North Dakota Department of Human Services
Summary of: Rhode Island (RI) Global Waiver
Prepared for Rep. Jim Kasper – December 2010

- There are 1,036,400 residents in Rhode Island (RI), 179,200 Medicaid enrollees, and roughly 1/5 of the state is on Medicaid.

- About 50% of the Medicaid enrollment is children and 50% adults.

- 74% of all RI Medicaid enrollees are in a managed care plan, operated by a managed care organization. They also have about 2,000 enrolled in their Primary Care Case Management Program. After speaking with Gary Alexander, Secretary of the Rhode Island Executive Office of Health and Human Services (EOHHS), he prefers a Primary Care Case Management model of care. Their PCCM has taken an enhanced primary care model approach that combines clinical tools with quality improvement methods to improve health outcomes. Tools include: clinical guidelines, patient registries, team care, monitoring, outreach and the formation of multidisciplinary teams that use continuous quality improvement.

- Prior to the Global Waiver, RI Medicaid had 11-12 Medicaid waivers, and the Medicaid State Plan. By implementing the Global Waiver (an 1115 Medicaid waiver), this has reduced this number to RI to the Global Waiver and State Plan only.

- Three major goals of Global Waiver initiative from the Executive Office of the Health and Human Services were:
    - Improve care and service delivery-break down silos, create a seamless service delivery system across the consumer's lifespan and centralize fiscal authority. These goals were accomplished by: eliminating the competition between the departments, centralizing the fiscal authority between all departments, and combining program administration from divisions that seemed to 'fit' together.
    - Modernization-improve administrative efficiencies by streamlining program procedures and leveraging resources across agencies, establish 'no wrong door' approach to services, and adopt best practices. These goals were accomplished by simplifying all applications across programs, redesigning the re-application system, and educating the public on the new application system.
    - Transparency-timely information about services, invite consumer input, full disclosure of reimbursement rates. These goals were accomplished by providing consumers more timely information on grant choices, holding focus groups or open forums for consumer input and providing public disclosures on big department purchases.

- The purpose of the Global Waiver from a Medicaid perspective was to:
    - Rebalance the publicly funded long term care system. This goal was accomplished by making long term care services more flexible such as paying for more in-home cares to prevent long term care placement, establishing a 'point' of entry into the long term care system for appropriate referrals, and offering more choices to the long term care delivery system such as adult daycare, PACE and live in caregivers.
    - Ensure access to a primary care medical home model.
    - Procure Medicaid funded services through cost effective strategies. This goal was accomplished by demanding greater performance requirements of all vendors and paying closer attention to the procurement of contractors/vendors.
    - Determine if the use of federal funds for populations or services that are not generally eligible for federal match is cost effective (i.e. behavioral health). This goal was accomplished by offering services for the elderly who were just above the Medicaid income threshold and providing behavioral health services for individuals with behavioral health needs just above the Medicaid income threshold.
    - Enhanced IT coordination of services across State agencies which improves capacity and efficiencies. This was done by increasing interagency collaboration, streamlining eligibility, RI received a 3.6 million IT infrastructure planning grant for this project.

The waiver was looked at favorably by CMS, as it provided some fiscal security by establishing a maximum federal contribution of a 12.075 billion ceiling for the five year waiver. The state of RI is at risk for expenditures above the ceiling. At this point, RI does not feel they will go over this benchmark.

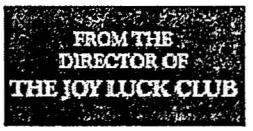
Gary Alexander, Secretary of EOHHS, stated that his approach with this waiver would have been a PCCM model of care. The enhanced primary care model has many advantages for both patients and clinicians as compared with competing models and he believes this model is less costly than the MCO model of care.

Rhode Island believes that the provisions of the Affordable Care Act will have significant impact on their waiver. In their words, "it will essentially kill their waiver".

Rhode Island Global Consumer Choice Compact Medicaid Waiver

News Article

Sources: Gary Alexander, Secretary of the Rhode Island Executive Office of Health and Human Services and http://www.dhs.ri.gov/FamilieswithChildren/HealthMedicalServices/MedicaidGlobalWaiver/tabid/399/Default.aspx



May 15, 2011

Rhode Island's Medicaid Experiment Becomes a Talking Point for Budget Cutters

By JANET ROBERTS

With Republicans pushing to rein in Medicaid costs, an experiment in Rhode Island is drawing the attention of some conservatives who say it has led to substantial savings without reducing care for the state's poorest patients.

The experiment is the closest to an example of the kinds of changes that Republicans say they want to make — limiting federal spending for Medicaid while giving states more freedom to decide what benefits to offer and how to control the costs.

But an examination of Rhode Island's experience shows it has not yielded the kinds of savings its supporters claim.

Federal spending on Medicaid continues to rise in Rhode Island, including payments the federal government would not be making otherwise. And unlike a Republican plan that passed the House last month, under which states could lose a substantial amount of federal financing for Medicaid, Rhode Island is virtually guaranteed more money than the state itself has estimated it needs.

Under the experiment, which was born in a 2009 agreement between the state and the federal Centers for Medicare and Medicaid Services, spending on Medicaid was capped at $12 billion through 2013. The state would be responsible for all costs above that amount, rather than sharing those expenses with the federal government.

