

Rhode Island Annual Medicaid Expenditure Report

Executive Office of Health and Human Services

June 2011

Medicaid Annual Expenditure Report

Statutory Mandate

R.I.G.L.42-7.2-5(d), the authorizing statute for EOHHS, authorizes the Secretary to:

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

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

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

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

Purposes of the Expenditure Report

Provide state policymakers with a comprehensive overview of state Medicaid expenditure 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 one or more of the five health & human services departments.
- ❖ Show enrollment and expenditure trends for Medicaid coverage groups by service type, care setting, and delivery mechanism.
- ❖ Identify areas in the Medicaid program where the state has flexibility and control over the scope, amount and duration of coverage and services.
- ❖ Establish a standard format for tracking and evaluating trends in annual Medicaid expenditures within and across departments.

Source Data and Analytic method

This report is based on SFY2010 and a five year historical Rhode Island Medicaid claims extract, with the following adjustments:

- ❖ Claims vs. Capitations: Since some state expenditures are paid out in capitation, not in claims, a subset of claims are “backed out” of total claims experience, and replaced with capitation expenditures for total expenditures. Adjusted claims are used when reporting on service specific expenditures. Reporting is based on date of service not on date of payment.
- ❖ Provider Payments not captured in claims: Some Medicaid provider and the Department of Behavioral Health, Developmental Disabilities & Hospitals (BHDDH) payments not captured in claims were added back in to these estimates
- ❖ Report based on SFY 2006-2010 data extract incurred thru SFY 2010, paid thru November 2010, estimated with IBNR (incurred but not reported).

Executive Summary (page 1 of 2)

Overview

During SFY 2010 Rhode Island's Medicaid program served approximately 216,000 Rhode Islanders – that is, 21% of Rhode Island's population were enrolled in Medicaid for some part of SFY 2010. Program expenditures for SFY 2010 totaled approximately \$1,987 million. Medicaid expenditure is divided among six state agencies, with \$1,356 million of total expenditure managed by the Department of Human Services (DHS), and \$396 million managed by BHDDH.

Under the Medicaid program, the federal government is typically responsible for approximately half of total expenditure (52.47%). However, the Federal Stimulus package increased the federal share substantially, to 63.89% beginning October 1, 2008, and ending December 31, 2010. This one time adjustment saved approximately \$207 million in state expenditures in SFY 2010.

Between SFY 2006 and 2010, total Rhode Island Medicaid medical expenses based on date of service have increased an average of 2.5 percent per year. This overall expenditure increase is associated with a 2.5 percent increase in per member per month (PMPM) costs, and a 0 percent average change in enrollment, which can be added together to determine average expenditure growth. Enrollment declined over the years SFY 2006 – 2009, but increased in SFY 2010 back to SFY 2006 levels. These expenditure trends compare quite favorably to both national Medicaid expenditures and state commercial per member per month cost trends.

Populations Served

Medicaid eligibles include elders, adults with disabilities, children and families, and children with special health care needs. Each of these populations have very different service needs and PMPM cost experience.

- ❖ Adults with disabilities account for the largest share of expenditure, with 2010 expenditure of \$690 million, and an average PMPM cost of \$1,996. The largest components of expenditure for this population are residential and rehabilitation services for the developmentally disabled (29%) and hospital care (25%).

- ❖ Elders account for \$453 million in total 2010 Medicaid expenditure, and the highest average cost per member per month (PMPM) of \$2,167. For this population, nursing facilities account for roughly two-thirds (66%) of expenditures.

- ❖ Children and families account for 68% of total enrollment and 26% of total expenditure, with total 2010 expenditure of \$462 million. Additionally, the federal match is increased to 66.83% for qualifying “optional” low income children and pregnant women under the Children's Health Insurance Program (CHIP).

- ❖ Children with special health care needs (CSHCN) is a relatively small population – accounting for 11 percent of total Medicaid expenditures and seven percent of enrollees, with total SFY 2010 expenditures of \$206 million. Expenditures on this population is dominated by professional behavioral health services, which account for just under half (43%) of total expenditures.

Executive Summary (page 2 of 2)

Medicaid Providers

Medicaid pays for services offered by a variety of providers. Hospitals and nursing facilities together account for nearly half (46%) of program expenditure. Key contributors to expenditure growth were hospitals, professional providers and home/community based service providers

❖Hospitals were the largest provider type, accounting for 28 percent of Medicaid expenditure in 2010. Hospital payments are also a key driver of Medicaid expenditure growth – as payments to hospitals increased by an average of 7.5% per year between 2006-2010 and accounted for more than half (57%) of all Medicaid expenditure growth in recent years.

❖Nursing facilities were the next largest provider type, accounting for 18% of expenditure in 2010. Expenditure on these providers has been increasing on average 1.8% per year between 2006-2010.

Managed Care

It is important to note that not all payments are made directly by Medicaid to service providers. Three-quarters of Medicaid eligibles are enrolled in managed care plans, up from 68% 5 years ago. These enrolled populations account for 45% of Medicaid expenditure.

❖Children and families who are not eligible for employer sponsored or Medicare coverage are generally all enrolled in managed care plans.

❖Starting in 2008, children with special health care needs, without other insurance coverage were required to enroll in managed care plans, resulting in 74% of this population now enrolled in managed care. In addition new managed care programs were established in 2008 to transition Medicaid eligible adults with disabilities to managed care. In 2010 38% of adults with disabilities were enrolled in managed care.

Utilization

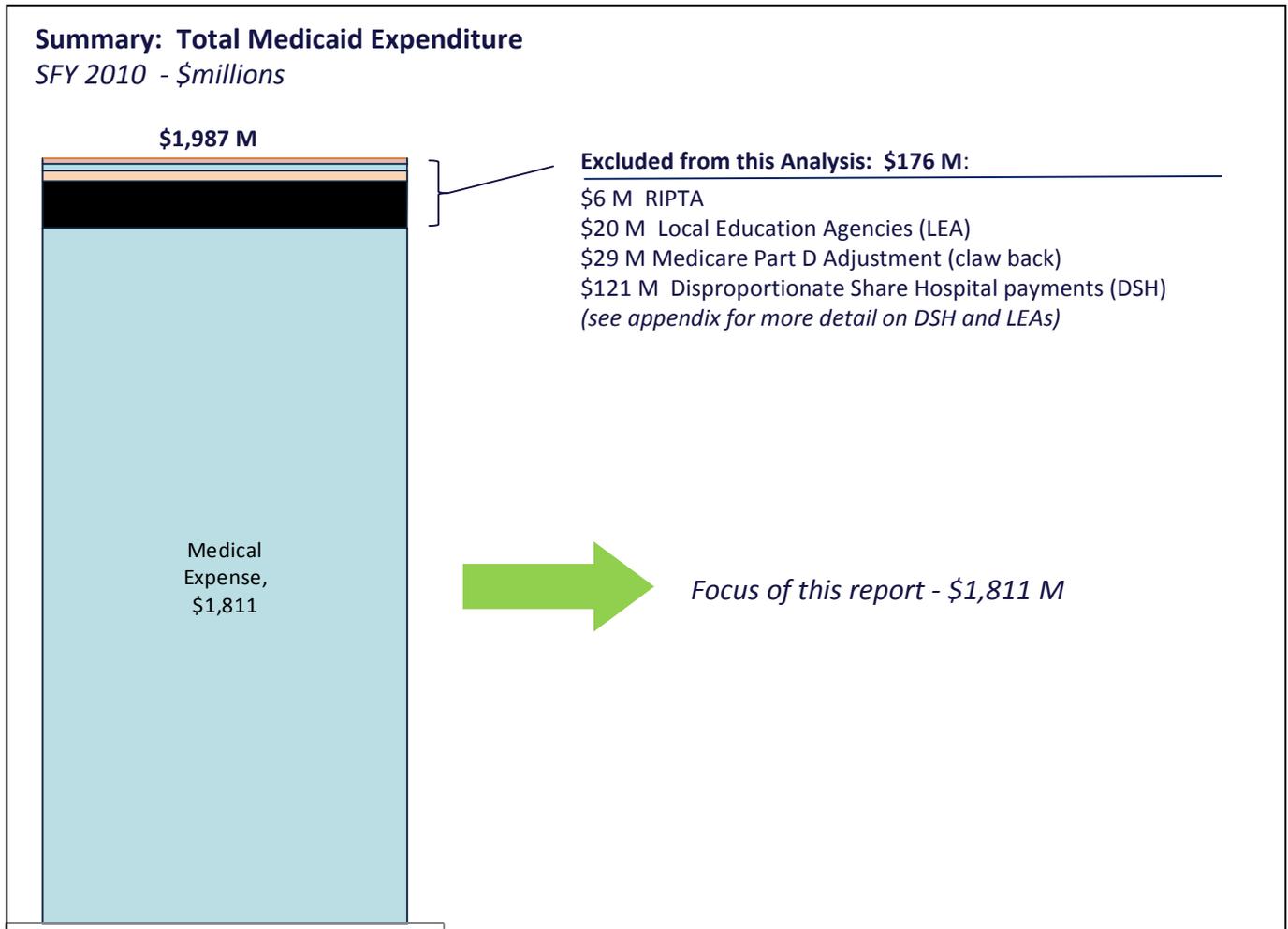
Medicaid expenditures are highly concentrated, as the top seven percent of users account for over two-thirds (68%) of expenditures. These 16,000 top utilizers spent, on average, \$69,000 per person, more than *sixty times* as much per person as those in the bottom 78 percent of users. Additionally, trends in utilization suggest that the Medicaid population may be shifting toward a higher cost profile – as the share of low cost users is declining while the number of high cost users is on the rise.

Table of Contents

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

a. Total Medicaid Expenditures, 2010

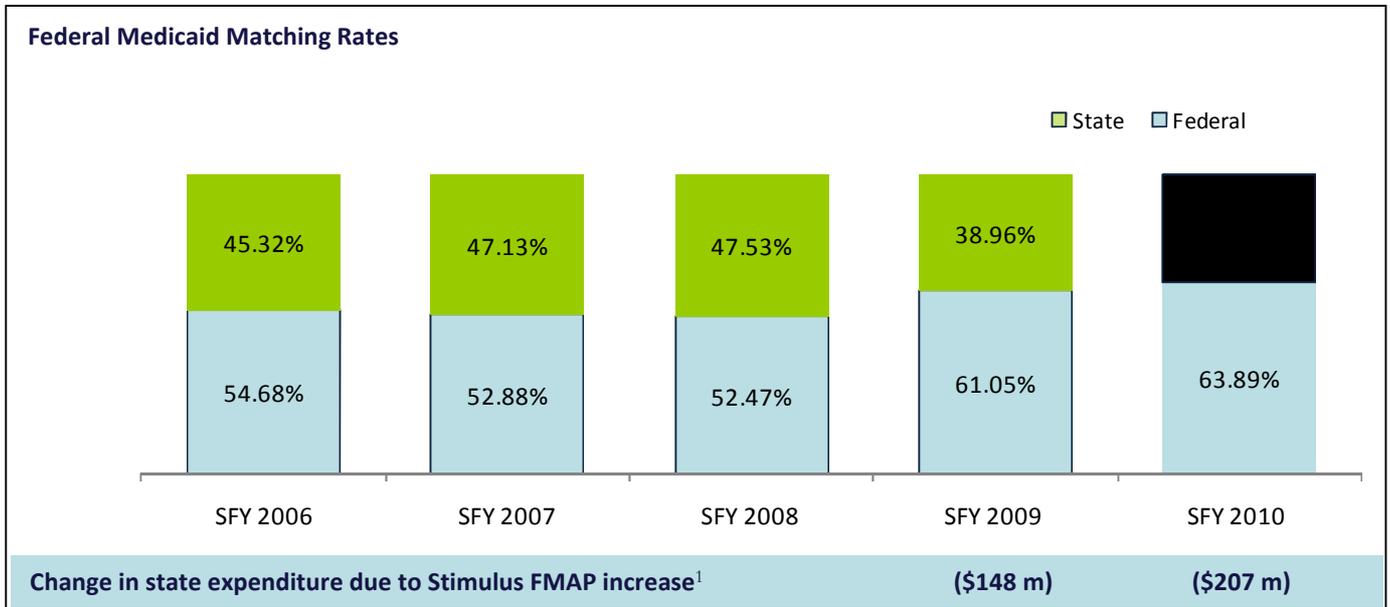
Medicaid expenditures total approximately \$1,987 million.



- ❖ In fiscal year 2010, Rhode Island incurred approximately \$1,987 million in Medicaid expenditures. This expenditure was split between state and federal funds. This report includes all Medicaid expenditures, including both state and federal funds.
- ❖ The analysis in this report excludes DSH (Disproportionate Share Hospital) payments, payments to LEAs (Local Educational Agencies) and RIPTA (Rhode Island Public Transit Authority), as well as payments for the Medicare Part D Adjustment. A summary of each of these exclusions is provided in the appendix.
- ❖ What follows is a variety of analyses intended to describe the different elements of Rhode Island's Medicaid program, and provide a common understanding of the key elements of Medicaid expenditure, as well as areas of expenditure growth.

b. FMAP Trends

Rhode Island is typically responsible for just under half of Medicaid expenditures; however, stimulus funds significantly reduced this state share for 2009 and 2010.

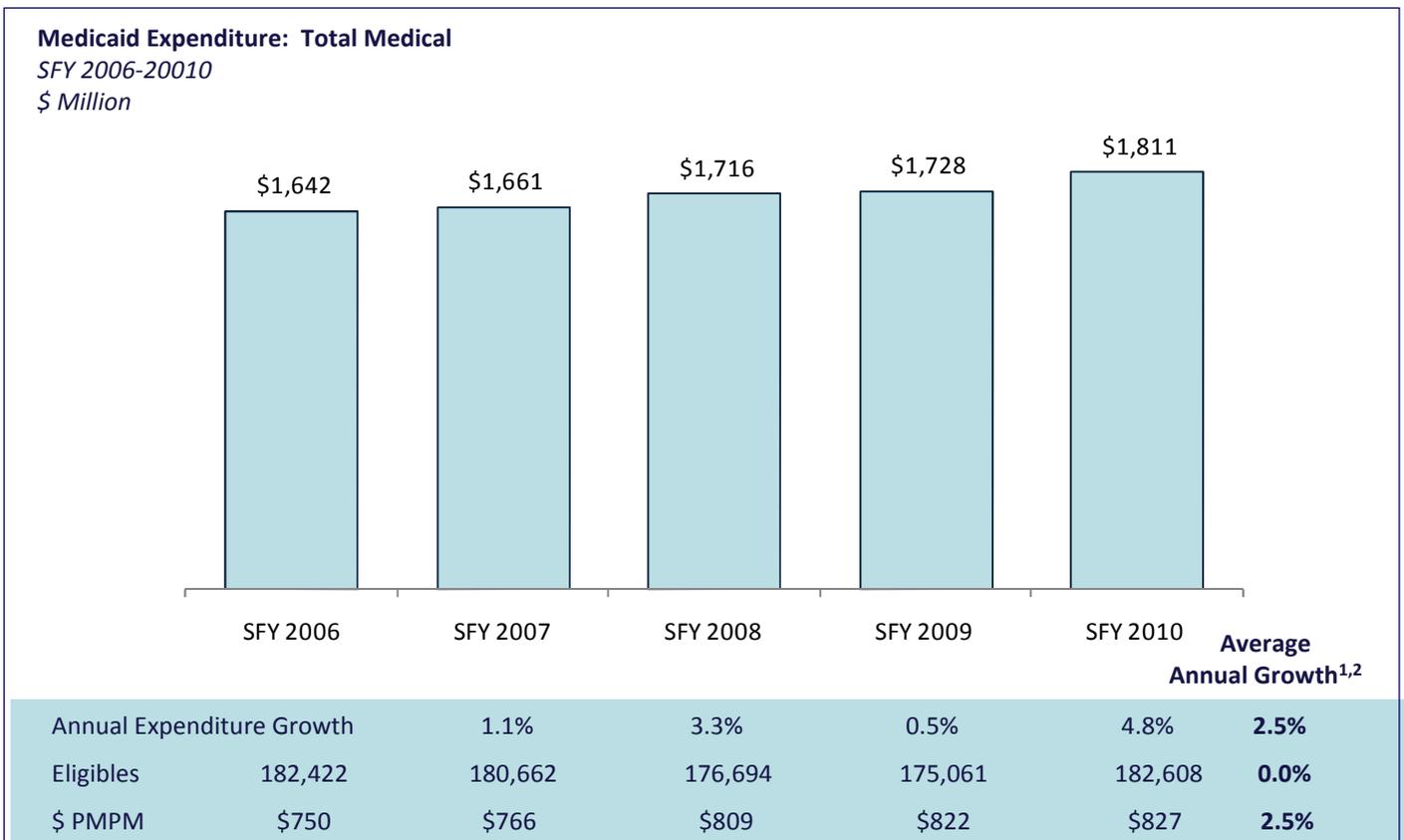


- ❖ While this report will review trends in total Medicaid medical expenditure, it is important to recognize that less than half of this expense falls to the Rhode Island budget. Funding is split between state and federal dollars, with Rhode Island typically responsible for just under half of all program expenditures.
- ❖ The current FMAP rate of 52.47% is almost four points lower than the SFY 2005 rate of 56.1%. However, the Federal Stimulus package increased FMAP by 11.42% percentage points, beginning October 1, 2008 and ending December 31, 2010. This resulted in an FMAP of 63.89% in SFY 2010, thereby providing a substantial reduction in the state share of Medicaid expenditure.. A comparison of the FMAP levels shows that the stimulus adjustment to FMAP saved ~\$148 M in state expenditures in SFY 2009 and ~\$207 M in SFY 2010. ¹
- ❖ In addition to the FMAP levels shown above, the federal match is enhanced for qualifying low income children and pregnant women under the CHIP program. CHIP is designed to build on Medicaid to provide insurance coverage to "targeted low-income children and pregnant women" who are uninsured and not eligible for Medicaid, typically from families with incomes up to 250 percent of the federal poverty level. In SFY 2010, Rhode Island received a 66.83% combined CHIP/FMAP federal match on 9,974 "optional" children and pregnant women who are in families with incomes above mandatory coverage levels.

1. Analysis based on FMAP only – does not include SCHIP match. Increase calculated as the difference between actual state expenditure and the amount the state would have spent at the FMAP rate of 52.47% without the federal stimulus increase.

c. Medicaid Expenditure Trends, 2006-2010

Over the past five years, Rhode Island Medicaid expenditures have been increasing an average 2.5 percent per year.



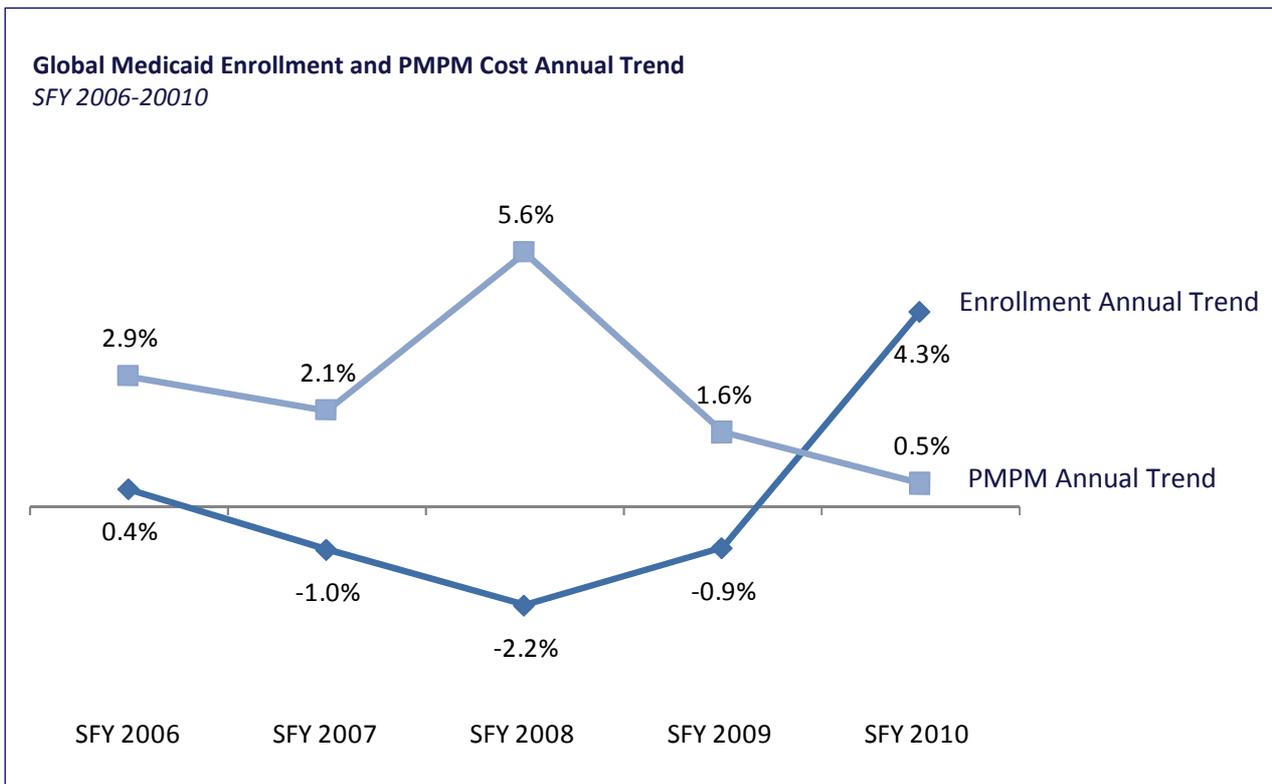
- ❖ Overall Medicaid expenditure has increased by approximately 2.5 percent per year over the last five years. 2009-10 expenditure growth is an increase of nearly 5%. Nearly all of the 2009-2010 increase is due to increases in enrollment.
- ❖ Note that the overall expenditure increase is broken down into per member per month (PMPM) cost increases and enrollment increases, which can be added together to determine average expenditure growth.
 - Enrollment declined steadily from 2006 to 2009 by 1-2% per year but then increased by 4.3% from 2009 to 2010, for a five-year average growth of 0%.
 - PMPM costs have increased over the past five years, with an average annual growth rate of 2.5%.

1. Calculated as compounded annual growth rate (CAGR) over period 2006-2010 as shown.

2. The low growth from 2006 to 2007 is explained in part by the introduction of Medicare Part D, which transitioned some pharmacy expenditure from Medicaid to Medicare. The state pays for part of this pharmacy expenditure back through the “claw back” payment.

c. Global Medicaid Enrollment and PMPM Cost Trends, 2006-2010

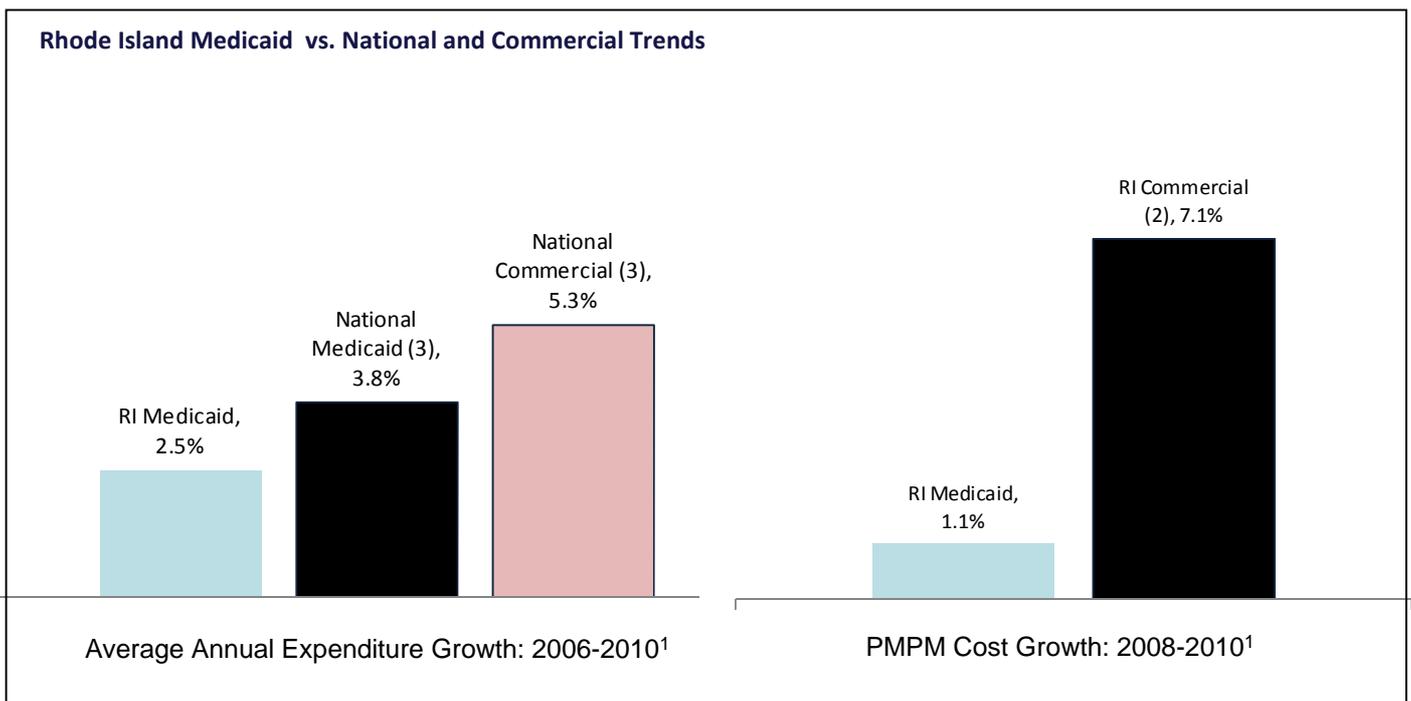
Enrollment had been declining between 2006 and 2009, but in 2010 jumped back to 2006 levels.



