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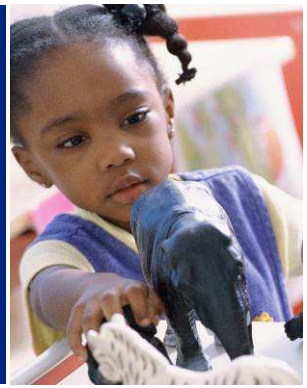
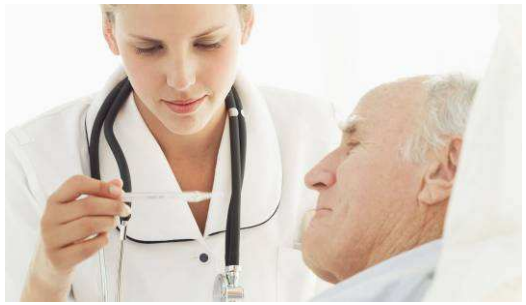




HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - **WITH REAL-WORLD PERSPECTIVE**.

An Independent Evaluation of Rhode Island's Global Waiver

January 23, 2012

Study Goal

- Since implementation of the GCW began in July of 2009, Rhode Island has pursued a variety of Medicaid initiatives to advance waiver goals and secure the continued financial viability of the program
- The purpose of this independent review is to evaluate the cumulative impact of these initiatives/actions relative to program costs and certain GCW goals.
- Additionally, we are interested in learning whether, and to what extent, those initiatives targeted at specific GCW policy objectives achieved the outcomes desired by the State.

Study Questions

1) Have initiatives changing Medicaid long-term care processes, procedures and provider payments affected enrollment, utilization, and cost of services and supports provided to elders and adults with disabilities in home and community based vs. institutional settings?

2) Have budget initiatives designed to reduce cost through care management affected health outcomes, particularly for those beneficiaries at risk for long-term care?

3) Have there been any factors that facilitated or impeded the states efforts to ensure that every Medicaid beneficiary has ***"the right services, at the right time, in the right- setting."***

Question #1 – Methodology and Results

- Have state LTC initiatives affected the utilization of institutional vs. community LTC services?
- Approach:
  - Review state reports to evaluate the actual implementation of planned LTC initiatives
  - Review prior studies of the impact of NH diversion initiatives
  - Review 3 years of Medicaid claims data to evaluate the utilization of institutional and community LTC services

Question #1 – Methodology and Results

Successful Implementation of the Global Waiver was impacted by:

- National recession and budget shortfalls
- ARRA MOE Requirements
- Affordable Care Act Provisions

System change is a dynamic and evolutionary process. Despite the barriers, Rhode Island successfully implemented 14 of the 22 Global Waiver activities with 7 of the remaining 8 in a development phase.

The cost containment initiatives undertaken by Rhode Island during State Fiscal Years (SFY) 2009 and 2010 were not solely driven by the Global Waiver. Rhode Island took an array of budget and program management improvement actions resulting in an estimated $55,233,507 in state fund savings with an estimated $22,944,288 attributable to the Global Waiver authority.

Question #1 – Methodology and Results

A Snapshot of Findings from the Brown University Center for Gerontology and Health Care Research

Change in Characteristics of Rhode Island Medicaid Population in Nursing Homes, 2008 – 2010

- 10% decrease in the proportion of new admissions with a 90 day or longer stay
- 12% decrease in persons who are admitted for post-acute care compared to those who are admitted from community settings
- Persons with stays less than 90 days admitted from community settings (using MDS data as a proxy for care needs) who may not meet the "highest" or "high" criteria decreased from 5.1% in 2008 to 2.5% in 2010. Likewise, persons with a length of stay greater than 90 days decreased from 10.9% in 2008 to 6.1% in 2010.

