
Rhode Island Annual Medicaid Expenditure Report – SFY 2014

Executive Office of Health and Human Services

June 2015

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Executive Summary: Purpose

Purposes of the Expenditure Report

The purposes of this report include the following:

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

Additional Notes

Definition of average annual rates methodology: This report shows trends in terms of an average annual trend rate based on five years of historical data in order to present longer term trends rather than year to year variation. An average annual increase of 1.0% per year from 2010 to 2014 is equivalent to an increase of 4.1% in total from 2010 to 2014.

Variance to Other Reports: The primary basis for identifying expenditures in this report is the actual date of service rather than paid date. Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for variance might include factors such as claim completion and rounding.

Executive Summary: Overview

Overview

During SFY 2014 Rhode Island's Medicaid program served approximately 240,000 Rhode Islanders, with an average of 201,000 enrolled at any one time. In addition, Medicaid eligibility was expanded on January 1, 2014, to adults without dependent children with incomes less than 138% of the federal poverty level. About 50,000 enrolled between January 1, 2014 and the end of the fiscal year.

Program expenditures overall for SFY 2014 totaled just over \$2 billion. Medicaid expenditures are divided among several state agencies, with \$1,587 million of expenditure managed in SFY 2014 by the Executive Office of Health and Human Services (EOHHS), and \$384 million managed by the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH).

Under the Medicaid program, the federal government is typically responsible for approximately half of total expenditure. In SFY 2014 the Federal Medical Assistance Percentage (FMAP) was 50.40% for the bulk of Medicaid expenditure. The FMAP is 100% for the Expansion population through the end of calendar year 2016.

Key Findings:

- ❖ Between SFY 2010 and 2014, total Rhode Island Medicaid medical expenditures based on date of service have increased an average of 1.1 percent per year. This trend rate excludes growth from the Expansion population.
- ❖ Enrollment has increased 2.3% per year on average over the last five years, excluding growth from the Expansion population. When including Expansion enrollment, enrollment increased 12.9% from SFY 2013 to SFY 2014.
- ❖ Per member per month (PMPM) costs have decreased 1.2% per year, from \$814 in SFY 2010 to \$775 in SFY 2014, or \$756 in SFY 2014 when including Expansion.
- ❖ These expenditure trends compare quite favorably to both national Medicaid total expenditures and state commercial per member per month cost trends.
- ❖ Adults with disabilities account for 34.6% of expenditure. Elders account for another 25.1%.
- ❖ Hospitals and nursing facilities account for nearly half (46%) of Medicaid expenditure.
- ❖ Eighty percent of Medicaid recipients are enrolled in managed care programs. Both of Rhode Island's Medicaid managed care organizations ranked in the top 10 Medicaid plans nationwide.
- ❖ A new managed care program called Rhody Health Options (RHO) was implemented during SFY 2014 in conjunction with the Integrated Care Initiative to better serve adults enrolled in both Medicaid and Medicare. RHO is a fully capitated model for long term care, long term services and supports, and other Medicaid-funded services.
- ❖ Claims expenditures are highly concentrated – the 6% of users with the highest costs account for 65% of claims expenditure

Executive Summary: Populations

Populations Served

Medicaid serves five different primary populations, each with very different service needs and PMPM cost experience.

- ❖ **Elders** includes adults over age 65, 96% of whom are also covered by Medicare. For those covered by both Medicaid and Medicare, Medicare is the primary payer for most acute and primary care services while Medicaid pays for services not paid for by Medicare (e.g., extended nursing home stays, home and community supports). Elders account for \$503 million in total SFY 2014 Medicaid expenditure, and have the highest average cost per member per month (PMPM) of \$2,270. Nursing facilities account for nearly two-thirds (66%) of expenditures for this population.
- ❖ **Adults with disabilities** includes adults under age 65 who have identified disabilities. Almost half (46%) of this population is also covered by Medicare. Adults with disabilities account for the largest share of expenditure, with SFY 2014 expenditure of \$693 million, and an average PMPM cost of \$1,838. The largest components of expenditure for this population are residential and rehabilitation services for persons with developmental disabilities (27%) and hospital care (23%). However, both expenditure on hospital care and the utilization measure of hospital inpatient days per thousand for this population have decreased over the last five years.
- ❖ **Children and families** includes low income children, parents and pregnant women who meet specific income requirements. Children and families account for 62.9% of total enrollment and 24.8% of total expenditure, with total SFY 2014 expenditure of \$497 million and an average PMPM of under \$300. Additionally, the federal match is increased to 65.28% for qualifying low income children and pregnant women under the Children's Health Insurance Program (CHIP). Most expenditure on this population is for hospital care (49%) and professional services (33%). Nearly all of this population is enrolled in managed care.
- ❖ **Children with special health care needs (CSHCN)** includes individuals under 21 who are eligible for SSI (Supplemental Security Income), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. These children account for 8.7% of total Medicaid expenditures and 5.4% of enrollees, with SFY 2014 expenditures of \$175 million. Expenditures on this population are dominated by professional behavioral health services, which account for just under half (41%) of total expenditures.
- ❖ **Expansion** includes low income adults without dependent children newly eligible under the ACA. Enrollment for this population began January 1, 2014, halfway through SFY 2014, and by the end of SFY 2014 there were nearly 50,000 Rhode Islanders enrolled. The Expansion population accounted for 6.8% of total SFY 2014 expenditure, or \$137 million (100% federally funded). This population mainly used hospital and professional services, accounting for 84% of expenditures on the Expansion population.

Executive Summary: Providers and LTSS

Medicaid Providers

Medicaid pays for services offered by a variety of providers. Hospitals and nursing facilities together account for nearly half of program expenditure. Key contributors to expenditure growth were nursing facilities and professional providers.

- ❖ Hospitals were the largest provider type, accounting for 27% of Medicaid expenditure in SFY 2014. Hospital payments had been a key driver of Medicaid expenditure growth, however total Medicaid payments to hospitals have decreased by an average of 1.0% per year since SFY 2010.
- ❖ Nursing facilities (including both nursing homes and hospice) were the next largest provider type, accounting for 19% of expenditure in SFY 2014. Total Medicaid payments to nursing facilities has been increasing on average 3.1% per year between SFY 2010-2014. Over the same period, nursing home days per thousand for the Elders population have decreased by 2.0% per year.
- ❖ The provider types with the highest average annual growth trends were professional services and home and community based services.
- ❖ Overall, acute, chronic and preventive services account for 60% of Medicaid expenditure and the remaining 40% are for long term services and supports.

Long Term Services and Supports

Long term services and supports (LTSS) include institutional care, home and community based services (HCBS), and residential and rehabilitation services for the developmentally disabled. Expenditures on LTSS account for \$796 million in total Medicaid expenditure in SFY 2014.

- ❖ HCBS and residential and rehabilitation services for the developmentally disabled are services provided to at-risk populations as alternatives to more costly nursing home/institutional options and account for \$314 million, 40% of the LTSS expenditure.
- ❖ Institutional care services account for the remaining \$482 million of LTSS expenditure. The largest category is nursing home services, accounting for 72% of institutional care expenditure and 44% of LTSS expenditure overall. Other institutional care expenditure is for hospice and Slater Hospital, Tavares and Zamabarano.
- ❖ The total expenditure for HCBS and nursing facilities is \$473 million in SFY 2014 (nursing facilities includes both nursing home and hospice care). The HCBS portion of that expenditure is 20.3%. This reflects the relative balance of expenditure between home and community based services and nursing facilities.
- ❖ For the elders population, expenditure on HCBS has been growing at 9.5% per year on average over the last 5 years. Nursing home expenditure has been growing at 2.3% per year on average. In addition, the total nursing home days used by Medicaid elders has decreased 0.5% on average per year over the last 5 years. Over the same period, nursing home cost per day for elders has increased from \$153 to \$171.

Executive Summary: Managed Care and High Utilizers

Managed Care

It is important to note that not all payments are made directly by Medicaid to service providers. In SFY 2014, 80% of Medicaid eligibles were enrolled in risk-based managed care plans. These enrolled populations accounted for 58% of Medicaid expenditure.

- ❖ Fifty-five percent of Medicaid eligibles were enrolled in RItE Care, which is a Medicaid managed care program for children and families. Another 6% were enrolled in Rhody Health Partners (RHP), a managed care program for adults with disabilities.
- ❖ Enrollment for RItE Care and RHP is divided between Neighborhood Health Plan and United Healthcare. Both of these Medicaid managed care organizations placed in the top 10 in a 2014 ranking of 273 Medicaid Health Plans nationwide by the National Committee for Quality Assurance.
- ❖ Rhody Health Options (RHO) is a new managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports, and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility. As of the end of SFY 2014 there were almost 17,000 eligibles enrolled in RHO.
- ❖ Five percent of Medicaid eligibles were enrolled in RItE Share, a premium assistance program for Medicaid eligibles with access to commercial insurance. This minimizes Medicaid expenditure by leveraging the employers' contributions.
- ❖ The newly eligible Expansion population is also enrolled in managed care.

High Utilizers

The six percent of Medicaid users with the highest costs, those with over \$25,000 in claims expenditure per year, account for nearly two-thirds (65%) of claims expenditures.

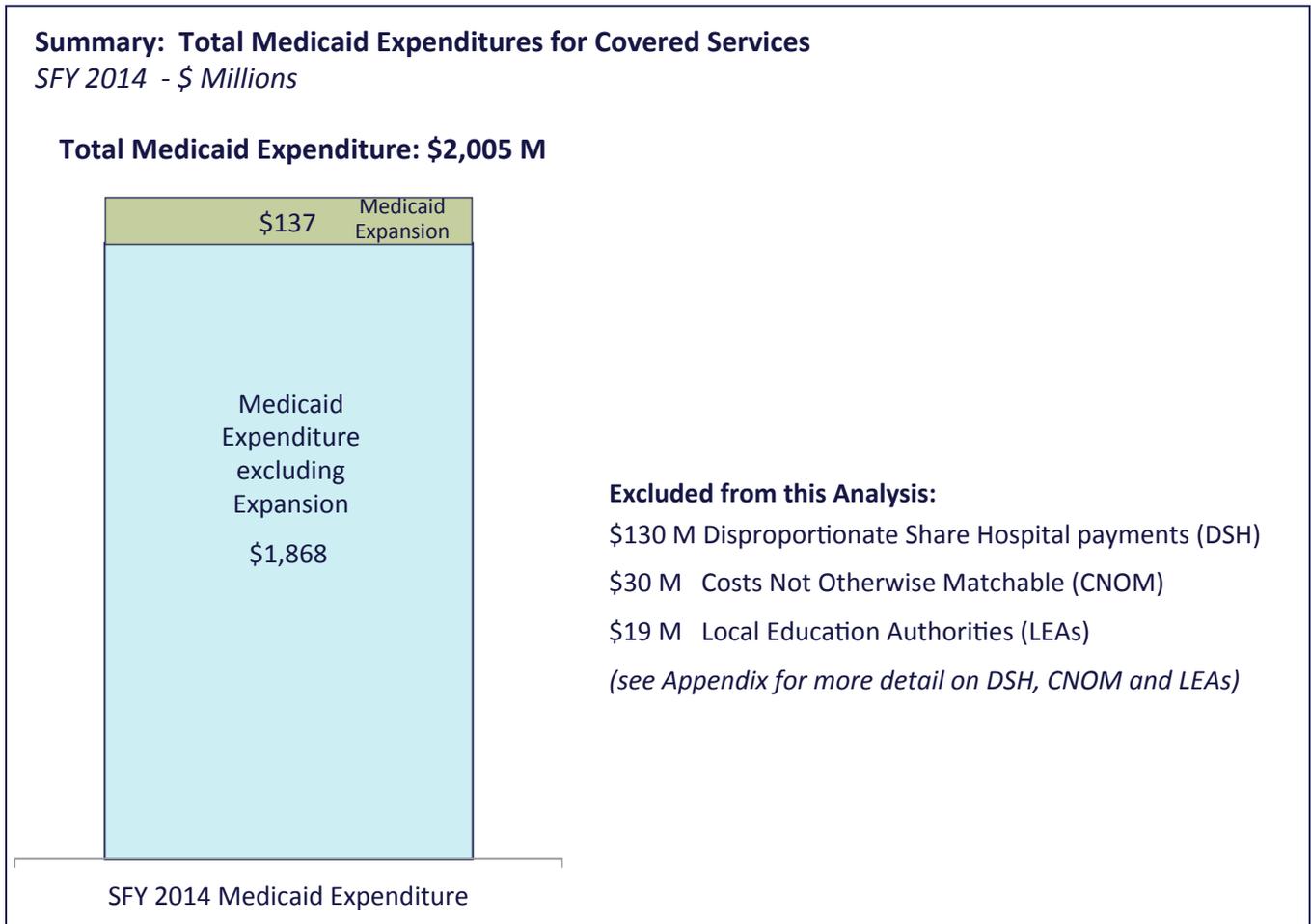
- ❖ High cost users are depicted in this report as those who incur \$15,000 or more per year in Medicaid claims expenditure. These high utilizers typically present with multiple, complex conditions, requiring care coordination across a variety of provider types. Eight percent of Medicaid users are high cost users and account for 73% of claims expenditure.
- ❖ Nearly half (45%) of claims expenditure for high cost users is for nursing facilities and residential and rehabilitation services for persons with developmental disabilities. Hospital services account for another 23% of high cost user claims expenditure.
- ❖ Elders and Adults with disabilities account for 77% of claims expenditure for high cost users. For the elders population, 93% of claims expenditure is attributable to high cost users.

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1a. Total Expenditures: Definitions and Exclusions

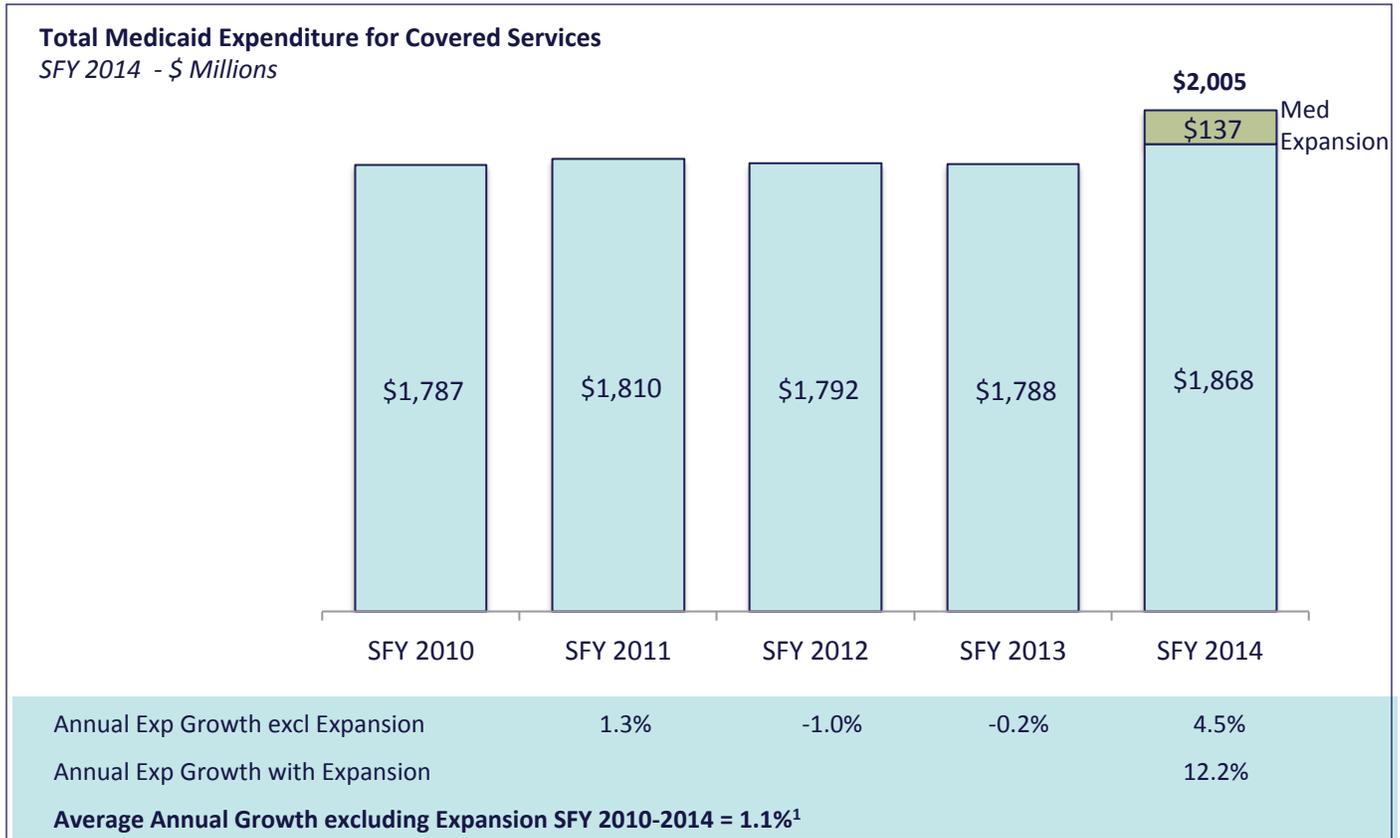
Medicaid expenditures in SFY 2014 totaled approximately \$2,005 million, including \$137 million for Medicaid Expansion.



- ❖ In state fiscal year 2014, Rhode Island incurred approximately \$2,005 million in Medicaid expenditures. This expenditure was split between state and federal funds. This report includes all Medicaid expenditures, including both state and federal funds.
- ❖ Starting January 1, 2014 (halfway through the fiscal year), Rhode Island expanded Medicaid coverage to childless adults under 138% FPL. Expenditure on this population during SFY 2014 was \$137 million and the state received 100% federal matching funds for this newly eligible population.
- ❖ The analysis in this report excludes \$130 million in DSH (Disproportionate Share Hospital) payments, \$30 million in costs not otherwise matchable (CNOM), and payments of \$19 million to LEAs (Local Education Authorities). More detail on the excluded payments is provided in the Appendix.
- ❖ The following report contains a variety of analyses describing the different elements of Rhode Island's Medicaid program in order to provide a common understanding of the key elements of Medicaid expenditure and areas of expenditure growth.

1b. Medicaid Expenditure Trends

Over the past five years, Rhode Island Medicaid expenditures have increased 1.1% per year on average, excluding the Medicaid expansion population.



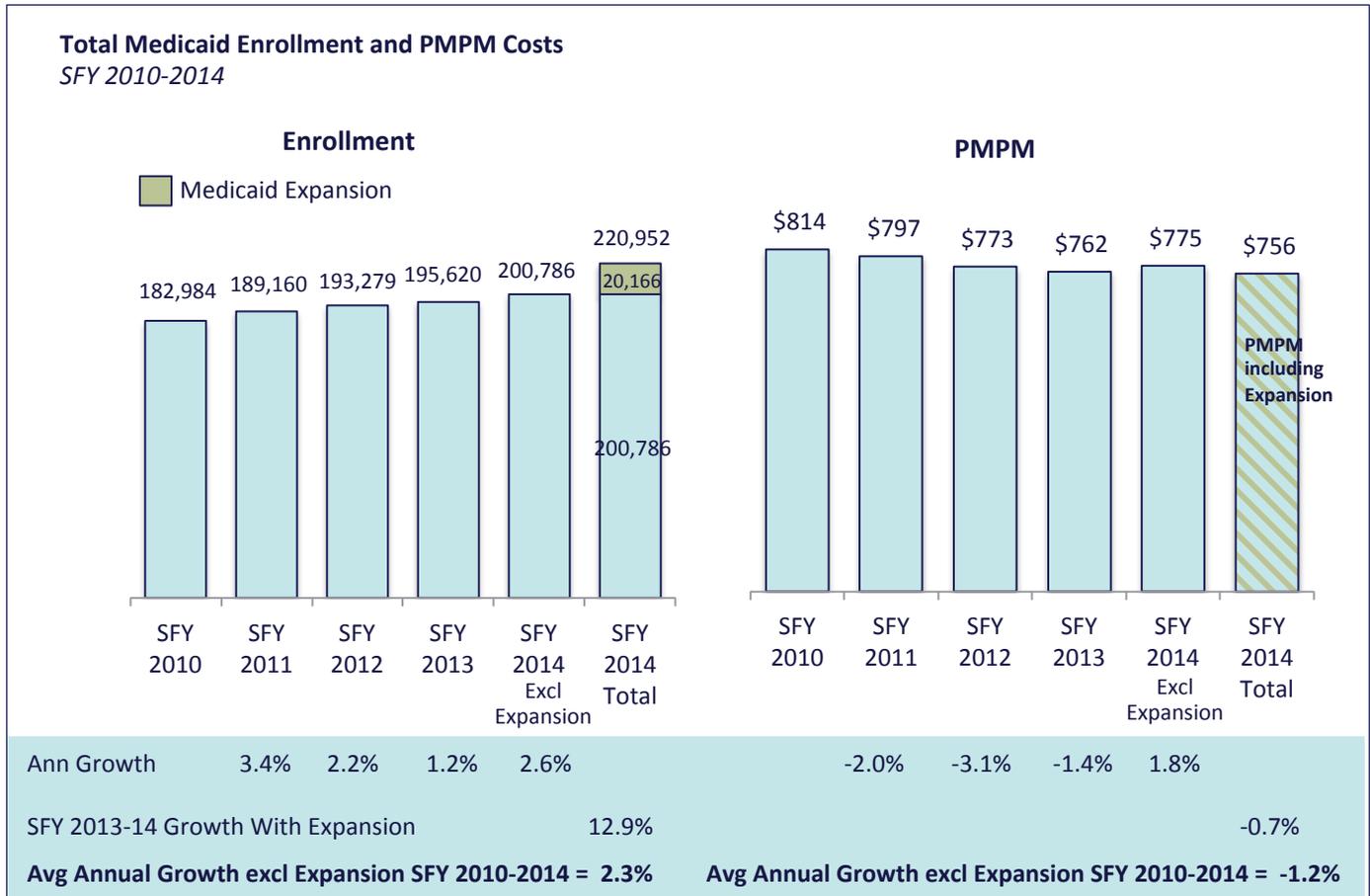
- ❖ Excluding the Medicaid Expansion population, overall Medicaid expenditures have increased by approximately 1.1% per year over the last five years.
- ❖ After two years of decreases, expenditure increased 4.5% from SFY 2013 to 2014, excluding the Expansion population.
- ❖ One contributing factor to the increase in expenditure was the ACA-mandated primary care physician rate increase in effect for calendar years 2013 and 2014, which increased payments to primary care physicians for certain services to match the Medicare Physician Fee Schedule. This factor, which was 100% federally funded, contributes approximately \$9 million or 0.5% to the growth between SFY 2013 and SFY 2014.
- ❖ Including the Expansion population, expenditure increased 12.2% from SFY 2013 to SFY 2014, however the state receives federal matching funds to cover 100% of the Expansion population through the end of calendar year 2016.²

¹Calculated as compounded annual growth rate (CAGR) over period SFY 2010-2014 as shown.

²Medicaid Enrollment and the Affordable Care Act, ASPE Issue Brief, March 2015

1b. Medicaid Expenditure Trends: Enrollment and PMPM

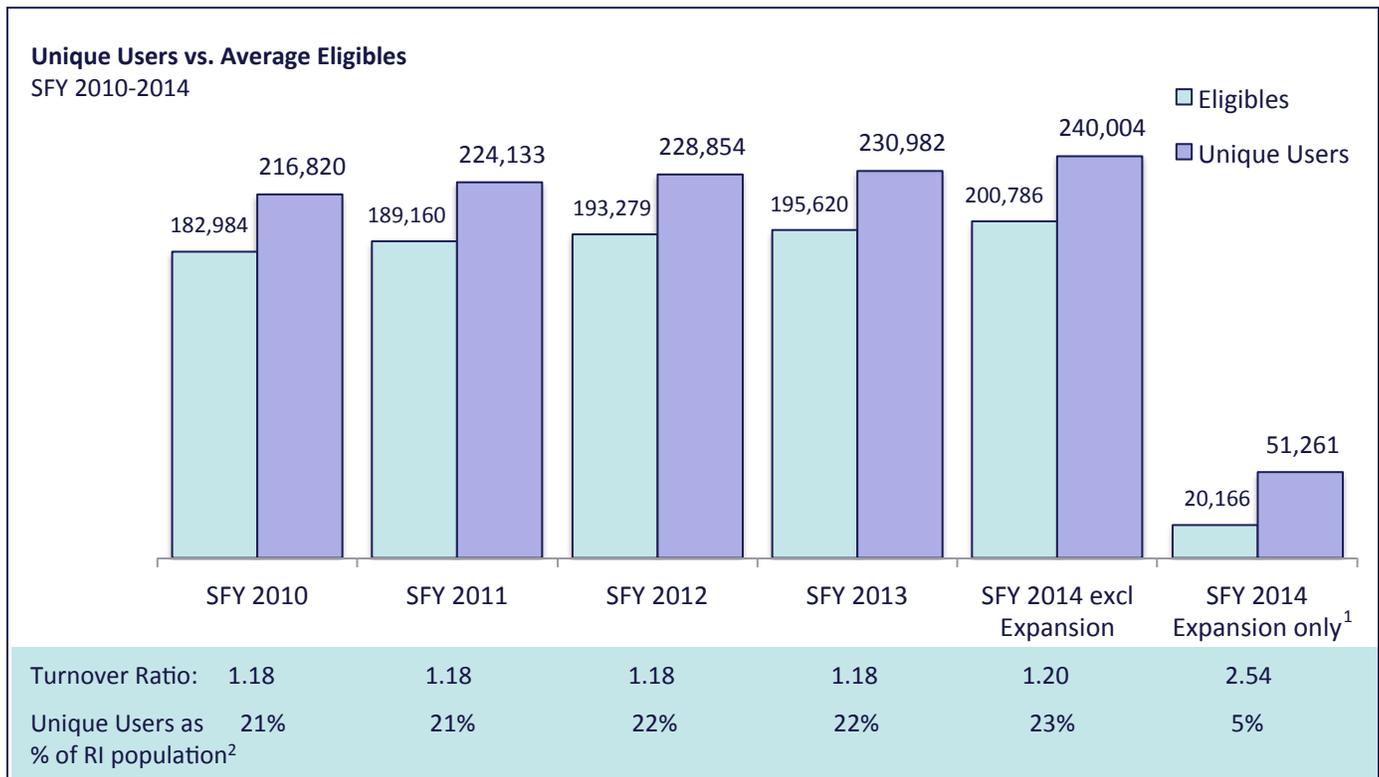
Average annual Medicaid enrollment has increased each year since SFY 2010 while PMPM costs have declined overall.



- ❖ Nearly all of the increase in total Medicaid expenditure in the last five years is due to increases in enrollment.
- ❖ Enrollment has increased 2.3% per year on average excluding Medicaid Expansion. The increase from SFY 2013 to SFY 2014 was 2.6% even before Medicaid Expansion.
- ❖ Including Medicaid Expansion, average enrollment has increased 12.9% from SFY 2013 to SFY 2014.
- ❖ PMPM costs have decreased annually from SFY 2010 through SFY 2013. There was a 1.8% increase in PMPM costs from SFY 2013 to SFY 2014, however half a percentage point of that increase is due to the federally-mandated primary care physician rate increase. PMPM costs are still lower in SFY 2014 than they were 5 years ago.
- ❖ Including the Medicaid Expansion population, the average PMPM for Medicaid overall is \$756, a decrease of 0.7% from SFY 2013. This is because the Expansion population is relatively lower cost.

