

## **FY 2003 State Budget - Part II**

### **Medicaid Expenditures and the RItE Care Program**

*This RIPEC Comments is the second part of RIPEC's analysis of the FY 2003 State Budget. It presents an analysis of the State's Medicaid budget and focuses on RItE Care, Rhode Island's Medicaid Managed Care Program, and RItE Share. Part I was published in April 2002 and includes an overview of the Governor's FY 2002 Revised and FY 2003 Budget request along with RIPEC's Comments on the overall fiscal plan. Part III will review Rhode Island's debt and the proposed bond referenda questions.*

#### **Highlights**

Total Medicaid spending of \$1.4 billion in FY 2003 represents nearly 27.0 percent of the State's total budget. Approximately \$650 million (45%) of the Medicaid budget is supported with general revenues and the \$780 million (55%) balance is from Federal funds.

Rhode Island Medicaid expenditures (adjusted for inflation) totaled \$1,220.0 million in FY 2000. In FY 2003, expenditures are expected to increase to \$1,431.4 million - a 17.3 percent (\$211.4 million) increase over that time period. Of the \$211.4 million increase, nearly 61.0 percent was attributable to additional Managed Care spending.

Managed Care (primarily RItE Care) accounted for \$208.2 million or 17.1 percent of the statewide Medicaid expenditures in FY 2000. For FY 2003, the Governor proposes expenditures for Managed Care in the amount of \$334.6 million, accounting for 23.4 percent of total Medicaid expenditures.

Expenditures for RItE Care (adjusted for inflation) increased from \$207.0 million in FY 2000 to an estimated \$332.9 million in FY 2003. From FY 2000 to FY 2003, expenditures increased by \$126.0 million, or 60.9 percent. RItE Care enrollment increased from 70,147 persons in FY 1996 to an estimated 132,500 persons in FY 2003. The increase in enrollment has principally been driven by state policies that have expanded both age and income eligibility thresholds.

Prescription drug expenditures (adjusted for inflation) grew from \$75.3 million in FY 2000 to an estimated \$106.3 million in FY 2003, a 41.1 percent increase. Pharmacy expenditures as a percentage of total Medicaid expenditures grew from 6.2 percent in FY 2000 to an estimated 7.4 percent in FY 2003.

## I. Overview of Medicaid

Grants and benefits to individuals represent the largest category of expenditures in the State operating budget. In FY 1996, grants and benefits represented 44.0 percent of total expenditures (expressed in 2003 dollars) and remained at that level in FY 2003 (43.6 percent). Grants and benefits include expenditures related to Medicaid, childcare and TANF as well as other income support programs administered by the State. In Rhode Island, all grant and benefit expenditures increased from \$1,873.6 million in FY 1996 to \$2,330.7 million in FY 2003, representing a \$457.1 million increase over the seven-year period, or 42.2 percent of the net increase in total spending statewide. Of the \$457.1 million increase (adjusted for inflation) in net spending from FY 1996 to FY 2003, about \$211.4 million, or 46.3 percent, were attributable to Medicaid expenditures.

**Table 1**  
**FY 1996 - FY 2003 Total State Expenditures by Category**  
**All Funds - Adjusted**

<b>Fund</b>	<b>1996 Actual</b>	<b>Percent of Total</b>	<b>2003 Proposed</b>	<b>Percent of Total</b>	<b>Increase</b>	<b>Share of Increase</b>
Personnel	\$1,113.6	26.1%	\$1,289.8	24.1%	\$176.2	16.3%
Operating	338.6	7.9%	358.6	6.7%	20.0	1.8%
Local Aid	634.7	14.9%	982.6	18.4%	347.9	32.2%
Grants & Benefits	1,873.6	44.0%	2,330.7	43.6%	457.1	42.2%
Capital & Debt Svs.	301.8	7.1%	382.6	7.2%	80.8	7.5%
<b>Total</b>	<b>\$4,262.3</b>	<b>100.0%</b>	<b>\$5,344.4</b>	<b>100.0%</b>	<b>\$1,082.1</b>	<b>100.0%</b>

Source: State Budget Documents - FY 1996 and FY 2003, and RIPEC calculations (Expressed in 2003 Dollars, based on CPI).

Given the State's deteriorating fiscal conditions and the increase in spending from Medical Assistance programs, this RIPEC *Comments* presents a comprehensive analysis of the State's Medicaid budget. It should be noted that this is the first time a consolidated Medicaid budget for all departments for out years has been published.

Many factors drive Medicaid expenditures. It would be beyond the scope of this RIPEC *Comments* to analyze all growth areas. However, its intent is to give an overview of Medicaid and focus on Rite Care and Rite Share, two recent initiatives within Medicaid. As discussed in this report Rite Care enrollments grew over 65.0 percent between FY 1996 and FY 2002, and total Managed Care expenditures grew by 156.2 percent. Rite Care is Rhode Island's Medicaid Managed Care Program. Rite Share, which is part of Rite Care, is a State program designed to enroll eligible people in employer sponsored health insurance plans.

## **What is Medicaid**

Medicaid was established in 1965 under Title XIX of the Social Security Act. It is a federal and state matching entitlement program administered by the states and provides health care coverage to low-income adults and children. It is the chief source of funding for long-term care for individuals with limited economic means, health care services for low-income adults with disabilities, health care coverage for low-income families and their children and pregnant women and infants. Medicaid now covers 44 million Americans who would otherwise lack health insurance or other resources to pay for health care services they may need.

## **Eligibility**

Medicaid requires states to cover certain groups of individuals and allows coverage of others on an optional basis. Federal matching funds are available at the same rate for all mandatory and optional eligibility groups and benefits. Regardless of whether individuals are covered on a mandatory or optional basis, there is a certain set of mandatory benefits and another larger set of benefits that states have the option to provide. According to the Department of Human Services 2001 Annual Report, all state Medicaid programs must cover the following people:

- Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI);
- Low-income Medicare beneficiaries;
- Individuals who would qualify today for the old Aid to Families with Dependent Children (AFDC) program 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 (FPL);
- Children who are at least age five and live in families with incomes up to the poverty level;
- Infants born to Medicaid-enrolled pregnant women; and
- Children in subsidized adoptive arrangements or who live in temporary substitute placement foster care, under a federally sponsored Title IV-E program.

In addition to the federal requirement, Rhode Island has chosen to cover the following optional groups under Medicaid:

- Individuals eligible for home and community based services waiver programs;
- Low-income elderly adults and adults with disabilities;
- Children up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through the State Children's Health Insurance Program;
- Individuals determined to be "medically needy" due to low income and resources or large medical expenses; and
- Children under age 18 with a disabling condition severe enough to require institutional care, but who live at home (the Katie Beckett provision).

