Medicaid & the Global Waiver

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Medicaid Fundamentals

Basic Elements

Insurances:

- The U.S. remains the only nation that is based on employer-purchased healthcare
- Privately insured individuals are generally drawn from the workforce, and typically are required to enroll during certain pre-set enrollment periods

Medicaid:

- Medicaid coverage is structured to cover and pay for comprehensive health services necessary for children; and adults with serious and chronic physical and mental health conditions
- No pre-set enrollment periods.
- Medicaid makes individuals eligible at the point of greatest health care need, eases their enrollment and retroactive.
- Medicaid (currently) limits permissible levels of patient cost-sharing, in recognition of most beneficiaries' virtual lack of discretionary income

Medicaid Basic Elements

Medicaid Financing:

- Federal-State partnership
- Federal Matching Assistance Program (FMAP)
  - Annual adjustment, 3-year average
  - Economic downturns
  - Deficit subsidy
- Every 1% change in FMAP equals approximately $12M in state general funds of federal contribution

Medicaid's Coverage Design Principles

- Nation's single largest source of health benefits, covering some 58 million children and adults
- Specifically designed to serve the needs of low-income beneficiaries as well as the severely disabled.
- Eligibility, benefit, and coverage structure mean that Medicaid takes on unique and irreplaceable healthcare task
- Children receive Early & Periodic Screening, Diagnostics, and Treatment (EPSDT) and Wrap-around coverage

EPSDT & Wrap Around Coverage

EPSDT Core Benefits:

- Periodic and "as needed" comprehensive health exams that include developmental assessments in addition to other exam elements
- All recommended immunizations
- Complete vision, dental and hearing services
- All diagnostic and treatment services needed
- A preventative purpose which translates into a preventative standard of medical necessity emphasizing the earliest possible health intervention in order to promote growth and development

Wrap Around Services - Family Supports:

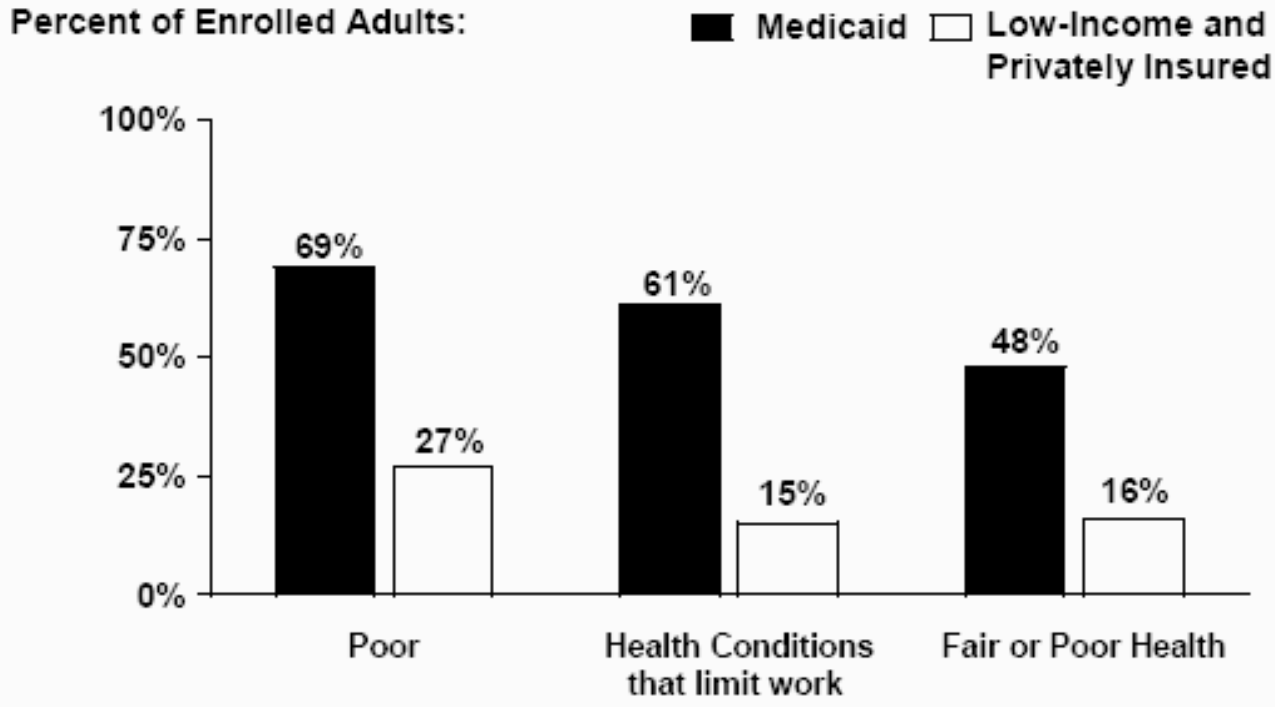
- Information about benefits and where to obtain EPSDT services
- Scheduling
- Transportation
- Links to other services such as WIC, Special education

Federal Cost Sharing Standards for Children Under 18 (State Option to Use)

2008 FPL(1): $10,400 2008 FPL(4): $21,200 +$3,600/additional	**"Mandatory" Children** *(Under age 6 up to 133% FPL and 6 to 17 up to 100% FPL)*	**Other Children with Family Income up to 150% FPL**	**Other Children with Family Income Above 150% FPL**
Most services	No charges allowed	Up to 10% of the cost of the service	Up to 20% of the cost of the service
Prescription drugs	Up to a maximum of $3 for "non-preferred" / $0 for preferred	Up to $3 for a non-preferred / may charge less for preferred	Up to 20% of cost for non-preferred / may charge less for preferred
Non-emergency use of an ER	Up to $6	Up to $6	Any amount
Preventive services	No charges allowed	No charges allowed	No charges allowed
Aggregate cap on charges	No cap	5% of monthly or quarterly income	5% of monthly or quarterly income
Premiums	Not allowed	Not allowed	Allowed with no upper limit except 5% cap

Figure 6

Medicaid Enrollees are Poorer and Sicker Than The Privately Insured



SOURCE: Coughlin et. al, 2004 based on a 2002 NSAF analysis for KCMU.

