RI Reinventing Medicaid: An Analysis

Summary

On February 26, 2015, Governor Raimondo signed Executive Order 15-08 to start her initiative to Reinvent Medicaid in Rhode Island. This analysis reviews materials presented by the Governor relating to EO 15-08.[1] Although purporting to create a "working group" to "develop a plan to improve the quality of care Rhode Islanders receive and reduce the costs for Rhode Island taxpayers," this analysis concludes Governor Raimondo has made it impossible for the "working group" to achieve these goals by:

- presenting faulty and misleading data and analyses;
- misidentifying "problems;"
- requiring unjustified budget cuts within preselected "six major strategies;"
- not permitting consideration of the actual problem: private health insurance companies generating enormous administrative costs and improperly rationing care; and
- not permitting consideration of an effective solution: a comprehensive single payer health care program for all Rhode Island residents such as that proposed by H. 5387.

1. Faulty and Misleading data analyses

a. Medicaid's Estimated Percentage of the RI Budget Is Overstated.

Governor Raimondo claims that 31.5% of "every state tax dollar goes to Medicaid." This seems to imply that nearly one-third of the State's *budget* is spent on Medicaid.[2] The revised SFY 2013 budget was $8.079 billion (Budget Office, Executive Summary, Fiscal Year 2014, pg. 6). With total Medicaid expenditures of $1.785 billion, this would calculate to a percentage of 22.1%. Moreover, it must be remembered that federal reimbursements pay for about 50% of this 22.1%. See 1.c., below.

Question: Did Governor Raimondo overstate Rhode Island's Medicaid's costs to create a false RI Medicaid "crisis?"

b. RI Medicaid Spending is Not Excessive Compared to Other States.

If the State Budget spending on Medicaid is 22.1% (including federal reimbursements), this puts Rhode Island's expenditures below the national average for all states. As cited in the CMS Actuarial Report for 2013, page 53, the National Association of State Budget Officers (NASBO) reported the average percentage Medicaid spending for all state budgets was 23.7% including both state and federal funding sources. Relative to the entire Budget, Rhode Island is not an outlier in the broader picture of Medicaid expenditures and may even be a little below other states in the percentage of the budget spent on Medicaid.

Question: Did Governor Raimondo ignore evidence that RI Medicaid spending is not an "outlier" compared to other states to create a false Medicaid "crisis?"

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[1] Data reviewed include that referenced in the PowerPoint, "Reinventing Medicaid: Sparking the Comeback for a Healthier Rhode Island," March 2, 2015, and other dates, found at www.reinventingmedicaid.ri.gov. Original slides establish assumptions underlying the "Medicaid reinvention" process.

[2] Other data cited by Governor Raimondo generally look at "state budgets." What "every state tax dollar" means is unclear.

c. Federal Reimbursement of RI Expenditures Are Ignored.

Governor Raimondo focuses on expenditures[3] without also examining all the revenues that are allocated to support the program. Her failure to consider federal revenues, in particular, is problematic and misleading. The RI Executive Office of Health and Human Services (EOHHS) "Rhode Island Annual Medicaid Expenditure Report" shows that the State share of Medicaid expenditures is "just under half of Medicaid expenditures." (pg. 9). In the SFY 2013 budget, the Federal Medicaid Assistance Percentage (FMAP) was 51.48%. Therefore, the amount of money coming only from Rhode Island tax payers is about $886 million. Moreover, it should not be forgotten that by cutting state Medicaid expenditures by $90 million, Governor Raimondo is also turning away $90 million in matching federal funds.

Question: Did Governor Raimondo ignore federal reimbursements to create a false RI Medicaid "crisis?"

d. Cherry picked data used

In addition to the data and analyses problems noted above, Governor Raimondo selectively chose data from different years and sources to establish the worst RI Medicaid picture possible.[4] For example, Governor Raimondo uses The Kaiser Family Foundation (KFF) 2011 data to show Rhode Island is second in the nation for total Medicaid spending per enrollee (slide #4), but on the next slide, which alleges that Rhode Island spends excessively on elderly enrollees and adult enrollees with disabilities, she uses State and CMS data from other years. Had Governor Raimondo used the KFF 2011 data for both slides #4 and #5, the evidence would look very different.

