

**Rhode Island Health Center Association**  
**Response to Request for Information # 7323387**

**Section 4.3.2 Understanding**

The Rhode Island Health Center Association (RIHCA) understands the procurement that DHS is preparing to issue for its managed care programs with a new contract period commencing on July 1, 2010. RIHCA does not intend to respond to the forthcoming RFP, nor to be considered a bidder. However, RIHCA is taking this opportunity to respond with comments regarding the present RFI with the understanding that the state is welcoming input from the community as it develops the RFP for the Medicaid program. RIHCA appreciates this opportunity and thanks the state for accepting these comments.

**Section 4.3.3 Organization and Experience**

RIHCA is a 501(c)(3) organization located in Providence, Rhode Island that supports, sustains, and strengthens Rhode Island's community health centers in their mission to provide high-quality comprehensive health care to underserved communities throughout the state. RIHCA is not an MCO, and does not intend to respond to the forthcoming RFP, nor to be considered a bidder. However, RIHCA is taking this opportunity to respond with comments regarding the present RFI with the understanding that the state is welcoming input from the community as it develops the RFP for the Medicaid program.

In a state with no county health departments, public hospitals or clinics, the community health centers serve as Rhode Island's public health infrastructure. Rhode Island's ten

community health centers provide preventive and primary care, dental and behavioral health services to over 112,000 Rhode Islanders at 27 locations across the state.

The health centers provide care to patients whether they have public insurance, private insurance, or are uninsured. Twenty-two percent (22%) of health center patients have private insurance, 28% are uninsured, 7% have Medicare coverage, and 43% are covered by Medicaid, including RItE Care, Fee For Service, Rhody Health Partners and Connect Care/Connect Care Choice. Rhode Island's community health centers provide care aimed at improving the health of low-income Rhode Islanders. Toward this goal, the health centers provide health care in a medical home setting, are adopting electronic health records, and participate in innovative projects. One of these projects, the Rhode Island Chronic Care Collaborative (RICCC) is a collaborative effort to examine different ways to manage and improve outcomes for patients with chronic illnesses. A community health center is also one of the five medical practices participating in the initial round of the Chronic Care Sustainability Initiative of Rhode Island (CSI-RI).

The health centers have a long history of working with the state's Medicaid insurers to improve the outcomes for our Medicaid patients. Because such a large portion of our 112,000 patients are publicly insured, we are keenly interested in the managed care service delivery system. For this reason, we are taking this opportunity to offer comments on the RFI for Medicaid Managed Care. Rhode Island's community health centers look forward to continuing our work with the state and with the Medicaid insurers on behalf of the low-income and vulnerable populations we serve.

#### **Section 4.3.4: Suggestions Regarding General MCO Requirements**

The RFI states that MCOs must be able to serve all Medicaid populations and provide all services. RIHCA would like to suggest that there is one population that would best be served within one, and not multiple, MCOs: children in substitute care. Currently this relatively small population is served by a single MCO. This is a special population requiring a level of expertise in order to serve most effectively. RIHCA recommends that the state not divide children in substitute care among several MCOs. This is a special population, and can be administered more effectively both by the state and the MCO if they are all covered by the same insurer.

#### **Section 4.3.5: Suggestions Regarding Operational Requirements**

RIHCA has a few suggestions regarding the operational requirements to be adopted by the state in the RFP. Specifically, we would encourage the state to (1) include the medical home model of care in the RFP; (2) support the adoption and use of Health Information Technology (HIT); (3) examine ways to increase enrollment and retention while decreasing member churn; and (4) evaluate whether there is any opportunity for savings by reviewing the delivery of case management services.

#### ***Medical Homes***

RIHCA commends the state on inclusion of the medical home model in this RFI, and hopes that the RFP includes the requirement that managed care organizations (MCOs) provide incentives to encourage and assist practices in developing their medical homes. The medical home model, particularly related to patients with chronic conditions, will lead to better clinical outcomes that will ultimately save money.

The National Committee for Quality Assurance (NCQA) defines a patient centered medical home:

The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.<sup>1</sup>

Health centers, in fulfilling their mission to provide primary and preventive care to patient populations who otherwise confront financial, geographic, language and cultural barriers accessing health care services, naturally contain many elements of a medical home.

The state should look at all opportunities to maximize funding offered by CMS and others designed to encourage states to adopt medical homes. This funding can help support medical practices; incentives are important in order to help practices by supplying the resources needed for providers to incorporate elements of the medical home, including HIT and case management and to meet accreditation requirements. The health centers fully support the integration of the medical home model into the state Medicaid program, and recommend that the state include this requirement in the RFP.

