

Rhode Island Annual Medicaid Expenditure Report

Executive Office of Health and Human Services

June 2012

Medicaid Annual Expenditure Report

Statutory Mandate

R.I.G.L.42-7.2-5(d), the authorizing statute for the Executive Office of Health and Human Services (EOHHS), requests 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 the health and 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.

Executive Summary (page 1 of 3)

Overview

During SFY 2011 Rhode Island's Medicaid program served approximately 224,000 Rhode Islanders. Twenty-one percent of Rhode Island's population were enrolled in Medicaid for some part of SFY 2011. Program expenditures for SFY 2011 totaled approximately \$1,824 million. Medicaid expenditure is divided among several state agencies, with \$1,375 million of total expenditure managed in SFY 2011 by the Department of Human Services (DHS), and \$393 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 (52.5%). However, the Federal Stimulus package increased the federal share substantially, to 63.89% beginning October 1, 2008, and ending December 31, 2010. Although the stimulus was phased out during this state fiscal year, this one time adjustment saved approximately \$171 million in state expenditures in SFY 2011. In SFY 2012 the Federal Medical Assistance Percentage (FMAP) will be 52.33%.

Between SFY 2007 and 2011, total Rhode Island Medicaid medical expenses based on date of service have increased an average of 3.0 percent per year. This overall expenditure increase is associated with a 1.9 percent average annual increase in per member per month (PMPM) costs, and a 1.1 percent average annual increase in enrollment, which can be added together to determine average annual expenditure growth. Enrollment declined over the years SFY 2007 through 2009, but increased in SFY 2010 back to higher than SFY 2007 levels and continued to increase in SFY 2011. These expenditure trends compare quite favorably to both national Medicaid expenditures and state commercial per member per month cost trends.

Populations Served

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

- ❖ **Adults with disabilities** account for the largest share of expenditure, with 2011 expenditure of \$702 million, and an average PMPM cost of \$1,977. The largest components of expenditure for this population are residential and rehabilitation services for persons with developmental disabilities (28%) and hospital care (26%).
- ❖ **Elders** account for \$475 million in total 2010 Medicaid expenditure, and the highest average cost per member per month (PMPM) of \$2,257. For this population, nursing facilities account for roughly two-thirds (64%) of expenditures.
- ❖ **Children and families** account for 68% of total enrollment and 26% of total expenditure, with total 2011 expenditure of \$467 million. Additionally, the federal match is increased to 67.02% for qualifying "optional" low income children and pregnant women under the Children's Health Insurance Program (CHIP).

(continued next page)

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Populations Served (continued)

- ❖ **Children with special health care needs (CSHCN)** account for ten percent of total Medicaid expenditures and seven percent of enrollees, with total SFY 2011 expenditures of \$179 million. Expenditures on this population are dominated by professional behavioral health services, which account for just under half (45%) of total expenditures.

Medicaid Providers

Medicaid pays for services offered by a variety of providers. Hospitals and nursing facilities together account for nearly half (48%) 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 29 percent of Medicaid expenditure in 2011. Hospital payments are also a key driver of Medicaid expenditure growth – as payments to hospitals increased by an average of 8.2% per year between 2007-2011.
- ❖ Nursing facilities were the next largest provider type, accounting for 19% of expenditure in 2011. Expenditure on these providers has been increasing on average 1.8% per year between 2007-2011.

Managed Care

It is important to note that not all payments are made directly by Medicaid to service providers. Seventy-seven percent of Medicaid eligibles are now enrolled in managed care plans. These enrolled populations account for 48% 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 77% 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 2011 47% of adults with disabilities were enrolled in managed care.
- ❖ Rhode Island's participating Medicaid Managed Care Health Plans have consistently ranked among the nation's top performing Health Plans according to commonly used Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

Community Care and Long Term Care

Expenditure on community care and long term care accounts for about 40% of total Medicaid expenditure (\$736 million) in SFY 2011. 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.

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Mandatory and Optional Services

Most of the expenditure on optional services is designed to reduce expenditure for mandatory services. Optional services accounted for \$527 Million in total Medicaid expenditure in SFY 2011, approximately 29% of total Medicaid expenditures. The largest component of optional services is residential and rehabilitation services for persons with developmental disabilities, including group homes. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services for persons with developmental disabilities.

High Cost Users

Medicaid expenditures are highly concentrated, as the top seven percent of users account for over two-thirds (67%) of expenditures.

- ❖ High cost users are defined as those who incur \$25,000 or more per year in Medicaid expenditure. 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.
- ❖ Eighty percent of expenditure for high cost users is for Elders and Adults with Disabilities. The largest categories of expenditure for high cost users are nursing facilities and residential and rehabilitation facilities for persons with developmental disabilities.

Utilization

Individuals covered by both Medicare and Medicaid have dual coverage (“duals”). Medicare is the primary payer for most medical services (e.g. hospital, physician, pharmacy) for 96% of elders and for 47% of adults with disabilities. 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.

- ❖ For dually-covered elders, both nursing home and hospice admissions per thousand decreased from SFY 2009 to 2011.
- ❖ Emergency room visits per thousand have decreased 10% per year since 2009 for adults with disabilities covered only by Medicaid.
- ❖ For children and families and for children with special healthcare needs, acute care utilization measures, such as inpatient admissions, emergency room (ER) admissions, and office visits, have decreased since 2009.

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.

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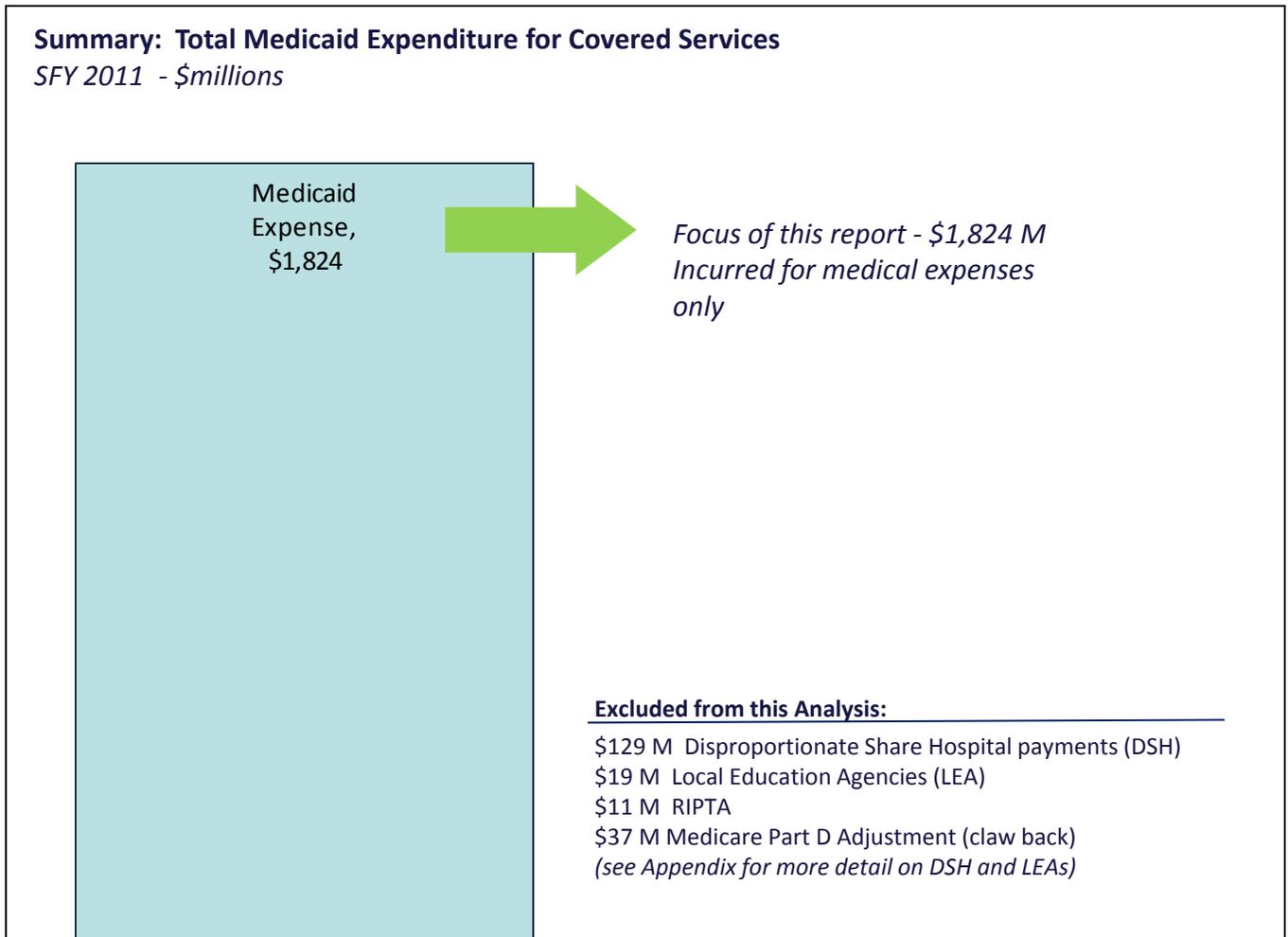
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1a. Total Medicaid Expenditures, 2011

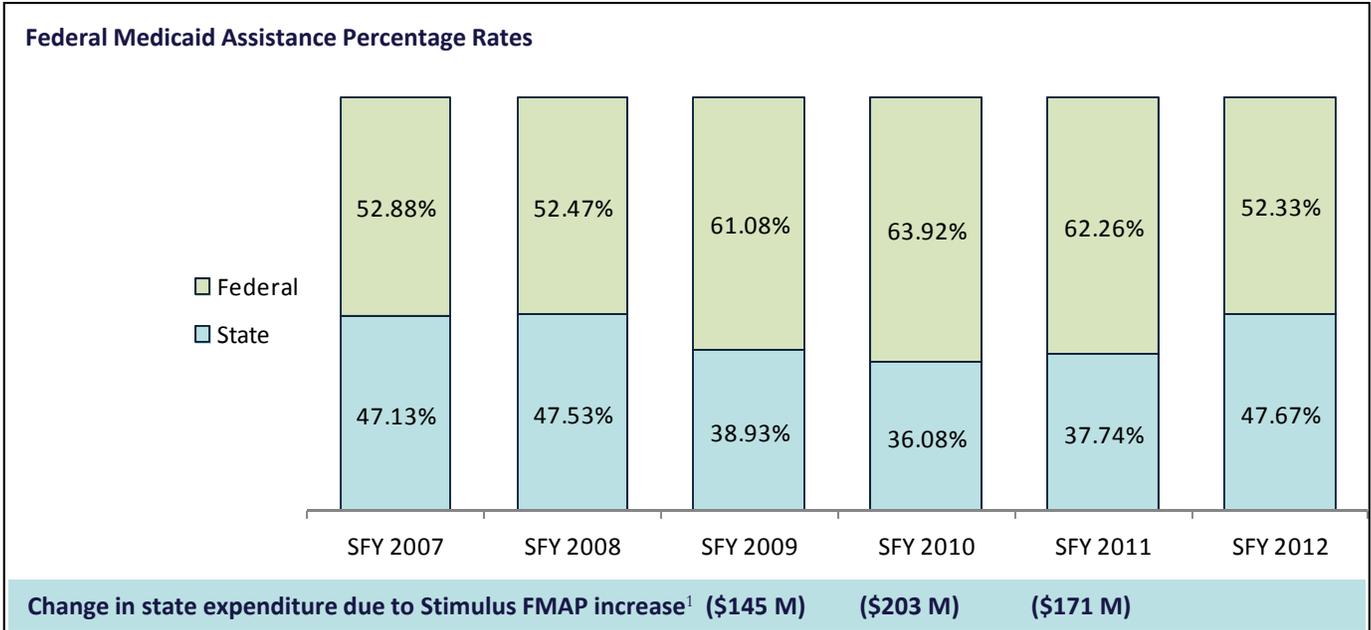
Medicaid expenditures total approximately \$1,824 million.



- ❖ In fiscal year 2011, Rhode Island incurred approximately \$1,824 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 \$129 million in DSH (Disproportionate Share Hospital) payments, payments of \$19 million to LEAs (Local Educational Agencies) and \$11 million in payments to RIPTA (Rhode Island Public Transit Authority), as well as payment of \$37 million for the Medicare Part D Adjustment. More detail on the DSH and LEA payments 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.

1b. FMAP (Federal Medicaid Assistance Percentage) Trends

The State of Rhode Island is typically responsible for just under half of Medicaid expenditures; however, stimulus funds significantly reduced state share for SFY 2009-11.

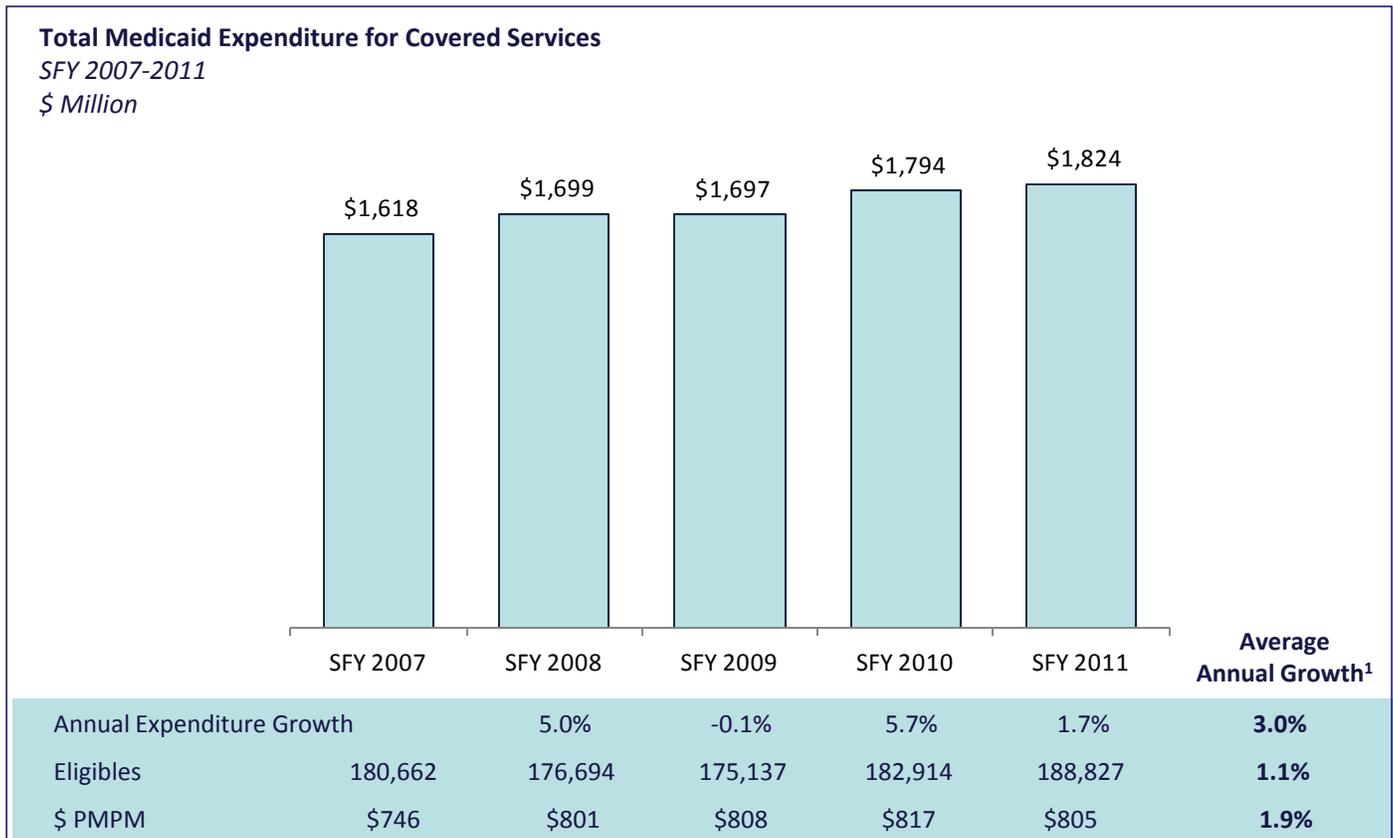


- ❖ While this report will review trends in total Medicaid medical expenditure, it is important to recognize that less than half of this expense falls to the Rhode Island budget. Funding is split between state and federal dollars, with Rhode Island typically responsible for just under half of all program expenditures.
- ❖ The current FMAP rate of 52% is almost four points lower than the SFY 2005 rate of 56%. However, the Federal Stimulus package increased FMAP by 11.42% percentage points, beginning October 1, 2008 and ending December 31, 2010. FMAP will go back to 52.33% in SFY 2012.
- ❖ Although the stimulus increase was phased out during SFY 2011, it still resulted in an average FMAP of 62.26%, 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 \$145 M in state expenditures in SFY 2009, \$203 M in SFY 2010, and \$171 M in SFY 2011.¹
- ❖ 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" from families with incomes up to 250 percent of the federal poverty level who are uninsured and not otherwise eligible for Medicaid. In SFY 2011, Rhode Island received a 67.02% combined CHIP/FMAP federal match on 9,186 "optional" children and pregnant women who are in families with incomes above mandatory coverage levels.

1. Analysis based on FMAP only – does not include CHIP match. Increase calculated as the difference between actual state expenditure and the amount the state would have spent at the FMAP rate of 52.51% without the federal stimulus increase.

1c. Medicaid Expenditure Trends, SFY 2007-2011

Over the past five years, Rhode Island Medicaid expenditures have been increasing an average 3.0 percent per year.

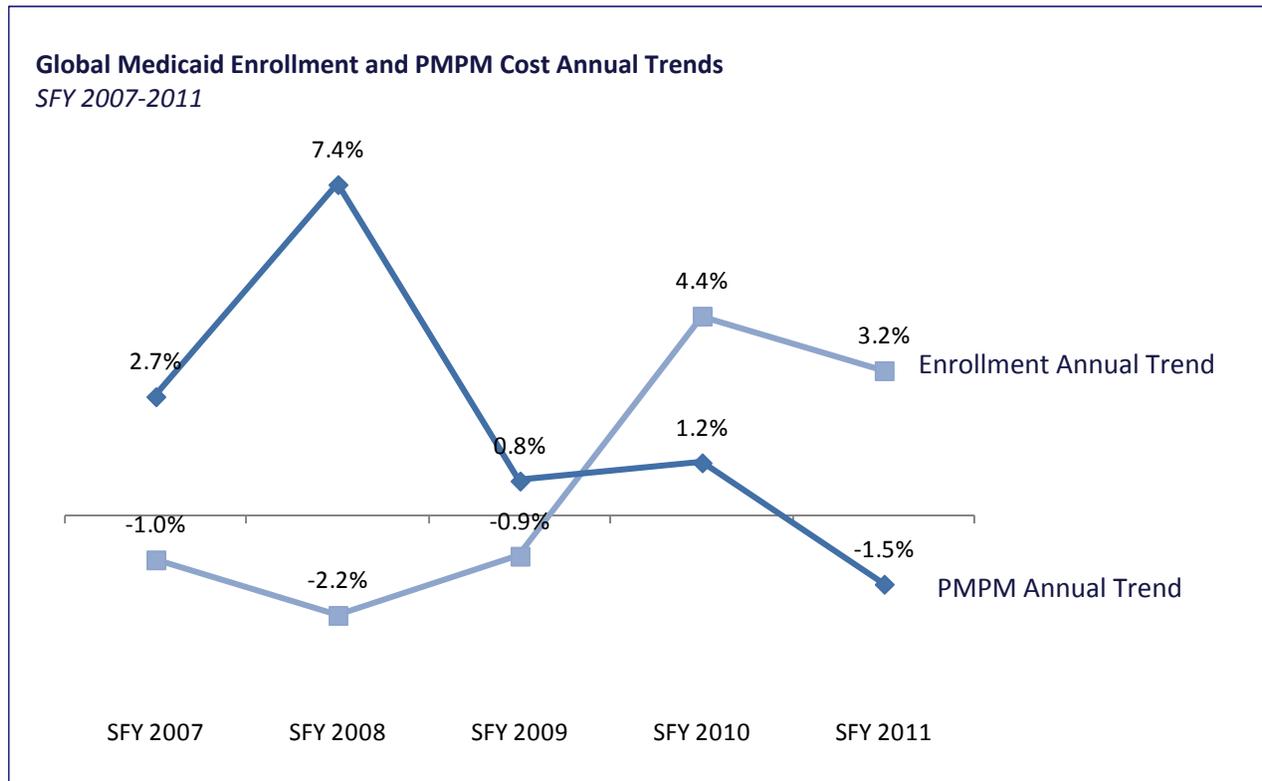


- ❖ Overall Medicaid expenditure has increased by approximately 3.0 percent per year over the last five years. From SFY 2010-2011 expenditure growth was an increase of just under 2%. Nearly all of the increase from SFY 2009-2011 was due to increases in enrollment.
- ❖ Note that the overall expenditure 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 decreased from SFY 2007 to 2009 but then increased in 2010 and 2011 for a five-year average growth of 1.1% per year.
 - PMPM costs increased from 2007 to 2010, but then decreased from 2010 to 2011. Over the five year period, PMPM costs have increased at an average annual rate of 1.9%.

