



Key Provisions of "The RI Consumer Choice Compact Waiver"

August 15, 2008

On July 29, the Governor provided the House and Senate Finance Committees with a copy of the "RI Consumer Choice Compact Waiver" which it will submit to CMS. The "global waiver", proposes to include all of the state's Medicaid programs, services and funding, except for disproportionate share funds for hospitals, payments to local educational agencies and administrative costs. The state would agree to operate the entire program within a fixed amount of funds over the next 3-5 years. This proposal is unprecedented – no other state has sought to include all of its Medicaid programs in one waiver, nor request that funds for Medicaid be provided as a "block grant."

The waiver is the state's "ask" of CMS – the actual details of the waiver will be negotiated between CMS and the Governor's office. Once CMS and the Governor's office reach agreement on the final "terms and conditions" of the waiver, the document will be reviewed by the General Assembly. The General Assembly can revoke the authority to agree to the waiver if it does not think the terms and conditions are in the best interest of the state and its residents. This document summarizes some of the key proposals in the Waiver document.

Federal – State Matching Financing to be Replaced by Capped Block Grant:

The waiver proposes eliminating the current federal-state financing of Medicaid in which state expenditures for Medicaid are matched with federal funds and replacing this "entitlement" to federal matching dollars with a block grant with a fixed amount of federal funds. The state would be required to spend a yearly "maintenance of effort" amount. Many Medicaid experts question whether it is legal for CMS to grant a request to waive the basic Medicaid financing structure.

The proposed amount of the federal block grant over the 3 – 5 years of the waiver proposal is calculated as 52.51% of total Medicaid spending in the first year of the waiver and 54% of total projected Medicaid spending for each of the next 4 years.

The state's maintenance of effort would be 23% of the general revenue budget for the corresponding waiver year. The actual amount the state would commit to Medicaid spending each year is not specified in the waiver and the document states that "the methodology for determining this dollar amount will be delineated as review of the waiver proposal moves forward".

Although it is proposing a block grant – with fixed federal expenditures, the state is also asking to have the federal government "protect the state through additional funding to cover any costs resulting from: a national epidemic state of emergency; major and

prolonged economic downturn; unanticipated and extraordinary events outside of the state's control that cause MA costs to increase at a substantial rate above project amounts; costs from any new legal obligations. Such requests have been denied to other states that have requested capped waivers for parts of their Medicaid programs (e.g., Vermont).

In addition, while asking to change the Medicaid financing system under which the state receives a federal match for funds it spends and instead receive a block grant of money, the state is still asking to be eligible for any additional federal financial participation or funding that becomes available to the states in the form of fiscal relief.

Limiting Coverage to “Mandatory Populations”

The waiver document states several times that the state is committing to cover “mandatory Medicaid populations”. While the document indicates the state does not immediately intend to end coverage for “optional Medicaid populations”, the state reserves the right to do so if expenditures exceed budgeted amounts. Who are the optional populations that could lose MA?¹

- Young children in families with income above 133% FPL
- Children 6 and older in families with income above 100% FPL
- Parents in families with income above 38% FPL
- Children with severe disabilities who are eligible through the “Katie Beckett” provisions of Medicaid
- Young adults who have been exited from foster care at 18.
- Women with breast and cervical cancer
- Adults with disabilities and seniors with income above 74% FPL
- Adults with disabilities and seniors who receive home and community-based services.

Limiting Benefits

The waiver proposes to allow DHS/EOHHS to change the amount, scope and duration of benefits for Medicaid beneficiaries. The state promises to provide “mandatory services” but could eliminate optional services, if costs exceed budget. Optional services include:

- Prescription medication
- Community Mental Health Services
- Substance Abuse Treatment Services
- Podiatry
- Optometry and eyeglasses
- Dental Services
- Day treatment services for individuals with developmental disabilities

The waiver references changing the scope of benefit package for Rite Care participants to more closely mirror commercial plans, but details are not provided.

¹ An amendment to state law would be required before coverage could be ended for some of these populations – e.g., children and families. For others, there is no entitlement in state law (e.g., Katie Beckett)

The state would be allowed to set up health opportunity accounts for higher income groups. What the state considers a “higher income” group is not specified. Health opportunity accounts would require Medicaid beneficiaries to meet a substantial deductible before they could access their standard Medicaid benefits. The state would contribute to the account to help the beneficiary pay for the costs they incur before Medicaid coverage starts, but the state is not required to fully offset those costs.

More Cost-sharing

The waiver proposal would allow the state to impose cost-sharing in the form of premiums and co-payments for services above those currently authorized. The waiver calls this “Smart payments.”

Cost-sharing for very low income children and families, seniors and adults with disabilities could be required. While the amount of cost-sharing for the adult groups is not specified, the waiver does specify cost-sharing for RItE Care families:

For families with income above 150% FPL – a monthly premium of 5%
For families with income between 133% and 150% FPL – a monthly premium of 3%.

These premiums are already authorized by the current 1115 Rite Care waiver (and approved by the General Assembly) and are the highest premiums in New England. Under current law, (and under the existing Rite Care waiver), infants and pregnant women are exempt from cost-sharing, but this exemption does not appear in the global waiver.

The global waiver seeks additional authority to charge co-payments to families with income below 133% FPL as follows:

Emergency Department visits for conditions that could have been treated in a doctor’s office:

\$3/visit for children and parents with income below 150% FPL
\$25/visit for children and parents with income above 150% FPL

Prescription Co-pays:

\$0 for generic drugs – all income levels
\$3 for brand name drugs – all income levels

All RItE Care recipients will soon be required to use only generic drugs – except for certain medications for which the state and the Health Plans determine a generic substitute is not appropriate. Since the beneficiary will have no option to choose a generic or brand name medication, requiring a co-payment for brand name medication makes little sense.

