

The Future of Medicaid



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*Federal Requirements • Medicaid State Plan • Rhode Island's Medicaid Program
Children and Families • Elderly Adults • What Services Do Beneficiaries Receive?
How Are Services Financed? • Operational Context • Program Reviews • Beneficiary Satisfaction
Enrollment Trends • Factors Influencing Costs • Federal Medical Assistance Percentage -- FMAP
Case Mix • Enrollment Rates • Beneficiary Acuity and Co-Morbidity
Children and Families in Managed Care • Nursing Home Residents • Utilization Rates
Institutional Long-term Care Services • Provider and Service Mix • Medicaid and the State Budget
Structural Impediments and Systems of Care Issues • Erosion of Private Insurance
Programs for Children and Families • RIte Care and Health Reform 2000
Children's Behavioral Health Redesign • Medicaid for Adults
Care Management for Adults with Disabilities and Elders • Long Term Care Transformation
Federal Deficit Reduction Act of 2006 • Making Health Insurance Affordable and Accessible
Health Care Agenda for Rhode Island • Affordable Health Insurance*



Why EOHHS Did this Study

The Rhode Island Medicaid program is the chief source of funding for long-term care for individuals with limited-means and for health care coverage and services provided to low-income elders and adults with disabilities, working families and children, and pregnant women and infants. In recent years, as health costs have climbed, annual expenditures for the program have continued to rise and at a higher rate than state general revenues. This imbalance is one of several factors with the potential to affect the Medicaid program's financial viability and sustainability in the years ahead. Of equal concern to state policy makers is the increasing number of uninsured Rhode Islanders. Whether the state's Medicaid program is an affordable and appropriate platform for addressing the needs of the uninsured is thus an important and, as yet, unresolved question.

It was with these issues and concerns in mind that the General Assembly and the Governor directed the Executive Office of Health and Human Services (EOHHS) to conduct a "study of the Medicaid programs administered by the state to review and analyze the options available for reducing or stabilizing the level of uninsured Rhode Islanders and containing Medicaid spending." (RIGL 42-7.2-12)

The scope of the program has made fulfilling this charge in a single report a challenge. Accordingly, this report is a beginning and one sufficient in breadth to provide decision makers with the information they need to discuss the viability of Medicaid today and to determine what the program can and should be in the years ahead.

This report includes an analysis of information and data drawn from a wide variety of sources. The Medicaid Management Information System (MMIS) provided the bulk of the data on program enrollment, case and service mix and cost trends. A significant number of the secondary sources of data used in this report included information that was provided directly by the state's health and human services agencies and/or pulled from the MMIS.

What the EOHHS Found

Medicaid is an integral facet of the state's health care system. In State Fiscal Year 2006, the program served nearly one-third of the state's population at some point in time at a cost of over \$800 million dollars in general revenue or about one-quarter of the state's budget for the year.

As the Medicaid program has evolved, it has been transformed into an influential health care financing mechanism. The program pays for better than half of the births each year statewide and is the principal, and in many instances, sole payer of long-term care. Medicaid is also an important source of health coverage for low-income children and families, elders, and individuals living with chronic and disabling conditions that do not have access to or cannot afford health care coverage. Additionally, Medicaid funds support a significant portion of the health care workforce and supply substantial patient revenue in hospitals, nursing facilities and the state's community mental health and health centers. Local governments in the state rely on Medicaid to fund the school-based services for children with special needs. And, due to joint federal-state financing, Medicaid is the single largest source of federal monies flowing into Rhode Island.

Given the program's expansive reach, any path the state chooses to pursue in planning for Medicaid's future has the potential to have a pronounced impact on beneficiaries and the providers and facilities the program supports. This report's breadth was dictated as much by this fact, as by the inordinately complex way in which the state organizes, finances and delivers services. Indeed, one of the principal findings presented in the report is that the fragmentation of Medicaid financing and administrative responsibilities makes it difficult to ensure that beneficiaries are provided the right level and kind of services in the most appropriate setting.

In general, we found that, when asked, beneficiaries report they are satisfied with the Medicaid services



they receive; the program also scores well on a variety of performance and outcome measures and compares favorably to the Medicaid programs in other states on these and several other quality indicators. Moreover, on many levels, the Medicaid program is a cost-effective investment; in SFY 2006, it cost less than \$400 on average to cover nearly 80,000 of the children and families enrolled in RItE Care/RItE Share – that is, about 35 percent of the entire Medicaid caseload. Yet, when looking at the distribution of costs across populations, we also found evidence indicating that a comparatively small number of beneficiaries with highly complex health care needs are responsible for a disproportionate share of program expenditures. Though the state should do more to assure these beneficiaries are receiving the services and supports they need in the appropriate setting, they are routinely excluded from Medicaid managed care and care management initiatives.

High cost beneficiaries are only one of several factors driving Medicaid expenditures today with the potential to exert fiscal pressure on the program in the future. By virtue of the program's size and cost, financing Medicaid will continue to be a challenge for the state. Medicaid forecasts we looked at from a variety of different sources highlighted the fiscal implications of further reductions in the federal funds contributed to the program and projected increases in enrollment in the out years as baby boomers age into eligibility. We found the rising number of uninsured Rhode Islanders and the changes in the commercial market responsible for this trend also to be of some concern. At this juncture, the state lacks the resources required to use Medicaid as the basis for universal access to health coverage. The analysis of the prospects for the future presented in this report indicates that this is unlikely to change in the near term. In sum, the findings of this study suggest strongly that the Medicaid program requires restructuring to address successfully rising program expenditures, increasing demand, and declining access to alternate forms of coverage.

The report concludes with an overview of the options for the future that focuses on implementing program wide reforms that enhance and take advantage of the Medicaid program's strengths. On the acute care side, we recommend that the state maximize its purchasing power by leveraging the total number of lives covered through Medicaid and the State Employee's Health Benefit Plan even though the pools are separate. Pursuing this option would afford the state the flexibility to better manage the cost, quality, and availability of the health care it finances. To address the issue of affordable health insurance it is critical that every dollar the state spends on acute and post acute care services achieves the best result. Moreover, it would also provide the state the opportunity to assess fully the cost-effectiveness of delegating the responsibility for administering and managing care to the participating commercial health plans. On the long-term care side, we recommend that the state broaden and hasten the infrastructure development and systems integration efforts now under way to implement a consumer driven, self-directed system of care. The goal here is to ensure that beneficiaries have access to the right services in the least restrictive and most appropriate setting.



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Section I: Overview

The future of the Rhode Island Medicaid program will be determined largely by the policy decisions state officials make today. Since 2000, many of these decisions have been shaped by instability in the state's budget environment and in the commercial health insurance market rather than by a broad-based strategic plan for the future that anticipates rather than reacts to such pressures. As a result, Medicaid is at a crossroads and it is not at all clear which path for the future of the program the state can or should pursue. What is certain, however, is that there is no simple or "right" route. Indeed, as this report will show, there are both challenges and opportunities ahead for the Medicaid program in any direction it takes.

The purpose of this report is to map out the strategies open to state policy makers as they make these difficult decisions. Toward this end, this report begins with an overview of the key issues confronting decision makers, moves on from there to describe and evaluate the role of Medicaid today, and then develops a framework for restructuring the program in the future.

The Issues

As the Medicaid program has evolved over the years, it has expanded beyond the traditional role of a safety net to become the principal source of health coverage and services for nearly two hundred thousand Rhode Islanders. Along the way, Medicaid has taken on a variety of roles that have transformed the program from a payer and purchaser of services into an integral component of the state's health care system, the chief financier of the long-term care industry and, as such, a major force to be reckoned with in the economy at large. It is this, Medicaid's expansive reach, which underlies concerns about the program's continued financial viability as well as its impact on access to affordable health care. In considering these issues, it is useful first to address the question of who the program serves and to what end.

Who Is Covered And What Services Do They Receive?

One of the most important aspects of the Rhode Island Medicaid program is the role it plays as a principal and supplemental source of health coverage. Though Medicaid was in some sense designed to serve in this capacity, it has only been in the last 15 years or so that the Rhode Island program's focus shifted from providing coverage to the very poor to assuring access to the low-income uninsured and under insured.

The state made its initial commitment to "assure access to comprehensive health care" for all Rhode Islanders through Medicaid in the Health Care Act for Children and Pregnant Women of 1993.¹ Recognizing that universal access was a goal that could only be "achieved over the course of several years," the 1993 Act established a framework for gradually expanding eligibility for health coverage designed to promote a set of principles often associated with managed care - e.g., "emphasis on primary and preventive care," providing a "medical home," and so forth.² The first step in this direction was the creation of RIte Care.

Over the last 15 years, Rhode Island has used its RIte Care managed care program to transform the largest component of the Medicaid program into a health insurance plan for low-income families who do not have access to or cannot afford commercial insurance. Today, the majority of Medicaid beneficiaries are the children and families enrolled in RIte Care. Though their health needs vary, the RIte Care population chiefly utilizes less intensive forms of care - i.e., preventative, primary, and acute care services - if not always in the most economical setting - e.g., emergency rooms v. primary care physician offices. Thus, although large in number, the RIte Care population is relatively healthy and the least expensive for the state to cover on a per capita basis.

The children requiring special health care, elders, and adults with disabilities covered by Medicaid generally have more complex needs and require an array of services that are often unavailable through a typical commercial health plan. For example, Medicaid is often the only source of health care for Rhode Islanders who have chronic disabling conditions or who have experienced a financially catastrophic illness and need both medical services and social supports -- e.g., personal care assistance, supervision, etc. -- to

¹ R.I.G.L. 42-12.3-2

² Ibid.



thrive. Medicaid also provides assistance to low-income Medicare beneficiaries to offset healthcare costs and fill the gaps in services. Moreover, Medicaid is the only public program that finances long-term care costs for elders and adults with disabilities in so many different settings.

By virtue of the fact that age and/or infirmity are conditions of eligibility for elders, adults with disabilities and certain children with special needs, the costs of care on a per capita basis are much higher for most members of these populations than those covered under RIte Care. Additionally, there are certain categories of eligibility that are specifically reserved for individuals who require expensive care/treatment, including those qualifying as “medically needy” and/or for certain kinds of institutionally based long-term care.

Since the program’s inception in the mid 1960s, federal Medicaid guidelines have always had what is referred to as an “institutional-bias” - that is, both eligibility for and access to covered services are more readily available to individuals requiring services in nursing facilities, hospitals and other institutional settings. In recent years, federal authorities have offered the states the option to use both alternative methods for determining income eligibility and Section 1915 Home and Community Based Service waivers to allow beneficiaries to obtain coverage while living in less restrictive residential settings and to take greater control over their care. The state has taken advantage of these opportunities and now provides Medicaid coverage to many individuals who otherwise might only qualify by giving up their independence.

In short, over the last 15 years, the state has used the Rhode Island Medicaid program as a mechanism for extending health coverage to uninsured and underinsured individuals at all stages of life who, due to limited resources and/or serious health conditions and illnesses, would otherwise not be able to obtain insurance. Thus far, however, the program’s scope has been limited to the populations that Medicaid has traditionally served - low-income children and families, elders, adults with disabilities. One of the questions the state is now exploring is whether it is appropriate and feasible for Medicaid to serve as a platform for providing health coverage to other populations, including adults without children.

Briefly, the rate of uninsured Rhode Islanders has grown since 2002, as a result of the sharp rise in commercial premiums, continuing decline in the number of employees with work related health coverage, and, to some extent, changes in the Medicaid program. Confronted with similar trends, there are about a dozen states - including Massachusetts - that have obtained federal approval for “super waivers” that have enabled them to redesign their Medicaid programs to pursue universal access to coverage. As is discussed later in this report, the state’s Office of the Health Insurance Commissioner (OHIC) is considering Rhode Island’s options for pursuing a similar strategy at the behest of Governor Carcieri.

At What Cost?

In Rhode Island, there is an emerging consensus that the Medicaid program as it is now configured can no longer be sustained in the current fiscal environment. At issue is the gap between state revenues and Medicaid operating costs.

The gap first surfaced in state fiscal year (SFY) 2001, as Rhode Island experienced the initial effects of an economic downturn, the availability of affordable employer-sponsored health insurance began to decline, and enrollment in the Medicaid program unexpectedly surged. The post 9/11 recession along with a drop in federal financial support and rising health costs exacerbated these trends and prompted state officials to institute a variety of measures to curb Medicaid enrollment growth, contain program cost, and improve the efficiency of services.

Since SFY 2003, these efforts have largely succeeded in slowing the rate of growth in Medicaid enrollment and cost. For example, between SFY 2003 and SFY 2006, there have been only marginal increases in the Medicaid caseload overall of, on average, about two percent per year; enrollment in the RIte Care program, which serves low-income children and families, actually declined by just over one percent in the last twelve months. Growth in Medicaid expenditures has also been curtailed to the point where program costs are rising at a significantly lower rate than in the commercial market.

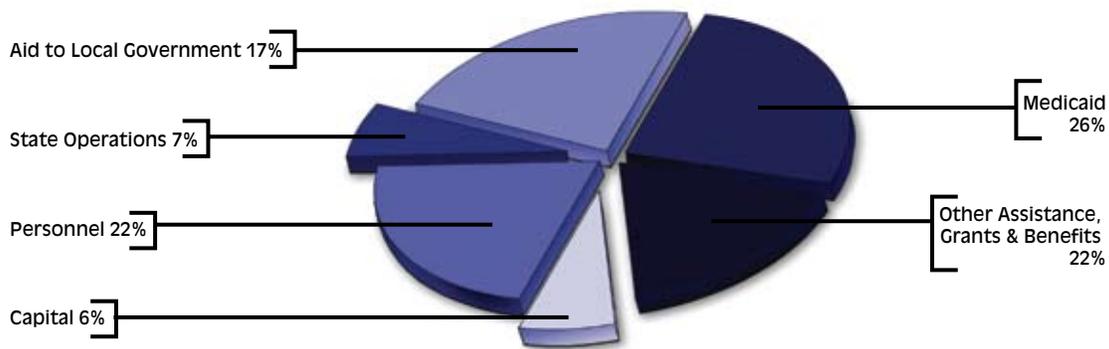
Despite these gains, and an economic rebound that has generated about three percent growth in state revenues for each of the last two years, the budget gap persists. Current fiscal projections for the state indicate that there will be an even larger chasm between general revenues and Medicaid program cost once again this



year and in state fiscal year (SFY) 2008. Medicaid expenditure forecasts presented later in this report suggest that, without significant changes in the program, overall costs may consume as much as fifty cents or more of every general revenue dollar by 2011.

The relationship between Medicaid costs and general revenues is also important because the program now constitutes such a large share of the state's annual budget. As indicated in Figure 1, in SFY 2007, Medicaid expenditures comprised about 26 percent of the state's total spending even though the federal government reimburses the state fifty-seven cents or more for every Medicaid dollar it spends. The program's hold on such a significant portion of the annual budget poses its own unique set of challenges for state policy makers.

Figure 1
State Budget SFY 2007



For example, although Medicaid has benefited Rhode Islanders, the program's high cost limits the resources available to address other pressing needs, spur economic growth, and/or prepare for an uncertain future. Thus, when confronted with a problem or proposal requiring an investment of general funds, state policy makers are in the unenviable position of having to choose between doing nothing, diverting funds from Medicaid or some other program, or raising new revenue. As the forecasts presented later in this report make clear, the range of choices open to the state will narrow as the majority of the baby boomers enter old age, program costs surge higher, and the gap between the rise in Medicaid expenditures and general revenues grows wider.

Sharing responsibility with the federal government for financing Medicaid has affected, and will continue to affect, the state's ability to balance program costs, revenues and other policy priorities. As Medicaid dollars are the single largest source of grant support to Rhode Island, the consequences of changes in federal funding for the state cannot be overstated.

First, there is the impact on state finances that results from even a marginal change in the federal government's share of Medicaid costs, or what is known as Federal Matching Assistance Percentage (FMAP).³ For example, reductions in FMAP between SFY 2004 and 2007 decreased federal contributions to the program by \$92.5 million. The major Medicaid cost containment initiatives implemented by the state over this same period offset about \$62.5 million of that amount, with general revenues covering the remaining \$30 million or so. The state's capacity to handle the decreases in FMAP expected in the years ahead is thus a critical issue.

Second, compounding the fiscal pressures created by declines in the FMAP have been recent efforts by federal authorities to interpret more narrowly the scope of benefits and services for which federal financial participation (FFP)⁴ is allowed and scrutinize more carefully the financing schemes (e.g., provider taxes and

³ The federal government calculates FMAP using a formula established in the Social Security Act. Under this formula, the FMAP is inversely proportional to a state's average personal income, relative to the national average.

⁴ Federal financial participation (FFP) is the term used to describe federal matching funds. To receive the FMAP for a Medicaid claim, the cost must be eligible for FFP under applicable federal policy, whether articulated in a federal law or regulation or CMS guidelines/guidance.



intergovernmental transfers) used by the states to maximize federal contributions.⁵ Although Rhode Island does not rely heavily on the latter to fund its Medicaid program, the opportunity for the state to utilize these alternative financing tools to offset rising program expenditures has all but evaporated due to the increase in federal restrictions and oversight. Moreover, the penchant of federal authorities to reinterpret/revisit long-standing program guidance and guidelines to render supportive services and expenses ineligible for FFP has exposed the state to additional financial risks.

And third, changes in federal policies and programs that touch Medicaid beneficiaries, such as Medicare, also have the potential to affect state expenditures. The establishment of the Medicare Part D prescription drug benefit is a case in point.

The state's ability to effectively manage the costs for care provided to beneficiaries that are dually Medicare and Medicaid Eligible has long been a challenge, at least in part, because Medicare pays for a significant portion of the care they receive. With the implementation of Medicare Part D, the federal government assumed financial responsibility and control over another important aspect of the care provided to dual eligibles on the acute and post-acute care side. Moreover, the state not only is responsible for reimbursing the federal government for the cost of that coverage through the so-called clawback, but has also borne much of the administrative expense associated with the large-scale and challenging transition to Medicare Part D. Additionally, federal policy exempting dual eligibles in the institutional setting from cost sharing has raised equity issues, as beneficiaries served through the state's Home and Community Based Services Waiver programs --- all of which require applicants to meet an institutional level of care to qualify - are required to pay a portion of their prescription drug costs. Not surprisingly, waiver beneficiaries have been pressuring the state to cover their cost sharing responsibilities, even though there is an effort under way by the state to establish nominal co-payments for prescriptions to all elders and adults with disabilities covered by Medicaid.

The Spillover Effects

Questions about the future of the Rhode Island Medicaid program cannot and should not be addressed solely in terms of the cross pressures in the state's budget environment or the impact on the uninsured. There is a growing body of evidence indicating that the Medicaid program's reach extends even further and now not only affects the health of the state budget and beneficiaries, but the work force and industry it supports and the broader economy as well.⁶

The available data for Rhode Island indicates that in FY 2007, with the FMAP set at 52.35%, the federal government contributes \$1.10 in funds for every dollar the state spends. Accordingly, to achieve a one-dollar (\$1.00) net savings in Medicaid costs, state policy makers realistically need to reduce program expenditures by \$2.10.⁷

The potential impact of even a marginal cutback in Medicaid expenditures on the state's overall economy - what is often referred to as the "multiplier effect" - is discussed in greater detail later in this report. In a state so heavily reliant on the health care industry, Medicaid expenditures have an impact on the financial status of health care workers, public and private providers, and health care organizations and delivery systems the program supports. Simply put, state policy makers must consider not only how program changes affect the health of beneficiaries, but of the industry that serves them and of the economy in which it is embedded as well.

5 The additional oversight of state financing and claiming activities was instituted early in this decade in conjunction with a variety of other program reforms and fiscal initiatives designed to stem the growth of the federal budget deficit. An overview of the purposes of this greater oversight is summarized in a statement made by Dennis Smith, Director of the Centers for Medicare and Medicaid Services (CMS) before the Subcommittee on Health, House Energy and Commerce Committee, on April 1, 2004. Available at <http://www.hhs.gov/asl/testify/t040401f.html>

6 For an overview of this research see: Kaiser Family Foundation, "The Role of Medicaid in State Economies: A Look at the Research," Publication #7075. (Washington, D.C.: Kaiser Commission on the Uninsured, 2004).

7 For an explanation of the role of FMAP and state budgets see Fossett, James and Burke, Courtney, "Medicaid and State Budgets in FY 2004: Why Medicaid Is So Hard to Cut," (Albany, NY: The Nelson A. Rockefeller Institute of Government, 2004).



Section 2: Descriptive Summary of the Medicaid Program

Medicaid is a federally sponsored health care program for individuals and families with limited incomes and resources. The program was established in 1965, as Title XIX of the U.S. Social Security Act to enable the states to provide health care to their most vulnerable populations. In the years since the program was created, Medicaid has become both the primary payer and purchaser of health care for many individuals and families in need. Today, Medicaid is the chief source of funding for long-term care for individuals with limited-means as well as for health care coverage and services provided to low income elders and adults with disabilities, working families and children, and pregnant women and infants.

This section of the report provides an overview of the federal requirements for Medicaid and then describes the key features of the Rhode Island program within this broader context.

Federal Requirements

The federal government pays a share of the cost for state administered health care provided through the Medicaid program. To obtain federal funding, states must operate their programs in compliance with federal statutory and regulatory requirements. States must cover certain categories of individuals (mandatory coverage groups) and have the option of covering others. Similarly, states must offer certain basic services, while also having the choice of providing an array of other, often essential, optional services.

Rather than establish a specific minimum level of each service, Title XIX mandates that the states set reasonable standards, comparable for all eligibility groups, that further the program's goals and comply with federal regulations requiring that Medicaid services be "sufficient in amount, duration and scope to reasonably achieve their purpose." Additionally, under the Medicaid law, states cannot "arbitrarily deny or reduce the amount, duration or scope of services to an otherwise eligible individual solely because of diagnosis, type of illness or condition."⁸ Within these parameters, states have flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery.

Medicaid State Plan

Title XIX requires that each state maintain a Medicaid State Plan that identifies the populations served, the criteria for determining eligibility, the scope of services provided, and the methods of service delivery. The Medicaid State Plan is submitted for approval to the Centers for Medicare and Medicaid Services (CMS), the federal agency within the U.S. Department of Health and Human Services (DHHS) with oversight responsibility for state Medicaid programs.

The CMS plays a critical role in assuring that Medicaid State Plan services meet the basic Title XIX program requirements including those outlined in Table 1.

Table 1: Medicaid State Plan Service Requirements Mandated by Title XIX⁹

- Services must be available to individuals on a comparable basis. With some exceptions, a state may not provide services that differ in amount or type to one v. another group of beneficiaries.
- Program beneficiaries must be guaranteed free choice in selecting from among qualified service providers when obtaining Medicaid services. That is, a state cannot require a person to obtain services from a specific provider to the exclusion of others.
- Medicaid services are required to be available statewide and eligible individuals must have ready access to them.
- The state must accept and make a prompt decision on an application for Medicaid services.
- Services may not be limited or rationed as a result of fiscal pressures or funding shortfalls. The state is obligated to provide services in its state plan to all eligible persons or change the state plan and terminate access to services for both current beneficiaries and applicants if funding is not available.
- Individuals must have the right to appeal adverse decisions concerning their eligibility or the authorization of services through the so-called "Fair Hearing" process.

8 42 C.F.R. § 440.230(c)

9 42 C.F.R. § 431.40



The Medicaid State Plan is an evolving rather than fixed document. A state must continually amend and/or revise its state plan to reflect the changes made in Medicaid program priorities and requirements. Changes to the Medicaid State Plan typically take the form of what are known as “State Plan Amendments” (SPAs), which are prepared by the states, generally on standardized forms involving minimal text, and submitted to the CMS for approval.¹⁰

The scope and complexity of the SPA approval process varies depending on the issue at hand and the policy priorities of the CMS at a given point in time. Generally, this process is much less difficult to navigate than the other avenues open to the states for changing their Medicaid programs.

Specifically, under certain circumstances, Title XIX allows the Secretary of the U.S. Department of Health and Human Services to grant a state’s request to waive Medicaid requirements under two sections of the law - Section 1915 and 1115 - to pursue policy innovations and/or implement programs that deviate from the standards related to comparability, state wideness, and the scope, amount and duration of services. To obtain the additional flexibility waivers afford, states typically have to prove one or more of the following:

- * Cost Neutrality -- *Medicaid expenditures with the waiver will not exceed projected costs without the waiver;*
- * Reinvestment -- *Any savings derived from providing coverage under the waiver will be reinvested to expand Medicaid eligibility or the scope of services beyond what is authorized through the state plan; and/or*
- * Goal Advancement-- *The policy innovations implemented as a result of the waiver of core Medicaid requirements will further the goals of the program set forth in Title XIX.*¹¹

The process for approving requests for waivers is multi-layered and may take upwards of six months to a year or more. Moreover, as Medicaid coverage and services may differ from those provided under the state plan, waiver authority is typically granted for a limited period of three to five years, depending on the type requested, and may not be renewed at the discretion of the DHHS. Table 2 provides a description of the most common form of waivers:

Table 2: Overview Of Section 1915 And 1115 Medicaid Waivers¹²

Section 1915 Program Waivers: Give states expanded flexibility to provide services to Medicaid beneficiaries using innovative or effective approaches that otherwise would not be permitted under Medicaid laws and regulations. The waivers are frequently used by states to promote home- and community-based services, or to use managed care in their Medicaid programs.

- * **Section 1915(b):** Allows states to waive Medicaid’s “freedom-of-choice” requirement, which generally ensures Medicaid beneficiaries have a choice of providers. With such a waiver, states may: require beneficiaries to enroll in managed care plans; create specialty care delivery systems, such as managed behavioral care; create programs that are not available statewide; or provide enhanced services for beneficiaries.
- * **Section 1915(c):** Also allows states to develop creative alternatives to placing Medicaid beneficiaries in nursing homes, hospitals or other institutions. Generally, these waivers allow states to provide home- and community-based services - including home health aide services and personal care services - to help individuals stay out of institutional settings and thus preserve their independence and ties to family and friends. States may also provide some non-medical services to eliminate the need for participants to be placed in an institution.

1115 Research and Demonstration Programs: Section 1115 of the Social Security Act gives the DHHS Secretary broad authority to authorize research, pilot, or demonstrations projects that are likely to assist in promoting the objectives of the Medicaid program. States have broad flexibility to test substantially new ideas in expanding coverage and service delivery. Additionally, states can obtain federal Medicaid matching funds to provide services that Medicaid otherwise could not cover and/or to cover individuals who otherwise would not be eligible for the Medicaid program.

¹⁰ 42 C.F.R.§ 430.12

¹¹ 42 C.F.R.§ 430.25

¹² Adapted from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp.



State Children's Health Insurance Program

In 1998, Congress established Title XXI of the U.S. Social Security Act creating the State Children's Health Insurance Program (SCHIP) for the purpose of providing health coverage to children who did not qualify for state Medicaid services. Like Medicaid, SCHIP is financed jointly by the federal government and the states and, as explained below, is often administered as part of or in tandem with a state's Medicaid program. Again as is the case with Medicaid, the CMS oversees the administration of the state SCHIPs.