- ❖ Nearly all of the 2009-2010 increase in total Medicaid expenditure is due to increases in enrollment.
- ❖ Between 2006 and 2009 enrollment declined 1-2% per year. However a 4.3% increase in enrollment from 2009 to 2010 brought enrollment back to 2006 levels. The five-year average enrollment growth rate of 0% is a result of this rebound to 2006 enrollment levels.
- ❖ PMPM costs have increased between 1% and 5% per year over the past five years. The most recent two years have shown lower increases of 1.6% and 0.5% respectively.

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

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



- ❖ Comparing Rhode Island Medicaid expenditure trends to national and state benchmarks provides some important context.
 - Overall expenditure growth over the years 2006-2010 compares favorably to national Medicaid expenditure trend – according to CMS, Medicaid expenditure trend over this time period increased an average 3.8% per year, vs. Rhode Island’s 2.5%³.
 - RI Medicaid PMPM (per member per month) cost trends also compare favorably to local commercial benchmarks. Between 2008 and 2010, Rhode Island’s Medicaid program experienced 1.1% average annual PMPM cost growth. Over this same period, the average annual commercial medical PMPM cost increase for Rhode Island commercial health plans was 7.1%².

¹ RI data is in state fiscal year. National benchmarks are in federal fiscal year. State commercial benchmark is in calendar year.

² Incurred claims per member per month, includes both small group and large group claims from BCBSRI, United and Tufts Health Plan. Source: OHIC, 2011 carrier rate filings, Exhibit 3.

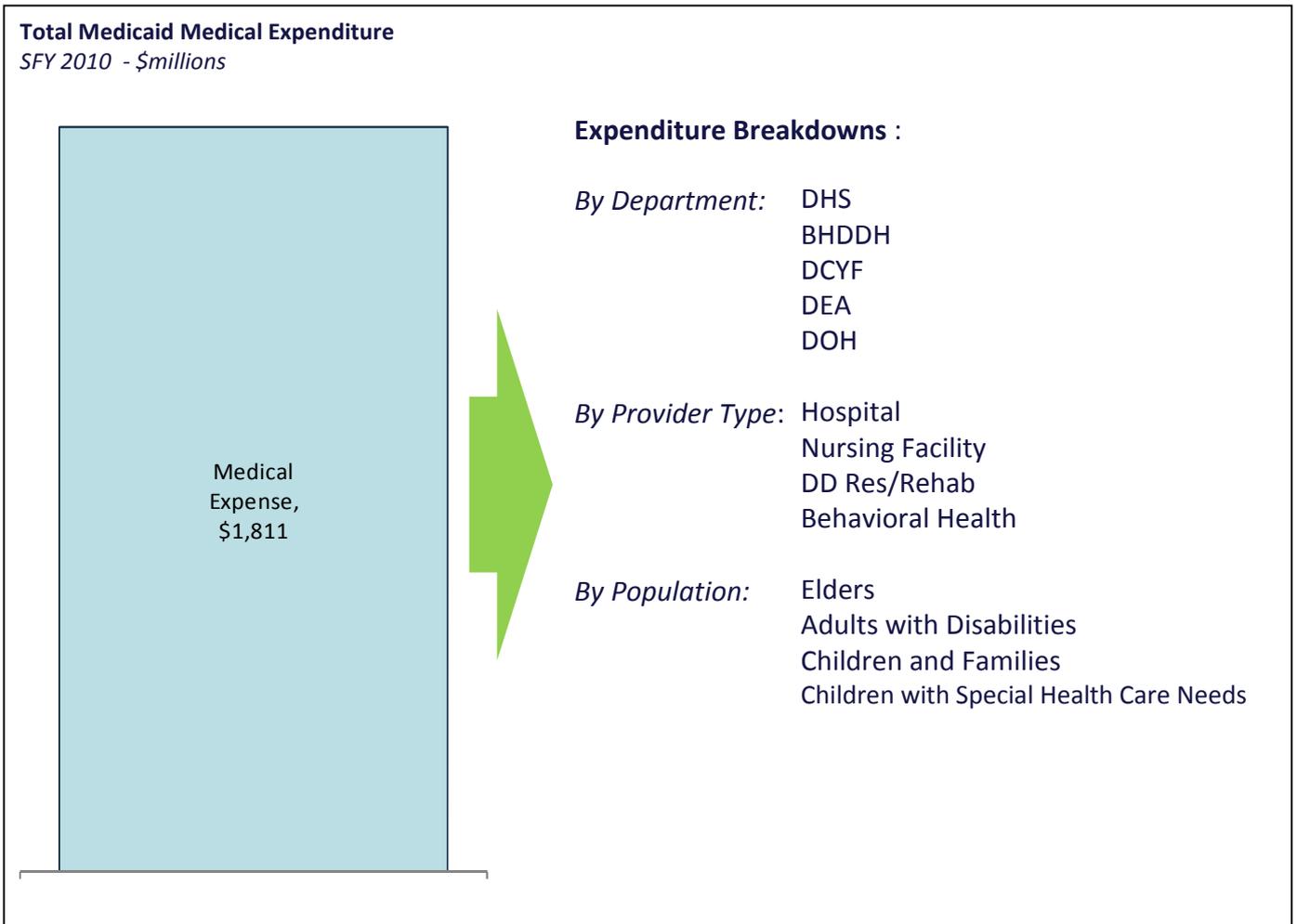
³ 2010 CMS National Health Expenditure Report. 2009 and 2010 data are projections.

Table of Contents

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

2. Expenditure Distributions

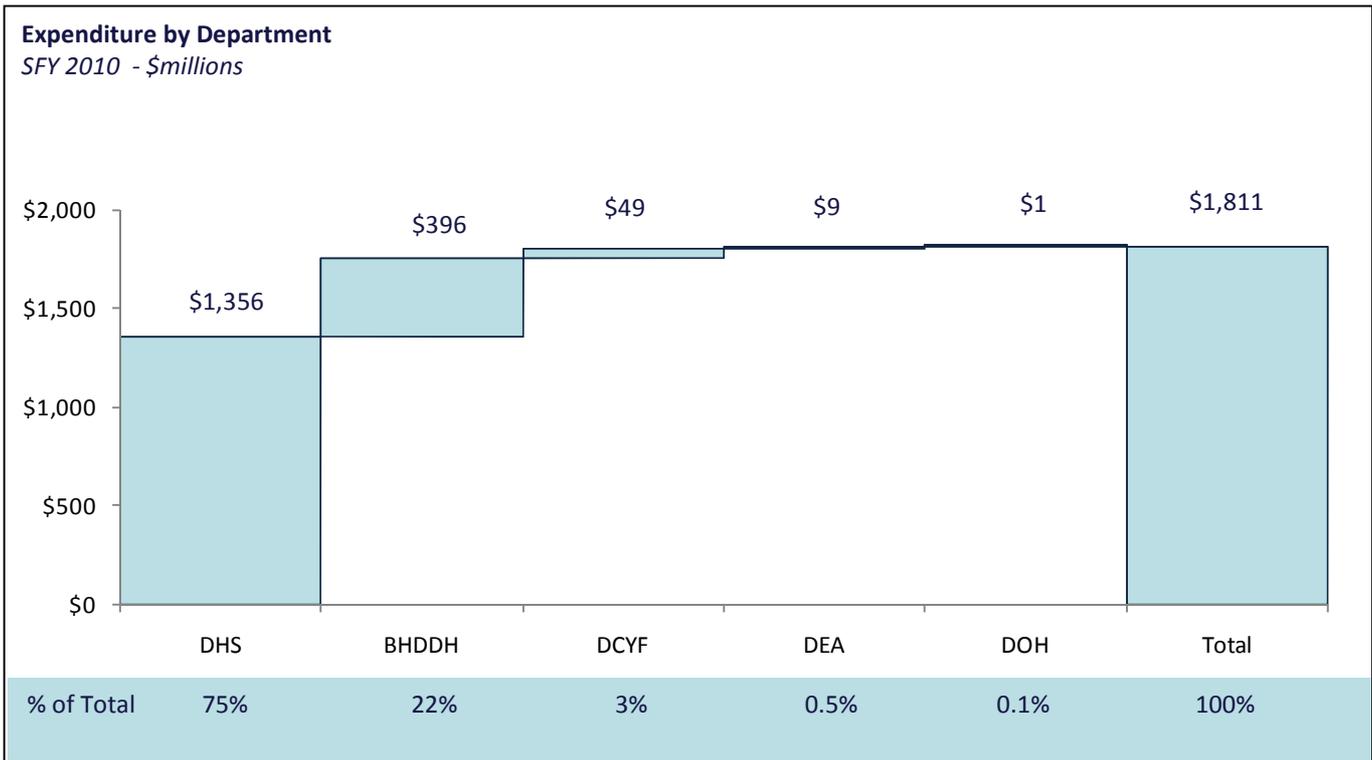
Medicaid expenditure can be broken down in several ways.



- ❖ Department refers to the five state departments responsible for administering components of the Medicaid program.
- ❖ Provider Type refers to the institution or professionals performing the services.
- ❖ Population defines Medicaid recipients by age and category of need.

2a. Expenditure by Department

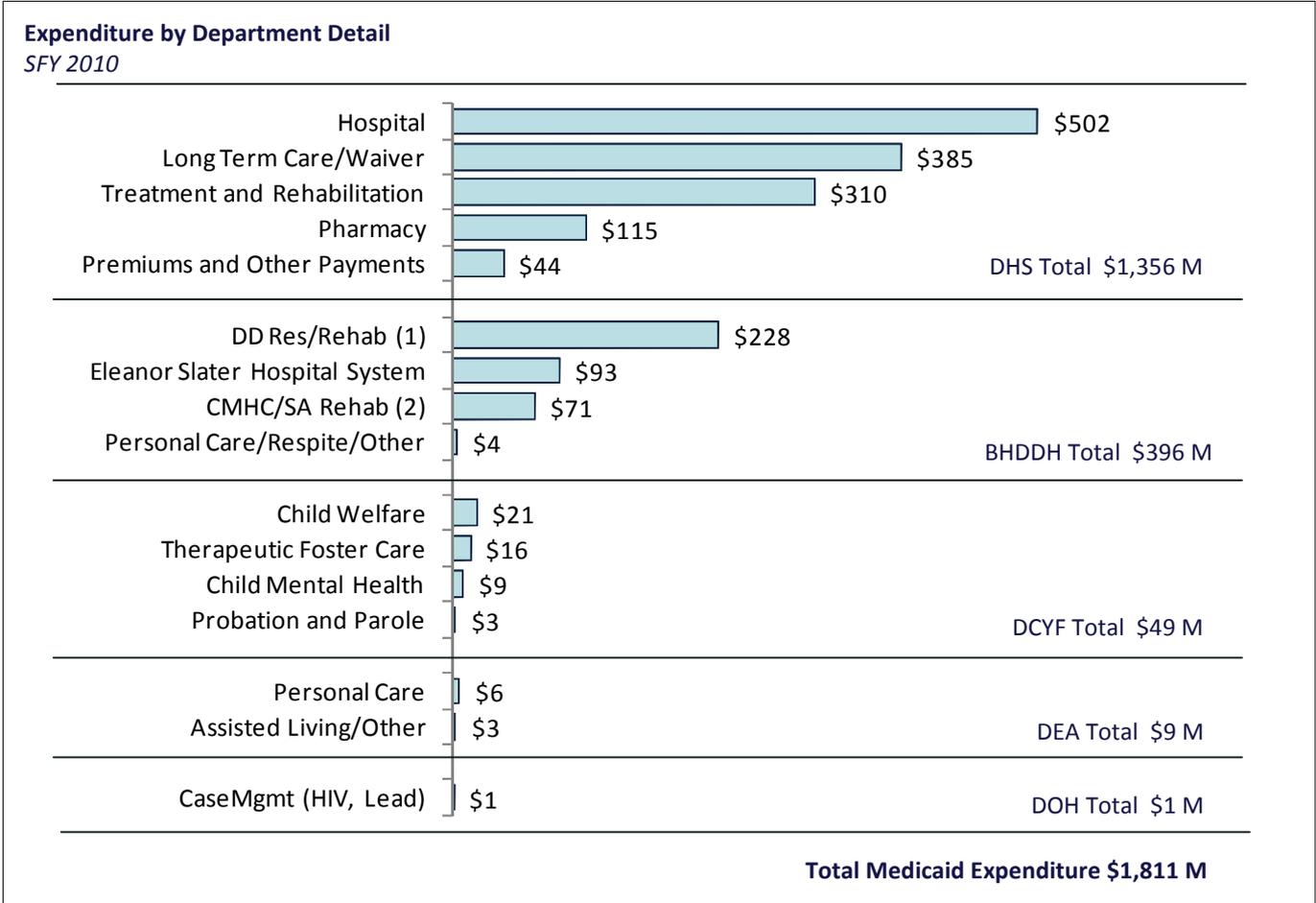
Medicaid services are administered through five state agencies



- ❖ There are five state departments responsible for administering components of the Medicaid program: The Department of Human Services (DHS), the Department of Behavioral Health, Developmental Disability and Hospitals (BHDDH), the Department of Children, Youth and Families (DCYF), the Department of Elderly Affairs (DEA), and the Department of Health (DOH).
- ❖ The majority of expenditure (75%) is administered by the Department of Human Services (DHS). This department is the lead administrator for the Medicaid contract with CMS.
- ❖ The Department of Behavioral Health, Developmental Disability and Hospitals (BHDDH), is the second largest, accounting for 22 percent of Medicaid program expenditures.
- ❖ Detail for each state department is shown on the next page.

2a. Expenditure by Department: State Agency Detail

Medicaid benefit expenditure detail for each of the five state agencies is shown below.



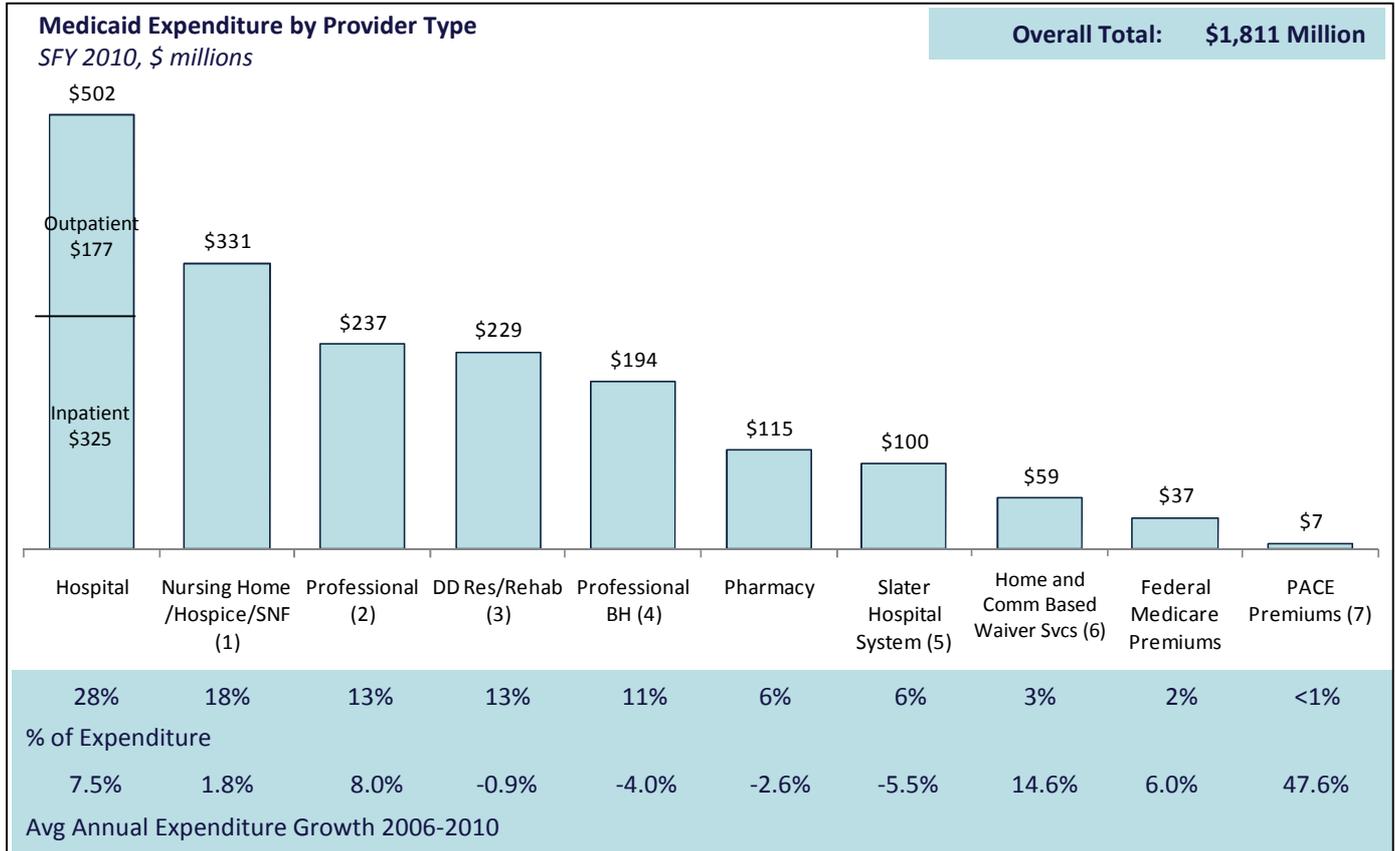
- ❖ The majority of expenditure (75%) is administered by the Department of Human Services (DHS). DHS funds most traditional Medicaid services – providing funding for hospital-based services (37%), long term care (28%), treatment and rehabilitation (23%), and pharmacy (8%).
- ❖ The Department of Behavioral Health, Developmental Disability and Hospitals (BHDDH) accounts for 22% of total Medicaid expenditure. BHDDH is responsible for three primary areas: the management of the Eleanor Slater Hospital system, residential facilities for the developmentally disabled population, and community based behavioral health and substance abuse services.
- ❖ The Department of Children, Youth and Families (DCYF), accounts for \$49 Million (3%) of Medicaid expenditure. DCYF administers programs serving children in the child welfare system, children in substitute care and children with behavioral health conditions.

¹ DD Res/Rehab is Developmentally Disabled Residential and Rehabilitation Services, which includes DD Group homes, DD rehabilitation (adult day care and adult day program), and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

² CMHC/SA Rehab is Community Mental Health Centers and Substance Abuse Rehabilitation.

2c. Expenditure by Provider Type

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

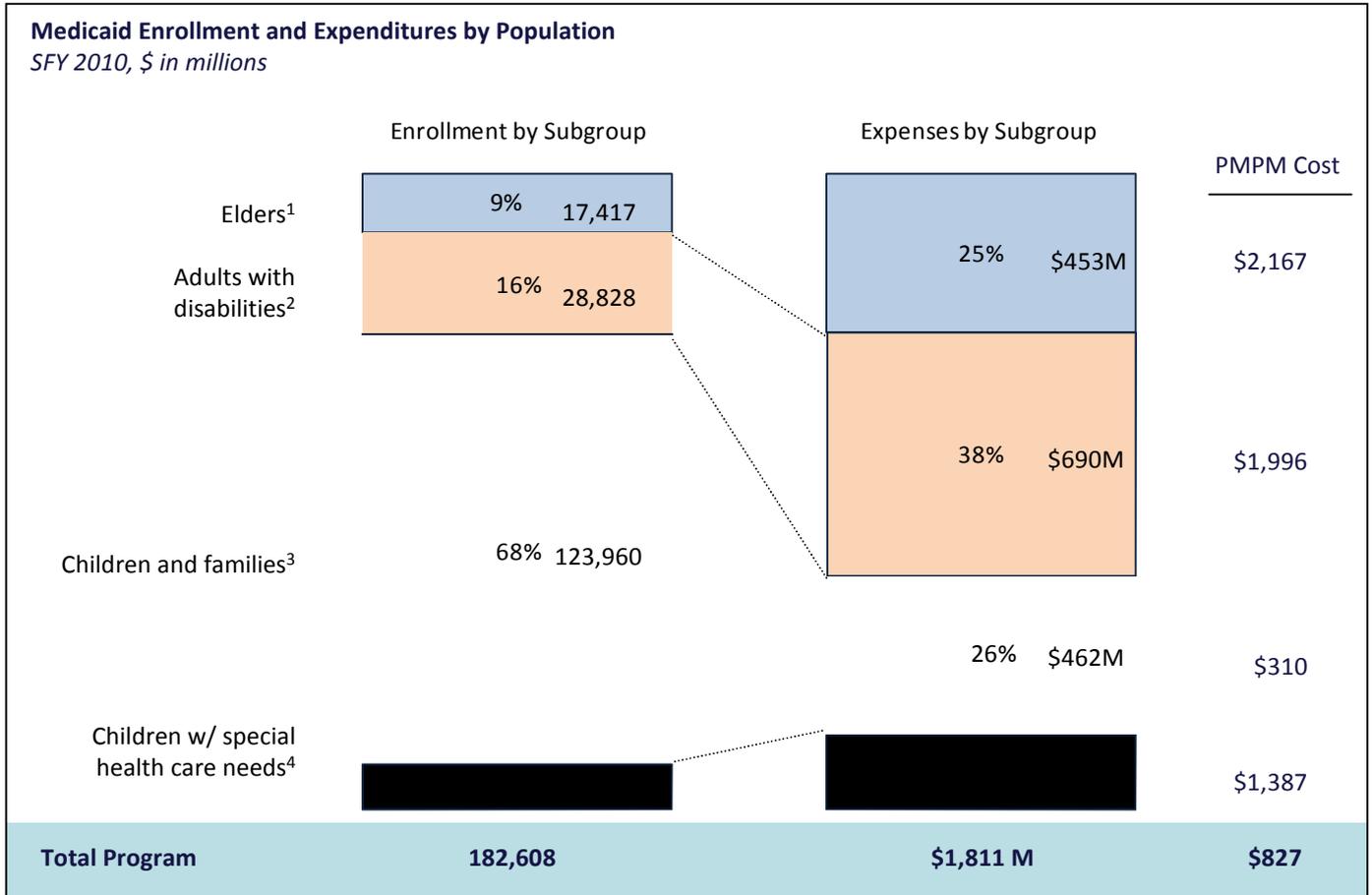


- ❖ The two largest provider types, accounting for nearly half (46%) of all RI Medicaid expenditure in 2010, were hospitals and nursing facilities (including nursing homes, hospice, and skilled nursing facilities). Key contributors to expenditure growth were hospitals, professional providers and home/community based services providers.
- ❖ Hospitals were the largest provider type, accounting for 28 percent of Medicaid expenditures in SFY 2010. Hospital payments are also a key driver of Medicaid expenditure growth – as payments to hospitals increased by an average of 7.5% per year between 2006-2010. Hospitals also accounted for over half (52%) of all Medicaid expenditure growth in recent years.

