Rhode Island Annual Medicaid Expenditure Report
State Fiscal Year 2009

Executive Office of Health and Human Services

October 2010

Statutory Mandate

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

"Beginning in 2006, prepare and submit to the governor and to the joint legislative committee for health care oversight, by no later than December 1 of each year, a comprehensive overview of all Medicaid expenditures included in the annual budgets developed by the departments. The directors of the 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 spending to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process.

❖Summarize Medicaid expenditures for eligible individuals and families covered by one or more of the five health & human services departments.

❖Show enrollment and spending 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.

❖Inform broader policy discussions about the future of the RI Medicaid program, the role it plays in the state's health care system, and its impact on the larger economy.

Source Data and Analytic method

This report is based on 2009 and five year historical Rhode Island Medicaid claims data extract, with the following adjustments:

❖Claims vs. Capitations: Since some state expenditure is paid out in capitation, not in claims, a subset of claims are "backed out" of total claims experience, and replaced with capitation expenditures

❖Provider Payments not captured in claims: Some Medicaid provider and MHRH payments not captured in claims were added back in to these estimates

❖Report based on SFY 2006-2009 data extract dated March 8, 2010 (97.17% complete)

Overview

In State Fiscal Year (SFY) 2009, the Rhode Island Medicaid program served 200,000 Rhode Islanders at some point in time, that is about 20% of Rhode Islanders were enrolled in Medicaid for at least part of the year. Program expenditures for SFY 2009 totaled approximately $1.9 billion. Of this amount, $1,730 million of this was medical expenses, which are the focus of this report. Medicaid spending is divided among six state agencies, with 70% of total spending managed by the Department of Human Services (DHS), and 24% managed by MHRH.

Under the Medicaid program, the federal government is typically responsible for approximately half of total spending (52.47%). However, the Federal Stimulus package increased the federal share substantially, to 63.89% beginning October 1, 2008 and ending December 31, 2010. This one time adjustment saved ~$148 in state expenditures in SFY 2009.

Between SFY2006 and 2009, total Rhode Island Medicaid medical expenditures have increased an average of 1.7 percent per year. This overall spending increase is made up of a 3.2 percent increase in unit costs, and a 1.4 percent decline in enrollment, which can be added together to determine average spending growth. These spending trends compare quite favorably to both national Medicaid expenditures and regional/local commercial cost trends.

Populations Served

Medicaid beneficiaries include the elderly, adults with disabilities, low income children and families and children with special health care needs. Each of these populations have very different service needs and cost experience.

- Adults with disabilities account for the largest share of expenditures, with 2009 spending of $663 Million, and an average cost per member per month (PMPM) of $1,970. The largest components of cost for this population are specialized behavioral health services (27%) and specialized group homes and institutions for the disabled.
- The elderly account for $437 Million in total 2009 Medicaid spending, and the highest average cost per member per month (PMPM) of $2,104. Costs for this population are dominated by payments to nursing homes, which account for about two-thirds (62%) of spending on this population.
- Children and families account for 67% of total enrollment, and about 23% of total costs, with total 2009 spending of $405 million. Additionally, the federal match is increased to 68% for qualifying "optional" low income children and families under the CHIP program. This population most closely resembles commercial populations and typically require much less intensive services.
- Children with special health care needs (CSHCN) is a relatively small population – accounting for 13% of total Medicaid expenditures and 7% of enrollees, with total 2009 spending of $225 million. Spending on this population is dominated by behavioral health services, which account for just over half (54%) of total expenditures.

Medicaid expenditures are highly concentrated, as the top 7% of users account for over two-thirds (70%) of expenditures. These 16,000 top utilizers spent, on average, $69,000 per person, more than *sixty times* as much per person as those in the bottom 78% of spenders. Additionally, trends in user profiles suggest that the Medicaid population may be shifting toward a higher cost profile – as the share of low cost users is declining while high cost users is on the rise. This shift in population mix could result in increased Medicaid costs and trends in coming years.

Medicaid Covered Services

Medicaid beneficiaries spending is divided between outpatient/professional care, institutional care, inpatient care and pharmacy.

❖Outpatient/professional care is the largest category of service, accounting for almost half (45%) of all service spending. This is split between behavioral health services (45%) and other outpatient/professional (55%) services. Other outpatient/professional services is the fastest growing category of service, increasing at an average rate of 8.2% per year.

❖Institutional care is the next largest category of service, accounting for about one-third (30%) of all service spending. This includes both nursing home services and care provided at one of the specialized mental health institutions. Spending on these services, while substantial, has been flat or declining over the past few years.

❖Inpatient care represents approximately 17% of all service spending. Inpatient spending had been increasing steadily between 2006 and 2008, but declined slightly from 2008 to 2009, resulting in an average increase of 2.8% per year .

Medicaid Providers

Medicaid pays for services offered by a variety of providers. Hospitals, behavioral health providers and nursing facilities together account for two-thirds of program spending. However, key contributors to spending growth were hospitals, professional providers and home/community based service providers

❖Hospitals were the largest provider type, consuming 27% of Medicaid spending in 2009. Hospital payments are also a key driver of Medicaid spending growth – as payments to hospitals increased by an average of 5% per year between 2006-2009 and accounted for about half (47%) of all Medicaid spending growth in recent years.

❖Behavioral health providers were the next largest provider type, accounted for 20% of spending in 2009. Spending on these providers has been relatively flat, with average annual increases of 0.9% between 2006-2008.

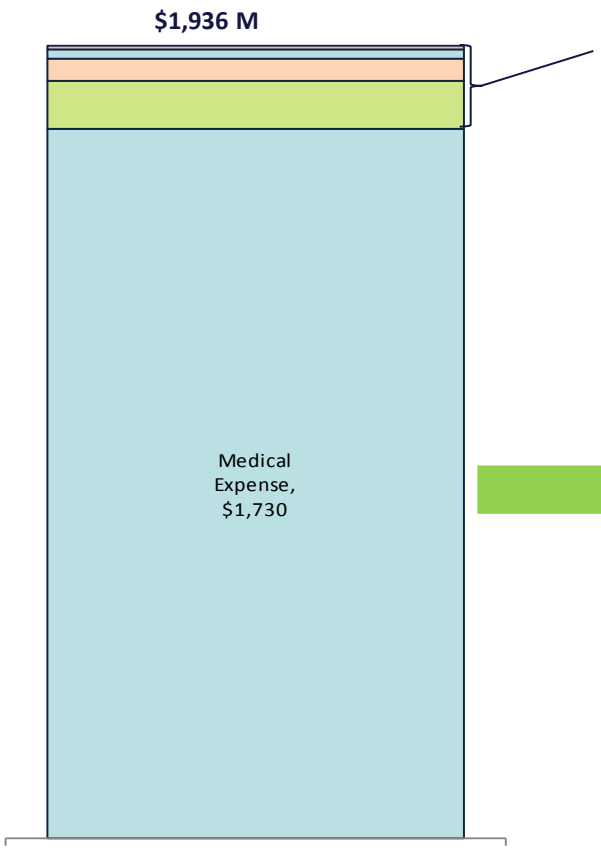
It is important to note that not all of these payments are made directly by Medicaid to service providers. About three-quarters (72%) of all Medicaid beneficiaries are enrolled in managed care organizations for primary and acute care services. Most of the managed care enrolled populations are children and families; however, two new managed care programs, Rhody Health Partners and ConnectCare Choice – are now options for disabled adults. Enrollment in Rhody Health Partners or ConnectCare Choice became mandatory for adults with disabilities on July 1, 2009.

Table of Contents

a. Total Medicaid Expenditures, 2009

Medicaid expenditures totaled approximately $2.0 billion in SFY 2009

Summary: Total Medicaid[1]
SFY 2009 - $millions



Other: $206 M:
$13 M RIPTA
$21 M Local Education Agencies
$52 M State-Only Populations and Services
$120 M DSH
(see appendix for more detail on each of these programs)

*This report focuses on qualified Medicaid **medical expenses,** which represent 89% of total Medicaid expenditures*

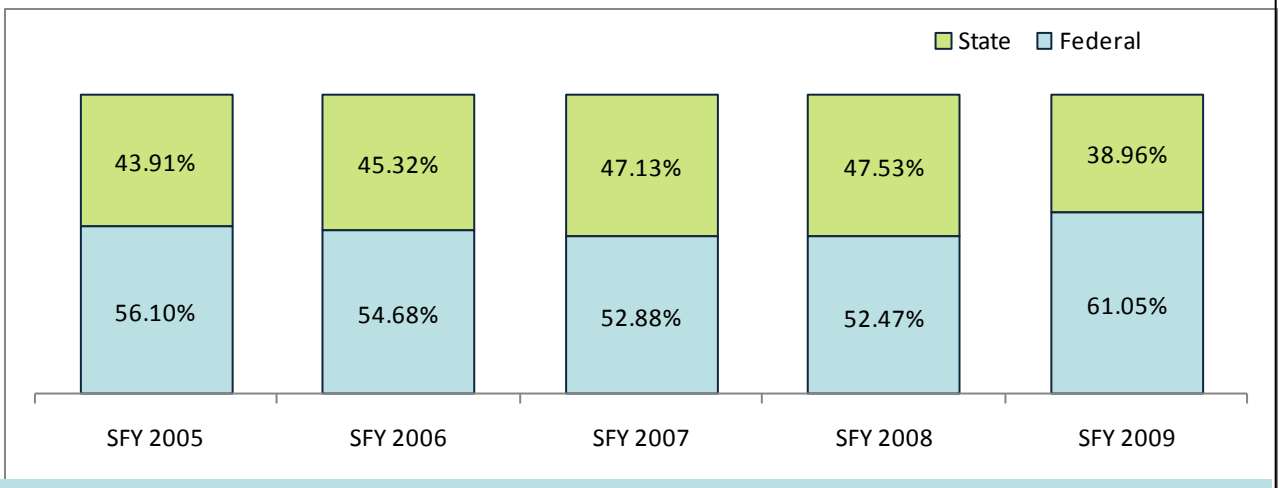
- In fiscal year 2009, Rhode Island incurred approximately $2.0 billion in Medicaid expenditures. This spending was split between state and federal funds.
- This report includes all Medicaid expenditures, including both state and federal funds. It focuses specifically on Medicaid Medical Services expenditures – which account for 89% of total Medicaid expenditures. The analysis that follows will exclude DSH (Disproportionate Share Hospital) Payments, payments to LEAs (Local Educational Agencies) and Rhode Island Public Transit Authority (RIPTA), as well as payments for populations and programs that do not qualify as federal Medicaid expenditures. A summary of each of these exclusions is provided in the appendix.
- What follows will describe the different elements of Rhode Island's Medicaid program, to provide a common understanding of the key elements of Medicaid spending, as well as areas of spending growth.

1. Source data for this analysis: MedicaidGlobal20100308xls-1, extracted March 8, 2010. Excludes program administration.

b. FMAP Trends

Rhode Island is typically responsible for about half of Medicaid expenditures; however, stimulus funds significantly reduced this state share for 2009

Federal Medicaid Matching Rates



Effective annual changes in state Medicaid costs due to FMAP changes				
	$23 m	$30 m	$7 m	($148 m)

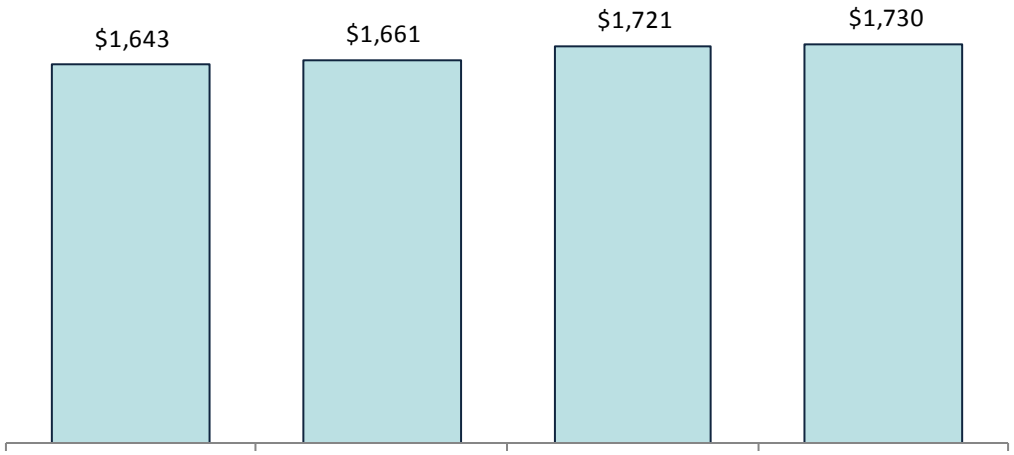
- Although this report reviews trends in total Medicaid medical expenditure, note that less than half of program spending is derived from the State's Annual Budget. Funding is split between state and federal dollars, with Rhode Island typically responsible for about half of all program expenditures.[1]
- Prior to 2009, FMAP rates had declined almost four points between SFY2005 and SFY 2008, resulting in significant increases in state expenditures for program costs.[2] However, the ARRA federal stimulus package increased FMAP by 11.42%, to 63.89% retroactive to October 1, 2008 and ending December 31, 2010. The higher FMAP results in a blended SFY2009 FMAP of 61.05%, thereby providing a substantial reduction in the state share of Medicaid spending. A comparison of the FMAP levels in 2008 to 2009, shows that the stimulus adjustment to FMAP saved ~$148 million in state expenditures in SFY 2009.
- In addition to the FMAP levels shown above, the federal match is enhanced for qualifying low income children and pregnant women under the Children's Health Insurance Program (CHIP). CHIP builds on Medicaid to provide insurance coverage to "targeted low-income children" who are uninsured and not eligible for Medicaid, and come from families with incomes up to 250% of the federal poverty level. In SFY 2009, Rhode Island received a 66.80% combined CHIP/FMAP federal match on children and pregnant women who are in families with incomes above mandatory coverage levels established in federal law. This enhanced federal match allowed Rhode Island to cover 49,663 children and pregnant women at approximately one-third of the total cost of coverage.

1. The Global waiver, which was negotiated to cover the Medicaid program beginning January 2009, retained the current model for FMAP going forward.
2. Analysis based on FMAP only – does not include SCHIP match. Effective increase calculated as the difference between actual state spending and the amount the state would have spent at the 2005 FMAP rate.

c. Global Medicaid Cost Trends, 2006-2009

Over the past four years, Rhode Island Medicaid expenditures increased an average 1.7% per year.

