Interim Report of the Medicaid Study Group

December 2006

Organization and Work of the Medicaid Study Group

In order to deliver high-quality care in a cost-effective manner, Governor Donald L. Carcieri established a Medicaid Study Group, with RIPEC's assistance, to propose options for a sustainable and fiscally responsible Medicaid program and improving effectiveness and efficiency.

The Study Group consisted of 26 members, representing provider groups, representatives from State government and RIPEC members. The Study Group organized into two subcommittees – the Subcommittees on Service Delivery and Finance. Both subcommittees have met four times since they began its work in October 2006. The Subcommittees discussed various proposals, and identified recommendations and options which are being transmitted to the Governor. A final report will be completed in the Spring of 2007.

Foreword to Interim Report

Rhode Island's Medicaid program's budget is growing rapidly, from $1.1 billion in fiscal year 2000 to almost $1.8 billion in fiscal year 2007, with State taxpayers paying about one-half of this latter amount. While this increase is not unique to Rhode Island (Medicaid expenditures are rising everywhere), the growing cost of Medicaid represents a potential critical situation for Rhode Islanders who are dependent upon Medicaid services.

However, it should be noted that healthcare is a major employer in Rhode Island, therefore, federal or state policy changes could impact Medicaid recipients as well as the State's economy.

To address Medicaid's future financial sustainability it was first necessary for the Study Group to determine what factors and programs were driving costs. The principle findings of the Study Group indicate the following:

Program costs are not being driven primarily by increasing Medicaid caseloads. Data presented by the Executive Office of Health and Human Services (EOOHHS) revealed that between FY 2003 and 2005 enrollment in Medicaid programs increased from 178,810 to 186,455, an increase of 4.3%. However, during this period, spending for Medicaid actually increased by 22%.

Data also shows that Medicaid spending has grown substantially faster than caseloads across all beneficiary groups. However, approximately 30% of Medicaid beneficiaries (elderly 9.7%, adults with disabilities 14.4%, and children with special health care needs 6.3%) account for four out of every five dollars of Medicaid spending.

There are significant differences in average Medicaid costs across population groups. For instance, the average per member Medicaid cost for adults with disabilities was $21,335 in FY 2005 compared to $2,420 for children and families in managed care. The

per member average Medicaid cost for children with special health care needs was $10,535, and for the elderly $24,165. Given this information, it should not be surprising that beneficiary groups contribute to Medicaid costs at different rates. According to the Executive Office of Health and Human Services, "it takes nearly a 2% increase in spending within the children and families in managed care population to equal a 1% increase in the adults with disabilities category."

So where are Medicaid dollars being spent? Three provider groups – hospitals ($310.3 million), nursing facilities ($306.0 million), and home and community-based service providers ($384.8 million) – account for two-thirds of total Medicaid spending.

Between FY 2003 and FY 2005 Medicaid spending for medical services (excludes disproportionate share payments, and expenditures for administration and operations) increased from $1,247.6 billion to $1,520.3 billion – an increase of $272.7 million (21.9%) – according to the Executive Office of Health and Human Services. Services to adults with disabilities represented almost one-half (46%) of the overall spending increase in Medicaid over this two year period. Spending for the elderly and for children and families in managed care represented 23% and 22%, respectively.

Of the $272.7 million increase in Medicaid spending between FY 2003 and 2005 approximately $.60 of every new dollar spent on Medicaid services was directed at two provider categories – hospitals $83.3 million or 31% and home and community-based services $75.7 million or 28%. Further analysis of utilization patterns is necessary to evaluate these trends.

Increasing hospital expenses were the largest contributors to acute care case increases for children with special health care needs, children and families in managed care, and adults with disabilities. It is important to disaggregate hospital spending by function and category of expenditure before meaningful options can be presented to enhance effectiveness and economies. Regarding long-term care, which constitutes 52% of Medicaid spending, home and community-based service expenses were the largest contributor to long-term care cost increases for children with special health needs and adults with disabilities. For the elderly population, nursing facility expenses are the largest contributor of long-term care increases.

The salient programmatic and financial implications derived from this information are obvious. The root causes are increased spending on services provided by institutions for both acute and long-term care. Therefore, information to support fundamental reforms of the system will require a thorough and comprehensive examination of the following:

- Medicaid's financial sustainability over the next five years, with sustainability defined in terms of the program's impact on the State's overall financial situation;
- The principle of reimbursement and the way institutional reimbursement is established;
- Benefit design, which includes a comparative analysis of the amount, duration and scope of benefits;

- The methods and procedures used to conduct utilization reviews for high-cost cases, particularly those where multiple agencies are involved;
- The roles, responsibilities and resources that the Executive Office of Health and Human Services will need to effectively provide for the coordination of Medicaid policy and service delivery and oversight; and
- The feasibility of shifting more program expenditures from fee for services to managed care.

