RIPEC

Comments on Your Government

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FY 2005 Medicaid Report

Selected Highlights

- Almost one out of every five Rhode Islanders receives Medicaid benefits. Since FY 2000, the overall Medicaid caseload increased from 146,439 to a projected 190,709 in FY 2005, an increase of 30.2 percent;
- Three-quarters of the caseload (142,936) are children and families covered primarily by the RIte Care program. Adults with disabilities and the elderly make up the balance of 47,773 persons;
- Rhode Island ranks second of the 50 states in per capita spending on Medicaid;
- Medicaid expenditures account for 28 cents of every dollar Rhode Island spends;
- Between FY 2000 and FY 2005, Medicaid spending in Rhode Island increased by 49.1 percent, from $1,115.1 million to a projected $1,663.2 million in FY 2005. This compares to a 34.4 percent increase in total State spending during that time period;
- Rhode Island Medicaid expenditures experienced an average annual growth rate of 8.3 percent between FY 2000 and FY 2005, compared to a national average annual growth rate of 9.4 percent;
- By FY 2009, general revenue expenditures are projected to increase from $730.4 million in FY 2005 to $934.2 million, an increase of $203.8 million, or 27.9 percent;
- While 75.0 percent of the Medicaid caseload is comprised of children and families, they account for one-third of all Medicaid expenditures. Adults with disabilities represent 14.3 percent of the caseload and account for 34.4 percent of all Medicaid expenditures. The elderly are 10.8 percent of the caseload consuming over one-quarter of all Medicaid appropriations;
- Between FY 2000 and FY 2005, RIte Care expenditures increased by $136.7 million to a projected $327.0 million in FY 2005, including expenditures for children with special health care needs; and
- The RIte Care caseload increased from 95,687 persons in FY 2000 to a projected 133,940 persons in FY 2005, representing an increase of 38,253 persons or 40.0 percent. This caseload includes approximately 5,400 children in foster care and with special health care needs. About two thirds of total RIte Care recipients are children.

June 2004

Executive Summary

Almost one out of every five Rhode Islanders receives Medicaid benefits. Since FY 2000, the overall Medicaid caseload increased from 146,439 to a projected 190,709 in FY 2005, an increase of 30.2 percent.

In FY 2005, Medicaid spending is projected to be $1,663.2 million, representing the largest component of the State budget, followed by personnel expenditures ($1,425.7 million) and local aid ($1,112.6 million).

Medicaid spending has grown by 49.1 percent since FY 2000. In FY 2000, it accounted for 25.2 percent of all state expenditures. In FY 2005, it is projected to account for 28.0 percent of total expenditures. In other words, Medicaid accounts for 28 cents of every dollar Rhode Island spends.

However, the rate of Medicaid expenditure growth in Rhode Island is below the national average. Between FY 2000 and FY 2005, the average annual growth rate in Rhode Island (8.3 percent) is about 1.0 percentage point below the national growth rate. While growth rates have been moderated, they still outpace the rate of inflation and are higher than the projected average annual general revenue growth rate of 6.0 percent between FY 2005 and FY 2009.

Given uncertainties about the future level of Federal support and demographic factors that will continue to influence Medicaid costs in the future, RIPEC recommends the following to control costs while enhancing the delivery of necessary medical services to needy Rhode Islanders:

- **Enhanced Coordination of Health and Human Services -** RIPEC believes that a Secretariat of Health and Human Services could provide the necessary resources and capacity to more effectively develop policy and coordinate and monitor health and human service agencies that have shared responsibilities;

- **Unified Medicaid Expenditure Reporting -** The State should be responsible for developing and maintaining a unified Medicaid expenditure reporting system, thus leading to greater accountability of department operations; and

- **Monitor Impact of Federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) -** The extent of the fiscal impact the MMA has on state budgets is not clear yet. Therefore, RIPEC suggests that the General Assembly and the Administration evaluate the impact the new law may have on Rhode Island's Medicaid budget.

RIPEC Comments

Summary of Findings

- Medicaid is a state-federal program that finances health care programs for almost one-fifth of Rhode Island's citizens and accounts for 28 cents of every dollar spent by the State's government;

- Since FY 2000, Medicaid has grown at an average annual rate of 8.3 percent in Rhode Island, and is projected to grow at 6.3 percent annually through the end of the decade; and

- Given the role Medicaid plays in Rhode Island's State budget, RIPEC believes there is a need for enhanced coordination among the five human services agencies to provide a more effective and efficient service delivery system. A key step is to improve Medicaid reporting, including a unified Medicaid budget and forecasting Medicaid expenditures and caseloads. To give a comprehensive overview, RIPEC has prepared this report to provide a consolidated Medicaid budget for FY 2000 to FY 2005.

Given uncertainties about the future level of Federal support and demographic factors that are projected to expand Medicaid costs in the future, it is critical that Medicaid programs be effectively planned, delivered and managed. The following *RIPEC Comments* highlights organizational and financial reforms meant to provide State decision-makers with information to maximize the use of Medicaid dollars in order to enhance the delivery of necessary medical services to needy Rhode Islanders.

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 and will increase to a projected 45.3 percent in FY 2005, based on the Governor's budget. 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 $1,560.4 million in FY 1996 to a projected $2,664.6 million in FY 2005, representing a $1,104.2 million increase over the nine-year period, or 70.8 percent over that time period. Since FY 1996, over 47 cents of every new dollar the State has spent was for grants and benefits. Of the total grants and benefits expenditures in FY 2005, Medicaid expenditures are projected to account for 62.4 percent or $1,663.2 million (excluding administrative costs). In FY 2005, Medicaid expenditures account for 28.0 percent of total State expenditures, up from 25.2 percent of expenditures in FY 2000.

Rhode Island Medicaid expenditures experienced an average annual growth rate of 8.3 percent between FY 2000 and FY 2005, compared to a national average annual growth rate of 9.4 percent. Based on Rhode Island State Budget Office projections, RIPEC estimates that in Rhode Island general revenue expenditures for Medicaid will grow by

approximately 6.3 percent between FY 2005 and FY 2009. Nationally, the annual growth rate is projected to be at around 9.1 percent in out-years.[1]

These trends in Medicaid spending growth will have an impact on Rhode Island's State budget. While growth rates have been moderated, they still outpace the rate of inflation and are higher than the projected average annual general revenue growth rate of 6.0 percent between FY 2005 and FY 2009.