Global Medicaid Expense: Total Medical
SFY 2006-2009
$ Million



					Average Annual Growth[1,3]
Annual Spending Growth		1.1%[3]	3.6%	0.5%	**1.7%**
Eligibles	182,422	180,662	176,620	174,718	**-1.4%**
$ PMPM	$750	$766	$812	$825	**3.2%**

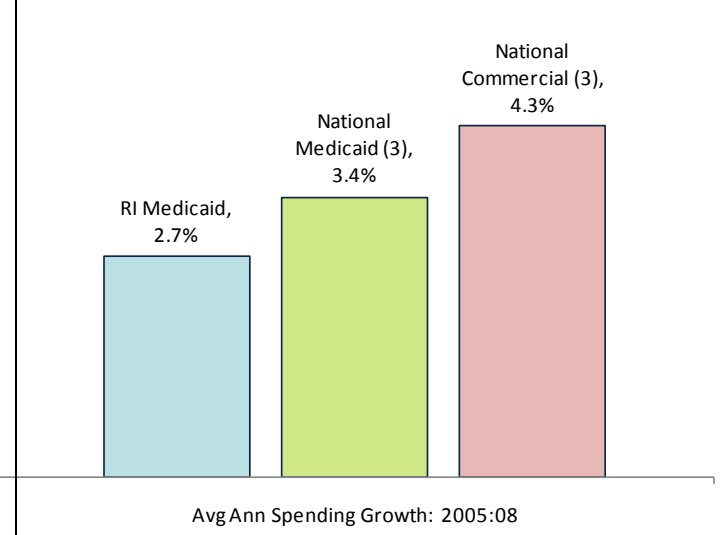
- Overall Medicaid spending has increased by approximately 1.7% per year over the last four years. State fiscal year 2008-09 spending growth is notably low at 0.5%.
- Note that this increase is broken down into unit cost (per member per month) and enrollment increases, which can be added together to determine average spending growth.
  - Enrollment has been declined steadily by 1-2% per year between SFY 2006-2009
  - Unit costs (per member per month) have increased at 3.2% annually during this same period, though between SFY 2008-09 there was an increase of only 1.6%.

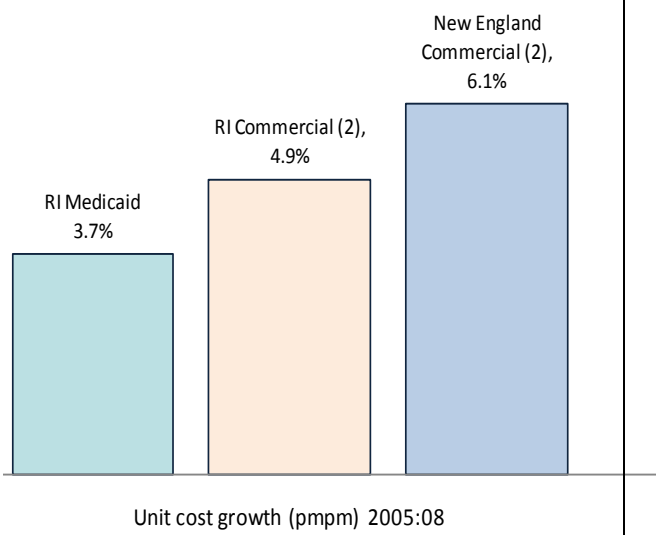
1. Calculated as compounded annual growth rate (CAGR) over period 2006-2009 as shown.
2. Source: 2009 CMS National Health Expenditure Report. 2009 data is a projection.
3. The low growth from 2006 to 2007 is explained in part by the introduction of Medicare Part D, which transitioned some pharmacy spend from Medicaid to Medicare. Excluding pharmacy, average annual growth would be 5.7 percent vs. 3.5% above. The state pays for part of this pharmacy cost back through the "clawback" payment, through general funds not specific to Medicaid.

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

RI Medicaid cost trends are notably low as compared to national Medicaid and regional private health insurer (commercial) experience.

Rhode Island Medicaid vs. National Cost Trends
2005-2009 [1]





- Comparing Rhode Island Medicaid spending to national and regional benchmarks provides some important context for these trends. Benchmarks were not available for 2009, so trends shown above reflect 2005 to 2008 data.
  - Overall spending growth over the years 2005-2008 compares favorably to national Medicaid expenditure trend – according to CMS, Medicaid spending trend over this time period increased an average 3.4% per year, vs. Rhode Island's 2.7%[3].
  - RI Medicaid unit cost trends also compare favorably to local and regional commercial benchmarks. Over the years 2005 to 2008, Rhode Island's Medicaid program experienced 3.7% average annual unit cost growth (PMPM). Over this same period, the average annual commercial medical cost (PMPM) increase for New England health plans was 6.1%, and specifically for Rhode Island health plans it was 4.9%[2].

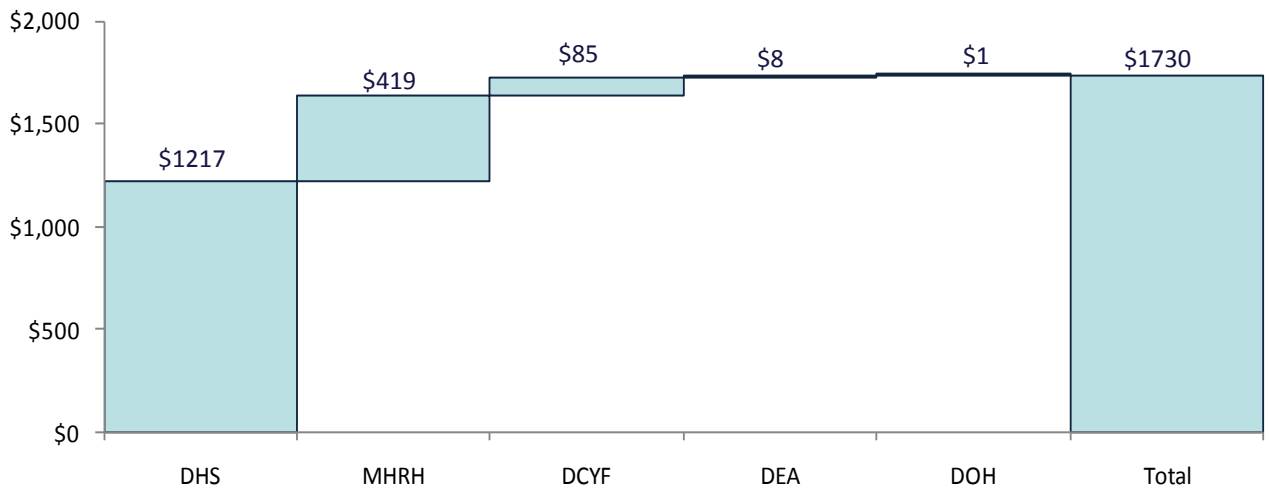
[1] RI data is in state fiscal year. National benchmarks are in federal fiscal year.
[2] Source: OHIC 2008 Health Plans' Performance Report.
[3] 2009 CMS National Health Expenditure Report. 2009 data is a projection.

Table of Contents

2a. Spending by Department

Medicaid services are administered through five state agencies

Spending by Department
SFY 2009 - $millions



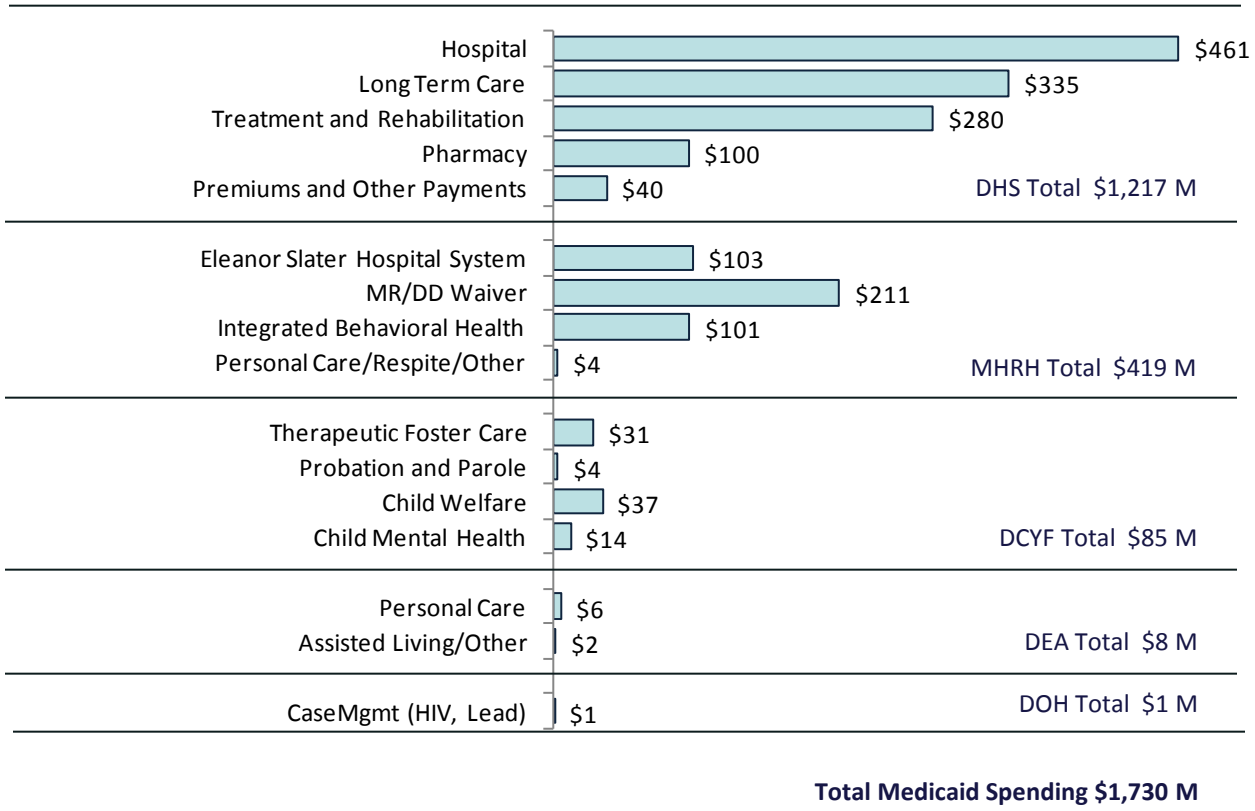
	DHS	MHRH	DCYF	DEA	DOH	Total
% of Total	70%	24%	5%	0.5%	0.1%	100%

- There are five state departments responsible for administering components of the Medicaid program.: The Department of Human Services (DHS), the Department of Mental Health, Retardation and Hospitals (MHRH), the Department of Children, Youth and Families (DCYF), the Department of Elderly Affairs (DEA), and the Department of Health (DOH).
- The majority of spending (70%) is administered by the Department of Human Services (DHS). The DHS is the lead administrator for the Medicaid global consumer choice waiver with CMS under EOHHS.
- The Department of Mental Health, Retardation and Hospitals (MHRH), is the second largest agency in terms of Medicaid spending , accounting for 24% of Medicaid program expenditures.
- Detail for each state agency is shown on the next page.

2a. Spending by Department: State Agency Detail

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

Spending by Department Detail
SFY 2009



- The majority of Medicaid spending (70%) is for programs administered by the Department of Human Services (DHS). The DHS pays for an array of Medicaid services across the lifespan and healthcare continuum – providing funding for hospital-based services (38%), long term care (28%), treatment and rehabilitation (23%), and pharmacy (8%).

- The Department of Mental Health, Retardation and Hospitals (MHRH) accounts for 24% of total Medicaid expenditure. MHRH is responsible for three primary areas: the management of the Eleanor Slater Hospital system (a state owned rehab hospital and long term psychiatric facility); persons with developmental disabilities residing in group homes; and the Integrated Behavioral Health (IBH) program, which provides community based behavioral health and substance abuse services through the community mental health centers.

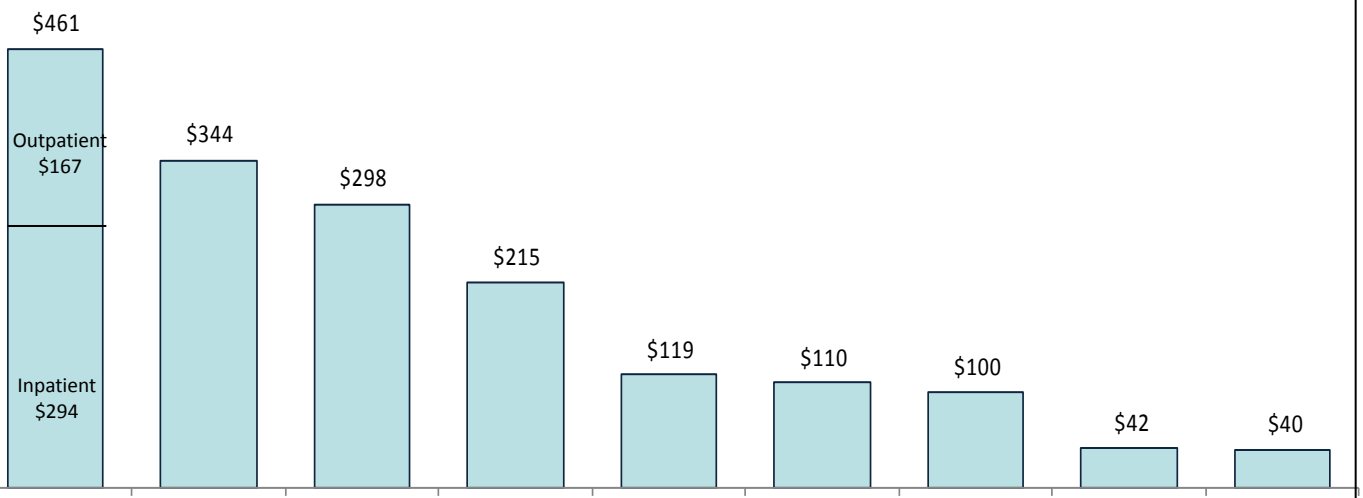
- The Department of Children, Youth and Families (DCYF), accounted for $85 Million (5%) of Medicaid spending in SFY 2009. DCYF provides health care services in programs serving children in

2b. Spending by Provider Type

Medicaid program funds are used to pay a variety of providers. Hospitals, specialized behavioral health providers and nursing facilities together account for two-thirds of program spending.