The following sections of this Interim Report include the proposal of members of the Study Group aimed at improving the delivery of services and controlling the rate of growth in future spending. These subcommittee reports outline topics that will require additional study and analysis, all of which are worthy of further consideration. The recommendations of the subcommittee do not provide specific proposals to help balance the FY 2008 State Budget nor do they result in comprehensive cost/benefit review of the Medicaid system.

If this process goes forward, the next steps might include:

- Redirecting the Study Group to focus on issues of sustainability, inter-agency coordination, reimbursement policies and principles, and to report on progress that is being made to implement the interim proposals; and
- Restructuring the Study Group to enhance its expertise in these areas, and ensure cooperation with state agencies, providers, and others.

A. Medicaid Subcommittee on Service Delivery

Attached are the initial recommendations of the Medicaid Subcommittee on Medicaid Service Delivery. The Subcommittee charge was to recommend changes in the structure and process for purchasing Medicaid Services to more efficiently deliver high quality, cost-effective access for Medicaid beneficiaries.

To accomplish this effort in the short amount of time made available, the Subcommittee employed the following process:

1. Divided the Medicaid population into four basic eligibility categories (Families and Children, Children with Special Health Care Needs, Adults with Disabilities, and the Elderly).
2. For each group, reviewed
    a. Data developed for this Subcommittee and the Finance Subcommittee.
    b. National best practices for purchasing services for each beneficiary group.
    c. Current state strategies for serving these groups.
    d. Public comments.
3. Developed, refined and prioritized potential areas for further work based on the following criteria: impact on cost and quality, probability and time frame for implementation, and consistency with overall purchasing principles and strategies.

The Subcommittee's recommendations are attached. In addition to these initiatives, the committee wishes to emphasize the following:

1. <u>These recommendations are preliminary and indicate fruitful areas for future work.</u> The time-limited nature of this process, the scope of the Medicaid program and limited analytical resources available all impacted the recommendations offered. We encourage further prioritization of these recommendations and implementation planning, integrated with current legislative requirements of the Executive Office of Health and Human Services regarding the same issues.

2. <u>The recommendations assume an overall strategy for purchasing Medicaid services.</u> This strategy should be based on a clear and measurable accountability for achieving value (high quality at low costs) for a given population, and a philosophical commitment to integrating medical care in a consumer-centric fashion. This has already been accomplished in the State's RIte Care program which, the Committee was informed, is consistently held up as a national model of both structure and outcomes. Applying these lessons to other, more complex and more expensive populations is the challenge.

3. <u>These recommendations require leadership and a multi-year commitment.</u> They generally are not new ideas. In addition, they do not lend themselves to budget-driven policy making and may face multi-stakeholder concerns. The committee

was informed by national and local experts that this will require focus, persistent, and collaborative leadership.

4. These recommendations occur in the context of rising health care costs which are rendering more people uninsured. The burden for financing the care for these uninsured people will continue to be shifted through complex payment subsidies and Medicaid financing upon the remaining insured population. Broad efforts for affordable health insurance and to slow the trend of medical expenses must continue.

5. These recommendations need to be addressed if the State is to have a financially sustainable Medicaid program and programmatic priorities should be reflected in the State's budgeting. Although savings will not be seen in this budget or the next – and the subcommittee recognizes that urgency - the alternatives consist of a continual cutting of benefits and enrollees, either of which may have significant unintended consequences.

Recommendations of the Medicaid Subcommittee on Service Delivery

The recommendations of the Subcommittee on Service Delivery are its response to its charge:

> To recommend changes in the structure and process for purchasing Medicaid services that will deliver high quality, cost-effective access for Medicaid beneficiaries.

These recommendations have emerged from the Committee's first four meetings. Each of the first four meetings of the Committee was devoted to a Medicaid eligibility category (Families and Children, Children with Special Health Care Needs, Adults with Disabilities and the Elderly). At each meeting, Committee members reviewed best practices nationally, current Rhode Island data and purchasing practices and public comment. At their meeting on December 7, 2006, committee members reviewed recommendations and issues which had emerged from the previous discussions and agreed to prioritize them.