### ***Health Information Technology (HIT)***

A good electronic health record system is a key component of a well-run medical home, and the health centers are innovators and early adopters in this arena. Seven of our health centers have adopted an electronic health record (EHR); an eighth will transition in March and the remaining health centers are on track to adopt EHRs over the next 12 – 18 months. As a further illustration of health centers' commitment to HIT, eCHC is a health center controlled network (HCCN), to which some Rhode Island community health centers belong. EHRs improve efficiency and clinical outcomes, aid in quality improvement, and streamline resource

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<sup>1</sup> See <http://www.ncqa.org/tabid/631/Default.aspx> (visited 1/29/2010).

management. Their greatest role is as a tool to increase the quality of care and positive outcomes.

In order to maximize the medical home, practices need to use an EHR. RIHCA hopes that the state will take whatever measures possible to maximize federal funds available to Medicaid providers through the American Recovery and Reinvestment Act (ARRA). In addition, incentives from MCOs to practices can assist them in adopting and using EHRs. Medicaid can be a powerful force to move practices to adoption of EHR. The Medicaid program, with its large provider panel, could truly assist the state in achieving its HIT goals. We would hope that the RFP would require the MCOs to assist the state in achieving this goal.

### ***Enrollment and Retention***

The state and MCOs should work to improve Medicaid enrollment and retention, and decrease the churn rate which is administratively expensive for both the state and MCOs. Working together with the EOHHS Modernization Committee, there are a number of strategies that can be implemented, saving the state considerable funds by reducing the administrative requirements of the Medicaid program. One promising strategy would be the use of ex parte renewal, and the use of information the state already has from other programs with overlapping eligibility. Managing this more effectively may produce savings and reduce the necessity for service cuts in other areas.

### ***Case Management***

The Global Waiver Implementation Taskforce Benefit Redesign Workgroup Acute and Primary Care Subcommittee submitted recommendations to the state on December 4, 2009. In these recommendations, it was noted that some patients might receive case management from multiple sources. The subcommittee recommended that care should be coordinated across

departments. Indeed it should also be coordinated across programs. There may be opportunities for savings that would improve the outcomes for children and adults by ensuring that for each patient there is only one person or agency with a centralized case management function.

At the time the CEDARR Family Centers were created, there were limited opportunities to coordinate case management. The initial vision was that these centers would provide that function for a select group of Medicaid children. Over time, more of these very complex children have become enrolled in managed care programs focused on their needs. It seems appropriate that this may be a time to review the function of programs like the CEDARR Family Centers and others to see if there is duplication of services. The state should explore every possible way to ensure effective, efficient and non-duplicative case management services for Medicaid patients, and consider putting such a requirement in the RFP. This is a real opportunity to decrease cost and increase the quality of service to Medicaid beneficiaries.

#### **Section 4.3.6: Suggestions Regarding Potential Areas of Program Change**

While every program has room for improvement, before commenting on specific areas listed in the RFI, RIHCA first wants to comment on the current benefit packages currently available under RIte Care and Rhody Health Partners. The Global Waiver Implementation Taskforce Benefit Redesign Workgroup Acute and Primary Care Subcommittee stated in its recommendations that there was strong consensus among members that Rhode Island is providing the right benefit package to our Medicaid populations. RIHCA hereby affirms this recommendation. These benefit packages have been developed through years of experience with the programs and the patient population. The benefits focus on primary and preventive care where treatment is more economical. This focus could be strengthened by additional support of the medical home model included in the RFI. In addition, the subcommittee also recommended

that the state investigate the use of integrative medicine as a means of lowering overall medical costs. RIHCA recommends that the state look at adding integrative medicine to the RFP.

### *Communities of Care*

RIHCA supports the concept of restricted health care communities for high utilizers of emergency departments (EDs). Further, the health centers may be a viable option for a network of primary care providers for this group of patients, and given our work with medical home initiatives and care for patients with chronic conditions, would be a good choice. Studies show reductions in ED visits for Medicaid patients who are health center users.<sup>2</sup> Other states with similar initiatives, like Washington State, have primary care provider networks consisting solely of community health centers.<sup>3</sup> In addition, Rhode Island's health centers have been working to increase access to services through measures such as extending hours and working towards co-location of medical and behavioral health services through, for example, a joint initiative of the Providence Center, Providence Community Health Centers Inc. and Blackstone Valley Community Health Care.

