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# Rhode Island Medicaid: Summary and Analysis of High Utilizers

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Draft Report

*April 1, 2015*

## Table of Contents

Introduction .....	3
Summary of Findings .....	7
Part 1: Overview of High Utilizers .....	9
Part 2: High Utilizers in the Community .....	12
Part 3: High Utilizers Receiving Maternity and Delivery Services .....	17
Part 4: High Utilizers in Institutional and Residential Facilities.....	20
Part 5: Additional Details on Individuals Residing in Nursing Homes .....	23
Appendix A1: Spending by Type of Service – Community High Utilizers .....	31
Appendix A2: Spending by Type of Service – Other High Utilizers .....	33
Appendix B: List of Figures.....	35
Appendix C: Sources and Notes for Figures.....	36

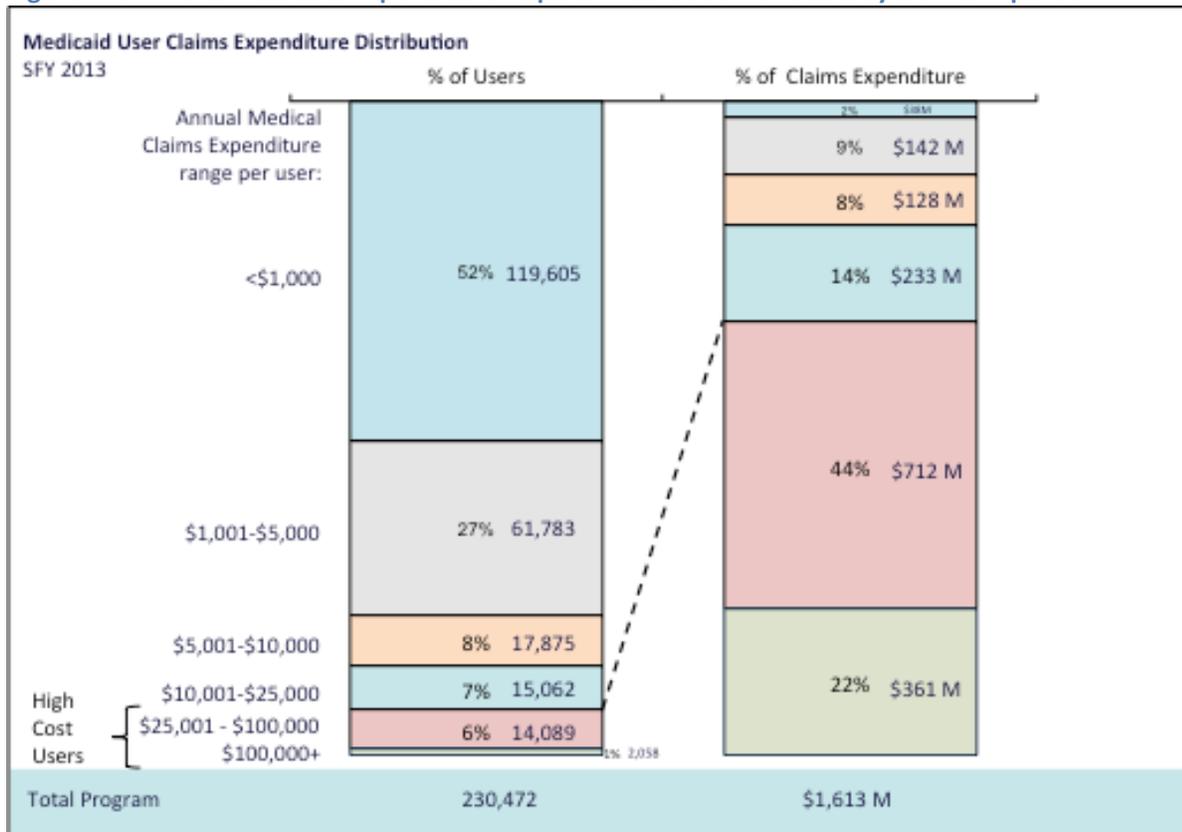
**A detailed list of sources and notes for all figures is located in Appendix C.**

## Introduction

The “*Working Group to Reinvent Medicaid*” was recently established by Governor Raimondo to identify substantial short and longer-term savings in the Rhode Island Medicaid program. This effort must begin with a detailed assessment of current spending to identify specific opportunities that will accomplish the triple aim -- improve or maintain customer experience and population health outcomes while reducing program cost.

High utilizers – the small number of members who account for a high share of program spending – are an obvious place to look for potential savings. As shown below and in the SFY 2013 Medicaid Expenditure Report, 7% of Medicaid users (~16,000 users) with costs over \$25,000 per year account for almost two-thirds (66%) of Medicaid claims expense. This phenomenon is not unique to Rhode Island, nor to public programs, as national statistics show that 5% of Americans account for nearly half of health care costs across the country.<sup>1</sup>

**Figure 1: SFY 2013 Medicaid Expenditure Report: Distribution of Users by Claims Expense**



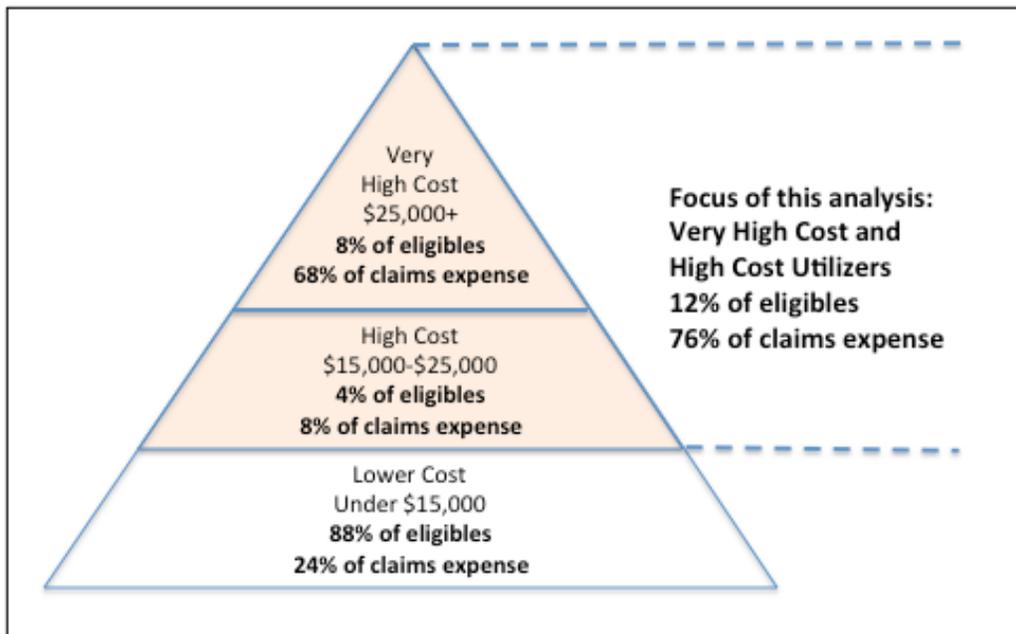
Source: SFY 2013 Medicaid Expenditure Report, page 32. Note: Data excludes DSH, CNOM, LEAs, and Early Family Planning and Early Intervention populations. Expense total is claims-specific payments. Certain expenditures (e.g. UPL, Medicare and PACE Premiums, admin portion of capitation) are not attributable to specific users and are excluded from this analysis. See Appendix C for additional details.

<sup>1</sup> “The Concentration of Healthcare Spending”, National Institute for Healthcare Management Foundation Data Brief July 2012. Based on analysis of MEPS 2009 data.

If those users with over \$25,000 in annual Medicaid expense are the “*very high cost users*,” it is also useful to explore those “*high cost*” users with between \$15,000 and \$25,000 in annual expense. This population can also be identified as high utilizers and, absent intervention, is potentially at high risk of moving into the over \$25,000 category.

Using this broader definition, **high utilizers made up 12% of average eligibles and 76% of Medicaid claims-specific expense**, as shown in Figure 2 below.

**Figure 2: Distribution of Eligibles and Expense into Cost Categories**



*Source: High Cost Users Report, Feb 2014. Excludes DSH, CNOM, and admin portion of capitation. Expense total is claims-specific payments. Certain expenditures (e.g. UPL, Medicare and PACE Premiums) are not attributable to specific users and excluded from this analysis. See Appendix C for details.*

Note that Figure 2 (and the majority of this report) differs slightly from Figure 1 above in that it is based on **average eligibles rather than unique users**. Average eligibles are a measure that allows for alignment with financial analysis, similar to FTEs.<sup>2</sup> In addition, Figure 2 and the analysis that follows include certain expenses that do not qualify for federal match and as such were excluded from the Medicaid Expenditure Report. See Appendix C for more details on the source data used.

Developing approaches to impact the costs and reduce the spending for these high utilizer populations requires an understanding of their circumstances – the programs and services they are accessing, their characteristics, and their health care needs. Toward this end, this report

<sup>2</sup> A unique user is an individual associated with a medical claim and is used to measure the number of individuals enrolled in Medicaid at any time during the fiscal year. Average eligible enrollment is annual FTEs (full time equivalents). For example, if a person enrolled for only 1 month, they would be included as a unique user. Two unique users each enrolled for 6 months would count as 1 average eligible

identifies three distinct groups of high utilizers, based on how they access care, and provides an assessment of each, as outlined below:

**Figure 3: Breakdown of SFY 2013 Claims Expense into Categories for Analysis**

<b>Total Medicaid</b> \$1.6 B – 199,013 average eligibles - \$682 pmpm				
<b>Lower Cost</b> \$384 M 175,772 avg elig \$182 pmpm	<b>High Utilizers &gt;\$15,000</b> \$1.2 B – 23,241 average eligibles - \$4,463 pmpm			
	<b>In the Community</b> \$496 M 12,275 avg elig \$3,368 pmpm	<b>Maternity/Delivery</b> \$68 M 1,525 avg elig \$3,695 pmpm	<b>Institutional/Residential</b> \$681 M - 9,441 avg elig - \$6,010 pmpm	
			<b>Other Inst/Res</b> \$382 M 4,326 avg elig \$7,350 pmpm	<b>Nursing Home</b> \$299 M 5,115 avg elig \$4,877 pmpm

Source: High Cost Users Report Feb 2014, see Appendix C for details.

The remainder of this report can be summarized as follows:

- **Part 1: High Utilizer Overview (green box):**  
Summary of high utilizers residing at home/in the community, those living in an institution or residential facility, and those receiving services that are pregnancy/delivery related
- **Part 2: High Utilizers “In the Community” (blue box)**  
Characteristics and health care needs of those high utilizers who are residing at home/in the community
- **Part 3: Maternity and Delivery High Utilizers (red box)**  
Characteristics and health care needs of those high utilizers who are pregnant and/or delivering a baby
- **Part 4: Institutional/Residential High Utilizers (orange box)**  
Characteristics and health care needs of those high utilizers residing in institutions and residential facilities
- **Part 5: Additional Details on Nursing Home Users (light orange box)**  
More specifics and details on long term nursing home residents (over 90 days), comparing them to Medicaid populations in community based care, and assessing migration patterns
- **Appendix A**  
Breakdown of spending by type of service for Community, Maternity/Delivery, and Institutional/Residential populations.