## II. Medicaid Expenditures and Caseloads

### National Trends

In recent years, states have experienced modest growth rates in Medicaid spending. However, the period of slow growth appears to be over, and Medicaid is once again emerging as a major budget driver. According to the National Association of State Budget Officers (NASBO) in its March 2002 report, total state spending within the United States in FY 2001 grew by 8.7 percent over the previous year, while state Medicaid spending grew by 11.6 percent during this time period. In FY 2002, total state spending is expected to grow by 6.6 percent, while total Medicaid expenditures are estimated to grow by 11.7 percent. This trend is expected to continue in FY 2003.

**Table 2**  
**FY 1996 - FY 1999 Per Capita Spending on Medicaid**

State	FY 1996		FY 1997		FY 1998		FY 1999		% Change 1996-1999
	Amount	Rank*	Amount	Rank*	Amount	Rank*	Amount	Rank*	
US**	\$459		\$462		\$527		\$664		44.7%
New England	583		602		688		878		50.5%
Connecticut	\$620	3	\$613	6	\$740	4	\$907	5	46.3%
Maine	581	6	628	5	599	8	919	4	58.2%
Massachusetts	620	4	630	4	750	3	942	3	51.9%
New Hampshire	471	17	472	20	511	22	648	16	37.6%
<b>Rhode Island</b>	<b>691</b>	<b>2</b>	<b>747</b>	<b>2</b>	<b>931</b>	<b>2</b>	<b>1,059</b>	<b>2</b>	<b>53.3%</b>
Vermont	513	10	524	11	595	9	790	7	54.0%

\* Rank within the U.S. (New York ranked first).

\*\* Figure for U.S. includes the District of Columbia.

Source: CQ's State Fact Finder 1998, 1999, 2001, and 2002, based on data from the Health Care Financing Administration (HCFA); and RIPEC calculations.

Based on data published by the Congressional Quarterly in its *State Fact Finder*, Rhode Island ranked second highest in Medicaid spending on a per capita basis from FY 1996 to FY 1999 (latest data available for a national comparison). Only New York had a higher per capita Medicaid spending. In Rhode Island, it increased from \$691 in FY 1996 (50.5 percent above the national average) to \$1,059 in FY 1999, where it was 59.5 percent above national average. It should be noted that State Medicaid spending reflects different program structures and policy choices, e.g. eligibility thresholds, as well as demographic factors and poverty levels.

On average, the New England states increased per capita Medicaid spending from \$583 in FY 1996 to \$878 in FY 1999. Compared to the New England average, Rhode Island's per capita spending was 18.5 percent higher in FY 1997 and 20.7 percent above the New England average in FY 1999.

### **Medicaid Finance**

Federal and state governments share Medicaid costs. For program administration, the federal contribution is set at 50 percent of costs in each state. For medical services, however, the federal matching rate varies among states. Each year the federal matching rate, known as the federal medical assistance percentage (FMAP) is adjusted. The FMAP is based on each state's per capita personal income relative to the nation as a whole for the three most recent years. States with relatively lower per capita incomes receive a higher federal match. The FMAP is reflected in Federal Fiscal Year and calculated two years in advance.

<b>Year</b>	<b>FFY Basis</b>		<b>SFY Basis</b>	
	<b>State</b>	<b>Federal</b>	<b>State</b>	<b>Federal</b>
1996	46.16	53.84	45.75	54.25
1997	46.10	53.90	46.12	53.89
1998	46.83	53.17	46.65	53.35
1999	45.95	54.05	46.17	53.83
2000	46.23	53.77	46.16	53.84
2001	46.21	53.79	46.22	53.79
2002	47.55	52.45	47.22	52.79
2003	44.60	55.40	45.34	54.66

Source: Rhode Island State Budget Office

The FMAP was 53.84 percent in Federal Fiscal Year (FFY) 1996 and has decreased to 52.45 percent in FFY 2002. For FFY 2003, Rhode Island is among the 23 states that will see an increase in their matching rates. Rhode Island's share of the U.S. population increased between 1999 and 2000. For Rhode Island, it will increase to 55.40 percent. The Governor's budget for FY 2003 includes approximately \$19.0 million in general revenue savings in the Department of Human Services, based on the increase in the FMAP.

Translating the Federal fiscal year into State fiscal year figures, the FMAP in FY 1996 was 54.25 percent and had decreased to 52.79 percent in FY 2002. It will increase to 54.66 percent in FY 2003.

## **Rhode Island Medicaid Expenditures**

Statewide Medicaid expenditures would increase from \$1,115.1 million in FY 2000 to \$1,431.4 million as proposed by the Governor in FY 2003 - representing a 28.4 percent (\$316.3 million) increase over this period of time.

Line Item/Depts.	FY 2000		FY 2001		FY 2002		FY 2003 Recommended		Change 2000-2003
	Amount	Percent of Total	Amount	Percent of Total	Amount	Percent of Total	Amount	Percent of Total	
Hospital-Regular	\$84.3	7.6%	\$93.2	7.3%	\$106.7	7.8%	\$97.0	6.8%	15.1%
Hospital-DSP	59.9	5.4%	102.8	8.1%	84.3	6.2%	85.5	6.0%	42.7%
Nursing Homes	245.6	22.0%	244.6	19.3%	255.0	18.7%	260.0	18.2%	5.9%
Managed Care	190.3	17.1%	231.0	18.2%	257.3	18.9%	334.6	23.4%	75.8%
Other	121.0	10.9%	155.3	12.3%	184.6	13.5%	157.8	11.0%	30.4%
Special Ed.	20.0	1.8%	26.3	2.1%	27.6	2.0%	28.9	2.0%	44.5%
Restricted Receipt	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	-83.3%
<i>Subtotal DHS</i>	<i>\$721.1</i>	<i>64.7%</i>	<i>\$853.2</i>	<i>67.3%</i>	<i>\$915.5</i>	<i>67.2%</i>	<i>\$963.8</i>	<i>67.3%</i>	<i>33.7%</i>
MHRH	\$312.6	28.0%	\$324.1	25.6%	\$348.6	25.6%	\$367.6	25.7%	17.6%
DCYF	75.7	6.8%	83.9	6.6%	92.4	6.8%	93.6	6.5%	23.6%
DOH	3.1	0.3%	3.5	0.3%	3.2	0.2%	3.0	0.2%	-3.2%
DEA	2.3	0.2%	2.7	0.2%	3.0	0.2%	2.8	0.2%	21.7%
Other	0.3	0.0%	0.3	0.0%	0.5	0.0%	0.6	0.0%	100.0%
<i>Subtotal</i>	<i>\$394.0</i>	<i>35.3%</i>	<i>\$414.5</i>	<i>32.7%</i>	<i>\$447.7</i>	<i>32.8%</i>	<i>\$467.6</i>	<i>32.7%</i>	<i>18.7%</i>
<b>Total</b>	<b>\$1,115.1</b>	<b>100.0%</b>	<b>\$1,267.7</b>	<b>100.0%</b>	<b>\$1,363.2</b>	<b>100.0%</b>	<b>\$1,431.4</b>	<b>100.0%</b>	<b>28.4%</b>

DSP= Disproportionate Share Payments  
 Note: Expenditures exclude administrative costs. DSP and Special Education payments represent payments to institutions that are translated into direct services to individuals.

