

**Statement by Gary D. Alexander**  
President and CEO of the Alexander Group, LLC  
“Strengthening Medicaid LTSS”  
A Public Hearing of the Commission on Long-Term Care  
“Strengthening Publicly and Privately Funded Long-Term Services and Supports”  
562 Dirksen Senate Office Building  
Washington, D.C.  
Thursday, August 1, 2013

**Introduction**

Thank you Chairman Chernof, Vice Chairman Warshawsky, and the other distinguished members of the Commission on Long-Term Care for the opportunity to testify on the subject of strengthening Medicaid’s Long-Term Services and Supports.

My name is Gary D. Alexander. I am the president and CEO of the Alexander Group, a consulting firm based in Providence, Rhode Island, and Philadelphia, Pa. Prior to forming the Alexander Group, I was secretary of public welfare for the Commonwealth of Pennsylvania, overseeing a budget of \$27.5 billion, 6 hospitals, 5 state intermediate facilities, 94 offices, and 16,500 employees. I served earlier as Rhode Island’s secretary of health and human services. With the help of my staff in the Ocean State, I designed and authored the 2009 landmark reform, the Rhode Island Global Consumer Choice Compact, also known as the global waiver.

“Strengthening Medicaid LTSS” could not be a more important topic. Not only is our population aging, with increasing numbers needing long-term care (LTC) and supports, but also demographic trends indicate even greater public resources will be required. LTC is a key factor driving up Medicaid costs, which are not just a federal concern but have become the largest budgetary items for the states, affecting both recipients and taxpayers.

I was asked today to offer my perspectives on how Rhode Island’s global waiver could provide states with a framework to reform Long Term Care and offer quality long term care supports that are cost effective.

**Rhode Island Global Waiver: The History**

When I served in Rhode Island, reform was imperative. At the time, more than 20 percent of the state population was on Medicaid. Moreover, Medicaid comprised more than 25 percent of the state budget, and Medicaid expenditures were growing annually

between 7 and 8 percent. Without reform, Medicaid would command more than half of Rhode Island’s budget by 2025. LTC was a major component of that growth, extending Medicaid to beyond its traditional “means-tested” population. Middle-class citizens would spend down into impoverishment, while others would shift or shield family resources to qualify for Medicaid, placing many in institutional-care settings.

At the same time, Rhode Island was doing little to lower Medicaid costs in general or in the LTC system in particular. Our focus was more on administering a myriad of home- and community-based “waivers,” each with varying rules, regulations, and service definitions rather than on concentrating on the people we were attempting to assist. Like other states, we had sought waivers—eleven across our enterprise—to avoid Medicaid’s historic institutional bias and a “one-size-fits-all” system. On the long-term care side, neither the waivers nor the federal rules were coordinated, creating huge inefficiencies. But we saw this programmatic and administrative overload as a window of opportunity to change the system to improve care quality and reduce costs.

Rhode Island was the first and only state to apply for—and secure—a global waiver covering acute care and long-term care and supports with a capped allotment on overall funding in exchange for unprecedented flexibility. The idea was to gain flexibility to administer Medicaid in ways that made sense. Part of that flexibility was used to consolidate and streamline all eleven waivers to create a person-centered and person-focused system. We wanted to promote the health and safety of recipients in a cost-effective manner, to make sure that the right services were available at the right time and setting. Our goal was to shift from a fragmented, provider-and-setting focused system (in which patients must adjust to providers’ time and practice patterns) to a person-centered focus for every recipient, irrespective of age, care needs, or eligibility basis. In essence, the global waiver was all about improving care for the person at a much lower cost.

CMS approved our global waiver as a five-year demonstration project that started in 2009, per Section 1115(a)(1) of the Social Security Act, with the following goals:

- Rebalance Medicaid LTC to increase access to Home- and Community-Based Services (HCBS)
- Ensure access to medical homes
- Realign payment and purchasing strategies with person-centered programmatic goals
- Ensure accessibility and comprehensive system of coordinated care focused on independence and choice
- Maximize available service options
- Promote accountability and transparency
- Encourage and reward health outcomes
- Advance administrative efficiencies to improve quality

