Rhode Island Annual Medicaid Expenditure Report

April, 2007

Executive Office of Health and Human Services
Jane A. Hayward, Secretary

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services

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A Message from the Secretary

Rhode Island's Medicaid program, which is funded by a combination of federal and state dollars, has touched the lives of nearly one-third of all our state's citizens over the past five years. From low-income elders and adults with disabilities to uninsured and underinsured working families and children with special health care needs, Medicaid has provided acute or long-term care services with a state price tag of approximately $760 million (FFY 2005).

This report is a follow-up to the expenditure report submitted to the Governor and the leadership of the General Assembly in December of last year that provided an overview of Medicaid spending for State Fiscal Year (SFY) 2005. It should be noted that the SFY 2006 data reflects the impact of Medicare Part D as well as the integration of former offline payments by MHRH into the Medicaid Management Information System ("MMIS").

The first report was required as part of the enacted fiscal year 2007 budget, to be prepared and submitted on an annual basis by December 1st, beginning in 2006. In order to meet that deadline for this past December, expenditure data from 2005 had to be used, as data from fiscal year 2006 was not available until after January 1st. To ensure state policymakers have access to the most timely information available, this report summarizes total Medicaid expenditures for SFY 2006 in the state across all agencies administering and financing federally funded Medicaid programs.

As in the first report, because this is the first time Medicaid expenditure information from a number of state agencies has been analyzed and compiled into one document, we have endeavored to establish a standard format for tracking and examining Medicaid trends that will inform policy and planning discussions concerning health care coverage and access. The information contained in these pages will provide a solid foundation for future discussions relative to the complexities of Medicaid financing and service delivery as well as the evolution of the program reflecting budget constraints and/or changes in the needs of Medicaid beneficiaries across the country and in Rhode Island.

Sincerely,

Jane A. Hayward

Secretary

RI Medicaid overview

Program Overview

What Is Medicaid?

The medical assistance program jointly funded by the federal government and the states established in 1965 as Title XIX of the U.S. Social Security Act.

Nationwide, Medicaid is the dominant state administered health care program covering low-income children and families, elders and persons with disabilities.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for establishing guidelines to administer the requirements of Title XIX and overseeing their implementation by state Medicaid programs.

Under these federal guidelines, there are specific “mandatory” categories of people and types of benefits that all state Medicaid programs must cover to receive federal matching payments.

States also have the flexibility to tailor certain aspects of the Medicaid program to meet their own needs.

States may obtain federal matching funds for covering several “optional” groups of individuals and services.

Each state has the discretion within federal guidelines to (1) establish its own eligibility process; (2) determine the type, amount, duration, and scope of services; (3) purchase and set payment rates for services; and (4) administer its own program.

Although the scope of state Medicaid programs vary, all are feeling the effects of the continued rise in health costs, the shifts in federal funding and policy priorities, and the increasingly more complex needs of the people they serve.

Notes on 2006 Report:

A portion of MHRH HCBS services in the amount of $7.4 million (formerly paid offline) are captured on this report for the first time.

Medicare Part D was implemented in January 2006. Although Medicare now covers most pharmaceutical costs for those who have both Medicaid and Medicare, the state pays back to the Federal Government a "clawback" which is approximately the amount the state would have paid for pharmacy benefits if Medicare Part D had not been instituted. The clawback amount is included as a pharmacy expenditure throughout this report.

DSH payments are not included unless specifically noted.

Medicaid Annual Expenditure Report

Statutory Mandate

R.I.G.L. 42-7.2-5(d), the authorizing statute for the EOHHS, authorizes the Secretary to:

Beginning in 2006, prepare and submit to the governor and to the joint legislative committee for health care oversight, by no later than December 1 of each year, a comprehensive overview of all Medicaid expenditures included in the annual budgets developed by the departments. The directors of the departments shall assist and cooperate with the secretary in fulfilling this responsibility by providing whatever resources, information and support shall be necessary.

Purposes of the Expenditure Report

Provide state policymakers with a comprehensive overview of state Medicaid spending to assist in assessing and making strategic choices about program coverage, costs, and efficiency in the annual budget process.

Summarize Medicaid expenditures for eligible individuals and families covered by one or more of the five health and human services departments.

Show enrollment and spending trends for Medicaid coverage groups by service type, care setting, and delivery mechanism.

Identify areas in the Medicaid program where the state has the most flexibility and control over the scope, amount and duration of coverage and services.

Establish a standard format for tracking and evaluating trends in annual Medicaid expenditures within and across departments.

Inform broader policy and planning discussions about the future of the RI Medicaid program, the role it plays in the state's health care system, and its impact on the larger economy.

Glossary of acronyms

A&D: Aged & disabled

CFMC: Children and families in managed care

CSHCN: Children with special health care needs

DCYF: Department of Children, Youth and Families

DEA: Department of Elderly Affairs

DSH: Disproportionate share hospitals

DHS: Department of Human Services

EOHHS: Executive Office of Health and Human Services

FFY: Federal fiscal year

FMAP: Federal Medicaid assistance percentage

HCBS: Home and community-based services

ICF/MR: Intermediate care facility/mental retardation

LEA: Local education agencies

LTC: Long term care

MHRH: Mental Health, Retardation and Hospitals

MR/DD: Mental retardation/developmental disabilities

MR Facility: Mental retardation facility

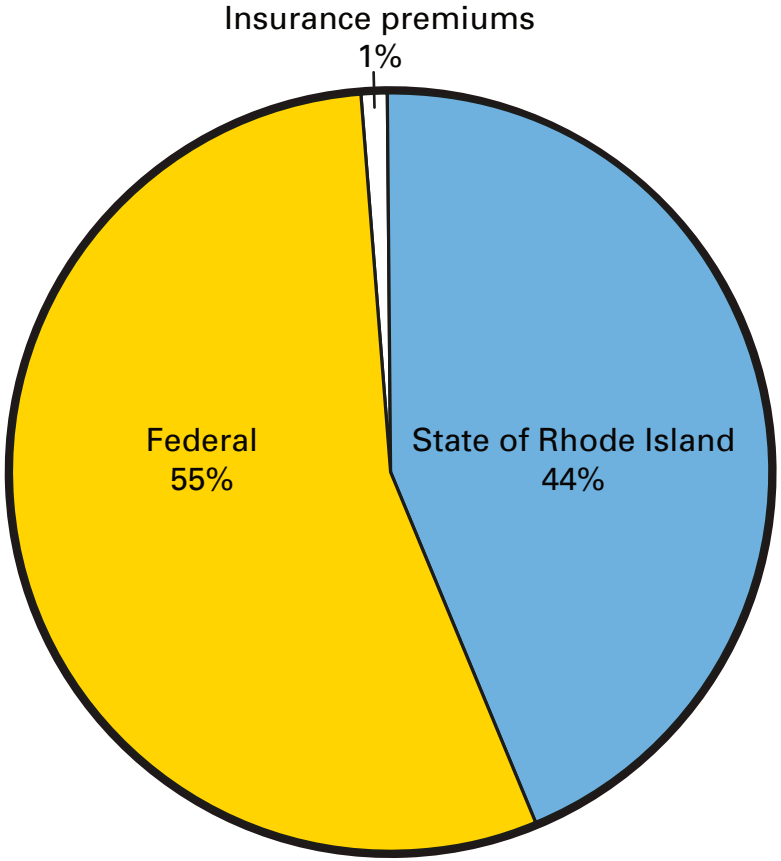
PCPM: Per capita per month

SFY: State fiscal year

RI Medicaid 2006

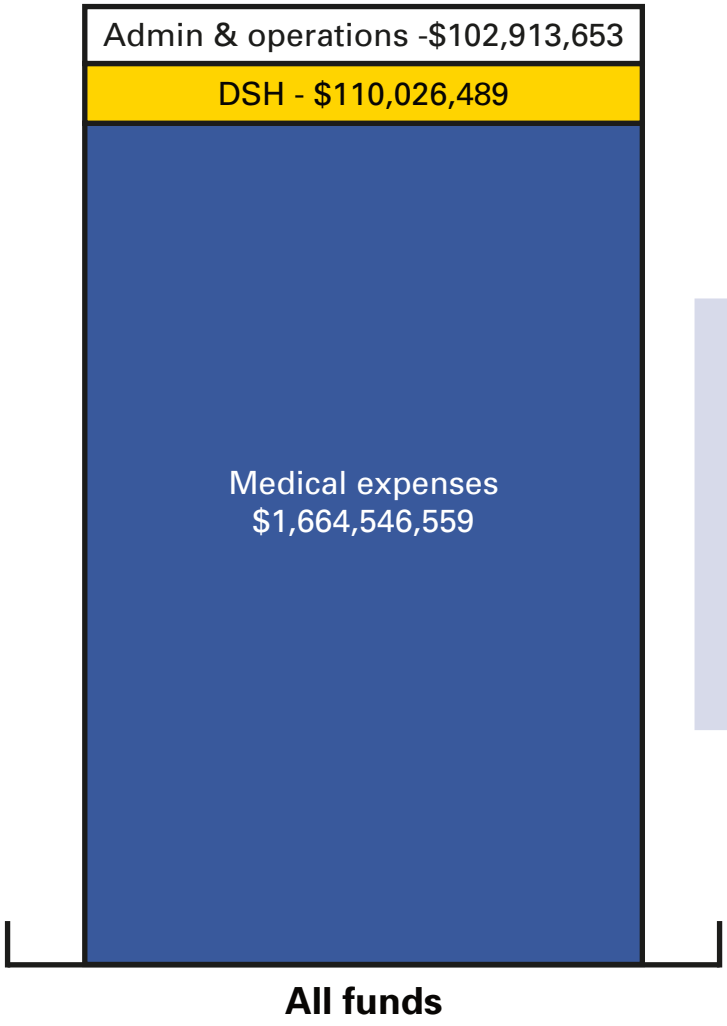
The federal government pays for 55% of overall Medicaid spending

Figure 1
Sources of funds,
SFY 2005



Medicaid expenditures total approximately $1.9 billion

Figure 2
SFY 2006



The focus of this report is on Medicaid medical expenses which represent 89% of total Medicaid expenses

Note: SFY 2006 reflects Medicare Part D "clawback" provisions and $7.4 Million in MHRH offline payments. All figures hereafter reflect these two components.

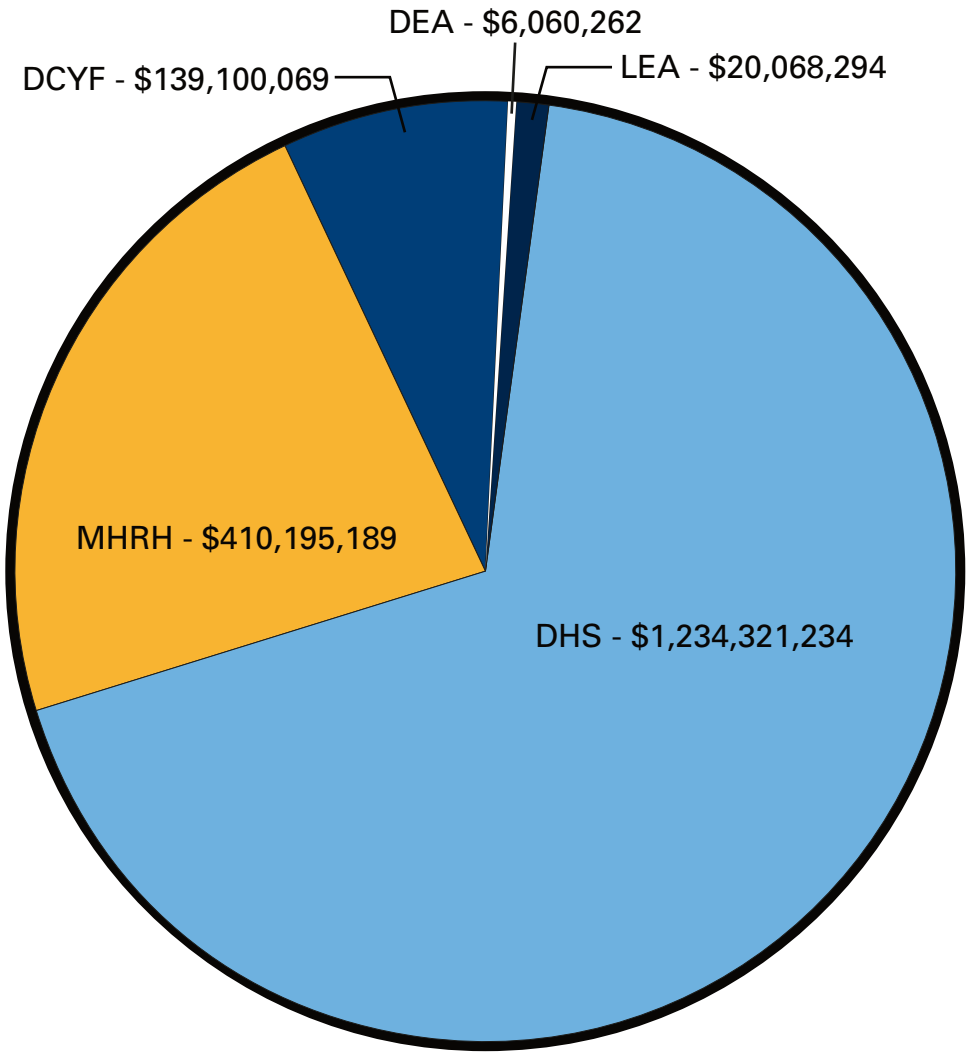
Note: Administrative & Operations reflects 2005, because full year 2006 numbers are not yet available

Note: Does not include psychiatric DSH/uncompensated care pool

Source: Medicaid claims extract & State budget documents

Medicaid benefit spending is spread across a number of state agencies and local school districts

Figure 3
Spending by department
SFY 2006



All funds

Source: Department of Human Services

Medicaid spending is spread across a number of state agencies and local school districts

Table 1

DHS	**Hospital**	**$252,942,922**
	Regular	142,916,434
	DSH/uncompensated care	110,026,488
	Long Term Care	**$328,948,897**
	Nursing Facilities	298,497,104
	Community-based long term care	30,451,793
	Managed care	**$403,074,108**
	Rite care - core	307,802,191
	Rite share	7,477,488
	Substitute care	7,746,462
	CSHCN's	20,877,334
	Out-of-plan (N/I rehab)	59,170,634
	Pharmacy	**$92,975,249**
	Claims payments	136,000,000
	Rebates	(49,292,870)
	Medicare Phased-down Contribution	17,800,000
	Drug Receivable	(11,531,881)
	Treatment and rehabilitation	**$80,390,850**
	Physician	19,072,728
	Oral health	21,845,655
	Rehabilitative services	39,472,467
	Medicare premiums	**$29,239,958**
	Other	**$46,738,508**
	Special education	**$20,068,294**
	Restricted receipt	**$10,741**
	TOTAL DHS	**$1,254,389,528**
MHRH	**Eleanor Slater Hospital system**	**$106,141,003**
	Elenor Slater Hospital	102,241,076
	Zambarano group homes	3,899,927
	MR/DD waiver	**$236,068,068**
	Public providers	48,532,736
	Private providers	186,114,878
	Supported living arrangements	1,420,454
	Integrated behavioral health	**$67,986,118**
	Community-based behavioral health	59,991,664
	Substance abuse treatment	5,524,430
	Other	2,470,024
	TOTAL MHRH	**$410,195,189**
DCYF	**Psychiatric hospital**	**$9,152,084**
	Rehab services	**$106,292,622**
	Managed care	**$23,655,363**
	TOTAL DCYF	**$139,100,069**
DEA	**Case management**	**$438,244**
	Personal care in assisted living	**$841,666**
	Community supports	**$4,780,352**
	Home Care	4,454,125
	Assistive Devices	2,350
	Home Modifications	16,135
	Other	307,742
	TOTAL DEA	**$6,060,262**
	TOTAL HEALTH	**$1,096,515**
	STATEWIDE TOTAL	**$1,810,841,563**