Source: RI Department of Human Services, State Budget, and RIPEC calculations

However, if one adjusts for inflation based on CPI, and expresses expenditures in 2003 dollars, adjusted expenditures would increase by 17.3 percent over this period of time. Table 4 reflects unadjusted and Table 5 (on the following page) adjusted Medicaid expenditures, excluding administrative related expenditures. It should be noted that the data reflect the Governor's recommended spending levels to fiscal years 2002 and 2003.

About two thirds of the Medicaid expenditures are spent by the Department of Human Services (DHS). Within DHS, expenditures for medical assistance are primarily driven by expenditures for Nursing Homes and Managed Care. In FY 2000, adjusted expenditures for Nursing Homes were \$268.7 million and accounted for 22.0 percent of total expenditures. In FY 2003, expenditures are expected to be \$260.0 million or 18.2 percent of total expenditures. From FY 2000 to FY 2003, adjusted expenditures are expected to decrease by 3.2 percent.

Managed Care, which is primarily RIt Care, accounted for \$208.2 million or 17.1 percent of the statewide Medicaid expenditures in FY 2000. For FY 2003, the Governor proposes expenditures for Managed Care in the amount of \$334.6 million, accounting for 23.4 percent of total Medicaid expenditures. From FY 2000 to FY 2003 expenditures, adjusted for inflation, for Managed Care will rise by an estimated 60.7 percent.

In FY 2003, the Governor proposed to enroll children with special health care needs into RIte Care. Total expenditures for that population would amount to \$57.8 million and were included in the line items 'Hospital' and 'Other' in previous years. DHS estimates that enrolling these children into RIte Care would reduce total expenditures by \$4.6 million to \$53.2 million.

Line Item/Depts.	FY 2000		FY 2001		FY 2002 Revised		FY 2003 Recommended		Adj. Change 2000-2003
	Amount	Percent of Total	Amount	Percent of Total	Amount	Percent of Total	Amount	Percent of Total	
Hospital-Regular	\$92.2	7.6%	\$99.1	7.3%	\$109.8	7.8%	\$97.0	6.8%	5.2%
Hospital-DSP	65.5	5.4%	109.4	8.1%	86.8	6.2%	85.5	6.0%	30.5%
Nursing Homes	268.7	22.0%	260.2	19.3%	262.4	18.7%	260.0	18.2%	-3.2%
Managed Care	208.2	17.1%	245.7	18.2%	264.7	18.9%	334.6	23.4%	60.7%
Other	132.4	10.9%	165.3	12.3%	189.9	13.5%	157.8	11.0%	19.2%
Special Ed.	21.9	1.8%	27.9	2.1%	28.4	2.0%	28.9	2.0%	32.0%
Restricted Receipt	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	-83.3%
<i>Subtotal DHS</i>	<i>\$788.9</i>	<i>64.7%</i>	<i>\$907.6</i>	<i>67.3%</i>	<i>\$942.0</i>	<i>67.2%</i>	<i>\$963.8</i>	<i>67.3%</i>	<i>22.2%</i>
MHRH	\$342.0	28.0%	\$344.8	25.6%	\$358.6	25.6%	\$367.6	25.7%	7.5%
DCYF	82.9	6.8%	89.3	6.6%	95.0	6.8%	93.6	6.5%	12.9%
DOH	3.4	0.3%	3.7	0.3%	3.3	0.2%	3.0	0.2%	-11.8%
DEA	2.5	0.2%	2.8	0.2%	3.1	0.2%	2.8	0.2%	12.0%
Other	0.3	0.0%	0.4	0.0%	0.6	0.0%	0.6	0.0%	100.0%
<i>Subtotal</i>	<i>\$431.1</i>	<i>35.3%</i>	<i>\$441.0</i>	<i>32.7%</i>	<i>\$460.6</i>	<i>32.8%</i>	<i>\$467.6</i>	<i>32.7%</i>	<i>8.5%</i>
<b>Total</b>	<b>\$1,220.0</b>	<b>100.0%</b>	<b>\$1,348.6</b>	<b>100.0%</b>	<b>\$1,402.6</b>	<b>100.0%</b>	<b>\$1,431.4</b>	<b>100.0%</b>	<b>17.3%</b>

DSP= Disproportionate Share Payments  
 Note: Expenditures exclude administrative costs and are adjusted for inflation, based on CPI. DSP and Special Education payments represent payments to institutions that are translated into direct services to individuals.  
 Source: RI Department of Human Services, State Budget, and RIPEC calculations

The Department of Mental Health, Retardation and Hospitals (MHRH) is responsible for direct and contractual service delivery to people with disabilities resulting from either mental illness or developmental disabilities, people who require long term inpatient hospital services, and people with substance abuse problems or addictions. The department spends about 26 percent of total Medicaid expenditures. Medicaid covers outpatient and residential rehabilitative counseling services, intensive outpatient services and methadone maintenance services, including rehabilitative counseling and administration of pharmacological intervention. The Rhode Island Community Mental Health Medicaid Program offers individuals with serious and persistent mental illness treatment and rehabilitative services including counseling and therapy, crisis intervention, residential services, multidisciplinary treatment planning and assertive community treatment.

The other departments that spend Medicaid include the Department of Children, Youth and Families; the Department of Health, the Department of Elderly Affairs; the Department of Elementary and Secondary Education; and the Child Advocate.

Prescription drug expenditures (adjusted for inflation and after rebates) grew from \$75.3 million in FY 2000 to an estimated \$106.3 in FY 2003, a 41.1 percent increase. The numbers include Medicaid expenditures for outpatient fee-for-service prescription drugs.

Pharmacy expenditures as a percentage of total Medicaid expenditures grew from 6.2 percent in FY 2000 to an estimated 7.4 percent in FY 2003.

### **Medicaid Caseload Trends**

Within the United States, adults (mostly mothers or pregnant women) and children amount to nearly 74.0 percent of Medicaid recipients. Nationally, people with disabilities and chronic conditions account for approximately 16.0 percent of enrollees, and the elderly make up the 10.0 percent balance of Medicaid recipients.

Population	FY 2000		FY 2001		FY 2002**		FY 2003**		% Change 2000-2003
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total	
Adults with Disabilities	20,646	14.1%	21,707	13.6%	23,073	13.5%	24,573	13.6%	19.0%
Elderly	18,251	12.5%	18,429	11.5%	18,502	10.8%	18,594	10.3%	1.9%
Children & Families*	107,542	73.4%	119,504	74.9%	129,389	75.7%	136,900	76.0%	27.3%
<b>Total</b>	<b>146,439</b>	<b>100.0%</b>	<b>159,640</b>	<b>100.0%</b>	<b>170,964</b>	<b>100.0%</b>	<b>180,067</b>	<b>100.0%</b>	<b>23.0%</b>

\* Includes Children & Families in Managed Care, children with special health care needs and children in foster care.  
 \*\* projected figures  
 Note: The monthly caseload of Medicaid recipients is the number of individuals enrolled in a given month regardless of the length of time they were eligible (from 1 to 31 days). The average monthly caseload for the year is calculated by averaging the caseload for 12 months.  
 Source: Department of Human Services and RIPEC calculations.