## **The Rhode Island Global Waiver: The Results**

The waiver enabled Rhode Island to become a “smart purchaser,” striving to make sure that every public health-care dollar spent delivered better value. Indeed, according to a December 2011 study by the Lewin Group, the Ocean State’s reform was “highly effective in controlling Medicaid costs” and improved “access to more appropriate services.” The report noted a decline in the number of low-need persons entering or remaining in nursing homes. Indeed, more Rhode Islanders were choosing to obtain the care they need at home or in community settings, like assisted or shared living. Level-of-Care (LOC) redesign focused on preventive care drove thousands of individuals into appropriate community settings. Nursing-home costs were reduced as a result of improved program management and acuity-based adjustments to the state’s payment methodologies. All Medicaid recipients, except for those with some additional coverage such as Medicare or private insurance, gained a medical home that provides care management and coordination.

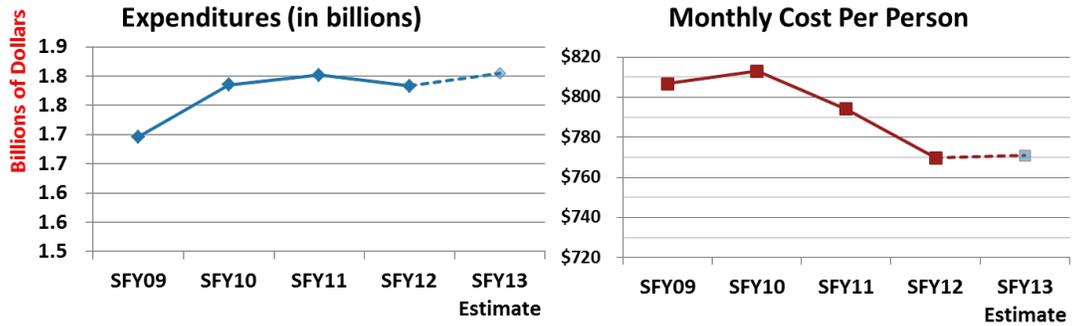
The Lewin study also “found evidence of lower emergency room utilization and improved access to physician services” from “care management programs” for Medicaid recipients with asthma, diabetes, heart problems, and mental-health disorders.

Contrary to earlier projections of 7- to 8-percent growth, Medicaid expenditures came under control. Expenditures grew 5.2 percent in SFY 2010 and 1.0 percent in SFY 2011 and decreased 1.1 percent in SFY 2012. The state has not finished calculating the growth rate for SFY 2013, but our estimate—based on preliminary reports to the state legislature—indicate a growth rate of about 1.2 percent this year. Rhode Island’s achievement in lowering Medicaid’s spending trajectory came about despite the fact that the caseload increased 4.5 percent in 2010, 3.4 percent in 2011, and 2.1 percent in 2012.

The efficiency gains can be best measured by the Per-Member Per-Month (PMPM) costs, which were \$813 in SFY 2010, \$794 in SFY 2011, and \$770 in SFY 2012. These are driving down the overall cost of the program, enabling Rhode Island to reverse trends. Our estimate indicates a PMPM cost of \$771 for SFY 2013. These trends should continue now that Rhode Island is implementing the global-waiver plan to integrate care for its nearly 40,000 dual-eligibles, and beginning to use new models like capitated tele-health.