Note: Does not include psychiatric DSH/uncompensated care pool

Source: State budget documents

School districts participating in the Medicaid program

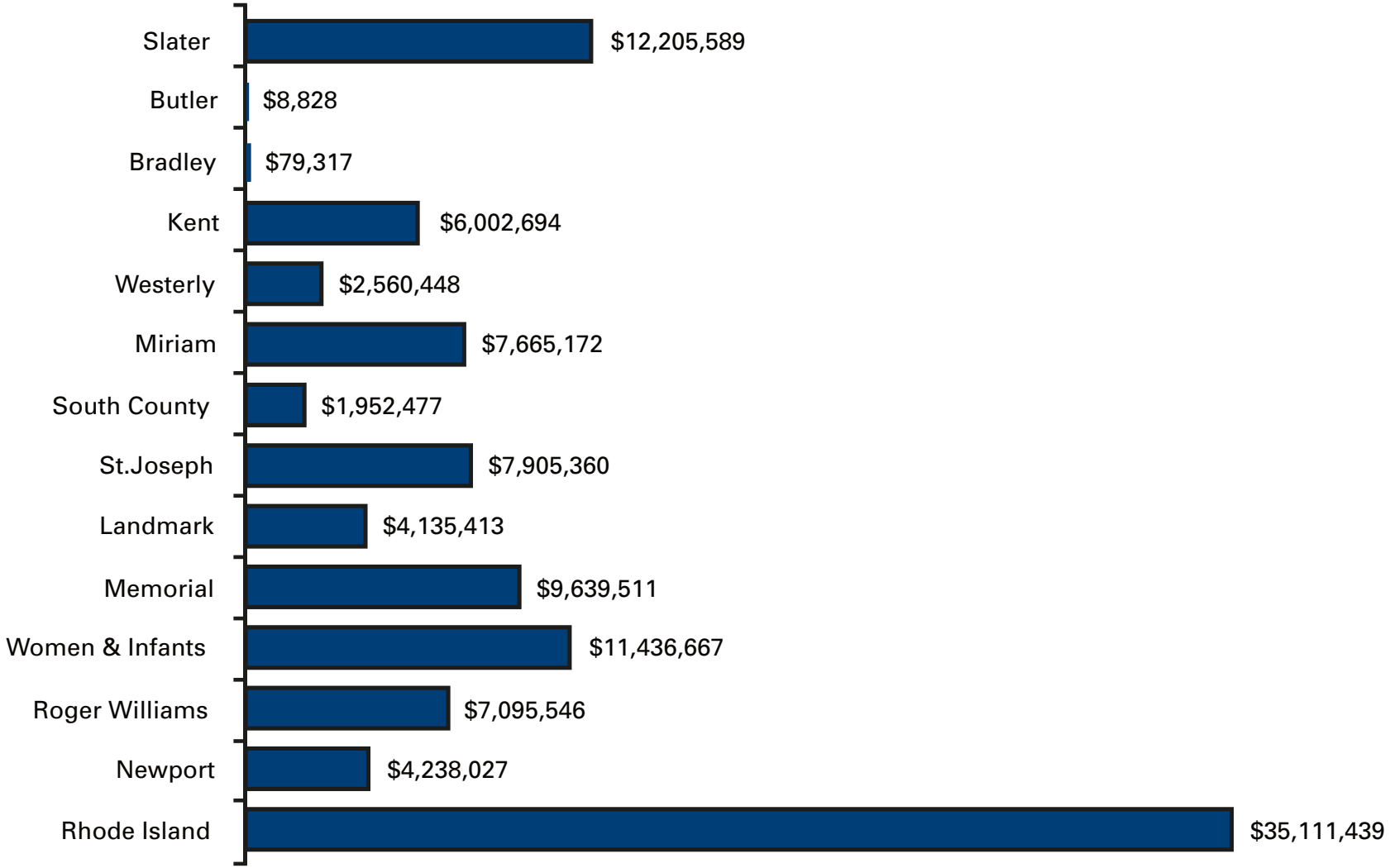
Table 2

Local Education Agency	Combined 2003	Combined 2004	Combined 2005	Combined 2006
Barrington	$ 273,520	$ 298,792	$ 333,656	$ 337,692
Bristol / Warren	$ 377,482	$ 473,470	$ 401,322	$ 382,262
Burrillville	$ 400,939	$ 319,067	$ 359,845	$ 300,680
Central Falls	$ 1,316,540	$ 1,727,250	$ 1,385,015	$ 1,312,106
Chariho	$ 160,478	$ 390,468	$ 207,971	$ 331,266
Coventry	$ 519,432	$ 623,113	$ 734,688	$ 525,756
Cranston	$ 1,879,510	$ 2,160,765	$ 1,134,916	$ 1,574,162
Cumberland	$ 658,270	$ 642,289	$ 673,816	$ 683,936
E. Greenwich	$ 287,979	$ 338,539	$ 341,179	$ 412,980
E. Providence	$ 1,258,055	$ 1,273,826	$ 1,085,027	$ 1,365,421
Exeter-W. Greenwich	$ 343,448	$ 330,473	$ 292,897	$ 263,713
Foster	$ 48,016	$ 68,107	$ 40,758	$ 28,090
Foster/Glocester	$ 85,800	$ 81,049	$ 72,352	$ 75,603
Glocester	$ 109,100	$ 175,654	$ 151,474	$ 183,895
Jamestown	$ 116,752	$ 73,160	$ 104,652	$ 130,851
Johnston	$ 602,726	$ 811,928	$ 770,654	$ 817,585
Lincoln	$ 403,557	$ 450,300	$ 711,074	$ 697,667
Narragansett	$ 261,650	$ 271,989	$ 174,248	$ 157,372
New Shoreham	$ -	$ -	$ -	$ -
Newport	$ 606,795	$ 750,265	$ 649,141	$ 488,811
Newport County Reg.	$ 636,288	$ 660,482	$ 525,864	$ 877,949
N.Kingstown	$ 775,152	$ 825,333	$ 768,272	$ 608,410
N.Providence	$ 461,637	$ 607,115	$ 744,100	$ 772,673
N.Smithfield	$ 204,443	$ 198,697	$ 203,084	$ 208,345
Pawtucket	$ 2,950,817	$ 2,416,996	$ 1,744,351	$ 2,001,764
Providence	$ 5,574,770	$ 5,622,819	$ 4,476,397	$ 3,862,974
School for the Deaf	$ 234,600	$ 149,747	$ 210,434	$ 98,179
Scituate	$ 105,600	$ 159,423	$ 180,350	$ 158,533
Smithfield	$ 314,875	$ 308,725	$ 265,862	$ 267,991
S.Kingstown	$ 764,661	$ 916,998	$ 700,393	$ 942,369
Warwick	$ 2,248,409	$ 1,970,802	$ 1,717,850	$ 1,861,235
W. Warwick	$ 578,538	$ 674,276	$ 535,998	$ 497,747
Westerly	$ 590,123	$ 601,282	$ 446,200	$ 413,588
Wm. M. Davies	$ -	$ -	$ 5,805	$ 54,802
Woonsocket	$ 1,125,643	$ 1,217,711	$ 1,173,791	$ 1,072,628
Kinston Hill Academy	$ 5,000	$ -	$ -	$ -
Paul Cuffee School	$ 1,900	$ 3,500	$ 100	$ 4,560
East Bay Educational Collab	$ -	$ 15,400	$ 18,500	$ 23,802
Met Career & Tech Ctr	$ -	$ 141,769	$ 178,271	$ 183,467
International Charter School	$ -	$ -	$ 13,800	$ 8,912
Blackstone Academy Charter	$ -	$ -	$ 33,530	$ 48,984
CVS Highlander Charter School	$ -	$ -	$ 14,407	$ 48,749
Compass Charter School	$ -	$ -	$ -	$ 7,409
Beacon Charter School	$ -	$ -	$ -	$ 7,948
The Learning Community	$ -	$ -	$ -	$ -
Totals	**$ 26,282,505**	**$ 27,751,579**	**$ 23,651,643**	**$ 24,102,867**

Source:
Department of
Human Services

Disproportionate share (DSH) Medicaid payments are made to subsidize the costs of providing care to indigent and very low income people

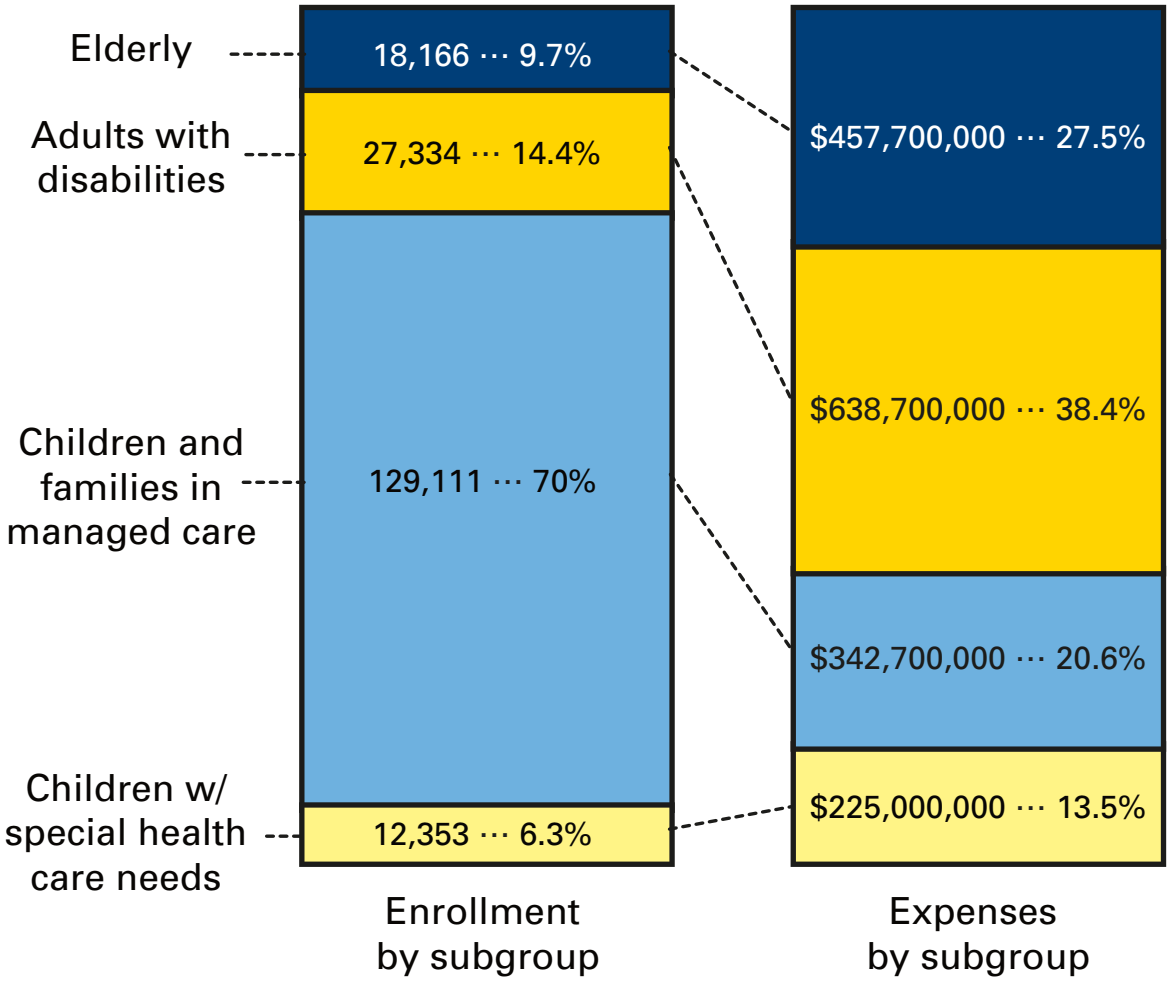
Figure 4
DSH/uncompensated care distribution by hospital
SFY 2006



Note: Does not include Psychiatric & Graduate medical education DSH pool
Source: Department of Human Services

Approximately 30% of Medicaid beneficiaries are responsible for 79% of total spending

Figure 5
Medicaid enrollment / expense comparison by subgroup
SFY 2006

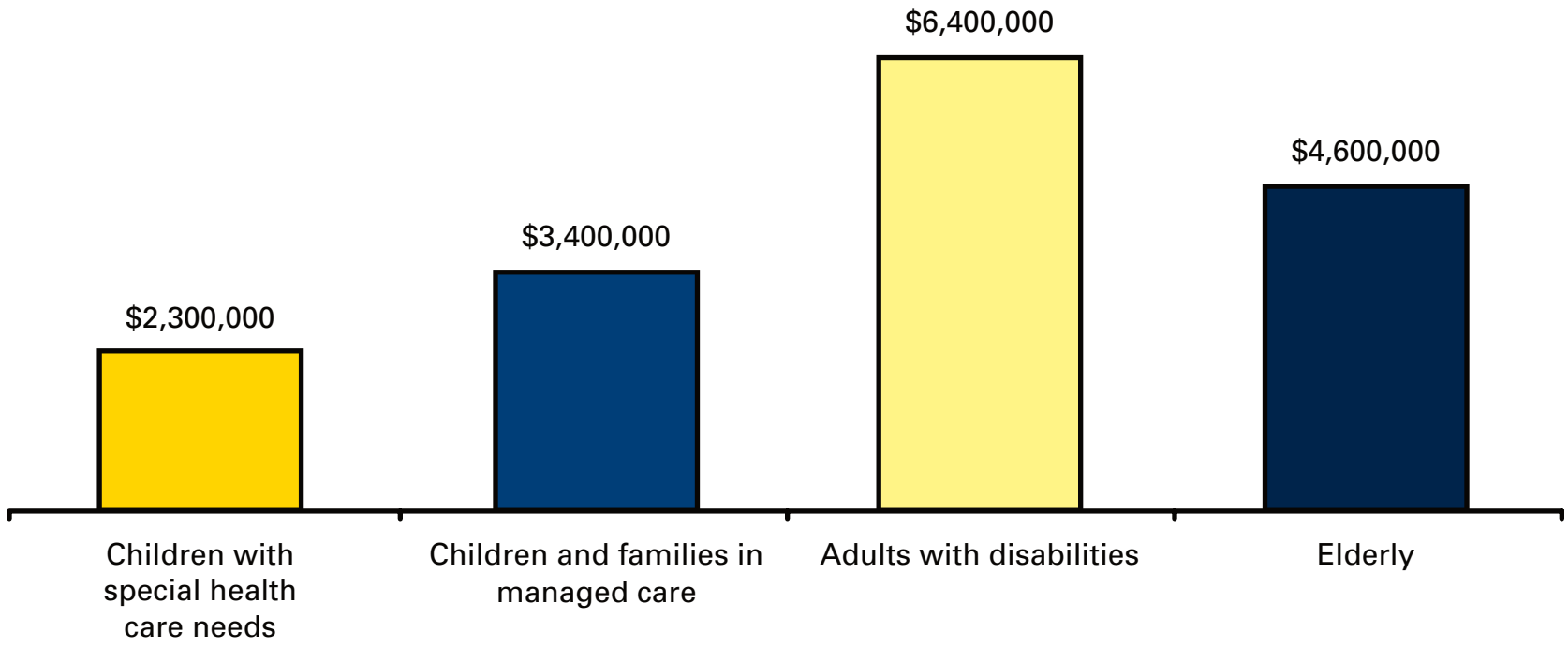


Source: Medicaid claims extract

Each beneficiary group contributes to Medicaid's costs at different rates

- For example it takes nearly a 2% increase in spending within the children and families in managed care population to equal a 1% increase in the adults with disabilities category