Note that this assessment should be considered an draft report, focused on the characteristics and health care needs of four populations of high utilizers, as described above. Additional populations and subgroups of these high utilizers shall be explored in the coming months, both in support of the “Reinventing Medicaid” Working Group and more broadly in support of ongoing program needs. Additionally, future updates shall incorporate SFY 2014 claims data, as soon as that data becomes available.

## Summary of Findings

### Part 1: Overview of High Utilizers:

Within the Medicaid program there are 26,990 “high utilizers”, those with annual claims over \$15,000. These high utilizers equate to 23,241 average eligibles (12% of total Medicaid average eligibles) and are responsible for 76% of Medicaid claims-based spending. These high utilizers tend to remain so over multiple years, as 62% of high utilizers in 2012 were also high utilizers in 2011 and 2013 – suggesting that identifying these high utilizers and attempting to deliver more cost effective services can have an impact. However, **developing approaches to impact costs and reduce spending for these high utilizer populations requires an understanding of their circumstances – the programs and services they are accessing, their characteristics, and their health care needs.** As such, high utilizers fall into three categories: those that reside in the community (40% of high utilizer cost); those that reside in institutions or residential facilities (55% of cost); and those that are receiving maternity and or delivery services (5% of cost). Each of these populations has very different characteristics and health care needs.

### Part 2: High Utilizers in the Community

High utilizers “in the community” account for 12,275 average eligibles and \$496 million (40%) of high utilizer costs. These “community based” high utilizers are spread across all Medicaid programs including Rte Care, Children with Special Health Care Needs (CSHCN), and ABD adults. However, across these different populations there was at least one consistent factor: co-occurring physical and mental health care needs. That is, 82% of the Medicaid spend on high utilizers in a community settings was spent on individuals for whom there was a diagnosis related to mental health or substance abuse (primary or otherwise). However, spending on the specific mental health and substance abuse claims only accounted for about 28% of the claims costs. **Based on this analysis one can conclude that most high utilizers “in the community” have multiple co-morbidities, with both physical and mental health care needs, and cost containment strategies must take an integrated approach.** Additionally, only 39% of this population of high utilizers remained high utilizers for three years in a row, compared to 62% in the overall population, suggesting that planned interventions may need to identify and target these individuals **before they become** high utilizers.

### Part 3: Maternity and Delivery High Utilizers

Those high utilizers receiving maternity and delivery related services accounted for 1,525 average eligibles (7% of high utilizer average eligibles) and \$68 million (5%) of high utilizer costs in SFY 2013. While most of this population consisted of pregnant women accessing services related to pregnancy and delivery, pregnant women were not the largest component of spending. **Instead, a very small population of newborns receiving neonatal intensive care services (NICU) was the largest component of cost.** With a ppm cost of \$16,046 they were Medicaid’s second highest unit cost subpopulation of high utilizers.

#### Part 4: Institutional/Residential High Utilizers

Institutional and Residential high utilizers account for 9,441 average eligibles (41%) and \$681 M (55%) of high utilizer costs. Over half of these institutional/residential high utilizers are nursing home residents – the rest are residents of rehabilitation hospitals, facilities for the developmentally disabled or hospice. **And although populations residing in rehabilitation hospitals account for a very small category of high utilizers (only 359 average eligibles) this group is the highest unit cost population of high utilizers in the Medicaid program, with an average unit cost of \$24,089 pmpm.**

One important reality of residential high utilizers is that nearly all the individuals residing in one of these settings are high utilizers – so **simply being in residential setting makes many of these individuals high utilizers.** Strategies to address this population’s cost must therefore focus on both “rebalancing” (identifying high-risk individuals and providing them with access to services that enable them to reside in community based settings) and ensuring that those whose needs are best met by institutional/residential care receive services in the highest quality, most cost effective setting possible.

#### Part 5: Additional Details on Nursing Homes

Almost one quarter (24%) of spending on high utilizers is for a subset of the institutional/residential high utilizers described in Part 4 -- individuals in nursing homes greater than 90 days. Multiple strategies have been implemented in recent years in an effort to rebalance the Medicaid population and thereby shift the nursing home population into home and community based services with modest results, as nursing home days per 1,000 average eligibles has declined by 1-4% per year over the past seven years.

Strategies aimed at rebalancing the Medicaid population away from nursing home settings must consider a few key findings. First, history shows that efforts to slow the transition TO nursing homes are likely to be more effective than transitioning individuals OUT of nursing home settings. Second, much of the nursing home population is already in a nursing home when becoming eligible for Medicaid, likely having entered a nursing home and then spent down their assets until they became Medicaid eligible. **This suggests that strategies to “rebalance,” away from nursing home settings and toward community based care likely would benefit from a multi-payer, population based approach, as these high risk individuals must be identified well before they spend down assets and become Medicaid eligible – before they enter a nursing home.** And finally, since the population typically residing in nursing homes has an average age of 82 and high rates of dementia, specialized services and supports, including in some cases constant monitoring, may be required in order to appropriately care for this population in a home and/or community based setting.

## Part 1: Overview of High Utilizers

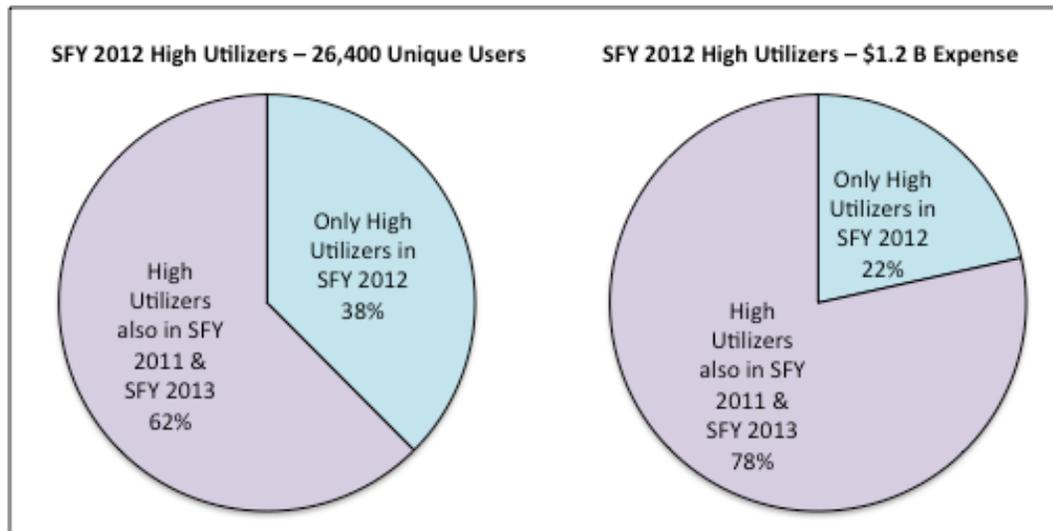
Total Medicaid				
Lower Cost	High Utilizers >\$15,000			
	In the Community	Maternity/Delivery	Institutional/Residential	
			Other Inst/Res	Nursing Home

Within the Medicaid program there are 26,990 “high utilizer” individuals, those with annual claims over \$15,000. These high utilizers equate to 23,241 average eligibles, about 12% of the average eligibles in the Medicaid program overall. These high utilizers are responsible for 76% of Medicaid claims-based spending.

A key consideration for the program’s ability to impact these costs is the utilization patterns of this population over time. Are the same individuals high utilizers year over year? Or are the high utilizers a different group each year?

A multi-year analysis of SFY 2012 high utilizers (also defined as those spending \$15,000 or more per year) found that **most high utilizers tended to remain so over multiple years, as 62% of high utilizers in 2012 were also high utilizers in both SFY 2011 and SFY 2013.** As shown in figure 4 below, these individuals who were high utilizers three years in a row also accounted for 78% of high utilizer expense in SFY 2012, suggesting that identifying these high utilizers and attempting to deliver more cost effective services can have an impact.

Figure 4: Year over Year Trend of High Utilizer Unique Users and Expense



Source: High Cost Users Report Feb 2014, see Appendix C for detail.

Note that this statistic varies significantly by population. In the “Community” population shown below, only 39% of high utilizers are high utilizers three years in a row compared to 62% in the

overall Medicaid population, as shown above. Additional discussion on the variation by population is included in Part 2.

Developing approaches to impact costs and reduce spending for these high utilizer populations requires an understanding of who they are – the programs and services they are accessing, their characteristics, and their health care needs.

Toward this end, this analysis classified high utilizers into three categories, as shown in Figure 5 below: individuals receiving care in the community, those using maternity and delivery services, and those receiving care in an institutional or residential setting. These distinctions were based on the premise that these three groups of high utilizers likely had very different characteristics and health care utilization experiences.

