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**Rhode Island Annual Medicaid Expenditure Report – SFY 2015**

**Executive Office of Health and Human Services**

**May 2016**

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# Executive Summary: Purpose

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## Purposes of the Expenditure Report

The purposes of this report include the following:

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

## Additional Notes

**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 present longer term trends rather than year to year variation. An average annual increase of 1.0% per year from 2011 to 2015 is equivalent to an increase of 4.1% in total from 2011 to 2015.

**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.

# Executive Summary: Overview

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## Overview

During SFY 2015 Rhode Island's Medicaid program served approximately 317,000 Rhode Islanders, with an average of 271,000 enrolled at any one time. This includes about 77,000 individuals enrolled in Medicaid Expansion, the program started January 1, 2014 to expand Medicaid eligibility to adults without dependent children with incomes less than 138% of the federal poverty level.

Program expenditures overall for SFY 2015 totaled \$2.3 billion. Medicaid expenditures are divided among several state agencies, with \$1,950 million of expenditure managed in SFY 2015 by the Executive Office of Health and Human Services (EOHHS), and \$335 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 2015 the Federal Medical Assistance Percentage (FMAP) was 50.30% for the bulk of Medicaid expenditure. The FMAP is 100% for the Expansion population through the end of calendar year 2016.

## Key Findings:

- ❖ Between SFY 2011 and 2015, total Rhode Island Medicaid medical expenditures based on date of service have increased an average of 1.6 percent per year. This trend rate excludes growth from the Expansion population.
- ❖ Enrollment has increased 2.9% per year on average over the last five years, excluding growth from the Expansion population. When including Expansion enrollment, enrollment increased 13.1% from SFY 2013 to SFY 2014 and another 22.4% from SFY 2014 to SFY 2015.
- ❖ Per member per month (PMPM) costs have decreased 1.3% per year, from \$797 in SFY 2011 to \$756 in SFY 2015, or \$714 in SFY 2015 when including the relatively lower cost Expansion population.
- ❖ These expenditure trends compare quite favorably to both national Medicaid total expenditures and state commercial per member per month cost trends.
- ❖ Adults with disabilities account for 31% of expenditure. Elders account for another 22%.
- ❖ Hospitals and nursing facilities account for nearly half (47%) of Medicaid expenditure.
- ❖ Eighty-seven percent of Medicaid recipients are enrolled in managed care programs. Both of Rhode Island's Medicaid managed care organizations were rated 4.5 out of 5 by the National Committee for Quality Assurance (NCQA).
- ❖ Claims expenditures are highly concentrated – the 6% of users with the highest costs account for 62% of claims expenditure.

# Executive Summary: Populations

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## Populations Served

Medicaid serves five 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. For those 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). Elders account for \$523 million in total SFY 2015 Medicaid expenditure, and have the highest average cost per member per month (PMPM) of \$2,301. Nursing facilities account for nearly two-thirds (65%) of expenditures for this population.
- ❖ **Adults with disabilities** includes adults under age 65 who have identified disabilities. Almost half (47%) of this population is also covered by Medicare. Adults with disabilities account for the largest share of expenditure, with SFY 2015 expenditure of \$709 million, and an average PMPM cost of \$1,859. The largest components of expenditure for this population are residential and rehabilitation services for persons with developmental disabilities (27%) and hospital care (21%). However, both expenditure on hospital care and the utilization measure of hospital inpatient days per thousand for this population have decreased over the last five years.
- ❖ **Children and families** includes low income children, parents and pregnant women who meet specific income requirements. Children and families account for 55% of total enrollment and 23% of total expenditure, with total SFY 2015 expenditure of \$524 million and an average PMPM of under \$300. Additionally, the federal match is increased to 65.02% for qualifying low income children and pregnant women under the Children's Health Insurance Program (CHIP). Most expenditure on this population is for hospital care (49%) and professional services (31%). Ninety-four percent of this population is enrolled in managed care.
- ❖ **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 7% of total Medicaid expenditures and 4% of enrollees, with SFY 2015 expenditures of \$171 million. Expenditures on this population are dominated by professional behavioral health services, which account for just under half (40%) of total expenditures.
- ❖ **Expansion** includes low income adults without dependent children newly eligible under the ACA on January 1, 2014. The Expansion population accounted for 22% of SFY 2015 enrollment and 17% of total SFY 2015 expenditure, or \$392 million. Expenditure for this population is 100% federally funded through the end of calendar year 2016. This population mainly used hospital and professional services, accounting for 79% of expenditures on the Expansion population. Nearly all (93%) were enrolled in managed care.

# Executive Summary: Providers and LTSS

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## Medicaid Providers

Medicaid pays for services offered by a variety of provider types. 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 30% of Medicaid expenditure in SFY 2015. Hospital payments had been a key driver of Medicaid expenditure growth, however total Medicaid payments to hospitals have decreased by an average of 1.3% per year since SFY 2011.
- ❖ Nursing facilities (including both nursing homes and hospice) were the next largest provider type, accounting for 17% of expenditure in SFY 2015. Total Medicaid payments to nursing facilities has been increasing on average 3.3% per year between SFY 2011-2015. Over the same period, nursing home days per thousand for non-Expansion Medicaid eligibles have decreased by 3.1% per year.
- ❖ The provider type categories with the highest average annual growth trends were professional services, home and community based services, and premiums.
- ❖ Overall, acute, chronic and preventive services account for 64% of Medicaid expenditure and the remaining 36% are for long term services and supports.

## Long Term Services and Supports

Long term services and supports (LTSS) include institutional care, home and community based services (HCBS), and residential and rehabilitation services for the developmentally disabled. These services are mainly focused on the elders and adults with disabilities populations. Expenditures on LTSS account for \$832 million in total Medicaid expenditure in SFY 2015.

- ❖ HCBS and residential and rehabilitation services for the developmentally disabled are services provided to at-risk populations as alternatives to more costly nursing home/institutional options and account for \$334 million, 40% of the LTSS expenditure.
- ❖ Institutional care services account for the remaining \$498 million of LTSS expenditure. The largest category is nursing home services, accounting for 73% of institutional care expenditure and 44% of LTSS expenditure overall. Other institutional care expenditure is for hospice and Slater Hospital, Tavares and Zamabarano.
- ❖ The total expenditure for HCBS and nursing facilities is \$494 million in SFY 2015 (nursing facilities includes both nursing home and hospice care). The HCBS portion of that expenditure is 22%. This reflects the relative balance of expenditure between home and community based services and nursing facilities.
- ❖ Expenditure on HCBS has been growing at 7.7% per year on average over the last 5 years. Nursing home expenditure has been growing at 3.7% per year on average. In addition, the utilization measure for non-Expansion Medicaid nursing home days per thousand has decreased 3.1% on average per year over the last 5 years.

# Executive Summary: Managed Care and High Utilizers

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## Managed Care

It is important to note that not all payments are made directly by Medicaid to service providers. In SFY 2015, 87% of Medicaid eligibles were enrolled in risk-based managed care plans. These enrolled populations accounted for 74% of Medicaid expenditure.

- ❖ Forty-nine percent of Medicaid eligibles were enrolled in RIte Care, which is a Medicaid managed care program for children and families. Another 5% were enrolled in Rhody Health Partners (RHP), a managed care program for adults with disabilities.
- ❖ Enrollment for RIte Care and RHP is divided between Neighborhood Health Plan and United Healthcare. Both of these Medicaid managed care organizations were rated 4.5 out of 5 by the National Committee for Quality Assurance (NCQA).
- ❖ Rhody Health Options (RHO) is a new managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports, and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility. In SFY 2015 6% of Medicaid eligibles were enrolled in RHO.
- ❖ Three percent of Medicaid eligibles were enrolled in RIte Share, a premium assistance program for Medicaid eligibles with access to commercial insurance. This minimizes Medicaid expenditure by leveraging the employers' contributions.
- ❖ The Expansion population is mainly enrolled in managed care.

## High Utilizers

The six percent of Medicaid users with the highest costs, those with over \$25,000 in claims expenditure per year, account for nearly two-thirds (62%) of claims expenditures.

- ❖ High cost users are depicted in this report as those who incur \$15,000 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. Nine percent of Medicaid users are high cost users and account for 71% of claims expenditure.
- ❖ Nearly half (42%) of claims expenditure for high cost users is for nursing facilities and residential and rehabilitation services for persons with developmental disabilities. Hospital services account for another 25% of high cost user claims expenditure.
- ❖ Elders and Adults with disabilities account for 71% of claims expenditure for high cost users. For the elders population, 84% of total population expenditure is attributable to high cost user claims.

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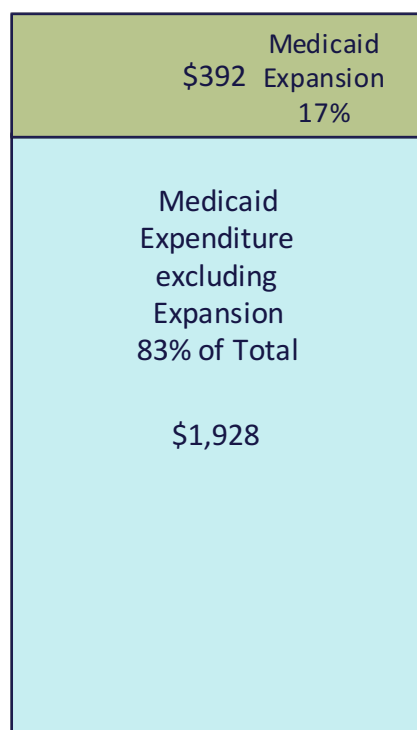
## 1a. Total Expenditures: Definitions and Exclusions

Medicaid expenditures in SFY 2015 totaled approximately \$2,319 million, including \$392 million for Medicaid Expansion.

### Summary: Total Medicaid Expenditures for Covered Services

SFY 2015 - \$ Millions – totals include rounding error

#### Total Medicaid Expenditure: \$2,319 M<sup>1</sup>



SFY 2015 Medicaid Expenditure

#### Excluded from this Analysis:

\$138 M Disproportionate Share Hospital payments (DSH)

\$15 M Costs Not Otherwise Matchable (CNOM)

\$19 M Local Education Authorities (LEAs)

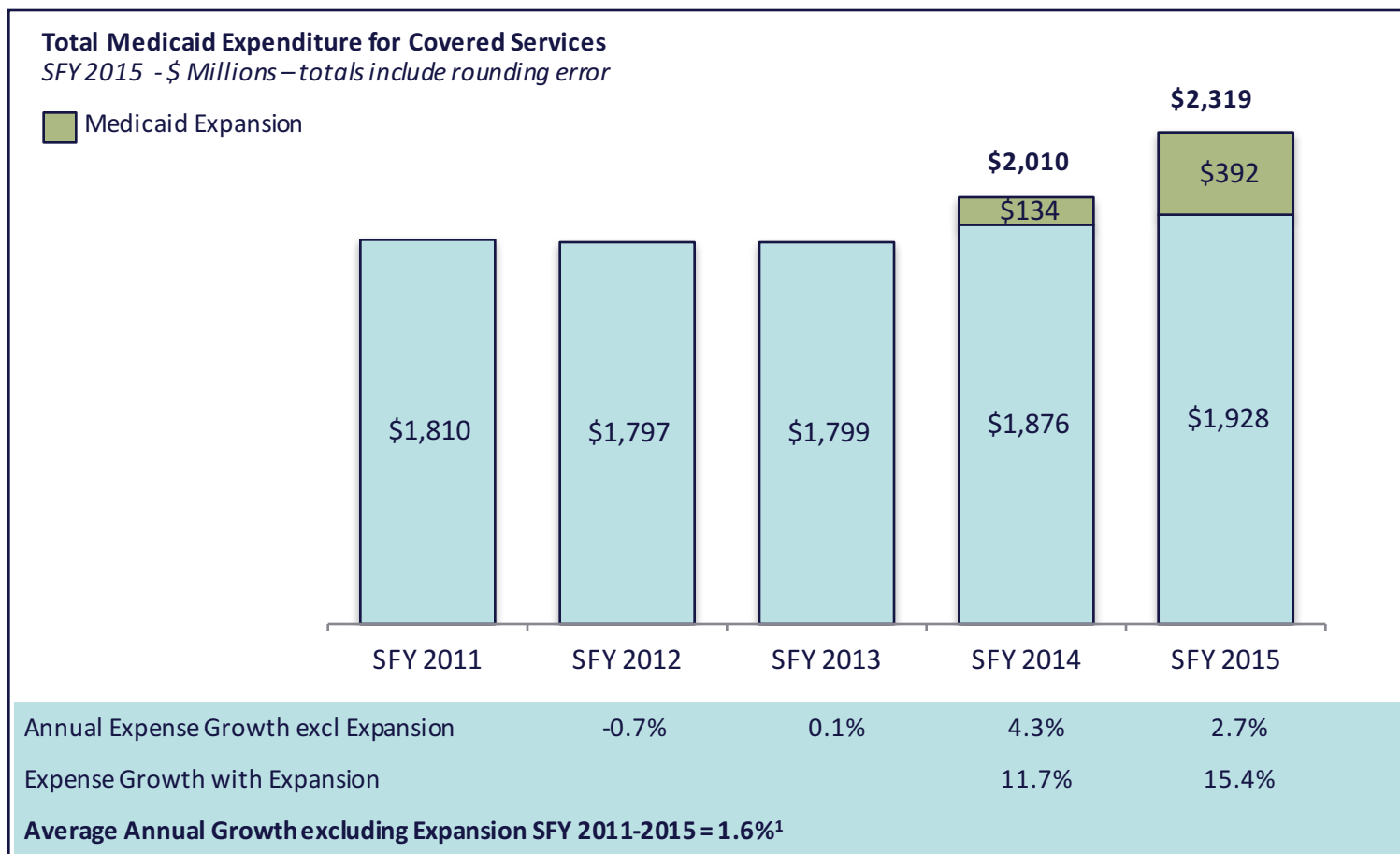
*(see Appendix for more detail on DSH, CNOM and LEAs)*

- ❖ In state fiscal year 2015, Rhode Island incurred approximately \$2,319 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.
- ❖ Starting January 1, 2014, Rhode Island expanded Medicaid coverage to childless adults under 138% FPL. Final expenditure on this population during SFY 2015 was \$392 million and the state received 100% federal matching funds for this newly eligible population.
- ❖ The analysis in this report excludes \$138 million in DSH (Disproportionate Share Hospital) payments, \$15 million in costs not otherwise matchable (CNOM), and payments of \$19 million to Local Education Authorities (LEAs). More detail on the excluded 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.

<sup>1</sup>Totals do not sum exactly due to rounding error.

## 1b. Medicaid Expenditure Trends

Over the past five years, Rhode Island Medicaid expenditures have increased 1.6% per year on average, excluding the Medicaid expansion population.



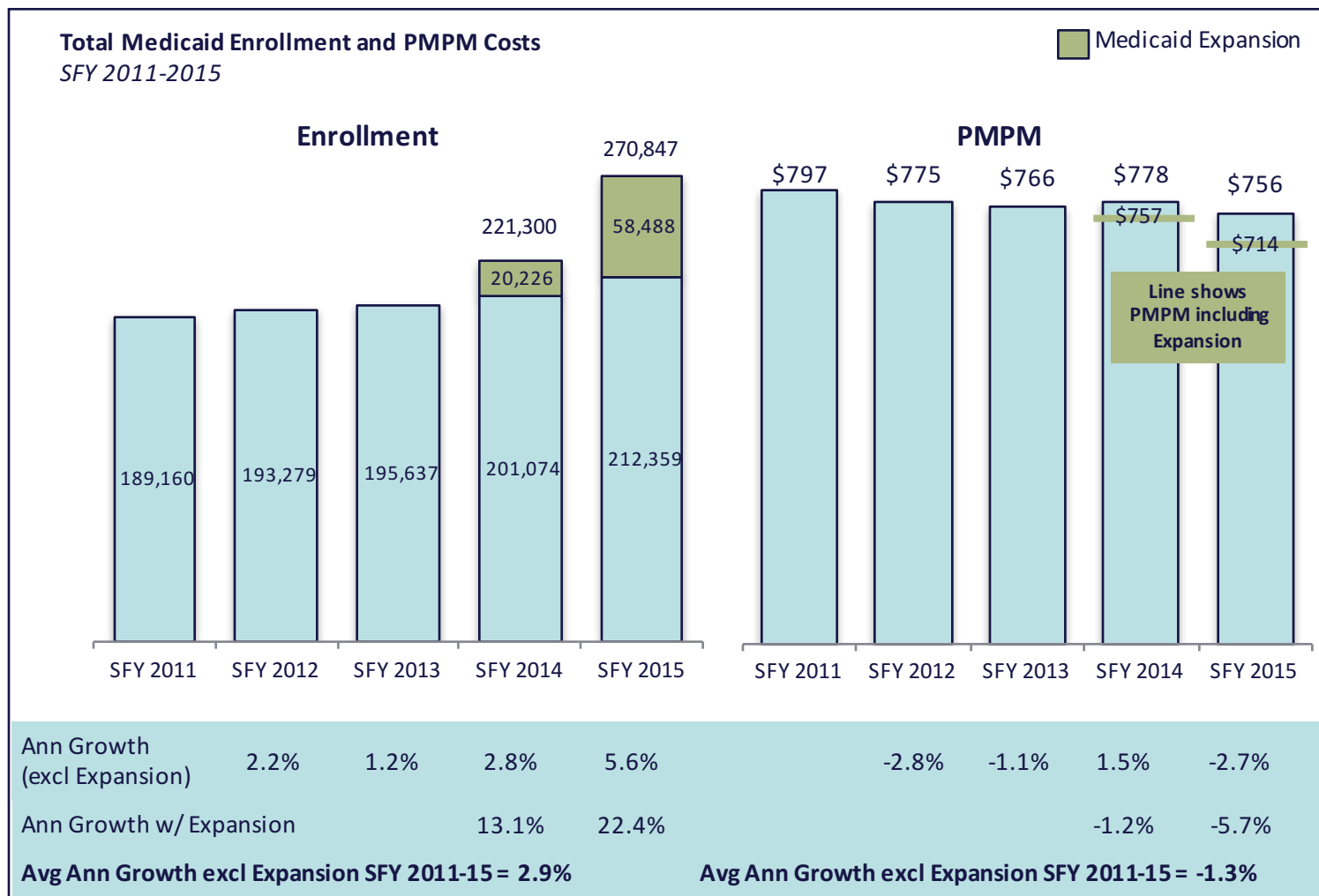
- ❖ Excluding the Medicaid Expansion population, overall Medicaid expenditures have increased by approximately 1.6% per year over the last five years.
- ❖ Expenditure decreased from SFY 2011 to SFY 2013, but then increased 4.3% from SFY 2013 to 2014, and 2.7% from SFY 2014 to SFY 2015, excluding the Expansion population.
- ❖ One contributing factor to the increase in expenditure was the ACA-mandated primary care physician rate increase in effect for calendar years 2013 and 2014, which increased payments to primary care physicians for certain services to match the Medicare Physician Fee Schedule. This rate increase, which was 100% federally funded, added approximately \$24 million in spending across SFY 2013-2015 – of this figure, roughly half occurred in SFY 2014.
- ❖ Including the Expansion population, expenditure increased 11.7% from SFY 2013 to SFY 2014 and 15.4% between SFY 2014 and SFY 2015, however the state receives federal matching funds to cover 100% of the Expansion population through the end of calendar year 2016.<sup>2</sup>

<sup>1</sup>Calculated as compounded annual growth rate (CAGR) over period SFY 2011-2015 as shown.

<sup>2</sup>Medicaid Enrollment and the Affordable Care Act, ASPE Issue Brief, March 2015

## 1b. Medicaid Expenditure Trends: Enrollment and PMPM

Average annual Medicaid enrollment has increased each year since SFY 2011 while PMPM costs have declined overall.

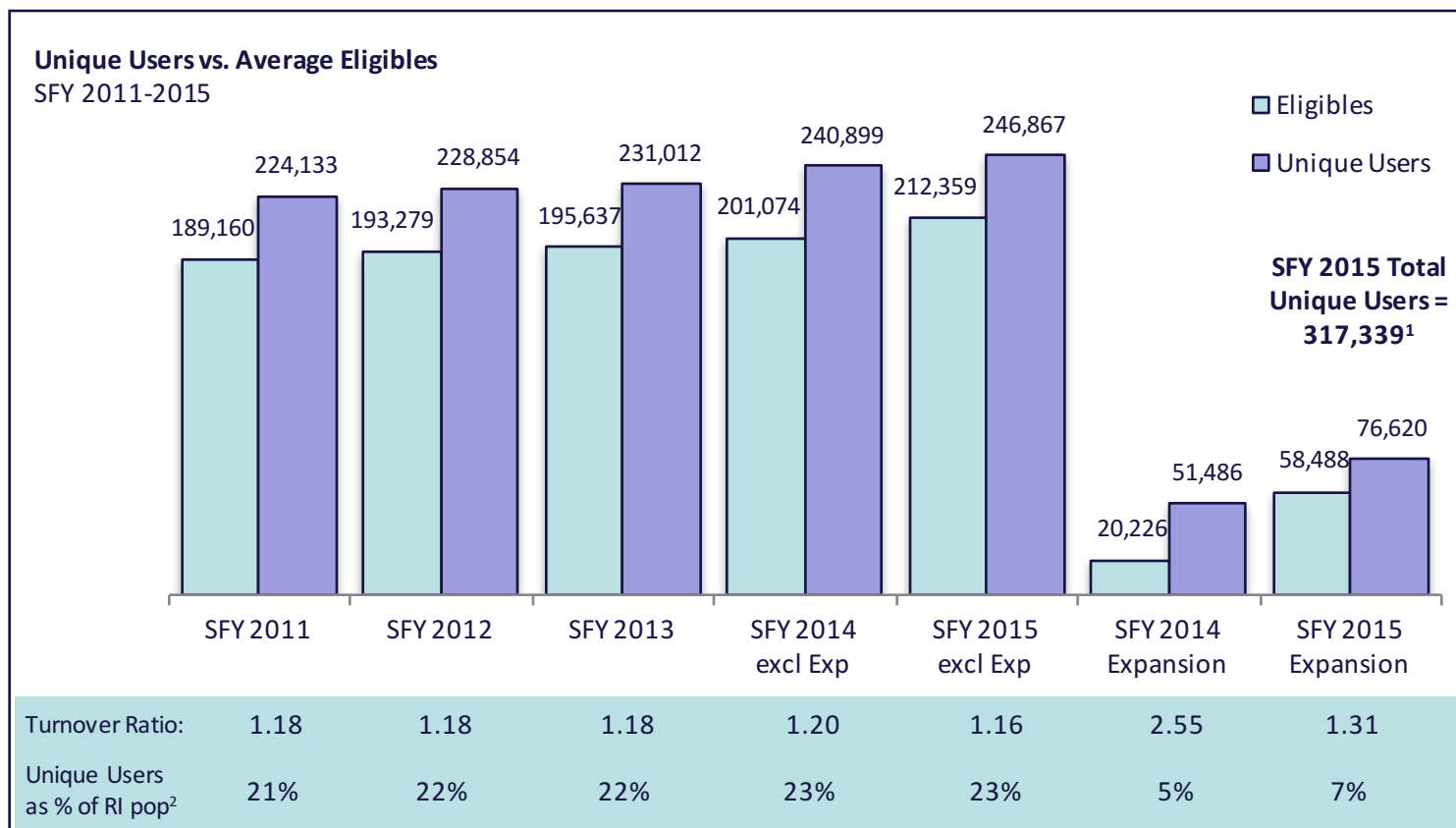


- ❖ Nearly all of the increase in total Medicaid expenditure in the last five years is due to increases in enrollment.
- ❖ Enrollment has increased 2.9% per year on average excluding Medicaid Expansion. The increase from SFY 2014 to SFY 2015 was 5.6% without including Medicaid Expansion.
- ❖ Including Medicaid Expansion, average enrollment increased 13.1% from SFY 2013 to SFY 2014 and 22.4% from SFY 2014 to SFY 2015.
- ❖ Over SFY 2011-2015, PMPM costs have decreased 1.3% per year on average. The PMPM cost for SFY 2015 excluding Expansion is lower than any of the last 5 years.
- ❖ Including the Medicaid Expansion population, the average PMPM for Medicaid overall is \$714, a decrease of 5.7% from SFY 2014. This is because the Expansion population is relatively lower cost.

Note: Annual enrollment totals in this report may differ from other State-issued reports and analyses due to differing treatment of retroactive enrollments and partial months of enrollment, among other factors.

## 1b. Medicaid Expenditure Trends: Unique Users

When including the Expansion population, about 30% of Rhode Island's population were enrolled in Medicaid for some part of SFY 2015.



- ❖ Unique users is a measure of the number of Rhode Islanders who were enrolled in Medicaid at any time during the fiscal year.<sup>3</sup> 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. 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.
- ❖ The higher turnover ratio for the Expansion population in SFY 2014 is due to the fact that Expansion enrollees were enrolled for at most 6 months of the year and many were enrolled for less than that. In SFY 2015, the turnover ratio still represents some impact of the phase-in of the Expansion population but is much closer to the typical annual turnover ratio.

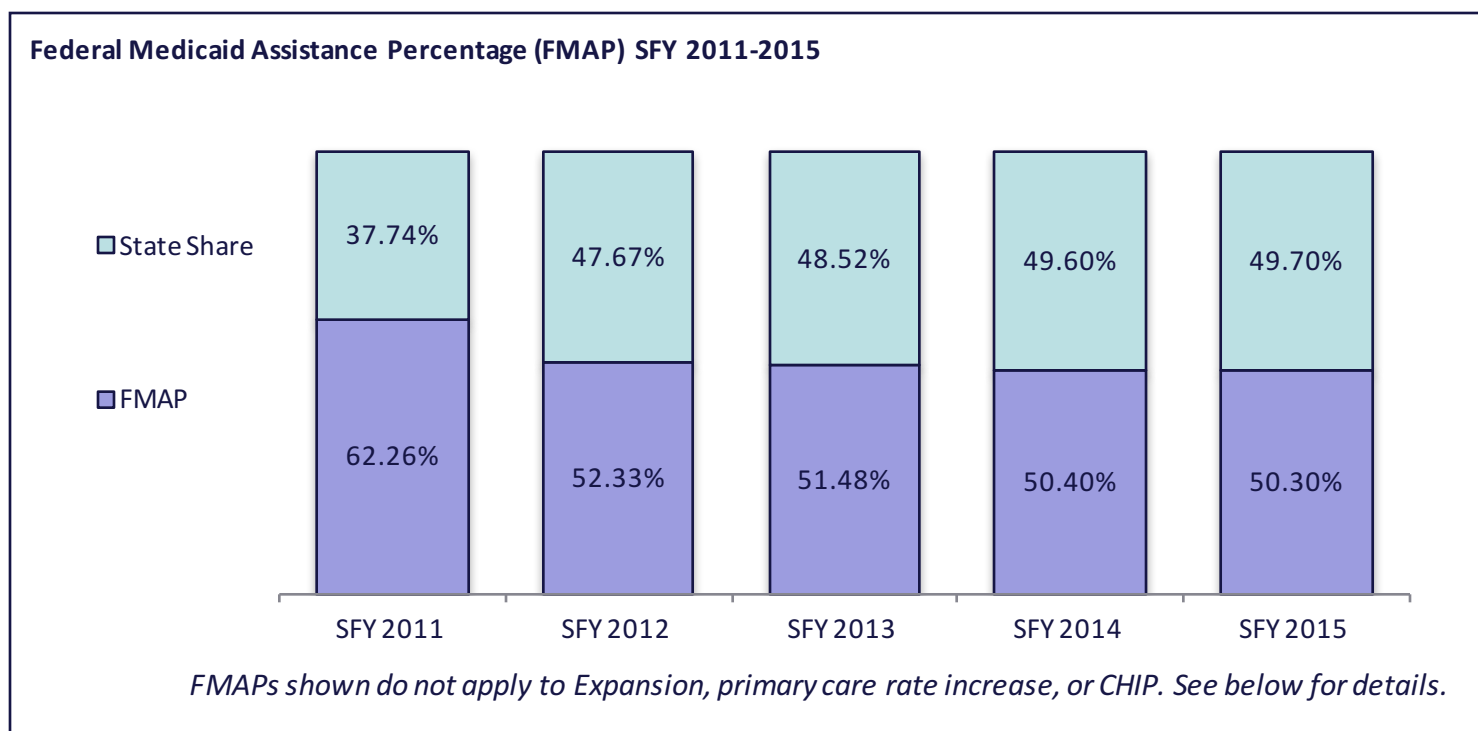
<sup>1</sup>Total unique users for SFY 2015 including Expansion excludes 6,148 users who overlap between expansion and non-expansion groups.