Enhanced Coordination of Health and Human Services

In its report *Organizing State Government for the 21st Century*, RIPEC noted that the human services function is shared by five cabinet level departments (DHS, DYCF, MHRH, DOA, and DEA), but there is no comprehensive mechanism to coordinate these functions. RIPEC noted that the creation of a Human Services Secretariat could strengthen coordination between related state functions, improve focus on strategic initiatives, and provide for greater accountability of department operations.

RIPEC believes that such a Secretariat could provide the necessary resources and capacity to more effectively develop policy, and coordinate and monitor health and human service agencies who have shared responsibilities.

Based on the Fiscal Fitness Team's recommendations, the Governor signed an Executive Order in March 2004, creating the Office of Health and Human Services. The creation of this Office is the first step in the Governor's plan to institute a cabinet-level Health and Human Services Secretariat which would encompass the Department of Human Services (DHS), the Department of Children, Youth, and Families (DCYF), the Department of Mental Health and Retardation (MHRH), the Department of Elderly Affairs (DEA), and the Department of Health (DOH).

This new organizational structure might help foster inter-departmental coordination of Medicaid policies and programs, thus leading to an enhanced system of service delivery. For example, both DHS and DCYF provide services for children's behavior health. An improved coordination of these services could lead to a more effective and efficient service delivery system for the children, parents, case workers, and the providers.

Unified Medicaid Expenditure Reporting

In addition, the Secretariat for Health and Human Services should be responsible for developing and maintaining a unified Medicaid expenditure reporting system, thus leading to greater accountability of department operations. Currently, only DHS reports its Medicaid expenditures and caseloads for population subgroups (the elderly, disabled, and children and families). The other departments that spend Medicaid money, such as the Department of Mental Health, Retardation and Hospitals and the Department of Children, Youth, and Families, are not required to do so. RIPEC also suggests that the Secretariat publish statewide Medicaid expenditures data and analysis as part of the budget process, including trend data. In order to monitor and evaluate the use of Medicaid resources, the Secretariat should collect and disseminate data to help evaluate

the utilization of Medicaid dollars. If the State does not establish a Secretariat, this responsibility should be assigned to an existing State agency.

Monitor Impact of Federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Although Medicare and Medicaid serve distinct populations, certain Medicare beneficiaries with low incomes and limited resources may also receive assistance through the Medicaid program. In 2002, these "dual eligibles" accounted for 16 percent of all Medicaid enrollees in Rhode Island.[2] Approximately 82 percent of all dual eligibles are eligible for full Medicaid benefits. For these beneficiaries, the State Medicaid program pays for services such as prescription drug coverage and long-term care that, although not available through Medicare, are offered as part of the State's Medicaid benefits package. Beyond these fully eligible individuals, Federal law mandates partial Medicaid coverage for certain other groups of qualified beneficiaries. In Rhode Island, total expenditures on dual eligibles accounted for about 52 percent ($715 million) of total Medicaid spending in 2002 and for 16 percent of all Medicaid enrollees.[2] The largest category of expenditure is for long-term care, representing approximately 68 percent of total dual eligible spending.

The Federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is expected to provide some relief to the states in this area. Under the provisions of the MMA, as of January 1, 2006, dual eligibles will receive prescription drug coverage under Medicare Part D. As a result, states will no longer need to cover them with their own outlays. If dual eligibles do not enroll in Part D, or if they need more coverage than is available under their Part D plan, states can provide it to them using their own funds, but they will no longer receive a Medicaid match.

However, other provisions of the new law could significantly lower the savings that states actually achieve. Chief among these is a "clawback" provision requiring states to continue financing some of the cost of providing the prescription drug benefit to dual eligibles. While precise state level estimates are not available, the Centers for Medicare and Medicaid Services (CMS) estimate that, between FY 2006 and FY 2013, Rhode Island will save $204 million.[2] Most of these savings will not materialize until after 2010 as the "clawback" percentage drops.

In the near term, however, the Congressional Budget Office estimates that the new law will actually cost some states more Medicaid spending. This is the result of clawback payments in 2006 that will, possibly, remain larger than the amount of fiscal savings that certain states will secure as a result of no longer providing prescription drug coverage to dual eligibles. Also, the new law places significant new responsibilities on states to administer Medicare's low income subsidy program. As a result of these new requirements, states may incur substantial administrative costs that will offset savings resulting from the elimination of state funded dual eligible drug coverage.

The extent of the fiscal impact the MMA has on state budgets is not clear yet. Therefore, RIPEC suggests that the General Assembly and the Administration evaluate the impact the new law may have on Rhode Island's Medicaid budget.

Fiscal Fitness and Health and Human Services

Improving the efficiency of the Medicaid program is closely linked to the successful implementation of recommendations included in the Governor's Fiscal Fitness Program. Fiscal Fitness recommendations with projected savings over $2.5 million total $138.6 million, or over three-quarters of all recommended savings and revenue enhancements. Of this amount, $60.9 million, or 44.0 percent, would result from proposals related to health and human services. Of that amount, $8.7 million would come from the creation of the Health and Human Services Secretariat and a single contract/procurement office.

Table 1

Fiscal Fitness Health & Human Services Recommendations in Excess of $2.5 Million

Fiscal Fitness Action	Savings
Health & Human Services	
Create Health and Human Services Secretariat	$4.2
Create a single contract/procurement office, Human Service - Secretariat	4.5
Improve children's behavioral health services, DCYF	9.5
Decrease overtime, DCYF	2.9
Reorganize long term care, DHS	12.5
Reorganize field operations, DHS	8.2
Improve eligibility monitoring, DHS	12.3
Centralize and strengthen estates and collections, DHS	3.0
Move a portion of disabled adults to managed care, DHS	3.8
Subtotal	*$60.9*
All Other Savings	*$77.7*
Total Projected Savings	**$138.6**

The FY 2005 State Budget includes cost-savings and revenue enhancements proposed by the Fiscal Fitness team, which would total $32.7 million. Savings related to eligibility monitoring and Medicaid cost improvement represent 25.7 percent (or $8.4 million) of these potential benefits.

Medicaid

Introduction

Nationally, Medicaid provides health and long-term care coverage to 51 million low-income children, families, seniors, and people with disabilities. Medicaid is jointly funded and administered by the states and the Federal government. It is expected that Medicaid expenditures in the United States will amount to $300 billion in FY 2004, according to the Congressional Budget Office, with the Federal government paying $169 billion in FY 2004 and the states spending an estimated $127 billion.

