Rhode Island Annual Medicaid Expenditure Report SFY 2017

Executive Office of Health and Human Services

June 2018

Purposes of this Report

The purposes of this report include the following:

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

Definition of average annual rates methodology: *This report shows trends in terms of an average annual trend rate based on three years of historical data in order to present longer term trends rather than year to year variation.*

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Executive Summary: Overview and Key Findings

Overview

During SFY 2017 Rhode Island's Medicaid program provided full medical coverage to approximately 335,000 distinct Rhode Islanders, with an average of 305,000 members enrolled at any one time.

Medical benefits expenditures totaled $2.5 billion for Medicaid covered services for fully covered populations in SFY 2017. This $2.5 billion expenditure is inclusive of federal funds, general revenues, and restricted receipts, with approximately 41% of spending coming from State sources. The effective Federal Medical Assistance Percentage (FMAP) was 59% on average across the Medicaid program.

Medicaid expenditures for fully covered populations are divided among several state agencies, with $2.1 billion of expenditure managed by the Executive Office of Health and Human Services (EOHHS), $351 million managed by the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH), and $41 million managed by the Department of Children, Youth, and Families (DCYF).

Key Findings:

- During SFY 2017 Rhode Island's Medicaid program served an average of **305,000 enrollees** with full Medicaid benefits. Another 17,600 average enrollees received partial benefits.
- **Total expenditures were $2.5 billion** in SFY 2017 for Medicaid covered services for the fully covered populations. The State spend another $0.2 billion for populations and services eligible for partial Medicaid financing.
- The state share of this expenditure was approximately 41% of total spend.

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

- Between SFY 2015 and 2017, total Medicaid expenditures increased an average of 3.1% per year.
- Enrollment has increased 6.1% per year on average over the last three years.
- Per member per month (PMPM) costs have decreased 2.7% per year, from $729 in SFY 2015 to $690 in SFY 2017.
- These expenditure trends compare quite favorably to both national Medicaid total expenditures and state commercial PMPM cost trends.
- Adults with disabilities account for 29% of expenditure. Elders account for another 24%.
- Hospitals and nursing facilities account for nearly half (42%) 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.

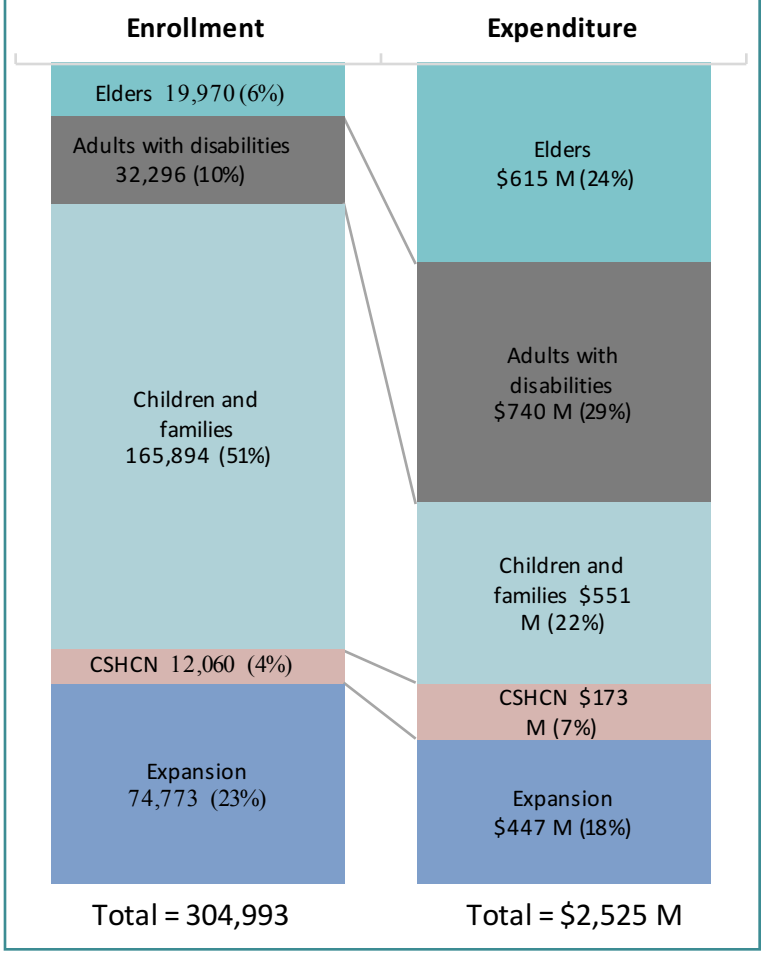
Executive Summary: Populations

Medicaid serves five different primary populations:

- **Elders** includes 19,970 adults over age 65, 95% of whom are also covered by Medicare.[1] Elders account for $615 million in SFY 2017 Medicaid expenditure with an average PMPM cost of $2,566, the highest of the five populations. Nursing facilities account for 56% of expenditures on Elders.
- **Adults with disabilities** includes 32,296 adults under age 65 who have identified disabilities. Almost half (48%) of this population is also covered by Medicare. Adults with disabilities account for the largest share of SFY 2017 expenditure, $740 million, and an average PMPM cost of $1,909. The largest components of expenditure for this population are for residential and rehabilitation services for persons with intellectual and developmental disabilities and for hospital care.
- **Children and families** includes 165,894 low income children, parents and pregnant women who meet specific income requirements. Children and families account for 51% of total enrollment and 22% of total expenditure, with total SFY 2017 expenditure of $551 million and an average PMPM of under $300. Most expenditure on this population is for hospital care and professional services. Ninety-four percent of this population is enrolled in managed care.
- **Children with special health care needs (CSHCN)** includes 12,060 individuals under 21 who are eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. These children account for 4% of enrollment and 7% of total Medicaid expenditures, with SFY 2017 expenditures of $173 million. Eighty-two percent of this population is enrolled in managed care.
- **Expansion** includes 74,773 low income adults without dependent children. The Expansion population, newly eligible under the ACA in 2014, account for 23% of SFY 2017 enrollment and 18% of total expenditure, or $447 million. This population mainly uses hospital and professional services. Nearly all (93%) were enrolled in managed care.

Medicaid Enrollment/Expenditure by Population

SFY 2017 - $ Millions



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

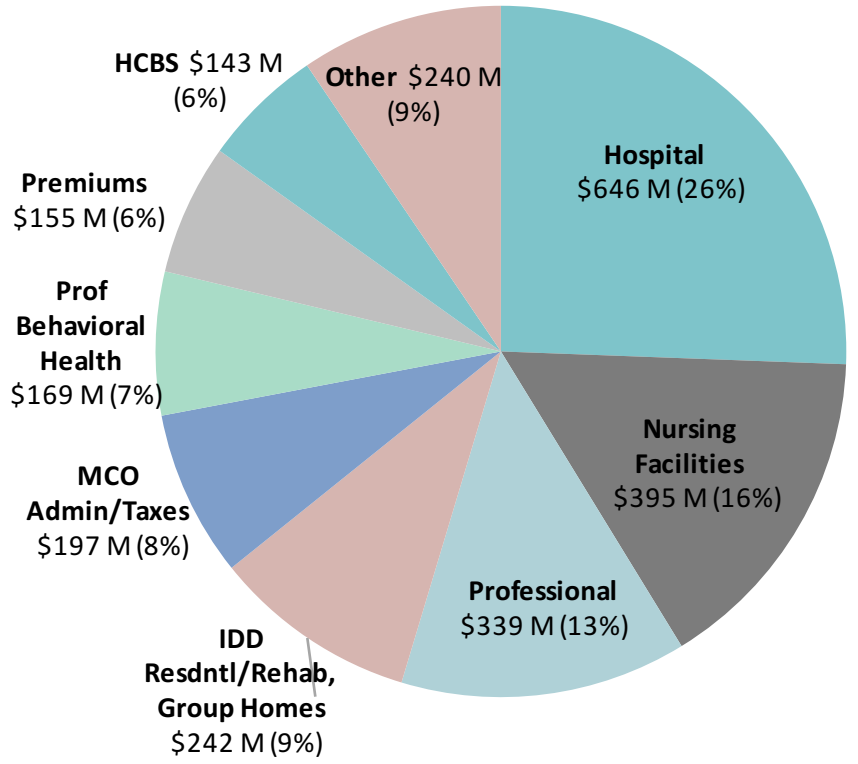
Executive Summary: Medicaid Providers

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

- Hospitals were the largest provider type, accounting for 26% of expenditures for fully covered Medicaid recipients in SFY 2017.[1]
- Hospital expenditures increased at 3.7% annually over the last three years.
- Nursing facilities (including both nursing homes and hospice) were the next largest provider type, accounting for 16% of expenditure.
- Total Medicaid payments to nursing facilities have been increasing on average 4.8% per year between SFY 2015-2017.
- The provider type with the highest average annual growth rate was home and community based services (HCBS), increasing at 10.5% on average over the last 3 years.
- This year's report breaks out administrative fees paid to managed care organizations (MCOs) as a separate provider type category. In previous years these expenditures were allocated across provider types. In SFY 2017 MCO admin fees and taxes accounted for 8% of expenditures.

Medicaid Expenditure by Provider Type

SFY 2017 - $ Millions – Total $2.5 B



Other includes pharmacy, and Slater Hospital, Tavares and Zambarano. The **IDD** provider type includes residential and rehabilitation services and group homes for persons with intellectual and developmental disabilities.

[1]When including those expenditures otherwise excluded from this report's analytics, hospitals expenditures increase to 29% of State's total Medicaid-related medical benefits outlays.

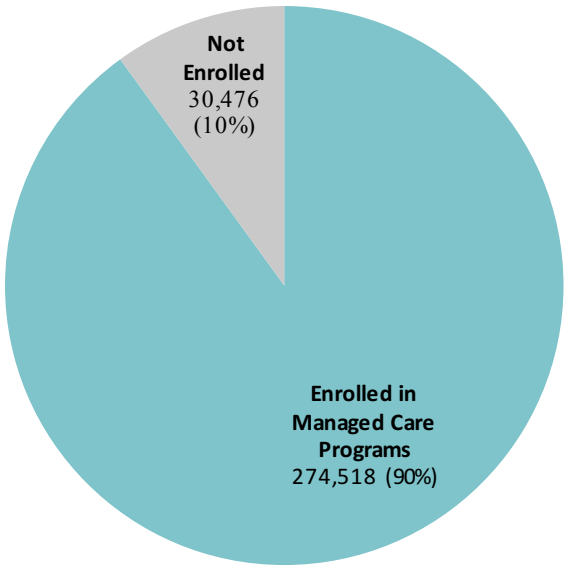
Executive Summary: Managed Care

For the 90% of Medicaid eligibles enrolled in managed care in SFY 2017, payments are made by Medicaid to the managed care plans rather than directly to service providers. These enrolled populations account for 78% 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 23% of eligibles are enrolled in managed care through Medicaid Expansion.
- Three percent of managed care enrolled eligibles make up 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.
- Five percent are enrolled in Rhody Health Options (RHO) and two percent are enrolled in the Integrated Care Initiative (ICI), which are fully capitated managed care programs for long term care, long term services and supports, and other Medicaid-funded services designed primarily for eligibles with both Medicaid and Medicare eligibility.
- 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 5.0 by the National Committee for Quality Assurance (NCQA). Tufts Health Plan began enrolling Medicaid members in SFY 2018 and will be reflected in the SFY 2018 version of this report.
- Two percent of Medicaid eligibles are enrolled in RIte Share, a premium assistance program for Medicaid eligibles with access to commercial insurance. This minimizes Medicaid expenditure by leveraging the employers' contributions.

Medicaid Eligibles by Enrollment

SFY 2017 – Total 304,993 Eligibles



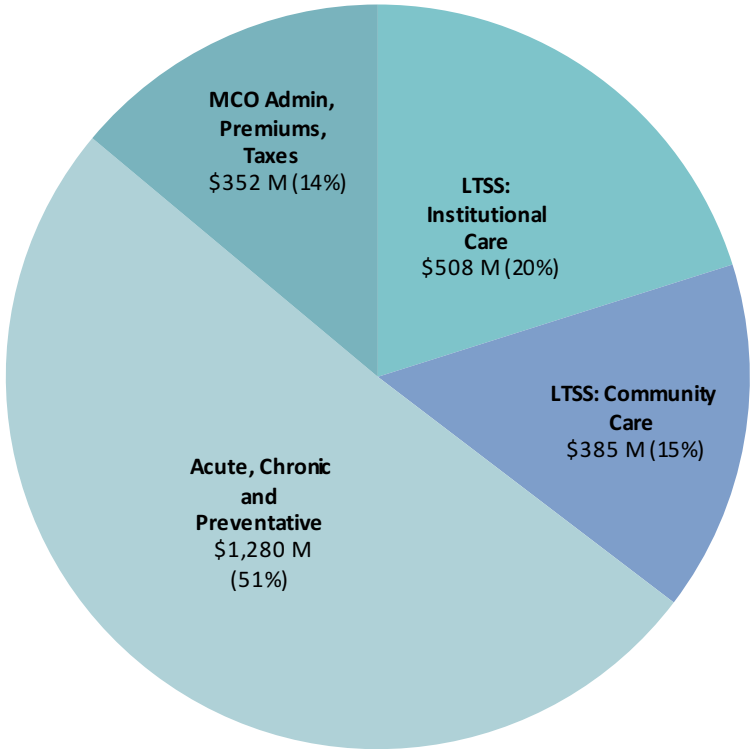
Executive Summary: Long Term Services and Supports

Long term services and supports (LTSS) include institutional care and community care. These services are mainly focused on the Elders and Adults with disabilities populations. Expenditures on LTSS account for $893 million in total Medicaid expenditure in SFY 2017, 35% of total.

- Community care services are provided to at-risk populations as alternatives to more costly nursing home/institutional options and account for $385 million, 43% of the LTSS expenditure. Community care includes home and community-based services (HCBS), residential and rehabilitation services for the intellectually and developmentally disabled, and group homes
- Institutional care services account for the remaining $508 million of LTSS expenditure. The largest category is nursing home services, accounting for 41% of LTSS expenditure overall. Other institutional care expenditure is for hospice and care in the Slater Hospital, and the Tavares and Zamabarano facilities.
- The balance of expenditure between nursing facilities (part of institutional care) and HCBS (part of community care)has been shifting over the last 5 years. In SFY 2017 HCBS accounted for 27% of the combined expenditure on both nursing facilities and HCBS compared to 21% in SFY 2013.
- Expenditure on HCBS has been growing at 10.5% per year on average over the last 3 years. Nursing home expenditure has been growing at 4.8% per year on average.
- Acute, chronic and preventive services and MCO admin, premiums and taxes account for the remaining 65% of Medicaid expenditure.

Medicaid Expenditure by Provider Type Category

SFY 2017 -- $ Millions – Total $2.5 B



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.
- In order to better examine the characteristics of this population, this report defines "high cost" users as those with over $15,000 of claims expenditure per year, adding another 3 percent of users to the top 6%. Therefore, 9% 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.
- High cost users can be divided into three categories: those who reside in institutions or residential facilities; those receiving maternity/delivery services; and the remainder who presumably reside "in the community." These community high cost users account for $687 million of claims expenditure in SFY 2017.
- Over half (59%) of community high cost user expenditure is for adults with disabilities and the Expansion population.
- Hospital inpatient and outpatient claims expenditure together account for 42% of community high cost user expenditure.
- Thirty-one percent of community high cost user claims expenditure is related to a diagnosis of mental disorders, including mental health and substance use.

Medicaid User Claims Expenditure

*SFY 2017 -- $ Millions – Total $2.0 B**

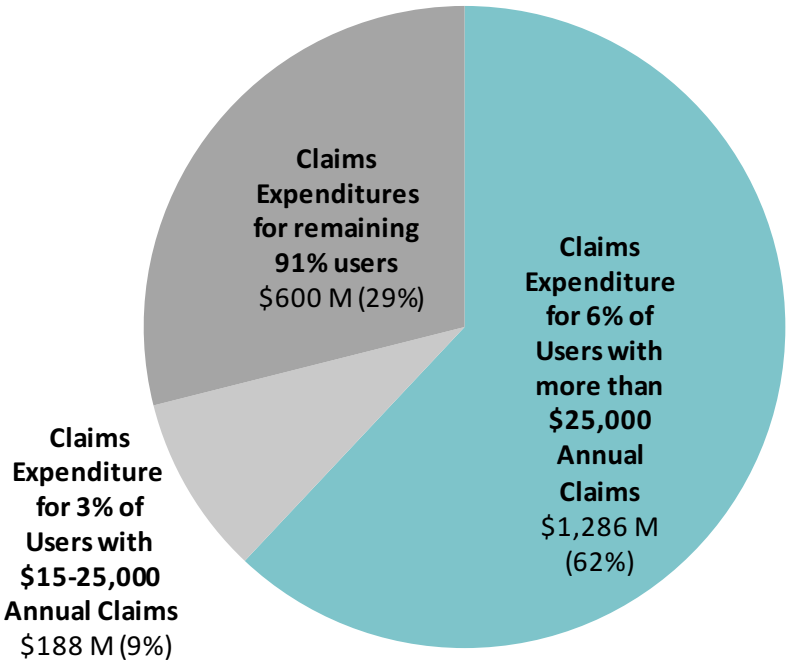


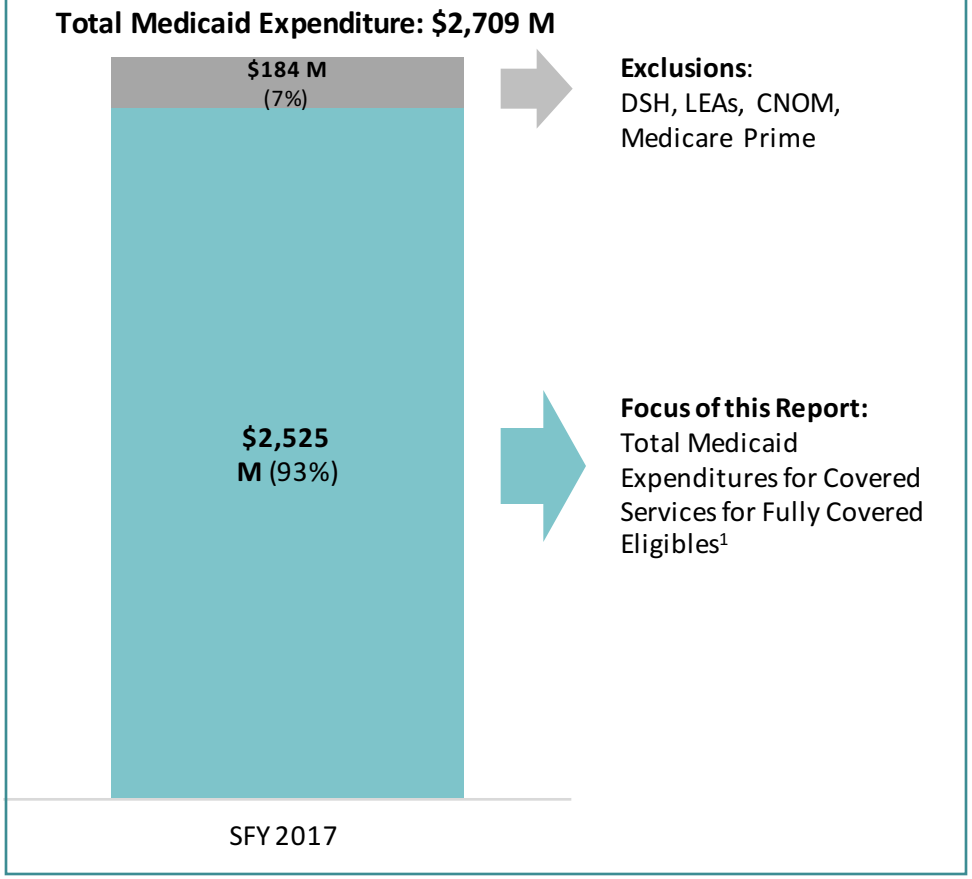
*Chart shows claims-specific payments only. Certain expenditures are not attributable to specific users.

Total Expenditures: Definitions and Exclusions

Medicaid expenditures in SFY 2017 totaled approximately $2.7 billion. Expenditures for covered services for fully covered populations, the focus of this report, totaled $2,525 million.

Summary: Total Medicaid Expenditures

SFY 2017 - $ Millions



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

- Medicaid expenditure is split between state and federal funds. This report includes all Medicaid expenditures, including both state and federal funds.
- The focus of this report is expenditures for covered services for fully covered populations. Certain expenditures and populations are excluded from the following pages of detailed analyses, including:
  - $140 million in Disproportionate Share Hospital (DSH) statutorily required payments intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety-net hospitals
  - $18 million in payments to Local Education Authorities (LEAs) for certain Medicaid services provided to students with special needs.
  - $16 million in CNOMs (costs not otherwise matchable) for certain state programs not traditionally allowable under Medicaid fund matching rules that can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible.
  - $10 million in Medicare Prime payments for individuals at qualifying income levels who only receive assistance with their Medicare premium payments.
- More detail on excluded payments is provided in the Appendix.

