Rhode Island Annual Medicaid Expenditure Report – State Fiscal Year 2008

Executive Office of Health and Human Services

A Message from the Secretary

The Medicaid Program provides health benefits to nearly one-third of Rhode Island's residents at some point each year. The program is the principal source of health coverage for low-income elders, persons with disabilities, and for children and families unable to obtain or afford the acute and long-term care services and supports they need. The annual cost of the Medicaid program reflects its expansive reach: Medicaid comprises nearly 25 percent of the State's budget each year and is by far the largest payer and purchaser of health care services in Rhode Island.

It was with the Medicaid Program's scope and cost in mind that the Secretary of the Executive Office of Health and Human Services (EOHHS) was directed to develop an annual report of Medicaid program expenditures. I am pleased to present ***The Medicaid Expenditure Report -- State Fiscal Year 2008,*** the third in a series prepared by the EOHHS since SFY 2005.

Production of the SFY 2008 report was delayed while resources were dedicated toward preparing and winning approval of the Global Consumer Choice Waiver and, more recently, to beginning the implementation process. The Executive Office of Health and Human Services was faced with additional obstacles through the challenging fiscal climate and the requirements of the federal American Recovery and Reinvestment Act (ARRA). The Medicaid Expenditure Report for SFY 2008 is particularly significant, nonetheless, because it shows Medicaid costs in the year prior to these seminal events.

The data presented in this report shows the need for the type of programmatic reform the Global Waiver allows, particularly with respect to long-term care services. The trends in both Medicaid costs and state general revenues clearly frame the fiscal challenges and the need to pursue alternative opportunities. With out-year forecasts showing declining revenues for the foreseeable future, the Medicaid Program will be confronting these challenges for some time. Were it not for the enhanced federal matching funds the state received under the ARRA, meeting the expectations in the SFY 2009 and SFY 2010 budgets would have required dramatic reductions in both eligibility and the scope of services provided to Rhode Island's Medicaid beneficiaries.

As we begin preparing the Medicaid budget for SFY 2011, this report and an update of SFY 2009 expenditures should guide and inform our decisions moving forward, serve as a reminder of how far reform has brought the program and how much remains to be done.

EXECUTIVE SUMMARY

In SFY 2008, the Rhode Island Medicaid program served an average daily census of 177,000 beneficiaries at a cost of approximately $2.0 billion. About 96 percent of the Medicaid expenditures for the year ($1.873 billion) was for medical expenses -- $1.745 billion for beneficiary health care claims, $110 million for Disproportionate Share Hospital payments (DSH), and $17.1 million for payments to Local Education Areas (LEAs) for Medicaid services. Additionally, there was $98.3 million spent to cover program administrative costs. ***As in years past, the focus of this expenditure report is on $1.745 billion in health care expenses or Medicaid "claims" for beneficiaries– the actual dollars spent on programs and services for beneficiaries. Administrative costs, and funds for DSH and the LEAs, though significant and important, are not the focus of this analysis.***

There are currently six public agencies that rely on Medicaid to finance major programs and services: the departments of Children, Youth and Families (DCYF), Education (DOE), Elderly Affairs (DEA), Health (DOH), Human Services (DHS), and Mental Health, Retardation and Hospitals (MHRH). The Executive Office of Health and Human Services (EOHHS) is the umbrella agency responsible for overseeing the Medicaid program across these agencies, with the exception of the Department of Education. The DHS, in its role as the single state Medicaid agency, manages about 67 percent of total program spending with MHRH responsible for 27 percent and the remaining 6 percent spread across the other agencies.

The findings of this report indicate that the Medicaid expenditure trends related to health care costs for beneficiaries that began in SFY 2005 continued in SFY 2008. During this period, health care expenditures rose an average of 3.5 percent per year, which compares favorably to the national trend of 4.2 percent for the same period. This modest growth in these expenditures can be explained, at least in part, by the introduction of Medicare Part D in 2006, which transitioned some pharmacy expenses from Medicaid to Medicare. The implementation of care management strategies such as Rhody Health Partners and Connect Care Choice have also played a significant role in moderating increases in Medicaid expenditures for health care services for beneficiaries.

Medicaid enrollment is another important factor contributing to the modest growth in medical expenses. Enrollment has decreased slightly (-1%) over the period from SFY 2005 to SFY 2008. The causes of this trend are multiple and difficult to isolate, but likely include increased cost-sharing for certain segments of the RIte Care and RIte Share populations and the implementation of citizenship verification requirements mandated by the federal Deficit Reduction Act of 2005.

Also, under the Medicaid program, the federal government is responsible for providing matching funds at a predetermined rate known as the federal medical assistance percentage or FMAP. In SFY 2008, the state's FMAP was 52.47 percent, just over half of total spending. Note that beginning in 2005, FMAP declined slightly every year. The state's share of program costs increased as a result by approximately $90 million. The drop in the growth of state revenues over this same period led to the adoption of a number of cost containment strategies designed to reduce the overall impact of the reduction in the federal contribution to the Medicaid Program. These strategies have slowed the pace of expenditure growth in a variety of areas.

Executive Summary

Despite these modest growth trends in health care costs, Rhode Island's fiscal condition at the end of SFY 2008 assured that Medicaid – with total program costs comprising about 25 percent of the state's annual budget -- would require further changes. Consequently, Medicaid reform became a top priority of Governor Carcieri's agenda for SFY 2009. Accordingly, the state decided to pursue, and ultimately received, a Medicaid Section 1115 waiver – the Global Consumer Choice Compact Waiver – that provides the framework for transforming the services provided under Rhode Island's Medicaid Program. The information contained in this report focuses on the Medicaid program prior to approval of the Global Waiver.

Concentration of Health Care Expenses

"Unique users" is a measure of the number of Rhode Islanders who were enrolled in Medicaid at any time during the fiscal year. By this measure, 217,000 Rhode Islanders, 21 percent of the total population, were enrolled in Medicaid for some part of SFY 2008.

An analysis of unique Rhode Island Medicaid users shows that the program, and particularly the children and families program, serves a broader spectrum of Rhode Islanders who enroll for a short period of time and then either return to other coverage options or go uninsured. Seventy eight percent of unique users access Medicaid services at a cost of less than $5000 per year.

The concentration of health care expenses provides important insights on how best to contain rising health care costs, and serves to inform more focused cost-containment strategies targeting chronic conditions. Medicaid expenditures are highly concentrated, as the top 7 percent of users account for roughly two-thirds (63%) of expenditures. Over the course of the year, each of the 15,000 top utilizers cost the Medicaid Program $72,000 on average, more than *forty times* as much per person as those in the bottom 78 percent of utilizers.

Spending by Service Category

Spending is divided among multiple service categories, or provider types, including specialized behavioral health services (20%), nursing facilities (18%) and professional services (15%). On an aggregate basis across all populations, pharmacy accounts for about 6 percent of total costs. Outpatient and professional services are the largest contributors to spending growth – with average annual growth rates of 12 and 9 percent respectively.

Approximately one third (30%) of total health care expenditures are for services not mandated by the federal government. These optional services, accounted for $521 million in 2008. Optional services include coverage for health practitioners other than physicians as well as for services related to care coordination and continuity. Optional services are in principle designed to reduce or offset spending on more expensive, mandatory inpatient/institutional services. The three largest components of optional services, capturing approximately 60 percent of all spending, are private and public group homes for persons with developmental disabilities and specialized behavioral health services provided through DCYF and MHRH.

Executive Summary

Care Management Arrangements

Care management arrangements account for approximately 25 percent of all health care expenditures. However, the cost of these arrangements varies significantly by population. Seventy-eight percent of the expenditures for children and families (the RIteCare/RIteShare programs) are through managed care accounts, but only 5 percent of spending for the elderly are paid in a similar manner. Enrollment for children and families became mandatory when the RIte Care program was implement in 1994. Mandatory enrollment in care management for children with special health care needs was implemented in SFY 2009. Two new care management programs, Rhody Health Partners and ConnectCare Choice, were recently introduced as options for adults and should, over time, increase the percent spending for the elderly. Under the Global Waiver, enrollment in one of these care management arrangements is mandatory. These new care management programs are designed for acute care, non-dual eligible beneficiaries and have experienced an uptake of over 88% on a voluntary basis alone.

Home and Community Based Service Waivers

Section 1915(c) of federal Medicaid law grants states the ability to establish waiver programs that provide Medicaid financed home and community based long term care services to certain individuals who have institutional level of care needs. These programs allow states to offer beneficiaries Medicaid covered services in less costly and less restrictive home and community settings as an alternative to institutional options. Health care services and supports provided to Medicaid beneficiaries served through home and community based waiver programs accounted for $329 million in 2008, or about 19 percent of total Medicaid health care expenditures. In SFY 2008, there were multiple HCBS waiver programs – six serving adults with disabilities and elders and three serving children and their families – targeting beneficiaries requiring different types of institutional level of care – that is, a hospital, nursing facility, or intermediate care facility for the mentally retarded or persons with disabilities. Of these waiver programs, The majority of HCBS health care expenditures (82%) in SFY 2008 were for the beneficiaries served in the waiver for persons with developmental disabilities/mental retardation.

Spending by Population

There are a complex array of Medicaid mandatory and optional coverage groups, each of which is distinguished by a specific set of eligibility characteristics. For the purposes of clarity, Rhode Island has combined coverage groups into several broad "population" categories that reflect the eligibility divisions established in federal Medicaid law and/or certain characteristics. These categories are: elders, adults with disabilities, low income children and families in managed care, and children with special health care needs. Each of these populations have very different service needs and cost experience.

Almost two thirds of Medicaid health care spending (61%) is on the elderly and adults with disabilities populations, which account for 26 percent of total caseload of Medicaid beneficiaries. The unit cost of services for the elderly is approximately $2,000 per month, a number which reflects their complex health needs, higher utilization and reliance on expensive care settings – e.g., nursing facilities. Children and families covered in RIte Care/RIte Share account for 67 percent of Medicaid enrollment, but only 24 percent of total health care cost. The lower per member per month (pmpm) unit cost, $292 pmpm, is indicative of the different case mix when compared to other Medicaid populations. RIte Care/RIte Share enrollees typically require less intensive services because they are younger, healthier and access high cost settings less often.

Executive Summary

The following summarizes key trends in Medicaid health care expenditures by population.

- Adult with disabilities account for the largest share of Medicaid health care expenditures, with total 2008 spending of $634 million, and an average cost per member per month (pmpm) of $1,914. The largest components of cost for this population are specialized behavioral health services (28%) and specialized group homes and institutions for beneficiaries..

- The elderly account for $431 million in total 2008 Medicaid health care spending, and the highest average cost per member per month (pmpm) of $2,056. Costs for this population are dominated by nursing homes, which account for $290 million or roughly two-thirds (67%) of spending on the elderly population.

- Children with Special Health Care Needs (CSHCN) is a relatively small population -- accounting for 15 percent of total Medicaid health care expenditures and 7 percent of enrollees. Total health car expenditures for CSHCN in SFY 2008 was $264 million. Over the last four years, spending on this population has experienced the highest rate of increase – with average annual increases of 8.8 percent per year. Spending on this population is dominated by specialized behavioral health services provided through the MHRH and DCYF, which account for nearly half (49%) of total expenditures.

- Children and families enrolled in managed care account for about one-fourth (24%) of total Medicaid health care expenditures at cost in SFY 2008 of $416 million, and an average cost per member per month of $292. Spending on this population has increased by approximately 5.9 percent per year over the past four years. Costs for this population are dominated by professional services (31.5%), $131.1 million, and inpatient services (30.1%), $125.4 million.

Table of Contents

What is Medicaid?

- **Overview**
  The Medicaid Program, jointly funded by the federal government and the states, was 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)**
  CMS is the federal agency responsible for establishing guidelines to administer the requirements of Title XIX and overseeing their implementation by state Medicaid programs.

- **Mandatory populations and services**
  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.

- **Optional populations and services**
  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.

- **State Role**
  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.

Medicaid Annual Expenditure Report

Statutory Mandate

The enabling authorizing statute for the EOHHS, authorizes the Secretary to prepare and submit to the governor and the joint legislative committee for health care oversight:

> *[E]ach 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.* R.I.G.L. 42-7.2-5(d)

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 efficiencies in the annual budget process. To provide policymakers with this info, the Executive Office of Health and Human Services will:

- 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.

Definitions and Clarifications

This report provides a comprehensive view of total Rhode Island Medicaid health care expenditures, including both federal and state funds for all federally qualified Medicaid populations and services. Some important clarifications about the report are provided below:

- **State Only Populations**
  This report does not include the following "State Only" populations which are administered through EOHHS but are not part of the federal Medicaid program: Drug Court, Special Education, Head Start, Immigrant Program, Institutes for Mental Health, Childcare providers, RI School of the Deaf.

- **Source Data and Analytical method**
  This report is based on actual medical claims data for the state fiscal years 2004 through 2008, with the following adjustments:
  - Claims vs. Capitations:
    Some State expenditures are paid out in capitation, not in claims, a subset of claims are "backed out" of total claims experience, and replaced with capitation expenditures
  - Provider payments not captured in claims:
    Some provider payments are not processed through the standard Medicaid claiming process (MMIS), and were therefore added back in to these estimates
  - Classification of Optional vs. Mandatory Services
    The classification of optional vs. mandatory services has been revisited from prior work, using an updated classification summary developed by the Kaiser Family Foundation. As such, comparisons to prior reports may be misleading.