Medicaid spending continues to grow significantly, but the annual rate of growth did decline in FY 2003 to 9.3 percent in 2003.[3] While this growth rate outpaced overall inflation, it was a slowdown from the 12.8 percent growth rate experienced in 2002. Factors contributing to the deceleration in spending growth included decisions in some states to limit Medicaid spending amid fiscal problems and a slowdown in enrollment growth as the economy improved.[1]

Rhode Island Medicaid expenditures experienced an average annual growth rate of 8.3 percent between FY 2000 and FY 2005. Based on Rhode Island State Budget Office projections, RIPEC estimates that in Rhode Island general revenue expenditures for Medicaid will grow by approximately 6.3 percent in the out-years. Nationally, the annual growth rate is projected to be at around 9.1 percent in out-years.[1] These projections do not include any impacts the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) will have on Medicaid spending. It is expected that state Medicaid programs will experience a decrease in drug spending in 2006 based on the implementation of the MMA. A detailed discussion on drug expenditures is provided in RIPEC's analysis of the *Pharmaceutical Assistance Program for the Elderly (RIPAE)* which was released on May 5, 2004.

These trends in Medicaid spending growth will have an impact on Rhode Island's State budget. Many factors drive Medicaid expenditures. The intent of this *Comments* is to give an overview of the Medicaid program, including Rhode Island's managed care program, RIte Care.

Overview of Medicaid

The Federal government matches state spending for the services Medicaid covers on an open-ended basis. For program administration, the Federal contribution is set at 50 percent of costs in each state. For medical services which represent the majority of expenditures, however, the Federal matching rate (adjusted annually), known as the Federal Medical Assistance Percentage (FMAP) varies by state. 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.

As can be seen in Table 2, Rhode Island is expected to receive a 55.5 percent matching rate in FY 2005, meaning that Rhode Island draws down $1.25 from the Federal government for every $1.00 it spends. Based on the Federal Jobs and Growth Tax Relief Reconciliation Act of 2003, the states received an enhanced FMAP rate in FY 2003 and FY 2004. The one-time FMAP enhancement provided by the Federal government established Rhode Island's FY 2003 enhanced rate at 55.6 percent and for FY 2004 at 58.8 percent, thereby increasing the Federal share of Medicaid spending. This Federal initiative was designed to provide immediate fiscal relief to the states of nearly $20 billion. In Rhode Island, the enhanced FMAP rate resulted in an additional $51.8 million in Federal funds in the FY 2003 and FY 2004 budgets to supplant general revenue Medicaid funds. In addition, the State received about $50 million in Federal funds as flexible grants. The FMAP is expected to return to the scheduled rate of 55.5 percent for Rhode Island in FY 2005.

Table 2
Federal Medical Assistance Percentage (FMAP)
2000 - 2005

FY*	State	Federal
2000	46.2	53.8
2001	46.2	53.8
2002	47.2	52.8
2003 B.	45.3	54.7
2003 E.**	44.4	55.6
2004 B.	44.1	55.9
2004 E.**	41.2	58.8
2005	44.5	55.5

Note: B = Base Year, E = Enhanced Rate
*State Fiscal Year
** Enhanced FMAP rate as part of federal Jobs and Growth Tax Relief Reconciliation Act of 2003.
Source: Rhode Island State Budget Office

Within broad national guidelines established by Federal statutes, regulations, and policies, each state establishes its own eligibility standards for Medicaid; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments.

According to the Rhode Island Department of Human Services *2003 Annual Medicaid 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 former 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 born after September 30, 1983, 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 who receive adoption assistance or who live in 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 and pregnant women 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 (SCHIP);
- Individuals determined to be "medically needy" due to low income and resources or large medical expenses;
- Children under age 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.

Also, most states have additional "state-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. In Rhode Island, major State programs include expanding eligibility to undocumented alien children and providing health insurance for children who would not qualify for Medicaid.

Medicaid Expenditures and Caseloads

National Trends

Medicaid's spending growth slowed in FY 2003. However, the growth rate still outpaces overall inflation. Nationally, the annual growth rate is projected to be at around 9.0 percent in out-years, a rate that would far outstrip state revenue growth even after a full economic recovery is underway.

Based on data published by the Congressional Quarterly in its *State Fact Finder*, Rhode Island's Medicaid spending on a per capita basis ranked second highest in FY 2001 (latest data available for a national comparison). Only New York had a higher per capita Medicaid spending. In Rhode Island, spending increased from $691 in FY 1996 (50.5 percent above the national average) to $1,185 in FY 2001, where it was 48.3 percent above national average. In Rhode Island, per capita Medicaid expenditures increased by 71.5 percent between 1996 and 2001, whereas within the U.S. expenditures increased by 74.1 percent during that time period. 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 $1,020 in FY 2001, an increase of 75.0 percent during that time period. Rhode Island's per capita spending was 18.5 percent higher in FY 1996 and 16.2 percent above the New England average in FY 2001.

Table 3
FY 1996 - FY 2001 Per Capita Spending on Medicaid

State	FY 1996 Amount	FY 1996 Rank*	FY 2001 Amount	FY 2001 Rank*	% Change 1996-2001
US**	$459		$799		74.1%
New England	583		1,020		75.0%
Connecticut	$620	3	984	8	58.7%
Maine	581	6	1,080	4	85.9%
Massachusetts	620	4	1,083	3	74.7%
New Hampshire	471	17	732	27	55.4%
Rhode Island	**691**	**2**	**1,185**	**2**	**71.5%**
Vermont	513	10	1,057	5	106.0%

* 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 and 2004, based on data from the Dept. of Health and Human Services' Ceners for Medicare and Medicaid Services (CMS); and RIPEC calculations.