1. Calculated as compounded annual growth rate (CAGR) over period SFY 2007-2011 as shown.

1c. Global Medicaid Enrollment and PMPM Cost Trends, 2007-2011

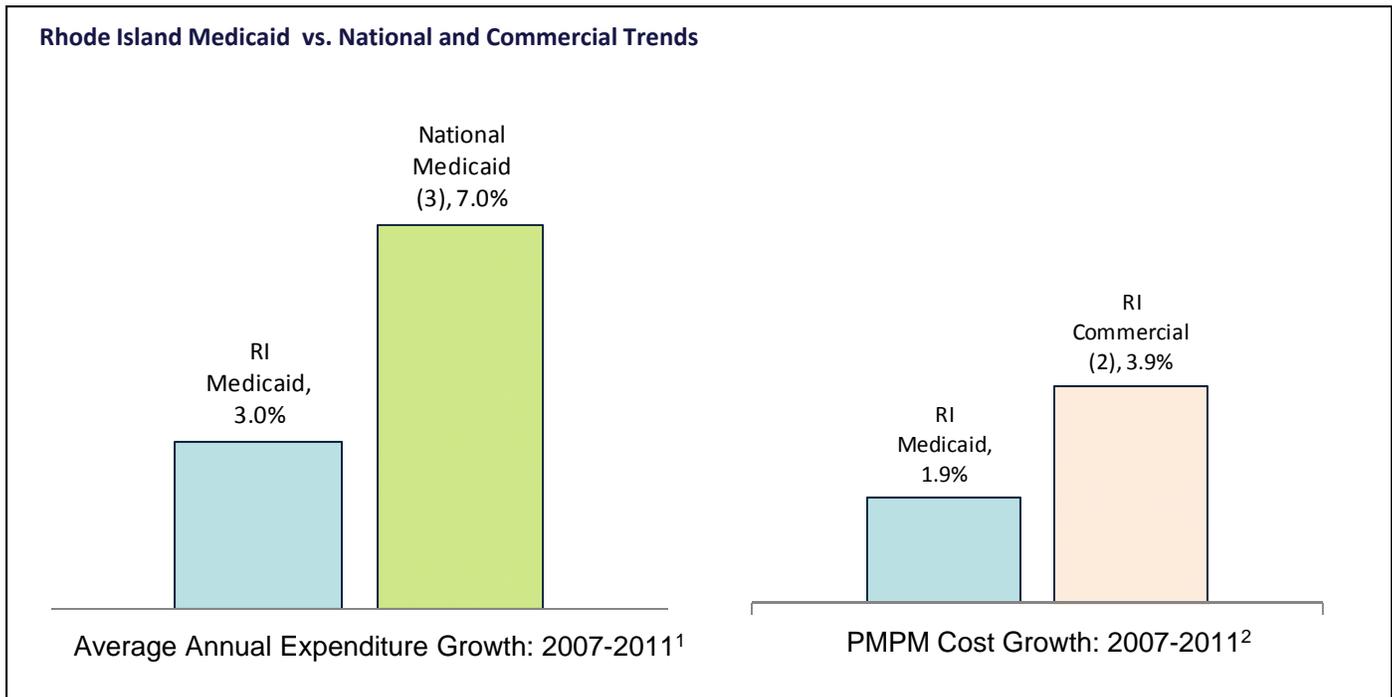
Enrollment had been declining between 2007 and 2009, but in 2010 jumped back to higher than 2007 levels and continued to increase in 2011.



- ❖ Nearly all of the 2009-2011 increase in total Medicaid expenditure is due to increases in enrollment.
- ❖ Between 2006 and 2009 enrollment declined 1-2% per year. However a 4.4% increase in enrollment from 2009 to 2010 brought enrollment back to 2006 levels. Enrollment increased another 3.2% from 2010 to 2011.
- ❖ PMPM costs increased in 2007 and 2008. In 2009 and 2010 PMPM costs continued to increase but at lower rates than previous years. Between 2010 and 2011 PMPM costs declined 1.5%.

1c. RI Medicaid Expenditure Trend vs. National, Regional Benchmarks

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



- ❖ Overall expenditure growth over the years 2007-2011 compares very favorably to national Medicaid expenditure trend – according to Centers for Medicare & Medicaid Services (CMS), Medicaid expenditure trend over this time period increased an average 7.0% per year, vs. Rhode Island’s 3.0%³.
- ❖ RI Medicaid PMPM (per member per month) cost trends also compare favorably to local commercial benchmarks. Between 2007 and 2011, Rhode Island’s Medicaid program experienced 1.9% average annual PMPM cost growth. Over a similar period (2008-2011), the average annual commercial medical PMPM cost increase for Rhode Island commercial health plans was 3.9%². Nationally, during this same period there has been an increase in high deductible plans and in co-payments by insured subscribers.
- ❖ The RI commercial benchmark may be understated because it only includes total incurred claims reported by the carriers, not any out of pocket costs borne by members. Medicaid plans generally have very low, if any, out of pocket costs for members.

¹ RI data in SFY. National benchmarks in FFY. State commercial benchmark in CY.

² Incurred claims per member per month, includes both small group and large group claims from Blue Cross Blue Shield RI, United Healthcare of New England and Tufts Health Plan. Source: Office of the Health Insurance Commissioner (OHIC), 2012 carrier rate filings. RI commercial benchmark is annual average growth for 2008-2011.

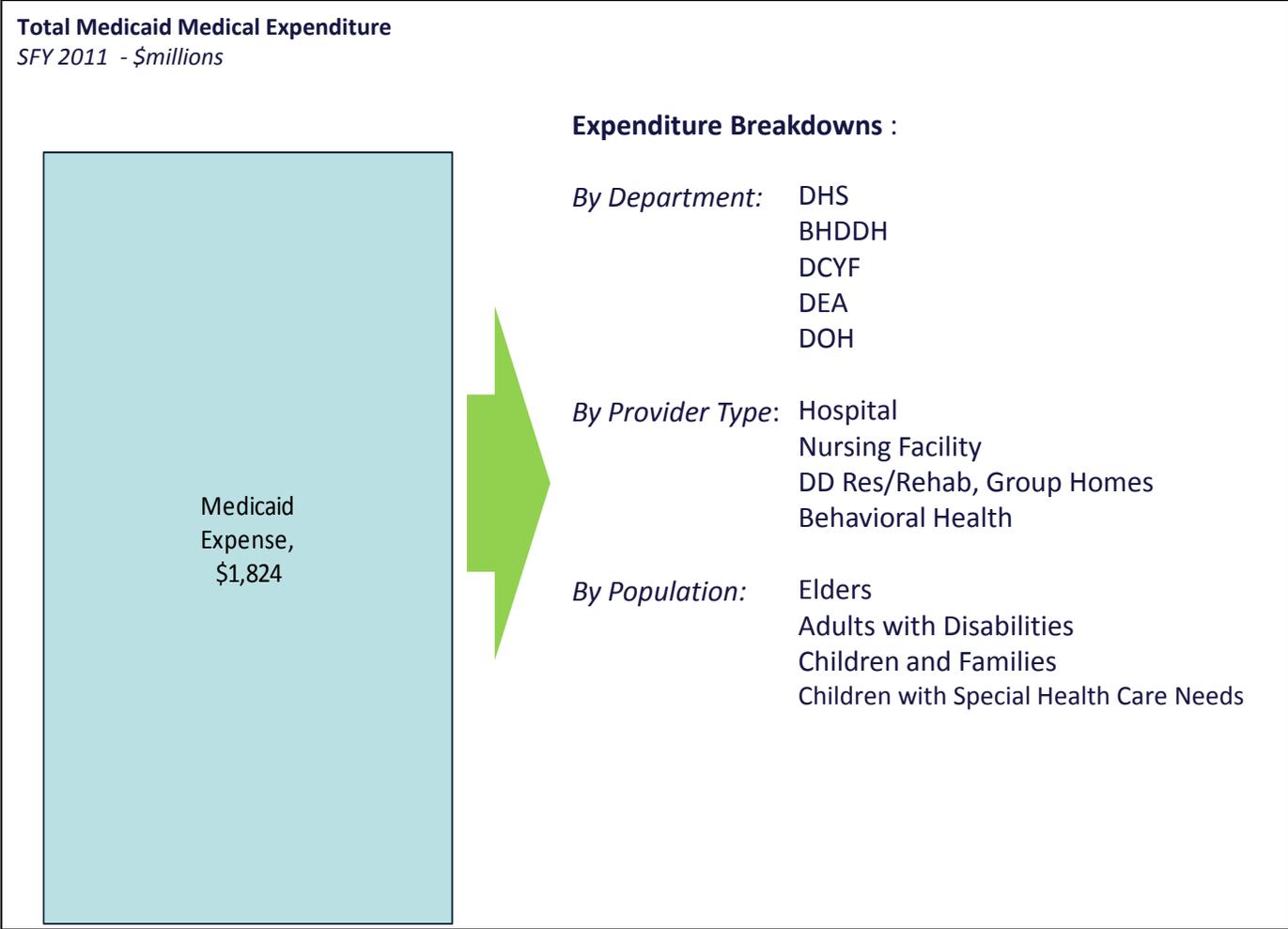
³ Source: 2011 CMS National Health Expenditure Report. 2010 and 2011 data are projections.

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2. Expenditure Distributions

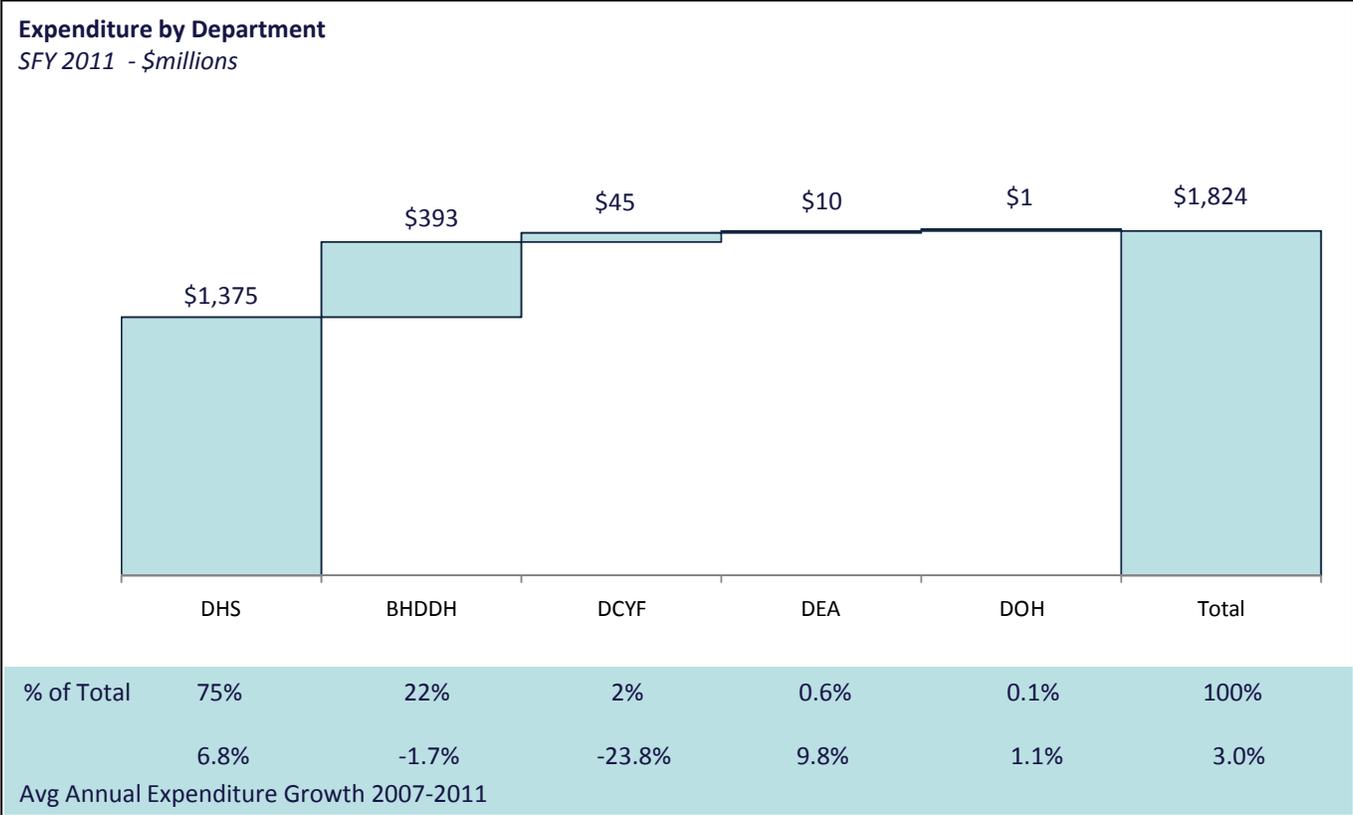
Medicaid expenditure can be broken down in several ways.



- ❖ Department refers to the state departments responsible for administering components of the Medicaid program. In 2012, the Department of Elderly Affairs (DEA) became a Division under DHS, but for purposes of this report, it is treated as a separate department as was reflected in SFY 2011.
- ❖ 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

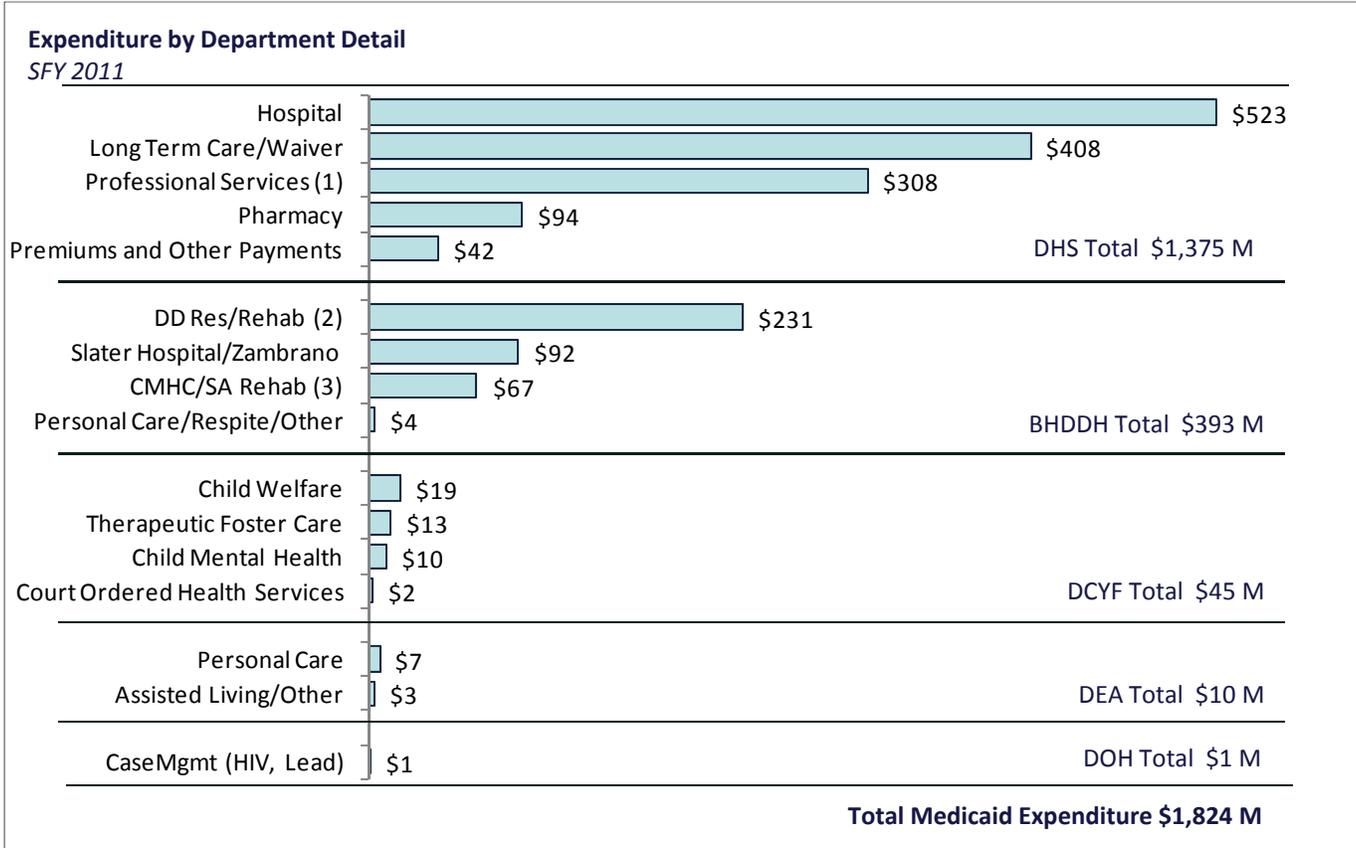
Medicaid services are administered through several state departments.



- ❖ In SFY 2011, the state departments responsible for administering components of the Medicaid program were: The Department of Human Services (DHS), the Department of Behavioral Healthcare, 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).
- ❖ Effective July 1, 2011, the Single State Medicaid Agency was transferred from the Department of Human Services to the Executive Office of Health and Human Services (EOHHS). For SFY 2011, the Medicaid program was administered under DHS, and this report reflects that previous structure.
- ❖ The majority of expenditure (75%) was administered by the Department of Human Services (DHS). This department is the lead administrator for the Medicaid contract with CMS.
- ❖ The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH), is the second largest, accounting for 22 percent of Medicaid program expenditures.
- ❖ Detail for each department is shown on the next page.

2a. Expenditure by Department: State Agency Detail*

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



- ❖ The majority of expenditure (75%) was administered by the Department of Human Services. DHS funds most traditional Medicaid services – providing funding for hospital-based services (38% of total DHS expenditure), long term care (30%), treatment and rehabilitation (22%), and pharmacy (7%).
- ❖ The Department of Behavioral Healthcare, Developmental Disability and Hospitals (BHDDH) accounts for 22% 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 \$45 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.