KAISER COMMISSION
Medicaid and the Uninsured

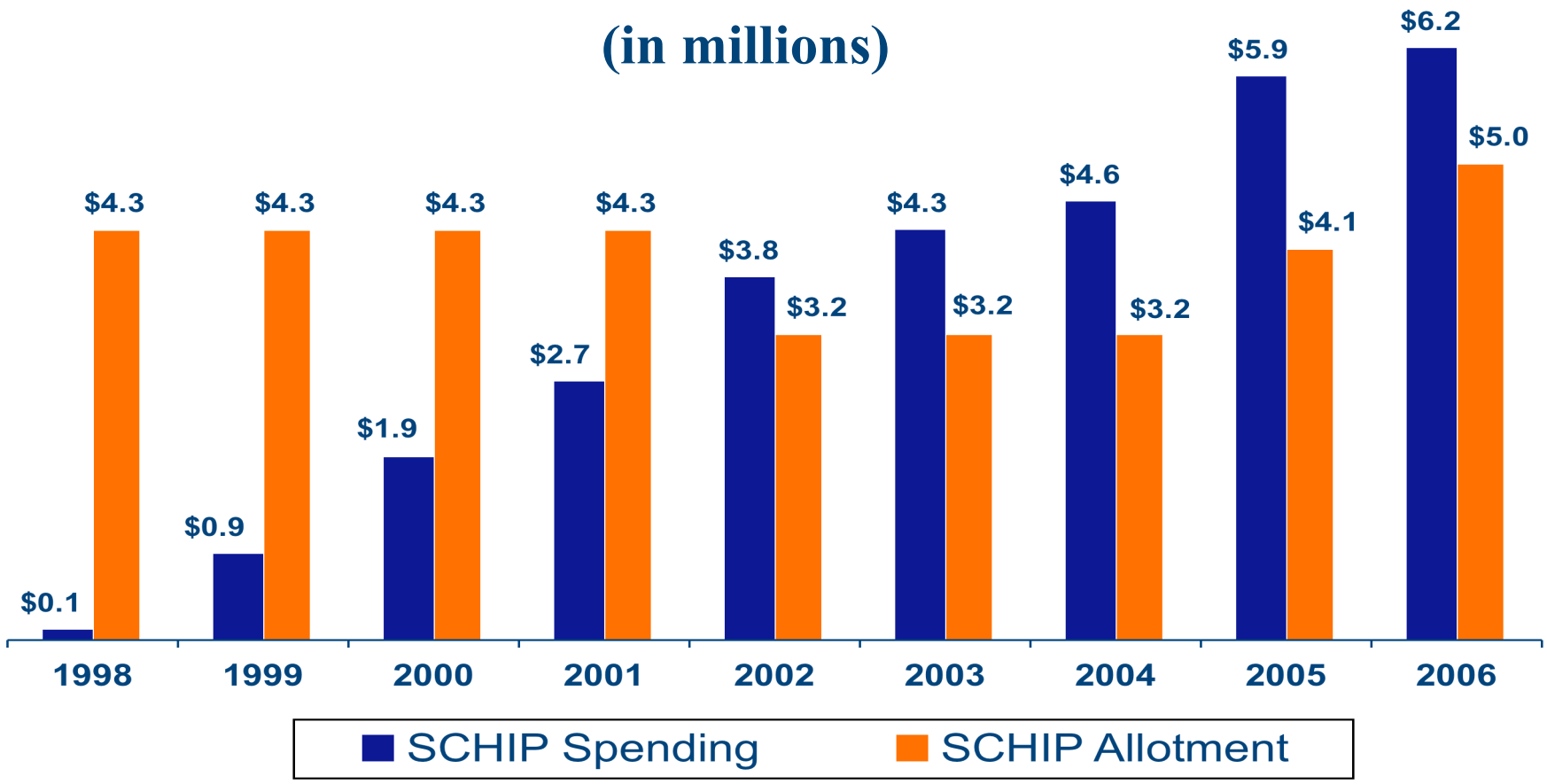
Medicaid's Evolution

- 1993, Clinton Administration:
  - using its authority under *§1115 of the Social Security Act*, began to encourage states to **expand** eligibility among additional "demonstration" populations through enrollment in health plans offering more limited benefits than the coverage available to "traditional" populations, with EPSDT wrap-around requirements for children.
    (Early and Periodic Screening, Diagnostic and Treatment)

Medicaid's Evolution

- 1997, State Children's Health Insurance Program (SCHIP), Title XXI of the BBA
  - Created new flexibility for states in the case of certain "targeted low income" children. At their option, states could **expand** Medicaid to reach additional children
  - Like Medicaid, SCHIP is a federal-state partnership, but with a cap placed on the federal spending.
  - SCHIP in RI = RIte Care
  - SCHIP receives enhanced FMAP
  - Shortfalls or deficits are usually managed by temporary FMAP increases.

SCHIP Spending is Rapidly Outpacing New Funds Being Made Available



Source: Data received from HHS, 2006.

Medicaid's Evolution

- 2003, Health Insurance Flexibility and Accountability (HIFA):
  - The Bush Administration continued this conversion to limited-benefit coverage by using §1115 demonstration authority to permit states to combine limited-benefit expansions for experimental populations *with* ***reduced*** *benefits to traditional beneficiary groups*.

Medicaid's Evolution

- 2005, Deficit Reduction Act (DRA):
  - The DRA opens a new era in Medicaid by permitting states to **limit the coverage** for poverty-level children and parents to "benchmark" or "benchmark-equivalent"
  - Changes to federal benefit standards
  - Weakening of federal cost sharing standards
  - NEW mandate to document citizenship

Appendix A. Comparing EPSDT and Benchmark Equivalent Coverage

EPSDT	Benchmark Equivalent Coverage
Periodic and "as needed" screening services that include: • Unclothed physical examination • Comprehensive health and developmental history (including assessment of both physical and mental health development) • Immunizations recommended by the CDC advisory committee on immunization practices (ACIP) • Laboratory tests including assessment of blood lead levels • Health education and anticipatory guidance	**Well-baby and well-child care, including age-appropriate immunizations** • Required at full actuarial equivalence • Undefined in content • Undefined in frequency
Vision services (periodic and as needed) • Assessment • Diagnosis • Treatment, including eyeglasses	**Vision services** • Not required • Undefined in content • If furnished, 75% of actuarial value
Hearing services (periodic and as needed) • Assessment • Diagnosis • Treatment, including hearing aids and speech therapy	**Hearing Services** • Not required • Undefined in content • If furnished, 75% of actuarial value
Dental services (periodic and as needed) • Preventative beginning not later than age 3 or earlier if medically indicated • Restorative beginning not later than age 3 or earlier if medically indicated • Emergency care beginning not later than age 3 or earlier if medically indicated	**Other appropriate preventive services as designated by HHS** • Required but only at Secretarial discretion • Undefined in frequency or content • If required by secretary, full actuarial value
Diagnostic and treatment services that are medically necessary and the need for which is disclosed by a periodic or interperiodic screen • Standard of coverage: early, to correct or ameliorate defects and physical and mental health conditions discovered by screening services, whether or not such services are covered under the state medical assistance plan. These services include: • Physician services • Hospital Services (outpatient and inpatient) • Federal qualified health center services • Rural health clinic services • Family planning services and supplies • Medical care or any other type of remedial care recognized under state law or furnished by	**Hospital, physician, and laboratory services** • Required • Undefined in frequency and standard of coverage • Full actuarial value **Prescription drugs** • Optional • Undefined • 75% actuarial value **Laboratory and x-ray services**

EPSDT	Benchmark Equivalent Coverage
licensed practitioners within the scope of their practice; as defined by state law • Home based care • Private duty nursing services • Dental services • Clinic services • Physical therapy and related services • Prescribed drugs • Dentures • Prosthetic devices • Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial service (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Services in an intermediate care facility for the mentally retarded and inpatient psychiatric services for individuals under age 21 • Nurse midwife and certified pediatric nurse practitioner services to the extent that such services are authorized under state law • Case management • Respiratory care • Personal care services • Any other medical or remedial care recognized by the Secretary of Health and Human Services	• Required • Undefined • Full actuarial value **Mental health services** • Optional • Undefined • 75% actuarial value **Vision services** • Optional • Undefined • 75% of actuarial value

Source: S. Rosenbaum and A.R. Markus, (2006). The Deficit Reduction Act of 2005: An Overview of Key Provisions and Their Implications for Early Childhood Development (The George Washington University School of Public Health and Health Services, Washington D.C. , February) [Prepared for the Commonwealth Fund]

Medicaid's Evolution

- 2007, SCHIP Reauthorization – extension through March 2009.
- Main issues:
  - Income eligibility levels
  - Immigration
  - Parents and childless adults
  - 'Crowd-out'

RI Approach: Misaligned Incentives

The State offers plans per capita payment levels

- actuarially equivalent to a benchmark
- not necessarily in relation to the actual needs of patients

