Rhode Island Annual Medicaid Expenditure Report

December 1, 2006

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

Hazard Building - 74 West Road, Cranston, Rhode Island 02920

(401)462-5274 (voice) (401)462-0241 (fax) TDD: 401/462-3363

A Message from the Secretary

The Rhode Island Medicaid program assures access to health care coverage and services for many of the State's low-income elders and adults with disabilities as well as for uninsured and underinsured working families and children with special health care needs. The program has become an integral element of the state's health care system because it touches the lives of so many people.

In fact, within the last five years, over 331,000 Rhode Islanders – about one-third of the state's population – received a Medicaid funded acute or long-term care service at some point. Additionally, in state fiscal year (SFY) 2006, 40 percent of all Rhode Island school-aged children, or just over 64,000 kids, were enrolled in the Medicaid program. Medicaid payments made to local school districts also support services provided to children with special learning needs. Further, nearly 25 percent of the state's healthcare workforce is funded by Medicaid.

Over the years, as the Medicaid program has evolved, the state's role in the organization, finance and delivery of services has expanded and become more complex. Today, all five of the state's health and human services departments falling under the purview of the Executive Office of Health and Human Services (EOHHS) administer programs and services funded in whole or in part by Medicaid (those departments are Elderly Affairs; Children, Youth and Families; Health; Human Services; and, Mental Health, Retardation and Hospitals). Medicaid payments support and, in some cases, sustain a broad array of service providers and facilities. Expenditures for the program are now the single largest component of the state's annual budget.

In State Fiscal Year (SFY) 2005 alone, enrollment in the Medicaid program through the five departments averaged 186,495. The total cost for services provided to enrollees during this period, including both state and federal dollars, was $1.627 billion, most of which was paid out in reimbursements to provider claims. The $760 million State dollars expended on the program in SFY 2005 represented just over 24% of Rhode Island's total spending in general revenues.

Over the last several years, changes in national policy priorities and in state's rate of federal matching funds have added to the RI Medicaid program's cost and complexity. For example, in federal fiscal year (FFY) 2006, the federal matching rate, known as the Federal Medicaid Assistance Percentage or FMAP, decreased from 55.38% to 54.45%, and resulted in a net loss of $15.5 million to the state. In FFY 2007, the FMAP dropped further to 52.35% and is expected to cause an additional $35 million decrease in federal matching funds.

The implementation of the Medicare Part D prescription drug plan in January 2006 presented another unique set of administrative and fiscal challenges. The data in this report covers the year prior to the start of Part D, thereby providing a sound baseline for evaluating its impact on Medicaid expenditures and access to services.

(continued)

Initial assessments of the first year of Medicare Part D suggest that it has helped reduce escalating Medicaid costs nationwide. Preliminary data looking at trends in Rhode Island Medicaid expenditures for the last five years, show that the rate of growth in program costs began to decline in SFY 2005 and today, is about half the annual increase in health costs in the commercial market – in SFY 2007 the growth rate in Medicaid is expected to be about 6%, compared to 10% in the commercial market.

Despite these gains, the reduction in federal resources and continued increased growth in underlying health costs, have raised state policymakers concerns about the RI Medicaid program's continuing financial viability and sustainability. In SFY 2007, for the third consecutive year, the growth in Medicaid expenditures are expected to rise at a higher rate than state revenues despite many successful efforts by the departments to contain enrollment growth, trim costs and improve program efficiency.

The state's complex system for administering and financing the Medicaid program has made it difficult to isolate and address the factors driving the continuing increase in cost across the five departments. The purpose of this expenditure report is to provide state policymakers with a comprehensive overview of state Medicaid spending that sheds light on some of these factors. Our goal is to provide information about Medicaid that will assist in assessing and making strategic and informed choices about program coverage, costs, and efficiency in the annual budget process.

Toward this end, the report summarizes Medicaid expenditures for eligible individuals and families covered by one or more of the five EOHHS departments. Additionally, the report shows enrollment and expenditure trends for Medicaid coverage groups – both optional and mandatory – by service type, care setting, and delivery mechanism. We also 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.

By law, this report is due to be completed and submitted to you and the Committee by no later than the first of December of each year. In order to meet this deadline, we were required to limit our analysis to Medicaid expenditure data from SFY 2005. Actual expenditure data for SFY 2006 will not be available until after the first of next year under the state's reconciliation process for Medicaid claims. For the purposes of this year's report, we plan to submit an update by February 1, 2007, presenting the SFY 2006 data on Medicaid expenditures.

As this is the first report, we have endeavored to establish a standard format for tracking and evaluating trends in annual Medicaid expenditures within and across departments that will inform policy and planning discussions about health care access and coverage and provide a solid foundation for the EOHHS study on the future of Medicaid, due out in March of 2007.

Jane A. Hayward

Secretary,
Executive Office of Health and Human Services

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.

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

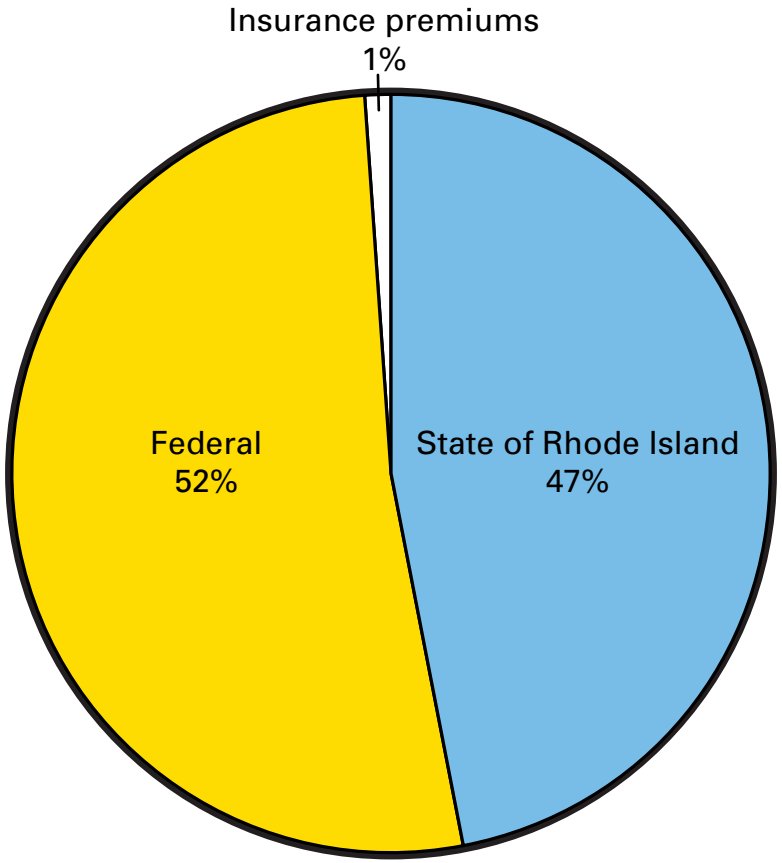
PCPM: Per capita per month

SFY: State fiscal year

RI Medicaid 2005

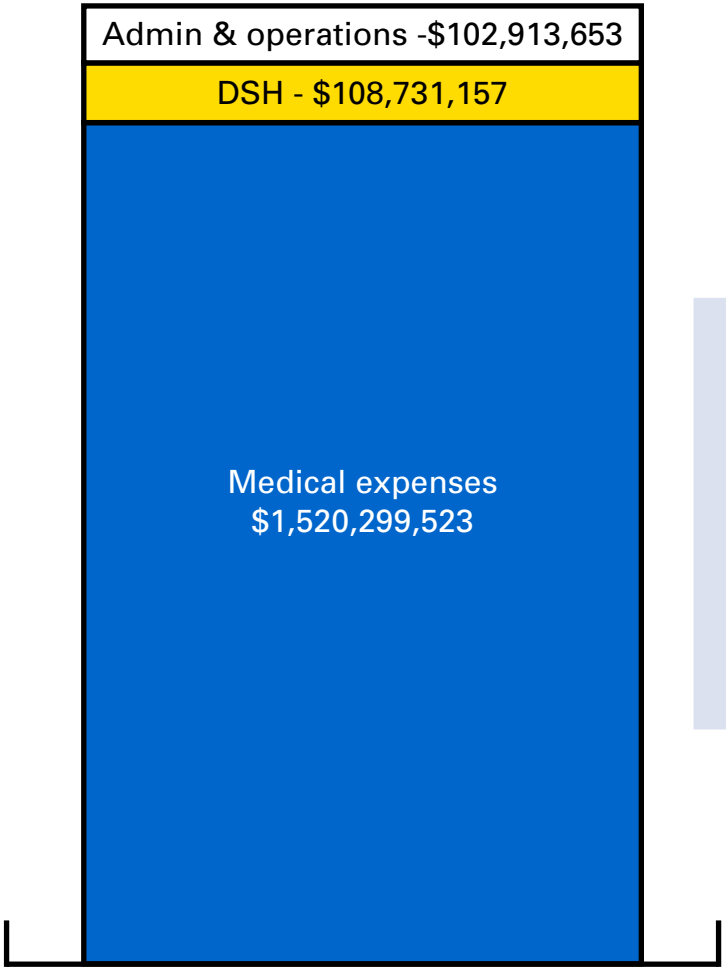
The federal government pays for more than 52% of overall Medicaid spending

Figure 1
Sources of funds,
SFY 2005



Medicaid expenditures total approximately $1.7 billion

Figure 2
SFY 2005



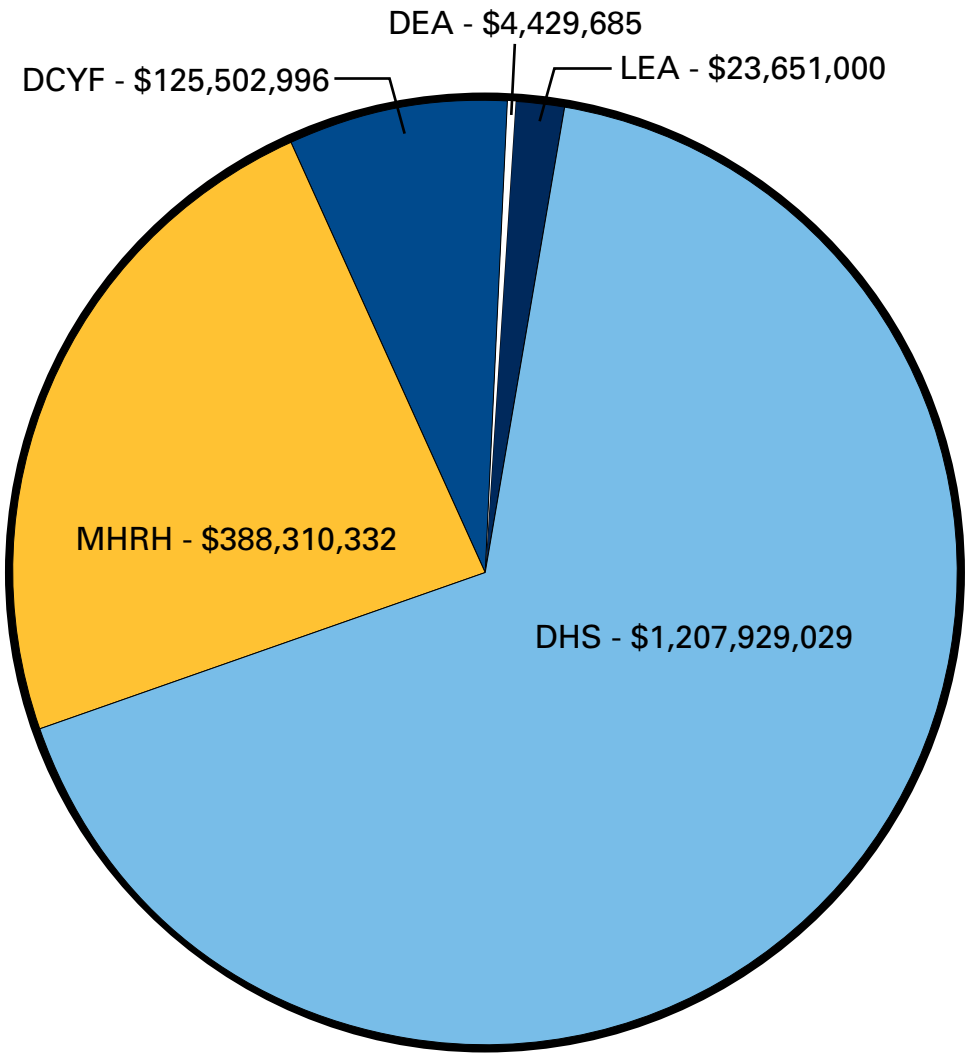
All funds

The focus of this report is on Medicaid medical expenses which represent 88% of total Medicaid expenses

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 2005



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**	**$244,244,916**
	Regular	135,513,759
	DSH/uncompensated care	108,731,157
	Long Term Care	**$321,836,550**
	Nursing Facilities	292,757,265
	Community-based long term care	29,079,285
	Managed care	**$355,960,572**
	Rite care - core	271,643,571
	Rite share	6,888,549
	Substitute care	6,800,000
	CSHCN's	15,393,030
	Out-of-plan (N/I rehab)	55,235,422
	Pharmacy	**$124,815,840**
	Claims payments	169,858,865
	Rebates	(45,043,025)
	Treatment and rehabilitation	**$70,991,730**
	Physician	18,388,908
	Oral health	18,312,655
	Rehabilitative services	34,290,167
	Medicare premiums	**$22,878,862**
	Other	**$ 47,956,231**
	Special education	**$19,238,891**
	Restricted receipt	**$5,437**
	TOTAL DHS	**$1,207,929,029**
MHRH	**Eleanor Slater Hospital system**	**$101,954,122**
	Elenor Slater Hospital	98,725,307
	Zambarano group homes	3,228,815
	MR/DD waiver	**$221,096,865**
	Public providers	45,425,121
	Private providers	174,286,967
	Supported living arrangements	1,384,777
	Integrated behavioral health	**$65,259,345**
	Community-based behavioral health	57,912,588
	Substance abuse treatment	5,099,557
	Other	2,247,200
	TOTAL MHRH	**$388,310,332**
DCYF	**Psychiatric hospital**	**$22,298,927**
	Rehab services	**$86,773,737**
	Managed care	**$16,430,332**
	TOTAL DCYF	**$125,502,996**
DEA	**Personal care in assisted living**	**$168,862**
	Community supports	**$4,260,823**
	Home Care	4,240,986
	Assistive Devices	4,236
	Home Modifications	15,601
	TOTAL DEA	**$4,429,685**