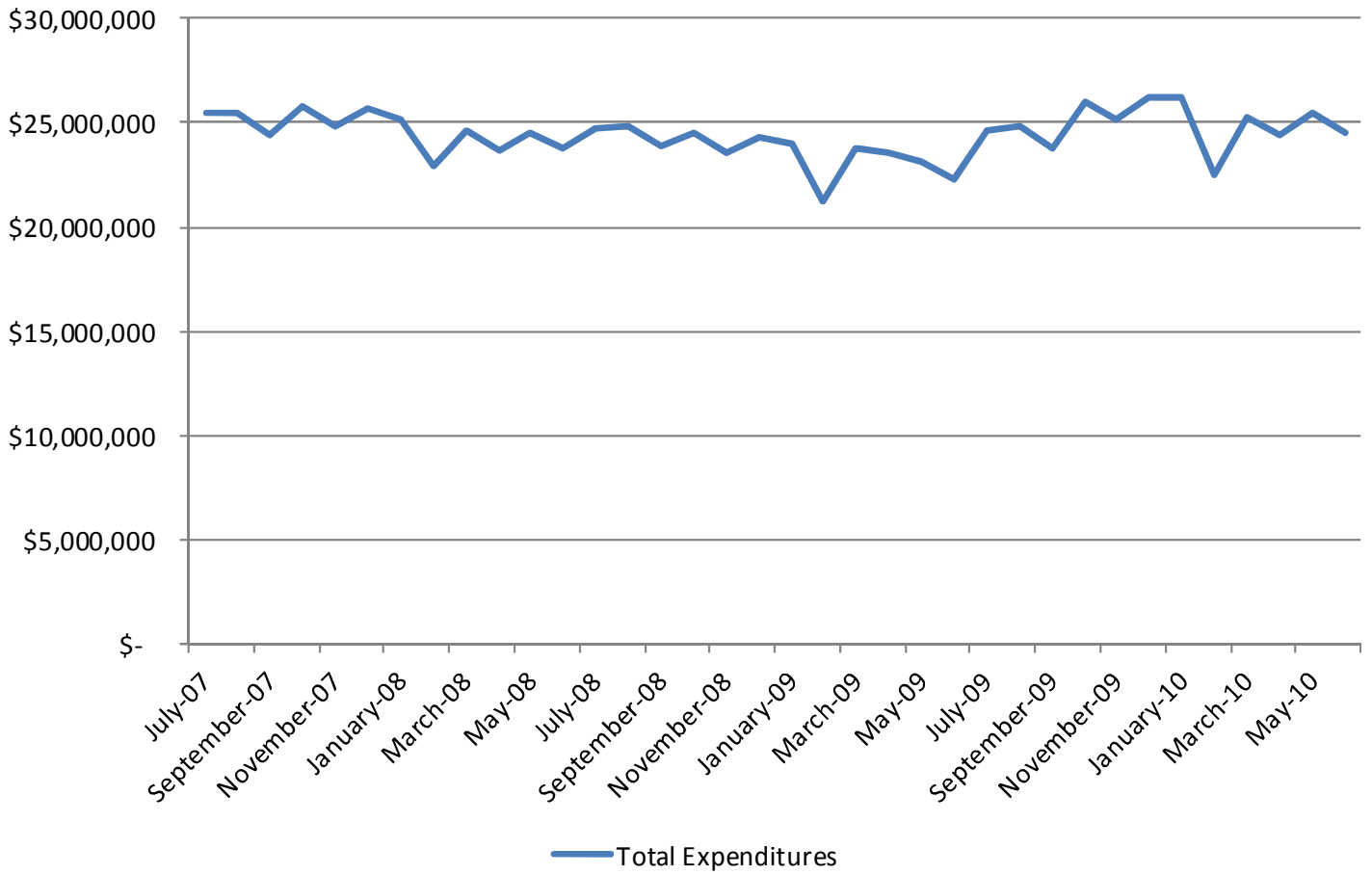
Question #1 – Methodology and Results

- Review of Medicaid claims data found reductions in the utilization of NH services, and increases in the use of community LTC services
- NH analysis excluded groups that were not targeted by the state's LTC initiatives including;
  - Eleanor Slater Hospital
  - Group Homes
  - Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) services
  - Medicare CoPay

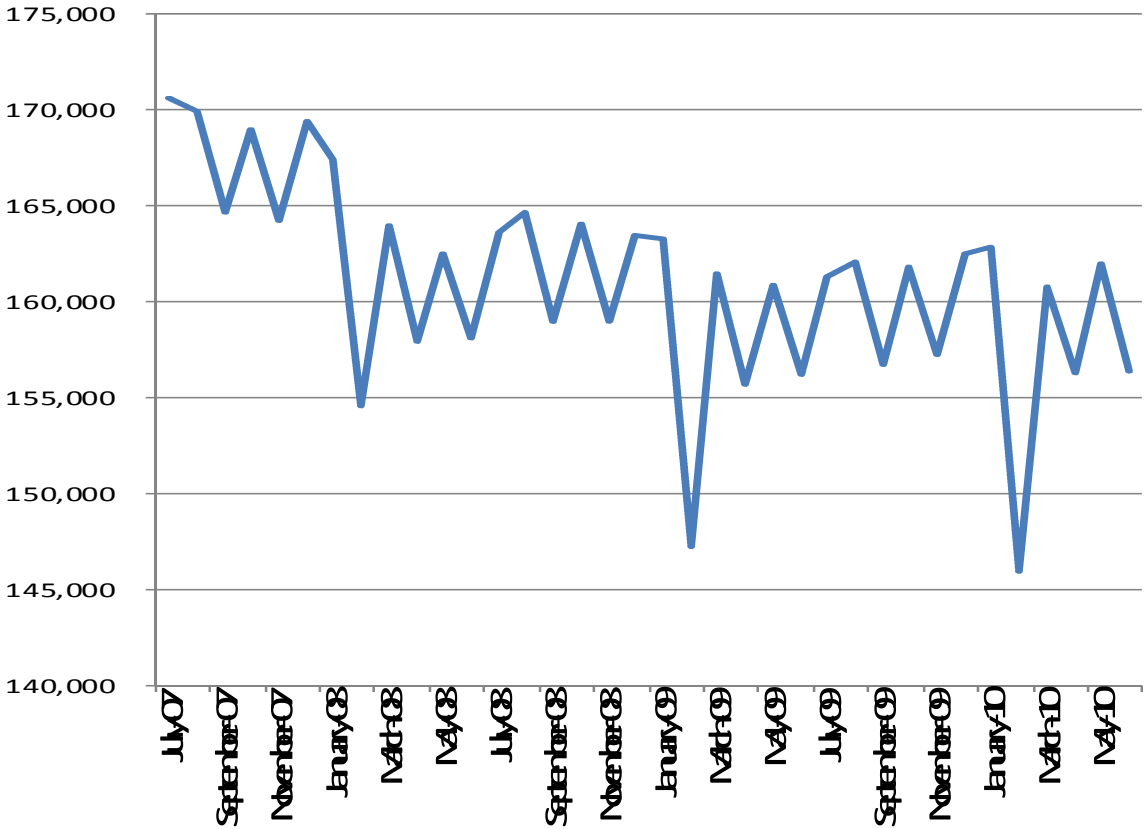
Question #1 – Methodology and Results

- The remaining study group included the majority of the Medicaid NH recipients
- Over the 3 year period
  - Monthly expenditures were relatively constant
  - Monthly nursing home patient days decreased
  - The number of unique NH residents in each month decreased over the study period

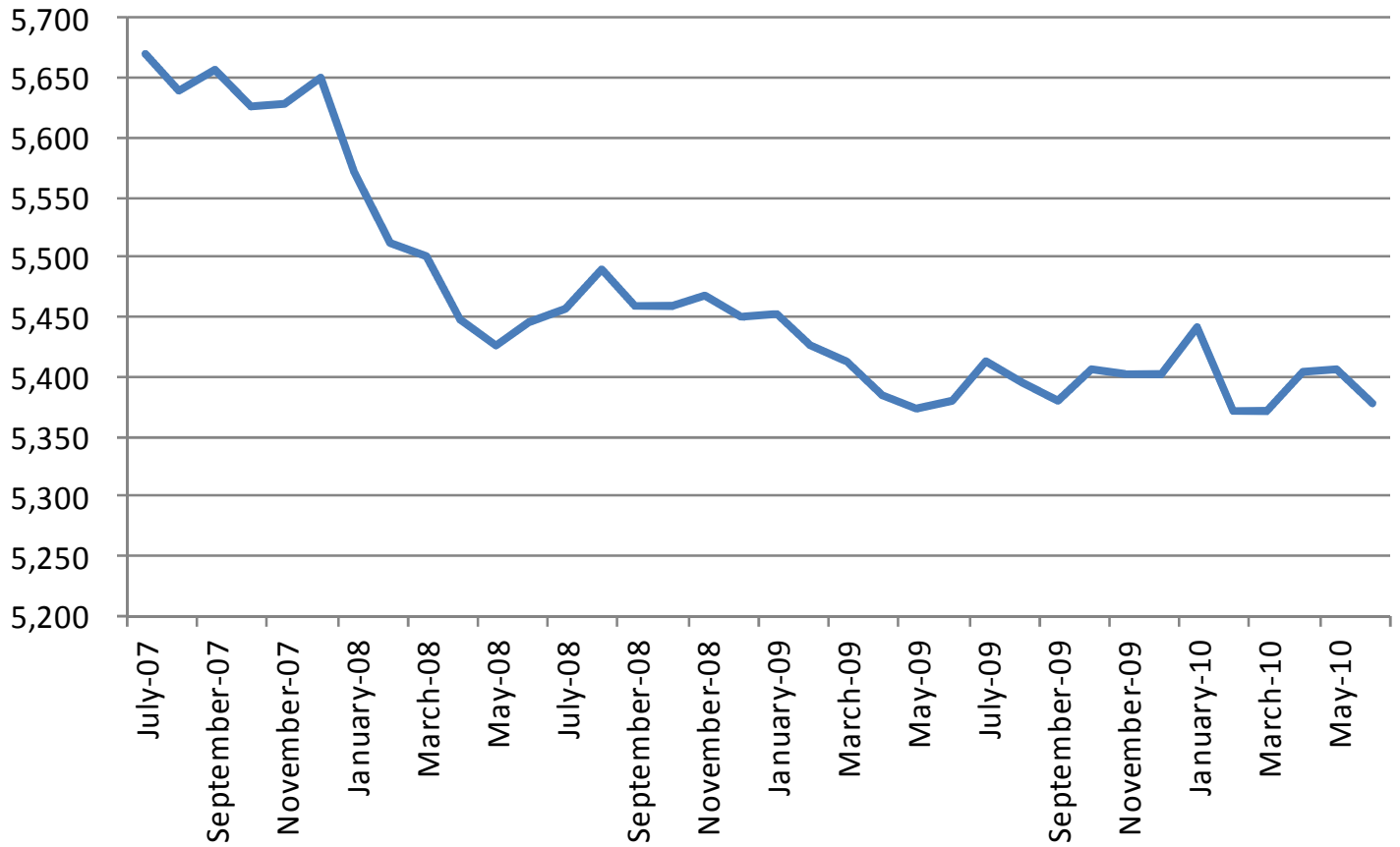
Total Nursing Home Expenditures by Month of Service