In general, the idea of requiring this group of patients to get care from one provider, one pharmacy, one hospital, etc. is a good start to coordinating the care of this difficult to manage group. However, Rhode Island only recently instituted mandatory participation in Rhody Health Partners or Connect Care/Connect Care Choice for all Medicaid-only disabled and elderly adults

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<sup>2</sup> National Association of Community Health Centers, the Robert Graham Center and Capital Link , Access Granted: The Primary Care Payoff, August 2007, available at <http://www.graham-center.org/online/graham/home/publications/monographs-books/2007/rgcmo-access-granted.html> (visited 1/29/2010) (citing Duggar BC, et al. *Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers*. Center for Health Policy Studies, 1994. Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 *Medical Care* 39(6):551-56, and Falik M, et al. "Comparative Effectiveness of FQHCs as Regular Source of Care: Application of Sentinel ACSC Events as Performance Measures." 2006 *Journal of Ambulatory Care Management*, 29(1):24-35.).

<sup>3</sup> See, e.g., Washington State's Community Collaboration for Appropriate Emergency Department Care, funded through the CMS ED Diversion grant.

in the state. It appears that the state may be using ED utilization data that pre-dates implementation of these programs. At least, the community has not yet seen data regarding whether these programs are working to direct health care choices of patients to lower-cost, primary and preventive alternatives, and in fact, it is likely much too early to be able to assess the efficacy of these programs as they only recently became mandatory. RIHCA believes that before instituting yet another new program, the state should evaluate the progress of these two new programs, and consider improving them. Once we have the data, the state in collaboration with insurers, hospitals, providers and the community can develop an appropriate program that really targets those relatively few patients who continue to drive costs.

In addition, one large cost-driver for this group of patients is high use of emergency departments. It would appear that this program will not be able to bar entry to emergency departments. The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 USC § 1395dd, requires emergency departments to see everyone who presents for care; federal Medicaid law requires that managed care organizations reimburse the hospitals for this care. The state should consider policy, legislative, and regulatory changes that comport with EMTALA and federal Medicaid law and decrease inappropriate emergency department use. For example, it might be possible to require emergency departments to evaluate patients and, if non-emergent, refer them back to their primary care physicians.<sup>4</sup> This might better address excessive unnecessary emergency department use for this group of patients. RIHCA would support state efforts to examine whether such policies could be implemented in Rhode Island.

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<sup>4</sup> One part of the Washington State ED diversion program involves a “golden ticket” program. If a patient seen in the ED, after triage and evaluation, is deemed to be non-emergent, the patient is given the option of being treated in the ED, or given a “golden ticket” for priority care at the partner health center, where the patient will be seen by the ED diversion specialist. Washington Association of Community and Migrant Health Centers, *Community Collaboration for Appropriate Emergency Department Care*, First Annual Report, October 2009. We understand from conversations with our colleagues in Washington that the golden ticket did not work as they had hoped, but it is still an example both of a potential diversion model and of the difficulties of ED diversion.

An initiative like the Communities of Care will require resources for providers and others involved in its implementation. In Washington State, money from the CMS ED diversion grant has been directed to providers to support program expenses such as additional staff, nurse triage phone line and educational materials.

### ***Hospital Reimbursement***

RIHCA supports the initiative to have the MCOs piggyback on state negotiations for rates. This provision should save the state money, and should be included in the RFP.

RIHCA supports initiatives that would replicate Medicare payment practices with respect to medical errors, hospital-acquired infections, never events, and bounce backs. These measures appear to improve the quality of care while reducing costs. RIHCA encourages the state to use the Medicare rules instead of developing a new set of standards, and to include this provision in the RFP.

### ***Pharmacy***

The RFI proposes to extend generic first medication requirements to children with special health care needs and Rhody Health patients. The medical providers at the community health centers understand the need to be mindful of costs, both to our individual low-income patients and to the health care system as a whole. Health center providers already prescribe generic medications wherever it is clinically acceptable. RIHCA therefore generally supports a policy requiring generic prescriptions, and when a new medication is prescribed, if there is an appropriate low-cost generic, providers should certainly begin treatment with the generic.

However, RIHCA does not believe that there is opportunity for significant savings with this provision and is very concerned about the potential for flawed implementation of an otherwise sensible policy. Many children with special health care needs, as well as disabled and

elderly adults enrolled in Rhody Health, have extremely complicated pharmaceutical regimens. Many of these include brand name drugs. Where these medicines have been working for patients for some period of time, the danger of arbitrarily switching to a generic medication can be great. If this policy is to be considered, RIHCA strongly recommends a grandfathering provision so that medically complicated patients who are stable on their medication are not adversely impacted. If this recommendation is rejected, providers must be given latitude to manage the transition of their patients. Each patient's medications must be reviewed individually and the transition planned carefully. If a patient is on ten medications, and four of them are brand name medications, the patient should, perhaps, be transitioned on only one medication at a time, so that if there are repercussions from the transition, the provider will be able to identify the cause. Timing of a transition should be another consideration; for example, a child treated for ADHD should have her medication transitioned during school vacation, and not during school exams. Also, there must be quick way for patients to return to their brand-name medications if they fail a generic trial. RIHCA recommends that if an expansion of the generic first requirement is included in the RFP, safeguards should be included that takes into account the complexity of many patients in the CSHCN and Rhody Health populations.