**Figure 5: Summary of High Utilizer Categories**

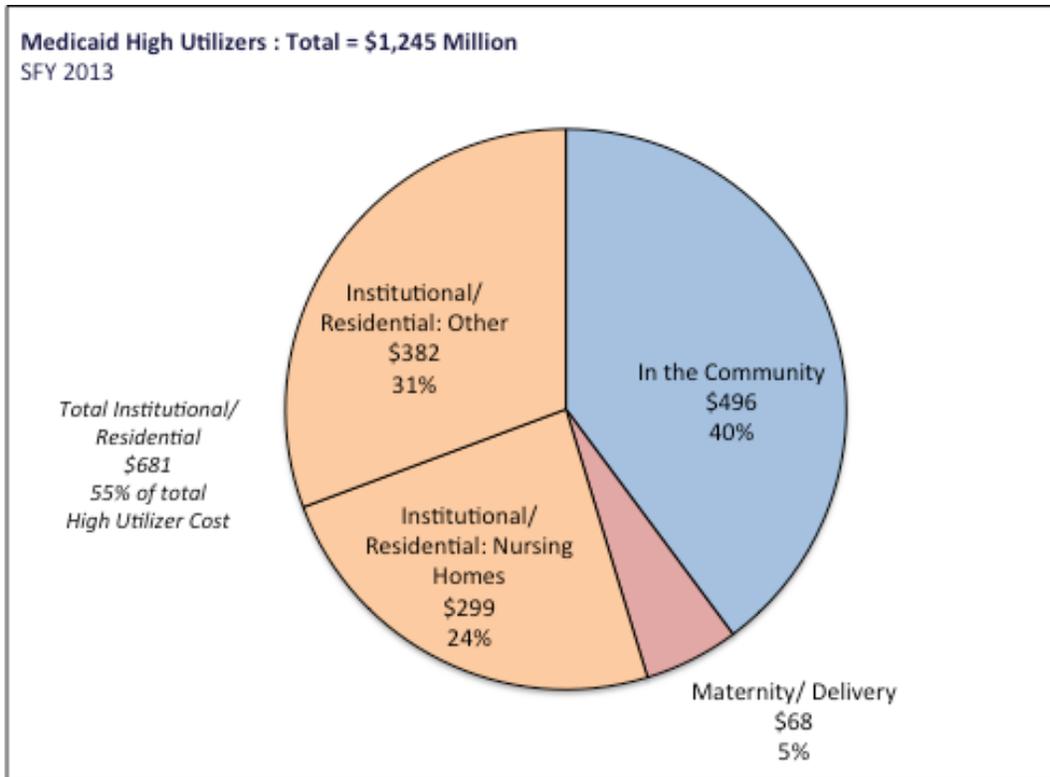
<b>High Utilizers &gt;\$15,000</b> <i>\$1.2 B – 23,241 average eligibles - \$4,463 pmpm</i>		
<b>In the Community</b> <i>\$496 M</i> <i>12,275 avg elg</i> <i>\$3,368 pmpm</i>	<b>Maternity/Delivery</b> <i>\$68 M</i> <i>1,525 avg elg</i> <i>\$3,695 pmpm</i>	<b>Institutional/Residential</b> <i>\$681 M</i> <i>9,441 avg elg</i> <i>\$6,010 pmpm</i>
All other high utilizers who do not fit into the categories at right (presumably living in the community).	Those individuals receiving maternity or delivery services, including: <ul style="list-style-type: none"> <li>• Neonatal intensive care services (NICU)</li> <li>• Pregnancy services</li> <li>• Maternity services</li> <li>• Delivery services</li> <li>• Other services for high cost newborns not associated with NICU claims</li> </ul>	Those individuals receiving care in an institutional or residential setting, including: <ul style="list-style-type: none"> <li>• Hospice – services provided to terminally ill individuals</li> <li>• Rehabilitation Hospital – specialized inpatient facilities with intensive rehabilitation services (Slater, Zambarano, Tavares)</li> <li>• Individuals in Nursing Homes &gt;90 days</li> <li>• Services for the developmentally disabled, including day care programs, home modifications, supported employment, etc.</li> <li>• Public and private residential facilities for the developmentally disabled</li> </ul>

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

Based on these categories, spending and enrollment can be broken down as follows:

- **Individuals receiving care in an institutional or residential setting** accounted for 9,441 average eligibles (41% of high utilizers) and \$681 Million in spending (55% of Medicaid spending on high utilizers).
- Those high utilizers receiving **maternity and delivery services** accounted for another 1,525 average eligibles (7% of high utilizers) and \$68 million in spending (5% of high utilizer spending).
- The rest of the high utilizers presumably are **living in the community**, and they account for 12,275 average eligibles (53% of high utilizers) and \$496 million in spending (40% of high utilizer spending), as shown in Figure 6 below.

Figure 6: Breakdown of High Utilizer Expense



Source: High Cost Users Report Feb 2014, see Appendix C for detail.

## Part 2: High Utilizers in the Community

Total Medicaid				
Lower Cost	High Utilizers >\$15,000			
	In the Community	Maternity/Delivery	Institutional/Residential	
			Other Inst/Res	Nursing Home

High utilizers residing “*in the community*” account for 12,275 average eligibles and \$496 million (40%) of high utilizer costs.

These “community based” high utilizers are enrolled in the following programs within Medicaid, as shown below – Rite Care children, Children with Special Health care Needs (CSHCN), RiteCare Adults, and ABD adults.

**Figure 7: Summary of High Utilizers in the Community**

High Utilizers	Expense \$M	Average Eligibles	pmpm	Description
<b>Total In the Community</b>	\$496 M	12,275	\$3,368	
<b>ABD Adults</b>	\$286 M	6,811	\$3,494	Aged, Blind and Disabled Adults
<b>Children with Special Health Care Needs (CSHCN)</b>	\$124 M	2,778	\$3,734	Children with Special Healthcare Needs <ul style="list-style-type: none"> <li>• Adoption Subsidy</li> <li>• Early intervention</li> <li>• Katie Beckett</li> <li>• SSI &lt;21</li> <li>• Substitute Care</li> </ul>
<b>Rite Care Children</b>	\$44 M	1,388	\$2,632	Children 0-20 on RiteCare
<b>Rite Care Adults</b>	\$42 M	1,299	\$2,714	Adults 20 and over on RiteCare

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

Note that the two highest cost population groups in community settings are ABD adults and children with special health care needs, as these two groups together capture 83% of spending on high utilizers in the community. Rite Care children and adults are a much smaller share (17%) of high utilizer spending in the community.

A key consideration for the program’s ability to impact these costs is the utilization patterns of this population over time. Are the same individuals high utilizers year over year? Or are the high utilizers a different group each year?

In contrast to the overall Medicaid High Utilizer population, **the Community High Utilizers are much less likely to be high utilizers year after year – 39% of Community High Utilizers remain High Utilizers three years in a row compared to 62% for all Medicaid High Utilizers (shown in Part 1).**

**Figure 8: Year over Year Trend of High Utilizers in the Community**

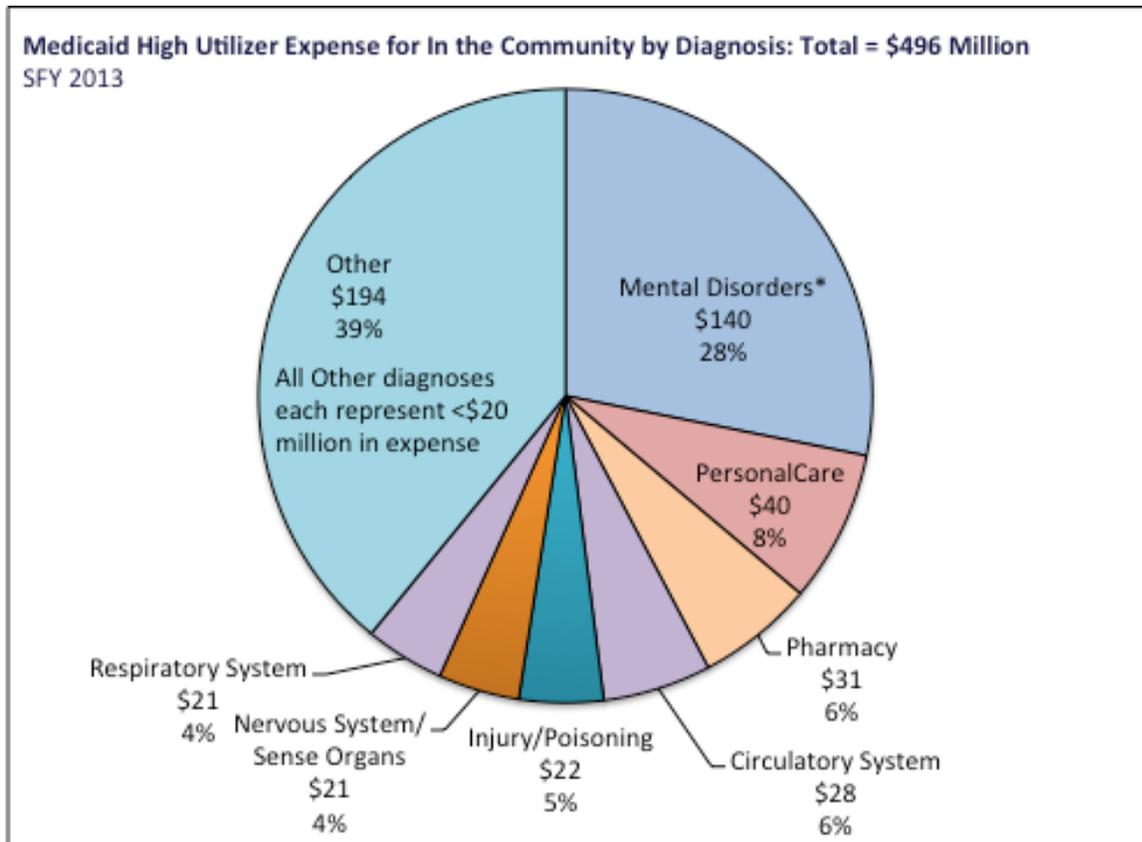
<b>Community High Utilizers</b>	<b>CSHCN</b>	<b>RC children</b>	<b>RC adults</b>	<b>ABD adults</b>	<b>Total</b>
Average Eligibles SFY 2013	2,778	1,388	1,299	6,811	<b>12,275</b>
Unique users SFY 2013	3,087	1,745	1,594	7,806	<b>14,232</b>
SFY 2013 High Utilizers who were also High Utilizers in SFY 2011 & 2012	1,672	292	187	3,386	<b>5,537</b>
<b>% of SFY 2013 High Utilizers who were also High Utilizers in SFY 2011 &amp; 2012</b>	<b>54%</b>	<b>17%</b>	<b>12%</b>	<b>43%</b>	<b>39%</b>

This also varies by subpopulation within the Community category, as shown above. Only 12-17% of RiteCare children and adults are High Utilizers three years in a row compared to 43% of ABD adults and 54% of Children with Special Healthcare Needs. As such, planned interventions may need to identify and target these individuals **before they become** high utilizers.

In order to understand the health care needs of this population, spending on each of these population groups was then classified by primary diagnosis code.

Of the \$496 million spent on “community based” high utilizers, **\$140 million (28%) was spent on mental health and substance abuse related claims (diagnosis category: “mental disorders”)**. Note that mental disorders was by far the highest cost diagnosis category for these high utilizers at \$140 Million, followed by personal care services<sup>3</sup> (\$40 Million) and pharmacy (\$31 Million), as shown below.

**Figure 9: Community High Utilizers by Primary Diagnosis**



Source: High Cost Users Report Feb 2014, see Appendix for detail.

\*Mental Disorders includes mental health and substance abuse-related diagnoses, including affective psychoses, childhood origin psychoses (including autism), schizophrenic disorders, developmental delays, neurotic disorders, drug dependence, alcoholic dependence and others.

Additional information on the breakdown of spending by type of service (inpatient, outpatient, professional, pharmacy, etc.) is included in Appendix A.

<sup>3</sup> Personal care services include the provision of human assistance to beneficiaries in their home. Such assistance most often relates to activities of daily living (ADLs) such as eating and drinking, bathing, dressing, grooming, toileting, transferring and mobility.

These findings were consistent across the population groups, with mental disorders as the highest cost diagnosis category for all community population groups. However, the share of total costs for mental disorders varied from 15% to 52% of the total, as shown below.

