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WHERE'S THE MONEY?
Analysis of Medicaid Budget Offers Clues For Payment Reform

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This article analyzes Arkansas Medicaid expenditures over the last seven years. It provides insight into where the money is spent and where the growth is, in an effort to focus the debate over the state's Medicaid Payment Improvement Initiative on data rather than anecdotal evidence.

The purpose of the state's initiative is to reduce the growth in Medicaid expenditures by moving physicians, hospitals, and other providers away from fee-for-service and its disincentive to control costs to a new model with bundled payments for episodes of care. An analysis of Medicaid data going back to 2005 shows that there are 19 specific types of provider services driving the growth, and six general program areas where Medicaid expenditures are concentrated.

Medicaid spending on physician services is not driving the growth that is the concern of the Governor and the Medicaid program, though physicians will be called on to modify referrals and practice patterns that affect growth categories. Some important areas of the Medicaid program are paid based on cost-based reimbursement, which presents its own disincentives to control costs that should be considered if the initiative is going to achieve meaningful reform. Also, many of Medicaid's costs are in program areas that do not involve "episodes" of care, but rather serve chronically ill or disabled recipients who will need Medicaid services for the rest of their lives.

MEDICAID TRANSFORMATION AND "PRIORITY AREAS"

Governor Beebe has repeatedly said that the current rate of Medicaid growth is unsustainable. Some 770,000 Arkansans depend on Medicaid, about a fourth of the state's population.[1]

[*] The authors wish to thank the Arkansas Medicaid staff for providing much of the data used in this article. As with any such endeavor, some decisions were made regarding classification of various expenditures, and different methods of analysis could yield different results.

According to state officials, Medicaid spending has been growing at a rate of 7% to 8%, higher than the state budget, inflation, and the growth in national income.[2] The state is facing a $60 million deficit in Medicaid in fiscal year 2013 and some $200 million in $2014.[3] State officials have said their goal is to slow the growth to 5%.

The Arkansas Health Payment Improvement Initiative, often referred to as "Transformation," is the Governor's controversial effort to bend the cost curve. The Governor has been particularly insistent that the longstanding fee-for-service methodology must go. State officials say it creates perverse incentives to deliver more care, not quality, cost-efficient care. They have proposed a new model in which multiple providers would divide up a single bundled payment for episodes of care. Governor Beebe sees Arkansas moving from a broken, fragmented system that rewards volume to an integrated, coordinated system that "rewards results and not just treatment."[4] The initiative also calls for health homes, evidence-based care, an all-payer claims database, and other features to promote more efficient, higher quality care, or "value-based purchasing."

The Department of Human Services (DHS) has identified nine specific "priority areas" for Medicaid payment reform, areas where officials believe the greatest impact can be felt first:

•Pregnancy and neonatal care
•Mental Health
•Diabetes type 2
•Musculoskeletal
•Cardiovascular disease
•Ambulatory upper respiratory tract infections
•Preventive services
•Developmental disabilities
•Long-term care

DHS has formed workgroups to address the priority areas. The goal is to have bundled payments and other changes for these nine areas in place by July 1, 2012.

The initiative is somewhat of a moving target. First, officials were going to move the entire system, then they narrowed their initial focus to these nine areas, and now they seem to be recognizing that all nine cannot be done within a year's time. The "partnerships" concept and bundling payments across different providers also seem to be losing steam, at least for the near future.

METHODOLOGY

To conduct this analysis we relied chiefly on a data set provided by DHS that broke Medicaid claims payments down by State Categories of Service, such as physician services, acute hospital inpatient services, and private skilled nursing facilities,[5] for each state fiscal year from 2005 through 2011. For our analysis of growth, we used average annual growth of 5% as a benchmark, because that is the stated goal of state officials for the annual growth rate in Medicaid expenditures. We started with state fiscal year (SFY) 2005 because that is the earliest data that

the state has been putting out to the public. State fiscal years run from July to June, e.g., SFY 2005 began on July 1, 2004 and ended June 30, 2005.