1b. Medicaid Expenditure Trends: Unique Users

When including the Expansion population, more than one-quarter of Rhode Island’s population were enrolled in Medicaid for some part of SFY 2014.



- ❖ Unique users is a measure of the number of Rhode Islanders who were enrolled in Medicaid at any time during the fiscal year.³ So, if a person enrolled, disenrolled, and reenrolled, they would count as one user. Similarly, if a person enrolled for only 1 month, they would be included as a unique user.
- ❖ The turnover ratio compares unique users to average eligibles. If the number of unique users is equal to the average eligibles -- that indicates that there is a steady population of eligibles that remain on the program for the full year. If the number of unique users is above the average eligibles (a turnover ratio of >1) -- this indicates Rhode Islanders are using Medicaid for shorter periods of time.
- ❖ The higher turnover ratio for the Expansion population is due to the fact that Expansion enrollment started halfway through the fiscal year. Those users were enrolled for at most 6 months and many were enrolled for less than that. Therefore over 51,000 unique users in the Expansion population account for 20,166 average eligibles because an “average eligible” accounts for 12 months of eligibility.
- ❖ According to the State Health Access Data Assistance Center (SHADAC), Rhode Island had 64,000 low income uninsured adults under 65 in 2013. This means that nearly eighty percent of them enrolled in Medicaid in the first six months of expansion.⁴

¹Total unique users for SFY 2014 including Expansion is 287,318 due to overlap between expansion and non-expansion groups.

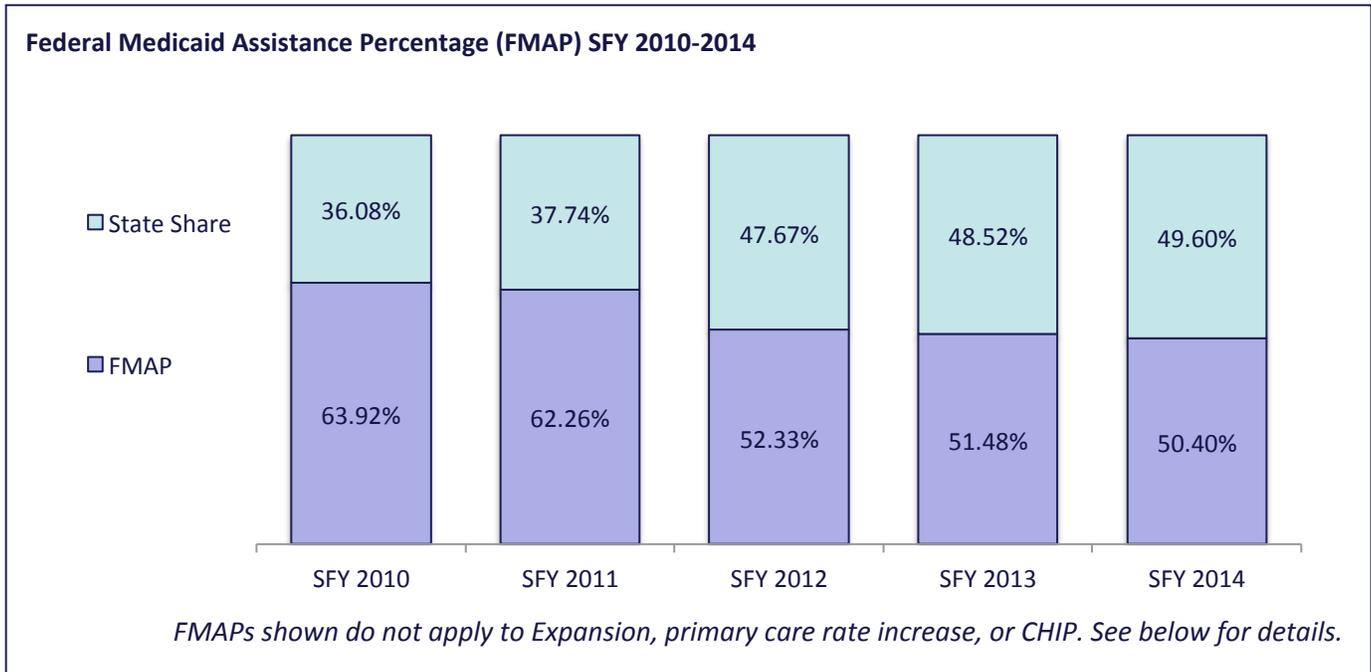
²Source: Population Division, US Census Bureau.

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

⁴SHADAC website. Data based on uninsured adults under 65 and under 138% FPL from American Community Survey 2013.

1c. Federal and State Share of Expenditures

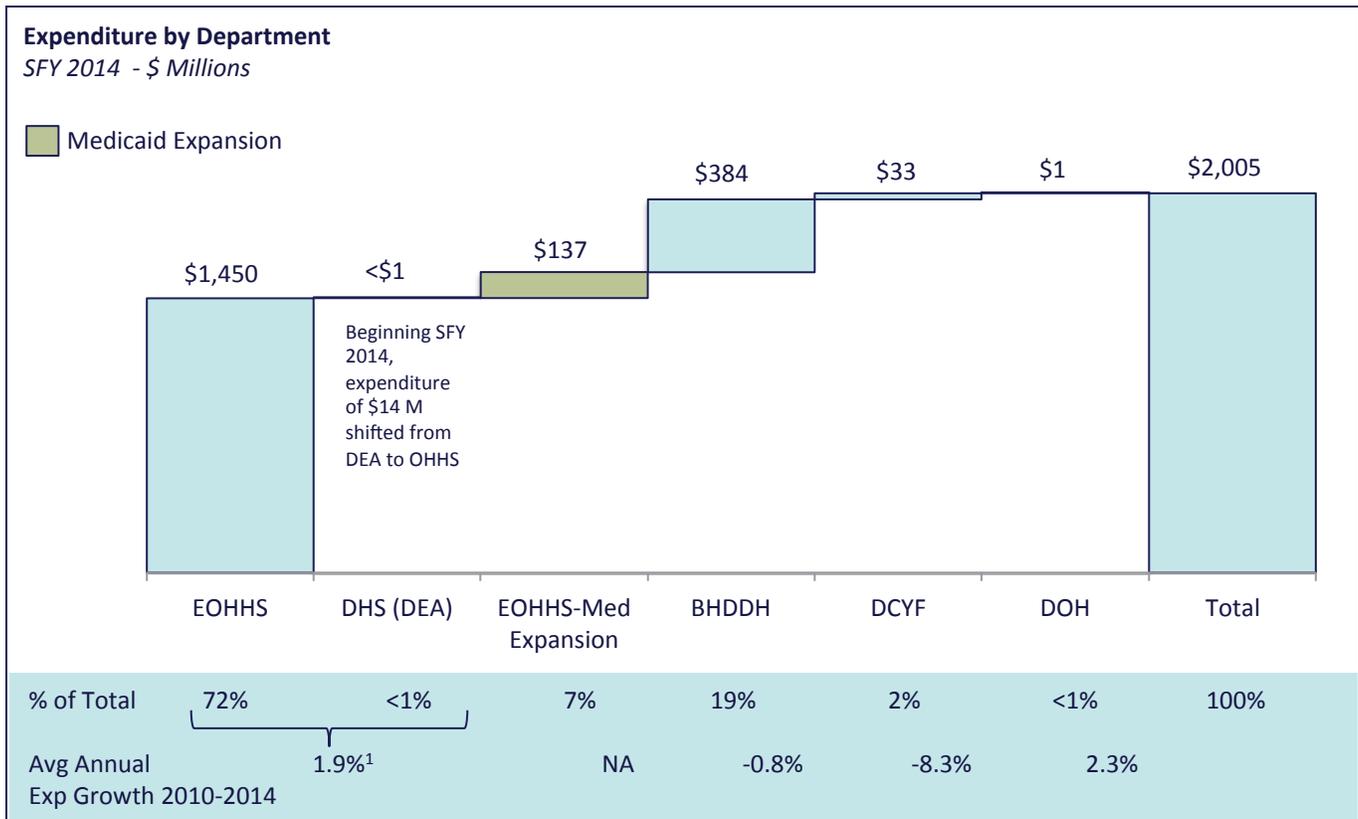
The State of Rhode Island is typically responsible for just under half of Medicaid expenditures.



- ❖ While this report will review trends in total Medicaid medical expenditure, it is important to recognize that less than half of this expenditure falls to the Rhode Island budget. Funding is split between state and federal dollars, with Rhode Island typically responsible for just under half of all program expenditures.
- ❖ Federal stimulus funding increased FMAP by 11 percentage points during SFY 2010-2011, which resulted in a substantial reduction in the state share of Medicaid expenditure for that time period.
- ❖ There are three instances of variation from the FMAP levels shown above:
 - The FMAP for the Medicaid Expansion population is 100% for SFY 2014. Expenditure for the Expansion population is covered entirely by the federal matching funds through the end of calendar year 2016.
 - During CY 2013 and CY 2014, the State was required to increase payments to primary care physicians for certain services to match the Medicare Physician Fee Schedule. The additional cost of this requirement was funded with 100% Federal matching funds.
 - The federal match is enhanced for qualifying low income children and pregnant women under the CHIP program. CHIP is designed to provide insurance coverage to children and pregnant women from families with incomes up to 250% of the federal poverty level who are uninsured and not otherwise eligible for Medicaid. In SFY 2014, Rhode Island received a 65.28% combined CHIP/FMAP federal match on 21,618 CHIP children and pregnant women.

1d. Expenditure by Department

Medicaid services are administered through several state departments.

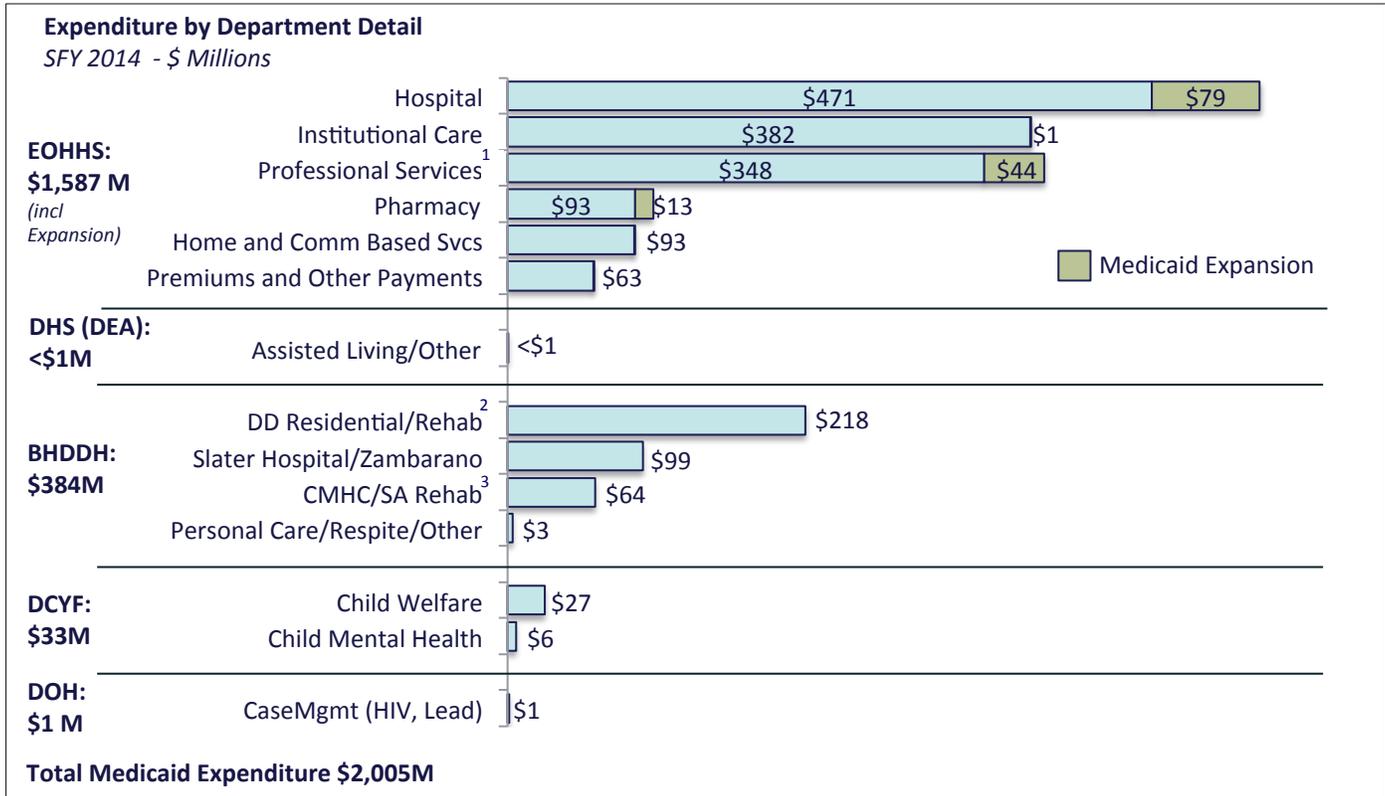


- ❖ In SFY 2014, the state departments responsible for administering components of the Medicaid program were: the Executive Office of Health and Human Services (EOHHS), the Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH), the Department of Children, Youth and Families (DCYF), the Division of Elderly Affairs in the Department of Human Services (DHS), and the Department of Health (DOH).
- ❖ The majority of expenditure (79%) is administered by EOHHS, including all expenditure for the Expansion population. This department is the lead administrator for the Medicaid contract with CMS. The Single State Medicaid Agency designation was transferred from DHS to EOHHS effective July 1, 2011.
- ❖ The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers the second largest share of Medicaid expenditure (19%).
- ❖ Detail for each department is shown on the next page.

¹Due to the shift in expenditure from DEA to OHHS in SFY 2014, the average annual growth rate is combined for those two departments.

1d. Expenditure by Department: State Agency Detail*

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



- ❖ The majority of expenditure (79%) is administered by the Executive Office of Health and Human Services. EOHHS funds most traditional Medicaid services, providing funding for hospital-based services (35% of total EOHHS expenditure), institutional care (24% of total EOHHS), professional services, and pharmacy.
- ❖ The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) administers another 19% of total Medicaid expenditure. BHDDH expenditures include three primary areas: the management of Slater Hospital, residential facilities for persons with developmental disabilities, and community based behavioral health and substance abuse services.
- ❖ The Department of Children, Youth and Families (DCYF), accounts for \$33 Million (2%) of Medicaid expenditure. DCYF administers programs serving children in the child welfare system, children in substitute care and children with behavioral health conditions.

* The purpose of this report is to provide a comprehensive overview of state Medicaid expenditures to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process. Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion and rounding.

¹Includes professional services for behavioral health.

²DD Residential/Rehab is Residential and Rehabilitation Services for persons with developmental disabilities, which includes DD Group homes, DD rehabilitation (adult day care and adult day program), and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

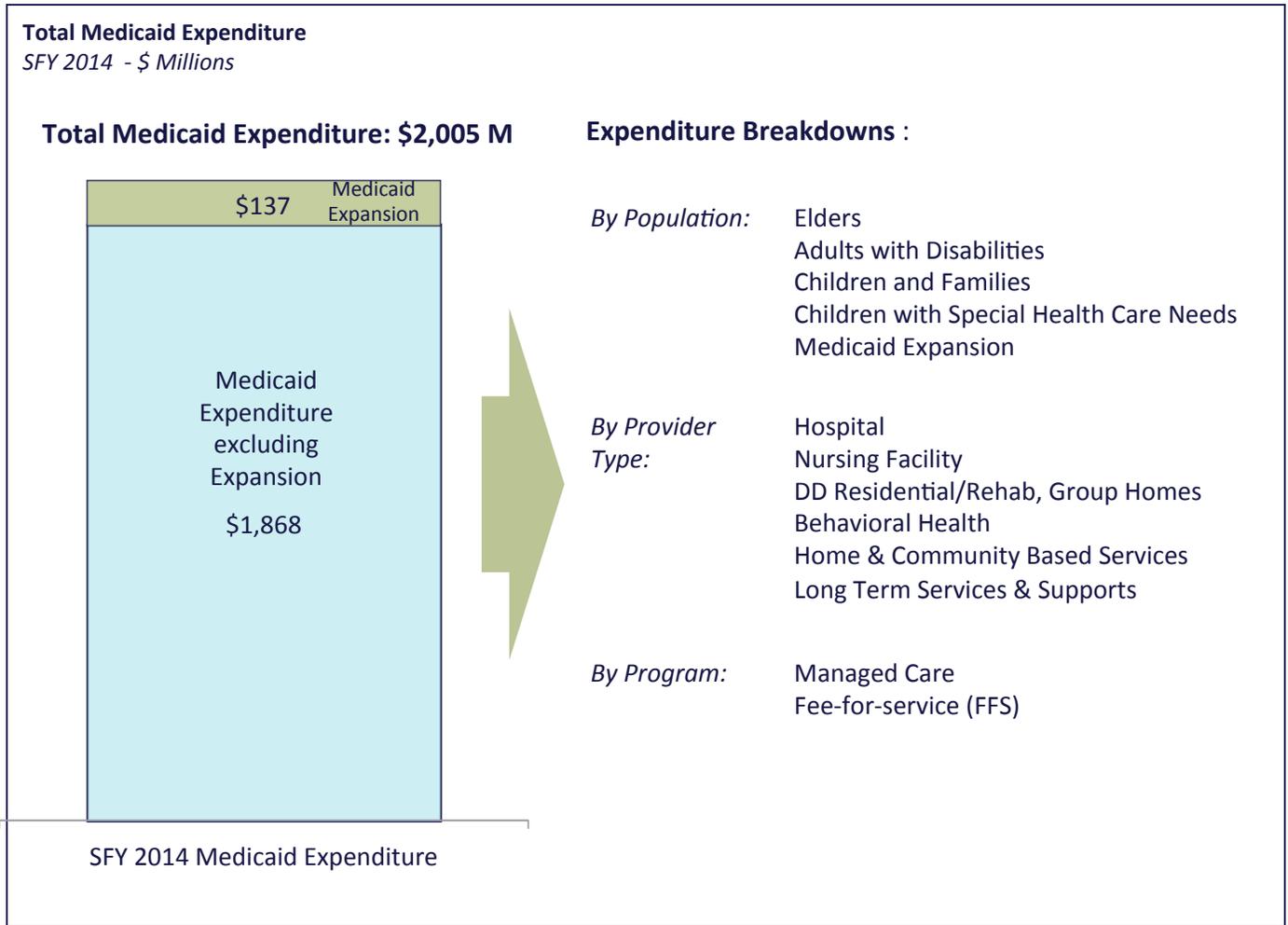
³CMHC/SA Rehab is Community Mental Health Centers and Substance Abuse Rehabilitation.

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2. Expenditure Distributions

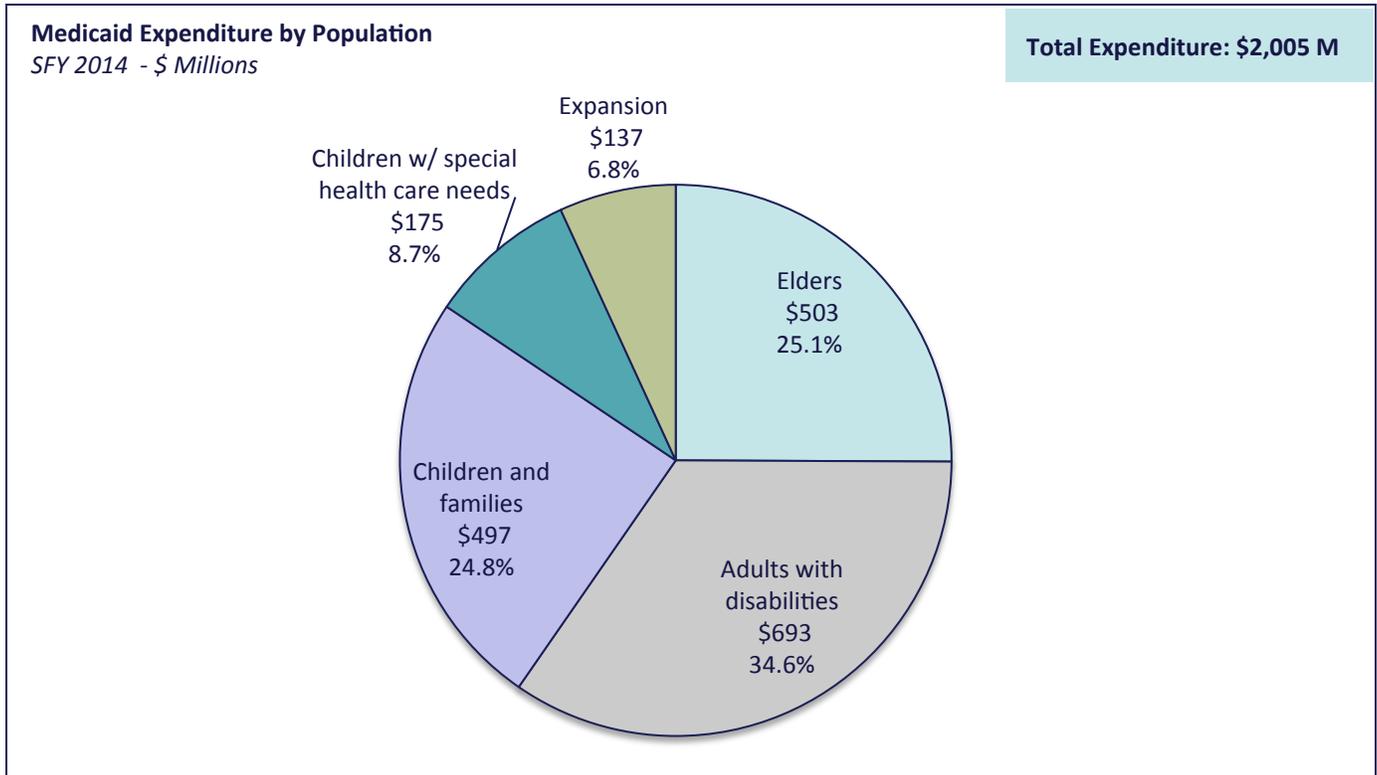
Medicaid expenditure can be broken down in several ways.



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

2a. Expenditure by Population

Over half of Medicaid expenditure (59.7%) is for Elders and Adults with Disabilities.



- ❖ **Elders** are adults over age 65, including those also eligible for Medicare. This population accounts for 25.1% of Medicaid expenditure, or \$503 million.
- ❖ **Adults with Disabilities** are adults under age 65 who have identified disabilities (does not include RItE Care enrolled adults). This population accounts for \$693 million in Medicaid expenditure, the largest portion of expenditure at 34.6% of total.
- ❖ **Children and Families** are low income children, parents and pregnant women who meet specific income requirements. This population accounts for another 24.8% of Medicaid expenditure, \$497 million.
- ❖ **Children with Special Health Care Needs (CSHCN)** are individuals under 21 eligible for SSI (Supplemental Security Income), children in Substitute (Foster) Care, Katie Beckett children, and Adoption Subsidy children. This population accounts for 8.7% of Medicaid expenditure.
- ❖ **Medicaid Expansion** are adults without dependent children with incomes under 138% FPL who were newly eligible for Medicaid as of January 1st 2014 under ACA expansion rules. This population accounts for 6.8% of Medicaid expenditure.

2a. Expenditure by Population

Medicaid expenditures per average eligible vary considerably by population.

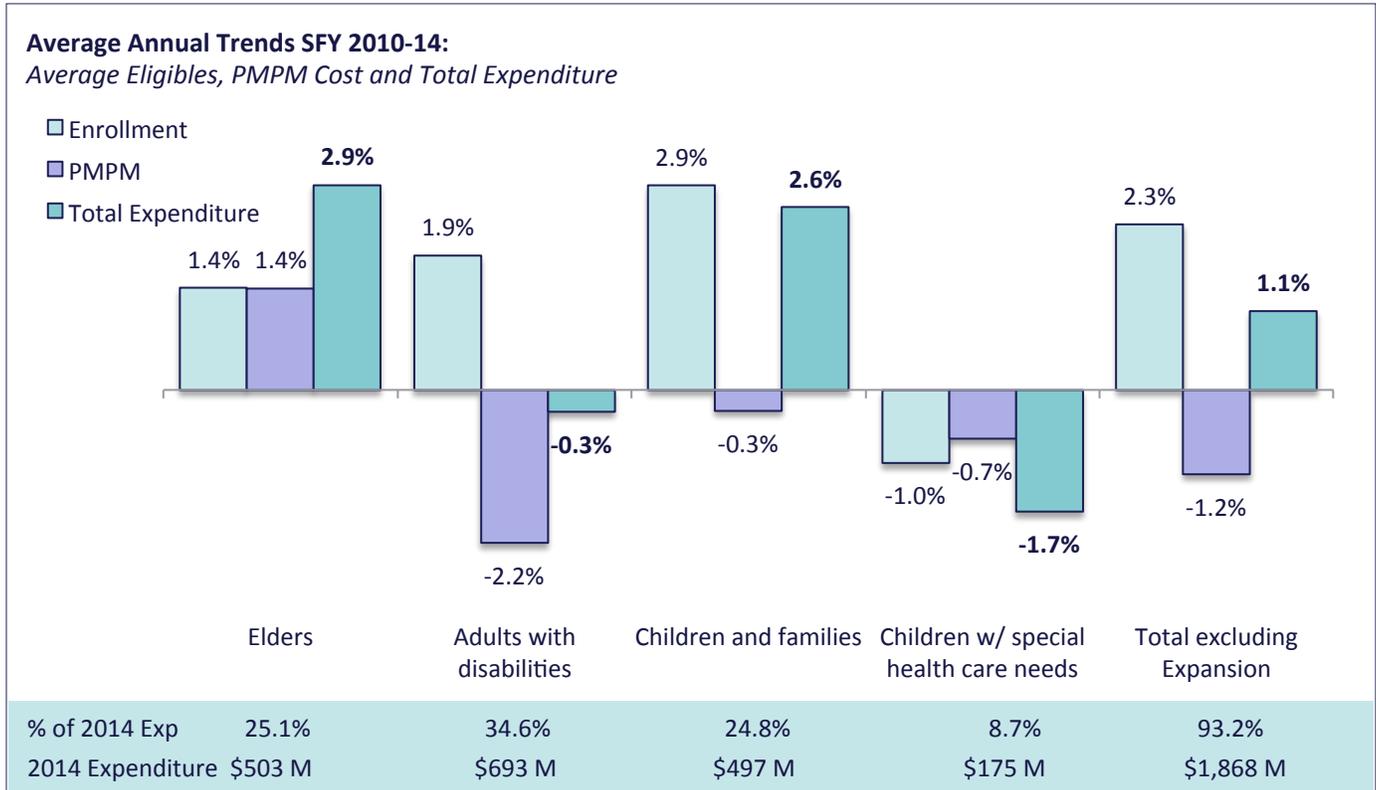
	Enrollment by Subgroup		Expenditure by Subgroup		PMPM Cost
Elders	8.4%	18,457			
Adults with disabilities	14.2%	31,437	25.1%	\$503 M	\$2,270
Children and families	62.9% 138,963		34.6%	\$693 M	\$1,838
			24.8%	\$497 M	\$298
Children w/ special health care needs	5.4%	11,929	8.7%	\$175 M	\$1,225
Expansion	9.1%	20,166	6.8%	\$137 M	\$567
Total Program	220,952		\$2,005 M		\$756

The Medicaid program served an average of 220,952 eligibles in SFY 2014, at an average cost per member per month of \$756. However, PMPM costs vary considerably by population.

