

# Health Reform and Medicaid:

## Expanding Access in Rhode Island



### Introduction

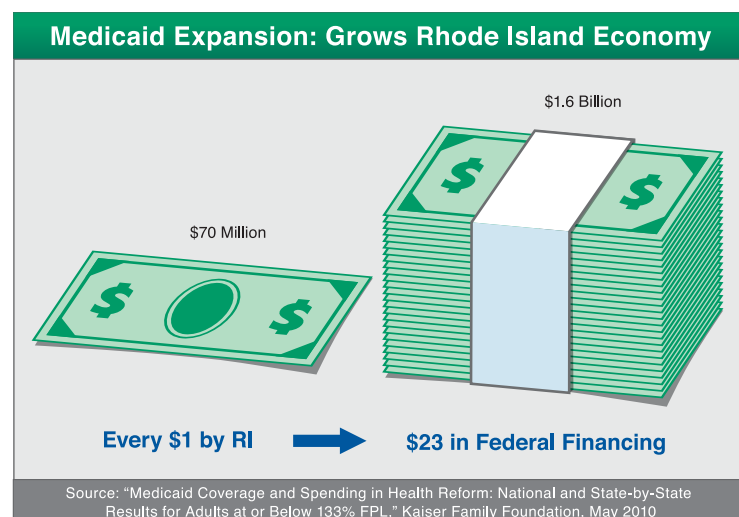
Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) expands eligibility for Medicaid, broadening coverage to nearly all persons at or below 133% of the Federal Poverty Level (FPL) and former foster care children up to age 26.<sup>1</sup> Medicaid expansion represents a fundamental change in the program—from one that offers coverage to groups of qualified low-income children, parents, seniors, disabled adults and pregnant women to one in which, for the first time, nearly everyone below a certain income is eligible.

According to the Rhode Island Healthcare Reform Commission, an estimated 40,610 currently uninsured adults without dependent children (at or below 133% FPL) will become eligible for Medicaid coverage in 2014.<sup>2</sup> Medicaid expansion is a central plank of the ACA's attempt to help nearly all Americans gain affordable health care coverage. Absent Medicaid expansion, people at a low income will struggle to find coverage on their own or will continue to be uninsured.

Many of those who will enroll in coverage for the first time will be healthy, young adults. A small number, however, will have significant levels of unmet medical needs. Many uninsured Rhode Islanders have been unable to afford coverage or access consistent health care, causing

them to defer needed medical care. By enrolling in Medicaid, many individuals will find a consistent source of comprehensive primary and specialty care for the first time, allowing them to improve their health without the fear of unmanageable medical debt or bankruptcy.

Rhode Island has established itself as a leader in providing coverage



to low-income residents through the Medicaid managed care programs RItE Care and Rhode Health Partners (RHP). The past and current success of these programs demonstrates that the state is ready to implement Medicaid expansion efficiently and in a manner that is cost effective, leading to better health for all Rhode Islanders.



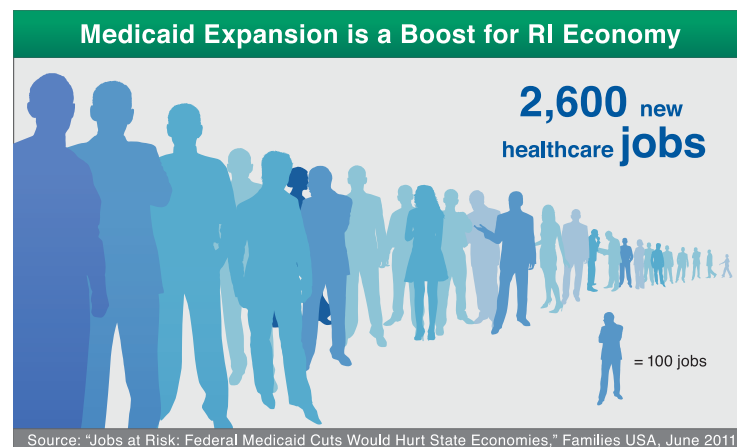
In preparation for 2014, this paper examines several key issues related to the challenge of enrolling and serving this new group:

- The benefits of Medicaid expansion for Rhode Island residents, state government and medical providers
- A review of the medical profile of likely new enrollees
- Strategies for outreach and enrollment that will result in the highest number of people obtaining coverage
- The opportunities for innovative clinical program design and service delivery, particularly for those with untreated chronic conditions

