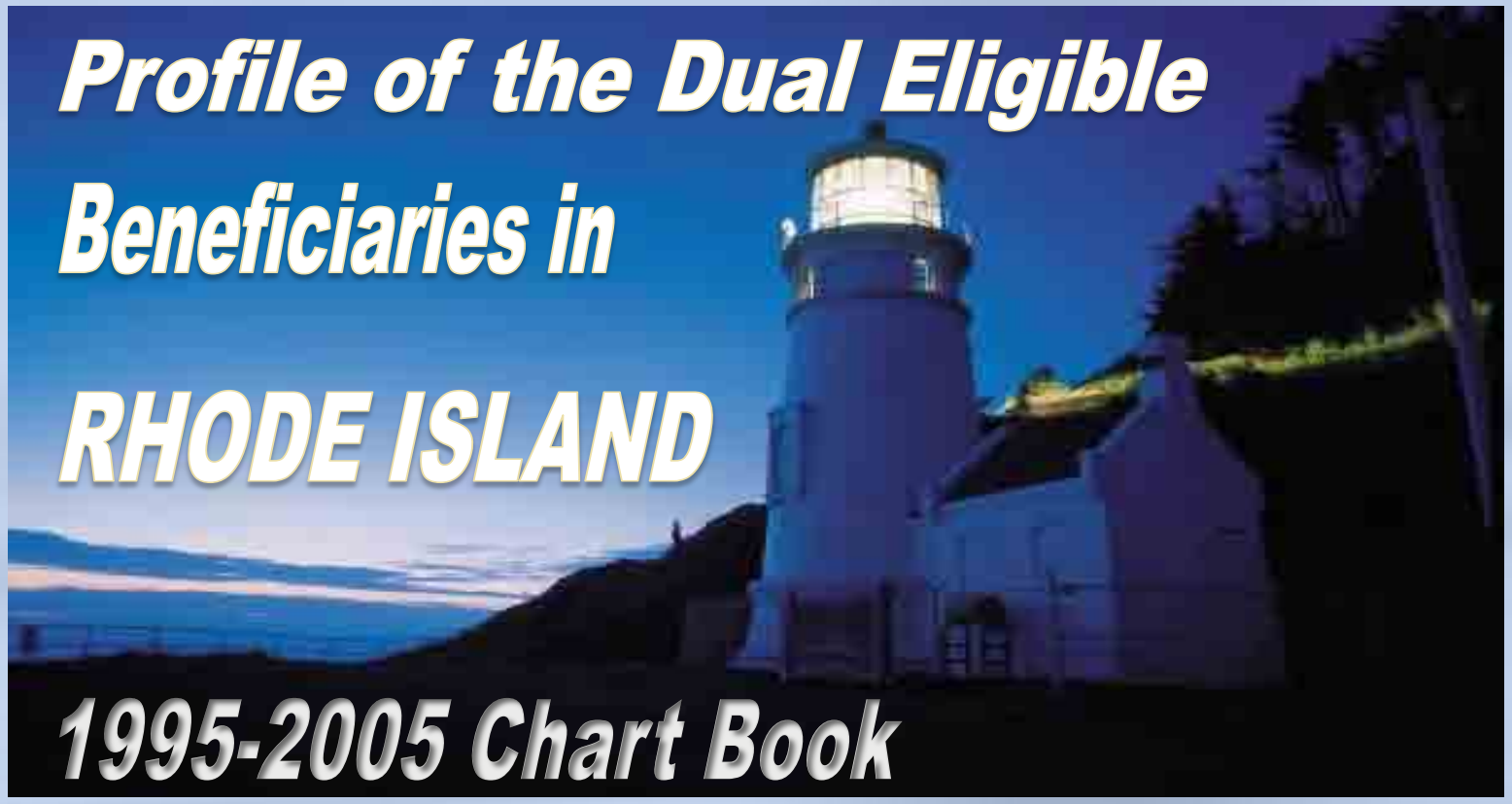
THE
UNIVERSITY
OF RHODE ISLAND
COLLEGE OF
PHARMACY

RHODES to INDEPENDENCE
URI
Creating Pathways to Work

September 2009

Profile of the Dual Eligible Beneficiaries in RHODE ISLAND



1995-2005 Chart Book

THINK BIG WE DO℠

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Background

Who are the dually eligible?

Dual eligibles are either senior citizens or people with disabilities who participate in both the Medicaid and Medicare public health programs. They can be either "fully" or "partially" dually eligible. Partially dually eligibles do not receive the full complement of Medicaid benefits. They are usually either seniors or people with disabilities who are receiving assistance paying the premiums or co-payments required by Medicare. Full dual eligibles, on the other hand, are receiving the full complement of Medicaid benefits and are the individuals we are analyzing in this Chart Book.

People become fully dual eligible in the following ways:

- They are less than 65 years old and meet Medicaid and Medicare disability criteria, or meet Medicare disability criteria and Medicaid low-income criteria,

OR

- They are 65 or older and qualify for Medicare benefits because of their age and work history and qualify for Medicaid low-income criteria.

What is Medicaid?

Medicaid is public health insurance for low-income seniors age 65 and over; people who are blind or disabled; children, pregnant women, and caretaker relatives.

Who is eligible for Medicaid?

People must be Rhode Island residents who meet certain income and resource guidelines and are either:

- Aged 65 and older
- Individuals with disabilities (adults and children)
- Children, pregnant women, and parents or caretaker relatives. Meeting certain household eligibility tests, related to Temporary Aid to Needy Families (TANF).

What benefits are provided under Medicaid?

Medicaid has two parts: Acute Care and Long Term Care and/or Chronic Care

1. *Acute Care* Covered benefits for adults who are "Categorically Needy" are the following:
    - Inpatient Hospital Services
    - Inpatient Psychiatric Hospital Services

- Outpatient Hospital Services:
  - Clinic And Emergency Room Care
  - Laboratory and X-Rays
  - Pharmacy
- Physician Services
- Pharmacy Services
- Dental Services
- Clinical Laboratory Services
- Durable Medical Equipment, Surgical Appliances, And Prosthetic Devices
- Certified Home Health Agency Services
- Podiatry Services
- Ambulance Services
- Community Mental Health Center Services
- Substance Abuse Services
- Nursing Facilities Services
- Optometric Services
- Intermediate Care Facility and Day Treatment Services for the Mentally Retarded
- Hospice Care Services
- Organ Transplant Services

2. Long Term Care and/or Chronic Care: Many duals are eligible for Medicaid through Long-Term Care. To qualify for Long-Term Care one must be over 65 years of age or have a disability. Individuals must meet certain financial and program criteria and be determined to require the level of care provided in an institution or nursing facility. Eligible individuals are offered a choice between an institution/nursing facility and home and community-based services through specific waivers. (Pre-Global Consumer Choice Waiver).

A) Institutional Services provide 24-hour care to individuals with disabilities or the elderly with significant levels of impairment. Residents receive the following:

- Room and Board
- Supervision
- Nursing Services
- Transportation
- Recreational and Social Services
- Necessary medical services not included in the daily rate are arranged for as needed.

B) Home and Community Based Waiver Services[1] are available for individuals who meet a nursing home level of care need. A variety of services may be

[1] Prior to the Global Consumer Choice Waiver obtained January 2009

available (depending on the specific waiver) including:

- Homemaker Services
- Case Management Services
- Home Health Aide Services
- Personal Care Services
- Respite Care Services
- Minor Home Modifications
- Residential Assisted Living
- Habilitative Services

What is Medicare?

Medicare is a health insurance program for people 65 years of age and older; some people with disabilities under age 65, and people with End-Stage Renal Disease (permanent kidney failure, requiring dialysis or transplant). Who have a work history or in case of a spouse is/was married to someone with the required work history.

What benefits are provided under Medicare?

Medicare has two parts: (As of 12/2005-Medicare Part D was added 1/2006)

1. Part A (Hospital Insurance): Helps pay for care in hospitals as an inpatient, critical access hospitals (small facilities that give limited outpatient and inpatient service to people in rural areas), skilled nursing facilities, hospice care, and some home health care.

2. Most people get Part A automatically when they turn age 65. They do not have to pay a monthly premium if they or a spouse paid Medicare taxes while they were working. Individuals who are 65 years of age or older and who did not pay Medicare taxes are often able to pay a premium for Part A.

- Part B (Medical Insurance): Helps pay for doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

- Most beneficiaries pay the Medicare Part B premium. In some cases amount is higher if the person did not choose Part B when he or she first became eligible at age 65. A person who chooses to have Part B usually has the premium deducted from his or her monthly Social Security, Railroad Retirement or Civil Service Retirement payment.