Medicaid expenditures vary by the population being served. According to the Kaiser Commission, low-income children and their parents represent about three-fourths of Medicaid beneficiaries, but their health coverage accounts for just 30 percent of total Medicaid spending. At the same time, persons with disabilities and the elderly account for most of Medicaid's costs. The elderly and disabled represent just one-quarter of Medicaid enrollees, but they account for 70 percent of Medicaid spending, reflecting their intensive use of acute and long-term care services.[3]

Rhode Island Medicaid Expenditures

Table 4
Rhode Island All Fund Medicaid Expenditures (in millions)

Line Item/Depts.	FY 2000 Amount	FY 2000 Percent of Total	FY 2005 Gov Rec Amount	FY 2005 Gov Rec Percent of Total	Change 2000-2005 Amount	Change 2000-2005 Percent
Hospital-Regular	$84.3	7.6%	$124.6	7.5%	$40.3	47.8%
Hospital-DSP	59.9	5.4%	108.2	6.5%	48.3	80.6%
Nursing Homes	245.6	22.0%	303.0	18.2%	57.4	23.4%
Managed Care	190.3	17.1%	367.9	22.1%	177.6	93.3%
Other	121.0	10.9%	221.3	13.3%	100.3	82.9%
Special Ed.	20.0	1.8%	44.0	2.6%	24.0	120.0%
Subtotal DHS	*$721.1*	64.7%	*$1,169.0*	*70.3%*	*$447.9*	*62.1%*
MHRH	$312.6	28.0%	$375.1	22.6%	$62.5	20.0%
DCYF	75.7	6.8%	106.3	6.4%	30.6	40.5%
DOH	3.1	0.3%	9.0	0.5%	5.9	191.2%
DEA	2.3	0.2%	2.9	0.2%	0.6	26.4%
Other	0.3	0.0%	0.8	0.0%	0.5	151.1%
Subtotal	*$394.0*	35.3%	*494.2*	*29.7%*	*100.2*	*25.4%*
Total	**$1,115.1**	**100.0%**	**$1,663.2**	**100.0%**	**$548.1**	**49.1%**

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

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 and will increase to a projected 44.8 percent in FY 2005. 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 $1,560.4 million in FY 1996 to a projected $2,664.6 million in FY 2005, representing a $1,104.2 million increase over the nine-year period, or 46.1 percent of the net increase in total spending statewide. Medicaid is the principal program providing direct services under grants and benefits.

The Governor's FY 2005 budget includes projected Medicaid expenditures of $1,663.2 million (excluding administrative costs). This amounts to 62.4 percent of the total grant and benefit expenditures of $2,664.6 million. In FY 2000, Medicaid expenditures amounted to 60.0 percent of the grant and benefit expenditures. Between FY 2000 and FY 2005, Medicaid expenditures are estimated to increase by $548.1 million or 49.1 percent. This translates into an average annual growth rate of 8.3 percent. This rate of growth outpaces the rate of inflation as well as the average annual growth rate of total State expenditures for all programs and sources (7.7 percent) during that time period. In FY 2005, Medicaid expenditures account for almost a third (28.0 percent) of total State expenditures, up from 25.2 percent of expenditures in FY 2000.

May 2004 Caseload Estimating Conference – Changes Impacting Projected Expenditures
Based on the Caseload Estimating Conference (CEC) in May 2004, FY 2004 expenditures for medical assistance programs are projected to amount to $1,103.6 million ($462.4 million in general revenues), representing an increase of $11.1 million. For FY 2005, the CEC is projecting expenditures in the amount of $1,128.3 million, an increase of $30.3 million ($15.6 million from general revenues) over the November projection of $1,098.0 million. However, the CEC does not estimate uncompensated care payments which are projected to be $83.4 million. Adding these payments would bring projected expenditures in FY 2005 to $1,211.7 million, of which $540.7 million would be from general revenues.

The net impact for additional Medicaid expenditures in fiscal years 2004 and 2005 is approximately $21.6 million in additional general revenue expenditures. However, the Caseload Estimating Conference agreed to include a number of expenditure proposals from the Governor's FY 2004 and FY 2005 budget requests that do not require law changes to implement. Most of these proposals relate to Medicaid expenditures. Overall, the CEC's changes to cash assistance programs and Medicaid expenditures, coupled with the inclusion of several of the Governor's budget recommendations affecting these programs, result in a net increase in expenditures of $5.7 million over the two fiscal years, with most of these additional expenditures relating to Medicaid. A detailed discussion of the May 2004 Revenue Estimating Conference is provided in RIPEC's report on the FY 2005 State Budget – Part III.

The Department of Human Services (DHS) is the State's principal agency for Medicaid related programs. More than two thirds (70.3 percent) of the Medicaid expenditures are spent by DHS. Within DHS, expenditures are primarily driven by expenditures for

Managed Care and Nursing Homes. These two programs together account for 40.4 percent of Medicaid expenditures statewide in FY 2005.

In FY 2000, expenditures for Nursing Homes were $245.6 million and accounted for 22.0 percent of total expenditures. In FY 2005, expenditures are projected to be $303.0 million or 18.2 percent of total expenditures. From FY 2000 to FY 2005, expenditures are projected to increase by $57.4 million or 23.4 percent. This translates into an average annual growth rate of 4.3 percent.

Managed Care, which is primarily RIte Care, accounted for $190.3 million or 17.1 percent of total statewide Medicaid expenditures in FY 2000. For FY 2005, the Governor proposes expenditures for Managed Care in the amount of $367.9 million, accounting for 22.1 percent of total Medicaid expenditures. From FY 2000 to FY 2005, expenditures for Managed Care are projected to increase by $177.6 million or 93.3 percent. This translates into an average annual growth rate of 14.1 percent. Of every new Medicaid Dollar, 32 cents was spent on Managed Care. However, one should note that the FY 2004 and FY 2005 Managed Care expenditures include enhanced reimbursements to RIPTA for bus passes for RIte Care clients, as well as expenses related to the enrollment of children with special health care needs into Managed Care. Expenses for these children were previously paid on a fee-for-service basis. A more detailed discussion of RIte Care is provided later in this report.

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. 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.

MHRH spends about 23 percent of the total Medicaid expenditures in Rhode Island. The Governor's FY 2005 budget includes Medicaid expenditures within MHRH in the amount of $375.1 million. This is an increase of $62.5 million or 20.0 percent over the FY 2000 expenditures ($312.6 million). Expenditures within MHRH include home and community based services such as group homes for adults with developmental disabilities and mental retardation.

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. Together, these departments are projected to spend $118.0 million on Medicaid in FY 2005, up

from $81.4 million in FY 2000. This represents 7.1 percent of the total Medicaid spending in FY 2005.

General Revenue Medicaid Expenditures

Total Medicaid expenditures increased from $1,115.1 million in FY 2000 to a projected $1,663.2 million in FY 2005. As noted earlier, there is a federal-state cost sharing design in funding Medicaid. For example, in FY 2005 the Federal government provides 55.5 percent of the total Medicaid expenditures, while the State provides 44.5 percent from general revenues.

