Rhode Island Annual Medicaid Expenditure Report SFY 2016

Executive Office of Health and Human Services

May 2017

Purpose of this Report

The purposes of this report include the following:

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

Variance to Other Reports:

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

The primary basis for identifying expenditures in this report is the actual date of service with an adjustment for incurred but not reported (IBNR) claims, rather than paid date. Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes due to differences in timing.

Other reasons for variance might include factors such as claim completion and rounding.

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.*

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Executive Summary: Overview and Key Findings

Overview

During SFY 2016 Rhode Island's Medicaid program served approximately 325,000 Rhode Islanders, with an average of 282,000 enrolled at any one time. This includes 86,000 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 on Medicaid covered services for SFY 2016 totaled $2.4 billion. Medicaid expenditures are divided among several state agencies, with $2 billion of expenditure managed in SFY 2016 by the Executive Office of Health and Human Services (EOHHS), and $340 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 2016 the Federal Medical Assistance Percentage (FMAP) was 50.32% for the bulk of Medicaid expenditure. For certain programs the FMAP is higher, including Expansion population, Children's Health Insurance Program (CHIP), and others.

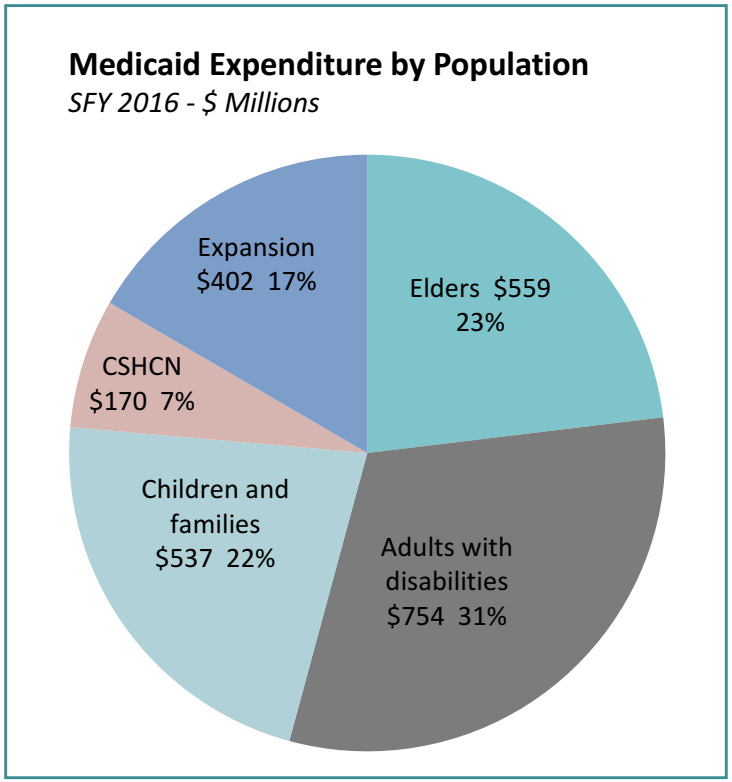
Key Findings:

- During SFY 2016 Rhode Island's Medicaid program served an average of **282,000 enrollees** at any one time during the year.
- Total expenditures for Medicaid covered services for SFY 2016 were **$2.4 billion**.
- Between SFY 2012 and 2016, total Medicaid expenditures have increased an average of 2.3% per year, excluding 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.
- Per member per month (PMPM) costs have decreased 0.5% per year, from $794 in SFY 2012 to $777 in SFY 2016, excluding the Expansion population. When including the Expansion population, overall Medicaid PMPM for SFY 2016 is $717.
- These expenditure trends compare quite favorably to both national Medicaid total expenditures and state commercial PMPM cost trends.
- Adults with disabilities account for 31% of expenditure. Elders account for another 23%.
- Hospitals and nursing facilities account for nearly half (45%) of Medicaid expenditure.
- Ninety 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 top 6% of users account for 62% of claims expenditure.

Executive Summary: Populations

Medicaid serves five different primary populations:

- **Elders** include 19,198 adults over age 65, 96% of whom are also covered by Medicare.[1] Elders account for $559 million in total SFY 2016 Medicaid expenditure, and have the highest average PMPM cost of $2,427. Nursing facilities account for sixty percent of expenditures for this population.
- **Adults with disabilities** include 32,080 adults under age 65 who have identified disabilities. Almost half (48%) of this population is also covered by Medicare. Adults with disabilities account for the largest share of expenditure, with SFY 2016 expenditure of $754 million, and an average PMPM cost of $1,958. The largest components of expenditure for this population are residential and rehabilitation services for persons with intellectual and developmental disabilities and hospital care.
- **Children and families** include 153,342 low income children, parents and pregnant women who meet specific income requirements. Children and families account for 54% of total enrollment and 22% of total expenditure, with total SFY 2016 expenditure of $537 million and an average PMPM of under $300. Most expenditure on this population is for hospital care and professional services. Ninety-five percent of this population is enrolled in managed care. The federal match is increased to 82.47% for qualifying low income children and pregnant women under the Children's Health Insurance Program (CHIP).



- **Children with special health care needs (CSHCN)** include 12,025 individuals under 21 who are eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. These children account for 7% of total Medicaid expenditures and 4% of enrollees, with SFY 2016 expenditures of $170 million. Eighty-two percent of this population is enrolled in managed care.
- **Expansion** includes 64,989 low income adults without dependent children, newly eligible under the ACA on January 1, 2014. The Expansion population accounted for 23% of SFY 2016 enrollment and 17% of total SFY 2016 expenditure, or $402 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 77% of expenditures on this population. Nearly all (95%) were enrolled in managed care.

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

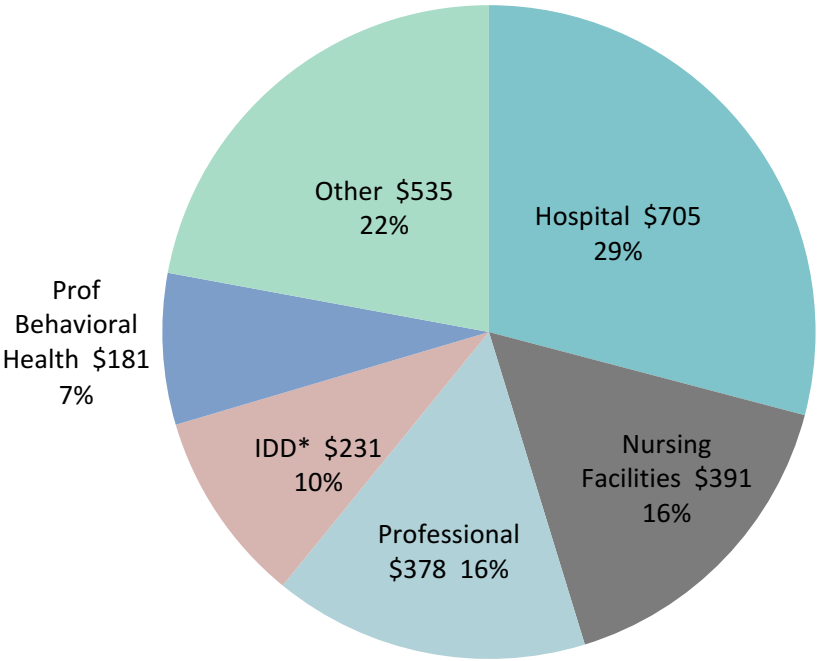
Executive Summary: Medicaid Providers

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

- Hospitals were the largest provider type, accounting for 29% of Medicaid expenditure in SFY 2016.
- Hospital expenditures increasing at 1.1% annually over the last five years, not including expenditure on the Expansion population.
- Nursing facilities (including both nursing homes and hospice) were the next largest provider type, accounting for 16% of expenditure in SFY 2016.
- Total Medicaid payments to nursing facilities have been increasing on average 2.7% per year between SFY 2012-2016 (trend rates do not include the Expansion population).
- The provider type categories with the highest average annual growth trends were professional services, home and community based services, and premiums.
- Other provider types detailed in the report include premiums; pharmacy; home and community-based services; and care provided in the Slater Hospital, Tavares and Zambarao facilities.

Medicaid Expenditure by Provider Type

SFY 2016 - $ Millions

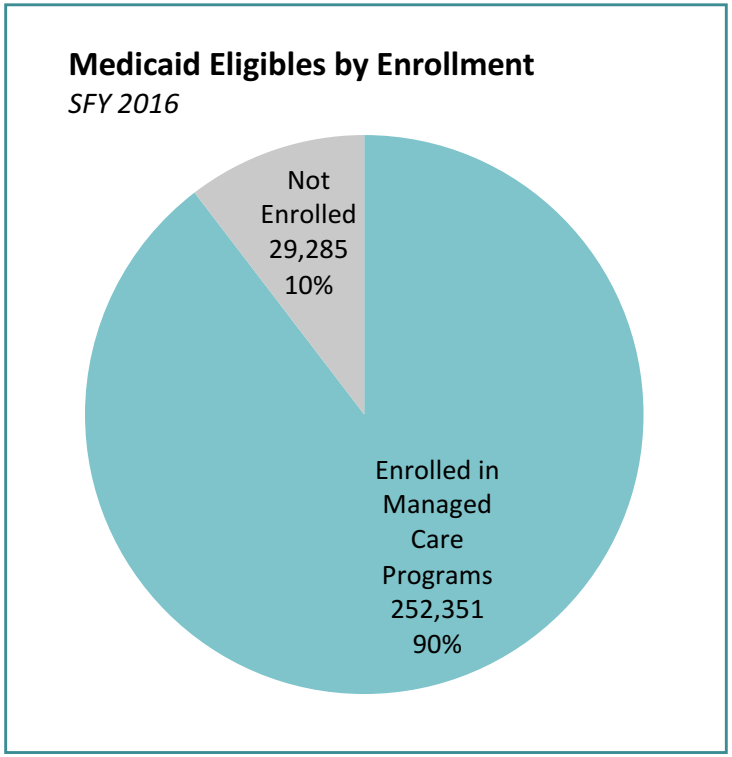


*The IDD provider type includes residential and rehabilitation services and group homes for persons with intellectual and developmental disabilities.

Executive Summary: Managed Care

Not all payments are made directly by Medicaid to service providers. In SFY 2016, 90% of Medicaid eligibles are enrolled in risk-based managed care plans. These enrolled populations accounted for 76% of Medicaid expenditure.

- Forty-nine percent of Medicaid eligibles are enrolled in managed care through RIte Care, which is a Medicaid managed care program for children and parents.
- Another 3% of managed care enrolled eligibles are the Children with Special Health Care Needs population.
- Five percent of eligibles are enrolled in Rhody Health Partners (RHP), a managed care program for adults with disabilities.
- The Expansion population is mainly enrolled in managed care.
- Enrollment in Medicaid managed care programs 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 managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term services and supports and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility. In SFY 2016 7% of Medicaid eligibles are enrolled in RHO.
- Three percent of Medicaid eligibles are 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.



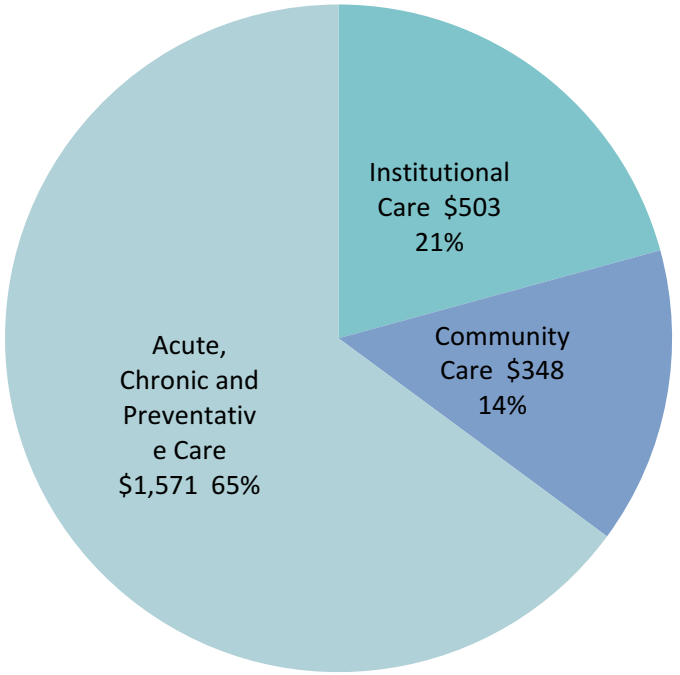
Executive Summary: Long Term Services and Supports

Long term services and supports (LTSS) include institutional care and community care. These services are mainly focused on the elders and adults with disabilities populations. Expenditures on LTSS account for $850 million in total Medicaid expenditure in SFY 2016, 35% of total.

- Community care services are provided to at-risk populations as alternatives to more costly nursing home/institutional options and account for $348 million, 41% of the LTSS expenditure.
- Institutional care services account for the remaining $503 million of LTSS expenditure. The largest category is nursing home services, accounting for 43% of LTSS expenditure overall. Other institutional care expenditure is for hospice and care in the Slater Hospital, Tavares and Zamabarano facilities.
- The balance of expenditure between nursing facilities and home and community based care (HCBS, a subset of Community Care) has been shifting over the last 5 years. In SFY 2016 HCBS accounted for 23% of the combined expenditure on both nursing facilities and HCBS compared to 20% in SFY 2012.
- Expenditure on HCBS has been growing at 7.2% per year on average over the last 5 years. Nursing home expenditure has been growing at 3.0% per year on average.
- Acute, chronic and preventive services account for the remaining 65% of Medicaid expenditure.

Medicaid Expenditure by Provider Type Category

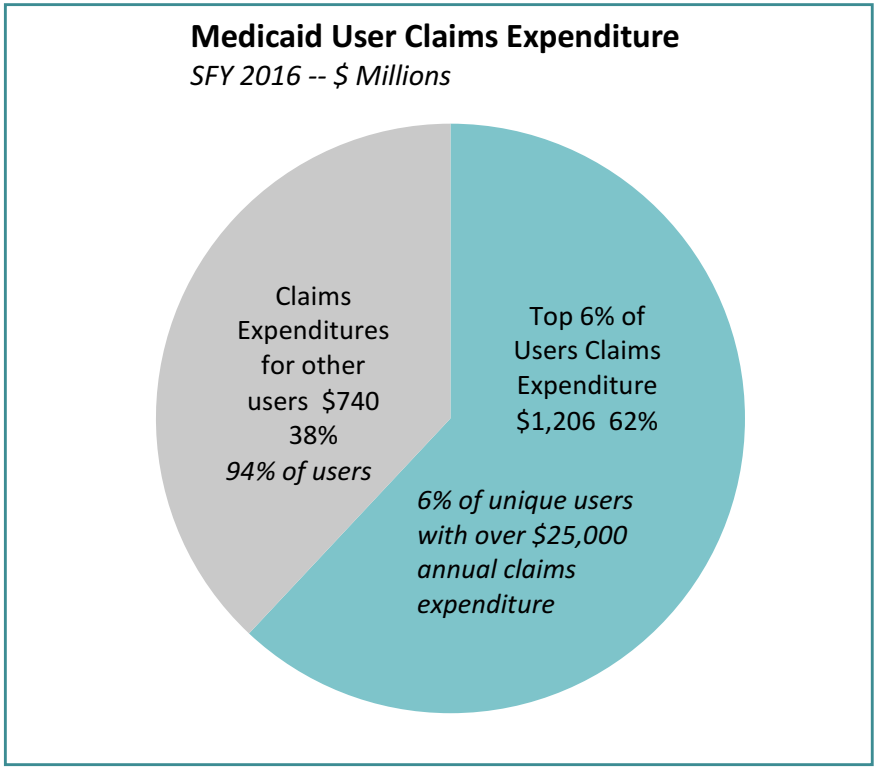
SFY 2016 -- $ Millions



Executive Summary: High Cost Users

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

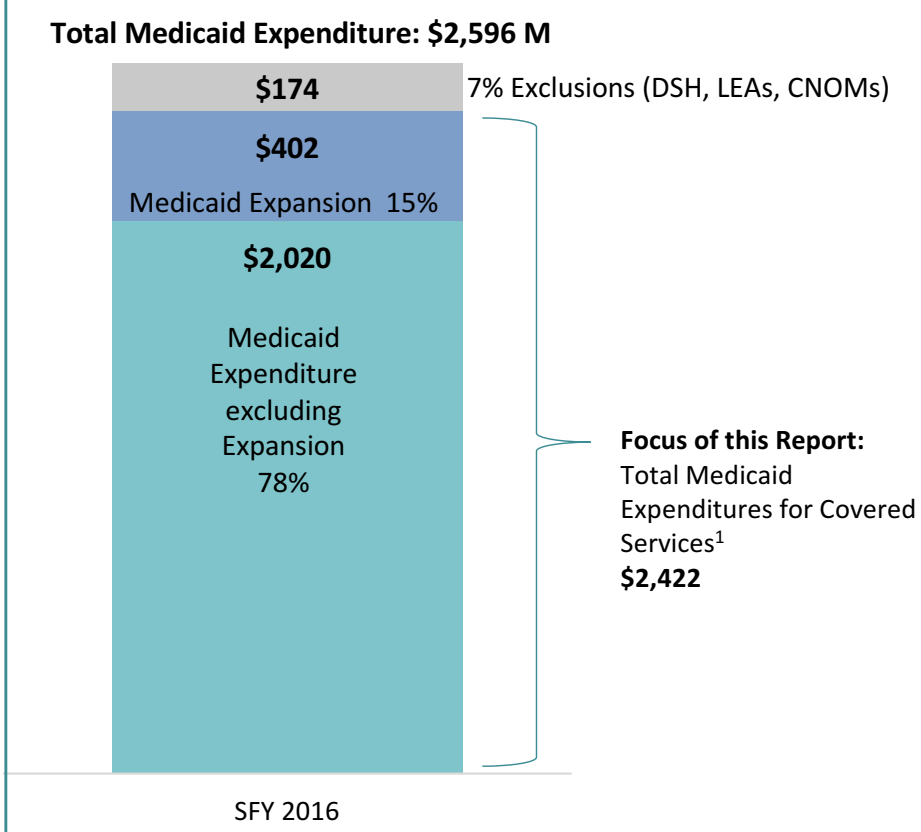
- This analysis examines the characteristics of "high cost" users, those with over $15,000 of claims expenditure of per year.
- Nine percent of Medicaid users are "high cost" users and account for 71% of claims expenditure.
- High Cost users typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- Forty-one percent of claims expenditure for high cost users is for nursing facilities and residential and rehabilitation services for persons with intellectual and developmental disabilities. Hospital services account for another 24% of high cost user claims expenditure.
- Together, elders and adults with disabilities account for 71% of claims expenditure for high cost users. For both of these populations, about three-quarters of total population expenditure is attributable to high cost user claims.



Total Expenditures: Definitions and Exclusions

Medicaid expenditures in SFY 2016 totaled approximately $2.6 billion. Expenditures for covered services totaled $2.4 billion, including $402 million for Medicaid Expansion.

Summary: Total Medicaid Expenditures
SFY 2016 - $ Millions



- Medicaid 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 adults without dependent children under 138% FPL. Expenditure on this population during SFY 2016 was $402 million and the state received 100% federal matching funds for this population.
- The analyses in this report exclude $141 million in Disproportionate Share Hospital (DSH) payments, $16 million in costs not otherwise matchable (CNOM), payments of $18 million to Local Education Authorities (LEAs), and EOHHS administrative expenditure. More detail on excluded payments is provided in the Appendix.
- In previous years, this report has excluded Medicare "clawback" payments. Officially known as the "phased-down state contribution", the clawback is a monthly payment made by each state to the federal Medicare program to help finance the Medicare drug benefit. This report includes $53 million in clawback payments, and all historical data shown has been updated to include clawback payments as well.

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

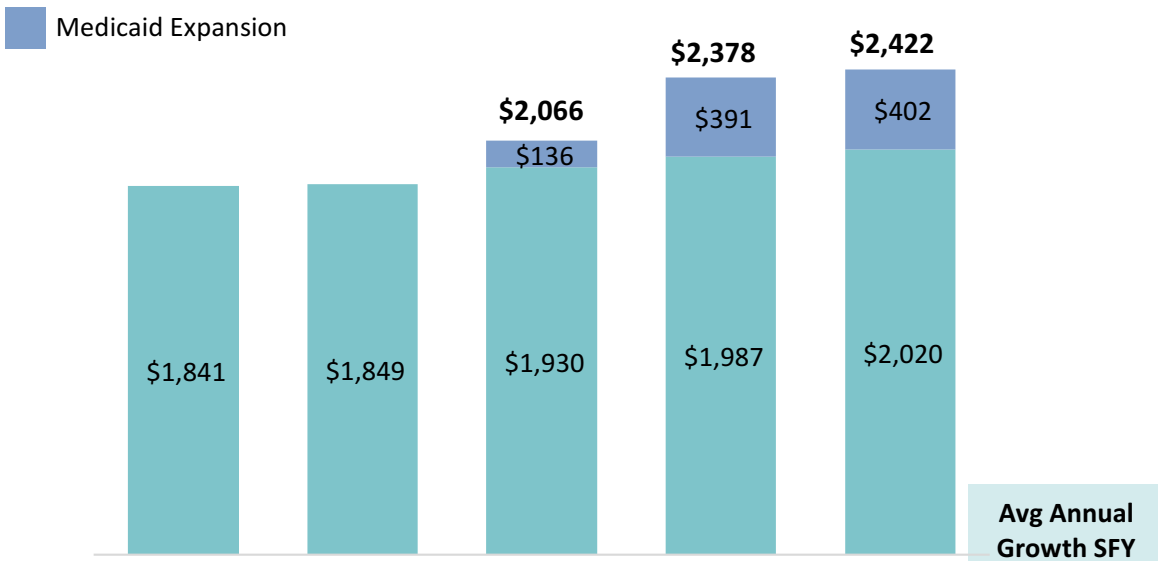
[1]Expenditures reflect medical benefits only and do not include EOHHS central management expenditures.

Medicaid Expenditure Trends

Over the past five years, Rhode Island Medicaid expenditures have **increased 2.3% per year on average**, excluding the Medicaid expansion population.

Total Medicaid Expenditure for Covered Services[1]

SFY 2012-2016 - $ Millions



		SFY 2013	SFY 2014	SFY 2015	SFY 2016	Avg Annual Growth SFY 2012-2016[2]
Annual Exp Growth	Excluding Expansion	0.4%	4.4%	2.9%	1.7%	**2.3%**
	With Expansion		11.7%	15.1%	1.8%	**7.1%**

- Including the Expansion population, expenditure increases for SFY13-14 and SFY14-15 were 11.7% and 15.1% respectively. However total expenditure growth including Expansion for SFY 15-16 has slowed to 1.8%.
- The state receives federal matching funds to cover 100% of the Expansion population expenditures for SFY 2016. For SFY 2017, FMAP for this population will be 97.5% and for SFY 2018 it is expected to be 94.5%.
- One contributing factor to the increase in expenditure in SFY 2013-15 was the ACA-mandated primary care physician rate increase in effect for calendar years 2013 and 2014.
  - This resulted in 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 for calendar years 2013 and 2014.
  - Roughly half of the total increased amount occurred in SFY 2014.

[1]Annual expenditure includes the spending for Medicare clawback payments that were excluded in previous year versions of this Report.