## Medicaid Expansion Helps All Rhode Islanders

### Federal Funding, State Economic Boost

Over the first five years, Rhode Island will see a return of \$23 for every \$1 it invests in Medicaid expansion. The federal government will cover 100% of the cost of Medicaid expansion from 2014 through 2016. Between 2017-2019, the federal matching will decrease yearly then



hold at 90%. The Kaiser Commission on Medicaid and the Uninsured estimates that between 2014 and 2019, Rhode Island will receive \$1.6 billion in additional Medicaid funding for the expansion population, while the state contribution will only grow by 0.7% above the current baseline (\$70 million over 5 years).<sup>3</sup>

The economic activity generated by this influx of federal funding will not only ensure health care for tens of thousands of our neighbors, but will also create or support up to 2,600 jobs.<sup>4</sup> In addition to ensuring care for many Rhode Islanders who currently struggle to afford necessary health services, these dollars will provide a strong stimulus to the Rhode Island economy and help physicians, hospitals and other providers who often provide care to the uninsured and receive no payment.

### Support for Rhode Island Hospitals

Hospitals are an integral part of the Rhode Island economy, accounting for one of every 16 jobs,<sup>5</sup> as well as a leading source of care for the uninsured. In 2009, Rhode Island hospitals provided a combined \$131 million of uncompensated care, mostly to uninsured individuals, the equivalent of 4% of total revenue.<sup>6</sup> One method to help hospitals pay for this care comes from the Medicaid Disproportionate Share Hospital (DSH) program, a joint state and federal program designed to help hospitals that see large numbers of uninsured and low-income patients. While this funding does not cover the full cost, in Rhode Island it has provided \$37.3 million in net revenue to hospitals.<sup>7</sup> Under the ACA, much of the DSH funding will be eliminated by 2019, as most of the uninsured will have access to coverage

that pays for their care. In states that choose not to expand Medicaid eligibility, however, the loss of DSH funding will greatly harm the ability of hospitals to provide care to the most vulnerable residents.

### Relief for Rhode Island Businesses

Reducing the number of uninsured by expanding eligibility for Medicaid will have a direct positive effect on Rhode Island employers and employees. The cost of care for those who do not have insurance are “baked into” the cost of coverage charged to businesses and individuals who purchase coverage. According to Families USA, “Private health insurance premiums are higher, at least in part, because uninsured people who receive health care often cannot afford to pay the full amount themselves. The costs of this uncompensated care are shifted to those who have insurance, ultimately resulting in higher insurance premiums for businesses and families.” The study concluded that in 2009 the average family plan cost an additional \$1,017 per year to pay for care for the uninsured.<sup>8</sup> With an increase in the number of people with insurance coverage, the ACA hopes to decrease this extra cost on businesses and families.

### A Profile of the Newly Eligible Adults

As we begin engaging newly eligible residents, it is helpful to understand the characteristics and medical profile of this group, as well to look at the experience of other states that have previously expanded coverage to similar groups.

There are 171 million uninsured adults at or below 133% FPL, representing 37% of all the uninsured in the United States.<sup>9</sup> According to the Kaiser Family Foundation, half of these adults are at or below 50% of FPL and have historically had difficulty accessing care, and thus have significant unmet health care needs.<sup>10</sup> “The uninsured suffer from negative health consequences due to their lack of access to necessary medical care... which leads to more serious health problems for many significantly higher mortality rates.”<sup>11</sup> An estimated 60% of uninsured adults have no usual source of care and 38% have not received any medical care for at least two years.<sup>12</sup> Moreover, more than four in ten uninsured adults with chronic conditions like diabetes or depression have not seen a doctor in over a year.<sup>13</sup>

