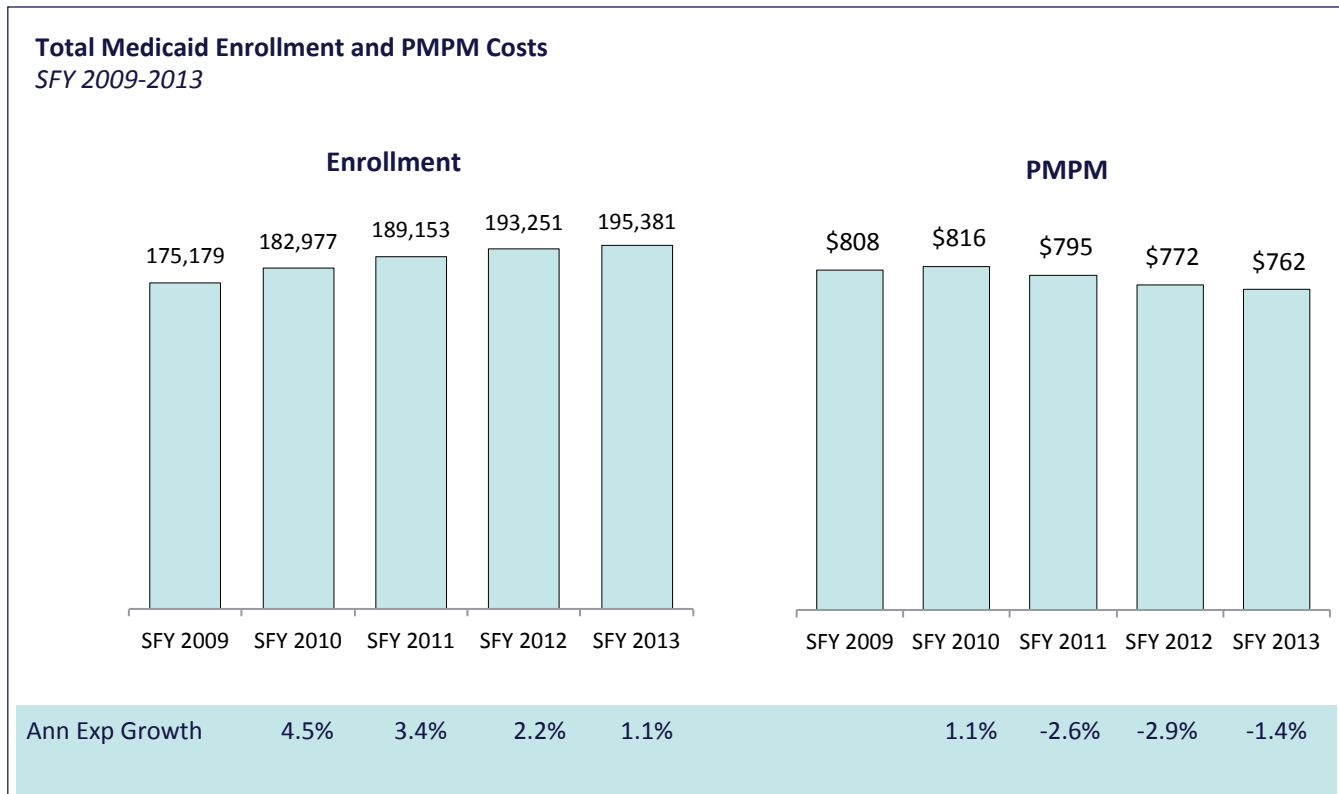


- ❖ Overall Medicaid expenditures have increased by approximately 1.3 percent per year over the last five years. However, from SFY 2011-2013 total expenditures have decreased.
- ❖ Note that the overall expenditure trend is broken down into per member per month (PMPM) cost trend and enrollment trend, which can be added together to determine average expenditure trend.
 - Enrollment has increased steadily over the five year period for a five-year average growth of 2.8% per year.
 - PMPM costs increased from 2009 to 2010, but then decreased from 2010 to 2013. Over the five year period, PMPM costs have decreased at an average annual rate of 1.5%.

¹Calculated as compounded annual growth rate (CAGR) over period SFY 2009-2013 as shown.

1c. Total Medicaid Enrollment and PMPM Cost Trends, SFY 2009-2013

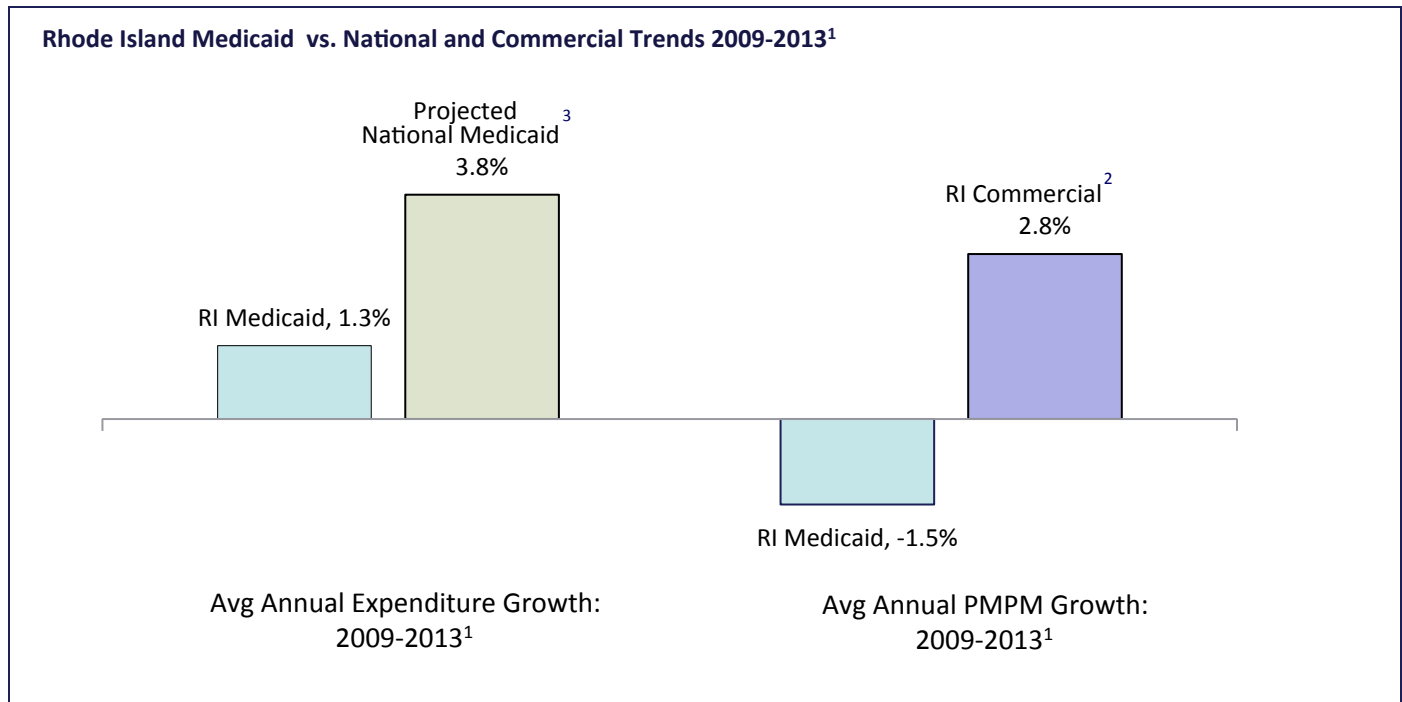
Enrollment has increased each year since SFY 2009 while PMPM costs have been declining each year since SFY 2010.



- ❖ Nearly all of the SFY 2011-2013 increase in total Medicaid expenditure is due to increases in enrollment.
- ❖ Between SFY 2006 and 2009 enrollment declined 1-2% per year. However a 4.5% increase in enrollment from SFY 2009 to 2010 brought enrollment back to 2006 levels. Enrollment continued to increase from SFY 2010-2013, but at progressively slower rates.
- ❖ PMPM costs increased from SFY 2008-2010 at about 1% per year. However PMPM costs have been declining annually since SFY 2010 and are lower in SFY 2013 than they were 5 years ago.

1c. RI Medicaid Expenditure Trend vs. National, Regional Benchmarks

RI Medicaid trends are notably low as compared to national Medicaid and regional Commercial experience.



- ❖ Overall expenditure growth over the years 2009-2013 compares very favorably to national Medicaid expenditure trend. According to Centers for Medicare & Medicaid Services (CMS), Medicaid national expenditure trend over this time period increased an average 3.8% per year, vs. Rhode Island Medicaid's trend of 1.3%.
- ❖ RI Medicaid PMPM (per member per month) cost trends also compare favorably to local commercial benchmarks. Between SFY 2009 and 2013, Rhode Island's Medicaid program experienced a decrease in average annual PMPM cost of 1.5% per year. The average annual commercial medical PMPM cost for Rhode Island commercial health plans over a similar period increased 2.8% per year.
- ❖ The RI commercial benchmark may underestimate PMPM growth because it only includes total incurred claims reported by the carriers, not any out of pocket costs borne by members. Medicaid plans generally have very low, if any, out of pocket costs for members.

¹RI Medicaid data in SFY. National benchmarks in FFY. RI commercial benchmark in CY.

²Incurred claims per member per month, includes both small group and large group claims from Blue Cross Blue Shield RI, United Healthcare of New England and Tufts Health Plan. Source: Office of the Health Insurance Commissioner (OHIC), 2014 carrier rate filings.

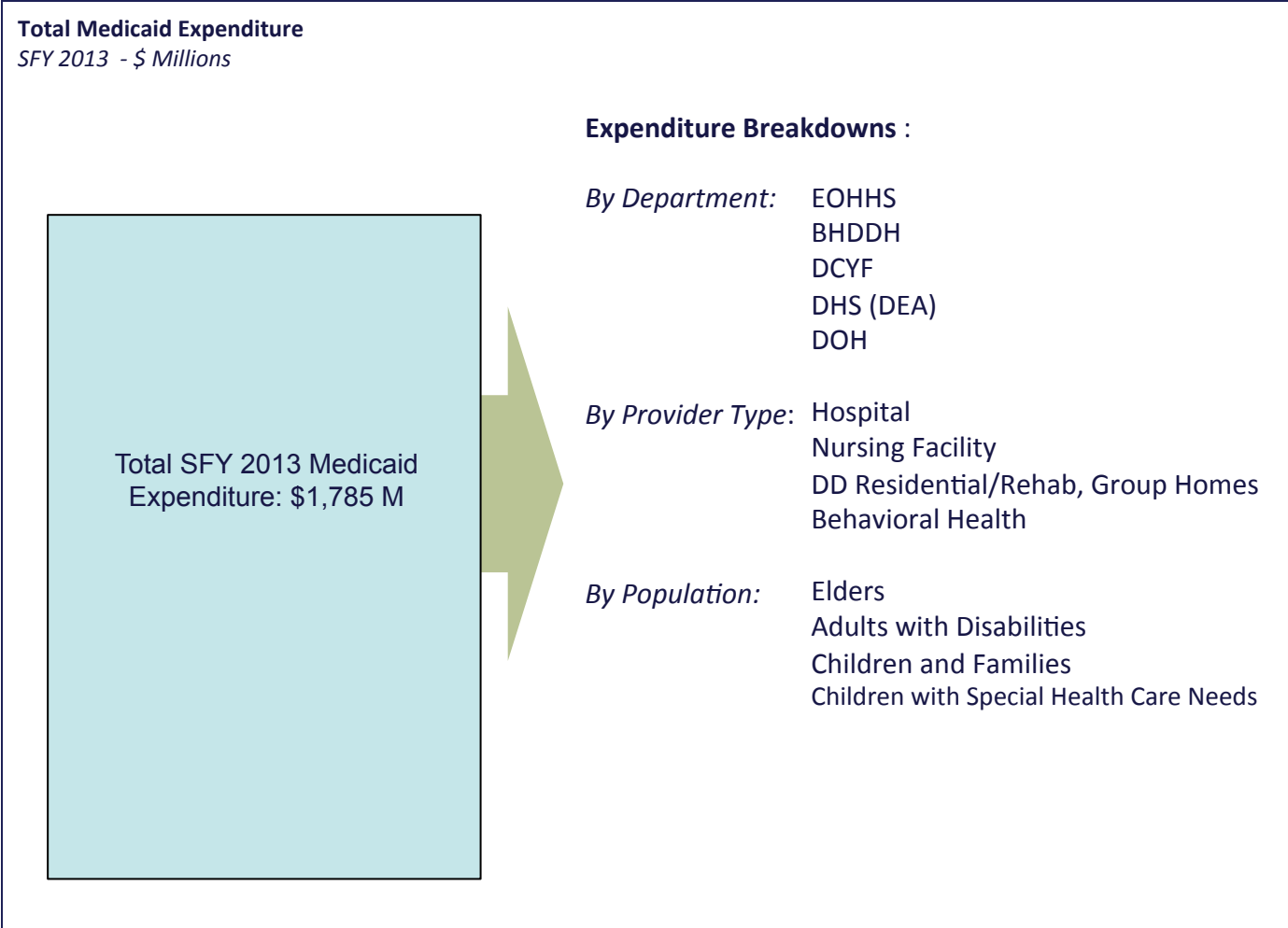
³Source: 2012 CMS National Health Expenditure Report. 2012 and 2013 data are projections.

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends
- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population
- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Long Term Services and Supports
- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail
- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

2. Expenditure Distributions

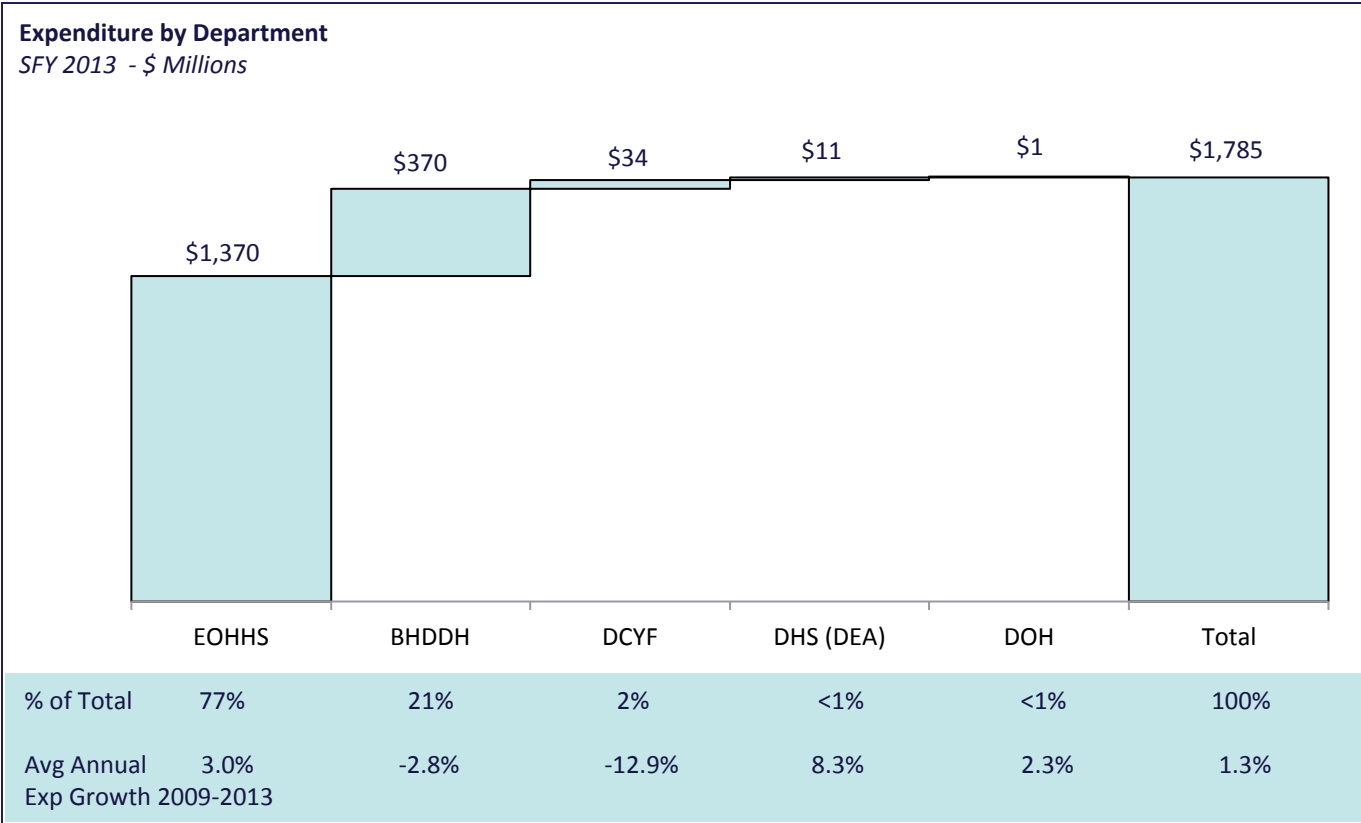
Medicaid expenditure can be broken down in several ways.



- ❖ Department refers to the state departments responsible for administering components of the Medicaid program. In 2012, the Department of Elderly Affairs (DEA) became a Division under the Department of Human Services (DHS). For the purposes of this report, DHS expenditures pertain to Medicaid expenditure through the Division of Elderly Affairs.
- ❖ Provider Type refers to the institution or the professionals performing the services.
- ❖ Population defines Medicaid recipients by age and category of need.

2a. Expenditure by Department

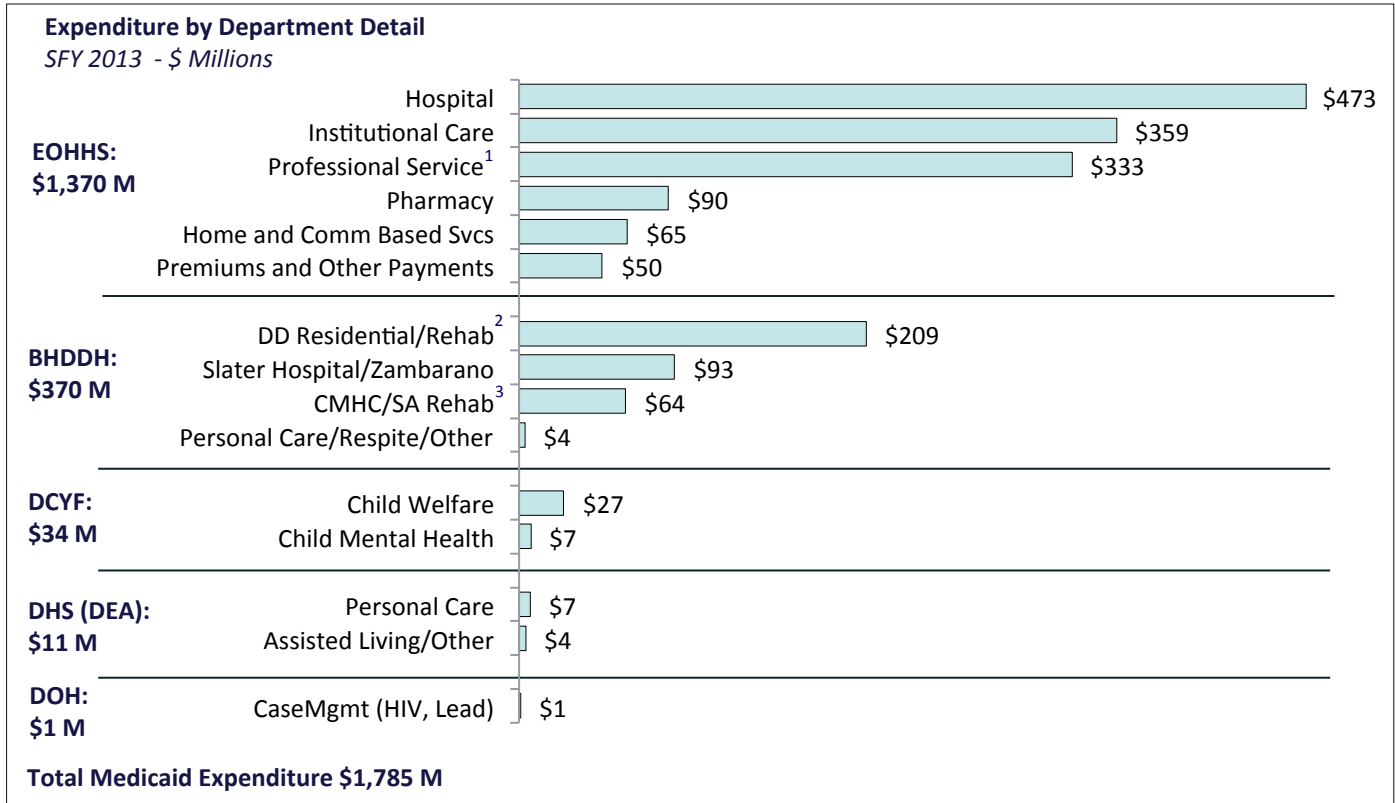
Medicaid services are administered through several state departments.