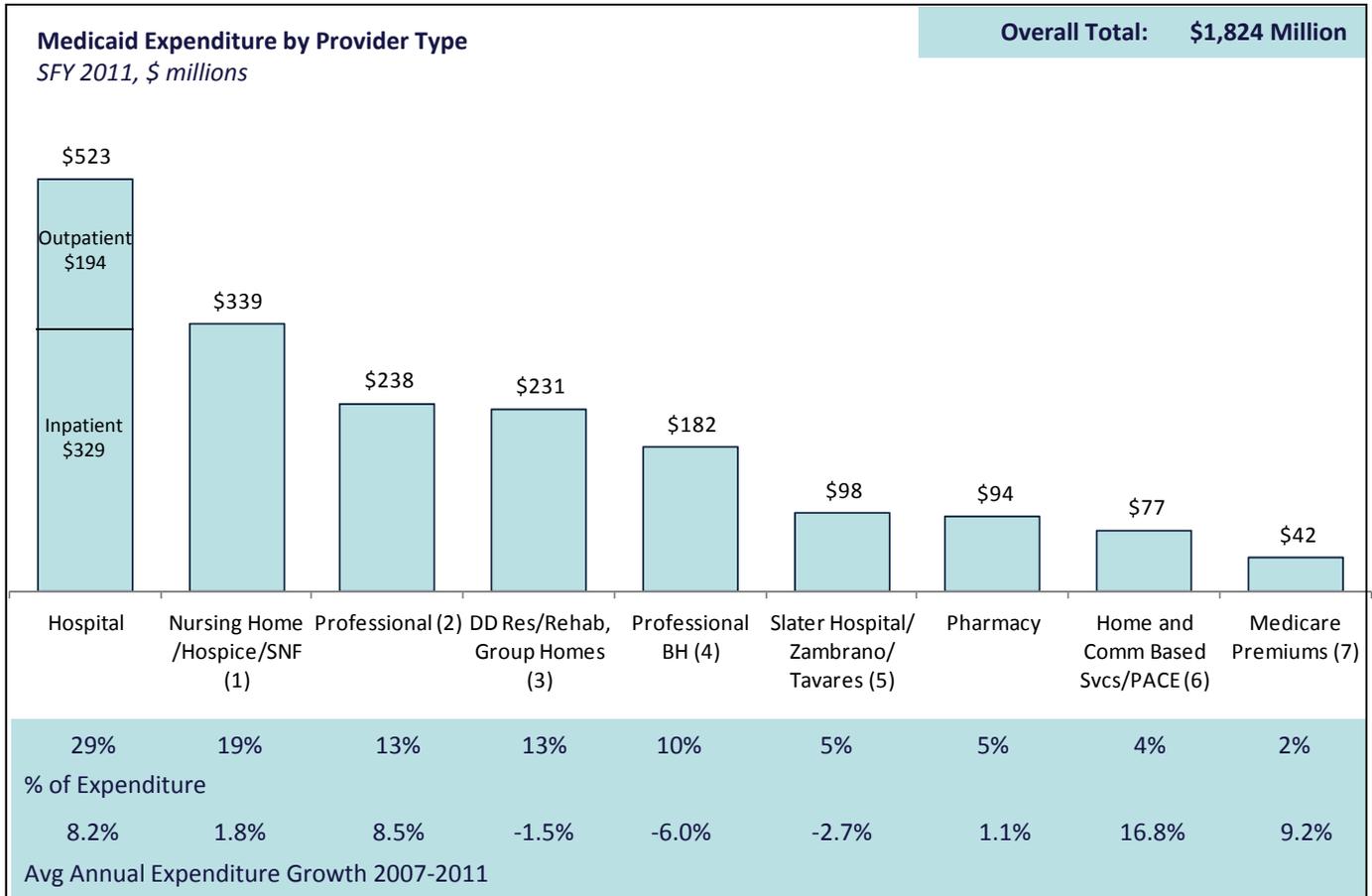
¹ Includes professional services for behavioral health.

² DD Res/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).

³ 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.

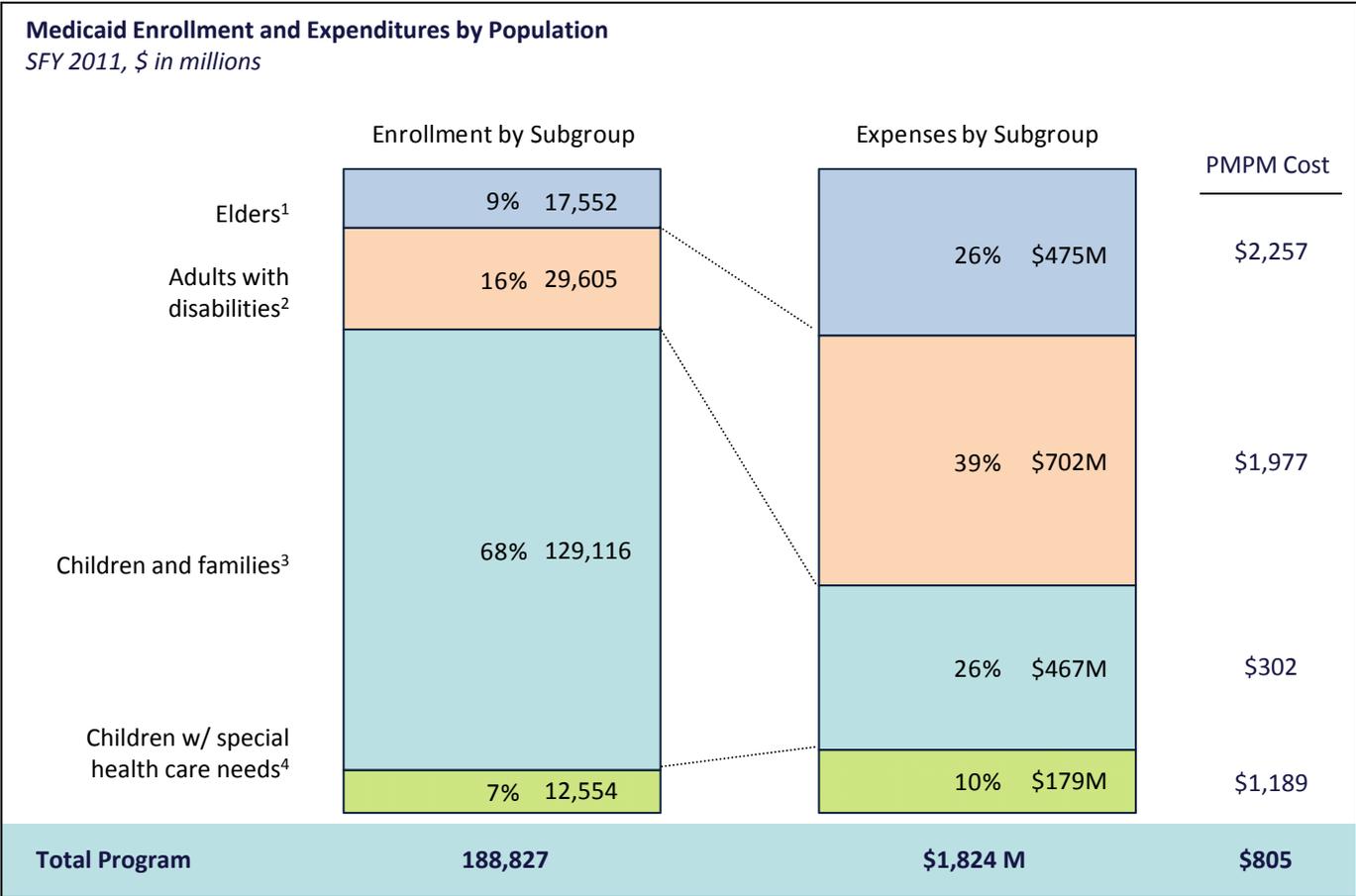


- ❖ The two largest provider types, accounting for nearly half (48%) of all RI Medicaid expenditure in SFY 2011, were hospitals and nursing facilities (including nursing homes, hospice, and skilled nursing facilities). Key contributors to expenditure growth were hospitals and professional providers.
- ❖ Hospitals were the largest provider type, accounting for 29 percent of Medicaid expenditures in SFY 2011. Hospital payments are also a key driver of Medicaid expenditure growth – as payments to hospitals increased by an average of 8.2% per year between 2007-2011.

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 DD Res/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).
 4 Professional 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.
 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, case management and Program of All-Inclusive Care of the Elderly (PACE).
 7 Medicaid pays Medicare premiums for qualifying individuals.

2d. Expenditure by Population

Medicaid expenditures vary considerably by population



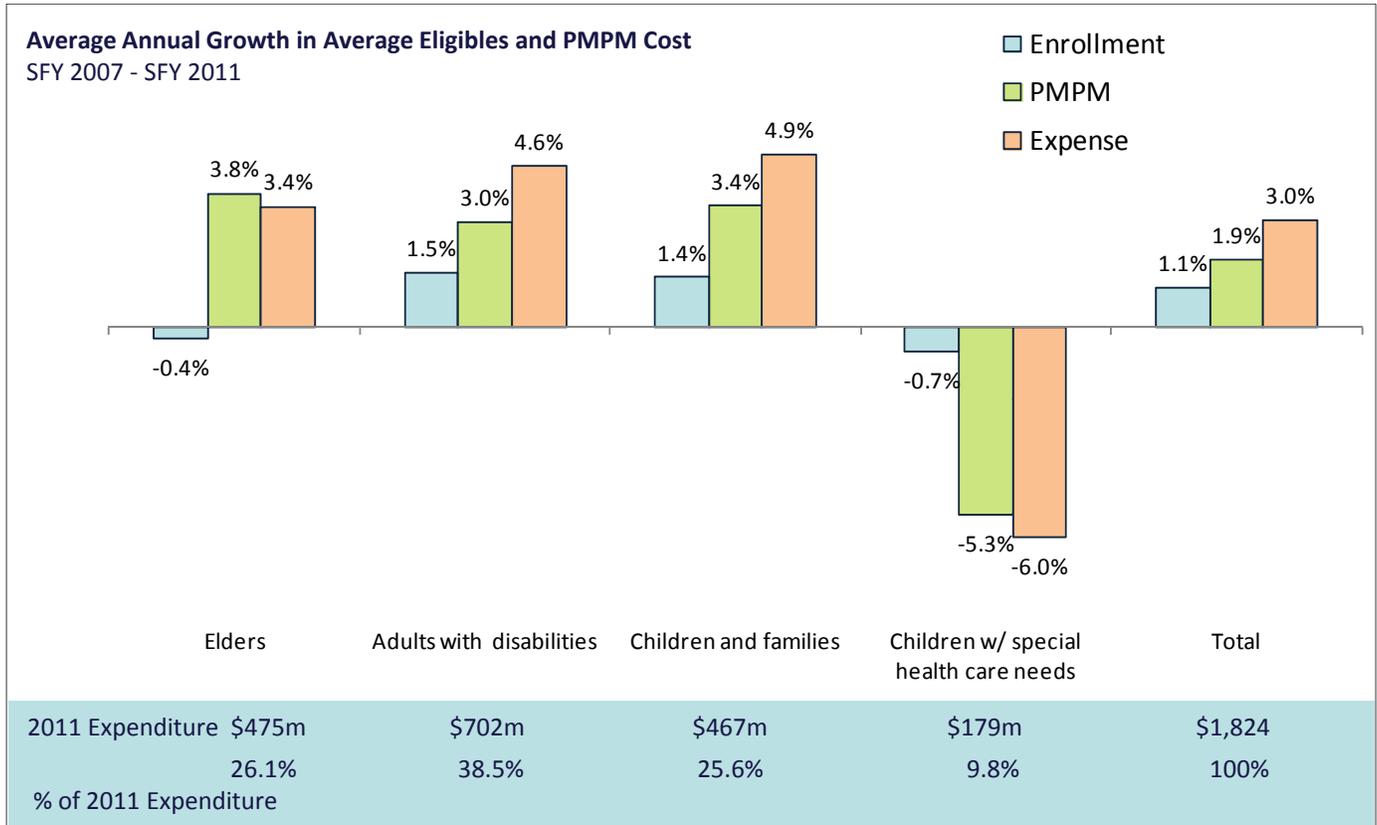
The Medicaid program served an average of 188,827 eligibles in SFY 2011, at an average cost per member per month of \$805. However, PMPM costs vary considerably by population.

- ❖ 65% of expenditure is on services for elders and adults with disabilities who together 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 with a PMPM cost of just over \$300.
- ❖ Another 10% 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 (Supplemental Security Income) who are under 21, Katie Beckett children, and Adoption Subsidy children.

2d. Expenditure By Population: Trends

Expenditure growth varies significantly by population.



- ❖ Overall Rhode Island Medicaid expenditures grew by approximately 3.0 percent per year between SFY 2007 and SFY 2011; however, this increase varied considerably by population.
- ❖ Elders account for 26.1% of overall spending in 2011 and have experienced a 3.4% average annual increase in expenditure since 2007. Nearly all of this increase is due to increased PMPM over that time period.
- ❖ Adults with disabilities account for the highest share of 2011 expenditure (38.5%) and the largest share of expenditure growth. The average annual growth in expenditure for this group for the last 5 years was 4.6%.
- ❖ Children and families experienced a 3.4% average PMPM growth over the past 5 years and an average enrollment growth of 1.4%. In comparison, Rhode Island commercial PMPM cost trend over the last 4 years is 3.9%¹.
- ❖ Children with special health care needs experienced a decrease in both PMPM and overall expenditure since 2009. This is partly due to programs that have reduced the portion of DCYF youth in residential settings compared to those in community-based settings.

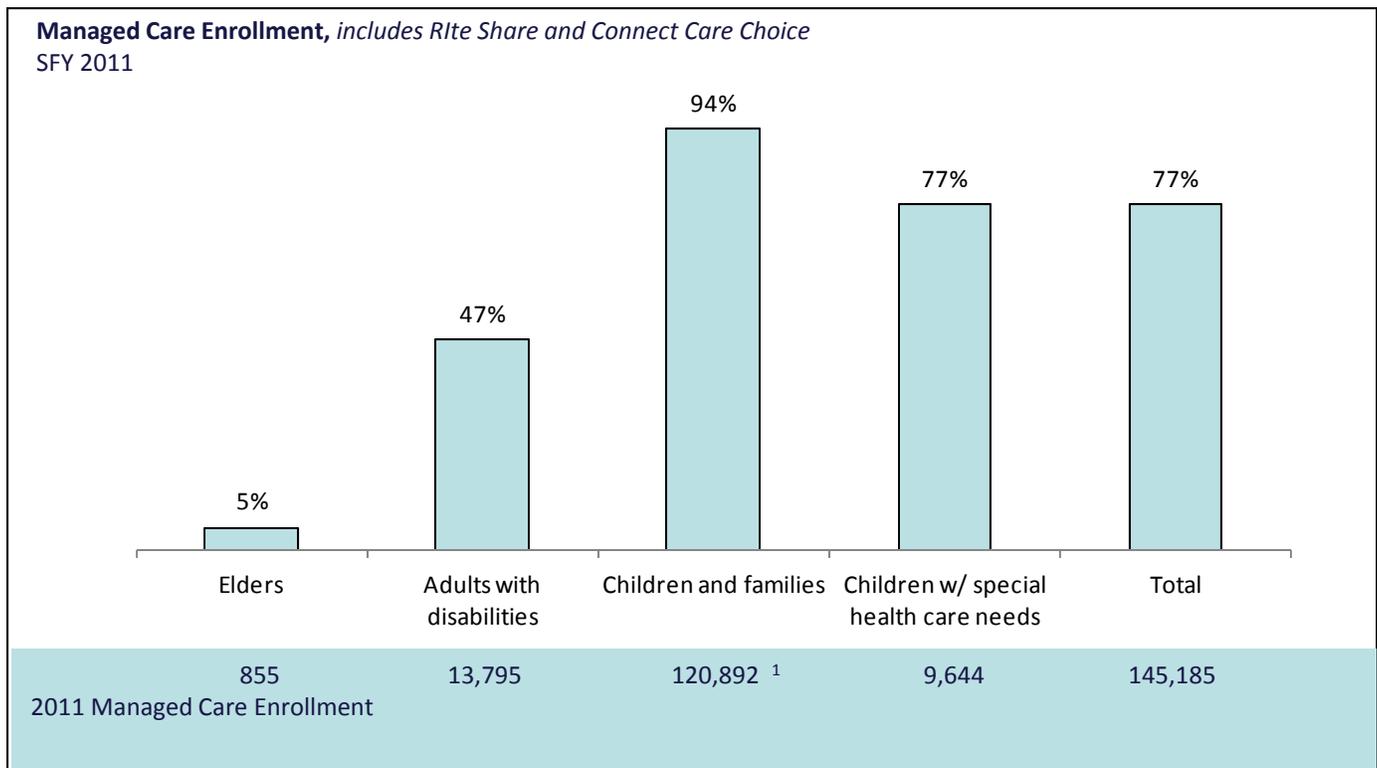
1. For commercial incurred claims from BCBSRI, United Healthcare New England and Tufts Health Plan, includes both large group and small group. Source: Office of the Health Insurance Commissioner (OHIC), 2012 carrier rate filings, exhibit 3.

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3a. Managed Care Enrollment

More than three quarters (77%) of all Medicaid eligibles are enrolled in some type of managed care, but this split varies by population subgroup.

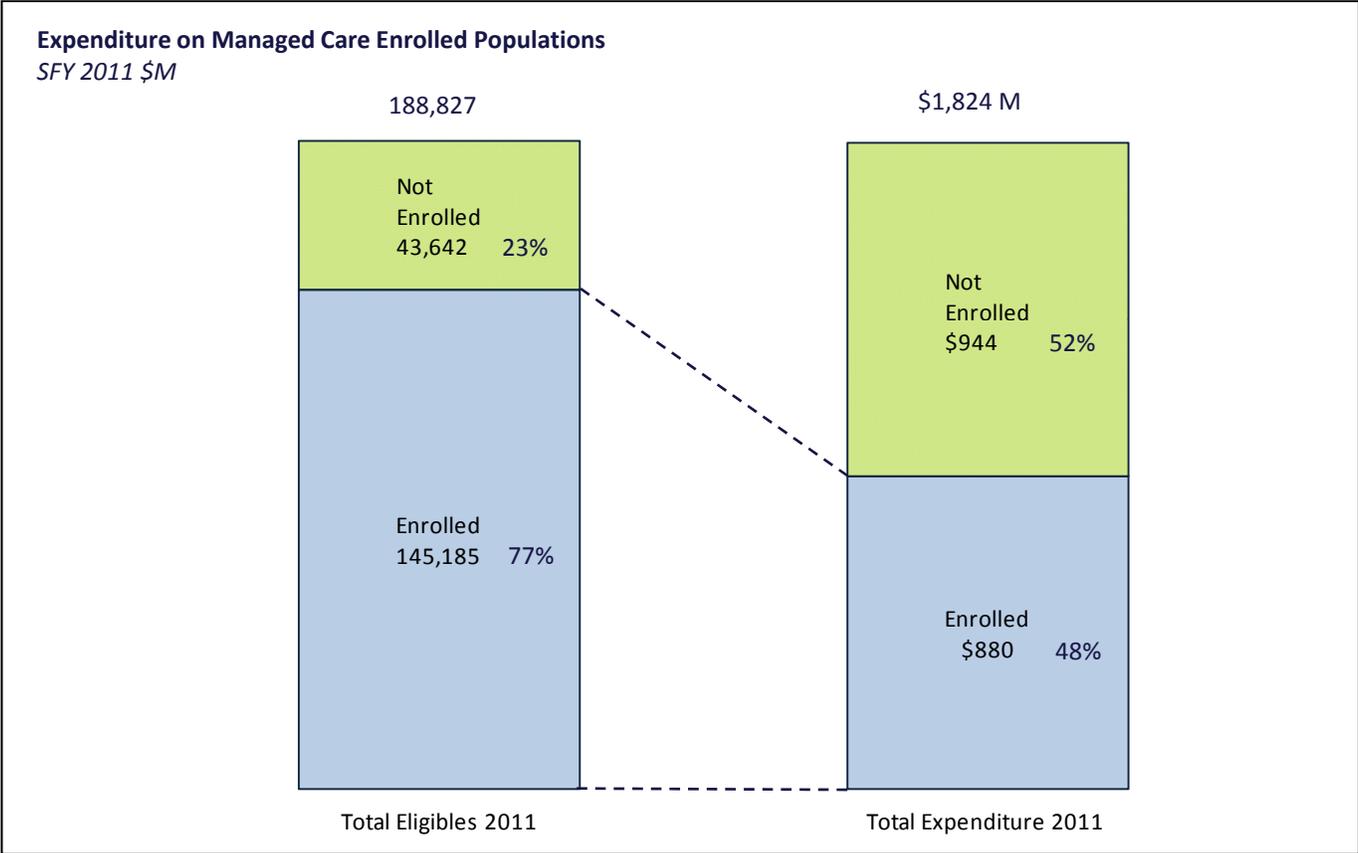


- ❖ Medicaid enrollees who do not have other insurance are enrolled in Medicaid managed care plans. The percentage of managed care enrollees varies by population due to variability in enrollment in outside insurance. For example, the majority of Elders in Medicaid are enrolled in insurance plans through Medicare.
- ❖ 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 2008, enrollment in Medicaid managed care became mandatory for children with special health care needs (CSHCN) without other insurance. About 77% were enrolled in Medicaid managed care in SFY 2011.
- ❖ Adult populations have historically been exclusively served in fee-for-service Medicaid. However, two new managed care programs were established in 2008 to transition adults to managed care: Connect Care Choice and Rhody Health Partners. Enrollment in managed care for this population has increased from near 0% to 47% with the introduction of these programs.

¹ Includes 10,883 RItE Share members.

3a. Managed Care Enrollment

The 77% of Medicaid eligibles enrolled in managed care plans account for 48% of Medicaid expenditure.