In exchange, the federal government granted Rhode Island more flexibility in how it runs its Medicaid program.

State health officials predicted the agreement would allow them to offer better and more efficient health care at less cost to taxpayers.

Some Republican governors, members of Congress and conservative commentators have seized on the Rhode Island experiment as proof that the Republican plan to turn Medicaid into a "block grant" program can work. Under such a program, states would get a set amount of federal money to spend on health care for the poor and disabled, along with the autonomy to decide how best to spend it.

Gary D. Alexander, a Republican and former Rhode Island secretary of health and human services, praised the agreement, which he negotiated, in a paper published this year. He said the state had saved more than $100 million in the first 18 months.

But Mr. Alexander's Democratic successor, Steven M. Costantino, said he "cannot substantiate those savings at this point."

Still, Mr. Alexander's estimates have been widely cited by those who support overhauling Medicaid.

Representative Cathy McMorris Rodgers, Republican of Washington State, is the co-sponsor of a plan introduced last week in Congress to lift rules that forbid states from changing Medicaid eligibility requirements. She considers the Rhode Island agreement to be a model for other states, said her press secretary, Riva Litman.

"That plan is supported by both parties in Rhode Island and has saved hundreds of millions of dollars through competition-driven efficiencies and accountability," Ms. Litman said.

The Rhode Island agreement shares the same goals as the block-grant plan proposed by Representative Paul D. Ryan, Republican of Wisconsin, and contained in the budget resolution that passed the House last month, said Conor Sweeney, a spokesman for Mr. Ryan. The idea is to give states the "freedom to tailor Medicaid to meet the needs of their unique populations," he said.

"Rhode Island's experience underscores the positive gains from loosening Washington's misguided one-size-fits-all approach that ties the hands of too many state governments," Mr. Sweeney said. "Governors across the country continue to demand less onerous restrictions from Washington so they can better deliver quality, affordable health care to their Medicaid populations."

During a Senate Finance Committee hearing in February, Senator Tom Coburn, Republican of Oklahoma, also pointed to the experiment in Rhode Island as a success.

"Why don't we just block-grant every state, take the rules off and let them do these strategies," he asked. "Rhode Island's obviously already figured it out."

Among the governors who support the idea are Chris Christie of New Jersey, who wants to pursue an agreement of his own with the federal government, and Scott Walker of Wisconsin, who wrote an article for the Op-Ed page in The New York Times last month contending that states' success with such agreements "shows that we can move beyond demonstration projects and let the federal government relinquish control over Medicaid."

States would gain more control through a block-grant program, but Rhode Island's Medicaid experiment is far different. For starters, the federal government is helping to pay for health care programs that otherwise would not be eligible for federal reimbursement. The state has received more than $44 million in such financing since the agreement took effect, said Mr. Costantino, who became secretary of Rhode Island's Executive Office of Health and Human Services about a year after the agreement was approved.

Total federal Medicaid spending surged in Rhode Island in 2009 and 2010, as it did in all states, because of the recession stimulus package. Rhode Island received an additional $320 million to help cover the program's costs.

Even absent the stimulus money, federal spending for Medicaid in Rhode Island increased at almost the same annual rate as during the five years before the agreement.

The agreement's impact on the state's bottom line is murkier. State spending dropped in 2009 and rose again the next year. Mr. Costantino said he has tried several times, to no avail, to corroborate the savings claimed by Mr. Alexander in his paper, which was published on the Web site of the conservative-leaning Galen Institute.

In an early version of the paper, Mr. Alexander said that Rhode Island had saved about $150 million during the first 18 months of the agreement. A later version lowered the estimate to $110 million. The paper does not detail how he arrived at those numbers, nor does it explain the reason for the change.

Mr. Alexander, now Pennsylvania's acting secretary of welfare, did not respond to requests for comment left with a spokesman in his office.

It is difficult to isolate the agreement's impact on spending, Mr. Costantino said, because so many additional factors drive state costs and spending decisions.

One thing is clear: Rhode Island's agreed-upon federal limit has not squeezed its $2 billion-a-year Medicaid program. And that is a key difference between Rhode Island's experience and the block-grant proposal: block grants would funnel less money to the states, but Rhode Island's agreement almost certainly guarantees the state more than it intends to spend.

Though Rhode Island's agreement limits federal contributions, the cap was set so high, Mr. Costantino said, that the state is unlikely to hit it. If it did, the state would be spending so much on Medicaid, the program would become unsustainable, he said.

Total spending in fiscal 2009 fell more than 25 percent below the agreement's annual target. Last year, spending was 17 percent below the target.

Contrast that with Mr. Ryan's plan, which would award the states annual grants that critics say would not keep pace with rising health care costs. The Congressional Budget Office estimates that federal Medicaid spending under the Ryan plan would fall 35 percent below current projections by 2022 and 49 percent below by 2030.

As for the flexibility the state gained under the agreement, Mr. Costantino says it is limited. Rhode Island still must get federal approval for major changes in its program.

And he does not agree with suggestions that Rhode Island's program is a model for how block grants could work.

"I don't think it's a fair comparison," Mr. Costantino said. "When one does an analysis of this program and you look at what I suspect a block grant would be, many of the tenets just do not match."

