RIte CARE / RIte SHARE
ANNUAL REPORT

PROGRAM YEAR
ENDING JULY 31, 2006

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CHAPTER 1

BACKGROUND AND OVERVIEW

In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program called RIte Care. RIte Care, implemented in August 1994, has the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

RIte Care was designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)[1] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

Over time, the populations eligible for RIte Care have expanded, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185 of the FPL (expansion under Section 1931 of the Social Security Act through a State Plan Amendment (SPA))
- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL

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[1]Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF) FIP is Rhode Island's program for the TANF-eligible population.

- Effective December 1, 2000, to maximize enrollment of children in foster care placements[2] from fee- for-service Medicaid to RIte Care

- Effective November 1, 2002, to establish a separate child health program to cover unborn children with family income up to 250 percent of the FPL

- Effective January 29, 2003, to enroll the following categories of children with special health care needs into RIte Care Health Plans on a mandatory basis[3]:

  - Blind/disabled children, and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)

  - Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children)

  - Children receiving subsidized adoption assistance

The May 1, 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI (State Children's Health Insurance Program, or SCHIP) of the Social Security Act. By Section SCHIP 1115 waiver approval (21-W-00002/1-01), effective January 18, 2001, Section 1931 parents and relative caretakers between 100 and 185 percent of the FPL, and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. Approved April 17, 2003, the separate child health program allows the State to provide comprehensive coverage for pregnant aliens who would not be otherwise eligible for Federal financial participation (FFP). These women are enrolled in RIte Care Health Plans.

It should be noted that the State received approval from the, then, Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS) on January 5, 1999 to expand SCHIP coverage to children under age 19 in households with income up to 300 percent of the FPL. The State has not yet implemented the approved amendment and has no immediate plans to do so due to ongoing budgetary constraints.

In addition to these covered populations, the RIte Care Health Plans must make coverage available to certain State-funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL

- Children who are uninsured whose household income is in excess of 250 percent of the FPL

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[2] Children in foster care are in enrolled in RIte Care on a voluntary basis.
[3] Children with special health care needs are also presently enrolled on a voluntary basis, as only one Health Plan, Neighborhood Health Plan of Rhode Island (NHPRI) has been willing to enroll this population. NHPRI is also the only Health Plan that has been willing to enroll children in foster care.

- Licensed family child care providers and their eligible dependents

As the subsequent chapters of this annual report show, RIte Care has been demonstrably successful in accomplishing its goals – at times, perhaps, too successful. RIte Care's enrollment grew substantially from 1998 through 2001 as a result of four significant events, occurring in tandem:

- As noted above, the State expanded eligibility to parents and relative caretakers of RIte Care-enrolled children up to 185 percent of the FPL, under Section 1931 of the Social Security Act.
- The State streamlined the RIte Care application process, by creating a short, mail-in application in English and Spanish and eliminating the face-to-face interview requirement for both the initial eligibility determination and for re-determination.
- The State embarked on an ambitious community-based outreach campaign to reach and enroll uninsured children and families.
- The State's commercial insurance market began to deteriorate, marked by sharp increases in premium rates offered to employers, reduced competition as a result of two of the State's commercial insurers suddenly exiting Rhode Island, and significant hospital and Health Plan losses.

Over the same period of time, RIte Care's enrollment grew by 41 percent – from 74,000 in November 1998 to 104,000 by June 2000. Before that time, RIte Care enrollment had remained relatively stable despite the incremental expansions in coverage for children described earlier. The magnitude of the enrollment growth caused large, unexpected increases in program costs.

While it is still unclear to the State which of these four events contributed most to RIte Care's enrollment growth, it was most likely the combination of all four. It is also unclear how much of RIte Care's growth was due to a shift from private, employer-sponsored insurance (ESI) coverage to public coverage (referred to in the research literature as either "substitution" or "crowd-out"), although to some degree this undoubtedly occurred. The four events are described in more detail below because of their ongoing impact on RIte Care in its August 1, 2002 to July 31, 2003 program year covered by this annual report.

1. EVENT ONE: RITE CARE EXTENDED ELIGIBILITY TO LOW-INCOME PARENTS

In 1998, the State of Rhode Island sought to extend eligibility for RIte Care to parents and relative caretakers of children enrolled in RIte Care for several reasons. First, feedback from RIte Care enrollees underscored the absence of comprehensive coverage for the entire family as a major program weakness, particularly for uninsured parents of enrolled children and women

covered under the Extended Family Planning (EFP) limited benefit package[4]. Second, the number of uninsured Rhode Island adults who were employed was increasing significantly (from 51.5 percent in 1996 to 69 percent in 1998)[5] due to the erosion in ESI. Third, the health care research literature offered persuasive evidence indicating that even the most ambitious and systematic efforts to promote prevention and other health goals for children and adolescents often fall short when parents and relative caretaker have limited access to health care[6].

Therefore, in July 1998, the State submitted another SCHIP Program Plan amendment requesting authority to extend coverage to the growing number of low income uninsured parents and relative caretakers. On December 29, 1998, after receiving specific guidance from the then Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid, or CMS), the State voluntarily withdrew the SCHIP amendment request for family coverage and submitted a Medicaid State Plan Amendment to establish a new eligibility group, effective November 1, 1998, consisting of families with children with incomes under 185 of the FPL, pursuant to Section 1931 of the Social Security Act.

2. EVENT TWO: STREAMLINED ELIGIBILITY WAS IMPLEMENTED

In October 1998, Rhode Island streamlined its application process for RIte Care. The application itself was shortened considerably – from 31 pages to 12 pages[7]. Documentation requirements were reduced from 13 to three items – pregnancy, income, and immigration status for non-citizens. Perhaps most significantly, the requirement for a face-to-face interview was replaced with a mail-in application for both initial eligibility determination and re-determination.

3. EVENT THREE: A SUCCESSFUL OUTREACH CAMPAIGN WAS UNDERTAKEN

Rhode Island embarked on an intensive, 18-month, community-based outreach campaign from January 1999 to June 2000. The campaign was designed to reach and enroll uninsured children and families. Incentive-based contracts with 32 community-based organizations (CBOs), where the CBOs were compensated for enrolling eligible individuals, proved highly successful. The contracts were targeted to communities with the largest number of uninsured children and combined with an extensive, Statewide, school-based outreach effort.

4. EVENT FOUR: THE STATE'S COMMERCIAL HEALTH INSURANCE ENVIRONMENT WAS UNSTABLE

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[4] Uninsured pregnant women retained comprehensive insurance coverage under RIte Care for only 60 days postpartum. After that, the women were eligible only for a limited family planning benefit package designed to help avert future pregnancies.

[5] An updated analysis is included as Appendix A.

[6] See, for example: Lambrew, J.M. *Health Insurance: A Family Affair,* George Washington University Center for Health Services Research and Policy, May 2001; Dubay, L. and G. Kenney. *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, Urban Institute, 2001; Hanson, K. "Is Insurance for Children Enough? The Link Between Parents' and Children's Health care Use Revisited," *Inquiry,*35, 1998; and Davidoff, A. et.al. *Patterns of Child-Parent Insurance Coverage: Implications for Coverage Expansions*, Urban Institute, November 2001.

[7] The application was later expanded to 20 pages, when a combined English/Spanish version was developed.

The unintended and unexpected consequence of the rapid increase in RIte Care enrollment and State policymaker responses to them are best understood within the broader context of developments in Rhode Island's health care system, particularly in the commercial health insurance market. Although Rhode Island had a robust economy for much of the 1990s, nearly one-third of families in the State had incomes that fell below 200 percent of the FPL. Unlike many of Rhode Island's sister States, with high percentages of low- and moderate-income wage earners, the rate of uninsured in the State remained relatively low until towards the end of the decade.

RIte Care, including its incremental expansions noted above, played an important role in maintaining a relatively low rate of uninsurance among the unemployed, low-wage workers, and children. However, the majority of working Rhode Islanders continued to obtain coverage through ESI. As of June 1999, the available data indicated that 77 percent of employers in the State offered ESI; 60 percent of employers who offered coverage paid the entire premium for individual coverage and 42 percent of employers who offered coverage paid the entire premium for family coverage[8]. In sum, for the better part of a decade, RIte Care served, as both the Governor and the General Assembly intended, as an effective means of providing coverage to uninsured individuals in these groups.

Based upon *Current Population Surveys* data from the U.S. Bureau of the Census and *Behavioral Risk Factor Surveillance Survey* (BRFSS) data from the Rhode Island Department of Health, the Medicaid Research and Evaluation Project of the Rhode Island Department of Human Services (DHS) analyzed uninsurance trends in the State through 1999 (see Appendix A for an updated analysis). This trend analysis showed that while uninsurance among Rhode Island's children had been declining; uninsurance among adults was still problematic. The trend analysis also showed that in Rhode Island:

- Males are more likely than females to lack health insurance
- The uninsurance rate among African-Americans is more than twice that for Whites
- Income level has the strongest association level with being uninsured
- Self-employed Rhode Islanders are three times more likely than Rhode Islanders who work for wages to be uninsured
- Among Rhode Islanders who work for wages, the overwhelming reason they lack insurance is they cannot afford the premiums

As the decade came to a close, it became increasingly apparent that access to affordable health coverage in Rhode Island was beginning to erode. During the same period that the costs of commercial health insurance began to escalate, the number of commercial carriers active in the State's insurance market plummeted unexpectedly leaving consumers with a modest choice of

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[8] The reference for the updated analysis is: Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island 1996-2000*, Medicaid Research and Evaluation Project, April 2002.

only two health plans. Within several months in the latter half of 1999, both Harvard Pilgrim Health Care of New England[9] and Tufts Health Plan of New England departed from the Rhode Island insurance market without warning – leaving 150,000 Rhode Islanders at-risk of becoming uninsured.[10] As a result, for many of those who were unable to afford the premiums charged by the remaining two commercial insurers in the State, enrollment in RIte Care became an attractive option. This was due in part to the fact that over the previous five years, RIte Care had virtually erased the stigma usually associated with public programs.

High increases during 1999 and 2000 in commercial health insurance policy renewal rates affected both employers and employees. The impact on small firms and low-wage workers was particularly pronounced; low-wage workers who were unable to afford higher premium share contributions were driven out of the commercial insurance market. Since RIte Care did not have provisions (due to Section 1931 restrictions) to deter substitution for families with incomes below 185 percent of the FPL and there was no waiting period for families who drop affordable ESI immediately prior to applying for RIte Care, some workers (and their dependents) may have shifted from ESI to RIte Care.[11]

Detailed review of RIte Care eligibility files from October 1997 to May 2001 indicated that nine percent of newly enrolled 8 through 18-year-old members between 100 and 185 percent of the FPL had ESI coverage at the time of application.[12]

During Calendar Year 1999, the first year following the Section 1931 expansion to parents and relative caretakers, only two Health Plans were accepting new RIte Care enrollees[13]: a commercial plan, United Healthcare of New England (UHCNE); and a Medicaid-only plan, Neighborhood Health Plan of Rhode Island (NHPRI)[14]. Data provided by UHCNE indicated that a number of RIte Care enrollees migrated to RIte Care from their commercial products.

It should also be noted that the State made a policy decision in the very beginning that only State-licensed health maintenance organizations (HMOs) would be allowed to participate in RIte Care. In Rhode Island, this also means that the HMOs are accredited by the National Commission for Quality Assurance (NCQA), since this is a requirement of State law. All three Health Plans participating in RIte Care have full, three-year accreditation. All three have their Medicaid product lines accredited by NCQA and all three received an "excellent" designation from NCQA for their Medicaid product lines. Both Coordinated Health Partners (BlueCHiP, or CHiP) and UHCNE are Medicare+Choice participating plans, for which their Medicare product lines also have received an "excellent" designation from NCQA.

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[9] It should be noted that when RIte Care began, both Harvard Community Health Plan and Pilgrim Health Care accepted enrollees. In 1995, these two plans merged.

[10] At the time Harvard Pilgrim Health Care of New England left the Rhode Island market, it had 7,508 RIte Care enrollees; Tufts Health Plan of New England was never a RIte Care-participating health plan.

[11] Although there are RIte Care eligibility requirements in place to discourage substitution of ESI (e.g., a four-month waiting period), they do not apply to families with incomes below 185 percent of the FPL because Section 1931 of the Social Security Act does not allow them.

[12] This number was determined for SCHIP reporting requirements, as a result of case-by-case analysis of all SCHIP applicants.

[13] Coordinated Health Partners, or Blue CHiP, was also participating in RIte Care but at that time was not accepting new enrollees.

[14] NHPRI was formed by the State's Federally qualified health centers (FQHCs).

5. THE GOVERNOR AND GENERAL ASSEMBLY RESPONDED ASSERTIVELY TO DEVELOPMENTS

In January 2000, then Governor Lincoln Almond convened a group of Administration staff, legislative leaders, and consumer and business representatives to find a solution to Rhode Island's deteriorating health insurance market. The Health Care Steering Committee (Steering Committee), as the workgroup was called, was jointly chaired by: Christine Ferguson, then Director of DHS; Senator Thomas Izzo, Chair of the Senate Health, Education and Welfare Committee; and Representative Gerard Martineau, House Majority Leader. The Steering Committee was broadly representative of employers, consumers, labor, and the legislative and executive branches of government. Health care providers and insurers were invited to attend meetings and provide testimony to the Steering Committee.

During the next six months, the Steering Committee focused on methods to stabilize the ESI market. Specifically, the Steering Committee examined methods to enable small businesses to maintain ESI by stabilizing premium rates and by assisting and encouraging low-wage workers to maintain ESI. The focus on small employers was due to the increasing number of businesses with less than 50 workers reporting the most volatile rate increases and the resulting difficulty in retaining and/or obtaining ESI, as well as the vital role these employers play in the State's overall economic health.

Governor Almond signed the resulting consensus legislative proposal into law on July 1, 2000. The legislation, Health Reform Rhode Island 2000, included the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

- **Part 1 –** Directing DHS to stabilize the RIte Care program by targeting resources to those most in need of coverage – low-wage families without access to affordable coverage, through:

  - Establishing cost-sharing requirements for certain RIte Care-eligible populations to promote both responsible utilization of health care services and to deter substitution.

  - Requiring mandatory participation in RIte Share of eligible individuals and families who have access to ESI. RIte Share is the premium assistance program created by the statute to support employees who have ESI coverage offered to enroll in or retain their ESI coverage. (This has been implemented under a separate Section 1906 Medicaid State Plan Amendment.)

- Authorizing DHS to establish additional eligibility requirements for RIte Care to further deter substitution (i.e., a waiting period for new applicants who were enrolled in ESI within six months prior to application)

- **Part 2 –** Reforming the health insurance marketplace to conform with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, stabilize premiums in the small group market by compressing rate bands, and guarantee issue of a basic health plan

- **Part 3 –** Establishing new financial reserve requirements for health insurance, consistent with the recommendations of the National Association of Insurance Commissioners (NAIC)

The passage of Part 1 of the Health Reform Rhode Island 2000 represented a significant and important consensus among the Governor and leaders in the General Assembly – RIte Care must be consistent with its original mission to assure access to coverage for the uninsured and to deter migration for ESI while assuring access to coverage for low income families. The Governor and General Assembly were also clear that if the RIte Care caseload and cost growth are not controlled by Part 1 of the statute, a roll-back of eligibility expansions currently in place for working families, particularly the Section 1931 expansion implemented in 1998 for parents and relative caretakers whose incomes are above TANF levels, would be considered.

On January 18, 2001, HCFA approved Rhode Island's request for a Section 1115 SCHIP demonstration waiver to allow the State to receive enhanced Federal match for parents and relative caretakers in the Section 1931 expansion group whose incomes are between 100 and 185 percent of the FPL and pregnant women whose incomes are between 185 and 250 percent of the FPL. This approval enables Rhode Island to receive enhanced SCHIP Federal Medical Assistance Percentage (FMAP) (about 68 percent) for those groups compared to FMAP for Medicaid of about 56 percent.

The RIte Share premium assistance program was implemented in February 2001 by signing up "participating employers" on a voluntary basis. Even though active marketing occurred, participation of employers was limited. In January 2002, DHS began paying participating employees' premium share amounts directly to the employees without employers having to sign up and participate in RIte Share. At the same time, enrollment in RIte Share became mandatory for Medicaid-eligible individuals whose employers offered an approvable health plan.

RIte Share has some characteristics that set it apart from other States' employer-subsidy programs. Rhode Island instituted unique features to streamline the administration of the program and maximize enrollment, including qualifying almost all health insurance plans offered in the current Rhode Island market as approved for participation in the program; providing all Medicaid benefits and co-payments not covered in an enrollee's ESI coverage once he or she is enrolled in RIte Share; and using an aggregate cost-effectiveness test (employer-based rather than family-specific). Rhode Island also initiated a Business Advisory Committee and has an active Consumer Advisory Committee that provides feedback on key elements of the program.

In addition, since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of the premiums for their health insurance coverage if their income is above 150 percent of the FPL. The monthly premium-share amounts by income level, effective August 1, 2002, are as follows[15]:

Income Level	Monthly Family Premium
150% - 185% of FPL	$61
185% - 200% of FPL	$77
200% - 250% of FPL	$92

It should be noted that these premium levels are among the highest cost-sharing in the nation[16], but are below the SCHIP ceiling on cost-sharing (5 percent of family income) and include no point of service copay requirements. As shown later in this report, these actions have helped ease some of Rhode Island's unanticipated budget pressures that resulted from eligible population expansions.

6. THE SECTIONS 1115 MEDICAID AND SCHIP WAIVERS HAVE BEEN EXTENDED UNTIL 2008

The initial period for the Section 1115 Medicaid waiver for RIte Care was August 1, 1994 to July 31, 1999. Important demonstration project dates include:

- Initial Waiver Application Submitted: July 20, 1993
- Initial Waiver Application Approved: November 1, 1993
- Demonstration Project Implemented: August 1, 1994
- First Waiver Extension Request Submitted: March 17, 1998
- First Waiver Extension Request Approved: September 17, 1998
- First Waiver Extension Expired: July 31, 2002
- Second Waiver Extension Request Submitted: April 16, 2002
- Second Waiver Extension Request Approved: July 29, 2002
- Second Waiver Extension Expired: July 31, 2005

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[15] Rhode Island law limits monthly premium payments to no more than three percent of a family's income. Prior to January 1, 2002, enrollees with incomes above 185 percent of the FPL had a choice of paying a portion of their premium each month along with a short schedule of co-payments or paying no premiums and being subject to a longer schedule of co-payments.

[16] Kaye, N. and K. Wysen. *Using Medicaid to Cover the Uninsured: Medicaid Participant Buy-In Programs*, National Academy of State Health Policy, May 2003.

- Third Waiver Extension Request Submitted: March 4, 2005
- Third Waiver Extension Request Approved: August 31, 2005
- Third Waiver Extension Expires: July 31, 2008

The Section 1115 SCHIP waiver was combined administratively with the Section 1115 Medicaid waiver so that both waivers expire on July 31, 2008. Important project dates for this waiver in relationship to the SCHIP State Plan include:

- Date SCHIP State Plan Submitted: January 5, 1998
- Date SCHIP State Plan Approved: May 8, 1998
- Date SCHIP State Plan Effective: October 7, 1997
- Date SCHIP State Plan Amendment 1 Submitted: November 10, 1998
- Date SCHIP State Plan Amendment 1 Approved: January 5, 1999
- Date SCHIP State Plan Amendment 1 Effective: Not yet implemented
- Date Section SCHIP Waiver Submitted: November 2, 2000
- Date Section 1115 SCHIP Waiver Approved: January 18, 2001
- Section 1115 SCHIP Waiver Effective Date: January 18, 2001
- Date SCHIP State Plan Amendment 2 Submitted: January 27, 2002
- Date SCHIP State Plan Amendment 2 Approved: September 19, 2002
- Date SCHIP State Plan Amendment 2 Effective: September 19, 2002
- Date SCHIP State Plan Amendment 3 Submitted: February 5, 2003
- Date SCHIP State Plan Amendment 3 Approved: April 17, 2003
- Date SCHIP State Plan Amendment 3 Effective Date: November 1, 2002
- Date SCHIP Section 1115 Waiver Extension Submitted July 13, 2005
- Date SCHIP Section 1115 Waiver Extension Approved August 31, 2005
- Section 1115 SCHP Waiver Expires: July 31, 2008

A new requirement under the waiver extension is for the State to prepare an evaluation design. The State submitted its *Draft Evaluation Design* to CMS on November 18, 2005 and submitted its *Final Evaluation Design* to CMS on July 20, 2006 after receiving CMS' comments on the draft on May 8, 2006. Table 1-1 shows the objectives and hypotheses for the demonstration.

Table 1-1

Objectives and Hypotheses for the Demonstration

Demonstration Objectives	Demonstration Hypotheses
To reduce uninsurance in the expansion population groups eligible for the demonstration	The rate of uninsurance in the expansion population groups eligible for the demonstration will be reduced as a result of this demonstration.
To provide all enrollees in the demonstration with a *medical home*	All enrollees in the demonstration will have a *medical home*.
To improve access to health care for populations eligible for the demonstration	Access to health care for populations eligible for the demonstration will be improved.
To increase the number of physicians participating in the State's Medical Assistance Program	The number of physicians participating in the State's Medical Assistance Program will increase as a result of this demonstration.
To increase preventive and other primary care provided to populations enrolled in the demonstration	Preventive and other primary care services provided to populations enrolled in the demonstration will increase.
To shift the locus of preventive care and other primary care from hospital emergency departments to other service delivery locations	The locus of preventive care and other primary care will shift from hospital emergency departments to other service delivery locations.
To increase the appropriate use of inpatient hospitals and hospital emergency departments	The appropriate use of inpatient hospitals and hospital emergency departments will increase.
To reduce infant mortality	The rate of infant mortality in the State will be reduced during the course of this demonstration.
To improve maternal and child health outcomes	Maternal and child health outcomes for populations enrolled in the demonstration will improve.
To improve the quality of care provided to populations enrolled in the demonstration	The quality of care provided to populations enrolled in the demonstration will improve.
To have a high satisfaction level with the demonstration project among enrolled populations	Populations enrolled in the demonstration will have a high level of satisfaction with the demonstration project.
To have the demonstration project be budget neutral	The cost to the Rhode Island Medical Assistance Program with the demonstration will be no greater than the cost would have been without the demonstration, adjusted for increases in inflation and population.

Wherever possible, subsequent chapters of this report will present information on the State's performance relevant to these hypotheses.

7. Administrative Improvements

The State has made a number of improvements over time to make the application and enrollment processes less burdensome, to stimulate enrollment, and to deter *crowd-out* (i.e., substituting public coverage for private coverage). Among these administrative improvements have been the following:

- *October 1998* – Implemented a streamlined mail-in application with minimal documentation requirements and eliminated face-to-face requirements to confirm eligibility

- *April 1999* – Initiated a RIte Care community-based enrollment outreach project, encompassing school-based outreach combined with contracts with 32 community-based organizations using performance-based incentives for locating and enrolling eligible children. This outreach project ended in June 2000.

- *January 2002* – Implemented monthly premiums at up to three percent of income for expansion enrollees over 150 percent of the FPL

- *August 2002* – Increased the monthly premiums but not to exceed five percent of income for expansion enrollees over 150 percent of the FPL

- *May 2004* – Made the RIte Care application available on-line in both English and Spanish

8. Delivery System Changes

As noted at the beginning of this section, the State of Rhode Island made a policy decision to only allow State-licensed HMOs to participate in RIte Care. There were originally five RIte Care-participating Health Plans: Coordinated Health Partners (CHP, or BlueCHiP), Harvard Community Health Plan (HCHP), Neighborhood Health Plan of Rhode Island (NHPRI), Pilgrim Health Care (PHC), and United HealthCare of New England (UHCNE). There have been several important changes to the Rhode Island HMO marketplace since then. First, HCHP and PHC merged in 1995, becoming Harvard Pilgrim Health Care (HPHC). Second, HPHC left[17] the Rhode Island market without warning in 1999. Finally, Blue Cross and Blue Shield of Rhode Island (BCBSRI) voluntarily gave up its State HMO license at the end of 2004.

In order to assure the availability of choices for RIte Care-eligible individuals, the State changed its policy to allow other than State-licensed HMOs to participate in RIte Care effective January 1, 2005. Non-HMOs must meet the following requirements:

- Be licensed as a health plan in the State

- Be accredited[18] by the National Committee for Quality Assurance (NCQA) as a Medicaid managed care organization (MCO)

- Meet certain State regulatory requirements[19] that HMOs must meet:

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[17] Tufts Health Plan of New England also left the Rhode Island market about the same time, although it had never participated in RIte Care.
[18] In Rhode Island, all HMOs must be accredited by NCQA. All three Health Plans have full three-year accreditation and received an "excellent" designation from NCQA. Of all the Medicaid plans in the nation, BCBSRI ranked first,, UHCNE ranked third, and NHPRI ranked sixth in 2005. Both BCBSRI and UHCNE have their Medicaid product lines accredited, as well as their Medicare product lines.
19 *Rules and Regulations for the Certification of Health Plans* (R23-17.13-CHP).

- Have professional services under the direction of a medical director who is licensed in Rhode Island and performs the functions specified in regulation (e.g., oversight of quality management)

- Make certain enrollees are only liable for co-payments and to have this provision in its provider contracts

- Meet "preventive health care services" requirements and provide them within time frames set by the HMO, according to accepted standards specific to age and gender

- Have a quality management program that is accredited

CHAPTER 2

PROJECT STATUS

This chapter reports on the State's progress in implementing its Section 1115 waivers, and provides a budget neutrality update for the RIte Care Medicaid Section 1115 waiver as well as a budget update for SCHIP.

1. RITE CARE IS FULLY OPERATIONAL

RIte Care has been operational since August 1994. Enrollment in RIte Care by Health Plan as of the end of the ninth program year (July 31, 2006) is shown in Table 2-1 below. The RIte Care "base" enrollment at the end of July 2006 was 117,199, 1,613 less than the RIte Care enrollment as of the end of July 2005 (118,812).[20]

Table 2-1

Enrollment in RIte Care by Health Plan, As of July 31, 2006

Health Plan	Number Enrolled	Percent
BlueCHiP	13,938	11.9%
NHPRI	68,765	58.7%
UHCNE	34,496	29.4%
Total	**117,199**	**100.0%**

Enrollment in the RIte Care population expansion groups as of July 31, 2006, in comparison to as of the end of July 2004 and July 2005, is shown in Table 2-2.

Table 2-2

RIte Care Enrollment of Expansion Groups as July 31, 2004, July 31, 2005, and July 31, 2006

Expansion Group	July 31, 2004 Enrollment	July 31, 2005 Enrollment	July 31, 2006 Enrollment
Parents/ Relative Caretakers up to 185% of FPL	12,089	12,367	10,782
Pregnant Women Between 185 and 250% of FPL	79	105	113
Children up to age 8 up to 250% of FPL	5,452	5,823	7,240
Children aged 8 to 19 up to 250% of FPL	10,800	11,328	12,039
Extended Family Planning	475	578	608
Children in Foster Care	2,128	2,180	2,315
Unborn Children up to 250% of FPL	487	576	529

[20] This excludes the 2,315 foster children and 4,432 children with special health care needs enrolled voluntarily in NHPRI as of July 31, 2006. NHPRI has been the only Health Plan willing to enroll such children.

It should be noted that Rhode Island was one of the first four States, along with Minnesota, New Jersey, and Wisconsin, to obtain SCHIP waivers to cover parents/relative caretakers and pregnant women. Researchers at the Urban Institute have noted the following advantages of SCHIP (as opposed to Medicaid) waivers[21]:

- A State can receive higher Federal matching rate than under Medicaid

- There is "allotment neutrality" under SCHIP, meaning that a State must not spend more than its total SCHIP allotment, as opposed to Medicaid waivers that must be "budget neutral," meaning that the program not cost any more than it would have (according to agreed-upon Special Terms and Conditions) without the waiver

The SCHIP waiver has helped the State, in part, to address its Medicaid budget pressures.

Apart from the parents/relative caretakers and pregnant women between 185 and 250 percent of the FPL shown above, the following SCHIP-eligible children were enrolled in RIte Care as of the end of the most recent reporting (from the Form CMS-64.21E) quarter (June 30, 2006):

- 6 to 12 less than 185% of FPL 4,920
- 6 to 12 greater than 185% of FPL 809
- 13 to 18 less than 185% of FPL 5,223
- 13 to 18 greater than 185% of FPL 933

If, at the time of enrollment, individuals do not choose a Health Plan in which to enroll, the State assigns them to one[22] according to a pre-determined algorithm. Ninety-three percent of enrollees chose their own Health Plan in the first year and auto-assignment to a Health Plan continues to be low. Since RIte Care enrollment began, 16,237 individuals, or 5.2 percent, have been auto-assigned to a Health Plan. An individual might also be assigned to a Health Plan, if the individual's (e.g., newborn's) family also belongs to that plan. This is because, as a matter of State policy, all family members must belong to the same Health Plan. If these "default" auto-assignments are taken into account, then there have been a total of 39,225 individuals, or 12.7 percent, who have been auto-assigned to a Health Plan since the beginning of enrollment. These auto-assignment percentages have remained constant for many years.