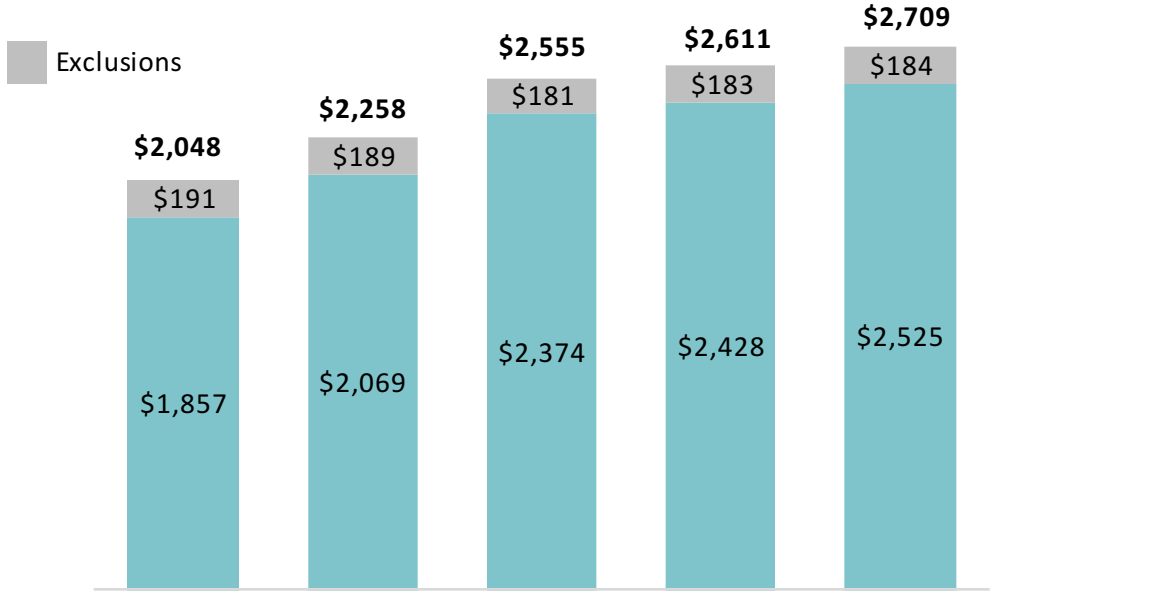
Note: This report looks at Medicaid expenditures for covered services and does not include state overhead and administrative costs related to managing the Medicaid program.

Medicaid Expenditure Trends

Following stabilization of ACA implementation in SFY 2015, Rhode Island Medicaid expenditures **increased 3.1% per year on average** from SFY 2015 to SFY 2017.

Total Medicaid Expenditure for Covered Services[1]

SFY 2013-2017 - $ Millions



	SFY13	SFY14	SFY15	SFY16	SFY17	**Avg Annual Growth SFY 2015-2017[2]**
Annual Expenditure Growth (net of exclusions)		10.9%	13.7%	2.3%	4.0%	**3.1%**

- Starting January 1, 2014, Rhode Island expanded Medicaid coverage to adults without dependent children and with incomes under 138% FPL. Expenditure on this population during SFY 2017 was $447 million and is included in the $2,525 million in expenditure for fully covered populations.
- Expenditure trends in this year's report focus on the three years since implementation of the ACA stabilized in SFY 2015. Therefore average annual trends shown here and on subsequent pages are based on the past 3 years. Previous years of this report showed a 5 year trend.
- Net of exclusions, expenditure increases for SFY 2015-2016 and SFY 2016-2017 were 2.3% and 4.0% respectively.

[1]Annual expenditure includes the spending for both fully covered and partially covered enrollees

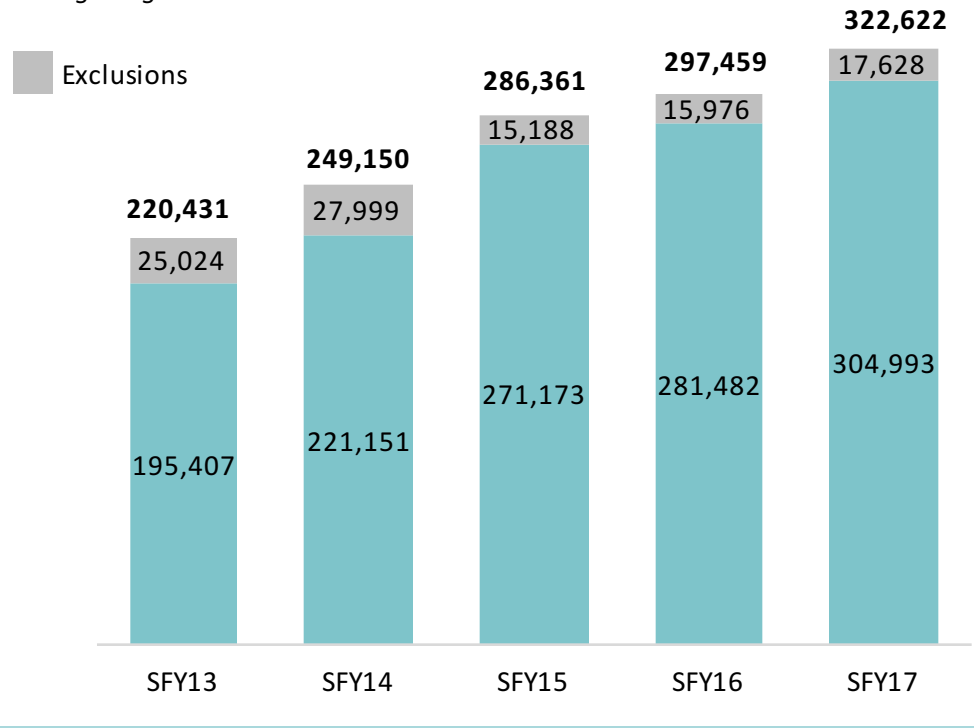
[2]Calculated as compounded annual growth rate (CAGR) over period SFY 2015-2017 as shown.

Medicaid Expenditure Trends: Enrollment

Average annual Medicaid enrollment of fully covered populations has **increased 6.1% per year on average** over the last 3 years.

Total Medicaid Enrollment

Average Eligibles - SFY 2013-2017



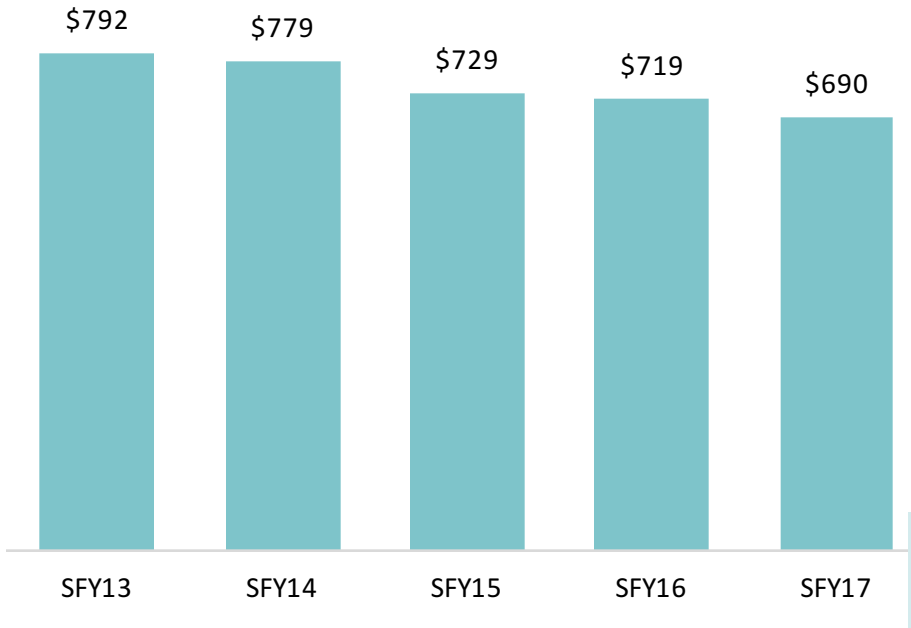
	SFY14	SFY15	SFY16	SFY17	Avg Annual Growth SFY 2015-2017
Annual Eligibles Growth (net of exclusions)	13.2%	22.6%	3.8%	8.4%	**6.1%**

- Total Medicaid enrollment increased 8.4% from SFY 2016 to SFY 2017. This includes the Expansion population.
- Excluded populations are members eligible for partial benefits such as individuals who receive assistance only with their Medicare premium payments and populations receiving services under a CNOM program.
- ACA implementation on January 1, 2014, resulted in enrollment increases for both Expansion and non-Expansion populations, as eligibility rules changed and outreach increased.

Medicaid Expenditure Trends: PMPM

Average annual Medicaid PMPM has **decreased 2.7% per year on average** over the last 3 years.

Total Medicaid PMPM – Fully Covered Populations/Services
SFY 2013-2017



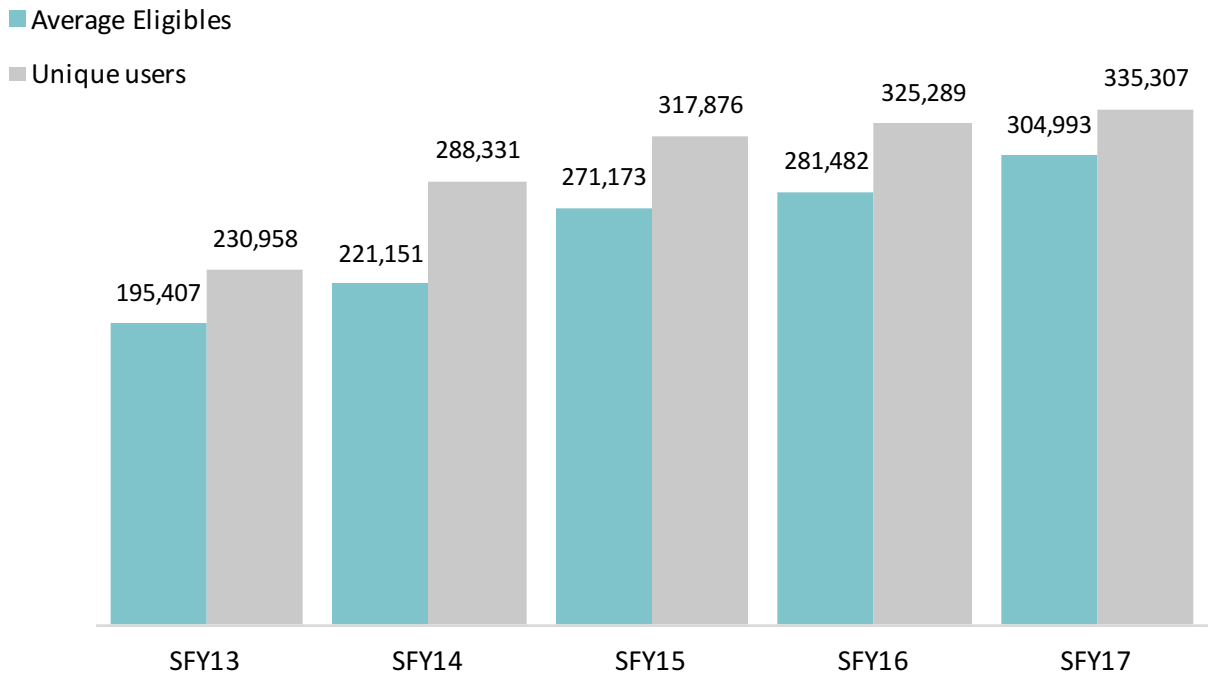
					Avg Annual Growth SFY 2015-2017
Annual PMPM Change (net of exclusions)	-1.6%	-6.4%	-1.4%	-4.0%	**-2.7%**

- The average PMPM for fully covered populations is $690 in SFY 2017, a decrease of 4.0% from SFY 2016.
- The steady decline in the average PMPM is reflective of the change in the overall nature of the State's enrolled Medicaid population, with growth since at least January 2014 being heavily concentrated among the non-disabled children and adults who have comparatively low costs.
- The reduction is also attributed to the implementation of the Raimondo Administration's Reinventing Medicaid initiatives in SFY 2016 that included certain programmatic changes, such as a 2.5% cut to hospital reimbursement rates, a 2.0% cut to nursing home reimbursement rates, and savings for new care coordination initiatives between the managed care organizations and providers.

Medicaid Expenditure Trends: Unique Recipients

About one-third of Rhode Island's population was enrolled in Medicaid for some part of SFY 2017.

Average Eligibles and Unique Recipients - Fully Covered Populations/Services
SFY 2013-2017



	SFY13	SFY14	SFY15	SFY16	SFY17
Turnover Ratio	1.18	1.30	1.17	1.16	1.10
Unique Recipients % of RI Pop[1]	22%	27%	30%	31%	32%

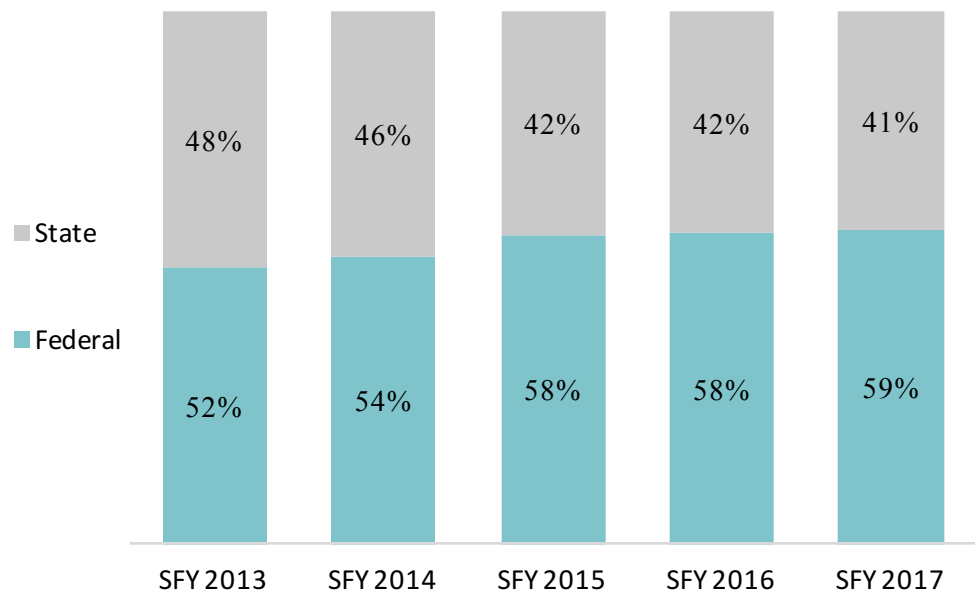
[1]Source: Population Division, US Census Bureau.

- Unique recipients is a measure of the number of individuals enrolled in Medicaid at any time during the fiscal year. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- The turnover ratio compares unique recipients to average eligibles. If the number of unique recipients is equal to the average eligibles, that indicates that there is a steady population of eligibles who remain on the program for the full year. If the number of unique recipients is above the average eligibles (a turnover ratio of >1), this indicates that some Rhode Islanders are using Medicaid for shorter periods of time.
- The higher turnover ratio for SFY 2014 is due to the fact that the Expansion population was enrolled for at most 6 months of the year and many were enrolled for less than that. In SFY 2015-2017, 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.

Effective Federal Medicaid Assistance Percentage (FMAP)
SFY 2013-2017



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

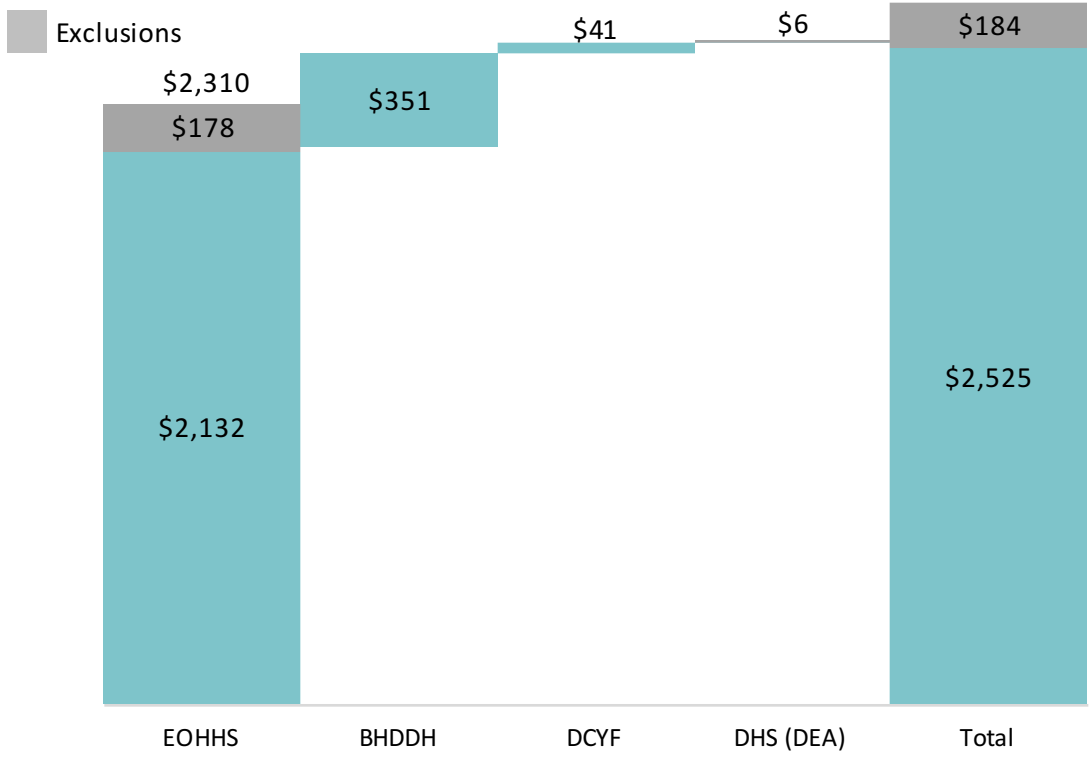
- While this report will review trends in total Medicaid medical expenditure, it is important to recognize that less than half of this expenditure falls to the Rhode Island budget.
- The chart at left shows effective state share across the Medicaid program, taking into account several variations from the basic FMAP levels, including:
  - The FMAP for the Medicaid Expansion population is 97.5% for SFY 2017. For SFY 2018 it is expected to be 94.5%.
  - The enhanced FMAP for the CHIP program was 88.61% in SFY 2017. The CHIP program provides full Medicaid benefits to uninsured children and pregnant women from families with incomes up to 250% of the federal poverty level. In SFY 2017, there were 24,850 average CHIP enrollees.
  - 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 (85%) is administered by EOHHS.

Expenditure by Department

SFY 2017 - $ Millions

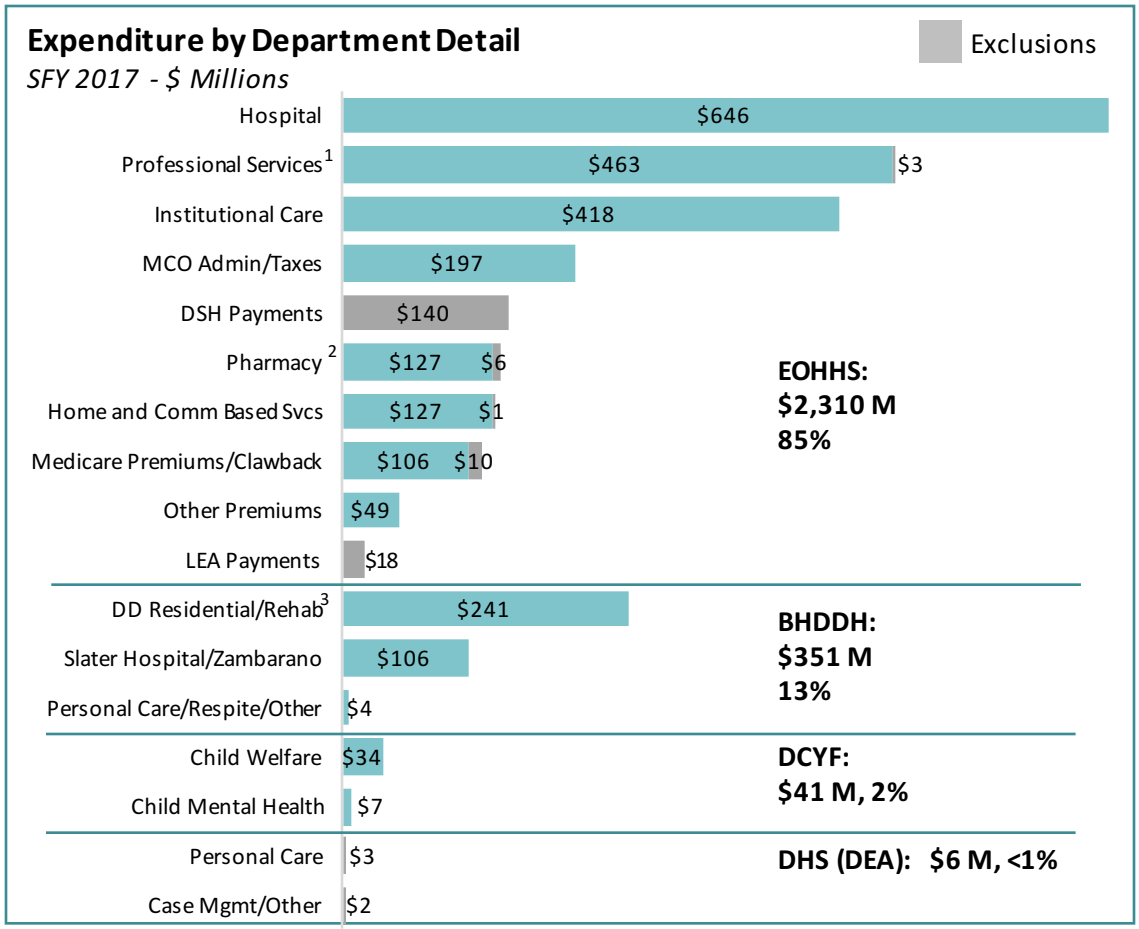


	EOHHS	BHDDH	DCYF	DHS (DEA)	Total
% of Total	85%	13%	2%	<1%	100%
Avg Annual Expenditure Change 2015-7 (Fully covered populations/services only)	3.4%	1.6%	2.8%	-0.1%	3.1%

- In SFY 2017, 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 (13%). Note that funding for intensive behavioral health services was transferred from BHDDH to EOHHS as of July 1, 2014.
- Detail for each department is shown on the next page.