- ❖ 59.7% of expenditure is on services for elders and adults with disabilities who together account for 22.6% of total eligibles. The PMPM cost for elders is over \$2,200 per member per month and the PMPM cost for adults with disabilities is over \$1,800.
- ❖ Services for children and families account for 62.9% of total enrollment and 24.8% of total expenditure with a PMPM cost \$298.
- ❖ Another 8.7% of expenditure is for children with special health care needs who represent 5.4% of eligibles at a PMPM of \$1,225.
- ❖ The newly eligible Medicaid Expansion population accounts for 9.1% of eligibles and 6.8% of overall expenditure, with a PMPM of \$567. Note that this population was only eligible for Medicaid halfway through SFY 2014, so each Expansion enrollee counted for at most 0.5 average eligibles.

2a. Expenditure By Population: Trends

Expenditure trends vary significantly by population.

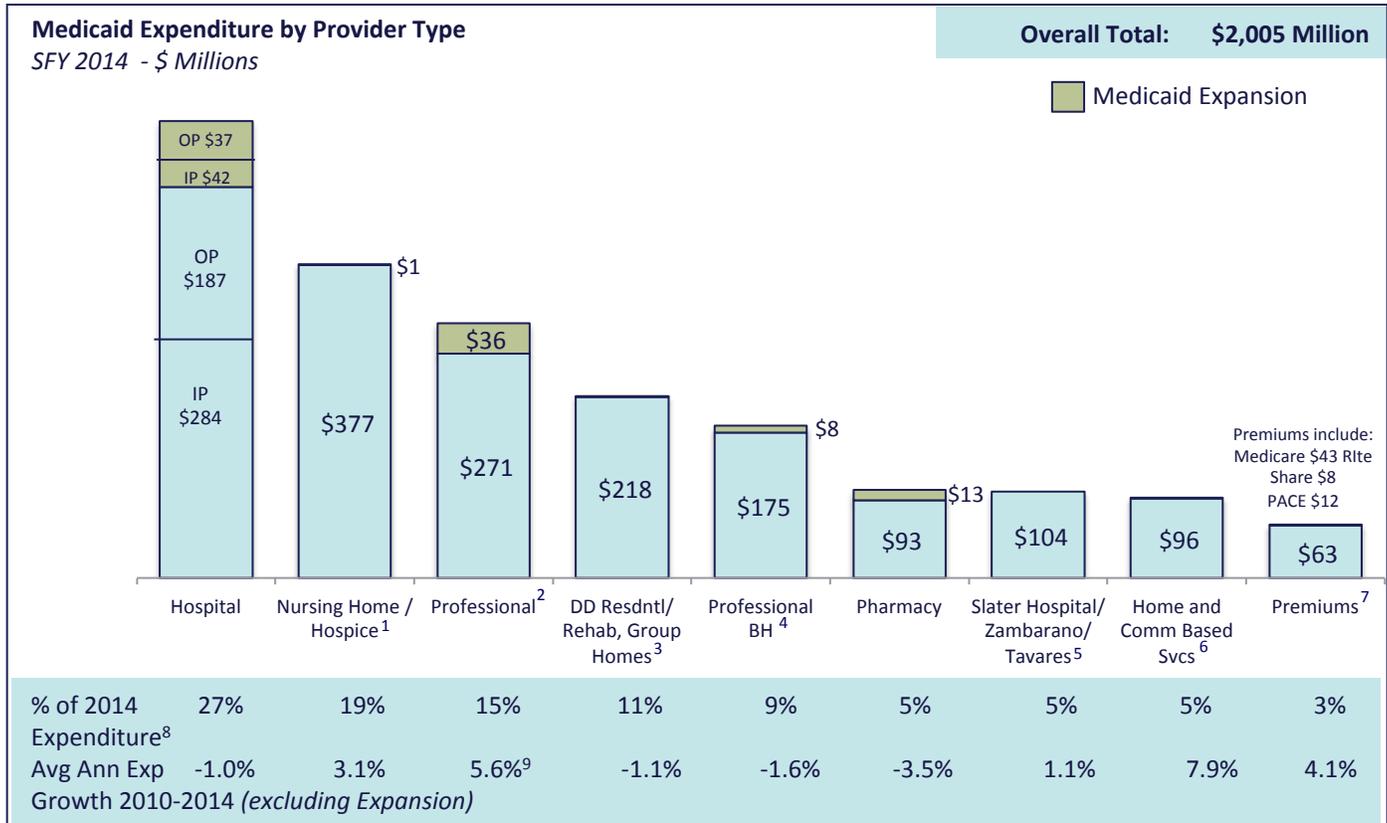


- ❖ Excluding expenditures on the Expansion population, overall Rhode Island Medicaid expenditures grew by approximately 1.1 percent per year between SFY 2010 and SFY 2014. Note that the overall expenditure trend is broken down into per member per month (PMPM) cost trend and enrollment trend, which can be added together to determine average expenditure trend.
- ❖ Elders account for 25.1% of overall spending in SFY 2014 and have experienced a 2.9% average annual increase in expenditure since SFY 2010. This increase is split about evenly between an increase in enrollment and an increase in PMPM.
- ❖ Adults with disabilities account for the highest share of SFY 2014 expenditure (34.6%). The average annual expenditure for this group decreased 0.3% per year on average over the last 5 years. The decrease was due to decreased PMPM (enrollment increased on average over the period).
- ❖ Children and families experienced a 2.6% average expenditure growth over the past 5 years and an average enrollment growth of 2.9%. This population, which is most closely comparable to the commercial population, had an average PMPM decrease of 0.3% compared with Rhode Island’s recent five year commercial PMPM cost trend of 2.4%¹.
- ❖ Children with special health care needs have experienced a decrease in both PMPM and overall expenditure since SFY 2010. This is partly due to programs that have reduced the portion of DCYF youth in residential settings compared to those in community-based settings.

¹For commercial incurred claims from BCBSRI, United Healthcare New England and Tufts Health Plan, includes both large group and small group. Source: Office of the Health Insurance Commissioner (OHIC), 2015 carrier rate filings Historical data tables.

2b. Expenditure by Provider Type

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



- ❖ The two largest provider types, accounting for nearly half (46%) of all RI Medicaid expenditure in SFY 2014, were hospitals and nursing facilities (including nursing homes and hospice). Key contributors to expenditure growth were nursing facilities and professional providers.
- ❖ Hospitals were the largest provider type, accounting for 27% of Medicaid expenditures in SFY 2014. Hospital payments have been decreasing at an average of 1.0% per year over the last 5 years not including expenditures on the Expansion population.

¹Nursing home includes skilled nursing facilities.

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

³DD Resdntl/Rehab is Residential and Rehabilitation Services for persons with developmental disabilities and includes public and private DD group homes, DD rehabilitation, and other BHDDH expense (including residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment).

⁴Professional Behavioral Health includes DHS, BHDDH and DCYF expense including, but not limited to, Professional Mental Health/Substance Abuse, CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation), CMHC, and Residential DCYF.

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

⁶Home 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.

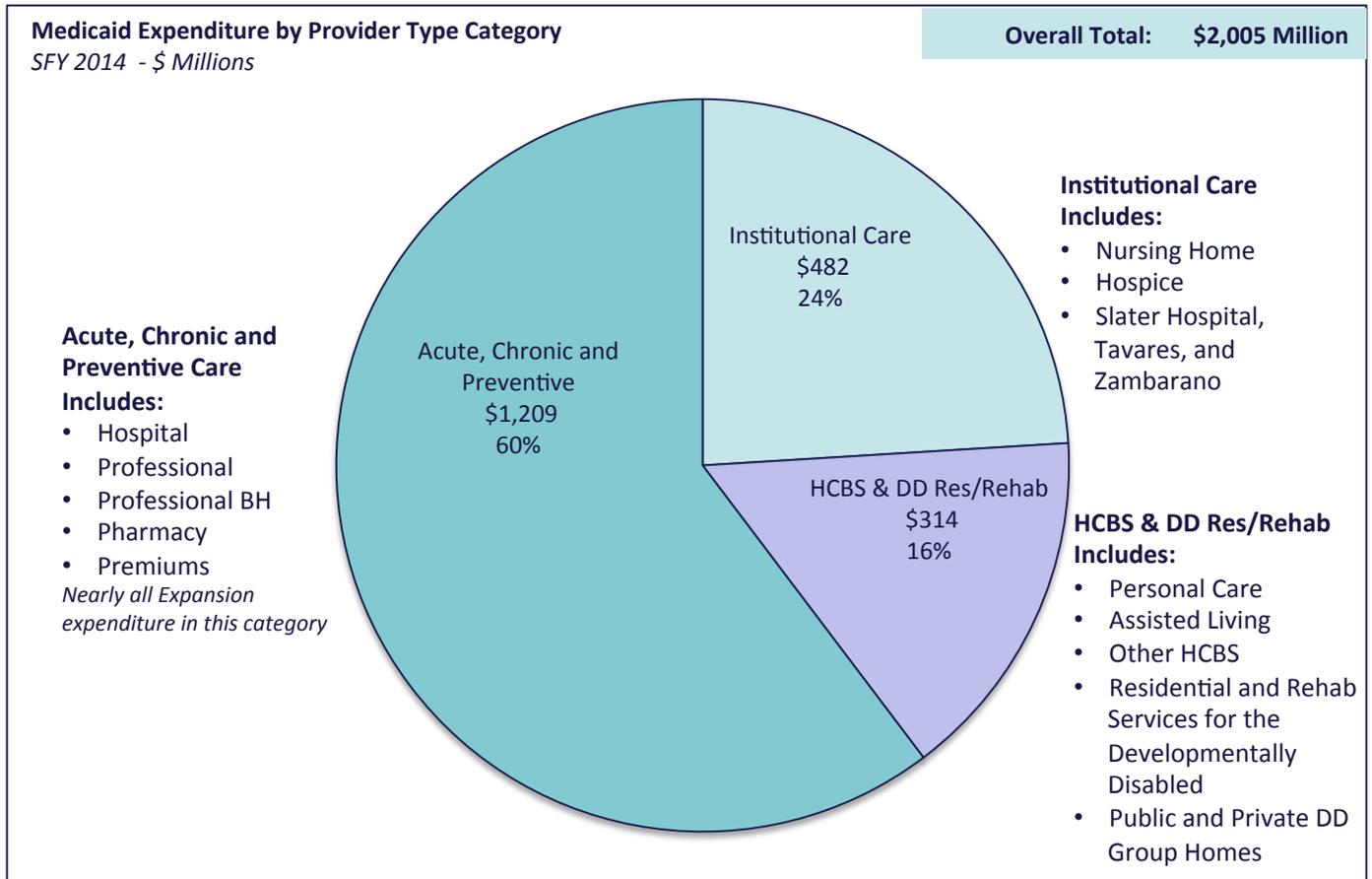
⁷Premiums includes Medicare premiums paid for qualifying individuals, premiums for PACE (Program of All-Inclusive Care of the Elderly) and Rlte Share premiums, which are the employee share of private insurance premiums paid on behalf of Medicaid eligibles who have access to private insurance.

⁸Percentages may not sum to 100% due to rounding error.

⁹Some of the increase in professional services is due to Primary Care Physician rate increase.

2b. Expenditure by Provider Type: Summary by Category

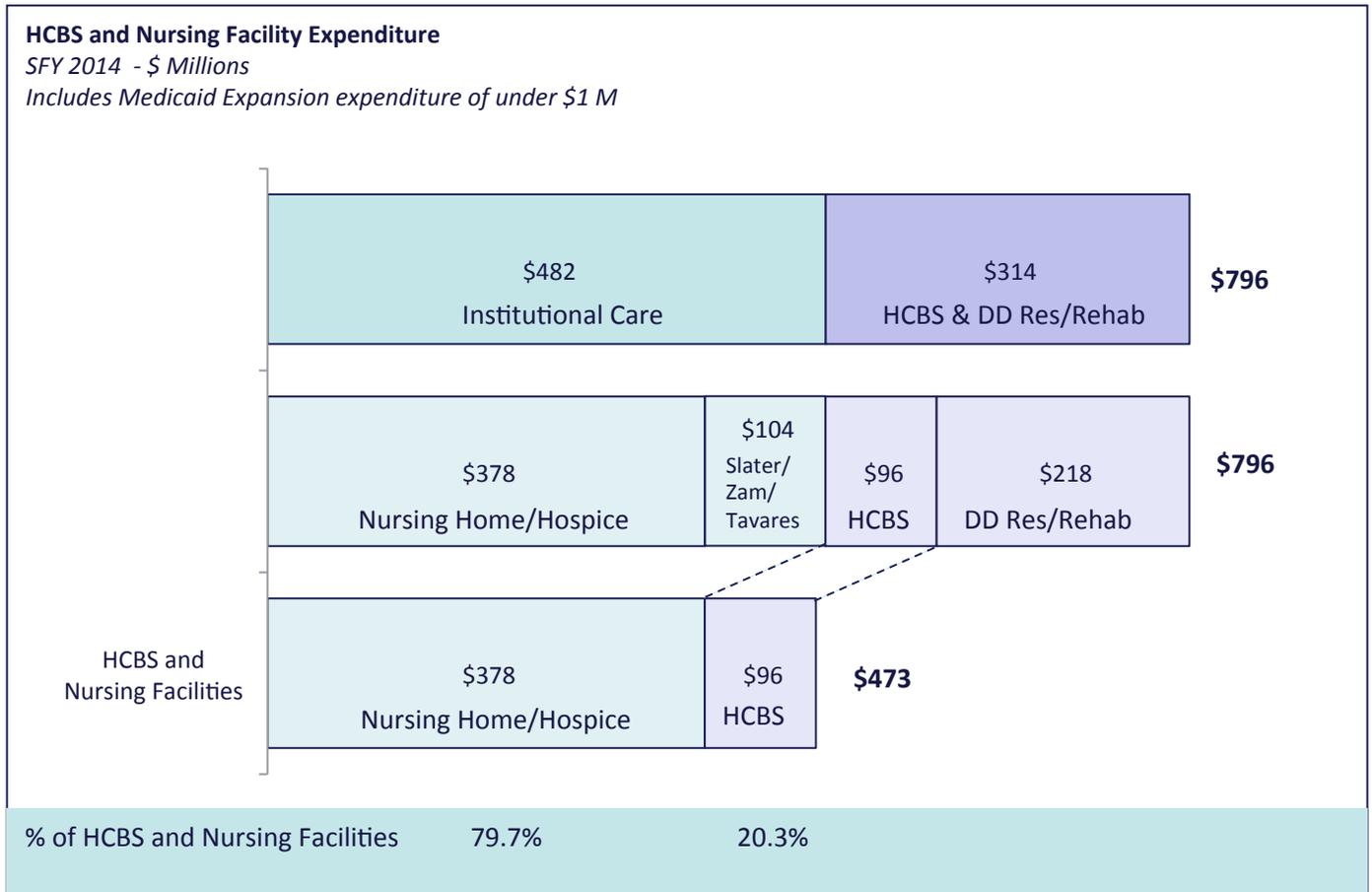
Overall, 40% of Medicaid expenditure is for Institutional Care, Home and Community Based Services, and residential and rehabilitation services for the developmentally disabled.



- ❖ Forty percent of Medicaid expenditure is for Long Term Services and Supports (LTSS), including institutional care, home and community based services, and residential and rehabilitation services for the developmentally disabled.
- ❖ The other 60% of Medicaid expenditure is for acute, chronic and preventive care services such as hospital, professional services, and pharmacy. Nearly all of the expenditure for the Expansion population falls into this category.

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

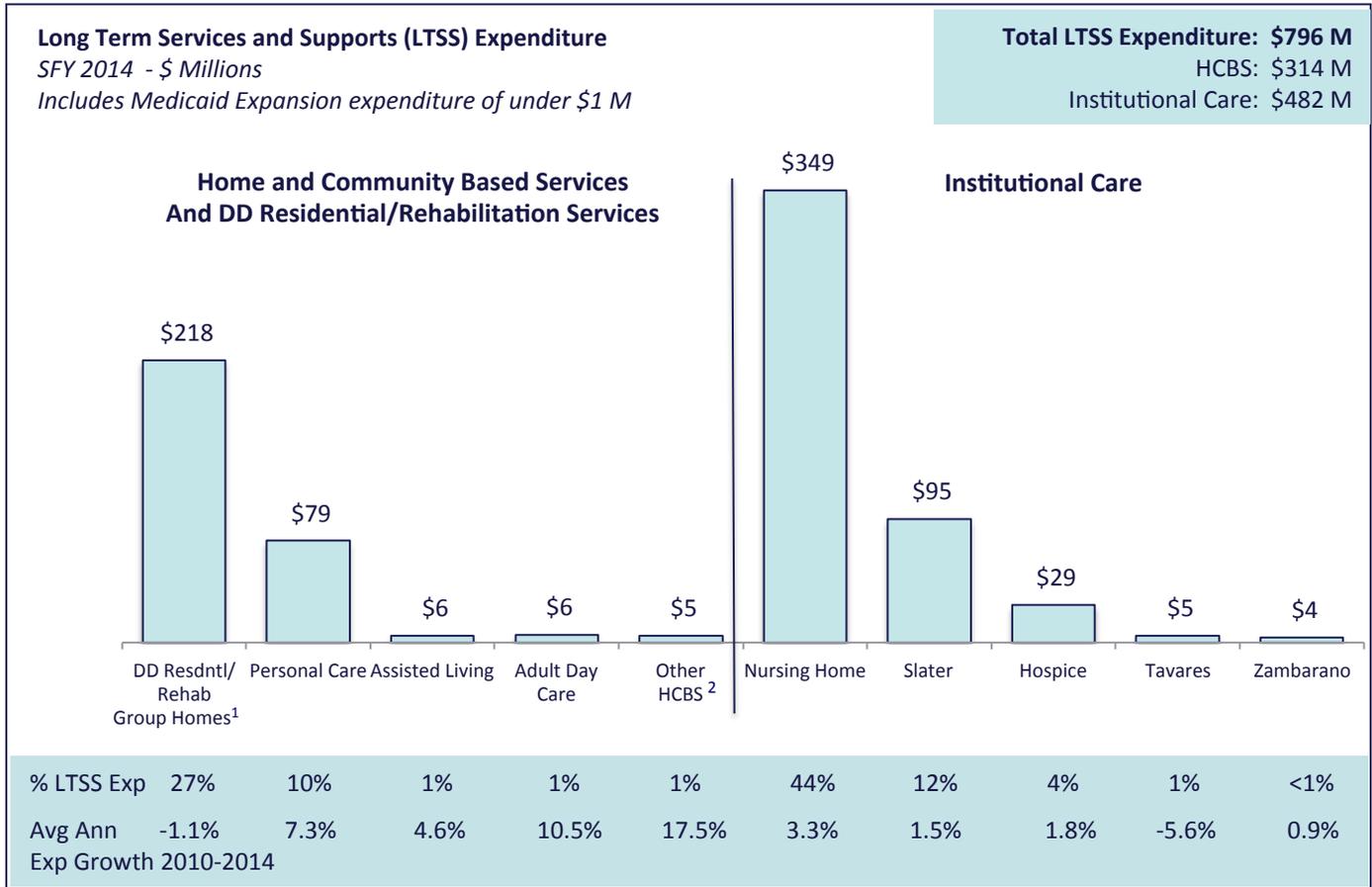
Over 20% of the expenditure for HCBS and nursing facilities is for HCBS.



- ❖ Long term services and supports expenditure can be broken into nursing facilities (including nursing homes and hospice), hospital-based care, HCBS and residential and rehabilitation services for the developmentally disabled.
- ❖ The total expenditure for HCBS and nursing facilities is \$473 million in SFY 2014. The HCBS portion of that expenditure is 20.3%. This reflects the relative balance of expenditure between home and community based services and nursing facilities.

2b. Provider Type Detail: LTSS Detail

Long term services and supports, including both institutional care and home and community based services, accounted for \$796 million in SFY 2014, about 40% of Medicaid expenditure.



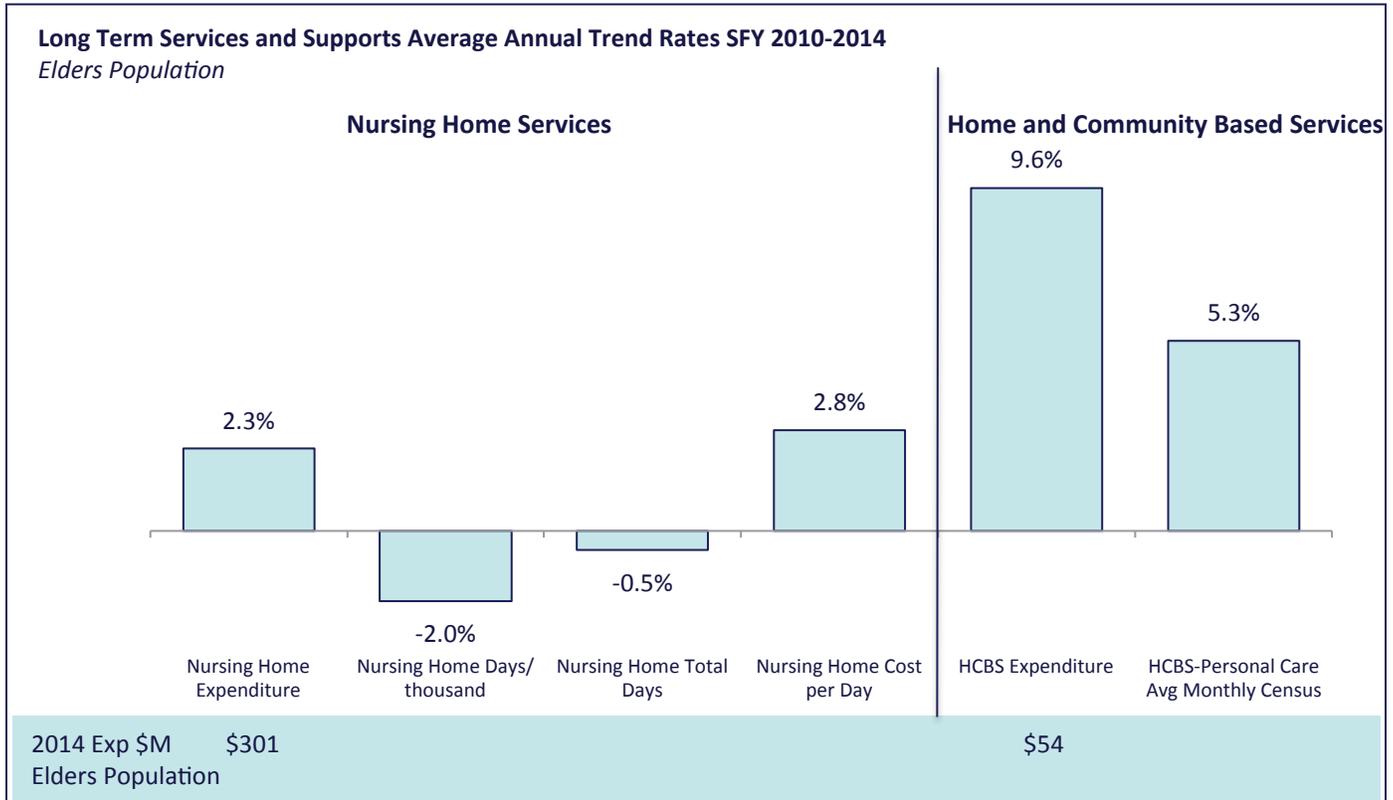
- ❖ The 1115 Medicaid Waiver subsumed the prior 1915(c) waivers, which granted the state the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide home and community based services to at-risk populations as alternatives to more costly nursing home/institutional options.
- ❖ A large portion of the growth in LTSS expenditures is for HCBS for the non-developmentally disabled population. These services, such as attendant/personal care and assisted living, are less expensive alternatives to nursing home/institutional options.
- ❖ Institutional care services account for 60% of LTSS expenditure. The largest category of institutional care is nursing homes, accounting for 44% of LTSS spending and 72% of spending on institutional care.

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

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

2b. Provider Type Detail: LTSS Trends

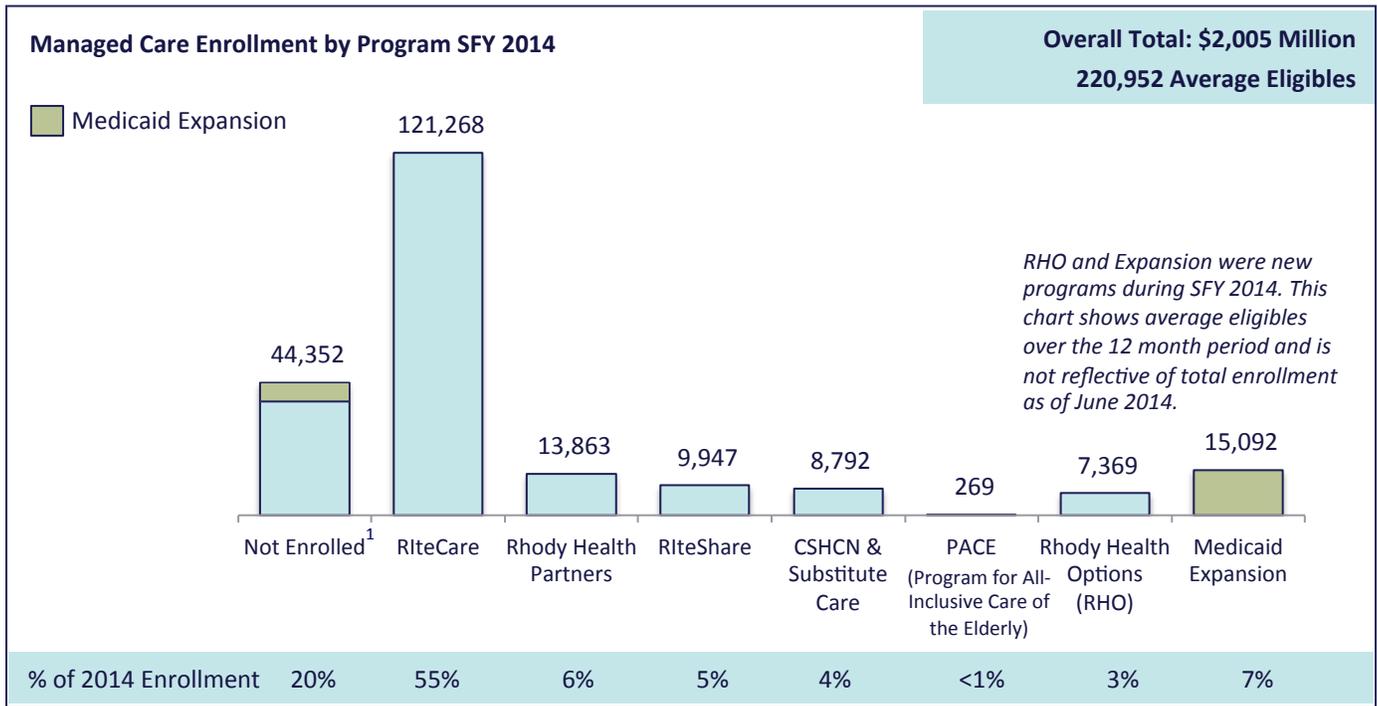
Expenditure on home and community based services is growing at a faster rate than spending on nursing homes for the elders population.



