SENATE FISCAL OFFICE

ISSUE BRIEF

Medicaid

SEPTEMBER 8, 2014

Medicaid is the single largest source of health coverage for Americans. The program was enacted into law by Title XIX of the Social Security Act of 1965, the same law that created Medicare. Unlike Medicare, which provides healthcare to the elderly regardless of income, Medicaid is a means-tested program that provides healthcare to the indigent. In 2012, 72.6 million people, almost 1 in 4 Americans, were enrolled in Medicaid some time during the year at a total cost of $415.2 billion.

Each state administers its own Medicaid program and is granted flexibility in establishing eligibility criteria, scope of services, and provider payment rates. Because of this flexibility, state programs can vary widely from one another but are coordinated and overseen by the federal Center for Medicare and Medicaid Services (CMS).

Under the Patient Protection and Affordable Care Act (ACA), beginning in CY2014 states may elect to expand Medicaid eligibility to include nearly all low income adults. This particularly benefits childless adults, who were previously ineligible for the program regardless of their income level. It is estimated that 11.0 million Americans will gain public health insurance coverage through this expansion.

Medicaid is jointly funded by the state and the federal government and accounts for more than 40 percent of all federal assistance to states. The federal share of spending is determined by the federal medical assistance percentage (FMAP), which varies by state based on each state's per capita income. CMS offers enhanced FMAPs for certain services or populations in order to fund capacity development or incent program innovation.

RHODE ISLAND MEDICAID PROGRAM

The Rhode Island Medicaid program served 230,000 Rhode Islanders in FY2013 and spent a total of $1.8 billion from all sources of funds on Medicaid services. Services are provided through five separate state agencies, overseen and coordinated through the Executive Office of Health and Human Services:

Department	FY2013 Spent	% of Total	Medicaid Programs
OHHS	$1,370.0	76.7%	RIte Care (Children and Families)
			Rhody Health Partners (Disabled Adults)
			Long Term/Nursing Home Care
BHDDH	370.0	20.7%	Substance Abuse Services
			Mental Health Services
			Developmental Disabilities Services
			Long Term and Psychiatric Hospital Care
DCYF	34.0	1.9%	Child Welfare, Foster Care
DHS	11.0	0.6%	Elderly Personal Care Services
Health	1.0	0.1%	HIV, Lead Case Management
Total	**$1,786.0**		

Additionally, over $45.0 million was spent to administer the Medicaid program in FY2013. These funds went towards eligibility determination, enrollment, claims processing, quality control, program integrity and fulfilling reporting requirements, among other functions.

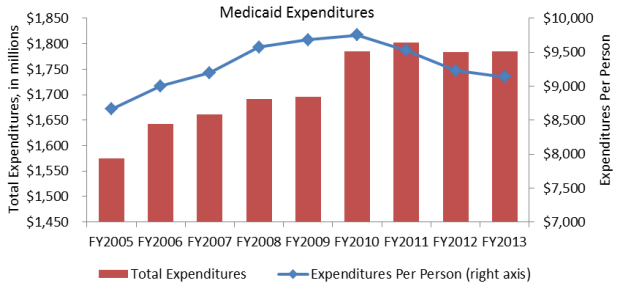
While most states are granted a number of exemptions (or "waivers") from various federally-mandaded Medicaid rules, the Rhode Island Medicaid program has operated under a single "global waiver" since 2009. The Global Consumer Choice Compact 1115 Waiver allows the State broader flexibility to research and pilot new healthcare alternatives, particularly in long term care. The original five-year waiver was approved by the General Assembly and became effective in 2009. It was renewed in 2014 and will expire in 2018.

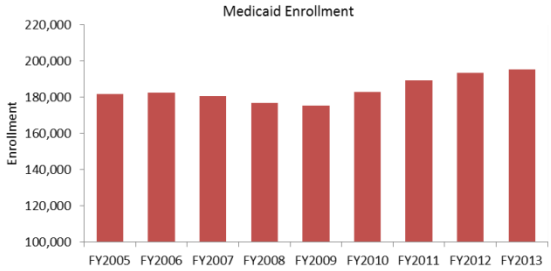
As allowed by the ACA, the State chose to expand eligibility for the Medicaid program as of January 1, 2014, to include nearly all adults under 138 percent of the federal poverty level. Previously, individuals must meet certain categorical requirements (such as disabled, TANF recipient, parent or pregnant) in addition to income requirements. In Rhode Island, these categorical requirements no longer apply and all adults with household income under $27,310 for a family of three are eligible (excluding undocumented individuals and certain legal immigrants). This expansion is expected to add 60,000 individuals to the program by the end of FY2015.