Rhode Island Medicaid Reform
Global Consumer Choice Compact Waiver

Rhode Island Global Consumer Choice Compact Medicaid Waiver
A National Model for MEDICAID REFORM

"Government should cost the least and do the most." **Thomas Paine,** ***Common Sense***

Entitlement Reform – *The Rhode Island Experience*

The United States is on a long-term unsustainable budgetary path. Entitlements are one of the largest spending categories in the federal budget and without real reform the nation will be forced to deplete resources from other programs like education and the environment. Medicaid, the largest spending category in state budgets, is one such entitlement in desperate need of reform and redesign. Its present growth rate and accompanying business model is unsustainable and archaic and it is driving states to reduce spending in areas that thwart economic growth and business development.

The leadership in Congress is promising to cut spending, reform entitlements, curb the size and influence of the federal establishment and demand recognition of the distinction between the powers granted to the federal government and those reserved to the states or to the people. The Medicaid Program is one such entitlement desperately needing reform. As President Reagan said in his first inaugural address:

> ..... great as our tax burden is, it has not kept pace with public spending. For decades we have piled deficit upon deficit, mortgaging our future and our children's future for the temporary convenience of the present. To continue this long trend is to guarantee tremendous social, cultural, political, and economic upheavals. You and I, as individuals, can, by borrowing, live beyond our means, but for only a limited period of time. Why, then, should we think that collectively, as a nation, we're not bound by that same limitation? We must act today in order to preserve tomorrow.

Unfortunately, we have not acted. Over the past 15 years, Medicaid has grown from about an average of 15% of state budgets to 25% today. Projections in most states say that without serious reform, it will make up approximately 35% to 40% of all state budgets in the next 5 years. One time fixes and federal government bailouts exacerbate the crisis and push states further into debt. A real solution to the Medicaid crisis is needed.

Rhode Island has already paved the way to reforming entitlements by crafting and implementing the most sweeping entitlement reform in the nation called the ***Global Consumer Choice Compact [Medicaid] Waiver.*** Rhode Island is the only state in the nation that crafted a waiver to address both federal and state fiscal calamity and reform a major entitlement. Here is a snapshot:

1. Rhode Island asked for a Block Grant with risk share and after lengthy negotiation and with the clock running out on the end of the Bush Administration, settled for a **capped** or aggregate allotment with traditional FMAP and FFP. The first capped Medicaid program in the nation.

2. The Rhode Island Waiver provides both the federal and state budgets with budgetary certainty because of the fixed allotment of funds over the 5 year period.
3. Provides a private sector approach to making changes to the waiver by putting a time limit on answers from the federal government and infuses private sector principles like competitive contracting and pay for performance.
4. Gives the state more flexibility to add, delete or modify benefits and waives certain provisions that up until this waiver were seen as sacred like "any willing provider".
5. Provides for an HSA type program with wellness and prevention incentives.
6. Creates **one** waiver across the lifespan [program] instead of 10 or 12 different and confusing waiver programs, which possess different rules and different federal bureaucrats to work with.
7. Focuses on the most costly populations, the elderly and disabled and provides innovative solutions to drive down the cost.
8. It uses tax-payer dollars for the neediest only as originally intended.
9. It provides freedom and independence to the consumer/person by placing people in the least restrictive settings and focuses on the person rather than the provider.
10. It provides the state with greater freedom to design and redesign programs with a new process to seek federal approval [reduction of red tape].
11. Focuses on Information Technology solutions and rooting out fraud and waste.

ORIGIN – *Impetus for Reform*

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 the individual states. Over the next four decades, the desire to supply health insurance to the needy blossomed into one of the nation's costliest programs, and without systemic reform, may bankrupt the nation.[1]

Like many social welfare programs, Rhode Island's Medicaid system has evolved over the years, expanding beyond the traditional role of a safety net to become the principal source of health coverage and services for approximately 250,000 Rhode Islanders, or one-fourth of the state's population. Medicaid has become an integral part of the State's health care system and the chief financier of the long-term care industry. By SFY2007, Rhode Island's Medicaid system ranked #2 in the nation for spending per capita, at $1,600 per citizen enrolled, had been growing at over 8% per year [with state revenues barely growing at 2.5%], and comprised close to 30% of the state's budget.[2]

At issue for the State was the financing of Medicaid and the growing gap between general revenues and Medicaid and remaining health and human services operating expenditures. Fiscal pressures,

[1] The original purpose of the Medicaid Program was to serve the neediest only and to allow states "to furnish rehabilitation and other services to help such families and individuals attain or retain capability for **independence** or self care. 42 U.S.C 1396. See Myers v. Reagan 776 F.2d. 241, 243 (8th Cir. 1985)

[2] Less than 10 years ago, Medicaid represented one-fifth of Rhode Island's budget. By SFY 2007, it had grown to over a quarter of the state's budget and, if left to the status quo, Medicaid would eventually take up more than one-third of all state spending in less than 10 years. Like most states, the State of Rhode Island had for a number of years been involved in strategies to improve the quality of services, allow for more choices, rebalance the service delivery system, and manage care. Even with all of the programs, waivers and alleged system re-designs, the state of Rhode Island had not been able to effectively reform its Medicaid program so that the focus would be on competition, prevention, wellness, personal responsibility, choice, consumer empowerment and independence.

service demand, institutional bias, lack of competition and care management and scant program integrity had colluded to push Rhode Island further down the path toward comprehensive Medicaid reform. Further, with Medicaid growth at an unsustainable rate, other vital programs like education, local aide and the environment would suffer.