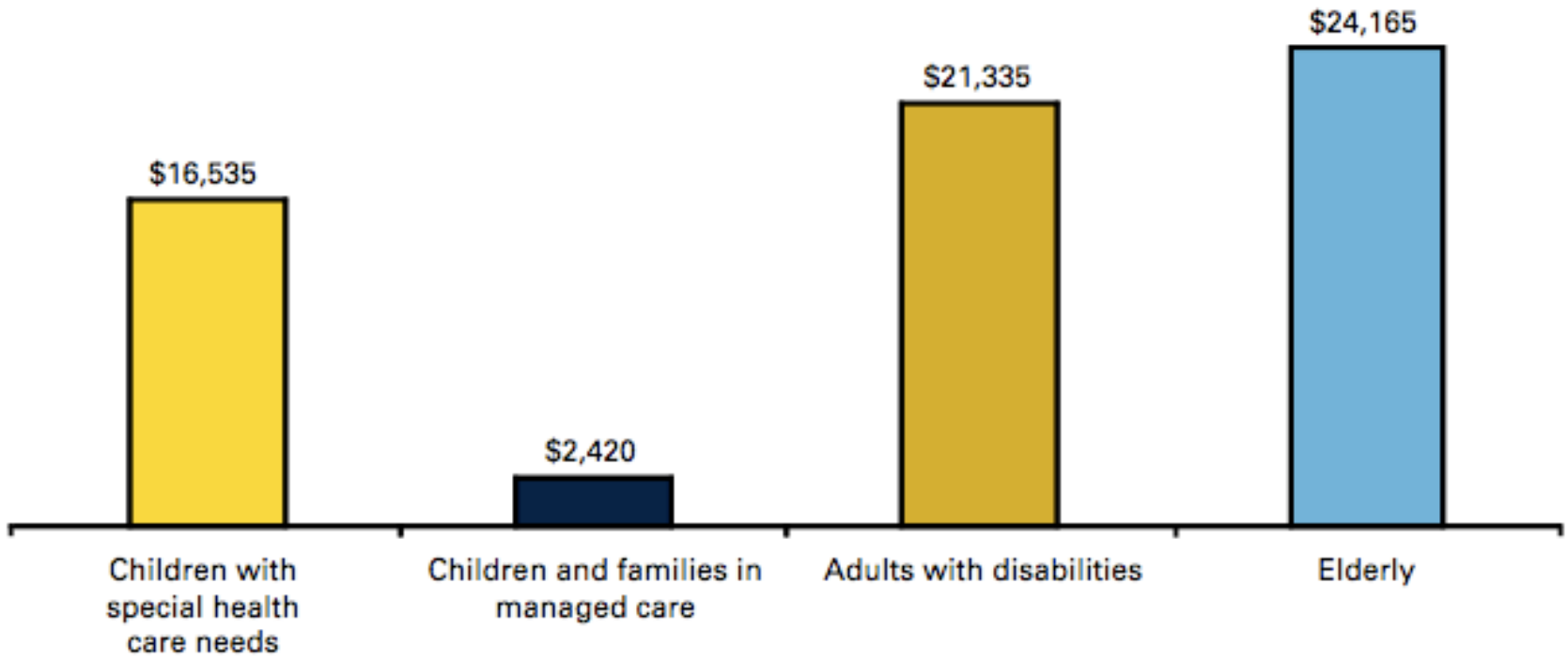
↓

Participating plans design - and redesign - their benefit and coverage rules in order to stay within the payment levels offered

↓

The Managed Care plans then pay providers on a fee-for-service basis

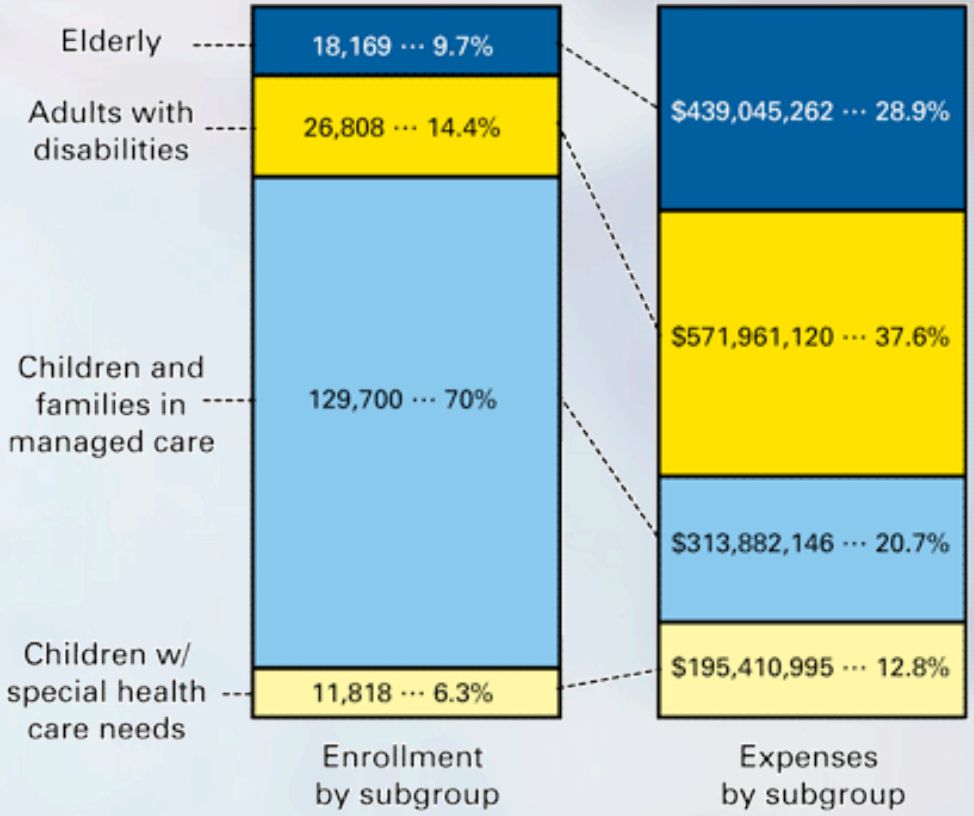
RI Per Member Average Medicaid Costs



Source: Medicaid claims extract

Children are not the Cost Drivers

Medicaid enrollment / expense comparison by subgroup
SFY 2005



RI Medicaid Cost Drivers

- Elderly and disabled adults represent 24% of enrollees and 67% of costs.

- This is a failure of the National policies to address the long-term care needs of America's aging population.

- RI has a higher % of nursing home residents than the national average that augments our problem.

- RI Medicaid expenditures are 2nd in the nation, per capita!

Control Strategies

Options:

- Limit benefit design
- Limit coverage for certain populations
- Cap the total amount of per-enrollee expenditures
- Increase cost sharing
- Limit eligibility
- Provider vs. patient management