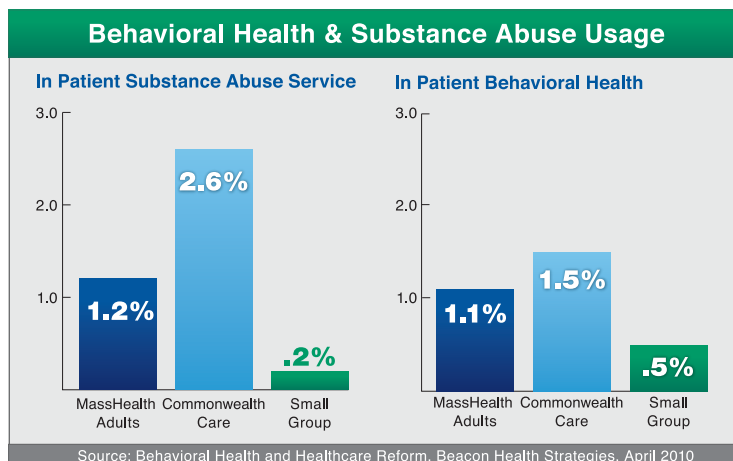
While a majority (53%) of the newly eligible are aged 26-54, they are more likely than current Medicaid adults to be either between 19-25 (34% vs. 17%) or between 55-64 (13% vs. 2%).<sup>14</sup> This group is 55% male and 45% female, with uninsured men much less likely to have received care than uninsured women. Nearly 65% live in households with at least one working adult. Additionally, this group is less likely than privately insured adults in the same income bracket to have received a college degree, though more likely than those currently enrolled in Medicaid.<sup>15</sup>

### Insights from Other States and National Studies

As Rhode Island prepares to enroll the newly eligible adults, it faces the challenge of having little clinical data through which we can understand their likely medical needs. Some information can be gleaned from the experience of states that currently have programs that cover this group. In reviewing several reports on these states the following characteristics have been noted:<sup>16</sup>

- In Arizona, 5 of 6 uninsured adults reported good or excellent health, and 1 in 6 reported poor or fair health, 1 in 3 report a chronic condition and 1 in 6 enrollees has a severe mental health disorder

- Childless adults who became enrolled in Oregon had a higher utilization across the spectrum compared to adult parents of the same income bracket, including twice as many inpatient admissions, twice as many ER visits, and three times as many mental illness or substance abuse visits
- Compared to Medicaid enrollees, Commonwealth Care enrollees (a Massachusetts program for low income adults not eligible for Mass-Care) at 100% FPL had higher rates of surgical admissions, hospital days, higher costs for certain services (including inpatient behavioral health, outpatient therapy, and both inpatient and outpatient surgeries)
- Among homeless adults, 45% experience behavioral health issues, and 46% have substance abuse issues
- For those who experience incarceration, 90% entering the corrections system do not have health insurance, and 64% have some form of behavioral health issue



There were also several noticeable trends in cost and enrollment:<sup>17</sup>

- Formerly uninsured patients with the greatest need enrolled first, partially driven by providers who currently treated them
- Average cost per beneficiary is likely to be higher than the cost for parents who are currently enrolled but less than that for adults with disabilities—in Arizona, childless adults were almost exactly at the mid-point between eligible parents (similar to RITE Care adults) and adults with disabilities (similar to RHP members)
- In Maine, the most expensive five percent of enrollees in the childless adult population accounted for 44% of all incurred medical costs
- Those with higher needs are less likely to churn out of Medicaid into other coverage

## Strategies for Outreach and Enrollment

One of the largest challenges will be successfully enrolling a group of people who have long been disenfranchised from medical coverage—both public and private. Rhode Island should set a goal of enrolling as many of the newly eligible beneficiaries as possible as quickly as possible. As a state with a successful history of providing coverage to low-income families and adults with disabilities, Medicaid expansion is an opportunity for Rhode Island to further its commitment. Medicaid expansion is also a potential economic boost for the state, its newly insured residents and the provider community.

### Prepare for Success

Rhode Island is implementing many policy initiatives that prepare the state for seamless expansion of Medicaid eligibility in 2014. Rhode Island was the first state in the nation to

receive Level 2 funding (\$58.5 million, awarded November 2011) for building a new Health Benefits Exchange, which will connect people to health coverage options. This funding is in addition to the original \$5 million grant awarded the state in May 2011, and Rhode Island's participation in a New England consortium of states that won an Early Innovators grant of \$36 million.<sup>18</sup> The key vision put forward by the state includes the innovative Unified Health Infrastructure Project (UHIP), an integrated computer system that will help Rhode Islanders and businesses access coverage from public, subsidized private, and non-subsidized private coverage.<sup>19</sup> Rhode Island has gone a step beyond, and plans to integrate other programs (such as childcare assistance, SNAP food benefits and WIC) into the new integrated eligibility system.