Each state is responsible for developing and implementing its own SCHIP, within the broad parameters set by Title XXI and federal regulations and guidelines, in accordance with a SCHIP State Plan.¹³ However, as Title XXI provides for an enhanced match that exceeds federal financial participation for Medicaid, states were prohibited from transferring to SCHIP children who were eligible for Medicaid under waivers or at the state's choice. This limitation in the law greatly disadvantaged Rhode Island by prohibiting the state from receiving the enhanced rate for the children the state opted to cover through RItE Care Medicaid waiver expansions before Title XXI was enacted in 1997.

Title XXI gives the state the option of implementing SCHIP for eligible individuals who were not covered prior to 1997 as a Medicaid expansion, as a separate health coverage plan or program, or in some combination thereof. States opting for a Medicaid expansion are required to provide children eligible under Title XXI with the full range of benefits available to individuals under the Medicaid State Plan, including Early Periodic Screening, Diagnosis and Treatment (EPSDT). Using this approach eliminates the administrative burden associated with implementing a separate program and essentially extends the Medicaid entitlement to SCHIP eligible children. Separate or combination SCHIP programs, though administratively more complex, allow states to use the greater flexibility Title XXI affords to design health care programs that meet the needs of some uninsured children. There are a significant number of states that use all three approaches for administering SCHIP programs to different populations.¹⁴

SCHIP was designed to provide a capped amount of funds to states on a matching basis for FFY 1998 through 2007. Federal payments under Title XXI are based on state expenditures under approved plans effective on or after October 1, 1997. Funds from states that have failed to use allotted SCHIP monies within the periods designated by federal requirements revert to the federal treasury and are reallocated to states that have exhausted their allotments. This redistribution of funds has helped sustain coverage for many of the states that, like Rhode Island, expanded Medicaid coverage to children before Title XXI was enacted. Congress is currently reviewing the options for reauthorizing SCHIP as well as the potential consequences on the growing rate of uninsured of taking no action.¹⁵

The Social Security Act also authorizes multiple waiver and demonstration authorities to allow states flexibility in operating SCHIP programs. As with Medicaid, under Section 1115 -- Research & Demonstration Projects -- the Secretary of the U.S. Department of Health and Human Services has broad authority to approve projects that test policy innovations likely to further the objectives of the State Children's Health Insurance Program. SCHIP Section 1115 waivers have been used by many states to extend health coverage to the parents of eligible children as well as to uninsured adults.

Rhode Island's Medicaid Program

In Rhode Island, the Department of Human Services (DHS) is currently designated in the Medicaid State Plan as the single state agency for the Medicaid program.¹⁶ As in most states, the responsibility for administering programs funded in whole or in part through Medicaid is shared by multiple health and human services agencies. In Rhode Island, these agencies function under the umbrella of the Executive

13 42 C.F.R. § 457

14 See: Kaiser State Health facts: <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=SCHIP+Program+Type>

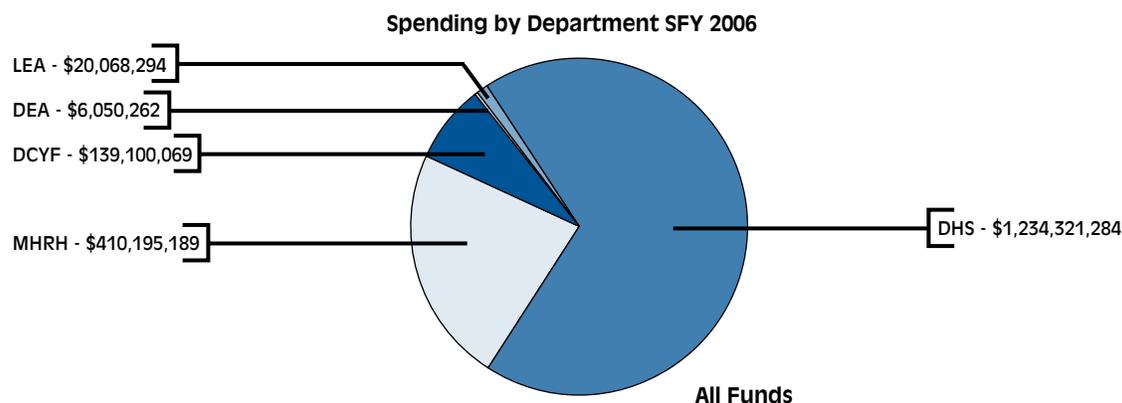
15 See: <http://www.kff.org/medicaid/upload/7574-2.pdf> for an overview of the some of the key issues with respect to reauthorization of the SCHIP program.

16 Federal law also requires each state to centralize administrative, legal and financial responsibility for its Medicaid program in a "single state agency." The unit of government designated as the single state agency maintains the Medicaid State Plan and, in this capacity, is responsible for administering or overseeing the administration of health care services and coverage provided under the Medicaid State Plan.

Office of Health and Human Services (EOHHS)¹⁷ and include the DHS and the departments of: Mental Health, Retardation and Hospitals (MHRH); Children, Youth and Families (DCYF); Health (HEALTH), and Elderly Affairs (DEA). Local Education Agencies (LEAs), operating in conjunction with the Rhode Island Department of Education, also administer Medicaid financed services.

Figure 2 shows the relative distribution of spending across the state agencies involved in some capacity in the organization, finance, and/or delivery of Medicaid funded programs.

Figure 2



In SFY 2006, the state's Medicaid program provided health coverage and services to about 227,000 Rhode Islanders at some point in time. The program encompasses a diverse array of beneficiaries who qualify for services on the basis of age, income and/or disability under one of the mandatory or optional coverage groups in Title XIX, or as SCHIP eligible children or parents under Title XXI. All Medicaid beneficiaries receive an equally broad range of services, again both mandatory and optional, through several different delivery mechanisms in the institutional or community-based setting.

The requirements applicants for the program must meet vary, depending on the basis for eligibility and, in some instances, the coverage group. For example, the income and asset limits for elders and adults with disabilities differ from those applied to children and families; similarly, the state uses a higher income standard to determine eligibility for long-term care.

The Rhode Island Medicaid program includes many different categories of eligibility based on one or more characteristic, nearly 80 percent of which are optional under Title XIX. Most of these optional groups consist of children and their parents with income above the levels established in Title XIX for mandatory coverage, who became eligible for Medicaid through the RIte Care waiver during a series of expansions in the mid to late 1990s. More recently, however, the trend has been to extend coverage via Section 1915 waivers to adults with disabilities and elders receiving care in the community who might otherwise only be eligible for full Medicaid State Plan services if they were cared for in the institutional setting.

A breakdown of the mandatory and optional groups covered under the Rhode Island Medicaid program is as follows:

Mandatory Coverage Groups -- Must be covered by all state Medicaid programs:

- 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;

¹⁷ EOHHS Medicaid responsibilities are set forth in See R.I.G.L. 42-7.2-5(a)-(d).



- Infants born to Medicaid-enrolled pregnant women; and
- Children who receive adoption assistance or who live in substitute or foster care, under a federally-sponsored Title IV-E program.

Optional Coverage Groups - The state has chosen to cover these additional groups or individuals and families:

- Low-income elderly adults and adults with disabilities;
- Individuals eligible for Home and Community Based Services Waiver programs;
- Children and pregnant women with income up to 250 percent of the FPL and parents with income up to 185 percent of the federal poverty level, including parents of children funded through SCHIP;
- Individuals determined to be “medically needy” due to low income and resources or to high medical expenses;
- Children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the “Katie Beckett” provision); and
- Women eligible for the breast and cervical cancer program.

For the sake of simplicity, these coverage groups are typically organized into four Medicaid “populations” that share key eligibility characteristics: children and families, children with special health care needs, adults with disabilities, and elders. The distribution of beneficiaries into these groups is as follows:

- Children & Families - 70%
- Children with special health care needs - 6%
- Adults with disabilities - 14%
- Elders - 10%

Beneficiaries in each of these groups are provided services through managed care, traditional fee-for-service, or through a waiver program. Children and families are served through the state’s Section 1115 managed care demonstration waiver, RIte Care and its sister premium assistance program, RIte Share. Children with special health care needs are served through RIte Care and fee-for-service. Adults with disabilities and elders receive Medicaid through either fee-for-service or one of the state’s Section 1915, Home and Community Based Services (HCBS) waivers. Table 3 describes each of the waivers, which beneficiaries are eligible, and the types of services provided.

Table 3: Selected RI Waiver Populations

Waiver:	Aged & Disabled	Elder	Developmental Disability	Habilitative	Assisted Living	Consumer -Directed (Personal Choice)
Target Population	Those 18 and over who are aged or have a disability that results in the need for help with *ADLs and IADLs	Those 65 and older who need help with ADLs and IADLs	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 began before age 22	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	Those 18 and older who require assistance with ADLs and IADLs and who are able to manage their own services or have a representative to manage services on their behalf

**ADL - Activities of daily living such as eating, bathing, toileting; IADL - Independent activities of daily living such as taking medications, managing money, shopping, housekeeping, etc.*

To summarize, Table 4 shows the eligibility pathways for each of the four major Medicaid populations. A brief descriptive profile of each population follows the table.

Medicaid Population	Eligibility Pathways
Children and families in managed care (children under 19 and their parents)	FIP/TANF; Section 1115(a) Waiver eligible; SCHIP; Certain poverty level children who are not eligible for TANF; 1931(e) expansion parents covered through Medicaid/SCHIP 1115 waiver
Children with special health care needs as an eligibility factor (under age 22)	Children who are: Blind and disabled SSI recipients; Katie Beckett eligible (eligible up to 18th birthday); DCYF substitute care; DCYF subsidized adoption
Adults with disabilities (age 22-64)	Blind and disabled recipients; Medically needy Blind & disabled persons at or below the poverty level; Long-term care eligible
Aged (age 65 and over)	Aged, blind and disabled SSI recipients; Medically needy; Persons at or below the poverty level; Long-term care eligible

Children and Families

As indicated above, children and families constitute the largest Medicaid population. With few exceptions, members of this population who are uninsured or without access to an alternative health plan are enrolled in the state’s Medicaid managed care program, RIte Care; those who are covered by or have access to a health plan comparable in cost to RIte Care are enrolled in RIte Share, the state’s premium assistance program for Medicaid eligible children and families.

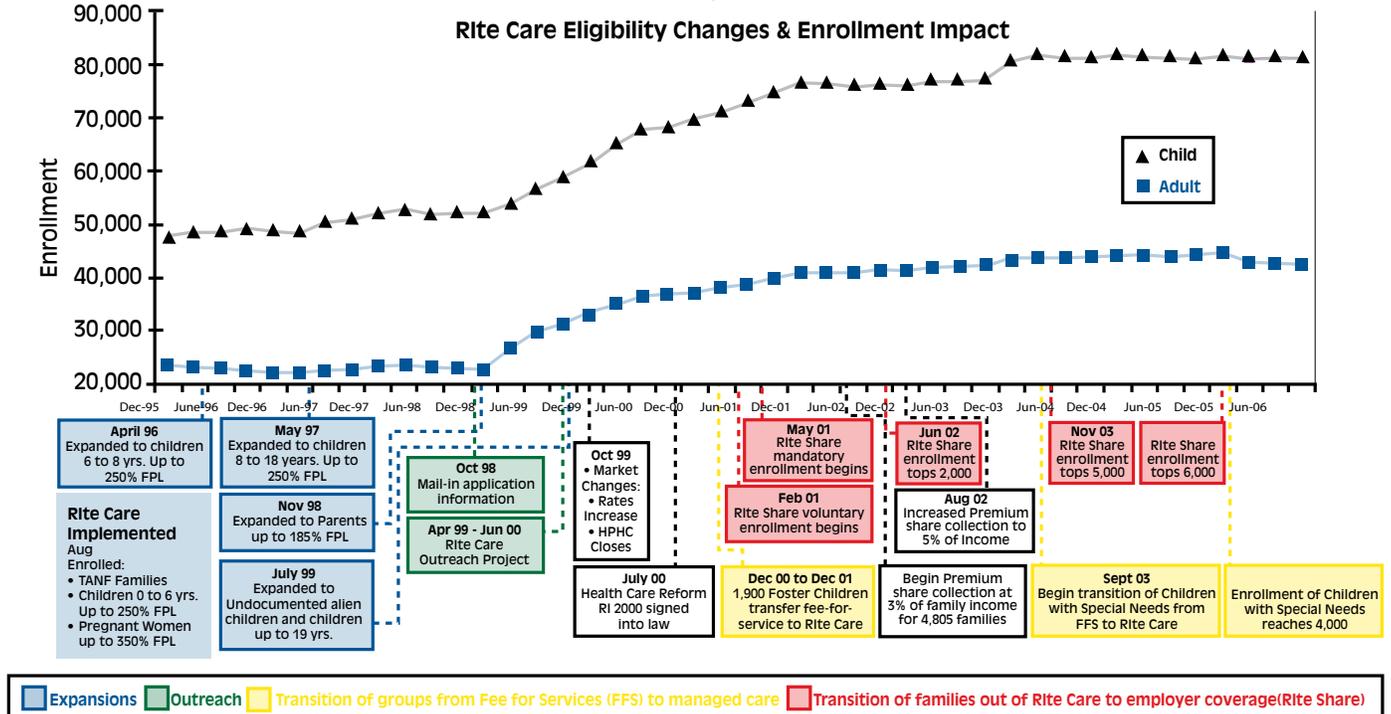
RIte Care was implemented in 1994, under a Section 1115(a) Medicaid demonstration waiver, to provide coverage for families eligible under the now defunct Aid to Families with Dependent Children (AFDC) program as well as pregnant women and children. When making the request for the RIte Care waiver, the state indicated to federal officials that its objective was to demonstrate that providing health coverage through a managed coordinated delivery system would improve service access, quality and outcomes and, at the same time, provide sufficient cost savings to expand Medicaid eligibility and maintain budget neutrality.¹⁹

Figure 3 shows the evolution of the RIte Care program since it was established. Note that until SFY 2000, the state made a series of expansions in eligibility for RIte Care for children and their parents with income considerably above the Title XIX mandatory coverage groups as well as several targeted by SCHIP. The sharp increase in enrollment that followed, in part as a response to these expansions, led to the implementation of the RIte Share program and several other reforms, including cost-sharing, designed to reserve RIte Care for the most needy. The full scope of these changes is explained elsewhere in the report.

¹⁹ Materials related to the RI RIte Care waiver, including the initial requests and various amendments is maintained on the CMS website at: <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp?filtertype=dual&datefilterinterval=&filtertype=data&datafiltertype=2&datafiltervalue=Rhode%20Island&keyword=&intNumPerPage=10&cmdFilterList=Show%2bItems>



Figure 3



In SFY 2006, there were 129,111 children and families enrolled in the three Rite Care health plans participating in the program under contract with the state, excludes the population of children with special needs. In SFY 2006, about two-thirds of the Rite Care enrollees were children, the overwhelming majority of whom had family income at or below 133 percent of the Federal Poverty Level. As of June 2006, there were 5,289 beneficiaries enrolled in Rite Share.

Children With Special Health Care Needs

The population of children with special health care needs (CSHCN) receives health care through Rite Care or fee-for-service Medicaid. For the purposes of this report, the CSHCN population includes:

- Children up to age 18 in state custody - i.e., substitute care - either in a group home or individual placement;
- Children 21 and under receiving Supplemental Security Income (SSI) due to disability;
- Children 18 and under eligible under Section 1902(e)(3) of the Social Security Act, know as the “Katie Beckett” provision; and
- Children 21 and under whose families receive adoption assistance.

Children with special health care needs eligible for Medicaid are primarily members of mandatory coverage groups under Title XIX. The exceptions are the children eligible through the Katie Beckett provision of the Medicaid law as well as those older than eighteen years of age and/or with income above the mandatory levels set for children in poverty.

Until 2000, CSHCN were largely served through fee-for-service Medicaid. At the initiative of both the DHS and the DCYF, in SFY 2001, the state began shifting certain groups of children with special needs from fee-for-service into Rite Care. The first group of children enrolled in Rite Care were in DCYF custody in substitute care (e.g., foster care homes). As of June 2006, there were 2,356 children in substitute care enrolled in Rite Care. This included over 200 children who returned to Rhode Island from out-of-state placements.

While enrolling children in substitute care into Rite Care, state officials developed a plan to bring other children with special health care needs into the Medicaid managed care program. In 2003, the state received federal approval of a waiver amendment authorizing the state to enroll Medicaid children with special health care needs into Rite Care, including uninsured children eligible through SSI, Katie Beckett, and subsidized adoption. A phased transition into Rite Care began in September 2003.



For a variety of reasons, not all CSHCN are permitted to enroll in RIte Care. Excluded groups include children who have other insurance, live in an institution or out of state, or participate in a waiver program administered by the RI Department of Mental Health, Retardation and Hospitals. Over 70 percent of the CSHCNs qualified to make the transition to managed care have opted for enrollment, which continues to be voluntary at this time.²⁰

In SFY 2006, the CSHCN population consisted of a total of 12,353 children from all four coverage groups; 7,052 were enrolled in RIte Care and 5,301 were in fee-for-service Medicaid.

Adults With Disabilities

Adults with disabilities who are eligible for Medicaid are generally between the ages of 19 and 64. Members of this population fall into one of the three coverage groups as either categorically or medically needy:

- Individuals with developmental disabilities and mental retardation;
- Individuals who are physically disabled and/or chronically ill; and
- Individuals who are severely and persistently mentally ill.

A special eligibility group for working adults with disabilities was established in January 2006. Called the Sherlock Plan, members of this population may have up to 250 percent of FPL in countable income,²¹ and up to \$10,000 in countable assets. Individuals eligible for the Sherlock Plan pay as their monthly premium all unearned income (such as Social Security income) over 100 percent of the poverty level and an amount equal to the RIte Care and RIte Share premiums on earned income over the Medically Needy Income Level (MNIL - \$733 per month in CY 2007).

Beneficiaries in the adults with disabilities population have a broad array of health care needs ranging from preventive to primary care to chronic and long-term care. Health coverage is currently provided to Medicaid eligible adults with disabilities on a fee-for-service basis in the community and a nursing facility or other institutional setting.

In SFY 2006, about 12 percent of the beneficiaries in this population (3,280 of 27,334) was served through one of the state's Section 1915, Home and Community Based Services (HCBS) waiver programs. Nearly 79 percent of these beneficiaries were covered through the state's HCBS waiver for persons with developmental disabilities/mental retardation, known as the DD/MR waiver. About 47 percent of the entire population - waiver and non-waiver - had some form of health insurance in addition to Medicaid, either Medicare or commercial coverage.

Elderly Adults

Elderly adults eligible for Medicaid must be 65 years of age and meet the state's income and assets tests. Income eligibility is generally limited to 100 percent of the FPL (\$817 per month for an individual in FY 2006) for individuals who meet the age criteria, though there are exceptions.²² In terms of resources or assets, individuals with income at or below the federal poverty level may have up to \$4,000 in countable assets. Those with income above the poverty level can have no more than \$2,000 in countable assets.

As is the case for adults with disabilities, the program also extends eligibility to elders with income higher than the poverty level, who have considerable medical expenses and qualify as "medically needy." Beneficiaries qualifying for coverage as medically needy frequently have alternating periods of eligibility and non-eligibility. In FY 2006, slightly under 1,000 of all non-long-term care enrollees applied for this category of eligibility at some point in time.

Though adults with disabilities are also eligible for Medicaid long-term care, most beneficiaries

20 Enrollment in this program is voluntary rather than mandatory given that only one health plan is participating in the program; choice of health plans is required by CMS if enrollment is to be mandatory.

21 Countable income includes all unearned income such as pensions or Social Security and one half of all earned income from employment after the first \$65 is deducted.

22 The income eligibility requirements for long-term care (LTC), the special working adult category, and Breast and Cervical Cancer program participants differ and are discussed in greater detail below.



receiving these benefits are in the elderly population. Income eligibility for long-term care allows an individual to qualify for Medicaid with income up to 300 percent of the federal Supplemental Security Income (SSI) benefit level (\$1,869 in CY 2007). Beneficiaries have to contribute to the cost of their care all income over \$55/month when residing in institutional settings; when living in the community, the cost share is any income above the poverty level. Medicaid pays for all room and board costs in institutional settings, but not in the community.

Long-term care applicants and beneficiaries are now evaluated on whether they have transferred assets over the five-year period prior to Medicaid application. Any applied penalty is in effect from the latter of the date of transfer or the date of Medicaid application, and can be applied for portions of a month. Long-term care applicants who wish to reside in the community may also qualify for Medicaid coverage when they have income above the 300 percent federal benefit level, but only if they pay toward the cost of their care all income above the MNIL (under Federal statute).

In FY 2006, there was an average monthly caseload of 18,166 beneficiaries in the elderly adult population. About 11 percent of that total received services through a HCBS waiver in the community, either at home or in a supportive housing setting such as assisted living. Approximately 98 percent of those covered by waivers had another form of health coverage. There has been an increase in the number of elders opting for care in the community in the last several years, though the number Medicaid funded nursing home residents has remained relatively constant over the same period.

What Services Do Beneficiaries Receive?

The state offers a wide range of mandatory and optional services to the four Medicaid populations it serves. Table 5 shows the breakdown of these services. An important nuance to the program is that for mandatory populations, a series of mandated services must be provided. Additional optional services are at the discretion of the state.

Federal Mandatory Services	Optional Services
<ul style="list-style-type: none"> • Inpatient hospital services • Outpatient hospital services • Rural health clinic services • Federally qualified health center services • Laboratory and x-ray services • Nursing facility services for individuals 21 and older • Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21 • Family Planning services • Physicians' services • Home health services for any individual entitled to nursing facility care • Nurse-midwife services to the extent permitted by State law • Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under state law 	<ul style="list-style-type: none"> • Podiatrists' services • Optometrists services • Dental services • Prescribed drugs • Dentures • Prosthetic devices • Eyeglasses • Diagnostic services • Preventive services • Rehabilitative services • Services in an Institution for Mental Disease for individuals age 65 and over • Inpatient psychiatric services for individuals under age 21 • Nursing facility services for individuals under age 21 • Personal care services • Transportation services • Case management services • Hospice services • TB services for certain TB infected individuals

As Table 5 suggests, the use of the term optional to describe the services in that category is somewhat misleading. For example, pharmaceuticals and certain rehabilitative services are classified as optional; all states currently cover both to some degree in their Medicaid programs as do the majority of commercial plans. More importantly, under federal law, if optional services are provided to mandatory populations they

must also be provided to optional populations. Thus, the flexibility of the states is, as a practical matter, quite limited when it comes to picking and choosing what services to cover under their state plans.

The information presented in Table 6 is a case in point: Services provided to the state's Medicaid beneficiaries are comparable, with one or two exceptions, to the services available in the Connecticut and Massachusetts Medicaid programs.

Table 6: Comparison of Medicaid Benefits -- 2007
Rhode Island, Massachusetts, Connecticut
(Categorically and Medically Needy)

ACUTE CARE	RI	MA	CT
1. Institutional/Clinical Services			
Freestanding Ambulatory	YES	YES	NO
Public Health/Mental Health Clinic	NO	YES	YES
Federally Qualified Health Center	YES	YES	YES
Inpatient Hospital	YES	YES	YES
Outpatient Hospital	YES	YES	YES
Rehab: Mental Health/Substance Abuse	YES	YES	NO
Rural Health	NO	YES	NO
2. Practitioners			
Certified Nurse Anesthetist	NO	NO	NO
Chiropractor Services	NO	NO	NO
Dental Services	YES	YES	YES
Medical/Remedial Care	YES	YES	YES
Dental Medical/Surgical	YES	YES	YES
Nurse Midwife	YES	YES	YES
Nurse Practitioner	YES	YES	YES
Optometrist	YES	YES	YES
Physician Services	YES	YES	YES
Podiatrist	YES	YES	NO
Psychologist	YES	YES	NO
3. Prescription Drugs			
	YES	YES	YES
4. Physical Therapy Services			
Occupational Therapy	NO	Limited	NO
Physical Therapy	NO	Limited	NO
Speech, Hearing & Language	NO	Limited	NO
5. Products & Devices			
Dentures	YES ^a	YES	YES*
Eyeglasses	1pair/2 years	YES	NO
Hearing Aids	YES	YES	YES
Medical Equipment & Supplies	YES	YES	YES
Prosthetic & Orthotic Devices	YES	YES	YES
6. Transportation Services			
Ambulance	YES	YES	YES
Non-Emergency Medical	YES	YES	YES
7. Other Services			
Diagnostic, Screening, Preventive	YES	YES	YES
EPSDT	YES	YES	YES
Extended Services for Pregnant Women	YES	YES	YES



Table 6: Comparison of Medicaid Benefits continued

ACUTE CARE (other services continued)	RI	MA	CT
Family Planning	YES	YES	YES
Lab - X-Ray Outside a Clinic	YES	YES	YES
Target Case Management	YES	YES	YES
LONG-TERM CARE SERVICES			
1. Community Based			
HCBS Waiver	YES	YES	YES
Home Health	YES	YES	YES
Hospice	YES	YES	YES
Personal Care Services	Waiver only	YES	YES
Private Duty Nursing	NO	YES	YES
PACE	YES	YES	YES
2. Institutionally-Based			
Inpatient Hospital, Nursing Facility,			
ICF/MR >65	YES	YES	YES
Inpatient Psychiatrist <21	YES	YES	YES
ICF/MR	YES	YES	YES
Nursing Facility	YES	YES	YES
Religious Non-Medical Institution	NO	NO	NO

* Limited benefit in both RI and CT - medically necessary to prevent/treat life threatening condition.

Source: Kaiser Family Foundation, Verified with each State's Medicaid Plan.

How Are Services Financed?

The financing of state Medicaid programs was initially modeled on the indemnity health insurance plans that dominated the private market at the time the program was established in the mid-1960s. Under this “fee-for-service” arrangement, Medicaid served as a “payer” of medical claims - i.e., participating providers submitted a bill for each service performed, which, in turn, was then paid by Medicaid. The rates of reimbursement paid to providers for these services when delivered in institutional settings - primarily hospitals and nursing facilities -- were eventually set formally in state law.

Although this approach for financing and paying for Medicaid services was relatively easy to administer, the state was unable to leverage the program’s spending volume to improve service access and quality and promote value. As Medicaid began to expand in the 1990s, Rhode Island policy makers made a conscious decision to take greater advantage of this leverage.

Like many other states across the nation, it was about this time that the Rhode Island Medicaid program started to use its purchasing power to transition from “payer” to “purchaser.” Value-based purchasing involves contracting upfront with an organization that accepts payment for an agreed upon price for a specified service or range of services for Medicaid beneficiaries. As the purchaser, the state sets standards related to quality and outcomes that the contracting entity is obligated to follow and for which it is ultimately held accountable. The state has the capacity to target services at all beneficiaries, a population or even a single coverage group when using this strategy. Moreover, the state can contract with one or multiple entities and purchase one service, a specified range of services, or all Medicaid covered services. And, in contrast to fee-for-service, value-based purchasing provides the state with the flexibility to set performance standards and adjust rates to encourage and reward access, efficiency and high quality outcomes.