Control Strategies

NYT, 9/15/08

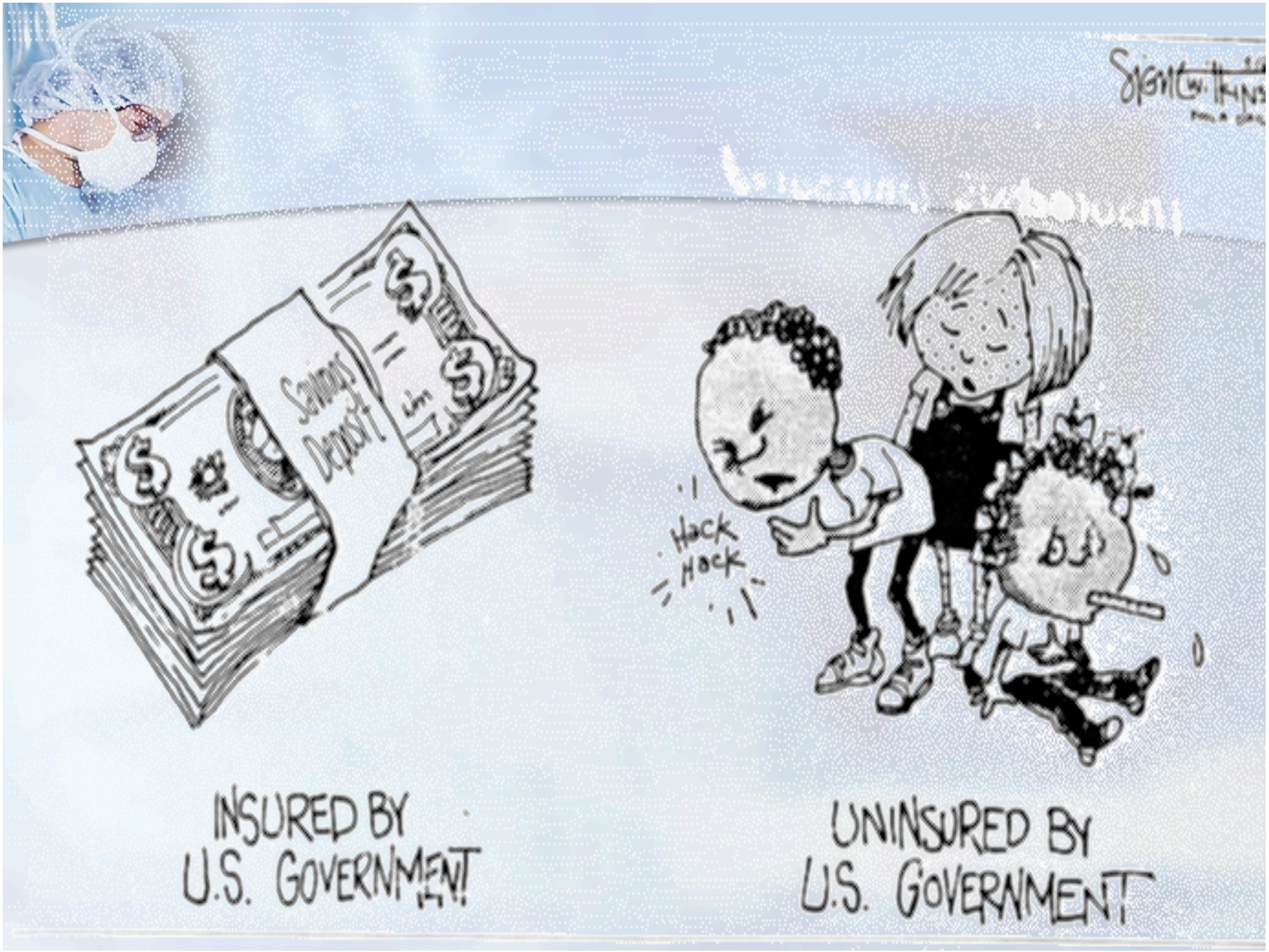
Employers are making the same choices…

Cutting Costs, Cutting Benefits

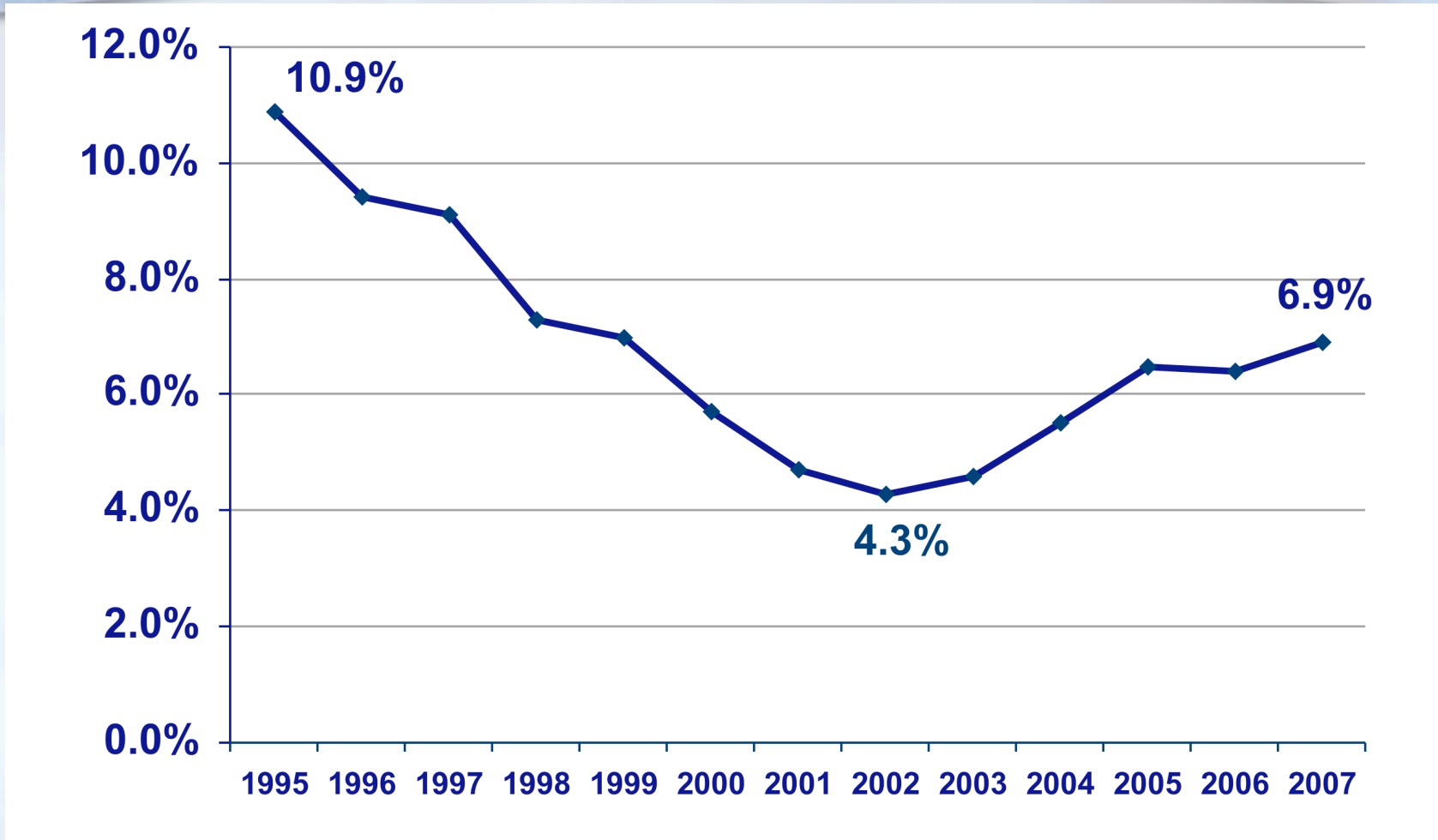
In a recent survey, employers said they planned to lower the cost of their employees' health benefits in 2009 by:

Raising deductibles and co-payments	59%
Changing employee premium requirements	47%
Improving the health management program	38%
Adding consumer-directed plans	19%
Reducing services that are covered	10%
Making eligibility requirements more strict	8%

Source: Mercer THE NEW YORK TIMES


Savings Deposit
Hack Hack
INSURED BY U.S. GOVERNMENT!
UNINSURED BY U.S. GOVERNMENT

Children without Health Insurance, Rhode Island, 1995-2007



Source: US Census Bureau, Current Population Survey, 1994-2008, three-year averages, compiled by Rhode Island KIDS COUNT. Data are for children under 18 years of age.