Medicaid Spending by Provider Type
SFY 2009, $ millions

Overall Total: $1,730 Million



	Hospital	Specialized BH (1)	Nursing Facility	Professional	MR Group Homes (4)	Specialized BH Institutions (2)	Pharmacy	Home and Comm Based Svcs (3)	Premiums
% of Spending	27%	20%	17%	12%	7%	6%	6%	2%	2%
Avg Annual Spending Growth 2006-2009	5.0%	0.9%	0.2%	6.9%	-2.9%	-4.2%	-5.7%	8.7%	11.0%

- The three largest provider types, accounting for two-thirds (64%) of all RI Medicaid spending in 2009, were hospitals, behavioral health providers and nursing facilities. However, key contributors to spending growth were hospitals, professional providers and home/community based service providers.
- Hospitals were the largest provider type, consuming 27% of Medicaid spending in 2009. Hospital payments are also a key driver of Medicaid spending growth – as payments to hospitals increased by an average of 5% per year between 2006-2009 and accounted for about half (47%) of all Medicaid spending growth in recent years.
- Specialized behavioral health providers were the next largest provider type, accounted for 20% of spending in 2009[1]. This includes targeted behavioral health services provided by MHRH and DCYF, as well as some specialized behavioral health services (i.e., CEDARR, CIS), provided by DHS. Spending on these providers has been relatively flat, with average annual increases of 0.9% between 2006-2008.

[1] BH reflects professional services provided through MHRH, DCYF, DHS BH (BH, CEDARR, CIS), NonInstitutionl/NonWaiver.
[2] BH Institutions include Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.
[3] Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, such as personal care, assisted living, case management.
[4] MR Group Homes include both public and private facilities.

2b. Spending by Provider Type: Hospital Detail

Hospitals were the largest provider type, consuming 27% of Medicaid spending in 2009, with average annual spending growth of 5.7%. However, spending growth has varied considerably by facility.

Medicaid Spending on Hospitals[1]
SFY 2009, $ million

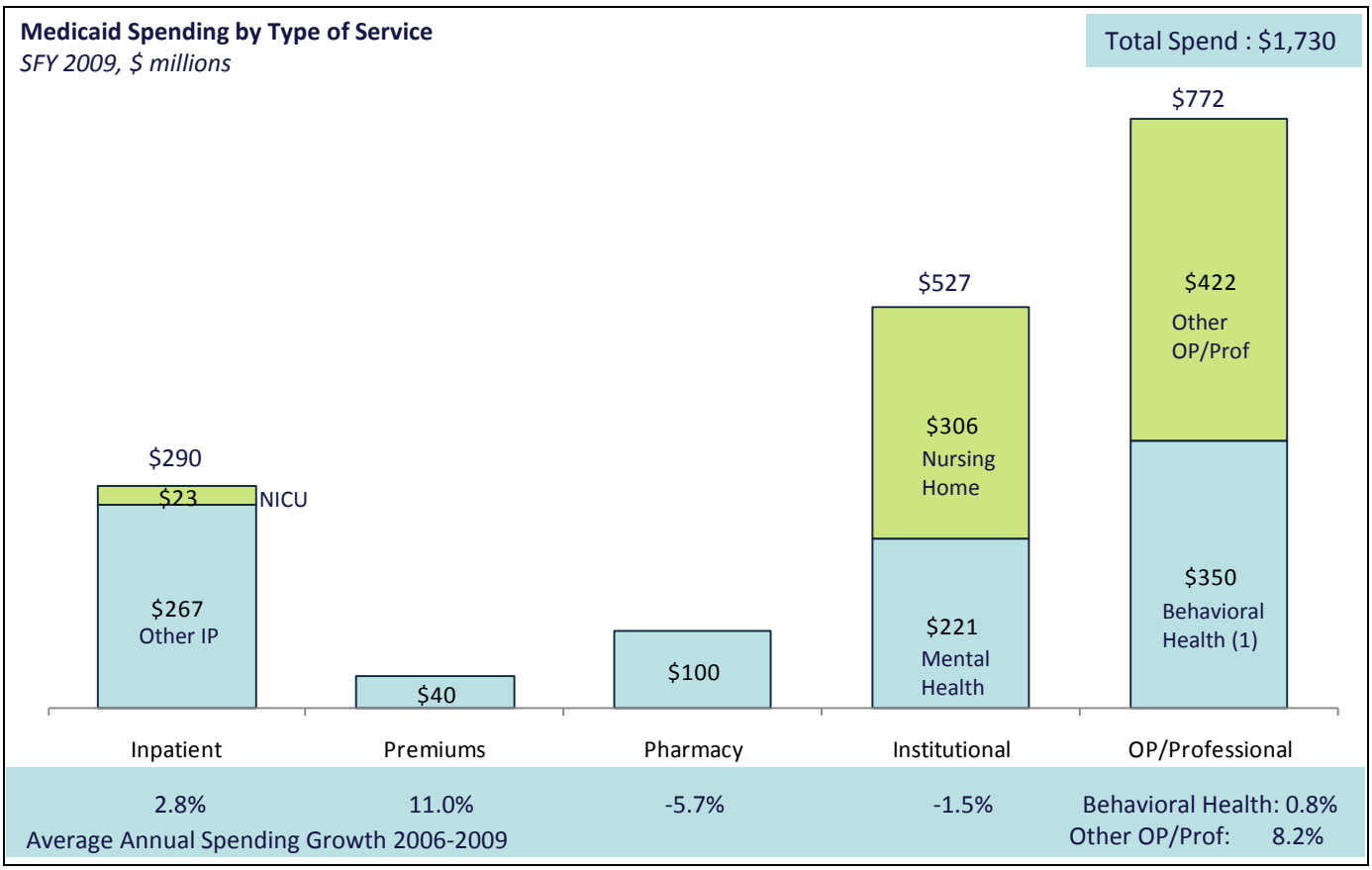
	Hospital	SFY 2009 Medicaid Spend ($M)[1]	% of SFY2009 Spend	Annualized Spending Growth (CAGR) 2006:09[1]
Care New England SFY 2009 Spend $113M % of total: 27% CAGR: 13%	Women & Infants	75	18%	13%
	Kent	28	7%	8%
	Butler	10	3%	37%
LifeSpan SFY 2009 Spend $158M % of total: 38% CAGR: 9%	Rhode Island	113	27%	8%
	Miriam	20	5%	13%
	Newport	8	2%	6%
	Bradley	18	4%	13%
	Landmark	17	4%	9%
	St.Joseph	21	5%	-8%
	Memorial	23	6%	14%
	Roger Williams	15	4%	4%
	Westerly	3	1%	6%
	South County	5	1%	4%
	Other	61	15%	-8%
	TOTAL	415	100%	5.7%

- Lifespan is the largest hospital system, measured by Medicaid payments, consuming about one-third (38%) of all hospital payments. LifeSpan includes Rhode Island Hospital, Miriam, Newport, Bradley and Butler. Spending increases at Lifespan averaged 9% per year, as compared to statewide average of 5.7%.
- Care New England is the second largest, hospital system, accounting for about one-fourth (27%) of all Medicaid spending on hospitals. Spending increases at Care New England have averaged 13%, more than double the statewide average.

1. Note hospital specific spending total of $415. This hospital detail is based on claims expenditure. Prior page (and the rest of this reprt is based on capitation payments plus risk share, which is not available for specific hospitals. Thus, numbers do not match across methods.

2c. Spending By Type of Service

Medicaid beneficiaries utilize a variety of different types of service, including inpatient, outpatient and professional, institutional, and pharmacy.



- Medicaid beneficiaries spending is divided between outpatient/professional care, institutional care, inpatient care and pharmacy.
- Outpatient/professional care is the largest category of service, accounting for almost half (45%) of all service spending. This is split between behavioral health services (45%) and other outpatient/professional (55%). Other outpatient/professional services is also the fastest growing category of service (other than premiums[2]), and is detailed on the following page.
- Institutional care is the next largest category of service, accounting for about one-third (30%) of all service spending. This includes both nursing home services and care provided at one of the specialized mental health institutions. Spending on these services, while substantial, has been flat or declining over the past few years.
- Inpatient care represents approximately 17% of all service spending. Inpatient spending had been increasing steadily between 2006 and 2008, but declined slightly from 2008 to 2009, resulting in an average increase of 2.8% per year .

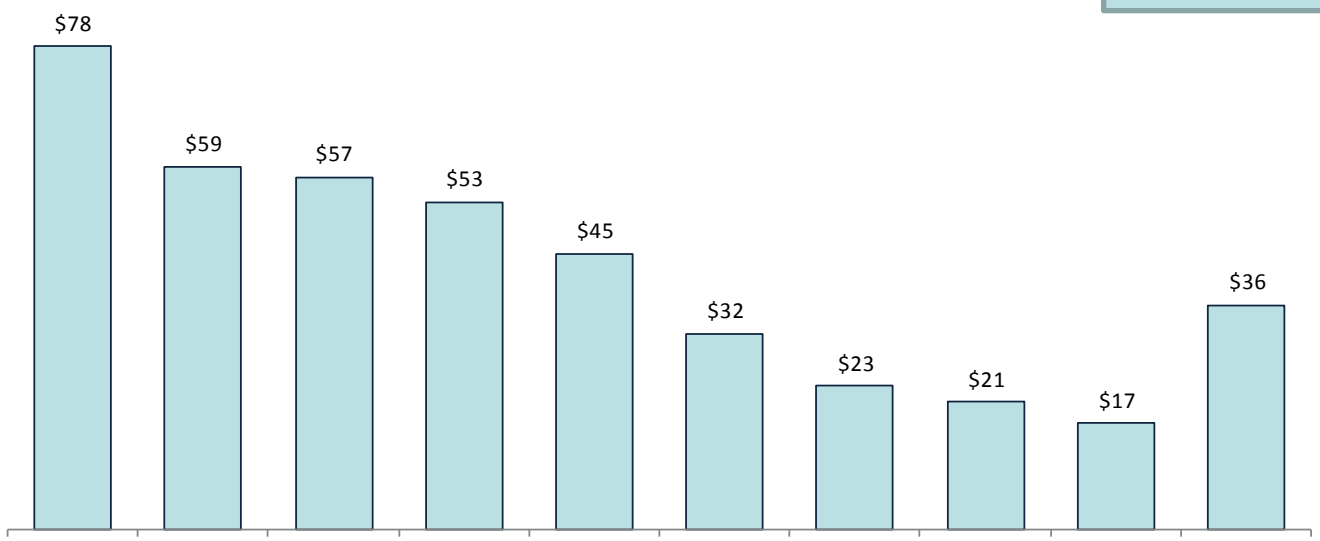
[1] Behavioral Health includes CEDARR, CEDARR direct, CEDARRS Center, CIS/CAITS, CMHC/Rehab Option, DCYF-Residential, Home/ Center Based Therapeutic, MHRH Offline Providers, MR Rehab, and ProjectConnect.
2. Medicaid pays the Medicare premiums for dually eligible Medicare-Medicaid enrollees.

2c. Spending by Type of Service: Other Outpatient and Professional Detail

Other outpatient/professional services includes a variety of services provided outside of the hospital/institutional setting, such as office visits, procedures, ER visits, etc.

Medicaid Spending by Type of Service: Other Outpatient and Professional Detail
SFY 2009, $ millions

Total Spend : $422



	E&M	Procedure	ER Visit	PersonalCare	XRay/ Lab/Tests	Dental	Hospice	DME/ Supplies	Amb/ Transport	Other [1]
% of total OP/Prof Spending (BH is 45%)	10%	8%	7%	7%	6%	4%	3%	3%	2%	5%
Average Annual Spending Growth 2006-2009	3.3%	8.9%	8.3%	9.7%	5.9%	7.8%	25.4%	4.7%	49.0%	3.7%

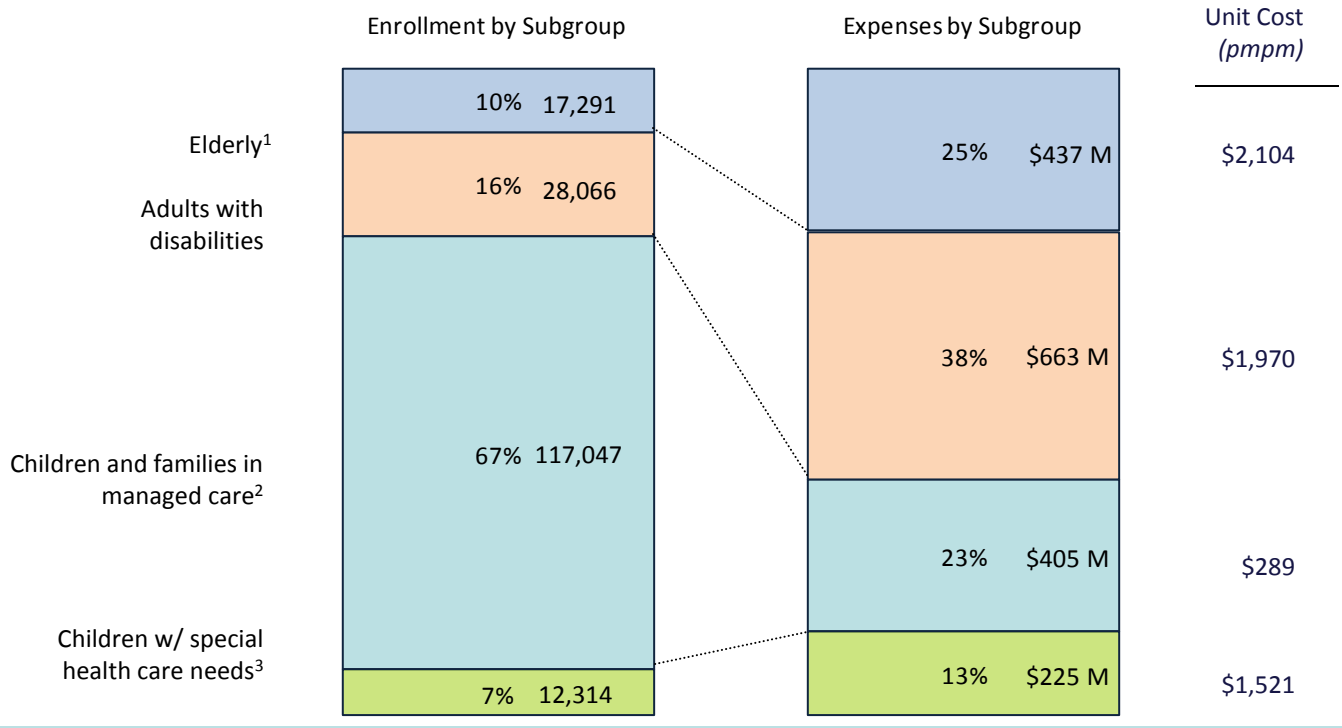
- Other outpatient/professional services is the fastest growing category of service, growing at 8.2% per year. This high trend is not unique to RI Medicaid, as a recent claims based analysis of commercial trends in Massachusetts reported a similar finding, also showing hospital outpatient and professional services as the two fastest growing type of service, with growth rates of 13.7 and 9.8% respectively.[2]
- Outpatient and professional costs includes a wide range of services provided outside of the hospital/institutional setting. Many of these services are relatively small overall cost, relative to total Medicaid spending of $1,730; however they are increasing rapidly.
- The fastest growing component is hospice services, which accounts for only 3% of total spending but is growing at an average of 25% per year. This is by design, through a DHS initiative working to transition beneficiaries in nursing home settings into more appropriate home based care.
- Increases in spending for procedures and ER visits are notably high, at 8.9% and 8.3% respectively. DHS was recently awarded a federal grant , supporting state-based efforts at ER diversion.