Rhode Island reflects the national trend. The projected figures for FY 2003 show that 76.0 percent of the total caseload are children and families in managed care and children with special health care needs and in foster care. The percentage of adults with disabilities and elderly total 13.6 percent and 10.3 percent respectively of the total caseload. Since FY 2000, the overall Medicaid caseload increased from 146,439 to an estimated 180,067 in FY 2003, a 23.0 percent increase over that time period. Of the 33,628 people increase in total caseload, nearly 90.0 percent was due to increases in the caseloads for children and families. This is principally due to expanded eligibility for that population group.

The caseload for adults with disabilities has increased from 20,646 to 24,573 in FY 2003, representing a 19.0 percent increase since FY 2000. The caseload for the elderly population increased from 18,251 in FY 2000 to 18,594 in FY 2003, a 1.9 percent increase. Children and families caseloads have increased from 107,542 to 136,900, representing a 27.3 percent over that time period.

Based on the May 2002 Caseload Estimating Conference, the total caseload for FY 2002 is projected to be 170,961 persons and for FY 2003 179,021 persons, an increase of 22.2 percent from FY 2000 to FY 2003.

## **Expenditures by Population Subgroups**

Table 7 shows total and per capita expenditures by population subgroup for FY 2000 to FY 2003, adjusted for inflation. Expenditures by population subgroup were only available for FY 2000 and FY 2001. From all the departments that spend Medicaid money, only DHS estimates its expenditures and growth rates for each population group for out-years. In order to estimate expenditures by population subgroup for FY 2002 and FY 2003, RIPEC calculated the expenditures by using DHS's estimated growth rates for each population and estimated expenditures from the Caseload Estimating Conference from November 2001. Also, it should be noted that some Medicaid expenditures are unallocable by population. Per capita expenditures were calculated by dividing each subgroup's expenditures by the total caseload.

	FY 2000 Expenditures		FY 2001 Expenditures		FY 2002* Expenditures		FY 2003* Expenditures		2000-2003 Change Expenditures		
	Total in mill.\$	Percent of Total	Total in mill.\$	Percent of Total	Total in mill.\$	Percent of Total	Total in mill.\$	Percent of Total	in mill.\$	Percent Change	Per Capita
Adults with Disabilities	\$409.2	33.5%	\$424.1	31.4%	\$450.4	32.1%	\$477.2	33.3%	\$68.0	16.6%	-2.0%
Elderly	374.3	30.7%	358.0	26.5%	369.1	26.3%	368.0	25.7%	-6.3	-1.7%	-3.5%
Children & Families**	358.8	29.4%	420.5	31.2%	468.2	33.4%	485.9	33.9%	127.1	35.4%	6.4%
Unallocable	77.7	6.4%	146.0	10.8%	114.9	8.2%	100.3	7.0%	22.6	29.1%	
<b>Total</b>	<b>\$1,220.0</b>	<b>100.0%</b>	<b>\$1,348.6</b>	<b>100.0%</b>	<b>\$1,402.6</b>	<b>100.0%</b>	<b>\$1,431.4</b>	<b>100.0%</b>	<b>\$211.4</b>	<b>17.3%</b>	

Note: Expenditures are expressed in 2003 Dollars, based on CPI  
\* Expenditures for FY 2002 and FY 2003 are estimated, based on DHS growth rates by population.  
\*\* Includes children and families in Managed Care, children with special health care needs and children in foster care.

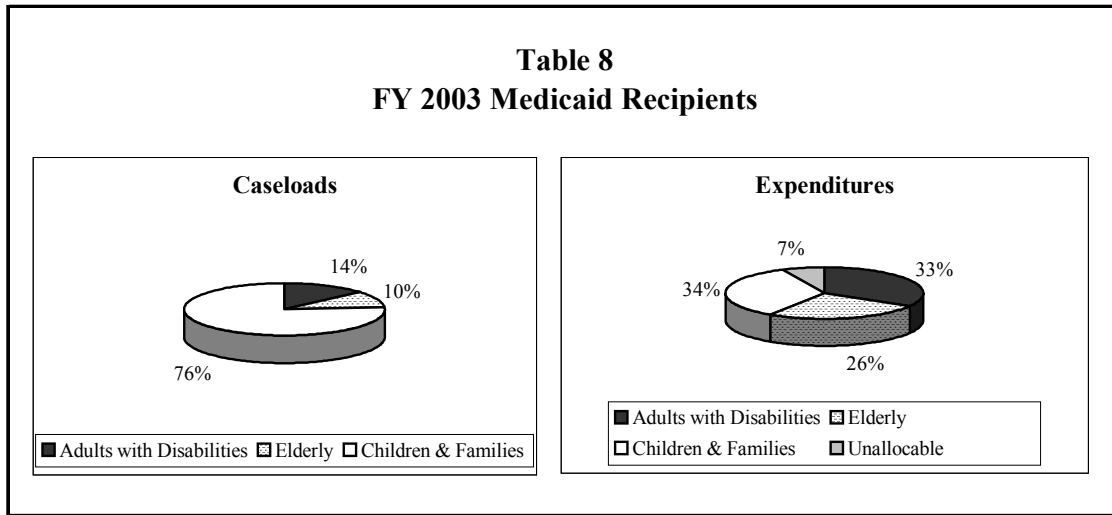
Source: DHS and RIPEC calculations

As noted above, the major subgroups are adults with disabilities, elderly, and children and families. In FY 2000, children and families accounted for 73.4 percent of the caseload and 29.4 percent of the Medicaid expenditures. Adults with disabilities made up 14.1 percent of the caseload and 33.5 percent of total Medicaid expenditures. The elderly population accounted for 12.5 percent of the caseload and 30.7 percent of all Medicaid expenditures.

Projected figures for FY 2003 show that children and families make up 76.0 percent of the caseload and 33.9 percent of all Medicaid expenditures. Adults with disabilities account for 13.6 percent of the caseload and 33.3 percent of the expenditures, and the elderly population make up 10.3 percent of the caseload and 25.7 percent of Medicaid expenditures.

As shown on Table 7, of the \$211.4 million net increase in Medicaid spending, approximately 60.0 percent of the increase (\$127.1 million) were attributed to additional spending for serving children and families. About 32.0 percent of the increase was due to additional spending for adults with disabilities. The balance is made up of unallocable expenditures and a decrease in spending for the elderly.

In FY 2003, expenditures for children and families are estimated to total \$485.9, and for adults with disabilities \$477.2 million. Expenditures for elderly are estimated to total \$368.0. From FY 2000 to FY 2003, expenditures for children and families increased by 35.4 percent and expenditures for adults with disabilities by 16.6 percent. Expenditures decreased by 1.7 percent for the elderly population.



Adults with Disabilities

Adults with disabilities are categorized as individuals with developmental disabilities and mental retardation, individuals who are severely and persistently mentally ill, and individuals that are physically disabled and/or chronically ill.

