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Medicaid Assisted Living In Rhode Island

Evaluation of Payment Methods

Research for the Rhode Island Department of Human Services

June 2011

Prepared under Sub-contract to the New England Consortium Systems Organization (NESCSO)

Table of Contents

Letter of Transmittal

June 15, 2011

Lawrence A. Ross
Asst. Director, Financial & Contract Mgmt.
600 New London Avenue Building #57
Cranston, RI 02920

Reference: Rhode Island Assisted Living Evaluation of Payment Method

Dear Larry,

Thank you for the opportunity to assist Rhode Island in development of an alternative reimbursement methodology for assisted living and in analyzing data for this project.

I am pleased to submit the final Evaluation of Payment Method as discussed with you on June 15, 2011 for your approval in accordance with CN-101 H1 ACS/NESCSO Contract.

Anyone with questions should feel free to contact me at (406-457-9587 office, 406-437-1886 cell or debra.stipcich@acs.inc.com).

Sincerely,

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Cc: Tom Marcello
Gerald Clay
Rick Jacobson
Darrell Bullocks

1 Introduction

Under the Global Waiver, the Department of Elderly Affairs (DEA) and Department of Human Services (DHS) have brought together the DEA and RIMFHC waivers for payment through the MMIS system. This provides the opportunity to reform the payment method to better align with the goals of Rhode Island's Global Waiver. DHS and DEA are looking for a payment method that would encourage increased access to assisted living services for persons in Medicaid long-term care and to decrease reliance on inappropriate institutional stays. In addition, the payment method should fit the Global Waiver's goal of a person-centered approach.

It is currently estimated that more than 900,000 Americans live in approximately 39,500 assisted living residences in the U.S. The average age of an assisted living resident is 86.9 years old, (typically a woman with multiple health conditions and an annual income of $19,000), and the average length of stay is 28.3 months. Fully one-third of residents will die while in assisted living while of the remaining two-thirds, approximately 60% will move to a nursing home.[1]

Assisted living charges are generally a base rate depending upon included services with additional services offered à la carte. Nationally, monthly charges vary from basic package rates of $2,740 (includes five or less services), standard package rates of $2,985 (six to nine services), to inclusive packages of $3,469 (10 or more services). The national average monthly charge in assisted living for Alzheimer's and dementia care is $4,267.[2]

Residents (or their families) usually pay with their own financial resources. Medicare does not pay for assisted living services. Some long-term care insurance policies may cover all or some of the costs. Most policies reimburse from $50/day to as much as $500/day based on the insurance product purchased by the resident. A growing number of policies pay benefits in terms of a monthly amount. Policies typically offer a choice of lifetime dollar amounts usually $100,000 to $300,000. The dollar amounts may correspond to a period of time. For example, a three-year policy at $100/day of benefits would provide a total of $109,500 for care. The Veteran's Aid and Attendance (A&A) Pension provides a three-tier benefit for veterans and surviving spouses. Some assisted living homes have their own financial assistance programs. In 2009, about 13% of assisted living residents nationwide received care paid for by Medicaid programs.[2]

2 Medicaid Purchasing of Assisted Living Services

The majority of state Medicaid programs pay for services in residential care settings through §1915 (c) home and community-based services (HCBS) waivers, the Medicaid personal care state plan option, and §1115 demonstration programs. States most often use the HCBS waiver option. A small number of states use the personal care state plan option and an even smaller number (six) use state general fund only.[3]

Under HCBS waivers states can use either a fixed per capita amount for each recipient or average the expenditures across all waiver recipients. States have the option of setting a cap on waiver services at a percentage of nursing home costs. Section 1915 of the Social Security Act and 42 CFR § 441.360(b) expressly prohibits Medicaid payment for room and board: living quarters, meals, utility bills, etc. However, Medicaid programs may pay for personal care services provided in the assisted living facility. Examples of "personal care services" are assistance provided to residents in bathing, dressing, eating, cooking, or cleaning. Waivers cover adult day care, private non-medical institutions, assisted living homes, and assisted living residents (apartment type complexes). There are diverse licensing requirements among the states.

The Supplemental Security Income ("SSI") program guarantees a very limited income to individuals who are aged, blind and/or disabled, and who have available savings of no more than $2,000. Twenty-four states provide an additional state supplement for SSI recipients residing in assisted living facilities. Twenty-three states limit the amount that facilities can charge Medicaid beneficiaries for room and board. These states usually limit room and board to the state's SSI payment plus a state supplement, if any, and minus a personal needs allowance. Only five states cover room and board. Examples of costs that are considered room and board include: rent, mortgage payments, title insurance; mortgage insurance; property and casualty insurance; property taxes; utilities; resident phone, cable TV, etc.; building and/or grounds maintenance; residents' "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals may be covered as a service); household supplies and equipment necessary for the room and board of the individual; and furnishings used by the individual.[3]

Medicaid in 47 states and the District of Columbia cover some type of assisted living. Two states (Alabama and Pennsylvania) do not provide any assisted living home payment. Kentucky offers only a state SSI supplement for personal care home recipients.

States use various methods of payment for assisted living homes: tiered rates, flat rates, plan of care rates, case-mix adjusted rates and percentage of nursing home payment rates. Some states use a blend of rate methods. There are a small handful of other payment methods, such as used by Tennessee, which pays based on the providers usual and customary charges.

All state Medicaid programs require a basic level of care in assisted living homes that includes but is not limited to: attendant care, chore services, companion services, laundry, homemaker/housekeeping, medication oversight (to the extent permitted under state law), personal care and services, and therapeutic social and recreational programming. Most also

require three daily meals and snacks (including diet care), escort services and non-medical transportation.

Table 2.1.1 below shows services included by state.

Table 2.1.1
State Specific Services included in Rate

State	Personal Care	Med Assist	Nursing Service	Nurs Eval	Therapy	Housekpg / Laundry	Social/ Recreat	Transport	24 hr Supervis	Assistive Devices	Meal Prep	Emerg Response	Service Coord	Chore Service	Other
AK	•					•	•	•			•		•		•
AZ	•	•	•												
AR	•	•	•	•			•	•							
CA	•	•				•	•	•	•		•		•		
CO	•	•				•			•		•		•	•	•
CT	•					•	•	•				•		•	•
DE	•		•										•		
DC	•					•		•	•				•		•
FL	•	•	•		•	•	•					•	•		•
GA	•	•							•						
HI	•	•				•					•				•
ID	•	•				•	•	•			•				•
IL	•	•	•	•		•	•		•						•
IN	•	•				•	•							•	•
IA	•		•					•		•		•		•	•
KS	•			•						•		•			•
LA	•	•	•			•		•							
ME	•					•									•
MD	•	•					•	•					•	•	•
MA	•												•		•
MI	•														
MN	•	•	•			•			•		•	•			•
MS	•	•	•			•	•	•				•		•	
MO	•	•													
MT	•	•				•	•		•			•			
NE	•	•				•	•	•							•
NV	•	•				•	•							•	•
NH	•	•				•	•		•			•	•		•
NJ	•	•	•	•		•		•			•			•	
NM	•	•				•	•	•	•		•		•		
NY	•		•		•										•
NC	•							•							
ND	•						•		•						
OH	•	•	•			•	•	•	•		•				
OK	•	•	•			•	•				•				•
OR	•	•				•	•	•							
PA*															
RI	•					•					•		•		•
SC	•	•													•
SD*															
TN	•	•				•									
TX	•	•					•	•	•						•
UT*	•	•	•		•	•	•		•		•			•	
VT	•	•	•	•		•	•		•						
VA*	•	•	•			•	•		•					•	•
WA	•	•	•												
WV	•														
WI	•		•			•			•		•				•
WY	•	•							•						
Total	**47**	**32**	**18**	**5**	**3**	**29**	**23**	**17**	**17**	**2**	**13**	**8**	**11**	**10**	**25**

Notes: Nursing services may include intermittent services, limited nursing services and delegation.

Other services:

AK: Managing money, writing letters, using the telephone.
CA: Social services.
CO: Shopping.
CT: Maintenance services.
DC: Personal care aide or homemaker aide.
FL: Behavior management; specialized medical equipment.
HI: Delegated procedures.
ID: Assistance with personal finances.
IL: Health promotion and exercise programs; ancillary services.
IN: Companion.
IA: Senior companion; nutritional counseling.
KS: Comprehensive support; wellness monitoring.
ME: Dietary service; see state summary.
MD: Personal hygiene supplies; nursing supervision and delegation.
MA: Nursing oversight
MN: Home care aide and home health aide tasks; central storage of medications.
NE: Escort; adult day care; essential shopping; health maintenance activities.
NV: Companion services.
NH: Must provide access to nursing services, rehabilitation and behavioral health.
NY: Personal care is covered by the SSI State Supplement; home care; medical equipment and adult day health care.
OK: Cognitive orientation.
PA: Services not determined
RI: 24-hour staffing; minor assistive devices; case management.
SC: Incontinence supplies.
TX: Home management; escort services.
UT: Nursing and skilled therapies are incidental to the provision of adult residential services.
VA: Companion.
WI: Services covered in RCACs. Supportive services means meals, housekeeping, laundry, arranging transportation and medical services. Other – counseling/psychotherapy.

*Table data from Robert L. Mollica, Ed.D., "State Medicaid Reimbursement Policies and Practices in Assisted Living", prepared for the National Center for Assisted Living American Health Care Association (Sept 2009)

2.1 Flat Rate Payment Method

Flat rates are used by 15 states. Rates are paid monthly or daily. Daily rates range from $35.04 to $69.75 per day. Rhode Island uses a flat rate of $42.16 as of July 1, 2010.

Flat rates are set using a variety of methods. Massachusetts sets its rate based on 2006 direct care cost data and Virginia's payment is set on a 2007 survey.

Time frames for adjustment of rates vary greatly by state. New Jersey adjusts its rates every three to four years and in New Hampshire rates are reviewed every two years. Other states have not adjusted their rates for many years.

Utah recently reduced its flat rate from $72.57 to $69.75 based on 2007 cost reports.

2.2 Tiered Payment Method

Tiered payment rates are used by 16 states. Tiers are set using various assessment tools or by assigning points based on the number or type of Instrumental Activities of Daily Living/Activities of Daily Living (IADL/ADL) assistance required by the resident. The assessments are generally done by case managers (a very small number of states require physician review or sign off). Tiered rates are resident specific and are paid either a daily rate or a monthly rate.

Some states base the tiers on the percentage of time the resident needs help with a minimum number of ADLs. A few states base the tiers on scores on both a number of ADLs and the resident's health status (acuity). Ohio assigns three levels of service and four categories of impairment; the payment is based on the highest level that the resident falls into.

Most states use three tier levels. Washington state has 17 levels of classification. Oregon uses five tiers but is looking at setting new rates at a percentage of the private market rate.

2.3 Other Payment Methods

Three states use a percentage of the states' nursing home reimbursement to pay assisted living homes. States that use this method set their percentages between 50% and 85%.

Some states fall between two types of payment. For example Mississippi bases its flat rate on case-mix adjusted rates paid to nursing homes while Nebraska uses a flat rate based on single/double occupancy and the rural or urban location of the home. Hawaii has a two tier system in which the rate varies by island.

Four states use a rate based on the plan of care (services are reimbursed individually for each resident). Montana has a basic service rate to which payment is added on for various ADLs and/or types of impairment.

Texas and Minnesota use a case-mix system. Texas bases its system on annual reports filed by providers and Minnesota's is a case-mix framework based on individual service packages.

2.4 New England State Payment Methods

Connecticut's rate is based on the number of units of service, both home health aid and nursing, that a resident requires on a weekly basis. There is a separate rate of $8.57 per day for CORE services that includes housekeeping, maintenance, security and laundry. Additional payments are made as follows:

- Occasional personal services: 1–3.75 hour per week-capped at $33.35 per day.
- Limited personal services: 4–8.75 hours per week-capped at $51.41 per day.
- Moderate personal services: 9–14.75 hours per week-capped at $67.49 per day.
- Extensive personal services: 15–25 hours per week- capped at $78.20 per day.

Maine has a complicated payment formula based on a combination of audited FYE 12/31/98 costs, peer group upper limits, and pass-through fixed costs. The rate for MaineCare beneficiaries is a base price adjusted by a case mix index determined by the Minimum Data Set-Assisted Living Services (MDS-ALS) assessment tool. The ALS rate is a $42 base price adjusted by the case mix resource group. The ALS rate is based on time studies.

Massachusetts has a flat rate of $40.33 a day effective April 1, 2008. The rate was based on 2006 direct care cost data submitted by providers. The payment includes two components, one for administrative costs and another for direct care. The service rate is based on the provision of two hours of personal care per day, case management, and nursing oversight (0.5 hours per day). The method includes a component for administration, calculated as 20% of the direct care costs. A cost adjustment factor is applied to account for differences between the base cost year and the rate years.