Over time, RI Medicaid has been transitioning from an after-the-fact payer of services to a value-based purchaser by increasing access to care management and managed care programs across populations. However, in a significant number of service areas, the state’s ability to pursue this approach is limited by



statutory provisions requiring that payments to providers be made at a set rate and/or by using a particular methodology - e.g., ratio of cost to charges for hospitals. Consequently, the state has chiefly focused on using contractual arrangements similar to those developed to purchase services for children and families in RIte Care managed care to buy services for certain segments of the populations currently receiving Medicaid through fee-for-service.

As is explained later in this report, one of the limitations of this approach is that many vendors are reluctant to assume some of the financial risk associated with providing coverage to the much smaller, fee-for-service populations. Not only do these populations have a significant percentage of beneficiaries with complex health needs, but many also receive services in high cost community-based and institutional settings. States that have successfully leveraged their purchasing power to obtain the high quality services these beneficiaries need and at the best price have pursued a variety of different service delivery approaches and, more importantly, revamped the way they set rates and make payments to providers. Indeed, in New England today, Rhode Island is one of the few states which uses a cost to charges method of reimbursing certain providers²³ and it is the sole state which continues to establish actual payment rates for so many different providers in law.²⁴

Operational Context

Over the years, the administration and financing of Medicaid funded programs in Rhode Island has been parceled out in bits and pieces of various sizes to each of the state's five health and human services departments. As shown in Table 7, one of the consequences of this decentralization is that multiple agencies share responsibility for the health coverage and services provided to the four major Medicaid populations. In turn, each of the health and human services agencies involved work with a network of community-based providers, some of which also overlap. The system that has emerged as a result is difficult for consumers to navigate and understand and vulnerable to criticism from all quarters - beneficiaries, advocates, and state policy makers --decrying the lack of coordination and accountability in the Medicaid program and alleging it is hindered by duplication, waste and inefficiency.

Population	Department of Human Services	Department of Children, Youth & Families	Department of Mental Health, Retardation & Hospitals	Department of Elderly Affairs	Department of Health	Local Education Agencies
Children & Families	RIte Care Health Plans - Basic MA plus FFS for wrap around services; Comprehensive Evaluation, Diagnosis, Assessment Referral & Re-evaluation (CEDARR) Family Services	Certain Behavioral Health Services	Substance Abuse Treatment		State Laboratory	Case Management & School-Related Services; Individualized Education Plans (IEPs) for MA-eligible Special Education Students

23 Maine changed its reimbursement methodology in January of 2007, but used cost to charges prior to that point.

24 See; Merlis, Mark, "Medicaid Reimbursement Policies," (Washington, DC: Congressional Research Services, U.S. Library of Congress) October 2004 and, for an overview of federal guidelines, see: Milligan, Charles J., "Medicaid Reimbursement Policy," (Baltimore, Maryland: University of Maryland - Baltimore County, Center for Health Program Development and Management, September 2006).



Table 7: Rhode Island Medicaid Purchased & Directly Provided Services by Department

Population	Department of Human Services	Department of Children, Youth & Families	Department of Mental Health, Retardation & Hospitals	Department of Elderly Affairs	Department of Health	Local Education Agencies
Children w/ Special Health Care Needs	Basic MA Services Thru Health Plans or Direct Pay to FFS Providers; CEDARR	Residential Placement; Certain Behavioral Health Services	Substance Abuse Treatment		State Laboratory	Case Management & School-related Services; Individualized Education Plans (IEPs) for MA-eligible Special Education Students
Adults w/ disabilities	Basic MA - FFS; Connect Care Choice - PCCM; Rhode Healthy Partners - Managed Care; HCBS Includes Assisted Living		Behavioral Health Services to SPMI's; Substance Abuse Treatment; CBS Service Includes DD/MR Adults; Slater Hospital	Assisted Living; Case Management; Assistive Technologies	Targeted Case Management for People with AIDS; State Laboratory	
Elderly Adults	Basic MA - FFS; Connect Care Choice - PCCM; Rhode Healthy Partners - Managed Care; HCBS Includes Assisted Living		Behavioral Health Services to SPMI's; Substance Abuse Treatment; HCBS Service Includes DD/MR Adults; Slater Hospital	Home Health Services; Case Management; Home Delivered Meals; Assisted Living; Assistive Technology; Minor Home Modifications; Companion Program	State Laboratory	

During the fiscal crisis of the last several years, state officials began to scrutinize more closely the various health care programs funded by Medicaid and the system in which it operates to determine whether, and to what extent, such criticisms are founded. The most comprehensive of these efforts was the review of the organization, financing and delivery of Medicaid services in Rhode Island conducted as part of Governor Carcieri's Fiscal Fitness audit between 2003 and 2004.

In brief, the audit found that Medicaid's programmatic and operational responsibilities had become highly fragmented and prone to inefficiency on the organizational and financing side, and throughout -- from the point in which eligibility was determined through to the delivery of services. As a result, the report stressed that greater interagency coordination and collaboration was required to assure that the Medicaid program would have the capacity to leverage limited resources to meet the changing needs of beneficiaries.

The Executive Office of Health and Human Services

With the findings of the Fiscal Fitness audit in mind, Governor Carcieri issued an Executive Order in March of 2004 establishing an Office of Health and Human Services within the executive branch



of government. The purpose of the office was to manage and facilitate coordination of all programs implemented by the state's five health and human services agencies, including Medicaid.

The Office of Health and Human Services, now a statutory agency renamed the Executive Office of Health and Human Services (EOHHS),²⁵ is headed by a Secretary who has been assigned an array of oversight responsibilities for the Medicaid program. These duties include preparing an annual report of Medicaid expenditures, directing the preparation of agency budgets, reviewing all proposals for Medicaid to assess their financial and administrative viability, and serving as the Governor's chief advisor on all program matters.

Since its inception by Executive Order, the office has directed a variety of independent studies, including this one, along with a number of interagency workgroups and projects that have revealed the extent of the fragmentation and overlap across agencies and the need for greater coordination in Medicaid funded programs. There are several recent EOHHS efforts in this area that are telling and thus worthy of note.

A 2005 study prepared by the office at the Governor's request examined the various different ways the state provides financial support to Medicaid beneficiaries in licensed assisted living residences. The report noted that the current funding scheme for assisted living involved three waivers, each with different eligibility criteria and payment rates, administered by two agencies, each of which shares responsibilities in some areas and acts as an independent agent in others (the DEA and DHS), as well supplemental SSI payments for some, but not other waiver eligible beneficiaries. This fragmentation made it difficult to assess the state's total financial commitment to assisted living and, more importantly, to determine whether Medicaid dollars were being used to purchase the services most needed by beneficiaries living in this setting.

More recently, the EOHHS has been facilitating an interagency workgroup focusing on investments in early childcare and education at the request of the state's Children's Cabinet. A matrix of programs administered by the five health and human services agencies that are targeted at children at risk up to age six shows that there are some 20 programs administered across the five health and human services agencies, several of which provide the same or similar Medicaid funded services to members of a single coverage group. The EOHHS interagency workgroup focusing on these programs is tasked with improving service coordination and management to ensure that limited resources are utilized efficiently, for those children who need services most and in the appropriate setting.

During the last year, the Secretary of EOHHS has been assigned the responsibility of overseeing several interagency projects and initiatives geared toward system change. In this capacity, the Secretary is leading interagency initiatives to redesign the system for providing children's behavioral services and for transforming the state's long-term delivery system (Perry-Sullivan/Real Choices Long-term Care Reform). Both of these projects involve all five of the health and human services agencies to some degree and are discussed in greater detail further on in this report.

Last, but of no less importance, the EOHHS is also leading a statewide effort to introduce the principles of best value purchasing into the procurement of health and human services more generally. The goal of this initiative, known as Buy RIte, is to ensure that every health and human services dollar spent achieves the best possible result.

Toward this end, the Secretary has established a Buy RIte Health and Human Services Purchasing Cooperative, composed of representatives of the five departments. The cooperative is responsible for establishing and implementing service procurements standards across agencies, reviewing current and proposed purchase agreements/contracts in accordance with these standards, and ensuring such agreements/contracts are fiscally sound and consistent with state budget and policy priorities.

²⁵ R.I.G.L. §42-7.2, was enacted in July 2006 as part of the SFY 2007 state budget.



Part II: Evaluation and Analysis





SECTION I: MEDICAID'S IMPACT AND PERFORMANCE

As the descriptive summary in Part I indicates, the Rhode Island Medicaid program is both multi-faceted and complex. Today, the program is not only an influential player in the state's health care system and an important economic force, but also an integral part of the social fabric of the communities it serves.

For example, analysis of the available data indicates that Medicaid now supports directly approximately 21,000 health care and related service jobs; this figure translates into nearly 28 percent of the total number of jobs in the Rhode Island health care industry. The associated wages total about \$604 million. Note, these figures do not include positions in state government that are funded in whole or in part with Medicaid dollars.

Medicaid's impact on the state's population is equally far-reaching. For example, at some point in SFY 2006:

- Twenty-three (23) percent of the state's population -- or nearly one in four Rhode Islanders -- received health care services paid for by Medicaid;
- Fifteen (15) percent of the state's elders were provided long-term care services through Medicaid; and
- Forty (40) percent of all Rhode Island school age children obtained health care services through RIte Care or RIte Share managed care.

Additionally, the patients and dollars flowing through the Medicaid program to health care providers play a significant role in shaping the amount and types of services available in several facets of the state's health care system. Specifically, analysis of the data available for SFY 2006 shows:

- Seventy-seven (77) percent of the money spent on home and personal health care services was paid for by Medicaid;
- Thirty-two (32) percent of all hospital admissions for mental health or substance abuse-related issues were funded at least in part by Medicaid;
- Forty (40) percent of the newborn and neonatal related hospital admissions were paid for by Medicaid; and
- Sixty-seven (67) percent of all nursing home stays were paid for at least in part by Medicaid.

These snapshots of the Medicaid program, although revealing, only hint at its full impact. The purpose of this section is to provide a more in-depth assessment of that impact using a variety of performance measures that look at Medicaid from different vantage points.

Program Reviews

There is an extensive body of literature that reviews the performance of state Medicaid programs relative to one another on a variety of levels. Due to federal guidelines requiring that states assess patients in certain waiver programs, beneficiaries are increasingly being asked to provide their own performance reviews. Though both external and beneficiary reviews each have limitations, the measures of program performance they provide are nevertheless instructive.

The View from Outside

In a recent evaluation of state Medicaid programs published by the consumer advocacy group Public Citizen, Rhode Island received high praise for the scope and amount of coverage its program provides, but harsh criticism for the low reimbursement rates paid to providers. Such mixed reviews of the state's Medicaid program are not uncommon. As Table 8 (page 26) shows, the state has frequently received



high ratings, recognition and awards for the Medicaid program’s performance - the high quality services it provides and healthy outcomes it has achieved -- particularly with respect to RItE Care. Yet, the Rhode Island Medicaid program has also been judged more negatively because of its high costs, fragmented operations, and penetration into certain areas of the commercial health insurance market.

Table 8: Summary and Focus of Select External Reviews of the RI Medicaid Program		
Positive	Mixed	Negative
Commonwealth Fund - Overall access and quality in programs for children and families	Public Citizen - Top five states for quality and access, bottom five states for reimbursement rates	Heritage Foundation - High cost, substitution of private insurance
Kaiser Foundation - RItE Care Managed Care	RIPEC - Service excellence, too costly	Disability Law Center - Services not provided in least restrictive setting
NCQA - Quality of RItE Care Plans	National Center on Mental Health Advocacy - Service excellence, but insufficient availability and access, particular of substance abuse services	
National Health Care Purchasing Association - value-based purchasing in RItE Care	AARP - Commitment to long-term care system reform, but slow to carry through	
Center for Health Care Strategies - Quality, access and value in RItE Care		

Other external reviews of the Medicaid program’s performance utilize quality measures targeted at certain levels of care and/or setting in which it is provided. One area that has been reviewed exhaustively is nursing home facilities.

As Table 9 indicates, Rhode Island rates well on the key process and health status measures developed by Medicare for the nursing home industry. Moreover, with few exceptions, Rhode Island nursing homes perform better on most indicators than the national average.



Table 9: Nursing Home Quality Measures

	Average in RI	National Average
Percent of long-stay residents given Influenza vaccination during the Flu Season	89%	87%
Percent of long-stay residents who were assessed and given Pneumococcal vaccination	86%	75%
Percent of long-stay residents whose need for help with daily activities has increased	14%	16%
Percent of long-stay residents who have moderate to severe pain	3%	5%
Percent of high-risk long-stay residents who have pressure sores	14%	12%
Percent of low-risk long-stay residents who have pressure sores	3%	2%
Percent of long-stay residents who were physically restrained	3%	6%
Percent of long-stay residents who are more depressed or anxious	11%	14%
Percent of low-risk long-stay residents who lose control of their bowels or bladder	44%	48%
Percent of long-stay residents who have/had a catheter inserted and left in their bladder	4%	8%
Percent of long-stay residents who spend most of their time in bed or in a chair	2%	4%
Percent of long-stay residents whose ability to move about in and around their room got worse	12%	12%
Percent of long-stay residents with a urinary tract infection	11%	9%
Percent of long-stay residents who lose too much weight	7%	8%
Percent of short-stay residents given Influenza vaccination during the flu season	80%	73%
Percent of short-stay residents who were assessed and given Pneumococcal vaccination	75%	66%
Percent of short-stay residents with delirium	2%	2%
Percent of short-stay residents who had moderate to severe pain	18%	22%
Percent of short-stay residents with pressure sores	18%	17%

The health plans participating in RItE Care have also received high marks for quality by the national accrediting agency - National Committee for Quality Assurance (NCQA). In short, those external reviews of service quality have generally been more positive than those evaluating the organization and financing of the Rhode Island Medicaid program.

Beneficiary Satisfaction

At present, there are no Medicaid-wide measures of beneficiary satisfaction and/or program quality. By its very nature, the program does not lend itself easily to performance measures of this kind across populations. However, there have been population and program specific reports focusing on beneficiary satisfaction in certain waiver programs, including RItE Care. A summary of several key indicators found in these reports is provided below.²⁶ (The appendix contains a complete listing of research reports and satisfaction studies.)

There are some indicators within population groups that suggest relatively high degree of satisfaction with the elements of the program. For example, the satisfaction and high quality of the state's RItE Care program is well documented.

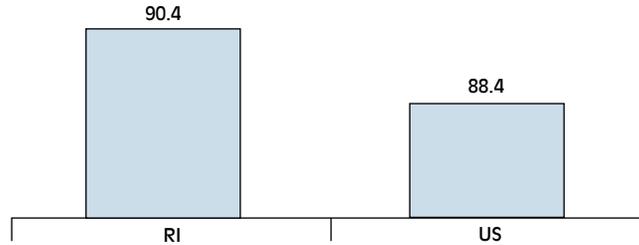
In the NCI study respondents in Rhode Island reported satisfaction with the Medicaid funded community based residences where they live.²⁷ This was a higher rate of satisfaction than the average of all respondents participating in the survey nationwide.

²⁶ Reports referenced here include: NCQA/HEDIS Measures, 2006; NMHS Indicators, 2005; Children with Special Health Care Needs Survey, 2001; MRDD NCI Outcomes, 2004

²⁷ Ibid. NCI.

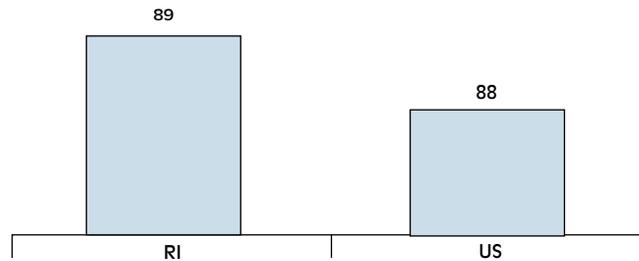


Figure 4
Percentage of Developmentally Disabled/Mentally Retarded Satisfied with Where They Live



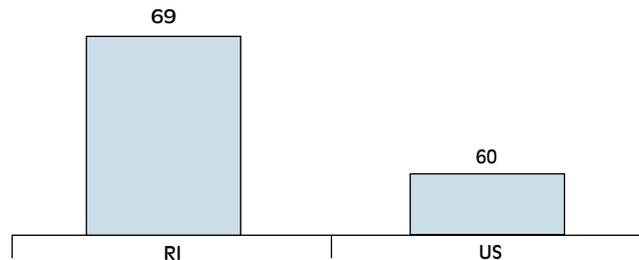
Similarly, patients in Rhode Island’s community mental health system also report higher levels of satisfaction than was reported nationwide. Note that this includes all individuals in the system, but is nevertheless telling as nearly 70 percent are Medicaid.

Figure 5
Positive General Satisfaction with Mental Health Services



In a national survey focusing on the CSHCN population conducted in 2001, Medicaid again scored well. Rhode Islanders with special needs children were substantially more satisfied with Medicaid coverage and services than parents living in other states.

Figure 6
Very Satisfied with Health Care Services CSHCN

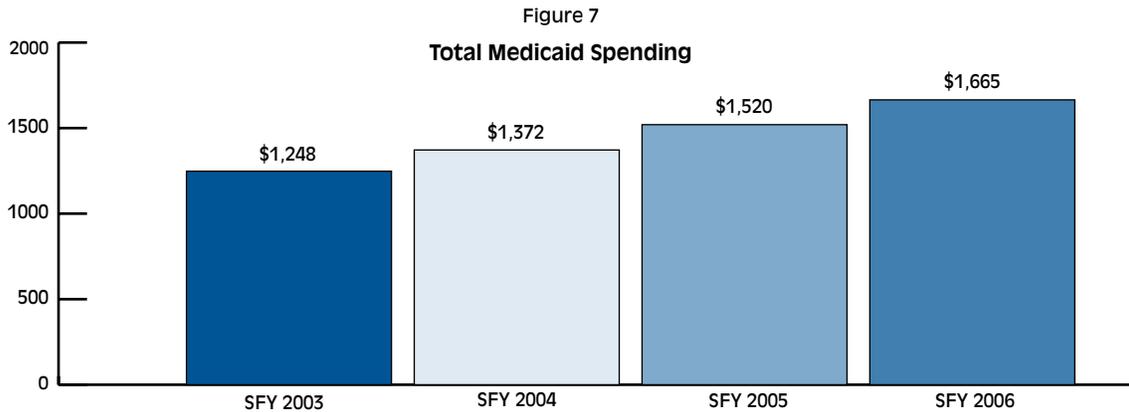


In sum, Medicaid beneficiaries in Rhode Island are comparatively more satisfied with the aspects of the program they have reviewed than their counterparts in other states. Note that satisfaction levels such as these are suggestive rather than conclusive indicators of program performance unless coupled with corollary data measuring beneficiary expectations and real health outcomes. Data related to both of these factors was not readily available when this analysis was prepared. Thus, the satisfaction measures presented here are best interpreted as “prima facie” evidence that beneficiaries have positive views of Medicaid rather than as the basis for programmatic or operational decisions.

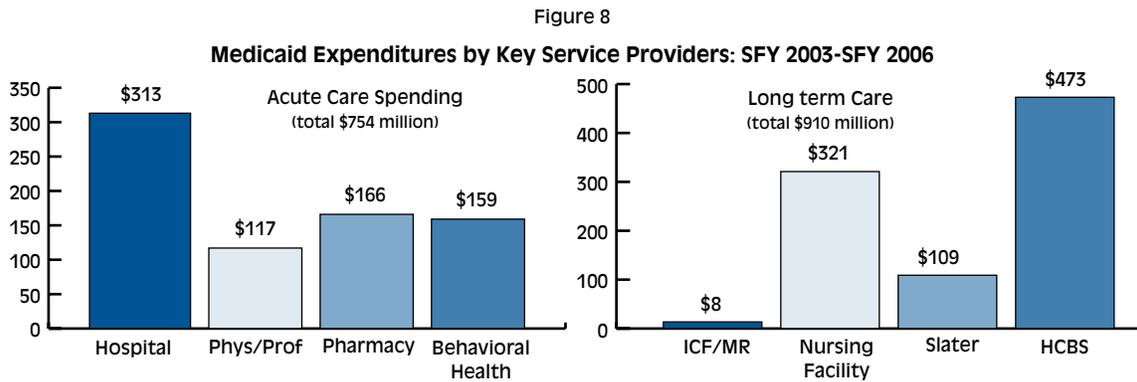


Total Medicaid Spending

Rhode Islanders continue to make a significant investment in the Medicaid program. In SFY 2006, total Medicaid expenditures were approximately \$1.7 billion. Over the last three years, Medicaid has grown 33 percent (Figure 7). In comparison, state employee health benefit costs have grown from \$131.4 million to approximately \$179.5 million or by 37 percent over the same period.²⁸



Where Medicaid dollars are flowing shows the areas in which the program's impact is the greatest. In general, Medicaid expenditures are spread across a range of service providers in acute care and long-term care. Figure 8 indicates the division of dollars between key service providers from SFY 2003 through SFY 2006. Note that nearly 55 percent of Medicaid spending is for providers that deliver long-term care services to beneficiaries.



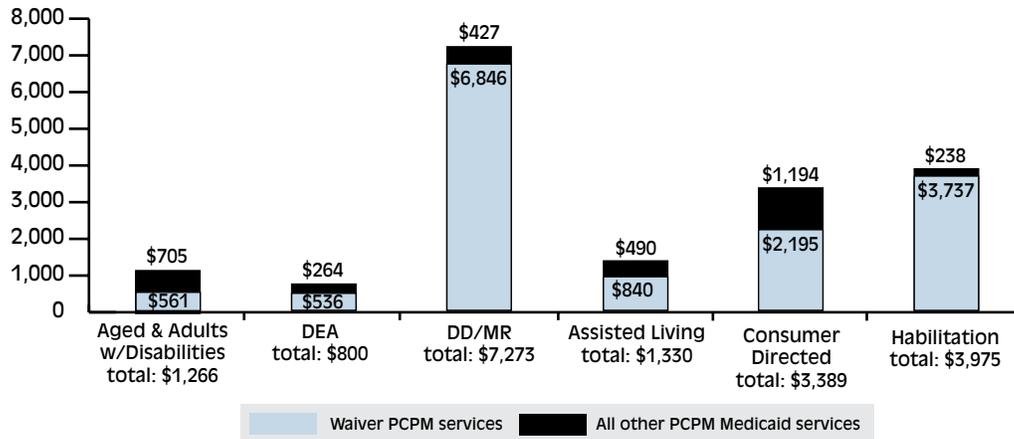
There are significant distinctions in the distribution of Medicaid dollars within these categories, particularly on the long-term care side. Figure 9 (page 30) highlights, for example, the great variation in the flow of Medicaid funds across HCBS waiver programs. The costs for the DD/MR waiver, which served 3,200 beneficiaries in SFY 2006, far exceeds spending on all of the state's other Home and Community Based Services waivers combined.

²⁸ Includes an estimate of the employee cost sharing of \$6.8 million for FY 2006. State Personnel Supplement FY 2007 Page I-9.



Figure 9

**HCBS waiver – Per Client Per Month Expenditures
FY 2006**



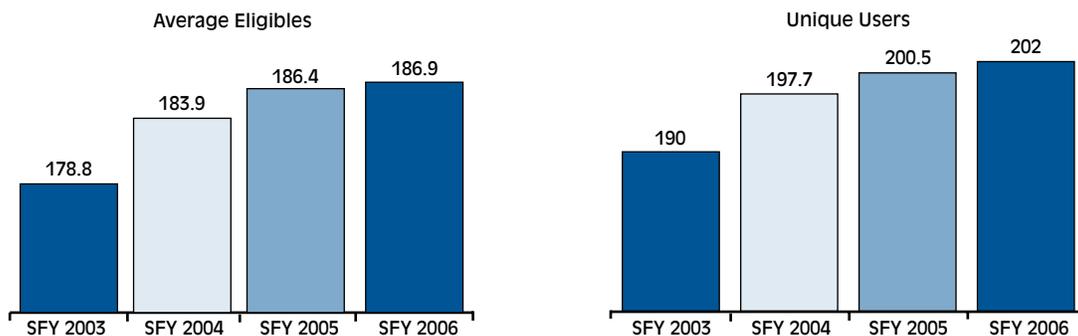
Enrollment Trends

Enrollment has also grown over the period from SFY 2003 to SFY 2006. However, the rate of growth varies depending on the method used for measuring enrollment trends. Average eligible growth measures the change in enrollees in “full year equivalents” - i.e., total number of beneficiary months divided by 12. By this measure, average eligibility growth increased by four percent during this period or a growth rate slightly higher than one percent per year.

The second measure of enrollment focuses on unique users or the total number of beneficiaries enrolled in Medicaid regardless of length of time in program. Using this alternative measure, the number of beneficiaries classified as unique users grew by approximately seven percent during SFY 2003 - SFY 2006 period or by nearly two percent per year on average, as indicated in Figure 10.

Figure 10

**Medicaid Enrollment Trends: Average Eligible v. Unique Users
SFY 2003-SFY 2006**



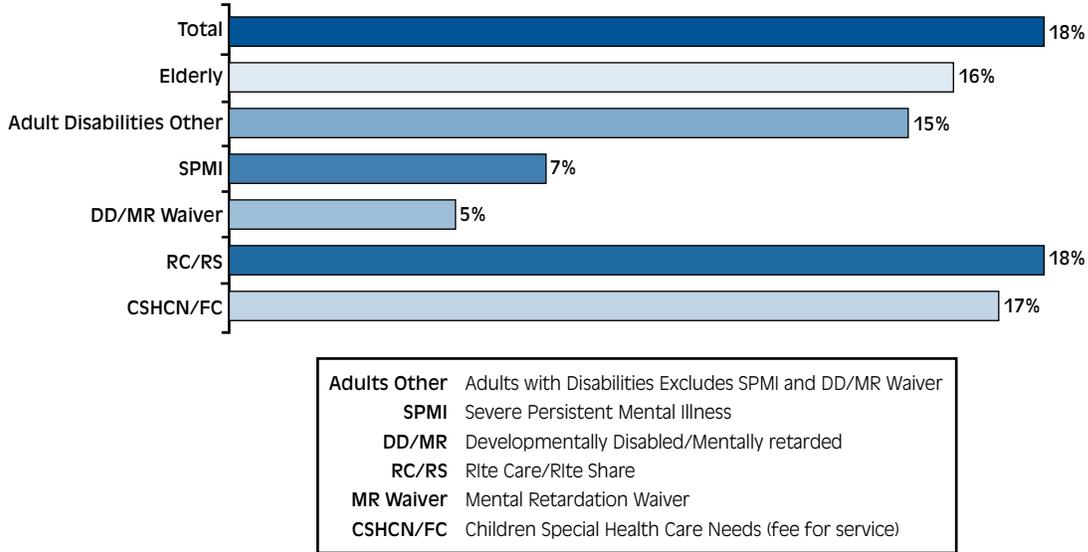
Irrespective of the method used to gauge enrollment trends over time, the growth in expenditures between SFY 2003 and SFY 2006 has clearly outpaced the increase in the number of Medicaid beneficiaries by as much as a factor of six.

When examining the impact of enrollment trends, member attrition is an important factor that must be considered and for two reasons. First, if attrition rates slow, overall enrollment would increase as would associated costs. Second, and most importantly, attrition affects the state’s ability to ensure continuity of care and proper care management, particularly for beneficiaries suffering from chronic diseases.