Services are provided in the community, in nursing homes, or other residential facilities. Services encompass, e.g., case management, personal care services, special medical equipment, homemaker services, emergency response services, and assisted living.

Expenditures, adjusted for inflation, for adults with disabilities rose from \$409.2 million in FY 2000 to an estimated \$477.2 million in FY 2003, a 16.6 percent increase. Expenditures as a percentage of total Medicaid expenditures declined from 33.5 percent in FY 2000 to an estimated 32.1 percent in FY 2002, and rise again in FY 2003 to an estimated 33.3 percent of total expenditures. This population group amounts for an estimated 13.6 percent of the caseload, yet requires 33.3 percent of the total expenditures in FY 2003.

Per Capita expenditures for adults with disabilities decreased from an annual \$19,819 in FY 2000 to an estimated \$19,419 in FY 2003, a 2.0 percent decrease. That means that the caseload grew at a faster rate than expenditures. Major drivers appear to be medical service utilization for existing enrollees and pharmacy costs.

Elderly Population

Services for the elderly include, e.g., case management, special medical equipment, meals-on-wheels, senior companion and emergency response services, and assisted living.

Expenditures, adjusted for inflation, for the elderly decreased by 1.7 percent, from \$374.3 million in FY 2000 to an estimated \$368.0 million in FY 2003. The expenditures as a percentage of the total spending by population subgroup decreased from 30.7 percent in FY 2000 to 25.7 percent in FY 2003. In FY 2003, this population is estimated to account for 10.3 percent of the total caseload and for 25.7 percent of the total expenditures. Per capita expenditures decreased from \$20,508 in FY 2000 to an estimated \$19,793 in FY 2003, a 3.5 percent decrease.

### Children and Families

This population encompasses children and families in managed care and is explained in greater detail on the following pages. It also includes children with special health care needs, who have physical disabilities, developmental disabilities and/or serious emotional disturbances. They receive services such as Early & Periodic Screening, Diagnostic and Treatment Services, home and community-based services, and private duty nursing and behavioral health services.

Children in foster care are also eligible for Medicaid benefits and receive a cash subsidy. Beginning in FY 2001, children in substitute placement were gradually moved into RIte Care. In FY 2003, the Governor proposes to integrate all health care services for these children in RIte Care.

Expenditures for children and families (including children with special health care needs and children in foster care) as proposed in the FY 2003 budget, increased from \$358.8 million in FY 2000 to an estimated \$485.9 million in FY 2003, a 35.4 percent increase. That population group amounted for 76.0 percent of the total caseload and 33.9 percent of expenditures in FY 2003. Per Capita expenditures increased by 6.4 percent, from \$3,336 in FY 2000 to an estimated \$3,550 in FY 2003.

### RIte Care

Expenses for children and families in managed care are principally related to RIte Care. Rhode Island's Medicaid Managed Care Program provides families on the Family Independence Program and eligible uninsured pregnant women, parents, and children up to age 19 with comprehensive health care. Families receive most medical care through participating Health Plans. The Department of Human Services purchases health insurance (RIte Care) or provides a premium subsidy for employer sponsored health insurance (RIte Share) for about 124,000 people in FY 2003. This model of health care purchasing begun in 1994 under the authority of an 1115 Research and Demonstration Waiver of Title XIX of the Social Security Act.

### RIte Care Eligibility

RIte Care has expanded eligibility thresholds in order to include a wider range of lower income families. Originally, the program covered children up to age six below 250 percent of the Federal Poverty Level (FPL) and pregnant women up to 350 percent FPL.

Changes in eligibility since 1996 include:

- April 1996 Eligibility expanded to include children aged 7 and 8 below 250 percent FPL.
- May 1997 Eligibility expanded to include children ages 8 to 18 up to 250 percent FPL.
- November 1998 Eligibility expanded to add parents of children ages 8 to 18 up to 185 percent FPL.
- July 1999 Eligibility expanded to include undocumented alien children and children up to age 19.
- February 2001 RIte Share voluntary enrollment begins.
- May 2001 RIte Share mandatory enrollment scheduled to begin.
- January 2002 Begin 3 percent premium share collection for families above 150 percent FPL and direct member reimbursement for Rite Share.

**Table 9**  
**Eligibility for RIte Care**  
**Based on Annual Gross Income**

Family Size	Family Coverage	Coverage for Children	Coverage for Preg. Women**
	185%FPL*	250%FPL*	350%FPL*
2	up to \$22,089	up to \$29,850	up to \$41,790
3	up to \$27,787	up to \$37,550	up to \$52,570
4	up to \$33,485	up to \$44,250	up to \$63,350
5	up to \$39,183	up to \$52,950	up to \$74,130
6	up to \$44,881	up to \$60,650	up to \$84,910

\*FPL=Federal Poverty Level 2002

\*\* A pregnant woman counts as two people.

Note: Figures are estimates.

Source: RI Department of Human Services

RIte Care eligibility includes children under age 19 in a family whose income is less than 250 percent of the Federal Poverty Level (FPL) or the parent of a child under the age of 18 in a family with an income less than 185 percent of the FPL. Pregnant women in a family with income under 350 percent of the FPL are also eligible.

As Table 9 shows, a family of three with an annual gross income up to approximately \$27,787 is eligible to receive health care through RIte Care. Children in a family of three are covered under RIte Care with an annual gross income up to approximately \$37,550. In that instance, only the child is covered, not the parent. A pregnant woman with a child receives health care coverage if her annual income is up to approximately \$52,570.

For the group of individuals that have to be covered, states are required to provide a certain set of mandatory benefits including hospital inpatient and outpatient care; physician services; laboratory and x-ray services; early periodic screening, diagnosis and treatment (EPSDT) for children.

**Table 10**  
**Medicaid Benefits Covered Under RItE Care**

<b>Mandatory State Plan Services</b>	<b>Optional State Plan Services*</b>	<b>Not Covered</b>
Physicians' services	Podiatrists' services	Chiropractic Treatment
Laboratory & x-ray services	Optometrists' services	Abortion services
Emergency Services	Health Education & Wellness	Infertility treatment
Home Health Care	Hospice Services	
In- & Outpatient hospital services	Medical Equipment & Supplies	
Maternity	Ambulance	
Nursing facility care (NFC) for individuals 21 and older	In- & Outpatient mental health	
Home health care for individuals entitled to NFC	Nursing Home care for individuals under age 21	
Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21	Prescription drugs	
Ambulatory services for individuals under age 18	Rehabilitative services	
Rural Health Clinic services	In- & Outpatient substance abuse	
Federally qualified Health Center Services	Transportation services	
Family planning services	Dental Services	
Nurse-midwife services (to the extent permitted by state law)	Dentures	
Certified Family Nurse Practitioner services (to the extent permitted by state law)	Eyeglasses	
	Diagnostic services	
	Preventive services	
	Personal Care services	
	Nutrition counseling by licensed dieticians for specific medical conditions	
	Smoking cessation classes for people who wish to quit smoking	
	Interpreter services for medical visits	
	Child birth education classes	
	Parenting classes	

\* Under EPSDT rules, many of these optional benefits must be provided to children when needed based on a screening.