Expenditure by Department: State Agency Detail

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



[1]Includes professional services for behavioral health.
[2]Total 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.

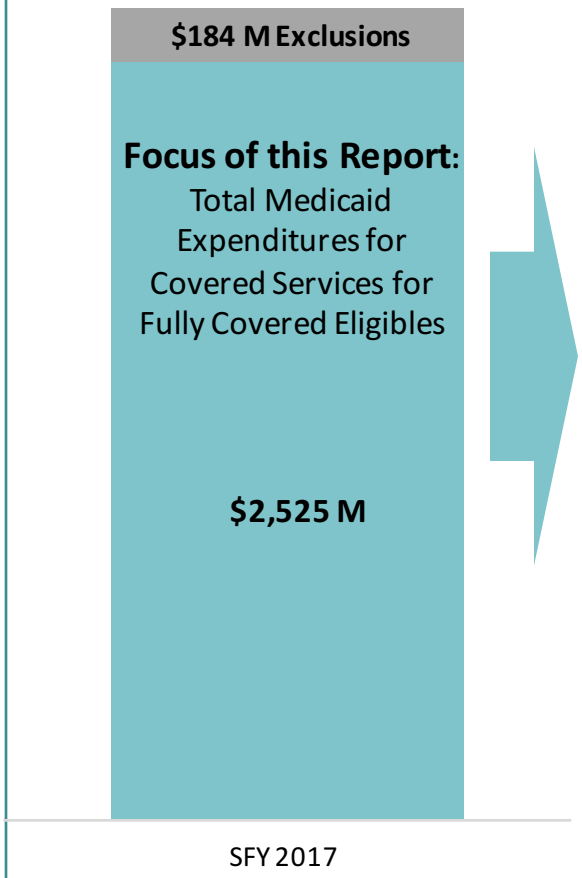
- EOHHS overall accounts for 85% of Medicaid expenditure. The biggest portion of that is for hospital-based services, accounting for 24% of EOHHS expenditure. Professional services account for 17% of EOHHS expenditure, and institutional care is another 15%.
- BHDDH expenditures include three primary areas: the management of Slater Hospital, residential facilities for persons with intellectual and developmental disabilities, and community based services.
- DCYF accounts for $41 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.
- DHS accounts for $6 million of Medicaid expenditure. This is mainly CNOM expenditure designed to forestall the need for persons served to become fully Medicaid eligible.

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, accrual vs. paid amounts, provider payouts, capitation vs. claim amounts, and rounding.

Expenditure Distributions

Medicaid expenditures can be broken down in several ways.

Medicaid Expenditures for Covered Services
SFY 2017 - $ 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
- MCO Admin/Taxes

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)

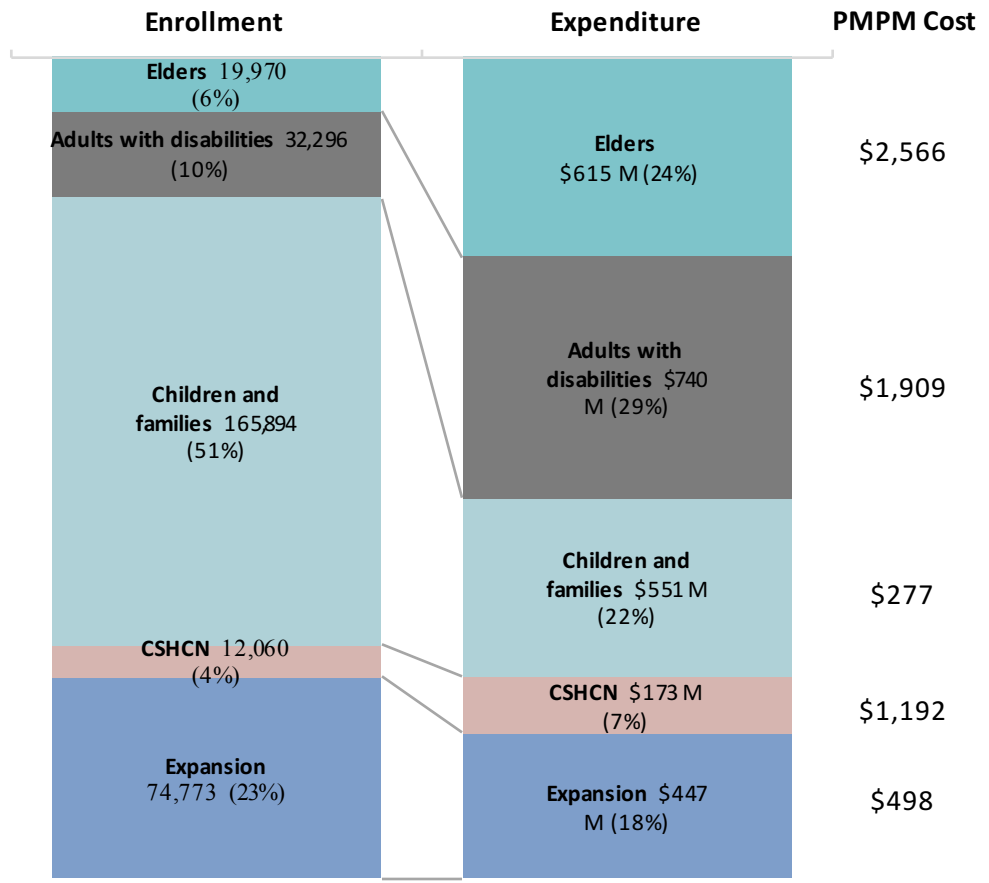
Breakdown by program shows expenditure by type of managed care program and amount of fee-for-service spending

Expenditure by Population

The Medicaid program served an average of 304,993 eligibles in SFY 2017 at an average cost per member per month of $690. However, PMPM costs vary considerably by population.

Medicaid Enrollment/Expenditure/PMPM by Population

SFY 2017 - $ Millions

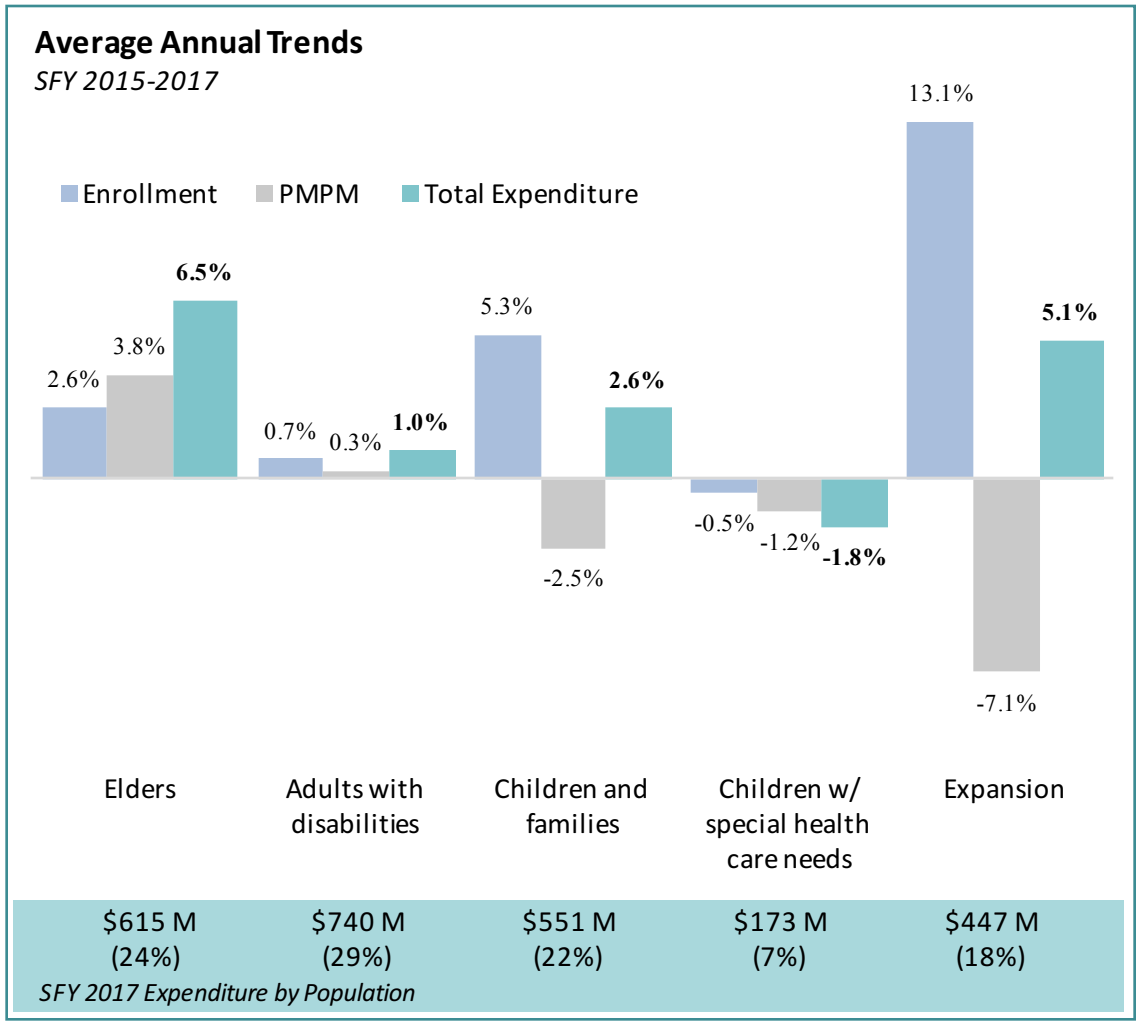


Total Program	304,993	$2,525 M	$690

- **Elders** are adults over age 65, including those also eligible for Medicare. Elders account for 6% of enrollment and 24% of expenditure, with a PMPM cost of $2,566.
- **Adults with disabilities** are adults under age 65 who have identified disabilities. They account for 10% of enrollment and 29% of expenditure, with a PMPM cost of $1,909.
- **Children and families** are low income children, parents and pregnant women who meet specific income requirements. This population accounts for over half of total enrollment (51%) and 22% of total expenditure, with a PMPM cost of $277.
- **Children with Special Health Care Needs (CSHCN)** are individuals under 21 eligible for Supplemental Security Income (SSI), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. CSHCN account for 4% of eligibles and 7% of expenditure at a PMPM of $1,192.
- **Medicaid Expansion** are adults without dependent children and with incomes under 138% FPL who were newly eligible for Medicaid as of January 1st 2014 under ACA expansion rules. Medicaid Expansion accounts for 23% of eligibles and 18% of overall expenditure, with a PMPM of $498.

Expenditure by Population: Trends

Expenditure trends between SFY 2015 and SFY 2017 differed for the various population groups.



The total expenditure trend can be broken into two composite pieces - the per member per month (PMPM) **cost** trend and the enrollment, or **volume**, trend. Over the last three years, between SFY 2015 and SFY 2017:

- Elders experienced a 6.5% average annual increase in expenditures. This composite increase is due to a combination of a 3.8% annual increase in PMPM and a 2.8% annual increase in enrollment.
- Adults with Disabilities expenditures increased 1.0%, with PMPM cost contributing 0.3% and volume contributing 0.7% to composite average annual increase.
- Children and Families experienced a 2.6% average annual expenditure growth rate due to the interaction between a 5.3% average annual increase in volume offset by a 2.5% average annual reduction in PMPM cost.
- Children with Special Healthcare Needs experienced an overall negative growth rate of 1.8% resulting from negative volume and cost trends of 0.5% and 1.2%, respectively.
- The Expansion population expenditures increased 5.1% annually, with a 13.1% average annual increase in enrollment offset by a 7.1% average reduction in PMPM.

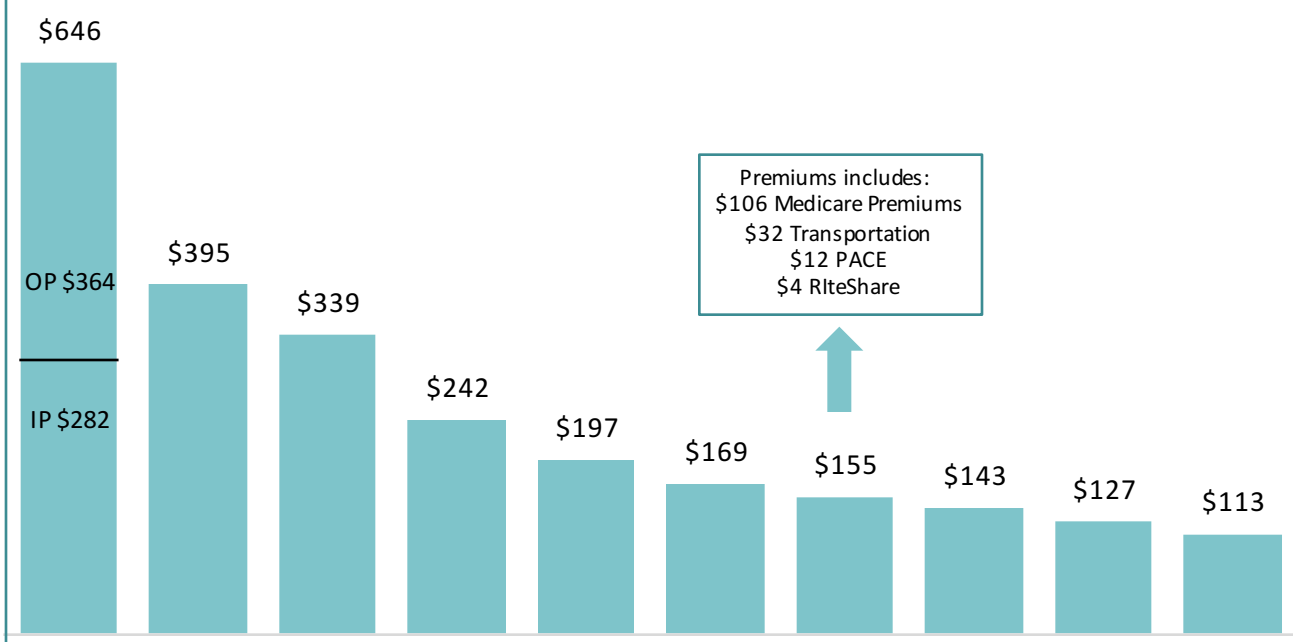
Expenditure by Provider Type

Medicaid program funds are used to reimburse a variety of providers. Together, hospitals and nursing facilities account for over forty percent of program expenditure in SFY 2017.

Medicaid Expenditure by Provider Type

SFY 2017 -- $ Millions

Total: $2,525 M



	Hospital	Nursing Home /Hospice	Professional	IDD Resdntl/ Rehab, Group Homes	MCO Admin /Taxes	Professional BH	Premiums	Home and Comm Based Svcs	Pharmacy	Slater Hosp/ Zambarano/ Tavares
% of 2017 Expenditure	26%	16%	13%	10%	8%	7%	6%	6%	5%	4%
Avg Ann Growth 2015-17	3.7%	4.8%	2.8%	3.4%	6.9%	-8.5%	7.5%	10.5%	0.8%	-1.3%

- Hospitals were the largest provider type, accounting for 26% of Medicaid expenditures in SFY 2017. Hospital payments have increased 3.7% per year on average over the last 3 years.
- Nursing facilities and professional services accounted for 16% and 13% of expenditures respectively.
- This year's report breaks out managed care organization (MCO) administrative costs and taxes separately for all years of data shown. In previous years these expenditures were allocated across the other provider types. In SFY 2017, 8% of expenditures went to MCO administration and state and federal taxes and fees assessed against MCOs.
- Detailed definitions of each provider type is included on the next page.

Expenditure by Provider Type: Definitions

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

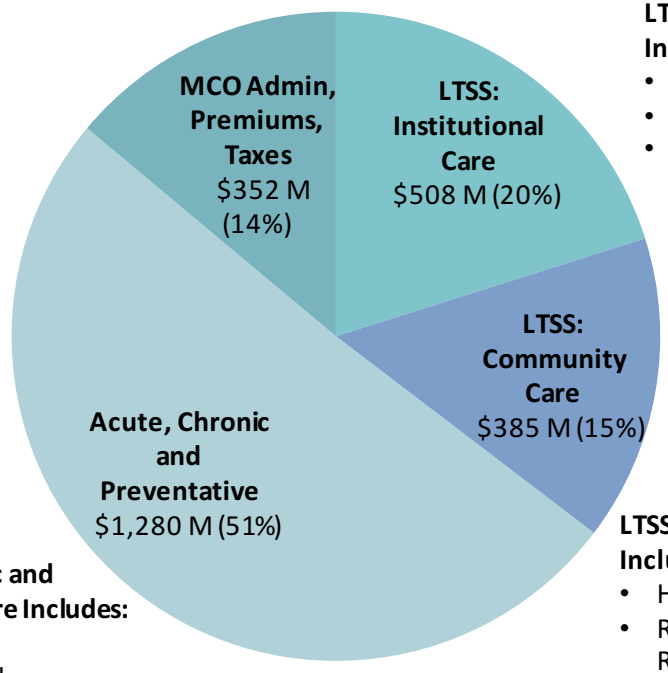
Acute, Chronic and Preventive Care	Hospital	Hospital includes inpatient and outpatient services.
	Professional	Professional includes physician, dental, DME/supplies, x-ray/lab/tests, ambulance, etc.
	Professional BH	Professional Behavioral Health includes DHS, BHDDH and DCYF services including, but not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

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 2017 -- $ Millions

Total: $2,525 M



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

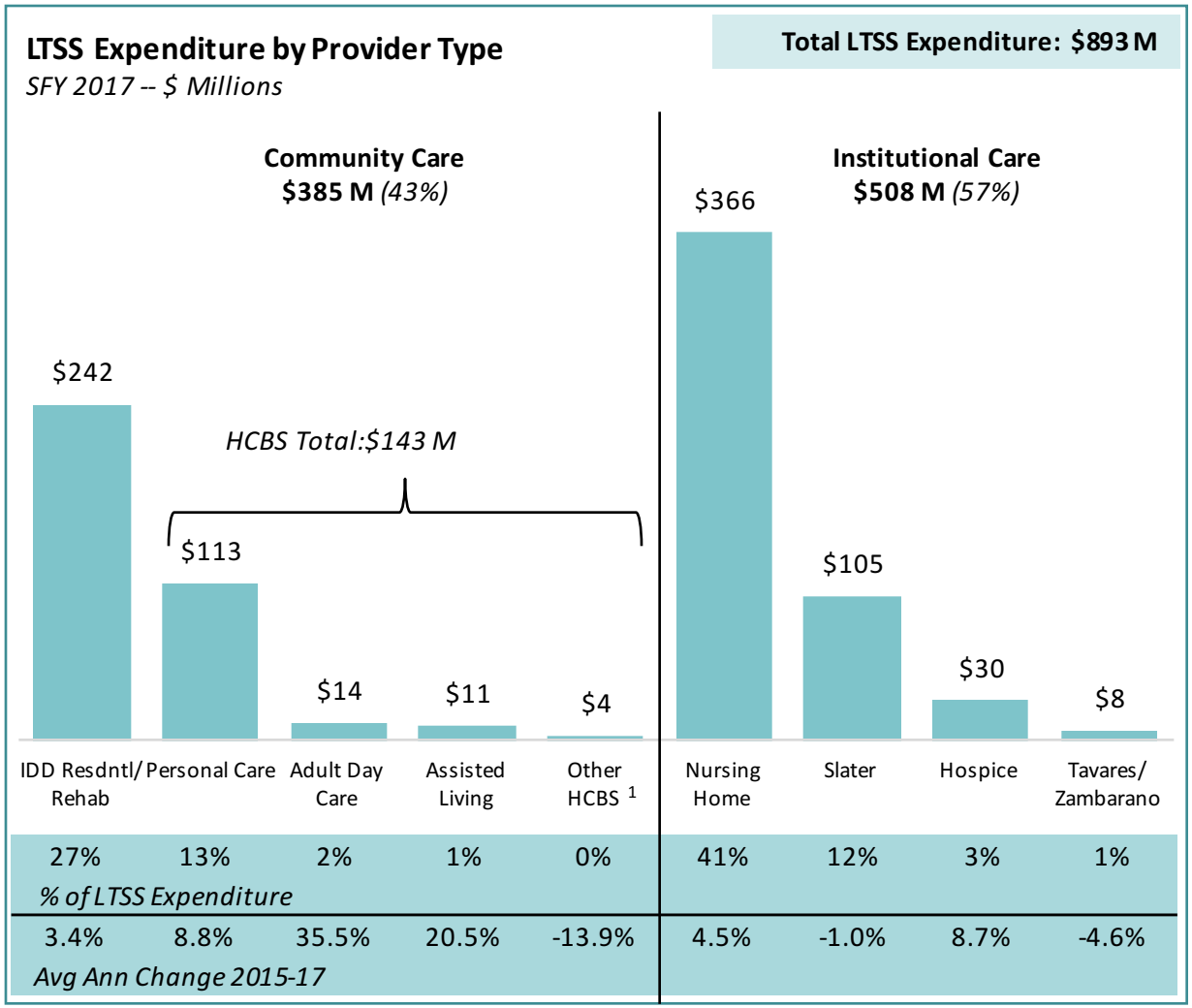
LTSS Community Care Includes:
- HCBS
- Residential and Rehab Services for the Intellectually and Developmentally Disabled
- Assisted Living
- Public and Private IDD Group Homes

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

- 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 (HCBS), residential and rehabilitation services for the intellectually and developmentally disabled, and group homes.
- Another 51% of Medicaid expenditure is for acute, chronic, and preventive care services such as hospital, professional services, and pharmacy.
- The remaining 14% of expenditure is for MCO administrative costs, premiums and taxes.
- There are several ways to categorize Medicaid-provided services. Other reports may group together services in different ways for different needs.

