

Chartbook Number 3

Analysis of Changes in Medicaid Expenditures from 2001 to 2003 for Long-Term Care Participants in HCBS and Institutional Settings

(3rd in a series of 6 special quantitative reports)

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Table of Contents

Table of Contents i
Tables i
Figures..... ii
Preface..... iv
Executive Summary v
Introduction..... 1
Research Questions 2
Background 3
 Data Acquisition 4
 State Finder File Data 4
 CMS Medicaid Data 7
 Creation of Person Months and Waiver/State Plan Analytic
 Groups..... 9
 Exclusion of Managed Care Person Months from Analysis 12
Results 21
 **Inpatient Hospital MA Payment (\$ per Person Month by
 Analytic Group across Three Years – 2001 thru 2003 ..** 21
 What is being measured? 21
 Descriptive Results: 21
 Interpretation 21
 **Residential LTC Medicaid Payment per Person Month
 (\$ by Analytic Group across Three years – 2001 thru
 2003**..... 26
 What is being measured? 26
 Descriptive Results: 26
 Interpretation 26
 **Total Ambulatory Service Medicaid Payment (\$ per
 Person Month in Group by Analytic Group across Three
 Years – 2001 thru 2003** 28
 What is being measured? 28
 Descriptive Results: 28

**Prescription Drug Medicaid Payment (\$ per Person
 Month in Group by Analytic Group across Three years –
 2001 thru 2003** 33
 What is being measured? 33
 Descriptive Results: 33
 Interpretation 33
**Percent Change in Service Utilization and Payments -
 Eight State Weighted Average**..... 38
 What is being measured? 38
 Descriptive Results: 38
 Interpretation 38
Conclusion 43

Tables

Table 1. HCBS Waivers offered in Each State (2003).....5
Table 2. Summary of State Plan Finder File Data by
 State.....6
Table 3. Summary of State Finder File Data Extraction
 Approaches.....6
Table 4. Summary of Waiver and State Plan
 Analytic Groups in 2003 for Cross-state Comparison.....11
Table 5. Demographic Summary for Medicaid FFS
 and Managed Care Enrollees by Waiver Analytic
 Group (2003).....16
Table 6. Demographic Summary for Medicaid FFS and
 Managed Care Enrollees by State Plan Analytic
 Group 2003).....17
Table 7. Medicaid FFS Person Months in Waiver
 And State Plan Analytic Groups by Dual Eligible
 Status (2003).....19

Table 8. Medicaid Managed Care Person Months in Waiver and State Plan Analytic Groups by Dual Eligible Status (2003).....20

Figures

Figure 1. Study Sample Development Process.....8
Figure 2. Percentage of Person Months in Medicaid Managed Care in Analytic Groups-(2003).....14
Figure 3a. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for MR/DD Waiver Group Medicaid-Only FFS Enrollees (2001 - 2003).....22
Figure 3b. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Aging/Disability Waiver Group Medicaid-Only FFS Enrollees (2001 – 2003).....22
Figure 3c. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Nursing Facility State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003).....23
Figure 3d. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Home Health State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003).....23
Figure 3e. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for MR/DD Waiver Group Dual FFS Enrollees (2001 - 2003).....24
Figure 3f. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003).....24
Figure 3g. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Nursing Facility State Plan Group Dual FFS Enrollees (2001 - 2003).....25

Figure 3h. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Home Health State Plan Group Dual FFS Enrollees (2001 - 2003).....25
Figure 4a. Average Nursing Home Medicaid Payment (\$) per Month, across States for Nursing Facility Medicaid Only FFS Enrollees (2001 - 2003).....27
Figure 4b. Average Nursing Home Medicaid Payment (\$) per Month, across States for Nursing Home Dual FFS Enrollees (2001 - 2003).....27
Figure 5a. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for MR/DD Waiver Group Medicaid-Only FFS Enrollees (2001 - 2003).....29
Figure 5b. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003).....29
Figure 5c. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for Nursing Facility State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003).....30
Figure 5d. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for Home Health State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003).....30
Figure 5e. Total Ambulatory Service Medicaid Payment (\$) per Person Month, across States for MR/DD Waiver Group Dual FFS Enrollees (2001 - 2003).....31
Figure 5f. Total Ambulatory Service Medicaid Payment (\$) per Person Month, across States for Aging/Disability Waiver Group Dual FFS Enrollees (2001 - 2003).....31

Figure 5g. Total Ambulatory Service Medicaid Payment (\$ per Person Month, across States for Nursing Facility State Plan Group Dual FFS Enrollees (2001 - 2003).....32

Figure 5h. Total Ambulatory Service Medicaid Payment (\$ per Person Month, across States for Home Health State Plan Group Dual FFS Enrollees (2001 - 2003).....32

Figure 6a. Prescription Drugs Medicaid Payment (\$ per Person Month in Group, across States for MR/DD Waiver Group Medicaid-Only FFS Enrollees (2001 - 2003).....34

Figure 6b. Prescription Drugs Medicaid Payment (\$ per Person Month in Group, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003)34

Figure 6c. Prescription Drugs Medicaid Payment (\$ per Person Month in Group, across States for Nursing Facility State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)35

Figure 6d. Prescription Drugs Medicaid Payment (\$ per Person Month in Group, across states for Home Health State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)35

Figure 6e. Prescription Drugs Medicaid Payment (\$ per Person Month, across States for MR/DD Waiver Group Dual FFS Enrollees (2001 - 2003)36

Figure 6f. Prescription Drugs Medicaid Payment (\$ per Person Month, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003).....36

Figure 6g. Prescription Drugs Medicaid Payment (\$ per Person Month, across States for Nursing Facility State Plan Group Dual FFS Enrollees (2001 - 2003).....37

Figure 6h. Prescription Drugs Medicaid Payment (\$ per Person Month, across States for Home Health State Plan Group Dual FFS Enrollees (2001 - 2003).....37

Figure 7a. Percent Change in Service Utilization and Payments - Eight State Weighted Average MR/DD Waiver Group Medicaid Only.....39

Figure 7b. Percent Change in Service Utilization and Payments - Eight State Weighted Average Aging/Disability Waiver Group Medicaid Only.....39

Figure 7c. Percent Change in Service Utilization and Payments - Eight State Weighted Average Nursing Home State Plan Group Medicaid Only40

Figure 7d. Percent Change in Service Utilization and Payments - Eight State Weighted Average Home Health State Plan Group Medicaid Only.....40

Figure 7e. Percent Change in Service Utilization and Payments - Eight State Weighted Average MR/DD Waiver Group Dual Eligible Enrollees.....41

Figure 7f. Percent Change in Service Utilization and Payments - Eight State Weighted Average Aging/Disability Waiver Group Dual Eligible Enrollees.....41

Figure 7g. Percent Change in Service Utilization and Payments - Eight State Weighted Average Nursing Home State Plan Group Dual Eligible Enrollees.....42

Figure 7h. Percent Change in Service Utilization and Payments - Eight State Weighted Average Home Health State Plan Group Dual Eligible Enrollees.....42

Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the entire study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems; 6 cross-cutting topic papers on issues in rebalancing; and a series of 6 Chartbooks with special quantitative analyses. Various products are posted on <http://www.hcbs.org>, on the CMS website at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage, and on the study director’s website at University of Minnesota at <http://www.hsr.umn.edu/LTCResourceCenter>. The special quantitative work was performed under the direction of Robert

L. Kane. We thank Glenn Mitchell and Su Wang (in Florida), Mike Baldwin and Bob Myers (in Minnesota), Kathy Leitch, Bill Moss, Patricia Richards, and Terry Rupp (in Washington) and Bill Clark and Karyn Anderson (at CMS) for their cooperation and assistance but the responsibility for all material rests with the authors.

The special quantitative studies for this project used secondary data from State and Federal sources to explore enrollment, service utilization, and expenditures for state LTC program recipients. In general, they compared Medicaid expenditures for participants in HCBS and nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. Chartbook Number 3 compares all Medicaid expenditures for participants receiving LTSS in the community (under Medicaid waivers or State plans) and those receiving LTSS services in institutions in 2001 to the same expenditures in 2003.

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Executive Summary

As part of a comprehensive study of rebalancing efforts in eight states (Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Washington, and Vermont), this paper presents the third in a series of analyses of Medicaid Analytic eXtract (MAX) data on the utilization of LTC and medical care services, by Medicaid LTC recipients. States use a combination of Medicaid state program funds (state plan services) as well as Medicaid Home and Community-Based Services (HCBS) waivers to fund and provide LTC services. These reports look at both utilization and expenditure on medical care services as well as long-term care services to examine the broader impact of rebalancing LTC on Medicaid spending.

This report is the third in a series of reports using MAX data, a refined data set of information originally gathered by each state as part of its claims data and submitted to CMS through its Medicaid Statistical Information System (MSIS).

The data presented here are restricted to Medicaid fee-for-service (FFS) payments. Previous reports presented analyses on 2001 and 2002 data separately. Subsequent reports will present analyses on combined Medicare and Medicaid data from the dual eligible enrollees as well as Diagnostic Cost Group (DCG) case mix adjustments.

Because the focus is on rebalancing, the analyses look separately at program participants who are covered by Medicaid HCBS waivers and those covered by Medicaid state plan services.

The research questions driving these analyses are:

1. How consistent is utilization of medical and LTC services across three years (2001-2003)?
2. How do the utilization and cost of LTC services (e.g., nursing facility, intermediate care facility (ICF), personal care, home health care, and transportation) by

Medicaid HCBS waiver participants and LTC state plan recipients differ across recipient groups and states?

3. How do the utilization and cost of medical services (e.g., hospital, emergency room, physician, physical therapy/occupational therapy/others, other practitioner, outpatient service, rehabilitation, hospice, other services, and pharmaceuticals) by HCBS waiver participants, and state plan recipients receiving LTC services differ across recipient groups and states?
4. How do the utilization and Medicaid costs of these services differ for dual eligible HCBS recipients and recipients covered only by Medicaid?

Identification of our study population came from finder files created by each state based on persons enrolled in each relevant waiver program or who had used state plan LTC services. Each person had specific months of participation in the relevant groups (enrollment or eligibility periods) which

were then linked to monthly claims data creating person month data for the analyses. Some of the eight states being examined have developed waiver programs to address specific conditions or populations. Others have focused efforts on more broad categories of participants. For comparison purposes we have focused our analyses on two waiver categories of interest: Aging and (Physical) Disability and Mental Retardation/ Developmental Disability (MR/DD). Our state plan groups of interest were limited to individuals who used nursing facility, intermediate care facility (ICF), home health, and personal care services. Our analysis is limited to Medicaid enrollees (including dual eligible) in FFS plans. Because reliable measures of utilization of services and their associated payment could not be obtained for Medicaid managed care enrollees, those covered by managed care were eliminated from this analysis. The number of person months in Medicaid managed care varied across states, ranging from virtually none in

Changes in Medicaid LTC Expenditures from 2001 to 2003,
May 2008

Washington, to over half for nursing facility recipients in Minnesota. We analyzed medical care services (including inpatient hospital, physician, physical therapy/occupational therapy/others, other practitioner, outpatient service, and prescription drugs) and LTC services focusing on nursing facility utilization. Our results look at each type of service separately.

There are some general trends in utilization and payment for medical and LTC services between 2001 and 2003.

- Payments for acute inpatient stays and ambulatory care services were steady between 2001 and 2003.
- Payments for nursing home stays and prescription drugs increased between 2001 and 2003.
- There was little difference in the payment trends for medical or LTC services across types of services between Medicaid only and dual eligible enrollees.

- There was little difference in the payment trends for medical or LTC services across types of services comparing across waiver and state plan analytic groups.

Introduction

This paper is one of several *Topics in Rebalancing* papers being produced by the University of Minnesota as a deliverable for the Centers for Medicare and Medicaid Services (CMS) funded project “Research on Program Management Techniques by States to Rebalance Their Long-Term Care Systems.” This multi-year project examines, through the use of both qualitative and quantitative methods, the management processes that states use to shift long-term care (LTC) resources, especially those funded through Medicaid, away from traditional LTC institutions to home and community-based services (HCBS). The qualitative component of the project was focused on identifying and describing the management approaches states use to “rebalance” their LTC services, including service expansion, service access, budgetary, and service linkage strategies. The quantitative portion of the project used secondary data from State and Federal sources to explore

enrollment, service utilization, and expenditures for state LTC program recipients. More information about the full project, including an Executive Summary, case studies on each of the participating states, and other topic papers may be found at <http://www.hsr.umn.edu/LTCResourceCenter> as well as <http://www.hcbs.org>.

This paper presents an analysis across three years (2001 thru 2003) using Medicare Analytic eXtract (MAX) data of expenditures on LTC and medical care services among Medicaid LTC recipients in the eight states participating in the study. The data presented here are restricted to Medicaid fee-for-service payments. Prior chartbooks presented utilization and expenditure data for 2001 and 2002 separately. Subsequent reports present analyses based on combined Medicare and Medicaid data from the dual eligible enrollees and Diagnostic Cost Group (DCG) case mix adjustments.

Research Questions

1. How consistent is utilization of medical and LTC services across years across three years (2001-2003)?*
2. How do the utilization and cost of LTC services (e.g., nursing facility, intermediate care facility (ICF), personal care, home health care, and transportation) by Medicaid HCBS waiver participants and LTC state plan recipients differ across recipient groups and states?*
3. How do the utilization and cost of medical services (e.g., hospital, emergency room, physician, physical therapy/occupational therapy/others, other practitioner, outpatient service, rehabilitation, hospice, other services, and pharmaceuticals) by HCBS waiver participants and state plan recipients receiving LTC services differ across recipient groups and states?*

4. How do the utilization and Medicaid costs of these services differ for dual eligible HCBS recipients and recipients covered only by Medicaid?*

Because the focus is on states' efforts to rebalance use of institutional and HCBS through implementing waiver programs, the analyses look separately at those program participants who are covered by Medicaid LTC waivers and those covered by Medicaid state plan services.

* These items are specifically addressed in this paper. Additional items will be addressed in subsequent reports.

Background

Currently, states are in varying stages of rebalancing their LTC systems. The diverse LTC systems developed in each state reflect the unique historical context found in each state as well as different approaches to developing LTC policies and programs. States use a combination of Medicaid state program funds (state plan services) as well as Medicaid HCBS waivers to fund and provide LTC services. Eight states are participating in the project: Arkansas, Florida, Minnesota, Pennsylvania, New Mexico, Texas, Vermont, and Washington. Each of these eight states offers a number of institutional and HCBS programs through its Medicaid state plans, including nursing homes and intermediate care facilities (ICFs) for the mentally retarded, as well as hospice, home health care, and personal care. The full scope of LTC state plan services and the nature of these services, however, varies across the states. In developing their HCBS waiver programs, each state has taken a

somewhat different approach in terms of several key factors: utilizing a number of specialized waivers versus a smaller number of consolidated programs serving a more diverse population, emphasizing waivers over state plan services, and providing waiver services through FFS or managed care programs. A list of the waiver programs offered in 2003 by each of the states participating in the project is found in Table 1.

Data Acquisition

State Finder File Data

Our study population consists of all Medicaid LTC recipients in each state during the years 2001, 2002, or 2003. Each state provided a “finder file” including all individuals who were eligible for a HCBS waiver and/or received an LTC service under the state plan at some point during any one of those years. These files were then matched against the CMS Medicaid claims data (discussed below) to permit analysis of medical and LTC service utilization and expenditures among HCBS waiver and other Medicaid LTC beneficiaries.

Each state provided finder file data for their relevant HCBS waivers (Table 1) as well as those state plan LTC services where data were available (Table 2). Table 3 summarizes the data extraction approaches used by each of the states to produce the HCBS and state plan finder files. As a result of

different data extraction methods, differences in utilization rates may be a result of different selection criteria used rather than actual differences in utilization (selection criteria based upon service use may show higher utilization than a method based upon authorization).