[1] Other includes Case Management, Assisted Living, Adult Day Care, Trauma Brain Rehab, OP Facility, EI/Early Start, and Drugs.
[2] Mathematica Policy Research analysis of commercial claims data for Massachusetts residents, 2007-08. Data includes self-insured business.

2d. Spending by Population

Medicaid spending varies considerably by population

Medicaid Enrollment and Expense by Population
SFY 2009



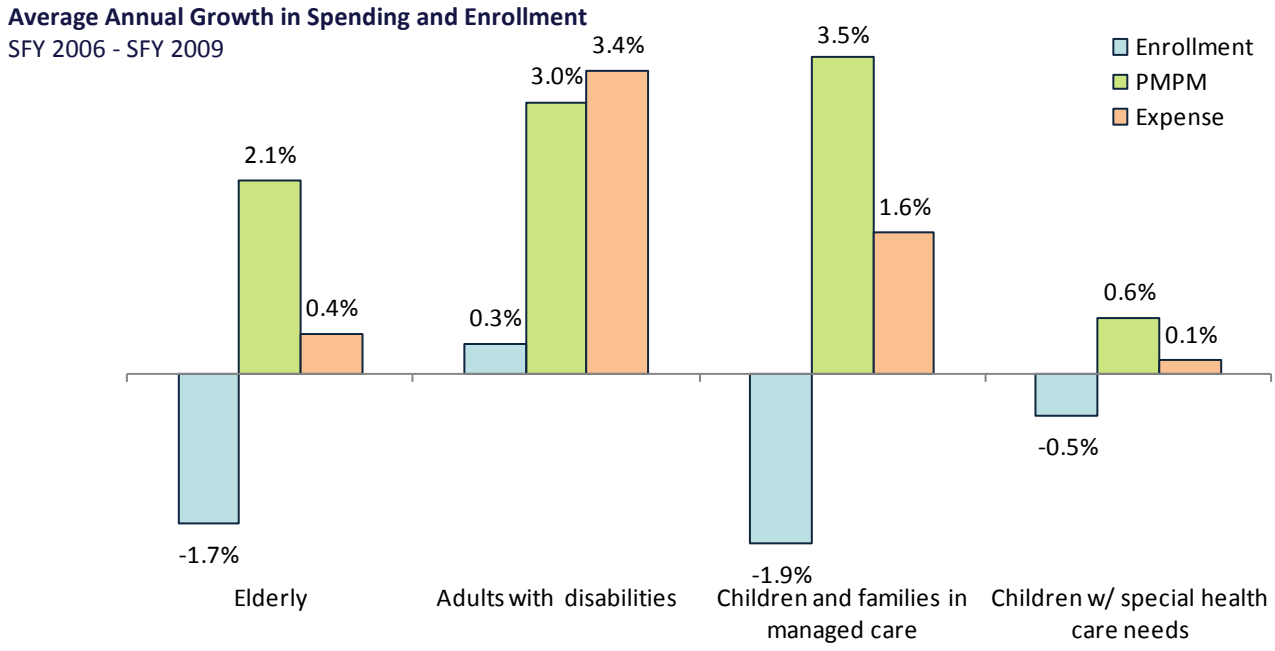
The Medicaid program served an average of 174,718 beneficiaries in SFY 2009, at an average cost per member per month of $825. However, costs vary considerably by population.

- Sixty-three percent of spending was for elders and adults with disabilities, who account for 26% of total beneficiaries.
- The unit cost of services for the elderly is approximately $2,100 per month, which is almost seven times the cost of services for children and families.
- Children and families account for 67% of total enrollment, but only 23% of total cost. As indicated by the PMPM unit cost, this population most closely resembles commercial populations, and typically require much less intensive services.

1. The elderly includes all adults over age 65. Adults with Disabilities includes all adults aged 19-65.
2. Children and Families includes low income children, parents and pregnant women who meet financial income requirements.
3. Children with Special Health Care Needs (CSHCN) includes children in Substitute (Foster) Care, Individuals eligible for SSI who are under 21, Katie Becket children, and Adoption Subsidy children.

2e. Spending By Population: Trends

Adults with Disabilities account for 38% of SFY 2009 spending and 71% of the spending growth.



2009 Spending	$437m	$663m	$405m	$225m
% of 2009 Spending	25%	38%	23%	13%
% of Spending Growth	7%	71%	21%	1%

- Overall Rhode Island Medicaid expenditures grew by approximately 1.7% per year between SFY 2006 and SFY 2009; however, this increase varied considerably by population.
- Adults with disabilities accounts for the largest spending growth over the past 4 years and is the only group that experienced a modest increase in enrollment. Beneficiaries in this eligibility category account for the highest share of 2009 spending and the largest share of spending growth.
- Spending on children and families has increased by 1.6% per year , with unit costs increasing by 3.5% per year. This rate of increase is below the growth in commercial insurance cost trends in of 6.1% in New England and 4.9% in Rhode Island which covers a similar population[1].

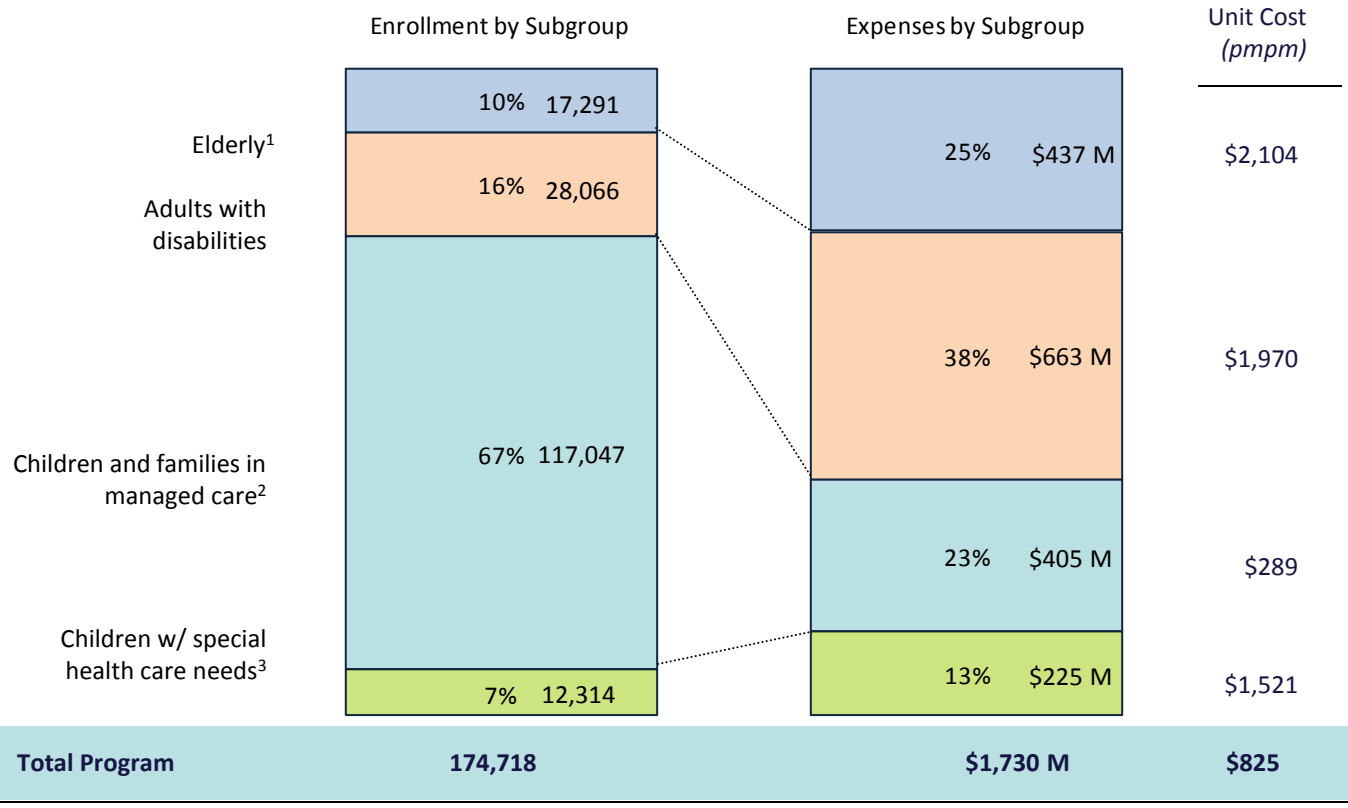
1. Commercial trends data from RI Health Plans' Performance Report (2008), published by OHIC.

Table of Contents

3. Reminder: Spending by Population

Medicaid spending varies considerably by population

Medicaid Enrollment and Expense by Population
SFY 2009



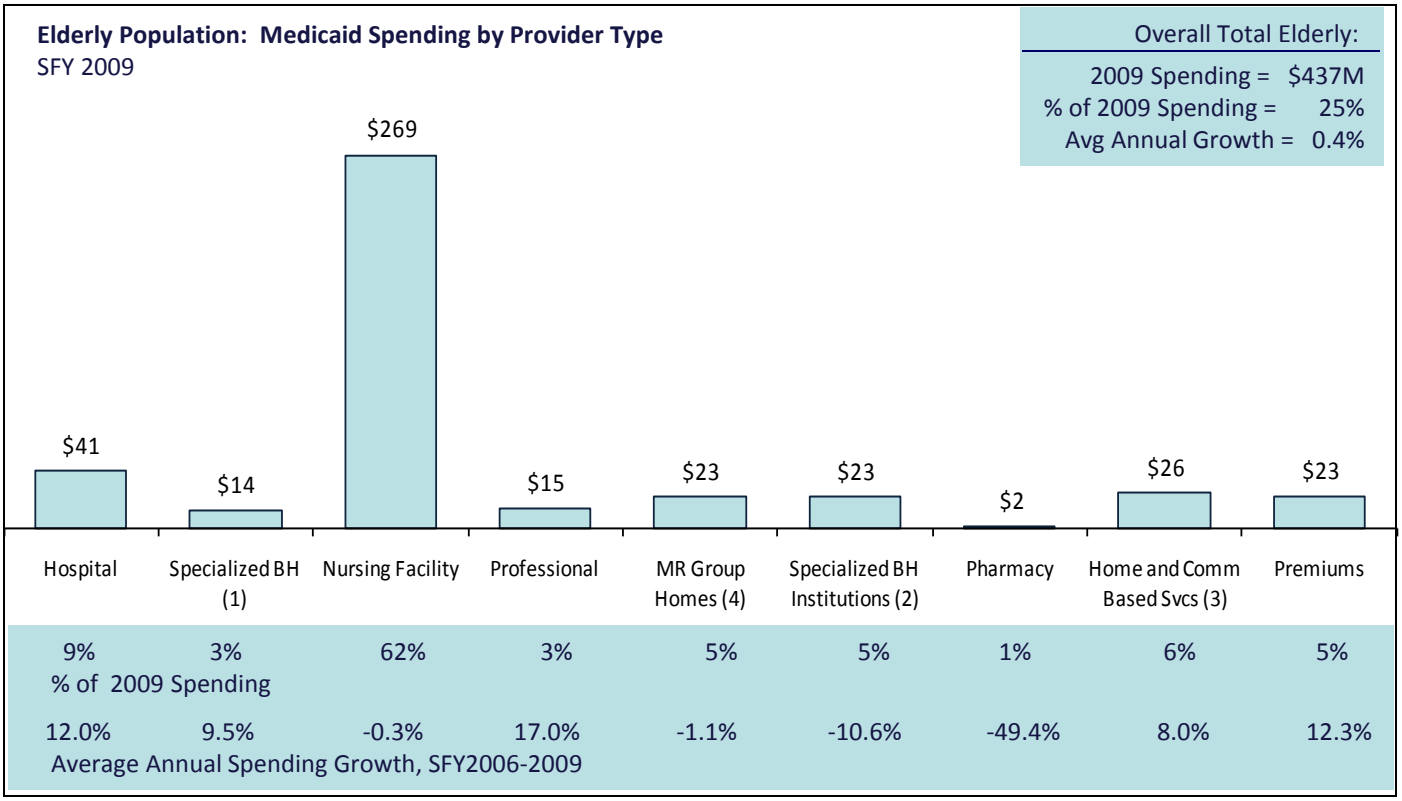
The Medicaid program served an average of 174,718 beneficiaries in SFY 2009, at an average cost per member per month of $825. However, costs vary considerably by population. See table above.

1. The elderly includes all adults over age 65. Adults with Disabilities includes all adults under age 65.
2. Children and Families includes low income children, parents and pregnant women who meet specific asset and income requirements.
3. Children with Special Health Care Needs (CSHCN) includes children in Substitute (Foster) Care, Individuals eligible for SSI who are under 21, Katie Becket children, and Adoption Subsidy children.

3a. Elderly Detail

Among elders, nursing facilities account for approximately two thirds of total expenditures.

Elderly Population: Medicaid Spending by Provider Type
SFY 2009



- Medicaid expenditures for elders totaled $437 Million in 2009, and has been essentially flat with an increase of 0.4% per year over the past 4 years.
- The decline in expenditures for elders is due in part by the introduction of Medicare Part D. A significant amount of expenditures for the elders are out of Medicaid and into Medicare.
- Although nearly two thirds (62%) of total Medicaid spending is for elders receiving nursing facility care. Expenditure growth has been slightly declining at a rate of 0.3 percent per year.
- Most of the growth in Medicaid expenditure for the elderly population has been in professional services, due in part to a strategic effort to invest in alternatives to institutional/nursing home care.

