

Medicaid Senate HHS Commission Presentation

November 30, 2021

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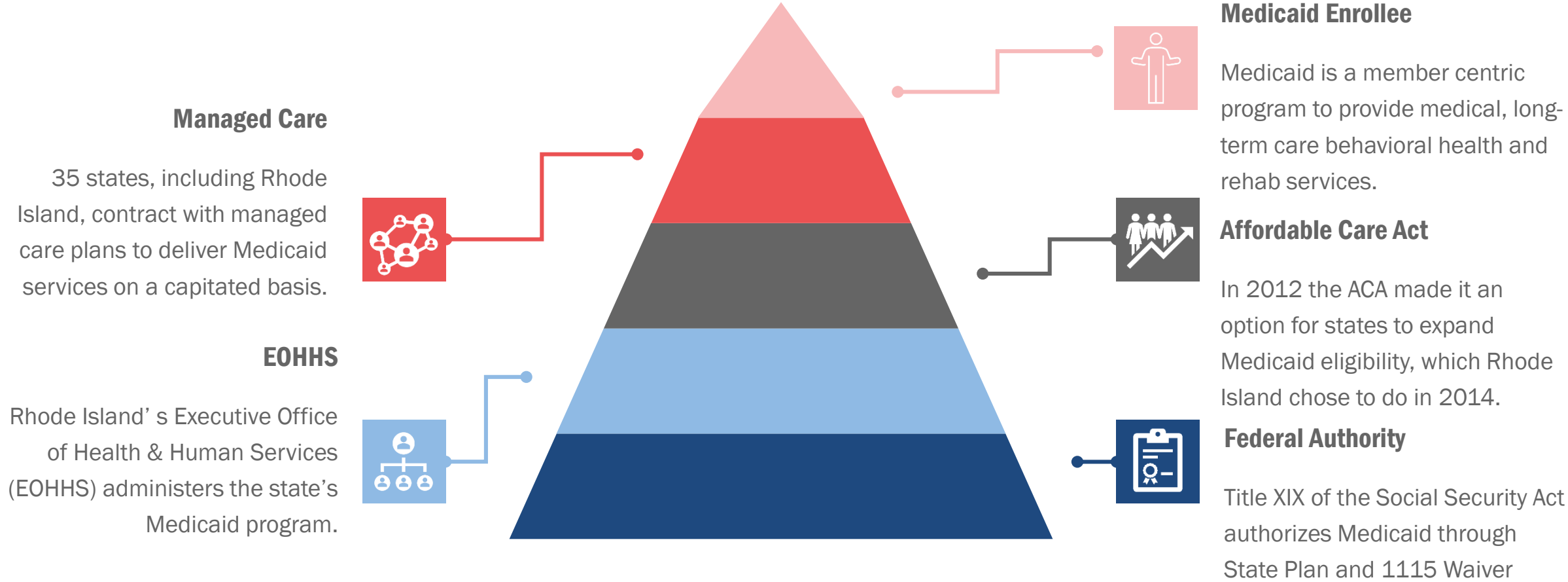
Agenda

1. Medicaid Overview and Initiatives
2. Medicaid Rate Setting
3. Managed Care Re-Procurement

Medicaid Overview

Medicaid Overview - Authority

Medicaid is a state and federally funded health insurer for people exhibiting categorical or financial need. The Center for Medicare and Medicaid Services (CMS) relies on states to administer their own Medicaid programs.



RI Medicaid Today – Eligibility

RI Medicaid coverage is extended to the following groups, largely dependent on income. Rhode Island has chosen to expand eligibility beyond what is federally mandated.