<sup>2</sup>Source: Population Division, US Census Bureau. <http://quickfacts.census.gov/qfd/states/44000.html>

<sup>3</sup>A unique user is an individual associated with a medical claim. Average eligible enrollment is annual FTEs (full time equivalents).

## 1c. Federal and State Share of Expenditures

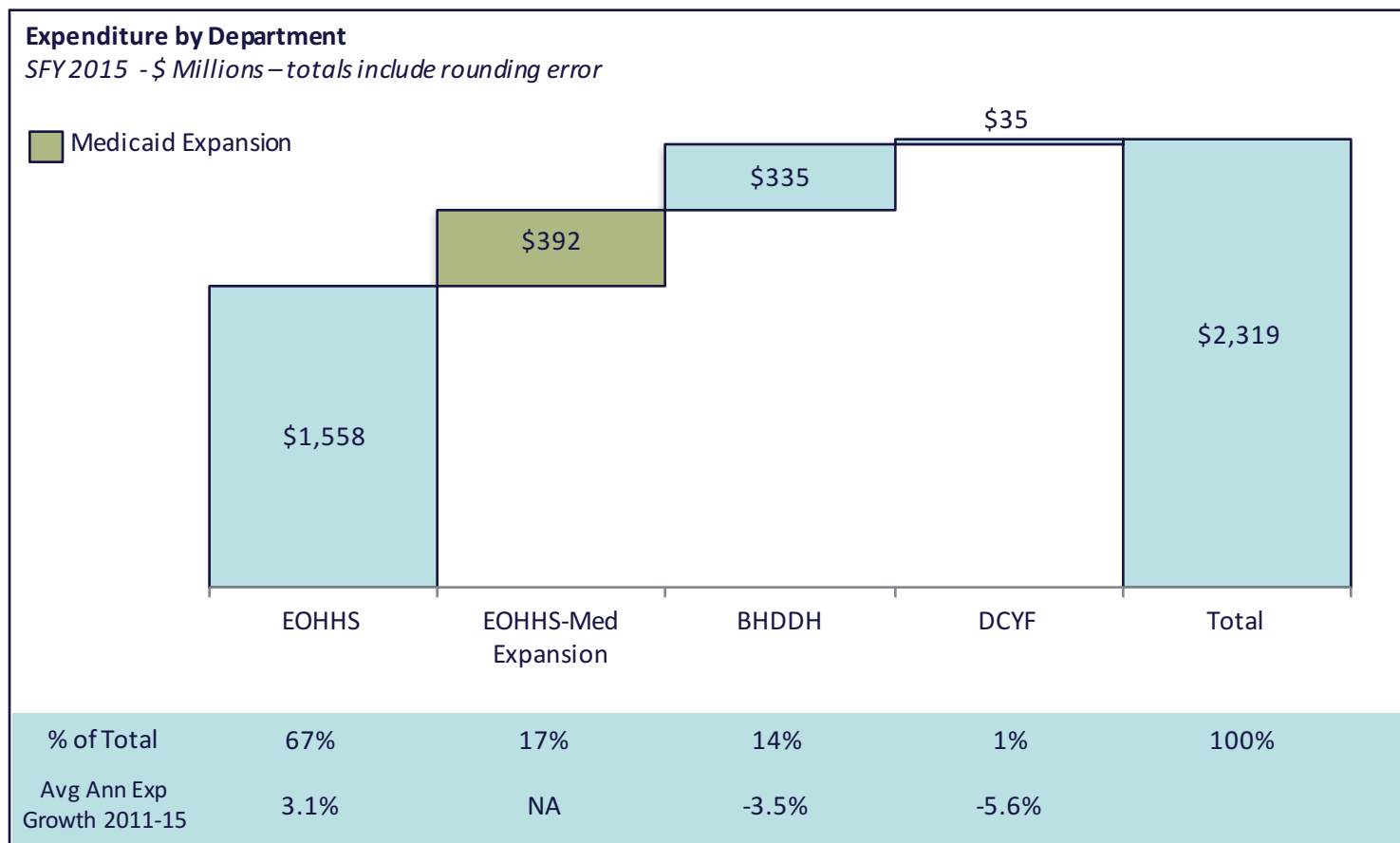
The State of Rhode Island is typically responsible for just under half of Medicaid expenditures.



- ❖ 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.
- ❖ Federal stimulus funding increased FMAP by 11 percentage points in 2008 - 2011, resulting in a reduction in state share of Medicaid expenditure for the affected years, including SFY 2011 as shown above.
- ❖ There are several instances of variation from the FMAP levels shown above:
  - The FMAP for the Medicaid Expansion population is 100% for SFY 2015. Expenditure for the Expansion population is covered entirely by the federal matching funds through December 2016.
  - During CY 2013 and CY 2014, the State was required to increase payments to primary care physicians for certain services to match the Medicare Physician Fee Schedule. The additional cost of this requirement was funded with 100% federal matching funds.
  - 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 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 2015, Rhode Island received a 65.02% combined CHIP/FMAP federal match on CHIP children and pregnant women.
  - There are also a few small programs with a 90% match, including Breast & Cervical Cancer Prevention & Treatment (BCCPT), Early Family Planning (EFP), and Money Follows the Person (MFP).

## 1d. Expenditure by Department

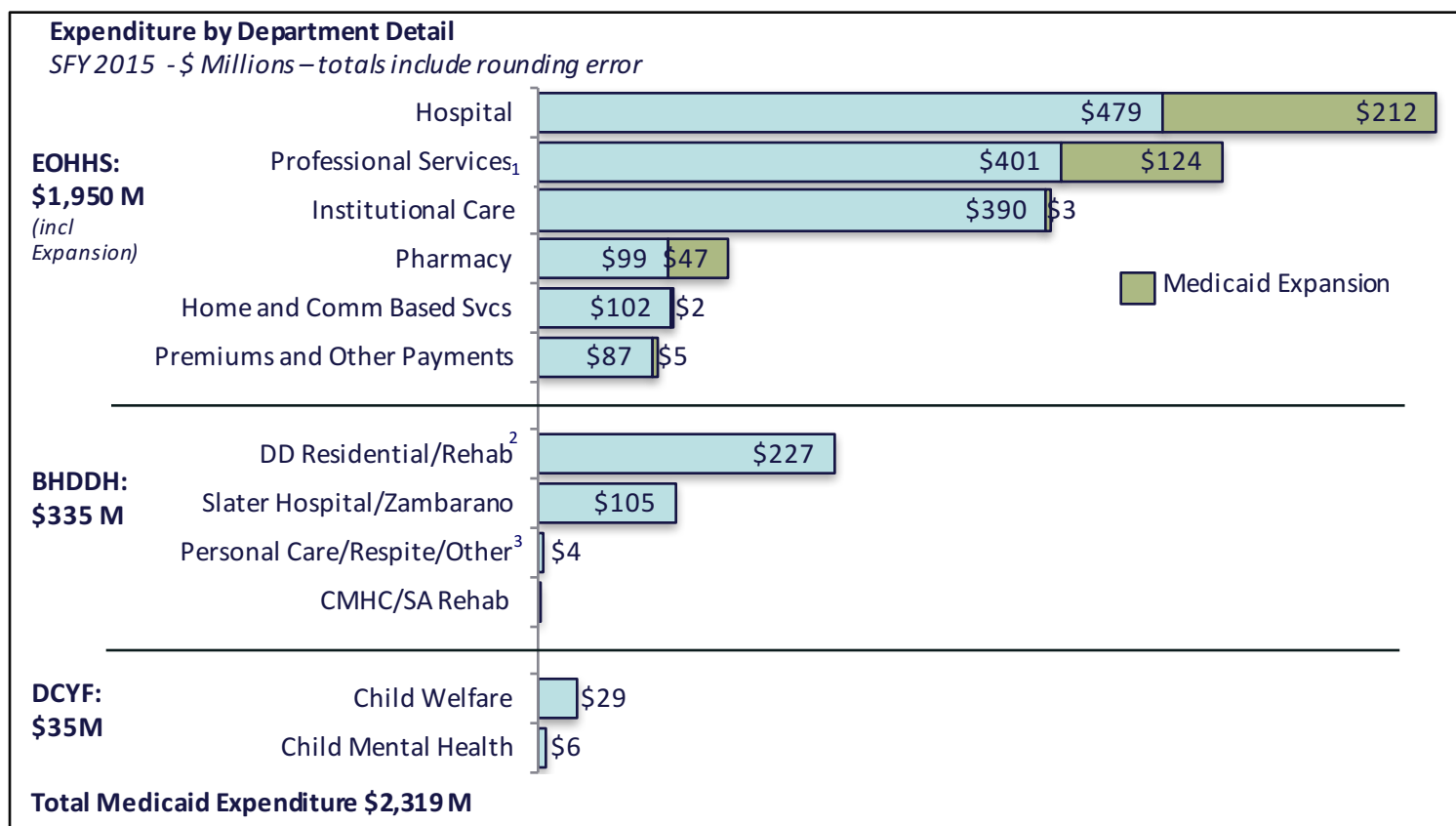
Medicaid services are administered through several state departments.



- ❖ In SFY 2015, 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 majority of expenditure (84%) is administered by EOHHS, including all expenditure for the Expansion population. This department is the lead administrator for the Medicaid contract with CMS. The Single State Medicaid Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
- ❖ The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers the second largest share of Medicaid expenditure (14%). Note that approximately \$65 million in funding for intensive behavioral health services was transferred from BHDDH to EOHHS as of July 1, 2014.
- ❖ Detail for each department is shown on the next page.

## 1d. Expenditure by Department: State Agency Detail\*

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



- ❖ The majority of expenditure (84%) 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), professional services (27% of total EOHHS), institutional care (20% of total EOHHS), professional services, and pharmacy.
- ❖ The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers another 14% 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 \$35 Million (1%) 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.

<sup>1</sup>Includes professional services for behavioral health.

<sup>2</sup>DD 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).

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

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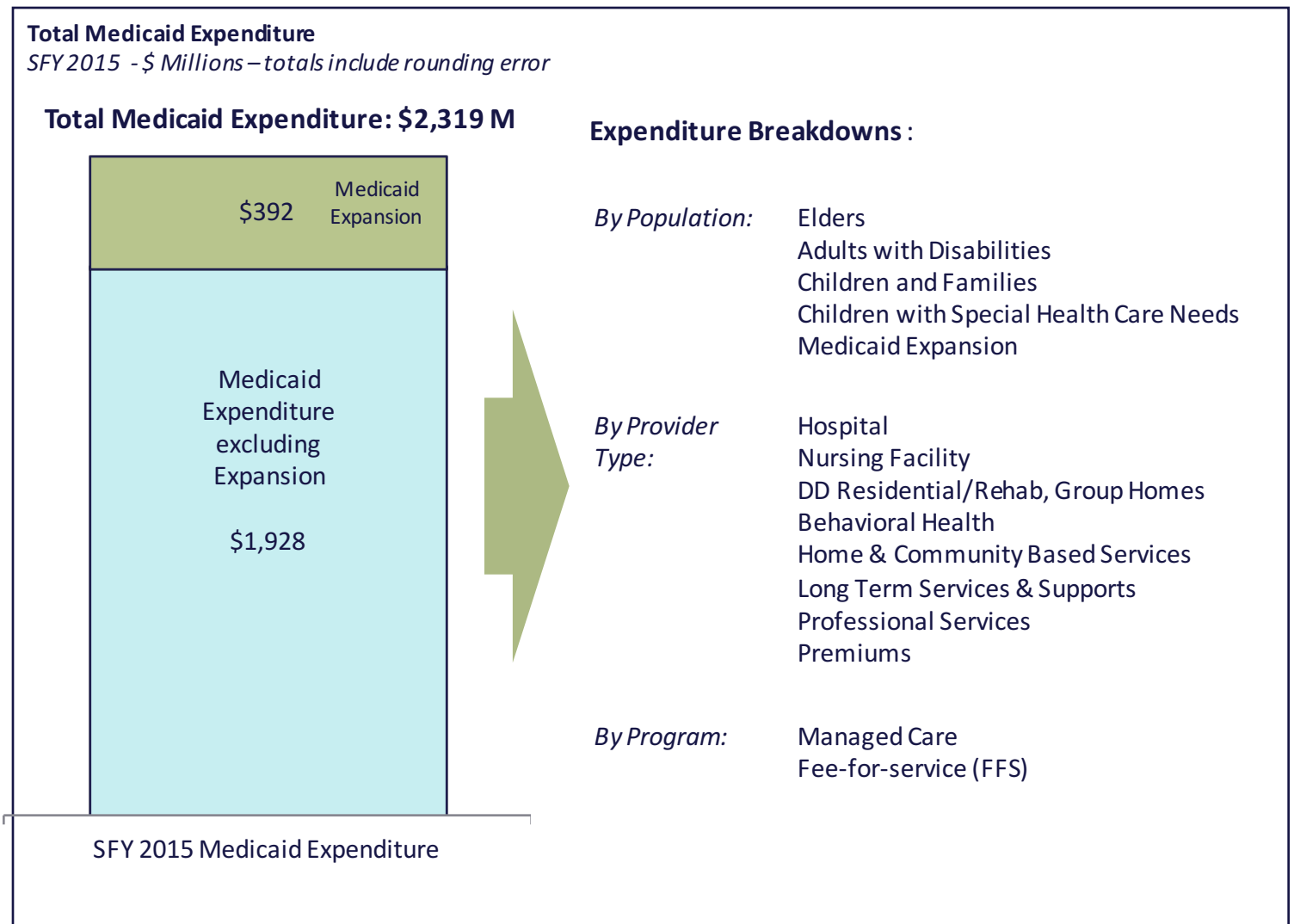
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## 2. Expenditure Distributions

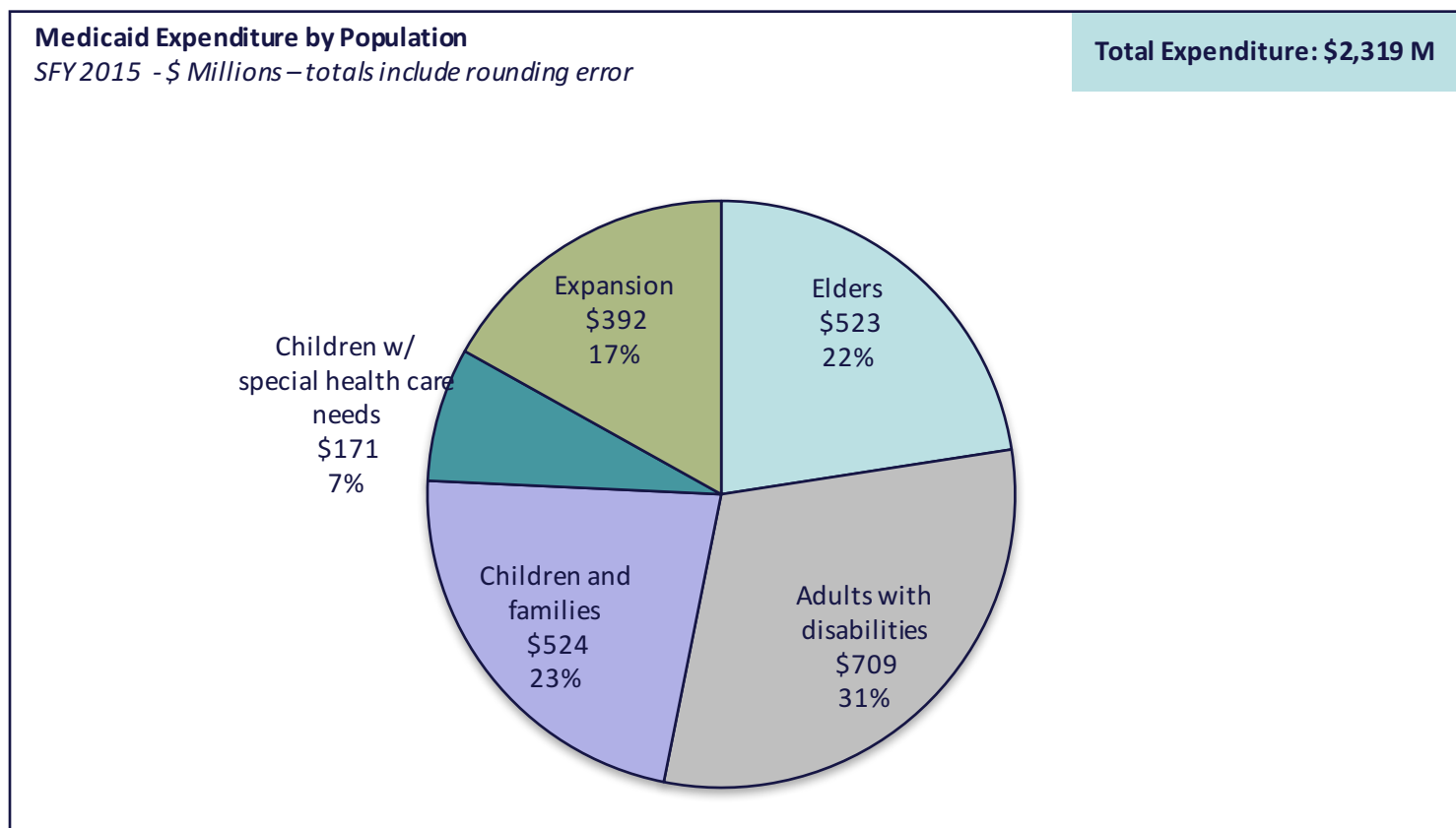
Medicaid expenditure can be broken down in several ways.



- ❖ Breakdown by population shows expenditure by Medicaid recipient age and category of need.
- ❖ Breakdown by provider type shows expenditure by the institution or the type of professional performing the services.
- ❖ Breakdown by program shows expenditure by type of managed care program and amount of fee-for-service spending.

## 2a. Expenditure by Population

Over half of Medicaid expenditure (53%) is for Elders and Adults with Disabilities.



- ❖ **Elders** are adults over age 65, including those also eligible for Medicare. This population accounts for 22% of Medicaid expenditure, or \$523 million.
- ❖ **Adults with Disabilities** are adults under age 65 who have identified disabilities (does not include RItE Care enrolled adults). This population accounts for \$709 million in Medicaid expenditure, the largest portion of expenditure at 31% of total.
- ❖ **Children and Families** are low income children, parents and pregnant women who meet specific income requirements. This population accounts for another 23% of Medicaid expenditure, \$524 million.
- ❖ **Children with Special Health Care Needs (CSHCN)** are individuals under 21 eligible for SSI (Supplemental Security Income), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. This population accounts for 7% of Medicaid expenditure.
- ❖ **Medicaid Expansion** are adults without dependent children with incomes under 138% FPL who were newly eligible for Medicaid as of January 1<sup>st</sup> 2014 under ACA expansion rules. This population accounts for 17% of Medicaid expenditure.

## 2a. Expenditure by Population

Medicaid expenditures per average eligible vary considerably by population.

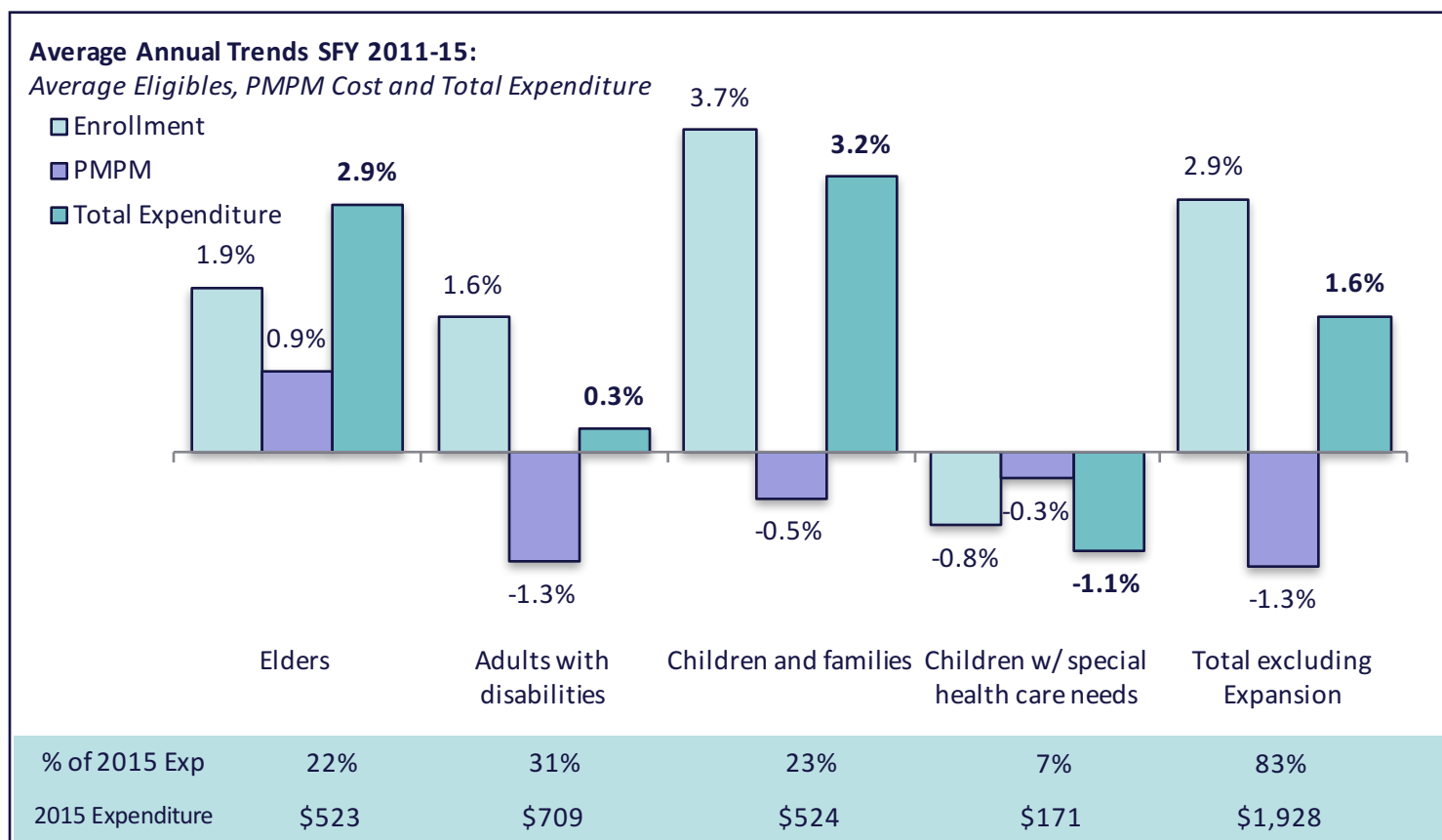
<b>Medicaid Enrollment and Expenditures by Population</b>					
<i>SFY 2015 - \$ Millions – totals include rounding error</i>					
	Enrollment by Subgroup		Expenditure by Subgroup		PMPM Cost
Elders	7%	18,944			
Adults with disabilities	12%	31,797	22%	\$523 M	\$2,301
Children and families	55%	149,449	31%	\$709 M	\$1,859
			23%	\$524M	\$292
Children w/ special health care needs	4%	12,169	7%	\$171 M	\$1,171
Expansion	22%	58,488	17%	\$392M	\$558
<b>Total Program</b>		<b>270,847</b>		<b>\$2,319 M</b>	<b>\$714</b>

The Medicaid program served an average of 270,847 eligibles in SFY 2015, at an average cost per member per month of \$714. However, PMPM costs vary considerably by population.

- ❖ 53% of expenditure is on services for elders and adults with disabilities who together account for 19% of total eligibles. The PMPM cost for elders is over \$2,300 per member per month and the PMPM cost for adults with disabilities is over \$1,800.
- ❖ Services for children and families account for 55% of total enrollment and 23% of total expenditure with a PMPM cost \$292.
- ❖ Another 7% of expenditure is for children with special health care needs who represent 4% of eligibles at a PMPM of \$1,171.
- ❖ The Medicaid Expansion population accounts for 22% of eligibles and 17% of overall expenditure, with a PMPM of \$558. Note that this population was newly eligible for Medicaid beginning in January 2014.

## 2a. Expenditure By Population: Trends

Expenditure trends vary significantly by population.