Committee members were asked to use the following criteria for evaluating potential recommendations:

1. Importance of proposal, based on consistency with overall purchasing principles and strategy.

2. Ability to effect cost-efficiency of Medicaid services purchased based on the State's "affordability principles:"
    a. Promoting primary care and prevention
    b. Care coordination for chronically ill
    c. Use of most appropriate setting

d. Following evidence-based care.

3. Probability of implementation

The listing of the proposals below reflects the committee members' rank-ordered priorities in each of four categories (program structure, children with special health care needs, adults with disabilities, and elderly). It should be noted that the rank orderings are directional only – giving initial indications of relative importance given limited resources. Future research and planning would be needed to pursue any of them.

I. Program Structure of Medicaid

1. Give MHRH programmatic and budgetary responsibility for acute care services for developmentally disabled and the severely and persistently mentally ill (SPMI), provided that the department has the necessary organizational infrastructure.

Current system
Currently, MHRH and DHS are mainly responsible to provide services for adults with disabilities. DHS has budgetary and programmatic responsibility for managing acute care services for the developmentally disabled and the SPMI population, while MHRH has that responsibility for long term care services. As a result, care management for the beneficiary and program accountability is uncoordinated.

Recommendation
Give MHRH budgetary and programmatic responsibility for the acute care portion of these populations, provided that the department has the necessary organizational infrastructure. Establish interagency agreements to delineate the responsibilities of the affected State departments (claims payment, provider contracting, beneficiary determination etc.).

2. Establish institutional rate reforms with performance incentives

Issue

For all populations, expenses for acute care services are increasing at a faster rate than long term care services. This appears to be due to cost-based reimbursement mechanisms, particularly in the institutional settings hospitals, nursing homes and other community-based medical providers for developmentally disabled.

Rhode Island does not "negotiate" rates with institutional providers, but does calculate rates using prospective, facility-specific, cost-based rate methodologies, the basis for which is set in state statute. Many other states have moved or are moving (e.g., Connecticut and Massachusetts) to systematic rate algorithms that move reimbursement off of a cost basis and create greater consistency, equity, and transparency.

Recommendation
Establish a multi-year process to change Medicaid basis for payment to institutional providers from cost-based mechanism to models which encourage operational efficiencies with performance-based incentives. Models from other states are available and analysis has been conducted by DHS. Consider the balance between state-provided services and purchased services where such overlaps occur. Finally, create incentives for cost based institutional providers to transition the services to needed community based services.

3. Improved data collection, availability and analytical capacity for all Medicaid populations

Current system
An increasing number of Medicaid services are recorded in the Medicaid Management Information System (MMIS), maintained by DHS, and the DHS Medicaid Annual Report reflects a commitment to a unified Medicaid picture. However, currently there is not a uniform database for all human service departments. These databases are not well interlinked. Therefore, a statewide analysis of caseloads and expenditures is not readily available for the Executive Office of Human Services or external reviewers. Furthermore, information is not easily accessible among agencies and analytical capacity for planning, assessment and budgeting varies greatly among agencies.

Recommendation
Take necessary steps to ensure greater coordination of data storage, retrieval and analysis among agencies. Establish standardized data sharing agreements among agencies. Investigate data warehousing capacity and whether these functions should be conducted at EOHHS. In pursuing this recommendation, investigate the availability of 90% federal financial support for technology investments made by State Medicaid Programs.

4. Function of Executive Office of Health and Human Services (EOHHS)

Issue
The Executive Office of Health and Human Services was established in legislation this past year. Medicaid is the unified financing vehicle to further EOHHS policy and departmental missions and mandates. Medicaid expenses occur in all five agencies that are part of EOHHS, although the bulk of expenses, the official Medicaid authority and the bulk of analytical capacity are within DHS.

Recommendation
The following questions should be addressed:
What is the appropriate division of responsibilities between agencies and EOHHS?
What agency or office should be the official Medicaid authority?
How can the Medicaid Director's role-whether in the secretariat or DHS- best direct this "unified financing vehicle" and what should the functional responsibilities be?

II. Children with Special Health Care Needs

1. Enroll Children with Special Health Care Needs into a managed care program with integrated funding and single state agency oversight

Current system
"Children with Special Health Care Needs" as used in this report includes four subpopulations for which medical services are provided by DHS and DCYF: children under 18 in substitute care (either in a group home or individual placement), children under 21 on Supplemental Security Income (SSI), children 18 and under enrolled under "Katie Beckett", and children under 21 whose families receive and adoption subsidy. Virtually all Medicaid-covered acute care services for these populations are purchased as Rite Care benefits, although families may "opt out" of the managed care program.

