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Governor

NEWS

Office of the Governor

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Global Medicaid Waiver Structure

- GLOBAL COMPACT COLLAPSES ALL EXISTING WAIVERS INTO A SINGLE SECTION 1115 (a) WAIVER

  - Includes all services and benefits to: (1) children and families through RIte Care, RIte Share, and fee-for-service Katie Beckett; (2) adults with disabilities and elders served through Rhody Health Partners, ConnectCare Choice, long-term care institutions (e.g., nursing facilities, Eleanor Slater Hospital) and in the community under Section 1915 (c) Home and Community Based Service Waivers (DEA, MR/DD, and Assisted Living).

  - Excludes Medicaid administrative costs, disproportionate share hospital payments (DSH) and services provided through Local Education Areas.

- MAINTAINS ADMINISTRATIVE AND PROGRAM RESPONSIBILITIES OF THE HEALTH AND HUMAN SERVICES DEPARTMENTS

  - Statutory framework charging the departments to serve particular populations and/or administer specific programs is retained on the operational level – e.g., MHRH and persons with disabilities & DCYF and children at risk or in protective services.

  - Coverage of all populations and programs under a single waiver designed to provide an integrated system of care that focuses on the changing and diverse needs of individual beneficiaries from cradle to grave.

Financing

- AGGREGATE BUDGET CEILING OF $ 12.1 BILLION DOLLARS OVER THE FIVE YEAR DEMONSTRATION PERIOD THOROUGH TO 2013

  - Five- year budget based on historical caseload and health utilization trends, accounting for a 7.814 percent inflation rate.
    - Year One (2009): $2.064 billion
    - Year Two (2010): $2.26 billion
    - Year Three (2011):$2.401 billion
    - Year Four (2012): $2.589 billion
    - Year Five (2013): $2.792 billion
      - Note: Budget allocated by calendar year

- Estimated savings of $358 million (total funds) over the five-year period.

- Savings from implementing Medicaid reforms under the waiver can be used to expand access to home and community based services and offset cost of state-funded programs for individuals who need or are at risk for institutionally-based long-term care (e.g., DEA co-payment program) or high cost Medicaid services.

- Expectation is that implementation of reforms will reduce overall program costs while ensuring access to the right services, at the right time and in the right setting.

❖ FEDERAL FINANCIAL PARTICIPATION FOLLOWS TRADITIONAL FORMAT IN WHICH FEDERAL GOVERNMENT PROVIDES A PERCENTAGE OF STATE COSTS IN MATCHING FUNDING (FMAP) AT PERCENT OF STATE SPENDING

  - Currently federal government pays 52% and state pays the remainder.

  - State only receives federal matching dollars for actual Medicaid expenditures – e.g., NOT A BLOCK GRANT in which state gets fixed allotment up front.

❖ STATE ABLE TO TAKE ADVANTAGE OF INCREASES IN FMAP INCLUDING AS PART OF A STIMULUS PACKAGE.

  - Any federal stimulus package would raise percent of costs federal government pays and will not affect negotiated budget neutrality – budget ceiling.

- Example, a 5.5% rise in FMAP the remainder of FY 2009 will increases federal payments by more than $70 million, but will not result in a comparable reduction in the 5-year budget ceiling.

❖ STATE MAY RENEOGTIATE CEILING AT ANY TIME IF NECESSARY.

- In the event of unforeseen dramatic increases in enrollment or costs due to natural disasters or further economic calamity, state may ask to revisit budget ceiling.

- Budget ceiling would also be renegotiated if state must accommodate changes in national health policy – e.g., federal law expanding Medicaid mandatory eligibility to populations not currently covered.

❖ ADDITIONAL FEDERAL MATCHING FUNDS AVAILABLE UNDER THE BUDGET CEILING FOR PROGRAMS NOW PAID FOR SOLEY WITH STATE REVENUES.

- Under the waiver, the state is authorized to receive matching funds for people with income up to 200% of the FPL in: DEA's co-payment program; DOH's HIV-AIDS program; MHRH's programs for the uninsured adults; and DCYF's programs for children voluntarily in state custody.