Children & Families

- Parents with children under age 18 with income up to 133% of the Federal Poverty Level (FPL)
- Pregnant women with income up to 253% of the FPL
- Children up to age 19 with income up to 261% of the FPL

ACA Expansion

- Childless adults ages 19-64 with income up to 133% of the FPL

Elders and Adults with Disabilities

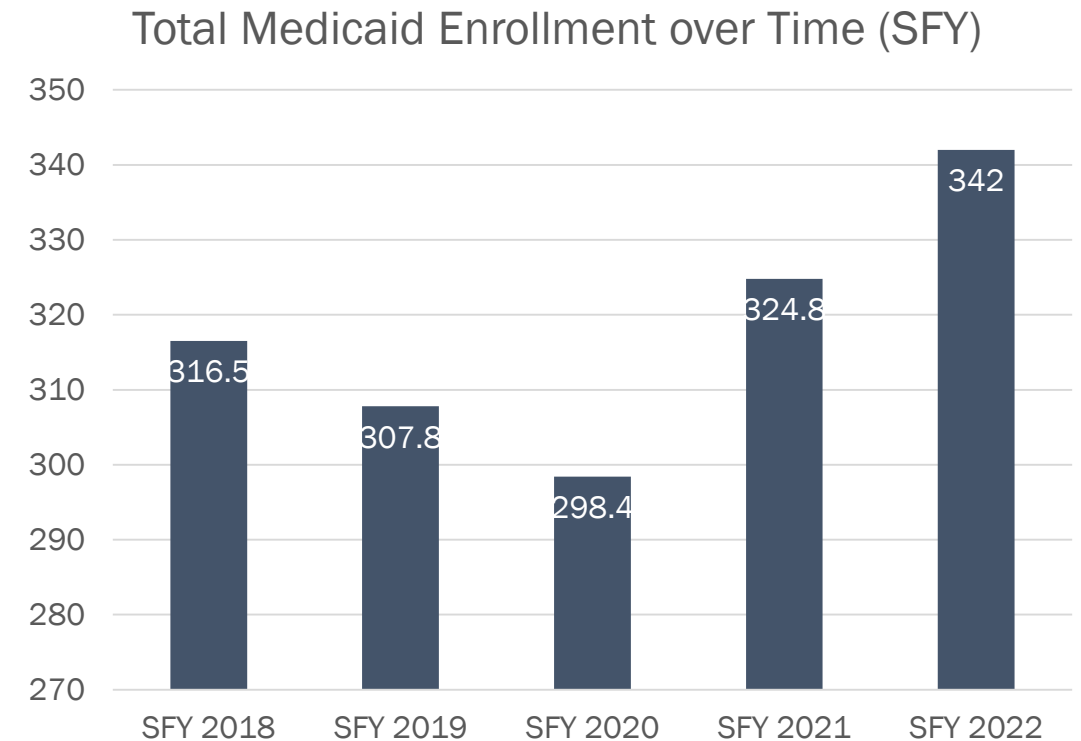
- Adults ages 65 and over with income up to 100% FPL and savings less than \$4,000 (single person) or \$6,000 (married couple)
- Adults receiving SSI

Special Populations (Children with Special Healthcare Needs, Substitute Care (DCYF), Extended Family Planning)

RI Medicaid Today - Enrollment

We cover ~342K Rhode Islanders in every city and town, including 55% of all children, 28% of adults and 12% of seniors in State. This represents a 15% increase over pre-pandemic levels.

Eligibility Category	Enrollment
Children and Families	174,099
Extended Family Planning	1,441
Child Welfare / DCYF	2,896
Children with Special Healthcare Needs	9,468
Expansion – Childless Adults	101,831
Aged, Blind, Disabled	27,765
Other	24,820



RI Medicaid Today – What We Cover

RI Medicaid must cover mandatory benefits per federal law, but may expand coverage to optional benefits. RI Medicaid coverage is generally considered comprehensive health insurance coverage. RI Medicaid has no cost shares or co-pays for these services.

Mandatory Benefits (All States Must Cover)

- Inpatient hospitalization
- Outpatient hospital services
- Primary care and physician services
- Lab and X Ray Services
- Home health services
- Nursing facility services
- Early and Periodic Screening, Diagnosis, and Treatment (Children’s Services)
- Non-emergency medical transportation

Optional Benefits (RI Chooses to Cover)

- Prescription Drugs
- Case management and home stabilization
- Assisted Living
- Home care / personal care services
- Physical therapy and occupational therapy
- Dental services
- Optometry
- Behavioral health, psychology and substance abuse disorder
- Interpreter services

RI Medicaid Today – Managed Care Organizations

88% - or 296K members – are in one of three managed care organizations. Managed care organizations (MCOs) are responsible for cost, quality and access for their populations. MCOs receive a monthly payment from the state for each member that they take care of. Members can select their own MCO when they become eligible and change once a year.