Note: Does not include psychiatric DSH/uncompensated care pool

Source: State budget documents

School districts participating in the Medicaid program

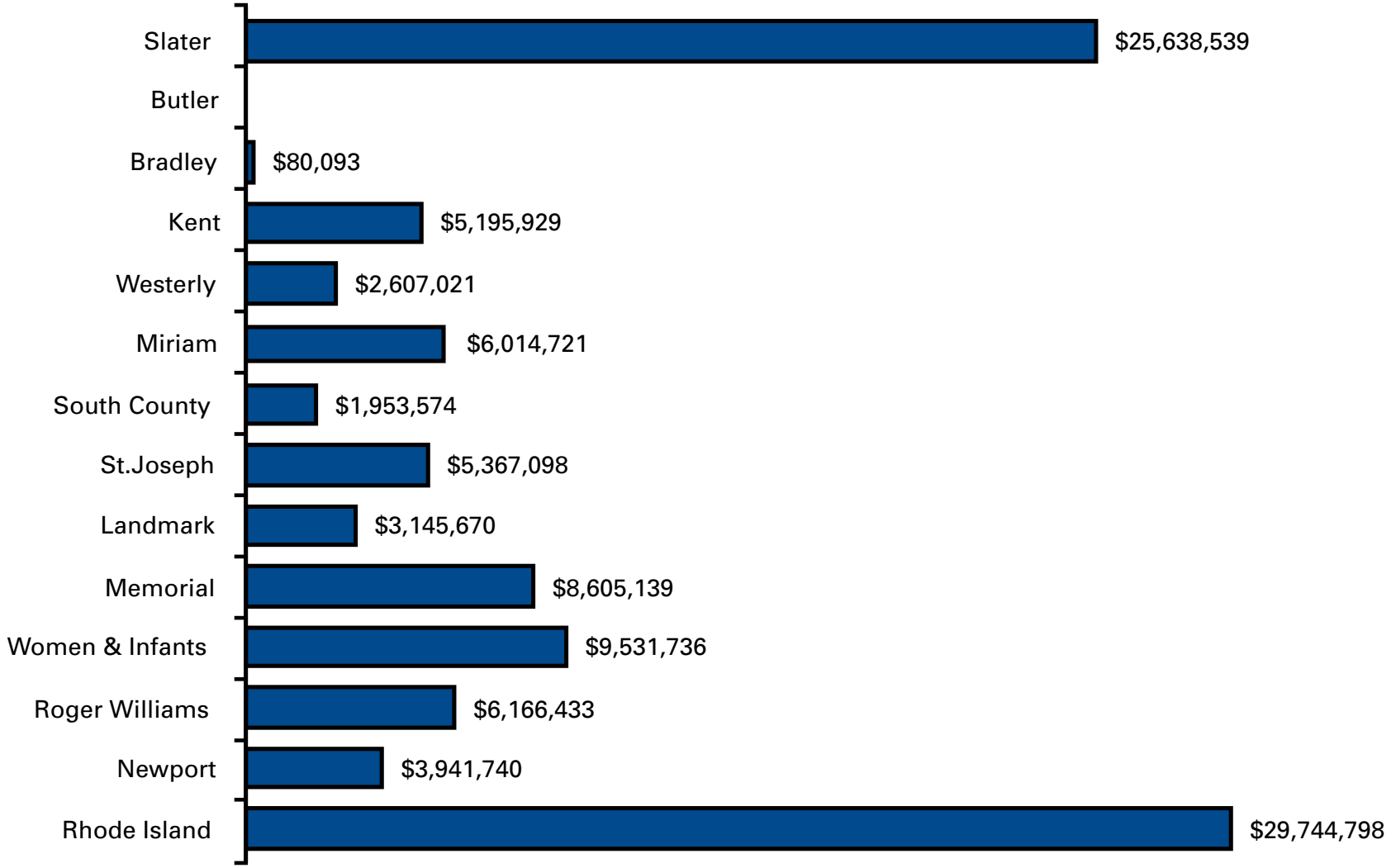
Table 2

Local Education Agency	Combined 2001	Combined 2002	Combined 2003	Combined 2004	Combined 2005
Barrington	$ 189,442	$ 337,362	$ 273,520	$ 298,792	$ 333,656
Bristol / Warren	$ 253,417	$ 571,256	$ 377,482	$ 473,470	$ 401,322
Burrillville	$ 282,691	$ 356,335	$ 400,939	$ 319,067	$ 359,845
Central Falls	$ 859,865	$ 1,128,647	$ 1,316,540	$ 1,727,250	$ 1,385,015
Chariho	$ 179,840	$ 304,269	$ 160,478	$ 390,468	$ 207,971
Coventry	$ 508,830	$ 550,030	$ 519,432	$ 623,113	$ 734,688
Cranston	$ 1,436,042	$ 1,592,576	$ 1,879,510	$ 2,160,765	$ 1,134,916
Cumberland	$ 532,343	$ 817,393	$ 658,270	$ 642,289	$ 673,816
E. Greenwich	$ 110,182	$ 306,362	$ 287,979	$ 338,539	$ 341,179
E. Providence	$ 863,679	$ 953,683	$ 1,258,055	$ 1,273,826	$ 1,085,027
Exeter-W. Greenwich	$ 144,048	$ 179,800	$ 343,448	$ 330,473	$ 292,897
Foster	$ 23,300	$ 44,008	$ 48,016	$ 68,107	$ 40,758
Foster/Glocester	$ 89,900	$ 41,600	$ 85,800	$ 81,049	$ 72,352
Glocester	$ 68,500	$ 91,500	$ 109,100	$ 175,654	$ 151,474
Jamestown	$ 75,900	$ 104,733	$ 116,752	$ 73,160	$ 104,652
Johnston	$ 342,944	$ 625,333	$ 602,726	$ 811,928	$ 770,654
Lincoln	$ 244,011	$ 289,700	$ 403,557	$ 450,300	$ 711,074
Narragansett	$ 116,491	$ 203,179	$ 261,650	$ 271,989	$ 174,248
New Shoreham	$ -	$ -	$ -	$ -	$ -
Newport	$ 523,281	$ 755,243	$ 606,795	$ 750,265	$ 649,141
Newport County Reg.	$ 414,184	$ 695,192	$ 636,288	$ 660,482	$ 525,864
N.Kingstown	$ 534,101	$ 745,084	$ 775,152	$ 825,333	$ 768,272
N.Providence	$ 488,410	$ 508,634	$ 461,637	$ 607,115	$ 744,100
N.Smithfield	$ 218,226	$ 149,647	$ 204,443	$ 198,697	$ 203,084
Pawtucket	$ 1,831,501	$ 2,150,986	$ 2,950,817	$ 2,416,996	$ 1,744,351
Providence	$ 5,105,903	$ 4,514,083	$ 5,574,770	$ 5,622,819	$ 4,476,397
School for the Deaf	$ 611,300	$ 350,000	$ 234,600	$ 149,747	$ 210,434
Scituate	$ 78,800	$ 89,700	$ 105,600	$ 159,423	$ 180,350
Smithfield	$ 227,421	$ 245,380	$ 314,875	$ 308,725	$ 265,862
S.Kingstown	$ 786,568	$ 675,088	$ 764,661	$ 916,998	$ 700,393
Warwick	$ 932,462	$ 1,506,557	$ 2,248,409	$ 1,970,802	$ 1,717,850
W. Warwick	$ 419,311	$ 441,274	$ 578,538	$ 674,276	$ 535,998
Westerly	$ 497,668	$ 535,551	$ 590,123	$ 601,282	$ 446,200
Wm. M. Davies	$ 4,763	$ 26,765	$ -	$ -	$ 5,805
Woonsocket	$ 980,920	$ 1,076,188	$ 1,125,643	$ 1,217,711	$ 1,173,791
Kinston Hill Academy	$ -	$ -	$ 5,000	$ -	$ -
Paul Cuffee School	$ -	$ -	$ 1,900	$ 3,500	$ 100
East Bay Educational Collab	$ -	$ -	$ -	$ 15,400	$ 18,500
Met Career & Tech Ctr	$ -	$ -	$ -	$ 141,769	$ 178,271
International Charter School	$ -	$ -	$ -	$ -	$ 13,800
Blackstone Academy Charter	$ -	$ -	$ -	$ -	$ 33,530
CVS Highlander Charter School	$ -	$ -	$ -	$ -	$ 14,407
Compass Charter School	$ -	$ -	$ -	$ -	$ -
Beacon Charter School	$ -	$ -	$ -	$ -	$ -
The Learning Community	$ -	$ -	$ -	$ -	$ -
Totals	**$ 19,976,244**	**$ 22,625,776**	**$ 26,282,505**	**$ 27,751,579**	**$ 23,651,643**