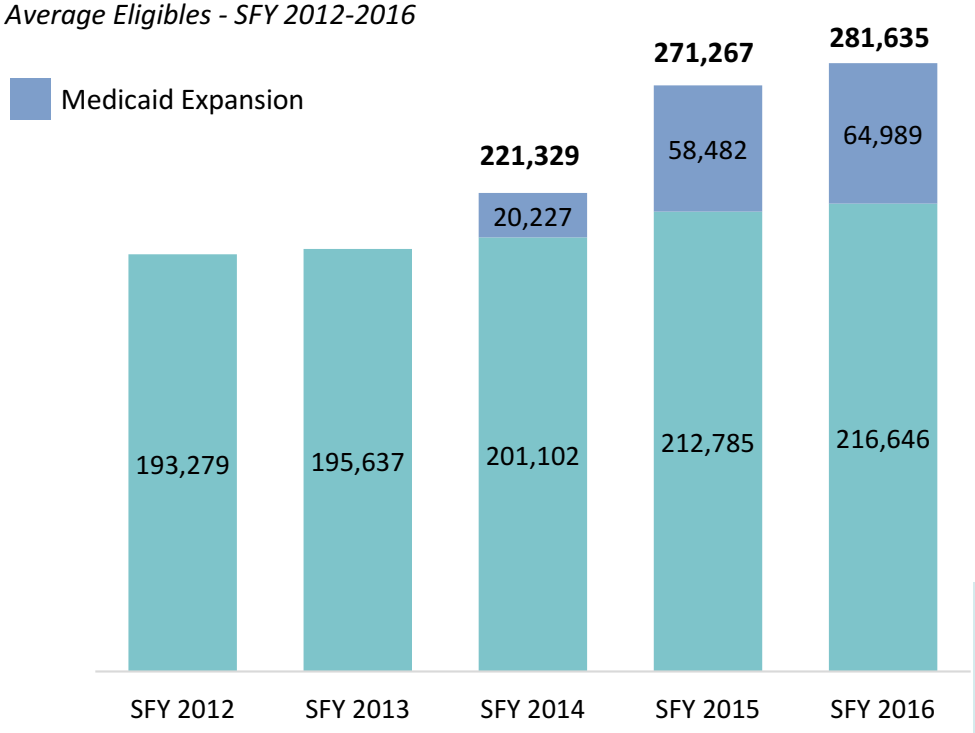
[2]Calculated as compounded annual growth rate (CAGR) over period SFY 2012-2016 as shown.

Medicaid Expenditure Trends: Enrollment

Average annual Medicaid enrollment has **increased 2.9% per year on average**, excluding Medicaid Expansion.

Total Medicaid Enrollment

Average Eligibles - SFY 2012-2016



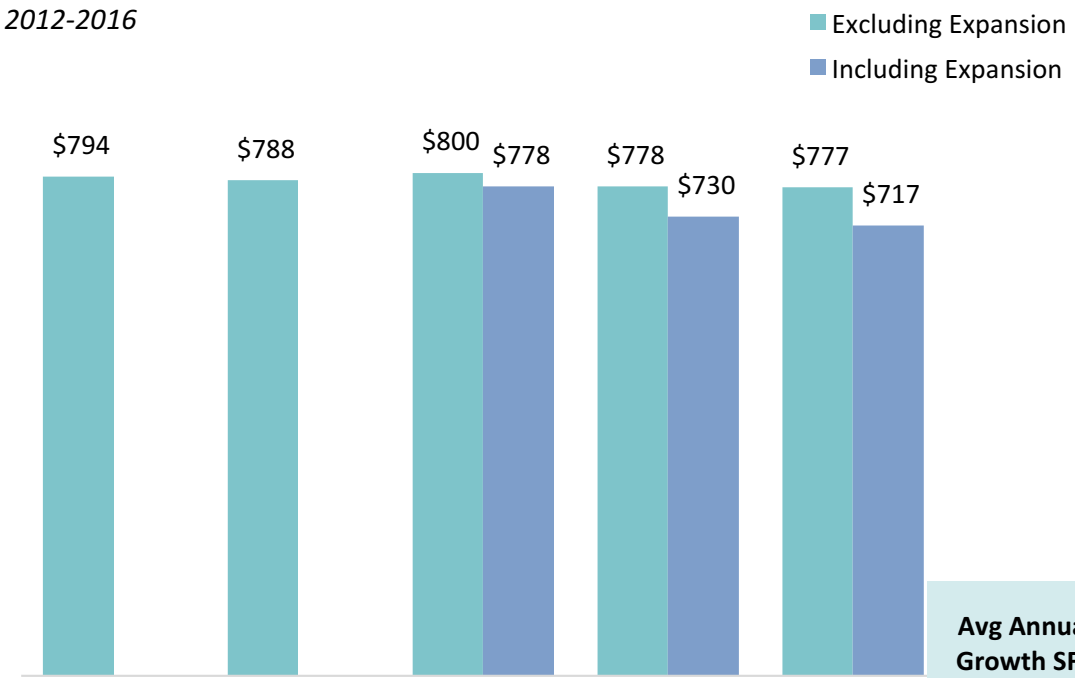
		SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	Avg Annual Growth SFY 2012-2016
Annual Enrollment Growth	Excluding Expansion		1.2%	2.8%	5.8%	1.8%	**2.9%**
	With Expansion			13.1%	22.6%	3.8%	**9.9%**

- ACA implementation on January 1, 2014, resulted in enrollment increases for both Expansion and non-Expansion populations, as eligibility rules changed and outreach increased.
- Including the Expansion population, total Medicaid enrollment increased 3.8% from SFY 2015 to SFY 2016.
- There was a surge in non-Expansion enrollment of 5.8% from SFY 2014 to SFY 2015, but the rate of increase slowed to historical levels from SFY 2015 to SFY 2016.
- Overall, including Expansion, Medicaid enrollment increased from 193,279 average eligibles in SFY 2012 to 281,635 average eligibles in SFY 2016, an average annual increase of 9.9%, with the bulk of the increase coming during the Expansion period.
- Eligibility counts reflect members eligible for full Medicaid benefits and does not include Partial Duals who receive assistance only with their Medicare premium payments.

Medicaid Expenditure Trends: PMPM

Average annual Medicaid PMPM has **decreased 0.5% per year on average**, excluding Medicaid Expansion.

Total Medicaid PMPM
SFY 2012-2016



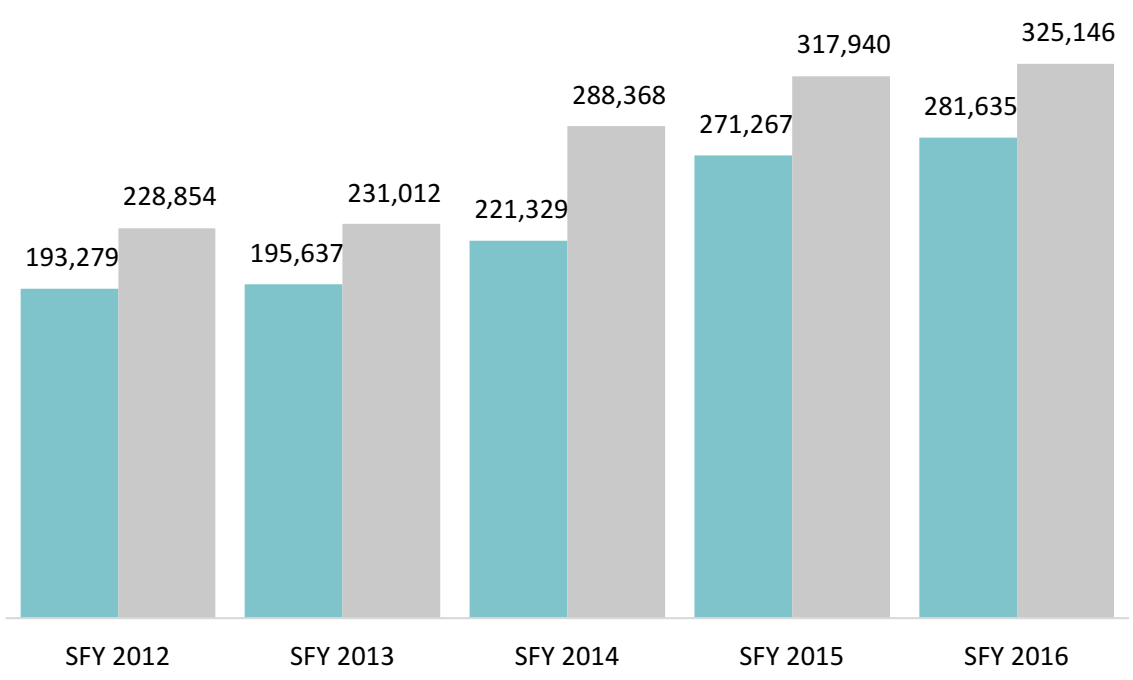
		SFY 2013	SFY 2014	SFY 2015	SFY 2016	Avg Annual Growth SFY 2012-2016
Annual PMPM Growth	Excluding Expansion	-0.8%	1.6%	-2.8%	-0.1%	**-0.5%**
	With Expansion		-1.2%	-6.1%	-1.9%	**-2.5%**

- Excluding Expansion, PMPM costs have decreased 0.5% per year on average since SFY 2012. The PMPM cost for SFY 2016 excluding Expansion is lower than any of the last 5 years.
- Including the Medicaid Expansion population, the average PMPM for Medicaid overall is $717, a decrease of 1.9% from SFY 2015.
- Overall average Medicaid PMPM, including Expansion, has decreased 2.5% on average over the last 5 years, from $794 in SFY 2012 to $717 in SFY 2016.
- SFY 2016 reduction in PMPM reflects implementation of Governor Gina Raimondo's Reinventing Medicaid savings initiatives that included certain programmatic changes, such as a 2.5% cut to hospital reimbursement rates and a 2.0% cut to nursing home reimbursement rates.

Medicaid Expenditure Trends: Unique Recipients

Including the Expansion population, **about 31% of Rhode Island's population were enrolled** in Medicaid for some part of SFY 2016.

Average Eligibles and Unique Recipients
SFY 2012-2016



	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Turnover Ratio	1.18	1.18	1.30	1.17	1.15
Unique Recipients % of RI Pop[1]	22%	22%	27%	30%	31%

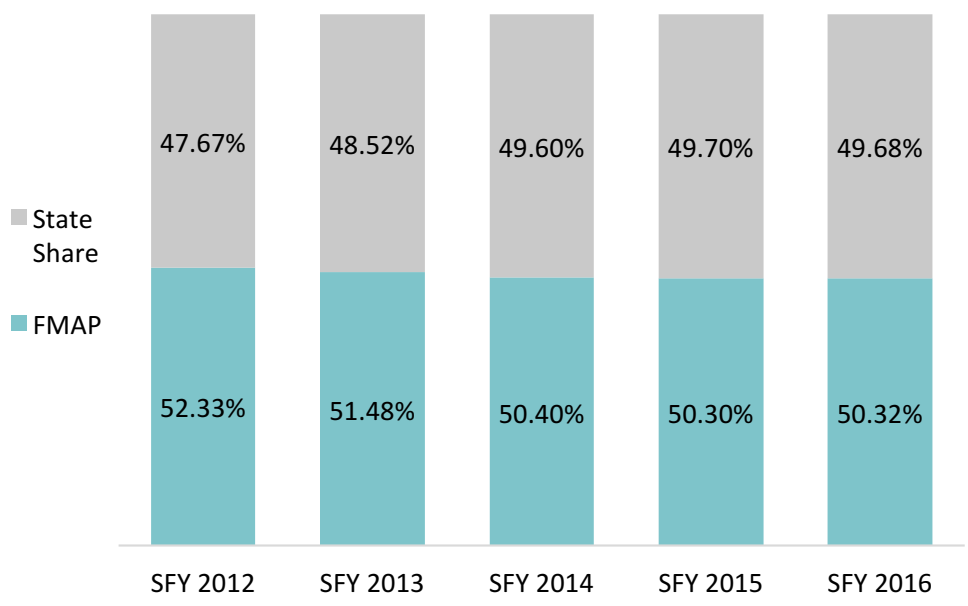
[1]Source: Population Division, US Census Bureau.

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

Federal and State Share of Expenditures

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

Federal Medicaid Assistance Percentage (FMAP)
SFY 2012-2016



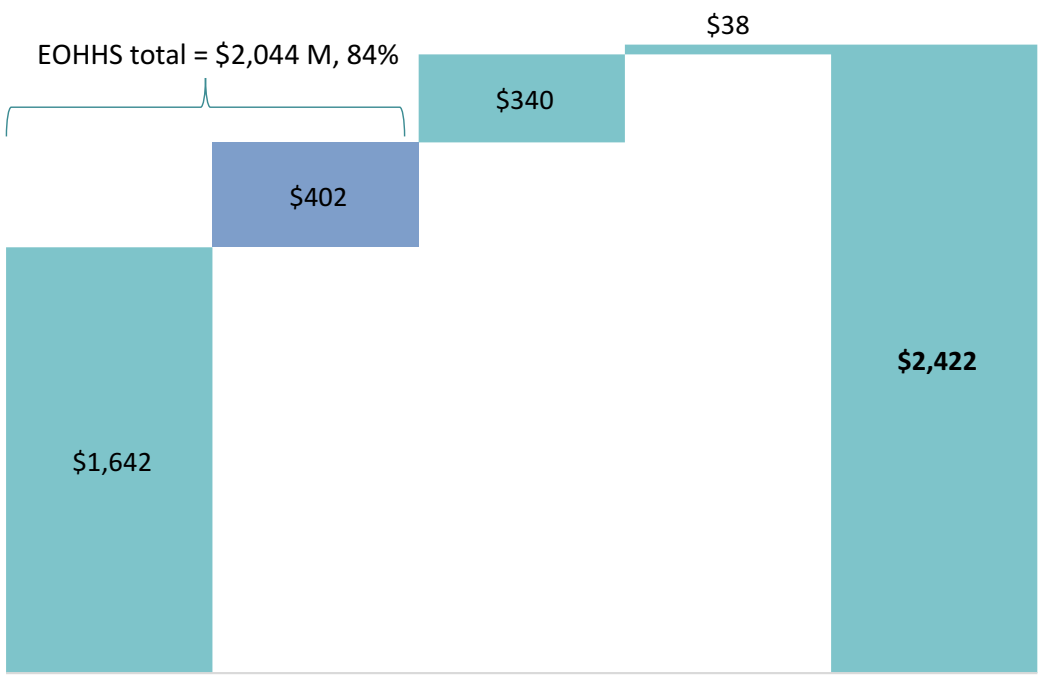
FMAPs shown reflect average during state fiscal year period and do not apply to Expansion, primary care rate increase, CHIP, and selected other programs.

- 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.
- There are several instances of variation from the FMAP levels shown on the chart at left:
  - The FMAP for the Medicaid Expansion population is 100% for SFY 2016. For SFY 2017, FMAP for this population will be 97.5% and for SFY 2018 it is expected to be 94.5%.
  - During CY 2013-2014, 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 24,571 enrollees in the CHIP program, which provides insurance coverage to uninsured children and pregnant women from families with incomes up to 250% of the federal poverty level who are not otherwise eligible for Medicaid. In SFY 2016, Rhode Island received a 82.47% 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) and Extended Family Planning (EFP).

Expenditure by Department

The majority of expenditure (84%) is administered by EOHHS, including all expenditure for the Expansion population.

Expenditure by Department
SFY 2016 - $ Millions

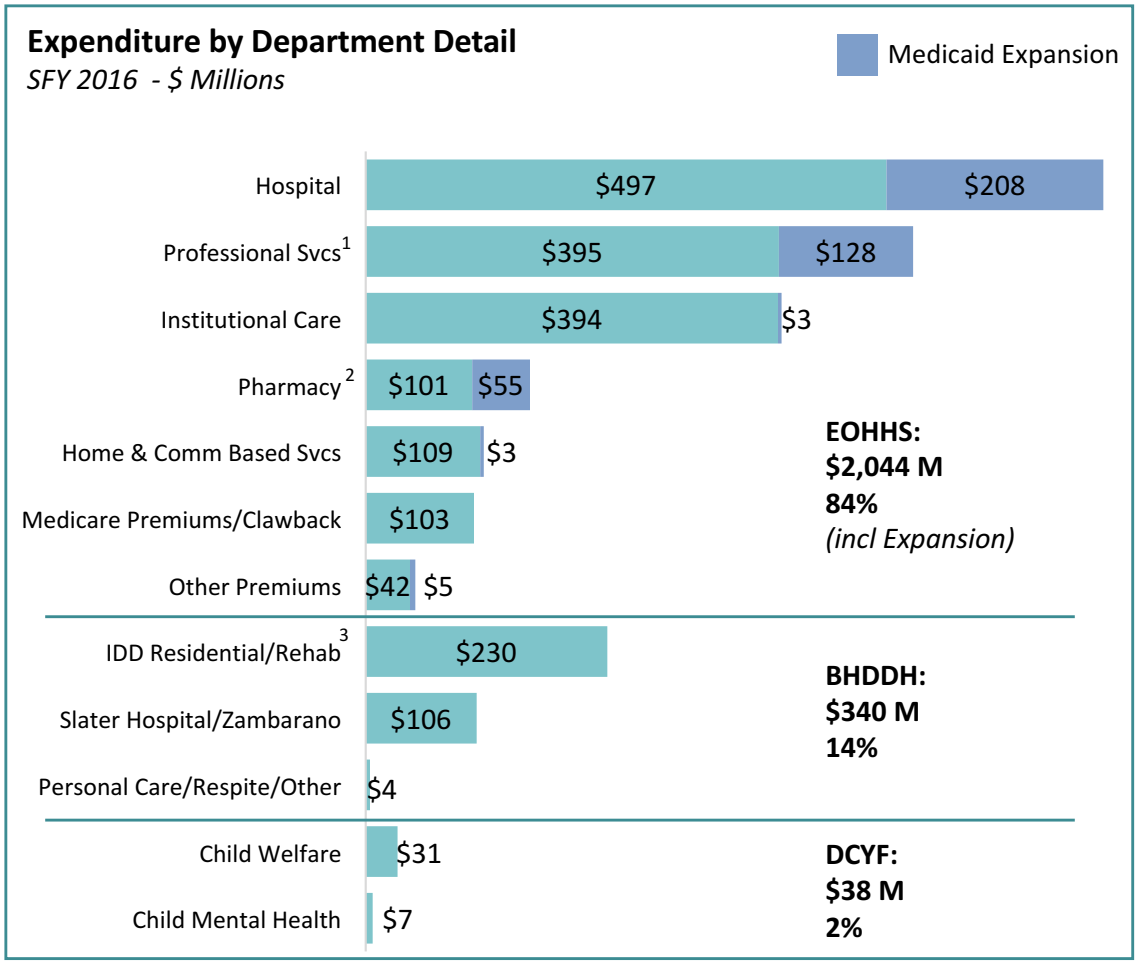


	EOHHS	EOHHS- Medicaid Expansion	BHDDH	DCYF	Total
% of Total	68%	17%	14%	2%	100%
Avg Ann Exp Growth 2012-6	3.5%		-2.2%	0.1%	

- In SFY 2016, the state departments responsible for administering components of the Medicaid program were: the Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH); and the Department of Children, Youth and Families (DCYF).
- EOHHS is the lead administrator for the Medicaid contract with CMS. The Single State Medicaid Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
- The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers the second largest share of Medicaid expenditure (14%). Note that funding for intensive behavioral health services was transferred from BHDDH to EOHHS as of July 1, 2014.
- Detail for each department is shown on the next page.

Expenditure by Department: State Agency Detail

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



- EOHHS overall accounts for 84% of Medicaid expenditure. The biggest portion of that is for hospital-based services, accounting for 34% of EOHHS expenditure. Professional services account for 26% of EOHHS expenditure, and institutional care is another 19%.
- BHDDH expenditures include three primary areas: the management of Slater Hospital, residential facilities for persons with intellectual and developmental disabilities, and community based services.
- DCYF accounts for $38 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.

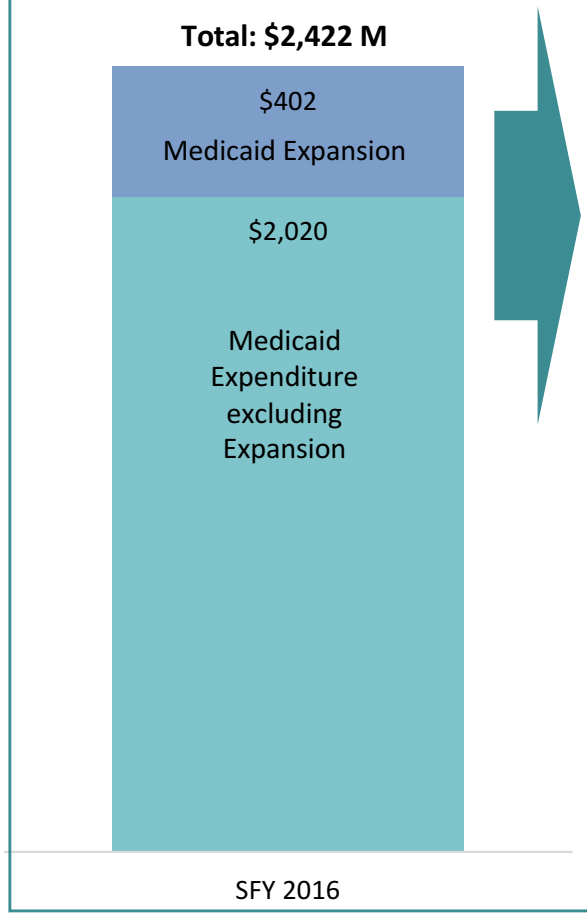
Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion and rounding.

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

Expenditure Distributions

Medicaid expenditures can be broken down in several ways.

Medicaid Expenditures for Covered Services
SFY 2016 - $ Millions



Expenditure Distributions include:

Breakdown by population:
- Elders
- Adults with Disabilities
- Children and Families
- Children with Special Health Care Needs
- Medicaid Expansion

Breakdown by population shows expenditure by Medicaid recipient age and category of need

Breakdown by provider type:
- Hospital
- Nursing Facility
- IDD Residential/Rehab, Group Homes
- Behavioral Health
- Home & Community Based Services
- Long Term Services & Supports
- Professional Services
- Premiums

Breakdown by provider type shows expenditure by the institution or the type of professional performing the services

LTSS Details:
- Types of LTSS Providers
- LTSS Trends

Further details on Long Term Services & Supports expenditures

Breakdown by program:
- Managed Care
- Fee-for-service (FFS)

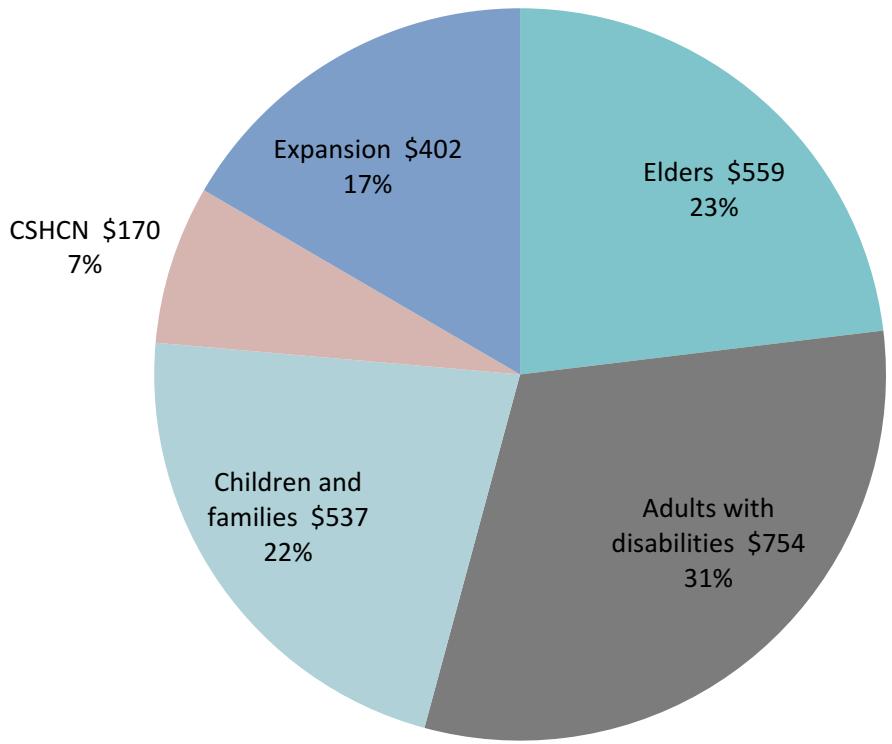
Breakdown by program shows expenditure by type of managed care program and amount of fee-for-service spending

Expenditure by Population

Over half of Medicaid expenditure (54%) is for Elders and Adults with Disabilities.