- Total amount of additional federal dollars of $22 million minimum per year to fund behavioral health and supplemental long term care services for low income individuals not currently receiving Medicaid.

❖ INFORMATION TECHNOLOGY PLANNING GRANT

- Additional federal of $3.4 million for technology costs associated with Waiver, including integration of Health Information Exchange Project (additional of $12.075 billion)

Flexibility

❖ UNDER WAIVER, STATE PROVIDED UNPRECEDENTED LEVEL OF FLEXIBILITY TO ENSURE RIGHT SERVICES, RIGHT TIME, RIGHT SETTING.

- RELIEF from onerous federal approval processes that hamper state's ability to successfully and/or expeditiously make changes in the program mandated by state law – e.g., Children Intensive Services change.

- FREEDOM from the institutional bias and arcane federal rules that pay for coverage in high cost venues (e.g., hospitals and nursing homes) but do not pay for coverage in less restrictive, appropriate settings (e.g., at home care, shared living, assisted living, etc.).

- AUTHORITY to tailor services to meet the individual needs of beneficiaries in the most cost – effective manner possible – e.g., rather than eliminate service entirely to save $$$, target access to those with greatest need.

- RESPONSIBILITY to ensure every beneficiary has access to the care they need and the ability to participate in decisions about their own health. – e.g., expanded availability of HCBS options.

- LEVERAGE to use the state's purchasing power to pay the best price for services and to encourage and reward high quality services and performance – e.g., selective contracting.

❖ SCOPE OF FLEXIBILITY NOT UNLIMITED.

- Medicaid still bound to comply with applicable and federal and state laws and policy.
- Significant parameters set with respect to beneficiary protections – see below.
- State must comply with administrative procedures requirements as well as federal and state laws mandating public participation in the Medicaid program.
- Federal partners continue to have major role in reviewing and approving significant changes.

❖ PRINCIPAL AREAS OF FLEXIBILITY.

- Service design and delivery.
- Purchasing and contracting of services.
- Expedited review of changes in payment methodology.
- Type and availability of services and settings covered.
- Variability in amount, duration and scope.

Eligibility, Services, Access

RI MEDICAID PROGRAM UNDER THE GLOBAL WAIVER		
	Status under the waiver	**Scope of change allowed with waiver flexibility**
1.Eligibility		
Mandatory populations	State must provide coverage --same as today	State may not use to change eligibility for mandatory populations.
Optional populations	State must maintain optional populations covered under the Medicaid State Plan as of November 1, 2008	Any changes require an amendment to the waiver and recalculation of 5-year budget ceiling. Optional populations given priority over waiver-eligible populations in the event eligibility roll-backs become necessary.
Waiver-eligible populations	Larger number of waiver-eligible populations. Do not have same beneficiary protections as mandatory and optional populations – same as today.	State may make changes – subject to CMS review --to preserve eligibility for optional and mandatory populations. Would require an amendment to the waiver and recalculation of 5-year budget ceiling.
2. Services		
Mandatory Services	State must provide mandatory services for mandatory populations.	State may tailor mandatory services to better meet the needs of individuals in optional/waiver eligible populations
Optional Services	State covers more optional services than today.	State may use its flexibility to alter scope, amount, and duration to tailor services to better meet individual needs of beneficiaries
HCB Waiver Services	State covers a broader array of core and preventive services.	State has flexibility to determine, on the basis of an assessment of level of care, scope, amount, and duration for all eligible beneficiaries.

RI MEDICAID PROGRAM UNDER THE GLOBAL WAIVER		
	Status under the waiver	**Scope of change allowed with waiver flexibility**
3. Access & Delivery System		
Acute Care	Mandatory enrollment of all beneficiaries in a care management program – either primary care case management (PCCM) or health plan – RIte Care, Rhody Health Partners, ConnectCare Choice	State may expand array of care management options available for beneficiaries in all populations without amending the waiver.
Long-term Care	New levels of care for determining the scope of services required for beneficiaries in each populations. Only those that meet the highest level of care will have access to institutionally-based services – e.g., nursing homes, residential treatment facilities, etc	State may NOT impose waiting lists for access to institutionally-based services for individuals requiring highest level of care; State may limit access to certain home and community based services based on medical need. State may provide certain home and community based services to beneficiaries at risk for long-term care.