New Hampshire's flat rate in 2009 is $2,185 a month. This rate method is based on state statutes which state that every two years, the Department of Health and Human Services must review Medicaid payment rates in comparison with: Medicare rates, Medicaid rates in other New England states, reimbursement rates of managed care companies and other commercial payers, and actual provider costs.

Vermont's payments are based on a three-tiered system that was developed using the Enhanced Residential Care assessment tool, review of other state reimbursement systems, and other assessment data. Residents receive scores in five areas: ADLs, bladder and bowel control, cognitive and behavior status, medication administration, and special programs (behavior management, skin treatment, or rehabilitation/ restorative care). Residents are assigned to a level (1 or 2) based on the extent of ADL impairments. Individuals with scores of six to 18 are assigned to Level 1 and individuals with scores between 19 and 29 are assigned to Level 2. The four remaining areas are rated, and additional points are assigned.

2.5 Summary

The most successful payment methodologies appear to be combined or tiered methodologies individualized to the state's needs. DHS was developing a new acuity rating tool under the Global Waiver in January 2009. If a tiered payment method or combination payment method is decided on, this tool may be part of the solution.

Table 2.5.1 below shows a summary of payment methodologies by state.

Table 2.5.1
2009 State Specific Rate Methodology

State	Flat	Tiered	Other	Care Plan	Rate	Enhanced State SSI	SSI payment	Personal Needs Allowance
AK	■				Base rate x multiplier for rural/frontier area. Also varies for type of resident	Y	$ 932	$ 100
AZ			■		Negotiated based on level of care	N	$ 674	$ 101
AR		■			$57.64 - $69.40 daily	N	$ 674	$ 61
CA		■			$52 - $82 daily	Y	$ 1,075	$ 125
CO	■				$49.01 daily	N	$ 674	$ 101
CT			■		Units of service + daily fee	N	$ 674	$ 164
DE		■			$692 - $2,240 monthly	Y	$ 814	$ 122
DC	■				$60.00 daily	Y	$ 1,159	$ 100
FL	■				ALE $32.30 daily ACS $9.28 daily	Y	$ 752	$ 54
GA	■				$35.04 daily	N	$ 674	$ 95
HI			■		$24.98 - $73.73 daily	Y	$ 1,276	$ 50
ID		■			$125.30 - $225.54 monthly	N	$ 674	$ 90
IL			■		60% avg NF rate	N	$ 674	$ 90
IN		■			$66.55 - $80.93 daily	N	$ 674	$ 52
IA				■	Up to $1,117 monthly	N	$ 674	$ 90
KS				■	$3.38 - $3.73 per unit	N	$ 674	Unknown
LA		■			Not set yet	N	$ 674	Unknown
ME			■		Varies by type of residence	Y	$ 908	$ 70
MD		■			$42.65 - $71.72 daily	Y	$ 858	$ 68
MA	■				$40.33 daily	Y	$830 - 966	Unknown
MI	■				$192.38 monthly	Y	$ 768	$ 44
MN			■		$1,149 - $5,346 montly depending on case-mix category	Y	$ 832 - 853	Unknown
MS			■		Case-mix adj rate paid to NF converted to daily rate $33.18	N	$ 674	Unknown
MO		■			$37 - $53 daily	Y	$830 - 966	$ 30
MT			■		$717 monthly plus add-ons	Y	$ 768	$ 100
NE		■			$1,649 - $2,432 monthly based on single/double and rural/urban	N	$ 674	$ 60
NV		■			$20 - $60 daily	Y	$ 1,065	$ 110
NH	■				$2,185 monthly	Y	$ 735	$ 56
NJ	■				$50, $60, $70 by residence licensure	Y	$ 824	$ 100
NM	■				$49.99 daily	N	$ 674	Unknown
NY			■		50% of RUG	Y	$ 1,368	$ 178
NC		■			$17.50 - $51.25 daily	Y	$ 1,253	$ 65
ND				■	Point system used to convert unmet needs to a rate	N	$ 674	$ 60
OH		■			$49.98 - $69.98 daily	N	$ 674	$ 50
OK		■			$42.24 - $79.73 daily	Y	$ 607	$ 46
OR		■			$1,525.70 - $2,878.70 monthly	N	$ 674	$ 141
RI	■				$36.32 daily	Y	$ 1,232	$ 100
SC			■		$16.00 per one hour unit of personal care	Y	$ 1,100	$ 57
SD	■				$30.64 daily	N	$ 674	$ 60
TN			■		UCR capped at $1,100 monthly	N	$ 674	Unknown
TX			■		Case-mix rate ranging from $22.66 - $66.18 daiy	N	$ 674	$ 85
UT	■				$69.75 daily	N	$ 674	Unknown
VT		■			$35.26 - $103.69 daily	Y	$ 722	$ 60
VA	■				$50.00 daily	Y	$1,350 - 1,	$ 75
WA		■			$48.95 - $174.89 daily	N	$ 674	$ 61
WV			■		Difference between income and $1,123.23 monthly	N/A	$ 674	Unknown
WI			■		Cap of 85% of NF rate	Y	$ 854	$ 65
WY		■			$42 - $50 daily	N	$ 674	Unknown

3 Assisted Living Residences Tour

On July 12 and 13, 2010, Darrell Bullocks and Debra Stipcich of ACS, Inc., Government Healthcare Solutions, toured six residences with Lawrence Ross of DHS, Paula Lipsey and two employees from DEA. The residences were: Scandinavian Home in Cranston, St. Elizabeth and Capital Ridge in Providence, Villa at St. Antoine in North Smithfield, Autumn Villa in Cumberland and Blackstone in Central Falls. There was a wide diversity in the physical aspects of the various residences and the mixture of services offered.

3.1 Residents

- All assisted living homes told us that there are two types of residents who require higher levels of care not necessarily related to ADLs or diagnosis. The terminology below is that used by the staff to describe these residents to us. The terminology was fairly consistent across the residences.
  - "Wanderers" are residents who require constant observation so they do not get lost or wander into an unsafe area.
  - "Reminders" are residents who not only require constant reminders or cueing to do the tasks of daily living but most often also require staff to do such tasks as physically get into the shower with them to make sure they really do wash. These residents have the capacity to carry out the tasks but cannot do so without someone giving them direction every step of the way.
- "Acceptable" levels of dementia were defined for us by St. Elizabeth's as:
  - Behavior that has the potential to bother others.
  - At risk for wandering.
  - Ability to self preserve in an emergency (F2 licensure).
    - Two of the facilities we talked to required residents to be capable of self-preservation, the others were licensed as F1.
- Three residences only accepted waiver residents who had already been living in the home and due to a reversal in finances became eligible for the waiver program. They did not accept waiver recipients from the community nor from nursing facilities
  - Two of these facilities told us that when a resident became waiver eligible they gave them a choice of accepting shared living quarters or moving out.
- One residence participated in RI Housing financing. It had designated rooms for RIMFAC waiver recipients. All waiver recipients shared a room. They also had DEA recipients. All DEA recipients were in double rooms.
- One residence had only waiver residents and in another residence the majority of the residents were waiver with only a few private pay residents. All residents shared rooms in both of these homes.
- Many of the rooms in these homes had no bath or only a half bath with a shared shower room.
  - In one residence four residents shared one bath between two double rooms.
  - One facility told us that it allows family to supplement personal needs (i.e. cigarettes, hair dresser, cable, telephone, etc.).
  - One residence provided tissues and toilet paper and another residence also provided soap and shampoo.
  - Two homes told us they provided furniture unless the resident wished to provide his or her own bed.
  - Two homes allowed small pets.

3.2 Services

- Two residences had special wings for residents with dementia.
  - Capital Ridge has a special locked unit attached to its nursing facility. It does not normally have waiver residents in this unit; however they have made one exception as they did not wish to separate a married couple. The spouse had community assets and was a private pay resident.
  - Villa at St. Antoine has an open wing. Because of this it does not accept wanderers. It would accept a waiver recipient if that person was already a resident when they became waiver eligible.
- Some residences performed all housekeeping services for the resident. This included laundry and making the bed daily. Other residences encouraged the residents to do their own laundry (other than linens) and to make their own beds as part of their daily activities.
- Many homes have regularly scheduled transportation. Any transportation outside of the regular schedule is an additional charge.
  - Two homes told us they did not provide transportation at all as they could not afford to do so. Both of these homes provided us with a list of services in which it was clearly stated that transportation was not included, although they would call to arrange for it.
- One home told us that it did have a couple of residents that went out for adult day care for a short time. They told us that these residents had been receiving adult day care prior to moving into the home and they felt it would have been disruptive to the resident to discontinue.
- We were informed that there was a Safe Haven residence that catered to elder abuse victims. We were also told that there was a residence for sexual predators or sexually aggressive residents. We did not visit either one of these.
- Two homes told us that they had taken residents from nursing facilities. One had moved residents from its own nursing facility into the assisted living residence and the other one told us it had taken residents from area nursing facilities.
- One home considers cueing to be additional personal care and charges for the service. This home also charges additional fees for assistance with self managed incontinence. In addition, this home charges for escort services to meals and/or activities.
- Miscellaneous services:
  - One home offered exercise classes including an arthritis exercise program.
    - Another home offered Wellness and fitness programs.
  - Two homes offered a short-stay assisted living program designed for rehab recovery or caregiver respite.

3.3 Financial

- All homes were very open when asked about their charges, what services were included and what services were à la carte.
  - Below are examples of charges. The list is not all inclusive.

  - $5,740 per month plus à la carte items capped at an additional $900 per month. There is also an additional $900 second person fee for married couples.
  - $4,500 per month (not including medication and continence management) plus à la carte services up to an additional $65 per day.
  - $2,500 per month private room with a bath not including transportation.
  - $1,800 per month double room without a bath not including transportation.
  - Rates ranging from $1,800-$3,200 per month including a shared bath and not including transportation.
- Dementia units range as follows:
  - Locked unit is $5,400 per month per person.
  - Open unit ranges from $9,440 for two people in a two bedroom unit, $8,000 for two people in a studio unit to $5,100 for one person in the smallest studio units. We were told that this charge covers the cost of the staff plus the margin (did not give us that figure).
- Most homes require a one time fee upon move in. Some require a security deposit.
  - One residence charges a one time fee of $1,800 and a security deposit of $1,500.
- All homes accept private payment and VA.
  - Most state in their brochures that they will accept PACE or Medicaid Waiver for dual occupancy only.
- Three homes told us their "breakeven" costs ranged from $2,300 to $2,700 per month.
  - RIALA tells us a cost gathering survey by them shows the cost of providing services to be between $3,105 and $3,493 per month.

4 Assisted Living Payment

4.1 Budgets and Rate Setting

There is not a separate budget line for assisted living services.

- The budget should not be less than the allowed amount for SFY 2009
- Since the purpose of the waiver is to provide services in a home setting at less cost than those in a nursing facility, the upper payment limit or ceiling would be the average daily rate paid for nursing facilities. This amount is $181 per day for 2010.
- We will keep in mind the adult day care rate which is $52.98 per day.

- The structure of payments and rates should be such that it would enable wider access of waiver recipients to assisted living home settings.
- The rate should be viable enough that it would encourage assisted living homes to draw residents from the nursing facility setting.

4.2 Assessment Tools

Many of the best payment methodologies for assisted living are based on an assessment of the recipients ADLs, diagnosis, acuity levels or a combination or all three. The assisted living residences in Rhode Island currently use three different tools depending on the payment source of the resident.

- RI Housing requires use of Appendix C of MDC.
- DEA uses UCAT.
- DHA uses a form called CMA.

DEA and DHS have developed an assessment tool to use for simulation purposes.

4.3 MMIS and InRhodes Potential Issues

Should a tiered and/or acuity payment method be selected by the state, DHS/DEA will need to determine how the recipient's level or tier is entered into the MMIS system. That may have to be done through the eligibility system. InRhodes is Rhode Island's eligibility system. The contractor who runs this system is different than the contractor who runs MMIS (HP).

In addition it has not yet been determined if the MMIS system has the capability to make recipient level payments or add-on payments at the provider level.

In the review of the analytical dataset, it was discovered that in addition to payments for assisted living providers, payments for attendant care, non-emergency transportation and housekeeper services were paid. All three claim types are CMS 1500's but there does not appear to be duplicate or bundled service edits in place for services that are to be included in the assisted living fee.

Unlike inpatient hospital claims, assisted living providers are paid for the date of discharge. In some cases the assisted living provider was paid for the date of discharge while a nursing facility was paid for the admit date, which were the same day. Since these are two different claim types there are no edits in place to check for duplicate payments.