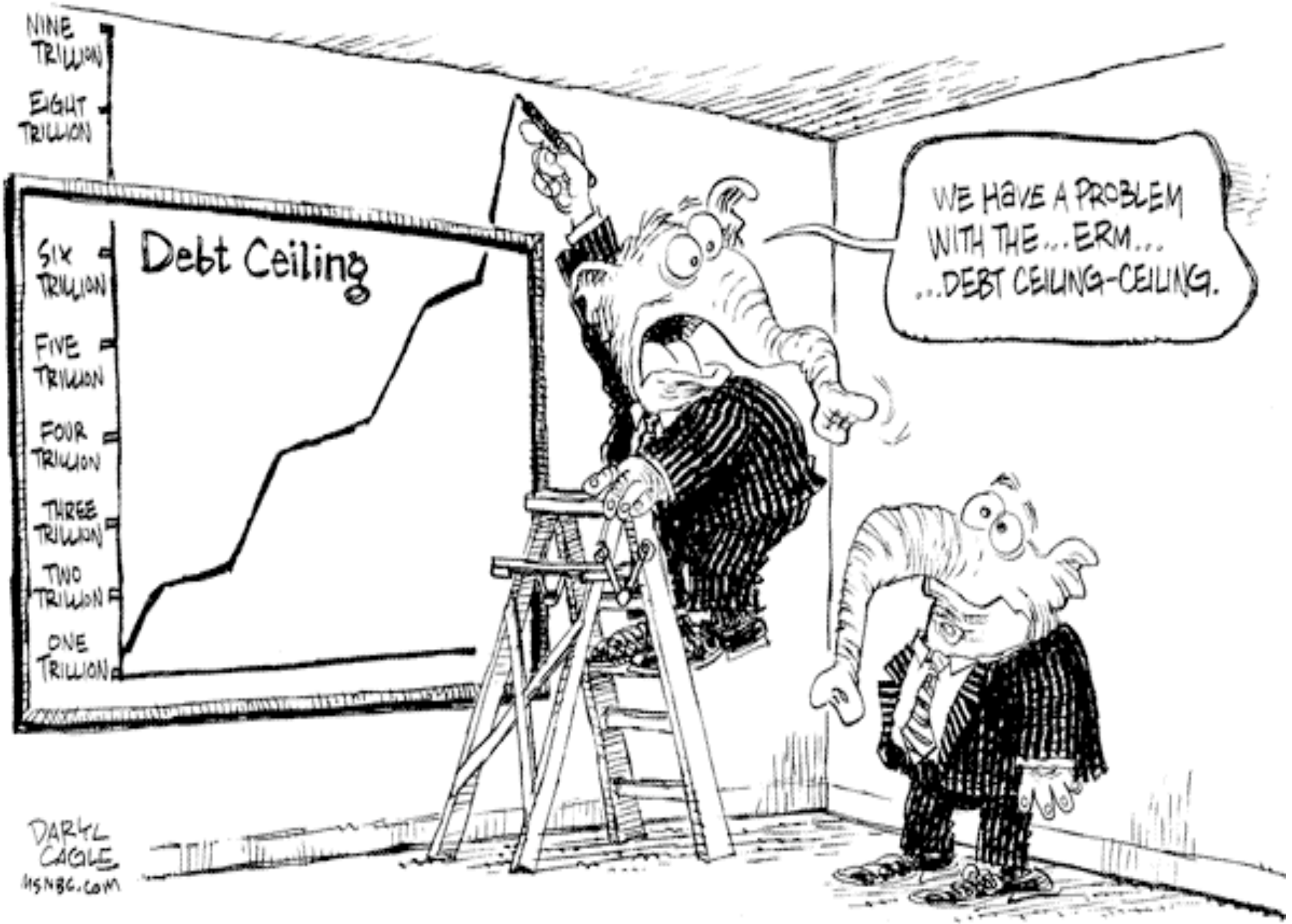
Ideological Debate

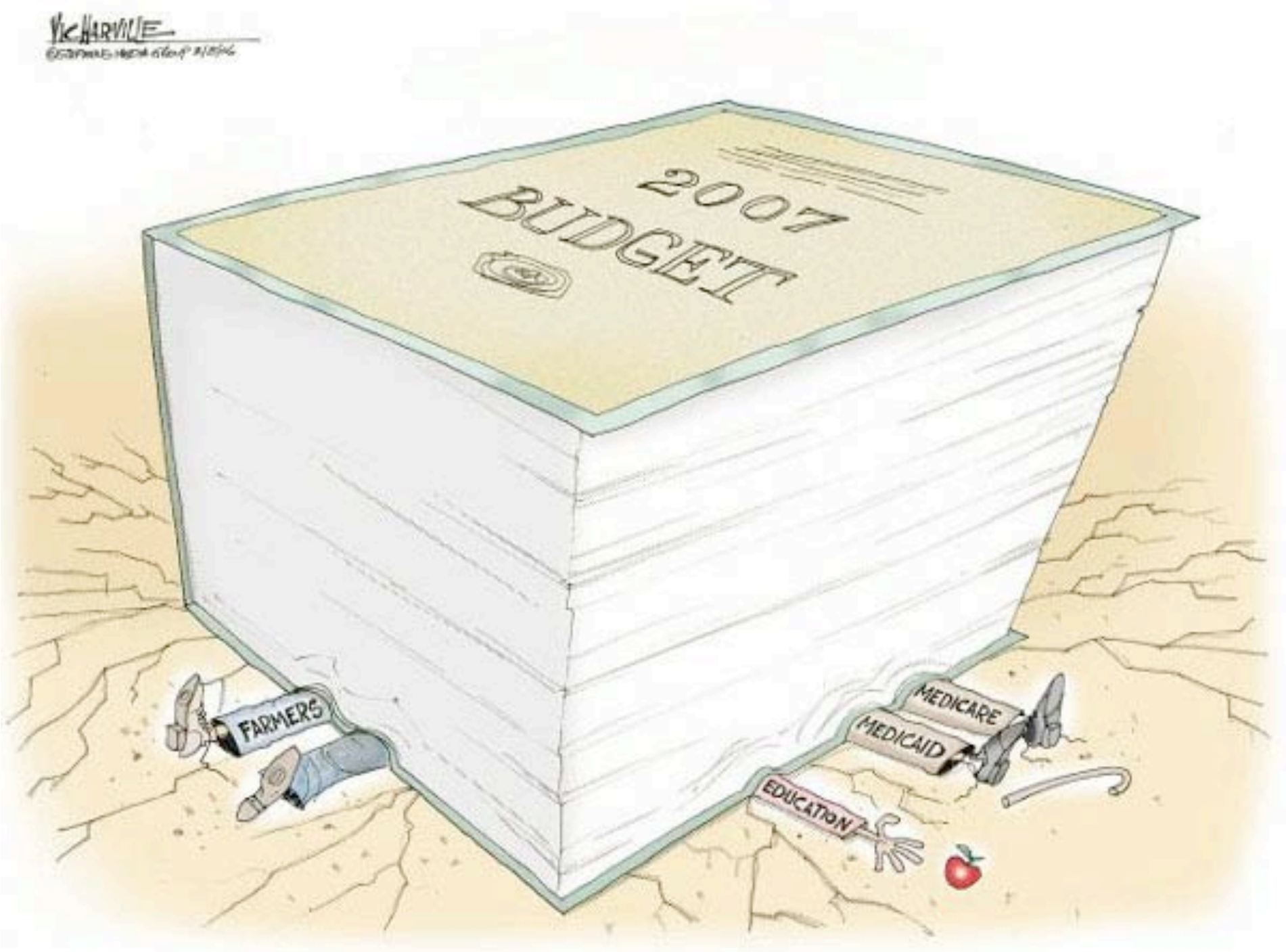
- Who is responsible for health care coverage and costs?
  - Individuals vs. state vs. employers vs. federal?
  - Entitlement? Right? Responsibility?
  - Federal standards vs. state flexibility


WELL, I CAN'T IMAGINE THIS SITUATION GETTING ANY WORSE...
I HAVE TO GO POTTY.
CAM
OTTAWACITIZEN
canadacartoons.com

Why Reform?

- A steady increase in the number of enrolled working-age adults and children as a result of:
  - sustained poverty
  - increasing unemployment
  - declining access to employer-sponsored benefits in low wage industries
- Aging society
- Greater survival of children and both non-elderly and elderly adults with serious health conditions


NINE TRILLION
EIGHT TRILLION
SIX TRILLION
FIVE TRILLION
FOUR TRILLION
THREE TRILLION
TWO TRILLION
ONE TRILLION
Debt Ceiling
WE HAVE A PROBLEM WITH THE... ERM... ...DEBT CEILING-CEILING.
DARYL CAGLE
MSNBC.COM


VICHARVILLE
2007
BUDGET
FARMERS
MEDICARE
MEDICAID
EDUCATION

Article 17

CHAPTER 42-12.4

THE RHODE ISLAND MEDICAID

REFORM ACT OF 2008

42-12.4-1. Short title. - This chapter shall be known and cited as "The Rhode Island Medicaid Reform Act of 2008.

42-12.4-2. Legislative intent. – (a) It is the intent of the general assembly that Medicaid

shall be a sustainable, cost-effective, person-centered and opportunity-driven program utilizing

competitive and value-based purchasing to maximize available service options; and

(b) It is the intent of the general assembly to fundamentally redesign the Medicaid Program in order to achieve a person-centered and opportunity driven program; and

(c) It is the intent of the general assembly that the Medical Assistance Program be a results oriented system of coordinated care that focuses on independence and choice that maximizes the available service options, promotes accountability and transparency; encourages

and rewards healthy outcomes and responsible choices; and promotes efficiencies through interdepartmental cooperation

Waiver Options

- Global vs. Population-specific?
- Global Cap vs. Per-capita Cap?
- Central vs. Distributed management of care?
- Block grant vs. Matching funds

Vermont Waiver

- Created single MCO for Medicaid beneficiaries
- Separate Acute Care waiver and Long-term care waivers
- Up to the level of the cap, the federal government continues to match expenses.
- Set at a level well above the amount the state expected to spend over the five-year waiver period.
- In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own non-Medicaid health programs, creating a fiscal windfall for the state.

Florida Waiver

- MCOs compete for Medicaid beneficiaries by offering different benefit packages
- People can change MCO, but only during open-enrollment, annually
- Or, receive risk-adjusted premium to purchase private coverage
- Class-action lawsuit

"The Waiver"

Application for the Rhode Island Consumer Choice Global Compact Waiver

The Rhode Island Global Consumer Choice Compact Waiver

Person-Centered, Opportunity Driven, Outcome-based, System of Coordinated Health Care

The RI Medicaid Global Waiver

3 Goals:

- Rebalance the Long Term Care System
  - Enhance access in most appropriate setting
- Manage care across all Medicaid Populations
  - *Build* on RIte Care, ConnectCare Choice (PCCM), PACE, and Rhody Health Partners to ensure coordinated and accessible care management for all Medicaid enrollees
- Complete transition from payer to purchaser
  - Link reimbursement to performance and quality of care
  - Selective purchasing

Eligibility, Programs & Services Under The Medicaid Global Waiver

The following will remain the same:

- Federally *mandated* populations and services
- RIte Care managed care design will continue (health plan & services)
- Institutional care settings will remain an option for individuals with the *highest* needs

Eligibility, Programs & Services Under The Medicaid Global Waiver

The following may be changed under the Global Waiver:

- Coverage for new populations:
  - Parents with children in state custody who are pursuing behavioral health treatment;
  - Elders at risk for long term care who could remain in their homes if they received home and community based services
- Income disregards for adults with disabilities living in the community
- Personal assistance budgets for individuals wanting to manage their own care (self-directed care)
- Wraparound services enabling children to transition home from residential
- Quality assurance and improvement systems

Eligibility, Programs & Services Under The Medicaid Global Waiver

The following may be changed under the Global Waiver:

- Cost-sharing for certain RIte Care populations above Federal allowances
- Waiting lists for optional populations (133% FPL and above)
- *Rate adjustments for providers* to enhance home and community-based system capacity
- Healthy Choice Accounts (HCAs) to provide incentives for health behaviors, use of primary care, and reduced use of emergency department
- Selective contracting

Financing Structure of the Medicaid Global Waiver

- Proposes single budget (single risk pool) for acute care and LTC services
- Proposes to eliminate the current federal matching system (FMAP) and to replace with a block grant with a *maximum amount* to be spent by the *state and federal governments* over the next 3-5 years
- The state would have a "maintenance of effort" (MOE) required amount of spending, which would be set at 23% of the general revenue budget for the waiver years (base year 2007). In effect, this caps the State's contributions.