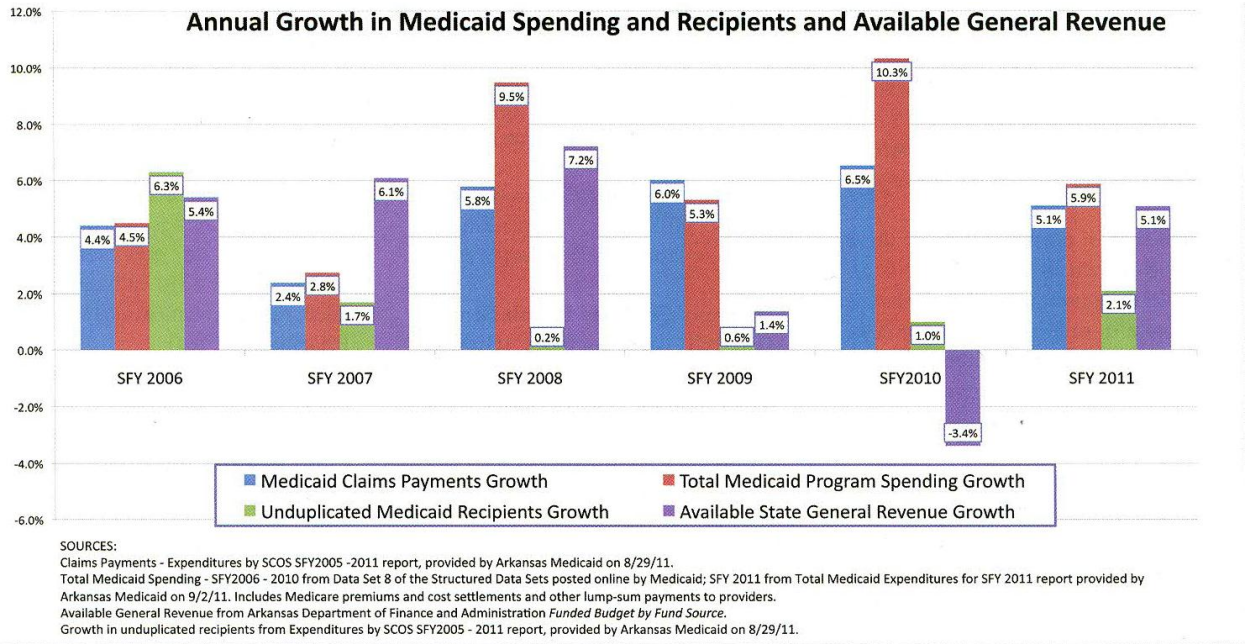
In this article we seek to address two questions: **(1) What are the opportunities for bending the Medicaid cost curve?** and **(2) Is the Payment Improvement Initiative aimed at those opportunities?** In answering the first question, we looked to see where the fastest growth is and where the bulk of the money goes. In answering question 2, we looked to see how closely Transformation is aligned with the opportunities for bending the cost curve.

This article does not make a judgment as to where any inefficiencies exist. Presumably, that is what the Medicaid workgroups and the state's hired consultant, McKinsey & Co., will do. The expenditures reflect state policy decisions, rate increases, increases in recipients, federal mandates, and cost-saving measures already undertaken. We discuss some important considerations such as the use of self-imposed provider taxes and intergovernmental transfers to fund some programs. The goal is not to say which programs are good or bad, but to identify issues that must be addressed if payment reform is likely to have its intended effect.

THE BIG PICTURE

The most recent data shows total Medicaid expenditures by all states increased at an average rate of 4.9% per year from 2004 to 2009.[6] By contrast, from SFY 2005 to 2011, Arkansas Medicaid expenditures grew at an average rate of 6.3%, not quite as high as we have been led to believe from state officials, but still higher than the average growth in the state general fund budget[7] of about 3.6% per year.

Based solely on an analysis of the State Categories of Services data, Medicaid expenditures have grown from $2.61 billion in state fiscal year 2005 to $3.51 billion in state fiscal year 2011, an average annual increase of 5.04%. These are "claims payments." The increase in claims payments essentially has performed at the level that has been publicly announced as the target for the Medicaid program.



SOURCES:
Claims Payments - Expenditures by SCOS SFY2005 -2011 report, provided by Arkansas Medicaid on 8/29/11.
Total Medicaid Spending - SFY2006 - 2010 from Data Set 8 of the Structured Data Sets posted online by Medicaid; SFY 2011 from Total Medicaid Expenditures for SFY 2011 report provided by Arkansas Medicaid on 9/2/11. Includes Medicare premiums and cost settlements and other lump-sum payments to providers.
Available General Revenue from Arkansas Department of Finance and Administration *Funded Budget by Fund Source.*
Growth in unduplicated recipients from Expenditures by SCOS SFY2005 - 2011 report, provided by Arkansas Medicaid on 8/29/11.

However, when you include payments that are not based on a recipient-specific, service-specific claim, then total Medicaid expenditures during that same time period have increased by an average of 6.3% per year. These additional payments include year-end lump-sum payments for certain providers and payments for Medicare premiums for recipients who are dually eligible for Medicaid and Medicare.

Per-recipient claims expenditures rose from an average of $3,797 to $4,540 during this time, an increase of 3.02%. The most recent national data shows Arkansas far below most of the nation in spending per recipient, ranked sixth lowest among the states in 2007.[8]

The majority of Arkansas' Medicaid program is funded by the federal government, and another significant portion is funded by provider fees, transfers from other programs or entities, tobacco settlement proceeds, and the soda pop tax. Nevertheless, the Medicaid program still relies heavily on state general revenue to fund the state share of the program. In SFY 2010, over $650[9] million in state general revenues were spent to fund the Medicaid program. Although the growth rates are not as high as commonly thought, the challenge becomes apparent when you compare these growth rates to the 3.6% growth in annual state general revenue available for distribution to programs including Medicaid over the SFY 2005 – SFY 2011 period. This disparity in the growth in program expenditures and available state revenue is a clear depiction of the need to "bend the Medicaid cost curve."