Only four percent of enrollees changed Health Plans when given the opportunity to do so during the first open enrollment period; only one percent during the second open enrollment period; and only three percent during the third open enrollment period. Health Plan changes during open enrollment have remained low since then.

Although enrollment has grown steadily over time, there has been a fair amount of "churning" of the enrolled population. There has been an unduplicated count of 309,816 individuals *ever* enrolled in RIte Care since the program began. Eligibility for RIte Care is normally re-

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[21] Howell, E., *et. al. Early Experience with Covering Uninsured Parents Under SCHIP*, Urban Institute, 2002.

[22] Individuals are auto-assigned to a specific Health Plan only if the plan is "open" to new enrollment. CHiP only opened to new enrollment in July 2001, after being closed to new enrollment since April 1995.

determined at 12-month intervals. However, new members were guaranteed enrollment in a Health Plan for six months, even if eligibility for Medicaid was lost. This was a policy made by the State in the beginning to encourage Health Plans to participate. This six-month eligibility guarantee was phased out in the tenth program year (2004).

The “churning” of eligibility, which has been in the range of 20 percent each year, has been of concern to policymakers, consumers, advocates, practitioners, and the Health Plans, particularly because of the discontinuities in members receiving needed health care. When someone loses eligibility for RIte Care, the individual must reapply to be reinstated into the program. It is not uncommon, therefore, for individuals to have several enrollment segments interspersed with gaps or periods of disenrollment. This has been the subject of separate study by DHS.[23] Table 2-3 shows the number of gaps in enrollment among RIte Care members enrolled during Calendar Year 2000. The table shows that almost one-quarter of the individuals enrolled in RIte Care had one or more gaps in enrollment during the year.

Table 2-3

Number of Gaps in Enrollment among RIte Care Members
Enrolled during Calendar Year 2000

Gaps	Number	Percent
None	99,919	76.3%
One	28,927	22.1%
Two	1,948	1.5%
Three	218	0.2%
Four	20	<0.0%
Five	1	<0.0%
Total	**131,033**	**100.0%**

Among those who were disenrolled from RIte Care during the year, about 60 percent re-enrolled within a year – 35 percent within 45 days and 25 percent between 46 and 365 days. This is shown as follows:

- 2,800 average monthly disenrollments

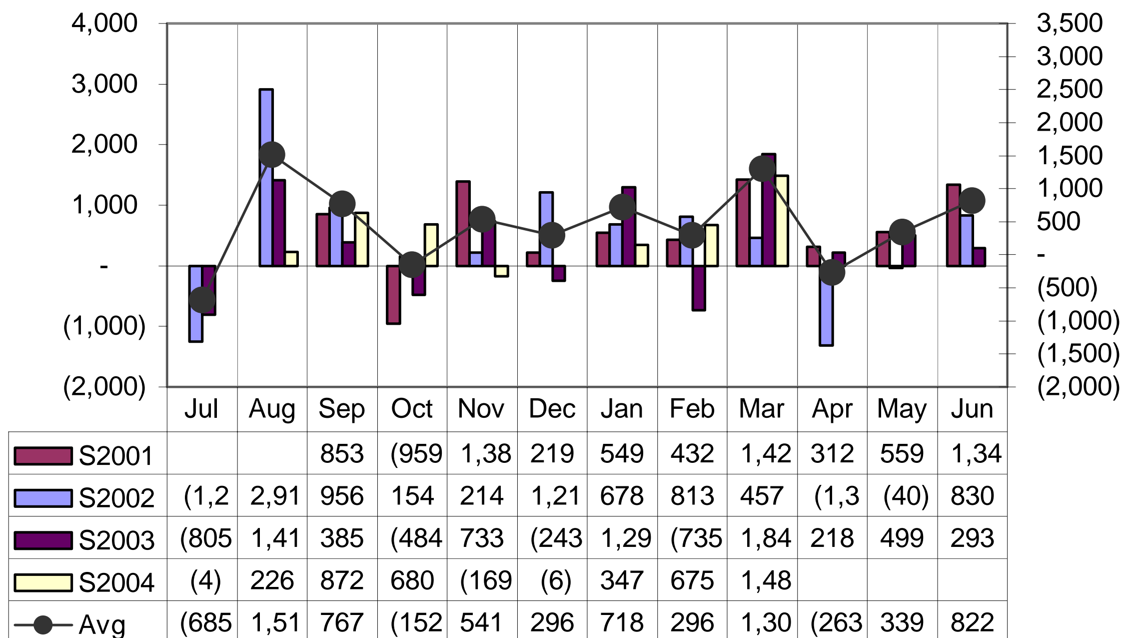
  - 243, or 8.7%, re-enrolled within 7 days
  - 577, or 20.6, re-enrolled within 8 to 29 days
  - 160, or 5.7%, re-enrolled within 30 to 45 days
  - 243, or 8.7%, re-enrolled within 46 to 89 days
  - 412, or 14.7%, re-enrolled within 90 to 365 days
  - 1,165, or 41.6%, did not re-enroll within one year

[23] Rhode Island Department of Human Services. *RIte Stats*, 1(2), September 2001.

The State believes that the streamlined eligibility described in Chapter 1, in combination with implementation of RIte Share as well as the newly designed and streamlined recertification form, has helped to mitigate the “churning” to the extent feasible absent universal health insurance coverage.

An analysis shows that there is a “seasonality” associated with the churning, as Figure 2-1 shows:

Figure 2-1



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
S2001			853	(959	1,38	219	549	432	1,42	312	559	1,34
S2002	(1,2	2,91	956	154	214	1,21	678	813	457	(1,3	(40)	830
S2003	(805	1,41	385	(484	733	(243	1,29	(735	1,84	218	499	293
S2004	(4)	226	872	680	(169	(6)	347	675	1,48			
Avg	(685	1,51	767	(152	541	296	718	296	1,30	(263	339	822

2. RITE SHARE IS FULLY OPERATIONAL

As indicated in Chapter 1, enrollment in RIte Share became mandatory for Medicaid-eligible individuals whose employers offered an approved health plan. Enrollment of both employees and employers in the RIte Share program has continued to grow. As of January 2002, 117 employers were approved for participation in RIte Share. As of July 2006, 1,056 employers were approved for participation in RIte Share, which is an apparent decrease from the 1,176 employers as of July 2005. However, the decrease is actually due to an upgrade of the RIte Care employer database that was made in October 2005. This resulted in culling a number of employers from the database that never actually participated in RIte Share.

Since February 2001, DHS has been transitioning RIte Care members into RIte Share. At the

time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition to a RIte Care member to RIte Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large rate increases through the magnitude of deductibles. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent. Thus, while plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and employees) particularly in a "down economy".

Figure 2-2 shows the incremental gains in enrollment in RIte Share through June 30, 2006. There were 5,365 individuals enrolled in RIte Share as of July 31, 2006, with 151 in the process of being enrolled in RIte Share. RIte Share enrollment is down from a year ago when enrollment was 5,710 reflecting partly an increase the costs of ESI that makes it more difficult to surmount RIte Share's cost-effectiveness test. The figure also shows that RIte Share has had its intended effect of stabilizing RIte Care enrollment, while increasing enrollment in ESI through RIte Share.

Figure 2-2

RIte Care/RIte Share Enrollment through June 30, 2006

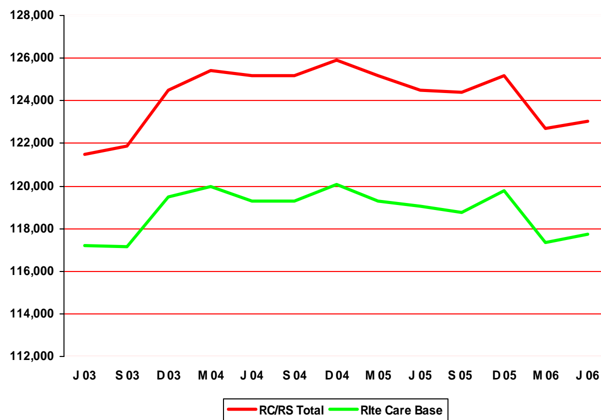


Table 2-4 provides some more detail on RIte Care and RIte Share enrollment by time period than does Figure 2-2.

Table 2-4

RIte Care and RIte Share Enrollment

Enrollment	RIte Care				RIte Share	Total
	Foster Care[24]	CSHCN[25]	All Other	Overall		
As of 12/31/01	1,899		115,286	117,185	111	117,296
As of 3/31/02	1,961		115,508	117,469	409	117,878
As of 6/30/02	1,983		115,041	117,024	1,596	118,620
As of 9/30/02	1,906		115,237	117,173	2,304	119,477
As of 11/30/02	1,983		115,495	117,478	2,450	119,928
As of 12/31/02	1,981		115,526	117,507	2,905	120,412
As of 3/31/03	2,138		116,640	118,778	3,511	122,289
As of 7/31/03	1,975		117,430	119,405	4,372	123,777
As of 9/30/03	1,959	393	117,154	119,506	4,701	124,207
As of 12/31/03	2,047	2,309	119,479	123,835	5,006	128,841
As of 3/31/04	2,029	3,334	119,986	124,649	5,432	130,081
As of 7/31/04	2,128	3,658	118,779	124,565	5,982	130,547
As of 9/30/04	2,102	3,708	119,294	125,104	5,873	130,977
As of 12/31/05	2,102	3,806	120,049	125,957	5,876	131,833
As of 3/31/05	2,158	3,913	119,311	125,382	5,884	131,266
As of 7/31/05	2,180	4,050	118,811	125,041	5,710	130,751
As of 9/30/05	2,184	4,143	118,741	125,068	5,640	130,708
As of 12/31/05	2,252	4,211	119,762	126,225	5,435	131,660
As of 3/31/06	2,260	4,278	117,360	123,898	5,336	129,234
As of 7/31/06	2,315	4,432	117,199	123,946	5,365	129,311

RIte Share makes ESI coverage affordable for many families while saving the State money; RIte Share pays all or part of the employee's share of coverage. As former Governor Lincoln Almond has noted in this regard:[26]

> "The efforts of the Department of Human Services staff have achieved important savings that will help us maintain the high quality of our health care insurance services. The expanded RIte Share enrollments help maintain health insurance that is affordable for low-income residents and the state itself, while at the same time supporting enrollment in employer-sponsored health insurance plans."

Jane Hayward, Director of DHS, has noted:[27]

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[24] It should be noted that even though enrollment is RIte Care is voluntary for them, 94 percent of children in foster care and 71 percent of children with special health care needs eligible to enroll in RIte Care (e.g., did not have third-party coverage or were not enrolled in another waiver) were enrolled in RIte Care

[25] *Ibid.*

[26] Rhode Island Department of Human Services. *Press Release*, July 9, 2002.

> "We are thrilled that RIte Share has enrolled so many families in such a short time period. It's a testament to the hard work of all staff who were involved with implementing RIte Share. We are encouraged by this early success as we head into our second year."

The State will continue to transition Medicaid-eligible families who have access to ESI into RIte Share in an effort to contain the growth in the cost of health insurance for Medicaid eligibles while simultaneously addressing the level of uninsurance in the State. The State's focus is clear, as Tricia Leddy, Administrator of DHS' Center for Child and Family Health, has noted:[28]

> "Our goal is to supplement employer-base coverage in an appropriate and cost-effective way. The key to why premium-assistance programs are so important for Medicaid is that they allow states to continue to reduce the number of uninsured using scarce state dollars most efficiently."

3. RITE CARE HAS CONTAINED MEDICAID COSTS FOR THE POPULATION SERVED BY THE DEMONSTRATION

Since RIte Care began in 1994, more than $1.9 billion has been spent on enrollee benefits. For the 2005 Waiver Year (August 1, 2005 to July 31, 2006), capitation payments were $204,906,031 and SOBRA[29]payments were $28,235,491 to Health Plans, as shown in Table 2-5, or 87 percent of RIte Care benefits payments.

Table 2-5

RIte Care Payments to Health Plans and Other Benefits through July 31, 2006

Cost Category	Amount
Monthly Capitation Payments	$258,301,349
SOBRA Payments	28,162,601
Subtotal	**$286,463,650**
Other Costs	
Incentive Payments	$1,700,846
Risk-Share Payments	899,966
Reinsurance/ Stop Loss	602,493

[27] Ibid.

[28] Academy for Health Services Research and Policy. *State Coverage Initiatives*, 8, August 2002, 1.

[29] The State pays a fixed dollar amount to each Health Plan for each delivery. The amount includes both the hospital and physician costs (including the costs of prenatal care).

Transportation Benefits	245,405
Out-of-Plan Payments for NICU	16,409,002
FQHC Supplemental Payments	6,622,510
Fee-for-Service	12,884,756
Window Replacement	19,942
Subtotal	**$39,384,920**
Total RIte Care Expenditures	**$325,848,570**
Premium Collection Offset	**($3,647,339)**
Total RIte Care	**$322,201,231**

In addition, to the capitation and SOBRA payments, the State makes other payments to the Health Plans or on behalf of enrollees as follows:

- **Incentive Payments** – In the RIte Care Health Plan Contracts effective July 1, 1998, the State established a performance incentive system, under which Health Plans can earn payments over and above capitation and SOBRA payments for the attainment of certain administrative, access, and clinical goals. The State did so "to improve care by using available health plan data on access and outcomes" and "to improve the quality of health plan performance data."[30] In the 2006 Waiver Year (WY), incentive payments totaled $1,700,846 compared to $1,378,964 in WY 2005 and compared to $1,107,438 in WY 2004.

- **Risk-Share Payments** – DHS has entered into risk-share arrangements with all three Health Plans. The purpose of these arrangements is to assure RIte Care-eligible individuals have a choice of Health Plans in which to enroll[31]. Under the risk-sharing methodology, risk is shared according to whether the actual Medical Loss Ratio[32] in any quarter is within agreed-upon ranges or "risk corridors." In WY 2006, risk-share payments amounted to $899,966 compared to $15,455,428 in WY 2005 and compared to $19,282,039 in WY 2004. In general, the more "adequate" the capitation and SOBRA rates are, the lower risk-sharing payments will be as the WY 2006 data demonstrate.

- **Reinsurance/Stop-Loss Payments** – Reinsurance in the prepaid health care environment is an important financial management mechanism. In RIte Care's early years, Health Plans had the option of obtaining their own reinsurance or having the State provide the reinsurance. This option reflected a State policy decision because of

[30] Dyer, M.B., M. Bailit, and C. Kokenyesi. *Working Paper: Are Incentives Effective in Improving the Performance of Managed Care Plans?*, Center for Health Care Strategies, March 2002.

[31] Federal regulations require that enrollees have a choice of plans in which to enroll.

[32] Medical Loss Ratio means Medical Expenses divided by Premium.

the volatility in the reinsurance market at that time as well as the entrance of at least one new Health Plan (NHPRI) into the market unable to obtain reinsurance initially. In 1996, DHS ceased reinsuring the Health Plans and required the Health Plans to retain their own reinsurance. In addition, some services have been covered by the Health Plans on a partial- risk basis from the beginning. Until December 31, 2004, transplants (where Health Plans must cover all costs up to the actual transplant of a bodily organ), Early Intervention (EI, where Health Plans must cover the first $3,000 in benefits), mental health care (where Health Plans must cover the first 30 days of inpatient care and the first 30 outpatient visits), substance abuse treatment (where Health Plans must cover the first 30 days of inpatient rehabilitation and the first 30 outpatient visits), and nursing home care (where Health Plans must cover the first 30 days of care) were the only services operating under RIte Care on a partial-risk basis. Effective January 1, 2005, only transplants, long-term care, and EI (in excess of the first $5,000 in benefits) are subject to stop-loss provisions. After these thresholds are reached, DHS reimburses the Health Plans for the cost of services above the threshold at 90 percent of the regular Medicaid fee-for-service rate or cost, whichever is less. In WY 2006, stop-loss payments were $602,493 compared to $2,114,661 in WY 2005 and compared to $2,025,287 in WY 2004 in stop-loss payments were made. The effect of the change in 2005 is reflected in the WY 2006 data.

- **Transportation** – DHS has had an agreement with the Rhode Island Public Transportation Authority (RIPTA) since the beginning of RIte Care for RIPTA to provide bus passes and other non-emergency transportation services (e.g., taxis) to RIte Care-eligible individuals. DHS has had this arrangement with RIPTA because of the importance of transportation in assuring access to needed health care services by low-income individuals. Until March 2004, these services were covered as direct services under the waiver. Beginning March 1, 2004, bus passes have been provided as an administrative cost. The agreement with RIPTA was modified accordingly. During WY 2006, DHS paid RIPTA $245,405 for "other" non-emergency transportation compared to $441,329 in 2005.

- **Out-of-Plan Payments[33] for Neonatal Intensive Care Unit (NICU)** – When the RIte Care Health Plan Contracts were renegotiated in July 1998, Health Plans were given the option of DHS assuming the risk of NICU services rendered at Women & Infants' Hospital versus the Health Plans retaining the risk for these services. This was done because of the historic, relatively high cost for these services for RIte Care-eligible individuals. Health Plans that elected to shift the risk for NICU services have a lower capitation rate for the under age one group. Currently, the State assumes the risk for all NICU services[34]. During WY 2006, $16,409,002 in NICU payments were made compared to $19,612,491 in WY 2005 and $16,600,384 in WY 2004.

- **FQHC Supplemental Payments** – At the beginning of the waiver, these were originally "transition" payments to ease the Federally Qualified Health Centers

[33] The State provides other out-of-plan benefits to RIte Care eligible individuals that are not reflected in Table 2-5.

[34] Previously, CHP had assumed the risk for NICU services.

(FQHCs) "transition" to manage care. There was also originally an annual "cap" of $3.3 million that was mutually agreed upon between the State and Health Care Financing Administration (HCFA, now CMS). In the revised Special Terms and Conditions (STCs) of the waiver dated August 31, 2001, the language of this STC eliminated the "cap". When the STCs were revised on July 29, 2002, the "transition" payments were renamed as "supplemental payments to FQHCs", which reflected these payments as the State's approach to the minimum Medicaid per visit reimbursement for FQHCs using a prospective payment methodology required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA). In WY 2006, $6,622,510 in FQHC supplemental payments were made compared to $4,389,054 in WY 2005 and $5,500,000 in WY 2004.

- **Fee-for- Service (FFS)** – These are payments made for in-plan demonstration services for eligible recipients but whose enrollment in a Health Plan was not yet effective on the date the service was provided. It also includes any applicable FFS payments due to retroactive eligibility and FFS as wraparound benefits for individuals enrolled in RIte Share. These latter expenditures include the cost of applicable co-payments and other eligible out-of-pocket costs under ESI. In WY 2006, $12,884,756 in FFS payments were made compared to $7,544,093 in WY 2005 and $7,296,265 in WY 2004.

- **Window Replacement** – These are expenditures for window replacement for homes inhabited by demonstration-eligible children who have been lead-poisoned. Since 2001, Rhode Island is the only State approved by CMS for such expenditures. During WY 2006, $19,942 in window replacement costs were made compared to $4,282 in WY 2005 and $8,480 in WY 2004.

As indicated earlier, the RIte Care Demonstration must be "budget neutral." The meaning of this term is controlled by the *Special Terms and Conditions* for the Medicaid Section 1115 waiver (11-W-00004/1)[35] as follows:

> "45. Rhode Island shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration including:
>
> - Capitation payments to MCOs for Medicaid benefits covered under this Demonstration
> - SOBRA "kick payments"
> - Neonatal intensive care unit payments to Women's and Infants Hospital
> - FQHC supplemental payments
> - Fee-for-service for services otherwise subject to budget neutrality, while eligible individuals in Groups 1, 2, and 3 are not enrolled in managed care
> - Reinsurance/stop-loss payments

[35] Centers for Medicare & Medicaid Services. *Special Terms and Conditions for Demonstration Number11-W-00004/1*, August 31, 2005, Section X.

- Performance incentive payments to MCOs
- RIte Share
- Risk-share payments
- Window replacement

The limit is determined by using a per capita cost method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration.

46. Rhode Island shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles in the five MEGs under this budget neutrality agreement, but not at risk for the number of current eligibles. By providing FFP for all current eligibles, Rhode Island will not be at risk for changing economic conditions. However, by placing Rhode Island at risk for the per capita costs for current eligibles, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

47. The five MEGs under this budget neutrality agreement are:

- TANF and TANF-related parents, children and pregnant women eligible for Medicaid under Rhode Island's existing state plan (Group 1);

- Children who are covered under 1115 demonstration authority who could be made eligible through a state plan amendment under section 1902(r)(2) and related provisions (Group 2);

- Parents and relative caretakers with income up to 185 percent FPL; and pregnant women with income from 185 to 250 percent of the FPL who are covered under 1115 demonstration authority who could be made eligible through a state plan amendment under section 1931 and related provisions(Group 3);

- Women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority (Group 4); and

- Children with special health care needs eligible for Medicaid under Rhode Island's existing Medicaid state plan and enrolled in RIte Care under this Demonstration on a mandatory basis (Group 5)."

Hypothesis:
The cost to the Rhode Island Medical Assistance Program with the demonstration will be no greater than the cost would have been without the demonstration, adjusted for increases in inflation and population.

As Table 2-6 shows, Rhode Island has operated within these budget neutrality limits across the first eleven years of the demonstration.[36] It should be noted that budget neutrality is tested over the entire demonstration period, not in any given year of demonstration. Thus, even though the costs under the waiver exceeded the budget neutrality limit the previous three years under the demonstration, overall, **the demonstration has operated within its budget neutrality limit.** Put another way, **RIte Care has achieved its goal of containing Medicaid expenditures.**

Table 2-6

Federal Budget Neutrality Summary for Waiver Years 1 – 12

	Budget Neutrality Limit		Waiver Expenditures		Variance	
	Gross Dollars	Federal Share	Gross Dollars	Federal Share	Gross Dollars	Federal Share
Original Waiver Period						
8/1/94 -7/31/95	$48,575,213	$26,954,386	$37,969,068	$21,068,157	$10,606,145	$5,885,350
8/1/95 – 7/31/96	$119,285,977	$64,545,642	$96,086,854	$51,993,115	$23,199,123	$12,553,045
8/196 – 7/3197	$121,839,003	$65,659,039	$120,307,290	$64,833,565	$1,531,713	$825,440
8/1/97 – 7/31/98	$125,204,629	$66,734,067	$119,616,791	$63,750,070	$5,587,838	$2,978,318
8/1/98 – 7/31/99	$139,625,464	$75,272,088	$129,313,100	$69,714,601	$10,312,364	$5,559,395
Subtotal Original Waiver Period	**$554,530,286**	**$299,165,222**	**$503,293,103**	**$271,359,508**	**$51,237,182**	**$27,801,548**
First Waiver Extension Period						
8/1/99 – 7/31/00	$170,059,915	$91,509,240	$152,082,287	$81,841,386	$17,977,628	$9,673,762
8/1/00 – 731/01	$175,706,215	$94,512,373	$168,548,392	$90,656,666	$7,157,823	$3,850,193
8/1/01 – 7/31/02	$179,654,337	$94,623,929	$174,688,556	$92,000,473	$4,965,781	$2,615,477
Subtotal Waiver Extension Period	**$525,420,467**	**$289,645,242**	**$495,319,235**	**$264,498,525**	**$30,101,232**	**$16,139,432**
Second Waiver Extension Period						
8/1/02 – 7/31/03	$199,479,803	$111,549,106	$203,884,375	$114,004,206	($4,404,572)	($2,455,100)
8/1/03 – 7/31/04	$227,849,104	$133.565,145	$233,949,592	$137,145,242	($6,100,488)	($3,580,097)
8/1/04 – 7/31/05	$266,153,287	$147,235,998	$280,996,788	$155,443,033	($14,843,500)	($8,207,035)
Subtotal Waiver Extension Period	**$693,482,194**	**$392,350,249**	**$718,830,755**	**$406,592,481**	**($25,348,560)**	**($14,250,567)**
Third Waiver Extension Period						

[36] The information in Table 2-6 includes the costs attributable to RIte Share.

8/1/05 - 7/31/06	$282,400,007	$153,766,804	$269,114,445	$146,532,815	$13,285,561	$7,233,988
8/1/06 – 7/31/07						
8/1/07 – 7/31/08						
Subtotal Waiver Extension Period	**$282,400,007**	**$153,766,804**	**$269,114,445**	**$146,532,815**	**$13,285,561**	**$7,233,988**
Cumulative Total	**$2,055,832,954**	**$1,134,927,517**	**$1,986,557,538**	**$1,088,983,329**	**$69,275,414**	**$36,932,736**

4. COST-SHARING HAS SAVED STATE BUDGET DOLLARS

To discourage *crowd-out* (i.e., substituting public coverage for ESI), the State is using a combination of cost-sharing and mandatory enrollment in RIte Share. Since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of their health insurance coverage if their income is above 150 percent of the FPL (e.g., $24,900 for a family of three as of March 1, 2006). In November 2001, families received two letters and an official notice about the change. The first monthly bills were sent in December 2001, requiring payment by January 1, 2002. Rhode Island was one of four States increasing enrollee cost-sharing in 2002, with another 11 States expected to do so in 2003[37].

The monthly family share amount by income level is shown in Table 2-7[38], comparing the original premium-share amounts to those in effect since August 1, 2002. These premium-share increases, instituted as a result of State law mandating that cost-sharing be raised, ranged from 42 to 57 percent.

Table 2-7

RIte Care and RIte Share Monthly Family Premiums

Income Level	Monthly Family Premium From 1/1/02 to 7/31/02	Monthly Family Premium As Of 8/1/02	Percentage Increase In Monthly Family Premium
150%-185% of FPL	$43	$61	42%
185%-200% of FPL	$53	$77	45%
200%-250% of FPL	$58	$92	57%

Monthly premium shares are collected in two ways:

- For RIte Care members, DHS sends a bill and the family pays DHS directly by mailing a check.

[37] Academy Health. *State of the State: Bridging the Health Coverage Gap*, January 2003.

[38] Rhode Island law limits monthly premium payments to no more than five percent of a family's income. Prior to January 1, 2002, enrollees with incomes above 185 percent of the FPL had a choice of paying a portion of their premium each month along with a short schedule of co-payments or paying no premiums and being subject to a longer schedule of co-payments.

- For RIte Share members, DHS deducts the monthly premium share from the amount it reimburses the member for the employee's share of employer coverage.

On a monthly basis, about 10 percent of all RIte Care/RIte Share families were subject to cost-sharing in 2002. Table 2-8 shows the number of families and individuals, by income level, active in cost-sharing as of July 2006. There were 5,486 families (13,707 individuals) active in cost-sharing at the end of July 2006, compared to 5,383 families (13,327 individuals) at the end of July 2005. There were 22,818 families *ever* active in cost-sharing through July 2006, compared to 19,517 families ever active in cost-sharing through the end of July 2005.

Table 2-8

Families and Individuals Active in Cost-Sharing as of July 2006

Income Level	Families	Adults	Children	Total Individuals
150-185% of FPL	3,572	4,384	5,961	10,345
185-200% of FPL	658	20	1,155	1,175
200-250% of FPL	1,200	54	2,022	2,076
250-350% FPL	56	54	57	111
Total	**5,486**	**4,512**	**9,195**	**13,707**

Most families make their cost-sharing payments on time. However, sanctions (i.e., disenrollment for non-payment of premiums) are applied when a family does not pay the required cost-sharing for two months. The sanction extends for four months. If the family meets eligibility criteria, the family may re-apply and return to coverage at the end of the four months. If at any time during the four months the family's income falls below 150 percent of the FPL, the family may re-apply and be found eligible for coverage. Pregnant women and infants under age one are not disenrolled for non-payment of cost-sharing and continue to incur a cost-sharing liability if their income is above 185 percent of the FPL. Table 2-9 shows the sanctions applied in State Fiscal Years (SFY) 2002 to 2006. As the table shows, 3,517 individuals were disenrolled for non-payment of cost-sharing in SFY 2006, which was up from 3,387 in SFY 2005 and a high of 4,707 in SFY 2003.

Table 2-9

Families and Individuals Disenrolled for Non-Payment of Cost-Sharing

State Fiscal Year	Families	Adults	Children	Total Individuals
2006	1,686	899	2,618	3,517
2005	1,608	871	2,516	3,387
2004	1,653	1,047	2,628	3,675
2003	1,969	1,441	3,266	4,707
2002	1,037	743	1,658	2,401

A May 2003 analysis of 1,853 families who were first *sanctioned* (i.e., terminated from participation in RIte Care for non-payment of premiums) in Calendar Year 2002 showed that 1,101, or 59 percent, of these families returned to RIte Care coverage. Another 82 families, or 4 percent, met other Medical Assistance criteria that allowed specific family members to continue coverage. The remainder of the families, 670, or 36 percent, had not returned to coverage by the time of the analysis.