**Figure 10: Community High Utilizers Expense by Primary Diagnosis by Population**

Primary Diagnosis	Percent of Community Population High Utilizer Expense by Diagnosis				
	ABD Adults Total = \$286M	CSHCN Total = \$124M	Rite Care Children Total = \$44M	Rite Care Adults Total = \$42M	Total Community Total = \$496M
<b>Mental Disorders*</b> <i>(Mental Health and Substance Abuse)</i>	<b>23%</b>	<b>37%</b>	<b>52%</b>	<b>15%</b>	<b>28%</b>
Personal Care	13%	1%	0%	0%	8%
Pharmacy	7%	4%	5%	11%	6%
Circulatory System	8%	1%	1%	6%	6%
Injury/Poisoning	5%	2%	4%	7%	4%
Nervous System/Sense Organs	4%	6%	4%	4%	4%
Respiratory System	5%	2%	4%	3%	4%
Other	35% All other diagnoses 4% or less	48% Other includes: Residential DCYF (15%), Intellectual Disability (7%), Condition influencing health status (7%), All other diagnoses 4% or less	30% Other includes: Congenital Anomalies (5%) All other diagnoses 4% or less	53% Other includes: Musculoskeletal (11%), Neoplasms (7%), Digestive System (7%), Symptoms ill-defined (6%) All other diagnoses under 5%	39%

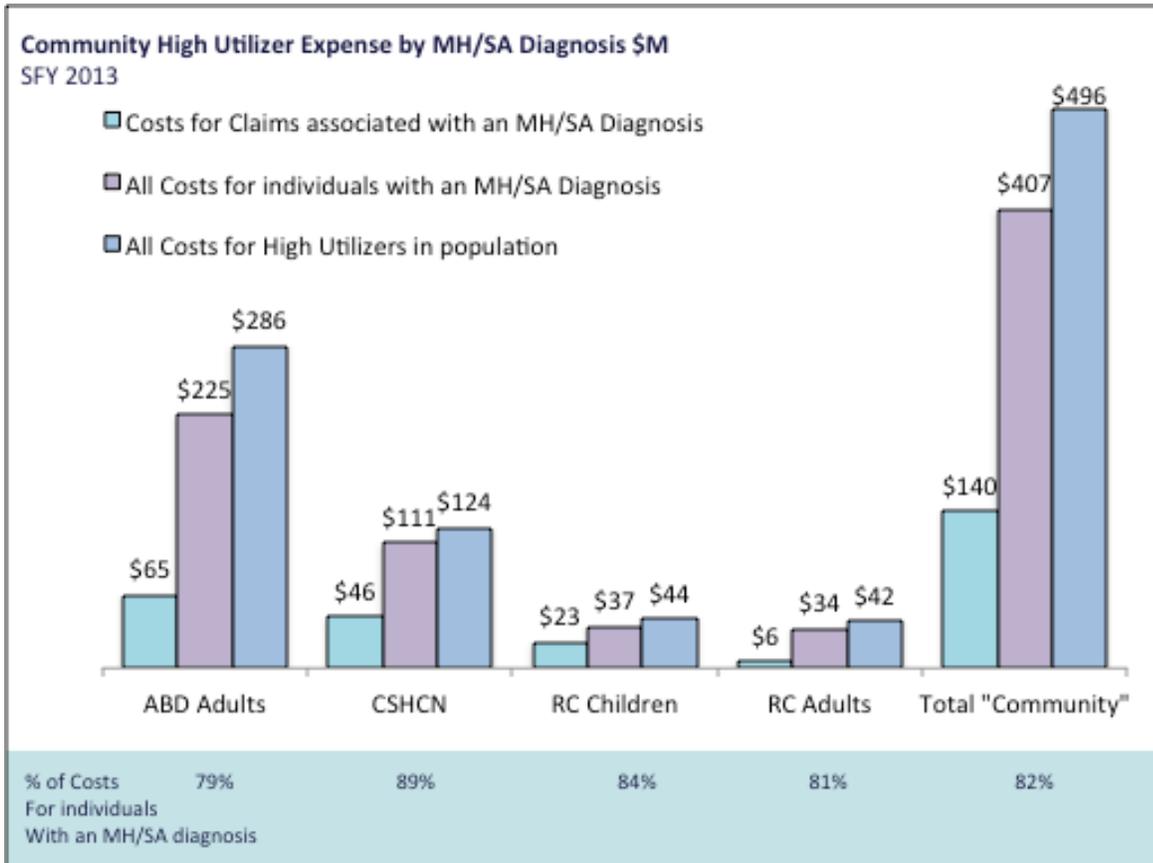
Source: High Cost Users Report Feb 2014, see Appendix C for detail.

\*Mental Disorders includes mental health and substance abuse-related diagnoses, including affective psychoses, childhood origin psychoses (including autism), schizophrenic disorders, developmental delays, neurotic disorders, drug dependence, alcoholic dependence and others.

Understanding the health care needs of these populations, however, requires a more detailed look at the spending patterns of individuals within this group. Specifically, given the high spending on mental health and substance abuse services, it is helpful to understand how much is spent on individuals with physical *and* mental health comorbidities.

Further analysis shows that **of the \$496 million spent on “community based” high utilizers, \$407 million (82%) was for individuals for whom there was a mental health or substance abuse claim.** This finding was relatively consistent across all subpopulations of the Community grouping, ranging from 79 to 89%.

**Figure 11: Community High Utilizer Expense by Diagnosis by Population**



Source: High Cost Users Report Feb 2014, see Appendix C for detail.

MH/SA is Mental Health and Substance Abuse, and is equivalent to the diagnosis category Mental Disorders.

**Thus, across all these different populations there appears to be at least one consistent factor: co-occurring physical and mental health care needs.** That is, most of the Medicaid spend on high utilizers in a community settings (82%) was spent on individuals for whom there was a diagnosis related to mental health or substance abuse (primary or otherwise). However, the spending was NOT concentrated in mental health/substance abuse services, as the specific mental health/substance abuse claims only accounted for about \$140 Million, or 28% of the claims.

Based on this analysis one can conclude that **most high utilizers in non-institutional settings have multiple co-morbidities, with both physical and mental health care needs, and cost containment strategies must take an integrated approach.**

### Part 3: High Utilizers Receiving Maternity and Delivery Services

Total Medicaid				
Lower Cost	High Utilizers >\$15,000			
	In the Community	Maternity/Delivery	Institutional/Residential	
			Other Inst/Res	Nursing Home

Medicaid covered services related to pregnancy and delivery for 4,733 deliveries in SFY 2013.<sup>4</sup> Only a small percentage of these maternity and delivery related services can be classified as high utilizer expenses.

High utilizers receiving maternity and delivery related services account for 1,525 average eligibles, 2,947 unique users, and \$68 million (5%) of high utilizer costs. Note that unlike the other High Utilizer populations discussed in this analysis, there is a large difference in the Maternity/Delivery population between the number of average eligibles (1,525) and the number of recipients, or unique users (2,947).<sup>5</sup> This section of the analysis will focus on recipients as a more meaningful measure for the maternity/delivery population.

Maternity and Delivery high utilizers fall into three basic categories:

- **Pregnant Women**

About 16% of Medicaid covered pregnant women (1,586 pregnant women) incurred complications of pregnancy and childbirth that classified them as high utilizers. Within the high utilizer population, these pregnant women account for the majority of the population of maternity and delivery high utilizers (54% of unique users). This population costs \$2,079 pmpm, for a total of \$28 Million in SFY 2013.

- **NICU Newborns**

Approximately 10% of Medicaid’s deliveries (428 newborns in SFY 2013) required neonatal intensive care services (NICU). Of those, there were 358 “high utilizer” newborns (with over \$15,000 in NICU costs). NICU newborns account for a small share of the maternity and delivery high utilizer population but they are very high cost. With a pmpm cost of \$16,046 they are Medicaid’s second highest unit cost subpopulation of high utilizers in this report, accounting for about \$31 Million in annual expenditure.

- **Other Newborns**

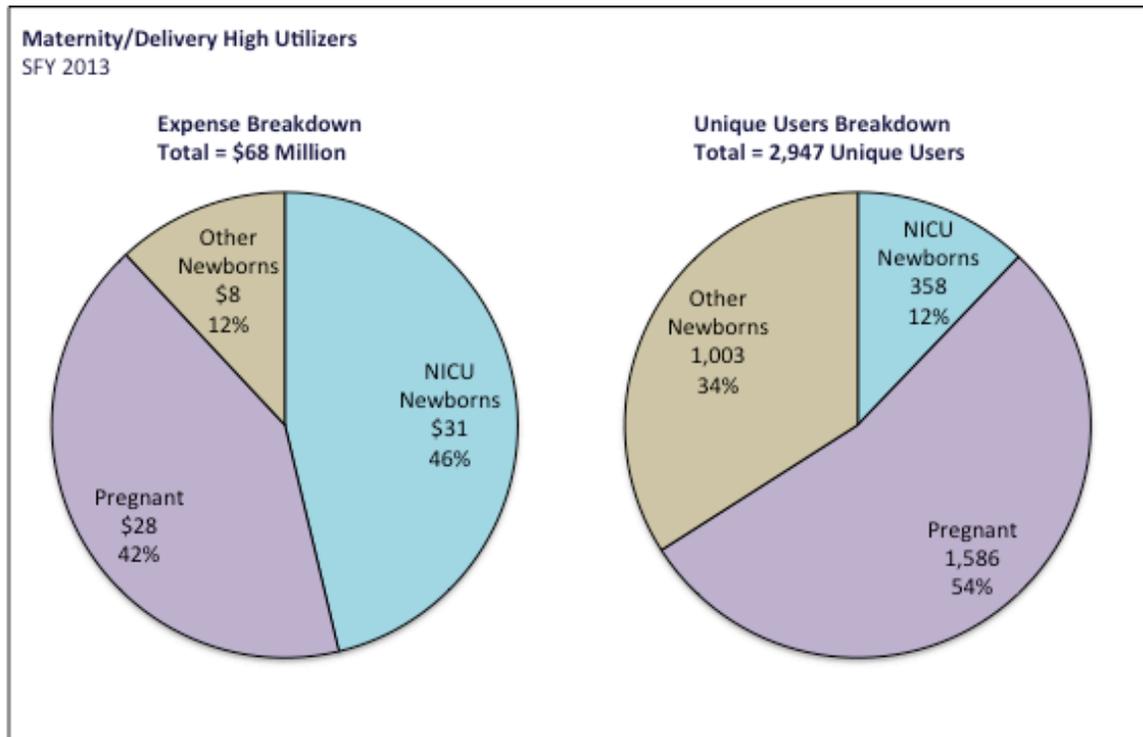
Another 1,003 newborns had over \$15,000 in Medicaid costs but were not associated with NICU claims. These account for another \$8 million in cost.

<sup>4</sup> Based on SOBRA claims.

<sup>5</sup> This is mainly due to timing as pregnancies and deliveries occur throughout the year.

As demonstrated in Figure 12 below, almost half (46%) of the spending on this population of high utilizers was on the 358 recipients of NICU services (12% of unique users in the maternity/delivery high utilizer category). The remaining half (54%) of spending was on the other 88% of unique users of pregnancy and delivery services.

**Figure 12: Maternity/Delivery High Utilizer Expense**



Source: High Cost Users Report Feb 2014, see Appendix C for detail.

**It is also helpful to note that most of the NICU population are high utilizers.** There were 428 newborns who received NICU services in 2013, and 84% were high utilizers. To put these costs in context, the average length of stay in the NICU for RiteCare newborns with NICU claims is 20.2 days at an average cost of \$2,760 per day.<sup>6</sup> This is not the case for most other maternity and delivery populations, as only 16% of overall Medicaid pregnant women and 9% of overall Medicaid other newborns were high utilizers.