Medicare and Medicaid Beneficiary Profile RI Compared to the US: 2005

Statistic	Rhode Island	United States
Population (2005)		
% age 20-49	42.4%	42.8%
% age 50-64 ***Key Trend: % Change from 1995: RI 50.5/US 44.8***	17.2%	17.0%
% age 65-84 ***Key Trend: % Change from 1995: RI (2.9)/US 9.2***	11.6%	10.7%
% age 85 and older	2.3%	1.8%
Characteristics of Population		
Household income **people under 65**		
•Poverty or below ***Key Trend: % Change '94-04: RI 18.6/US (11.9)***	20.7%	22.9%
•At/below 200% of poverty	24.5%	29.5%
Household income **people 65 and over**		
•Poverty or below	8.1%	9.8%
•At/below 200% of poverty	30.2%	28.1%
Medicaid Enrollees (2001)	193,800	47,060,700
% Elderly	11.9%	10.9%
% Disabled	16.8%	14.9%
% Population **under age 65** in poverty who have Medicaid	51.4%	43.2%
Key Trend: Total Medicaid Enrollment % Change '92-01: RI 56.3/US 31.6		
Medicaid Payments (as % of total) (FY 2002)		
% Spent on Elderly	26.9%	24.3%
% Spent on Disabled	47.3%	43.3%
% Spent on Long Term Care (FY 2004)	31.6%	31.6%
Medicaid expenditures as % of total state budget (FY 2003)	26.3%	21.4%
Key Trend: Nursing Home Residents over age 65 %Change '94-04: RI 2.1/US (15.6)		
Medicare Beneficiaries	173,000	41,385,000
% Also Covered by Medicaid (Full or Partial) (2003)	20%	19.0%
% Disabled (under age 65) (2004)	16.2%	15.4%

Source 2005 AARP State Profiles

- The overall population in the age cohort 50-64 has ***increased*** 50.5% in RI, outpacing the US ten-year trend which was only 44.8%. Rhode Islanders under age 65 at or below poverty ***increased*** by 18.6% (compared with a ***decline*** of 11.9% nationally).
  - Although RI provides coverage to 51.4% of Medicaid-eligible residents (compared to 43.2% nationally), a significant number of Medicaid-eligible people with disabilities are not enrolled. The disabled population accounted for 16.8% of total Medicaid enrollees (national percentage was 14.8%).
  - RI Medicaid expenditures (2002) for the disabled were 47.3% of the total – this was 4% higher than the national average.

- The overall population in the 65+ age cohort actually ***decreased*** in RI by 2.9%, while the US saw an ***increase*** in this population by 9.2%.
  - During 2005, the number of RI nursing home residents in this cohort ***increased*** by 2.1% (compared with a ***decline*** of 15.6% nationally).
  - The elderly comprised 11.9% of RI Medicaid enrollees (2005) (compared with 10.9% nationally).
  - In 2002, RI Medicaid expenditures for the elderly represented 26.9% of total expenditures, 3% higher than the national average.

Executive Summary

This Chart Book highlights demographics, healthcare services, expenditures and the variation in cost by settings of care for seniors and people with disabilities in Rhode Island who were enrolled in both Medicare and Medicaid between 1995 -2005. Objectives and Findings of this Chart Book are outlined below:

OBJECTIVE 1: *To compare Medicare and Medicaid spending patterns for the dual population in Rhode Island.*

FINDINGS

- The Medicaid program bears the significant share of the cost for the duals, which remained relatively constant over the ten year period at 70% even though costs climbed in both programs. (Chart 5) Medicare contributes substantially less for both the disabled and frail elderly cohorts where there has been a constant split of 25% /75% between the programs. (Chart 6)

- Medicare's share of costs is greater for duals living in the Community though steadily decreasing in relation to Medicaid's share. By 2005, there was a 50/50 split, down from 75/25 (1995).
    - Medicaid's share for Community residents ***increased*** more sharply (412%) than Medicare's (94%), due in large part to the explosion in pharmaceutical costs. (Chart 10)

- While there is a similar trend in the Long Term Care (LTC) Community (excluding those in the Developmental Disabilities Waiver), since 1995 Medicare's share in comparison with Medicaid's has ***decreased*** from 61% in 1995 to 47% in 2005. (Chart 7)
    - Medicaid cost increases outpaced Medicare for LTC Community duals of 57% (only 9% for Medicare). This is probably attributable to the change in home health care payment policy imposed by Congress in 1997. (Chart 11)

    - Although Medicaid consistently outspends Medicare for Institutional duals, the expenditure increase over the ten years was actually higher for Medicare at 42% than for Medicaid (10%). Medicare experienced significantly higher costs for institutions and HCBS for this cohort. (Chart 12)

OBJECTIVE 2: *To understand the impact of Medicare policy changes on the Medicaid program by analyzing Medicare's policy change in the 1997 budget bill that reduced home health care payments.*

FINDINGS

- Changes in Medicare policy implemented by the Balanced Budget Act of 1997 created a significant drop in home health costs for the Medicare program between 1999-2003. There was a 3% ***decline*** in costs. During this time frame, Medicaid continued climbing and significantly ***increased*** by 17% predominantly due to waiver services. (Chart 13)

- In 2000, average yearly Medicaid costs for LTC Community setting ($43,226) were higher than average yearly costs in the Institution ($42,405).
  - Average annual Medicare costs declined from 1995-2005 almost $2,000 for duals (with and without DD waiver participants) due to:
    - Medicare reduced payments for home health, therefore costs were shifted directly to Medicaid;
    - DD Waiver group home costs are included; and
    - Nursing home reimbursement increases had not taken place for a number of years in RI. (Chart 7)

OBJECTIVE 3: *To understand the differences among various age cohorts of dual-eligibles in Rhode Island.*

FINDINGS

- Between 1995-2005, the number of RI dual eligibles aged 20-64 ***increased*** by 61% while those over age 65 ***declined*** by 25%. The disabled elderly was the only elderly cohort to increase. (Chart 1)
  - Due to the fact that there has been an 18.6% ***rise*** in Rhode Islanders under 65 living at or below the poverty level (compared to the national average of 11.9% ***reduction*** for people under 65 living in poverty)[2], this trend is likely to continue.

- Consistent with Chart Book findings, AARP national trends over the past ten years document the overall population with a disability is ***increasing*** faster (44%) than the aged population (9.2%).[3] In RI, the

[2] See page 5, *Medicare and Medicaid Beneficiary Profile RI Compared to the US: 2005*
[3] *Ibid*

65-84 cohort ***decreased*** 2.9% while the 50-64 cohort ***increased*** 50%.[4]

- Individuals with disabilities were much less likely to join a managed care plan than any of the other cohorts, ***increasing*** to only 4% of the total cohort over the ten year period as compared to ***increases*** of 17% and 16% for Seniors and Frail Elderly respectively. (Chart 4)

- In 1995, the proportion of enrollees by age cohort is similar to their respective expenditures. By 2005, the population shift between the elderly (23% ***decline***), frail elderly (32% ***decline***), and the disabled (56% ***increase***) is dramatic. If this trend continues, considering the variation in per member yearly costs, (excluding DD Waiver participants) $51,000 for frail elderly, $31,000 for elderly and $22,000 for people with disabilities, there should be a reduction in Medicaid expenditures predominantly due to the higher use of HCBS for people with disabilities. (Chart 8)

OBJECTIVE 4: *To understand acuity variations among duals by analyzing settings of care.*

FINDINGS

- Most of the duals in RI have been residing in the Community with a relatively small percentage living in Institutions. This gap increased between 1995-2005. By 2005, 67% of duals lived in the Community without a nursing home level of care need. When we include the LTC Community dwellers, an astounding 80% of the dual population were living in a Community setting. (Chart 2)
  - By 2005, the average yearly cost of care for Community duals is the lowest at $13,400 (Chart 7) constituting 27% of combined Medicare and Medicaid costs. (Chart 9)
  - LTC Community (w/o DD Waiver) cost an average of $38,800. (Chart 7) and is only 12% of the combined Medicare and Medicaid costs in 2005. (Chart 9)
- There has been a 38% ***reduction*** between 1995-2005 of duals living in Institutions but the highest average cost of care in 2005 was for the 23% of duals who are living in Institutions (an astronomical $80,900) (Chart 7) – this constitutes 48% of total

[4] *Ibid*

Medicare and Medicaid expenditures. (Chart 9) The average cost for the duals with nursing home level of care need—but living in the LTC Community, including those in the DD waiver, is $65,200 much closer to an Institutional dual's average yearly cost primarily due to the amount expended for group homes for the DD population. (Chart 7)

- Medicaid's **highest service cost** depends greatly on setting of care. For Community dwellers prescription drugs far exceed any other service rising from 55% in 1995 to 59% of total costs in 2005. (Chart 10) For the LTC Community the most prevalent service was HCBS at 92% in 1995, falling substantially to 78% in 2005, still comprising by far the highest cost service. (Chart 11) For duals in Institutions, institutional expenditures were 71% of the total in '95 and 67% of the total in '05. (Chart 12)

- On the other hand, Medicare's **highest service expenditure** is hospitals for all settings of care. The percentage change in the various settings over time is of significance. For Community duals hospital expenditures accounted for 58% of total costs in 1995, falling to 45% of total costs by 2005. (Chart 10) LTC Community hospital costs were 44% of the total in 1995 but rose to 47% of the total by 2005. (Chart 11)

- The most interesting change occurred in the Institution setting of care. In 1995, hospital costs represented 43% of the total and by 2005 were only 37% of the total. In addition, this was the only setting of care in which Medicare expenditures represented a greater percentage cost increase than Medicaid, is indicative of the urgent need to look more closely at services where a significant expenditure increase took place. Institutional costs climbed dramatically by 111%, to 33% of the total in 2005 -up from 22% in 1995. Although not as significant in overall dollars spent HCBS costs experienced a 184% increase over the ten year period (4% of the total, up from 2% in 2005). (Chart 12)

Data and Methodology

Sources of Data

- Medicaid: Rhode Island Medicaid Management Information System eligibility and claims data files
- Medicare: CMS Standard Analytical Files
- Data derived from all RI Medicare beneficiaries with Medicare with Part A and Part B Coverage. Unless noted, only Medicare Fee-For-Service beneficiaries were included.