Total Nursing Home Days by Month of Service



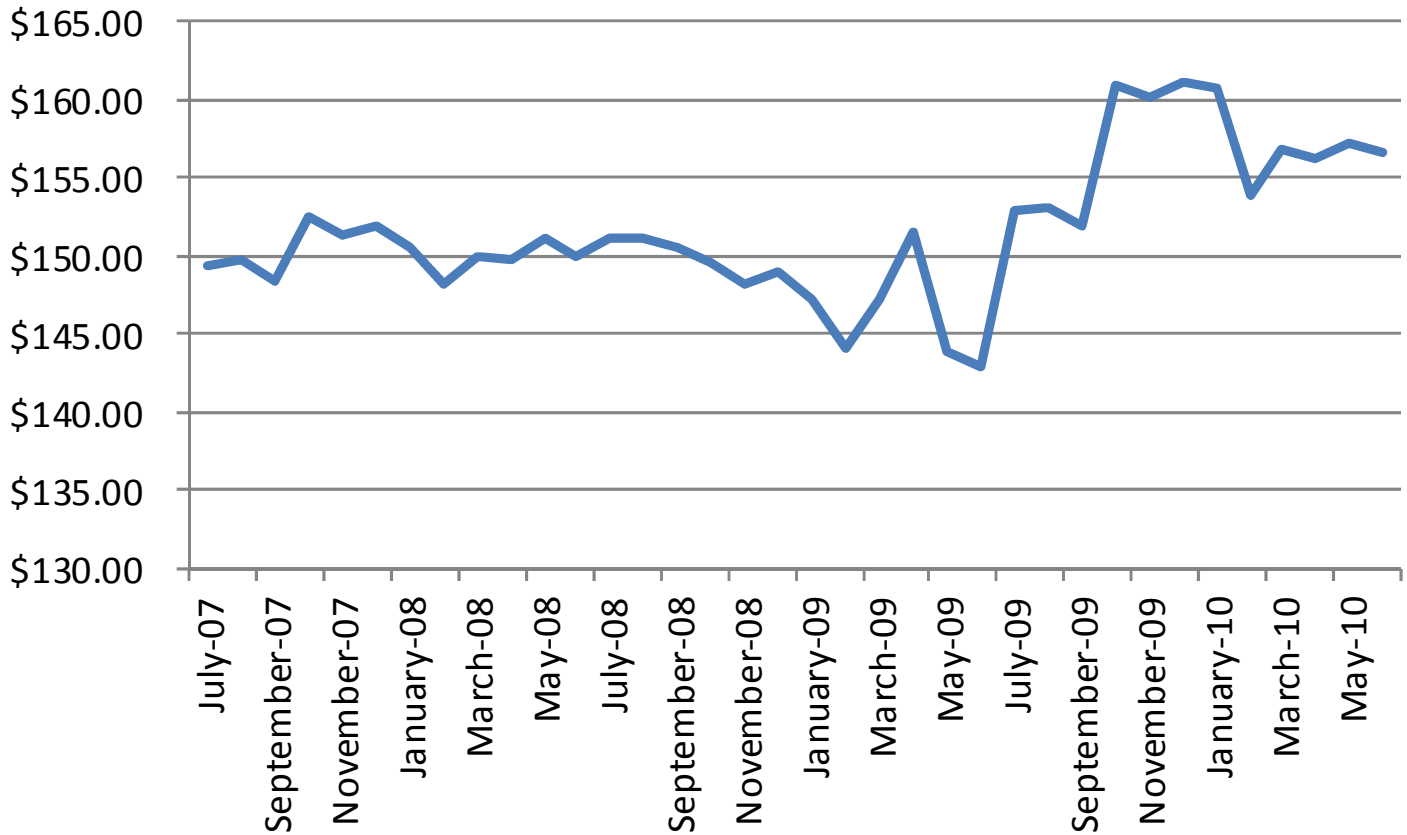
Unique Nursing Home Residents by Month of Service



Question #1 - Methodology and Results

- The state also undertook budget initiatives that changed their NH reimbursement methodology
- The average cost per nursing home day was evaluated for each month of the study period
- The average cost per day was relatively constant throughout FY08 and FY09 and there was a slight increase in FY10