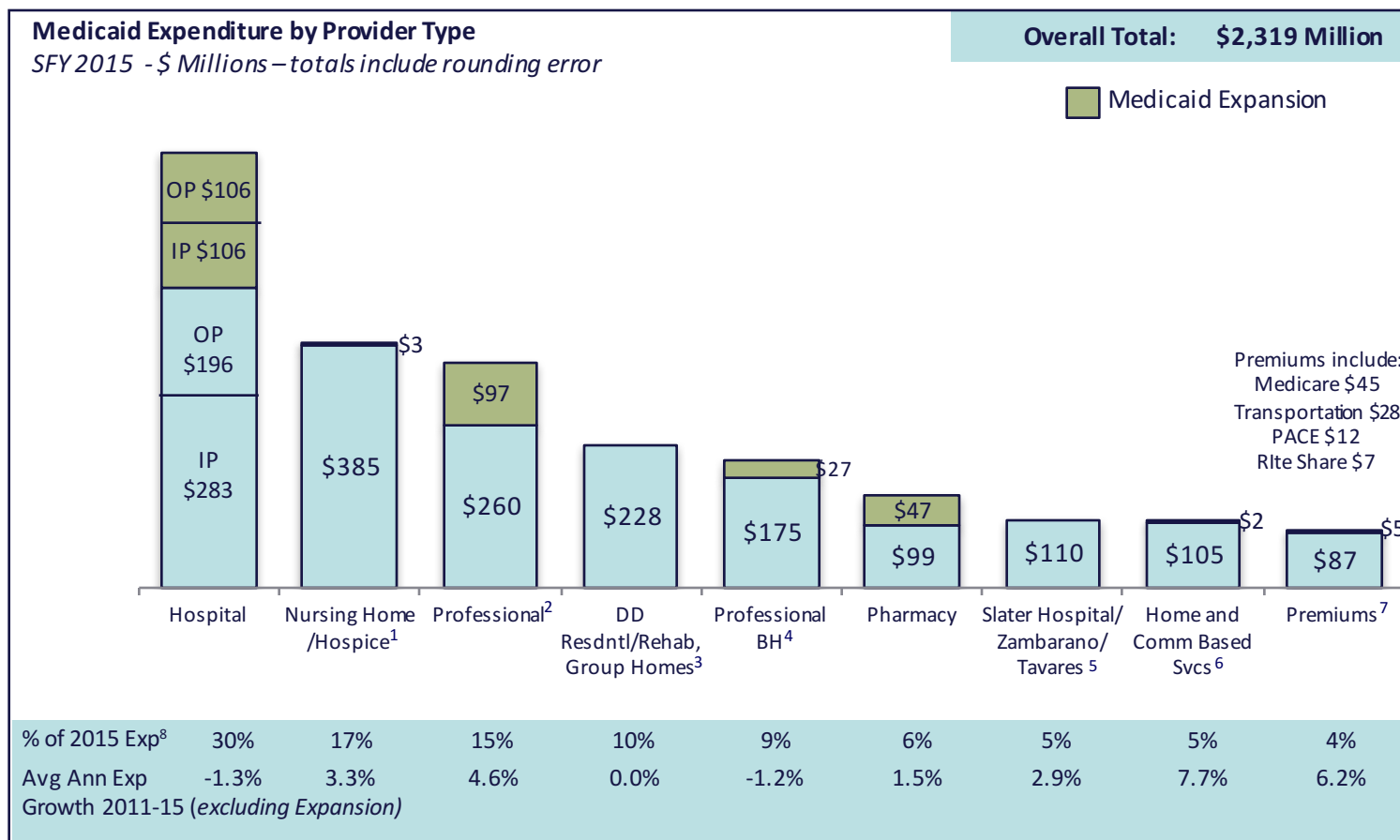


- ❖ Excluding expenditures on the Expansion population, overall Rhode Island Medicaid expenditures grew by approximately 1.6 percent per year between SFY 2011 and SFY 2015. Note that the overall expenditure trend is broken down into per member per month (PMPM) cost trend and enrollment trend, which can be added together to determine average expenditure trend.
- ❖ Elders account for 22% of overall spending in SFY 2015 and have experienced a 2.9% average annual increase in expenditure since SFY 2011. This increase is about 2/3 due to an increase in enrollment and 1/3 due to an increase in PMPM.
- ❖ Adults with disabilities account for the highest share of SFY 2015 expenditure (31%). The average annual expenditure for this group increased 0.3% per year on average over the last 5 years.
- ❖ Children and families experienced a 3.2% average expenditure growth over the past 5 years and an average enrollment growth of 3.7%. This population, which is most closely comparable to the commercial population, had an average PMPM decrease of 0.5% compared with Rhode Island's recent five year commercial PMPM cost trend for CY 2010-2014 of 2.4%<sup>1</sup>.
- ❖ Children with special health care needs have experienced a decrease in both PMPM and overall expenditure since SFY 2011. This is partly due to programs that have reduced the portion of DCYF youth in residential settings compared to those in community-based settings.

<sup>1</sup>For 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), 2015 carrier rate filings Historical data tables..

## 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 2015, were hospitals and nursing facilities (including nursing homes and hospice). Key contributors to expenditure growth were nursing facilities and professional providers.
- ❖ Hospitals were the largest provider type, accounting for 30% of Medicaid expenditures in SFY 2015. Hospital payments have been decreasing at an average of 1.3% per year over the last 5 years not including expenditures on the Expansion population.

<sup>1</sup>Nursing home includes skilled nursing facilities.

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

<sup>3</sup>DD 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).

<sup>4</sup>Professional 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.

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

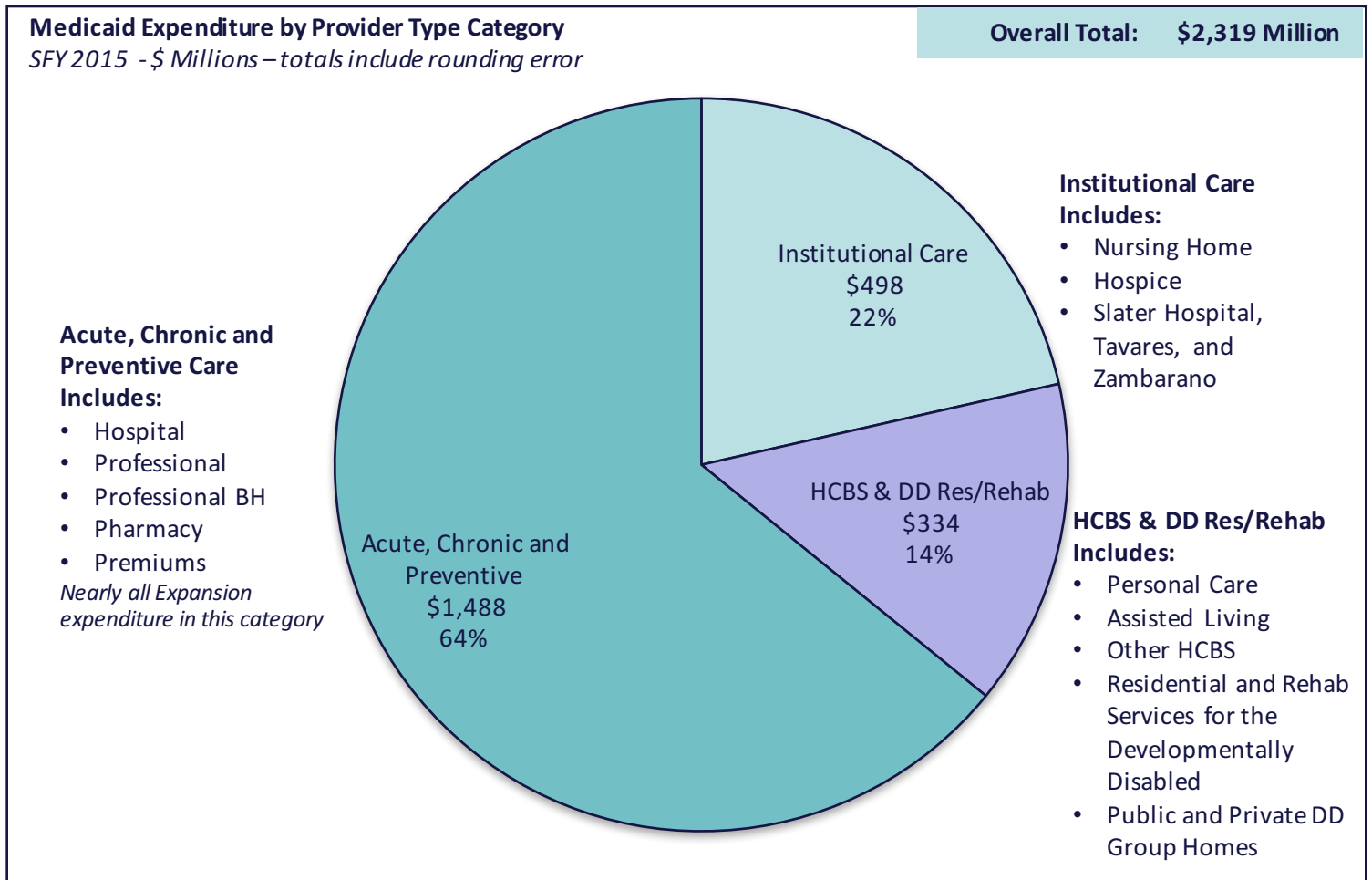
<sup>6</sup>Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, such as personal care, assisted living, and case management.

<sup>7</sup>Premiums includes Medicare premiums paid for qualifying individuals, transportation premiums, premiums for PACE (Program of All-Inclusive Care of the Elderly) and Rite Share premiums, which are the employee share of private insurance premiums paid on behalf of Medicaid eligibles who have access to private insurance.

<sup>8</sup>Percentages may not sum to 100% due to rounding error.

## 2b. Expenditure by Provider Type: Summary by Category

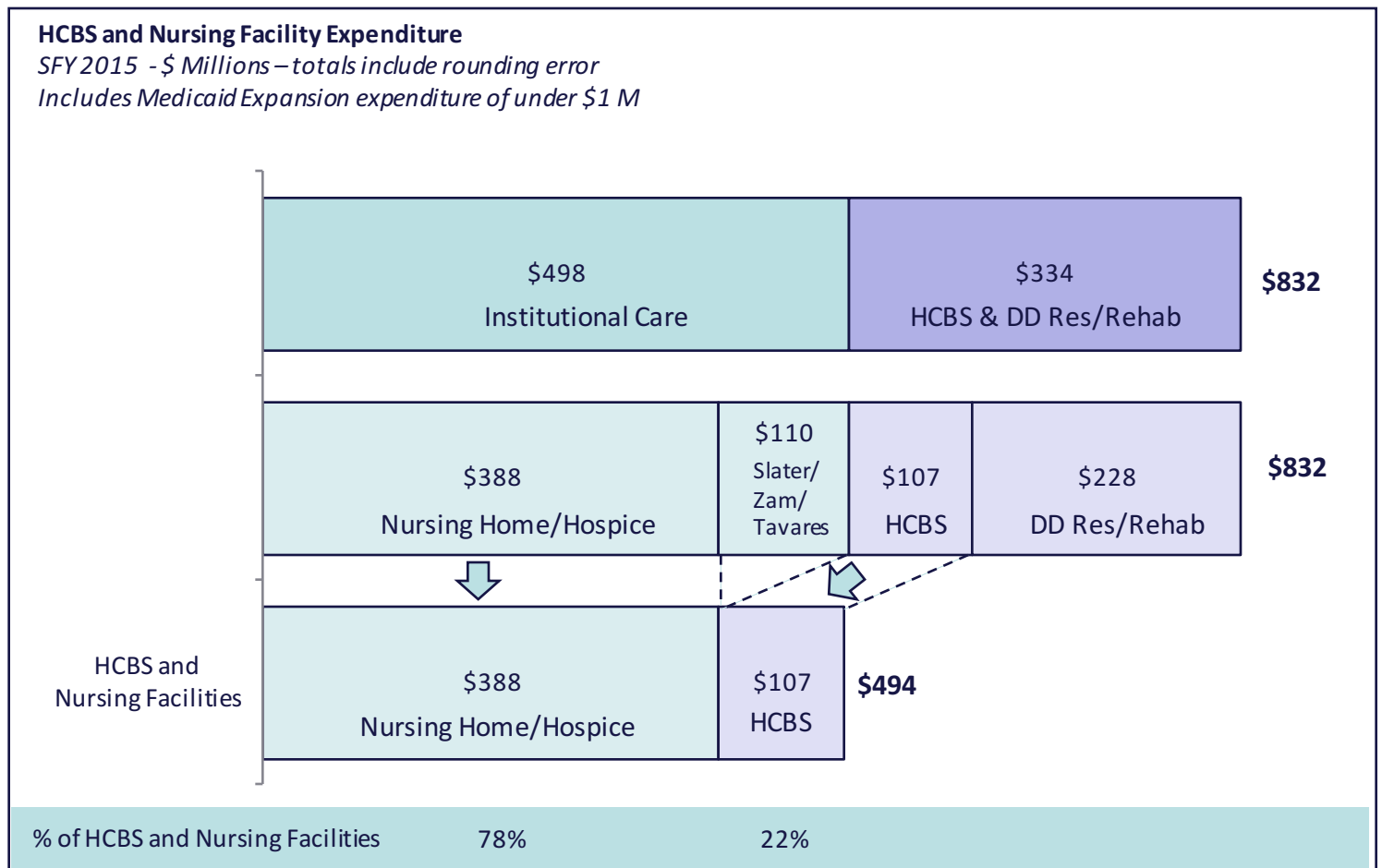
Overall, 36% of Medicaid expenditure is for Institutional Care, Home and Community Based Services, and residential and rehabilitation services for the developmentally disabled.



- ❖ Over one-third (36%) of Medicaid expenditure is for Long Term Services and Supports (LTSS), including institutional care, home and community based services, and residential and rehabilitation services for the developmentally disabled.
- ❖ The other 64% of Medicaid expenditure is for acute, chronic and preventive care services such as hospital, professional services, and pharmacy. Nearly all (99%) of the expenditure for the Expansion population falls into this category.

## 2b. Expenditure by Provider Type: HCBS and Nursing Facilities

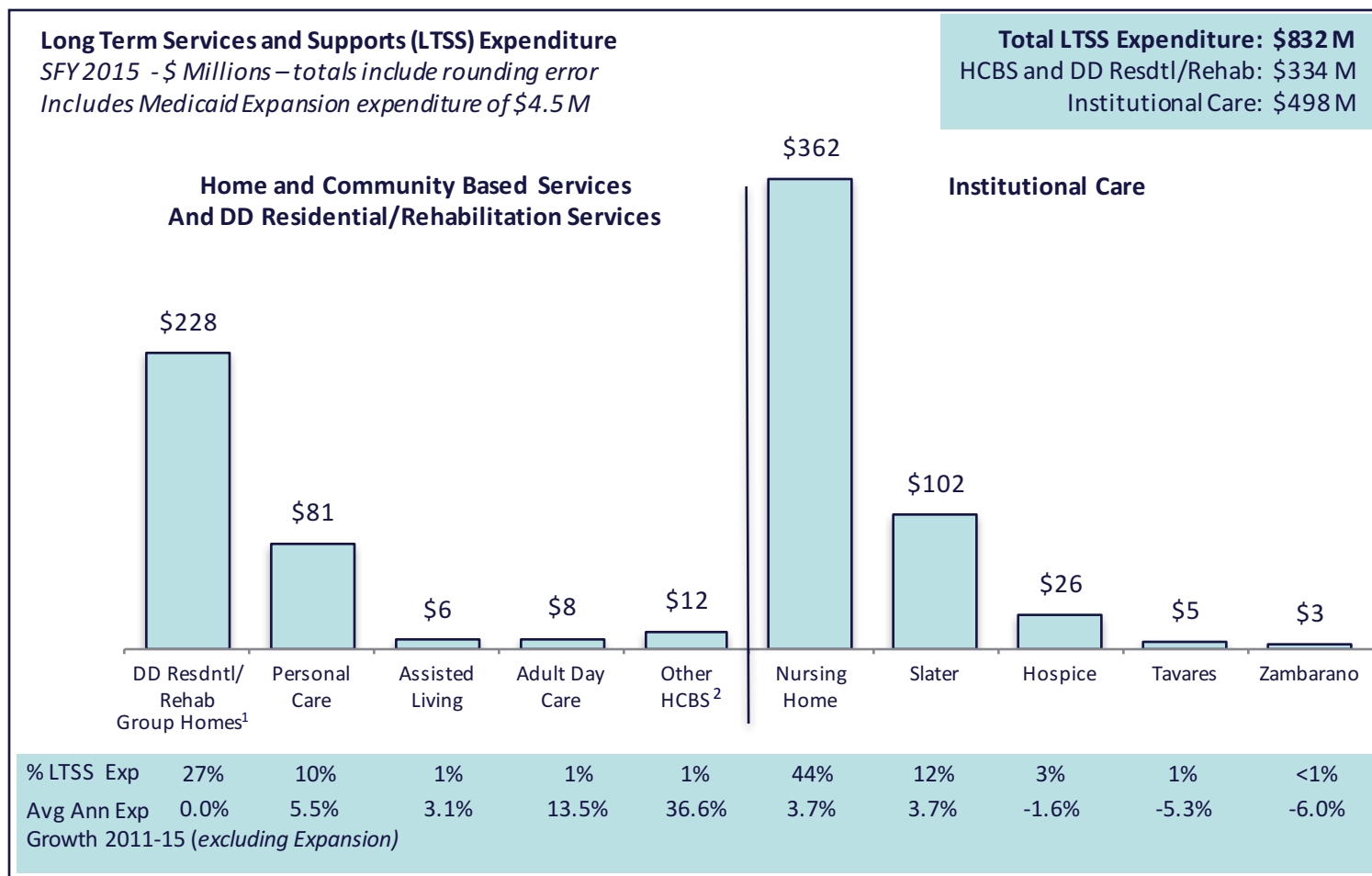
Over 20% of the expenditure for HCBS and nursing facilities is for HCBS.



- ❖ Long term services and supports expenditure can be broken into nursing facilities (including nursing homes and hospice), hospital-based care, HCBS and residential and rehabilitation services for the developmentally disabled.
- ❖ Forty percent of long term services and support expenditure (\$334 million) is for HCBS and residential and rehabilitation services for the developmentally disabled.
- ❖ The total expenditure for HCBS and nursing facilities is \$494 million in SFY 2015. The HCBS portion of that expenditure is 22%. This reflects the relative balance of expenditure between home and community based services and nursing facilities.

## 2b. Provider Type Detail: LTSS Detail

Long term services and supports, including both institutional care and home and community based services, accounted for \$832 million in SFY 2015, about 36% 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.
- ❖ 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 60% 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.

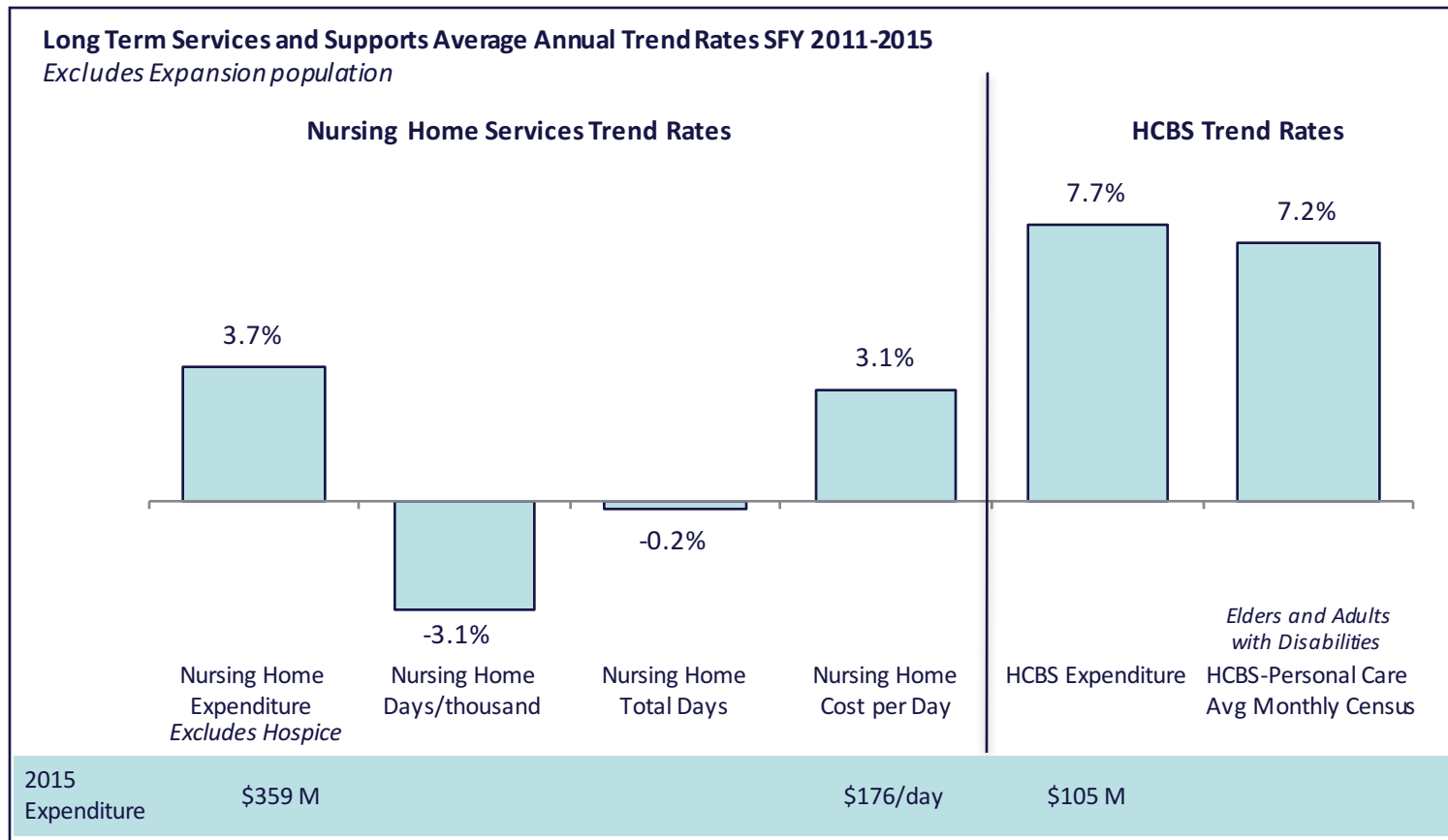
<sup>1</sup>DD Resdntl/Rehab is Residential and Rehabilitation Services for persons with developmental disabilities and includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications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

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



## 2b. Provider Type Detail: LTSS Trends

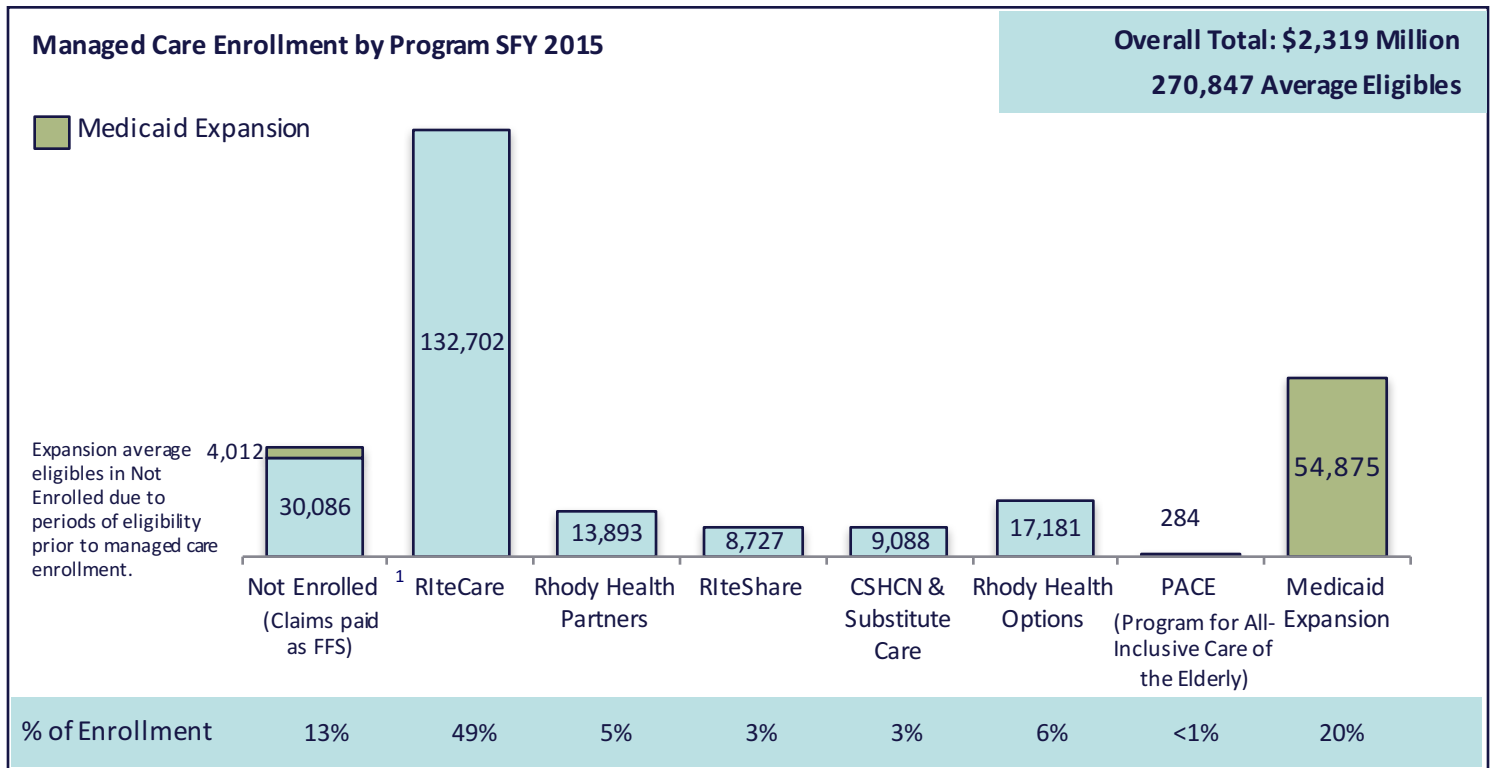
Expenditure on home and community based services is growing at a faster rate than spending on nursing homes.



- ❖ Nursing home expenditure accounted for \$359 million in SFY 2015, with an average annual increase of 3.7% per year on average since SFY 2011.
- ❖ Over the same period, days per thousand for individuals in nursing homes decreased 3.1% per year on average. Nursing home days in total decreased 0.2% per year between SFY 2011 and SFY 2015.
- ❖ Nursing home cost per day has increased from \$155 to \$176 between SFY 2011 and SFY 2015, about 3.1% on average per year.
- ❖ Expenditure on home and community based services is \$105 million and is growing at 7.7% per year on average. A measure of the usage of HCBS is the average monthly census for personal care services, which increased by 7.2% per year on average over the last 5 years for the combined elders and adults with disabilities populations.

## 2c. Managed Care Enrollment

About 87% of Medicaid average eligibles are enrolled in managed care programs.

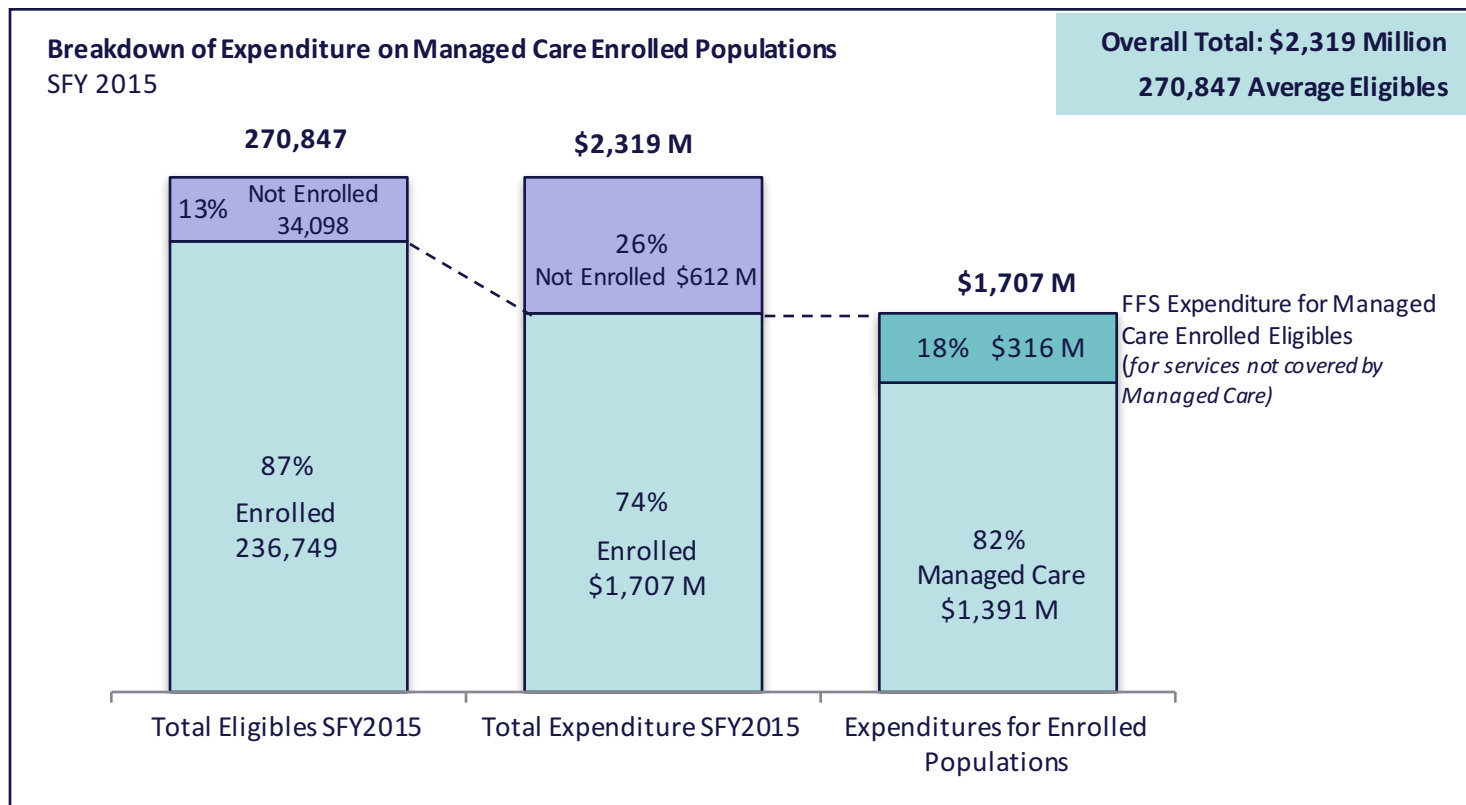


- ❖ Medicaid enrollees who do not have other insurance are enrolled in Medicaid managed care plans. About 13% of Medicaid eligibles are not enrolled in some sort of managed care program.
- ❖ During SFY 2015 RIte Care and Rhody Health Partners (RHP) enrollment was divided between Neighborhood Health Plan (NHP) and United Healthcare (UHC). RIte Care mainly serves children and families. RHP is a managed care program for adults with disabilities.
- ❖ RIte Share is a program designed to allow Medicaid eligibles with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditure by leveraging the employer's contribution. In SFY 2015 there were 8,727 Medicaid eligibles enrolled in the RIte Share program.
- ❖ Rhody Health Options is a new managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports, and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility.