- **Comparisons to Prior Report**
  The first Rhode Island Annual Medicaid Expenditure Report was submitted to the legislature in December, 2006. The expenditures presented in that report were based on claims experience only – it therefore did not adjust for capitations and other non-claims based provider payments. The current report therefore updates the 2004-05 data to more accurately reflect these payments.

- **Comparisons to Medicaid Global Consumer Choice Waiver Financials**
  The historical Medicaid cost and trend analysis that was performed in support of the Global Waiver was intended to capture the program as it existed, with adjustments to history for purposes of establishing "best estimates" of future expenses. As there were a number of exclusions and adjustments that were necessary for that analysis, a slightly different "picture" of Medicaid cost experience is presented in the SFY 2008 Medicaid Expenditure Report.

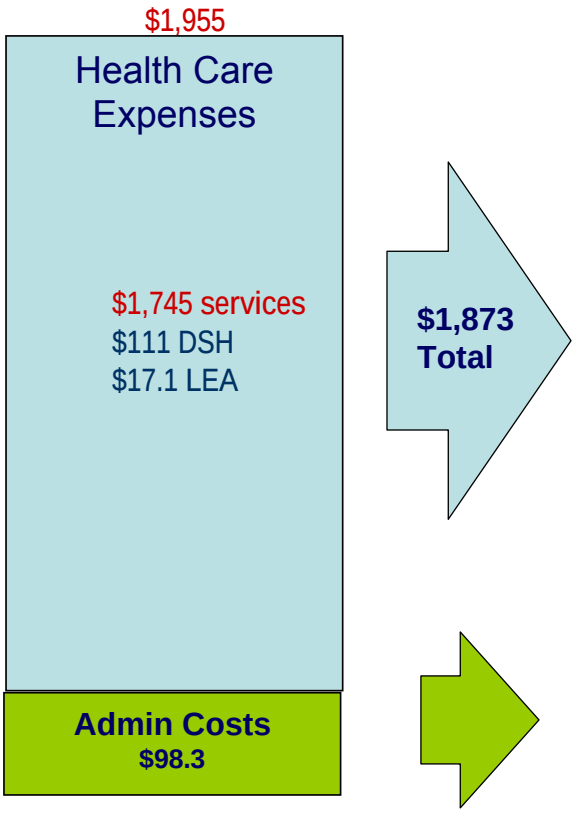
Acronyms and Abbreviations

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
PMPM:	Per member per month
SFY:	State fiscal year

Total Medicaid Expenditures, 2008

Medicaid expenditures total approximately $2.0 billion

Summary: Total Medicaid[1]
SFY 2008 - $millions



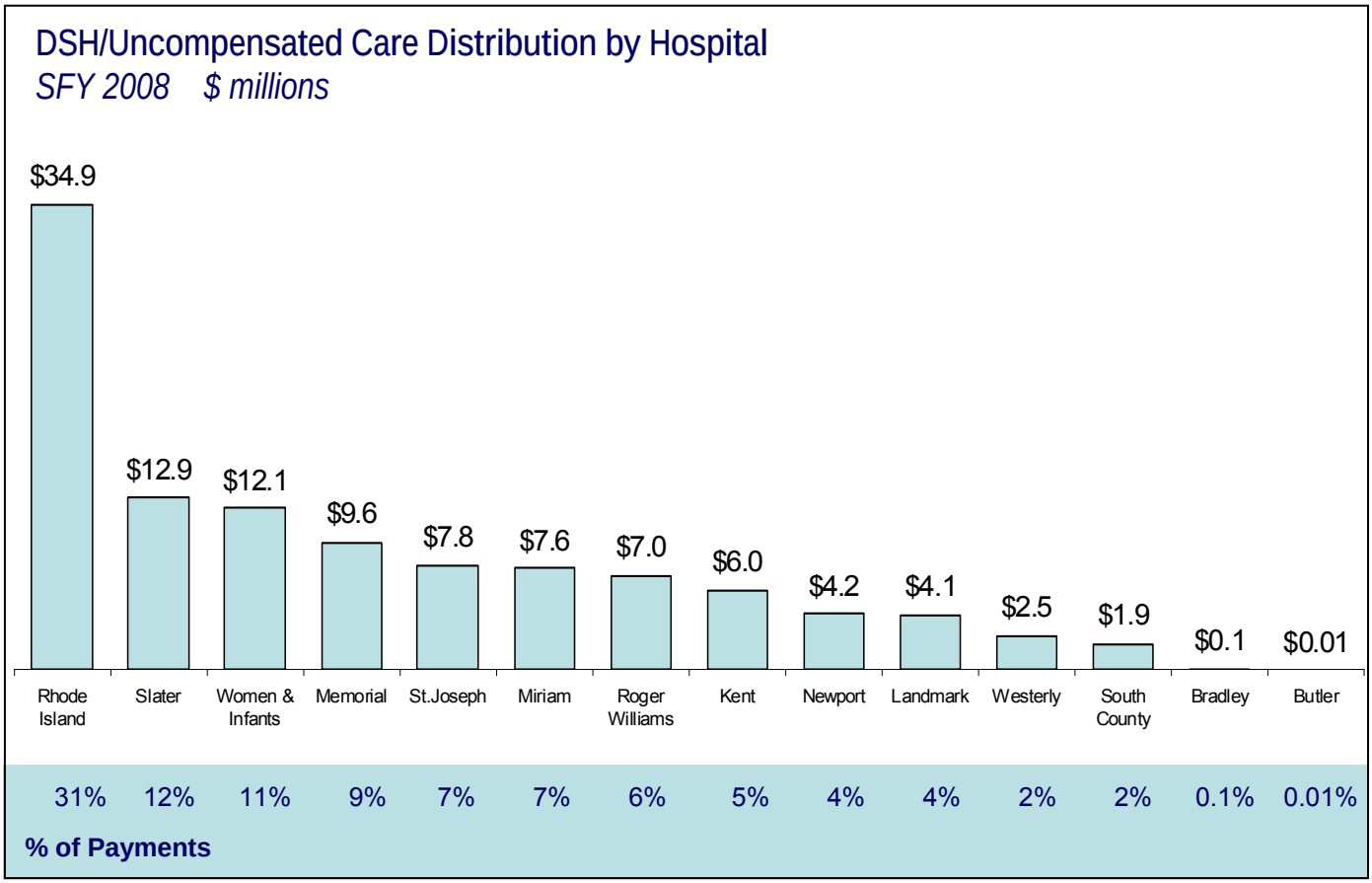
The report focuses on the $1.745 billion, of a total of $1.873 billion, spent on beneficiary health care expenses – equal to about 89% of total program expenditures.

Total Administrative Costs in SFY 2008 is 5 % of total Medicaid program costs of nearly $2.0 billion.

- In SFY 2008, Rhode Island incurred approximately $2.0 billion in Medicaid expenditures. This spending was split between state and federal funds
- This report will focus on Medicaid medical claims for beneficiaries. These expenditures account for 89 percent of total Medicaid program costs and 93 percent of all total Medicaid health care expenses. What follows is a variety of analysis intended to describe the different elements of Rhode Island's Medicaid program, and provide a common understanding of key opportunities for cost reduction, as well as areas of spending growth that may be in need of additional focus
- The analysis that follows excludes DSH (Disproportionate Share Hospital) Payments, and payments to LEAs (Local Educational Agencies), though a summary of spending in each of these areas is provided for review.

Disproportionate Share Hospitals (DSH)

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



- A total of $111 million in DSH funds was paid out to hospitals in 2008.
- The State's two largest hospitals – Rhode Island and Women and Infants – together accounted for 42% of total DSH payments
- DSH payments are not included in the Medicaid spending analysis that follows in this report.

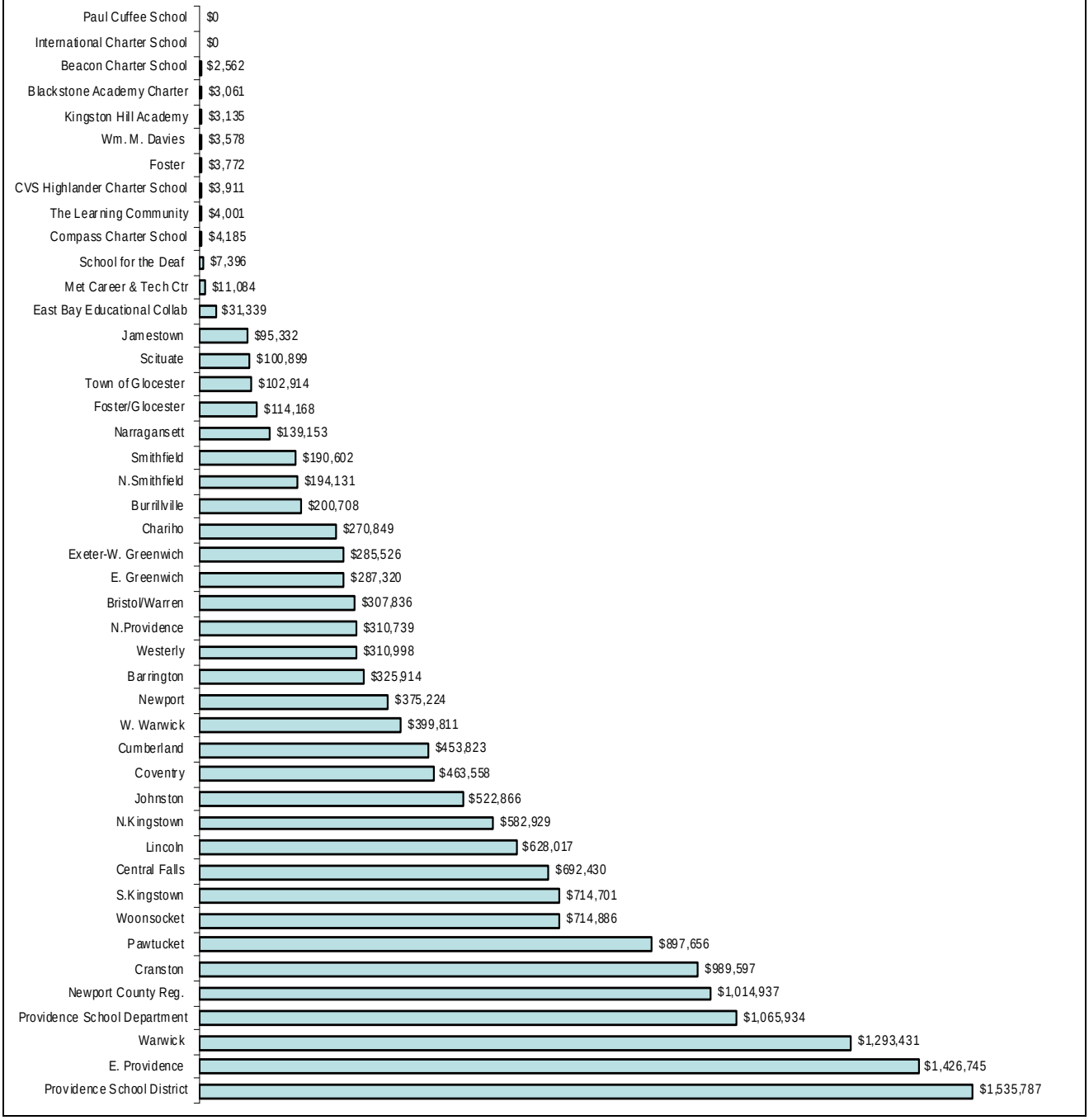
Note: Does not include Psychiatric & Graduate medical education DSH pool

Local Education Agencies

Local Education Agencies (LEAs) account for $17.1 million in total Medicaid expenditures. Forty-five school districts participate. Two districts (Providence and E. Providence) account for 24% of total LEA expenditures

Medicaid Funding to Local Education Agencies (LEAs)

SFY 2008

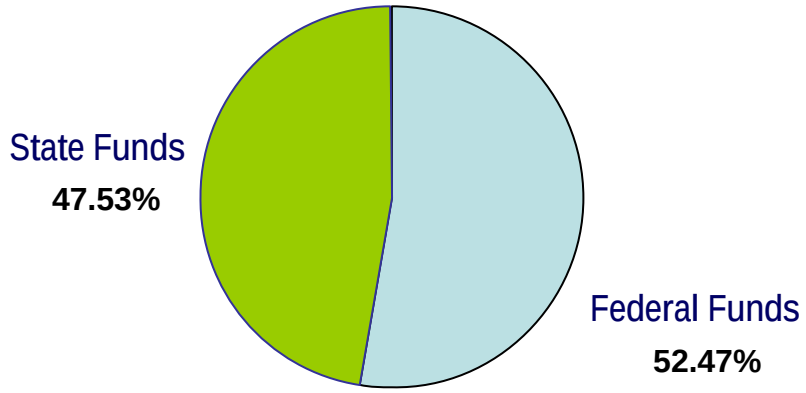


Note: LEA expenditures are excluded from the Medicaid spending analysis that follows in this report

Federal Contribution (FMAP)

The federal government pays for more than half of overall Medicaid spending

Global Medicaid Expense: Sources of Funds
SFY 2008



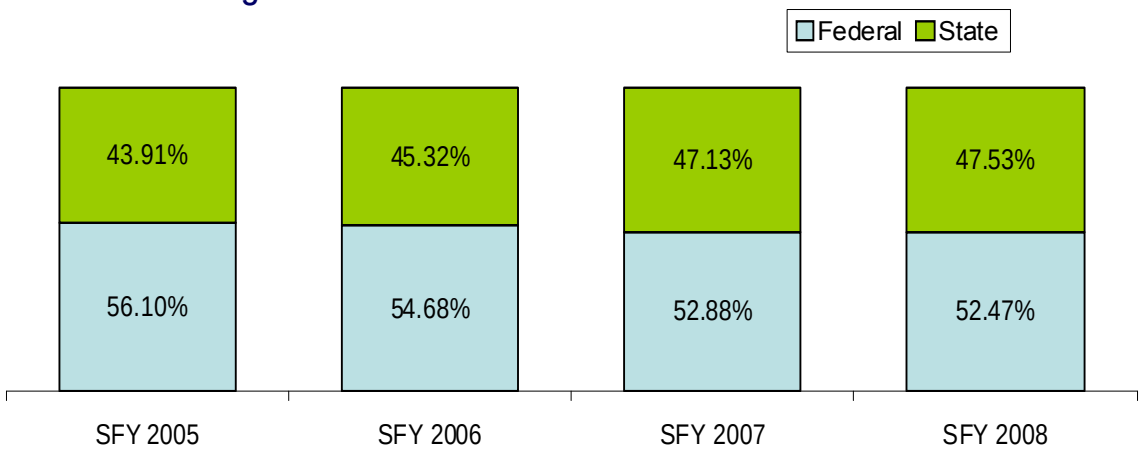
- The $2.0 billion in overall Medicaid expenditures is split between state and federal dollars, with Rhode Island responsible for 47.53 percent of most Medicaid expenditures in 2008
- This federal match is enhanced for qualifying low income children and families under the federal SCHIP program. SCHIP is designed to build on Medicaid to provide insurance coverage to “targeted low-income children” who are uninsured and but not eligible for Medicaid – that is, children from families with incomes up to 250 percent of the federal poverty level.
- In SFY 2008, RI received, through its 1115 Waiver, a 68 percent combined SCHIP/FMAP federal match on “optional” children, parents and pregnant women in families with incomes above mandatory coverage levels.