- ❖ In SFY 2013, 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), the Department of Children, Youth and Families (DCYF), the Division of Elderly Affairs in the Department of Human Services (DHS), and the Department of Health (DOH).
- ❖ The majority of expenditure (77%) is administered by EOHHS. This department is the lead administrator for the Medicaid contract with CMS. The Single State Medicaid Agency 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 expenditure (21%).
- ❖ Detail for each department is shown on the next page.

2a. Expenditure by Department: State Agency Detail*

Medicaid benefit expenditure detail for each of the departments is shown below.



- ❖ The majority of expenditure (77%) is administered by the Executive Office of Health and Human Services. EOHHS funds most traditional Medicaid services, providing funding for hospital-based services (35% of total EOHHS expenditure), institutional care (26% of total EOHHS), professional services, and pharmacy.
- ❖ The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers another 21% of total Medicaid expenditure. BHDDH expenditures include three primary areas: the management of Slater Hospital, residential facilities for persons with developmental disabilities, and community based behavioral health and substance abuse services.
- ❖ The Department of Children, Youth and Families (DCYF), accounts for \$33 Million (2%) of Medicaid expenditure. DCYF administers programs serving children in the child welfare system, children in substitute care and children with behavioral health conditions.

* 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 and rounding.

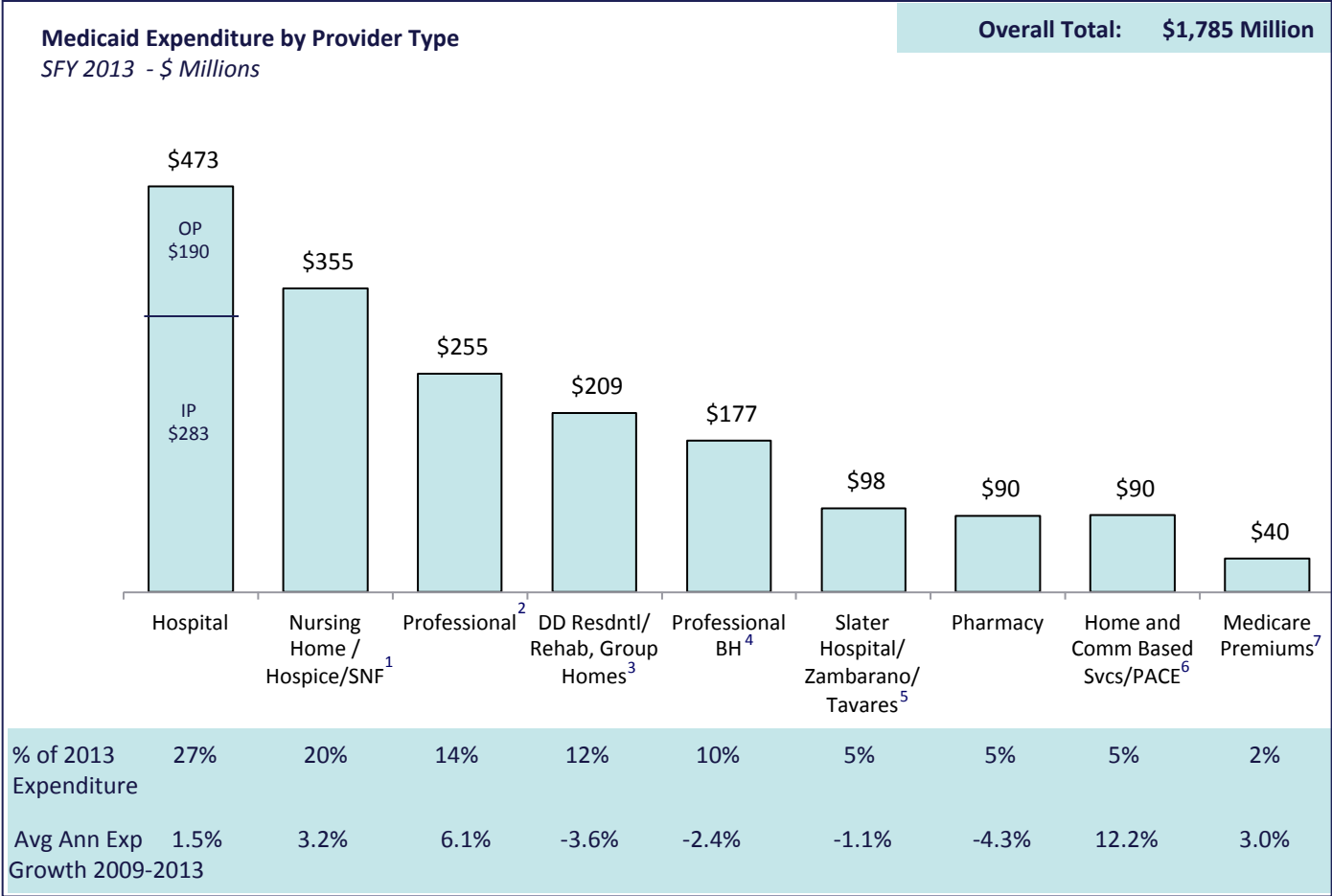
¹Includes professional services for behavioral health.

²DD Residential/Rehab is Residential and Rehabilitation Services for persons with developmental disabilities, which includes DD Group homes, DD rehabilitation (adult day care and adult day program), and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

³CMHC/SA Rehab is Community Mental Health Centers and Substance Abuse Rehabilitation.

2b. Expenditure by Provider Type

Medicaid program funds are used to reimburse a variety of providers. Together, hospitals and nursing facilities account for nearly half of program expenditure.



- ❖ The two largest provider types, accounting for nearly half (47%) of all RI Medicaid expenditure in SFY 2013, were hospitals and nursing facilities (including nursing homes, hospice, and skilled nursing facilities). Key contributors to expenditure growth were nursing facilities and professional providers.
- ❖ Hospitals were the largest provider type, accounting for 27% of Medicaid expenditures in SFY 2013. Hospital payments have been a key driver of Medicaid expenditure growth in the past, however payments have been decreasing in the last 3 years from a high of \$511 M in SFY 2011 to \$473 M in SFY 2013.

¹SNF: Skilled Nursing Facility

²Professional includes, but is not limited to, Physician, Dental, DME/Supplies, X-Ray/Lab/Tests, and Ambulance.

³DD Resdntl/Rehab is Residential and Rehabilitation Services for persons with developmental disabilities and includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

⁴Professional Behavioral Health includes DHS, BHDDH and DCYF expense including, but not limited to, Professional Mental Health/Substance Abuse, CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation), CMHC, and Residential DCYF.

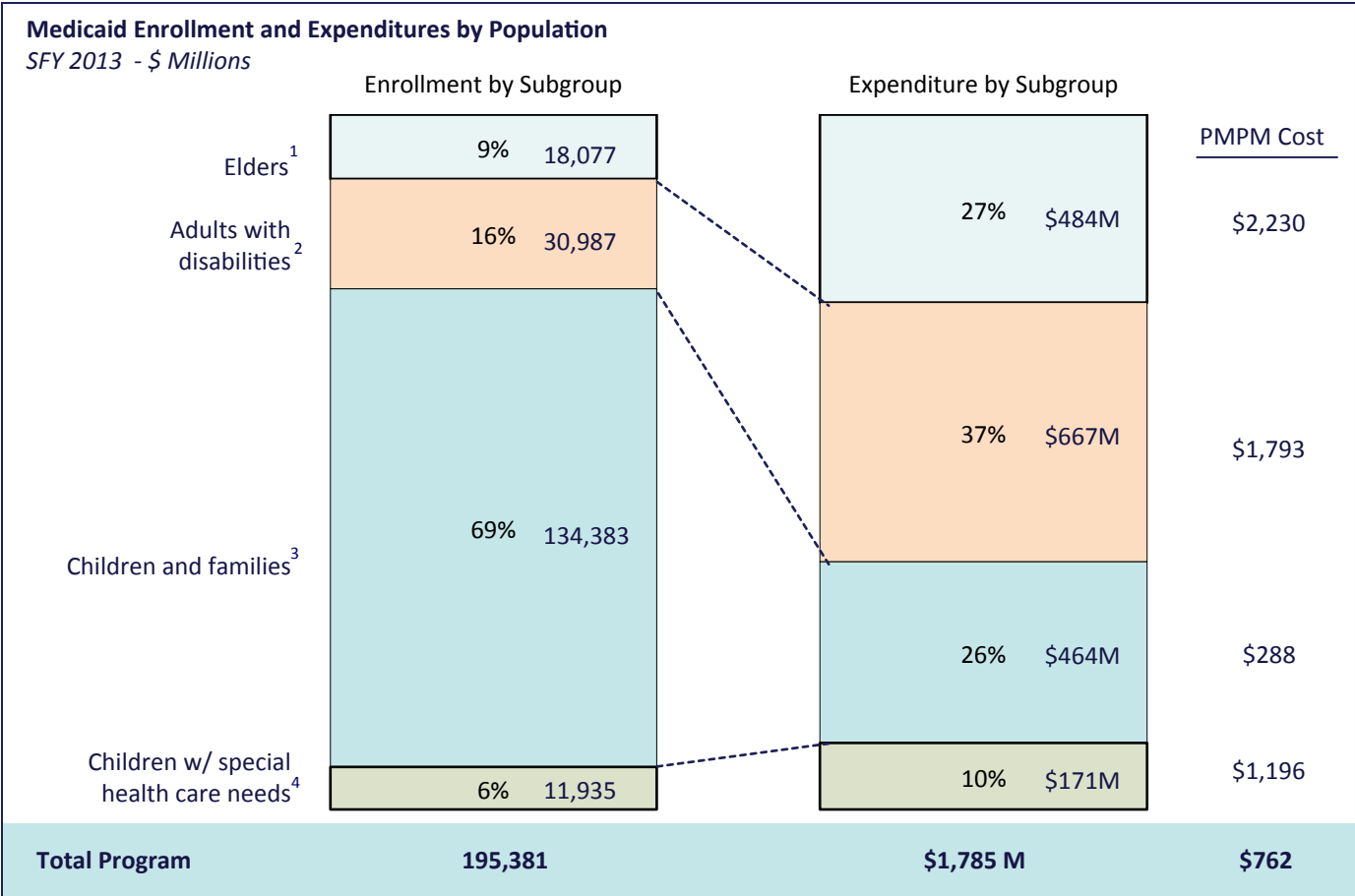
⁵Slater Hospital, Tavares and Zambarano are specialized facilities for severely disabled adults or children.

⁶Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, such as personal care, assisted living, case management and Program of All-Inclusive Care of the Elderly (PACE).

⁷Medicaid pays Medicare premiums for qualifying individuals.

2c. Expenditure by Population

Medicaid expenditures vary considerably by population.



The Medicaid program served an average of 195,381 eligibles in SFY 2013, at an average cost per member per month of \$762. However, PMPM costs vary considerably by population.

- ❖ 64% of expenditure is on services for elders and adults with disabilities who together account for 25% of total eligibles. The PMPM costs for elders is over \$2,200 per member per month and the PMPM cost for adults with disabilities is just under \$1,800.
- ❖ Services for children and families account for 69% of total enrollment and 26% of total expenditure with a PMPM cost \$288.
- ❖ Another 10% of expenditure is for children with special health care needs who represent 6% of eligibles at a PMPM of nearly \$1,200.

¹Elders include all adults over age 65.

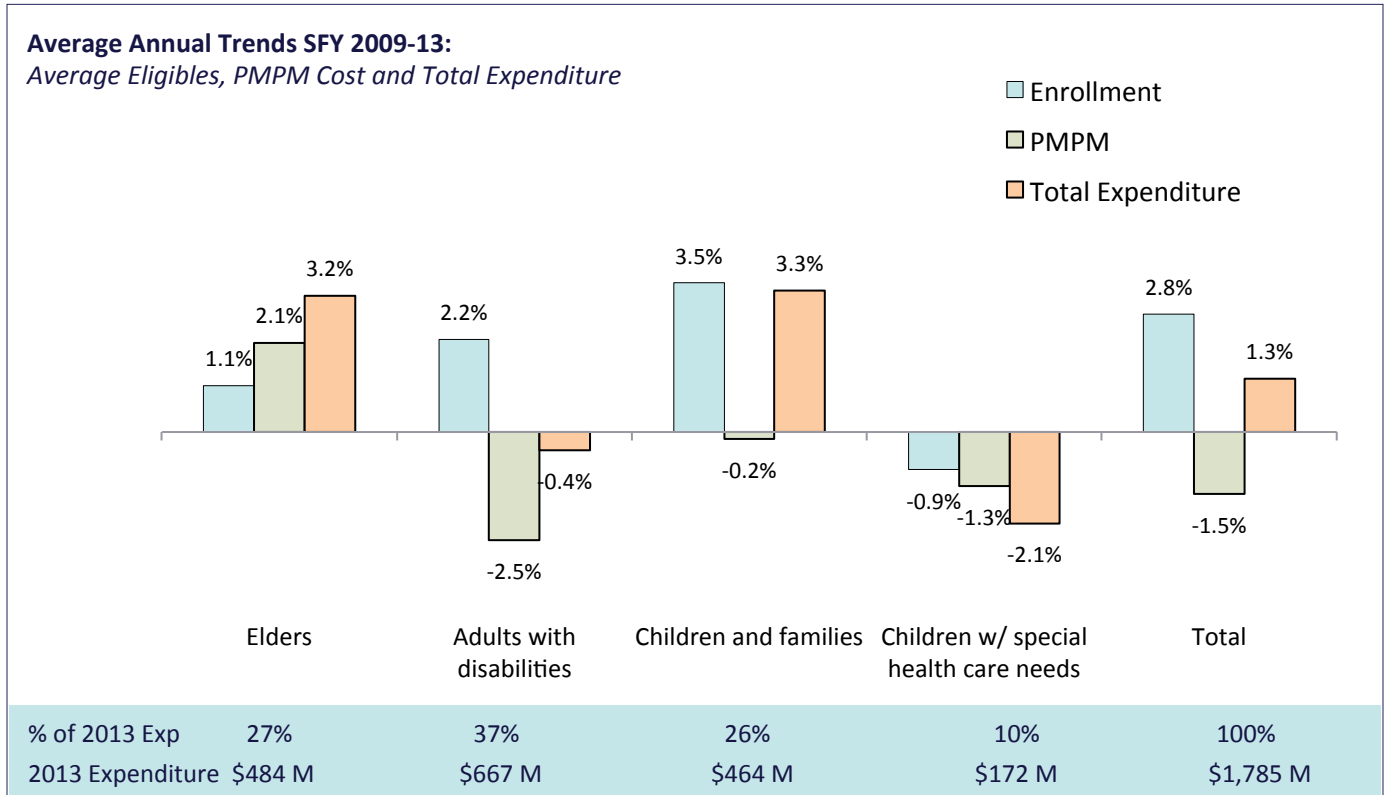
²Adults with Disabilities includes adults under age 65 who have identified disabilities (does not include RIte Care enrolled adults).

³Children and Families includes low income children, parents and pregnant women who meet specific income requirements.

⁴Children with Special Health Care Needs (CSHCN) includes individuals under 21 eligible for SSI (Supplemental Security Income), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children.

2c. Expenditure By Population: Trends

Expenditure trends vary significantly by population.



- ❖ Overall Rhode Island Medicaid expenditures grew by approximately 1.3 percent per year between SFY 2009 and SFY 2013, however this trend varied considerably by population.
- ❖ Elders account for 27% of overall spending in SFY 2013 and have experienced a 3.2% average annual increase in expenditure since SFY 2009. One-third of the increase is due to increased enrollment and the other two-thirds is due to increased PMPM.
- ❖ Adults with disabilities account for the highest share of SFY 2013 expenditure (37%). The average annual expenditure for this group decreased 0.4% per year on average for the last 5 years. The decrease was all due to decreased PMPM (enrollment increased on average over the period).
- ❖ Children and families experienced a 3.3% average expenditure growth over the past 5 years with an average enrollment growth of 3.5% and an average PMPM decrease of 0.2%. In comparison, Rhode Island’s recent 5 year commercial PMPM cost trend is 2.8%¹.
- ❖ Children with special health care needs experienced a decrease in both PMPM and overall expenditure since SFY 2009. This is partly due to programs that have reduced the portion of DCYF youth in residential settings compared to those in community-based settings.

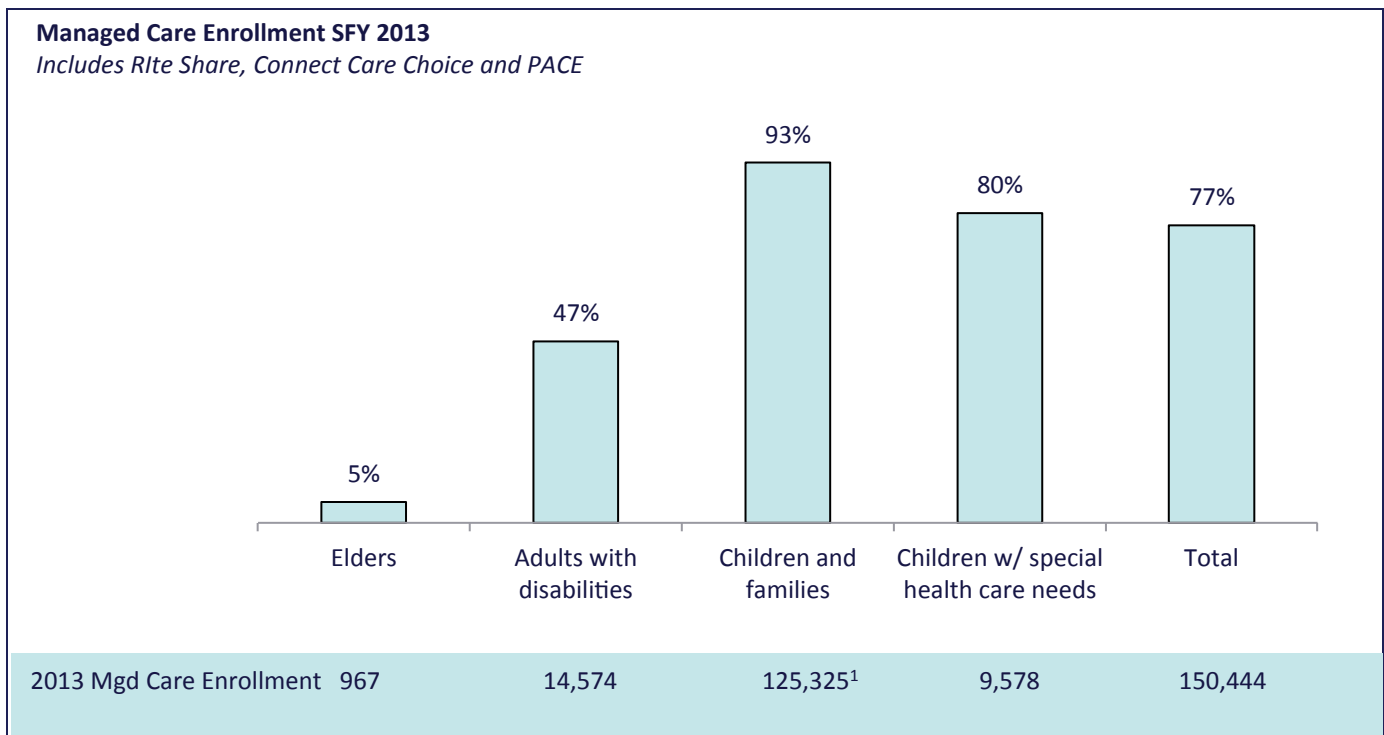
¹For commercial incurred claims from BCBSRI, United Healthcare New England and Tufts Health Plan, includes both large group and small group. Source: Office of the Health Insurance Commissioner (OHIC), 2014 carrier rate filings, exhibit 3.