5. SCHIP CONTINUES TO BE AN IMPORTANT SOURCE OF FUNDS FOR RITE CARE AND RITE SHARE

Table 2-10 shows the State's SCHIP budget for Federal Fiscal Year 2006, which includes costs for the State's approved SCHIP Program Plan: the original Medicaid expansion group of 8 through 18-year olds and the separate child health insurance program which covers pregnant women who do not otherwise meet Medicaid/SCHIP residency requirements. The table also shows the costs for the State's approved population expansions under its SCHIP 1115 demonstration waiver for parents and relative caretakers from 100 percent to 185 percent of the FPL and pregnant women between 185 percent and 250 percent of the FPL.

Table 2-10

SCHIP Expenditures for Federal Fiscal Year 2006

Benefit Costs – Title XXI State Plan	2006
Managed Care Payments	**$19,770,735**
Fee-for-Service **(including SOBRA for pregnant aliens)**	**$15,068,029**
Total Benefit Costs	**$34,838,763**

Administration Costs – Title XXI State Plan	
Personnel	**$1,348,643**
General Administration	**$1,305,632**
Contractors	**$704,261**
Claims Processing	**$125,761**
Outreach/Marketing costs	**$251,522**
Other	**$131,767**
Total Administration Costs	**$3,867,586**
10% Administrative Cap	**$3,870,635**

Total Costs – Title XXI State Plan	
Federal Title XXI Share	**$26,366,764**
State Share	**$12,339,585**

TOTAL COSTS OF APPROVED SCHIP PLAN	$38,706,349

Table 2-10 continued…

Table 2-10 (continued)

SCHIP Expenditures for Federal Fiscal Year 2006

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 SCHIP Waiver)	2006
Benefit Costs for Parents	
Managed Care Payments	$36,924,462
Fee-for-Service	$3,067,505
Total Benefit Costs for Waiver Population	**$39,991,967**
Benefit Costs for Pregnant Women	
Managed Care Payments	$354,271
Fee-for-Service	$650,005
Total Benefit Costs for Waiver Population	**$1,004,276**
Total Benefit Costs for Waiver Populations	**$40,996,243**
Administration Costs	
Personnel	$1,589,516
General Administration	$1,538,882
Contractors	$830,077
Claims Processing	$148,228
Outreach/Marketing costs	$296,656
Other	$155,307
Total Administration Costs	**$4,558,666**
10% Administrative Cap	**$4,558,477**
Federal Title XXI Share	**$31,032,004**
State Share	**$14,522,905**
TOTAL COSTS OF DEMONSTRATION	**$45,554,909**
TOTAL SCHIP COSTS	**$84,261,258**

CHAPTER 3

QUANTITATIVE AND CASE STUDY FINDINGS

This chapter presents RIte Care utilization data, member satisfaction information, and information about complaints, grievances, and appeals filed by RIte Care members with the Health Plans. The utilization data provide a quantitative overview of the services rendered to RIte Care enrollees, with reference to national data and benchmarks where available and when applicable. Satisfaction data provide a commentary by enrollees on the services they receive, as do complaint, grievance, and appeals data. Together, these data, which form the core of RIte Care service monitoring efforts, lend a rich perspective on the success of the RIte Care program. This is amplified upon in Chapter 5, where findings from the demonstration's research and evaluation initiatives are presented.

1. UTILIZATION OF SERVICES CONTINUES TO BE MONITORED CLOSELY

The RIte Care Health Plans have worked diligently to implement an encounter data reporting system. Such a reporting system is one of the Special Terms and Conditions imposed by the Federal Government in granting the State the waivers necessary to implement RIte Care. An encounter data system is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities. Unique features and functional components of encounter data include:

- **Episode-specific**: services associated with a particular episode of care are grouped together
- **Person-level**: able to track individuals though the system
- **Standardized**: all Health Plans are reporting using the same definition
- **Longitudinal**: able to track people across reporting periods
- **Comprehensive**: able to track people across service and treatment categories

Tracking medical encounters from a point of service (e.g., a physician's office) through claim processing by the Health Plans to a data processing component to functional analytical files presents many operational challenges. As the Federal Government, Rhode Island, and the other waiver States have learned, it takes at least three years to achieve a level of consistency in reporting by Heath Plans in order to have usable encounter data.

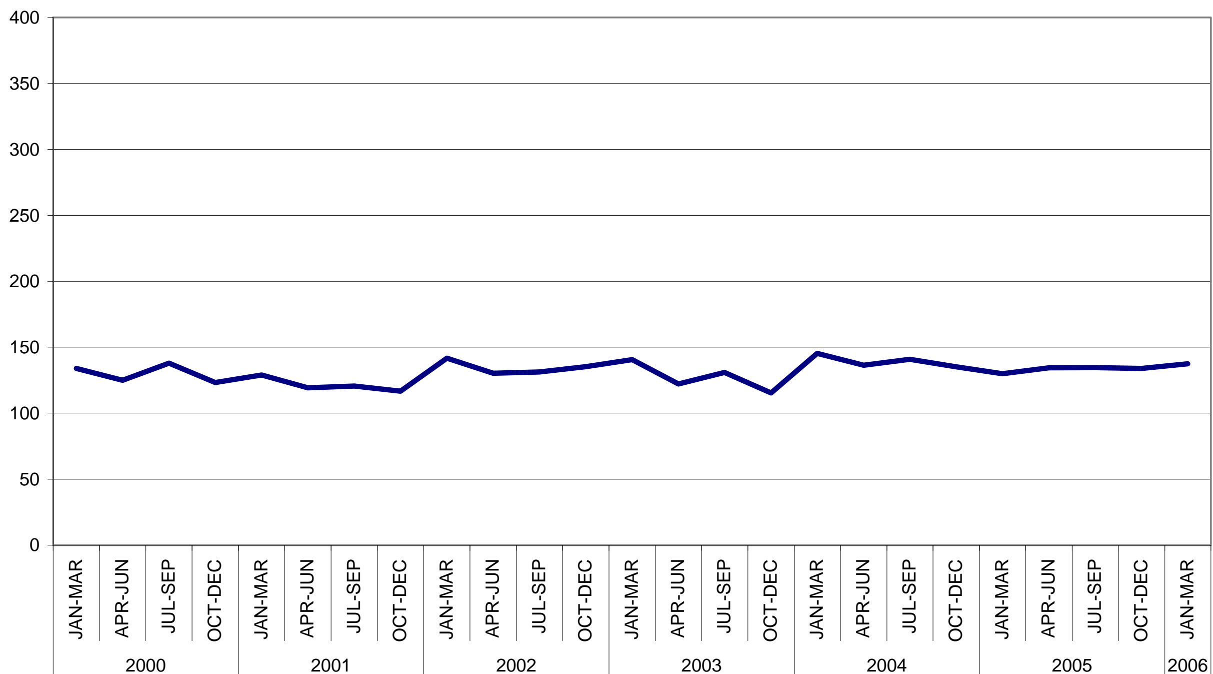
Information from the Rhode Island Encounter Data System has been reported since 1998, when a level of reporting consistency was reached and data were verified. Summary information from the Encounter Data System on RIte Care enrollees' use of services is reported below. Monitoring utilization is important in assuring that enrollees have access to needed services and assuring that services are provided most efficiently (in the lowest cost and most appropriate setting). Except where noted, information is presented through the third quarter of State Fiscal

Year 2006 (SFY 2006 ended June 30, 2006). Quarterly rates have been annualized (by multiplying by four) in order to be comparable to national and commercial benchmarks, which are commonly reported on an annual basis, and to facilitate comparisons across quarters. Quarterly rates are also useful in identifying seasonal changes in health services as well as noting consistency within and among Health Plans from one quarter to the next.

(1) Inpatient Admissions

Figure 3-1 shows the rate of inpatient admissions on a quarterly basis from the first quarter of State Fiscal Year (SFY) 2000 through the second quarter of SFY 2006. Inpatient admission rates have been remarkably constant, at a bit more than 140 admissions per 1,000 RIte Care member-months. Overall, inpatient admission rates were slightly higher in the early days of RIte Care – reaching almost 150 per 1,000 member-months in early SFY 1997. Since then, they have decreased steadily and have leveled off at about 140 per 1,000 member-months.

Figure 3-1
RIte Care Inpatient Admissions per 1,000 Member-Months by Quarter
(CY 2000-2006)



The distribution of inpatient admissions by type during Calendar Year (CY) 2005 (through the second quarter), compared to CY 2002 through CY 2004, is shown in Table 3-1 below. As the

table shows, the relative distribution of admissions by type has remained constant over the past four fiscal years.

Table 3-1

Percentage Distribution of Inpatient Administrations by Type, CY 2002 - CY 2005

Type of Admission	CY 2002	CY 2003	CY 2004	CY 2005
Medical/Surgical	31.5%	30.0%	31.1%	30.5%
Maternity	31.2%	28.9%	29.4%	31.4%
Newborn	25.7%	28.5%	27.9%	26.8%
Psychiatric	6.3%	6.5%	6.7%	6.8%
NICU	2.9%	2.8%	2.6%	2.8%
Substance Abuse	2.4%	2.2%	2.3%	1.7%

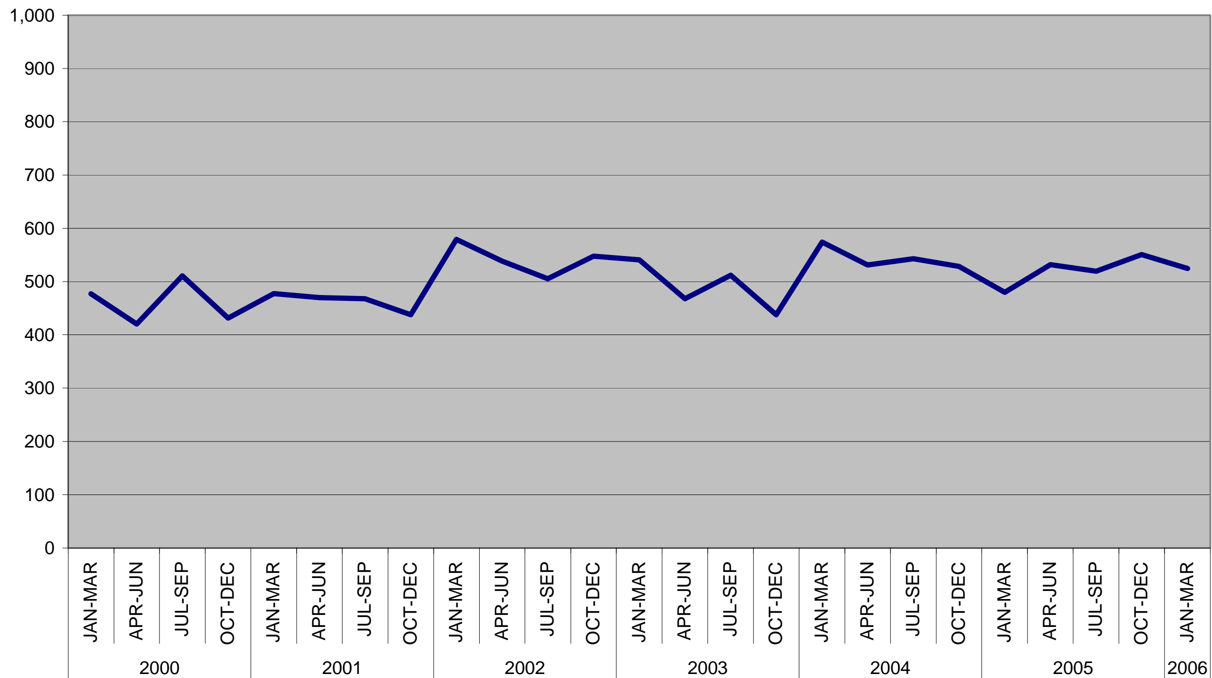
These distributions are about what one would expect in a population comprised largely of mothers and children.

These inpatient admission rates follow national trends in the general population quite closely. According to the National Center for Health Statistics, inpatient stays have declined from 160 per 1,000 population in 1980 to 119 per 1,000 population in 2003.[39] Furthermore, rates in the Northeast are about 25 percent higher among women of childbearing age. Therefore, the inpatient admission rates for RIte Care are clearly within expected values.

Figure 3-2 shows total hospital days per 1,000 member-months from the 1st quarter of SFY 2000 through the third quarter SFY 2005. As the figure shows, total hospital days have been more variable than admissions – ranging from just under 500 days per 1,000 member-months to just over 600 days per 1,000 member-months. However, the average has been hovering around 500 days per 1,000 member-months over the past eight quarters.

It should be noted that the denominator used changed in preparing the *2005 RIte Care/RIte Share Annual Report*. Previously, the denominator was based on the average number of enrollees in a quarter. Now, the denominator is based on the average number of member-months in a quarter. This change was done to better take into account the "churning" in the enrolled population and to conform to how the Health Plans monitor utilization. The smaller denominators result in an increased utilization of five to ten percent, all other things being equal.

[39] National Center for Health Statistics. *Health, United States: 2005*, Table 96.



The distributions of the inpatient days per 1,000 member-months by type of admission during CY 2005 (through the second quarter), compared to CYs 2002 through 2005, are shown in Table 3-2 below.

Table 3-2

Inpatient Days per 1,000 Member-Months by Type, CY 2002 - CY 2005

Type of Admission	CY 2002	CY 2003	CY 2004	CY 2005
Medical/Surgical	164.9 days	158.9 days	175.9 days	151.9 days
Maternal	121.8 days	119.1 days	117.8 days	121.2 days
Newborn	100.0 days	104.1 days	103.0 days	96.2 days
NICU	88.0 days	81.5 days	70.1 days	77.7 days
Psychiatric	57.3 days	58.0 days	64.2 days	64.3 days
Substance Abuse	10.6 days	12.9 days	13.0 days	9.1 days

Like the rate of admissions, the above distribution is about what one would expect to see in a population comprised of low income mothers and children, as well as children in State foster care and children with special health care needs.

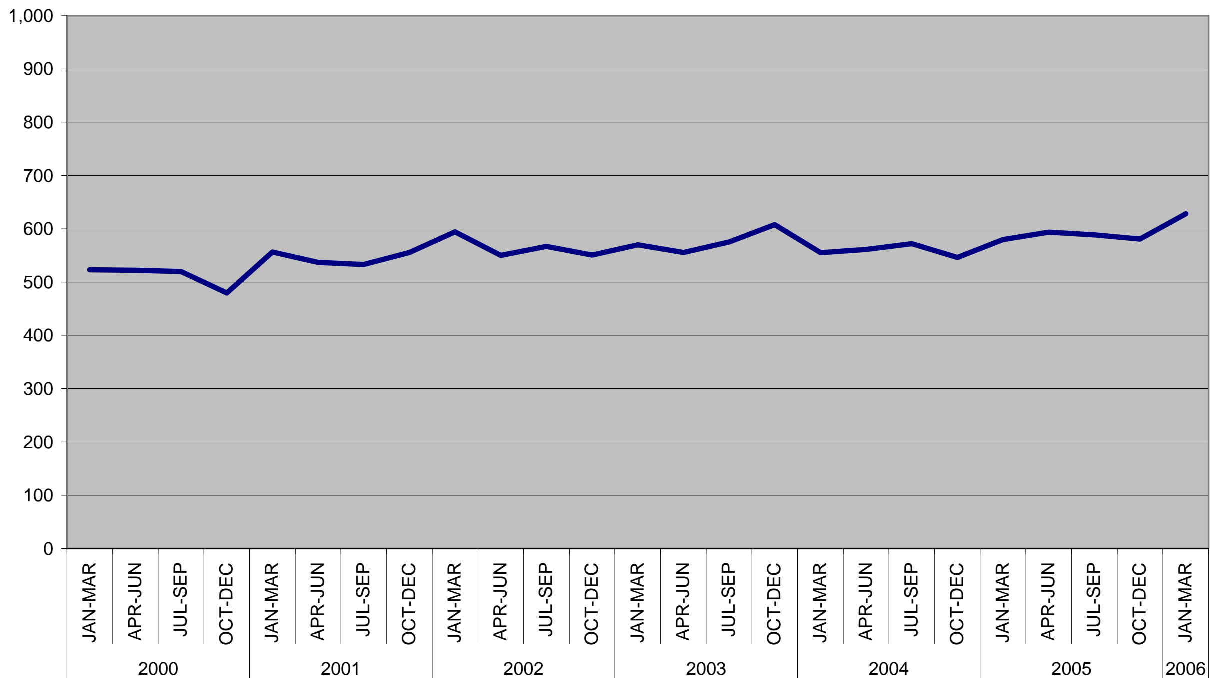
Average length of stay (excluding NICU) has been fairly stable, varying from about 3.0 to 3.5 days per admission. Overall, average length of stay was 3.6 days persons under 18 in 2003 and was 3.8 for persons aged 18 to 44 (groups that comprise a majority of the RIte Care enrolled population).[40]

During SFY 2006, average length of stay by delivery type for RIte Care was over two days for vaginal deliveries and almost five days for deliveries by C-section. These average stays are higher than the minimum requirements set in both State and Federal law of two and four days, respectively.

(2) Hospital Emergency Department (ED) Utilization

Figure 3-3 shows the ED utilization rate from the 1st quarter of SFY 2000 to SFY 2006 (through the third quarter). ED utilization in RIte Care has increased since the beginning of SFY 1999. Figure 3-3 shows that ED visits fluctuated between 500 and 600 per 1,000 member-months. The ED rate peaked at an annual rate of about 600 per 1,000 member-months in third quarter of SFY 2003 and remained below that level since then, until the most recent quarter (third quarter 2006) when it peaked again over 600 visits per 1,000 member-months.

Figure 3-3
RIte Care Total Visits to Emergency Departments per 1,000 Member-Months by Quarter
(CY 2000-2006)

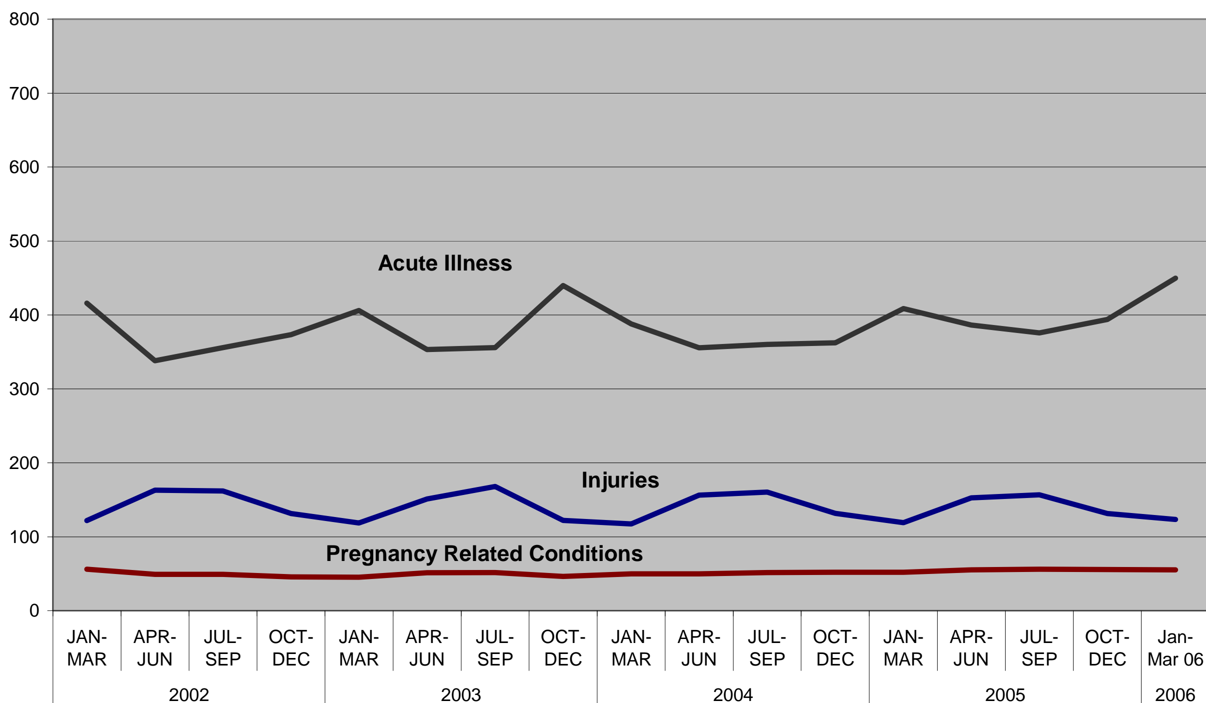


[40] *Ibid.*

These rates are much higher than the age-adjusted national average, even among children who are poor (less than 100 percent of the FPL) and near poor (less than 200 percent of the FPL)[41], but well below the pre-RIte Care rates that exceeded 700 per 1,000 Medicaid recipients.

Trends in ED utilization have been examined further[42], and a more recent analysis is presented here. Figure 3-4 shows annualized ED utilization by quarter and treatment category: acute illness, injuries, and conditions related to pregnancy. Acute illness includes all non-accidental conditions that are not related to pregnancy such as otitis media, asthma, fever, and non-specific symptoms such as chest pain. Mental illness and substance abuse are also included in the acute illness category. The injury category includes all accidental injuries including motor vehicle accidents and poisoning as well as the more obvious conditions such as fractures, lacerations, and contusions. The last category, conditions related to pregnancy, is particularly important because of the relatively high percentage of women of child-bearing age in the RIte Care population. Data are from January – March 2002 through January – March 2006.

Figure 3-4
RIte Care ED Utilization Rates by Quarter and Treatment Category.
(Calendar Year 2000-2006)



There was about a 20 percent variation in annualized ED utilization rates due to injuries from quarter to quarter and there appeared to be some seasonal variation as well – with spring and summer months being somewhat higher than fall and winter months. The ED utilization rates due to injuries averaged about 150 visits per 1,000 member-months, which is almost identical to

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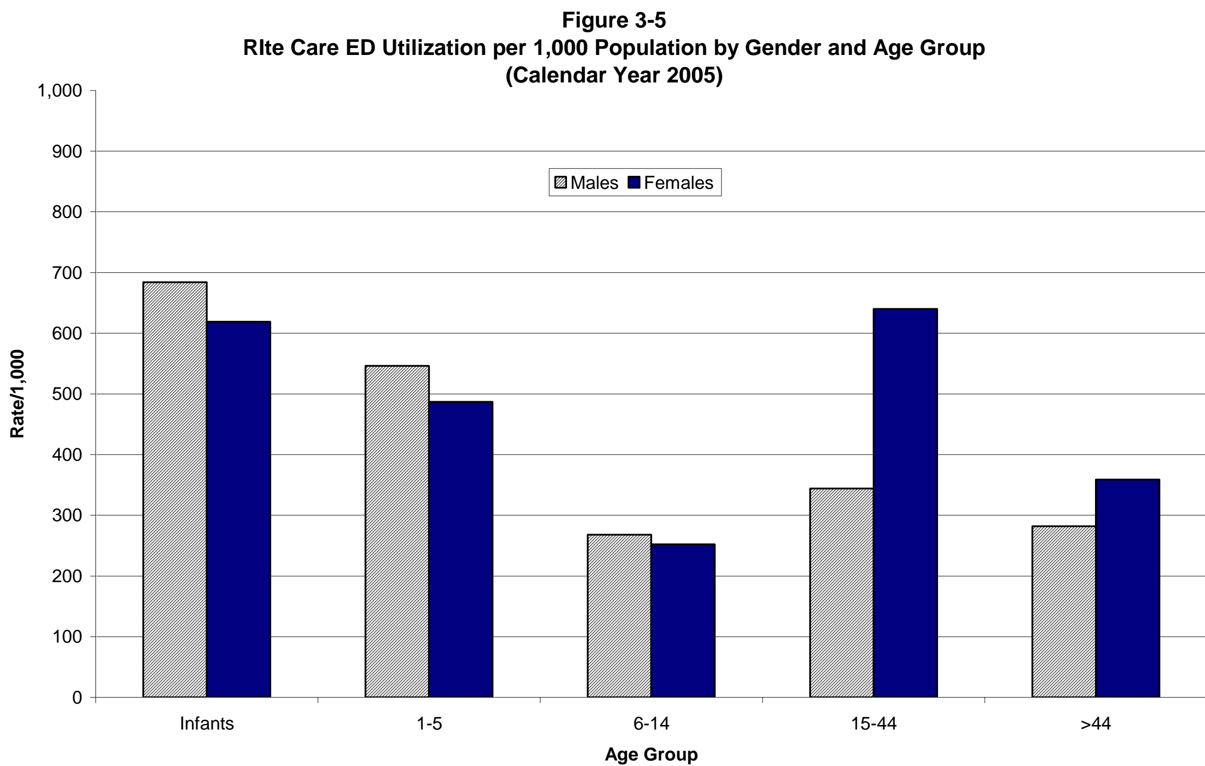
[41] *Ibid.* Table 81.

[42] Rhode Island Department of Human Services. *RIte Stats*, 1(3), January 2002. Also, see Chapter 5 for the results of a ED clinical focused study.

national rates.[43] ED utilization rates for acute illness have varied, but have stabilized around 400 visits per 1000 member-months. ED utilization rates for pregnancy-related conditions have been fairly constant at about 50 visits per 1,000 member-months. However, ED utilization for pregnancy-related conditions is considerably higher in the RIte Care population than it is nationally, even when adjusting for age and gender.[44]

As Figure 3-5 shows, ED utilization rates varied considerably by age and gender during Calendar Year 2005. ED utilization rates were highest among females aged 15 to 44 and lowest among females aged 6 to 14. ED utilization rates were higher for males than that for females among infants and children up to age 14. These findings are similar to those reported in the *RIte Stats, Volume 1, Issue 3*.[45]

Figure 3-5
RIte Care ED Utilization per 1,000 Population by Gender and Age Group
(Calendar Year 2005)



These analyses suggest that additional attention may need to be paid to some of theses areas. Absent an epidemic of a particular disease, one would not expect to see the variations in rates for acute illness. This may reflect the rapid expansion of RIte Care, with there being some degree of delay in integrating new enrollees into primary care. However, the age and gender analyses suggest that site of prenatal and primary care may play a role in ED rates particularly for "after-hours" services. Preliminary analysis indicates that enrollees who receive their primary or

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[43] National Center for Health Statistics. *Op. Cit.*, Table 89.

[44] McCaig, L.F. and E.W. Nawar. "National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary, *Advance Data*, No. 372, June 23, 2006.

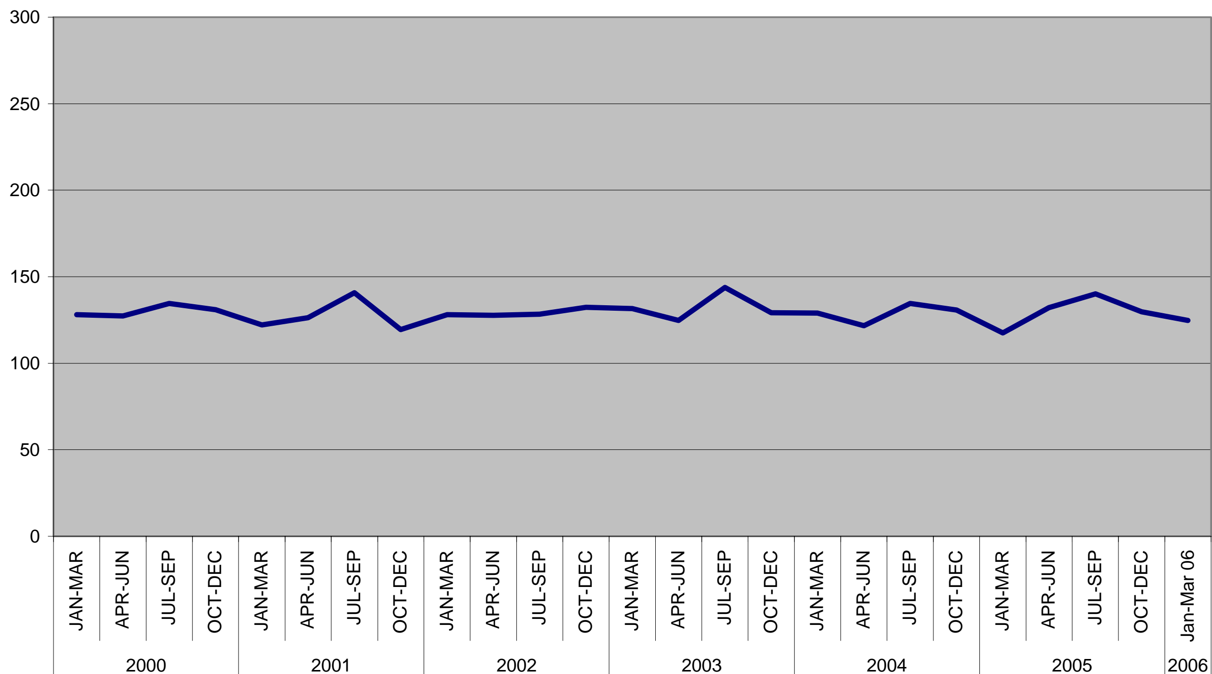
[45] Hhttp://www.ritecareresearch.org/reportspubs/RIStats/RIteStats_vol1_iss3.pdfH

prenatal care at certain hospital clinics have higher ED utilization rates than those who receive their primary or prenatal care at private physician offices or at health centers. RIte Care program policies, reflecting Federal limitations, probably also play a role in the above findings (see Chapter 4).