WHERE THE GROWTH IS

In this section, we analyzed expenditure growth in specific Categories of Service. In some cases, Categories of Service were combined in order to provide an accurate comparison between 2005 and 2011. In those cases, it was not possible to calculate the growth in recipients since some recipients are counted in more than one category. We excluded any category that started the

comparison period with fewer than 1,000 recipients or less than $1 million in expenditures since increases in such relatively small numbers produced misleading percentages.

We highlighted these 19 categories solely because they are the "cost drivers" in terms of growth, meriting attention from Medicaid. It will be up to Medicaid, providers and stakeholders, on a case by case basis, to determine, after further study, whether fee-for-service or bundled payments or some other method is the best model for any particular category.

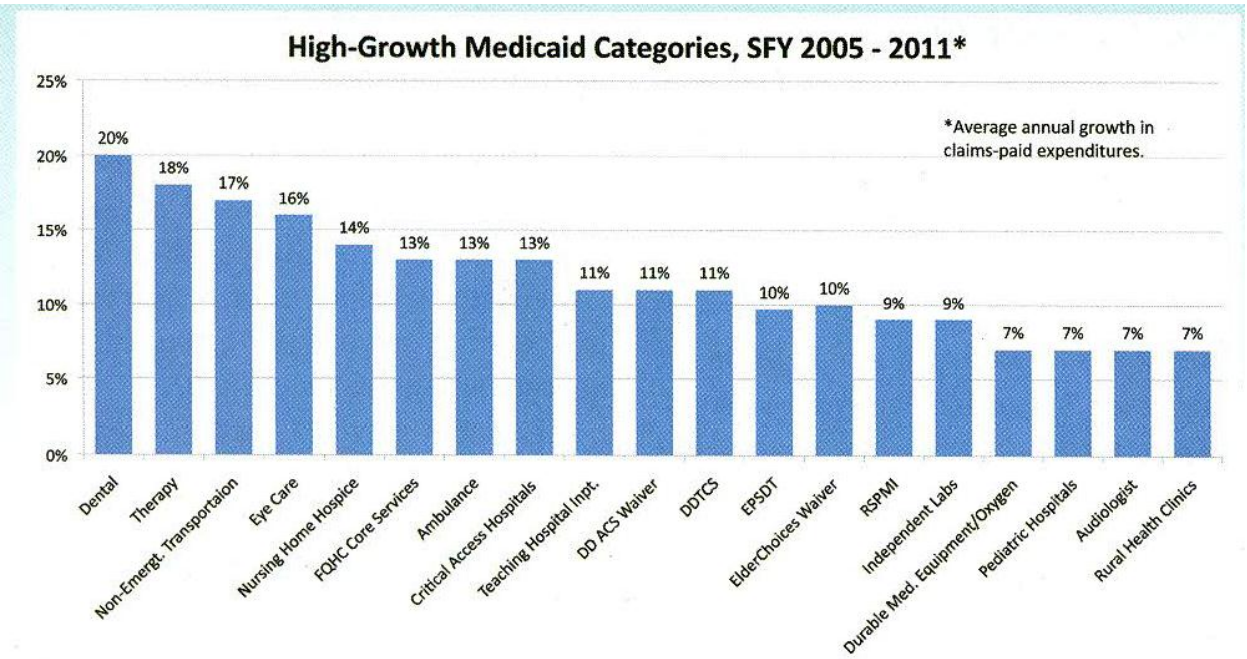
Note that in most if not all of these areas, the growth in expenditures is attributable to conscious policy decisions by the state in order to improve access, avoid more costly care in other settings, comply with federal requirements, or other considerations. For instance, the largest growth occurred in dental services, but that was the result of a decision by the state to significantly increase reimbursement to dentists in order to increase the dismal access to dental care for children. Alternative Community Services, DDTCS, and Elderchoices all grew significantly, but they are considered cost-effective alternatives to institutional care. Some of the growth, such as federally qualified health centers, occurred in underserved areas. That is not to say that payment reform cannot include these high-growth areas, but it will have to be crafted carefully to address the circumstances that prompted the increased expenditures under the current model.

1. Dental (Growth: 20%) (SFY 2011 Expenditures: $106 million) (DHS Priority Area: No)

2. Therapy (Growth: 18%) (SFY 2011 Expenditures: $91 million) (DHS Priority Area: Yes?[10])

3. Non-Emergency Transportation (NET) (Growth: 17%) (SFY 2011 Expenditures: $38.8 million) (DHS Priority Area: No)

4. Eye Care (Growth: 16%) (SFY 2011 Expenditures: $19 million) (DHS Priority Area: No)



5. Hospice in Nursing Homes (Growth: 14%) (SFY 2011 Expenditures $22.5 million) (DHS Priority Area: No)

6. Federally Qualified Health Centers (FQHC) core services (Growth: 13%) (SFY 2011 Expenditures $12.3 million) (DHS Priority Area: Yes)