Table 1. HCBS Waivers offered in Each State (2003)

State	Waivers in Each State	Number Served or Authorized in 2003
Arkansas	ElderChoices Waiver	7,387
	Alternatives for Adults with Physical Disabilities Waiver	1,477
	Alternative Community Services Waiver (DD)	2,919
	Family Friends Respite Waiver 1 (respite for children with physical disability)	200
	Family Friends Respite Waiver 2 (respite for children with mental retardation/development disability)	124
Florida	Aging and Disabled Adults Waiver	13,913
	Nursing Home Diversion Waiver	2,061
	Assisted Living for Elderly Waiver	4,163
	Disability Services Waiver	20,032
	Family/Supported Living Waiver	8
	Channeling Waiver	1,715
	Project AIDS Care Waiver	6,431
	Katie Beckett Waiver	4
TBI and Spinal Cord Injury Waiver	221	
Minnesota	Elderly Waiver	15,386
	Community Alternative Care Waiver	203
	Community Alternative for Disabled Individuals Waiver	9,558
	DD-MR/Related Conditions Waiver	15,299
	Traumatic Brain Injury Waiver	1,146
New Mexico	Disabled and Elderly Waiver	2,483
	Mental Retardation/Developmental Disability Waiver	3,254
	Developmental Disability with Medically Fragile Condition Waiver	168
	HIV/AIDS Waiver	29

State	Waivers in Each State	Number Served or Authorized in 2003
Pennsylvania	PA Department of Aging Waiver	14,481
	Attendant Care Waiver	3,386
	Elwyn Waiver	49
	Michael Dallas Waiver	53
	OBRA Waiver	577
	Independence Waiver	415
	Consolidated MR/DD Waiver	14,706
	Infant, Toddlers, and Families Waiver	4,245
	Person/Family Directed Support Waiver	7,231
Texas	Community-Based Alternatives Waiver	40,619
	Community Living Assistance and Support Services Waiver	1,905
	Medically-Dependent Children's Program Waiver	1,153
	Deaf-Blind Multiple Disabilities Waiver	144
	Consolidated Waiver Program Home and Community-Based Services Waiver	207
		8,228
Vermont	Enhanced Residential Care Waiver	206
	Home-Based Waiver	1,280
	Developmental Services (DD) Waiver	1,916
	Traumatic Brain Injury (TBI) Waiver	49
Washington	Community Options Program Entry System (COPES)	30,838
	Community Alternative Program	11,008
	Medically Needy Residential Waiver	179

Table 2. Summary of State Plan Finder File Data by State

State	State Plan Groups			
	Homecare	Intermediate Care Facility	Nursing Facility	Personal Care
Arkansas	X	X	X	X
Florida	X	X	X	-
New Mexico	X	X	X	X
Minnesota	X	X	X	X
Pennsylvania	X	X	X	-
Texas	-	X	X	X
Vermont	X	X	X	-
Washington	X	X	X	X

Table 3. Summary of State Finder File Data Extraction Approaches

State	Selection Criterion			
	State Plan Services		HCBS Waivers	
	Authorization/ Eligibility	Services use; Claims	Authorization/ Eligibility	Services use; Claims
Arkansas		X	X	
Florida		X		X
Minnesota		X	X	
New Mexico		X		X
Pennsylvania		X	MR/DD	Aging
Texas	X		X	
Vermont		X		X
Washington		X	MR/DD	Aging

CMS Medicaid Data

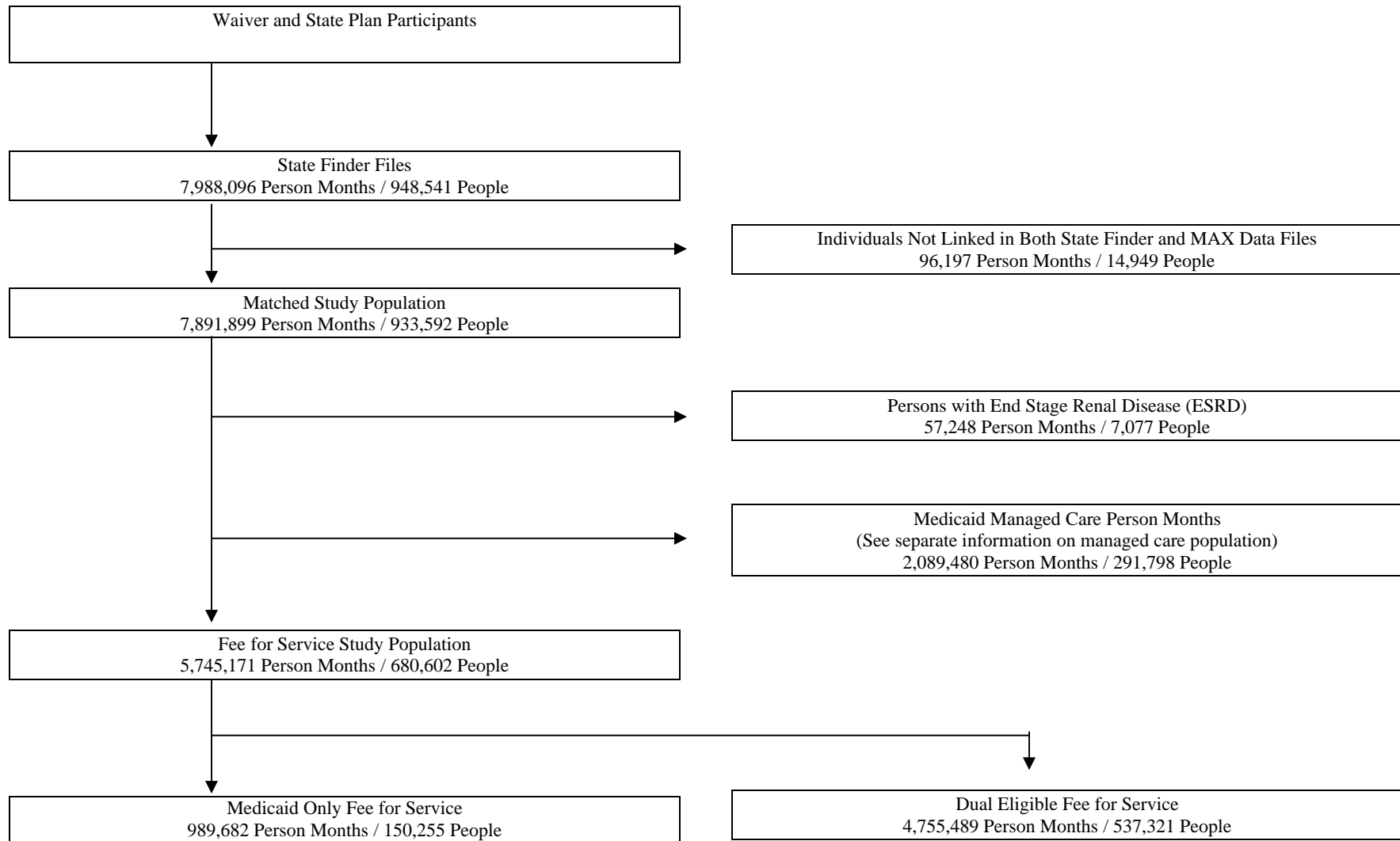
Utilization and cost data for medical and LTC services were obtained from the Medicaid Analytic eXtract (MAX) files created by CMS. MAX data is a refined data set built (under a contract with MPR) from the Medicaid claims data submitted by each state as part of its Medicaid Statistical Information System (MSIS). Using the CMS Eligible Identifier Number obtained from the MAX PS file, we extracted all claims from the MAX utilization files (MAX IP: inpatient, MAX LT: long-term care, MAX OT: other services, MAX RX: prescription drugs) pertaining to the persons identified. For inpatient hospital and LTC claims, we also produce secondary files which combine individual claims into contiguous “stays.” Claims are combined into a stay when there is a continuous record of claims with no internal gap of more than 7 days.

Our study population includes all individuals who are enrolled in a relevant Medicaid waiver or LTC state plan

service, including dual eligible recipients or those enrolled in both Medicaid and Medicare as a result of age or disability. We linked state finder files with MAX data. Fewer than 3% of all individuals across the eight states failed to match MAX records. Figure 1 traces the development of our analytic sample.

We excluded from our study population those individuals identified as having end stage renal disease (ESRD). Although they represent a small portion of the population (less than 1% across the eight states), their high utilization of services could skew the results. Therefore, these individuals, identified through diagnoses associated with their claims data, were excluded from our study population.

Figure 1. Study Sample Development Process



Creation of Person Months and Waiver/State Plan Analytic Groups

Person month is the unit of analysis. For each person, we identified the primary waiver program (if any) in which they were enrolled in each month, and set flags indicating the utilization of the various services of interest. In months where no waiver enrollment was indicated, but utilization of a state plan LTC service of interest was reported, we classified the person month as “state plan.”

In order to make comparisons, our analysis summarized in this report focuses on the larger HCBS waivers in each state serving the aging and disabled populations. Specific waiver groups in each state were grouped (based on their eligible population) into the following two waiver categories: Aging and (Physical) Disability and Mental Retardation/Developmental Disability (MR/DD). For instance, in Arkansas,

enrollees in the Alternative Community Services Waiver were placed in the MR/DD category and those in the Elderly Choice waiver or the Alternatives for Adults with Physical Disability waiver were both included in the Aging and Disability category. Specific waiver groups that did not fall into these waiver categories were excluded from the analysis.

Our state plan groups of interest across the eight states consisted of those individuals who used nursing facility, ICF, home health, and personal care services. For each person month classified as “state plan” we identified the primary LTC state plan service used by each individual during that month. Use of a state plan service was used to assign person months to state plan groups for comparison purposes. Some individuals were listed in some state finder files as utilizing exclusively hospice or targeted case management state plan services. Because the provision of these services and the types of specific assistance

included varied widely across states, we excluded these individuals from our analysis.

The waiver and state plan analytic groups from each state that are included in our cross-state comparison are presented in Table 4. All eight states have waiver groups in the MR/DD and Aging & Disability categories. All eight states also have ICF/MR and nursing facility state plan analytic groups. Texas does not have home health; and Florida, Pennsylvania, and Vermont do not have personal care as a state plan group.

Table 4. Summary of Waiver and State Plan Analytic Groups in 2003 for Cross-state Comparison

State	Waiver Groups		State Plan Groups			
	Mental Retardation/Developmental Disability	Aging & Disability	Nursing Facility	Intermediate Care Facility	Home Health	Personal Care
Arkansas	Alternative Community Services Waiver	<ul style="list-style-type: none"> Elderly Choice Waiver Alternatives for Adults with Physical Disability Waiver 	Yes	Yes	Yes	Yes
Florida	Developmental Disability Waiver	Aging and Disabled Adults Waiver	Yes	Yes	Yes	-
New Mexico	Mental Retardation/Developmental Disability Waiver	Disabled Elderly Waiver	Yes	Yes	Yes	Yes
Minnesota	Mental Retardation/Related Conditions Waiver	<ul style="list-style-type: none"> Elderly Waiver Community Alternative for Disabled Individuals Waiver 	Yes	Yes	Yes	Yes
Pennsylvania	Consolidated Mental Retardation/Developmental Disability Waiver	<ul style="list-style-type: none"> PA Department of Aging Waiver Attendant Care Waiver 	Yes	Yes	Yes	-
Texas	<ul style="list-style-type: none"> Home and Community-Based Services Waiver Community Living Assistance and Support Services Waiver 	Community-Based Alternatives Waiver	Yes	Yes	-	Yes
Vermont	Developmental Services Waiver	<ul style="list-style-type: none"> Enhanced Residential Care Waiver Adult Disability Waiver 	Yes	Yes	Yes	-
Washington	Community Alternatives Program	Community Options Program Entry System	Yes	Yes	Yes	Yes

Exclusion of Managed Care Person Months from Analysis

Our analysis is limited to Medicaid enrollees in FFS plans (including dual eligible). MAX data include enrollment in prepaid Medicaid plans as well as premium payments made by Medicaid into prepaid plans. Some service data are found in the MAX files, but the data are inconsistently reported and there are no cost data available. Managed care claims were reported either as FFS claims with associated payments, encounter claims without payment details, or in some cases went unreported despite enrollment in the group. Reliable measures of service utilization and associated payment could not be obtained for Medicaid managed care enrollees.

Therefore, we excluded managed care person months from the analysis (Figure 1).

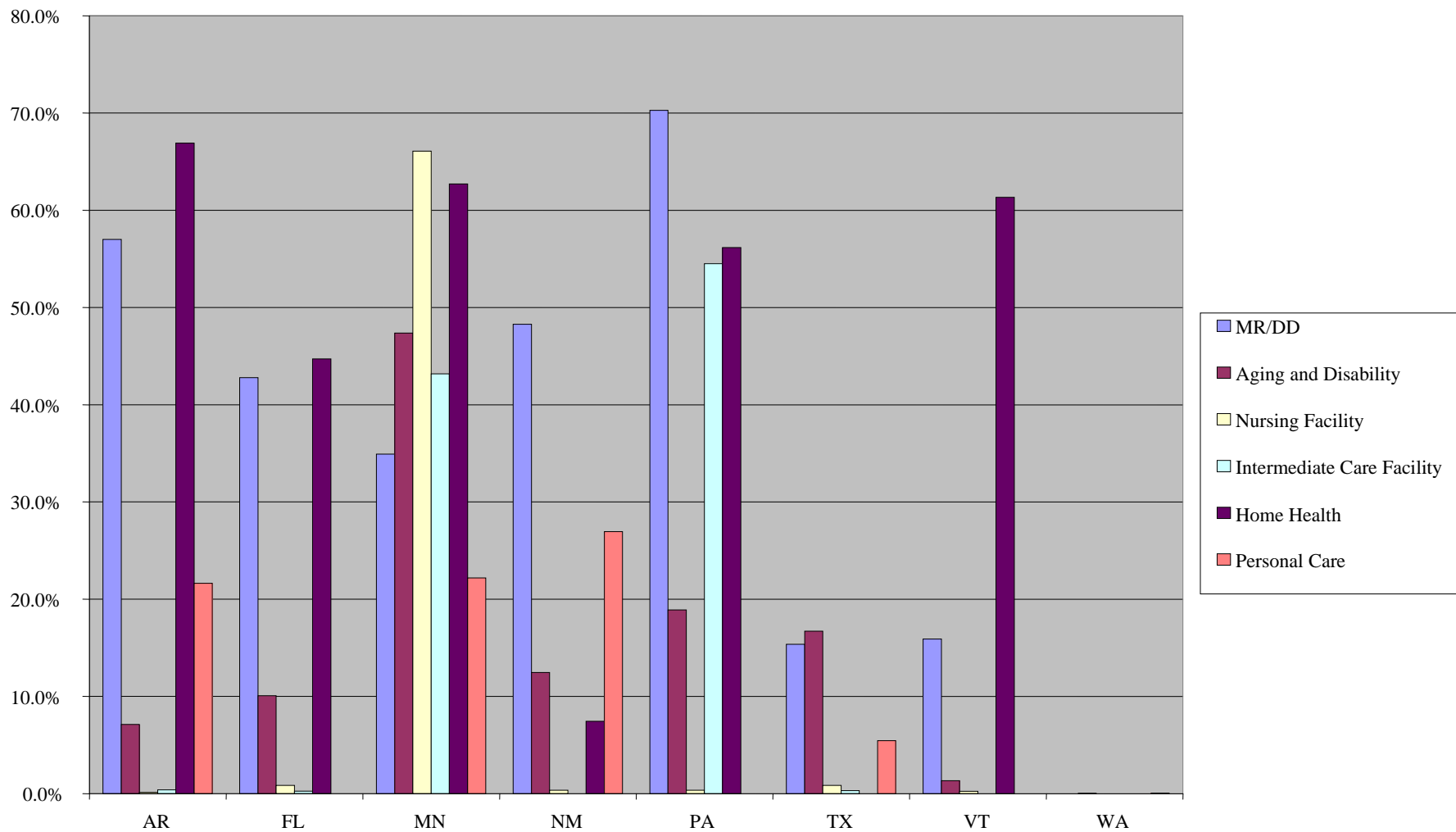
The proportion of person months in Medicaid managed care greatly varied across states (Figure 2), ranging from almost 0% in Washington, to just over 70% for nursing facility

state plan in Pennsylvania. Minnesota had the highest percentage of Medicaid managed care enrollment across the waiver and state plan services among the eight states, followed by Pennsylvania. Medicaid managed care enrollment increased the most in Arkansas from 2001 to 2003; the percentage of person months in managed care in the other seven states remained relatively unchanged.

Managed care enrollment indicated in the MAX data represents different variants of managed care. Managed care enrollees can be enrolled in a comprehensive plan, a dental plan, a behavioral plan, a primary care case management plan, some other managed care plan, or a combination of plans. Comprehensive Medicaid managed care plans may include comprehensive acute health care services but may not include some or all LTC services such as nursing home stays. Some of the waiver programs in some states are also offered through a managed care plan.

In our exclusion of managed care person months from our analyses, an exception was made for Washington. In the 2001 MAX data for this state there was very little managed care enrollment of any kind for waiver and state plan recipients alike. In Washington's 2002 and 2003 MAX data, almost every Medicaid enrollee in our study population showed a managed care component. In most cases the data indicated enrollment in a prepaid mental health plan (and not a comprehensive managed care plan). Instead of deleting a significant number of Washington person months from our 2002 and 2003 analyses, we chose to retain these person months because the pattern of service utilization had not changed from 2001. In contrast to Washington's managed care cases, the majority of managed care person months we omitted from the 2002 and 2003 analysis in other states were comprehensive Medicaid managed care plan enrollees.

Figure 2. Percentage of Person Months in Medicaid Managed Care in Analytic Groups-2003



Tables 5 through 8 show basic demographic data on the managed care individuals excluded from our analysis compared to Medicaid only FFS individuals in our analysis. In those states where the managed care population is larger, such as Minnesota, Pennsylvania, and Florida, the pattern of age, gender, and race is fairly consistent with the FFS population. However, in some instances, the managed care population is slightly younger, and fewer are white. In many instances the managed care population is more urban than the FFS enrollees. There are considerably fewer managed care enrollees who are dual eligible for Medicaid and Medicare (except in Minnesota state plan groups) than the FFS population in each state.