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends
- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population
- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Long Term Services and Supports
- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail
- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

3a. Managed Care Enrollment

More than three quarters (77%) of all Medicaid eligibles are enrolled in some type of managed care, but the proportion varies by population subgroup.

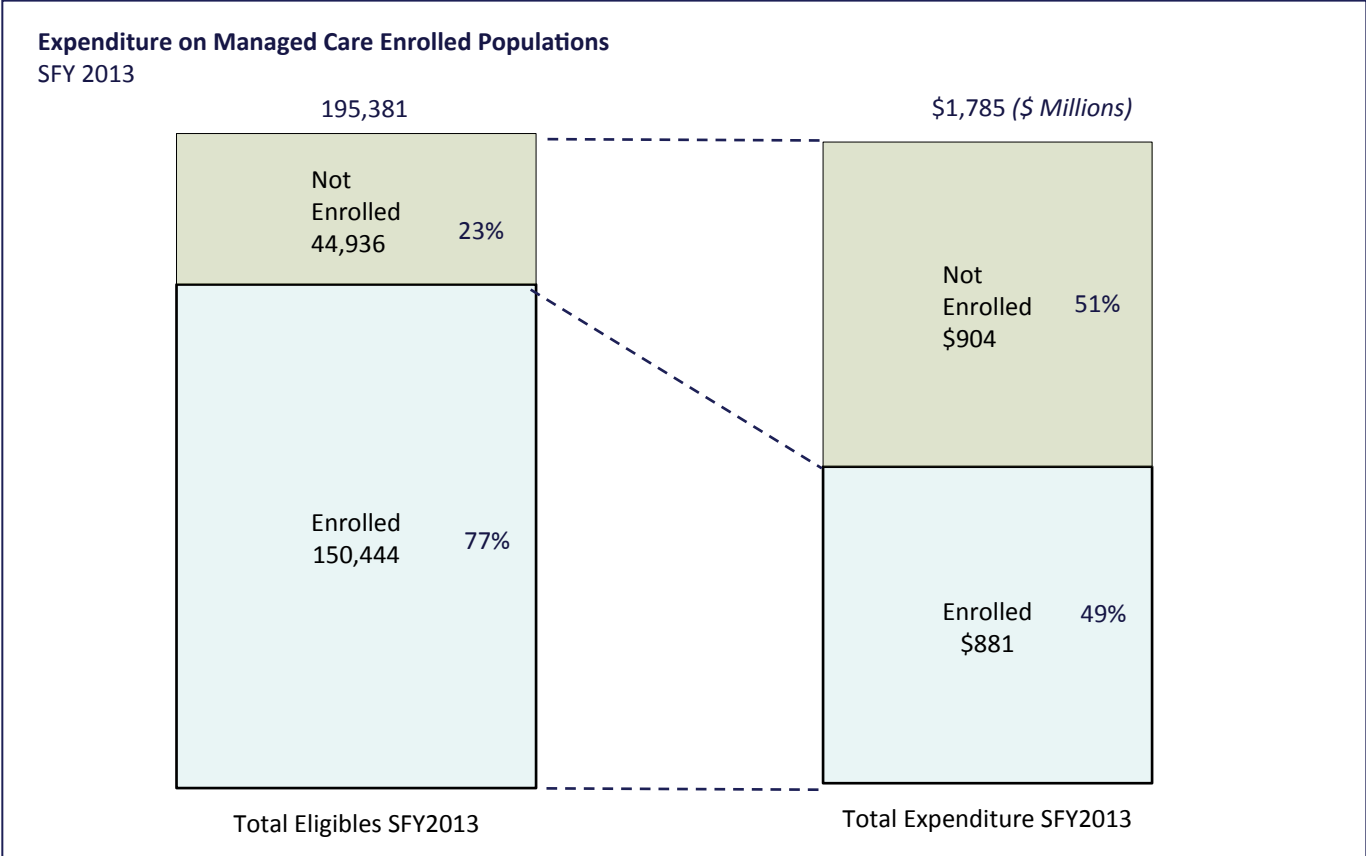


- ❖ Medicaid enrollees who do not have other insurance are enrolled in Medicaid managed care plans. The percentage of managed care enrollees varies by population due to variability in enrollment in outside insurance. For example, the majority of Elders in Medicaid are enrolled in insurance plans through Medicare.
- ❖ Three quarters (77%) of all Medicaid eligibles are enrolled in either Medicaid managed care plans under Rite Care and Rhody Health Partners, or enrolled in Rite Share, Connect Care Choice, or PACE (Program for All-Inclusive Care of the Elderly).
- ❖ In 2008, enrollment in Medicaid managed care became mandatory for children with special health care needs (CSHCN) without other insurance and by SFY 2013 80% were enrolled in managed care.
- ❖ Adult populations have historically been served in fee-for-service Medicaid. However, enrollment in managed care for this population increased to 47% in SFY 2013 due to the introduction in 2008 of two programs to transition adults to managed care: Connect Care Choice (CCC) and Rhody Health Partners (RHP). RHP is a risk-based managed care program. CCC is a primary care case management program (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

¹Includes 10,883 Rite Share members.

3a. Managed Care Enrollment

The 77% of Medicaid eligibles enrolled in managed care plans account for 49% of Medicaid expenditure.

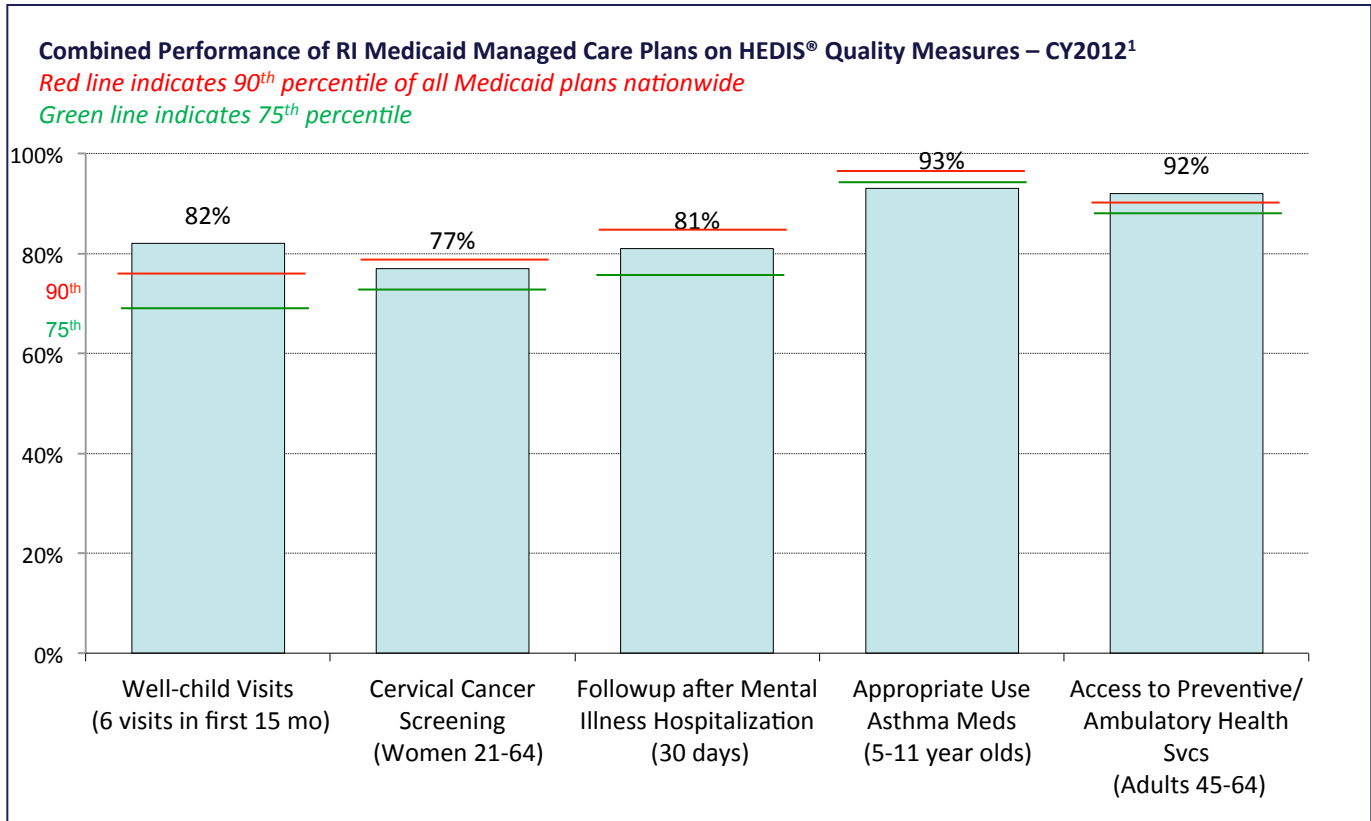


- ❖ Three quarters (77%) of all Medicaid eligibles are enrolled in either Medicaid managed care plans under Rite Care and Rhody Health Partners, or enrolled in RItE Share, Connect Care Choice, or PACE (Program for All-Inclusive Care of the Elderly). These “enrolled populations” account for about 49% of Rhode Island Medicaid expenditures.¹
- ❖ During SFY 2013 RItE Care and Rhody Health Partners managed care enrollment was divided between Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE). Blue Cross Blue Shield of RI ceased participation in RItE Care as of December 2010.
- ❖ 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 expenditure by leveraging the employer’s contribution. In SFY 2013 there were 10,883 Medicaid eligibles enrolled in the RItE Share program.
- ❖ Connect Care Choice is a program that provides access to advanced medical homes for adults with chronic conditions in order to help coordinate health care needs and link to support services in the community. In SFY 2013, there were 1,673 Medicaid eligibles enrolled in Connect Care Choice.

¹Most of the enrolled population is RItE Care families, which typically are lower cost populations than elders or disabled adults.

3a. Managed Care Quality Indicators

Both of Rhode Island's participating Medicaid Managed Care Organizations (MCOs) ranked in the top 10 Medicaid plans in the nation in SFY 2013.

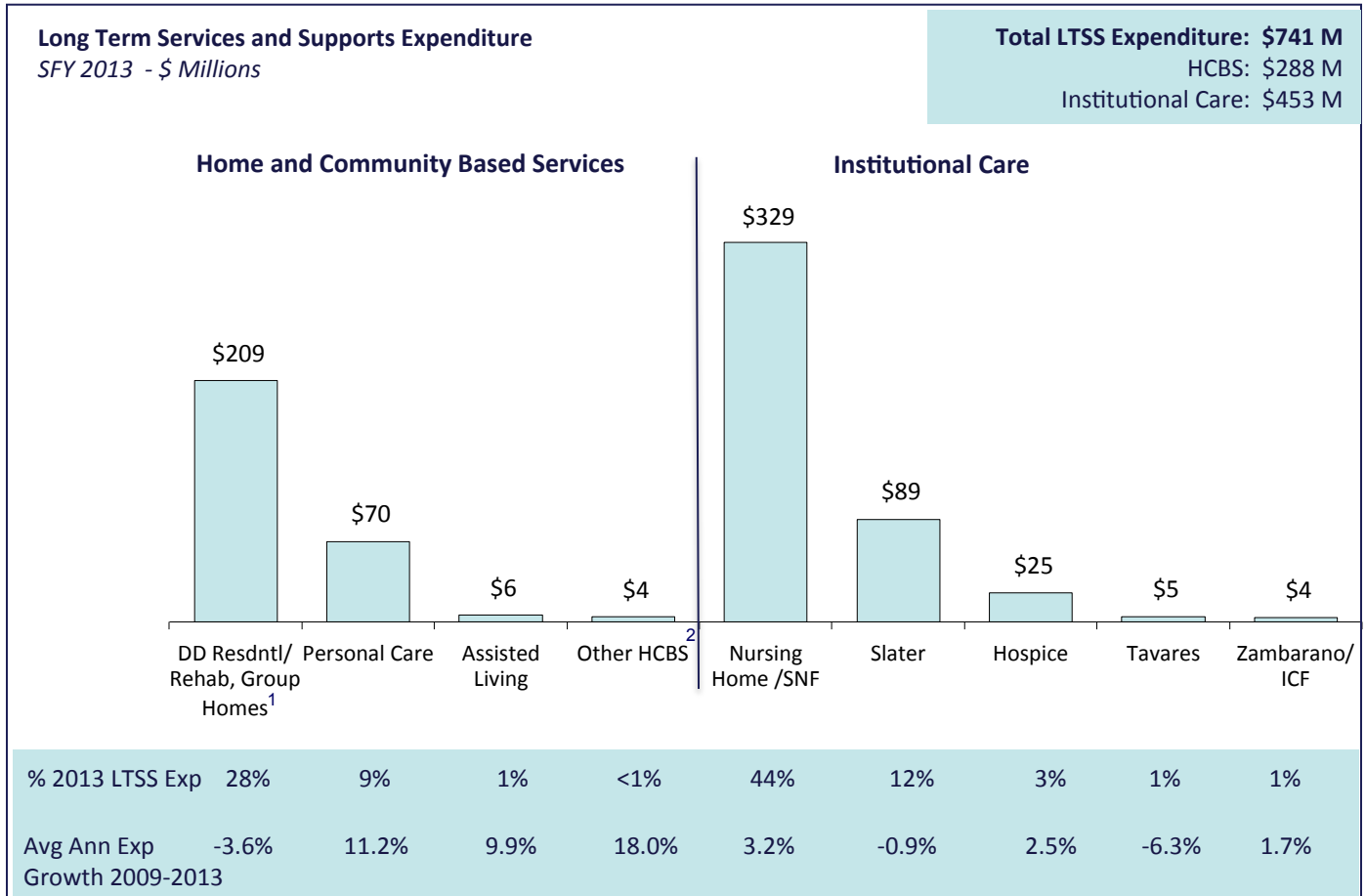


- ❖ In September 2013, the National Committee for Quality Assurance (NCQA) ranked over 260 Medicaid Health Plans nationwide. Both Rhode Island MCOs ranked in the top 10, with NHPRI ranked 4th and United Healthcare ranked 8th.¹
- ❖ On the HEDIS® measures assessing the percentage of enrollees who had six or more well-child visits during their first 15 months of life and the measure of adults 45-64 with access to preventative health services, both of Rhode Island's Medicaid Health Plans ranked above the 90th percentile compared with Medicaid health plans nationally.
- ❖ Rhode Island's Medicaid Health Plans exceeded the 75th percentile on the cervical cancer screening measure (percent of women 21-64 who received Pap tests to screen for cervical cancer) and the measure for having an outpatient follow-up mental health service within at least 30 days after discharge from a hospitalization for certain mental health disorders.
- ❖ On the HEDIS® measure of children with asthma who were appropriately prescribed medication, Rhode Island's Medicaid Health Plans are just below the 75th percentile. Children who use asthma medications appropriately can prevent unnecessary emergency department visits and hospitalizations.

¹Source: Monitoring Quality and Access in RItCare and Rhody Health Partners, RI EOHHS, October 2013. Results are reported in the aggregate, not by individual health plan.

3b. Long Term Services and Supports (LTSS)

Long term services and supports, including both institutional care and home and community based services, accounted for \$741 million in SFY 2013, about 41% of Medicaid expenditure.



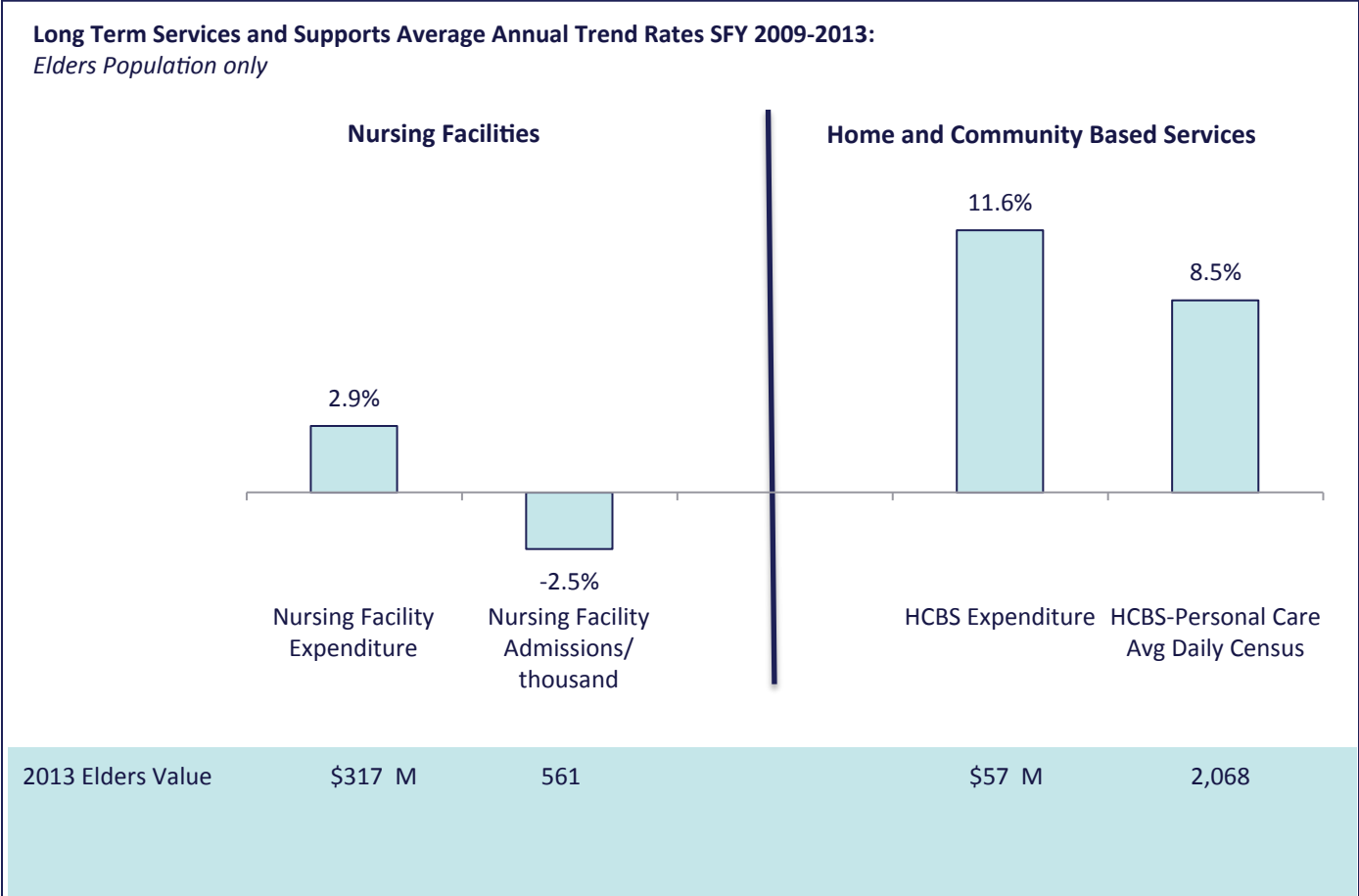
- ❖ The 1115 Medicaid Waiver subsumed the prior 1915(c) waivers, which granted the state the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide home and community based services to at-risk populations as alternatives to more costly nursing home/institutional options.
- ❖ Home and community based services (HCBS) across all agencies account for 39% of the total expenditure on long term services and supports (LTSS). A large portion of the growth in LTSS expenditures is for HCBS for the non-developmentally disabled population. These services, such as attendant/personal care and assisted living, are less expensive alternatives to nursing home/institutional options.
- ❖ Institutional care services account for 61% of LTSS expenditure. The largest category of institutional care is nursing homes, accounting for 44% of LTSS spending and 73% of spending on institutional care.

¹DD Resdntl/Rehab is Residential and Rehabilitation Services for persons with developmental disabilities and includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

²Other HCBS includes DME (e.g. Home Modifications), Case Management, Meals, Shared Living and other.

3b. LTSS Detail: Elders

Expenditure on home and community based services is growing at a faster rate than spending on nursing facilities.



