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:

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I. INTRODUCTION

In November of 1993, the State of Rhode Island was granted a Section 1115 waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program 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 program 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 (State Children's Health Insurance Program, or SCHIP) of the Social Security Act. By Section SCHIP 1115 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.

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:

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

[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.

- 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 – at times, perhaps, too successful. 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, 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 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 SPA.)

- **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 employer-sponsored insurance (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 among 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) 2004, however, some information is reported for the end of Calendar Year 2004.

II. RHODE ISLAND UNINSURANCE TRENDS

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.

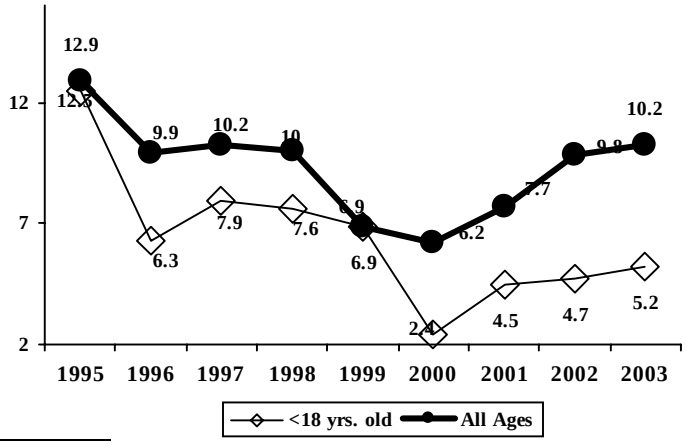
As noted in Chapter I, the State conceived and implemented RIte Care population expansions to reduce the level of uninsurance incrementally, including, where permissible, through use of SCHIP. The time period immediately before enactment of the Balanced Budget Act of 1997 (which included SCHIP) is the 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 without health insurance coverage as of July 1, 1996.

According to the most recent *Current Population Survey* (CPS)[5], the level of uninsurance in Rhode Island in 2003 (the most recent year for which data are available) was 10.2 percent overall and 5.2 percent for children as Figure 1 shows. Rhode Island had[6] the second lowest rate of uninsurance 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.

Figure 1

Percent of Uninsured Rhode Islanders by Age Group: 1995 - 2003



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

[5] U.S. Census Bureau. *Current Population Survey, September 2004.*

[6] *Ibid.*

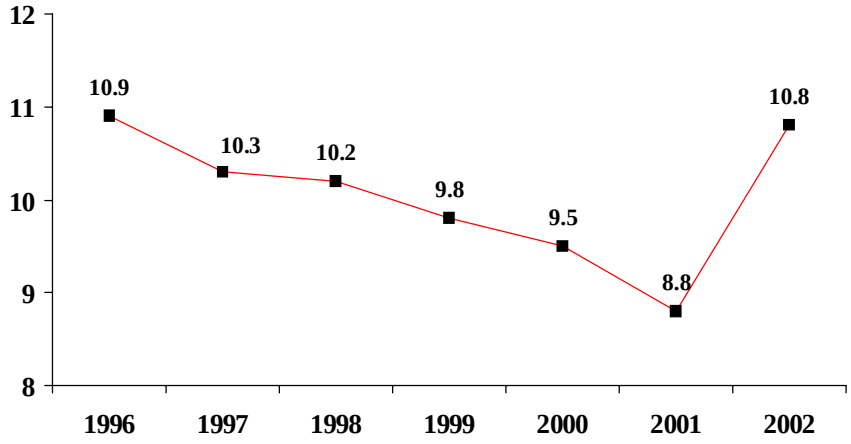
[7] Griffin, J. *Ibid*.

The 2001 – 2003 three-year average[8] showed that Rhode Island had, at 9.3 percent, the second lowest rate of uninsurance in the nation behind Minnesota, at 8.2 percent, which was 38 percent less than the national average of 15.1 percent. The 2002 – 2003 two-year average showed that Rhode Island was tied[9] with Hawaii, New Hampshire, and Vermont, at 10.1 percent, behind Minnesota, at 8.3 percent, which was 34 percent less than the national average of 15.4 percent. Rhode Island was no longer the national leader in the uninsurance rate for children under age 19 at or below 200 percent of the FPL[10], the standard used nationally for SCHIP. The data showed the uninsurance rate for low-income children in Rhode Island in 2003 was 3.5 percent – 7th lowest in the nation, behind New Hampshire, Vermont, Maine, Michigan, Hawaii, and Minnesota. Rhode Island's uninsurance rate for low-income children in 2003 was 53 percent less than the national rate of 7.4 percent.