Table 5. Demographic Summary for Medicaid FFS and Managed Care Enrollees by Waiver Analytic Group (2003)

State	Demographic		Medicaid Fee-for-Service Waiver Groups		Medicaid Managed Care Waiver Groups	
			MR/D D	Aging/ Disability	MR/D D	Aging/ Disability
AR	N	# Persons	1,201	7,254	1,617	613
	Age	Mean Age	39.4	76.1	21.7	53.7
		Range (Min-Max)	5-82	20-111	0-64	17-98
		% Female	45.8%	74.4%	42.3%	56.8%
	Race	% White	81.2%	72.8%	73.6%	69.8%
	Urban	% Metro	55.3%	38.5%	57.0%	38.4%
FL	N	# Persons	11,221	11,631	8,508	1,292
	Age	Mean Age	41.1	77.8	30.6	67.9
		Range (Min-Max)	17-88	22-108	17-86	21-106
		% Female	44.6%	77.9%	43.8%	73.9%
	Race	% White	72.3%	54.8%	51.7%	48.6%
	Urban	% Metro	87.4%	82.6%	89.9%	85.7%
MN	N	# Persons	14,306	14,240	621	7,467
	Age	Mean Age	31.0	63.4	65.0	79.4
		Range (Min-Max)	1-97	1-107	2-98	1-109
		% Female	41.8%	68.2%	49.6%	78.7%
	Race	% White	88.6%	89.4%	94.3%	86.6%
	Urban	% Metro	67.2%	60.9%	54.2%	60.3%
NM	N	# Persons	1,638	2,122	1,612	226
	Age	Mean Age	40.6	75.1	25.5	49.9
		Range (Min-Max)	6-90	4-105	1-74	4-97
		% Female	43.4%	70.2%	41.1%	67.2%
	Race	% White	43.5%	43.0%	46.1%	41.5%
	Urban	% Metro	67.4%	46.0%	76.7%	51.3%
PA	N	# Persons	4,385	14,614	10,222	3,021
	Age	Mean Age	41.6	77.1	42.6	55.2
		Range (Min-Max)	5-95	19-111	1-95	18-103
		% Female	43.9%	75.5%	42.5%	65.9%
	Race	% White	94.6%	75.0%	79.2%	55.8%
	Urban	% Metro	54.1%	76.4%	95.7%	95.8%
TX	N	# Persons	7,155	26,163	829	5,770
	Age	Mean Age	34.7	72.1	29.7	67.7
		Range (Min-Max)	3-91	16-112	7-86	2-108
		% Female	42.0%	70.3%	42.3%	72.8%
	Race	% White	61.3%	50.2%	59.4%	37.8%
	Urban	% Metro	85.3%	63.1%	96.2%	97.3%
VT	N	# Persons	1,571	1,272	318	17
	Age	Mean Age	39.9	74.5	21.6	52.4
		Range (Min-Max)	3-90	19-109	4-67	18-93
		% Female	43.7%	71.1%	37.4%	82.3%
	Race	% White	77.8%	81.3%	67.3%	82.3%
	Urban	% Metro	26.1%	33.6%	33.4%	35.2%
WA	N	# Persons	10,680	22,885	-	-
	Age	Mean Age	30.4	71.8	-	-
		Range (Min-Max)	1-92	0-109	-	-
		% Female	42.2%	72.5%	-	-
	Race	% White	86.8%	85.2%	-	-
	Urban	% Metro	88.3%	84.7%	-	-

Table 6. Demographic Summary for Medicaid FFS and Managed Care Enrollees by State Plan Analytic Group (2003)

State	Demographic		Medicaid FFS State Plan Groups				Medicaid Managed Care State Plan Groups			
			NF	ICF	Home Health	Personal Care	NF	ICF	Home Health	Personal Care
AR	N	# Persons	16,534	1,628	376	5,434	34	6	760	1,498
	Age	Mean Age	78.6	35.6	45.5	72.4	52.6	12.2	14.7	46.3
		Range (Min-Max)	13-109	0-68	0-97	20-126	19-83	2-18	2-80	4-94
	Gender	% Female	72.6%	40.2%	60.5%	78.9%	45.4%	0.0%	53.0%	68.3%
	Race	% White	82.0%	76.2%	57.6%	54.8%	48.4%	25.0%	54.7%	56.8%
	Urban	% Metro	45.4%	70.5%	38.7%	30.3%	63.6%	50.0%	48.4%	34.1%
FL	N	# Persons	70,380	3,269	56,497	-	1,187	17	64,407	-
	Age	Mean Age	79.3	43.67	51.7	-	58.4	21.6	21.3	-
		Range (Min-Max)	0-123	5-99	0-123	-	0-99	9-39	0-106	-
	Gender	% Female	68.1%	41.5%	62.9%	-	56.3%	29.4%	52.3%	-
	Race	% White	69.5%	71.1%	44.7%	-	41.7%	58.8%	31.5%	-
	Urban	% Metro	89.5%	84.5%	85.5%	-	93.7%	78.5%	84.8%	-
MN	N	# Persons	14,126	2,100	4,638	5,876	15,690	208	12,369	922
	Age	Mean Age	77.9	44.0	28.6	31.6	85.4	73.1	20.8	66.4
		Range (Min-Max)	17-109	4-85	0-101	0-100	18-116	21-90	0-101	0-102
	Gender	% Female	65.6%	45.2%	63.2%	47.9%	75.8%	52.8%	71.3%	66.8%
	Race	% White	91.1%	94.5%	58.3%	54.2%	94.9%	100.0%	43.5%	18.4%
	Urban	% Metro	60.5%	62.3%	62.2%	84.6%	57.8%	52.4%	77.7%	94.0%
NM	N	# Persons	5,812	268	363	6,581	39	2	32	2,508
	Age	Mean Age	79.2	43.5	19.4	71.3	46.0	24	8.1	51.1
		Range (Min-Max)	11-114	9-85	0-100	19-108	1-87	18-30	0-56	6-99
	Gender	% Female	65.3%	47.7%	53.1%	72.1%	56.4%	100.0%	53.1%	66.9%
	Race	% White	60.6%	64.5%	10.4%	34.6%	51.2%	50.0%	31.2%	36.9%
	Urban	% Metro	49.8%	56.3%	57.0%	46.4%	69.2%	100.0%	56.2%	48.6%

Table 6 continued. Demographic Summary for Medicaid FFS and Managed Care Enrollees by State Plan Analytic Group (2003)

State	Demographic		Medicaid FFS State Plan Groups				Medicaid Managed Care State Plan Groups			
			NF	ICF	Home Health	Personal Care	NF	ICF	Home Health	Personal Care
PA	N	# Persons	74,189	1,888	1,967	-	739	2,236	2,395	-
	Age	Mean Age	81.4	50.9	38.7	-	66.4	42.5	23.7	-
		Range (Min-Max)	1-115	4-94	2-89	-	1-103	4-91	2-91	-
	Gender	% Female	73.4%	44.3%	75.5%	-	59.6%	44.9%	68.4%	-
	Race	% White	86.5%	89.7%	90.9%	-	66.3%	76.9%	67.5%	-
Urban	% Metro	81.3%	53.7%	50.6%	-	95.2%	97.7%	80.1%	-	
TX	N	# Persons	55,430	7,147	-	81,751	834	48	-	4,957
	Age	Mean Age	78.7	40.5	-	70.1	67.2	24	-	58.8
		Range (Min-Max)	2-120	5-89	-	2-110	5-103	7-54	-	2-105
	Gender	% Female	71.3%	43.6%	-	71.7%	64.3%	41.6%	-	76.9%
	Race	% White	66.5%	69.3%	-	35.4%	41.9%	47.9%	-	28.9%
Urban	% Metro	69.5%	82.5%	-	74.4%	95.3%	97.9%	-	95.6%	
VT	N	# Persons	2,814	9	665	-	14	-	1,295	-
	Age	Mean Age	82.7	58.8	48.2	-	52.2	-	28.6	-
		Range (Min-Max)	4-109	28-77	0-107	-	28-74	-	0-88	-
	Gender	% Female	71.6%	66.6%	55.4%	-	71.4%	-	56.5%	-
	Race	% White	74.1%	88.8%	73.9%	-	78.5%	-	74.4%	-
Urban	% Metro	21.3%	0.0%	32.5%	-	35.7%	-	29.6%	-	
WA	N	# Persons	15,692	61	1,072	11,102	-	-	-	-
	Age	Mean Age	77.6	48.4	49.7	63.2	-	-	-	-
		Range (Min-Max)	5-109	17-85	0-99	0-104	-	-	-	-
	Gender	% Female	67.2%	65.5%	61.6%	70.8%	-	-	-	-
	Race	% White	87.8%	91.8%	74.5%	68.7%	-	-	-	-
Urban	% Metro	90.0%	100%	83.1%	88.8%	-	-	-	-	

Table 7. Medicaid FFS Person Months in Waiver and State Plan Analytic Groups by Dual Eligible Status (2003)

State	Number of Person Months	Waiver Groups		State Plan Groups			
		MR/DD	Aging/ Disability	NF	ICF	Home Health	Personal Care
AR	Total	13,646	73,925	166,841	19,328	3,290	62,807
	Medicaid Only	1,390	4,455	15,923	8,967	1,086	3,177
	Dual	12,256	69,470	150,918	10,361	2,204	59,630
	% Dual	89.8%	94.0%	90.5%	53.6%	67.0%	94.9%
FL	Total	130,530	122,656	597,961	38,459	246,825	-
	Medicaid Only	12,950	1,418	46,667	15,105	37,020	-
	Dual	117,580	121,238	551,294	23,354	209,805	-
	% Dual	90.1%	98.8%	92.2%	60.7%	85.0%	-
MN	Total	168,573	136,655	93,645	24,003	19,107	53,065
	Medicaid Only	83,988	37,855	10,798	5,884	10,485	39,891
	Dual	84,585	98,800	82,847	18,119	8,622	13,174
	% Dual	50.2%	72.3%	88.5%	75.5%	45.1%	24.8%
NM	Total	18,773	20,095	51,628	3,105	820	62,155
	Medicaid Only	2,048	598	5,320	1,281	699	4,914
	Dual	16,725	19,497	46,308	1,824	121	57,241
	% Dual	89.1%	97.0%	89.7%	58.7%	14.8%	92.1%
PA	Total	50,805	147,863	643,026	22,217	19,998	-
	Medicaid Only	18,832	14,601	38,736	4,013	16,537	-
	Dual	31,973	133,262	604,290	18,204	3,461	-
	% Dual	62.9%	90.1%	94.0%	81.9%	17.3%	-
TX	Total	49,492	292,320	567,279	83,145	-	847,748
	Medicaid Only	28,341	32,401	47,582	36,851	-	126,059
	Dual	21,151	259,919	519,697	46,294	-	721,689
	% Dual	42.7%	88.9%	91.6%	55.7%	-	85.1%
VT	Total	18,212	10,936	23,513	80	3,132	-
	Medicaid Only	5,922	1,007	906	28	951	-
	Dual	12,290	9,929	22,607	52	2,181	-
	% Dual	67.5%	90.8%	96.1%	65.0%	69.6%	-
WA	Total	124,916	214,010	134,833	701	2,697	105,778
	Medicaid Only	67,527	26,328	10,930	139	2,395	49,699
	Dual	57,389	187,682	123,903	562	302	56,079
	% Dual	45.9%	87.7%	91.9%	80.2%	11.2%	53.0%

Table 8. Medicaid Managed Care Person Months in Waiver and State Plan Analytic Groups by Dual Eligible Status (2003)

State	Number of Person Months	Waiver Groups		State Plan Groups			
		MR/DD	Aging/Disability	NF	ICF	Home Health	Personal Care
AR	Total	18,091	5,665	246	78	6,654	17,340
	Medicaid Only	16,728	4,344	193	76	6,542	15,922
	Dual	1,363	1,321	53	2	112	1,418
	% Dual	7.5%	23.3%	21.5%	2.6%	1.7%	8.2%
FL	Total	97,608	13,736	4,982	96	199,616	-
	Medicaid Only	85,616	6,537	3,802	95	190,922	-
	Dual	11,992	7,199	1,180	1	8,694	-
	% Dual	12.3%	52.4%	23.7%	1.0%	4.4%	-
MN	Total	90,468	122,990	182,283	18,236	32,104	15,133
	Medicaid Only	83,988	37,855	2,574	117	23,482	1,959
	Dual	6,480	85,135	179,709	18,119	8,622	13,174
	% Dual	7.2%	69.2%	98.6%	99.4%	26.9%	87.1%
NM	Total	17,514	2,863	181	-	66	22,907
	Medicaid Only	17,123	1,867	178	-	66	21,081
	Dual	391	996	3	-	0	1,826
	% Dual	2.2%	34.8%	1.7%	-	0	8.0%
PA	Total	120,125	34,447	2,203	26,604	25,603	-
	Medicaid Only	45,242	12,407	844	10,460	23,825	-
	Dual	74,883	22,040	1,359	16,144	1,778	-
	% Dual	62.3%	64.0%	61.7%	60.7%	6.9%	-
TX	Total	8,982	58,583	4,741	254	-	48,706
	Medicaid Only	6,085	12,055	1,660	172	-	24,046
	Dual	2,897	46,528	3,081	82	-	24,660
	% Dual	32.3%	79.4%	65.0%	32.3%	-	50.6%
VT	Total	3,439	147	55	-	4,966	-
	Medicaid Only	3,068	109	44	-	4,782	-
	Dual	371	38	11	-	184	-
	% Dual	10.8%	25.9%	20.0%	-	3.7%	-
WA	Total	-	-	-	-	-	-
	Medicaid Only	-	-	-	-	-	-
	Dual	-	-	-	-	-	-
	% Dual	-	-	-	-	-	-

Results

Inpatient Hospital MA Payment (\$) per Person Month by Analytic Group across Three Years – 2001 thru 2003

What is being measured?

The next series of graphs presents the annual Medicaid payment amount per person month in an analytic group – total inpatient hospital Medicaid payments divided by the total number of person months in the analytic group (users and nonusers of the service) across three years 2001–2003 for each of the eight states. We have added a line indicating the weighted average across the eight states. The weighted average is calculated by summing the total payments per person month per analytic group across all eight states and dividing that number by the prorated number of person months (sum of person months in each state per analytic group divided by the total number of person months of all eight states). Separate graphs have been prepared for each waiver and state plan group.

Descriptive Results:

Figures 3a-d Medicaid Only Enrollees FFS Inpatient Hospital Costs

- The trend in per person payments for inpatient hospital stays shows little change between 2001 and 2003 across the different waiver and state plan groups.
- The trend in per person payments for inpatient hospital stays between 2001 and 2003 is generally similar across states with one or two states increasing or decreasing slightly over time.
- A few specific waiver and state plan groups in certain states (NM, VT, AR) show variability across years, resulting from a small number of enrollees in that group. Changes across years in these states may be less a

function of systematic trends and more a function of adding or losing a small number of individuals with large expenditures.

Figures 3e-h Dual Eligible Enrollees FFS Inpatient Hospital Costs

- There is a similar pattern comparing MA only and dual eligible enrollees by group by state across years. The weighted average across the eight states remains flat or steady.
- The trend in per person payments for inpatient hospital stays show little change between 2001 and 2003 across the different waiver and state plan groups.
- The trend in per person payments for inpatient hospital stays between 2001 and 2003 is similar across states.
- A few specific waiver and state plan groups in certain states (WA, PA, NM) show variability across years, primarily due to a small number of enrollees in that group.

Interpretation

Inpatient hospital expenditures did not change substantially over time.