Figure 6
Value of 1% change in spending
by beneficiary group
SFY 2006

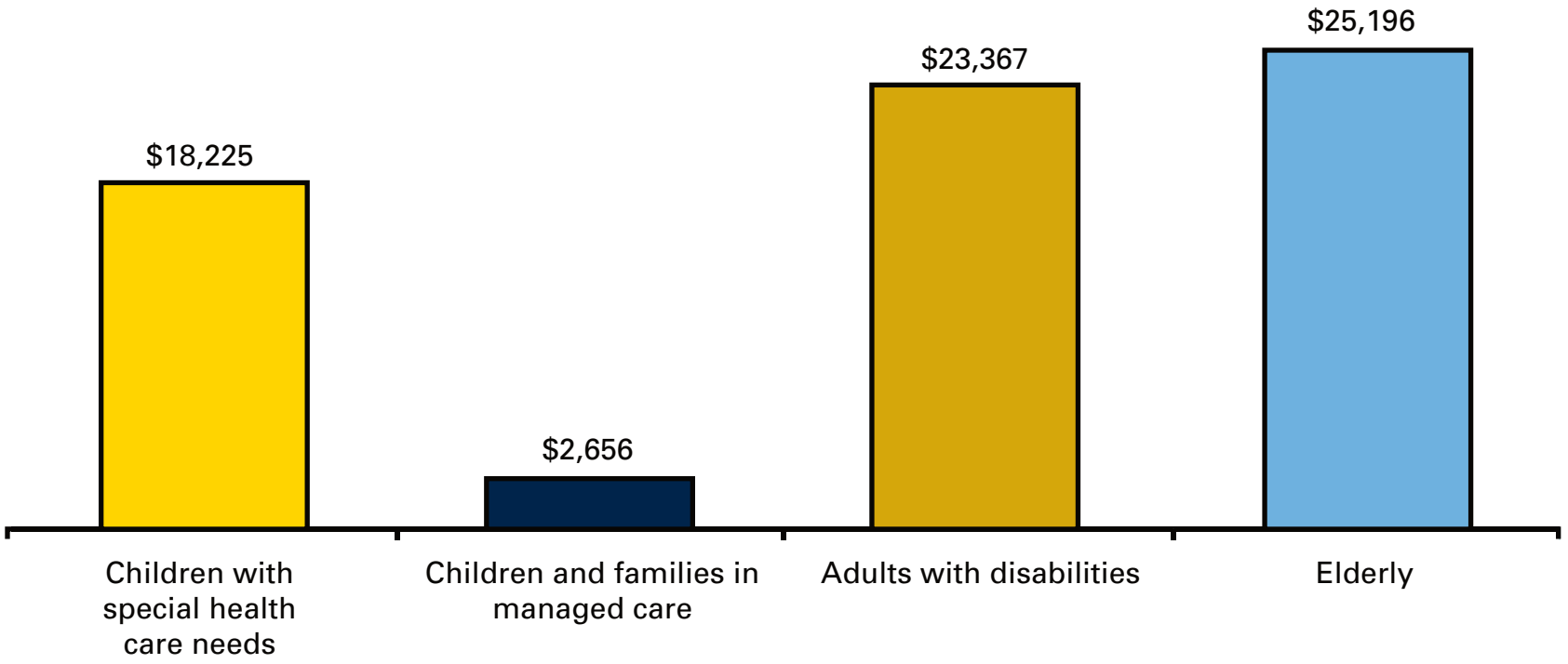


Source: Medicaid claims extract

There is a significant difference in average Medicaid costs across populations

- Adults with disabilities & the elderly may also participate in Medicare

Figure 7
Per member average annual Medicaid Costs
SFY 2006

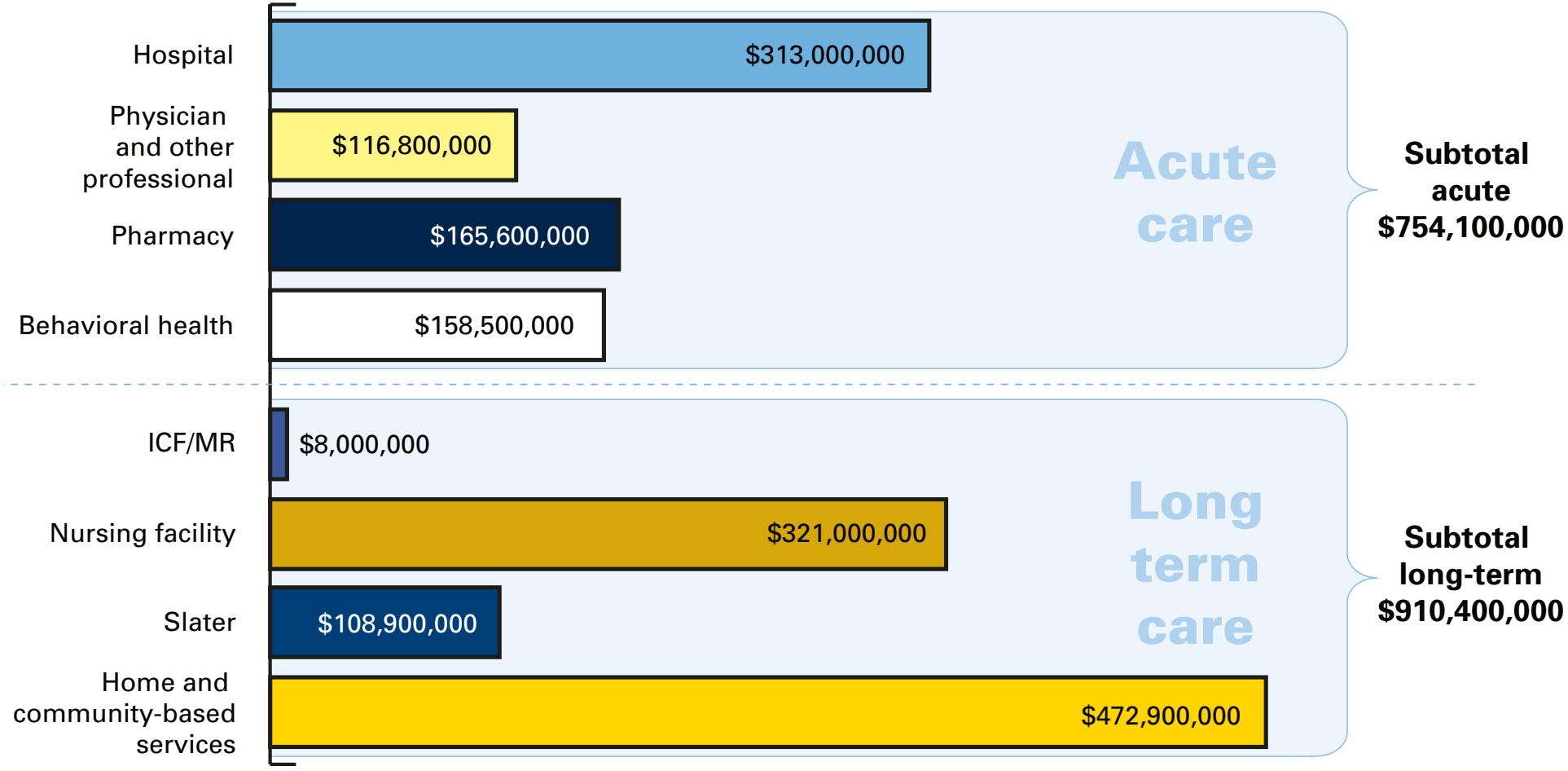


Source: Medicaid claims extract

Three provider groups represent 66.5% of total Medicaid spending

- 54.7% of Medicaid spending is to provide long term care to individuals

Figure 8
Medicaid expenses by service provider
SFY 2006

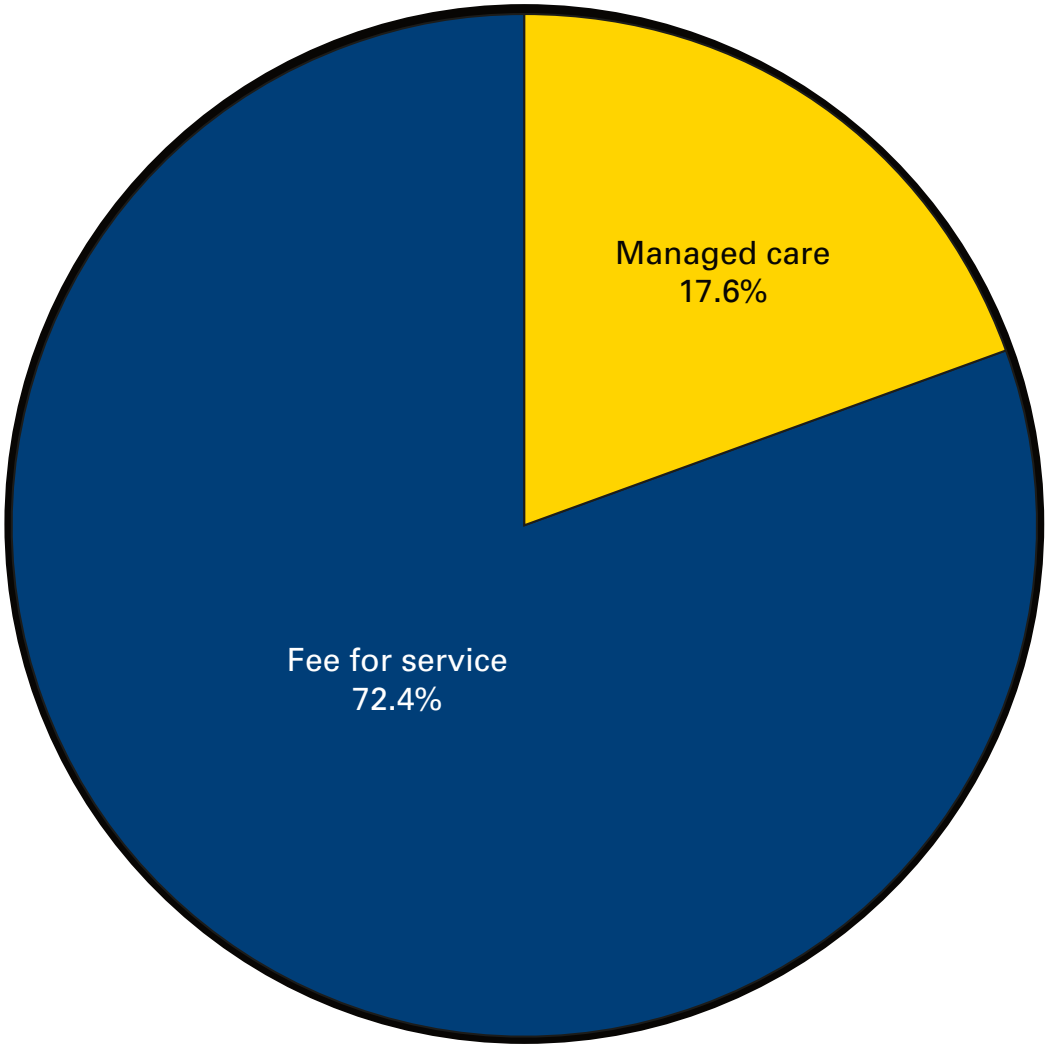


Note: HCBS includes both services in consumers' homes and group home settings

Source: Medicaid claims extract

The majority of RI's Medicaid program expenditures are purchased through fee for service arrangements

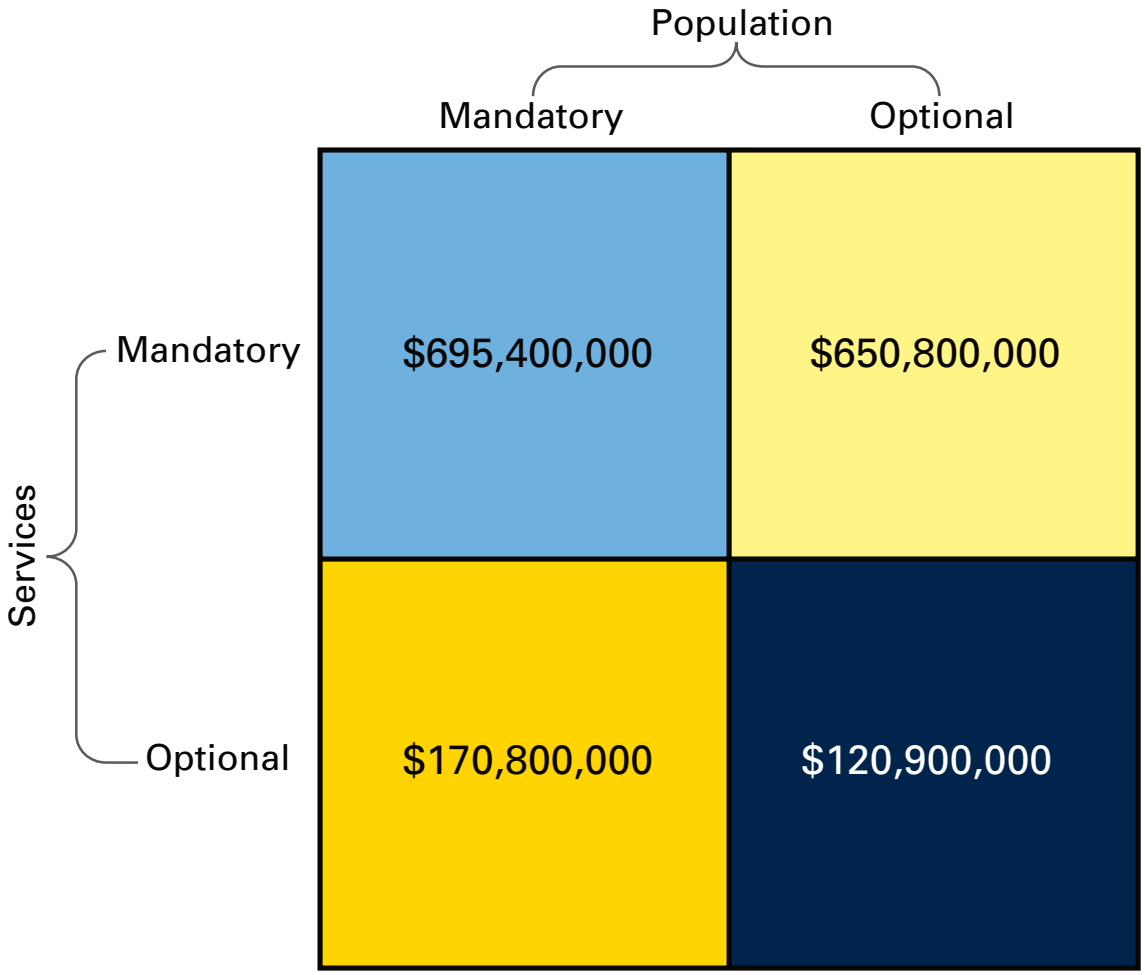
Figure 9
Fee for service vs managed care
SFY 2006



Source: Medicaid claims extract

Approximately 40% of Medicaid spending is mandated by federal law, the remaining spending is a function of state law

Figure 10
Incurred expense, by population and service group
SFY 2006



Note: Federal guidelines require optional populations receive the same services as mandatory populations

Note: Excludes $26 M in waiver costs; Includes $7.4 million in MHRH offline payments; Optional/Optional quadrant includes $64 million in EPSDT

Source: Medicaid claims extract

Medicaid mandatory and optional populations & services - 1 of 2

Table 3

Federal mandatory populations	Federal mandatory services	Optional services
• Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI) ; • Low income Medicare beneficiaries; • Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state's 1996 AFDC eligibility requirements ; • Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines; • Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level; • Infants born to Medicaid-enrolled pregnant women; • Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program.	• Inpatient hospital services • Outpatient hospital services • Rural health clinic services • Federally qualified health center services • Laboratory and x-ray services • Nursing facility services for individuals 21 and older • Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21 • Family Planning services • Physicians' services • Home health services for any individual entitled to nursing facility care • Nurse-midwife services to the extent permitted by State law • Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under State law	• Podiatrists' services • Optometrists services • Dental services • Prescribed drugs • Dentures • Prosthetic devices • Eyeglasses • Diagnostic services • Preventive services • Rehabilitative services • Services in an IMD for individuals age 65 and over • Inpatient psychiatric services for individuals under age 21 • NF services for individuals under age 21 • Personal care services • Transportation services • Case management services • Hospice services • TB services for certain TB infected individuals

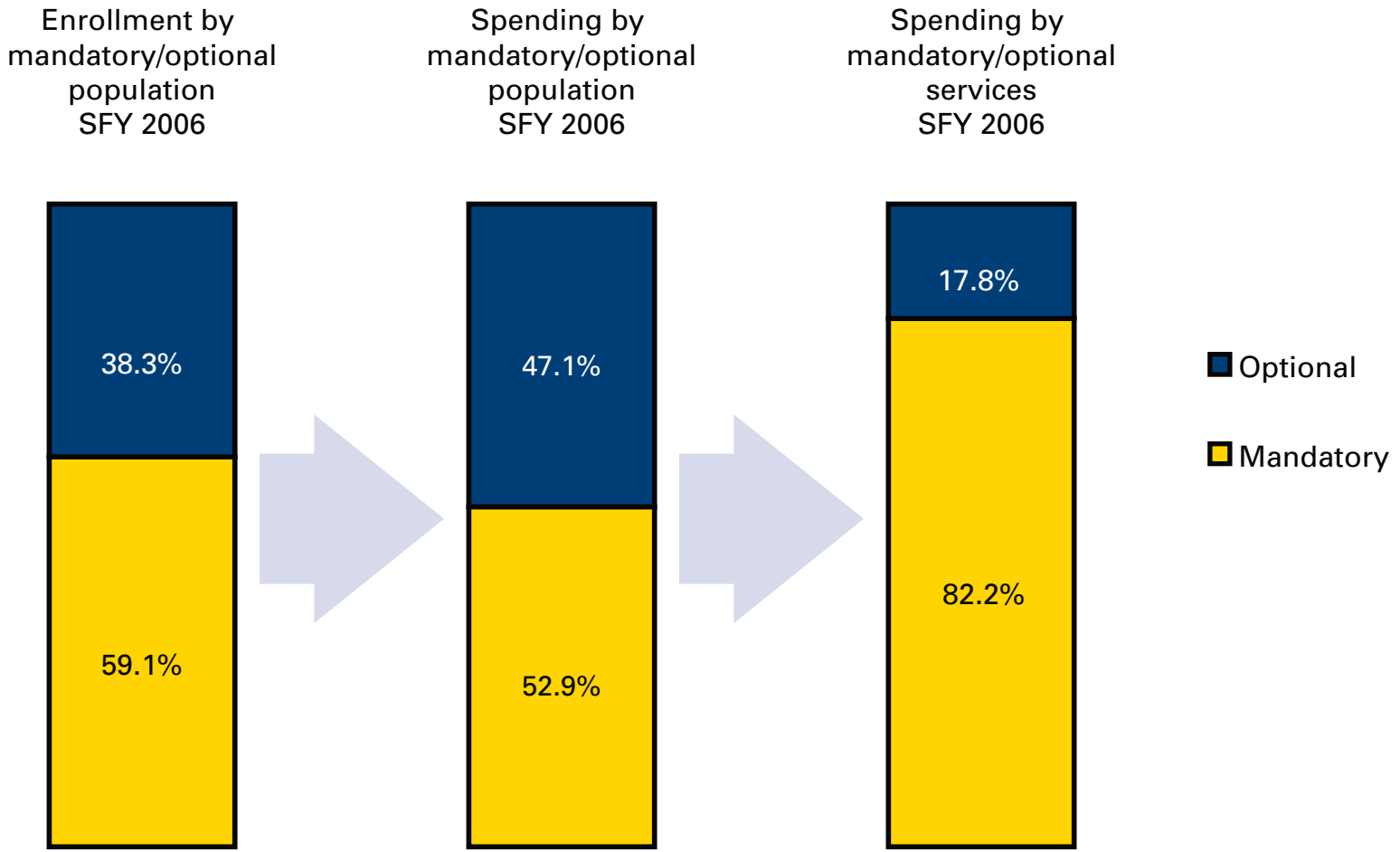
Medicaid mandatory and optional populations & services - 2 of 2