Because of some of the concerns about CPS data and the fact that Rhode Island covers 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"[11], with a sample size of more than twice that of the CPS. Figure 2 shows uninsurance data for Rhode Island for adults based on BRFSS, and shows that the level of unisurance among adults was somewhat higher in 2002 than that reported using CPS data. The increased level of

Figure 2

Percent Uninsured Rhode Islanders Ages 18-64: 1996-2002



[8] U.S. Census Bureau, *Op. Cit.*, Table 9.

[9] *Ibid.*

[10] *Ibid.*, Table HI10.

[11] 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.

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[12]. 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

- 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, the 46 percent of the unemployed were uninsured

- The percent of uninsured children, based on those less than 65 years of age 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 20001

- 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 is being conducted again by the Rhode Island Department of Health this fiscal year.

[12] 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.

III. RITE CARE FOR CHILDREN AND FAMILIES

RIte Care has been operational since August 1994. The initial period for the Section 1115 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. DHS is in the process of preparing a request to the Federal Government to extend the waiver 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 enables Rhode Island to receive a then 69.22 percent Federal Medical Assistance Percentage (FMAP) in Federal Fiscal Year 2004 for those parents, relative caretakers and pregnant women up to the State's SCHIP allotment (compared to a then FMAP for Medicaid of 58.35 to 58.98 percent[13]).

3. 1 RIte Care Enrollment Has Stabilized

Enrollment[14] in RIte Care by Health Plan as of the end of June 30, 2004 is shown in Table 1 below.

Table 1

Enrollment in RIte Care for Children and Families by Health Plan, as of June 30, 2004

Health Plan	Number Enrolled	Percent
BlueCHiP	12,780	10.7%
NHPRI	67,352	56.5%
UHCNE	39,147	32.8%
Total	**119,279**	**100.0%**

CHP = Coordinated Health Partners, or BlueCHiP
NHPRI = Neighborhood Health Plan of Rhode Island
UHCNE = United HealthCare of New England

As the next section shows, enrollment in RIte Care has stabilized while enrollment in RIte Share has grown.

[13] Revised FMAP due to Title V of Jobs and Growth Tax relief Reconciliation Act of 2003.
[14] 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.

In SFY 2004, 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. Ninety-seven (97) percent of the RIte Care members had household incomes below 185 percent of the FPL, or below $28,990 for a family of three. Almost twenty-two (21.6) 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 18.2 percent of RIte Care members. The majority of RIte care enrollees lived in Rhode Island's core cities – Providence (36.6 percent), Pawtucket (10.7 percent), Woonsocket (6.6 percent), Cranston (5.4 percent), and Central Falls (5.3 percent).

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 SCHIP FMAP.

3.2 RIte Care Has Changed Patterns of Care

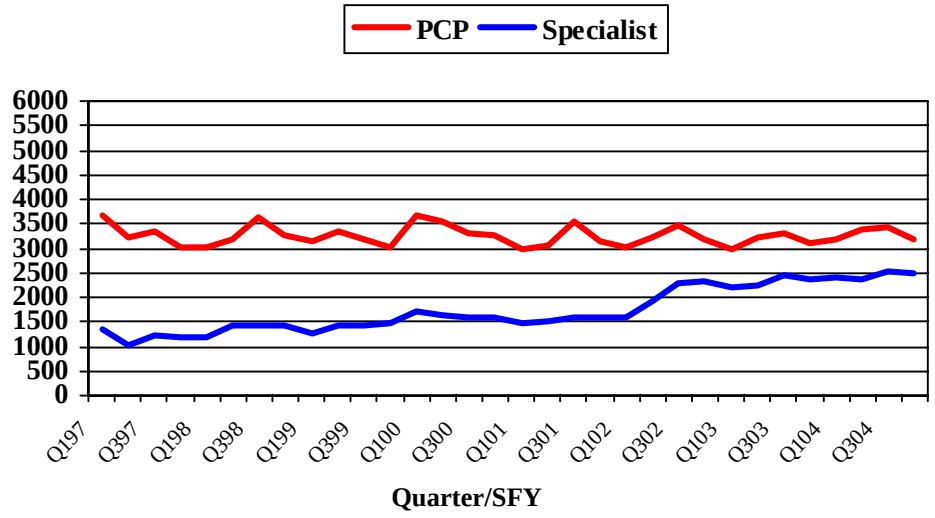
Not only has RIte Care demonstrably increased the number of low- and moderate-income Rhode Islanders who are insured, but the program has facilitated the ability of enrollees to obtain services and has changed patterns of care. The following illustrates these accomplishments:

- 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 six per year from SFY 1997 through SFY 2004, as Figure s 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 Members by Quarter (SFY 1997 - 2004)

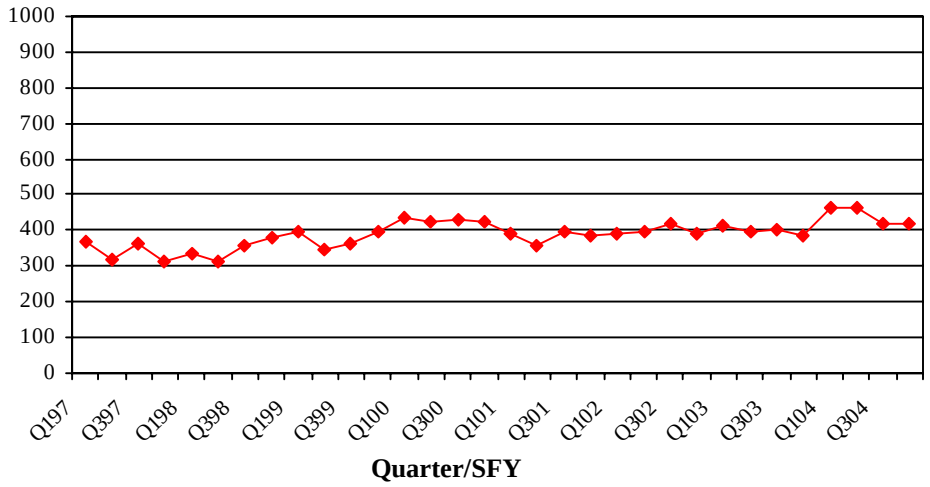


Note: Quarterly rates have been annualized by multiplying by 4

- Decreased hospital emergency department (ED) utilization by more than 40 percent from 1993 to 2004. 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 and have leveled off at around 400 visits per 1,000 enrollees since then as Figure 4 shows. Nonetheless, enrollees who have used the ED report they are satisfied with its accessibility as Section 3.3 shows.

Figure 4

RIte Care Visits to the Emergency Department per 1,000 Members by Quarter (SFY 1997 - 2004)



Note: Quarterly rates have been annualized by multiplying by 4

- 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 82 percent in 2002 (RIte Care).[15] Although a gap between the Medicaid population and the privately insured population persists, the gap was cut in half from 1993 to 2002.

- Adequacy of prenatal care, as measured by the Kotelchuck Adequacy of Prenatal Care Index, improved significantly for pregnant Medicaid women, from 55 percent in 1993 to 72 percent in 2002 (RIte Care).[16] 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 2002.

[15] Griffin, J. *The Impact of RIte Care on the Adequacy of Prenatal Care and the Health of Newborns: Ten Year Profiles and Trends of Births by Insurance Status, 1993 -2002*, RI Medicaid research and Evaluation Project, May 2004.
[16] *Ibid.*

3.3 RIte Care Has Excellent Member Satisfaction

The results of the 2003 RIte Care Member Satisfaction Survey, which had a sample designed to be effective at a 25 percent response rate (plus or minus 5 percent) in measuring member satisfaction at the RIte Care program level at a 95 percent confidence, are shown below:

- Some 98 percent of respondents reported that, overall, they were very satisfied or satisfied with RIte Care. Comparative satisfaction rates from prior surveys are shown in Table 2.

Table 2

Overall Member Satisfaction

2003	2001	2000	1999	1998	1997	1996
97.8%	98.3%	96.6%	98.3%	96.6%	96.5%	95.7%

- Ninety-seven percent of respondents said they were very satisfied or satisfied with the services of their regular doctor. This is comparable to prior surveys, as shown in Table 3.

Table 3

Respondent Satisfaction with Their Regular Doctor

2003	2001	2000	1999	1998	1997	1996
96.7%	97.0%	96.4%	96.1%	96.2%	94.8%	96.4%

- Almost 82 percent of respondents said they (or their child) saw their doctor the same day when they called for an appointment when sick; 96.5 percent said they were seen either the same day or the next day.