- ❖ Nursing home expenditure for the elders population accounted for \$301 million in SFY 2014, with an average annual increase of 2.3% per year on average since SFY 2010.
- ❖ Over the same period, days per thousand for elders in nursing homes decreased 2.0% per year on average. Nursing home days in total for elders decreased 0.5% per year between SFY 2010 and SFY 2014.
- ❖ Nursing home cost per day for elders has increased from \$153 to \$171 between SFY 2010 and SFY 2014, about 2.3% on average per year.
- ❖ Expenditure on home and community based services for elders is \$54 million and is growing at 9.6% per year on average. A measure of the usage of HCBS is the average monthly census for personal care services, which increased for the elders population by 5.3% per year on average over the last 5 years.

3a. Managed Care Enrollment

Eighty percent of Medicaid average eligibles are enrolled in managed care programs.

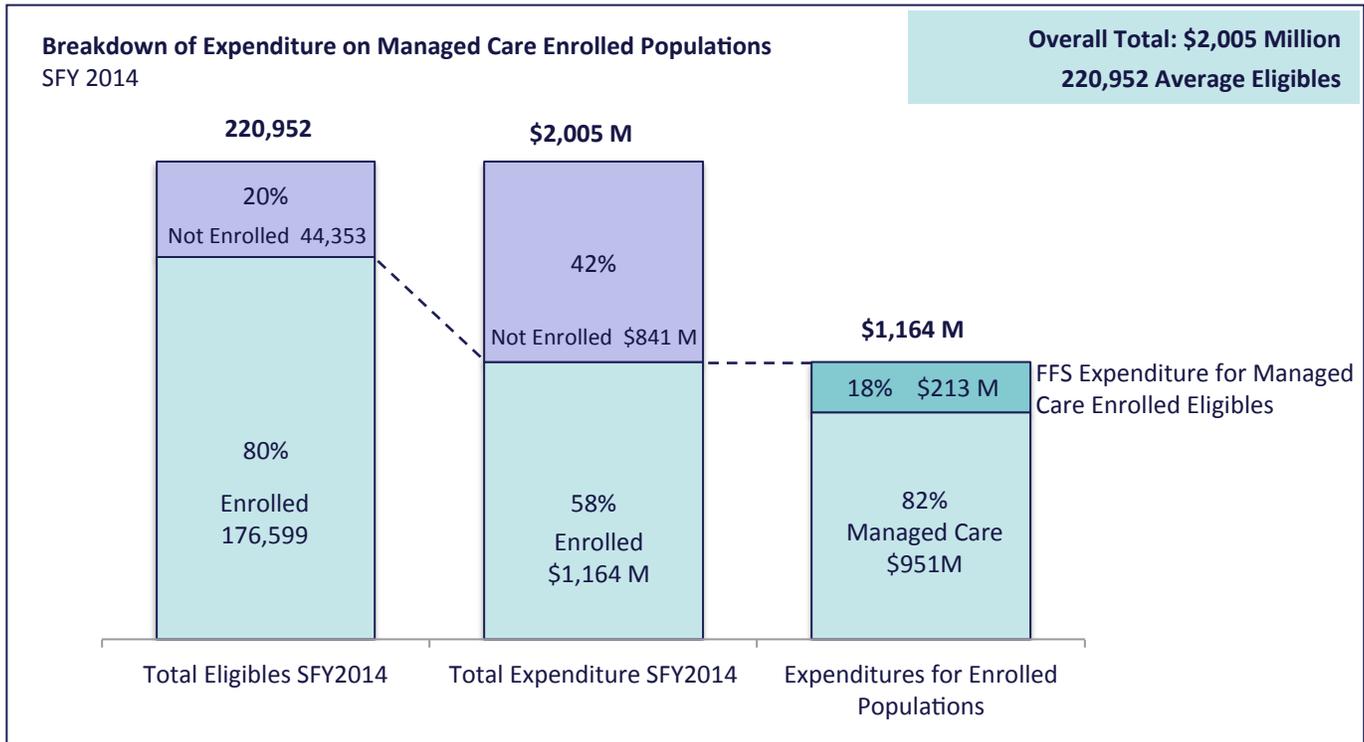


- ❖ Medicaid enrollees who do not have other insurance are enrolled in Medicaid managed care plans. Less than 20% of Medicaid eligibles are not enrolled in some sort of managed care program.
- ❖ During SFY 2014 RItE Care and Rhody Health Partners (RHP) enrollment was divided between Neighborhood Health Plan (NHP) and United Healthcare (UHC). RItE Care mainly serves children and families. RHP is a managed care program for adults with disabilities.
- ❖ RItE Share is a program designed to allow Medicaid eligibles with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee’s share of the premium. This minimizes Medicaid expenditure by leveraging the employer’s contribution. In SFY 2014 there were 9,947 Medicaid eligibles enrolled in the RItE Share program.
- ❖ Rhody Health Options is a new managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports, and other Medicaid-funded services designed for eligibles with both Medicaid and Medicare eligibility.
- ❖ Because RHO and Expansion were introduced during SFY 2014, enrollment was phased in during the year and is steadily growing for both programs. By the end of SFY 2014, enrollment in RHO was 16,933 eligibles and enrollment in Expansion managed care was 46,585 eligibles (49,771 for the Expansion population in total).

¹Not enrolled includes 3,025 eligibles enrolled in Connect Care Choice and Connect Care Choice Community Partners because claims are paid within the Fee For Service structure. Not enrolled also includes 5,074 Expansion average eligibles due to periods of eligibility prior to managed care enrollment.

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

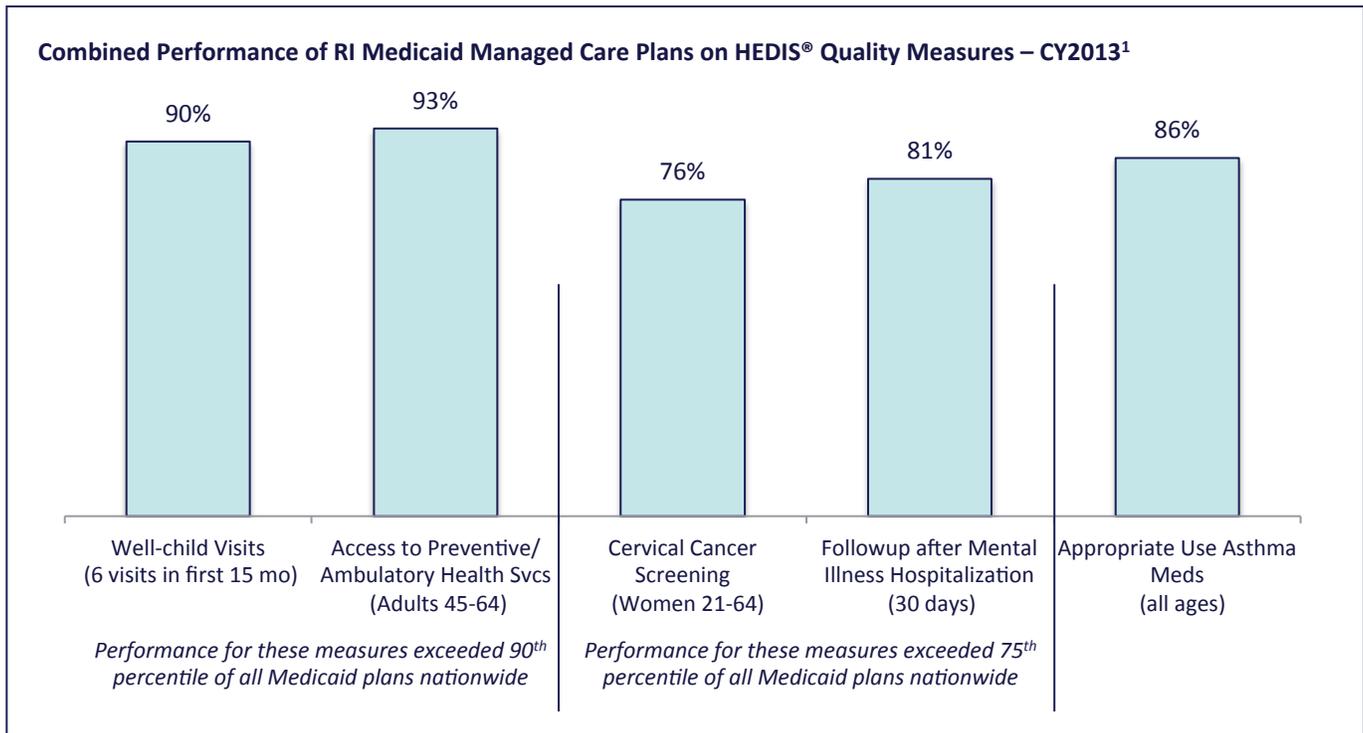
The 80% of Medicaid eligibles enrolled in managed care plans account for 58% of Medicaid expenditure.



- ❖ Eighty percent of Medicaid eligibles are enrolled in a managed care program, including RItE Care, RItE Share, Rhody Health Partners, Rhody Health Options, or PACE. These enrolled populations account for more than half (58%) of Medicaid expenditure in SFY 2014.
- ❖ Of the \$1,164 million in expenditure on managed care enrolled populations, \$951 million was paid through managed care programs. The remaining \$213 M was paid for FFS claims for managed care enrolled eligibles. These FFS claims include NICU, certain behavioral health services, specialized services for children with special healthcare needs, dental care, transportation, and pre-managed care enrollment eligibility.
- ❖ Unenrolled populations include eligibles enrolled in Connect Care Choice and Connect Care Choice Community Partners, which are primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure. In SFY 2014, there were 3,025 Medicaid eligibles enrolled in Connect Care Choice and Connect Care Choice Community Partners.
- ❖ Typically there is a period of eligibility for new Medicaid enrollees before they can be enrolled in managed care programs. During this period any claims are paid as FFS claims. Due to the rapid enrollment in Expansion, about 23% of the expenditure on the Expansion population was paid as FFS claims even though all eligibles were enrolled in managed care plans as soon as possible.

2c. Managed Care: Quality Indicators

Both of Rhode Island’s participating Medicaid Managed Care Organizations (MCOs) ranked in the top 10 Medicaid plans in the nation in CY 2014.



- ❖ In September 2014, the National Committee for Quality Assurance (NCQA) ranked over 273 Medicaid Health Plans nationwide. Both Rhode Island MCOs ranked in the top 10, with NHPRI ranked 5th and United Healthcare ranked 7th.¹
- ❖ On the HEDIS® measures assessing the percentage of enrollees who had six or more well-child visits during their first 15 months of life and the measure of adults 45-64 with access to preventive health services, both of Rhode Island’s Medicaid Health Plans ranked above the 90th percentile compared with Medicaid health plans nationally.
- ❖ Rhode Island’s Medicaid Health Plans exceeded the 75th percentile on the cervical cancer screening measure (percent of women 21-64 who received Pap tests to screen for cervical cancer) and the measure for having an outpatient follow-up mental health service within at least 30 days after discharge.
- ❖ On the HEDIS® measure of individuals with asthma who were appropriately prescribed medication, Rhode Island’s Medicaid Health Plans did not achieve the 75th percentile, however RI did meet and/or exceed the national Medicaid average of 77% across all age cohorts.
- ❖ In addition, RI was designated the highest performing state in the country on the Child Core Set of health care quality measures for FFY 2013. RI reported a rate in the top quartile for 13 of the 15 frequently reported measures.² RI was the only state to achieve higher performance status overall and in all 3 domains measured.

¹Source: Monitoring Quality and Access in RIte Care and Rhody Health Partners, RI EOHHS, October 2014. Results are reported in the **28** aggregate, not by individual health plan.

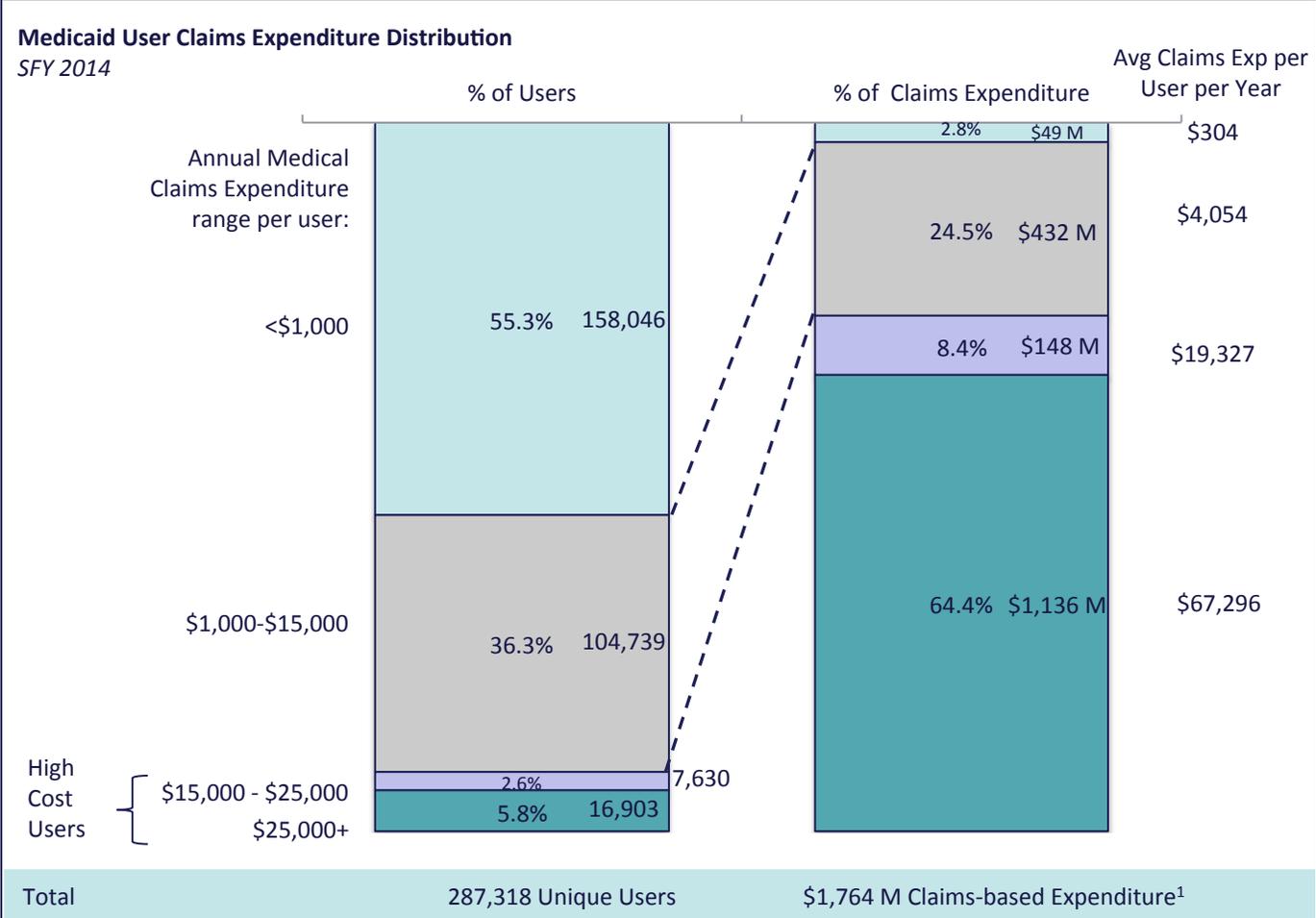
²The State of Children’s Health Care Quality in Medicaid and CHIP, Centers for Medicare & Medicaid Services Analytic Brief, May 2015.

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3a. High Utilizers: By Expenditure Level

The 6% of Medicaid users with the highest costs account for almost two thirds (65%) of Medicaid claims expenditure.

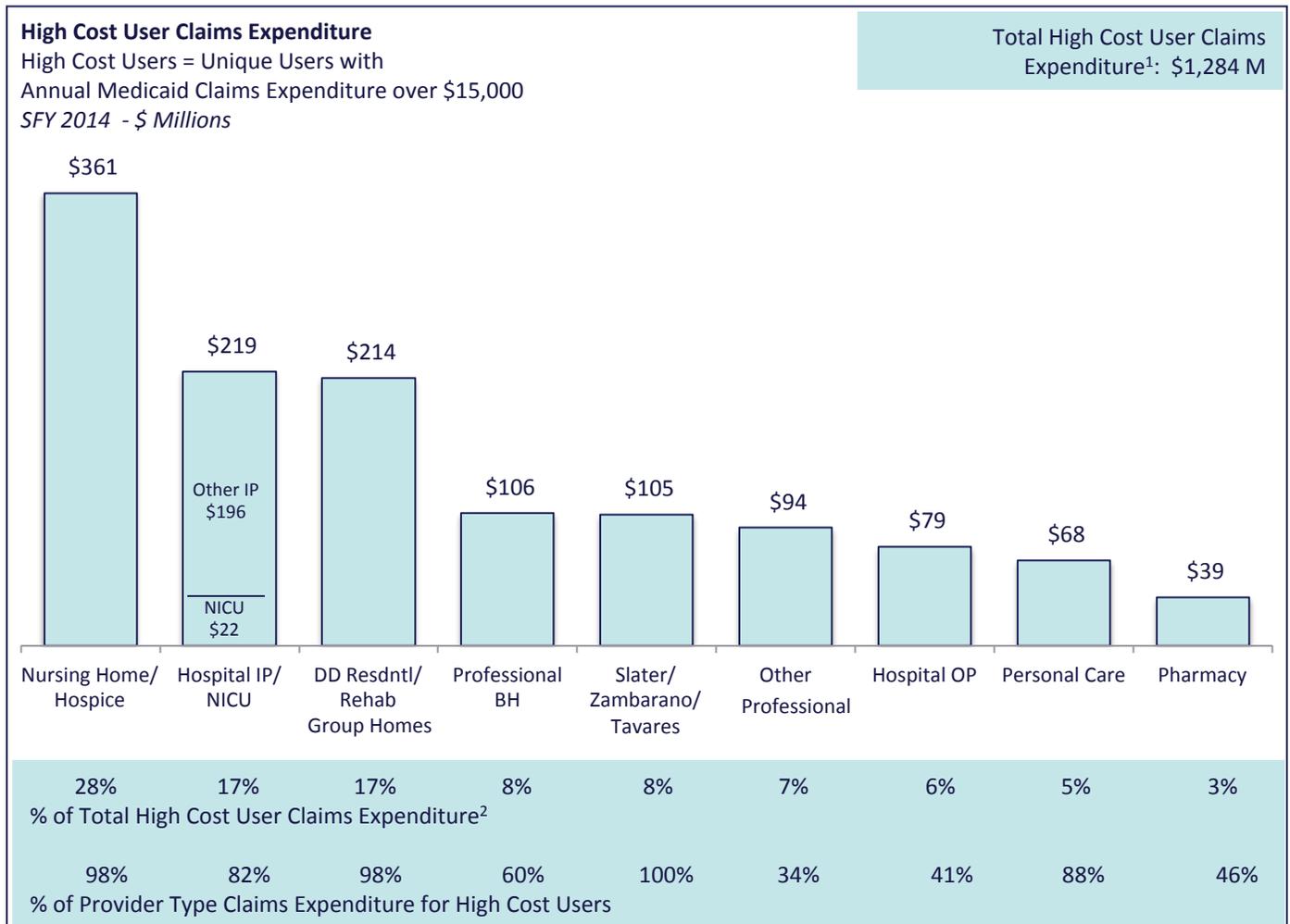


- ❖ Medicaid claims expenditures are highly concentrated, as the 5.9% of Medicaid users with the highest costs account for almost two-thirds (64.8%) of claims expenditures.
- ❖ In order to look at spending by user, it is necessary to look at “unique users” rather than average eligibles. A unique user is an individual associated with a medical claim. Average eligible enrollment is annual full time equivalents, or 12 months of eligibility.
- ❖ Unique users with over \$15,000 of claims expenditure of per year are designated as “high cost” for the purposes of this analysis. There are 24,533 high cost users (8.4% of users) who account for \$1,284 million (72.8%) in claims expenditure. These high cost users typically present with multiple, complex conditions, requiring care coordination across a variety of provider types.
- ❖ On the other end of the spectrum, 55.3% of Medicaid users access services at a cost of less than \$1,000 per year and account for 2.8% of claims expenditure, averaging \$304 in claims expenditure per user.

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

3b. High Utilizers: By Provider Type

Nearly half (45%) of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.



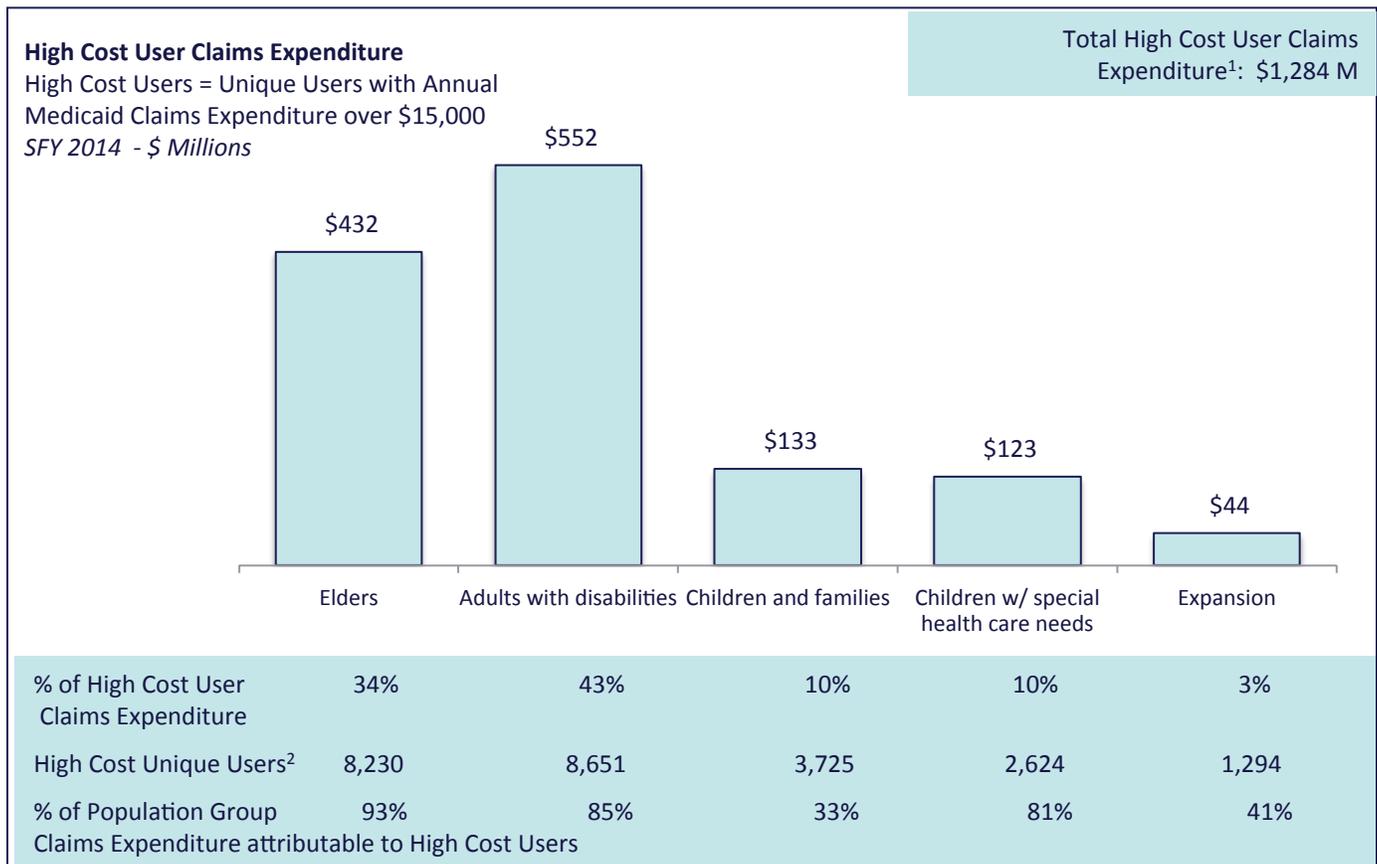
- ❖ Nursing facilities account for 28% of the claims expenditure for high cost users, and residential and rehabilitation services for persons with developmental disabilities account for another 17%.
- ❖ Hospital services account for another 23% of high cost user claims expenditure, including 15% for inpatient, 6% for outpatient, and 2% for Neonatal Intensive Care Unit (NICU) services.
- ❖ 98% of the claims expenditure for nursing facilities and 100% of the claims expenditure for Slater Hospital, Zambarano and Tavares is for high cost users. This is due to extended stays in institutions for users of those services.

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

²Percentages may not sum to 100% due to rounding error.

3c. High Utilizers: By Population

Elders and adults with disabilities account for 77% of claims expenditure for high cost users.



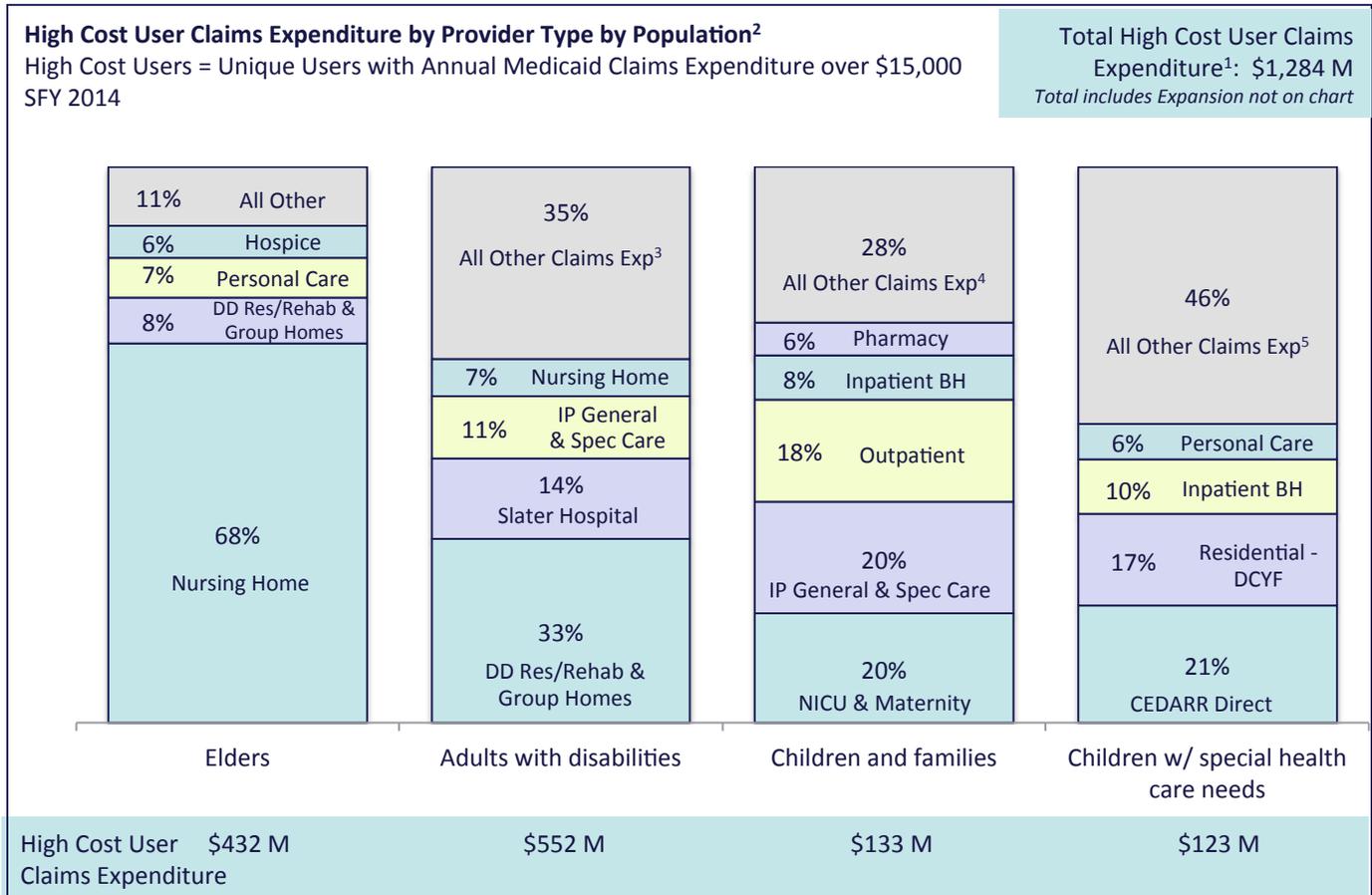
- ❖ High cost users are defined as unique users with over \$15,000 of Medicaid claims expenditure in SFY 2014.
- ❖ Elders account for 34% of claims expenditure for high cost users and have the highest proportion of claims expenditure for high cost users, with 93% of claims expenditure attributable to high cost users.
- ❖ Adults with disabilities account for 43% of high cost user claims expenditure, and 85% of adults with disabilities claims expenditure is attributable to high cost users.
- ❖ Children and families account for 10% of high cost user claims expenditure with 33% of claims expenditure attributable to high cost users. Children with special health care needs account for another 10% of claims expenditure and 81% of claims expenditure attributable to high cost users.
- ❖ The Expansion population accounted for 3% of high cost user claims expenditure.