7. Ambulance (Growth: 13%) (SFY 2011 Expenditures: $21.7 million) (DHS Priority Area: No)

8. Critical Access Hospitals (Growth: 13%) (SFY 2011 Expenditures 27.0 million) (DHS Priority Area: Yes)

9. Teaching Hospital Inpatient (UAMS) (Growth: 11%) (SFY 2011 Expenditures: $75 million) (Does not include additional inpatient payments such as cost settlements and upper payment limit payments which totaled $90 million in SFY 2010, the most recent data available.) (DHS Priority Area: Yes)

10. DDS Alternative Community Services (ACS) Waiver[11] (Growth: 11%) (SFY 2011 Expenditures: $160 million) (DHS Priority Area: Yes)

11. Developmental Day Treatment Clinic Services (DDTCS) (Growth: 11%) (SFY 2011 Expenditures: $149 million) (DHS Priority Area: Yes)

12. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (Growth: 10% overall) (SFY 2011 Expenditures: $30.2 million) (DHS Priority Area: No)

13. Elderchoices Waiver (Growth: 10%) (SFY 2011 Expenditures: $66 million) (DHS Priority Area: Yes)

14. Community Mental Health (RSPMI) (Growth: 9%) (SFY 2011 Expenditures: $284 million) (DHS Priority Area: Yes)

15. Independent Laboratories (Growth: 9%) (SFY 2011 Expenditures: $9.5 million) (DHS Priority Area: Yes, indirectly)

16. Durable Medical Equipment/Oxygen: (Growth: 7%) (SFY 2011 Expenditures: $44.5 million) (DHS Priority Area: No)

17. Pediatric Hospitals (Growth: 7%) (SFY 2011 Expenditures: $140 million) (Does not include other payments such as cost settlements which totaled $110 million in SFY 2010, the latest data available.) (DHS Priority Area: Yes)

18. Audiologist General (Growth: 7%) (SFY 2011 Expenditures: $2 million) (DHS Priority Area: No)

19. Rural Health Clinics (Growth: 7%) (SFY 2011 Expenditures: $10.9 million) (DHS Priority Area: Yes)

Is the Payment Improvement Initiative aimed at the growth areas? In part. The central feature of the initiative is bundled payments for episodes of care, with the focus obviously on physician and hospital services. Many of the growth areas, however, are outside the physician-hospital arena. Other aspects of the initiative, such as health homes, should affect all growth areas, but will rely heavily on physician clinics to coordinate much of that care. The problem is that many of the growth areas are not big enough to bend the cost curve, which is why we examine the high-cost programs in the next section.

WHERE THE MONEY IS

In this section, we looked at where the bulk of the Medicaid budget is spent, grouping services by program areas, rather than each individual Category of Service. The following services comprise 86% of the Medicaid claims paid in SFY 2011. Although not all of these areas are increasing at greater than 5% a year, they are such big parts of the Medicaid budget that any reform effort will have to include them to succeed.

1. Hospitals

When all expenditures are counted, including the cost settlements and other payments they received, total inpatient and outpatient payments to hospitals in SFY 2010 amounted to $963 million, making it the most expensive provider group in the Medicaid budget. (We used SFY 2010 because data for non-claims payments were not available for SFY 2011.) There are two general categories of payments to hospitals:

Claims-Based Payments: For inpatient services, most medical-surgical hospitals receive a rate per day that is calculated to approximate the cost of providing care, subject to a capped dollar amount. A subset of hospitals known as critical access hospitals, which are smaller hospitals in underserved areas, receive a rate equal to their allowable costs with no cap, in recognition of the important role they play in the areas they serve. From SFY 2005 to SFY 2011, per diem inpatient payments to all medical-surgical–hospitals increased from $306 million to $420 million, an increase averaging 5.43% per year.