- ~187K members as of October 2021
- Includes DCYF-Child Welfare population, exclusively.
- Also includes joint Medicaid / Medicare product called Integrity aka MMP



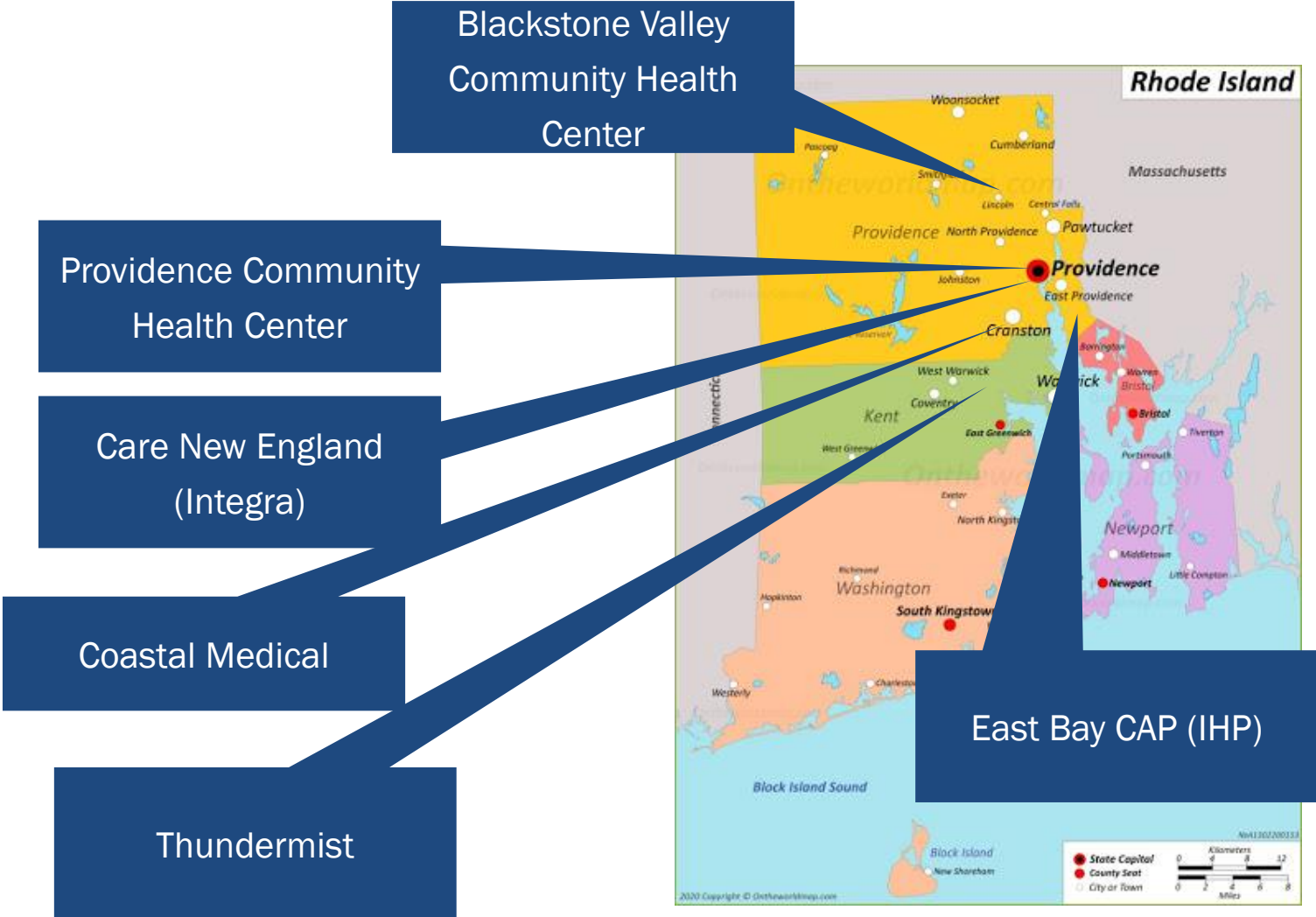
- ~97K members as of October 2021
- Includes primarily child and family, single adults and adult disabled population



- ~17K members as of May 2021
- New entrant into the RI Medicaid program in 2016

RI Medicaid Today –Accountable Entities

About to enter their fourth year, many Medicaid providers are organized as Accountable Entities. AEs are responsible for the primary and behavioral health care of their members. They work to make and keep their populations healthy, avoid hospitalizations and improve quality of care. These are the physicians and health care providers that most Medicaid members interact with. These AEs include health centers (PCHC, IHP, BVCHC), Hospitals (Integra/CNE, Prospect) and Primary Care (Coastal Medical).