1 SNF: Skilled Nursing Facility
 2 Professional includes, but is not limited to, E&M, Procedures, Dental, DME/Supplies, X-Ray/Lab/Tests, and Ambulance.
 3 Developmentally Disabled Residential and Rehabilitation services includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).
 4 Professional Behavioral Health includes DHS, BHDDH and DCYF expense including, but not limited to, Professional MH/SA, CEDARR, CMHC, and Residential DCYF.
 5 Slater Hospital System includes Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.
 6 Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, such as personal care, assisted living, and case management. Does not include waiver services for the developmentally disabled population (eg, group homes).
 7 PACE is Program for All-Inclusive Care for the Elderly, which began in 2005. Annual expenditure growth shown here is for 2008-2010.

2d. Expenditure by Population

Medicaid expenditures vary considerably by population



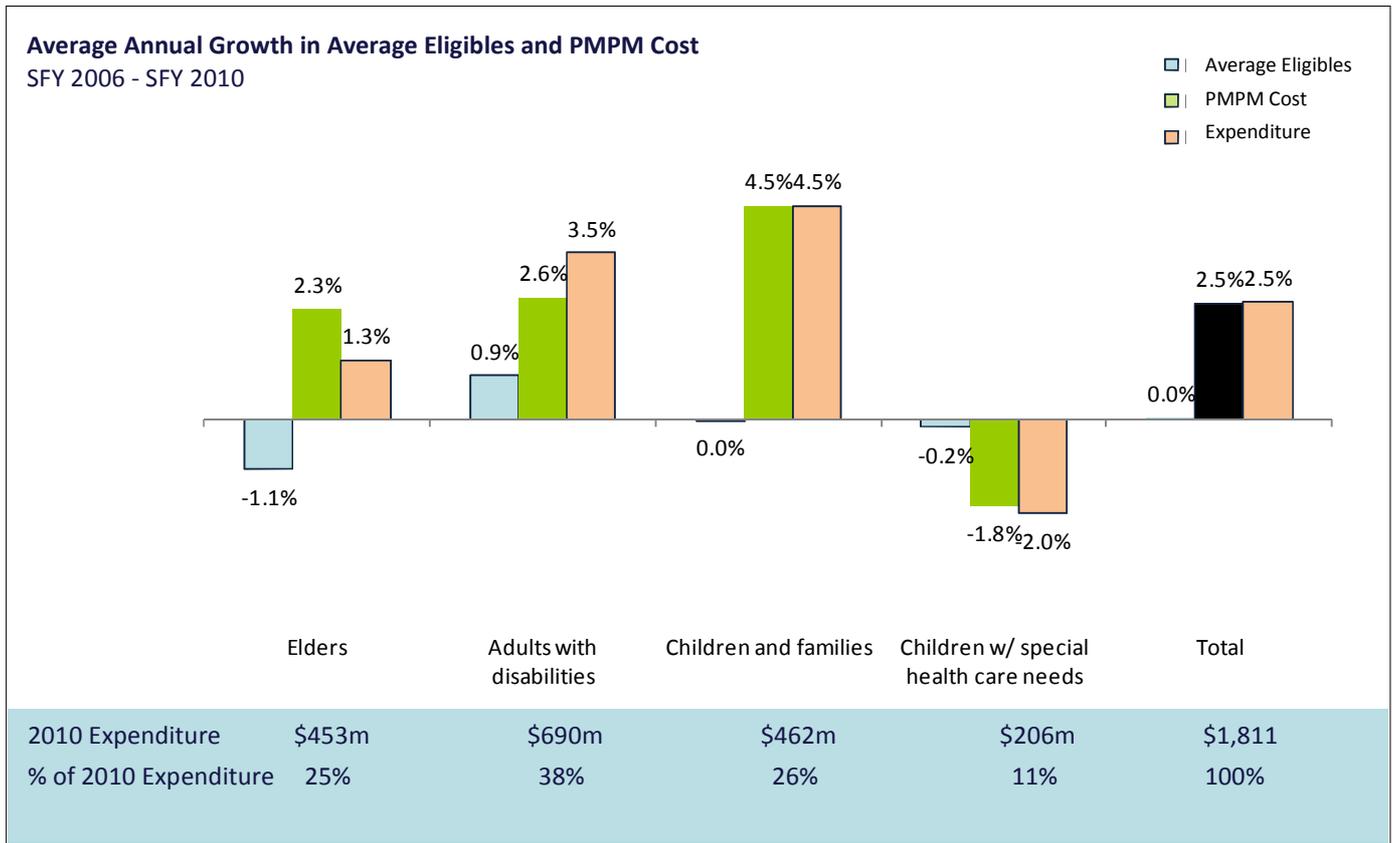
The Medicaid program served an average of 182,608 eligibles in SFY 2010, at an average cost per member per month of \$827. However, PMPM costs vary considerably by population.

- ❖ 63% of expenditure is on services for elders and adults with disabilities; who account for 25% of total eligibles. The PMPM costs for both of these populations are close to \$2,000 per member per month.
- ❖ Services for children and families account for 68% of total enrollment and 26% of total expenditure. As indicated by the PMPM cost of just over \$300.
- ❖ Another 11% of expenditure is for children with special health care needs who represent 7% of eligibles.

1. Elders include all adults over age 65.
 2. Adults with Disabilities includes adults under age 65 who have identified disabilities or complex medical needs (does not include RIte Care enrolled adults).
 3. Children and Families includes low income children, parents and pregnant women who meet specific income requirements.
 4. Children with Special Health Care Needs (CSHCN) includes children in Substitute (Foster) Care, Individuals eligible for SSI who are under 21, Katie Becket children, and Adoption Subsidy children.

2d. Expenditure By Population: Trends

Expenditure growth varies significantly by population.



- ❖ Overall Rhode Island Medicaid expenditures grew by approximately 2.5 percent per year between SFY 2006 and SFY 2010; however, this increase varied considerably by population.
- ❖ Adults with disabilities account for the largest overall enrollment growth over the past 4 years. This group also accounts for the highest share of 2010 expenditure and the largest share of expenditure growth.
- ❖ Expenditure on children and families has increased by 4.5% percent per year , with PMPM costs increasing by 6.1% per year, part of this increase is due to the premium tax. By way of reference, Rhode Island commercial PMPM cost trends over the last 3 years are 7.1%¹.

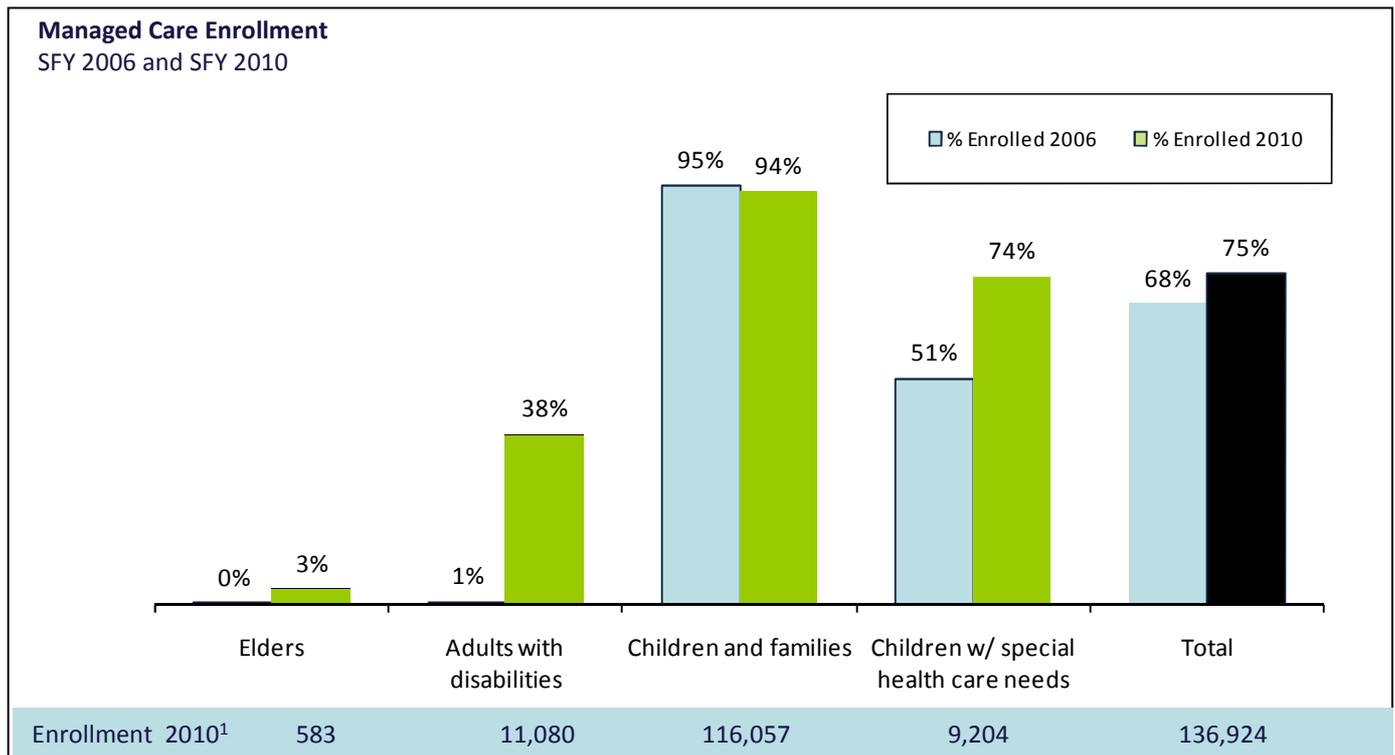
1. For commercial incurred claims from BCBSRI, United and Tufts, includes both large group and small group. Source: OHIC, 2011 carrier rate filings, exhibit 3.

Table of Contents

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

3a. Managed Care Enrollment

Three quarters (75%) of all Medicaid eligibles are enrolled in Medicaid managed care plans, but this split varies by population subgroup.¹

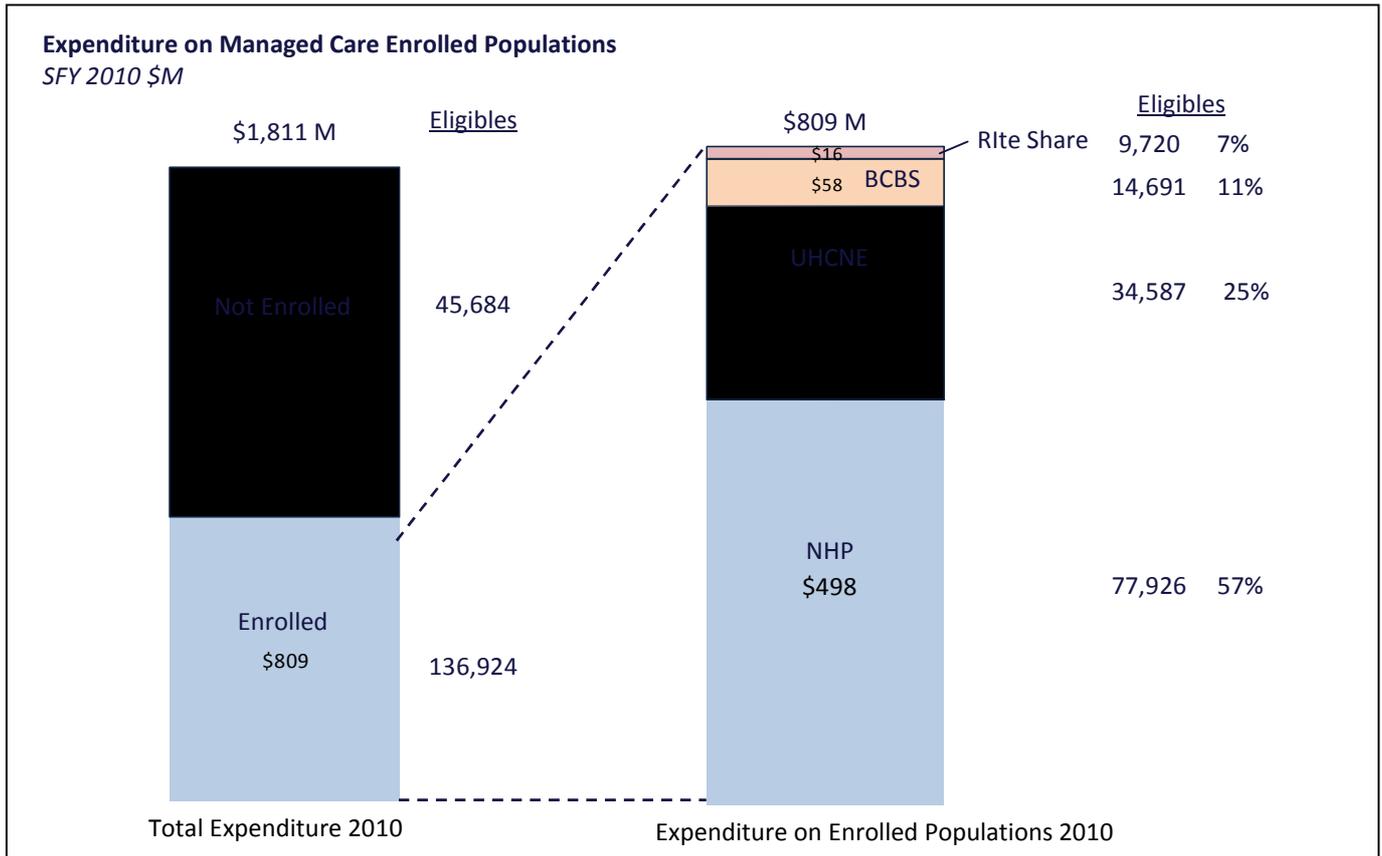


- ❖ Children and families were generally enrolled in one of the three managed care plans unless they had other insurance coverage (e.g. employer sponsored coverage, Medicare).
- ❖ In SFY 2005, children with special health care needs (CSHCN) were enrolled in Neighborhood Health Plan, unless they “opted out” and chose to enroll in fee-for-service Medicaid. Beginning in the Fall of 2008, managed care options for this population were expanded to include UnitedHealth Care, and enrollment in Medicaid managed care became mandatory for those Medicaid eligible children without other insurance. About 74% were enrolled in Medicaid managed care in SFY 2010.
- ❖ Adult populations have historically been exclusively in fee-for-service Medicaid. However, two new managed care programs were established in 2008 to transition adults to managed care: ConnectCare Choice began enrolling adults in February 2008; and Rhody Health Partners began in April 2008.

¹Managed care enrollment includes 9,720 RItE Share members.

3a. Managed Care Enrollment

The 75% of Medicaid eligibles enrolled in managed care plans account for 45% of Medicaid expenditure.

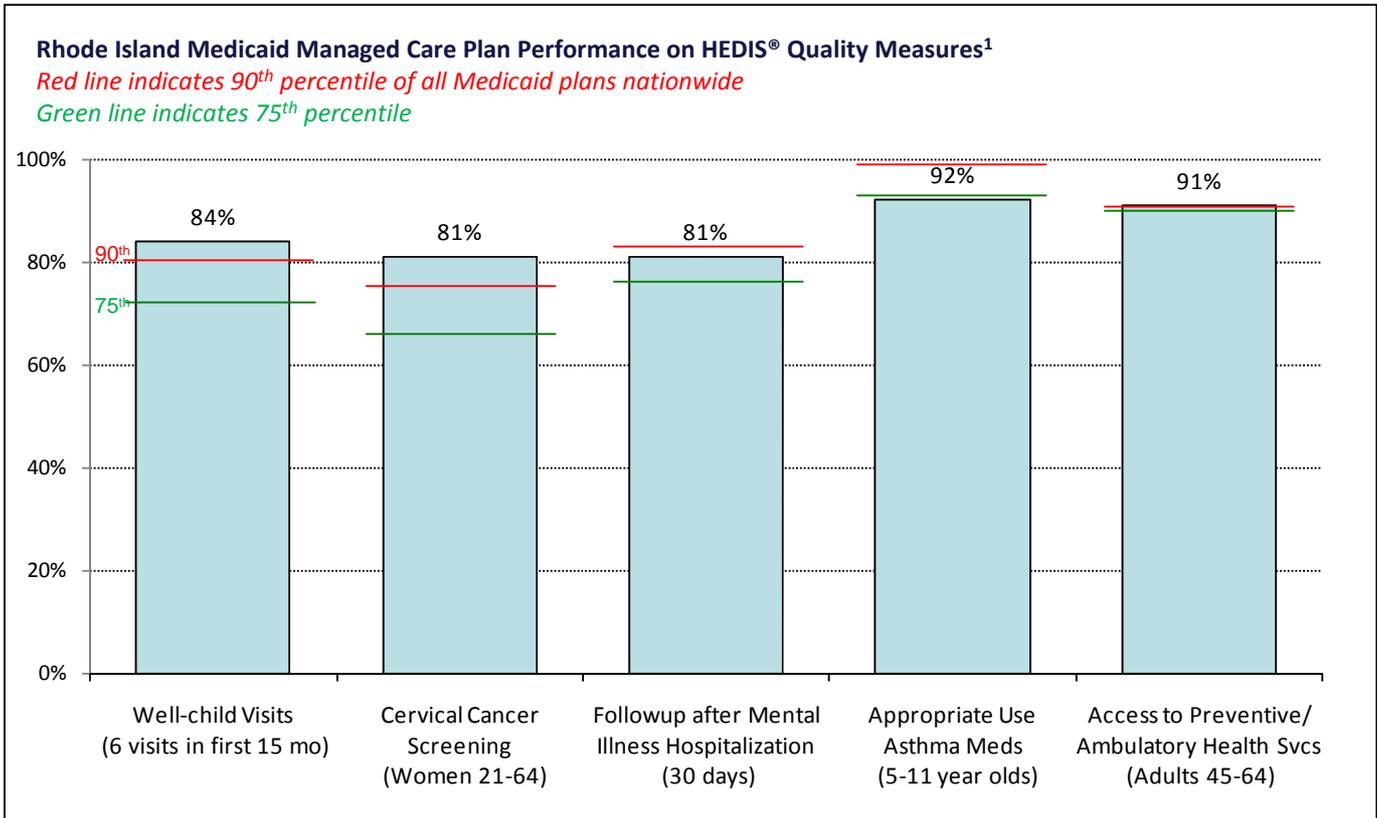


- ❖ Three quarters (75%) of all Medicaid eligibles are enrolled in Medicaid managed care plans. These “enrolled populations” account for about 45% of Rhode Island Medicaid expenditures.¹
- ❖ During SFY 2010 managed care enrollment was divided among three health plans. Neighborhood Health Plan of Rhode Island (NHPRI) is the largest carrier, accounting for 57% of managed care enrollment. UnitedHealth Care of New England (UHCNE) accounts for another 25% of eligibles, and Blue Cross Blue Shield of Rhode Island (BCBSRI) is the smallest plan with approximately 11%. (As of December 2010, BCBSRI ceased participation in RIte Care.)
- ❖ RIte Share is a program designed to allow Medicaid eligibles to retain their employer sponsored commercial coverage, while at the same time leveraging employer contributions, thereby minimizing Medicaid program expenditure. As such, Medicaid pays the employee’s share of the premium for Medicaid eligibles who have access to qualified employer-based insurance coverage. Approximately 9,720 Medicaid eligibles were enrolled in the RIte Share program in SFY 2010.

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

3a. Managed Care Quality Indicators

Rhode Island’s participating Medicaid Managed Care Health Plans have consistently ranked among the nation’s top performing Health Plans.

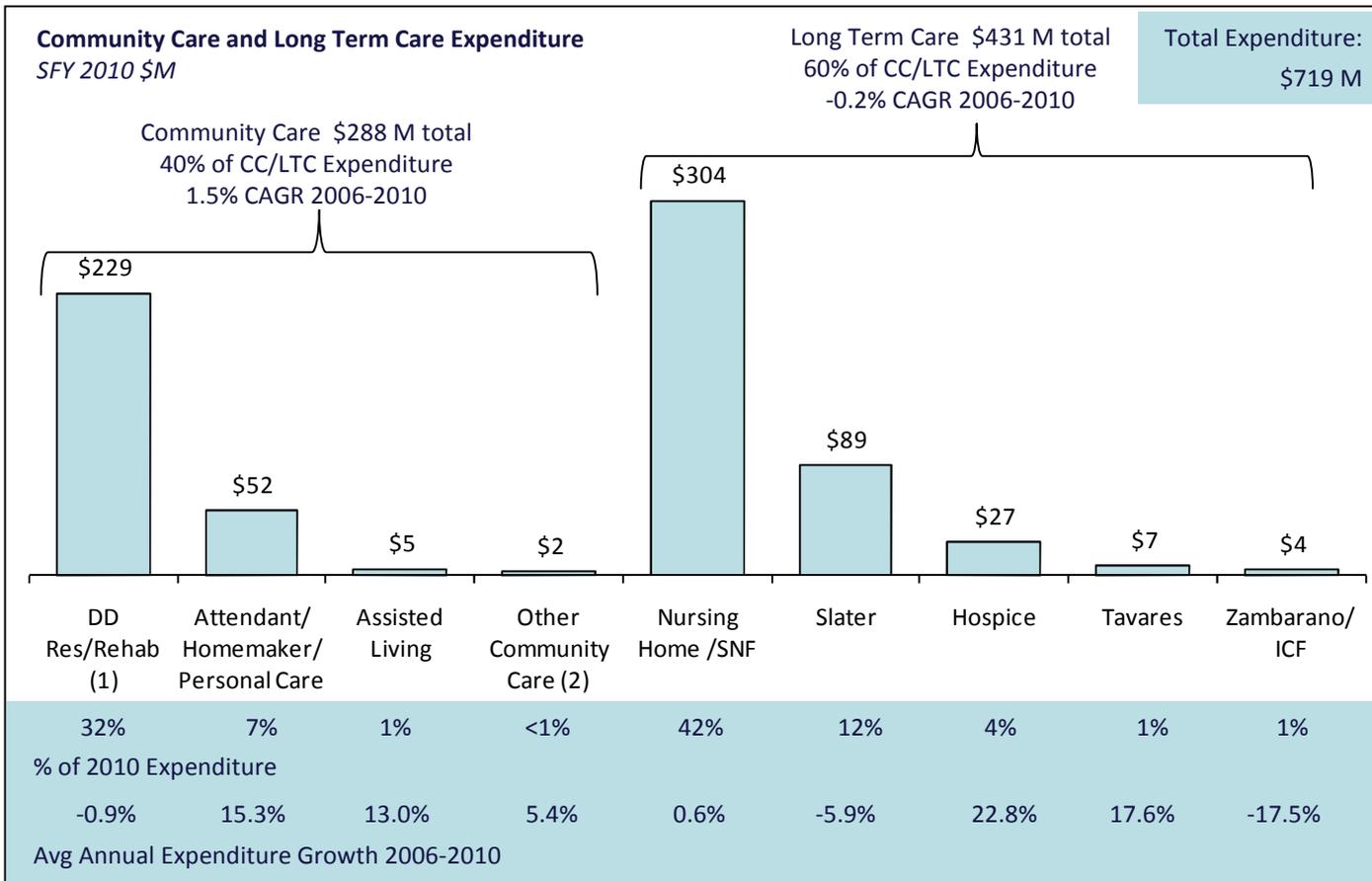


- ❖ On the HEDIS® measure assessing the percentage of enrollees who had six or more well-child visits with a primary care provider during their first 15 months of life, all of RItE Care’s Health Plans ranked above the 90th percentile compared with all Medicaid health plans in the nation.
- ❖ RItE Care’s Health Plans did well on the cervical cancer screening measure and exceeded the 90th percentile for the past three years. This measures the percent of women 21-64 who received one or more Pap tests to screen for cervical cancer.
- ❖ RItE Care’s Health Plans reached the 90th percentile for having an outpatient follow-up mental health service within at least 30 days after discharge from a hospitalization for certain mental health disorders.
- ❖ On the HEDIS measure of children with asthma who were appropriately prescribed medication, RItE Care’s Health Plans reached the 75th percentile. Children who use asthma medications appropriately can prevent unnecessary emergency department visits and hospitalizations .
- ❖ 91% of RItE Care adults ages 45-64 received preventive and primary care visits during the year.

1. Results are reported in the aggregate, not by individual health plan.

3b. Community Care and Long Term Care

Community care and long term care accounted for \$719 million in 2010, about 40% of total Medicaid expenditure.



- ❖ The Global Medicaid Waiver subsumed the prior 1915(c) waivers, which granted the state the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide home and community based services to at-risk populations as a alternatives to more costly nursing home/institutional options.
- ❖ Community care accounts for 40% of the total expenditure on home and community based care and long term care. The vast majority of community based care expenditure is for the developmentally disabled population.
- ❖ Most of the expenditure on long term care is for nursing homes (70% of long term care expenditures).
- ❖ Most of the growth in expenditures is on home and community based care (e.g. personal care, assisted living, hospice) which are less expensive alternatives to nursing home/institutional options.