(3) Fertility Rates

Figure 3-6 shows the fertility rates for RIte Care enrollees from the 1st quarter of SFY 2000 to the 3rd quarter of SFY 2006. Fertility rates (i.e., the number of live births per 1,000 female enrollees aged 15 to 44) are important to examine because they affect other utilization patterns in RIte Care. Inpatient admissions, hospital days, primary care provider (PCP) visits, and ED utilization are all influenced by pregnancy and newborn care. As Figure 3-6 shows, the fertility rates illustrate quarter-to-quarter variability, averaging around 130 live births per 1,000 female enrollees aged 15 to 44.

Figure 3-5
RIte Care Fertility Rates by Quarter
(CY 2000-2006)



These rates are substantially higher than the most recently calculated national fertility rate of 66.1.[46] Given that pregnant women are an expansion population group for RIte Care, these data should not be surprising. However, the high rate of teen births in Rhode Island compared to the teen birth rates in all other areas of New England is of particular concern. Rhode Island's teen birth rate is high both for first time teen mothers and repeat births to teens. Of significance to RIte Care is the fact that two-thirds of the teen births in Rhode Island are paid for by RIte Care,

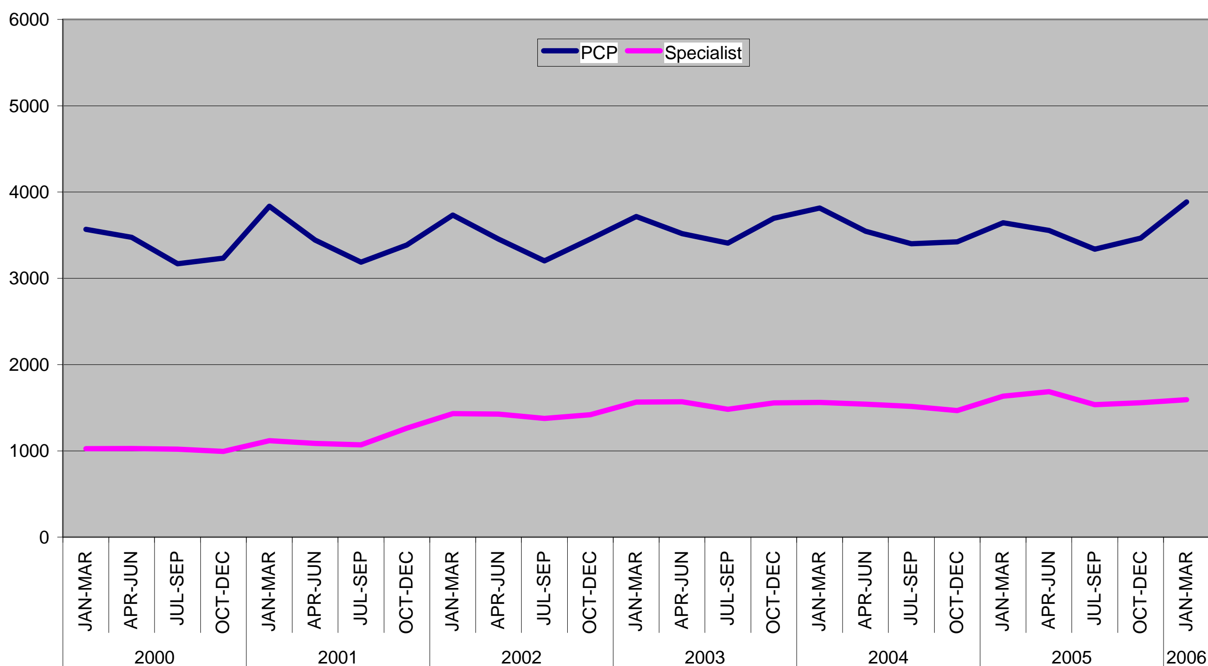
[46] National Center for Health Statistics. *Op. Cit.*, Table 3.

and these infants are also enrolled in RIte Care. Also important is that the female population enrolled in RIte Care has been increasing, with the eligibility expansion to parents of enrolled children. As a result, the absolute number of live births has actually been increasing, as reported through encounter data, from a low of around 3,300 in SFY 1997 to 5,211 in CY 2006, for example. Finally, as will be shown in Chapter 5, the differences in the inter-birth interval (i.e., the time between live births) between women on Medicaid and commercially insured women have virtually disappeared since RIte Care was implemented.

(4) Outpatient Visits

Assuring access to primary care providers (PCPs) and specialists has been one of the main goals of RIte Care from its very beginning. Figure 3-7 shows the number of PCP visits and specialist visits per 1,000 enrollees from the 1st quarter of CY 2000 to the third quarter of SFY 2006. As the data in Figure 3-7 show, RIte Care enrollees have fairly broad access to PCP and specialist services. Average PCP visits per enrollee have averaged about 3,500 per 1,000 member-months and specialist visits per enrollee have averaged around 1,500 per 1,000 member-months. This means that RIte Care enrollees average around five physician visits per year. However, Figure 3-7 also shows an increase in specialist visits per 1,000 member-months, which is a function of the increase in enrollment of foster children and children with special health care needs.

Figure 3-7
RIte Care Outpatient Visits to PCPs and Specialists per 1,000 Member-Months by Quarter
(CY 2000-2006)



These rates are reasonably comparable to national population estimates based on the National Ambulatory Medical Survey[47] as well as Medicaid and commercial benchmarks.[48] Most national benchmarks estimate average outpatient physician visits at about six per year, although these averages include the elderly and other high users of health services. Enrollees, themselves, report that services are accessible.

2. RITE CARE CONTINUES TO HAVE EXCELLENT MEMBER SATISFACTION

Hypothesis:
Populations enrolled in the demonstration will have a high level of satisfaction with the demonstration project.

Each year since 1996, DHS has had a contractor conduct an annual member satisfaction survey (except for 2002 and 2005, due to severe resource limitations). The results of the *2004 RIte Care Member Satisfaction Survey,* which had a sample designed to be effective at a 25 percent response rate (plus or minus 5 percent) in measuring member satisfaction at the RIte Care program level at a 95 percent confidence, are shown below:

- Some 98 percent of respondents reported that, overall, they were very satisfied or satisfied with RIte Care. Comparative satisfaction rates from prior surveys are shown in Table 3-3.

Table 3-3

Overall Member Satisfaction

2004	2003	2001	2000	1999	1998	1997	1996
97.9%	97.8%	98.3%	96.6%	98.3%	96.6%	96.5%	95.7%

- Ninety-seven percent of respondents said they were very satisfied or satisfied with the services of their regular doctor. This is comparable to prior surveys, as shown in Table 3-4.

Table 3-4

Respondent Satisfaction with Their Regular Doctor

2004	2003	2001	2000	1999	1998	1997	1996
96.7%	96.7%	97.0%	96.4%	96.1%	96.2%	94.8%	96.4%

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[47] *Ibid*., Table 90.

[48] National Committee for Quality Assurance. *Quality Compass 2006*.

- Almost 82 percent of respondents said they (or their child) saw their doctor the same day when they called for an appointment when sick; 96.5 percent said they were seen either the same day or the next day. In 2001, only 70 percent of respondents reported that they (or their child) saw their doctor the same day when they called for an appointment when sick.

- Some 93 percent of respondents reported that they had seen their regular doctor within the past 12 months – the highest percentage ever reported.

- Almost 92 percent of respondents said they were either very satisfied or satisfied with reaching their regular doctor evenings, nights, weekends, and holidays. This percentage is the highest ever reported, as shown in Table 3-5.

Table 3-5

Respondent Satisfaction with Reaching Their Regular Doctor Evenings, Nights, Weekends, and Holidays

2004	2003	2001	2000	1999
91.7%	91.5%	88.8%	87.2%	90.1%

- Nearly 95 percent of respondents said they were very satisfied or satisfied with getting a referral to a specialist. These results are comparable to prior years, as shown in Table 3-6.

Table 3-6

Respondent Satisfaction with Getting Specialist Referrals

2004	2003	2001	2000	1999	1998	1997	1996
94.6%	94.6%	94.4%	93.8%	94.9%	93.2%	92.0%	92.7%

- Eighty-six percent of respondents were very satisfied or satisfied with their (or their child's) emergency room treatment, if they used an emergency room (ER). This was the highest level ever reported, as shown in Table 3-7.

Table 3-7

Respondent Satisfaction with Emergency Room Treatment

2004	2003	2001	2000	1999
86%	86%	82%	79%	84%

Because a *RIte Care Member Satisfaction Survey* was not conducted during the most recent waiver program year, information is presented below from the *Consumer Assessment of Healthcare Providers and Systems* (CAPHS® 3.0H) Adult Medicaid Consumer Satisfaction

Survey that each RIte Care-participating Health Plan had performed for 2006 (for Measurement Year 2005). In viewing the reported satisfaction percentages for CAHPS® versus the *RIte Care Member Satisfaction Survey*, it is important to be mindful that the psychometric properties between the two surveys differ significantly. As such, **CAHPS® will always report substantially lower satisfaction percentages** than the *RIte Care Member Satisfaction Survey*.

Table 3-8 shows the Measurement Year 2005 CAHPS® *Overall Ratings* and *Composite Score Percentages* for the three Health Plans and in comparison 2005 CAHPS® national Medicaid average. As the table shows, RIte Care consumer satisfaction is high compared to national benchmarks.

Table 3-8

Measurement Year 2005 CAHPS® *Overall Ratings* and *Composite Score Percentages*

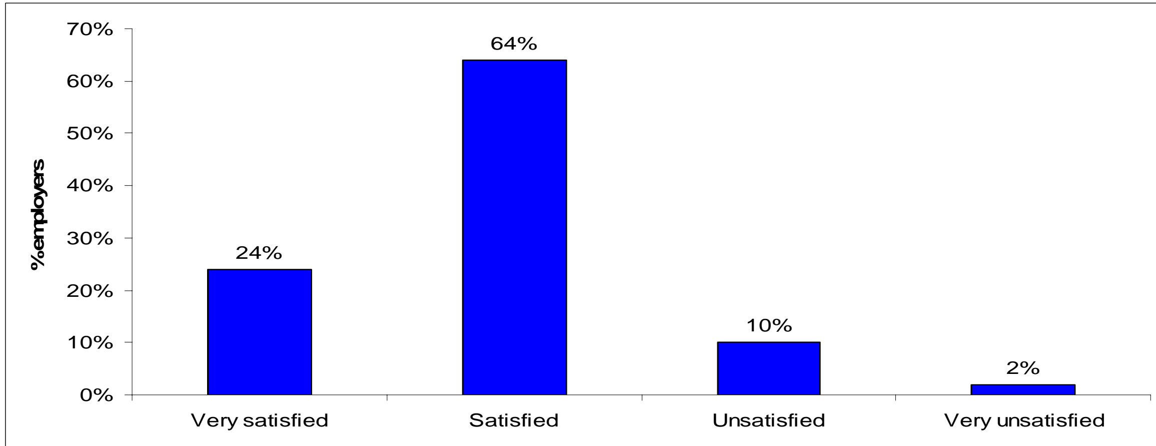
Measures	BCBSRI	NHPRI	UHCNE	2005 National Medicaid Average
Overall Ratings				
Health Plan Overall	83.7%	85.9%	77.7%	71.3%
Health Care Overall	84.6%	77.3%	76.9%	72.5%
Personal Doctor Overall	80.3%	81.7%	81.8%	77.0%
Specialist Overall	81.2%	68.6%	75.2%	75.4%
Composite Score Percentages				
Getting Needed Care	85.9%	79.6%	78.8%	73.6%
Getting Care Quickly	82.7%	74.1%	76.5%	72.1%
How Well Doctors Communicate	93.5%	89.4%	91.7%	86.1%
Courteous and Helpful Office Staff	94.0%	88.5%	92.0%	88.0%
Customer Service	75.4%	79.0%	70.2%	69.7%

The State recently had its first RIte Share satisfaction survey conducted, as a component of the *2005Rhode Island Employer Survey*.[49] As Table 3-9 shows, employers rate RIte Share very highly.

[49] Maxwell, J. *et.al. 2005 Rhode Island Employer Survey: Employer Satisfied with RIte Share*, JSI Research and Training Institute, Inc., August 4, 2006.

Table 3-9

Employer Satisfaction with RIte Share



3. THE STATE MONITORS COMPLAINTS, GRIEVANCES, AND APPEALS

Enrollees may file a complaint, grievance, or appeal with their Health Plan[50] at any time. Since RIte Care enrollment began, Health Plans have submitted quarterly reports to DHS summarizing the complaints made and whether or not they were resolved. Table 3-10 below shows that there were 3,110 complaints, or about 25 complaints per 1,000 enrollees when the "churning" of eligibility in the population is considered, made during SFY 2006. This was up from the 2,580 complaints in SFY 2005, but still considerably less than the 3,637 complaints made in SFY 2003. Some fifty-nine percent (59.3 percent) percent of these complaints were "non-medical" in nature, with 53.8 percent being "other" which is generally consistent with SFY 2005. (This is in contrast to SFY 2004 where the majority of complaints were "medical" in nature.) There were 334 complaints made involving transportation, 105 quality of care complaints made, 77 complaints made involving a request for an interpreter, 66 complaints made concerning denial of services, 11 complaints made involving days to appointment, and only three complaints made involving a specialist referral.

Table 3-10

Enrollee Complaints Made to the Health Plans in SFY 2006

Area	Number of Complaints	Percent
1. Medical		
a. Quality of Care	105	3.4%
b. Days to Appointment	11	0.4%
c. Specialist Referral	3	<0.1%

[50] Enrollees may also register complaints with the State at any time including availing themselves of the DHS Fair Hearing process.

d. Denial of Services	66	2.1%
e. Transportation	334	10.7%
f. Request for Interpreter	77	2.5%
g. Other Medical	671	21.6%
Subtotal – Medical	1,267	40.7%
2. Non-Medical		
a. Provider Staff	139	4.5%
b. Health Plan Staff	25	2.3%
c. Office Waiting Time	7	0.8%
d. Other Non-Medical	1,672	53.8%
Subtotal – Non-Medical	1,843	59.3%
3. Total	**3,110**	**100.0 %**

Of the complaints made, 92.4 percent were resolved during the State's 2006 fiscal year which was up from 90.9 percent in FY 2005 and 79.3 percent in SFY 2004.

The Health Plans also submit quarterly grievance and appeals logs to the State. Table 3-11 below summarizes this information for SFY 2006. There were 370 grievances/appeals, or about three per 1,000 enrollees, filed by enrollees with the Health Plans in SFY 2006, up slightly from 377 in SFY 2005 and down from 497 in SFY 2004. The most frequent type of grievance/appeal filed involved a denial of service (137, or 37.0 percent). The second most frequent type of grievance/appeal filed was "other" (120, or 32.4 percent), which included dissatisfaction with the plan, a claims filing issue, and disenrollment requests. The third most frequent type of grievance/appeal filed was involving non-authorizations (43, or 11.6 percent). There were 36 (9.7% percent) grievances/appeals filed for non-covered benefits and 34 (9.2 percent) grievances/appeals filed for quality of care.

Of the grievances/appeals resolved during the fiscal year, 175, or 47.3 percent were resolved in favor of the enrollee, 93, or 25.1 percent, were resolved in favor of the Health Plan, and 102, or 27.6 percent, having a different resolution (e.g., for quality-related grievances/appeals).

Table 3-11

Number of Enrollee Grievances and Appeals Made to Health Plans in SFY 2006

Type of Grievance/Appeal	Resolved in Enrollee's Favor	Resolved in Health Plan's Favor	Other Resolution	Total	Percent
Non-Authorization	41	2	-0-	43	11.6%
Denial of Service	76	61	-0-	137	37.0%
Non-covered Benefit	25	10	1	36	9.7%
Quality of Care	-0-	3	31	34	9.2%
Other	33	17	70	120	32.4%
Total	**175**	**93**	**102**	**370**	**100.0%**
Percent	**47.3%**	**25.1%**	**27.6%**	**100.0%**	

CHAPTER 4

POLICY AND ADMINISTRATIVE ISSUES

This chapter summarizes policy and administrative issues for both RIte Care and RIte Share.

1. BUDGETARY CONSTRAINTS

The economy in Rhode Island has not improved in the last two fiscal years. Governor Carcieri and the General Assembly have taken a number of steps to stabilize the State budget, but there are still budget deficits projected for SFY 2007 and beyond. DHS faces significant ongoing challenges in meeting budgetary targets. RIte Share plays an important role in budgetary controls. Enrollment of children with special health care needs into RIte Care has already had an important impact on budgetary controls, as did the voluntary enrollment in RIte Care of foster children before them. Beginning September 2003, children in adoption subsidy arrangements, children on SSI, and Katie Beckett-eligible children were offered enrollment into RIte Care. Enrollment was actually phased in over a six-month period to ensure a smooth transition from fee for service to managed care.

The State has used a combination of SCHIP and Medicaid waivers, as was encouraged under the Health Insurance Flexibility and Accountability (HIFA) demonstration waivers, to expand coverage to uninsured children and families. Rhode Island still has better than national average uninsurance rates, but uninsurance levels continue to increase.

Despite the successful budget savings initiatives described above, Rhode Island is very concerned about its ability to maintain coverage of its current SCHIP populations. Maintaining these expansions will require continuing the Section 1115 SCHIP waiver and Federal SCHIP funds adequate to support the current population. Rhode Island's current SCHIP allotment is insufficient to support its SCHIP enrollees. In 2004, the State expended its Federal SCHIP allotment by March and also in March for its 2005 Federal SCHIP allotment. The State has been relying on "redistributed funds" to provide Federal matching for its SCHIP population. As other States' SCHIP expenditures grow, Rhode Island is concerned that there will be insufficient Federal SCHIP funds available to support Rhode Island's SCHIP program in SFY 2007 and beyond. Rhode Island's concern about this issue cannot be overstated.

Governor Carcieri and the Rhode Island General Assembly have responded to the budget pressures by enacting some cutbacks on eligibility, including, for example, instituting a $10,000 liquid resource limit, where there had been no resource test previously, and also enacting legislation to improve insurance coverage and take some pressures off of the Medicaid budget, including, for example:

- **H 7025 Substitute A – Health Care for Families** – This legislation requires DHS prepare a "public health access employer report" annually. The following information

will need to be provided for each employer with 250 or more "public health access beneficiaries" (i.e., RIte Care, RIte Share, and/or Medicaid) in a year:

- o Name and address of employer
- o Number of "public health access beneficiaries" who are employees of the employer
- o Number of "public health access beneficiaries" who are spouses or dependents of employees of the employer
- o Whether the employer offers health benefits
- o Whether the employer participates in RIte Share
- o The cost to the State for providing public health access benefits to their employees and enrolled dependents

The report is due to the General Assembly by the third Tuesday in January of each year, presumably beginning in January 2007 as the legislation took effect "on passage". This bill is the directed at "outing" those employers who are taking advantage of public health programs at no direct cost to them.

- **S 2369 Substitute A – Immunizations** – This legislation will expand required immunizations under current law to adults to include adult influenza immunization and will, beginning State Fiscal Year 2007, assess insurers to pay for them.

- **H 7145 Substitute A – Coverage of Dependent Children** – This bill will extend the coverage on dependent children covered under group health insurance policies up to age 25, if the child is enrolled full- or part-time in a post-secondary educational institution. If that child is not, the insurer must offer the child a "conversion" policy. This legislation is designed to affect a population that tends to be uninsured.

- **H 7926 Substitute A – High Risk Pool (S 2264 Substitute A – High Risk Pool)** – This legislation amends the existing legislation on high risk pools to authorize the Office of the Health Insurance Commissioner (OHIC) to pursue Federal funding to develop a high risk pool for the individual market.

- **H 8243 – Transparency of Information on Health Care Quality and Cost (S 3170 – Substitute A)** – This bill requires OHIC to submit a report to the General Assembly by March 15, 2007 on proposed methods for insurers to "make facility-specific data and other medical service-specific data available" on cost and quality to facilitate consumers making informed choices on where to seek care.

- **S 2107 Substitute A – Individual and Small Business Insurance** – This bill amends the individual health insurance statute to provide for reinsurance for individuals, but only for those individuals who "purchase the direct wellness health benefit plan". It also amends the small group insurance statute along the same lines but with the additional caveat that it only applies to small businesses that pay it least 50 percent of the single coverage premiums.

- **SB 2848 Substitute A – Small Group and Individual Health Insurance** – This legislation amends the existing small group and individual insurance statutes principally by replacing the current language pertaining to "Standard and Economy Health Benefit Plans" with a "Wellness Benefit Plan". Unlike the benefit plans that it replaces, a Wellness Benefit Plan is not defined in statute but will be defined in regulation by OHIC. The plan needs to provide incentives for employers, providers, health plans, and consumers that:

    - Focus on primary care, prevention, and wellness
    - Actively manage the chronically ill population
    - Use the least cost, most appropriate setting
    - Use evidence based, quality care

  The "annualized individual premium rate" for the plan is targeted to be less than 10 percent of the "average statewide wage". The plan will need to be made available on or before May 1, 2007.

As important as these legislative initiatives are, their results will not be felt immediately. Sufficient Federal Medicaid and SCHIP funding will be essential in assuring that the percentage of "insured" population does not fall further. With respect to SCHIP in particular, the 2007 SCHIP reauthorization provides opportunities for fundamental improvements in the fund allocation formulae that have penalized Rhode Island because it is small and moved to cover low-income children prior to enactment of the Balanced Budget Act of 1997 (BBA). It is essential that the reauthorization provide for other than the uncertainty of redistributed funds to assure adequate financing.

2. HEALTH PLAN AVAILABILITY

When the State's Section 1115 SCHIP demonstration began on January 18, 2001, there was only one Health Plan available to new enrollees: NHPRI. Since that time, both UHCNE and BlueCHiP opened to new members. Thus, demonstration-eligible individuals have a choice of Health Plans, which is important given the volatility in the health insurance market in the State noted in Chapter 1 and given the requirements of the June 14, 2002 *Final Rule* implementing the Medicaid managed care provisions of the Balanced Budget Act of 1997 (BBA). Nonetheless, only NHPRI has agreed to be available to enroll foster children and children with special health care needs. As a consequence, enrollment for them in RIte Care is voluntary and the following remained in FFS Medicaid as of July 31, 2006:

- Foster children – 399
- Children with special health care needs – 5,326

The State also tried to increase the total number of RIte Care-participating Health Plans during its last procurement cycle in SFY 2005, but no additional plans were willing to submit proposals.

The State remains very concerned about the commercial marketplace. No new plans are expected to enter the market, particularly given the current commercial market that is dominated

by one carrier. Annual premium rate increases in the commercial market have remained in double digits for the past five years.

The State also remains concerned about the ability of businesses (and their employees) to afford employer-sponsored coverage and the impact on public programs if employers/employees drop coverage. This concern is well-founded as an analysis of the latest *Current Population Survey* (CPS) data[51] show. Even though the percent of Rhode Islanders under age 65 with ESI increased from 62.3 percent in 2004 to 64.3 percent in 2005, this percentage was still substantially less than the 77.7 percent in 2000.

In addition, as noted in Chapter I Blue Cross and Blue Shield of Rhode Island (BCBSRI), the parent company of BlueCHiP, gave up its HMO license for BlueCHiP effective January 1, 2005. How BCBSRI's decision will affect the rest of the Rhode Island health insurance market is unknown, and the unknown is a concern.

3. CROWD-OUT AND RITE SHARE

The State's goal in pursuing a Section 1115 SCHIP waiver was to provide access to comprehensive health insurance for uninsured families. However, it was never the State's intent that RIte Care would be a substitute for ESI. In 2001, the State pursued and received CMS approval to implement the following measures to prevent substitution: (1) to implement a mandatory Section 1906 premium assistance program through a Medicaid State Plan Amendment (SPA); (2) to apply cost-sharing as monthly premium and/or point-of-service co-payments for certain expansion groups (Section 1115 waiver amendment); and (3) to institute a waiting period for certain expansion groups (Section 1115 waiver amendment).

The State, as described earlier, did implement the mandatory premium assistance program, RIte Share and the premium cost-sharing, only, to determine if they could stem substitution. Implementing the waiting period would leave families without coverage – and without care. This is not something the State has been willing to do up to now. Mandatory enrollment in RIte Share ensures that any RIte Care enrollee or applicant with access to employer-sponsored coverage enrolls in that coverage, thus eliminating substitution, or "crowd-out."

As noted in Chapter 2, the State is proud of what it has been able to achieve with RIte Share in such a short period of time. An analysis[52] of the financial savings due to RIte Care shows that for every 1,000 enrolled in RIte Share, there is roughly $1 million in gross savings. This is shown in detail in Table 4-1, which shows the estimated RIte Share savings for SFYs 2001 through SFY 2006. As the table shows, RIte Share savings have increased over time. There have been aggregate Gross RIte Share Savings of $16,194,095 and Net Savings[53] of $14,997,973 since RIte Share began, through SFY 2006. In SFY 2006, the Net Savings per Family per month was $184 and the Net Savings per Individual per month was $57. As the table shows, these savings are down somewhat from prior years as the costs of ESI have risen.

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[51] U.S. Census Bureau, *Current Population Survey, August 2006*, Tables HI04 and HI05

[52] Rhode Island Department of Human Services. *RIte Share Premium Assistance Program: Estimated Savings*, January 2006. The full report may be viewed at: Hhttp://www.ritecareresearch.org/reportspubs/RIteShare/RS%20Savings%20Report%20SFY04%20with%20admin%201-12-06.pdfH.

[53] This is Gross Savings less the cost of State-paid deductibles, co-payments, coinsurance, and wraparound benefits that are referred to in the aggregate as "Supplemental Benefits".

Table 4-1

RIte Share Gross and Net Savings

	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
(1) Potential RIte Care Cost	$10,800	$827,100	$5,403,600	$8,859,600	$9,977,850	$9,495,000
(2) Gross Savings	$949	$301,206	$2,860,069	$4,073,062	$4,467,331	$3,874,303
(3) Supplemental Benefits	$256	$9,162	$325,623	$861,081	$959,472	$1,239,009
(4) Net Savings (3-2)	$692	$292,045	$2,534,446	$3,211,981	$3,507,858	$2,635,295
(5) Savings per Family Per Month	$40	$164	$238	$207	$201	$184
(6) Savings per Individual per Month	$12	$51	$74	$65	$63	$57

Several circumstances make it challenging for RIte Share to realize its full potential for enrollment:

- Employers are not required to submit information about their health insurance benefits to the Department of Human Services, making it difficult to transition RIte Care members to RIte Share.

- Federal ERISA laws pre-empt any State law that would require employers to enroll RIte Share eligible families in the employer-sponsored health insurance outside of open enrollment periods.

- Federal Medicaid rules mandate different levels of benefits for family members (children, adults, and pregnant women) making it complex for RIte Share to wrap-around varying benefit levels within a family.

- Increases in premiums are being passed on to employees, making it more difficult to meet cost-effectiveness tests for Federal financial participation (FFP).

- Employers are adopting health plans with increased member cost-sharing (e.g., high deductibles) and scaled-down benefits that make it harder to “warp around” Medicaid.

- Health Savings Accounts (HSAs) and other flexible benefit programs make it more difficult to mandate that employees take up coverage.

4. HOSPITAL EMERGENCY DEPARTMENT UTILIZATION

In Chapter 3, it was noted that hospital emergency department (ED) utilization has been increasing. While substantially less than the pre-waiver period where some 50 percent of Medicaid recipients in the State's lowest socioeconomic areas received their primary care at the ED[54], the current trend in a managed care environment is a concern. DHS believes that the trend may be due partly to program policy. When RIte Care enrollees experienced some ED access difficulties early on, the State implemented a policy requiring the Health Plans to pay for a *medical screening examination* for RIte Care enrollees to determine whether or not a medical emergency existed.[55] It should be noted that this followed shortly after enactment of the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, Health Plan pricing innovations (namely, paying an all-inclusive ED rate that includes the medical screening examination fee) and the BBA-mandated "prudent layperson" language have challenged the Health Plans' ability to manage this benefit. A substantial co-payment is a primary mechanism available to Health Plans on the commercial side of their business to try to control, somewhat, ED utilization; this has been, however, an issue for CMS.

ED utilization is expensive on both per unit and aggregate bases. The State may need some relief from CMS to permit Health Plans to manage this benefit as they do under their commercial products. In the meantime, the State continues to explore with the Health Plans innovative ways to try to manage ED utilization better.

5. POTENTIAL FEDERAL POLICY AND OTHER CHANGES

The State's plan is to maintain the *status quo* from a program perspective. This may or may not be possible, given the changes going on at the Federal level.