Table 5
Rhode Island General Revenue Medicaid Expenditures (in millions)

	FY 2000		FY 2005 Rec		FY 2000-2005 Change	
Line Item/Depts.	Gen Rev	Percent of Total	Gen Rev	Percent of Total	Amount	Percent
Hospital-Regular	$38.9	7.8%	$56.3	7.7%	$17.4	44.7%
Hospital-DSP	27.6	5.5%	48.3	6.6%	20.6	74.6%
Nursing Homes	113.4	22.7%	134.5	18.4%	21.1	18.6%
Managed Care	87.8	17.6%	163.0	22.3%	75.2	85.6%
Other	55.9	11.2%	98.3	13.5%	42.4	75.9%
Special Ed.	10.8	2.2%	19.6	2.7%	8.8	81.1%
Subtotal DHS	*$334.4*	*67.0%*	*$519.9*	*71.2%*	*$185.4*	*55.5%*
MHRH	$127.2	25.5%	$159.5	21.8%	$32.2	25.3%
DCYF	35.0	7.0%	45.8	6.3%	10.8	30.8%
DOH	1.4	0.3%	3.6	0.5%	2.2	158.7%
DEA	1.1	0.2%	1.3	0.2%	0.2	17.5%
Other	0.0	0.0%	0.3	0.0%	0.3	0.0%
Subtotal	*$164.7*	*33.0%*	*$210.5*	*28.8%*	*$45.8*	*27.8%*
Total	**$499.1**	**100.0%**	**$730.4**	**100.0%**	**$231.2**	**46.3%**

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, House Fiscal Staff, and RIPEC calculations

General revenue expenditures increased from $499.1 million in FY 2000 to a projected $730.4 million in FY 2005, an increase of $231.2 million or 46.3 percent during that time period. This translates into an average annual growth rate of 7.9 percent. Of the general revenue expenditures of $730.4 million in FY 2005, 22.3 percent are spent on Managed Care. In FY 2000, Managed Care accounted for 17.6 percent of general revenue expenditures. In FY 2005, general revenue expenditures for Managed Care are projected to amount to $163.0 million, an increase of $75.2 million or 85.6 percent from FY 2000 ($87.8 million). Managed Care is primarily the Rite Care program which is explained in more detail below.

Table 6 projects general revenue expenditures until FY 2009, based on State Budget Office assumptions used in the five-year forecast. Between FY 2005 and FY 2009, expenditures for Medicaid are projected to grow annually on average by 6.3 percent, slightly higher than the projected general revenue growth rate of 6.0 percent. This

Medicaid expenditure growth rate is lower than the projected national average annual rate of 9.1 percent.

Table 6
Rhode Island General Revenue Medicaid Expenditures (in millions)

	FY 2005 Rec		*FY 2009**		FY 2005-09 Change		
Line Item/Depts.	**Gen Rev**	**Percent of Total**	***Amount***	***Percent of Total***	**Amount**	**Percent**	**Share of Growth**
Hospital-Regular	$56.3	7.7%	*$78.9*	*8.4%*	$22.6	40.2%	11.1%
Hospital-DSP	48.3	6.6%	*67.7*	*7.2%*	19.4	40.2%	9.5%
Nursing Homes	134.5	18.4%	*152.9*	*16.4%*	18.4	13.7%	9.0%
Managed Care	163.0	22.3%	*218.4*	*23.4%*	55.4	34.0%	27.2%
Other	98.3	13.5%	*137.8*	*14.8%*	39.5	40.2%	19.4%
Special Ed.	19.6	2.7%	*27.4*	*2.9%*	7.9	40.2%	3.9%
Subtotal DHS	*$519.9*	*71.2%*	*$683.1*	*73.1%*	*$163.3*	*31.4%*	*80.1%*
MHRH	$159.5	*21.8%*	*$189.6*	*20.3%*	$30.1	18.9%	14.8%
DCYF	45.8	*6.3%*	*54.1*	*5.8%*	8.3	18.1%	4.1%
DOH	3.6	*0.5%*	*5.1*	*0.5%*	1.5	40.2%	0.7%
DEA	1.3	*0.2%*	*1.8*	*0.2%*	0.5	40.2%	0.3%
Other	0.3	*0.0%*	*0.5*	*0.1%*	0.1	40.2%	0.1%
Subtotal	*$210.5*	*28.8%*	*$251.1*	*26.9%*	*$40.5*	*19.3%*	19.9%
Total	**$730.4**	**100.0%**	***$934.2***	***100.0%***	**$203.8**	**27.9%**	**100.0%**
Projected Average Annual Medicaid Growth Rate						**6.3%**	
Projected Average Annual General Revenue Growth Rate						**6.0%**	

DSP= Disproportionate Share Payments

* General revenue outyear expenditure estimates based on State Budget Office assumptions.

Source: RI Department of Human Services, House Fiscal Staff, and RIPEC calculations

One should keep in mind that a forecast is built on certain assumptions, including the growth in the caseload, the change in the FMAP, as well as the CPI index. Expenditures in out-years are influenced by demographic shifts, as well as program changes on the state and Federal level. For example, the Federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will impact Rhode Island's Medicaid spending in future years. Under the act, dual eligibles (persons who are eligible under Medicaid and Medicare) will receive prescription drug coverage under Medicare Part D as of January, 2006. The new law will provide some fiscal relief to the State. However, the extent of this relief is not known yet. The forecast does not include any savings based on the act.

By FY 2009, general revenue expenditures are projected to increase to $934.2 million, an increase of $203.8 million from FY 2005. Of the increase, $55.4 million or 27.2 percent are projected to be attributable to expenditure growth in managed care. Hospital expenditures (including disproportionate share payments) are projected to increase by $42.0 million between FY 2005 and FY 2009, amounting to 20.6 percent of the net

increase in expenditures during that time period. The net balance of $106.3 million is attributable to expenditures for nursing homes ($18.4 million), other medical assistance expenditures ($47.4 million), and expenses within the various other departments ($40.5 million). If one assumes a projected FMAP rate of 55.2 percent in FY 2009, total Medicaid spending would amount to a projected $2,084.3 million in FY 2009.

Rhode Island Medicaid Caseload Trends by Population Subgroup

Within the United States, low-income children and their parents represent about three-fourths of Medicaid beneficiaries, while persons with disabilities and the elderly account for one-quarter of Medicaid enrollees.

