State of Rhode Island Office of the Health Insurance Commissioner
Social and Human Service Programs Review Advisory Council
Meeting Minutes
April 18, 2023
9:00 A.M. to 10:00 A.M.

Attendance

Members:

Co-Chair Commissioner Cory King, Co-Chair Elena Nicolella, Co-Chair Sam Salganik, Beth Bixby, Garry Bliss, Margaret Holland McDuff, Linda Katz, Tanja Kubas-Meyer, Maureen Maigret, Carrie Miranda, Nicholas Oliver, Laurie-Marie Pisciotta, Lisa Tomasso (on behalf of Teresa Paiva Weed), John Tassoni

Rhode Island Office of the Health Insurance Commissioner Staff:

Molly McCloskey

Unable to attend:

James Nyberg

Minutes

1. Call to Order

Co-Chair Elena Nicolella called the meeting to order.

2. Review of March 23rd Meeting Minutes

The council approved the March 23, 2023 meeting minutes.

3. OHIC Social and Human Service Programs Review Updates

Molly McCloskey reviewed the next meeting dates. OHIC will be extending meetings to 90-minutes when possible. Co-Chair Sam Salganik summarized the March 23, 2023 meeting.

4. Feedback and Discussion on Report 1

5. Discussion of Upcoming Reports

Agenda items 4 and 5 were covered simultaneously.

OHIC Social and Human Service Programs Review vendor, Milliman, presented to the advisory council. The presentation covered project background and review of phases, finance report updates, and programmatic report updates. The presentation slides can be viewed here.

Ian McCulla, from Milliman, reviewed Report 1 - Phase 1: An assessment and detailed reporting on social and human services program rates, including rates currently being paid and the date of the last increase, which OHIC submitted to the Governor and General Assembly on March 31, 2023. He asked if any of the council members had any feedback on Report 1 – Phase 1. Molly McCloskey reminded advisory council members that Phase 2 of the report will include updates based on stakeholder feedback.

Sam Salganik asked for clarification around what will be included in Phase 1 of the project versus Phase 2. Commissioner King explained that OHIC created an explainer document, Phased Approach Application Across Tasks, to further clarify what Phase 1 and Phase 2 of each report will look like. Additionally, it was

clarified that for the purposes of Report 1 – Phase 1, and other finance reports on reimbursement rates, social and human service program rates are defined as those in which the state has a contract with a nonstate entity to provide services on a fee-for-service basis. Other reports required by the statute will focus on programmatic elements rather than rates. In the programmatic reports, additional programs that provide services that do not meet the fee-for-service definition may be included in scope.

Sam pointed out that the report displays the last rate change. He stated that the Commissioner had previously indicated that there are not system records that indicate whether that change was an increase or a decrease or by how much. For example, in 2016, the Cedar Program was redesigned and there was a large change in scope, but there was a rate decrease. Sam asked if there was a process where advisory council members could share evidence with OHIC around rate changes that were decreases. The Commissioner responded that that is exactly the information OHIC is looking for from advisory council members. The statute says, “date of last increase”, but it is not practical to go back and mine through what might exist in internal agency documents and spend many thousands of dollars to identify the date that the rate was last increased. The Commissioner reiterated that he would like the council members to let him know about any decreases. He also explained how the report differentiates between recent temporary COVID-related rate changes and the changes prior. Sam asked if council members submit a decrease with supporting evidence, can some sort of appendix of foot note be added to the report. The Commissioner said yes.

Margaret Holland McDuff asked if there was a system in place in the Medicaid office to inventory whether rate changes were an increase or decrease. The Commissioner said that he was not aware of an existing inventory. Whenever Gainwell, Medicaid’s vendor, changes a rate they submit a formal document, but we would have to go back and review all of those documents to find out what was an increase versus a decrease. The Commissioner stated that after asking Gainwell and Milliman about this, he concluded that the effective date supplemented with council member’s feedback was the most efficient way to go about this. Margaret stated that this project presents and opportunity to look at this process, tweak it, and make it better. By the end of this review, we will be looking at how all of the pieces of the system work together.

Nicholas Oliver stated that it is worth noting that the effective date of a rate change may not be the implementation date. Rates changes sometimes have to be retroactively reconciled, which can be challenging for providers. Effective date and implementation date are two different dates.

Elena Nicolella said that one of the big picture take aways is the lack of a consistent approach to rates. She thinks that a recommendation that acknowledges the need to update rates on a more predictable basis would be helpful.