Provider Type Detail: LTSS Detail

Long term services and supports, including both institutional care and community care, accounted for $893 million in SFY 2017, about 35% of Medicaid expenditure.



- 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 57% of LTSS expenditure. The largest category of institutional care is nursing homes, accounting for 41% of LTSS spending and 72% of spending on institutional care.
- Forty-three percent of long term services and support expenditure ($385 million) is for Community Care services, including services for the IDD population and HCBS.
- The HCBS growth rate of 8.8% is due in part to a 7.5% rate increase in October 2016. These services, such as personal care and assisted living, are less expensive alternatives to nursing home or institutional options.

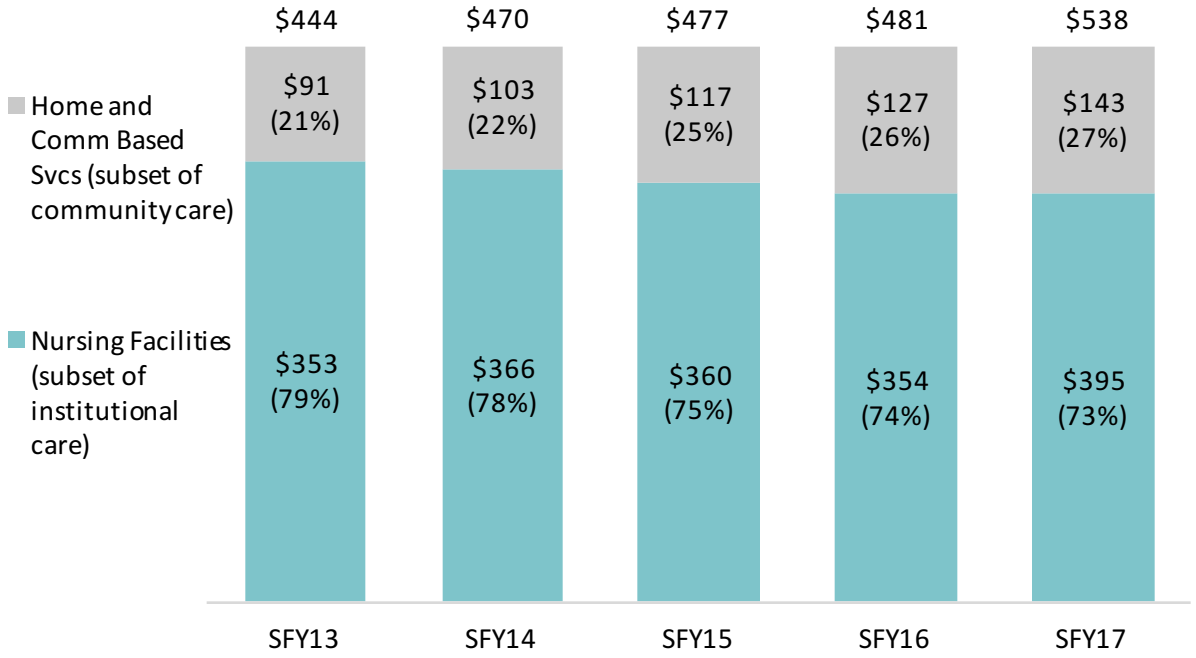
[1]Other HCBS includes DME (e.g. Home Modifications), Case Management, Meals, Shared Living and other.

LTSS Detail: 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 2013-2017 -- $ Millions



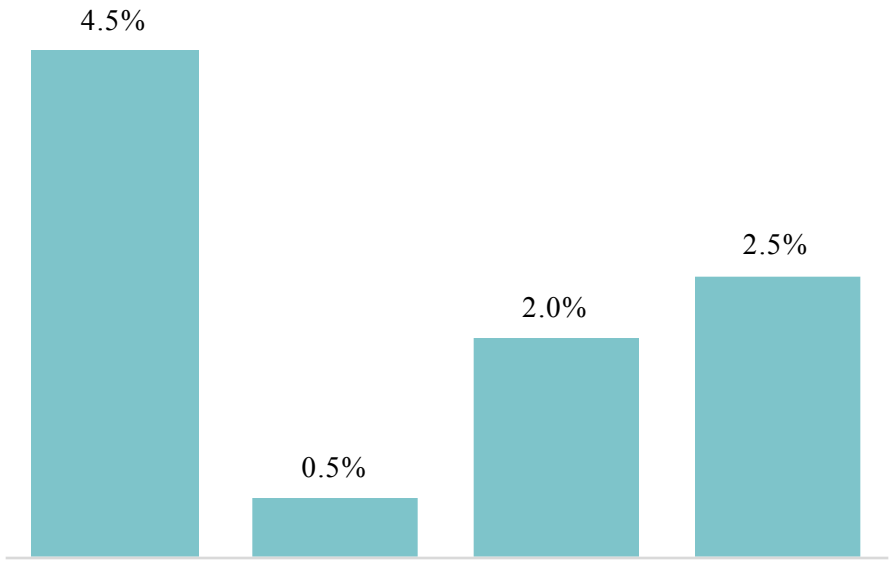
% Change in HCBS Expenditure	3.8%	-1.8%	-1.7%	11.7%
% Change in Nursing Facilities Expenditure	13.5%	13.1%	8.9%	12.1%

- A key consideration for LTSS services is the transition away from nursing facilities and into home and community based services (HCBS).
- The chart at left shows just HCBS and nursing facility expenditure, excluding other LTSS expenditure on IDD and on Slater Hospital, Zambarano and Tavares.
- 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 2017 HCBS accounted for 27% of the total expenditure on both nursing facilities and HCBS compared to 21% in SFY 2013.

LTSS Detail: Nursing Home Trends

Nursing home expenditure has increased 4.5% per year on average since SFY 2015.

Nursing Home Services Average Annual Trend Rates
SFY 2015-2017



	Nursing Home Expenditure	Nursing Home Days/thousand (Elders and adults with disabilities)	Nursing Home Total Days	Nursing Home Cost per Day
SFY 2017 Value	$366 M[1]	37,757	1,973,411	$185/day

- Nursing home expenditure accounted for $366 million[1] in SFY 2017. SFY 2017 expenditures are consistent with EOHHS' year-end accrual for nursing home payments net of anticipated recoupments against advances paid within the fiscal year. This amount may be revised in subsequent Medicaid Expenditure Reports.
- Over the last three years, nursing home days per thousand for elders and adults with disabilities increased by 0.5% per year on average. Nursing home days in total increased 2.0% per year on average.
- Nursing home cost per day (calculated as total expenditure divided by total days) has increased from $174 to $185 between SFY 2015 and SFY 2017, about 2.5% on average per year. Cost per day reflects payment by EOHHS after deducting member patient share.
- Total expenditure for nursing homes includes allocated premium payments and advances, so the calculated cost per day shown here may differ from the actual payment rates and rates shown in other reports.

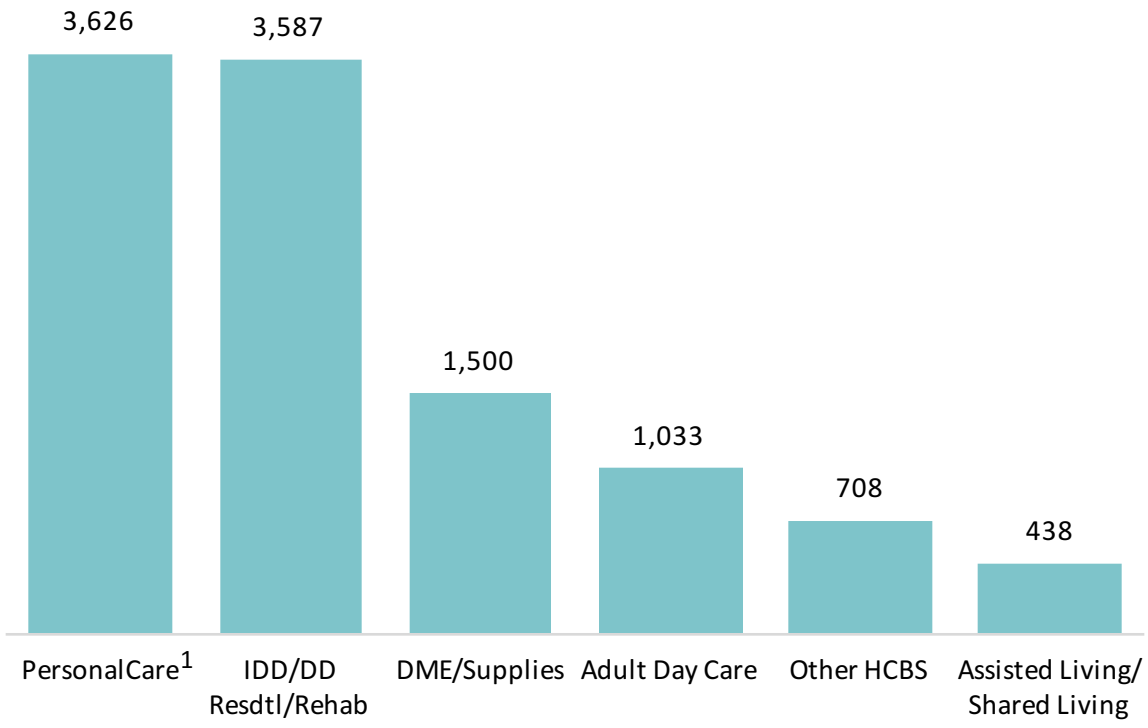
[1]Total spending on Nursing Home, Skilled Nursing Home, and Hospice care was $395 million.

LTSS Detail: HCBS Utilization

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

Home and Community Based Services
Average Monthly Census
SFY 2017

Elders and Adults with Disabilities
Average Eligibles = 32,296



- The largest category of home and community based services (HCBS) is personal care services, with an average monthly census for elders and adults with disabilities of 3,626 recipients in SFY 2017.
- Residential and rehabilitation services for intellectually and developmentally disabled individuals had an average monthly census in SFY 2017 of 3,587 recipients and a growth rate of 0.8% since SY 2015.
- The category with the highest increase in average monthly census is adult day care, with an average annual increase of 13.7% per year over the last 3 years.
- Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.
- Utilization data for members receiving services under the ICI program is not available in a form to be included in this chart. Due to this missing data, these census totals and growth rates may be understated.

[1]Personal Care includes support for activities of daily living (ADLs) in a rehabilitative or long term care setting.

Expenditure by Managed Care Enrollment Status

Overall, 66% of total Medicaid expenditure is paid through managed care programs.

Expenditures by Managed Care Enrollment Status
SFY 2017

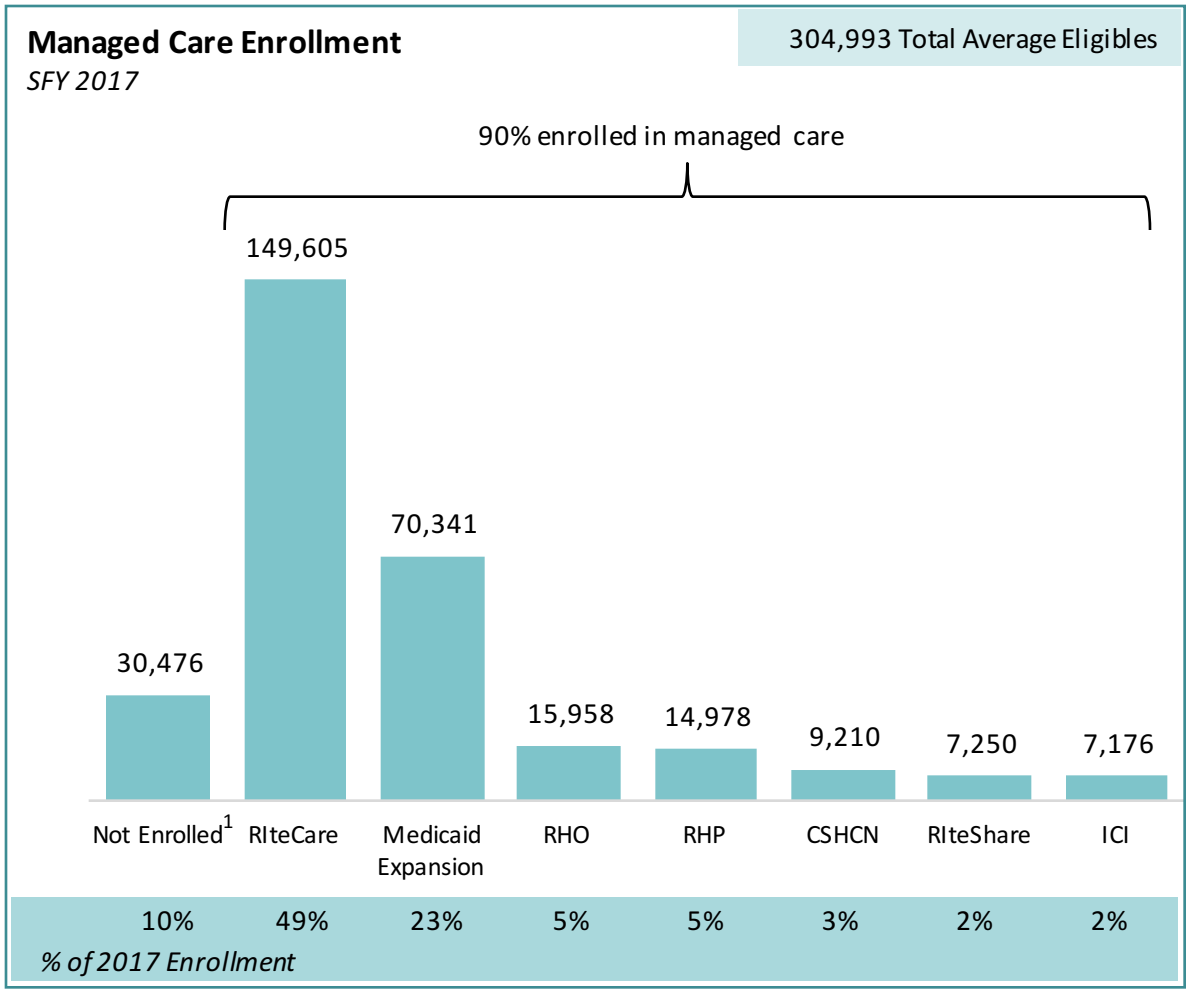
	Managed Care Enrolled *274,518 Eligibles (90%)*	Not Enrolled[1] *30,476 Eligibles (10%)*	Total Expenditure
Managed Care Expenditure	**$1,668 M** **66%** Managed Care Expenditure for Managed Care Enrolled Eligibles		**$1,668 M** **66%**
Other Expenditure	**$294 M** **12%** Other Expenditure for Managed Care Enrolled Eligibles (*for services not covered by Managed Care)*	**$563 M** **22%** Expenditure for Eligibles Not Enrolled in Managed Care	**$934 M** **34%**
Total Expenditure	**$1,962 M** **78%**	**$563 M** **22%**	**$2,525 M**

[1]Unenrolled populations include 2,880 Medicaid eligibles enrolled in a primary care case management (PCCM) service where Medicaid paid providers for enhanced care management within the fee-for-service structure. EOHHS eliminated this program in November 2017 (SFY 2018).

- 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 (78%) of Medicaid expenditure in SFY 2017.
- Of the $1,962 million in expenditure on managed care enrolled populations, $1,668 million was paid through managed care programs, accounting for 66% of total Medicaid expenditure.
- The remaining $294 million in expenditure on managed care enrolled populations was paid for FFS claims and Medicare/transportation premiums for managed care enrolled eligibles.
- FFS claims for managed care enrolled populations include services such as NICU, adult dental care, and wrap payments for federally qualified health centers (FQHC), as well as the long-term care services and supports for the ID/DD population administered by BHDDH. In January 2016 (SFY 2017), the MCOs began paying for certain behavioral health services and specialized services for children with special healthcare needs that were previously paid on a FFS basis.

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.

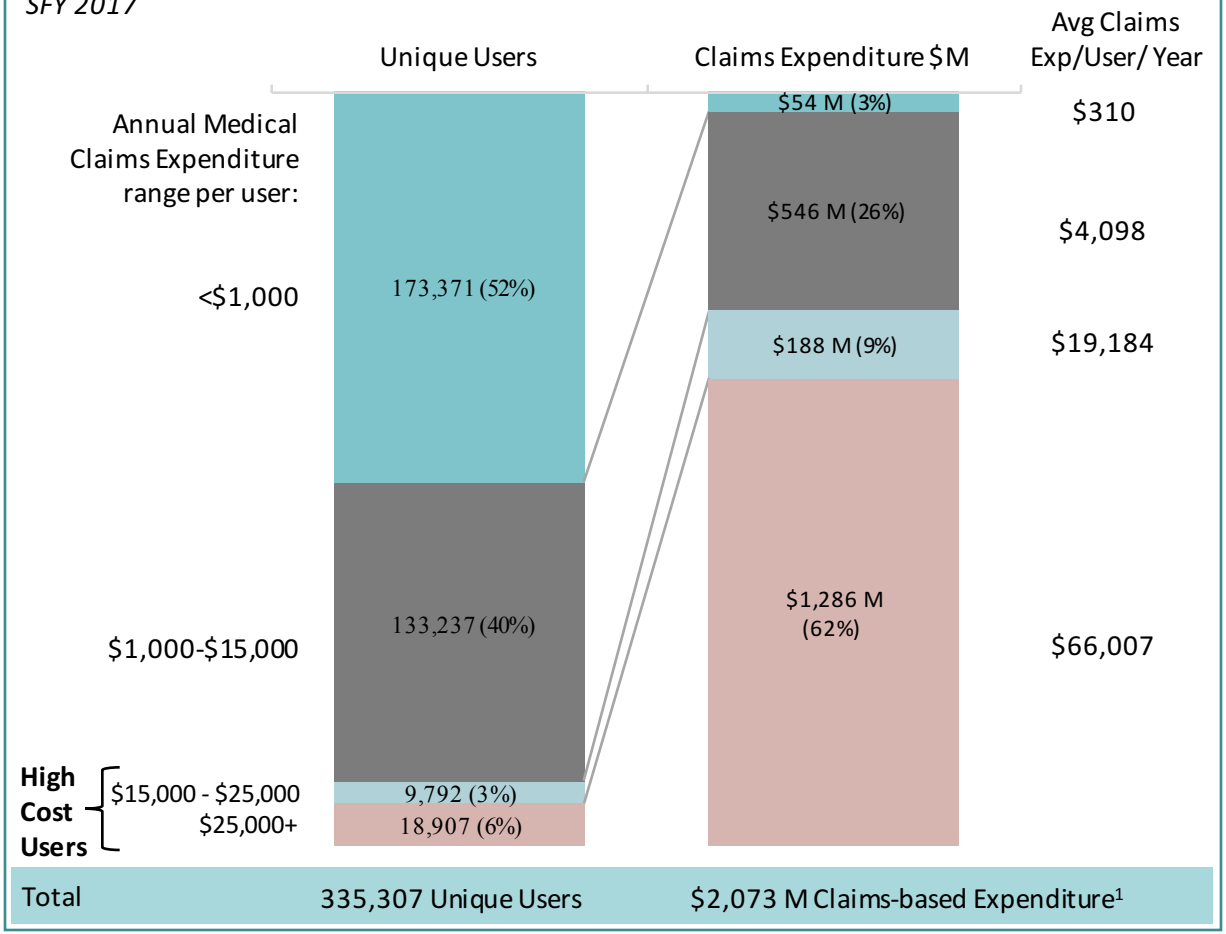
- Managed care enrollment is divided between Rhode Island's two Medicaid Managed Care Organizations (MCOs), Neighborhood Health Plan (NHP) and United Healthcare (UHC). Tufts Health Plan began enrolling Medicaid members in SFY 2018 and will be reflected in the SFY 2018 version of this report.
- **RIte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

High Cost Users: By 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 2017



- In order to look at spending by user, it is necessary to look at "unique users" rather than average eligibles. A unique user is an individual associated with a medical claim. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- In order to better examine the characteristics of this population, this report defines "high cost" users as those with over $15,000 of claims expenditure per year, adding another 3 percent of users to the top 6%. There are 28,699 "high cost" users (9%) who account for $1,474 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, 52% 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.

