Annual Report
On the Department Of Human Services' Implementation Of Programs To Address Uninsurance Among Rhode Islanders

Submitted to:

Permanent Joint Committee on Health Care Oversight

Submitted by:

Gary Alexander
Acting Director
Rhode Island Department of Human Services

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I. INTRODUCTION

In November of 1993, the State of Rhode Island was granted a Section 1115 Medicaid waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration project called RIte Care. RIte Care, implemented in August 1994, has the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

Over the years, RIte Care has continued to evolve in response to the State's experience in operating the project and as a result of national and State policy initiatives. One of the most significant changes in the project has been the increase in the number of populations eligible for RIte Care. RIte Care was initially designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)[1] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

Over time, the populations eligible for RIte Care have expanded, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185 of the FPL (expansion under Section 1931 of the Social Security Act through a State Plan Amendment (SPA))

[1]Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF), FIP is Rhode Island's program for the TANF-eligible population.

- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL

- Effective December 1, 2000, to maximize enrollment of children in foster care placements[2] from fee-for-service Medicaid to RIte Care

- Effective November 1, 2002, to establish a separate child health program to cover unborn children with family income up to 250 percent of the FPL

- Effective January 29, 2003, to enroll the following categories of children with special health care needs into RIte Care Health Plans on a mandatory basis[3]:

    - Blind/disabled children, and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)

    - Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children)

    - Children receiving subsidized adoption assistance.

The May 1, 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI of the Social Security Act (State Children's Health Insurance Program, or SCHIP) of the Social Security Act. By Section 1115 SCHIP waiver approval (21-W-00002/1-01), effective January 18, 2001, Section 1931 parents and relative caretakers between 100 and 185 percent of the FPL, and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. Approved April 17, 2003, the separate child health program allows the State to provide comprehensive coverage for pregnant aliens who would not be otherwise eligible for Federal financial participation (FFP). These women are enrolled in RIte Care Health Plans.

The two waivers (i.e., Medicaid and SCHIP) were combined for administrative purposes and both were extended through July 31, 2008.

It should be noted that the State received approval from the, then, Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS) on January 5, 1999 to expand SCHIP coverage to children under age 19 in households with income up to 300 percent of the FPL. The State has not yet implemented the approved amendment and has no immediate plans to do so due to ongoing budgetary constraints.

In addition to these covered populations, the RIte Care Health Plans must make coverage available to certain State-funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

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[2] Children in foster care are in enrolled in RIte Care on a voluntary basis.

[3] Children with special health care needs are also presently enrolled on a voluntary basis, as only one Health Plan, Neighborhood Health Plan of Rhode Island (NHPRI) has been willing to enroll this population. NHPRI is also the only Health Plan that has been willing to enroll children in foster care.

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL

- Children who are uninsured whose household income is in excess of 250 percent of the FPL

- Licensed family child care providers and their eligible dependents

RIte Care has been demonstrably successful in accomplishing its goals. RIte Care's enrollment grew substantially from 1998 through 2001 as a result of four significant and concurrent events described below:

- The State expanded eligibility to parents and relative caretakers of RIte Care-enrolled children up to 185 percent of the FPL, under Section 1931 of the Social Security Act.

- The State streamlined the RIte Care application process, by creating a short, mail-in application in English and Spanish and eliminating face-to-face interviews for both the initial eligibility determination and for re-determination.

- The State embarked on an ambitious community-based outreach campaign to reach and enroll uninsured children and families.

- The State's commercial insurance market began to deteriorate, marked by sharp increases in premium rates offered to employers, reduced competition as a result of two of the State's commercial insurers suddenly exiting Rhode Island, and significant hospital and health plan losses.

Over the same period of time, RIte Care's enrollment grew by 41 percent – from 74,000 in November 1998 to 104,000 by June 2000. Before that time, RIte Care enrollment had remained relatively stable despite the incremental expansions in coverage for children described earlier. The magnitude of the enrollment growth caused unexpected increases in program costs.

While it is still unclear to the State which of these four events contributed most to RIte Care's enrollment growth, it was most likely the combination of all four. It is also unclear how much of RIte Care's growth was due to crowd-out (dropping employer sponsored insurance for RIte Care), although to some degree this undoubtedly occurred.

In January 2000, then Governor Lincoln Almond convened a group of Administration staff, legislative leaders, and consumer and business representatives to find a solution to Rhode Island's deteriorating health insurance market. The Health Care Steering Committee (Steering Committee), as the workgroup was called, was convened to be broadly representative of employers, consumers, labor, and the legislative and executive branches of government. Health care providers and insurers were invited to attend meetings and provide testimony to the Steering Committee. During the next six months, the Steering Committee focused on methods to stabilize the employer-sponsored insurance (ESI) market. Specifically, the Steering Committee examined methods to enable small businesses to maintain ESI by stabilizing premium rates and by assisting and encouraging low-wage workers to maintain ESI. The focus on small employers was due to the increasing number of businesses with less than 50 workers reporting the most volatile rate

increases and the resulting difficulty in retaining and/or obtaining ESI, as well as the vital role these employers play in the State's overall economic health.

Governor Almond signed the resulting consensus legislative proposal into law on July 1, 2000. The legislation, Health Reform Rhode Island 2000, included the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

- **Part 1 –** Directing DHS to stabilize the RIte Care program by targeting resources to those most in need of coverage – low-wage families without access to affordable coverage, through:

  - Authorizing DHS to establish eligibility requirements for RIte Care to deter substitution (i.e., a waiting period for new applicants who were enrolled in ESI within six months prior to application)

  - Establishing cost-sharing requirements for certain RIte Care-eligible populations to promote both responsible utilization of health care services and development of additional disincentives for substitution

  - Requiring mandatory participation in RIte Share of eligible individuals and families who have access to ESI. (This was implemented under a separate Section 1906 Medicaid State Plan Amendment.)

- **Part 2 –** Reforming the health insurance marketplace to: (a) conform with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, (b) stabilize premiums in the small group market by compressing rate bands, and (c) guarantee issue of a basic health plan

- **Part 3 –** Establishing new financial reserve requirements for health insurance, consistent with the recommendations of the National Association of Insurance Commissioners (NAIC)

RIte Share, the State of Rhode Island's premium assistance program for Medicaid-eligible individuals who have access to ESI, had the following implementation timelines:

- *February 2001* – Initiated voluntary enrollment in RIte Share

- *April 2001* – Began transitioning RIte Care enrollees with access to ESI to RIte Share

- *February 2002* – Began mandatory enrollment in RIte Share of eligibles with access to qualified ESI

The passage of Part 1 of the Health Reform Rhode Island 2000 represented a significant and important consensus between the Governor and leaders in the General Assembly – RIte Care must be consistent with its original mission to provide coverage to the truly uninsured and migration from ESI to RIte Care should be deterred. The Governor and General Assembly were

also clear that if the RIte Care caseload and cost growth are not controlled by Part 1 of the statute, a roll-back of eligibility expansions currently in place for working families, particularly the Section 1931 expansion implemented in 1998 for parents and relative caretakers whose incomes are above TANF levels, will be considered.

Section 40-8.4-7 of Health Reform Rhode Island 2000 stipulates:

> "The Department of Human Services shall investigate and develop opportunities for individuals and/or employers to buy into, at the individual's or employer's expense, one or more programs the department may establish under this chapter or chapter 12.3 of title 42 to address uninsurance among Rhode Islanders, and shall provide a report on such efforts to the Permanent Joint Committee on Health Care Oversight established pursuant to section 40-8.4-14 on or before February 15 of each year."

This document is the subject report, which is organized as follows:

- Rhode Island Uninsurance Trends
- RIte Care for Children and Families
- RIte Share for Children and Families
- Cost-Sharing for Children and Families
- RIte Care for Children with Special Health Care Needs

In general, program information is reported for State Fiscal Year (SFY) 2006, although some information is reported for the RIte Care "Program Year" (ending July 31, 2006).

II. RHODE ISLAND UNINSURANCE

Uninsurance was an important issue for the State and a motivating factor for implementing RIte Care, with a particular emphasis on uninsured children. RIte Care was ahead of the curve nationally and preceded enactment of SCHIP.

As noted in Chapter I, the State conceived and implemented RIte Care population expansions to reduce the level of uninsurance incrementally, including, where permissible, through use of SCHIP. The time period immediately before enactment of the Balanced Budget Act of 1997 (which included SCHIP) is the reference point for analysis of Rhode Island's success in impacting the uninsurance rate in the State.

According to the U.S. Bureau of the Census[4], in 1996 90.1 percent of the Rhode Island population was covered by public or private health insurance and 9.9 percent were uninsured. With an estimate of 235,283 children in Rhode Island as of July 1, 1996, this means that there were an estimated 23,500 children without health insurance coverage as of July 1, 1996.

Based upon data from the most recent *Current Population Survey* (CPS)[5], Figure 1 shows that 11.8 percent of Rhode Islanders of all ages were uninsured in 2005 – an increase from 10.9 percent in 2004. Rhode Island was tied with Nebraska[6] in having the 13th lowest rate of uninsured in the nation, surpassed by Minnesota, Iowa, Hawaii, Massachusetts, Wisconsin, New Hampshire, Pennsylvania, Maine, Kansas, Connecticut, Michigan, and Vermont, respectively. In comparison, in 2004 Rhode Island was ranked eighth and in 2002 Rhode Island had the second lowest rate of uninsured in the nation, surpassed only by Vermont with a rate of 9.5 percent. In 2000, Rhode Island had the lowest uninsurance rate[7] in the country for both children and the total population. The figure also shows that after experiencing a sustained, declining trend in the level of uninsurance in the State, in 2001 the level of unisurance increased and has continued to do so.

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[4]Bennefield, R. L. "Health Insurance Coverage: 1996", *Current Population Reports: Consumer Income*

[5] U.S. Census Bureau, *Current Population Survey, August 2006*, Tables HI04 and HI05

[6] *Ibid.*

[7] Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island, 1995-2002*, RI Medicaid Research and Evaluation Reports. May 2004.

Figure 1

Percent of Uninsured Rhode Islanders by Age Group: 1995 - 2005

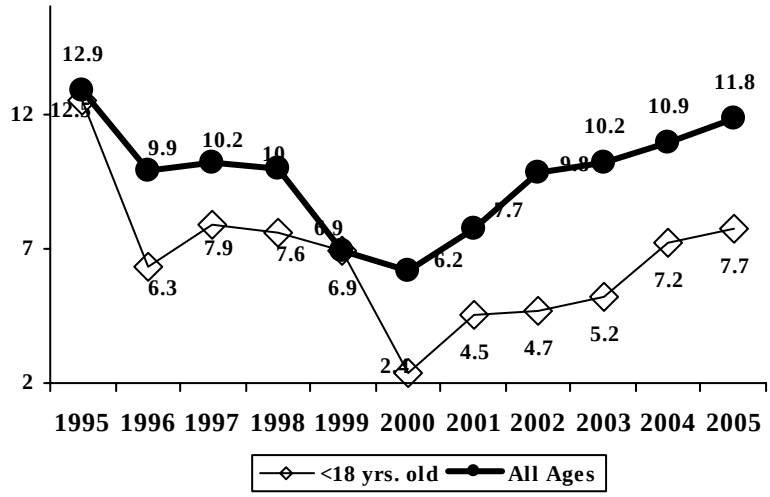


Figure 1 also shows that the percentage of uninsured children in the State continues to grow. In 2005, 7.7 percent of the children were uninsured, which was ninth in the nation behind New Hampshire, Hawaii, Massachusetts, Vermont, Iowa, Michigan, Minnesota, and Nebraska, respectively.

The 2002 – 2004 three-year average was 10.5 percent, placing Rhode Island fifth, behind Minnesota, Hawaii, Iowa, and Wisconsin, respectively.[8] However, the 2003 – 2005 three-year average was11.0 percent, placing Rhode Island tenth, behind Minnesota, Hawaii, Iowa, and Wisconsin, New Hampshire, Maine, Vermont, Massachusetts, and Kansas, respectively.[9] The 2003 – 2004 two-year average for Rhode Island was 10.5 percent, placing the State sixth behind Minnesota, Hawaii, Maine, Iowa, and Wisconsin, respectively.[10] However, the 2004 – 2005 two-year average for Rhode Island was 11.4 percent, tying the State with Nebraska, North Dakota, and Vermont for 11th behind Minnesota, Iowa, Hawaii, Wisconsin, Maine, New Hampshire, Massachusetts, Kansas, Pennsylvania, and, Connecticut, respectively, yet still 27.2 percent below the two-year national average of 15.7 percent uninsured.[11]

Rhode Island was no longer the national leader in the uninsurance rate for children under age 19 at or below 200 percent of the Federal poverty level (FPL)[12], the standard used nationally for the State Children's Health Insurance Program (SCHIP). The data showed the uninsurance rate for low-income children in Rhode Island in 2005 was 3.5 percent, placing the State ninth behind New Hampshire, Hawaii, Massachusetts, Vermont, Iowa, Michigan, Minnesota, and Nebraska, respectively. In comparison, in 2004 Rhode Island's uninsurance rate for low-income children was 4.3 percent – 13th lowest in the nation (down from 7th in 2003). Rhode Island's uninsurance

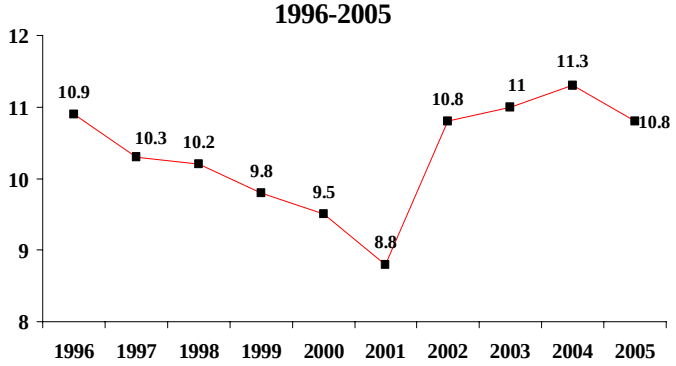
[8] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2004*, Table 9.
[9] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2005*, Table 10.
[10] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2004*, Table 9.
[11] U.S. Census Bureau, *Income, Poverty, and Health Insurance in the United States: 2005*, Table 10.
[12] U.S. Census Bureau, *Current Population Survey, August 2006*, Table HI10.

rate for low-income children in 2004 was 39 percent less than the national rate of 7.1 percent.

Because of some historical concerns about CPS data and the fact that Rhode Island covers some adults under its Section 1115 SCHIP waiver, Rhode Island has been making greater use of the Behavioral Risk Factor Surveillance System (BRFSS) data to examine uninsurance among adults in Rhode Island aged 18 to 64. BRFSS reports on those "uninsured at the time of the phone survey"[13], with a sample size of more than twice that of the CPS. Figure 2 shows the percent of uninsured adults in Rhode Island was 10.8 percent in 2005, which was an improvement from 11.3 percent in 2004 based on BRFSS data.

Figure 2

Percent Uninsured Rhode Islanders Ages 18-64: 1996-2005



Since 2001, the increased level of uninsurance was due to continued erosion in coverage by employer-sponsored insurance (ESI).

The Department of Human Services (DHS) has also been making increased use of the Health Interview Survey (HIS). The HIS is a survey conducted periodically by the Rhode Island Department of Health. The most recent analysis of HIS data summarizes 1990, 1996, and 2001 survey results[14]. In 2001, a random sample of 2,600 Rhode Island households were interviewed by telephone for the HIS, covering 6,877 individuals. Summary findings are as follows:

- The typical demographic characteristics of the uninsured in Rhode Island: is that they are between the ages of 18-34 years of age, male, White non-Hispanic, not married, completed high school or have a GED, low-income, employed, and live in a household of more than three persons.

[13] Rhode Island Department of Health. *Rhode Island's Uninsured Working Age Adult Population in 2005*, November 29, 2006. See: http://www.health.ri.gov/chic/statistics/Uninsured2005.ppt#268,1,Rhode Island's Uninsured Working Age Adult Population in 2005

[14] Bogen, K. *Who Are the Unisured in Rhode Island? Demographic Trends, Access to Care, and Health Status for the Under 65 Population*. RI Medicaid Research and Evaluation Reports, September 2004.

- The population groups that were disproportionately represented, or were more likely to be uninsured, included: Hispanics, unemployed persons, core city residents, and those who lived alone.

- Although the employed were insured at a higher rater, most uninsured Rhode Islanders are employed (61 percent). However, 46 percent of the unemployed were uninsured.

- The percent of uninsured children in Rhode Island has declined 50 percent from 8.4 percent in 1990 to 3.8 percent in 2001. Uninsured children were disproportionately represented in the age group 6-12 years of age, which comprised 50 percent of the uninsured children in Rhode Island. Children under 5 years of age had the highest rate of insurance coverage, with only 2.5 percent uninsured.

- The percent of uninsured under 65 years of age in Rhode Island declined from 10.5 percent in 1990 to 7.8 percent in 2001, as did the percent of uninsured women aged 15-44 from 10.9 percent in 1990 to 7.8 percent in 2001.

- The majority of the uninsured in Rhode Island are White, while 22 percent were Hispanic. However, 17 percent of all Hispanics were uninsured compared to only 6 percent for Whites.

- Nearly 50 percent of the uninsured in Rhode Island had incomes under 200 percent of the FPL and over 70 percent of the uninsured had incomes below 300 percent of the FPL.

The HIS was conducted again by the Rhode Island Department of Health, but the results have not yet been released.

Whether Rhode Island is first in the nation, or 3rd or 13th, according to CPS**, the effect of RIte Care (and, now, RIte Share) on the rate of uninsured for low- and moderate-income families is undeniable.**

III. RITE CARE FOR CHILDREN AND FAMILIES

RIte Care has been operational since August 1994. The initial period for the Section 1115 Medicaid waiver for RIte Care was August 1, 1994 to July 31, 1999. On September 17, 1998, the State was notified that its request to extend the waiver period through July 31, 2002 had been granted. On July 29, 2002, the State was notified that its request to extend the waiver period through July 31, 2005 had been granted. On August 31, 2005, the State was notified by the Federal Government that the waiver was extended through July 31, 2008.

On January 18, 2001, the Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS) approved Rhode Island's request for a Section 1115 SCHIP demonstration waiver to allow the State to receive enhanced Federal match for parents and relative caretakers in the Section 1931 expansion group whose incomes are between 100 and 185 percent of the FPL and pregnant women whose incomes are between 185 and 250 percent of the FPL. This approval enabled Rhode Island to receive 68.12 percent Federal Medical Assistance Percentage (FMAP) in Federal Fiscal Year 2006 for those parents, relative caretakers and pregnant women up to the State's SCHIP allotment (compared to a FMAP for Medicaid of 54.45 percent[15]).

3. 1 RIte Care Enrollment Has Stabilized

RIte Care has been operational since August 1994. Enrollment[16] in RIte Care by Health Plan as of the end of the 12th waiver program year (July 31, 2006) is shown in Table 1 below. The RIte Care enrollment of 117,199 at the end of July 2006 was almost 1,600 less than the RIte Care enrollment as of the end of July 2005 (118,772) and July 2004 (118,779).

Table 1

Enrollment in RIte Care by Health Plan, As of July 31, 2006

Health Plan	Number Enrolled	Percent
BCBSRI	13,938	11.9%
NHPRI	68,765	58.7%
UHCNE	34,496	29.4%
Total	**117,199**	**100.0%**

BSBCRI = Blue Cross and Blue Shield of Rhode Island, or BlueCHiP
NHPRI = Neighborhood Health Plan of Rhode Island
UHCNE = UnitedHealthcare of New England

[15] This is less than the revised 2004 FMAP due to Title V of Jobs and Growth Tax Relief Reconciliation Act of 2003 of 58.98 percent and the 55.38 percent in FFY 2005.
[16] These enrollment figures do not include children in foster care or children with special health care needs who are enrolled in NHPRI on a voluntary basis. Enrollment of these populations is discussed in Chapter VI.

Enrollment in the RIte Care population expansion groups as of July 31, 2006, in comparison to as of the end of July 2004 and 2005, is shown in Table 2.

Table 2

RIte Care Enrollment of Expansion Groups as July 31, 2004, July 31, 2005, and July 31, 2006

Expansion Group	July 31, 2004 Enrollment	July 31, 2005 Enrollment	July 31, 2006 Enrollment
Parents/Relative Caretakers up to 185% of FPL	12,089	12,367	10,782
Pregnant Women Between 185 and 250% of FPL	79	105	113
Children up to age 8 up to 250% of FPL	5,452	5,823	7,240
Children aged 8 to 19 up to 250% of FPL	10,800	11,328	12,039
Extended Family Planning	475	578	608
Children in Foster Care	2,128	2,180	2,315
Unborn Children up to 250% of FPL	487	576	529

As Chapter IV shows, enrollment in RIte Care has stabilized while enrollment in RIte Share has grown.