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

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

3c. High Utilizers: By Population Detail

The services used by high cost users varies by population.



- ❖ The largest category of claims expenditure for high cost elders is nursing homes, accounting for 68% of claims expenditure on high cost elders.
- ❖ The largest category of expenditure for high cost adults with disabilities is residential and rehabilitation services for the developmentally disabled, accounting for 33% of claims expenditure for high cost adults with disabilities.
- ❖ For children and families, high cost user claims expenditure is mainly hospital-related. The largest category of claims expenditure for high cost users in this population is maternity and NICU services, accounting for 20% of claims expenditure. Another 20% is for hospital inpatient general and specialty care, and 8% is for inpatient behavioral health services.
- ❖ CEDARR Direct services account for 21% of high cost user claims expenditure for the high cost users in the children with special healthcare needs population. Residential DCYF services account for 17%.

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

²Expansion population not shown here due to limited claims experience during phased in enrollment.

³Other claims expenditure for adults with disabilities includes professional behavioral health, inpatient behavioral health, pharmacy, outpatient and other professional.

⁴Other claims expenditure for children and families is mainly professional services.

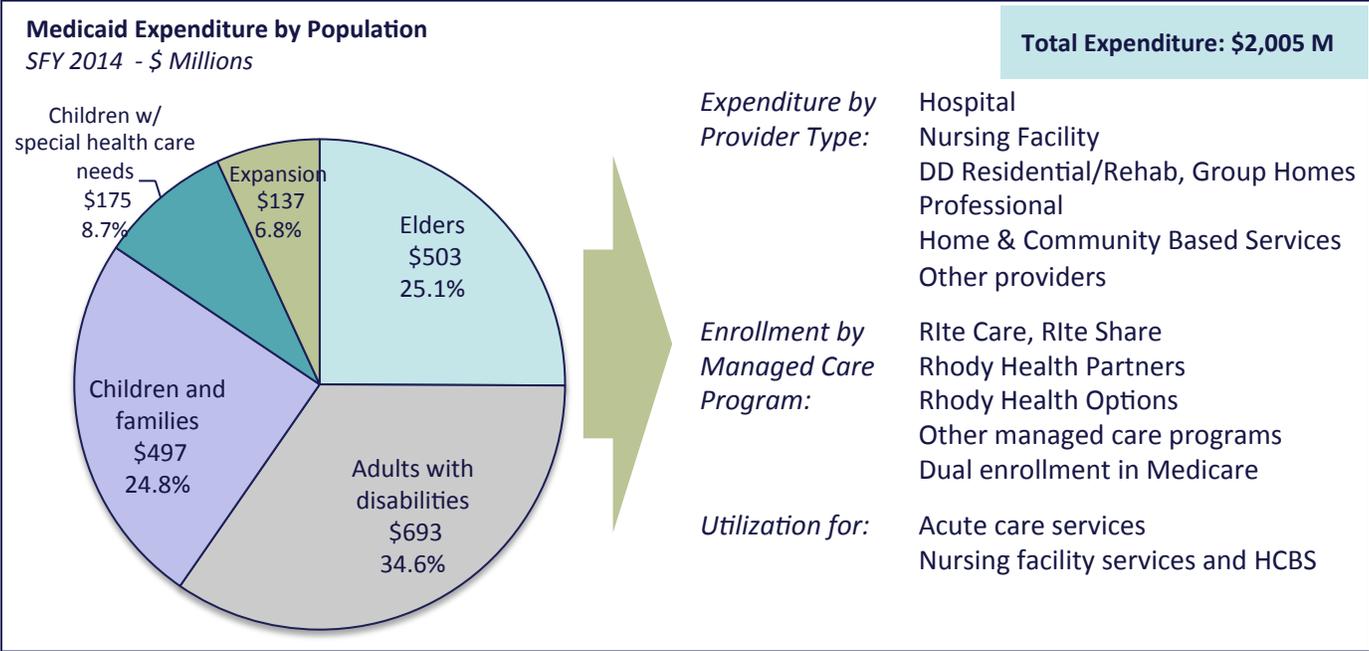
⁵Other claims expenditure for CSHCN includes other professional, other inpatient, outpatient, pharmacy, and Slater Hospital/Tavares.

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4. Expenditure Detail by Population

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

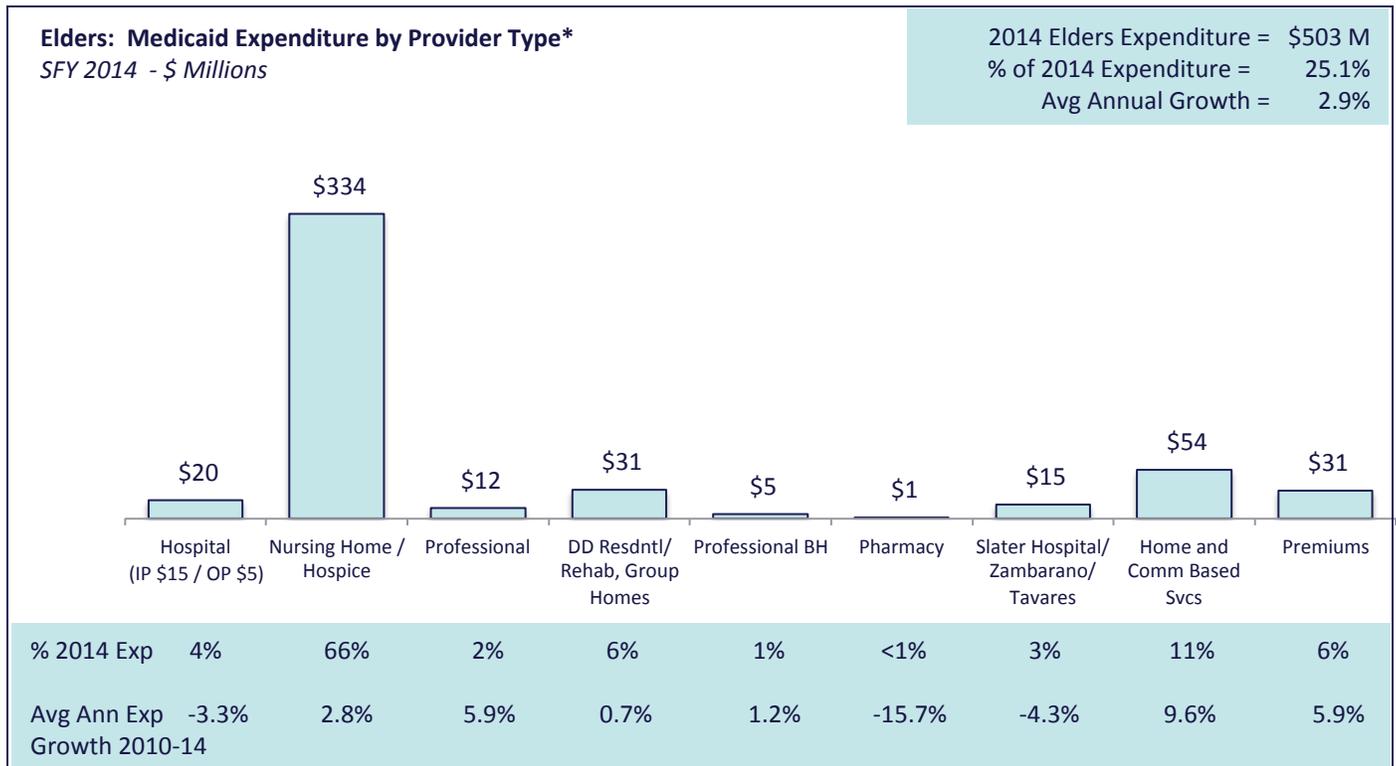


This section contains details on expenditures for each population group as follows:

- ❖ **Elders:**
 - ✓ Expenditure by provider type
 - ✓ Managed care enrollment by type of program, including dual enrollment in Medicare
 - ✓ Nursing facility and HCBS utilization
- ❖ **Adults with Disabilities:**
 - ✓ Expenditure by provider type
 - ✓ Managed care enrollment by type of program, including dual enrollment in Medicare
 - ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims
 - ✓ Nursing facility and HCBS utilization
- ❖ **Children and Families:**
 - ✓ Expenditure by provider type
 - ✓ Managed care enrollment by type of program
 - ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims
- ❖ **Children with Special Healthcare Needs:**
 - ✓ Expenditure by provider type
 - ✓ Managed care enrollment by type of program
 - ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims
- ❖ **Expansion**
 - ✓ Expenditure by provider type
 - ✓ Managed care enrollment by type of program
 - ✓ Acute care services utilization – hospital days and admissions, office visits, pharmacy claims

4a. Elders: Expenditure by Provider Type

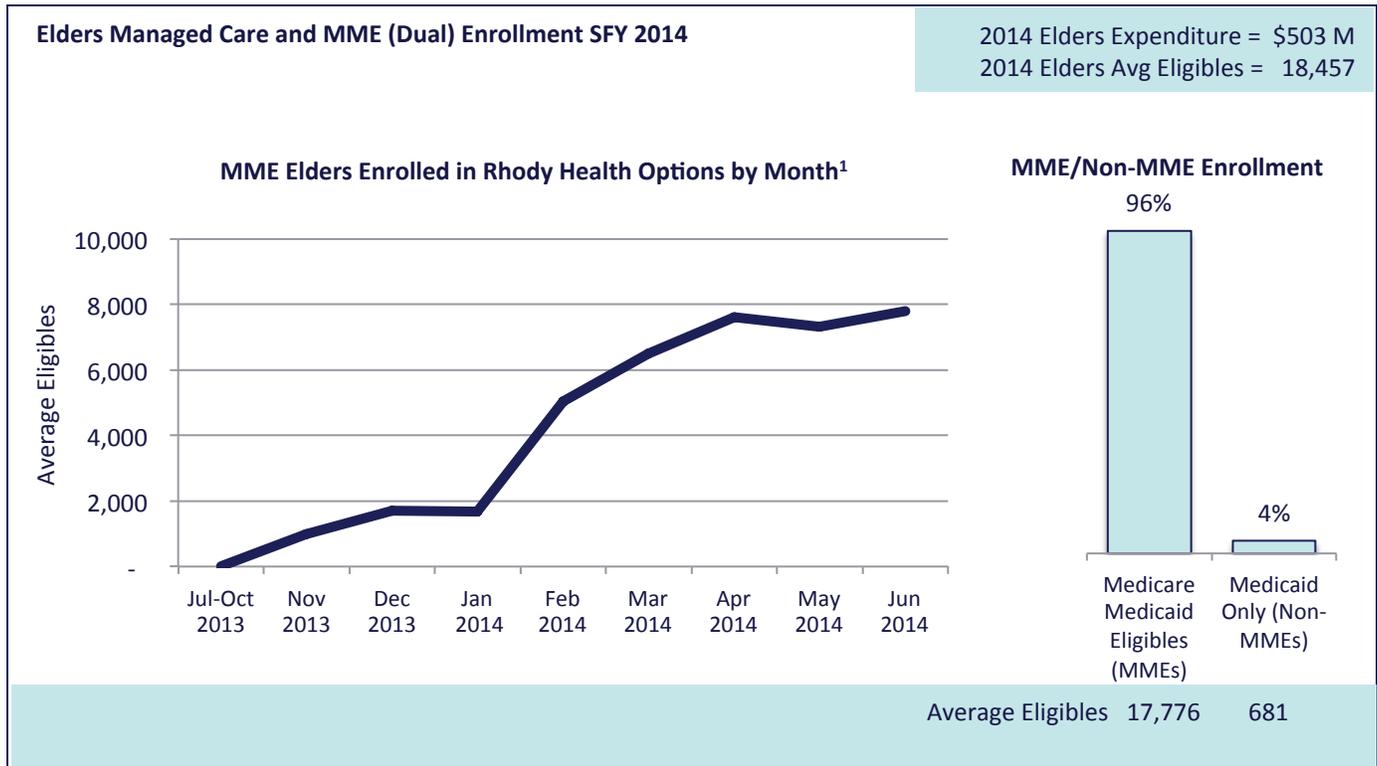
Nursing facilities account for approximately two thirds of total expenditure for elders.



- ❖ Medicaid expenditures on elders totaled \$503 million in SFY 2014 and have been increasing at 2.9% per year over the past 5 years. The large majority of elders are also eligible for Medicare, which was the primary payor for most medical services (e.g. hospital, physician); consequently those expenditures were not paid by Medicaid and are not included here.
- ❖ Nursing facilities (including nursing homes and hospice) account for nearly two-thirds (66%) of total Medicaid expenditure on elders. The increase in nursing facility expenditure has been slightly lower than the increase in overall expenditure for this population - an average annual increase of 2.8 percent per year.
- ❖ Most of the growth in Medicaid expenditure for elders has been in nursing facility services and home and community based services. The increase in home and community based services is due in part to an effort to invest in alternatives to institutional/nursing home care.

4a. Elders: Managed Care and Dual Enrollment

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

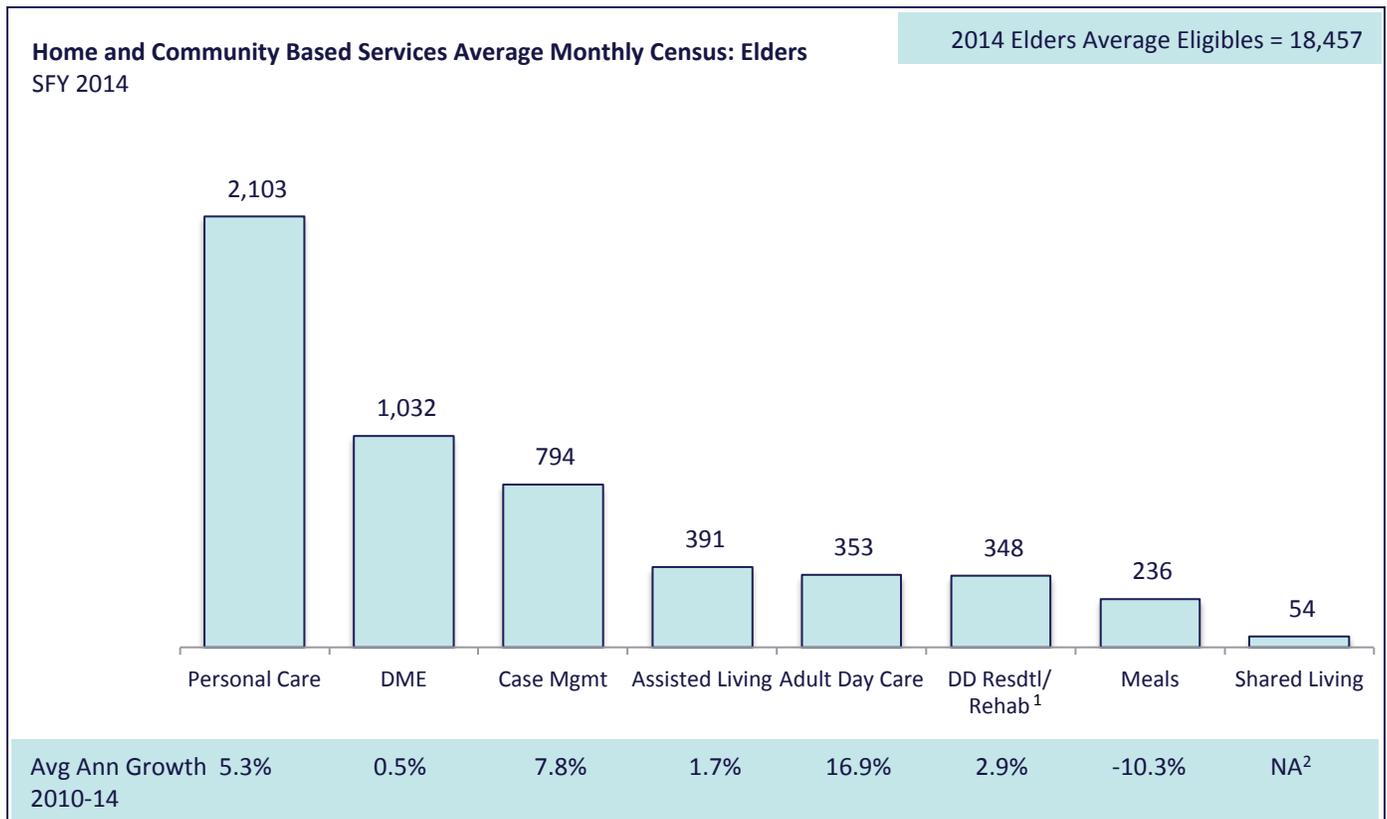


- ❖ Ninety-six percent of elders are covered by both Medicare and Medicaid (called MMEs or dual eligibles).
- ❖ For the elders who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, physician, pharmacy).
- ❖ Rhody Health Options is a new managed care program rolled out in SFY 2014 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports (LTSS), and other Medicaid-funded services to more fully meet the needs of people with both Medicaid and Medicare eligibility.
- ❖ RHO was rolled out in November 2013, and enrollment was phased in over the rest of SFY 2014. By the end of SFY 2014, 7,786 elders were enrolled in RHO.
- ❖ There are 1,016 elders who are enrolled in Connect Care Choice and Connect Care Choice Community Partners, primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

¹Chart does not include adults with disabilities population enrolled in RHO.

4a. Elders: HCBS Utilization

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



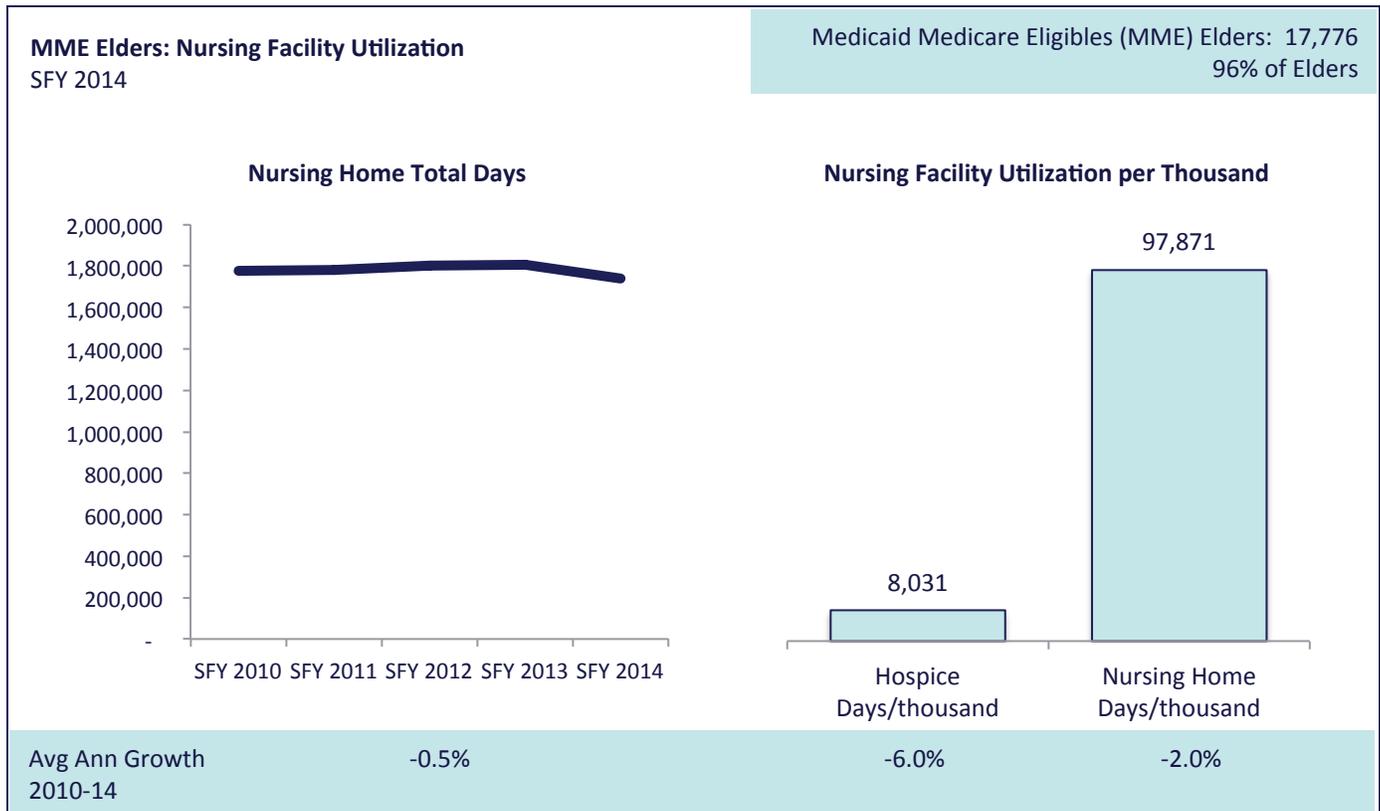
- ❖ The largest category of home and community based services (HCBS) is personal care services, with an average monthly census of 2,013 recipients in SFY 2014. The monthly census for elders for this category has increased at 5.3% per year since SFY 2010.
- ❖ The two categories with the highest increase in average monthly census are adult day care and case management, with average annual increases of 16.9% and 7.8% respectively.
- ❖ Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.

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

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

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

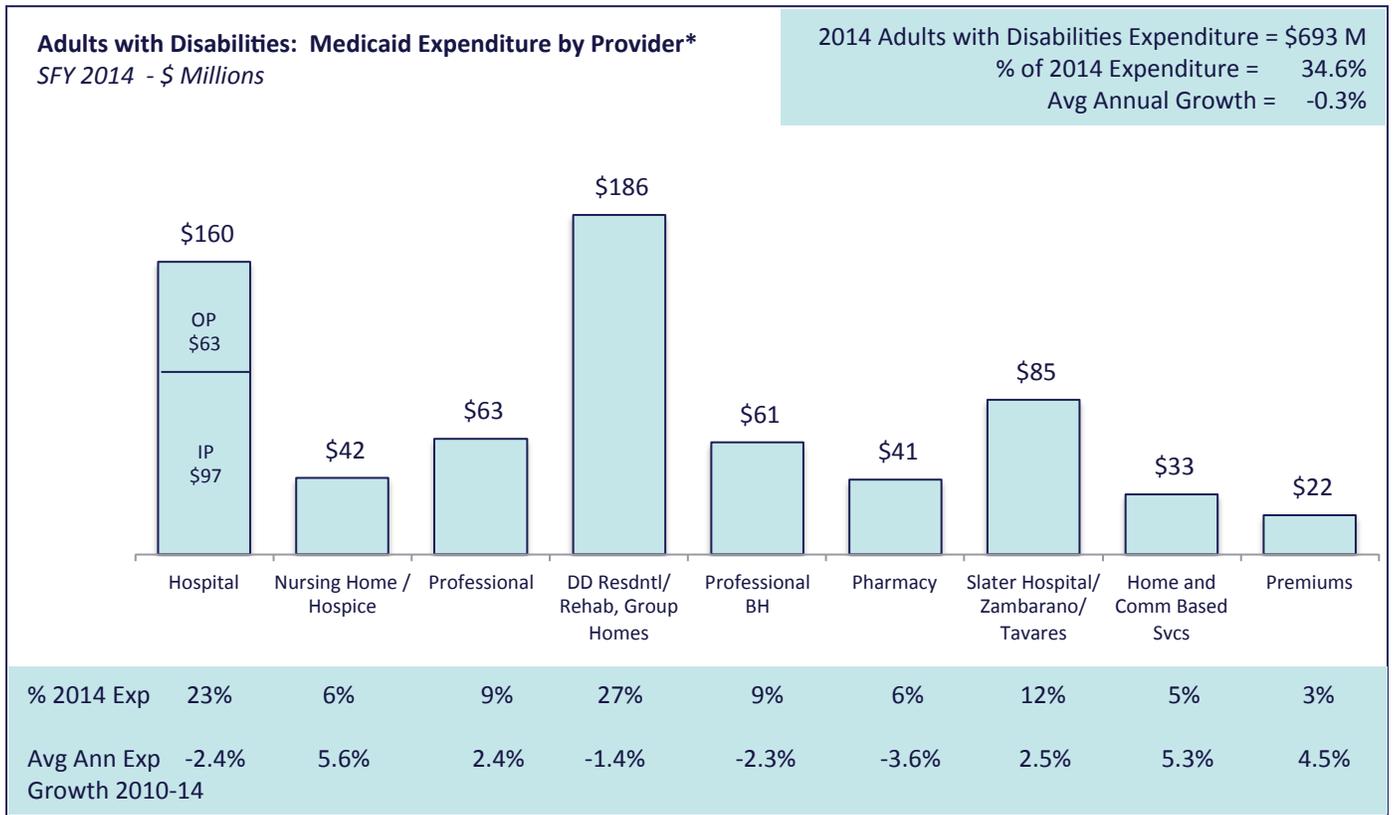
For MME Elders, nursing home days per thousand eligibles decreased 2.0% per year from SFY 2010 to 2014.



- ❖ Ninety-six percent of elders are Medicaid Medicare eligibles (MMEs, also called duals). For these elders covered by both Medicare and Medicaid, Medicare is the primary payer for the majority of acute and primary care services while Medicaid covers long term services and supports.
- ❖ Despite a growth in MME elders average eligibles over the last 5 years, the total nursing home days for this population has decreased by 0.5% per year on average.
- ❖ Nursing home days per thousand for MME elders were 97,981 in SFY 2014. This measure has decreased by an average annual rate of 2.0% since SFY 2010.
- ❖ Hospice days per thousand for MME elders have decreased at a rate of 6.0% on average per year over the last 5 years to 8,031 per thousand in SFY 2014.