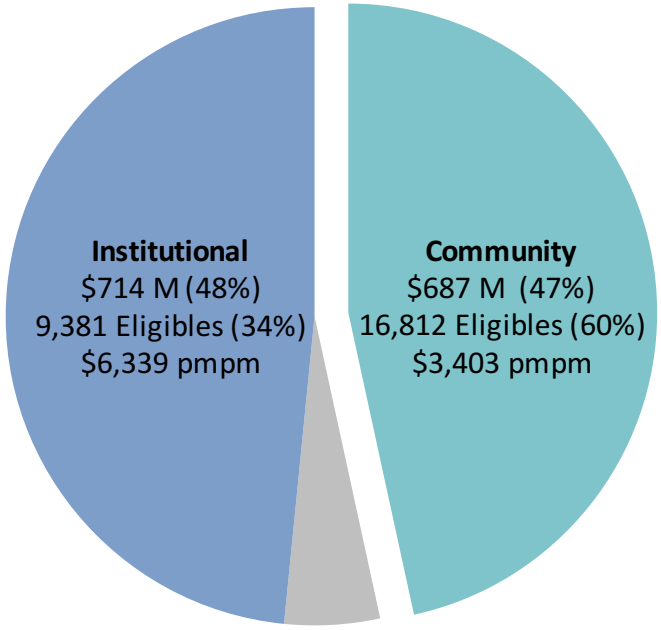
[1]Total of claims-specific payments. Certain expenditures (e.g. UPL, Medicare and PACE Premiums) not attributable to specific users.

High Cost Users: By Cohort

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

High Cost User Claims Expenditure by Cohort
Users with Annual Medicaid Claims Expenditure over $15,000
SFY 2017 -- $ Millions

Total High Cost User Claims Expenditure[1]: $1,474 M
Average Eligibles[2]: 27,799



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

- Developing approaches to impact the costs and reduce the spending for high cost users requires an understanding of their circumstances and characteristics, the programs and services they are accessing, and their health care needs.
- Institutional high cost users account for 48% of high cost user expenditure and include nursing home residents, individuals residing in rehabilitation hospitals, and those in group homes and facilities for the intellectually and developmentally disabled. Nearly all the individuals residing in one of these settings are high cost users.
- High cost users receiving maternity and delivery services are mainly infants receiving NICU services and other high cost mothers and newborns.
- This remainder of this section will focus on the characteristics of high cost users who do not fall into the institutional or maternity categories, those presumably living in the community.

[1]Based on claims-specific payments only. Does not include pharmacy rebates.
[2]In order to look at spending by user, it is necessary to look at "unique users", as on previous slide, however an analysis of PMPM costs requires looking at average eligibles. Thus the rest of the high cost user analysis considers average eligibles as based on those unique users who are determined as "high cost".

High Cost Users in the Community: By Population

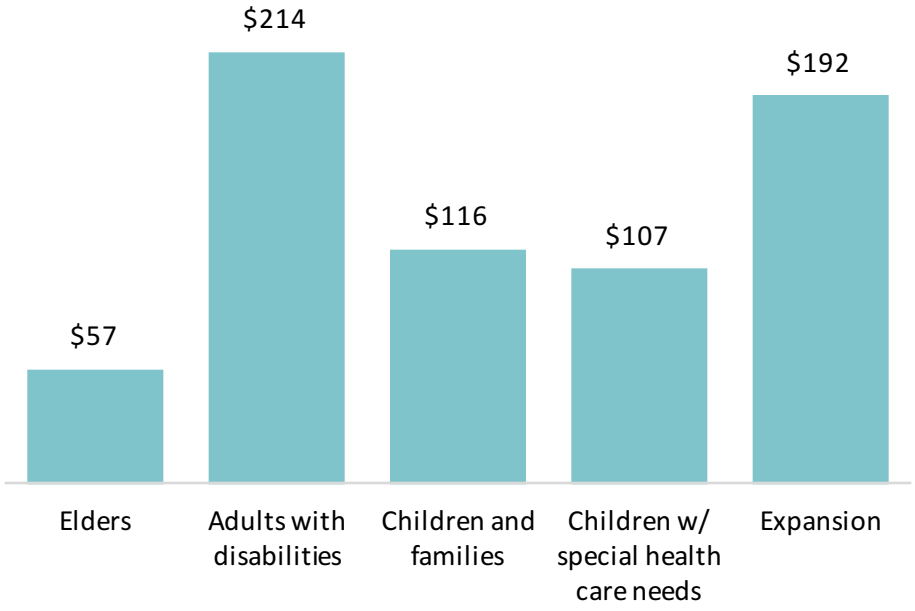
Adults with disabilities and the Expansion population account for 59% of claims expenditure for high cost users in the community.

Community High Cost User Claims Expenditure by Population

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

SFY 2017 -- $ Millions

Total Community High Cost User Claims Expenditure[1]: $687 M
Eligibles: 16,812



	Elders	Adults with disabilities	Children and families	Children w/ special health care needs	Expansion
% of Community High Cost User Claims Expenditure	8%	31%	17%	16%	28%
# Comm High Cost Eligibles	1,751	4,878	3,227	2,039	4,917
% of Population Group Total Expenditure attributable to Comm High Cost User Claims	9%	29%	21%	62%	43%

- Elders account for 8% of claims expenditure for high cost users in the community. High cost elders are more typically in institutions such as nursing homes and are therefore do not fall into the community subset of high cost users.
- Adults with disabilities account for 31% of community high cost user claims expenditure, and 29% of adults with disabilities total expenditure is attributable to community high cost user claims expenditure.
- The Expansion population accounts for 4,917 community high cost user eligibles and 28% of community high cost user expenditure.

[1]Based on claims-specific payments only. Does not include pharmacy rebates.

High Cost Users in the Community: By Provider Type

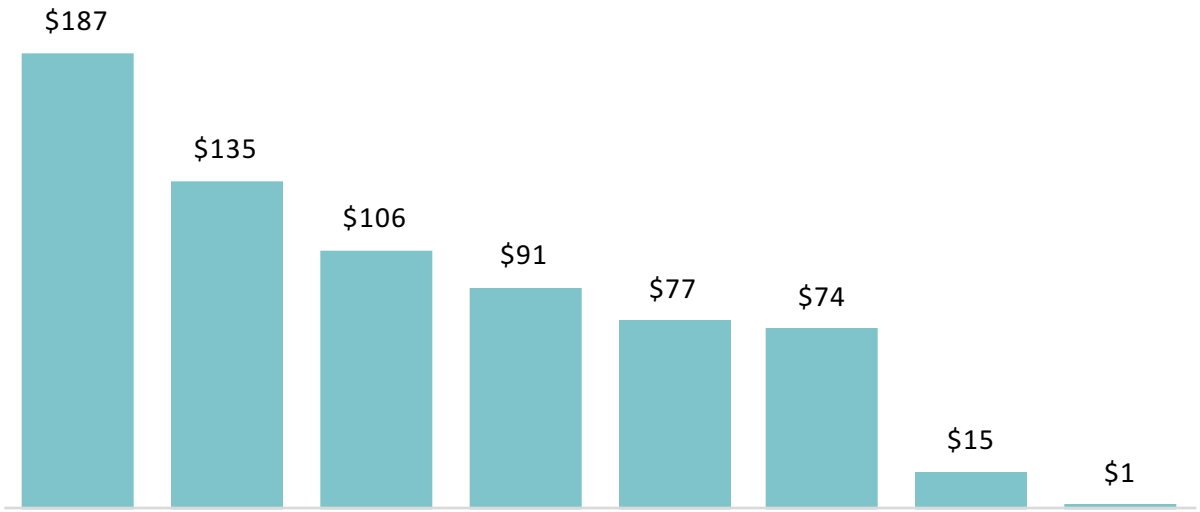
Over one-quarter of community high cost user claims expenditure is for hospital inpatient services.

Community High Cost User Claims Expenditure by Provider

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

SFY 2017 -- $ Millions

Total Community High Cost User Claims Expenditure[1]: $687 M



Hospital Inpatient	Pharmacy *before rebates*	Hospital Outpatient	Professional	Professional BH	Home and Comm Based Svcs	Nursing Home /Hospice	IDD Resdntl/ Rehab, Group Homes
27%	20%	15%	13%	11%	11%	2%	<1%
% of Total Community High Cost User Claims Expenditure							
51%	54%[2]	38%	27%	46%	52%	4%	1%
% of Provider Type Total Expenditure attributable to Community High Cost User Claims							

- Hospital inpatient and outpatient claims expenditure together account for 42% of community high cost user expenditure.
- Community high cost users' claims account for over half (51%) of hospital inpatient expenditure.
- Twenty percent of community high cost user claims expense is for pharmacy claims. This expense is before accounting for pharmacy rebates.

[1]Based on claims-specific payments only. Does not include pharmacy rebates.

[2]This measure is amount of community high cost user pharmacy expense as a percent of total pharmacy cost before rebates.

High Cost Users in the Community: By Diagnosis

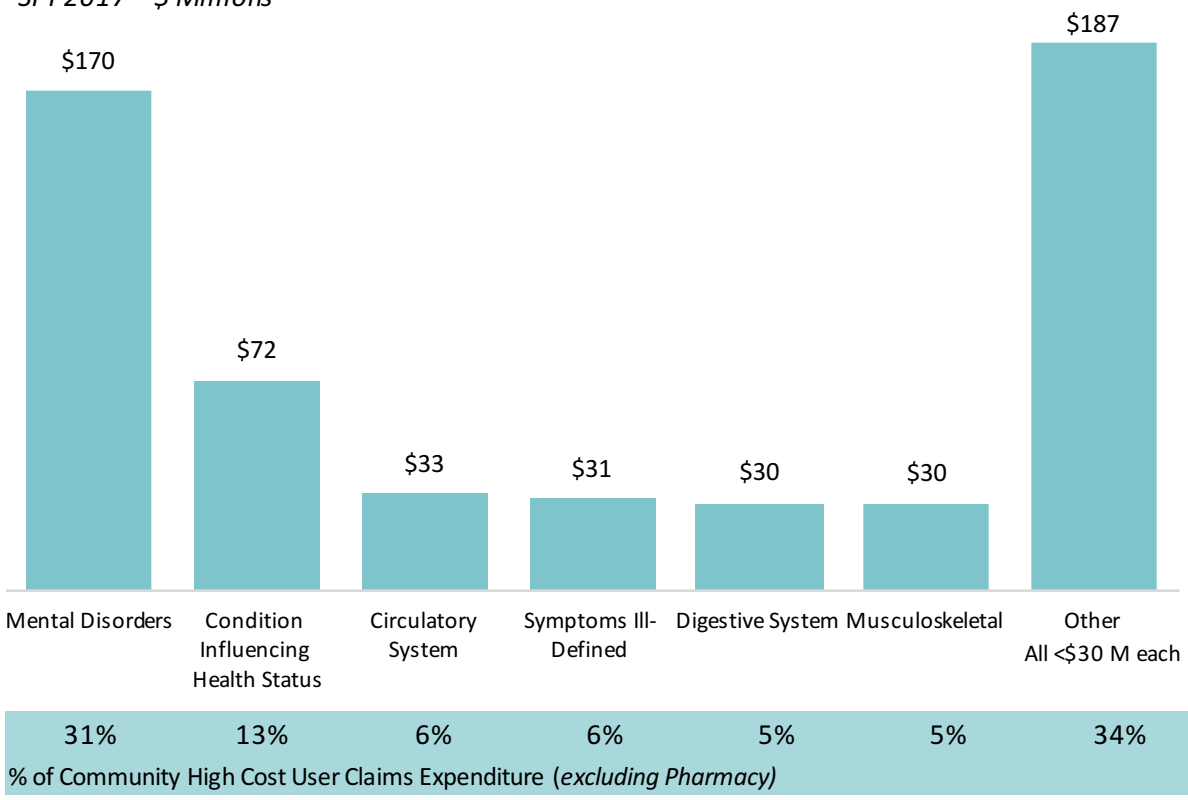
Almost one-third of the claims expenditure for community high cost users is for a diagnosis of mental disorders.

Community High Cost User Claims Expenditure by Diagnosis

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

SFY 2017 -- $ Millions

Total Community High Cost User Claims Expenditure[1]: $552 M *(excludes pharmacy)*



- Within mental disorders, $135 million of claims expenditure is for a diagnosis related to mental health while the remaining $35 million is for diagnosis related to substance use disorder.
- The next most common diagnosis for community high users, accounting for 13% of claims expenditure, is "condition influencing health status", which is mainly related to bed confinement.
- Pharmacy claims expenditure is excluded from this analysis because pharmacy claims are not associated with a diagnosis code.

High Cost Users in the Community: Diagnosis Details

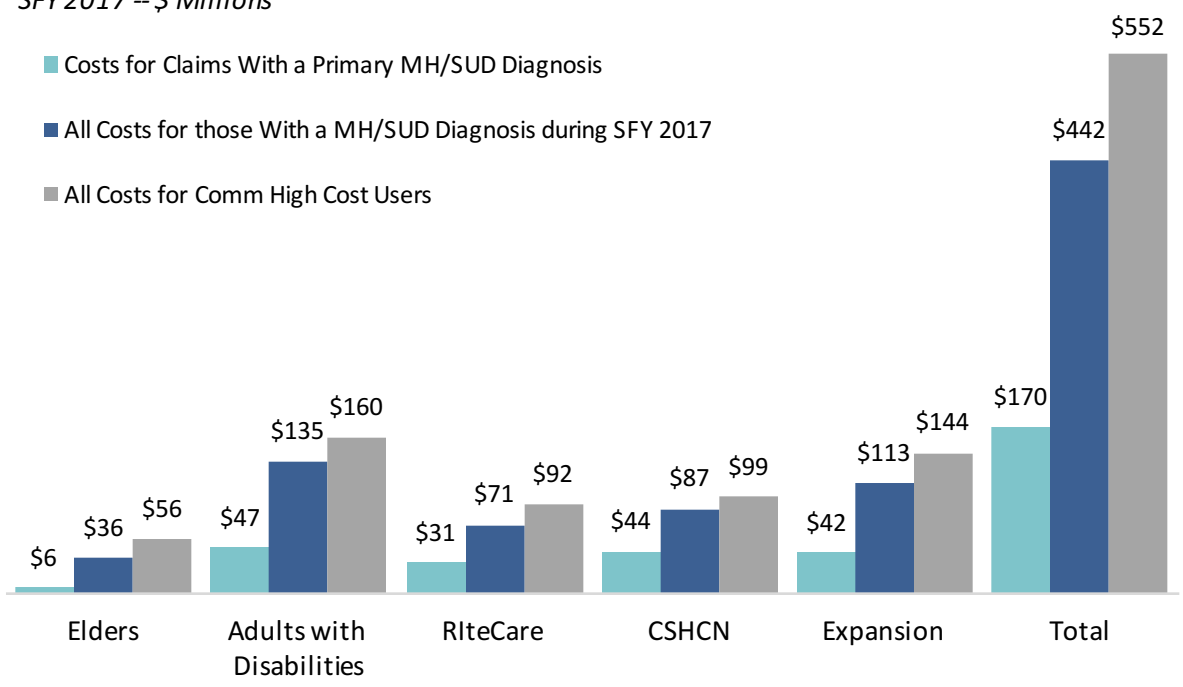
Eighty percent of the expenditure on community high cost users was for individuals for whom there was a mental health (MH) or substance use disorder (SUD) diagnosis during the year.

Community High Cost User Claims Expenditure by Diagnosis

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

SFY 2017 -- $ Millions

Total Community High Cost User Claims Expenditure[1]: $552 M *(excludes pharmacy)*



Elders	Adults with Disabilities	RIteCare	CSHCN	Expansion	Total
10%	29%	34%	45%	29%	31%

% of Costs Associated with Members with a Primary MH/SUD Diagnosis

Elders	Adults with Disabilities	RIteCare	CSHCN	Expansion	Total
64%	84%	77%	88%	79%	80%

% of Costs Associated with MH/SUD Diagnosis during SFY 2017

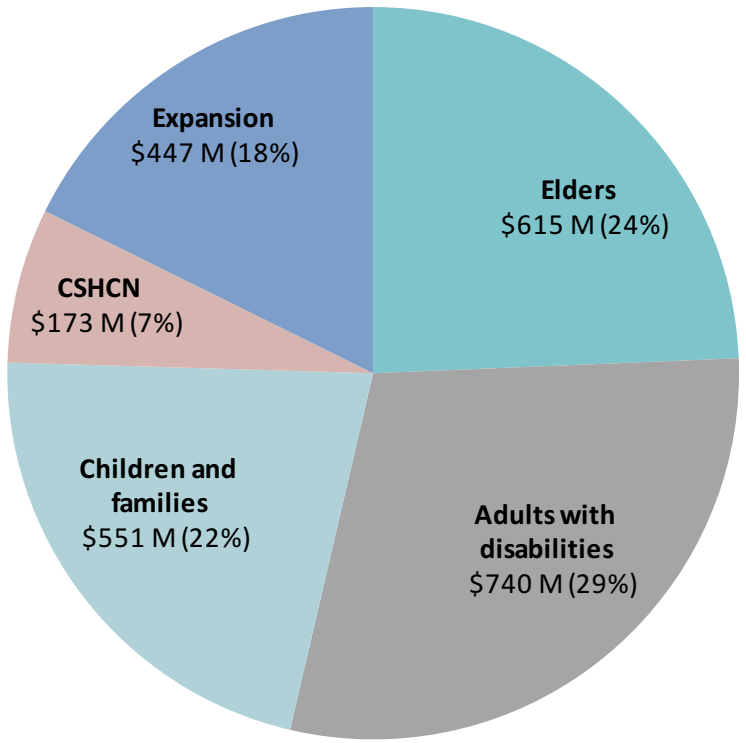
- Of the $552 million spent on community high cost users, $442 million (80%) was for individuals for whom there was a mental health or substance use disorder claim at some point during the fiscal year.
- However, the spending was NOT concentrated in mental health/substance use services, as the specific MH/SUD claims only accounted for about $170 million, or 31% of the claims costs.
- These findings are relatively consistent across all populations of community high cost users.

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 2017 - $ Millions

Total: $2,525 M



- **Elders**:
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in Medicare and Medicaid
- **Adults with Disabilities**:
  - Expenditure by provider type
  - Managed care enrollment by type of program
  - Dual enrollment in Medicare and Medicaid
  - Acute care services utilization – hospital days and, office visits, pharmacy claims
- **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

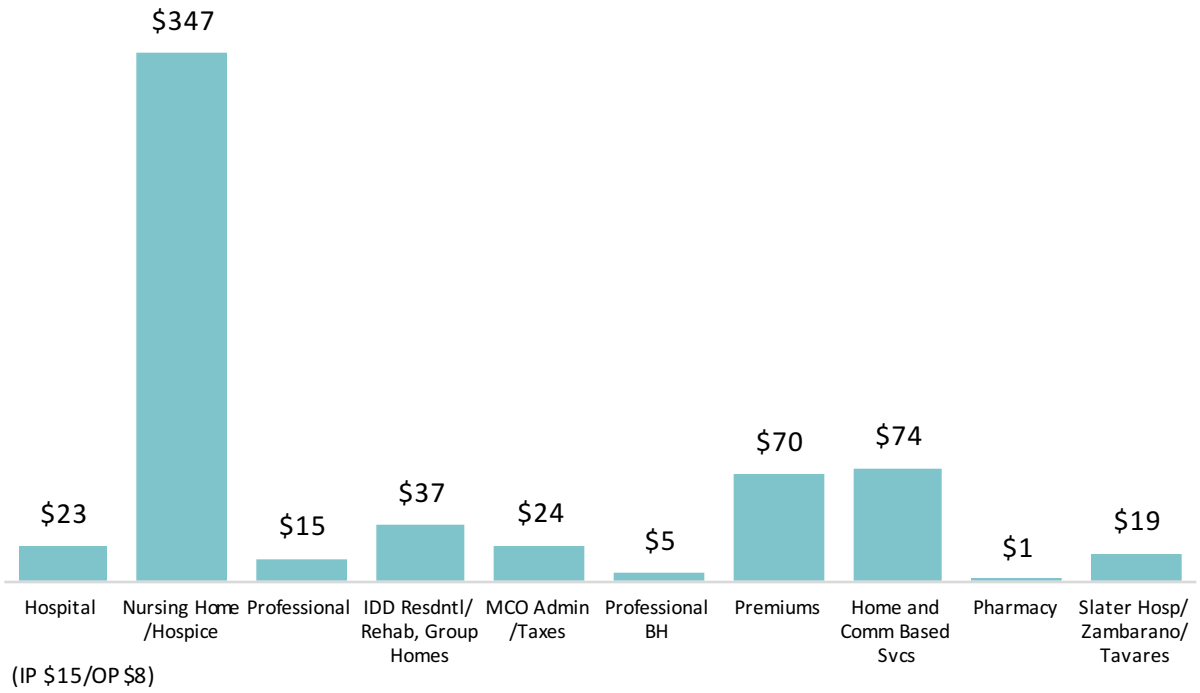
Elders: Expenditure by Provider Type

Nursing facilities (including nursing homes and hospice) account for 56% of total Medicaid expenditure on elders.