- ❖ Nursing facility expenditure for the elders population accounted for \$317 Million in SFY 2013, an average annual increase of 2.9% per year on average since SFY 2009. Over the same period, admissions per thousand for elders in nursing facilities decreased 2.5% per year on average.
- ❖ Expenditure on home and community based services is about one-fifth of nursing facility expenditure, but growing at a much higher rate – 11.6% per year on average since SFY 2009. A measure of the usage of HCBS is the average daily census for personal care services, which increased by 8.5% per year on average over the last 5 years.

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends

- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population

- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Long Term Services and Supports

- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail

- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases

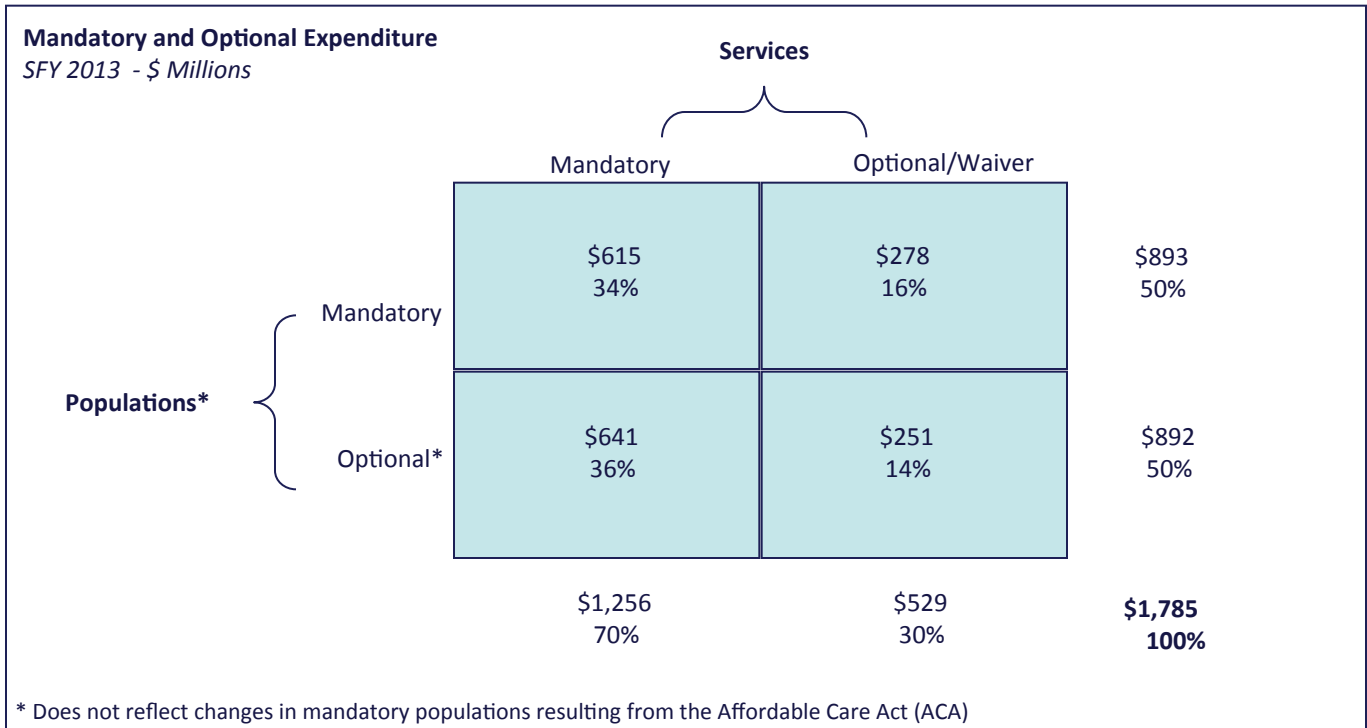
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)

- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)

- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

4. Federal Medicaid Expenditure Classifications

Under federal guidelines, there are “mandatory” populations and services that all state Medicaid programs must cover to receive federal matching payments. However, certain provisions of the Affordable Care Act (ACA) alter these definitions effective in 2014.



- ❖ States may obtain federal matching funds for covering several “optional” groups of individuals and services. Optional services are generally intended to reduce expenditure for mandatory services¹ (e.g. pharmacy is an optional service).
- ❖ In addition, Federal guidelines require that optional populations receive the same services as mandatory populations – so states cannot eliminate these services for optional populations while retaining them for mandatory populations.

¹ For example, pharmacy, outpatient behavioral health, and hospice are all sizable components of optional services that, if eliminated, would likely result in offsetting increases in mandatory expenditure

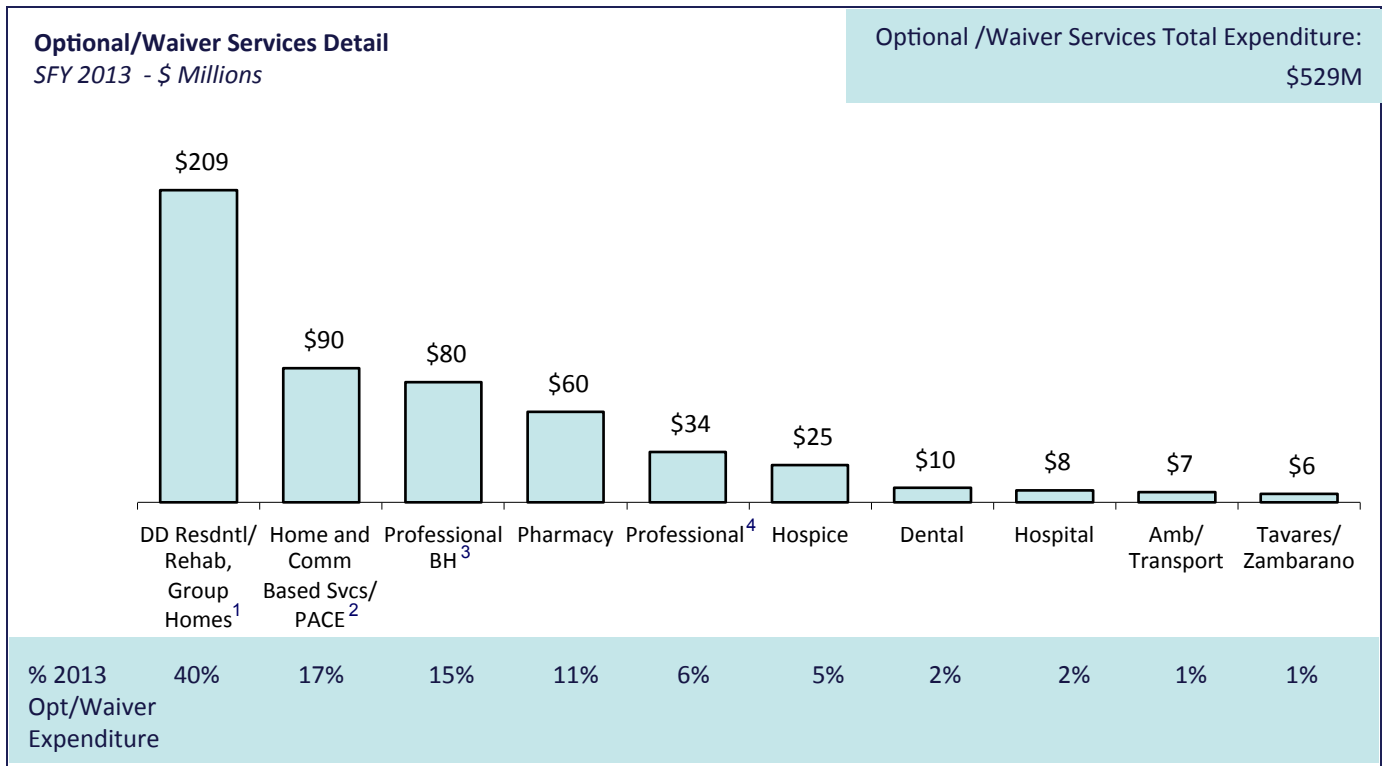
4a. Populations and Services

Federal health reform maintenance of effort restrictions do not pertain to optional services. Optional services are generally intended to reduce expenditure for mandatory services.

Federal Mandatory Populations	Optional Populations
<ul style="list-style-type: none"> • Recipients of SSI or Supplemental Security Disability Insurance (SSDI) • Low income Medicare beneficiaries • Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state’s 1996 AFDC eligibility requirements • Children under age six and pregnant women with family income at or below 133% FPL • Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level • Infants born to Medicaid-enrolled pregnant women • Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program 	<ul style="list-style-type: none"> • Low-income elderly adults or adults with disabilities • Individuals eligible for Home and Community Based Services waiver programs • Children up to 250% FPL, including children funded through the Children’s Health Insurance Program (CHIP) • Individuals determined to be “medically needy” due to low income and resources or too large medical expenses • Children under 19 with a disabling condition severe enough to require institutional care, but who live at home (the “Katie Beckett” provision) • Women eligible for Breast and Cervical Cancer program
Federal Mandatory Services	Optional Services
<ul style="list-style-type: none"> • Inpatient hospital services • Outpatient hospital services • EPSDT: Early and Periodic Screening, Diagnostic, and Treatment services • Nursing facility services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and x-ray services • Family planning services • Nurse midwife services • Certified pediatric and family nurse practitioner services • Freestanding birth center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women 	<ul style="list-style-type: none"> • Prescription drugs • Clinic services • Physical/occupational/speech/respiratory therapies • Other diagnostic, screening, preventive and rehabilitative services • Private duty nursing services and personal care services • Other practitioner services, incl podiatry, optometry and chiropractic • Dental services • Dentures, prosthetics, eyeglasses • Hospice • Case management • Services for individuals age 65+ in an institution for mental disease (IMD) • Services in an intermediate care facility for the mentally retarded (ICF/MR) • State Plan Home and Community Based Services- 1915(i) • Self-directed personal assistance services- 1915(j) • Community First Choice Option- 1915(k) • TB related services

4b. Optional Services Detail

Most of the expenditure on optional/waiver services is designed to reduce expenditure for mandatory services.



- ❖ Optional and waiver services accounted for \$529 Million in total Medicaid expenditure in SFY 2013, approximately 30% of total Medicaid expenditures.
- ❖ The largest component of optional/waiver services (40% of expenditure) is residential and rehabilitation services for persons with developmental disabilities, including group homes. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services for those populations.
- ❖ Under EPSDT provisions, services that are optional for adults are mandatory for children, e.g., pharmacy.

¹DD Res/Rehab is Residential and Rehabilitation Services for persons with developmental disabilities and includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

²Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, such as personal care, assisted living, case management., and Program of All-Inclusive Care of the Elderly (PACE).

³Professional BH includes DHS, BHDDH and DCYF expense including, but not limited to, Professional MH/SA, CEDARR, CMHC, and Residential DCYF.

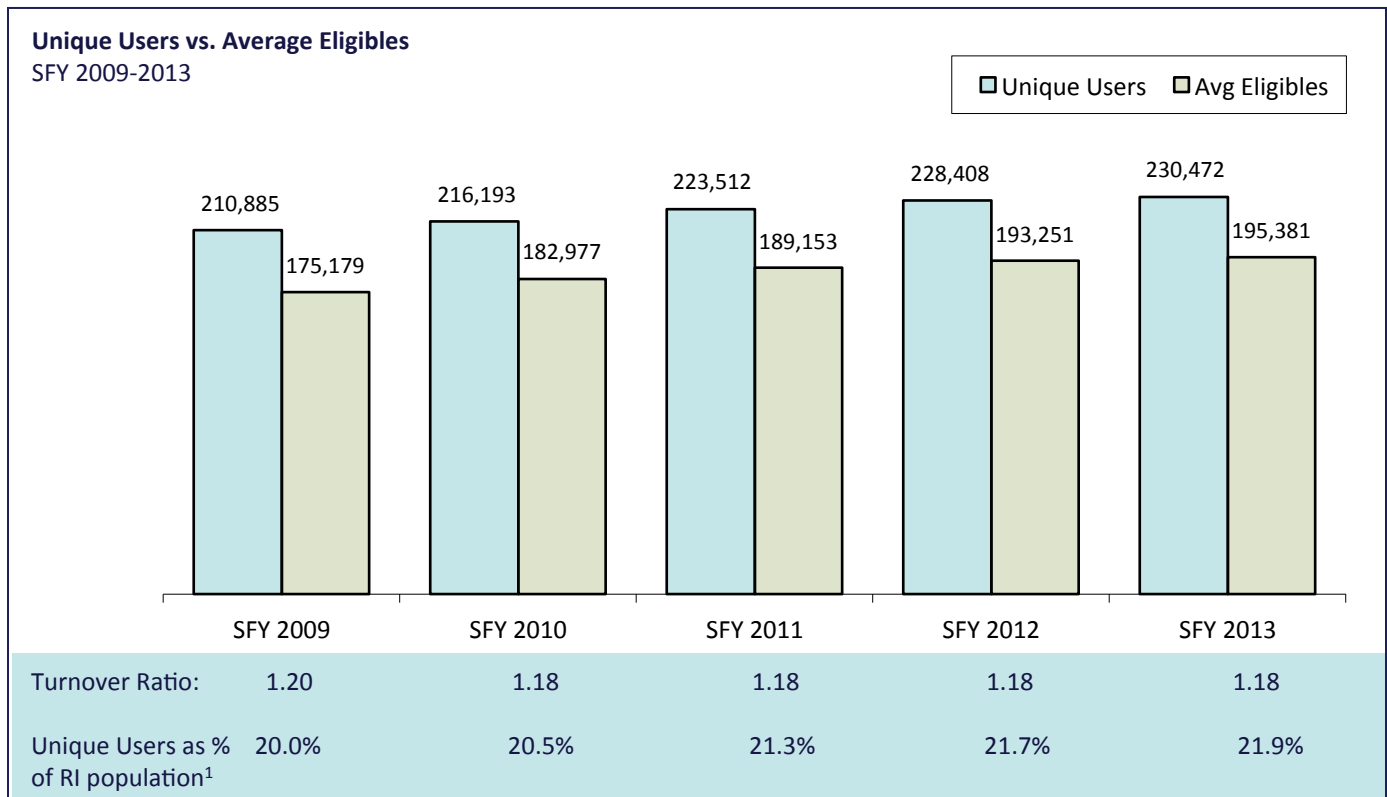
⁴Professional includes, but is not limited to, E&M, Procedures, Dental, DME/Supplies, X-Ray/Lab/Tests, and Ambulance.

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends
- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population
- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Long Term Services and Supports
- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail
- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

5a. Unique Users

About one-fifth of Rhode Island's population, or 230,000 Rhode Islanders, were enrolled in Medicaid for some part of SFY 2013.



- ❖ Unique users is a measure of the number of Rhode Islanders who were enrolled in Medicaid at any time during the fiscal year.² So, if a person enrolled, disenrolled, and reenrolled, they would count as one user. Similarly, if a person enrolled for only 1 month, they would be included as a unique user.
- ❖ The turnover ratio compares unique users to average eligibles. This provides an indicator of the role of the Medicaid program in Rhode Island. If the number of unique users is equal to the average eligibles -- that indicates that there is a steady population of eligibles that remain on the program for the full year. If the number of unique users is above the average eligibles (a turnover ratio of >1) -- this indicates Rhode Islanders are using Medicaid for shorter periods of time.
- ❖ A recent Kaiser Family Foundation study found that 17.4% of Rhode Islanders indicated they had Medicaid coverage compared to 16.5% of residents nationally. Statistics listed for other New England states included: Massachusetts: 20.2%, Connecticut: 13.2%, Vermont: 23.6%, New Hampshire: 7.0%, and Maine: 22.2%.³

¹ Source: Population Division, US Census Bureau.

² A unique user is an individual associated with a medical claim. Average eligible enrollment is annual FTEs (full time equivalents).

³ Source: "Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending", Kaiser Commission on Medicaid and the Uninsured, Revised November 2012.

5b. Expenditure by User: High Cost Cases

The top 7% of Medicaid users account for two thirds (66%) of Medicaid claims expenditure.

Medicaid User Claims Expenditure Distribution		SFY 2013			
Annual Medical Claims Expenditure range per user:	% of Users		% of Claims Expenditure	Turnover Ratio	
<\$1,000	52% 119,605		2% \$38M	1.26	
			9% \$142 M	1.12	
			8% \$128 M	1.11	
			14% \$233 M	1.09	
			44% \$712 M	1.05	
\$1,001-\$5,000	27% 61,783				
\$5,001-\$10,000	8% 17,875				
\$10,001-\$25,000	7% 15,062				
High Cost Users {	\$25,001 - \$100,000	6% 14,089			
	\$100,000+	1% 2,058			
Total Program	230,472		\$1,613 M¹	1.18	

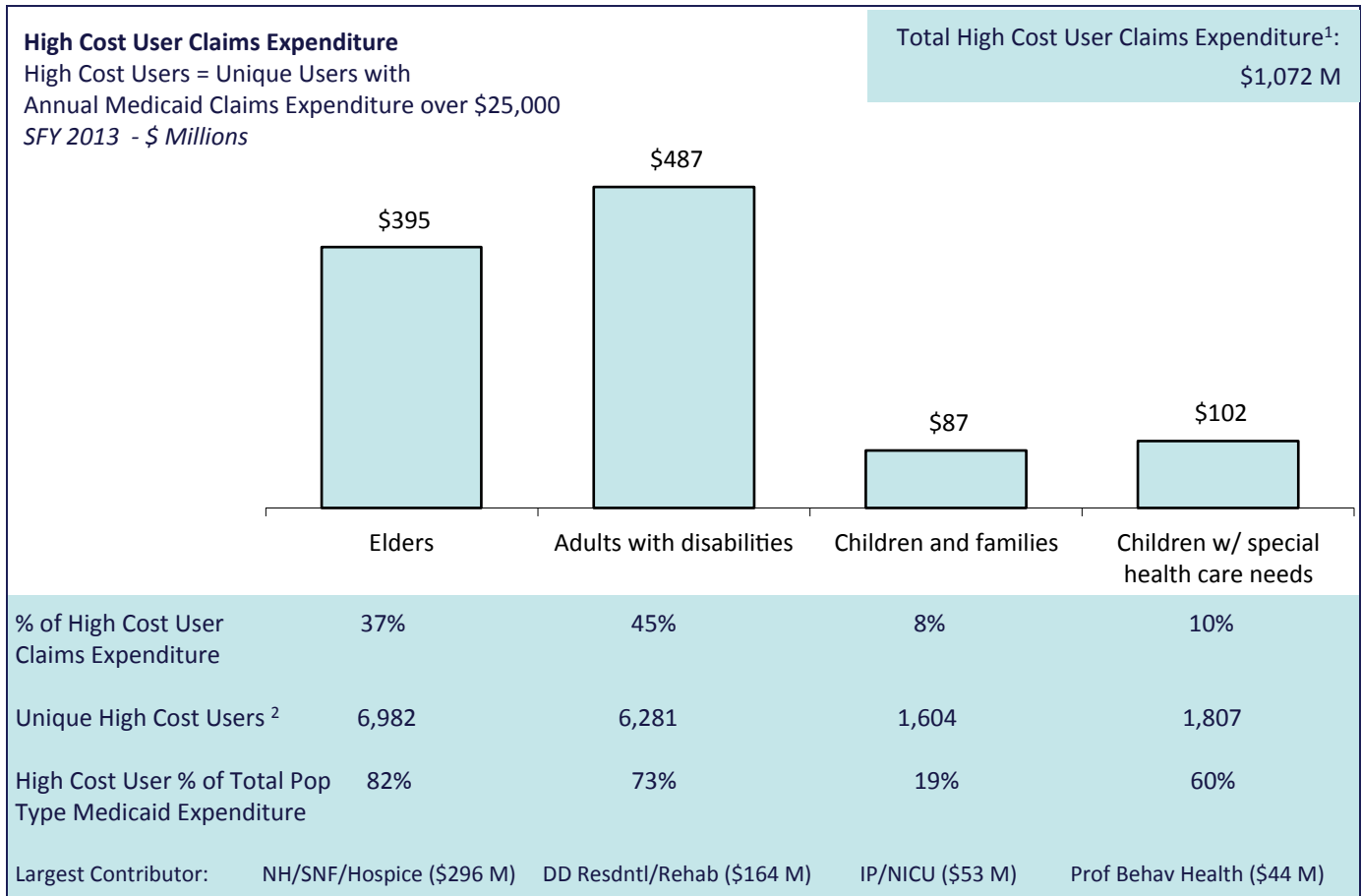
- ❖ Medicaid claims expenditures are highly concentrated, as the top seven percent of Medicaid users account for two-thirds (66%) of claims expenditures. This is similar to national statistics, as five percent of the US population accounts for nearly half of overall US health care expenditure.²
- ❖ On the other end of the spectrum, seventy nine percent of Medicaid users access Medicaid services at a cost of less than \$5,000 per year, with an average annual claims expenditure of \$992 per person. Thus, the top 7% of users spent, on average, \$66,396 per person in SFY 2013, almost seventy times as much per person as those in the bottom 79 percent of users.
- ❖ The turnover ratio (ratio of unique users to average eligibles) also varies among user types. High cost users have a turnover ratio that is close to one (1.05 for the top 7% of users) – indicating that this population tends to remain on the program for the full year. These high utilizers typically present with multiple, complex conditions, requiring care coordination across a variety of providers. In contrast, lower cost users have a turnover ratio of 1.26, indicating more individuals with shorter periods of Medicaid eligibility.