Table 4

Optional populations	Federal mandatory services	Optional services
• Low-income elderly adults or adults with disabilities; • Individuals eligible for Home and Community Based Services waiver programs; • Children up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through the State Children's Health Insurance Program; • Individuals determined to be "medically needy" due to low income and resources or to large medical expenses; • Children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision); • Women eligible for Breast and Cervical Cancer program.	• Inpatient hospital services • Outpatient hospital services • Rural health clinic services • Federally qualified health center services • Laboratory and x-ray services • Nursing facility services for individuals 21 and older • Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21 • Family Planning services • Physicians' services • Home health services for any individual entitled to nursing facility care • Nurse-midwife services to the extent permitted by State law • Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under State law	• Podiatrists' services • Optometrists services • Dental services • Prescribed drugs • Dentures • Prosthetic devices • Eyeglasses • Diagnostic services • Preventive services • Rehabilitative services • Services in an IMD for individuals age 65 and over • Inpatient psychiatric services for individuals under age 21 • NF services for individuals under age 21 • Personal care services • Transportation services • Case management services • Hospice services • TB services for certain TB infected individuals

Mandatory populations and services represent a significant portion of state Medicaid spending

Figure 11



Note: Excludes some waiver enrollment

Source: Medicaid claims extract

A category of optional spending is in community-based waivers providing alternatives to mandatory institutional care

Table 5
Selected RI waiver populations

Waiver:	Aged and disabled	Elder	Developmental disability	Habilitative	Assisted living	Consumer-directed (Personal Choice)
Target population	Those 18 and over who are aged or have a disability that results in the need for help with ADLs and IADLs	Those 65 and older who need help with ADLs and IADLs	People of any age who meet Developmental Disability criteria: substantial functional limitation in major life areas caused by permanent mental and/or physical impairment that begins before age 22.	Those 18 and older who have severe physical and/or cognitive disabilities resulting in the need for ongoing skilled services or 24 hour supports	Those 18 and older who require assistance with ADLs and IADLs	Those 18 and older who require assistance with ADLs and IADLs and who are able to manage their own services or have a representative to manage services on their behalf

HCBS Waiver Services

Table 6

	Aged and disabled	DEA	Assisted living	Habilitative	MR/DD	Consumer directed
Case management	X	X	X	X	X	X
Homemaker	X	X			X	X
Personal care	X	X		X	X	X
Home delivered meals	X	X			X	X
Minor assistive devices	X	X	X	X	X	X
Minor home mod.	X	X		X	X	X
Emergency response system	X	X			X	X
Assisted living		X	X			
Senior companion	X	X				
Respite					X	
Adult foster care					X	
Consumer directed goods & services					X	X
Residential habilitation				X	X	
Day habilitation				X	X	
Specialized homemaker					X	
Supported employment				X	X	
Rehabilitation				X		

RI Home and Community-based Medicaid Waiver summary

Table 7

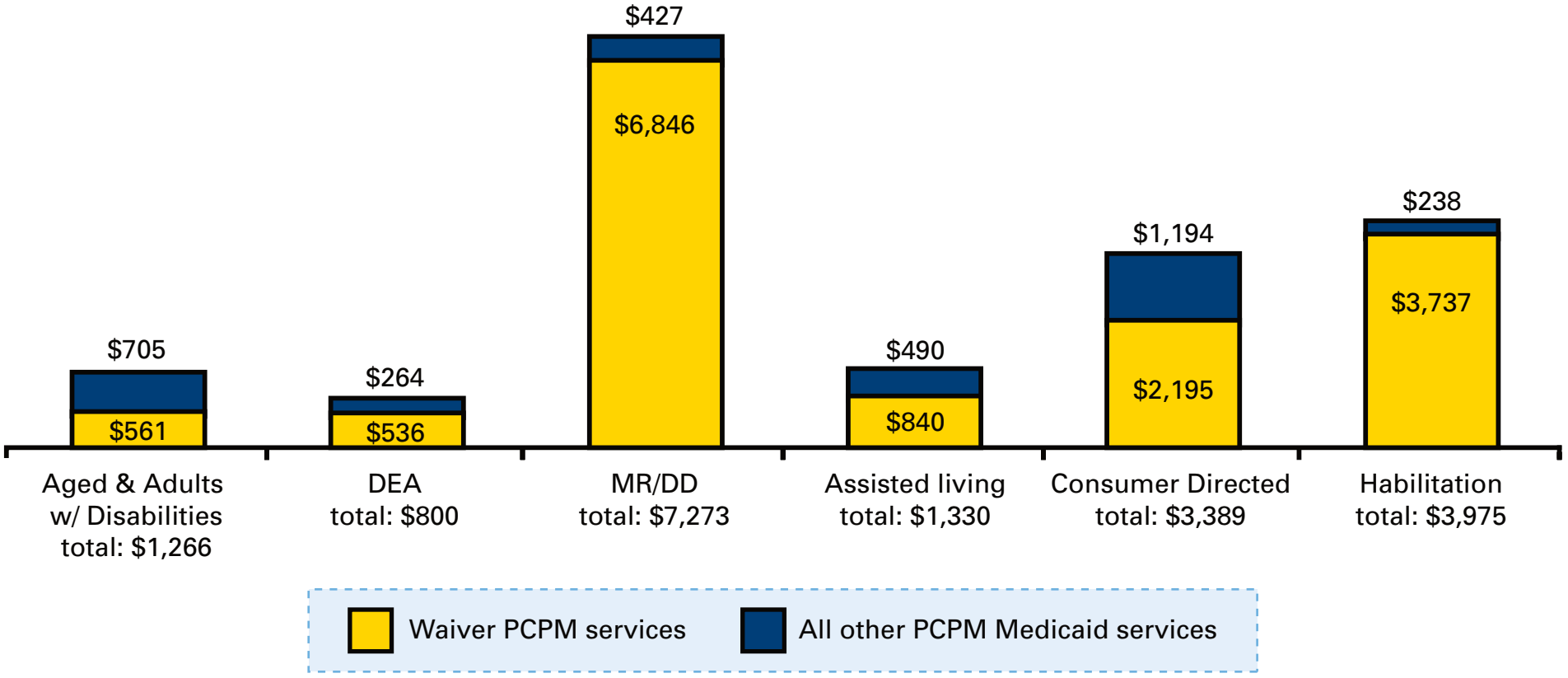
Waiver	A&D	DEA	Asst living	Consumer directed (Personal Choice)	Habilitative	MR/DD
Year started	1983	1988	1999	1986	2002	1983
Administering agency	DHS	DEA	DEA/DHS	DHS/PARI	DHS	MHRH
Population characteristics	NF Level of Care: Age & Disability	NF Level of Care: Age	NF Level of Care: Age & Disability	NF Level of Care: Age & Disability	Hospital Level of Care: Disability	ICF/MR Level of Care: Developmental Disability
Daily cap	1,750	950	200*	150	25	3500
SFY 2005 participants	1,823	742	246	99	25	3,211

*Assisted Living annual cap is 350 people but any given month the cap cannot exceed 200 people.

NOTE: Consumer directed waiver was replaced by Personal Choice Cash and Counseling waiver effective March 1, 2007

Home and community-based services waiver participant per capita per month Medicaid expenditures

Figure 12
HCBS waiver
PCPM expenditures
CMS 372 Reporting
FY 2006



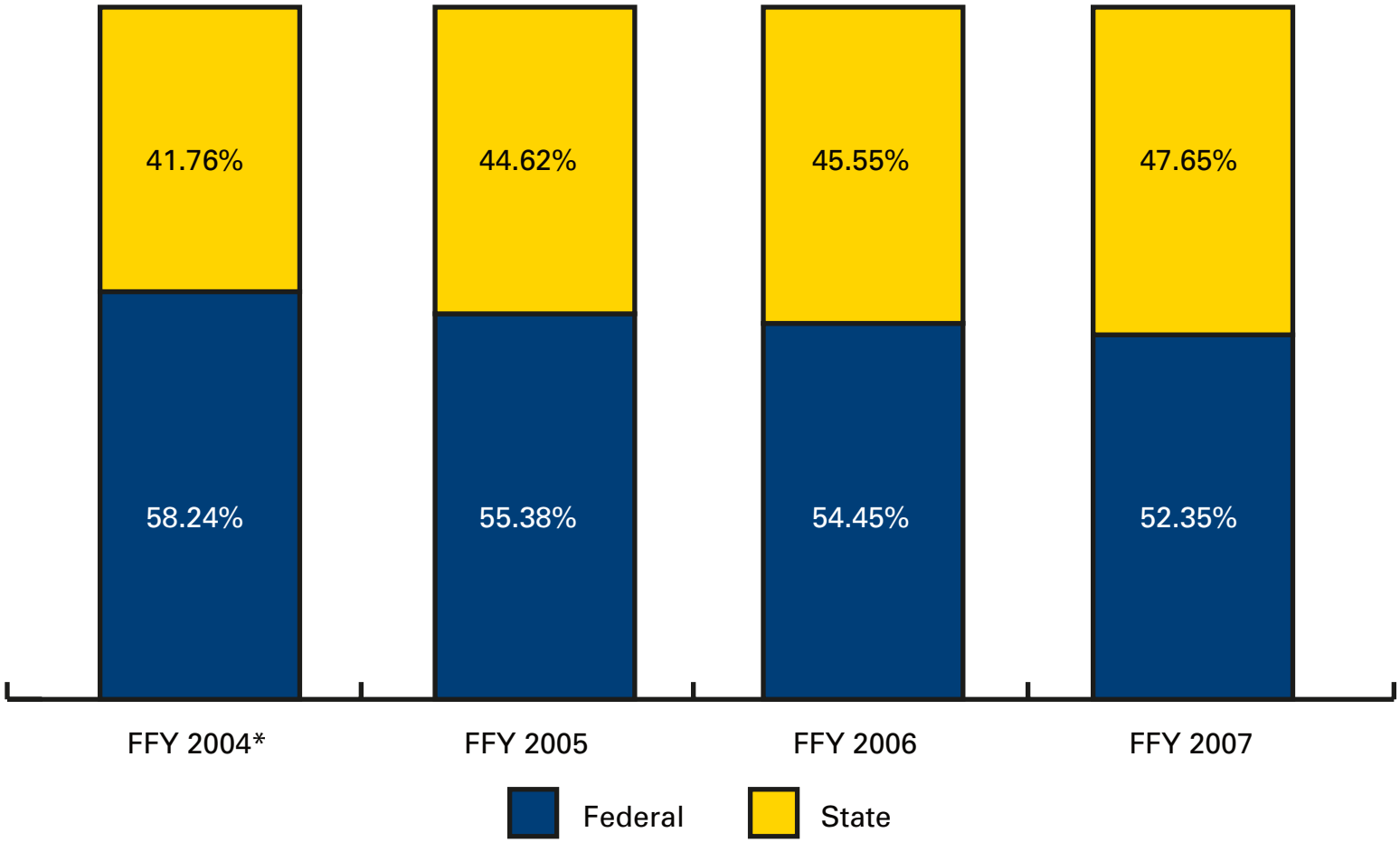
Source: Department of Human Services

RI Medicaid trends

RI is paying for an increasing share of Medicaid expenditures

- Lowest FMAP possible is 50%
- Every 1% change in Federal portion of FMAP equals approximately $18 million in state general funds

Figure 13
Federal Medicaid matching rates

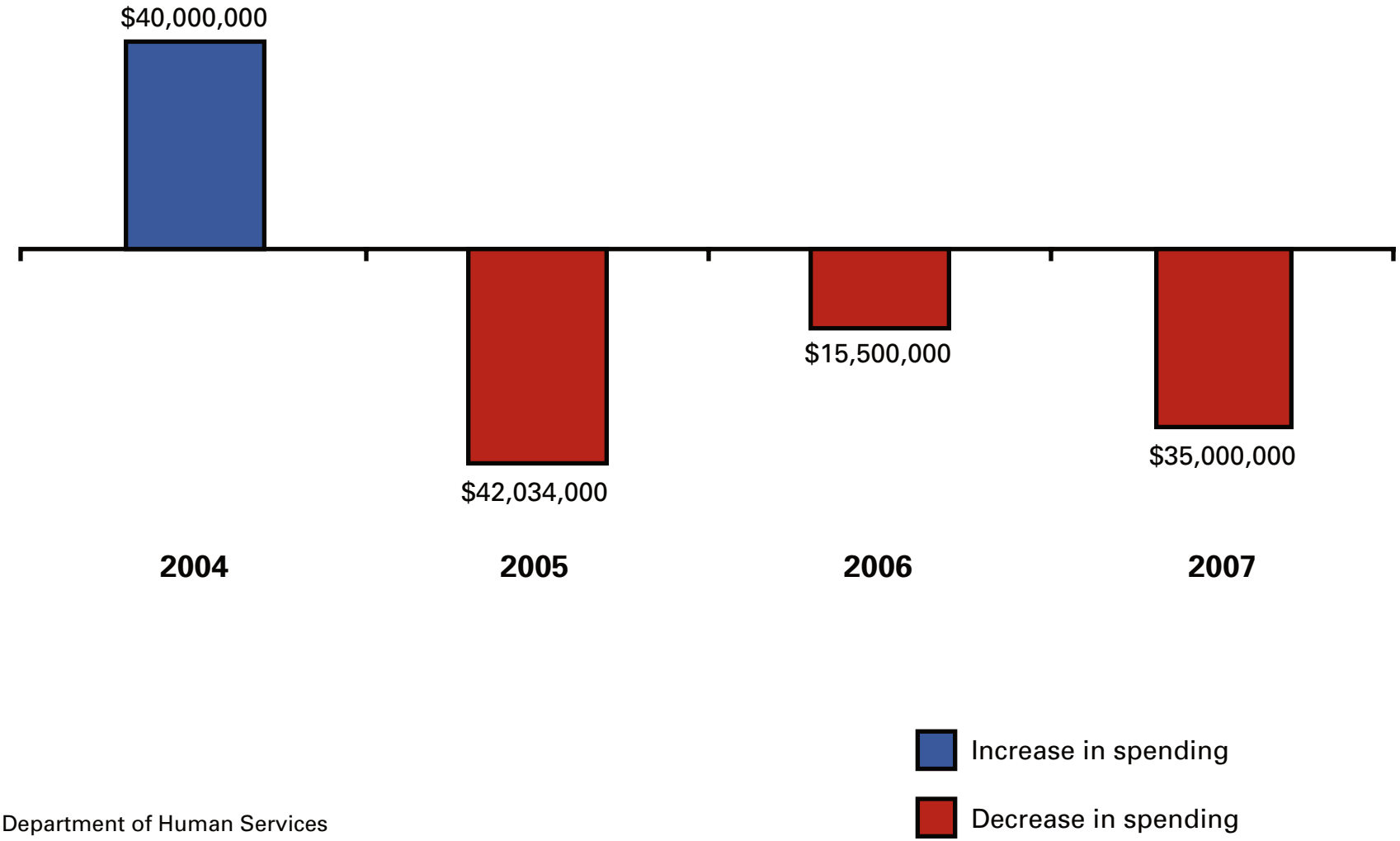


*Notes federal windfall based on special legislation, *Jobs and Economic Tax Relief Reconciliation Act of 2003*

Source: Department of Human Services

Declining federal assistance increases the cost of the Medicaid program for Rhode Island regardless of medical expense trends