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 2005

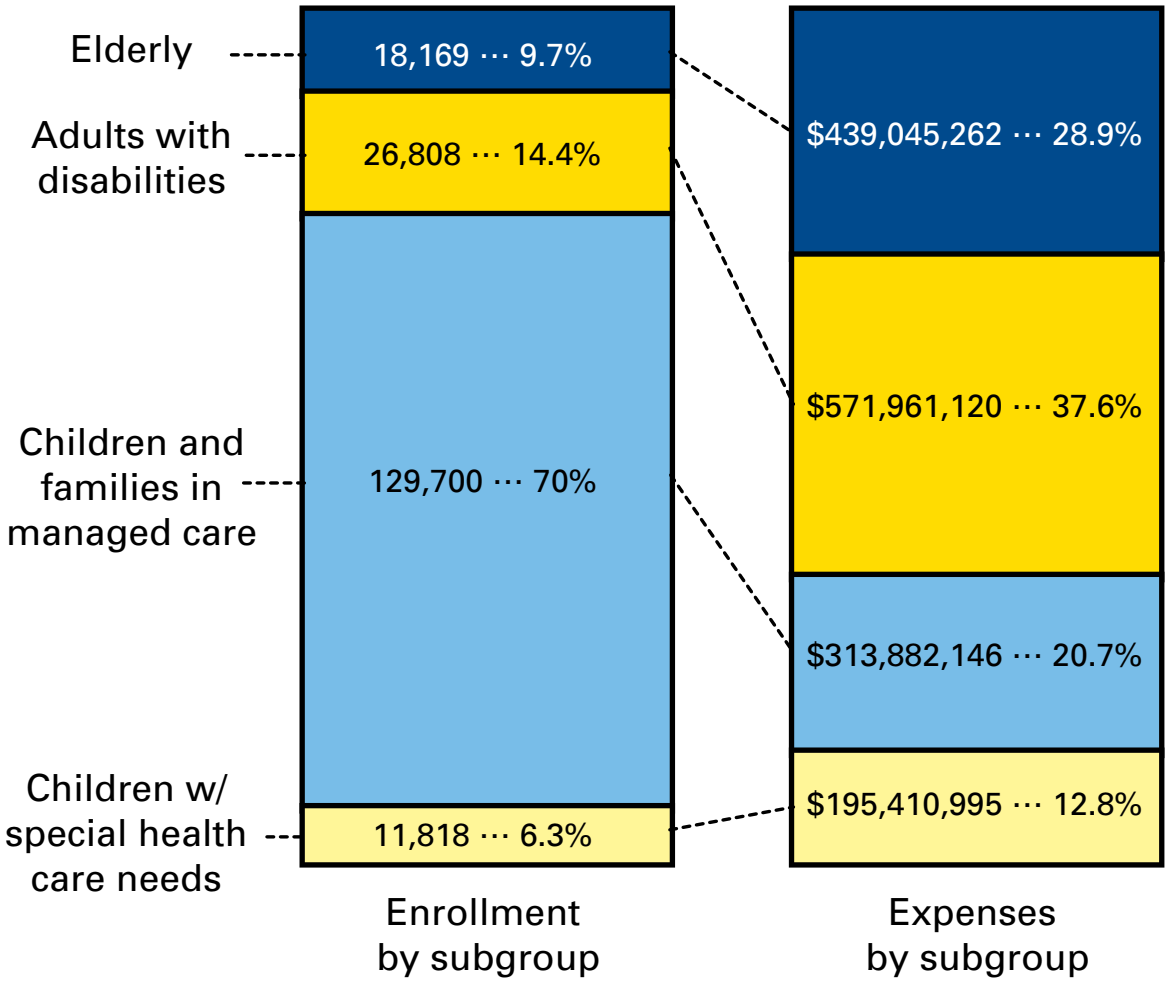


Note: Does not include Psychiatric & Graduate medical education DSH pool

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 2005

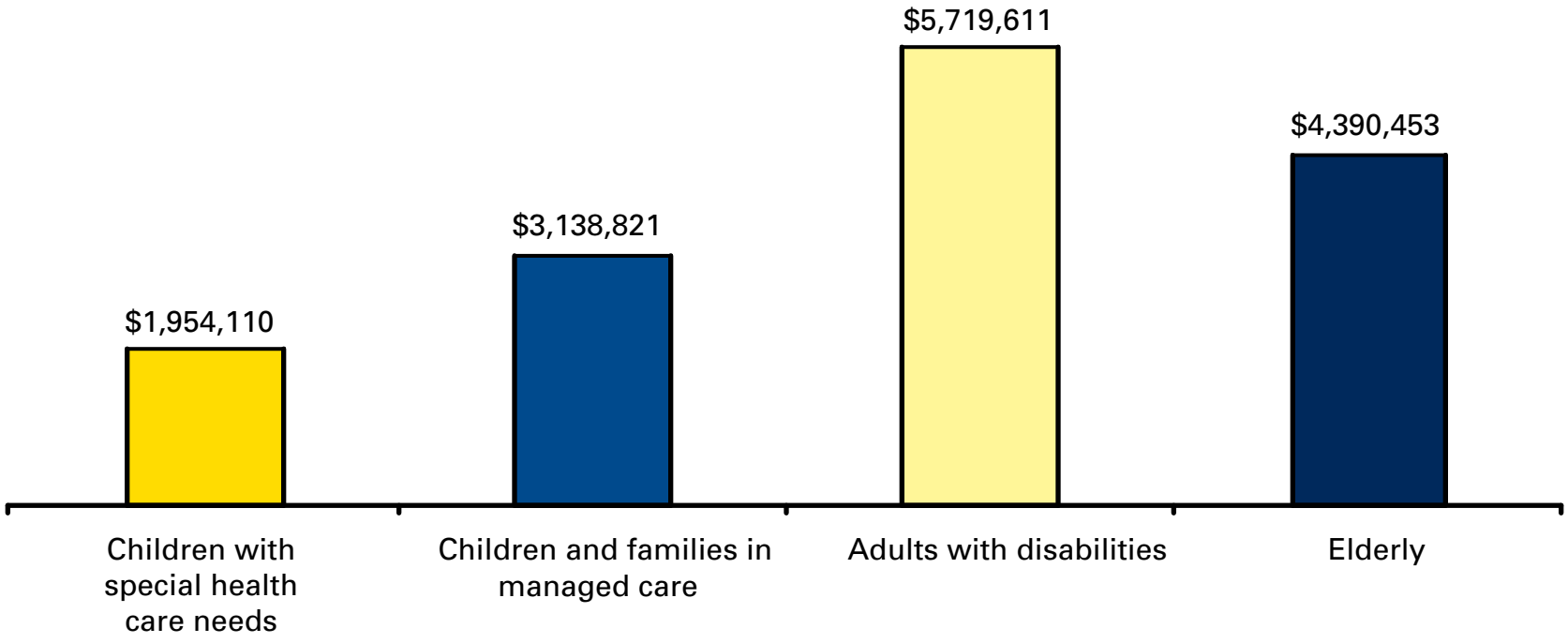


Source: Medicaid claims extract

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 2005

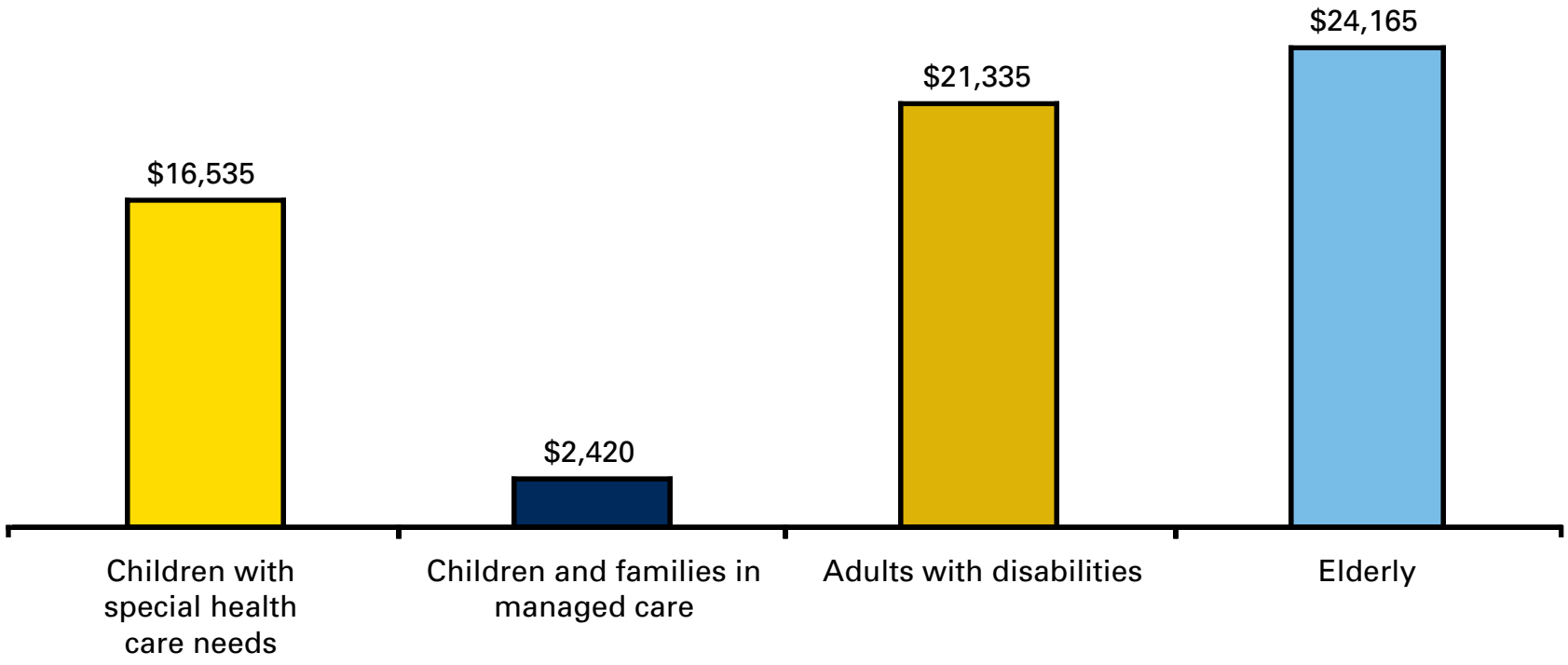


Source: Medicaid claims extract

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 Medicaid costs
SFY 2005

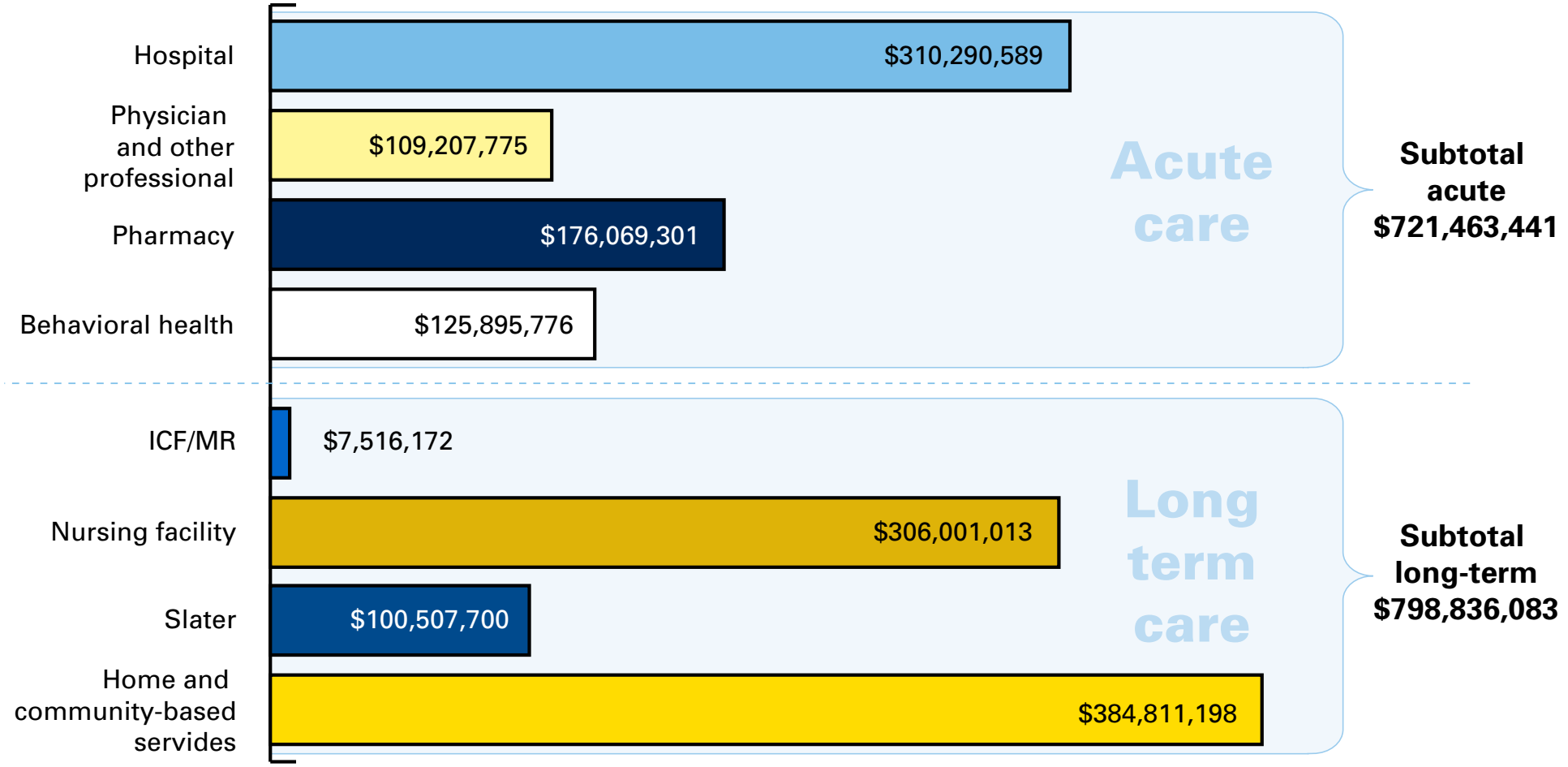


Source: Medicaid claims extract

Three provider groups represent 66% of total Medicaid spending

- 52% of Medicaid spending is to provide long term care to individuals

Figure 8
Medicaid expenses by service provider
SFY 2005

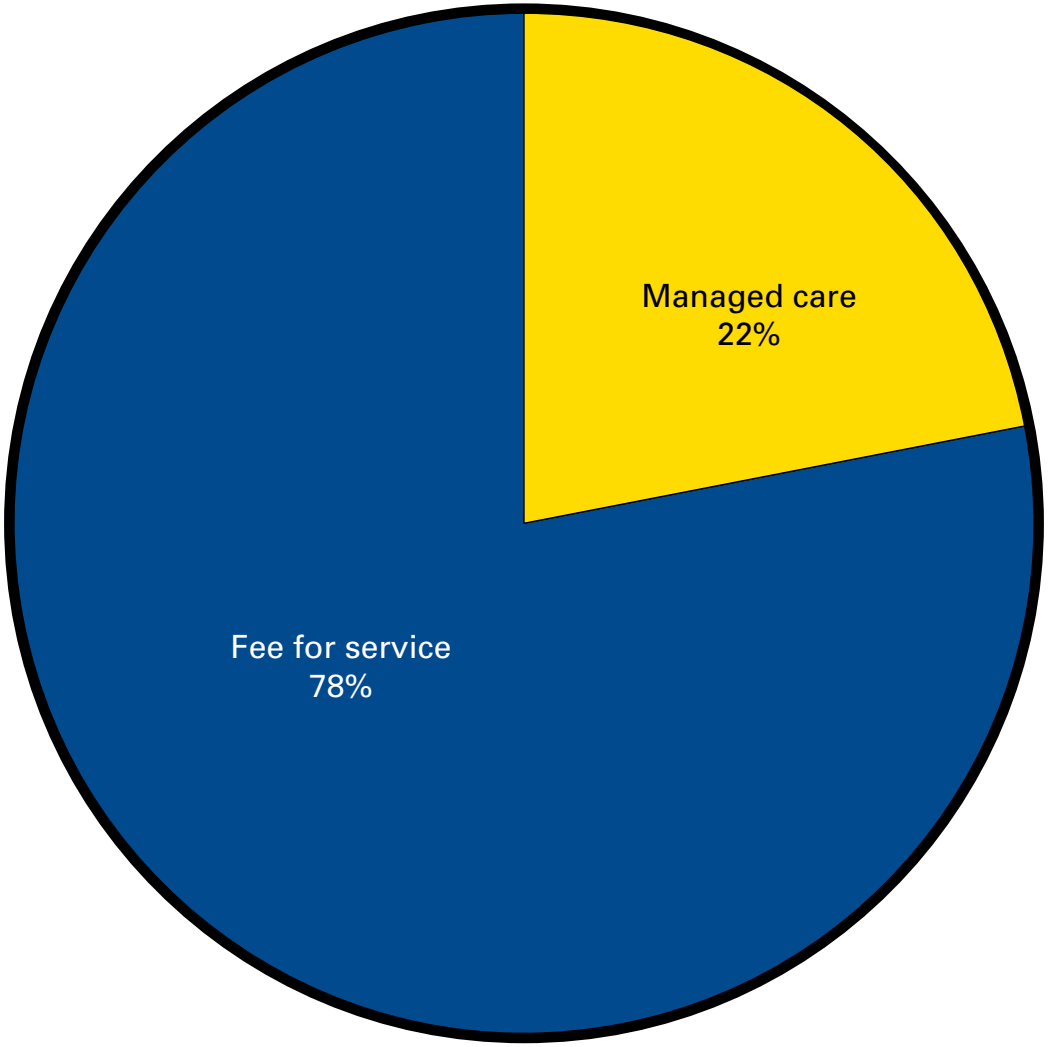


Note: HCBS includes both services in consumers' homes and group home settings

Source: Medicaid claims extract

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

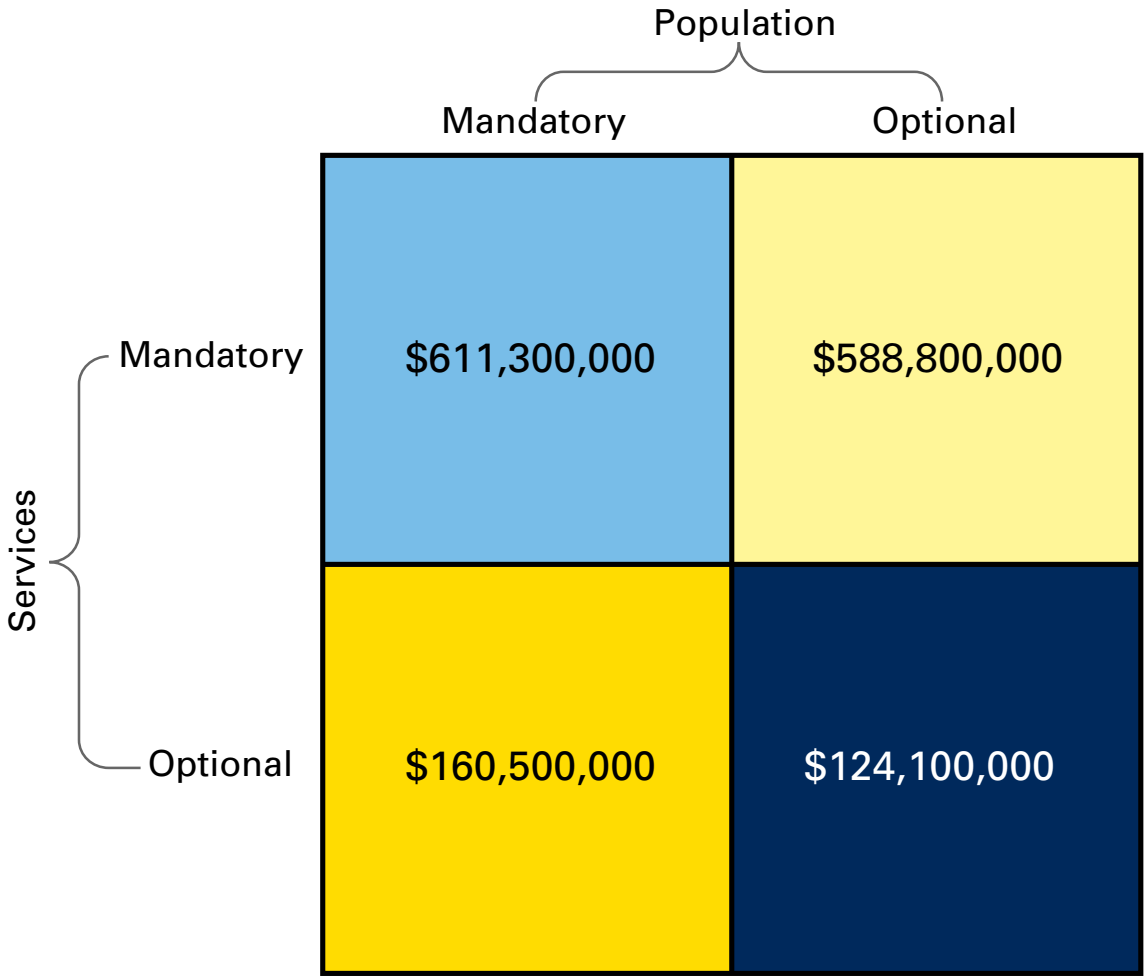
Figure 9
Fee for service vs managed care
SFY 2005