Rhode Island and the nation are currently experiencing a full-blown recession. Rhode Island is feeling the pressures of the economic downward spiral, with increasing unemployment [at 12% 3rd highest in the nation] and decreasing general revenues. The single largest piece of the state's budget is health and human services, and simply cutting programs alone does not address the problems that only systemic reform and change can achieve. Governor Donald Carcieri and Health and Human Services Secretary Gary Alexander set out to fix the problem and make the program sustainable for those who need it most with six underlying principles:

1. *CHOICE*
2. *INDEPENDENCE and FREEDOM*
3. *QUALITY*
4. *COMPETITION*
5. *PERSONAL RESPONSIBILITY*
6. *EMPOWERMENT*

In addition, the traditional Medicaid Program, which operates under multiple waivers and amendments with different and cumbersome administrative rules and procedures, was inefficient, costly and broken. Efforts to make programmatic changes piecemeal were hamstrung by onerous federal approval requirements. Medicaid was unsustainable and antiquated. The need for reform was real.

REAL REFORM – Global Waiver

On August 8, 2008, Governor Carcieri and Secretary Alexander took bold action to address the Medicaid issue by applying for the ***Global Consumer Choice Compact Waiver*** under Section 1115 (a) of Title XIX. In fact, this was the most comprehensive attempt to fundamentally change the Medicaid system and end the current entitlement.

Rhode Island's initial application requested an aggregate allotment [block grant], similar to the TANF Block Grant created in 1996.[3] A fixed amount of funding was requested from the Centers for Medicare and Medicaid Services [CMS] to cover Medicaid services over the five-year demonstration with a maintenance of effort by the state. The state also requested to keep a portion of the federal savings incurred in order to incentivize an emphasis on cost containment and quality. The state requested complete freedom to define mandatory and optional populations and customize mandatory and optional benefits and services.

[3] This block grant request would have terminated the Federal Financial Participation formula and given the state a straight TANF-like block grant.

During the process, a few members of Congress put intense pressure to squash the proposal because of the cap and flexibility provided to the state.[4] Rhode Island resisted these pressures knowing that there was enough money in the system to support the population without asking the federal government for more money and that the added flexibility would allow the state to sustain the program and improve quality. In the end, although CMS rejected the full scope of the state's initial request, it did allow an unprecedented amount of flexibility and some relief from onerous federal rules; this gave Rhode Island the most comprehensive entitlement reform in the nation's history.

The State received approval of the waiver in January 2009 and entered into an agreement to begin full implementation of the waiver on July 1, 2009. The Goal was straightforward: Relieve the onerous programmatic and administrative burdens on the State by allowing Rhode Island to adapt the program to meet the changing needs of its state, recipients and fiscal realities. Simply put: Give the state relief from federal mandates and greater freedom and independence to tailor its program to meet the needs of its population.

The centerpiece of Rhode Island's innovative Global Waiver is a new State-federal compact that provides both federal and state governments with greater budget certainty and the State with substantially greater flexibility and freedom than is typically available under federal program guidelines.[5] In exchange for the flexibility, Rhode Island is operating the Medicaid program under an aggregate budget ceiling of $12.075 billion dollars through to 2013.[6] Even with an aggregate budget cap, Rhode Island was confident that with greater flexibility and relief to operate its program with less onerous federal rules, Rhode Island would not exceed the cap. Rhode Island became the first state in the nation to cap its entire Medicaid program.

As a result of this historic agreement, the Waiver establishes a new streamlined and expedited 45 day approval process for any changes to benefits or program during the 5 year demonstration period; establishes new levels of care for the determination of long term care eligibility that will serve to place priority on high quality and less expensive community based placements over costly institutionalized care, and give consumers meaningful choice; allow for benefits in any optional and mandatory program to be "customized" to fit the needs of the person[7]; allow for priority to be placed on preventative services, wellness and personal responsibility; establish a healthy choice account that will reward healthy behaviors with appropriate incentives; allow new purchasing

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[4] A few members of Congress urged CMS to reject Rhode Island's proposal because they refused to accept anything outside of the traditional Medicaid program. The Democratic leadership in the Rhode Island General Assembly however, showed great courage by supporting the proposal because of its innovative design. The Democratic leadership in the General Assembly was an equal partner with the executive branch in the approval process and but for their support, the waiver would not have been approved.

[5] Title XIX of the Social Security Act is the law governing the Medicaid Program. Federal law sets minimum standards for states to run the Medicaid program, though states have some flexibility to design their programs within these limits. States may ask the Secretary of the U.S. Department of Health and Human Services (DHHS) to put aside or "waive" certain provisions of the law. A "waiver" refers to an agreement between the federal government and the state that defines the circumstances under which the state is exempt from the specific provisions of the federal Medicaid law waived. The federal waiver authority in this section of the Social Security Act allows the Secretary of the U.S. DHHS to approve research and demonstration projects that give the states the latitude to pursue the innovative, and comprehensive reform Rhode Island needed.
Term "Global" Refers to: Scope of the Demonstration Project. The State proposed to demonstrate that by operating the RI Medicaid program under a single Section 1115 waiver, the State would be able to implement reforms program wide.
Waiver's Unique Financial Arrangement. The "global" waiver financing mechanism sets a fixed or aggregate sum of dollars for program operations for a set period in exchange for the flexibility to determine how the dollars are spent.