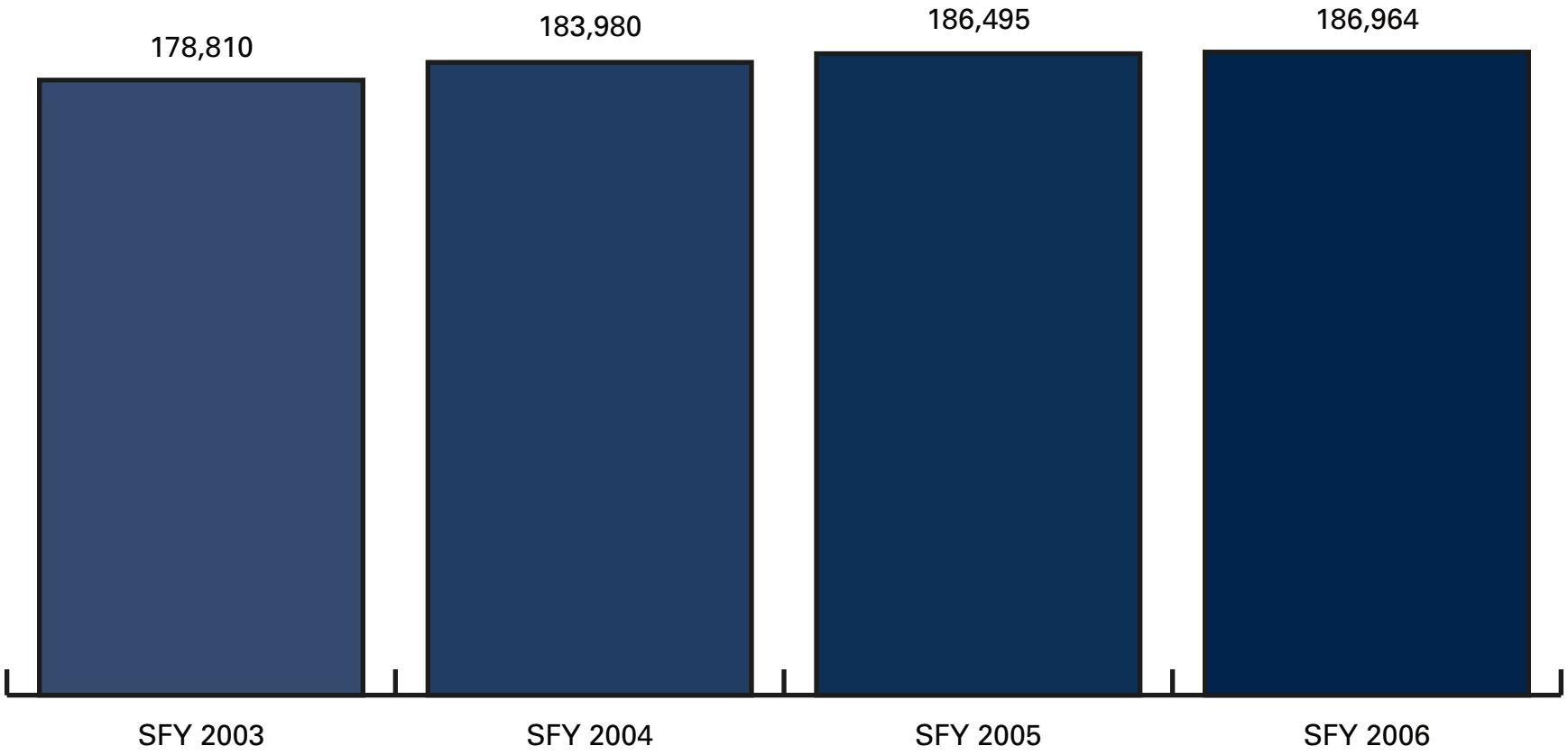
Figure 14
Value of change in FMAP
FFY 2004 - FFY 2007



Source: Department of Human Services

Medicaid enrollment's average annual growth rate since 2003 is 1.5%

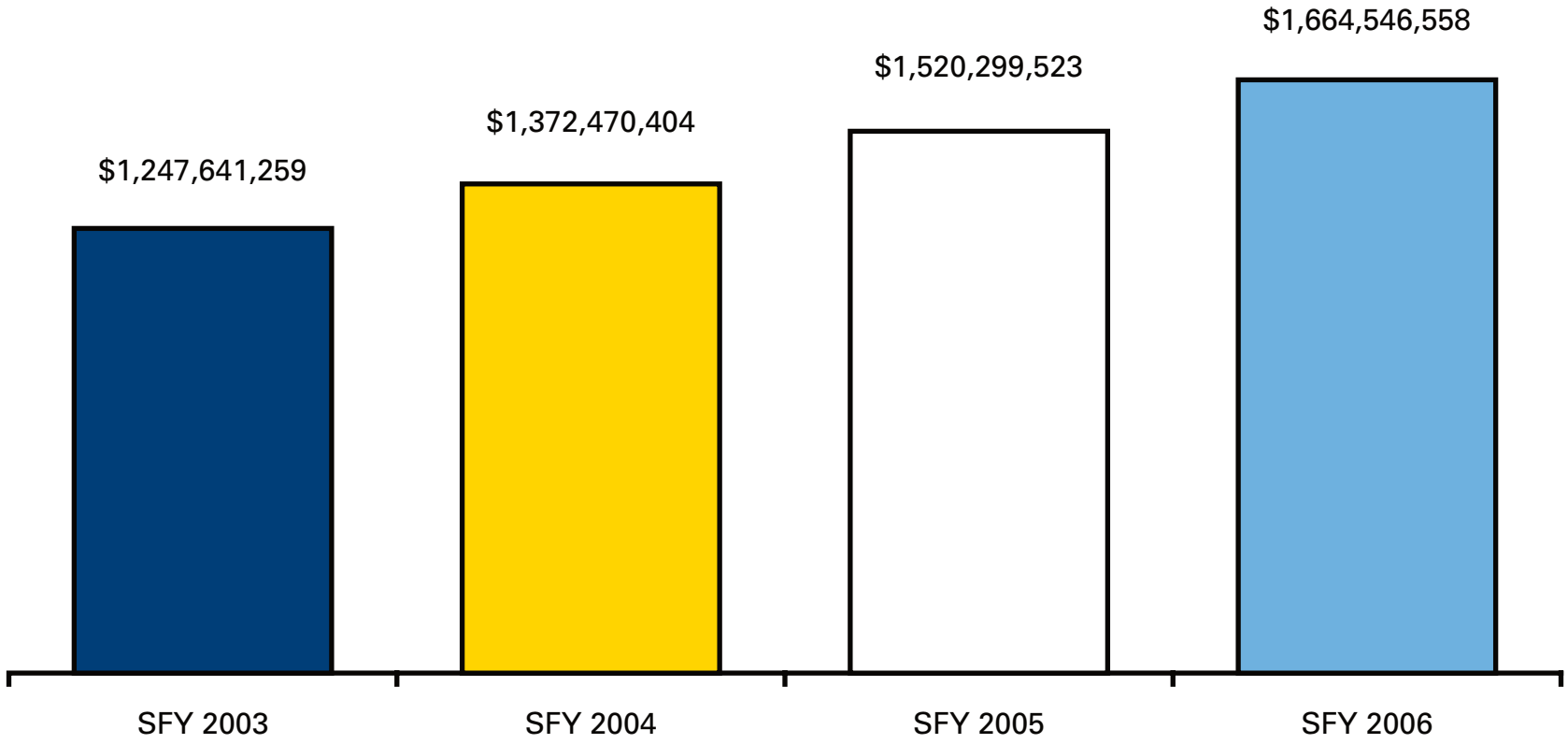
Figure 15
Enrollment trends



Source: Medicaid claims extract

Medicaid spending has grown by an average annual rate of 8.72%

Figure 16
Total Medicaid spending
(all funds)



Source: Medicaid claims extract

Medicaid spending has grown substantially faster than caseloads across all beneficiary groups

Figure 17
Average Annual Change in Enrollment
SFY 2003 - SFY 2006

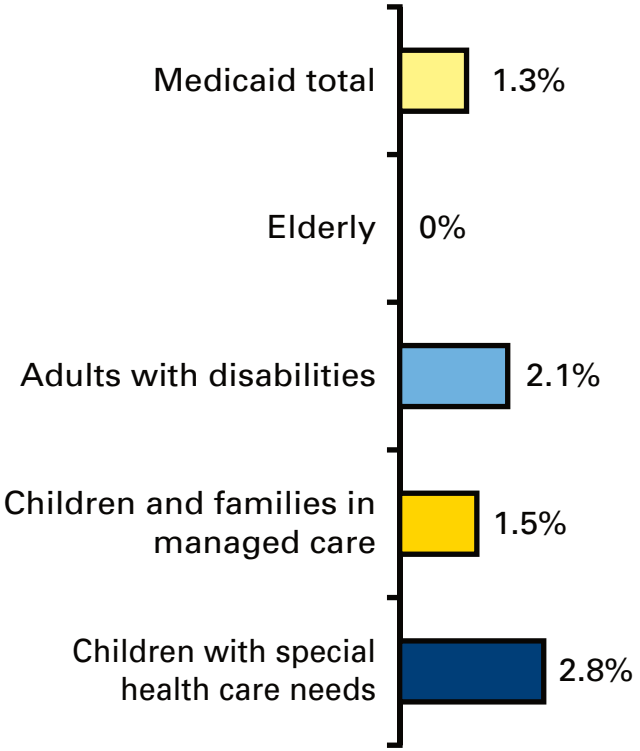
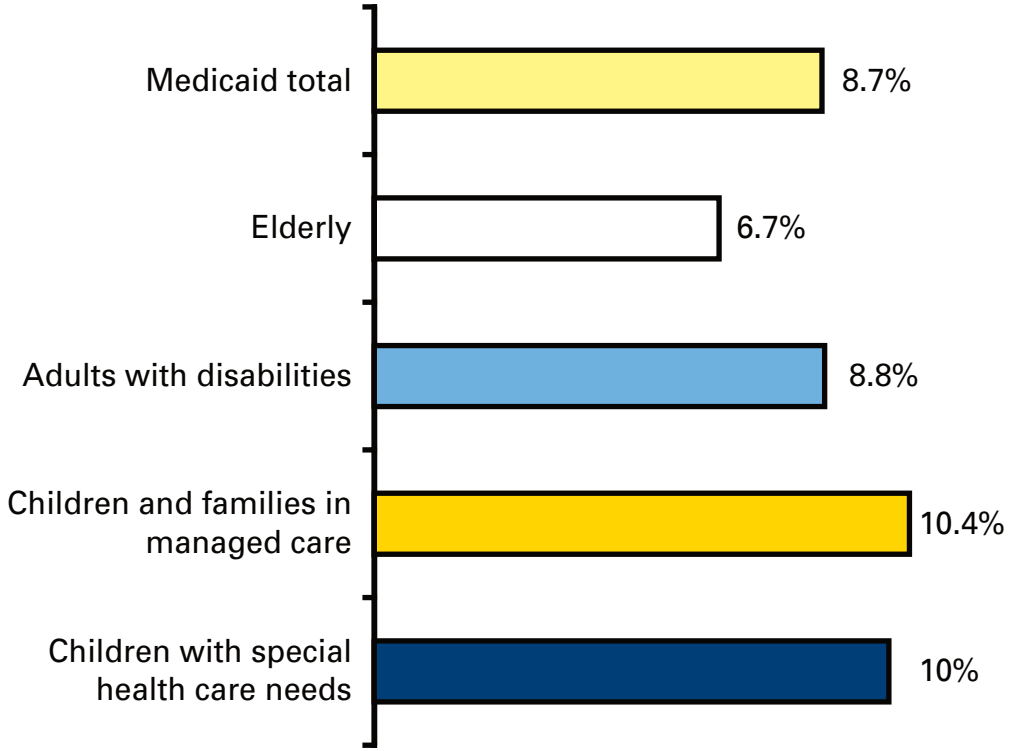


Figure 18
Average Annual Change in Spending
SFY 2003 - SFY 2006



Source: Medicaid claims extract

Emphasis on expanding coverage has driven enrollment growth but spending increases are across all populations

Figure 19
Change in enrollment
mandatory versus optional populations
SFY 2003 - SFY 2006

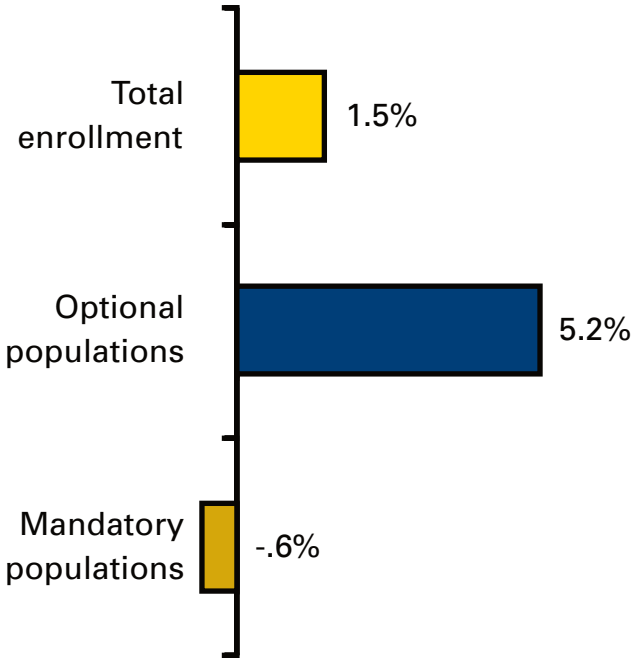
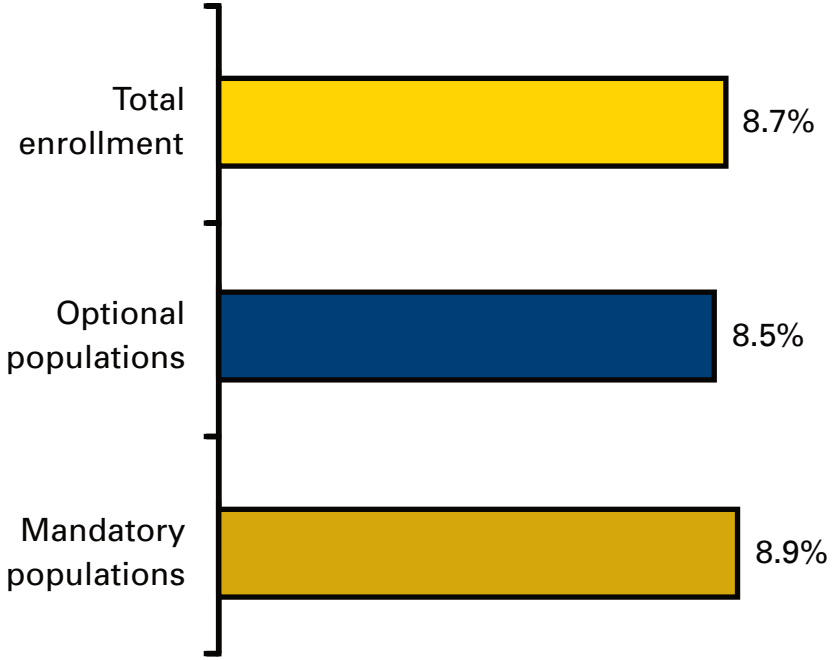


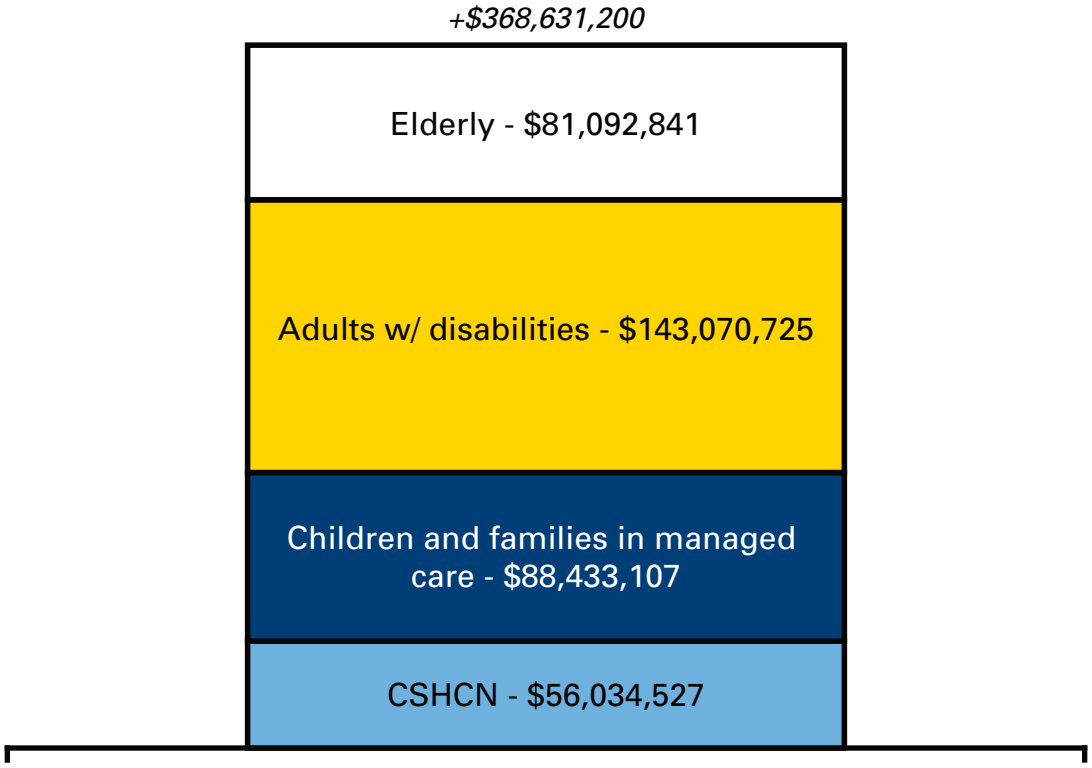
Figure 20
Change in spending
mandatory versus optional populations
SFY 2003 - SFY 2006



Source: Medicaid claims extract

Adults with disabilities represent 39% of the overall spending increase in Medicaid over the last three years