The KFF table previously cited shows Rhode Island spending $13,820 per Aged enrollee and $20,601 for Individuals with Disabilities, compared to $16,162 and $20,576, the amounts shown in slide #5. This is important because the KFF table also shows the average US spending per enrollee to be $13,249 and $16,643, respectively. While Rhode Island ranks second in overall average spending per enrollee in the KFF data from slide #4, our State would be 25th in average enrollee spending on the Aged and 11th on average spending for Individuals with Disabilities.

In other words, Rhode Island is not significantly different from other states on spending for the very high cost populations shown in slide #5 when the directly comparable KFF data are used for each population. Moreover, a report by ConvergenceRI closely examined the high expenditure amount alleged in Slide #5 and found it incorrect.[5]

Question: How reliable is Governor Raimondo's data given her apparent willingness to improperly compare data from different datasets to best create a RI Medicaid "crisis?"

e. Rhode Island Demographics Do Not Justify Medicaid "reinvention"

PowerPoint (slide #11) points out many figures that describe the Rhode Island population getting Medicaid. There is a high percentage of elderly and they receive a large amount supplemental income assistance. Moreover, we are told that 25% of Medicaid recipients account for the highest proportion of spending, approximately 64% (slide #12) and 7% of enrollees account for slightly more than two-thirds

[3] See Kaiser Family Foundation data at http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/

[4] The State's fiscal year runs from July 1 to June 30, which is different from the federal fiscal year.

[5] See http://convergenceri.com/stories/Inaccurate-numbers-analysis-may-undercut-Medicaid-working-group,1349

of this total. Governor Raimondo appears to conclude these facts put RI is in a unique position that calls for "reinventing" our Medicaid program.

She has, however, ignored data from the CMS's "2013 Actuarial Report on the Financial Outlook of Medicaid" Figure 1 which is similar to the EOHHS 2013 Expenditure Report showing that nationally in 2012 the Aged and Disabled made up 26% of Medicaid enrollees (9% and 17%, respectively) and accounted for 65% (21% and 44%) of spending. Thus, Rhode Island's demographics do not cause its Medicaid spending to be out of line with other states. If other states are spending about what Rhode Island spends for its neediest population, Governor Raimondo needs to have other evidence that high costs of caring for that the Aged and Disabled should be lowered – and apparently, she does not.

Question: Where is the evidence that costs for caring for Rhode Island Aged and Disabled are unnecessarily high and must be cut?

2. Problems With Identified "Problems"

a. Misidentification of "What Drives Health Care Costs"

Governor Raimondo answers the question, "What Drives Health Care Costs?" (slide #8) with misleading statements. In the first box, it says, "High Utilization - Rhode Island ranks 24th in avoidable hospital use and costs." Clearly, this tries to imply that RI Medicaid patients overuse hospital or other services in ways that justify reduced funding. In fact, what the "24th" ranking means is that RI could do much better at providing "timely and preventive care and follow-up care."[6] That is, "high utilization" could be reduced by more care by physicians and thus, *increased* funding is justified to bring utilization down. The second box says, "lack of care coordination - fragmentation of delivery – especially between physical and mental health." While "coordination" is a fine goal, it cannot be achieved if we do not *first* address the larger problem that Medicaid patients cannot find mental health services because of low reimbursement rates. Physical health care providers need someone to coordinate with before such coordination can be increased. Again, *more* funding is required, not less. The third box, which says, "Expensive services – Provider consolidation and payer fragmentation = reduced capacity to negotiate, increased administrative burden," is also problematic. First, "provider consolidation" appears to have equal weight with "payer fragmentation" despite the fact that the latter dwarfs the former in terms of causing unnecessary increased costs. Second, Governor Raimondo appears to believe incorrectly that the problem with "payer fragmentation" is that multiple payers cannot coordinate to force providers to lower their charges. The real proven problems, however, are that multiple payers create enormous excessive administrative costs and unfairly ration care. See www.pnhp.org. These real problems are *never* addressed by Governor Raimondo in any of her materials. The fourth box identifies RI's "Aging Population" and is misleading because this demographic fact does not justify "reinventing" Medicaid, as discussed above.

Questions:

Why does Governor Raimondo ignore the only proven "driver of health care cost" that clearly most affects the RI economy and health care – i.e., the multi-payer private health insurance system?

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[6] The Commonwealth Fund study that provided this "24th" number says "avoidable" includes, "indicators of hospital use that might have been reduced with timely and effective care and follow-up care."