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 2005



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

Note: Excludes some waiver costs

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

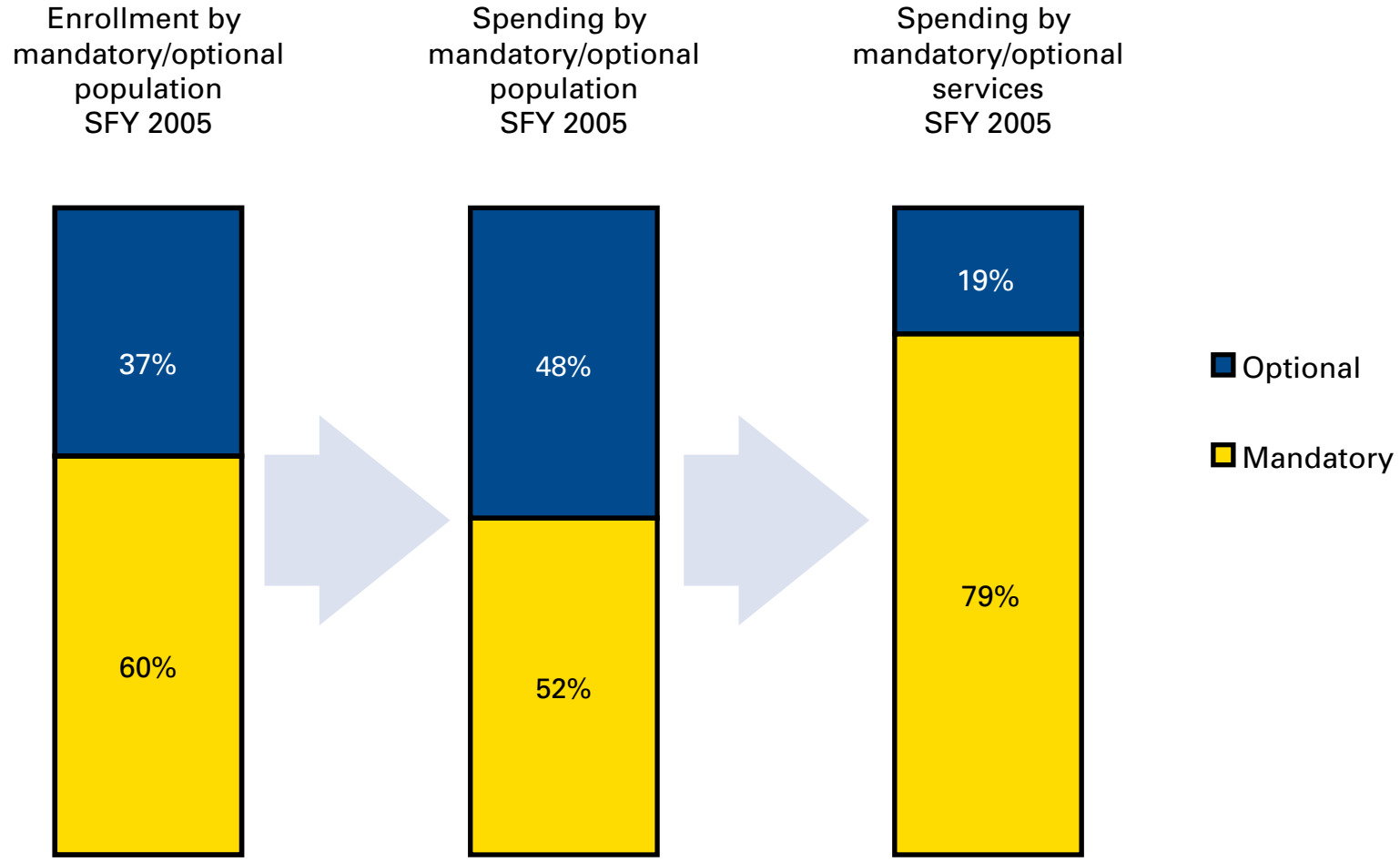
Medicaid mandatory and optional populations & services - 2 of 2

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 costs

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 (PARI)
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

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 prep						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

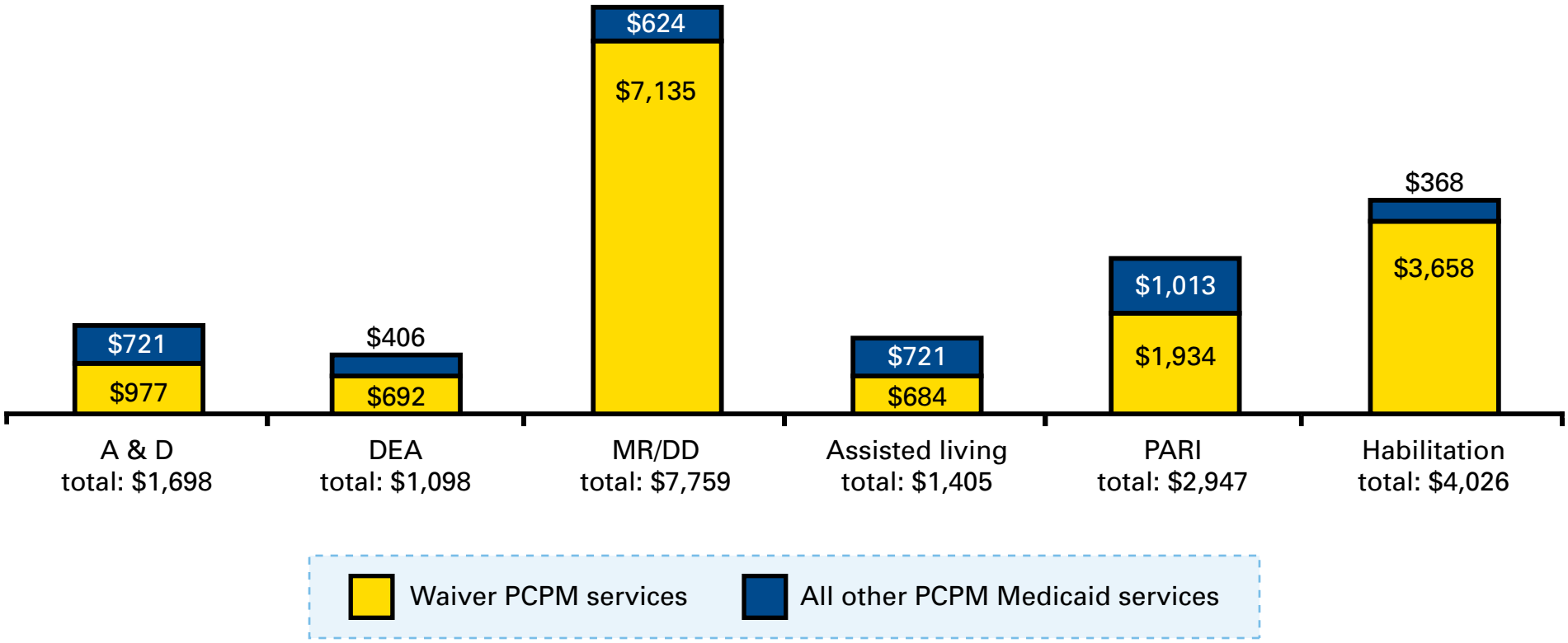
Table 7

Waiver	A&D	DEA	Asst living	Consumer directed (PARI)	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: Hemi- or Quadriplegic	Hospital Level of Care: Disability	ICF/MR Level of Care: Developmental Disability
Daily cap	1,750	950	200*	150	25	3500
SFY 2005 participants	1,747	608	288	88	24	2,780

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

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

Figure 12
HCBS waiver
PCPM expenditures
SFY 2005



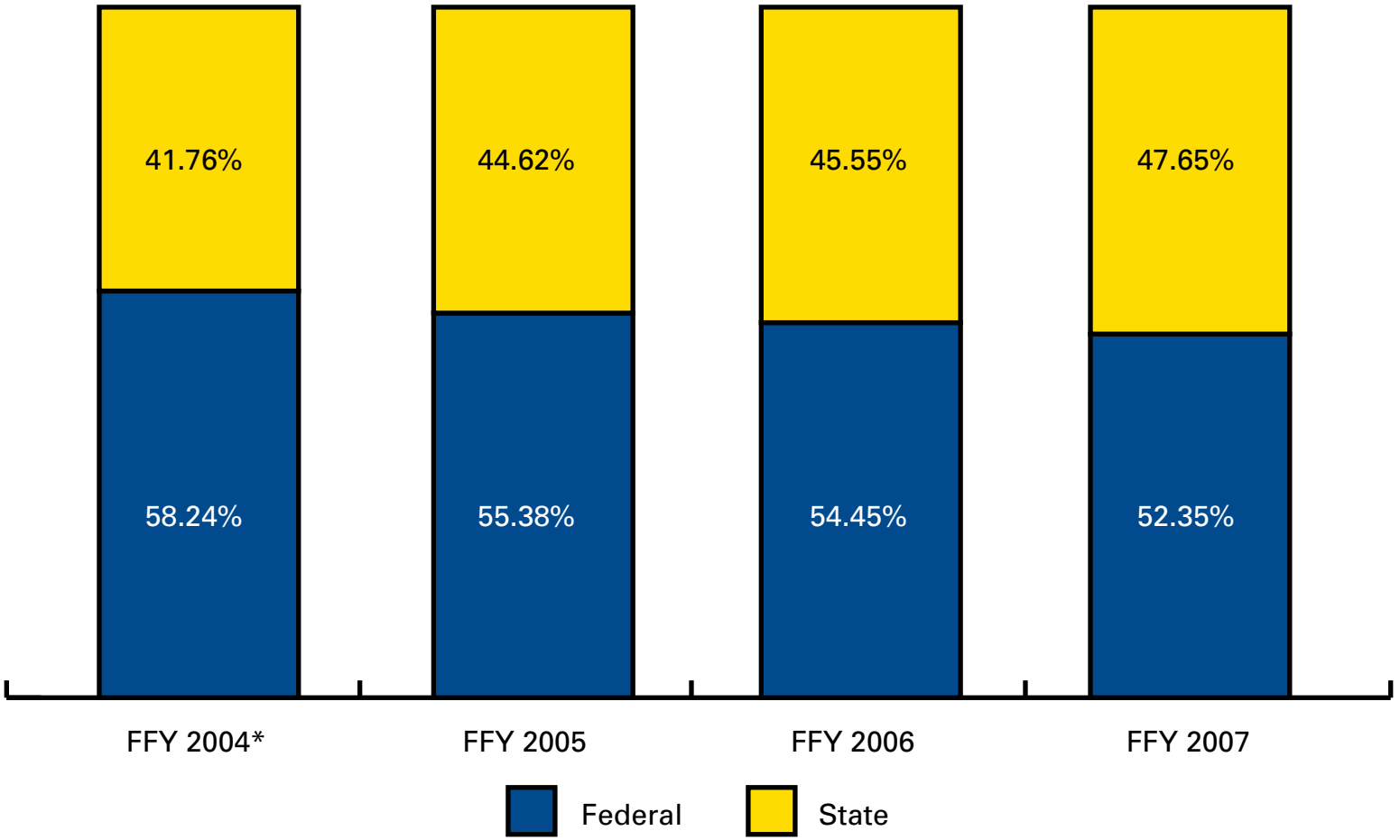
Source: Department of Human Services

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

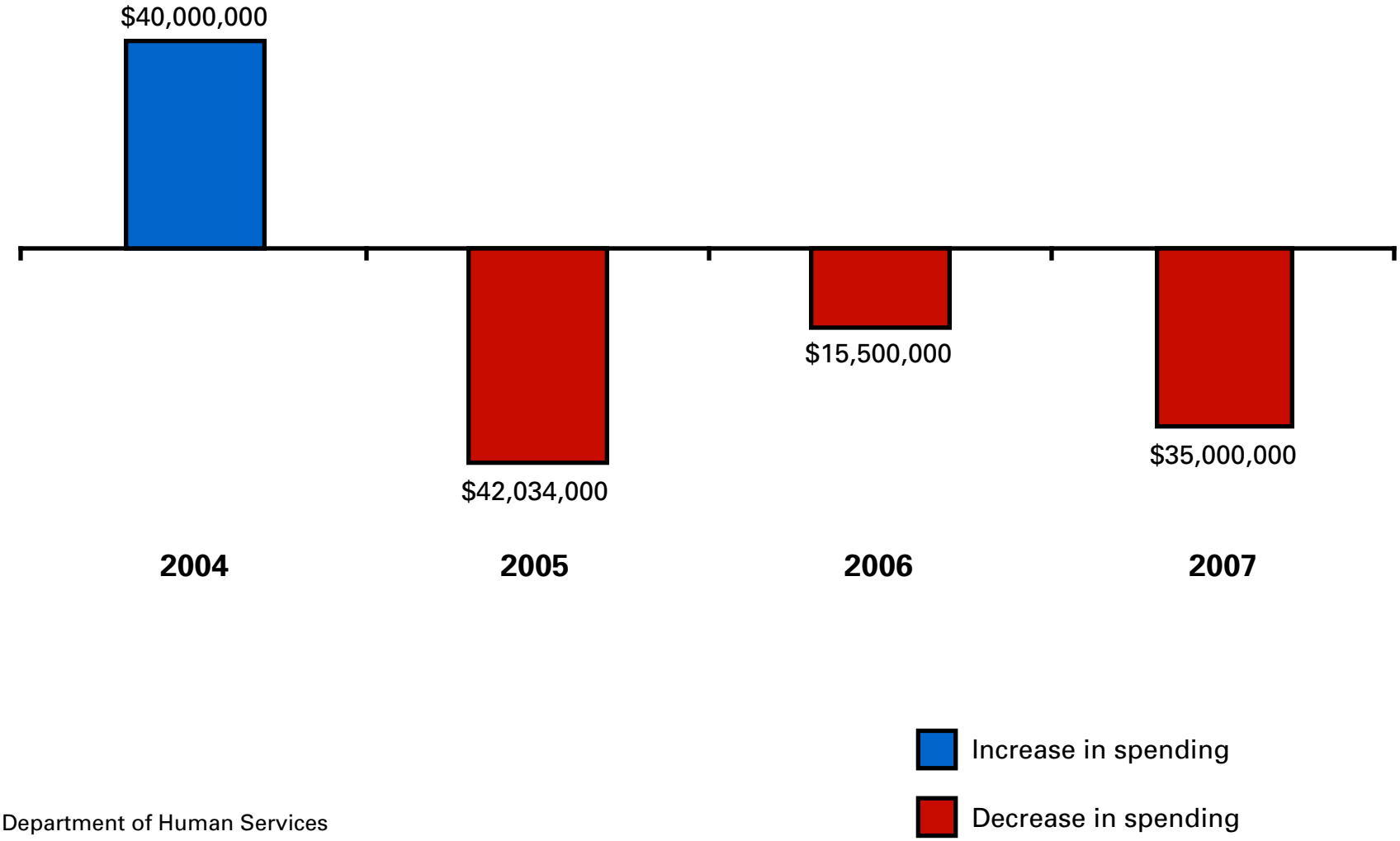


*Notes federal windfall based on special legislation, *Jobs and Economic Tax Relief Reconciliation Act of 2003*