May 2008

Figure 3a. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for MR/DD Waiver Group Medicaid-Only FFS Enrollees (2001 - 2003)

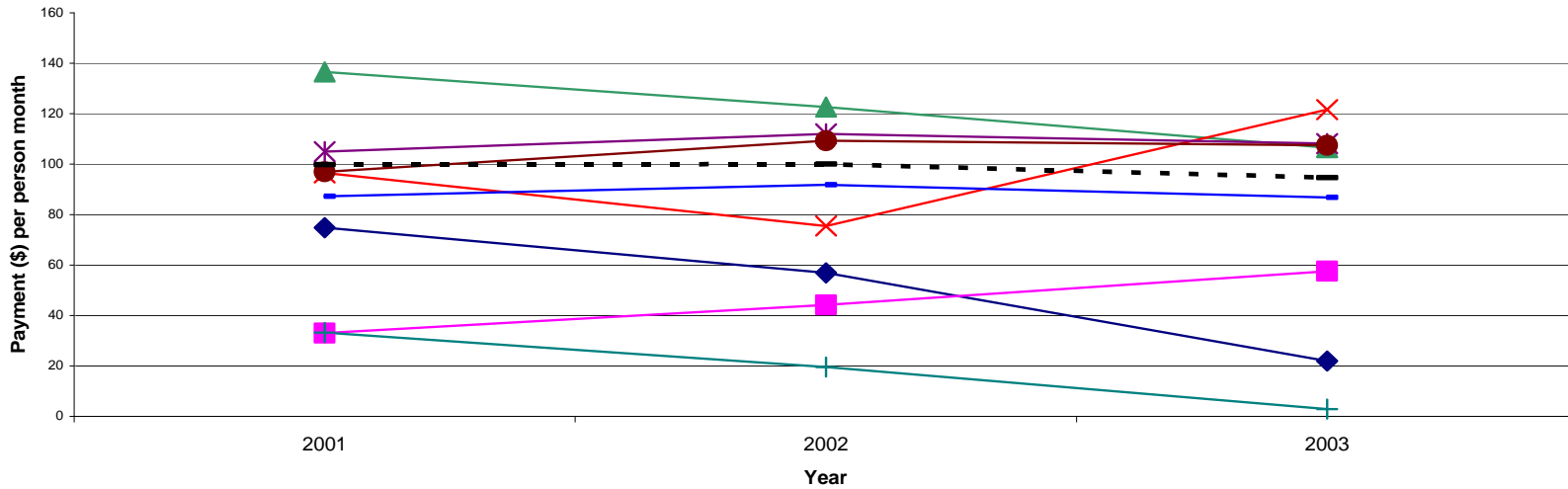
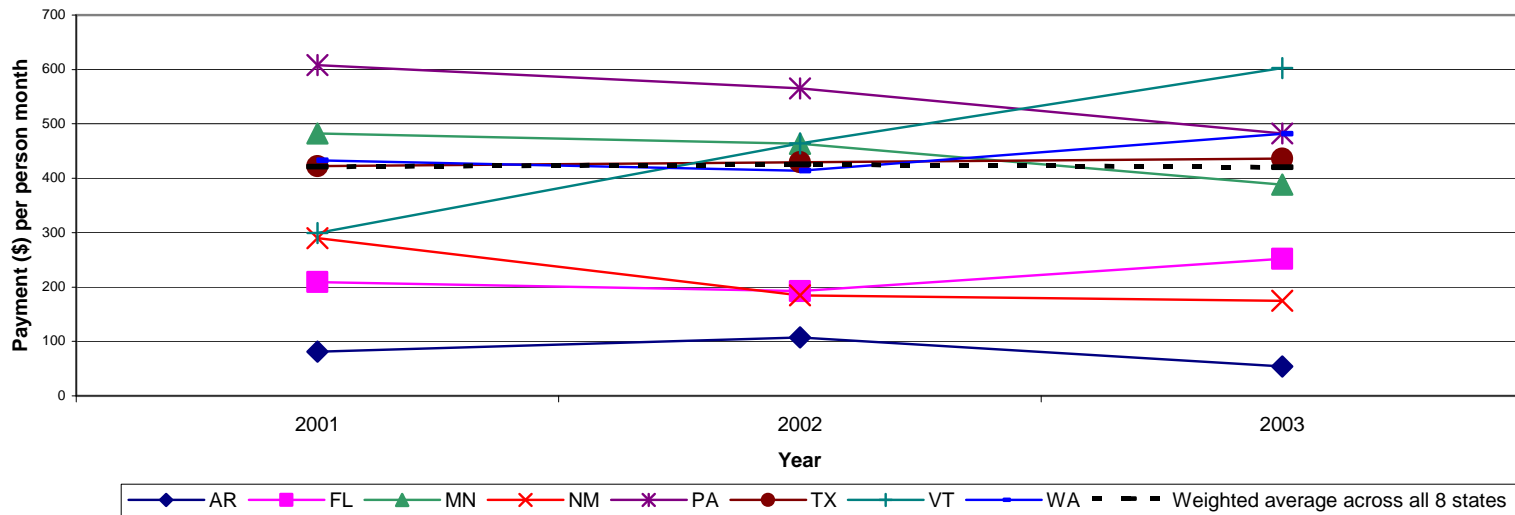


Figure 3b. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Aging/Disability Waiver Group Medicaid-Only FFS Enrollees (2001 - 2003)



May 2008

Figure 3c. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Nursing Facility State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)

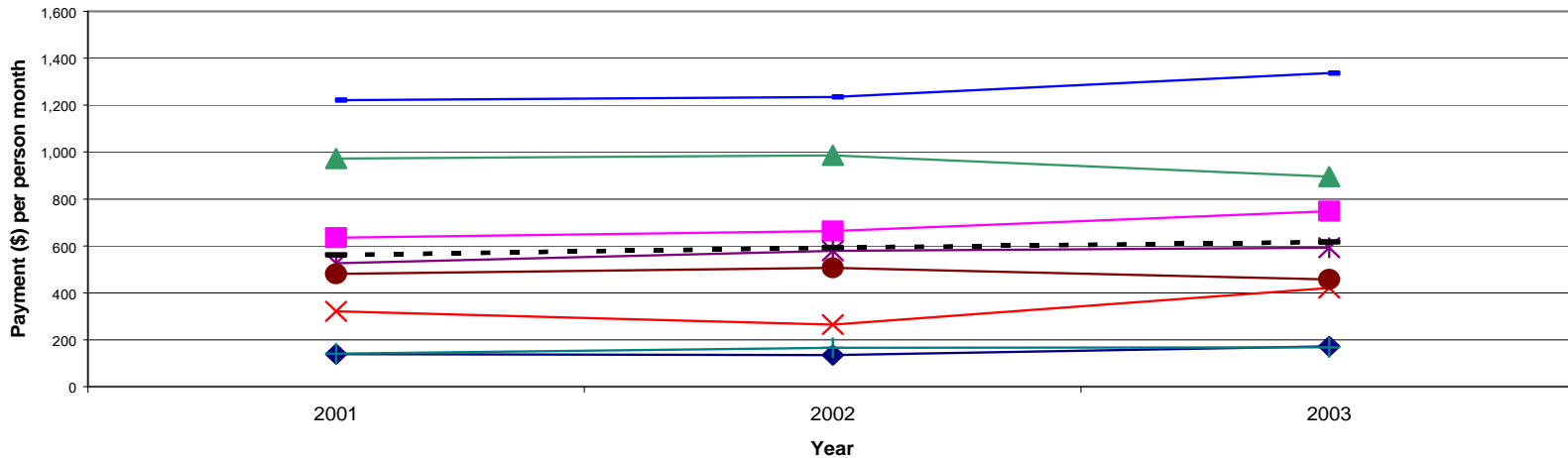
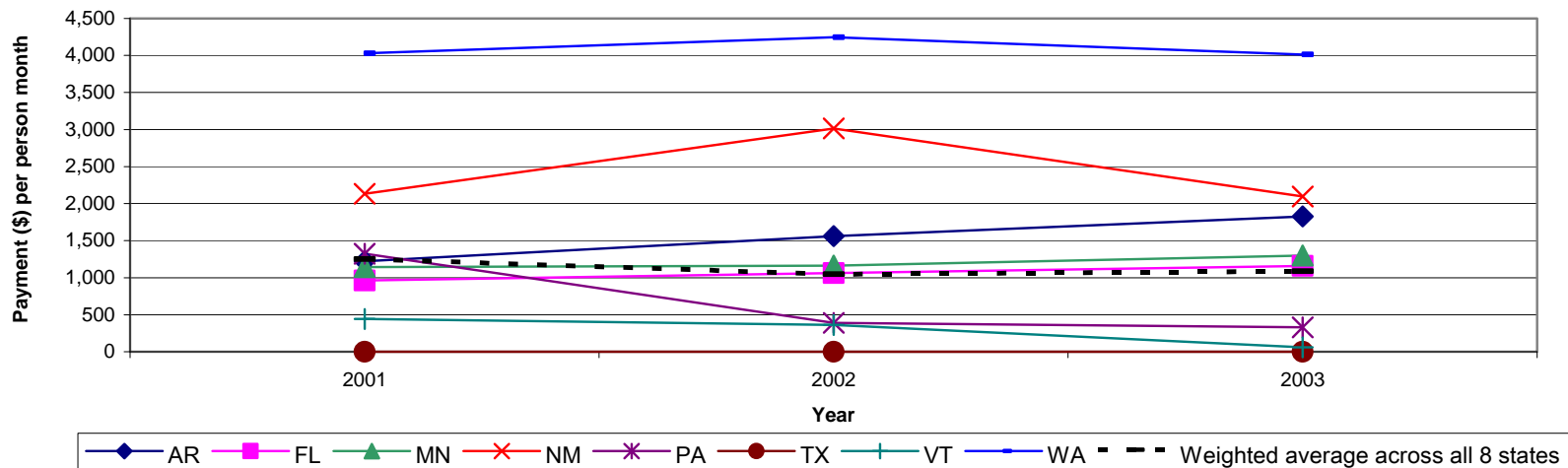


Figure 3d. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Home Health State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)



May 2008

Figure 3e. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for MR/DD Waiver Group Dual FFS Enrollees (2001 - 2003)

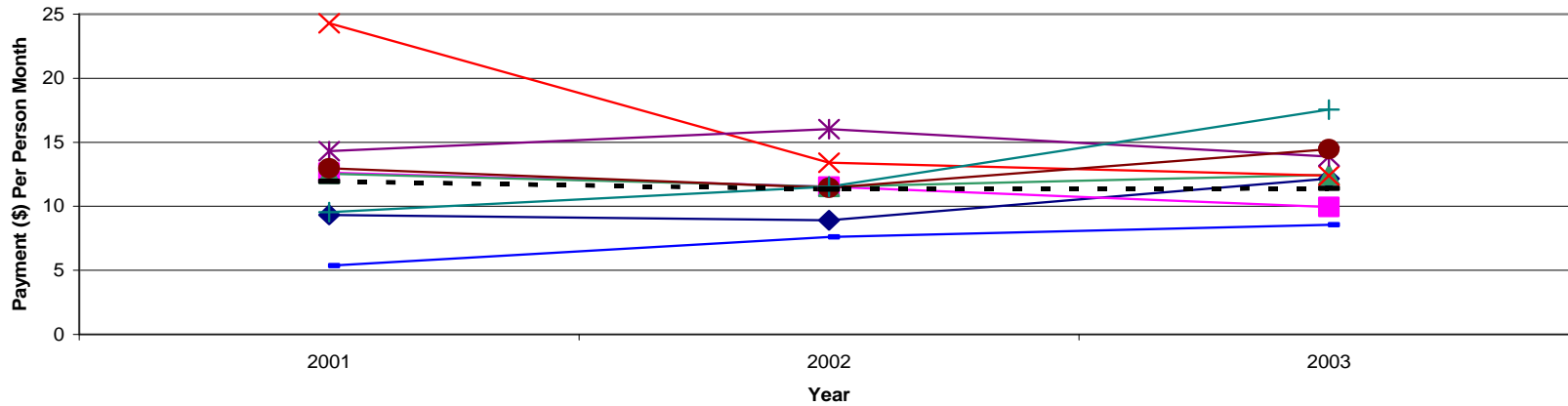
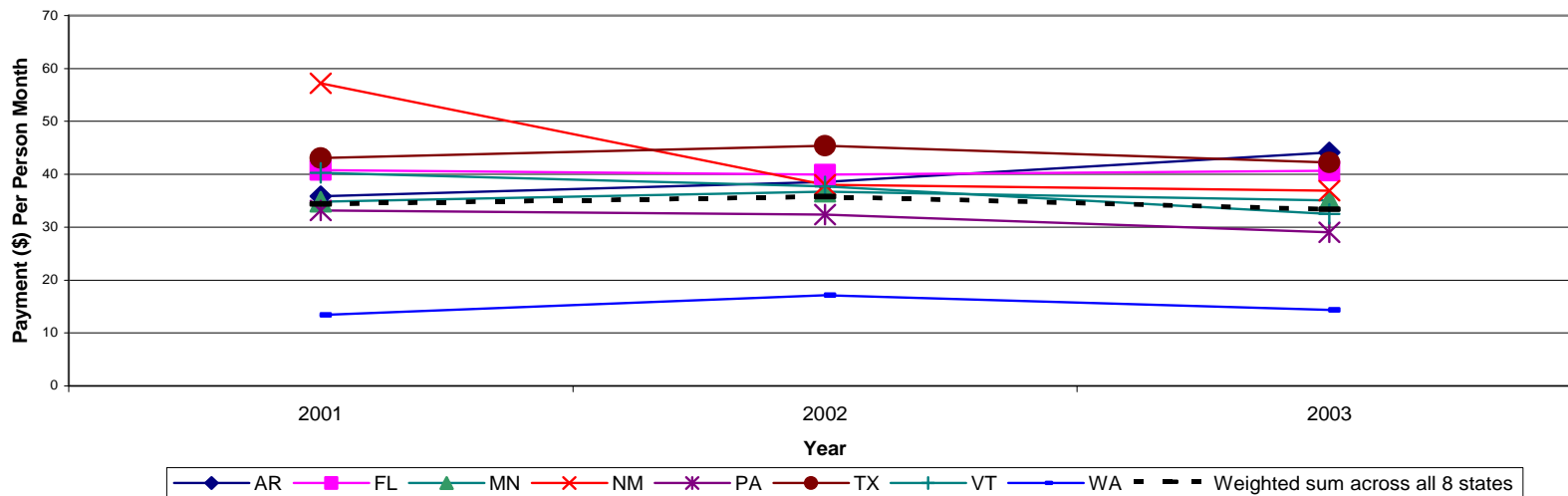


Figure 3f. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003)



May 2008

Figure 3g. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Nursing Facility State Plan Group Dual FFS Enrollees (2001 - 2003)

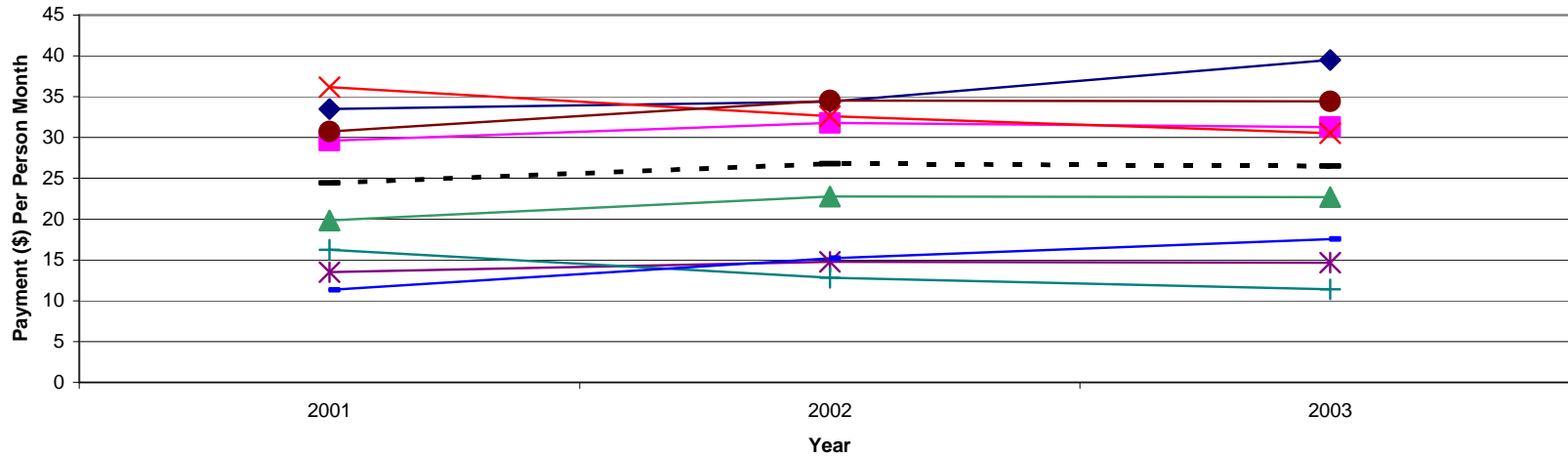
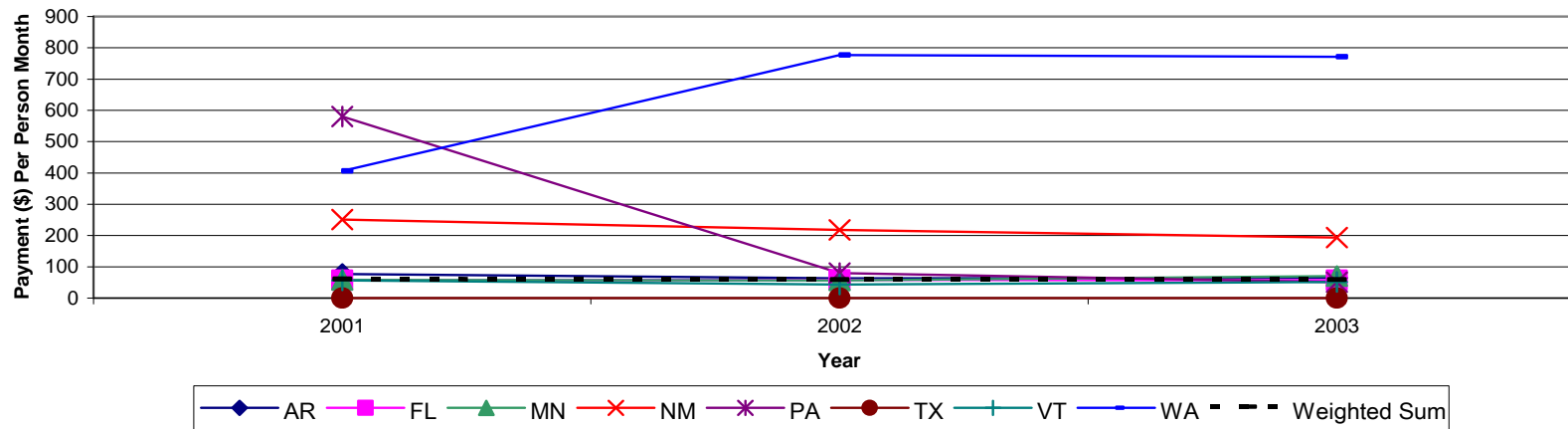


Figure 3h. Inpatient Hospital Medicaid Payment (\$) per Person Month, across States for Home Health State Plan Group Dual FFS Enrollees (2001 - 2003)



Residential LTC Medicaid Payment per Person Month (\$) by Analytic Group across Three years – 2001 thru 2003

What is being measured?