4b. Adults with Disabilities: Expenditure by Provider Type

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

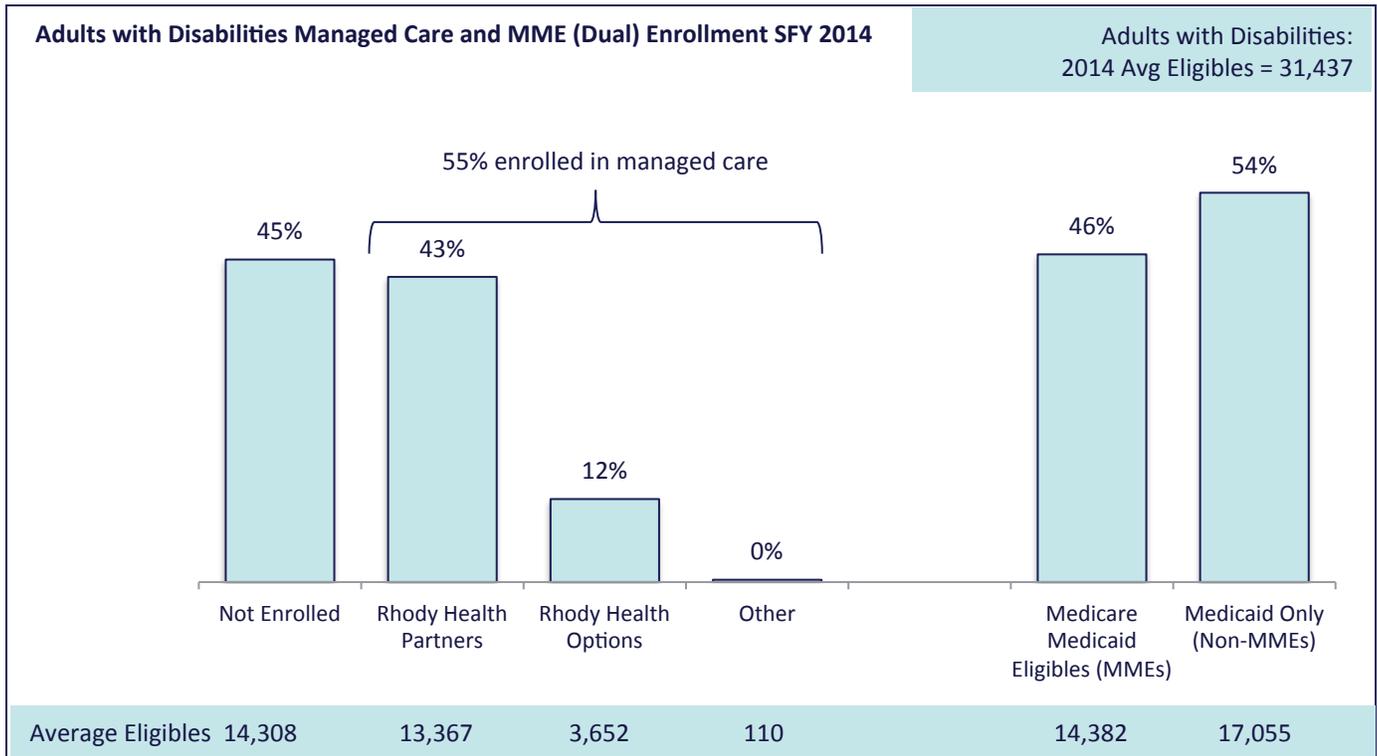


- ❖ Adults with disabilities account for the largest share of Medicaid expenditures, with total SFY 2014 expenditure of \$693 million. Expenditure for this population has decreased by approximately 0.3% per year over the past 5 years.
- ❖ Hospital and residential and rehabilitation services for persons with developmental disabilities are the two largest categories of expenditure for this population, accounting for 23% and 27%, respectively. However, expenditure in both these categories has been decreasing over the last 5 years – a decrease of 2.4% per year on average for hospital and a decrease of 1.4% per year on average for residential and rehabilitation services for persons with developmental disabilities.
- ❖ Similar to the elders population, the highest rate of growth in Medicaid expenditure for the adults with disabilities population has been for nursing facility services and home and community based services.

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

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

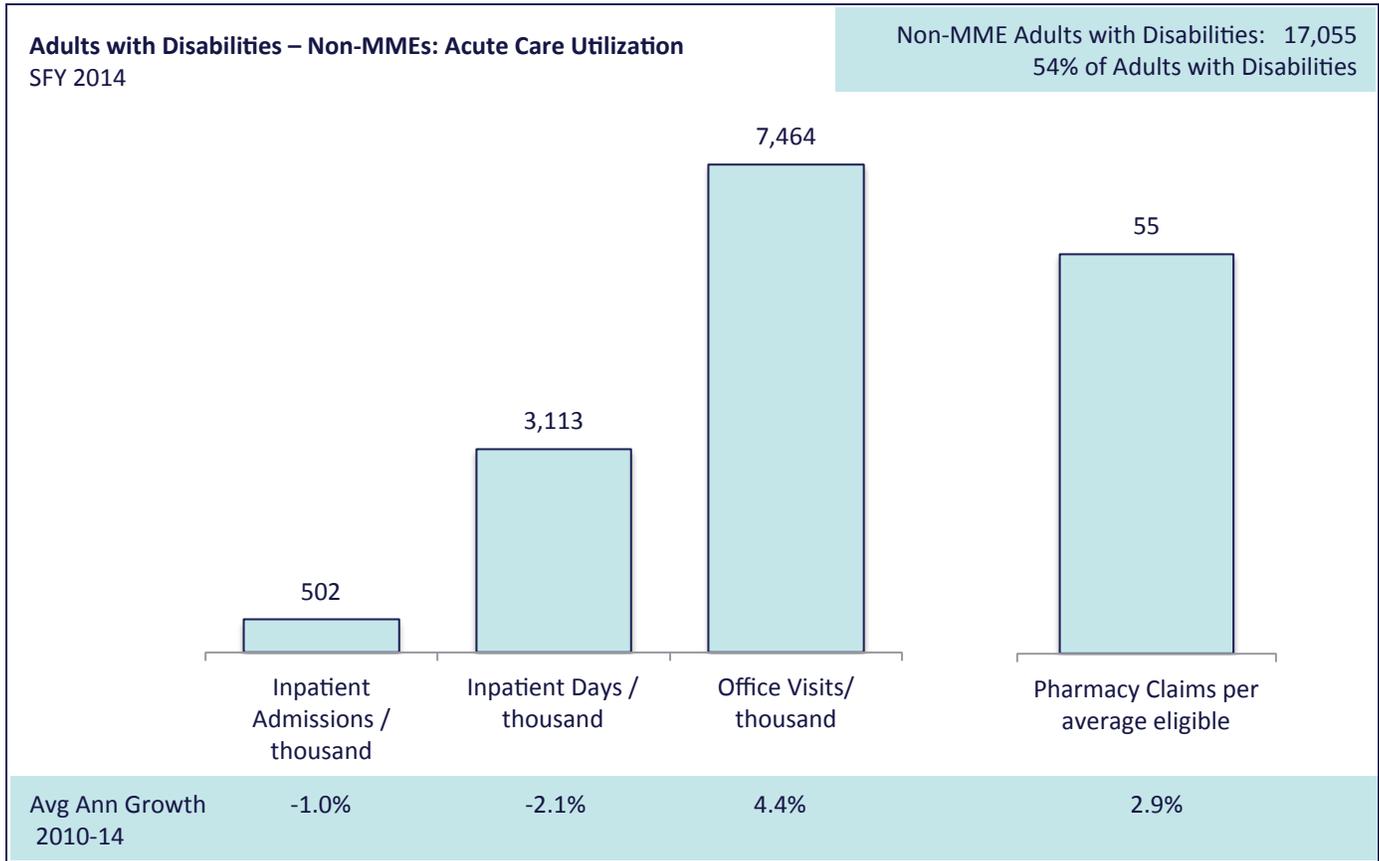
More than half of adults with disabilities are enrolled in managed care.



- ❖ Forty-six percent of adults with disabilities are covered by both Medicare and Medicaid (called MMEs or dual eligibles). For the adults with disabilities who are dually enrolled, Medicare is the primary payer for most acute and primary care services (e.g., hospital, physician, pharmacy).
- ❖ Adult populations had historically been served in fee-for-service Medicaid. However, over half of this population is now enrolled in managed care due to the introduction two programs to transition adults to managed care:
 - ❖ Rhody Health Partners (RHP) is a managed care program introduced in 2008.
 - ❖ Rhody Health Options is a new managed care program rolled out in November 2013 in conjunction with the Integrated Care Initiative. It is a fully capitated model for long term care, long term services and supports (LTSS), and other Medicaid-funded services designed for people with both Medicaid and Medicare eligibility. This chart shows the average eligible enrollment in RHO over the 12 month period of SFY 2014 as RHO was phased in. The enrollment as of the end of SFY 2014 was 9,147 adults with disabilities.
- ❖ In addition there are 1,995 adults with disabilities in the Not Enrolled category who are enrolled in Connect Care Choice and Connect Care Choice Community Partners, primary care case management programs (PCCM) where Medicaid pays providers for enhanced care management within the fee-for-service structure.

4b. Adults with Disabilities: Acute Care Utilization

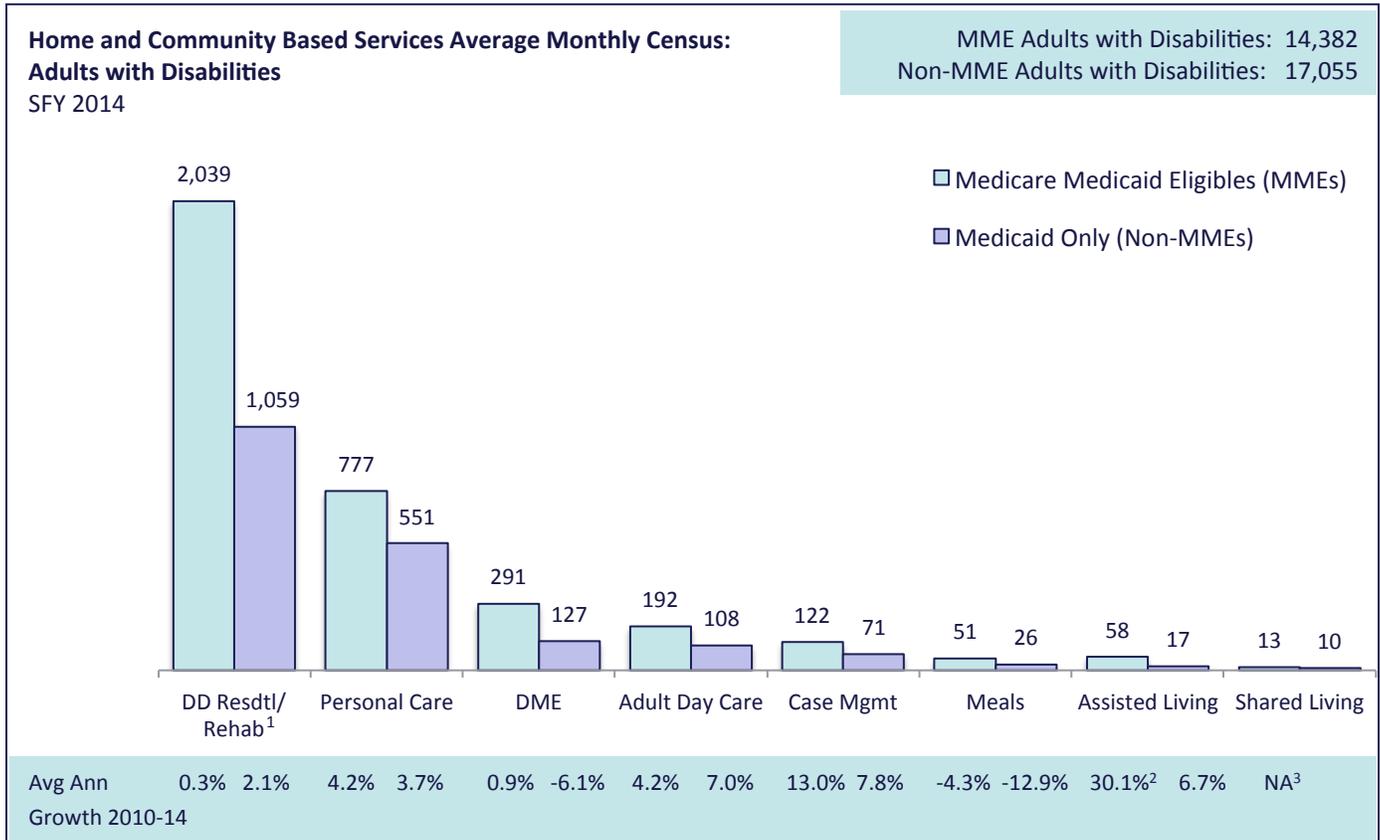
Both inpatient admissions and days per thousand have declined over the last 5 years for adults with disabilities with Medicaid-only coverage (non-MMEs).



- ❖ Forty-six percent of adults with disabilities are covered by both Medicare and Medicaid. For those dually enrolled eligibles, Medicare is the primary payer for the majority of acute and primary care services. Utilization shown here is for the 54% of adults with disabilities without Medicare coverage (Non-MMEs).
- ❖ Non-MME adults with disabilities averaged 7,464 office visits per thousand eligibles per year in SFY 2014, an increase of 4.4% per year on average in the last 5 years.
- ❖ Over the same period, inpatient admissions/thousand and inpatient days/thousand for this population have decreased at an annual rate of 1.0% and 2.1% respectively.
- ❖ Pharmacy claims for non-MME adults with disabilities are 55 per average eligible per year, and have been growing at a rate of 2.9% per year on average over the last 5 years.

4b. Adults with Disabilities: HCBS Utilization

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



- ❖ Forty-six percent of adults with disabilities are covered by both Medicare and Medicaid. Medicare is the primary payer for the majority of acute and primary care services.
- ❖ The largest category of home and community based services is residential and rehabilitation services for developmentally disabled individuals, with an average monthly census of 2,039 recipients in SFY 2014 for MMEs and 1,059 recipients for Non-MMEs.
- ❖ The second largest category is personal care services, with an average monthly census of 777 recipients in SFY 2014 for MMEs and 551 recipients for Non-MMEs. The monthly census for this category is growing at 4.2% per year on average for MMEs and at 3.7% per year on average for Non-MMEs.
- ❖ Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.

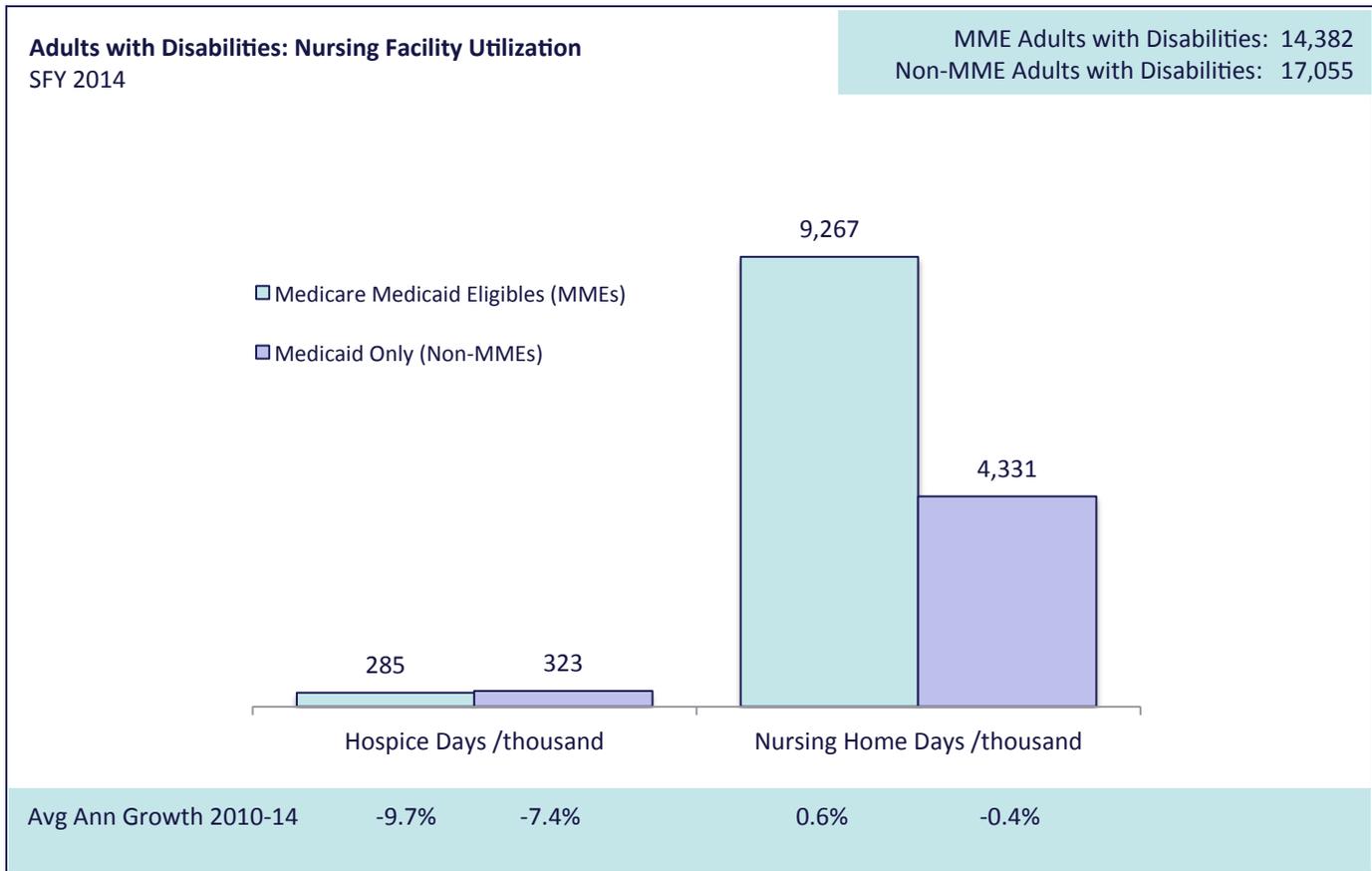
¹DD Resdtl/Rehab are residential and rehabilitation services for the developmentally disabled and include residential habilitative, day habilitative, adult day program, respite, home modifications and supported employment for those with developmental disabilities.

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

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

4b. Adults with Disabilities: Nursing Facility Utilization

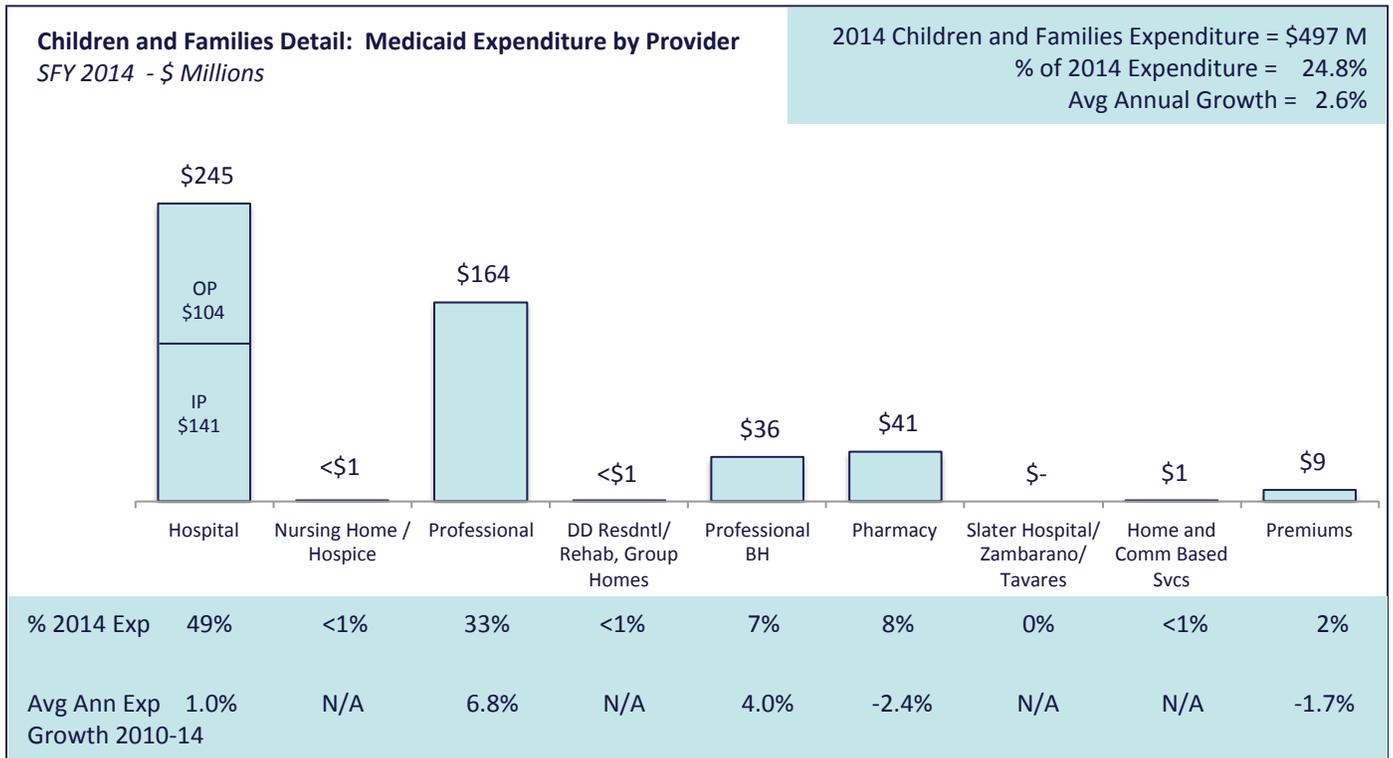
Nursing home days per thousand have increased less than 1% per year since SFY 2010 for MME adults with disabilities and have decreased since SFY 2010 for Non-MME adults with disabilities.



- ❖ Forty-six percent of adults with disabilities are covered by both Medicare and Medicaid (MMEs). Medicare is the primary payer for the majority of acute and primary care services. Long term services supports are primarily covered through Medicaid.
- ❖ For MME adults with disabilities, hospice days decreased 9.7% per year and nursing home days per thousand increased 0.6% per year on average since SFY 2010.
- ❖ Nursing home days per thousand for Non-MME adults with disabilities were 4,331 per thousand for SFY 2014, a decrease of 0.4% per year since SFY 2010.

4c. Children and Families: Expenditure by Provider

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



- ❖ Children and families account for one-fourth (24.8%) of total Medicaid expenditures, with SFY 2014 expenditure of \$497 million. Expenditure for this population has increased by 2.6% per year over the past 5 years.
- ❖ Most expenditure on children and families is divided between professional and hospital care, with hospital care accounting for nearly half (49%) of expenditure.
- ❖ A major component of expenditure relates to prenatal care and births. Annually, approximately 47% of Rhode Island’s births are covered through RItE Care.¹
- ❖ It is important to note that the federal match is enhanced for qualifying low income children and pregnant women under the CHIP program. CHIP is designed to build on Medicaid to provide insurance coverage to children and pregnant women from families with incomes up to 250 percent of the federal poverty level who are uninsured and not otherwise eligible for Medicaid. In SFY 2014, Rhode Island received a 65.28% combined CHIP/FMAP federal match on 21,618 CHIP children and pregnant women who are in families with incomes above mandatory coverage levels.

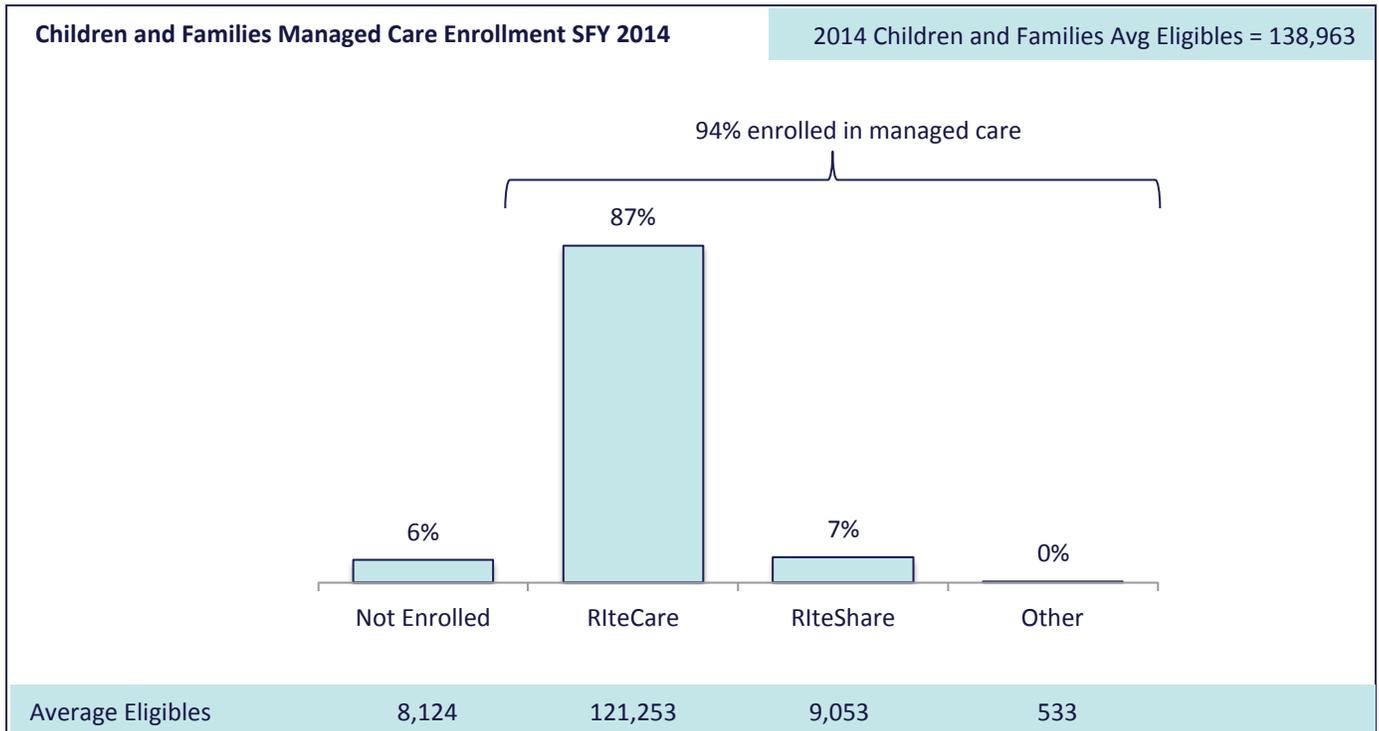
N/A indicates expenditure in this category too small to calculate a meaningful trend rate.

*See footnotes on page 21 for Provider Type definitions.