Source: Department of Human Services

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

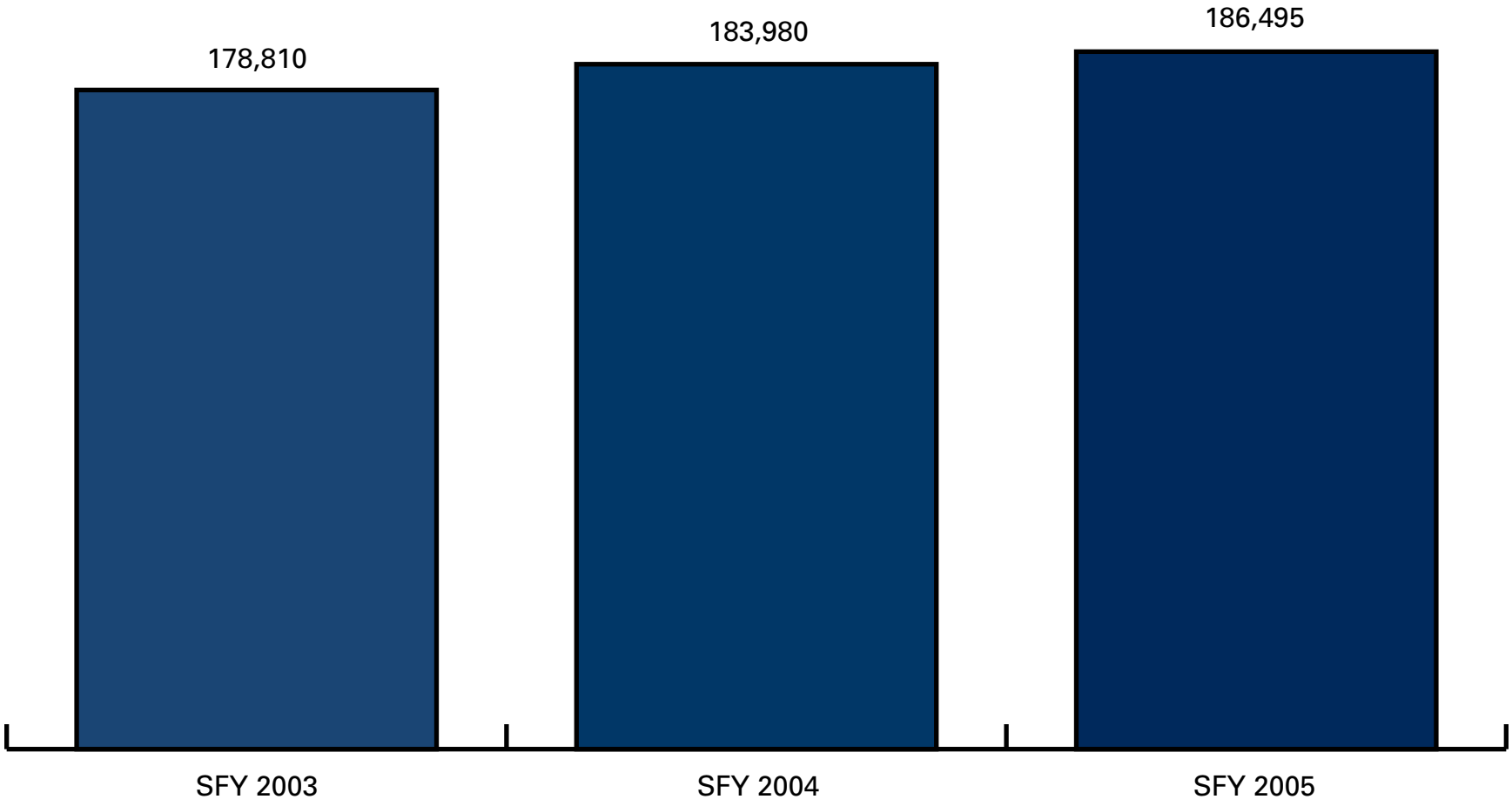
Figure 14
Value of change in FMAP
FFY 2004 - FFY 2007



Source: Department of Human Services

Medicaid enrollments have increased by 4% since 2003

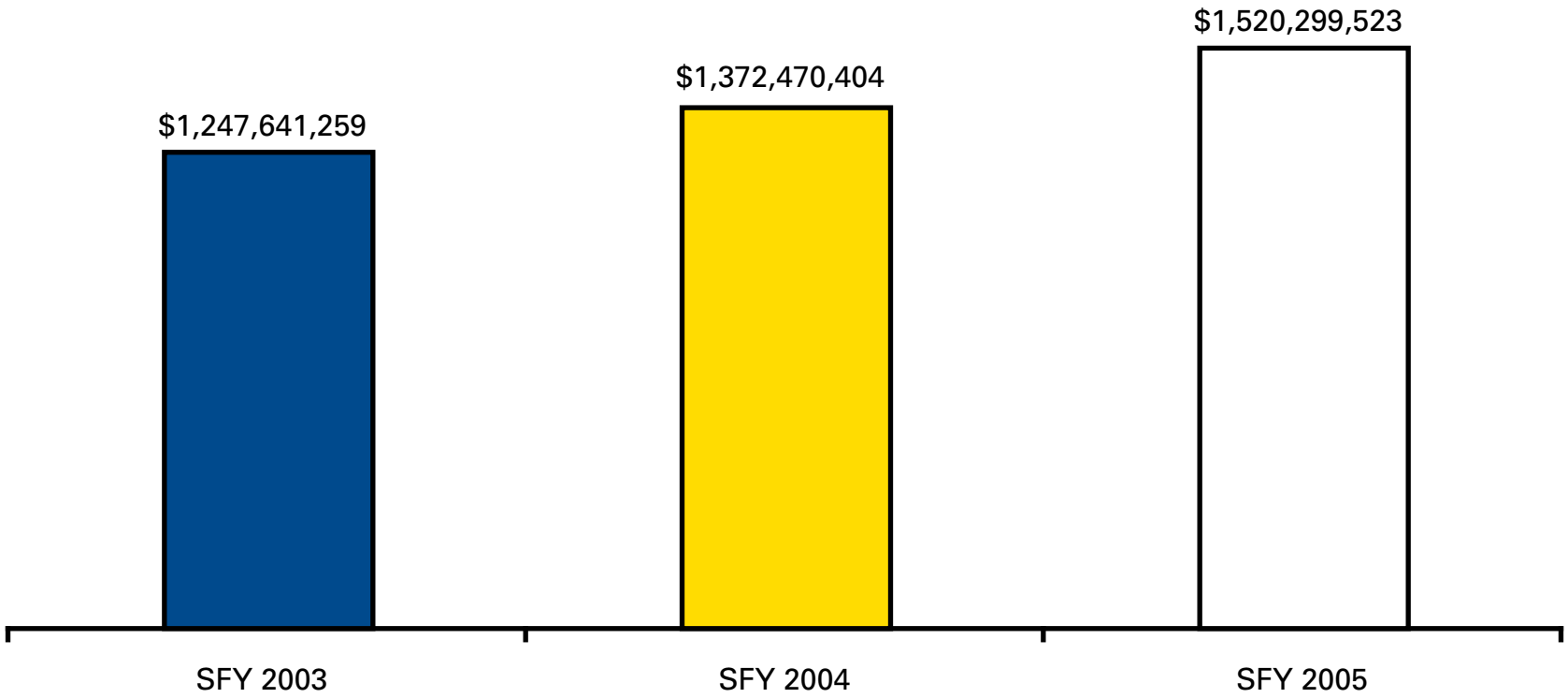
Figure 15
Enrollment trends



Source: Medicaid claims extract

Medicaid spending has grown by 22% since 2003

Figure 16
Total Medicaid spending
(all funds)



Note: Excludes DSH and administrative costs

Source: Medicaid claims extract

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

Figure 17
Change in enrollment
SFY 2003 - SFY 2005

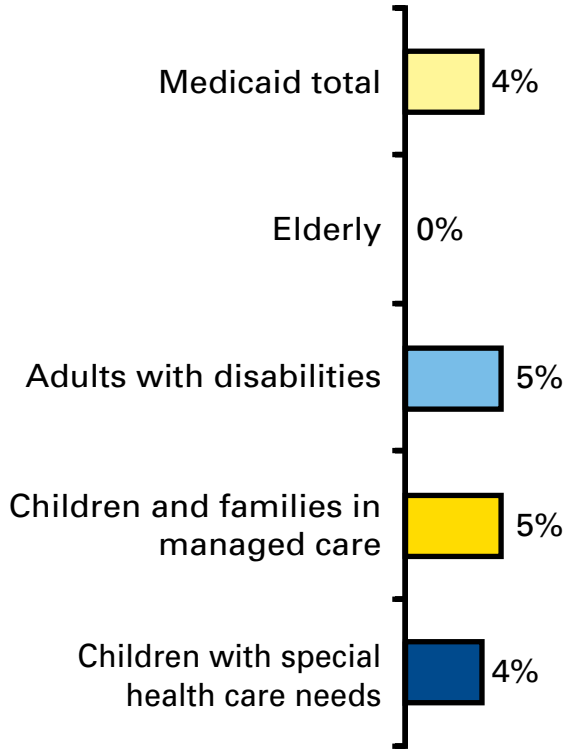
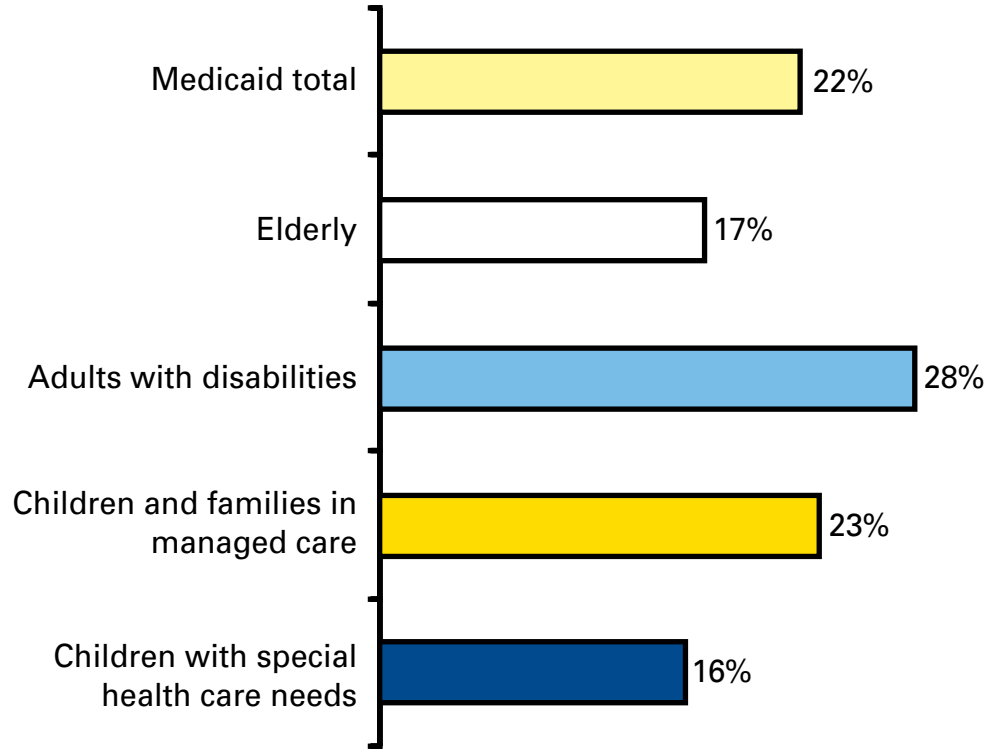


Figure 18
Change in spending
SFY 2003 - SFY 2005



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 2005

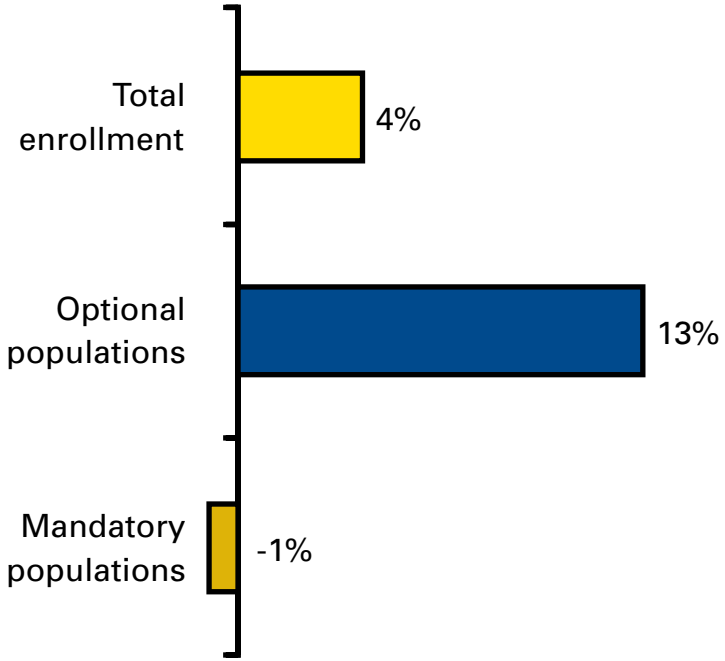
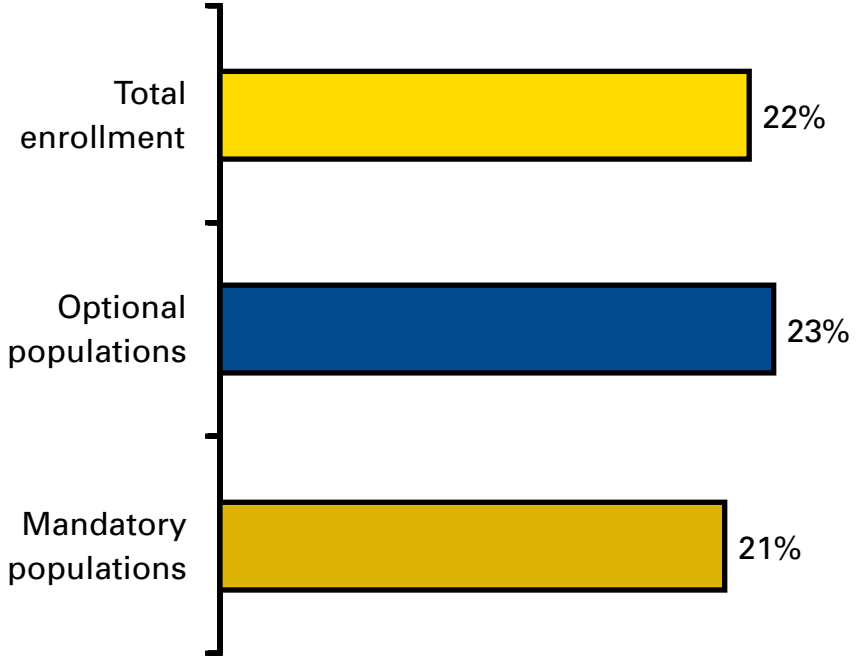