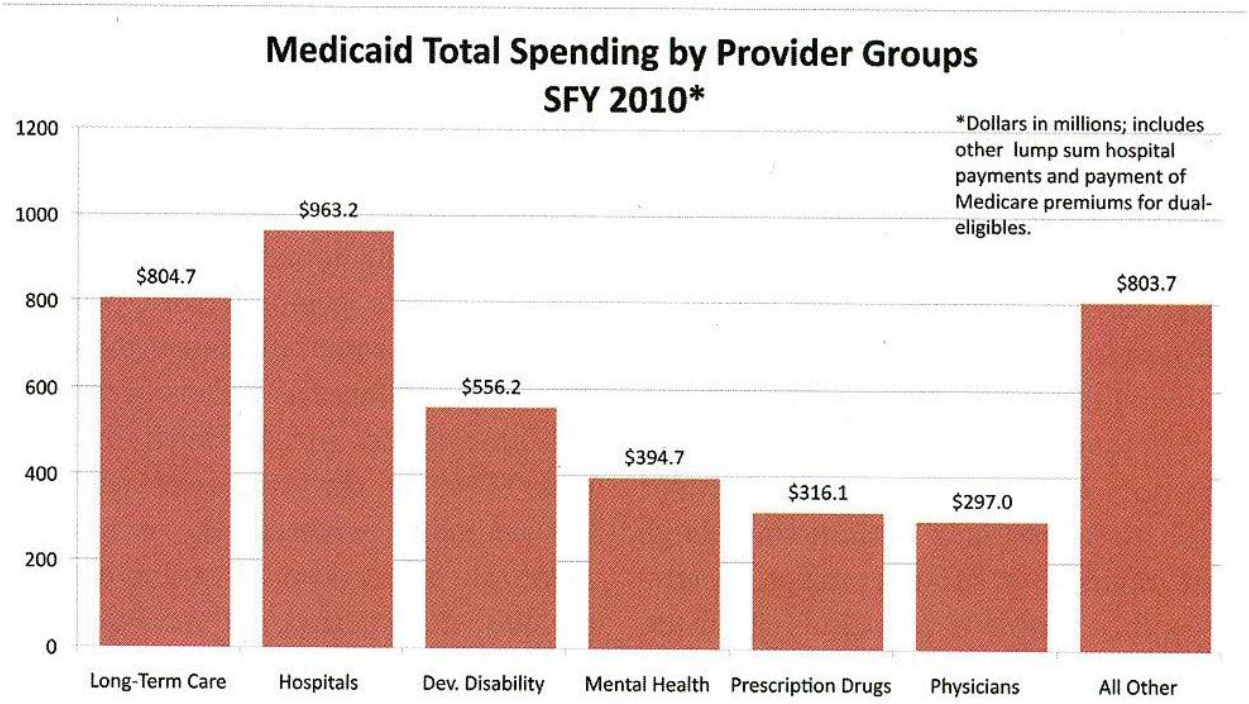
On the outpatient side, hospitals receive reimbursement on a fee-for-service basis. For outpatient services, Medicaid spending increased from $86 million to $116 million from SFY 2005 to SFY 2011, an annual average increase of 5.19%.

Other Payments: The second category of hospital payments consists of an array of payments made to hospitals under various payment mechanisms that are not tied to a particular patient-day or a particular outpatient service. These payments are over and above their per diem inpatient payments or fee-for-service outpatient payments. These payments go by different names, but they rely on federal Medicaid regulations which allow some hospitals individually and many hospitals collectively to receive adjustments that bring their total reimbursement up to an amount that approximates (or at least approaches) their reasonable costs of providing care. The payments include cost settlements, upper payment limit payments, quality payments, access payments, and disproportionate share payments. They totaled $236 million in SFY 2005 and approximately $433 million in SFY 2010, the latest year for which data are available, representing an average annual increase of 13%.

For its other payments, UAMS provides the state match from its general revenue appropriations. These payments are critical funds for safety net hospitals, but many analysts believe the amount and allocation of such payments can distort payment reforms designed to produce efficient, effective care. Arkansas is one of five states using cost reimbursement for hospital inpatient care.[12] UAMS also receives cost settlements for certain non-cost-based programs, i.e., its physician services, RSPMI services, and Child Health Management Services (CHMS).

A new source of additional funding for most hospitals comes from "access payments," for which the state match is generated by a hospital provider fee. These increases represent no net cost to the state. In fact, increases in other programs are also financed by provider fees on nursing homes and ICF-MRs. These fees and transfers make it difficult to assess what the *real* cost of the Medicaid program is to the state and the real impact of various payment reforms that may be considered. All of these types of payments deserve a closer look in the process of payment reform to ensure that they serve appropriate policy objectives as opposed to being obscured "under the radar" because their funding comes from outside the Medicaid general revenue funded budget.

Medicaid Transformation certainly includes hospital payments. However, it is not clear how the bundled payments will address the cost settlements and other payments described above.