<sup>1</sup>Not enrolled includes 5,083 eligibles enrolled in Connect Care Choice and Connect Care Choice Community Partners because claims are paid within the Fee For Service structure.

## 2c. Expenditure by Program: Managed Care vs. FFS

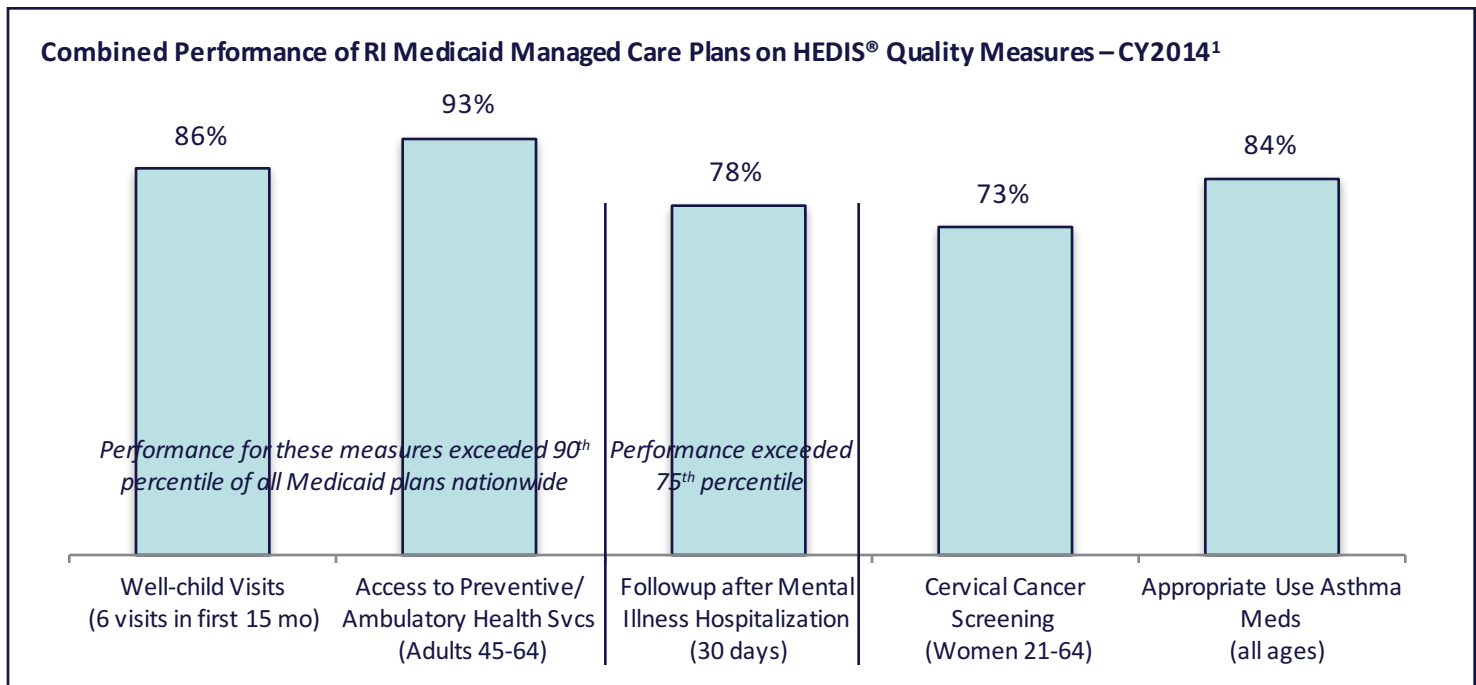
The 87% of Medicaid eligibles enrolled in managed care plans account for 74% of Medicaid expenditure.



- ❖ Eighty-seven percent of Medicaid eligibles are enrolled in a managed care program, including RIte Care, RIte Share, RhodyHealth Partners, RhodyHealth Options, or PACE. These enrolled populations account for about three-quarters (74%) of Medicaid expenditure in SFY 2015.
- ❖ Of the \$1,707 million in expenditure on managed care enrolled populations, \$1,391 million was paid through managed care programs. The remaining \$316 M was paid for FFS claims for managed care enrolled eligibles. These FFS claims include services for enrolled populations not covered by managed care, such as NICU, certain behavioral health services, specialized services for children with special healthcare needs, dental care, and transportation, as well as pre-managed care enrollment eligibility.
- ❖ Unenrolled populations include eligibles enrolled in Connect Care Choice and Connect Care Choice Community Partners, which are primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure. In SFY 2015, there were 5,083 Medicaid eligibles enrolled in Connect Care Choice and Connect Care Choice Community Partners.

## 2c. Managed Care: Quality Indicators

Both of Rhode Island's participating Medicaid Managed Care Organizations (MCOs) were rated 4.5 out of 5 in CY 2015.



- ❖ The ranking methodology that has been in use by the National Committee for Quality Assurance (NCQA) from 2005-2014 was retired in 2015. The methodology was replaced with a rating methodology, similar to the Center for Medicaid and Medicaid Services (CMS) Five Star rating system. The NCQA rating consists of three types of quality measure domains: clinical quality, consumer satisfaction, and results from NCQA's review of the Health Plan's health quality processes.
- ❖ NCQA rated more than 1,300 health insurance plans nationally based on these three types of quality domains. Both Neighborhood Health Plan of Rhode Island (NHPRI) and United Health Care Community Plan (UHCP) had a total performance rating of 4.5.<sup>2</sup>
- ❖ 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 preventive health services, both of Rhode Island's Medicaid Health Plans ranked above the 90<sup>th</sup> percentile compared with Medicaid health plans nationally.
- ❖ As a result of significant modifications made to the Cervical Cancer Screening (CCS) measure in HEDIS 2014, a rate was not reported in Quality Compass 2014®. As such the score was recorded but the measure was considered baseline and not eligible for an incentive in 2015.
- ❖ On the HEDIS® measure of individuals with asthma who were appropriately prescribed medication, Rhode Island's Medicaid Health Plans did not meet or exceed the national Medicaid average across all age cohorts. However, Rhode Island did meet the 90<sup>th</sup> percentile for the 19-50 and 51- 64 year age cohort specific to RhodyHealth Expansion.

<sup>1</sup>Source: Monitoring Quality and Access in RIte Care and Rhody Health Partners, RI EOHHS, October 2015. Results are reported in the aggregate, not by individual health plan.

<sup>2</sup>A plan that is the top decile of plans = 5. A plan that is in the top 3rd of plans, but not in the top 10th = 4.

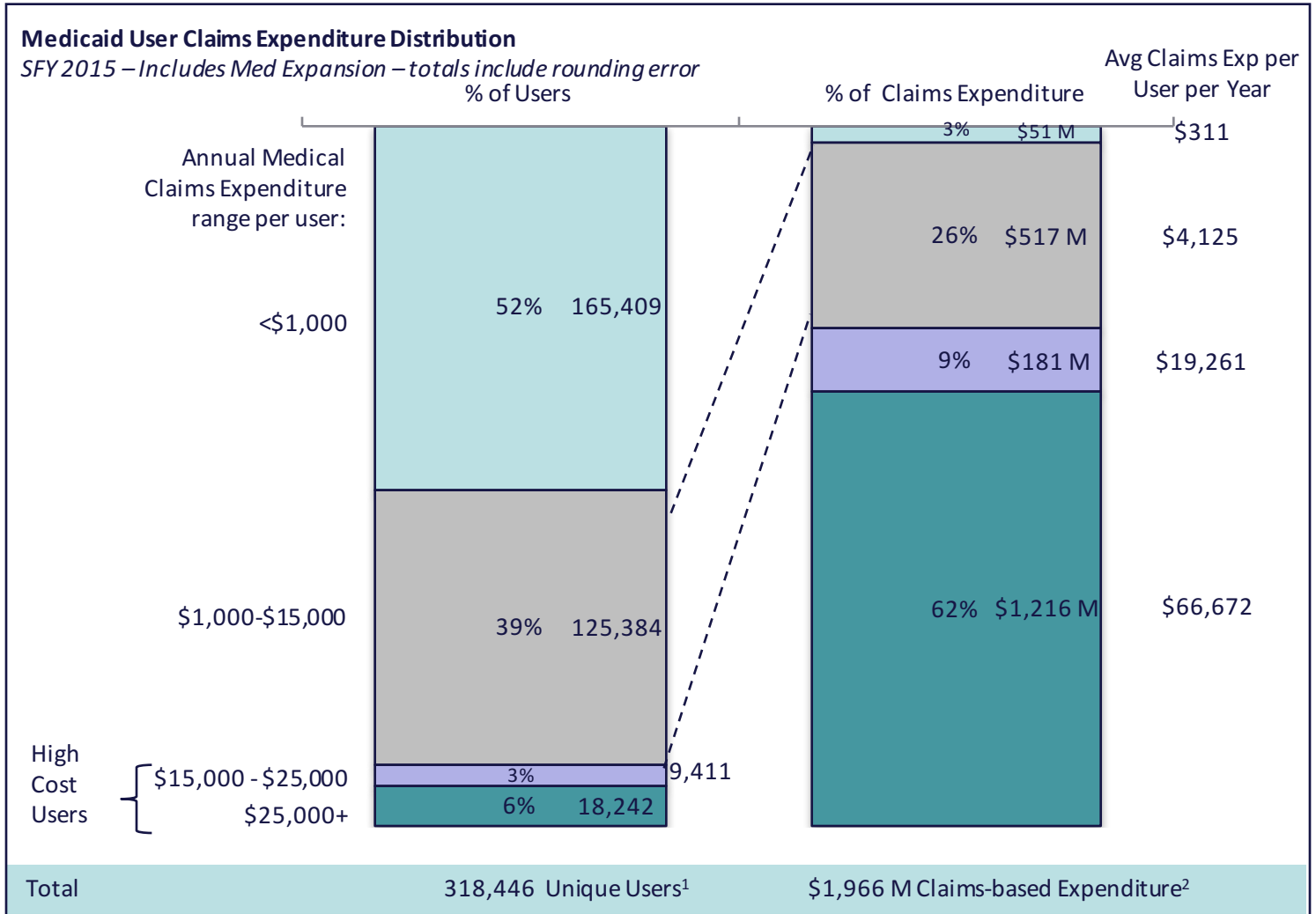
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### 3a. High Utilizers: By Expenditure Level

The 6% of Medicaid users with the highest costs account for almost two thirds (62%) of Medicaid claims expenditure.



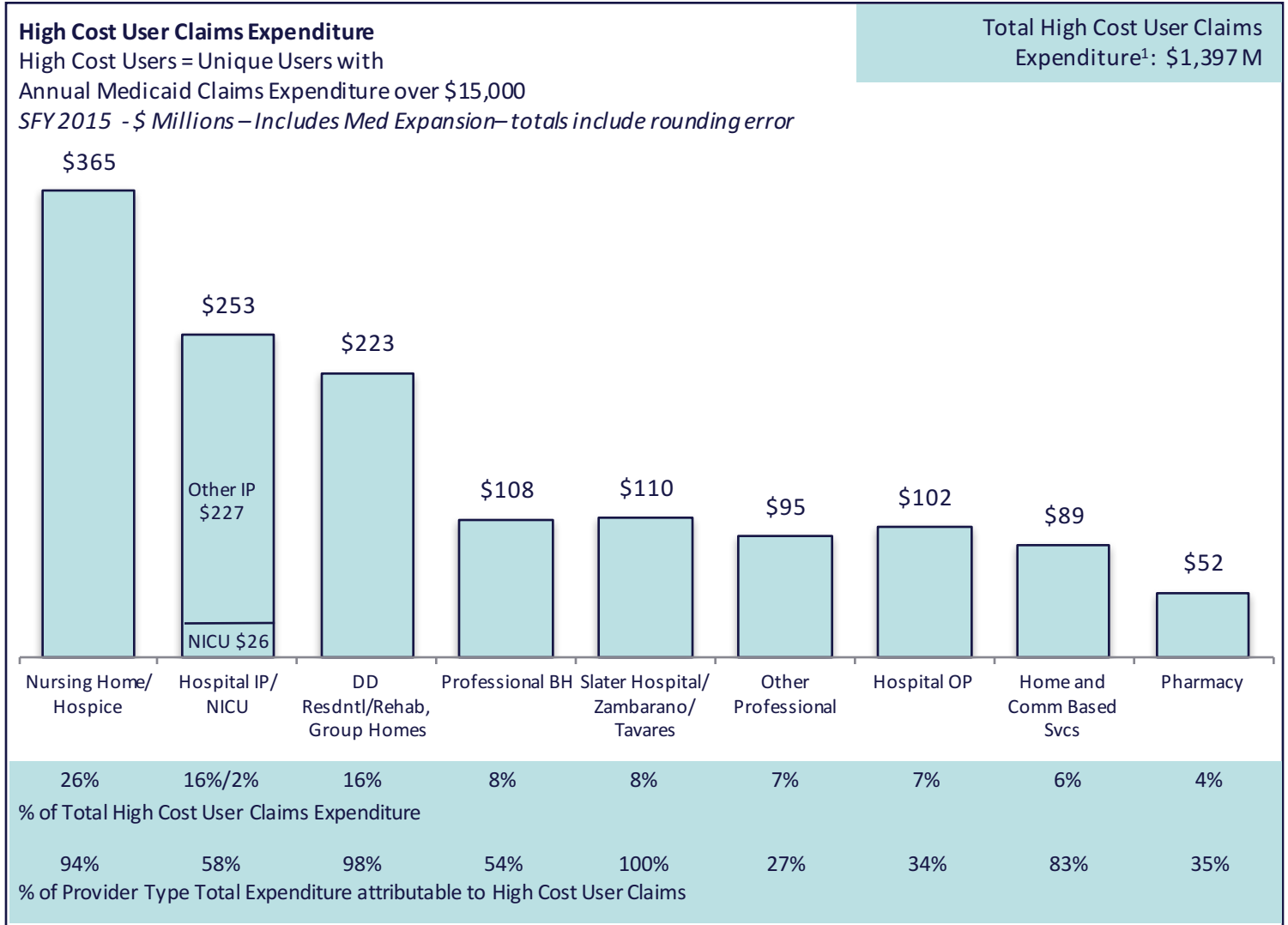
- ❖ Medicaid claims expenditures are highly concentrated, as the 6% of Medicaid users with the highest costs account for almost two-thirds (62%) of claims expenditures.
- ❖ In order to look at spending by user, it is necessary to look at “unique users” rather than average eligibles. A unique user is an individual associated with a medical claim. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- ❖ Unique users with over \$15,000 of claims expenditure of per year are designated as “high cost” for the purposes of this analysis. There are 27,653 high cost users (9% of users) who account for \$1,397 million (71%) in claims expenditure. These high cost users typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- ❖ On the other end of the spectrum, 52% of Medicaid users access services at a cost of less than \$1,000 per year and account for 3% of claims expenditure, averaging \$311 in annual claims expenditure per user.

<sup>1</sup>Includes overlap in users across cost categories. Overall total unique users for SFY 2015 is 317,339.

<sup>2</sup>Total of claims-specific payments. Certain expenditures (e.g. UPL and Medicare and PACE Premiums) are not attributable to specific users.

### 3b. High Utilizers: By Provider Type

About 42% of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.

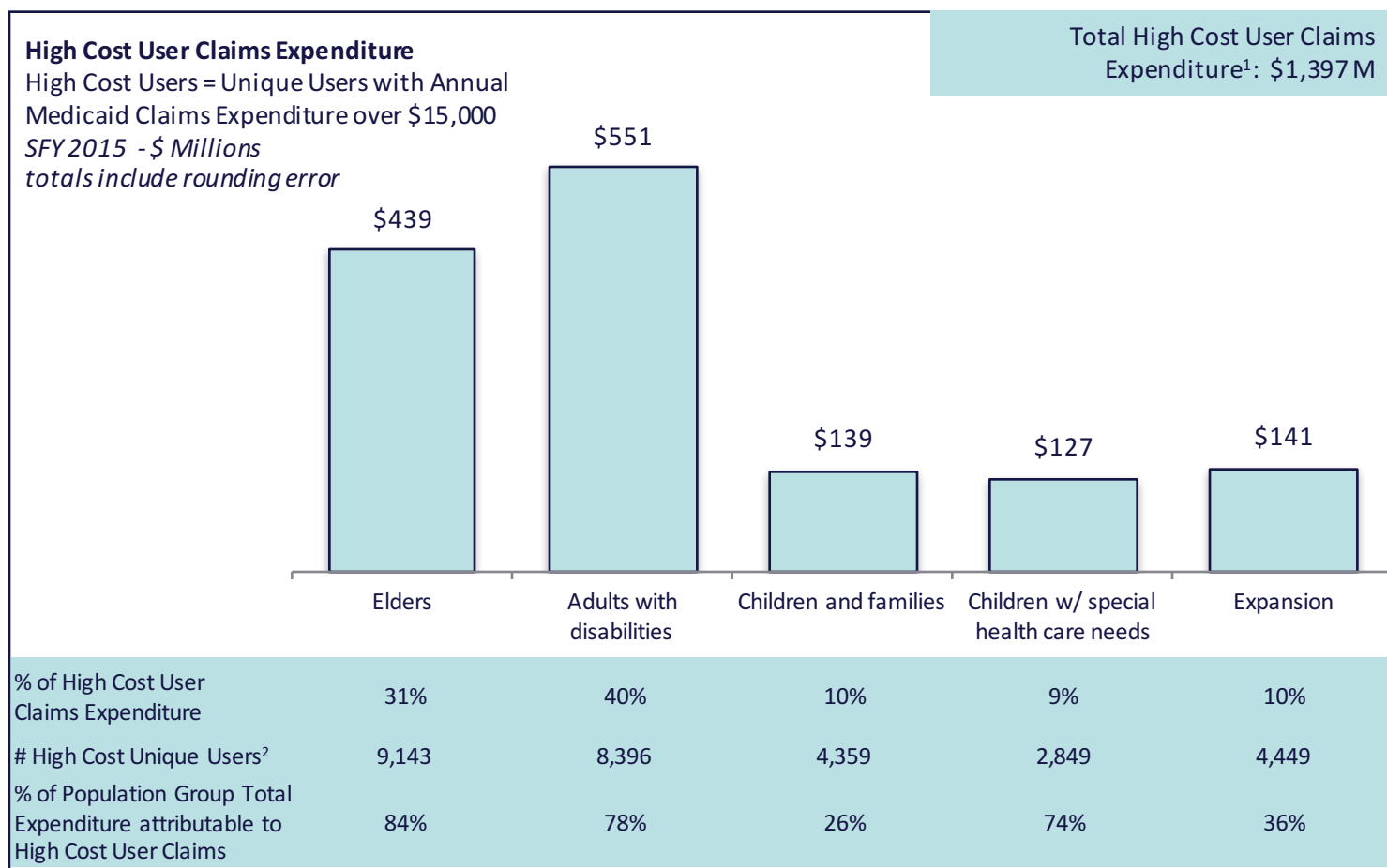


- ❖ Nursing facilities account for 26% of the claims expenditure for high cost users, and residential and rehabilitation services for persons with developmental disabilities account for another 16%.
- ❖ Hospital services account for 25% of high cost user claims expenditure, including 16% for inpatient, 7% for outpatient, and 2% for Neonatal Intensive Care Unit (NICU) services.
- ❖ 94% of the total expenditure for nursing facilities and 100% of the total expenditure for Slater Hospital, Zambarano and Tavares is for claims expense for high cost users. This is due to extended stays in institutions for users of those services.

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

### 3c. High Utilizers: By Population

Elders and adults with disabilities account for 71% of claims expenditure for high cost users.



- ❖ High cost users are defined as unique users with over \$15,000 of Medicaid claims expenditure in SFY 2015.
- ❖ Elders account for 31% of claims expenditure for high cost users and have the highest proportion of total expenditure for high cost user claims, with 84% of total expenditure attributable to high cost user claims expenditure.
- ❖ Adults with disabilities account for 40% of high cost user claims expenditure, and 78% of adults with disabilities total expenditure is attributable to high cost user claims expenditure.
- ❖ Children and families account for 10% of high cost user claims expenditure with 26% of total expenditure attributable to high cost users claims. Children with special health care needs account for another 9% of claims expenditure.
- ❖ The Expansion population accounted for 10% of high cost user claims expenditure.

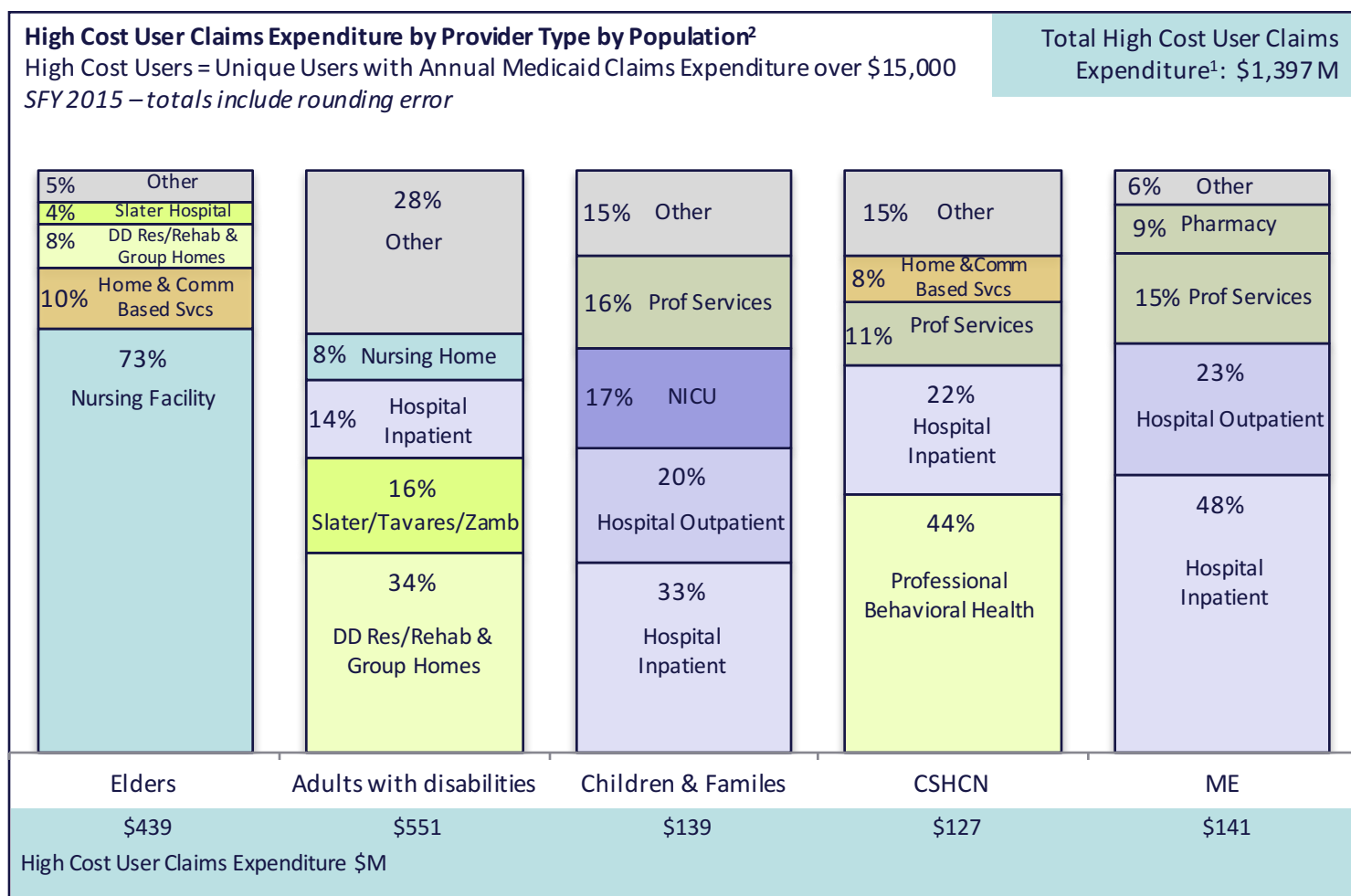
<sup>1</sup>Based on claims-specific payments only. Certain expenditures (e.g. UPL (upper payment limit) and Medicare and PACE Premiums) are not attributable to specific users.

<sup>2</sup>Total high cost unique users by population does not equal overall total due to overlap between eligibility groups.



### 3c. High Utilizers: By Population Detail

The services used by high cost users varies by population.



- ❖ The largest category of claims expenditure for high cost elders is nursing facilities, accounting for 73% of claims expenditure on high cost elders.
- ❖ The largest category of expenditure for high cost adults with disabilities is residential and rehabilitation services for the developmentally disabled, accounting for 34% of claims expenditure for high cost adults with disabilities.
- ❖ For children and families, high cost user claims expenditure is mainly hospital-related. The largest category of claims expenditure for high cost users in this population is hospital inpatient services, accounting for 33% of claims expenditure. Another 20% is for hospital outpatient services, and 17% is for NICU services.
- ❖ Professional behavioral health services account for 44% of high cost user claims expenditure for the high cost users in the children with special healthcare needs population.
- ❖ The Expansion population high cost claims expenditure is also mainly hospital-related, with 71% of high user claims expenditure for hospital inpatient and outpatient services.