Source: 2008 FFIS (Federal Funds Information for States). Calculated based on federal fiscal year, adjusted to state fiscal year, based on consistent monthly share

FMAP Trends

Rhode Island is paying for an increasing share of Medicaid expenditures

Federal Medicaid Matching Rates



Effective increase in state spend due to FMAP reduction

SFY 2006	SFY 2007	SFY 2008
$23 m	**$53 m**	**$63 m**

- FMAP rates declined almost four points between SFY2005 and SFY 2008, resulting in significant increases in State expenditures over the past four years. The lowest FMAP possible under federal law is 50 percent.
- Every one percentage point change in the federal portion of FMAP adds approximately $17 million to the State's share of expenditures (general funds). A comparison of the FMAP levels in 2005 to 2008, shows that the declining FMAP cost the State an additional $63 million in 2008.
- The Global waiver, which was negotiated to cover the Medicaid program beginning in January 2009, retained the current model for FMAP going forward, without any waiver specific adjustments.
- Under the ARRA stimulus package, FMAP has increased to 63.89 percent retroactively to October 1, 2008 and ending December 31, 2010. This one time adjustment will provide a substantial reduction in the State share of Medicaid spending.

1. Analysis based on FMAP only – does not include SCHIP match
Source: 2008 FFIS (Federal Funds Information for States). Calculated based on federal fiscal year, adjusted to state fiscal year, based on consistent monthly share

Global Medicaid Cost Trends, 2005-2008

Over the past four years, Rhode Island Medicaid expenditure has been increasing an average 3.5% per year.

Global Medicaid Expense: Total Medical

SFY 2005-2008

$ Million

					Average Annual Growth[1,3]
Annual Expend. Growth		5.0%	0.1%[3]	5.3%	**3.5%**
Pers. Eligible	181,846	182,608	180,790	176,647	**-1.0%**
$ PMPM	$722	$755	$764	$823	**4.5%**

- Overall spending growth compares favorably to national Medicaid expenditure trend – according to CMS, Medicaid spending trend over this time period increased an average 4.2 percent per year[2], vs. Rhode Island's 3.5 percent.
- Note that this increase is broken down into unit cost (per member per month) and enrollment increases, which can be added together to determine average spending growth.
  - Enrollment has been flat or declining over the past four years
  - Unit costs (per member per month) have increased at 4.5 percent annually, a rate well below regional commercial/private insurance medical inflation trends (8-12 percent per year)

1. Calculated as compounded annual growth rate (CAGR) over period 2005-2008 as shown.
2. Source: 2008 CMS National Health Expenditure Report. 2008 data is a projection.
3. The low growth from 2006 to 2007 is explained in part by the introduction of Medicare Part D, which transitioned some pharmacy spend from Medicaid to Medicare. Excluding pharmacy, average annual growth would be 5.7 percent vs. 3.5 percent. The state pays for part of this pharmacy cost back through the "clawback" payment, through general funds not specific to Medicaid.

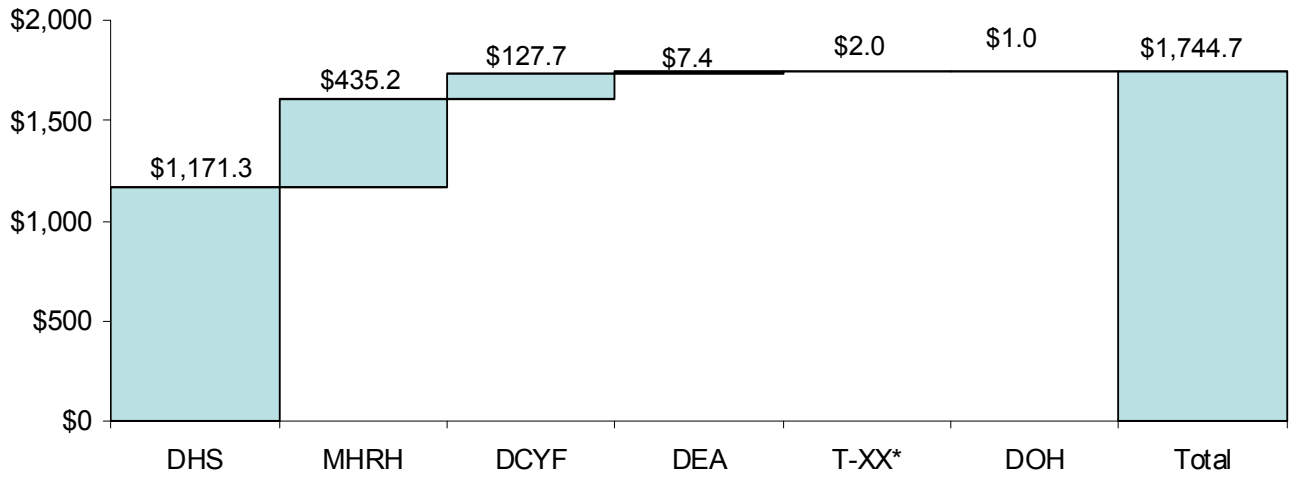
Note: These total exclude $17 Million in LEA spending and $111 Million in DSH

Table of Contents

a. Spending by Department

Medicaid benefit spending is spread across a number of state agencies

Spending by Department
SFY 2008 - $millions



	DHS	MHRH	DCYF	DEA	T-XX*	DOH	Total
% of Total	67%	25%	7%	0.4%	0.1%	0.1%	100%

- The majority of spending (67 percent) is administered by the Department of Human Services (DHS). This department is the lead administrator for the Medicaid program with CMS.
- The Department of Mental Health, Retardation and Hospitals (MHRH) accounts for 25 percent of total Medicaid expenditures. MHRH is responsible for three primary areas: the management of the Eleanor Slater Hospital system; populations enrolled in the MR/DD waiver; and the Integrated Behavioral Health (IBH) program, which provides community based behavior health and substance abuse services.
- Note that this chart does not include $17.1 million in spending on local education agencies (LEAs), which is distributed among 45 agencies.
- Detail for each agency follows..

Note: Chart excludes $111 million in DSH and $17.1 million for LEAs. Also excludes $27,000 in Indian HC expense.
* T-XX is Title XX Personal Care Services.

a. Spending by Department

Medicaid health care spending detail by State agency

Spending by Department Detail
SFY 2008

Hospital	**$245,459,999**
Long Term Care	**$334,279,741**
Nursing Facilities	$307,533,959
Community Based	$26,745,782
Treatment and Rehabilitation	**$156,515,463**
Physician	$134,379,455
Oral Health	$22,136,008
Pharmacy	**$43,015,373**
Claims Payments	$62,730,612
Rebates	-$19,715,239
Premiums and Other Payments	**$392,062,674**
Capitation	$345,547,425
Medicare Premiums	$33,782,025
Other Premiums/Payments	$12,733,224
Total DHS	**$1,171,333,250**

Eleanor Slater Hospital System	**$105,008,134**
Eleanor Slater Hospital	$101,464,396
Zambarano Group Homes	$3,543,737
MR/DD Waiver	**$222,113,636**
Public Providers	$49,151,077
Private Providers	$81,313,830
MHRH Residential/Waiver	$90,248,762
Supported Living Arrangements	$1,399,967
Integrated Behavioral Health	**$103,829,808**
Community Based	$102,429,808
Substance Abuse Treatment	$1,400,000
Personal Care/Respite/Other	**$4,241,810**
Total MHRH	**$435,193,387**

Psychiatric Hospital	**$403,056**
Therapeutic Foster Care	**$48,267,039**
Probation and Parole	**$4,087,183**
Child Welfare	**$44,008,883**
Child Mental Health	**$30,914,741**
Total DCYF	**$127,680,902**

Personal Care	**$5,231,224**
Assisted Living/Other	**$2,171,573**
Total DEA	**$7,402,798**

Title XX Personal Care	**$2,040,917**

CaseMgmt (HIV, Lead)	**$1,038,498**
Total DOH	**$1,038,498**

Indian Health Ctr	**$27,445**

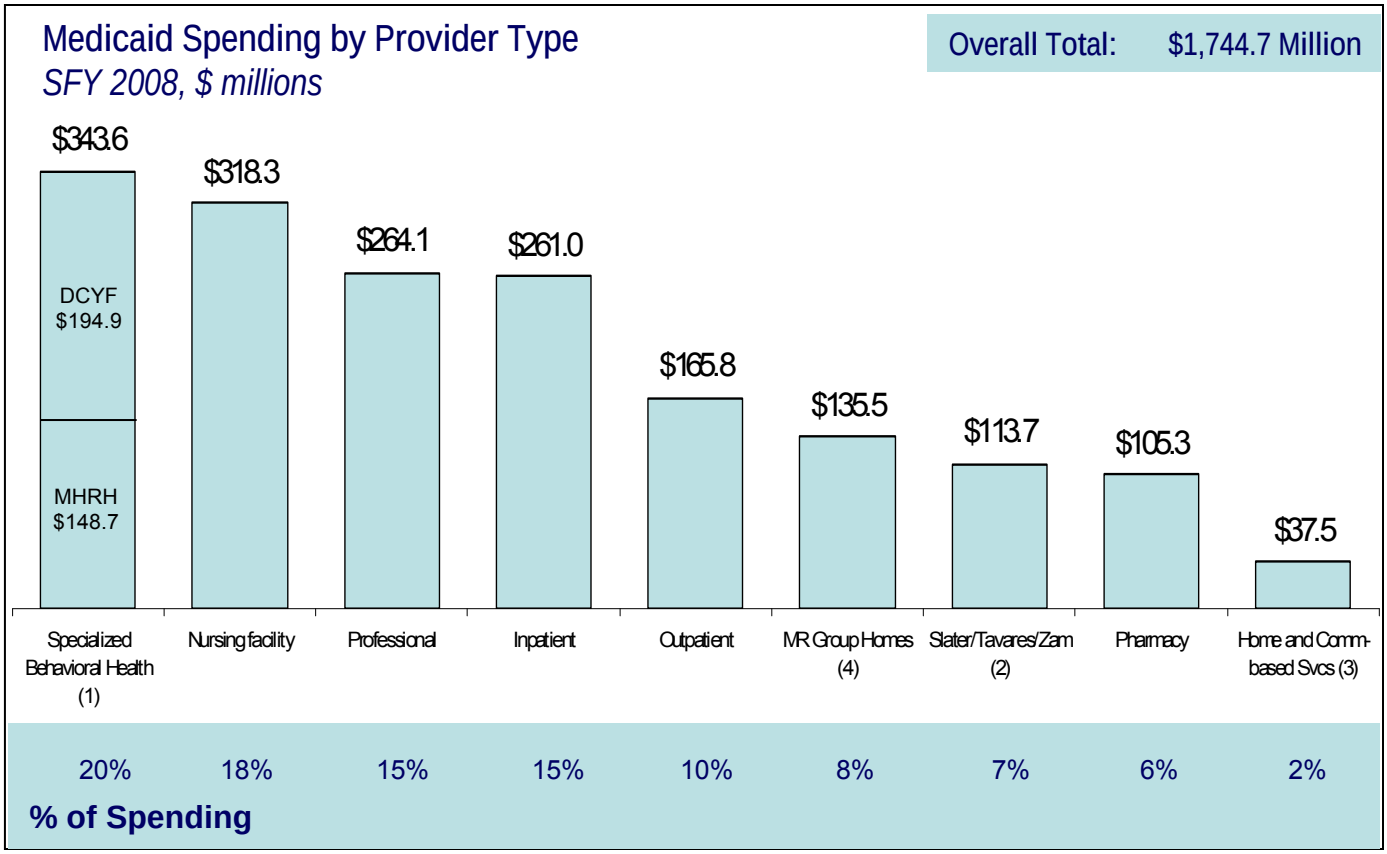
STATEWIDE TOTAL	**$1,744,717,196**

Note: Excludes $111 million in DSH and $117 million for LEAs.