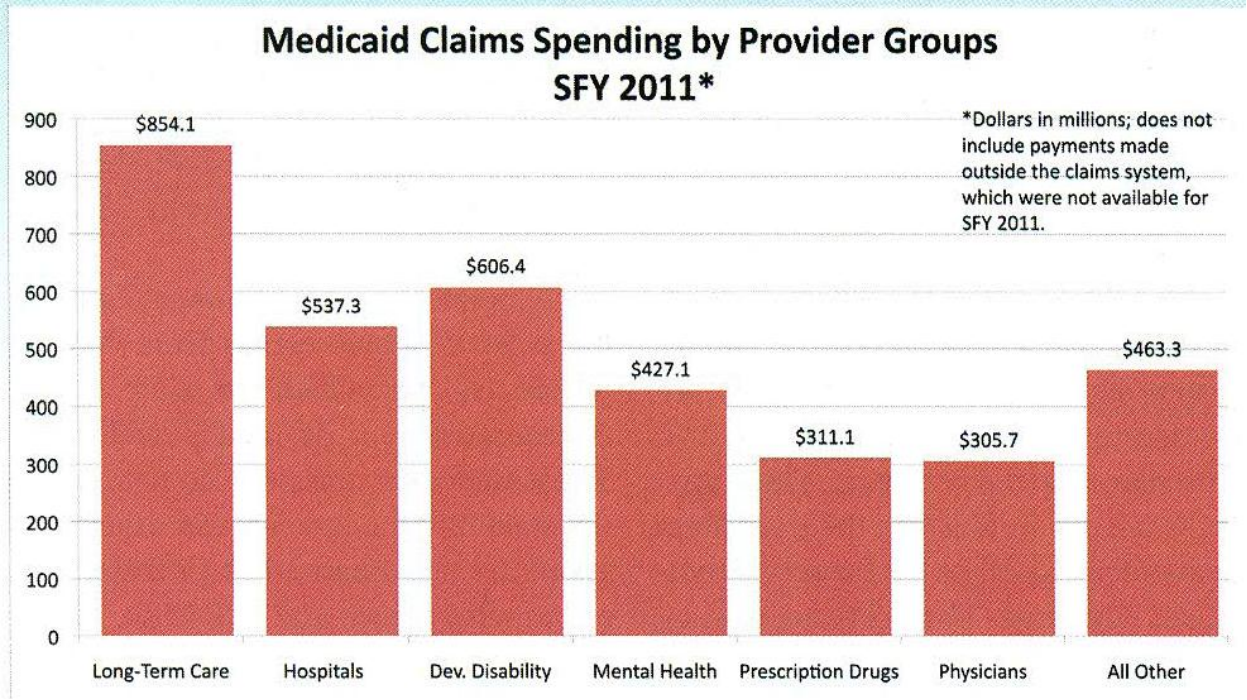
2. Long-Term Care for the Elderly

The next most expensive part of the budget is long-term care services for the elderly. Nursing homes, Elderchoices, personal care, home health, assisted living and a few other smaller programs totaled $854 million in SFY 2011.[13] This is due in large part to the fact that private insurance and Medicare cover very little in the way of long-term care.

Private nursing homes received $590 million in 2011, which means that they make up the most expensive single category of service in the entire Medicaid budget. While nursing home admissions have been almost flat since 2005 (an increase of less than 1%), nursing home expenditures are still rising at an average annual rate of 4.46%. Long-term care rates are based on a provider's allowable costs. Certain components of the cost are capped, but dollars spent on direct patient care are essentially reimbursed dollar for dollar (based on the Medicaid percentage in the nursing facility).

The primary alternatives to the nursing home level of care for elderly Arkansans are two waiver programs, Elderchoices and assisted living. Elderchoices provides help with housekeeping, chores, meals, and other services to recipients who would need nursing home care but for these services. The assisted living program, called Living Choices, pays for services in assisted living facilities. Both programs are designed to save money in relation to nursing home care, while also allowing the recipient to continue to live in the community rather than in an institution. Although the raw numbers for these two p[rograms demonstrate large cost savings, a more complete analysis will be required to include all of the other services that waiver participants use compared to nursing home residents. The ratio of the state's long-term care expenditures for institutional care vs. home-and-community-based services has gone from 79% institutional/21% HCBS to 74%/26% in 2011.

In spite of the savings opportunities, enrollment in the waiver programs has been relatively anemic, due to caps (or restrictive eligibility criteria) imposed by the state. Over the 2006 to 2011 period, the state increased the number served by Elderchoices by only 304 persons, from 7,323 to 7,627. The state increased the number of assisted living slots well over a thousand percent, but an increase from 112 to 771 people is hardly noticed when compared to a nursing home population of 18,144.



Supporters of nursing homes contend that the aggregate cost to Medicaid will increase if a state eliminates the caps for programs like Elderchoices and assisted living. Studies indicate there may be some truth to this, though advocates contend the trend is only short term, and that costs actually decrease over time as long as the state implements a comprehensive transition strategy to reduce reliance on nursing homes. [14]

The state's personal care program also pays for some assistance to recipients in their homes as well as in residential care facilities and assisted living facilities. However, the number of recipients has actually decreased, the reimbursement rate is low despite two increases in the 2006-2011 period, and the amount of services is limited to 64 hours a month. If utilized properly, providers contend this program saves the state considerable money by reducing nursing home admissions and hospitalizations, but Medicaid has not put forward any data to verify that.

Long-term care is listed as a priority area for Medicaid Transformation, but so far it is not clear what the state's strategy is. The state has announced a new "universal assessment" for all applicants for long-term care services, which would base a recipient's funding allocation on his or her needs regardless of the setting. The state has also discussed correcting distortions in care settings, making sure services are matched to "activities of daily living." Long-term care, by

definition, does not involve an "episode of care," so it is not clear how these services really fit into payment reform,

3. Developmental Disabilities Services

The third largest group of services are those for individuals with developmental disabilities, such as cerebral palsy, epilepsy, autism, and intellectual disability, making up some $600 million[15] of the Medicaid budget in 2011. In contrast to services for the elderly, the state's continuum of care for the developmentally disabled is weighted much more toward the community. The proportion between expenditures on community providers and expenditures on institutional providers is just the reverse of the elderly long-term care category.

The main vehicle for providing community services to individuals with developmental disabilities is the Alternative Community Services (ACS) waiver program, which pays for an array of supports to help individuals remain in the community as opposed to an institution. In 2011, Medicaid providers served 4,055 individuals in the ACS waiver program, as compared to 1,687 individuals in the large state-run institutions known as Human Development Centers and smaller, private residential settings known as intermediate care facilities for the mentally retarded (ICF-MRs). Although the expenditures in the ACS program increased an annualized average of about 11% a year, the average expenditure per recipient is $39,000, far below the cost of the Human Development Centers or smaller ICFs, where expenditures exceeded $90,000 per unduplicated recipient in SFY 2011. These numbers do not include other medical services that individuals with developmental disabilities use.