Average Cost per Nursing Home Day by Month of Service



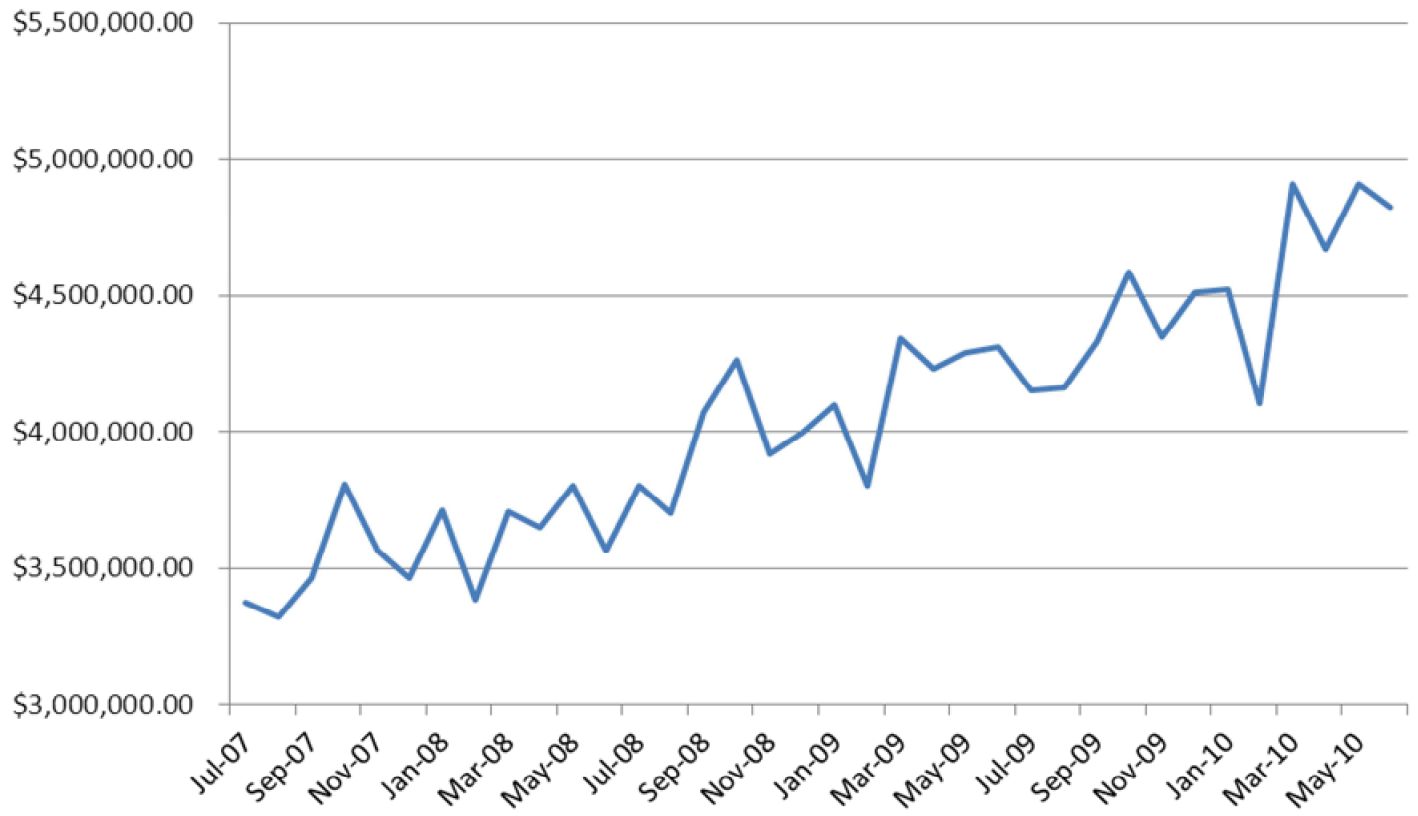
Question #1 – Methodology and Results

- The utilization of community based services was evaluated for eight HCBS classification categories;
  - Adult Day Care, Assisted Living Care, Home Health Aides, Personal Care Services, Assistive Devices -Home Modifications, Emergency Response Systems, Home Delivered Meals, BHDDH Waiver Services
- Medicaid populations that were not the focus of the state's initiatives or that had incomplete data were excluded from the analysis including;
- DEA members, BHDDH members, and members enrolled in the Self Directed Care Waiver

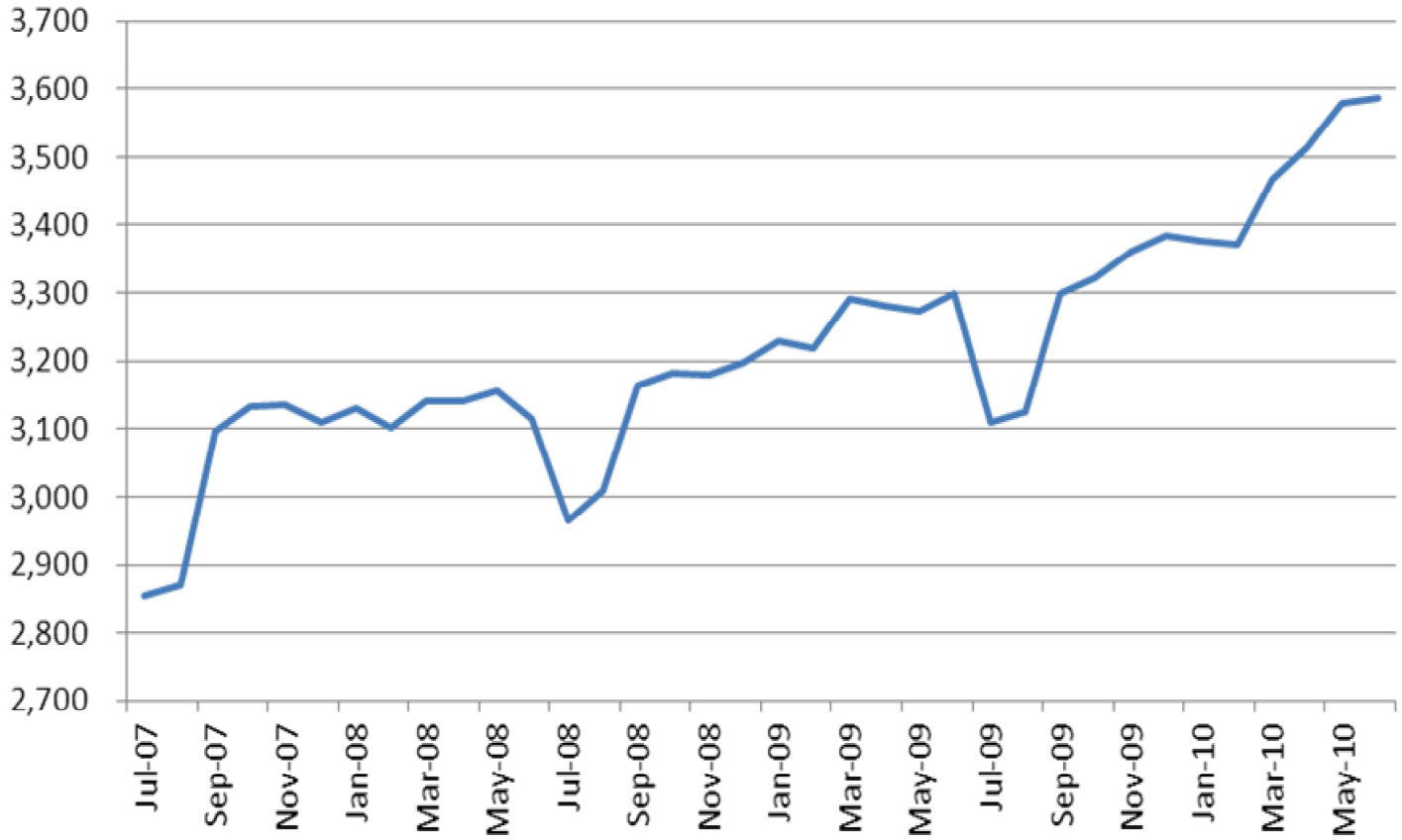
Question #1 – Methodology and Results

- For the included population HCBS services rose consistently during the three year period
  - The number of unique HCBS users grew by over 600 members
  - Monthly expenditures increased by over $1 million per month
  - PCS accounted for the majority of the spending
  - PCS showed the largest increase in the number of unique users