¹ Developmentally Disabled Residential and Rehabilitation services includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

²Other community care includes DME (e.g., ERS, Home Modifications), Case Management, Meals and other.

Table of Contents

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

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

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

- 4. Mandatory and Optional**
 - a. Mandatory and Optional Overview
 - b. Optional Services Detail

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

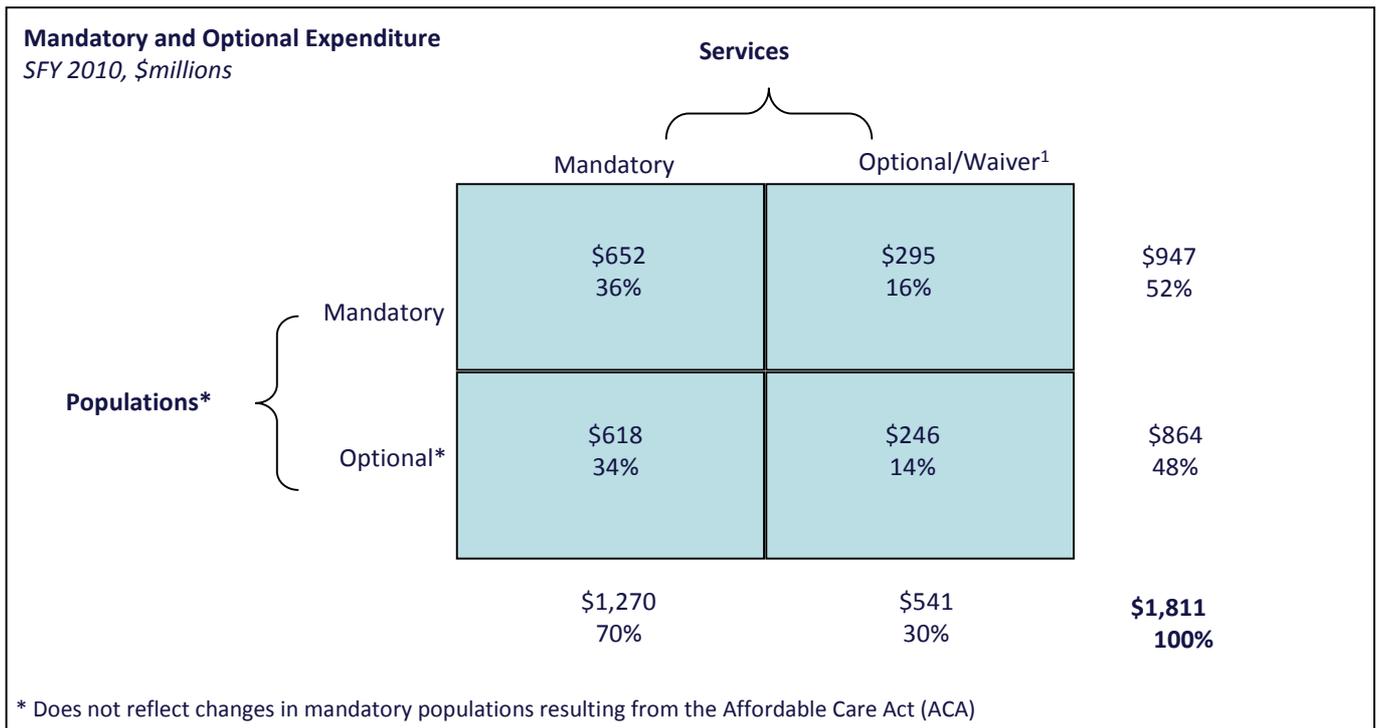
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families (C+F)
 - d. Children with Special Health Care Needs (CSHCN)

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

- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms

4a. Mandatory/Optional Expenditure Overview

Under federal guidelines, there are “mandatory” populations and services that all state Medicaid programs must cover to receive federal matching payments. However, the maintenance of effort (MOE) requirements of the new federal law enacted in March 2010 substantially change the traditional definition of mandatory populations.



Traditional Medicaid Law

- ❖ States may obtain federal matching funds for covering several “optional” groups of individuals and services. Optional services are generally intended to reduce expenditure for mandatory services² (e.g. pharmacy is an optional service).
- ❖ In addition, Federal guidelines require that optional populations receive the same services as mandatory populations – so states can not generally eliminate these services for optional populations but retain them for mandatory populations.

Changes under Health Care Reform

Under the ACA Medicaid is bound by a MOE restriction which requires continuation of services for any population receiving services as of March 2010.

¹ Includes \$59M in expenditure on Waiver services (evenly split between mandatory and optional populations).

² For example, pharmacy, outpatient behavioral health, and hospice are all sizable components of optional services that, if eliminated, would likely result in offsetting increases in mandatory expenditure

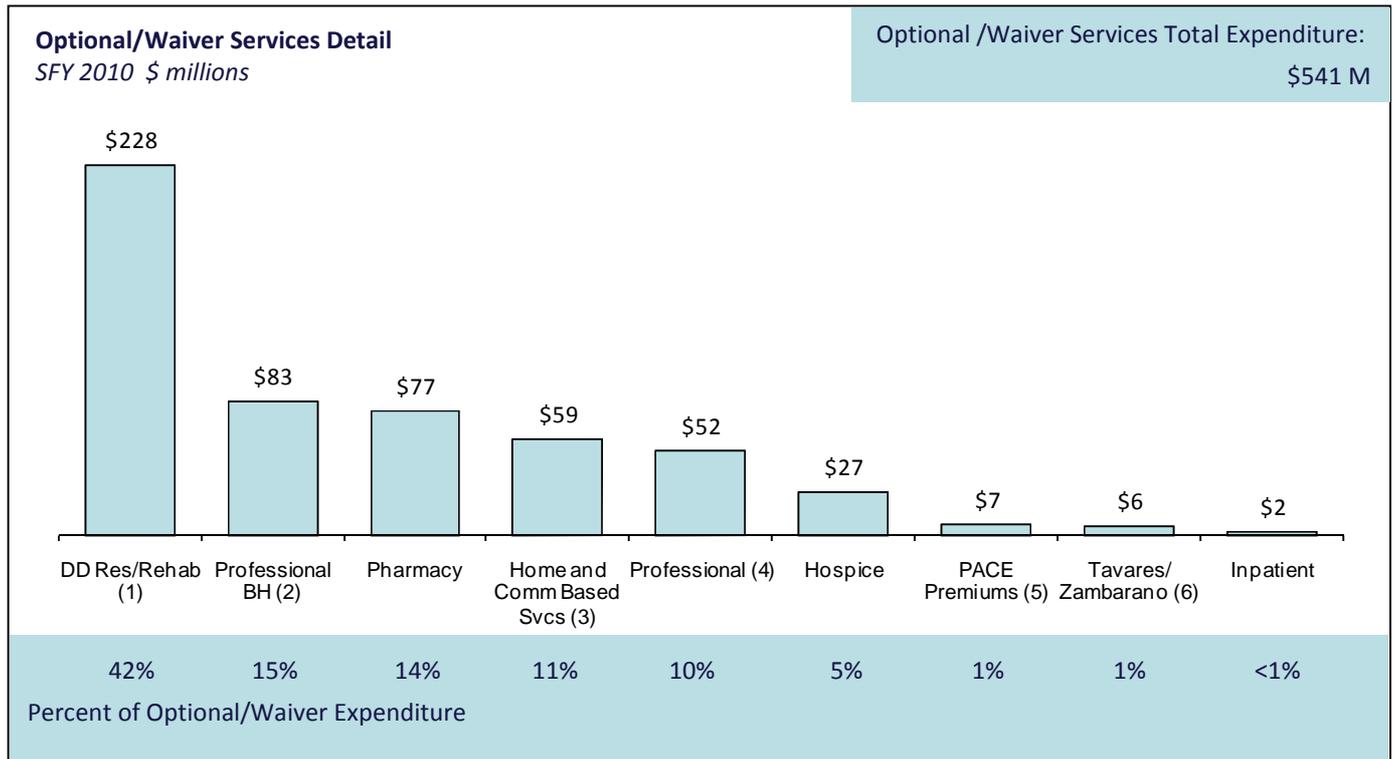
4b. Mandatory/Optional: Services

Federal health reform maintenance of effort restrictions do not pertain to optional services. Optional services include lower cost practitioners and services that provide care coordination or continuity.

Federal mandatory services	Optional/Waiver Services
2010 Expenditure: \$1,270 M	2010 Expenditure: \$541 M
<p>Acute Care</p> <ul style="list-style-type: none"> ❖ Physicians' services ❖ Laboratory and x-ray services ❖ Inpatient hospital services ❖ Outpatient hospital services ❖ Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21 ❖ Family Planning and supplies ❖ Federally qualified health center (FQHC) services ❖ Rural health clinic services ❖ Nurse-midwife services to the extent permitted by State law ❖ Services of certified pediatric and family nurse practitioners to the extent they are authorized to practice under State law 	<p>Acute Care</p> <ul style="list-style-type: none"> ❖ Rehabilitation and other therapies ❖ Prescription drugs ❖ Medical care or remedial care furnished by other licensed practitioners ❖ Clinic services ❖ Dental services, dentures ❖ Prosthetic devices, eyeglasses, DME ❖ Primary care case management ❖ TB-related services ❖ Other specialist medical or remedial care
<p>Institutional Services</p> <ul style="list-style-type: none"> ❖ Nursing facility services for individuals 21 and older 	<p>Institutional Services</p> <ul style="list-style-type: none"> ❖ Intermediate care facility services for the developmentally disabled (ICF/DD) ❖ Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases ❖ Inpatient psychiatric hospital services for individuals under 21
<p>Home and Community Based Services</p> <ul style="list-style-type: none"> ❖ Home health care services for any individual entitled to nursing facility care 	<p>Home and Community Based Services</p> <ul style="list-style-type: none"> ❖ Home and Community Based Waiver Services ❖ Other home health care ❖ Targeted case management ❖ Respiratory care services for ventilator dependent individuals ❖ Personal care services Hospice Services ❖ Services furnished under a Pace Program

4b. Mandatory/Optional: Optional Services Detail

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



- ❖ Optional and waiver services accounted for \$541 Million in total Medicaid expenditure in SFY 2010, approximately 30% of total Medicaid expenditures. Of that, waiver services accounted for \$59 million.
- ❖ The largest component of optional services (42% of optional services expenditure) is residential and rehabilitation services for the developmentally disabled. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services for developmentally disabled populations.
- ❖ Under EPSDT provisions, services that are optional for adults are mandatory for children, e.g., pharmacy.

¹ Developmentally Disabled Residential and Rehabilitation services includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

² Professional BH includes DHS, BHDDH and DCYF expense including, but not limited to, Professional MH/SA, CEDARR, CMHC, and Residential DCYF.

³ Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, such as personal care, assisted living, case management.

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

⁵ PACE is Program for All-Inclusive Care for the Elderly.

⁶ Tavares and Zambarano are specialized facilities for severely disabled children or adults

Table of Contents

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

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

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

- 4. Mandatory and Optional**
 - a. Mandatory and Optional Overview
 - b. Optional Services Detail

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

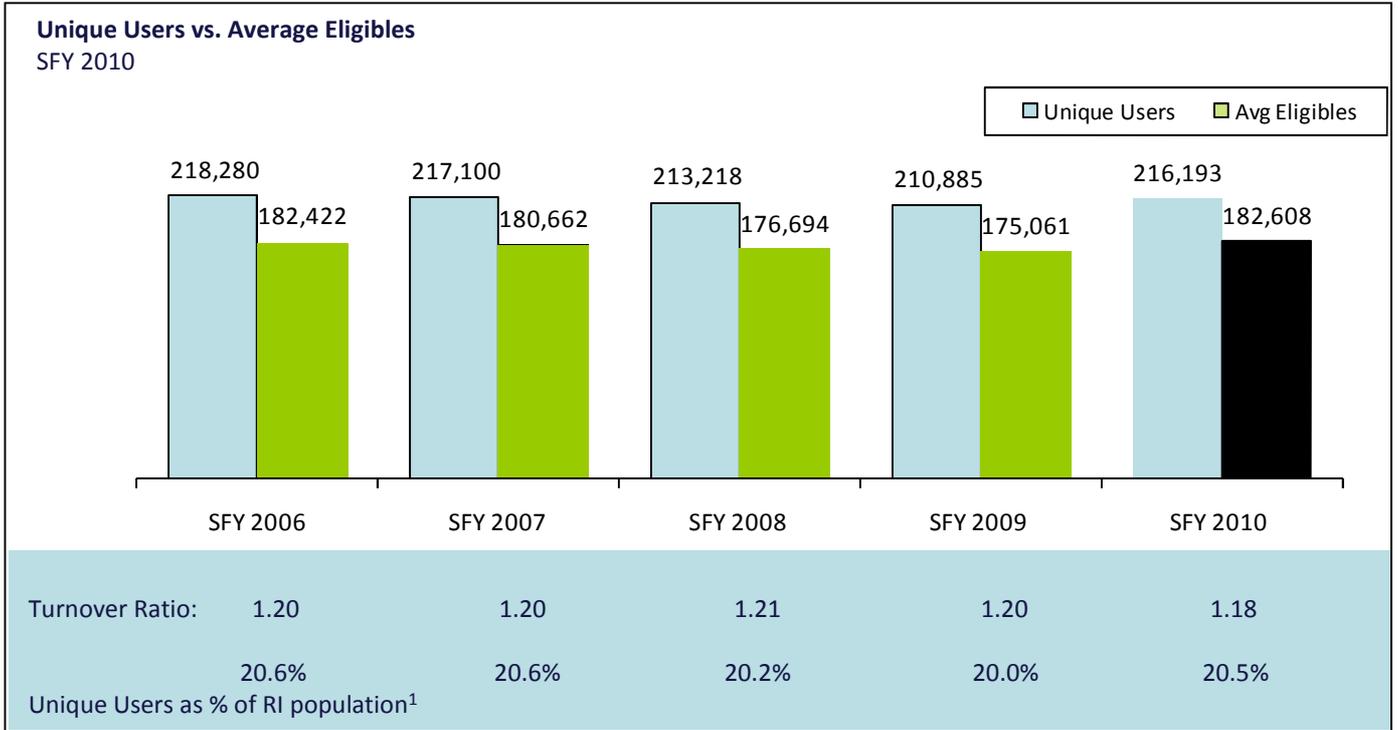
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families (C+F)
 - d. Children with Special Health Care Needs (CSHCN)

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

- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms

5a. Unique Users

216,000 Rhode Islanders, or 21% of Rhode Island’s population, were enrolled in Medicaid for some part of SFY 2010.



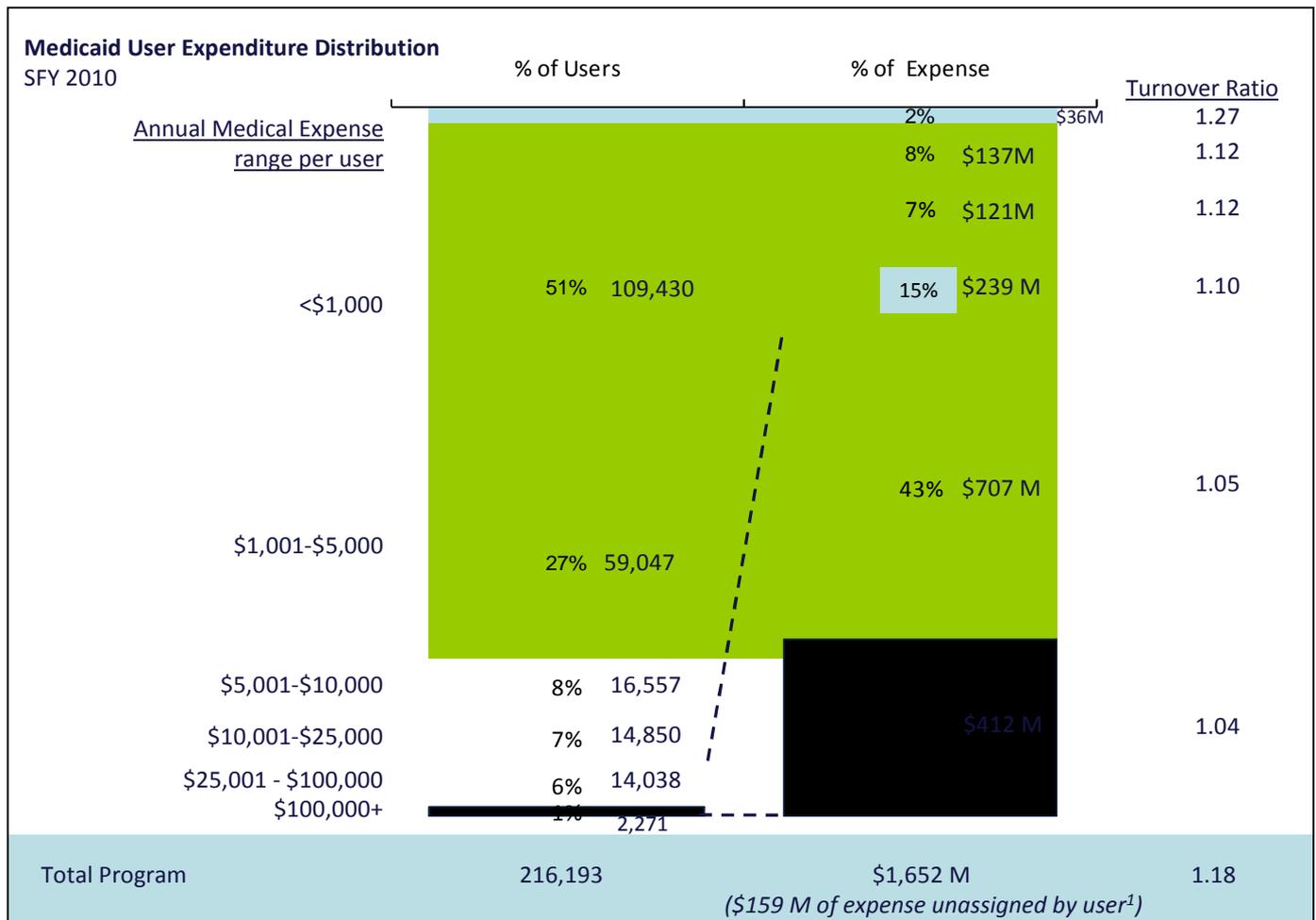
- ❖ Unique users is a measure of the number of Rhode Islanders who were enrolled in Medicaid at any time during the fiscal year.² So, if a person enrolled, disenrolled, and reenrolled, they would count as one user. Similarly, if a person enrolled for only 1 month, they would be included as a unique user.
- ❖ Comparing unique users to average eligibles provides an assessment of the role of the Medicaid program in Rhode Island. If the number of unique users is equal to the average eligibles -- that indicates that there is a steady population of eligibles that remain on the program for the full year. If the number of unique users is above the average eligibles (a ratio of >1) -- this indicates the program is serving a broader spectrum of Rhode Islanders.

1. Source: Population Division, US Census Bureau.

2. A unique user is an individual associated with a medical claim. Average eligible enrollment is annual FTEs.

5b. Expenditure by User: High Cost Cases

The top seven percent of Medicaid users account for over two thirds (68%) of Medicaid expenditure.

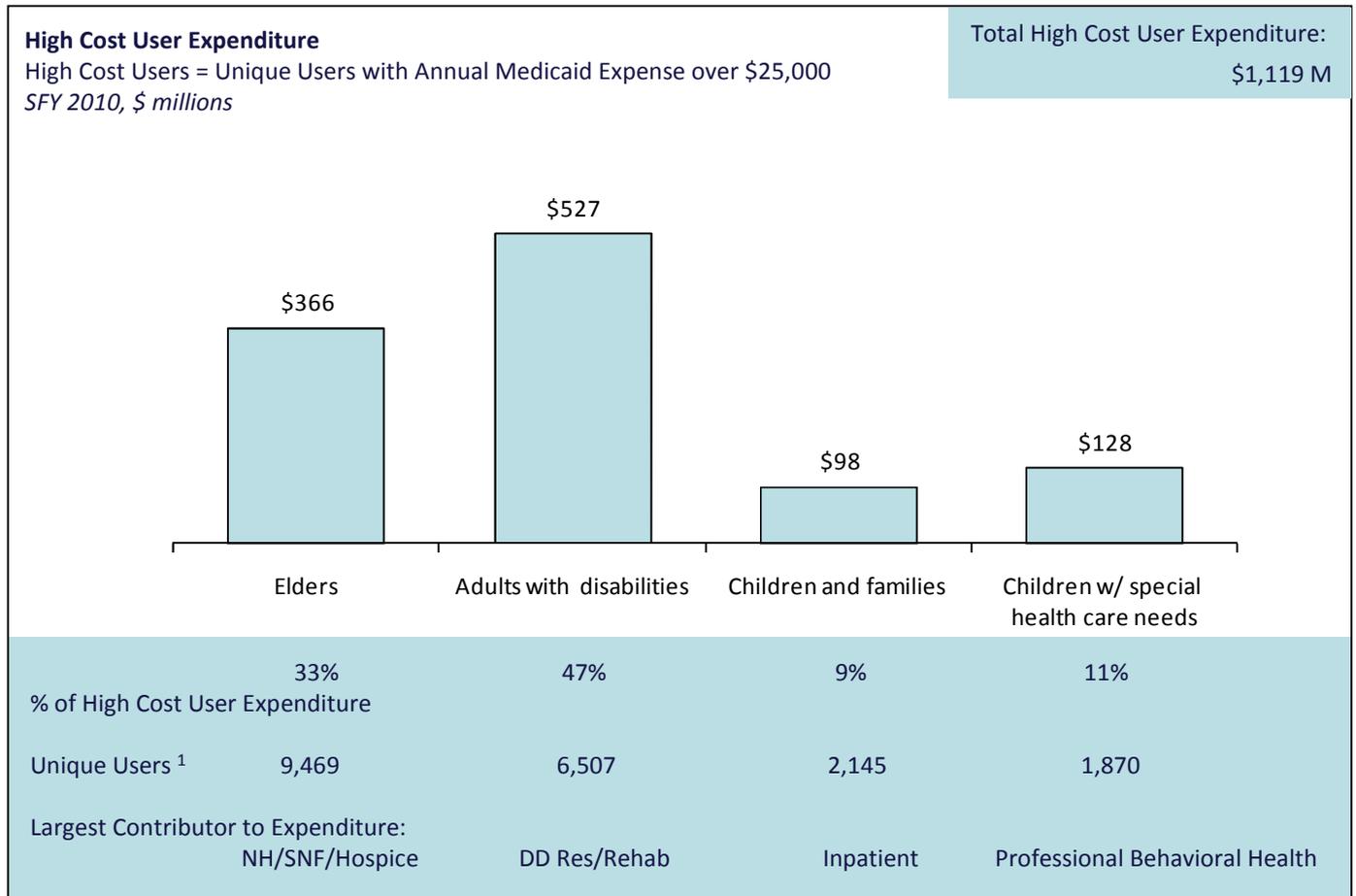


- ❖ Medicaid expenditures are highly concentrated, as the top seven percent of Medicaid users account for more than two-thirds (68%) of expenditures. This is similar to national statistics, as five percent of the US population accounted for 49 percent of overall US health care expenditure². On the other end of the spectrum, seventy eight percent of Medicaid users access Medicaid services at a cost of less than \$5,000 per year. Thus, the 16,309 top utilizers spent, on average, \$68,606 per person, more than *sixty times* as much per person as those in the bottom 78 percent of users.
- ❖ Additionally, the high cost users have a turnover ratio that is close to one (1.04 for the top 1% of users) – indicating that this population tends to remain on the program for the full year. These high utilizers typically present with multiple, complex conditions, requiring care coordination across a variety of provider types. This suggests a sustained need for care management, focused on high cost/chronically ill populations.