Data Base Construction

- Link enrollment data technique; Primary keys
- Rhode Island SSN - CMS SSN
- Rhode Island SSN – CMS HIC
- Rhode Island Name – CMS Nam
- Validating Information
- Date of Birth
- Gender
- State HIC

Aggregate data sets developed by JEN Associates so that EXCEL programming could be used to analyze specific data base elements for the dual eligible population in RI.

- Standardize payment categories
- Extract clinical data
- Construct person-level analytic records
- Construct population-level databases

Key Created Data Elements Defined

1. **Settings of Care**
   - *Community:* Person living in their own home or in a group home. Generally not in a Medicaid Waiver.
   - *Long-term Care Community:* Person living in their own home or a group home, with a level of care need equivalent to a nursing home level of care. Generally in a Medicaid Waiver.
   - *Institution:* Person living in a nursing home or a state institution due to the individual's level of care needs.

2. **Disabled Elderly**
   - An individual whose original beneficiary status in Medicare was "disabled" but has now turned 65. The new cohort was developed to be able to evaluate disease trajectory and other variables particular to the disabled elderly. This cohort is generally lost in national Medicare data bases because once a disabled individual hits 65 they are categorized as "Senior".

3. **Person Counts**

   Determined by calculating "a program eligible month" for the Medicare and Medicaid programs separately.
   - For Medicare, there are 12 monthly eligibility status flags in the annual denominator record for a beneficiary. The monthly status includes whether an individual is Part A-only, Part B-only, or Part A&B and also denotes whether an individual is enrolled in a managed care plan. Medicare population count is based on the Medicare eligible months divided by 12.

   - For Medicaid, date spans are determined –any month that is included in the date span is a Medicaid eligible month as long as the aid category indicates full Medicaid eligibility - as opposed to a state-only program or QMB/SLMB-only limited benefits. Medicaid program population counts are based on Medicaid eligible months divided by 12.

   - Dual eligible program counts are based on concurrent months of Medicaid and Medicare divided by 12 in the year.

The above methodology was developed in order to produce more accurate statistics of Medicaid-only, Medicare-only, and dual eligibles without double counting. People who transition in the year are counted fractionally.

Dual Eligible Population and Expenditure Comparisons in Rhode Island

Demographics

- ***Chart 1:*** Age Cohorts: 1995 vs.2005
- ***Chart 2:*** Setting of Care: 1995-2005
- ***Chart 3:*** Medicare FFS vs. Managed Care: 1995-2005
- ***Chart 4:*** Medicare FFS vs. Managed Care by Age Cohort: 1995-2005

Medicare vs. Medicaid Spending on Duals

- ***Chart 5:*** Total Expenditure Trend: 1995-2005
- ***Chart 6:*** Expenditures by Age Cohort: 1995-2005
- ***Chart 7:*** Average Cost/Dual by Setting of Care: 1995-2005

Combined Medicare & Medicaid Spending On Duals

- ***Chart 8:*** Age Cohort (with and without DD Waiver Participants): 1995-2005
- ***Chart 9:*** Setting of Care (with and without DD Waiver Participants): 1995-2005

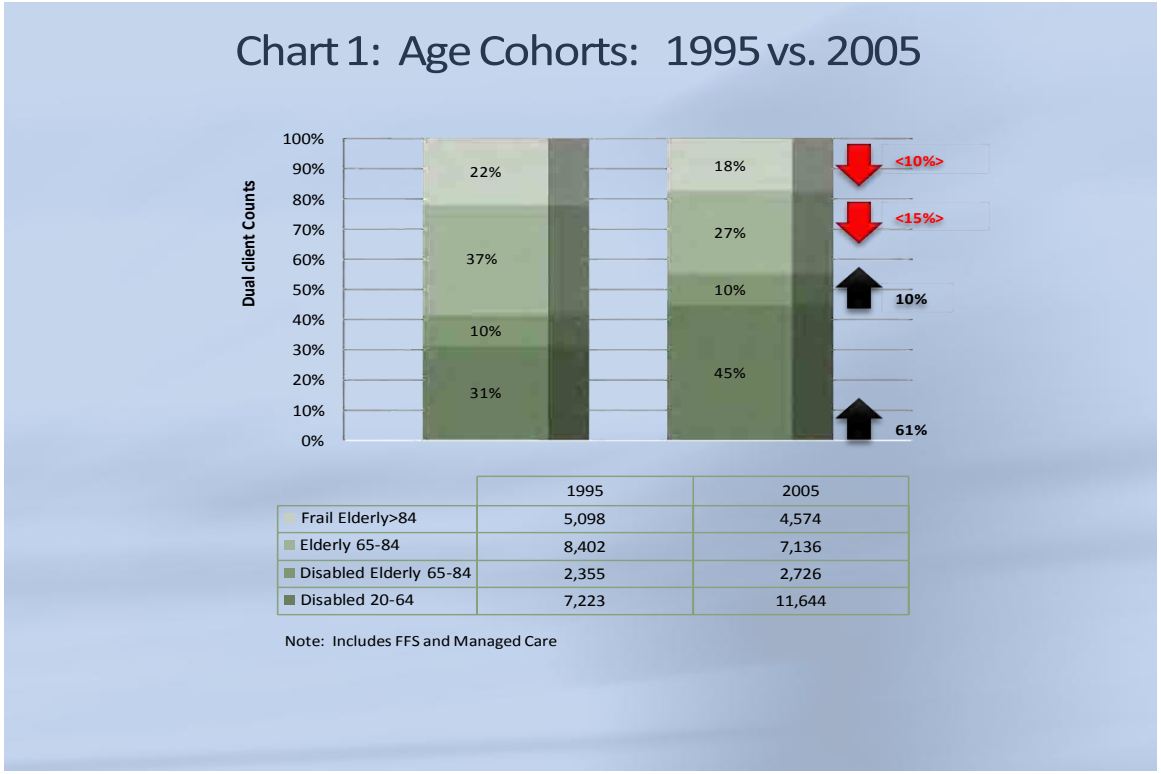
Medicare & Medicaid Service Expenditures by Setting of Care

- ***Chart 10:*** Community Duals: 1995-2005
- ***Chart 11:*** Community Long Term Care Duals: 1995-2005
- ***Chart 12:*** Institutionalized Duals: 1995-2005

Taking a Closer Look

- ***Chart 13:*** Home & Community Based Services: 1995-2005
- ***Chart 14:*** Medicaid Prescription Drug Costs: 1995-2005

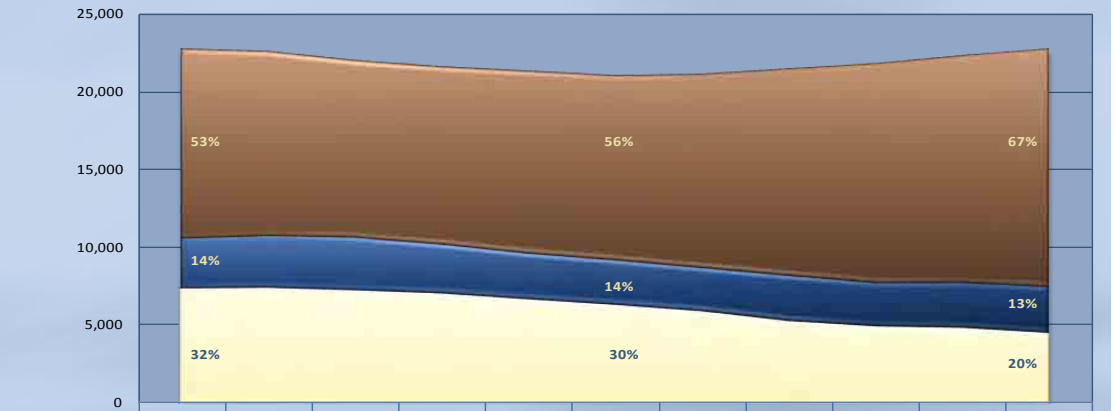
Demographics



- Between 1995 and 2005, duals 20-64 ***increased*** by 61% while those over 65 ***decreased*** by 25%.