¹ Total of claims-specific payments. Certain expenditures (e.g. UPL, Medicare and PACE Premiums) are not attributable to specific users.

² Source: “The Concentration of Healthcare Spending”, National Institute for Healthcare Management Foundation Data Brief July 2012. Based on analysis of MEPS 2009 data

5b. Expenditure by User: High Cost Cases

Elders and adults with disabilities account for over eighty percent of claims expenditure for high cost users.



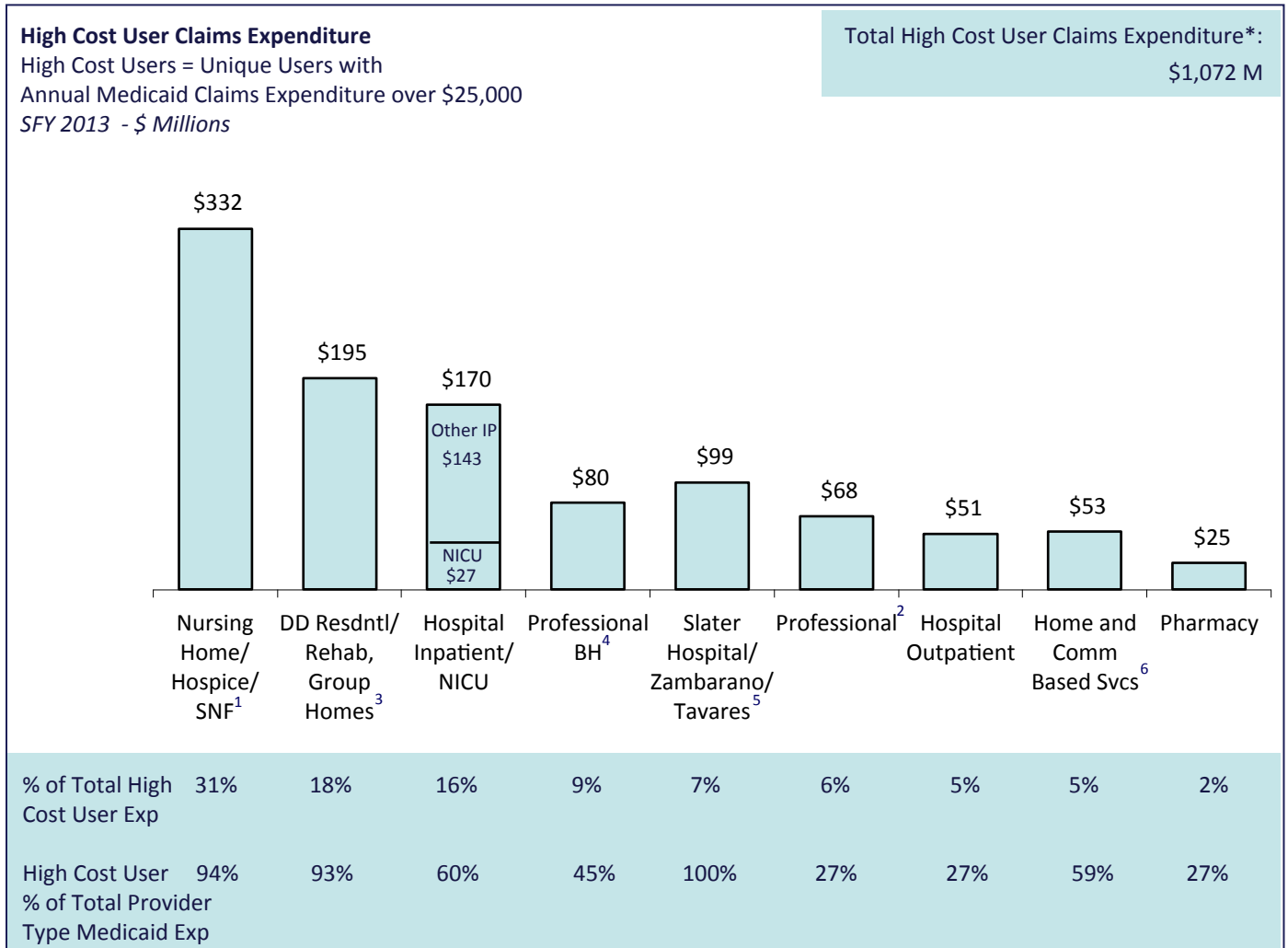
- ❖ Elders and adults with disabilities together account for 82% of claims expenditure for the highest cost users. (High cost users defined as unique users with over \$25,000 of Medicaid claims expenditure in SFY 2013). Also, high cost user claims expenditure accounts for 82% of total spending for Elders and 73% of total spending for adults with disabilities.
- ❖ The largest category of claims expenditure for high cost elders is nursing facilities (nursing homes, skilled nursing facilities and hospice), accounting for \$296 million (28%) of overall claims expenditure for high cost users. The largest category of expenditure for high cost adults with disabilities is residential and rehabilitation facilities for persons with developmental disabilities, which account for another \$164 million (15%) of overall claims expenditure for high cost users.
- ❖ For children and families, the largest category of expenditure for high cost users is hospital inpatient services, including Neonatal Intensive Care Unit (NICU), accounting for 5% of overall claims expenditure for high cost users. Professional behavioral health services for children with special health care needs accounts for another 4% of overall claims expenditure for high cost users.

¹Based on claims-specific payments only. Certain expenditures (e.g. UPL (upper payment limit), Medicare and PACE Premiums) are not attributable to specific users.

²Total sums to more than the overall 16,147 high cost unique users due to overlap between eligibility groups.

5b. Expenditure by User: High Cost Cases

Nearly half (49%) of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.



- ❖ Nursing facilities account for 31% of the claims expenditure for high cost users, and residential and rehabilitation services for persons with developmental disabilities account for another 18%.
- ❖ In addition, claims expenditure for high cost users accounts for over 90% of total expenditure for nursing facilities, residential and rehabilitation services for persons with developmental disabilities, and Slater Hospital, Zambarano and Tavares.
- ❖ Many high cost users are those who are institutionalized year-round.

*Based on claims-specific payments only. Certain expenditures (e.g. UPL (upper payment limit), Medicare and PACE Premiums) are not attributable to specific users.

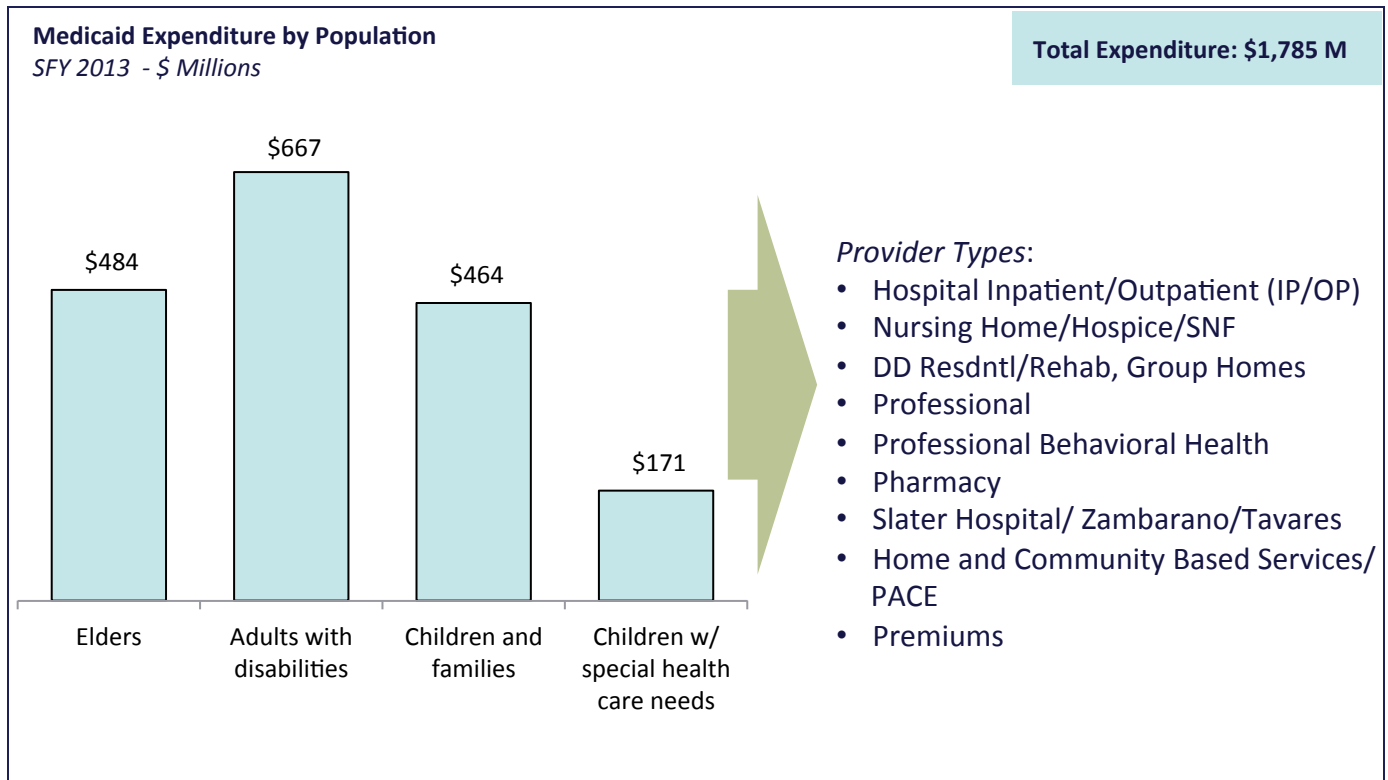
See page16 for footnotes and definitions of service categories.

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends
- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population
- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Home and Community Based Services and Long Term Services and Supports
- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail
- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

6. Expenditure Detail by Population and Provider Type

Medicaid expenditure by provider type varies considerably depending on the specific population.

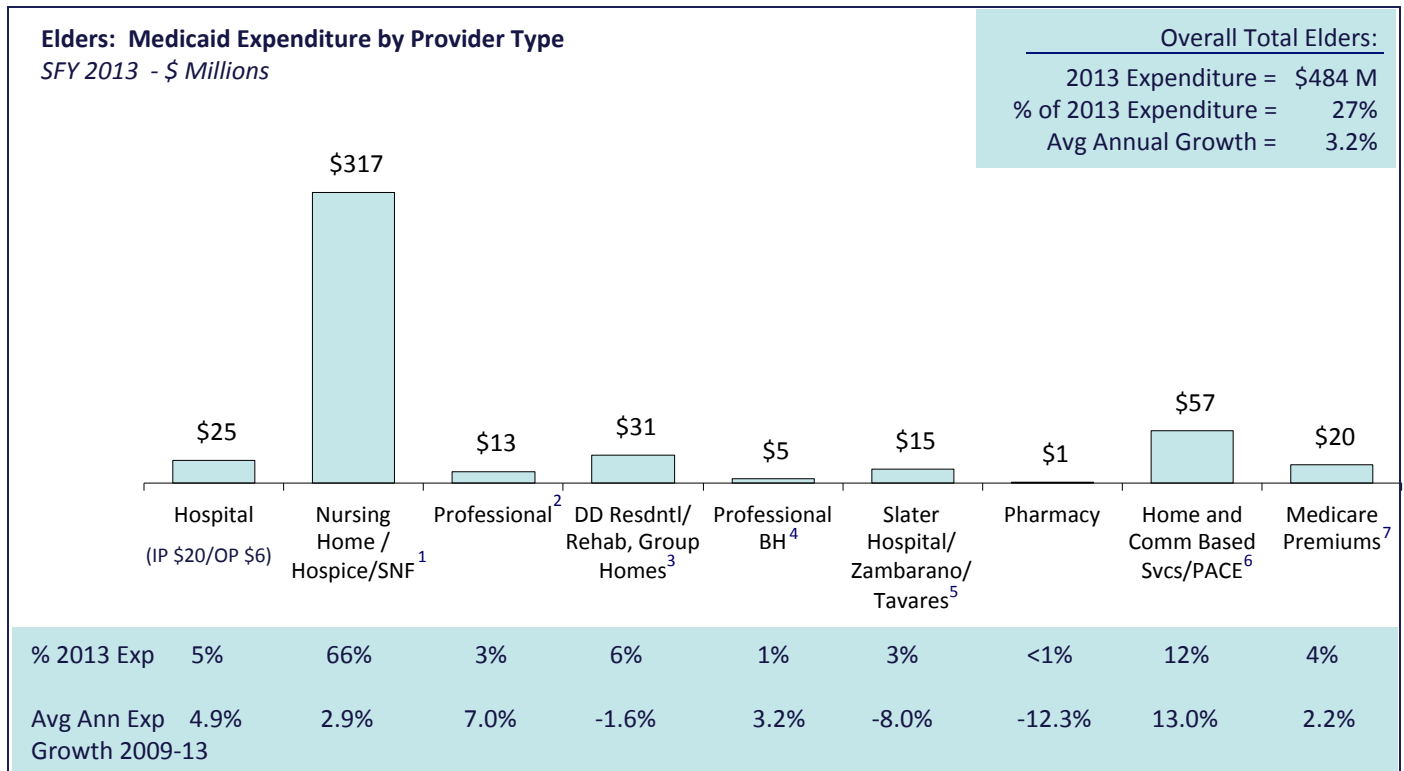


In order to review expenditure by population in more detail, it is useful to look at expenditure by provider type within each population group.

- ❖ **Elders:** adults over age 65, including those also eligible for Medicare.
- ❖ **Adults with Disabilities:** adults under age 65 who have identified disabilities (does not include RIte Care enrolled adults).
- ❖ **Children and Families:** low income children, parents and pregnant women who meet specific income requirements
- ❖ **Children with Special Health Care Needs (CSHCN):** individuals under 21 eligible for SSI (Supplemental Security Income), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children.

6a. Elders Detail

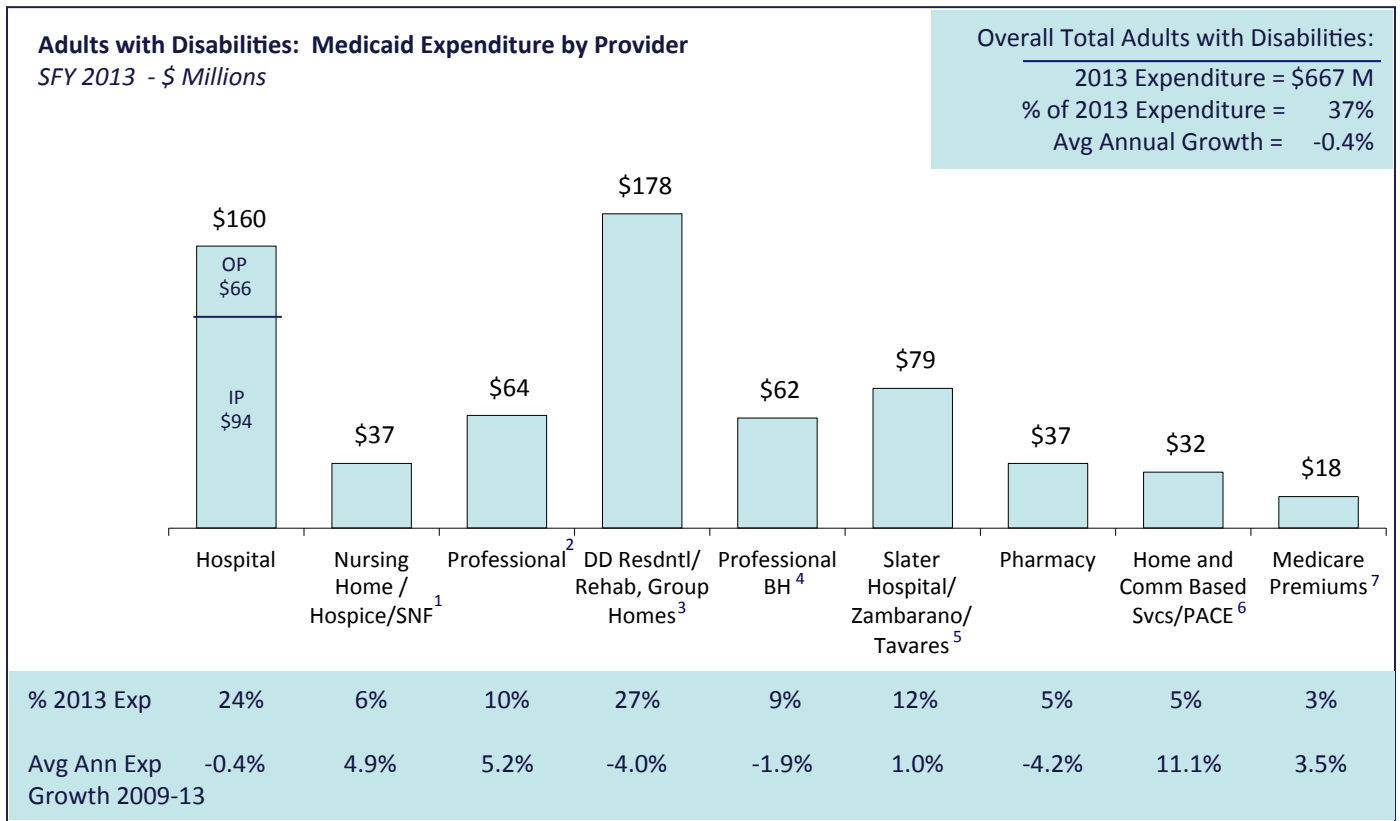
Nursing facilities account for approximately two thirds of total expenditure for elders.



- ❖ Medicaid expenditures on elders totaled \$484 million in SFY 2013 and has been increasing at 3.2% per year over the past 5 years. The large majority of elders are also eligible for Medicare, which was the primary payor for most medical services (e.g. hospital, physician); consequently those expenditures were not paid by Medicaid and are not included here.
- ❖ Nursing facilities (including nursing homes, hospice and skilled nursing facilities) account for nearly two thirds (66%) of total Medicaid expenditure on elders. The increase in nursing home expenditure has been slightly lower than the increase in overall expenditure for this population - an average annual increase of 2.9 percent per year.
- ❖ Most of the growth in Medicaid expenditure for elders has been in nursing home services and home and community based services. The increase in home and community based services is due in part to an effort to invest in alternatives to institutional/nursing home care.