First, there are expected rule changes dealing with targeted case management and rehabilitation services. There is also the Administration's proposal to eliminate FFP for the administrative cost and transportation components of Medicaid school-based services. These potential changes, and others under consideration at the Federal level of which the State is not presently aware, would place even greater constraints on the State budget. The State's presumption here is that any changes would represent a tightening of the criteria for the availability of FFP. It matters not whether the areas affected would constitute in- versus out-of-plan benefits, as the State would be forced to decide what would or would not be retained from an overall program (and State budget) perspective.

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[54] Griffin, J. Changes in Access and Quality of Pediatric Health Care in Inner City Providence from 1993 to 1995: Results of the RIte Care Infant Health Survey, MCH Evaluation, Inc., April 28, 1998.

[55] This was in lieu of some Health Plans requiring prior authorization for ED services, requiring enrollees to come to a particular site, or staffing some EDs and treating RIte Care enrollees differently than commercially members.

Second, The State will also be undergoing its first Payment Error Rate Methodology (PERM) review for SCHIP Wavier Program Year 12. The State has estimated that compliance with the October 5, 2005 *Interim Final Rule* would exceed Federal estimates by at least two-fold and would force the State to make programmatic changes. The magnitude of the impact on SCHIP, for example, would be the equivalent of 344 enrollees. It would consume the State's entire administrative allotment that is subject to a 10 percent cap. The State does not believe that these types of consequences are what Congress intended when it enacted the Improper Payments Information Act, to which the *Proposed Rule* is directed.

Third, the PERM review is but one of an increasing number of Federal components of the new Medicaid Integrity Program (MIP). For example, CMS has identified[56] the following program areas as priorities:

- Nursing and personal care including related to long-term care and home health
- Prescription drugs and the underlying cost of drugs
- DME and other medical suppliers
- Improper claims from hospitals and individual practitioners

What it will cost the State to "cooperate" with MIP is unknown at this time, but it will indeed pressure the State budget because there is no new Federal funding for the States for MIP. The Federal presumption is that MIP will result in savings to both the Federal Government and the States, but that remains to be seen. In the meantime, there will be a real cost to the States to cooperate with MIP as well as an additional administrative burden on the States. With respect to the latter, the State expects not a week will go by that the State will need to address some MIP requirement or activity.

Fourth, the State is not always aware of changes in Federal policy. It used to be that new Federal policy was communicated to the States via formalized mechanisms (e.g., rulemaking, *State Medicaid Director Letter*(s), and *State Medicaid Manual*). While there still is rulemaking and *SMDL*s, the State has become increasingly aware of atypical, off-line policymaking.

Finally, as indicated in the above point, the Rhode Island's *modus operandi* is to seek Federal guidance prior to pursuing something new or making a change. In most instances, the State submits such requests for guidance in writing to the CMS Central and/or Regional Offices. The State has been experiencing increasing delays in Federal responses to the State's requests. This is problematic when the State's seeking guidance has been motivated by an audit finding or a State legislative mandate.

6. TEENAGE PREGNANCY

The importance of the fertility rate on RIte Care was discussed in Chapter 3. Teenage pregnancy ("teen births") is an important factor in the overall fertility rate and RIte Care, and has been the subject of separate study.[57] The study showed that Rhode Island had the highest rate of teen

[56] Centers for Medicare and Medicaid Services. *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program: FY 2006 – 2010,* July 18, 2006.

[57] Griffin, J. *Teen Births in Rhode Island: A Needs Assessment*, Medicaid Research and Evaluation Project, March 2002. See, also: Griffin, J. *The*

births in New England, and that the teen birth rate was higher among Medicaid recipients than privately insured teens. The following illustrates the latter point:

- One in ten births in Rhode Island was to a teenager
- Medicaid pays for two out of three teen births
- One in five Medicaid births was to teens compared to one in 20 privately insured births

The study highlighted the following risk factors as contributing differentially, when compared to the other New England States, to the teen birth rate in Rhode Island:

- Rhode Island had the highest poverty rate in New England
- Rhode Island had the highest rate of high school dropouts and teens not working in New England
- Rhode Island had more barriers to family planning services for teens than other New England States

A more recent analysis[58] shows Medicaid births to teens have decreased from 23.2 percent of all Medicaid births in 1993 to 17.0 percent in 2004. In 1993, 1,065 of the 4,598 Medicaid births were to teen mothers, whereas in 2004 the number of teen births dropped to 932 of the 5,478 Medicaid births. While the gap is closing between private and Medicaid births, the Medicaid teen birth rate is still five times higher than for privately insured. In 2004, approximately one in five births to teens on Medicaid was to a young woman who was already a mother (20.1 percent) compared to15.8 percent for privately insured teens. This Medicaid rate has made a steady decline over the life of the demonstration project.

Interestingly, analysis[59] shows that post-welfare reform teen mothers on Medicaid are more likely to be married, have graduated from high school, and have received adequate prenatal care. They are less likely to smoke and to have low birth weight babies. While these are positive findings no doubt attributable to RIte Care including the family planning waiver component of the demonstration (i.e., the extended family planning program, or EFP), the State nonetheless needs to continue to search for ways to impact the teen birth rate further.

7. ORAL HEALTH

Access to appropriate dental care has been an ongoing issue for low-income children and families in the State that pre-dates the implementation of RIte Care. According to Rhode Island's Kids Count, children eligible for Medicaid experience twice the ratio of untreated dental disease as more affluent children. Of all Rhode Island children under age 21 in public insurance

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Effect of RIte Care on Teen Births in Rhode Island: 1993 –1999, Medicaid Research and Evaluation Project, December 2001.

[58] Griffin, J. *The Impact of RIte Care on the Health of Pregnant Women and Their Newborns: 1993-2004*, RI Medicaid Research and Evaluation Reports, March 2006.

[59] *Ibid.*

programs (RIte Care and Medicaid), only one in three access primary and preventive dental care. Proper dental care is very important to an individual's overall health. Chronic, poor oral health is associated with failure to thrive in toddlers, reduced school performance, poor self-image, and increased absenteeism in school-aged children.

To help address the issue, the Robert Wood Johnson Foundation awarded the State a grant for *State Action for Oral Health Access*. Rhode Island was one of six States to receive this award. The State has thoroughly analyzed its own Medicaid claims data and performed an extensive literature review including review of what other States have tried to address the same issue. The State has convened various work groups and had many meetings with stakeholders, in order to gain as much perspective as possible on the problem. The State has explored:

- Contracting options
- Enrollment options
- Service coverage/benefit design options

The challenge will be to balance these options designed to increase access to dental care, while containing costs. This is a significant challenge indeed, as States such as Michigan and Tennessee have learned the hard way. Rhode Island submitted a Sections 1915(b)(1) and 1915(b)(4) waiver application to CMS on December 30, 2005 for a dental benefit management program for Medicaid children born on or after May 1, 2000, as an initial step to try to improve dental care access for Medicaid children in the State. On March 12, 2006, CMS approved this waiver application. Beginning September 1, 2006, these Medicaid-eligible children will be automatically enrolled in UnitedHealthcare Dental – RIte Smiles, a prepaid ambulatory health plan (PAHP). Some 33,000 Medicaid-eligible children are expected to be enrolled in RIte Smiles in its first waiver year.

8. BUDGET NEUTRALITY

Table 2-6 showed that the demonstration has not been able to operate within its budget neutrality limits over the past three years of the waiver, although the demonstration has been able to do so over the entire life of the demonstration. This has been a concern to both the State and CMS. Accordingly, the State requested that its capitation costs by population group eligible under the waiver be "re-based" in order to better reflect the Rhode Island marketplace. CMS approved this request, effective January 1, 2005, which is taken into account in the budget neutrality calculations for WY 2005 in Table 2-6. However, the State remains concerned that, going forward, the annual "trend" factor, or the percentage at which capitation costs are allowed to increase each year, approved by CMS will be inadequate and that the State will continue to have difficulty operating the demonstration within the budget neutrality limits because of this.

CMS has shared the State's concern and, in fact, addressed this concern in Section 27 of the STCs[60] for the waiver as follows:

> "27. **Milestone Requirement.** The parties acknowledge the projection that the expenditures under RIte Care, as currently configured programmatically, will be above

[60] This is from the January 13, 2006 version of the STCs.

the approved budget neutrality ceiling in demonstration year 14 (8/1/07 through 7/31/08). By March 1, 2006 the State shall submit a draft budget plan to CMS that describes the State's plan to achieve budget neutrality over the life of the demonstration; revisions are expected by the end of July 2006. CMS shall review and approve the budget plan including but not limited to the basis for calculation of budget neutrality. Subsequently the State shall implement the approved budget plan. Some examples of areas to explore in developing this plan include, but are not limited to, implementing existing authorities pertaining to co-payments and waiting lists, examining the adequacy of the current MCO rate structure to assure access, quality and Health Plan participation, or defining a preferred drug list.

a) The State shall submit at the end of WY 13 (8/1/06 through 7/31/07), a budget neutrality assessment that reflects the budget plan and any proposed amendments at which time CMS will complete an interim review of all reported expenditures under the demonstration up to this date and projected expenditures for WY 14.

b) Should CMS' review at the end of WY 13 (8/1/06 through 7/31/07(of the budget neutrality assessment indicate the State will not be budget neutral at the end of WY 14, CMS will not consider extending the demonstration, as currently structured at the end of WY 14.

c) The State agrees in advance that it will return any FFP to the Federal Government determined by CMS to be over the approved budget neutrality ceiling.

d) At the time CMS' determination is made, the State and CMS will develop an appropriate timeline and methodology for remittance."

The State submitted its draft *Budget Neutrality Plan* to CMS on February 28, 2006. By the end of this waiver program year, CMS had not responded to the draft. Therefore, the State did not submit a final plan to CMS by the end of July as required by the STCs. In addition, CMS had not provided the State with the budget neutrality reporting "format" that was referenced as "attached" in Section 25 of the STCs. The draft *Budget Neutrality Plan* is included in this report as Appendix C, and describes specific cost monitoring and cost savings initiatives.

CHAPTER 5

CONDUCT OF DEMONSTRATION EVALUATION

From the very beginning of RIte Care, the State has taken to heart the fact that it is a *demonstration* initiative. Accordingly, the State crafted and has implemented an extensive research and evaluation program to determine how well RIte Care has done in accomplishing its goals (set forth in Chapter 1). This program includes some of the mechanisms already described in earlier chapters: member satisfaction survey, encounter data system, and complaints, grievances, and appeals reporting. In addition, there have been a myriad of special studies and Health Plan oversight to assess how well RIte Care (and, now, RIte Share) is doing. These internal activities have included, for example, analysis of Health Plan filings with the Rhode Island Department of Business Regulation, on-site monitoring reviews of Health Plan operations, performance incentive system reporting, external quality review organization (EQRO) studies, and collaborative studies with the Brown University. The results of these activities have been used not only for assessment for assessment's sake but to refine and expand RIte Care (and, now, RIte Share).

In 1998, Rhode Island received a demonstration grant from the Robert Wood Johnson Foundation's Center on Health Care Strategies to develop a *Health Indicator System for Rhode Islanders on Medicaid*[61]. This project brought fundamental change through the establishment of the Evaluation Studies Workgroup and the emergence of a partnership between program staff and health services researchers. The Workgroup includes researchers from Brown University, DOH staff, DHS staff, and contracted evaluation services (with MCH Evaluation, Inc.) This project produces and trends health indicators including access, quality, health status, and health outcome measures for the Medicaid population from existing public databases and surveys, and through special studies. The existing databases and surveys include:

- MMIS
- Linked Infant Birth/Death File
- Birth File
- Hospital Discharge File
- Health Interview Survey
- Behavioral Risk Factor Surveillance Survey

It should be noted that Rhode Island has also served as a living laboratory for external entities studying Medicaid managed care and SCHIP, like by U.S. Department of Health and Human Services (DHHS) and CMS contractors and grantees such as Mathematica Policy Research and The Urban Institute, the U.S. General Accounting Office, the DHHS Office of the Inspector General, the Substance Abuse and Mental Health Services Administration of DHHS, and other interested entities such as the Kaiser Commission on Medicaid and the Uninsured, National Academy for State Health Policy, the American Public Human Services Association, etc. Not a

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[61] For more information on Rhode Islanders indicators, please see: http://dhs.state.ri.us/dhs/reports/dhcresys.htm.

week goes by without the State fulfilling some external inquiry concerning RIte Care and/or RIte Share.

This chapter summarizes, from the State's internal activities (with reference to external studies, where applicable and appropriate), how well RIte Care has done in the following areas:

- Access to care
- Quality of care
- Containing costs

1. WITHOUT ANY DOUBT, RITE CARE HAS IMPROVED ACCESS TO CARE

Access to care has multiple dimensions. One dimension, for example, is providing access to care for individuals who had no or limited access due to being uninsured. Another dimension, for example, is improving access for those who had coverage but nonetheless had difficulty obtaining the services they needed. Each dimension is considered separately below.

(1) RIte Care Has Reduced the Level of Uninsurance in the State

Hypothesis:
The rate of uninsurance in the expansion population groups eligible for the demonstration will be reduced as a result of this demonstration.

While the enrollment numbers for the RIte Care expansion groups (and RIte Share) presented in Chapter 2 speak for themselves, they need to be put into the appropriate context. Uninsurance was an important issue for the State and a motivating factor for implementing RIte Care with a particular emphasis on uninsured children. RIte Care was ahead of the curve nationally and preceded enactment of SCHIP.

As noted in Chapter 1, the State conceived and implemented RIte Care population expansions to reduce the level of uninsurance incrementally, including, where permissible, through use of SCHIP. The time period immediately before enactment of the BBA (which included SCHIP) is the reference point for analysis of Rhode Island's success in impacting the uninsurance rate in the State.

According to the U.S. Bureau of the Census[62], the number of persons covered and not covered by health insurance in the State of Rhode Island in 1996 was 940,000. Of this total, 93,000 (with a standard error of 13,000), or 9.9 percent (with a standard error of 1.3 percent), were not covered by insurance. Preliminary estimates[63], not adjusted for the uninsured or sample design, of the uninsured children in Rhode Island as of July 1, 1996, were as follows:

[62]Bennefield, R.L. "Health Insurance Coverage: 1996", *Current Population Reports: Consumer Income*

[63]U.S. Bureau of the Census. "Estimates of the Population of the U.S., Region, and States by Selected Age Groups and Sex: Annual Time Series, July 1, 1990. to July 1, 1996," St-96-10

Percent with No Health Coverage, Ages 0 to 17, Rhode Island, 1996

Income Group	Percent Uninsured
<100% FPL	19.2 %
100 to 199% FPL	13.1
200 to 299% FPL	7.5
300 to 399% FPL	1.6
≥400% FPL	1.0
Don't Know	19.1
Refused	14.1
Total	**9.5 %**

With an estimate of 235,283 children in Rhode Island as of July 1, 1996, this means that there were an estimated 22,352 without health insurance coverage as of July 1, 1996.

Although these estimates have not been adjusted, the State believes that the number of uninsured children targeted under its SCHIP Program Plan would have been less than 14,000[64] as of July 1, 1996.

The State's efforts have had a remarkable impact on the uninsurance rate for children in the State. CPS data showed that in 2000, 6.2 percent of the overall population in Rhode Island lacked health insurance and 2.4 percent (this is a three-year average) of children lacked health insurance – both, at that time, the lowest in the nation[65]. CPS data for 2001 show that there had been some erosion in insurance coverage in the State. Overall, 7.7 percent of the population in Rhode Island lacked insurance coverage[66], the second lowest in the nation. The 1999 – 2001 three-year average[67] showed that Rhode Island had, at 7.2 percent, the lowest rate of uninsurance in the nation, which was one-half of the national average of 14.5 percent. However, Rhode Island was no longer the national leader in the uninsurance rate for children under age 19 at or below 200 percent of the FPL[68]. The data showed the uninsurance rate for low-income children in Rhode Island in 2001 was 3.2 percent (with a standard error of 1.0 percent) – 7th lowest in the nation, behind Iowa, Massachusetts, Minnesota, Missouri, Vermont, and Wisconsin.

Based upon data from the most recent *Current Population Survey* (CPS)[69], Figure 1 shows that 11.8 percent of Rhode Islanders of all ages were uninsured in 2005 – a decline from 10.9 percent in 2004. Rhode Island was tied with Nebraska[70] in having the 13th lowest rate of uninsured in the nation, surpassed by Minnesota, Iowa, Hawaii, Massachusetts, Wisconsin, New Hampshire, Pennsylvania, Maine, Kansas, Connecticut, Michigan, and Vermont, respectively. In comparison, in 2004 Rhode Island was ranked eighth and in 2002 Rhode Island had the second

[64] 22,352 x 61.4% = 13,724

[65] U.S. Bureau of the Census, *Current Population Survey, March 2001*.

[66] U.S. Bureau of the Census, *Current Population Survey, March 2002*, Table HI06.

[67] U.S. Bureau of the Census, *Health Insurance Coverage: 2001*, Table 4.

[68] U.S. Bureau of the Census, *Current Population Survey, March 2002*, Table HI10.

[69] U.S. Census Bureau, *Current Population Survey, August 2006*, Tables HI04 and HI05

[70] *Ibid.*

lowest rate of uninsured in the nation, surpassed only by Vermont with a rate of 9.5 percent. In 2000, Rhode Island had the lowest uninsurance rate[71] in the country for both children and the total population. The figure also shows that after experiencing a sustained, declining trend in the level of uninsurance in the State, in 2001 the level of unisurance increased and has continued to do so.

Figure 1

Percent of Uninsured Rhode Islanders by Age Group: 1995 - 2005

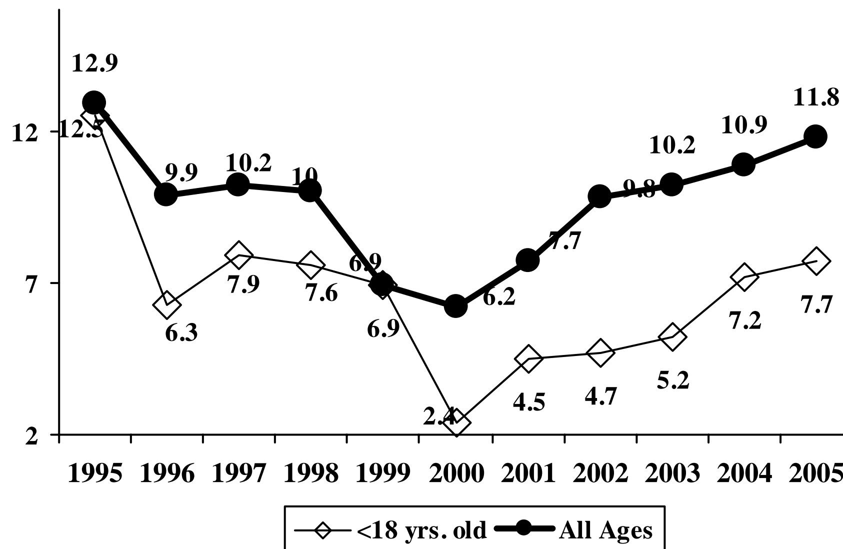

Figure one also shows that the percentage of uninsured children in the State continues to grow. In 2005, 7.7 percent of the children were uninsured, which was ninth in the nation behind New Hampshire, Hawaii, Massachusetts, Vermont, Iowa, Michigan, Minnesota, and Nebraska, respectively.

The 2002 – 2004 three-year average was 10.5 percent, placing Rhode Island fifth, behind Minnesota, Hawaii, Iowa, and Wisconsin, respectively.[72] However, the 2003 – 2005 three-year average was11.0 percent, placing Rhode Island tenth, behind Minnesota, Hawaii, Iowa, and Wisconsin, New Hampshire, Maine, Vermont, Massachusetts, and Kansas, respectively.[73] The 2003 – 2004 two-year average for Rhode Island was 10.5 percent, placing the State sixth behind Minnesota, Hawaii, Maine, Iowa, and Wisconsin, respectively.[74] However, the 2004 – 2005 two-year average for Rhode Island was 11.4 percent, tying the State with Nebraska, North Dakota, and Vermont for 11th behind Minnesota, Iowa, Hawaii, Wisconsin, Maine, New Hampshire, Massachusetts, Kansas, Pennsylvania, and, Connecticut, respectively, yet still 27.2

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[71] Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island, 1995-2002*, RI Medicaid Research and Evaluation Reports. May 2004.
[72] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2004*, Table 9.
[73] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2005*, Table 10.
[74] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2004*, Table 9.

percent below the two-year national average of 15.7 percent uninsured.[75]

Rhode Island was no longer the national leader in the uninsurance rate for children under age 19 at or below 200 percent of the Federal poverty level (FPL)[76], the standard used nationally for the State Children's Health Insurance Program (SCHIP). The data showed the uninsurance rate for low-income children in Rhode Island in 2005 was 3.5 percent, placing the State ninth behind New Hampshire, Hawaii, Massachusetts, Vermont, Iowa, Michigan, Minnesota, and Nebraska, respectively. In comparison, in 2004 Rhode Island's uninsurance rate for low-income children was 4.3 percent – 13th lowest in the nation (down from 7th in 2003). Rhode Island's uninsurance rate for low-income children in 2004 was 39 percent less than the national rate of 7.1 percent.

In using CPS data, it is important to keep in mind that the *Current Population Survey* "was not designed as a health insurance survey."[77] While the CPS provides valuable trend information, "comparisons with other surveys have indicated that its estimates for the uninsured tend to be somewhat higher than other major surveys, indicating that underreporting may be a larger problem for the CPS than for some other major surveys that ask questions about insurance coverage."[78] The underreporting for Rhode Island may be considerable. For example, in March 2001 new questions were added to the CPS specifically dealing with SCHIP coverage. Data for Rhode Island showed[79] SCHIP coverage estimates to be 83 percent less than the actual SCHIP coverage in the State (as reported by the State to CMS).

The State of Rhode Island has also used Behavioral Risk Factor Surveillance System (BRFSS)[80] data to examine uninsurance in Rhode Island.[81] Key characteristics of uninsured working-age adults in 2003 were as follows:

- Younger working-age adults were more likely to be uninsured – 19 percent of those 18 to 34, 7 percent 55 to 49, and 7 percent 50 to 64 were uninsured

- Males were more likely as females to be uninsured within each age group

- The proportion of low-income persons without coverage (23 percent) is over seven times higher than for persons with household income exceeding $50,000 (3 percent)

- The proportion of working-age minority adults who were uninsured was almost four times the proportion of working-age White adults who were uninsured

[75] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2005*, Table 10.
[76] U.S. Census Bureau, *Current Population Survey, August 2006*, Table HI10.

[77] Nelson, C. T. and R. J. Mills. *The March CPS Health Insurance Verification Question and Its Effect on Estimates of the Uninsured*, U.S. Bureau of the Census, August 2001, 6.

[78] *Ibid.*

[79] Nelson, C. T. and R. J. Mills. *The Characteristics of Persons Reporting State Children's Health Insurance Program Coverage in the March 2001 Current Population Survey*, U.S. Bureau of the Census, August 2002.

[80] CPS was a random sample of 1,057 Rhode Island households in 2004 that collects data on type of health insurance for specific age and income groups. The BRFSS sample for 2003 was a random sample of 3,166 persons 18 to 64 years of age (3,843 total households). BRFSS collects demographic, health access measures, as well as employment and income information.

[81] Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island – 2003 Update*, RI Medicaid Research and Evaluation Project, April 2005.

- Unemployed working-age adults were almost four times more likely to be uninsured than employed working-age adults (30 percent compared to 8 percent) and 50 percent higher compared to the self-employed uninsured (20 percent)

An important factor in the increased uninsurance in the State continues to be unemployment[82], as well the rising cost of insurance in the State.

Whether Rhode Island is first in the nation, or 3rd or 8th, according to CPS**, the effect of RIte Care (and, now, RIte Share) on the rate of uninsured for low- and moderate-income families is undeniable.** These programs have made a difference and part of it is due to a concerted effort to enroll people. The State undertook a well-defined outreach effort to identify and enroll uninsured children in RIte Care Health Plans. The State also implemented activities, made possible by other changes in the BBA, to simplify the application and enrollment process. This was done to remove barriers associated with applying and enrolling through a "welfare" environment. Examples of some of the outreach strategies implemented include:

- Accessing the National Governor's Association sponsored "Insure Kids Now" hotline
- Providing funding for outreach workers to 32 community-based organizations to enroll new children each month
- Targeted mailings to community organizations and school-based personnel
- Distributing information to every school-aged child Kindergarten through 6th grade in the State
- Obtaining media coverage in professional newsletters and Rhode Island newspapers
- Using the Department of Human Services Web-site to disseminate information
- Providing public service announcements and radio and television interviews through the media
- Streamlining the mail-in application in both English and Spanish
- Supporting a bilingual information line.

Increasing the number of insured individuals in the State is an important policy matter because the State understands fully the link between insurance and unmet health care needs.[83] As the next section shows, improved insurance coverage has led to improved access to care.

(2) RIte Care Has Improved Access to Care

[82] Bureau of Labor Statistics, U.S. Department of Labor.

[83] The Henry J. Kaiser Family Foundation. "Children's Health – Why Health Insurance Matters," *Kaiser Commission on Medicaid and the Uninsured Key Facts*, May 2002.

Not only has RIte Care demonstrably increased the number of low- and moderate-income Rhode Islanders who are insured, but the program has facilitated the ability of enrollees to obtain services and has changed patterns of care. The following illustrates these accomplishments:

Hypothesis:
The number of physicians participating in the State's Medical Assistance Program will increase as a result of this demonstration.

- Increased primary care physician (PCP) participation in Medicaid from 350 physicians pre-RIte Care to over 900 physicians post-RIte Care (representing in excess of 90 percent of the practicing PCPs in the State).

Hypothesis:
All enrollees in the demonstration will have a medical home.

- Every enrollee in RIte Care has a PCP, who is the enrollee's "medical home." Most specialists in the State also participate in RIte Care.

Hypothesis:
Preventive and other primary care services provided to populations enrolled in the demonstration will increase.

- Increased average per enrollee physician visits from two per year pre-RIte Care (1993) to five per year from SFY 1997 through the second quarter of SFY 2005. It should be noted that visits to health care specialists have increased to almost 2 per enrollee per year.

Hypothesis:
The locus of preventive care and other primary care will shift from hospital emergency departments to other service delivery locations

Hypothesis:
The appropriate use of inpatient hospitals and hospital emergency departments will increase.

- Decreased emergency department (ED) visits and hospital utilization by more than 20 percent from 1993 to 2005. ED visits, which were 750 per 1,000 Medicaid recipients pre-RIte Care, to 500 to 600 visits per 1,000 enrollees post-RIte Care. Enrollees who have used the ED report they are satisfied with its accessibility.

Hypothesis:
Access to health care for populations eligible for the demonstration will be improved.

- The vast majority of RIte Care enrollees report that care, of all types, is accessible in satisfaction surveys.

The State monitors the adequacy of the service delivery system on an ongoing basis. Provider network listings are updated periodically and these listings are matched as necessary with enrollee/ applicant listings to assess any network gaps in primary care provider (PCP) availability, for example. Geo-access analyses have also been performed.

The various analyses demonstrate clearly that there is sufficient provider capacity available for not only current enrollment levels but to accommodate ongoing expansion.

The State has performed special studies concerning access to care. The following highlights some of the key findings from several of these studies:

- **Prenatal Care and Birth Outcomes Study** –This study[84], originally based on data through 1995 and reported in *RIte Care Program Quarterly Report: October 1996 through December 1996*, was updated using Calendar Year 2003 birth certificate data from the Office of Vital Statistics of the Rhode Island Department of Health. Study results, using the 1995 data, were also published in the *American Journal of Public Health*[85]. Highlights from the most recent data update show that access to prenatal care has improved:

  - Early entry into prenatal care for pregnant Medicaid women (i.e., in the first trimester) **improved significantly** from 76.6 percent in 1993 (pre-RIte Care) to 84.2 percent in 2004 (RIte Care). Although a gap between the Medicaid population and the privately insured population persists, the gap was cut in more than half from 1993 to 2004.

  - Adequacy of prenatal care, as measured by the Kotelchuck Adequacy of Prenatal Care Index, **improved significantly** for pregnant Medicaid women, from 70.1 percent in 1993 (pre-RIte Care) to 82.2 percent in 2003 (RIte Care) as Figure 5-3 shows. Once again, although the gap between the Medicaid population and the privately insured population persists, it was cut by more than 60 percent from 1993 to 2003.

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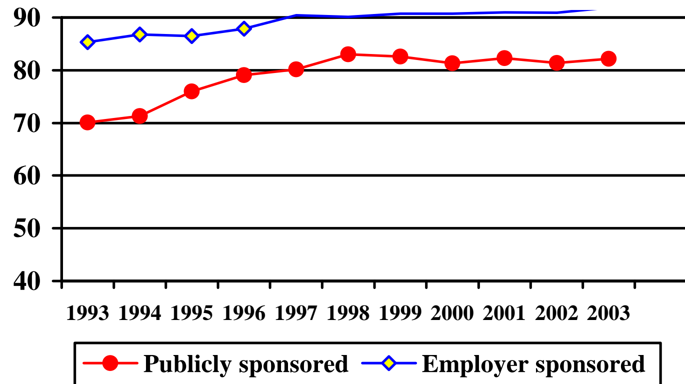
[84] Griffin, J. *The Impact of RIte Care on the Health of Pregnant Women and Their Newborns: 1993-2004*, RI Medicaid Research and Evaluation Project, March 2006.