Table of Contents

b. Spending by Provider Type

Medicaid health care spending is spread across multiple provider types



- Overall Rhode Island Medicaid health care expenditures totaled $1744.7 million in SFY 2008. This was spread across multiple provider types.
- Twenty percent of Medicaid spending health care in 2008 was on specialized behavioral health services provided through MHRH and DCYF.
- Nursing homes were the next largest contributor to expenditures, accounting for 18 percent of total spending.

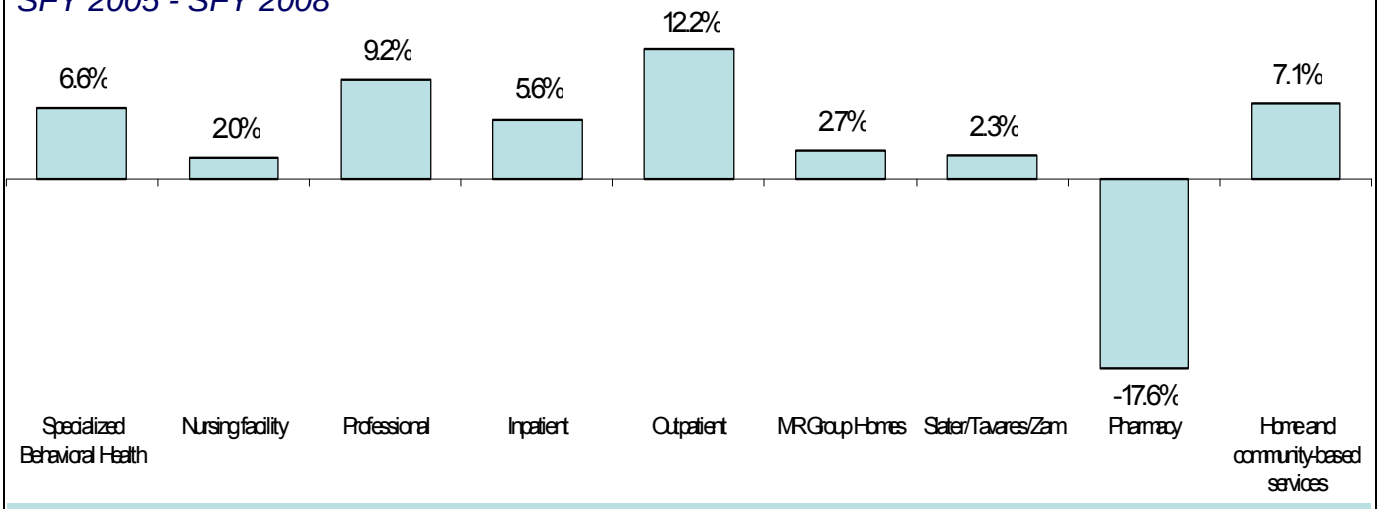
1. Specialized behavioral health services includes only those behavioral health services provided by MHRH and DCYF. Additional behavioral health services (traditional office visits, etc) paid through DHS are included in the professional services.
2. Slater is an institution for severely disabled adults. Tavares is a similar institution for severely disabled children. And Zambarano is a specialized group home targeting the severely disabled.
3. Home and Community Based Services (HCBS) includes both services in consumers' homes and group home settings.
4. MR Group Homes include both public and private facilities

b. Spending by Provider Type: Trends

Spending growth is disproportionately attributed to outpatient and professional services

Cumulative Average Annual Growth in Spending by Provider Type
SFY 2005 - SFY 2008

Overall Average Growth: 3.5%



	Specialized Behavioral Health	Nursing facility	Professional	Inpatient	Outpatient	MR Group Homes	Slater/Tavares/Zam	Pharmacy	Home and community-based services
% of 2008 Spending	20%	18%	15%	15%	10%	8%	7%	6%	2%
% of Spending Growth[1]	24%	7%	24%	16%	19%	4%	3%	NA	3%

- Specialized behavioral health services accounted for the largest share of spending (20%) and an even higher share of spending growth. This includes spending through DCYF and MHRH services. Nursing facilities account for the 2nd largest share of total Medicaid expenditures, though spending in this area has experienced only modest increases.
- Professional and outpatient services have both experienced disproportionately high rates of growth over the past five years, together accounting for almost half of all spending growth.
- Pharmacy experienced a one time decline during this period due to the introduction of Medicare Part D, which transitioned a significant amount of pharmacy spending for the lowest income and most frail elderly and persons with disabilities out of Medicaid and into Medicare.

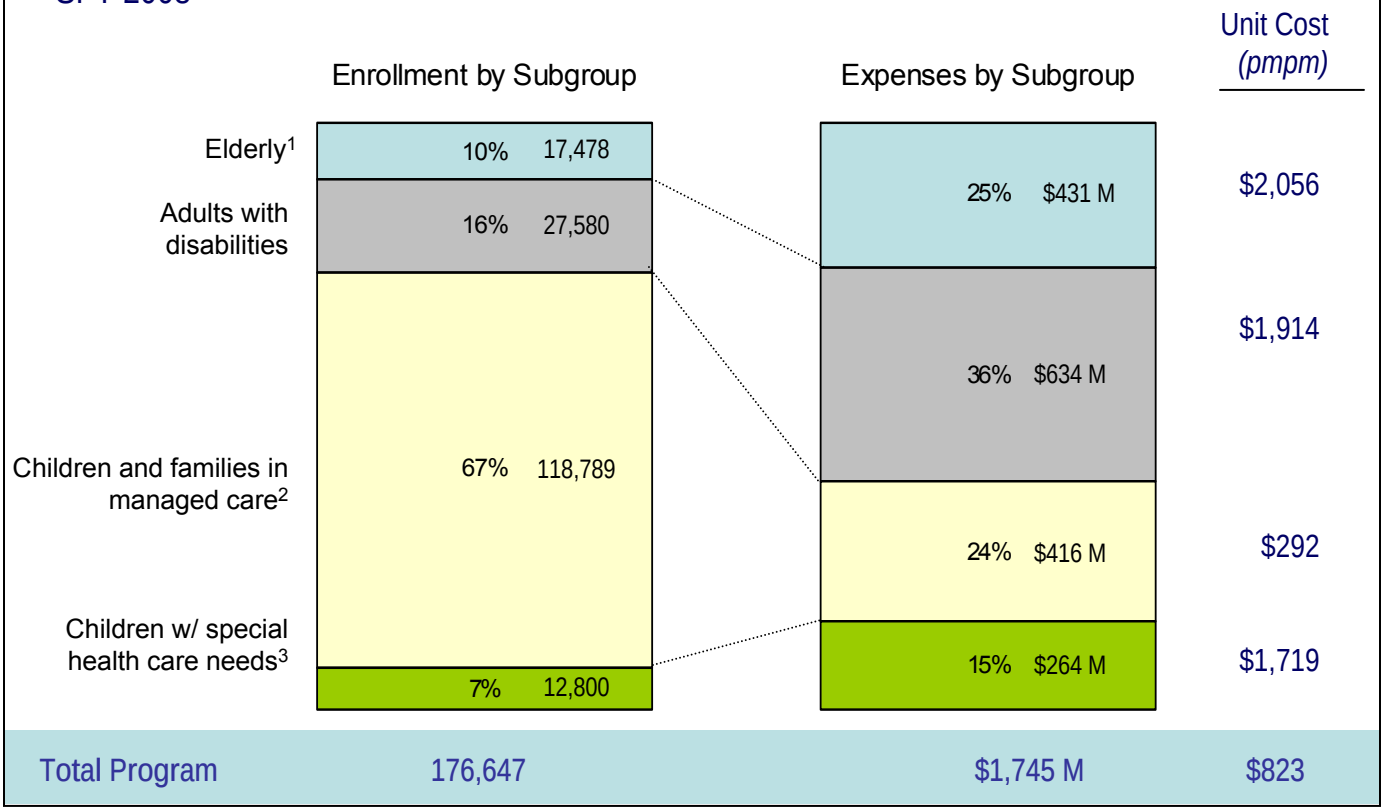
1. This measure excludes pharmacy, due to the one time decline experienced in 2007 due to Medicare Part D.

Table of Contents

c. Spending by Population

Medicaid spending varies considerably by population

Medicaid Enrollment and Expense by Population
SFY 2008



The Medicaid program's average daily census was 176,647 beneficiaries in SFY 2008, at an average cost per member per month of $823. However, costs varied considerably by population.

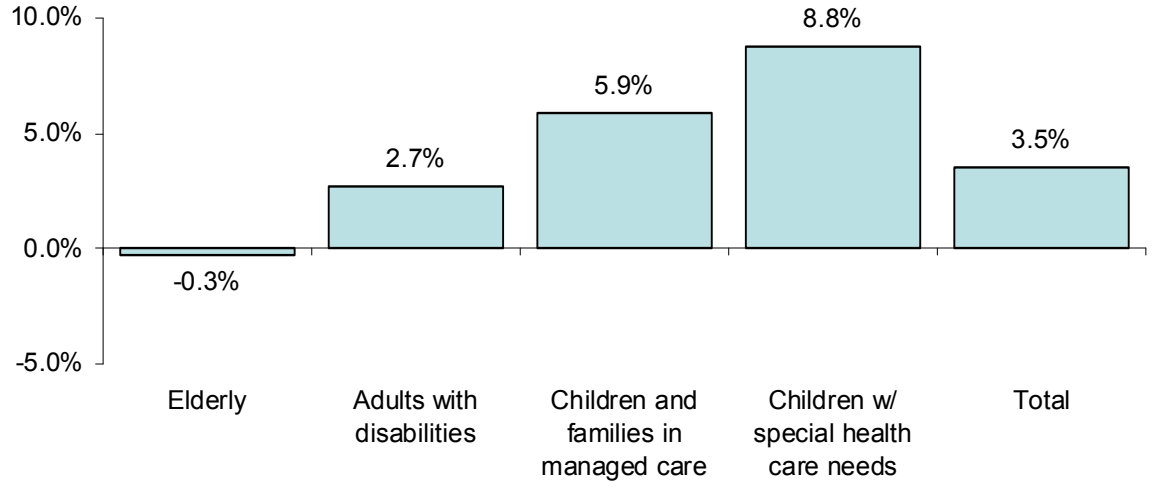
- Sixty-one percent (61%) of spending is on the elderly and adults with disabilities, who account for about 26 percent of total beneficiaries
- The unit cost of services for the elderly is approximately $2,000 per month.
- Children and families account for 67 percent of total enrollment and 24 percent of total cost.

1. The elderly includes all adults over age 65. Adults with Disabilities includes all adults under age 65.
2. Children and Families includes low income children, parents and pregnant women who meet specific asset and income requirements.
3. Children with Special Health Care Needs (CSHCN) includes children in Substitute (Foster) Care, Individuals eligible for SSI who are under 21, Katie Becket children, and Adoption Subsidy children.

c. By Population: Spending Trends

Spending growth is disproportionately attributed to Children with Special Health Care Needs – 15% of 2008 spending but 35% of spending growth.

Average Annual Growth in Spending
SFY 2005 - SFY 2008



	Elderly	Adults with disabilities	Children and families in managed care	Children w/ special health care needs	Total
2008 Spending	$431m	$634m	$416m	$264m	$1,745m
% of 2008 Spending	25%	36%	24%	15%	100%
% of Spending Growth	(2%)	29%	39%	35%	100%

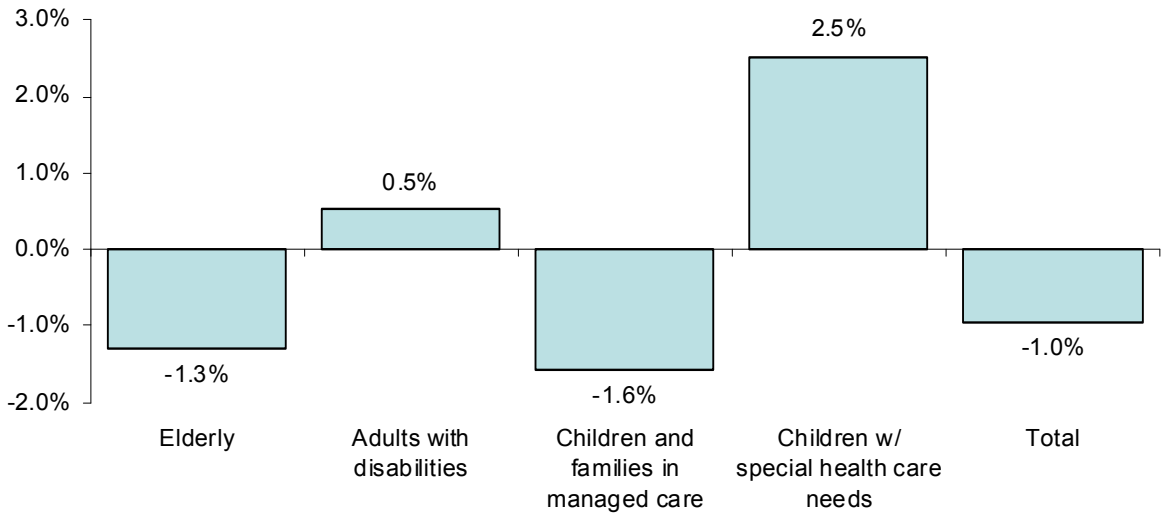
- Children with special health care needs is a small subset of the Medicaid population, Services for beneficiaries in this group have experienced the highest rate of expenditure growth due to the scope and intensity of services. Health care expenditures for this Medicaid population account for 35 percent of total expenditure growth.
- Spending on children and families has increased by 6.2 percent per year. This management of care for this population most closely resembles a commercial health plan; health care expenditures on this population compare favorably to general medical inflation in the commercial market (8 – 12 percent)[1].
- The low spending growth experienced by the elderly population is driven in part by the introduction of Medicare Part D during this time period, which transitioned a significant amount of pharmacy spending for the elderly out of Medicaid and into Medicare.