However, some behavioral health services remain out-of-plan benefits and continue to be administered by DCYF on a fee for service basis. In addition, group homes and community based providers are providing and getting paid for out of plan clinical long term care (habilitative) services for Children with Special Health Care Needs that are not well coordinated with in-plan services. Some are paid for through DCYF and some through DHS.

Recommendation
Take necessary steps locally and federally to make all medical services for these populations an "in-plan benefit" and to make enrollment mandatory, as deemed feasible. Provide for joint oversight of this aspect of the Rite Care contract by DCYF for children who receive rehabilitative services in a residential setting under court order. Transfer budget resources to DHS. Adjust Rite Care contract and CSN rates accordingly. Change statutory language to reflect the departments' responsibilities.

Clearly and specifically identify those children and youth who require rehabilitative services in residential setting. Establish an integrated plan of care for these children and youth between DCYF designed staff and staff assigned by the health plan to assure quality services and efficient use of resources. An assessment of the needs of the child or youth and the assignment of appropriate staff from DCYF and the health plan should be accomplished within 48 hours of the court action which assigned the child or youth to DCYF custody. Recommend required budgetary and contractual changes.

2. Require interagency/health plan case management teams for the sickest and most expensive children (interim measure)

Current system
The committee was informed that approximately 2% of the children with special health care needs account for 69% of the behavioral health care costs. They are using services from DCYF, DHS and Neighborhood Health Plan of Rhode Island, with multiple case managers and poor coordination.

Recommendation
A coordinated case management approach among agency and health plan staff could result in a patient specific strategy to improve quality and reduce costs and improve outcomes for children. Moving all services in plan would address this issue. If that is not accomplished, establish a case management team with representatives from DHS, DCYF and NHPRI for these patients. Identify the medical home and the family decision makers for each child. Link case management plan to payment authority to ensure coordination.

3. Systematic program evaluation for Children with Special Health Care Needs and children in substitute care in managed care

Current system
The first group of children in substitute care (foster children) and children with special health care needs were moved into managed care in 2000 and 2002, respectively. Data are available through NHPRI and DHS to monitor outcomes and costs of needed services for these children.

Recommendation
Make program evaluation of Children with Special Health Care Needs for RIte Care a priority. Establish and report on outcome measures as appropriate. These data should be compiled in the type of program evaluation that has been a hallmark of Rite Care since its inception.

III. Adults with Disabilities

1. Establish enrollment timelines and goals to move adults with physical disabilities into Connect Care (primary care management) and managed care programs that include services provided under home and community based waivers

Current system
In response to legislative direction, DHS is developing managed care and primary care case management options for this population. It is not clear to the committee what the timeline is for enrollment in these programs. The committee was informed by national experts that both models have been successful with this population depending on the local provider and health plan environment, but it was not clear that Rhode Island had enough of a population to sustain these models plus a fee for service option. The recently

released Federal Medicaid Commission report recommended expansion of Medicaid managed care to serve persons with disabilities and the elderly.

Recommendation
Evaluate whether a three choice model (FFS, Primary Care Case Management and Managed Care) is sustainable in Rhode Island and consistent with purchasing principles established above. Criteria for this assessment should consider cost, quality and access. Make recommendations for specific enrollment timelines and projecting budgetary impacts for the models chosen.

There is much to be gained from applying DHS' five years of experience in managed care for children with special health care needs to the adults with disabilities population. In these populations, the chronically ill beneficiaries consume large amounts of resources. Care coordination by the financing entity can be supplemented with improved chronic care management at the patient's medical home. This "chronic care model" has been shown to lower cost and improve quality. The State is the recipient of a grant to facilitate improving measures and financial incentives for medical homes to improve chronic care management, and Medicaid stands to benefit from implementation of these steps.

Whether as part of the managed care program or primary care case management program, Medicaid purchasing contracting and payment strategies should be changed to support the adoption of the chronic care model in primary care settings.

2. Expand personal choices waiver

Issue
A small group of adults with disabilities have access to a program "Personal Choices" which gives them limited flexibility to select the services and providers they want with Medicaid funds. Nationally these are known as "cash and counseling models". The committee was informed that initial feedback locally is positive.

Recommendation
Conduct program assessment and expand the number of slots available under this waiver program, if the assessment study results are positive.