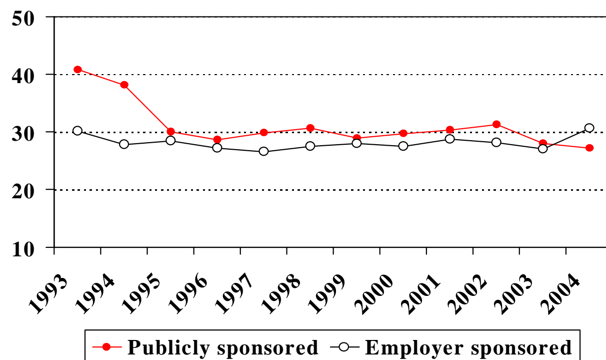
[85] Griffin, J. F., *et. al.* "The Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island," *American Journal of Public Health*, 89(4), April 1999, 497 – 501.

Figure 5-3



- Short interbirth interval (i.e., less than 18 months) is associated with low birth weight. The number of women on Medicaid waiting at least 18 months between births increased from 58 percent of pre-RIte Care (1993) to 72 percent post-RIte Care (2004), as Figure 5-4 shows. This closed the gap between Medicaid and commercially-insured women on this issue. In fact, for the first time commercially insured women had a greater percentage of short interbirth interval births than did women on Medicaid in 2004.

Figure 5-4



- **Infant Health Survey** – This survey[86] was conducted to assess the impact of RIte Care on access to and the quality of pediatric primary care in an inner city high-risk

[86] Griffin, J. *Changes in Access and Quality of Pediatric Health Care in Inner City Providence from 1993 to 1995: Results of the RIte Care Infant Health Survey*, MCH Evaluation, Inc., April 28, 1998.

population. The study was initiated prior to individuals enrolling in RIte Care Health Plans, so that the effects of RIte Care could be clearly discerned. Specifically, the sample for this study involved two inner city birth cohorts. The first, 1993 Cohort (i.e., pre-RIte Care), consisted of all resident births for Providence inner city census tracts 1 through 7, 12 through 14, 19 and 26 that occurred from March 1, 1993 through July 30, 1993. The second, 1995 Cohort (i.e., post-RIte Care), consisted of all inner city births from the same census tracts and born from March 1, 1995 through July 30, 1995. The 1993 Cohort consisted of 588 births and the 1995 Cohort consisted of 475 births. Infants covered by Medicaid comprised 75 percent of the 1993 Cohort and 79 percent of the 1995 Cohort.

Face-to-face interviews were conducted with mothers when the infants were one-year old. The response rate in 1993 was 58.3 percent and the response rate in 1995 was 70.5 percent. Data sources were linked and included the birth certificate file, mother interview, and pediatric medical record.

The major findings from this study after RIte Care was implemented on the following measures were:

- In 1993, 54 percent of inner city infants had their first physician visit at or before two weeks. In 1995, this percentage rose to 70 percent.

- In 1993, 85 percent of inner city infants had five or more pediatric preventive visits in the first year of life. In 1995, the percentage rose to 88 percent.

- In 1993, 88 percent of inner city infants were up-to-date on their immunizations. In 1995, this percentage rose to 95 percent. There were statistically significant improvements in the following EPSDT services: physical examination, height/weight, vision screening, and anemia screening.

- In 1993, 19 percent of the infants were referred to specialty care by their primary care provider and 44 percent of these infants were seen within two weeks for a specialty care appointment. In 1995, 28 percent of the infants were referred to specialty care, and 71 percent were seen within two weeks for a specialty care appointment.

- In 1993, 62 percent of the infants were treated in the emergency department. In 1995, the rate was 60 percent. In 1993, the emergency department visit rate was 164 visits per 100 infants. In 1995, this rate decreased to 138 visits per 100 infants.

- In 1993, 20 percent of the infants were admitted to a hospital. In 1995, 19 percent were admitted to a hospital. In 1993, the average length of stay was 5.7 days. In 1995, the average length of stay decreased to 4.2 days.

- o In 1993, 20 percent of mothers reported that a lack of transportation stopped them from obtaining primary care for their infant. In 1995, this percentage decreased to 13 percent. In 1993, 14 percent of mothers reported that an inability to find childcare for other children stopped them from obtaining primary care for that infant. In 1995, this percentage decreased to 10 percent. In 1993, 9 percent of mothers reported that a lack of a telephone stopped them from obtaining primary care for that infant. In 1995, this percentage decreased to 5 percent.

These findings are consistent with the later data on utilization of services in Chapter 3. In reviewing the findings of the Infant Health Survey, it is important to keep in mind that before RIte Care, more than 50 percent of the inner city population received its primary care in hospital emergency rooms. Thus, **the patterns of where this population receives it primary care have changed while access to services has improved.**

- **Behavioral Health Care Access Study**[87] – This study was completed and submitted to CMS in 1998 and included intensive, on-site review of Health Plan compliance with behavioral health contract provisions established to address concerns related to provider specialization and the multiethnic, multilingual nature of the enrolled RIte Care population.

  Highlights of the behavioral health special analysis findings were as follows:

  - o Participating Health Plans are accredited by the National Committee for Quality Assurance.
  - o All Health Plans have well-defined intake processes and appropriate appointment access standards.
  - o All Health Plans coordinate in- and out-of-plan benefits.
  - o All Health Plans assign complex cases to intensive case management.
  - o Provider networks meet all statutory and contractual requirements, and all Health Plans have a credentialing exceptions policy and/or use out-of-network providers on a case-by-case basis.

  The study showed the following areas to be in need of improvement: (1) access for non-English speaking enrollees, and (2) access for child sexual abuse evaluations.

- **Emergency Room Utilization Clinical Focused Study** – The importance of ER (or ED) utilization was highlighted in both Chapters 3 and 4. Knowing that ER utilization was decreasing significantly, the State had its then EQRO, IPRO, conduct

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[87] Birch & Davis Health Management Corporation. *RIte Care Behavioral Health Access Study*, 1998.

a clinical focused study of ER utilization in 1998 The findings from this study[88] were as follows:

- **Demographics** -- Children (enrollees aged 17 and under) made up nearly 60 percent of the population of emergency room users; this was roughly equal to the percentage of children enrolled in RIte Care at that time.

- **Weekends and After-Hours** - Thirty-two percent of patient visits to the emergency room occurred on weekends. This did not differ significantly from the expected rate of 29 percent based on a normal distribution. There was no evidence that inappropriate emergency utilization increased after normal working hours.

- **Appropriateness of Emergency Room Utilization** - Fifty-two percent of emergency room utilization was either inappropriate (i.e. condition could be appropriately treated in a physician's office, for example, otitis media) or for an ambulatory care-sensitive condition (i.e. condition could have been prevented with appropriate ongoing care and treatment, for example, asthma, emergencies). Comparisons of utilization rates showed no significant difference among Health Plans.

- **Nurse and Physician Screening Rates** - Over 99 percent of enrollees in the sample were screened by a nurse and/or physician. It is important to remember in this regard that Health Plans were required contractually to pay for a medical screening examination to determine whether or not a medical emergency existed.

- **Emergency Room Coordination With PCPs and Health Plans** – Fifty-two percent of the time there was no documented contact between the ER and the Health Plans or PCP regarding the provision of services. ER coordination either during the visit or after discharge was documented in only 9 percent of the cases. A comparative analysis of the coordination rates by Health Plans did not indicate significant differences.

- **Health Plan Prior Authorization for Emergency Room Utilization** – Health Plans prior-authorized less than one-third of the emergency room visits made by enrollees.

- **Emergency Room Services** – Of the 497 enrollees in the study who presented to the emergency room, 394, or 79 percent, received ER services over and above a medical screening examination. The most common services provided in the ER were laboratory, radiology, medication other than parental, monitoring, and wound care. Sixty percent of the enrollees who inappropriately utilized the ER received services, while 89 percent of those

[88] Island Peer Review Organization. *Emergency Room Utilization Study*, March 6, 1998.

who appropriately utilized the emergency room received services. These rates did not vary significantly by Health Plan. .

- **Ambulatory-Care Sensitive Conditions –** Twenty-nine percent of enrollees had conditions that were ambulatory-care sensitive. Although some of these cases may warrant utilization of the emergency room, further investigation would be necessary to determine what percentage of these visits could have been avoided through more intensive prior/ongoing management in an ambulatory setting.

As was indicated earlier, there is no question that ER care is accessible – perhaps too accessible, as noted in Chapter 4.

More recently, the Family Health Survey was conducted.[89] The purpose of the Family Health Survey was to determine the effect of disruption of health coverage on access, utilization, and satisfaction with health care for low-income children and adolescents less than eighteen years old who had been continuously enrolled in RIte Care for at least one year. Highlights of the survey are provided below

Characteristics of Children

White children were more likely to have continuous health care coverage (62.4 percent) than Hispanic children (20.8 percent) or Afro-American children (12.4 percent). Similarly, White children were less likely to have intermittent coverage (50.3 percent) and Hispanic children most likely to have intermittent coverage (29.0 percent) followed by Afro-American children (15.5 percent).

Children between the ages of 5-11 were more likely to have continuous coverage, whereas children aged 1-4 and 12-18 were more likely to have intermittent coverage. English-speaking individuals were significantly more likely to have continuous coverage whereas Spanish-speaking individuals are more likely to have intermittent coverage.

Characteristics of Parents and Families

Children with intermittent coverage were significantly more likely to live in families that experience other household disruptions than children with continuous coverage. The majority of parents of children with gaps in coverage were without health coverage (58.6 percent), 34.1 percent changed jobs, 25.5 percent could not pay their rent, 25.5 percent moved, and 18.6 percent did not have telephones.

These household disruptive factors were significantly less likely to exist for children with continuous health care coverage.

Health Status

[89] Griffin, J. *Do Gaps in Children's Health Coverage Make a Difference? Results of the RIte Care Family Health Survey*, RI Medicaid Research and Evaluation Project, September 2004.

There were no significant differences in the perceived health status or incidence of chronic health problems between children with gaps in health insurance and those without such gaps. Both groups were equally unable to participate in normal activities due to illness the same amount of time.

Access to Health Care

Access to care was high for both children with continuous and intermittent coverage as measured by such factors as having a usual place for routine care, having a personal doctor and having check up visits.

There were significant differences in where children were likely to go for routine care. Children with intermittent care were significantly more likely to go to a community health center for their routine care (28.6 percent) than children with continuous care (17.7 percent). Children with continuous care were significantly more likely to private doctors than children with gaps in coverage (67.9 percent compared to 56.8 percent). There were no significant differences between the groups in where they went for urgent care. Those with gaps in insurance coverage had much more difficulty getting medical care than those with continuous coverage (28.3 percent compared to 7.4 percent).

Yet, children with gaps in coverage are three times more likely not to see a doctor with in the last year (9.7 percent compared to 3.2 percent) and almost four times more likely to have difficulty getting care (28.3 percent compared to 7.4 percent) than children with continuous coverage.

Utilization of Health Care

The utilization patterns of health care resources were similar between the two groups, except children gaps in coverage were significantly more likely not to have a well-child check up (9.7 percent compared to 3.2 percent).

Barriers to Health Care

Parents of children with intermittent coverage had significantly more barriers that caused a delay or not getting the required care (e.g., not enough money to pay the doctor and waiting too long for an appointment).

The complete report may be accessed at:

http://www.ritecareresearch.org/reports/pubs/RIteCare/FHS_full_reort2.pdf

2. RITE CARE HAS IMPROVED QUALITY OF CARE AND HEALTH OUTCOMES

Some of the above information (e.g., the results of the Infant Health Survey) reflects on the quality of care increments that have occurred since RIte Care was implemented. This section describes more broadly the positive impact that RIte Care has had on quality of care and health outcomes.

Hypothesis:
Maternal and child health outcomes for the populations enrolled in the demonstration will improve.

(1) RIte Care Has Improved Infant and Child Health Outcomes

The Infant Health Survey reported on above also showed that the number of low birth weight infants born to Medicaid-enrolled mothers in a matched birth cohort in "very low poverty" inner city tracts decreased from 10.1 percent in 1993 to 5.1 percent in 1995 – a 50 percent reduction.[90] Perhaps not unrelated, an analysis[91] of infant mortality in Rhode Island from 1990 to 1999 showed:

- From 1990 to 1999, the infant mortality rate declined 36 percent for infants "with public insurance" – from 10.7 deaths per 1,000 births to 6.8 deaths per 1,000 births.

- The gap between the public insurance infant mortality rate and private insurance infant mortality rate was reduced by over half, from 4.3 points in 1990 to 1.5 points in 1999.

- The neonatal mortality (i.e., less than 28 days after birth) for infants with public insurance decreased 23 percent, from 6.2 death per 1,000 births in 1990 to 4.8 deaths per 1,000 births in 1999.

- The postneonatal mortality (i.e., 28 days or more after birth) for infants with public insurance decreased more sharply, 57 percent, from 4.5 deaths per 1,000 births in 1990 to 1.9 deaths per 1,000 births in 1999. Postneonatal mortality is considered a measure of access to pediatric care.[92]

- A more up-to-date analysis[93] in Figure 5.5 shows the general decline in infant mortality over the past 10 years for publicly insured infants. In two of the 10 years, the public rate was actually less than the privately insured rate including in 2004 at 4.9 per 1,000 live births.

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[90] Griffin, J. *Op. Cit.*

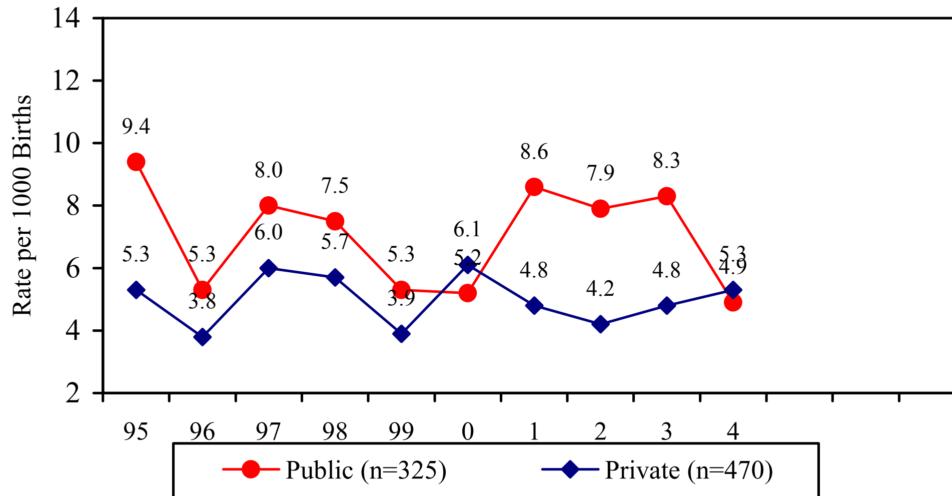
[91] Griffin, J. *Rhode Island Infant Mortality 1990 – 1999: Changes in Causes of Death and Period of Death by Insurance Status*, Medicaid Research and Evaluation Project, March 2002.

[92] Centers for Disease Control. "Postneonatal Mortality Surveillance – US 1980 – 1994," *Morbidity and Mortality Weekly Reporter*, 47 (15), 1998.

[93] Griffin, J. *Health Indicator Data Book*, July 28, 2006.

Figure 5-5

Infant Mortality in Rhode Island by Insurance Status, 1990-2004



Patrick Vivier, M.D., Ph.D., Associate Professor in the Departments of Pediatrics and Community Health at Brown University, has led several collaborative studies involving RIte Care. These studies have shown:

- In a study[94] of lead screening and lead poisoning comparing the Medicaid and commercially insured population enrolled in the same managed care organization, the data in Table 5-1 show that the rates of screening are comparable irrespective of insurance type but children enrolled in Medicaid have nearly three times the level of lead poisoning:

Table 5-1

Lead Screening and Lead Poisoning Rates Comparing Medicaid and Commercially Insured Children Enrolled in the Same Managed Care Organization

Measure	Commercial	Medicaid
Lead Screening		
Percent Ever Screened	87.2%	88.0%
Percent Never Screened	12.7%	12.0%
Lead Poisoning		
Percent ≥ 10 ug/dL	6.6%	16.8%
Percent < 10 ug.dL	93.3%	83.2%

[94] O'Haire, C., et.al. *Lead Screening and Lead Poisoning in Medicaid and Commercially Insured Children Enrolled in the Same Managed care Organization*, American Public Health Association Poster Session, forthcoming.

There were no statistically significant differences in screening levels by gender or location, but the lead poisoning levels were significantly different by location. As expected, residents of core cities had higher levels of blood poisoning.

- In a study[95] of immunization status of 19- to 35-month-old children who had been continuously enrolled in RIte Care for at least one year, the immunization rates were as follows:

    - The overall immunization rate for having received all indicated doses of Dta/DTP, polio, Hib, MMR, and hepatitis B was 75 percent

    - When hepatitis B was excluded from the assessment, 81 percent of children were up to date for all doses of the remaining four vaccines

These results compare favorably with national and Rhode Island rates as measured in the Centers for Disease Control and Prevention National Immunization Survey (NIS)[96] as Table 5-2 shows:

Table 5-2

Immunization Coverage Rates for 19- to 35-month-olds as Measured by NIS

Sample	Overall* %	DtaP %	Hib%	Hepatitis B %	MMR %	Polio %
National	76	81	93	84	91	91
Rhode Island	81	89	96	87	95	96
RIte Care	81	87	94	88	91	95

* Overall status includes all vaccines except hepatitis B

- In a study[97] of lead screening, 79.8 percent of children aged 19 to 35 months who had been continuously enrolled in RIte Care for at least one year had a documented blood lead screen test. Minority children, children in homes with other than English spoken in the home, and children living in the "core cities" all had statistically significant higher screening levels. These are important results given the risk factors associated with lead poisoning. Screening levels also varied by primary care site:

    - Office-based 67.8 percent
    - Health center 85.8 percent
    - Hospital-based clinic 88.6 percent
    - Staff model HMO 90.9 percent

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[95] Vivier, P. M., *et.al.* "An Analysis of the immunization status of preschool children enrolled in a statewide Medicaid managed care program," *The Journal of Pediatrics*, 139(5), November 2001, 624-629.

[96] Centers for Disease Control and Prevention. "National, State, and Urban Area Vaccination Coverage Levels among Children 19 – 35 Months – United States, 1997," *Morbidity and Mortality Reporter*, 47, 1997, 547-554.

[97] Vivier, P.M., *et.al.* "A Statewide Assessment of Lead Screening Histories of Preschool Children Managed in a Medicaid Managed Care Program," *Pediatrics*, 108(2), 2001.

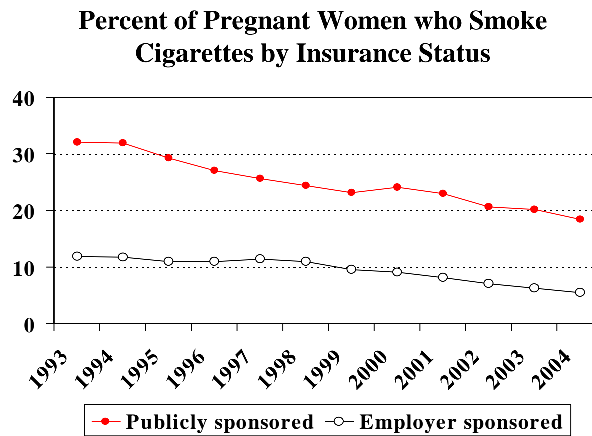
These screening rates were dramatically higher than those published in national surveys.[98] Children enrolled in RIte Care also had a higher percentage (at 29.4 percent) of elevated blood lead levels (≥10mg/dL) on at least one test, when compared to national data[99] (at 8.6 percent).

The State of Rhode Island recognizes the importance of lead screening in order to intervene early. It is also important to recognize in this regard that DHS supports a Comprehensive Lead Center Program that includes window replacement and removal of certain other lead hazards in the homes of lead poisoned children as a RIte Care covered benefit.

(2) RIte Care Has Had a Positive Impact on Maternal Health

The percentage of pregnant women on Medicaid who smoked during pregnancy decreased significantly from 33 percent pre-RIte Care to 18 percent in 2004, as Figure 5-6 shows[100].

Figure 5-6



Hypothesis:
The quality of care provided to populations enrolled in the demonstration will improve.

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[98] Kaufmann, R. B., *et.al.*, "Elevated Blood Lead Levels and Blood Lead Screening among US Children Aged One to Five Years: 1988 – 1994," *Pediatrics*, 106(6), 2000.

[99] *Ibid.*

[100] Griffin, J. *The Impact of RIte Care on the Health of Pregnant Women and Their Newborns: 1993-2003*, RI Medicaid Research and Evaluation Project, March 2006.

(3) RIte Care's Performance Incentive Program Is Producing Desired Results

As described in Chapter 2, a performance incentive program was implemented in July 1, 1998, under which Health Plans can earn payments over and above capitation payments for the attainment of administrative, access, and clinical goals. DHS offers each Health Plan monetary incentives[101] as a reward for improvements in performance, and the accuracy and completeness of data submitted. The State did so "to improve care by using available health plan data on access and outcomes" and "to improve the quality of health plan performance data."[102] This was part of an ongoing strategy of partnership with the Health Plans, with both the State and the Health Plans committed to continuous quality improvement for RIte Care. The "approach leverages a comparatively small amount of money in spotlight areas that DHS considers important."[103]

The program began with 21 (19 in SFY 2004) measures in three areas, or categories, of focus: nine (8 in SFY 2004) for the administrative category, five for the access to care category, and seven (6 in SFY 2004) for the clinical category. The 27 measures for SFY 2006 (which are Attachment M of the RIte Care Health Plan Contract) are included as Appendix A hereto, and include the following areas:

- Member Services – 4 measures
- Medical Home/Preventive Care – 15 measures
- Women's Health – 2 measures
- Chronic Care – 3 measures
- Behavioral Health – 1 measure
- Resource Maximization – 2 measures

Each measure is clearly defined, has a numeric *standard* to be achieved, and has *scoring guidelines*. Table 1 shows the relative value of each of the performance categories (e.g., access). The percentage and PMPM allocations reflect the relative importance of each category to the State, with the *clinical* areas being the most important, as Table 5-3 shows. Health plans can earn up to $1.25 per member per month (PMPM) in incentive payments for achieving specific performance goals. As Appendix A shows, the relative importance to the State that a given measure represents is reflected in the *value* assigned to the measure.

[101] The total incentive pool equals approximately one percent of total capitation payments made to the Health Plans.
[102] Dyer, M.B., M. Bailit, and C. Kokenyesi. *Working Paper: Are Incentives Effective in Improving the Performance of Managed Care Plans?*, Center for Health Care Strategies, March 2002.
[103] Rhode Island Department of Human Services. *Rhode Island Medicaid Program: Annual Report Fiscal Year 2001*, 42.

Table 5-3

Performance Categories for SFYs 2005 and 2006

Performance Categories	Percent Allocation	PMPM Allocation
Member Services	20 %	$ 0.25
Medical Home/ Preventive Care	50 %	$ 0.625
Women's Health	10 %	$ 0.125
Chronic Care	10 %	$ 0.125
Behavioral Health	5 %	$ 0.0625
Resource Maximization	5 %	$ 0.0625
Total	**100%**	**$ 1.25**

Measures were selected so that the Health Plans could develop strategies to improve performance. All *administrative* measures were actual requirements of the contract between DHS and the Health Plans. The *access* measures are either contract requirements (e.g., access urgent care) or priority areas for the State (e.g., well-child visits). *Clinical* measures were a mix of Health Plan Employer Data and Information Set (HEDIS®) measures (e.g., cervical cancer screening rates) and areas of particular interest to the State (e.g., prenatal care, using the Kotelchuk Index). Now, the clinical measures are exclusively HEDIS® measures. Both the *access* and *clinical* measures were selected for their applicability to the characteristics, particularly age and gender, of RIte Care enrollees

In 2006, the State changed its payment methodology and now pays performance incentives based on the following:

- If a Health Plan meets or exceeds the 90th percentile[104] target for Medicaid HEDIS® or CAHPS® measures, the Health Plan will get the full award for those measures;

- If a Health Plan meets or exceeds the 75th percentile target for Medicaid HEDIS® or CAHPS® measures, they health plan will get a partial award for those measures;

- If the 75th percentile is not met for a measure, then no incentive award is given.

- If a Health Plan meets or exceeds the target specified in RIte Care's contract language, then the plan will receive the full award for those measures.

- If the target specified in RIte Care's contract is greater than the HEDIS® measure target, and if a Health Plan met the 90th percentile for the HEDIS® measure, but did not meet the target specified in the contract language, the Health Plan would still receive the full award for meeting the 90th percentile.

[104] A health plan that meets or exceeds the 90th percentile scored higher than 90 out of 100 plans.

The Health Plans have been making considerable progress towards attaining the standards set forth under the Performance Incentive Program. Table 5-4 shows that the Health Plans were able to receive a significant portion of the potential incentive payments as a result of their performance in SFY 2006. In the table, 0.0000 means that the plan received a score of zero for whatever reason (e.g., a HEDIS® measure was "rotated" in the 2005 measurement year and not reported for that year) while a score of 1.0000 means that the plan met or exceeded the performance standard for that measure (see Appendix A for the performance standards). Because RIte Care-participating Health Plans are NCQA-accredited, the State has access to the HEDIS® data submitted for the Health Plans Medicaid product lines.

Table 5-4

Percent of Potential Incentive Payments Received by the Health Plans in SFY 2006

Measure	Plan Score for Each Measure		
	BlueCHiP	**NHPRI**	**UHCNE**
Member Services			
1. ID card within 10 days	0.7750	1.0000	1.0000
2. Member handbook within 10 days	0.6917	1.0000	1.0000
3.New member calls completed within 30 days	1.0000	0.8346	0.7000
4. Grievances and appeals within contractual timeframes	0.5400	0.9400	0.6150
Medical Home/Preventive Care			
5.Members have access to emergency services	0.8697	1.0000	0,5000
6. Members satisfied with access to urgent care	1.0000	1.0000	0.9000
7. Members have access to urgent care appts. after business hours	0.0000	0.0000	0.0000
8. Members have PCP phone access after hours	0.0000	0.0000	0.0000
9. Adult members had an ambulatory or preventive care visit	0.9869	0.9901	1.0000
10. Members had well-child visits in the first 15 months of life	1.0000	1.0000	1.0000
11. Members had well child visits in the 3rd to 6th years of life	0.9690	1.0000	1.0000
12. Adolescents received MMR2 + 3xHepB by 13th birthday	1.0000	1.0000	1.0000
13. Children received immunizations by 2nd birthday	1.0000	1.0000	1.0000
14. Children received periodic PCP visits	1.0000	0.9984	0.9984
15. Children received ≥1 lead screen before 2nd birthday	0.9521	0.9331	0.9515
16. Members ≥18 received advise on smoking cessation	1.0000	1.0000	0.0000
17. Pregnant members received timely prenatal care	1.0000	1.0000	0.0000
18. Pregnant members received timely postpartum care	1.0000	0.0000	0.0000
19. Adolescent PCP Care	0.0000	0.0000	0.0000
Women's Health			
20. Women 18 - 64 received cervical cancer screening	1.0000	1.0000	1.0000
21. Sexually active women 16 - 25 received Chlamydia screening	0.0000	0.0000	0.5000
Chronic Care			
22. Children with asthma use appropriate medications	1.0000	1.0000	1.0000
23. Adults with diabetes had HbA1C testing	0.0000	0.9543	0.0000
24. Antidepressant compliance	0.0000	0.0000	0.0000
Behavioral Health			
25. Members ≥6 received follow-up by 30 days post-discharge	1.0000	1.0000	1.0000
Resource Maximization			
26. Generic drug substitution rate	1.0000	1.0000	1.0000
27.DHS notified of TPL within 15 days	0.9965	1.0000	1.0000

It should be noted that in 2001, DHS received a Purchaser Award from the National Health Care Purchasing Institute for the program to recognize DHS' "value purchasing" management philosophy. In January 2003, a report[105] from The Commonwealth Fund highlighted that "Rhode Island's experience illustrates that much can be done to improve quality as well as efficiency through relatively modest quality improvement initiatives."