- If we include the disabled elderly, which is a specialized age cohort we have been tracking, then those over 65 actually only ***decreased*** by 15%. It is important to note that this population was originally Medicare disabled. Most data extracted on the Medicare population does not segment out this population.

Chart 2: Setting of Care : 1995 – 2005

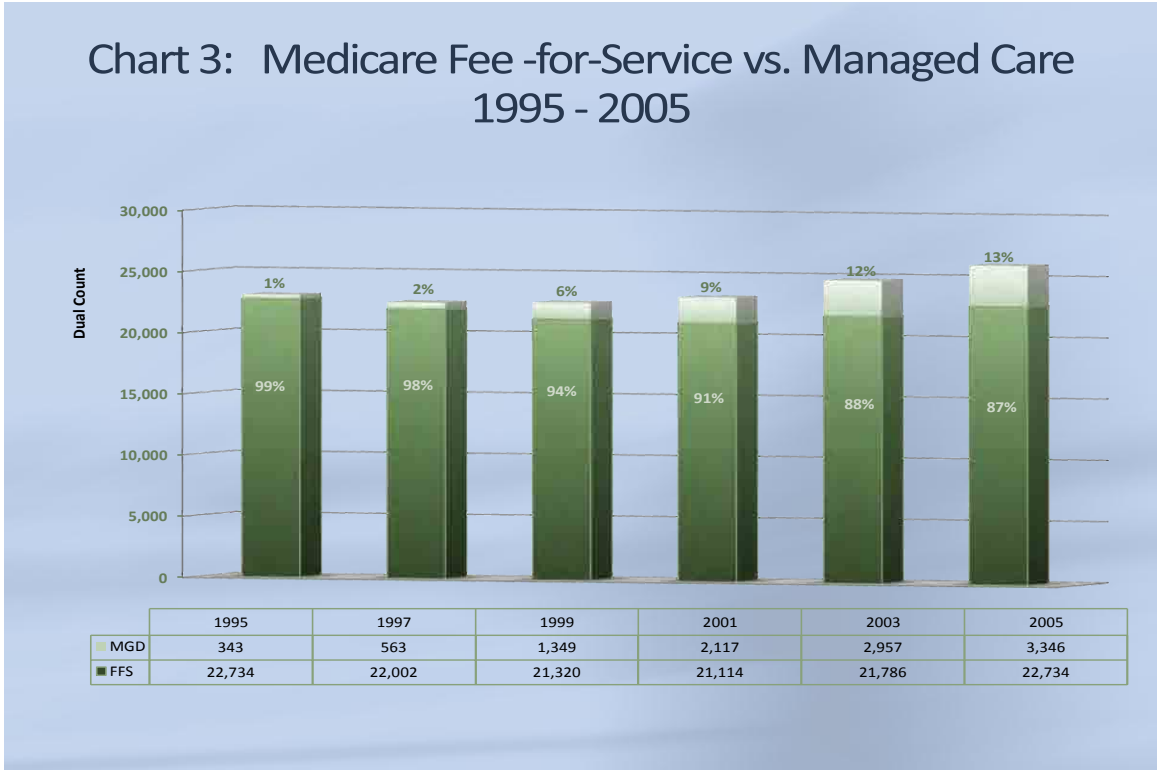


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Community	12,150	11,824	11,342	11,379	11,677	11,814	12,390	13,230	14,022	14,531	15,216
LTC Community	3,247	3,378	3,438	3,203	2,994	2,919	2,832	2,957	2,827	2,931	2,999
Institution	7,338	7,379	7,221	7,016	6,650	6,297	5,893	5,272	4,937	4,844	4,519

- Over this period of time, the *Community* duals ***increased*** by 25%, accounting for 67% of the duals in 2005, while *Institutional* duals ***decreased*** by 38%, accounting for only 20% of the duals in 2005.

- It is interesting to note that while the *LTC Community* duals actually ***decreased*** slightly by 8% their percentage of the total remained relatively constant at 13% through 2005.

Demographics

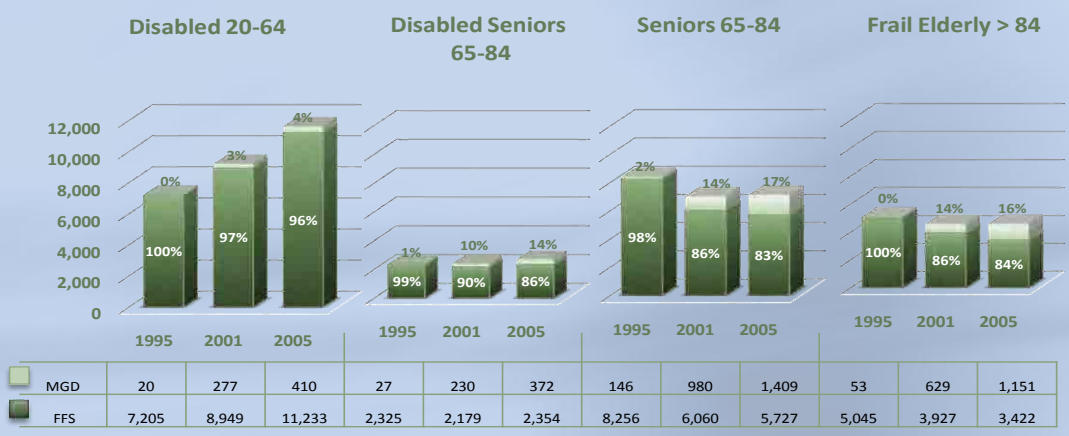


- Duals enrolled in Medicare managed care ***increased*** dramatically from 343 in 1995 to 3,346 in 2005-an ***increase*** of 875%.

- While those duals enrolled in fee-for-service remain the overwhelming majority ***increasing*** from 23,077 in 1995 to 26,079 in 2005—this was only a 13% ***increase***.

Demographics

Chart 4: Medicare: Fee-for-Service vs. Managed Care by Age Cohort: 1995 - 2005

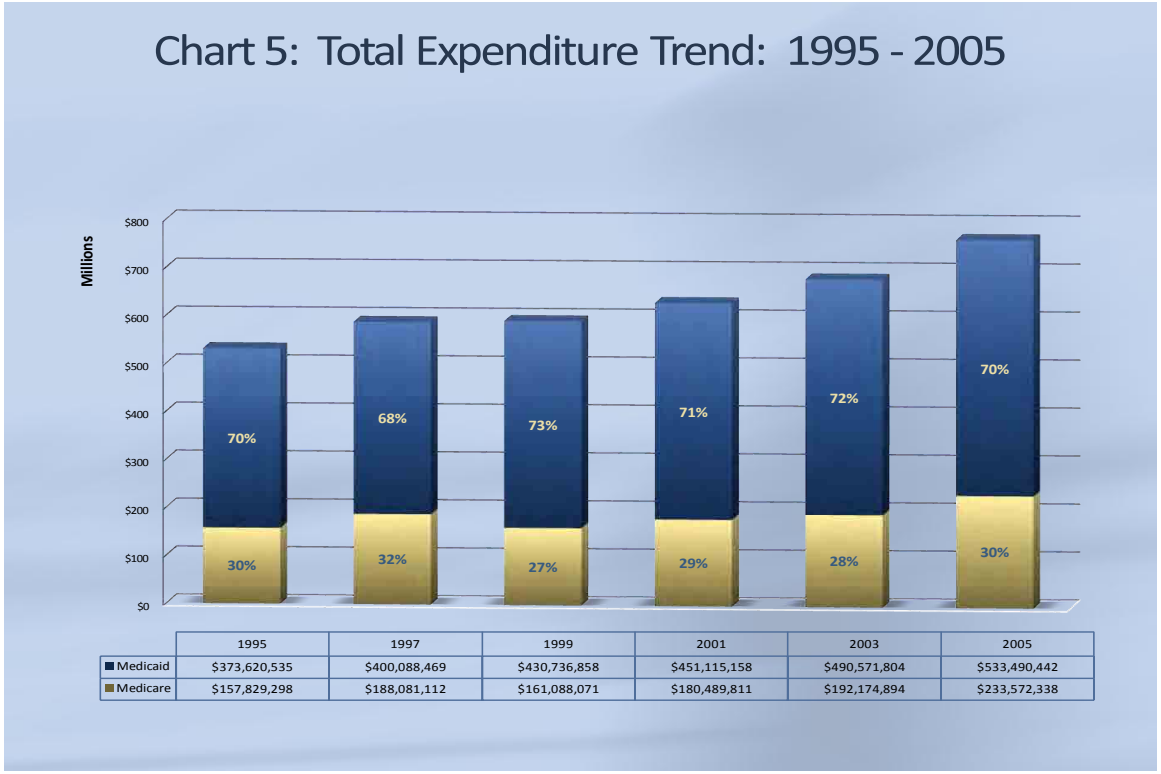


	1995	2001	2005	1995	2001	2005	1995	2001	2005	1995	2001	2005
MGD	20	277	410	27	230	372	146	980	1,409	53	629	1,151
FFS	7,205	8,949	11,233	2,325	2,179	2,354	8,256	6,060	5,727	5,045	3,927	3,422

- The most significant increase in Medicare managed care enrollment occurred in the 65-84 cohort which went up 1,263 people- an ***increase*** of 865% between '95-'05, meanwhile those seniors who were first Medicare disabled had the lowest increase at 127%--only going up 345 people.