While providing that a “smart premium or co-pay is a form of cost-sharing that is “outcome” oriented rather than a means of shifting or distributing costs”, the only likely “outcome” of the proposed cost-sharing is likely to be disenrollment from coverage because monthly premiums are unaffordable or inability to pay for necessary services – co-payment for medications for people with income below poverty.

Restricting entitlement to long-term care services (in facilities or in the community) for seniors and for adults and children with disabilities

The global waiver proposes to implement a new three-tier level of care determination process for eligibility for long term care services for seniors, adults with disabilities and children with disabilities. Those who qualify for the highest level of care will be entitled to services – either in a long-term care facility (nursing facility, ICF-MR, pediatric hospital) or in the community.

Those determined to need a “high level of care” will be eligible for “core” home and community based services including shared living, assisted living and home care services and supports. Those who are determined to need a preventive level of care will have access to certain preventive services. However, only those who are determined to be in the “highest level” will be entitled to services. For seniors and people with disabilities who are determined to need a “high level” of care, services are provided as long as funding is available.

The waiver proposal does not describe the clinical criteria for each of the levels of care. A DHS- led working group has proposed the criteria for levels of care for nursing facility services, but there has been no discussion of levels of care for adults or children with disabilities.

The new levels of care could result in current recipients becoming ineligible for the home and community based services on which they rely – since some who are receiving these services now might not be eligible under the new standards of the “highest” level of need. Even if eligibility is preserved for those currently receiving services, this proposal will result in a restriction of availability of services to vulnerable Rhode Islanders.

The global capped waiver is not necessary to “save \$67 million” in FY 2009

The Governor’s office has promoted the Global Waiver as necessary to achieve \$67 million in Medicaid savings in FY 2009. However, as the following chart shows, the administration already has the authority to achieve most of those savings without any additional federal waiver authority and for some of the programmatic changes it would only need simple-to-obtain state plan amendments of 1915(b) waivers.

The key feature of the global waiver, as well as the largest part of the proposed Medicaid “savings” for FY 09 is related to “rebalancing long term care” for seniors – to provide more community-based alternatives. Using current waivers, the administration could achieve some of the proposed \$22 million savings by just starting the activities it says are necessary (helping to avoid discharges from hospitals to NF by having staff at hospitals

to counsel individuals and families; changing rates for community-based services, etc.). The administration could also seek state plan amendments or a separate 1115 waiver to obtain any additional authority it needed to increase access to community-based services. An 1115 waiver that capped spending per person (as does the RIte Care 1115 waiver) instead of capping funds for the entire Medicaid program, would be a much more responsible way to proceed.

The following chart shows how the state anticipates saving \$67 million in FY 2009 and whether any additional authority from the federal government is necessary to achieve those savings:

Proposal	State Savings (millions)	Action Required/ New Federal authority
I. REBALANCING LONG TERM CARE		
DHS - Rebalance LTC for seniors	\$22.1	Implement current Perry-Sullivan plan; state plan amendment and/or 1115 waiver could be pursued
MHRH - Vouchers and “shared living” for adults with developmental disabilities	\$10.5	Can accomplish with current waiver. No additional federal authority needed
DCYF – program redesign to increase home and community based services and avoid 300 residential placements for children	\$3.5	System design already in place.
DCYF – reduce time at training school	\$1.5	No new federal authority necessary
MHRH – increase community supports to help adults with serious and persistent mental illness avoid hospitalization	\$5	No new federal authority necessary
II. MANAGING CARE		
“Consumer directed health care” – cost sharing for RIte Care families at 133% FPL and increasing cost-sharing for families above 150% FPL. Co-pay for non-generic medication and for unauthorized use of ER. Healthy choice accounts	\$2.3	Cost-sharing allowed under current 1115 waiver. Amendment of 1115 waiver RIte Care waiver to establish healthy choice accounts..
Selective Contracting (children’s behavioral health - \$7.7 m; selective contracting for hospitals under RIte Care - \$1.7 m.)	\$9.4	No additional federal authority needed
Katie Beckett Power Account = cost sharing	\$1.7	Allowed under current 1115 Rite Care waiver for children in managed care. SPA or waiver to require cost-sharing for children in

		fee for service. Note: this “savings” was not authorized by the general assembly for FY 09.
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Reduced benefit package for parents in Rite Care	\$.6	State plan amendment to eliminate dental. Rite Care waiver to limit other services (OTC medication; podiatry)
Mandatory Managed Care for Adults with disabilities and seniors	\$1.3	State plan amendment to make enrollment mandatory instead of voluntary
Mandatory Primary Care Case Management for Adults with disabilities and seniors	\$3.5	State plan amendment to make enrollment mandatory instead of voluntary
Mandatory enrollment of children with special health care needs into Rite Care	\$1.3	Allowed under current 1115 Rite Care waiver.
Fair share employer sponsored insurance	\$2.8	Mandated by state law, no federal authority required
Reduce managed care administrative costs	\$2.8	Already implemented
Premium “accountability” – change rules for Rite Care families that lose coverage due to failure to pay premiums	\$.5	Allowed under current 1115 Rite Care waiver
III. “Smart Purchasing”		
Selective contracting for in-patient psychiatric services	\$3.0	1915(b) Freedom of Choice waiver
Selective contracting for out-patient non-urgent surgery	\$.4	1915(b) Freedom of Choice waiver
Dispensing fee, PDL for anti-psychotic medication, hospital pharmacy rebates, reduce rate for Bradley Step down program	\$1.4	No federal authority required
State funded in-patient psychiatric beds	\$1.5	