Nicholas Oliver stated that, as of 2018, home care rates had a statutory inflation increase built into statute. He asked if an annual increase for all social and human service programs might be something that OHIC would propose as a part of this project. The Commissioner replied that OHIC recommendations are going to govern rates, and there may be some process recommendations, but which services get an automatic inflation update in statute is a question that the agencies, the Governor, and the legislature are going to have to work out.

Elena stated that it would be helpful to get information from Milliman, that could potentially come up during the benchmarking process, that indicates whether regularly scheduled increases connected to a certain index is considered an effective and efficient way for state governments to approach rates. The

Commissioner said that even if there is an inflation escalator attached to a rate, it still leaves the question, is the base rate correct? Updating a low base or a base that doesn't cover costs is something that the providers are going to be concerned about. He said that he would like a process where we can do a deep dive on all rates. Part of our tool kit will include independent rate models on some rates, but we are going to have to prioritize and won't be able to do a deep dive on every single one of the 600 codes that are in appendix 1.

Sam said that he hopes that all of the data we are collecting is archived in a way that can inform us 10 years from now because we don't currently have a good archive of rates. The Commissioner said that we should utilize the resources that the general assembly gave us to do this work, put the information into the public domain, and make sure that it is curated over time.

Linda Katz stated that she supports the idea around individual providers documenting what has actually gone on with rates in terms of increases versus decreases. She said that she appreciates that we are trying to get to the right number, but she is unsure if we will ever get there, so a big part of this project is documenting what has gone on. Linda said that she also wanted to highlight that there is no inflation update for the Independent Provider or Personal Care Assistance programs. It is important to show the general assembly that there are different ways that home-based care can be delivered, and some have a mandatory increase, which still may not be sufficient, but other parts of the home care system does not have automatic increases.

Margaret stated that though some rates were increased last year, those rate increase are not included in the current proposed budget. So, some rates are about 20 years old. Even though there is a rate increase from last year, we still need to advocate to the legislature because the rate increases were not included in the Governor's budget. There was an increase and then it was reduced. This confuses the process. She stated that she wanted the advisory council to think about what an ongoing rate process will look like.

Ian continued the presentation on the remaining finance reports. He reviewed Task 3 – utilization trends from 1/1/17 – 12/31/2 – on slide 11. Ian stated that the level of resource intensity required to do various analyses varies. Task 3 is a claims-based analysis for Medicaid claims, which can be done efficiently across a number of services.

Elena asked, what question is task 3 looking to answer? The report will help us to understand what percentage of services are delivered through the managed care system. The Commissioner agreed that that will be one of the contextual points of task 3. The statute states that this be "an assessment and detailed reporting on utilization trends from the period of January 1, 2017, through December 31, 2021, for social and human service programs." So, we will be performing that analysis to fulfill that obligation. When OHIC delivers rate recommendations to EOHHS and its constituent agencies, they have to take those recommendations and operationalize them in terms of budget decision packages and cost them out. We want the utilization data to flow through to make that a seamless process. OHIC is already having internal conversations with EOHHS about what that process looks like and we hope that the analysis that we do for this report would not only fulfil the statutory obligation but also provide inputs to the budget development.

Sam stated that he hopes that we don't try to read too much into what increasing or decreasing utilization in a service or category means. Decreasing utilization can be read as demand going down but it could also be read as supply constraint. It is very difficult to pick that apart. He recommended

contextualizing that it is really hard to draw conclusions about what is driving utilization increases or decreases and how rates play into that. Margaret agreed that assumptions should not be made about what drives utilization. Some providers have decided to stop providing certain services because they were losing money. This report simply reflects utilization over the past 5 years, but it doesn't say what the need is and what the need will be in the future.

Ian continued the presentation and reviewed slide 12, which summarizes task 8 – National and regional Medicaid benchmarks. This is one of the more resource intensive reports in terms of identifying similar state benchmarks, reviewing program manuals to ensure consistency across the service definitions, and then making any adjustments that are needed to create a consistent comparison between the services in different states as much as possible. The Commissioner reiterated that this report is resource intensive, so we are focusing on a limited scope of services – home care and substance use disorder rates. The Commissioner encouraged the members to view phase 1 of this report as a proof of concept run, evaluate it, and bring feedback about its efficacy because this is one of the methods we are going to use to analyze other rates. The Commissioner addressed the title of the task in the statue, which refers to reporting on national and regional Medicaid rates. He stated that a U.S. average doesn't make much sense. We felt that initially a focusing on the New England states is most appropriate. In the next report that Ian will describe, we are importing this national perspective, in a sense, by using Medicare rates, which is a national payer that calibrates to geographies based on cost of living and other factors.