1. Commercial trends based on data provided by the RI Office of the Health Insurance Commissioner. The 6.2% per year spending growth can be split into enrollment growth (-1.6%) and unit cost (pmpm) growth (7.8%). The unit cost growth of 7.8% is slightly below/in line with commercial trends of 8-12%.

c. By Population: Enrollment Trends

Enrollment has been relatively flat across all Medicaid populations over the past four years

Average Annual Change in Enrollment
SFY 2005 - SFY 2008



2008 Enrollment	17,478	27,580	118,789	12,800	176,647
% of 2008 Enrollment	10%	16%	67%	7%	100%

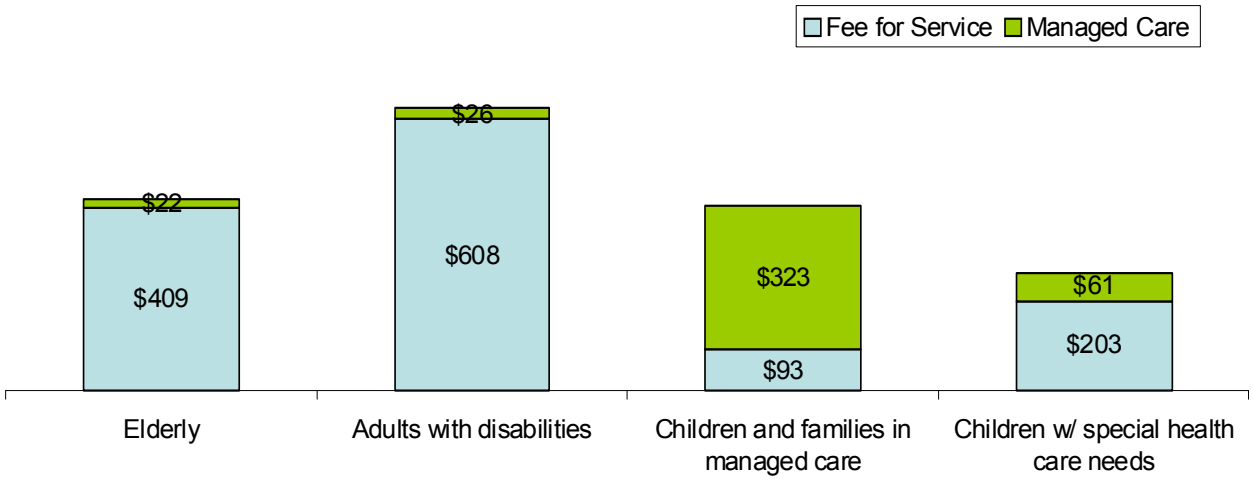
- Overall, Medicaid enrollment has been flat or declining over the past four years – with an average annual decline of 1 percent.
- Only Children with Special Health Care Needs have experienced a modest increase in enrollment; they remain a relatively small share of total Medicaid beneficiaries, however.

c. By Population: FFS vs. Managed Care

The majority of Rhode Island's Medicaid program health care expenditures are purchased through fee for service arrangements.

Fee for Service vs Managed Care Expenditures
SFY2008, $ Million

Overall Total:		
Mgd Care =	$432M	25%
FFS =	$1,313M	75%



Percent Managed Care	Elderly	Adults with disabilities	Children and families in managed care	Children w/ special health care needs
	5%	4%	78%	23%

- One-fourth (25%) of Rhode Island Medicaid expenditures are the result of services is purchased through managed care arrangements.
- Children and families are generally enrolled in one of three RIte Care managed care plans: Neighborhood Health Plan, United Healthcare or Blue Cross Blue Shield of Rhode Island, unless they "opt out" and choose to enroll in traditional fee for service Medicaid. About three-fourths of children and families Medicaid beneficiaries were enrolled in a managed care health plan.
- In SFY 2008, CSHCN were generally enrolled in Neighborhood Health Plan, unless they "opted out" and chose to enroll in fee for service Medicaid. About one fourth are in managed care. Beginning last fall (Fall '08), managed care options for this population were expanded to include United Healthcare and enrollment in one of the three managed care health plans became mandatory.
- Adult populations have historically been exclusively in fee for service Medicaid programs. However, two new managed care programs were established in 2008, transitioning adults to managed care: ConnectCare Choice began enrolling adults in February 2008; and Rhody Health Partners began in April 2008.

c. By Population: HCBS Waivers

The HCBS waiver programs provided home and community based care as an alternative to higher cost inpatient/institutional care

Home and Community Based Waiver Populations

Waiver:	# Persons/cost	Target population:
Aged and disabled	1,582 $42 Million	Those 18 and over who are aged or have a disability that results in the need for help with ADLs and IADLs
Elder	466 $8 Million	Those 65 and older who need help with ADLs and IADLs
Developmental Disability	3,299 $271 Million	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.
Personal Choice/ Habilitative/ Quad	176 $2.7 Million	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 and who are able to manage their own services.
Assisted living	173 $5 Million	Those 18 and older who require assistance with ADLs and IADLs
Total	5,696 Persons $329 Million	Note: The separate HCBS waivers have been collapsed under the Global Consumer Choice Waiver, effective July 1, 2009.

- Section 1915(c) of federal Medicaid law grants states the ability to qualify certain populations who meet specified levels of care for home based services. These programs are intended to allow states to provide home based care as an alternative to more costly nursing home/institutional options.

c. By Population: HCBS Waivers

Populations enrolled in Medicaid through home and community based waiver programs accounted for $329 million in expenditures in 2008, or 19% of total costs

Home and Community Based Waiver
vs. Non-Waiver Population Expenditures

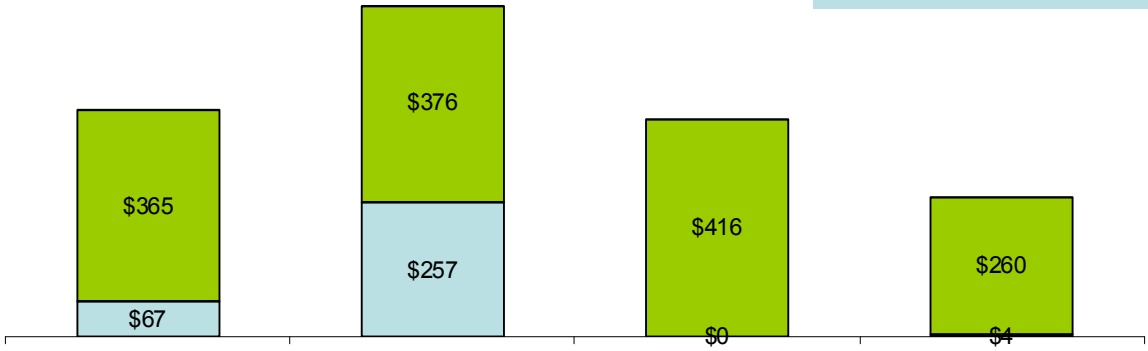
SFY2008

Total Spending:

Waiver =	$329M	19%
NonWaiver =	$1,416M	81%

Total Persons Eligible:

Waiver =	5,696	3%
NonWaiver =	170,951	97%



Share of Waiver					
Spending	20%	78%	0%	1%	=100%
Persons	33%	65%	0%	2%	=100%

- Populations enrolled in Medicaid through home and community based waiver programs accounted for 19 percent of total Medicaid health care spending and about 3.0 percent of total enrollment in Medicaid SFY 2008.
- In SFY 2008, most of the Medicaid beneficiaries enrolled in HCBS waivers were adults with disabilities. These beneficiaries accounted for 78 percent of total waiver spending and 65 percent of all waiver beneficiaries. Elders account for a much smaller percentage on both dimensions.

Table of Contents

d. Mandatory/Optional Spending Overview

Approximately 37% of Medicaid spending is mandated by federal law.

Incurred expense, by population and service group
SFY 2008, $millions

Populations \ Services	Mandatory	Optional	
Mandatory	$639.6 37%	$297.0 17%	$936.6 54%
Optional	$584.2 33%	$223.9 13%	$808.1 46%
	$1,223.8 70%	$520.9 30%	$1,744.7 100%

- Under federal guidelines, there are specific “mandatory” populations 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” populations and services under federal law as well.
- Narrowly defined, mandatory services provided to mandatory populations accounted for only 37 percent of total Rhode Island Medicaid health care expenditures. However, optional services are generally intended to reduce spending for mandatory services – for example, pharmacy, outpatient behavioral health, hospice . All are sizable components of optional services that, if eliminated, would likely result in offsetting increases in spending on mandatory services.
- In addition, federal guidelines require that optional populations receive the same services as mandatory populations. As a result, states can not generally eliminate optional services for optional populations but retain them for mandatory populations.

d.Mandatory/Optional: Populations

Approximately 46% of Medicaid spending is on optional populations

Federal mandatory populations	Optional populations
Persons Eligible: 103,964 Mandatory Expenditures: $639.6m Optional Expenditures*: $297.0m	Persons Eligible: 72,683 Expenditures: $808.1m
❖ 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; and ❖ Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program.	❖ 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); and ❖ Women eligible for Breast and Cervical Cancer program.

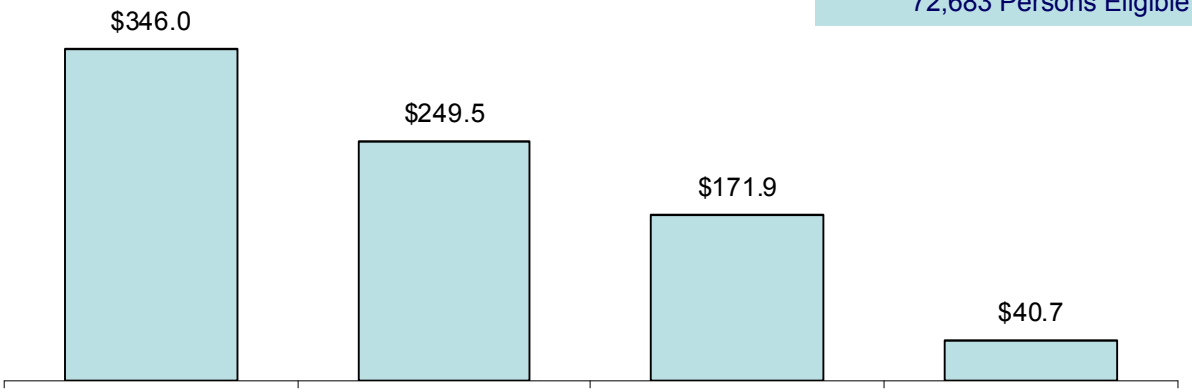
*Optional services for Mandatory Populations.

d. Mandatory/Optional: Optional Populations

Most of the spending on optional populations (75%) is for the elderly or disabled adults.

Spending on Optional Populations Detail
SFY 2008, $Million

Optional Populations Total:
$808.1M Spending
72,683 Persons Eligible



	Elderly	Adults with disabilities	Children and families in managed care	Children w/ special health care needs
% of Optional Spending:	43%	31%	21%	5%
Persons Eligible:	9,870	7,221	52,909	2,684

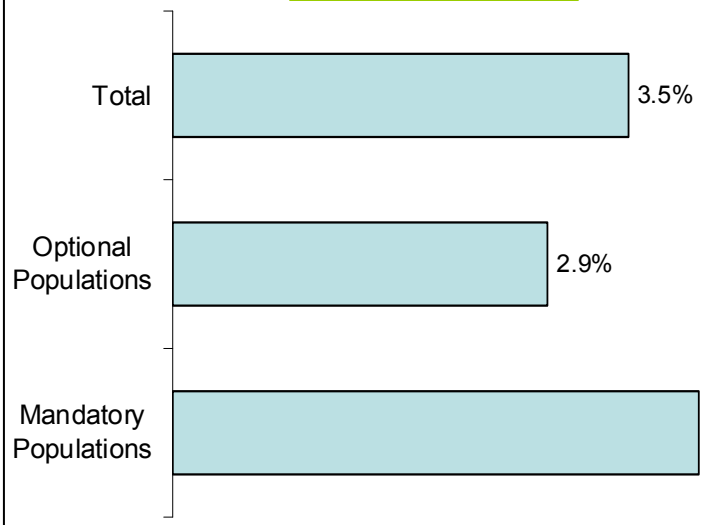
- Most of the spending on optional populations is on the elders and adults with disabilities. This includes low-income elderly adults or adults with chronic physical and behavioral health conditions and disabilities, beneficiaries in HCBS waiver programs, and individuals determined to be "medically needy" due to low income and resources and large medical expenses.
- The vast majority (72%) of spending on optional populations is on mandatory services. A further detailed breakdown shows that about half of Medicaid health care spending on optional populations is for institutional care.[1]
- Children and families account for approximately $172 million in spending for optional populations – 21 percent of the total Medicaid health care spending on optional populations. This includes children up to 250 percent and parents up to 185 percent of the federal poverty level.
- Children with special health care needs account for approximately $41 million in spending for optional populations – 5 percent of total Medicaid spending on optional populations. This includes children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision).