- In this eleven year period, it is striking that the frail elderly duals enrolled in managed care ***increased*** to 16% of the total cohort while the disabled duals only ***increased to*** a mere 4% of the total cohort.

Medicare vs. Medicaid Spending on Duals

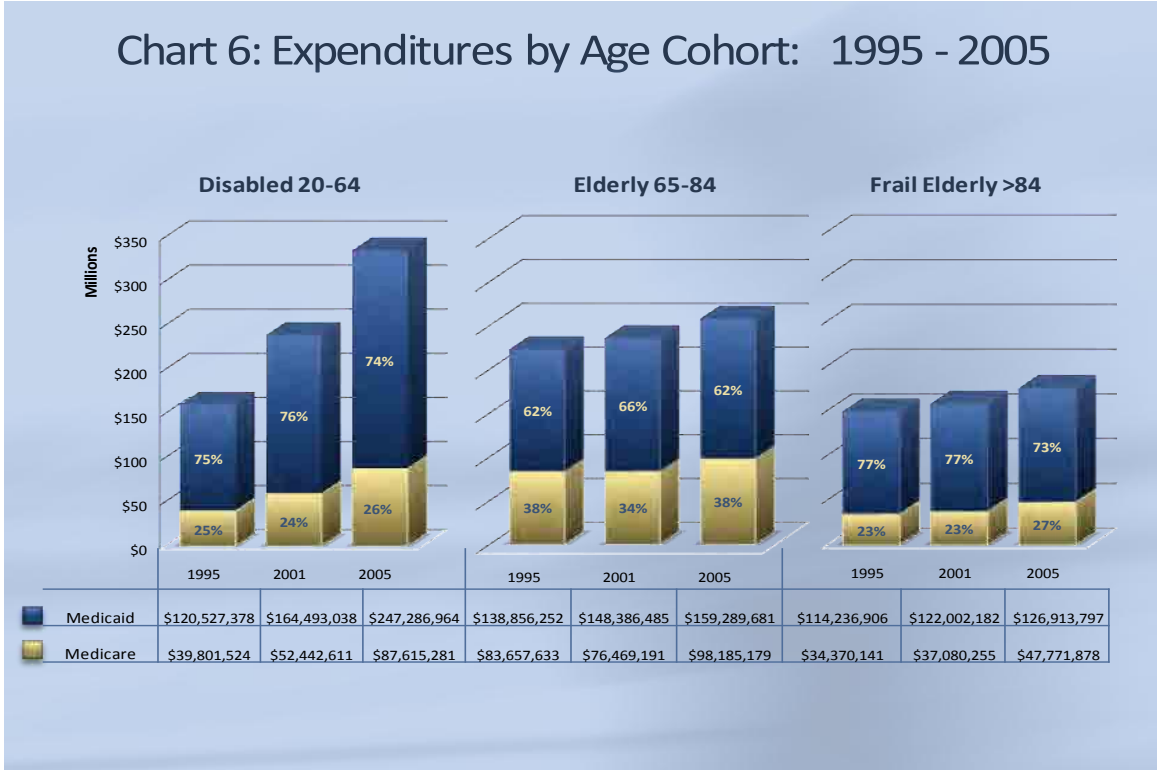


	1995	1997	1999	2001	2003	2005
Medicaid	$373,620,535	$400,088,469	$430,736,858	$451,115,158	$490,571,804	$533,490,442
Medicare	$157,829,298	$188,081,112	$161,088,071	$180,489,811	$192,174,894	$233,572,338

- Although Medicaid and Medicare share the total health care costs for the duals, between '95-'05 RI's Medicaid share was consistently in the 70% range while Medicare's share remained in the 30% range.

- Even though Medicaid expenditures for duals in RI are significantly greater than Medicare expenditures, Medicare expenditures ***increased*** by 48% while Medicaid expenditures ***increase*** was 43% during this eleven year period.

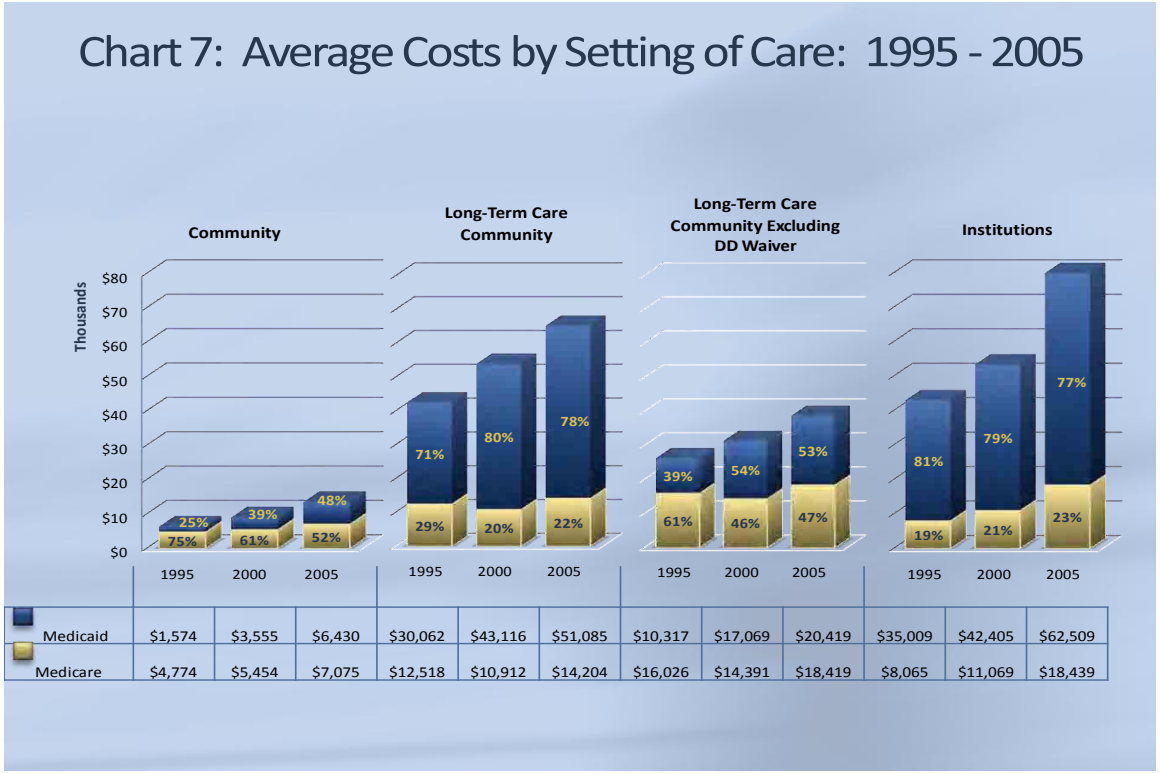
Medicare vs. Medicaid Spending on Duals



- Although Medicare expended the most dollars on the 65-84 cohort, this age group had the lowest increase in the eleven year time span at 17%. The greatest increase in Medicare was for the 20-64 age cohort at 120%- ***increasing*** almost $48 million.

- In comparison, the ***greatest increase*** in Medicaid at 105% was also for the 20-64 age cohort. By 2005, the $247 million spent on this cohort was significantly greater than the $159 million spent on the 65-84 age cohort. Interesting to note is that the *Frail Elderly* had the ***lowest increase*** at only 11%.