Do the "working group" members affiliated with companies that would be adversely affected by a single payer system have a conflict of interest that prevents them from truly seeking to find the real problems with and solutions to our health care problems?

b. Citing High Costs, Per Se, Does Not "Prove" Medicaid Cuts are Needed"

Governor Raimondo clearly states that the fundamental "problem" (slide #14) is simply that "Rhode Island Medicaid costs are too high" relative to the total budget and on a per enrollee basis. Even assuming, for the sake of argument, that all of Governor Raimondo's "high cost" figures are accurate (and as noted above, they are not), do these costs "prove" Medicaid "reinvention" is necessary?

One circle mentions "fraud, waste, and abuse," but Governor Raimondo has not shown that it exists in the Rhode Island Medicaid program to the extent that it justifies the cuts she is recommending.[7] Another circle tells us we need to focus on "high cost, high utilization populations," which, as discussed above, should justify more, not less, spending. The last circle, perhaps the most unexplored in the presentation, refers to aligning the Medicaid program with "commercial payers, public employees, and Medicare." What this means is unclear. If it means that these payer groups should bargain collectively and force hospitals, nursing homes and physicians to accept lower reimbursement, which is the only way this idea could try to "save money," this "reform" would be quite ineffective. Since Medicaid reimbursement is already significantly lower the Medicare, many physicians, particularly in mental health where reimbursement is the lowest of all, refuse to see Medicaid patients. Because these patients will have even more difficulty finding a physician who will see them, more will end up in emergency rooms, which will drive costs up even further.[8] So, again, where is the proof that such "aligning" justifies cuts?

Question: Where is the proof that shows "high costs" are not justified and should be cut by a Medicaid "reinvention?"

a. Failure to Recognize Increasing Revenues is an Option

By focusing on high Medicaid costs as the primary cause of Rhode Island's budget woes, Governor Raimondo entirely ignores a far more important cause: giving away revenues and refusing to seek more. Taxes were cut under the Almond, Carcieri, and Chaffee administrations; in fact while Carcieri was governor taxes were cut twice. In each instance, analysts recognized that these gave disproportionate benefits to the wealthy. In fact, RI's tax cuts for the rich were the 2nd biggest of the decade compared to all other states.[9] Even a fiscally conservative publication like *Forbes Magazine* has noted that the idea that deep tax cuts can result in a boom in economic activity and boost state revenues is "fiscal snake oil."[10] In addition, numerous "Tax Expenditures" alleged to provide incentives to grow the economy, such as the debacle of the RI Economic Development Corporation's $75 million loan

[7] The actual budget document for SFY 2016 might raise the question of why this circle was even included in the presentation. Page 9 of the Executive Summary includes some amounts. The EOHHS is developing a system to monitor and prevent waste, fraud, and abuse that is expected "to save $1.0 *million* [emphasis added] in FY2016." BHDDH (a department under EOHHS that accounts for approximately one-fifth of Medicaid expenditures) and EOHHS are each developing service verification systems that are expected to save another $2.9 *million* [emphasis added] over an unspecified period (presumably a fiscal year). This is small change in the context of the previously cited $1.785 billion Medicaid program.

[8] How public employees are involved is not clear since presumably they are neither an indigent nor uninsured part of the population. And why is Medicare mentioned? The EOHHS expenditure report informs us that Medicaid pays the portion of costs for the eligible population that Medicare does not cover, i.e., Medicare is already covering some of the costs of caring for the "high cost/high utilization" recipients. Were this not the case the impact on the budget would be even higher. It is not clear what new strategy could be employed of which Medicare would be further involved.

[9] See http://www.rifuture.org/ris-tax-cuts-for-the-rich-were-2nd-biggest-of-decade.html

[10] http://www.forbes.com/sites/beltway/2014/07/15/whats-the-matter-with-kansas-and-its-tax-cuts-it-cant-do-math/

guarantee to 38 Studios, also account for other foregone revenues. Highly touted reforms that were supposed to produce budget savings failed to live up to their rosy promises. What is certain is that cutting Medicaid will turn away $90 million in federal funding that would definitely have been spent in the state.

Question: Why does Governor Raimondo only consider cutting Medicaid expenditures (primarily hurting the poor), rather than reviewing and reversing past tax cuts that have primarily benefited the wealthy?