**Figure 13: Maternity/Delivery High Utilizers as Percent of Total**

Recipients (Unique Users)	NICU Newborns	Pregnant	Other Newborns	Total
Lower Utilizers \$0-\$15,000	70	8,137	3,965	12,172
High Utilizers >\$15,000	358	1,586	1,003	2,947
<b>Total</b>	<b>428</b>	<b>9,723</b>	<b>4,968</b>	<b>15,119</b>
<b>% of recipients that are High Utilizers</b>	<b>84%</b>	<b>16%</b>	<b>20%</b>	<b>19%</b>

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

Note: These are unique users, i.e. individuals associated with a medical claim. The number of unique users is higher than the number of average eligibles, which measures annual FTEs (full time equivalents). For example, two unique users each enrolled for 6 months would count as 1 average eligible.

Additional information on the breakdown of spending by type of service (inpatient, outpatient, professional, pharmacy, etc.) is included in Appendix A.

<sup>6</sup> Source: ACE Report, SFY 2013. See Appendix C for details. There are additional NICU costs associated with non-RiteCare populations but the length of stay is similar.

## Part 4: High Utilizers in Institutional and Residential Facilities

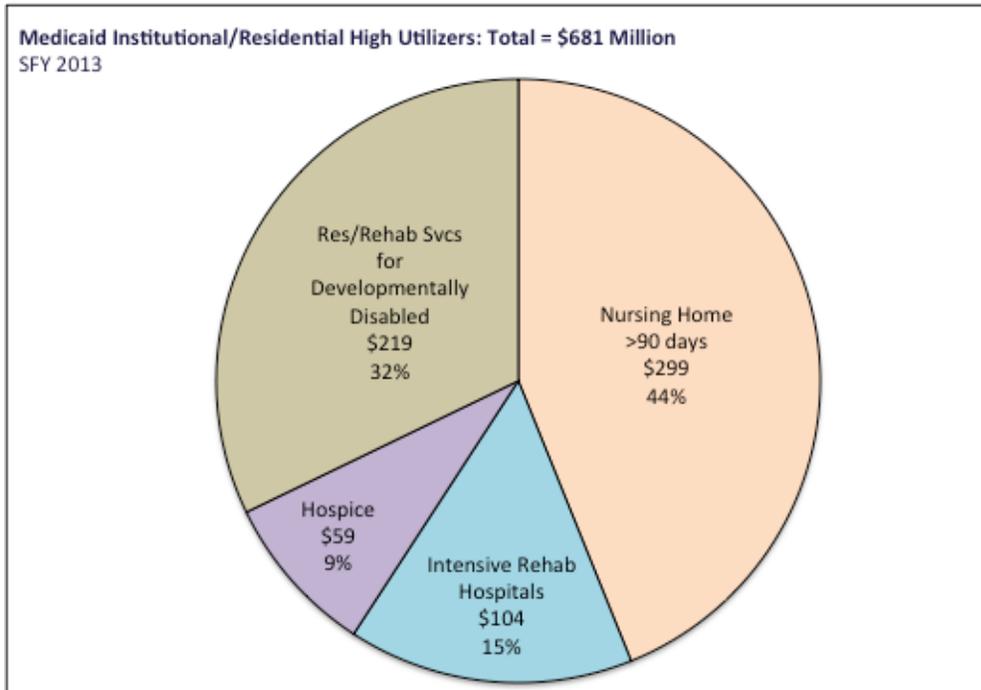
Total Medicaid				
Lower Cost	High Utilizers >\$15,000			
	In the Community	Maternity/Delivery	Institutional/Residential	
			Other Inst/Res	Nursing Home

In SFY 2013 there were 9,441 institutional and residential average eligibles who accounted for \$681 M (55%) of high utilizer costs. These institutional and residential average eligibles include four primary population subcategories:

- Nursing Home >90 days**  
 Over half (54%) of the 9,441 institutional and residential high utilizer average eligibles have been in nursing homes for greater than 90 days. This sub-category is responsible for 44% (\$299 million) of the institutional and residential high utilizer spending.
- Residential and Rehabilitation Services for the Developmentally Disabled**  
 Another 2,907 average eligibles (31% of institutional/residential high utilizer eligibles) are receiving residential and rehabilitation services for the developmentally disabled and are responsible for \$219 M in spending. These services include public and private residential facilities for persons with developmental disabilities, adult day programs, rehabilitation and habilitative services, home modifications and supported employment. This does NOT include costs for adult mental health residential services.
- Intensive Rehabilitation Hospitals**  
 Populations residing in a rehabilitation hospital (Slater Hospital, Zambarano and Tavares) account for \$104 million in spending (15% of institutional/residential high utilizer spending) but capture a very small number of high utilizers (only 359 average eligibles, or 4% of institutional/residential high utilizer eligibles). However, this subcategory is the highest unit cost population of high utilizers in the Medicaid program, with an average unit cost of \$24,089 pmpm.
- Hospice**  
 Populations receiving hospice care account for the final eleven percent of high utilizers in this category (1,060 average eligibles) and 9% of spending. These costs include both professional services payments and payments to institutions (e.g., nursing homes) for individuals receiving hospice services.<sup>7</sup>

<sup>7</sup> See Appendix A2 for more details on the breakdown of hospice costs by provider type.

Figure 14: Breakdown of Residential High Utilizers



*Intensive Rehabilitation Hospitals include Slater Hospital, Zambarano and Tavares.*

*Source: High Cost Users Report Feb 2014, see Appendix C for detail.*

Additional information on the breakdown of spending by type of service (inpatient, outpatient, professional, pharmacy, etc.) is included in Appendix A.

It is also important to understand the reality of these institutional/residential high utilizers – based on expenditures of \$15,000 or more **simply being in an institutional or residential setting makes many of these individuals high utilizers.**

As shown below, nearly all of the average eligibles in nursing homes over 90 days were high utilizers. This holds true for individuals in intensive rehabilitation hospitals (Slater Hospital, Zamabarano and Tavares) as well. Almost all (95%) of the average eligibles in hospice were also high utilizers, and about three-fourths of those receiving residential and rehabilitation services for the developmentally disabled were high utilizers.

**Figure 15: Institutional/Residential High Utilizers as Percent of Total**

Average Eligibles	Nursing Home >90 days	Intensive Rehab Hospital	Hospice	Developmentally Disabled Res/Rehab Svcs	Total
Lower Utilizers \$0-\$15,000	24	0	52	866	942
High Utilizers >\$15,000	5,115	359	1,060	2,907	9,441
<b>Total</b>	<b>5,139</b>	<b>359</b>	<b>1,113</b>	<b>3,773</b>	<b>10,383</b>
<b>% of average eligibles that are High Utilizers</b>	<b>100%</b>	<b>100%</b>	<b>95%</b>	<b>77%</b>	<b>91%</b>

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

Given that Medicaid eligibles living in an institutional or residential setting are, almost by definition, high utilizers, strategies to address this population of high cost utilizers must focus on two primary areas. First, “rebalancing” - identifying high-risk individuals and providing them with access to services that enable them to remain in community based settings. And second, for those individuals whose needs are best met by institutional/residential care, ensuring that the services are provided in the highest quality, most cost effective setting possible.

## Part 5: Additional Details on Individuals Residing in Nursing Homes

Total Medicaid				
Lower Cost	High Utilizers >\$15,000			
	In the Community	Maternity/Delivery	Institutional/Residential	
			Other Inst/Res	Nursing Home

One group of institutional/residential high utilizers – those in nursing homes >90 days – are a large enough subset to warrant a more detailed assessment.

Individuals residing in nursing homes for over 90 days account for almost one-quarter (24%) of all high utilizer expense (about \$299 million in SFY 2013), and a similar share (22%) of high utilizer average eligibles (5,115 average eligibles). As such, it is useful to specifically examine ways to better leverage community based care for this population.

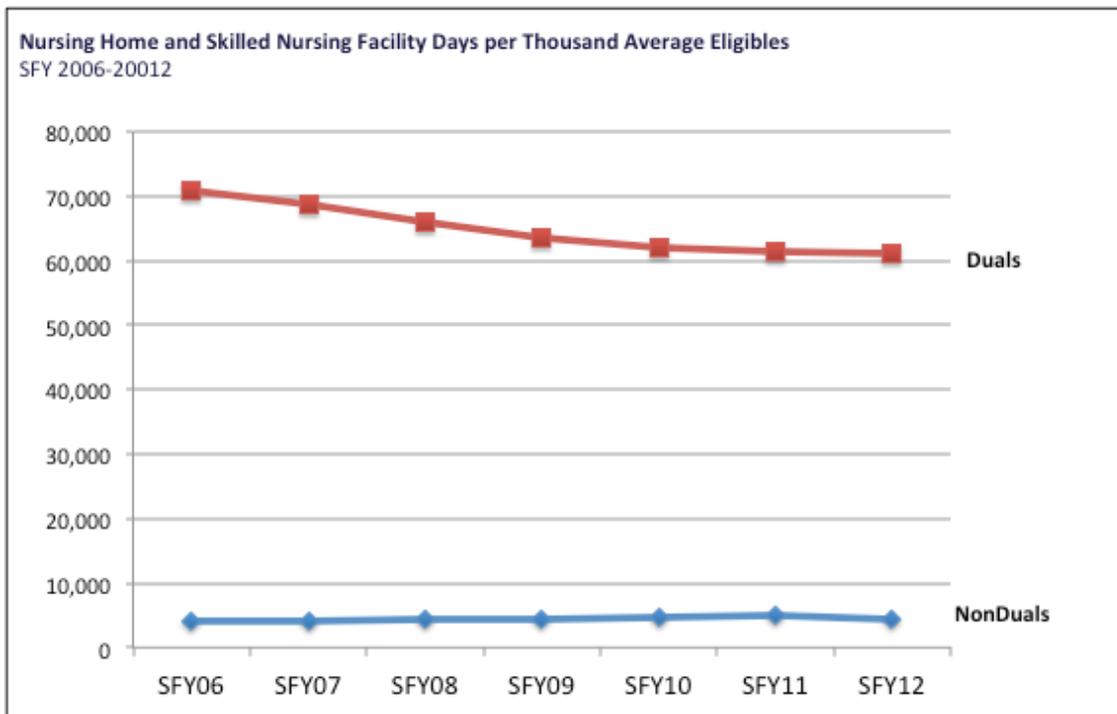
Home and Community Based Services (HCBS) are a set of Medicaid services that allow individuals to remain in their homes rather than moving to a nursing home setting. Currently about 2,000 Medicaid individuals over age 65 are receiving services in an HCBS setting<sup>8</sup> compared to the 5,139 average eligibles receiving nursing home services over 90 days<sup>9</sup>.

<sup>8</sup> Source: SFY 2013 Medicaid Expenditure Report, page 44, Average Daily Census for Personal Care services for Elders.