ENROLLMENT AND EXPENDITURE HISTORY

From FY2005 and FY2013, Rhode Island Medicaid expenditures grew by $210.0 million or 13.3 percent. Expenditures are expected to grow more steeply beginning in FY2014 when eligibility in the program was expanded as described above.

During the same period, enrollment grew by about 13,500 or 7.4 percent while annual cost per person grew 5.5 percent. Annual cost per person has trended downward since FY2010 primarily due to lower utilization of hospital services, a trend also noted nationally.

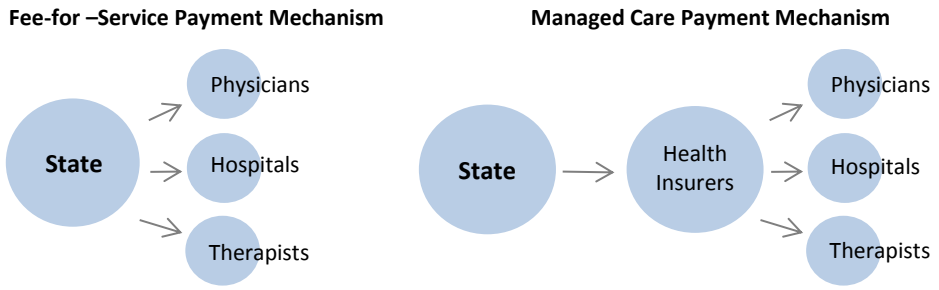




EXPENDITURE PROFILE

Expenditures by Payment Mechanism

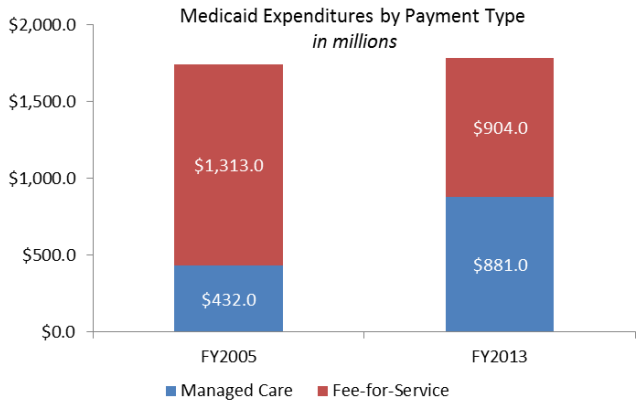
The Medicaid program purchases services for their members through two broad payment mechanisms: Fee-for-service (FFS), through which the State pays providers directly for services provided, and managed care (MC) through which the State pays a monthly fee for each enrolled beneficiary to a health insurer that then contracts with and pays healthcare providers such as hospitals, physicians, and rehabilitative therapists among others.



Neighborhood Health Plan of Rhode Island and United Healthcare of New England are currently under contract to provide managed care services to children and families (through the RIte Care program) and to most adults with disabilities (through the Rhody Health Partners program).

These managed care organizations (MCOs) receive a capitated (per-enrollee) payment for each of the Medicaid beneficiaries they serve. For this capitated payment, the MCOs must provide all the health care each patient needs. If costs are higher than the capitated payment, the MCO loses money. If costs are lower, it gains though both gains and losses are limited by the current risk-share/gain share agreement. The current contract is set to expire at the end of FY2015. The next five-year contract will be worth almost $10.0 billion and is anticipated to be the largest contract in the State's history.

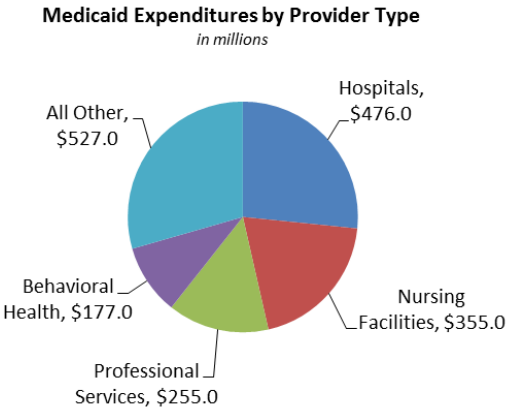
The Rhode Island Medicaid program is distinct in its broad and growing utilization of managed care to contain costs and improve care. As the accompanying graph depicts, managed care has grown from 24.8 percent of Medicaid expenditures in FY2005 to 50.5 percent in FY2013.