4.4 Project Schedule

Based on new information received during the tour and issues identified above, the schedule below outlines the project timeline and responsible parties.

Project Schedule			
Deliverable	**Due Date**	**Responsible Party**	**Decision**
ACS received data download	14-Jun-10	ACS	Completed
Summary of analytical dataset to DHS	23-Jun-10	ACS	Completed
DHS approves analytical summary	30-Jun-10	DHS	Completed
Report on Best Practices in Medicaid Purchasing and Payment Rate Comparison	9-Jul-10	ACS	Completed
Meet with workgroup in RI and tour AL facilities	July 12-13, 2010	ACS/DHS/DEA	Completed
ACS deliver 1st draft of Evaluation of Payment Method for AL	6-Aug-10	ACS	Completed
ACS, DHS and DEA finalize temporary assessment tool	13-Aug-10	ACS/DHS/DEA	Completed
WebEx meeting with DHS and workgroup	17-Aug-10	ACS/DHS/DEA	Completed
DHS approves first draft of Evaluation of Payment Method for AL	23-Aug-10	DHS	Completed
DHS/DEA delivers results of completed assessment tools to ACS	3-Sep-10	DHS/DEA	Completed October 18, 2010
ACS delivers 2nd draft of Evaluation of Payment Method for AL and 1st simulations	6-Dec-10	ACS	Completed
Meeting in RI with DHS and workgroup	16-Dec-10	ACS/DHS/DEA	Completed
DHS approves 2nd draft of Evaluation of Payment Method for AL and 1st simulations	16-Dec-10	DHS	Completed
ACS deliver final document Evaluation of Payment Method for AL	15-Jun-11	ACS	Completed
DHS approves final document Evaluation of Payment Method for AL	24-June-11	DHS	Completed

5 Criteria Used in Recommending Payment Policy

As a guide to making payment policy recommendations, we propose to use the following criteria.

- ***Access and Acuity***: In practice, this means paying more for patients who need more care and less for patients who need less care. If payment is too low for residents requiring higher levels of care (such as residents with dementia), then providers are penalized for accepting those residents and will seek to avoid them, especially over time as decisions are made about capital spending and what services to offer. If payment is too high for low-acuity patients, or patients with few ADLs, the impact is exactly the opposite.
- ***Fairness:*** Fairness is simply defined as paying similarly for similar care.
- ***Purchasing Clarity:*** Purchasers should know what they're buying—such as what services and ADLs each recipient is receiving. A central problem with the current payment method is that it provides no clarity about purchasing.
- ***Quality:*** Very few payment methods specifically reward quality care; indeed, many methods can reward poor quality. Although pay-for-quality initiatives are not the focus of this project, the design of the payment method should facilitate quality measurement and incentives where possible.
- ***Control Over Spending:*** Any organization needs to have control over its own spending. The current method gives the state a certain amount of control over spending in the coming year but it does not give the state control over what it is purchasing. The current payment method has no mechanism that the state can use to target funds at specific areas where there may be access problems.
- ***Administrative Ease:*** A flat rate is administratively simple for the state. Going to a tiered rate would require the state to complete a score sheet on each recipient. The recipient would need to be rescored and the tier possibly adjusted within MMIS each time their assessment changed. With add-on payments the state would have the burden of determining if a provider still met the criterion. Tiered and add-on payments also add complexity to MMIS systems.
- ***Simplicity:*** As modern health care strains the boundaries of human comprehension, simplicity is a virtue all by itself. It has also been true in the past that some payment methods were so complex that providers could not figure out the incentives even if they wanted to. That said none of the alternatives is simple.
- ***Data Integrity:*** All payment methods depend on incoming data, and all data have issues. Ideally, data used to calculate payment should be specific, verifiable, relevant and consistently defined. In order to bring consistency to a tiered payment method, the state would need to use one assessment tool and one score sheet that would leave little room for interpretation.

6 Payment Method Options

Because new payment methods at times involve legislative changes, state plan changes or waiver changes history shows that new payment methods are often in place for 10, 15 or even more years.

While it is important to keep the design of the payment method as simple as possible since added complexity could increase costs for both providers and the MMIS claims processing system and could increase the administrative burden of the providers and the state, the payment method must also meet the goals of the state.

6.1 Option 1 — Flat Rate Plus

A flat per diem rate would continue to be paid for each full day of service provided to a resident. A provider specific add-on payment would be added to each claim at the end of adjudication for those providers meeting criteria for enhanced services. Examples of this are:

- The provider accepted at least one Medicaid resident from the community as opposed to accepting Medicaid residents only if they had previously been private pay.).
- At least thirty-five percent of the residents are from either or both RIMFHC or DEA waivers.
- The provider has at least one resident admitted from a nursing home (this would need to be qualified that this was not a resident who went back and forth between an assisted living residence and a nursing home on the same campus or owned by the same company.).

The provider would be required to contact the state and to offer evidence that it had met the criteria for the add-on payment. The provider would only receive one additional payment per claim even if they met all three of the criteria. The provider should notify the state when it no longer meets the criteria. It would behoove the state to review the status on a regular basis.

The provider would receive this extra payment for each recipient in the residence not just the individuals meeting the criteria. This payment method would also allow the state the option of making a different add-on payment for each separate criterion.

The advantage of this payment method is that this option would require minimal changes to the state's MMIS system and would not require an assessment and score sheet. The disadvantages on the provider's side are it could require providers to change from billing on a CMS 1500 to a UB04. A flat per diem rate would continue to be paid for each full day of

service provided to a resident. A provider specific add-on payment would be added to each claim at the end of adjudication for those providers meeting criteria for enhanced services. Claims must be billed monthly (for a full month) except in cases of partial eligibility. The big disadvantage for the state is that it discourages more acute residents and encourages acceptance of less acute residents.

6.2 Option 2 — Tiered Acuity

For this payment option residents would be assessed into tiers based on ADLs requiring personal service. Each level would receive a score. Examples are shown below:

- Level 1 – occasional personal services 0.5-5 hours per week could receive a score of 5.
- Level 2 – limited personal services 5.5-9 hours per week could receive a score of 10.
- Level 3 – moderate personal services 9.5-15 hours per week could receive a score of 15.
- Level 4 – extensive personal services 15.5 plus hours per week could receive a score of 20.

Scores could also be assigned based on a patient's acuity or other conditions that affect the level of care required. The following are examples:

- Management of decubitus ulcers, wound care or other widespread skin diseases, score of 5.
- Requires high levels of cueing and cannot self evacuate in case of emergency, score of 10.
- Conditions requiring respiratory therapy and supplemental oxygen score of 15.
- Unable to self manage ostomy or incontinence, score of 20.
- Organic brain damage, dementia or spinal core injury, score of 30.

The per diem payment would be based on the resident's scores with lowest payment for the lowest score and higher payment for the highest score. For example:

- A total score of 5 would receive the base per diem rate.
- A total score of 6-20 would receive a per diem payment of base + 25 %
- A total score of 21-40 would receive a per diem payment of base + 45 %
- A total score of 41 and above would receive a per diem payment of base + 55 %

The levels shown above are just examples. Percentages could be adjusted based on budget or to meet other requirements.

The disadvantage to this payment option is that it requires changes to the state's MMIS and/or InRhodes system. Another disadvantage is it would require an assessment tool to be completed by caseworkers or social workers and to be scored by either the caseworkers or social workers or state personnel. One of the advantages would be that the state would have more clarity over the services it was purchasing.

6.3 Option 3 — Tiered Acuity Plus

This payment method option would combine aspects of both option 1 and option 2. Residents would be assessed and scored to fall into levels as shown in option 2 above. In addition, providers could receive add-on payments based on the criteria in option 1.

Resident levels and add-on amounts would be adjusted based on budget and any other state requirements.

This is the most complicated of the three options. This option would have the disadvantages of options 1 and 2 as far as changes to MMIS and/or InRhodes. It would also require someone to complete the score sheets and would require someone from the state to verify on a regular basis that the providers met the criteria for the enhanced add-on payments.

The principal advantage to this payment option is the control it gives the state. This payment option meets the states needs to increase access, provide clarity of purchasing and may allow the state to provide payment for quality in the future once measurements can be defined.

6.4 Recommendation

Below is a scorecard which grades the current method and the three options shown above based on the criteria shown in section 5.

Scorecard Recommendation				
Scorecard	**Current Payment Method**	**Option 1**	**Option 2**	**Option 3**
Access and Acuity	D	C	B	A
Fairness	B	B	B	B
Purchasing Clarity	C	C	B	A
Quality	D	D	D	D
Control Over Spending	C	C	B	B
Administrative Ease	B	B	C	C
Simplicity	B	B	C	C
Data Integrity	B	B	C	C

One benefit of designing a payment method expected to be in place for many years is that the structure itself should accommodate a wide range of payment policy choices. For example, we propose a structure that accommodates recipient level reimbursement. That means that the state may base payment on an individual's level of need or acuity. In the current MMIS environment this may be accomplished by assigning separate eligibility codes through the InRhodes system and a different rate in the MMIS plan of benefits for separate eligibility codes or it could be accomplished through the use of state assigned modifiers that have different fee multipliers. Either method will require a system change. Another example that we propose is functionality to allow provider-specific "add-on" payments on each claim that

are separate from the basic payment. This field could be used to make "bonus" or incentive payments for access, disproportionate share of waiver residents, pay-for-quality incentives, or for other purposes. If such add-on payments are needed, then the functionality is there. If add-on payments are not needed, then the data field is simply filled with zeroes. The current MMIS system was set up to allow add-on payments for UB04 hospital billers.

Currently assisted living claims are billed on CMS 1500s in Rhode Island. In the 2011 UB04 manual there is a type of bill code '086X' for Residential Facility. Since assisted living is generally paid through a HCBS waiver these are not considered 'healthcare' services so they could be billed on any transaction (or paper form). However, it makes sense to use the UB04 and to use this bill type since it exists. In addition use of the UB04 form would allow the state to edit claims that "double-bill" that is claims that are billed for the same last date in an assisted living resident and the same first date of service in a nursing home or visa versa. There is no binding national requirement to bill these services in any specific manner via paper and if they're not truly healthcare services then there's no national requirement for electronic billing either.

7 Analytic Dataset

The analytical dataset summarized in this report will serve as the basis for subsequent analysis.

The analytical dataset is based on MMIS claims (final adjusted claims and original claims never adjusted) with first dates of service between July 1, 2008 and June 30, 2009 and with a paid date through September 2009. The dataset excludes Medicare crossovers and the Enhanced SSI population. It does include minimal data for payments made to assisted living homes outside of the MMIS.

Throughout this document, we use allowed charge or the allowed amount versus paid amount. The allowed amount is the payment amount "allowed" for a service by the payer. If the patient or a third party (other than Medicare) is liable for some part of the allowed amount, then the actual Medicaid reimbursement to the provider equals the allowed amount minus patient cost-sharing minus third party liability and incurment. Because patient cost-sharing and third party amounts can vary greatly from claim to claim, allowed amount is used when designing a new payment methodology because it is the payment set for the service.

The dataset is divided into four sections. The data is only for residents that were in homes reimbursed in the MMIS system. We did not receive individual resident identification for those whose stays were reimbursed outside of the MMIS system. The first set of tables relates to assisted living homes only. The second set of tables shows fee-for-service (FFS) payments for residents in assisted living homes. The third set of tables details claims reimbursed through Rhody Health Partners (RHP) for people living in assisted living homes. Only a small number of residents were enrolled in RHP in 2009 so the majority of their claims were paid through FFS. Finally, we have supplied charts that drill down into the details of several high-cost provider categories and high-cost diagnosis categories.

Only a small number of residents were enrolled in RHP in 2009 so the majority of their claims were paid through FFS. Finally, we have supplied charts that drill down into the details of several high-cost provider categories and high-cost diagnosis categories.

Table 7.0, found in Appendix A, shows the official ICD-9-CM diagnosis categories we use.

7.1 Assisted Living

In FY 2009, Medicaid paid for 235 people to live in assisted living homes. While this group appears to be fairly stable, there were 52 who went into and out of nursing facilities. Of these, 38 went from assisted living to nursing facility, seven had one nursing facility stay and went back to assisted living, four had two nursing home stays and remained in the nursing facility at the end of FY 2009, and three had two nursing home stays and returned to assisted living.

Table 7.1.1, found in Appendix A, shows utilization and payment data by home. Three homes—Bristol, St. Elizabeth and Forest Farm—account for three-quarters of utilization. As expected, the homes bill one month at a time, showing days in the "units" field, with the allowed amount per unit working out to the Medicaid fee of $36.32 per day or about $1,090 per month. Actual reimbursement to the homes was $2,164,272, or 96% of the allowed amount, with the difference being small amounts of patient liability (likely related to incurment).