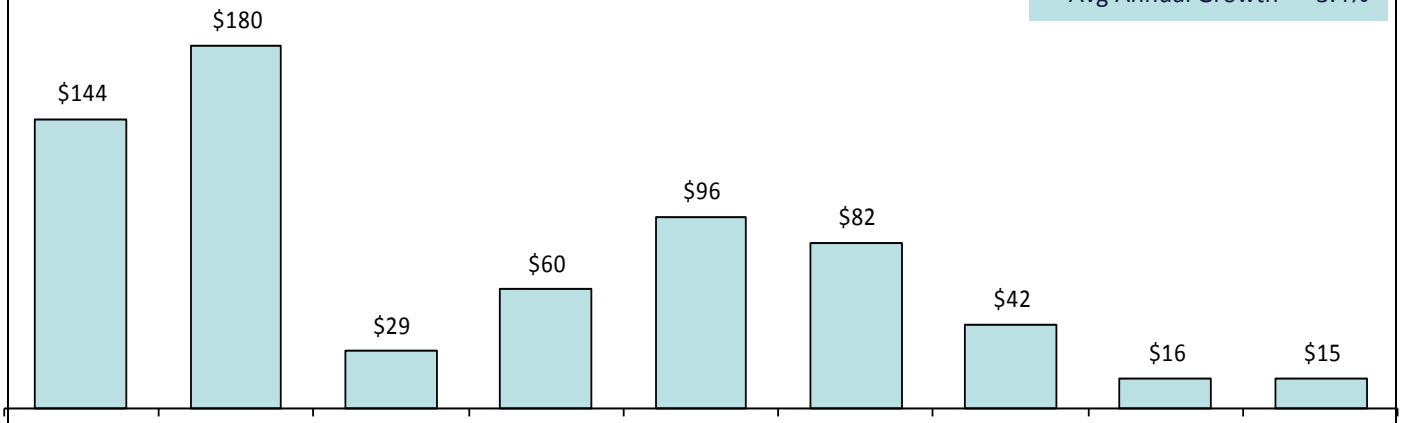
[1]Specialized BH reflects Professional services provided through MHRH, DCYF, DHS BH (BH, CEDARR, CIS)., NonInstitutionl/NonWaiver Services.
[2] Specialized BH Institutions include Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.
[3]Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, including personal care, assisted living/case management, etc.
[4]MR Group Homes include both public and private facilities.

3b. Adults with Disabilities Detail

The adults with disabilities population have professional expenses for behavioral health that are the largest contributor to cost increases

Adults with Disabilities: Medicaid spending by Provider
SFY 2009

Overall Total ADD:
2009 Spending = $663M
% of 2009 Spending = 38%
Avg Annual Growth = 3.4%



	Hospital	Specialized BH (1)	Nursing Facility	Professional	MR Group Homes (4)	Specialized BH Institutions (2)	Pharmacy	Home and Comm Based Svcs (3)	Premiums
% of 2009 Spending	22%	27%	4%	9%	14%	12%	6%	2%	2%
Average Annual Spending Growth, SFY2006-2009	6.5%	3.9%	5.5%	19.8%	-3.1%	-2.8%	-2.1%	12.2%	9.9%

- Beneficiaries in the eligibility group of adults with disabilities account for the largest share of Medicaid expenditures, with total 2009 spending of $663 million. Total spending for this population has increased by approximately 3.4% per year over the past 4 years.
- The introduction of Medicare Part D also affected growth trends for this population.
- Behavioral health services account for approximately 27% of total Medicaid spending for Adults with Disabilities.
- Most of the growth in Medicaid expenditures for the adults with disabilities population has been in professional services.

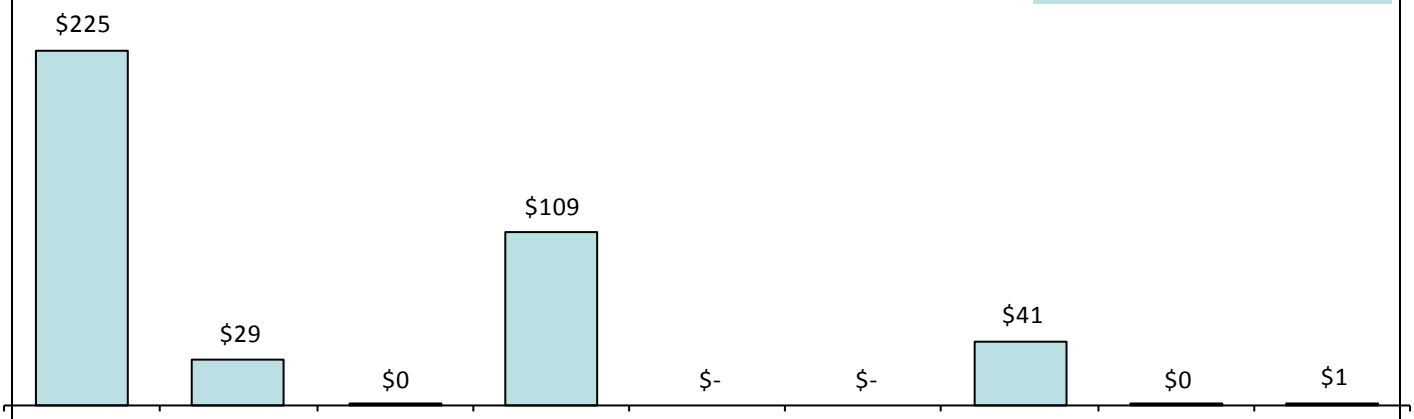
[1]Specialized BH reflects Professional services provided through MHRH, DCYF, DHS BH (BH, CEDARR, CIS)., NonInstitutionl/NonWaiver Services.
[2] Specialized BH Institutions include Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.
[3]Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, including personal care, assisted living/case management, etc.
[4]MR Group Homes include both public and private facilities.

3c. Children and Families

In the low income children and families populations in hospital cost increases are due to growth in professional expenses.

Children and Families Detail: Medicaid Spending by Provider
SFY 2009

Overall Total C+F:
2009 Spending = $405M
% of 2009 Spending = 23%
Avg Annual Growth = 1.6%



	Hospital	Specialized BH (1)	Nursing Facility	Professional	MR Group Homes (4)	Specialized BH Institutions (2)	Pharmacy	Home and Comm Based Svcs (3)	Premiums
% of 2009 Spending	55%	7%	0%	27%	0%	0%	10%	0%	0%
Average Annual Spending Growth, SFY2006-2009	4.0%	-3.7%	-7.7%	1.5%	NA	NA	-5.7%	16.2%	5.0%

- Children and families account for about one-fourth (23%) of total Medicaid expenditures, with 2009 spending of $405 Million. Spending on this population has increased by 1.6% per year over the past 4 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" who are uninsured, typically from families with incomes up to 250% of the federal poverty level. In SFY 2009, Rhode Island received a 66.80% combined CHIP/FMAP federal match on children and pregnant women who are in families with incomes above mandatory coverage levels.
- Spending on children and pregnant women is divided between professional, inpatient and outpatient services. Inpatient and outpatient services experienced the highest growth – with a 4 percent average annual increase.

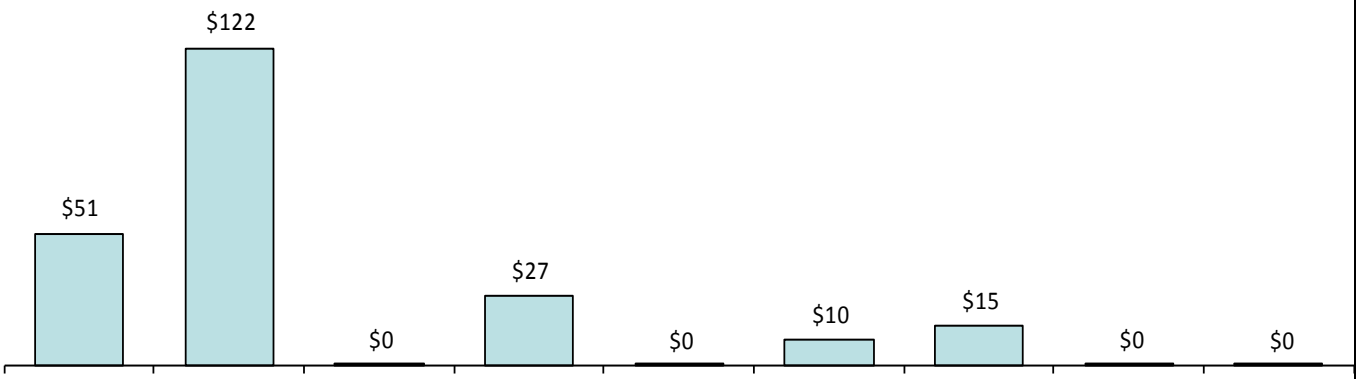
[1]BH reflects Professional services provided through MHRH, DCYF, DHS BH (BH, CEDARR, CIS)., NonInstitutionl/NonWaiver Services.
[2] Specialized BH Institutions include Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.
[3]Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, including personal care, assisted living/case management, etc.
[4]MR Group Homes include both public and private facilities.

3d. Children with Special Health Care Needs

For the children with special health care needs population professional expenses and pharmacy are the largest contributors to cost increases.

Children with Special Health Care Needs Detail:
Medicaid Spending by Provider Type
SFY 2009

Overall Total CSHCN:
2009 Spending = $225M
% of 2009 Spending = 13%
Avg Annual Growth = 0.1%



	Hospital	Specialized BH (1)	Nursing Facility	Professional	MR Group Homes (4)	Specialized BH Institutions (2)	Pharmacy	Home and Comm Based Svcs (3)	Premiums
% of 2009 Spending	23%	54%	0%	12%	0%	4%	7%	0%	0%
Average Annual Spending Growth, SFY2006-2009	1.0%	-2.7%	-0.7%	4.4%	-82.8%	5.8%	18.4%	-29.1%	-6.5%

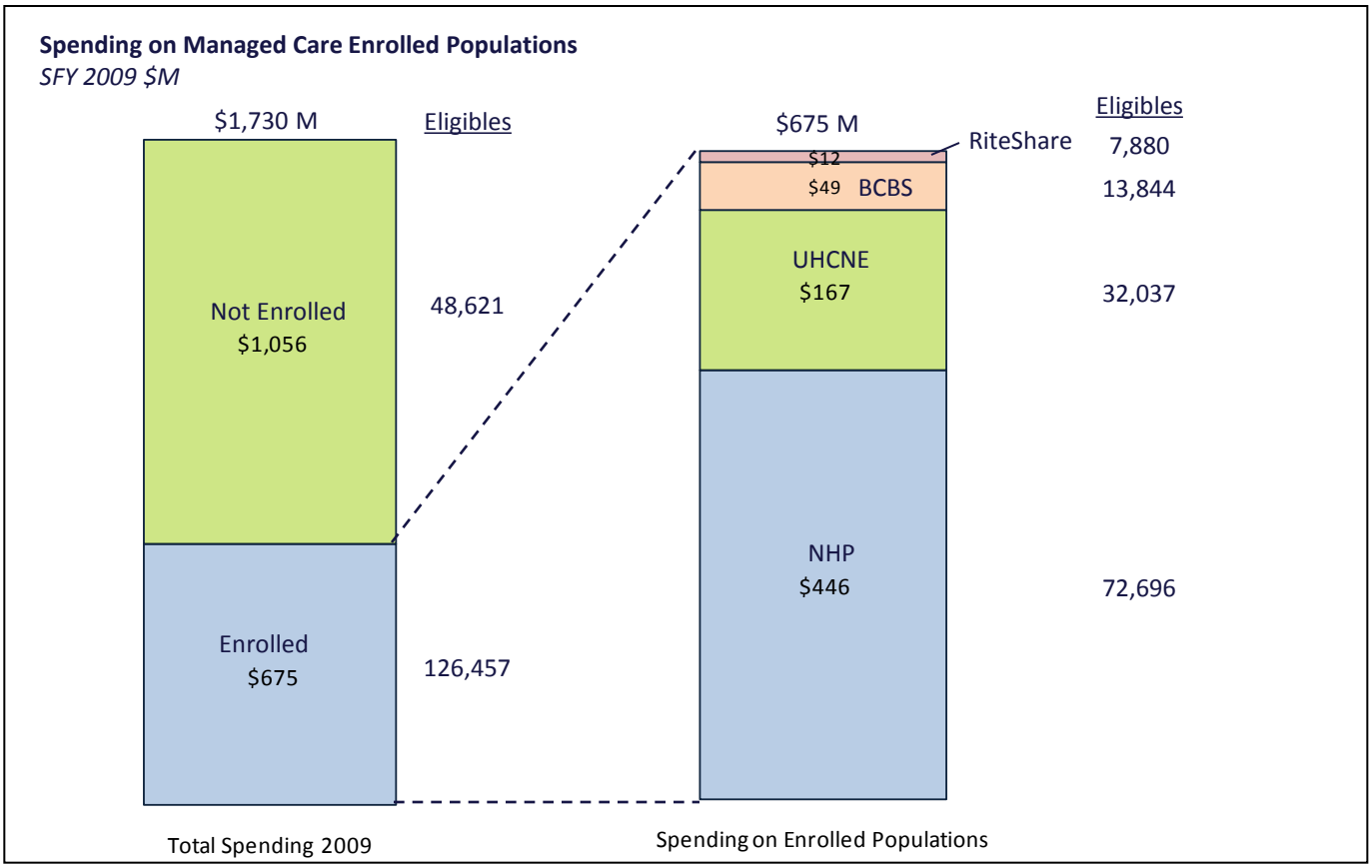
- Children with Special Health Care Needs (CSHCN) is a relatively small population -- accounting for 13% of total Medicaid expenditures and 7% of enrollees, with total 2009 spending of $225 million.
- Spending on this population is dominated by behavioral health services, which account for just over half (54%) of total expenditures.

[1] BH reflects Professional services provided through MHRH, DCYF, DHS BH (BH, CEDARR, CIS)., NonInstitutionl/NonWaiver Services.
[2] BH Institutions include Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.
[3] Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, including personal care, assisted living/case management, etc.
[4] MR Group Homes include both public and private facilities.

Table of Contents

4a. Fee for Service (FFS*) and* Managed Care

About three quarters (72%) of all Medicaid beneficiaries are enrolled in managed care plans.