### ***Selective Contracting/Preferred Provider Networks***

Selective Contracting and Preferred Provider Networks are often good strategies to realize savings. RIHCA notes that the examples in the RFI include laboratory, durable medical equipment and radiology, but we would also encourage the state to consider the health centers as a possible preferred primary care provider network for some groups of patients. Health center driven networks have a capacity to manage care and increase quality while delivering services to the state's most vulnerable populations effectively and efficiently.

There are ten community health centers with 27 locations throughout the state, and the health centers have a proven track record of providing high-quality low-cost care to low-income and vulnerable Rhode Islanders in a medical home setting. In general, medical expenses for community health center patients are 41% lower than those for patients seen elsewhere.<sup>5</sup> For these reasons, the state may wish to consider establishing a preferred primary care provider network using the community health centers.

As far as other selective contracting or preferred provider networks, RIHCA encourages the state to collaborate with providers and the community to ensure that such programs do not increase administrative burden on providers or decrease access to services for patients. As an example, one possible concern that the community health centers have is with selective contracting for laboratory services. Currently, each community health center has a laboratory contract. As a part of the agreement, many of the labs provide the health centers with on-site phlebotomists. This is a service offered to patients as part of the comprehensive medical home model at the community health centers. At some community health centers, patients can see their health providers, get their labs drawn, visit the pharmacy and undergo some tests and procedures. This sort of one-stop-shopping reflects the needs of the communities we serve. We are concerned that patients might choose not to have recommended tests if transportation and other barriers are presented. The state's goal should be to support the health centers as we provide comprehensive services to low-income and vulnerable populations. While this does not preclude selective contracting, it is our hope that any such provision would take into account comments from the community in an effort to best serve this patient population.

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<sup>5</sup> National Association of Community Health Centers, the Robert Graham Center and Capital Link , Access Granted: The Primary Care Payoff, August 2007, available at <http://www.graham-center.org/online/graham/home/publications/monographs-books/2007/rgcmo-access-granted.html> (visited 1/29/2010).

## ***Benefit redesign and management***

RIHCA CEO Jane Hayward chaired the Global Waiver Implementation Taskforce's Benefit Redesign Workgroup Acute and Primary Care Subcommittee, which submitted six pages of recommendations to the state on December 4, 2009. We are pleased to see some of these recommendations are included in the RFI. In addition, RIHCA endorses the Subcommittee recommendations, and directs the state's attention to them for more detail regarding benefit redesign.

Specifically in reaction to the ideas presented in the RFI, RIHCA believes that moving some of the services in plan makes sense. The state should require plans from the MCOs regarding how they will implement the integration of new provider groups and work to ensure continuity of care for patients during this process.

In addition, as stated above, RIHCA believes that the current benefit package is essentially the correct one. Elimination of relatively low-cost services, such as dental and podiatry, might not lead to anticipated savings, and has been shown to increase expenses down the line, in terms of increased ED visits and more expensive medical care required.<sup>6</sup> Money might be saved in the short term, but these short-sighted strategies would be costly in the long-term.

With respect to the proposal to limit some services, RIHCA recognizes that there are some tests that may be over-ordered, or not medically indicated, and of course it is appropriate

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<sup>6</sup> In Massachusetts, for example, the state achieved minimal savings from cutting adult dental benefits; some costs were shifted to other areas, including the state's Uncompensated Care Pool. See Kaiser Commission on Medicaid and the Uninsured, *Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience*, September 2005. The California experience confirms:

Good dental care begins with a periodic or comprehensive oral exam that averages \$41 and \$60 (Medi-Cal fees run \$15 and \$25), respectively. Poor preventive dental care can lead to costly stopgap emergency treatment (\$172 median) that typically provides only temporary pain relief through medication and, in some acute cases, surgical care or hospitalization (\$5,044 median).

California HealthCare Foundation, *Emergency Department Visits for Preventable Dental Conditions in California*, 2009.

for Medicaid to limit coverage for these; where they constitute a change from current practice, we encourage the state to seek and take into account comments from the community, and particularly medical providers, before instituting the change.

### **Conclusion**

RIHCA is grateful for this opportunity to comment on the present RFI. We recognize that these are difficult times, and that there are difficult decisions to make. It is our hope that the community health centers will continue to be part of the solution in providing access to high-quality, effective primary care services to low-income and vulnerable Rhode Islanders. We look forward to continuing our partnerships with the state and Medicaid Managed Care Organizations.