Figure 11

Estimated Attrition in Medicaid Population



The difference between average number of Medicaid eligible individuals and unique users provides insights into the role of attrition in the Medicaid program. Figure 11 shows the estimated attrition rates across populations. Because enrollment growth is essentially flat, the rate of attrition implies that in SFY 2006, thirty-six percent of the Medicaid beneficiaries who were unique users were “new.”²⁹ The specific reasons for this level of attrition are not known, but it is likely a multi-faceted problem resulting from changes in eligibility status, documentation issues, relocation, or death.

²⁹ Note that some of this attrition may actually be “churn” of beneficiaries who are disenrolled or leave the program and return.



SECTION II. MEDICAID COST DRIVERS

The assessment of the RI Medicaid program in the previous section indicates that, although performing well overall, total spending is of paramount concern. Moreover, how Medicaid dollars are being spent - by population or coverage group, types of services, and settings - appears to have a greater impact on program expenditures than enrollment. The purpose of this section of the report is to examine these spending trends to identify the factors contributing to the rise in Medicaid expenditures and to analyze the way they are shaping the options for the future.

Factors Influencing Costs

There are multiple factors influencing the rise in state Medicaid program expenditures, including enrollment trends, case/disease mix, utilization rates, provider setting and reimbursement levels. In short, as one observer stated the point, Medicaid costs are driven by: “who receives care, what care they receive, who provides it, what the provider is paid and the basis for payment.”³⁰

Complicating matters further, Medicaid program costs are also tied to the state’s level of Federal Medical Assistance Percentage (FMAP). As explained earlier, FMAP is the percentage of the Medicaid program reimbursed by the federal government; under federal policy guidelines, every state must receive at least a 50 percent reimbursement via the FMAP.

Federal Medical Assistance Percentage -- FMAP

FMAP is by far the least complicated of the factors driving Medicaid costs, even though its impact on costs is far reaching. For example, in Rhode Island each one percent decrease in FMAP translates into an increase to the state general fund of approximately \$15 million. Accordingly, a one percent drop in FMAP can have a significant impact on state finances.

As shown in Table 10, Rhode Island had the second largest decrease in FMAP in the nation from 2004 to 2007. The overall impact on the state as a result of this drop was a decrease in federal funds of \$92 million over a three-year period.

State	FFY 2004-2007	FFY 2005-2007
Wyoming	-17.7%	-8.6%
Rhode Island	-11.2%	-5.5%
South Dakota	-8.3%	-4.7%
North Dakota	-9.2%	-4.1%
Montana	-9.0%	-3.9%
Nevada	-6.8%	-3.5%
New Mexico	-7.5%	-3.2%
Oklahoma	-7.3%	-2.9%
Nebraska	-7.8%	-2.9%
Alabama	-6.6%	-2.8%

Quantifying the Contribution of Various Other Cost Drivers

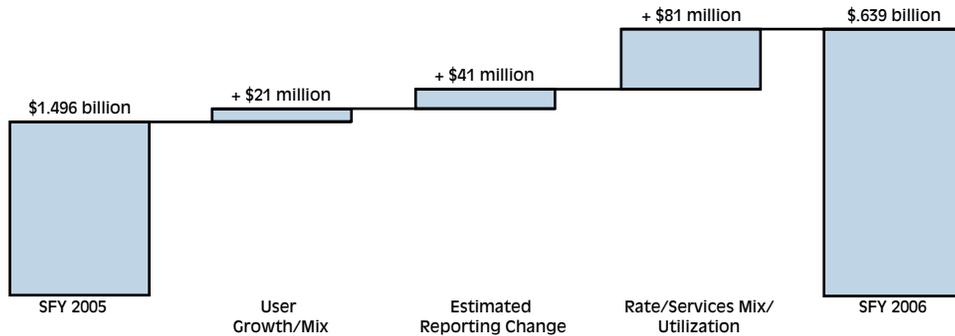
A cost driver analysis was created to assist in assessing the contribution of each of several other factors to overall increases in Medicaid expenditures between SFY 2005 and 2006. Figure 12 (Page 34) shows the results of this analysis.

About \$21 million of the increase between these years was due to enrollment growth and the user case

30 “Medicaid Spending Growth and Options for Controlling Costs,” Statement of Donald B. Marron, Acting Director of the U.S. Congressional Budget Office (CBO), before the Special Committee on Aging, United States Senate, July 13, 2006, (Washington, DC:CBO) p.13.

mix. An estimated \$81 million of the rise in cost was related to reimbursements, service mix and utilization rates. The balance of the increase in overall program expenditures resulted from technical changes -- i.e., certain MHRH program expenditures that had been tracked off-line were shifted to the state's Medicaid Management Information System (MMIS). The factors that influence costs in this area of Medicaid expenditures -- the \$41 million of MHRH costs that were "off-line" -- is unclear at this time.

Figure 12
Relative Impact of Various Medicaid Cost Drivers: SFY 2005-2006



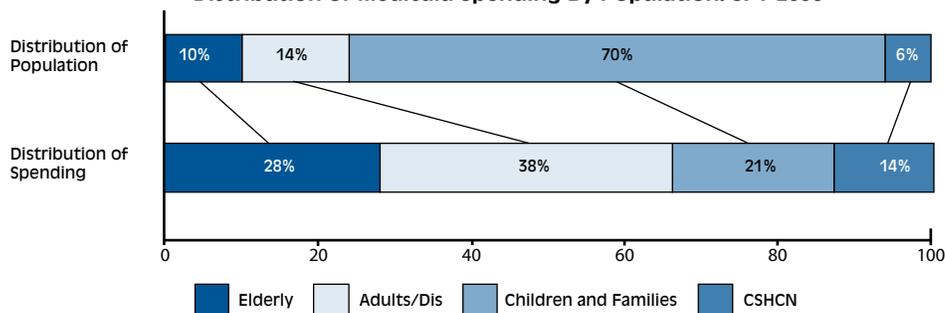
Note that the numbers in Figure 12 are estimates. Data limitations do not permit a detailed analysis of changes in provider settings, utilization levels, or intensity of services.

Case Mix

From the outset, Medicaid was designed to serve individuals and families who otherwise cannot afford and/or obtain the health coverage or services they need. The Medicaid program's enrollee or case mix has largely been dictated by this mandate and a corollary set of federal and state laws and regulations that serve similar purposes. The state's ability to influence the enrollee mix within this framework is limited for two reasons: (1) Medicaid is an entitlement program and, as such, the state has only marginal control over how many individuals are enrolled; and (2) Title XIX provisions requiring coverage of certain individuals greatly restricts the state's discretion to determine who is covered.

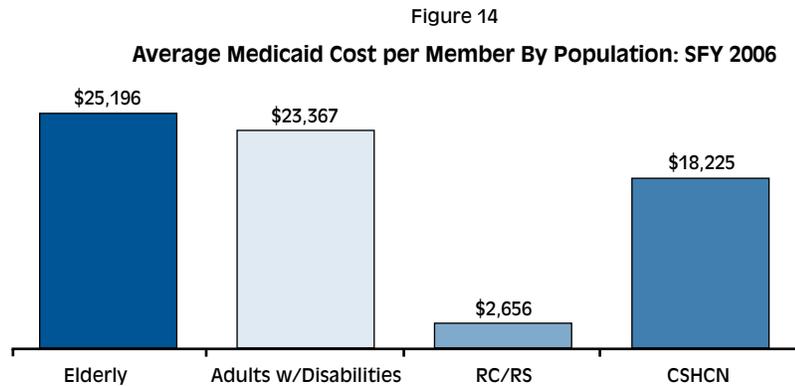
The mandatory coverage groups that all state Medicaid programs must serve under Title XIX are composed of individuals with very low incomes and few resources who are uninsured or underinsured or, due to age and/or disability, who are in frail health and require long-term care, intensive services and multiple supports that are unavailable or unaffordable by other means. By virtue of these characteristics, Medicaid beneficiaries in mandatory coverage groups tend to be high-need, high-cost service utilizers. As is explained elsewhere in this report, by contrast, beneficiaries in the optional coverage groups are primarily children and families - e.g., RIt Care enrollees - who have less complex service needs and are less costly to cover. Thus, Medicaid spending is not evenly distributed across the various eligible populations. For example, as shown in Figure 13, approximately thirty (30) percent of the Medicaid population was responsible for seventy nine (79) percent of total spending in SFY 2006.

Figure 13
Distribution of Medicaid Spending By Population: SFY 2006





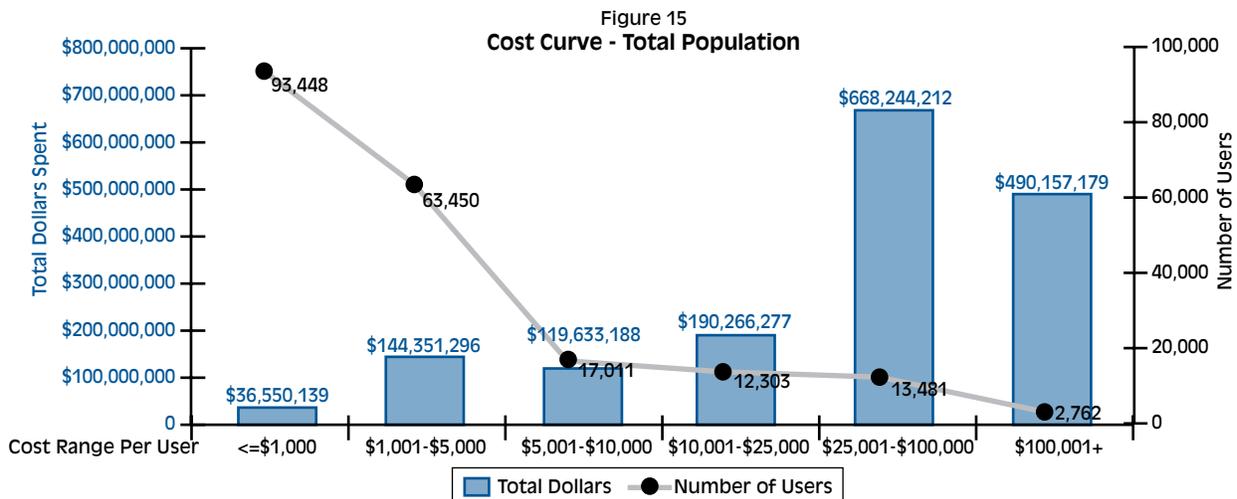
Accordingly, per member average costs also vary significantly across populations. Figure 14 shows the range in average costs by population category.



Average expenditures for some Medicaid populations are higher than others by as much as a factor of ten -- e.g., children and families in RIte Care v. the elderly. The service needs of beneficiaries in each of these groups clearly influence costs. It is no surprise, thus, that the average Medicaid cost per member is higher for children with special health care needs, adults with disabilities and elders - populations predominately made-up of mandatory coverage beneficiaries who have complex health needs - than for RIte Care enrollees - a population with a large number of relatively healthy optional beneficiaries.

These averages mask significant variations among Medicaid beneficiaries within each of the four major populations. The cost distribution curve below was created to examine costs across populations by spending levels beyond the averages presented in the Figure 14. The results of this analysis are presented in Figure 15. Note all figures are based on the average cost per user during SFY 2006.

As the distribution curve demonstrates, one percent of the state's Medicaid population is responsible for 31 percent of total Medicaid spending; moreover, approximately eight percent of the population is responsible for over seventy 70 percent of all Medicaid expenditures.

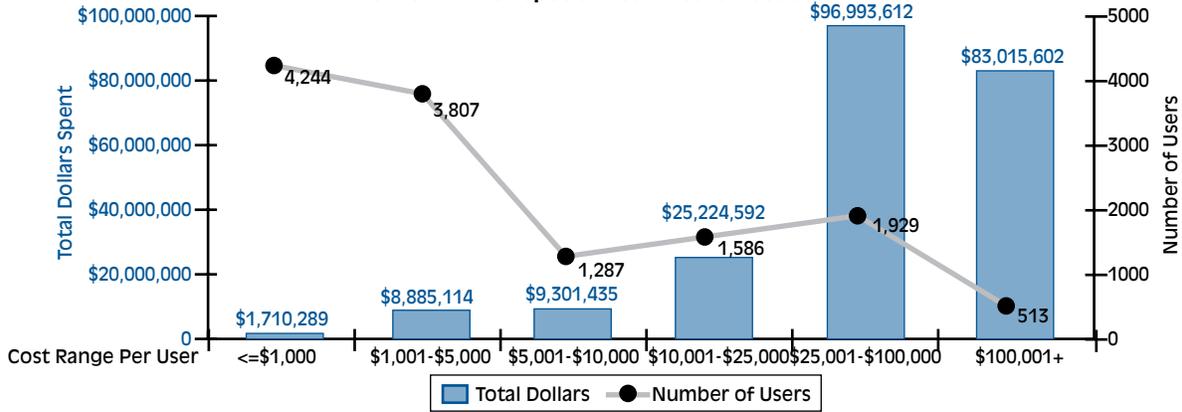


At the low end of the distribution curve, the medical costs averaged \$391 for about 93,000 Medicaid beneficiaries in SFY 2006. By contrast, on the other end of the cost continuum, the state spent an average of \$177,000 for each of just over 2,700 beneficiaries.

The cost curves for each population are equally revealing. For example, Figure 16 (page 36) shows that, though there are a significant percentage of high cost beneficiaries in the CSHCN population (about 2,500 cases), expenditures for the majority - 4,244 - fall at the other end of the distribution curve.

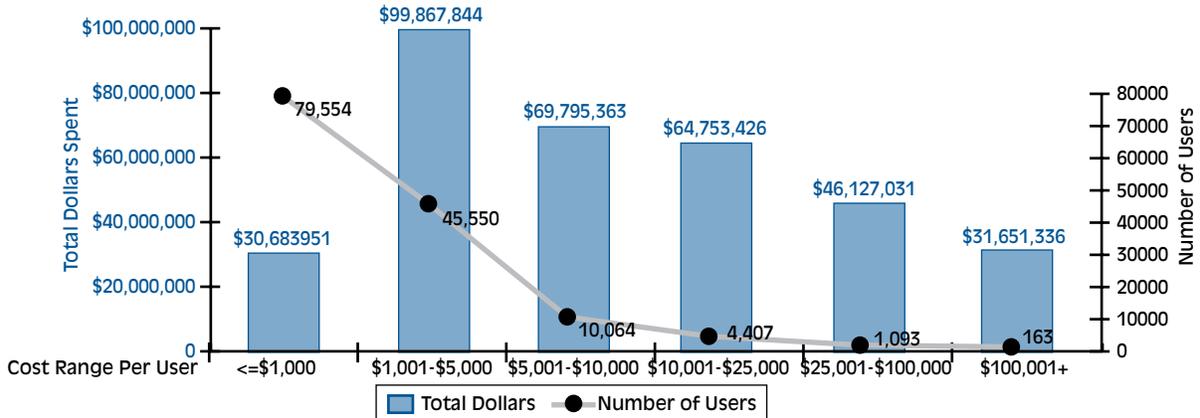


Figure 16
Figure - Cost Distribution
Children with Special Health Care Needs



As indicated in Figure 17, the trends in cost per user in the CSHCN population are even more pronounced for children and families in Rite Care. Indeed, based on this analysis, the majority of beneficiaries in this population - nearly 80,000 persons in total -- actually cost the state substantially less than \$1,000 per year -- \$391.

Figure 17
Cost Distribution - RITE CARE/RITE SHARE

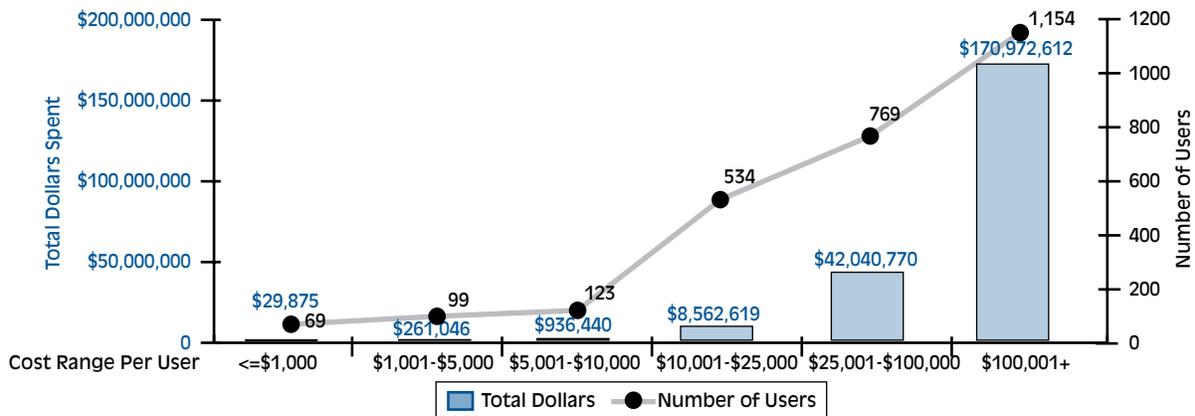


The children and families population is not only the largest, but has by far the lowest cost per beneficiary in Medicaid. The sheer size of the population has a significant impact on expenditures, however.

The cost per user pattern shifts when looking at beneficiaries in the Developmental Disabilities/Mental Retardation (DD/MR) waiver, a coverage group within the adults with disabilities population. As Figure 18 (page 37) makes clear, the overwhelming majority of users served by the waiver fall at the high end of the cost distribution curve.



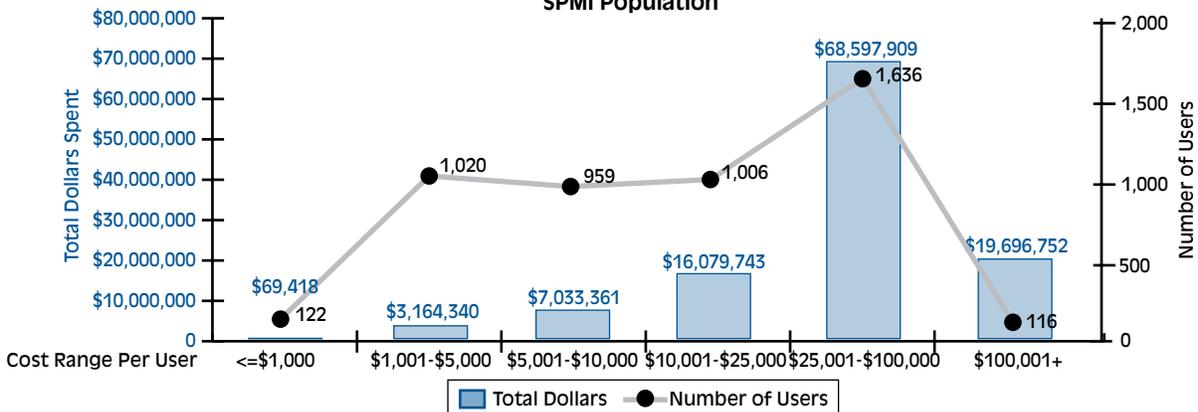
Figure 18
Cost Distribution
DD/MR Waiver



Given the complex health care needs of beneficiaries in the waiver, a significant number of high cost users is to be expected. In fact, all beneficiaries in the DD/MR waiver receive long-term supports for the activities of daily living and over half reside in full 24-hour supportive residences. The actual dollar amounts expended per user per year on the high end of the cost distribution curve substantially exceed that for other Medicaid populations and coverage groups, with the exception of the elderly.

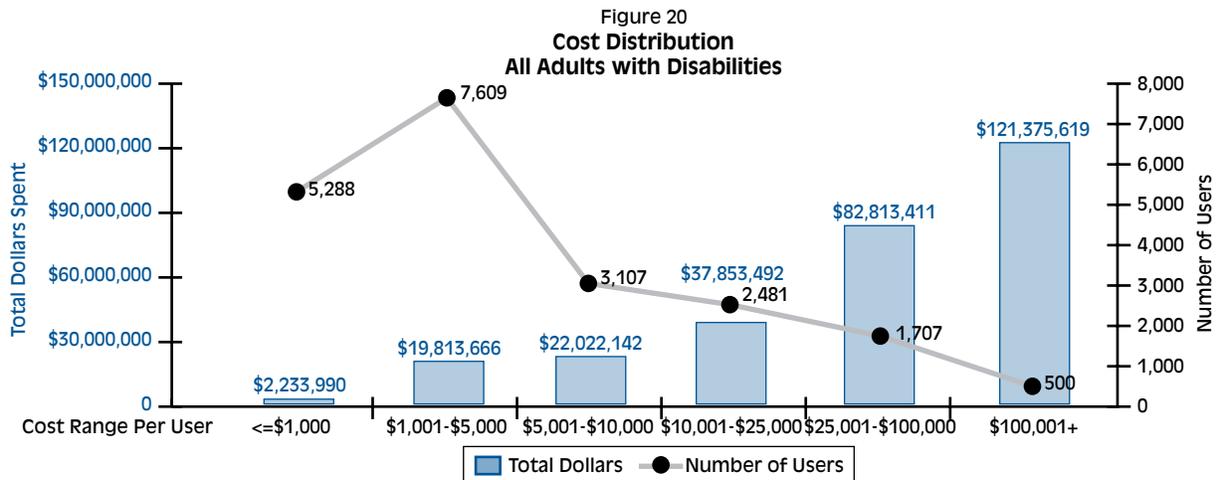
Figure 19 presents the cost per user distribution curve for another coverage group within the adults with disabilities populations - persons with severe and persistent mental illnesses (SPMI).

Figure 19
Cost Distribution
SPMI Population

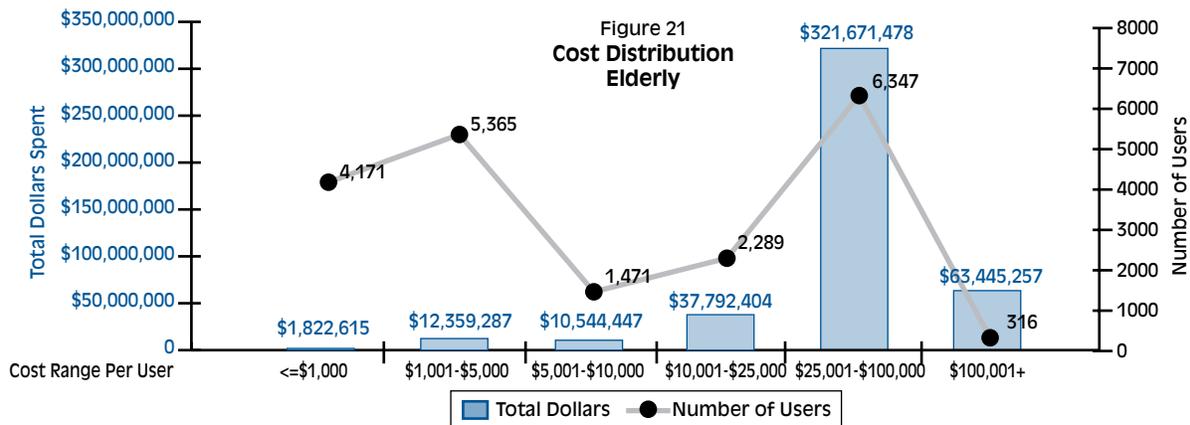


Cost per user in this coverage group fluctuates more widely than in other populations, as there are a significant number of beneficiaries in the middle range, and a small number at both ends of the cost distribution curve.

In contrast to these two coverage groups (SPMI and DD/MR waiver beneficiaries), the cost per user for the adults with disabilities population as a whole shows a pattern similar to the one noted for children and families. Figure 20 (page 38) shows that the cost per unique user in this population overall is on the low to middle end of the distribution curve.



The adults with disabilities and elderly Medicaid populations are often considered to be similar in both service needs and costs. The data presented in Figure 21 indicates that there are significant distinctions between the two, at least from the perspective of cost per user. The large number of elders on the high cost side of the distribution curve is in large part due to nursing home expenditures. If the data were adjusted to control these costs, the distribution curve for the two populations would be more similar - that is, there would be a larger number of users on the low end of the cost curve.



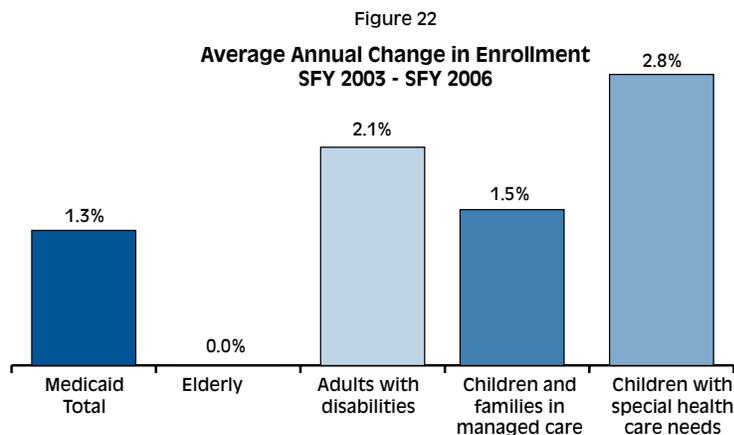
There are a number of factors that have contributed to disparities in the distribution of costs across populations. As noted earlier, in some instances, it is the illness/acuity of beneficiaries, the types of services provided, and/or the settings in which care is delivered. Of critical importance is that recent efforts by the state to improve services to the adult populations “carved out” many of the high cost beneficiaries and focused instead on managing the care of users at the middle and lower ends of the cost distribution curve. This includes the soon to be implemented health plans for both elders and adults with disabilities. Yet, as these distribution curves reveal, *care management is necessary for all beneficiaries and, in particular, for those who are high cost users, to ensure that the right services are being provided in the most appropriate setting.*

Enrollment Rates

In recent years, total Medicaid spending has grown nearly six times faster than enrollment in the program. This indicates that overall change in the number of beneficiaries enrolled in the program is not one of the principal drivers of Medicaid cost increases. However, as the case mix analysis above suggests, who is enrolled may be a significant factor driving expenditures.

Figure 22 (page 39) shows the growth rates among key population groups. Two high-cost populations

-- CSHCNs³¹ and Adults with Disabilities -- grew in number at a substantially higher rate than the overall Medicaid population during the period examined, from SFY 2003 through SFY 2006.



Although increases in enrollment have not significantly driven costs during the last three years, there have been instances in the past when an increase in the number of beneficiaries had a direct impact on growth in expenditures.

Specifically, RItE Care's enrollment grew sharply from SFY 1998 through 2001, before eventually leveling off once again around 2002. In the two-year period after the expansion to parents in 1998, RItE Care enrollment increased by 41 percent - from 74,000 in November of that year to 104,000 in June of 2000. The cost to the state for the enrollment growth in SFY 2001 alone was an estimated \$50 million dollars.

A variety of factors contributed to this spike in enrollment including, but not limited to:

- Expansion of eligibility to parents and relative caretakers of RItE Care enrolled children up to 185 percent of the FPL;
- Introduction of a mail-in application and reform of the determination process to eliminate administrative barriers to eligibility;
- Implementation of an ambitious, federally financed community out-reach program to enroll uninsured children and their parents;
- Instability in the commercial health insurance market as a result of a decline in employer-sponsored coverage, two major insurers leaving the state, and an unprecedented increase in premiums; and
- Low-income families substituting RItE Care for employer sponsored insurance due to increases in premiums and co-pays, benefit reductions and declines in employer contributions.