In addition to the ACS program, many more recipients are served through clinic-based habilitation programs called developmental day treatment clinic services (DDTCS), and through physical, occupational, and speech therapy. ACS, DDTCS and therapy are all high-growth areas. The growth, or at least that in ACS and DDTCS, was presumably a calculated decision to help keep individuals with developmental disabilities out of more costly institutions, especially while the state was facing two lawsuits over that very issue.

The state is looking at ways to address this population through Medicaid Transformation. It has been receptive to suggestions by developmental disability providers who have advocated use of the "health home" model to serve this population. The idea is that the state would use DD providers (in coordination with primary care physicians) as health homes to coordinate all the care for individuals with developmental disabilities, since DD providers see the individuals on a regular basis, often daily, and hopefully can reduce hospitalizations and emergency room visits.

As with the elderly in long-term care, it is not clear how the state intends to proceed with payment reform. These recipients, who generally will need services for the rest of their lives, do not fit neatly into an episode-based model.

4. Mental Health

In addition to the RSPMI outpatient programs, the state funds inpatient psychiatric care for children and certain school-based mental health services. In all, Medicaid spent $427.1 million or

9.7% of the total Medicaid budget on inpatient and outpatient mental health services in SFY 2011. This represents an average annual increase of 6.77% across the seven years. Two-thirds of that spending is on RSPMI outpatient services. The state has long struggled with the best way to manage and pay for RSPMI services, vacillating between bundled payments and fee-for-service.

Inpatient psychiatric services are provided to recipients under the age of 21. Psychiatric hospitals are reimbursed for their care on a cost basis, but the costs are capped at a given percentile of all the per diem costs, and there is no annual reconciliation. Unlike other cost-based providers, this methodology forces the psychiatric hospitals to control or reduce their costs in order to live within the Medicaid rate.

The Medicaid Payment Improvement Initiative does include mental health as a priority area. It originally planned to address only ADHD at the start, a diagnosis which the state says represents about $55.7 million a year, with 18,920 patients, for an average expenditure per recipient of $2,944 (excluding drug costs). The state initially presented a "prototype" of a new RSPMI payment method for ADHD, which is more detailed than that provided for any of the priority areas. The prototype appears to be based on a bundled payment for a year's worth of pre-approved services, the amount of payment and services depending on the level of care needed. This development of levels of care is similar to the prior reimbursement mechanism for RSPMI; however, in that system, payments were still paid on a fee-for-service basis. Presumably, the new system will not be based on fee-for-service payments. Recently, Medicaid officials have indicated that the Mental Health group may not confine its focus to ADHD.

5. Prescription Drugs

The prescription drug component of Medicaid cost the state $311 million in SFY 2011. It has seen significant change over the last few years. The most notable change has been the implementation of the Medicare drug benefit, known as Medicare Part D. For Medicaid enrollees who are also eligible for Medicare, the majority of their drug costs are covered under Medicare Part D. The growth in Medicaid prescription drug spending since the implementation of Part D has averaged less than 1% per year. The state is required to reimburse Medicare for a portion of the Part D expenses for Arkansas Medicaid recipients, but even accounting for this "clawback" payment does not change the growth rate significantly. The state also implemented an evidence-based pharmacy program that has increased the dollar value of rebates received from manufacturers while promoting the use of drugs that are most effective within a particular class of drugs. In short, the Medicaid prescription drug program, which was once seen as a big Medicaid cost driver in Arkansas and elsewhere, is now a smaller part of the Medicaid budget, and net expenditures are increasing well below the target rate of 5% per year.

Prescription drugs are not a separate priority under Transformation but would be affected through changes in some of the other priority areas. For instance, the state plans to look at physicians who prescribe expensive name-brand drugs instead of generics for upper respiratory infections.

6. Physicians

Much of the focus of the state reform effort is on changing the way physicians are paid, i.e., moving them away from fee-for-service to bundled payments for episode of care. However, Medicaid spending on actual physician services is not driving the increase in spending. In 2011, Medicaid spent about $305.7 million on physician services, an average increase of 3.9% per year since 2005, which is less than the 5% target. In addition, spending on physician services has declined from 8% to 7% of the total Medicaid budget. Yet, in Medicaid Transformation, seven of the nine priority areas involve treatment for clinical conditions and preventive care services that have exclusive or significant physician involvement. This has led some to question whether the initiative is out of sync with the actual cost drivers in Medicaid.

Of course, physicians do drive some of the other costs through their prescriptions and orders for other services. This points to the importance of physician involvement in all areas of payment reform, since physicians will be the key to managing many of the services for the populations and conditions included in the payment reform initiative.