5. Problems with Governor Raimondo's "Six Major Strategies"

Despite saying that the "working group" will develop the Medicaid "reinvention," Governor Raimondo has already preselected "six major strategies" set forth in her proposed SFY2016 budget and noted that the working group is expected to find "savings" of amounts that she has also already predetermined.[11] The innovations in health care delivery noted in the "strategies" may accomplish their aims and save money, but if the goal is to improve health outcomes, they should be piloted and studied first to make sure they work and are saving money, before funding is cut. It is disturbing that in a confusing slide #2, "triple aims" are listed as: improving health, improving patient experience and saving money - and they are given equal weight. The determination to cut funding first and then try innovations would imply which of the "triple aims" is actually the main one.

Questions:

Why does Governor Raimondo propose Medicaid "Reinvention" cut funding first and *then* try to pilot or study the suggested innovative delivery programs?

Will Governor Raimondo place blame on the delivery programs if they fail to create the savings she has predetermined they must deliver?

Will the fact that Governor Raimondo has laid out "strategies" and budget cuts in her 2015 proposed budget force the "working group" merely to rubber stamp her decision to cut Medicaid?

Will the "working group" be able to demand proper research about and funding of delivery side programs Governor Raimondo merely cites as vehicles to cut Medicaid costs?

The "six strategies" and why they do not justify immediate Medicaid cuts are as follows:

Strategy 1: ***Targeted Interventions for the highest cost/highest need populations****. This strategy involves the promotion and use of community health teams, community health workers, housing supports, and appropriate institutional care settings to reduce over-utilization of high-intensity, high-cost services. This strategy may also include the piloting of an ACO model for this focused population in FY 2016.*

Problems: While the community based initiatives are admirable efforts, they require more funding for implementation and analysis, not funding cuts. Also, as noted above, there is no real evidence that Rhode Island Medicaid "over-utilization" justifies funding cuts.

Strategy 2: ***Value-based Payment in Managed Care.*** *The Executive Office may seek to modify current risk-sharing arrangements with Medicaid managed care organizations, tie MCO, administrative rates to value-based payment standards, refine the Federally Qualified Health Center Incentive Program, and institute selective contracting for certain services.*

[11] See Governor Raimondo's SFY2015 proposed budget.

Problems: There is little evidence that "value-based payment in Managed Care" is an effective strategy for holding down costs.[12] In addition, Governor Raimondo, should learn from our neighboring state, Connecticut. Despite being nicknamed, "The Insurance Capitol of the World," Connecticut barred private insurance companies from their Medicaid program when an audit showed that they were running up what the state deemed to be excessive charges.[13] Also, it should be noted that contracting for specific services means that the network of providers available to Medicaid recipients will be reduced, increasing the likelihood that these patients will be unable to access outpatient care and be forced into emergency room care.

Strategy 3: ***Value-based Payment in Long-term Services and Support.*** *In concert with the Financial Alignment Demonstration (Phase II of the Integrated Care Initiative), the Executive Office may institute a "quality withhold" for long-stay nursing facility patients.*

Problems: This is just a declaration of intent to reduce funding and reimbursement to long-term care facilities - who will most likely respond by refusing to admit Medicaid patients. While the state budget may benefit, the poor patients affected will likely be devastated.

Strategy 4: ***Value-based Payment in Hospitals.*** *The Executive Office may institute re-admission penalties in alignment with Medicare, eliminate or adjust the DRG "policy adjuster" for neonatal intensive care services, develop a bundled payment mechanism for childbirth services, and institute a Delivery System Reform Incentive Program (DSRIP).*

Problems: This initiative assumes "waste" on the "delivery side" of health care. Data from the Robert Wood Johnson Foundation and CMS do not support this contention. This is just a declaration of intent to reduce reimbursements to hospitals – who already face a $60 billion reduction in Medicare reimbursement over the next ten years under the Affordable Care Act. Again, this is a benefit to the state budget, but a detriment to the quality and availability of health care in Rhode Island.

Strategy 5: ***Better Coordinated Care for Individuals with Behavioral Healthcare Needs***. *The Executive Office may pursue shared savings agreements with Community Mental Health Centers for and eliminate or adjust the DRG "policy adjuster" for inpatient behavioral health services*.

Problems: Medicaid reimbursements to mental health professionals are already so low under Medicaid that most Medicaid recipients can only get their care from Community Health Centers. Many patients have difficulty getting to these few centers and waiting times are very long already. Reducing funding will not help this situation. Any time there is an "incentive" program put in place, there will be harm to the Medicaid population in need of mental health care because they are at such high risk for readmission – not because they are negligent, but because they cannot find adequate primary care.