Medicaid Expenditure by Population
SFY 2016 - $ Millions

Total: $2,422 M



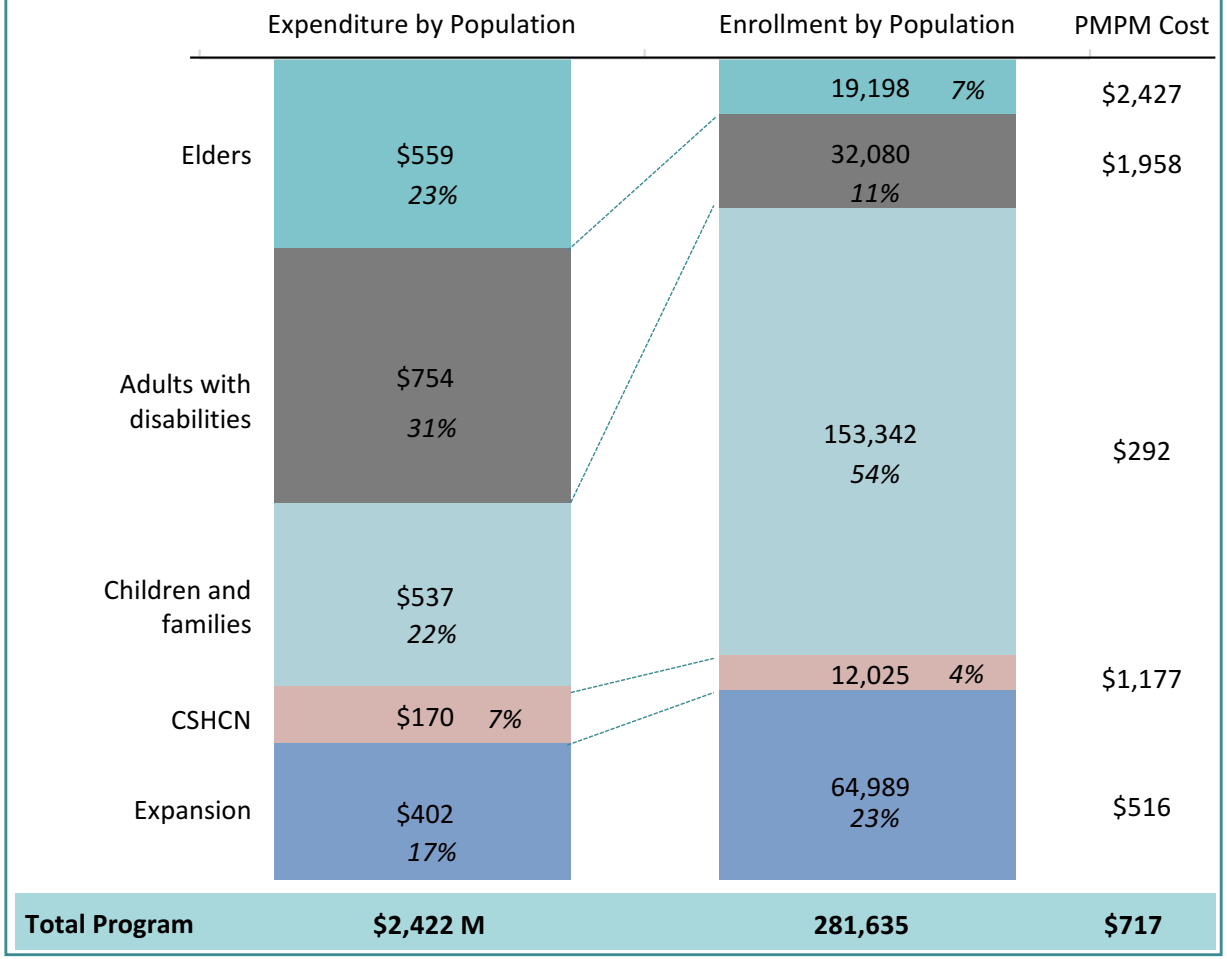
- **Elders** are adults over age 65, including those also eligible for Medicare. This population accounts for 23% of Medicaid expenditure, or $559 million.
- **Adults with Disabilities** are adults under age 65 who have identified disabilities (does not include RIte Care enrolled adults). This population accounts for $754 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 22% of Medicaid expenditure, $537 million.
- **Children with Special Health Care Needs (CSHCN)** are individuals under 21 eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. 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 1st 2014 under ACA expansion rules. This population accounts for 17% of Medicaid expenditure.

Expenditure by Population

The Medicaid program served an average of 281,635 eligibles in SFY 2016, at an average cost per member per month of $717. However, PMPM costs vary considerably by population.

Medicaid Expenditure by Population

SFY 2016 - $ Millions



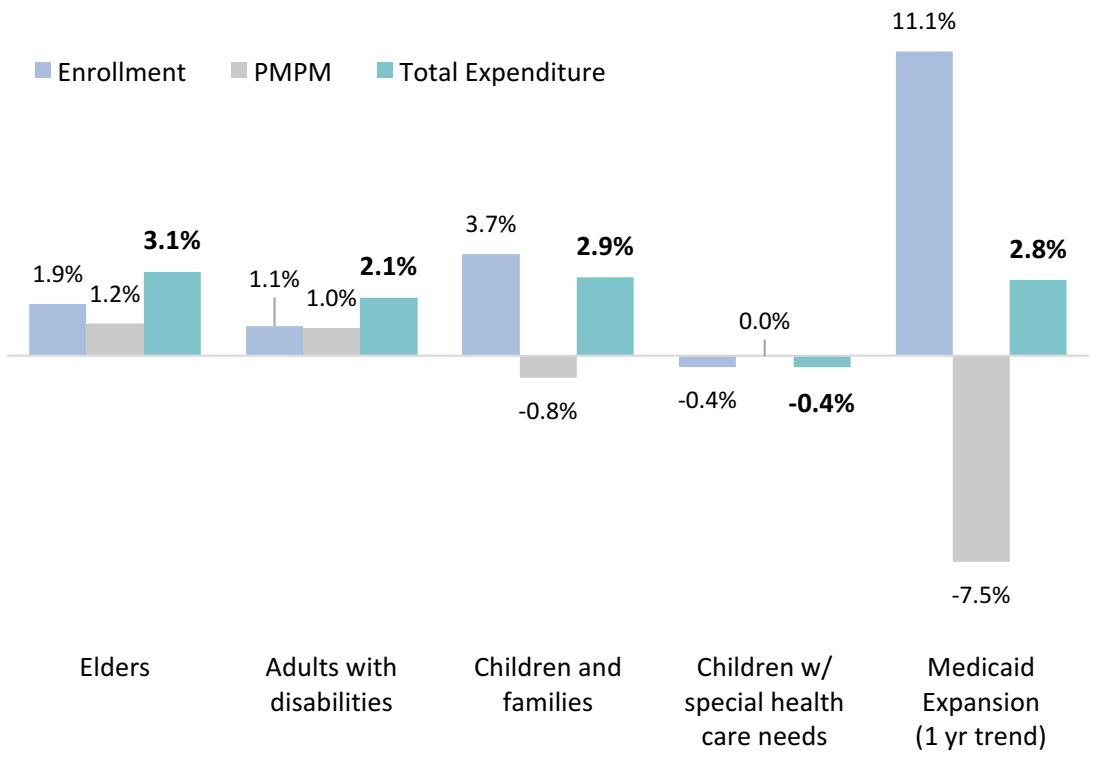
- **Elders** account for 23% of expenditure and 7% of enrollment, with a PMPM cost of $2,427. This population has the highest PMPM of the population groups shown in this report.
- **Adults with Disabilities** account for 31% of expenditure and 11% of enrollment, with a PMPM cost of $1,958.
- Together, elders and adults with disabilities account for 54% of expenditure and 18% of total eligibles.
- **Children and families** account for over half of total enrollment (54%) and 22% of total expenditure with a PMPM cost of $292.
- **CSHCN** account for 7% of expenditure and 4% of eligibles at a PMPM of $1,177.
- **Medicaid Expansion** accounts for 23% of eligibles and 17% of overall expenditure, with a PMPM of $516.

Expenditure by Population: Trends

Expenditure trends between SFY 2012 and SFY 2016 differed for the various population groups.

Average Annual Trends

SFY 2012-2016 – Medicaid Expansion Trends for SFY 2015-2016



2016 Expenditure by Population

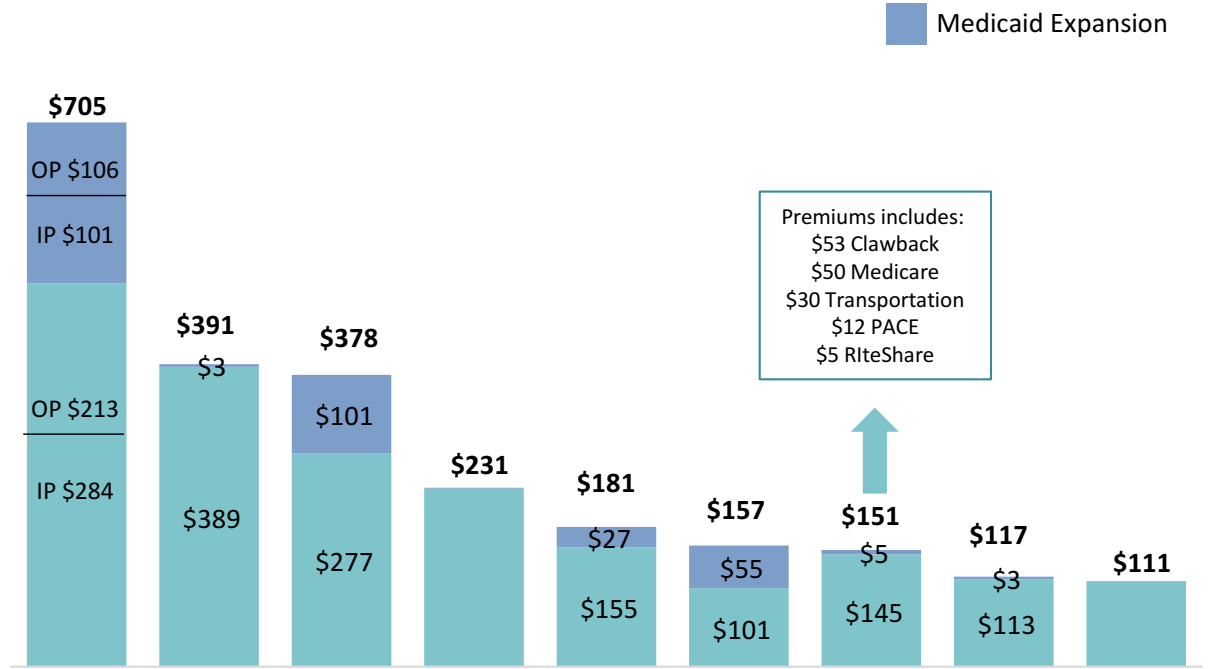
- The total expenditure trend can be broken into two composite pieces - the per member per month (PMPM) cost trend and the enrollment trend.
- Elders have experienced a 3.1% average annual increase in expenditure since SFY 2012. This increase is about 2/3 due to an increase in enrollment and 1/3 due to an increase in PMPM.
- Adults with disabilities expenditure has increased 2.1% per year on average over the last 5 years.
- Children and families experienced a 2.9% average expenditure growth over the past 5 years and an average enrollment growth of 3.7%. This population had an average annual PMPM decrease of 0.8% .
- Children with special health care needs have experienced a decrease in PMPM and overall expenditure since SFY 2012.
- The Medicaid Expansion population has experienced a 2.8% increase in expenditure since SFY 2015 even though enrollment has grown 11.1% in the same one year period.

Expenditure by Provider Type

Medicaid program funds are used to reimburse a variety of providers. Together, hospitals and nursing facilities account for nearly half (45%) of program expenditure in SFY 2016.

Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Total: $2,422 M



	Hospital	Nursing Home /Hospice	Professional	IDD Resdntl/ Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
% of 2016 Expenditure	29%	16%	16%	10%	7%	6%	6%	5%	5%
Avg Ann Growth 2012-16 (excluding Expansion)	1.1%	2.7%	4.9%	3.0%	-3.8%	1.6%	6.9%	7.2%	0.7%

- Hospitals were the largest provider type, accounting for 29% of Medicaid expenditures in SFY 2016.
- Including Expansion, hospital payments have increased 4.9% in the one year from SFY 2015 to SFY 2016.
- Not including expenditures on the Expansion population, hospital payments have been increasing at an average of 1.1% per year over the last 5 years,.
- Nursing facilities and professional services each accounted for 16% of expenditure.
- Expansion population expenditure was concentrated in hospital, professional, and pharmacy services.
- Two-thirds of the Premiums expenditure is for Medicare clawback payments and Medicare premiums. The remainder is for transportation, PACE, and RIteShare premiums.
- Detailed definitions of each provider type is included on the next page.

Expenditure by Provider Type: Definitions

Medicaid providers can be grouped into three categories – acute care, institutional care, and community-based services.

Acute, Chronic and Preventive Care	Hospital	Hospital includes inpatient and outpatient services.
	Professional	Professional includes Physician, Dental, DME/Supplies, X-Ray/Lab/Tests, Ambulance, etc.
	Professional BH	Professional Behavioral Health includes DHS, BHDDH and DCYF expense including, but not limited to, Professional Mental Health/Substance Abuse, Cedar services (Comprehensive, evaluation, diagnosis, assessment, referral, re-evaluation services), CMHC, and Residential DCYF.
	Pharmacy	Prescription and over-the-counter medications, net of pharmacy rebates
	Premiums	Premiums includes Medicare premiums paid for qualifying individuals, Medicare clawback payments, 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.
Institutional Care	Nursing Home/Hospice	Nursing home includes skilled nursing facilities. Hospice includes home-based, inpatient, and nursing facility-based hospice care.
	Slater Hospital, Tavares, and Zambarano	Slater Hospital, Tavares and Zambarano are specialized facilities for severely disabled adults or children.
Community Care	IDD Resdntl/ Rehab, Group Homes	Residential and Rehabilitation Services for persons with intellectual and developmental disabilities, including public and private IDD group homes, IDD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).
	HCBS	Home and Community Based Services (HCBS) are services provided as an alternative to nursing home/institutional options, such as personal care, assisted living, and case management.

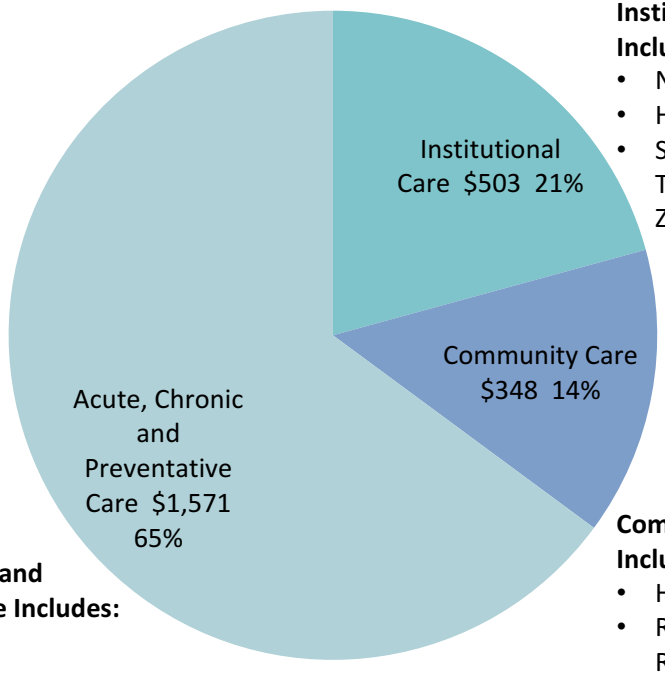
Please note that administrative dollars paid to health plans are allocated across provider types based on distribution of claims for purposes of this report.

Expenditure by Provider Type Summary

Overall, 35% of Medicaid expenditure is for Institutional Care and Community Care, together referred to as Long Term Services and Supports (LTSS).

Medicaid Expenditure by Provider Type Category
SFY 2016 -- $ Millions

Total: $2,422 M



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

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

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

Nearly all Expansion expenditure in this category

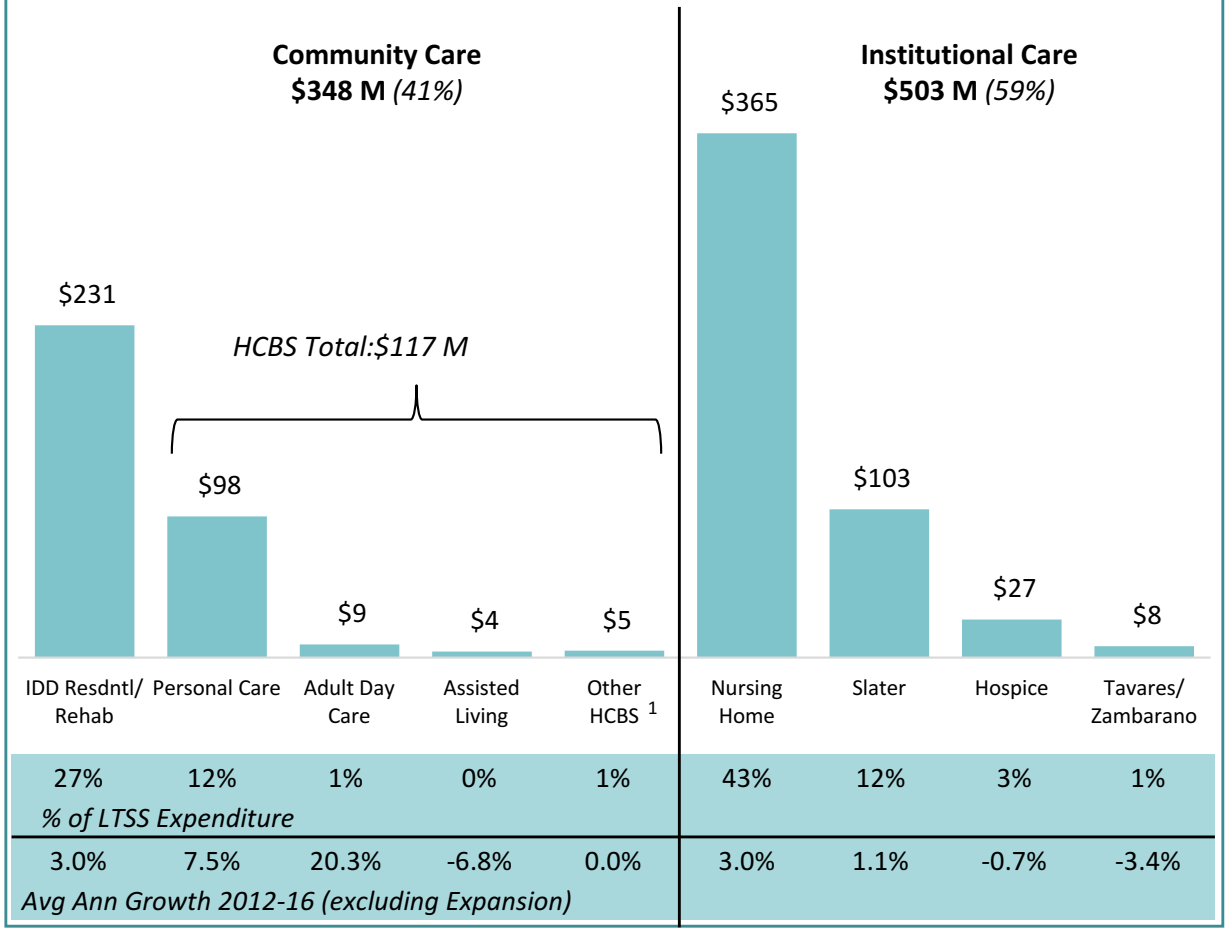
- Over one-third (35%) of Medicaid expenditure is for Long Term Services and Supports (LTSS), including institutional care and community care.
  - Institutional care includes nursing facilities and care in the Slater Hospital and Tavares and Zambarano facilities.
  - Community Care includes home and community-based services, residential and rehabilitation services for the intellectually and developmentally disabled, and group homes.
- The other 65% of Medicaid expenditure is for acute, chronic and preventive care services such as hospital, professional services, and pharmacy.
- Nearly all (98%) of the expenditure for the Expansion population falls into the Acute, Chronic, and Preventative Care category.
- There are several ways to categorize Medicaid-provided services. Other reports may group together services in different ways for different needs.

Provider Type Detail: LTSS Detail

Long term services and supports, including both institutional care and community care, accounted for $850 million in SFY 2016, about 35% of Medicaid expenditure.

LTSS Expenditure by Provider Type
SFY 2016 -- $ Millions

Total LTSS Expenditure: $850 M



- The 1115 Medicaid Waiver granted Rhode Island the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide home and community based services to at-risk populations as alternatives to more costly nursing home/institutional options.
- Institutional care services account for 59% of LTSS expenditure. The largest category of institutional care is nursing homes, accounting for 43% of LTSS spending and 73% of spending on institutional care.
- Forty-one percent of long term services and support expenditure ($348 million) is for Community Care services, including services for the IDD population and HCBS.
- One driver of the growth in Community Care expenditures is for HCBS for the non-intellectually/developmentally disabled population. These services, such as personal care and assisted living, are less expensive alternatives to nursing home or institutional options.

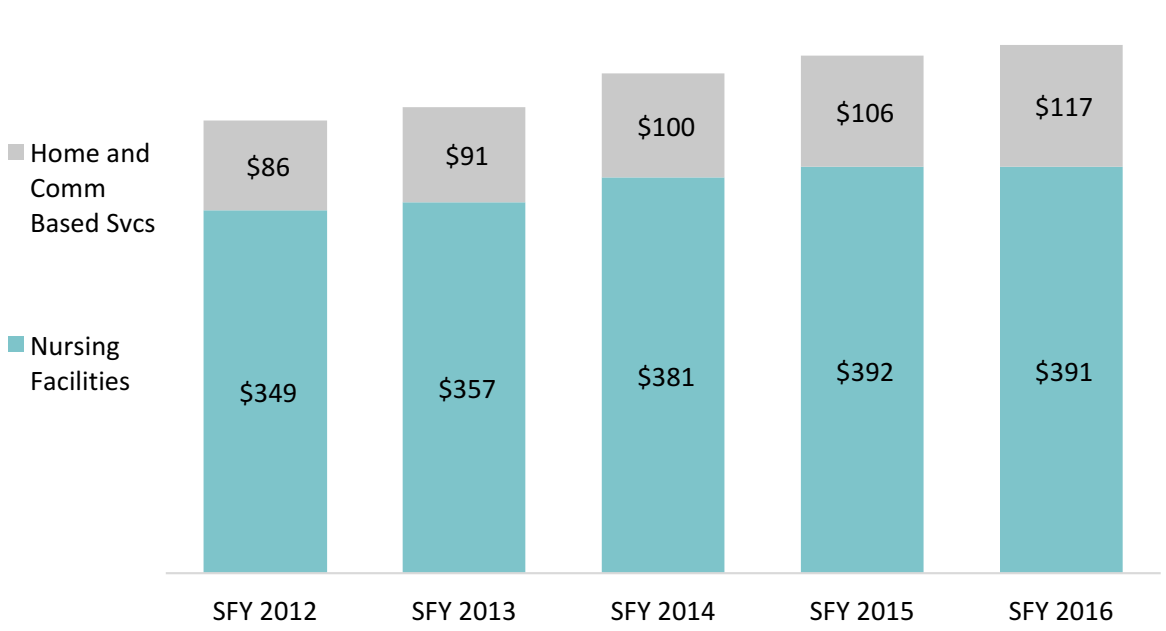
[1]Other HCBS includes DME (e.g. Home Modifications), Case Management, Meals, Shared Living and other.