From Table 7.1.1, it is clear that the homes charge Medicaid the Medicaid fee. Hospitals and some other provider types, by contrast, have a single set of charges for all payers regardless of what payment is expected. The only consequence of the homes' charging practices is that the pay-to-charge ratio of 100% is essentially meaningless, and we will not refer to it again.

Table 7.1.2, found in Appendix A, shows characteristics of the assisted living population at each home. In the top three homes by utilization, the Medicaid residents are almost exclusively age 65 years and older. Overall, it is fair to say that seniors make up the bulk of the population, albeit with a few younger residents who presumably need assistance due to disability.

Table 7.1.3, found in Appendix A, shows certain payments to assisted living homes that were made outside the MMIS in FY 2009. In this table, we show the "paid" or reimbursed amount rather than the allowed amount, since only the paid amount is available for the non-MMIS claims.

As noted earlier, Bristol, St. Elizabeth and Forest Farm represent three-quarters of assisted living payments made through the MMIS. Several other homes, however, receive a large part of their payments outside the MMIS. We expect to receive further information on these payments from the State.

7.2 Other Fee for Service Claims

All tables in this section show services reimbursed under fee-for-service Medicaid while the recipient was in an assisted living home. There may have been other claims incurred by the recipient during FY 2009 while the recipient was residing elsewhere. Those claims are not included here.

Please note that all tables referred to in this section are in the appendix of this document. Tables for this section appear in Appendix A.

Tables 7.2.1 Appendix A and 7.2.2 Appendix A, provide FFS claim information by category of service and by the site of the service as indicated on the claim. Several categories of service are broken out into further detail in Section 5.

In Table 7.2.1 Appendix A, it appears that almost all Medicaid residents in assisted living homes receive targeted case management for mental health issues.

In Table 7.2.2 Appendix A, there are a few anomalous place of services values—like skilled nursing facility—but we suspect that these reflect imprecise billing by provider staff who may not know the difference between an assisted living home and other types of care.

Claim and resident counts vary due to the fact that in some categories residents may have several different types of claims during the year or more than one claim for a specific type of service or diagnosis. For example, pharmacy claims have no diagnosis or one claim for a resident may have multiple lines with a different category of service assigned to each line on the claim. Financial totals, however, are always the same.

Table 7.2.3 Appendix A, details the diagnosis information on the FFS claims. Only principal diagnosis was used, although we would expect many people in assisted living homes to have significant secondary diagnoses as well. Additional detail for several diagnosis categories is shown is Section 5.

Table 7.2.4 Appendix A, shows utilization and payments by state aid categories.

7.3 RHP Managed Care Claims

The tables shown in 7.3 Appendix A are for services reimbursed under Rhody Health Partners while the recipient was in an assisted living home. There may have been other claims incurred by the recipient during 2009 while the recipient was residing elsewhere. Those claims are not included here.

Pharmacy claims have not been included in these tables as minimal data was received.[4] These tables also show paid amounts instead of allowed amounts because fields for billed charges and allowed amounts were not received for all provider types.

7.4 Detailed Information

This chart in 7.4 Appendix A provides a more detailed analysis of some of the information in Section 7.3. The first set of charts provides further details of other FFS claims by provider type. We have broken down claims for mental health clinics, durable medical equipment and ambulance provider by procedure codes. The next set of charts breaks out the top diagnostic categories by individual diagnosis.

8 FY 2010 Dataset

This section contains updated statistics for the 2010 analytical dataset. The analytical dataset is based on MMIS claims (final adjusted claims and original claims never adjusted) with first dates of service between July 1, 2009 and April 2010 and with a paid date through June 30, 2010. The dataset excludes Medicare crossovers and the Enhanced SSI population.

Throughout this document, we use allowed charge or the allowed amount versus paid amount. The allowed amount is the payment amount "allowed" for a service by the payer. If the patient or a third party (other than Medicare) is liable for some part of the allowed amount, then the actual Medicaid reimbursement to the provider equals the allowed amount minus patient cost-sharing minus third party liability and incurrent. Because patient and third party amounts can vary greatly from claim to claim, allowed amount is used when designing a new payment methodology because it is the payment set for the service.

Effective September 1, 2009, claims for both DEA and DHS waiver services are processed through the Rhode Island (RI) Medicaid Management Information System (MMIS). This is a change from the 2009 analytical dataset analysis where payments for DEA waiver services were paid outside of the MMIS. Between July 1, 2009 and August 31, 2009 approximately $719,551 were paid outside the MMIS.

The breakdown of the 2010 analytical dataset is shown in the tables located in Appendix B of this document. We have chosen to highlight two major categories of RI Assisted Living resident claim payments to include waiver claim payments and fee for service claim payments.

8.1 Assisted Living

From July 2009 to April 2010 RI Medicaid facilitated access to assisted living services for 500 individuals at a cost of $4.3 million. As noted in the 2009 analytic dataset, assisted living and nursing home stays often intersect. During the FY 2010 data collection period, 105 or 21% of assisted living residents had a nursing home stay. The claim data shows that of the 105 individuals that had a nursing home stay, 43% went from assisted living into nursing home care and remained in the nursing home; 10% received care in the nursing home setting and returned to assisted living; and the remaining 47% had stays that began in the nursing home setting with a transition to assisted living where they either remained or transitioned back to the nursing home.

Tables 8.1.1 Appendix B through 8.3.5 Appendix B of this document summarizes our findings relative to the FY 2010 assisted living dataset. We summarize the data highlighting payments for DEA and DHS waiver residents and Medicaid expenditures for their assisted living and fee for service stays.

Please note that as of September 1, 2009, RI Medicaid began to process both DEA and DHS waiver services through the Medicaid Management Information System. As a result, the total

allowed amount shown in the tables for this section is $3.6 million dollars which does not include $719,551 in DEA payments that were paid outside the MMIS between July 1, 2009 and August 31, 2009. In addition, we had a complete years worth of data for the FY 2009 study whereas our data collection period for FY 2010 is for ten months; from July 1, 2009 to April 30, 2010. We estimate total payments for FY 2010 to be in the neighborhood of $5 million.

Table 8.1 Appendix B shows total payments made during the collection period both inside and outside of the MMIS.

Table 8.1.2 Appendix B shows total payments to the assisted living homes during our data collection period. The facilities are ranked by total allowed amount. In 2009 we had little to no information regarding charges and units for the services that were paid outside of the MMIS. Given the September 1, 2009 change to process DEA waiver services through the MMIS, we now have a more accurate picture of total payments.

Please note that the total payment per day amount is $36.32 for most of the facilities shown in the chart. That per diem amount was increased to $42.16 subsequent to the FY 2010 data collection period.

Table 8.1.3 Appendix B shows facility payments for DEA and DHS residents and the total DEA and DHS census for each facility. This table does not include DEA payments of $719,555 that were made outside the MMIS between July 1, 2009 and August 31, 2009

The FY 2010 RI assisted living census shown in table 8.1.4 Appendix B indicates that the total unique resident count in the FY 2010 dataset is 500. In addition, we see that the average daily census for all assisted living facilities is 327 and the average monthly census is 363. Note that residents are transferred to hospitals and into and out of nursing homes frequently. As a result, the average daily census only reflects the days which the resident was actually in the Assisted Living residence which can vary depending on their need for services outside the facility such as inpatient hospital care. However, if the resident is in a facility for any day in a given month, they would be included in the average monthly census totals. We also see the average age in the FY 2010 dataset is 82. The age range for this data collection period is 47 to 102.

Table 7.1.2 Appendix A of this document, contains the 2009 census. In 2009, the unique census was 235 (DHS only). In addition 186 DEA residents were paid outside the MMIS. The average monthly census in 2009 was 180 excluding the 186 DEA residents. In 2009 the average resident age was 85; the age range in 2009 was 85 to 101.

Table 8.1.5 Appendix B illustrates payments by aid category for DEA and DHS residents. Total payment exceeds 3.6 million dollars. The top five aid categories ranked by total allowed amount represent over 98 % of expenditures. The top five aid categories are:

- Cat Needy Cash Assist / Aged
- Cat Needy Home Comm Base Svc / Aged
- Cat Needy Cash Assist / Disabled
- Med Needy Individual / Aged
- Cat Needy Home Comm. Base Svc / Disabled

8.2 Fee for Service Claims

The tables in this section represent services reimbursed under a fee-for-service (FFS) methodology while the recipient was a resident in an assisted living home.

Table 8.2.1 Appendix B shows 2010 payments for assisted living residents who received a service in a category outside of the assisted living structure to include MH Clinic, inpatient, ambulance and pharmacy services to mention a few. Here we see that the top five categories represent more than 75% of total RI Medicaid expenditures. Total expenditures exceed $2.1 million. The top five service categories include:

- MH Clinic
- Ambulance
- Inpatient
- Prescribed Drugs
- DME Other

Table 8.2.2 Appendix B summarizes FFS payments by diagnosis category. Here we see that the top diagnosis categories represent over 85% of total expenditures. Total expenditures exceed $2.1 million. The top five categories include:

- Mental disorders
- Signs & symptoms
- Visit Codes
- Neoplasm
- Musculoskeletal

*Please note that we did not include payments for pharmacy claims in this chart. Pharmacy claims do not contain diagnosis codes. The total for the pharmacy claims is $394,970.

For comparison purposes, please consider table 7.2.3 Appendix A. This table is from the 2009 data analysis and shows the 2009 diagnosis categories ranked by total allowed amount. We do see a shift in diagnosis categories from 2009 to 2010. We also see disproportionate DHS expenditures for the 2010 respiratory disorder diagnoses category as compared to 2009. In 2009 the top five inpatient stays for respiratory disorders in terms of allowed amount, ranged from $1,397 to $108,059 for DHS residents. In 2010, the range was $573 to $5290. Essentially, the data suggests that residents suffered significantly less from respiratory disorders in 2010.

Table 8.2.3 represents total payments by aid category relative to FFS stays in the FY 2010 dataset. Total payments exceed $2.1 million. The top five aid categories represent over 92% of total expenditures. The top five categories ranked by allowed are:

- Cat Needy Cash Assist / Disabled
- Cat Needy Cash Assist / Aged
- Cat Needy Home Comm Base Svc / Aged
- Cat Needy Medical Asst Eligible / Aged
- Cat Needy No Cash Assist / Disabled Adult

8.3 Detailed Information

This section provides greater detail relative to the Fee for Service (FFS) category data shown in table 8.2.1 Appendix B and the FFS diagnosis category summary data shown in table 8.2.2 Appendix B. We provide detailed information for procedure code utilization for the MH Clinic, Ambulance, and DME categories of service in the FY 2010 dataset. We also provide detail line information relative to diagnosis code utilization for Mental Disorders and Signs and Symptoms as shown in table 8.2.2 Appendix B. More details for any of the tables in this document can be provided upon request. We also show expenditures by waiver type, DEA or DHS in the 2010 tables.

Table 8.3.1 Appendix B contains the detail line procedure code information for the Mental Health Clinic category of service. Total expenditures to Mental Health Clinics for services they provided to assisted living residents in FY 2010 during the data collection period were $418,237. The top five procedures account for 97% of payments. The top five procedures include the following:

- H0040 Assertive Community Treatment Program, Per Diem
- H0036 Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes
- X0341 Local Code
- H2017 Psychosocial Rehabilitation Services, Per 15 Minutes
- H2011 Crisis Intervention Service, Per 15 Minutes

In 2010 DEA expenditures account for 71% of the total expenditure. DHS residents account for 21% of the total expenditure.

Table 7.4.1Appendix A shows the top five Mental Health procedure codes for 2009. Total DHS expenditures in FY 2009 were $161,473.

Table 8.3.2 Appendix B contains detail line procedure code information for the Ambulance category of service shown in table 8.2.1 Appendix B. The total expenditure for this category of service is $346,607. Two procedure codes account for 97% of expenditures in this category of service to include:

- A0130 Non-Emergency Transportation: Wheel-Chair Van
- A0425 Ground Mileage, Per Statute Mile

In 2010, DEA expenditures account for 64% of total expenditures and DHS account for 36%. In FY 2009 A0130 and A0425 accounted for 98% of total expenditures also. See table 8.3.2A Appendix B.

Table 8.3.3 Appendix B shows the line item procedure detail for the DME category of service (COS) expenditures. The total expenditure for this COS is $252,126 in the 2010 ten month data collection period. Disposable diapers and pads account for 92% of expenditures in this category. DEA resident expenditures account for 82% of total expenditures at $206,322 while DEA residents account for 18% of total DME expenditures at $45,804.