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

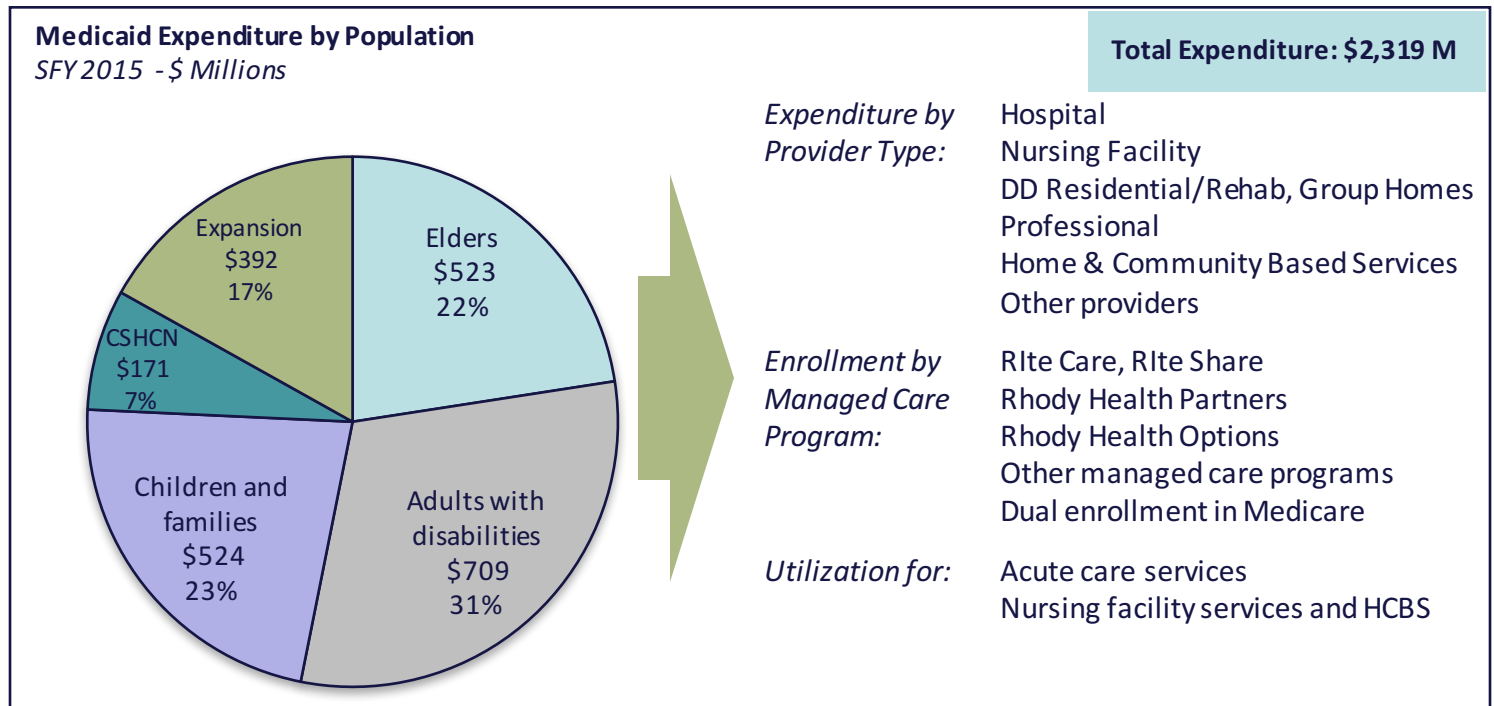
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## 4. Expenditure Detail by Population

In order to get a clearer picture of the characteristics of each population, it is useful to look at expenditures, enrollment, and utilization for each group separately.



This section contains details on expenditures for each population group as follows:

### ❖ Elders:

- ✓ Expenditure by provider type
- ✓ Managed care enrollment by type of program, including dual enrollment in Medicare
- ✓ Nursing facility and HCBS utilization

### ❖ Adults with Disabilities:

- ✓ Expenditure by provider type
- ✓ Managed care enrollment by type of program, including dual enrollment in Medicare
- ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims
- ✓ Nursing facility and HCBS utilization

### ❖ Children and Families:

- ✓ Expenditure by provider type
- ✓ Managed care enrollment by type of program
- ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims

### ❖ Children with Special Healthcare Needs (CSHCN):

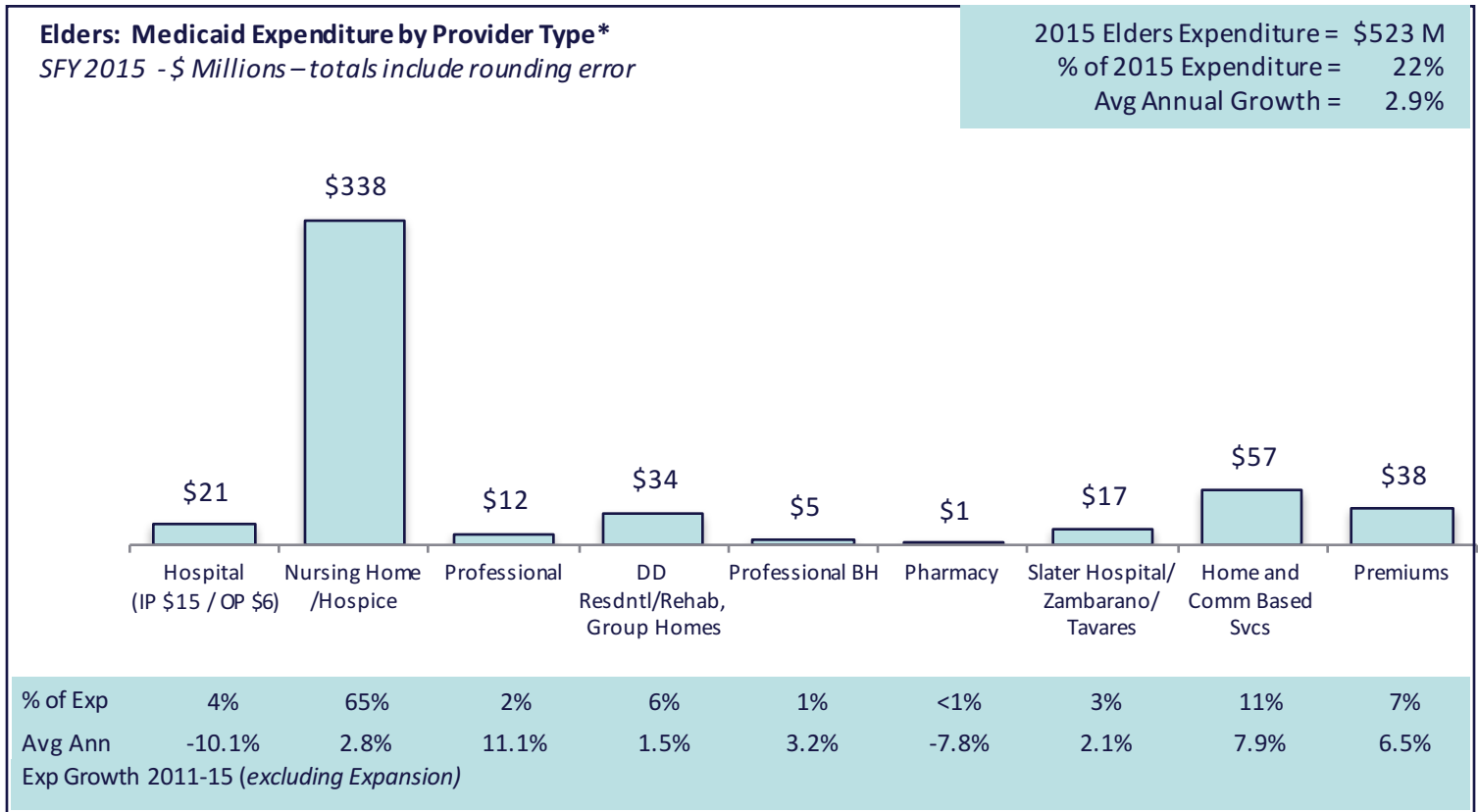
- ✓ Expenditure by provider type
- ✓ Managed care enrollment by type of program
- ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims

### ❖ Expansion

- ✓ Expenditure by provider type
- ✓ Managed care enrollment by type of program
- ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims

## 4a. Elders: Expenditure by Provider Type

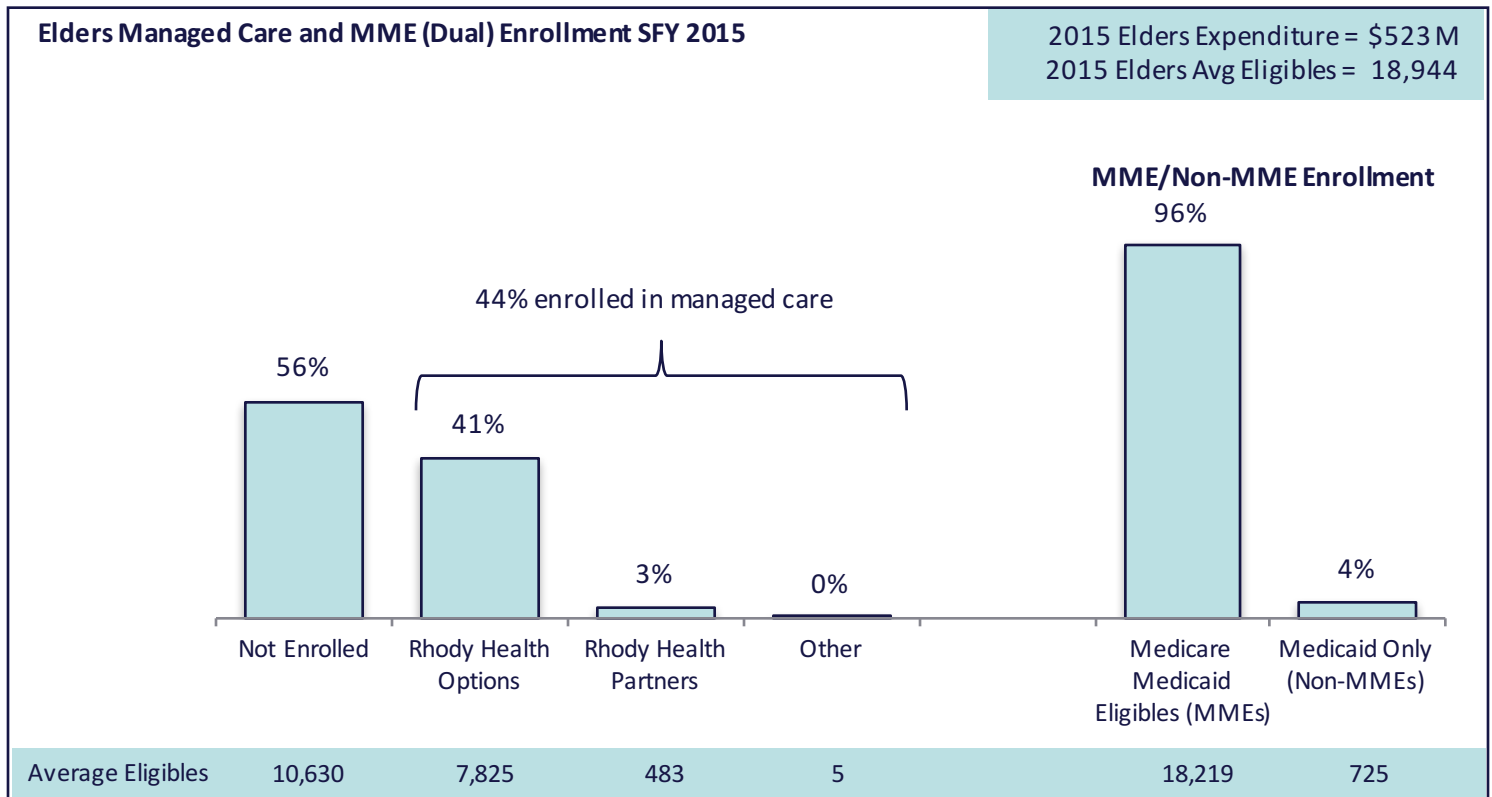
Nursing facilities account for approximately two thirds of total expenditure for elders.



- ❖ Medicaid expenditures on elders totaled \$523 million in SFY 2014 and have been increasing at 2.9% per year over the past 5 years. The large majority of elders are also eligible for Medicare, which was the primary payer 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 and hospice) account for nearly two-thirds (65%) of total Medicaid expenditure on elders. The increase in nursing facility expenditure has been slightly lower than the increase in overall expenditure for this population - an average annual increase of 2.8 percent per year.
- ❖ Most of the growth in Medicaid expenditure for elders has been in nursing facility 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.

## 4a. Elders: Managed Care and Dual Enrollment

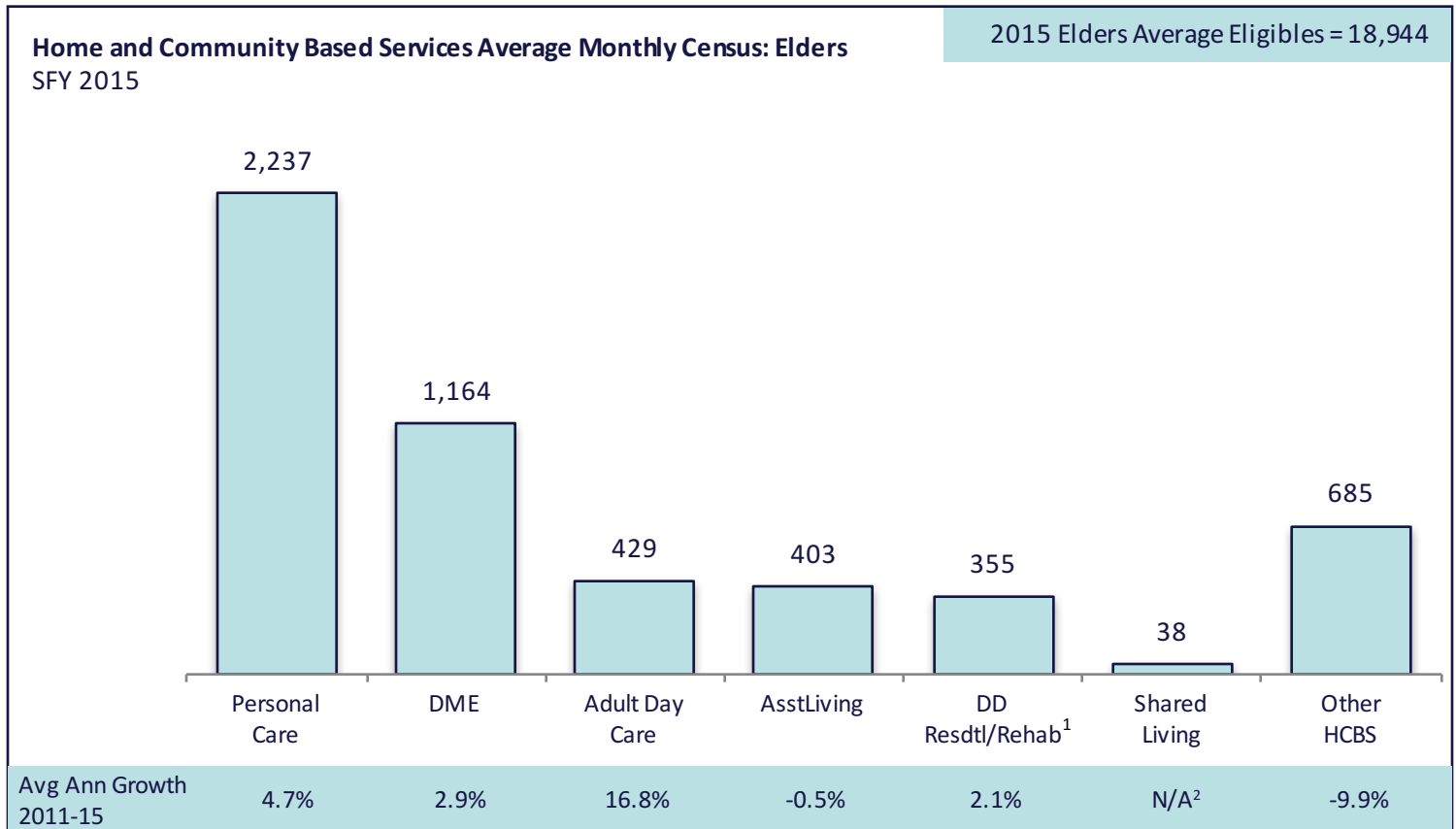
Rhody Health Options rolled out in November 2013 and has enrolled more than 17,000 eligibles, about 8,000 of whom are elders, in a managed-care like program for long term care and long term services and supports.



- ❖ Ninety-six percent of elders are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- ❖ For the elders who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, physician, pharmacy).
- ❖ Rhody Health Options is a new managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports (LTSS), and other Medicaid-funded services to more fully meet the needs of people with both Medicaid and Medicare eligibility.
- ❖ The RHO program includes both elders and adults with disabilities. The total RHO enrollment for was 17,181 average eligibles in SFY 2015.
- ❖ In SFY 2015, 2,000 elders were enrolled in Connect Care Choice and Connect Care Choice Community Partners, primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

## 4a. Elders: HCBS Utilization

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.



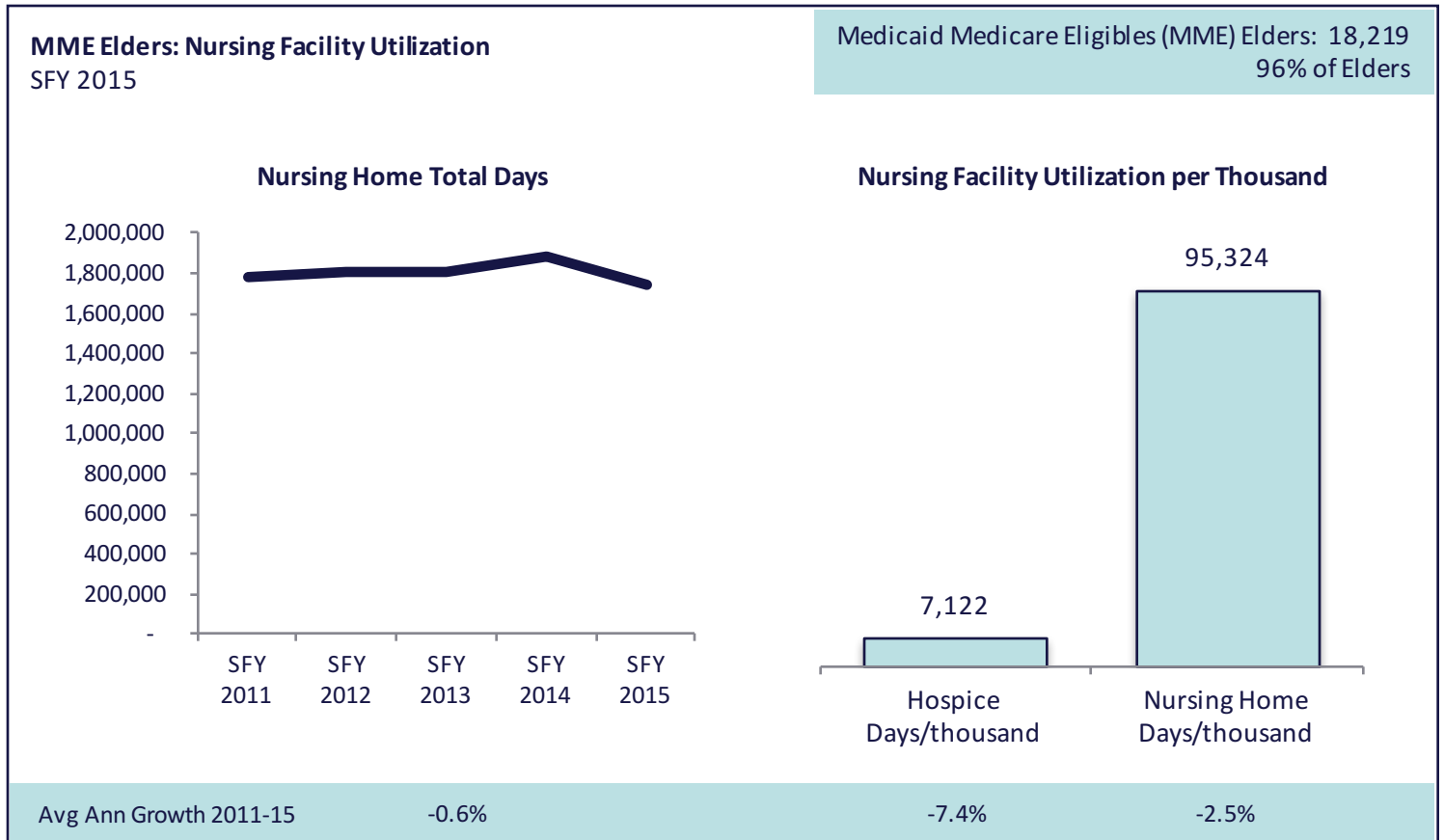
- ❖ The largest category of home and community based services (HCBS) is personal care services, with an average monthly census for elders of 2,237 recipients in SFY 2015. The monthly census for elders for this category has increased at 4.7% per year since SFY 2011.
- ❖ The category with the highest increase in average monthly census is adult day care, with an average annual increase of 16.8% per year.
- ❖ Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.

<sup>1</sup>DD Resdtl/Rehab are residential and rehabilitation services for the developmentally disabled and include residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment for those with developmental disabilities.

<sup>2</sup>The shared living program was initiated in SFY 2011 so growth rates are not meaningful.

## 4a. Elders: Nursing Facility Utilization (MME only)

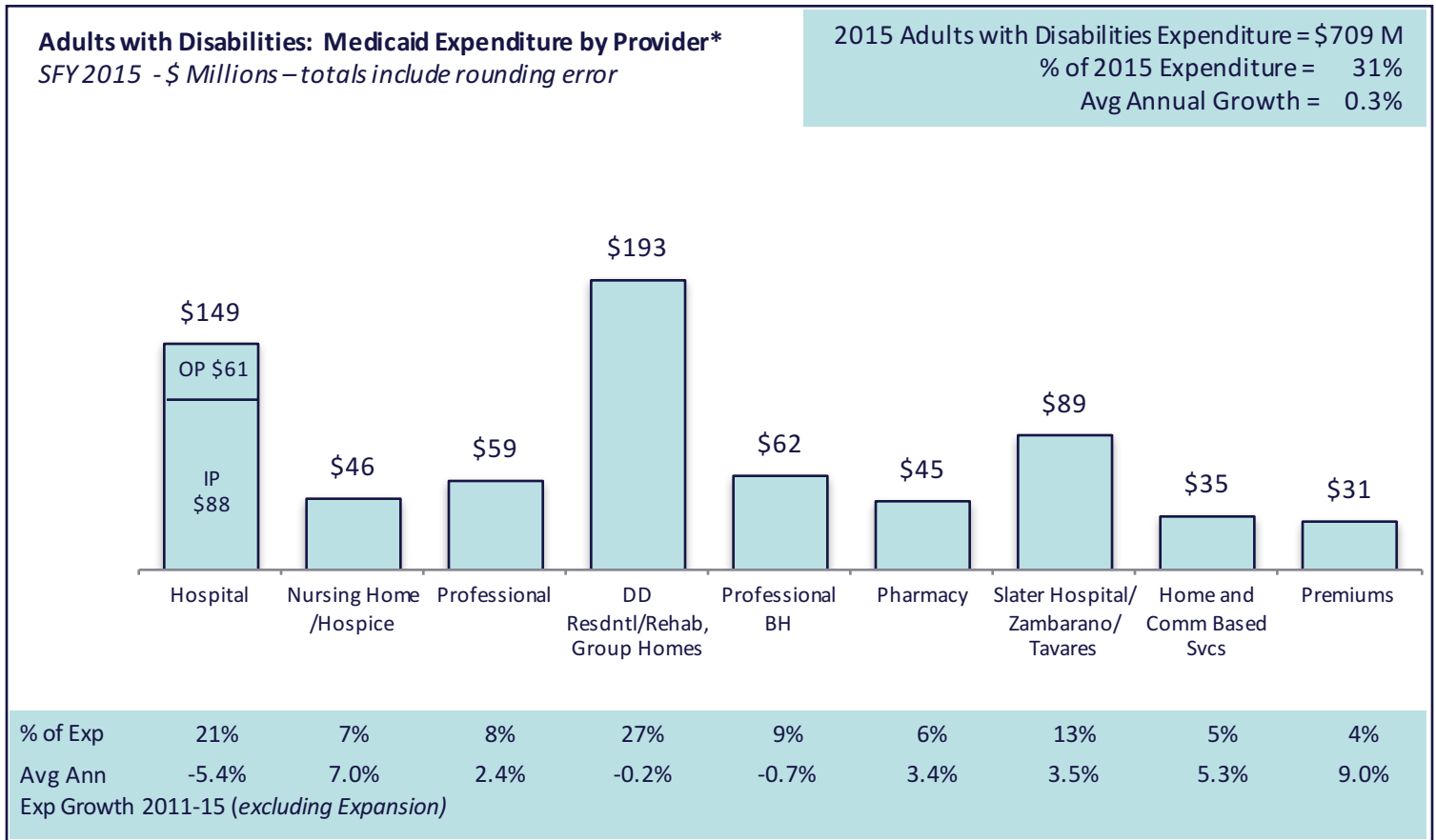
For MME Elders, nursing home days per thousand eligibles decreased 2.5% per year from SFY 2011 to 2015.



- ❖ Ninety-six percent of elders are Medicaid Medicare eligibles (MMEs, also called duals). For these elders covered by both Medicare and Medicaid, Medicare is the primary payer for the majority of acute and primary care services while Medicaid covers long term services and supports.
- ❖ Despite a growth in MME elders average eligibles over the last 5 years, the total nursing home days for this population has decreased by 0.6% per year on average.
- ❖ Nursing home days per thousand for MME elders were 95,324 in SFY 2015. This measure has decreased by an average annual rate of 2.5% since SFY 2011.
- ❖ Hospice days per thousand for MME elders have decreased at a rate of 7.4% on average per year over the last 5 years to 7,122 per thousand in SFY 2015.