In SFY 2006, children under age 18 accounted for 66 percent of the RIte Care caseload in the year. Approximately three-quarters of the adults enrolled were female. Seventy-three percent of RIte Care enrollees were below the Federal poverty level (e.g., $24,135 for a family of three as of January 1, 2006). Almost twenty-two percent of the population spoke a language other than English as their primary language at home. The second most common language, Spanish, was spoken by approximately 18 percent of RIte Care members. The majority of RIte care enrollees lived in Rhode Island's core cities – Providence, Pawtucket, Woonsocket, Cranston, and Central Falls.

It should be noted that Rhode Island was one of the first four States, along with Minnesota, New Jersey, and Wisconsin, to obtain SCHIP waivers to cover parents/relative caretakers and pregnant women at the higher level of federal match of SCHIP.

3.2. Administrative Improvements Have Been Made to RIte Care

The State has made a number of improvements over time to make the application and enrollment processes less burdensome, to stimulate enrollment, and to deter *crowd-out* (i.e., substituting public coverage for private coverage). Among these administrative improvements have been the following:

- *October 1998* – Implemented a streamlined mail-in application with minimal documentation requirements and eliminated face-to-face requirements to confirm eligibility

- *April 1999* – Initiated a RIte Care community-based enrollment outreach project, encompassing school-based outreach combined with contracts with 32 community-based organizations using performance-based incentives for locating and enrolling eligible children. This outreach project ended in June 2000.

- *January 2002* – Implemented monthly premiums at up to three percent of income for expansion enrollees over 150 percent of the FPL

- *August 2002* – Increased the monthly premiums but not to exceed five percent of income for expansion enrollees over 150 percent of the FPL.

- *May 2004* – Made the RIte Care application available on-line in both English and Spanish

3.3 Delivery System Changes Were Made to RIte Care in 2005

As noted in Chapter I, the State of Rhode Island made a policy decision to only allow State-licensed HMOs to participate in RIte Care. There were originally five RIte Care-participating Health Plans: Coordinated Health Partners (CHP, or BlueCHiP), Harvard Community Health Plan (HCHP), Neighborhood Health Plan of Rhode Island (NHPRI), Pilgrim Health Care (PHC), and United HealthCare of New England (UHCNE). There have been several important changes to the Rhode Island HMO marketplace since then. First, HCHP and PHC merged in 1995, becoming Harvard Pilgrim Health Care (HPHC). Second, HPHC left[17] the Rhode Island market without warning in 1999. Finally, Blue Cross and Blue Shield of Rhode Island (BCBSRI) voluntarily gave up its State HMO license at the end of 2004.

In order to assure the availability of choices for RIte Care-eligible individuals, the State changed its policy to allow other than State-licensed HMOs to participate in RIte Care effective January 1, 2005. Non-HMOs must meet the following requirements:

- Be licensed as a health plan in the State

- Be accredited[18] by the National Committee for Quality Assurance (NCQA) as a Medicaid managed care organization (MCO)

- Maintain certain State regulatory requirements[19] that HMOs must meet:

[17] Tufts Health Plan of New England also left the Rhode Island market about the same time, although it had never participated in RIte Care.

[18] In Rhode Island, all HMOs must be accredited by NCQA. All three Health Plans have full three-year accreditation and received an "excellent" designation from NCQA. Of all the Medicaid plans in the nation, NHPRI ranked first, BCBSRI ranked second, and UHCNE ranked fourth in 2006. Both BCBSRI and UHCNE have their Medicaid product lines accredited, as well as their Medicare product lines.

[19] *Rules and Regulations for the Certification of Health Plans* (R23-17.13-CHP).

- Have professional services under the direction of a medical director who is licensed in Rhode Island and performs the functions specified in regulation (e.g., oversight of quality management)

- Make certain enrollees are only liable for co-payments and to have this provision in its provider contracts

- Meet "preventive health care services" requirements and provide them within time frames set by the HMO, according to accepted standards specific to age and gender

- Have a quality management program that is accredited

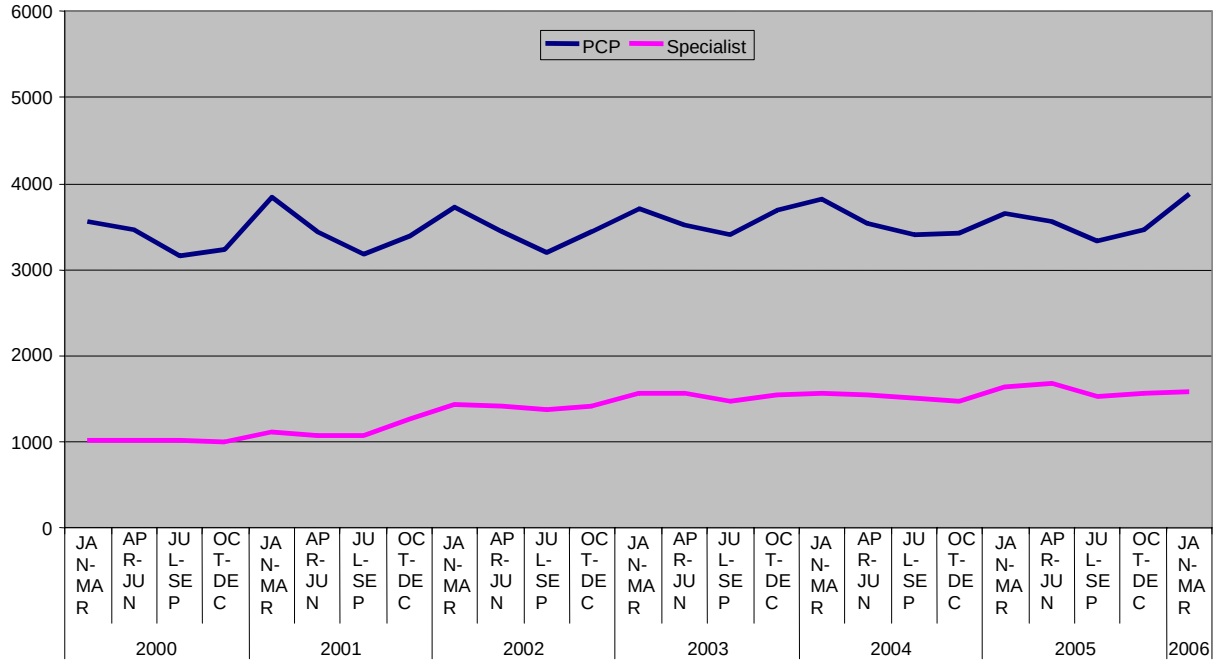
3.4 RIte Care Has Changed Patterns of Care

Not only has RIte Care demonstrably increased the number of low- and moderate-income Rhode Islanders who are insured, but the program has facilitated the ability of enrollees to obtain services and has changed patterns of care. The following illustrates these accomplishments:

- Increased primary care physician (PCP) participation in Medicaid from 350 physicians pre-RIte Care to over 900 physicians post-RIte Care (representing in excess of 90 percent of the practicing PCPs in the State). Every enrollee in RIte Care has a PCP, who is considered the enrollee's "medical home." Most specialists in the State also participate in RIte Care.

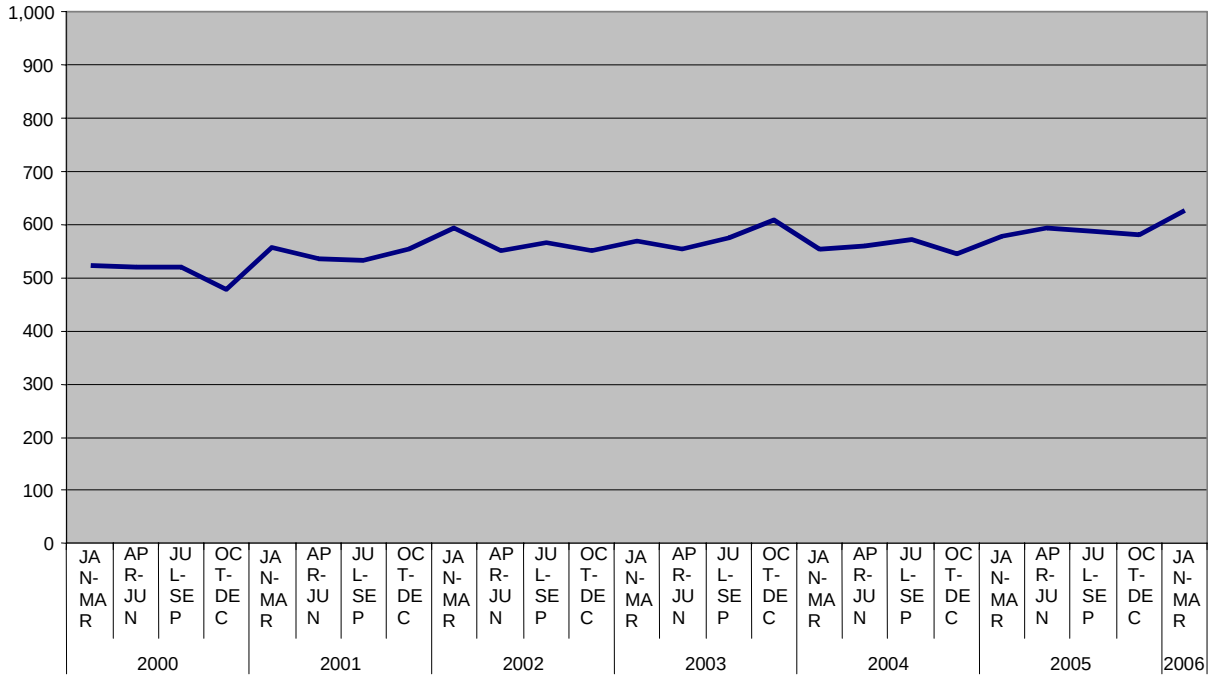
- Increased average per enrollee physician visits from two per year pre-RIte Care (1993) to five per year through the second quarter of SFY 2006, as Figure 3 shows. It should be noted that visits to health care specialists have averaged two per enrollee per year.

Figure 3
RIte Care Outpatient Visits to PCPs and Specialists per 1,000 Member-Months by Quarter (CY 2000-2006)



- Decreased hospital emergency department (ED) utilization by more than 40 percent from 1993 to 2000. ED visits, which were 750 per 1,000 Medicaid recipients pre-RIte Care, peaked at about 450 visits per 1,000 enrollees in early SFY 2000. Using the managed care industry standard of visits per 1,000 member-months, Figure 4 shows the ED utilization rate from the 1st quarter of SFY 2000 to SFY 2006 (through the third quarter). ED utilization in RIte Care has increased since the beginning of SFY 1999. Figure 4 shows that ED visits fluctuated between 500 and 600 per 1,000 member-months. Nonetheless, enrollees who have used the ED report they are satisfied with its accessibility as Table 7 in Section 3.5 below shows.

Figure 4
RIte Care Total Visits to Emergency Departments per 1,000 Member-Months by Quarter
(CY 2000-2006)



- Early entry into prenatal care for pregnant Medicaid women (i.e., in the first trimester) improved significantly from 76 percent in 1993 (pre-RIte Care) to 84.2 percent in 2004 (RIte Care).[20] Although a gap between the Medicaid population and the privately insured population persists, the gap was cut in half from 1993 to 2004.

- Adequacy of prenatal care, as measured by the Kotelchuck Adequacy of Prenatal Care Index, improved significantly for pregnant Medicaid women, from 70 percent in 1993 to 82 percent in 2003 (RIte Care).[21] Once again, although the gap between the Medicaid population and the privately insured population persists, it was cut by more than 60 percent from 1993 to 2003.

3.5 RIte Care Has Excellent Member Satisfaction

Each year since 1996, DHS has had a contractor conduct an annual member satisfaction survey (except for 2002 and 2005, due to severe resource limitations). Because a *RIte Care Member Satisfaction Survey* was not conducted during the most recent waiver program year, information is presented below from the *Consumer Assessment of Healthcare Providers and Systems*

[20] Griffin, J. *The Impact of RIte Care on the Health of Pregnant Women and Their Newborns: 1993-2004*, RI Medicaid Research and Evaluation Project, March 2006.

[21] *Ibid.*

(CAPHS® 3.0H) Adult Medicaid Consumer Satisfaction Survey that each RIte Care-participating Health Plan had performed for 2006 (for Measurement Year 2005). In viewing the reported satisfaction percentages for CAHPS® versus the *RIte Care Member Satisfaction Survey*, it is important to be mindful that the psychometric properties between the two surveys differ significantly. As such, **CAHPS® will always report substantially lower satisfaction percentages** than the *RIte Care Member Satisfaction Survey*.

Table 3 shows the Measurement Year 2005 CAHPS® *Overall Ratings* and *Composite Score Percentages* for the three Health Plans and in comparison 2005 CAHPS® national Medicaid average. As the table shows, RIte Care consumer satisfaction is high compared to national benchmarks.

Table 3

Measurement Year 2005 CAHPS® *Overall Ratings* and *Composite Score Percentages*

Measures	BCBSRI	NHPRI	UHCNE	2005 National Medicaid Average
Overall Ratings				
Health Plan Overall	83.7%	85.9%	77.7%	71.3%
Health Care Overall	84.6%	77.3%	76.9%	72.5%
Personal Doctor Overall	80.3%	81.7%	81.8%	77.0%
Specialist Overall	81.2%	68.6%	75.2%	75.4%
Composite Score Percentages				
Getting Needed Care	85.9%	79.6%	78.8%	73.6%
Getting Care Quickly	82.7%	74.1%	76.5%	72.1%
How Well Doctors Communicate	93.5%	89.4%	91.7%	86.1%
Courteous and Helpful Office Staff	94.0%	88.5%	92.0%	88.0%
Customer Service	75.4%	79.0%	70.2%	69.7%

3.6 RIte Care Has Improved Health Outcomes

The following illustrates how effective RIte Care has been in improving health outcomes for enrollees:

- Short interbirth interval (i.e., less than 18 months), which is associated with low birth weight**,** declined by more than 20 percent for Medicaid mothers from 1993 (pre-RIte Care) to 2004 (RIte Care).[22] The gap between women on Medicaid and privately insured women on this measure **virtually disappeared** by 1999.

[22] *Ibid.*

- An analysis[23] of infants death in Rhode Island from 1990 to 1999 showed that the rate of preventable infant deaths decreased significantly in families with public coverage:

    - From 1990 to 1999, the infant mortality rate declined 36 percent for infants "with public insurance" – from 10.7 deaths per 1,000 births to 6.8 deaths per 1,000 births

    - The gap between the public insurance infant mortality rate and private insurance infant mortality rate was reduced by over half, from 4.3 points in 1990 to 1.5 points in 1999

    - The neonatal mortality (i.e., less than 28 days after birth) for infants with public insurance decreased 23 percent, from 6.2 death per 1,000 births in 1990 to 4.8 deaths per 1,000 births in 1999

    - The post neonatal mortality (i.e., 28 days or more after birth) for infants with public insurance decreased more sharply, 57 percent, from 4.5 deaths per 1,000 births in 1990 to 1.9 deaths per 1,000 births in 1999. Postneonatal mortality is considered a measure of access to pediatric care.[24]

- In a study[25] of immunization status of 19- to 35-months-old children who had been continuously enrolled in RIte Care for at least one year, the immunization rates were as follows:

    - The overall immunization rate for having received all indicated doses of Dta/DTP, polio, Hib, MMR, and hepatitis B was 75 percent

    - When hepatitis B was excluded from the assessment, 81 percent of children were up to date for all doses of the remaining four vaccines

    These results compare favorably with national and Rhode Island rates as measured in the Centers for Disease Control and Prevention National Immunization Survey (NIS)[26] as Table 4 shows.

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[23] Griffin, J. *Rhode Island Infant Mortality 1990 – 1999: Changes in Causes of Death and Period of Death by Insurance Status*, Medicaid Research and Evaluation Project, March 2002.

[24] Centers for Disease Control and Prevention. "Postneonatal Mortality Surveillance – US 1980 – 1994," *Morbidity and Mortality Weekly Reporter*, 47 (15), 1998.

[25] Vivier, P. M., *et.al.* "An Analysis of the Immunization Status of Preschool Children Enrolled in a Statewide Medicaid Managed Care Program," *The Journal of Pediatrics*, 139(5), November 2001, 624-629.

[26] Centers for Disease Control and Prevention. "National, State, and Urban Area Vaccination Coverage Levels among Children 19 – 35 Months – United States, 1997," *Morbidity and Mortality Reporter*, 47, 1997, 547-554.

Table 4

Immunization Coverage Rates for 19- to 35-month-olds as Measured by NIS

Sample	Overall*%	DTaP%	Hib%	Hepatitis B %	MMR %	Polio %
National	76	81	93	84	91	91
Rhode Island	81	89	96	87	95	96
RIte Care	81	87	94	88	91	95

* Overall status includes all vaccines except hepatitis B

- In a study[27], 79.8 percent of children aged 19 to 35 months who had been continuously enrolled in RIte Care for at least one year had a documented blood lead screen test. Minority children, children in homes with other than English spoken in the home, and children living in core cities all had statistically significant higher screening levels. These are important results given the risk factors associated with lead poisoning. Screening levels also varied by primary care site:

  - Office-based 67.8 percent
  - Health center 85.8 percent
  - Hospital-based clinic 88.6 percent
  - Staff model HMO 90.9 percent

  These screening rates were dramatically higher than those published in national surveys.[28]

  The screenings found that children enrolled in RIte Care had a higher percentage (at 29.4 percent) with elevated blood lead levels (>10 mg/dl) on at least one test, when compared to national data[29] (at 8.6 percent).

  The State of Rhode Island recognizes the importance of lead screening in order to identify lead poisoning and intervene early. It is also important to recognize in this regard that DHS supports a Comprehensive Lead Center Program that includes window replacement as a RIte Care covered benefit.

3.7 RIte Care Has Been Budget Neutral

As a condition of receiving the waiver from the Federal Government making RIte Care possible, the RIte Care demonstration must be "budget neutral." This means that the demonstration cannot cost more than it would have absent the demonstration, within agreed-upon allowances for increases in costs (called "trend factors").

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[27] Vivier, P.M., *et.al.* "A Statewide Assessment of Lead Screening Histories of Preschool Children Managed in a Medicaid Managed Care Program," *Pediatrics*, 108(2), 2001.

[28] Kaufmann, R. B., *et.al.*, "Elevated Blood Lead Levels and Blood Lead Screening among US Children Aged One to Five Years: 1988 – 1994," *Pediatrics*, 106(6), 2000.

[29] *Ibid.*

As Table 5 shows, Rhode Island has operated within these budget neutrality limits across the first ten years of the demonstration. It should be noted that budget neutrality is tested over the entire demonstration period, not in any given year of demonstration. Thus, even though the costs under the waiver exceeded the budget neutrality limit in three of the twelve years under the demonstration to date, overall, the demonstration has been under its budget neutrality limit. Put another way, RIte Care has achieved its goal of containing Medicaid expenditures.