Is the Payment Improvement Initiative aimed at the largest expenditures? Yes, but the prioritization is open to question. All six of the largest program areas are included in the Transformation priority areas, but the initiative is focused heavily on physicians, the least costly among the six. The state's plans for elderly, developmentally disabled, and chronically mentally ill recipients are still largely unknown. As part of any payment reform, the state and providers will need to come up with a health home model that fits these populations and determine which providers will be responsible for coordinating their care and how they will be compensated.

CONCLUSION

The predominant feature of Arkansas' reform initiative is bundled payments for episodes of care. Bundled payments and related concepts have been tested in limited form around the country, primarily in the private insurance market and in Medicare. However, Medicaid is not a typical insurance program. Medicaid is the sole or dominant payer for institutional and community services for elderly, developmentally disabled, and chronically mentally ill recipients. That is where a large share of both growth and expenditures are. In those contexts, one is typically dealing with long-term or life-long conditions, not "episodes" of care. Many of the providers for those populations do not believe the state's model fits their programs. State officials seem to agree, but have not articulated a clear path ahead. It is not clear how cost-based reimbursement for hospitals and other cost-based providers will fit into the bundled payments for episodes of care. The Payment Improvement Initiative will need to be modified in a number of respects to achieve meaningful reform in the Arkansas Medicaid market.

[1] Div. of Med. Servs., Ark. Dep't of Human Servs., *Arkansas Medicaid Program Overview SFY 2010*, at 11 (2010) , *available at* https://www.medicaid.state.ar.us/Download/general/MOB-SFY10.pdf.

[2]In Arkansas, from FY2001-02 through the initial distribution for FY2011-12, the general revenue distributed budget has grown at an average rate of 3.01% per year. Office of Budget, *Funded Budget by Fund Source Fiscal Year 2002 and Fiscal Year 2012*, ARK. DEP'T OF FIN. & ADMIN. (January 27, 2011 and July 13, 2011), http://www.dfa.arkansas.gov/offices/budget/Pages/fundedBudgets.aspx. *See also*, Kaiser Family Found., *U.S. Health Care Costs: Background Brief*, KAISEREDU.ORG, http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx (last updated March 2010).

[3] Charlie Frago, *Sides Air Proposals to Repair Medicaid*, ARKANSAS DEMOCRAT-GAZETTE, March 20, 2011.

[4] *See, e.g.*, Governor's Inaugural Address, Jan. 11, 2011, available in print at http://governor.arkansas.gov/newsroom/index.php?do:newsDetail=1&news_id=2688; Alison Sider, *For Medicaid Revamp, State Sets July Goal*, ARKANSAS DEMOCRAT-GAZETTE (Aug. 23, 2011).

[5] In some cases, the definition of categories of services was changed over the SFY2005-2011 period, which affected the ability to make comparisons in some areas. In many cases, categories of services are so specific that it was necessary to combine categories to demonstrate the actual expenditures for commonly-used categories. Finally, there are additional payments that are made outside the claims paid system; those expenditures were derived largely from data sets that Medicaid made available on the internet.

[6] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Spending Growth Over the Last Decade and the Great Recession, 2000-2009*, at 8 (2011), available at http://www.kff.org/medicaid/upload/8152.pdf.

[7] General revenues available for distribution to state agencies and programs. Office of Budget, *Funded Budget by Fund Source, Fiscal Year 2005 and Fiscal Year 2011*, ARK DEPT. OF FIN. & ADMIN. (2010, 2011); http://www.dfa.arkansas.gov/offices/budget/Pages/fundedBudgets.aspx.

[8] Kaiser Family Found., STATEHEALTHFACTS.ORG, available at http://www.statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4.

[9] Medicaid Structured Data Set 8, available on the Arkansas website in shared files for Medicaid Transformation at https://ardhs.sharepointsite.net/DMS%20Public/Forms/AllItems.aspx?RootFolder=%2fDMS%20Public%2fMedicaid%20Transformation%2fArkansas%20Medicaid%20Structured%20Data%20Sets&FolderCTID=&View=%7b501C27B5%2dA45A%2d4E54%2dB124%2dF4A2118D63F0%7d.

[10] Developmental disabilities is listed as a priority area, and most therapy is provided to individuals with developmental disabilities, but the state has not said whether it intends to include therapy in that priority area. This section includes speech, occupational, and physical therapy provided to recipients in all settings.

[11] "Waiver" in this context refers to the flexibility afforded state Medicaid programs under Section 1915(c) of the Social Security Act to establish home-and-community-based programs for individuals who otherwise would need to be in an institution.

[12] Deborah Bachrach, J.D., *Payment Reform: Creating a Sustainable Future for Medicaid*, Center for Health Care Strategies Policy Brief at 6, 8 (May 2010), available at http://www.chcs.org/usr_doc/Medicaid_Payment_Reform_Brief.pdf.

[13] Estimate only; precise amount not available because some services include small numbers of non-elderly.

[14] Robert L. Mollica et al, *Taking the Long View: Investing in Medicaid Home and Community-Based Services is Cost-Effective* (2009), available at http://assets.aarp.org/rgcenter/il/i26_hcbs.pdf.

[15] Estimate only; precise amount not available due to inclusion of some children without developmental disabilities in therapy category.