Source: Rhode Island Department of Human Services

States are permitted to cover a range of optional services including prescription drugs, dental care, physical therapy and related services, care in institutions for the developmentally disabled, home care and personal care services. However, EPSDT provisions require that any services deemed necessary as a result of the screening must be provided. As a result, large shares of "optional services" for children are, in fact, mandatory.

For the optional groups Rhode Island choose to cover, it must provide the mandatory benefits listed in Table 10 and may provide any of the optional benefits.

Caseload Trends

Beginning in FY 1995, the population that was formerly covered under the Aid to Families with Dependent Children (AFDC) program had been enrolled in RIte Care. Enrollment in FY 1995 was 26,994. Table 11 provides data on RIte Care enrollment from FY 1996 to FY 2003. Enrollment increased from 70,147 persons in FY 1996 to an estimated 132,500 persons in FY 2003 (the caseload for FY 2003 includes an additional 8,500 children which the Governor proposed to include into RIte Care). This represents an increase of 62,353 persons from FY 1996 to FY 2003. During that time period, enrollment increased by 88.9 percent, which translates into an average rate of growth of 12.7 percent, or nearly 8,908 persons per year. The expansion in FY 2000 and FY 2001 is mainly due to the fact that eligibility was expanded to parents up to 185 percent FPL and to children up to 19 years. About two thirds of total RIte Care recipients are children.

**Table 11**  
**FY 1996 - FY 2003**  
**RIte Care Enrollment**

<b>Year</b>	<b>Total</b>	<b>Percent Change</b>
1996	70,147	
1997	71,497	1.9%
1998	74,742	4.5%
1999	76,816	2.8%
2000	95,687	24.6%
2001	107,526	12.4%
2002*	117,000	8.8%
2003*	132,500	13.2%
1996-2003 Change	62,353	88.9%

\* Projected Caseload Enrollment for FY 2002 and 2003, based on the Casel. Est. Conf. in November 2001 and DHS projections. Caseload for FY 2003 includes an add. 8,500 children which the Governor proposed to include into RIte Care.

Source: DHS and RIPEC calculations.

Based on the Caseload Estimating Conference in May 2002 and DHS projections, RIte Care enrollment would be 121,875 persons in FY 2003. Including the enrollment of 8,500 children on SSI into RIte Care would bring the caseload to 130,375 persons. This would increase enrollment by 60,228 or 85.9 percent from FY 1996 to FY 2003.

Expenditures

As stated before, RIte Care related expenditures make up the majority of all Managed Care expenditures. Expenditures for RIte Care, adjusted for inflation, increased from \$207.0 million in FY 2000 to an estimated \$332.9 million in FY 2003. From FY 2000 to FY 2003, expenditures increased by \$125.9 million, or 60.8 percent. The majority of the increase in FY 2003 over FY 2002 is due to the fact that the Governor has proposed to enroll children with special health care needs in RIte Care.

**Table 12**  
**RIte Care Expenditures**  
**Adjusted and Unadjusted for Inflation**  
**(in millions)**

<u>Year</u>	<u>Unadjusted</u>	<u>Percent Change</u>	<u>Adjusted</u>	<u>Percent Change</u>
FY 2000	\$189.2		\$207.0	
FY 2001	229.5	21.3%	244.2	18.0%
FY 2002*	256.1	11.6%	263.5	7.9%
FY 2003*	332.9	30.0%	332.9	26.3%
2000-2003 Change	\$143.7	76.0%	\$125.9	60.8%

\* FY 2002 are revised expenditures, FY 2003 are recommended expenditures.

Source: State Budget, and RIPEC calculations, based on CPI.

As noted earlier, there is a federal-State cost sharing design in funding Medicaid. Of the \$207.0 million in adjusted expenditures in FY 2000, general revenues amounted to \$95.3 million. In FY 2003, general revenue expenditures are estimated to be \$148.0 million of total RIte Care expenditures, a 55.3 percent increase (\$52.7 million).

Proposed Changes to RIte Care in FY 2003

The administration has proposed a series of changes to Managed Care with anticipated savings of \$9.85 million in all funds in FY 2003 (see Table 13). These include the integration of Children's Intensive Services (CIS), restructuring the reimbursement rates for neonatal intensive care, eliminating retroactive eligibility payments for all new enrollees, enrolling children with special health care needs and foster care adoptive children in RIte Care, and the integration of inpatient behavioral health services for foster care children.

The Children's Intensive Services (CIS) program provides services and supports to children and families to avoid inpatient admissions for mental health services and provide timely discharge following necessary inpatient care and appropriate community based assistance during periods of acute need. These services have been an out of plan benefit

for RItE Care enrollees. If these services would not be included in RItE Care, DHS projects a total state and federal expense of \$11.2 million for these services in FY 2003 for approximately 640 children. This translates into annual costs of \$17,578 per child. The integration of these services is expected to result in total savings of \$2.0 million in FY 2003.

**Table 13**  
**Governor's Proposed Changes to RItE Care for FY 2003 (in millions)**

<b>Proposal</b>	<b>Savings</b>	
	<b>All Funds</b>	<b>Gen. Rev.</b>
Integration of Children's Intensive Services*	\$2.00	\$0.91
Restructuring reimbursement rates for neonatal intensive care	1.20	0.54
Eliminating retroactive eligibility payments for all new enrollees	0.40	0.18
Enrolling children on SSI	4.60	2.10
Enrolling foster care adoptive children	0.95	0.43
Integration of inpatient behavioral health services for foster care ch.	0.70	0.32
<b>TOTAL</b>	<b>\$9.85</b>	<b>\$4.48</b>

\* Expenditures for CIS are estimated to be \$11.2 million for FY 2003, if not included in RItE Care.

Source: Governor's FY 2003 Budget

The administration is also proposing to restructure reimbursement rates for neonatal intensive care services with anticipated savings of \$1.2 million in FY 2003. In July 1998, Medicaid agreed to assume the risk of Women and Infants Hospital Neonatal Intensive Care Unit (NICU) admissions. The current contract establishes a two-tiered daily rate structure; with a higher rate for infants weighing 1,000 grams or less (2.2 pounds) and a lower rate for infants over 1,000 grams. A review of Medicaid NICU admissions for FY 2001 shows that the majority of Medicaid NICU admissions were to infants over 2,500 grams (5.5 pounds). The administration proposes a change to the rate structure to a three-tiered rate structure, with an additional level for infants over 2,500 grams at birth or some other strategy to reduce this expense.

The proposal to eliminate retroactive eligibility payments for all new enrollees is expected to result in total savings of \$400,000. On January 1, 2001 the Department of Human Services established a policy to restrict retroactive coverage for certain groups covered under the 1115 RItE Care waiver. This proposal seeks to extend those restrictions to all coverage groups under the waiver. Since the coverage provides reimbursement to providers for services already delivered (while the applicant was without coverage before applying for RItE Care or RItE Share), this will not affect access to care. Three-month

retroactive eligibility for Medicaid applicants who are disabled or aged will remain in place.