Table 5

Federal Budget Neutrality Summary for Waiver Years 1 – 12

	Budget Neutrality Limit		Waiver Expenditures		Variance	
	Gross Dollars	**Federal Share**	**Gross Dollars**	**Federal Share**	**Gross Dollars**	**Federal Share**
Original Waiver Period						
8/1/94 -7/31/95	$48,575,213	$26,954,386	$37,969,068	$21,068,157	$10,606,145	$5,885,350
8/1/95 – 7/31/96	$119,285,977	$64,545,642	$96,086,854	$51,993,115	$23,199,123	$12,553,045
8/196 – 7/3197	$121,839,003	$65,659,039	$120,307,290	$64,833,565	$1,531,713	$825,440
8/1/97 – 7/31/98	$125,204,629	$66,734,067	$119,616,791	$63,750,070	$5,587,838	$2,978,318
8/1/98 – 7/31/99	$139,625,464	$75,272,088	$129,313,100	$69,714,601	$10,312,364	$5,559,395
Subtotal Original Waiver Period	**$554,530,286**	**$299,165,222**	**$503,293,103**	**$271,359,508**	**$51,237,182**	**$27,801,548**
First Waiver Extension Period						
8/1/99 – 7/31/00	$170,059,915	$91,509,240	$152,082,287	$81,841,386	$17,977,628	$9,673,762
8/1/00 – 731/01	$175,706,215	$94,512,373	$168,548,392	$90,656,666	$7,157,823	$3,850,193
8/1/01 – 7/31/02	$179,654,337	$94,623,929	$174,688,556	$92,000,473	$4,965,781	$2,615,477
Subtotal Waiver Extension Period	**$525,420,467**	**$289,645,242**	**$495,319,235**	**$264,498,525**	**$30,101,232**	**$16,139,432**
Second Waiver Extension Period						
8/1/02 – 7/31/03	$199,479,803	$111,549,106	$203,884,375	$114,004,206	($4,404,572)	($2,455,100)
8/1/03 – 7/31/04	$227,849,104	$133.565,145	$233,949,592	$137,145,242	($6,100,488)	($3,580,097)
8/1/04 – 7/31/05	$266,153,287	$147,235,998	$280,996,788	$155,443,033	($14,843,500)	($8,207,035)
Subtotal Waiver Extension Period	**$693,482,194**	**$392,350,249**	**$718,830,755**	**$406,592,481**	**($25,348,560)**	**($14,250,567)**
Third Waiver Extension Period						
8/1/05 - 7/31/06	$282,400,007	$153,766,804	$269,114,445	$146,532,815	$13,285,561	$7,233,988
8/1/06 – 7/31/07						
8/1/07 – 7/31/08						
Subtotal Waiver Extension Period	**$282,400,007**	**$153,766,804**	**$269,114,445**	**$146,532,815**	**$13,285,561**	**$7,233,988**
Cumulative Total	**$2,055,832,954**	**$1,134,927,517**	**$1,986,557,538**	**$1,088,983,329**	**$69,275,414**	**$36,932,736**

3.8 Third-Party Liability

Making certain RIte Care is the payer of last resort is of ongoing importance in dealing with the State's budgetary issues. The Rhode Island General Assembly enacted legislation (Section 40-6-9.1 of the General Laws of Rhode Island) that enables a data match for DHS to identify and pursue other sources of payment for covered services. The statute applies to "all health insurers, including, but not limited to, health maintenance organizations, third party administrators, nonprofit medical service corporations and nonprofit hospital corporations" that must report information on private coverage for Medicaid eligibles to DHS upon request.

The initial data match was delivered on August 1, 2003, for private health insurance policies active from April 1, 2002 to April 1, 2003. The total[30] Medicaid records matched (i.e., on Social Security Number, date of birth, first five letters of the last name, and first three letters of the first name) with other coverage were 29,157. Of these, 19,239, or 66 percent, represented new information and 1,960, or 7 percent, represented updates to information already in the MMIS. In addition, 7,282, or 25 percent, were already known to the MMIS.

Table 6 shows the third-party liability (TPL) segments identified via the data match for all of Medicaid by quarter during SFY 2006.

Table 6

Third-Party Liability Segments Identified Via Data Match by Quarter in SFY 2006

Quarter	Medical TPL	Pharmacy TPL	Total New/Updated Policies
1st Quarter 2006	3,772	6,257	10,266
2nd Quarter 2006	3,784	3,787	6,521
3rd Quarter 2006	6,184	7,203	10,980
4th Quarter 2006	7,456	4,556	10,389
Total	**21,196**	**21,803**	**38,156**

The total cost avoidance due to TPL during SFY 2006 was $13,247,124, compared to $10,040,918 during SFY 2005. In addition, cost recoveries in SFY 2006 were $3,172,674, compared $4,276,144 in SFY 2005. The total[31] savings, through a combination of cost avoidance and cost recoveries were $16,419,798, compared to $14,317,062 in SFY 2005.

With the State's evolving experiences gained through these data matches, the State believes that future quarterly data matches will continue to hold great promise in assuring the appropriateness of public payments for health care under both RIte Care and RIte Share (as well as all of Medicaid) and, thus, containing public expenditures.

[30] It should be noted that the data match is for all of Medicaid, not just for RIte Care and RIte Share.
[31] *Ibid.*

3.9 RIte Care's Performance Incentive Program Is Producing Desired Results

A performance incentive program was implemented for RIte Care in July 1, 1998, under which Health Plans can earn payments over and above capitation payments for the attainment of administrative, access, and clinical goals. DHS offers each Health Plan monetary incentives[32] as a reward for improvements in performance, and the accuracy and completeness of data submitted. The State did so "to improve care by using available health plan data on access and outcomes" and "to improve the quality of health plan performance data."[33] This was part of an ongoing strategy of partnership with the Health Plans, with both the State and the Health Plans committed to continuous quality improvement for RIte Care. The "approach leverages a comparatively small amount of money in spotlight areas that DHS considers important."[34]

The Health Plans have been making considerable progress towards attaining the standards set forth under the Performance Incentive Program. Table 7 shows that the Health Plans were able to receive a significant portion of the potential incentive payments as a result of their performance in SFY 2006. In the table, 0.0000 means that the plan received a score of zero for whatever reason (e.g., a HEDIS® measure was "rotated" in the 2005 measurement year and not reported for that year) while a score of 1.0000 means that the plan met or exceeded the performance standard for that measure (see Appendix D for the performance standards). Because RIte Care-participating Health Plans are NCQA-accredited, the State has access to the HEDIS® data submitted for the Health Plans Medicaid product lines.

[32] The total incentive pool equals approximately one percent of total capitation payments made to the Health Plans.
[33] Dyer, M.B., M. Bailit, and C. Kokenyesi. *Working Paper: Are Incentives Effective in Improving the Performance of Managed Care Plans?*, Center for Health Care Strategies, March 2002.
[34] Rhode Island Department of Human Services. *Rhode Island Medicaid Program: Annual Report Fiscal Year 2001.*

Table 7

Percent of Potential Incentive Payments Received by the Health Plans in SFY 2006[35]

Measure	Plan Score for Each Measure		
	BlueCHiP	NHPRI	UHCNE
Member Services			
1. ID card within 10 days	0.7750	1.0000	1.0000
2. Member handbook within 10 days	0.6917	1.0000	1.0000
3.New member calls completed within 30 days	1.0000	0.8346	0.7000
4. Grievances and appeals within contractual timeframes	0.5400	0.9400	0.6150
Medical Home/Preventive Care			
5.Members have access to emergency services	0.8697	1.0000	0.5000
6. Members satisfied with access to urgent care	1.0000	1.0000	0.9000
7. Members have access to urgent care appts. after business hours	0.0000	0.0000	0.0000
8. Members have PCP phone access after hours	0.0000	0.0000	0.0000
9. Adult members had an ambulatory or preventive care visit	0.9869	0.9901	1.0000
10. Members had well-child visits in the first 15 months of life	1.0000	1.0000	1.0000
11. Members had well child visits in the 3rd to 6th years of life	0.9690	1.0000	1.0000
12. Adolescents received MMR2 + 3xHepB by 13th birthday	1.0000	1.0000	1.0000
13. Children received immunizations by 2nd birthday	1.0000	1.0000	1.0000
14. Children received periodic PCP visits	1.0000	0.9984	0.9984
15. Children received ≥1 lead screen before 2nd birthday	0.9521	0.9331	0.9515
16. Members ≥18 received advise on smoking cessation	1.0000	1.0000	0.0000
17. Pregnant members received timely prenatal care	1.0000	1.0000	0.0000
18. Pregnant members received timely postpartum care	1.0000	0.0000	0.0000
19. Adolescent PCP Care	0.0000	0.0000	0.0000
Women's Health			
20. Women 18 - 64 received cervical cancer screening	1.0000	1.0000	1.0000
21. Sexually active women 16 - 25 received Chlamydia screening	0.0000	0.0000	0.5000
Chronic Care			
22. Children with asthma use appropriate medications	1.0000	1.0000	1.0000
23. Adults with diabetes had HbA1C testing	0.0000	0.9543	0.0000
24. Antidepressant compliance	0.0000	0.0000	0.0000
Behavioral Health			
25. Members ≥6 received follow-up by 30 days post-discharge	1.0000	1.0000	1.0000
Resource Maximization			
26. Generic drug substitution rate	1.0000	1.0000	1.0000
27.DHS notified of TPL within 15 days	0.9965	1.0000	1.0000

[35] 0.00 means that the measure was rotated and not evaluated during the measurement year.

3.10 RIte Care's Quality Performance Is Nationally Recognized

RIte Care Health Plans have been nationally recognized for their quality. In fact, in 2006 the RIte Care Health Plans were ranked[36] among "America's Best Health Plans" in terms of quality compared to the other Medicaid plans in the country as follows:

- **1st** – NHPRI, with an aggregate score of 90.3
- **2nd** – BCBSRI with an aggregate score of 89.6
- **4th** – UHCNE, with an aggregate score of 88.5

[36] See: http://www.usnews.com/usnews/health/best-health-insurance/rankings/medicaid.htm.

IV. RITE SHARE FOR CHILDREN AND FAMILIES

The goal of the RIte Share premium assistance program is to support families in their efforts to obtain or maintain private, employer-sponsored health insurance. Enrollment in RIte Share is mandatory for Medicaid-eligible individuals whose employers offer an approved health plan. Enrollment of both employees and employers in the RIte Share program has continued to grow. As of January 2002, 117 employers were approved for participation in RIte Share. As of July 2006, 1,056 employers were approved for participation in RIte Share, which is an apparent decrease from the 1,176 employers as of July 2005. However, the decrease is actually due to an upgrade of the RIte Care employer database that was made in October 2005.

Since the program started, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

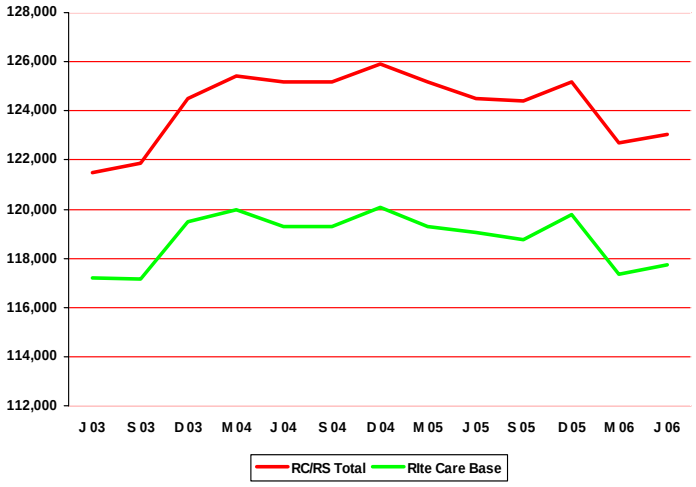
In order to transition a RIte Care member to RIte Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance market present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large premium rate increases through the magnitude of deductibles. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent. Thus, while plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and employees) particularly in a “down economy”.

Figure 5 shows the incremental gains in enrollment in RIte Share through June 30, 2006. There were 5,298 individuals enrolled in RIte Share as of June 30, 2006 with another 243 in the process of being enrolled. RIte Share enrollment is down from 5,710 individuals enrolled in RIte Share as of July 31, 2005, with 48 in the process of being enrolled in RIte Share and 5,982 enrolled in RIte Share as of June 30, 2004. This decline in enrollment reflects, partly, an increase the costs of ESI that makes it more difficult to surmount RIte Share’s cost-effectiveness test. Other reasons are discussed in Section 4.2 below, where the challenges facing RIte Share are presented.

The figure also shows that RIte Share is having its intended effect of stabilizing RIte Care enrollment.

Figure 5

RIte Care/RIte Share Enrollment through June 30, 2006



RIte Share makes ESI coverage affordable for many families while saving the State money; RIte Share pays all or part of the employee's share of coverage and the employer pays their share. The State will continue to transition Medicaid-eligible families who have access to ESI into RIte Share in an effort to contain the growth in the cost of health insurance for Medicaid eligibles while simultaneously addressing the level of uninsurance in the State.

4.1 RIte Share Has Saved Money

An analysis of the financial savings due to RIte Care showed that for every 1,000 enrolled in RIte Share, there is roughly $1 million in gross savings. A more recent update is shown in detail in Table 8, which shows the estimated RIte Share savings for SFYs 2001 through SFY 2006. As the table shows, RIte Share savings have increased over time. There have been aggregate Gross RIte Share Savings of $20,355,175 and Net Savings[37] of $4,705,670 since RIte Share began, through SFY 2006.

[37] This is Gross Savings less the cost of State-paid deductibles, co-payments, coinsurance, and wraparound benefits that are referred to in the aggregate as "Supplemental Benefits".

Table 8

RIte Share Gross and Net Savings[38]

	SFY 2002	SFY2003	SFY 2004	SFY 2005	SFY 2006
(1) RIte Care Capitation	$775,469	$5,266,865	$9,490,506	$12,026,068	$13,354,659
(2) Risk Share	$38,818	$292,251	$892,289	$658,296	$125,677
(3) Stop-Loss	$5,486	$21,358	$102,010	$101,066	$25,528
(4) CHC Transition Payments	$19,394	$142,388	$254,425	$392,656	$353,468
(5) Subtotal (1+2+3+4)	$839,168	$5,682,863	$10,739,231	$13,178,087	$13,859,333
(6) Cost-Share Paid	$ 0	$199,845	$317,749	$362,801	$361,437
Total RIte Care Benefit Expenditures Avoided (5-6)	**$839,168**	**$5,483,018**	**$10,421,481**	**$12,815,286**	**$13,497,896**
RITE SHARE EXPENDITURES					
(1) Premium Subsidies	$406,453	$2,364,815	$4,633,295	$5,490,561	$5,639,660
(2) Supplementary Benefits	$14,870	$340,048	$1,055,245	$1,265,004	$1,491,723
Total RIte Share Benefit Expenditures	**$421,323**	**$2,704,863**	**$5,688,540**	**$6,755,566**	**$7,131,383**
RITE SHARE SAVINGS					
(1) Federal-Level Savings	$256,502	$1,754,867	$3,077,369	$3,876,479	$4,072,738
(2) State-Level Savings	$161,343	$1,023,289	$1,655,573	$2,183,241	$2,293,775
(3) RIte Share Benefit Savings (RC Expenditures Avoided minus RIte Share Expenditures)	**$417,845**	**$2,778,155**	**$4,732,942**	**$6,059,720**	**$6,366,513**
(4) State-Funded RIte Share Administrative Expenses	$332,270	$507,796	$538,968	$607,151	$625,366
(5) Total (State and Federal-Funded) RIte Share Administrative Expenses	$644,540	$1,015,592	$1,077,936	$1,214,302	$1,250,732
(6) State-Level RIte Share Savings, net of RS admin costs (2-4)	**$(170,927)**	**$515,493**	**$1,116,605**	**$1,576,090**	**$1,668,409**
(7) Public (State and Federal) RIte Share Savings, net of RS admin costs (3-5)	$(266,695)	$ 1,762,563	$ 3,655,006	$4,845,418	$5,115,781

[38] The figures in this table are updated based on an analysis completed in February 2007. Figures vary slightly from previous reports due to claims completion, retroactive eligibility adjustments and financial reconciliations with health plans.

4.2 Challenges Facing RIte Share

Several circumstances make it challenging for RIte Share to realize its full potential for enrollment:

- Employers are not required to submit information about their health insurance benefits to the Department of Human Services, making it difficult to transition RIte Care members to RIte Share.

- Federal ERISA laws pre-empt any State law that would require employers to enroll RIte Share eligible families in the employer-sponsored health insurance outside of open enrollment periods.

- Federal Medicaid rules mandate different levels of benefits for family members (children, adults, and pregnant women) making it complex for RIte Share to wrap-around varying benefit levels within a family.

- Increases in premiums are being passed on to employees, making it more difficult to meet cost-effectiveness tests for Federal financial participation (FFP).

- Employers are adopting health plans with increased member cost-sharing (e.g., high deductibles) and scaled-down benefits that make it harder to "warp around" Medicaid.

- Health Savings Accounts (HSAs) and other flexible benefit programs make it more difficult to mandate that employees take up coverage.

V. COST-SHARING FOR CHILDREN AND FAMILIES

The RIte Care Stabilization Act of 2000 mandated cost-sharing for RIte Care and RIte Share families with family income above 150 percent of the FPL ($22,890 for a family of three). Since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of their health insurance coverage if their income is above 150 percent of the FPL (e.g., 24,900 for a family of three as of March 1, 2006). In November 2001, families received two letters and an official notice about the change. The first monthly bills were sent in December 2001, requiring payment by January 1, 2002. As of August 1, 2002, State law mandated that cost-sharing be raised to approximately five percent of the FPL. This amount ranges from about $61 to $92 per month. Rhode Island was one of four States increasing enrollee cost-sharing in 2002, with another 11 States were expected to do so in 2003[39].

Monthly premiums are collected in two ways:

- For RIte Care, DHS sends a bill and the family pays DHS directly by mailing a check, paying cash at a community site or by debit/credit card over the phone

- For RIte Share, DHS deducts the monthly premium from the amount it reimburses the member for the employee's share of employer coverage

On a monthly basis, about 10 percent of all RIte Care/RIte Share families are subject to cost-sharing. Table 9 shows the number of families and individuals, by income level, active in cost-sharing as of July 2006. There were 5,486 families (13,707 individuals) active in cost-sharing at the end of July 2006, compared to 5,383 families (13,327 individuals) at the end of July 2005. There were 22,818 families *ever* active in cost-sharing through July 2006, compared to 19,517 families ever active in cost-sharing through the end of July 2005.

Table 9

Families and Individuals Active in Cost-Sharing as of July 2006

Income Level	Families	Adults	Children	Total Individuals
150-185% of FPL	3,572	4,384	5,961	10,345
185-200% of FPL	658	20	1,155	1,175
200-250% of FPL	1,200	54	2,022	2,076
250-350% FPL	56	54	57	111
Total	**5,486**	**4,512**	**9,195**	**13,707**

[39] Academy Health. *State of the State: Bridging the Health Coverage Gap*, January 2003.

Most families make their cost-sharing payments on time. However, sanctions (i.e., disenrollment for non-payment of premiums) are applied when a family does not pay the required cost-sharing for two months. The sanction extends for four months. If the family meets eligibility criteria, the family may re-apply and return to coverage at the end of the four months. If at any time during the four months the family's income falls below 150 percent of the FPL, the family may re-apply and be found eligible for coverage. From January 2002 to September 2005, pregnant women and infants under one were not disenrolled for non-payment of cost-sharing but continued to incur a cost-sharing liability if their income was above 185 percent of the FPL. Beginning in October 2005, pregnant women and infants under age one are exempt from paying monthly RIte Care premiums, as a result of legislation passed by the General Assembly in June 2005.

Table 10 shows the sanctions applied in State Fiscal Years (SFY) 2002 to 2006. As the table shows, 3,517 individuals were disenrolled for non-payment of cost-sharing in SFY 2006, which was up from 3,387 in SFY 2005 and a high of 4,707 in SFY 2003.

Table 10

Families and Individuals Disenrolled for Non-Payment of Cost-Sharing

State Fiscal Year	Families	Adults	Children	Total Individuals
2006	1,686	899	2,618	3,517
2005	1,608	871	2,516	3,387
2004	1,653	1,047	2,628	3,675
2003	1,969	1,441	3,266	4,707
2002	1,037	743	1,658	2,401

A May 2003 analysis of 1,853 families who were first *sanctioned* (i.e., terminated from participation in RIte Care for non-payment of premiums) in Calendar Year 2002 showed that 1,101, or 59 percent, of these families returned to RIte Care coverage. Another 82 families, or 4 percent, met other Medical Assistance criteria that allowed specific family members to continue coverage. The remainder of the families, 670, or 36 percent, had not returned to coverage by the time of the analysis.

VI. RITE CARE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Enrollment of children with special health care needs into RIte Care began in November 2000 with the enrollment of children in foster care (substitute placement). Because NHPRI was the only Health Plan participating in RIte Care willing to enroll this population, children in foster care are enrolled on a voluntary basis.[40] As of June 30, 2006, there were 2,356 children in foster care enrolled in RIte Care (or 86 percent of these children eligible to be enrolled in RIte Care) compared to 2,200 children as of June 30, 2005.

On January 29, 2003, the State was notified by the Centers for Medicare & Medicaid Services (CMS) that its RIte Care waiver amendment request to enroll children with special health care needs on a mandatory basis (excluding children in foster care who were already being enrolled voluntarily) into RIte Care Health Plans had been approved. Prior to this waiver amendment, children with special health care needs had been served through the Medicaid fee-for-service system, which tends be fragmented, to have limited choice and access[41], and to have multiple systems of care.

Children with special health care needs covered under the waiver include the following groups of Medicaid-eligible children up to age 21:

- Blind/disabled children and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)
- Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children)
- Children receiving subsidized adoption assistance

At the time of the submission of the request for this waiver amendment, the State estimated that there were approximately 8,800 children who would be affected by it.