Figure 21
Spending change by beneficiary category
SFY 2003 - SFY 2006

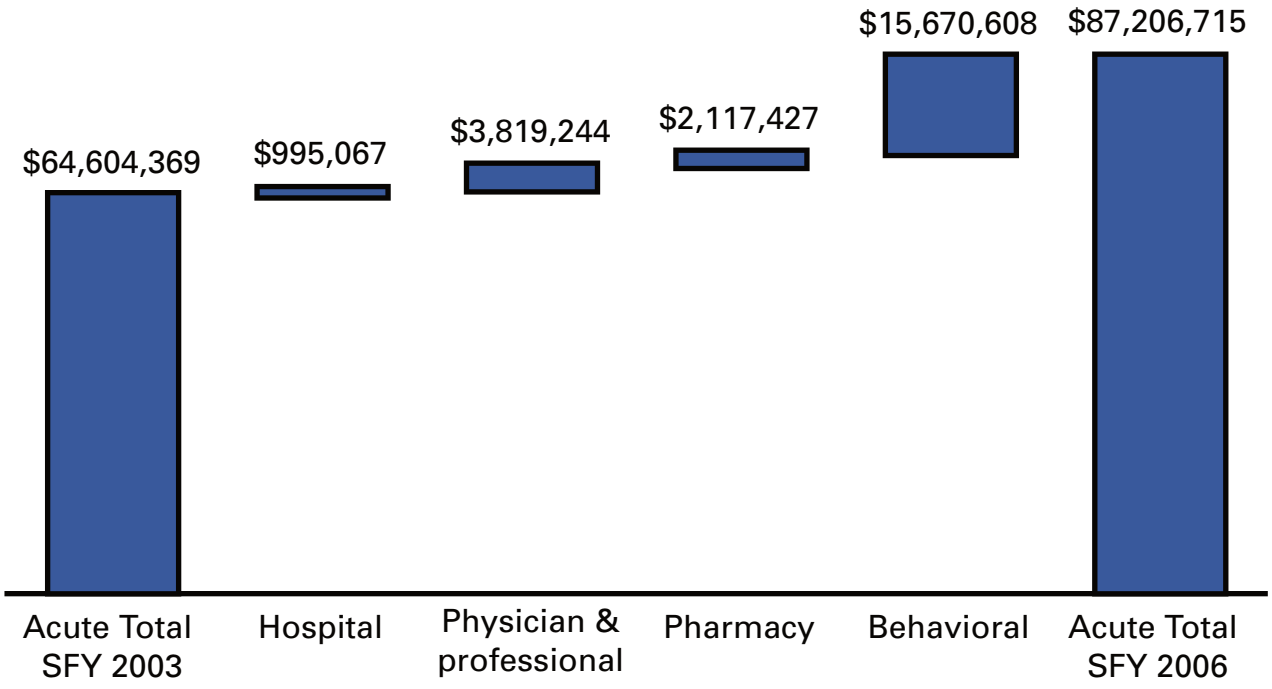


Source: Medicaid claims extract

Spending analysis by beneficiary category

In the children with special health care needs population behavioral health expenses are the largest contributor to acute care cost increases

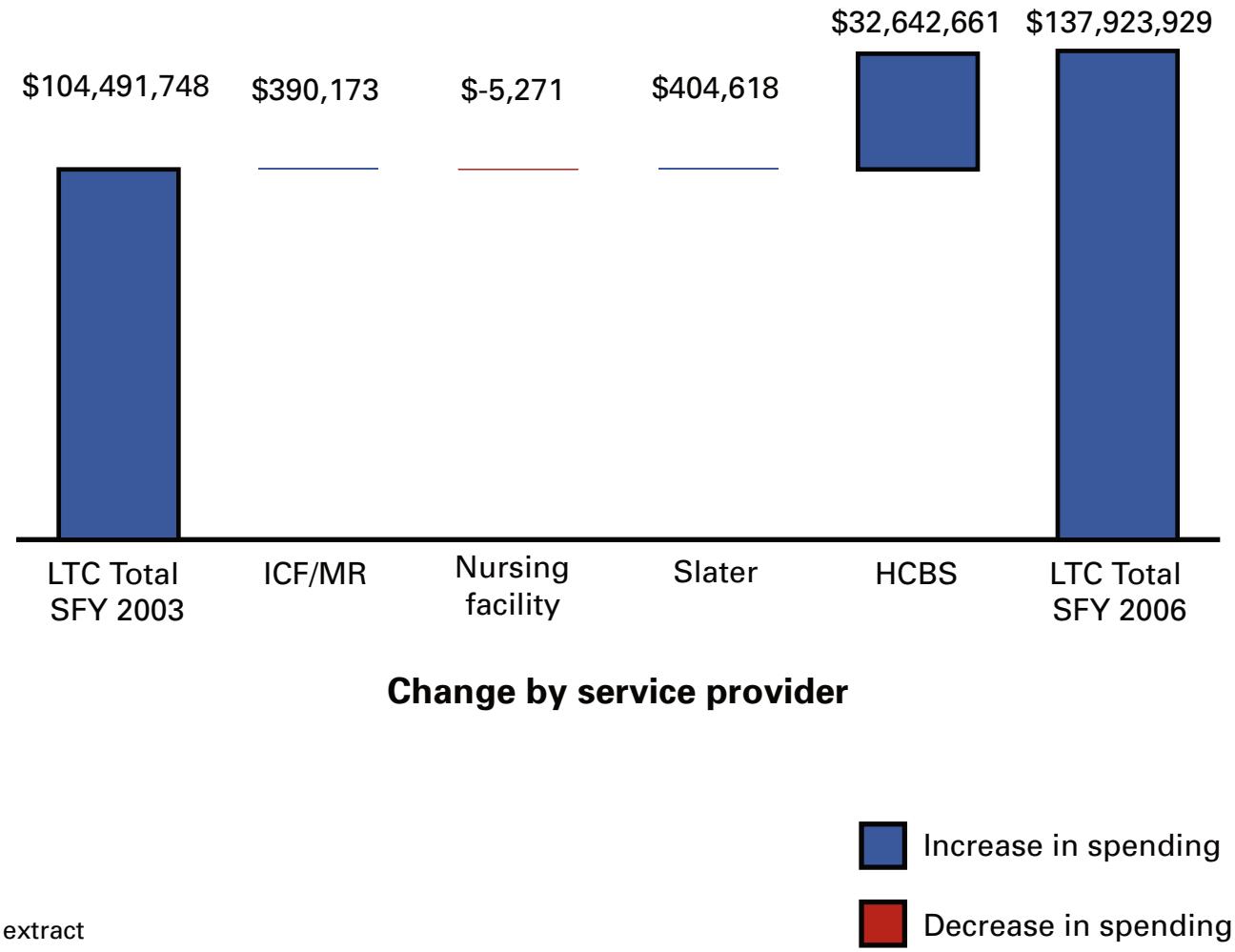
Figure 22
Change in Medicaid spending - children with special health care needs by service provider SFY 03 to SFY 06



Source: Medicaid claims extract

In the children with special health care needs population home and community-based service expenses (HCBS) are the largest contributor to long-term care cost increases

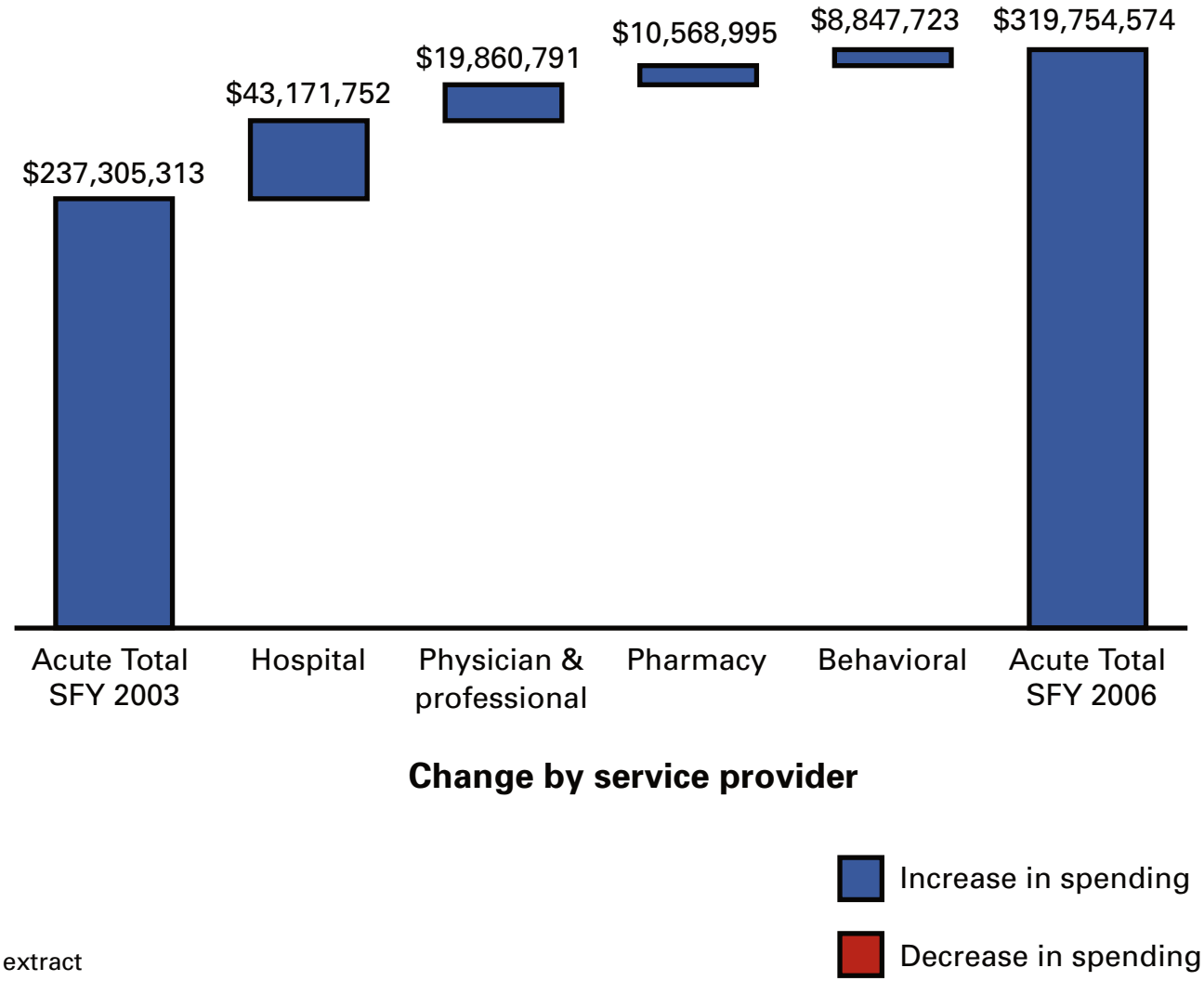
Figure 23
Change in Medicaid spending - children with special health care needs by service provider SFY 03 to SFY 06



Source: Medicaid claims extract

In the children and families in managed care population hospital expenses are the largest contributor to acute care cost increases

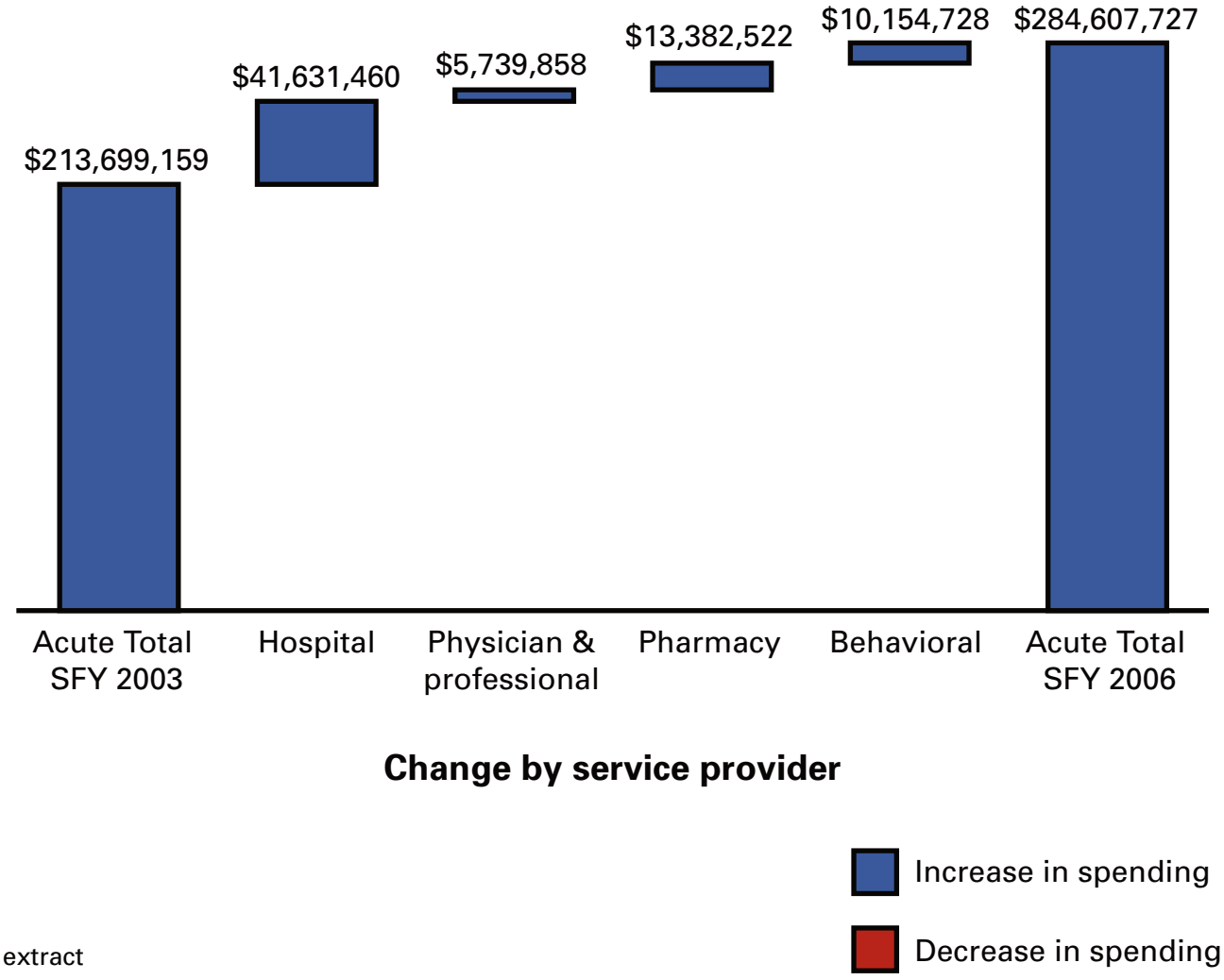
Figure 24
Change in Medicaid spending - children and families in managed care by service provider SFY 03 to SFY 06



Source: Medicaid claims extract

In the adults with disabilities population hospital expenses are the largest contributor to acute care cost increases

Figure 25
Change in Medicaid spending - adults with disabilities by service provider SFY 03 to SFY 06

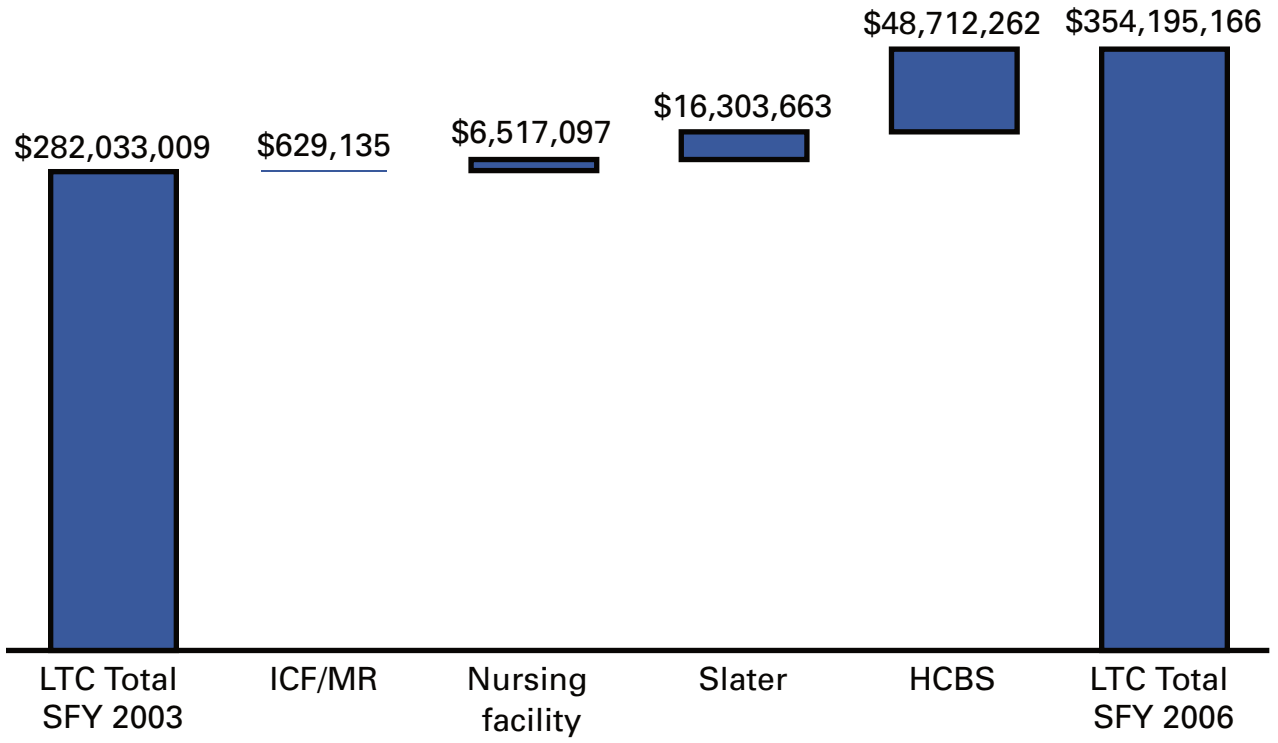


Source: Medicaid claims extract

In the adults with disabilities population home and community-based service expenses (HCBS) are the largest contributor to long-term care cost increases