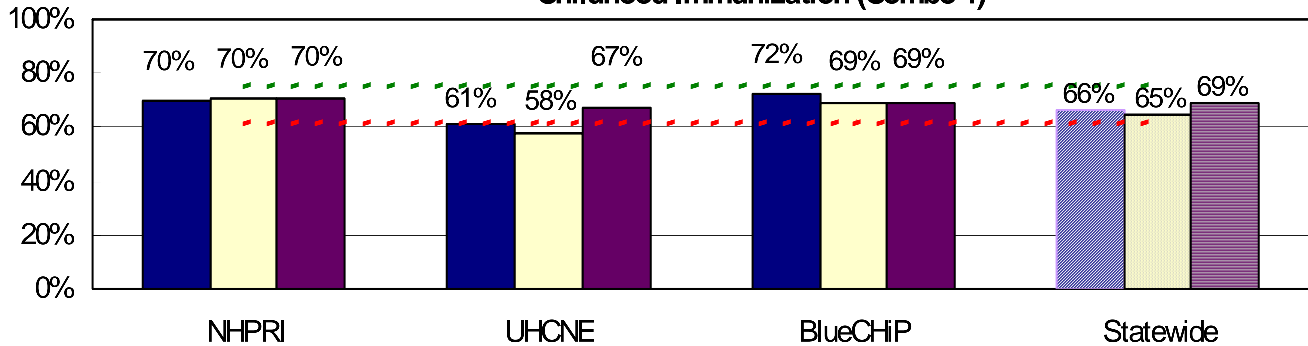
The State of Rhode Island believes that its experiences with the Performance Incentive Program to date demonstrate that it is possible for the health care delivery system to respond positively to financial incentives to improve access to and the quality of health care. This does not happen overnight, however; it takes time and concerted work effort to achieve. The State has learned that in order to accomplish this, it has been important to:

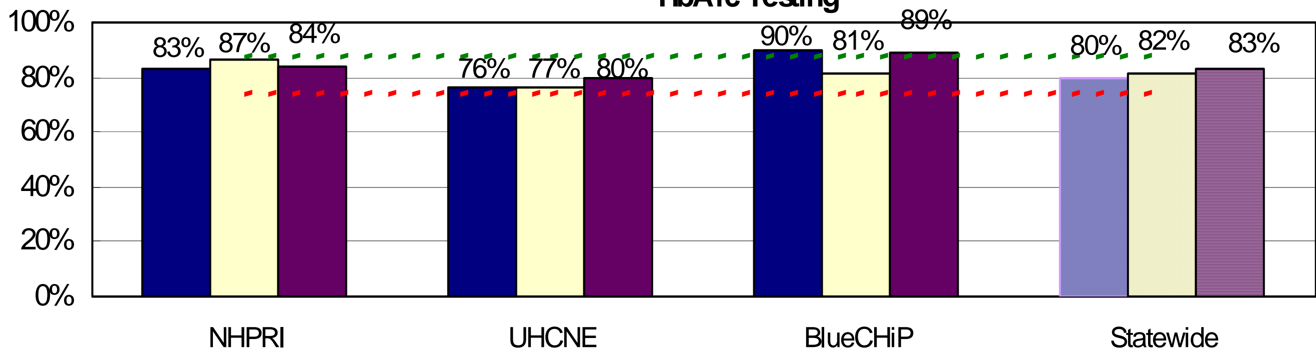
- Use a collaborative process and partner with the Health Plans
- Provide adequate administrative support
- Structure incentives to reward improvement
- Use measures that are subject to management intervention by the plans to make improvements in performance
- Stick with the same measures over several years
- Expect some variation in performance over time
- Make certain rewards are real dollars
- Be flexible
- Minimize the burden on Health Plans and the State
- Build on existing processes

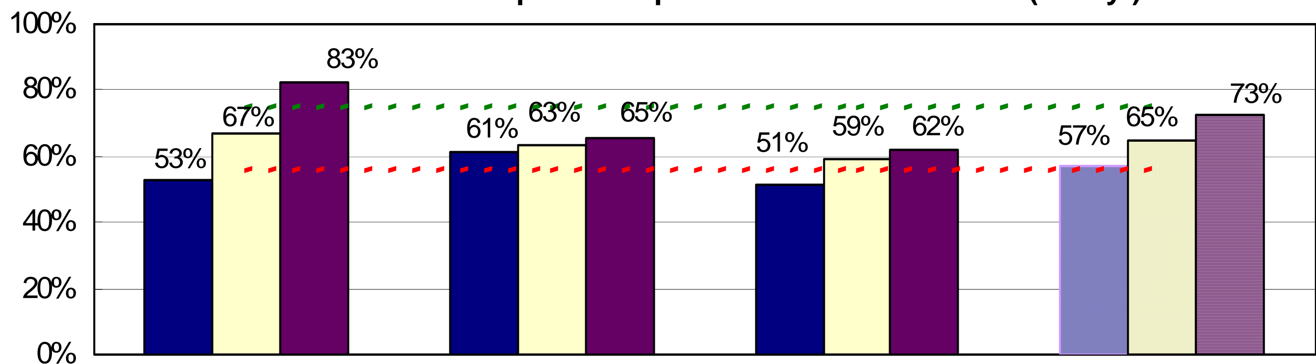
(4) RIte Care Health Plans Undergo Annual External Quality Review

Since promulgation of the external quality review (EQR) regulations on January 24, 2003, Rhode Island has had its external quality review organization (EQRO), IPRO, perform an annual EQR of each Health Plan. This conforms to the requirement that the State must ensure that: "a qualified external quality review organization (EQRO) performs an annual EQR for each contracting MCO."[106] Results from the most recent aggregate EQR detailed technical report[107]are presented below and show RIte Care's continuous quality improvement and exceptional performance against national benchmarks over the past three years.

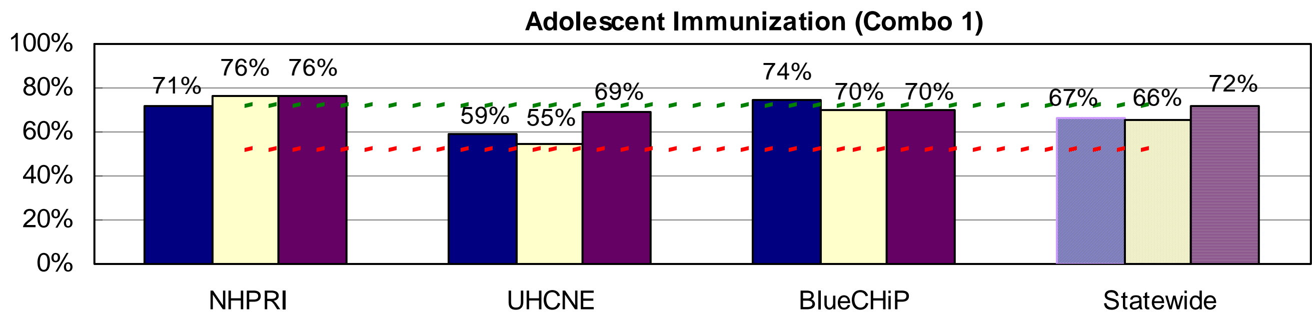
[105] Silow-Carroll, S. *Building Quality Into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations: Field Report*, The Commonwealth Fund, January 2003, 21.
[106] 42 CFR 438.350(a).
[107] IPRO. *Annual External Quality Review Aggregated Technical Report for the RIte Care Medicaid Managed Care Program:* Reporting Years 2003-2005, March 2006.

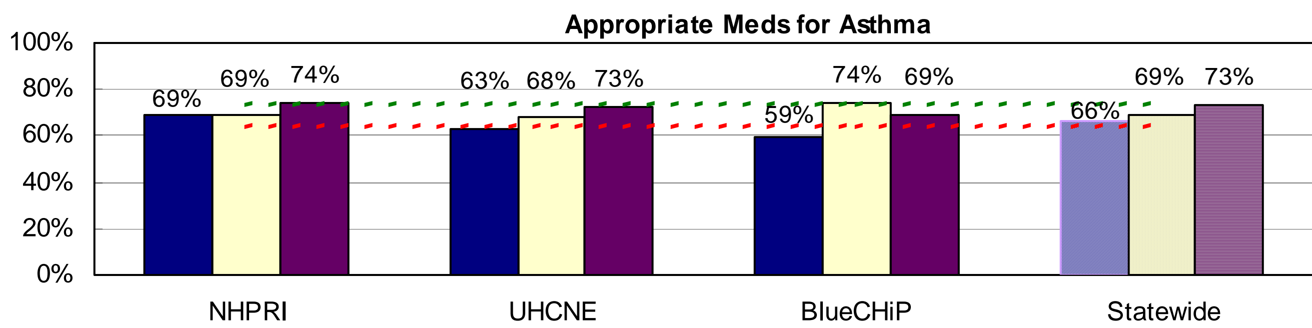

Childhood Immunization (Combo 1)
100%
80%
60%
40%
20%
0%
70% 70% 70%
61% 58% 67%
72% 69% 69%
66% 65% 69%
NHPRI
UHCNE
BlueCHiP
Statewide

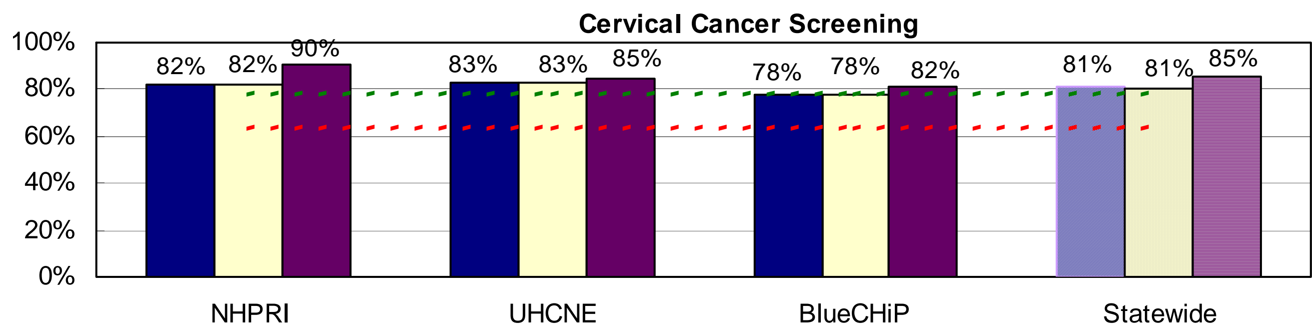

HbA1c Testing
100%
80%
60%
40%
20%
0%
83% 87% 84%
76% 77% 80%
90% 81% 89%
80% 82% 83%
NHPRI
UHCNE
BlueCHiP
Statewide

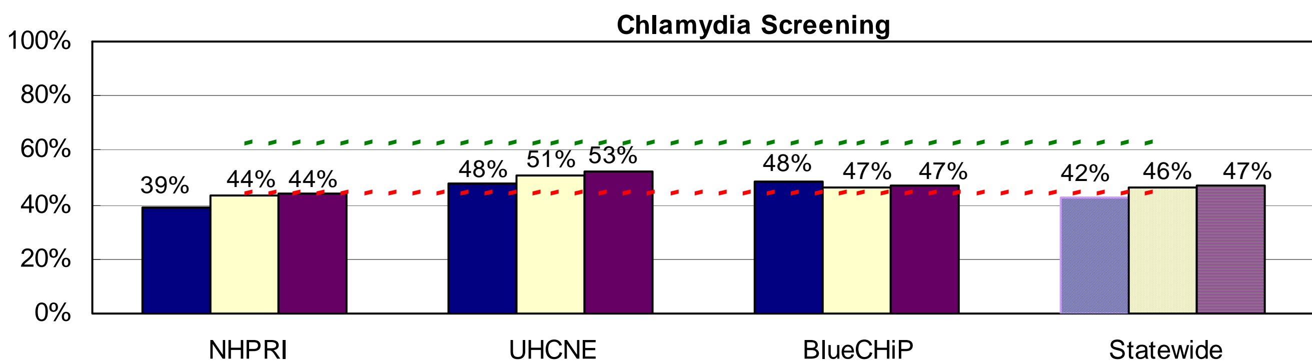

Follow-Up After Hospitalization for Mental Illness (30 Days)
100%
80%
60%
40%
20%
0%
53% 67% 83%
61% 63% 65%
51% 59% 62%
57% 65% 73%
NHPRI
UHCNE
BlueCHiP
Statewide

HEDIS® 2003
HEDIS® 2004
HEDIS® 2005
HEDIS® 2004 Medicaid MEAN
HEDIS® 2004 Medicaid 90th Percentile

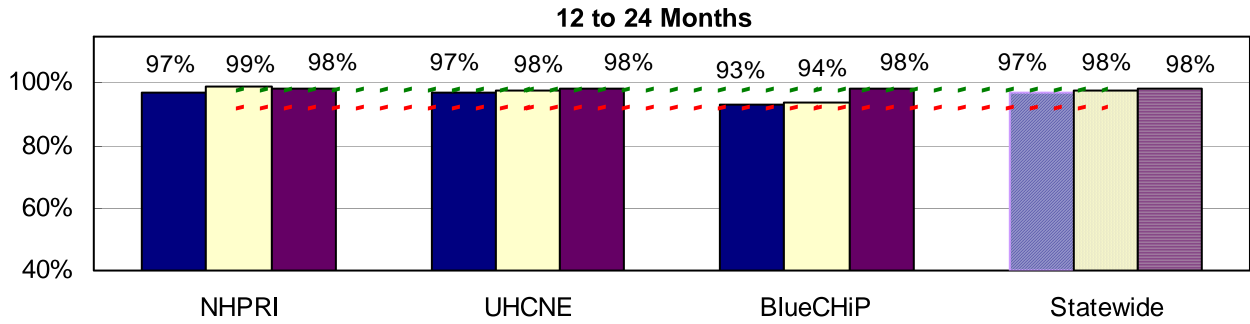

Adolescent Immunization (Combo 1)
100%
80%
60%
40%
20%
0%
71%
76%
76%
59%
55%
69%
74%
70%
70%
67%
66%
72%
NHPRI
UHCNE
BlueCHiP
Statewide

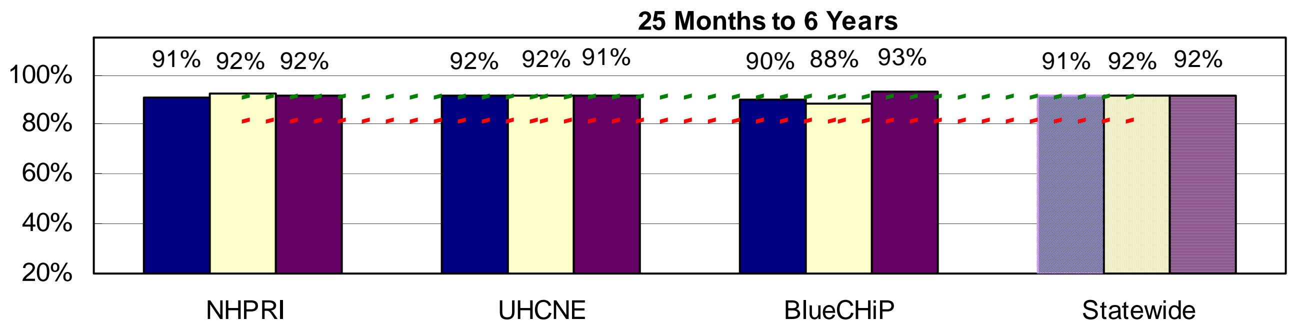

Appropriate Meds for Asthma
100%
80%
60%
40%
20%
0%
69%
69%
74%
63%
68%
73%
59%
74%
69%
66%
69%
73%
NHPRI
UHCNE
BlueCHiP
Statewide

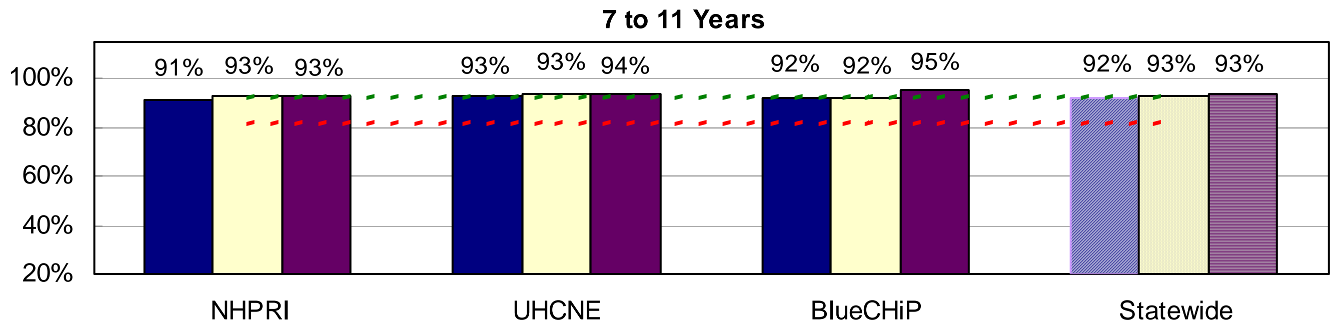

Cervical Cancer Screening
100%
80%
60%
40%
20%
0%
82%
82%
90%
83%
83%
85%
78%
78%
82%
81%
81%
85%
NHPRI
UHCNE
BlueCHiP
Statewide

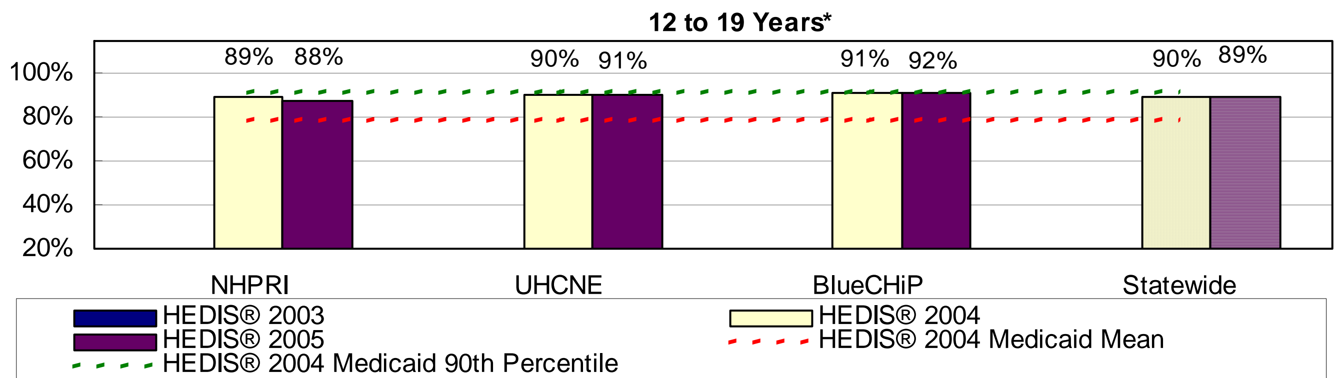

Chlamydia Screening
100%
80%
60%
40%
20%
0%
39%
44%
44%
48%
51%
53%
48%
47%
47%
42%
46%
47%
NHPRI
UHCNE
BlueCHiP
Statewide

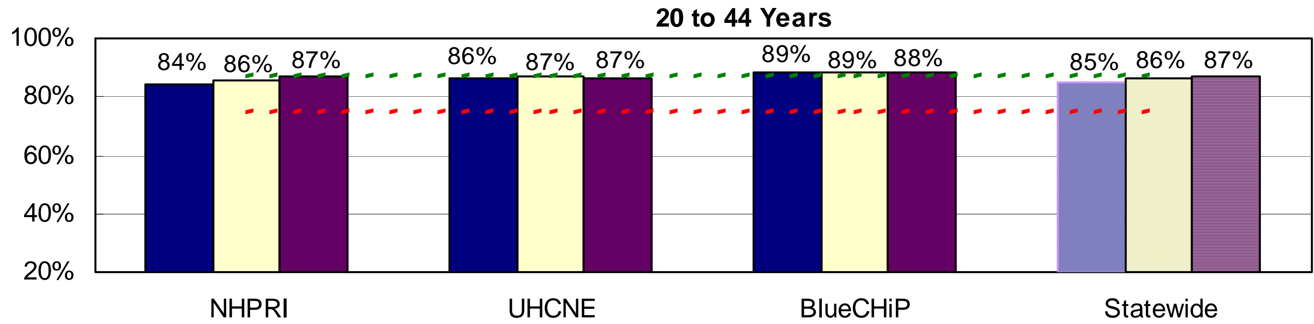
HEDIS® 2003
HEDIS® 2004
HEDIS® 2005
HEDIS® 2004 Medicaid MEAN
HEDIS® 2004 Medicaid 90th Percentile

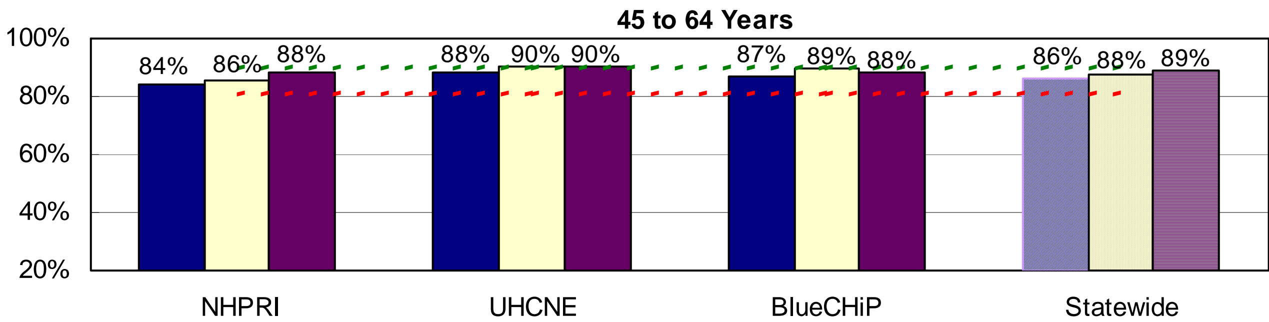

12 to 24 Months
100%
80%
60%
40%
97% 99% 98%
97% 98% 98%
93% 94% 98%
97% 98% 98%
NHPRI
UHCNE
BlueCHiP
Statewide

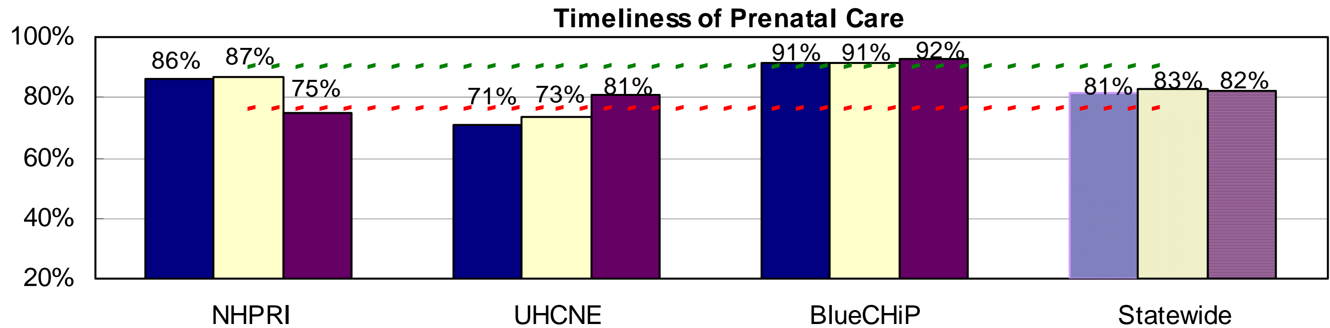

25 Months to 6 Years
100%
80%
60%
40%
20%
91% 92% 92%
92% 92% 91%
90% 88% 93%
91% 92% 92%
NHPRI
UHCNE
BlueCHiP
Statewide

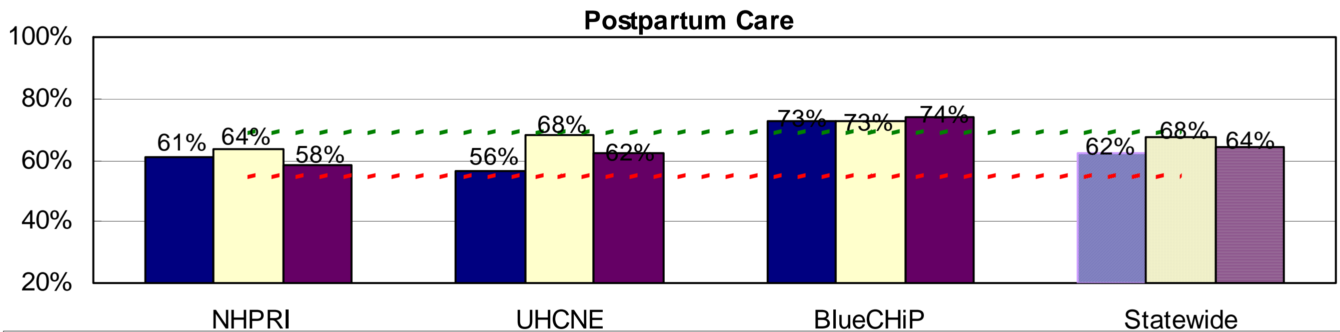

7 to 11 Years
100%
80%
60%
40%
20%
91% 93% 93%
93% 93% 94%
92% 92% 95%
92% 93% 93%
NHPRI
UHCNE
BlueCHiP
Statewide


12 to 19 Years*
100%
80%
60%
40%
20%
89% 88%
90% 91%
91% 92%
90% 89%
NHPRI
UHCNE
BlueCHiP
Statewide
HEDIS® 2003
HEDIS® 2004
HEDIS® 2005
HEDIS® 2004 Medicaid Mean
HEDIS® 2004 Medicaid 90th Percentile

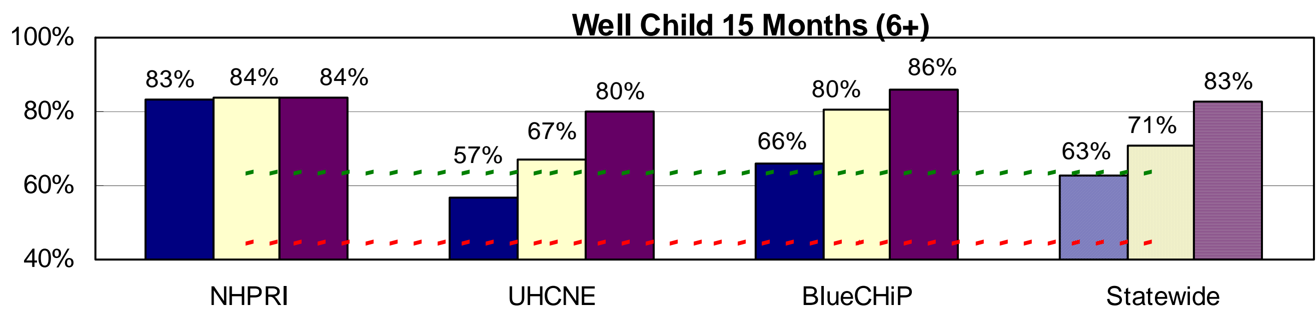

20 to 44 Years
100%
80%
60%
40%
20%
84%
86%
87%
86%
87%
87%
89%
89%
88%
85%
86%
87%
NHPRI
UHCNE
BlueCHiP
Statewide

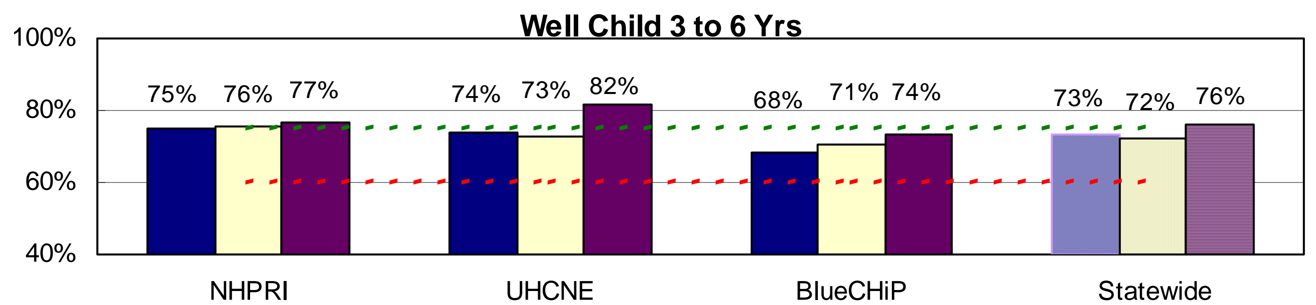

45 to 64 Years
100%
80%
60%
40%
20%
84%
86%
88%
88%
90%
90%
87%
89%
88%
86%
88%
89%
NHPRI
UHCNE
BlueCHiP
Statewide

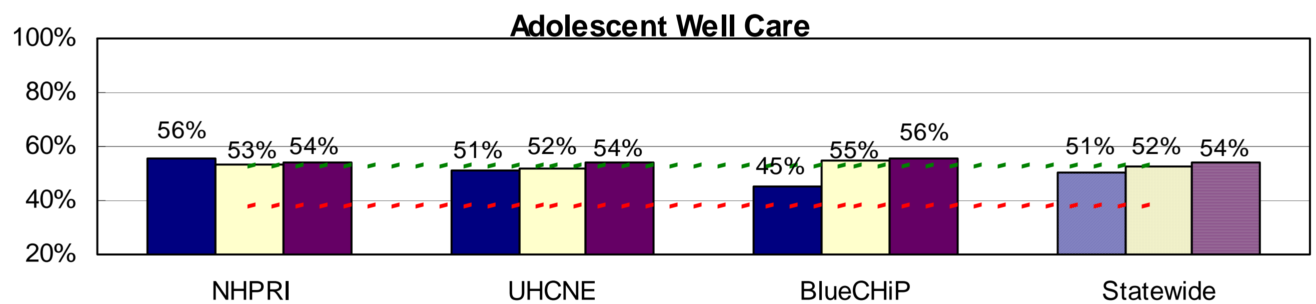

Timeliness of Prenatal Care
100%
80%
60%
40%
20%
86%
87%
75%
71%
73%
81%
91%
91%
92%
81%
83%
82%
NHPRI
UHCNE
BlueCHiP
Statewide

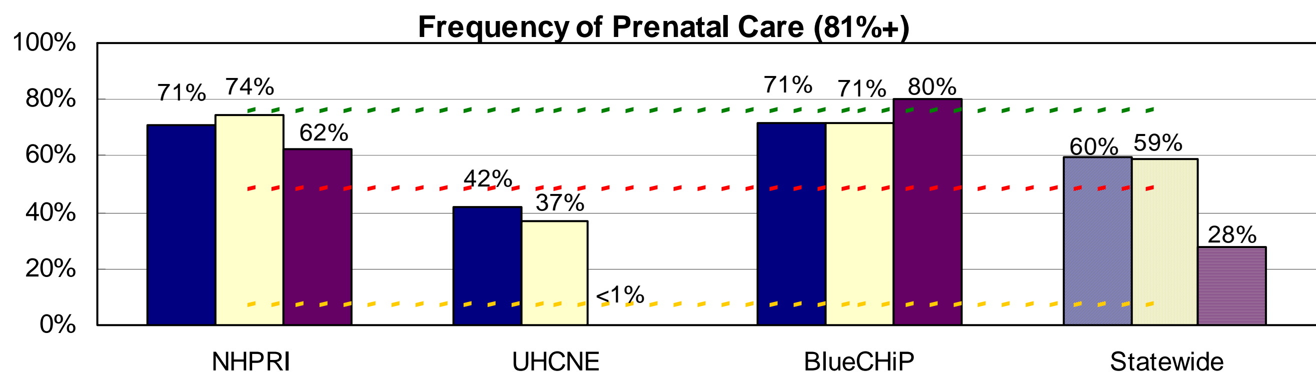

Postpartum Care
100%
80%
60%
40%
20%
61%
64%
58%
56%
68%
62%
73%
73%
74%
62%
68%
64%
NHPRI
UHCNE
BlueCHiP
Statewide

HEDIS® 2003
HEDIS® 2004
HEDIS® 2005
HEDIS® 2004 Medicaid Mean
HEDIS® 2004 Medicaid 90th Percentile









HEDIS® 2003
HEDIS® 2004
HEDIS® 2005
HEDIS® 2004 Medicaid Mean
HEDIS® 2004 10th Percentile
HEDIS® 2004 Medicaid 90th Percentile

(5) RIte Care's Quality Performance Is Nationally Recognized

RIte Care Health Plans have been nationally recognized for their quality. In fact, in 2005 the RIte Care Health Plans were ranked[108] among "America's Best Health Plans" in terms of quality compared to the other Medicaid plans in the country as follows:

- **1st** – BCBSRI, with an aggregate score of 92.0
- **3rd** – UHCNE, with an aggregate score of 90.2
- **6th** – NHPRI, with an aggregate score of 89.8

5. The State Has Made Information On The Demonstration Available On The DHS Website

During 2004, the State created a separate Website, accessible through the DHS Website, to make research and demonstration information available to the public. The subject Website is:

http://www.ritecareresearch.org

6. RITE CARE HAS CONTAINED COSTS

As illustrated clearly in Chapter 2, the RIte Care demonstration has been **budget neutral**.