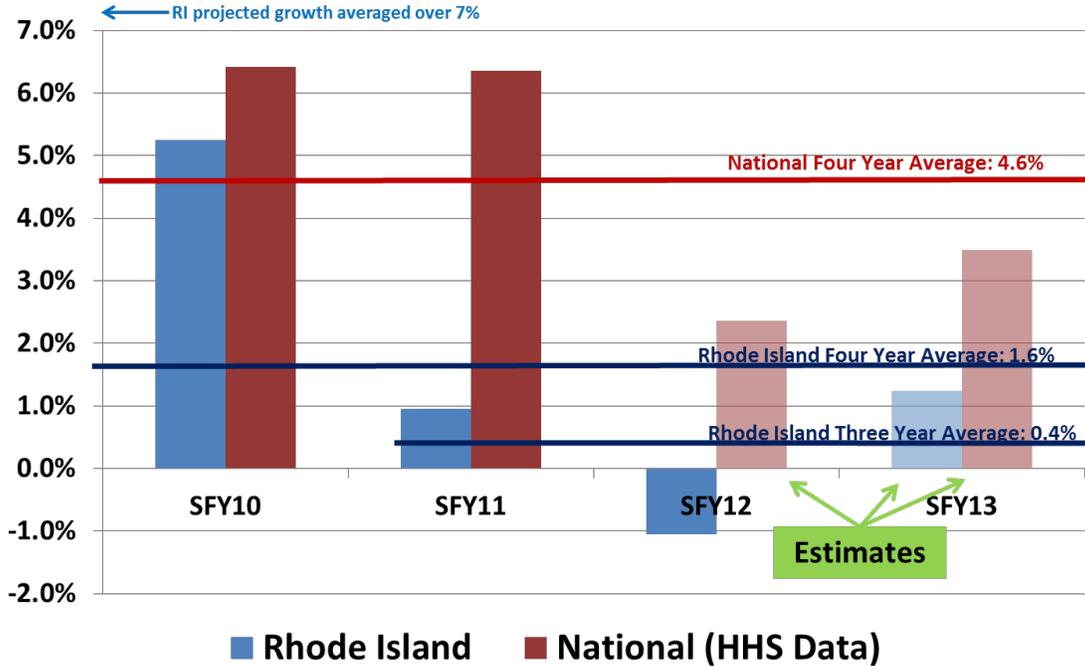
A comparison with national data from the federal HHS Office of the Actuary confirms the promise of the global waiver. Rhode Island’s Medicaid-expenditure growth was projected to exceed the national average. Instead, the state’s pattern now falls far below it, estimated at 1.6 percent, compared to the estimated national-budget growth of 4.6 percent over the same four-year span. The estimated national-PMPM growth over the same period is 1.3 percent, compared to –1.1 percent for Rhode Island.

## Rhode Island Medicaid Global Waiver Annual Expenditure Growth 2009-2013

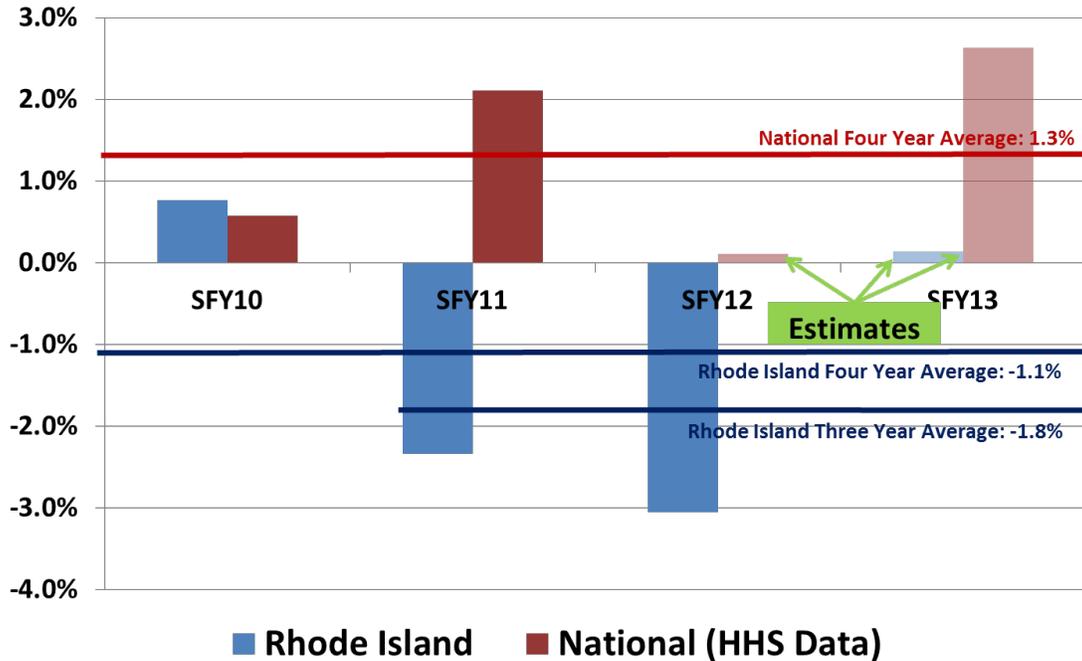


	SFY09	SFY10	SFY11	SFY12	SFY13 Estimate
Expenditures (in millions)	\$1,696	\$1,785	\$1,802	\$1,783	\$1,805
Growth		5.2%	1.0%	-1.1%	1.2%
Caseload	175,179	182,977	189,131	193,030	195,141
Monthly Cost Per Person	\$807	\$813	\$794	\$770	\$771