Elders: Medicaid Expenditure by Provider Type

SFY 2017 -- $ Millions

Elders Expenditure =	$615 M
% of 2017 Expenditure =	24%
Avg Annual Growth =	6.5%



4%	56%	2%	6%	4%	1%	11%	12%	0%	3%
% of 2017 Expenditure									
7.4%	5.1%	6.8%	4.6%	20.2%	0.5%	8.8%	10.3%	-7.1%	2.1%
Avg Ann Growth 2015-17									

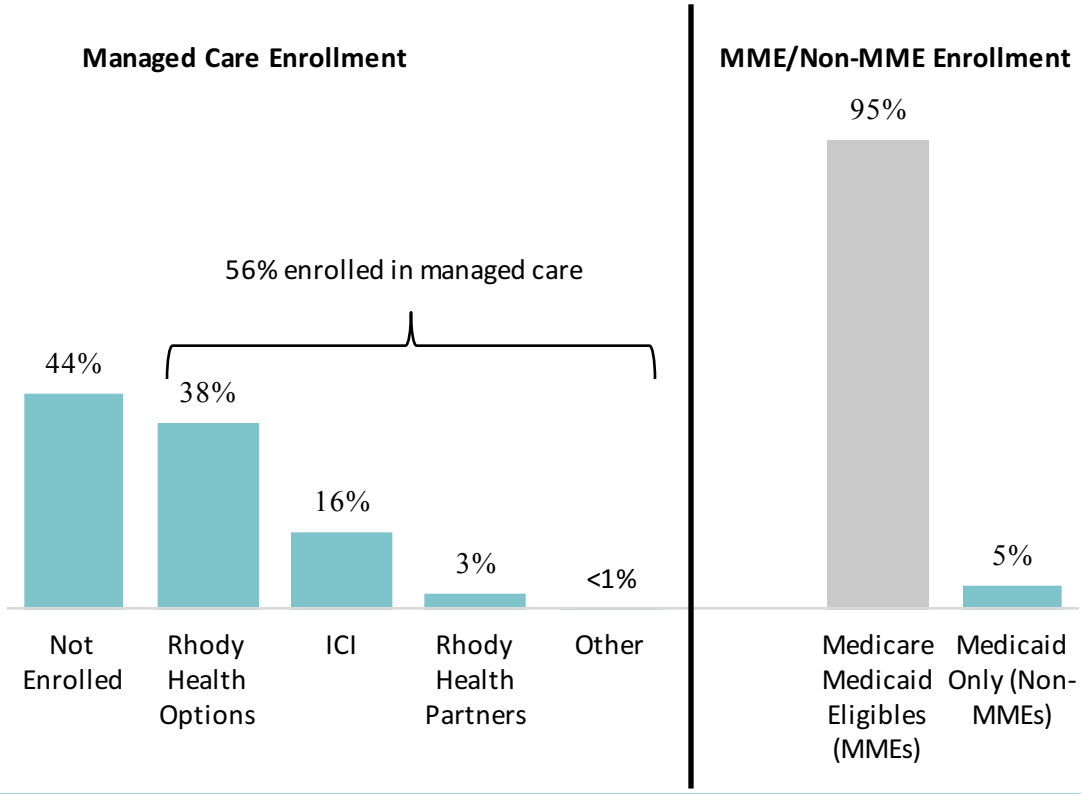
- Medicaid expenditures on elders totaled $615 million in SFY 2017 and has been increasing at 6.5% per year over the past 3 years.
- The large majority of elders are also eligible for Medicare, which was the primary payer for most medical services (e.g. hospital, professional). Consequently those expenditures 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 5.1% 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

Overall 56% of elders are enrolled in managed care programs.

Elders: Managed Care and MME (Dual) Enrollment
SFY 2017

Elders Expenditure = $615 M
Elders Average Eligibles = 19,970



	Not Enrolled	Rhody Health Options	ICI	Rhody Health Partners	Other	Medicare Medicaid Eligibles (MMEs)	Medicaid Only (Non-MMEs)
Average Eligibles	8,716	7,548	3,097	582	28	18,473	725

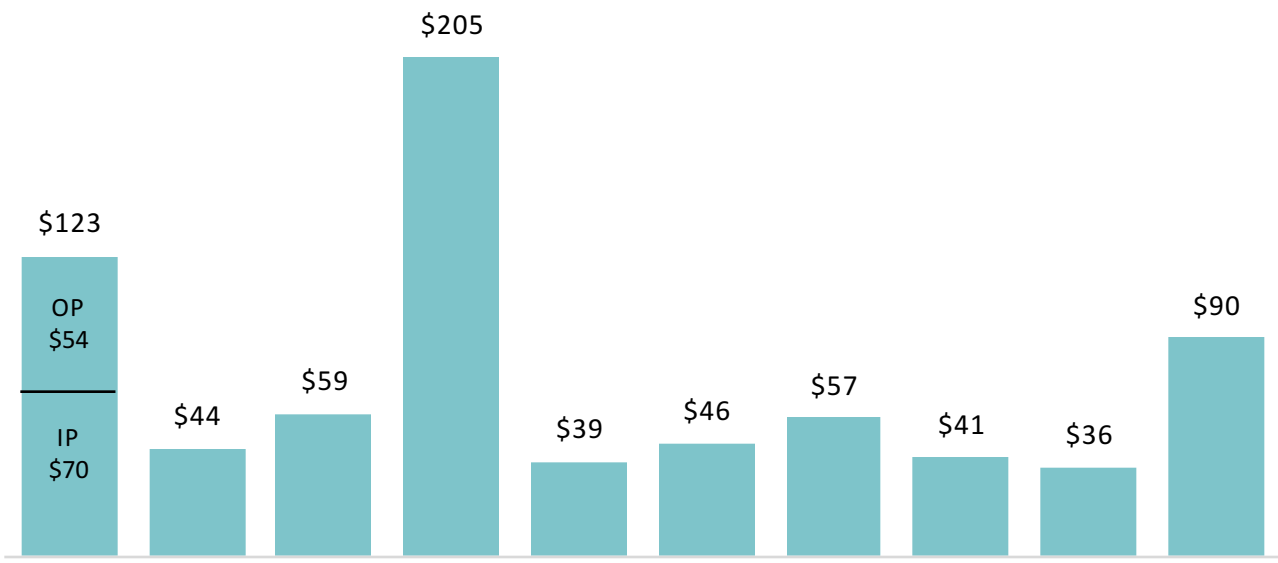
- Ninety-five percent of elders are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- For the elders who are dually enrolled, Medicare is the primary payer for most acute and and primary care services (e.g., hospital, professional, pharmacy).
- Thirty-eight percent of elders are enrolled in Rhody Health Options (RHO) and another 16% are enrolled in the Integrated Care Initiative (ICI), both of which are fully capitated managed care programs for long term care, long term services and supports (LTSS), and other Medicaid-funded services designed primarily for individuals with both Medicaid and Medicare eligibility.

Adults with Disabilities: 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 2017 -- $ Millions

Adults with Disabilities Expenditure = $740 M
% of 2017 Expenditure = 29%
Avg Annual Growth = 1.0%



Hospital	Nursing Home /Hospice	Professional	IDD Resdntl/ Rehab, Group Homes	MCO Admin /Taxes	Professional BH	Premiums	Home and Comm Based Svcs	Pharmacy	Slater Hosp/ Zambarano/ Tavares
17%	6%	8%	28%	5%	6%	8%	6%	5%	12%
% of 2017 Expenditure									
-1.7%	2.1%	2.8%	3.2%	24.0%	-12.3%	7.4%	4.6%	-5.7%	-2.3%
Avg Ann Growth 2015-17									

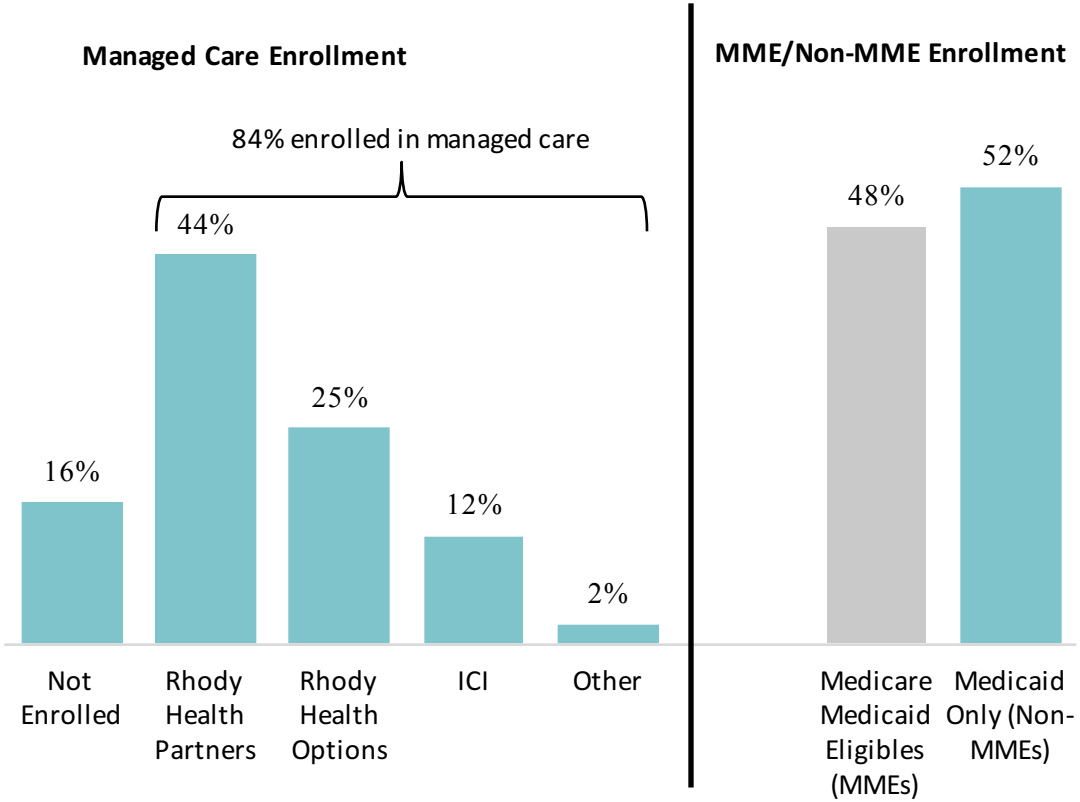
- Adults with disabilities account for the largest share of Medicaid expenditures, with total SFY 2017 expenditure of $740 million. Expenditure for this population has increased by approximately 1.0% per year over the past 3 years.
- Hospital and residential and rehabilitation services for persons with intellectual and developmental disabilities account for 17% and 28% of expenditure, respectively.
- However, expenditure for hospital services has been decreasing 1.7% per year on average over the last 3 years.

Adults with Disabilities: Managed Care Enrollment

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

Adults with Disabilities: Managed Care and MME (Dual) Enrollment
SFY 2017

Adults with Disabilities Expenditure = $740 M
Average Eligibles = 32,296



	Not Enrolled	Rhody Health Partners	Rhody Health Options	ICI	Other	Medicare Medicaid Eligibles (MMEs)	Medicaid Only (Non-MMEs)
Average Eligibles	5,234	14,364	7,967	4,002	728	15,407	16,889

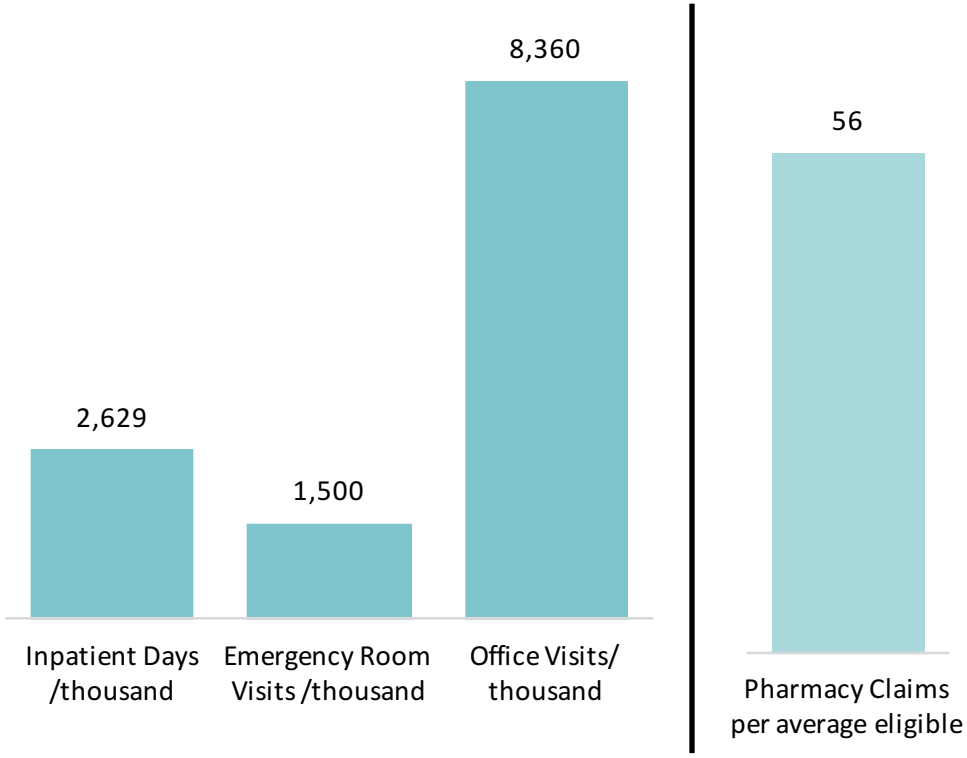
- Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- For the adults with disabilities who are dually enrolled, Medicare is the primary payer for most acute and and primary care services (e.g., hospital, physician, pharmacy).
- 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 2017 84% of this population was enrolled in managed care.

Adults with Disabilities: Acute Care Utilization

All acute care utilization measures have increased over the last 3 years for adults with disabilities with Medicaid-only coverage (non-MMEs).

Adults with Disabilities: Non-MMEs: Acute Care Utilization
SFY 2017

Non-MME Adults with Disabilities = 16,889
52% of Adults with Disabilities



	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2015-2017	3.8%	5.9%	8.4%	4.1%

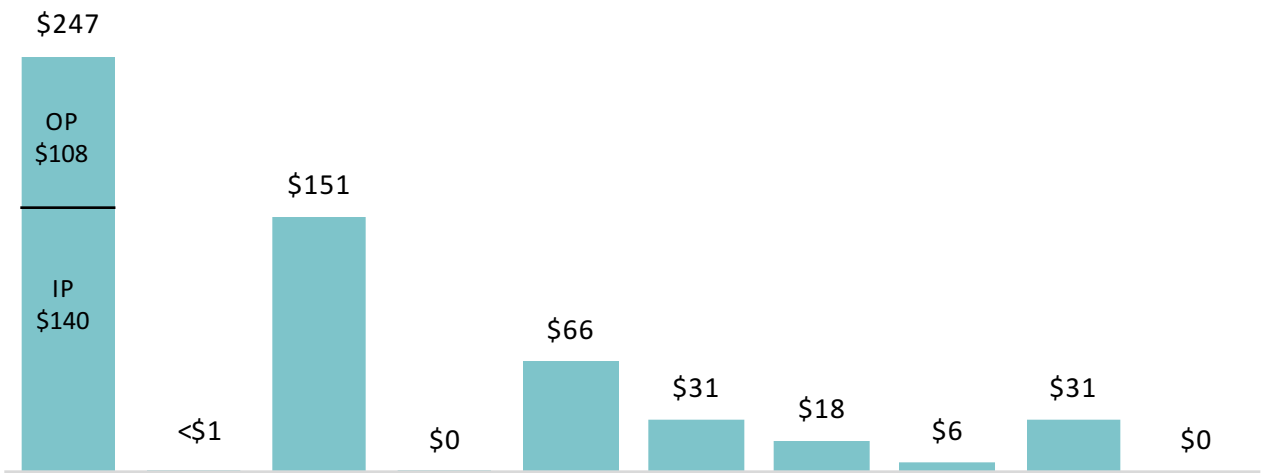
- Fifty-two percent of adults with disabilities are covered by only Medicaid. Utilization shown here is for the adults with disabilities without Medicare coverage (Non-MMEs).
- Acute care utilization is not shown for dual enrolled adults with disabilities (MMEs) because Medicare is the primary payer for most acute care services.
- Non-MME adults with disabilities averaged 8,360 office visits per thousand eligibles per year in SFY 2017, an increase of 8.4% per year on average in the last 3 years.
- Over the same period, inpatient days/thousand for this population have increased at an annual rate of 3.8%.
- Pharmacy claims for non-MME adults with disabilities average 56 claims per average eligible per year, and have been increasing at a rate of 4.1% per year on average over the last 3 years.

Children and Families: Expenditure by Provider Type

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

Children and Families:
Medicaid Expenditure by Provider Type
SFY 2017 -- $ Millions

Children and Families Expenditure = $551 M
% of Expenditure = 22%
Avg Annual Growth = 2.6%



	Hospital	Nursing Home /Hospice	Professional	IDD Resdntl/ Rehab, Group Homes	MCO Admin /Taxes	Professional BH	Premiums	Home and Comm Based Svcs	Pharmacy	Slater Hosp/ Zambarano/ Tavares
% of 2017 Expenditure	45%	<1%	27%	0%	12%	6%	3%	1%	6%	0%
Avg Ann Growth 2015-17	4.2%	18.8%	1.5%	14.5%	9.7%	-8.0%	-0.4%	28.3%	-6.0%	N/A

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/

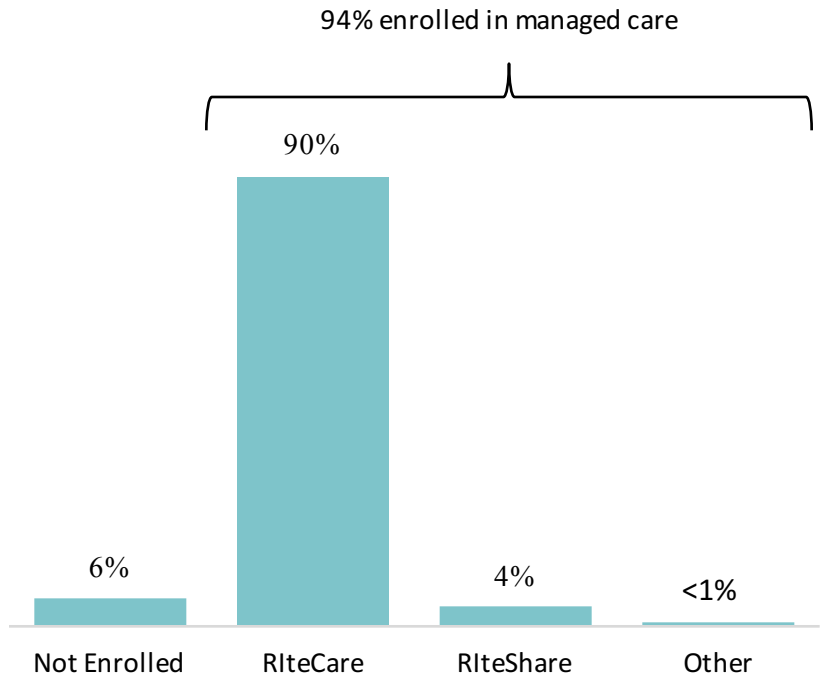
- Children and families account for about one-fourth (22%) of total Medicaid expenditures, with SFY 2017 expenditure of $551 million. Expenditure for this population has increased by 2.6% per year over the past 3 years.
- Most expenditure on children and families is divided between professional and hospital care, with hospital care accounting for almost half (45%) 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]
- The enhanced federal match for the CHIP program was 88.61% in SFY 2017. The CHIP program provides full Medicaid benefits to uninsured children and pregnant women from families with incomes up to 250% of the federal poverty level. In SFY 2017, there were 24,850 average 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 2017

Children and Families Expenditure = $551 M
Average Eligibles = 165,894



	Not Enrolled	RIteCare	RIteShare	Other
Average Eligibles	9,243	149,602	6,347	703

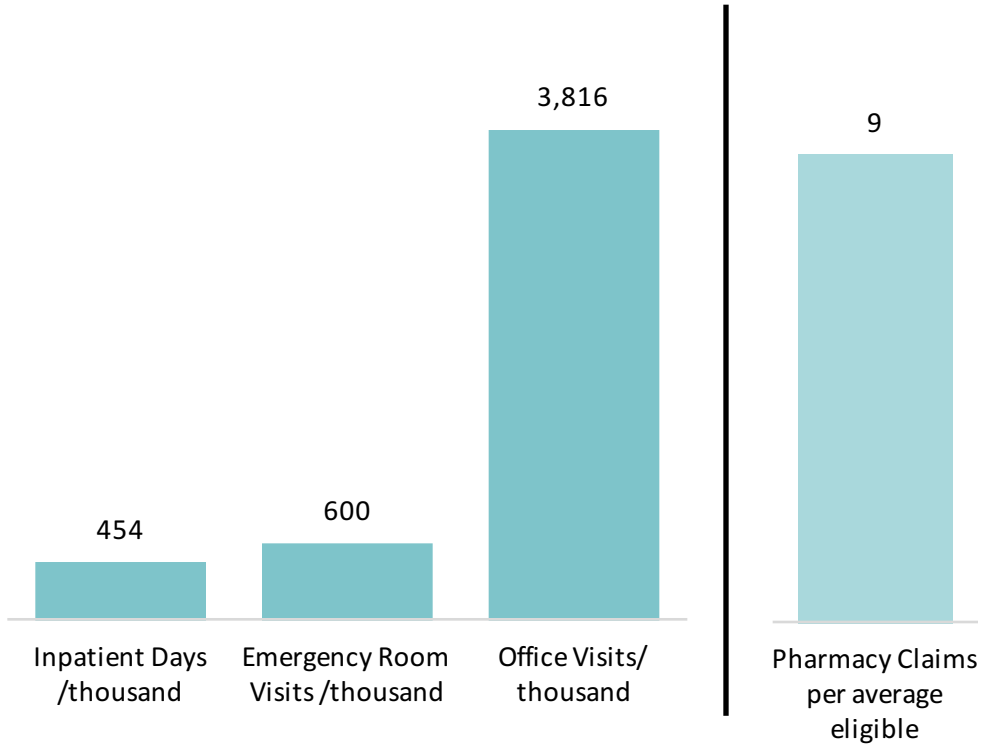
- Ninety percent of children and families are enrolled in a Medicaid managed care program through RIte Care. These enrollees are divided between Neighborhood Health Plan (NHP) and United Healthcare (UHC).
- RIte Share is a program designed to allow Medicaid eligibles with access to qualified employer-based 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 2017 there were 6,347 Medicaid eligible children and parents enrolled in the RIte Share program.
- The unenrolled children and families include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

Children and Families: Acute Care Utilization

For children and families, inpatient days per thousand have increased by 1.3% per year on average since SFY 2015.