Total Expenditures in 2009 for DHS residents were $59,059. See table 7.4.2 in Appendix A of this document.

Table 8.3.4 Appendix B shows detail diagnoses utilization for the mental disorders diagnosis category listed in chart table 8.2.2 Appendix B. Here we see that the total expenditure for the mental disorder category is $678.599. DEA residents account for 69% of expenditures while DHS residents account for 30% of expenditures in our ten month data collection period. The top five diagnoses for assisted living residents account for more than 88% of total expenditures. Ranked by allowed amount, the top five diagnosis categories are as follows:

- Schizophrenic Disorders
- Episodic Mood Disorders
- Anxiety
- Nonorganic Psychoses
- Dementia

Table 7.4.4 Appendix A shows the FY 2009 expenditure by Mental Health Diagnoses for DHS residents.

Table 8.3.5 Appendix B shows the detail for the Signs and Symptoms category of service found in table 8.2.2 Appendix B. Expenditures for the Signs and Symptoms DX category equal $294,177 for a ten month period. The top five diagnoses account for 95% of total expenditures. The top five diagnoses relate to the following:

- Urinary System
- Musculoskeletal Systems
- Unknown Causes Of Morbidity And Mortality
- Respiratory System
- General Symptoms

DEA residents accounted for 76% of the total expenditure while DHS residents accounted for 24% of the total expenditure during our ten month data collection period.

Table 7.4.6 Appendix A shows the detail for FY 2009 signs and symptoms.

8.4 Summary

The FY 2010 dataset is the most comprehensive dataset we have reviewed to date. By comprehensive, we mean that it contains detailed data for both DEA and DHS claim services. Overwhelmingly, the data shows that DEA residents are significantly more expensive as compared to their DHS counterparts. The 2010 data yields the following insights:

1. The top five facilities account for more than 48% of Medicaid expenditures. The top five facilities ranked by total MMIS payment are as follows:
    a. Bristol
    b. Saint Elizabeth
    c. Summer Villa
    d. Autumn Villa
    e. Forest Farm
2. The age range for RI assisted living residents is between 47 and 102. The average age in this population is 82.

3. The average daily census for all RI Assisted Living Facilities is 323 residents. The average monthly census is 363.

4. RI assisted living residents generated $2.1 million dollars in FFS expenditures. The most common physical health diagnoses include defects of the Urinary, Musculoskeletal and Respiratory systems. The most common mental health disorders include Schizophrenia, Mood and Anxiety and Psychoses disorders. This population has significant ambulance transport and DME diapers and pad utilization.

5. DEA residents are more resource intensive when compared to their DHS counterparts.

9 Simulations

The genesis of a new payment method entails an assessment and a payment simulation. This section is devoted to the Rhode Island Assisted Living payment simulation. In order to aid the payment simulation development process, officials within the Rhode Island Medicaid organization, DHS and DEA, developed an assessment tool. The purpose of the assessment tool was to group residents into tiers based on the level of care required by the resident with the activities of their daily living.

A three tier approach was used with score ranges as follows:

- 0 to 10 equaling Tier I,
- 11 to 16 equaling Tier II
- 17 and above Tier III.

A case sample size of 53 residents were taken and scored. Of these residents, 22 (42% of the total), were scored at Tier I, 19 (36% of the total), scored at Tier II and 12 (23% of the total), scored at Tier III.

The average monthly census DEA and DHS and was 363 for 2010. For the simulations it was decided by DHS to use the average monthly DHS/DEA census for the months of July, August and September 2010, which are 369 residents.

As of July 1, 2010 the assisted living daily rate is $42.16. Using an average monthly census of 369, the estimated annual expenditures would be $5,786,038.40.

9.1 Simulation 1- Adult Day Care Rate

This simulation sets one daily rate for all residents at the current Adult Day Care rate which is $52.98 per day. Here we see that total expenditures under this approach are $7.2 million.

Table 9.1 Assisted Living Rate Equals Adult Day Care Rate								
Avg Monthly Census	Current Assisted Living Rate	Adult Day Care Rate	Current Monthly Rate	Proposed Monthly Rate	Difference Between Monthly Rate	Estimated Current Expenditures	Proposed Expeditures	Annual Difference Between Current and Proposed
376	**$42.16**	**$52.98**	**$1,282.37**	**$1,611.48**	**$329.11**	**$ 5,786,038**	**$ 7,270,975**	**$ 1,484,937**

9.2 Simulation 2- Tiered Rates

The following simulations use a three tiered method. The lowest rate used in all three simulations is no less than the current rate of $42.16.

Simulation 9.2A uses a highest rate equal to the adult day care rate and a Tier II rate calculated at the midpoint between the lowest rate and the highest rate.

Table 9.2A Highest Tier Rate Not to Exceed Adult Day Care Rate						
	% of Sample Cases	# of Residents	Daily Rates	Estimated Expenditures	Proposed Monthly Rate	Difference Between Current Monthly Rate and Proposed
Tier I=Current rate	42%	156	$ 42.16	$ 2,401,752	$ 1,282.37	$ -
Tier II = Mid point	36%	135	$ 47.56	$ 2,339,916	$ 1,446.62	$ 164.25
Tier III = ADC rate	23%	85	$ 52.96	$ 1,645,637	$ 1,610.87	$ 328.50
Totals	**100%**	**376**		**$ 6,387,305**		
Annual Difference Between Current and Proposed				**$ 601,267**		

For simulation 9.2B data from other states using a three tier method was used to calculate the difference in payment between the three tiers. On average Tier II was 38 % higher than Tier I and Tier III was 86 % higher than Tier III.

Table 9.2B National average difference between tiers in states using three levels						
	% of Sample Cases	# of Residents	Daily Rates	Estimated Expenditures	Proposed Monthly payment	Difference Between Current Monthly Rate and Proposed
Tier I=Current rate	42%	156	$42.16	$ 2,401,751.79	$1,282.37	$ -
Tier II = 38% higher than Tier I	36%	135	$58.34	$ 2,870,263.04	$1,774.50	$ 492.13
Tier III = 86% higher than Tier II	23%	85	$78.51	$ 2,439,505.58	$2,387.96	$ 1,105.59
Totals	**100%**	**376**		**$ 7,711,520.41**		
Annual Difference Between Current and Proposed				**$ 1,925,482**		

Simulation 9.2C calculates daily rates based on a total expenditure amount that would not exceed the amount in simulation 1.

Table 9.2C Expenditure Not To Exceed $7,270,975.20						
	% of Sample Cases	# of Residents	Daily Rates	Estimated Expenditures	Proposed Monthly payment	Difference Between Current Monthly Rate and Proposed
Tier I= current rate	42%	156	$ 42.16	$ 2,401,752	$ 1,282.37	$ -
Tier II = Mid point	36%	135	$ 55.50	$ 2,730,312	$ 1,687.97	$ 405.61
Tier III = highest rate	23%	85	$ 68.83	$ 2,138,769	$ 2,093.58	$ 811.21
Totals	**100%**	**376**		**$ 7,270,833**		
Annual Difference Between Current and Proposed				**$ 1,484,794**		

9.3 Simulation 3- Tiered Rates Plus

DHS and DEA requested a payment option that would allow them to encourage providers to accept residents from a nursing facility. The assumption was made that a resident coming from a nursing facility would likely fall into the high end of a Tier III assessment and costs would be greater for at least the first month in the assisted living residence. It was determined that a "bonus" payment should be made for the first 30 days of a new resident placed from a nursing facility. This would not apply to residents who go back and forth between a nursing facility and assisted living. The payment needed to be appropriate enough to encourage access and to help defray the additional costs of the first months stay. Additional payment of $500 for the first 30 days was used in the following simulations.

During the FY 2010 data collection period, 105 or 21% of assisted living residents had a nursing home stay. The claim data shows that of the 105 individuals that had a nursing home stay, 43% went from assisted living into nursing home care and remained in the nursing home; 10% received care in the nursing home setting and returned to assisted living; and the remaining 47% had stays that began in the nursing home setting with a transition to assisted living where they either remained or transitioned back to the nursing home. For simulation purposes 47% of 105 (49 residents) was used to calculate bonus payments.

A bonus payment was applied to the three simulations shown in 9.2.

Simulation 9.3A uses a Tier III rate equal to the adult day care rate and a Tier II rate calculated at the midpoint between the lowest rate and the highest rate. It calculates an additional $500 payment for the first 30 days for 49 residents placed from a nursing facility into assisted living. This would in essence make a Tier IV level of payment for those residents for their first 30 days. After the first month the payment for these residents would revert back to Tier III or their assessed level if different.

Table 9.3A Highest Tier Rate Not to Exceed Adult Day Care Rate Plus $500 Bonus								
	% of Sample Cases	# of Residents	Daily Rates	Estimated Expenditures	Proposed Monthly payment	1st Month Payment Plus Bonus	Difference Between Current Monthly Rate and Proposed	Total Bonus payments
Tier I = Current rate	42%	156	$42.16	$ 2,401,752	$1,282.37		$0.00	
Tier II = Mid point	36%	135	$47.56	$ 2,339,916	$1,446.62		$164.25	
Tier II = ADC rate	23%	85	$52.96	$ 1,645,637	$1,610.87		$328.50	
Tier IV Bonus Payment		49	$69.63	$ 102,351		$2,088.80	$806.43	$ 24,500
Totals	**100%**	**376**		**$ 6,489,656**				
Annual Difference Between Current and Proposed				**$ 703,618**				

Data from other states using a three tier method was used to calculate the difference in payment between the three tiers for simulation 9.3B. On average Tier II was 38 % higher than Tier I and Tier III was 86 % higher than Tier I. An additional $500 payment was added for the first 30 days for 49 residents placed from a nursing facility into assisted living. This is a Tier IV level of payment for those residents for their first 30 days. After the first month the payment for these residents would revert back to Tier III or their assessed level if different.

Table 9.3B
National average difference between tiers in states using three levels Plus $500 Bonus

	% of Sample Cases	# of Residents	Daily Rates	Estimated Expenditures	Proposed Monthly payment	1st Month Payment Plus Bonus	Difference Between Current Monthly Rate and Proposed	Total Bonus payments
Tier 1 = Current rate	42%	156	$42.16	$ 2,401,752	$1,282.37		$0.00	
Tier II = 38% higher than Tier I	36%	135	$58.34	$ 2,870,263	$1,774.50		$492.13	
Tier III = 86% higher than Tier I	23%	85	$78.51	$ 2,439,506	$2,387.96		$1,105.59	
Tier IV Bonus Payment		49	$95.17	$ 139,907		$2,855.25	$1,572.88	$ 24,500
Totals	**100%**	**376**		**$ 7,851,428**				
Annual Difference Between Current and Proposed				**$ 2,065,389**				

Simulation 9.3C is based on daily rates not to exceed the total expenditure amount in simulation 1. A Tier IV was created to add an additional $500 payment for the first 30 days for 49 residents placed from a nursing facility into assisted living. After the first month the payment for these residents would revert back to Tier III or their assessed level if different.

Table 9.3C
Expenditure Not To Exceed $7,270,975.20 Plus $500 Bonus

	% of Sample Cases	# of Residents	Daily Rates	Estimated Expenditures	Proposed Monthly payment	1st Month Payment Plus Bonus	Difference Between Current Monthly Rate and Proposed	Total Bonus payments
Tier I = current rate	42%	156	$42.16	$ 2,401,752	$1,282.37		$0.00	
Tier II = Mid point	36%	135	$55.31	$ 2,720,964	$1,682.19		$399.83	
Tier III = highest rate	23%	85	$68.45	$ 2,023,040	$2,082.02		$799.65	
Tier IV Bonus Payment		49	$85.12	$ 125,122		$2,553.50	$1,271.13	$ 24,500
Totals	**100%**	**376**		**$ 7,270,877**				
Annual Difference Between Current and Proposed				**$ 1,484,839**				

10 Conclusion

Assisted living is largely a private-pay business. Most people living in assisted living residences pay for expenses from private money sources. Because of this assisted living residences have little incentive to take Medicaid recipients.

Since federal law prohibits payment of room and board a Medicaid payment method is limited to covering direct services and unlike nursing facility care assisted living is not an entitlement program. DHS and DEA however recognize that an assisted living model is not only less expensive than nursing facility care but that it is beneficial to a recipient to be placed in a

community setting when possible. Therefore the state is looking for a payment method that would encourage increased access to assisted living services for Medicaid recipients and to decrease reliance on inappropriate nursing facility stays. Because Medicaid must compete with private pay in this market the best way to encourage access is an increase in payment that more closely approaches cost. Budgetary constraints may very well be the deciding factor in any change to payment for assisted living.