The average Medicaid payment amount per person month in an analytic group by year - total Medicaid payments for nursing home for all beneficiaries in the year divided by the total number of person months in the analytic group (users and nonusers of the service) across three years (2001 – 2003) for each of the eight states. We have added a line indicating the weighted average across the eight states. The weighted average is calculated by summing the total payments per person month per analytic group across all eight states and dividing that number by the prorated number of person months (sum of person months in each state per analytic group divided by the total number of person months of all eight states). Because the majority of analytic groups do not utilize nursing homes at all or have very low rates of utilization, we are reporting nursing home payments for only the nursing home state plan analytic group.

Descriptive Results:

Figure 4a. Medicaid Only FFS Nursing Home Costs

- There is virtually no use of nursing facilities or intermediate care facilities by waiver participants or Medicaid recipients utilizing other LTC services such as home health or personnel care.
- The average cost of nursing home care for nursing home residents increases slightly between 2001 and 2003 for all states except New Mexico.

Figure 4b. Dual FFS Enrollees

- The expenditures on nursing homes are lower in the dual eligible group compared to the Medicaid only group. This is consistent with expectations. Medicare expenditures are not captured in the data presented.
- The average cost of nursing home care for nursing home residents increases slightly between 2001 and 2003 for all states except Minnesota.

Interpretation

- Residential LTC options, including nursing homes are not being used by participants primarily utilizing HCBS.
- While costs have held steady in inpatient hospital care and ambulatory care, nursing home costs continue to rise somewhat.

Figure 4a. Average Nursing Home Medicaid Payment (\$) per Month, across States for Nursing Facility Medicaid Only FFS Enrollees (2001 - 2003)

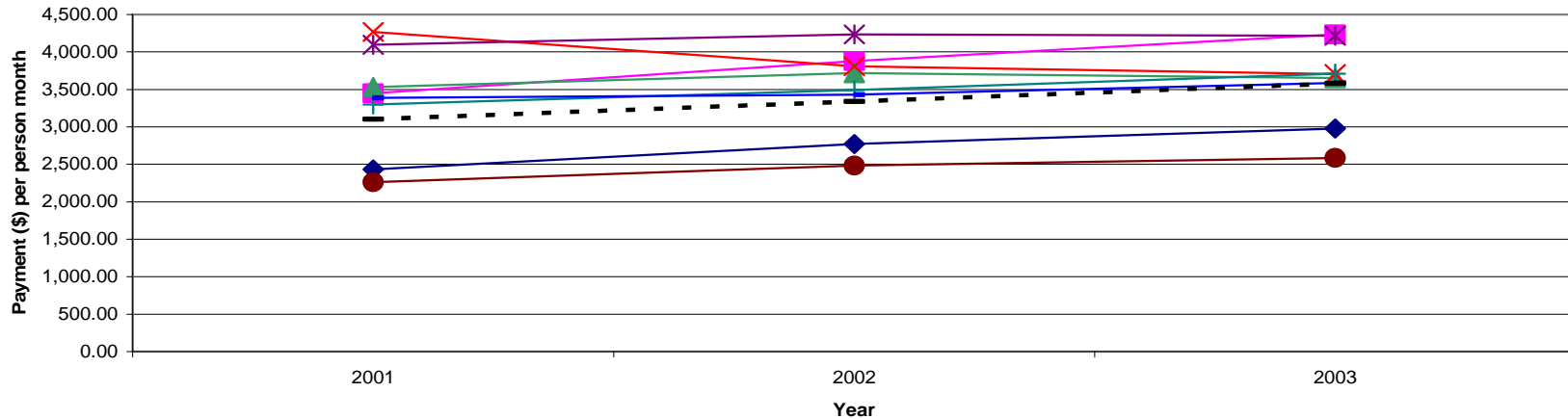
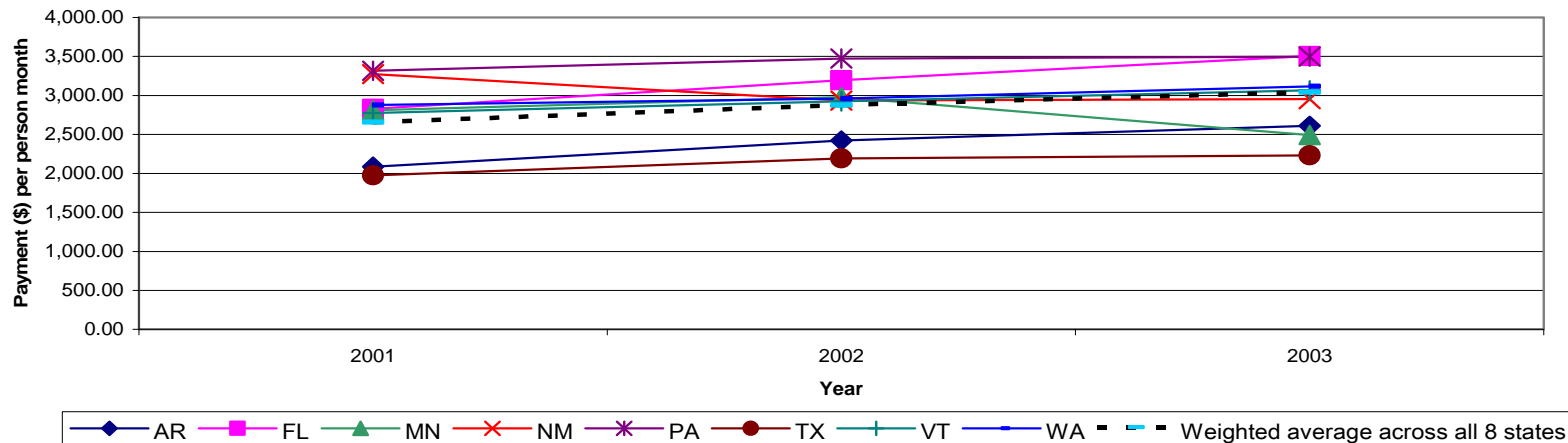


Figure 4b. Average Nursing Home Medicaid Payment (\$) per Month, across States for Nursing Home Dual FFS Enrollees (2001 - 2003)



Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group by Analytic Group across Three Years – 2001 thru 2003

What is being measured?

The annual Medicaid payment amount for ambulatory services per person month in an analytic group divided by the total number of person months in the analytic group (users and non users of the service) across three years (2001 – 2003) for each of the eight states. We have added a line indicating the weighted average across the eight states. The weighted average is calculated by summing the total payments per person month per analytic group across all eight states and dividing that number by the prorated number of person months (sum of person months in each state per analytic group divided by the total number of person months of all eight states). Separate graphs have been prepared for each waiver and state plan group. Ambulatory services include physician, other practitioner (such as nurse practitioner and nurse midwife), and outpatient services (including outpatient hospital, and clinic visits).

Descriptive Results:

Figures 5a-d. Medicaid Only FFS Ambulatory Care Costs

- The trend in per person payments for ambulatory services shows little change between 2001 and 2003 across the different waiver and state plan groups.
- The trend in per person payments for ambulatory services between 2001 and 2003 is generally similar across states.
- There is a sizeable and steady increase in total ambulatory care payments in NM and VT for aging and disabled waiver recipients and WA home health state plan participants between 2001 and 2003. This increase

may reflect variation due to a small number of enrollees with varying service use rather than an overall increase in payments over time.

- Smaller increases or decreases are shown for MR/DD waiver, nursing home and home health state plan enrollees in MN and NM and in VT and PA home health state plan enrollees. AR rates were much higher than other states.

Figures 5e-h. Dual FFS Enrollees Ambulatory Care Costs

- The trend in per person payments for ambulatory services shows little change between 2001 and 2003 across the different waiver and state plan groups. AR rates were much higher than other states.
- The trend in per person payments for ambulatory services between 2001 and 2003 is similar across states.
- There is a sizeable and steady increase in total ambulatory care payments in Washington for home health care recipients and a decline in per person payments in PA between 2001 and 2003. This increase may reflect variation due to a small number of enrollees with varying service use rather than an overall increase in payments over time.

Interpretation

- The difference between Medicaid only payments and dual eligible payments reflects the role of Medicare coverage which is not reported in this data.
- There is little change in overall payments for ambulatory services between 2001 and 2003.

Figure 5a. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for MR/DD Waiver Group Medicaid-Only FFS Enrollees (2001 - 2003)

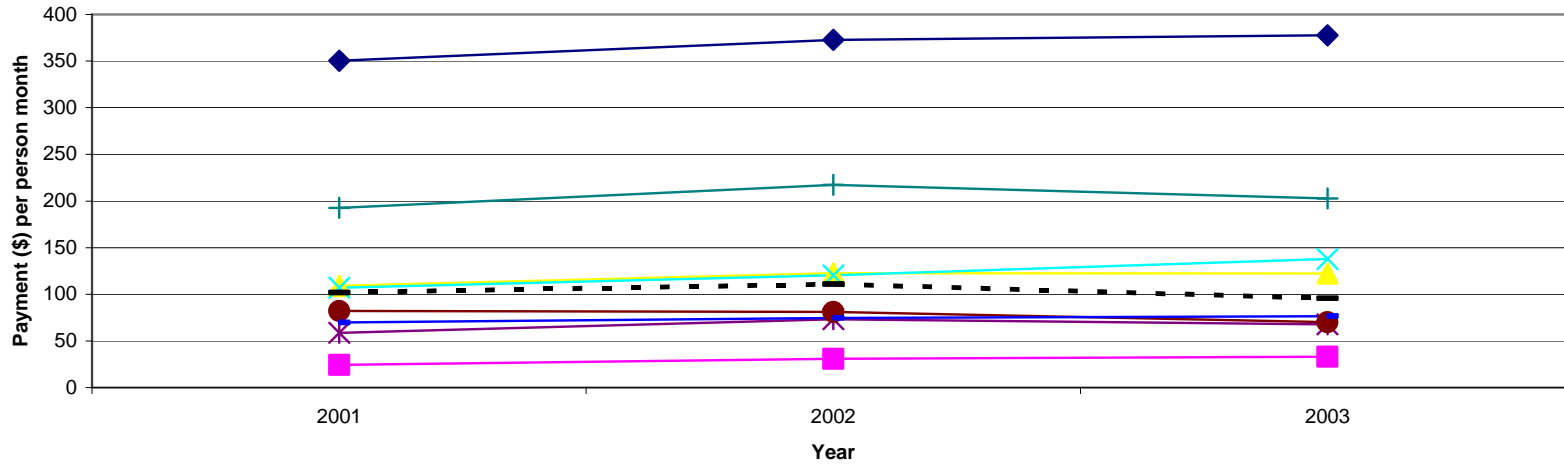


Figure 5b. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003)

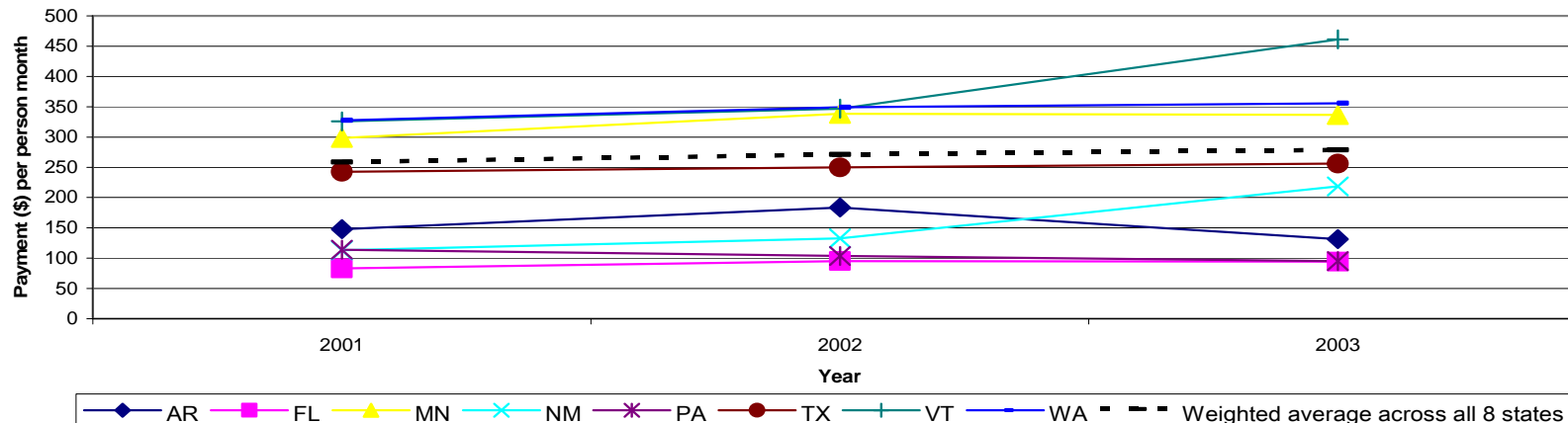


Figure 5c. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for Nursing Facility State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)

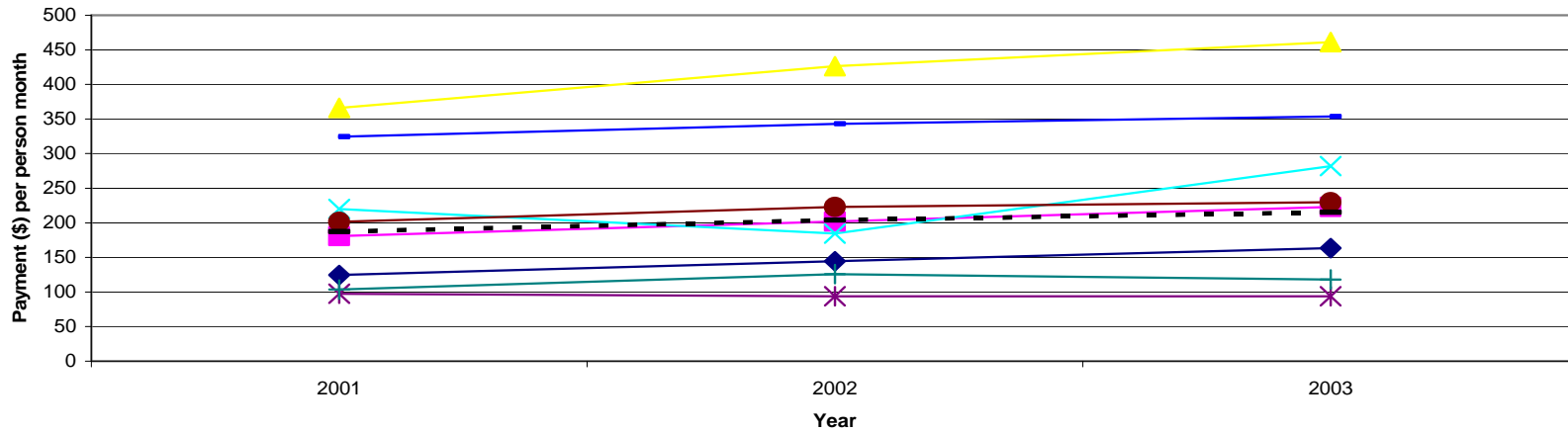


Figure 5d. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, across States for Home Health State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)

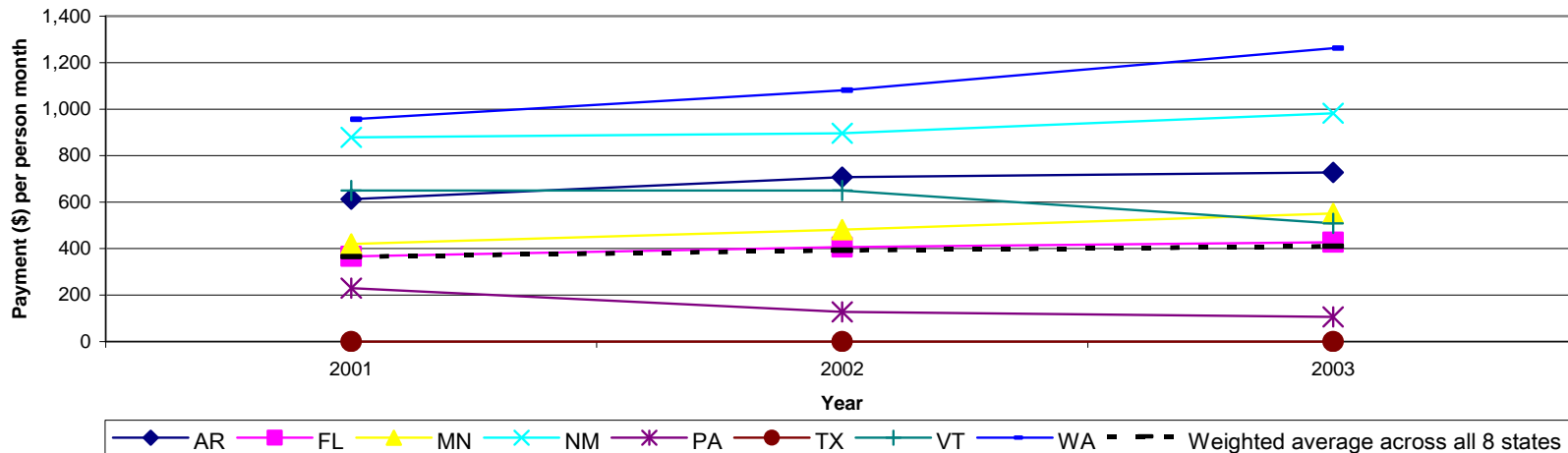


Figure 5e. Total Ambulatory Service Medicaid Payment (\$) per Person Month, across States for MR/DD Waiver Group Dual FFS Enrollees (2001 - 2003)