Rhode Island's caseloads reflect the national trend. The projected figures for FY 2005, based on the Rhode Island Department of Human Services' testimony before the November 2003 Caseload Estimating Conference, show that 74.9 percent of the total caseload are children and families, including children in foster care and with special health care needs. The percentage of adults with disabilities and the elderly total 14.3 percent and 10.8 percent respectively of the total caseload.

Table 7
Rhode Island Medicaid Average Monthly Caseload by Population Subgroup
FY 2000 to FY 2005

	FY 2000		*FY 2005**		2000-2005 Change	
Population	Number	Percent of Total	*Number*	*Percent of Total*	Number	Percent
Adults with Disabilities	20,646	14.1%	*27,195*	*14.3%*	6,549	31.7%
Elderly	18,251	12.5%	*20,578*	*10.8%*	2,327	12.7%
Children & Families**	107,542	73.4%	*142,936*	*74.9%*	35,394	32.9%
Total	**146,439**	**100.0%**	***190,709***	***100.0%***	**44,270**	**30.2%**

*Caseload for FY 2005 is projected, based on DHS testimony before the November 2003 Caseload Estimating Conference.
** Includes Children & Families in Managed Care, children with special health care needs and children in foster care.
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.

Since FY 2000, the overall Medicaid caseload increased from 146,439 to a projected 190,709 in FY 2005, an increase of 30.2 percent over that time period. Overall, in FY 2005, about 18.0 percent of the total state population are Medicaid recipients. Of the projected increase of 44,270 people in Medicaid caseload, 80.0 percent is due to increases in the caseloads for children and families, which is primarily the RIte Care population.

Children and families caseloads have increased from 107,542 in FY 2000 to a projected 142,936 in FY 2005, representing a 32.9 percent increase over that time period. Caseloads for this group include children and families in managed care, as well as children in foster care and with special health care needs. The caseload for adults with disabilities has increased from 20,646 in FY 2000 to a projected 27,195 in FY 2005, representing a 31.7 percent increase. The caseloads for the elderly population increased

from 18,251 in FY 2000 to a projected 20,578 in FY 2005, a 12.7 percent increase during that time period.

The caseloads by population as a percent of the total caseload remained fairly stable between FY 2000 and FY 2005. In FY 2000, adults with disabilities accounted for 14.1 percent of the total caseload. It is projected that the caseload in FY 2005 will account for 14.3 percent of the total caseload. The caseload for the elderly as a percent of the total is projected to decline from 12.5 percent of the total caseload in FY 2000 to 10.8 percent in FY 2005. Children and families accounted for 73.4 percent of the total caseload in FY 2000 and will increase to 74.9 percent in FY 2005.

Medicaid Expenditures by Population Subgroup

Table 8 shows total expenditures by population subgroup for FY 2000 and FY 2005. In order to estimate expenditures by population subgroups for FY 2005, RIPEC calculated the expenditures by using the average growth rate between FY 2000 and FY 2003. Also, it should be noted that some Medicaid expenditures, such as disproportionate share payments to hospitals, cannot be allocated by population.

Table 8
FY 2000 - FY 2005 Expenditures by Population Subgroup
(in $ million)

	FY 2000		*FY 2005**				2000-2005 Change		
	Amount	Percent of Total	*Amount*	*Percent Change*	*Percent of Total*	*Percent Change*	Amount	Percent	Percent of Change
Adults with Disabilities	$373.6	33.5%	*$572.1*	*4.5%*	*34.4%*	*4.5%*	$198.6	53.2%	36.2%
Elderly	342.3	30.7%	*435.1*	*4.0%*	*26.2%*	*4.0%*	92.8	27.1%	16.9%
Children & Families**	327.8	29.4%	*552.7*	*5.5%*	*33.2%*	*5.5%*	224.9	68.6%	41.0%
Unallocable	71.4	6.4%	*103.2*	*2.0%*	*6.2%*	*2.0%*	31.9	44.6%	5.8%
Total	**$1,115.1**	**100.0%**	***$1,663.2***	***4.5%***	***100.0%***	***4.5%***	**$548.1**	**49.2%**	**100.0%**

* Expenditures for FY 2005 are projected, based on average growth rates by population.

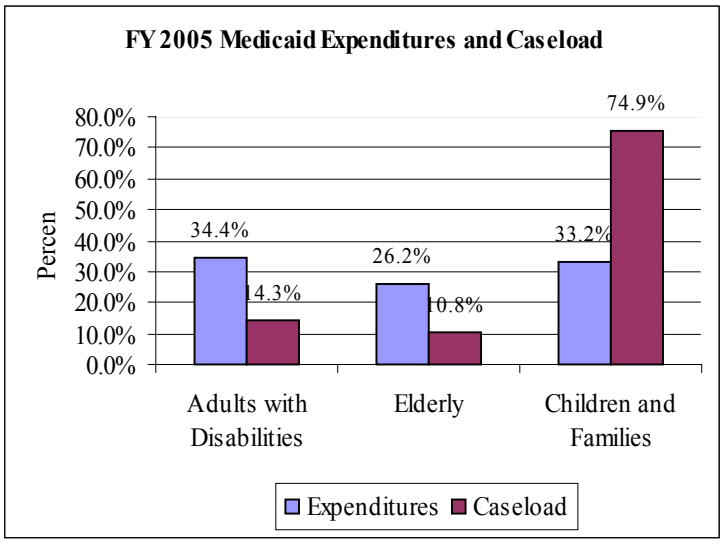
** Includes children and families in Managed Care, children with special health care needs and children in foster care.

Source: DHS and RIPEC calculations

Total Medicaid expenditures increased from $1,115.1 million in FY 2000 to a projected $1,663.2 million in FY 2005, an increase of $548.1 million or 49.2 percent during that time period. In FY 2005, expenditures for adults with disabilities are projected to total $572.1 million, and expenditures for children and families $552.7 million. Expenditures for the elderly population are projected to total $435.1 million. The $103.2 million balance is attributable to expenditures that cannot be allocated to specific population groups.

Of the projected net increase of $548.1 million, approximately 41.0 percent ($224.9 million) is attributable to additional spending for serving children and families. About 36.2 percent of the increase is due to additional spending for adults with disabilities ($198.6 million). The elderly population accounted for 16.9 percent of the additional spending ($92.8 million).