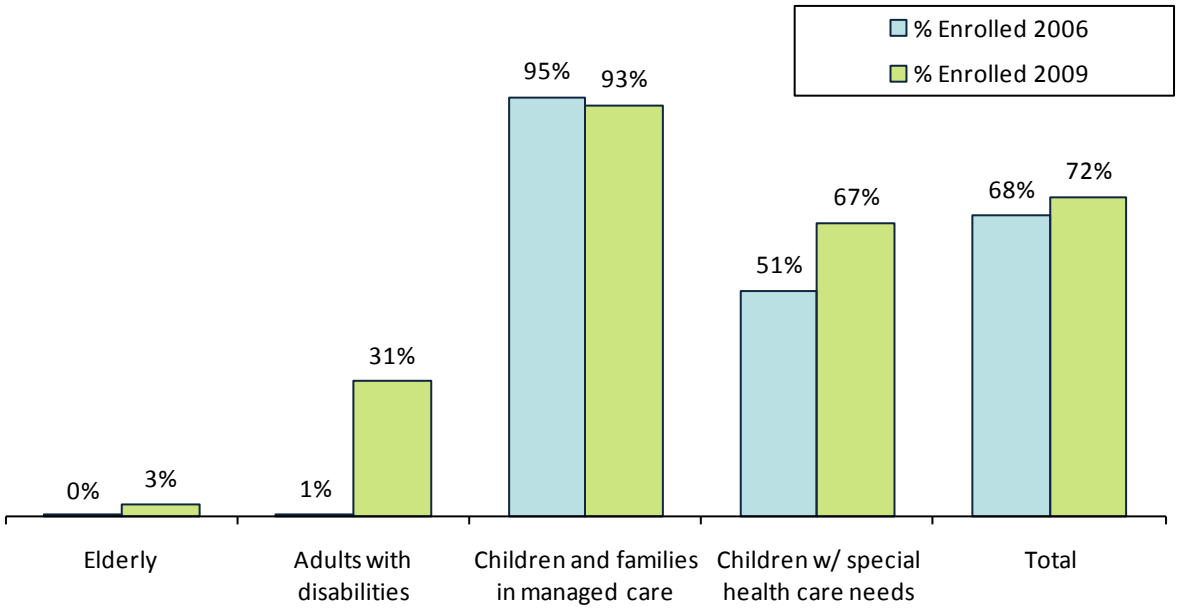
- About three quarters (72%) of all Medicaid eligibles are enrolled in Managed Care Organizations (MCO). These "enrolled populations" account for about 39% of Rhode Island Medicaid expenditures.[1]
- Managed Care enrollment is divided between three health plans. Neighborhood Health Plan (NHP) is the largest carrier, accounting for 60% of managed care enrollment. United Health Care of New England (UHCNE) accounts for another 30% of beneficiaries, and Blue Cross Blue Shield of Rhode Island (BCBSRI) with approximately 10% of enrollment.
- RIte Share is a program designed to allow Medicaid beneficiaries to retain their commercial coverage, while at the same time leveraging employer contributions, thereby minimizing Medicaid program spending. As such, Medicaid pays the employee's share of the premium for Medicaid eligibles who have access to qualified employer based insurance coverage. Approximately 7,880 Medicaid eligibles are enrolled in the Rite Share program.

1. Much of the enrolled population is RIteCare families, which typically are lower cost populations than the elderly or disabled

4a. Fee for Service (FFS) *and* Managed Care

About three quarters (72%) of all Medicaid eligibles are enrolled in managed care plans, but this varies considerably by population subgroup.

Managed Care Enrollment
SFY 2006 and SFY 2009



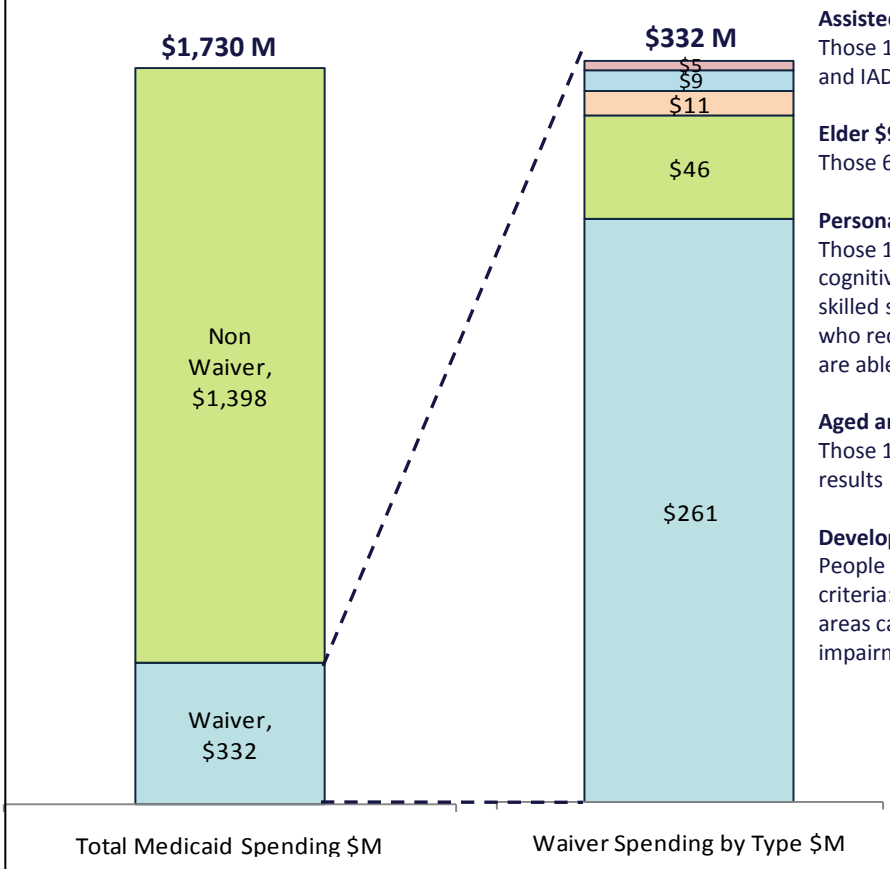
	Elderly	Adults with disabilities	Children and families in managed care	Children w/ special health care needs	Total
Enrollment 2009	473	8,606	109,184	8,195	126,457

- Children and families are generally all enrolled in one of the three MCO's.
- In SFY 2009, Children with Special Health Care Needs (CSHCN) were mandatorily enrolled in Medicaid MCO's (Neighborhood Health Plan and UnitedHealth Care) if they had no other insurance coverage.
- Adult populations have historically been exclusively in fee for service Medicaid programs. However, two new managed care programs were established in 2008, transitioning adults to managed care: ConnectCare Choice began enrolling adults in February 2008; and Rhody Health Partners began in April 2008.

4b. Home and Community Based Waiver (HCBW) Populations

Populations enrolled in Medicaid through home and community based services (HCBS) accounted for $332 Million in 2009 or 19% of total Medicaid expenditures

Home and Community Based Waiver Populations



Assisted Living $5m, 177 enrolled
Those 18 and older who require assistance with ADLs and IADLs

Elder $9m 449 enrolled
Those 65 and older who need help with ADLs and IADLs

Personal Choice/Habilitative/Quad $11M 250 enrolled
Those 18 and older who have severe physical and/or cognitive disabilities resulting in the need for ongoing skilled services or 24 hour supports. Those 18 and older who require assistance with ADLs and IADLs and who are able to manage their own services

Aged and Disabled $46m 1,600 enrolled
Those 18 and over who are aged or have a disability that results in the need for help with ADLs and IADLs

Developmental Disability $261m, 3,390enrolled
People of any age who meet Developmental Disability criteria: substantial functional limitation in major life areas caused by permanent mental and/or physical impairment that begins before age 22.

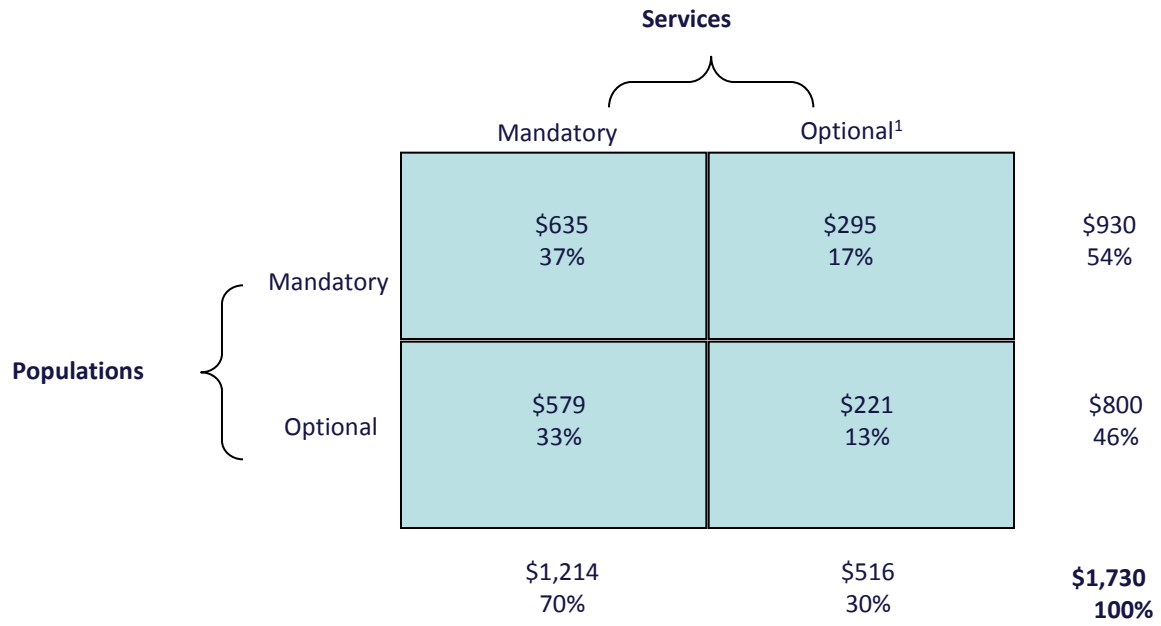
- The Global Waiver subsumed the Section 1915(c) waiver programs in January 2009. Section 1915 (c) of federal Medicaid law grants the states the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide at risk populations with home based care as an alternative to more costly nursing home/institutional options.
- Each of the programs above targets a specific subpopulation that meet the specified level of need (without HCBS they would need institutional/nursing home care).
- Populations enrolled in Medicaid through home and community based services (HCBS) accounted for $332 Million in 2009 or 19% of total Medicaid expenditures but only 3% of beneficiaries.
- The vast majority of Home and Community Based Waiver expenditures (79%) are for the Developmental Disability (DD) population.

Table of Contents

5. Mandatory/Optional Spending Overview

Approximately 37% of Medicaid spending is mandated by federal law.

Mandatory vs. Optional Spending
SFY 2009, $millions



- **Mandatory populations and services**
  Under federal guidelines, there are specific "mandatory" categories of people and types of benefits that all state Medicaid programs must cover to receive federal matching payments.
- **Optional populations and services**
  States also have the flexibility to tailor certain aspects of the Medicaid program to meet their own needs. States may obtain federal matching funds for covering several "optional" groups of individuals and services.
- Narrowly defined, mandatory services provided to mandatory populations account for only 37% of total Rhode Island Medicaid expenditure. However, optional services are generally intended to reduce spending for mandatory services – for example, pharmacy, outpatient behavioral health, hospice – are all sizable components of optional services that, if eliminated, would likely result in offsetting increases in mandatory spending.
- 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.

[1] Includes $41M in spending on Waiver services (evenly split between mandatory and optional populations).

5a. Mandatory/Optional: Populations

Approximately 46% of Medicaid spending is on optional populations, most of whom are low-income or disabled individuals.

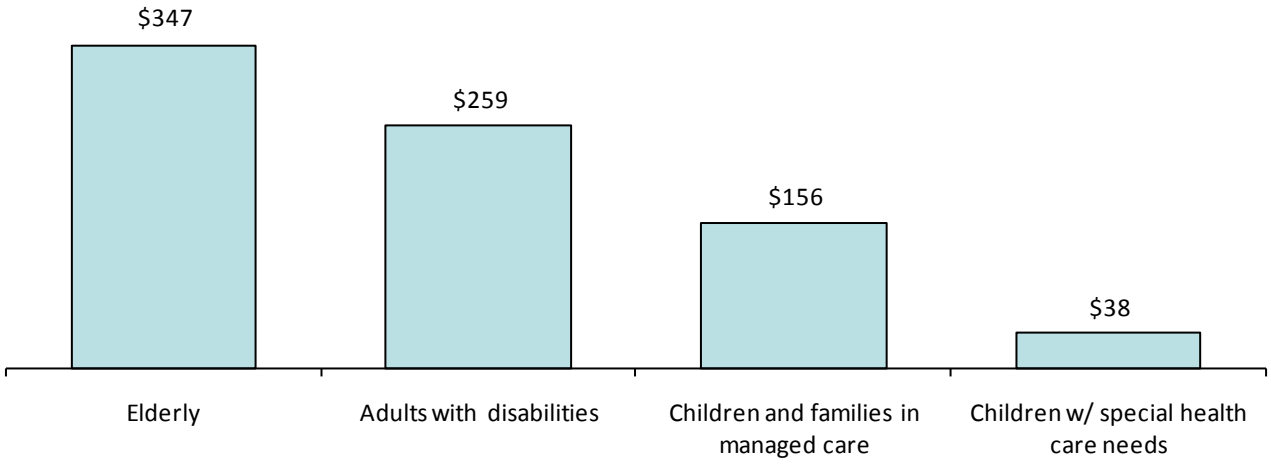
Federal Mandatory Populations	Optional Populations
Eligibles: 102,707 Expenditure: $930 M	Eligibles: 72,011 Expenditure: $800 M
❖ Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI) ❖ Low income Medicare beneficiaries; ❖ Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state's 1996 AFDC eligibility requirements ❖ Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines ❖ Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level ❖ Infants born to Medicaid-enrolled pregnant women; ❖ Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program.	❖ Low-income elderly adults or adults with disabilities ❖ Individuals eligible for Home and Community Based Services waiver programs ❖ Children up to 250 percent and parents up to 175 percent of the federal poverty level, including children funded through the State Children's Health Insurance Program; ❖ Individuals determined to be "medically needy" due to low income and resources or to large medical expenses ❖ Children under 19 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision) ❖ Women eligible for Breast and Cervical Cancer program

5a. Mandatory/Optional: Optional Populations

Most of the spending on optional populations (75%) is for the elderly or disabled adults.