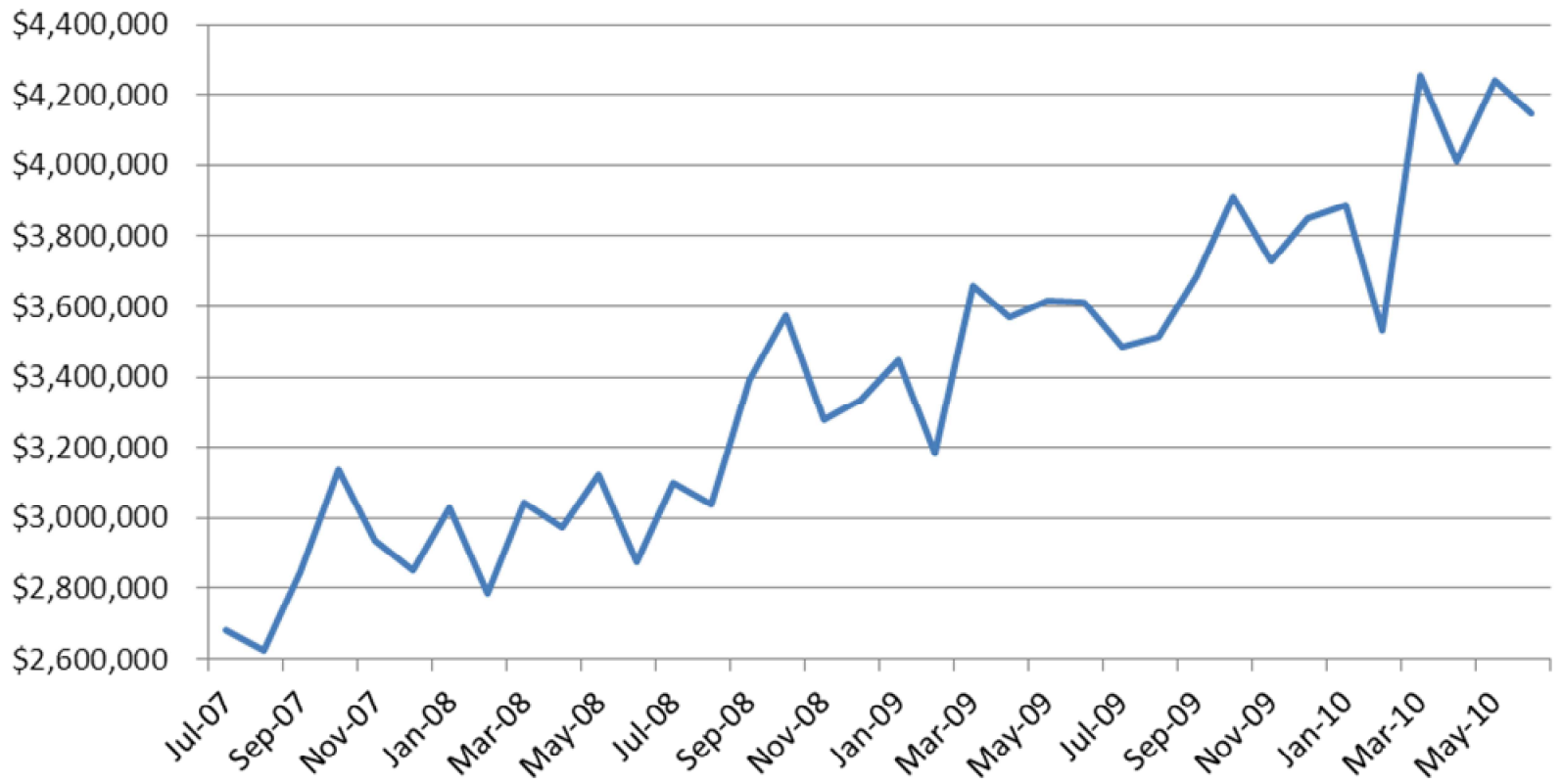
Monthly Expenditures for HCBS Services, SFY08-SFY10



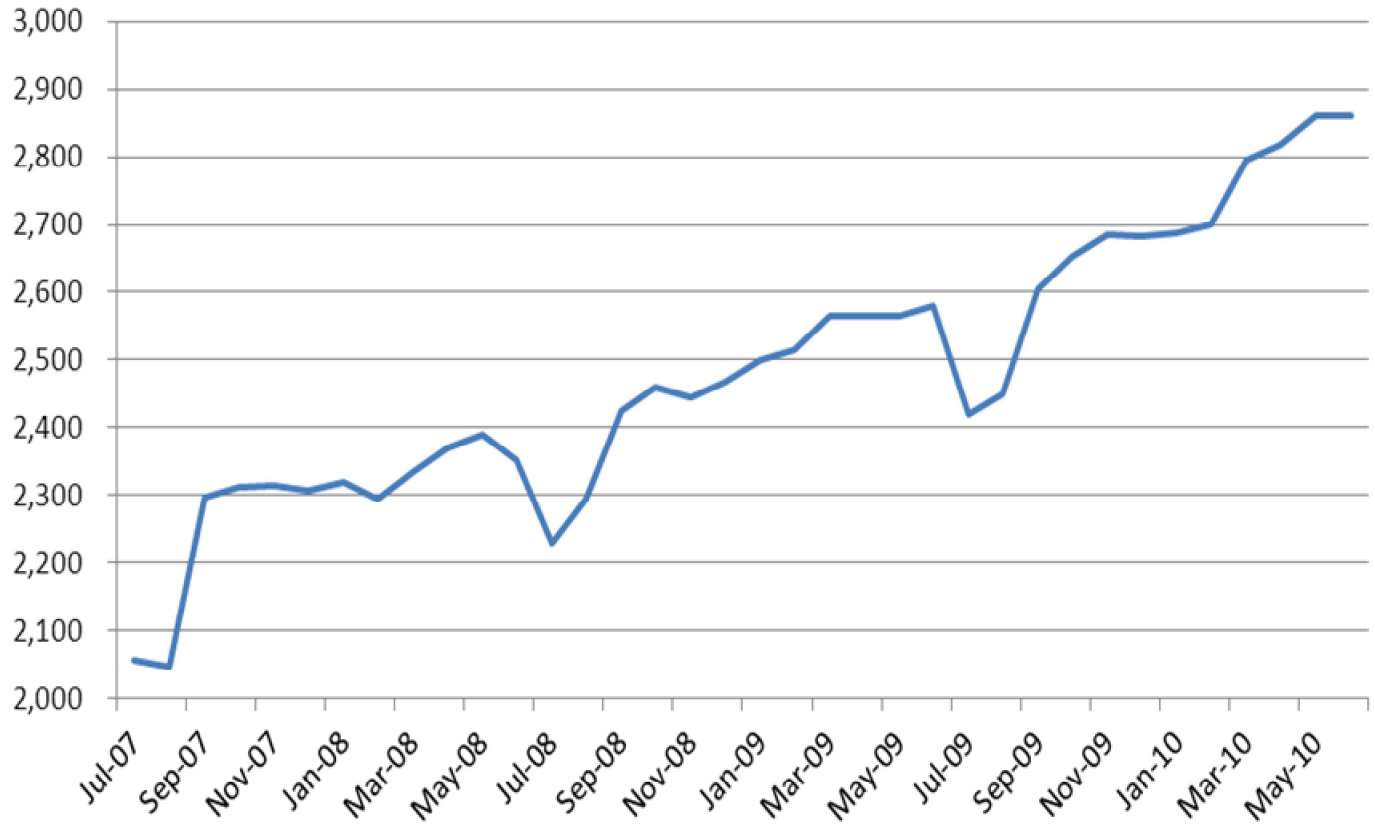
Number of Unique User of HCBS Services, SFY08-SFY10 (General Medicaid)