IV. Elderly

1. Accelerate moving people into home-and-community based services by reducing dependence on institutional care

Current system
The Committee was informed that Rhode Island's expenditures for institutions for the elderly as a percent of total expenditures are one of the highest percentages in the country. The Committee was also briefed on efforts by DHS over time to increase the portion of dollars and services in the community based settings. Under the Deficit

Reduction Act (DRA) states can amend their State Medicaid Plans to offer HCBS as a State plan optional benefit. This would be a significant step towards ending the "institutional bias". There also are planning funds available for these purposes. In Rhode Island work has begun, funded by a five-year Real Choice System Change Transformation Grant, and the State has applied for a "Money Follows the Person" Grant.

Recommendation

The work to create more community based alternatives for Medicaid elders needs to be accelerated. Although there are many stakeholders in such a process, it would have to be led by DHS. Further research would address the questions:

- What could Rhode Island do to serve more elderly in home and community-based settings?
- At the same time, how could the State tighten the standard for admission to institutions to establish cost-efficiency and how will this affect the need for institutional services?
- Should Rhode Island apply for a Money Follows the Person ("MFP) grant from the federal government to transition more elderly from nursing homes to the community?
- Do the current multiple stakeholder group processes serve to promote this process or inhibit it?
- How could incentives for Medicaid-dependent long term care providers be created to establish and transition to new community based service capacity as demand for institutional services decreases?
- How could caregivers of elders be educated on their options under Medicaid? A consumer driven model will require this.

2. Contract with existing Medicare Advantage Special Needs Plans to create a global capitation (combining finding streams from Medicare and Medicaid) for the dually eligible, thus providing incentives to the manage care plan to provide a full spectrum of acute and long-term services in an effective and efficient manner.

Issue

The committee was informed that integrating Medicare and Medicaid funding for elders can result in significant improvements in the quality of services for these elders. There are three models of special needs plans operating in Rhode Island: United Health Plan's Evercare, Optima (BCBSRI and NHPRI) and a PACE model. Only the PACE model (through Carelink) is currently operating with Medicaid and Medicare funding.

Recommendation

Research and, if appropriate, pursue waivers on State Plan changes, waivers to implement Medicaid/Medicare funding for Special Needs Plans in Rhode Island.

3. Research the feasibility of a long-term care partnership program for Rhode Island (this recommendation is based on the Deficit Reduction Act)

Issue

Under the long-term care partnership program, states can design policies to increase the role of private long-term care insurance in financing long-term services by allowing persons who purchase qualified long-term care insurance policies to shelter some or all of their assets when they apply for Medicaid after exhausting their policy benefits.

Recommendation

Research would address the following questions:
Should Rhode Island design such a program?
What would be the impact on the health insurance market?
What should the key provisions be? What are the options?

B. Medicaid Subcommittee on Finance

The Medicaid Subcommittee on Finance was charged with the responsibility of reviewing how the Medicaid program was being administered as well as analyzing existing benefits and reimbursements in order to assess the cost-effectiveness of the Medicaid program. As a result of this review, the Subcommittee identified several options aimed at assuring that high-quality medical services are delivered in the most cost-effective manner in order to enhance the sustainability and affordability of the State's Medicaid programs.

In developing these options, the Subcommittee looked at the level and types of mandatory and optional services, ways to maximize federal financial support, and case management practices.

The Subcommittee was asked to consider the potential impact interim recommendations might have on the FY 2008 budget. However, the Subcommittee found that most of the options might require additional research, and may not have an immediate impact on next year's State Budget.

Options compiled by the Medicaid Subcommittee on Finance

The options listed below have emerged from the four committee meetings. At its meeting on December 5, 2006, committee members discussed these proposals and whether they should be presented to the Governor for further consideration.

URI Pharmacy Report

A study conducted by the URI Health Care Utilization Management Center has found 11 separate pharmaceutical programs operated by state government. Those programs are broken down into two functional types: distributive (direct dispensing) and managed (contract with a pharmacy network to dispense).

Distributive

- Rhode Island Training School (RITS)
- Rhode Island Department of Corrections (RIDOC)
- URI Health Services (URI)
- Eleanor Slater Hospital (ESH)
- Rhode Island Veterans Home (VH)

Managed

- Rhode Island Medicaid Program (MA)
- State Employees Prescription Benefit (SORI)
- Rhode Island Pharmaceutical Assistance to the Elderly Program (RIPAE)
- AIDS Drug Assistance Program (ADAP)
- Community Medical Assistance Program (CMAP)

The URI report recommended nine specific actions be taken to more efficiently deliver pharmaceuticals to clients in the safest, most cost effective manner. These recommendations are electronic claims processing, reporting standards, coordination of benefits/eligibility systems, pharmacy networks, rebate management infrastructure, formularies and treatment protocols, clinical and management support systems, purchasing channels, and electronic health records.