Projected figures for FY 2005 show that children and families make up 74.9 percent of the caseload and 33.2 percent of all Medicaid expenditures. Adults with disabilities account for 14.3 percent of the caseload and 34.4 percent of the expenditures, and the elderly population make up 10.8 percent of the caseload and 26.2 percent of the expenditures. About 6.2 percent of the expenditures are not allocable by population.

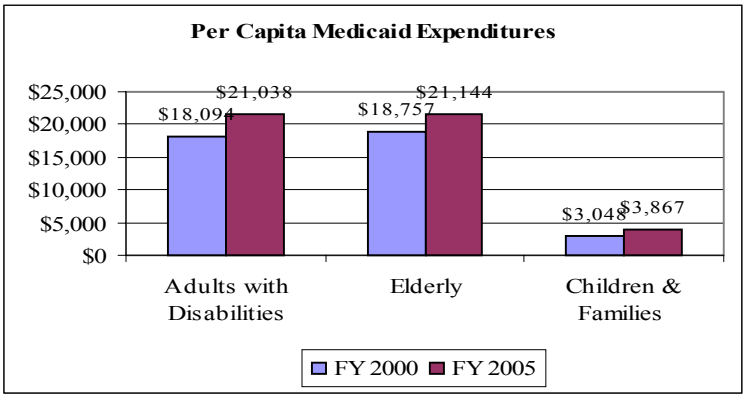


Adults with Disabilities

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 include case management, personal care services, special medical equipment, homemaker services, emergency response services, and assisted living.

Expenditures for adults with disabilities rose from $373.6 million in FY 2000 to a projected $572.1 million in FY 2005, a 53.2 percent increase. Expenditures as a percentage of total Medicaid expenditures increased from 33.5 percent in FY 2000 to an estimated 34.4 percent in FY 2005. This population group amounts for an estimated 14.3 percent of the caseload, yet requires 34.4 percent of the total expenditures in FY 2005.

Per capita expenditures for adults with disabilities increased from an annual $18,094 in FY 2000 to a projected $21,038 in FY 2005, a 16.3 percent increase during that time period. That means that expenditures grew at a faster rate than the caseload.



Elderly Population

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

Expenditures for the elderly increased by 26.2 percent, from $342.3 million in FY 2000 to a projected $435.1 million in FY 2005. The expenditures as a percentage of the total spending by population subgroup decreased from 30.7 percent in FY 2000 to 26.2 percent in FY 2005. In FY 2005, this population is estimated to account for 10.8 percent of the total caseload and for 26.2 percent of the total expenditures. Per capita expenditures increased from $18,757 in FY 2000 to a projected $21,144 in FY 2005, a 12.7 percent increase.

As was the case for the disabled population, expenditures for the elderly grew at a faster rate than the caseload. Growth in expenditures is attributable to Federal Medicare premium payments and pharmacy costs. According to DHS, Medicare premiums, which are paid by Medicaid for all dually eligible recipients, will rise over 13.0 percent in FY 2004 and FY 2005, reflecting the increases in the Part B premium as well as increased enrollment of low-income seniors in the Medicare Buy-in program. Pharmacy costs for this population are projected to continue to increase by approximately 12.5 percent, according to DHS. (Medicare Part B covers physician and outpatient hospital care as well as other medical screening and prevention services).

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 in foster care and 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.

Expenditures for children and families (including children with special health care needs and children in foster care) increased from $327.8 million in FY 2000 to a projected $552.7 million in FY 2005, a 68.6 percent increase. That population group amounted for 74.9 percent of the total caseload and 33.2 percent of expenditures in FY 2005. Per capita expenditures increased by 26.9 percent, from $3,048 in FY 2000 to an estimated $3,867 in FY 2005.

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 approximately 133,940 people in FY 2005. This health care

purchasing program began 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.
- November 2000 — Begin enrollment of children in foster care into Managed Care
- February 2001 — RIte Share voluntary enrollment begins.
- May 2001 — RIte Share mandatory enrollment begins.
- January 2002 — Begin 3 percent cost share for families above 150 percent FPL and direct member reimbursement for Rite Share.
- August 2002 — Begin 5 percent cost share for families above 150 percent FPL and direct member reimbursement for Rite Share.
- September 2003 — Begin enrollment of children with special health care needs.

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 $28,990 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 $39,175. 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 $54,845.

Table 9
Eligibility for RIte Care
Based on Annual Gross Income

Family Size	Poverty Threshold	Family Coverage	Coverage for Children	Coverage for Preg.Women**
	100%FPL*	185%FPL*	250%FPL*	350%FPL*
2	$12,490	up to $23,107	up to $31,225	up to $43,715
3	15,670	up to $28,990	up to $39,175	up to $54,845
4	18,850	up to $34,873	up to $47,125	up to $65,975
5	22,030	up to $40,756	up to $55,075	up to $77,105
6	25,210	up to $46,639	up to $63,025	up to $88,235

*FPL=Federal Poverty Level 2004

** A pregnant woman counts as two people.

Note: Figures are estimates.

Source: RI Department of Human Services and US Dept. of Health and Human Services

Caseload and Expenditure Trends

Beginning in FY 1995, the population that was formerly covered under the Aid to Families with Dependent Children (AFDC) program and now the Family Independence Program (FIP) were enrolled in RIte Care. Table 10 provides data on RIte Care enrollment from FY 1996 to FY 2005. Enrollment increased from 70,147 persons in FY 1996 to a projected 133,940 persons in FY 2005. This represents an increase of 63,793 persons from FY 1996 to FY 2005. During that time period, enrollment increased at an average annual rate of growth of 7.5 percent, or about 7,088 persons per year. Since FY 2003, the caseload has increased at an average annual rate of 5.3 percent. About two thirds of total RIte Care recipients are children.

As part of managed care, beginning in January 1997, health care for certified family providers was provided. In January 1999, the State began contributing to the health care expenditures for employees of eligible licensed child care centers. In FY 2005, it is projected that the State contributes approximately $2.2 million in health care related expenditures for these employees. The expansion in FY 2000 and FY 2001 is due to the fact that eligibility was expanded to parents up to 185 percent FPL and to children up to 19 years. Also, in 2000 and 2001 approximately 2,000 children in foster care were transitioned from fee-for-services to managed care.