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

4c. Children and Families: Managed Care Enrollment

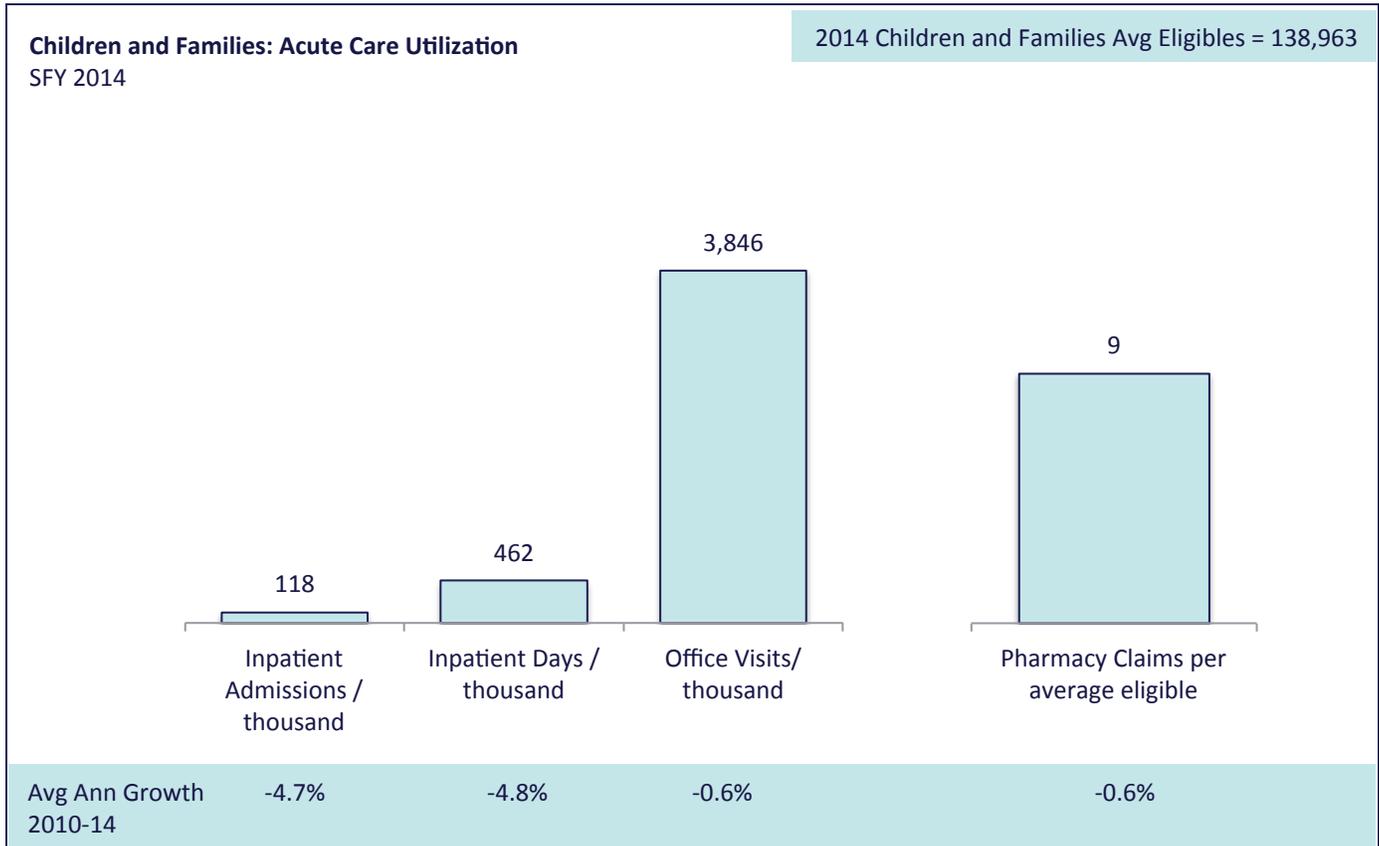
Nearly all children and families are enrolled in managed care.



- ❖ Eighty-seven percent of children and families are enrolled in a Medicaid managed care program through RIte Care. These enrollees are divided between Neighborhood Health Plan (NHP) and United Healthcare (UHC).
- ❖ RIte Share is a program designed to allow Medicaid eligibles with access to qualified employer-based insurance coverage to retain that commercial coverage by having Medicaid pay the employee's share of the premium. This minimizes Medicaid expenditure by leveraging the employer's contribution. In SFY 2014 there were 9,053 Medicaid eligible children and families enrolled in the RIte Share program.
- ❖ The unenrolled children and families include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

4c. Children and Families: Acute Care Utilization

For children and families, inpatient admissions and inpatient days per thousand have decreased about 5% per year on average since SFY 2010.

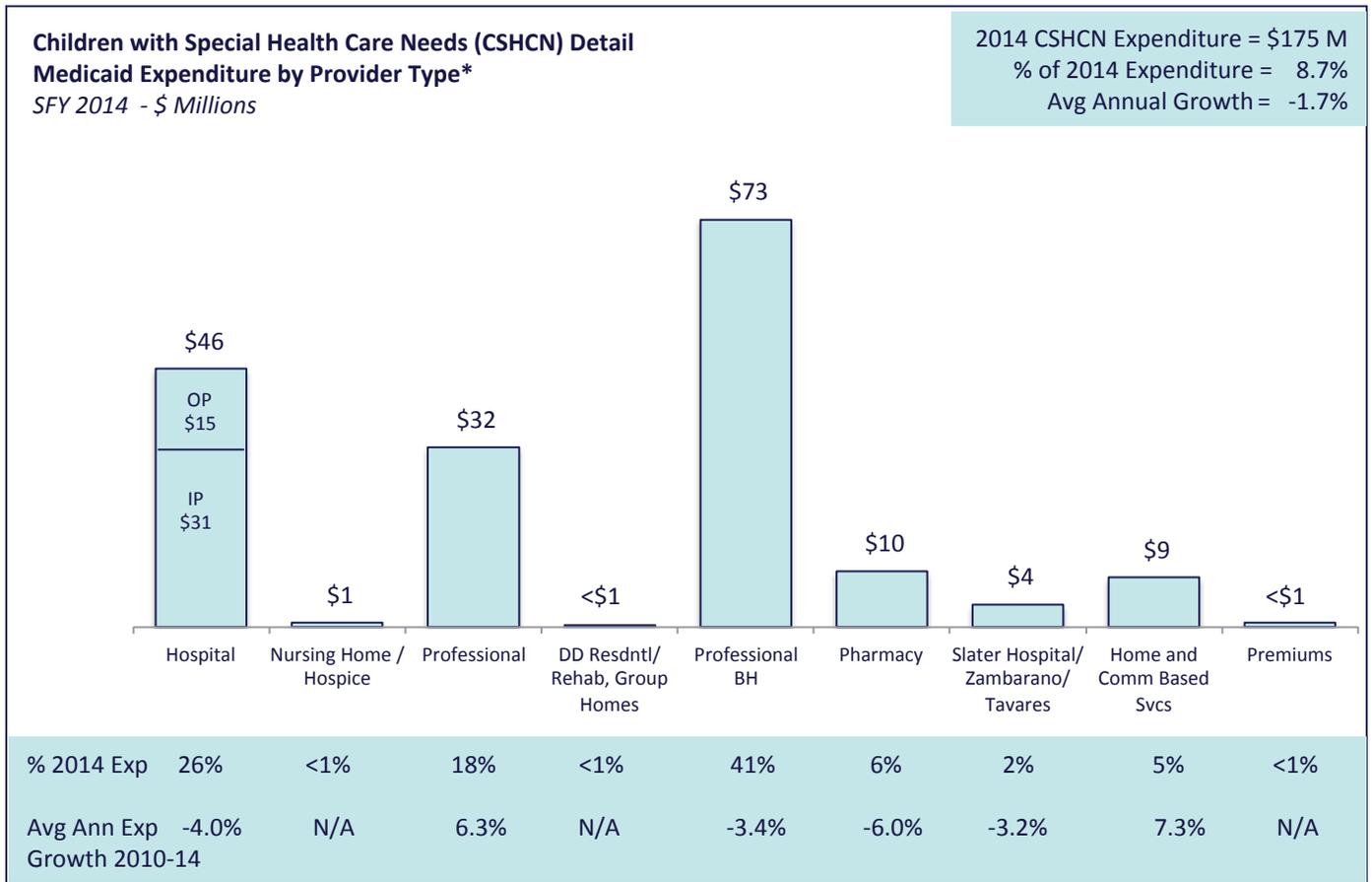


- ❖ For children and families, all acute care utilization measures have decreased since SFY 2010. Inpatient admissions per thousand and days per thousand have decreased about 5% per year on average since SFY 2010. Office visits per thousand and pharmacy claims per thousand have decreased at 0.6% per year on average.
- ❖ Pharmacy claims for children and families are 9 per average eligible per year and have decreased 0.6% per year on average over the last 5 years.
- ❖ About 66% of inpatient admissions and 57% of inpatient days are maternity related (including maternity, nursery and NICU). Annually, approximately 47% of all RI births are covered through RIte Care.¹

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

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

In the population of children with special health care needs, professional behavioral health accounts for 41% of all expenditure.

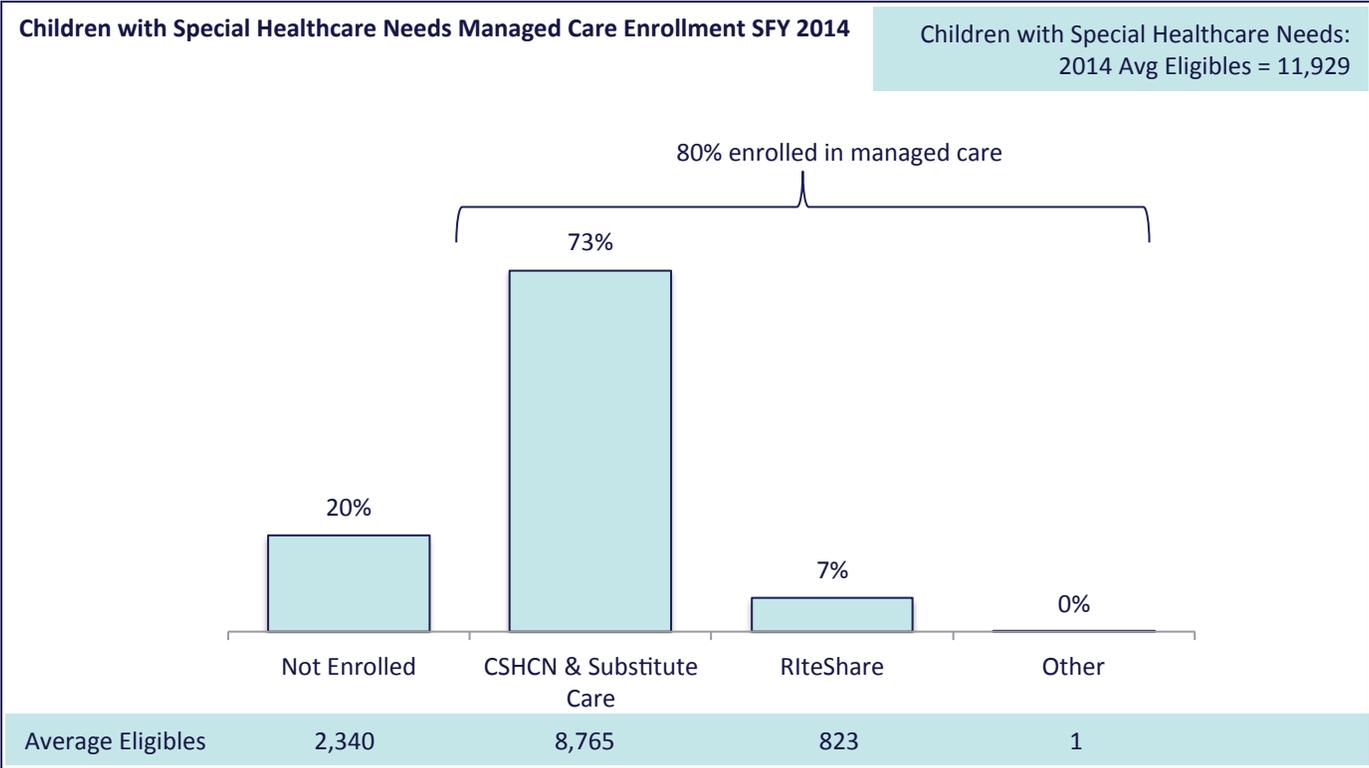


- ❖ Children with Special Health Care Needs (CSHCN) is a relatively small population -- accounting for nine percent of total Medicaid expenditures and five percent of enrollees, with total SFY 2014 expenditure of \$175 million.
- ❖ Expenditure for this population is dominated by professional behavioral health services, which account for \$73 Million in CSHCN expenditures (41%). Professional behavioral health services include CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation) and CEDARR Direct services, residential DCYF services, and professional mental health, substance abuse, and other services.

N/A indicates expenditure in this category too small to calculate a meaningful trend rate.
*See footnotes on page 21 for Provider Type definitions.

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

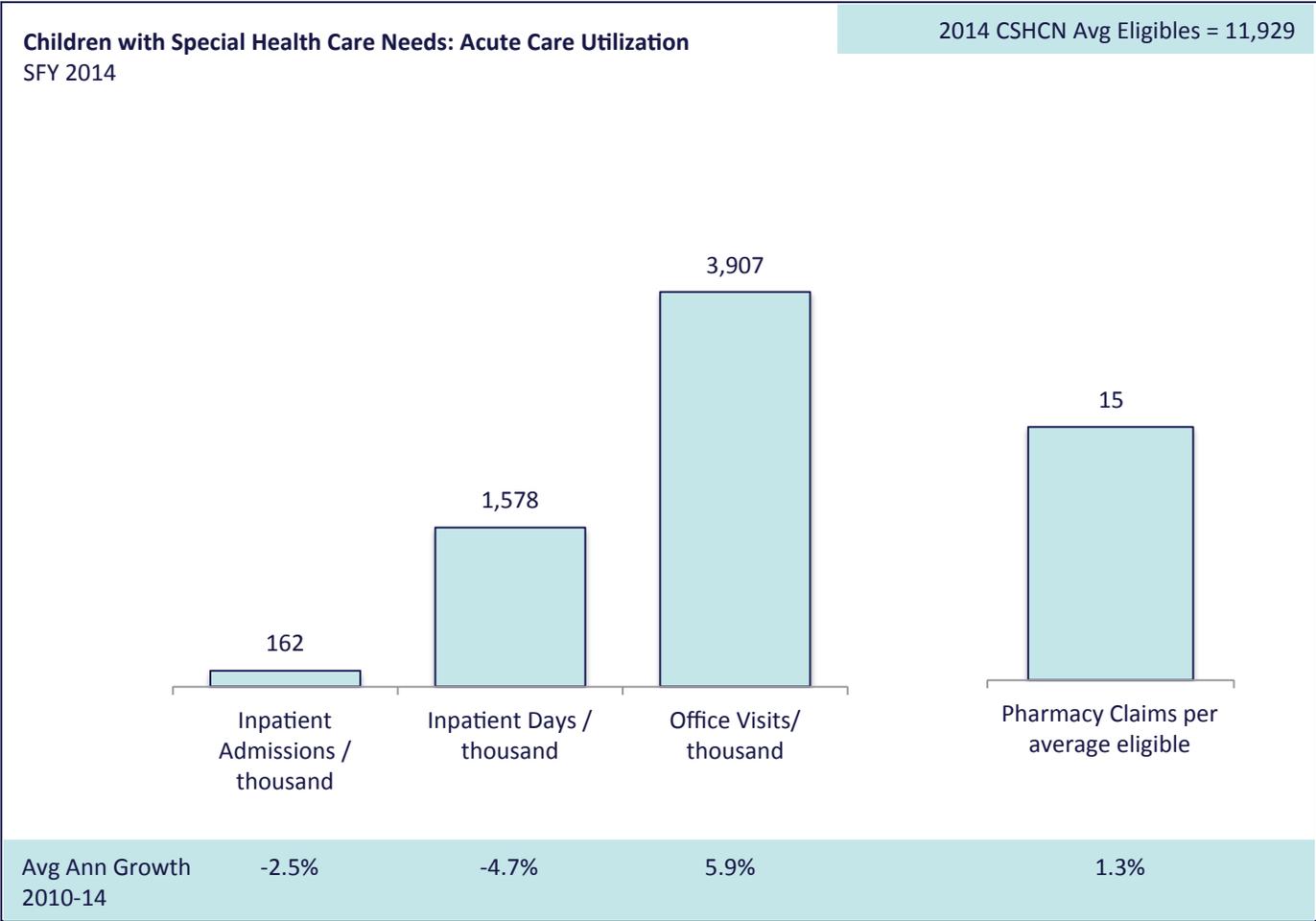
About 80% of children with special healthcare needs are enrolled in managed care.



- ❖ In 2008, enrollment in Medicaid managed care became mandatory for children with special health care needs (CSHCN) without other insurance. In SFY 2014 80% were enrolled in managed care.
- ❖ The unenrolled children with special healthcare needs include those with other insurance and new enrollees during the period prior to enrollment in a health plan.

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

For children with special health care needs, inpatient admissions and inpatient days per thousand have both decreased since SFY 2010.

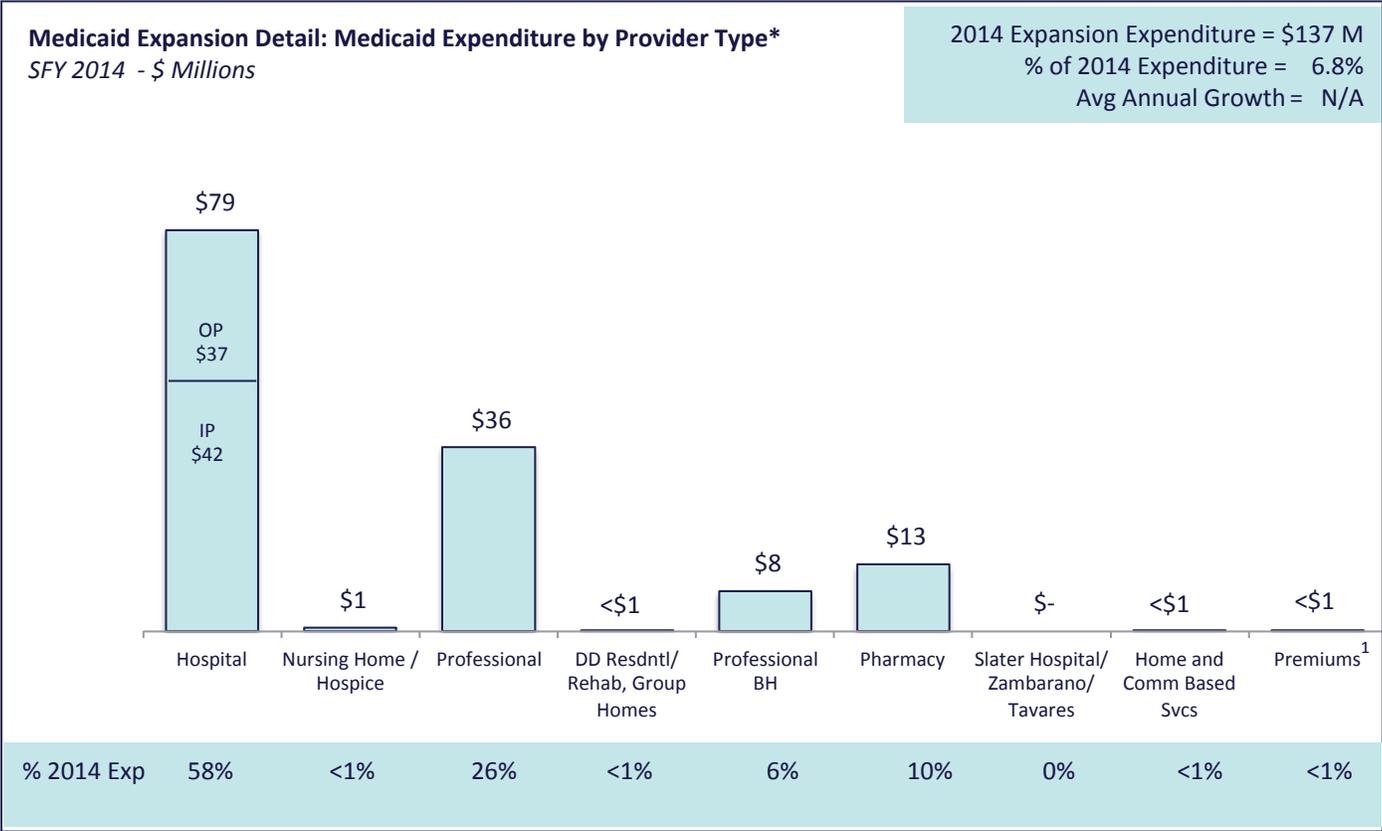


- ❖ Inpatient admissions per thousand have decreased over the last 5 years at an average rate of 2.5% per year to 162 per thousand in SFY 2014.
- ❖ Office visits per thousand have increased at an average rate of 5.9% per year since SFY 2010 to 3,907 visits per thousand in SFY 2014.
- ❖ More than half (58%) of inpatient admissions per thousand are for behavioral health. In terms of inpatient days, 75% are related to behavioral health.¹
- ❖ Pharmacy claims per average eligible have increased at 1.3% per year over the last 5 years.

¹Includes admissions and days in the Children’s Residential and Family Treatment (CRAFT) program at Bradley Hospital.

4e. Medicaid Expansion: Expenditure by Provider

The Expansion population mainly utilized hospital and professional services during their first 6 months of eligibility.



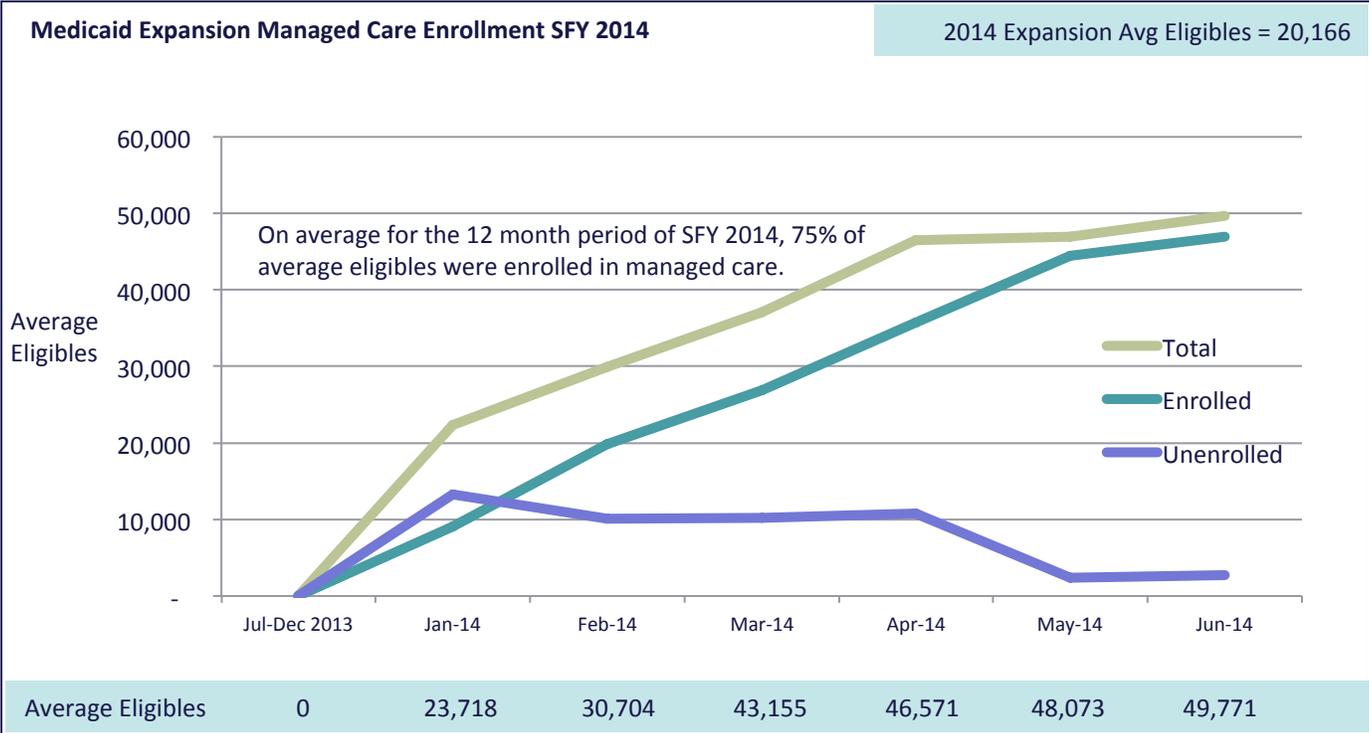
- ❖ The Expansion population accounted for \$137 million in expenditure in SFY 2014, 7% of total Medicaid expenditure.
- ❖ The two largest provider types for the Expansion population are hospital and professional services, accounting for 84% of expenditure.
- ❖ The population used almost no long term services and supports. However this population was only newly eligible for Medicaid starting January 1, 2014.

*See footnotes on page 21 for Provider Type definitions.

¹Amount is for RIte Share premiums

4e. Medicaid Expansion: Managed Care Enrollment

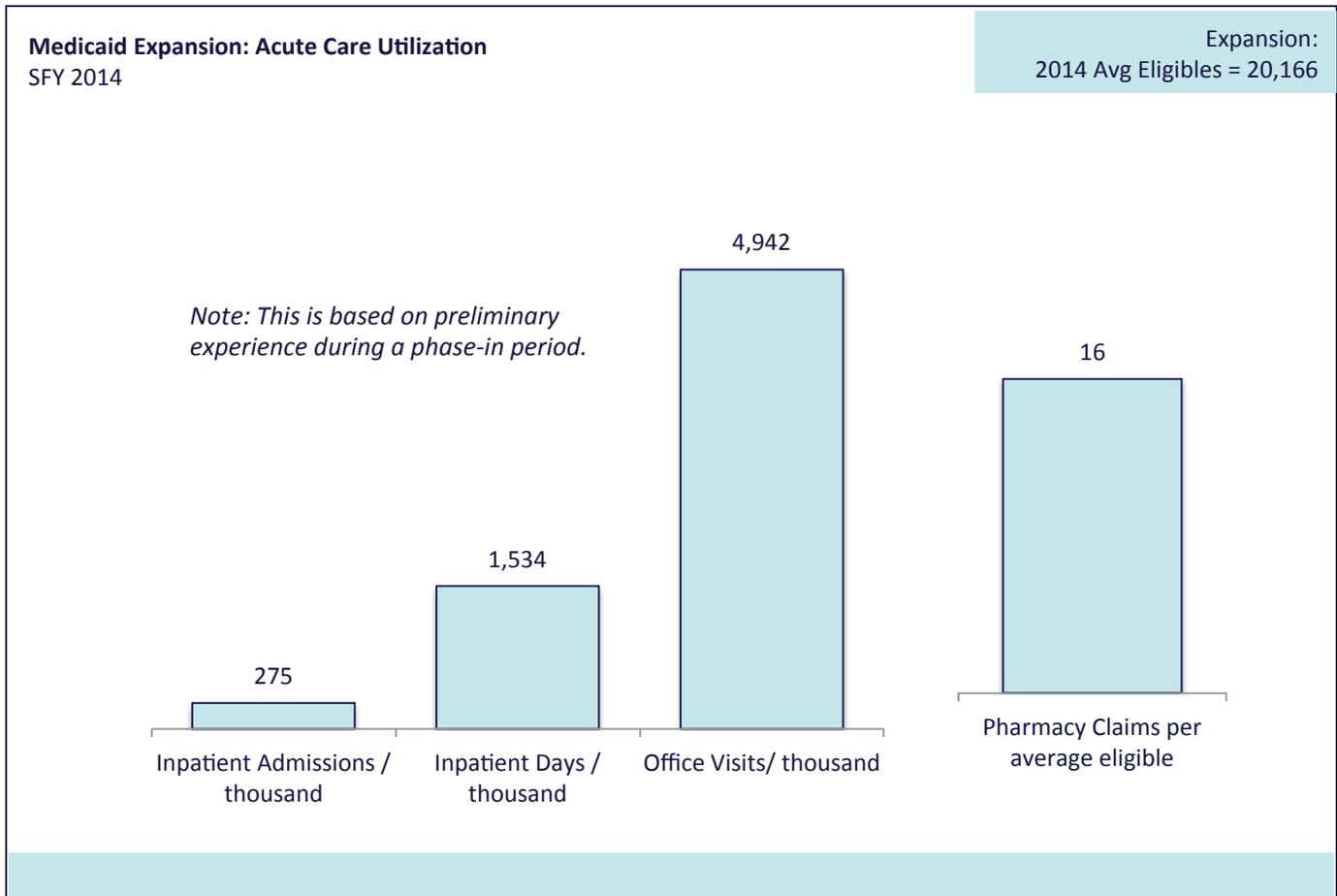
The Expansion population is mainly enrolled in managed care programs. The unenrolled average eligibles are a function of enrollment phase-in.