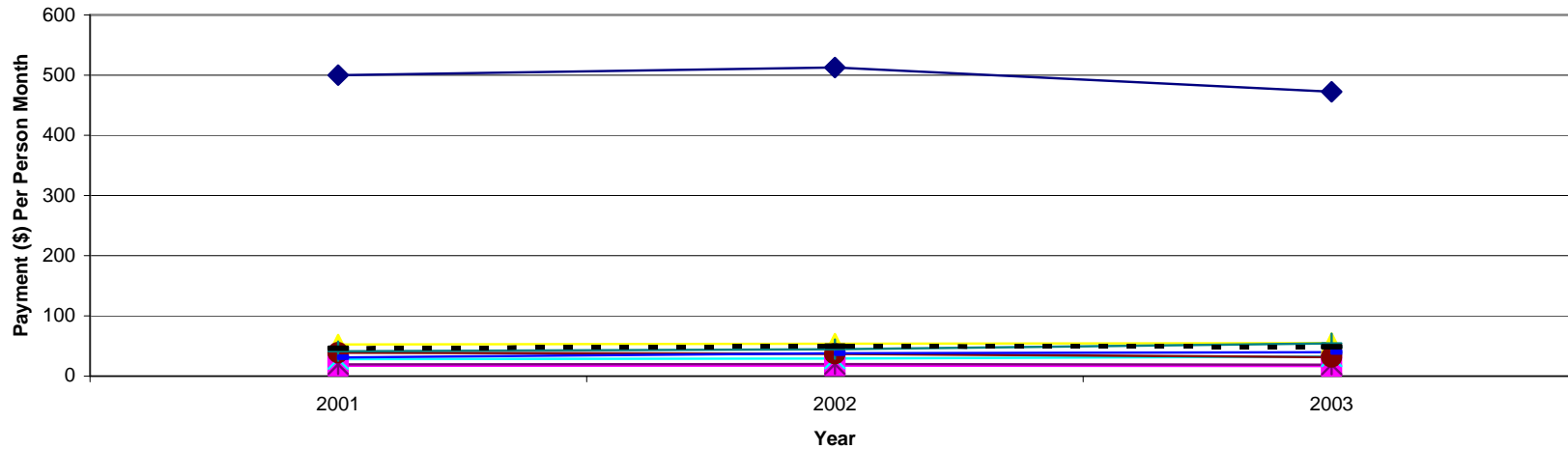


Figure 5f. Total Ambulatory Service Medicaid Payment (\$) per Person Month, across States for Aging/Disability Waiver Group Dual FFS Enrollees (2001 - 2003)

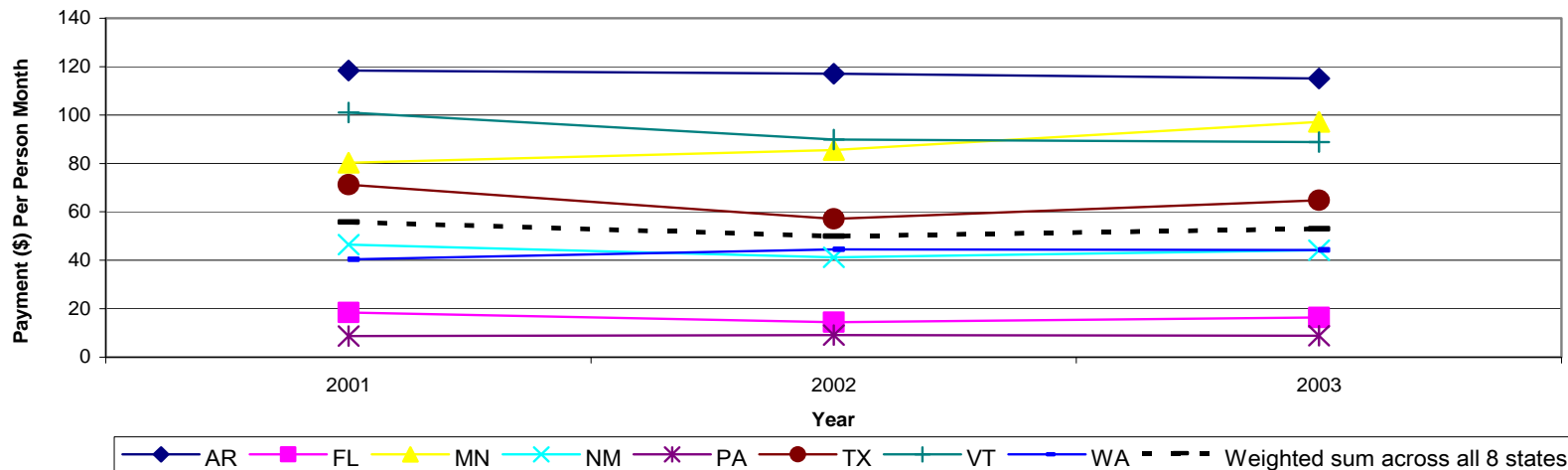


Figure 5g. Total Ambulatory Service Medicaid Payment (\$) per Person Month, across States for Nursing Facility State Plan Group Dual FFS Enrollees (2001 - 2003)

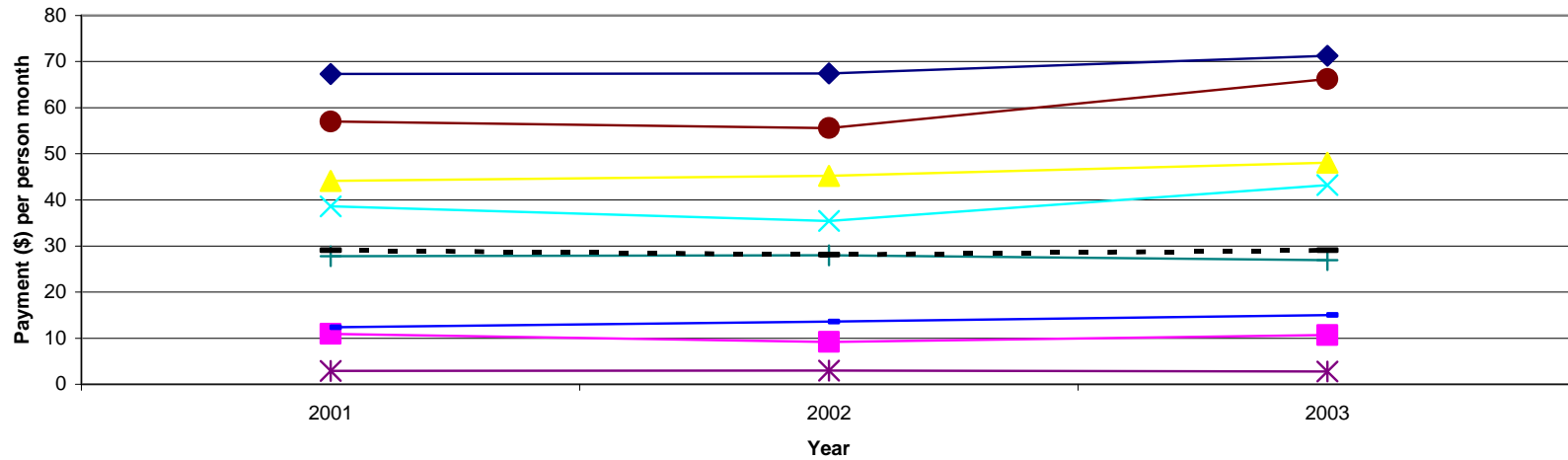
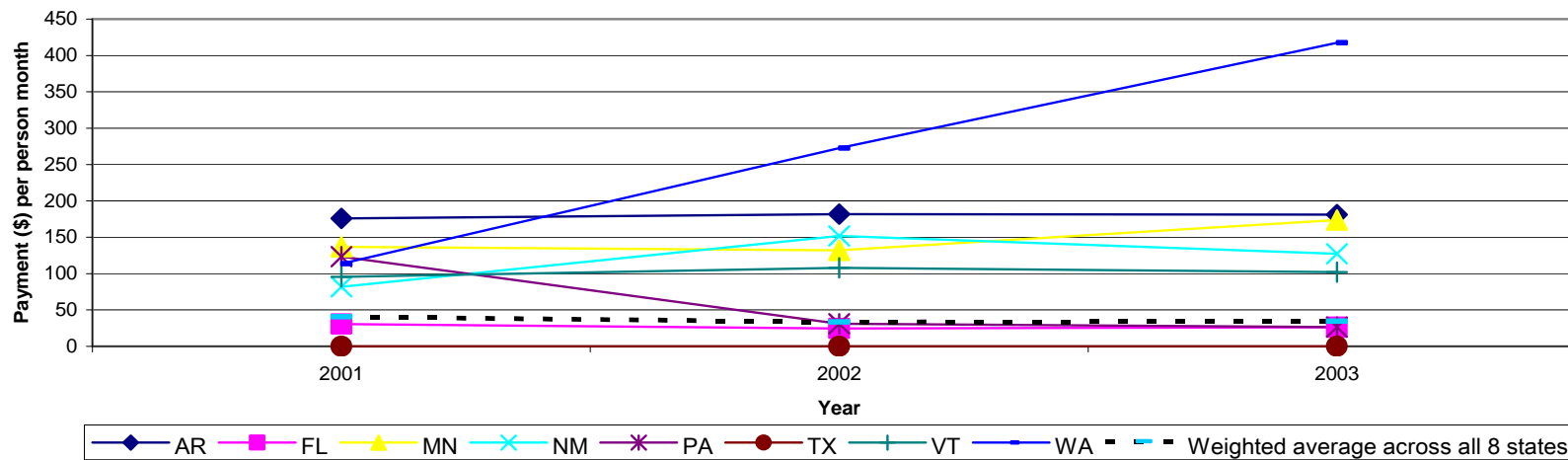


Figure 5h. Total Ambulatory Service Medicaid Payment (\$) per Person Month, across States for Home Health State Plan Group Dual FFS Enrollees (2001 - 2003)



Prescription Drug Medicaid Payment (\$) per Person Month in Group by Analytic Group across Three years – 2001 thru 2003

What is being measured?

The annual Medicaid payment amount per person month in an analytic group for prescription drugs divided by the total number of person-months in the analytic group across three years (2001 – 2003) for each of the eight states. We have added a line indicating the weighted average across the eight states. The weighted average is calculated by summing the total payments per person month per analytic group across all eight states and dividing that number by the prorated number of person months (sum of person months in each state per analytic group divided by the total number of person months of all eight states). Separate graphs have been prepared for each waiver and state plan group.

Descriptive Results:

Figures 6a-d. Medicaid Only FFS Prescription Drug Costs

- The trend in per person payments for prescription drugs increases between 2001 and 2003 across the different waiver and state plan groups.
- The increasing trend in per person payments for prescription drugs between 2001 and 2003 are generally

similar across states with one exception in the AR home health state plan analytic group.

- Texas shows the greatest increase over time. A few states such as MN and FL show a slight decline between 2001 and 2002 with an increase between 2002 and 2003, showing an overall increase over the three year period.
- Generally the greatest increase in per person drug payments occurred between 2002 and 2003.

Figures 6e-h. Dual FFS Enrollees Prescription Drug Costs

- Total payment for prescription drugs as well as the trend over time are similar between Medicaid only and dual eligible participants.
- Overall patterns among states and service categories across the three years is generally similar.

Interpretation

- The total cost of prescription drugs increased across all eight states and across all analytic groups. The reason behind the greater increase from 2002-2003 is not apparent.

Figure 6a. Prescription Drugs Medicaid Payment (\$) per Person Month in Group, across States for MR/DD Waiver Group Medicaid-Only FFS Enrollees (2001 - 2003)

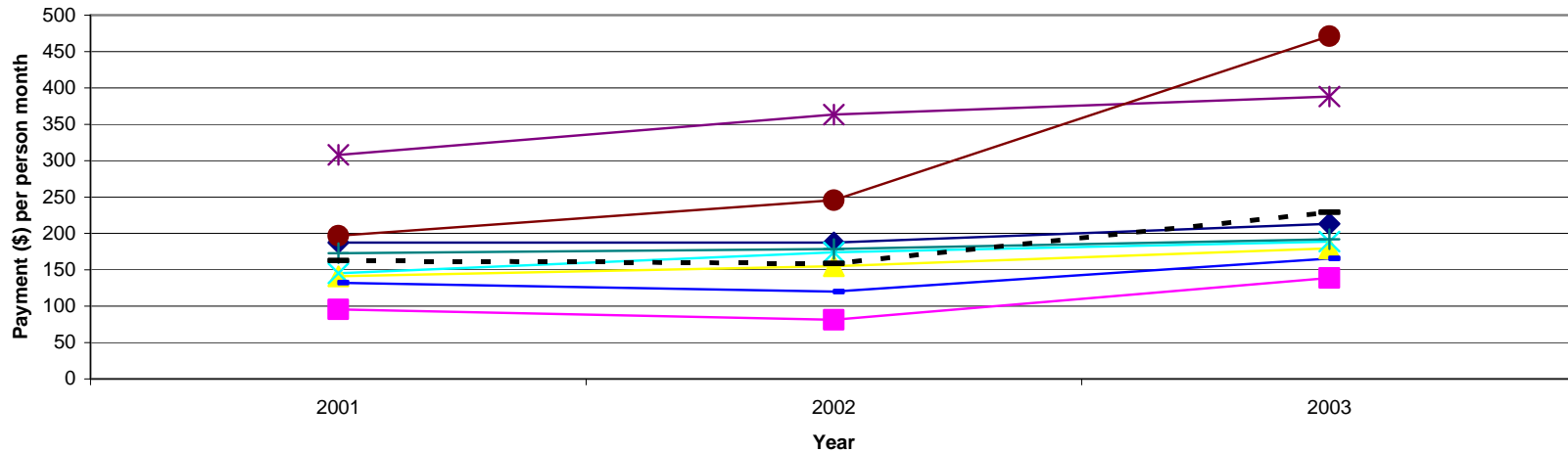


Figure 6b. Prescription Drugs Medicaid Payment (\$) per Person Month in Group, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003)

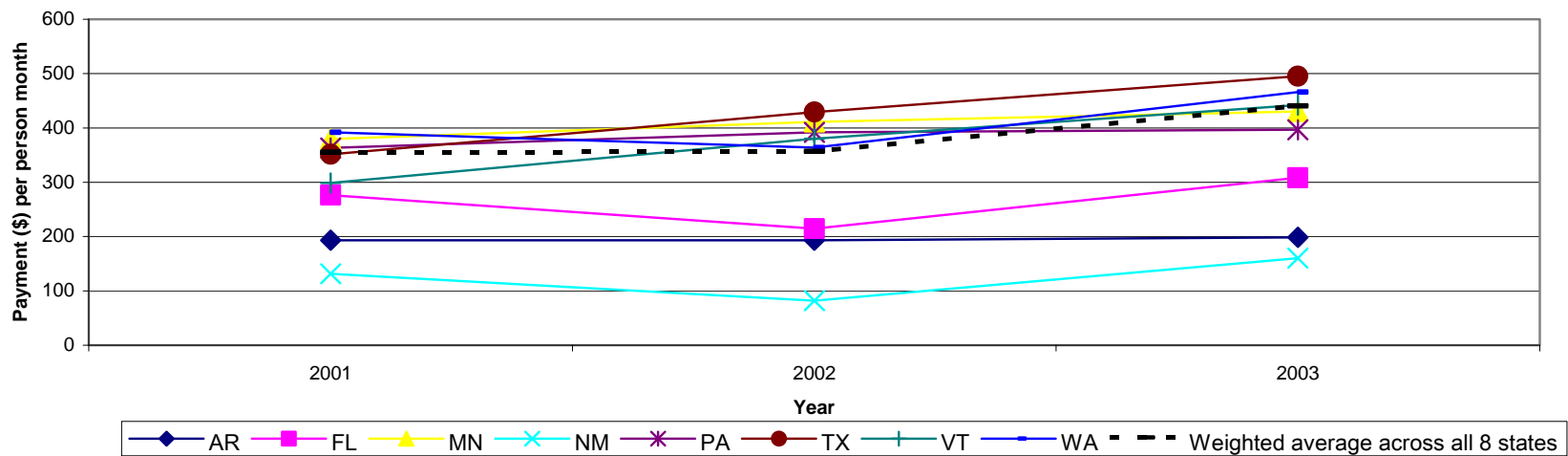


Figure 6c. Prescription Drugs Medicaid Payment (\$) per Person Month in Group, across States for Nursing Facility State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)