## 4b. Adults with Disabilities: Expenditure by Provider Type

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



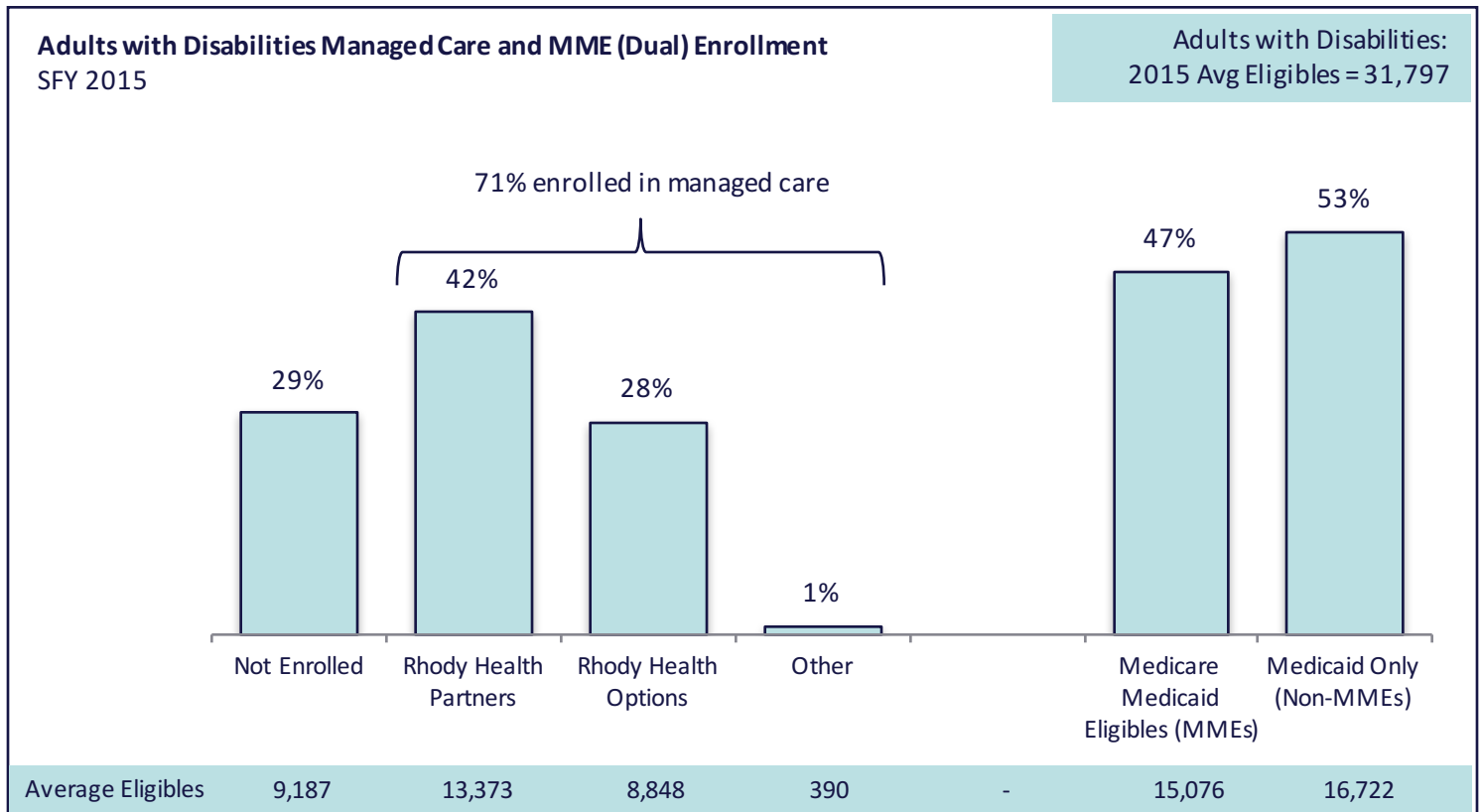
- ❖ Adults with disabilities account for the largest share of Medicaid expenditures, with total SFY 2015 expenditure of \$709 million. Expenditure for this population has increased by approximately 0.3% per year over the past 5 years.
- ❖ Hospital and residential and rehabilitation services for persons with developmental disabilities are the two largest categories of expenditure for this population, accounting for 21% and 27%, respectively. However, expenditure in both these categories has been decreasing over the last 5 years – a decrease of 5.4% per year on average for hospital and a decrease of 0.2% per year on average for residential and rehabilitation services for persons with developmental disabilities.
- ❖ Similar to the elders population, nursing facility services and home and community based services have experienced high growth rates for the adults with disabilities population.

\*See footnotes on page 21 for Provider Type definitions and notes.



## 4b. Adults with Disabilities: Managed Care and Dual Enrollment

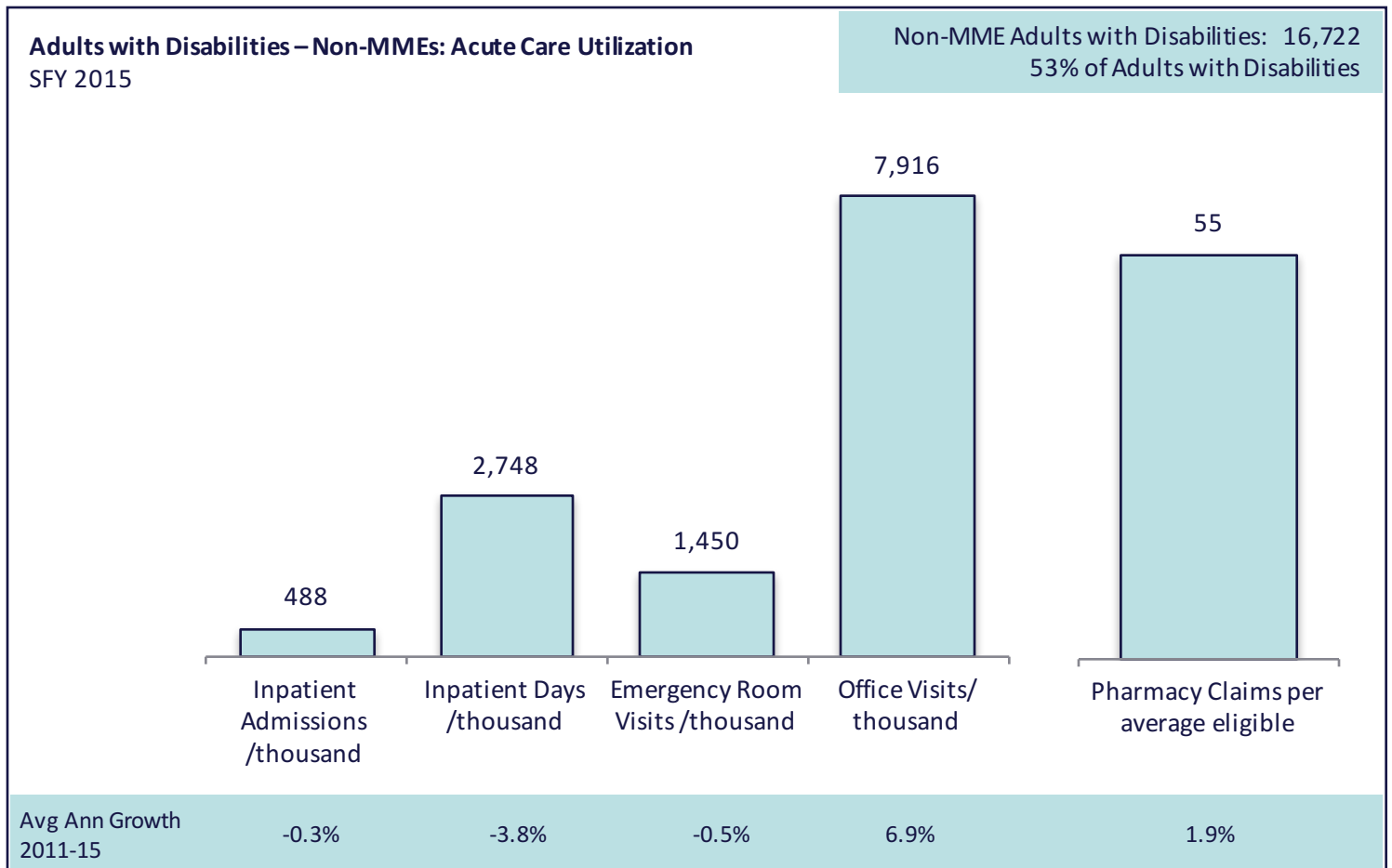
More than 70% of adults with disabilities are enrolled in managed care.



- ❖ Forty-seven percent of adults with disabilities are covered by both Medicare and Medicaid (called MMEs or dual eligibles). For the adults with disabilities who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, physician, pharmacy).
- ❖ Adult populations had historically been served in fee-for-service Medicaid. However, over 70% of this population was enrolled in managed care in SFY 2015 due to the introduction of two programs to transition adults to managed care:
  - ❖ Rhody Health Partners (RHP) is a managed care program introduced in 2008.
  - ❖ Rhody Health Options is a managed care program rolled out in November 2013 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports (LTSS), and other Medicaid-funded services designed for people with both Medicaid and Medicare eligibility. The RHO program includes both elders and adults with disabilities. The total RHO enrollment for both populations is 17,181 average eligibles in SFY 2015.
- ❖ In addition, 3,061 adults with disabilities in the Not Enrolled category were enrolled in SFY 2015 in Connect Care Choice and Connect Care Choice Community Partners, primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

## 4b. Adults with Disabilities: Acute Care Utilization

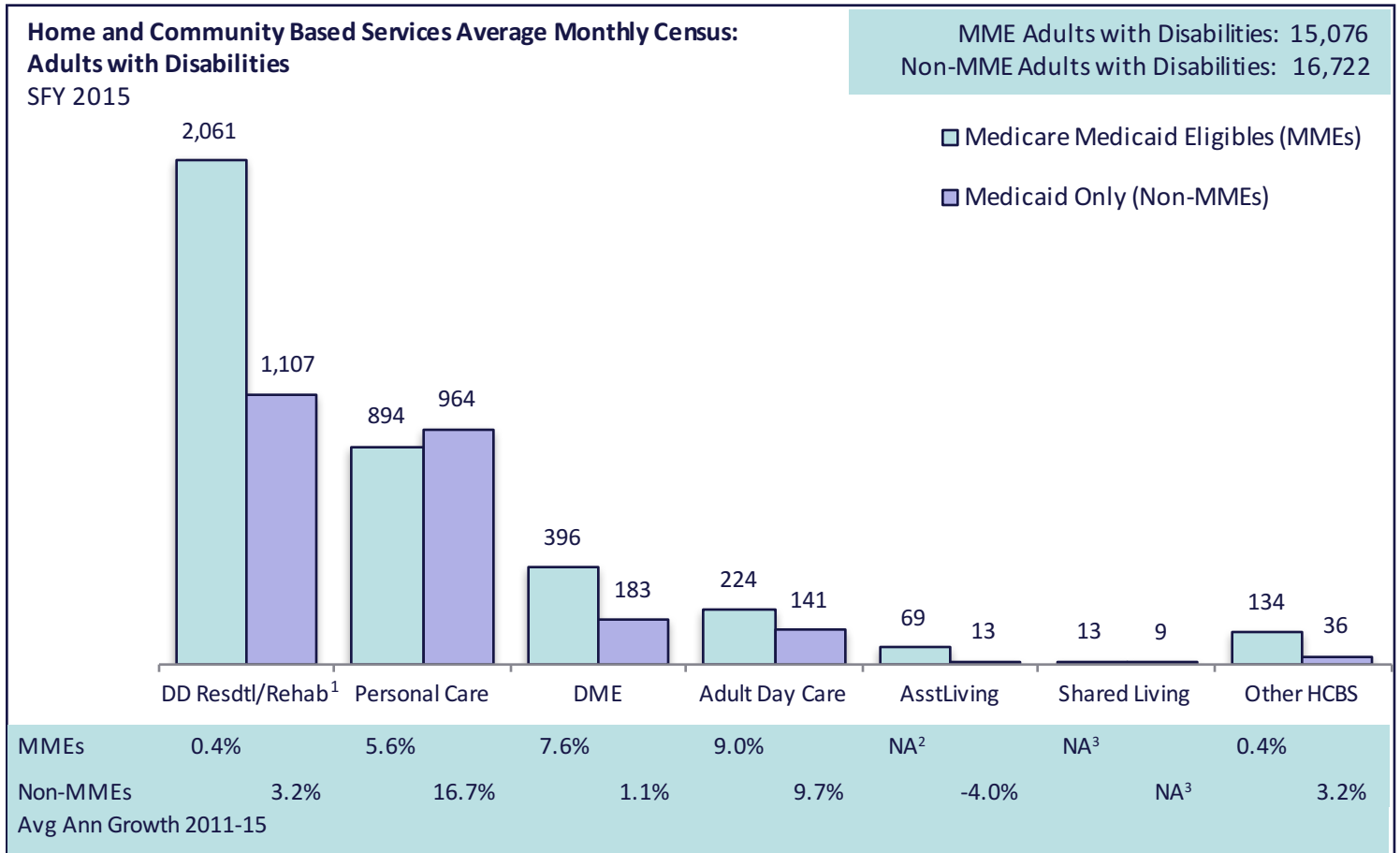
Both inpatient admissions and days per thousand have declined over the last 5 years for adults with disabilities with Medicaid-only coverage (non-MMEs).



- ❖ Forty-seven percent of adults with disabilities are covered by both Medicare and Medicaid. For those dually enrolled eligibles, Medicare is the primary payer for the majority of acute and primary care services. Utilization shown here is for the 53% of adults with disabilities without Medicare coverage (Non-MMEs).
- ❖ Non-MME adults with disabilities averaged 7,916 office visits per thousand eligibles per year in SFY 2015, an increase of 6.9% per year on average in the last 5 years.
- ❖ Over the same period, inpatient admissions/thousand and inpatient days/thousand for this population have decreased at an annual rate of 0.3% and 3.8% respectively.
- ❖ Emergency room visits/thousand decreased at a rate of 0.5% per year on average for this population over the last 5 years.
- ❖ Pharmacy claims for non-MME adults with disabilities average 55 claims per average eligible per year, and have been growing at a rate of 1.9% per year on average over the last 5 years.

## 4b. Adults with Disabilities: HCBS Utilization

The largest categories of home and community based services for adults with disabilities are residential and rehabilitation services for the developmentally disabled and personal care services.



- ❖ Forty-seven 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 for adults with disabilities is residential and rehabilitation services for developmentally disabled individuals, with an average monthly census of 2,061 recipients in SFY 2015 for MME adults with disabilities and 1,107 recipients for Non-MME adults with disabilities.
- ❖ The second largest category is personal care services, with an average monthly census of 894 recipients in SFY 2015 for MME adults with disabilities and 964 recipients for Non-MME adults with disabilities.
- ❖ The monthly census for this category is growing at 5.6% per year on average for MME adults with disabilities and at 16.7% per year on average for Non-MME adults with disabilities.

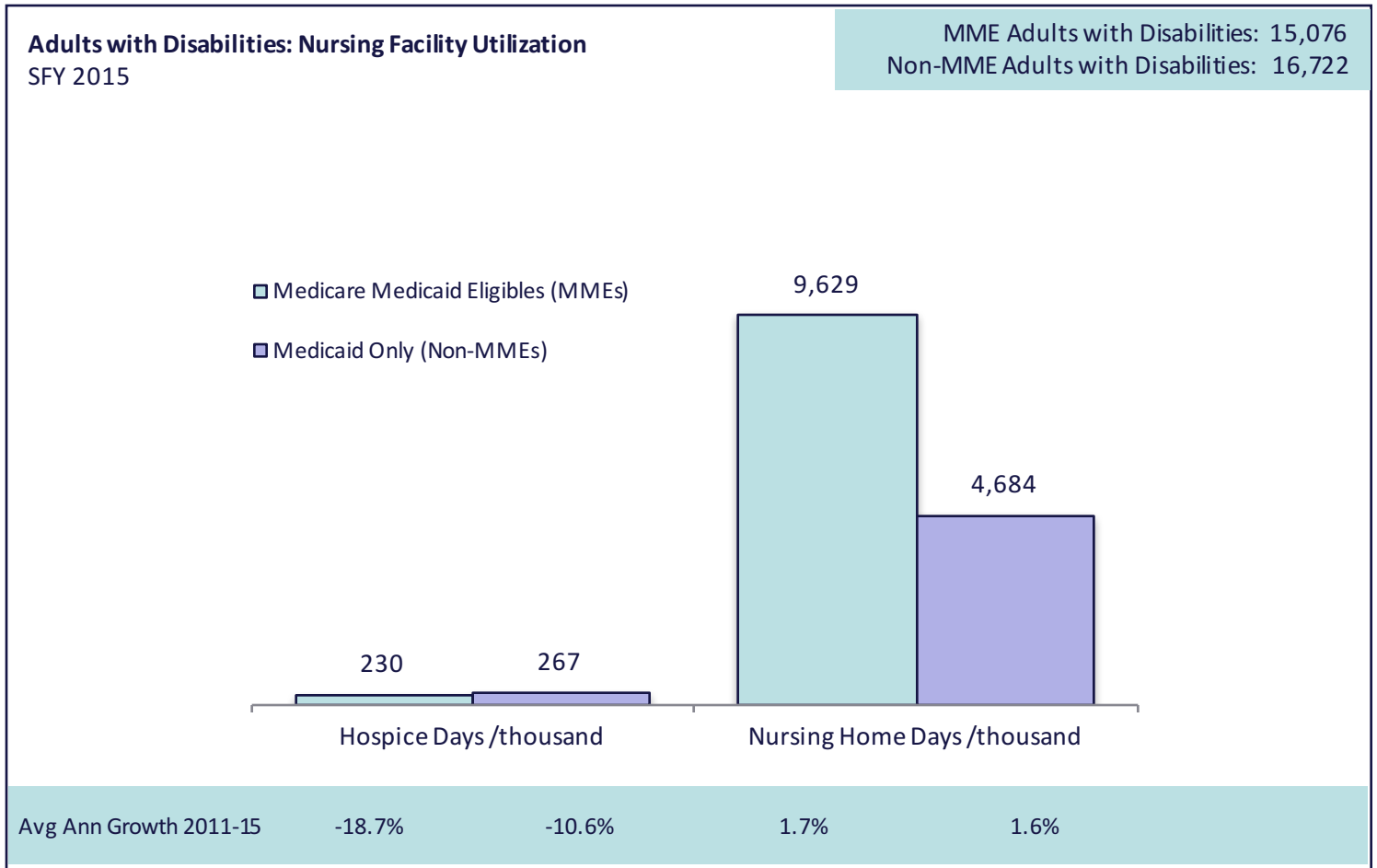
<sup>1</sup>DD Resdtl/Rehab are residential and rehabilitation services for the developmentally disabled and include residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment for those with developmental disabilities.

<sup>2</sup>Annual growth rate for MME assisted living is not meaningful due to a jump in monthly census from SFY 2010-2012. Census has been steady SFY 2012-2014.

<sup>3</sup>The shared living program was initiated in SFY 2011 so growth rates are not meaningful.

## 4b. Adults with Disabilities: Nursing Facility Utilization

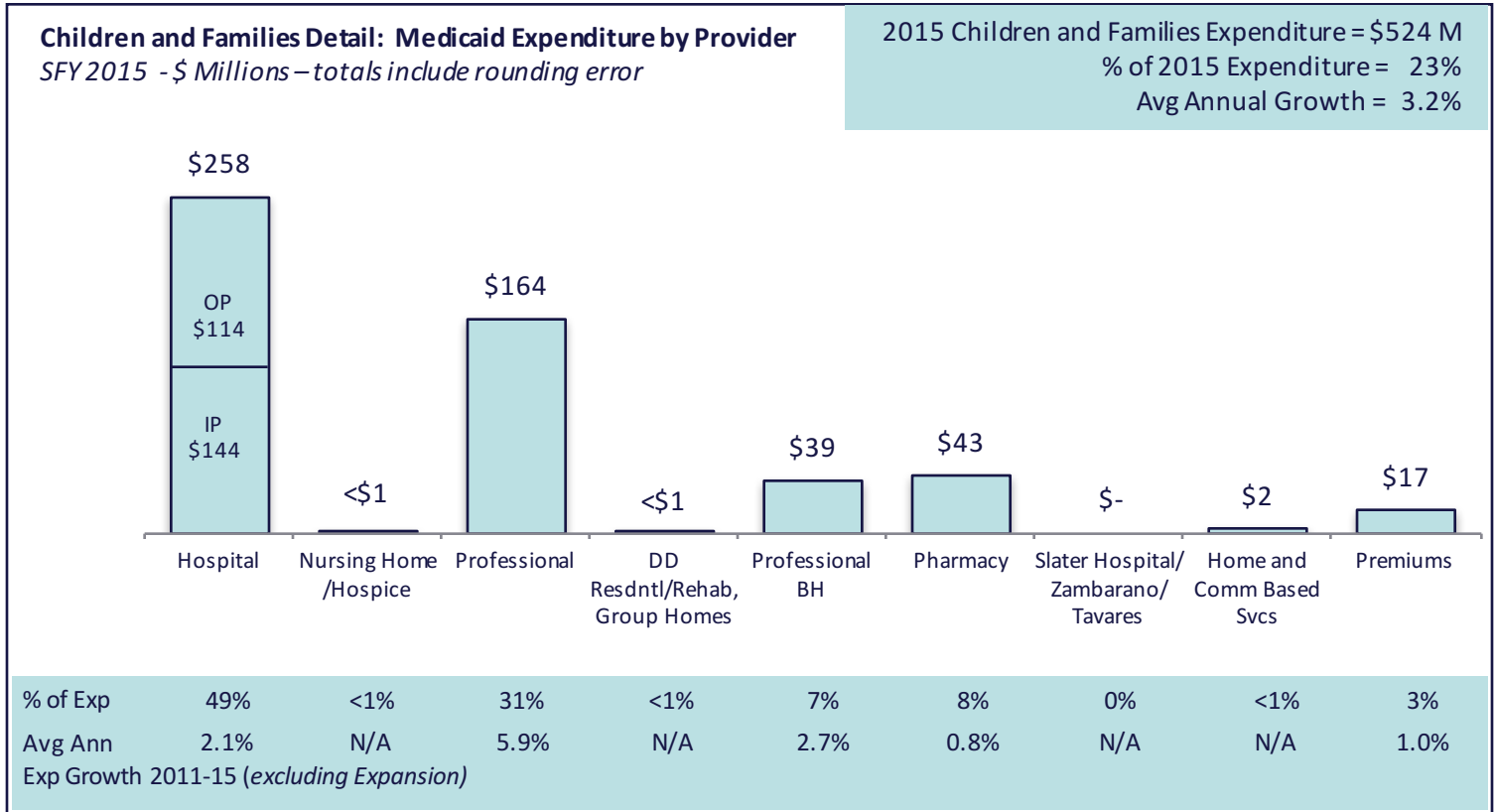
Nursing home days per thousand have increased 1.7% and 1.6% per year since SFY 2011 for MME and Non-MME adults with disabilities, respectively.



- ❖ Forty-seven 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 MME adults with disabilities, hospice days decreased 18.7% per year and nursing home days per thousand increased 1.7% per year on average since SFY 2011.
- ❖ Nursing home days for Non-MME adults with disabilities were 4,684 per thousand for SFY 2015, an increase of 1.6% per year since SFY 2011.

## 4c. Children and Families: Expenditure by Provider

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



- ❖ Children and families account for about one-fourth (23%) of total Medicaid expenditures, with SFY 2015 expenditure of \$524 million. Expenditure for this population has increased by 3.2% per year over the past 5 years.
- ❖ Most expenditure on children and families is divided between professional and hospital care, with hospital care accounting for nearly half (49%) 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 .<sup>1</sup>
- ❖ 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 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 2015, Rhode Island received a 65.02% combined CHIP/FMAP federal match on CHIP children and pregnant women who are in families with incomes above mandatory coverage levels.

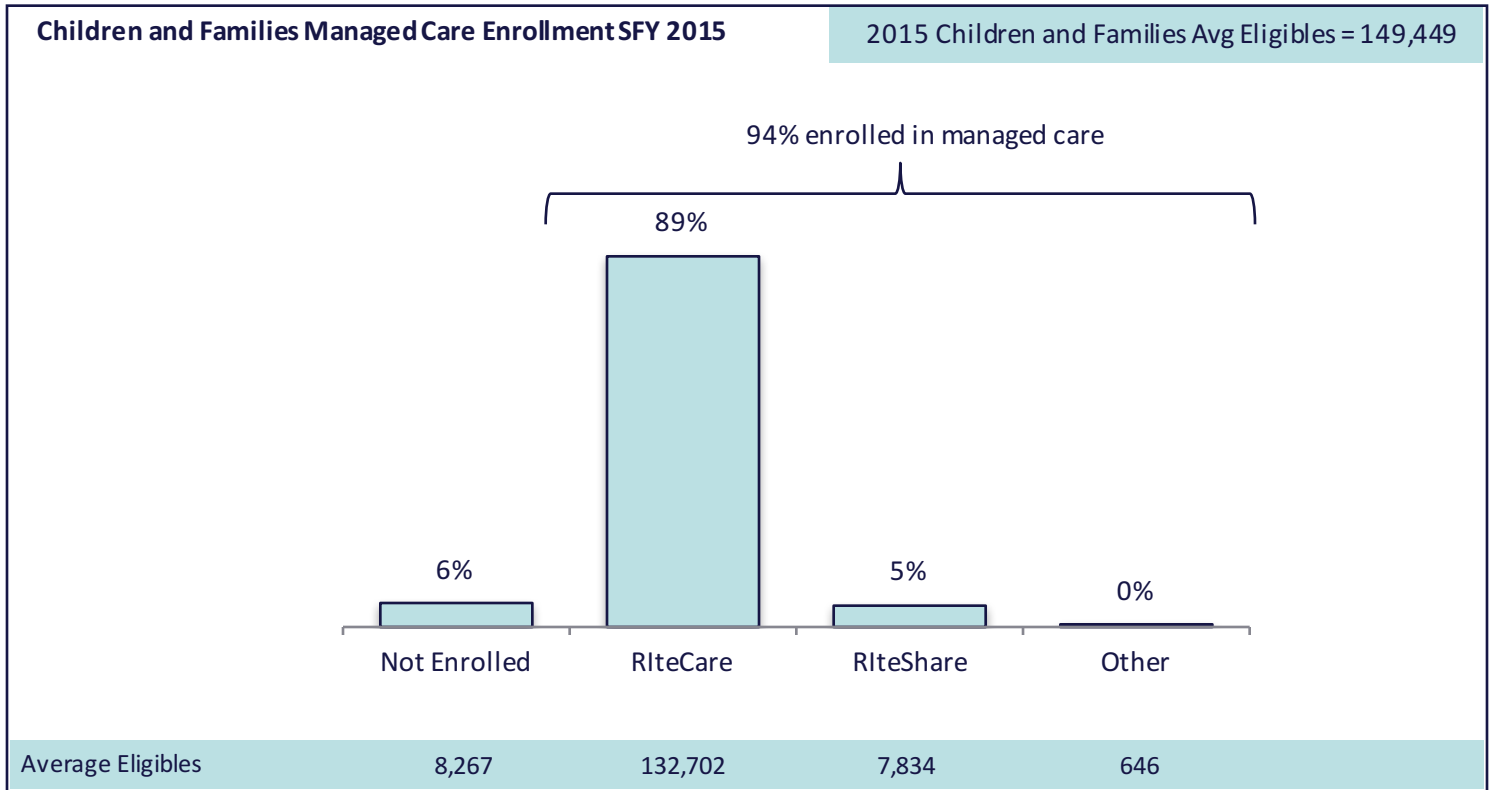
N/A indicates expenditure in this category too small to calculate a meaningful trend rate.

\*See footnotes on page 21 for Provider Type definitions.