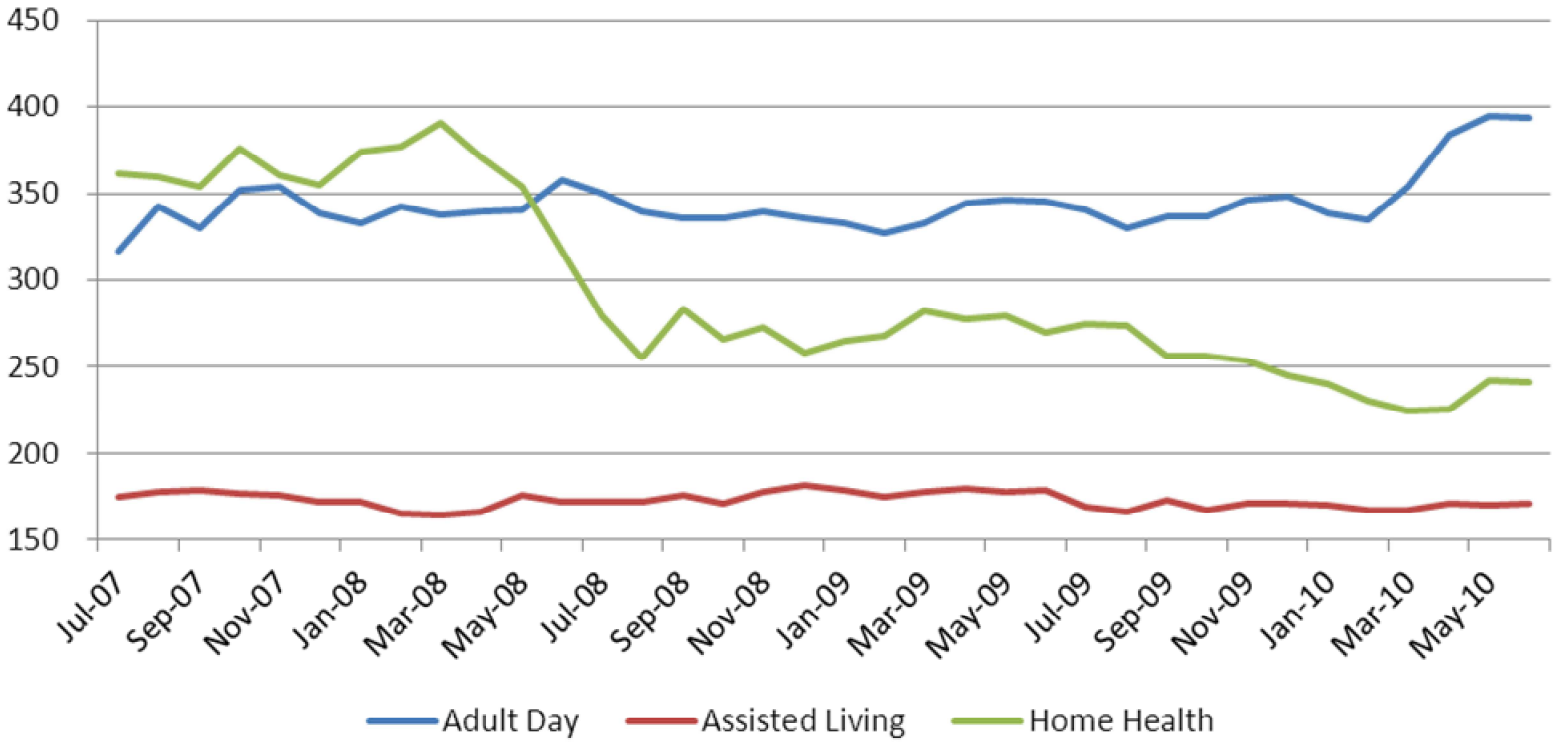
Monthly Personal Care Expenditures SFY08 - SFY10