[6] Essentially, Medicaid is capped at $12.075Billion over the 5-year period of the waiver. Originally, the state sought approval to operate a block grant much like the TANF program. CMS did not allow the state to proceed with a block grant and insisted that the state operate under the traditional federal-state matching arraignment. Rhode Island is the first state in history to request a block grant for its Medicaid program.

[7] Authority to **target and tailor services** in the right place, time and setting. This is not allowed in any other state's Medicaid program to the extent that Rhode Island has received.

strategies that focus on quality and competition; waive the "any willing provider" Medicaid provisions; and consolidate all 11 waivers with their different rules and policies into one waiver with streamlined regulations that focuses on the consumer over the lifespan.[8] *With the Waiver – State has latitude to preserve coverage and services for those with the greatest need or re-tool benefit packages to ensure coverage for the maximum number of beneficiaries with in established budget constraints.*

Further, the state is allowed to access federal financial participation [FFP] for state only funded programs covering low-income populations at-risk for institutional care. These are called Costs Not Otherwise Matchable [CNOM] and are designed to delay the need for high costly institutional settings. Secretary Alexander and his team successfully negotiated inclusion of these populations in the Wavier, resulting in approximately $100 million in additional federal funds over the 5-year period. The state also negotiated a $3.6Million dollar planning grant to reengineer the state's antiquated eligibility system to comport with its MMIS system and upgrade program integrity efforts, enhance its health care data warehouse, initiate telemedicine for home care and track recipient health utilization and nutrition to comport with the healthy rewards program.

Global Waiver Fundamentals

Basis of the Compact: Programmatic and Administrative Flexibility and Fiscal Certainty.

Administrative Flexibility Waiver: Global Waiver establishes a new and unique review process in which level of federal scrutiny is commensurate with proposed scope of change in the Medicaid program.

Category I Change: State required to report nature of the change. No prior approval necessary.	Change that is administrative in nature: -changes to prior authorization process; -additional HCBS benefits.
Category II Change: State initiatives an expedited 45 day review process. Federal approval of change required to obtain federal matching funds for proposed. Decision on day 45.[9]	Programmatic change not requiring review of budget neutrality agreement: -changes to payment methodologies; -addition, change or elimination of optional benefits.
Category III Change: State request to change waiver scope, purpose or component that has an impact on the financial agreement. Requires federal review and approval of the an amendment to the Global Waiver under Section 1115 of the federal Medicaid law (Title XIX).	Requires review of budget neutrality agreement: -eligibility changes; -elimination of a mandatory service.

[8] The Global Waiver also offers the state great opportunity to streamline its bureaucracy by consolidating all of the old waivers into one global waiver. Under the old system, the state operated many waivers with different reporting requirements, timelines, goals and scant oversight that were managed and operated across five [5] health and human services agencies. Each department coveted their own waiver[s] leaving little room for coordination and oversight. Currently the Executive Office of Health and Human Services [EOHHS] is utilizing this new compact to functionally reorganize divisions and programs, streamline operating procedures, reduce redundancies, combine units and create efficiencies that never would have been possible under the old system. Through the waiver the state also created an Assessment and Coordination Unit to review all placements to ensure that that all recipients receive care in the most appropriate and least restrictive setting.

[9] Up until the Global Waiver, states often had to wait three, six, nine or sometimes twelve months just to receive an answer from the Federal Government. Unlike the Federal Government, states must have a balanced budget. These long delays in obtaining answers greatly contributed to state deficits and created unnecessary burdens for state staff trying to operate in an antiquated system.

Rhode Island Medicaid Reform
Global Consumer Choice Compact Waiver

Federal Fiscal Certainty Under the Waiver

Global Waiver creates a new financial arrangement between the State and the federal government establishing a maximum federal contribution toward Medicaid program costs during the five-year Global Waiver Demonstration. The State and the federal government agree to an aggregate spending ceiling over the five years of the waiver demonstration of $12.075 billion and the State is at risk for any increases in enrollment and per participant per month cost trends that drive Medicaid expenditures above the aggregate spending ceiling. The federal contribution continues to be determined by State Medicaid expenditures – that is, the State only receives federal matching funds for what it actually spends on the program.

Waiver Proposal Incorporated Reform Goals Into Five Component Areas:

1. **Rebalancing the System** to reduce the institutional bias and promote home and community based alternatives, and create new choices and settings. Strategies and policies focused on making it easier to access home and community based alternatives.
2. **Care Management** – Mandate care coordination to achieve better health outcomes, implement primary care medical home [PCMH] for all recipients, integrate services and systems of care, and encourage and reward personal responsibility, service performance, and wellness.
3. **Smart Purchasing and Payments** -- Institute competitive and value-based purchasing approaches program-wide, refocus program integrity efforts, and ensure all payers and beneficiaries contribute an appropriate and fair share.
4. **CNOM** – Obtain federal matching funds to support the continuation of state-funded programs that serve populations at risk for Medicaid and/or high cost institutional care.[10]
5. **Program Integrity** – through the use of technology initiate efforts to combat waste, fraud and abuse.