7. SUMMARY

In Chapter 4, it was noted that Rhode Island has been the subject of much research, investigation, and scrutiny. The National Health Policy Forum at The George Washington University recently completed a review[109] of RIte Care and RIte Share. Supported by the David and Lucille Packard Foundation, which has enabled the National Health Policy Forum to focus on the importance of health insurance coverage and access to health services for low-income and families, the review is titled: *Doing It RIte: Exploring a Decade of Health Care Innovation*. The review may be summarized best as follows[110]:

> "The RIte Care program has been widely heralded as a success and an illustration that not all managed care is alike. Ongoing evaluations of the program have found increased enrollee access to primary care, specialty services, and improved health outcomes. And 97 percent of enrollees indicate that they are satisfied with RIte Care. Initial concerns from the advocacy community also seem to have been ameliorated."

The review team's "impressions" were as follows[111]:

---

[108] See: Hhttp://www.usnews.com/usnews/health/best-health-insurance/rankings/medicaid.htmH.

[109] National Health Policy Forum. *Doing It RIte: Exploring a Decade of Health Coverage Innovation*, The George Washington University, May 27-29, 2003.

[110] *Ibid.*, 2.

[111] *Ibid.*, 7-11.

- The importance of the term “willing co-conspirators” cannot be overemphasized in Rhode Island

- The commitment to children’s coverage was articulated by the creation of a Children’s Cabinet in 1991

- The Consumer Advisory Council (CAC) to the DHS has played an integral role in driving policymaking

- The advantages of being a small state came through clearly in the study of Rhode Island’s programs

- The notion of flexibility, both internally and externally, is of paramount importance in Rhode Island

- The commitment to program evaluation has played a critical role in the success and survival of Rhode Island’s health coverage expansion efforts

- Rhode Island has become a recognized leader in health coverage expansion

- The SCHIP program has been an invaluable financing source, but dependence on these funds could prove problematic in future years

- Rhode Island has stressed that the importance of preventive care is amplified when serving children

“Impressions” about RIte Care were:

- Managed care can work quite effectively under the right circumstances

- The commercial insurance market has had a significant impact on public health delivery systems in Rhode Island

- The successes illustrated by serving more vulnerable populations – rather than just healthy women and children – in RIte Care has led the State to expand the model to new populations

However, RIte Share was rightly viewed as “a work in progress”:

- The business community in Rhode Island has also exhibited a significant commitment to providing health benefits

- The RIte Share program – one of only a handful of successful premium assistance programs in operation in the country – vividly illustrates the potential of the public-private partnership

- The RIte Share program targeted the "low-hanging fruit"

- Implementation challenges remain

The review also underscored a number of challenges:

- The addition of a monthly premium to RIte Care has received mixed reviews

- Rhode Island still faces some issues with program retention

- Low-income children face a myriad of health and social challenges that are interconnected

- The transition of children with special health care needs may act as another litmus test of the effectiveness of managed care for people who are elderly or have disabilities

- The flexibility provided and utilized through Federal waivers has changed the face of Medicaid forever

The State believes this is a fair assessment of what has been accomplished.
More recently, *Governing*[112] has noted:

> "Rhode Island has the best record in the country at providing women with prenatal care. Credit goes to its RIte Care program, which has improved children's health generally. The key to this managed care effort comes in setting standards for provider performance and then following up to see that they are met. Attention to pre- and post-natal care results in lower infant mortality."

Governing[113] has also noted:

> "A few states have revamped their organization and management systems to ensure better access to medical care by keeping costs control. Rhode Island stands out in this respect."

Perhaps the RIte Care/RIte Share progress to date is summarized best as follows:[114]

> ". . . health insurance coverage alone is not the ultimate goal of such efforts. Improved health status and outcomes, improved access to care and improved quality of care are the desired results."

We believe the foregoing demonstrates that this is precisely what has been achieved in Rhode Island. In fact, Rhode Island has received some recognition for this as noted previously. In

[112] "Children's Care: Sudden Reversal", *Governing*, February 2004.
[113] "States that Stand Out", *Governing*, February 2004.

[114] Ferguson, C. C. and T. Leddy. "The 'New Medicaid': An Incremental Path To National Health Care Reform," *Family Planning Perspectives*, 31(3), June 1999, 149.

2001, DHS was honored to be among a handful of corporate and public purchasers to receive a Purchaser Award from the National Health Care Purchasing Institute for the RIte Care program to recognize DHS' "value purchasing" management philosophy. But perhaps the best description of RIte Care's success is embedded in the titles of the two recent national reports about RIte Care referenced previously – *Building Quality into RIte Care: How Rhode Island is Improving Health Care for its Low Income Populations* and *Doing It RIte: Exploring a Decade of Health Coverage Innovation*.

On December 6, 2004, the State celebrated the 10th anniversary of RIte Care at a luncheon attended by some 200 people at the Providence Marriott. In covering the event, *The Providence Journal* reported[115]:

> " 'They committed themselves early on to documenting the impact of the program,' Robert E. Hurley, professor of health administration at Virginia commonwealth University, in Richmond, said in a phone interview. 'You can see quite early and quite convincingly that beneficiaries are better off. The state is more aware of what it's buying. You build into the program a culture of improvement . . . I think people in Rhode Island should be very proud of what RIte Care has accomplished,' agreed Alan Weil, executive director and president of the National Academy for State Health Policy, Portland, Maine. "I think it's safe to say, you have a really innovative and effective program."

115 Freyer, F.J. "RIte Care marks decade of 'tremendous success'", *The Providence Journal*, December 7, 2004.

APPENDIX A

PERFORMANCE INCENTIVE GOALS FOR SFY 2006

APPENDIX A

2006 RIte Care Performance Goal Program Summary

Measurement Period: Calendar Year 2005

I. MEMBER SERVICES

1. Identification cards are distributed within ten (10) calendar days of Plan receipt of enrollment notification from DHS.

Standard: 98 percent
Reference Period: Calendar year 2005

Denominator is the number of all new-to-Plan enrollees whose enrollment has been communicated to the Plan via the MCKR-500 or by DHS/CCFH print screen. (Newborns and EFP excluded from goal program, but not from goal standard.)

Numerator is the number of new-to-Plan enrollees who have been mailed a new member ID card within 10 days of DHS enrollment notification.

Performance Assessment:

Review of Policies and Procedures
Detailed monthly reports with method to track time from enrollment to distribution of cards, showing turnaround time (TAT)
Actual performance as demonstrated in reports

2. Member handbooks are distributed within ten (10) calendar days of Plan receipt of enrollment notification.

Standard: 98 percent
Reference Period: Calendar year 2005

Denominator is the number of all new-to-Plan enrollees whose enrollment has been communicated to the Plan via the MCKR-500 or by DHS/CCFH print screen. (Newborns and EFP excluded from goal program, but not from goal standard.)

Numerator is the number of new-to-Plan enrollees who have been mailed a new member handbook within 10 days of DHS enrollment notification.

Performance Assessment:

Review of Policies and Procedures
Detailed monthly reports with method to track time from enrollment to distribution of member handbooks, showing turnaround time (TAT)
Actual performance as demonstrated in reports

3. A new member welcome call is completed within 30 calendar days from Plan notification of enrollment via MCKR-500 or DHS/CCFH screen print.

Standard: 65 percent
Reference Period: Calendar year 2005
Must be RIte Care specific

Denominator is the number of all new-to-Plan enrollees whose enrollment has been communicated to the Plan via the MCKR-500 or by DHS/CCFH print screen.

Numerator is the number of new-to-Plan enrollees who have a documented, completed new member "welcome call" within 20 days of DHS notification of enrollment.

Performance Assessment:

Part I. Policies and Procedures

Definitions of attempted and completed
Documentation of effort to contact

Part II. Health Plan tracking and monitoring

Reports demonstrating days from enrollment to completed call
Monthly performance against standard

4. Member and provider administrative, clinical (medical, behavioral health and pharmacy) appeals are resolved within contractual timeframes.

Standard: 97 percent
Reference Period: Calendar year 2005
Based on RIte Care standards

Denominator is the number of appeals received during the calendar year. (Quality of Care complaints are excluded.)

Numerator is the number of appeals resolved within the contractual timeframes.

Performance Assessment:

Review Policies and Procedures for identifying and acting upon grievances and appeals
Ensure that processes are in place to notify members of opportunities for grievances and appeals and for DHS Fair Hearing
Review logs or other Health Plan mechanisms for tracking complaints, grievances and appeals and resolution turnaround times
If no grievances (or appeals) ability to demonstrate resolution of issue before its elevation to grievance or appeal level
If grievances and appeals are present, percent resolved timely
Review the timing of the submission of contractually required informal complaint, grievance and appeals reports
Review templates of denial correspondence

II. PREVENTIVE CARE, MEDICAL HOME AND ACCESS TO CARE

1. Members have access to emergency services (CAHPS®).

Standard: 90 percent
Reference year: Calendar year 2005
RIte Care specific

Performance Assessment:

Health Plan's written materials for members provide clear direction for obtaining

care in the case of emergency:
— Member handbook
— Member ID card
Additional member education material on emergency, e.g. newsletter, other mailings
Provider contract, manual and provider education regarding policies on member access to emergency care
CAHPS survey questions on access to emergency care

2. Members were satisfied with access to urgent care (CAHPS®).

Standard: 80 percent
Reference year: Calendar year 2005
RIte Care specific

Performance Assessment:

Health Plan has established policies and procedures to inform members and providers (including behavioral health and pharmacy) about member access to urgent care and the RIte Care access standard.
Provider contract, manual and provider education regarding urgent care policy and RIte Care standard
Plans will specifically demonstrate members have sufficient telephone access to PCPs after business hours (including weekends and holidays) and that the PCP or covering PCP (TBD).
Plans will specifically demonstrate members have sufficient access to PCPs during business hours (TBD).
CAHPS® survey questions on access to urgent care

3. Members had access to urgent care appointments during business hours.

During 2006, the State and Health Plans have developed a proposed combined measure that addresses access to urgent care during business hours and access to PCPs after business hours (see Item II-4 below). This proposed measure will address ED utilization. A baseline rate of ED utilization will be calculated for calendar year 2005, based upon encounter data received by 03/31/2006. This combined measure will not be included in the award calculation for CY 2005.

4. Members had PCP telephone access after business hours.

During 2006, the State and Health Plans have developed a proposed combined measure that addresses access to urgent care during business hours (see Item II-3 above) and access to PCPs after business hours. This proposed measure will address ED utilization. A baseline rate of ED utilization will be calculated for calendar year 2005, based upon encounter data received by 03/31/2006. This combined measure will not be included in the award calculation for CY 2005.

5. Adult members had an ambulatory or preventive care visit.

Standard: 90 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the National Center for Quality Assurance (NCQA).

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

6. Child members had an ambulatory or preventive care visit.

Standard: 90 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

This measure will not be included in the award calculation for CY 2005. Please refer to Item II-11.

7. **Members had well-child visits in their first 15 months of life.**

Standard: 85 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

8. Members had well-child visits in their 3rd through 6th years of life.

Standard: 80 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

9. Adolescents who turned 13 years old received a second dose MMR and three Hepatitis B immunizations prior to their 13th birthday.

Standard: 75 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

10. Children who turned two years old received 4 DtaP/DT, 2 IPV, I MMR, 3 Hib, 3 Hepatitis B, and VZV immunizations.

Standard: 75 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

11. Children had a visit with a Health Plan PCP (HEDIS® Access).

Standard: 98 percent for members between 12 – 24 months of age; 95 percent for members between 25 months and six years of age, members between seven and 11 years of age, and 12 – 19 years of age.
Reference period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessments are based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominators are the HEDIS® denominators.

Numerators are the HEDIS® numerators.

12. Children received at least one age appropriate blood lead screen prior to their second birthday.

Standard: 85 Percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on analysis of the Plan's encounter data for CY 2005, received by 03/31/2006, or RI Department of Health data.

Denominator: All children who reach 24 months of age during the reference period and who have been enrolled with the Health Plan at least 31 days.

Numerator: Of the children identified in the denominator, all those with a blood lead screen between their 9th and 24th month.

13. Members 18 years of age and older received advice to quit smoking.

Standard: 70 percent
Reference Year: Calendar year 2005

RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited CAHPS® data submission to the NCQA.

Denominator is the CAHPS® denominator.

Numerator is the CAHPS® numerator.

14. Pregnant members received timely prenatal care.

Standard: 85 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

15. Pregnant members received timely postpartum care.

Standard: 90 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

16. Proposed New HEDIS® Use of Services Goal: Members between 12 – 21 years of age had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner.

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans have developed a proposed set of measures to address teen pregnancy. (Please refer to Items III-3 and III-4.) This proposed measure would address adolescents' receipt of well care. A baseline rate will be calculated for calendar year 2005.

III. WOMEN'S HEALTH

1. Female enrollees 18 – 64 years of age received cervical cancer screening.

Standard: 85 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

2. Female enrollees 16 – 25 years identified as sexually active received Chlamydia screening.

Standard: 85 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

3. First-time pregnancies for female enrollees less than 20 years of age decreased.

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans have developed a proposed set of incremental measures to address teen pregnancy. Please refer to Item II-16 for the baseline measurement of adolescent well care utilization.

4. Subsequent pregnancies for female enrollees less than 20 years of age decreased.

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans have developed a proposed set of measures to address teen pregnancy. Please refer to Item II-16 for the baseline measurement of adolescent well care utilization.

IV. CHRONIC CARE

1. Members between five and 17 years of age with asthma used appropriate medications.

Standard: 70 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Measure:

The measure should be reported for the following age stratifications:

- Members between five and nine years of age
- Members between 10 and 17 years of age
- The combined rate for members between five and 17 years of age

Denominators are the HEDIS® denominators.

Numerators are the HEDIS® numerators.

2. **Adult members with diabetes had HbA1c testing.**

Standard: 90 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

3. **Proposed New Chronic Care Goal (HEDIS® Effectiveness of Care Measure): Members 18 years of age and older as of the 120th day of the measurement year who were diagnosed with a new episode of depression and treated with antidepressant medication, and who remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.**

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans proposed that a new chronic care measure be added to the Performance Goal Program (HEDIS® Anti-depressant Medication Management: Effective Acute Phase Treatment). A baseline rate for this proposed HEDIS® measure will be calculated for calendar year 2005.

V. BEHAVIORAL HEALTH

1. **Members six years of age or older who were hospitalized for treatment of mental health disorders received a follow-up visit up to 30 days post discharge.**

Standard: 65 percent
Reference Period: Calendar year 2004
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

VI. RESOURCE MAXIMIZATION

1. **Health Plan notifies the Department of Human Services of any potential source of third-party liability (TPL) within five (5) days of such source becoming known to contractor or its subcontractors.**

Standard: 90 Percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Review of Policies and Procedures regarding TPL

Established method and reporting for internal review of TPL
Timely and regular reports provided to Center for Child and Family Health

2. Rate of prescription substitution of generic alternatives for brand-name medications, where generic equivalents exist.

Standard: 1 percent improvement annually
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's encounter data for CY 2005, received by 03/31/2006.

Denominator is the total number of prescription encounters, excluding over the counter (OTC) prescriptions.

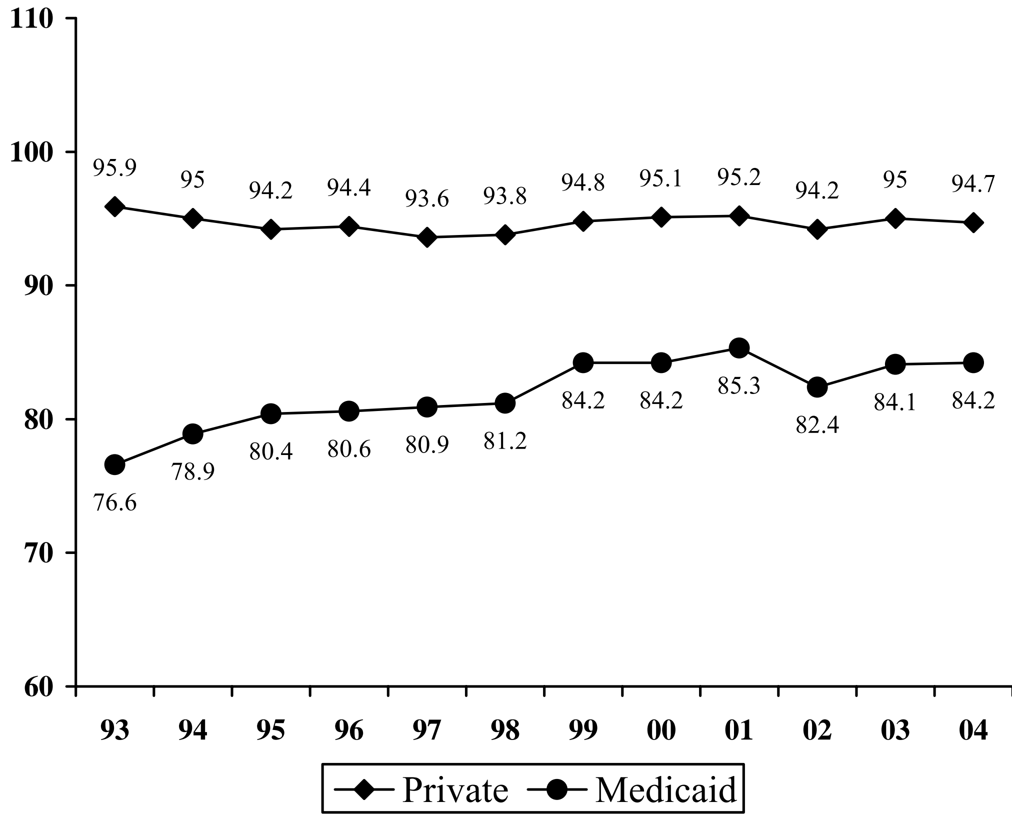
Numerator is the number of prescription encounters, excluding OTC claims, with a generic indicator.

APPENDIX B

THE IPMACT OF RITE CARE ON PREGNANT WOMEN AND THEIR NEWBORNS: 1993 - 2004

APPENDIX B

Percent of Women who Began Prenatal Care in
First Trimester by Insurance Coverage 1993-2004



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305)

APPENDIX C

DRAFT BUDGET NEUTRALITY PLAN

APPENDIX C

DRAFT BUDGET PLAN[116] FOR THE SECTION 1115 WAIVER DEMONSTRATION FOR PROJECT NO. 11-W-00004/1-01

Guiding Principles

This budget plan was formulated using four guiding principles. Application of these principles to the demonstration project ensures an affordable and accountable health care financing and delivery system. These guiding principles are:

- Focus on primary care, prevention and wellness
- Effective programs for the management of care for persons with chronic disease
- Efforts to promote use of care in the least-costly, most clinically appropriate setting
- A means to disseminate evidence-based clinical research for the delivery of high-quality, cost-effective health care

The above principles have been used to develop the current managed care organization (MCO) contracts that were put into place January 1, 2005, as well as new rates and performance requirements were effective January 1, 2006. These principles will continue to guide Rhode Island in the structure of future contracts and in other areas that affect the delivery of health care services to demonstration enrollees.

Budget Neutrality Monitoring Process

The Rhode Island Department of Human Services (DHS) has instituted a monthly meeting to review the budget neutrality status of the demonstration. The review includes both an update of the budget neutrality calculations through the end of the prior month as well as an examination of aggregate budget neutrality over the life of the demonstration. This meeting is also being used to review the status of initiatives to monitor and control demonstration expenditures and the ongoing effects of these initiatives on budget neutrality. As needed, these meetings will also be used to consider other initiatives or options for ensuring budget neutrality over the life of the demonstration.

The outcomes of these monthly meetings provide input to the monthly teleconferences with the Centers for Medicare & Medicaid Services (CMS) required by Section 24 of the Special Terms and Conditions (STCs) for the demonstration. On a quarterly basis, the results of the monthly meetings will also be used as a basis for reporting to CMS as required by Section 25 of the STCs. In addition and in conformance with Section 27 of the STCs, DHS will prepare budget neutrality assessments for submission to CMS at the end of Waiver Years (WYs) 12 and 13, respectively, projected through the end of WY 14. These assessments will be an outgrowth of the ongoing monthly reviews of budget neutrality.

[116] Was submitted to CMS on February 28, 2006, when the Rhode Island General Assembly was early in its 2006 session.

Below, some of the initiatives that the State has implemented to better control demonstration expenditures are described. These initiatives may be modified over time, and new ones may be added, as a result of the continuous monitoring of budget neutrality.

Payments to MCOs

Capitation payments for demonstration enrollees are by far the largest expenditure under the demonstration project. Because of the need to constrain the growth rate of demonstration costs, DHS closely examined the MCO capitation rates and the requirements for delivering services under the MCO contracts. DHS began the process of better controlling costs during the development and negotiation of the current MCO contract, which began January 1, 2006. The table below shows capitation rates effective January 1, 2006 in comparison to July 1, 2005.

Capitation Group	7/1/05 Rate	1/1/06 Rate	Percentage Increase
M/F <1	$ 445.43	$466.73	4.8%
M/F 1-5	$ 114.46	$114.24	(0.2%)
M/F 6-14	$ 97.27	$101.16	4.0%
M 15-44	$ 175.15	$186.33	6.4%
F 15-44	$ 250.31	$275.40	10.0%
M/F 45+	$ 418.64	$439.48	5.0%
SOBRA	$6,620.00	$6,843.00	3.4%
EFP	$ 29.42	$33.04	12.3%

These rate increases compare favorably with 12.89 percent that the State had projected based upon its historical trend as well as the 6 percent *Trend Rate* contained in STCs.

New MCO Performance Requirements

The new contract includes measures that will improve the efficiency of delivering services, while paying an actuarially sound rate that assures access, quality and MCO participation. DHS added a new performance requirement to its contracts with MCOs for the contracting period January 1, 2006 through June 30, 2007. This new performance requirement will result in cost savings in both the near term and over time. Each MCO must develop and implement medical management initiatives, examples of which include:

- Establishment of an inpatient admission avoidance program to reduce inpatient days per 1,000 member-months
- Implementation of a “Medicaid-only” formulary targeted to result in pharmacy cost savings
- Execution of a behavioral healthcare management initiative
- Other medical management initiatives, to be proposed by the MCO, such as programs to address emergency department utilization, acute rehabilitation, anesthesia reimbursement, radiology utilization review, the promotion of primary care provider access, laboratory and pathology contracting, and vendor arrangements for injectable medications.

The medical management initiatives are designed to achieve $4.38 per month per month (PMPM) in savings. These new measures were taken into consideration when the capitation payment rates for the new contract period were developed. The result of the new performance measure requirements and capitation payment rates is a lower rate of growth in demonstration expenditures. In addition, as a result of the new MCO contracts, Rhode Island expects risk-share payments to be less than previously projected.

Non-MCO State Initiatives

DHS is examining other initiatives to better constrain the growth in demonstration costs. Among the initiatives being examined are:

- **Permitting Utilization Review (UR) Agents to have more flexibility** – Presently, State UR regulations limit the ability of UR agents to manage care. DHS has explored with the Rhode Island Department of Health, the State department that certifies UR agents, to exempt Medicaid from some of the more restrictive requirements that limit the UR agent's ability to manage care directly with patients and their families or to manage care on-site (e.g., in a hospital). Either through amendment of the State UR statute or amendment of the RIte Care Health Plan Contract that would place DHS' requirements in conflict with the UR regulations, DHS will seek to give UR agents (i.e., the MCOs or any MCO subcontractors with delegated UR authority) the latitude to manage care such as neonatal intensive care unit (NICU) and inpatient behavioral healthcare. It should also be noted that DHS will monitor this area closely, recognizing that the particular portions of the UR regulations to be eased were established because of abuse by in the UR industry. DHS will make certain that this does not occur.

- **Expanding cost-sharing** – DHS is considering extending cost-sharing to households between 133 and 150 percent of the Federal poverty level (FPL). Cost-sharing would be three percent of family income, or $42 per month for the family's share of the premium. DHS is also considering increasing cost-sharing for families with incomes in excess of 150 percent of the FPL, as Table 2 shows. The new amounts be considered would still be within the Federal limits for the State Children's Health Insurance Program (SCHIP).

Table 2

Cost-Sharing Increases Being Considered by Rhode Island

Income Level	Monthly Family Premium As Of 8/1/02	New Monthly Premium Being Considered
150%-185% of FPL	$61	$80
185%-200% of FPL	$77	$98
200%-250% of FPL	$92	$106

- **Reduce Transitional Medical Assistance (TMA) from 18 to 12 months** – Rhode Island is considering reducing TMA from 18 to 12 months, which is the Federal minimum. This reduction would affect about 3,000 Medicaid families (9,000 individuals), although DHS estimates that 15 percent of the individuals would be found eligible under other Medicaid eligibility categories or by paying cost-sharing for their children.

- **Reduce Eligibility** – The State is also considering other reductions in eligibility. For example, the State is considering eliminating eligibility for some 6,800 parents and relative caretakers in households with incomes in excess of 133 percent of the FPL. Children in such households would continue to be eligible, however, through cost-sharing.

Such possible programmatic changes to constrain costs, while being considered, have not yet been adopted or implemented.

Conclusion

As a result of this budget plan including initiatives or options being contemplated but not yet adopted or implemented, the demonstration will continue to be budget neutral.