6b. Adults with Disabilities Detail

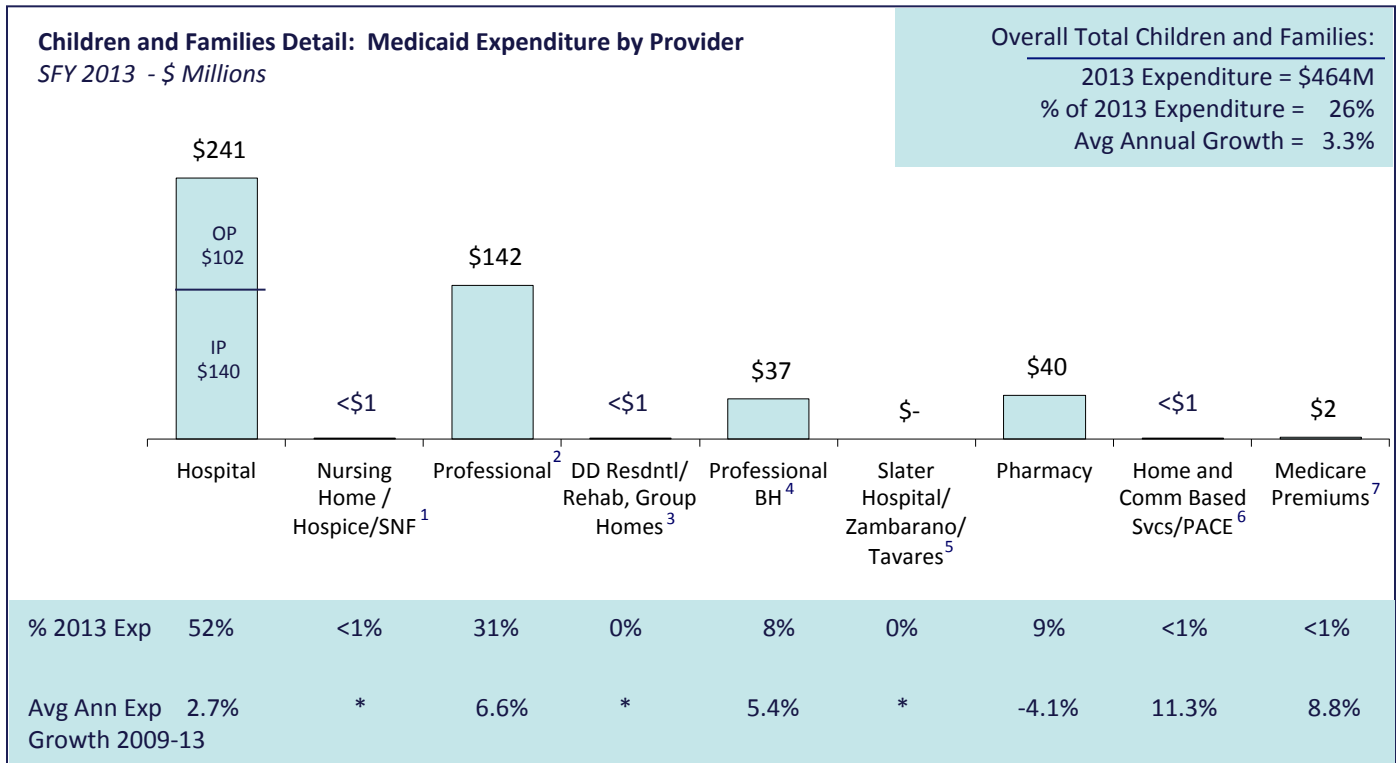
For adults with disabilities, residential and rehabilitation services for persons with developmental disabilities, along with hospital services, account for more than half of expenditures.



- ❖ Adults with disabilities account for the largest share of Medicaid expenditures, with total SFY 2013 expenditure of \$667 million. Expenditure for this population has decreased by approximately 0.4% per year over the past 5 years.
- ❖ Hospital and residential and rehabilitation services for persons with developmental disabilities are the two largest categories of expenditure, accounting for 24% and 27%, respectively, of total Medicaid expenditure on adults with disabilities.
- ❖ The highest rate of growth in Medicaid expenditure for the adults with disabilities population has been among home and community based services providers. The number of adults with disabilities receiving services from HCBS providers has also increased over the last 5 years (see next section for more details).

6c. Children and Families

In the children and families population, hospital and professional services are the largest contributors to expenditure increases



- ❖ Children and families account for about one-fourth (26%) of total Medicaid expenditures, with SFY 2013 expenditure of \$464 million. Expenditure for this population has increased by 3.3% per year over the past 5 years.
- ❖ It is important to note that the federal match is enhanced for qualifying low income children and pregnant women under the CHIP program. CHIP is designed to build on Medicaid to provide insurance coverage to "targeted low-income children and pregnant women" from families with incomes up to 250 percent of the federal poverty level who are uninsured and not otherwise eligible for Medicaid. In SFY 2013, Rhode Island received a 66.003% combined CHIP/FMAP federal match on 21,144 "optional" children and pregnant women who are in families with incomes above mandatory coverage levels.
- ❖ Most expenditure on children and families is divided between professional and hospital care, with hospital care accounting for over half (52%) of expenditure.
- ❖ A major component of expenditure relates to prenatal care and births. Annually, approximately 47% of Rhode Island's births are covered through RIte Care.⁸

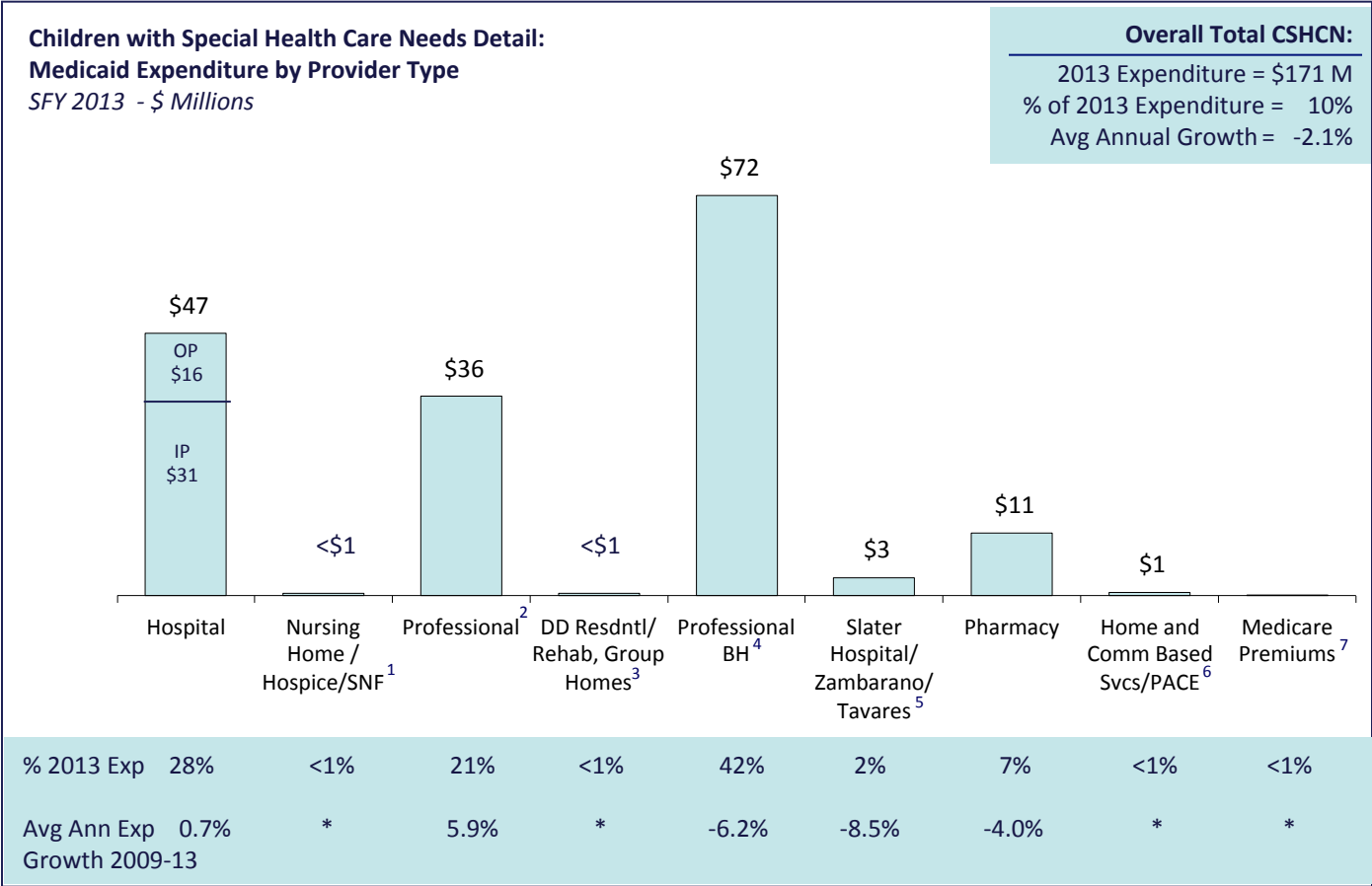
* Indicates expenditure in this category too small to calculate a meaningful trend rate.

See footnotes on page 17 for Provider Type definitions.

⁸Source: <http://www.health.ri.gov/data/birth/>

6d. Children with Special Health Care Needs

In the population of children with special health care needs, professional behavioral health accounts for nearly half (44%) of all expenditure.



- ❖ Children with Special Health Care Needs (CSHCN) is a relatively small population -- accounting for ten percent of total Medicaid expenditures and six percent of enrollees, with total SFY 2013 expenditure of \$171 Million.
- ❖ Expenditure for this population is dominated by professional behavioral health services, which account for \$72 Million in CSHCN expenditures (42%). Professional behavioral health services include CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation) and CEDARR Direct services (\$29 million), residential DCYF services (\$26 million), and professional mental health, substance abuse, and other services.

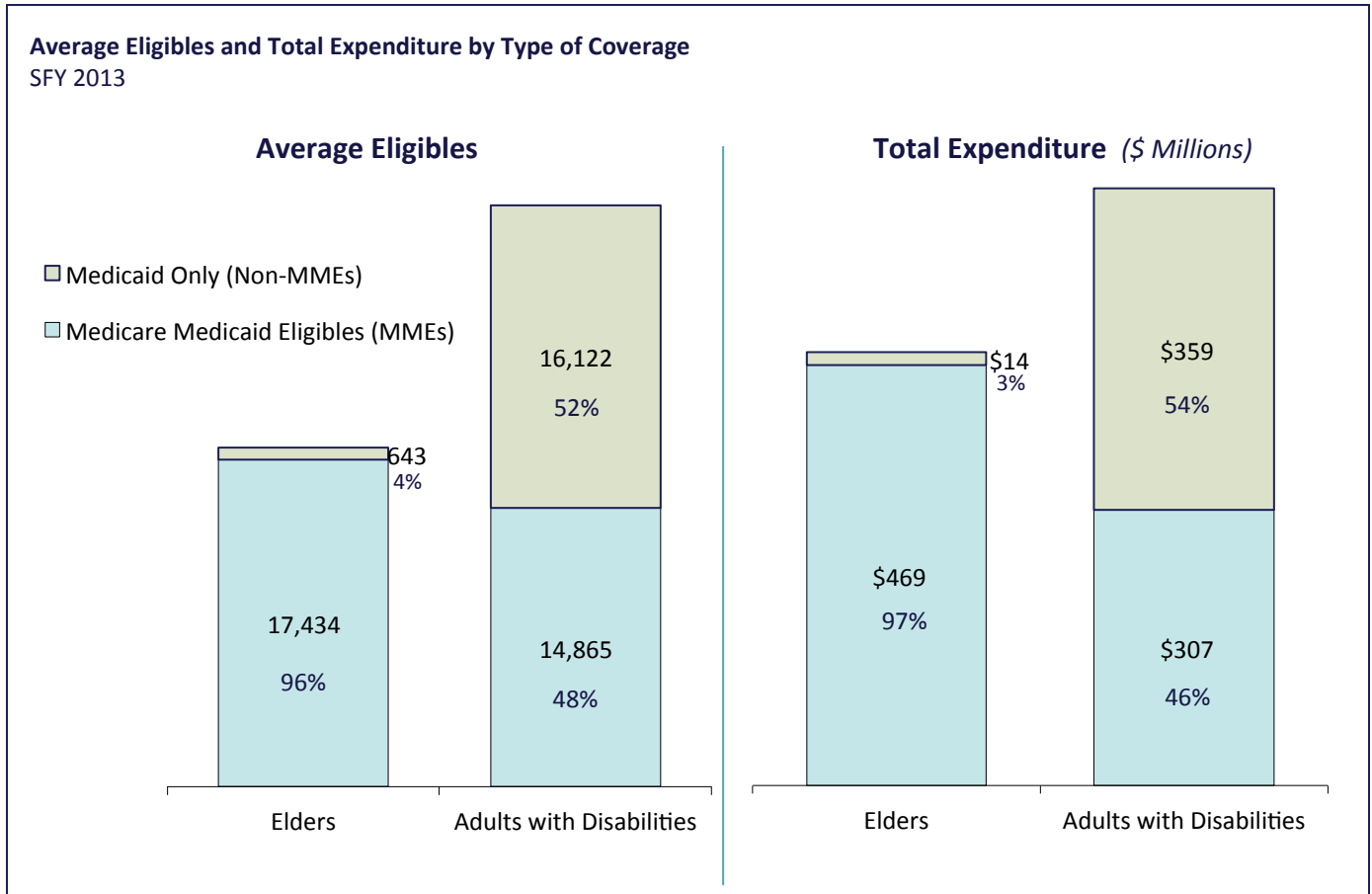
* Indicates expenditure in this category too small to calculate a meaningful trend rate. See footnotes on page 17 for Provider Type definitions .

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends
- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population
- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Long Term Services and Supports
- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail
- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)
- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

7a. Utilization by Population: Overview

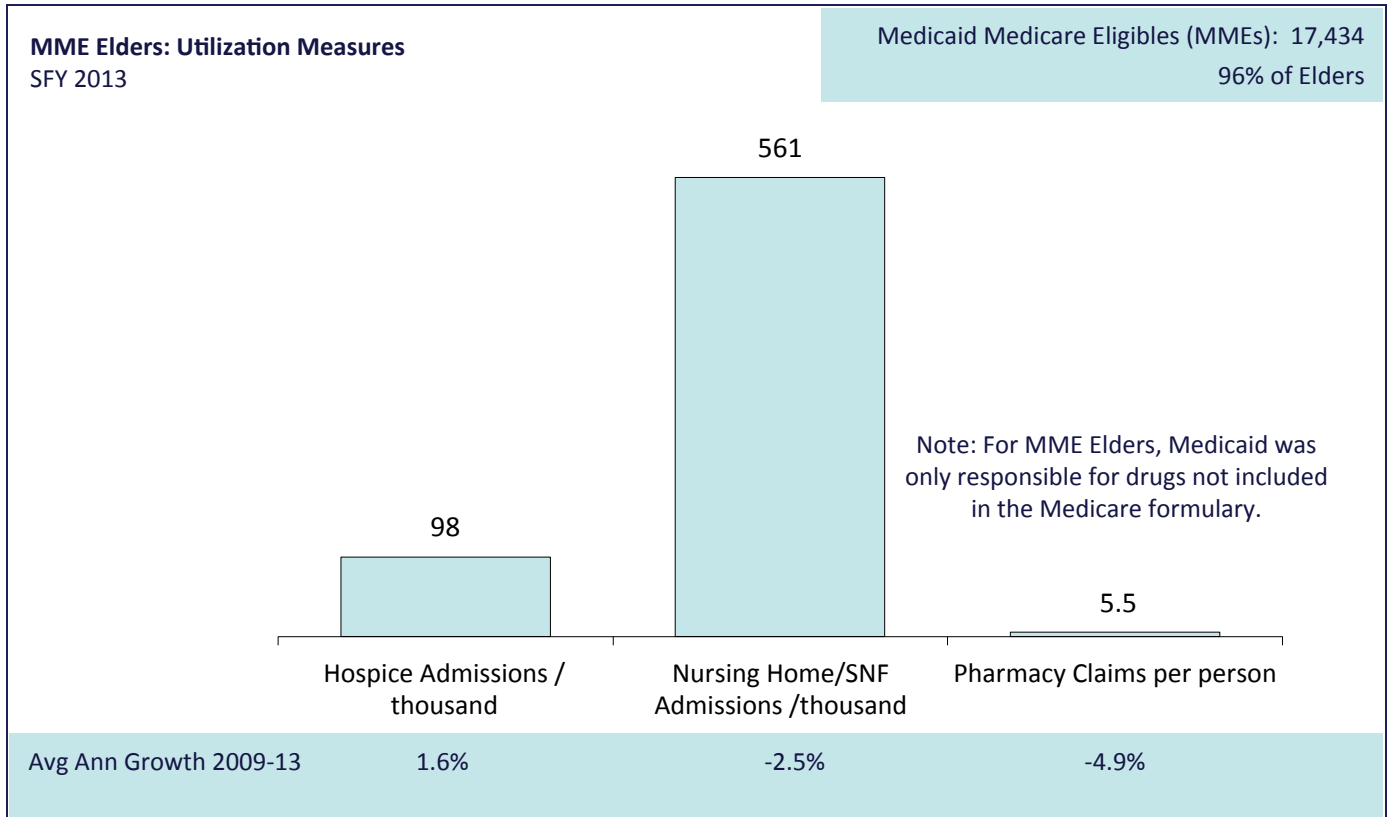
Individuals covered by both Medicare and Medicaid are known as MMEs (Medicaid Medicare Eligibles – also referred to as “duals”). 96% of Elders and 48% of Adults with Disabilities are MMEs.



- ❖ Ninety-six percent of elders and forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid (called MMEs or dual eligibles). Similarly, 97% of expenditures for elders and 46% of expenditures for adults with disabilities are for MMEs.
- ❖ For MMEs, Medicare is the primary payer for most acute and primary care services (e.g., hospital, physician, pharmacy) while Medicaid pays for services not paid for by Medicare (e.g., extended nursing home stays, home and community supports).
- ❖ The majority of services covered by Medicaid for MMEs are long term services and supports. For persons covered only by Medicaid (non-MMEs), Medicaid pays for all covered services.

7a. Utilization by Population: MME Elders

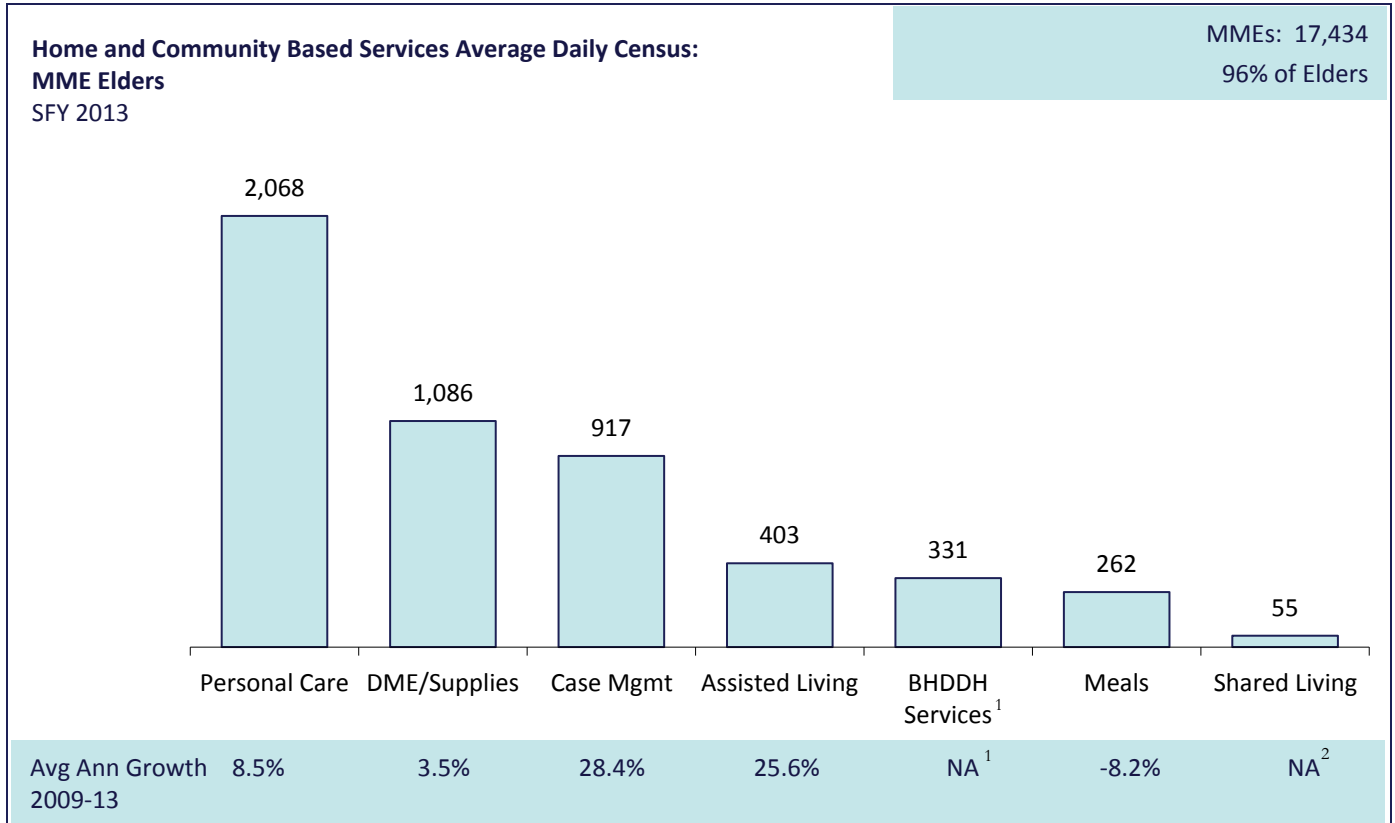
For MME Elders, hospice admissions per thousand increased 1.6% per year and nursing home admissions decreased 2.5% per year from SFY 2009 to 2013.