Several of these initiatives have been undertaken:

- Statewide – Electronic medical records are one of the Governor's key health care agenda items. Several state agencies are involved in developing a statewide system; the Governor proposed and the General Assembly approved a bond that would help pay the State pay its share of development costs.
- URI – URI is attempting to join the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP). The MMCAP would allow URI to purchase pharmaceuticals through a large multi-state purchasing pool.
- RIDOC – Corrections has begun a coordination of benefits program, in cooperation with the Medicaid Program, to ensure the State is maximizing federal cost sharing opportunities.
- MHRH – CMAP
- RIPAE is a program that provides prescription drug cost assistance to Rhode Island residents 65 and older who meet specific income guidelines and those 55 and older who are disabled. This program has undergone significant change since the inception of Medicare Part D. RIPAE – EA has transferred pharmacy benefits management to DHS/EDS and is in the process of implementing TPL and asset/means tests for pre-screening and on an ongoing basis.
- ADAP –This program provides pharmaceutical assistance and social services to those that are positive for AIDS/HIV. This program covers individuals up to 400% of FPL. As federal dollars continue to decline, many states have been exploring cost containment strategies (mainly waiting lists for pharmaceutical assistance).

Option
Should the Governor coordinate pharmaceutical purchasing across state government to meet the needs of clients and maximize taxpayer dollars?

Some members raised concerns about the cost-benefits of a single State pool for pharmacy purchases. One member raised some concern over the potential savings when just increasing the size of the purchasing pool. Manufacturers give discounts when you purchase more of their specific drug. This type of guarantee is usually through a PDL or formulary design.

State Only Funded Programs

Children and Families

- State funded RIte Care for uninsured children under 250% of FPL who are not eligible for Federal Medicaid/SCHIP due to immigration status; this includes undocumented, as well as documented, but unqualified children (barred for five years).
    - Article 40 of the FY07 State budget closed entry to RIte Care to these children effective 12/31/2006. Approximately 3,000 children were grandfathered into RIte Care through the General Assembly's enacted budget. Savings (federal match) may be found if/when some of this population becomes eligible for Federal Medicaid/SCHIP (five year waiting period for Legal Permanent Residents).

- Health insurance subsidy for center based child care providers. The Starting RIght Health Care Insurance Assistance Program allows approved (by the Child Care Assistance Program – CCAP) center-based child care providers can seek up to 50% reimbursement for health care costs for workers who devote at least 75% of their time to direct care of children. Assistance is capped at a maximum of $170 per employee per month and at least 40% of the center's census must be CCAP assisted children.

Children with Special Health Care Needs

- DHS currently operates a state-funded respite program for parents and caregivers of children with special needs. This program provides short-term care for children with disabilities in order to give the parents a break from their role as primary care giver. A 1990 GAO report found that respite services help prevent abuse, neglect, and promote family unity. Additionally, respite care improves the likelihood that the child will continue to live at home and avoid institutionalization.
    - NOTE: DHS is currently working on 2 waiver requests to CMS to allow respite care as a Medicaid service (which would then receive federal matching funds). The waiver requests will be submitted in December 2006.

- The Deficit Reduction Act has provided some opportunity to seek federal matching funds for certain previously SSI eligible families of children with special health care needs. The Family Opportunity Act restores benefits to families previously eligible for assistance but was subsequently dropped due to increases in family income.

Option

Should the Governor explore DRA opportunities to maximize federal match potential in these state only funded programs?

The committee was supportive. One member asked that the Governor try to work with the federal government to try to get these "state only" populations included in the Medicaid pool.

Benefit Comparison

A preliminary comparison of the Rhode Island Medicaid benefit package with the plans offered in the commercial market has been provided to committee members.

Option
Should the Governor explore benefit parity with neighboring state's Medicaid programs and the commercial market?

Two members offered criticism of this option. One stated that the State has been most successful when better managing (RIte Care) rather than restricting or limiting benefits. Additionally, a member cautioned that further restricting benefits may drive more people away from insurance, management of those benefits would pull people in. One member stated that the comparison should not only include neighboring states. Instead, a more comprehensive review of Medicaid benefit packages around the country should be provided.