Medicare vs. Medicaid Spending on Duals

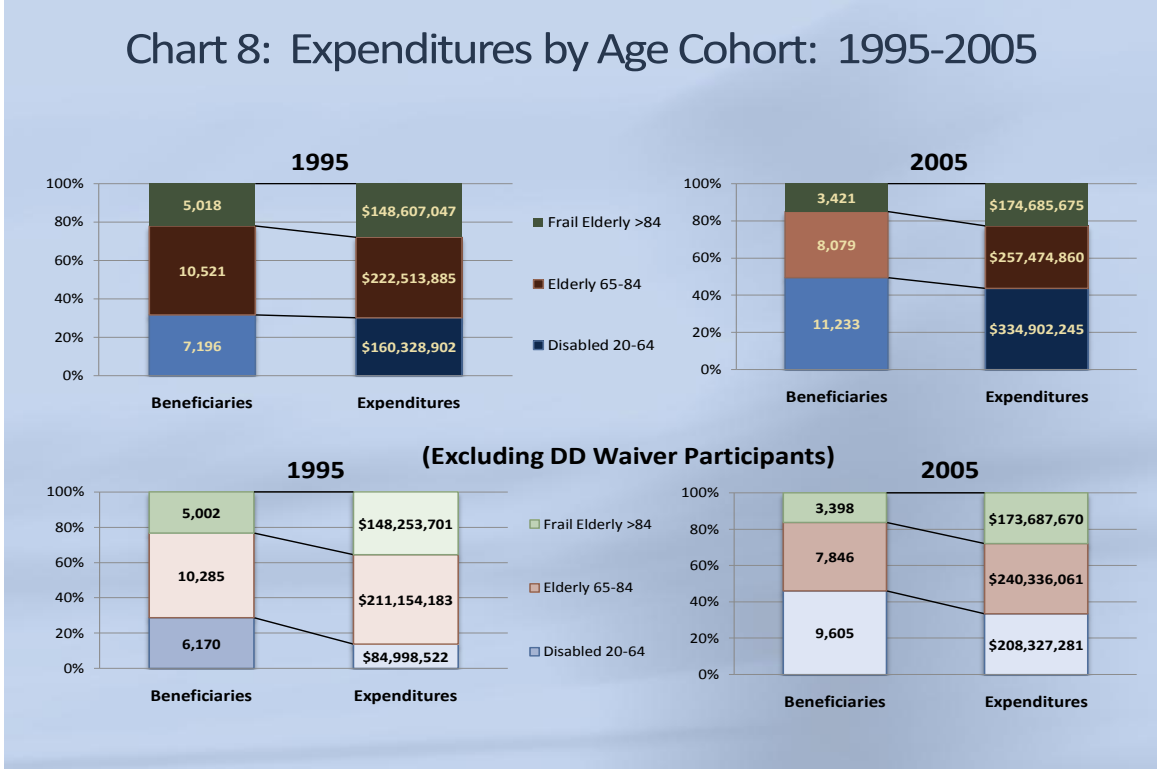


- The highest yearly average cost for Medicaid remains duals in *Institutions* which ***increased*** $27K per person or 79% in the eleven year period. The lowest cost remained duals in the *Community* at $6,430 for ’05, even though it had the highest percentage ***increase*** at 309%.

- The *Community* was also the lowest setting of care cost for Medicare at $7,075 in ‘05 or a 48% ***increase*** over the time frame. Meanwhile, the highest cost was equal for duals in *LTC Community & Institutions* in ‘05, when excluding the DD waiver participants, at $18K per person. The greatest cost ***increase*** was 129% for duals in *Institutions.*

- When the DD waiver participants are excluded, Medicaid’s cost for *LTC Community* were significantly less every year from a per person average ***reduction*** of $20K in ’95 to a $31K ***reduction*** in ’05.

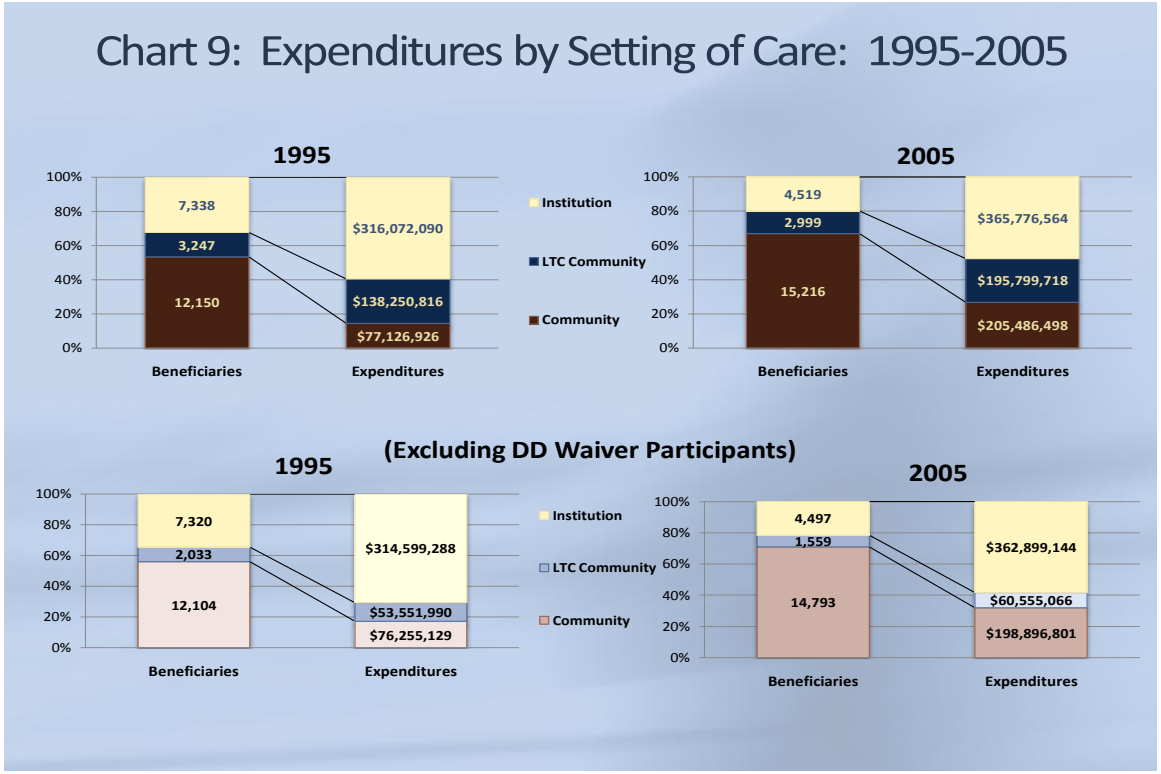
Combined Medicare & Medicaid Spending on Duals



- In 1995, the percentage of enrollees by age cohort respective to their costs was *Frail Elderly* 22% vs. 28%; *Elderly* 46% vs. 42%; *Disabled* 32% vs. 30%. By 2005, although there was a significant ***reduction*** in *Frail Elderly* now 15% of enrollees their costs were 23%; *Elderly* ***reduced*** to 36% and their costs ***reduced*** to 34%; *Disabled* ***increased*** to 49% but their costs only ***increased*** to 44%.

- When DD waiver participants were excluded the relationship changed as follows: in '95 the *Disabled* are 29% vs. 19%; the *Elderly* were 48% vs. 48%; *Frail Elderly* were 23% vs. 33%. By 2005, the *Frail Elderly* ***fell*** to 16%; the *Elderly* ***fell*** to 38%; the *Disabled* ***rose*** to 46%. Expenditure changes: *Frail Elderly* ***fell*** to 28%; *Elderly* fell to 39%; *Disabled* ***rose*** to 33%.

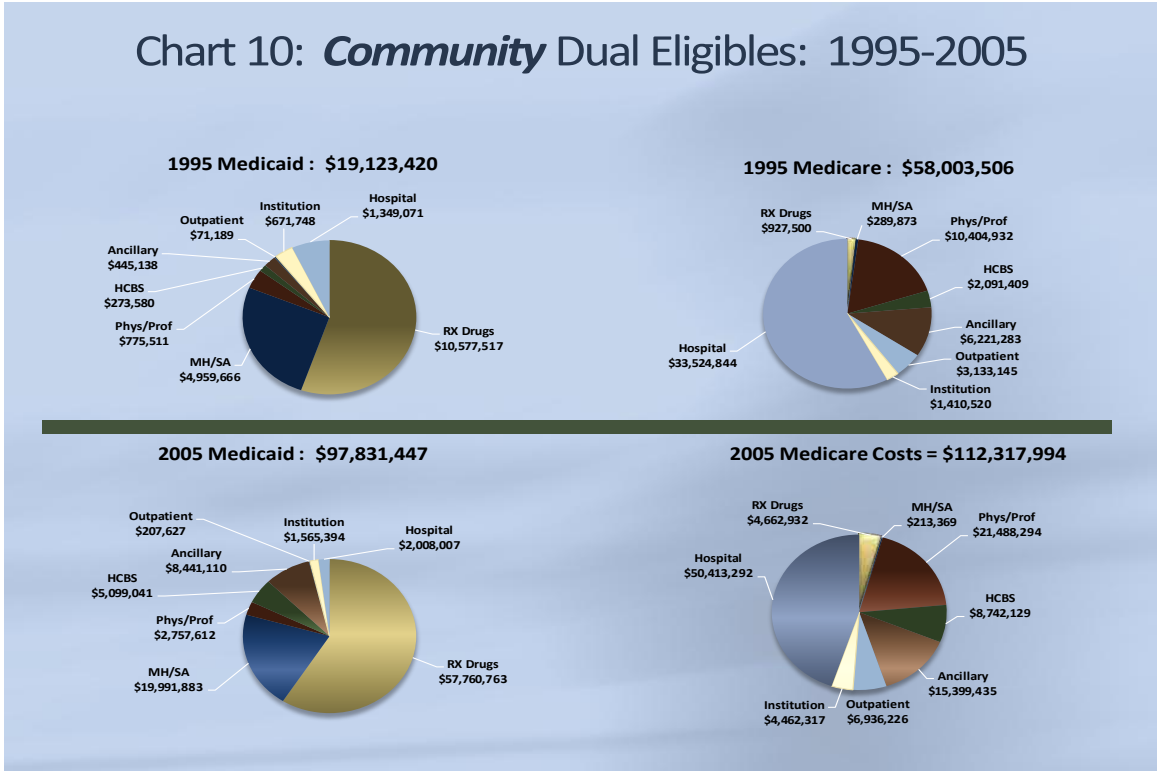
Combined Medicare & Medicaid Spending on Duals