Expenditure by Provider Type: LTSS Rebalancing

Over the last 5 years, the ratio of nursing facility expenditure to HCBS expenditure has decreased.

Balance of Nursing Facility and HCBS Expenditure

SFY 2012-2016 -- $ Millions



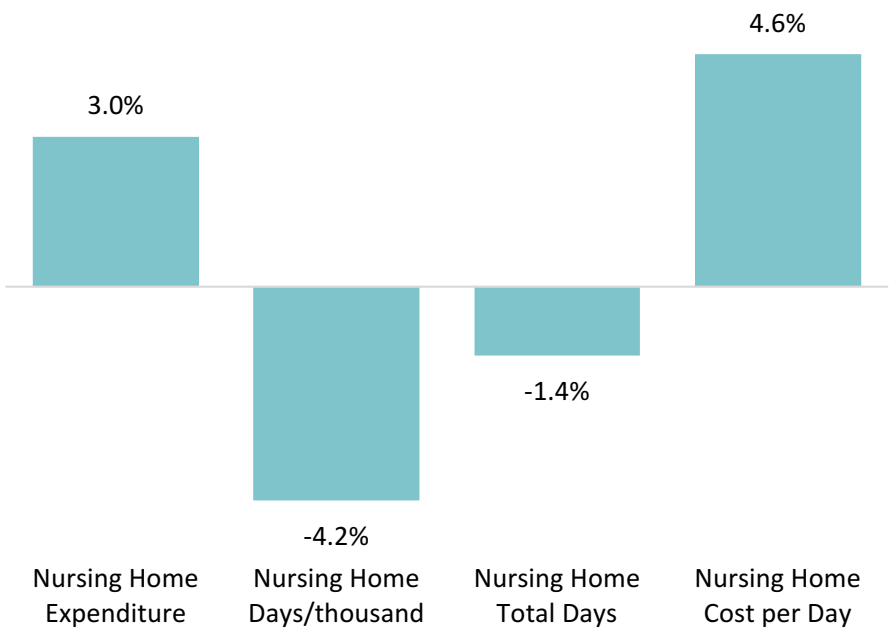
	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
% HCBS	20%	20%	21%	21%	23%
% Nursing Facilities	80%	80%	79%	79%	77%

- A key consideration for LTSS services is the transition away from nursing facilities and into home and community based services (HCBS).
- One way to measure the rebalancing trend is to examine the ratio of expenditure between nursing facility services (part of Institutional Care) and HCBS (part of Community Care).
- The balance of expenditure between nursing facilities and HCBS has been shifting over the last 5 years. In SFY 2016 HCBS accounted for 23% of the total expenditure on both nursing facilities and HCBS compared to 20% in SFY 2012.

Provider Type Detail: Nursing Home Trends

Nursing home total days and days per thousand have decreased over the last five years, while total nursing home expenditure has increased.

Nursing Home Services Average Annual Trend Rates
SFY 2012-2016



	Nursing Home Expenditure	Nursing Home Days/thousand	Nursing Home Total Days	Nursing Home Cost per Day
SFY 2016 Expenditure	$365 M		1,910,645	$191/day

- Nursing home expenditure accounted for $365 million in SFY 2016, with an average annual increase of 3.0% per year on average since SFY 2012.
- Over the same period, days per thousand for nursing homes decreased by 4.2% per year on average.
- Nursing home days in total decreased 1.4% per year on average between SFY 2012 and SFY 2016.
- Nursing home cost per day (calculated as total expenditure divided by total days) has increased from $160 to $191 between SFY 2012 and SFY 2016, about 4.6% on average per year.
- Total expenditure for nursing homes includes allocated capitation and premium payments, so the calculated cost per day shown here may differ from the actual payment rates.

Expenditure by Managed Care Enrolled and Not Enrolled

Overall, 61% of total Medicaid expenditure is paid through managed care programs.

Expenditure for Enrolled Populations
SFY 2016

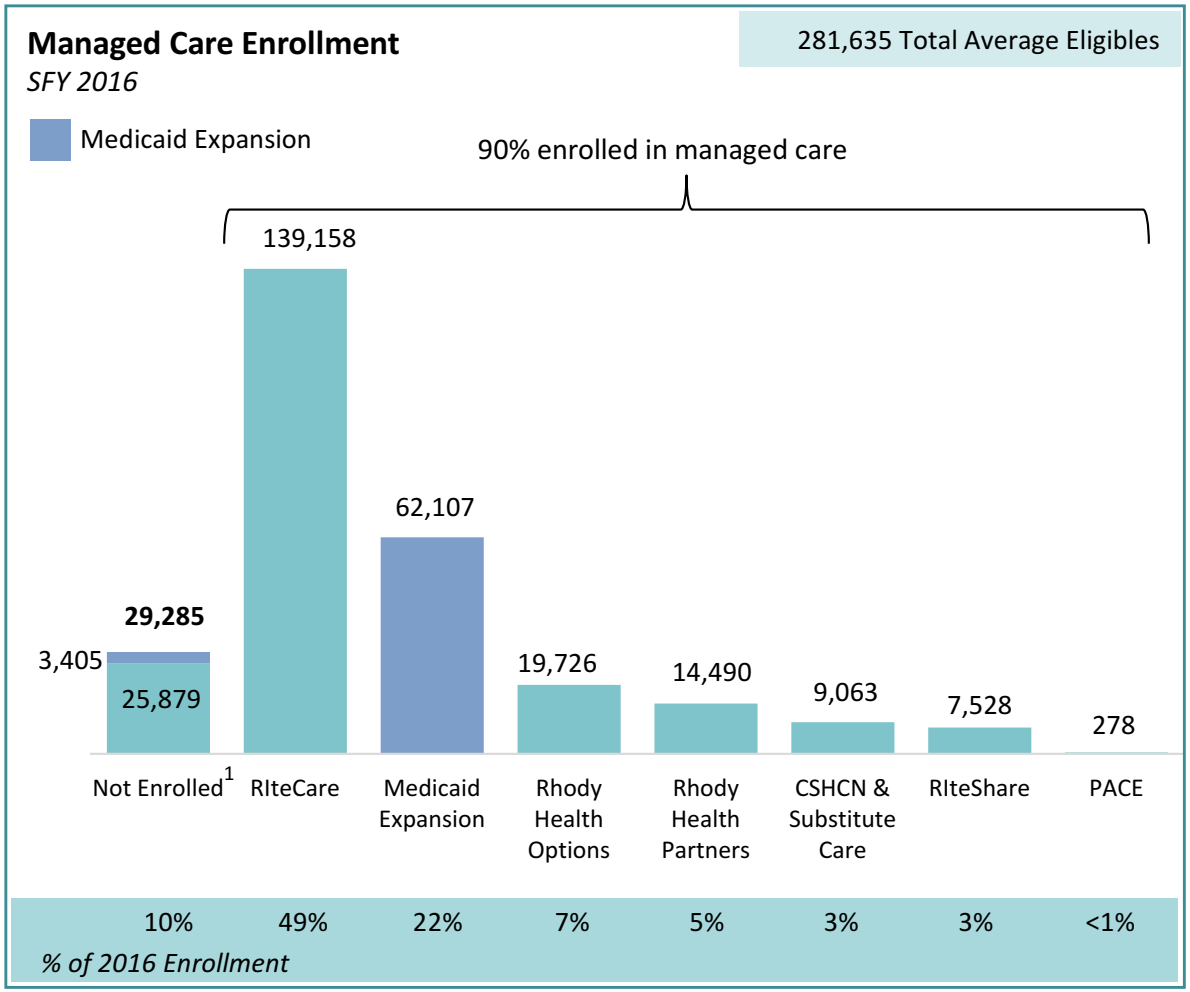
	Managed Care Enrolled *252,351 Eligibles (90%)*	Not Enrolled[1] *29,285 Eligibles (10%)*	Total Expenditure
Managed Care Expenditure	**$1,488 M** **61%** Managed Care Expenditure for Managed Care Enrolled Eligibles		**$1,488 M** **61%**
Other Expenditure	**$346 M** **14%** Other Expenditure for Managed Care Enrolled Eligibles (*for services not covered by Managed Care)*	**$588 M** **24%** Expenditure for Eligibles Not Enrolled in Managed Care	**$934 M** **39%**
Total Expenditure	**$1,834 M** **76%**	**$588 M** **24%**	**$2,422 M**

[1]Unenrolled populations include 2,357 Medicaid 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.

- Ninety percent of Medicaid eligibles are enrolled in managed care programs, including RIte Care, RIteShare, Rhody Health Partners, Rhody Health Options, and PACE. These enrolled populations account for about three-quarters (76%) of Medicaid expenditure in SFY 2016.
- Of the $1,834 million in expenditure on managed care enrolled populations, $1,488 million was paid through managed care programs, accounting for 61% of total Medicaid expenditure.
- The remaining $346 million in expenditure on managed care enrolled populations was paid for FFS claims and premiums for managed care enrolled eligibles.
  - FFS claims include services such as Neonatal Intensive Care Unit (NICU), certain behavioral health services, specialized services for children with special healthcare needs, and dental care
  - Premiums for managed care enrollees include Medicare premiums and transportation.
- On January 1, 2016, EOHHS moved the expenditures for certain behavioral health services for children and adults enrolled in managed care into the payments made to the health plans, reducing FFS expenditures for the managed care enrolled population.

Managed Care Enrollment

Medicaid enrollees who do not have other insurance are enrolled in Medicaid managed care plans. About 90% of Medicaid average eligibles are enrolled in some sort of managed care programs.



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

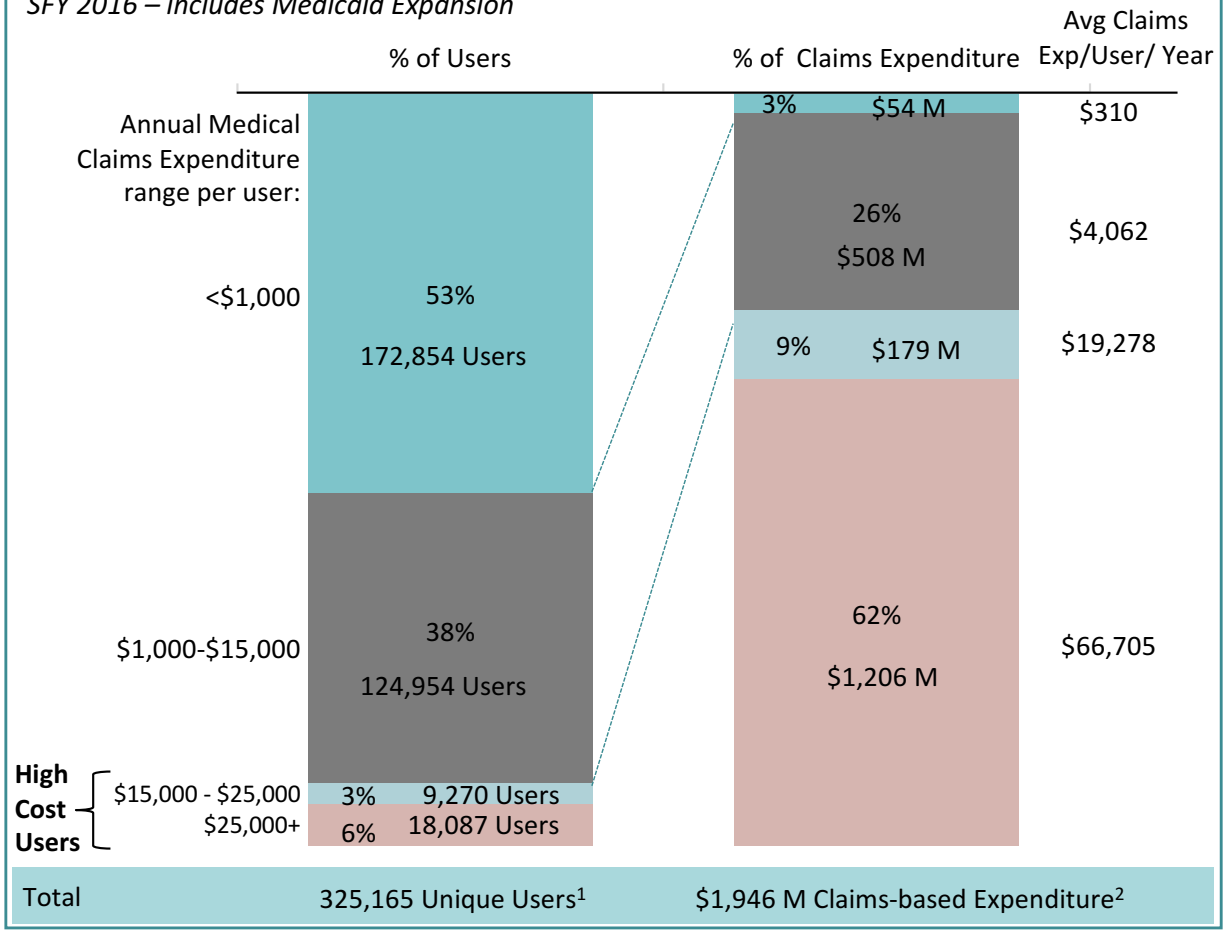
- Managed care enrollment is divided between Rhode Island's two Medicaid Managed Care Organizations (MCOs), Neighborhood Health Plan (NHP) and United Healthcare (UHC).
- **RIte Care** mainly serves children and parents. **Rhody Health Partners** is is a managed care program for adults with disabilities.
- The Medicaid Expansion and CSHCN populations are also enrolled in managed care programs.
- **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.
- **Rhody Health Options** is a fully capitated managed care program for long term care, long term services and supports, and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility.

High Cost Users: By Expenditure Level

Medicaid claims expenditures are highly concentrated. The top 6% of Medicaid users account for almost two thirds (62%) of Medicaid claims expenditure.

Medicaid User Claims Expenditure Distribution

SFY 2016 – includes Medicaid Expansion



- 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 or capitation payment. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- This analysis examines the characteristics of "high cost" users, those with over $15,000 of claims expenditure of per year. There are 27,357 of these "high cost" users (9%) who account for $1,385 million (71%) in claims expenditure.
- 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, 53% of Medicaid users access services at a cost of less than $1,000 per year and account for 3% of claims expenditure, averaging $310 in annual claims expenditure per user.

[1]Includes overlap in users across cost categories.

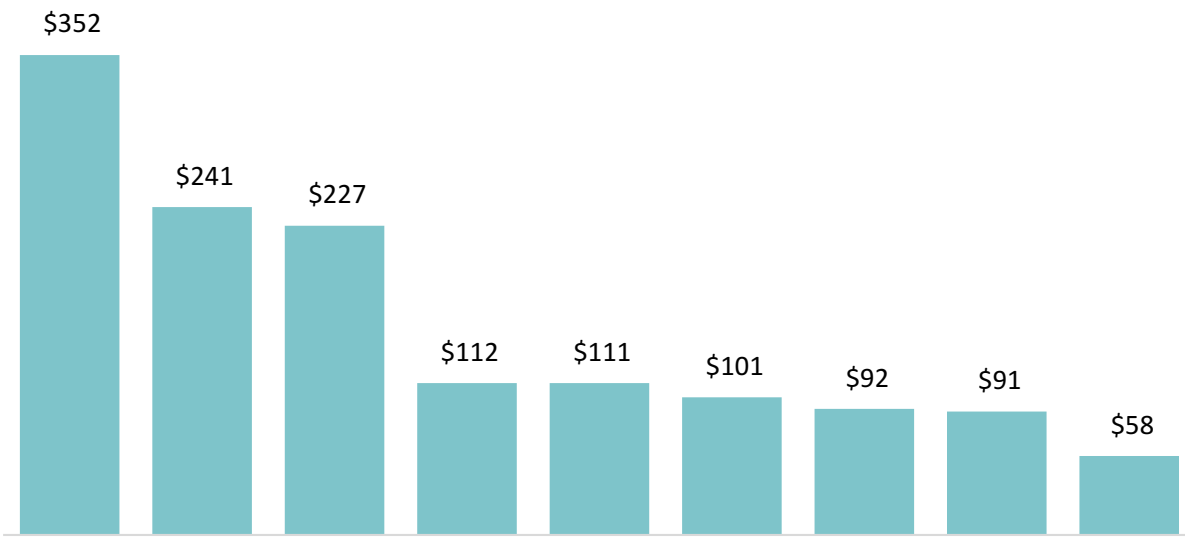
[2]Total of claims-specific payments. Certain expenditures (e.g. UPL, Medicare and PACE Premiums) not attributable to specific users.

High Cost Users: By Provider Type

About 41% of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with intellectual and developmental disabilities.

High Cost User Claims Expenditure by Provider
Users with Annual Medicaid Claims Expenditure over $15,000
SFY 2016 -- $ Millions – includes Medicaid Expansion

Total High Cost User Claims Expenditure[1]: $1,385 M



Nursing Home/ Hospice	Hospital Inpatient	IDD Resdntl/ Rehab, Group Homes	Slater Hospital/ Zambarano/ Tavares	Other Professional	Hospital Outpatient	Professional BH	Home and Comm Based Svcs	Pharmacy
25%	17%	16%	8%	8%	7%	7%	7%	4%
% of Total High Cost User Claims Expenditure								
90%	63%	98%	100%	29%	32%	51%	78%	37%
% of Provider Type Total Expenditure attributable to High Cost User Claims								

- Nursing facilities account for 25% of the claims expenditure for high cost users, and residential and rehabilitation services for persons with intellectual and developmental disabilities account for another 16%.
- Hospital services account for 24% of high cost user claims expenditure, including 17% for inpatient and 7% for outpatient. Inpatient includes Neonatal Intensive Care Unit (NICU) services.
- 90% 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.

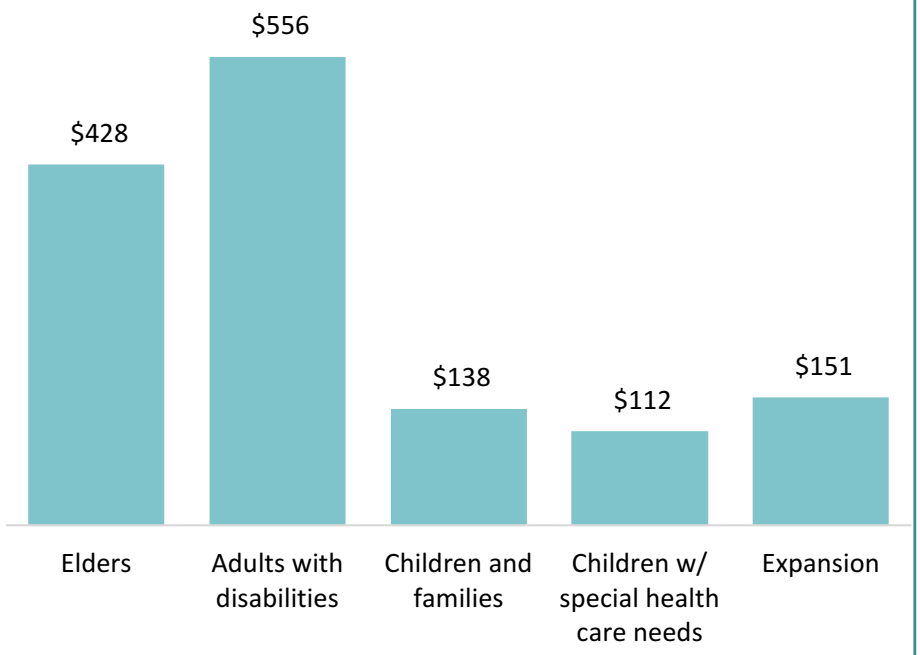
[1]Based on claims-specific payments only.

High Cost Users: By Population

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

High Cost User Claims Expenditure by Population
Users with Annual Medicaid Claims Expenditure over $15,000
SFY 2016 -- $ Millions – includes Medicaid Expansion

Total High Cost User Claims Expenditure: $1,385 M



	Elders	Adults with disabilities	Children and families	Children w/ special health care needs	Expansion
% of High Cost User Claims Expenditure	31%	40%	10%	8%	11%
# High Cost Unique Users[1]	8,219	9,251	4,140	2,477	4,748
% of Population Group Total Expenditure attributable to High Cost User Claims	77%	74%	26%	66%	38%

[1]Total high cost unique users by population does not equal overall total due to overlap between eligibility groups.

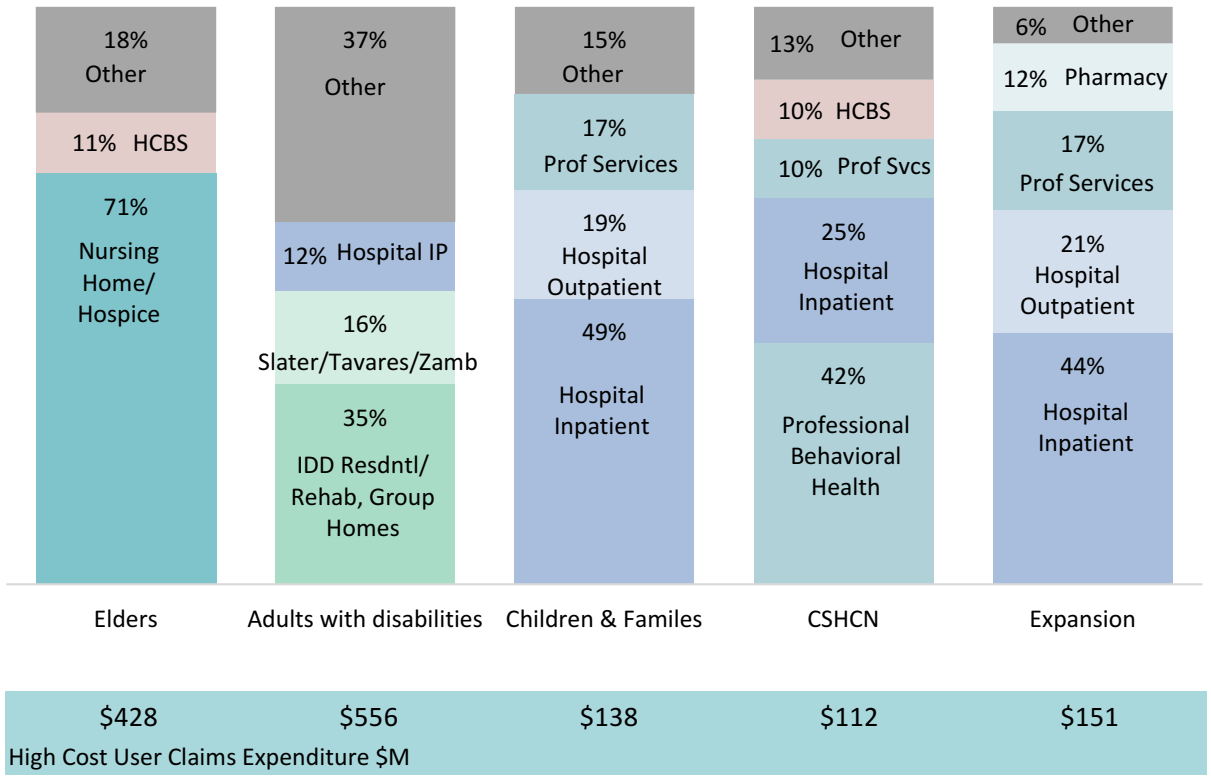
- Elders account for 31% of claims expenditure for high cost users and have the highest proportion of total expenditure for high cost user claims, with 77% of total expenditure attributable to high cost user claims expenditure.
- Adults with disabilities account for 40% of high cost user claims expenditure, and 74% 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 8% of claims expenditure.
- The Expansion population accounted for 11% of high cost user claims expenditure.