In pursuing this waiver amendment, the State did so to build upon its successes with RIte Care and to extend what it had learned to design and implement a service delivery strategy for children with special health care needs. Specifically, the State sought to increase accountability, provide focused oversight and monitoring, improve cost-effectiveness of health coverage, and integrate family coverage for these populations of Medicaid-eligible children. The State believes that these children can benefit from improved access to and coordination of care afforded through RIte Care, using a service delivery strategy that focuses on the child's unique needs, the strength of the family, and coordination of services. Slowing the rate of increases in costs is an anticipated by-product of improved care.

[40] Federal regulations require that at least two health plans be available in order to enroll any given population on a mandatory basis.

[41] For example, under Medicaid fee-for-service less than 40 percent of practicing physicians in the State participate. Under RIte Care, more than 90 percent of the practicing physicians participate.

The State provided significant opportunity for public input in the development of this waiver amendment, including:

- **Stakeholder meetings** – Thirteen stakeholder meetings were scheduled over a four-month period that began on March 25, 2002. The initial meeting was attended by approximately 125 individuals.

- **Additional stakeholder input** – Additional informational meetings were held with advocacy groups, providers, State agencies, and RIte Care participating Health Plans.

- **Other stakeholder communication** – The DHS Web site was updated to include information on the proposed Waiver amendment. Letters and fact sheets were mailed to parents, guardians, and adult caretakers of the targeted children.

Notices of public meetings were published in *The Providence Journal*.

As indicated above, the State's waiver approval was to enroll all eligible children with special health care needs on a mandatory basis in RIte Care-participating Health Plans. Because only NHPRI agreed to enroll these children, these children are being enrolled into NHPRI on a voluntary basis.[42] A policy decision was made to phase in enrollment, beginning in September 2003. The phase-in was considered important to allow DHS (and its contractors) to work with the affected families to make certain each child's health care needs were known in order to assure continuity of care and to educate families how to access care within a managed care environment.

At the time that this voluntary enrollment was scheduled to begin, there were 8,799 children on Medical Assistance in the three categories above. Of these children, 5,006 were deemed eligible to enroll in managed care (e.g., were not covered under another waiver, did not have other insurance coverage, or were not too old). As of June 30, 2006, 4,417 children with special health care needs had enrolled in a Health Plan compared to 4,001 enrolled as of June 30, 2005 and 3,540 enrolled as of June 30, 2004. This is estimated to be approximately 80 percent of those eligible to be enrolled (e.g., not participating in another waiver or have third-party coverage). Table 11 shows a breakdown of those children with special health care needs not enrolled in a Health Plan as of June 30, 2006 and the reasons why they are not enrolled:

[42] BlueCHiP and United Healthcare of New England have declined to enroll these children. Federal regulations require that at least two plans be available in order to enroll a population on a mandatory basis.

Table 11

Children with Special Health Care Needs Not Enrolled in RIte Care as of June 30, 2006, by Reason

Reason Not Enrolled in RIte Care	Population Group			
	Children on SSI	Katie Beckett Children	Adoption Subsidy	Total
Excluded for TPL	579	1,155	924	2,658
In Long-Term Care	16			16
In MR/DD Waiver	78	1	3	82
Located Out-of-State	51		68	119
Excluded for Clinical Reasons	47	49	9	105
Pending Review	23	4	17	44
Other*	1,829	189	317	2,335
Total	**2,623**	**1,398**	**1,338**	**5,359**

*Principally those who do not want to enroll in a Health Plan

APPENDIX A

The Impact of RIte Care on the Health of Pregnant Women and Their Newborns, 1993-2004

ATTACHMENT B

Profiles and Trends of the Uninsured in Rhode Island: 2005 Update

APPENDIX C

RIte Care Performance Goal Program: 2005 & 2006 Results

The Impact of RIte Care on the Health of Pregnant Women and Their Newborns 1993 – 2004

Prenatal Care and Birth Outcomes
Health Indicator Trends

Prepared by:
Jane Griffin, MPH
RI Medicaid Research and Evaluation Project
March 2006

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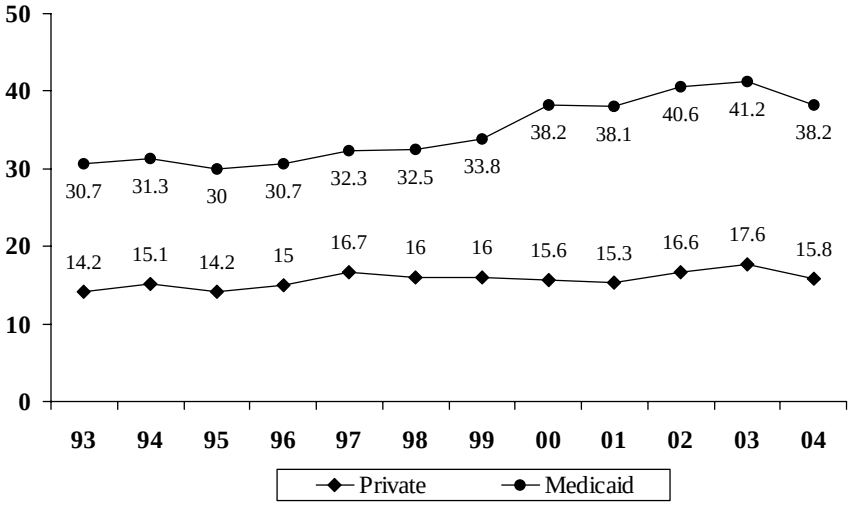
Characteristics of Mothers

Table 1 Number of RI Births 1993-2004 By Insurance Coverage and by Age												
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Total RI Resident Births	**13,565**	**13,078**	**12,422**	**12,300**	**12,076**	**12,201**	**11,958**	**12,065**	**12,200**	**12,441**	**12,690**	**12,309**
Medicaid Births	4,598	4,305	3,510	3,971	3,619	3,618	3,554	4,271	4,533	4,543	4,700	5,478
% of Total Births	33.9	32.9	28.3	32.3	30.0	29.6	29.7	35.4	37.2	36.5	37.0	44.5
Total Teen Births < 20 yrs	1,444	1,409	1,267	1,299	1,322	1,312	1,211	1,255	1,229	1,160	1,077	1,159
Medicaid Teen Births	1,065	987	721	790	718	713	683	839	870	803	781	932
% of Total Teen Births	73.7	70.1	56.9	60.8	54.3	54.3	56.4	66.8	70.8	69.2	72.5	80.4
Medicaid Births by Race												
White	2,410	2,250	1,961	2,248	1,949	1,866	1,781	1,912	2,040	2,023	2,010	2,514
Black	698	629	403	491	396	438	420	609	648	626	681	718
Hispanic	1,168	1,134	882	994	1,050	1,083	1,099	1,479	1,560	1,565	1,698	1,864
Asian	322	262	215	237	223	230	248	268	285	328	310	382

* Insurance Coverage – self-reported by mother at delivery

Figure 1
Percent of Births to Immigrant Mothers
by Insurance Coverage 1993-2004



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305)

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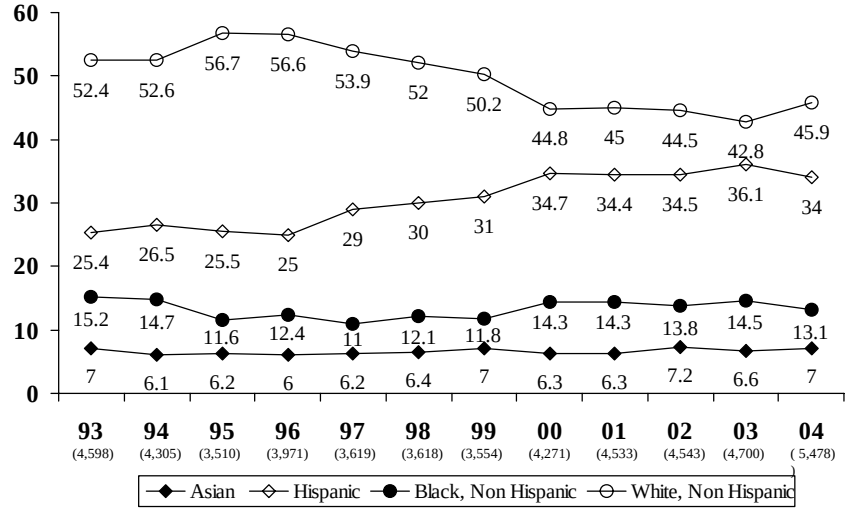

Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305)

Figure 3
Percent of Mothers Who are ≥ 35 Years Old
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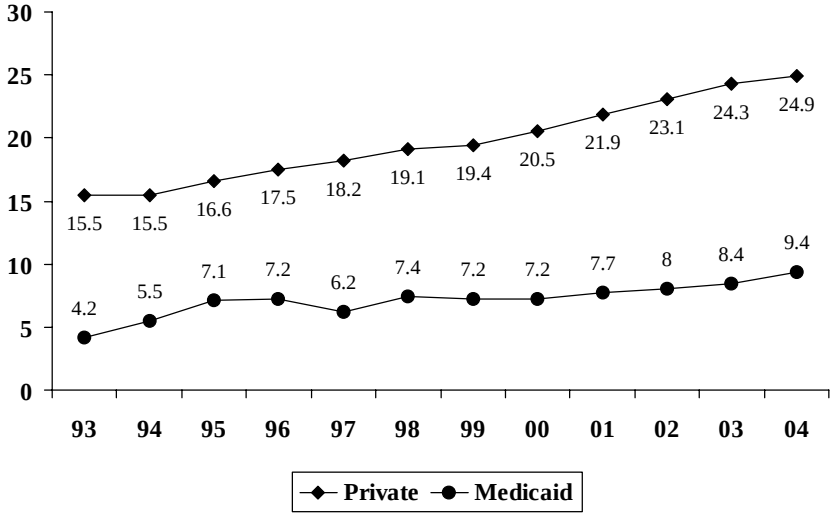

Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305) * Self Report

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Percent of First Time Births to Mothers Who are ≥ 35 Years Old
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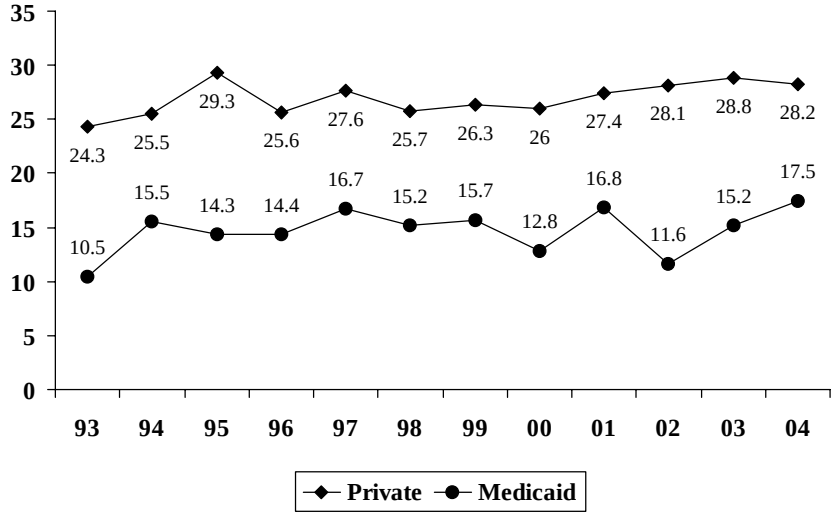

Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305) * Self Report

Prenatal Care

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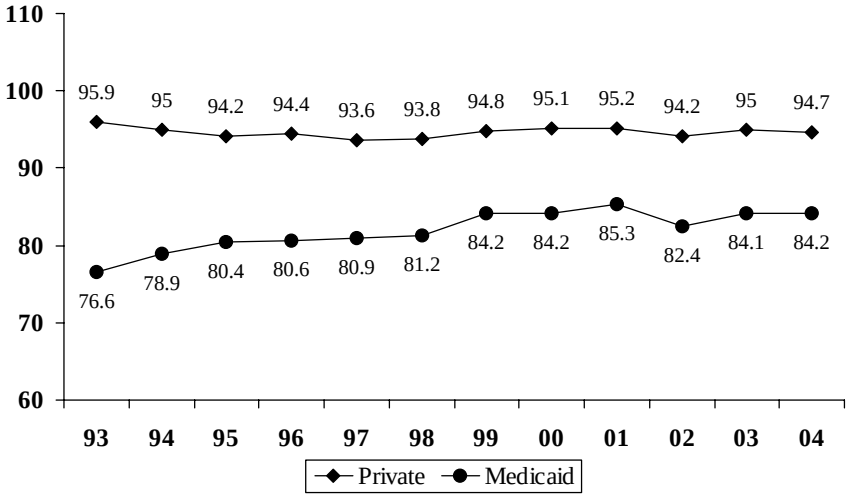

Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305)

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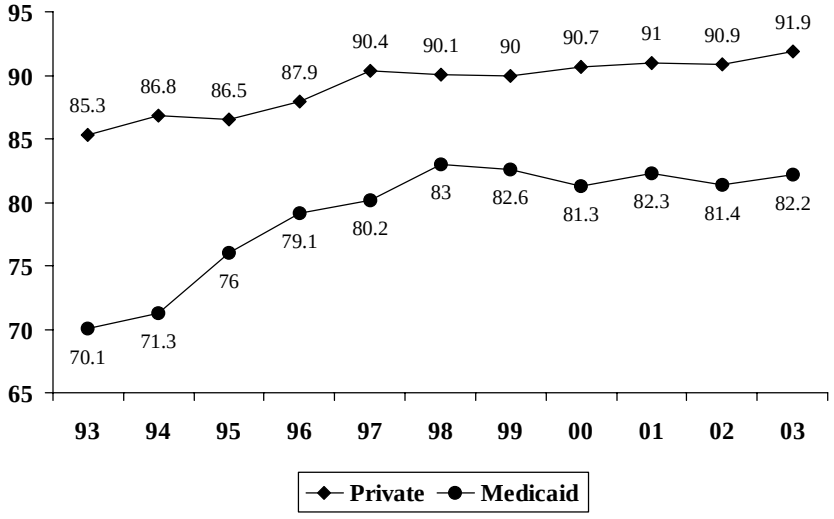

Data Source: Medicaid Research & Evaluation Project
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Maternal Health

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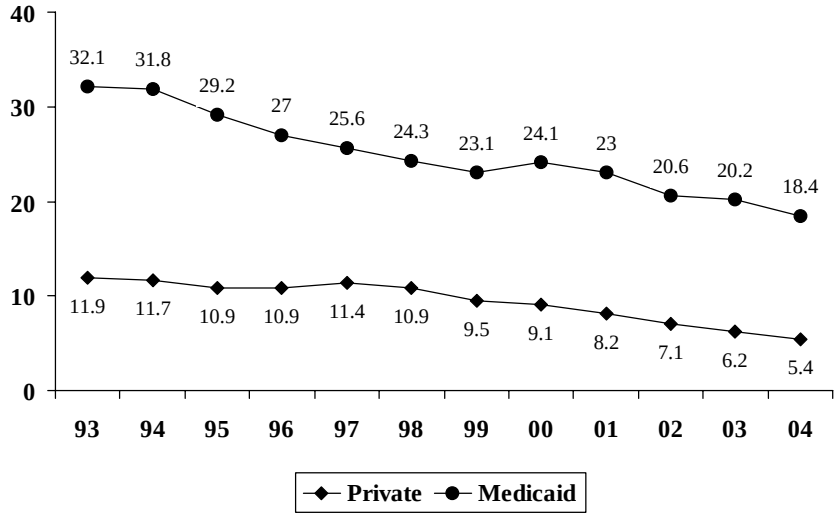

Data Source: Medicaid Research & Evaluation Project
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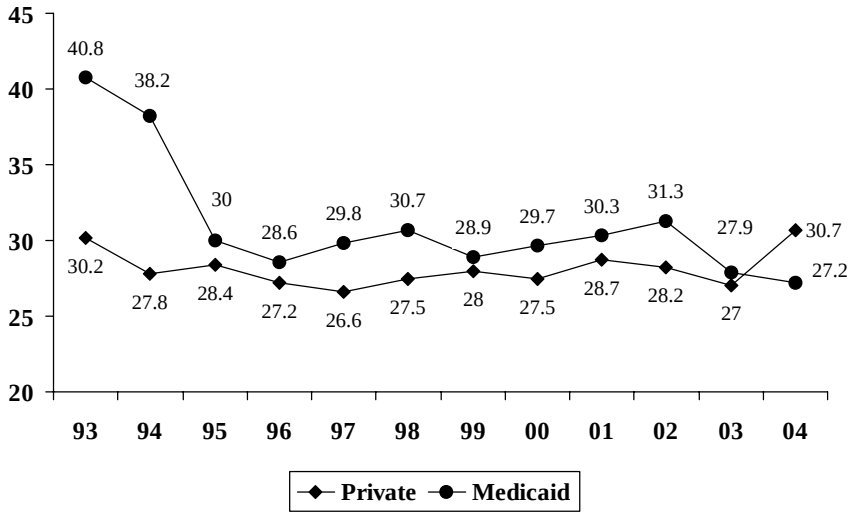

Data Source: Medicaid Research & Evaluation Project
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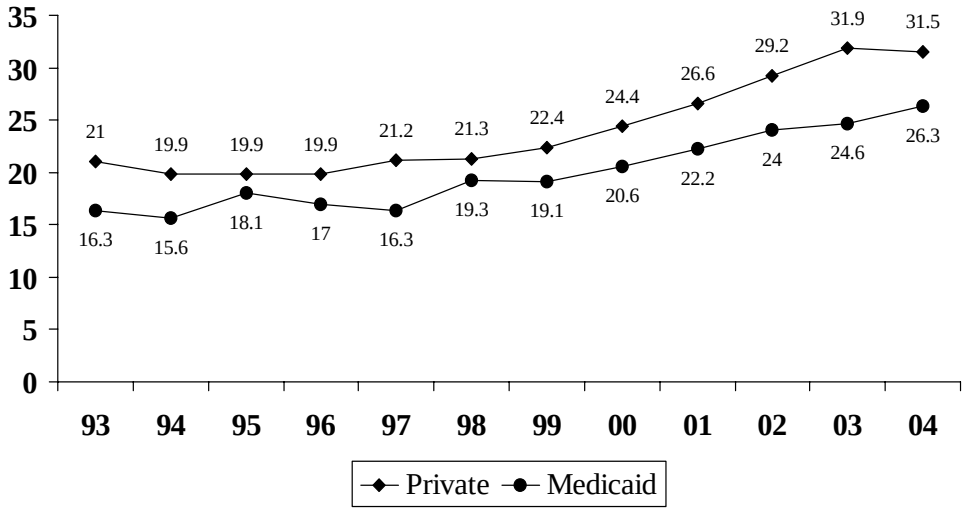

Data Source: RI Medicaid Research and Evaluation Project – Vital Statistics Birth File 1996-2004, RI Department of Health

Birth Outcomes

Figure 9
Percent Low Birthweight
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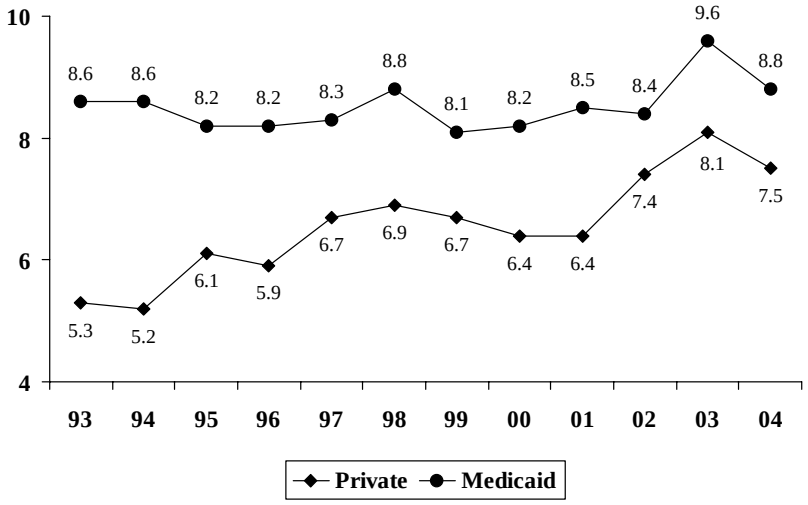