In addition to these 5 goals, the waiver also provides an improved organizational framework to integrate services across all populations because the state is operating one waiver instead of eleven.[11] Silos between programs and administrators are slowly dissipating, services are becoming more consumer-based and rules and regulations are becoming more coherent and less onerous because the waiver focuses on the lifespan of the individual.

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[10] RI's Global Waiver Federal Cap Agreement allows for immediate relief for State-only Funded programs. CNOM means Costs Not Otherwise Matchable. These are state only funded programs that the State of Rhode Island now receives a federal match according to the matching formula. The State of Rhode Island advocated to make these programs matchable because they delay the need for institutionalization and provide preventive services. This means Rhode Island will receive approximately 100Million dollars over the 5 year period to accelerate and promote less costly community based alternatives and prevention and wellness initiatives. These federal funds are assisting Rhode Island to improve quality and drive down the cost of health care and costly institutional care.

[11] Operating eleven or twelve waivers [programs] with different rules, procedures and processes put a tremendous administrative burden on states. Each waiver has its own sets of regulations and its own federal staff. These federal staff members and waivers are not integrated across the lifespan of the consumer. This provides confusion, scant coordination across populations and costs the states additional administrative expenditures because of the system is not seamless.

Rhode Island Medicaid Reform
Global Consumer Choice Compact Waiver

IMPLEMENTATION

The Global Waiver has been a major success in its first 18 months since implementation began on July 1, 2009.

Some Global Waiver **Accomplishments** in the first 18 months:

- ✓ Established Assessment and Coordination Organization and New Office of Community Programs – *address functional need and preventive services and not institutional levels of care.*
- ✓ Consolidated 11 Waivers into 1 with new streamlined policies and regulations
- ✓ Implemented new Levels of Care – Preventive, High and Highest
- ✓ Added new Community Based Alternatives and options *[greater choice]*
- ✓ Over 1200 individuals transitioned out of or diverted from costly institutions, out of state placements etc..*[nursing homes, group homes, etc]*
- ✓ Nursing Home Rate Reform
- ✓ Hospital Payment Rate Reform – *in process*
- ✓ Implemented Patient Centered Medical Home [100% enrollment achieved]
- ✓ Implemented Emergency Room Diversion [utilization reduced 30%]
- ✓ Utilized Smart Purchasing strategies like Selective Contracting *[any willing provider waived]*
- ✓ Implemented Behavioral Health Acute Stabilization Unit
- ✓ Developmental Disability Rate Reform – *in process*
- ✓ Child Welfare Rate and placement reform – *in process*
- ✓ Multi-agency high cost case review - $4 Million saved
- ✓ Communities of Care implemented – Prevention and Wellness
- ✓ State Maximum Allowable Costs for Pharmacy
- ✓ Implemented Transparency Portal for Medicaid Rates and Payments
- ✓ Human Services/Medical Transportation redesign and reorganization

Rhode Island Medicaid Reform
Global Consumer Choice Compact Waiver

- ✓ **$100 Million estimated saved in 18 months through reform efforts** [no eligibility cuts]. $146 Million projected by June 2011.[12]

- ✓ Additional $50 Million saved through Program Integrity Efforts and aggressively eradicating waste, fraud and abuse [Audit, TPL, tax intercept and more]

- ✓ $25 Million dollars in new federal funds [CNOMs] to delay institutionalization in the first 18 months. Budget relief.

- ✓ Growth in Medicaid has approximately been cut in half from over 8% to 3% in the past 18 months.

Since implementation [in the first 18 months], the Waiver has saved approximately $110 Million dollars through reform efforts, cost containment strategies and program integrity and is one of the reasons why Rhode Island possessed a state budget surplus in SFY2010. In regards to the aggregate budget cap, at its current expenditure rate, Rhode Island is on track to only spend approximately $9.3 Billion of the allotted $12.075 Billion. *SEE Budget Neutrality below*[13] Rhode Island is successfully showing that more money is not the solution; comprehensive reform and freedom from onerous federal mandates work. The Global Medicaid Waiver is seen as a model for state Medicaid reform and could be replicated by each state.

SAVINGS SFY10 and SFY11 enacted

Program Area	ALL FUNDS TOTAL
Rebalancing	$21,020,447
Care Management	$34,618,007
Smart Purchasing	$40,714,293
Program Integrity	$8,967,022*
CNOMS	$41,291,800
TOTAL *Not included Audit = $40M	$146,611,515