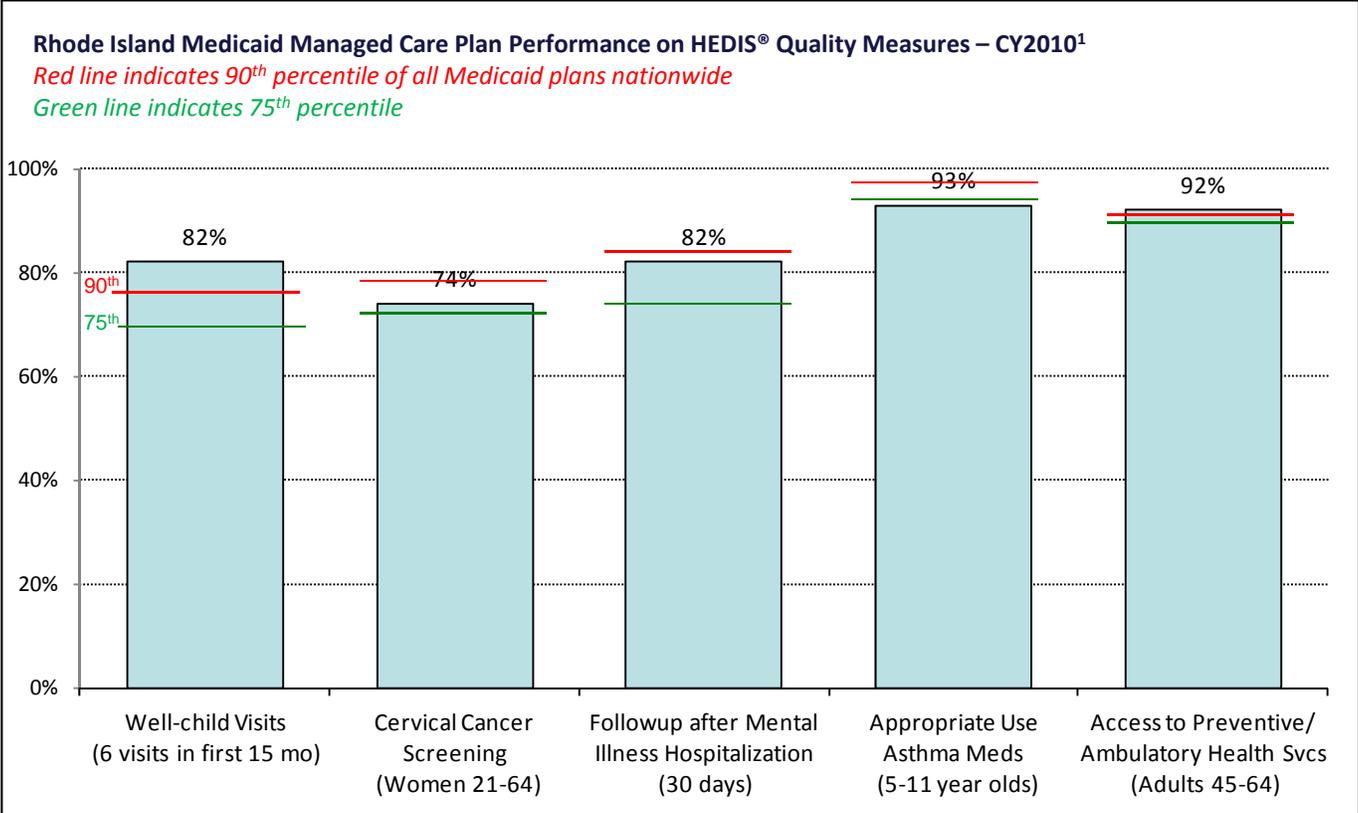


- ❖ Three quarters (77%) of all Medicaid eligibles are enrolled in either Medicaid managed care plans, RIte Share, or Connect Care Choice. These “enrolled populations” account for about 48% of Rhode Island Medicaid expenditures.¹
- ❖ During SFY 2011 managed care enrollment was divided among three health plans: Neighborhood Health Plan of Rhode Island (NHPR), United Healthcare of New England (UHCNE) and Blue Cross Blue Shield of Rhode Island (BCBSRI). As of December 2010, BCBSRI ceased participation in RIte Care.
- ❖ 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 2011, there were 10,883 Medicaid eligibles enrolled in the RIte Share program.
- ❖ Connect Care Choice is a program that provides access to advanced medical homes for adults with chronic conditions in order to help coordinate health care needs and link to support services in the community. In SFY 2011, there were 2,027 Medicaid eligibles enrolled in Connect Care Choice.

1. Most 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 according to HEDIS® measures (Healthcare Effectiveness Data and Information Set).

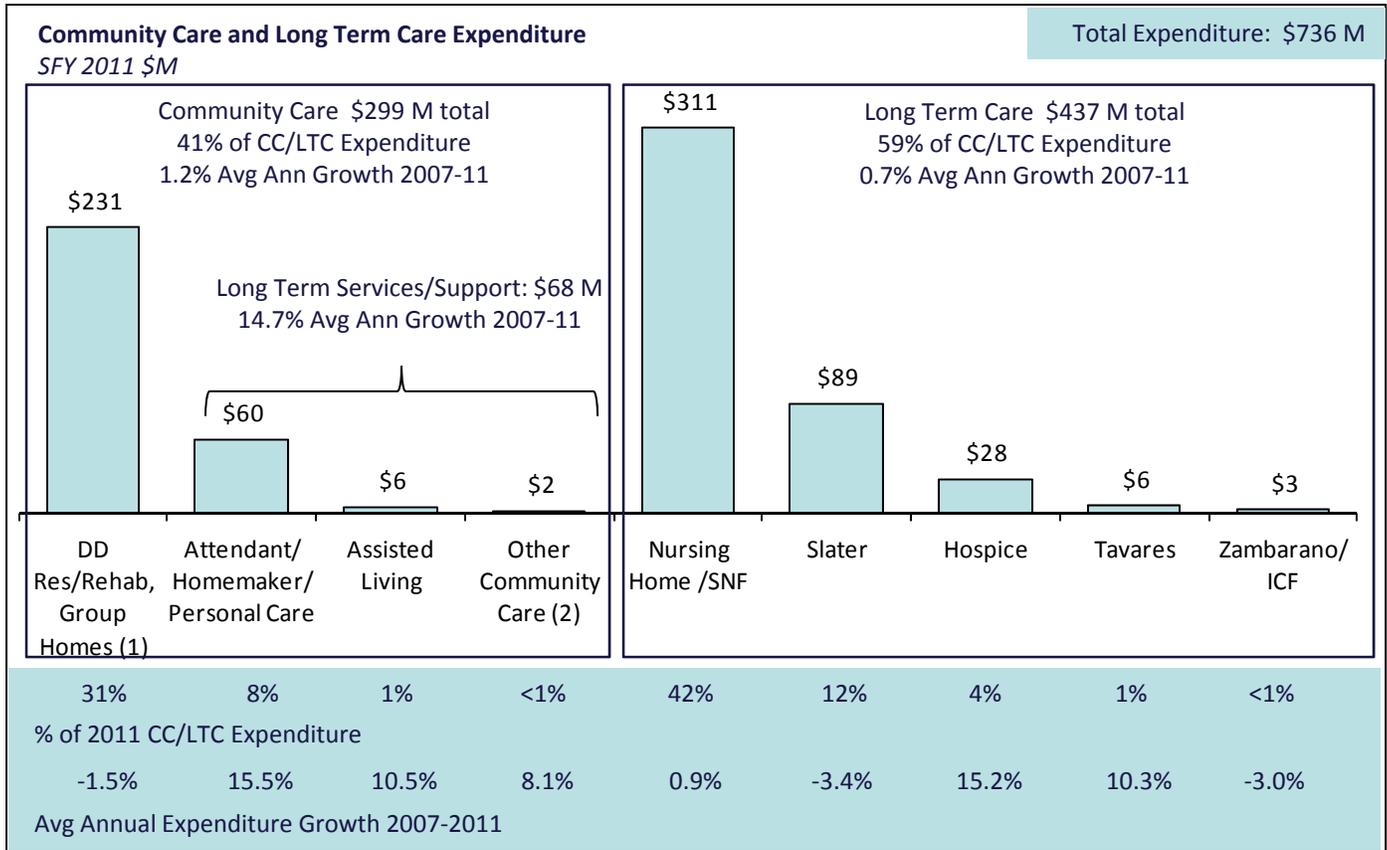


- ❖ On the HEDIS® measure assessing the percentage of enrollees who had six or more well-child visits with a primary care provider during their first 15 months of life, all of RIte Care’s Health Plans ranked above the 90th percentile compared with all Medicaid health plans in the nation.
- ❖ RIte Care’s Health Plans did well on the cervical cancer screening measure and exceeded the 75th 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 nearly 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 are just below the 75th percentile. Children who use asthma medications appropriately can prevent unnecessary emergency department visits and hospitalizations .
- ❖ 92% of RIte Care adults ages 45-64 received preventive and primary care visits during the year., which is above the 90th percentile.

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 \$736 million in SFY 2011, 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 41% of the total expenditure on home and community based care and long term care. Most of the expenditure on long term care is for nursing homes (71% of long term care expenditures).
- ❖ A large portion of the growth in expenditures is on long term services and support in community care, such as attendant/personal care and assisted living. These services are less expensive alternatives to nursing home/institutional options. In comparison, expenditure on residential services for persons with developmental disabilities has decreased since 2007 due to a reduction in negotiated rates.

¹ DD Res/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 community care includes DME (e.g. Home Modifications), Case Management, Meals and other.

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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, certain provisions of the Affordable Care Act (ACA) alter these definitions effective in 2014.

Mandatory and Optional Expenditure
SFY 2011, \$millions

| | | Services | | |
|--------------|-----------|----------------|------------------------------|-------------------------------|
| | | Mandatory | Optional/Waiver ¹ | |
| Populations* | Mandatory | \$653 36% | \$282 15% | \$936 51% |
| | Optional* | \$644 35% | \$245 14% | \$888 49% |
| | | \$1,297 71% | \$527 29% | \$1,824 100% |

* Does not reflect changes in mandatory populations resulting from the Affordable Care Act (ACA)

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 maintenance of effort restriction which requires continuation of services for any population receiving services as of March 2010.

¹ Includes \$68M in expenditure on Waiver services (\$37M for mandatory populations and \$31 for 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

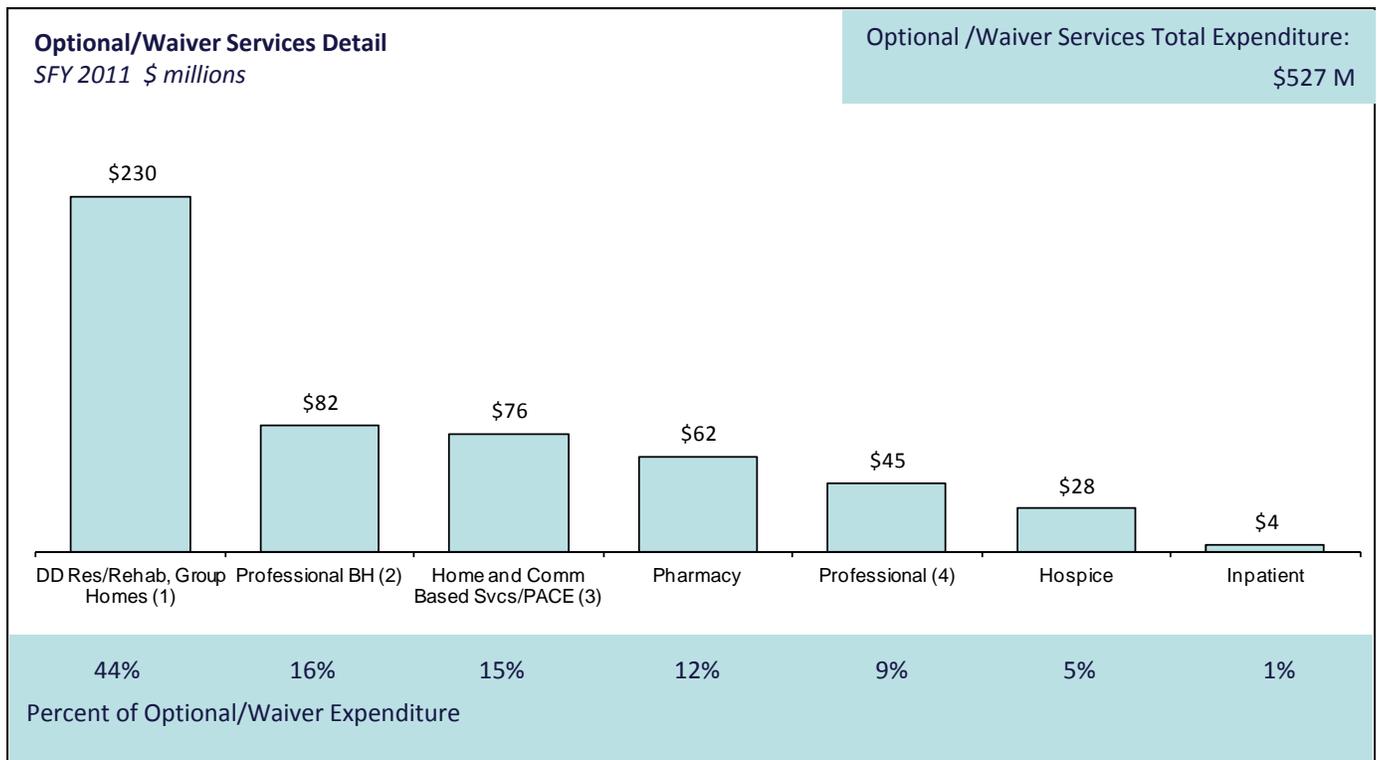
4b. Mandatory/Optional: Services

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 |
|---|---|
| 2011 Expenditure: \$1,297 M | 2011 Expenditure: \$527 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 ❖ Intermediate care facility services for persons with developmental disabilities (ICF/DD) | <p>Institutional Services</p> <ul style="list-style-type: none"> ❖ 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 \$527 Million in total Medicaid expenditure in SFY 2011, approximately 29% of total Medicaid expenditures. Of that, waiver services accounted for \$68 million.
- ❖ The largest component of optional services (44% of optional services expenditure) is residential and rehabilitation services for persons with developmental disabilities, including group homes. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services for those populations.
- ❖ Under EPSDT provisions, services that are optional for adults are mandatory for children, e.g., pharmacy.

¹ DD Res/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).

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, and Program of All-Inclusive Care of the Elderly (PACE).

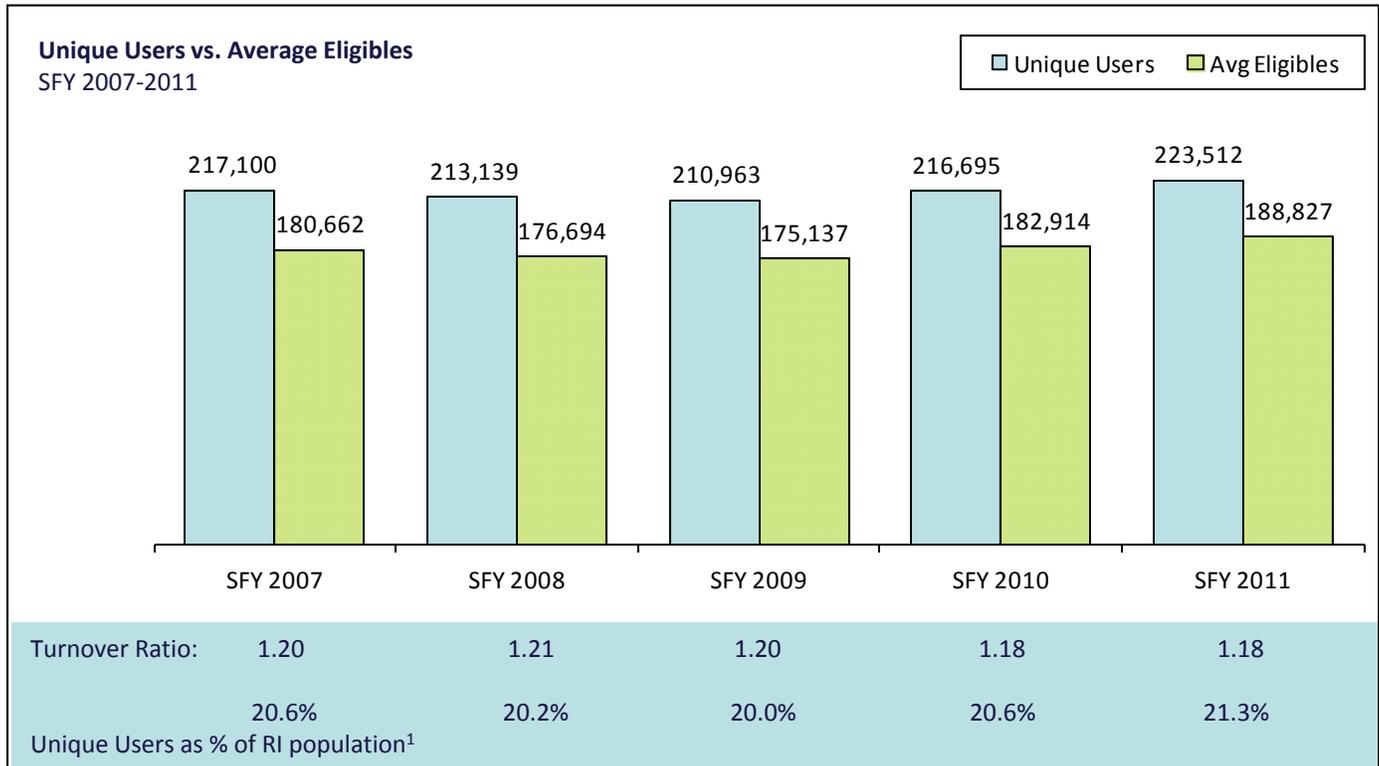
⁴ Professional includes, but is not limited to, E&M, Procedures, Dental, DME/Supplies, X-Ray/Lab/Tests, and Ambulance.

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5a. Unique Users

About one-fifth of Rhode Island’s population, or 224,000 Rhode Islanders, were enrolled in Medicaid for some part of SFY 2011.



- ❖ 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 (full time equivalents).

5b. Expenditure by User: High Cost Cases

The top seven percent of Medicaid users account for two thirds (67%) of Medicaid expenditure.