- In ’95, the percentage of enrollees by setting of care varied greatly compared to their respective costs. *Community* dwellers were 54% vs. only 15% of costs; *LTC Community* was 14% vs. 26%; people in *Institutions* were 32% but costs were 59%. By ’05, *Community* dwellers ***climbed*** to 67% vs. only 27% of costs, while people in *Institutions* ***fell*** to 20% but costs were 48%. There were insignificant changes in *LTC Community* dwellers.

- When DD waiver participants were excluded in 1995, the most significant changes were the ***reduction*** in *LTC Community* dwellers to 9% with costs ***dropping*** to 12% and people in *Institutions* ***rising*** to 34% of total and costs ***climbing*** to 71%. By ’05, *Community* dwellers ***rose*** to 71% of total and costs to 32%; people in *Institutions* ***declined*** to 22% of total and costs were 58%. Again, there were insignificant changes for *LTC Community* dwellers.

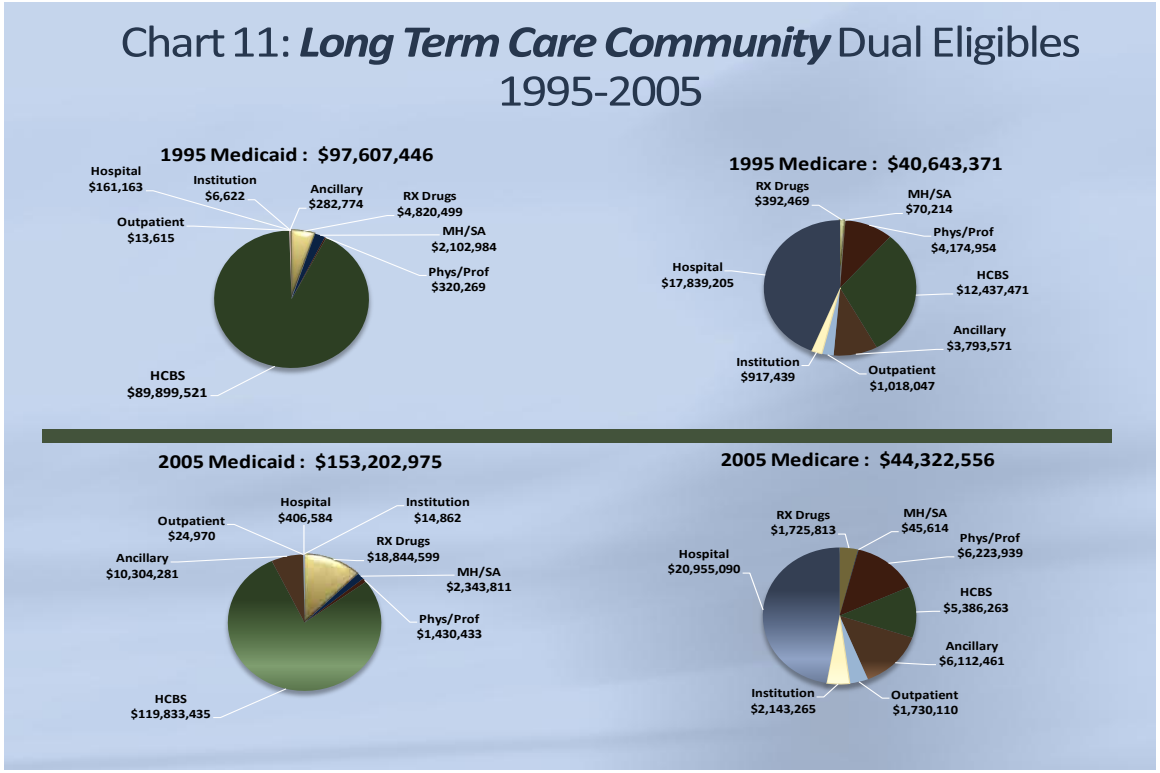
Medicare & Medicaid Service Expenditures by Setting of Care



- Medicaid's overall expenditure increase for *Community* duals between '95-'05 was 412%. The highest service expenditure was prescription drugs. In '95 drugs were 55% of total costs and in '05 they ***rose*** to 59% of total costs, which was a 446% ***increase*** from '95. MH/SA, the second highest expenditure also ***increased*** significantly by 303%. The largest increases in service expenditures over the eleven year period were for Ancillary (costs ***increased*** $8M) and HCBS (costs ***increased*** $4.75M) services.

- Medicare's overall expenditure increase for the eleven year period was only 94%. The highest service expenditure was hospitals which in '95 were 58% of the total cost but by '05 ***fell*** to 45% of the total cost. All other services ***increased*** their percentages: HCBS ***rose*** to 8% of total; Drugs ***rose*** to 4% of total; Ancillary to 14% of total; Physicians to 19% of total; Outpatient to 6% of total and Institutions to 4% of total.

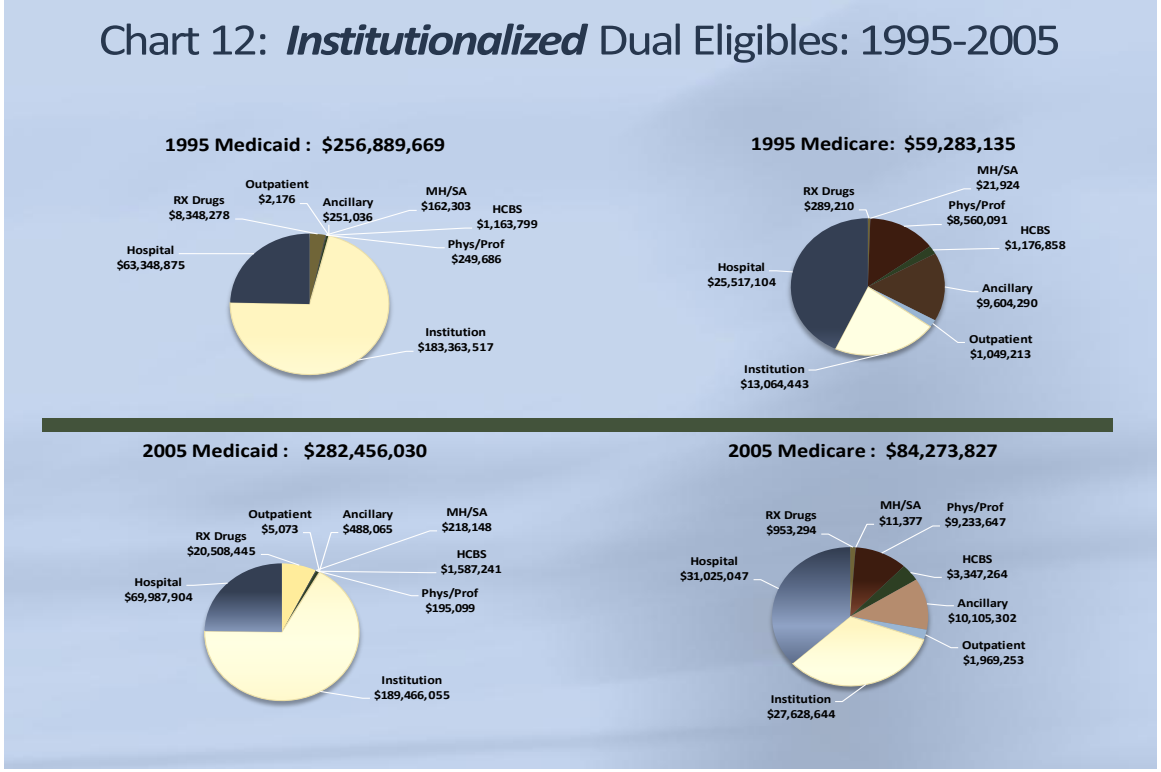
Medicare & Medicaid Service Expenditures by Setting of Care



- Medicaid's overall expenditure increase for *LTC Community* duals between '95-'05 was 57%. The highest service expenditure was for HCBS. In '95 HCBS were 92% of the total cost but by '05 they ***dropped*** to 78% of the total cost—but this was still a 33% ***increase*** over '95. The services that increased most significantly over the eleven year period were prescription drugs-to 12% of total cost from 5% and Ancillary-rising to 7% of total cost from .03%.