Irrespective of the cause(s), the consequences of this growth in RItE Care proved to be far-reaching, especially relative to the state budget. Concern that enrollment trends would continue culminated in the adoption of a series of initiatives designed to stabilize the RItE Care program. These initiatives, which were established in the Health Reform 2000 Act, included the implementation of a monthly premium for families with income above 150 percent of the FPL and the RItE Share premium assistance program for beneficiaries with access to employer-sponsored insurance that meets certain cost and benefit criteria.

In the years since the state took these actions, there have been several other changes instituted in the Medicaid program that have altered eligibility requirements and/or services in ways that are likely to stabilize or curb enrollment growth further for some or all populations. Among the most notable of these changes are:

- Institution of a \$10,000 asset test for children and families in RItE Care;
- Verification of U.S. citizenship as condition of eligibility for all Medicaid recipients - mandated by the federal government in the U.S. Deficit Reduction Act of 2005;

³¹ Enrollment increases in the CSHCN population may be at least partially due to changes in the way they are counted as they have been transitioned from fee-for-services to managed care or from the jurisdiction of one department to another.



- Implementation of the Medicare Part D prescription drug benefit for adults with disabilities and elders;³² and
- Adoption of more restrictive requirements related to the transfer of assets by applicants for long-term care coverage.

Beneficiary Acuity and Co-Morbidity

The data above indicate clearly that the number of Medicaid beneficiaries has not been a significant cost driver in recent years, but that case mix - or what types of beneficiaries are enrolled - does appear to have an impact on program expenditures. To determine the extent to which the health conditions and service needs of beneficiaries influence the distribution of costs within and across populations, an effort was made to gather and analyze acuity and co-morbidity data.

One of the consequences of the decentralization and fragmentation of programmatic responsibilities across the five health and human service departments is that there is no standardized method for aggregating and analyzing this type of data system wide. Medicaid Management Information System (MMIS) claims data does provide information in certain diagnostic categories, but the focus is on the services rendered rather than on the condition of the beneficiary who utilized them in most cases.

Although each of the departments administering Medicaid programs has, at some point or another, examined beneficiary acuity and co-morbidity, gaining access to consistently valid and reliable data for the purposes of this study proved to be a challenge; in some instances, the data was maintained in a format that made it difficult to manipulate and analyze; often the information available was dated or unreliable; and in still other instances, the data focused narrowly on a small segment of a population or a particular coverage group. The fact that several of the departments administer different programs that serve the same beneficiaries within and across populations complicated matters further; data on the same group of beneficiaries, provided by different agencies, was sometimes inconsistent and not always comparable.

As a consequence, the data presented in this section of the report is derived from multiple sources and is somewhat uneven. For example, there is more information about beneficiaries in certain populations than about those in others and much of the data analyzed is from secondary sources or inferred from MMIS claims history.

Children and Families in Managed Care

As the cost distribution curves (Figures 15-21) demonstrated earlier, more than 50 percent of the RItE Care population utilizes services costing less than \$400 per year. For the remainder of this population, Table 11 suggests that births and related issues (maternity / newborn) rather than typical disease states are the largest driver of medical expenses. However, the state has implemented a series of initiatives in RItE Care to manage disease states such as asthma typically found in the pediatric population.

Type of Admission	CY 2002	CY 2003	CY 2004	CY 2005
Medical/Surgical	31.5%	30.0%	31.1%	30.5%
Maternity	31.2%	28.9%	29.4%	31.4%
Newborn	25.7%	28.5%	27.9%	26.8%
Psychiatric	6.3%	6.5%	6.7%	6.8%
Neonatal Intensive Care Unit	2.9%	2.8%	2.6%	2.8%
Substance Abuse	2.4%	2.2%	2.3%	1.7%

Children with Special Health Care Needs

Much of the available data on the acuity levels of the CSHCN populations is located in reports targeting children with special health care needs in residential placements and/or who are participating the

³² Prior to implementation of Medicare Part D, some beneficiaries in these populations with income up to the poverty level enrolled in Medicaid because they did not have access to or could not afford any other type of prescription drug coverage.



Children’s Intensive Services (CIS) program.³³ These reports indicate that a significant number of children in the CSHCN population have behavioral and emotional conditions requiring mental health services. In SFY 2005, for example, 89 percent of the children receiving DCYF residential services fell into this category as did 56 percent of the children residing in shelters. Of those participating in the CIS, the percent with moderate to severe behavioral diagnosis requiring mental health services was about 65 percent.

A national study³⁴ conducted on children in substitute care found that they were more likely than other Medicaid eligible children to have a behavioral health or substance abuse condition in combination with a physical condition. They also had a higher likelihood of co-morbidities than adoption assistance children, but were less likely than Supplemental Security Income (SSI) children to have multiple diagnoses. The comparative data in the study reported that Medicaid eligible children in substitute care in the CSHCN population in Rhode Island were more likely to have behavioral health than substance abuse conditions, but otherwise showed the same incidence of co-morbidities as similarly situated children nation wide between 1998 and 2001.

The available data focusing on SSI children in the CSHCN population in the state and nationwide indicated that, in SFY 2006, the total percentage of beneficiaries under age 17 in this category in Rhode Island was 13 percent; the national average was 14 percent.³⁵ The National Survey of SSI Children Families (NSCF) conducted by the U.S. Social Security Administration, which examined children receiving SSI in 2000, found that the majority under age 17 nationwide (56 percent) had a physical disability coupled with either a behavioral health or learning disability. The NSCF survey also found that of the SSI children in this group, nearly two-thirds (62 percent) experienced illnesses related to their conditions requiring hospitalization for a period of two days or more. Although the NSCF study compared SSI children across states on these dimensions, Rhode Island was mentioned only insofar as it fell within the mean relative to national averages.³⁶

One of the most frequently cited features of the CSHCN population is that a large number of beneficiaries across coverage groups have conditions requiring psychiatric hospitalization. The available data indicates that a significant number of children with special health care needs are hospitalized for these services. It is unclear, however, whether it is the severity of their conditions or the lack of service options in alternative settings that is actually driving the hospitalizations rates shown in Table 12.

**Table 12: Psychiatric Hospitals
Children Under Age 19 Served at Rhode Island Psychiatric Hospitals, 2006**

	Bradley Hospital General Psychiatric Services		Bradley Hospital Developmental Disabilities Program		Butler Hospital General Psychiatric Services		Butler Hospital Child Intensive Services Unit	
	# Served	Average Length of Stay	# Served	Average Length of Stay	# Served	Average Length of Stay	# Served	Average Length of Stay
Inpatient	700	19 days	55	126 days	559	17.5 days	52	47 days
Residential	65	129 days	16	345 days	--	--	--	--
Partial Hospitalization	227	23 days	17	31 days	74	4.6 days	--	-
Outpatient	1,225	5 visits	272	6 visits	94	NA	--	--

33 See: RI Data Analytic Center Research Reports, prepared by the Consultation Center of the Yale University School of Medicine including: “Trends and Performance Outcomes in Residential and Shelter Services FY02-FY05,” (March 2006); “Who is Being Served by Children’s Intensive Services (CIS)?,” (February 2006); and “Trends and Characteristics of Purchase of Service (POS) Placements for Children in Foster Care: January 1, 2004 -December 31, 2005,” (February 2006). See also: RI Department of Human Services, “Characteristics and Enrollment Patterns of Children with Special Health-care Needs in RI Medicaid: Calendar Year 2005,” RIte Stats, Volume IV, Issue 2 (April 2007).

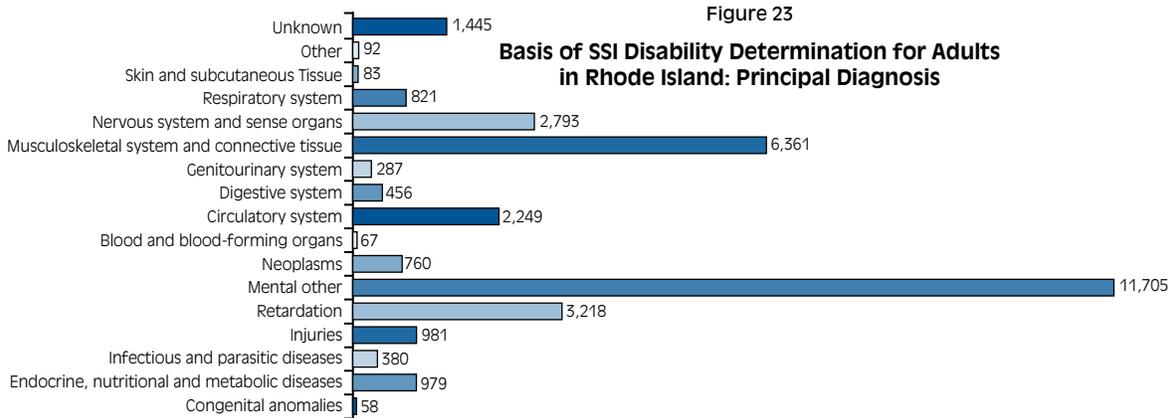
34 Rosenbach, Margo, “Children in Foster Care: Challenges in Meeting Their Health Care Needs Through Medicaid,” (Princeton, NJ: Mathematica Policy Institute, March 2001).

35 See “Statehealthfacts at: <http://www.statehealthfacts.org/cgi-bin/healthfacts>

36 See: SSA, Office of Policy, “A Profile of Children with Disabilities Receiving SSI,” at: <http://www.ssa.gov/policy/docs/ssb/v66n2/v66n2p21.html>.

Adults in Medicaid

Figure 23 shows the principal diagnosis for the purposes of disability determination for Supplemental Security Income recipients in Rhode Island. This information is useful because it provides a picture of the primary medical conditions affecting a large percentage of the individuals with disabilities in Rhode Island and, as result, captures the scope of the challenges facing the system.



Behavioral health related conditions are by far the largest qualifying medical factor for SSI disability determination.³⁷ However, as Table 13 shows, most adults with disabilities suffer from a number of co-morbidities, many of which can be contained with appropriate pharmaceutical therapy and disease management activities.

Table 13: SSI Determinations for Adults in Rhode Island: Major Medical Conditions	
Common/Costly Primary Medical Conditions Totals	12,380
Hypertension	3744
Diabetes	2650
Chronic Obstructive Lung Disease	2457
Asthma	1452
Coronary Heart Disease	1178
Congestive Heart Failure	450
HIV	386
Sickle Cell	25
Quadriplegia	23
Cystic Fibrosis	14
Primary or Co-occurring Behavioral Health Conditions	
Psychiatric and Substance Abuse --Entire Range Totals	7409
Common Behavioral Health Conditions	
Depression	2621
Major Depression	1881
Schizophrenia	1375
Drug Dependence	1221
Tobacco Use	926
Alcohol Dependence	456
Post Traumatic Stress Disorder	445
Bipolar Disorder	202
Total Individuals	15,210

³⁷ Note: Some developmental & intellectual disabilities are classified as other mental conditions and not included in the mental retardation/developmental disabilities classification



Data about specific medical conditions affecting adults with developmental disabilities covered through Medicaid under the DD/MR waiver are not readily available. It is important to note that unlike other Medicaid populations, these beneficiaries often have conditions requiring lifelong services. Nevertheless, the state does use a rating system to measure the relative support needs of beneficiaries within this coverage group. Table 14 shows the ratings and types of support, with Level 1 representing the lowest level of support and Level 4 the highest.

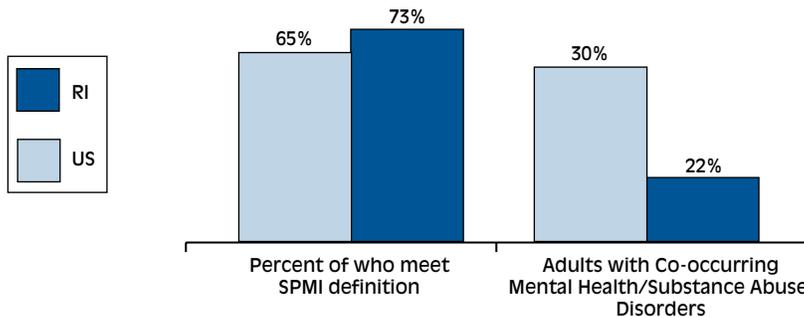
Type of Support	Level of Support			
	1	2	3	4
24-Hour Residential Support	8	365	543	529
Non 24-Hour Residential Support	137	205	95	37
Individual Program - Day Habilitation	101	1400	930	735
Individual Program - Family Support	242	220	184	155
Totals	488	2190	1752	1456

*Note: Day habilitation services are provided to all DD/MR waiver beneficiaries (2120) and a smaller group of non-waiver beneficiaries (446).

Based on National Center for Mental Health Services reports, among beneficiaries in the population of adults with disabilities in Rhode Island who use the publicly financed mental health system, fewer meet the diagnostic criteria for severe and persistent mental illness (SPMI) than is the average nationwide. (See Figure 24.) However, the data also indicated that Rhode Islanders in this system are more likely to have co-occurring substance abuse issues than the national patient population. Hospital discharge data supports this finding.

Figure 24

Percentage of Adults Using Public Mental Health Services Meeting SPMI Criteria: RI vs. US



Nursing Home Residents

To develop a portrait of the level of care needs of Medicaid nursing home residents, three measures of acuity were analyzed using data gathered from the American Health Care Association (AHCA) and the Personal Assistance Services Center at University of California-SF: MMI is the Management Measurement Index; RUG is resource group utilization, and average ADL is the average number of Activities of Daily Life (ADL) requiring assistance for nursing home residence. The results of this analysis are presented in Table 15 (page 44).

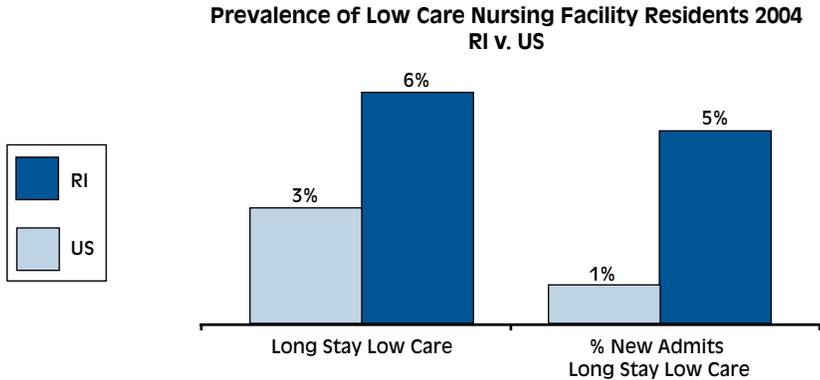


Table 15: Comparison of Acuity Levels of Nursing Facility Residents RI v. Selected States					
State	MMI	State	RUG	State	Avg. ADL
ND	76.3	MT	5.3	IL	3.45
IA	77.3	IL	5.3	OK	3.61
NE	78.5	SD	5.3	CT	3.69
WY	78.5	ND	5.4	MO	3.71
MT	82.8	IA	5.4	KS	3.74
RI	82.9	WY	5.4	NH	3.76
WI	83.8	KS	5.4	RI	3.76
AK	85.3	NH	5.4	AR	3.77
IL	86.8	MN	5.4	TX	3.78
MO	86.9	RI	5.5	LA	3.78

As the data in the table show, Rhode Island nursing home residents have acuity levels that, by comparison, are much lower than those of residents in most other states - e.g., the bottom ten states with similarly situated nursing home patients nationwide. Although these data do include private pay residents, they are relevant to this study because the overwhelming majority of residents (upwards of 85 percent) are Medicaid beneficiaries.

The relatively low levels of acuity suggest that there may be a significant number of nursing home residents that can be, and perhaps should be, transitioned back into the community. As Figure 25 shows, however, analysis of the health conditions of nursing home residents found that Rhode Island has a substantially lower percentage that are considered low care than is the average nationwide.³⁸ This suggests that there are significant challenges ahead for the state’s ongoing efforts to transition more beneficiaries residing in nursing homes back into the community.

Figure 25



Utilization Rates

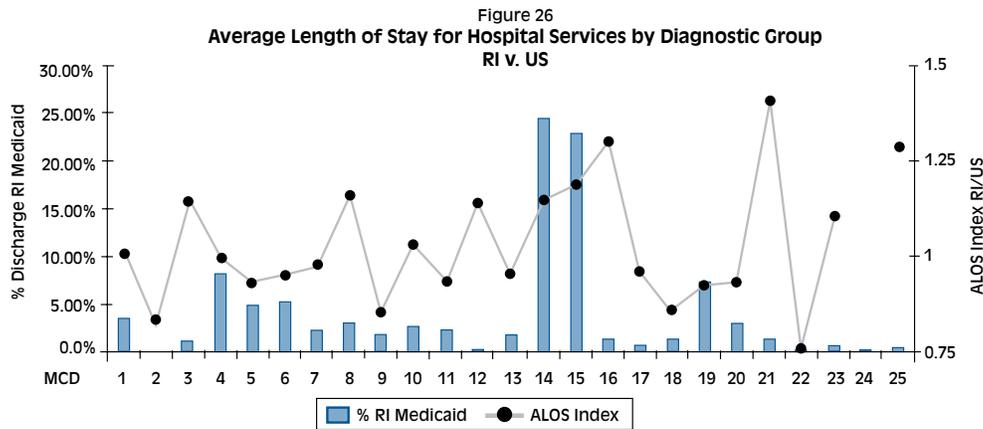
Utilization rates are in part a function of several factors, including practice patterns, disease acuity, the availability of needed services, and patient preferences. Moreover, utilization rates also vary by type of service used.

The scope and amount of Medicaid benefits is often conceived of as one of the principal cost drivers of the program. As the description of covered benefits in Section II of the first part of this report indicated, Rhode Island’s benefit offerings are consistent with other states in the region. Hence, it is not necessarily the scope of the benefits being offered, but how widely and appropriately they are used that may be a factor driving costs.

38 Source: Vincent Mor et al, Unpublished manuscript, “Prospects for Transferring Nursing Home Residents to the Community” NIA Grant #23622

Hospital Services

Comparing the mix of services that Medicaid beneficiaries use to individuals with other types of coverage provides insights into benefit utilization. For example, as shown in Figure 26 and Table 16 the average length of stay (ALOS) for Rhode Island Medicaid beneficiaries for several key major diagnostic groups appears to be longer than the national averages (e.g., Neonatal Intensive Care Unit or NICU), but consistent with the statewide averages regardless of payer. This suggests that utilization trends among Medicaid beneficiaries are being affected by broader provider practice patterns.



* The codes for the major diagnostic categories are spelled out in Table 16.

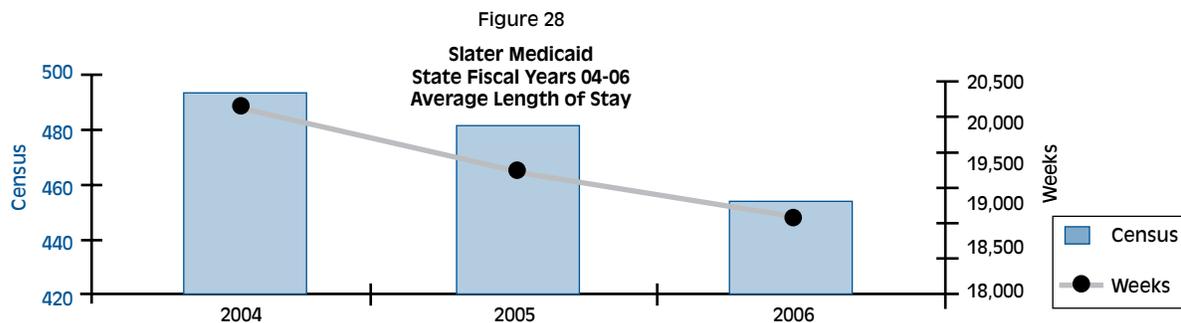
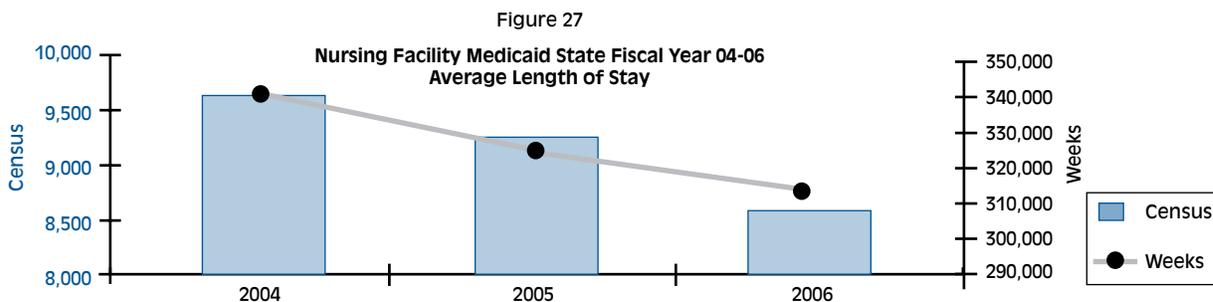
Major Diagnostic Category - 2003		Average Length of Stay		Difference
		Medicaid	All Payers	
1	Diseases & Disorders of the Nervous System	6.03	5.43	11%
2	Diseases & Disorders of the Eye	3.17	3.33	-5%
3	Diseases & Disorders of the Ear, Nose, Mouth & Throat	4.16	3.73	11%
4	Diseases & Disorders of the Respiratory System	5.53	6.10	-9%
5	Diseases & Disorders of the Circulatory System	4.71	4.42	6%
6	Diseases & Disorders of the Digestive System	4.73	5.27	-10%
7	Diseases & Disorders of the Hepatobiliary System & Pancreas	5.57	5.72	-3%
8	Diseases & Disorders of the Musculoskeletal System & Cann Tissue	6.08	4.53	34%
9	Diseases & Disorders of the Skin, Subcutaneous Tissue & Breast	4.42	4.54	-3%
10	Endocrine, Nutritional & Metabolic Diseases & Disorders	4.29	4.14	3%
11	Diseases & Disorders of the Kidney & Urinary Tract	4.88	5.02	-3%
12	Diseases & Disorders of the Male Reproductive System	5.13	3.31	55%
13	Diseases & Disorders of the Female Reproductive System	2.98	3.10	-4%
14	Pregnancy, Childbirth & the Puerperium	2.96	3.02	-2%
15	Newborns & Other Neonates with Condin Orig In Perinatal Period	4.52	4.17	8%
16	Diseases & Disorders of Blood, Flood Forming Organs, Immunologic Disorders	6.51	4.91	33%
17	Myelaprdiferative Diseases & Disorders, Poorly Differentiated Neoplasm	6.82	8.11	-16%
18	Infectious & Parasitic Diseases, Systemic Or Unspecified Sites	6.46	7.65	-16%
19	Mental Diseases & Disorders	8.92	8.71	2%
20	Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders	5.11	4.68	9%
21	Injuries, Poisonings & Toxic Effects of Drugs	5.37	4.45	21%
22	Burns	7.14	9.64	-26%
23	Factors Influencing Health Stat & Ctr Contacts With Health Services	13.73	11.46	20%
24	Multiple Significant Trauma	*	13.52	#Value
25	Human Immunodeficiency Virus Infections	11.36	9.83	16%



Over the last several years, there has been a substantial increase in Medicaid emergency department (ED) expenditures that has been driven largely by the Rite Care population. Though the direct cause for this spike in utilization is unclear, beneficiaries and Medicaid officials report that ED utilization is primarily a function of an access problem. There is anecdotal evidence to suggest that a combination of factors are involved ranging from reimbursement issues limiting physicians willing to take Medicaid patients, office hours not being conducive to working families' schedules and relative few primary care and/or urgent care facilities in areas with large concentrations of Medicaid beneficiaries.

Institutional Long-term Care Services

Figures 27 and 28 show trends in average lengths of stay (ALOS) and census counts in nursing homes. Both census and total weeks declined significantly over the three years studied, although average weeks per person slightly increased for both settings in the third year. Despite this declining census and lower lengths of stay - Rhode Island has the fourth highest nursing home occupancy rate (92.3%) in the country.³⁹



An interesting phenomenon occurs with institutional long-term care services. The population distribution factored by length of stay looks like a barbell. To determine the cause of this distribution, a subset of the total population was analyzed to determine actual distribution of lengths of stay. This subset includes all persons who had a discharge within the three-year period from SFY 2004 to SFY 2006 (except due to death), and those who had the full three-year length of stay; total stays of those institutionalized on the first day of the study period; and all who have been transitioned through the state's Real Choice's Nursing Facility Transition Grant Program.⁴⁰

³⁹ KFF State Health Facts, Nursing Home Occupancy Rates, 2005

⁴⁰ People in an institution on the last day of the study period (June 30, 2006) but who were not institutionalized on the first day (July 1, 2003) were not included in this analysis because their full length of stay could not be determined.

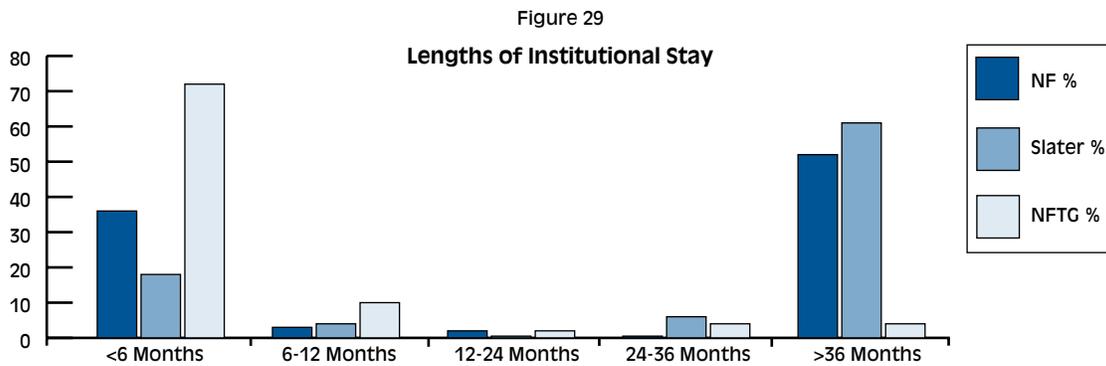


Note that the Real Choices System Changes (RCSC) Nursing Facility Transition Grant (NFTG) was awarded to the state by the CMS in 2002 for the purposes of developing: (1) a system to transition people with multiple complex needs from institutional to community settings; (2) a referral process between state long-term care PASSR reviewers and the transitional program; and (3) a day program for persons with severe cognitive disabilities, such as brain injuries. Five hundred thirty-three (533) Medicaid beneficiaries have been transitioned under the auspices of the grant since implementation began.

Analysis of the length of stay, discharge and the NFTG data revealed that most beneficiaries examined had been in the institutional setting for more than three years. Among those who left, the majority was discharged less than six months after admission. In the state operated Eleanor Slater Hospital, residents discharged in less than six months may be primarily beneficiaries with behavioral health issues, though there is no concrete data directly addressing this issue.