Spending Projections

Rhode Island Waiver Projections (in millions of dollars)						
	FFY 09	FFY10	FFY11	FFY12	FFY13	5-year total
Medicaid expenditure forecast	$2,074	$2,257	$2,454	$2,677	$2,924	$12,386
Federal block grant	$1,089	$1,219	$1,325	$1,446	$1,579	$6,658
State MOE	$754	$799	$822	$850	$878	$4,103
Total anticipated spending (block grant + MOE)	$1,843	$2,018	$2,147	$2,296	$2,457	$10,761
Difference between total spending and expenditure forecast	$231	$239	$307	$381	$467	$1,625
Federal share of total spending	59%	60%	62%	63%	64%	62%

Deficit

* The difference between total spending and the expenditure forecast, as well as the federal share of total expenditures, were calculated by CBPP based on written and oral testimony at the August 5 hearing (http://www.ohhs.ri.gov/medicaid/pdf/WaiverPresentationHouse8-08.pdf).

R.I. Seeks Limits on Medicaid Spending
Washington Post
September 5, 2008

"By the state's own estimates, the combined total of state and federal expenditures would fall substantially short of projected needs, with the gap growing from $231 million next year to nearly $500 million in fiscal 2013. Rhode Island proposes to fill that gap by delivering health care more efficiently, primarily by reducing demand for such high-cost facilities as nursing homes and increasing the availability of in-home and community-based care for the elderly and the disabled."

"But the proposal also seeks to charge poor families a premium for using the emergency room instead of visiting a primary-care doctor, to increase co-payments and premiums beyond the level set by federal law, and to restrict access to certain facilities and 'optional' services, such as dental care, including by establishing waiting lists and 'restricting services to certain geographical areas of the state.'"

"Optional" Populations and Services

Maximum Annual Income Eligibility Levels for "Mandatory" and "Optional" Beneficiaries in Rhode Island*		
	Mandatory	Optional
Children under six years old	At or below 133 percent of the poverty line ($23,408)	Between 133 and 250 percent of the poverty line ($44,000)
Children from six to 19	Below the poverty line ($17,600)	Between 100 and 250 percent of the poverty line ($44,000)
Parents	Below 38 percent of the poverty line ($6,648)	Between 38 and 175 percent of the poverty line ($30,800)
Seniors and people with disabilities	Below 74 percent of the poverty line ($7,696)	Between 74 and 100 percent of the poverty line ($10,400)

*Amounts based on poverty guidelines for a family of 3 for children and parents and for a single individual for seniors and people with disabilities.

Examples:

- Prescription medications
- Dental care
- Transportation services
- Community-based services like day treatment for individuals with developmental disabilities

"Optional" Populations

"Optional" Populations

Does saving direct costs on 'optional' populations and services actually save the system money?

Or, are we in a pay now or pay later system?

We do not lose money by covering everyone.

We gain the ability to manage the care more effectively

'Rate Adjustments'

Gary Alexander: Sustainable Medicaid reform for R.I.

Providence Journal
01:00 AM EDT on Thursday, August 28, 2008
GARY ALEXANDER

IN 1965, the Medicaid program was created to provide health coverage to a limited number of low-income and disabled people Distinct from the similarly-named Medicare program, Medicaid is funded jointly by the federal government and individual states. Over the next four decades, the desire to supply health insurance to the needy turned into one of the nation's most costly programs. Without systemic reform, it may bankrupt Rhode Island….

…The first and foremost purpose of Medicaid should be to provide the highest quality of care and services to individuals who cannot afford it and the state's most vulnerable, ***not to line the pockets of health-care providers.***

RI Medicaid vs Medicare

AAP Medicaid Reimbursement Survey: Rhode Island

2007/08 Medicaid Payments for Commonly Reported Pediatric CPT™ Codes

	Medicaid	Medicare	%Medicare
Preventive Medicine Services - ≈ 33.5% MC			
99381 - New Patient, under 1 year	$37.00	$95.52	38.7%
99382 - New Patient, 1 through 4 years	$37.00	$101.27	36.5%
99383 - New Patient, 5 through 11 years	$37.00	$101.46	36.5%
99384 - New Patient, 12 through 17 years	$42.00	$110.39	38.0%
99385 - New Patient, 18 through 39 years	$27.24	$110.39	24.7%
99391 - Established Patient, under 1 year	$27.00	$74.60	36.2%
99392 - Established Patient, 1 through 4 years	$27.00	$83.13	32.5%
99393 - Established Patient, 5 through 11 years	$27.00	$82.38	32.8%
99394 - Established Patient, 12 through 17 years	$27.00	$90.57	29.8%
99395 - Established Patient, 18 through 39 years	$27.00	$91.32	29.6%
99401 - Individual Counseling, 15 min	NC	$38.40	--
99402 - Individual Counseling, 30 min	NC	$64.45	--
Office and Other Outpatient Services - ≈ 37.9% MC			
99201 - New Patient, office visit	$16.72	$36.01	46.4%
99202 - New Patient, expanded office visit	$27.24	$63.03	43.2%
99203 - New Patient, low complexity	$29.00	$93.41	31.0%
99204 - New Patient, moderate complexity	$45.00	$142.38	31.6%
99205 - New Patient, high complexity	$46.00	$178.87	25.7%
99211 - Established Patient, office visit	$8.05	$20.18	39.9%
99212 - Established Patient, expanded office visit	$20.64	$37.14	55.6%
99213 - Established Patient, low complexity	$20.64	$60.55	34.1%
99214 - Established Patient, moderate complexity	$27.00	$91.82	29.4%
99215 - Established Patient, high complexity	$32.00	$124.32	25.7%
92551 - Screening test, hearing evaluation	$8.00	NIS	--
92567 - Tympanometry, hearing evaluation	$11.56	$21.19	54.6%
99173 - Screening test, visual acuity	NC	$2.59	--
Newborn Care			
99431 - Initial newborn care	$38.18	$56.42	67.7%
99433 - Subsequent newborn care	$24.00	$29.99	80.0%
99435 - Admit and discharge on same day	$65.02	$76.53	85.0%
99436 - Physician attendance at delivery	$65.02	$72.02	90.3%
99440 - Newborn resuscitation	$33.00	$141.30	23.4%
54150 - Circumcision; newborn	$25.20	$129.48	19.5%