Rhode Island is concurrently upgrading its Medicaid Management Information System, which enrolls eligible residents into Medicaid coverage.<sup>20</sup> One further sign of Rhode Island's recognition as a national leader is the Robert Wood Johnson Foundation's "State Health Reform Assistance Network" grant, which will "support technical assistance, research, consumer engagement, online networking and leadership development to help states most effectively expand and improve coverage."<sup>21</sup> Ultimately, the decision Rhode Island has made around Exchange technology will facilitate improved coordination and sharing of information in order to make access to coverage and transitions between types of coverage as seamless as possible for enrollees.

### Collaborate with Community Partners

A key strategy for the state will be to collaborate with organizations and agencies that currently serve uninsured adults. These organizations will be key partners as the state works to inform newly eligible individuals of their options and how to navigate the system. Of particular importance will be medical provider sites where the uninsured currently receive care such as community health centers, hospitals and free clinics. Other organizations include food pantries, Community Action Programs, Head Start locations, job training centers, SNAP and WIC service providers, homeless agencies, the Department of Corrections, and organizations that work with ex-offenders in transition.<sup>22</sup>

Rhode Island can learn from its own past experience.<sup>23</sup> In 1998, the year after Congress created the State Children's Health Insurance Program, the RI Department of Human Services initiated a successful campaign to enroll as many children and families into RIte Care as possible.<sup>24</sup> Strategies included working with 31 community organizations, distribution of multi-lingual materials, school-based outreach, radio advertising and supporting the hiring of 16 additional staff at partner agencies. Rhode Island also developed a version of the Navigator program, creating the Family Resource Counselors (FRC) network. FRCs are located at dozens of community health centers, hospitals and other agencies and assist individuals and families with applying for RIte Care.

When Massachusetts enacted health care reform in 2006, they achieved near-universal health coverage in two years. An effective outreach strategy was central to this success. Massachusetts officials based their efforts on three main strategies:<sup>25</sup>

1. Building an effective education, outreach and enrollment infrastructure
2. Using multiple channels and vehicles to reach the uninsured
3. Providing comprehensive technical assistance to partners

Rhode Island has already tackled the first strategy. Examining the Massachusetts experience demonstrates the steps Rhode Island should take to effectively reach and enroll the

largest possible number of newly eligible residents. The Massachusetts Office of Medicaid and their new Connector (health insurance exchange) worked together and found the following to be the most effective elements of a successful outreach program:<sup>26</sup>

**Developed and distributed outreach materials:**

- Included multiple languages, mailing to potential enrollees, and distribution via community partners such as health centers, hospitals, school nurse offices, social service agencies and local businesses

**Engaged the provider community and health plans (especially Medicaid Managed Care Organizations):**

- Used data from community health centers and hospitals to identify eligible uninsured patients and pro-actively enrolling them

**Worked in cooperation with consumer advocacy groups:**

- Provided \$11.5 million to partner community organizations to assist residents in obtaining information and coverage (similar to ACA Navigator program)
- Issued grants with on-going technical assistance and training for front-line staff at partner organizations

**Monitored and assessed the impact of program efforts**

- Aggregated data from community partners and state agencies in order to ensure effective use of resources

### Effective Communication

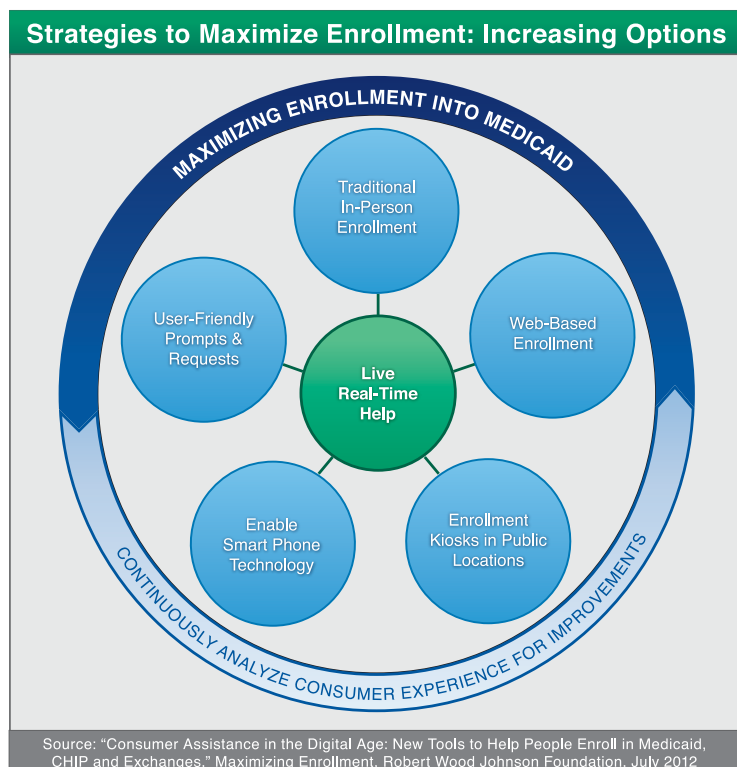
Communicating the opportunity to enroll in the new health coverage options available via the ACA is particularly important for this audience. Studies have shown that one barrier to accessing care among low-income childless adults is the belief that Medicaid and other programs are not meant for them due to past ineligibility.<sup>27</sup> Helping potential enrollees understand the positive benefits—including access to care, reduction of medical debt, and the high quality of care—encourages people to enroll.<sup>28</sup> Also found to be important is the way in which Medicaid is described. Using specific, plain language phrases like “low-cost or free” instead of the more broad “affordable” is better understood by potential enrollees. Finally, the inclusion of specific medical benefits in the description helped potential enrollees to understand exactly what they will be eligible for as members—with hospitalizations, check-ups and prescriptions being the most important services to name.