A key component of Rhode Island's Global Consumer Compact Waiver is the commitment to rebalance the State's long term care system. The stated goal is to ensure appropriate utilization of institutional services and facilitate access to community-based services and supports. In this way, Rhode Island is striving to assure that the elderly and disabled residents of Rhode Island receive appropriate care in the least intensive setting practical. As part of that process, Rhode Island has undertaken activities to improve access to community based services and supports, including Assisted Living. Task number 2.4 in the Waiver plan calls for expanded access to Assisted Living services. The Waiver recognizes that Assisted Living is a key component in the continuum of community based services. These services allow elderly and disabled Rhode Islanders to defer or avoid institutional care in a nursing facility, thereby maintaining their maximum level of independence and personal dignity.

A rational approach to reimbursement for Assisted Living services is key to meeting the goals of the Global Waiver for long-term care services. As state workers identify persons who could appropriately transition out of nursing facility care, there need to be sufficient options in the community to facilitate those transitions.

As reported in Section 3.3 three homes told us their "breakeven" costs ranged from $2,300 to $2,700 per month and RIALA tells us a cost gathering survey by them shows the cost of providing services to be between $3,105 and $3,493 per month. They did not tell us if this was the cost per resident in single or shared rooms. The current room and board allowance for waiver recipients is $700 for shared occupancy and $1,132 for single occupancy. The lowest proposed monthly payment under these simulations is a Tier I payment set at the current rate of $1,282.37 and the highest proposed rate is a Tier IV payment of $2,855.25 shown in 9.3B.

The majority of recipients (42%) fall into the Tier I category which would mean a total payment of $1,982.37 for shared and $2,414.37 for single occupancy. Tier I falls short of the "breakeven" point in all simulations except when you consider that most residences that accept Medicaid residents have shared occupancy. This would put payment for Tier I at $3,964.74 for a single room occupied by two Medicaid residents.

Simulation 9.3C would bring total payments for shared occupancy (which is generally the only occupancy assisted living residences will allow for waiver recipients) to $1,982.37 per resident for Tier I (42% of recipients), $2,382.19 per resident for Tier II (36% of recipients) and to $2,782.02 per resident for Tier III (23% of recipients). For those people falling into Tier IV the first month payment would be $3,253.50 per resident.

Implementation of the majority of these simulations may require changes to the MMIS system and may require instructions to providers on use of modifiers or CPT/HCPCS codes in order to receive appropriate payment.

Appendix A

Table 7.0

Table 7.0 Diagnosis Categories			
Category	First DX	Last DX	Short Description
1	1	139	Infectious Dis
2	140	239	Neoplasms
3	240	279	Endocrine,Nutrit,Metabolic Dis
4	280	289	Blood Dis
5	290	319	Mental Dis
6	320	389	Nervous Sys & Sensory Dis
7	390	459	Circulatory Dis
8	460	519	Respiratory Dis
9	520	579	Digestive Dis
10	580	629	Genitourinary Dis
11	630	679	Preg & Childbirth
12	680	709	Skin Diseases
13	710	739	Musculoskeletal Dis
14	740	759	Congenital Anomalies
15	760	779	Cond Orig Perinatal
16	780	799	Signs & Symptoms
17	800	999	Injury & Poisoning
	V01	V89	Visit (V) Codes
	E800	E999	External Causes (E) Codes

Table 7.1.1

Table 7.1.1 Assisted Living Homes							
Name	Claims SFY 09	Units	Charges	Allowed	Allowed /Unit	Avg Allowed Per Claim	Avg Units Per Claim
Bristol	729	21,254	$ 771,945	$ 771,945	$ 36.32	$ 1,059	29
ST Elizabeth	526	14,753	$ 535,829	$ 535,829	$ 36.32	$ 1,019	28
Forest Farm	391	10,908	$ 396,179	$ 396,179	$ 36.32	$ 1,013	28
Blackstone	96	2,914	$ 105,836	$ 105,836	$ 36.32	$ 1,102	30
The Bridge at Cherry	53	1,773	$ 64,395	$ 64,395	$ 36.32	$ 1,215	33
Ethan Place	54	1,632	$ 59,274	$ 59,274	$ 36.32	$ 1,098	30
West Bay	45	1,363	$ 49,504	$ 49,504	$ 36.32	$ 1,100	30
United Methodist Ret	38	1,086	$ 39,444	$ 39,444	$ 36.32	$ 1,038	29
Cortland Place	37	1,069	$ 38,826	$ 38,826	$ 36.32	$ 1,049	29
Willows	36	1,062	$ 38,572	$ 38,572	$ 36.32	$ 1,071	30
Frassati	24	730	$ 26,514	$ 26,514	$ 36.32	$ 1,105	30
Horizon Bay	24	728	$ 26,441	$ 26,441	$ 36.32	$ 1,102	30
Autumn Villa	24	724	$ 26,296	$ 26,296	$ 36.32	$ 1,096	30
B-VII New Eng	24	697	$ 25,315	$ 25,315	$ 36.32	$ 1,055	29
Village	22	669	$ 24,298	$ 24,298	$ 36.32	$ 1,104	30
Pocasset Bay	14	372	$ 13,511	$ 13,511	$ 36.32	$ 965	27
East Bay	11	334	$ 12,131	$ 12,131	$ 36.32	$ 1,103	30
Totals	**2,148**	**62,068**	**$2,254,310**	**$2,254,310**	**$36.32**	**$ 1,049**	**29**

Table 7.1.2

Table 7.1.2 Assisted Living Census					
Name	Unique Count Residents 2009	Avg Monthly Census 2009	Avg Resident Age	Min Resident Age	Max Resident Age
Bristol	79	61	80	67	89
ST Elizabeth	61	44	86	67	98
Forest Farm	42	33	86	62	96
Blackstone	8	8	81	46	99
The Bridge at Cherry	6	4	76	54	87
West Bay	6	4	92	83	99
Ethan Place	5	5	85	63	98
Horizon Bay	5	2	85	53	99
Methodist	4	3	88	80	95
Willows	4	3	77	49	93
B-VII New Eng	3	2	90	84	96
Cortland Place	3	3	98	98	99
Autumn Villa	2	2	72	61	83
Frassati	2	2	98	92	101
Pocasset Bay	2	1	87	79	93
Village	2	2	84	66	100
East Bay	1	1	81	64	99
Totals	**235**	**180**	**85**	**46**	**101**

Table 7.1.3

Table 7.1.3 Paid Outside MMIS			
Provider Name	Paid Outside MMIS	Paid in MMIS	Total Paid
Bristol	$ 8,432	$ 719,519	$ 727,951
ST Elizabeth		$ 518,221	$ 518,221
Forest Farm		$ 385,793	$ 385,793
Summer Villa	$ 241,349	$ -	$ 241,349
Autumn Villa	$ 206,261	$ 26,296	$ 232,556
Blackstone Valley	$ 70,829	$ 105,836	$ 176,665
West Bay Manor	$ 114,067	$ 49,504	$ 163,572
B-VII New England	$ 126,085	$ 24,695	$ 150,780
OES Home of Rhode Island	$ 84,811	$ 58,523	$ 143,334
United Methodist	$ 100,643	$ 39,444	$ 140,086
Cortland Place Health	$ 101,085	$ 38,208	$ 139,293
Darlington Assisted	$ 134,913	$ -	$ 134,913
Darlington Assisted	$ 114,112	$ -	$ 114,112
Horizon Bay	$ 63,712	$ 25,375	$ 89,088
Senior Lifestyle	$ 74,617	$ -	$ 74,617
The Bridge at Cherry	$ 7,379	$ 63,252	$ 70,631
ST Joseph Living Center	$ 66,345	$ -	$ 66,345
The Willows	$ 29,742	$ 33,152	$ 62,894
Pocasset Bay Manor	$ 41,440	$ 13,511	$ 54,951
Manchester Manor	$ 40,606	$ -	$ 40,606
East Bay Manor	$ 28,015	$ 12,131	$ 40,146
Frassati		$ 26,514	$ 26,514
Tockwotton Home	$ 26,236	$ -	$ 26,236
Senior Lifestyle	$ 24,557	$ -	$ 24,557
Village		$ 24,298	$ 24,298
Totals	**$ 1,705,236**	**$ 2,164,272**	**$ 3,869,509**

Table 7.2.1

Table 7.2.1 Category of Service							
COS Description	Units	Claims	Residents	Charges	Allowed	Allowed Per Resident	Allowed Per Claim	Allowed Per Unit
Inpatient	5,559	10	3	$ 423,091	$ 262,684	$ 87,561	$ 26,268	$ 47
MH Clinic	3,531	335	20	$ 167,275	$ 161,473	$ 8,074	$ 482	$ 46
TCM-Mental Health	7,777	1,843	220	$ 116,289	$ 116,289	$ 529	$ 63	$ 15
Ambulance	25,475	1,123	85	$ 310,139	$ 97,185	$ 1,143	$ 87	$ 4
Prescribed Drugs	235,372	3,703	186	$ 141,018	$ 78,391	$ 421	$ 21	$ 0
DME Other	62,228	386	80	$ 77,734	$ 58,660	$ 733	$ 152	$ 1
Home Health Private	192	14	5	$ 21,699	$ 12,840	$ 2,568	$ 917	$ 67
Outpatient	200	43	8	$ 48,781	$ 11,626	$ 1,453	$ 270	$ 58
Hospice	63	6	3	$ 10,900	$ 10,398	$ 3,466	$ 1,733	$ 165
Day Care	104	11	2	$ 25,383	$ 5,510	$ 2,755	$ 501	$ 53
MR Rehab	5	5	1	$ 7,219	$ 5,494	$ 5,494	$ 1,099	$ 1,099
FQHC Dental	79	40	14	$ 4,960	$ 4,925	$ 352	$ 123	$ 62
Physician	134	97	18	$ 16,988	$ 4,426	$ 246	$ 46	$ 33
Dental Adult	117	52	26	$ 9,295	$ 3,670	$ 141	$ 71	$ 31
HCBS DEA Waiver	690	34	2	$ 183,938	$ 3,658	$ 1,829	$ 108	$ 5
Dentures, Adult	10	7	7	$ 6,857	$ 2,798	$ 400	$ 400	$ 280
FQHC Family Practice	22	9	1	$ 1,150	$ 1,147	$ 1,147	$ 127	$ 52
Optometrist Supplies	41	16	14	$ 2,357	$ 1,130	$ 81	$ 71	$ 28
Independent Lab	139	51	8	$ 5,704	$ 999	$ 125	$ 20	$ 7
Optometrist Services	24	22	20	$ 1,182	$ 474	$ 24	$ 22	$ 20
Podiatrist Services	23	13	4	$ 1,718	$ 455	$ 114	$ 35	$ 20
DME DEA Waiver	10	9	2	$ 345	$ 343	$ 172	$ 38	$ 34
Physician X-Ray	14	11	5	$ 1,460	$ 226	$ 45	$ 21	$ 16
Optician Supplies	5	2	2	$ 265	$ 175	$ 87	$ 87	$ 35
Homemaker	19	1	1	$ 86	$ 86	$ 86	$ 86	$ 5
DME	1	1	1	$ 68	$ 46	$ 46	$ 46	$ 46
Physician Lab Services	2	1	1	$ 300	$ 46	$ 46	$ 46	$ 23
Optician Services	2	2	2	$ 56	$ 40	$ 20	$ 20	$ 20
Totals	**341,838**	**7,847**	**741**	**$ 1,586,257**	**$ 845,194**	**$ 1,141**	**$ 108**	**$ 2**