Global Waiver: Myths vs. Reality

MYTHS	REALITY
Global Waiver replaces the Medicaid entitlement with a block grant. State could overspend in the early years and have exhaust resources for the program early on to offset growing budget deficits.	Global waiver preserves traditional financing approach in which state receives a federal match for Medicaid expenditures up to an agreed upon budget ceiling. Accordingly, federal matching dollars would only be available for Medicaid expenditures authorized under federal law, policy and the waiver
The budget ceiling is too low and the state will reach the cap well before the five year waiver period ends.	Budget ceiling was set based on an exhaustive review of historical trends in enrollment and health costs and assessment of state resources. Given current fiscal constraints facing the state, RI realistically does not have sufficient resources for Medicaid expenditures to exceed the budget ceiling. Moreover, the state can renegotiate the budget ceiling at anytime if projected savings or expenditures vary widely from projections.
If the state reaches the ceiling too quickly, eligibility for vulnerable beneficiaries will have to be rolled back.	Eligibility roll back without the waiver are far more likely than with the waiver. Without the waiver the only options the state has to cut costs quickly are to roll back eligibility or cut one or more services for all beneficiaries. With the waiver, the state has the flexibility to achieve similar savings by targeting services based on need, pursuing more competitive pricing for services and paying for coverage in less expensive and restrictive settings.
By accepting the budget ceiling, the state is limiting its ability to take advantages of changes in or comply with federal mandates or health policies that expand access or coverage.	The state and the federal government both agree that the budget ceiling will be adjusted to facilitate major changes in policy that would require RI to expand the program. Increases in federal financial participation – the percent the federal government pays of

MYTHS	REALITY
	each dollar the state spends – will not affect the budget ceiling in any way.
The Medicaid agency will have the flexibility to change eligibility and services without input from state policy makers or the public.	The flexibility the state is receiving concerns federal rules, processes and procedures only. The Medicaid agency may only make changes in program eligibility and services when directed to do so by state law, budget initiatives, or other democratic processes. Such changes will also have to be presented for public notice and comment through the state's administrative rule making process. Additionally, the terms and conditions of the waiver require that all changes be subject to federal and state laws and regulations requiring public notice and input.
Placing all programs under a single waiver will lead to infighting among populations and their advocates for scarce resources.	The goal of the global waiver is to establish an integrated system of care that focuses on individual beneficiaries and assures each has access to the services they need from cradle to grave. By eliminating artificial boundaries separate services by a beneficiary's age or condition, we will be removing the silos that have protected certain populations and providers, put others at risk and created the service gaps and inefficiencies in the program.

MYTHS	REALITY
The waiver creates new levels of care and an assessment process that will force people out of nursing homes and create waiting lists for even the most basis services.	NO ONE IN A NURSING HOME TODAY WILL BE FORCED TO LEAVE AGAINST THEIR WILL. The new levels of care and the assessment process will assure that every beneficiary has access to the care they need in the most appropriate setting. Beneficiaries now in nursing homes will not be required to leave – unless they want to or their condition improves using the levels of care in place today and they have access to an appropriate alternative. The same is true for current beneficiaries in group home settings. NO BENEFICIARY REQUIRING AN INSTITUTIONAL LEVEL OF CARE WILL BE DENIED SERVICES. Beneficiaries requiring an institutional level of care – which will become the highest level of care under the waiver -- will have access to the institutions and will not be subject to waiting lists. If a beneficiary in this category prefers to be cared for in a home and community based setting that has met a cap or enrollment limit, they will remain in the institution and be given priority status if there is a waiting list over beneficiaries with lower level of care needs. BENEFICIARIES WILL HAVE ACCESS TO MEDICALLY NECESSARY SERVICES. The state does have the authority to limit the amount, duration and scope of home and community based services for beneficiaries in the high and preventive groups, but only to the extent medical necessity allows. The State may limit the number of hours or type of home and community based services at the high level and/or establish waiting lists for beneficiaries for certain kinds of these services for beneficiaries at this and the preventive level. This does not apply to medical services.