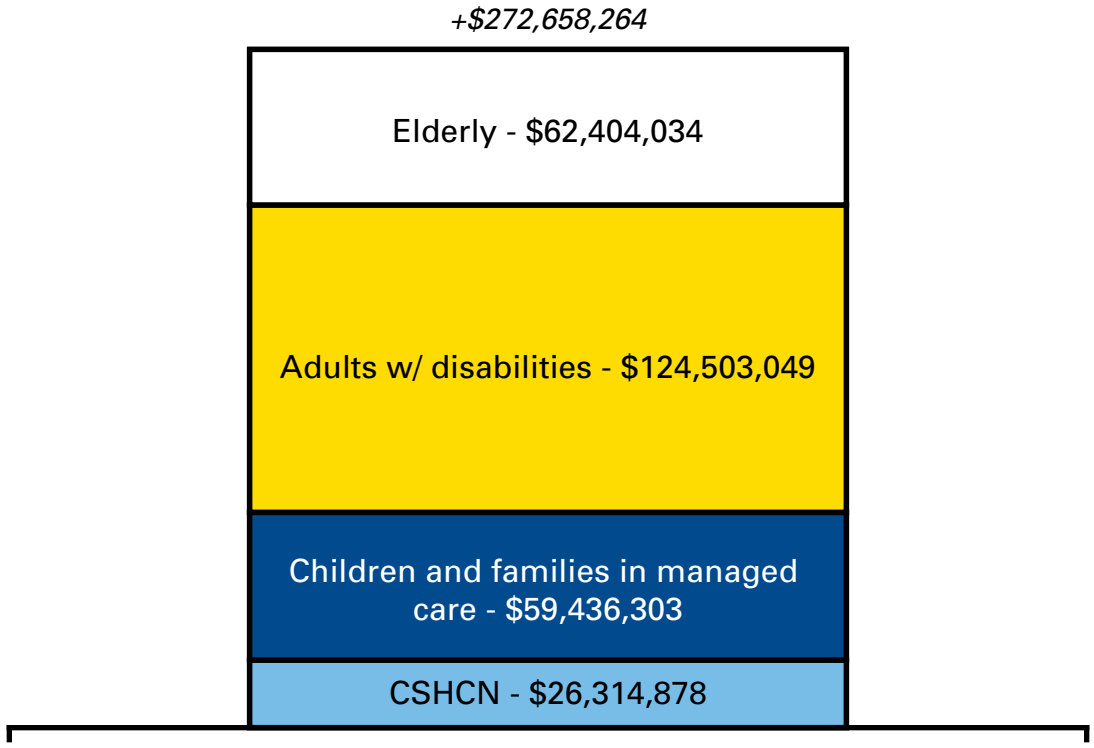
Figure 20
Change in spending
mandatory versus optional populations
SFY 2003 - SFY 2005



Source: Medicaid claims extract

Adults with disabilities represent 46% of the overall spending increase in Medicaid over the last two years

Figure 21
Spending change by beneficiary category
SFY 2003 - SFY 2005

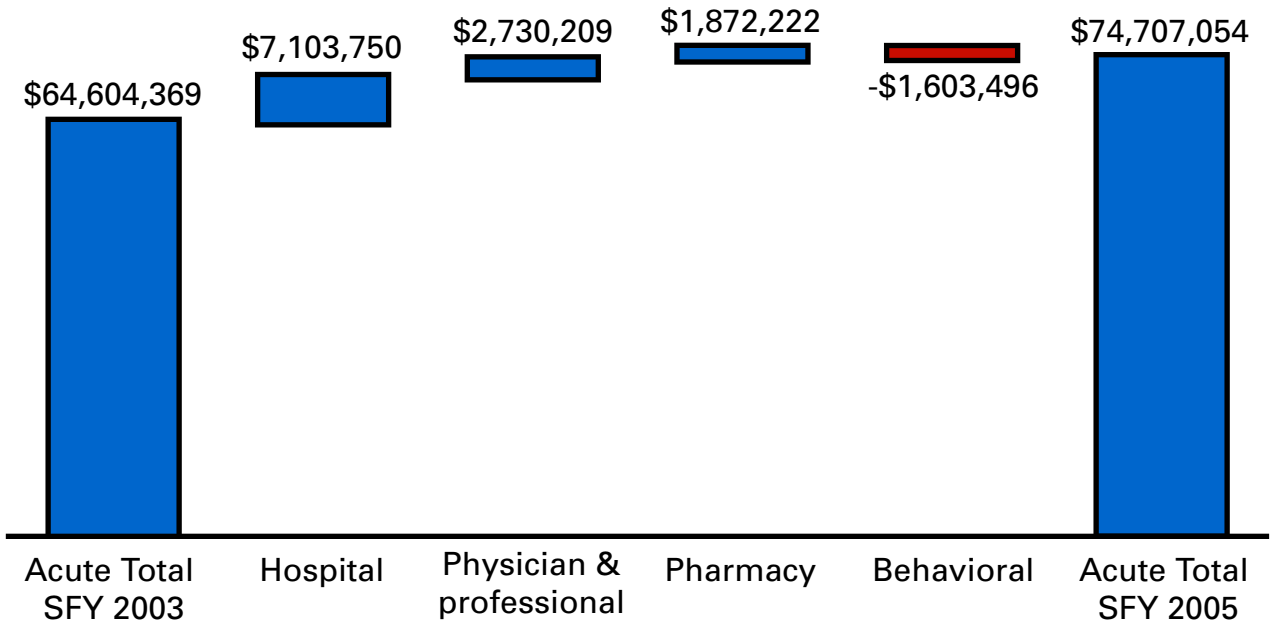


Source: Medicaid claims extract

Spending analysis by beneficiary category

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

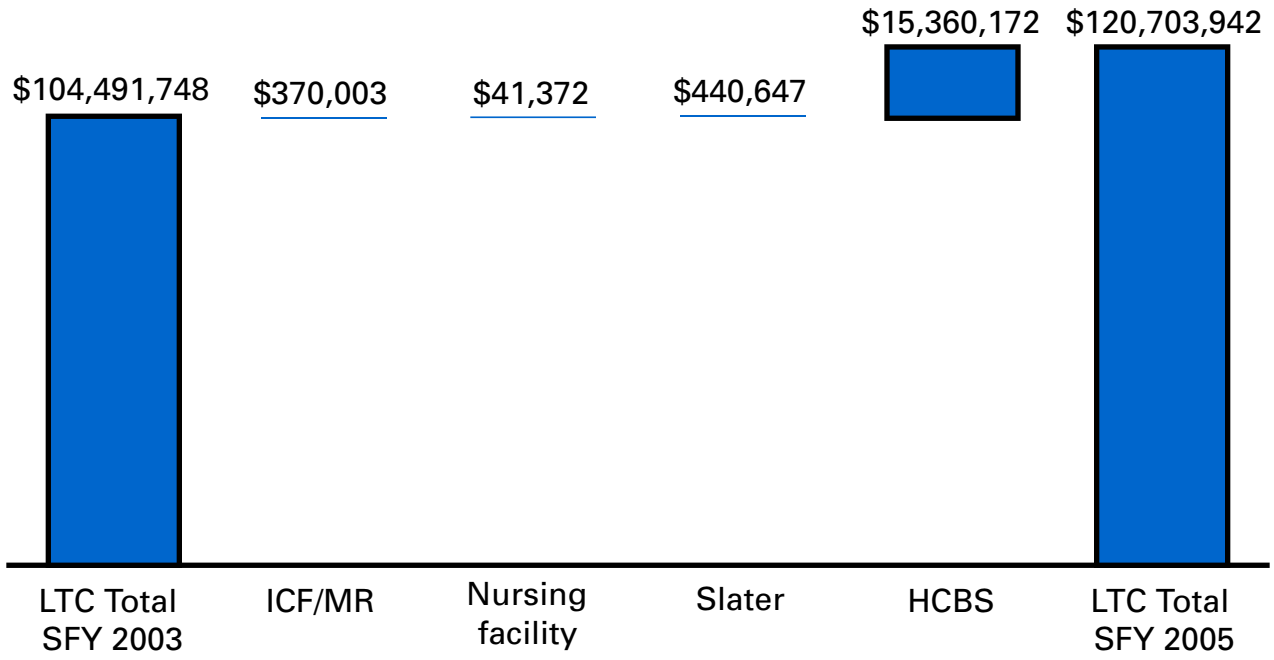
Figure 22
Change in Medicaid spending - children with special health care needs by service provider SFY 03 to SFY 05



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

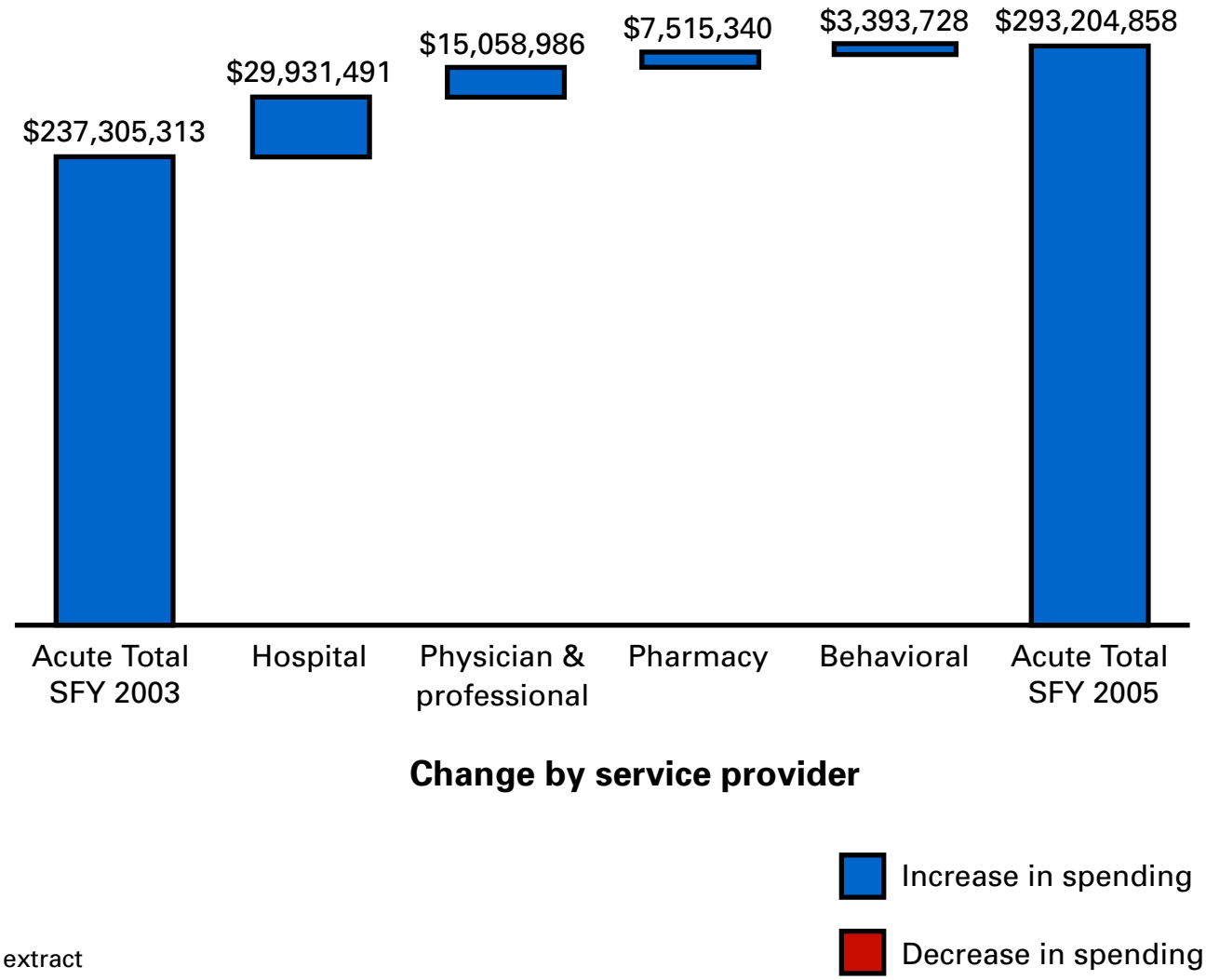
Figure 23
Change in Medicaid spending - children with special health care needs by service provider SFY 03 to SFY 05



Source: Medicaid claims extract

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

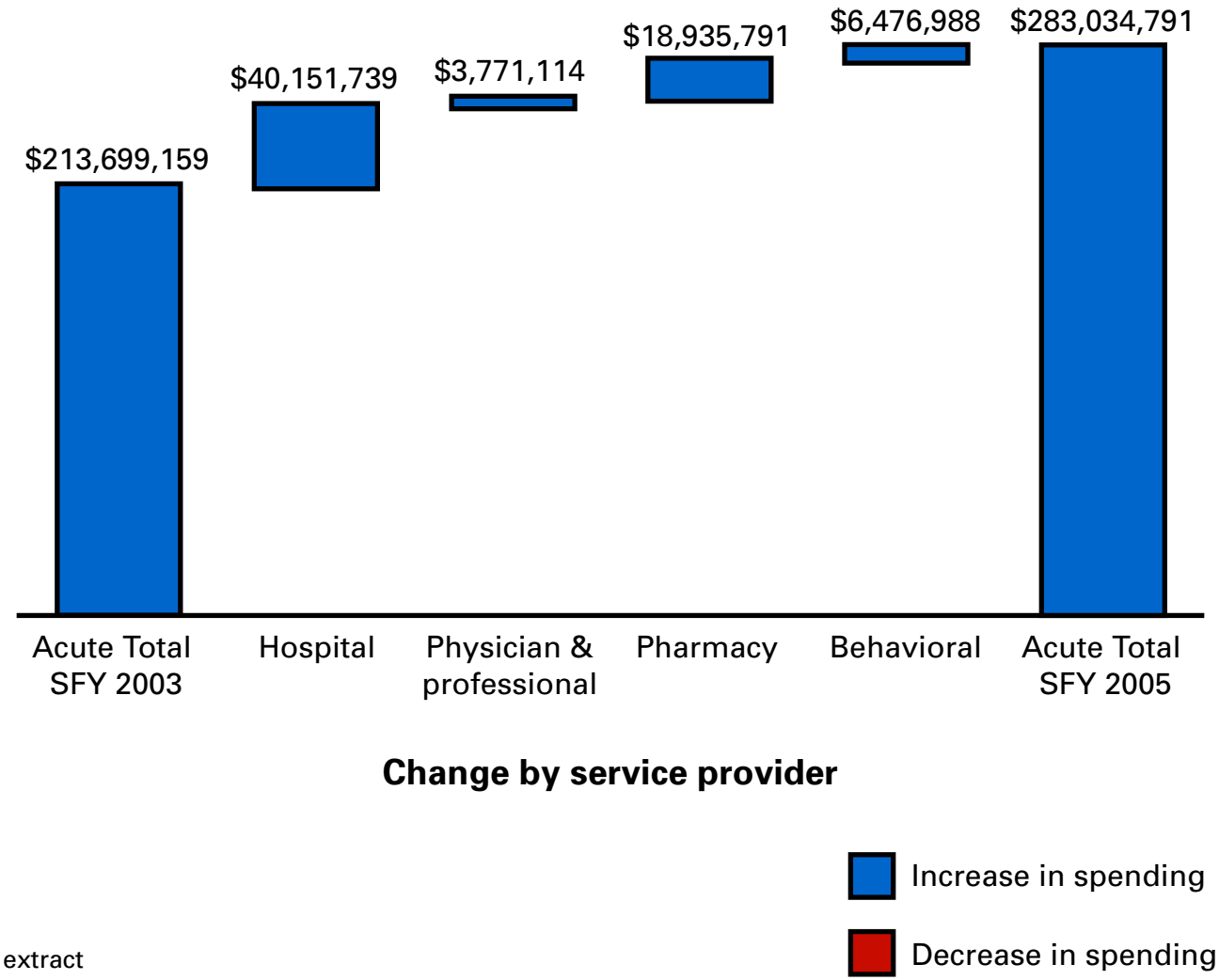
Figure 24
Change in Medicaid spending - children and families in managed care by service provider SFY 03 to SFY 05