1. Expense unassigned by user includes provider payouts, UPL, Medicare Premiums, PACE premiums, and managed care admin.
 2. "The High Concentration of US Health Care Expenditures," AHRQ, 2006 <http://www.ahrq.gov/research/ria19/pendria.pdf>

5b. Expenditure by User: High Cost Cases

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

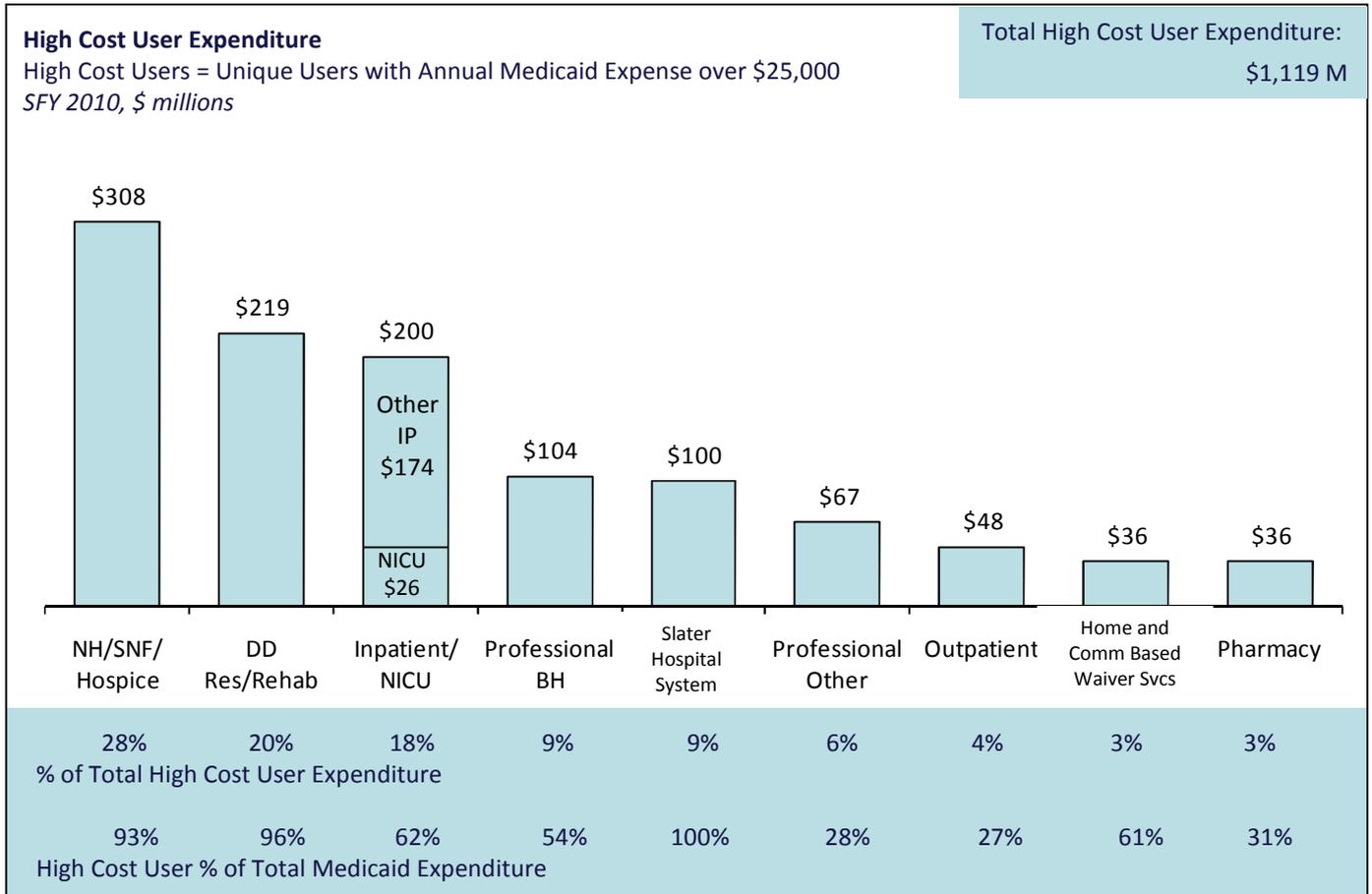


- ❖ Expenditure on elders and adults with disabilities accounts for eighty percent of expenditure on the highest cost users. (High cost users defined as unique users with over \$25,000 of Medicaid expense in 2010).
- ❖ The largest category of expenditure for high cost elders is nursing facilities (nursing homes, skilled nursing facilities and hospice), accounting for \$276 million (25%) of overall expenditure on high cost users. The largest category of expenditure for high cost adults with disabilities is residential and rehabilitation facilities for the developmentally disabled, which account for another \$188 million (17%) of overall expenditure on high cost users.
- ❖ For children and families, the largest category of expenditure for high cost users is hospital inpatient services, accounting for 5% of overall expenditure on high cost users. Professional behavioral health services for children with special health care needs account for another 4% of overall expenditure on high cost users.

1. Total sums to more than the overall 16,309 high cost unique users due to overlap between eligibility groups.

5b. Expenditure by User: High Cost Cases

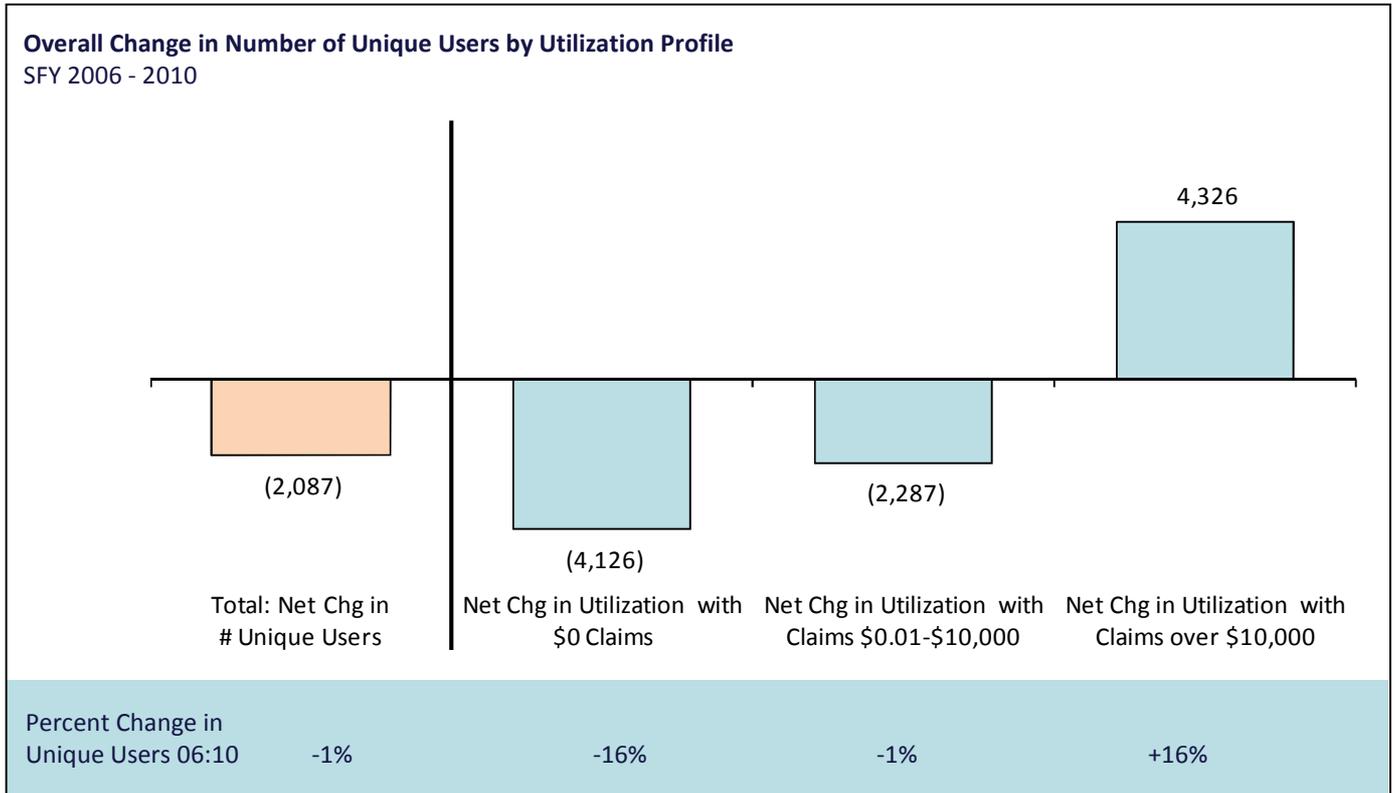
Nearly half (48%) of expenditure on high cost users is on nursing facilities and developmentally disabled residential and rehabilitation services.



- ❖ Nursing facilities account for 28% of the expenditure on high cost users, and residential and rehabilitation services for the developmentally disabled account for another 20%.
- ❖ In addition, expenditure on high cost users accounts for over 90% of total expenditure for nursing facilities, developmentally disabled residential and rehabilitation services, and the Slater Hospital System (including Zambarano and Tavares).
- ❖ Many high cost users are those who are institutionalized year-round

5b. Expenditure Trends by User

Over the past few years, the Medicaid utilization has shifted toward higher cost users, which could result in cost and trend increases over the coming years.



A shift in utilization profiles toward a higher cost population could affect the program cost structure and expenditure trends over the coming years. Although the data does not account for medical cost inflation, it appears that over the past few years the Medicaid utilization profile has in fact shifted toward higher cost utilizers.

❖ Overall, Medicaid has experienced a slight decline in the number of unique utilizers, down approximately 1 percent over the past five years.

❖ However, this decline has not been consistent across all categories of users. In fact, over the past five years, Medicaid has seen a decline in low cost utilizers and an increase in high cost utilizers.

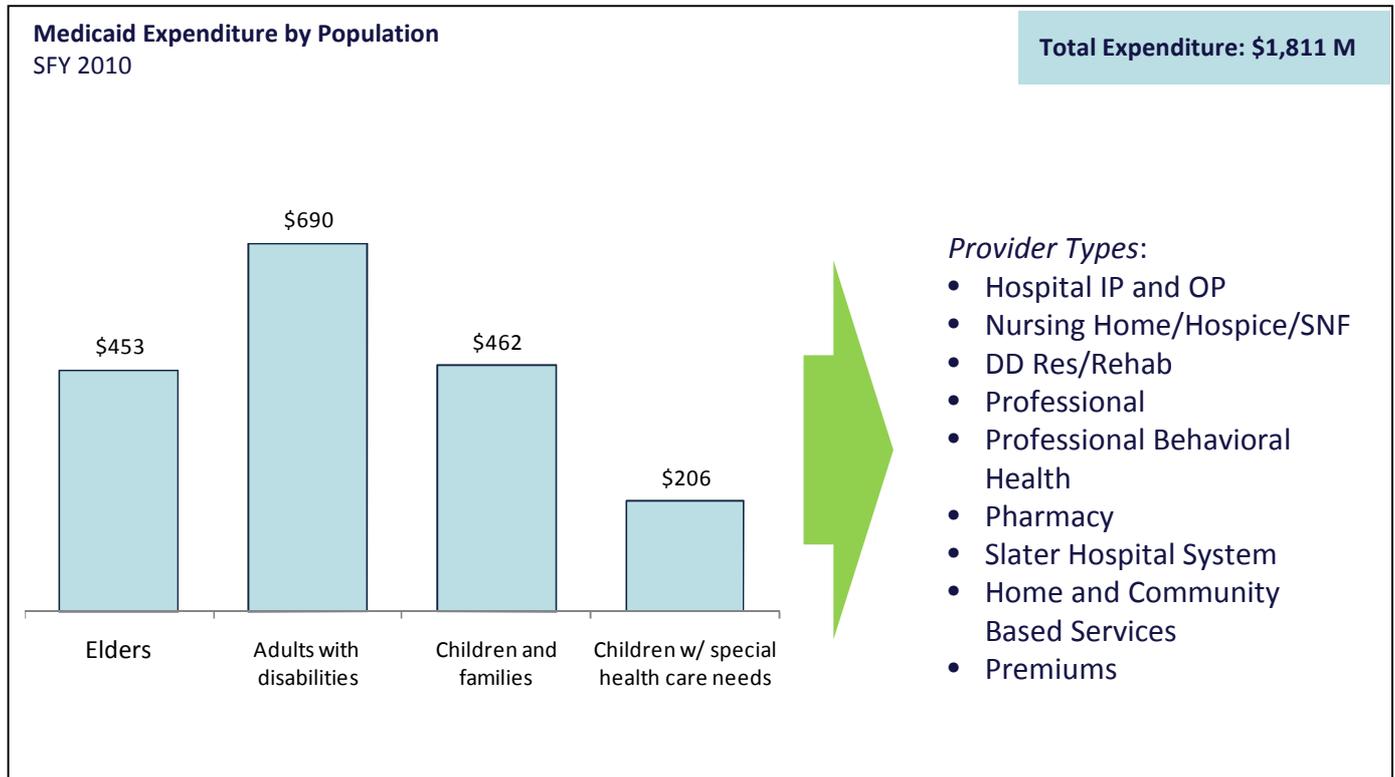
- Nonusers (users with \$0 in claims expense) declined by a much greater proportion than average (16% vs. 1% average); while high utilizers (users with claims over \$10,000) actually increased by 16 percent over this period.
- One driver of this change could be that the cost of medical services has increased over the last 5 years, however the exact impact of that is difficult to quantify.

Table of Contents

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

6. Expenditure Detail by Population and Provider Type

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

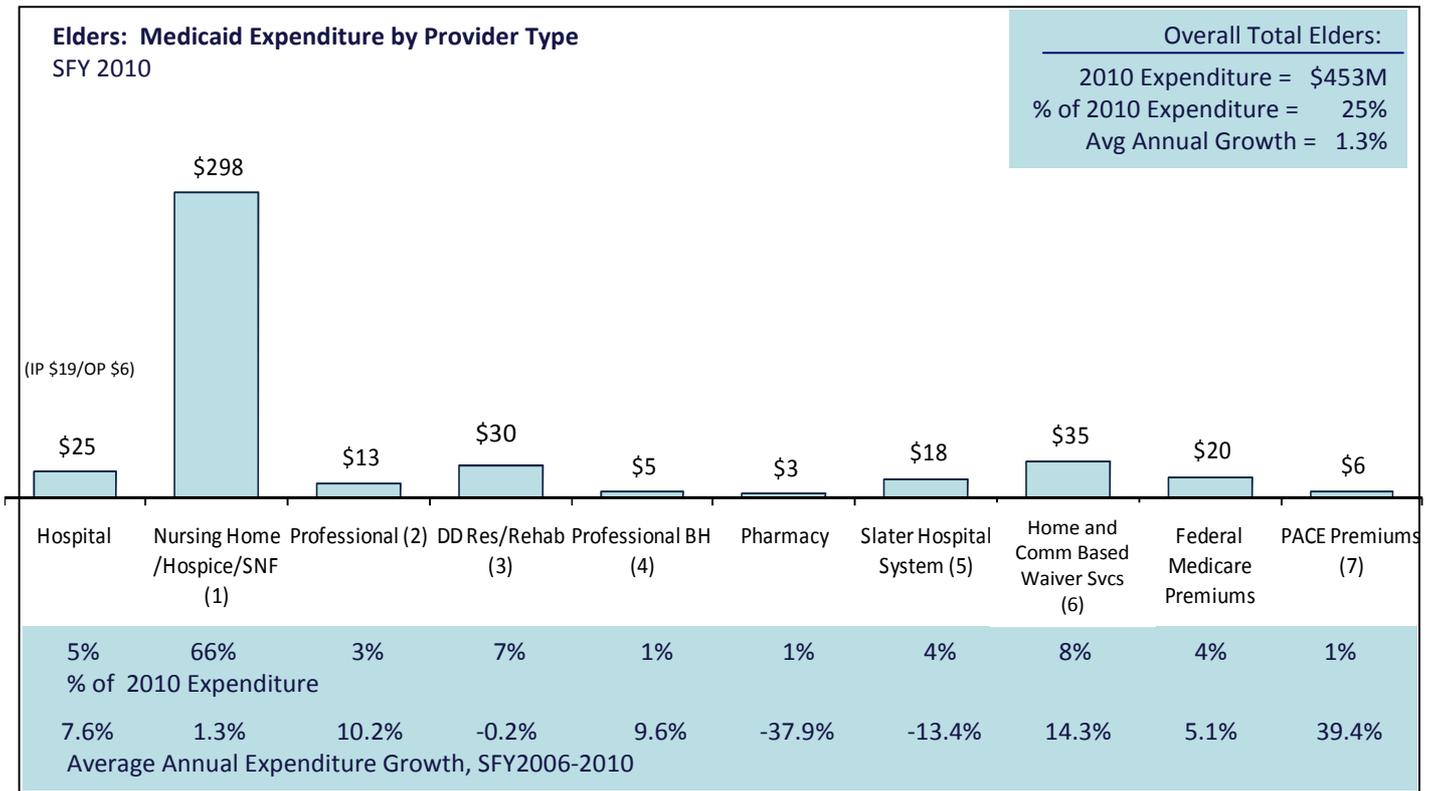


In order to review expenditure by population in more detail, it is useful to look at expenditure by provider type within each population group.

- ❖ Elders includes all adults over age 65.
- ❖ Adults with Disabilities includes adults under age 65 who have identified disabilities or complex medical needs (does not include RIte Care enrolled adults).
- ❖ Children and Families includes low income children, parents and pregnant women who meet specific income requirements
- ❖ Children with Special Health Care Needs (CSHCN) includes children in Substitute (Foster) Care, Individuals eligible for SSI who are under 21, Katie Becket children, and Adoption Subsidy children.

6a. Elders Detail

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

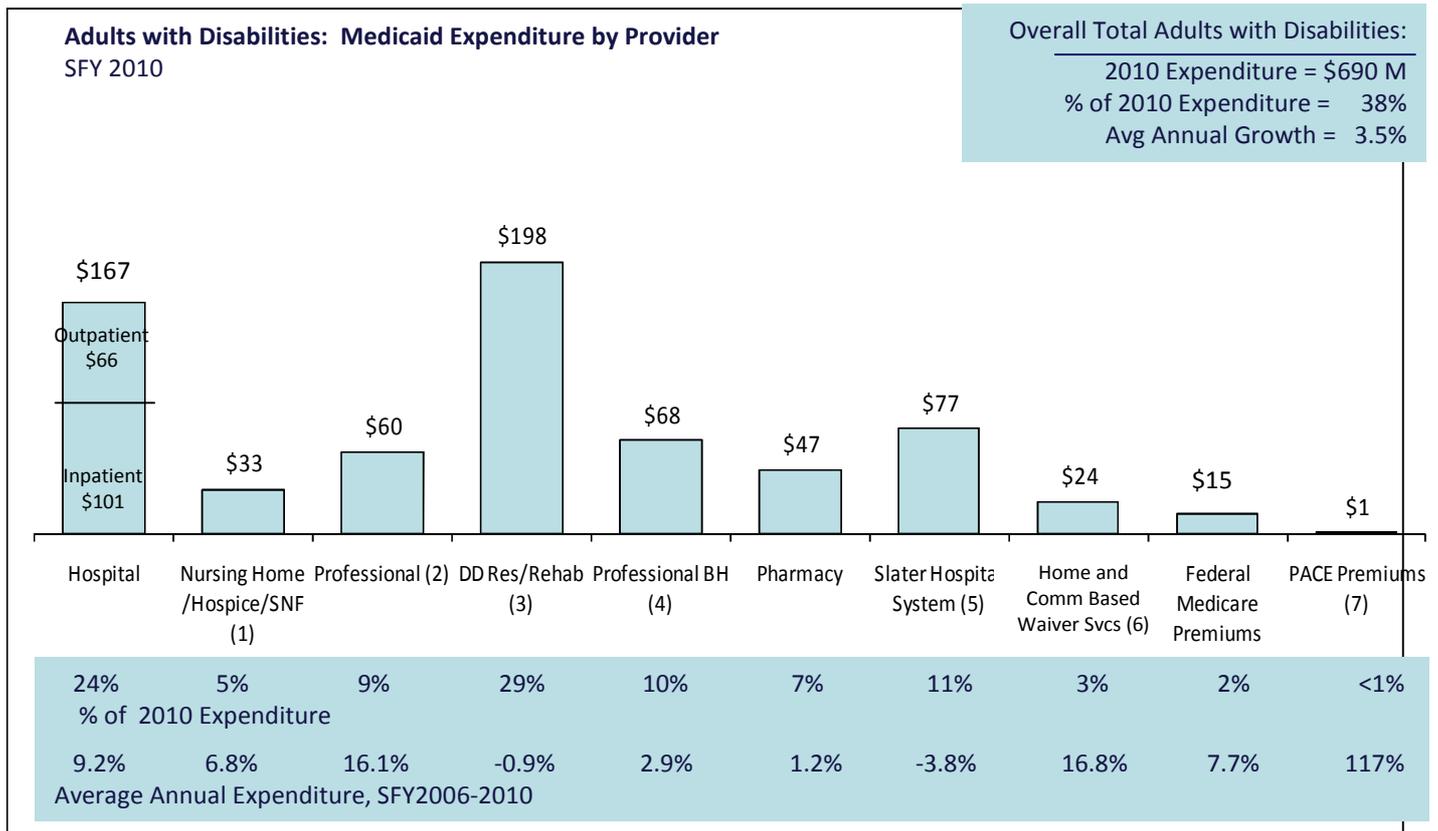


- ❖ Medicaid expenditures on elders totaled \$453 Million in 2010, and has been increasing slightly at 1.3% per year over the past 5 years. The large majority of elders are also eligible for Medicare, which is the primary payor for most medical services (e.g. hospital, physician); consequently those expenses are not paid by Medicaid and are not included here.
- ❖ The slow growth in expenditures for this population can be explained in part by the introduction of Medicare Part D, which transitioned a significant amount of pharmacy expenditure for elders out of Medicaid and into Medicare.
- ❖ Nursing facilities (including nursing homes, hospice and skilled nursing facilities) account for nearly two thirds (66%) of total Medicaid expenditure on elders. However, the increase in nursing home expenditure for this population has been relatively small - an average annual increase of 1.3 percent per year.
- ❖ Most of the growth in Medicaid expenditure for elders has been in home and community based services and professional services, due in part to an effort to invest in alternatives to institutional/nursing home care.

See footnotes on page 15 for Provider Type definitions and notes.

6b. Adults with Disabilities Detail

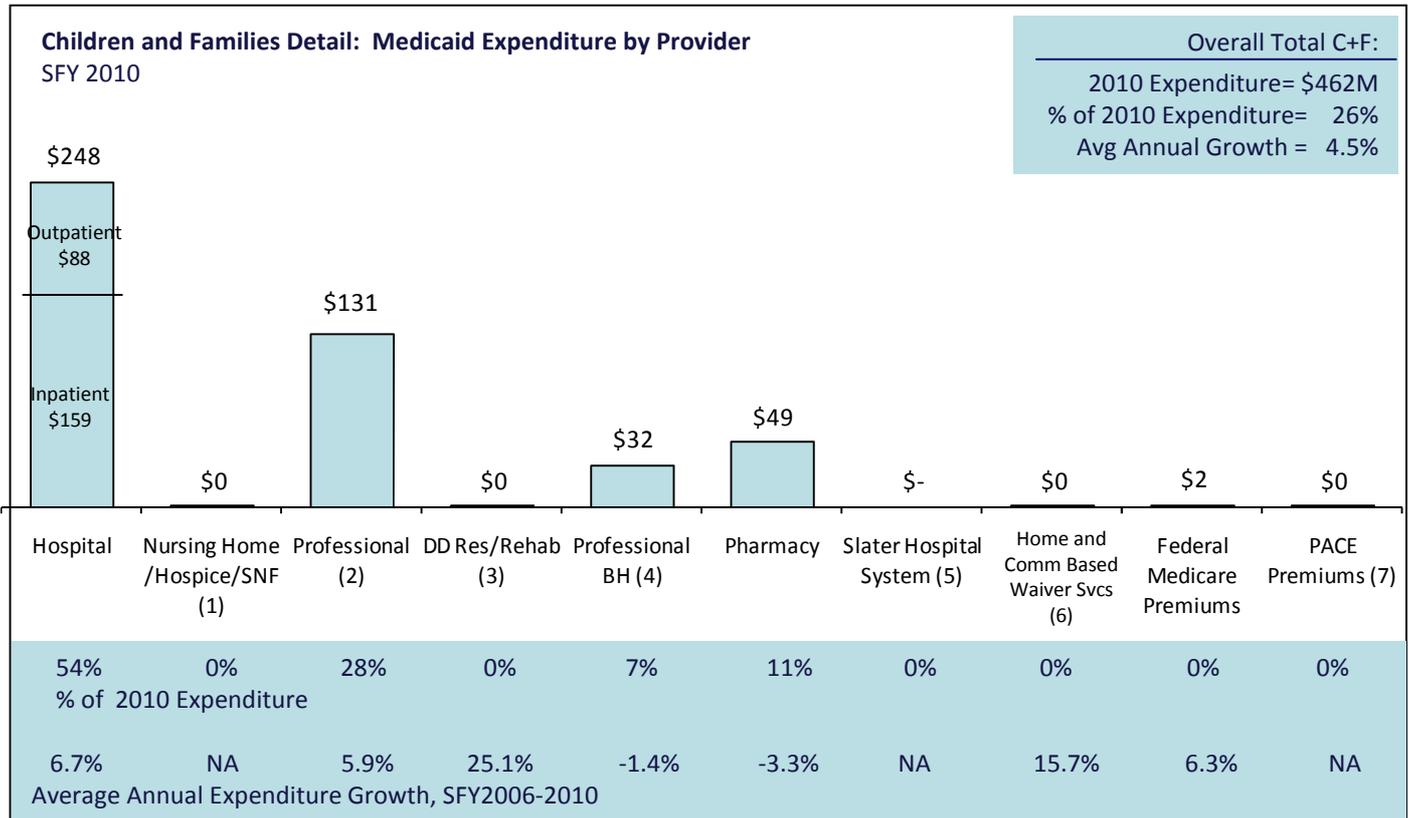
For adults with disabilities, residential and rehabilitation services for the developmentally disabled along with hospital services, account for more than half of expenditures.