### RI Expenditure Growth Now Significantly Below National Average



## RI Per-Person Cost Growth is Well Below National Average



However impressive, the savings could have been greater. As with any negotiation, CMS did not approve our initial request. We initially requested a block grant with a “gain-sharing” system based on performance measures and reinvesting a portion of the savings into preventative health care. We sought flexibility on mandatory populations and full relief from burdensome federal red tape in order to initiate greater cost sharing, incorporate employment, gain additional administrative streamlining, utilize predictive analytics, and implement health-savings accounts for all recipients coupled with market-based reforms. Although these requests were denied, we accepted and worked within the parameters granted by CMS.

We can't know for certain what the savings would have been had CMS approved all the components of our initial request. However, we believe the savings would have doubled. Instead of an average Medicaid-expenditure growth rate of 1.6 percent—or 3-percentage points below the national average growth rate of 4.6 percent during the four-year period—Rhode Island would have likely *reduced* its Medicaid expenditures by an average of 1.4 percent a year, a full 6-percentage points below the national average.

### What Are the Lessons Learned from Rhode Island?

**Lesson Learned #1: Multiple waivers create inefficiencies and poorer outcomes. Global waivers do just the opposite, allowing the state to adapt to change quickly and efficiently.**

Deviations from federal preconceived notions of how Medicaid LTC should operate force states to seek multiple waivers or state-plan amendments, which can be a

cumbersome and difficult process. Moreover, managing multiple waivers create program silos, inefficiencies, and poorer outcomes for recipients. Having one global waiver with a spending cap gave the state needed flexibility to align service definitions and payment methodologies and break down operational and programmatic silos. Example: Rhode Island was able to quickly implement shared living as a service for elders and adapt rapidly. Without the waiver, this cost-effective service could have taken years to implement.

**Recommendation:** Encourage more states to use global waivers across their entire enterprise. Increase the level of flexibility for states to integrate and innovate.

**Lesson Learned #2: The spending cap toppled the foundations of the Medicaid culture of continually increasing spending.** Before the global waiver, the state government rightly presumed that “if the state spends a dollar it can’t afford, the federal government is happy to match it with dollars they don’t have.” Bringing about a rethinking of that modus operandi, the five-year spending cap forced the state to immediately reform, redesign, and be cost-conscious. Without an urgency to save, government will never be cost-effective. The spending culture was not unique to Rhode Island. It emanates from Washington, D.C.; states to one degree or another have adopted the same irresponsible thinking. Example: In Rhode Island, managers quickly implemented payment reforms to ensure that the state stayed under the agreed upon cap. Under normal circumstances, managers lack any urgency to be cost effective.

**Recommendation:** Cap total overall Medicaid spending, initiate competition between the states, require better health outcomes, and allow flexibility to force cost-conscious redesign and reform.

**Lesson Learned #3: The global waiver originated in the State of Rhode Island with a Republican governor and Democratic legislature.**

The global waiver idea was not developed here in the corridors of Capitol Hill or in the office suites of CMS. No, it was a bottom-up solution that came from “the people,” of a small state. One-size-fits-all solutions rarely work. Every state is different, having unique demographics, history, and institutional settings. Rhode Island’s solution originated from the hard work of Rhode Island officials. It would be a mistake for the federal government to take Rhode Island’s program and impose it on all the other states, assuming what worked in Rhode Island will work elsewhere. Example: Rhode Island’s flexibility allowed the state to target and modify benefits to the recipient rather than the institution or the provider. If a small cohort of recipients requires podiatric services as a preventive measure, the state may offer these services without having to open up these services to the entire caseload. To the best of my knowledge, this was the first and only time that a state was allowed to stratify the recipient population into groups that are sufficiently homogeneous to enable arranging a set of commonly needed supports and services to meet expected needs.