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

## 4c. Children and Families: Managed Care Enrollment

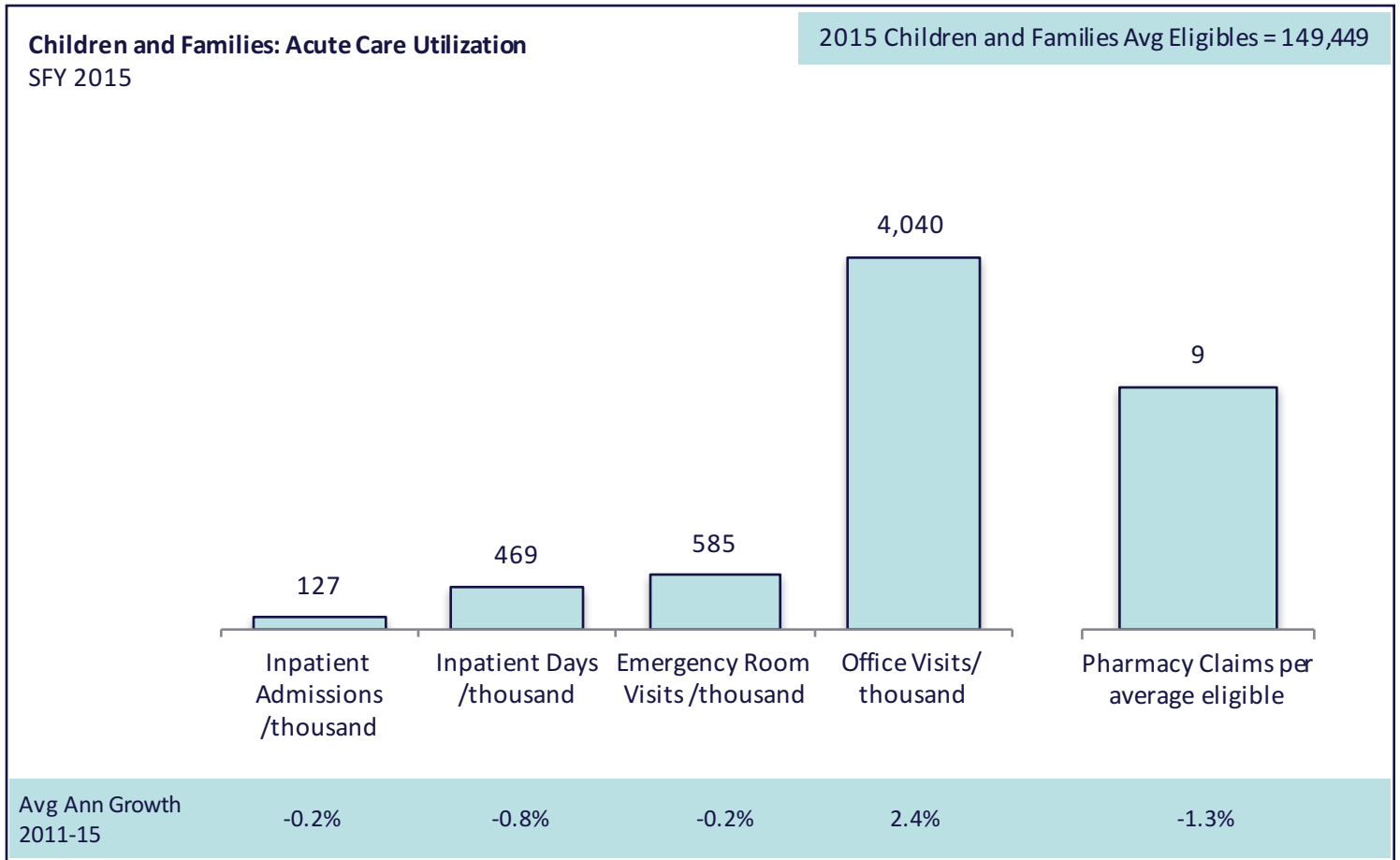
Nearly all children and families are enrolled in managed care.



- ❖ Eighty-nine percent of children and families are enrolled in a Medicaid managed care program through RIte Care. These enrollees are divided between Neighborhood Health Plan (NHP) and United Healthcare (UHC).
- ❖ 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 2015 there were 7,834 Medicaid eligible children and families enrolled in the RIte Share program.
- ❖ The unenrolled children and families include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

## 4c. Children and Families: Acute Care Utilization

For children and families, inpatient admissions and inpatient days per thousand have decreased on average since SFY 2011.

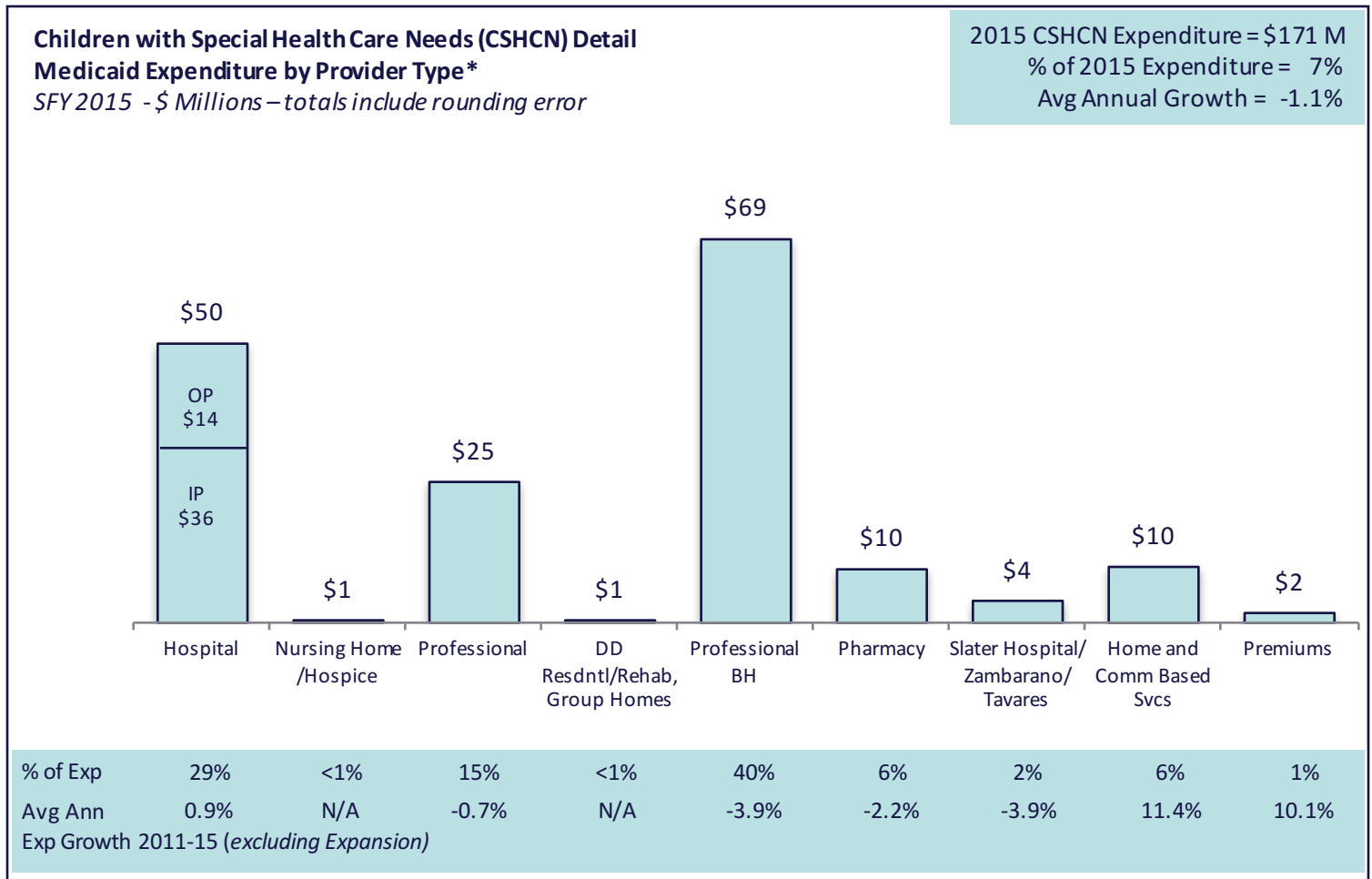


- ❖ For children and families, hospital-based acute care utilization measures have decreased since SFY 2011. Inpatient admissions per thousand and emergency room visits / thousand have both decreased 0.2% per year on average since SFY 2011. Office visits per thousand have increased at 2.4% per year on average over the same period.
- ❖ Pharmacy claims for children and families average 9 claims per average eligible person per year and have decreased 1.3% per year on average over the last 5 years.
- ❖ About 59% of inpatient admissions and 54% of inpatient days are maternity related (including maternity, nursery and NICU). Annually, approximately 47% of all RI births are covered through RIte Care.<sup>1</sup>

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

## 4d. Children with Special Health Care Needs: Expenditure by Provider

In the population of children with special health care needs, professional behavioral health accounts for 40% of all expenditure.



- ❖ Children with Special Health Care Needs (CSHCN) comprise a relatively small population -- accounting for seven percent of total Medicaid expenditures and five percent of enrollees, with total SFY 2015 expenditure of \$171 million.
- ❖ Expenditure for this population is dominated by professional behavioral health services, which account for \$69 million in CSHCN expenditures (40%). Professional behavioral health services include CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation) and CEDARR Direct services, residential DCYF services, and professional mental health, substance abuse, and other services.

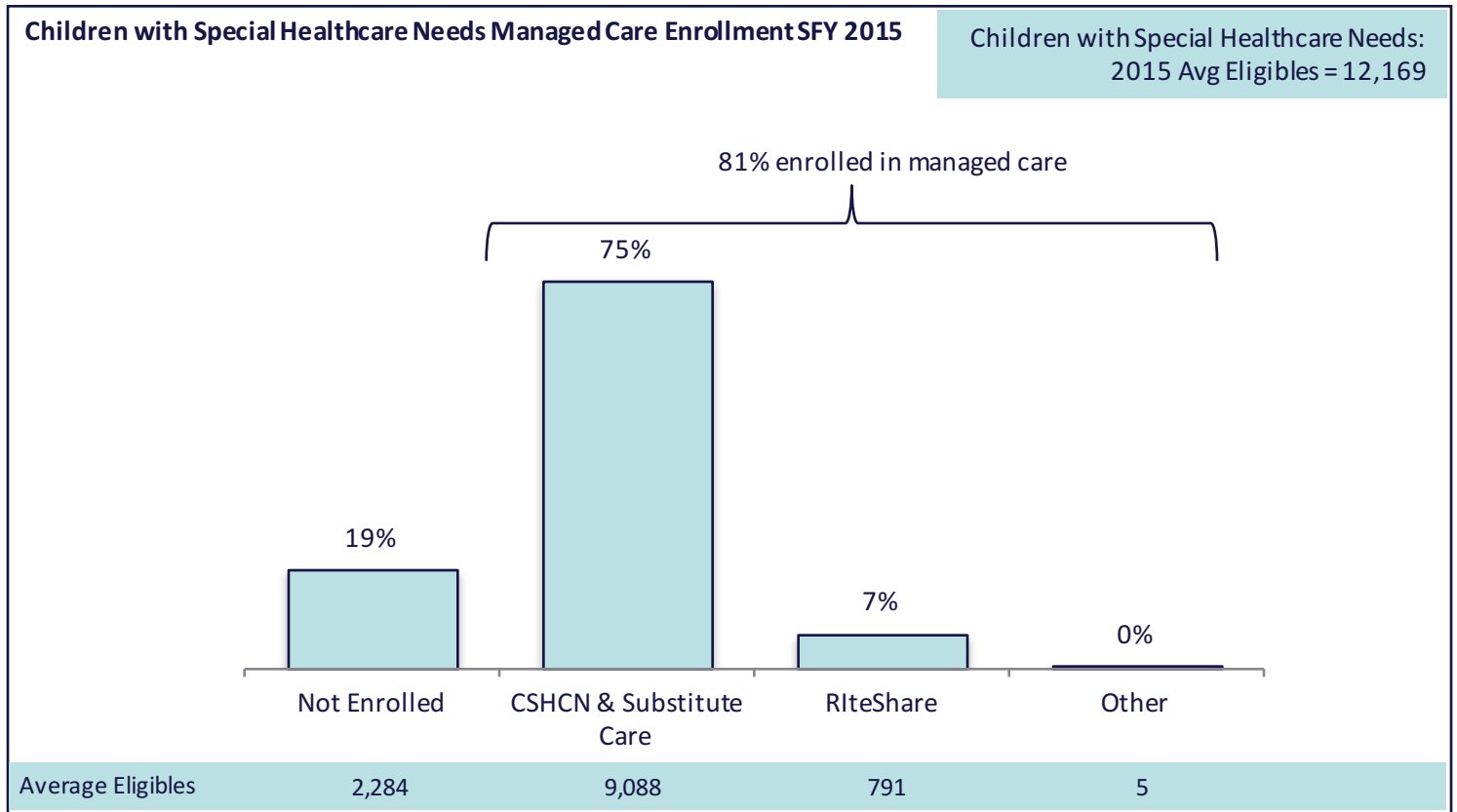
N/A indicates expenditure in this category too small to calculate a meaningful trend rate.

\*See footnotes on page 21 for Provider Type definitions.



## 4d. Children with Special Healthcare Needs: Managed Care Enrollment

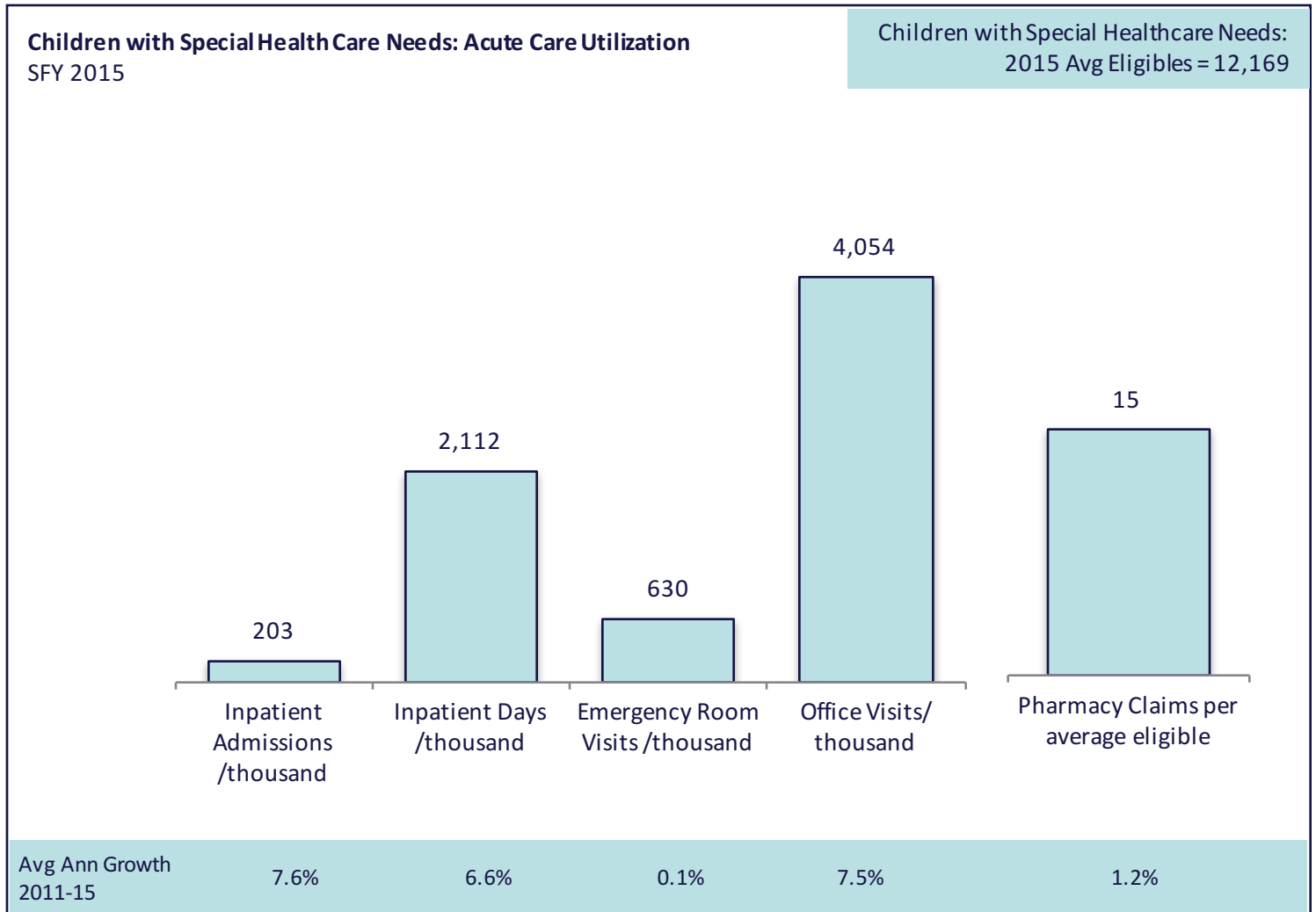
Over 80% of children with special healthcare needs are enrolled in managed care.



- ❖ In 2008, enrollment in Medicaid managed care became mandatory for children with special health care needs (CSHCN) without other insurance. In SFY 2015 81% were enrolled in managed care.
- ❖ The unenrolled children with special healthcare needs include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

## 4d. Children with Special Health Care Needs: Acute Care Utilization

For children with special health care needs, emergency room visits per thousand have remained nearly flat since SFY 2011.

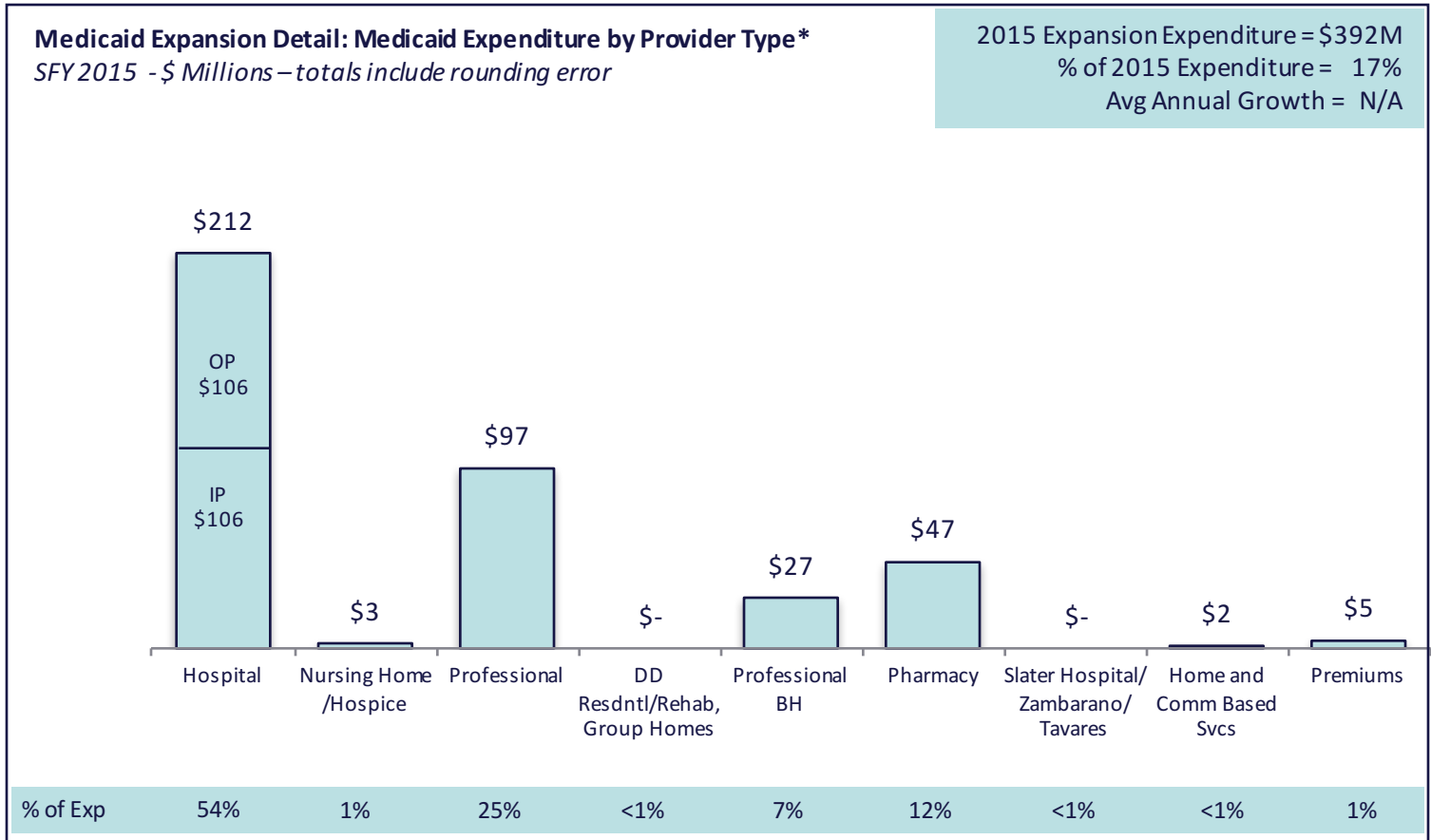


- ❖ Inpatient admissions per thousand have increased over the last 5 years at an average rate of 7.6% per year to 203 per thousand in SFY 2015.
- ❖ Office visits per thousand have increased at an average rate of 7.5% per year since SFY 2011 to 4,054 visits per thousand in SFY 2015.
- ❖ More than half (63%) of inpatient admissions per thousand are for behavioral health. In terms of inpatient days, 80% are related to behavioral health.<sup>1</sup>
- ❖ Pharmacy claims per average eligible have increased at 1.2% per year over the last 5 years.

<sup>1</sup>Includes admissions and days in the Children's Residential and Family Treatment (CRAFT) program at Bradley Hospital.

## 4e. Medicaid Expansion: Expenditure by Provider

The Expansion population mainly uses hospital and professional services.

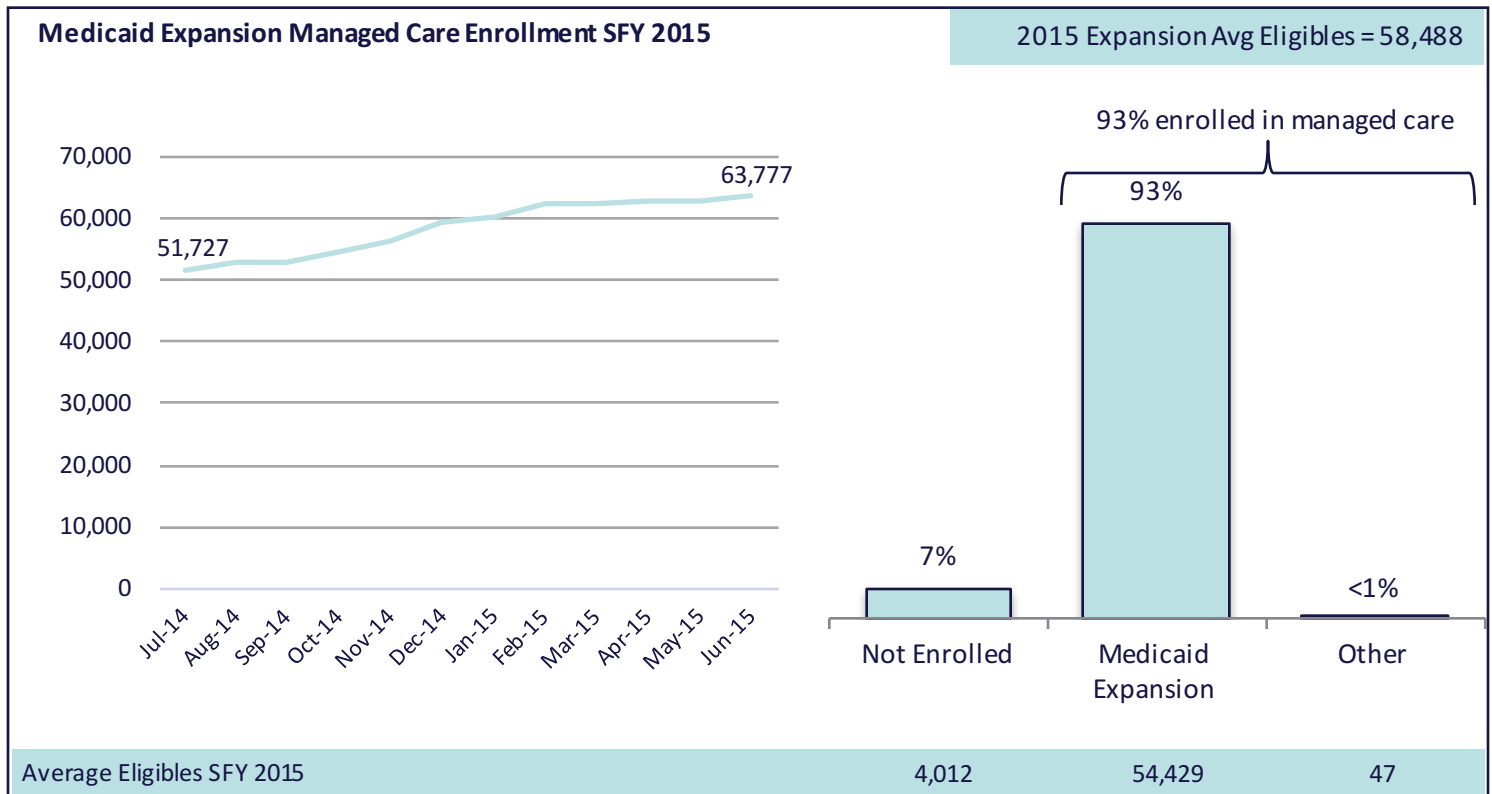


- ❖ The Expansion population accounted for \$392 million in expenditure in SFY 2015, 17% of total Medicaid expenditure.
- ❖ The two largest provider types for the Expansion population are hospital and professional services, accounting for 79% of expenditure.
- ❖ The population used almost no long term services and supports. However this population first became eligible for Medicaid starting January 1, 2014.

\*See footnotes on page 21 for Provider Type definitions.

## 4e. Medicaid Expansion: Managed Care Enrollment

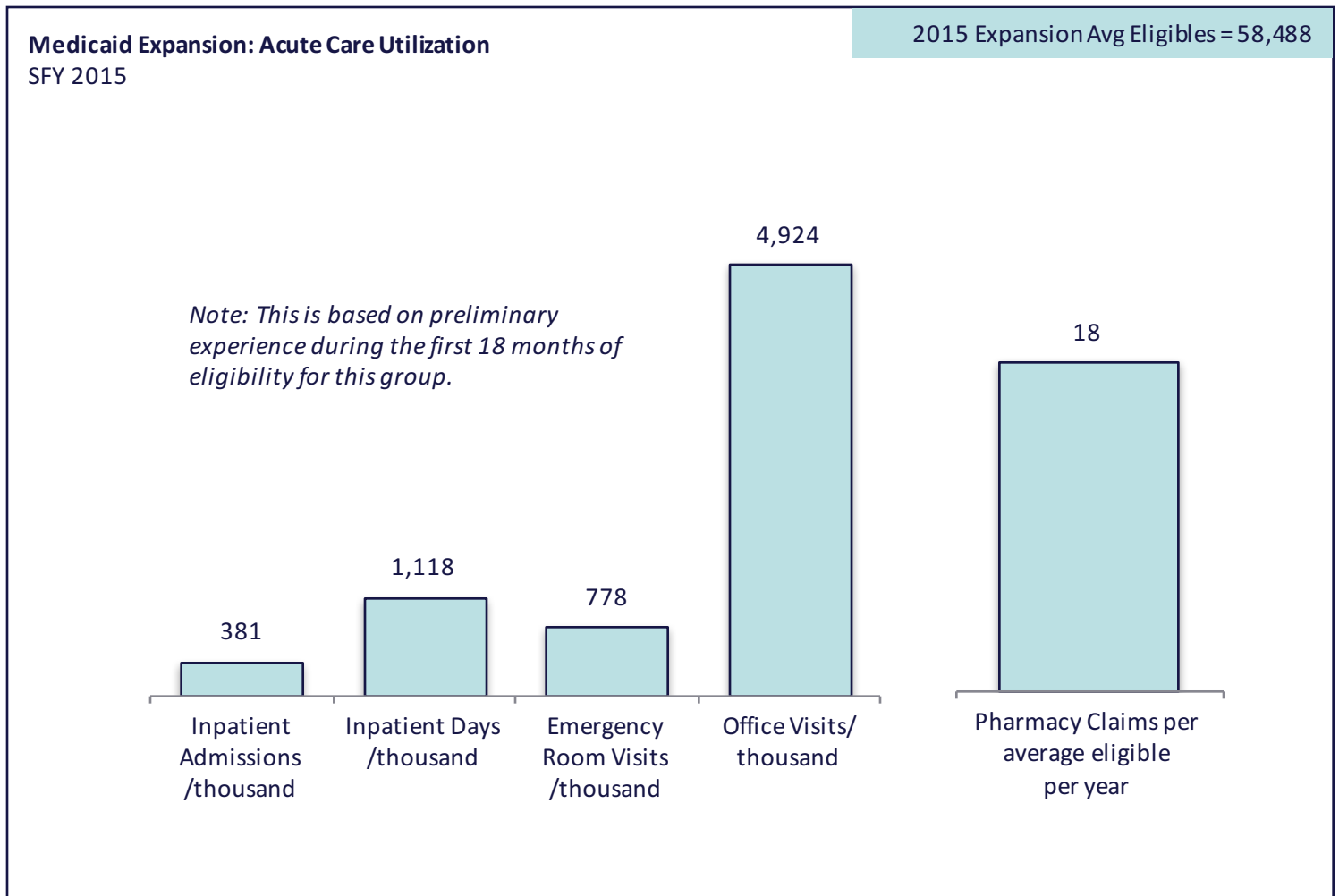
The Expansion population is mainly enrolled in managed care programs.