- ❖ Adult with disabilities account for the largest share of Medicaid expenditures, with total 2010 expenditure of \$690 Million. Expenditure for this population has increased by approximately 3.5% per year over the past 5 years.
- ❖ Residential and rehabilitation services for developmentally disabled adults is the largest category of expenditure, accounting for approximately 29% of total Medicaid expenditure on adults with disabilities.
- ❖ The largest rate of growth in Medicaid expenditure for the adults with disabilities population has been in professional services and in home and community based services.

6c. Children and Families

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



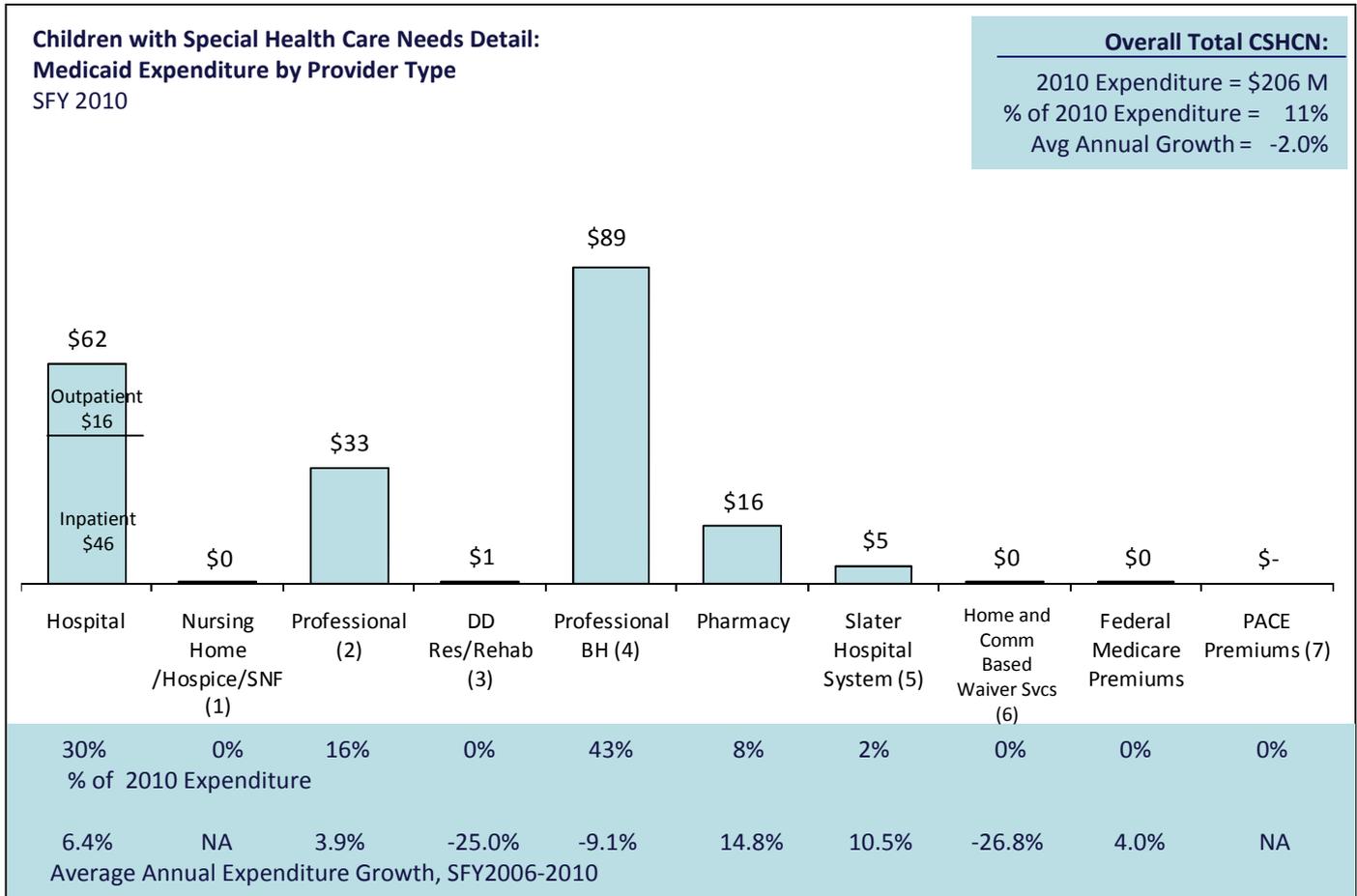
- ❖ Children and families account for one-fourth (25%) of total Medicaid expenditures, with 2010 expenditure of \$462 Million. Expenditure for this population has increased by 4.5% per year over the past 5 years.
- ❖ It is important to note that the federal match is enhanced for qualifying low income children and pregnant women under the CHIP program. CHIP is designed to build on Medicaid to provide insurance coverage to "targeted low-income children and pregnant women" who are uninsured and not eligible for Medicaid, typically from families with incomes up to 250 percent of the federal poverty level. In SFY 2010, Rhode Island received a 66.83% combined CHIP/FMAP federal match on 9,974 "optional" children and pregnant women who are in families with incomes above mandatory coverage levels.¹
- ❖ Most expenditure on children and families is divided between professional, hospital care and pharmacy, with hospital care accounting for over half (54%) of expenditure. Hospital care (inpatient and outpatient services) experienced the highest growth – with a 6.7% average annual increase.
- ❖ A major component of expenditures relate to prenatal care and births. Annually, approximately 40% of Rhode Island’s births are covered through RItE Care.

See footnotes on page 15 for Provider Type definitions.

¹ Source: Testimony of the Department of Human Services Relating to Medical Assistance, May 2010 Caseload Conference, April 30, 2010.

6d. Children with Special Health Care Needs

In the children with special health care needs population professional behavioral health accounts for nearly half (43%) of all expenditure.



- ❖ Children with Special Health Care Needs (CSHCN) is a relatively small population -- accounting for eleven percent of total Medicaid expenditures and seven percent of enrollees, with total 2010 expenditure of \$206 Million.
- ❖ Expenditure for this population is dominated by professional behavioral health services, which account for just under half (43%) of total expenditures.

Table of Contents

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

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

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

- 4. Mandatory and Optional**
 - a. Mandatory and Optional Overview
 - b. Optional Services Detail

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

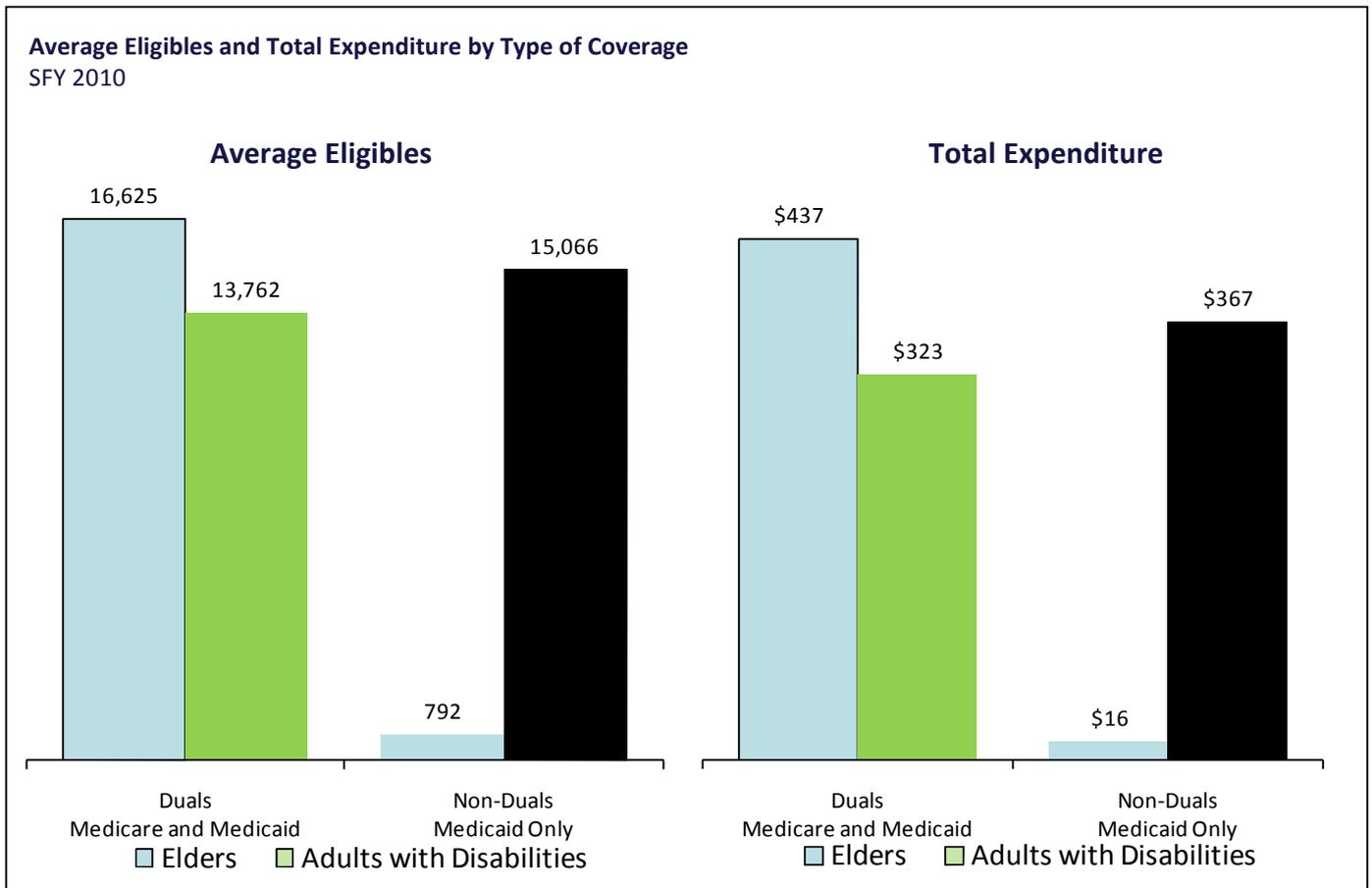
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families (C+F)
 - d. Children with Special Health Care Needs (CSHCN)

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

- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms

7a. Utilization by Population: Overview

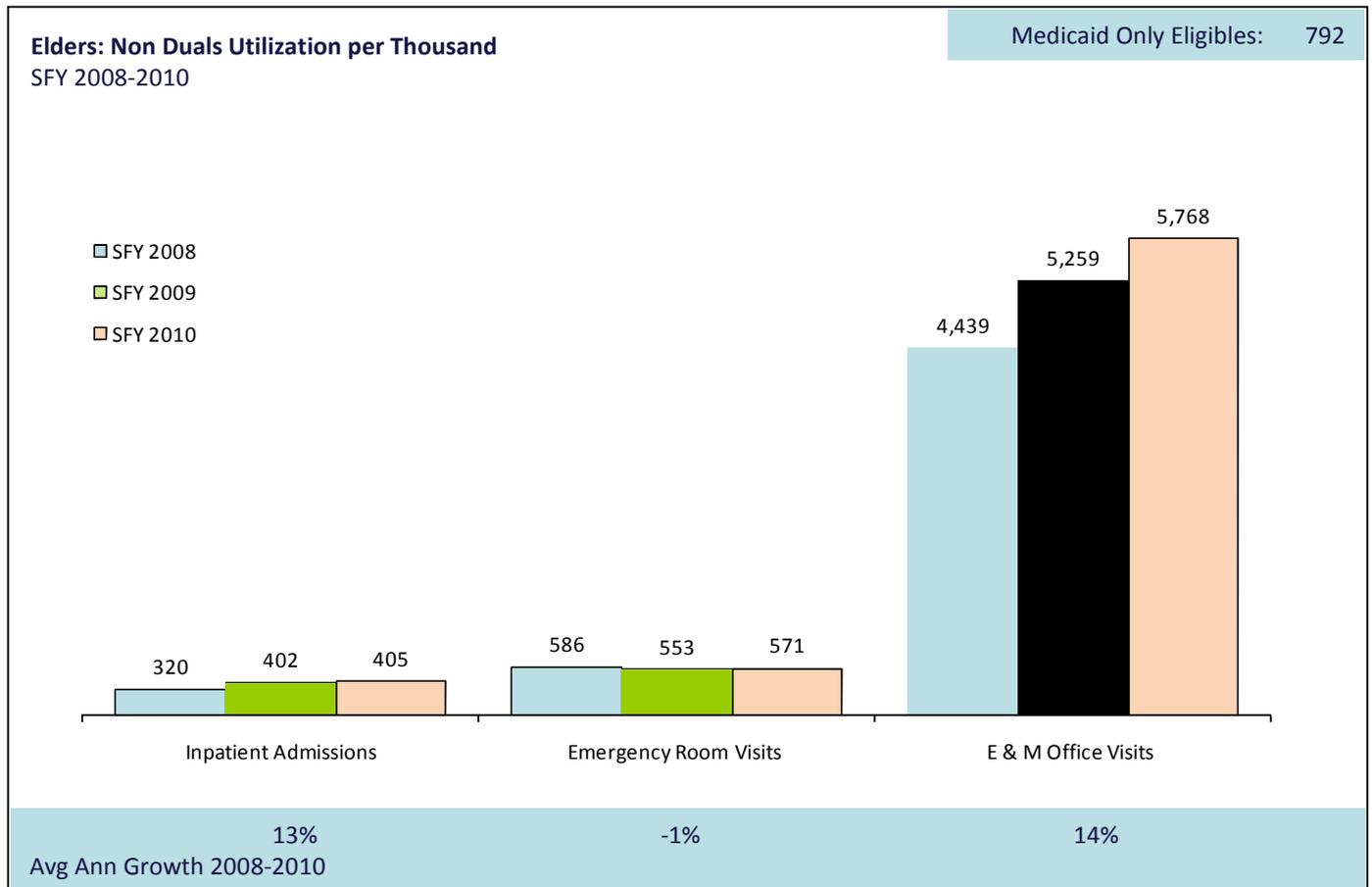
Individuals covered by both Medicare and Medicaid have dual coverage (“duals”). Medicare is the primary payer for the majority of services for 95% of elders and for 48% of adults with disabilities. Medicare is the primary payor for most medical services (e.g. hospital, physician, pharmacy). Medicaid pays for services not paid for by Medicare (e.g. extended nursing home stays, home and community supports). For “non-duals”, (persons covered only by Medicaid) Medicaid pays for all covered services.



- ❖ Ninety-five percent of elders and forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid (called dual eligibles).
- ❖ Similarly, 96% of expenditures for elders and 47% of expenditures for adults with disabilities are for dual eligibles covered by both Medicare and Medicaid.
- ❖ For these dual eligibles, Medicare is the primary payer for the majority of services. Medicaid only covers services not paid by Medicare.
- ❖ The majority of services covered by Medicaid for dual eligibles are long term care services.

7a. Utilization by Population: Elders

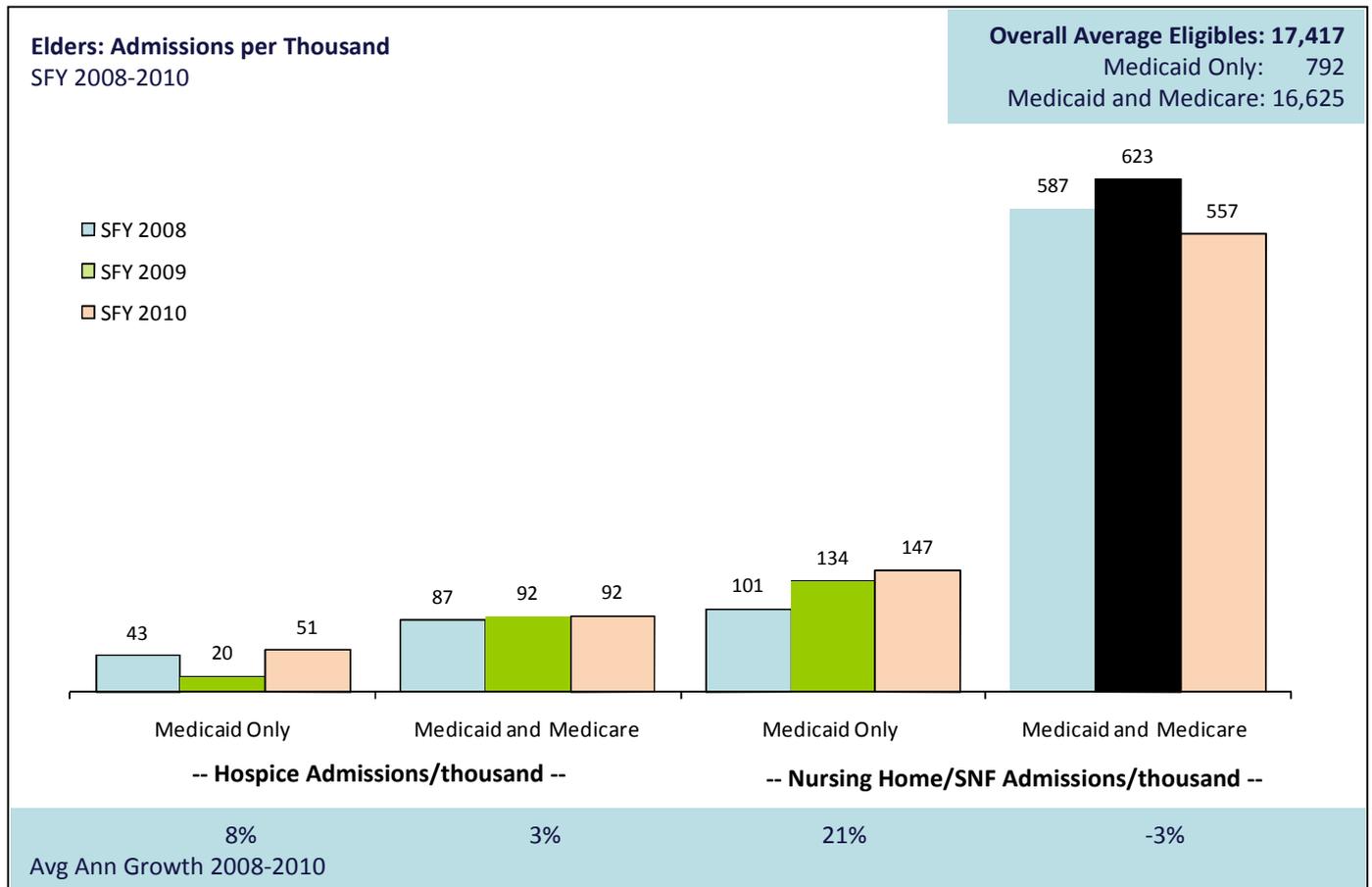
For persons eligible for Medicaid only (non-duals), Medicaid is the primary payor for medical services.



- ❖ Medicaid-covered emergency room visits per thousand is growing slightly (2% per year). However Medicaid-covered office visits per thousand have increased 27% on average per year for the last 3 years.
- ❖ For the ~800 elders covered only by Medicaid, each eligible averaged 5.7 office visits per year in SFY 2010, and that has increased from 4.4 office visits per year per eligible in SFY 2008, an average increase of 14% per year.
- ❖ Inpatient admissions increased over the period while emergency room visits have been consistent.

7a. Utilization by Population: Elders

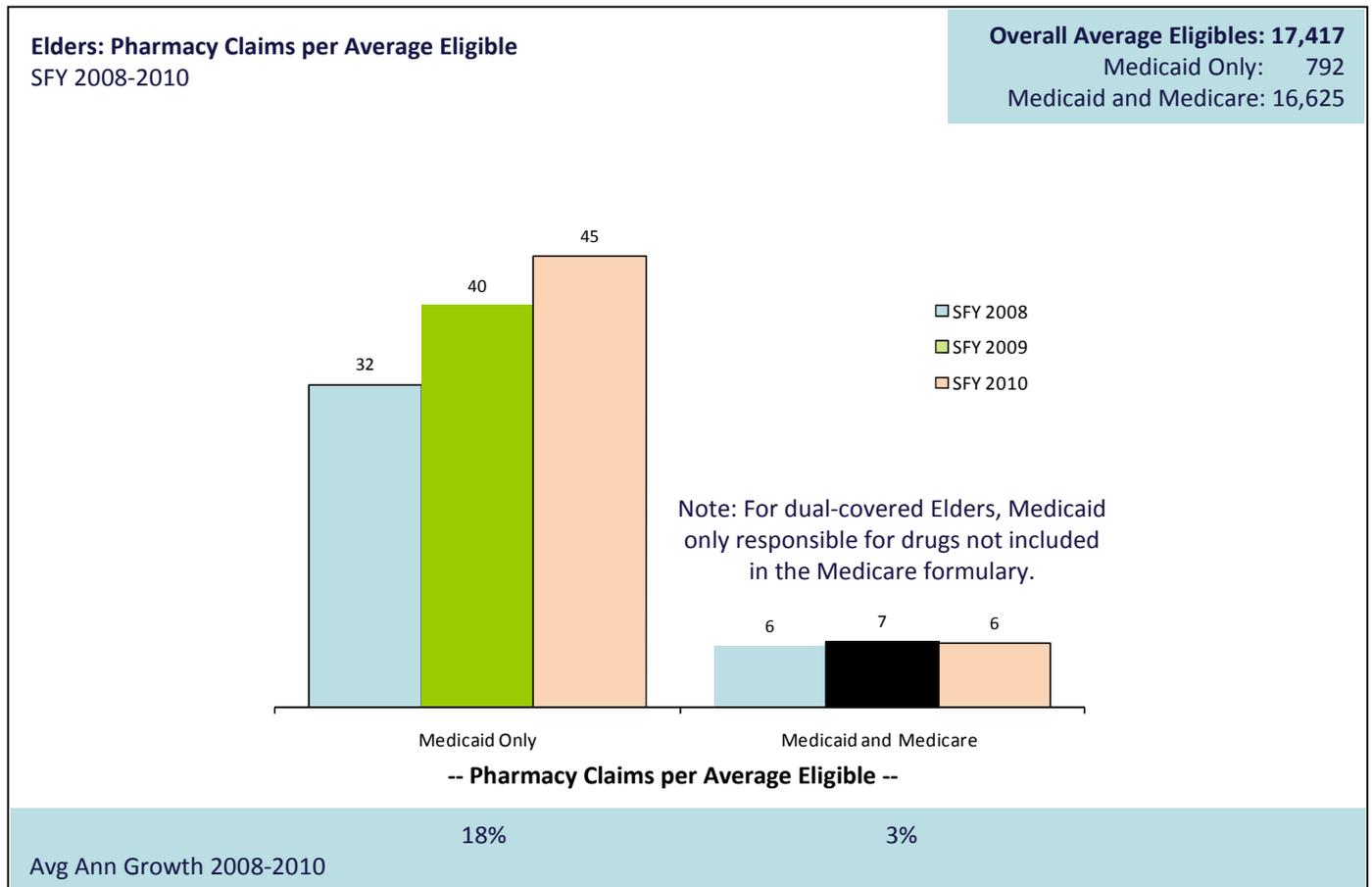
For duals, nursing home and hospice admissions per thousand combined increased by 6% in 2009 over 2008, but dropped between 2008 and 2010. For non-duals, the combined total increased each year.