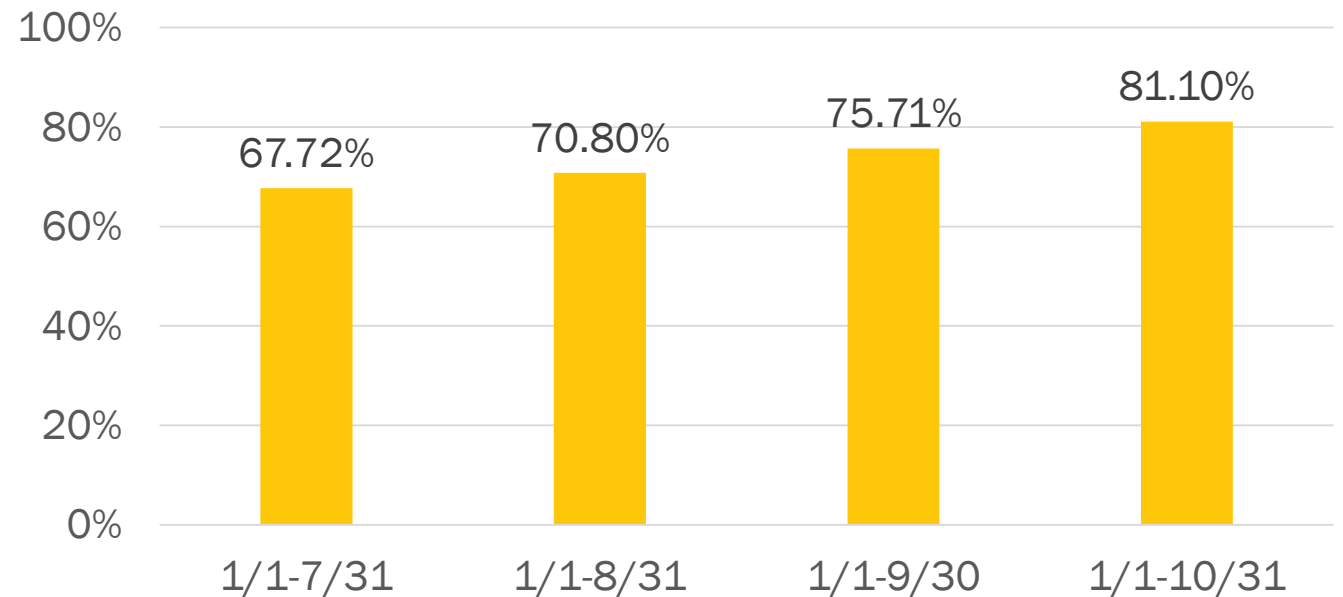


RI Medicaid – Response to COVID-19

We were at the forefront of the COVID-19 response. We applied for ~80 emergency authorities and launched 18 financial programs with over \$50M budgeted to ensure access to benefits.

- **For Workers:** ~\$20M in worker supports for congregate care and home care workers as “hazard pay” during COVID-19 to ensure that no-one during COVID was making less than \$15 / hr.
- **For Pediatricians:** \$7M in relief and rate supplements tied to improvements in Medicaid children receiving vaccinations and check-ups. Results show a 13 percentage point increase.
- **For Children’s Services and EI Providers:** \$5M in provider relief tied to re-opening plans to meet family’s needs.
- **For Long-Term Service and Supports Providers:** \$25M across 10 different programs to support providers and expand home and community-based options

Child & Adolescent Access to Primary Care: Proportion of Medicaid Children receiving Primary Care Services Following Pay for Performance COVID Program