Data Source: Medicaid Research & Evaluation Project
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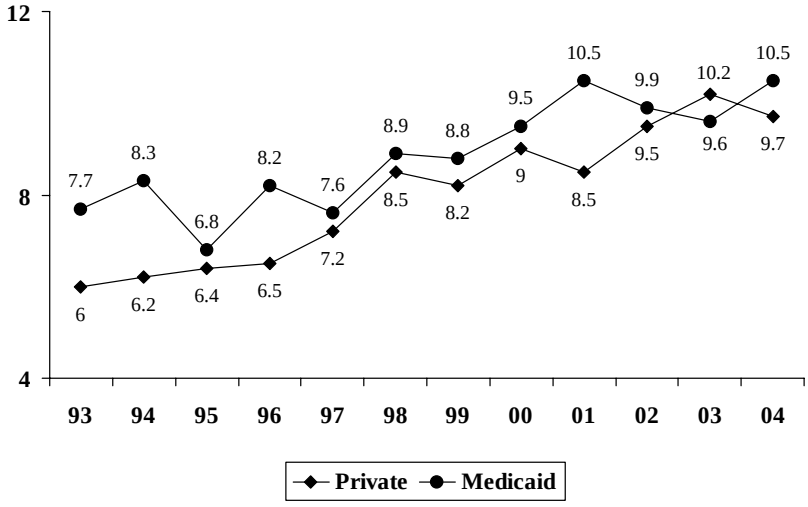

Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305)

Figure 11
Percent of Multiple Births
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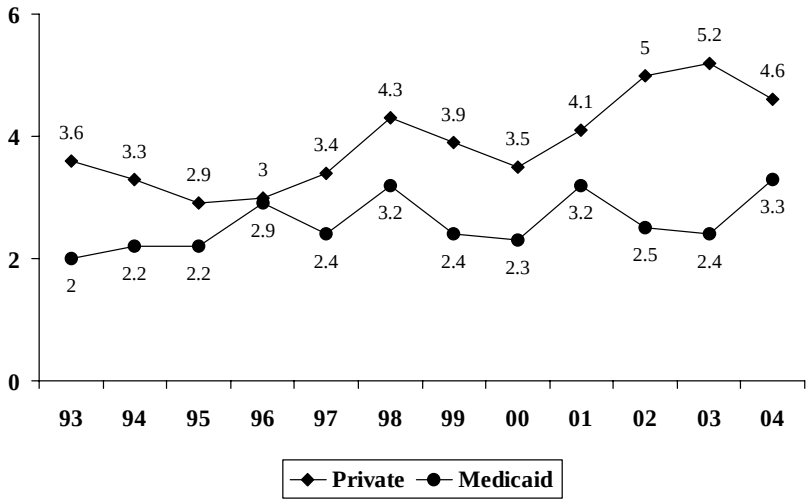

Data Source: Medicaid Research & Evaluation Project
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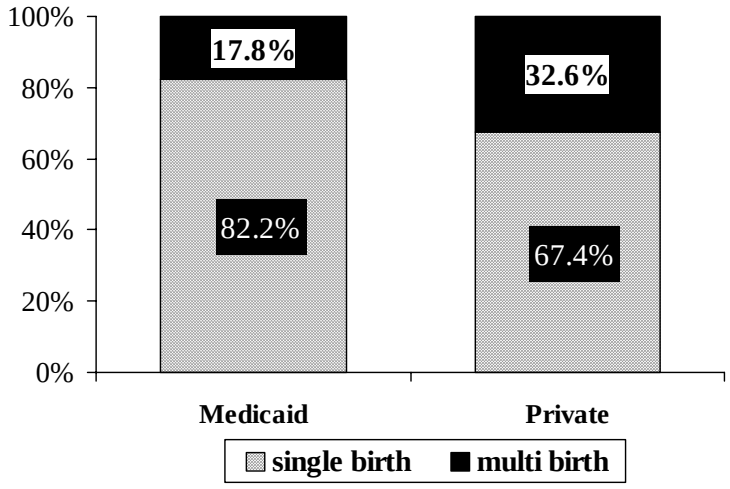


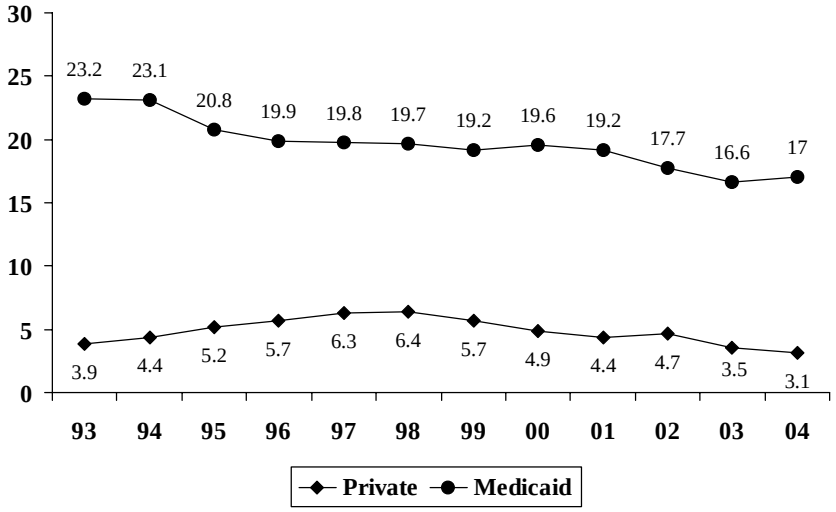
Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=149,305)

Table 2
Birth Outcomes for Mothers on Medicaid 1993-2004

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
# Medicaid Births	**4,598**	**4,305**	**3,510**	**3,971**	**3,619**	**3,618**	**3,554**	**4,271**	**4,533**	**4,543**	**4,700**	**5,478**
# VLBW (<1500 grams)	63	57	37	47	50	58	53	71	73	81	81	87
# MLBW (1500-2499 grams)	331	307	246	280	253	260	234	279	313	298	368	396
# Preterm	318	319	210	290	224	255	268	397	463	445	447	576
# Multiple birth *	92	92	76	115	85	117	84	97	143	112	113	183
# Cesarean Births *	700	634	599	639	568	659	650	844	972	1,048	1,125	1,420
# Mothers ≥35	191	236	246	286	223	266	254	329	347	365	393	512

Teen Pregnancy

Figure 12
Percent of Total Births to Teenagers <20 years Old
by Insurance Coverage 1993-2004



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n=15,144)

Figure 13
Percent of Second Time or Higher Births to Teen Mothers
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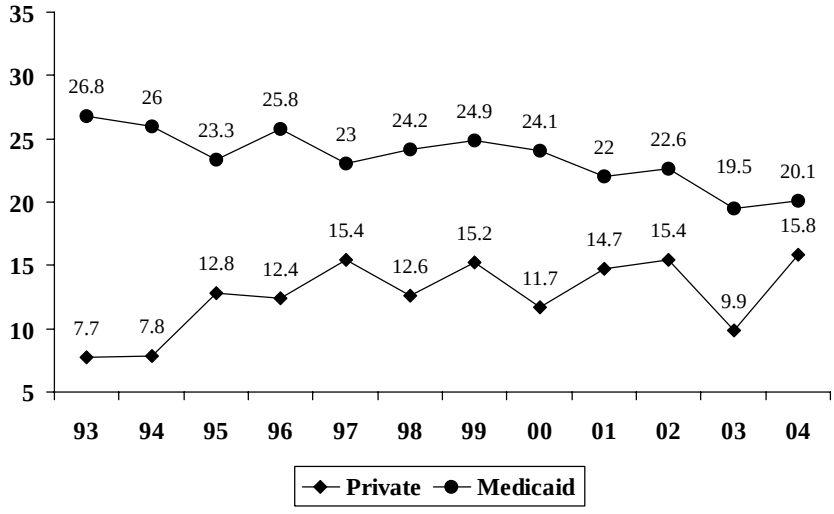


Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2004 – (n= 15,144)

RI Medicaid Research and Evaluation Reports

Profiles and Trends of the Uninsured in Rhode Island – 2005 Update

TABLES AND FIGURES

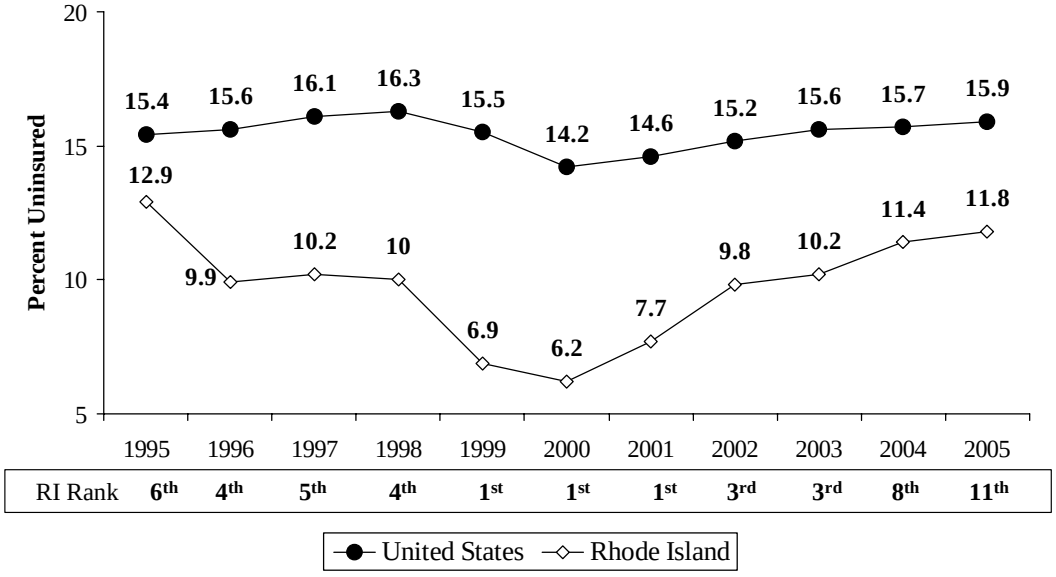
October 2006

Prepared by Jane Griffin, MPH
RI Medicaid Research and Evaluation Project

Figure 1

The Percent of Uninsured in Rhode Island is Rising at a Faster Rate than the US

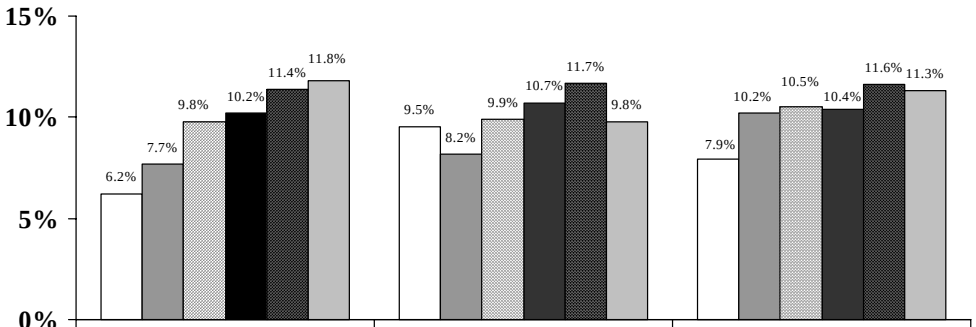
1995-2005 – All Ages



Data Source: Medicaid Research and Evaluation Project
U.S. Bureau of Census, Current Population Survey, 1995-2005 (September Estimate)

Figure 2

Rhode Island's Rate of Uninsurance Continues to Rise whereas the Rate in Neighboring States is Declining

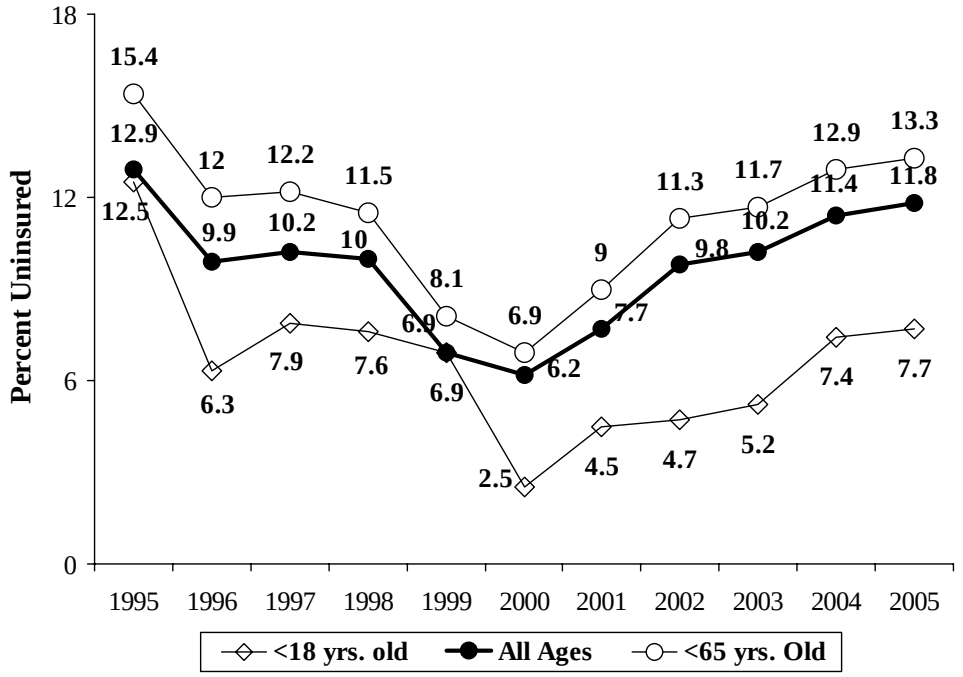


	Rhode Island	Massachusetts	Connecticut
2000	6.2%	9.5%	7.9%
2001	7.7%	8.2%	10.2%
2002	9.8%	9.9%	10.5%
2003	10.2%	10.7%	10.4%
2004	11.4%	11.7%	11.6%
2005	11.8%	9.8%	11.3%

Source: RI Medicaid Research and Evaluation Project, U.S. Census Bureau
September Estimates, Current Population Reports 2000-2005, All Ages

Figure 3

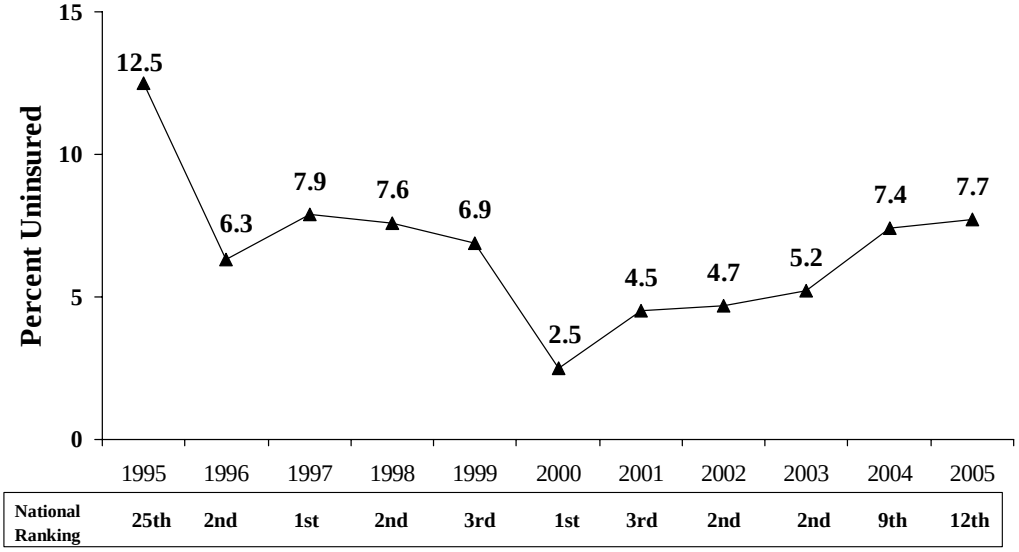
The Rise in RI Uninsured Was Seen in All Groups



Data Source: Medicaid Research and Evaluation Project
US Bureau of the Census, Current Population Surveys 1995-2005 (September estimates)

Figure 4

Percent Uninsured Rhode Island Children
< 18 Years Old - 1995-2005



Data Source: Medicaid Research and Evaluation Project, RI Access Project
US Bureau of the Census, Current Population Surveys 1995-2005 (September estimates)

Table 1
The Number of Non-Elderly Uninsured in Rhode Island Almost Doubled from 2000-2005: The Largest Increase was Seen in Children

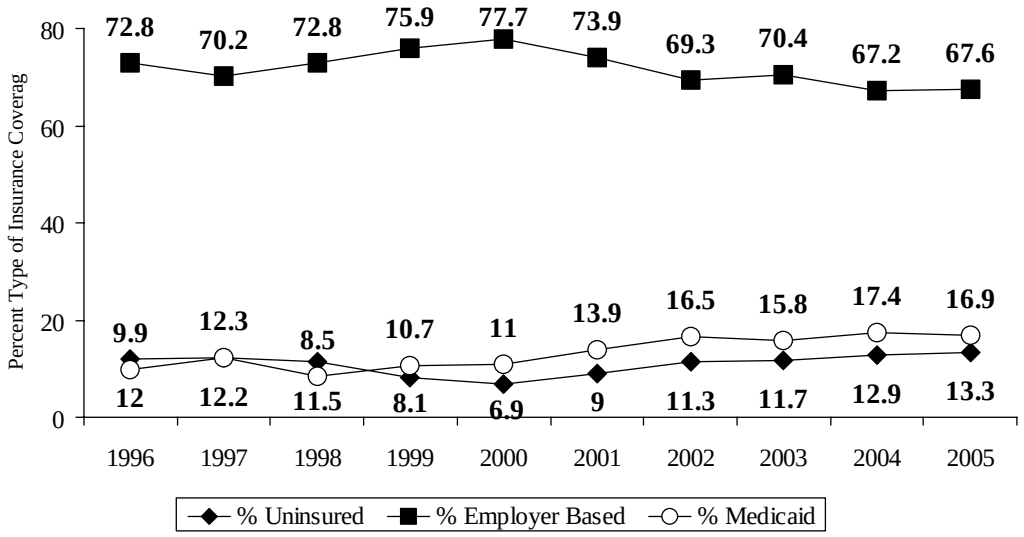
	2000	2001	2002	2003	2004	2005	% Increase 2000-2005
<18 years old							
Number Uninsured	6,196	11,152	11,648	12,887	18,339	19,082	208.0%
Percent Uninsured	2.5%	4.5%	4.7%	5.2%	7.4%	7.7%	
18-64 years old							
Number Uninsured	55,804	69,481	89,591	91,935	97,234	100,075	79.3%
Percent Uninsured	8.6%	10.7%	13.8%	14.2%	15.0%	15.4%	
Total <65							
Number Uninsured	62,000	80,633	101,239	104,822	115,573	119,157	92.2%
Percent Uninsured	6.9%	9%	11.3%	11.7%	12.9%	13.3%	

Data Source: RI Medicaid Research & Evaluation Project
Census 2000, CPS September annual estimates 2000-2005

* RI Census 2000 population numbers by age used for estimates:
<18 (n=247,822)
18-64 (n=648,105)`
Total <65 (n=895,917)

Figure 5

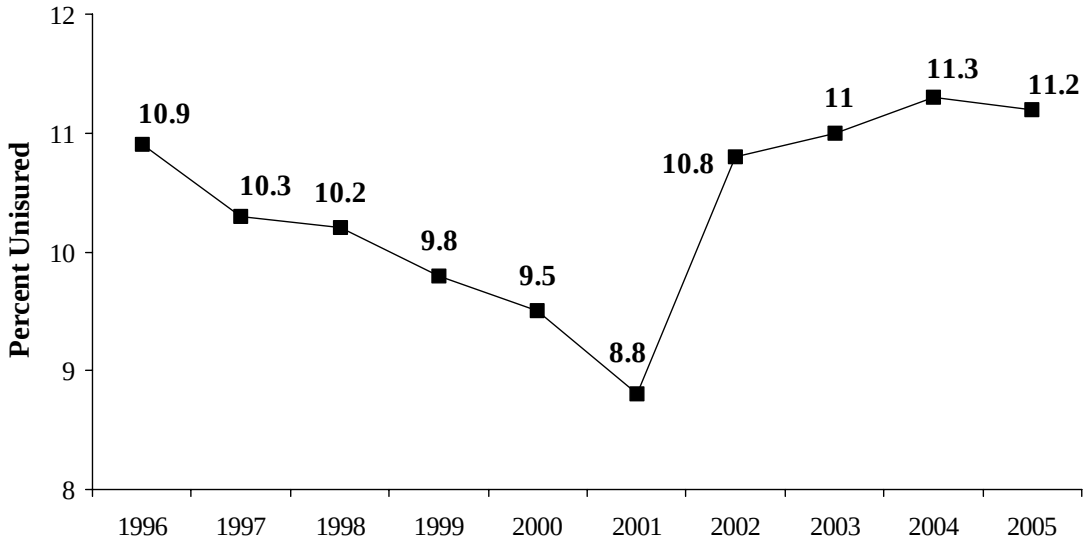
In 2005 there was a Slight Increase in Employer Based Health Coverage and the Uninsured and a Slight Decrease in Medicaid



Data Source: Medicaid Research and Evaluation Project
US Bureau of the Census, Current Population Surveys 1996-2005 (September estimate)
Age Group = <65 years old