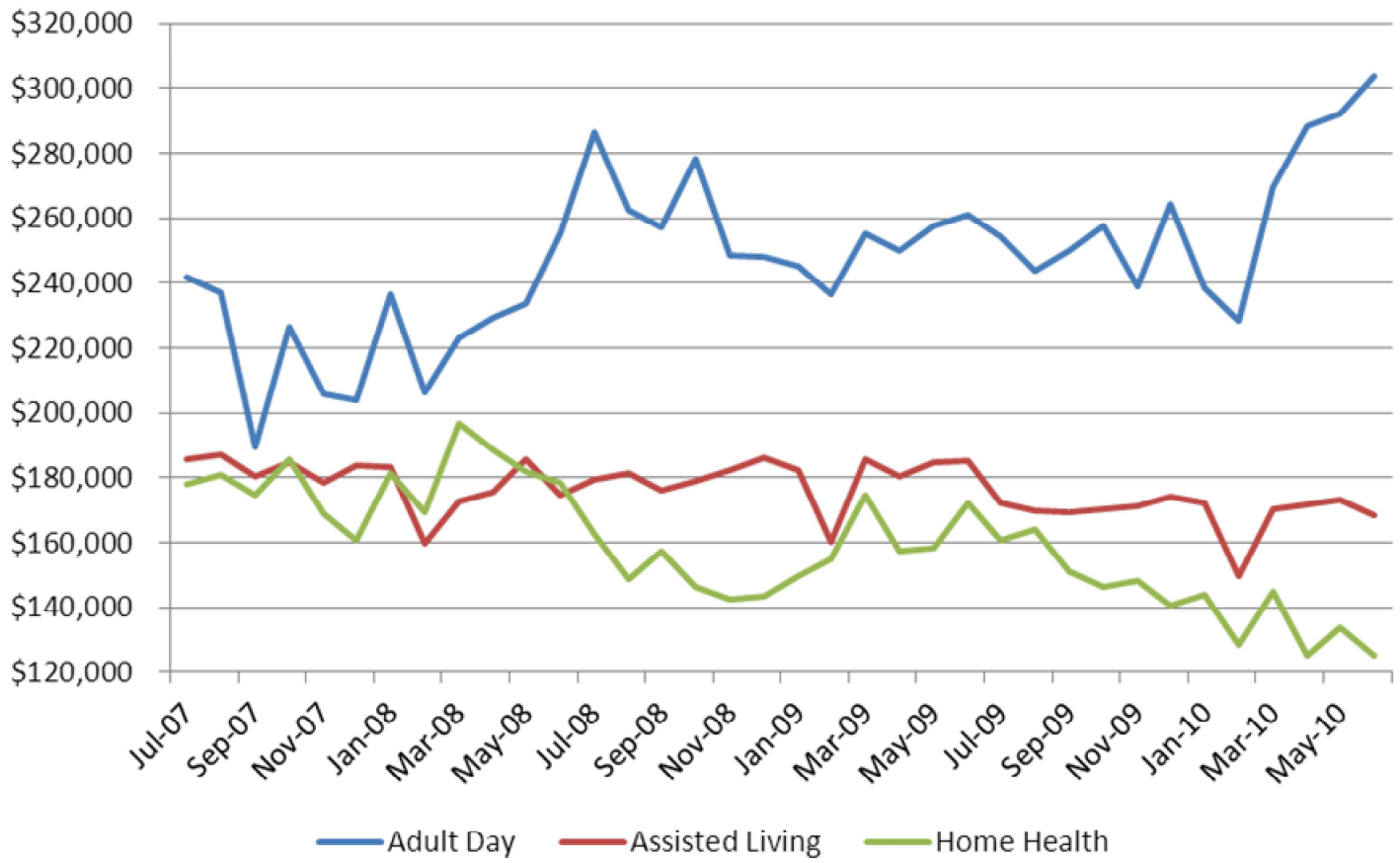
Personal Care Users SFY08 - SFY10



Unique Users HCBS Services SFY08 - SFY10



Monthly Expenditures HCBS Services SFY08 - SFY10



Question #1 – Methodology and Results

- The number of unique LTC users increased by 1.5% during the study period
  - NH users declined 3.0% from SFY08 to SFY10
  - HCBS users increased by 9.5%
- Total LTC expenditures increased by 4.1% during the study period
  - NH expenditures increased by 0.8%
  - HCBS expenditures increased by 26.2%

HCBS and Nursing Home Users and Expenditures

Fiscal Year	Avg HCBS Users	Total HCBS Dollars	Avg. NH Users	Total NH Dollars	Avg LTC Users	Total LTC Dollars
SFY08	3,082	$42.8m	5,565	$296m	8,646	$339m
SFY09	3,191	$48.8m	5,434	$284m	8,626	$332m
SFY10	3,375	$54.0m	5,398	$299m	8,772	$353m
SFY08 to SFY10	+9.5%	+26.2%	-3.0%	+0.8%	+1.5%	+4.1%

Question #1 – Methodology and Results

- The state's NH diversion efforts resulted in a growth in the utilization of HCBS services and a reduction in NH utilization
- If the ratio of NH users to HCBS users had not changed the state would have spent significantly more funds on LTC services
- Lewin estimates that the state's diversion efforts resulted in a total savings of $35.7 million over the study period
  - SFY 10 savings were estimated at $17.1 million

Question #1 – Methodology and Results

- The state also revised the NH rate methodology to account for the acuity of residents
  - The number of members with ADLs requiring extensive or total assistance rose from 3.8 ADLs in 2008 to 4.0 ADLs in 2010, an increase of 5.3 percent
  - For new members, the average number of ADLs requiring extensive or total assistance rose from 3.6 ADLs in 2008 to 4.0 in 2010 an increase of 11.1 percent.
- During this period, NH rates rose at the inflation rate
- Assuming a conservative 5% increase in acuity, state rate actions generated savings of $15 million.

Question # 2 – Methodology and Results

- Have care management initiatives affected health outcomes and reduced costs?
- To evaluate the impact of these initiatives, members enrolled in care management programs were compared to members in unmanaged FFS
- Cohort comparisons were also conducted to compare a members prior utilization experience when they were in FFS with their utilization when they were enrolled in a care management program

Question # 2 – Methodology and Results

- Beginning in 1994 the TANF population was mandatorily enrolled in the RIteCare program.
  - The TANF population was excluded from the analysis, since there are no TANF members in unmanaged FFS and any prior FFS experience is more than a decade old
- By SFY10 the state expanded its mandatory managed care enrollment initiatives to mandatorily enroll children with special health care needs (CSHCN) and people with disabilities.
- These populations were the focus of the care management effectiveness analysis
  - LTC residents and members in BHDDH waiver programs were excluded from the care management effectiveness analysis.

Question # 2 – Methodology and Results

- In SFY10 the risk scores for adults with disabilities and CSHCN enrolled in the RIte Care, Rhody Health Partners, and Connect Care Choice programs had higher risk scores than the members that remained in unmanaged FFS.
- After adjusting for risk and accounting for the cost of carved out services that were still paid in the FFS system, members in Rite Care and Rhody Health Partners had lower cost.

Average Cost PMPM and Risk Scores for Adults with Disabilities

Care Management Program	SFY09 Average Cost	SFY09 Average Risk Score	SFY09 Risk Neutral Cost	SFY10 Average Cost	SFY10 Average Risk Score	SFY10 Risk Neutral Cost
Connect Care Choice	$1,790.32	4.38	$408.32	$2,004.78	4.47	$448.21
Rhody HP *	$981.35	3.41	$287.49	$1,052.70	3.49	$301.62
FFS	$1,652.50	3.88	$425.90	$1,182.83	3.07	$384.85

*This is the average Rhody HP rate for each fiscal year and does not include the FFS cost for services excluded from the benefit package. FFS costs for adults with disabilities averaged approximately $150 PMPM during SFY09 and SFY10.

Average Cost PMPM and Risk Scores for CSHCN

Care Management Program	SFY09 Average Cost	SFY09 Average Risk Score	SFY09 Risk Neutral Cost	SFY10 Average Cost	SFY10 Average Risk Score	SFY10 Risk Neutral Cost
Fee For Service	$1,445.19	1.28	$1,130.67	$1,441.77	1.32	$1,092.87
RIte Care HMO*	$803.71	1.51	$532.76	$848.44	1.52	$559.25

*This is the average RIte Care rate for each fiscal year and does not include the FFS cost for services excluded from the benefit package. FFS costs for CSHCN average approximately $400 PMPM during SFY09 and SFY10.