### Simplify Enrollment

Another key element for success is simplification of the enrollment process. As we have seen, Rhode Island is already taking steps to make enrollment easier via the UHIP. Using the Exchange website, the telephone hotline and other efforts to increase access to Medicaid will be central to achieving maximum enrollment among the eligible.<sup>29</sup> The state’s plan to use the UHIP infrastructure to enroll people participating in other programs will also be an effective strategy, especially if the state uses the technology to identify and pro-actively enroll persons eligible for Medicaid.<sup>30</sup>

The Maximizing Enrollment Project of the Robert Wood Johnson Foundation suggests a series of best practices. These include: enabling online services to be accessed through mobile smart phones, ensuring online enrollment system prompts for missing information before allowing an applicant to move to next section, making online “chat” services

available, tracking where applicants abandon or make mistakes in enrolling processes in order to revise and improve forms and procedures, installing computer kiosks in locations such as social service agencies and other government offices, and enacting strategies for the reduction of in person encounters and renewals.<sup>31</sup>



### Assist Enrollees with Accessing and Navigating the System

The ACA includes funding for states to create Navigator programs. State Exchanges will provide grants to community or consumer-focused non-profits to “conduct outreach and help consumers and small employers connect to health coverage.” State Exchanges will need to train navigators to work with vulnerable populations about the various coverage options available to residents, and the

proper handling of sensitive consumer information such as tax and identification materials. Building on existing networks, such as RIte Care’s system of Family Resource Counselors,<sup>32</sup> the Navigator program will make best use of its limited resources by focusing on the most vulnerable populations. Those who have been long alienated from health insurance coverage are less likely to have experience navigating complex eligibility and enrollment procedures.<sup>33</sup>

## Strategies for Access and Service Delivery

The Rhode Island Healthcare Reform Commission estimates 70,000 people will gain coverage in our state as a result of implementing the ACA, including those who gain commercial coverage through the Health Insurance Exchange, those who gain employer-sponsored coverage and those who enroll in Medicaid.<sup>34</sup> As the number of people seeking medical services grows, Rhode Island will need to assess its capacity to serve these individuals. According to a report from the Kaiser Family Foundation, “system-wide gaps in primary care access are exacerbated in Medicaid by the geographic maldistribution of the primary care workforce, lack of transportation and other poverty-related barriers to care.”<sup>35</sup> Additionally, access to specialists and mental health care services are of paramount concern.

### Integrate Systems of Care

Rhode Island must be prepared with clinical programs designed to meet the needs of newly enrolled residents, including those with chronic conditions and unmet medical needs.

One goal is team-based care that integrates physical and behavioral health, provided in a setting that assists members with care coordination. As many new members may have low literacy skills and a lack of experience with the health care system, care coordination must be emphasized in order to ensure that members receive the highest possible benefit from being newly insured.<sup>36</sup>

Over the last several years, Rhode Island has begun to examine how better to work with Medicaid members who have the greatest needs. The state is currently implementing a new managed long term supports and services program for Medicaid members, and will expand this project to integrating care for those who are eligible for both Medicaid and Medicare, beginning in 2014. The programs developed for this initiative will be in place to meet the needs of newly eligible Medicaid members.