Figure 6

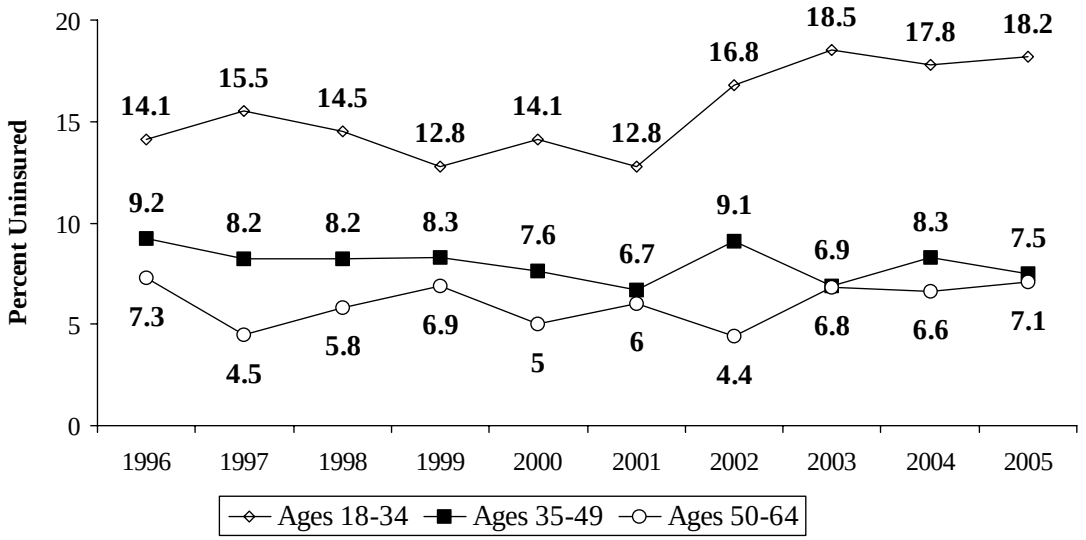
According to the 2005 BRFSS the Proportion of Uninsured Working-Aged Rhode Islanders (18-64) Stayed About the Same



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2005, RI Department of Health
Age Group = 18-64 years old

Figure 7

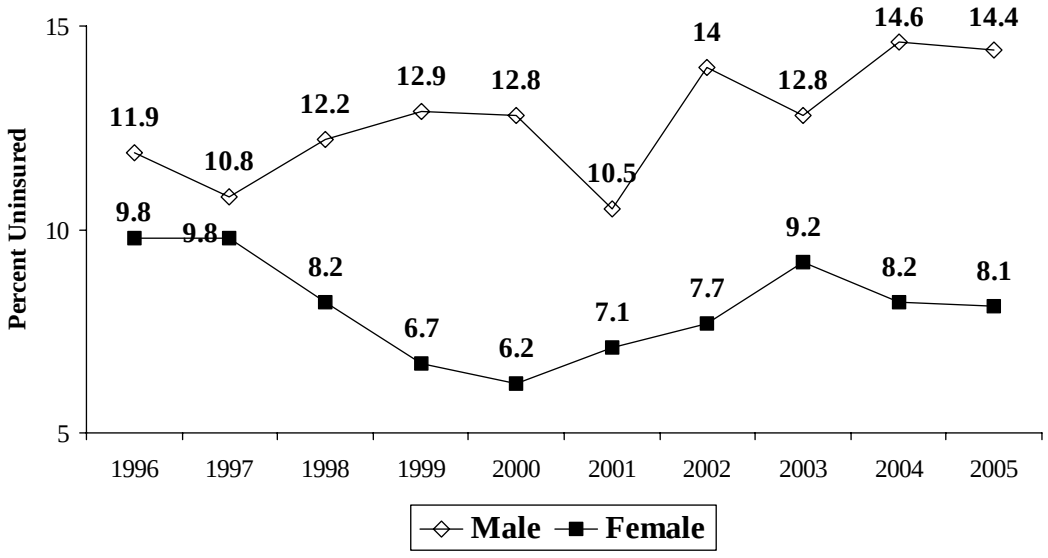
The Proportion of Uninsured has Consistently been Higher for the Youngest Age Group 18-34



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2005, RI Department of Health

Figure 8

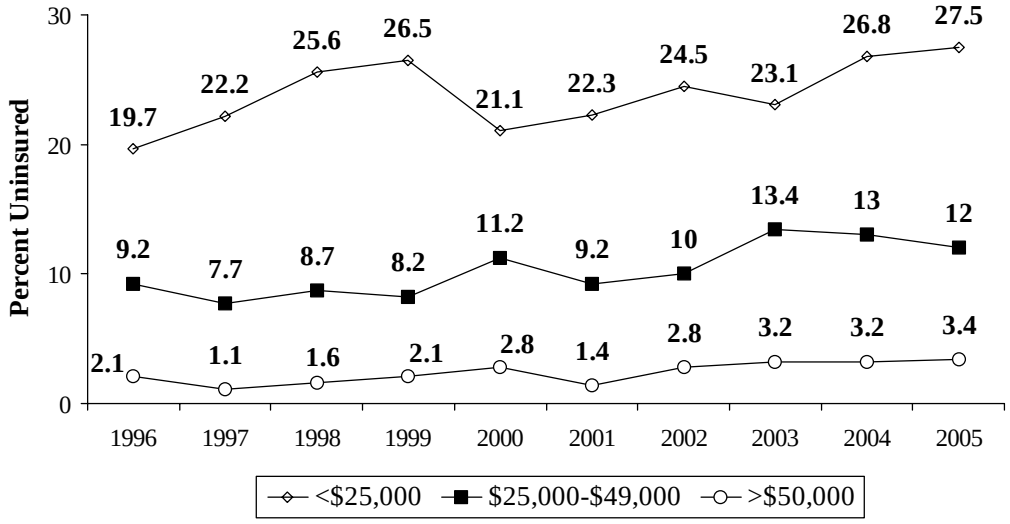
Rhode Island Males Are Almost Twice as Likely to be Uninsured



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2005, RI Department of Health
Age Group = 18-64 years old

Figure 9

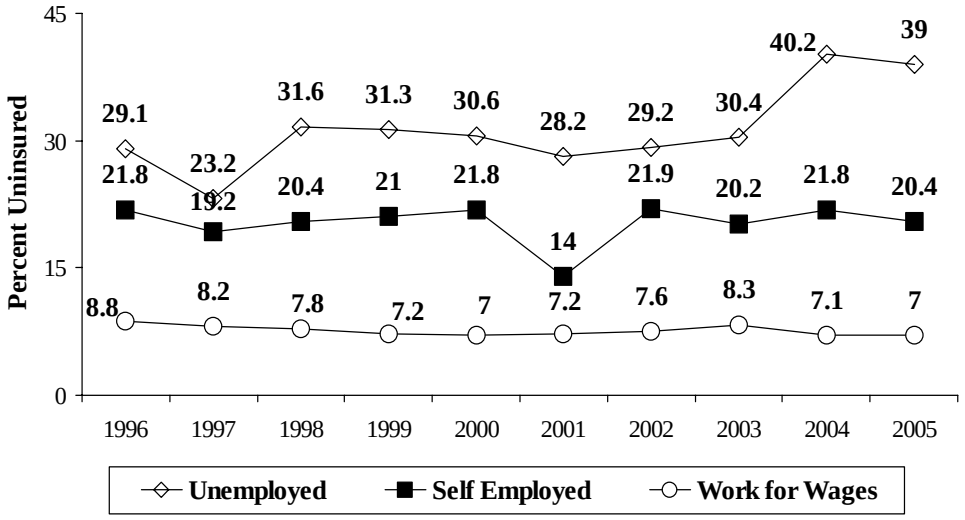
Lower Income Rhode Islanders are Twice as Likely to be Uninsured Compared to Middle Income Rhode Islanders



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2005, RI Department of Health
Age group = 18-64 years old

Figure 10

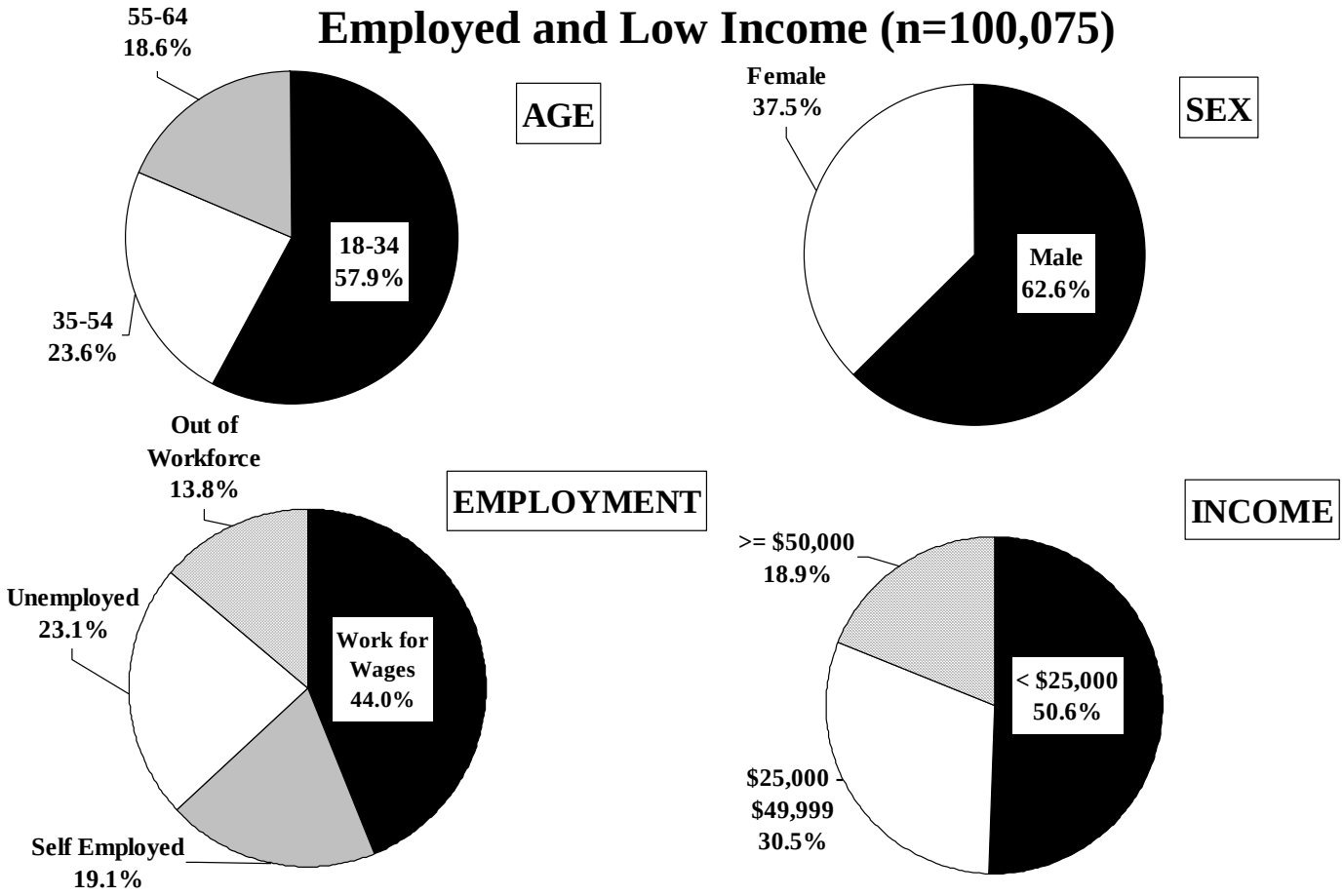
Unemployed Rhode Islanders Have Consistently had Highest Rate of Uninsured



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2005, RI Department of Health
Age group = 18-64 years old

Figure 11

RI Uninsured in 2005 are Primarily Young, Male, Employed and Low Income (n=100,075)



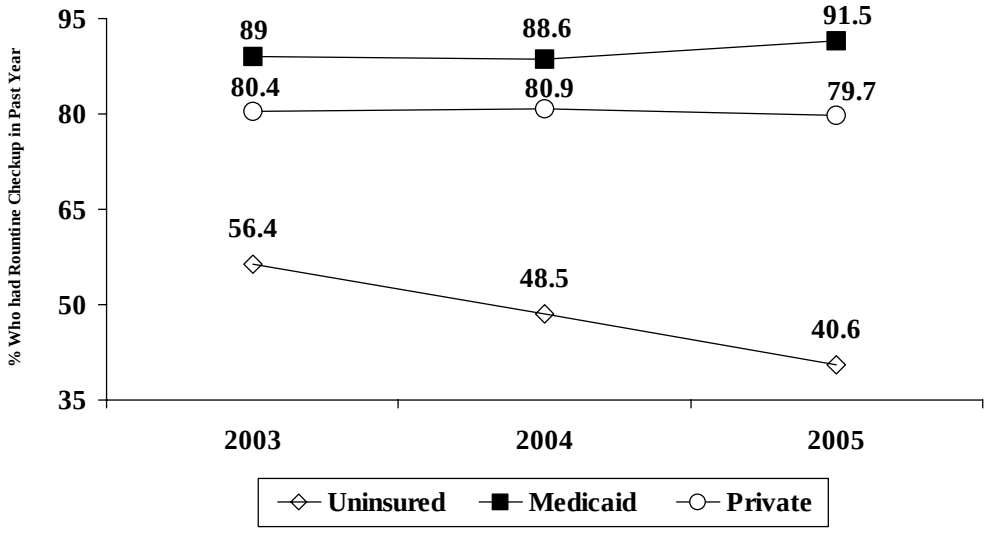
Data Source: Medicaid Research and Evaluation Project; Behavioral Risk Factor Surveillance System 2005, RI DOH

[1] Note: Estimate of Number of Uninsured is from Census, CPS (September 2005 estimates) and proportions are from 2005 BRFSS Age Group = 18-64 years old, (n=100,075)

Figure 12

Percent Rhode Islanders Who Had Routine Check-up in Past year

The Uninsured have Less Access to Primary Health Care than Other Insurance Coverage Groups and the Gap is Widening

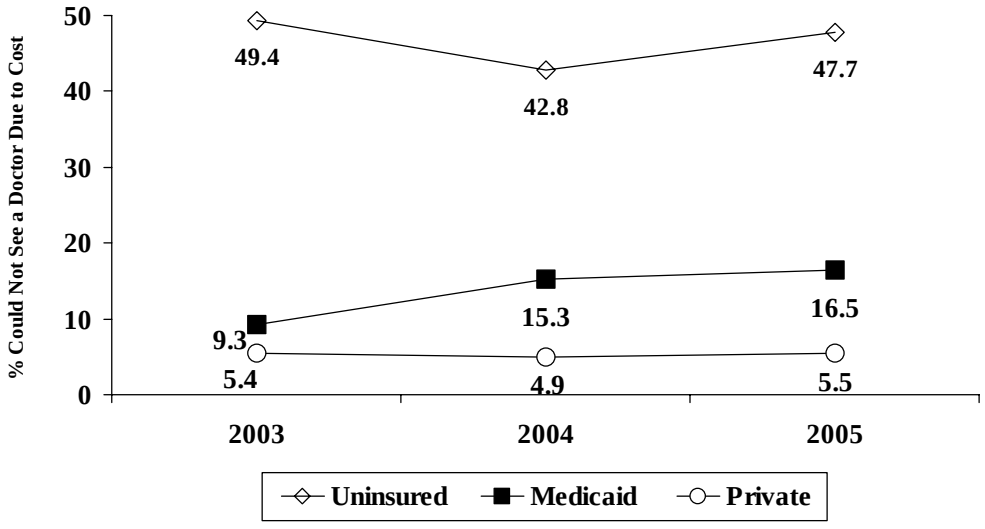


Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2005, RI Department of Health
Age group = 18-64 years old

Figure 13

Percent of Rhode Islanders who Could Not See Doctor Due to Cost

The Uninsured Face More Financial Barriers to Health Care than Other Insurance Coverage Groups



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 2005, RI Department of Health
Age group = 18-64 years old

RIte Care's Performance Goal Program

2005 and 2006 Results

October 2006

Rhode Island Department of Human Services
Center for Child and Family Health

Introduction

There is increasing interest nationally in Pay-For-Performance programs as a way for states to improve health outcomes and develop ongoing quality improvement programs. In 1998, the Rhode Island Department of Human Services (DHS) began a Performance Goal Program, the second of its kind in the country, for health plans participating in RIte Care, the state's Medicaid managed care program. The intent of the program was to reward health plans for improvements in health care delivery and outcomes for its RIte Care enrollees.

The Performance Goal Program (PGP) specifies certain access and quality standards that are monitored by the State. This is one of several ways DHS holds health plans accountable for their performance. Now in its ninth year, RIte Care's Performance Goal Program, continues to show improvement in health care access and quality in all three of its participating health plans. Through the PGP, the State has been able to leverage its considerable buying power to obtain better access and quality for RIte Care enrollees.[1]

In 2005, the National Committee on Quality Assurance (NCQA) listed all three of Rhode Island's Medicaid managed care health plans as being among the top six Medicaid managed care plans in the nation.[2] This recognition is testament to the quality improvement efforts of the health plans and their ongoing partnership with the RI Department of Human Services (DHS). Ongoing feedback to the plans and the provision of financial incentives have contributed to overall program quality and the success of RIte Care.

In 2005, NCQA listed all three of Rhode Island's Medicaid managed care health plans as being among the top six Medicaid managed care plans in the nation.

Rhode Island's RIte Care Program

RIte Care is Rhode Island's Medicaid managed health care program for uninsured families, children and pregnant women. The goals of RIte Care are to improve access to care, the quality of care, and health outcomes while containing costs. RIte Care is administered by the Center for Child and Family Health at the Rhode Island Department of Human Services. There are three health plans that participate in the RIte Care Program - Blue Cross and Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and UnitedHealthcare of New England. RIte Care provides comprehensive, coordinated care to approximately 124,000 Rhode Islanders or 12% of the State's population.

[1] See Appendix A, for a copy of the Performance Goals as specified in the health plans' contracts.
[2] U.S. News & World Report/ NCQA, *America's Best Health Plans: Medicaid, 2005.* See Appendix E.

Description of the Performance Goal Program

Since its beginning in 1998, RIte Care's Performance Goal Program has been steadily refined. In 2004, the State undertook a more fundamental redesign both to align the program more strongly to nationally recognized performance benchmarks and to clearly establish superior performance levels as the basis for incentive awards. CAHPS® and HEDIS® provide opportunities for assessing plan performance relative to Medicaid managed care health plans across the nation. Plans can receive the full award for being in the top 10 percent of all Medicaid plans on a given measure and a partial award for being in the top quarter. [3] This report focuses on results from 2005 and 2006 (calendar year 2004 and 2005 data), the two years that the new performance categories and measures were put in effect. For information on previous years results, 1999-2004, see Appendix B.

There are six performance categories in RIte Care's Performance Goal Program. The categories are weighted differently; more emphasis is placed on the 'Medical Home/Preventive Care' category. See **Table 1**. Within each of these categories are specific performance measures. See **Table 2** for the list of performance measures by category.

Table 1. Performance Categories (2005 and 2006)

Performance Categories	Percent Allocation	Per Member Month Allocation
1. Member Services	20 %	$ 0.25
2. Medical Home/ Preventive Care	50 %	$ 0.625
3. Women's Health	10 %	$ 0.125
4. Chronic Care	10 %	$ 0.125
5. Behavioral Health	5 %	$ 0.0625
6. Resource Maximization	5 %	$ 0.0625
Total	100%	$ 1.25

Health plans can earn up to $1.25 per member month in incentive payments for achieving specific performance goals. Each goal has measures that have clearly defined numeric standards that have to be achieved in order to receive a monetary award.

Rhode Island uses state-specific and national Medicaid HEDIS® and CAHPS® measures.

[3] See page 4 and Appendix C for more information on incentive payment methodology.