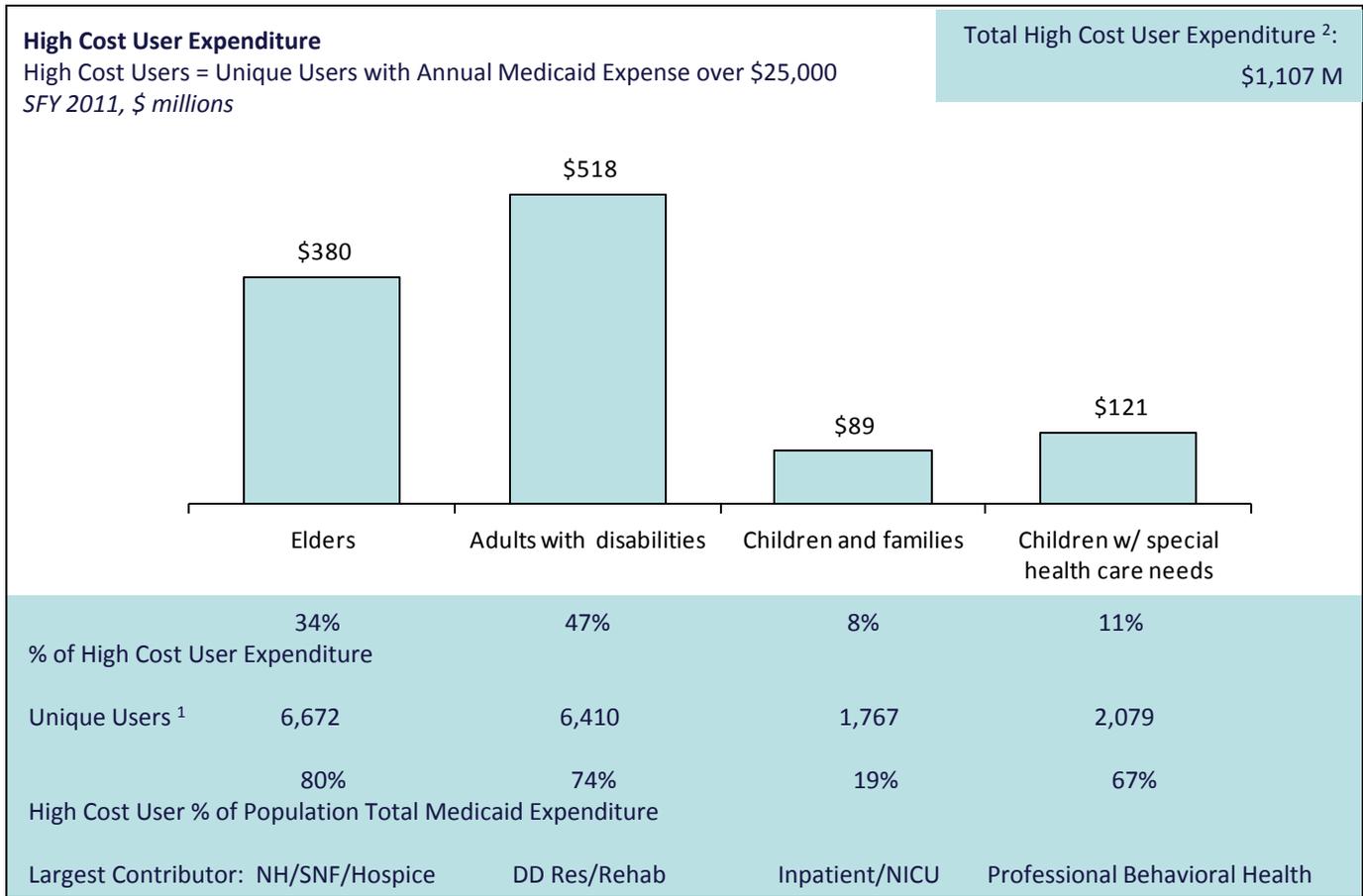
| Medicaid User Expenditure Distribution SFY 2011 | | % of Users | % of Expense | Turnover Ratio |
|--|----------------|--|--------------|----------------|
| Annual Medical Expense range per user | | | | |
| <\$1,000 | 53% 117,425 | 2% \$37M | 1.26 | |
| | | 8% \$136M | 1.12 | |
| | | 7% \$123M | 1.12 | |
| | | 15% \$239 M | 1.10 | |
| \$1,001-\$5,000 | 26% 58,435 | 43% \$712 M | 1.05 | |
| \$5,001-\$10,000 | 7% 16,713 | | | |
| \$10,001-\$25,000 | 7% 14,821 | 24% \$396 M | 1.04 | |
| \$25,001 - \$100,000 | 6% 13,949 | | | |
| \$100,000+ | 1% 2,169 | | | |
| Total Program | 223,512 | \$1,643 M | 1.18 | |
| | | <i>(\$181 M of expense unassigned by user¹)</i> | | |

- ❖ Medicaid expenditures are highly concentrated, as the top seven percent of Medicaid users account for two-thirds (67%) 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 nine percent of Medicaid users access Medicaid services at a cost of less than \$5,000 per year, with an average expenditure of \$982 per person. Thus, the 16,118 top utilizers spent, on average, \$68,707 per person in SFY2011, about *seventy 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 (upper payment limit), Medicare Premiums, PACE premiums, and managed care administrative cost.
 2. "The High Concentration of US Health Care Expenditures," AHRQ, 2006. <http://www.ahrq.gov/research/ria19/expendria.pdf>

5b. Expenditure by User: High Cost Cases

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

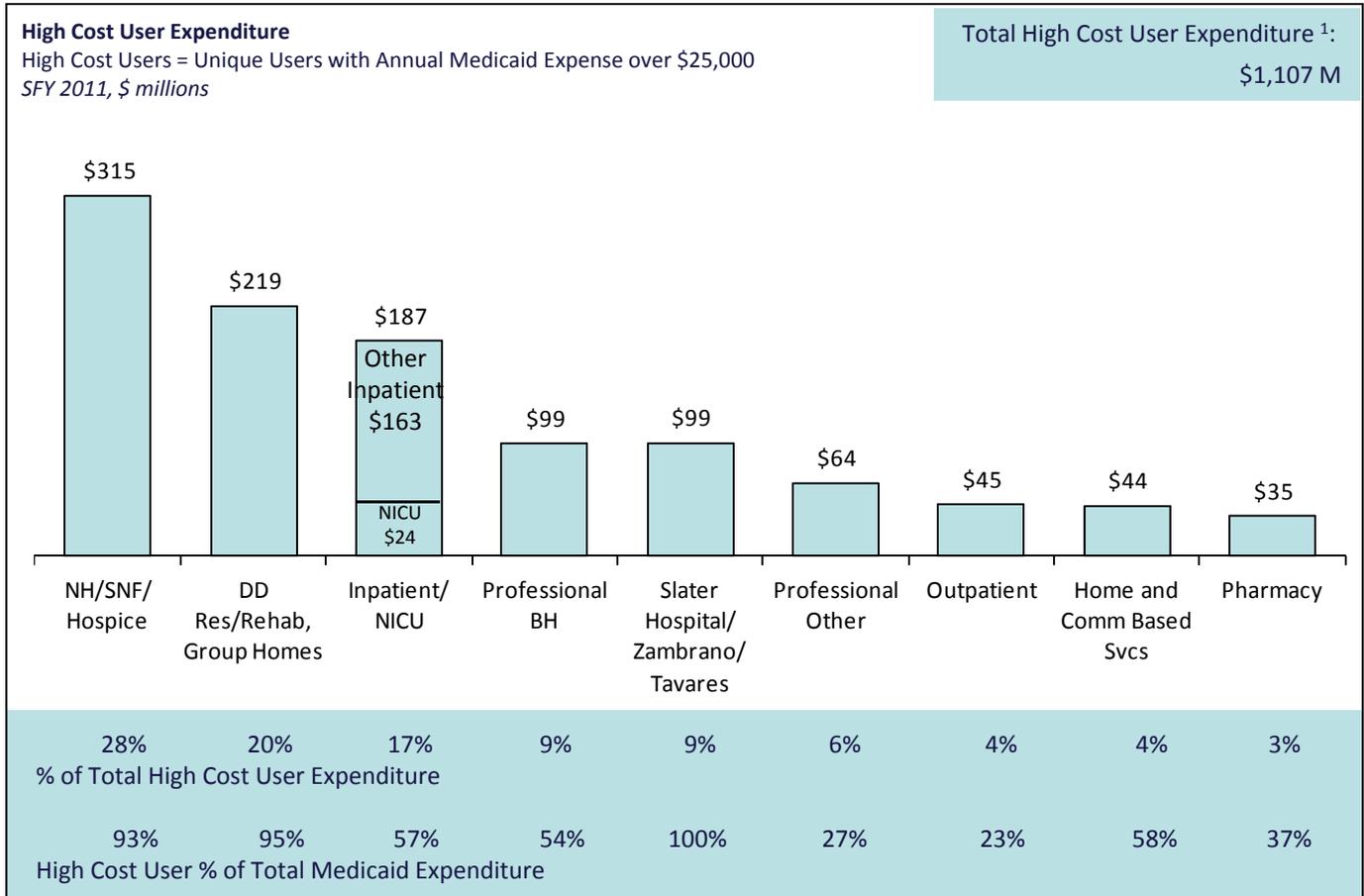


- ❖ Expenditure on elders and adults with disabilities accounts for eighty percent of expenditure on the highest cost users. (High cost users defined as unique users with over \$25,000 of Medicaid expense in SFY 2011). Also, high cost user expenditure accounts for 80% of total spending on Elders and 74% of total spending on adults with disabilities.
- ❖ The largest category of expenditure for high cost elders is nursing facilities (nursing homes, skilled nursing facilities and hospice), accounting for \$281 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 persons with developmental disabilities, which account for another \$186 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, including Neonatal Intensive Care Unit (NICU), accounting for 5% of overall expenditure on high cost users. Professional behavioral health services for children with special health care needs account for another 5% of overall expenditure on high cost users.

1. Total sums to more than the overall 16,118 high cost unique users due to overlap between eligibility groups.
 2. Expense unassigned by user includes provider payouts, UPL (upper payment limit), Medicare Premiums, PACE premiums, and managed care administrative cost.

5b. Expenditure by User: High Cost Cases

Nearly half (48%) of expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.

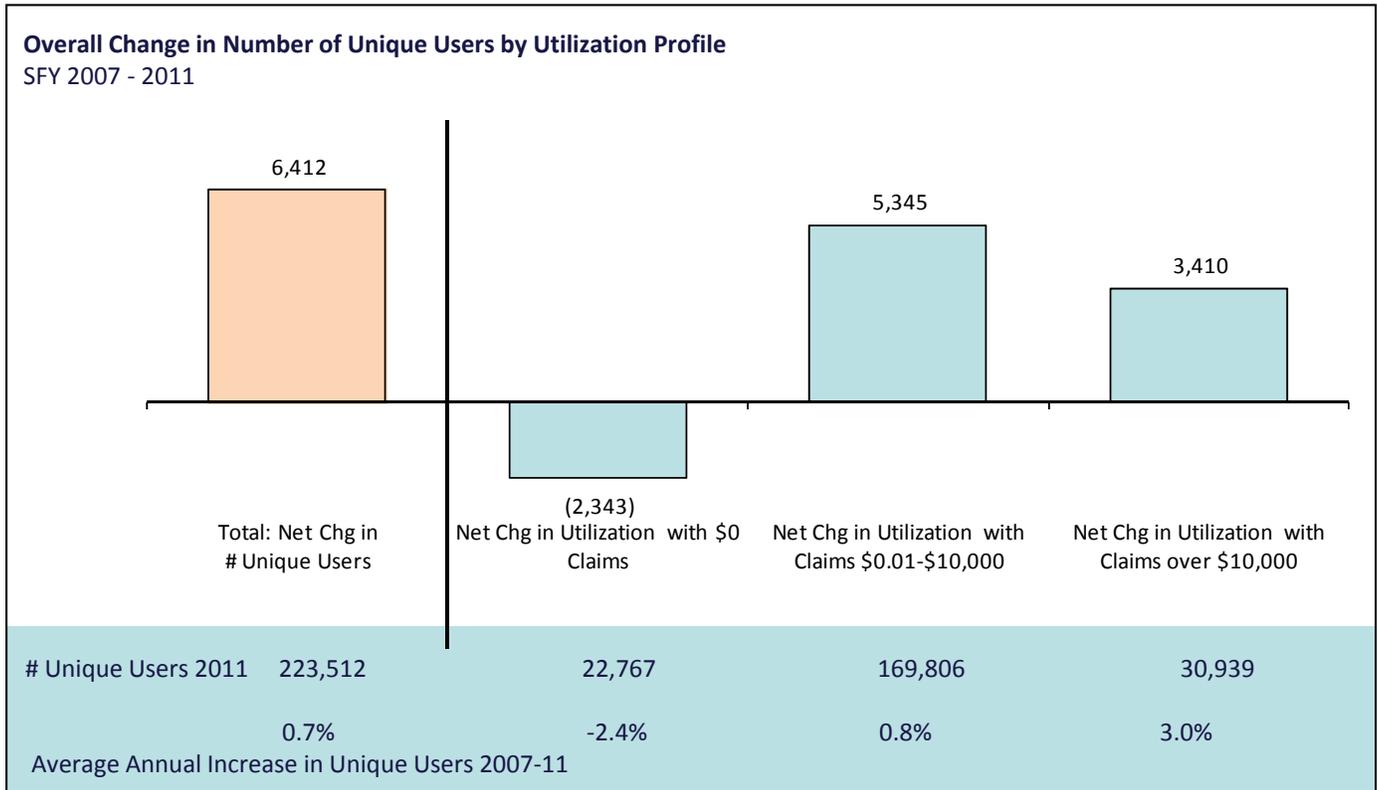


- ❖ Nursing facilities account for 28% of the expenditure on high cost users, and residential and rehabilitation services for persons with developmental disabilities account for another 20%.
- ❖ In addition, expenditure on high cost users accounts for over 90% of total expenditure for nursing facilities,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

1. Expense unassigned by user includes provider payouts, UPL (upper payment limit), Medicare Premiums, PACE premiums, and managed care administrative costs.
 2. See page16 for footnotes and definitions of service categories.

5b. Expenditure Trends by User

Over the past five years the number of higher cost users has been increasing at a faster rate than the average increase in users.



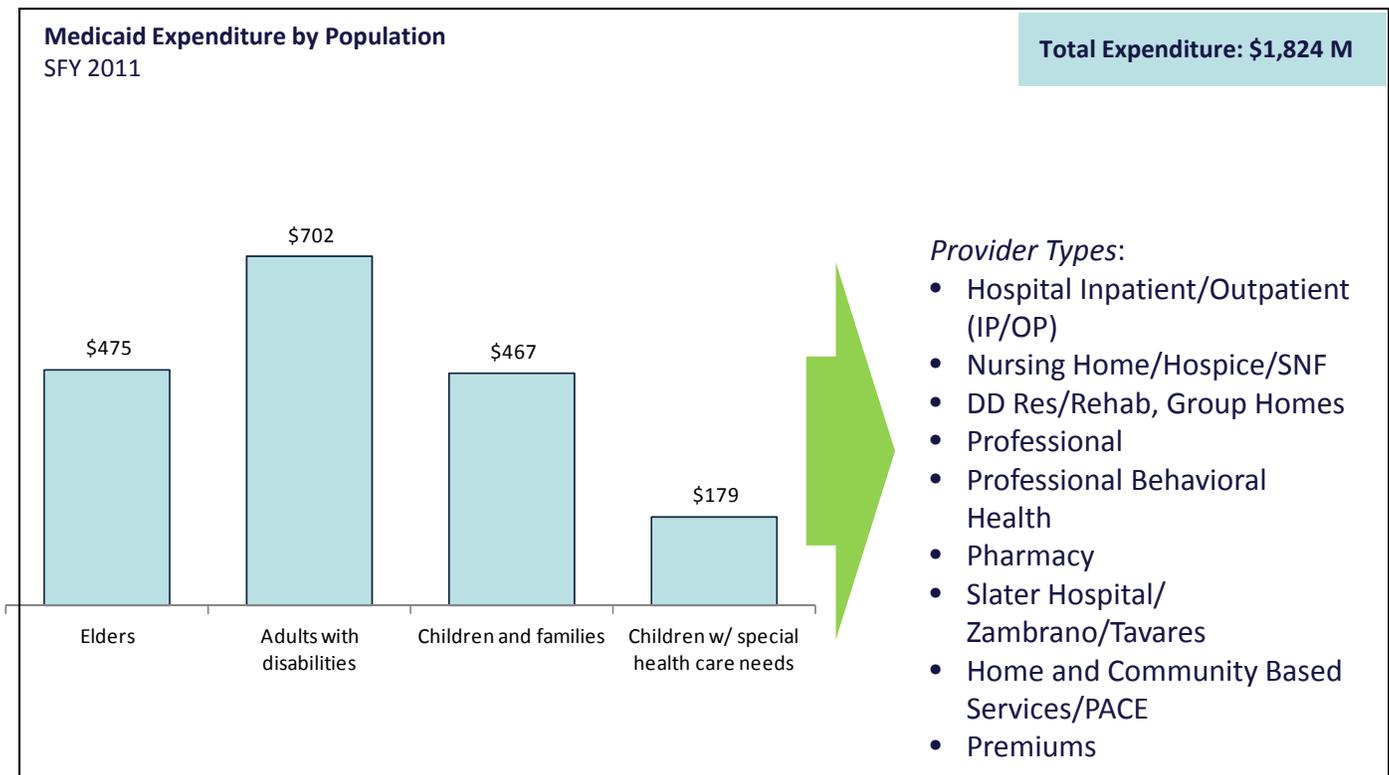
- ❖ Overall, Medicaid has experienced a 0.7% average annual increase in the number of unique users over the past 5 years. This is slightly less than the increase in average eligibles (1.1%).
- ❖ There has been a decrease in the number of unique users with \$0 claims, however this group is relatively small, with only 22,767 users in 2011.
- ❖ There has been a larger relative increase in the number of users with utilization over \$10,000 per year – 3.0% average annual increase vs. the overall increase of 0.7%. A shift in utilization profiles toward a higher cost population could affect the program cost structure and expenditure trends over the coming years.

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6. Expenditure Detail by Population and Provider Type

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

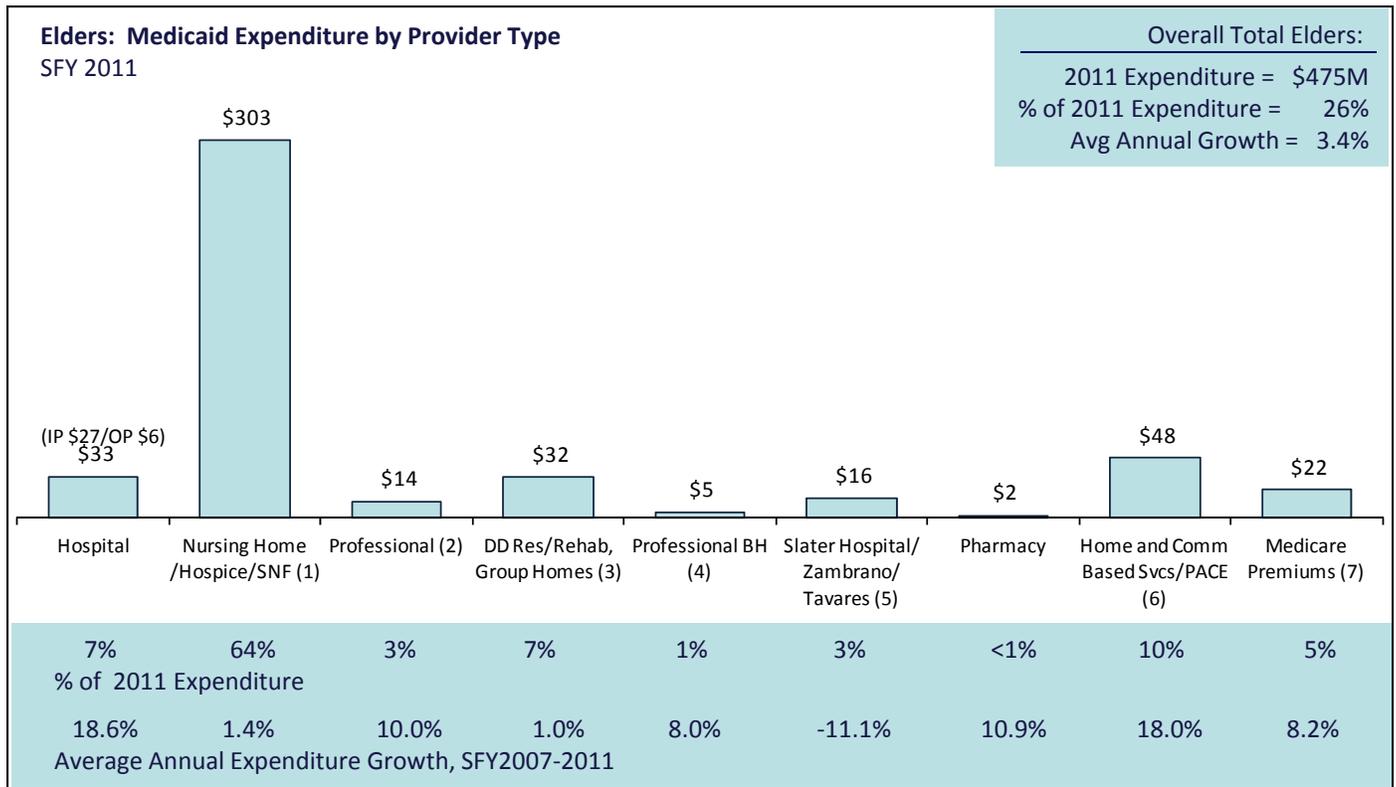


In order to review expenditure by population in more detail, it is useful to look at expenditure by provider type within each population group.

- ❖ Elders includes 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 (Supplemental Security Income) who are under 21, Katie Beckett children, and Adoption Subsidy children.