A particular focus has been on behavioral health and substance abuse issues. In 2010, the General Assembly enacted legislation creating the Special Senate Commission to Study Emergency Department Diversion. In studying the role of emergency care for individuals with substance abuse needs, it found “emergency departments serve a critical function in Rhode Island, yet the system is faced with an over utilization of high cost resulting in high levels of non-urgent behavioral health usage that could be more effectively treated in alternative settings.”<sup>37</sup> As many of these individuals gain coverage, Rhode Island will benefit from following the recommendations of this Commission, including the call to “Create state-wide care partnerships to enhance patient-centered systems of care to include on-demand services, 24-hour triage center programs, mobile outreach transportation teams, and telephone triage systems.”

Rhode Island primary care providers must prepare for patients who have spent years disenfranchised from the medical care system and will present with a high level of unmet needs. In addition, these patients may have a history of non-adherence to care plans due to inability to afford doing so (including not filling prescriptions, receiving prescribed tests, getting screened for common conditions) and have a higher likelihood of poor lifestyle behaviors (lack of exercise, poor eating habits etc.). The Rhode Island community health centers saw 38,000 uninsured patients in 2011,<sup>38</sup> and are well prepared to continue serving these patients as they transition to full coverage through Medicaid or an Exchange insurance plan.

### **Coordinate Care and Service Delivery**

The success of RIte Care and Rhody Health Partners demonstrates that Rhode Island can build upon its current partnership of state agencies, managed care organizations, and community providers to provide high quality care for new Medicaid enrollees. Managed care organizations have the flexibility and provider relationships to create coordination strategies that result in the best outcomes for members. This flexibility also allows for a collaborative approach to building new services as the needs of patients change. As Rhode Island implements Medicaid expansion, managed care organizations will have the experience of their current work with the state and providers in creating a new program for those eligible for both Medicaid and Medicare. The new services and provider relationships developed for dually eligible beneficiaries will be a benefit for those among the Medicaid expansion population who are people with a high utilization of services and need for care coordination.

### **Considerations for Specific Populations**

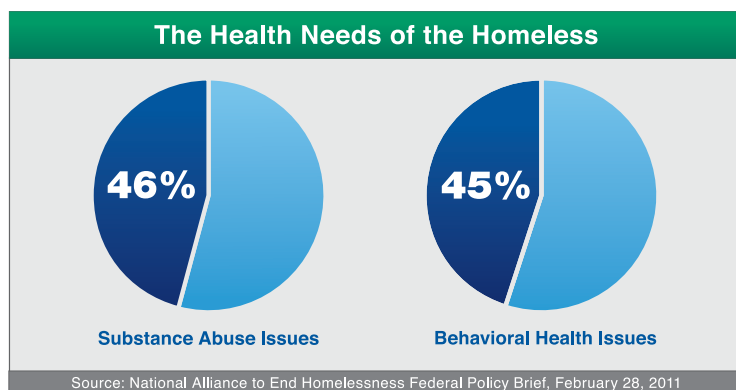
Coverage expansion under the ACA presents Rhode Island with the opportunity to connect a large number of residents with consistent, comprehensive medical care, and also



to keep former foster children connected with their health care. For those with untreated behavioral health or substance abuse conditions, this may lead to positive changes including reduced prison recidivism, less frequent emergency care, a reduction in chronic homelessness and a higher rate of recovery from addiction. By helping vulnerable populations gain and maintain coverage and consistent care, Rhode Island can meet their health care needs earlier, in a manner that is more cost effective, and improve life for these individuals and Rhode Islanders as a whole.

### Coverage for Former Foster Children

The ACA extends categorical Medicaid eligibility up to age 26 for people who were formerly in foster care, similar to the new rule allowing parents to keep children on their commercial family plans. To be eligible, a youth must have been in foster care when they turned age 18 and have been enrolled in Medicaid at that time.<sup>39</sup> According to the Georgetown University Center for Children and Families, “Children and youth in foster care have high rates of acute and chronic medical, mental health and developmental problems, making it vitally important that they be provided with high-quality, coordinated health care.” Most foster children across the nation receive health coverage through Medicaid. Rhode Island extends RIte Care coverage for youth aging out of foster care up to age 21, an option for states created by Fostering Connections Act of 2008. Those who age out “experience high rates of... poor physical and mental health,” according to RI Kids Count.<sup>40</sup> In addition to extended eligibility, the ACA provides other Medicaid supports for foster children, such as inclusion in the “Health Homes” initiative that Rhode Island has developed for Children with Special Health Care Needs, through the RI CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-evaluation) Family Centers.<sup>41</sup>