- ❖ Ninety-five percent of elders are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services.
- ❖ For those covered by both Medicare and Medicaid, nursing home/skilled nursing facility admissions per thousand were 557 in 2010. This number has decreased from 587 in 2008.
- ❖ Admissions for elders covered only by Medicaid were 147 per thousand in 2010 and increasing at 21% per year.

7a. Utilization by Population: Elders

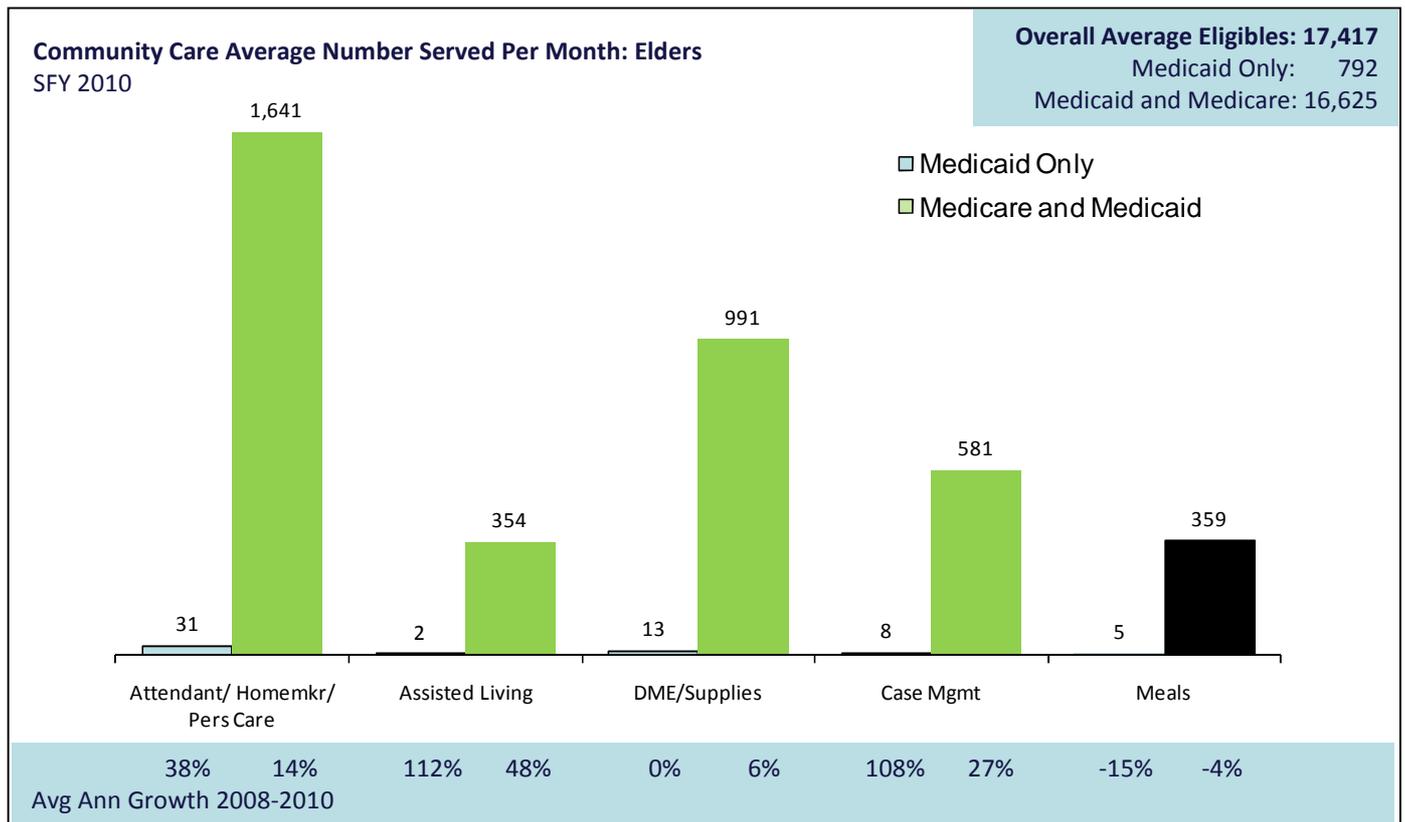
Medicare Part D covers the majority of pharmacy claims for eligibles covered by both Medicare and Medicaid.



- ❖ Ninety-five percent of elders are covered by both Medicare and Medicaid. Medicare Part D covers most of the pharmacy claims for this population. Medicaid is only responsible for drugs not included in the Medicare formulary.
- ❖ For dual-covered elders, Medicaid was responsible for an average of 6 pharmacy claims per eligible in 2010, an increase of 3% per year over the last 3 years.
- ❖ For elders without Medicare coverage, Medicaid was responsible for 45 claims per eligible in 2010, up from 32 claims per eligible in 2008, an average increase of 18% per year.

7a. Utilization by Population: Elders

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

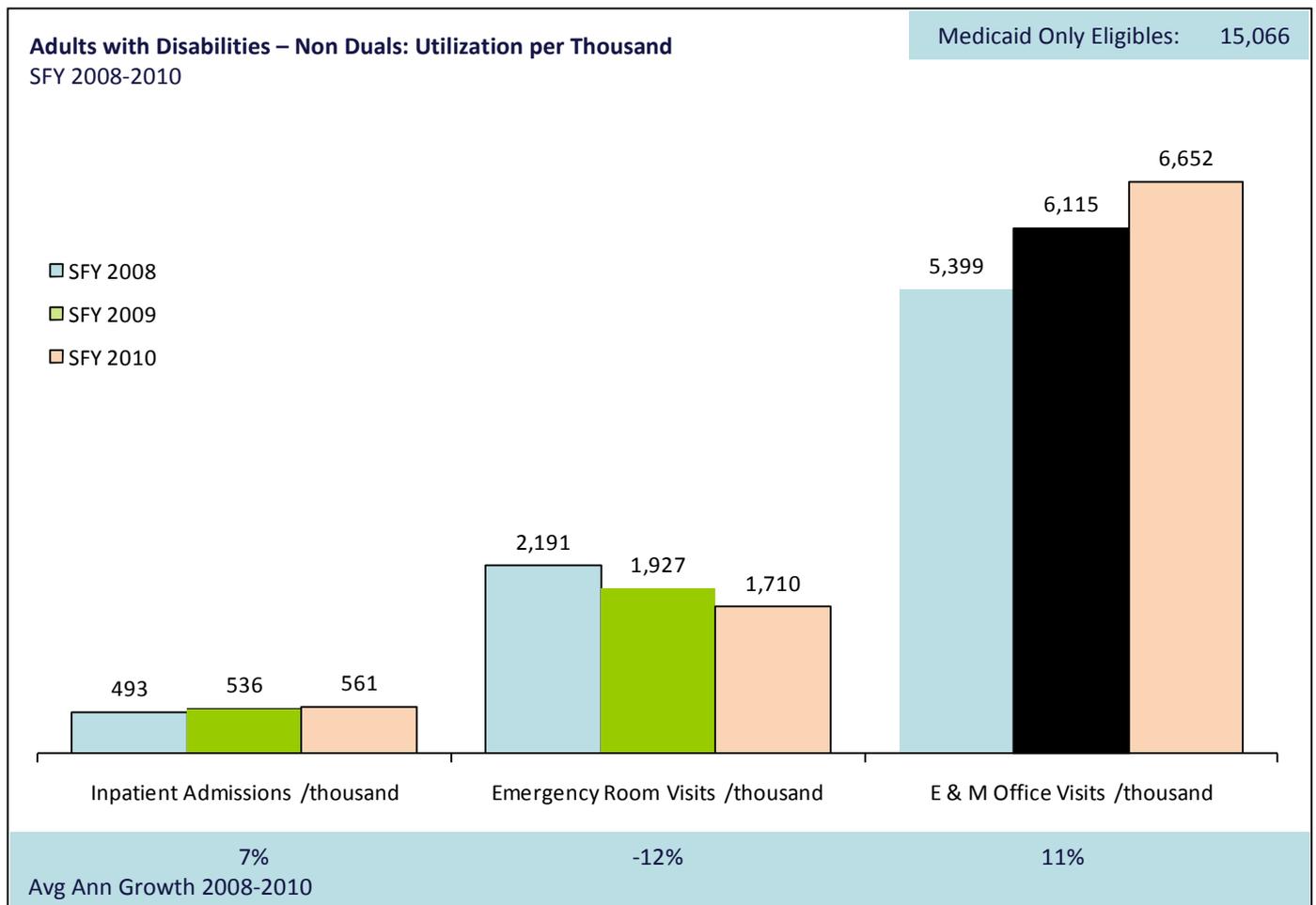


- ❖ The highest growth categories for community care are case management and assisted living.
- ❖ The largest category of the community care is for attendant/homemaker/personal care services, with an average of 1,641 recipients in 2010. The daily census for this category is growing at 14% per year for elders covered by both Medicaid and Medicare.

¹ Case management for elders grew from a daily census of 1 in 2008 and 2 in 2009 to 127 in 2010, thus resulting in an extremely high average annual growth rate.

7b. Utilization by Population: Adults with Disabilities

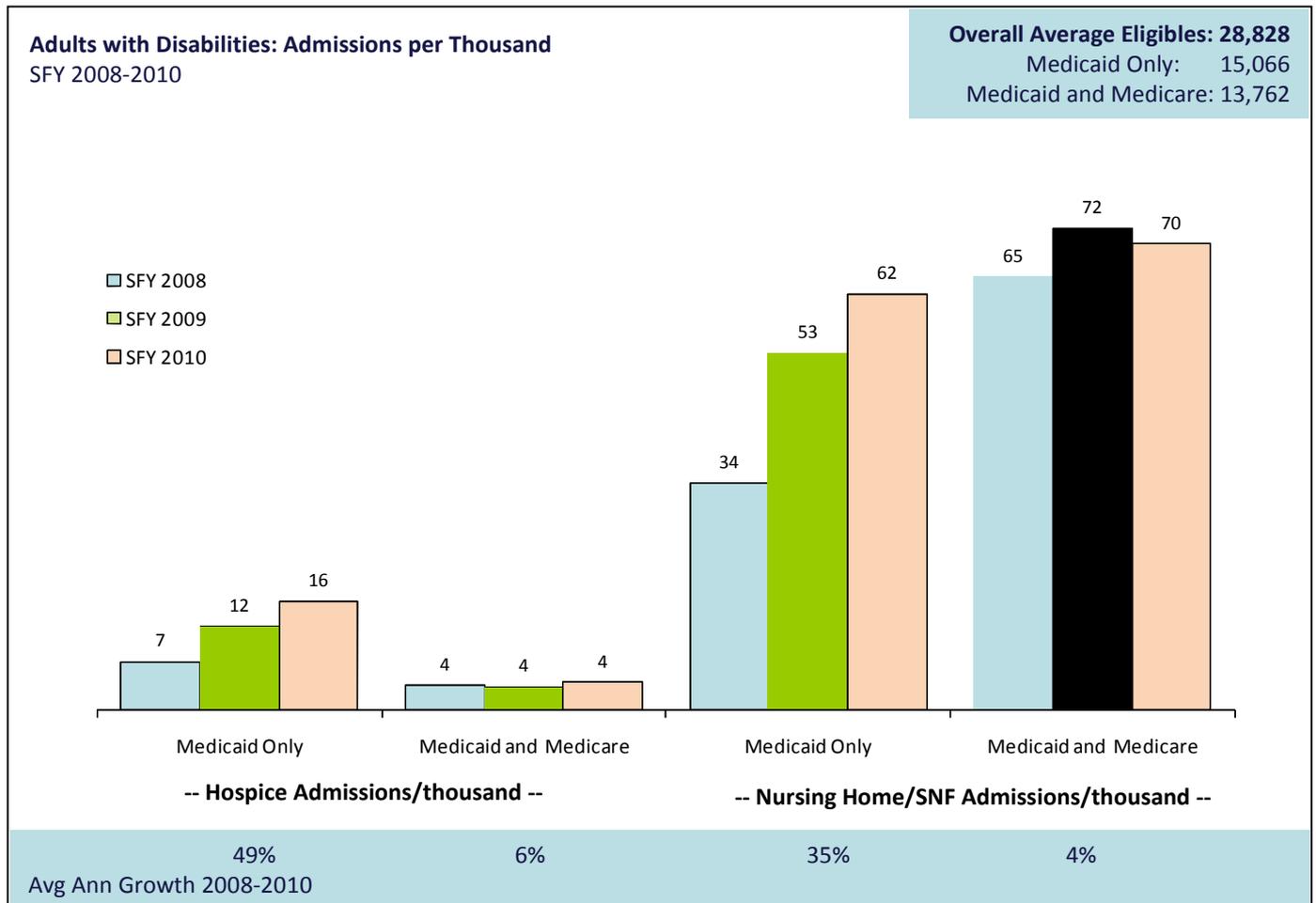
Emergency room visits per thousand have decreased 12% per year since 2008 for adults with disabilities with Medicaid-only coverage (non-duals).



- ❖ Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services. Utilization shown is for non-duals.
- ❖ Emergency room visits per thousand have decreased 12% per year since 2008 for adults with disabilities covered by Medicaid.
- ❖ For those covered only by Medicaid, each eligible averaged 6.7 office visits per year in 2010, up from 5.4 office visits per year per eligible in 2008.

7b. Utilization by Population: Adults with Disabilities

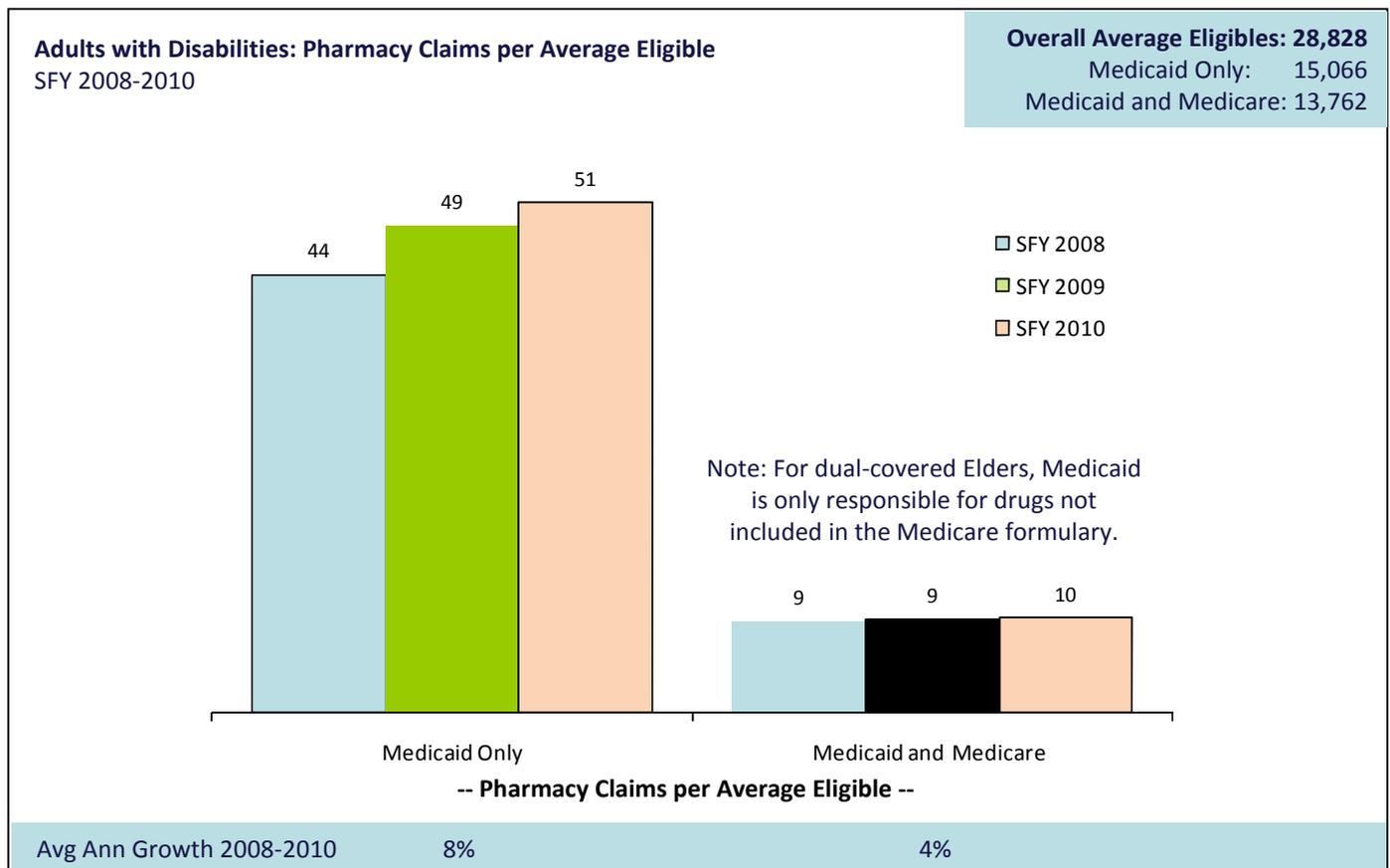
Nursing home and hospice admissions per thousand have increased significantly for adults with disabilities with only Medicaid coverage.



- ❖ Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services. Long term care services are primarily covered through Medicaid.
- ❖ For the adults with disabilities covered only by Medicaid, hospice admissions increased 49% per year and nursing home/skilled nursing facility admissions per thousand increased 35% per year since 2008.
- ❖ Nursing home/skilled nursing facility admissions per thousand for those covered by both Medicare and Medicaid were 70 per thousand for 2010, up from 65 in 2008, an increase of 4% per year.

7b. Utilization by Population: Adults with Disabilities

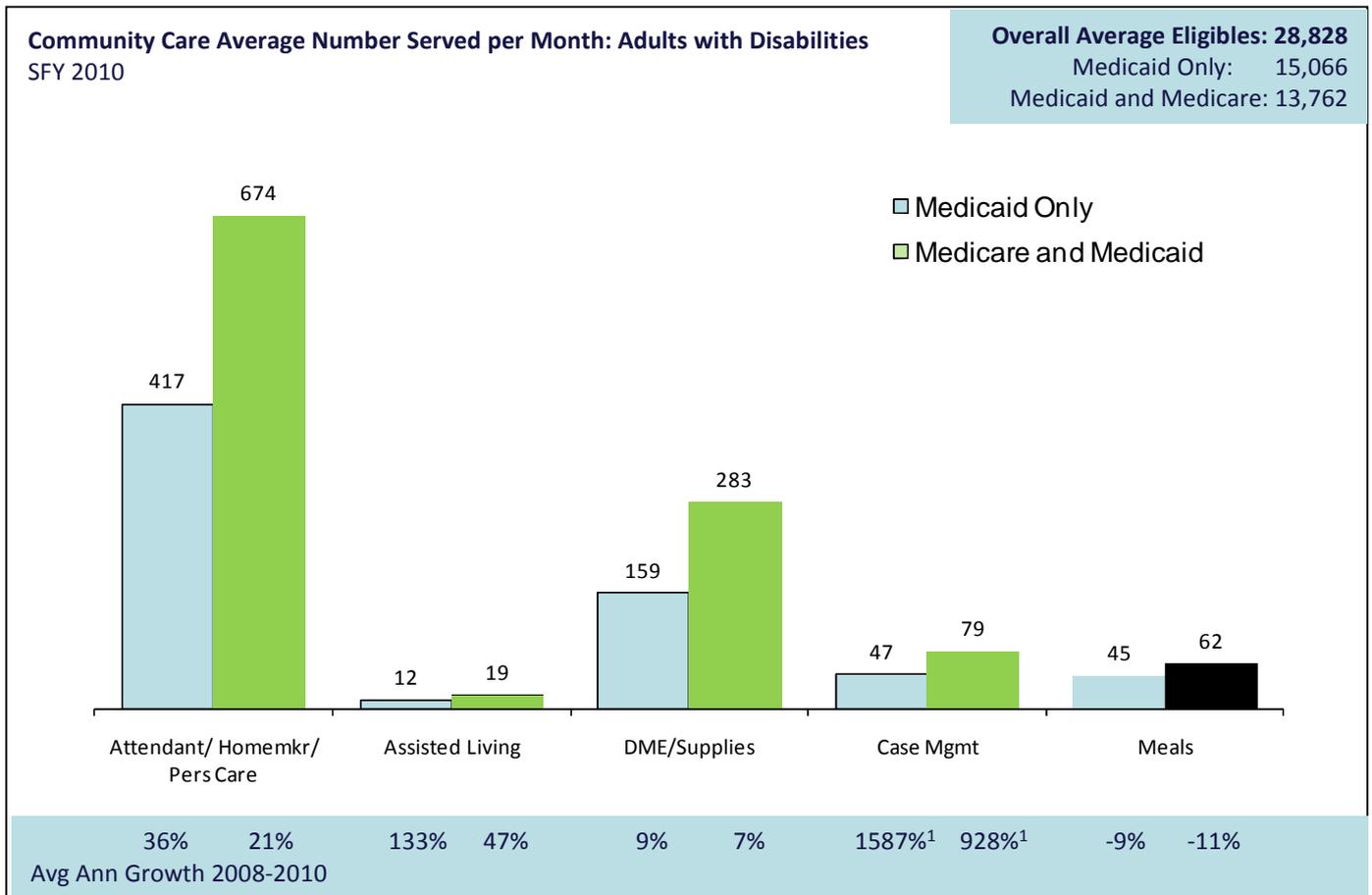
Adults with disabilities averaged 51 pharmacy claims per year in 2010.



- ❖ Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid. Medicare Part D covers most of the pharmacy claims for this population. Medicaid is only responsible for drugs not included in the Medicare formulary.
- ❖ For dual-covered adults with disabilities, Medicaid was responsible for an average of 10 pharmacy claims per eligible in 2010, an increase of 4% per year over the last 3 years.
- ❖ For adults with disabilities without Medicare coverage, Medicaid was responsible for 51 claims per eligible in 2010, up from 44 claims per eligible in 2008, an average increase of 8% per year.

7b. Utilization by Population: Adults with Disabilities

As for elders for adults with disabilities, the largest category of community based care is attendant, homemaker, and personal care services.

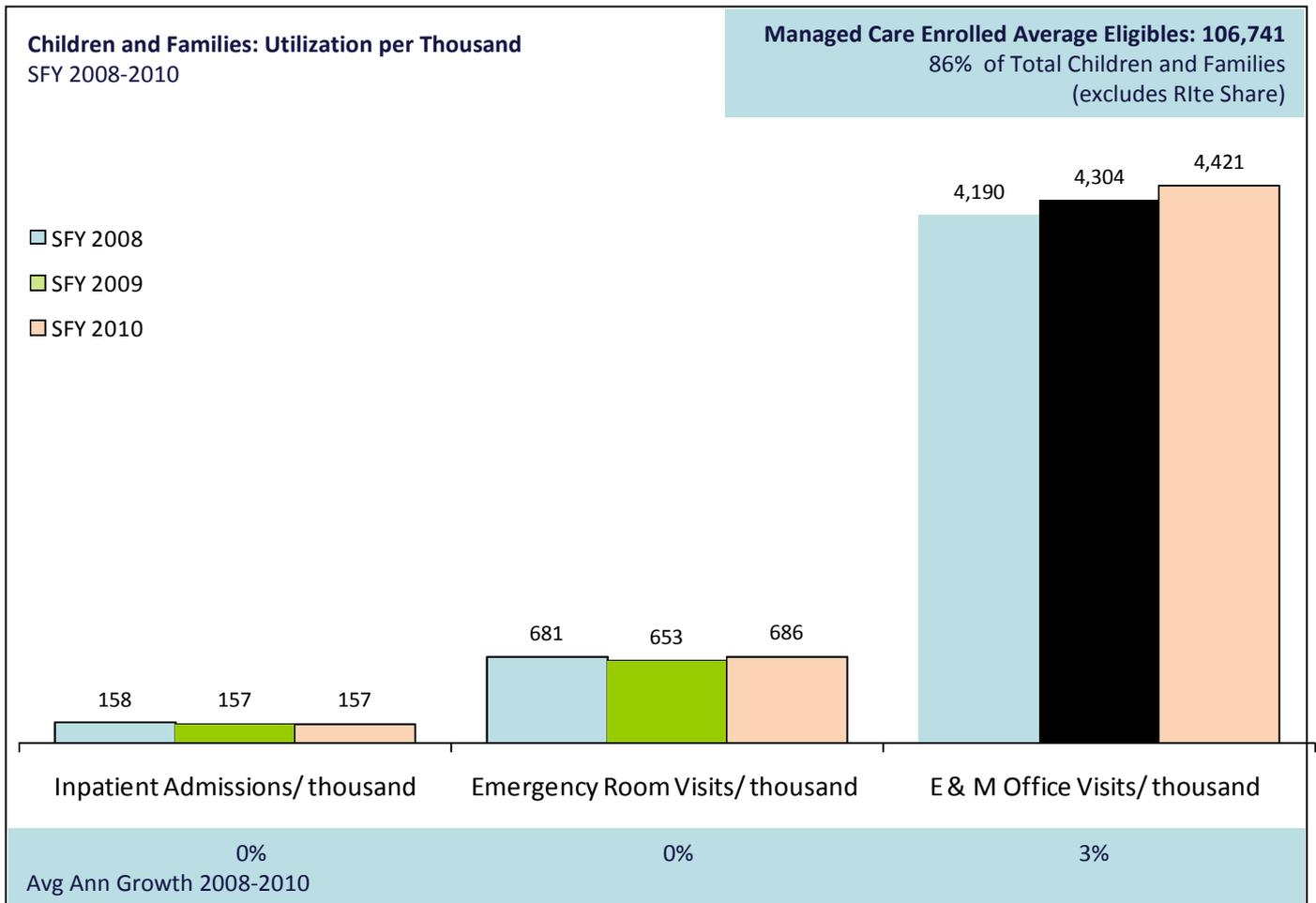


- ❖ Forty-eight percent of adults with disabilities are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services.
- ❖ The highest growth categories for community care are case management and assisted living, however the case management numbers are growing from a near 0 base in 2008.
- ❖ The largest category of community care is attendant/homemaker/personal care services, with an average of 674 recipients in 2010. The daily census for this category is growing at 21% per year for adults with disabilities covered by both Medicaid and Medicare.