<sup>9</sup> See Figure 15. There are 5,139 total average eligibles in nursing homes >90 days, 5,115 of these are high utilizers.

Multiple strategies have been implemented in recent years in an effort to “rebalance” the Medicaid population and thereby shift the nursing home population into home and community based services. These efforts have had a modest impact to date, as nursing home days per thousand average eligibles for the duals population over the last 7 years have declined by 1-4% per year, as shown below. More recently, the Integrated Care Initiative (ICI) was explicitly developed to improve transitions of care from the hospital or nursing home back to member’s homes and rebalance the long-term care system to support home and community-based living vs. institutional care. This program began in November of 2013 so results are not yet available.

**Figure 16: Nursing Home/SNF Days per Thousand**



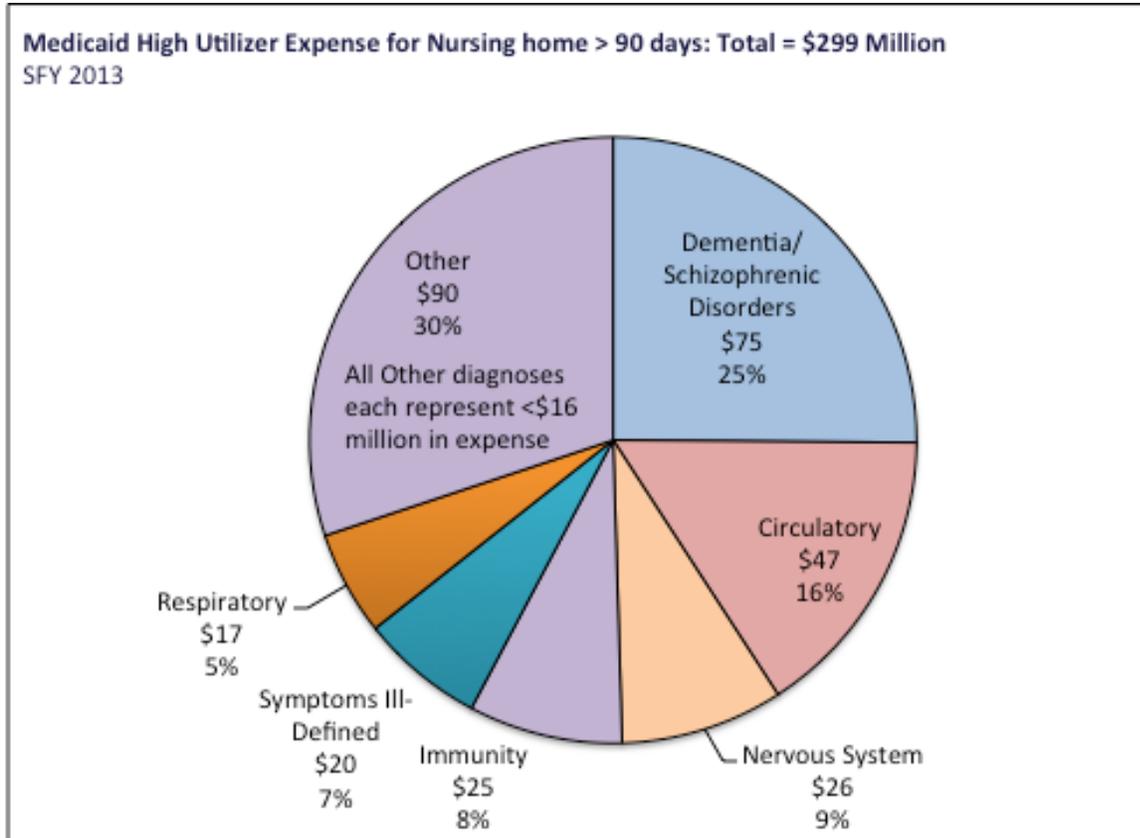
Source: Global Medicaid Waiver, 2013, supporting analysis. Based on MMIS claims extract from SFY 2012.

In order to effectively rebalance this population and accomplish a transition away from nursing homes and toward community based solutions, it is important to understand the characteristics, health care needs, and migration patterns of this population.

## A. Demographics and Health Needs

As shown in Figure 17, a full one-quarter (25%) of the expense for high utilizers in nursing homes over 90 days is for primary diagnoses of dementia or schizophrenic disorders. This is by far the largest diagnosis category – the next largest share of expense is for circulatory diagnoses at 16% of high utilizer nursing home expense. Dementia and schizophrenic disorders diagnoses include affective psychoses, other organic psychotic conditions (chronic), neurotic disorders, depressive disorders and others.

Figure 17: Nursing Home Expense by Primary Diagnosis



Source: High Cost Users Report Feb 2014, see Appendix C for detail.

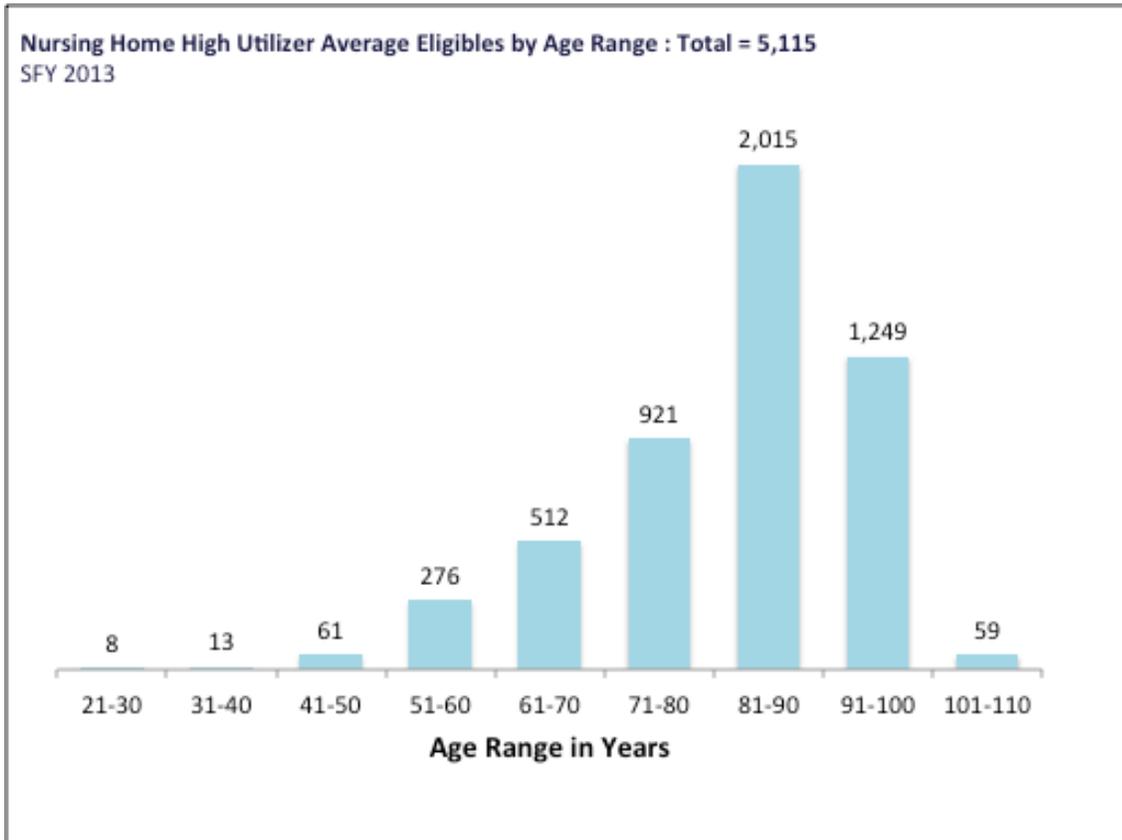
Dementia and Schizophrenic Disorders include affective psychoses, other organic psychotic conditions (chronic), neurotic disorders, depressive disorders and others.

“Other” includes 20 other diagnoses – Musculoskeletal (\$16 M), Specific Procedures/AfterCare (\$14 M), Injury/Poisoning (\$14 M), Genitourinary System (\$13 M), Digestive System (\$10 M), Infectious/Parasitic (\$5 M), Skin/Subcutaneous Tissue (\$3 M), Blood/Blood Forming Organs (\$3 M), Neoplasms (\$3 M), and 11 others with spending under \$2.5 M.

Additional information on the breakdown of spending by type of service (inpatient, outpatient, professional, pharmacy, etc.) is included in Appendix A.

In addition to having a high prevalence of dementia/schizophrenic diagnoses, two-thirds of this population (65%) was over 80 years old, as shown below. Multiple studies have shown that health care costs and complexity increases significantly at approximately 80 years of age – thus, this age distribution would likely require substantial services and supports if cared for in a community based setting.<sup>10</sup>

**Figure 18: Nursing Home High Utilizer Population by Age Range**



Source: High Cost Users Report Feb 2014, see Appendix C for detail.

<sup>10</sup> 2011 Actuarial Report on the Financial Outlook for Medicaid, Office of the Actuary, Center for Medicare and Medicaid Services, Department of Health and Human Services, page 22.

It is also helpful to compare the characteristics of Medicaid eligibles in a nursing home vs. those who reside in HCBS settings.

Key findings (as shown in Figure 19 below):

- Nursing home residents and the HCBS population have **similar incidence of multiple chronic conditions**; in fact, HCBS population is actually more likely to have multiple chronic conditions.
- However, nursing home residents have a much **higher incidence of dementia and behavioral health comorbidity** than those residing in home and community based settings. Two-thirds (68%) of nursing home residents have such health comorbidities as compared to only one-third (36%) of the HCBS population.
- **Nursing home residents are significantly older.** The average age of the population in nursing homes is 82 compared to an average age in HCBS populations of 68.

**Figure 19: Characteristics of Nursing Home vs. HCBS Populations**

	Average Eligibles (SFY 2013)	Average Age (SFY 2008) <sup>11</sup>	Percent with Multiple Chronic Conditions (SFY 2011)	Percent with Dementia/ Behavioral Health Comorbidity (SFY 2011)
Nursing Home	5,139	82	60%	68%
HCBS	2,068	68	74%	36%

*Multiples sources, see Appendix C. HCBS average age based on Aged & Disabled Waiver population.*

Given the age and behavioral health care needs of the nursing home population, specialized services and supports, including in some cases constant monitoring, may be required in order to appropriately care for this population in a home and/or community based setting.

## B. Migration Patterns

It is useful to analyze where Medicaid nursing home residents came from prior to being in a nursing home, and where they go when they leave. In this way, one can explore the opportunity to slow the migration from community-based settings to nursing home care.