1. Based on claims analysis, December 2008

d. Mandatory/Optional Populations: Trends

Spending growth is disproportionately attributed to mandatory populations

Growth in Spending on Mandatory vs. Optional Populations
SFY 2005 - SFY 2008



	Enrollment Growth	Unit Cost Growth (pmpm)	Major Populations Contributing to Spending Growth[1]
Total	-1.0%	4.5%	
Optional Populations	1.8%	1.0%	RiteCare (58%) Disabled Adults (25%)
Mandatory Populations	-2.7%	6.9%	CSHCN (45%) Disabled Adults (31%)

- Spending growth has been significantly higher for mandatory populations than optional populations. Spending on mandatory populations grew an average of 4 percent per year between SFY 2005 and SFY 2008. Notably, the unit cost trend was even higher, at 6.9 percent per year on average, as it was offset by enrollment declines.
  - About half (45%) of this increase in spending on mandatory populations is attributable to children with special health care needs
- Overall, costs for optional populations have experienced much slower growth, with average unit cost growth that is about I percent per year.

1. The elderly did not contribute significantly to spending growth, partly due to the introduction of Medicare Part D, which transitioned a significant amount of pharmacy spend for the elderly out of Medicaid and into Medicare

d. Mandatory/Optional Spending: Services

Optional services include lower cost practitioners other than physicians, and services that provide care coordination or continuity.

Federal mandatory services	Optional Services
Mandatory Expenditure: $639.6m Optional Expenditure*: $584.2m	Expenditure: $520.9m
Acute Care ❖ Physicians' services ❖ Laboratory and x-ray services ❖ Inpatient hospital services ❖ Outpatient hospital services ❖ Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21 ❖ Family Planning and supplies ❖ Federally qualified health center (FQHC) services ❖ Rural health clinic services ❖ Nurse-midwife services to the extent permitted by State law ❖ Services of certified pediatric and family nurse practitioners to the extent allowable	**Acute Care** ❖ Rehabilitation and other therapies ❖ Prescription drugs ❖ Medical care or remedial care furnished by other licensed practitioners ❖ Clinic services ❖ Dental services, dentures ❖ Prosthetic devices, eyeglasses, DME ❖ Primary care case management ❖ TB-related services ❖ Other specialist medical or remedial care
Institutional Services ❖ Nursing facility services for individuals 21 and older	**Institutional Services** ❖ Intermediate care facility services for the mentally retarded (ICF/MR) ❖ Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases ❖ Inpatient psychiatric hospital services for individuals under 21
Home and Community Based Services ❖ Home health care services for any individual entitled to nursing facility care	**Home and Community Based Services** ❖ Home and Community Based Waiver Services ❖ Targeted case management ❖ Respiratory care services for ventilator dependent individuals ❖ Personal care services Hospice Services ❖ Services furnished under a Pace Program

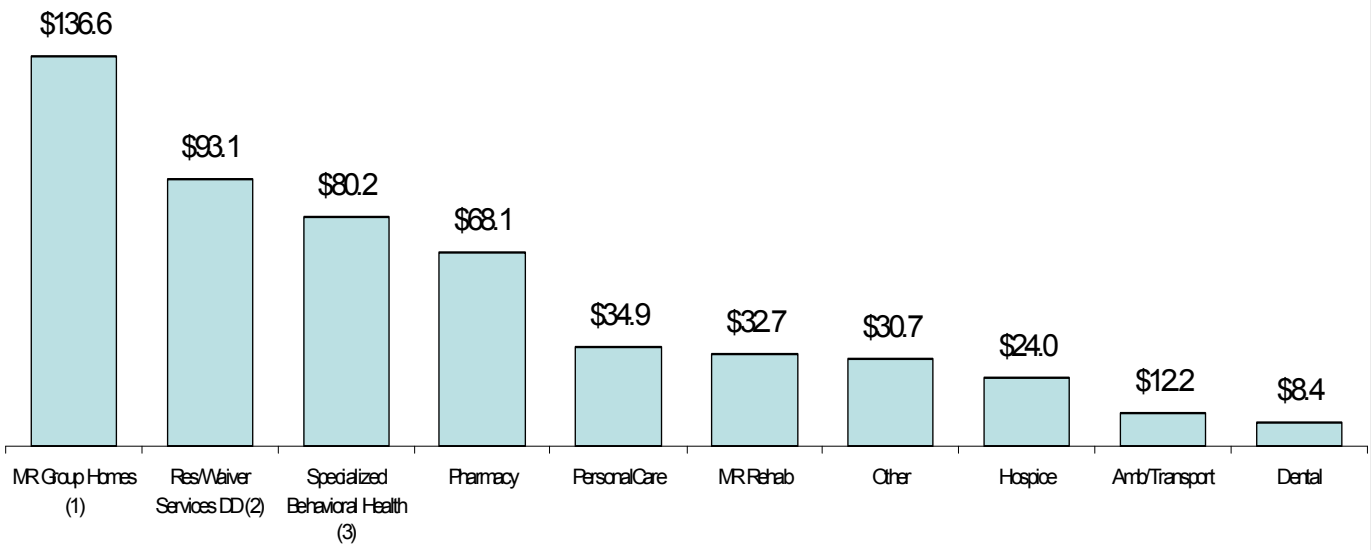
*Mandatory services for optional populations.
Source: "Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories", June, 2005, Sommers, Ghosh, The Urban Institute

d. Mandatory/Optional: Optional Services

Most of the spending on optional services is designed to reduce spending for mandatory services

Optional Services Detail
SFY 2008 $ millions

Optional Services Total Spending: $520.9M



% of Optional Spending									
26%	18%	15%	13%	7%	6%	5%	2%	2%	6%

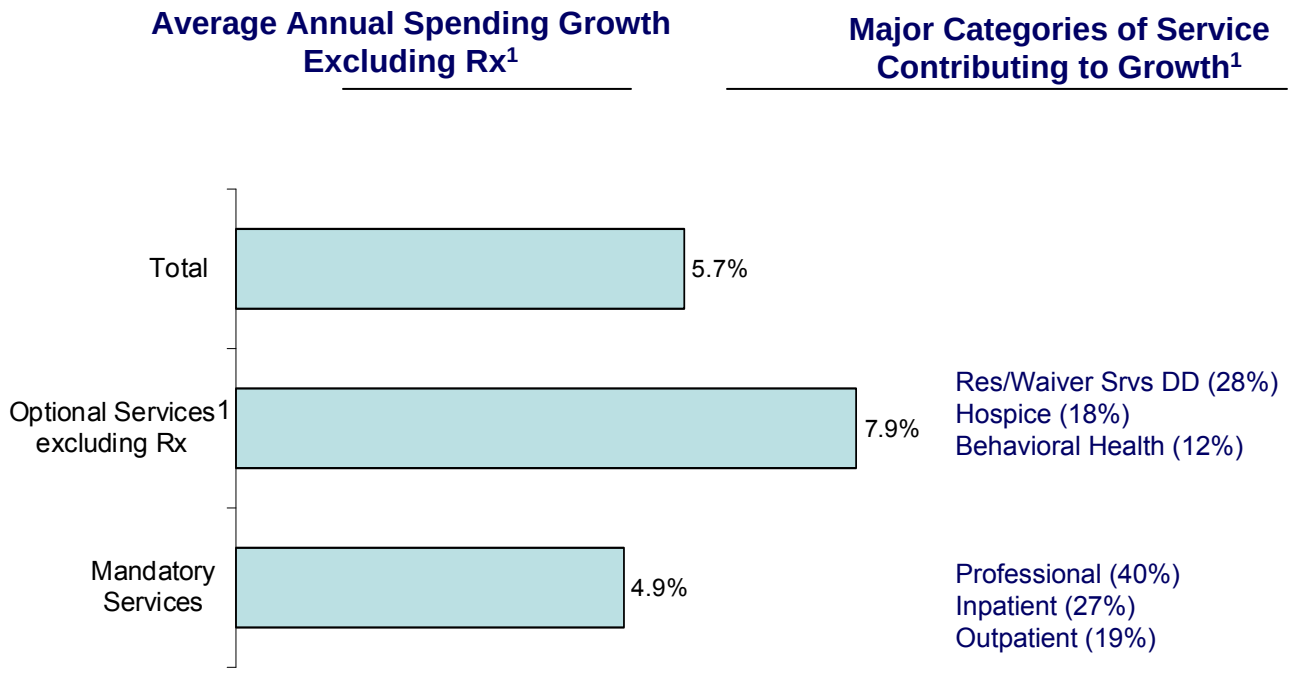
- Optional services accounted for $521 million in total Medicaid spending in SFY 2008, or approximately 30 percent of total Medicaid expenditures.
- The largest components of optional services are Residential/Waiver services for the population with developmental disabilities (including group homes) and specialized behavioral health professional services. These services provide an important alternative to more expensive (mandatory) inpatient/institutional services for beneficiaries with mental retardation/developmentally disabilities.

1. MR Group Homes includes public and private facilities for mentally retarded individuals.
2. Res/Waiver Services DD are Residential/Waiver services for the developmentally disabled population
3. Specialized behavioral health services includes only those behavioral health services provided by MHRH and DCYF.

d. Mandatory/Optional Services: Trends

Spending growth is disproportionately attributed to optional services, and specifically behavioral health and hospice

Growth in Spending on Mandatory vs. Optional Services Excluding Rx[1]
SFY 2005 - SFY 2008



- Optional services (excluding pharmacy) grew at an average annual rate of 7.9 percent a year between 2005 and 2008. This is driven mostly by behavioral health services and hospice.
- Mandatory services grew at 4.9 percent per year, with most of the growth in professional services.

1. This measure of average annual spending growth excludes pharmacy, which experienced a one time decline due to the introduction of Medicare Part D, which transitioned a significant amount of pharmacy spend for the elderly out of Medicaid and into Medicare. Including pharmacy, total spending growth would be 3.5% as shown elsewhere in this report.

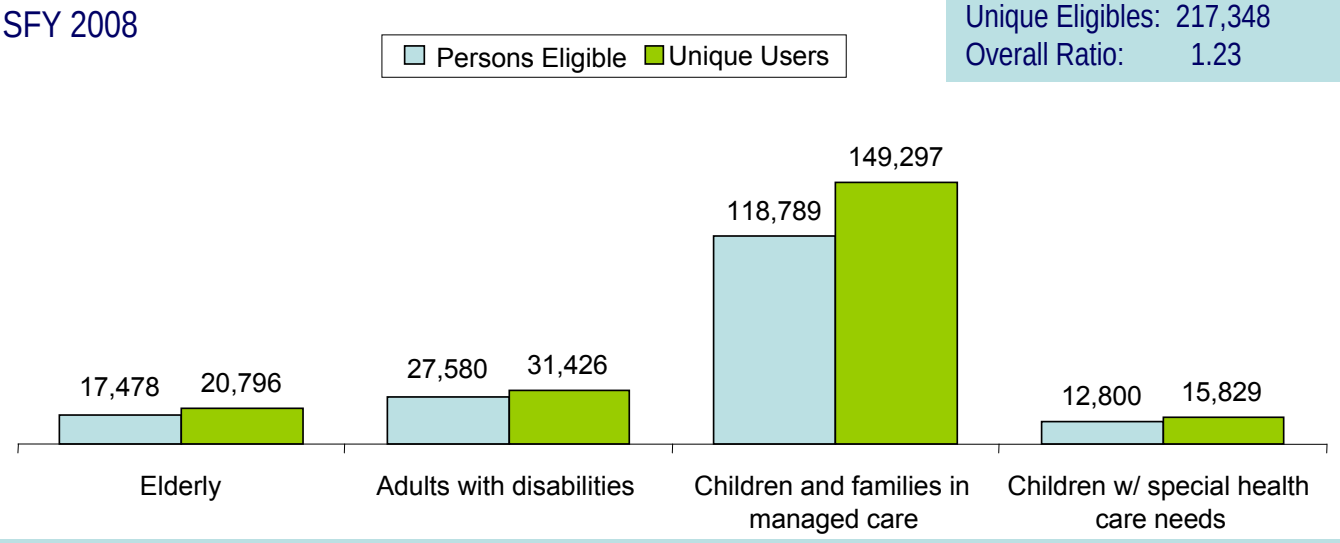
Table of Contents

e. User Profile: Unique Users

217,000 Rhode Islanders, 21% of the total population[1], were enrolled in Medicaid for some part of SFY 2008.