Table 10
Rite Care Expenditures and Caseloads

	Caseloads		Expenditures		
Year	Amount	Percent Change	Amount (in millions)	Percent Change	Per Enrollee
FY 1996	70,147		$118.0		$1,682
FY 1997	71,497	1.9%	139.5	18.2%	1,951
FY 1998	74,742	4.5%	140.0	0.4%	1,873
FY 1999	76,816	2.8%	141.6	1.1%	1,843
FY 2000	95,687	24.6%	190.3	34.4%	1,989
FY 2001	107,526	12.4%	231.0	21.4%	2,148
FY 2002	116,393	8.2%	257.3	11.4%	2,211
FY 2003	120,896	3.9%	282.4	9.8%	2,336
FY 2004*	127,685	5.6%	285.4	1.1%	2,235
FY 2005*	133,940	4.7%	327.0	11.9%	2,441
FY 1996-2005 Change					
Amount	63,793		$209.0		$759
Average Annual Percent	7.5%		12.0%		4.2%

*FY 2004 are revised expenditures and FY 2005 expenditures as recommended by the Governor. FY 2004 and FY 2005 include transportation expenditures. FY 2004 and FY 2005 data include caseloads for children with special health care needs and its related expenditures.
Source: State Budgets, and RIPEC calculations.

In September 2003, the Department of Human Services began enrollment of Medicaid eligible children with special health care needs into Managed Care. Before this initiative, approximately 8,500 children received health care on a fee-for-service basis. As of May 2004, about 3,400 children with special health care needs have their routine and specialized health care needs met through the Neighborhood Health Plan of Rhode Island (NHPRI). The department expects that this shift in enrollment from fee-for-service

delivery into managed care will account for savings in general revenues. However, it is too early to determine the exact amount of savings in general revenues. One should note that the RIte Care expenditures and caseloads in Table 10 include a caseload of 2,136 children with special health care needs and related expenditures of $16.0 million for FY 2004 and a caseload of 3,928 children and related expenditures of $32.4 million in FY 2005. The FY 2005 budget also includes a caseload of approximately 2,000 children in foster care and related expenditures of about $10.0 million for foster care health plan payments.

RIte Care related expenditures make up the majority of all Managed Care expenditures. Expenditures for RIte Care increased from $118.0 million in FY 1996 to a projected $327.0 million in the Governor's FY 2005 budget. From FY 1996 to FY 2005, expenditures increased by $209.0 million, translating into an average annual growth rate of 12.0 percent. Expansions in eligibility levels between FY 1996 and FY 2001 led to an increase in caseload and expenditures for the program. However, eligibility levels have remained consistent since FY 2001, leading to a slower rate of expenditure growth. Changes to the program in recent years include the transitioning of children with special health care needs into managed care.

The majority of the increase in FY 2005 over FY 2004 is primarily attributable to an adjustment for medical costs for families and children and a slight increase in the caseload. The Governor's FY 2005 budget also includes $10.6 million (including $5.3 million in general revenues) to enhance reimbursements to RIPTA for bus passes for Rite Care clients. The Governor proposes that DHS will pay the Rhode Island Public Transit Authority (RIPTA) $44 per month for 20,000 bus passes which will amount to $3.0 million in additional revenues in FY 2005 for RIPTA, in conjunction with the plan for a $0.6 cent reduction in RIPTA's share of the gas tax.

Per capita expenditures for RIte Care increased from $1,682 in FY 1996 to a projected $2,441 in FY 2005, translating into an average annual growth rate of 5.0 percent during that time period.

As noted earlier, there is a Federal-State cost sharing design in funding Medicaid. Of the $85.7 million in Rite Care expenditures in FY 1996, general revenue expenditures amounted to $38.9 million. In FY 2005, general revenue expenditures are estimated to be $139.5 million of total RIte Care expenditures, an increase of $100.6 million during that time period. Of the $118.0 million in expenses for RIte Care in FY 1996, $54.3 million was from general revenues. In FY 2005, of the $327.0 million in projected expenditures, $143.7 million will be from general revenues.

RIte Share

The RIte Care Stabilization Act of 2000 established the RIte Share program. The program's intent is to support families in their efforts to obtain or maintain private, employer-sponsored health insurance. RIte Share pays all or part of an eligible families employer-based health insurance cost, as long as that cost is less than a family's cost of coverage under RIte Care. In these instances the State pays less than it would pay if it had

to pay the RIte Care premium. Enrollment in RIte Share is mandatory for Medicaid-eligible individuals whose employer offers an approved health plan.

Voluntary enrollment into RIte Share began in February 2001. When enrollment into RIte Share became mandatory in May 2001, the Department of Human Services estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, enrollment in the program faces various challenges. According to DHS, the increasing cost of commercial insurance is reducing the affordability of coverage for small employers. As a result, businesses will either drop coverage or shift the costs to employees. Therefore, the number of families without access to an employer-sponsored coverage or for whom RIte Share is not cost-effective is projected to increase and, instead they may be enrolled in RIte Care. Also, under Federal law employers are not required to submit information about their health insurance benefits to DHS, making it difficult to transition RIte Care members to RIte Share. As of April 2004, more than 1,000 employers participate in RIte Share and about 6,000 individuals were enrolled in RIte Share. The department estimates that it can transition between 150 and 200 RIte Care members to RIte Share each month.

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 of the FPL ($23,505 for a family of three). This amount ranges from about $61 to $92 per month. As Table _ shows, a family of three with an annual income between $23,505 and $28,990 pays $61 monthly for their health insurance. Given the current rate of growth, the department estimates that it will collect $3.6 million ($1.4 million from general revenues) in FY 2005 from family cost sharing.

Table 11
Income Level and Family Premium

Income level (FPL)	Annual Income Family of 3	Monthly Family Premium
150% - 185%	$23,505 - $28,990	$61
185% - 200%	$28,991 - $31,340	$77
200% - 250%	$31,340 - $39,175	$92

Source: DHS

According to the Department of Human Services, approximately 4,420 families (as of June 2003) are required to contribute monthly premiums. If families fail to pay their premiums for two months they will be dropped from health insurance and cannot re-enroll for four months. An average of 150 families a month are sanctioned for failure to pay premiums.

[1] Stephen Heffler, et al., "Health Spending Projections Through 2013", *Health Affairs*, February 2004.
[2] Federal Reserve Bank of Boston. "New England Fiscal Facts", Winter 2003/2004, Issue No. 32.
[3] Kaiser Commission on Medicaid and the Uninsured. "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004 – Results from a 50-State Survey", September 2003.