6a. Elders Detail

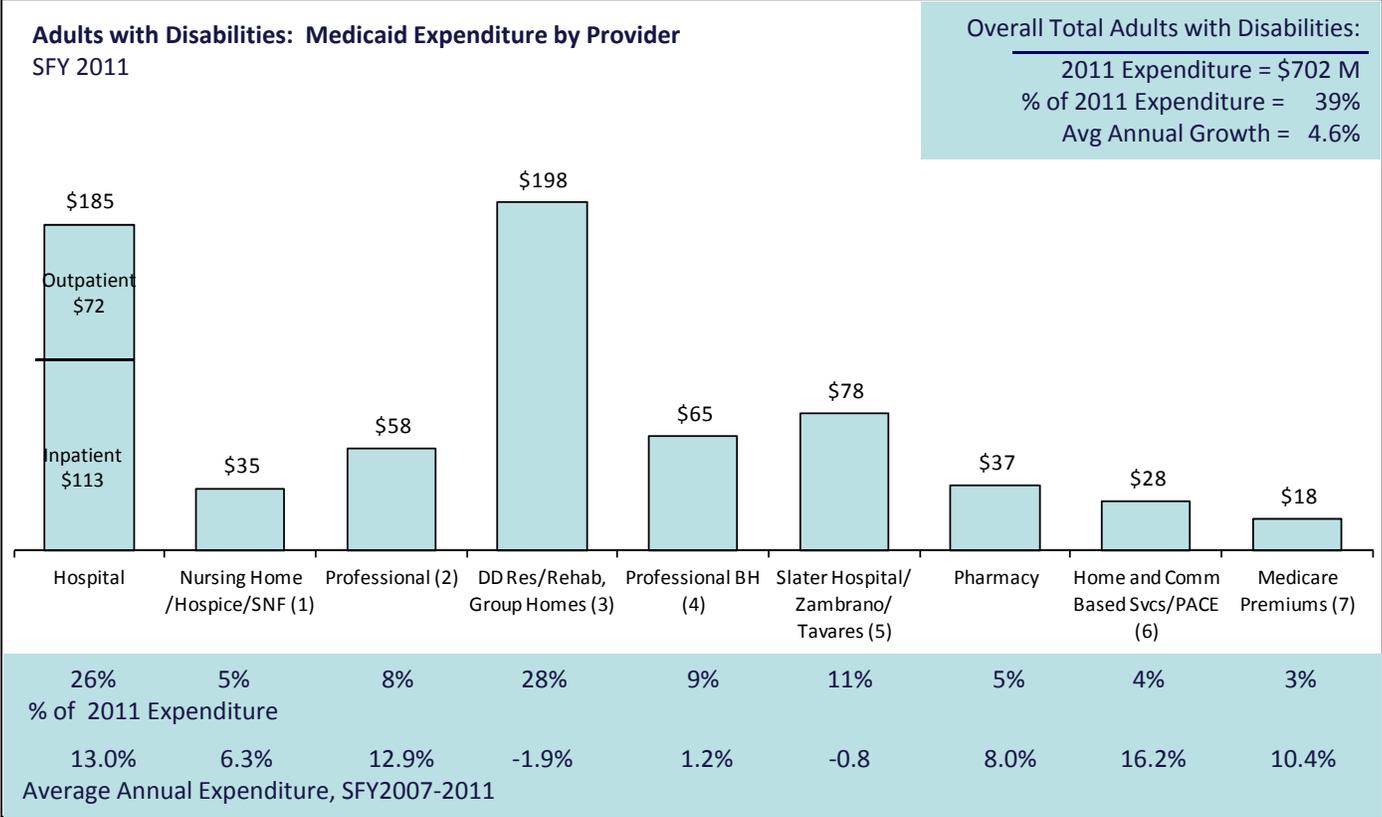
Nursing facilities account for approximately two thirds of total expenditure for elders.



- ❖ Medicaid expenditures on elders totaled \$475 Million in SFY 2011, and has been increasing at 3.4% 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 expenses were not paid by Medicaid and are not included here.
- ❖ Nursing facilities (including nursing homes, hospice and skilled nursing facilities) account for nearly two thirds (64%) of total Medicaid expenditure on elders. The increase in nursing home expenditure has been relatively lower than the increase in overall expenditure for this population - an average annual increase of 1.4 percent per year.
- ❖ Most of the growth in Medicaid expenditure for elders has been in hospital, nursing home services and in 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.

6b. Adults with Disabilities Detail

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

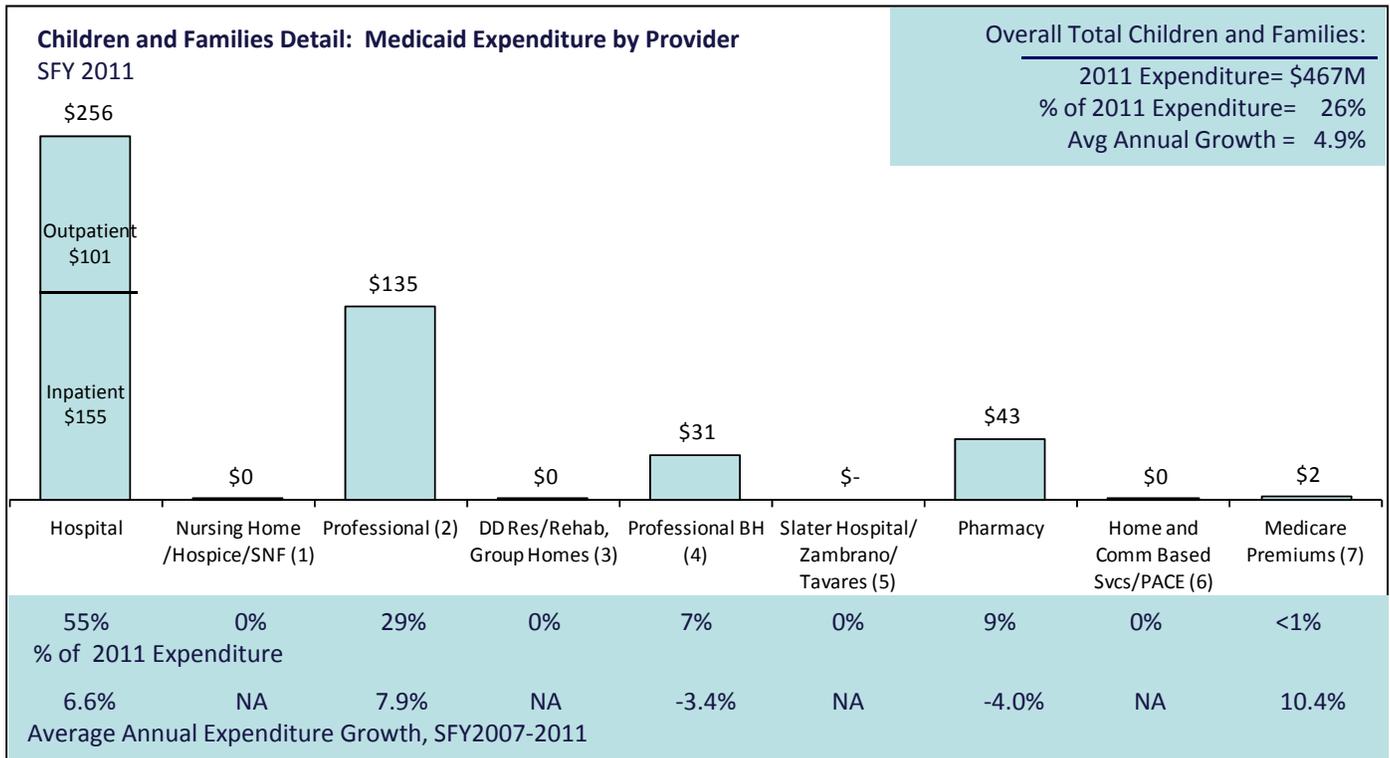


- ❖ Adult with disabilities account for the largest share of Medicaid expenditures, with total SFY 2011 expenditure of \$702 Million. Expenditure for this population has increased by approximately 4.6% per year over the past 5 years.
- ❖ Hospital and residential and rehabilitation services for persons with developmental disabilities are the two largest categories of expenditure, accounting for 26% and 28%, respectively, of total Medicaid expenditure on adults with disabilities.
- ❖ The provider type with the highest rate of growth in Medicaid expenditure for the adults with disabilities population has been home and community based services.

See footnotes on page 16 for Provider Type definitions.

6c. Children and Families

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



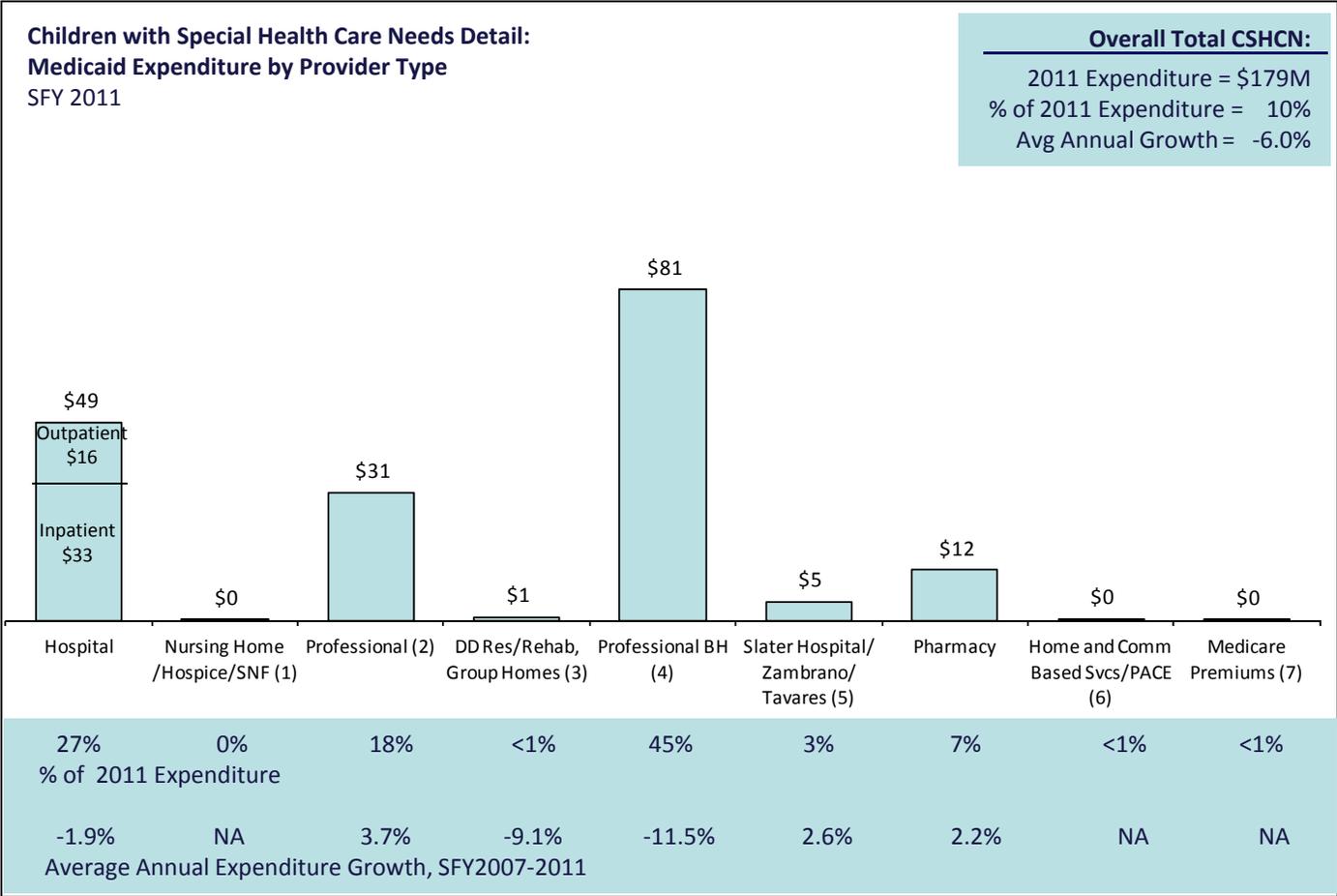
- ❖ Children and families account for one-fourth (26%) of total Medicaid expenditures, with SFY 2011 expenditure of \$467 Million. Expenditure for this population has increased by 4.9% per year over the past 5 years.
- ❖ It is important to note that the federal match is enhanced for qualifying low income 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" from families with incomes up to 250 percent of the federal poverty level who are uninsured and not otherwise eligible for Medicaid. In SFY 2011, Rhode Island received a 67.02% combined CHIP/FMAP federal match on 9,186 "optional" children and pregnant women who are in families with incomes above mandatory coverage levels.
- ❖ Most expenditure on children and families is divided between professional and hospital care, with hospital care accounting for over half (55%) of expenditure. Both categories experienced high growth – with 6.6% and 7.9% average annual increases respectively.
- ❖ 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.

See footnotes on page 16 for Provider Type definitions.

¹ Source: RI Vital Statistics, Birth File 2000-2010, RI Medicaid Research and Evaluation Project

6d. Children with Special Health Care Needs

In the population of children with special health care needs, professional behavioral health accounts for nearly half (45%) of all expenditure.



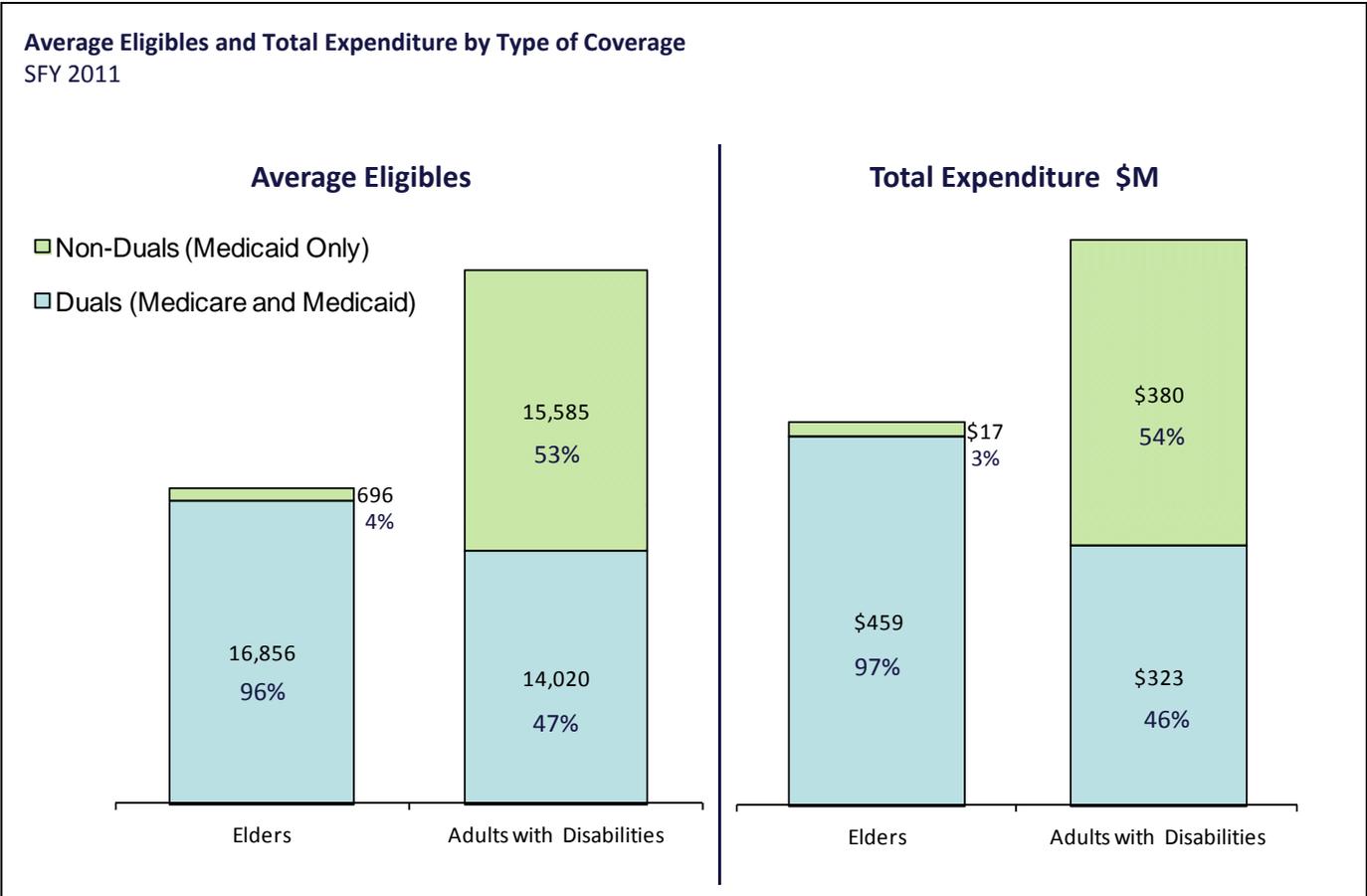
- ❖ Children with Special Health Care Needs (CSHCN) is a relatively small population -- accounting for ten percent of total Medicaid expenditures and seven percent of enrollees, with total SFY 2011 expenditure of \$179 Million.
- ❖ Expenditure for this population is dominated by professional behavioral health services, which account for just under half (45%) of total expenditures.

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7a. Utilization by Population: Overview

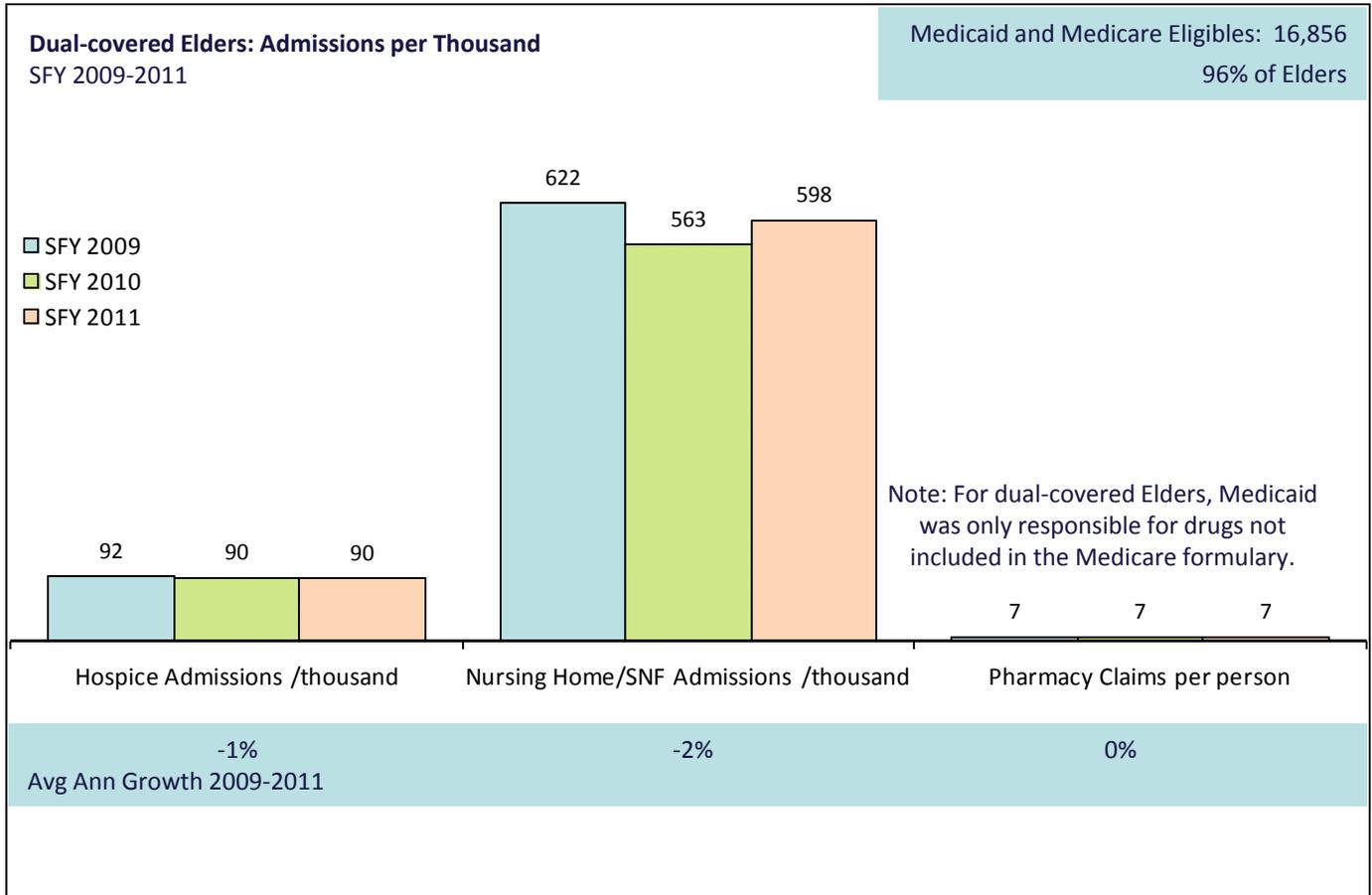
Individuals covered by both Medicare and Medicaid have dual coverage (“duals”). Medicare is the primary payer for most medical services (e.g. hospital, physician, pharmacy) for 96% of elders and for 47% of adults with disabilities. Medicaid pays for services not paid for by Medicare (e.g. extended nursing home stays, home and community supports). For “non-duals” (persons covered only by Medicaid), Medicaid pays for all covered services.