Table 7.2.2

Table 7.2.2 Place of Service								
Description	Units	Claims	Resident	Charges	Allowed	Allowed Per Resident	Allowed Per Claim	Allowed Per Unit
Inpatient Hospital	5,576	17	3	$ 425,399	$ 263,212	$ 87,737	$ 15,483	$ 47
Community Mental Health Center	2,961	263	14	$ 124,605	$ 118,904	$ 8,493	$ 452	$ 40
Ambulance - Land	25,475	1,123	85	$ 310,139	$ 97,185	$ 1,143	$ 87	$ 4
Home	51,781	804	107	$ 296,331	$ 87,835	$ 821	$ 109	$ 2
Assisted Living Facility	16,586	636	123	$ 66,565	$ 63,575	$ 517	$ 100	$ 4
Other Place of Service	2,519	865	98	$ 68,752	$ 47,154	$ 481	$ 55	$ 19
Unassigned	125,362	1,914	97	$ 71,653	$ 38,059	$ 392	$ 20	$ 0
Group Home	415	37	2	$ 31,186	$ 31,179	$ 15,589	$ 843	$ 75
Blank	67,928	1,091	79	$ 39,155	$ 24,987	$ 316	$ 23	$ 0
Office	470	184	69	$ 33,831	$ 20,203	$ 293	$ 110	$ 43
Outpatient Hospital	239	75	8	$ 53,552	$ 12,687	$ 1,586	$ 169	$ 53
Hospice	63	6	3	$ 10,900	$ 10,398	$ 3,466	$ 1,733	$ 165
Indian Health Service Free-	27,583	465	21	$ 20,695	$ 9,188	$ 438	$ 20	$ 0
Mobile Unit	181	11	2	$ 8,450	$ 8,450	$ 4,225	$ 768	$ 47
School	13,088	233	25	$ 13,392	$ 7,819	$ 313	$ 34	$ 1
Nursing Facility	110	40	13	$ 4,936	$ 1,668	$ 128	$ 42	$ 15
Skilled Nursing Facility	8	8	2	$ 1,535	$ 1,255	$ 627	$ 157	$ 157
Custodial Care Facility	11	10	1	$ 1,320	$ 506	$ 506	$ 51	$ 46
Emergency Room - Hospital	9	7	3	$ 1,488	$ 284	$ 95	$ 41	$ 32
Ambulatory Surgical Center	1	1	1	$ 850	$ 281	$ 281	$ 281	$ 281
Pharmacy	1,422	22	7	$ 658	$ 202	$ 29	$ 9	$ 0
Independent Laboratory	22	18	3	$ 854	$ 161	$ 54	$ 9	$ 7
Tribal 638 Free-Standing Facility	28	2	2	$ 11	$ 1	$ 1	$ 1	$ 0
Totals	**341,837**	**7,832**	**768**	**$ 1,586,257**	**$ 845,194**	**$ 1,101**	**$ 108**	**$ 2**

Table 7.2.3

Table 7.2.3 Diagnosis Category						
Principal Diagnosis	Claims	Residents	Charges	Allowed	Allowed Per Resident	Allowed Per Claim
Respiratory Dis	103	7	$ 399,100	$ 239,848	$ 34,264	$ 2,329
Mental Disorders	449	31	$ 190,947	$ 175,679	$ 5,667	$ 391
Visit (V) Codes	1,996	210	$ 341,619	$ 149,861	$ 714	$ 75
Blank	4,019	196	$ 215,737	$ 117,746	$ 601	$ 29
Signs & Symptoms	413	59	$ 84,073	$ 51,521	$ 873	$ 125
Circulatory Dis	192	27	$ 64,074	$ 30,300	$ 1,122	$ 158
Genitourinary Dis	179	9	$ 121,364	$ 19,740	$ 2,193	$ 110
Skin Diseases	108	6	$ 65,708	$ 19,577	$ 3,263	$ 181
Nervous Sys & Sensory Dis	119	45	$ 47,721	$ 18,600	$ 413	$ 156
Musculoskeletal Dis	184	30	$ 37,023	$ 16,134	$ 538	$ 88
Infectious Dis	9	5	$ 3,464	$ 2,184	$ 437	$ 243
Neoplasms	21	4	$ 5,477	$ 1,412	$ 353	$ 67
Endocrine, Nutrit, Metabolic Dis	23	8	$ 2,957	$ 1,103	$ 138	$ 48
Injury & Poisoning	11	9	$ 4,290	$ 791	$ 88	$ 72
Blood Dis	7	4	$ 1,050	$ 268	$ 67	$ 38
Congenital Anomalies	2	1	$ 225	$ 225	$ 225	$ 113
Digestive Dis	3	2	$ 1,429	$ 205	$ 103	$ 68
Totals	**7,838**	**653**	**$ 1,586,257**	**$ 845,194**	**$ 1,294**	**$ 108**

Table 7.2.4

Table 7.2.4 Aid Category							
Aid Category Code	Aid Category Desc	Claims	Residents	Charges	Allowed	Allowed Per Recipient	Allowed Per Claim
AD	Needy Cash Assist/Disabled	2,564	39	$ 834,363	$ 548,686	$ 14,069	$ 214
AA	Needy Cash Assist/Aged	3,106	131	$ 297,342	$ 163,721	$ 1,250	$ 53
WA	Needy Home Comm Base Svc/Aged	1,334	69	$ 310,814	$ 64,180	$ 930	$ 48
LD	Needy Medical Asst Eligible/Disabled	214	1	$ 82,187	$ 31,135	$ 31,135	$ 145
WD	Needy Home Comm Base Svc/Disabled	212	2	$ 35,433	$ 19,567	$ 9,784	$ 92
LA	Needy Medical Asst Eligible/Aged	203	22	$ 15,087	$ 11,258	$ 512	$ 55
MA	Med Needy Individual/Aged	193	13	$ 10,164	$ 5,852	$ 450	$ 30
BA	Needy No Cash Assist/Aged	5	4	$ 867	$ 796	$ 199	$ 159
	Totals	**7,831**	**281**	**$ 1,586,257**	**$ 845,194**	**$ 3,008**	**$ 108**

Table 7.3.1

Table 7.3.1 RHP Managed Care Claims Diagnosis Categories						
DX Category	Claims	Residents	Charges	Paid	Paid Per Resident	Paid Per Claim
Nervous Sys & Sensory Dis	17	2	$ 6,131	$ 15,674	$ 7,837	$ 922
Signs & Symptoms	19	3	$ 3,968	$ 10,648	$ 3,549	$ 560
Endocrine, Nutrit, Metabolic Dis	9	3	$ 1,221	$ 8,169	$ 2,723	$ 908
Skin Diseases	10	2	$ 1,021	$ 3,280	$ 1,640	$ 328
Mental Disorders	16	2	$ 2,310	$ 1,546	$ 773	$ 97
Circulatory Dis	5	1	$ 110	$ 1,229	$ 1,229	$ 246
Injury & Poisoning	5	2	$ 929	$ 914	$ 457	$ 183
Musculoskeletal Dis	3	2	$ 230	$ 432	$ 216	$ 144
Neoplasms	2	1	$ 1,150	$ 249	$ 249	$ 124
Infectious Dis	1	1	$ 460	$ 208	$ 208	$ 208
Respiratory Dis	1	1	$ 250	$ 113	$ 113	$ 113
Visit (V) Codes	4	2	$ 308	$ 79	$ 40	$ 20
Blood Dis	3	2	$ 161	$ 38	$ 19	$ 13
Totals	**95**	**24**	**$ 18,249**	**$ 42,578**	**$ 1,774**	**$ 448**

Table 7.3.2

Table 7.3.2 RHP Managed Care Claims Provider Type							
Provider Type	Units	Claims	Residents	Paid	Paid Per Resident	Paid Per Claim	Paid Per Unit
Hospital	15	11	3	$ 21,610	$ 7,203	$ 1,965	$ 1,441
Group Provider	45	7	2	$ 14,080	$ 7,040	$ 2,011	$ 313
Physician	24	24	1	$ 2,069	$ 2,069	$ 86	$ 86
Independent Radiology	6	6	1	$ 1,185	$ 1,185	$ 198	$ 198
CMHC/Rehab Option	14	11	1	$ 1,125	$ 1,125	$ 102	$ 80
Outpatient Facility	12	11	1	$ 863	$ 863	$ 78	$ 72
Home Health	6	1	1	$ 780	$ 780	$ 780	$ 130
Ambulance	4	4	1	$ 275	$ 275	$ 69	$ 69
Independent Lab	15	15	1	$ 275	$ 275	$ 18	$ 18
DME	224	3	1	$ 174	$ 174	$ 58	$ 1
Licensed Therapist	1	1	1	$ 100	$ 100	$ 100	$ 100
Optometrist	1	1	1	$ 42	$ 42	$ 42	$ 42
Totals	**367**	**95**	**15**	**$ 42,578**	**$ 21,131**	**$ 5,507**	**$ 2,549**

Chart 7.4.1

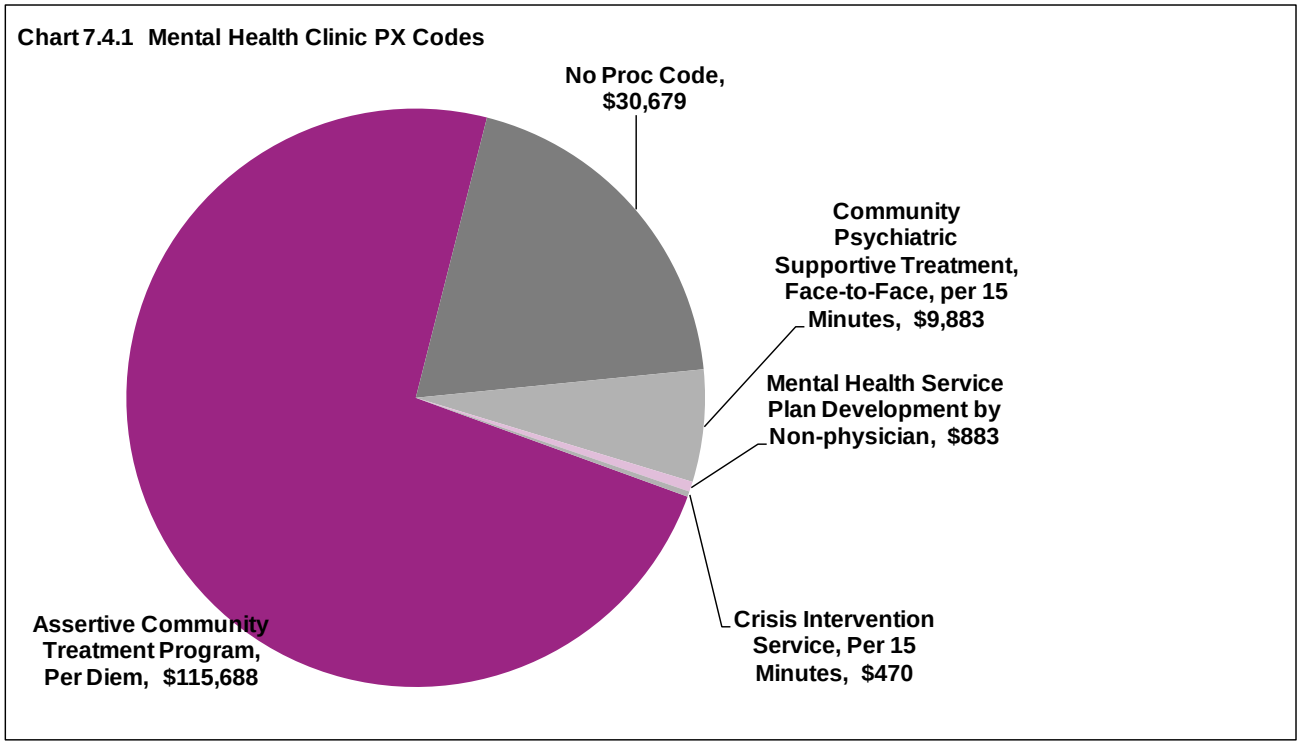
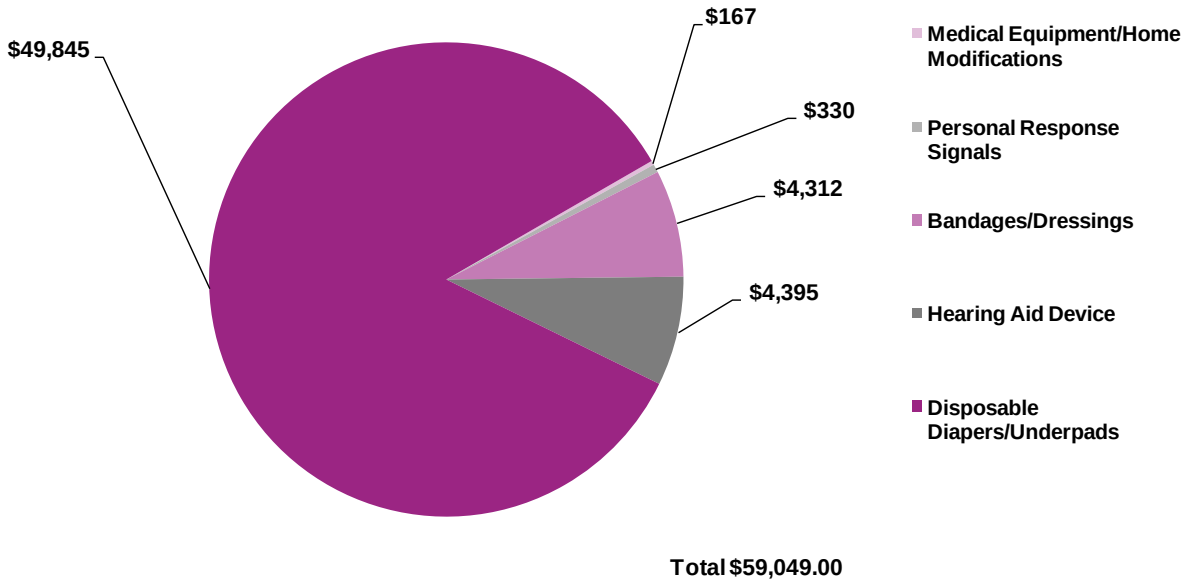