Managed care expenditures were further increased in FY2014 when $303.0 million in long term care services that were previously paid for through a fee-for-service arrangement with nursing homes were incorporated into the monthly per-enrollee fees paid to Neighborhood Health Plan. An additional $60.0 million in behavioral healthcare services, also currently paid for through fee-for-service arrangements, is anticipated to be incorporated into monthly capitated rates during FY2015.

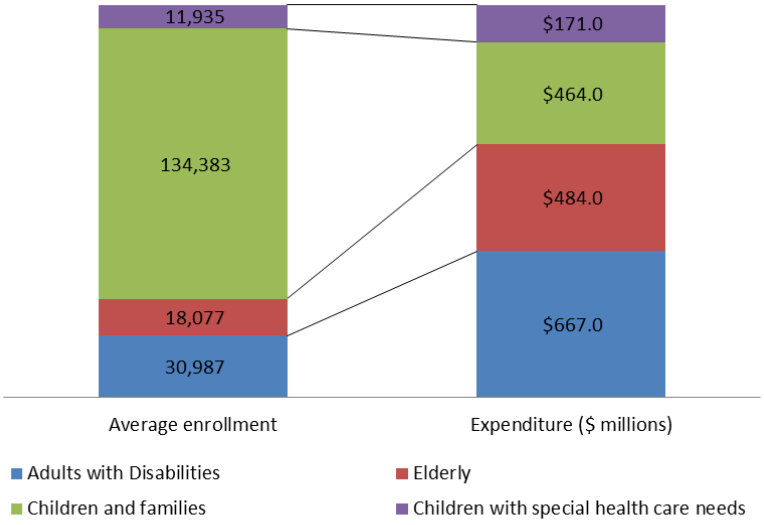
Expenditures by Provider

In FY2013, hospitals accounted for 26.6 percent of Medicaid spending ($476.0 million), of which $283.0 million (59.8 percent) was for inpatient services. The next largest provider group was nursing facilities, which accounted for $355.0 million or 19.8 percent of Medicaid spending. Professional services, which include therapies and physician office visits, accounted for 14.2 percent of spending. Other provider settings included residential and day services for the developmentally disabled ($209.0 million, 11.7 percent), the state-run Eleanor Slater hospital system ($98.0 million, 5.5 percent), and long term care services provided in the home and community ($90.0 million, 5.0 percent).



Expenditures by Population

As is frequently noted, per-person Medicaid spending varies widely by population. For example, though children and families make up 69.0 percent of enrollment and represent the largest enrollment group, they account for only 26.0 percent of expenditures. Conversing, the elderly account for only 9.0 percent of Medicaid enrollment, yet account for 27.0 percent of expenditures.



Spending is extremely concentrated as 7.0 percent of enrollees (about 16,000 individuals) account for 66.0 percent of Medicaid expenditures ($1.1 billion). These enrollees cost an annual average of $67,063 per person, more than 70 times the average for the rest of the Medicaid population. OHHS reports that this profile is similar to national statistics.

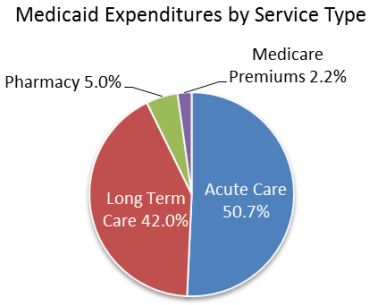
The following table profiles the FY2013 average per person cost by population.

Population	Average Annual Cost
Elderly	$26,774
Adults with Disabilities	21,525
Children with Special Health Care Needs	14,328
Children and Families	3,453
Average	**$9,141**

Care for the elderly has historically been the most expensive and averaged almost $27,000 per year due to the high cost of nursing home care. While Medicare covers an elderly person's medical, pharmacy, and hospital care, long term care in both nursing homes and community-based settings is covered by Medicaid.

Expenditures by Type of Service

Medicaid services fall into two main categories: *acute care*, which includes hospital care, lab and X-ray services among others; and *long term care*, which includes residential care and room and board for the elderly and for individuals with developmental disabilities. Other services types include Medicaid-paid Medicare premiums and prescription drugs. The amount paid by Medicaid for prescription drugs has fallen sharply since 2006 when pharmacy coverage for many individuals shifted from Medicaid to Medicare.