RI Medicaid – Objectives and Select Initiatives

Objectives	Select Initiatives
Access to the right care at the right time	<ul style="list-style-type: none"> • Planning for PHE unwinding and re-starting Medicaid renewals and terminations • COVID-19 vaccine administration • Governor’s Down payment Proposal on Early Intervention and Pediatrics • Monitoring BBB Bill for Postpartum Coverage Extension
Quality care	<ul style="list-style-type: none"> • Managed Care Re-procurement • NF Transformation
To pay for value, not volume	<ul style="list-style-type: none"> • HSTP Sustainability Plan • LTSS, HCBS and BH HSTP Investments
Improve population health	<ul style="list-style-type: none"> • Community Resource Platform, Participatory Budgeting and Rhode to Equity • Doula and Community Health Worker Budget Implementation
Rebalance the delivery system	<ul style="list-style-type: none"> • HCBS FMAP (ARPA) workforce investments, no wrong door, self-directed expansion, CCBHC infrastructure payments
Excellent service	<ul style="list-style-type: none"> • Fill vacancies within organization • MES/MMIS Modernization

Medicaid Rate Setting

Medicaid Rate Setting - Overview

There are three ways Medicaid rates are set or amended. These mechanisms do not include “blending” funding from other sources like grants that often go to Medicaid providers (e.g. BH SAHMSA grants)

- Managed Care Rate Setting Process
- Fee For Service Rate Setting
- Managed Care Directed Payments under 42 CFR Section 438.6(b) such as incentive payments, directed payments, quality withholds, value based purchasing, or minimum rates.

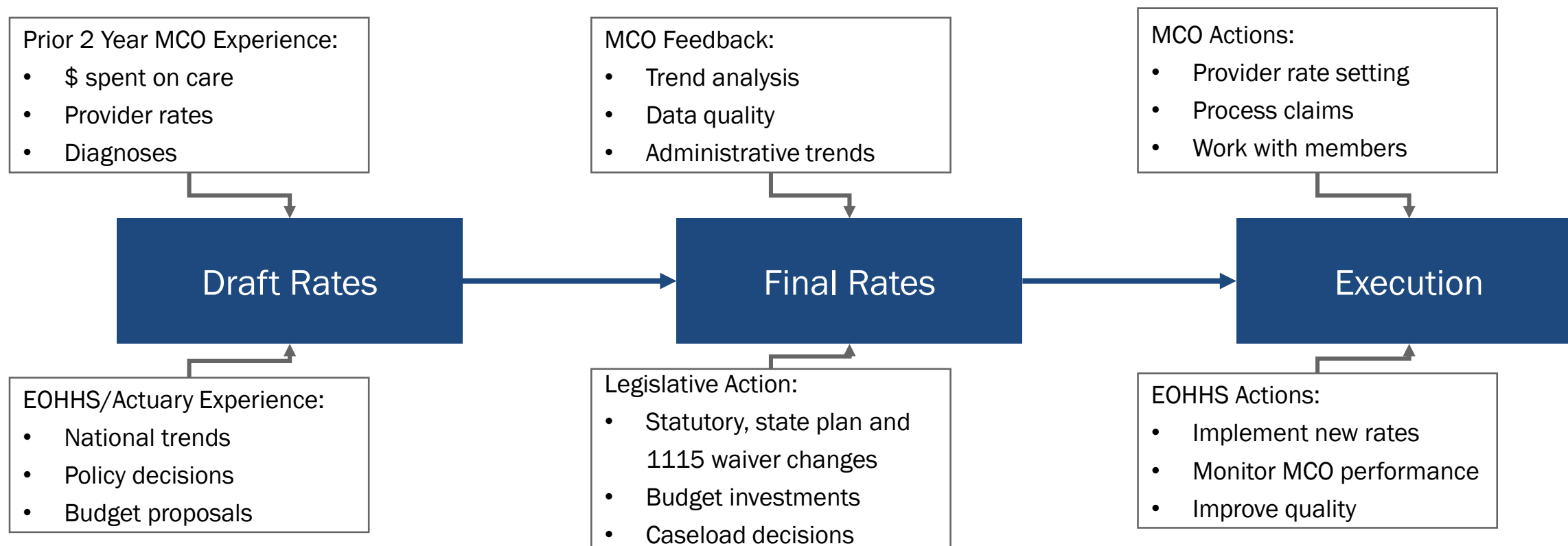
A Medicaid rate needs 1) a service or services in a bundle to be provided, 2) a price per service, 3) an eligible group of patients for that service, 4) eligible providers.