- Almost 92 percent of respondents said they were either very satisfied or satisfied with reaching their regular doctor evenings, nights, weekends, and holidays. This percentage is the highest ever reported, as shown in Table 4.

Table 4

Respondent Satisfaction with Reaching Their Regular Doctor Evenings, Nights, Weekends, and Holidays

2003	2001	2000	1999
91.5%	88.8%	87.2%	90.1%

- Nearly 95 percent of respondents said they were very satisfied or satisfied with getting a referral to a specialist. These results are comparable to prior years, as shown in Table 5.

Table 5

Respondent Satisfaction with Getting Specialist Referrals

2003	2001	2000	1999	1998	1997	1996
94.6%	94.4%	93.8%	94.9%	93.2%	92.0%	92.7%

- Eighty-six percent of respondents were very satisfied or satisfied with their (or their child's) emergency room treatment, if they used an emergency room (ER). This was the highest level ever reported, as shown in Table 6.

Table 6

Respondent Satisfaction with Emergency Room Treatment

2001	2000	1999
82%	79%	84%

3.4 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 2002 (RIte Care).[17] The gap between women on Medicaid and privately insured women on this measure virtually disappeared by 1999.

- An analysis[18] of infant 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

[17] *Ibid.*

[18] 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.

- 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 postneonatal 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.[19]

- In a study[20] 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)[21] as Table 7 shows.

Table 7

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[22], 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.

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

[20] 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.

[21] 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.

Minority children, children in homes with other than English spoken in the home, and children living in the "core city" 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.[23]

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[24] (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.

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[22] 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.

[23] 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.

[24] *Ibid.*

3.5 Third-Party Liability

Under Rhode Island State law and Federal Regulations (42 CFR Section 432, 433, and 477.20), the Rhode Island Medical Assistance Program is the payer of last resort for medical care. The Rhode Island Medical Assistance Program requires that a provider fully utilize a recipient's third party resources before billing the Medical Assistance Program.

The term "third party" means any insurer, individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical costs of an injury, disease, disability, or other medical service for a recipient of the Medical Assistance Program.

Making certain that the Medicaid Program (as well as RIte Care) is the payer of last resort is of primary importance in dealing with the State's budgetary issues. The Rhode Island General Assembly enacted legislation (Section 40-6-9.1) 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.

This law has provided an enormous supplement to the Department's TPL activities, by identifying other sources of payment. The initial data match was delivered on August 1, 2003, for private health insurance policies. The total Medicaid records matched with other coverage were 29,157. Of these, 19,239, or 66 percent, represented new addition, 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. Subsequent quarterly matches will continue to assure compliance with appropriate health care payments, thus, containing public expenditures.

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 2004, 969 employers were approved for participation in RIte Share.

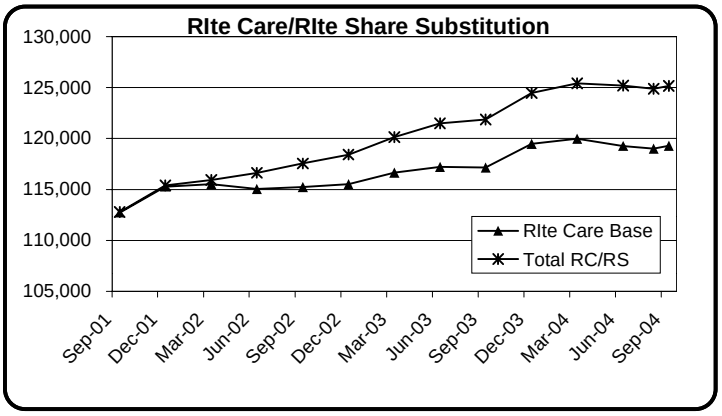
Since the program started, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial 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. **Recent 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 rate increases through raising deductibles. For example, while a $200 deductible may reduce the premium rate by, 3 to 4 percent, a $750 deductible may reduce the premium rate by as much as 9 to 10 percent.

Figure 5 shows the incremental gains in enrollment in RIte Share through June 30, 2004. There were 5,899 individuals enrolled in RIte Share as of June 30, 2004, compared to 4,268 individuals enrolled in RIte Share as of June 30, 2003. The figure also shows that RIte Share is having its intended effect of stabilizing RIte Care enrollment, while increasing RIte Share enrollment.