- ❖ Ninety-six percent of elders and forty-seven percent of adults with disabilities are covered by both Medicare and Medicaid (called dual eligibles).
- ❖ Similarly, 97% of expenditures for elders and 46% of expenditures for adults with disabilities are for dual eligibles.
- ❖ 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: Dual-covered Elders

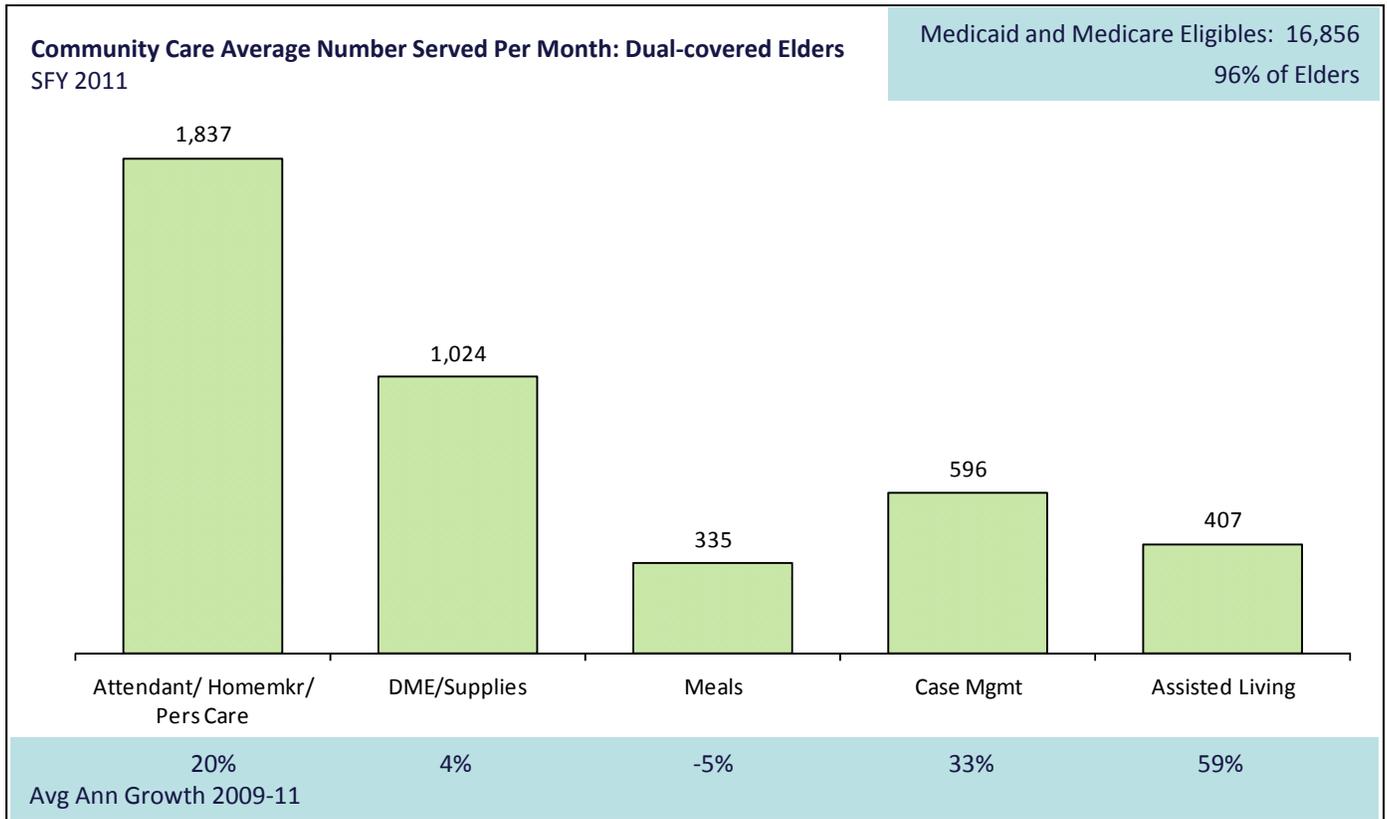
For dual-covered Elders, both nursing home and hospice admissions per thousand decreased from SFY2009 to 2011.



- ❖ Ninety-six 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 598 in SFY 2011. This number has decreased from 622 in 2009. Hospice admissions per thousand also decreased from SFY 2009 to 2011.
- ❖ 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 7 pharmacy claims per eligible in 2011, similar to claims over the last 3 years.

7a. Utilization by Population: Elders

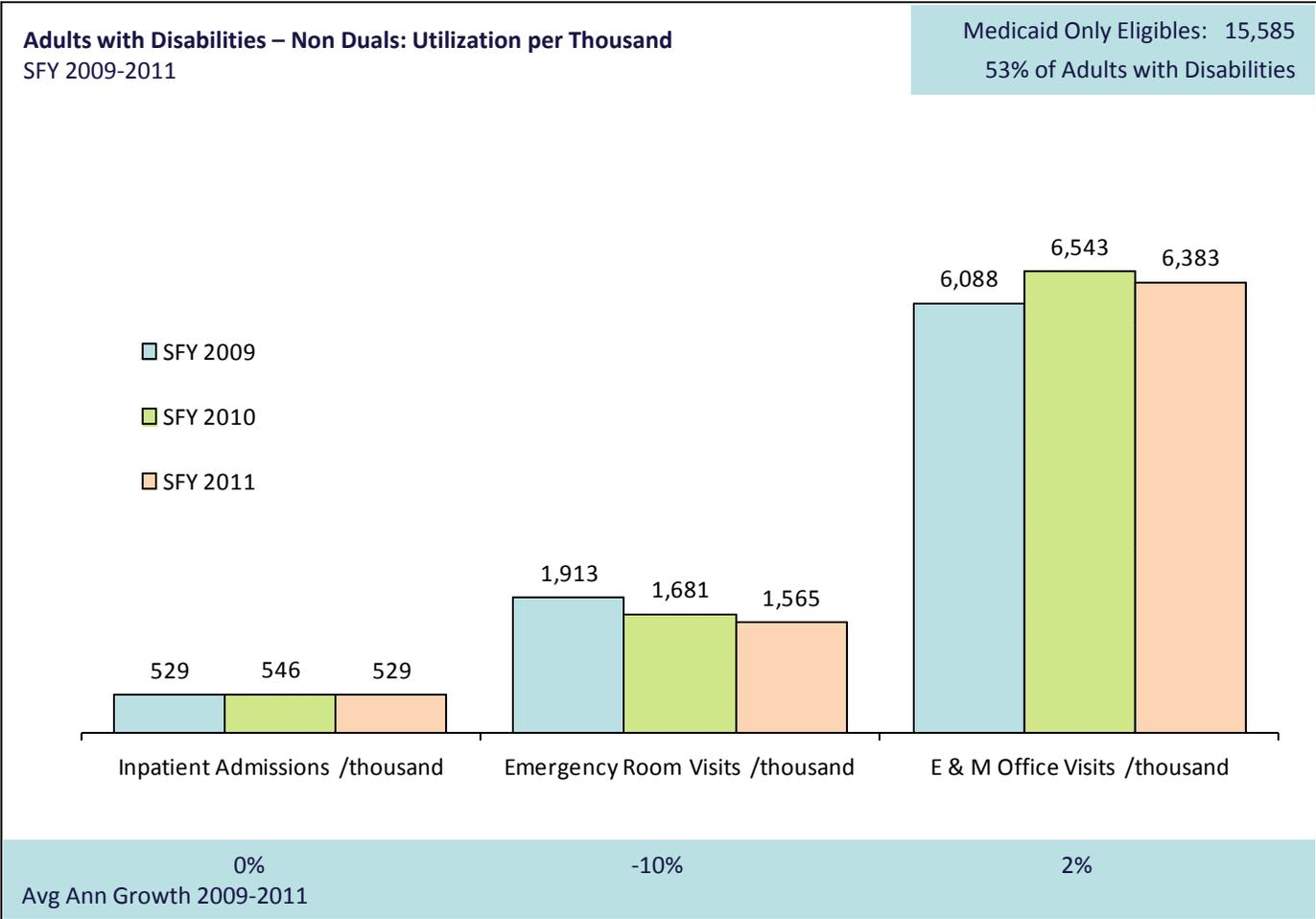
For some elders home and community based services enable them to remain in a community setting rather than be admitted to or remain in a nursing home. The largest category of community based care for elders is attendant, homemaker and personal care services.



- ❖ 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 1,837 recipients in 2011. The daily census for this category is growing at 20% per year for elders covered by both Medicaid and Medicare.
- ❖ Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.
- ❖ For the 696 elders covered only by Medicaid, the average daily census for attendant/homemaker/personal care services was 26 recipients. All other categories of community care had an average daily census of less than 10 recipients.

7b. Utilization by Population: Adults with Disabilities

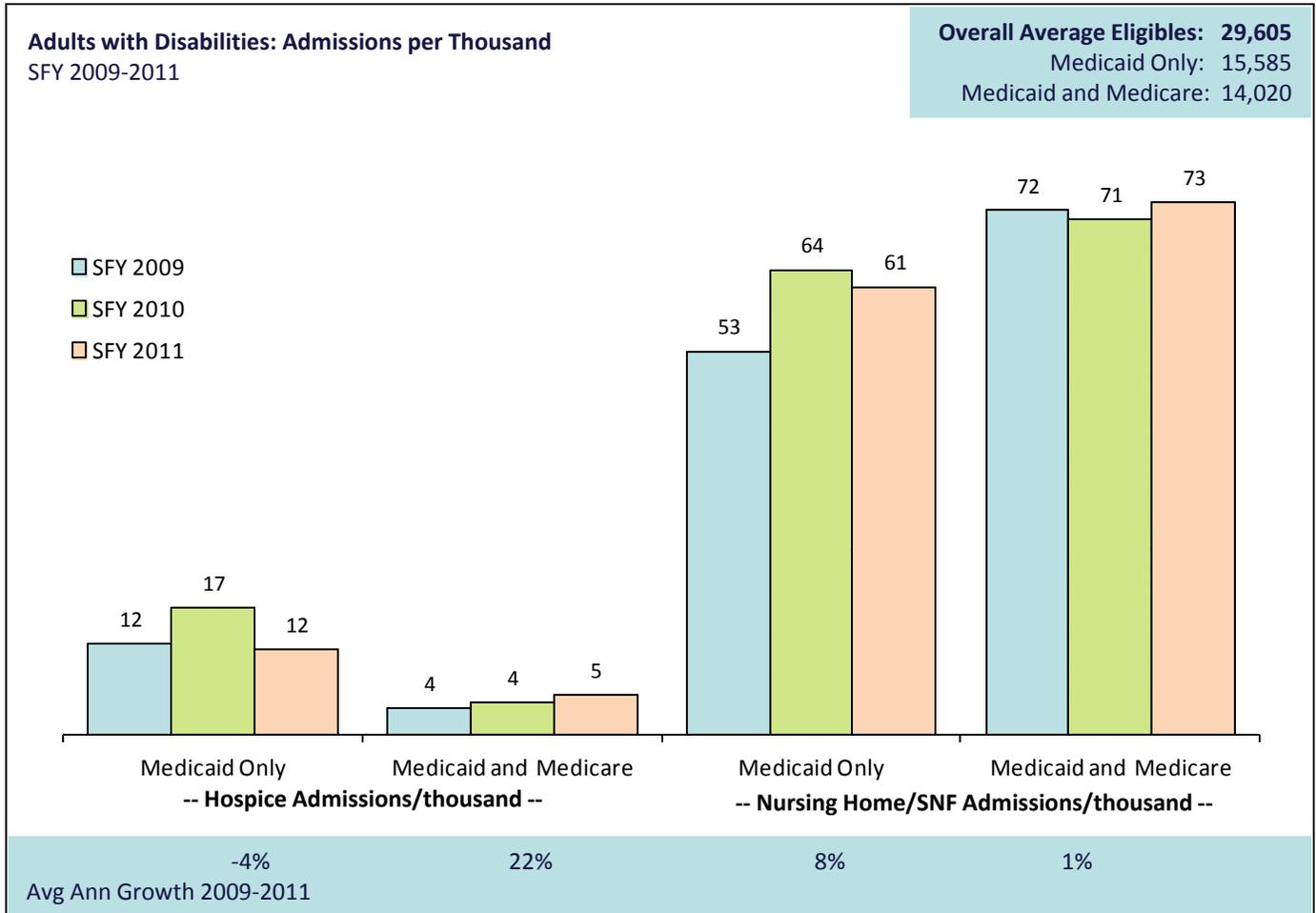
Emergency room visits per thousand have decreased 10% per year since 2009 for adults with disabilities with Medicaid-only coverage (non-duals).



- ❖ Forty-seven 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 the 53% of adults with disabilities without dual coverage.
- ❖ Emergency room visits per thousand have decreased 10% per year since 2009 for adults with disabilities covered only by Medicaid.
- ❖ For those covered only by Medicaid, each eligible averaged 6.4 office visits per year in 2011, slightly up from 6.1 office visits per year per eligible in 2008.

7b. Utilization by Population: Adults with Disabilities

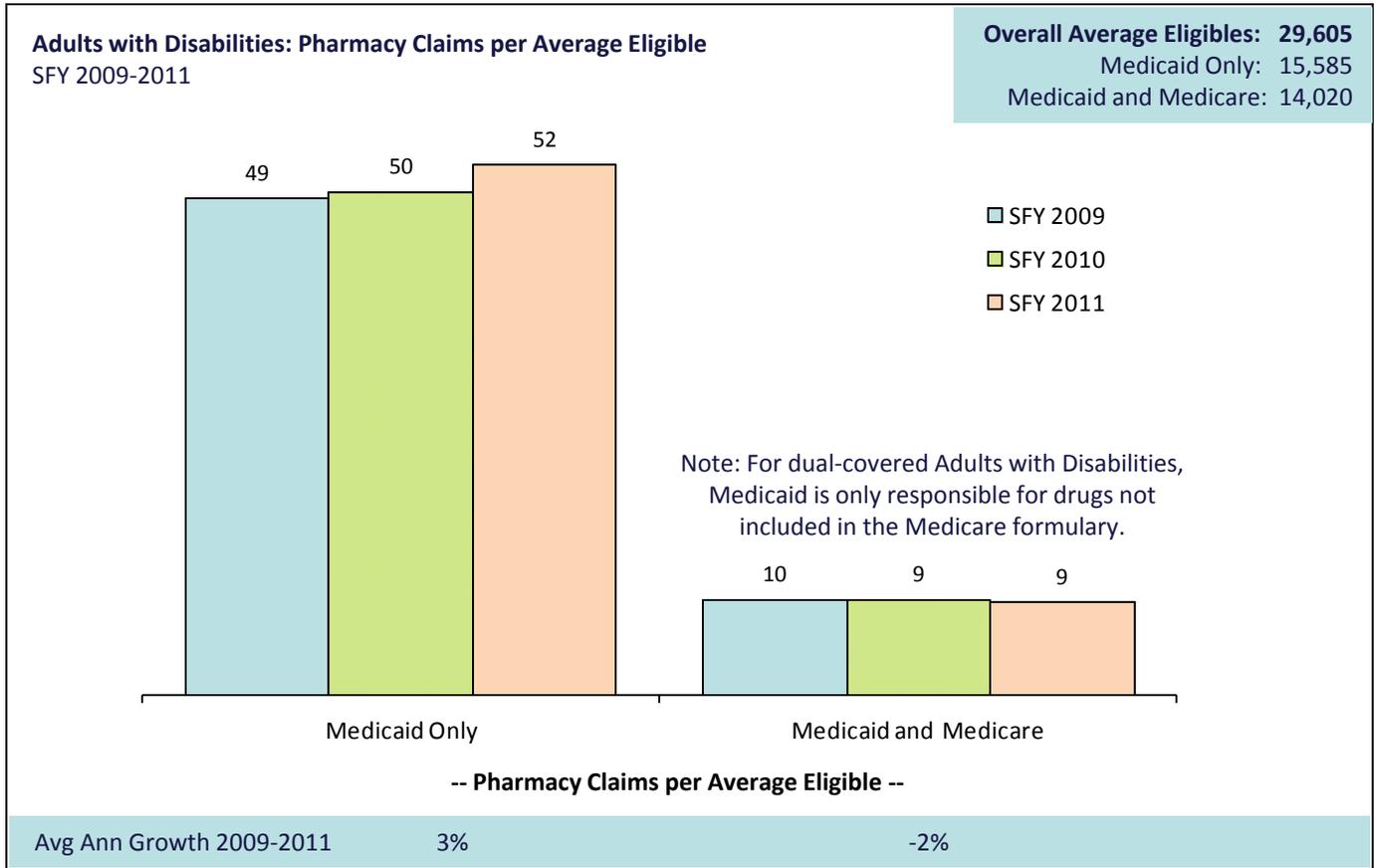
Nursing home admissions per thousand have increased 8% per year since 2009 for adults with disabilities with only Medicaid coverage.



- ❖ Forty-seven 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 decreased 4% per year and nursing home/skilled nursing facility admissions per thousand increased 8% per year since 2009.
- ❖ Nursing home/skilled nursing facility admissions per thousand for those covered by both Medicare and Medicaid were 73 per thousand for 2011, an increase of 1% per year since 2009.

7b. Utilization by Population: Adults with Disabilities

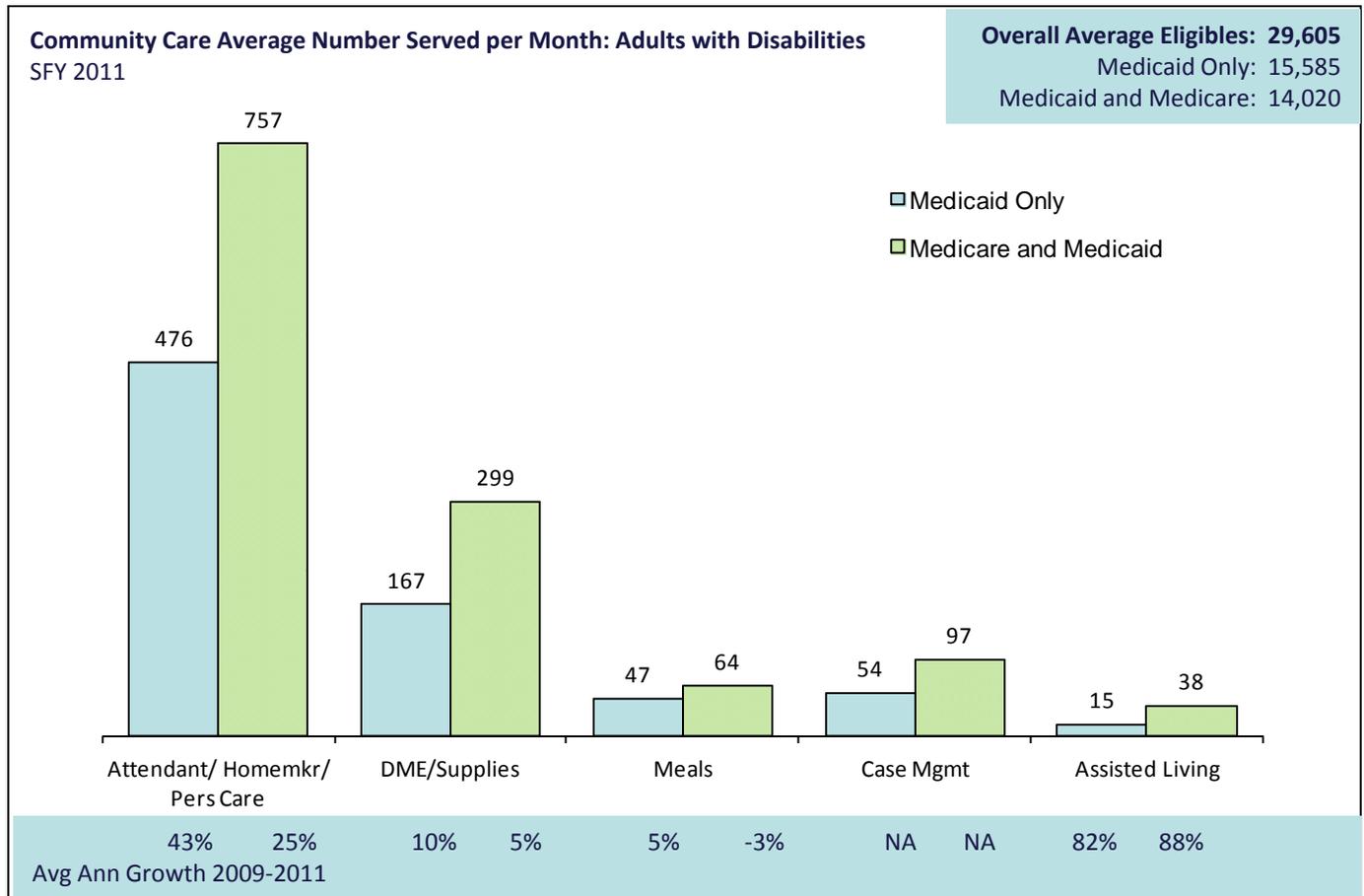
Adults with disabilities averaged 52 pharmacy claims per year in 2011 for those covered only by Medicaid.