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 05

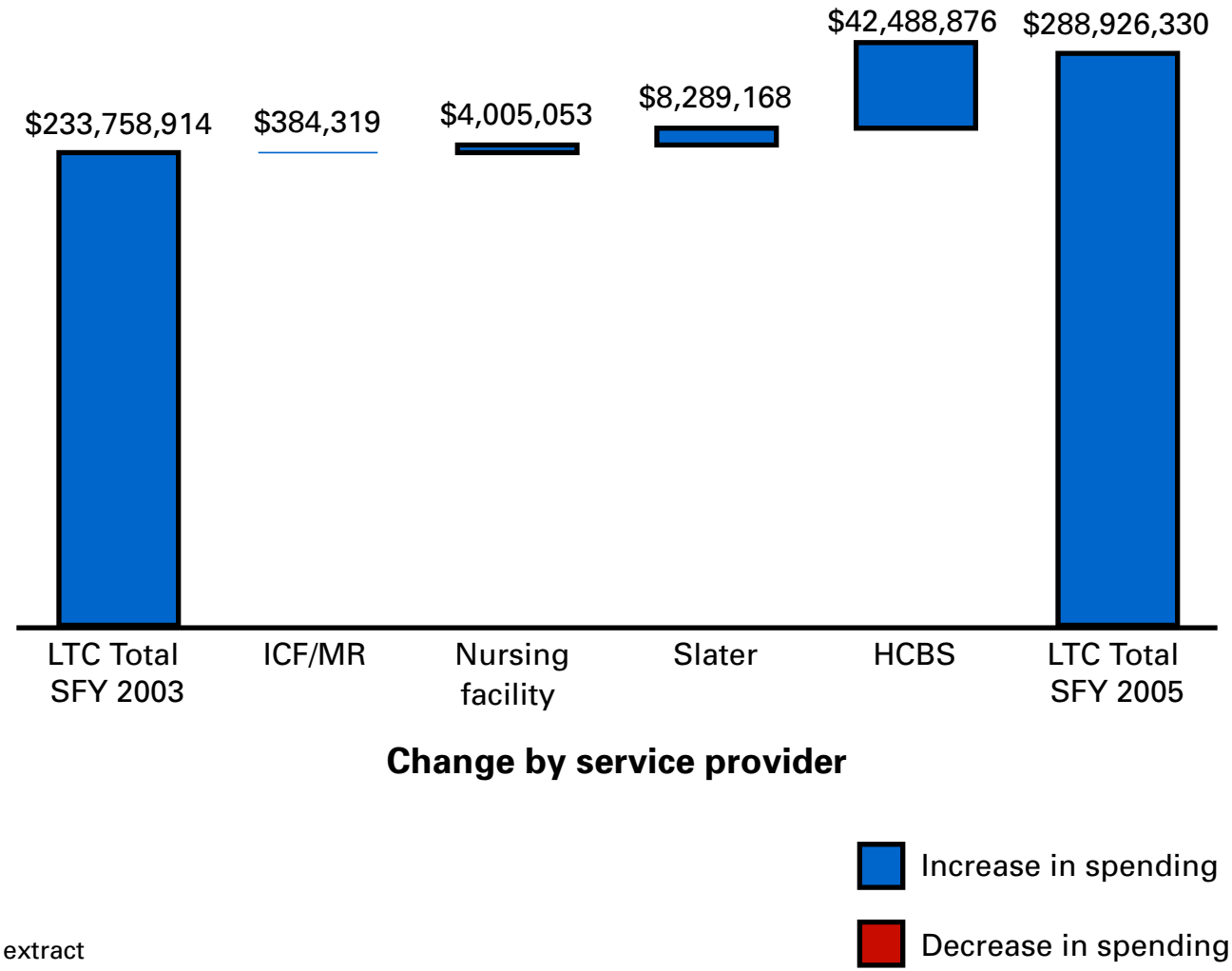


Source: Medicaid claims extract

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

• Does not reflect impact of Medicare Part D

Figure 26
Change in Medicaid spending - adults with disabilities by service provider SFY '03 to SFY '05

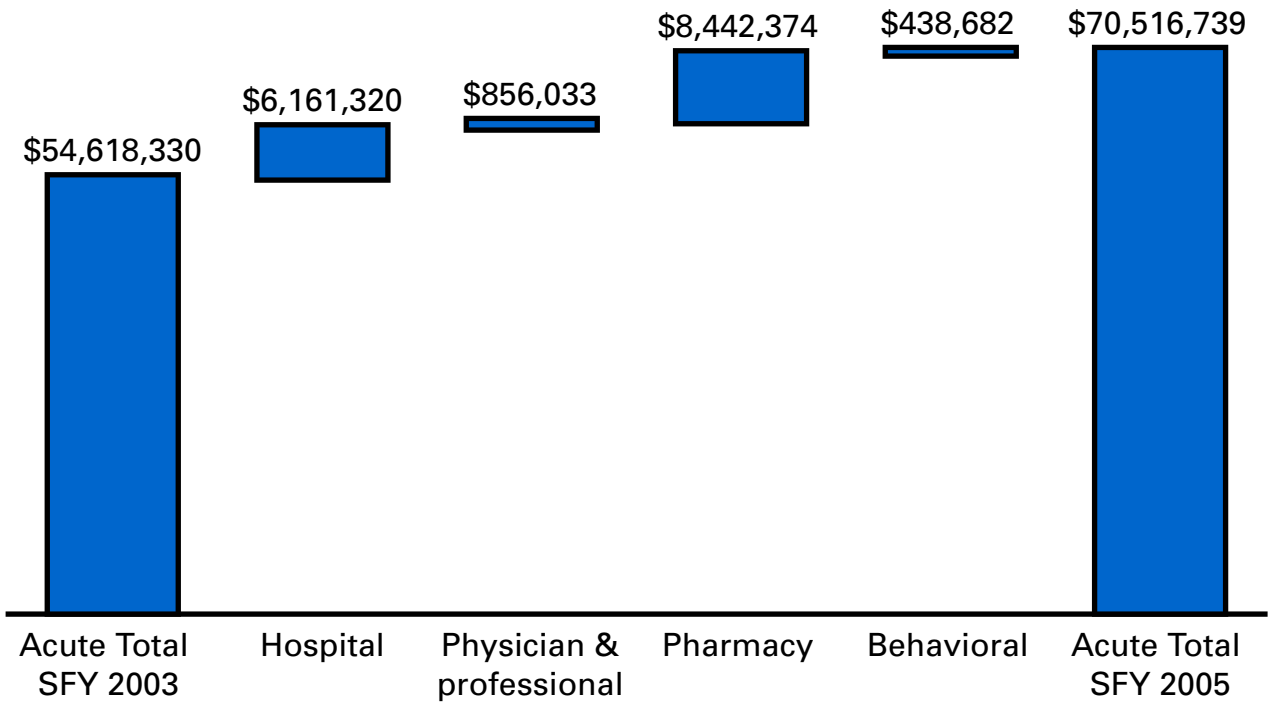


Source: Medicaid claims extract

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

• Does not reflect impact of Medicare Part D

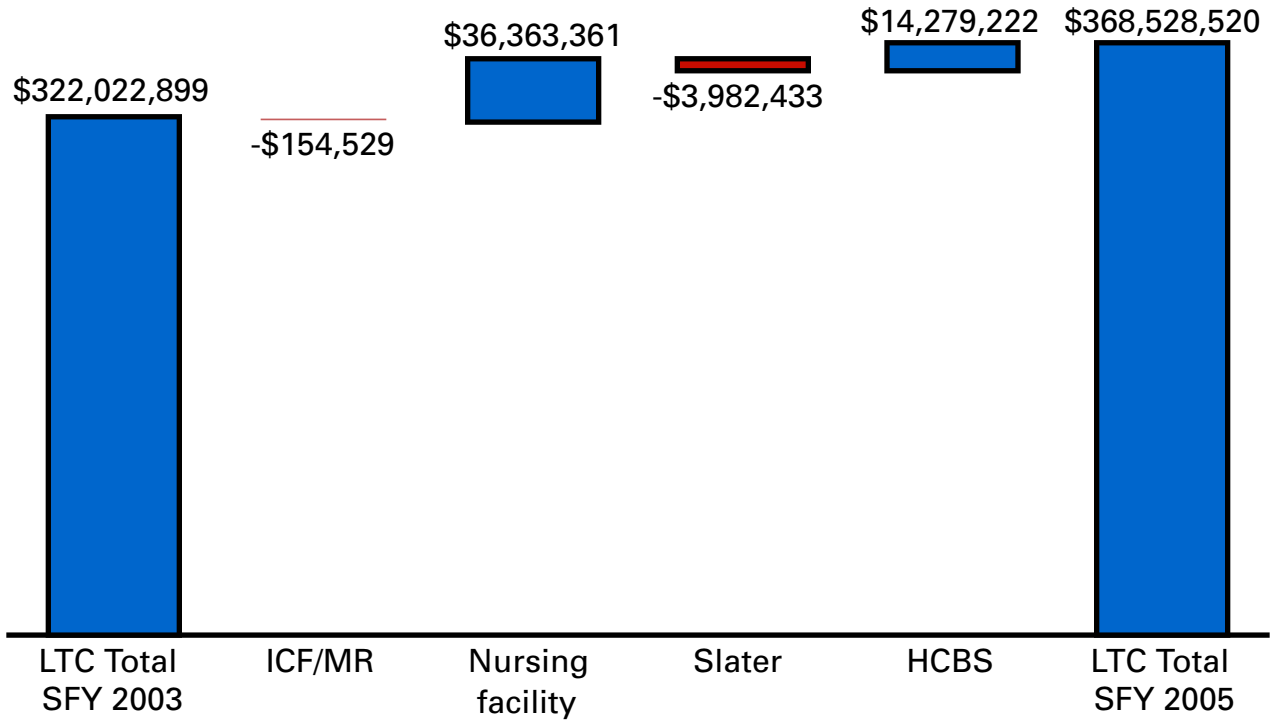
Figure 27
Change in Medicaid spending - elderly by service provider SFY 03 to SFY 05



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 05



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
Change in Medicaid spending by type of care
SFY 2003 - SFY 2005

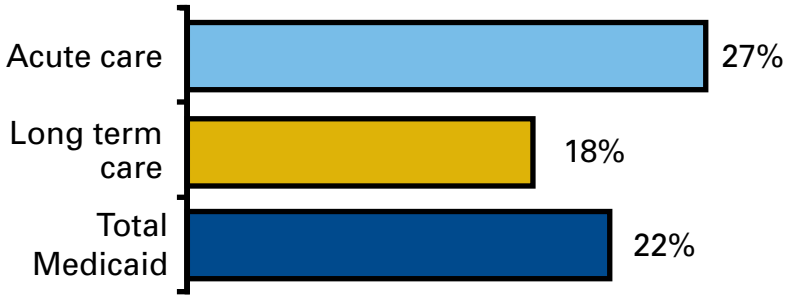
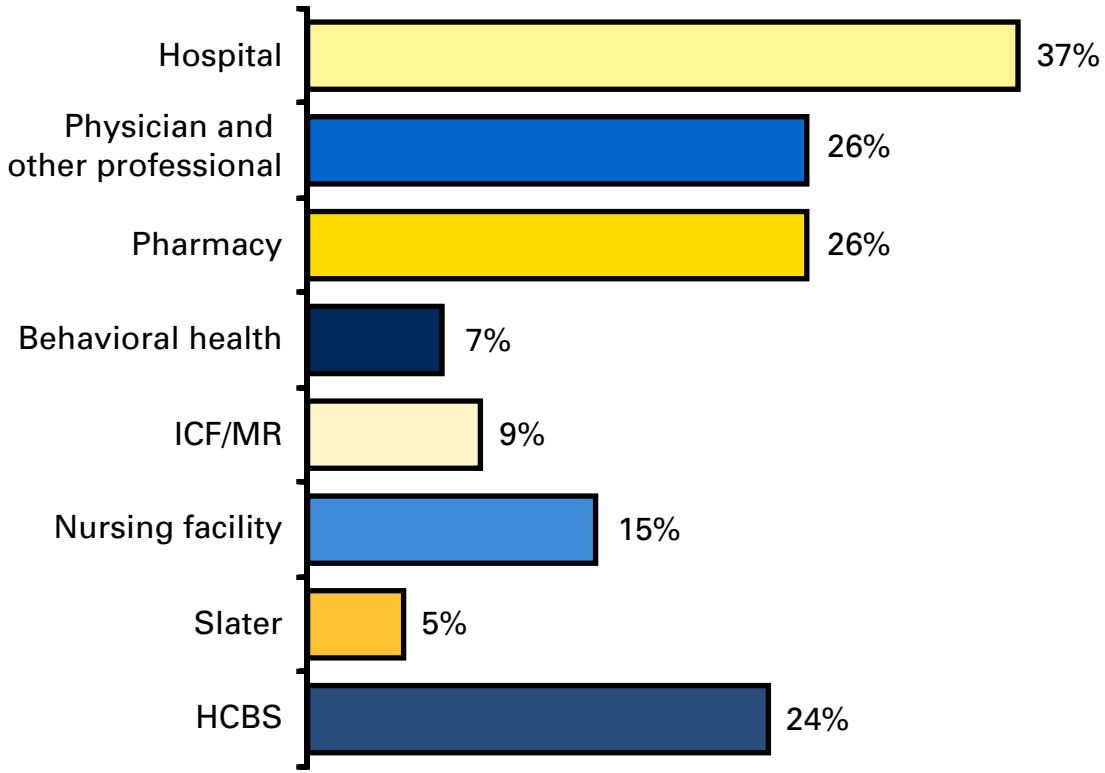