- ❖ The Medicaid Expansion population is expected to entirely enroll in managed care. Expansion eligibility commenced halfway through the state fiscal year, and enrollment phased in over the next 6 months and continued into SFY 2015. Therefore there are some months of eligibility for new enrollees prior to enrollment in a health plan.
- ❖ On average for the 12 month period of SFY 2014, 75% of average eligibles in the Expansion population were enrolled in managed care. One average eligible represents 12 months of eligibility. Because Expansion eligibles did not enroll until January 1, 2014, they had at most 6 months of eligibility.
- ❖ The proportion of enrolled eligibles increased as enrollment was phased in. As of the end of SFY 2014, there were 49,771 eligibles in the Expansion population and 94% of them were enrolled in managed care.

4e. Medicaid Expansion: Acute Care Utilization

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



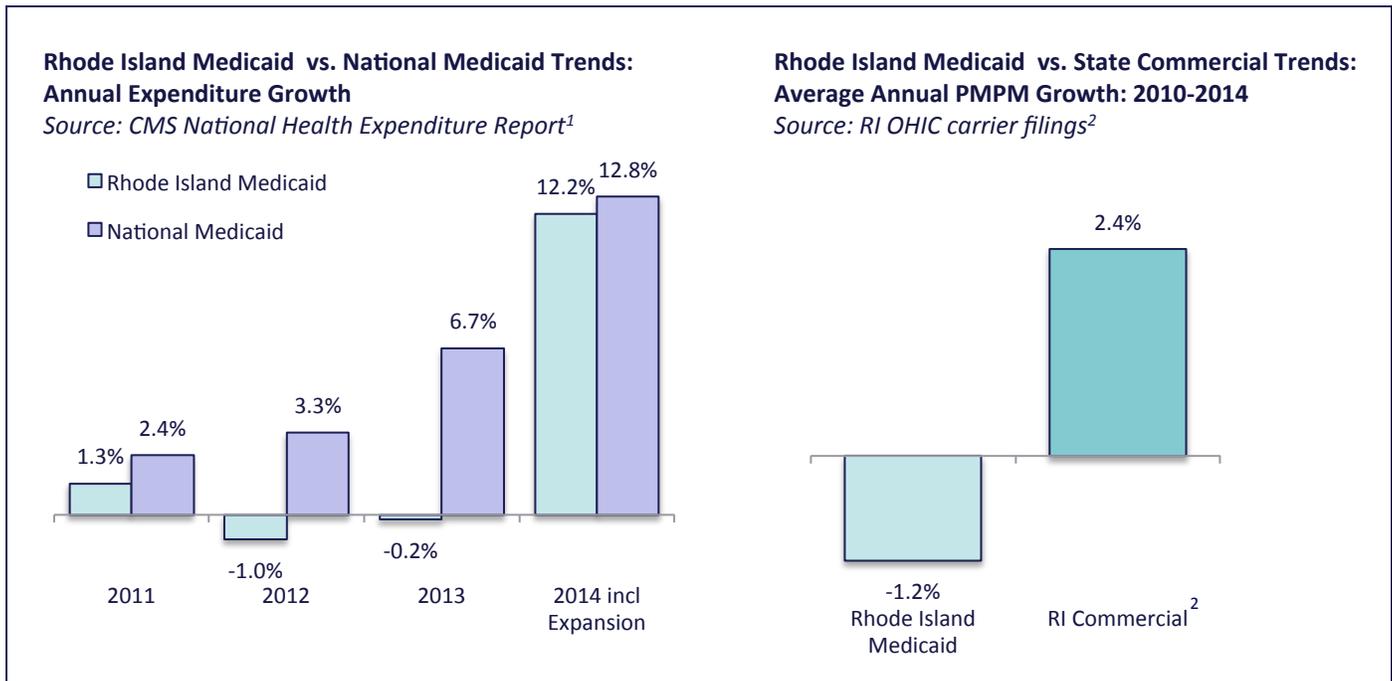
- ❖ The Medicaid Expansion population had 275 inpatient admissions per thousand and 1,534 inpatient days per thousand during SFY 2014.
- ❖ In addition this population had 16 pharmacy claims per 12 months of eligibility.
- ❖ Utilization statistics in terms of average eligibles reflects the experience during a six month period when the population was enrolling. Utilization in the future may be different from what is shown here.

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

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



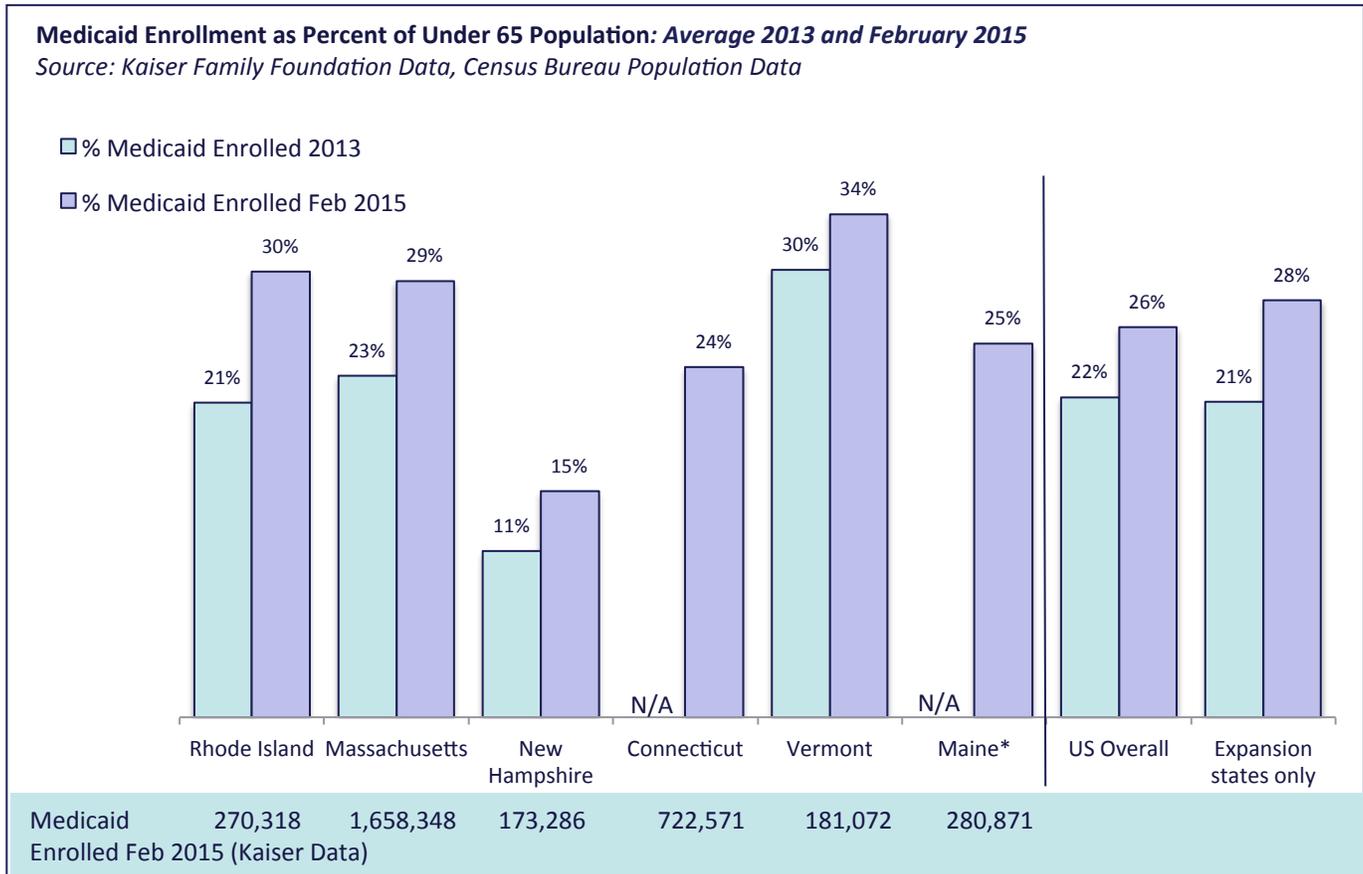
- ❖ Overall state expenditure growth compares very favorably to Centers for Medicare & Medicaid Services (CMS) national Medicaid expenditure trend for the years 2011 through 2014.
- ❖ Including the Expansion population, RI Medicaid growth rate was 12.2% from 2013 to 2014. National projected Medicaid growth for the similar timeframe was 12.8%. That 12.8% national measure included projections that not all states would expand Medicaid and would presumably be higher if all states nationwide expanded Medicaid eligibility under ACA.
- ❖ Rhode Island Medicaid PMPM (per member per month) cost trends excluding Expansion compare favorably to local commercial benchmarks. Between SFY 2010 and 2014, the state Medicaid program experienced a decrease in average annual PMPM cost of 1.2% per year. The average annual commercial medical PMPM cost for RI commercial health plans over a similar period increased 2.4% per year.
- ❖ The RI commercial benchmark may underestimate PMPM growth because it only includes total incurred claims reported by the carriers, not any out of pocket costs borne by members. Medicaid plans generally have very low, if any, out of pocket costs for members.

¹National growth rates in FFY. Source: 2013 CMS National Health Expenditure Report. 2013 and 2014 data are projections.

²Incurred claims per member per month, includes both small group and large group claims from Blue Cross Blue Shield RI, United Healthcare of New England and Tufts Health Plan. Source: Office of the Health Insurance Commissioner (OHIC), 2015 carrier rate filings. Data in CY.

5a. National Medicaid Trends: Medicaid Enrolled Population

According to Kaiser Family Foundation data, Rhode Island's Medicaid enrollment is 30% of under 65 population compared to an average of 28% across all 30 states that expanded Medicaid under ACA.



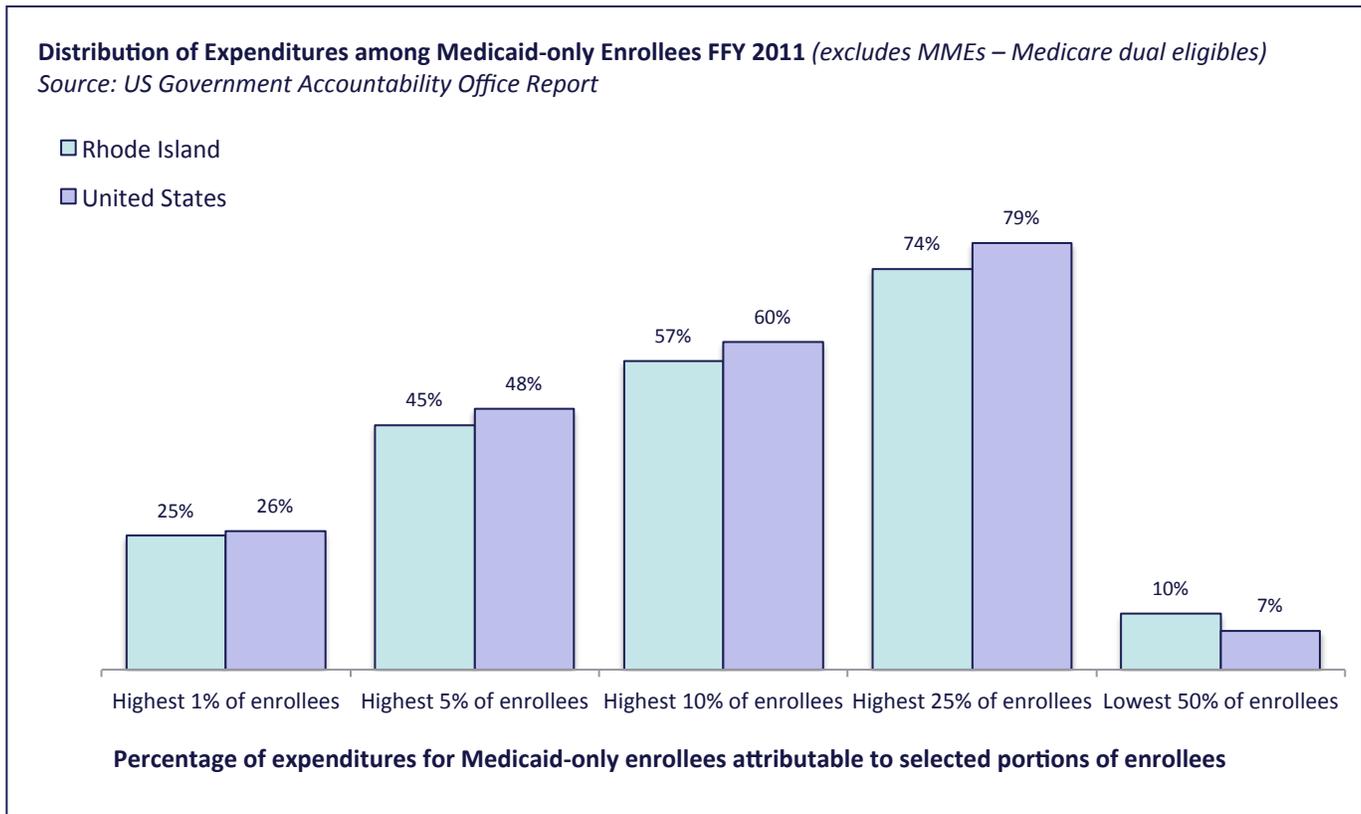
- ❖ The Kaiser Family Foundation compiled Medicaid enrollment data for all states for the period July to September 2013 and for February 2015. The Kaiser data was converted for the purposes of this chart to percent of population under 65 for each state using data from the US Census Bureau.
- ❖ According to these sources, Rhode Island Medicaid enrollment as a percent of under 65 population was 21% on average during 2013 and increased to 30% by February of 2015.
- ❖ Massachusetts has seen a similar increase in percent of under 65 population enrolled in Medicaid.
- ❖ Nationally, states that expanded Medicaid have seen an increase of enrolled population from 21% on average prior to expansion up to 28% on average by February 2015.

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

Source: Total Monthly Medicaid and CHIP Enrollment, Average July to September 2013 and February 2015. Kaiser Family Foundation dataset. Population data from US Census Bureau, 2010.

5b. Cost/Utilization Benchmarks: Distribution of Expenditures

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



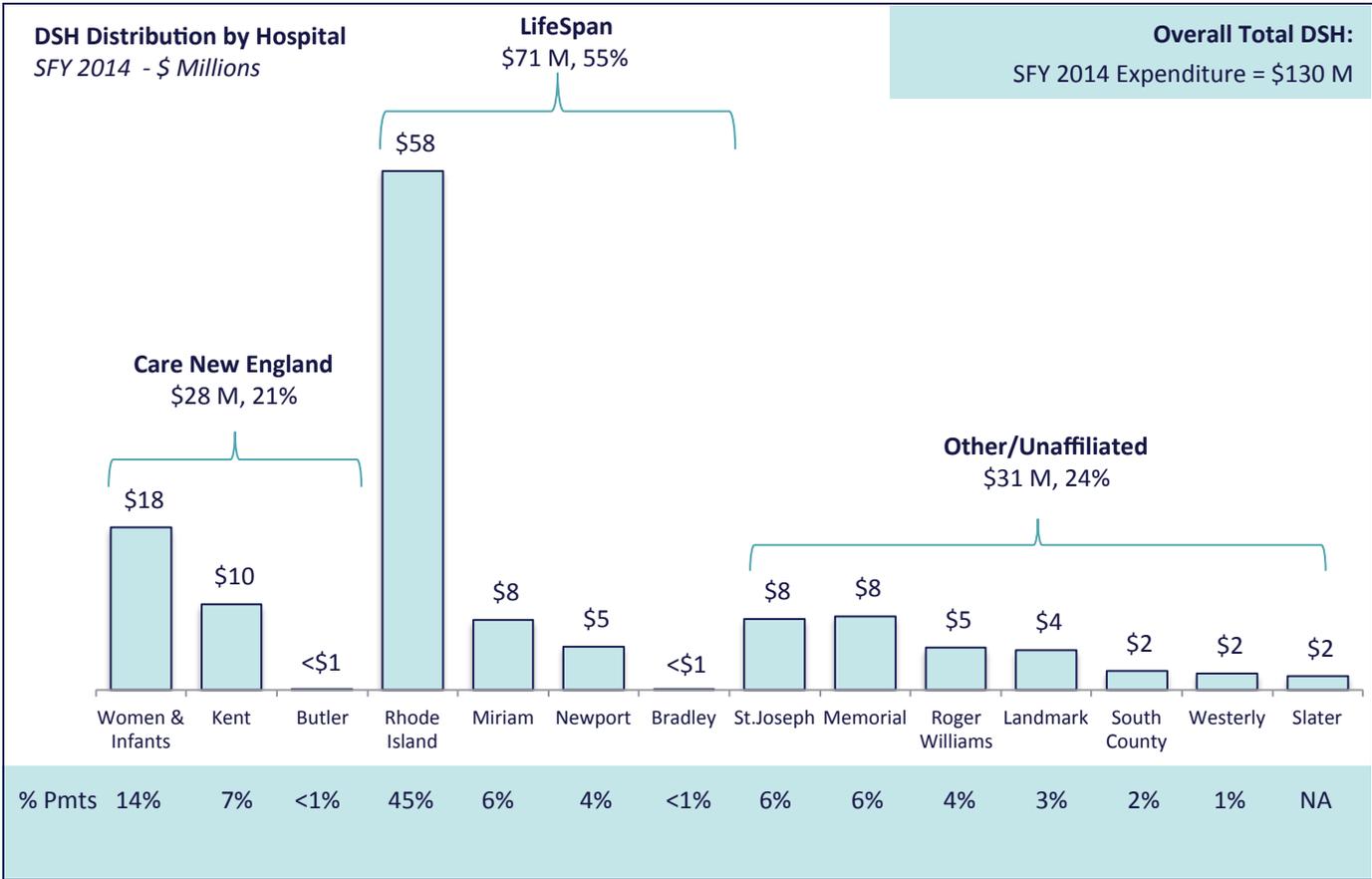
- ❖ Both nationwide and in Rhode Island, the top 1% of Medicaid enrollees account for about one-quarter of total Medicaid expenditure. Top top 5% of enrollees account for nearly half.
- ❖ On the other end of the spectrum, the lowest 50% of enrollees account for 10% of Medicaid expenditure in Rhode Island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

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

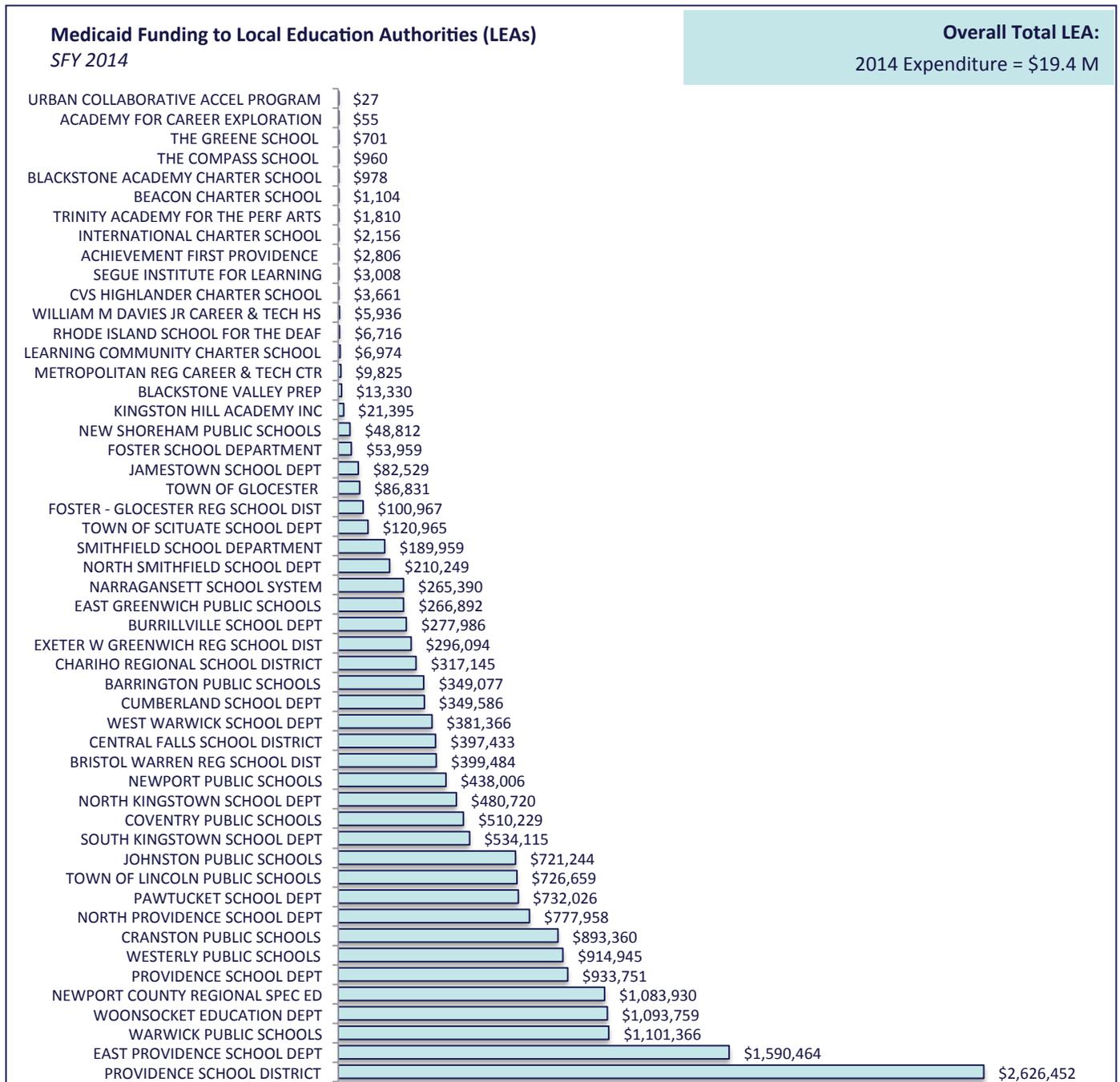
Disproportionate share (DSH) Medicaid payments are intended to subsidize the cost of providing care to indigent and very low income people.



- ❖ A total of \$130 million in DSH funds was paid out to hospitals in SFY 2014.
- ❖ The state’s two largest hospitals – Rhode Island and Women and Infants – together accounted for 59% of total DSH payments
- ❖ DSH payments are not included in the Medicaid expenditure analysis in this report.

6a. Exclusions: (2) Local Education Authorities

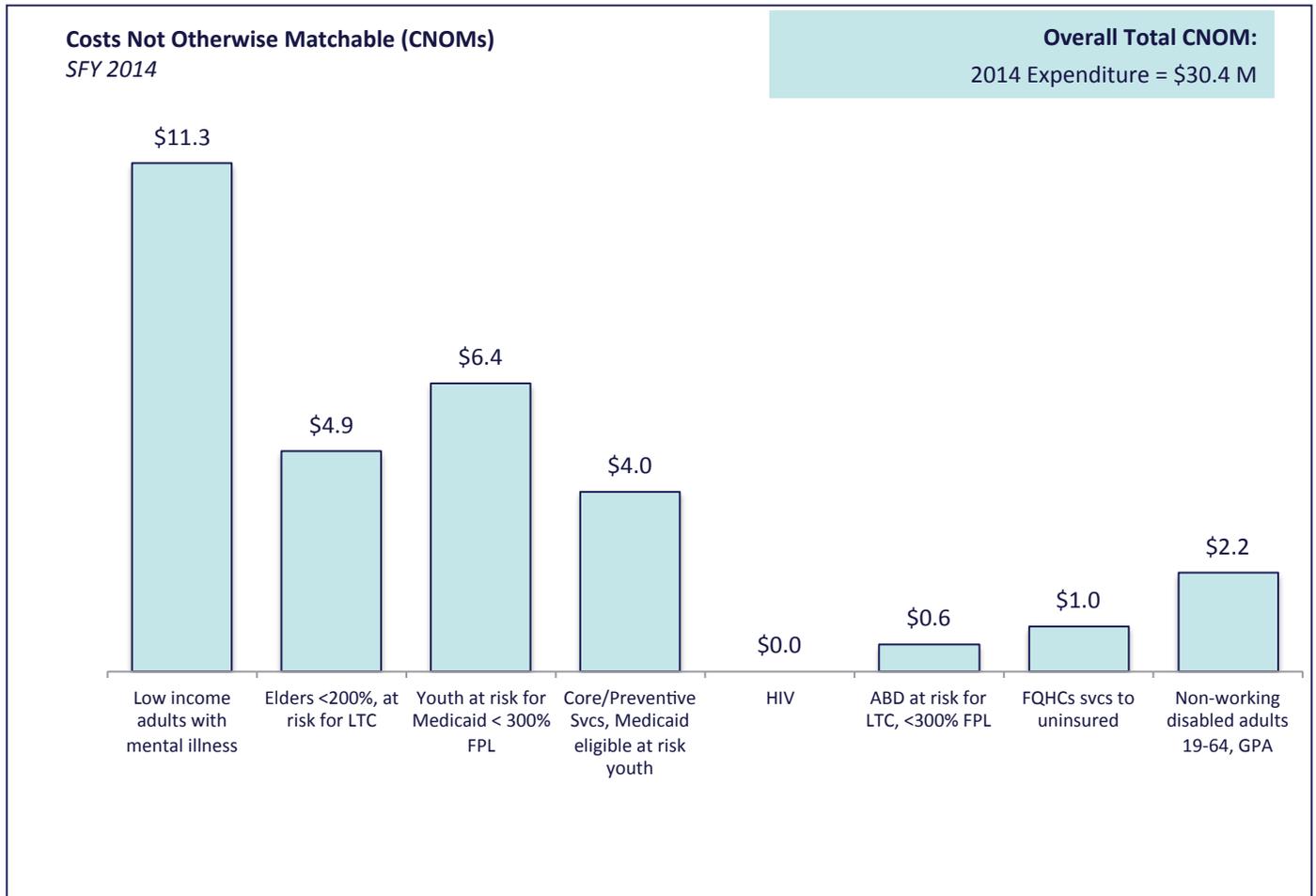
Local Education Authorities (LEAs) account for \$20 million in total expenditures in 51 school districts.



- ❖ 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.

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

Costs Not Otherwise Matchable (CNOMs) account for \$30 million in total expenditures.



❖ CNOM expenditures are not included in the Medicaid expenditure analysis in this report.

6b. Acronyms and Abbreviations

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

6c. Sources and Notes

Source Data and Analytic Method

This report is based on SFY 2014 and a five year historical Rhode Island Medicaid claims extract:

- ❖ Includes claims, capitation payments, premiums and provider payouts.
- ❖ Reflects data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through November 2014
- ❖ Capitations, premiums and payouts are proportionately allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information with IBNR.

Variance to Other Reports

The purpose of this report is to provide a comprehensive overview of state Medicaid expenditures to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process. Expenditure amounts used in this report may vary from expenditures reported for financial reconciliation or other purposes. Reasons for any variance might include factors such as claim completion, rounding and allocation of non-claims based expenditures.