High Cost Users: By Population Detail

The services used by high cost users varies by population.

High Cost User Claims Expenditure
Users with Annual Medicaid Claims Expenditure over $15,000
SFY 2016

Total High Cost User Claims Expenditure: $1,385 M



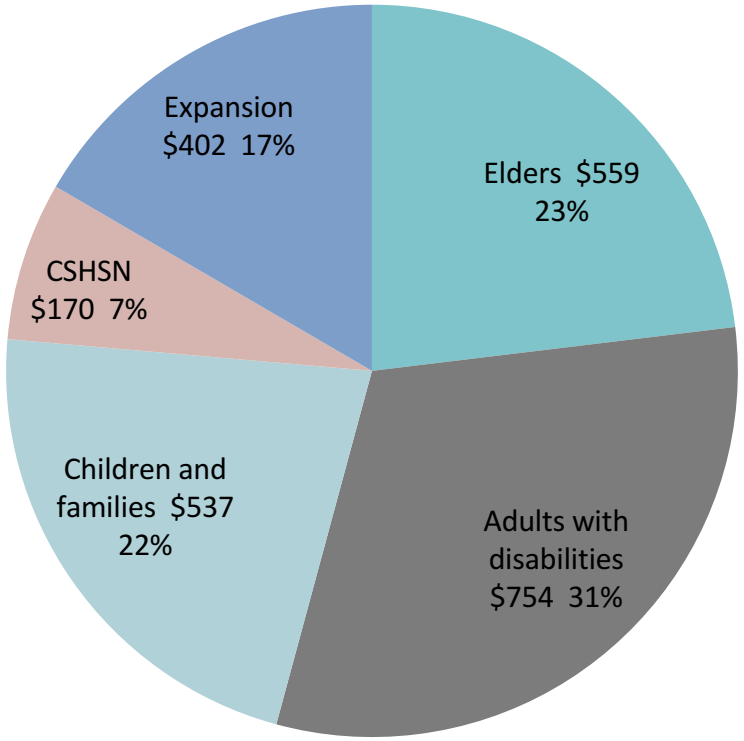
- The largest category of claims expenditure for high cost elders is nursing facilities, accounting for 71% of claims expenditure on high cost elders.
- The largest category of expenditure for high cost adults with disabilities is residential and rehabilitation services for the intellectually and developmentally disabled, accounting for 35% of claims expenditure.
- 68% of high cost claims expenditure for children and families and 65% of high cost claims expenditure for the Expansion population is hospital-related, including both inpatient and outpatient services.
- Professional behavioral health services account for 42% of high cost user claims expenditure for the high cost users in the children with special healthcare needs population.

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:

Medicaid Expenditure by Population
SFY 2016 - $ Millions

Total: $2,422 M



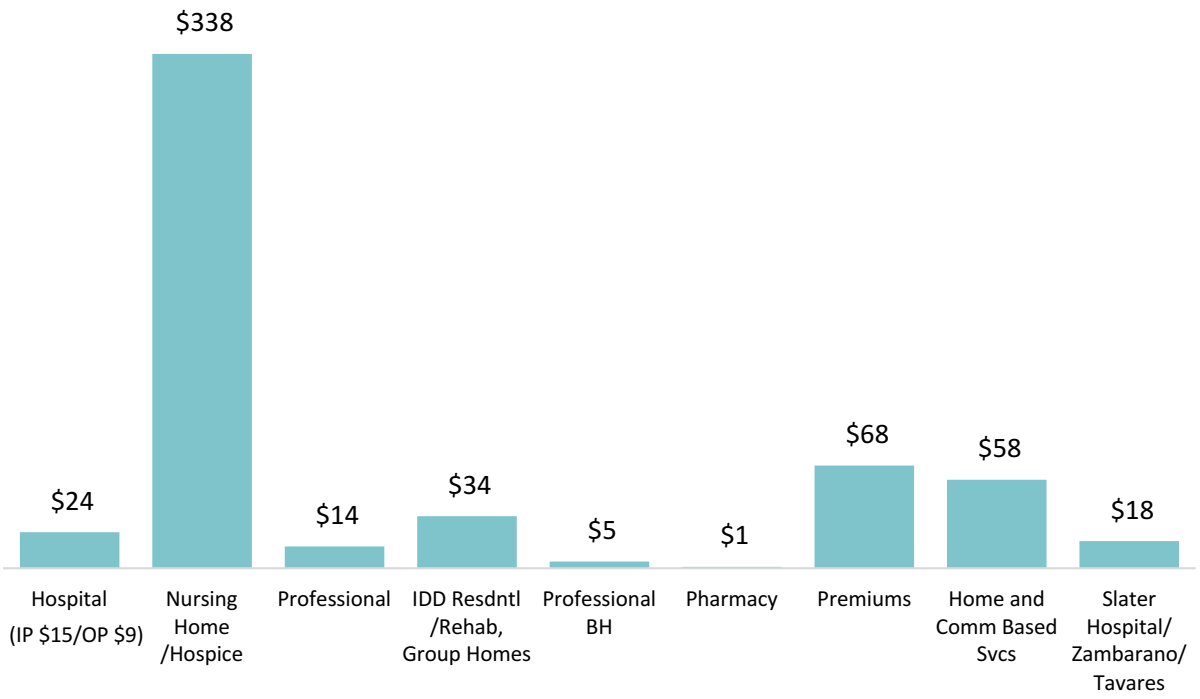
- **Elders**:
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in Medicare
  - Nursing facility and HCBS utilization
- **Adults with Disabilities**:
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in 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
- **Children with Special Healthcare Needs (CSHCN):**
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization
- **Expansion:**
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Acute care services utilization

Elders: Expenditure by Provider Type

Nursing facilities (including nursing homes and hospice) account for sixty percent of total Medicaid expenditure on elders.

Elders: Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Elders Expenditure =	$559 M
% of 2016 Expenditure =	23%
Avg Annual Growth =	3.1%



Hospital (IP $15/OP $9)	Nursing Home /Hospice	Professional	IDD Resdntl /Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
4%	60%	3%	6%	1%	<1%	12%	10%	3%
% of 2016 Expenditure								
0.0%	2.0%	16.0%	3.0%	-0.3%	1.0%	7.8%	5.3%	-0.4%
Avg Ann Growth 2012-16								

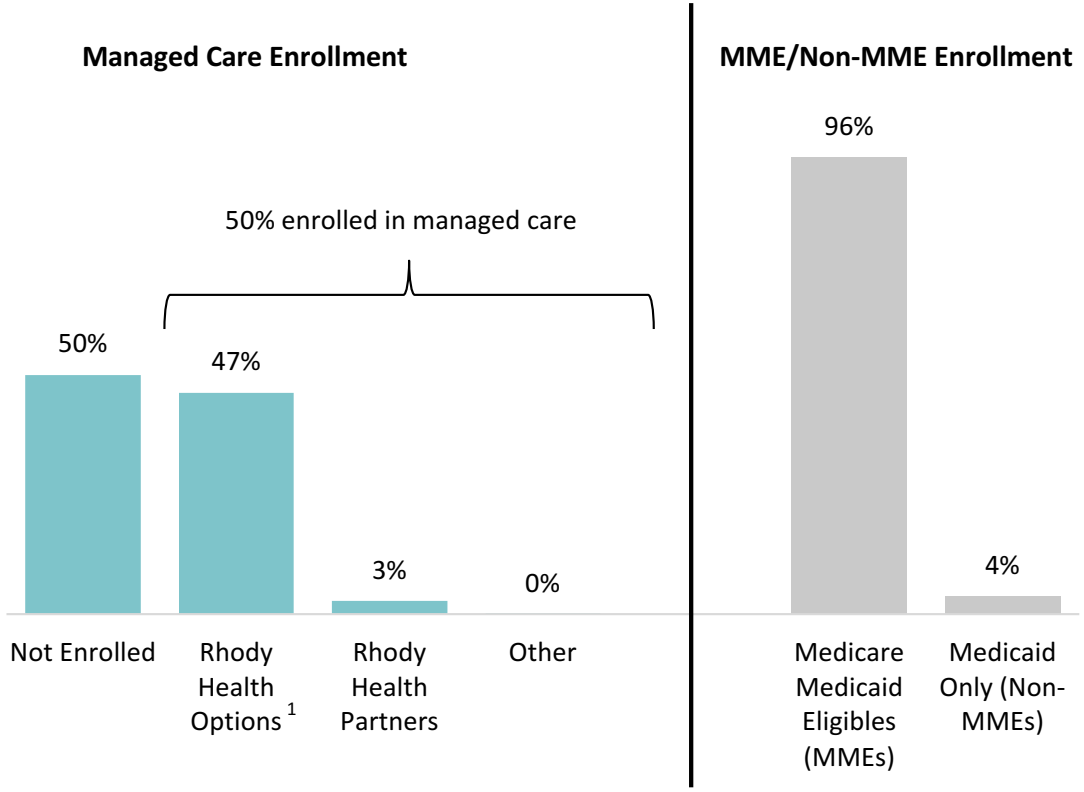
- Medicaid expenditures on elders totaled $559 million in SFY 2016 and has been increasing at 3.1% per year over the past 5 years.
- The large majority of elders are also eligible for Medicare, which was the primary payer for most medical services (e.g. hospital, professional). Consequently those expenditures were not paid by Medicaid and are not included here.
- The increase in nursing facility expenditure has been lower than the increase in overall expenditure for this population - an average annual increase of 2.0 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

Elders: Managed Care and Dual Enrollment

Rhody Health Options rolled out in 2013 and has enrolled nearly 20,000 eligibles, about 9,000 of whom are elders, in a managed care program for duals and/or members needing long term services and supports.

Elders: Managed Care and MME (Dual) Enrollment
SFY 2016

Elders Expenditure = $559 M
Elders Average Eligibles = 19,198



	Not Enrolled	Rhody Health Options [1]	Rhody Health Partners	Other	Medicare Medicaid Eligibles (MMEs)	Medicaid Only (Non-MMEs)
Average Eligibles	9,691	8,957	539	11	18,473	725

- 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 and primary care services (e.g., hospital, professional, pharmacy).
- Rhody Health Options is a fully capitated managed care program for long term care, long term services and supports (LTSS), and other Medicaid-funded services designed to more fully meet the needs of people with both Medicaid and Medicare eligibility.
- The Not Enrolled category includes 935 elders enrolled in Connect Care Choice and Connect Care Choice Community Partners (CCC/CP), which are primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

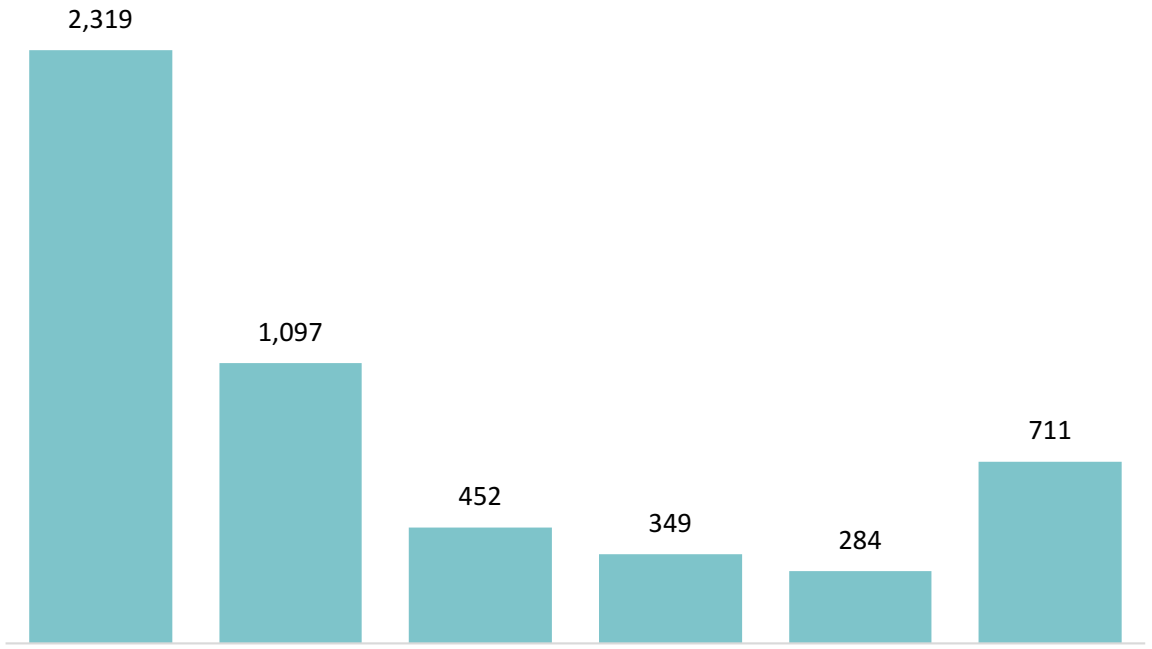
[1]Chart does not include approx. 10,000 adults with disabilities population enrolled in Rhody Health Options.

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.

Elders: Home and Community Based Services
Average Monthly Census
SFY 2016

Elders Average Eligibles = 19,198



	Personal Care	DME	Adult Day Care	IDD Resdtl/Rehab	Assisted Living	Other HCBS
Avg Ann Growth 2012-2016	4.1%	1.0%	15.6%	0.7%	-6.9%	-6.0%

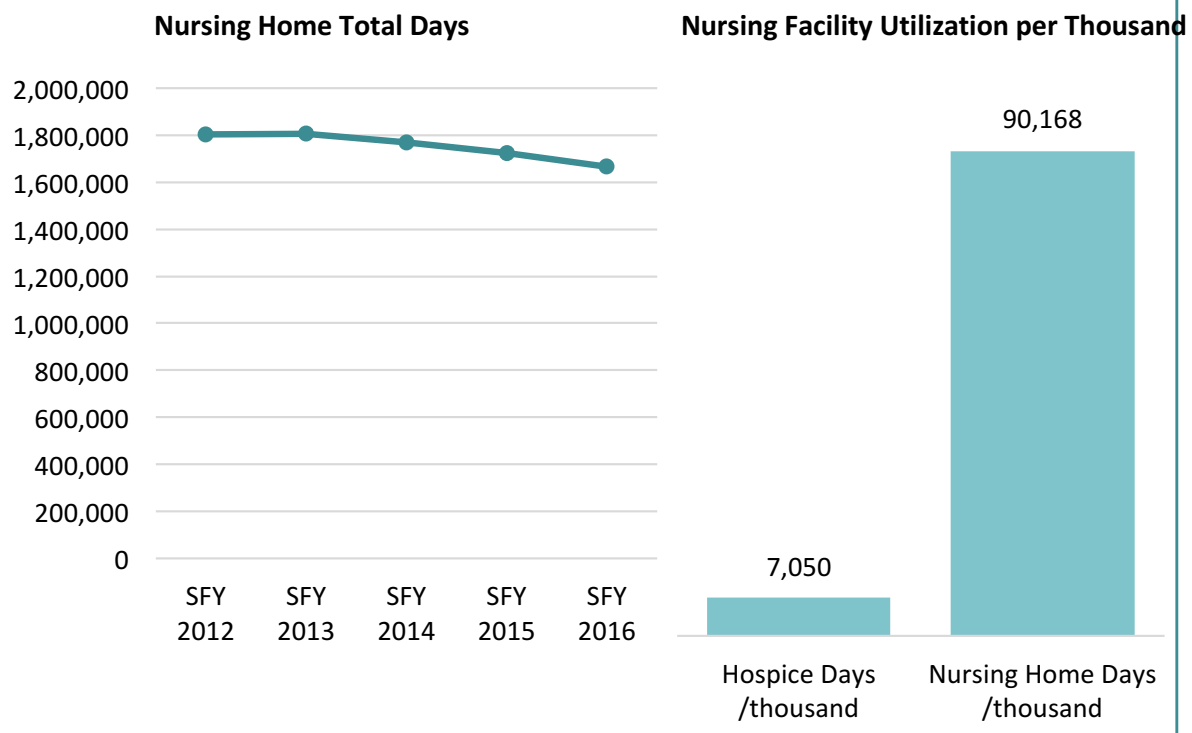
- The largest category of home and community based services (HCBS) is personal care services, with an average monthly census for elders of 2,319 recipients in SFY 2016. The monthly census for elders for this category has increased at 4.1% per year since SFY 2012.
- The category with the highest increase in average monthly census is adult day care, with an average annual increase of 15.6% per year.
- Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.

Elders: Nursing Facility Utilization (MME only)

For MME Elders, nursing home days per thousand eligibles decreased 3.7% per year from SFY 2012 to 2016.

MME Elders: Nursing Facility Utilization
SFY 2016

MME Elders: 18,473
96% of Elders



Avg Ann Growth 2012-2016	-1.9%	-7.3%	-3.7%

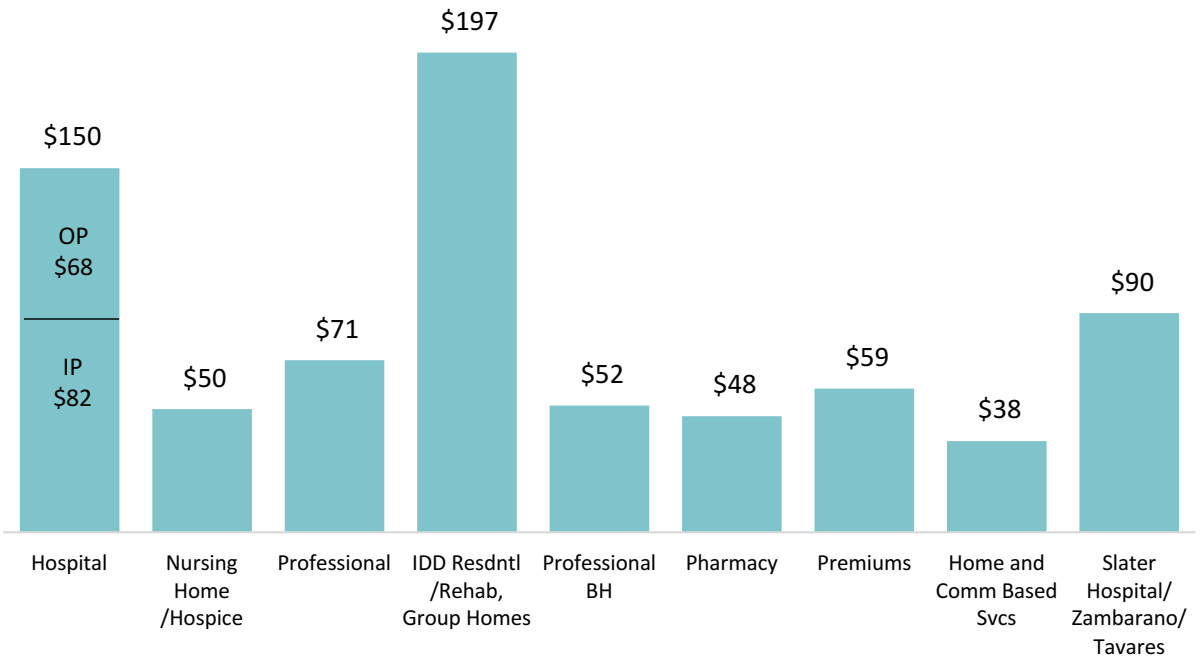
- Ninety-six percent of elders are Medicaid Medicare eligibles (MMEs, also called duals). For these elders covered by both Medicare and Medicaid, Medicare is the primary payer for the majority of acute and primary care services while Medicaid covers long term services and supports.
- The total nursing home days for this population has decreased by 1.9% per year on average over the last 5 years.
- Nursing home days per thousand for MME elders were 90,168 in SFY 2016. This measure has decreased by an average annual rate of 3.7% since SFY 2012.
- Hospice days per thousand for MME elders have decreased at a rate of 7.3% on average per year over the last 5 years to 7,050 per thousand in SFY 2016.

Adults with Disabilities: Expenditure by Provider Type

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

Adults with Disabilities:
Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Adults with Disabilities Expenditure = $754 M
% of 2016 Expenditure = 31%
Avg Annual Growth = 2.1%



20%	7%	9%	26%	7%	6%	8%	5%	12%
% of 2016 Expenditure								
-2.4%	8.1%	6.5%	3.1%	-4.2%	3.9%	9.1%	5.5%	0.8%
Avg Ann Growth 2012-16								

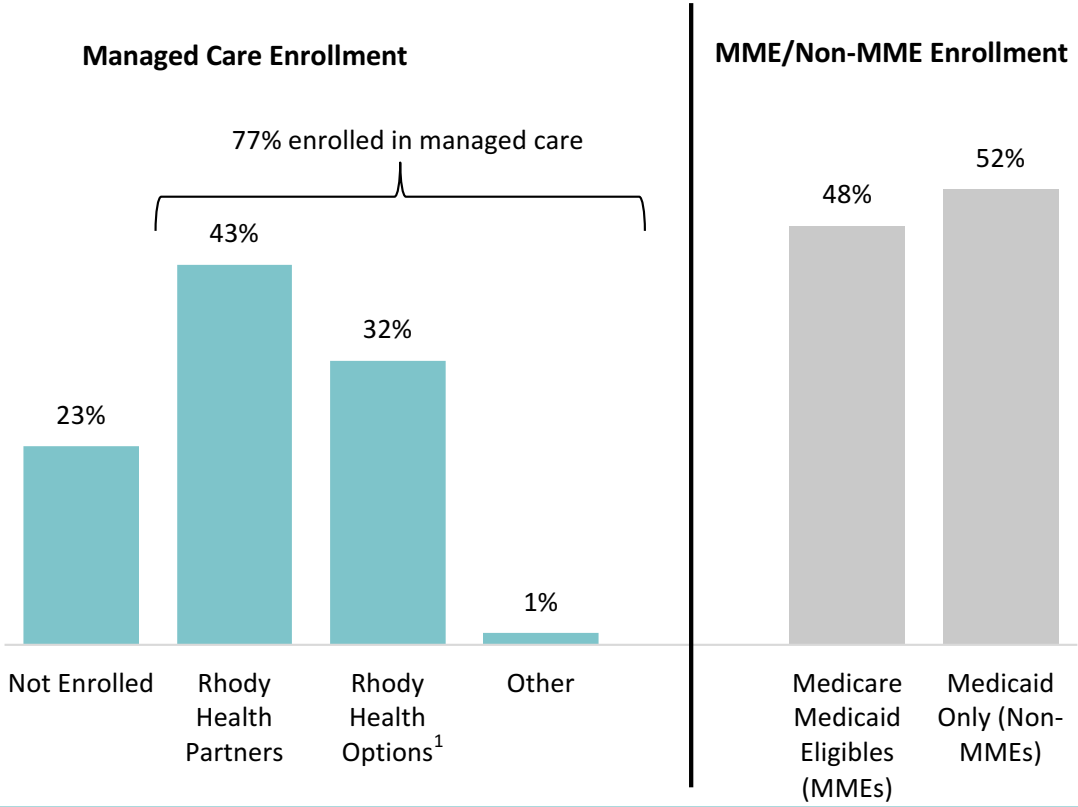
- Adults with disabilities account for the largest share of Medicaid expenditures, with total SFY 2016 expenditure of $754 million. Expenditure for this population has increased by approximately 2.1% per year over the past 5 years.
- Hospital and residential and rehabilitation services for persons with intellectual and developmental disabilities account for 20% and 26% of expenditure, respectively.
- However, expenditure for hospital services has been decreasing 2.4% per year on average over the last 5 years.
- Similar to the elders population, both nursing facility services and home and community based services have experienced high growth rates for the adults with disabilities population.