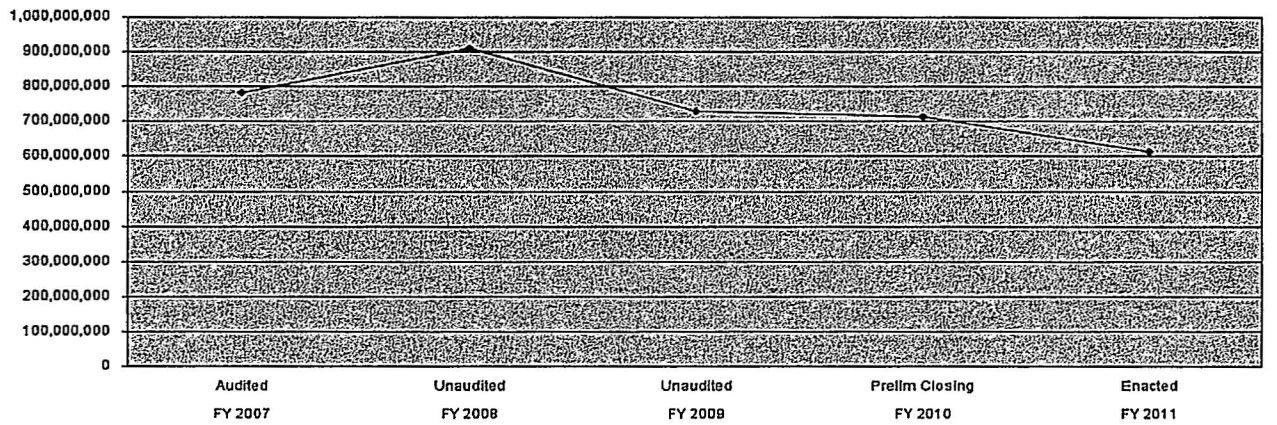
[12] Figures are approximate because the state is in the middle of the fiscal year.

[13] As of July 2010, Rhode Island had only spent $2.7Billion of the allotted $3.8Billion during the time period from January 2009 to July 2010. This is $1.1Billion dollars under the aggregate cap. This proves that more money is not the solution.

Rhode Island Medicaid Reform
Global Consumer Choice Compact Waiver

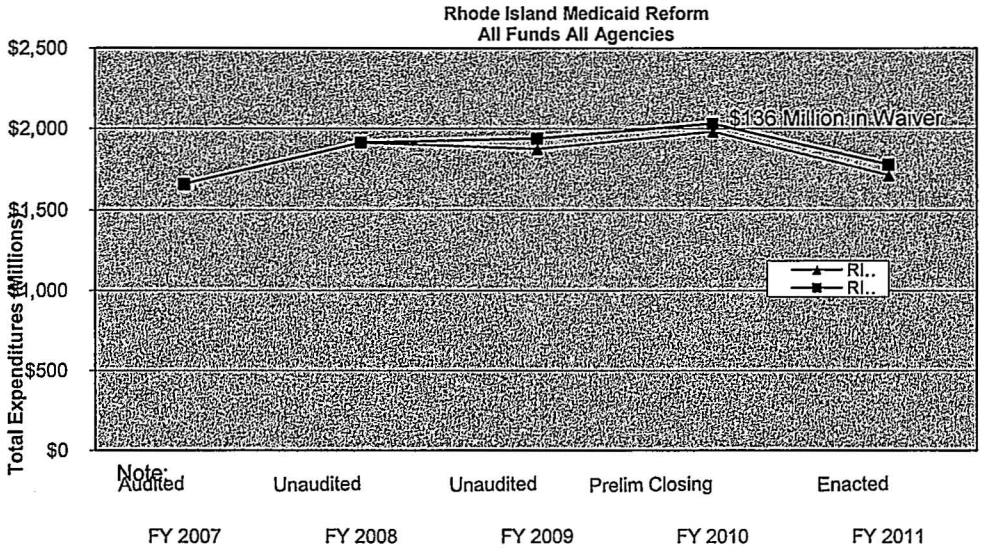
General Revenue Medicaid Expenditures

Note-Includes DSH payments & LEA
-Includes federal stimulus dollars
-Assumes extension of FMAP in FY 11



By the end of SFY2011, Rhode Island will save approximately $146 Million dollars with CNOMs [$100+ Million estimated savings through November 2010] even with all of the onerous ARRA [Federal Stimulus] restrictions in place. Without some of the provisions of ARRA, and if Rhode Island had been granted its original proposal, the Global Waiver might have had projected savings of $220 Million during this same period.

Rhode Island Medicaid Reform
Global Consumer Choice Compact Waiver



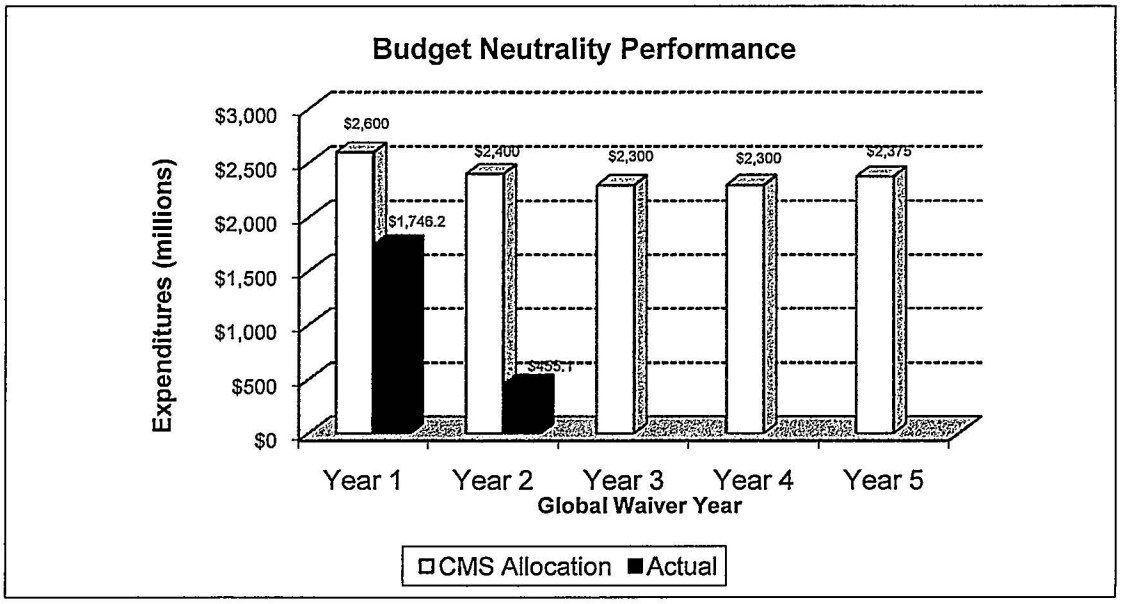
BUDGET NEUTRALITY PERFORMANCE through June 30, 2010