**Engage the Chronically Homeless**  
Medicaid expansion offers a chance to dramatically improve care for the homeless and reduce homelessness. The main benefits of Medicaid expansion to many at risk of homelessness is the reduction

of financial pressures that lead to a loss of housing, as well as improved access to medical care for those who experience homelessness. The Kaiser Family Foundation notes “Medicaid expansion will help the homeless by enabling agencies that serve them to divert resources now spent on medical care to other services such as finding housing and jobs.”<sup>42</sup>

According to the Center for Health Care Strategies, “For many individuals with complex chronic health conditions, homelessness and housing instability can be the most significant impediments to health care access, often resulting in excessive utilization of expensive inpatient and crisis services.”<sup>43</sup> When the National Alliance to End Homelessness examined the opportunities for homeless people under the ACA, it concluded that Medicaid expansion could lead to positive outcomes in the lives of those who experience short-term as well as chronic homelessness.<sup>44</sup>

Among their suggestions to state policy makers are:

- Include representatives from homeless advocacy and support organizations in planning Medicaid expansion
- Protect and expand access to mental health and substance abuse services for Medicaid enrollees
- Adopt Medicaid home and community-based services approaches that are oriented to those in supportive housing arrangements
- Implement outreach and enrollment strategies in a manner to prevent the chronically homeless from slipping through the cracks
- Support health systems changes to increase the availability and attractiveness of non-emergency room facilities for the homeless

### Reduce Recidivism and Save State Funds

Rhode Island should engage the criminal justice system in order to enroll eligible adults. Opportunities include pre-trial detention, incarceration, during probation and as part of discharge planning. In 2011, there were over 15,000 people committed into detention, with a daily average census in Rhode Island facilities of 3,237.<sup>45</sup> Medicaid programs are prohibited by federal law from paying for medical care while a person is incarcerated. In 1997, the federal government instituted a rule allowing states to use Medicaid funding to cover health care for inmates who were hospitalized for over 24 hours, judging them to no longer be inmates for the duration of their stay. This ruling was not widely publicized, and few states took advantage of the opportunity, as only a small percentage of inmates were qualified for Medicaid. With the expansion of eligibility to everyone at or below 133% of federal poverty level, however, a much larger number of those in the corrections system will be eligible for Medicaid. States can realize savings by moving health care costs from state-only funding into Medicaid. For example, Mississippi instituted the 1997 rule in 2009, and has seen over \$10 million in savings.<sup>46</sup>

Rhode Island should consider retaining Medicaid eligibility for adult prisoners and institute procedures to take advantage of the 1997 rule. Rhode Island should also implement enrollment processes for pre-trial detainees (those held prior to adjudication or sentencing), an option made available under the ACA.<sup>47</sup> The median pre-trial length of stay in Rhode Island is four days. Nearly 13,000 remain in a facility for three or more days, while 7,000 remain for five or more days.<sup>48</sup> Rhode Island can implement a program to enroll eligible persons who are in custody during the pre-trial period so that upon release they will be covered by Medicaid.

Improving access for ex-offenders to behavioral health and substance abuse services can make a dramatic impact on the rate of recidivism, with a positive impact on the lives of those affected as well as on the state budget. A U.S. Department of Justice report found that half of state inmates and one-third of federal inmates committed their offense while under the influence of illegal drugs or alcohol, and 1 in 6 reported committing the offense for which they were serving a sentence for obtaining money for their addiction.<sup>49</sup> Ensuring access to post-incarceration treatment for ex-offenders has been shown to reduce recidivism; for example, in the State of Washington, expanding eligibility for Medicaid resulted in a reduction of recidivism between 21% and 33% among three groups of individuals treated for chemical dependency, leading to a savings of \$5,000-\$10,000 for each treated person.<sup>50</sup> Another study, conducted in California, demonstrated that substance abuse

treatment during and after incarceration reduced recidivism from 75% to 27%.<sup>51</sup> Because the expansion population will be fully paid for by the Federal government from 2014-2016, Rhode Island has a chance to positively affect the health and future of exiting offenders with limited cost to the state budget.