Mandatory vs. Optional Disease Management

DHS has developed a voluntary disease management program for those enrolled in Medicaid. This product was designed to better meet this population's medical needs, balance supportive services between community based and institutional settings of care, and to curb expenditure growth. The goal of any disease management program is to utilize appropriate services and avoid unnecessary admissions to institutional care settings.

DHS has proposed a program a primary care case management model and a comprehensive health plan model that would enroll a smaller subset of this population as a pilot. This would include 150 children with special health care needs, who are enrolled in RIte Care and will age out of the program at 21, and 2,800 adults with disabilities. There are 15,210 adults with disabilities living in the community in Rhode Island. The pilot approach was chosen to develop buy-in from the served community.

While this pilot is a good first step, some states have taken a more aggressive approach to mandating disease management across their Medicaid population. West Virginia has taken advantage of flexibility offered through the DRA to offer differing benefit packages to their children and families population. On July 1, 2006, West Virginia began offering 160,000 children and parents (half their Medicaid population) a choice between two benefit packages: one is a basic package based on the current Medicaid plan; the other provides the beneficiary enhanced benefits if they sign a "Medicaid Member Agreement". This plan requires the beneficiary to choose a primary care physician and

work with their provider to develop a plan of care with desired outcomes. The beneficiary can enhance their benefit package (gain access to additional services such as smoking cessation and nutrition education) by complying with the plan and reaching desired outcomes. West Virginia does not expect to realize immediate cost benefits, but does expect to see dramatic improvements in long term health care outcomes.

Additionally, some states have focused, not on specific Medicaid populations (i.e. children and families), but on specific diseases. The most common diseases targeted by states have been asthma, diabetes, HIV/AIDS, and hypertension. States have shown varying degrees of success; however, many states have seen sizable reductions in ER visits.

Option
Should the Governor more aggressively implement a disease management program across Medicaid populations?

One member pointed out that the success of disease management programs hinges on a stable enrollment in the plan. Beneficiaries that leave the plan after a short period of time will see less beneficial impact than those that are involved for longer periods. Another member commented that splitting the management of adults with disabilities into multiple programmatic solutions could impact any potential benefits of this option.

Case Review

Several members of the committee expressed concern that a small number of cases are responsible for a high percentage of total expenditures in each served population. In each population categories (adults with disabilities, elderly, children and families, and children with special health care needs) there is a cohort of extremely expensive cases that are driving expenditures.

Option
Should the Governor create an interdisciplinary case review process in the Executive Office of Health and Human Services to examine cost drivers in the most expensive 50 cases in each population group?

Members were generally supportive, but would like some additional information. One member stated that understanding these cases will better enable the State to understand the costs drivers for the remaining 80% of beneficiaries.

Program Integrity

- Example of how program integrity is conducted at DHS.
    - *Front End Detection Unit* – In FY05, the Governor proposed and the General Assembly approved the creation of the Front End Detection Unit at DHS.

- *Medical Assistance Eligibility Documentation* – This recently passed budget article was created to augment the documentation of certain Medical Assistance program eligibility criteria to improve program integrity in the following ways:
    - Require documentation of residence for Medical Assistance/RIte Care applications. This documentation would be third party verifications such as but not limited to leases, mortgage statements and utility bills.
    - Establish criteria in the Medical Assistance/RIte Care program similar to that in the Family Independence and Child Care Assistance programs to have the Front End Detection Unit review all applications submitted by families and individuals who have moved to Rhode Island within 90 days from the date of application.
    - To establish a resource limit of $10,000 for the RIte Care program. Such resources would include accessible, liquid resources.

Option
Should the Governor develop consistent program integrity measures, similar to those instituted by DHS, across the Health and Human Services agencies?

There was consensus that the State should be providing benefits to only those who are eligible. One member was concerned that the question focuses only on screening for eligibility fraud and ignores potential provider fraud (the Attorney General has a Medicaid fraud unit) and DHS has taken steps to manage suspicious claim practices.

Medical Malpractice

There are four general approaches to medical malpractice reform:

- *Insurance Market Interventions* – This would be considered a temporary measure to provide relief to doctors to address the lack of affordable insurance. These interventions include provider subsidies and state run insurance programs. Several states have used an HMO tax to fund malpractice subsidies to eligible physicians.
- *Tort Reforms* – This type of reform deals with the way medical malpractice cases travel through the court system. Generally, tort reforms deal with the size of medical malpractice awards or the number of suits that make it to the courts.
- *Alternative Dispute Resolution* – This approach attempts to resolve medical malpractice cases before they reach the courts.
- *Patient Safety Efforts* – These efforts focus on improving patient safety to avoid the likelihood of medical errors. The hope is that these efforts will reduce errors, therefore reduce medical malpractice insurance rates.