State*	PRIMARY CARE CODES : *Preventive Medicine Services*								
	99381	99382	99383	99384	99385	99391	99392	99393	99394
Alabama	NC	NC	NC	NC	NC	$27.00	$27.00	$27.00	$27.00
Alaska	$138.46	$149.29	$147.09	$159.53	$153.53	$107.82	$120.26	$119.16	$131.10
Arizona	$94.16	$101.46	$99.96	$108.41	$108.41	$73.28	$81.73	$80.98	$89.03
Arkansas	$56.41	$56.41	$56.41	$56.41	$56.41	$56.41	$56.41	$56.41	$56.41
California	$45.33	$47.13	$54.83	$65.78	NC	$34.69	$37.39	$43.85	$54.83
Colorado	$55.05	$55.05	$55.05	$55.05	$55.05	$69.02	$77.31	$40.15	$40.15
Connecticut	$93.60	$93.60	$93.60	$93.60	$93.60	$93.60	$93.60	$93.60	$93.60
Delaware	$95.67	$103.08	$101.53	$110.05	$110.05	$74.40	$82.91	$82.14	$90.32
Dist of Columbia	$80.00	$45.00	$45.00	$60.00	$60.00	$30.00	$30.00	$30.00	$45.00
Florida	$71.59	$71.59	$71.59	$71.59	$71.59	$71.59	$71.59	$71.59	$71.59
Georgia	$67.38	$67.38	$55.38	$55.38	$55.38	$67.38	$67.38	$67.38	$55.38
Hawaii	$95.00	$95.00	$95.00	$95.00	$95.00	$95.00	$95.00	$95.00	$95.00
Idaho	$104.89	$117.73	$116.98	$130.47	$130.47	$86.69	$99.80	$99.42	$112.64
Illinois	$91.9*	$98.65*	$98.60*	$104.96*	$104.96*	$69.52*	$77.87*	$76.84*	$84.62*
Indiana	$39.85	$34.52	$38.82	$32.00	$48.94	$24.35	$24.36	$25.01	$25.32
Iowa	$91.55	$98.26	$97.59	$108.61	$105.30	$74.71	$82.48	$82.15	$92.94
Kansas	$40.00	$35.00	$35.00	$35.00	$30.00	$26.00	$25.00	$25.00	$25.00
Kentucky	$78.58	$89.90	$89.90	$101.22	$95.21	$67.57	$78.58	$78.58	$89.90
Louisiana	$58.65	$58.65	$58.65	$58.65	$58.65	$58.65	$58.65	$58.65	$58.65
Maine	$47.15	$48.48	$50.40	$49.87	$45.43	$43.75	$44.50	$45.25	$46.50
Maryland	$85.95	$92.36	$90.41	$98.07	$98.07	$64.94	$72.60	$71.62	$79.02
Massachusetts (ε+10)	$87.85*	$93.77*	$92.47*	$99.25*	$99.25*	$70.36*	$77.14*	$76.49*	$83.06*
Michigan	$86.72	$93.36	$91.46	$99.37	$99.37	$65.83	$73.74	$72.79	$80.39
Minnesota	$35.43	$30.28	$32.96	$34.60	$42.48	$25.54	$25.95	$25.95	$28.84
Mississippi	$80.78	$87.40	$85.74	$93.37	$93.37	$61.58	$69.19	$68.54	$76.15
Missouri	$60.00	$60.00	$60.00	$60.00	NP	$60.00	$60.00	$60.00	$60.00
Montana	$97.94	$104.66	$102.96	$110.80	$94.89	$78.51	$86.39	$85.54	$93.08
Nebraska	$90.82	$95.60	$105.16	$114.72	$124.28	$76.48	$81.26	$86.04	$90.82
Nevada	$59.07	$59.07	$59.07	$59.07	$59.07	$59.07	$59.07	$59.07	$59.07
New Hampshire	$44.80	$44.80	$44.80	$47.04	$40.32	$62.07	$62.07	$62.07	$62.07
New Jersey	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00	$25.00
New Mexico	$150.55	$150.55	$150.55	$150.55	$150.55	$89.83	$89.83	$89.83	$89.83
New York	$30.00	$30.00	$30.00	$30.00	$30.00	$30.00	$30.00	$30.00	$30.00
North Carolina	$80.33	$80.33	$80.33	$98.51	$98.51	$80.33	$80.33	$80.33	$81.57
North Dakota	$84.09	$90.72	$89.62	$97.73	$97.73	$66.02	$73.76	$73.02	$80.40
Ohio	$50.70	$57.61	$57.51	$64.52	$61.21	$44.18	$51.12	$51.12	$58.36
Oklahoma	$85.71	$92.69	$91.39	$74.76	$99.54	$67.23	$75.00	$74.35	$81.98
Oregon	$71.10	$76.55	$75.00	$81.40	$81.48	$53.98	$60.46	$59.69	$65.91
Pennsylvania	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00
Rhode Island	$37.00	$37.00	$37.00	$42.00	$27.24	$27.00	$27.00	$27.00	$27.00
South Carolina	$78.75	$78.75	$78.75	$78.75	$78.75	$63.00	$63.00	$63.00	$63.00
South Dakota	$53.05	$53.05	$53.05	$53.05	$53.05	$53.05	$53.05	$53.05	$53.05
Texas	$84.51	$92.47	$92.09	$100.43	$100.43	$77.75	$85.07	$84.72	$92.40
Utah	$67.84	$77.00	$77.00	$86.17	$81.85	$57.09	$66.22	$66.22	$75.39
Vermont	$101.10	$109.01	$106.81	$116.01	$116.01	$76.85	$86.06	$106.81	$116.01
Virginia	$83.04	$89.72	$88.45	$96.09	$96.09	$64.90	$72.55	$71.91	$79.22
Washington	$71.60	$79.23	$82.41	$88.78	$90.69	$54.73	$62.69	$66.19	$72.55
West Virginia	$69.40	$75.30	$74.42	$81.21	$76.78	$54.63	$61.42	$61.13	$67.32
Wisconsin	$56.96	$56.96	$56.96	$56.96	$56.96	$56.96	$56.96	$56.96	$56.96
Wyoming	$120.12	$129.32	$126.69	$137.65	$137.65	$91.18	$102.14	$100.83	$111.35

Source: 2007/8 AAP Medicaid Reimbursement Survey. Copyright 2008 American Academy of Pediatrics. * See abbreviations and (foot)notes, by state, at front and end of report.

RI RANKING: 46th 44th 45 45 48 47 47 47 47th


RI Medicaid Waiver

Concerns

RI is asking the federal government for permission to convert it current Medicaid program from an entitlement to a block grant.

If expenditures or caseload grow beyond projected levels:

- Economic downturn,
- New medical technology,
- Natural disaster
- Epidemic, etc.

then the state would face a choice between paying the added cost solely with state funds or cutting eligibility, services, and/or payments to health care providers.

Concerns

"RI is seeking complete and unprecedented flexibility to make changes in eligibility and services for many beneficiaries without any federal oversight"

- Establish waiting lists
  - May have to wait for a spot to open up before becoming eligible to receive care
  - Waiting lists for LTC, affecting seniors and people with disabilities
  - Proposal is vague whether children would continue to receive EPSDT services

Abstracted from 8/21/2008 letter to Michael Levitt, from Baucus and Rockefeller

Concerns

"RI is seeking authority to charge copayments in excess of levels established under the DRA, including prescription copayments for all children, even those with incomes below the poverty line"

- The State "reserves its authority to impose new or revise existing cost-sharing requirements to mandatory populations" without further federal review

Abstracted from 8/21/2008 letter to Michael Levitt, from Baucus and Rockefeller

Concerns

Seeks to "build" on RIte Care's success

- Maintains managed care arrangements
- But only promises for 'mandatory' populations
- Although RIte Care shown to be most efficient model, waiver may decreases services and eligibility, not increase them as SCHIP envisions.

Concerns

The programmatic changes proposed in Article 17 can be achieved through waivers that do not force children, elderly and the disabled to compete for services and funds, and subject the State to undo risk