• Reflects impact of Medicare Part D and related "clawback" provisions in SFY '06

Figure 26
Change in Medicaid spending - adults with disabilities by service provider SFY '03 to SFY '06

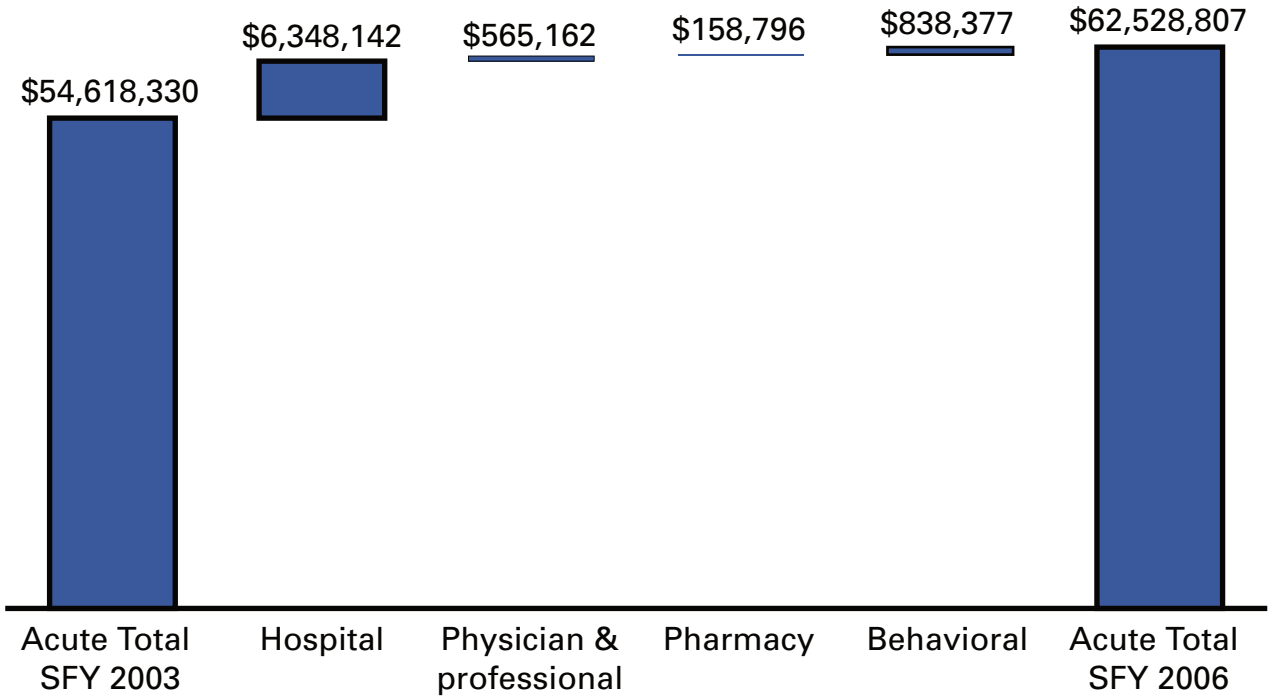


NOTE: Includes MHRH HCBS funding that was previously offline
Source: Medicaid claims extract

In the elderly population hospital expenses are the largest contributor to acute care cost increases

• Reflects impact of Medicare Part D and related "clawback" provisions

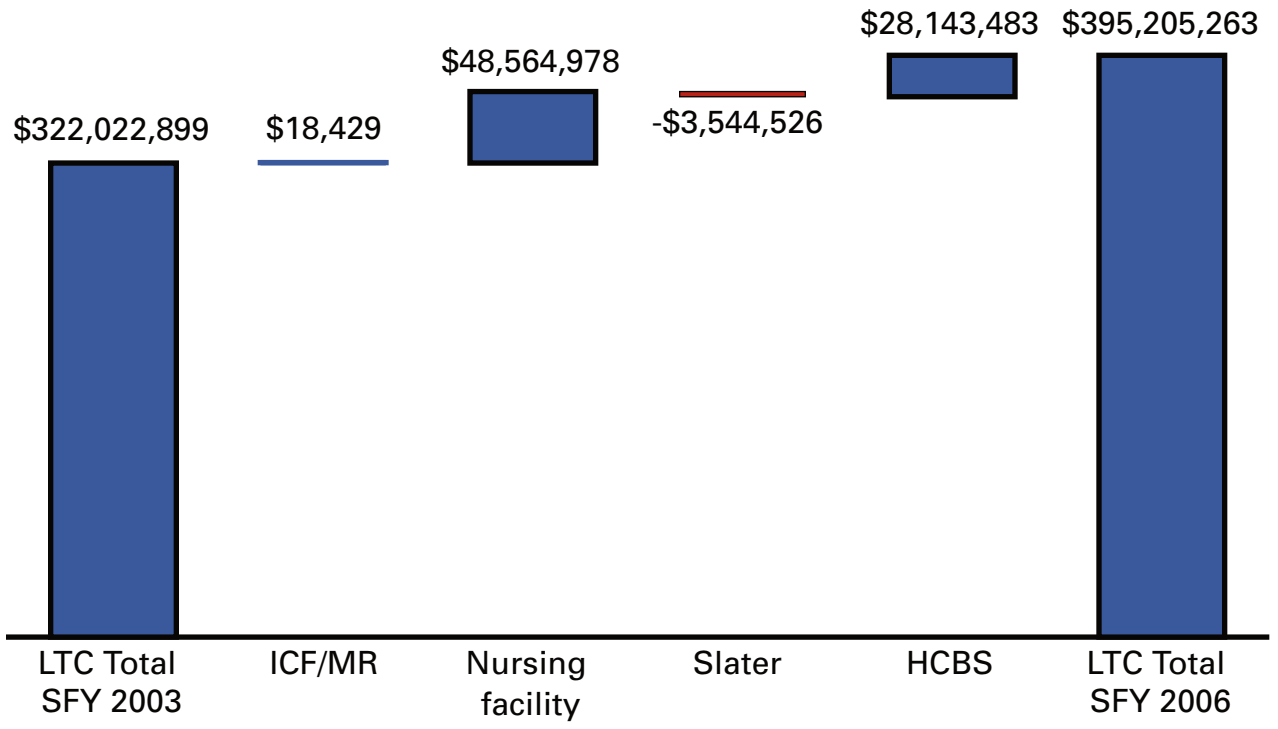
Figure 27
Change in Medicaid spending - elderly
by service provider SFY 03 to SFY 06



Source: Medicaid claims extract

In the elderly population nursing facility expenditures are the largest contributor to long-term care cost increases

Figure 28
Change in Medicaid spending - elderly
by service provider SFY 03 to SFY 06

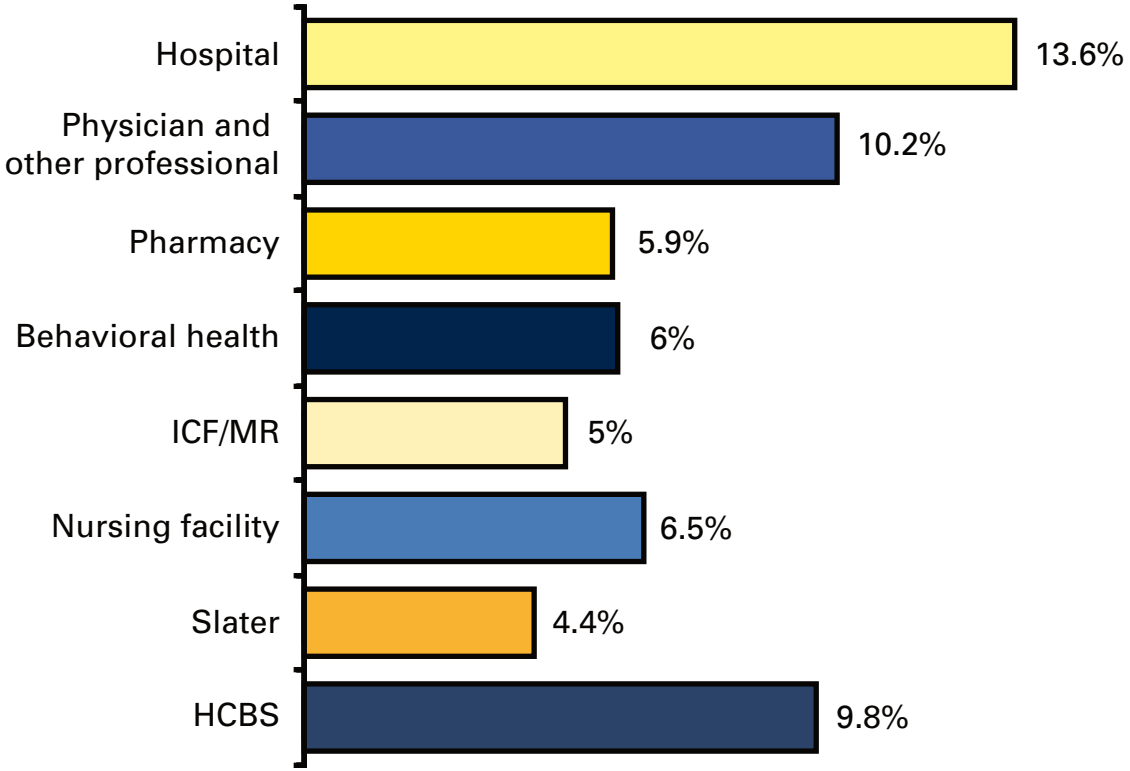


Source: Medicaid claims extract

Overall across all beneficiary categories, acute care spending, primarily with hospitals, is growing faster than long term care costs

Figure 29
Average Annual Change in Medicaid Spending by type of care
SFY 2003 - SFY 2006

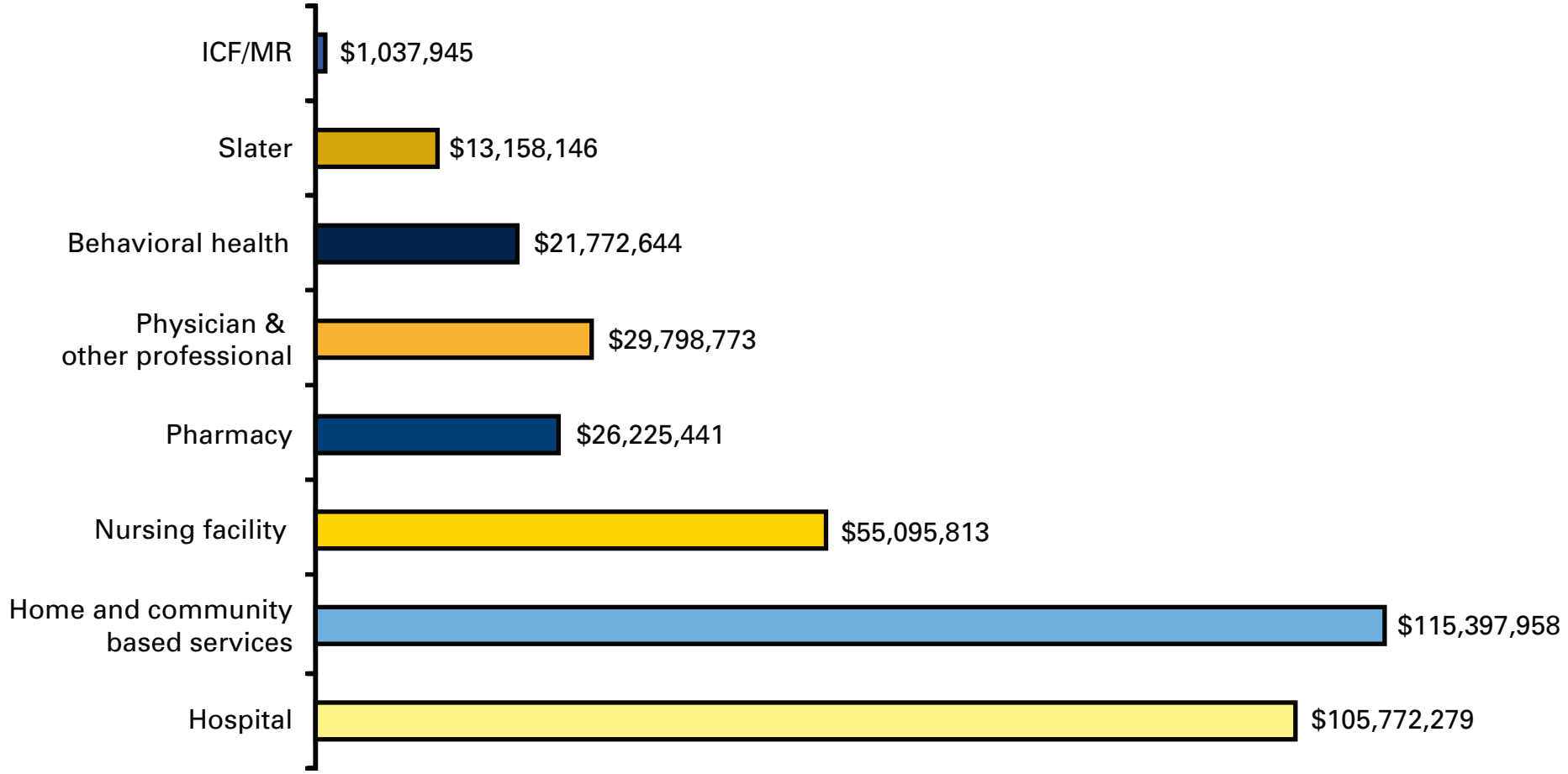
Figure 30
Average Annual Change in Medicaid Spending by service provider
SFY 2003 - SFY 2006



Source: Medicaid claims extract

Approximately 58% of the spending increase in the last two years is within two provider categories

Figure 31
Spending increase by provider
SFY 2003 - SFY 2006

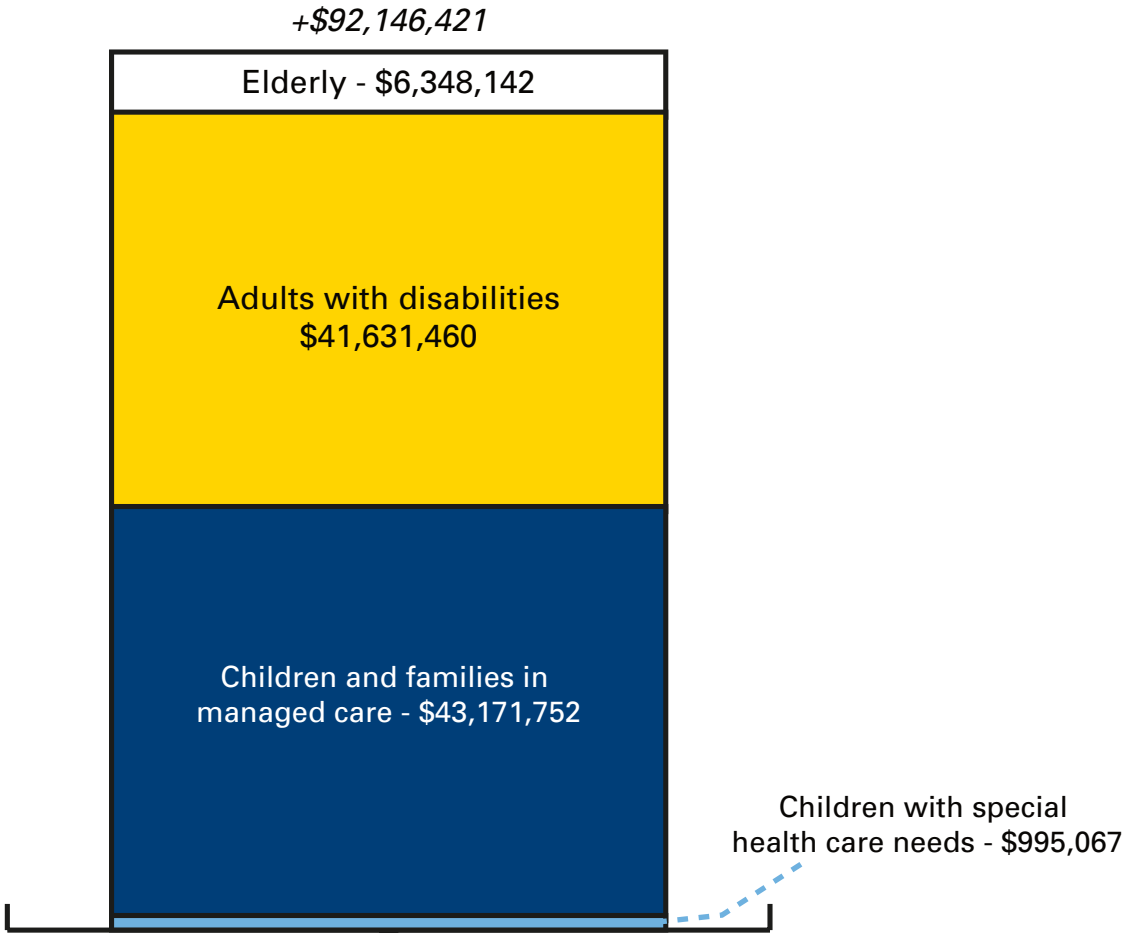


Source: Medicaid claims extract

Spending analysis by beneficiary category & fastest growing provider groups

Increased spending for hospitals by adults with disabilities represents nearly 50% of the total increase in overall hospital spending – the fastest growing provider expenditure category