Table 2. HEDIS®, CAHPS®[4] and State-Specific Measures Used 2005 and 2006

Performance Category and Measures	Type of Measure
1. Member Services	
ID cards sent within 10 days	State-specific
Member handbook sent within 10 days	State-specific
New member calls completed within 30 days	State-specific
Grievance & appeals in contractual time frame	State-specific
2. Medical Home/ Preventive Care	
Members had access to emergency services	CAHPS®
Members were satisfied with access to urgent care	CAHPS®
Adults had an ambulatory or preventive care visit	HEDIS®
Infants had well-child visits in first 15 months of life	HEDIS®
Children had well-child visits in 3rd-6th year of life	HEDIS®
Adolescents receive 2nd MMR + 3rd HepB before 13th bday	HEDIS®
Children receive immunizations by 2nd birthday	HEDIS®
Children receive periodic PCP visits	HEDIS®
Children received at least 1 Pb screen before 2nd birthday	State-specific
Members over 18 yrs received advice on smoking cessation	CAHPS®
Pregnant members received timely prenatal care	HEDIS®
Postpartum members received timely postpartum care	HEDIS®
Access to emergency services	CAHPS®
Satisfied with urgent care access	CAHPS®
Adolescent PCP visit*	HEDIS®
3. Women's Health	
Women 18-64 years old received cervical cancer screening	HEDIS®
Sexually active women 16-25 years old received chlamydia screening	HEDIS®
4. Chronic Care	
Children with asthma use appropriate meds (5-17 yrs.)	HEDIS®
Adults with diabetes had HbA1c testing	HEDIS®
Antidepressant Rx management*	HEDIS®
5. Behavioral Health	
Members 6 years old and older get follow up by 30 days post discharge	HEDIS®
6. Resource Maximization	
Notify DHS of TPL (third party liability) within 15 days	State-specific
Generic prescription drug substitution rate	State-specific

* Indicates that these performance measures are new in 2006.

[4] Medicaid HEDIS® and CAHPS® measures are standardized, audited measures used by Medicaid health plans across the nation. See Appendix D.

Incentive Payment Methodology

DHS pays performance incentives based on the following:

- If a health plan meets or exceeds the 90th percentile[5] target for Medicaid HEDIS® or CAHPS® measures, the health plan will get the full award for those measures;

- If a health plan meets or exceeds the 75th percentile target for Medicaid HEDIS® or CAHPS® measures, the health plan will get a partial award for those measures;

- If the 75th percentile is not met for a measure, then no incentive award is given.

Since 1998, DHS has specified performance goal standards in its contracts with health plans (Appendix A). DHS still maintains these contract standards, but uses them in conjunction with HEDIS® and CAHPS® measures as follows:

- If a health plan meets or exceeds the target specified in RIte Care's contract language, then the plan will receive the full award for those measures.

- If the target specified in RIte Care's contract is greater than the HEDIS® measure target, and if a health plan met the 90th percentile for the HEDIS® measure, but did not meet the target specified in the contract language, the health plan would still receive the full award for meeting the 90th percentile HEDIS® measure.

Over time, it is anticipated that the program will further transition so that awards are fully based on HEDIS® /CAHPS® percentiles where those measures are applicable. See Appendix D for more detail on how performance measures are assessed.

[5] A health plan that meets or exceeds the 90th percentile scored higher than 90 out of 100 Medicaid plans.

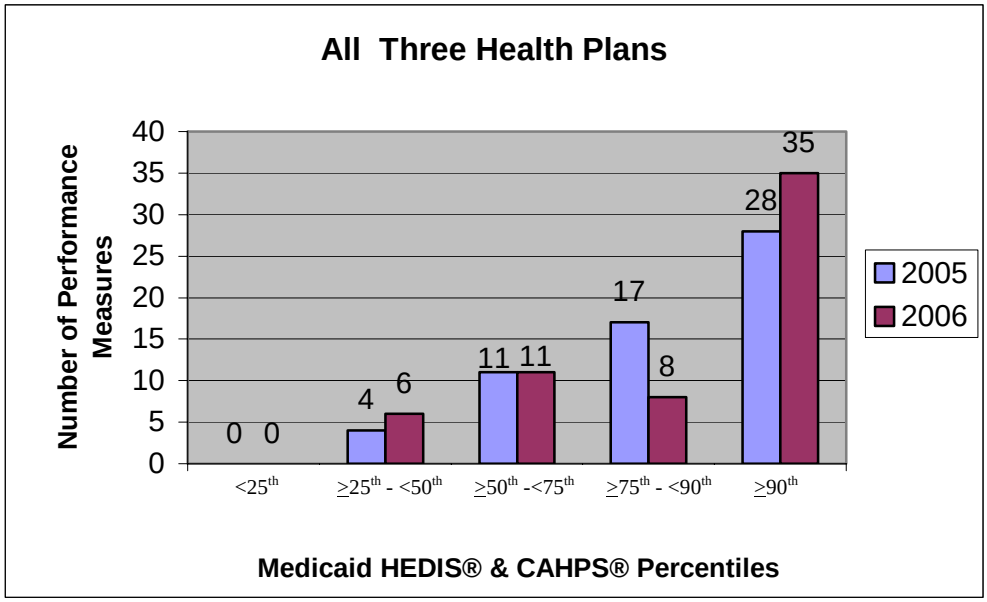
RIte Care Performance Goal Results 2005 & 2006

Figures 1 through 4 provide a summary of the results for 2005 and 2006. The results include the three health plans that participate in the RIte Care Program. Each health plan is scored on twenty (20) HEDIS® and CAHPS® measures. This yields a total of sixty (60) measures or actual scores for all three plans combined.

Figure 1 shows the distribution of the 60 scores for all three plans in relation to the national cohort of Medicaid managed care plans. It shows the number of times where the results were:

- below the 25th percentile,
- greater than or equal to the 25th percentile but less than the 50th percentile,
- greater than or equal to the 50th percentile but less than the 75th percentile,
- greater than or equal to the 75th percentile but less than the 90th percentile, or
- greater than or equal to the 90th percentile.

Figure 1. Distribution of Performance Goal Results for All Three Health Plans in Relation to National Cohort of Medicaid Managed Care Plans



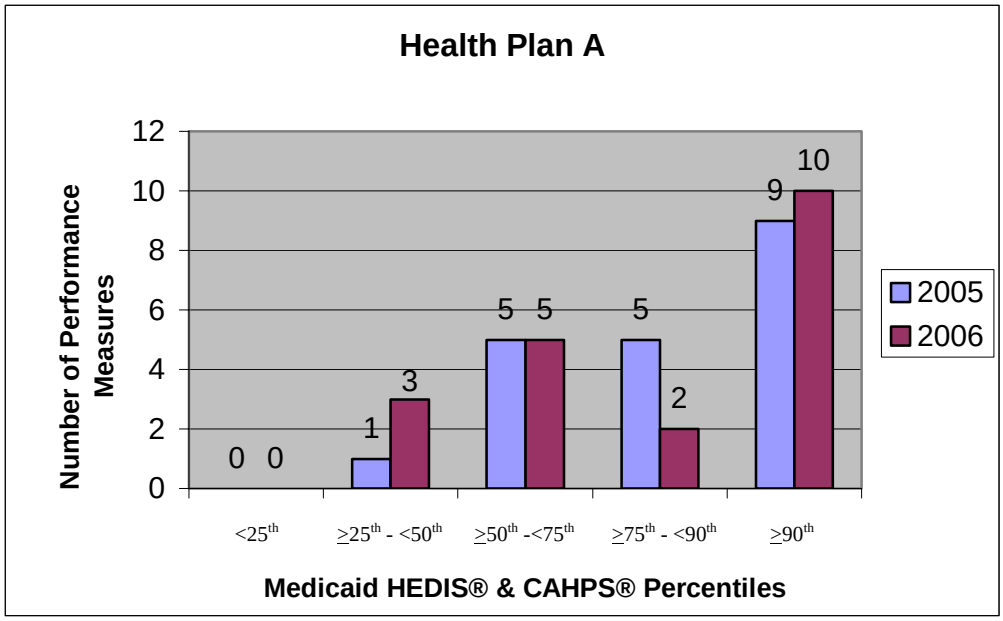
N= 60, total number of plan scores possible

As can be seen in Figures 1 through 4, Rhode Island's RIte Care health plans scored very highly in both 2005 and 2006; and in 2006, all three plans improved on their 2005 performance.

Out of a total of 60 HEDIS® and CAHPS® measures possible, 28 measures, or 47 percent, were equal to or greater than the 90th percentile in 2005. In 2006, 35 measures, or 58 percent, were equal to or greater than the 90th percentile (Figure 1).

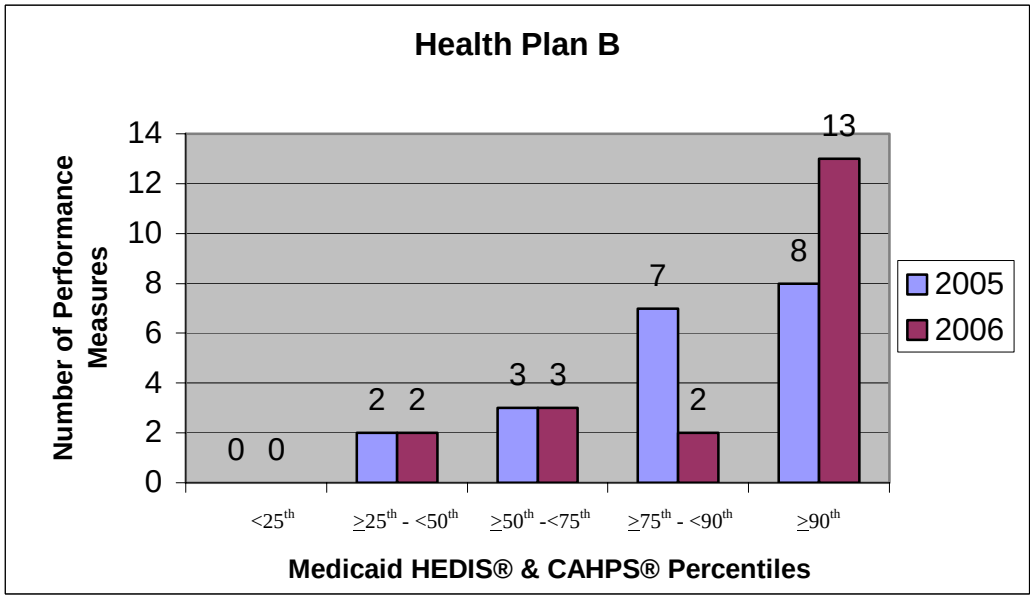
In Figures 2 through 4, the health plans' individual results are presented. Again, even individually, there was improvement in the number of measures that met or exceeded the target from 2005 to 2006.

Figure 2. Distribution of Performance Goal Results for Health Plan A in Relation to National Cohort of Medicaid Managed Care Plans



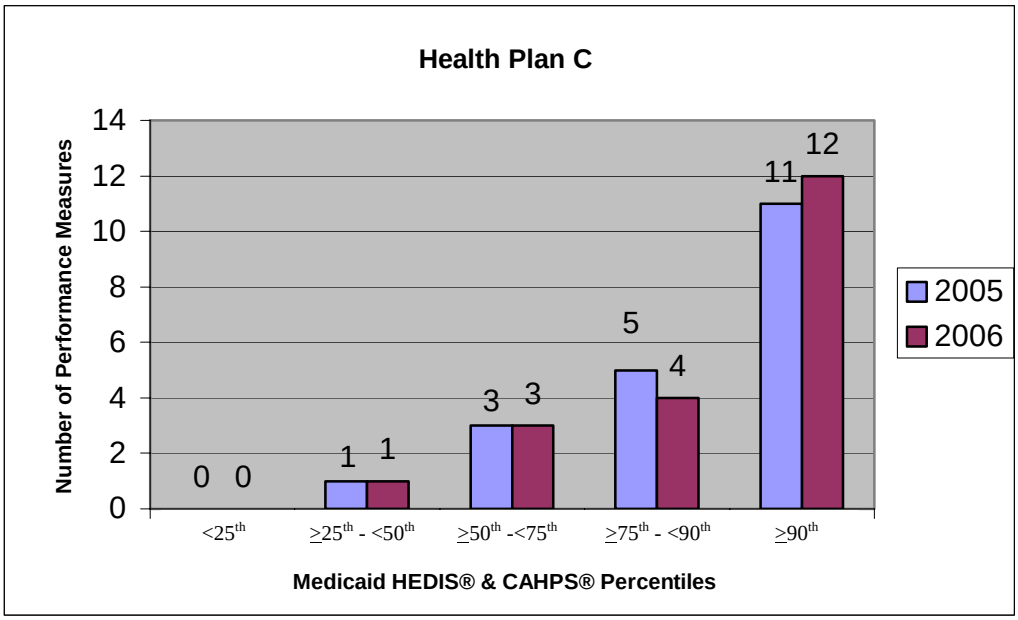
N= 20, total number of plan scores possible

Figure 3. Distribution of Performance Goal Results for Health Plan B in Relation to National Cohort of Medicaid Managed Care Plans



N= 20, total number of plan scores possible

Figure 4. Distribution of Performance Goal Results for Health Plan C in Relation to National Cohort of Medicaid Managed Care Plans



N= 20, total number of plan scores possible

DHS has shared the Performance Goal Program results with the three RIte Care health plans so that they have information on their own health plan and the results of the other two health plans. DHS can look at the year-to-year improvement in certain measures and also know if the health plan had implemented any specific strategies in these areas. The success of RIte Care's Performance Goal Program can be seen in these results and the continued partnership with the health plans to improve health care quality and access for RIte Care enrollees.

The following 20 performance measures were used to calculate Figures 1 through 4.

Table 3. HEDIS® and CAHPS® Measures

HEDIS® Measures:

1. Well Child Visit 1st 15 Months - Six or More Visits Rate
2. Adult Acc Prev/Amb Health Services - Rate Age 20-44
3. Medications Use for Asthma - Rate: Age 5 to 9
4. Medications Use for Asthma - Rate Age 10 - 17
5. Child Access Primary Care Provider - Rate 25 Mos. - 6 Yrs.
6. Child Access Primary Care Provider - Rate - Age 7-11
7. Cervical Cancer Screening - Reported Rate
8. Childhood Immunization Status - Combo 2 Rate
9. Child Access Primary Care Provider - Rate 12-24 Mos.
10. Prenatal Postpartum Care - Rate - Timeliness of Prenatal Care
11. Well Child Visit in 3, 4, 5, 6 Yrs - Reported Rate
12. Follow-up After Hospitalization for Mental Illness - Rate - 30 Days
13. Prenatal Postpartum Care - Rate - Postpartum Care

14. Adult Acc Prev/Amb Health Services - Rate Age 45-64
15. Comprehensive Diabetes Care - Rate - HbA1c Testing
16. Chlamydia Screening - Rate: Age 16 to 20
17. Chlamydia Screening - Rate: Age 21 to 25

CAHPS® Measures:

18. Emergency Care/"How long did you have to wait?"
19. Urgent Care/"How often did you get care as soon as you wanted?"
20. Medical Assistance With Smoking Cessation - Advising Smokers to Quit

Lessons Learned in Designing a Performance Goal Program

Other states that are interested in starting a Performance Goal Program should consider lessons learned from Rhode Island's experience.

- *Choose goals that are appropriate and best meet the mission of the program.*
  In the original design, the goal categories were grouped as clinical, access, and administrative goals. These areas of focus were expanded in the redesign to more clearly delineate areas of program interest.

- *Address and redesign the measures and targets as needed to best meet program goals.*
  While the core of the Rhode Island performance goal program remains unchanged, specific methods and practices have changed or even been eliminated over time.

- *Select HEDIS® measures that are clinically relevant to your Medicaid managed care program's target population.*
  The RIte Care Program focuses on children under age 19, families and pregnant women. As a result, our PGP has targeted specific HEDIS® measures that address the delivery of comprehensive clinical care for this population, such as: timely prenatal and postpartum care; primary care utilization; the timely receipt of pediatric immunizations; and the use of appropriate asthma medications, to name a few.

- *Use nationally recognized measures and standards.*
  There are several advantages to this approach. Using standard, audited measures increases confidence in the results and comparison with national benchmarks facilitates the development of achievable goals. Additionally, if health plans have NCQA accredited programs, or collect HEDIS® and CAHPS® measures, they do not incur additional cost.

- *Work collaboratively with health plans.*
  States can use a performance program to improve relations between the purchaser and plans. It is an opportunity to coach health plans through internal or external issues that may impact performance. While some states may have developed incentive programs with the intention of dropping health plans that do not meet

their standards, Rhode Island's goal was to support and improve the performance of its three participating health plans. A collaborative approach between the state and the health plans was emphasized from the beginning.

- *Choose targets that are appropriate to the health plan environment.*
  Rhode Island is fortunate to have some of the nation's best Medicaid health plans, so using the Medicaid 90th percentile as a standard is reasonable. Health plans were able to meet some, although not all, of the Medicaid HEDIS® and CAHPS® 90th percentiles in 2005 and 2006.

- *Performance programs can produce real and significant changes in health plan performance.*
  There were significant improvements in the Medical Home/ Preventive Care category of performance measures from 2005 to 2006. These were the specific areas that Rhode Island wanted to focus on.

- *Understand that a performance goal program does not guarantee immediate improved health plan performance in all areas. There may be variable improvement across goals.*
  In the first six years of the Performance Goal Program, there was improvement in administrative and access measures, but not a sustained, overall improvement in clinical measures. Rhode Island realigned its goals to focus more on preventive care and having a 'medical home.'

- *Take advantage of the important benefits beyond health plan performance that a performance goal program can foster.*
  In Rhode Island's case, collateral benefits included: greater dialogue with health plans, more effective health plan focus on internal processes, and improved data exchange between state agencies.

- *Make financial incentives real and worthwhile.*
  In Rhode Island, the financial incentive is a total of $1.25 per member per month (PMPM) potentially available to each health plan. With more emphasis and incentive dollars placed on preventive care/ medical home measures, health plans focused on those areas first.

Appendices

Appendix A: Attachment M, from the RIte Care Contract (with Health Plans) SFY 2005

Appendix B: RIte Care Performance Goal Program Results: SFY 1999-2004

Appendix C: 2006 RIte Care Performance Goal Program Summary

Appendix D: Information on HEDIS® and CAHPS® / CY 2005 national HEDIS® and CAHPS® data

Appendix E: U.S. News & World Report/ NCQA, America's Best Health Plans: Medicaid, 2005.

Appendix A

Performance Goals from the RIte Care Contract - Attachment M

AREA	GOAL	RITE CARE STANDARD	SOURCE OF MEASURE
MEMBER SERVICES	Identification cards were distributed within 10 days of being notified of enrollment.	98%	Health Plan
	Member handbooks were distributed within 10 days of being notified of enrollment.	98%	Health Plan
	New member calls were completed within 20 calendar days from notification.	65%	Health Plan
	Grievances and appeals were resolved within Federal (BBA) time frames.	97%	Health Plan
MEDICAL HOME /PREVENTIVE CARE	Members had access to emergency services.	90%	CAHPS®
	Members were satisfied with access to urgent care.	80%	CAHPS®
	Members had access to urgent care appointments during business hours.	95%	To Be Determined with Health Plan Input
	Members had PCP telephone access after business hours.	95%	To Be Determined with Health Plan Input
	Adult members had an ambulatory or preventive care visit.	90%	HEDIS®
	Child members had an ambulatory or preventive care visit.	90%	HEDIS®
	RIte Care members had well-child visits in their first 15 months of life.	85%	HEDIS®
	RIte Care members had well-child visits in their 3rd through 6th years of life.	80%	HEDIS®

Appendix A

Performance Goals from the RIte Care Contract - Attachment M

AREA	GOAL	RITE CARE STANDARD	SOURCE OF MEASURE
MEDICAL HOME /PREVENTIVE CARE (Continued)	Adolescents in RIte Care who turned 13 years old, received a second dose MMR, three hepatitis B immunizations prior to their 13th birthday.	75%	HEDIS®
	Children enrolled in RIte Care who turned 2 years old, received 4 DtaP/DT, 3 IPV, 1 MMR, 3 Hib, 3 hepatitis B and 1 VZV immunizations.	75%	HEDIS®
	Children enrolled in RIte Care had a visit with a Health Plan PCP. (HEDIS Access)		
	12-24 months	98%	HEDIS®
	25 months – 6 years	95%	HEDIS®
	7-11 years	95%	HEDIS®
	12-19 years	95%	HEDIS®
	Children received at least one age-appropriate blood lead screen prior to their second birthday.	85%	To Be Determined With Health Plan Input
	RIte Care members 18 years of age and older received advice to quit smoking (CAHPS).	70%	CAHPS®
	Pregnant RIte Care members received timely prenatal care and timely postpartum care.		
	Prenatal	85%	HEDIS®
	Postpartum	90%	HEDIS®

Appendix A

Performance Goals from the RIte Care Contract - Attachment M

AREA	GOAL	RITE CARE STANDARD	SOURCE OF MEASURE
WOMENS' HEALTH	RIte Care-enrolled women 18-64 years received cervical cancer screening .	85%	HEDIS®
	RIte Care-enrolled women 16-25 years of age identified as sexually active received chlamydia screening.	50%	HEDIS®
	First time pregnancies for RIte Care-enrolled females <20 years of age decreased.	5% Decrease Annually	To Be Determined With Health Plan Input
	Subsequent pregnancies in RIte Care enrolled females <20 years of age with one or more children in household decreased.	10% Decrease Annually	To Be Determined With Health Plan Input
CHRONIC CARE	Child RIte Care members with asthma used appropriate medications.	70%	HEDIS®
	Adult RIte Care members with diabetes had HbA1c testing.	90%	HEDIS®
	New chronic care goal		To Be Determined With Health Plan Input
BEHAVIORAL HEALTH	Members 6 years of age and older received a follow-up visit after hospitalization for mental illness up to 30 days post-discharge.	65%	HEDIS®
RESOURCE MAXIMIZATION	Generic Drugs Substitution Rate	1% Improvement Annually	Encounter Data
	Health Plans notified DHS of any potential source of third party liability within five (5) business days of such source becoming known to contractor.	90%	Health Plans

Appendix B

RIte Care's Performance Goal Program 1999-2004

At the start of the program in 1998, there were three performance categories: administrative, access and clinical. Within these three broad areas there were specific measures that represented the State's expectation for performance in each of the areas. The categories were weighed differently, with more emphasis placed on clinical goals.