- ❖ Ninety-six percent of elders are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services.
- ❖ For MME elders, nursing home/skilled nursing facility admissions per thousand were 561 in SFY 2013. This measure has decreased by an average annual rate of 2.5% since SFY 2009.
- ❖ Hospice admissions per thousand have increased for MME elders at a rate of 1.6% on average per year over the last 5 years to 98 per thousand in SFY 2013.
- ❖ Medicare Part D covers most of the pharmacy claims for this population. Medicaid is only responsible for drugs not included in the Medicare formulary. For MME elders, Medicaid was responsible for an average of 5.5 pharmacy claims per eligible in SFY 2013, a decrease of 5% per year on average since SFY 2009.

7a. Utilization by Population: MME Elders

Home and community based services enable some elders to remain in a community setting rather than be admitted to or remain in a nursing home. The largest category of home and community based care for elders is personal care services.



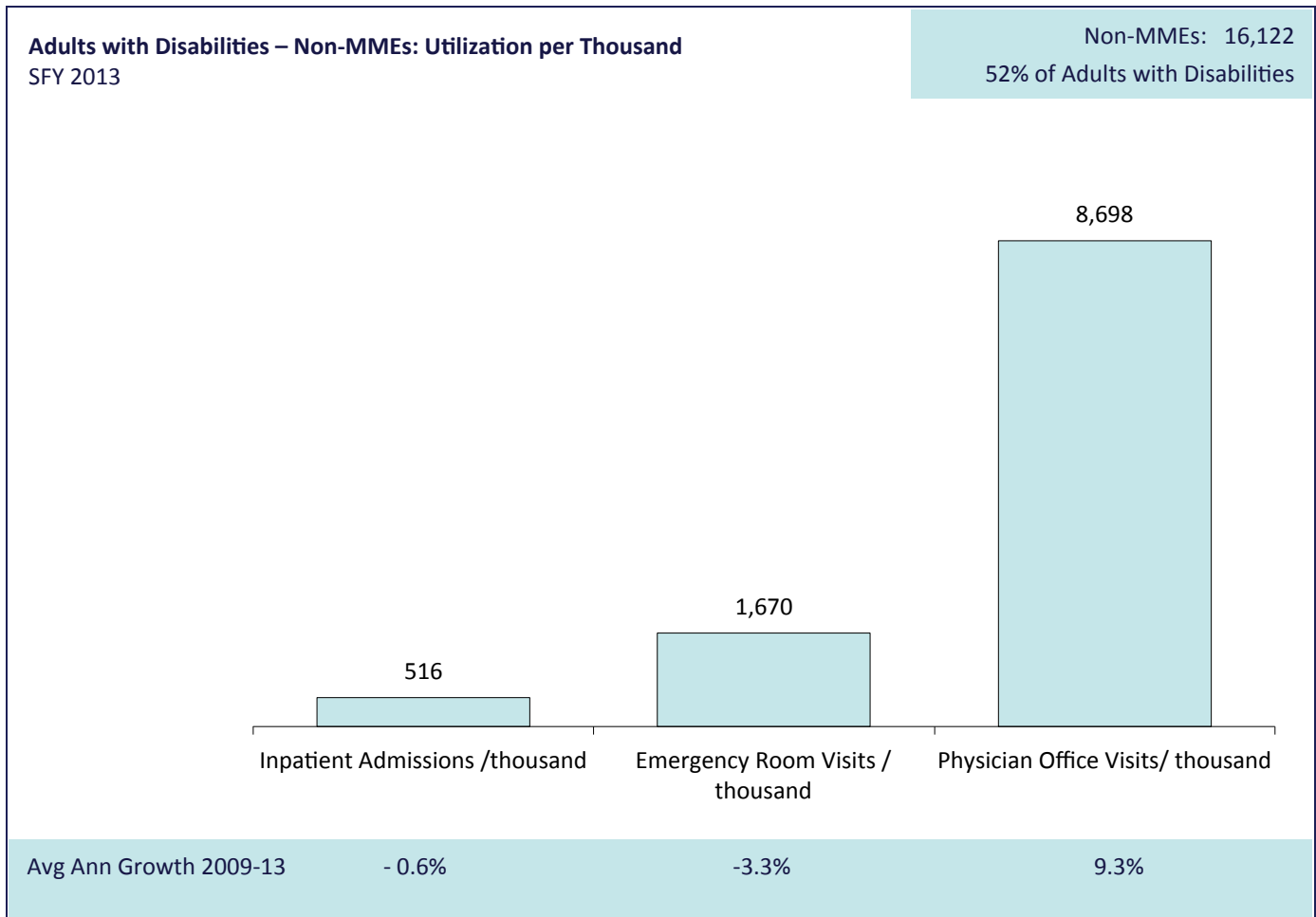
- ❖ The largest category of home and community based services (HCBS) is personal care services, with an average of 2,068 recipients in SFY 2013. The daily census for this category has increased at 8.5% per year since SFY 2009 for MME elders.
- ❖ Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.
- ❖ For the 643 non-MME elders, the average daily census for personal care services was 50 recipients. All other categories of HCBS had an average daily census of less than 25 recipients.

¹BHDDH Services includes residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment for those with developmental disabilities. Annual growth rates for BHDDH services are not applicable due to changes in tracking methodologies.

²Shared living is a new program, initiated in SFY 2011, so growth rates are not meaningful.

7b. Utilization by Population: Adults with Disabilities

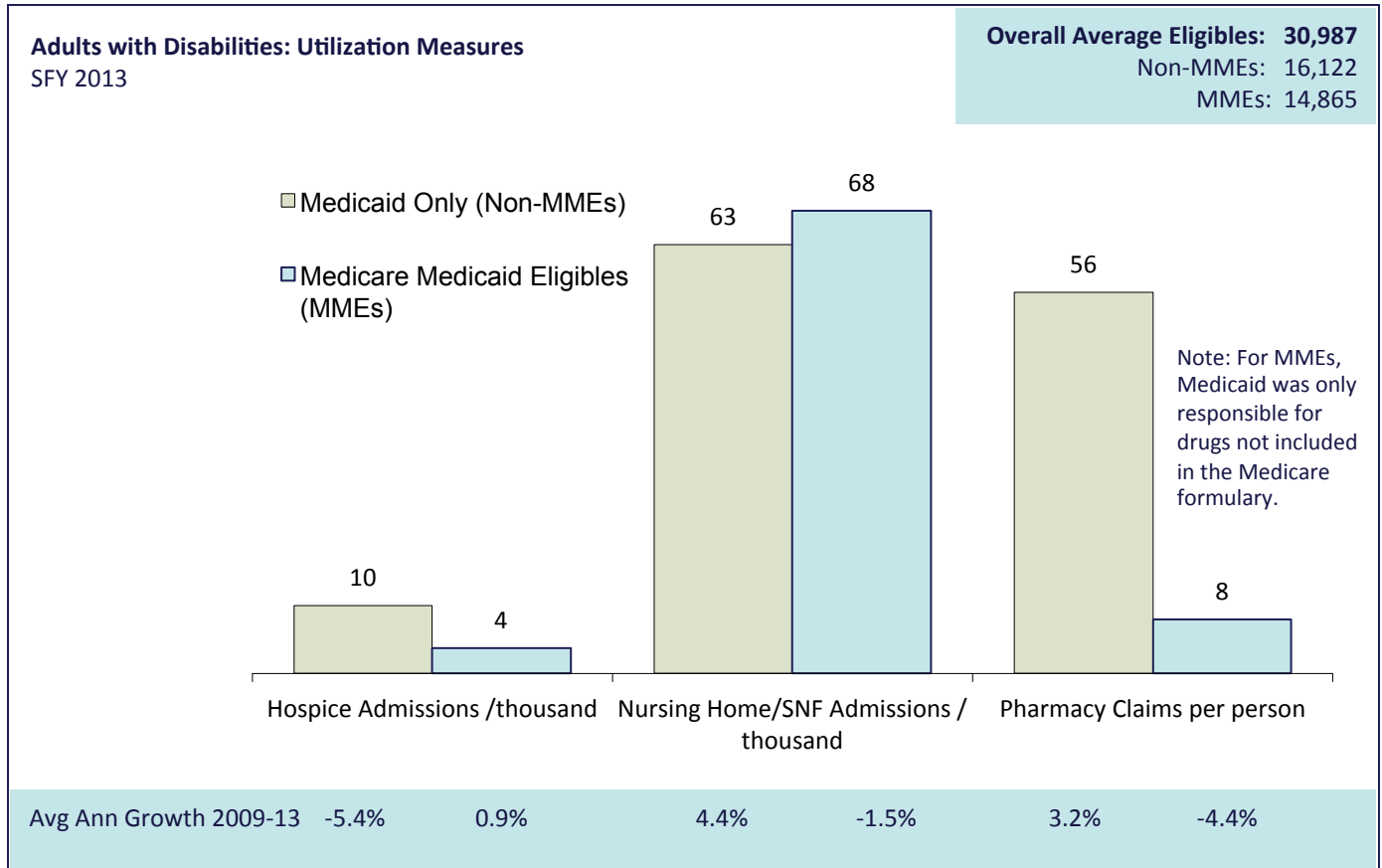
Inpatient admissions and emergency room visits have declined since SFY 2009 for adults with disabilities with Medicaid-only coverage (non-MMEs).



- ❖ Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services. Utilization shown is for the 52% of adults with disabilities without Medicare coverage (Non-MMEs).
- ❖ Non-MME adults with disabilities averaged 8.7 office visits per year in SFY 2013, an increase of 9% per year on average in the last 5 years. Over the same period, inpatient admissions and ER visits for this population have decreased at an annual rate of 0.6% and 3.3% respectively.
- ❖ ER visits for this population decreased from 1,921 per thousand in SFY 2009 to the 1,670 per thousand shown for SFY 2013.

7b. Utilization by Population: Adults with Disabilities

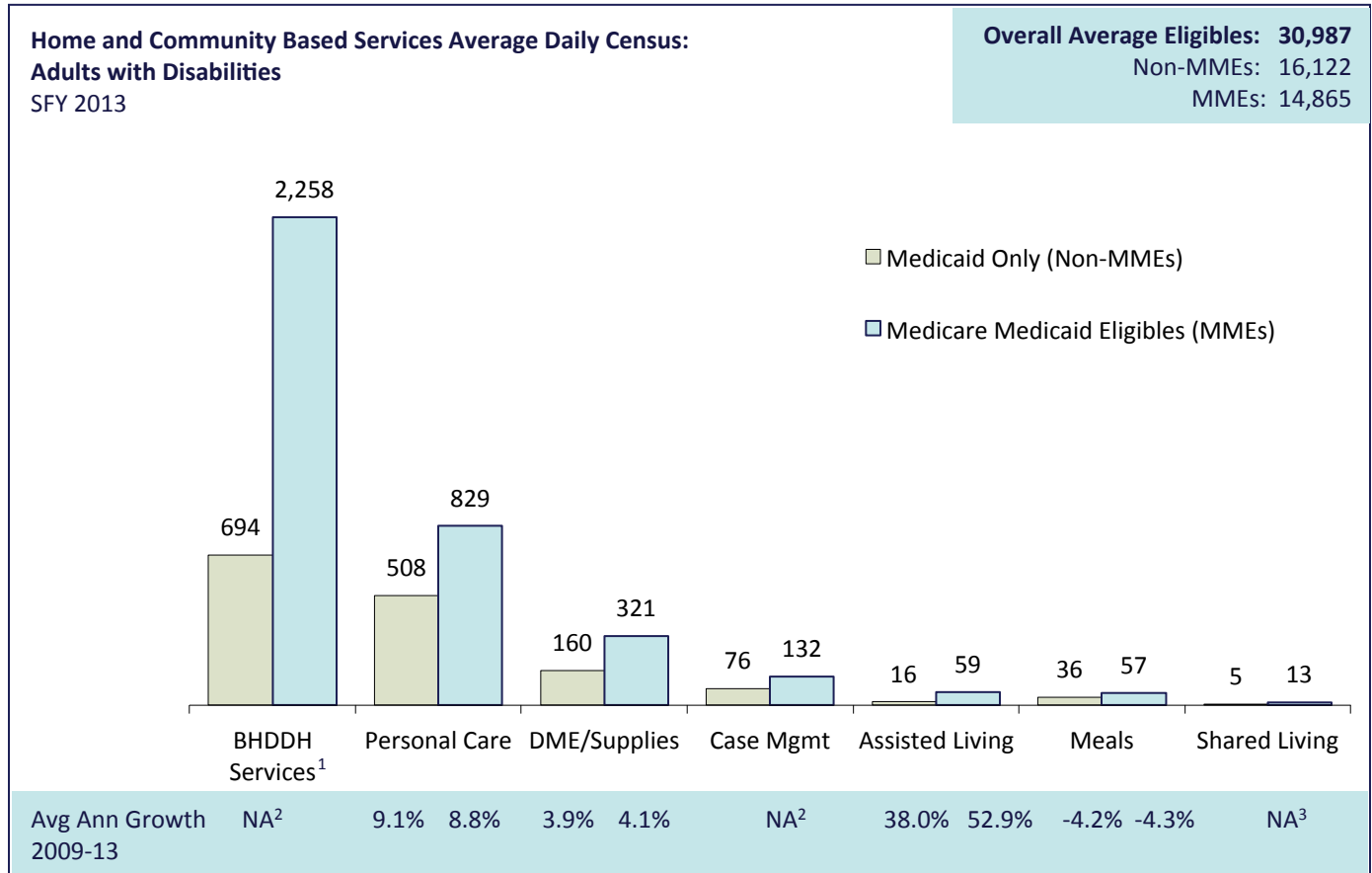
Nursing home admissions per thousand have increased 4% per year since SFY 2009 for Non-MME adults with disabilities.



- ❖ Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid (MMEs). Medicare is the primary payer for the majority of acute and primary care services. Long term services supports are primarily covered through Medicaid.
- ❖ For Non-MME adults with disabilities, hospice admissions decreased 5% per year and nursing home/skilled nursing facility admissions per thousand increased 4% per year since SFY 2009.
- ❖ Nursing home/skilled nursing facility admissions per thousand for MME adults with disabilities were 68 per thousand for SFY 2013, a decrease of 1.5% per year since SFY 2009.
- ❖ Medicare Part D covers most of the pharmacy claims for MME adults with disabilities. Medicaid is only responsible for drugs not included in the Medicare formulary. For Non-MME adults with disabilities, Medicaid was responsible for 56 claims per eligible in SFY 2013, an average increase of 3% per year in the last 5 years.

7b. Utilization by Population: Adults with Disabilities

The largest categories of home and community based services for adults with disabilities is BHDDH services and personal care services.



- ❖ Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services.
- ❖ The largest category of home and community based services (HCBS) is BHDDH services for developmentally disabled individuals, with an average of 694 recipients in SFY 2013 for Non-MMEs and 2,258 recipients for MMEs.
- ❖ The second largest category is personal care services, with an average of 508 recipients in SFY 2013 for Non-MMEs and 829 recipients for MMEs. The daily census for this category is growing at 9% per year on average for both Non-MMEs and MMEs.
- ❖ Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.

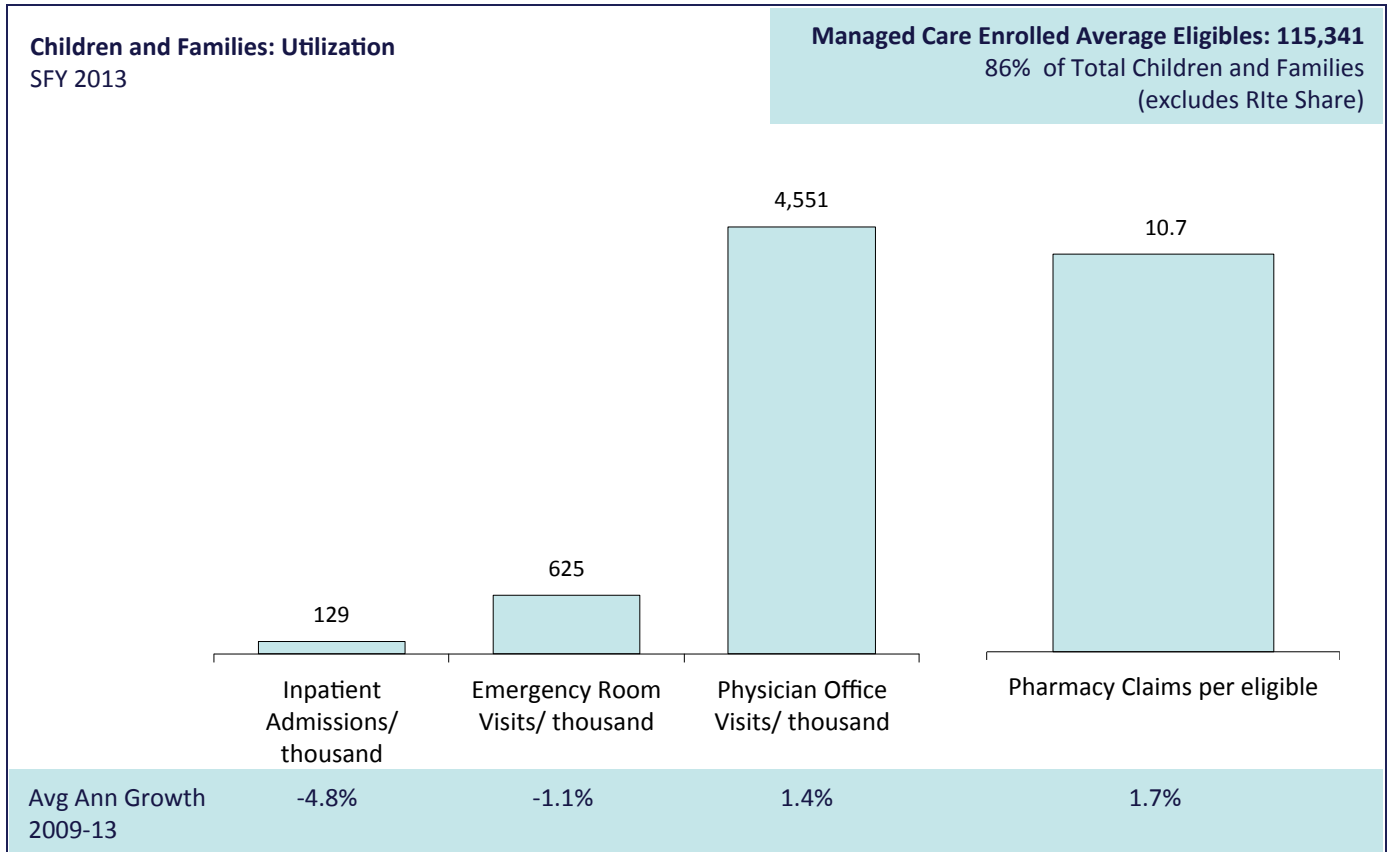
¹BHDDH Services includes residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment for those with developmental disabilities.

²Annual growth rates for BHDDH services are not applicable due to changes in tracking methodologies.

³Shared living is a new program, initiated in SFY 2011, so growth rates are not meaningful.

7c. Utilization by Population: Children and Families

For children and families in managed care, inpatient admissions per thousand and emergency room visits per thousand have decreased since SFY 2009. Physician office visits per thousand and pharmacy claims per thousand have increased since SFY 2009.