The Budget Neutrality results through the first six quarters of the Global Waiver Demonstration project (1/1/09 thru 6/30/10). Cumulative expenditures for this time period total nearly $2.7 billion, or $1.1 billion below the Global Waiver spending cap of $3.8 billion.

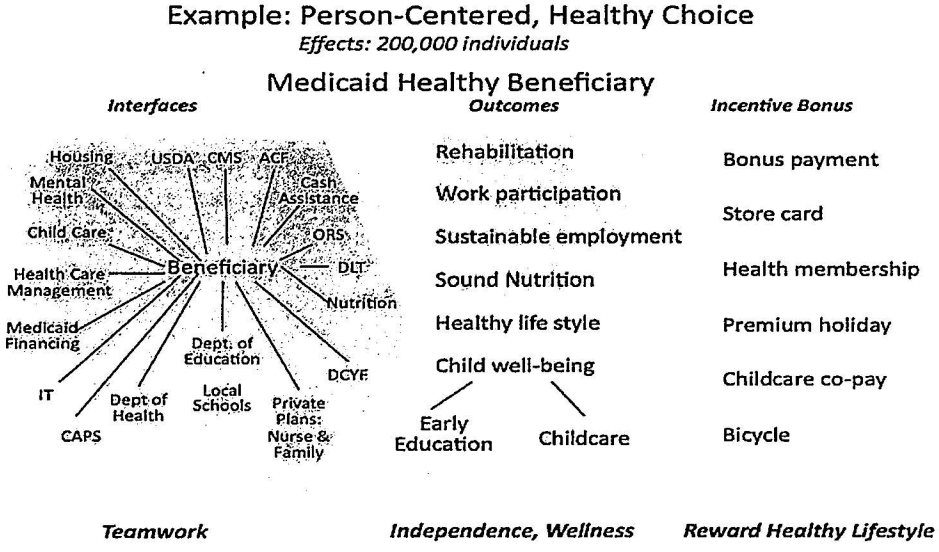
Results through the quarter ending 9/30/10 have not yet been finalized, however, preliminary indications are that Rhode Island's favorable variance under the spending cap will increase to approximately **$1.2** billion dollars.

	CMS Allocation		Actual Expenditures		Under/(Over) Spending Cap	
Calendar Year	Annual Spending Cap	Cumulative Spending Cap	Annual	Cumulative	Annual	Cumulative
2009	$2,600,000,000	$2,600,000,000	$1,746,161,860	$1,746,161,860	$853,838,140	$853,838,140
2010	$2,400,000,000	$5,000,000,000	$941,750,181	$2,687,912,041	$258,249,819	**$1,112,087,959**
2011	$2,300,000,000	$7,300,000,000				
2012	$2,400,000,000	$9,700,000,000				
2013	$2,375,000,000	$12,075,000,000				
Total	$12,075,000,000					

Rhode Island Medicaid Reform
Global Consumer Choice Compact Waiver



Rhode Island's Waiver changes the paradigm for how a Medicaid recipient is assessed and treated. The goal is to assist individuals to gain independence, foster personal responsibility and freedom from government programs.



Conclusion:

The message is clear that the status quo is unacceptable. The Rhode Island experience is living proof that a fixed amount of federal and state funding and relief from federal regulations will encourage states to tailor and design services in the most appropriate settings and place. Rhode Island is the

only state to act and achieve success, proving that bigger government and more money are not the solution. The Rhode Island experience is quietly being noticed as the mother of innovation and a model for the nation.

This waiver is ground breaking. Why?

1. It provides federal and state budgetary certainty. Something no state has ever been granted.
2. It controls cost and expenditures in the program, provides real reform, establishes greater program integrity and roots out fraud and waste in the system.
3. The Waiver infuses private sector principles like competitive contracting, performance-based contracting and transparency into the Medicaid Program.
4. It uses tax-payer dollars for the neediest only as originally intended.
5. It provides freedom, independence and choice to the consumer/person by placing people in the least restrictive and right settings and focuses on the person.
6. It provides the state with greater freedom to design and redesign programs with a new streamlined process to seek federal approval [reduction of red tape] and to waiver onerous federal rules.
7. It provides the state with the freedom to design programs for its citizens on the local level rather than a "federal one size fits all" and it makes the program simple and seamless rather than complex.

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****This paper was crafted and compiled in December 2010 while still RI Secretary****