Children and Families: Acute Care Utilization
SFY 2017

Children and Families Average Eligibles = 165,894



	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2015-2017	1.3%	2.3%	-0.7%	-2.3%

- For children and families, emergency room visits per thousand have increased at 2.3% per year since SFY 2015.
- 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 2.3% per year on average over the last 3 years.
- About 50% 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/

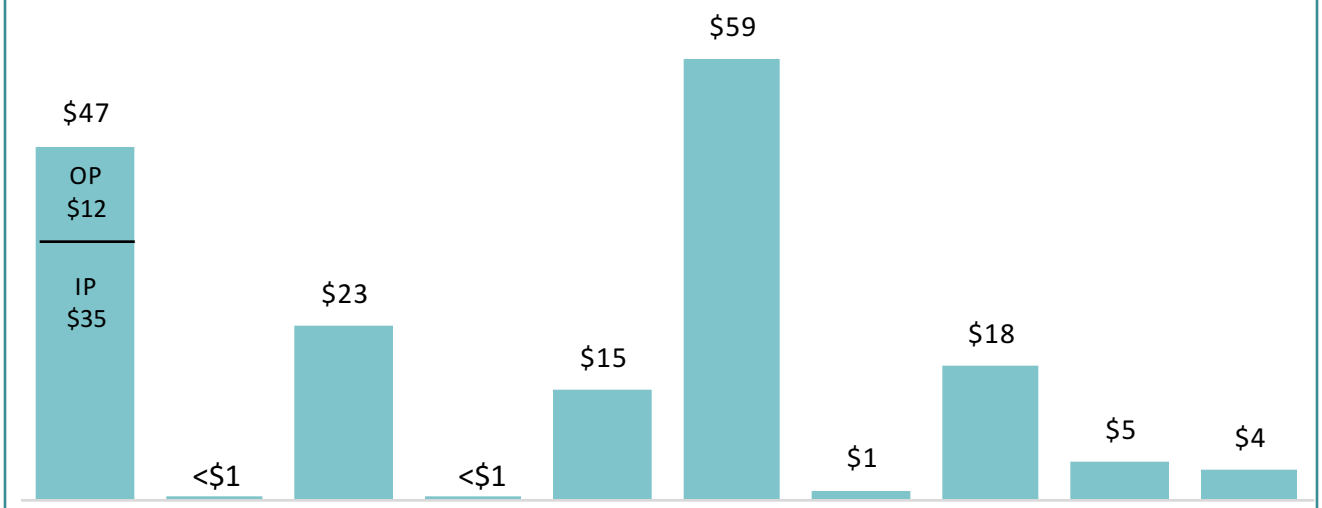
Children with Special Health Care Needs (CSHCN): Expenditure by Provider Type

In the population of children with special health care needs, professional behavioral health accounts for 34% of all expenditure.

CSHCN: Medicaid Expenditure by Provider Type

SFY 2017 -- $ Millions

CSHCN Expenditure = $173 M
% of Expenditure = 7%
Avg Annual Growth = -1.8%



	Hospital	Nursing Home /Hospice	Professional	IDD Resdntl/ Rehab, Group Homes	MCO Admin /Taxes	Professional BH	Premiums	Home and Comm Based Svcs	Pharmacy	Slater Hosp/ Zambarano/ Tavares
% of 2017 Expenditure	27%	<1%	13%	<1%	9%	34%	1%	10%	3%	2%
Avg Ann Growth 2015-17	2.4%	N/A	3.4%	N/A	27.3%	-11.6%	-1.0%	17.7%	-21.2%	-4.1%

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

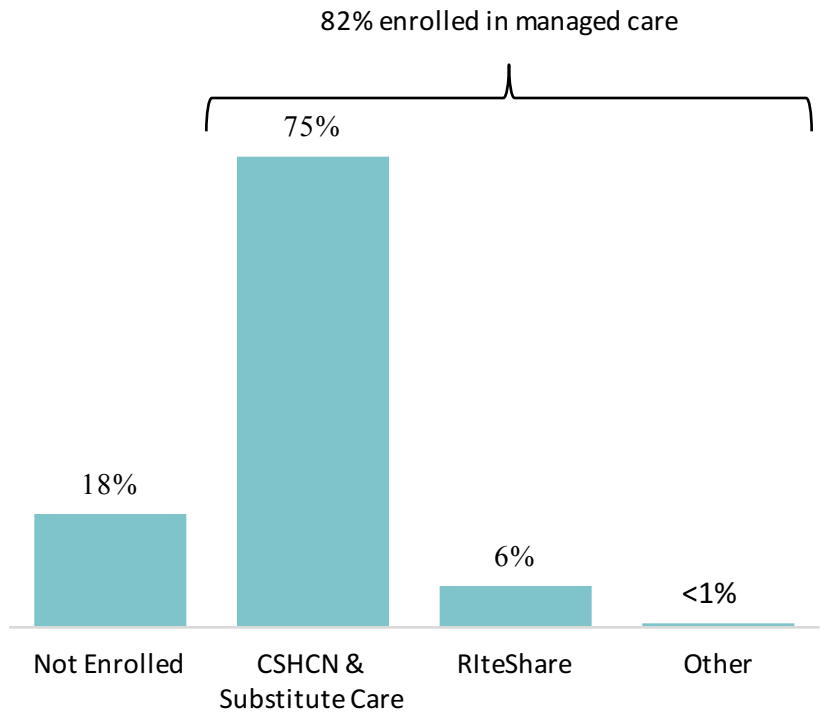
- Children with Special Health Care Needs (CSHCN) comprise a relatively small population, accounting for seven percent of total Medicaid expenditures and four percent of enrollees.
- Expenditure for this population is dominated by professional behavioral health services, which account for $59 million in CSHCN expenditures (34%). Professional behavioral health services include Cedar (Comprehensive, evaluation, Diagnosis, assessment, referral, re-evaluation) and Cedar Direct services, residential DCYF services, and professional mental health, substance use disorder, and other services.

Children with Special Health Care Needs: Managed Care Enrollment

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

CSHCN: Managed Care Enrollment
SFY 2017

CSHCN Expenditure = $173 M
Average Eligibles = 12,060



	Not Enrolled	CSHCN & Substitute Care	RIteShare	Other
Average Eligibles	2,169	9,084	769	38

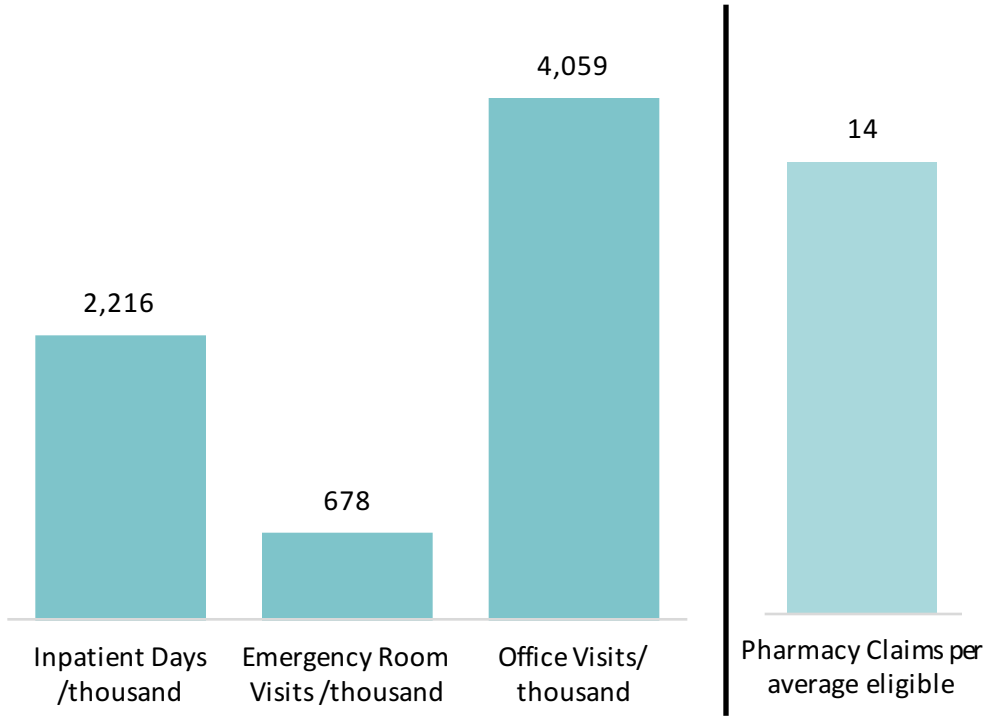
- In 2008, enrollment in Medicaid managed care became mandatory for children with special health care needs (CSHCN) and without other insurance. In SFY 2017 82% were enrolled in managed care.
- The unenrolled children with special healthcare needs include those with other insurance and new enrollees 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 increased by 4.5% per year on average since SFY 2015.

CSHCN: Acute Care Utilization
SFY 2017

CSHCN Average Eligibles = 12,060



	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2015-2017	6.3%	4.5%	1.3%	-1.8%

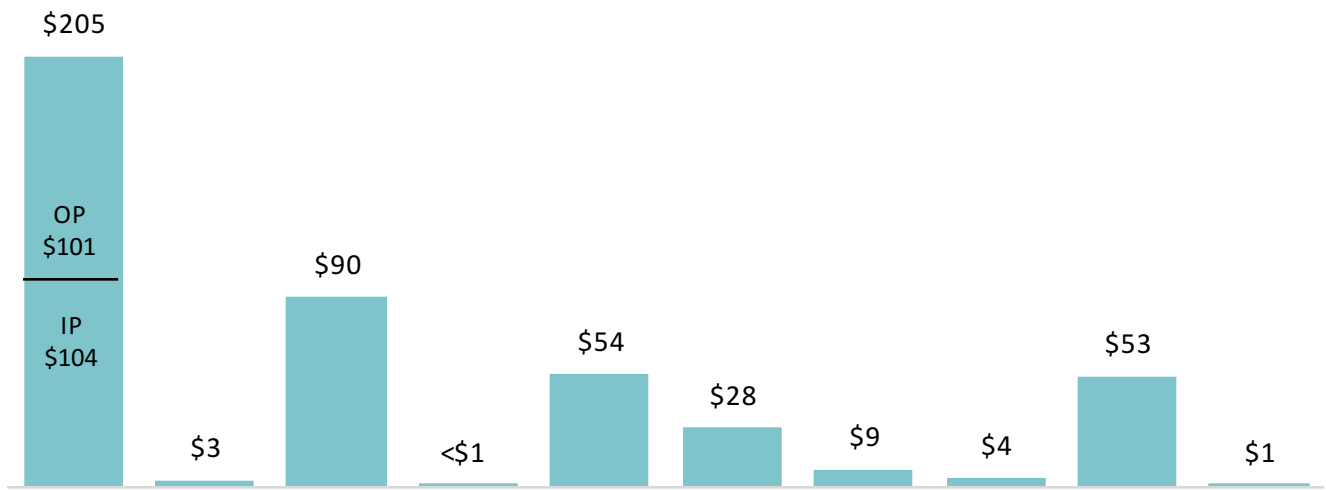
- Inpatient days per thousand have increased over the last 3 years at an average rate of 6.3% per year.
- Office visits per thousand have increased at an average rate of 1.3% per year since SFY 2015 to 4,059 visits per thousand in SFY 2017.
- Eighty percent of inpatient days are related to behavioral health admissions (including days in the Children's Residential and Family Treatment (CRAFT) program at Bradley Hospital.)
- Pharmacy claims per average eligible have decreased at 1.8% per year over the last 3 years.

Expansion: Expenditure by Provider Type

The Expansion population mainly uses hospital and professional services.

Expansion: Medicaid Expenditure by Provider Type
SFY 2017 -- $ Millions

Expansion Expenditure = $447 M
% of Expenditure = 18%



	Hospital	Nursing Home /Hospice	Professional	IDD Resdntl/ Rehab, Group Homes	MCO Admin /Taxes	Professional BH	Premiums	Home and Comm Based Svcs	Pharmacy	Slater Hosp/ Zambarano/ Tavares
% of 2017 Expenditure	46%	1%	20%	<1%	12%	6%	2%	1%	12%	<1%
Avg Ann Growth 2015-17	7%	19%	4%	N/A	-10%	6%	20%	35%	16%	N/A

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

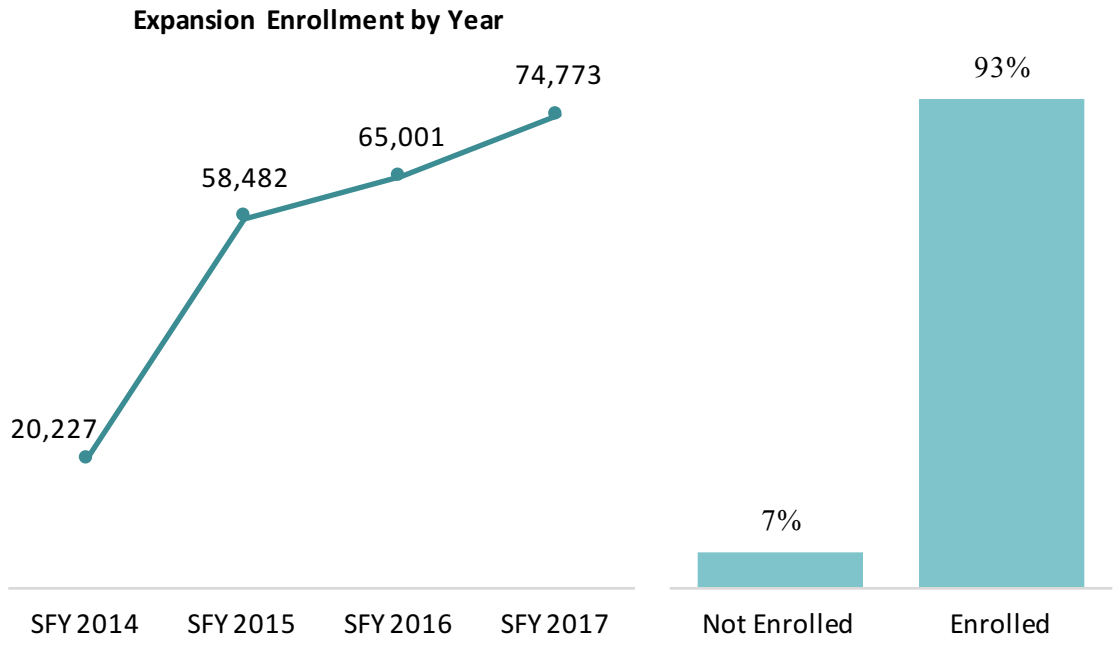
- The Expansion population became eligible for Medicaid starting January 1, 2014.
- This population accounted for $447 million in expenditure in SFY 2017, 18% of total Medicaid expenditure.
- The two largest provider types for the Expansion population are hospital and professional services, accounting for 66% 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 2017

Expansion Average Eligibles = 74,773



Average Eligibles	5,114	69,659

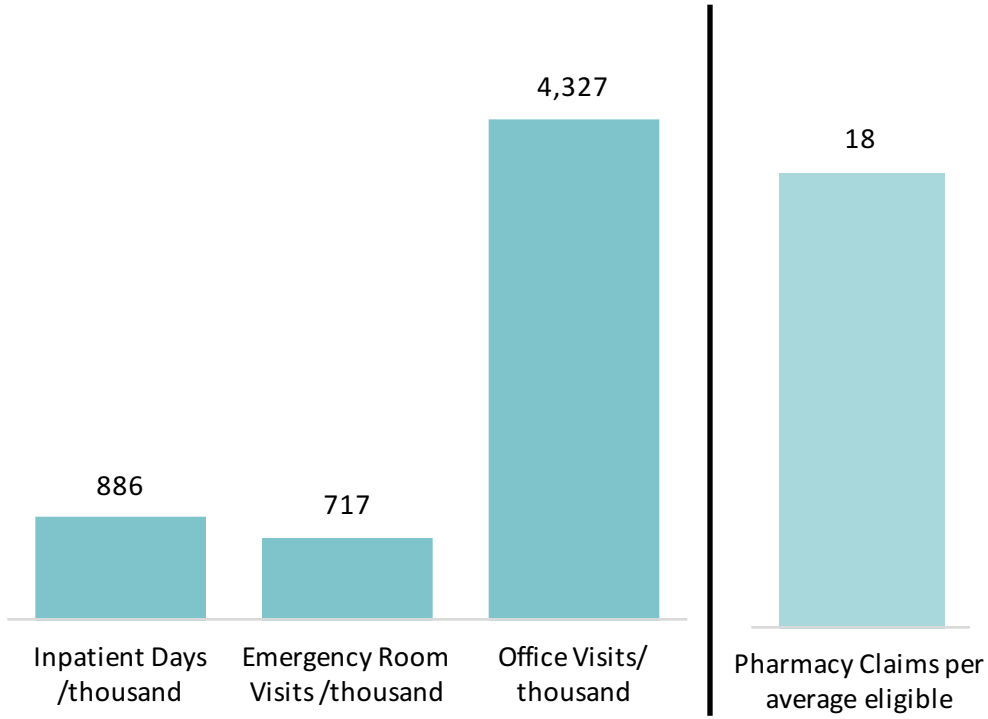
- The Medicaid Expansion population is almost entirely enrolled in managed care. However new enrollees experience an initial period in fee-for-service prior to enrollment in a health plan.
- Expansion eligibility commenced in January 2014 and was mainly stabilized by the end of SFY 2015.

Expansion: Acute Care Utilization

The Expansion population had an average of 18 pharmacy claims per 12 months of eligibility.

Expansion: Acute Care Utilization
SFY 2017

Expansion Average Eligibles = 74,773



	Inpatient Days /thousand	Emergency Room Visits /thousand	Office Visits/ thousand	Pharmacy Claims per average eligible
Avg Ann Growth 2015-2017	-5.2%	-3.6%	-4.3%	-0.5%

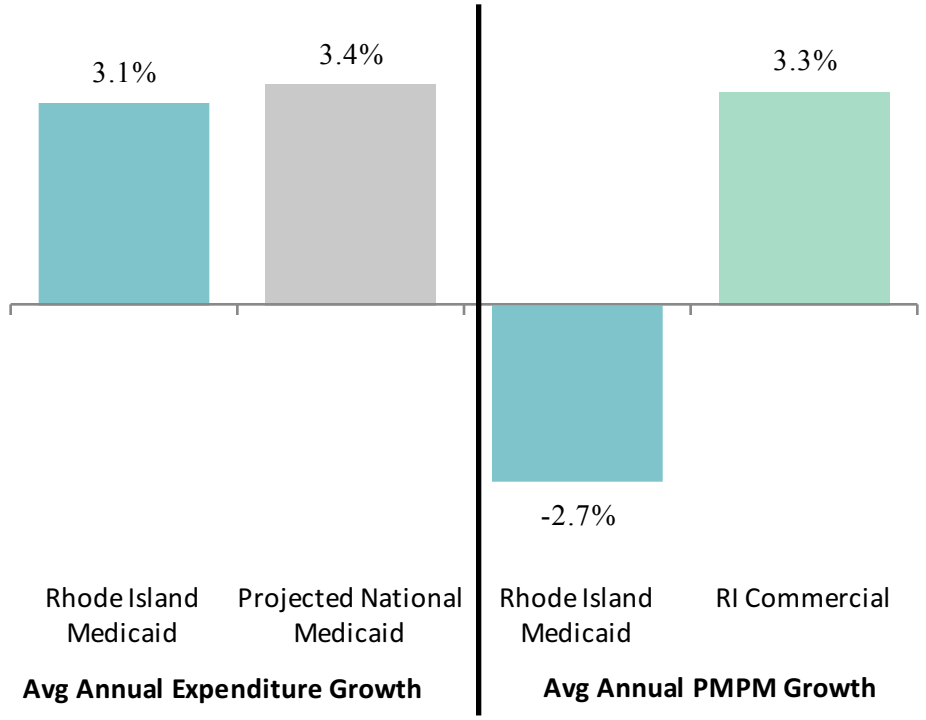
- The Medicaid Expansion population had 886 inpatient days per thousand during SFY 2017.
- The Expansion population used about 4.3 office visits per average eligible.
- All acute care utilization measures for the Expansion population have decreased over the last 3 years.