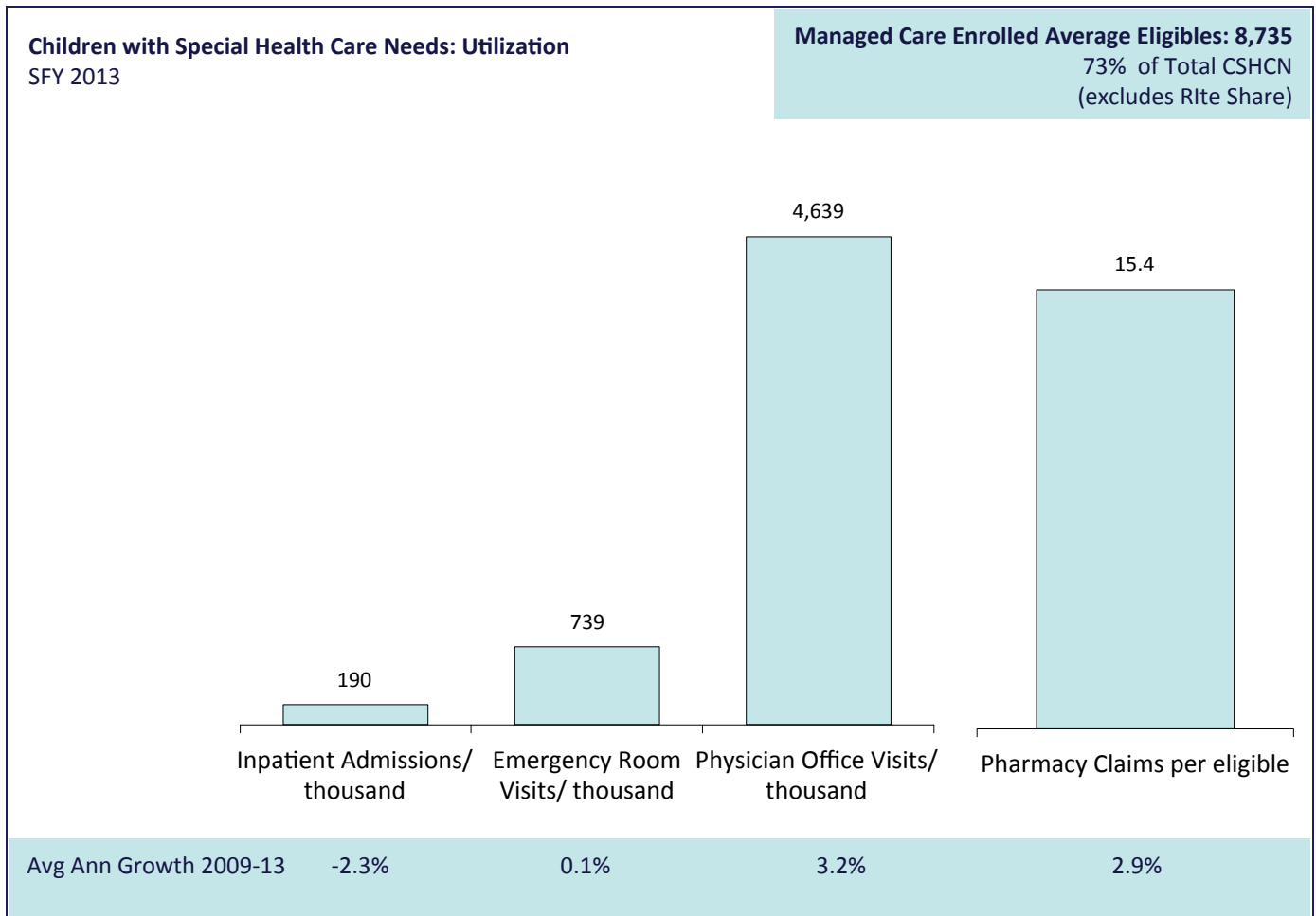


- ❖ Eighty-six percent of children and families are enrolled in managed care through Medicaid managed care organizations (MCOs). Another 7% are covered by Employer Sponsored Insurance (ESI) through the RIte Share program. RIte Share is not included in the data above.
- ❖ About 65% of inpatient admissions per thousand are maternity related (including maternity, nursery and NICU). Annually, approximately 47% of all RI births are covered through RIte Care¹.
- ❖ For children and families in managed care, inpatient admissions per thousand and emergency room visits per thousand have decreased since SFY 2009. Physician office visits per thousand have increased at 1% per year on average.
- ❖ Pharmacy claims per eligible have increased almost 2% per year on average since SFY 2009 to 10.7 claims per eligible in SFY 2013.

¹ Source: <http://www.health.ri.gov/data/birth/>

7d. Utilization by Population: Children with Special Health Care Needs

For children with special health care needs in managed care, inpatient admissions per thousand have decreased since SFY 2009 and emergency room visits per thousand have stayed relatively flat.



- ❖ Seventy-three percent of children with special health care needs are enrolled in managed care through Medicaid MCOs.
- ❖ More than half (55%) of inpatient admissions per thousand are for behavioral health.
- ❖ Inpatient admissions per thousand have decreased over the last 5 years at an average rate of 2% per year to 190 per thousand. ER visits per thousand have stayed flat over the last 5 years.
- ❖ Office visits per thousand have increased at an average rate of 3% per year since SFY 2009 to 4,639 visits per thousand in SFY 2013.
- ❖ Pharmacy claims per eligible have increased at 3% per year over the last 5 years.

Table of Contents

- 1. RI Medicaid Overview**
 - a. Definitions and exclusions
 - b. Federal Contribution (FMAP)
 - c. Overall Medicaid Expenditures and Trends

- 2. RI Medicaid Expenditure Distributions**
 - a. By Department
 - b. By Provider Type
 - c. By Population

- 3. Specialized Population Distributions**
 - a. Managed Care Enrollment and Quality Indicators
 - b. Long Term Services and Supports

- 4. Federal Medicaid Expenditure Classifications**
 - a. Populations and Services
 - b. Optional Services Detail

- 5. Unique Users and High Cost Cases**
 - a. Unique Users
 - b. High Cost Cases

- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)

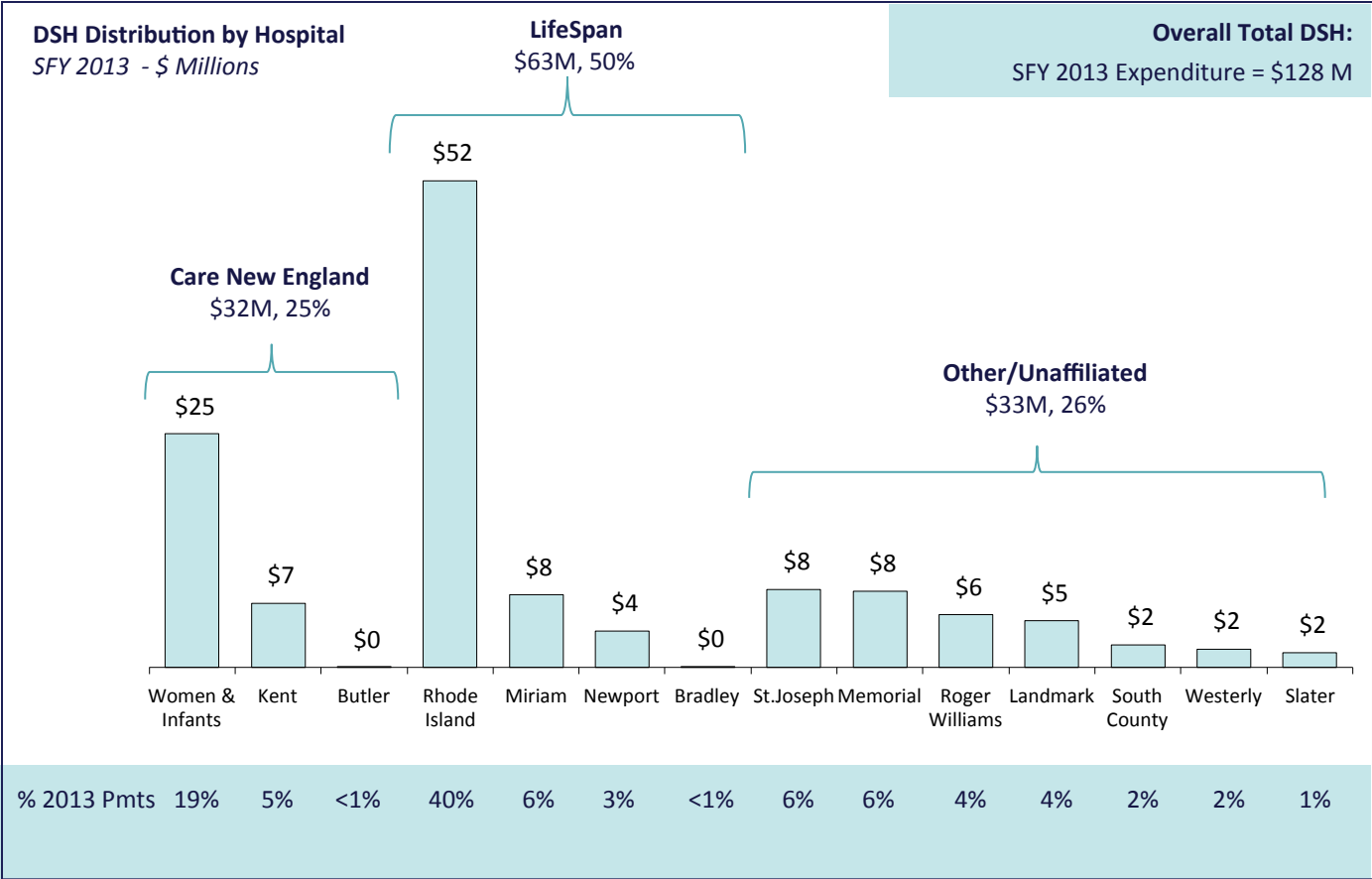
- 7. Utilization by Population**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families
 - d. Children with Special Health Care Needs (CSHCN)

- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms
 - c. Sources and Notes

Appendix A: Exclusions

(1) Disproportionate Share Hospitals (DSH)

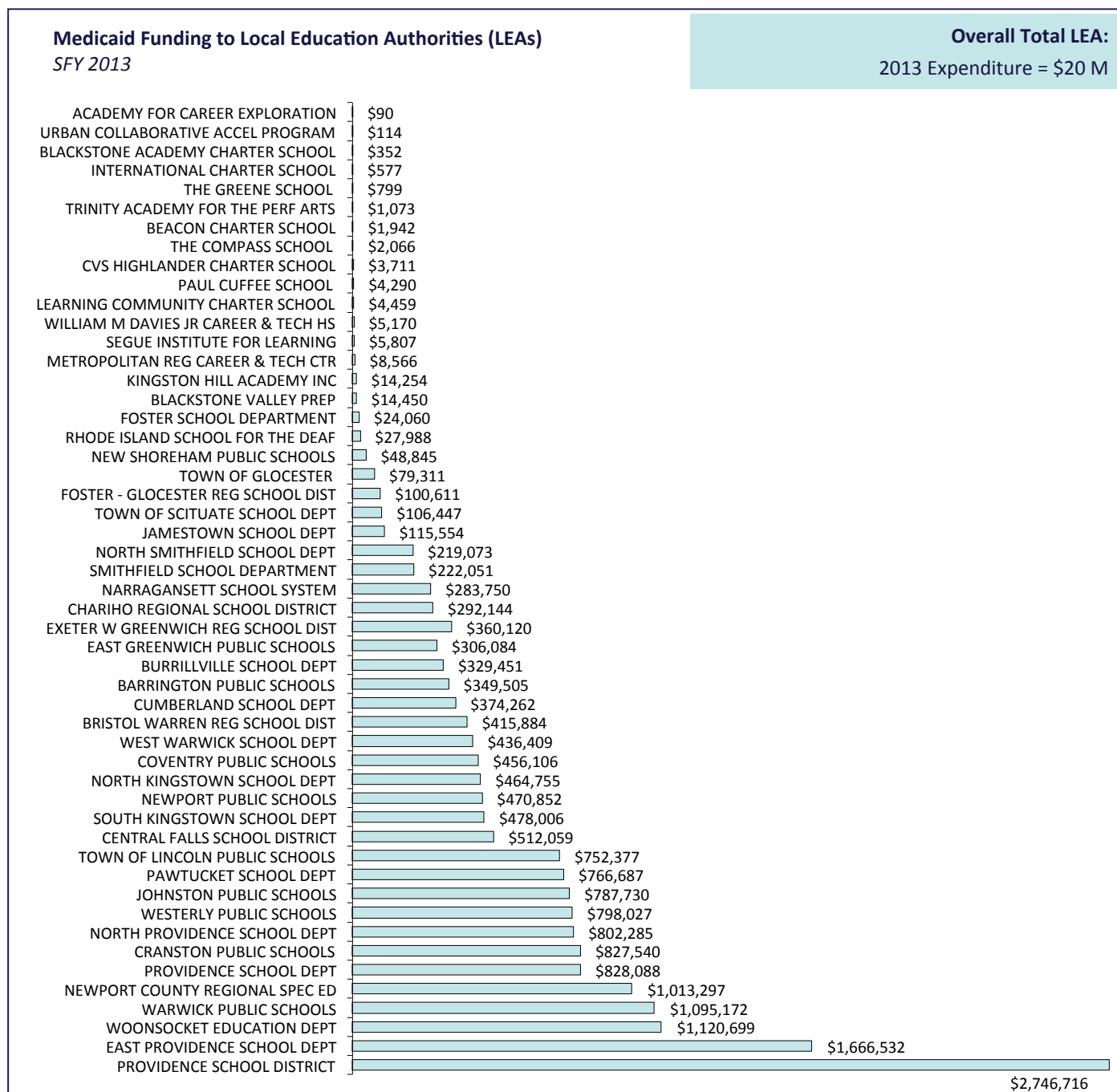
Disproportionate share (DSH) Medicaid payments are intended to subsidize the cost of providing care to indigent and very low income people.



- ❖ A total of \$128 million in DSH funds was paid out to hospitals in SFY 2013.
- ❖ The state’s two largest hospitals – Rhode Island and Women and Infants – together accounted for 59% of total DSH payments
- ❖ DSH payments are not included in the Medicaid expenditure analysis in this report.

Appendix A: Exclusions (2) Local Education Authorities

Local Education Authorities (LEAs) account for \$20 million in total expenditures in 51 school districts.

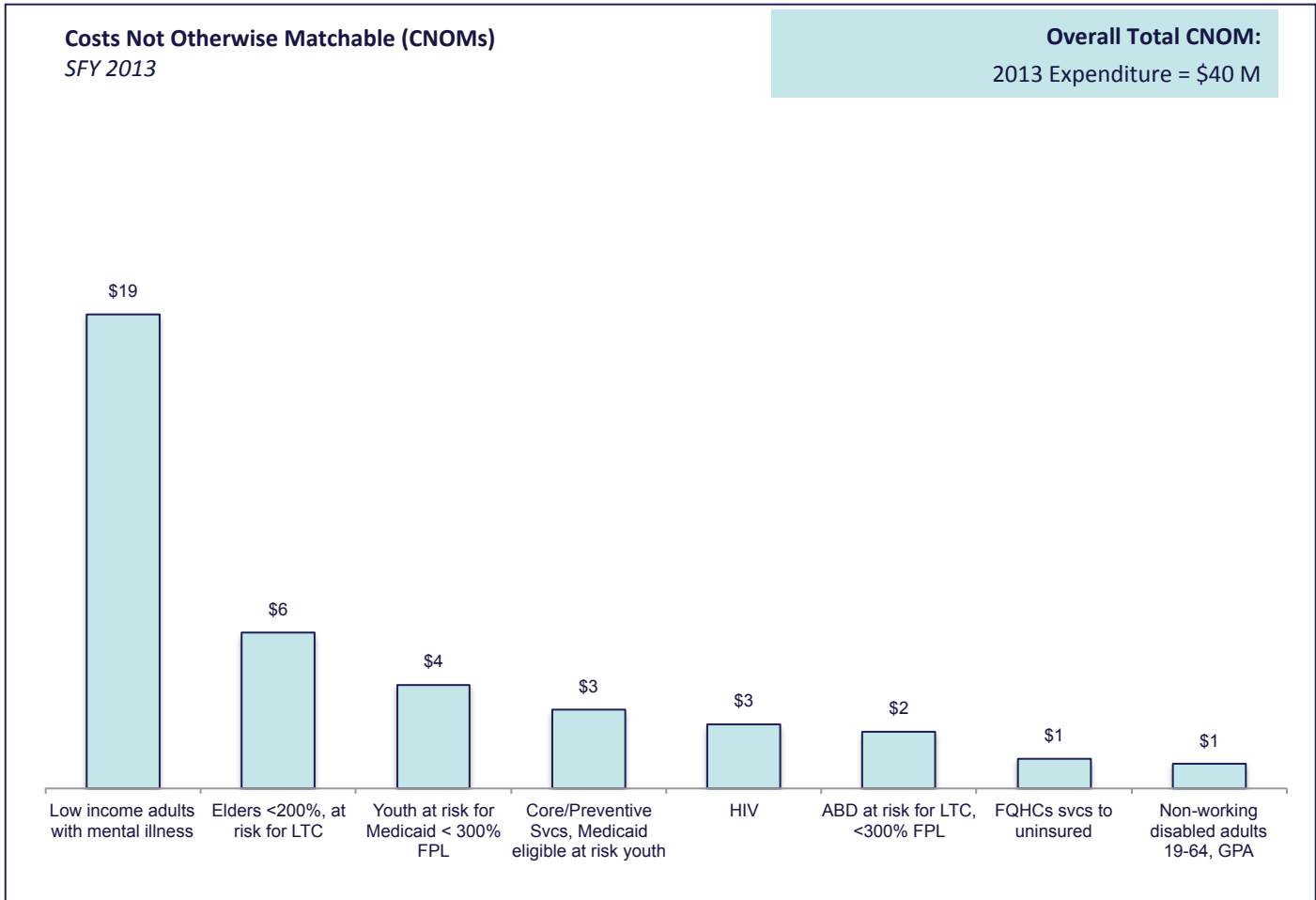


- ❖ For LEA expenditures, the non-federal share is paid by the LEAs.
- ❖ LEA payments are not included in the Medicaid expenditure analysis in this report.

Appendix A: Exclusions

(3) Costs Not Otherwise Matchable (CNOM)

Costs Not Otherwise Matchable (CNOMs) account for \$40 million in total expenditures.



❖ CNOM expenditures are not included in the Medicaid expenditure analysis in this report.

Appendix B: Acronyms and Abbreviations

ACA:	Affordable Care Act
BCBSRI :	Blue Cross Blue Shield of Rhode Island
BHDDH:	Behavioral Healthcare, Developmental Disability, and Hospitals
CHIP:	Children’s Health Insurance Program
CMHC:	Community Mental Health Center
CMS:	Centers for Medicare and Medicaid
CNOM:	Costs Not Otherwise Matchable
CSHCN:	Children with Special Health Care Needs
DCYF:	Department of Children, Youth and Families
DD:	Developmentally Disabled
DEA:	Department of Elderly Affairs
DSH:	Disproportionate Share Hospitals
DHS:	Department of Human Services
DME:	Durable Medical Equipment
DOH:	Department of Health
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
HEDIS:	Healthcare Effectiveness Data and Information Set
ICF:	Intermediate Care Facility
IP:	Hospital Inpatient
LEA:	Local Education Agencies
LTSS:	Long Term Services and Supports
MCO:	Medicaid Managed Care Organization
MME:	Medicaid Medicare Eligibles
NHPRI :	Neighborhood Health Plan of Rhode Island
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
RIPTA:	Rhode Island Public Transit Authority
SA:	Substance Abuse
SNF:	Skilled Nursing Facilities
SFY:	State Fiscal Year
SSI:	Supplemental Security Income
UHCNE:	UnitedHealth Care of New England
UPL:	Upper Payment Limit

Appendix C: Sources and Notes

Source Data and Analytic Method

This report is based on SFY 2013 and a five year historical Rhode Island Medicaid claims extract:

- ❖ Includes claims, capitation payments, premiums and provider payouts.
- ❖ Reflects data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through November 2013
- ❖ Capitations, premiums and payouts are allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information with IBNR.

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 and rounding.