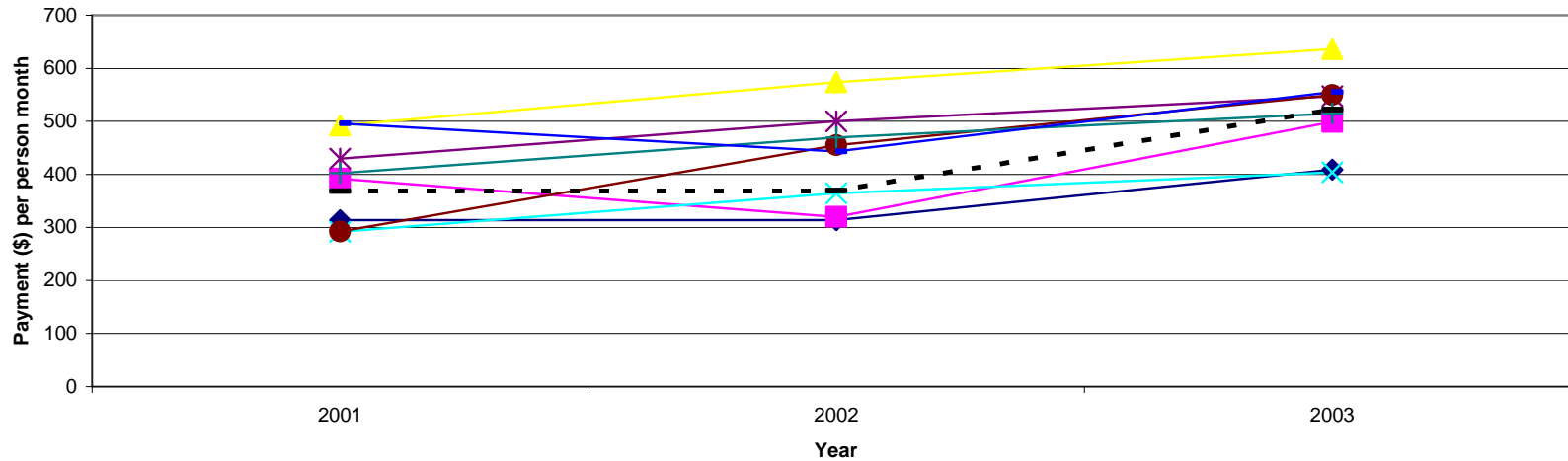


Figure 6d. Prescription Drugs Medicaid Payment (\$) per Person Month in Group, across states for Home Health State Plan Group Medicaid-Only FFS Enrollees (2001 - 2003)

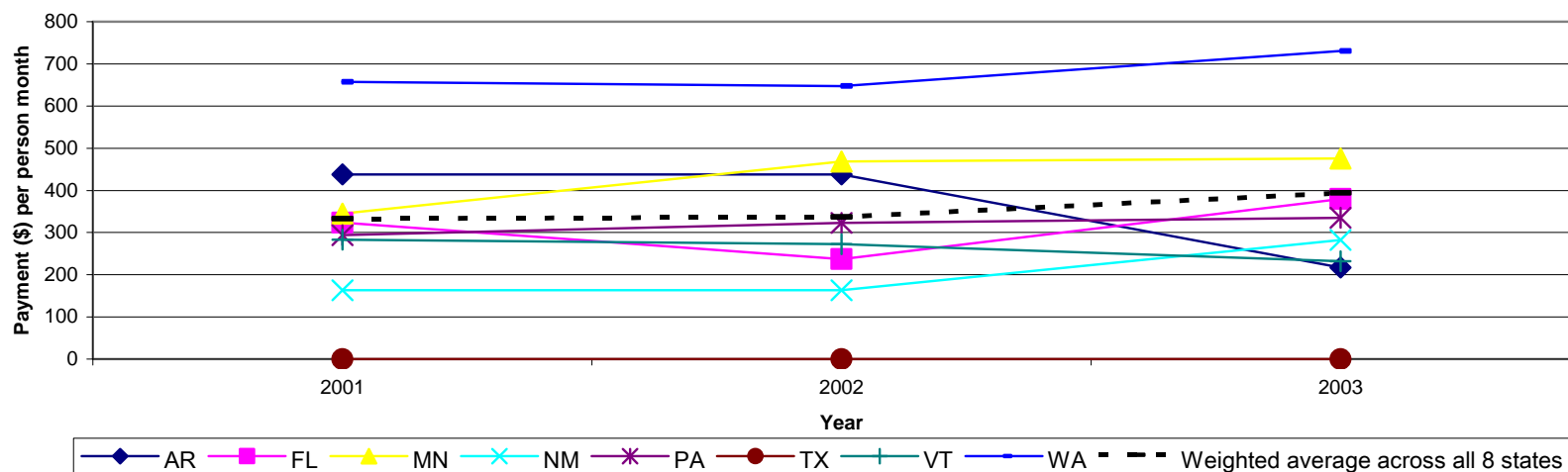


Figure 6e. Prescription Drugs Medicaid Payment (\$) per Person Month, across States for MR/DD Waiver Group Dual FFS Enrollees (2001 - 2003)

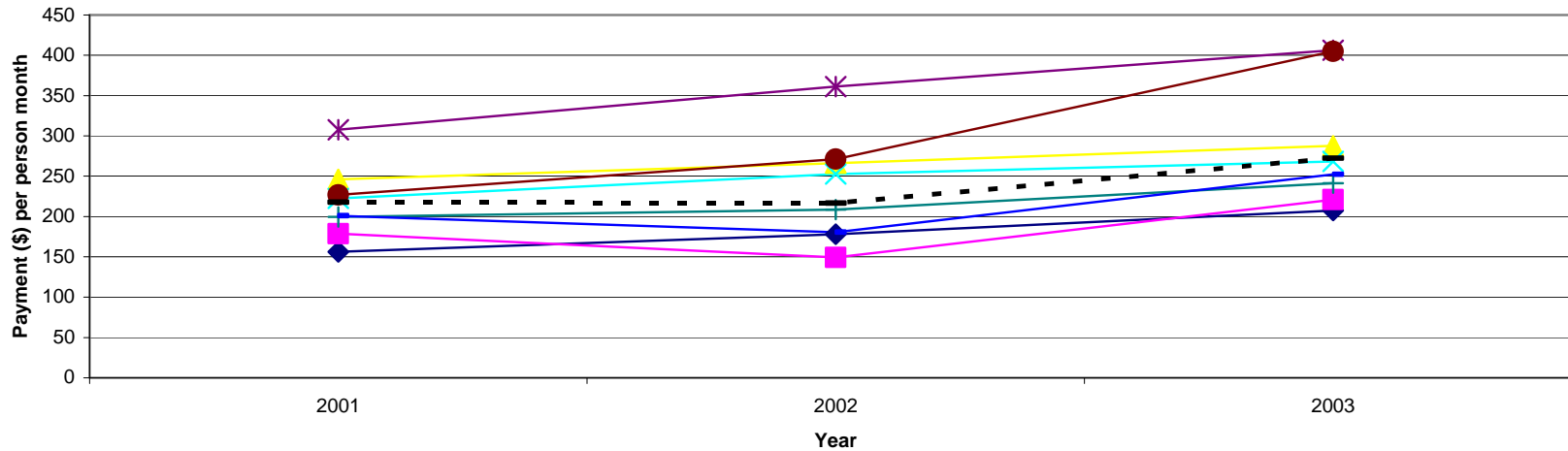
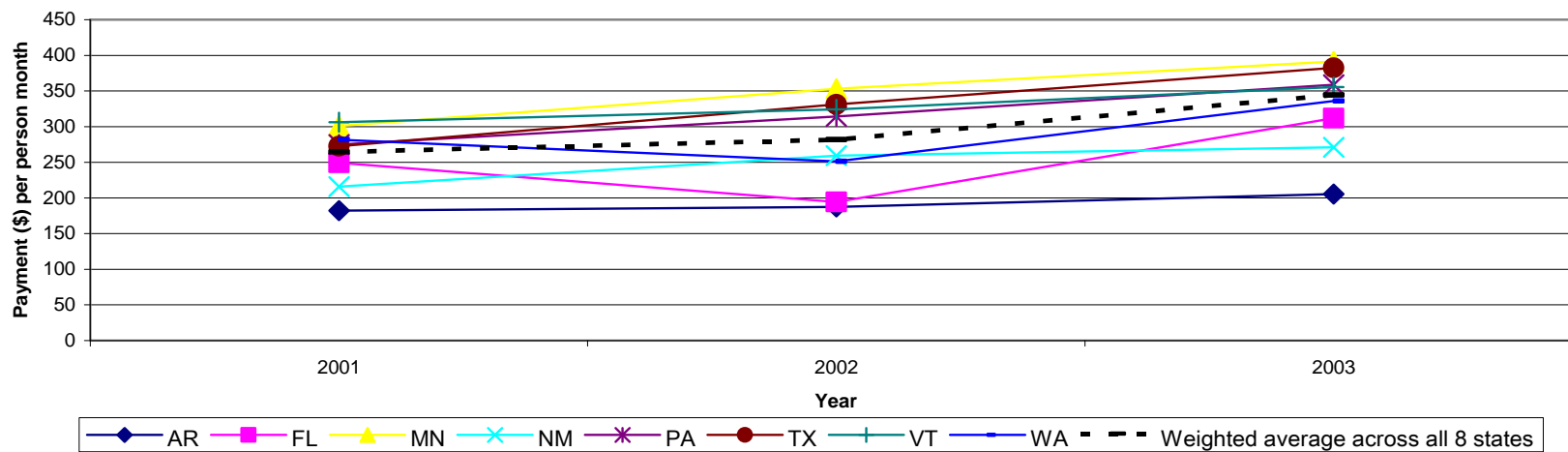


Figure 6f. Prescription Drugs Medicaid Payment (\$) per Person Month, across States for Aging/Disability Waiver Group Dual- FFS Enrollees (2001 - 2003)



May 2008

Figure 6g. Prescription Drugs Medicaid Payment (\$) per Person Month, across States for Nursing Facility State Plan Group Dual FFS Enrollees (2001 - 2003)

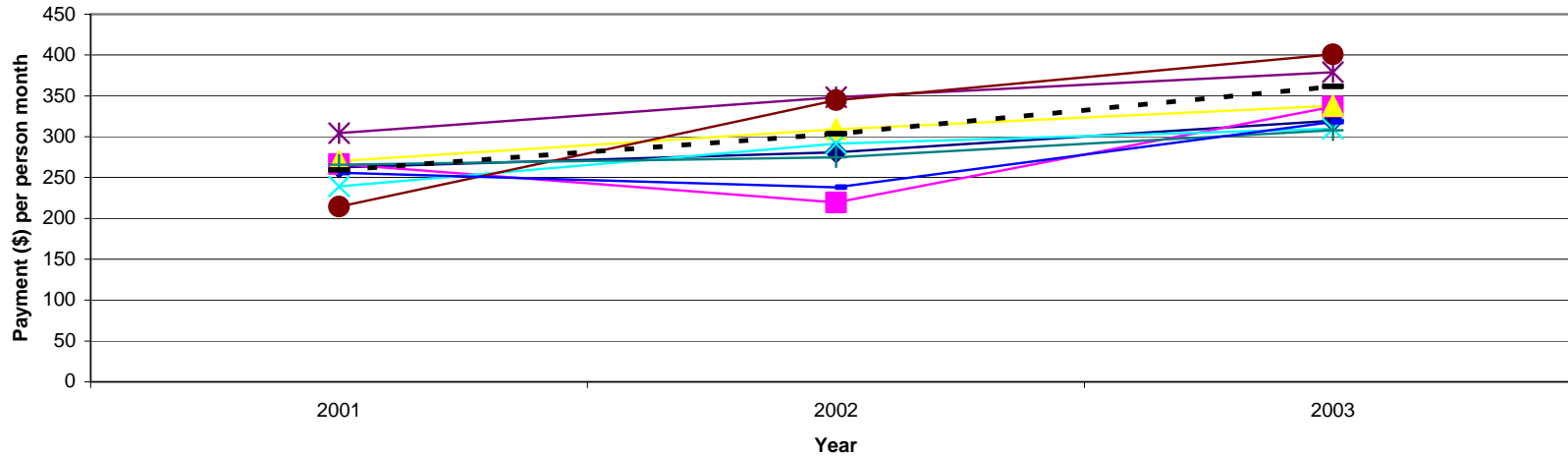
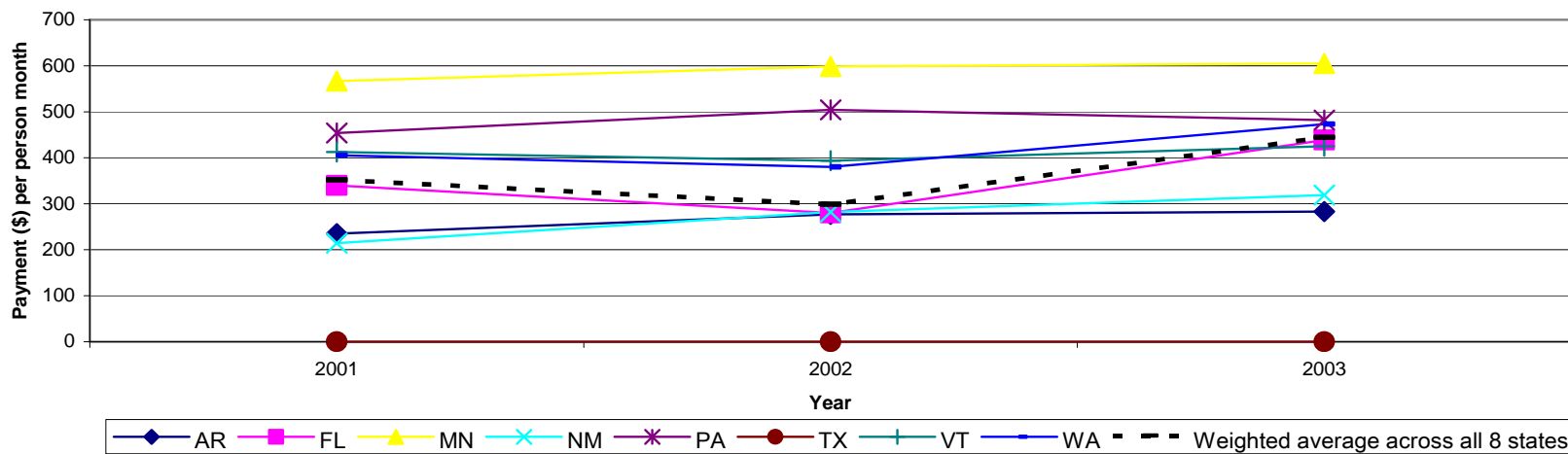


Figure 6h. Prescription Drugs Medicaid Payment (\$) per Person Month, across States for Home Health State Plan Group Dual FFS Enrollees (2001 - 2003)



Percent Change in Service Utilization and Payments - Eight State Weighted Average

What is being measured?

The next series of graphs shows essentially the same information in a slightly different format. We are showing the weighted average in service utilization and costs across all eight states, comparing various types of service utilization and cost by waiver and state plan analytic group. The weighted average is calculated by summing the total payments per person month per analytic group across all eight states and dividing that number by the prorated number of person months (sum of person months in each state per analytic group divided by the total number of person months of all eight states). Separate graphs have been prepared for each waiver and state plan group. This presentation highlights the relative change over time across types of services within a specific analytic group.

Descriptive Results:

Figures 7a-d. Medicaid only Enrollees

- In general utilization and payments for inpatient stays and ambulatory services were flat or showed only slight changes over the three year period. This trend was fairly consistent across analytic groups.
- Nursing home payments increased across all analytic groups.
- Drug payments increased across all analytic groups except for aging and disabled waiver enrollees.

Figures 7e-h. Dual Eligible Enrollees

- The pattern of change across years and analytic groups was similar between Medicaid only and dual eligible enrollees.
- Inpatient utilization and payments were generally steady or showed modest change over time except for inpatient utilization in the MR/DD waiver group.
- Prescription drug costs increased in all analytic groups.
- Nursing home utilization and costs increased in the two waiver groups; however, this change may be due to large changes in a very smaller number of individuals.

Interpretation

- There was a similar trend across waiver and state plan groups relative to payments for medical and LTC services.
- Nursing home and drug payments are putting increasing pressure on Medicaid FFS programs across the eight states.