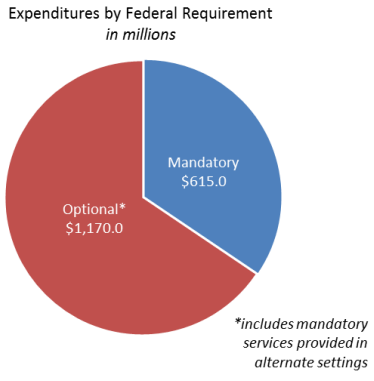


COVERED POPULATIONS AND SERVICES

In order to receive federal Medicaid matching funds, states are required to cover certain population groups (mandatory eligibility groups) but are given flexibility in setting individual eligibility criteria within federal minimum standards. State statute and CMS waiver approval have allowed the Rhode Island Medicaid program to expand health coverage beyond the federal minimums for the following groups.

	Federal Minimum	RI Medicaid
Children		
0-5 years old	133% FPL	250% FPL
6-18 years old	100% FPL	250% FPL
Adults 19 - 65		
Pregnant	133% FPL	133% FPL
Disabled	75% FPL	100% FPL
Parents	28% FPL	133% FPL
"Childless Adults"	Not required	133% FPL
Aged Age 65+	75% FPL	100% FPL

Among the estimated fifty paths to Medicaid eligibility, Rhode Island extends Medicaid eligibility to qualified persons who may have too much income to qualify under the above criteria but who have significant medical care expenses. This option allows these medically needy individuals to "spend down", subtracting their medical expenses from their income for the purpose of determining Medicaid eligibility.



To receive federal Medicaid matching funds, states are also required to cover a mandated set of health care services such as physician, hospital, laboratory and x-ray services. Like optional populations, states may apply for waivers from CMS that permit them to offer services beyond those required by the federal government. Generally, these waivers are given for services such as pharmacy, dental, outpatient behavioral health and hospice that, if eliminated, are likely to result in larger expenditures for mandatory services.

In Rhode Island, 34.5 percent of FY2013 Medicaid spending is for populations or services mandated by federal law. The remaining spend, 65.5 percent or $1,170 million, is considered optional and is a function

of State law. This is a shift from FY2005 spending, when 41.2 percent was mandatory and 58.8 percent was optional. In FY2013, residential and rehabilitative services for persons with developmental disabilities was the largest category of optional services. Under a Medicaid waiver, individuals are provided residential care in group homes and adult day programs in the community as an alternative to more costly institutional options.

Optional Services	FY2013
Services for the Developmentally Disabled	$209.0
Community Care for the Elderly	90.0
Professional Behavioral Health Care	80.0
Pharmacy	60.0
Professional Services and Supplies	34.0
Hospice	25.0
Dental	10.0
All Other	21.0
Total	**$529.0**

in millions

The Affordable Care Act limits the ability of states to reduce Medicaid eligibility, even for optional populations. Specifically, states are required to maintain "eligibility standards, methodologies, and procedures" that are no more restrictive than those in effect on March 23, 2010 (the date of the Act's passage). States may request relief from this maintenance of effort (MOE) provision from the federal government if they have or project a budget deficit for the current or following state fiscal year. However, this MOE exemption may only be applied to non-pregnant, non-disabled adults whose incomes are above 133 percent of the FPL.

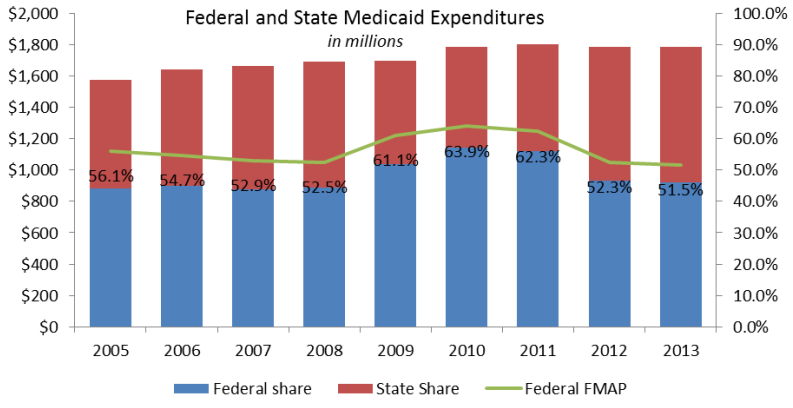
While CMS allows states to impose copayments, coinsurance, deductibles and other similar charges on most Medicaid-covered benefits, Rhode Island's program does not include any out-of-pocket costs for enrollees.