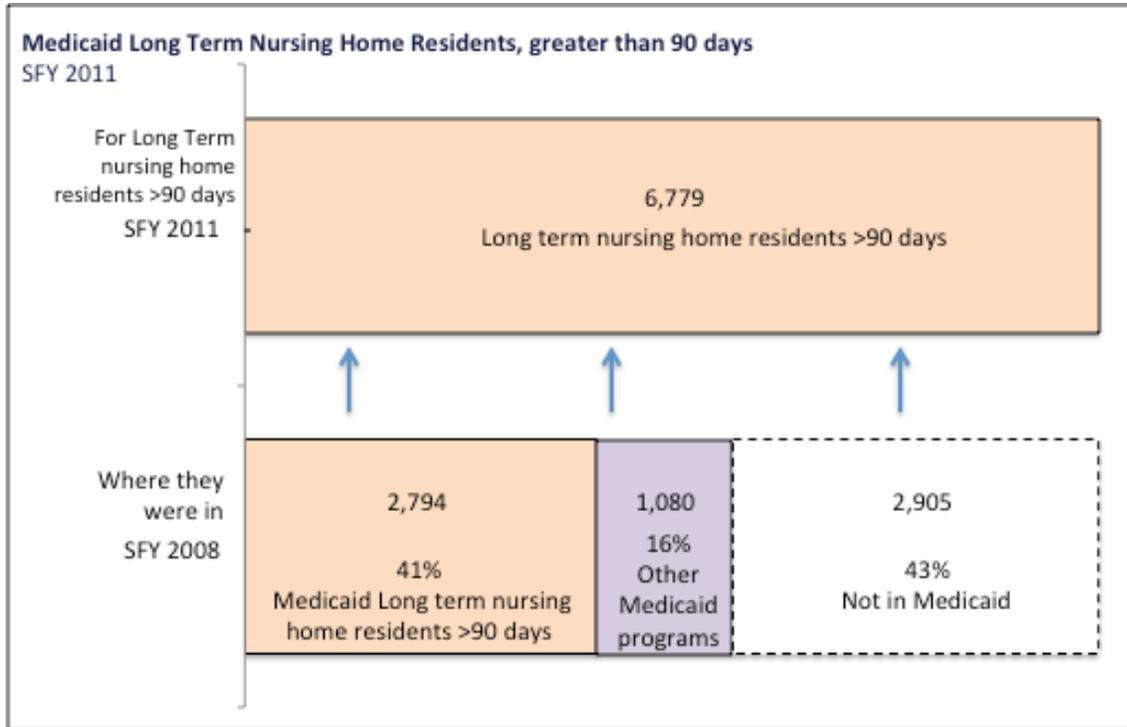
Note that this more detailed analysis of the nursing home population migration patterns requires a longitudinal study of long term nursing home residents – tracking and following individuals over time to understand their changing needs. As such, this analysis was based on a slightly different data set, consisting of only the population of dual eligibles (Medicaid and Medicare eligible) who have been determined eligible for long term nursing home services (greater than 90 days). Since

<sup>11</sup> Although the data for average age is from 2008, it is consistent with the SFY 2013 data that show 65% of the nursing home population is over 80 years of age, see Figure 18.

most (84%) of nursing home spending actually falls into this category (spending on dual eligible, long term nursing home service-eligible ABD adults), this analysis reasonably represents the high utilizer population of nursing home residents.<sup>12</sup>

The figure below shows the paths into Medicaid-covered long term nursing home care services and the percent of the SFY 2011 long term nursing home residents, greater than 90 days, using each path.

**Figure 20: Paths into Medicaid Long Term Nursing Home Care, greater than 90 days**



Source: Long Term Care Duals Report, June 2012. See Appendix C for details.

As shown in Figure 20 above, 41% of long term nursing home residents >90 days were already long-term nursing home residents three years earlier. Another 43% were *not in Medicaid at all* three years earlier, which means they were likely already in a long-term care facility and were spending down assets, resulting in their eligibility for Medicaid.

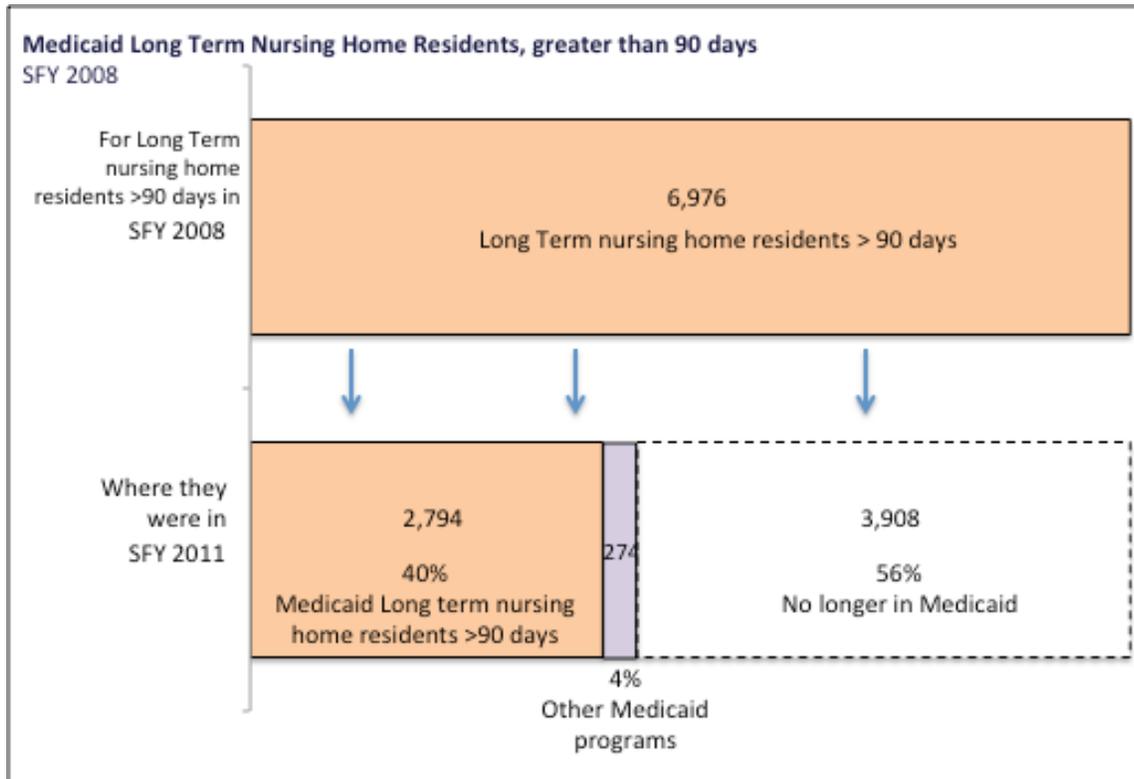
**Only 16% of long-term nursing home residents >90 days transitioned from other Medicaid programs in the previous three years.** Because it is a relatively small portion of long term nursing home residents, efforts to slow this transition will likely have only a modest impact on overall nursing home utilization patterns. Effectively slowing the transition into nursing home care likely would benefit from a multi-payor approach, identifying the 43% of eligibles who were not in

<sup>12</sup> Source: Based on \$329 million in Long Term Services and Supports spending on Nursing Homes/Skilled Nursing Facilities in SFY 2013 Medicaid Expenditure Report, page 24, and \$276 million in Long Term Care Nursing Home spending on dual ABD adults in the Rhyth Health Options report (see Appendix C for details).

Medicaid before they enter a nursing home and begin to spend down their assets, and ensuring that cost effective alternatives are identified and encouraged.

It is also useful to look at the paths out of long term nursing home care services. Starting in SFY 2008, the chart below looks at what happens to long term nursing home residents, greater than 90 days, three years later.

**Figure 21: Paths out of Long Term Nursing Home Care, greater than 90 days**



Source: Long Term Care Duals Report, June 2012. See Appendix C for details.

An analysis of the same long term nursing home residents data shows that of the 6,976 long term nursing home residents >90 days in SFY 2008, 40% of them were still long term nursing home residents three years later. Another 56% were not in Medicaid at all three years later, a loss of eligibility most likely due to death. **A very small percentage of the long-term nursing home resident population (4%) transitioned out of nursing homes and into other community based Medicaid programs within three years.**<sup>13</sup>

<sup>13</sup> A more recent migration analysis in the Rhody Health Options Report supports these findings with data showing that 45% of long term nursing home residents >90 days in SFY 2010 were still receiving long term nursing home care services in SFY 2013. A little over 1% of the SFY 2010 long term nursing home residents moved into Waiver programs by SFY 2013, and the remainder (56%) had either left Medicaid or transitioned to other programs.

In summary, strategies aimed at “rebalancing” must consider three key findings:

- History shows that efforts to slow the transition TO nursing homes are likely to be more effective than transitioning individuals OUT of nursing home settings.
- But much of the nursing home population is already in a nursing home when becoming eligible for Medicaid, likely having entered a nursing home and then spent down their assets until they became Medicaid eligible. This suggests that strategies to “rebalance,” away from nursing home settings and toward community based care would benefit from a multi-payer approach, as these high risk individuals must be identified well before they spend down assets and become Medicaid eligible – before they enter a nursing home.
- And since the population currently residing in nursing homes has an average age of 82 and high rates of dementia, specialized services and supports, including in some cases constant monitoring, may be required in order to appropriately care for this population in a home and/or community based setting.

## Appendix A1: Spending by Type of Service – Community High Utilizers

Figure 22 below details Community High Utilizer spending by type of service. For each subpopulation in the Community category, the percentage breakdown of spending by type of service is also shown. Any service type that represents more than 30% of the spending for that subpopulation is highlighted.

Figure 22: Community High Utilizer Spending by Type of Service

Type of Service	CSHCN	RiteCare Children	RiteCare Adults	ABD Adults	Total Community
Inpatient	\$21,708,594	\$17,022,201	\$15,437,621	\$86,905,149	\$141,073,565
Outpatient	\$7,848,914	\$6,787,486	\$11,239,638	\$36,587,096	\$62,463,133
Professional	\$90,438,163	\$17,782,028	\$10,862,531	\$132,326,284	\$251,409,005
Pharmacy	\$4,480,856	\$2,243,095	\$4,710,879	\$19,128,295	\$30,563,125
Institutional	\$0	\$0	\$0	\$8,484,425	\$8,484,425
Crossover	\$7,128	\$161	\$56,804	\$2,133,311	\$2,197,404
<b>Total Community</b>	<b>\$124,483,655</b>	<b>\$43,834,971</b>	<b>\$42,307,472</b>	<b>\$285,564,559</b>	<b>\$496,190,658</b>

Type of Service	CSHCN	RiteCare Children	RiteCare Adults	ABD Adults	Total Community
Inpatient	17%	39%	36%	30%	28%
Outpatient	6%	15%	27%	13%	13%
Professional	73%	41%	26%	46%	51%
Pharmacy	4%	5%	11%	7%	6%
Institutional	0%	0%	0%	3%	2%
Crossover	0%	0%	0%	1%	0%
<b>Total Community</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

Figure 23 below lists utilization and cost statistics for ER, Primary and Specialty Care Visits for each subpopulation.