According to the U.S. General Accounting Office (GAO), losses on medical malpractice claims are the major driver of increases in the cost of malpractice insurance. The

Congressional Budget Office (CBO) has estimated the cost of medical malpractice insurance is increasing at twice the rate of total health care spending; specifically, ob-gyn, internists and general surgeons are experiencing the highest increases in premiums. In general, it is theorized that a reform of medical malpractice laws will result in a decreased likelihood of doctors practicing defensive medicine. There are few studies available that show changes in medical malpractice laws having a significant impact on Medicaid spending or the overall health care market. Several studies have shown caps on non-economic and a ban on punitive damages would, on average, lower premiums nationwide by 25-33%. A reduction of this magnitude would not have a significant impact on health care costs. Medical malpractice represents less than 2% of overall health care spending; a 25-33% reduction in premiums would reduce health care costs by only 0.4-0.5%.

Approaches:
Pennsylvania – Instituted long and short-term reforms to reduce malpractice premiums and retain doctors. Reforms instituted in Pennsylvania in 2002 and 2003 included: cap on punitive damages, limiting hospital vicarious liability, and limiting the allowable timeframe to file a lawsuit, and a premium abatement program. The abatement program provides premium reductions (up to 100%) to qualified doctors.

Since these tort reform measures were passed medical malpractice insurance rates have begun to decrease. Despite these rate decreases, cesarean births (a good measure of defensive medicine) have continued to increase at a rate of 8% per year. Medical malpractice reform is still considered an important component of the increases in overall spending increases in health care. The slow response to changes in doctor's insurance rates can be attributed to the time it takes to change individual behavior. It is expected that the measures used to track defensive medicine will begin to decline in the coming years.

Option
Should the Governor propose medical malpractice reforms in an attempt to lower malpractice insurance rates in Rhode Island?

Members were supportive. Several members expressed an opinion that tort reform was needed and the lack of action may start to deplete the number of doctors practicing in Rhode Island.

Provider Tax/Temporary Surcharge to Address Short-Term Costs

- Hospital License Fee -- A hospital licensing fee was created in statute in FY1995 at a 2.2% of gross patient services revenue for each hospital. Currently, the hospital license fee is at a rate of 3.56% (net patient services revenue for the hospital fiscal year ending on or after January 1, 2004).
    - If the hospital license fee were raised to 6%, this could generate a total of approximately $113 million in revenue, representing an additional $43.5

million. The change in hospital license fee would require a statutory change of RIGL 23-17-38.1.

- HMO Tax -- Several states have enacted HMO taxes to increase revenues. Last year, Maryland enacted a 2% tax on HMO premiums. The revenue generated from the assessment was used to subsidize doctor's medical malpractice premiums, which had increase 70% over the past two years.

Option
Should the Governor pursue a provider tax/temporary surcharge to address short-term budget shortfalls?

This proposal was strongly objected to by the members representing hospitals. They feel this type of assessment punishes one segment of the health care market, would likely force several hospitals into financial trouble, and pass costs on to businesses and consumers.

Hospital Expenditures

- ER Utilizations – To determine if there are any differences in the rates of ER utilization the average number of visits per member per year to the ER for Medicaid, BCBS of RI, and United was calculated (ER visits in 2005/total membership). DOH began collecting ER utilization data in 2005; therefore, there are no long term trends available for comparison
  - Medicaid – .56 visits
  - BCBS – .30 visits
  - United – .21 visits

- ER Costs -- To determine if there are differences in the ER costs in each of the three categories, average ER cost per member per year was calculated.
  - Medicaid -- $582
  - BCBS -- $360
  - United -- $278

- Births by Cesarean – According to DOH, the rate of cesarean births in Rhode Island have been climbing since 1995 (1994 - 17.3%; 2004 - 28.8%). Data indicates that women with private insurance are more likely (30.9%) to have a cesarean birth as women on Medicaid (26.0%).

Options
Should the Governor pursue reforms to Medicaid ER utilization and cost?

This proposal was not discussed in detail, but no major objections were raised. One member pointed out that several health plans have started to push reforms that focus on primary care.

Medicaid Study Group

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