Unique Users vs. Average Persons Eligible
SFY 2008

Total Persons Eligible: 176,647
Unique Eligibles: 217,348
Overall Ratio: 1.23



Elderly	Adults with disabilities	Children and families in managed care	Children w/ special health care needs
1.19	1.14	1.26	1.24

Ratio: Unique Users per Average Persons Eligible

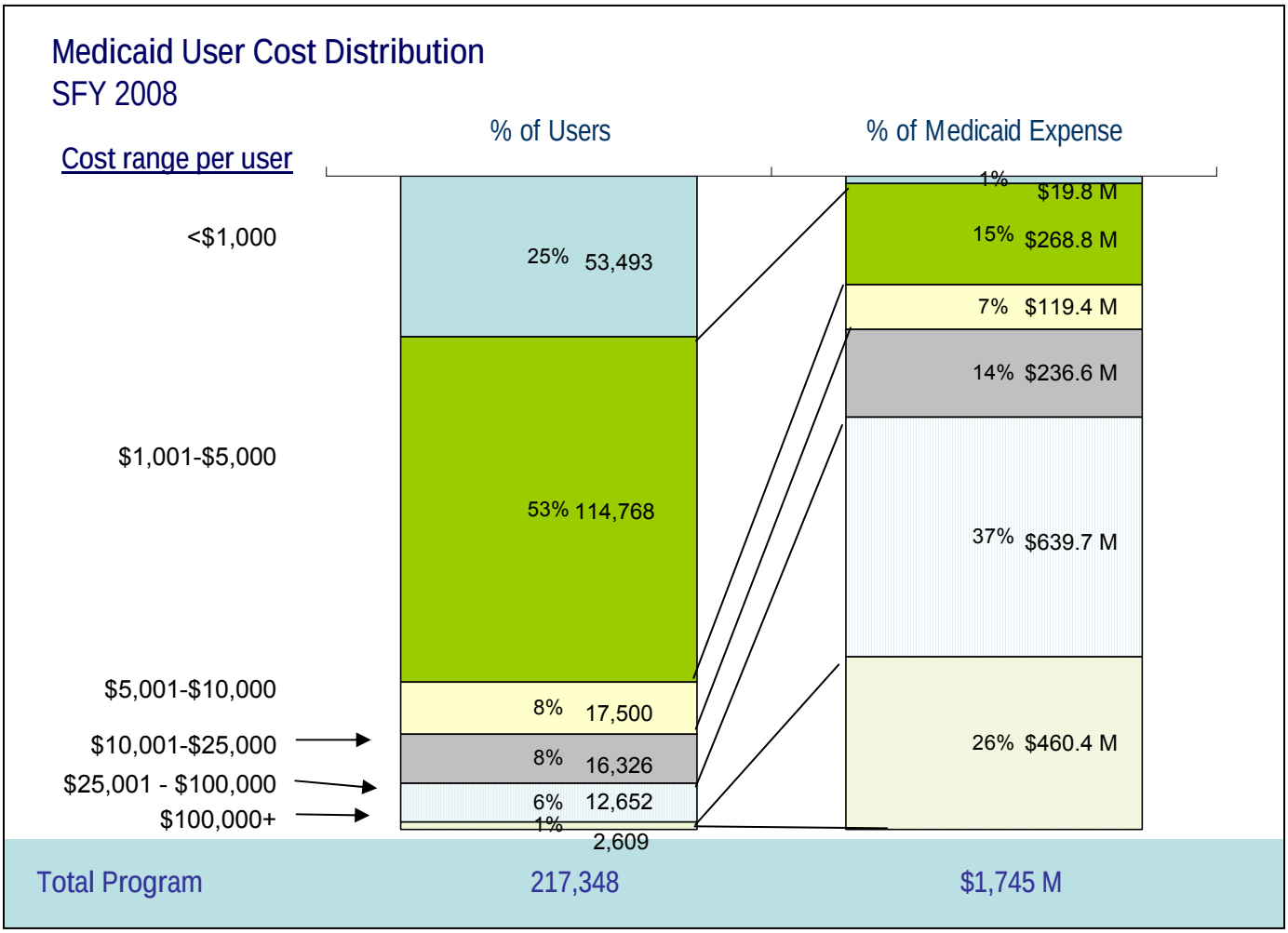
- Unique users is a measure of the number of Rhode Islanders who were enrolled in Medicaid at any time during the fiscal year. If a beneficiary enrolled, disenrolled, and re-enrolled, that beneficiary would count as one unique user. Similarly, if a person enrolled for only one month, he or she would also be included as a unique user.

- By this measure, Rhode Island's Medicaid program, and particularly the children and families program, appears to serve a broader spectrum of Rhode Islanders.

Note: A unique user is an individual associated with a medical claim. Average eligible enrollment is annual FTEs.
1. Based on CPS estimated RI population of 1,044,000

e. Spending by User Profile: High Cost Cases

The top seven percent of Medicaid users account for roughly two thirds (63%) of Medicaid spending.



- The concentration of health care expenses provide important insights on how best to contain rising health care costs, and serves to inform more focused cost-containment strategies targeting chronic conditions..
- Medicaid expenditures are highly concentrated, as the top seven percent of Medicaid users account for roughly two-thirds (63%) of expenditures. This is similar to national statistics, as the top 5 percent of the US population accounted for 49 percent of overall US health care spending[1].
- On the other end of the spectrum, 78 percent of Medicaid users access Medicaid services at a cost of less than $5000 per year. Thus, the 15,261 top utilizers spent, on average, $72,083 per person, more than *forty times* as much per person as those in the bottom 78 percent of spenders.

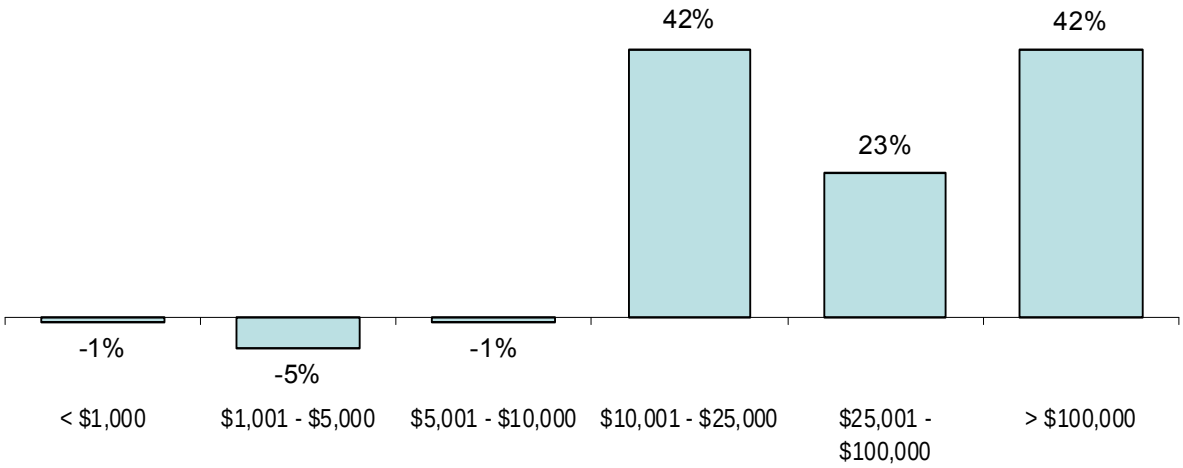
1. "The High Concentration of US Health Care Expenditures," AHRQ, http://www.ahrq.gov/research/ria19/expendria.pdf

e. Spending Trends by User Profile

High cost cases account for the vast majority of spending increases

Percent of Overall Spending Increase by User Type
SFY 2005 vs. 2008

Overall
2008 Avg Annual Cost/User : $8,027



	< $1,000	$1,001 - $5,000	$5,001 - $10,000	$10,001 - $25,000	$25,001 - $100,000	> $100,000	
% of Users	17%	58%	9%	8%	7%	1%	= 100%
2008 Average Cost per User	$370	$2,342	$6,824	$14,492	$50,560	$176,461	

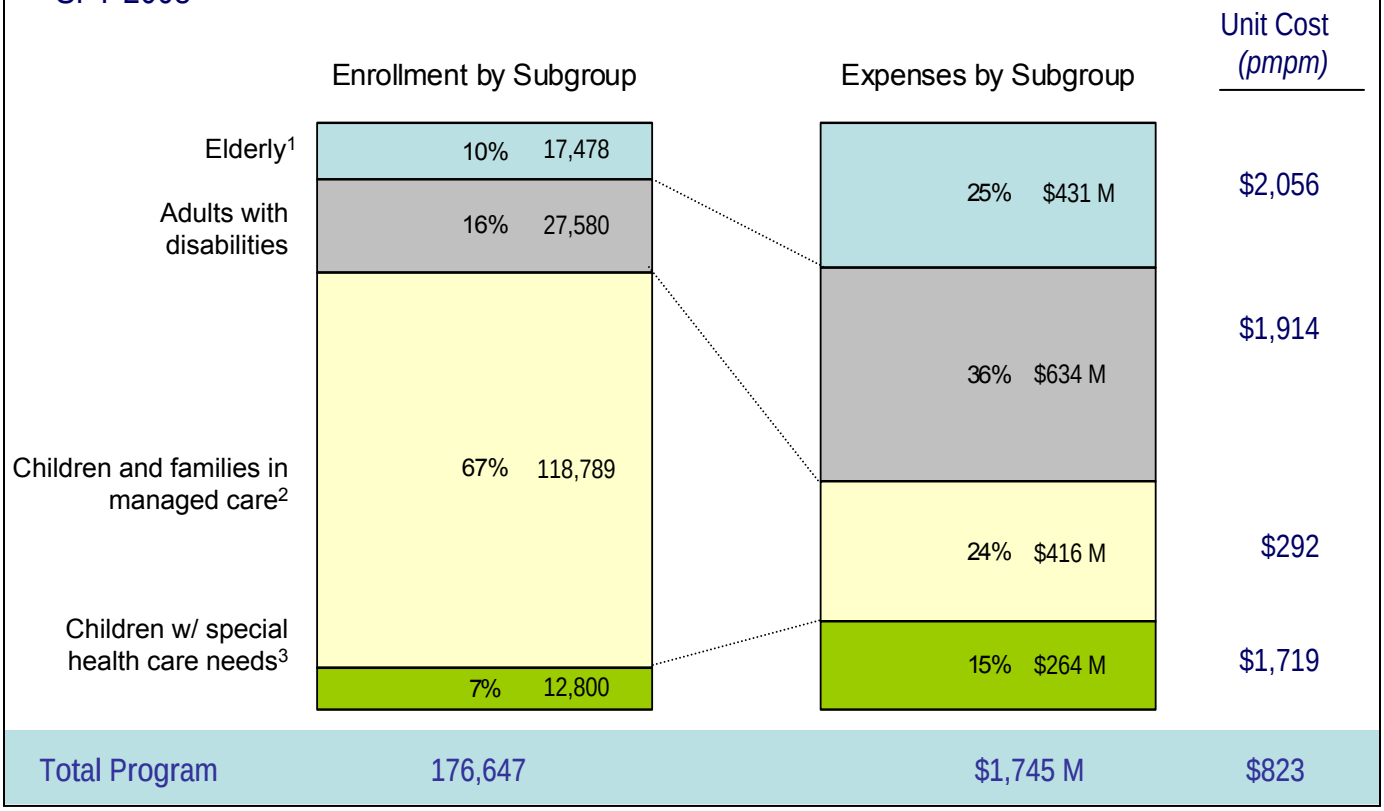
- Virtually all of the growth in Medicaid health care expenditures is attributed to beneficiaries that are in the high utilizer category – that is, those beneficiaries accounting for over $10,000 in medical costs per year. And almost half of the growth in health care costs is attributed to the top 1 percent of users.

Table of Contents

Reminder: Spending by Population

Medicaid spending varies considerably by population

Medicaid Enrollment and Expense by Population
SFY 2008



The Medicaid program served an average of 176,647 eligible persons in SFY 2008, at an average cost per member per month of $823.

1. The elderly includes all adults over age 65. Adults with Disabilities includes all adults under age 65.
2. Children and Families includes low income children, parents and pregnant women who meet specific asset and income requirements.
3. Children with Special Health Care Needs (CSHCN) includes children in Substitute (Foster) Care, Individuals eligible for SSI who are under 21, Katie Becket children, and Adoption Subsidy children.

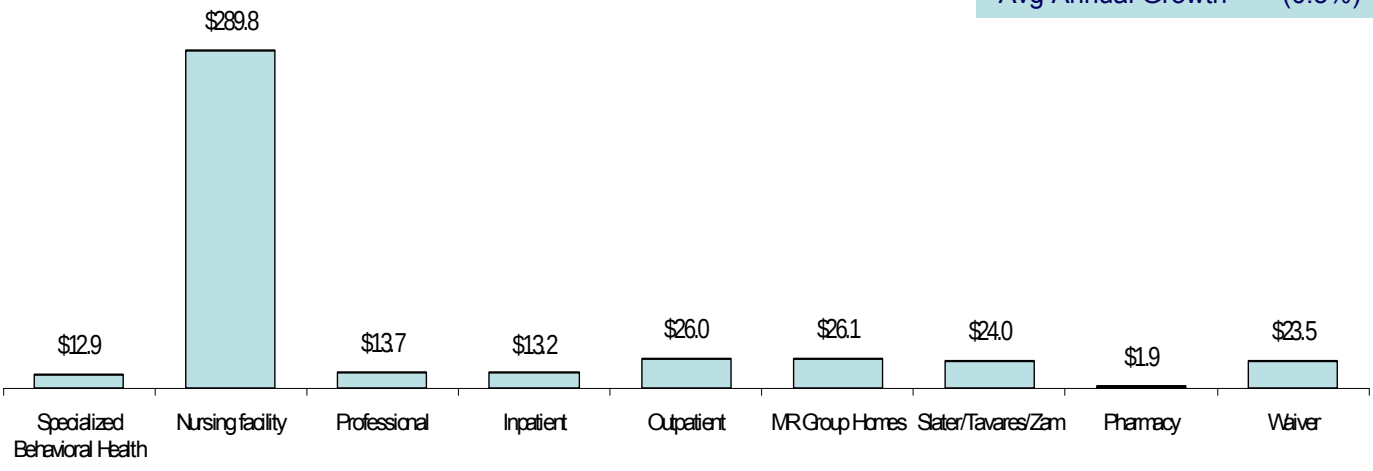
Elderly Detail

In the elderly population, nursing facilities account for approximately two thirds of total expenditure.