Adults with Disabilities: Managed Care Enrollment

More than three-quarters (77%) of adults with disabilities are enrolled in managed care.

Adults with Disabilities: Managed Care and MME (Dual) Enrollment
SFY 2016

Adults with Disabilities Expenditure = $754 M
Average Eligibles = 32,080



	Not Enrolled	Rhody Health Partners	Rhody Health Options[1]	Other	Medicare Medicaid Eligibles (MMEs)	Medicaid Only (Non-MMEs)
Average Eligibles	7,292	13,938	10,424	426	15,369	16,711

[1]Chart does not include approx. 9,000 elders population enrolled in Rhody Health Options.

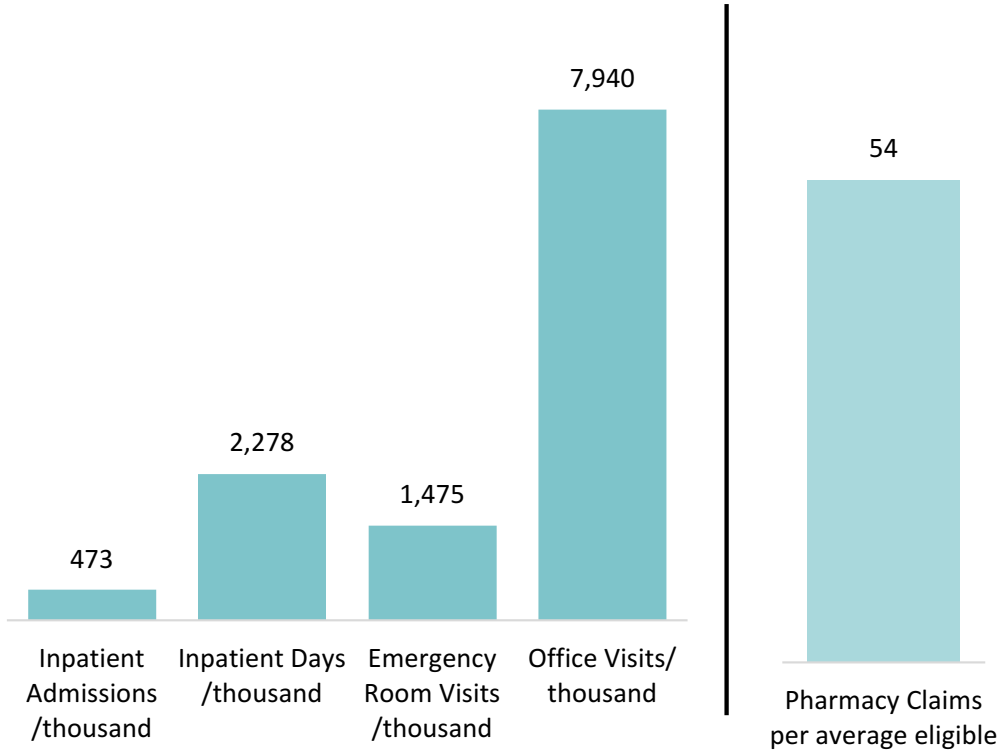
- Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- For the adults with disabilities who are dually enrolled, Medicare is the primary payer for most acute and and primary care services (e.g., hospital, physician, pharmacy).
- Adult populations had historically been served in fee-for-service Medicaid but have been transitioned to managed care over the last several years. In SFY 2016 77% of this population was enrolled in managed care.
- In addition, 1,413 adults with disabilities in the Not Enrolled category were enrolled in SFY 2016 in Connect Care Choice and Connect Care Choice Community Partners, PCCM programs where Medicaid pays providers for enhanced care management within the fee-for-service structure.

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).

Adults with Disabilities:
Non-MMEs: Acute Care Utilization
SFY 2016

Non-MME Adults with Disabilities = 16,711
52% of Adults with Disabilities



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2012-2016	-1.8%	-8.1%	-1.3%	3.7%	0.2%

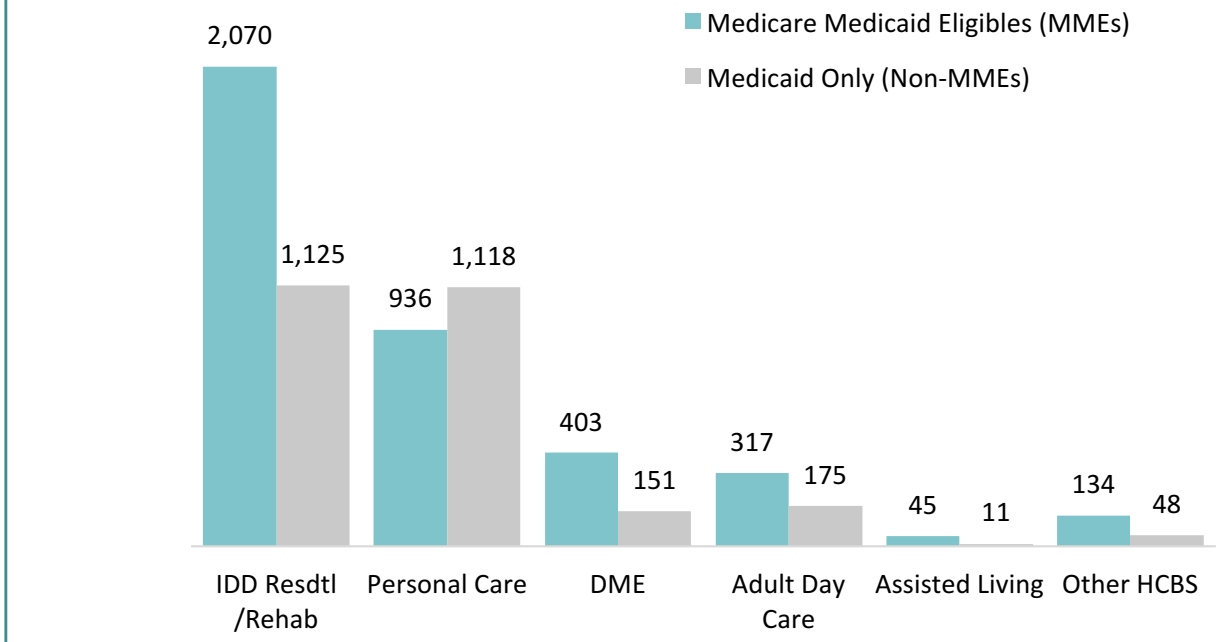
- Fifty-two percent of adults with disabilities are covered by only Medicaid. Utilization shown here is for the adults with disabilities without Medicare coverage (Non-MMEs).
- Acute care utilization is not shown for dual enrolled adults with disabilities (MMEs) because Medicare is the primary payer for most acute care services.
- Non-MME adults with disabilities averaged 7,940 office visits per thousand eligibles per year in SFY 2016, an increase of 3.7% 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 1.8% and 8.1% respectively.
- Pharmacy claims for non-MME adults with disabilities average 54 claims per average eligible per year, and have been increasing at a rate of 0.2% per year on average over the last 5 years.

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 intellectually and developmentally disabled and personal care services.

Adults with Disabilities:
Home and Community Based Services
Average Monthly Census
SFY 2016

Non-MME Adults with Disabilities = 16,711
MME Adults with Disabilities = 15,369



Avg Ann Growth 2012-2016	IDD Resdtl /Rehab	Personal Care	DME	Adult Day Care	Assisted Living	Other HCBS
MMEs	0.2%	5.4%	7.9%	18.6%	-4.4%	-7.7%
Non-MMEs	3.4%	19.8%	-2.7%	15.4%	-10.4%	-20.2%

- Residential and rehabilitation services for intellectually and developmentally disabled individuals had an average monthly census in SFY 2016 of 2,070 recipients for MME adults with disabilities and 1,125 recipients for Non-MME adults with disabilities.
- The second largest category of HCBS for this population is personal care services, with an average monthly census of 936 recipients in SFY 2016 for MME adults with disabilities and 1,118 recipients for Non-MME adults with disabilities.
- The monthly census for personal care services is growing at 5.4% per year on average for MME adults with disabilities and at 19.8% per year on average for Non-MME adults with disabilities.

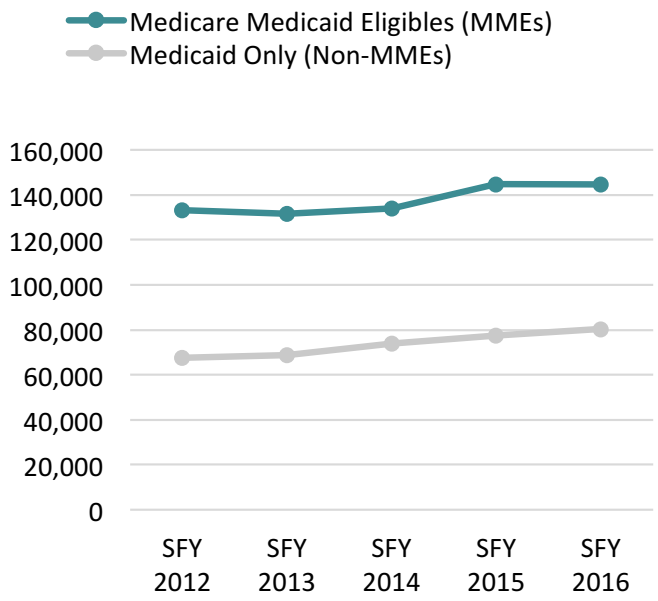
Adults with Disabilities: Nursing Facility Utilization

Nursing home days per thousand have increased 4.6% per year since SFY 2012 for non-MME adults with disabilities and decreased 0.4% per year for MME adults with disabilities.

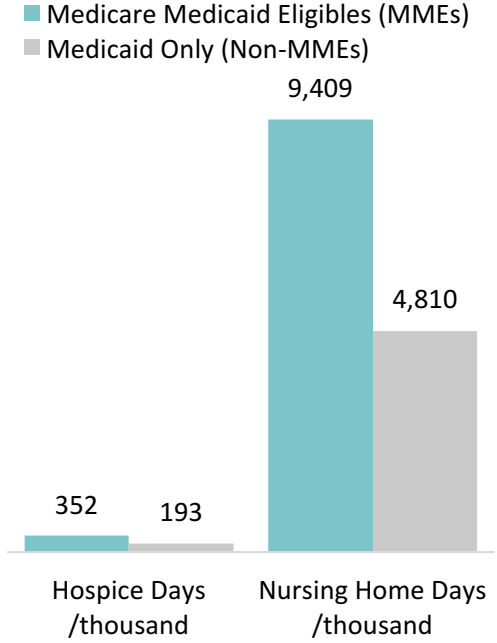
Adults with Disabilities:
Nursing Facility Utilization
SFY 2016

Non-MME Adults with Disabilities = 16,711
MME Adults with Disabilities = 15,369

Nursing Home Total Days



Nursing Facility Utilization per Thousand



Avg Ann Growth 2012-2016			Hospice Days /thousand		Nursing Home Days /thousand	
MMEs	2.1%		-2.9%		-0.4%	
Non-MMEs		4.4%		-13.9%		4.6%

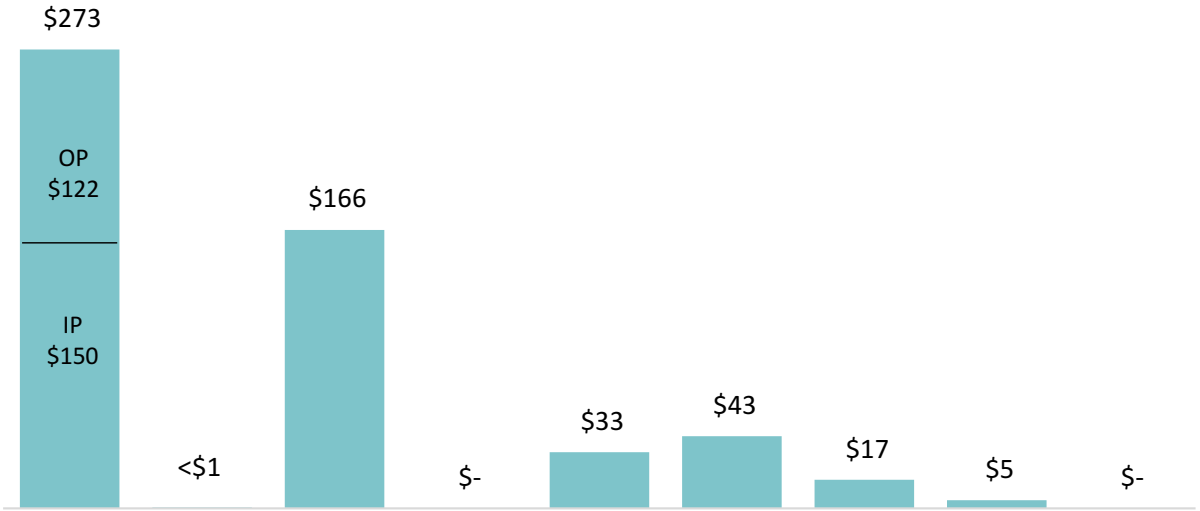
- Long term services supports are primarily covered through Medicaid for both MME and Non-MME adults with disabilities.
- For MME adults with disabilities, hospice days decreased 2.9% per year and nursing home days per thousand decreased 0.4% per year on average since SFY 2012.
- Nursing home days were 9,409 per thousand for MME adults with disabilities and 4,810 per thousand for Non-MME adults with disabilities in SFY 2016.
- Note that nursing home days for this population represent 12% of total Medicaid nursing home days since elders account for the majority of nursing home days overall.

Children and Families: Expenditure by Provider Type

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

Children and Families:
Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Children and Families Expenditure = $537 M
% of 2016 Expenditure = 22%
Avg Annual Growth = 2.9%



Hospital	Nursing Home /Hospice	Professional	IDD Resdntl /Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
51%	0%	31%	0%	6%	8%	3%	1%	0%
% of 2016 Expenditure								
3.2%	6.9%	4.6%	N/A	-3.3%	0.2%	-1.9%	N/A	N/A
Avg Ann Growth 2012-16								

N/A indicates expenditure in this category too small to calculate a meaningful trend rate.
[1]Rate based on currently available data for 2008 – 2012. Source: http://www.health.ri.gov/data/birth/

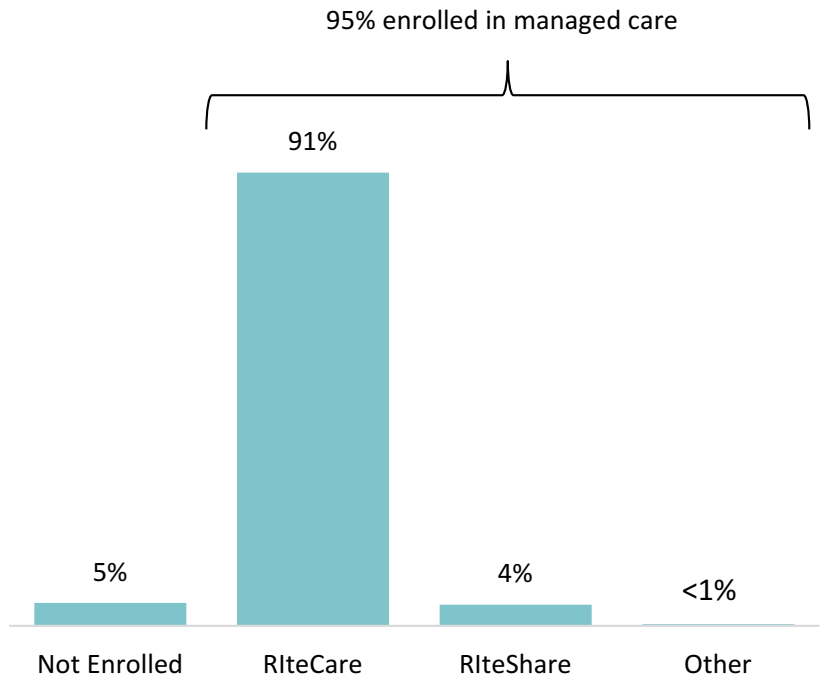
- Children and families account for about one-fourth (22%) of total Medicaid expenditures, with SFY 2016 expenditure of $537 million. Expenditure for this population has increased by 2.9% per year over the past 5 years.
- Most expenditure on children and families is divided between professional and hospital care, with hospital care accounting for more than half (51%) 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.[1]
- Federal match is enhanced for 24,571 qualifying low income children and pregnant women under the CHIP program. In SFY 2016, Rhode Island received an 82.47% federal match on CHIP enrollees.

Children and Families: Managed Care Enrollment

Nearly all children and families are enrolled in managed care.

Children and Families: Managed Care Enrollment
SFY 2016

Children and Families Expenditure = $537 M
Average Eligibles = 153,342



	Not Enrolled	RIteCare	RIteShare	Other
Average Eligibles	7,028	139,158	6,630	526

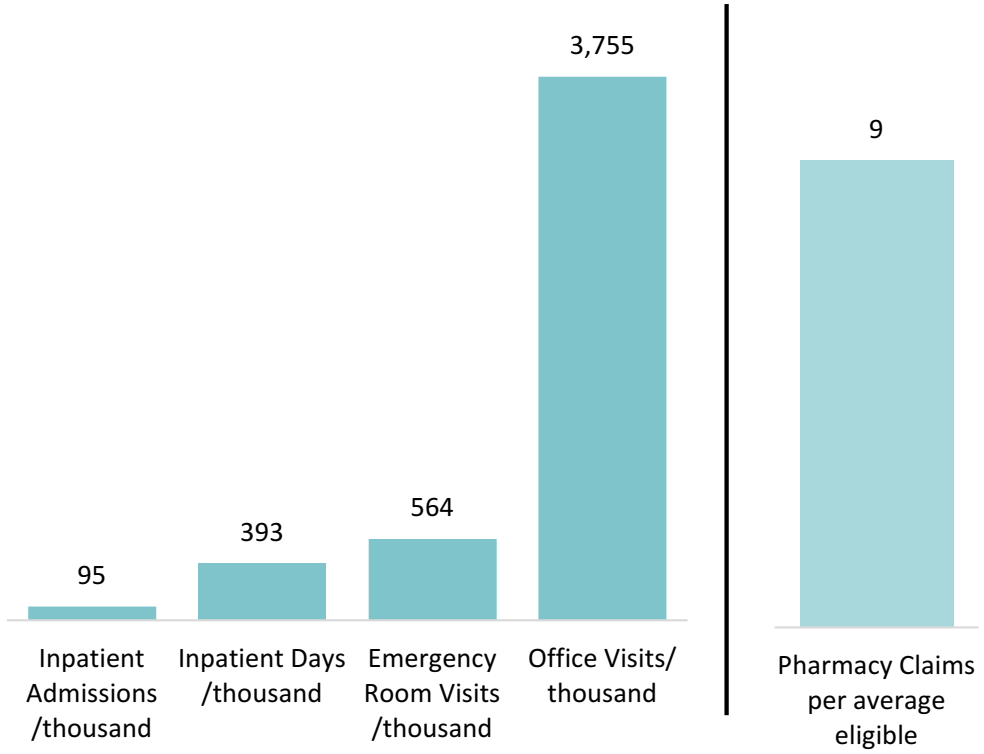
- Ninety-one percent of children and families are enrolled in a Medicaid managed care program through RIte Care. These enrollees are divided between Neighborhood Health Plan (NHP) and United Healthcare (UHC).
- RIte Share is a program designed to allow Medicaid eligibles with access to qualified employer-based 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 2016 there were 6,630 Medicaid eligible children and parents enrolled in the RIte Share program.
- The unenrolled children and families include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

Children and Families: Acute Care Utilization

For children and families, inpatient admissions and inpatient days per thousand have decreased on average since SFY 2012.

Children and Families: Acute Care Utilization
SFY 2016

Children and Families Average Eligibles = 153,342



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2012-2016	-6.3%	-5.1%	-1.2%	0.0%	-1.9%

- For children and families, hospital-based acute care utilization measures have decreased since SFY 2012. Inpatient admissions per thousand and emergency room visits per thousand have decreased 6.3% per year and 1.2% per year, respectively, since SFY 2012.
- Office visits per thousand have stayed essentially flat over the same period.
- Pharmacy claims for children and families average 9 claims per average eligible person per year and have decreased 1.9% per year on average over the last 5 years.
- About 41% of inpatient admissions and 42% of inpatient days are maternity related (including maternity, nursery and NICU). Annually, approximately 47% of all RI births are covered through RIte Care.[1]

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

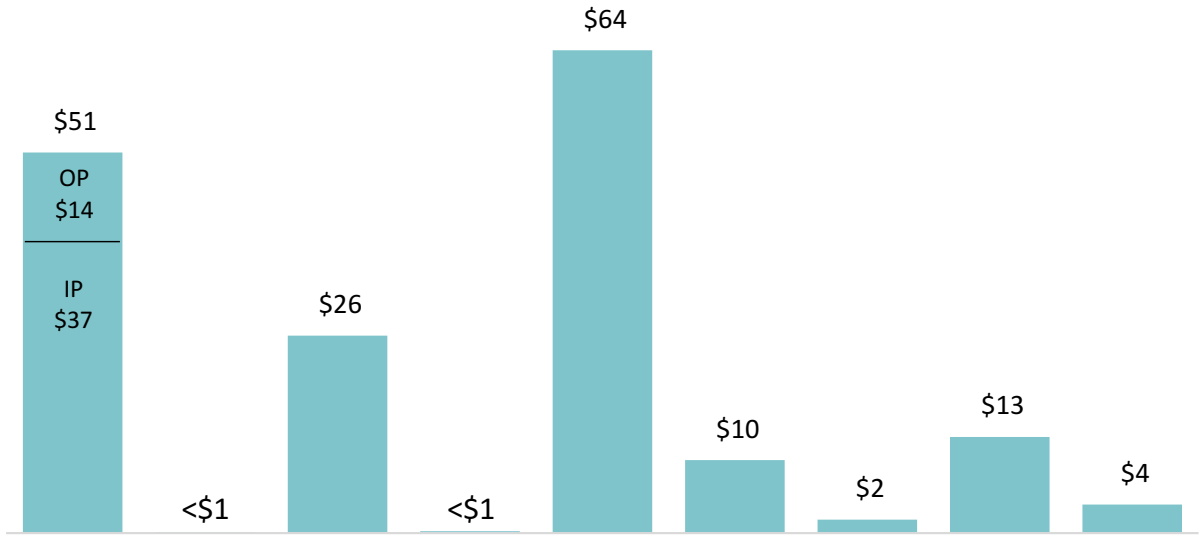
Children with Special Health Care Needs (CSHCN): Expenditure by Provider Type

In the population of children with special health care needs, professional behavioral health accounts for 38% of all expenditure.