- Medicare's overall expenditure increase for the eleven year period was only 9%. The highest service expenditure was hospitals which in '95 were 44% of the total and by '05 were 47% of the total. The most dramatic changes were in HCBS which ***fell*** 57% and was now 12% of total cost from 29% in '95 and in Institutions which ***increased*** to 5% of total cost from 2%. Physician services ***rose*** from 10% of total cost to 14%.

Medicare & Medicaid Service Expenditures by Setting of Care

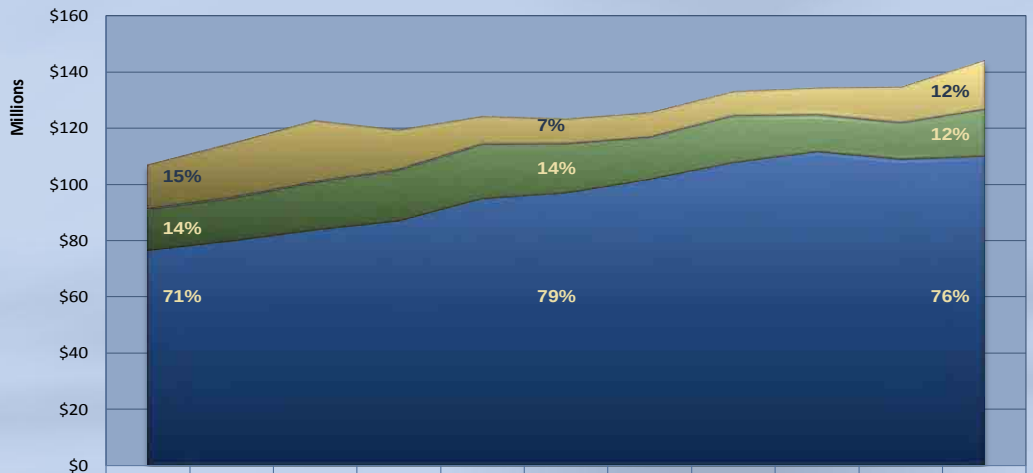


- Medicaid's overall expenditure increase for *Institutionalized* duals between '95-'05 was 10%. The highest service expenditure was obviously for Institutions. In '95 Institutions were 71% of the total but by '05 they ***dropped*** to 67% of the total cost—with only a 3% cost ***increase***. The services that increased most significantly over the eleven year period were prescription drugs- ***rising*** 146% to 7% of total cost from 3% and hospitals-***rising*** 10% but remaining 25% of total cost.

- Medicare's overall expenditure increase for the eleven year period was only 42%. This was the only setting that had a greater percentage increase over Medicaid for the period. Although the highest service expenditure was for hospitals which in '95 were 43% of the total- by '05 it was ***down*** to 37% of total costs. The most dramatic changes were in Institutions which ***increased*** 111% and was now 33% of total cost ***up*** from 22% in '95 and HCBS which ***increased*** 184% and was now 4% of total cost from 2% in '95.

Taking a Closer Look

Chart 13: Home and Community Based Services (HCBS) Medicare vs. Medicaid Expenditures: 1995 - 2005



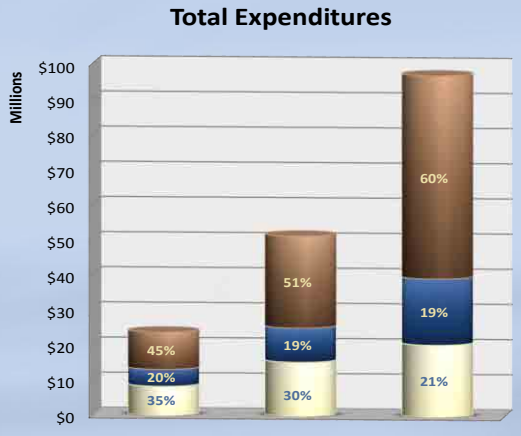
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Medicare	$15,705,738	$19,328,203	$21,796,949	$14,198,102	$9,953,893	$8,913,661	$8,814,272	$8,702,248	$9,649,132	$12,774,431	$17,475,657
Medicaid Non-Waiver	$14,701,087	$15,356,495	$17,081,492	$18,156,978	$19,373,398	$17,483,164	$15,038,380	$16,690,701	$13,178,829	$13,012,905	$16,697,841
Medicaid Waiver	$76,635,813	$79,917,814	$83,834,299	$87,035,153	$94,879,457	$96,906,579	$101,678,223	$107,581,071	$111,455,588	$108,776,393	$109,821,875

- The Medicaid program is the predominate payer for HCBS for the duals hitting a high of 93% in 2000- split between Waiver (79%) and Non-Waiver (14%). Non-Waiver services are those HCBS that Community Medicaid participants receive such as adult day and rehab services for the behavioral health clients. Between '95-'05, HCBS expenditures ***increased*** in Medicare by 11%, Medicaid Non-Waiver by 14% but most significantly in Medicaid Waiver by 43%.

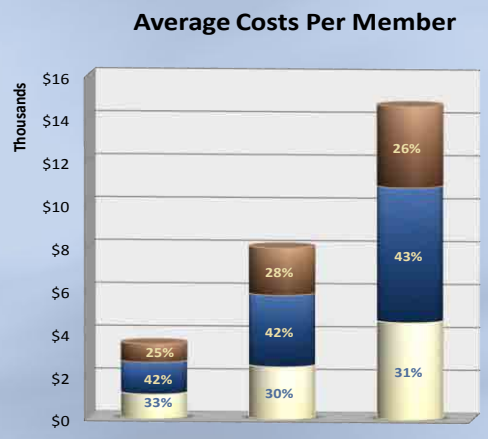
- As a percentage of total costs, Medicare significantly ***dropped*** from 15% in '95 to 7% in 2000 but is on the ***rise*** again in 2005 at 12%. This was a direct result of the Medicare policy changes in the 1997 Balanced Budget Act. Medicaid Waiver percentages ***increased*** from 71% in'95 to 79% to 76% in '05. Medicaid Non-Waiver remained at 14% until 2005 when it ***dropped*** to 12% of total costs.

Taking a Closer Look

Chart 14: Medicaid Prescription Drug Costs by Setting of Care 1995 - 2005



	1995	2000	2005
Community	$10,577,517	$26,164,486	$57,760,763
LTC Community	$4,820,499	$9,737,041	$18,844,599
Institution	$8,348,278	$15,411,137	$20,508,445



	1995	2000	2005
Community	$871	$2,215	$3,796
LTC Community	$1,485	$3,336	$6,284
Institution	$1,138	$2,447	$4,539

- The total Medicaid expenditures for prescription drugs in all settings of care has escalated dramatically between '95-'05. The highest percentage increase occurred in the *Community* by 446%; followed by *LTC Community* at 291% and *Institution* at 146%.

- Turning to "average cost/member", even though the greatest total expenditure is in the *Community* setting, it is the *LTC Community* setting that has the highest per member cost at $6,284 in '05. Although the lowest per member cost remains the *Community* at $3,796 in '05, this setting had the largest percentage increase over the eleven year period which was 336%; followed closely behind by *LTC Community* at 323%; and *Institution* at 299%.

Acknowledgments

Principle Author and Editor:

- Elaina Goldstein, J.D., MPA, Executive Director, Rhodes to Independence, URI College of Pharmacy
  - Contact Information: Email: elaina@uri.edu; Phone: 401.462.6264

Data Base Construction:

- JEN Associates, Daniel Gilden, President, Cambridge, MA

Data Retrieval and Presentation:

- Arthur Schnure, Consultant, Rhodes to Independence, URI College of Pharmacy

Editorial Review:

- Alan Tavares, Executive Director, Rhode Island Partnership for Home Care
- Nancy Wooten, Ph.D., M.H.A., M.A., Consultant, Rhodes to Independence, URI College of Pharmacy

Chart Book Design and Layout:

- Jean DiPippo, Consultant, Rhodes to Independence, URI College of Pharmacy

Rhodes to Independence operates under the auspices of the University of Rhode Island College of Pharmacy and is funded by a U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Infrastructure Grant

Rhodes to Independence

College of Pharmacy; 350 Fogarty Hall; Kingston, RI 02881
401.462.6163 – RhodestoIndependence.org