Medicaid Trends: National Medicaid and State Commercial

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

Rhode Island Medicaid vs. National and Commercial Trends

SFY 2015-2017[1], see below for sources



- Overall expenditure growth over the years SFY 2015-2017 was similar to the national Medicaid expenditure trend. According to Centers for Medicare & Medicaid Services (CMS), Medicaid national expenditure trend over this time period increased an average 3.4% per year, vs. Rhode Island Medicaid's trend of 3.1%.
- Rhode Island Medicaid PMPM (per member per month) cost trends compare favorably to local commercial benchmarks. Between SFY 2015 and 2017, the state Medicaid program experienced a decrease in average annual PMPM cost of 2.7% per year. The average annual medical PMPM cost for RI commercial health plans over a similar period increased 3.3% per year.[1]

[1]RI Commercial trend for CY 2015-2017. National trend for FFY 2015-2017.

Sources: National Medicaid Trend from 2017 CMS National Health Expenditure Report.

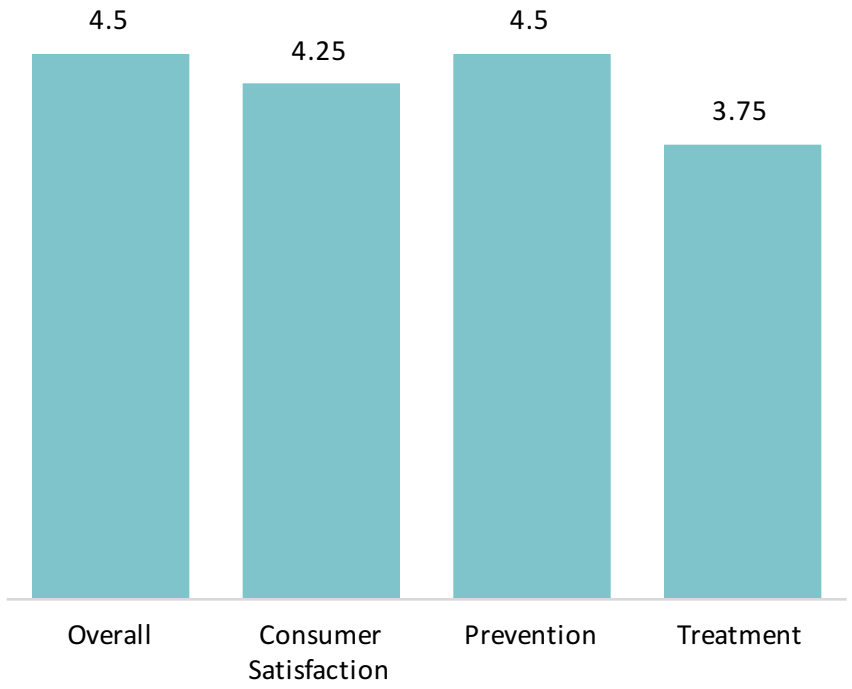
RI Commercial trend from Office of the Health Insurance Commissioner (OHIC), 2017 carrier rate filings, Allowed claims per member per month, includes small group and large group claims from Blue Cross Blue Shield RI, United Healthcare of New England, Neighborhood Health Plan and Tufts Health Plan.

Managed Care: Quality Indicators

Both of Rhode Island's participating Medicaid Managed Care Organizations (MCOs) received an overall plan rating of 4.5 out of 5.0 from the National Committee for Quality Assurance (NCQA) for 2017-8.

NCQA Health Insurance Plan Ratings

Average for Rhode Island MCOs, 2017-2018



- Only 11 MCOs across the country received an overall rating of 4.5 or above.
- NCQA ratings consists of three types of quality measure domains: clinical quality, consumer satisfaction, and results from NCQA's review of the Health Plan's health quality processes.
- Ratings of 4.0 and above are considered "high performance." Both Rhode Island MCOs scored in the high performance range for consumer satisfaction and prevention domains.
- Consumer satisfaction indicates members' opinions of their plan's care, services, and physicians.
- Prevention indicates how well plans provide screenings, immunizations, and other preventative services.
- Treatment indicates a plan's performance in treating chronic and acute conditions.

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

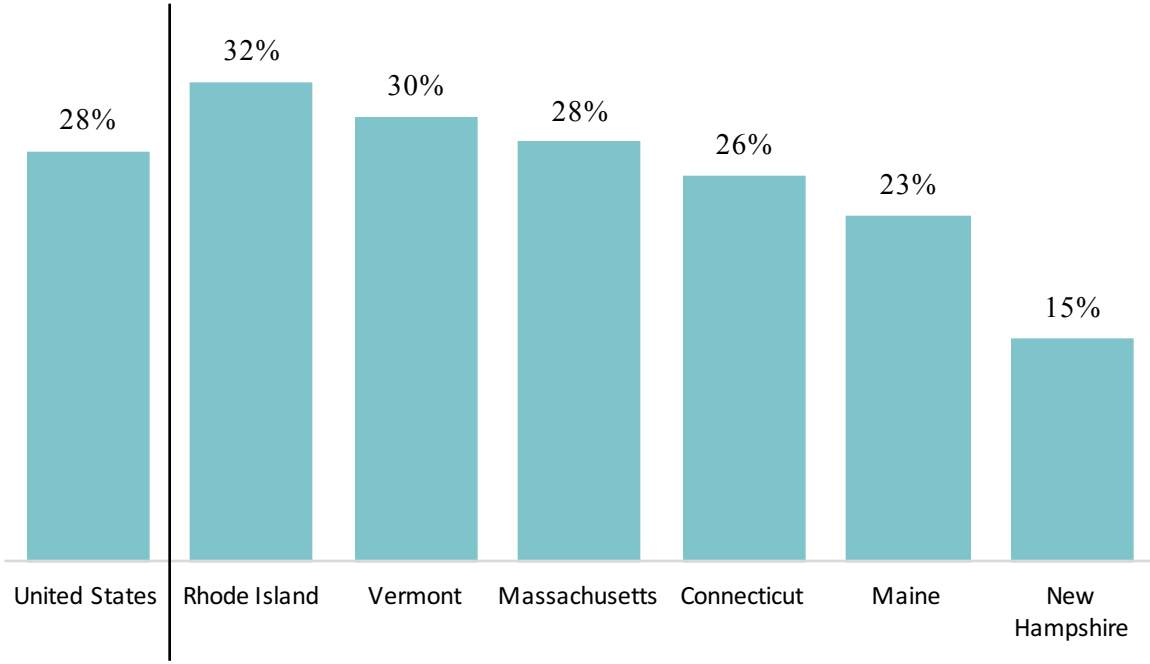
Medicaid Trends: Medicaid Enrolled Population

According to enrollment data as of the end of SFY 2017, Rhode Island's Medicaid enrollment is 32% of population under 65, the highest percentage of the New England states.

Medicaid Enrollment as Percent of Under 65 Population

July 2017

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



United States	Rhode Island	Vermont	Massachusetts	Connecticut	Maine	New Hampshire
74,646,180	313,103	168,455	1,627,506	799,837	266,623	187,798

Medicaid Enrollment, July 2017

- 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 28% of the population under 65 is enrolled in Medicaid.

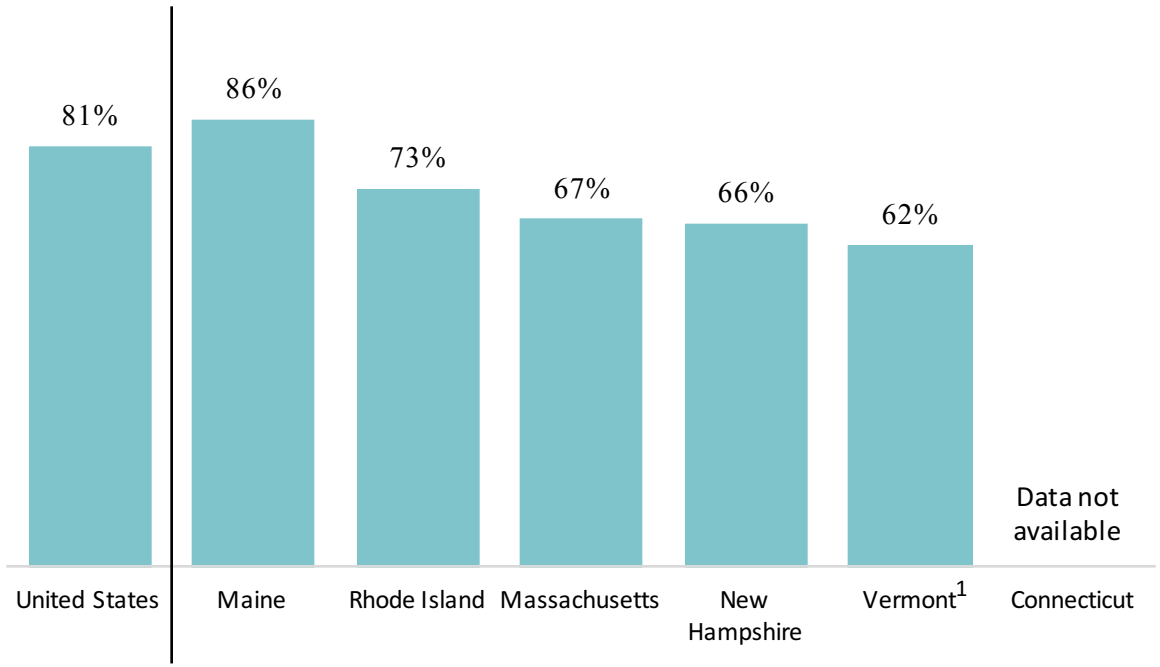
Medicaid Trends: Managed Care Enrollment

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

Managed Care Enrollment as Percent of Medicaid Enrollment

2016

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

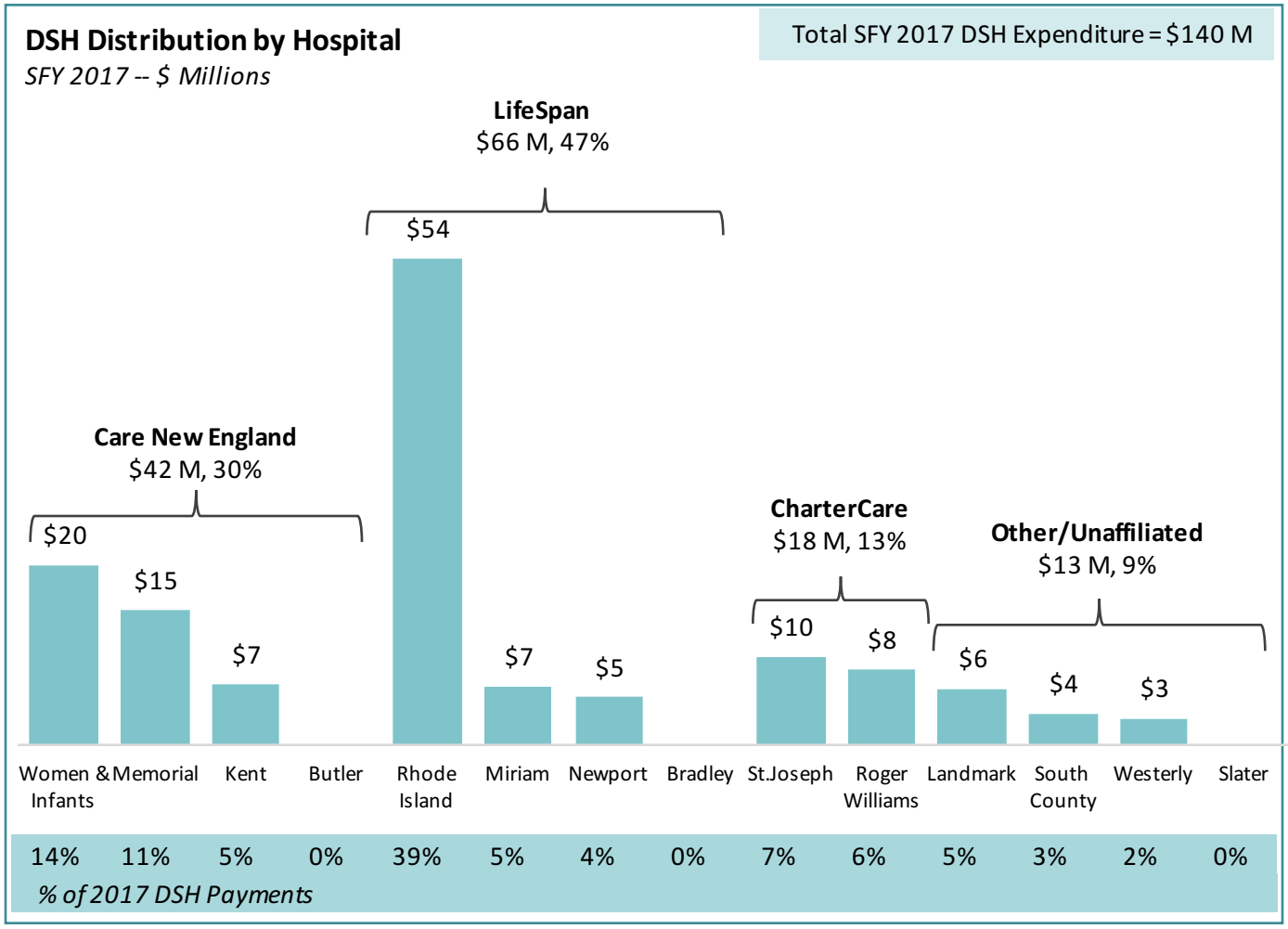


- Total Medicaid enrollment for this chart is defined as beneficiaries enrolled in any Medicaid managed care program, including comprehensive MCOs, limited benefit MCOs, and PCCMs.
- Nationally the average percent of Medicaid managed care enrollment is 81%.
- This data differs from the managed care enrollment data shown earlier in this report because it is based on data from 2016 in order to allow comparison to national and regional data.
- For SFY 2017, Rhode Island managed care enrollment is 90% of eligibles, a difference from the 73% shown in this Kaiser report.

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

Exclusions: (1) Disproportionate Share Hospitals (DSH)

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



- A total of $140 million in DSH funds was paid out to hospitals in SFY 2017.
- 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.

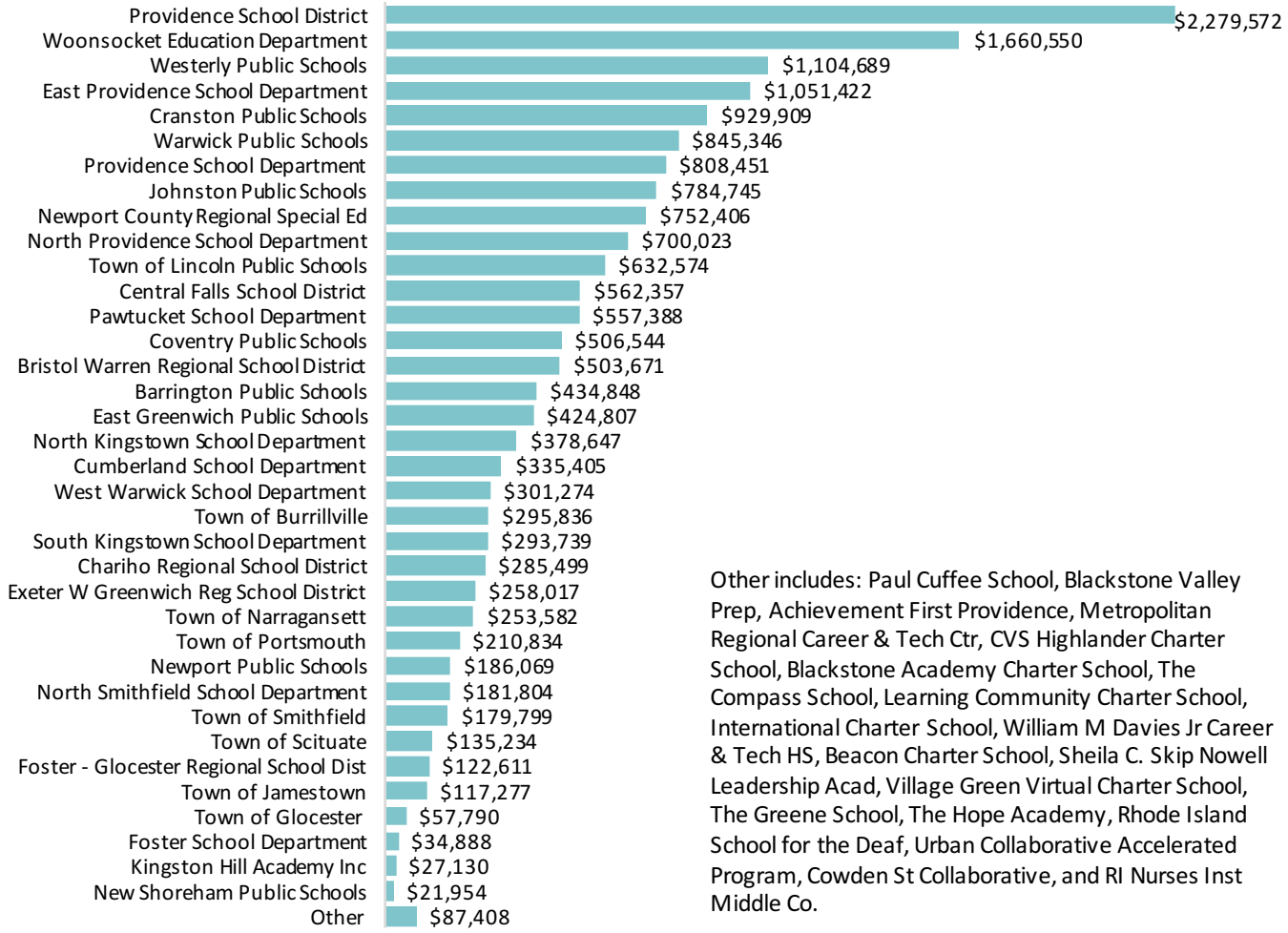
Exclusions: (2) Local Education Authorities (LEA)

Local Education Authorities (LEAs) account for $18 million in total expenditures in 55 school districts.

Medicaid Funding to Local Education Authorities (LEAs)

SFY 2017

Total SFY 2017 LEA Expenditure = $18 M



Other includes: Paul Cuffee School, 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, 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, Urban Collaborative Accelerated Program, Cowden St Collaborative, and RI Nurses Inst Middle Co.

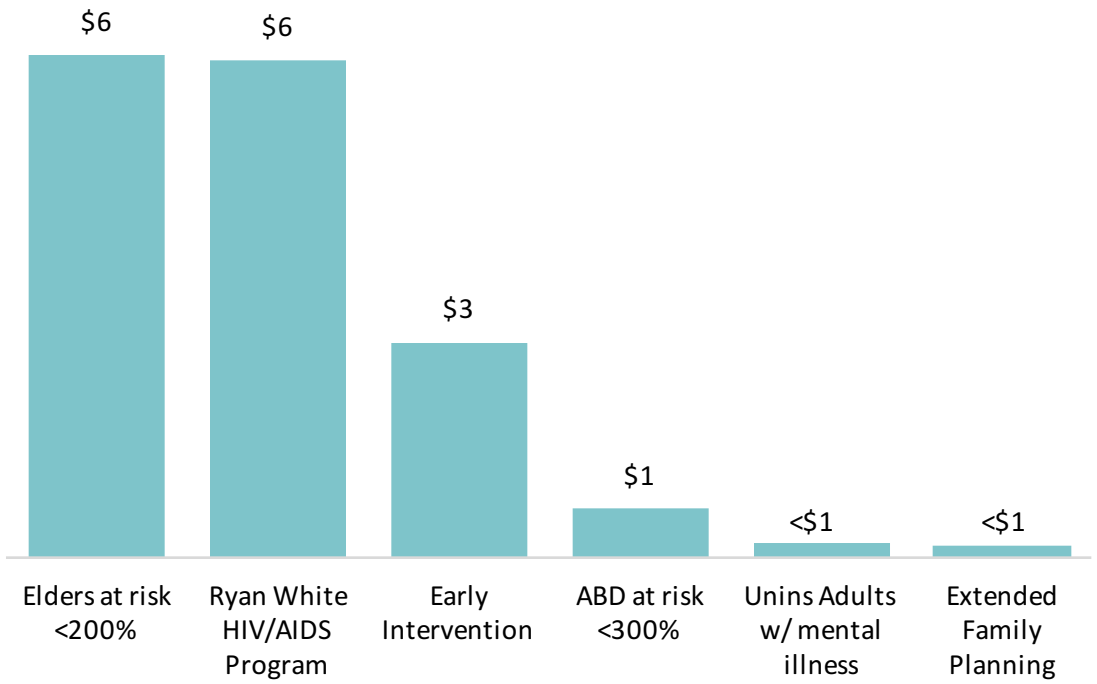
- LEAs provide special education services in their districts.
- For LEA expenditures, the state share is paid with LEA funds.
- LEA payments are not included in the Medicaid expenditure analysis in this report.

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

Costs Not Otherwise Matchable (CNOMs) account for $16 million in total expenditures.

Costs Not Otherwise Matchable (CNOMs)
SFY 2017 -- $ Millions

Total SFY 2017 CNOM Expenditure = $16 M



- Under the terms of Rhode Island's 1115 Waiver Demonstration agreement with the federal government, certain state programs not traditionally allowable under Medicaid fund matching rules can receive federal funding if they forestall the need for persons served to become fully Medicaid eligible.
- These CNOM 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
MH: Mental Health
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
SFY: State Fiscal Year
SSI: Supplemental Security Income
SUD: Substance Use Disorder
UHCNE: UnitedHealth Care of New England
UPL: Upper Payment Limit

Sources and Notes

Source Data and Analytic Method

This report is based on SFY 2017 and five year historical Rhode Island Medicaid systems extracts, including claims, capitation payments, premiums, and provider payouts.

- Data is based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through September 2017.
- 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.