Figure 5

RIte Care/RIte Share Enrollment Update as of September 30, 2004 *



	RIte Care Base	RIte Share Current	Total RC/RS
Qtr ending S-01	112,733	40	112,773
Qtr ending D-01	115,286	111	115,397
Qtr ending M-02	115,508	409	115,917
Qtr ending J-02	115,041	1,596	116,637
Qtr ending S-02	115,237	2,304	117,541
Qtr ending D-02	115,526	2,905	118,431
Qtr ending M-03	116,640	3,511	120,151
Qtr ending J-03	117,218	4,268	121,486
Qtr ending S-03	117,154	4,701	121,855
Qtr ending D-03	119,479	5,006	124,485
Qtr ending M-04	119,986	5,432	125,418
Qtr ending J-04	119,279	5,899	125,178
August-04	119,008	5,880	124,888
September-04	119,294	5,873	125,167
Net Change This Month	**286**	**(7)**	**279**

* Includes RIte Care base population and foster children;
does not include children with special health care needs.

RIte Share makes ESI coverage affordable for many families while saving the State money because RIte Share pays all or part of the employee's share of coverage and the employer pays their share. The State will continue its efforts 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.

As of June 30, 2004, 5,899 individuals were enrolled in insurance through the RIte Share premium assistance program, rather than in full cost RIte Care, at a savings of $3.7M in FY04 ($1.4M general revenue).

4.1 Difficulties 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 by employers to employees, making it more difficult for the state 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 "wrap 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., $23,505 for a family of three). 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 expected to do so during 2003[25].

Monthly premiums are collected in two ways:

- For RIte Care, DHS sends a bill and the family pays DHS directly by mailing a check
- 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 10 shows the number of families and individuals, by income level, active in cost-sharing as of December 2004. There were 5,205 families (13,142 individuals) active in cost-sharing in December 2004, the majority of whom (64 percent) were below 185 percent of the FPL. In comparison, there were 4,420 families (11,676 individuals) active in cost-sharing at the end of June 2003. There were 16,880 families *ever* active in cost-sharing through December 2004.

Table 8

Families and Individuals Active in Cost-Sharing as of December 2004

Income Level	Families	Adults	Children	Total Individuals
150-185% of FPL	3,307	4,302	5,568	9,870
185-200% of FPL	620	33	1,051	1,084
200-250% of FPL	1,278	83	2,105	2,188
Total	**5,205**	**4,418**	**8,724**	**13,142**

[25] 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. Pregnant women and infants under age one are not disenrolled for non-payment of cost-sharing and continue to incur a cost-sharing liability if their income is above 185 percent of the FPL. Table 11 shows the sanctions applied in SFYs 2003 and 2004. As the table shows, 3,675 individuals were disenrolled for non-payment of cost-sharing in SFY 2004, which is down from 4,707 in SFY 2003.

Table 9

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

State Fiscal Year	Families	Adults	Children	Total Individuals
2004	1,653	1,441	3,266	3,675
2003	1,969	1,047	2,628	4,707

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.[26] As of June 30, 2004, there were 2,102 children in foster care enrolled in RIte Care (or 92.8 percent of the children eligible).

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 enrolled) 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[27], 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 apply lessons learned in the design and implementation of a service delivery system 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

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

[27] 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.

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.

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.[28] 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 covered under another waiver, did have other insurance coverage, or were not too old). As of June 30, 2004, 3,540 children with special health care needs had enrolled in NHPRI. 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).

[28] BlueCHiP and United Healthcare of New England 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.

APPENDIX A

State Medicaid Managed Care Evaluations and Reports: Themes, Variations, and Lessons

www.chcs.org/usr_doc/StateMonitoringEvaluation.pdf

ATTACHMENT B

RIte Care marks decade of 'tremendous success'

www.rikidscount.org/matriarch/d.asp?From=Search&PageID=316&PageName2=NewspaperArticlesinPDF&p=&PageName=RIte+Care+marks+decade+of+tremendous+success120604%281%29%2Epdf

APPENDIX C

State of the States 2003 – Bridging the Health Coverage Gap

www.statecoverage.net/pdf/stateofstates2003.pdf

APPENDIX D

The "RIte Care" for Rhode Island

www.rikidscount.org/matriarch/d.asp?PageID=127&PageName2=PubRepCoveringKidsNews&p=&PageName=November+04.pdf

APPENDIX E

Governing Magazine Public Officials of the Year 2004

Governing Magazine, November 2004

www.governing.com/articles/recent.htmT