Elderly Population: Medicaid Spending by Provider Type
SFY 2008

Overall Total Elderly:

2008 Spending =	$431M
% of 2008 Spending =	25%
Avg Annual Growth[1] =	(0.3%)



	Specialized Behavioral Health	Nursing facility	Professional	Inpatient	Outpatient	MR Group Homes	Slater/Tavares/Zam	Pharmacy	Waiver
% of 2008 Spending	3%	67%	3%	3%	6%	6% [1]	6%	0%	5%
Average Annual Spending Growth, SFY2005-2008	11.1%	1.5%	12.0%	(2.5%)	33.5%	8.7%	(7.0%)	NA[2]	7.0%

- Medicaid health care expenditures on the elder population totaled $431 million in 2008, and has been essentially flat, with –0.3 percent growth over the past four years.
- The decline in expenditures for this population can be explained in part by the introduction of Medicare Part D, which transitioned a significant amount of pharmacy spend for the elderly out of Medicaid and into Medicare.
- Nursing facilities account for two thirds (67%) of total Medicaid health care spending on the elderly population. However, the increases in nursing home expenditures for this population have been fairly modest – an average annual increase of only 1.5 percent per year.
- Most of the growth in Medicaid health care expenditures for the elderly has been in outpatient and professional services, due in part to a strategic effort to invest in alternatives to institutional/nursing facility care.

1. Specialized behavioral health services includes only those behavioral health services provided by MHRH and DCYF. Additional behavioral health services (traditional office visits, etc) paid through DHS are included in the professional services. Slater is an institution for severely disabled adults. Tavares is a similar institution for severely disabled children. And Zambarano is a specialized group home targeting the severely disabled. MR/DD Group Homes are facilities for developmentally disabled individuals.

2.This measure includes pharmacy, which experienced a one time decline due to Medicare Part D.

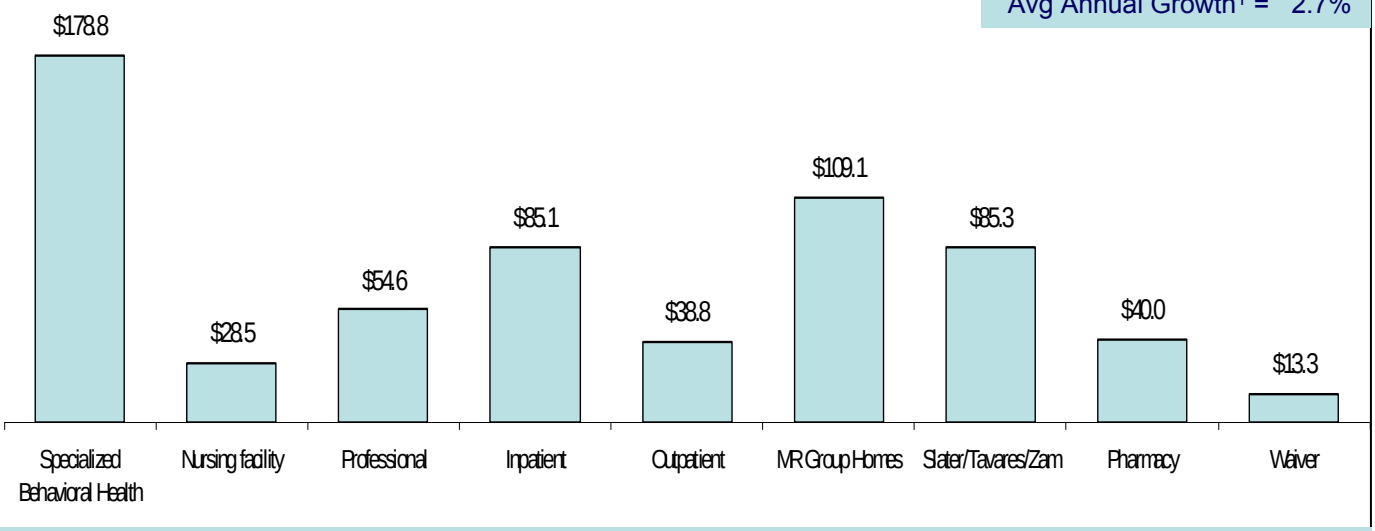
Adults with Disabilities Detail

In the adults with disabilities population, professional expenses for behavioral health are the largest contributor to cost increases.

Adults with Disabilities: Medicaid spending by Provider SFY 2008

Overall Total ADD:

2008 Spending = $634M
% of 2008 Spending = 36%
Avg Annual Growth[1] = 2.7%



	Specialized Behavioral Health	Nursing facility	Professional	Inpatient	Outpatient	MR Group Homes	Slater/Tavares/Zam	Pharmacy	Waiver
% of 2008 Spending	28%	4%	9%	13%	6%	17%	13%	6%	2%
Avg Annual Spending Growth, SFY2005-2008	5.9%	6.8%	15.3%	3.3%	6%	1.6%	5.3%	NA[1]	9.9%

- Adult with disabilities accounted for the largest share of Medicaid healthcare expenditures, with total SFY 2008 spending of $634 Million. Spending on this population has increased by approximately 2.7 percent per year over the past four years.
- The relatively low spending growth for this population also can be explained in part by the introduction of Medicare Part D.
- Specialized behavioral health services account for approximately 28 percent of total Medicaid spending on adults with disabilities.
- Most of the growth in Medicaid health care expenditures for the adults with disabilities population has been in professional services.

1. This measure includes pharmacy, which experienced a one time decline due to the introduction of Medicare Part D, which transitioned a significant amount of pharmacy spend out of Medicaid and into Medicare.

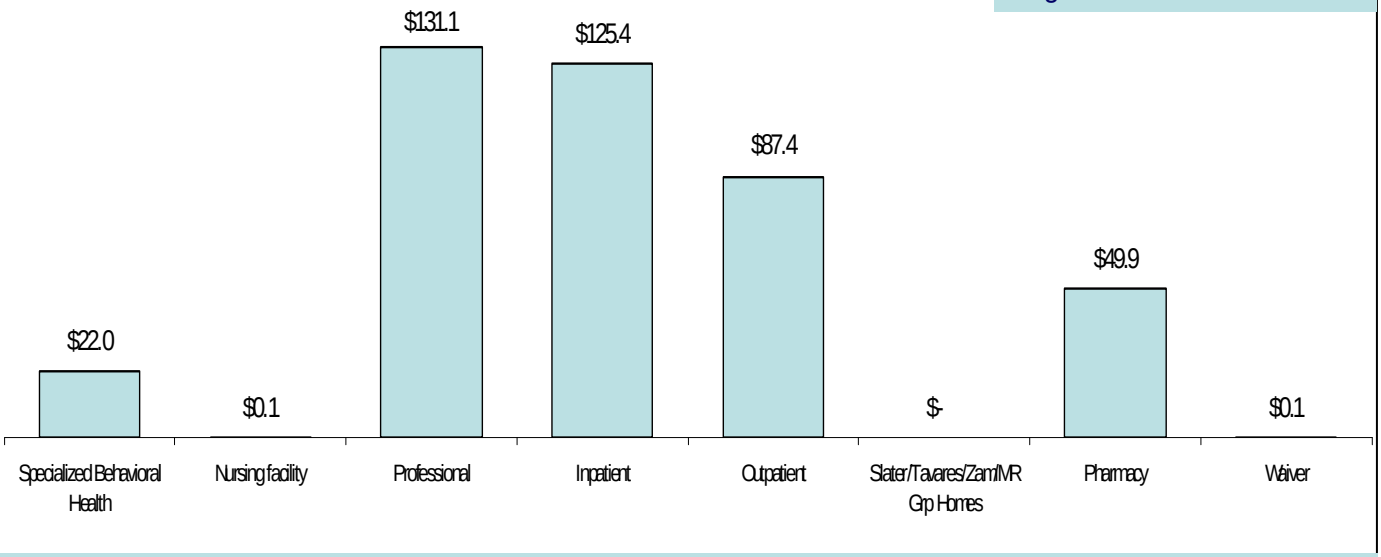
Children and Families

In the children and families in managed care population, hospital expenses and professional expenses are the largest contributors to cost increases

Children and Families Detail: Medicaid Spending by Provider SFY 2008

Overall Total C+F:

2008 Spending = $416M
% of 2008 Spending = 24%
Avg Annual Growth[1] = 5.9%



	Specialized Behavioral Health	Nursing facility	Professional	Inpatient	Outpatient	Slater/Tavares/ZamIMR Grp Homes	Pharmacy	Waiver
% of 2008 Spending	5%	0%	32%	30%	21%	0%	12%	0%
Average Annual Spending Growth, SFY2005-2008[1]	9.0%	NA[2]	5.1%	8.5%	10.1%	0%	(4.1%)[1]	NA[2]

- Children and families account for about one-fourth (24%) of total Medicaid expenditures, with total 2008 spending of $416 Million. Spending on this population has increased by approximately 5.9 percent per year over the past four years.
- Spending on children and families is divided between professional, inpatient and outpatient services. Outpatient services have experienced the highest growth – with a 10.1 percent average annual increase.

1. This measure includes pharmacy, which experienced a one time decline due to the introduction of Medicare Part D, which transitioned a significant amount of pharmacy spend (mostly for the elderly and ADD populations, but some children and families expenses) out of Medicaid and into Medicare.
2. Too small to measure reasonable average growth rates. Waiver spending increased from $43,000 in 2005 to $141,000 in 2008. Nursing facility spending increased from $25,000 in 2005 to $63,000 in 2008.

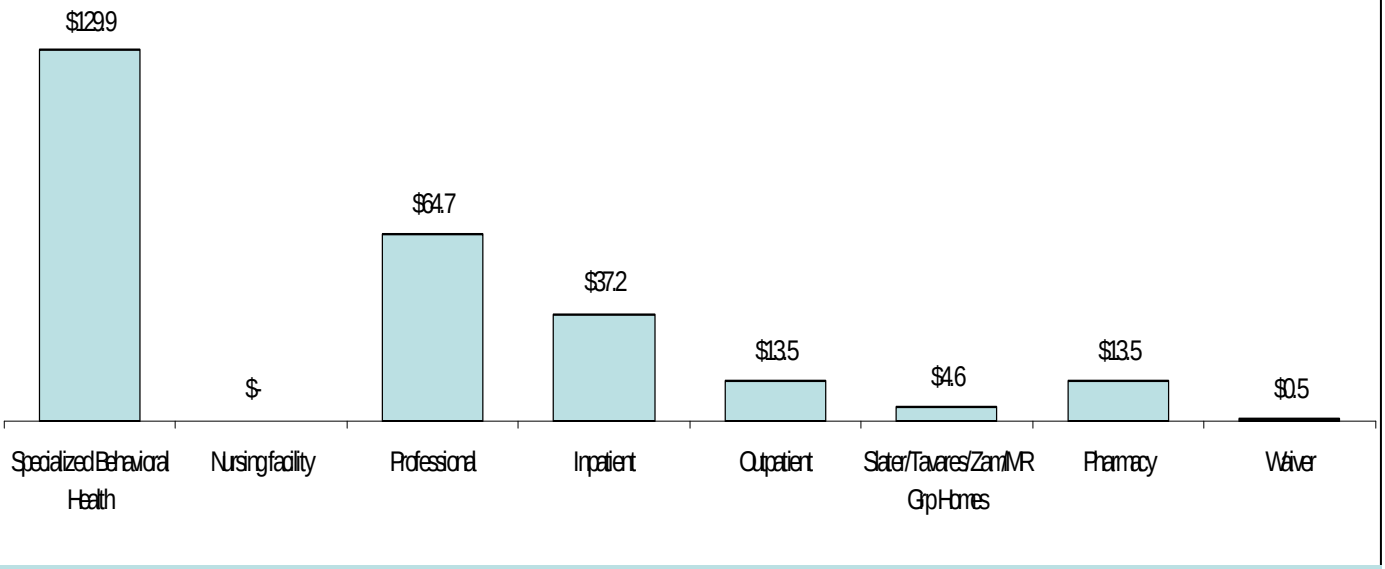
Children with Special Health Care Needs

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

Children with Special Health Care Needs Detail: Medicaid Spending by Provider Type SFY 2008

Overall Total CSHCN:

2008 Spending = $264M
% of 2008 Spending = 15%
Avg Annual Growth[1] = 8.8%



	Specialized Behavioral Health	Nursing facility	Professional	Inpatient	Outpatient	Slater/Tavares/Zami MR Grp Homes	Pharmacy	Waiver
% of 2008 Spending	49%	0%	25%	14%	5%	2%	5%	0%
Average Annual Spending Growth, SFY2005-2008[1]	6.8%	0%	13.4%	5.3%	18.2%	3.5%	15.1%	NA[1]

- Children with special health care needs (CSHCN) is a relatively small population -- accounting for 15 percent of total Medicaid expenditures and seven percent of enrollees, with total 2008 spending of $264 Million. However, spending on the CSHCN population has experienced the highest rate of increase over the past four years – with average annual increases of 8.8 percent per year.
- Spending on the CSHCN population is dominated by specialized behavioral health services, which account for about half (49%) of total expenditures.

1. Waiver spending decreased from $1.2million in 2005 to $530,000 in 2008.