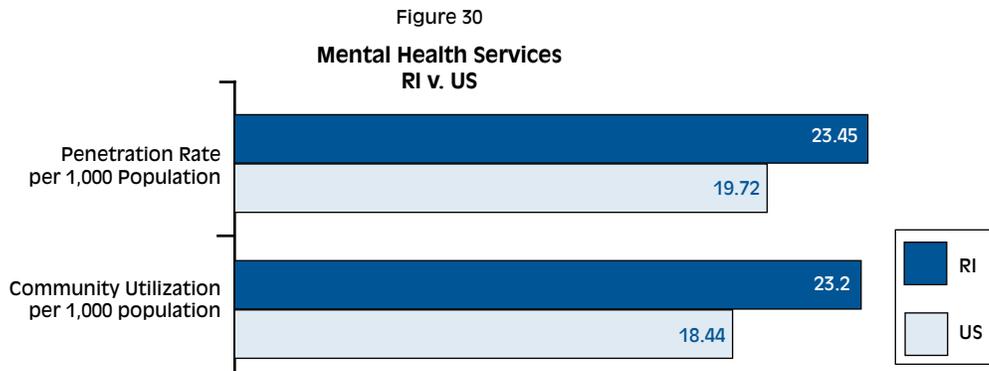
Beneficiaries who remain in a nursing facility for more than six months can no longer retain their housing costs, so there is an incentive to leave before that time. Additionally, within the first six months, beneficiaries may be less likely to become acclimated to the institutional setting. Experience under the NFTG also indicates that it is much easier and quicker for beneficiaries to transition out of a facility within the first six months of admission. Moreover, moving beneficiaries who have had a very long stay (greater than 24 months) back into the community may be unfeasible in many cases as homes are often sold or transferred during the period of nursing facility care.

Beneficiaries who are nursing facility residents for a minimum of three years are often thought to be a “typical” Medicaid-funded population. However, many beneficiaries only become eligible for Medicaid after exhausting their own private resources while receiving institutional care or as a result of their need for long-term care - e.g., Medicare does not cover lengthy stays in the long-term care setting. The most unexpected finding of the analysis is that relatively few beneficiaries had stays between six months and three years in duration. Figure 29, shows a comparison of length of stay across facilities and under the NFTG.



Other Key Services

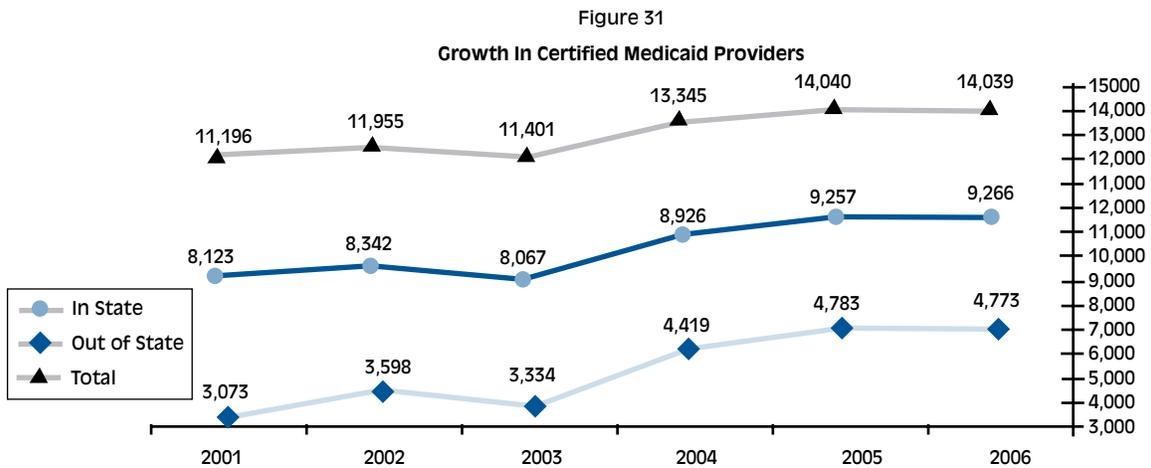
More Rhode Islanders use the publicly supported mental health system than is the case nation wide, as indicated in Figure 30.



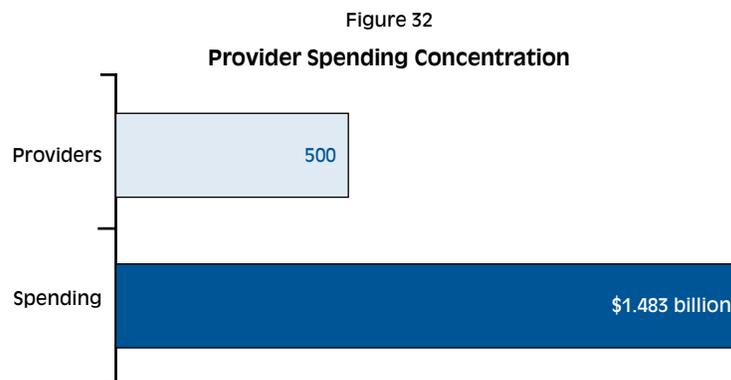
Medicaid claims data for both the elderly and adults with disabilities populations show that this trend holds for beneficiaries in the community, including those residing in their own homes, assisted living and other supportive state subsidized residential settings. For example, in SFY 2006, 56 percent of the Medicaid beneficiaries in assisted living residences over age 65 used one or more services provided through the state's system of Community Mental Health Centers (CMHC) during the year; in the adults with disabilities population under age 65, 72 percent utilized behavioral health services, and upwards of 50 percent were classified as severely and persistently mentally ill. For some beneficiaries in the CSHCN population, utilization of services through the CMHC was just as high: about 73 percent of the children in substitute care and 68 percent of the children eligible through SSI received services provided by the CMHCs during the period from SFY 2003 through SFY 2006.

Provider and Service Mix

There are currently 14,000 vendors certified by the state to provide services to Medicaid beneficiaries. As indicated in Figure 31, the number of certified providers has grown by 25 percent since 2001 largely due to the increase in out-of-state providers.



State policy makers have questioned whether, and to what extent, the proliferation of certified providers has contributed to the rise in Medicaid program expenditures - i.e., provider induced demand. Although it is difficult to measure created demand with any degree of reliability, it is worth pointing out that only four percent of the providers currently certified to participate in the program represent approximately 91 percent of all Medicaid spending.

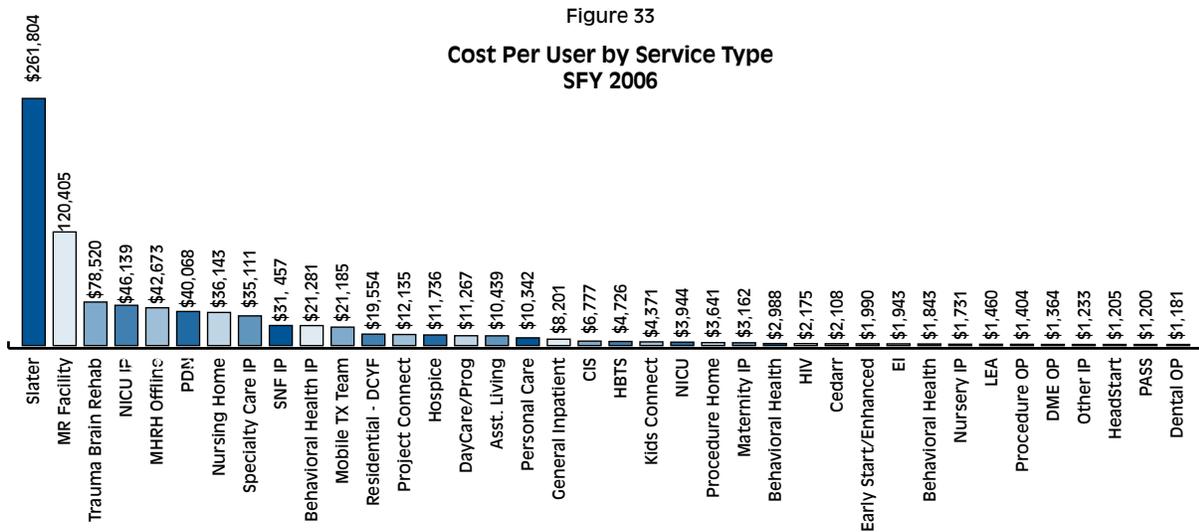


These figures are not surprising given the pattern of Medicaid spending for providers. As previously noted, long-term care costs represent 55 percent of state Medicaid expenditures. Most of this spending is concentrated in the 169 DD/MR waiver group homes, 88 nursing homes and Slater Hospital. The largest single component of acute care spending is with 20 hospitals for inpatient admissions, emergency room



utilization and outpatient services. Combined, these providers represent \$859 million in total Medicaid spending in SFY 2006.

Service costs vary significantly by type across the Medicaid program. Figure 33 shows the cost per user for services financed by Medicaid.



To obtain an accurate representation of service costs under one of the state's Home and Community Based Services waivers, it is necessary to examine total Medicaid expenditures for beneficiaries - waiver and non-waiver. For example, under the HCBS waiver for DD/MR, total waiver costs in the state in SFY 2004 -- the last year for which comparable data is available -- were the second highest in the nation, at \$77,052 per beneficiary. This spending level was comparable to that of Delaware -- \$82,421 per beneficiary. Nationally, the average spending per waiver beneficiary during this same period was \$37,784.⁴¹

Table 17: Top 5 States Per Participant	HCBS DD/MR Waiver Cost Per Participant	Waiver % of Total DD/MR Spending
Delaware	\$82,421	43%
Rhode Island	\$77,052	82%
Maine	\$73,462	64%
Tennessee	\$66,042	44%
New Mexico	\$64,144	80%
US	\$37,784	41%

The wide disparity in state versus national average costs is often attributed to the fact that waiver comparisons do not include state expenditures for adults with developmental disabilities served in the institutional setting, primarily intermediate care facilities for persons with mental retardation (ICF/MRs). It is not possible to determine the validity of this explanation with the data currently available, though Rhode Island does serve far fewer beneficiaries in this coverage group in such settings. Studies that have looked at services for beneficiaries in this population nationwide indicate, however, that ICF/MR versus waiver comparisons vary greatly from state to state and that, in some cases, expenditures for waiver services exceed ICF/MR costs.⁴²

Reimbursement Methodologies

Reimbursement methodologies and the level of payment they generate influence the availability of

⁴¹ *State of the States in Developmental Disabilities*:2005 Table 7 pg. 30.

⁴² Braddock, D., Hemp, R., Coulter, D., Haffer, L., and Thompson, M. *The State of the States in Developmental Disabilities*. (Denver, Co: University of Colorado, 2007).

services for Medicaid beneficiaries and ultimately the cost of the system. Rhode Island’s system of fee setting for institutional care is based on cost reimbursement principles. There are some exceptions where the state pays flat-based and case mix rates. However, the state’s flexibility in setting these rates is limited as both payment methodologies and rates are often established in federal or state laws or regulations. In fact, approximately \$706 million or 42 percent of the state’s Medicaid expenditures are in part driven by reimbursement principles established in state law. Table 18 illustrates some of the provider types subject to these laws.

Legal Reference	Provider
40-8.9-7	Community-based Long-term Services
40-8-13.1	Out-of -State Hospitals
48-8-13.2	In-State Hospitals
40-8-1	Nursing Facilities

As noted in the first part of this report, Table 19 shows that Rhode Island is one of the few remaining states using a ratio of cost to charges to reimburse hospitals for their services. Other payment mechanisms such as diagnostic related groups (DRGs) essentially offer a “price” for medical services; the method used by the state reimburses on the expense-base of the given hospital delivering the service. In areas where the state uses value-based purchasing through, for example, managed care contracts, the limitations of the reimbursement and payment methodologies established in state law are not necessarily applicable.

Per Stay-Medicare DRG	CA, CO, IA, IL, KS, KY, MI, MN, MT, NC, ND, NE, NH, NJ, NM, OH, PA (1), SC, SD, TX, UT, WI, WV
Per Diem	AK, AZ, FL, LA, MO, MS (1), OK, T, VT (2)
Per Stay - AP or Champus DRGs	DC, GA, IN, NY, VA, WA
Per Stay - Other	DE, MA, NV, WY
Cost Reimbursement	AL, AR, CT, ID, ME, RI
Regulated Charges with APR-DRGs	MD

(1) APR - DRGs

(2) Moving to DRGs

Source: ACS Government Healthcare Solutions

**Note: Maine changed its reimbursement methodology in January 2007 to a combination strategy that includes per stay Medicare DRG and cost reimbursement.*

In general, the state’s reliance on a cost-based method of reimbursement renders the Medicaid program vulnerable to fluctuations in the financial status of providers. Figure 34 shows the percentage that wages represent the total “market basket” for a variety of provider types. Wages are a significant factor; in nearly every case, they surface as the largest component of the cost base of health care providers.

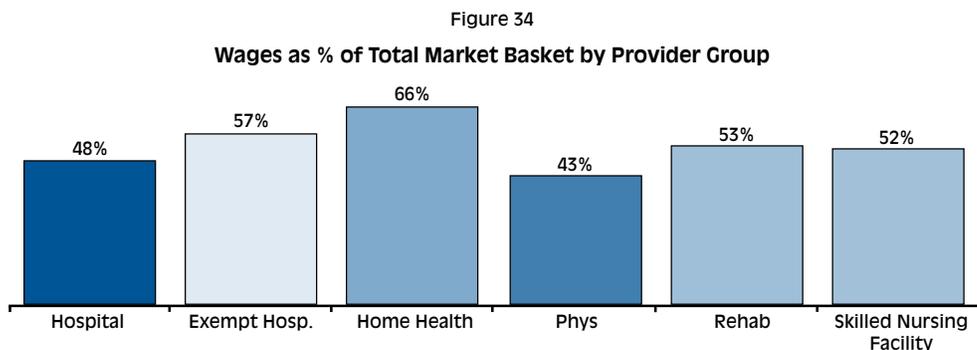
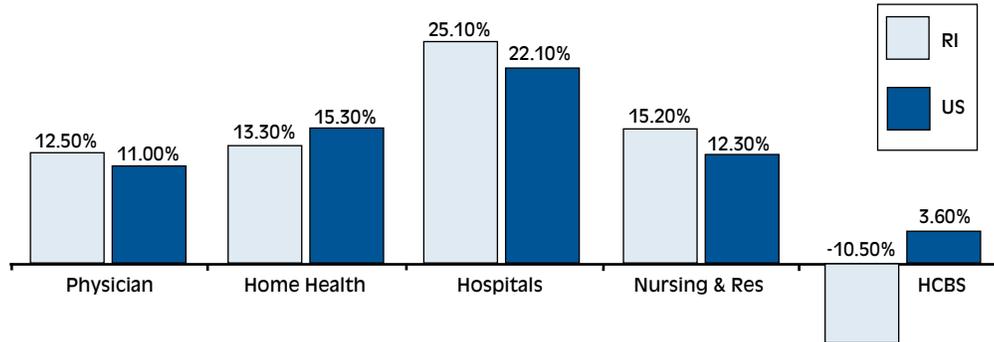




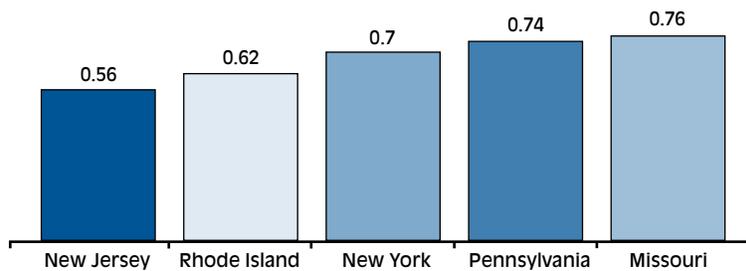
Figure 35 shows average weekly wage increases in the state compared to the nation. Health care wages in Rhode Island have grown faster than wages nationwide, with the notable exception of home health and community-based services. It is important to stress that wage increases in the state have been driven, at least in part, by the shortage in nursing and allied health professionals.

Figure 35
**Comparison of US versus RI Average Weekly Healthcare Wages by Major Providers Category
 Cumulative Increases 2001 to 2005**



Additional concerns regarding reimbursement structure include physician reimbursement. Rhode Island Medicaid fee-for-service reimbursement for physicians is the second lowest in the country (Figure 36) according to information for SFY 2003, the last year for which comparative data was available. Some of the utilization issues discussed previously may be a function of this low level of physician reimbursement and subsequent limited access to physicians and specialists.

Figure 36
**Medicaid Fee for Service Physician Reimbursement Medicaid Index
 Five Lowest Reimbursement States
 US = 1.00**



In sum, the state's current rate setting and reimbursement system is inflexible and, in many instances, ties payments to other health care cost drivers. This has compounded the impact of rising health costs on the Medicaid program and limited the state's ability to leverage its purchasing power and invest resources in areas with potential to maximize the value for each dollar it spends. Absent reform of this system, the state's primary method for pursuing value-based purchasing in Medicaid will continue to be through managed care contracts. As is the case with RIte Care, these contracts often include significant administrative overhead costs that could be allocated to pay for direct services under other rate setting and reimbursement schemes.





Part III: Prospects for the Future



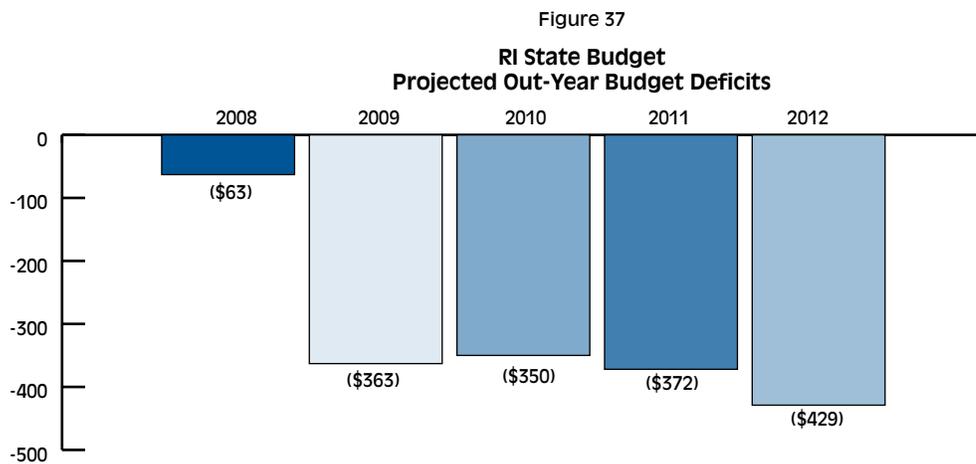


Section I. Key Issues Facing The Medicaid Program

In Part I of this report, an overview was provided of the challenges the Medicaid program poses for state policy makers both today and in the years ahead. This section of the report examines several of the key issues confronting the state at greater length.

Medicaid and the State Budget

Since SFY 2001, the state of the Rhode Island has faced the dilemma of structural budget deficits. All indications are that these deficits are likely to continue going forward. The state budget office forecasts annual deficits in excess of \$350 million dollars per year for next five years; cumulative out-year deficits total an estimated \$1.577 billion (Figure 37). Given the size of the Medicaid program, and its impact on the state budget, Medicaid will be a contributing factor to the size of the deficit and to any actions the state pursues to close the gap between the increase in growth in revenues and expenditures for many years to come.



To gauge the potential impact of the Medicaid program on state finances in the years ahead, a series of forecasts were developed using different methods. As forecasting is by its very nature an imprecise science, the outcomes predicted may not emerge if conditions change or if the underlying assumptions are too narrow or broad. Accordingly, the forecasts presented here are designed to provide directional guidance about the Medicaid program rather than serve as the basis for financing decisions.

The basic approach used to construct each of the Medicaid forecasts was to hold eligibility standards constant and consider only changes in demographics and medical expenditure trends. Based on these assumptions, six different approaches were used to develop the out-year estimates based on the following:

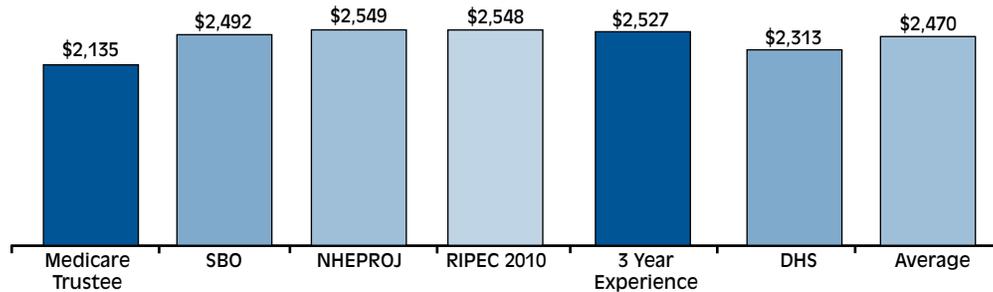
- Rhode Island Public Expenditure Council (RIPEC) 2020: Derived from the RIPEC Report: Rhode Island 2010;⁴³
- Trustee: Based on using Medicare Trustee Healthcare Spending Multipliers;
- DHS: Forecast prepared by the Department of Human Services, the single state agency for Medicaid in Rhode Island;
- SBO: Forecast prepared by the State Budget Office, Rhode Island Department of Administration, from the State Five Year Forecast;

43 The RIPEC number is their forecast for FY2010

- NHEPROJ: Forecast based on National Health Expenditure Projections; and
- Three Year Experience: Based on the prior three years of health expenditures for the Medicaid program trending forward.

Figure 38

Medicaid Spending Forecasts: 2011 Estimate



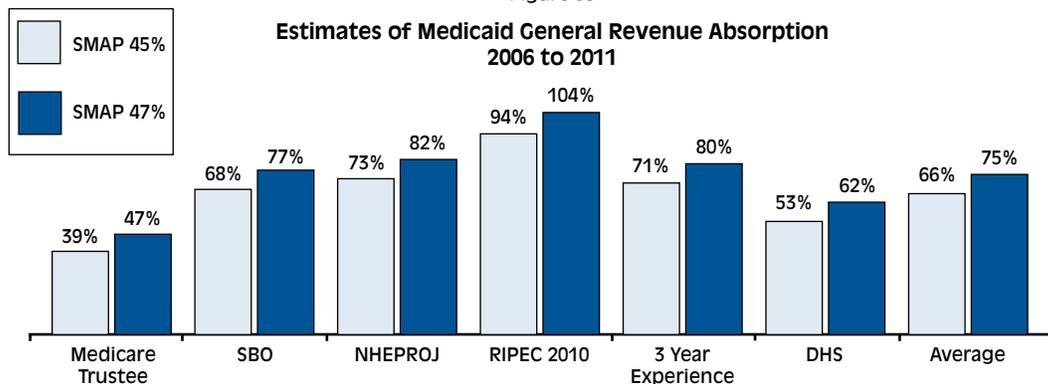
Despite the different approaches used in the six forecasts, four predict that Medicaid expenditures will range between \$2.3 and \$2.5 billion in 2011. Based on the average of the forecasts of \$2.47 billion, Medicaid spending (all funds) may grow by \$660 million over the next several years.

Given the structural deficit issues confronting the state, it is important to gauge the portion of each additional dollar of general revenue the state generates that may be consumed by Medicaid expenditures for the out-years if program costs rise as predicted in these forecasts. The role that FMAP plays in determining total state outlays for Medicaid makes this exercise particularly difficult. To address the FMAP issue, the Medicaid expenditures data were manipulated to account for potential changes in the federal contribution toward program expenditures.

The first analysis (Figure 39) is based on a FMAP rate of about 53 percent - the lowest level of federal assistance provided to the state in recent years. In this analysis, the state's level of assistance - designated as SMAP - is 47 percent and, in some respects, presents the "worst-case" scenario for evaluating the impact of the growth of Medicaid spending on state revenue. Figure 39 also presents the results of a second analysis, which shows how much of each new dollar of state revenue is absorbed by Medicaid with the FMAP at 55 percent and the SMAP at 45 percent; this is the current and more favorable ratio of federal to state dollars contributed toward the program.

Figure 39

**Estimates of Medicaid General Revenue Absorption
2006 to 2011**



Based on the spending forecasts and anticipated growth in general revenues, in the not too distant future, Medicaid may well absorb between 66 and 75 percent of every dollar in state revenue. The worst-case scenario approach shows Medicaid requiring more general revenue than is forecast by 2011. Independent forecasts show similar results. A study conducted by McKinsey for the National Medicaid

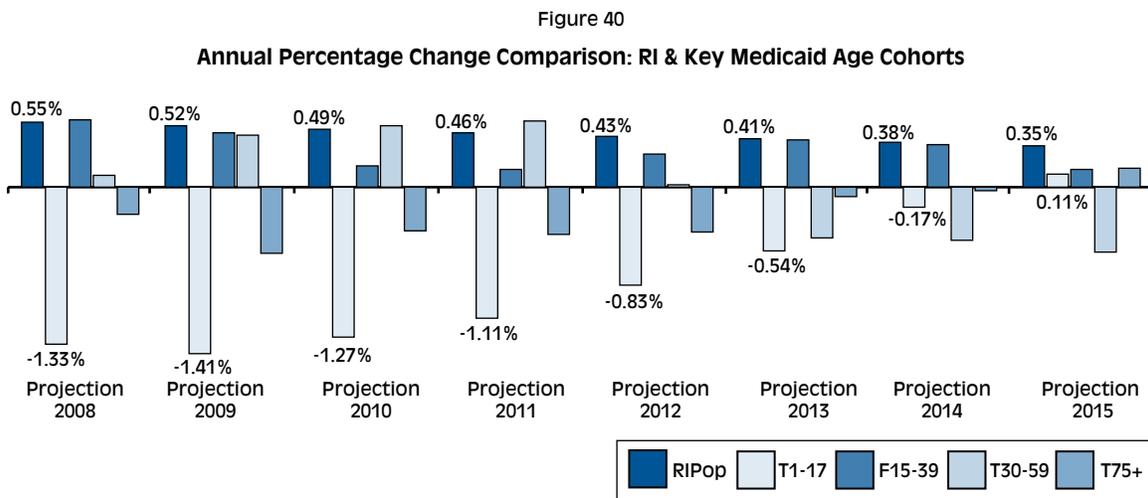


Commission estimated that Medicaid would absorb 50 - 75 percent of Rhode Island state general revenues by 2009.⁴⁴

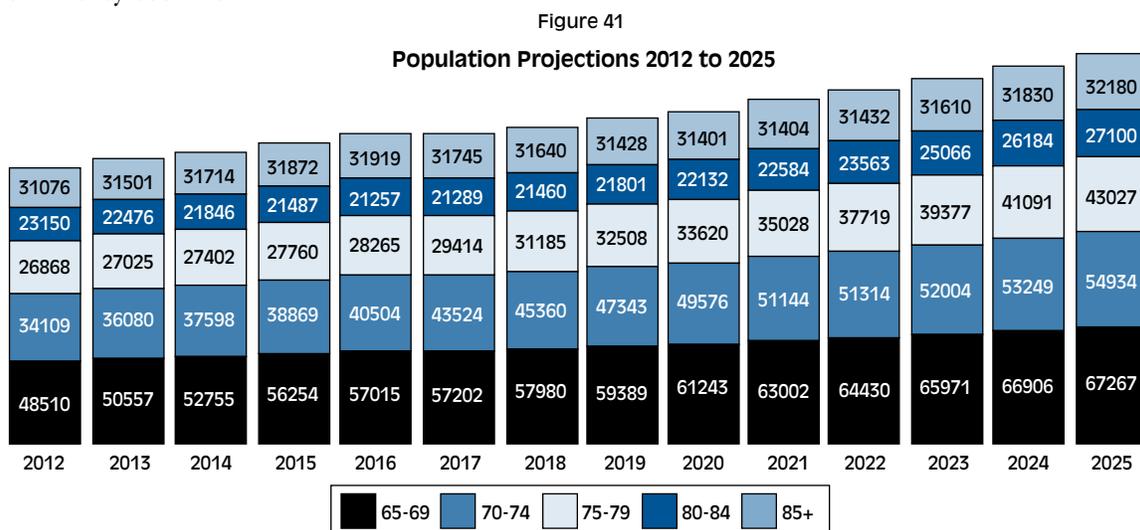
It is important to reiterate here that these projections do not take into consideration a wide range of variables with the potential to make the Medicaid absorption rate significantly less onerous or worse. For example, if the state's economy experiences a downturn or boom period, not only are there likely to be corresponding fluctuations in revenue, but possibly in eligibility for enrollment and/or in underlying health costs as well.