CSHCN: Medicaid Expenditure by Provider Type

SFY 2016 -- $ Millions

CSHCN Expenditure = $170 M
% of 2016 Expenditure = 7%
Avg Annual Growth = -0.4%



Hospital	Nursing Home /Hospice	Professional	IDD Resdntl /Rehab, Group Homes	Professional BH	Pharmacy	Premiums	Home and Comm Based Svcs	Slater Hospital/ Zambarano/ Tavares
30%	<1%	15%	<1%	38%	6%	1%	8%	2%
% of 2016 Expenditure								
2.0%	N/A	-1.1%	N/A	-3.8%	-2.3%	6.9%	14.5%	4.0%
Avg Ann Growth 2012-16								

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

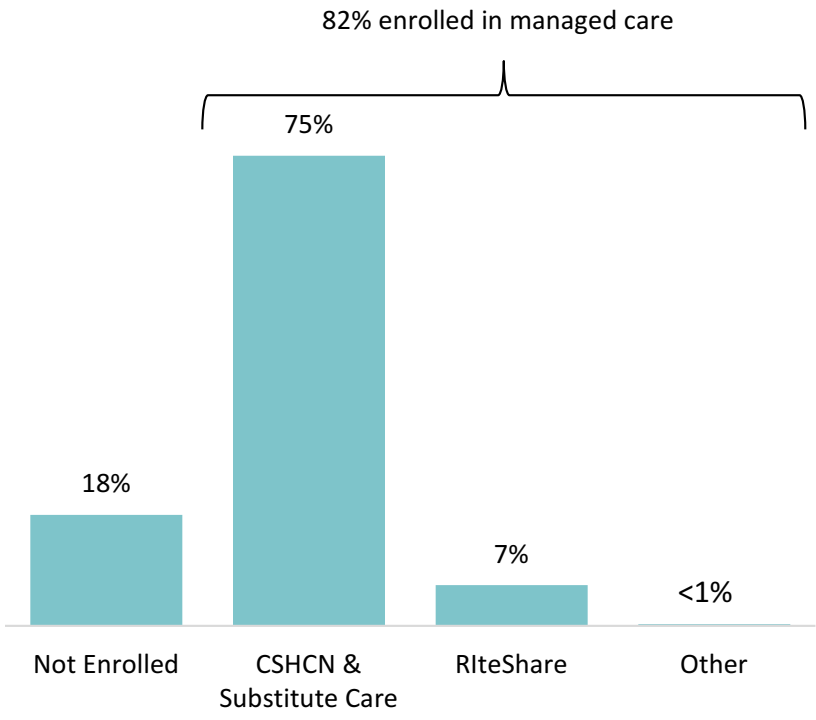
- Children with Special Health Care Needs (CSHCN) comprise a relatively small population, accounting for seven percent of total Medicaid expenditures and four percent of enrollees.
- Expenditure for this population is dominated by professional behavioral health services, which account for $64 million in CSHCN expenditures (38%). Professional behavioral health services include Cedar (Comprehensive, evaluation, Diagnosis, assessment, referral, re-evaluation) and Cedar Direct services, residential DCYF services, and professional mental health, substance abuse, and other services.

Children with Special Health Care Needs: Managed Care Enrollment

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

CSHCN: Managed Care Enrollment
SFY 2016

CSHCN Expenditure = $170 M
Average Eligibles = 12,025



	Not Enrolled	CSHCN & Substitute Care	RIteShare	Other
Average Eligibles	2,146	9,063	787	29

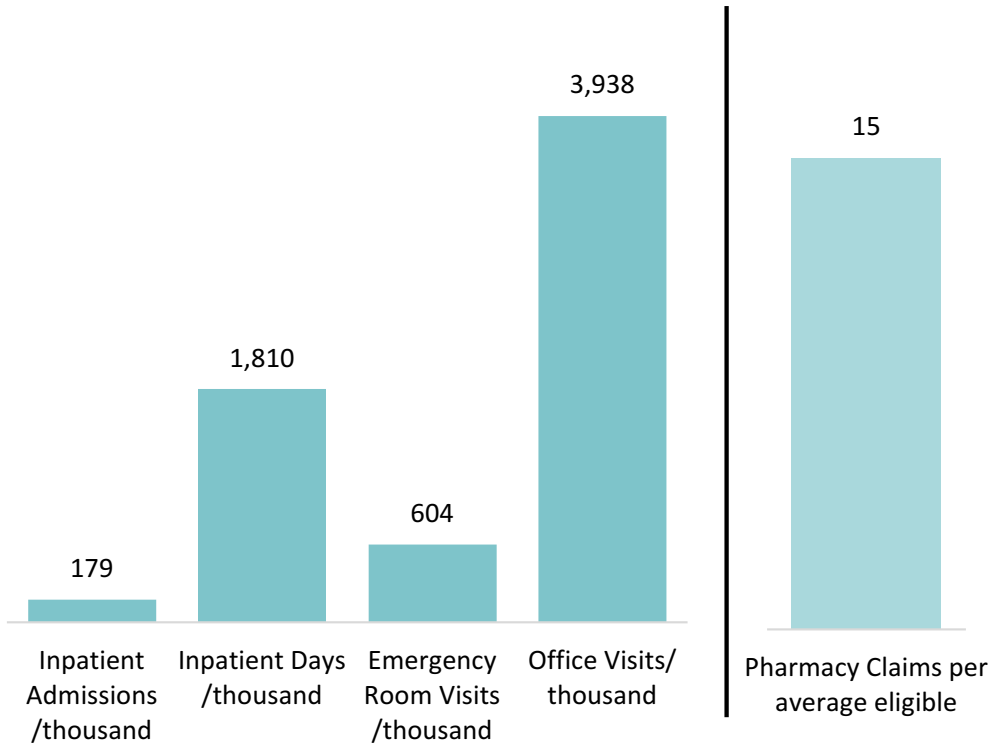
- In 2008, enrollment in Medicaid managed care became mandatory for children with special health care needs (CSHCN) without other insurance. In SFY 2016 82% were enrolled in managed care.
- The unenrolled children with special healthcare needs include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

Children with Special Health Care Needs: Acute Care Utilization

For children with special health care needs, emergency room visits per thousand have decreased by 1.3% per year on average since SFY 2012.

CSHCN: Acute Care Utilization
SFY 2016

CSHCN Average Eligibles = 12,025



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2012-2016	3.6%	4.2%	-1.3%	5.3%	0.1%

- Inpatient admissions per thousand have increased over the last 5 years at an average rate of 3.6% per year to 179 per thousand in SFY 2016.
- Office visits per thousand have increased at an average rate of 5.3% per year since SFY 2012 to 3,938 visits per thousand in SFY 2016.
- Almost half (45%) of inpatient admissions per thousand are for behavioral health. In terms of inpatient days, 52% are related to behavioral health.[1]
- Pharmacy claims per average eligible have increased at 0.1% per year over the last 5 years.

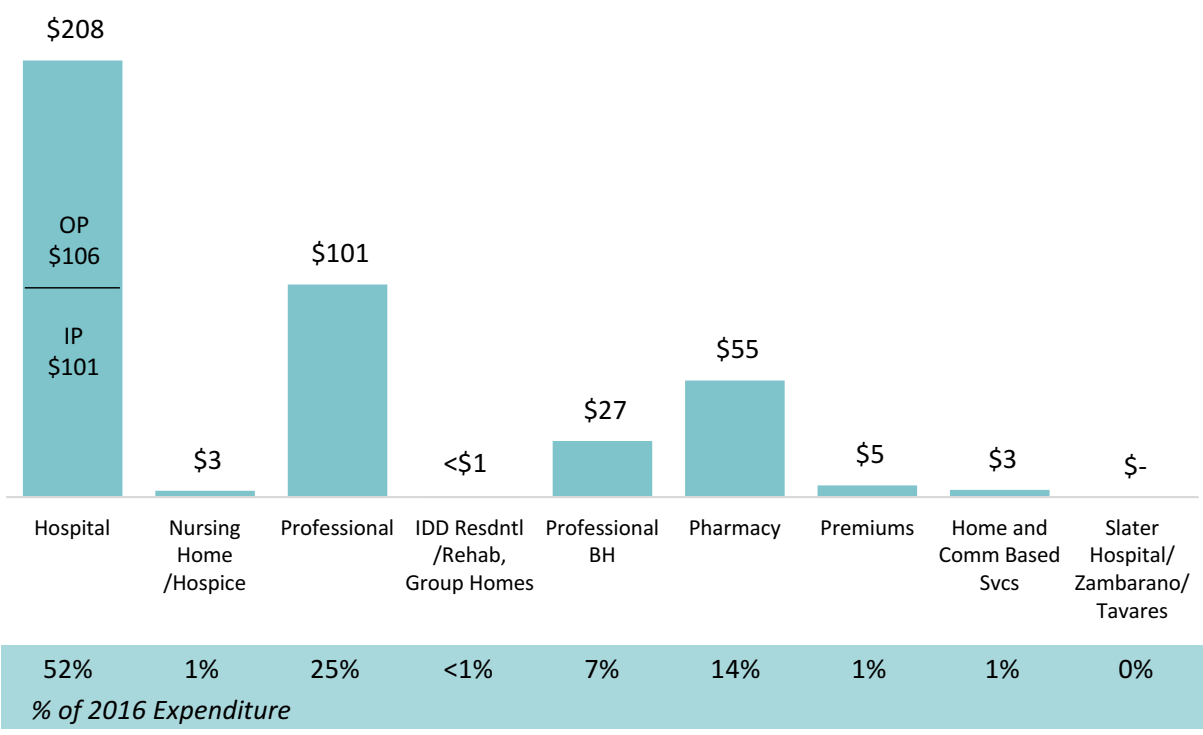
[1]Includes days in the Children's Residential and Family Treatment (CRAFT) program at Bradley Hospital.

Expansion: Expenditure by Provider Type

The Expansion population mainly uses hospital and professional services.

Expansion: Medicaid Expenditure by Provider Type
SFY 2016 -- $ Millions

Expansion Expenditure = $402 M
% of 2016 Expenditure = 17%



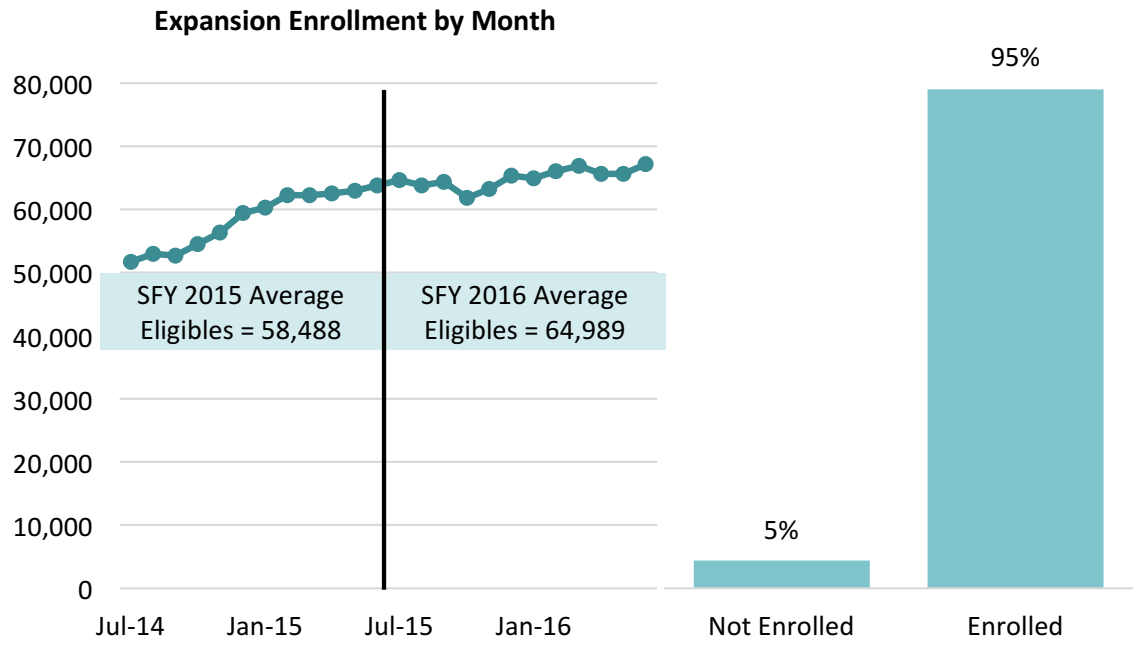
- The Expansion population became eligible for Medicaid starting January 1, 2014.
- This population accounted for $402 million in expenditure in SFY 2016, 17% of total Medicaid expenditure.
- The two largest provider types for the Expansion population are hospital and professional services, accounting for 77% of expenditure.
- The Expansion population used almost no long term services and supports.

Expansion: Managed Care Enrollment

The Expansion population is mainly enrolled in managed care programs

Expansion: Managed Care Enrollment
SFY 2016

Expansion Average Eligibles = 64,989



Average Eligibles	3,405	61,584

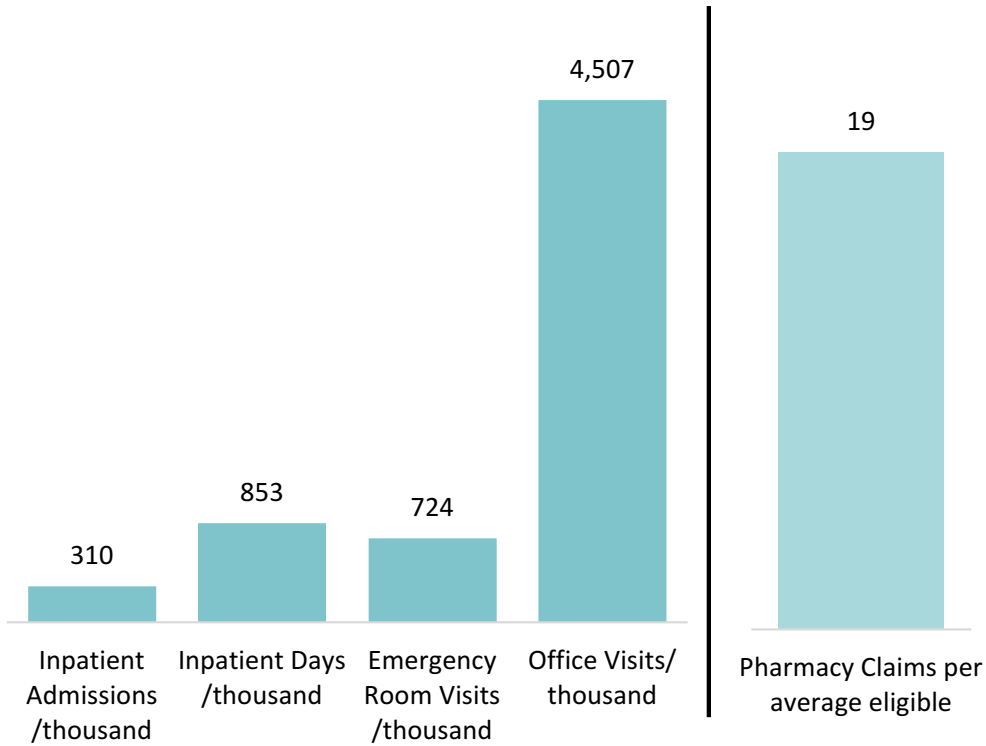
- The Medicaid Expansion population is expected to entirely enroll in managed care. However new enrollees experience an initial period in fee-for-service prior to enrollment in a health plan.
- Expansion eligibility commenced in January 2014 and was still phasing in during SFY 2015. Enrollment has mainly stabilized for SFY 2016, increasing by 2,505 eligibles between July 2015 and June 2016.

Expansion: Acute Care Utilization

The Expansion population had an average of 19 pharmacy claims per 12 months of eligibility.

Expansion: Acute Care Utilization
SFY 2016

Expansion Average Eligibles = 64,989



	Inpatient Admissions /thousand	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Growth **SFY 2015-2016**	12.5%	-2.4%	-2.6%	-0.9%	4.3%

Note: Growth rate on this chart is for one year, not the average annual rate for five years.

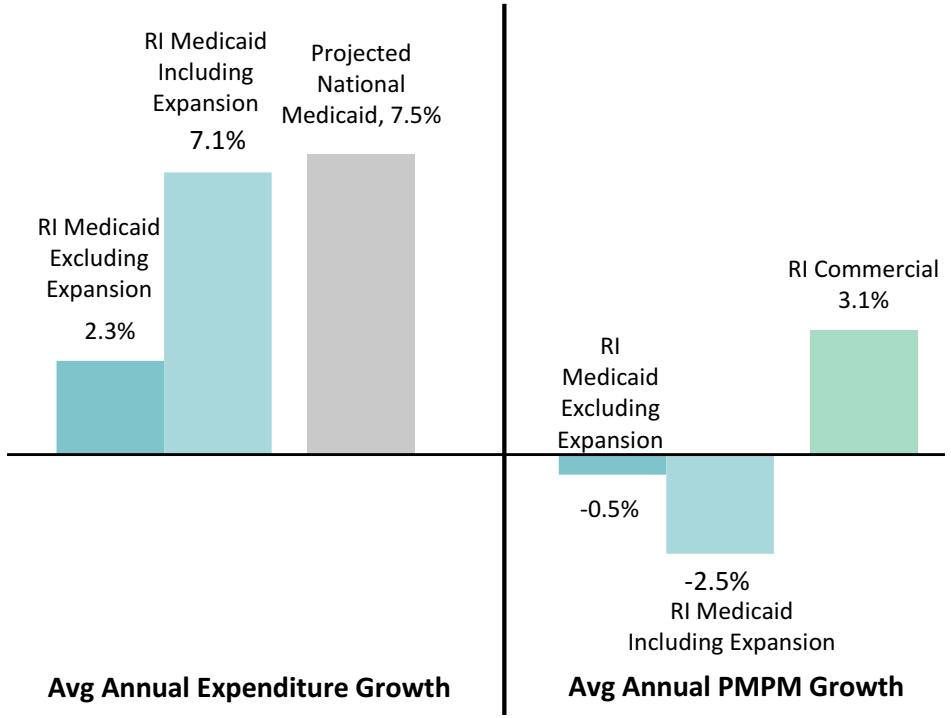
- The Medicaid Expansion population had 310 inpatient admissions per thousand and 853 inpatient days per thousand during SFY 2016.
- The Expansion population used about 4.5 office visits per average eligible.
- The Expansion population was newly eligible during SFY 2014, so data is not available to calculate a five-year average growth rate. However, trend rates from SFY 2015 to 2016 show a decrease in utilization for the Expansion population for inpatient days, ER visits, and office visits per thousand.

Medicaid Trends: National Medicaid and State Commercial

RI Medicaid trends were comparable to national Medicaid trends including the expenditure on the Expansion population. RI Medicaid trends were notably lower than regional Commercial experience over a similar period.

Rhode Island Medicaid vs. National and Commercial Trends

SFY 2012-2016[1], see below for sources



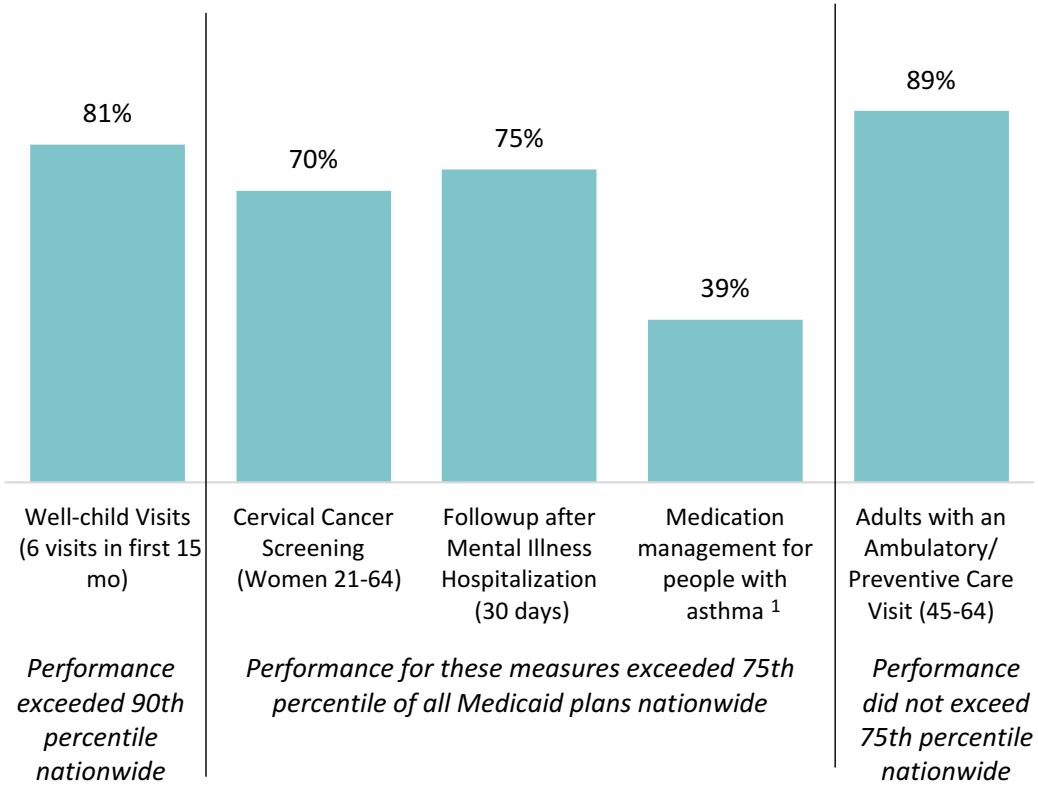
- Overall expenditure growth over the years 2012-2016 was similar to the national Medicaid expenditure trend. According to Centers for Medicare & Medicaid Services (CMS), Medicaid national expenditure trend over this time period increased an average 7.5% per year, vs. Rhode Island Medicaid's trend of 7.1%.
- The 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.
- Rhode Island Medicaid PMPM (per member per month) cost trends compare favorably to local commercial benchmarks. Between SFY 2012 and 2016, the state Medicaid program experienced a decrease in average annual PMPM cost of 2.5% per year, including Expansion. The average annual medical PMPM cost for RI commercial health plans over a similar period increased 3.1% per year.[1]
- 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.

[1]RI Commercial trend for CY2011-2015. National trend for FFY 2012-2016.
Sources: National Medicaid Trend from 2016 CMS National Health Expenditure Report. RI Commercial trend from Office of the Health Insurance Commissioner (OHIC), 2016 carrier rate filings, 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.

Managed Care: Quality Indicators

Both of Rhode Island's participating Medicaid Managed Care Organizations (MCOs) received an overall plan rating of 4.5 out of 5 from the National Committee for Quality Assurance (NCQA) for 2016.

Combined Performance of RI Medicaid Managed Care Plans on Selected HEDIS Quality Measures
CY 2015



- NCQA ratings consists of three types of quality measure domains: clinical quality, consumer satisfaction, and results from NCQA's review of the Health Plan's health quality processes.
- Selected HEDIS® quality measures are shown at left demonstrating the combined performance of RI Medicaid Managed Care Organizations.
- On the HEDIS® measures assessing the percentage of enrollees who had six or more well-child visits during their first 15 months of life, both of Rhode Island's Medicaid Health Plans ranked above the 90th percentile compared with Medicaid health plans nationally.
- On the HEDIS® measures of cervical cancer screening, follow-up after mental illness hospitalization, and medication management for people with asthma, Rhode Island's Medicaid Health Plans ranked above the 75th percentile compared with other plans nationwide.

[1]HEDIS 2016 retired the *Use of Appropriate Mediations for People with Asthma* and replaced with *Medication Management for People with Asthma.*
Sources: NCQA data from Kaiser Family Foundaiton report: Medicaid MCO Quality Ratings, based on NCQA 2016-2017 ratings.
HEDIS data from Monitoring Quality and Access in RIte Care and Rhody Health Partners, RI EOHHS, October 2016. Results are reported in aggregate, not by health plan.