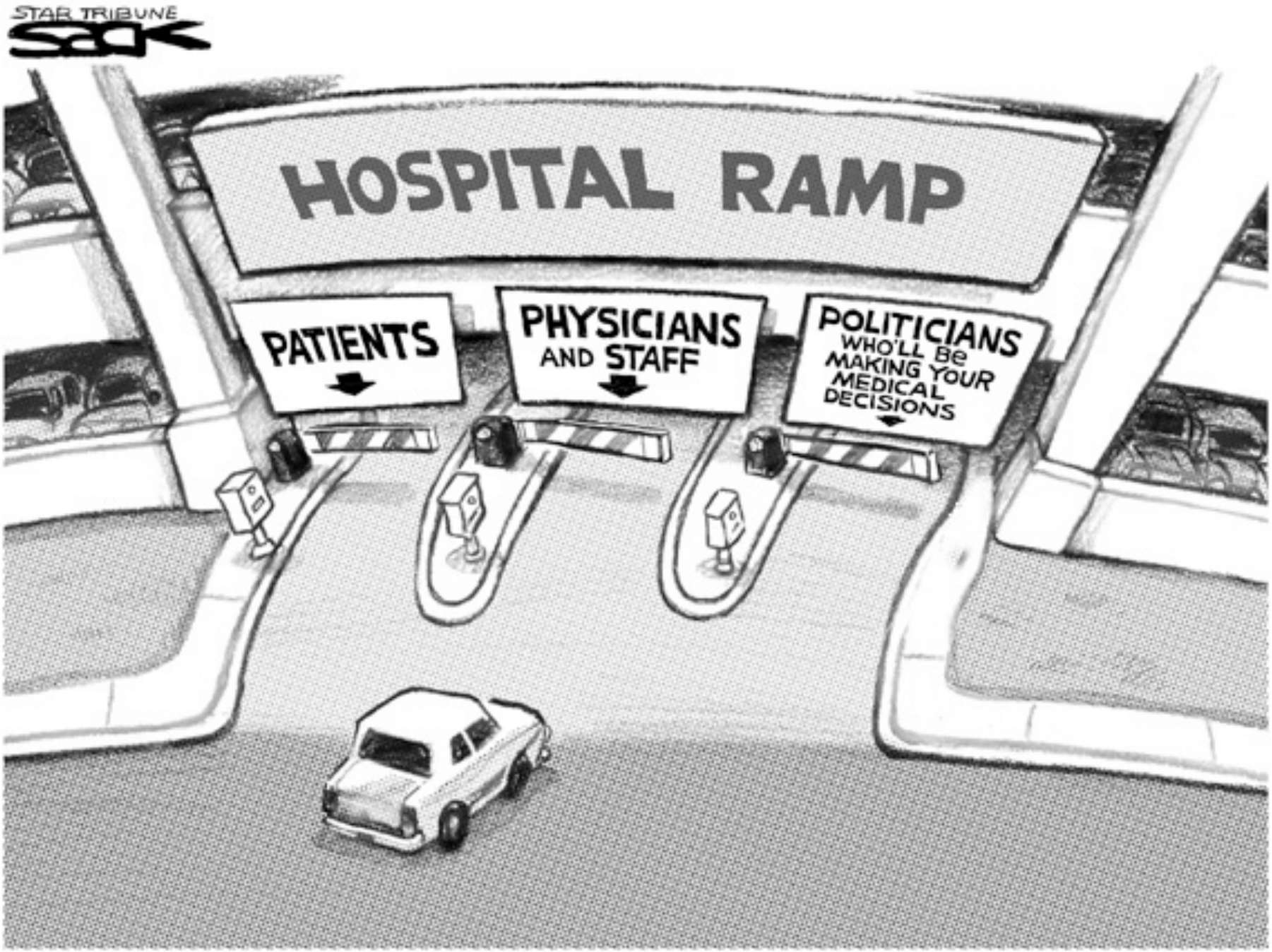
Concerns

- $67 M has been proposed as potential savings from current expenditures, although it is a $231 M deficit projected for FY2009
- The projected $67 M savings has already been assumed to help balance the RI FY2009 Budget
- We also will lose the $74 M in match dollars for the 'unspent' $67 M
- Since these savings have been already 'spent' to balance the budget. If they are achieved, there are no dollars to reinvest into the system, unless we achieve even greater savings.


Our children shouldn't
have to fight to get
the health care
coverage they deserve.
Legislative solutions
are at hand.

Timeline of the Medicaid Global Waiver

- **July 29, 2008** –Waiver application submitted by EOHHS/ DHS to the House and Senate Finance Committees.
- **August 5, 2008 –** Joint House and Senate Finance committee hearing held regarding waiver application
- **August 7 – ??? –** *Presumed* time period of negotiation between the state and CMS
- **Upon agreement –** Legilsature has 30 days to veto


STAR TRIBUNE
SACK
HOSPITAL RAMP
PATIENTS
PHYSICIANS AND STAFF
POLITICIANS WHO'LL Be MAKING YOUR MEDICAL DECISIONS

Summary and Conclusions

- Healthcare financing is an insurance-based capital market

- US is the only nation to use an employer-based purchasing system
  - If the employer doesn't offer coverage (i.e. small business), then the 'working poor' without health insurance

- Healthcare management is an administrative *business* by payers, without collaborative models with providers
  - *Managing physicians, not patients*
  - This continues with transparency and public reporting initiatives

- Providers remain disadvantaged compared to payers by anti-trust laws

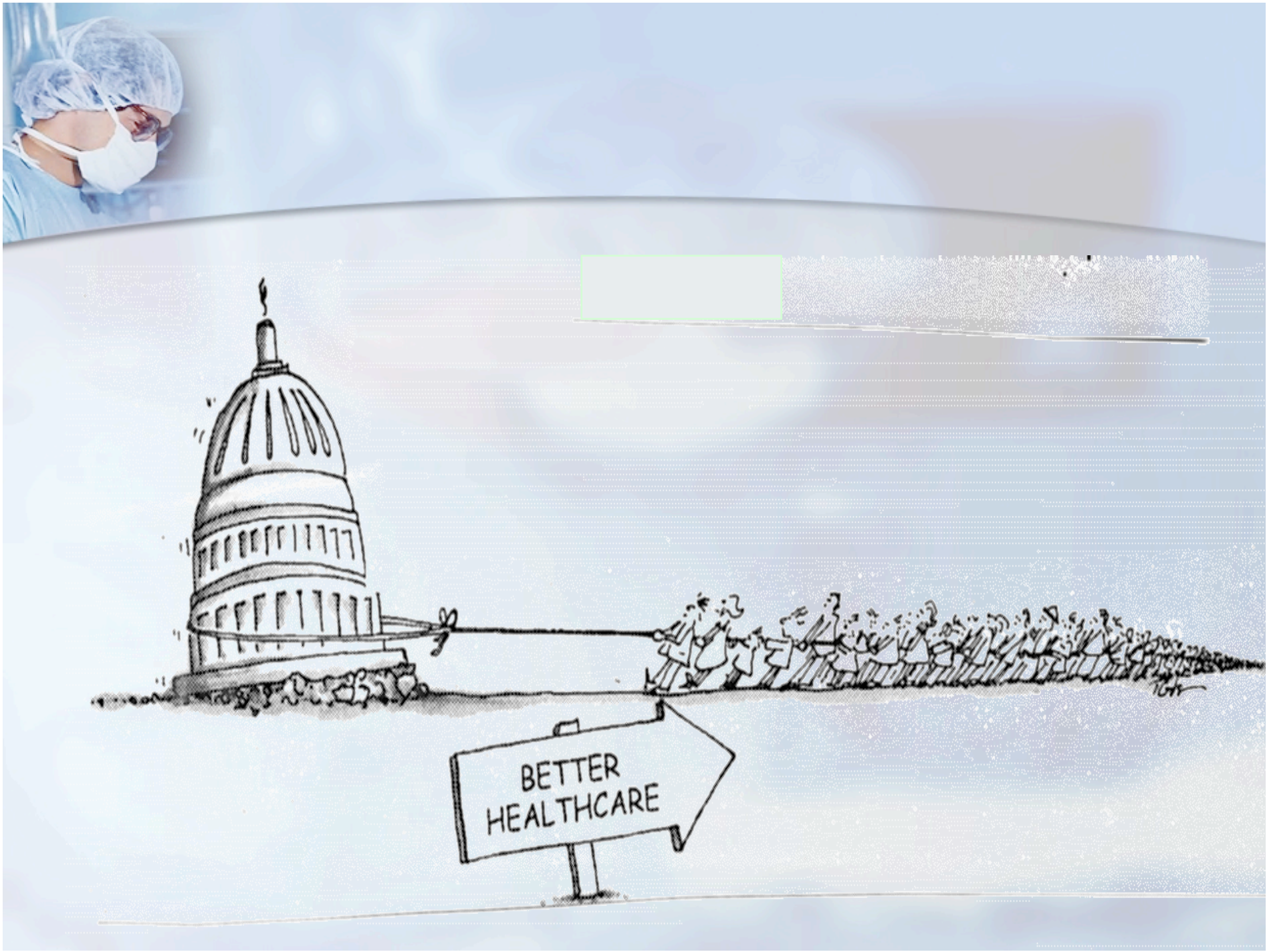
- We already pay for everyone's health coverage, through contracting, premium increases etc. We do not lose money by covering everyone, we gain the ability to manage the care more effectively

Summary and Conclusions:
Children's Healthcare & Medicaid

- Children's health insurance is often within Medicaid/SCHIP
  - Adults with disabilities/LTC, NOT children, are the cost drivers
  - Federal policy has failed to manage these services
  - 1115 waivers and others could address these issues at State level

- Global waiver too risky for children's services and RI
  - Pools children and acute care services with adults and LTC into one COMPETING budget
  - Decreases chance to renegotiate or benefit from any future FMAP increases

- We still need appropriate Medicaid reform with enough State flexibility
  - Requires changes in Federal policy
  - A RIte Care-like program can benefit the adult population.
  - There is no need to absorb RIte Care into a new global model
  - Can achieve waivers to reform LTC without jeopardizing the federal-state partnership for this high risk populations


BETTER
HEALTHCARE