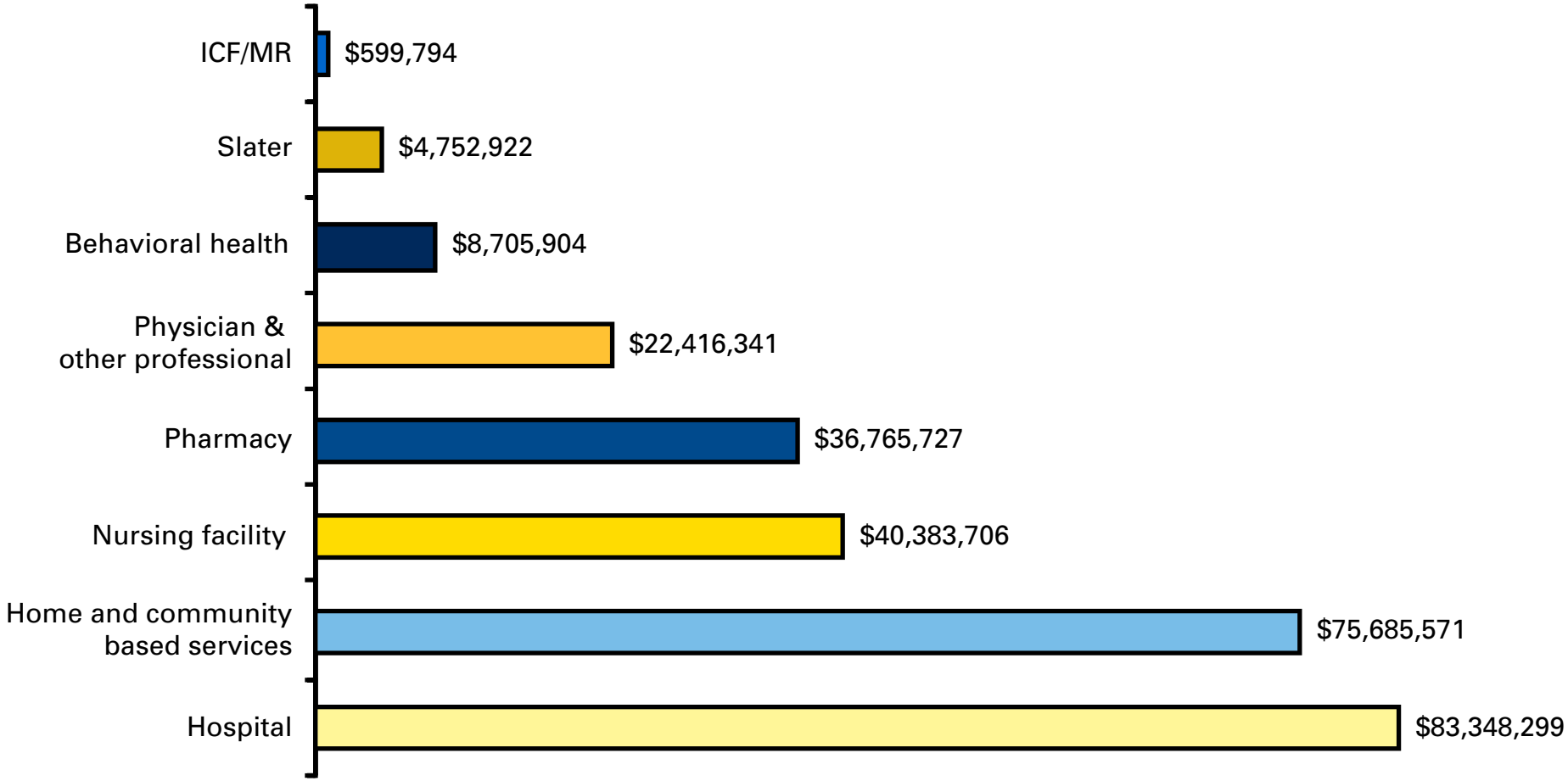
Figure 30
Change in Medicaid spending by service provider
SFY 2003 - SFY 2005



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 2005

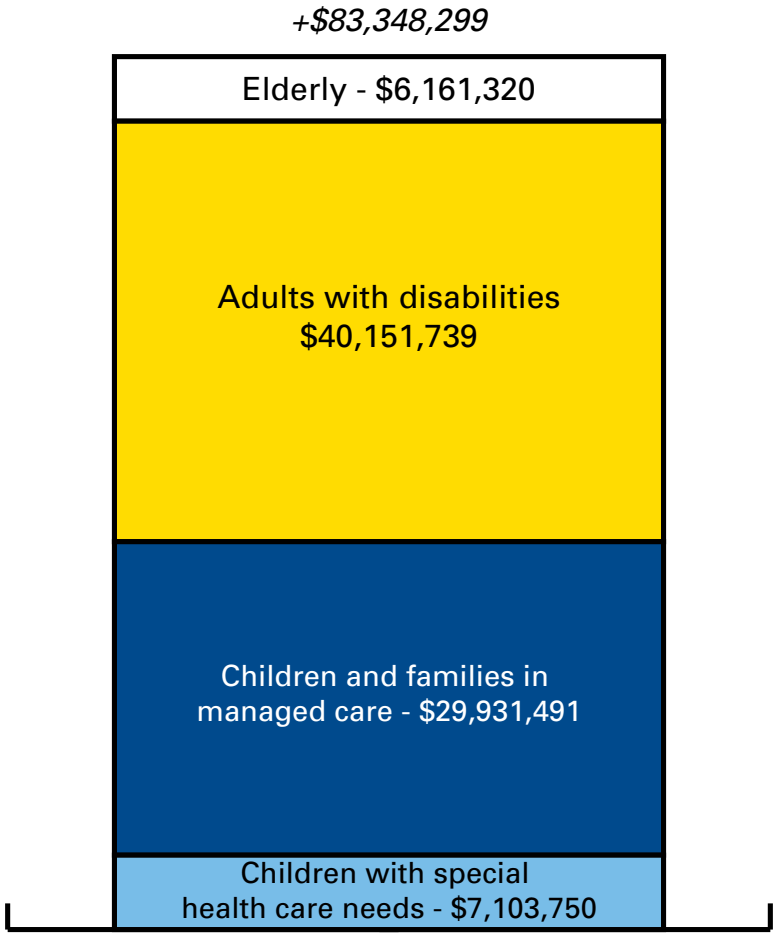


Source: Medicaid claims extract

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 2005

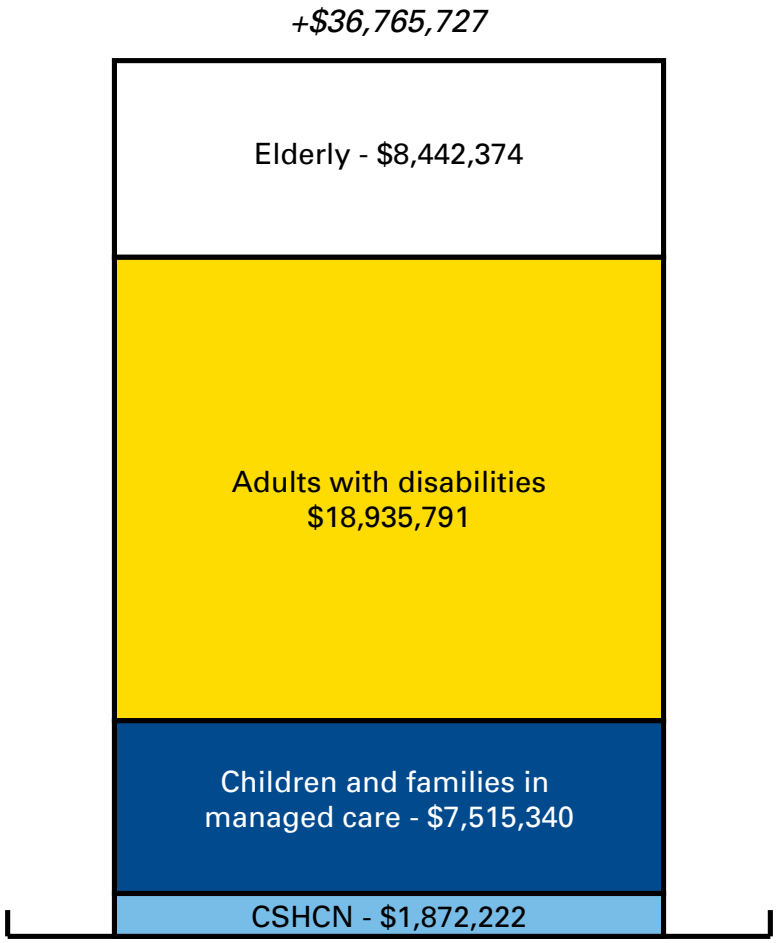


Source: Medicaid claims extract

Increased spending for pharmacy by adults with disabilities represents nearly 52% of the total increase in overall pharmacy spending

- Does not reflect impact of Medicare Part D

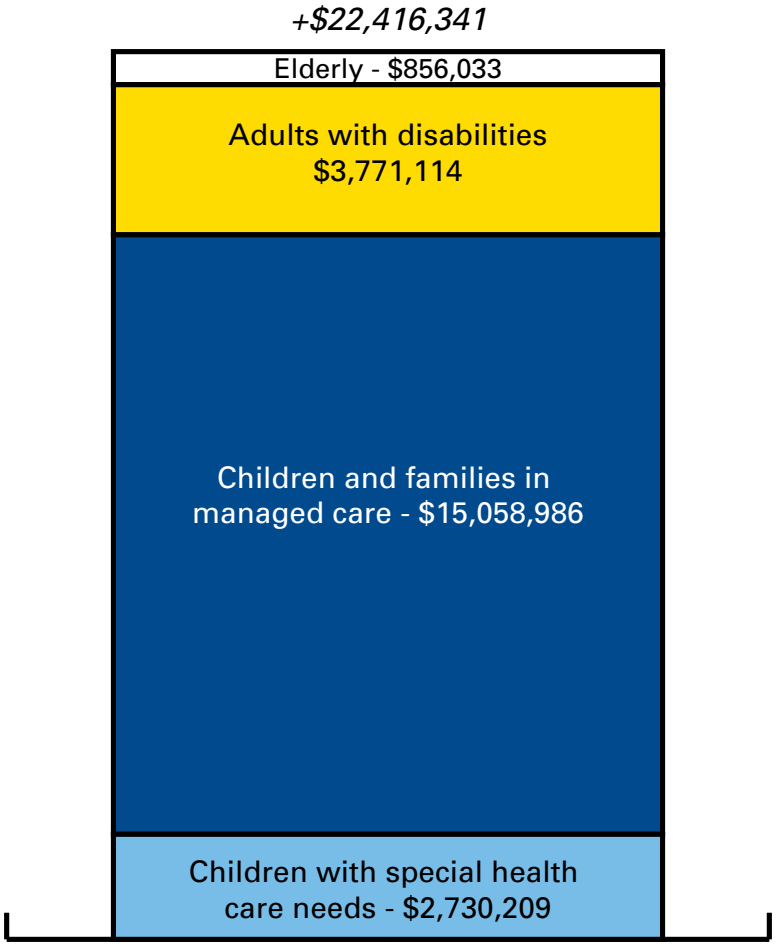
Figure 33
Contribution to pharmacy spending increase by beneficiary category
SFY 2003 - SFY 2005



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

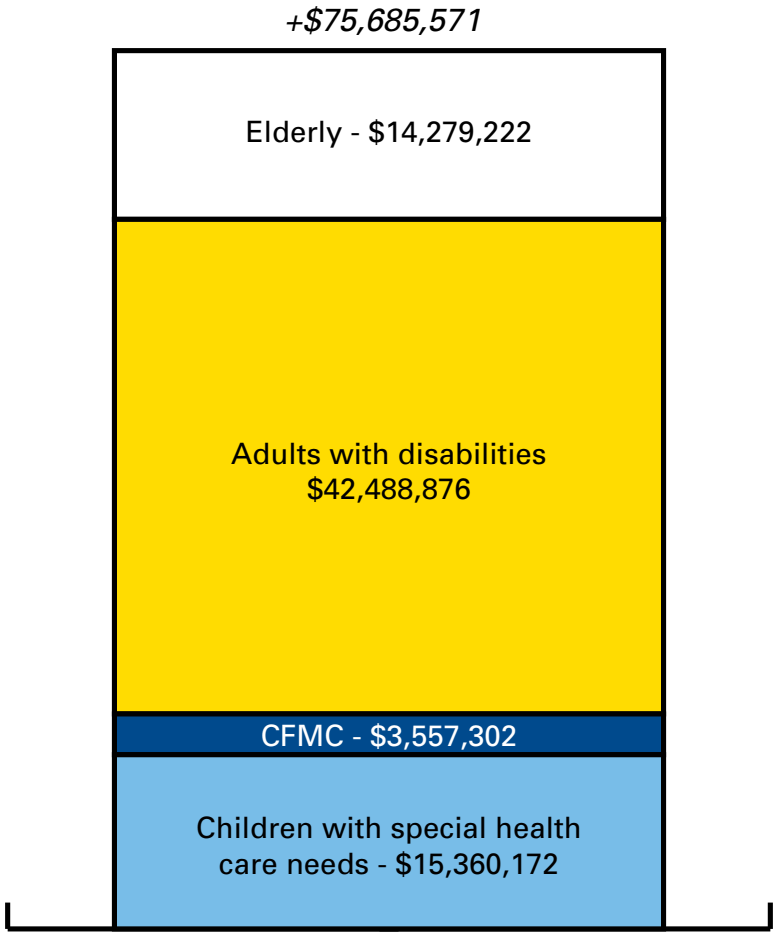
Figure 34
Contribution to physician and other medical services increase by beneficiary category
SFY 2003 - SFY 2005



Source: Medicaid claims extract

Increased spending for home and community based services (HCBS) by adults with disabilities represents 56% of the total increase in overall HCBS spending

Figure 35
Contribution to HCBS spending increase
by beneficiary category
SFY 2003 - SFY 2005



Source: Medicaid claims extract

Items for consideration

This spending analysis raises a number of key questions to be considered in the Future of Medicaid report

- What role should Medicaid play within RI's health care market?
    - Should it be a safety net for vulnerable populations or the basis of affordable health insurance?
- What impact does Medicaid have on the state's economy?
- What is the flexibility to design different benefit packages across populations?
- Is the current rate setting for Medicaid providers efficient, effective and appropriate?
- How do you maintain consistency and accountability in value-based purchasing across five departments?
    - What percentage of services and costs can be diverted to lower cost settings with improved quality?
    - Will better integrated services lower costs and improve outcomes?
- How should RI respond to looming changes in federal law and regulations?
    - Changing FMAP
    - Provider tax limitations
    - Definitional changes
    - DRA "flexibility"

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%**