- ❖ Forty-seven 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 9 pharmacy claims per eligible in 2011, a decrease of 2% per year over the last 3 years.
- ❖ For adults with disabilities without Medicare coverage, Medicaid was responsible for 52 claims per eligible in 2011, up from 49 claims per eligible in 2009, an average increase of 3% per year.

7b. Utilization by Population: Adults with Disabilities

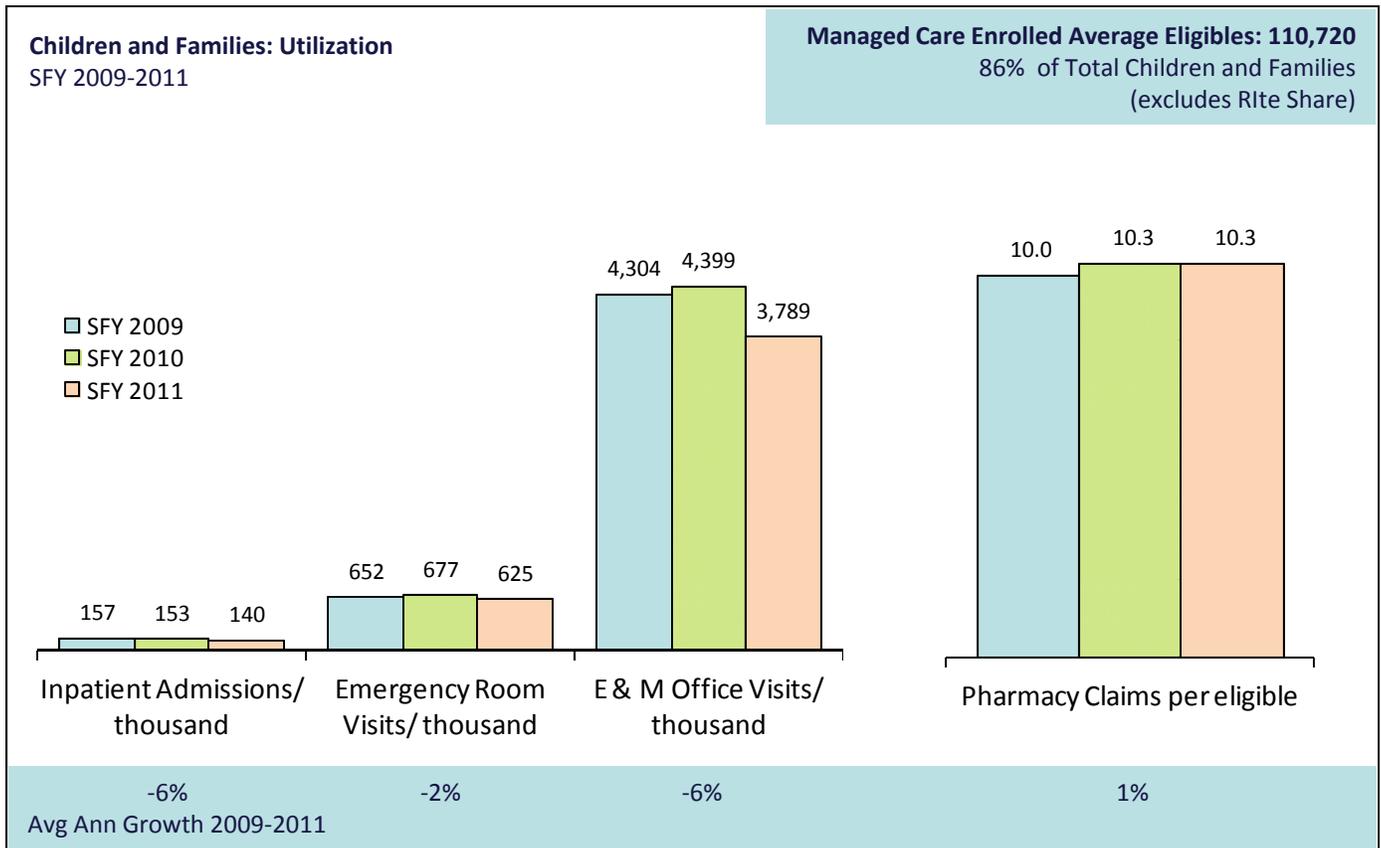
Similarly to elders, the largest category of community based care for adults with disabilities is attendant, homemaker, and personal care services.



- ❖ Forty-seven 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.
- ❖ Large portions of expenditure for case management and for assisted living were paid off-line in 2009, and are not readily attributable to individual recipients. Because of this, during 2009-2011 growth rates cannot be accurately calculated for these areas.
- ❖ The largest category of community care is attendant/homemaker/personal care services, with an average of 757 recipients in 2011 for duals and 476 for Medicaid only. The daily census for this category is growing at 25% per year for adults with disabilities covered by both Medicaid and Medicare.
- ❖ Some eligibles may be receiving more than one service, resulting in overlap in the average number of eligibles served.

7c. Utilization by Population: Children and Families

For children and families in managed care, inpatient admissions per thousand and emergency room and office visits per thousand have all decreased since 2009.

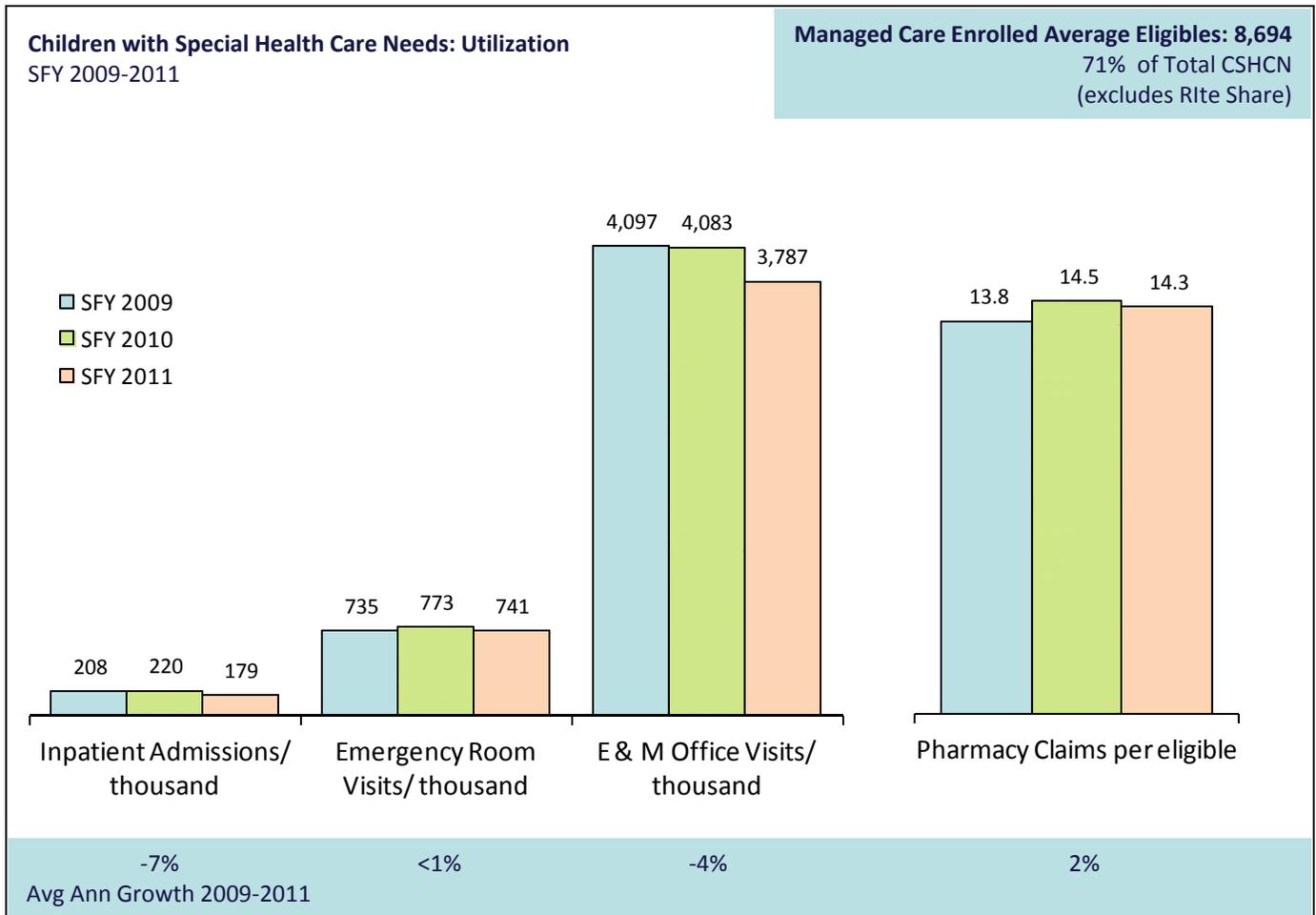


- ❖ Eighty-six percent of children and families are enrolled in managed care through Medicaid managed care organizations (MCOs). Another 8% are covered by Employer Sponsored Insurance (ESI) through the RIte Share program. RIte Share is not included in the data above.
- ❖ Over 65% of inpatient admissions per thousand are maternity related (including maternity, nursery and NICU). Annually, approximately 47% of all RI births are covered through RIte Care¹.
- ❖ For children and families in managed care, inpatient admissions per thousand and emergency room and office visits per thousand have all decreased since 2009.
- ❖ Pharmacy claims per eligible have increased from 10.0 per year in 2009 to 10.3 per year in 2011.

¹ Source: RI Vital Statistics, Birth File 2000-2010, RI Medicaid Research and Evaluation Project

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 office visits per thousand have decreased in the last 3 years.



- ❖ Seventy-one percent of children with special health care needs are enrolled in managed care through Medicaid MCOs.
- ❖ Almost half (47%) of inpatient admissions per thousand are for behavioral health.
- ❖ Office visits per thousand have decreased over the last three years, from 4.1 visits per eligible per year to 3.8 visits per eligible per year.
- ❖ Pharmacy claims per eligible have increased at 2% per year over the last 3 years, from 13.8 per year in 2009 to 14.3 per year in 2011.

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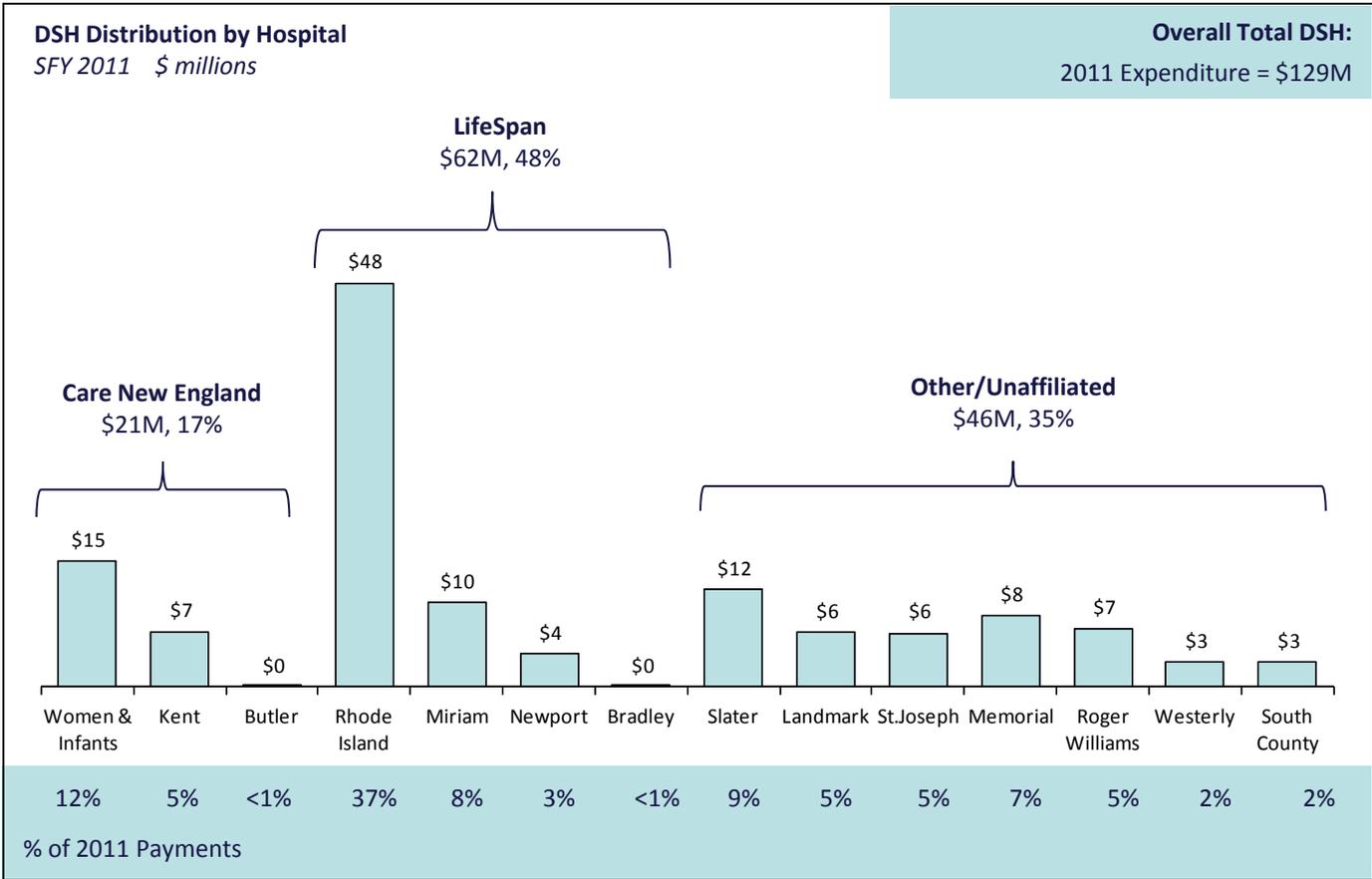
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Appendix A: Exclusions (1) Disproportionate Share Hospitals (DSH)

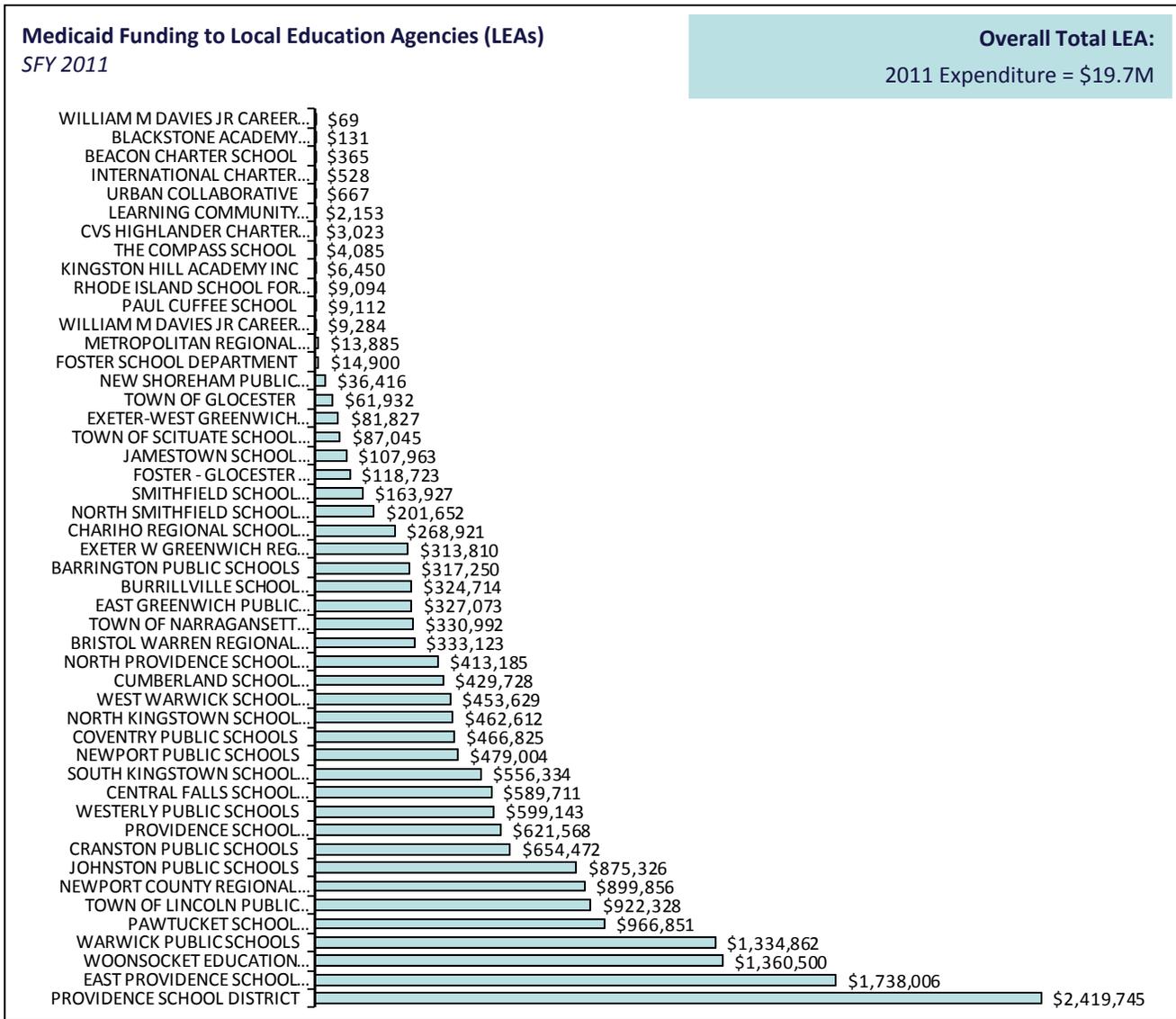
Disproportionate share (DSH) Medicaid payments are intended to subsidize the cost of providing care to indigent and very low income people.



- ❖ A total of \$129 million in DSH funds was paid out to hospitals in SFY 2011.
- ❖ 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 \$19.4 million in total Medicaid expenditures. 48 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

| | |
|-----------------|--|
| ACA: | Affordable Care Act |
| BCBSRI : | Blue Cross Blue Shield of Rhode Island |
| BHDDH: | Behavioral Healthcare, Developmental Disability, and Hospitals |
| CC: | Community Care |
| CHIP: | Children’s Health Insurance Program |
| CMHC: | Community Mental Health Center |
| CMS: | Centers for Medicare and Medicaid |
| 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 |
| LTC: | Long Term Care |
| MCO: | Medicaid Managed Care Organization |
| NHPRI : | Neighborhood Health Plan of Rhode Island |
| NICU: | Neonatal Intensive Care Unit |
| OP: | Hospital Outpatient |
| PACE: | Program of All-Inclusive Care of the Elderly |
| PMPM: | Per member per month |
| RIPTA: | Rhode Island Public Transit Authority |
| SA: | Substance Abuse |
| SNF: | Skilled Nursing Facilities |
| SFY: | State Fiscal Year |
| SSI: | Supplemental Security Income |
| UHCNE: | UnitedHealth Care of New England |

Appendix C: Sources and Notes

Source Data and Analytic method

This report is based on SFY2011 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 2011
- ❖ Capitations, premiums and payouts are 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 and rounding.