Figure 32
Contribution of hospital spending increase by beneficiary category
SFY 2003 - SFY 2006

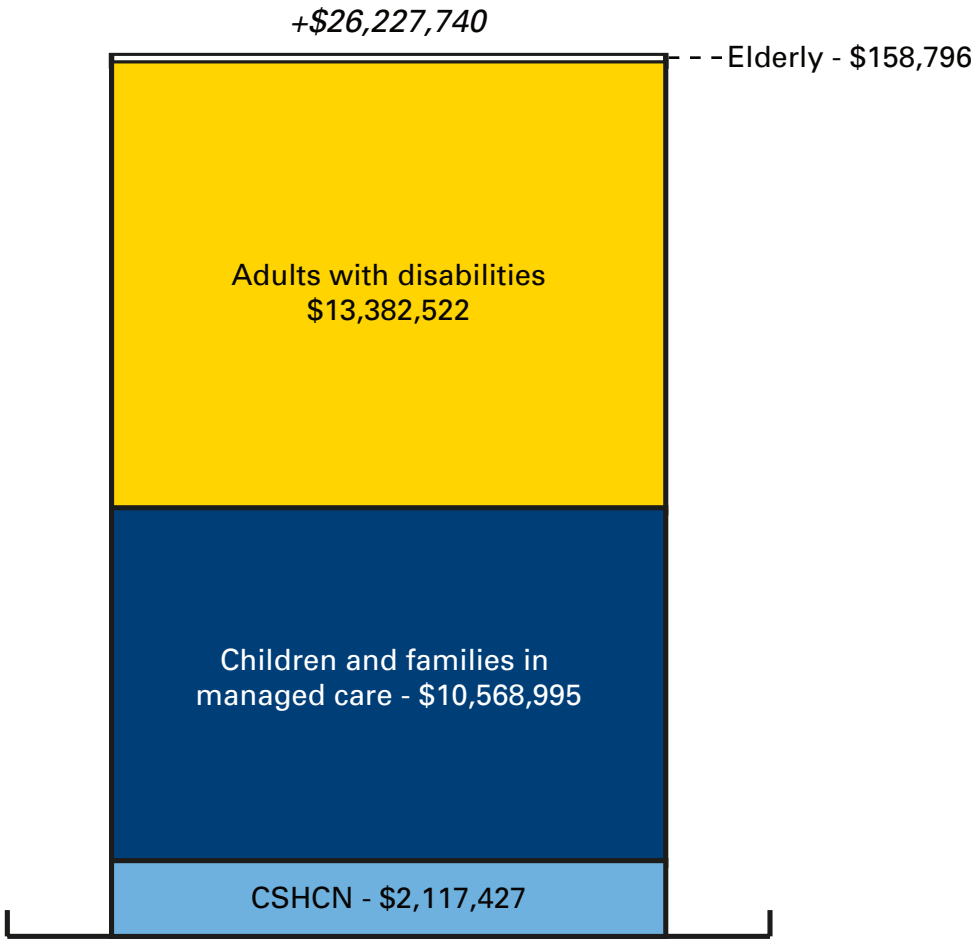


Source: Medicaid claims extract
Note: Changes in children and families in managed care includes a classification of behavioral health inpatient expenses.

Increased spending for pharmacy by adults with disabilities represents nearly 51% of the total increase in overall pharmacy spending

- Reflects impact of Medicare Part D and related "clawback" provisions

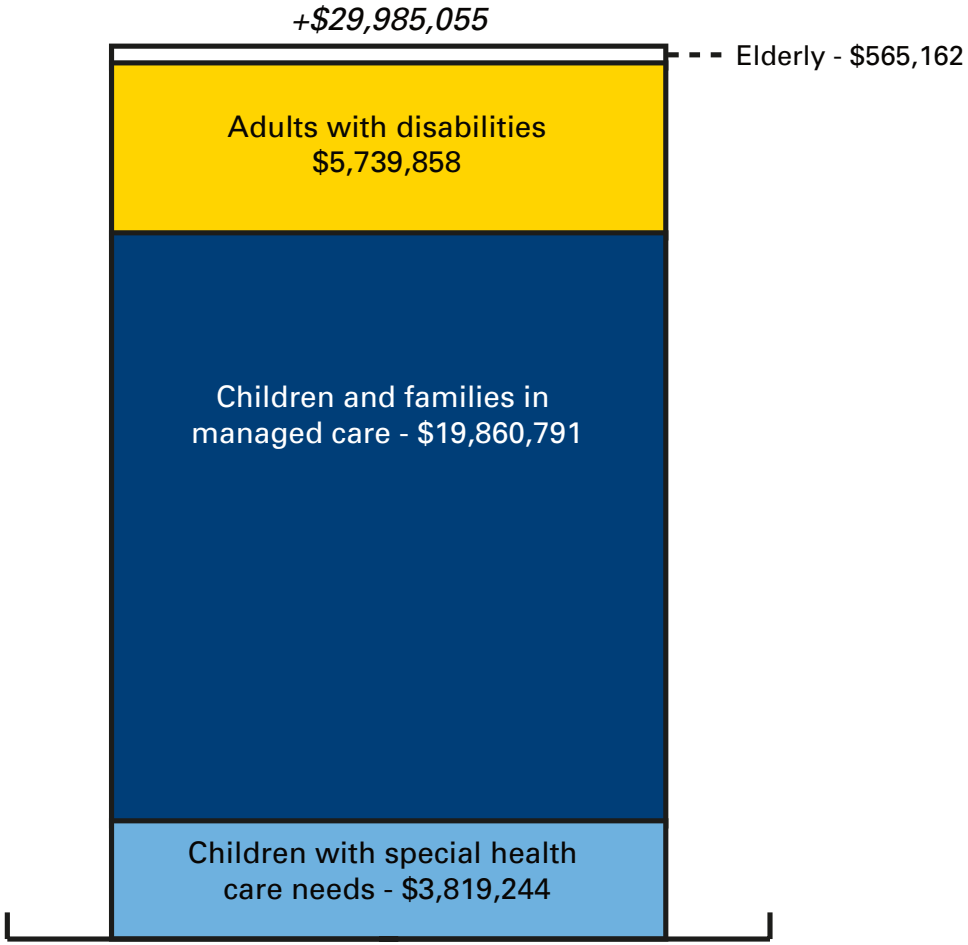
Figure 33
Contribution to pharmacy spending increase
by beneficiary category
SFY 2003 - SFY 2006



Source: Medicaid claims extract

Increased spending for physicians and other medical professionals by children and families in managed care represents 67% of the total increase in overall medical professionals spending

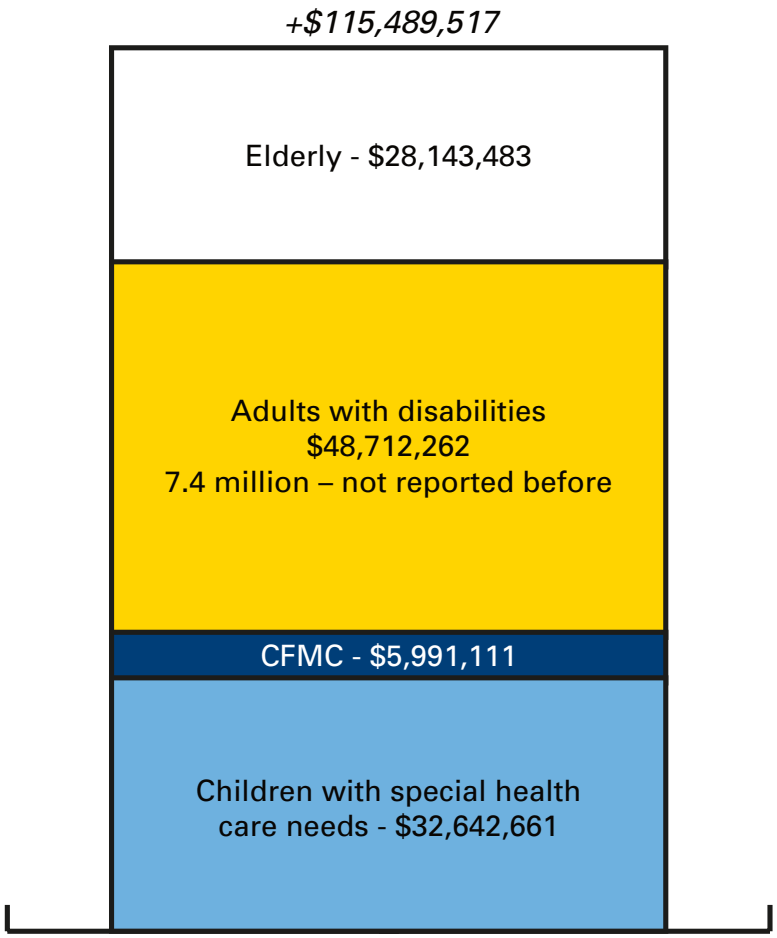
Figure 34
Contribution to physician and other medical services increase by beneficiary category
SFY 2003 - SFY 2006



Source: Medicaid claims extract

Increased spending for home and community based services (HCBS) by adults with disabilities represents 42% of the total increase in overall HCBS spending

Figure 35
Contribution to HCBS spending increase
by beneficiary category
SFY 2003 - SFY 2006



Source: Medicaid claims extract

Appendix

Comprehensive Medicaid budget

		Program Expenditures - All Funds			Program Expenditures - State Funds		
		(Actual) FY2004	(Actual) FY2005	(Estimated) FY2006	(Actual) FY2004	(Actual) FY2005	(Estimated) FY2006
DHS	**Hospital**	**232,000,579**	**244,244,916**	**252,942,922**	**100,733,104**	**111,856,818**	**117,310,163**
	Regular	124,715,403	135,513,759	142,916,434	53,554,181	63,344,714	67,193,097
	DSH	107,285,176	108,731,157	110,026,488	47,178,923	48,512,104	50,117,066
	Long Term Care	**318,256,798**	**321,836,550**	**328,948,897**	**131,234,190**	**143,282,532**	**148,798,529**
	Nursing Homes	291,981,426	292,757,265	298,497,104	120,399,458	130,336,353	135,023,800
	Community-based Long Term Care	26,275,372	29,079,285	30,451,793	10,834,732	12,946,179	13,774,729
	Managed Care	**307,385,923**	**355,960,572**	**403,074,109**	**124,802,084**	**156,401,663**	**171,132,275**
	RIte Care - Core	252,793,275	271,643,571	307,802,191	102,330,553	118,992,441	130,515,691
	RIte Share	5,300,000	6,888,549	7,477,488	2,181,596	3,056,267	3,187,823
	Substitute Care	6,400,000	6,800,000	7,746,462	2,634,380	3,016,980	3,302,493
	CSHCN's	6,798,000	15,393,030	20,877,334	2,798,206	6,829,480	8,900,482
	Out-of-Plan (N/I Rehab)	36,094,648	55,235,422	59,170,634	14,857,349	24,506,495	25,225,786
	Pharmacy	**124,903,059**	**124,815,840**	**92,975,249**	**51,432,581**	**55,490,626**	**52,159,704**
	Claims Payments	159,747,558	169,858,865	136,000,000	65,780,849	75,515,854	61,924,265
	Rebates	(34,844,499)	(45,043,025)	(49,292,870)	(14,348,268)	(20,025,228)	(22,338,543)
	Medicare Phased-down Contribution			17,800,000			17,800,000
	Drug Receivable			(11,531,881)			(5,226,018)
	Treatment and Rehabilitation	**66,731,456**	**70,991,730**	**80,390,850**	**27,478,679**	**31,561,503**	**36,431,525**
	Physician	17,214,756	18,388,908	19,072,728	7,088,692	8,175,341	8,643,379
	Oral Health	17,410,446	18,312,655	21,845,655	7,169,273	8,141,440	9,900,014
	Rehabilitative Services	32,106,254	34,290,167	39,472,467	13,220,713	15,244,722	17,888,133
	Medicare Premiums	**20,463,968**	**22,878,862**	**29,239,958**	**8,426,653**	**10,171,484**	**13,250,964**
	Other	**20,959,051**	**47,956,231**	**46,738,508**	**8,630,518**	**21,320,381**	**22,350,964**
	Special Education	**33,119,199**	**19,238,891**	**20,068,294**	**13,267,429**		
	Restricted Receipt	**8,981**	**5,437**	**10,741**			
	TOTAL DHS	**1,123,829,014**	**1,207,929,029**	**1,254,389,528**	**466,005,238**	**530,085,007**	**561,434,125**
	dsh adj		**1,099,197,872**	**1,144,363,040**		**481,572,903**	**511,317,059**
				4.11%			**6.18%**
				3.85%			**5.91%**
MHRH	**Eleanor Slater Hospital System**	**100,857,726**	**101,954,122**	**106,141,003**	**41,472,821**	**45,432,071**	**48,209,017**
	Eleanor Slater Hospital	97,340,644	98,725,307	102,241,076	40,026,846	43,995,205	46,436,936
	Zambarano Group Homes	3,517,082	3,228,815	3,899,927	1,445,975	1,436,866	1,772,081
	MR/DD Waiver	**221,415,251**	**221,096,865**	**236,068,068**	**91,122,890**	**98,186,886**	**107,196,011**
	Public Providers	46,208,622	45,425,121	48,532,736	19,002,915	20,060,503	22,198,135
	Private Providers	173,901,452	174,286,967	186,114,878	71,582,503	77,510,739	84,354,126
	Supported Living Arrangments	1,305,177	1,384,777	1,420,454	537,472	615,644	643,750
	Adult Foster Care						
	Integrated Behavioral Health	**63,881,099**	**65,259,345**	**67,986,118**	**26,332,738**	**29,011,960**	**30,805,019**
	Community-based Behavioral Health	57,060,129	57,912,588	59,991,664	23,483,423	25,746,248	27,182,585
	Substance Abuse Treatment	5,295,970	5,099,557	5,524,430	2,177,670	2,269,152	2,507,455
	Other	1,525,000	2,247,200	2,470,024	671,645	996,560	1,114,979
	TOTAL MHRH	**386,154,076**	**388,310,332**	**410,195,189**	**158,928,449**	**172,630,917**	**186,210,047**
DCYF	**Psychiatric Hospital**	**24,100,953**	**22,298,927**	**9,152,084**	**9,664,622**	**9,932,218**	**4,158,636**
	Rehab Svs	**93,742,378**	**86,773,737**	**106,292,622**	**37,591,237**	**38,650,095**	**48,298,542**
	Managed Care	**8,692,898**	**16,430,332**	**23,655,363**	**3,485,903**	**7,318,273**	**10,748,813**
	TOTAL DCYF	**126,536,229**	**125,502,996**	**139,100,069**	**50,741,762**	**55,900,586**	**63,205,991**
DEA	**Case Management**			**438,244**			**199,620**
	(Personal Care in) Assisted Living	**89,016**	**168,862**	**841,666**	**36,514**	**75,346**	**383,379**
	Community Supports	**3,261,313**	**4,260,823**	**4,780,352**	**1,337,790**	**1,901,179**	**2,043,273**
	Home Care	3,219,708	4,240,986	4,454,125	1,320,724	1,892,328	2,028,854
	Assistive Devices	2,571	4,236	2,350	1,054	1,890	7,070
	Home Modifications	39,034	15,601	16,135	16,012	6,961	7,349
	other			307,742			
	TOTAL DEA	**3,350,329**	**4,429,685**	**6,060,262**	**1,374,304**	**1,976,525**	**2,626,272**
HEALTH	**TOTAL HEALTH**	**-**	**-**	**1,096,515**	**-**	**-**	**494,857**
	STATEWIDE TOTAL	**1,639,869,648**	**1,726,172,042**	**1,810,841,563**	**677,049,753**	**760,593,035**	**813,971,292**
				4.91%			**7.02%**