Performance Goal Categories: 1999-2004

Performance Categories	Percentage Allocation	PMPM Allocation
Administrative	20 %	$ 0.25
Access	30 %	$ 0.375
Clinical	50 %	$ 0.625
Total	100 %	$ 1.25

Health plans could earn up to $1.25 per member per month (PMPM) in incentive payments for achieving specific performance goals and measures.

The chart on the next page shows the results of the RIte Care Performance Goal Program for 1999 through 2004. The results represent the percentage of payout awarded to all three health plans out of a total of what was possible to be awarded. This gives an indication of trends in performance and also shows the variability from year to year for some measures. If a space is left blank, it means that the measure was no longer collected for that year. If the measure has a 0%, it means that no award was given. The "Totals for each area," represent the percentage of payout awarded to the three health plans based on the total amount that was possible to achieve per category.

On balance, health plans demonstrated improvement from 1999 through 2004 though there are exceptions in certain measures. In some cases (e.g., assurance of access to ER and urgent care), modifications in methodology as the program was refined resulted in reduced scores. And in other cases, data transfer issues impacted lead screening scores. Scores in the performance goal program are known to understate actual performance in this area. The transition to standardized measures with national benchmarks has helped to strengthen the program overall.

State Fiscal Years 1999- 2004

'I. Area: ADMINISTRATION MANAGEMENT						
	1999	2000	2001	2002	2003	2004
Temp ID cards w/in 10 days, permanent in 45 days	79%	62%	38%	56%	70%	47%
Mbr hdbk w/in 10 days	77%	57%	38%	61%	48%	35%
PCPs assigned w/in 20 days	68%	62%	47%	69%	73%	83%
Avg speed to answer 30 secs or <	46%	52%	57%	87%	86%	35%
Grievance & appeals in statutory time frames	54%	89%	63%	89%	69%	78%
Pay clean claims in 30 days	63%	61%	45%	87%	92%	97%
Pay claims to ER for medical screening	44%	98%	100%	100%	100%	100%
Notify DHS of TPL w/in 15 days	88%	93%	98%	76%	68%	83%
Call aban. Rate < 5%	60%	75%	92%			

II. Area: ACCESS						
	1999	2000	2001	2002	2003	2004
Mbrs seeking ER, receive servcs immed.	96%	75%	80%	60%	61%	53%
Mbrs seeking urgent care, receive w/in 24 hrs	92%	88%	87%	40%	43%	62%
Mbrs seeking non-er, non-urg BehHlth rec w/in 5days	17%	22%	28%	19%	6%	31%
New adlt mbr receive 1st PCP visit w/in 90 days	52%	50%	19%	85%	89%	92%
New ped mbr recieve 1st PCP visit w/in 90 days	78%	72%	50%	93%	98%	98%

III. Area: CLINICAL CARE						
	1999	2000	2001	2002	2003	2004
1. Mbrs < 2 yrs immunized re: EPSDT	84%	71%	85%	80%	80%	91%
2. Mbrs >6,<21 EPSDT age-approp screenings	49%	72%	72%	95%	95%	93%
3. Preg women adequate+ prenatal -Kotelchuk	43%	51%	26%	64%	61%	30%
4. Avg matern LOS, 2 days vag/4daysC-sec"	90%	100%	100%	0%	0%	0%
5. Lead screening level	53%	19%	0%	29%	23%	22%
6a. Pap rates age 16-20	35%	36%	55%	60%	48%	25%
6b. Pap rates age 20-64	91%	92%	97%	100%	100%	100%
7. BH readmission rate w/90 days <20%	91%					

Totals for each area	1999	2000	2001	2002	2003	2004
total admin	61.7%	71.5%	65.9%	83.7%	79.8%	74.8%
total access	65.7%	61.8%	44.0%	73.2%	75.8%	81.5%
total clinical	63.1%	57.7%	68.2%	68.6%	65.8%	59.5%
total money given out	64.0%	62.0%	60.6%	73.2%	71.6%	69.2%

Appendix C

2006 RIte Care Performance Goal Program Summary

Measurement Period: Calendar Year 2005

I. MEMBER SERVICES

1. Identification cards are distributed within ten (10) calendar days of Plan receipt of enrollment notification from DHS.

Standard: 98 percent
Reference Period: Calendar year 2005

Denominator is the number of all new-to-Plan enrollees whose enrollment has been communicated to the Plan via the MCKR-500 or by DHS/CCFH print screen. (Newborns and EFP excluded from goal program, but not from goal standard.)

Numerator is the number of new-to-Plan enrollees who have been mailed a new member ID card within 10 days of DHS enrollment notification.

Performance Assessment:

Review of Policies and Procedures
Detailed monthly reports with method to track time from enrollment to distribution of cards, showing turnaround time (TAT)
Actual performance as demonstrated in reports

2. Member handbooks are distributed within ten (10) calendar days of Plan receipt of enrollment notification.

Standard: 98 percent
Reference Period: Calendar year 2005

Denominator is the number of all new-to-Plan enrollees whose enrollment has been communicated to the Plan via the MCKR-500 or by DHS/CCFH print screen. (Newborns and EFP excluded from goal program, but not from goal standard.)

Numerator is the number of new-to-Plan enrollees who have been mailed a new member handbook within 10 days of DHS enrollment notification.

Performance Assessment:

Review of Policies and Procedures
Detailed monthly reports with method to track time from enrollment to distribution of member handbooks, showing turnaround time (TAT)
Actual performance as demonstrated in reports

3. A new member welcome call is completed within 30 calendar days from Plan notification of enrollment via MCKR-500 or DHS/CCFH screen print.

Standard: 65 percent
Reference Period: Calendar year 2005
Must be RIte Care specific

Denominator is the number of all new-to-Plan enrollees whose enrollment has been communicated to the Plan via the MCKR-500 or by DHS/CCFH print screen.

Numerator is the number of new-to-Plan enrollees who have a documented, completed new member "welcome call" within 20 days of DHS notification of enrollment.

Performance Assessment:

Part I. Policies and Procedures

Definitions of attempted and completed
Documentation of effort to contact

Part II. Health Plan tracking and monitoring

Reports demonstrating days from enrollment to completed call
Monthly performance against standard

4. Member and provider administrative, clinical (medical, behavioral health and pharmacy) appeals are resolved within contractual timeframes.

Standard: 97 percent
Reference Period: Calendar year 2005
Based on RIte Care standards

Denominator is the number of appeals received during the calendar year. (Quality of Care complaints are excluded.)

Numerator is the number of appeals resolved within the contractual timeframes.

Performance Assessment:

Review Policies and Procedures for identifying and acting upon grievances and appeals
Ensure that processes are in place to notify members of opportunities for grievances and appeals and for DHS Fair Hearing
Review logs or other Health Plan mechanisms for tracking complaints, grievances and appeals and resolution turnaround times
If no grievances (or appeals) ability to demonstrate resolution of issue before its elevation to grievance or appeal level
If grievances and appeals are present, percent resolved timely
Review the timing of the submission of contractually required informal complaint, grievance and appeals reports
Review templates of denial correspondence

II. PREVENTIVE CARE, MEDICAL HOME AND ACCESS TO CARE

1. Members have access to emergency services (CAHPS®).

Standard: 90 percent
Reference year: Calendar year 2005
RIte Care specific

Performance Assessment:

Health Plan's written materials for members provide clear direction for obtaining care in the case of emergency:

— Member handbook
— Member ID card
Additional member education material on emergency, e.g. newsletter, other mailings
Provider contract, manual and provider education regarding policies on member access to emergency care
CAHPS survey questions on access to emergency care

2. Members were satisfied with access to urgent care (CAHPS®).

Standard: 80 percent
Reference year: Calendar year 2005
RIte Care specific

Performance Assessment:

Health Plan has established policies and procedures to inform members and providers (including behavioral health and pharmacy) about member access to urgent care and the RIte Care access standard.
Provider contract, manual and provider education regarding urgent care policy and RIte Care standard
Plans will specifically demonstrate members have sufficient telephone access to PCPs after business hours (including weekends and holidays) and that the PCP or covering PCP (TBD).
Plans will specifically demonstrate members have sufficient access to PCPs during business hours (TBD).
CAHPS® survey questions on access to urgent care

3. Members had access to urgent care appointments during business hours.

During 2006, the State and Health Plans have developed a proposed combined measure that addresses access to urgent care during business hours and access to PCPs after business hours (see Item II-4 below). This proposed measure will address ED utilization. A baseline rate of ED utilization will be calculated for calendar year 2005, based upon encounter data received by 03/31/2006. This combined measure will not be included in the award calculation for CY 2005.

4. Members had PCP telephone access after business hours.

During 2006, the State and Health Plans have developed a proposed combined measure that addresses access to urgent care during business hours (see Item II-3 above) and access to PCPs after business hours. This proposed measure will address ED utilization. A baseline rate of ED utilization will be calculated for calendar year 2005, based upon encounter data received by 03/31/2006. This combined measure will not be included in the award calculation for CY 2005.

5. Adult members had an ambulatory or preventive care visit.

Standard: 90 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the National Center for Quality Assurance (NCQA).

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

6. Child members had an ambulatory or preventive care visit.

Standard: 90 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

This measure will not be included in the award calculation for CY 2005. Please refer to Item II-11.

7. Members had well-child visits in their first 15 months of life.

Standard: 85 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

8. Members had well-child visits in their 3rd through 6th years of life.

Standard: 80 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

9. Adolescents who turned 13 years old received a second dose MMR and three Hepatitis B immunizations prior to their 13th birthday.

Standard: 75 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

10. Children who turned two years old received 4 DtaP/DT, 2 IPV, I MMR, 3 Hib, 3 Hepatitis B, and VZV immunizations.

Standard: 75 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

11. Children had a visit with a Health Plan PCP (HEDIS® Access).

Standard: 98 percent for members between 12 – 24 months of age; 95 percent for members between 25 months and six years of age, members between seven and 11 years of age, and 12 – 19 years of age.
Reference period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessments are based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominators are the HEDIS® denominators.

Numerators are the HEDIS® numerators.

12. Children received at least one age appropriate blood lead screen prior to their second birthday.

Standard: 85 Percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on analysis of the Plan's encounter data for CY 2005, received by 03/31/2006, or RI Department of Health data.

Denominator: All children who reach 24 months of age during the reference period and who have been enrolled with the Health Plan at least 31 days.

Numerator: Of the children identified in the denominator, all those with a blood lead screen between their 9^{th} and 24^{th} month.

13. Members 18 years of age and older received advice to quit smoking.

Standard: 70 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited CAHPS® data submission to the NCQA.

Denominator is the CAHPS® denominator.

Numerator is the CAHPS® numerator.

14. Pregnant members received timely prenatal care.

Standard: 85 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

15. Pregnant members received timely postpartum care.

Standard: 90 percent
Reference Year: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

16. Proposed New HEDIS® Use of Services Goal: Members between 12 – 21 years of age had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner.

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans have developed a proposed set of measures to address teen pregnancy. (Please refer to Items III-3 and III-4.) This proposed measure would address adolescents' receipt of well care. A baseline rate will be calculated for calendar year 2005.

III. WOMEN'S HEALTH

1. Female enrollees 18 – 64 years of age received cervical cancer screening.

Standard: 85 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

2. Female enrollees 16 – 25 years identified as sexually active received Chlamydia screening.

Standard: 85 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

3. First-time pregnancies for female enrollees less than 20 years of age decreased.

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans have developed a proposed set of incremental measures to address teen pregnancy. Please refer to Item II-16 for the baseline measurement of adolescent well care utilization.

4. Subsequent pregnancies for female enrollees less than 20 years of age decreased.

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans have developed a proposed set of measures to address teen pregnancy. Please refer to Item II-16 for the baseline measurement of adolescent well care utilization.

IV. CHRONIC CARE

1. Members between five and 17 years of age with asthma used appropriate medications.

Standard: 70 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Measure:

The measure should be reported for the following age stratifications:

- Members between five and nine years of age
- Members between 10 and 17 years of age
- The combined rate for members between five and 17 years of age

Denominators are the HEDIS® denominators.

Numerators are the HEDIS® numerators.

2. Adult members with diabetes had HbA1c testing.

Standard: 90 percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

3. Proposed New Chronic Care Goal (HEDIS® Effectiveness of Care Measure): Members 18 years of age and older as of the 120th day of the measurement year who were diagnosed with a new episode of depression and treated with antidepressant medication, and who remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.

This measure will not be included in the award calculation for CY 2005. During 2006, the State and Health Plans proposed that a new chronic care measure be added to the Performance Goal Program (HEDIS® Anti-depressant Medication Management: Effective Acute Phase Treatment). A baseline rate for this proposed HEDIS® measure will be calculated for calendar year 2005.

V. BEHAVIORAL HEALTH

1. Members six years of age or older who were hospitalized for treatment of mental health disorders received a follow-up visit up to 30 days post discharge.

Standard: 65 percent
Reference Period: Calendar year 2004
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's final audited HEDIS® data submission to the NCQA.

Denominator is the HEDIS® denominator.

Numerator is the HEDIS® numerator.

VI. RESOURCE MAXIMIZATION

1. Health Plan notifies the Department of Human Services of any potential source of third-party liability (TPL) within five (5) days of such source becoming known to contractor or its subcontractors.

Standard: 90 Percent
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessments:

Review of Policies and Procedures regarding TPL
Established method and reporting for internal review of TPL
Timely and regular reports provided to Center for Child and Family Health

2. Rate of prescription substitution of generic alternatives for brand-name medications, where generic equivalents exist.

Standard: 1 percent improvement annually
Reference Period: Calendar year 2005
RIte Care specific

Performance Assessment:

Assessment is based on the Plan's encounter data for CY 2005, received by 03/31/2006.

Denominator is the total number of prescription encounters, excluding over the counter (OTC) prescriptions.

Numerator is the number of prescription encounters, excluding OTC claims, with a generic indicator.

Appendix D

Rhode Island uses the following national benchmark data from **National Committee on Quality Assurance (NCQA)** and **Agency for Healthcare Research and Quality (AHRQ).** This information is published annually and provides states with a national cohort of Medicaid managed care plans to compare to.

Health Plan Employer Data and Information Set (HEDIS®)

HEDIS® measures are standardized performance measures that give States, health plans and consumers the ability to compare the performance of managed care plans. HEDIS® measures include: the effectiveness of care, access and availability of care, cost of care, and member satisfaction. HEDIS® measures were established by the National Committee on Quality Assurance (NCQA), a non-profit organization, whose primary goal is to improve the quality of health care through measurement, transparency and accountability. Close to 250 organizations, representing over 400 health plans nationwide, submit HEDIS® data annually to NCQA. NCQA ranks Medicaid and non-Medicaid health plans annually.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. CAHPS® survey results can be used to compare and report on performance and improve the quality of care. CAHPS® data is administered by the Agency for Healthcare Research and Quality at the U.S. Department of Health & Human Services.

The following chart is an example of national HEDIS® and CAHPS® data that was used in 2006. Rhode Island uses the most current national data that is available in comparing its health plan data. (See next page.)

RITE CARE PERFORMANCE GOAL PROGRAM
NATIONAL MEDICAID HEDIS® & CAHPS® MEASURES USED – CY 2005

HEDIS® Measures:

Measure Description	# of MCOs	Avg.	10th %ile	25th %ile	50th %ile	75th %ile	90th %ile
W15 Well Child Visit 1st 15 Months - Six or More Visits Rate	129	46.82	15.97	40.12	48.49	56.57	67.74
AAP Adult Acc Prev/Amb Health Services - Rate Age 20-44	92	75.75	62.24	70.56	78.55	83.61	85.4
ASM Medications Use for Asthma - Rate: Age 5 to 9	120	62.75	45.1	58.1	66.56	72.34	76.36
ASM Medications Use for Asthma - Rate Age 10 - 17	121	61.81	51.99	58.7	64.06	69.49	72.73
AWC Adolescent Well-Care - Reported Rate*	125	40.33	29.39	33.1	39.11	47.62	55.32
CAP Child Access Primary Care Provider - Rate 25 Mos. - 6 Yrs.	96	81.56	68.69	78.27	84.63	87.86	91.32
CAP Child Access Primary Care Provider - Rate - Age 7-11	95	82.38	70.75	77.16	83.75	89.55	92.81
CCS Cervical Cancer Screening - Reported Rate	137	64.52	51.05	58.88	64.51	72.26	76.62
CIS Childhood Immunization Status - Combo 2 Rate	142	62.87	47.81	56.69	66.02	71.53	75.67
CAP Child Access Primary Care Provider - Rate 12-24 Mos.	96	91.8	79.72	91.08	94.58	97.06	98.19
AIS Adolescent Immunization Status - Hepatitis B Rate	104	61.02	34.24	49.16	63.27	74.33	80.78
PPC Prenatal Postpartum Care - Rate - Timeliness of Prenatal Care	138	78.25	63.75	73.68	81.27	86.42	89.54
W34 Well Child Visit in 3, 4, 5, 6 Yrs - Reported Rate	126	61.87	44.74	55.96	64.19	70.8	77.54
FUH Follow-up After Hospitalization for Mental Illness - Rate - 30 Days	39	54.31	22.42	44.06	54.84	70.56	81.25
PPC Prenatal Postpartum Care - Rate - Postpartum Care	139	55.89	38.89	50.8	58.39	65.21	69.83
AAP Adult Acc Prev/Amb Health Services - Rate Age 45-64	92	81.06	65.98	78.11	84.24	87.28	88.7
AIS Adolescent Immunization Status - MMR Rate	104	71.63	49.65	61.19	74.67	82.6	90.21
AMM Antidepressant Medication Mngmt - Rate for Effective Acute Phase Treatment*	32	46.41	37.21	41.59	46.35	51.47	55.06
CDC Comprehensive Diabetes Care - Rate - HbA1c Testing	114	74.95	59.12	70	78.79	84.18	88.81
CHL Chlamydia Screening - Rate: Age 16 to 20	117	45.23	27.5	37.34	46.63	53.09	63.55
CHL Chlamydia Screening - Rate: Age 21 to 25	117	48.2	28.64	38.66	51.07	58.29	64.47

CAHPS® Measures:

Measure Description	# of MCOs	Avg.	10th %ile	25th %ile	50th %ile	75th %ile	90th %ile
Q17: Emergency Care/"How long did you have to wait?"	77	54.41	44.13	48.48	52.48	59.09	67.3
Q16: Urgent Care/"How often did you get care as soon as you wanted?"	77	81.68	74.24	78.07	81.58	85.51	88.73
Medical Assistance With Smoking Cessation - Advising Smokers to Quit	71	67.03	56.99	63.25	67.86	71.81	74.34

*Asterisk indicates that baseline data were collected for the first time this year.

Appendix E

U.S. News & World Report/ NCQA
America's Best Health Plans: Medicaid, 2005

The 2005 managed-care Honor Roll recognizes commercial, Medicare, and Medicaid health plans that stand out in new *U.S. News* rankings. The rankings were compiled from data collected and analyzed by the National Committee for Quality Assurance, managed care's major accrediting body. See the complete rankings for Medicaid plans.

1 Blue Cross & Blue Shield of Rhode Island (POS)*
Rhode Island
Score: 89.4

2 Kaiser Foundation Health Plan of Hawaii (HMO)
Hawaii
Score: 88.0

3 Neighborhood Health Plan of Rhode Island (HMO)
Rhode Island
Score: 87.9

4 BlueShield of Northeastern New York (HMO)
New York
Score: 87.8

5 UPMC Health Plan (HMO)
Pennsylvania
Score: 87.2

6 UnitedHealthCare of New England (HMO)
Rhode Island
Score: 87.0