¹ Growth rates are high due to a near 0 average daily census in 2008 and 2009.

7c. Utilization by Population: Children and Families

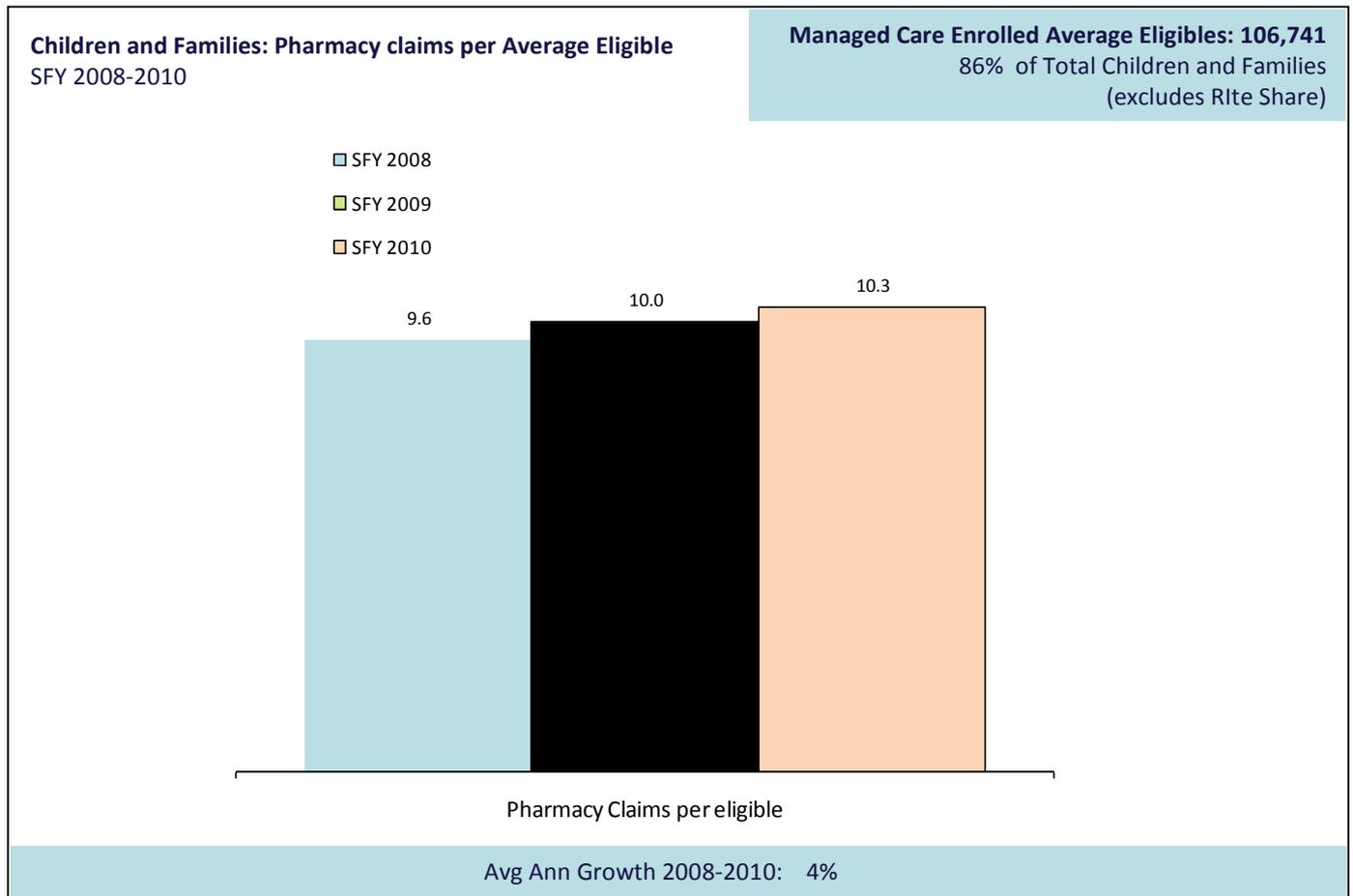
For children and families in managed care, inpatient admissions per thousand and emergency room visits per thousand have not increased in the last 3 years.



- ❖ Eighty-six percent of children and families are enrolled in managed care through Medicaid managed care organizations (MCOs). Another 8% are covered by Employer Sponsored Insurance (ESI) through the RIte Share program. RIte Share is not included in the data above.
- ❖ Over 60% of inpatient admissions per thousand are maternity related (including maternity, nursery and NICU). Annually, approximately 40% of all RI births are covered through RIte Care.
- ❖ Office visits per thousand have increased slightly from 4.2 visits per eligible per year to 4.4 visits per eligible per year.

7c. Utilization by Population: Children and Families

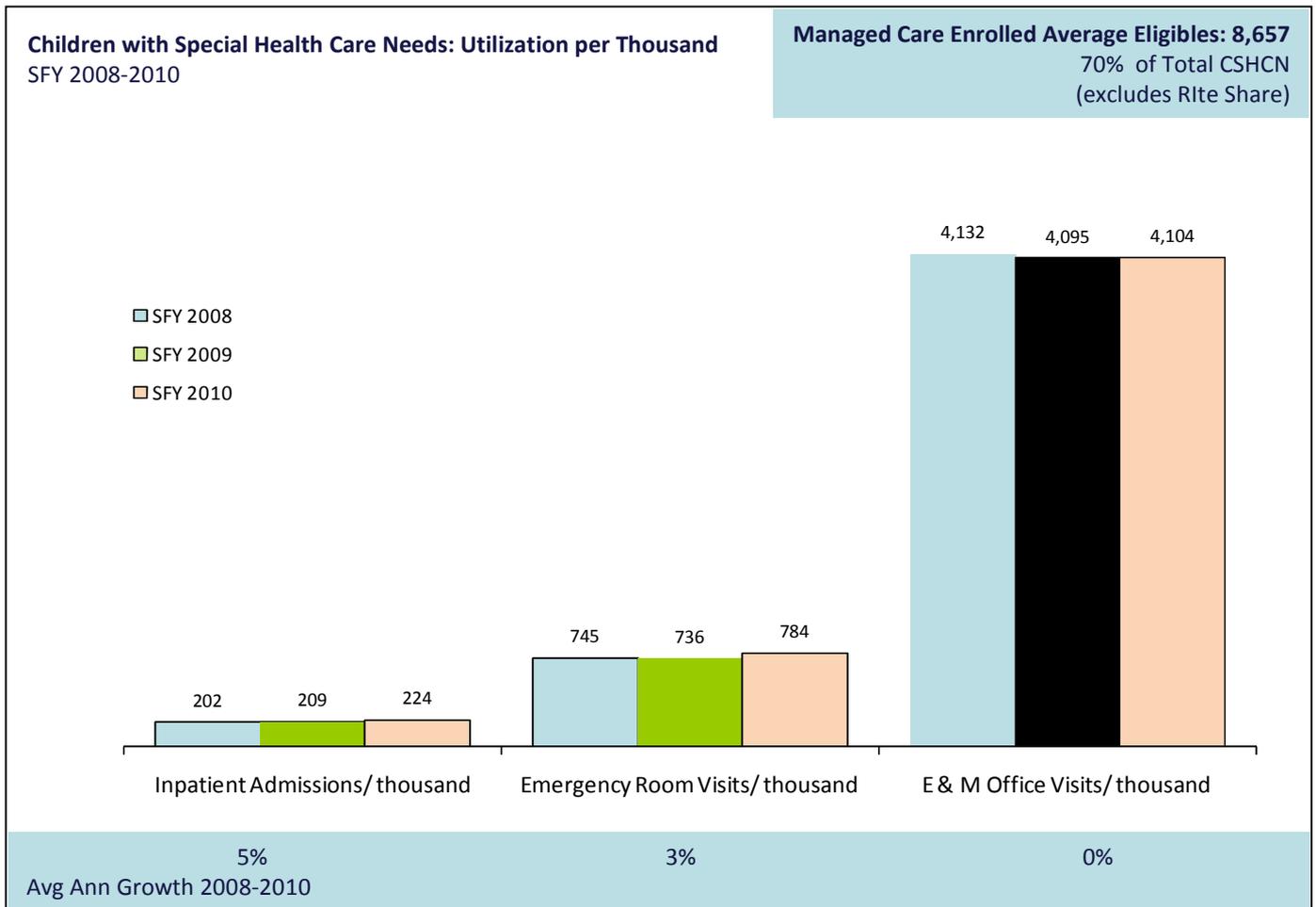
Pharmacy claims per eligible for children and families in managed care have increased at 4% per year over the last 3 years.



- ❖ Eighty-six percent of children and families are enrolled in managed care through Medicaid MCOs. Another 8% are covered by ESI under the RIte Share program.
- ❖ Pharmacy claims per eligible have increased from 9.6 per year in 2008 to 10.3 per year in 2010.

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

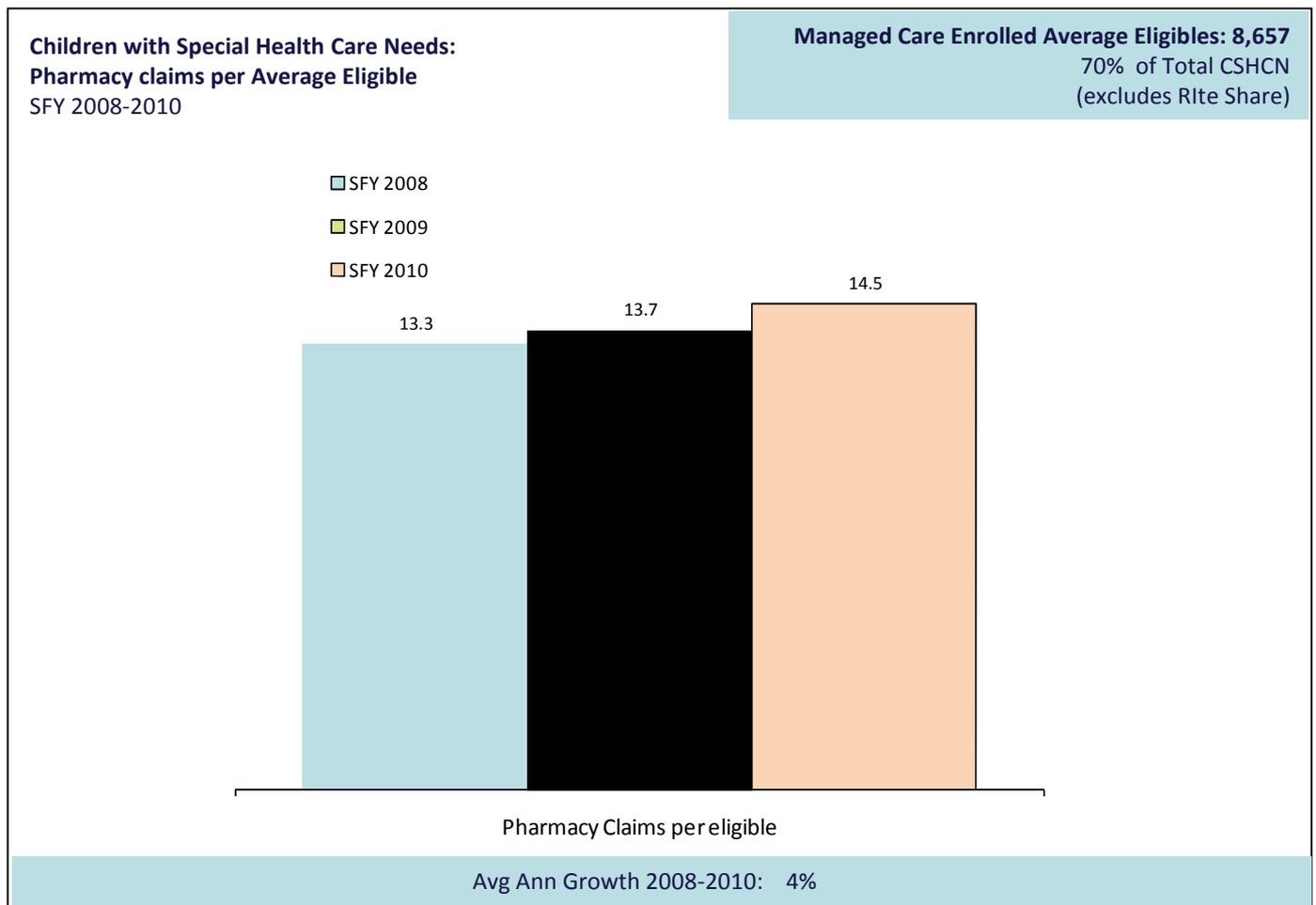
For children with special health care needs in managed care, inpatient admissions per thousand and emergency room visits per thousand have increased slightly in the last 3 years.



- ❖ Seventy percent of children with special health care needs are enrolled in managed care through Medicaid MCOs.
- ❖ Over half (53%) of inpatient admissions per thousand are for behavioral health.
- ❖ Office visits per thousand have stayed relatively flat over the last three years, decreasing from 4.13 visits per eligible per year to 4.10 visits per eligible per year.

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

Pharmacy claims per eligible for children with special health care needs in managed care have increased at 4% per year over the last 3 years.



- ❖ Seventy percent of children with special health care needs are enrolled in managed care through Medicaid MCOs.
- ❖ Pharmacy claims per eligible have increased from 13.3 per year in 2008 to 14.5 per year in 2010.

Table of Contents

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

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

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

- 4. Mandatory and Optional**
 - a. Mandatory and Optional Overview
 - b. Optional Services Detail

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

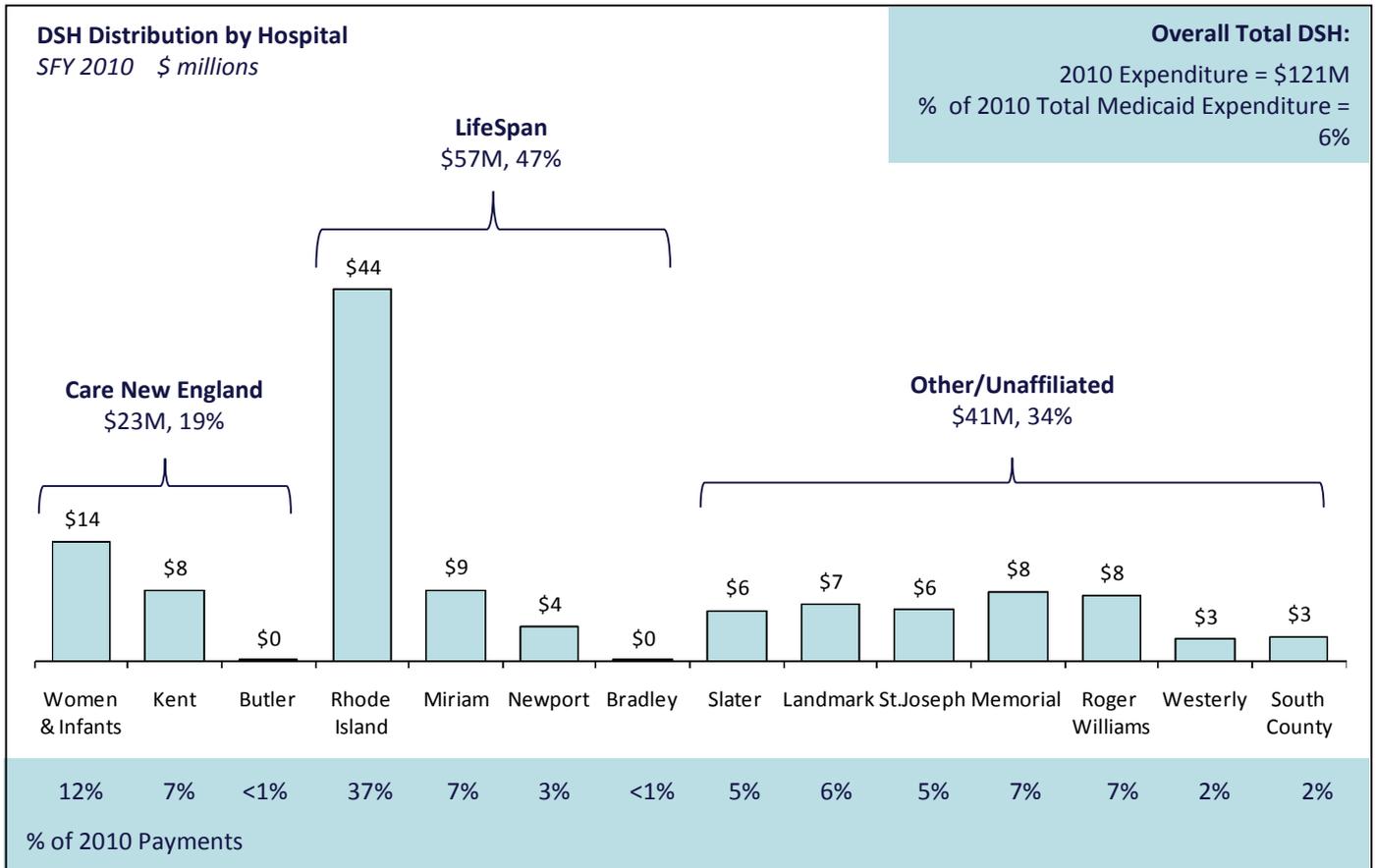
- 6. Expenditure Detail by Population and Provider Type**
 - a. Elders
 - b. Adults with Disabilities
 - c. Children and Families (C+F)
 - d. Children with Special Health Care Needs (CSHCN)

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

- 8. Appendices**
 - a. Details on Expenditure Exclusions
 - b. Acronyms

Appendix A: Exclusions (1) Disproportionate Share Hospitals (DSH)

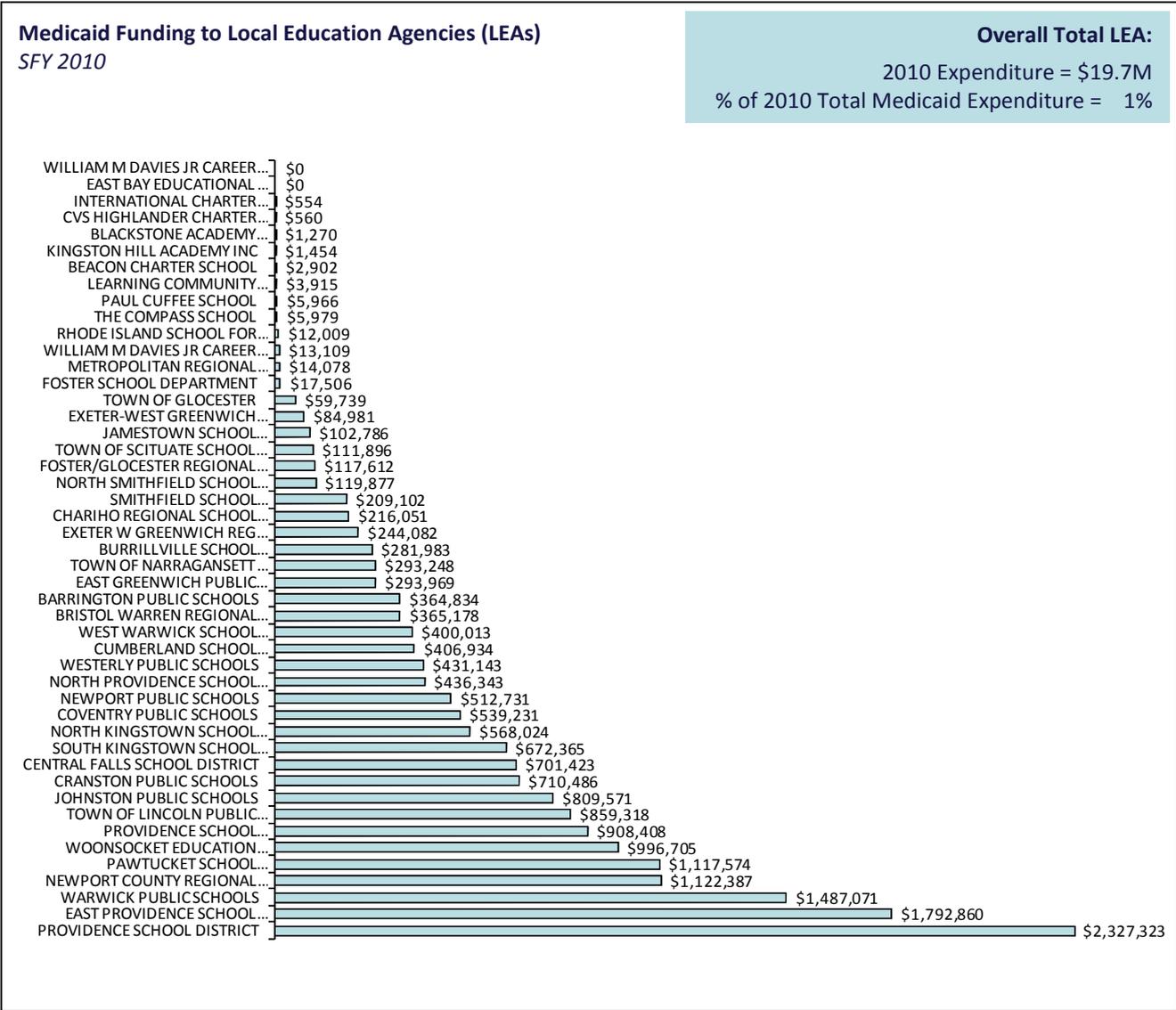
Disproportionate share (DSH) Medicaid payments are intended to subsidize the cost of providing care to indigent and very low income people



- ❖ A total of \$121 million in DSH funds was paid out to hospitals in 2010.
- ❖ The state’s two largest hospitals – Rhode Island and Women and Infants – together accounted for 49% of total DSH payments
- ❖ DSH payments are not included in the Medicaid expenditure analysis in this report.

Appendix A: Exclusions: (2) Local Education Agencies

Local Education Agencies (LEAs) account for \$19.7 million in total Medicaid expenditures. 45 school districts participate.



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

Appendix B: Acronyms and Abbreviations

A&D:	Aged & disabled
BHDDH:	Behavioral Health, Developmental Disability, and Hospitals
C+F:	Children and families
CSHCN:	Children with special health care needs
DCYF:	Department of Children, Youth and Families
DD:	Developmentally Disabled
DEA:	Department of Elderly Affairs
DSH:	Disproportionate Share Hospitals
DHS:	Department of Human Services
EOHHS:	Executive Office of Health and Human Services
FFY:	Federal fiscal year
FMAP:	Federal Medicaid Assistance Percentage
HCBS:	Home and community-based services
ICF:	Intermediate care facility
LEA:	Local education agencies
LTC:	Long term care
PMPM:	Per member per month
SNF:	Skilled nursing facilities
SFY:	State fiscal year