Spending on Optional Populations Detail
SFY 2009, $Million

Optional Populations Total:
$800 M Spending
72,011 Eligibles



	Elderly	Adults with disabilities	Children and families in managed care	Children w/ special health care needs
% of Spending on Optional Pops:	43%	32%	20%	5%
Eligibles:	9,740	7,913	51,838	2,521

- Most of the spending on optional populations is on the elderly or adults with disabilities, many who are under 100% of the federal poverty limit. This includes low-income elderly adults or adults with disabilities, individuals eligible for Home and Community Based Services, and individuals determined to be "medically needy" due to low income and resources or to large medical expenses.
- The vast majority (72%) of spending on optional populations is for mandatory services. A further detailed breakdown shows that 50% of Medicaid spending on optional populations is for institutional care., such as inpatient services and nursing homes.[1]
- Children and families account for approximately $156 million in spending for optional populations – 20% of total Medicaid spending. This includes children and pregnant women up to 250% and parents up to 175% of the federal poverty level.
- Children with special health care needs account for approximately $38 million in spending for optional populations – 5% of total Medicaid spending. This is predominantly children under 19 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision) and subsidy eligible adopted children.

[1] Based on claims analysis, March 2010

5b. Mandatory/Optional: Services

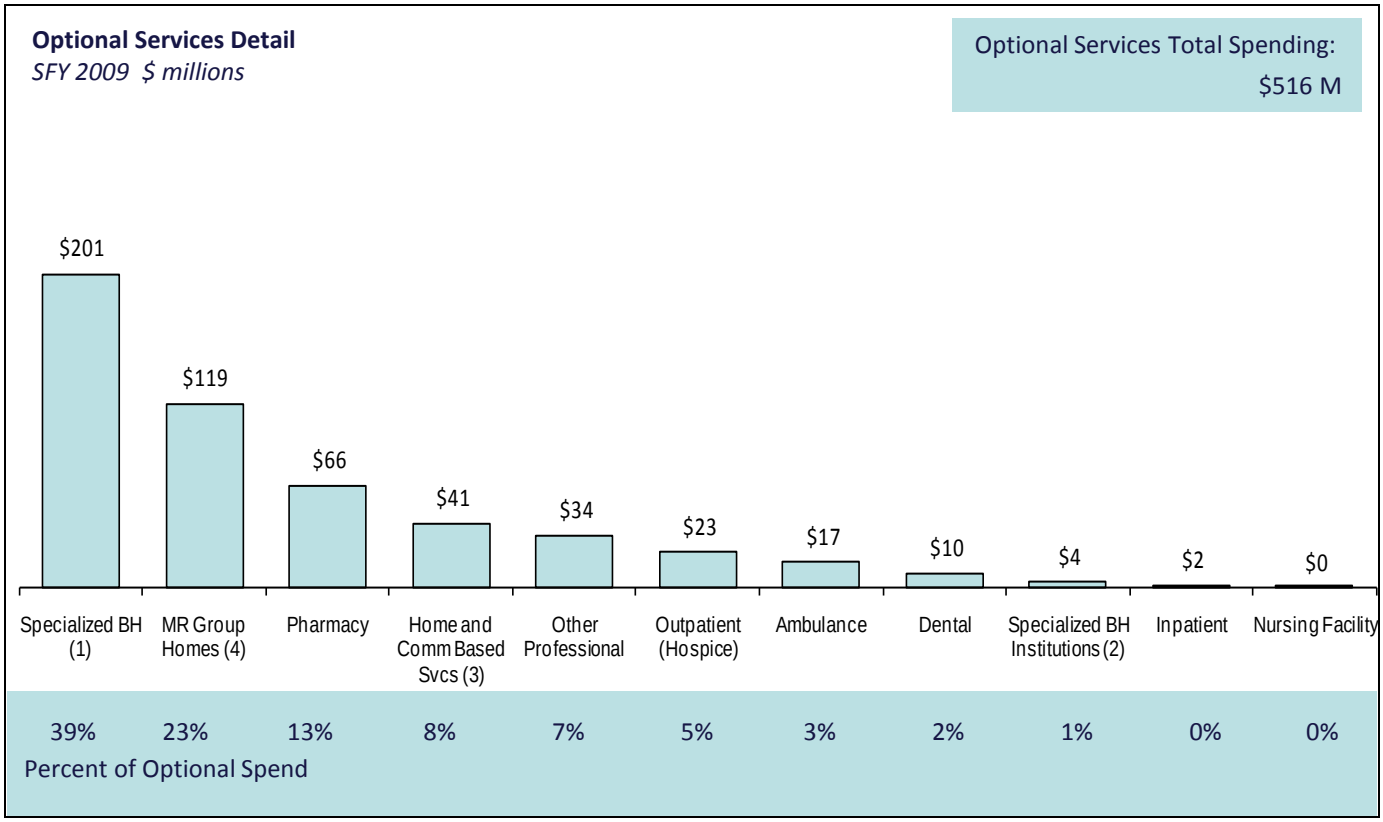
Optional services include lower cost practitioners other than physicians, and services that provide care coordination or continuity.

Federal mandatory services	Optional Services
Expenditure: $1,214 M	Expenditure: $475 M
Acute Care ❖ 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	**Acute Care** ❖ 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
Institutional Services ❖ Nursing facility services for individuals 21 and older	**Institutional Services** ❖ Intermediate care facility services for the mentally retarded (ICF/MR) ❖ Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases ❖ Inpatient psychiatric hospital services for individuals under 21
Home and Community Based Services ❖ Home health care services for any individual entitled to nursing facility care	**Home and Community Based Services** ❖ 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

Source: "Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories", June, 2005, Sommers, Ghosh, The Urban Institute

5b. Mandatory/Optional: Optional Services

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



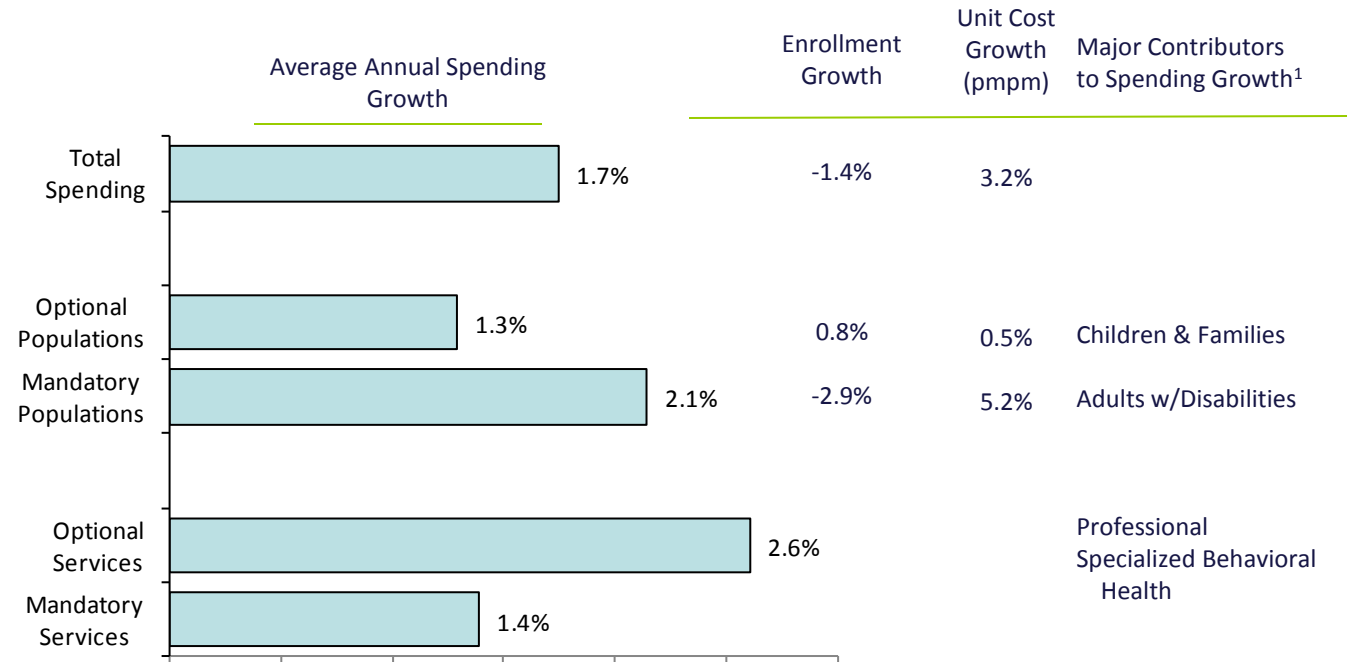
- Optional services accounted for $516 million in total Medicaid spending in SFY 2009, approximately 30% of total Medicaid expenditures.
- The largest components of optional services are behavioral health services and group homes for the MR population. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services for the Mentally Retarded/Developmentally Disabled populations.

[1]BH reflects Professional services provided through MHRH, DCYF, DHS BH (BH, CEDARR, CIS)., NonInstitutionl/NonWaiver Services.
[2] BH Institutions include Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.
[3]Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, including personal care, assisted living/case management, etc.
[4]MR Group Homes include both public and private facilities.

5c. Mandatory/Optional: Trends

Spending growth is disproportionately attributed to mandatory populations

Growth in Spending on Mandatory vs. Optional Populations
SFY 2006 - SFY 2009



- **Spending growth has been higher for mandatory populations.** Spending on mandatory populations grew an average of 2.1% per year between SFY 2006 and SFY 2009. Notably, the unit cost trend was higher, at 5.2% per year on average, as it was offset by enrollment declines.
  - The majority of spending growth in mandatory populations is on adults with disabilities (82%). CSHCN experienced a slight decline during this period.
- Optional populations have experienced much slower growth, with average unit cost growth that is about one percent per year.
- Optional services grew at an average annual rate of 2.6% per year between 2006 and 2009. This is driven mostly by behavioral health and professional. services Excluding pharmacy spending, optional services grew 5.2% per year between 2006 and 2009.

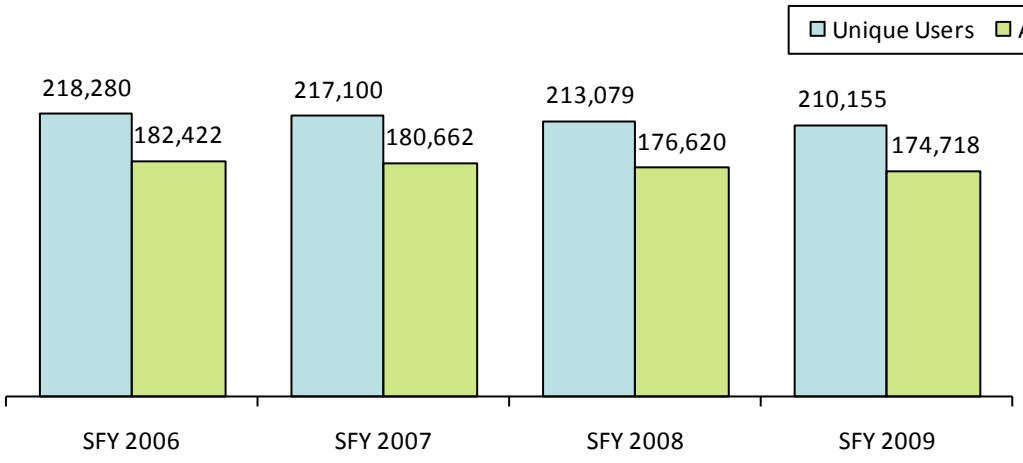
1. The elderly did not contribute significantly to spending growth, partly due to the introduction of Medicare Part D, which transitioned a significant amount of pharmacy spend for the elderly out of Medicaid and into Medicare

Table of Contents

5. User Profile: Unique Users

Approximately 210,000 Rhode Islanders, or 20% of Rhode Island's population[1], were enrolled in Medicaid for some part of SFY 2009.

Unique Users vs. Average Eligibles
SFY 2009



	SFY 2006	SFY 2007	SFY 2008	SFY 2009
Turnover Ratio:	1.20	1.20	1.21	1.20
Unique Users as % of RI population	20.6%	20.6%	20.2%	20.0%

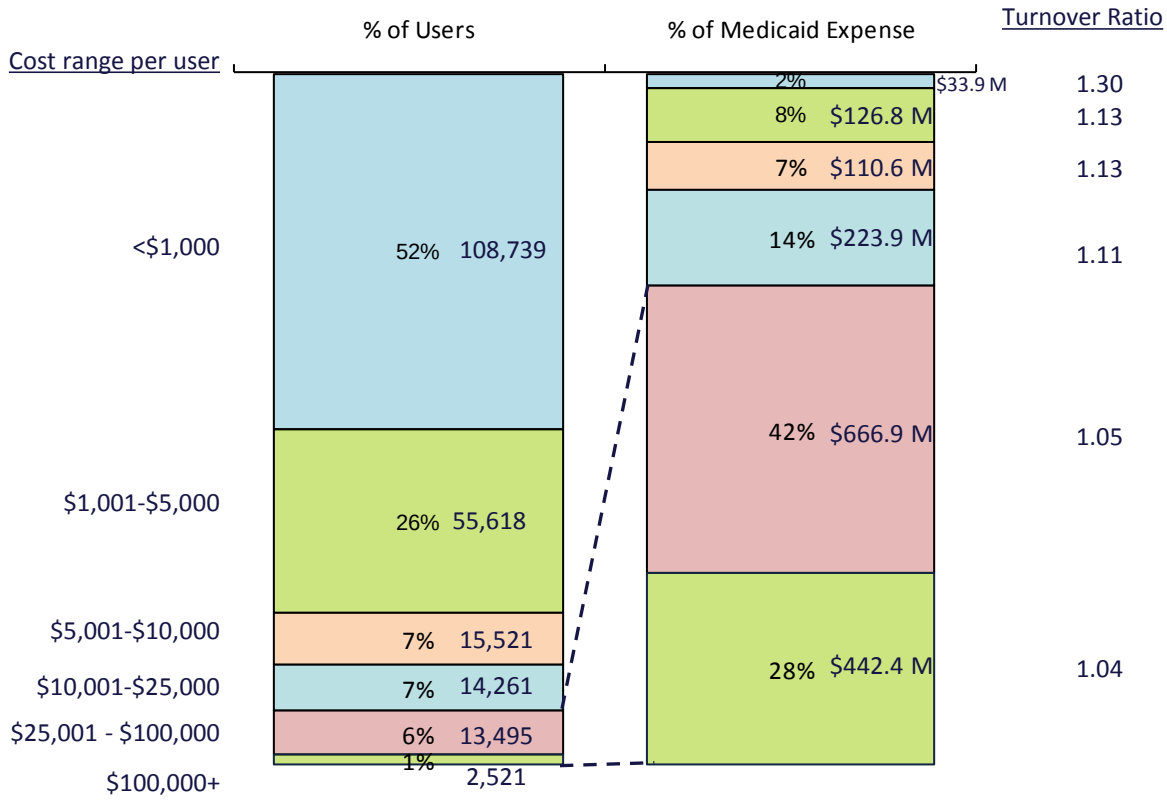
- Unique users is a measure of the number of Rhode Islanders who were enrolled in Medicaid at any time during the fiscal year.[2] This means that if a person enrolled, disenrolled, and reenrolled, they would count as one person. Similarly, if a person enrolled for only 1 month, they would be included as a unique user.
- Comparing unique users to average Medicaid 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) -- that indicates the program is serving a broader spectrum of Rhode Islanders, some of whom enroll for a short period and then return to other coverage options.
- By this measure, the Medicaid program appears to serve a relatively broad spectrum of Rhode Islanders who might enroll for a short period of time.