Elena asked, as a part of fulfilling this task, if it comes up that other states tie rates to an index, can we document that? The Commissioner replied by saying that that can be documented, but that he has learned that there are so many idiosyncratic variations across Medicaid programs. It is frustrating. There is a lack of standardization from one state to another and there are a number of one-off judgment calls that agencies are making in states, which is why we have to dedicate a lot of resources to the normalization of rates. Elena suggested that if Milliman finds a best practice process in another state, it should be highlighted. The Commissioner agreed.

Ian continued the presentation, reviewing task 9 – private pay rate benchmarks – which will include provider billed amounts, commercially negotiated rates, Rhode Island Medicaid MCO rates, and Medicare benchmarks. Claims data will be used for this report so a larger breadth of services can be reviewed. The flipside is that we don't have the same level of detail on the provider requirements and things of that nature, so there will be less adjustments and refinements inherent within these benchmarks. There are certain data availability and data use restrictions that will be covered in the report – for example, commercial insures don't cover all the services within the scope of the social and human service programs review. There are also Medicaid MCO reimbursement restrictions, so we need to make sure that we are sufficiently blinding the data so that no individual MCOs reimbursement information is being disclosed.

Natalie Angel, from Milliman, presented on the programmatic report updates. Beginning on slide 15, she reviewed task 2 – eligibility standards and processes of social and human service programs. Phase 1 will be educational, and phase 2 will include evaluation and assessment.

Tanja stated that she is interested to learn why some of the programs are handled the way that they are. For example, DCYF uses a procurement process as opposed to using available Medicaid rates, which may be because of blended funding, but it would be good to know why.

Natalie reviewed task 4 – the structure of state government as it relates to the provision of services by social and human service providers – on slide 16.

Linda asked if the report would include a description of the source of funding for some of the non-Medicaid programs. For example, how much federal block grant funding and general revenue funds go into certain programs. Natalie said that the report doesn't currently include that but that she would look into that.

Natalie reviewed task 5 – accountability standards – on slide 17.

Maureen Maigret pointed out that in some cases different departments are involved with the same provider in terms of licensing or certification, which needs to be looked at.

John Kasey, from Milliman, summarized task 6 – professional and personnel requirements – on slide 18. This report will include the same services as task 8. Phase 2 will expand the set of services included.

Natalie reviewed task 7 – access to social and human service programs – on slide 19. Sam asked if early intervention could be added to the list. Margaret asked if she could send others to add if she thinks of them. Natalie encouraged that.

John Tassoni asked if the project has enough funding to be completed. The Commissioner said that there has only been one month of invoicing, but that he doesn't think that OHIC will run out of money. However, OHIC has to dedicate our fixed appropriation to all of these tasks, and we want to do a good job so part of the purpose of this advisory council is transparency around how we are allocating those resources. It is going to be an iterative process but if you ask me that question in three months, I might have a slightly different answer.

John Tassoni talked about how a number of agencies he represents have differing, proprietary, MCO rates to provide the same services. It is not a good way to do business with behavioral health services and it is causing major problems. Margaret agreed that it is an issue. Access to attorneys, negotiations, and other factors play into rate decisions. It is particularly an issue from an equity lens. The Commissioner said that he would have to defer specific questions around this to the Medicaid program. Margaret said that this is not in the scope of this analysis, but it is something for the advisory council to think about. Public transparency is important since these are public dollars.

Sam stated that there has been a movement, even amongst commercial payers, towards transparency. He said that he believes that commercial payers have to publish their rate schedules now, or he thinks they will have to soon. He pointed out that there was something earlier in the presentation about Medicaid MCO rates being proprietary. Sam said that he is not sure that he agrees with that statement. MCOs might disagree, but there has been a transparency movement across the healthcare industry. It's different now than it was 5 years ago in terms of transparency in rates. The Commissioner stated that he is in favor of rate transparency.

John said that he brought it up because there is limited access to care and these types of practices will lead to more providers closing, exacerbating the currently limited access to care. We are going to lose agencies.

Linda asked about the fact that there would be MCO rates included in the report, but we wouldn't be able to tell which MCO is providing what rate. The Commissioner confirmed this and stated that the report will include a composite rate. There are three MCOs in the market currently and they all have to have utilization within a particular service in order to calculate that composite rate. There are some data and legal constraints around publishing information.

6. Public Comment

None

7. Adjournment