MEDICAID FINANCING

Medicaid is jointly funded by the state and federal governments and accounts for almost half of the federal funds received by the State. Different services are funded with differing degrees of federal financial participation. For most Medicaid services, however, the federal share of spending is determined by the federal medical assistance percentage (FMAP). The FMAP represents the proportion of Medicaid spending in each state that comes from federal funds.

The FMAP for each state is based on the ratio of the state's per capita personal income to the national per capita personal income. The formula is designed so that a state with a per capita personal income equal to the national average will have an FMAP of 55.0 percent. States with lower incomes have higher FMAPs (up to a statutory maximum of 83.0 percent) and states with higher incomes have lower FMAPs (down to a statutory minimum of 50.0 percent).

In FY2009 through FY2011, the American Recovery and Reinvestment Act (ARRA) provided significant financial assistance to states through a temporary increase in the FMAP rate. The ARRA-enhanced FMAP resulted in $148.0 million additional federal funding in FY2009, $206.1 million in FY2010, and $166.1 million in the FY2011.



The above graph shows Rhode Island's effective FMAP by state fiscal year. Since the expiration of ARRA, the State's FMAP has increased and with the State paying for an increasing share of Medicaid expenditures. The FMAP decreased from 52.33% in FY2012 to 51.48% In FY2013 and cost the State an additional $19.3 in general revenue. At FY2013 expenditure levels, a .1 percent decrease in the federal portion of the FMAP adds approximately $1.8 million to the State's share of expenditures. For state fiscal year 2014, Rhode Island's FMAP is 50.40 percent, which means that the federal government is responsible for just over half of Medicaid spending.

The regular FMAP determines federal financial participation for most medical and health insurance services. Other expenditures such as those for services to low income children and those to develop the program's new IT eligibility system (UHIP) are matched at different levels, as specified in federal law. The FY2014 budget includes the following levels federal participation:

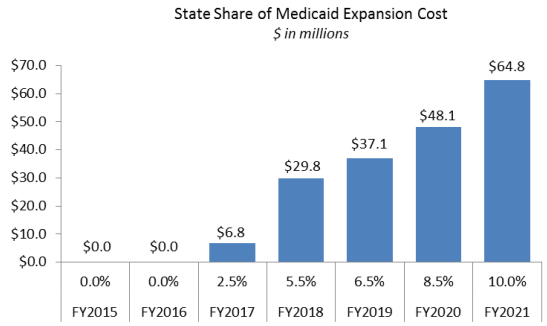
FY2014	FMAP
Regular FMAP	50.4%
Low Income Children (CHIP)	65.0%
Program Administration	50.0%
Expansion Population	100%*
Health Home Services	90%*
UHIP System Development	90%*

** Enhanced FMAP time-limited*

The federal government has extended 100 percent federal funding for those newly eligible under the Affordable Care Act's expansion of Medicaid to all adults, regardless of disability or family situation. This rate is only available to states such as Rhode Island that have adopted the new adult group. It is set to decrease according to the following schedule:

Calendar Year	FMAP
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and beyond	90%

In FY2015, Medicaid expansion under the Affordable Care Act represents an influx of almost $500.0 million in new federal funding with no impact on general revenue. In the long term, however, it is projected cost over $60.0 million in general revenue by FY2021 as follows.



An enhanced FMAP rate for health home services is offered for eight quarters to enable states to build community and social support capacity for those with chronic conditions. The State has received this enhanced funding in the past for its programs to support children with special healthcare needs and for

those with serious and persistent mental illness. The current health home initiative is in support of those with opioid addiction and is set to expire in FY2015.

Enhanced funding for the replacement of the State's Medicaid eligibility and enrollment IT system is available through CY2015. The Unified Health Infrastructure Project (UHIP) is a $135.3 million two phase IT project. The first phase supports HealthSource RI (HSRI), the State's health insurance marketplace mandated under the federal health reform law, while the project's second phase replaces the State's existing health and human service eligibility system with an integrated eligibility system. A collaborative undertaking between the Office of Health and Human Services, Department of Health, Office of the Health Insurance Commissioner, the Department of Human Services, and the Department of Administration, it will allow Rhode Islanders to enroll in public and private health insurance plans and in other state social service programs through a single online interface. The portion of the project associated with the design and implementation of a new Medicaid eligibility system qualifies for 90 percent federal funding.