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.

5. Spending by User Profile: High Cost Cases

The top seven percent of Medicaid users account for over two thirds (70%) of Medicaid spending.

Medicaid User Cost Distribution
SFY 2008



Total Program	217,348	$1,604 M *($126 M of expense unassigned by user)*	1.20

- The concentration of health care expenses provide important insights on how best to contain rising health care costs, and serves to inform more focused cost-containment strategies targeting chronic conditions.

- Medicaid expenditures are highly concentrated, as the top 7% of Medicaid users account for more than two-thirds (70%) of expenditures. This is similar to national statistics, as the top 5% of the US population accounted for 49% of overall US health care spending[1]. On the other end of the spectrum, 78% of Medicaid users access Medicaid services at a cost of less than $5000 per year. Thus, the 16,016 top utilizers spent, on average, $69,261 per person, more than *sixty times* as much per person as those in the bottom 78% of spenders.

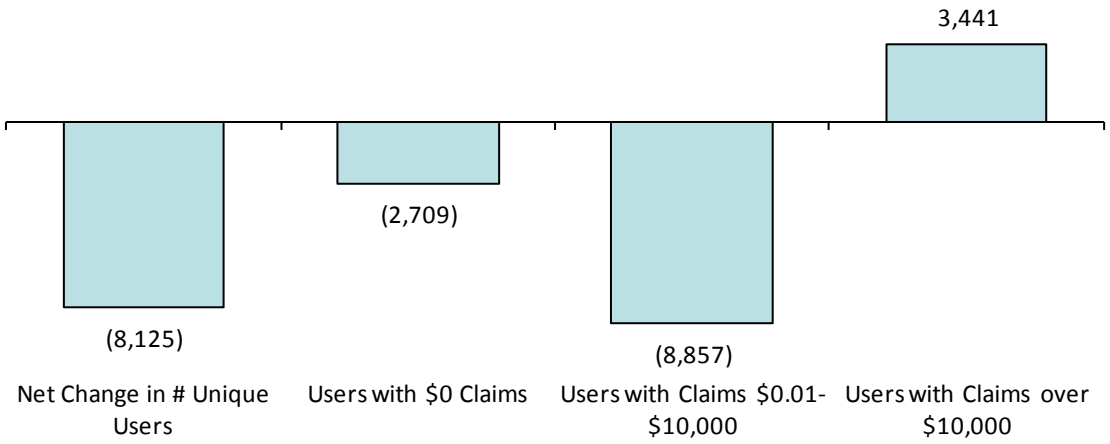
- Additionally, the high cost users have a turnover ratio that is close to one (1.04 for the top 1% of users) – indicating that this population tends to remain on the program for the full year. These high utilizers typically present with multiple, complex conditions, requiring care coordination across a variety of provider types. This suggests a sustained opportunity for care management, focused on high cost/chronically ill populations.

1. "The High Concentration of US Health Care Expenditures," AHRQ, 2006 http://www.ahrq.gov/research/ria19/expendria.pdf

5. Spending Trends by User Profile

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

Overall Change in Number of Unique Users by User Profile
SFY 2006 - 2009



	Net Change in # Unique Users	Users with $0 Claims	Users with Claims $0.01-$10,000	Users with Claims over $10,000
Percent Change in Unique Users 06:09	-4%	-11%	-5%	+13%

A shift in user profiles – toward a higher cost population or toward a lower cost population – could significantly affect the program cost structure and expenditure trends. Over the past few years, it appears that the Medicaid user profile has in fact shifted toward higher cost users, which could result in cost and trend increases over the coming years.

❖Overall, Medicaid has experienced a modest decline in the number of unique users, down approximately 4% over the past three years.

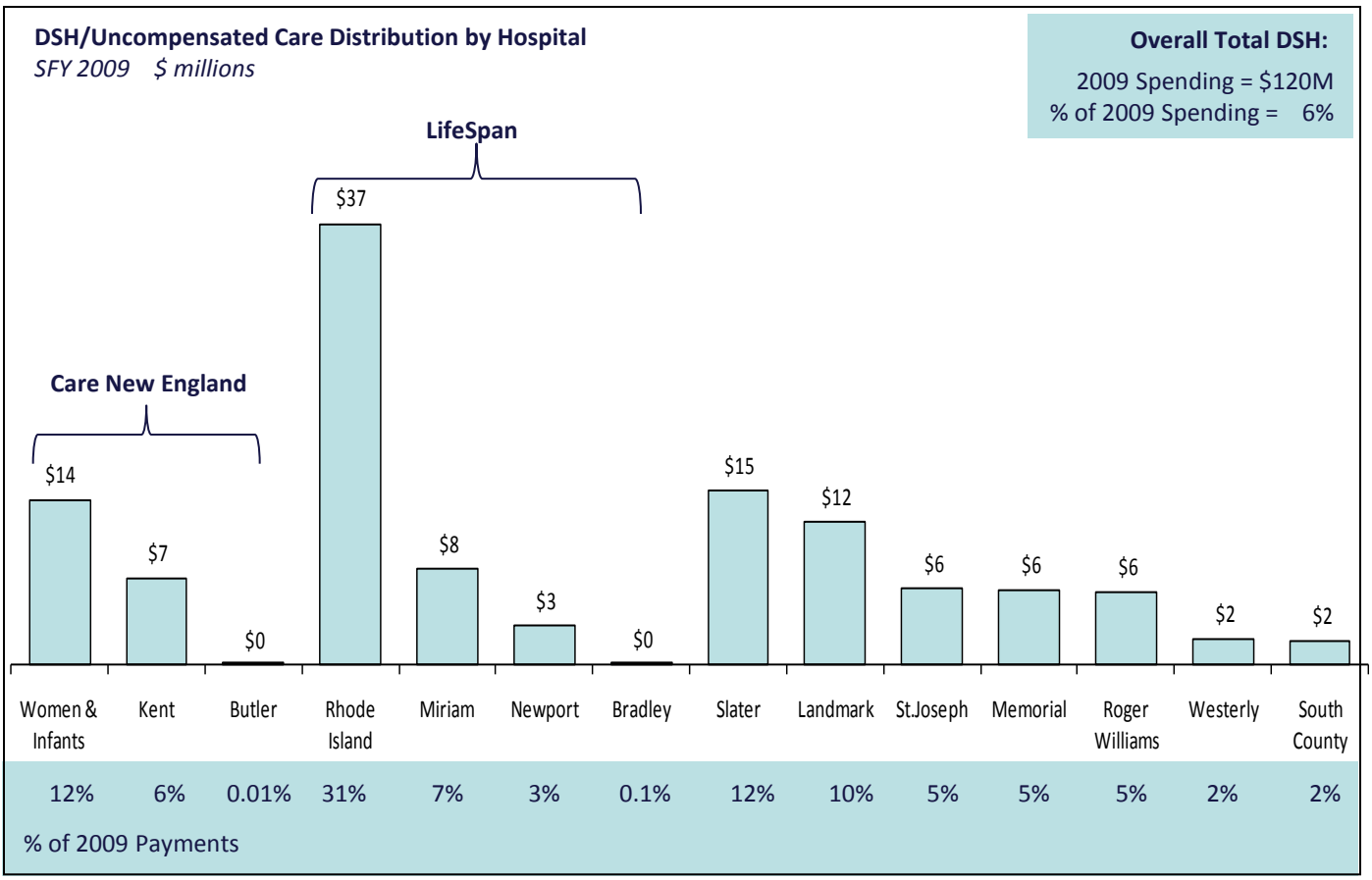
❖However, this modest decline has not been consistent across all categories of users. In fact, over the past three years, Medicaid has seen a decline in low cost users and an increase in high cost users.

- Nonusers (users with $0 in claims expense) declined; while high users (users with claims over $10,000) increased by 13% over this period.

Table of Contents

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

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



- A total of $120 million in DSH funds was paid out to hospitals in 2009.
- The state's two largest hospitals – Rhode Island and Women and Infants – together accounted for 43% of total DSH payments
- DSH payments are not included in the Medicaid spending analysis in this report.

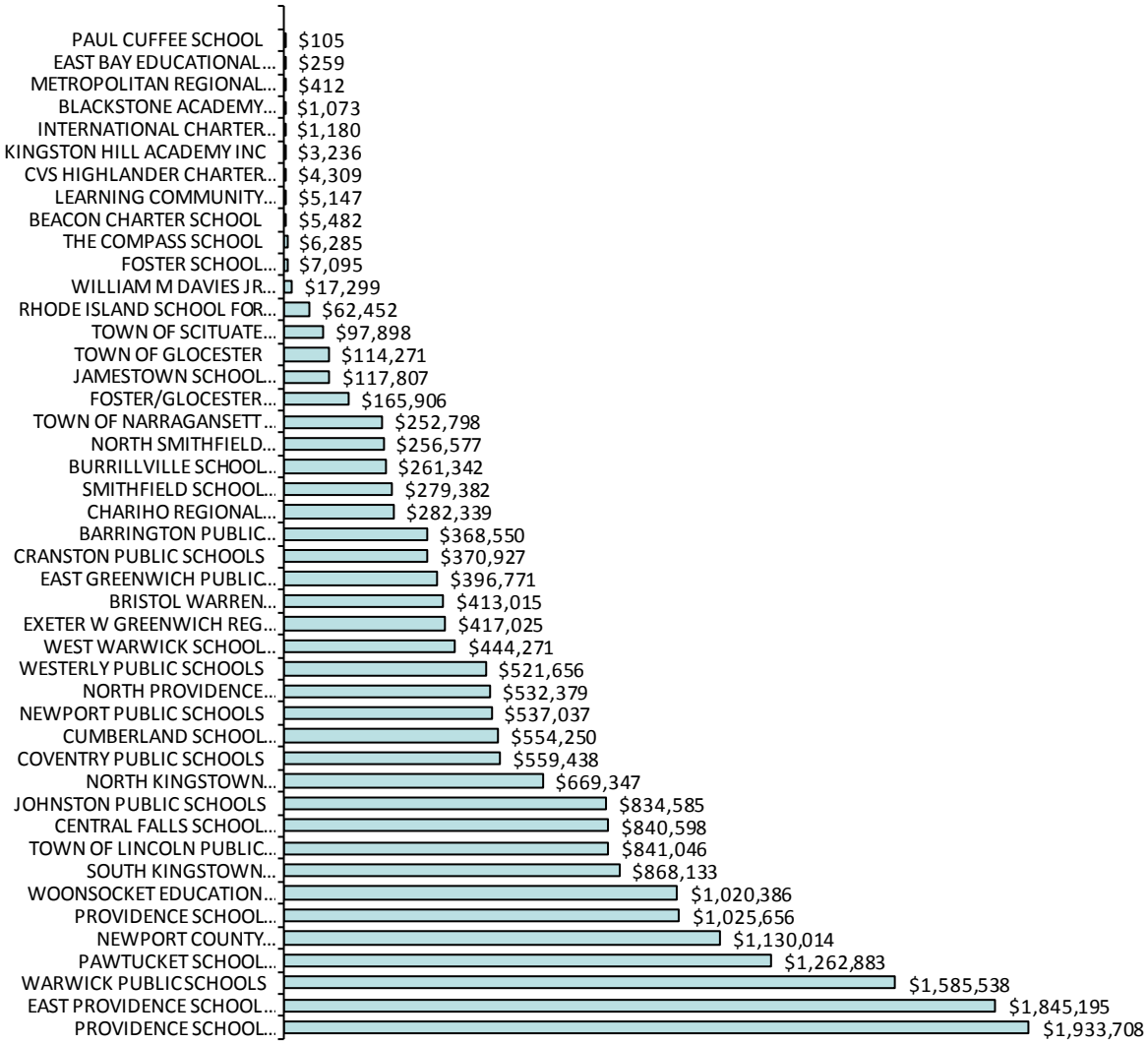
Note: Does not include Psychiatric & Graduate medical education DSH pool.

Appendix A: Exclusions: (2) Local Education Agencies

Local Education Agencies (LEAs) account for $20.9 million in total Medicaid expenditures. 45 school districts participate. Two districts (Providence and E. Providence) account for 23% of total LEA expenditures.

Medicaid Funding to Local Education Agencies (LEAs)
SFY 2009

Overall Total LEA:
2009 Spending = $20.9M
% of 2009 Spending = 1%



Note: LEA expenditures are excluded from the Medicaid spending analysis in this report.

Appendix B:
Acronyms and Abbreviations

A&D:	Aged & disabled
CFMC:	Children and families in managed care
CSHCN:	Children with special health care needs
DCYF:	Department of Children, Youth and Families
DEA:	Department of Elderly Affairs
DSH:	Disproportionate Share Hospitals
DHS:	Department of Human Services
EOHHS:	Executive Office of Health and Human Services
FFY:	Federal fiscal year
FMAP:	Federal Medicaid assistance percentage
HCBS:	Home and community-based services
ICF/MR:	Intermediate care facility/mental retardation
LEA:	Local education agencies
LTC:	Long term care
MHRH:	Mental health, retardation and hospitals
MR/DD:	Mental retardation/developmental disabilities
MR Facility:	Mental retardation facility
PMPM:	Per member per month
SFY:	State fiscal year