Strategy 6: ***Improved Program Oversight and Efficiency.*** *The Executive Office will focus resources on strengthening verification processes and controls and ensuring agency-wide consistency in eligibility determination and payment rates for high-cost services. The Executive Office may also look to re-design the Connect Care Choice primary care case management program and increase the commercial insurance mandate for Early Intervention services.*

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[12] See, e.g., http://pnhp.org/blog/2014/02/20/value-based-insurance-the-journey-from-hype-to-evidence-based-policy/, and www.forbes.com/sites/theapothecary/2014/07/21/where-is-the-value-in-health-care/,

[13] See http://kaiserhealthnews.org/news/connecticut-drops-insurers-from-medicaid/

Problems: This assumes that there is fraud and waste in Medicaid registration and services delivered. There is no evidence of this. RI Medicaid expenditures are in line with every other state and other states are not attempting to "reinvent" Medicaid with cuts like Governor Raimondo is seeking. Also, in the last decade, the federal government has attempted twice to work with the private insurance companies by letting them participate in Medicare Advantage. In both cases, expenses under these plans rose much faster than standard Medicare, as the insurance companies found ways to circumvent the requirements, overstated the degree of illness in the people they insured, and inflated charges to Medicare.[14] Reasonably, we can only expect the same thing will happen if private insurance companies participate in RI Medicaid. See discussion of what happened in Connecticut, above.

5. The Real Solution to RI's Health Care and Economic Problems is to Adopt A Single Payer Program

A real solution to the problems identified in Governor Raimondo's PowerPoint already exists for Rhode Island: House Bill 5387, which proposes a single-payer, comprehensive healthcare coverage program for all Rhode Islanders. A 2015 Report about Rhode Island's health care insurance problem prepared by Professor Gerald Friedman, head of the Economics Department at UMass Amherst, supports this legislation and can be found at www.phnp.org/ri.

Key Facts about a Single Payer Program

Rhode Islanders already pay enough money to have comprehensive and universal health insurance but are not getting these due to the current multi-payer system.

Between 1991 and 2014, health care spending per person rose by over 250% – rising much faster than income – and greatly reducing the disposable income of Rhode Islanders.

Medical related bankruptcies are 62% of personal bankruptcies and of these, 69% had insurance at the time of their bankruptcy.

Even after the Affordable Care Act is fully implemented, 4% of Rhode Islanders will not have insurance – resulting in as many as 116 Rhode Islanders dying unnecessarily from lack of insurance each year.

What the Rhode Island single payer program would do:

- ✓ Provide comprehensive health care coverage to all Rhode Island residents with most Rhode Islanders paying less for health care than they are currently paying;
- ✓ Improve access to health care;
- ✓ Save approximately $4000 per resident per year by 2024 and put more money into the Rhode Island economy.
- ✓ Significantly reduce health care dollars spent on administrative costs and shift these dollars to actual provision of health care (providers would save almost $1 billion in administrative costs in the first year);
- ✓ Decrease administrative burdens on health care providers and allow them to spend more time providing health care;
- ✓ Eliminate the burden of health insurance costs and administrative obligations on Rhode Island businesses and thereby make them more competitive and profitable. In the first year, payroll contributions to the single payer plan would be over $1.2 billion less than current private health insurance premiums.

[14] E.g., http://www.cms.gov/mmrr/Downloads/MMRR2014_004_02_a06.pdf

- ✓ Contain health care costs (reduced administration and control over monopolistic pricing) would save 23% of current expenditures in the first year with larger savings in subsequent years.
- ✓ Create a significant economic stimulus for the state by attracting businesses to and keeping businesses in Rhode Island because of reduced health insurance costs, a particular boon to small businesses and their employees.

If Governor Raimondo truly wants innovation she would stop crusading for "reinventing" Medicaid and advocate for the expeditious passage of H 5387. Unfortunately, it seems inevitable that powerful corporate interests who seek to preserve the current system, will no doubt fight with all their might against H 5387, just as they have all single payer efforts, see Wendell Potters', Deadly Spin: An Insurance Company Insider Speaks Out on How Corporate PR Is Killing Health Care and Deceiving Americans.

Question: Why does Governor Raimondo not allow the "working group" to consider the best solution to Rhode Island's health care system and economic problems – i.e., a single payer program?

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For more information, go to: www.pnhp.org/ri

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