Demographics

At the present time, Rhode Island's slow population growth has effectively limited the impact that enrollment has in driving expenditures, at least based on present eligibility standards. Figure 40 indicates that this trend is likely to continue into the foreseeable future unless there is a significant shift in either federal or state eligibility requirements. In fact, most key Medicaid age cohorts appear to be growing in size at a somewhat slower pace than the population statewide.



There is evidence, however, that the aging of the population will have a significant impact on Medicaid costs beginning in 2013, as the majority of baby boomers reach 65. Figure 41 shows the demographic wave of the baby boomers.



⁴⁴ The Challenges for Medicaid: An Economic Assessment. Presentation to the Medicaid Commission, July 27, 2005. McKinsey & Company



Within a decade of 2012, the U.S. Bureau of Census estimates there will be an additional 11,600 elderly individuals over the age of 75 in Rhode Island. The need for long-term care and end-of-life care is expected to increase proportionally as more and more aging baby boomers become what is often referred to as “the oldest of the old” - i.e., age 75 and older. The available data on Medicaid in Rhode Island today indicates that the oldest of the old is both the largest and highest cost group of beneficiaries within the elderly population.

The aging of the population affects the state’s program in a number of other ways as well. For example, the Coleman Institute estimates that there are 2,989 beneficiaries with developmental disabilities living with caregivers over the age of 60.⁴⁵ As these caregivers age and confront health issues of their own, their ability to continue to provide services and supports to beneficiaries will diminish in all likelihood. In turn, the role that Medicaid plays in caring for these beneficiaries will also increase.

Structural Impediments and Systems of Care Issues

If the demand for and costs of the Rhode Island Medicaid program rise as predicted, the state’s capacity to handle both will be affected by the way services are organized, financed and delivered. The fragmentation in the Medicaid program noted throughout this report has made it difficult to manage service access, quality and cost system-wide.

On the financing side, the chief issues include the way Medicaid is funded and the process for estimating caseload growth and costs. Currently, the state appropriates Medicaid funds by program within specific departments, even though they often share responsibility for the health coverage and services provided to beneficiaries. This makes it difficult to determine total Medicaid expenditures within and across populations and to access the data required to assess whether beneficiaries are receiving the appropriate care in the right setting and at the best value.

The system used at present to estimate Medicaid case loads compounds these difficulties. Some departments and programs are subject to the process, while others are not. Expenditures for programs that support Medicaid beneficiaries or that Medicaid supplements are often excluded, making it difficult to ascertain total state spending on a population or coverage group as a whole.

For example, the Medicaid waivers, some of which include beneficiaries with the highest cost of care, are not subject to the caseload estimating process. Consequently, the costs associated with covering elders and adults with disabilities covered through waivers were not, until recently, included when considering overall long-term care expenditures. This, in turn, hampered efforts to assess cost, capacity and utilization across long-term care settings.⁴⁶

Children’s behavioral health is another case in point. There is both data and ample anecdotal evidence indicating that psychiatric hospitalization stays for certain children are inordinately long due largely to the lack of step down residential care options in the system. For the state to fully assess whether it is financially sound to make the investments required to fill this gap, it is necessary to first examine the total number of public dollars being spent from all sources - i.e., not only Medicaid, but other state and federal programs as well - and the scope of services needed to optimize and promote each child’s health and well-being. Yet, the DCYF programs that are the basis of Medicaid eligibility for a significant number of these beneficiaries are also not subject to the caseload estimating process. Thus, in these and several other instances, the state’s capacity to reallocate and/or steer rather than react to trends in Medicaid spending is limited.

There are care management issues that are also noteworthy. The decentralization of programmatic responsibilities across agencies has made it difficult to coordinate services and respond quickly and efficiently to the changing needs of beneficiaries. The state’s ability to manage the care of the dual eligible population has not been fully realized due to federal control over Medicare dollars and service access. Likewise, evaluating utilization trends system-wide can be a challenge in instances in which multiple agencies are involved in service delivery, each of which is authorized to provide distinct types of services or levels of care.

⁴⁵ *State of the States in Developmental Disabilities*, 2005 Table 18 p. 60

⁴⁶ As discussed in the next section, the Perry-Sullivan, Long Term Care Reform Act of 2006, established global budgeting for publicly financed long-term care.



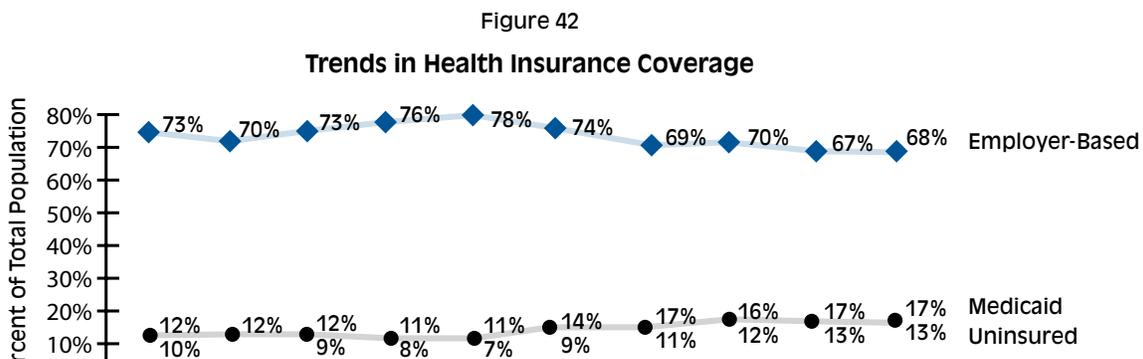
As each agency administering Medicaid programs has developed its own system for purchasing and paying for services, whether the state is obtaining the best services for every Medicaid dollar spent is also an open question. A recent Executive Office of Health and Human Services (EOHHS) study found instances in which multiple agencies were purchasing the same set of services from several different Medicaid providers at widely varying rates.

Since it was established, the EOHHS has taken the initial steps to develop a coordinated Medicaid budget while, at the same time, lending direction and support to interagency initiatives designed to integrate care systems, increase the range of service options and promote beneficiary choice. The five health and human services agencies and the EOHHS are also active participants in a broader initiative to build the Rhode Island's health information technology infrastructure and, as such, the state's capacity to integrate and manage services across systems and provide beneficiaries with the information they need to make reasoned choices about their care. Toward this end, Medicaid program officials have retooled certain aspects of the MMIS and implemented a web-based resource locator for beneficiaries. The Medicaid program is also an important player in a more ambitious effort to establish an electronic medical record that will facilitate the exchange of data providers need to improve care access and quality for beneficiaries and all Rhode Islanders.

Erosion of Private Insurance

The employer-based insurance market in Rhode Island has been eroding over the last several years. As a result, there has been an increase in the number of uninsured adults and children in the state and renewed interest in the role that Medicaid plays in providing access to affordable health coverage.

Between 2000 and 2005, the percent of Rhode Islanders covered by private insurance dropped from a high of 78 percent to just below 68 percent. During this same period, the number of uninsured Rhode Islanders (under 65) almost doubled from 62,000 in 2000 to roughly 120,000 in 2005, as indicated in Figure 42.

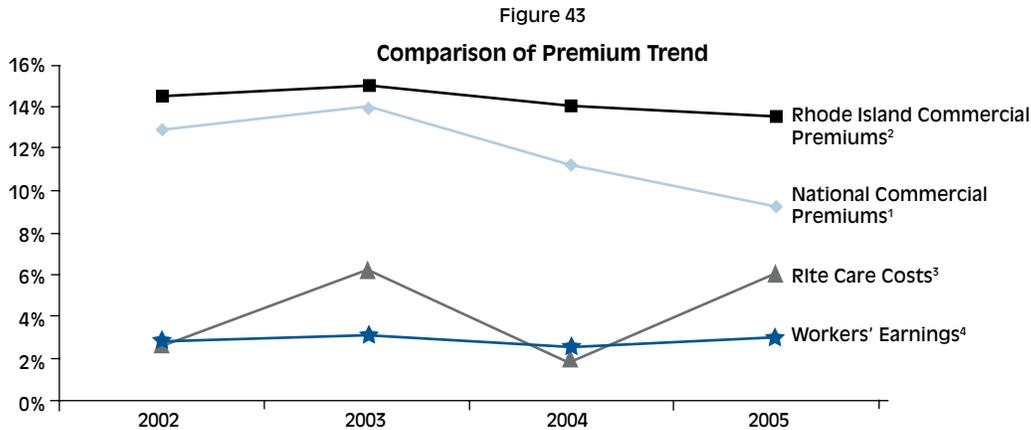


As indicated in Table 20, if this trend were to continue unchecked, by 2010, Rhode Island would face a significant insurance crisis, with an estimated 19.5 percent of the population uninsured.

Table 20	Percent of Population, 2005	4-Year Average Increase	Resulting Population Mix, 2010 Estimate
Employer-based Coverage	67.6%	-1.6%	54.8%
Medicaid*	16.9%	+0.1%	17.7%
Uninsured	13.3%	+1.1%	19.5%

The factors contributing to the decline in health insurance coverage are multiple and complex. Rising health care premiums are certainly an important contributing factor. For example, over the four year period covering 2002 through 2005, national health insurance premiums increased by a total of 56 percent.

Premiums in the commercial health insurance market climbed at an even higher pace -- 70 percent -- over this same time period.



Note that relative to these two benchmarks, RItE Care trends were remarkably low: over the same four year period, RItE Care costs increased by only 18 percent. This low trend is a testament to some of the unique characteristics of the RItE Care model - such as value-based purchasing, and the continued focus on access, quality and health outcomes.

The rise in premiums has influenced access to Medicaid and commercial coverage through employers in a variety of ways. First, employers are shifting costs to employees through increased premiums, deductibles and co-insurance. This had made employer-sponsored insurance (ESI) less affordable, particularly for low-wage workers, who qualify for Medicaid. Second, the significant increases in the cost of ESI have threatened the continued viability of the state's Medicaid RItE Share premium assistance program.

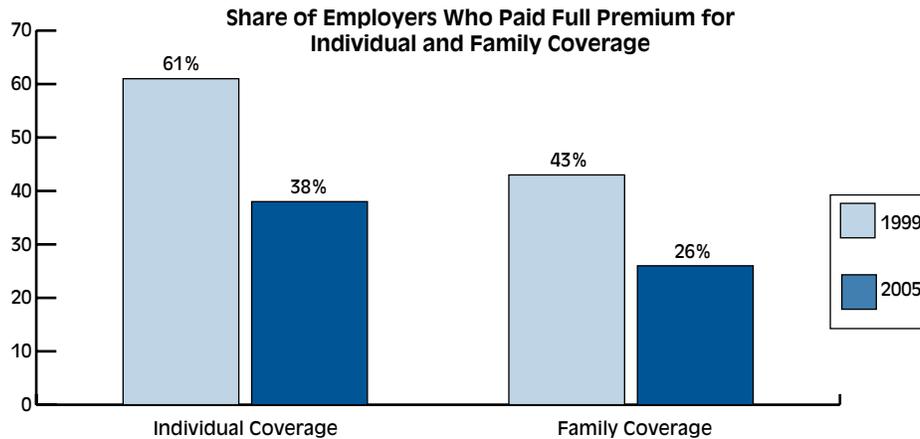
As noted earlier, the purpose of the RItE Share program was to stabilize growth in the RItE Care program and bolster the system for providing employer sponsored insurance at a time when the commercial market was in a state of flux. Simply put, RItE Share is designed to prevent Medicaid eligible families with access to ESI from dropping coverage to enroll in RItE Care.

For example, some individuals who are eligible for RItE Care work in settings where they have access to employer sponsored coverage. In these cases, RItE Share pays for the employee share of the premium and applicable co-pays and deductibles in order to meet federal Medicaid comparability requirements. However, under federal law, the state is only permitted to enroll Medicaid eligible individuals in RItE Share when it is cost effective to do so. RItE Share is only a cost effective approach as long as the combined costs of the premium share and other co-insurance and co-pays are less than the alternative of paying for coverage through RItE Care. Typically, the overall RItE Care costs are less than the costs of the ESI. However, the employer's contribution to the premium usually makes RItE Share a cost-effective option. This approach effectively leverages employer dollars and minimizes the state contributions for eligible working families.

Yet, Figure 44 shows that many employers have responded to the rising cost of health insurance by increasing employee cost sharing - both in terms of premium contributions and at the point of service. For example, in 1999, some 61 percent of Rhode Island employers paid the full premium for individual coverage. In 2005, only slightly more than a third (38%) of employers paid the full premium.



Figure 44



In addition, employers have been rapidly shifting to plan designs with higher coinsurance, co-pays and deductibles in an effort to save money. In 2005, nearly 50 percent of new insurance business sold in Rhode Island (by both commercial carriers) included some form of deductible or coinsurance.

The problem with this increased cost shifting is two-fold. First, the number of individuals and families that are uninsured has begun to rise because low-wage workers who do not qualify for Medicaid choose to “go bare” rather than pay the high premiums and deductibles. Second, ESI coverage through RIte Share is becoming a less viable option to RIte Care for those workers who are Medicaid eligible because of the cost effective test.

In considering the implications of the decline in ESI, the uncertain future of RIte Share, and the growing ranks of uninsured Rhode Islanders, the question has surfaced once again about whether the Medicaid program is an appropriate platform for providing universal access to health coverage. The structural deficits confronting the state today make this a far more difficult question to answer now than when it was first considered by state policy makers 15 years ago. The forecasts presented earlier in this part of the report clearly show that Medicaid expenditures will continue to grow at a faster pace than state revenues in the short term, even if there are no expansions in eligibility. Continued declines in commercial alternatives, due to the erosion of ESI or changes in other market forces, and their potential impact on Medicaid enrollment and expenditures were not factored into the forecasts; nor, for that matter, were the long term costs to the state of a substantial increase in the number of uninsured.





Section II: Medicaid's Continual Evolution

During the last several years, the state has endeavored to respond to several of the issues outlined in the previous section. For the most part, these efforts have focused on improving the management and coordination of care, containing cost and systems transformation. This section of the report provides an overview of the changes in the program and in its larger operational context that have occurred as a result.

Programs for Children and Families

Several of the most significant changes in the Rhode Island Medicaid program over the last decade have targeted programs serving children and families and children with special health care needs.

RIte Care and Health Reform 2000

The RIte Care program has been subject to incremental changes since it was first implemented in 1994. An effort at more comprehensive systemic change occurred in 2001, subsequent to unprecedented growth in both enrollment and program costs.

Specifically, a boom in RIte Care enrollment and the attendant unanticipated increase in program costs became apparent early in 2000, shortly after Governor Lincoln Almond's newly established statewide Steering Committee on Health Care began reviewing the state's options to stabilize the commercial health insurance market and assess the feasibility of using RIte Care to expand coverage to uninsured working adults without children.⁴⁷ Once the scope of the cost overruns in the RIte Care program became clear, the focus of the Steering Committee's work shifted to containing enrollment growth in the program and preventing further erosion in access to commercial alternatives, particularly employer-sponsored insurance (ESI).

The Steering Committee's work culminated in the enactment of Health Reform Rhode Island 2000, a wide-ranging policy initiative designed to stabilize RIte Care enrollment and the commercial health insurance market and improve access to ESI, particularly among small employers.

The initiative was composed of the components outlined below in Table 21.

Table 21: Major Components of Health Care Reform 2000

Rite Care Stabilization	Commercial Health Insurance Market Reforms	Regulation of Health Insurer Solvency and Viability
Target Rite Care to those most in need of coverage and promote responsible utilization by requiring enrollees to pay a share of the costs for coverage.	Reform the health insurance marketplace by adopting a series of policy and legislative changes.	Establish a new financial reserve requirement for health insurance consistent with the recommendations of the National Association of Insurance Commissioners (NAIC).
Cost-sharing: Families with income at or above 150 percent of the FPL must pay a monthly premium, not to exceed 5% of total income.	HIPAA Compliance: Conform individual, small and large employer markets to the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 related to guaranteed issue and renewal, portability, and continuous coverage, etc.	
Rite Share Premium Assistance: Families with access to ESI that meets certain cost and coverage standards are required to enroll with state paying the employees share of the premium for family coverage.	Rate Reform: Stabilize premiums in the small groups market by compressing rate bands and applying the principles of adjusted community rating, reducing rating factors, and guaranteeing issue of a basic health plan providing comprehensive coverage.	

⁴⁷ The Governor's Steering Committee was established with great fanfare in January of 2000. By March of that year, Medicaid program officials reported to the Governor and the General Assembly that increased enrollment in RIte Care had created an unexpected additional \$50 million dollars in expenditures for the year.



The enactment of the RItE Care stabilization component of Health Reform Rhode Island 2000 represented a significant and important consensus among state officials, including the Governor, leaders of the General Assembly, and Medicaid program administrators: RItE Care must be consistent with its original mission to assure access to coverage for the uninsured.

Milestones designed to achieve this end are summarized below:

Table 22: Health Reform 2000-- RItE Care Milestones

- **January 18, 2001** - Federal approval of a Section 1115 SCHIP demonstration waiver that provided an enhanced federal match for parents and relative caretakers in the 1998 expansion group with income between 110 and 185 percent of the FPL and pregnant women with income between 185 and 250 percent of the FPL. Approval enabled the state to preserve RItE Care expansions while efforts to stabilize the growth in RItE Care enrollment were underway.
- **February 1, 2001** - Implementation of the RItE Share Premium Assistance Program by signing up “participating employers” on a voluntary basis.
- **January 1, 2002** - Institution of monthly premium cost sharing for RItE Care/RItE Share families with income at or above 150 percent of the FPL.⁴⁸ Current levels are among the highest in the nation. ⁴⁹As of July 2006, 5,486 families (13,707 individuals) were subject to cost sharing -- about 10 percent of all RItE Care and RItE Share enrollees.
- **January 1, 2002** - RItE Share enrollment became mandatory for Medicaid-eligible children and families whose employers offered an approvable health plan.⁵⁰

As a result of Health Reform 2000 initiatives and a variety of the other cost containment measures taken by the state since 2002, RItE Care/RItE Share enrollment began to ebb in 2003 and actually declined somewhat in the last fiscal year.

Children’s Behavioral Health Redesign

Much of the growth in RItE Care enrollment since Health Reform 2000 was enacted has been due to the transition of children with special health care needs from traditional fee-for-service into managed care. Although an important milestone in the program’s evolution, the movement of these children into RItE Care has not fully addressed one of the central issues affecting the children with special health care needs population (CSHCN) - the complex and costly system for providing behavioral health care services noted earlier.

Since 2000, state officials have expressed concern over whether the CSHCN population is receiving the appropriate level and kind of behavioral health services and in the right setting. These concerns became more pronounced once the transition to RItE Care began and it became clear that the costs for behavioral health services were driving the increase in expenditures for the entire population, both those covered through RItE Care and in fee-for-service Medicaid.

For example, from SFY 2004 through SFY 2006 the average per person costs for children in all four coverage groups in the CSHCN population increased at an annualized rate of 2.7 percent for “in plan” services. By contrast, the annual rise in cost for out of plan Medicaid services was 7.8 percent, nearly all of which was attributable to behavioral health services. Note that most behavioral health services are coordinated but not covered out-of-plan services in RItE Care and that the highest utilizers of these services in the CSHCN population, children in residential placements and institutions, are not permitted to enroll in managed care or are no longer covered by the plan once they enter these settings. The differences in how behavioral health services are provided and paid for through Medicaid (in plan v. out of plan;

48 Income Level Monthly Family Premium: 150% - 185% FPL= \$61; 185% - 200% FPL= \$77; 200% - 250% FPL = \$92

49 See also: Kaye, N. and K. Wyses. *Using Medicaid to Cover the Uninsured: Medicaid Participant Buy-In Programs*, (National Academy of State Health Policy, May 2003.)

50 Although about half of the states have established premium assistance programs through Medicaid, RItE Share has some characteristics that set it apart including: qualifying almost all health insurance plans offered in the current Rhode Island market for participation in the program; providing all Medicaid benefits and co-payments not covered in an enrollee’s ESI coverage once enrolled in RItE Share; and using an aggregate cost-effectiveness test (employer-based rather than family-specific).



managed care v. fee-for-service) have made it difficult for the state to determine whether the behavioral health needs of these children are being met in the most appropriate and cost-effective manner and setting.

To shed light on these issues, several groups of stakeholders have been convened over the last several years to examine the opportunities to improve the continuum of care for behavioral health services for children. In 2005, the Rhode Island General Assembly directed the DCYF and DHS to work together to design a continuum of care that: (1) encourages the use of service alternatives to psychiatric hospitalization; (2) reviews the need for and utilization of each service in order to better match services and programs to the needs of children and families; and (3) continuously improves the quality of and access to services.

A report produced by this collaboration found that the state's system for providing behavioral health care is fragmented and lacks a cohesive overarching policy.⁵¹ The report indicated that, as a result, a disproportionate number of children are being inappropriately hospitalized or allowed to languish in 24-hour treatment settings due to poor transition planning and the lack of step-down and community-based alternatives. Also noted was the need for a continuum of care for children's behavioral health services that promotes the use of alternatives to hospitalization, emphasizes family supports and reviews/manages the utilization of services relative to the needs of each child and family. To move the Medicaid program in this direction, the report set forth a series of options to fundamentally change the system for providing behavioral health services for state policy makers to consider.

In response to continuing growth in behavioral health expenditures in the CSHCN population in both SFY 2006 and 2007, and increased concern about whether beneficiaries were able to access the right types of service in the right setting, state policy makers made the decision to take action on one of the options presented in the report. In February 2007, under the direction of the Secretary of the Executive Office of Health and Human Services, the DHS and DCYF began implementation of an initiative designed to transform children's behavioral health service delivery into an integrated system. Key components of this newly redesigned system are noted in Table 23.

Table 23: Key Elements of Integrated Behavioral Health System Initiative

- Establishment of a Care Management Entity (CME) for the highest need children: For the several hundred (e.g., 250-300) high-risk/highest-need/highest-cost children and youth with serious emotional, behavioral and mental health needs. The CME will be responsible for assuring a full continuum of medically necessary physical and behavioral health services as well as non-medical social/child welfare services.
- Move behavioral health services that are currently "Out of Plan" into the Rite Care contracts. Contracts with the Rite Care health plans will be amended to move the out-of-plan behavioral health services in-plan. The health plans would then be single accountable entities responsible for providing a comprehensive array of medically necessary behavioral health preventive, diagnostic and treatment services including CIS, residential treatment, and home based therapeutic services (HBTS). This includes the core Rite Care contracts as well as the contracts for substitute care children and other CSHCNs.
- For children in fee-for-service Medicaid - contract with an accountable behavioral health managed care organization for behavioral health services: The state will contract with a behavioral health managed care organization for the delivery of the comprehensive array of medically necessary behavioral health services. Medically necessary physical health services will not be the responsibility of the managed care organization and would continue to be paid through Medicaid FFS.

Medicaid for Adults

In the adult population, Medicaid only serves a person after they have been found to have a severe and permanent disability or have reached age 65. A survey of working age adults with disabilities on Medicaid conducted in 2004 found that the average number of major diagnoses was three per person;⁵² data presented earlier in this report indicates that elders enrolled in Medicaid also have multiple diagnoses. Realizing that almost everyone in these two categories has a chronic condition, the state began implementation of several

⁵¹ EOHHS, "Report to the Governor and the General Assembly on Development of a Continuum of Children's Behavioral Health Programs". (February 1, 2006)

⁵² Op Cit.



initiatives that focus on achieving the optimal health of beneficiaries while, at the same time, maximizing the number of high quality services available to them. Though rising costs have also been a factor driving change in programs serving adults with disabilities and elders, it has been these larger concerns - service access, quality, and choice of care setting - that have prompted the systemic reforms outlined below.

Care Management for Adults with Disabilities and Elders

In 2002, the state initiated the first of several important program changes designed to improve the coordination of services provided to Medicaid beneficiaries 21 years of age and older who live with chronic and disabling illnesses and conditions. As indicated in Table 24, the focus of these initiatives has been to promote wellness and better health through care management and service coordination while, at the same time, to increase the range of delivery options available to adults with disabilities and elders living in the community.

Table 24: Medicaid Chronic Care Management Initiatives for Adults with Disabilities and Elders

- **Connect CARRE Program:** Implemented in 2002, Connect CARRE is a voluntary care management program developed in response to concerns about the cost and quality of care for fee-for-service Medicaid adults with disabilities and elders. The goals of the Connect CARRE Program are to: improve wellness of chronically ill beneficiaries by facilitating greater self management and advocacy; nurse case management interventions; shift care from the more costly inpatient settings to the community and ambulatory settings when appropriate; increase access to behavioral health services and supports; and improve disease specific medication compliance.
- **ConnectCare Choice:** Scheduled to begin implementation in the Spring of 2007, Connect Care Choice is a care management and wellness program that uses a Primary Care Case Management (PCCM) model of delivery. Building on the strengths of the Connect Carre program, but targeted to those at lower levels of medical risk, the program will provide an enhanced benefit package including access to community based Nurse Care Managers. The participating physicians must meet a strict set of contracting standards to be sure they offer the full benefit of a Medical Home. In exchange for meeting the standards and providing timely reports on patient care, physicians will receive an enhanced reimbursement.
- **Rhody Health Partners:** A comprehensive managed care option for adults age 21 and over, Rhody Health Partners will offer fully integrated preventative, acute and post acute care services to beneficiaries without another source of coverage. Through contracts with established health plans, individuals will undergo initial health screening, then receive the full complement of coordinated health benefits. Although long-term supports may eventually be incorporated within plans, they will initially be carved out. Participation in the program will be optional for beneficiaries and is expected to begin in the Fall of 2007.

Long Term Care Transformation

Beginning in 1998, Rhode Island stakeholders including all health and human services departments, providers, consumer and family representatives from all parts of the long term care sector have convened multiple times to develop a shared vision for long-term care that included concrete action steps to move to create a responsive system predicated on consumer choice, quality and responsible financing. This effort culminated in a proposal calling for the implementation of a consumer-centered, integrated system of care known as Living RIte. Although Living RIte was targeted at both acute and chronic care, the proposal's central goal was the "establishment of a dynamic long-term care system that supports quality, independence, choice and the coordination of services with the necessary public and private funding."⁵³

In the years since the Living RIte initiative surfaced, the state has conducted two comprehensive reviews of publicly financed long-term care, established a legal framework for revamping the system, and pursued and received a number of grants to fund the development of a strategic plan to guide the implementation of reform and a process for seeing it through.