- ❖ The Medicaid Expansion population is expected to entirely enroll in managed care. However new enrollees experience an initial period in fee-for-service prior to enrollment in a health plan.
- ❖ Expansion eligibility commenced in January 2014 and was still phasing in during SFY 2015. The average eligibles for SFY 2015 is 58,488, however enrollment increased from 51,727 eligibles in July 2014 to 63,777 eligibles in June 2015.

## 4e. Medicaid Expansion: Acute Care Utilization

The Expansion population used almost 5 office visits per average eligible.



- ❖ The Medicaid Expansion population had 381 inpatient admissions per thousand and 1,118 inpatient days per thousand during SFY 2015.
- ❖ In addition this population had an average of 18 pharmacy claims per 12 months of eligibility.

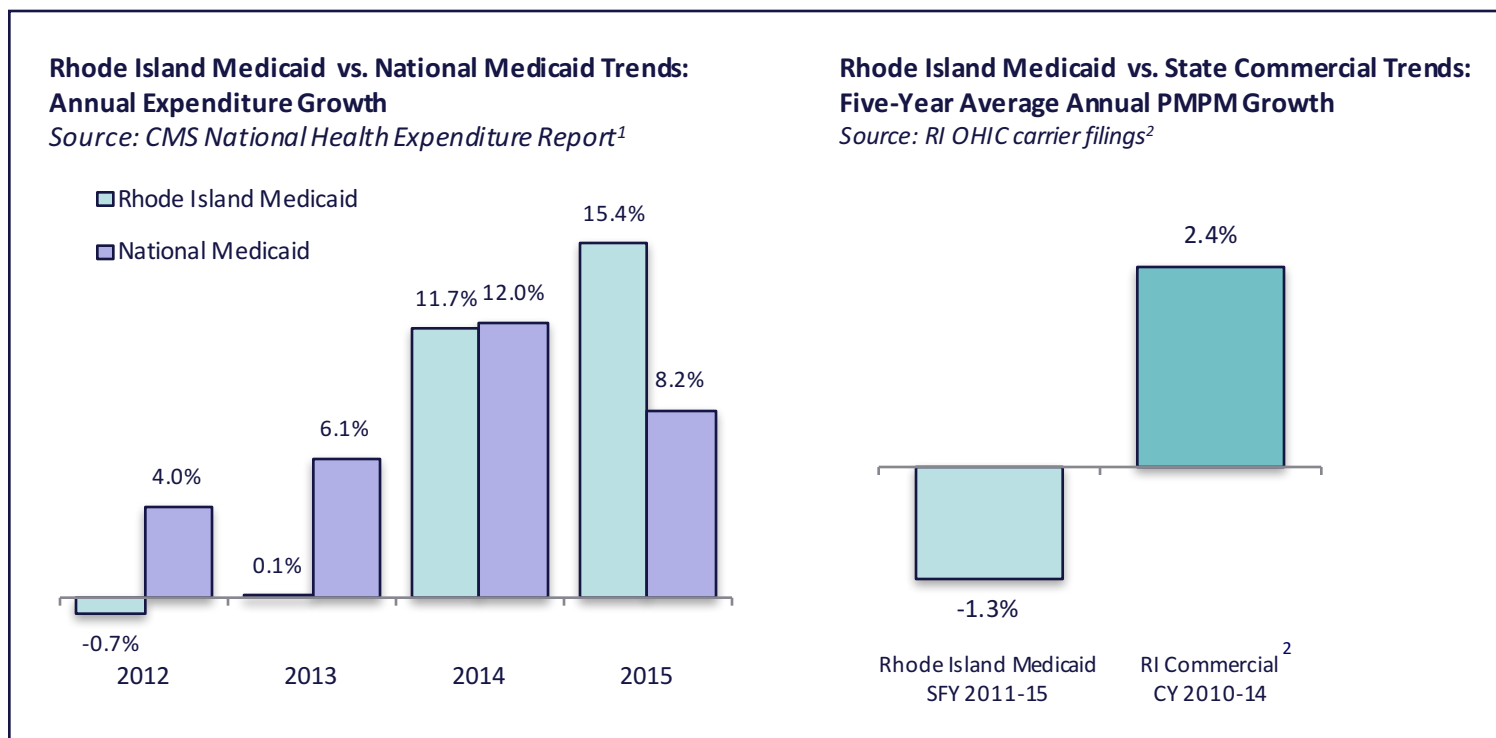
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## 5a. National Medicaid Trends: National Medicaid and State Commercial

RI Medicaid trends were notably low as compared to national Medicaid and regional Commercial experience prior to Expansion.



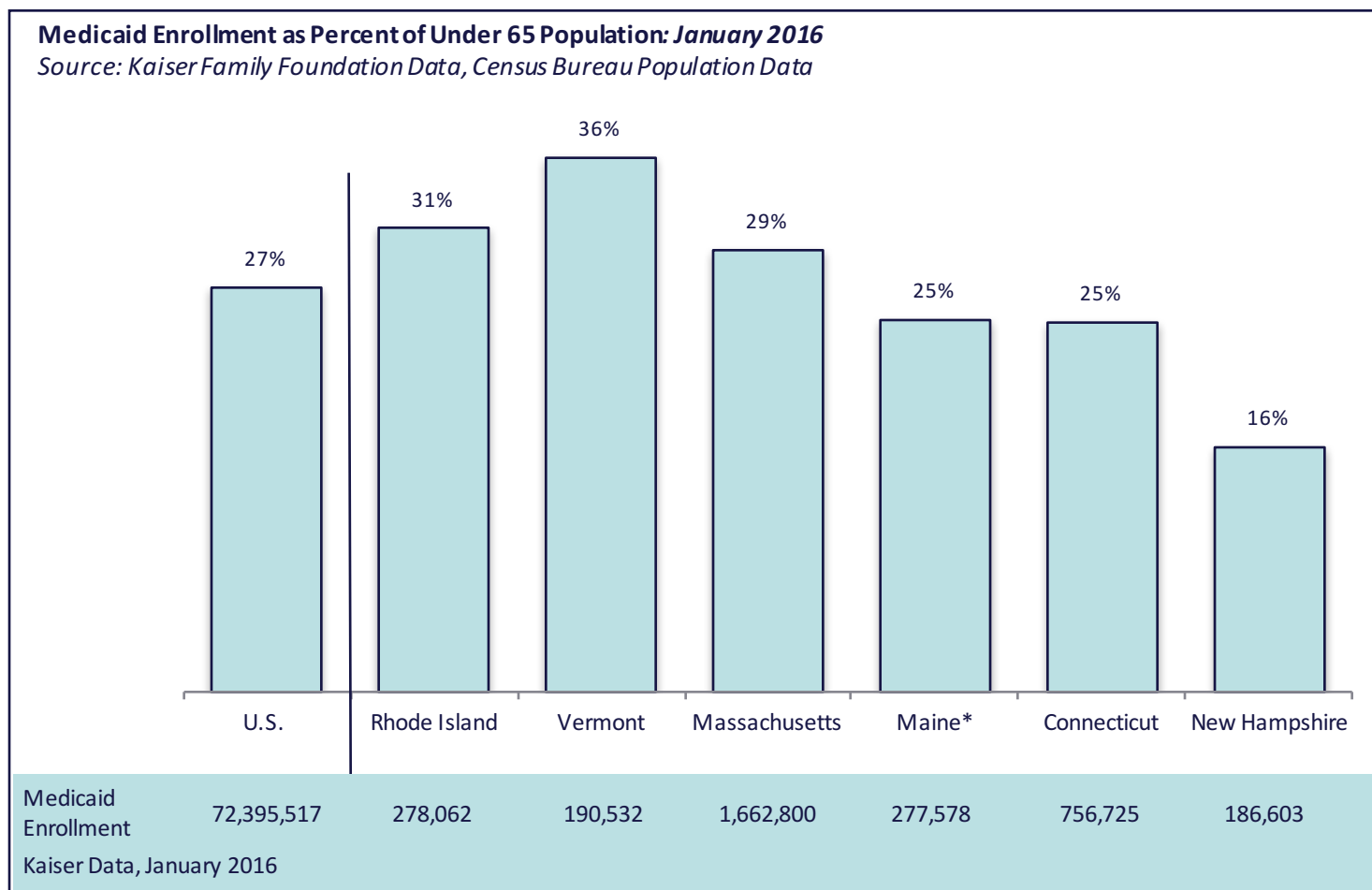
- ❖ Overall state expenditure growth compared very favorably to Centers for Medicare & Medicaid Services (CMS) national Medicaid expenditure trend for the years 2012 and 2013, prior to Medicaid Expansion.
- ❖ Including the Expansion population, RI Medicaid growth rate was 11.7% from 2013 to 2014. National projected Medicaid growth for the similar timeframe was 12.0%. That 12.0% national measure included projections that not all states would expand Medicaid and would presumably have been higher if all states nationwide had expanded Medicaid eligibility under ACA.
- ❖ Between 2014 and 2015, RI Medicaid growth rate was 15.4% including Expansion (2.8% excluding Expansion). The CMS national projected trend for the same period was 8.2% across all states.
- ❖ Rhode Island Medicaid PMPM (per member per month) cost trends excluding Expansion compare favorably to local commercial benchmarks. Between SFY 2011 and 2015, the state Medicaid program experienced a decrease in average annual PMPM cost of 1.3% per year. The average annual commercial medical PMPM cost for RI commercial health plans over a similar period increased 2.4% per year.<sup>2</sup>
- ❖ 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.

<sup>1</sup>Source: 2015 CMS National Health Expenditure Report. National growth rates in FFY. 2014 & 2015 data are projections.

<sup>2</sup>Source: Office of the Health Insurance Commissioner (OHIC), 2015 carrier rate filings. Data in CY for 2010-2014. Incurred 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.

## 5a. National Medicaid Trends: Medicaid Enrolled Population

According to January 2016 Kaiser data, Rhode Island's Medicaid enrollment is 31% of its population under 65, compared to 27% nationally.



- ❖ The Kaiser Family Foundation compiles Medicaid enrollment data for all states monthly, with the latest data available for January 2016. The Kaiser data was converted for the purposes of this chart to percent of population under 65 for each state using data from the US Census Bureau.
- ❖ According to these sources, Rhode Island Medicaid enrollment as a percent of its population under 65 was 31% in January of 2016.
- ❖ The New England state with the highest percentage Medicaid enrollment is Vermont. Rhode Island is second.
- ❖ Nationally 27% of the population under 65 is enrolled in Medicaid.

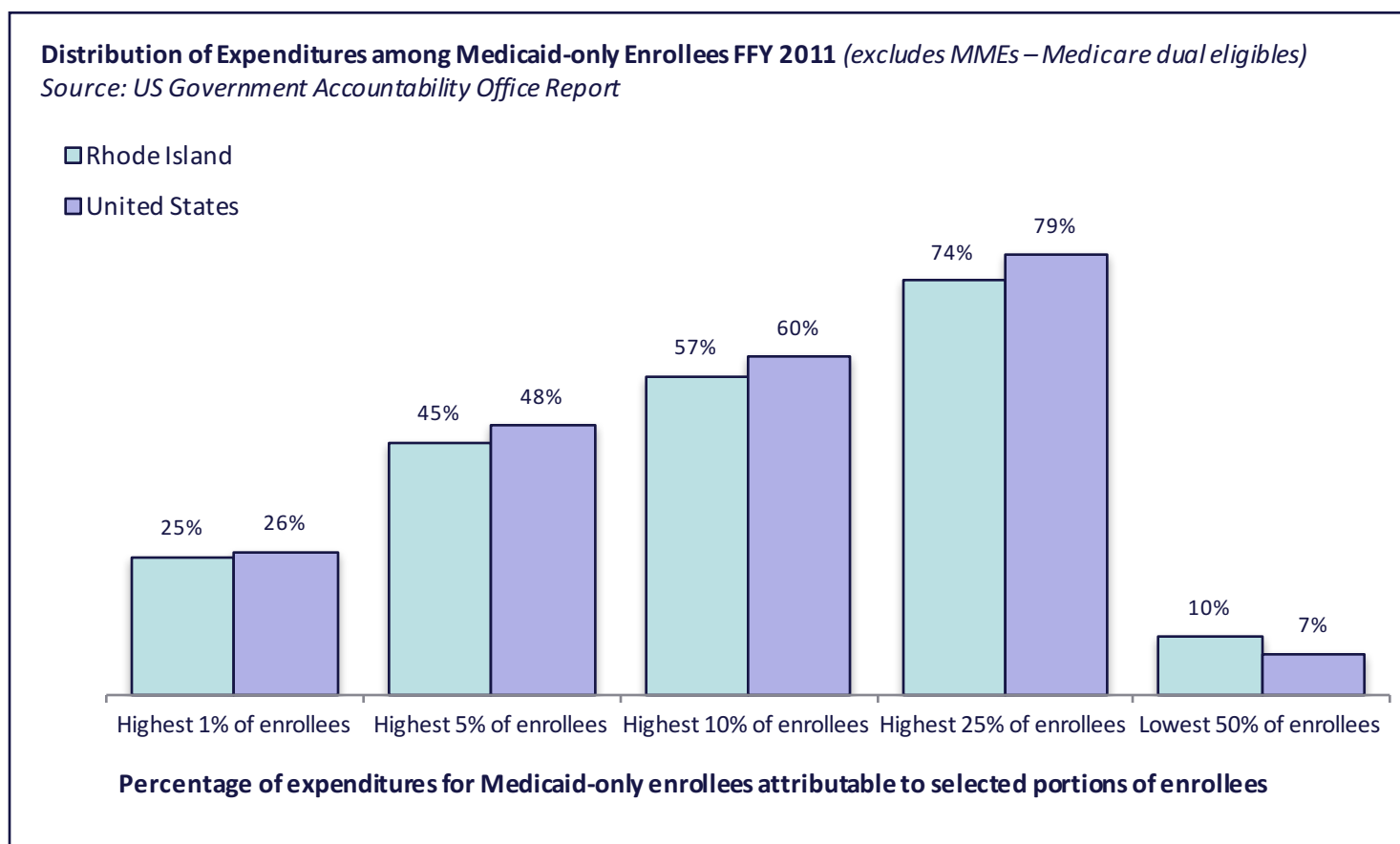
\*Maine has not adopted Medicaid expansion. All other New England states did adopt Medicaid expansion.

Source: Total Monthly Medicaid and CHIP Enrollment, January 2016. Kaiser Family Foundation dataset. Population data from US Census Bureau, 2010.



## 5b. Cost/Utilization Benchmarks: Distribution of Expenditures

According to a US GAO study, Rhode Island is fairly consistent with national benchmarks in terms of the amount of Medicaid expenditure attributable to the highest cost enrollees.



- ❖ Both nationwide and in Rhode Island, the top 1% of Medicaid enrollees account for about one-quarter of total Medicaid expenditure. Top top 5% of enrollees account for nearly half.
- ❖ On the other end of the spectrum, the lowest 50% of enrollees account for 10% of Medicaid expenditure in Rhode Island and 7% nationally.
- ❖ This data differs from the high utilizer statistics shown earlier in this report because it excludes dual eligibles in Medicare and is based on data from 2011.

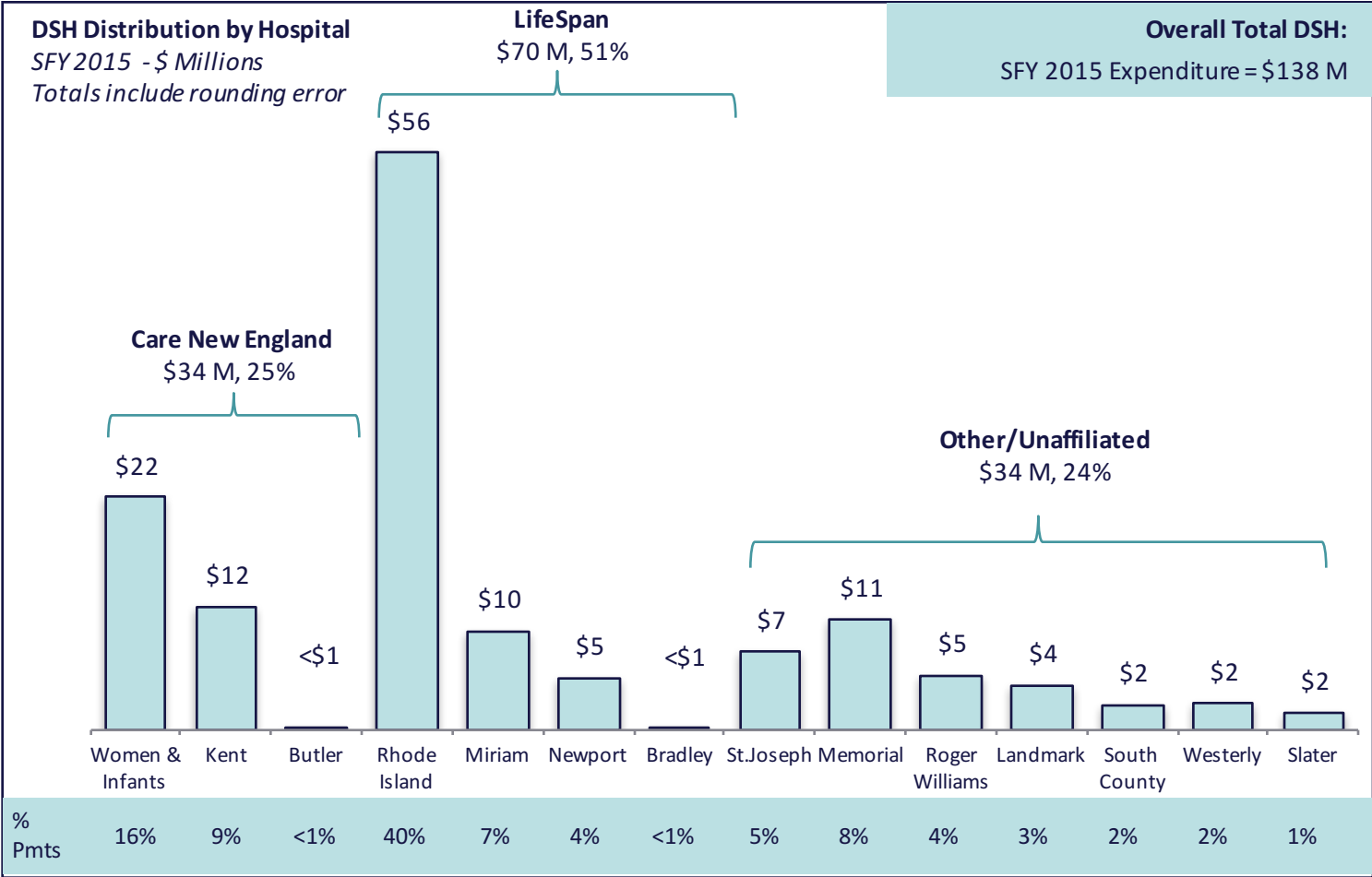
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### 6a. Exclusions: (1) Disproportionate Share Hospitals (DSH)

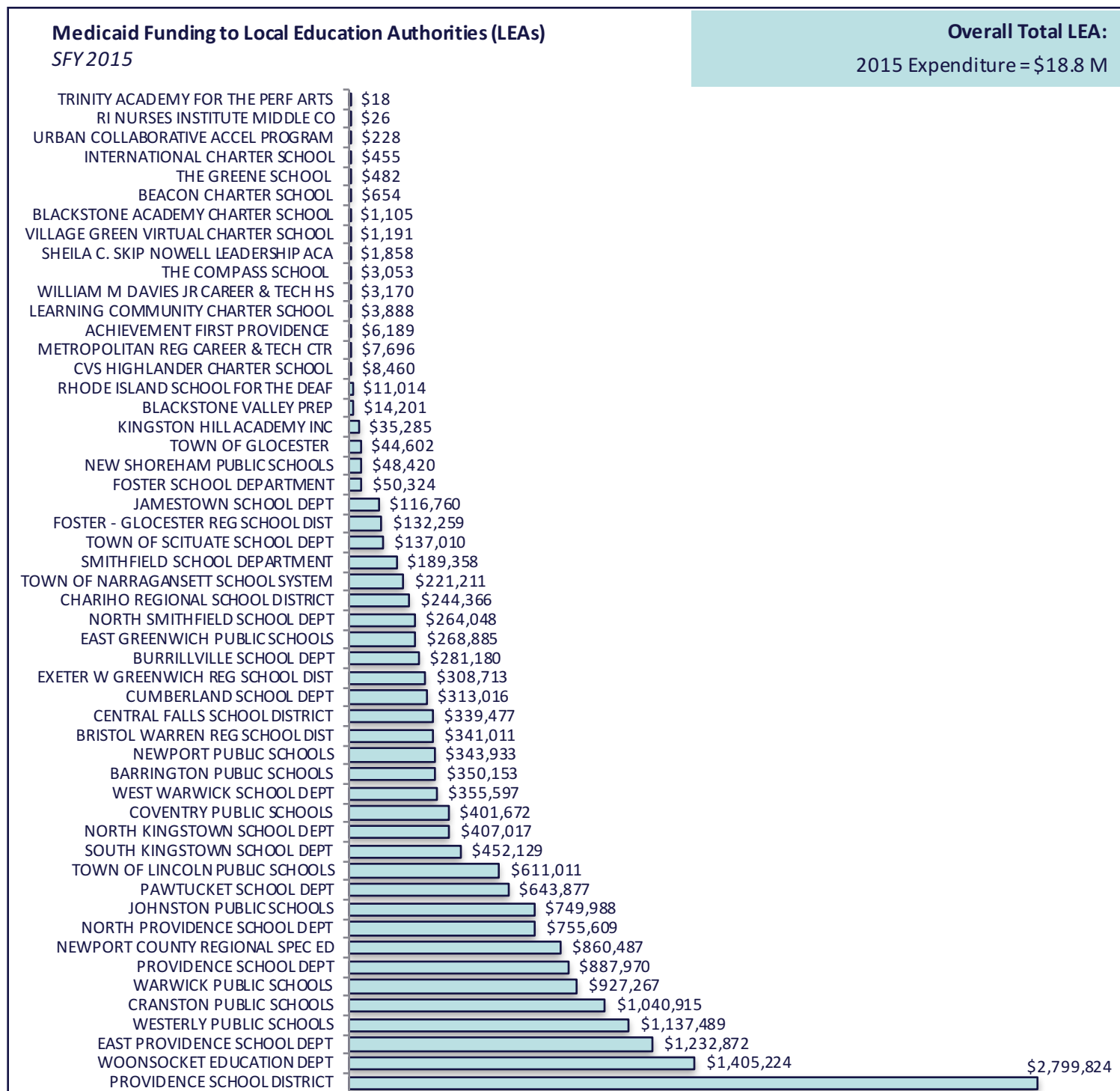
Disproportionate share (DSH) Medicaid payments are intended to subsidize the cost of providing care to indigent and very low income people.



- ❖ A total of \$138 million in DSH funds was paid out to hospitals in SFY 2015.
- ❖ The state’s two largest hospitals – Rhode Island and Women and Infants – together accounted for 56% of total DSH payments
- ❖ DSH payments are not included in the Medicaid expenditure analysis in this report.

## 6a. Exclusions: (2) Local Education Authorities

Local Education Authorities (LEAs) account for \$19 million in total expenditures in 52 school districts.



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

# 6a. Exclusions: (3) Costs Not Otherwise Matchable (CNOM)

Costs Not Otherwise Matchable (CNOMs) account for \$15.5 million in total expenditures.



❖ CNOM expenditures are not part of the core Medicaid program and as such are not included in the Medicaid expenditure analysis in this report.

## 6b. Acronyms and Abbreviations

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<b>ACA:</b>	Affordable Care Act
<b>BCBSRI:</b>	Blue Cross Blue Shield of Rhode Island
<b>BHDDH:</b>	Behavioral Healthcare, Developmental Disability, and Hospitals
<b>CHIP:</b>	Children's Health Insurance Program
<b>CMHC:</b>	Community Mental Health Center
<b>CMS:</b>	Centers for Medicare and Medicaid
<b>CNOM:</b>	Costs Not Otherwise Matchable
<b>CSHCN:</b>	Children with Special Health Care Needs
<b>DCYF:</b>	Department of Children, Youth and Families
<b>DD:</b>	Developmentally Disabled
<b>DEA:</b>	Department of Elderly Affairs
<b>DSH:</b>	Disproportionate Share Hospitals
<b>DHS:</b>	Department of Human Services
<b>DME:</b>	Durable Medical Equipment
<b>DOH:</b>	Department of Health
<b>EOHHS:</b>	Executive Office of Health and Human Services
<b>ER:</b>	Emergency Room
<b>FFY:</b>	Federal Fiscal Year
<b>FMAP:</b>	Federal Medicaid Assistance Percentage
<b>HCBS:</b>	Home and Community-Based Services
<b>HEDIS:</b>	Healthcare Effectiveness Data and Information Set
<b>ICF:</b>	Intermediate Care Facility
<b>IP:</b>	Hospital Inpatient
<b>LEA:</b>	Local Education Agencies
<b>LTSS:</b>	Long Term Services and Supports
<b>MCO:</b>	Medicaid Managed Care Organization
<b>MME:</b>	Medicaid Medicare Eligibles
<b>NHPRI :</b>	Neighborhood Health Plan of Rhode Island
<b>NICU:</b>	Neonatal Intensive Care Unit
<b>OP:</b>	Hospital Outpatient
<b>PACE:</b>	Program of All-Inclusive Care of the Elderly
<b>PCCM:</b>	Primary Care Case Management
<b>PMPM:</b>	Per member per month
<b>RIPTA:</b>	Rhode Island Public Transit Authority
<b>SA:</b>	Substance Abuse
<b>SFY:</b>	State Fiscal Year
<b>SSI:</b>	Supplemental Security Income
<b>UHCNE:</b>	UnitedHealth Care of New England
<b>UPL:</b>	Upper Payment Limit

## 6c. Sources and Notes

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### Source Data and Analytic Method

This report is based on SFY 2015 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 2015
- ❖ Capitations, premiums and payouts are proportionately 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, rounding and allocation of non-claims based expenditures.