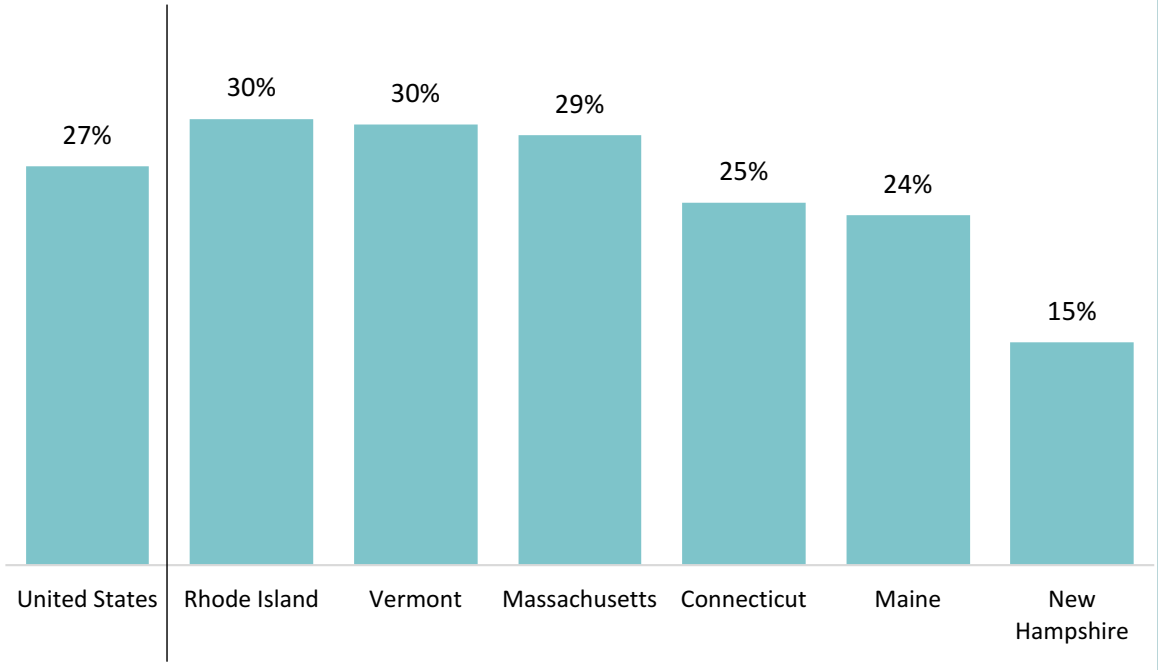
Medicaid Trends: Medicaid Enrolled Population

According to November 2016 enrollment data, Rhode Island's Medicaid enrollment is 30% of its population under 65, the highest percentage of the New England states.

Medicaid Enrollment as Percent of Under 65 Population

November 2016

Source: Manatt analysis of CMS Medicaid/CHIP enrollment data and Census Bureau Population Data



72,395,517	290,809	166,794	1,665,877	750,009	269,051	186,377

Medicaid Enrollment, Nov 2016

- CMS compiles Medicaid enrollment data for all states monthly. This enrollment 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.
- After Rhode Island, Vermont had the second highest percentage Medicaid enrollment of the New England states.
- Nationally 27% of the population under 65 is enrolled in Medicaid.

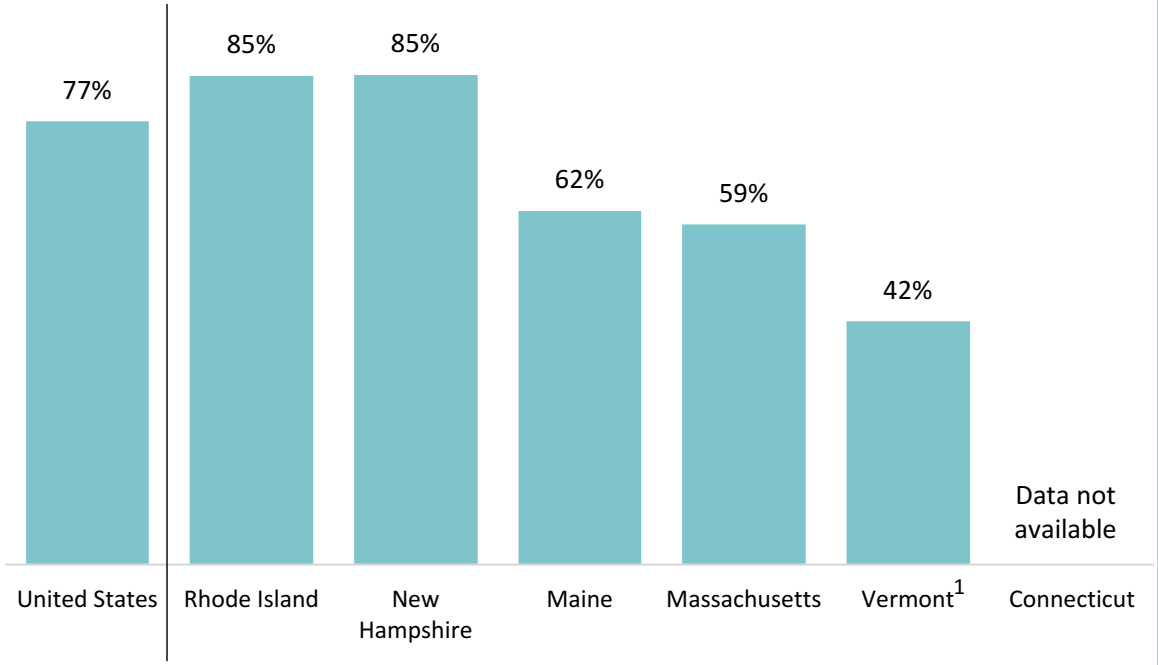
Medicaid Trends: Managed Care Enrollment

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

Managed Care Enrollment as Percent of Medicaid Enrollment

January 2014

Source: Kaiser Family Foundation report, based on CMS enrollment data



- Total Medicaid enrollment for this chart is defined as beneficiaries enrolled in any Medicaid managed care program, including comprehensive MCOs, limited benefit MCOs, and PCCMs.
- Nationally the average percent of Medicaid managed care enrollment is 77%.
- This data differs from the managed care enrollment data shown earlier in this report because it is based on data from 2014 in order to allow comparison to national and regional data.
- For SFY 2016, Rhode Island managed care enrollment is 90% of eligibles, an increase from the 85% shown in this Kaiser report.

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

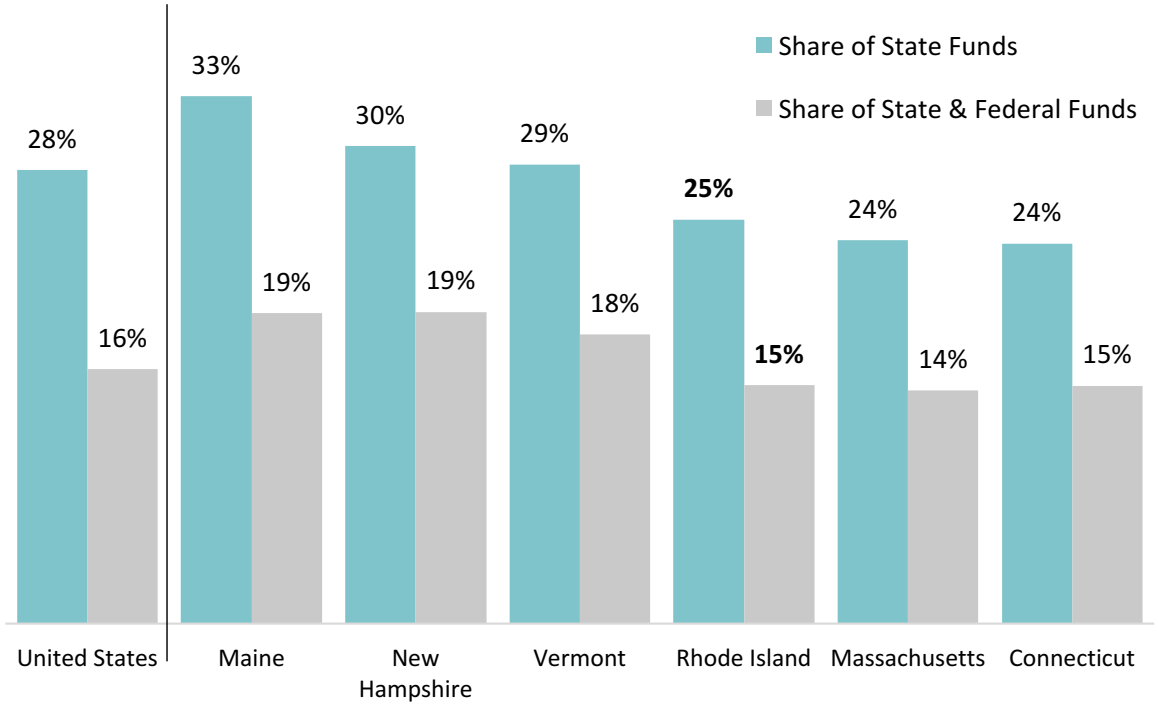
Medicaid Trends: Share of State/Federal Spending

Medicaid spending in Rhode Island accounted for about 25% of state funds in the state budget for SFY 2015.

Medicaid Spending as a Share of State and Federal Funds in State Budgets

SFY 2015

Source: Manatt analysis of National Association of State Budget Officers (NASBO) data



- Across all states, the average share of state funds dedicated to Medicaid spending is about 28%, and the average share of both state and federal funds dedicated to Medicaid spending is about 16%.
- In Maine, New Hampshire and Vermont , Medicaid spending represents a higher share of state and federal funds than in Rhode Island.

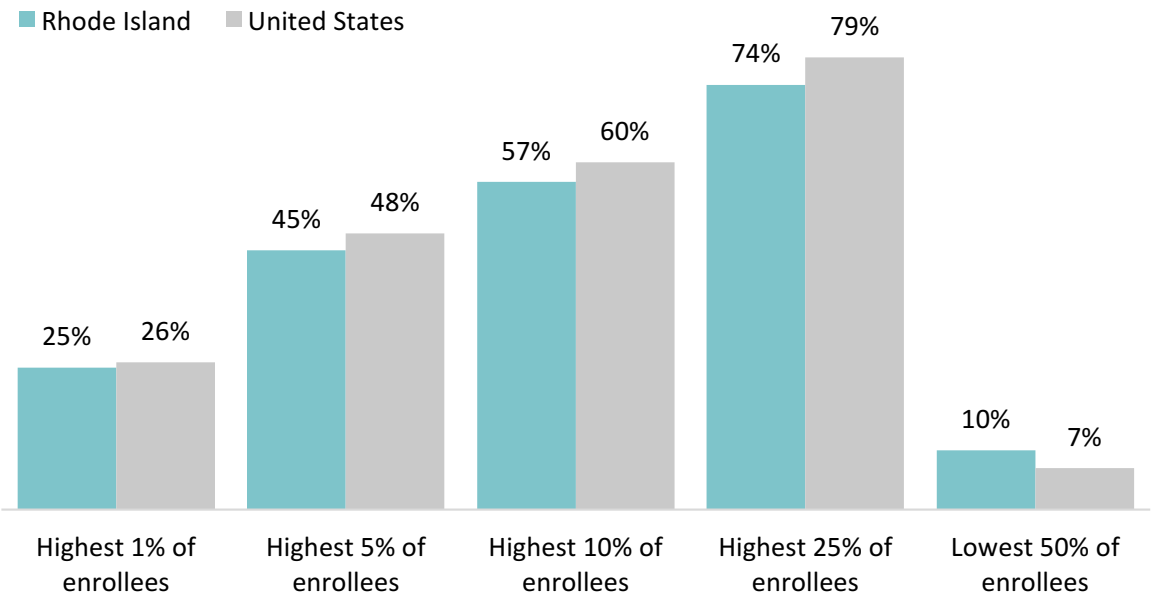
Medicaid Trends: Cost/Utilization Benchmarks

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

Distribution of Expenditures among Medicaid-only Enrollees FFY 2011

(excludes MMEs – Medicare dual eligibles)

Source: US Government Accountability Office Report

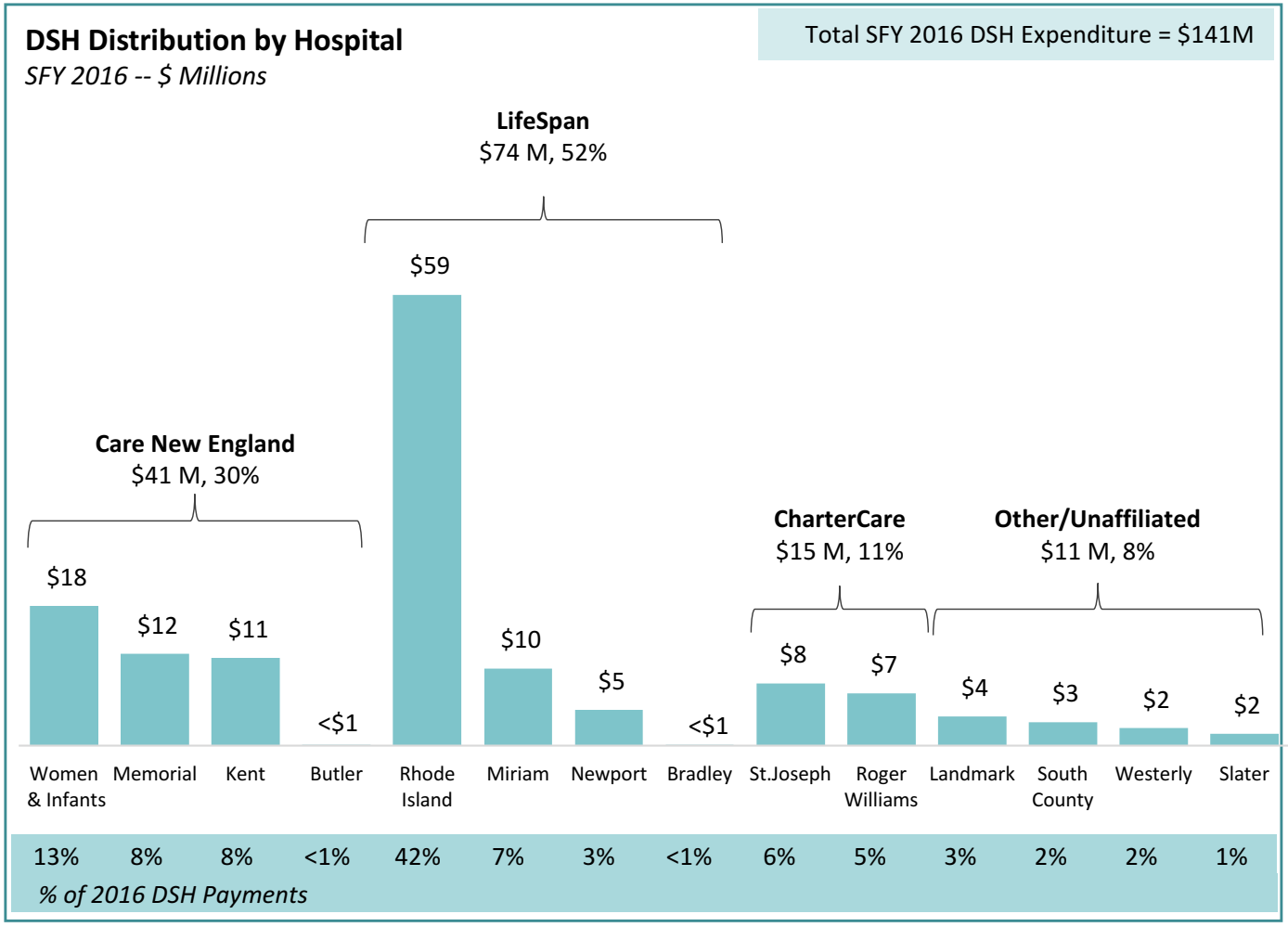


Percentage of expenditures for Medicaid-only enrollees attributable to selected portions of enrollees

- The GAO report from 2011 showed that both nationwide and in Rhode Island, the top 1% of Medicaid enrollees account for about one-quarter of total Medicaid expenditure. The 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 cost user statistics shown earlier in this report because it excludes dual eligibles in Medicare and is based on data from 2011 in order to allow comparison to available national data.

Exclusions: (1) Disproportionate Share Hospitals (DSH)

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



- A total of $141 million in DSH funds was paid out to hospitals in SFY 2016.
- The state's two largest hospitals – Rhode Island and Women and Infants – together accounted for 55% of total DSH payments
- DSH payments are not included in the Medicaid expenditure analysis in this report.

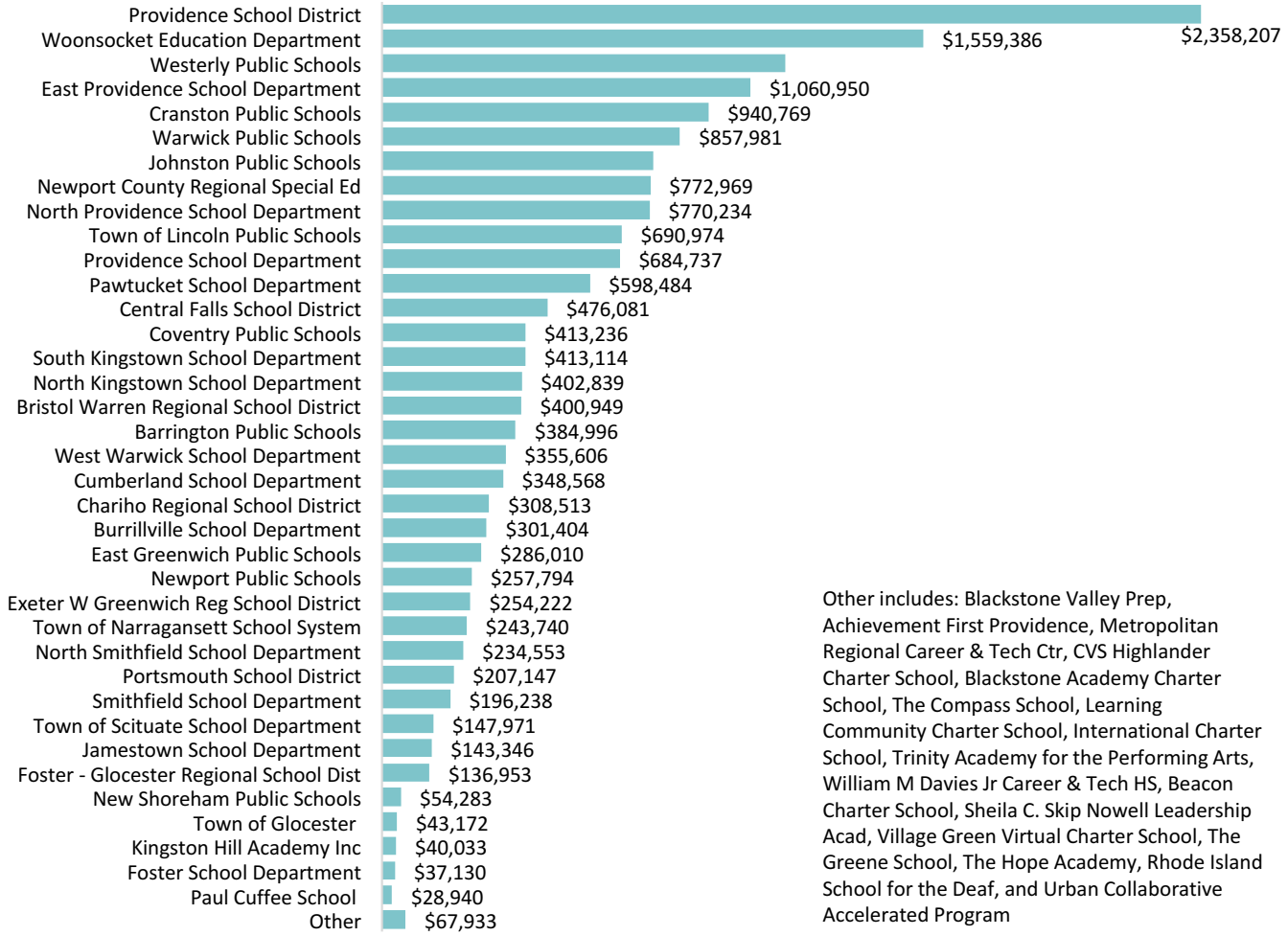
Exclusions: (2) Local Education Authorities (LEA)

Local Education Authorities (LEAs) account for $18 million in total expenditures in 54 school districts.

Medicaid Funding to Local Education Authorities (LEAs)

SFY 2016

Total SFY 2016 LEA Expenditure = $18 M



Other includes: Blackstone Valley Prep, Achievement First Providence, Metropolitan Regional Career & Tech Ctr, CVS Highlander Charter School, Blackstone Academy Charter School, The Compass School, Learning Community Charter School, International Charter School, Trinity Academy for the Performing Arts, William M Davies Jr Career & Tech HS, Beacon Charter School, Sheila C. Skip Nowell Leadership Acad, Village Green Virtual Charter School, The Greene School, The Hope Academy, Rhode Island School for the Deaf, and Urban Collaborative Accelerated Program

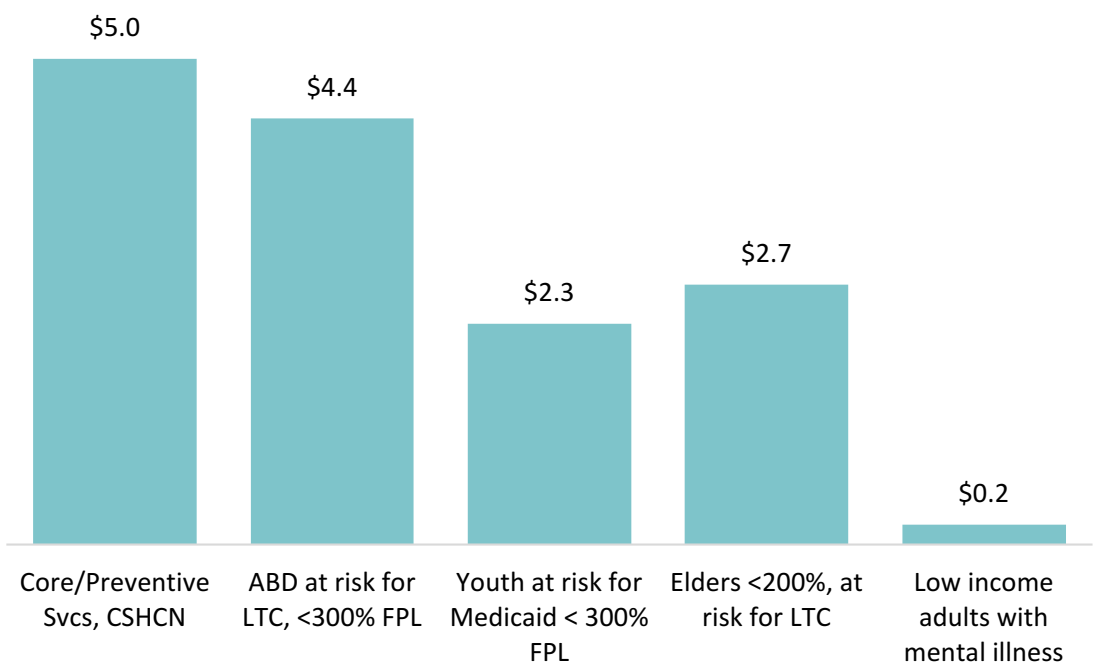
- LEAs provide special education services in their districts.
- For LEA expenditures, the match to the federal share is paid with LEA funds.
- LEA payments are not included in the Medicaid expenditure analysis in this report.

Exclusions: (3) Costs Not Otherwise Matchable (CNOM)

Costs Not Otherwise Matchable (CNOMs) account for $15 million in total expenditures.

Costs Not Otherwise Matchable (CNOMs)
SFY 2016 -- $ Millions

Total SFY 2016 CNOM Expenditure = $15M



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

Acronyms and Abbreviations

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

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 Services
CNOM: Costs Not Otherwise Matchable
CSHCN: Children with Special Health Care Needs
DCYF: Department of Children, Youth and Families
IDD: Intellectually and Developmentally Disabled
DEA: Department of Elderly Affairs
DSH: Disproportionate Share Hospitals
DHS: Department of Human Services
DME: Durable Medical Equipment
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
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
SFY: State Fiscal Year
SSI: Supplemental Security Income
UHCNE: UnitedHealth Care of New England
UPL: Upper Payment Limit

Sources and Notes

Source Data and Analytic Method

This report is based on SFY 2016 and a five year historical Rhode Island Medicaid systems extracts:

- Including claims, capitation payments, premiums and provider payouts.
- Reflecting data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through November 2016
- 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.