Along the way, certain features of the original Living RIte proposal have been adopted, while others

53 Long-Term Care Shared Vision Consensus, October 29, 1998.



have been abandoned or adapted to accommodate advances in health information technology, shifts in state and federal policy priorities and changes in the way Medicaid funded services are organized, financed and delivered. However, the goal of long-term system reform, first articulated in Living RIte, largely remains the same.

One of the chief objectives of long-term care reform has long been to ensure that individuals with chronic and disabling conditions are able to maintain their independence and obtain the integrated services they need in the least restrictive living arrangement possible, preferably in their own homes. Once Rhode Island's only large ICF/MR was closed along with the state psychiatric hospital in 1994, most efforts geared toward deinstitutionalization have revolved around nursing facility transitions and the prevention of long-term stays. A recent proposal to expand the scope of these efforts to include the state's long-term care hospital, Eleanor Slater, will bring further systemic change and in an area where transitions and prevention of long stays is particularly difficult.

A summary of the major Medicaid related initiatives that have shaped and/or have facilitated reform efforts are outlined in Table 25.

Table 25: Summary of Medicaid-related Long-Term Care Initiatives

- **Real Choices Systems Transformation Grant (RCST):** A five-year grant awarded to the state in 2006 targeting elders and adults with disabilities on Medicaid who receive long-term care supports. The goal of the grant is to implement the state's strategic plan for long-term care reform designed to improve access to LTC supports, develop and institute a comprehensive quality management system, and establish and maintain an effective financing system for LTC supports. The RCST grant supports and furthers the goals of the state's two other RCST grants focusing on ensuring Medicaid beneficiaries receive the care they need in the most appropriate and least restrictive setting.
- **The 2006 Long Term Care Reform Act:** Known as Perry-Sullivan Reform, the Act established a mandate and framework for making several major changes in the state's long-term care system which directly affect Medicaid. The most significant of these changes relates to transitional efforts and the reinvestment of any Medicaid savings derived from reduced nursing facility days directly to home and community-based services. Based on estimates of first year savings, the state has submitted requests to CMS for three 1915(c) waiver amendments (Aged and Disabled, Habilitation, and PersonalChoice) to add Community Transitional Services, and additional waiver slots in community-based settings where current capacity has been reached.
- **Consumer-Directed Care:** Rhode Island received a Robert Wood Johnson Foundation Cash and Counseling grant in 2004, to develop and implement a new statewide cross-population consumer-directed program. Since 1986, Rhode Island has had a 1915(c) fee-for-service consumer directed waiver targeted to those with hemi- or quadriplegia operated by an Independent Living Center. During 2006, the original waiver was phased out while a new Independence Plus 1915(c) waiver (entitled PersonalChoice) that features budget and employer authority was phased in. The PersonalChoice waiver is expected to eventually include approximately 450 people (more than 10% of the state's nursing facility level of care waiver population), and is available without any waiting lists to anyone meeting the appropriate level of care.
- **PACE:** The Program for All-Inclusive Care for the Elderly or PACE program coordinates and provides comprehensive, primary, specialty, and preventative medical care, as well as community support and social services enabling older individuals to continue residing in the community. The Department of Human Services in collaboration with the Department of Elderly Affairs and the University of Rhode Island worked together with CareLink, a non profit management service organization, to establish a PACE Program in Rhode Island. The PACE Program began enrolling beneficiaries on December 1, 2005.

Federal Deficit Reduction Act of 2006

Concern over rising Medicaid costs at the national level has also created new programmatic opportunities for the states on the federal side that in some ways serve as a counterbalance to the challenges posed by the additional oversight discussed earlier. In particular, the Federal Deficit Reduction Act (DRA) of 2006 affords states the flexibility to tailor certain aspects of their programs through the state plan amendment process that, in the past, would have necessitated Secretarial approval of a formal waiver

request - e.g., imposition of cost-sharing, alter benefit packages, tighten eligibility, and expand home and community based services, etc. Even though federal approval is still required for such amendments, the criteria for authorization are much less restrictive.

Congress recently succeeded in curtailing the flexibility granted to the states by the DRA in certain areas, despite the commitment of President Bush to push for further Medicaid reforms. Indeed, in President Bush's proposed budget for the next fiscal year, the states are given a variety of new programmatic options, including using Medicaid disproportionate share funds to subsidize commercial health coverage for the uninsured. Table 26 lists the Medicaid initiatives related to the DRA that the state was required or opted to pursue in SFY 2007 and SFY 2008.

Table 26: RI Medicaid Initiatives Under the DRA

Initiative	Required/Optional by Under Federal Law	Implementation Status/ Impact
Verification of citizenship	Required	Implemented January 1, 2007
RI False and Fraudulent Claims Act	Optional	Enacted June 2007
Long Term Care Partnerships	Optional	Implementation Underway
Medicaid Integrity	Required	Enacted June 2007
LTC - Transfer of Assets Reforms	Required	Implemented February 2006
LTC - Caps on Home Equity	Required	Implemented January 2006

Making Health Insurance Affordable and Accessible

Since 2001, state policy makers concerned about rising Medicaid costs and the decline in access to employer-sponsored insurance have begun to look more carefully at their relationship to one another and, more generally, to the availability of affordable health insurance coverage in Rhode Island. As a result, there are a variety of health reform initiatives and proposals in play with the potential to influence the scope and costs of the Medicaid program in the future.

Health Care Agenda for Rhode Island

In October of 2005, Governor Carcieri announced an agenda for reforming the state's health care system. The Governor's agenda reaffirmed several of the key goals established in the Health Care Act for Children and Pregnant Women of 1993 and in the Health Reform Act of 2000, and added several others related to health information technology, promoting wellness and promoting value-based health care purchasing. The Governor's five initiatives, including the goals of each, are:

- **Wellness** -- By 2010, achieving the first "Well State" designation in the country by the Wellness Councils of America and cutting in half the number of Rhode Islanders with unhealthy and unsafe habits.
- **Balanced Health Care Delivery System** -- By 2010, having a health care system with more emphasis on primary care and a balanced deployment of hospital-based and specialty care resources.
- **Anywhere, Anytime Health Information** -- By 2010, the majority of Rhode Islanders will have health information accessible electronically.
- **Affordable Small Business Insurance** --By 2010, the number of small business employees enrolled in employer-sponsored health insurance will be increased by 10,000, or 15 percent.
- **Smart Public Sector Purchasing** -- By 2010, reduce the rate of growth of the State's medical expenses by two percentage points, improve health plan performance, and utilize value-based contracts to drive changes in the health care delivery system.

In the years since the agenda was first announced, state policy makers in the executive and legislative branches have worked together to bring several important items to fruition, including establishment of a low cost wellness health benefit plan that must be offered to employers by all health insurers with



businesses in the small employer and individual health insurance markets. In addition, the state has pursued and received a number of grants from the federal government and foundations that support on-going efforts to build the infrastructure for an electronic health information system that is user friendly, secure and capable of delivering high quality and accurate data to consumers, providers and payers.

Affordable Health Insurance

Whether, and the extent to which, these and other health care reform initiatives under consideration will affect the Rhode Island Medicaid program depends in large part on the path the state ultimately chooses to address the issue of affordable health insurance. The EOHHS, Office of the Health Insurance Commissioner (OHIC), and Department of Human Services are currently reviewing the state's options for making cost-effective health insurance coverage available for all Rhode Islanders.

As in many other states that have focused on this issue, there is a broad based consensus in Rhode Island that expanding access to affordable coverage is necessary to stem the growth in the rate of the uninsured. There is also significant agreement that the state can and should play a role in this process. The difficult questions, thus, have been: (1) how to subsidize coverage for those who "go bare" due to lack of resources, and; (2) what is the responsibility of each individual and employer for health insurance coverage. For the purposes of this report, the more germane question is: what role can and should the Medicaid program play, given current fiscal constraints, while preserving coverage for those Rhode Islanders who have the greatest need?

In response to these questions, the state has established that any system for making cost effective health insurance coverage accessible to all Rhode Islanders must meet the following objectives:

- Requires private investment in affordable coverage.
- Promotes products and benefits that address the underlying cost of health insurance in Rhode Island.
- Minimizes the pressure on government to assume full financial responsibility for providing coverage to the increasing population of uninsured Rhode Islanders.

Legislation was introduced by the OHIC in February of 2007 authorizing the DHS to request a Medicaid waiver permitting the state to expand coverage to adults without children, and families with income up to 400 percent of the FPL, providing sufficient funds are appropriated. It appears that if and when the funds become available, Medicaid may be an integral component of any initiative to extend coverage to the uninsured. Recent census data indicates that 78 percent of uninsured Rhode Islanders have income under 300 percent of the FPL. Many of these individuals will not be able to afford health coverage without Medicaid involvement or some other mechanism for providing public support.





Part IV: Findings And Recommendations





Section I. Findings And Implications For Medicaid

There are several important decisions about Medicaid the state needs to make when choosing which path to pursue going forward. These decisions will be based on the answers to a number of critical questions, including:

- What role should Medicaid play in providing access to quality, affordable health care?
- How “consumer-centric” should Medicaid be?
- How much “capability” should be built inside state government to manage the Medicaid program?

In searching for the answers to these questions, the following findings of this study and their broader implications need to be considered carefully:

- Medicaid has evolved as both a payer and purchaser into a financing vehicle for acute care and long-term care services for Rhode Islanders.
- Significant budget constraints on the state level are likely to continue for the foreseeable future.
- Medicaid performs well, but needs to be transformed to achieve the flexibility necessary to enhance access and quality while containing costs.
- Any efforts to facilitate transformation must overcome a number of structural impediments inherent to the Medicaid program.

Figure 1: Medicaid finances and/or underwrites acute care and long-term care health coverage and services for a significant segment of the state’s population.

As the Medicaid program has transformed from a safety net program into a payer and purchaser of health care services for over 200,000 Rhode Islanders, its impact on the health care system, the state’s budget and the larger economy has become substantial. Today, the program provides coverage to a significant segment of the state’s population, many of whom would be otherwise unable to afford or obtain health insurance. In addition, Medicaid money drives both system design and capacity in several service categories and among certain service providers. Given the breadth of the program’s reach, any significant reductions in Medicaid enrollment or expenditures without concurrent efforts in other areas such as expanding affordable health insurance options will only exacerbate the increasing problem of the uninsured.

Over the last ten years, the state has endeavored to leverage the Medicaid program’s considerable financial power in the health care market place by utilizing value-based purchasing when feasible on the acute and post acute care side and, more recently, by implementing global-based budgeting on the long-term care side. Although these efforts have improved the quality and cost-effectiveness of Medicaid coverage and services in many areas, the rate setting and reimbursement system is one of several factors that has prevented the state from using its financial leverage to obtain greater value and achieve better outcomes program wide. As indicated below, the fragmented way in which the state budgets and administers Medicaid has also hamstrung these efforts by making it difficult to assess where and how well the health care dollars available are being spent.

Proposals to initiate a comprehensive reform to the state’s existing Medicaid rate-setting and reimbursement scheme have generally met with resistance from stakeholders concerned that payment levels will decline. Accordingly, the state has opted to pursue incremental changes that either alter the payment methods/rates set in law at the margins or by-pass them entirely through contracting, both of which incur other costs. The analyses presented in this report indicate that, to leverage Medicaid’s financial power to meet the challenges ahead, a more pro-active approach to rate/reimbursement reform is necessary.



Figure 2: Medicaid will continue to exert significant pressure on the state budget and state budget constraints will continue to influence Medicaid's role in the health care system.

Recent history and forecasts suggest that Medicaid will remain at the forefront of state budget discussions for the foreseeable future, both because of its size and the increasing portion of state dollars involved. As the budget process is currently configured, decisions about Medicaid are typically reactions to growth in the program's costs given general revenues estimated and collected. Reducing the pressure to fill the gap between the growth in Medicaid costs and general revenues requires that the state address the factors driving the continued increase in Medicaid program expenditures -- utilization, reimbursement and service setting.

The information on cost drivers included in this report highlight areas where concerted action by the state has the potential to stabilize the Medicaid program in the short term. As discussed above, changing the rate-setting and reimbursement system to enhance the state's flexibility and leverage on the financing side can assist in containing costs while promoting quality. To address the case mix and utilization factors, the state could benefit by establishing an EOHHS team of clinicians and agency officials to carefully review the care provided to high cost beneficiaries to ensure they are receiving the appropriate mix of services in the most cost-effective setting given their needs.

In short, changing the emphasis in what is monitored by policy makers - legislative and executive - and managed at the department level - to focus on these factors would provide the state with the opportunity to target more directly the root causes of Medicaid spending growth rates rather than their symptoms.

Figure 3: Although the Medicaid program performs well, there are several areas that need increased attention when considering long-range demographic trends and whether or not Medicaid is the appropriate platform for assuring access to affordable health insurance in Rhode Island.

A number of key services paid for by Medicaid exhibit high levels of patient satisfaction and good health indicators. Additionally, Medicaid spending growth rates, while significant, have been below private sector and State Employee Health Benefit Plan (SEHBP) rates. However, utilization of some services appears high compared to national norms, appropriate settings may not be utilized for some services, and a very small number of cases represent a substantial portion of total spending overall in certain populations.

Unfortunately, high cost cases do not easily lend themselves to traditional risk-based managed care approaches. The EOHHS team approach mentioned above is an option in the short-term. Overall, however, the administrative and management arm of the Medicaid program does not have the resources or capacity as currently configured to manage high-cost cases on a routine basis. For example, health information systems, while advancing, have not yet reached the point where it is possible to review all the relevant medical and social data affecting the level of Medicaid care/services provided to beneficiaries across populations. This, in turn, makes it difficult to evaluate services and assess outcomes - two of the critical steps in effective care management. Thus, where to build the capacity to better manage care and how it will be financed are crucial issues that the state must address in moving forward.

Of equal importance is whether Medicaid is the appropriate vehicle for dealing with the growing number of uninsured Rhode Islanders in light of demographic trends, particularly the expansion in the number of Medicaid eligible elders as the baby boom ages and the rising percent of the uninsured that are low-income. The report shows clearly that Medicaid expenditures for the elderly are substantially higher than for other populations as a significant number are served in the nursing home setting. Containing the costs for the elderly population by delaying or preventing the transition of beneficiaries from the community into the institutional setting is and must continue to be a priority going forward. Similarly, forecasts presented in the report are based on current eligibility levels. The financial picture for Medicaid in the future must be re-assessed when going forward with any affordable health insurance initiative to take into account recent data showing that the overwhelming majority of the uninsured today have income



under 300 percent of poverty and, as such, are likely to be Medicaid eligible.

Figure 4: Any efforts to transform Medicaid must overcome the structural limitations inherent to the program.

Medicaid currently has significant power to transform the way some health services are delivered, particularly in long-term care, because of the amount of buying power it represents. The state does not have the same leverage in the acute setting, even though the size of the population covered is quite large. The state's ability to harness the purchasing power it does have is complicated by many factors, including two that have already been discussed here: (1) the myriad of government agencies, various programs and waivers, eligibility characteristics, and contracting and payment methods that utilize Medicaid as their principal financing mechanism; and (2) the lack of clear information transparent across departments about the service needs of beneficiaries and whether there is sufficient capacity available in the system to meet those needs. The joint federal-state funding scheme for Medicaid, the state's narrowly focused caseload-cost estimating process, the shifts in federal policy and funding priorities, and the vast network of providers involved in the program are all also factors that have, or have the potential to, influence the success of efforts to transform Medicaid in the years ahead. And last, but just as importantly, the number of new initiatives and activities that must be implemented to transform Medicaid may sap so much of the program's management capacity that ongoing operating issues may suffer. It is critical to note that these structural limitations are not unique to Rhode Island. State Medicaid programs nationwide are struggling to overcome the same or similar obstacles to systems transformation.





Section IX: The Future of Medicaid

In assessing the prospects for the Future of Medicaid, there are a few key operating principles, derived from the findings of this study, that should be considered when weighing the options:

- “Take care of the people with no other options first”
- “Right service, right setting, right time, right result”
- “For everyone a medical home with all the necessary information”
- “Leverage all available money”
- “Remember the taxpayer”

Medicaid is, at base, a health care program for those without access to coverage and services. Over time, as a result of federal waivers, state plan amendments and other approaches Medicaid in Rhode Island has become the basis for providing access to health insurance to a large number of citizens. Before any major expansion is considered, the state’s obligation is to the mandatory populations Medicaid serves. The economic reality is, though, that limiting or rolling back eligibility to the state’s optional coverage groups is not feasible at this time; with so few health coverage alternatives available due to the high cost of commercial health insurance, these optional groups are, as a matter of fact, mandatory from the state’s perspective.

Medicaid needs to ensure that beneficiaries have access to the right service when it is needed. However, Medicaid needs to pay equal attention to making sure services are delivered in the appropriate setting and that the right results are being obtained. To make this possible, it is necessary to increase the use of assessments to gauge service needs and of information systems to support tracking of patient care and to develop and implement performance and outcome measures.

Medicaid’s design can be used to leverage funds from sources other than state government. State funds are already leveraged by federal funds. As RIte Share has shown, Medicaid can be used to keep private sector money in the acute care insurance system. Similar consideration needs to be given to how to use Medicaid to further leverage private sector and personal resources for both acute care and long-term care financing.

Medicaid consumes a significant portion of state resources and will continue to in the future. The extent that Medicaid is allowed to grow substantially faster than general revenue growth over other equally important programs will be “crowded out.”

What Does Medicaid Look Like Going Forward

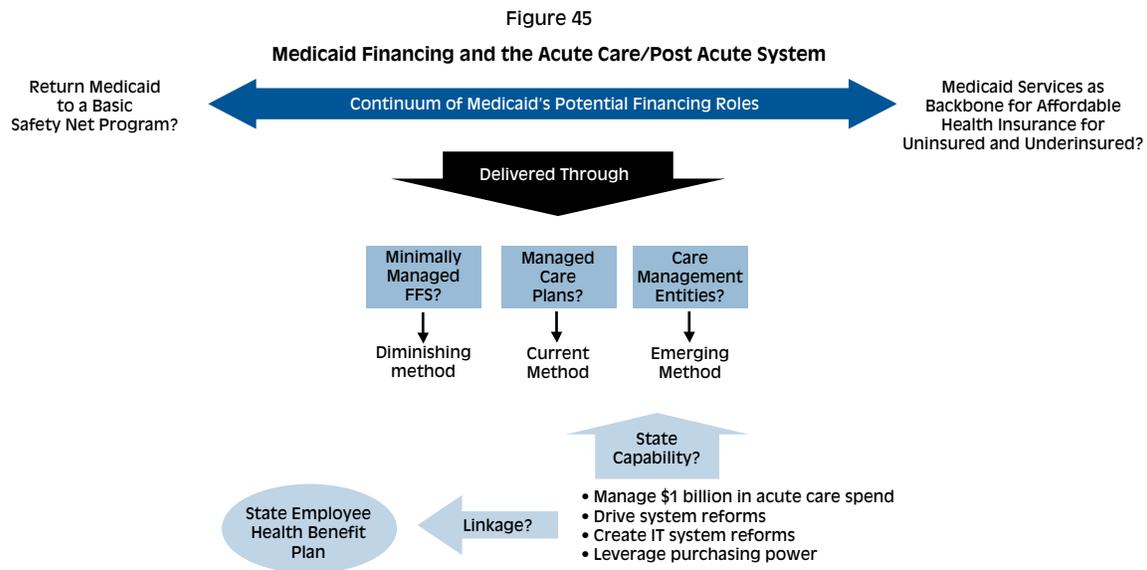
As described earlier, Medicaid is a financing mechanism for two key health care systems: the acute care system and the long term care system. For some of the Medicaid populations there is overlap between the two due to their chronic medical conditions. However, Medicaid pays for services in some cases where it is the least significant payer; in these circumstances, its ability to influence the care delivery model is limited. It is important for Medicaid to plan within the realities of the larger context in which these acute and long-term care systems operate. The characteristics of the two systems are so sufficiently different that separate consideration is necessary to show the important role they play with respect to one another and the larger health care system.

Toward these ends, what follows describes a vision for the two systems over the next decade as the state prepares for the challenges of meeting the medical needs of the baby boomers. It is intended as the

beginning of a discussion about which path Medicaid in Rhode Island should pursue and what types of initiatives must be implemented to transform this vision into a reality.

Medicaid and the Acute/Post-Acute Care System

Figure 45 provides a graphical representation of the framework of decisions to be made regarding the future of Medicaid within the acute care system.



The key initial decision point for state policy makers concerns the depth at which Medicaid penetrates the uninsured population and provides a financing vehicle for their health care. Additionally, Medicaid can also address the need for an affordable health insurance product. Although the specifics can vary and significant work needs to be done to actually implement such a program, Medicaid can either provide a “subsidy” or directly pay for an “insurance” product. In all likelihood, the state will have to utilize both mechanisms irrespective of whether policy makers choose a comprehensive or a segmented needs-based approach to achieve greater access to affordable health insurance.

Work underway focusing on this issue as part of the Governor’s health care agenda has taken several first steps: developing and requiring the marketing of an affordable wellness insurance plan, proposing legislation that provides the authority for an expansion of Medicaid to cover uninsured adults, building the infrastructure for health information exchanges, etc. The financing issues remain unresolved, however. As a result, the future of the affordable health insurance effort is very much tied to the future of the Medicaid program.

The data presented in this report indicate that in any future program financed all or in part by Medicaid, service utilization needs to be subjected to some form of care management. Depending on the nature of the care management model, flexibility may need to be provided in areas such as reimbursement methodologies to make sure that they remain consistent with contemporary clinical practices. Additionally, a system of reimbursement needs to be developed to support preventive/well care and chronic care management that is separate from traditional models of reimbursement.⁵⁵ Moreover, a true “medical home” needs to be created that provides care managers or physicians with the appropriate information and tools to manage all aspects of a patient’s care.⁵⁶ Incentives should be linked to successful care management

⁵⁵ Chronic Care Sustainability Initiative is developing potential models.

⁵⁶ The Patient Experience Lab of the Business Innovation Factory has developed some interesting concepts of what a true “medical home” should look like and be able to do.



rather than putting primary care medical homes directly at risk for patient utilization. Gain-sharing linked to successful management rather than risk-sharing should be considered.

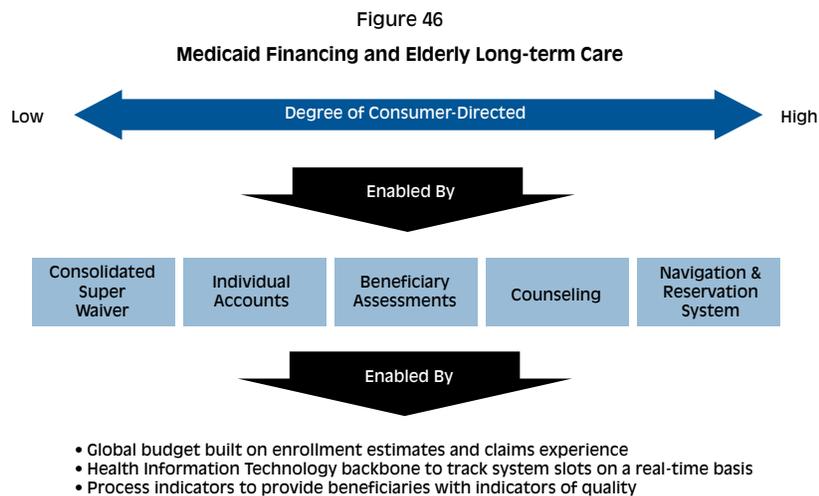
This, in turn, triggers the next major question: should the state develop the capacity to manage the care it finances? Presently, the state out sources this activity to the health plans for the RItE Care population and, to a lesser degree, uses a primary care case management model for segments of other populations. Conceptually, it is possible for the state to develop its own care management program and become a *de facto* managed care organization, in theory this would allow state taxpayers to recapture the profits generated by care management entities and reinvest any savings generated from care management into the state budget.⁵⁷ Doing so while possible, would require a significant investment in state capacity - people, expertise and systems.

When Medicaid is viewed with the state employee health benefit program, nearly \$1 billion is presently spent by the state on the acute care system each year. Therefore, a subset of this question is how tied should Medicaid acute care reforms be to the State Employee Health Benefit Plan (SEHBP), if at all. Linking to the SEHBP provides both financing vehicles with significantly more purchasing power, thus enabling system reform through market forces driven by contracting rather than regulation.

However, pursuing this type of Medicaid reform has significant consequences and raises an array of challenges. State personnel rules and pay scales may need to be changed. Incentive structures would need to be put in place for case managers. Information technology investments would also be necessary. However, the state is already pursuing several of these changes, particularly smart purchasing and health information technology, as part of the Governor’s broader agenda for health care system reform.

Medicaid and the Long-term Care System

Figure 46 provides a graphic representation of the framework of decisions that need to be made about the future of Medicaid within the long-term care system. This discussion is specific to the elderly population within Medicaid. However, the underlying principles represented in this proposal also apply to other long-term care populations, such as adults with disabilities.



The basic premise here is that the consumer should be at the center of the long-term care system and that the money for services should be attached to the consumer. The key question for consideration is to what degree. In theory, “money follows the person” today since payments are made when a beneficiary accesses the service; in practice, however, available slots are centrally controlled and line items are created

⁵⁷ Vermont has developed a similar program. NYC Health and Hospitals Corporation has developed a managed care entity.



for provider categories rather than beneficiaries.

An alternative system that is truly consumer-driven would be one in which money is budgeted based on anticipated enrollment and then distributed to an account providing long-term care recipients with an individualized budget. Prior to the development of the budget as a person nears entering the long-term care system an assessment is made to evaluate their level of need and assistance. This would trigger an individualized care plan and establishes a budget controlled by the beneficiary. The navigation and reservation system - identifying where necessary services are available and how to obtain them -- streamlines information flow to determine what services are available in what areas using real-time information. Counselors or designated caregivers give advice and make reservations in the system.

Medicaid would still be responsible for setting and establishing payment rates to providers. It would also define to a degree the benefit package. Additionally the state would be responsible for all quality and regulatory issues. And, to be determined regular assessments would be conducted to ensure that the budget accurately reflects the needs of the individual beneficiaries.

This type of model poses a number of issues for consideration. The following must remain at the forefront of consideration when looking to create a model similar to the one just described:

- Efficiency of services and labor utilization
- Number of eligible enrollees
- Ensuring that emergency flex capacity is available
- Industry restructuring and transition
- Absorptive capacity and scale up of new services
- Regulation and caps on high cost institutional services
- Investment funds for the enabling navigation and reservation system

Several operational issues would need to be considered:

- Implementing a global budget built on enrollment and actuarial estimates based on claim patterns
- An IT backbone operating on a real-time basis
- Use of process indicators to provide measures of quality and performance about qualified vendors
- Instituting reimbursement methods that allow and support price-based payment rather than cost-based reimbursement



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