The administration also proposes in the FY 2003 budget to integrate children on SSI into the RIte Care Program. Presently, approximately 6,000 children with special health care needs are in the Medical Assistance Program. The fee-for-service reimbursement amounts to a projected expense by DHS of \$57.8 million in FY 2003. This translates into annual costs of \$9,633 per child. Home and community-based services were the largest expenditure category for this group. DHS is seeking a federal waiver to allow these children to be enrolled in health plans that will integrate all of their medically necessary services. DHS anticipates savings of \$4.6 million through reduced hospitalization and emergency room visits that can be prevented by providing access to such services in RIte Care. Pending submission of and federal approval of the waiver request, enrollment will begin by September 2002.

Also, children in the Adoption Assistance Program (formally foster children) who do not have access to commercial health insurance will move from Medicaid fee-for-service to RIte Care. For those children in the Adoption Assistance Program with access to other health insurance, the Department of Human services will identify that insurance coverage and coordinate assistance with payment as appropriate. DHS anticipates that the improved utilization management and coordination with available commercial benefits will result in savings of \$950,000 in FY 2003.

During FY 2002, the Department of Human Services, in coordination with the Department of Children, Youth and Families, established procedures for and enrolled all children in substitute care (foster care) in RIte Care for their health care services, including outpatient behavioral health services. In FY 2003, the state plans to integrate all behavioral health services into participating health plans including psychiatric care as needed for children in foster care. DHS expects savings of \$700,000.

### **RIte Share**

In response to the rapid growth in RIte Care enrollment, the State enacted the Health Reform Act of Rhode Island in 2000. Established in February 2001, RIte Share is designed to have eligible families who have access to a qualified employer health insurance enroll in the employer's health plan rather than in the RIte Care program. DHS would subsidize the employee's portion of the premiums and also pay for part or all of the family's co-payments. The program's goal is to limit the number of people dropping employer sponsored health coverage while maintaining eligibility for those who are uninsured and who do not have access to employer sponsored coverage.

Voluntary enrollment into RIte Share began in February 2001. The Department of Human Services focused on encouraging employers to participate in the RIte Share program. However, enrollment into the RIte Share program has been slow for various reasons. When the program was implemented, it was estimated that about half of all working families would have access to employer sponsored health insurance, which would amount to about 20,000 persons in FY 2002 and about \$8.5 million in savings.

DHS is now implementing the next phase of the RIte Share program and will require that persons eligible for Medical Assistance, who also have access to an approved employer-sponsored health insurance plan, enroll in that plan even if the employer is not participating in RIte Share. In these instances, the State will reimburse the employee, rather than the employer, for the employee's share of the cost of the employer-based insurance.

As of April 2002, 866 persons are enrolled in RIte Share. DHS projects in its testimony before the Joint Committee on Health Care Oversight on April 29, 2002 that by the end of FY 2002 an estimated 2,000 people and in FY 2003 an estimated 6,000 people will be enrolled in the program. Based on the testimony, savings for FY 2002 are estimated to be \$160,000, and in FY 2003 \$1.7 million.

In addition, beginning in January 2002, all families enrolled in RIte Care or RIte Share are required to pay part of the cost of the premium for their health insurance coverage if their income is above 150 percent FPL. Previously, families whose income was above 185 percent FPL had a choice of paying a co-payment or a small premium. Now, all families enrolled in RIte Care or RIte Share that have income above 150 percent FPL are required to pay a premium to maintain their comprehensive health coverage.

**Table 14**  
**Income Level and Family Premium**

Income level (FPL)	Annual Income Family of 3	Monthly Family Premium
150% - 185%	\$22,530 - \$22,787	\$43.00
185% - 200%	27,788 - 30,040	53.00
200% - 250%	30,041 - 37,550	58.00

Source: DHS

Approximately 4,900 families received letters from DHS in December 2001, requiring them to contribute monthly premiums, beginning in January 2002. Families will receive reminder letters if the bill has not been paid. However, if two months go by with no payments made, families will be disenrolled from health insurance. If a family is disenrolled for failure to pay, they will be ineligible for health coverage through RIte Care or RIte Share for a period of four months. Pregnant women and children under 1 year of age will not be disenrolled for failure to pay the premium. As of March 2002, about 85.0 percent of the families paid their premiums.

### III. Changes to the Governor's FY 2003 Budget as Adopted by the General Assembly

Table 15 summarizes the changes to the Governor's FY 2003 Budget regarding Medicaid and RItE Care as recommended by the General Assembly. The General Assembly adds \$22.9 million in expenditures in all funds, including \$10.8 million in general revenues, for the Medicaid program. These additional expenditures are partially offset by savings in the amount of \$6.5 million, including \$3.0 million in general revenues. Total additional expenditures for FY 2003 amount to \$16.4 million, including \$7.8 million in general revenues.

**Table 15**  
**Changes to the Governor's FY 2003 Budget**  
**Regarding Medicaid and RItE Care**  
**As Adopted By The General Assembly**  
**(in millions)**

Items	Gen.Rev.	Federal	Total
<u>Additional Expenditures</u>			
Children's Intensive Services	\$0.3	\$0.3	\$0.6
Medical Assistance based on May Casel.Est.Conf.	\$6.5	\$6.9	\$13.4
Disproportionate Share Hospitals	\$3.0	\$3.8	\$6.8
Mental Health Services	\$1.0	\$1.1	\$2.1
<i>Subtotal</i>	<i>\$10.8</i>	<i>\$12.1</i>	<i>\$22.9</i>
<u>Savings</u>			
Medical Assistance Data Matching	(\$0.5)	(\$0.5)	(\$1.0)
RItE Care Provider 6% Increase Delay from Jan.1 to June 1	(\$2.0)	(\$2.5)	(\$4.5)
RItE Care/RItE Share Premium Cost Share	(\$0.5)	(\$0.6)	(\$1.0)
<i>Subtotal</i>	<i>(\$3.0)</i>	<i>(\$3.6)</i>	<i>(\$6.5)</i>
<b>Total</b>	<b>\$7.8</b>	<b>\$8.5</b>	<b>\$16.4</b>

Source: FY 2003 Budget as adopted by the General Assembly

#### Additional Expenditures

The General Assembly adds \$0.6 million in all funds for Children's Intensive Services. Additional funding is needed to meet increased utilization needs.

The General Assembly also adds \$13.4 million in total funds for Medical Assistance expenditures, based on revised Medical Assistance expenditures as estimated by the Caseload Estimating Conference which met in May 2002.

The community hospitals in Rhode Island receive payments from DHS and the Federal government for uncompensated care they provide to uninsured and indigent patients. These payments are known as Disproportionate Share (DSH) payments. To provide additional funds for payments to hospitals, the General Assembly increased the cap on chargeable services from 6.05 percent to 6.75 percent and the uncompensated care index from 4.9 percent to 5.25 percent in FY 2003. This amounts to an additional \$6.8 million of expenditures in all funds.