**Recommendation:** Have the federal government set broad parameters but encourage bottom-up solutions.

**Lesson Learned #4:** While CMS approved of Rhode Island’s global waiver, it also limited its total success.

Had CMS allowed Rhode Island to implement all aspects of its current waiver, and had it granted its initial request, the state could have fully transformed its Medicaid system. In this respect, CMS undermined needed innovation and reform, even with provisions it approved. Example: Rhode Island’s waiver permitted the creation of “Healthy Choice Accounts” to influence healthy behaviors, engage recipients in considering care cost and quality, and drive market-based reforms across acute and long-term services. But CMS stopped Rhode Island from implementing this innovation. Further, the global waiver granted the state an administratively simplified process to make changes over the five year period. But if you asked the state how this provision has operationalized, I am sure that they will tell you that it did not work out as efficiently as we hoped. The federal government has a way of micromanaging that leads to inertia and thwarts efficiency.

**Recommendation:** Limit the authority of CMS to decline innovative ideas as long as broad parameters of health and safety are met.

**Lesson Learned #5:** Allowing states to keep a portion of the federal savings will incentivize savings and innovation.

The current design of Medicaid encourages states to maximize drawing down of federal dollars. States may abhor spending their own money but feel good when they spend more federal money instead. The only way to beat the system is to change it. States need to be encouraged to save federal money, and nothing will work better than gain sharing. Example: Although the federal government did allow Rhode Island to draw down additional funds for long-term support costs that were not otherwise matched, it was not done in a performance-based approach.

**Recommendation:** Incentivize states to save money by adopting performance-based gain-sharing principles geared toward reinvesting in preventative services and experimenting with innovative cost-effective models of care.

**Lesson Learned #6:** Redesigning LTC takes dedication and hard work—lots of it.

Speaking from my professional experience, bureaucracies have tremendous inertia. Our governmental systems are not designed for encouraging innovation; more often than not, they stifle even the slightest notion of it. Layered on top is the maze of competing political interest and advocacy groups. Welfare systems, including Medicaid LTC, are complex systems, requiring expertise from many different fields. So it also takes knowledge on how to put all the pieces together to make it work.

Nonetheless, we can be very innovative. There are many knowledgeable and talented persons, some serving our federal and state governments. Part of being successful is knowing how to motivate and move people. You need commitment from a governor, the state legislature, and the federal government in order for change to happen.

**Recommendation: The federal government should encourage innovation and help facilitate change. Getting to “Yes” should be the norm.**

### Conclusion

That the current Medicaid LTC system is inefficient is an understatement. We can run a more effective Medicaid system at lower costs, if we are willing to allow states to reform and redesign the system. The Rhode Island global waiver shows a better way. With that flexibility, Rhode Island was able to segment patient populations, reduce administrative burdens, and quickly implement proven solutions. Even with its limitations, the success of the Rhode Island global waiver demonstrates that change is possible if CMS would allow the states to innovate and lead. In the Ocean State, **the net result was better health for recipients** on both the acute and long-term care continuum. And that’s no small feat, because better health is what all Americans want.

\* \* \* \* \*

**The Alexander Group, LLC (AG)** is a government and business consulting firm that delivers cutting-edge data-driven solutions, strategic business development, and innovative health-care and technology platforms—to improve efficiency, effectiveness, and quality for our clients. AG possesses unique expertise in the government health-care marketplace, built upon two decades of operating large-scale health and human services agencies and pioneering innovative reforms that saved states billions of dollars and improved service quality. Founded in 2013 by reformer Gary D. Alexander, the firm is the only group of public officials who have designed, implemented, and managed nationally acclaimed reforms like the Rhode Island Global Medicaid Waiver and, in Pennsylvania, *The Enterprise-Wide Program-Integrity Plan* and *The Health and Human Services County-Block Grant*.

With specialties in Medicaid, Medicare, long-term care, and social-welfare programs, AG provides clients clarity at the intersection of business and public policy while identifying opportunities that enhance the bottom-line and improve the lives of people. Rather than remediate complex and outdated assistance programs piecemeal, we help states reform and restructure their entire public-welfare systems. Deploying cost-effective savings methodologies to ensure a value-, transparent-, and efficiency-based system, our reforms drive innovation, improve service quality and performance, incentivize accountability, modernize operations, and root out fraud, waste, and abuse.