## Conclusion

The expansion of Medicaid eligibility is a transformative moment. A broad cross section of Rhode Islanders who have traditionally lacked access to consistent and comprehensive care will be able to develop relationships with medical providers, improve their own health and well-being, and address long-standing health issues. Rhode Island as a whole will see benefits—new federal dollars to stimulate economic growth, support for medical care providers, and jobs for Rhode Island residents. This opportunity comes with challenges. The Rhode Island Medicaid program must work with its partners to design an effective outreach and enrollment strategy, reaching those who will be eligible for coverage for the first time. Providers are preparing for new patients, many of whom will present with a heavy burden of unmet needs, including behavioral health and substance abuse issues. With a history of Medicaid innovation, pioneering work on new enrollment technology, and robust planning for Navigators and other forms of consumer assistance, Rhode Island is ready to meet the challenge. It is critically important for Rhode Island and our thousands of traditionally underserved residents that this new program succeed and it is up to us to act now and make sure we get it right.

## Notes

1. Due to changes in methodology for determining income, eligibility will effectively be at 138% FPL.
2. "Who Goes Where Under Federal Healthcare Reform," RI Office of the Health Insurance Commissioner, Revised August 2012; 28,201 newly eligible adults are expected to enroll, along with an additional 3,675 adults and children who are currently eligible for Medicaid but not enrolled, and, 11,735 residents who move from private coverage, for total of 43,431 new enrollees; 7-9,000 may leave Medicaid for Exchange coverage.
3. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Family Foundation, May 2010. Note: KFF estimates are based on their own enrollment projections, which exceed RI state officials' estimates.
4. "Jobs at Risk: Federal Medicaid Cuts Would Hurt State Economies," Families USA, June 2011.
5. Hospital Association of RI—Guide to Hospitals 2012 [http://www.hari.org/Members/Newsroom/Guide\\_To\\_Hospitals/Guide\\_to\\_Hospitals.aspx](http://www.hari.org/Members/Newsroom/Guide_To_Hospitals/Guide_to_Hospitals.aspx)
6. "RI Uncompensated Care Hospital Data, 2009" RI Department of Health Report, Feb 2009.
7. "Senate Issue Brief: Medicaid Disproportionate Share Hospital Payments," Rhode Island State Senate Fiscal Office Issue Brief, August 2010.
8. "Hidden Health Tax: Americans Pay a Premium," Families USA, May 2009.
9. "Expanding Medicaid Under Health Reform: A Look at Adults At or Below 133% of Poverty," Kaiser Family Foundation, April, 2010.
10. Ibid.
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12. "Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years," KFF, July 2010.
13. "Expanding Medicaid Under Health Reform: A Look at Adults At or Below 133% of Poverty," Kaiser Family Foundation, April, 2010.
14. "Expanding Medicaid Under Health Reform: A Look at Adults At or Below 133% of Poverty," Kaiser Family Foundation, April, 2010.
15. "Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years," KFF, July 2010.
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17. Ibid.
18. <http://healthreform.kff.org/State-Exchange-Profiles/Rhode-Island.aspx>
19. <https://www.purchasing.ri.gov/RIVIP/StateAgencyBids/7449637.PDF>
20. <http://www.purchasing.ri.gov/RIVIP/StateAgencyBids/7449412.PDF>
21. Robert Wood Johnson Foundation. 'RWJF Seeks Coverage of 95 Percent of All Americans by 2020.' May 6, 2011. <http://www.rwjf.org/coverage/product.jsp?id=72289>
22. "Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform," Center for Health Care Strategies/Community Oriented Correctional Health Services, January, 2011.
23. "Rite Care Outreach Report," RI Department of Human Services, October 2000.
24. Assisted by a Robert Wood Johnson Foundation grant that created the Covering Kids program, led by RI Kids Count.
25. "Effective Education, Outreach, and Enrollment Approaches for Population Newly Eligible for Health Coverage," Blue Cross Blue Shield of Massachusetts Foundation Toolkit Series, March 2012.
26. "Massachusetts Health Reform: A Five-Year Progress Report," BCBSMA Foundation, November 2011.
27. "Preparing for 2014: Findings from Research With Lower-Income Adults in Three States," State Health Reform Assistance Network, Robert Wood Johnson Foundation, June 2012.
28. Ibid.
29. "Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach Under Health Care Reform," Kaiser Family Foundation, April 2010.
30. Unified Health Infrastructure Project RFP: <https://www.purchasing.ri.gov/RIVIP/StateAgencyBids/7449637.PDF>
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