Figure 23: Select Type of Service Statistics for Community High Utilizers

Measure		CSHCN	RiteCare Children	RiteCare Adults	ABD Adults
Emergency Room Visits	Admissions/thousand	1,036	1,490	2,764	2,098
	Cost per admission	\$451	\$631	\$616	\$638
E&M Primary Care Visits	Admissions/thousand	4,501	8,155	8,889	4,988
	Cost per admission	\$109	\$107	\$76	\$80
E&M Specialty Care Visits	Admissions/thousand	8,252	9,918	15,472	11,867
	Cost per admission	\$243	\$132	\$92	\$89

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

Note: E&M stands for Evaluation and Management.

Figure 24 below shows the days per thousand, cost per day, and average length of stay (ALOS) for Inpatient services for Community High Utilizers.

**Figure 24: Community High Utilizer Inpatient Statistics**

		<b>Days/1k</b>	<b>Cost/Day</b>	<b>ALOS*</b>
<b>CSHCN</b>	<b>Inpatient Total</b>	<b>5,988</b>	<b>\$1,305</b>	<b>11.1</b>
	Behavioral Health	3,152	\$1,269	9.3
	Specialty Care	513	\$2,797	10.4
	General	515	\$2,387	3.9
	Kraft	1,580	\$530	144.9
	SNF	198	\$953	20.0
	Nursery	30	\$4,106	78.8
	Other	0	\$0	0.0
<b>RiteCare Children</b>	<b>Inpatient Total</b>	<b>8,751</b>	<b>\$1,402</b>	<b>8.2</b>
	Behavioral Health	4,419	\$1,271	7.6
	General	1,339	\$2,451	3.9
	Specialty Care	746	\$2,899	6.6
	Kraft	2,202	\$524	113.8
	Rehab	23	\$1,095	9.2
	Maternity	4	\$2,095	4.4
	SNF	11	\$598	7.0
	Nursery	6	\$944	5.8
	Other	0	\$0	0.0
<b>RiteCare Adults</b>	<b>Inpatient</b>	<b>\$6,613</b>	<b>\$1,797</b>	<b>5.1</b>
	General	2,858	\$2,409	3.8
	Specialty Care	999	\$2,541	6.3
	Behavioral Health	1,952	\$1,021	5.8
	Rehab	237	\$1,087	13.9
	SNF	568	\$308	13.1
	Other	0	\$0	0.0
<b>ABD Adults</b>	<b>Inpatient</b>	<b>8,086</b>	<b>\$1,578</b>	<b>6.6</b>
	General	2,793	\$2,068	4.9
	Specialty Care	1,634	\$2,282	9.4
	Behavioral Health	2,789	\$997	7.1
	SNF	679	\$307	10.7
	Rehab	174	\$1,185	14.8
	Maternity	17	\$3,206	3.7
	Other	0	\$0	0.0

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

\*ALOS: Average Length of Stay

## Appendix A2: Spending by Type of Service – Other High Utilizers

The tables below (Figures 25 and 26) break out Maternity/Delivery and Institutional/Residential High Utilizer spending by type of service and show the percentage breakdown of spending by type of service for each subpopulation. Any service type that represents more than 30% of the spending for that subpopulation is highlighted.

**Figure 25: Maternity/Delivery High Utilizer Spending by Type of Service**

Type of Care	NICU	Pregnant	Other Newborn	Total Maternity/Delivery
Inpatient	\$27,947,646	\$12,296,289	\$5,951,485	\$46,195,420
Outpatient	\$193,410	\$7,779,545	\$479,137	\$8,452,092
Professional	\$2,533,872	\$7,431,306	\$1,633,259	\$11,598,436
Pharmacy	\$271,506	\$934,252	\$141,113	\$1,346,871
Institutional	\$0	\$10,373	\$0	\$10,373
Crossover	\$0	\$7,692	\$0	\$7,692
<b>Total</b>	<b>\$30,946,434</b>	<b>\$28,459,456</b>	<b>\$8,204,994</b>	<b>\$67,610,884</b>

Type of Care	NICU	Pregnant	Other Newborn	Total Maternity/Delivery
Inpatient	90%	43%	73%	68%
Outpatient	1%	27%	6%	13%
Professional	8%	26%	20%	17%
Pharmacy	1%	3%	2%	2%
Institutional	0%	0%	0%	0%
Crossover	0%	0%	0%	0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

**Figure 26: Institutional/Residential High Utilizer Spending by Type of Service**

Type of Care	Hospice	Intensive Rehab Hospital	Nursing Home >90	Res/Rehab for Dev Disabled	Total Inst/Res
Inpatient	\$3,843,174	\$2,532,282	\$4,260,747	\$2,691,473	\$13,327,677
Outpatient	\$24,843,735	\$323,777	\$696,227	\$1,187,256	\$27,050,996
Professional	\$1,314,865	\$1,676,168	\$5,043,583	\$179,402,654	\$187,437,270
Pharmacy	\$92,260	\$158,776	\$514,694	\$1,737,809	\$2,503,539
Institutional	\$28,485,213	\$98,899,617	\$287,571,313	\$33,436,619	\$448,392,762
Crossover	\$251,556	\$132,167	\$1,275,461	\$561,158	\$2,220,341
<b>Total</b>	<b>\$58,830,803</b>	<b>\$103,722,788</b>	<b>\$299,362,025</b>	<b>\$219,016,969</b>	<b>\$680,932,584</b>

Type of Care	Hospice	Intensive Rehab Hospital	Nursing Home >90	Res/Rehab for Dev Disabled	Total Inst/Res
Inpatient	7%	2%	1%	1%	2%
Outpatient	42%	0%	0%	1%	4%
Professional	2%	2%	2%	82%	28%
Pharmacy	0%	0%	0%	1%	0%
Institutional	48%	95%	96%	15%	66%
Crossover	0%	0%	0%	0%	0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: High Cost Users Report Feb 2014, see Appendix C for detail.

## Appendix B: List of Figures

Figure 1: SFY 2013 Medicaid Expenditure Report: Distribution of Users by Claims Expense .....	3
Figure 2: Distribution of Eligibles and Expense into Cost Categories.....	4
Figure 3: Breakdown of SFY 2013 Claims Expense into Categories for Analysis .....	5
Figure 4: Year over Year Trend of High Utilizer Unique Users and Expense .....	9
Figure 5: Summary of High Utilizer Categories .....	10
Figure 6: Breakdown of High Utilizer Expense .....	11
Figure 7: Summary of High Utilizers in the Community.....	12
Figure 8: Year over Year Trend of High Utilizers in the Community .....	13
Figure 9: Community High Utilizers by Primary Diagnosis .....	14
Figure 10: Community High Utilizers Expense by Primary Diagnosis by Population .....	15
Figure 11: Community High Utilizer Expense by Diagnosis by Population .....	16
Figure 12: Maternity/Delivery High Utilizer Expense.....	18
Figure 13: Maternity/Delivery High Utilizers as Percent of Total .....	19
Figure 14: Breakdown of Residential High Utilizers.....	21
Figure 15: Institutional/Residential High Utilizers as Percent of Total .....	22
Figure 16: Nursing Home/SNF Days per Thousand.....	24
Figure 17: Nursing Home Expense by Primary Diagnosis.....	25
Figure 18: Nursing Home High Utilizer Population by Age Range .....	26
Figure 19: Characteristics of Nursing Home vs. HCBS Populations.....	27
Figure 20: Paths into Medicaid Long Term Nursing Home Care, greater than 90 days .....	28
Figure 21: Paths out of Long Term Nursing Home Care, greater than 90 days .....	29
Figure 22: Community High Utilizer Spending by Type of Service .....	31
Figure 23: Type of Service Statistics for Community High Utilizers .....	31
Figure 24: Community High Utilizer Inpatient Statistics .....	32
Figure 25: Maternity/Delivery High Utilizer Spending by Type of Service .....	33
Figure 26: Institutional/Residential High Utilizer Spending by Type of Service .....	34

## Appendix C: Sources and Notes for Figures

Figures	Source	Notes
1	SFY 2013 Medicaid Expenditure Report	<p>Publicly available at <a href="http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RI_Medicaid_Expend_SFY2013.pdf">http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RI_Medicaid_Expend_SFY2013.pdf</a></p> <p>This report is based on SFY 2013 and a five year historical Rhode Island Medicaid claims extract dated November 2013:</p> <ul style="list-style-type: none"> <li>• Includes claims, capitation payments, premiums and provider payouts.</li> <li>• Reflects data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through November 2013</li> <li>• Capitations, premiums and payouts are allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information with IBNR.</li> <li>• Excludes Disproportionate Hospital Payments (DSH), Local Education Authorities (LEA), Costs not otherwise Matchable (CNOM), Early Family Planning and Early Intervention populations (expenses that did not qualify for a federal match)</li> </ul> <p>As noted in Figure 1, this specific chart includes only claims-based Medicaid expenditure, and as such excludes Upper Payment Limit (UPL), Medicare and PACE Premiums, and administrative portion of capitation</p>
2 - 15	High Cost Users Report, Feb 2014. Additional analysis, March 2015.	<p>Internal Medicaid Report based on SFY 2013 and a five year historical Rhode Island Medicaid claims extract dated October 2013. This is similar to the dataset used for the SFY 2013 Medicaid Expenditure Report with the following differences:</p> <ul style="list-style-type: none"> <li>• IBNR completion rates are different due to the timing difference of the extract (October 2013 vs. November 2013)</li> <li>• Includes expenses for Early Family Planning and Early Intervention populations and for Local Educational Authorities that were excluded in the Medicaid Expenditure Report</li> </ul>

16	Global Medicaid Waiver, Feb 2013, supporting analysis	Internal Medicaid analysis using the SFY 2012 and five year historical Rhode Island Medicaid claims extract used for the SFY 2012 Medicaid Expenditure Report.  Reflects data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid thru November 2012.
17-18	High Cost Users Report, Feb 2014	See above
19	High Cost Users Report, Feb 2014	<i>Source for number of nursing home average eligibles</i> See above
19	SFY 2013 Medicaid Expenditure Report	<i>Source for HCBS average daily census data.</i> See page 44 of the Medicaid Expenditure Report. Data based on average daily census for individuals receiving Personal Care Services.
19 20-21	Long Term Care Duals Report, June 2012	<i>For 19: Source for average age, chronic conditions and dementia/behavioral health comorbidity.</i> Internal Medicaid Report using a SFY 2008-2011 claims extract. Includes expense for Dual eligible ABD adults 21+ Excludes Early Family Planning (EFP), Partials, PACE, and Substitute Care.
22-26	High Cost Users Report, Feb 2014	See above

#### Additional Sources Cited:

Rhody Health Options Report	Internal Medicaid Report using a SFY 2010-2013 claims extract. Reflects data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through October 2013.  This was used to support the percent of Nursing Home spending for LTC Duals on page 28 (footnote 12) and is the source for the SFY 2010-2013 Nursing Home migration analysis on page 29 (footnote 13).
ACE Medicaid Report	Internal Medicaid Report using the SFY 2013 and five year historical Rhode Island Medicaid claims extract used for the SFY 2013 Medicaid Expenditure Report.  Source for the RiteCare NICU average length of stay (ALOS) and average NICU cost/day measures used on page 19 (footnote 6)