Moving Medicaid rates away from fee-for-service and towards quality linked payments, value-based payments or population-based payments is critical over time to increase quality and decrease cost trend.

All require inclusion in the Governor Recommended Budget and approval from the General Assembly. All require state plan/waiver, technology changes and policy guidance for implementation. Can take ~2 years from conception to full implementation of a new initiative.

Managed Care Rate Setting Detail

For our MCOs, EOHHS annually sets a per-member per month rate based on observed costs, State policy decision and national trends. These are adopted through the budget and caseload process. For example, an MCO covering a single female between ages 30-39 would get \$536 per month from the state. That is the capitation rate. MCOs set their own rates with participating providers.



Managed Care Re- Procurement

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EOHHS Medicaid Managed Care (MCO) Procurement: What We Heard

~9 Month Discovery Assessment and Planning Process

- **April 2021 Public Request for Information (RFI):** 19 responses from potential bidders, providers and stakeholders.
- **May 2021 Member Survey and Focus Groups:** Survey administered online and paper in 12 different languages receiving over 2300+ responses. Also held member focus group to learn about consumer experience and areas for improvement.
- **November 2020-Present, Cross-Agency Working Groups:** Feedback sessions with DCYF, DHS, DOC, RIDOH, BHDDH and HSRI to help address state-wide health goals.
- **Expert Interviews, National Reviews and Expert Policy Analysis:** Implement best practice and utilize other state examples to meet future program needs

Summary of What We Heard and Learned

“Support the integration of behavioral health care and primary care; Reform incentives and change the ways we pay for care; Implement payment reform to reduce unnecessary and low-value care; Implement quality improvement initiatives” – RI Foundation “Health in Rhode Island: A Long-Term Vision”

“I got general instructions [after hospital discharge] but they really didn't help me deal with the recovery process at all. I don't think they took the fact that I live alone and have no family/relatives into consideration. I could have used help.” – Member Survey

“Allow providers close to the patient to provide care and service coordination.” – RFI Responses

“MCOs can support AEs and other providers as they screen and intervene on member's social risk factors... Electronic tools, such as recording screening results in electronic health records (EHRs) and Community Resource Referral Platforms, will facilitate screening and intervention processes.” – RFI Responses

“State should use an independent ‘broker’ to help members select and MCO and members should be encouraged to choose a primary care doctor.” – RFI Responses

“We observed for many years the growing complexity of the MCO contract settlement process and the challenges facing EOHHS in ensuring the validity of the data supporting that process.” – Dennis Hoyle, Auditor General, Letter Dated July 16, 2021

EOHHS Medicaid Managed Care (MCO) Procurement : What We'll Improve

RFP released in November 2021 for contracts to potentially take effect in July 2022. New contract will make the progress in the four key areas below, building on our values of choice, engagement and race equity:

1 Empower Members to Make Informed Choices

- Allow DCYF families to choose among all MCOs, not just one, for all DCYF families.
- Allow Medicaid LTSS members who were with an MCO prior to LTSS determination to stay in their MCO for acute and behavioral health needs to not interrupt benefits.
- Develop beneficiary support broker to provider counseling on member choice and options.

3 Advance Health Equity

- Require MCOs to ensure that community feedback reflects demographics of their membership.
- Require MCOs to obtain formal certifications in health equity.
- Require MCOs to report quality data by race and ethnicity.

2 Improve Care Coordination and Management

- Allow providers to manage care coordination, if properly staffed and at a member's request.
- Require MCOs to ensure members have a centralized care plan, with responsible points of contact.
- MCOs must develop data sharing standards with AEs, and continue movement toward value-based payments

4 Finance to Support Quality, Access and Budget Predictability

- Utilize risk mitigation to stop backstopping MCO losses, eliminate reconciliation payments and protect taxpayer dollars from MCO excess profits.
- Pay MCOs in full only if certain quality measures achieved.
- Liquidated damages for not meeting SLAs for data quality, member services, and access to care requirements.

Any Questions?

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