Figure 7a. Percent Change in Service Utilization and Payments - Eight State Weighted Average MR/DD Waiver Group Medicaid Only

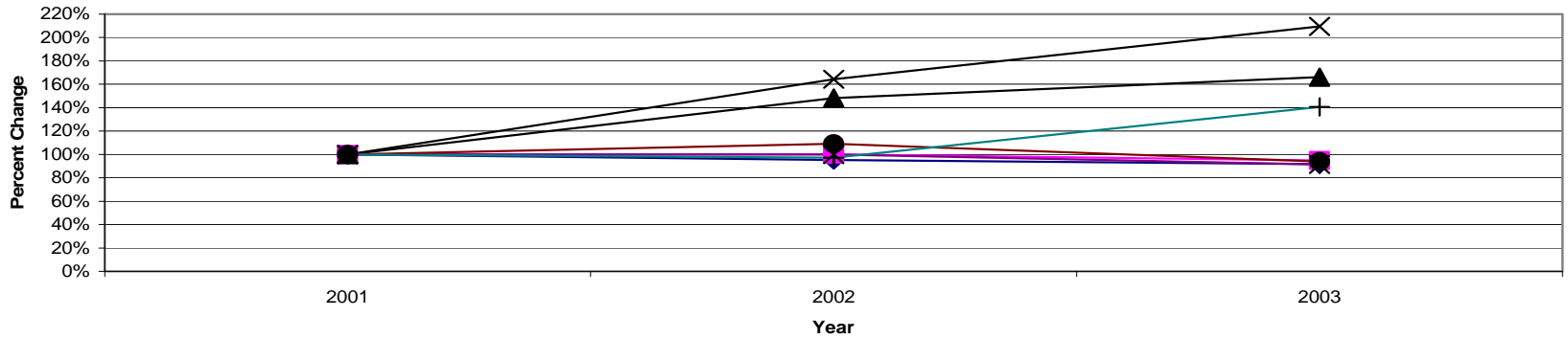


Figure 7b. Percent Change in Service Utilization and Payments - Eight State Weighted Average Aging/Disability Waiver Group Medicaid Only

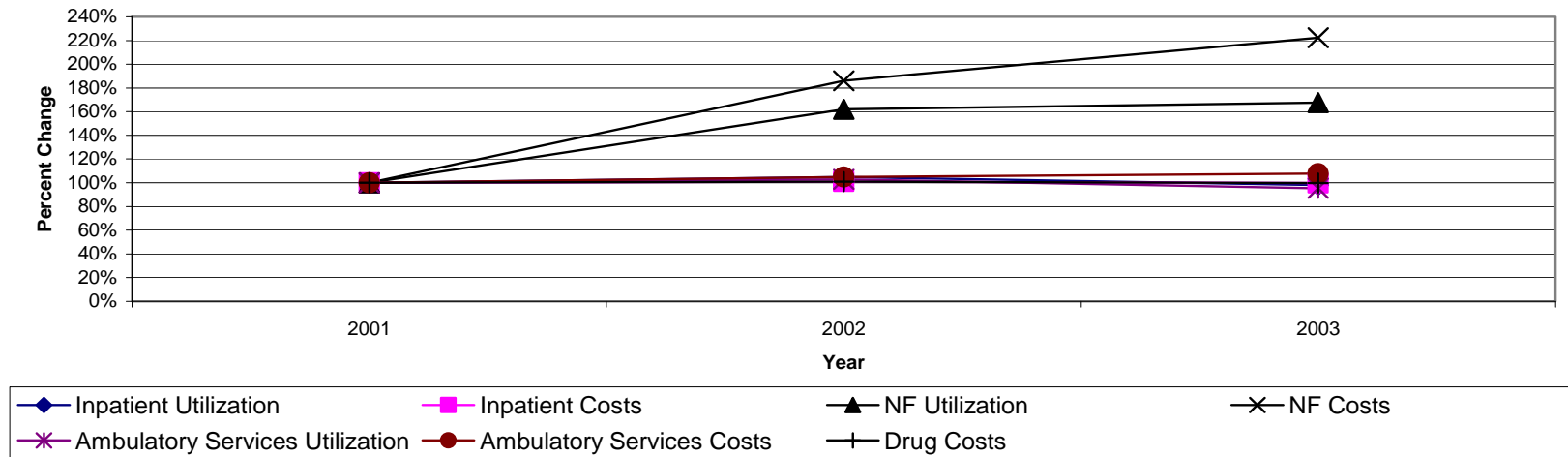


Figure 7c. Percent Change in Service Utilization and Payments - Eight State Weighted Average Nursing Home State Plan Group Medicaid Only

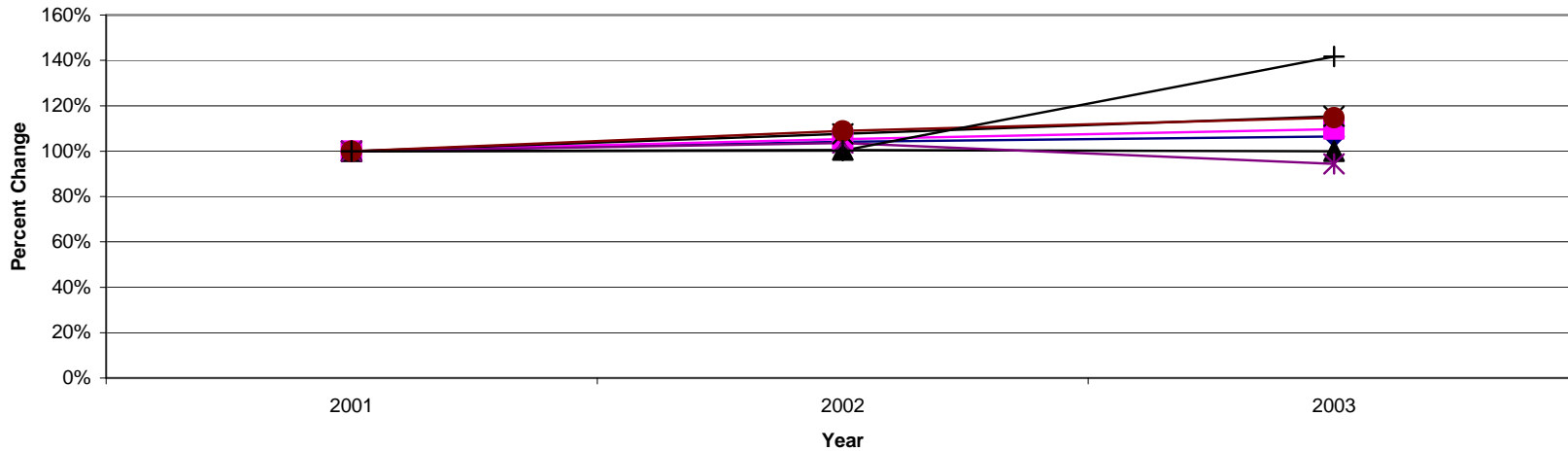


Figure 7d. Percent Change in Service Utilization and Payments - Eight State Weighted Average Home Health State Plan Group Medicaid Only

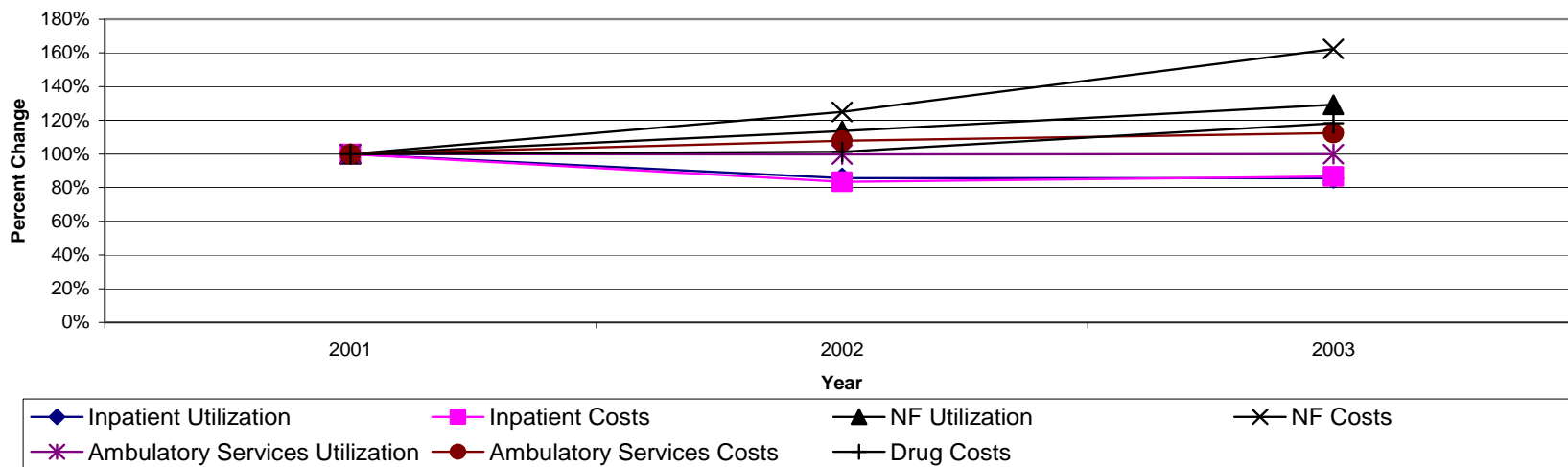


Figure 7e. Percent Change in Service Utilization and Payments - Eight State Weighted Average MR/DD Waiver Group Dual Eligible Enrollees

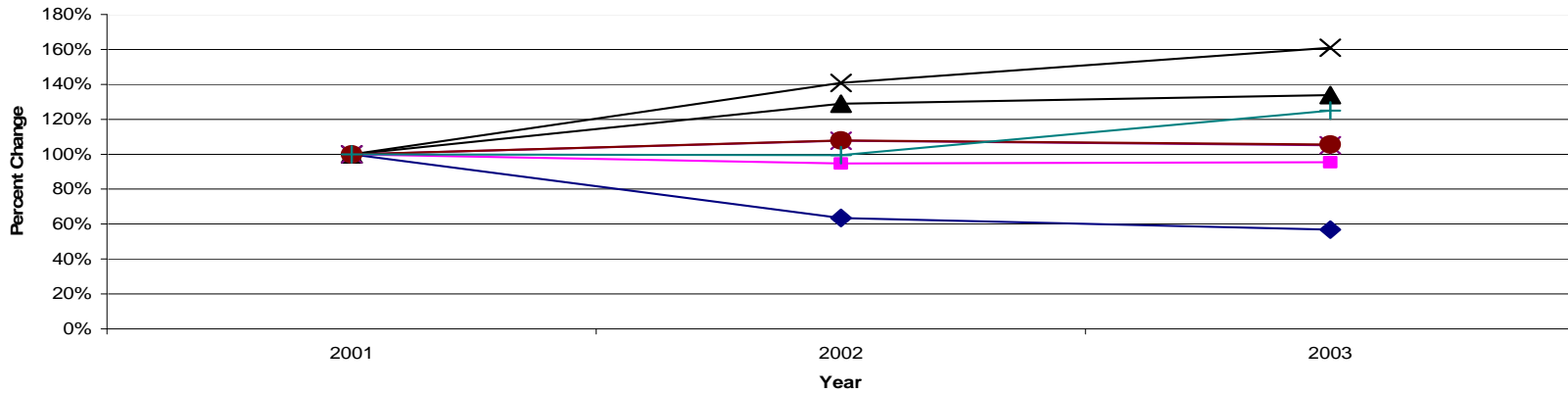


Figure 7f. Percent Change in Service Utilization and Payments - Eight State Weighted Average Aging/Disability Waiver Group Dual Eligible Enrollees

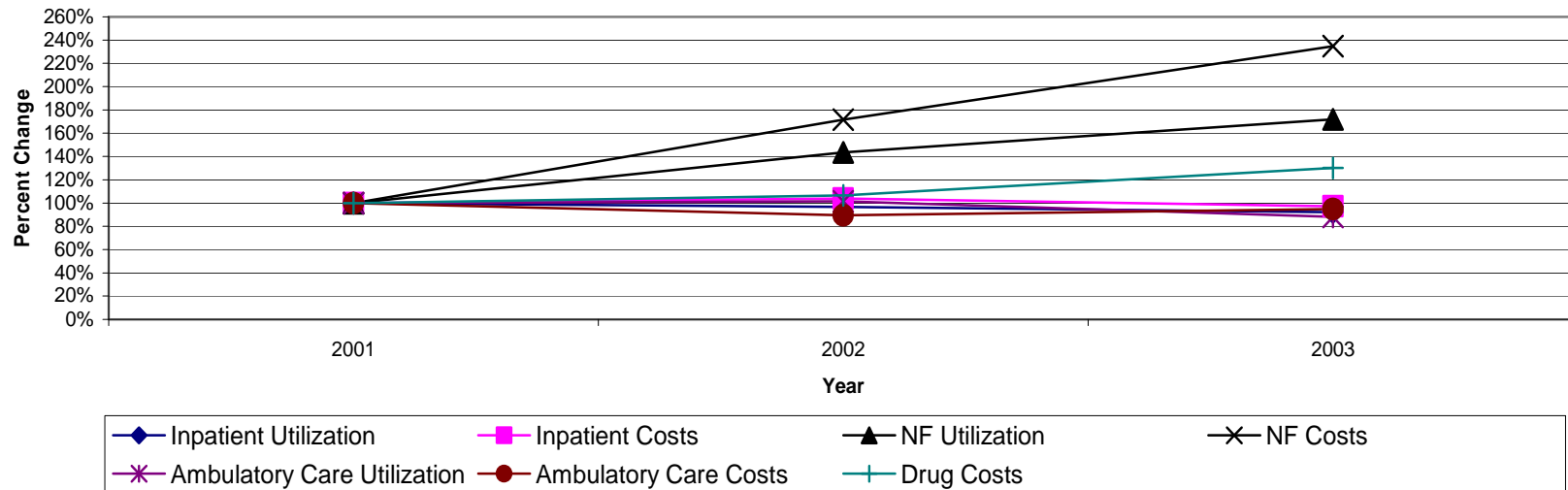


Figure 7g. Percent Change in Service Utilization and Payments - Eight State Weighted Average Nursing Home State Plan Group Dual Eligible Enrollees

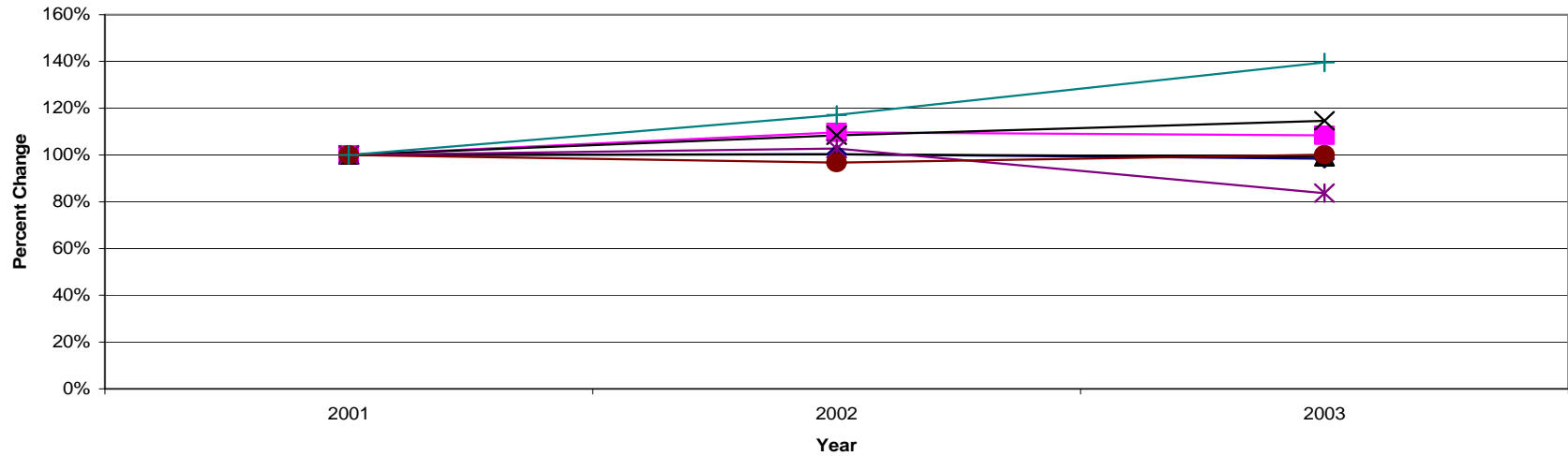
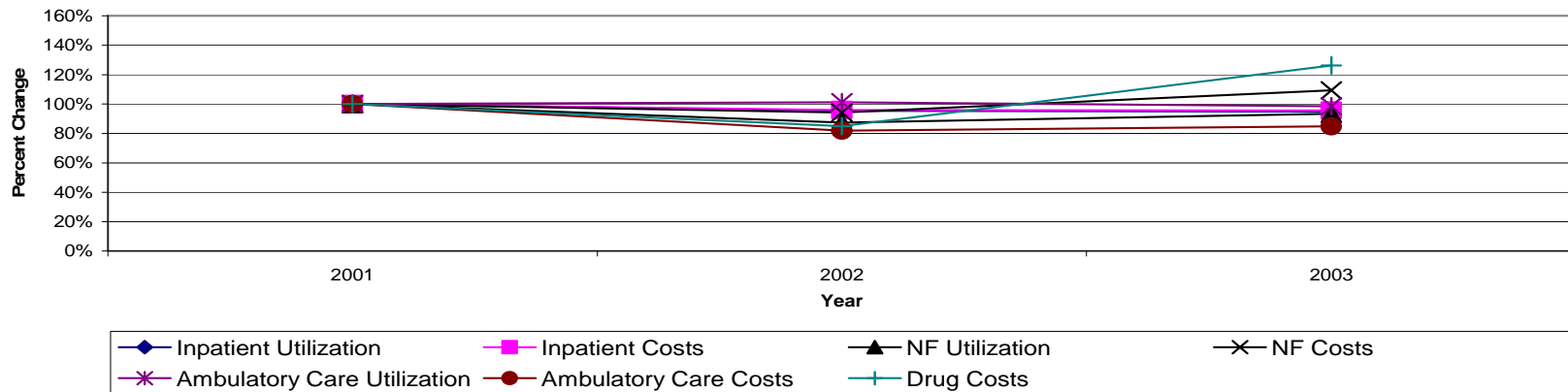


Figure 7h. Percent Change in Service Utilization and Payments - Eight State Weighted Average Home Health State Plan Group Dual Eligible Enrollees



Conclusion

There are some general trends in utilization and payment for medical and LTC services between 2001 and 2003.

- Payments for acute inpatient stays and ambulatory care services were steady between 2001 and 2003.
- Payments for nursing home stays and prescription drugs increased between 2001 and 2003.
- There was little difference in payment trends across types of services between Medicaid only and dual eligible enrollees.
- There was little difference in payment trends across types of services comparing across waiver and state plan analytic groups.