Question # 2 – Methodology and Results

- To estimate the fiscal impact of the care management initiatives, Lewin made a conservative estimate that the rates for the managed care programs included a 2% to 5% savings versus a comparable population in FFS
- This results in an estimate between $4.7 million and $11.9 million
- The risk adjusted comparison of costs for members in these programs versus unmanaged FFS more than substantiates this estimate
  - The FFS comparison was not used to estimate the savings because of the size of the FFS population, and the inability of the study to adjust the FFS population to exclude members that were not eligible to enroll in the care management programs

Question # 3 – Methodology and Results

- Have there been any factors that facilitated or impeded the states efforts to ensure that every Medicaid beneficiary has ***"the right services, at the right time, in the right- setting."***
- For members enrolled in care management initiatives two analyses were done to evaluate their access to more appropriate services
  - A cohort analysis was conducted for members that transitioned from FFS in SFY09 to a care management program in SFY10
    - Their utilization of inpatient, emergency room and physician visits were compared in each setting

Service Utilization by Cohort Transitioning from FFS to Care Management

Eligibility Group	Managed Care Program	Cohort Size	2009			2010		
			Inpatient Admits	ER Visits	Physician Visits	Inpatient Admits	ER Visits	Physician Visits
CSHCN	RIte Care	57	26	40	457	24	26	1,010
Adults with Disabilities	Connect Care Choice	324	253	1,208	2,293	299	1010	2,356
Adults with Disabilities	Rhody HP	200	99	278	1,203	135	182	1,661

Question # 3 – Methodology and Results

- All three care management programs showed significant increases in the number of physician visits received by members in the cohort
- The number of ER visits was also reduced for the cohort in all three care management programs
- Inpatient admissions fell for CSHCN that enrolled in the Rite Care program.

Question # 3 – Methodology and Results

- An analysis was conducted of the utilization of physician and emergency room services for members with chronic conditions in a care management program versus members in unmanaged fee for service
  - Members with asthma, cardiac conditions, diabetes and mental health disorders, were identified by processing their claims through the Episode Risk Grouper (ERG)
  - Members with both asthma and diabetes were included in the results for both disease conditions in the tables that follow

Prevalence Rates for Disabled Members by Age Category

Age Category	Member Count	Asthma Prevalence Rate	Mental Health Prevalence Rate	Cardiac Prevalence Rate	Diabetes Prevalence Rate
CSHCN	7,550	22.5%	42.5%	8.6%	5.3%
Adults with Disabilities	14,715	27.9%	53.6%	43.4%	34.8%

Service Utilization by CSHCN with Chronic Conditions

Disease Condition	Care Management Status	Member Count	ER Utilization Per 1,000 Per Year	Physician Utilization Per 1,000 Per Year
Cardiac	Fee For Service	170	496	13,976
Cardiac	RIte Care	371	610	18,715
Asthma	Fee For Service	287	619	14,110
Asthma	RIte Care	1,206	655	12,897
Diabetes	Fee For Service	75	735	12,653
Diabetes	RIte Care	274	783	24,893
Mental Health	Fee For Service	502	597	17,280
Mental Health	RIte Care	2,307	581	13,903

Service Utilization by Adults with Disabilities with Chronic Conditions

Disease Condition	Care Management Status	Member Count	ER Utilization Per 1,000 Per Year	Physician Utilization Per 1,000 Per Year
Cardiac	Connect Care Choice	581	3,131	10,194
Cardiac	Fee For Service	570	2,108	6,703
Cardiac	Rhody HP	3,313	1,354	11,133
Asthma	Connect Care Choice	389	4,050	11,079
Asthma	Fee For Service	271	2,804	7,916
Asthma	Rhody HP	2,227	1,650	12,210
Diabetes	Connect Care Choice	545	3,129	10,418
Diabetes	Fee For Service	408	2,197	7,192
Diabetes	Rhody HP	2,601	1,339	11,961
Psych	Connect Care Choice	635	3,510	9,272
Psych	Fee For Service	720	2,359	5,567
Psych	Rhody HP	3,586	1,755	10,063

Question # 3 – Methodology and Results

- For adults with disabilities access to physician services was higher for RHP and Connect Care Choice members versus unmanaged FFS for all four chronic conditions
- RHP members had lower ER utilization for all four chronic conditions
- CSHCN that had cardiac disorders and diabetes had higher physician utilization in the RIte Care program
- The utilization of ER services by CSHCN with chronic conditions was largely unaffected

Summary of Findings

- The state implemented a series of waiver initiatives and budget initiatives that helped to reduce Medicaid costs
  - The Lewin Group evaluated the impact of three of these initiatives and estimated savings of approximately $56 - $61 million for the period we evaluated
  - These initiatives along with the other initiatives that have already been implemented, and those initiatives that are currently being implemented will yield significant savings in future periods

Rhode Island Cost Containment Initiatives

Program Management Provisions requiring State Agency and/or Legislative Action	Provisions requiring additional CMS Approval	Global Waiver Provisions Approved by CMS in January 2009
Long Term Care Rebalancing		
• Nursing Home Case Review (SFY09) • **Nursing Facility Rate Cut (SFY09)** • Nursing Facility – No COLA (SFY12)	• Money Follows the Person (SFY12)	• **Nursing Facility Diversion/Transition (SFY10)** • Implementation of Nursing Facility Acuity Adjuster (SFY10 and SFY11)
Managed Care		
• Administration Reduction MCO and PCCM (SFY09 and SFY10) • High Cost Case Review (SFY09 and SFY10) • Increase Children's Health Account (SFY12)	• Generic Rx (SFY09) • Change in Children's Intensive Services Delivery System (SFY09)	• **Mandatory Enrollment in Managed Care for Children with Special Needs, Elders, and Persons with Disabilities (SFY10)** • MCO Re-Procurement (SFY11)
Smart Purchasing & Payments		
• Reduction of Non-Emergency Transportation Rates (SFY12) • Redesign Transportation Purchasing and Management (SFY12) • Program Integrity (e.g. fraud, Collections) (SFY11 and SFY12) • Enhanced Recoveries – Estate and TPL (SFY11 and SFY12)	• Rate Cuts – NICU, HTBS, Hospice to name a few (SFY09 and SFY 12) • Hospital Rate Reform – APR, DRG Inpatient and Out of State Reduction (SFY10)	• Selective Contracting – Shared Living (SFY11) • Redesign of Home Health Services payment (SFY12) • Elimination of Co-Share payments Rite Share (SFY12) • Re-Procurement of MCO plans, Selective Contracting Hospitals Outpatient (SFY12)
Benefit Redesign		
	• CEDARR Service Redesign (SFY11)	• Redesign Habilitation Program (SFY11) • Redesign Personal Choice Program (SFY11 & SFY12) • Add Pain Management Benefit (SFY12)
Estimated Savings (State Funds)		
$22,892,894	**$9,396,325**	**$22,944,288**