Additional expenditures of \$2.1 million in all funds are needed for Medicaid eligible expenditures in the integrated mental health program based on increased utilization of mental health services.

### Savings

The General Assembly recommends total savings of \$6.5 million, including \$3.0 million in general revenues for FY 2003. Of that amount, \$1.0 million will be saved within the medical assistance program due to changes in the method by which third party health insurer information is obtained.

An additional \$4.5 million in all funds will be saved by delaying the RItE Care 6.0 percent provider increase from January 1, 2003 to June 1, 2003.

Savings to the RItE Care program of \$1.0 million in all funds are made due to increases in the premium share portion charged to approximately 4,500 families with incomes greater than 150 percent of FPL. This increase would require monthly payments from RItE Care clients for FY 2003 of \$60 to \$90 per month.

## **IV. Comments**

State expenditures for medical assistance programs have been one of the key drivers in the Ocean State's growing budget since FY 1996. All grants and benefits expenditures, which includes Medicaid, increased from \$1,873.6 million in FY 1996 to \$2,330.7 million in FY 2003 (adjusted for inflation), representing a \$457.1 million increase over the seven-year period, or 42.2 percent of the net increase in total spending statewide. Of the \$457.1 million increase in net spending from FY 1996 to FY 2003, about \$211.4 million, or 46.3 percent, were attributable to Medicaid expenditures. In FY 2003, total Medicaid spending of an estimated \$1.4 billion represents nearly 27.0 percent of the State's total budget.

The following highlights a few areas where RIPEC feels the State can implement improvements to the management of Medicaid and translate these changes to future savings.

### **Oversight and Monitoring of Programs**

#### **Implementing a Consolidated Medicaid Budget**

The Department of Human Services is the designated single state agency for Medicaid and ensures that all state agencies engaged in Medicaid comply with Medicaid requirements on quality, access and availability of services, as well as those ensuring fiscal integrity and accountability.

In its 2001 Annual Report on Medicaid, DHS published a budget with Medicaid expenditures for all departments for FY 2001. However, there are no projections for total Medicaid spending for FY 2002 and FY 2003. Only DHS reports its Medicaid expenditures and caseloads for population subgroups (the elderly, disabled, and children and families) for those years. The other departments that spend Medicaid money, mainly the Department of Mental Health, Retardation and Hospitals as well as the Department of Children, Youth and Families, are not required to do so.

No comprehensive overview of Medicaid expenditures was available for FY 2002 and FY 2003. Therefore, RIPEC has prepared this report to provide a consolidated Medicaid budget for FY 2000 to FY 2003.

Medicaid expenditure reporting should be strengthened. RIPEC suggests that the Department of Human Services should consolidate the expenditures and publish statewide Medicaid expenditures data as part of the budget process, including trend data as well as expenditures for the prior, the current and the upcoming fiscal year.

Monitoring Programs

The Department of Human Services administers or supervises the implementation of the State's Medicaid plan, including ensuring the accuracy of all financial and program reports as well as overseeing the scope and accessibility of services. Table 16 gives an overview of the Medicaid services by department. In order to monitor and evaluate the use of Medicaid resources, DHS should collect and disseminate data to help evaluate the utilization of Medicaid dollars.

**Table 16**  
**Rhode Island Medicaid Services by Department**

DHS	DCYF	MHRH	DEA	DOH	LEA
Basic Medicaid services through direct pay to fee-for service providers	Behavioral health services for children	Behavioral health services to adults with severe and persistent mental illness	Home and Community Based Services*	Targeted case man. for people with AIDS	Case man. and school-related serv. for children
Basic Medicaid services through Health Plans (Managed Care) for Children and Families and fee-for-service wrap-around services	Residential placement for children	Substance abuse treatment for adults with disabilities and the elderly		State laboratory	Individualized education plans for Medicaid eligible special education students
Home and Community Based Services*		Home and Community Based Services* incl. group homes for adults with developmental disabilities and mental retardation			
CEDARR services**		Slater Hospital			
<p>*Home and Community Based Services:            DHS administers the Aged and Disabled Waiver Program;            DHS and the People Actively Reaching Independence (PARI) administer the Physically Disabled waiver;            DHS, the Department of Elderly Affairs and the Rhode Island Housing and Mortgage Finance Corporation administer the Assisted Living waiver;            DHS and the Department of Mental Health, Retardation and Hospitals (MHRH) administer the Mentally Retarded, Developmentally Disabled waiver; and            DHS and the Department of Elderly Affairs administer a waiver for Community Based Elderly Medicaid recipients.</p>					
<p>**CEDARR = Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation Initiative for children with special health care needs</p>					
<p>Source: DHS</p>					

Addressing Prescription Drug Expenditures

Prescription drug expenditures are forecast to grow faster than any other medical service sector over the next decade, albeit at a slightly slower pace than in recent years.

Table 17 shows Rhode Island Medicaid Pharmacy expenditures from FY 2000 to FY 2003. Expenditures (adjusted for inflation) grew from \$75.3 million in FY 2000 to an estimated \$106.3 in FY 2003, a 41.1 percent increase. Pharmacy expenditure growth outpaced total Medicaid expenditure growth. While adjusted total Medicaid expenditures grew by 3.8 percent in FY 2002 and an estimated 2.3 percent in FY 2003, pharmacy expenditures grew by 11.7 percent in FY 2002 and an estimated 12.0 percent in FY 2003.



**Table 17**  
**FY 2000 - FY 2003 Rhode Island Pharmacy Expenditures**  
(In million dollars)

	FY 2000	FY 2001	FY 2002*	FY 2003*
<u>Unadjusted</u>				
Net after Rebates	\$68.8	\$79.8	\$92.2	\$106.3
Percent Change		16.0%	15.5%	15.3%
Percent Change 2000-2003				54.5%
<u>Adjusted for Inflation</u>				
Net after Rebates	\$75.3	\$84.9	\$94.9	\$106.3
Percent Change		12.8%	11.7%	12.0%
Percent Change 2000-2003				41.1%
Percent of Total Medicaid Exp.	6.2%	6.3%	6.8%	7.4%

\* Projected expenditures

Note: Expenditures include outpatient prescribed drugs paid on a fee-for-service basis.

Source: DHS and RIPEC calculations based on CPI

Due to budget constraints, states are considering various initiatives in addressing prescription drug expenditures. A survey conducted and updated in May 2002 by the National Conference of State Legislators (NCSL) shows that the bills under consideration cover several approaches, including pharmaceutical discount programs, manufacturer rebates, inter-agency bulk purchasing and interstate buying, as well as forms of price negotiations or price controls.

There is no obvious solution in addressing escalating prescription drug expenditures. Rhode Island, however, needs to monitor growth in spending for prescription drugs and explore options to control future costs by considering the possibility of interstate buying, interagency cooperation and enhanced drug utilization review processes.