Chart 7.4.2

Chart 7.4.2 FFS DME PX Codes



Total $59,049.00

Chart 7.4.3

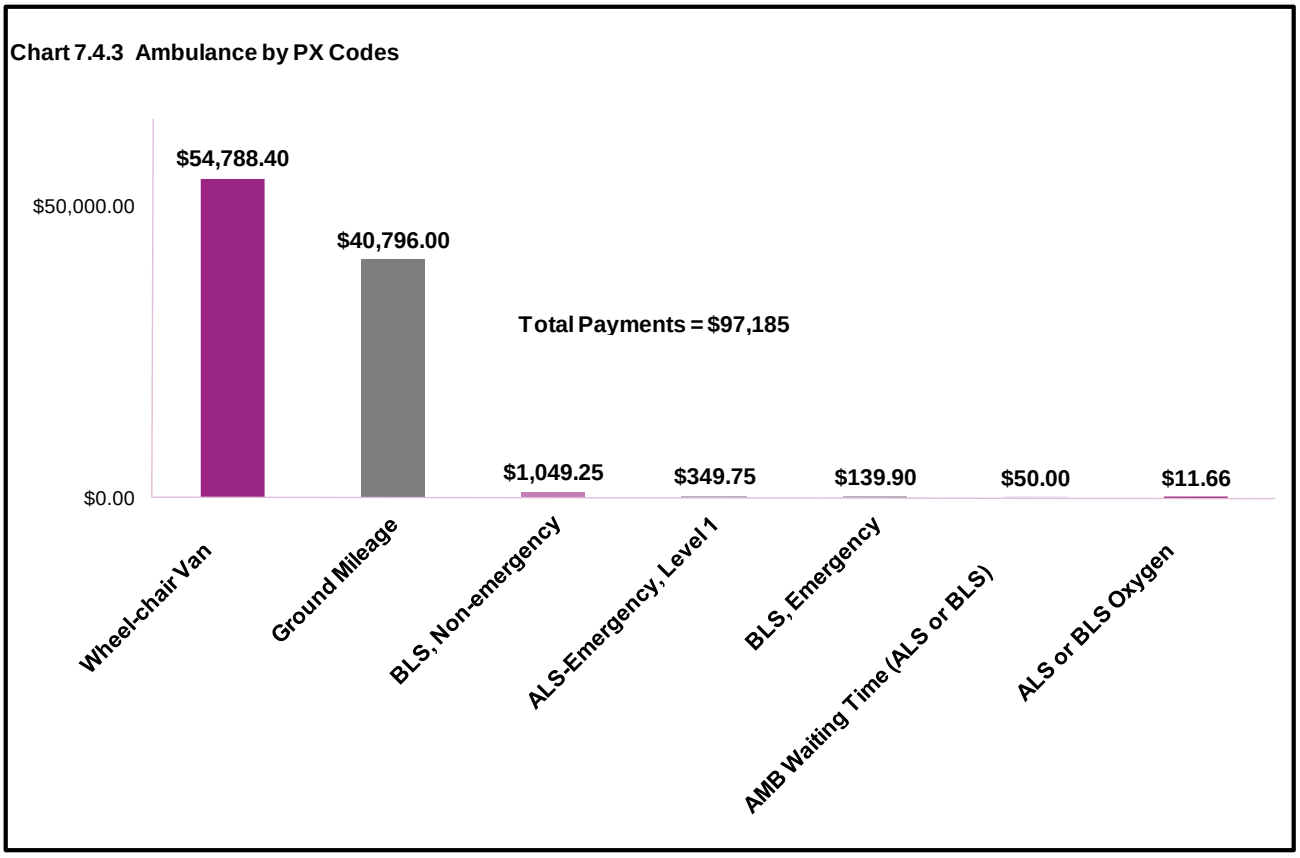


Chart 7.4.3 Ambulance by PX Codes
$50,000.00
$0.00
$54,788.40
$40,796.00
Total Payments = $97,185
$1,049.25
$349.75
$139.90
$50.00
$11.66
Wheel-chair Van
Ground Mileage
BLS, Non-emergency
ALS-Emergency, Level 1
BLS, Emergency
AMB Waiting Time (ALS or BLS)
ALS or BLS Oxygen

Chart 7.4.4

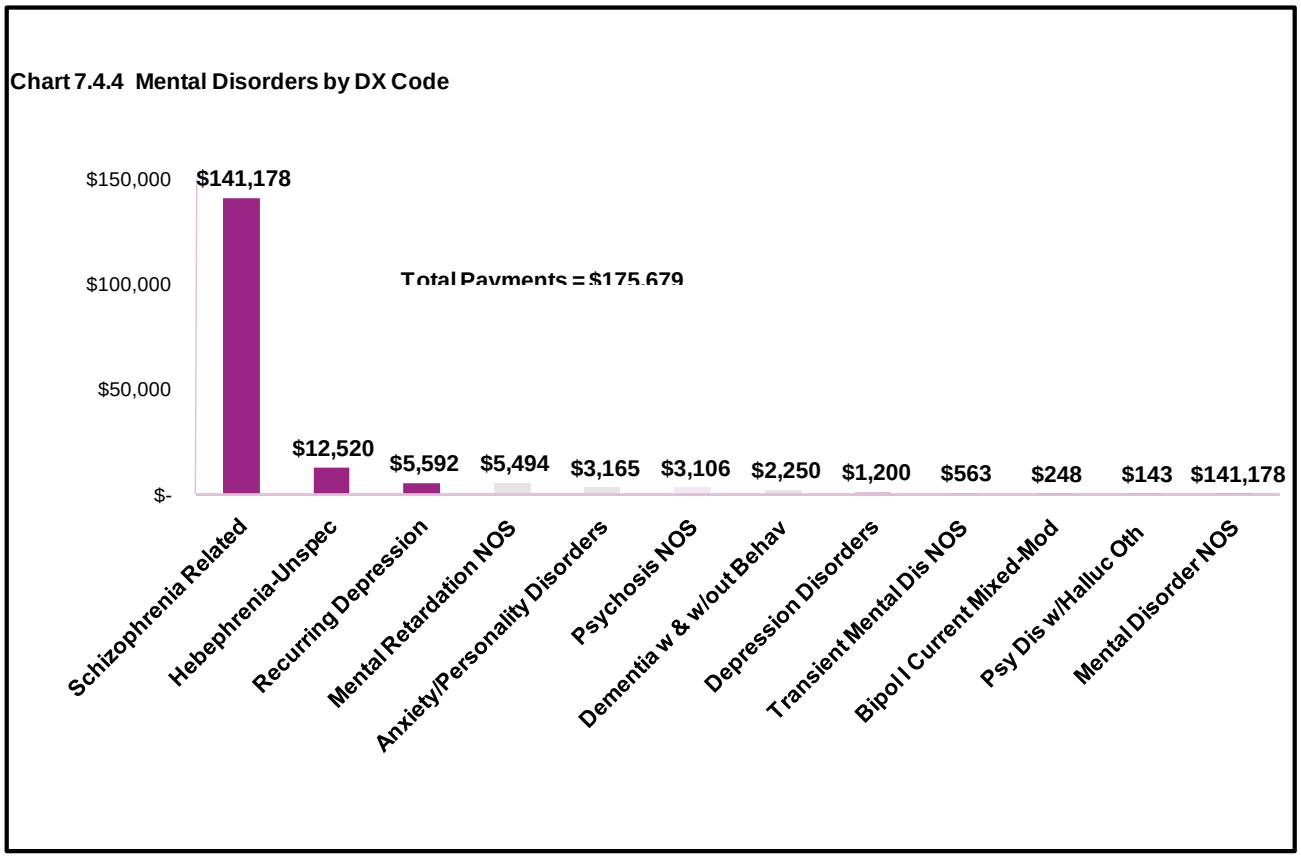


Chart 7.4.4 Mental Disorders by DX Code
$150,000
$100,000
$50,000
$-
$141,178
$12,520
$5,592
$5,494
$3,165
$3,106
$2,250
$1,200
$563
$248
$143
$141,178
Schizophrenia Related
Hebephrenia-Unspec
Recurring Depression
Mental Retardation NOS
Anxiety/Personality Disorders
Psychosis NOS
Dementia w & w/out Behav
Depression Disorders
Transient Mental Dis NOS
Bipol I Current Mixed-Mod
Psy Dis w/Halluc Oth
Mental Disorder NOS

Chart 7.4.5

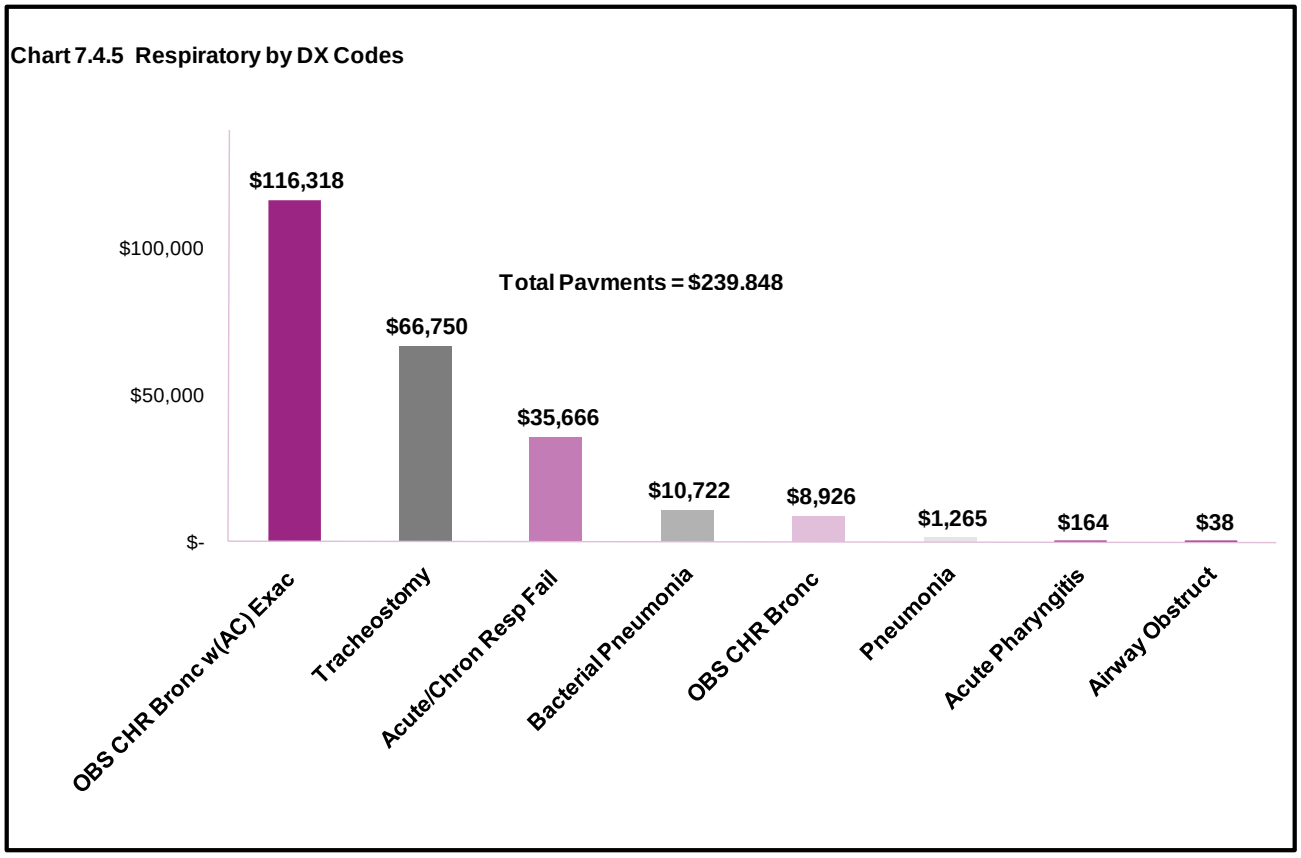


Chart 7.4.5 Respiratory by DX Codes
$116,318
$66,750
$35,666
$10,722
$8,926
$1,265
$164
$38
$100,000
$50,000
$-
Total Pavments = $239.848
OBS CHR Bronc w(AC) Exac
Tracheostomy
Acute/Chron Resp Fail
Bacterial Pneumonia
OBS CHR Bronc
Pneumonia
Acute Pharyngitis
Airway Obstruct

Table 7.4.6

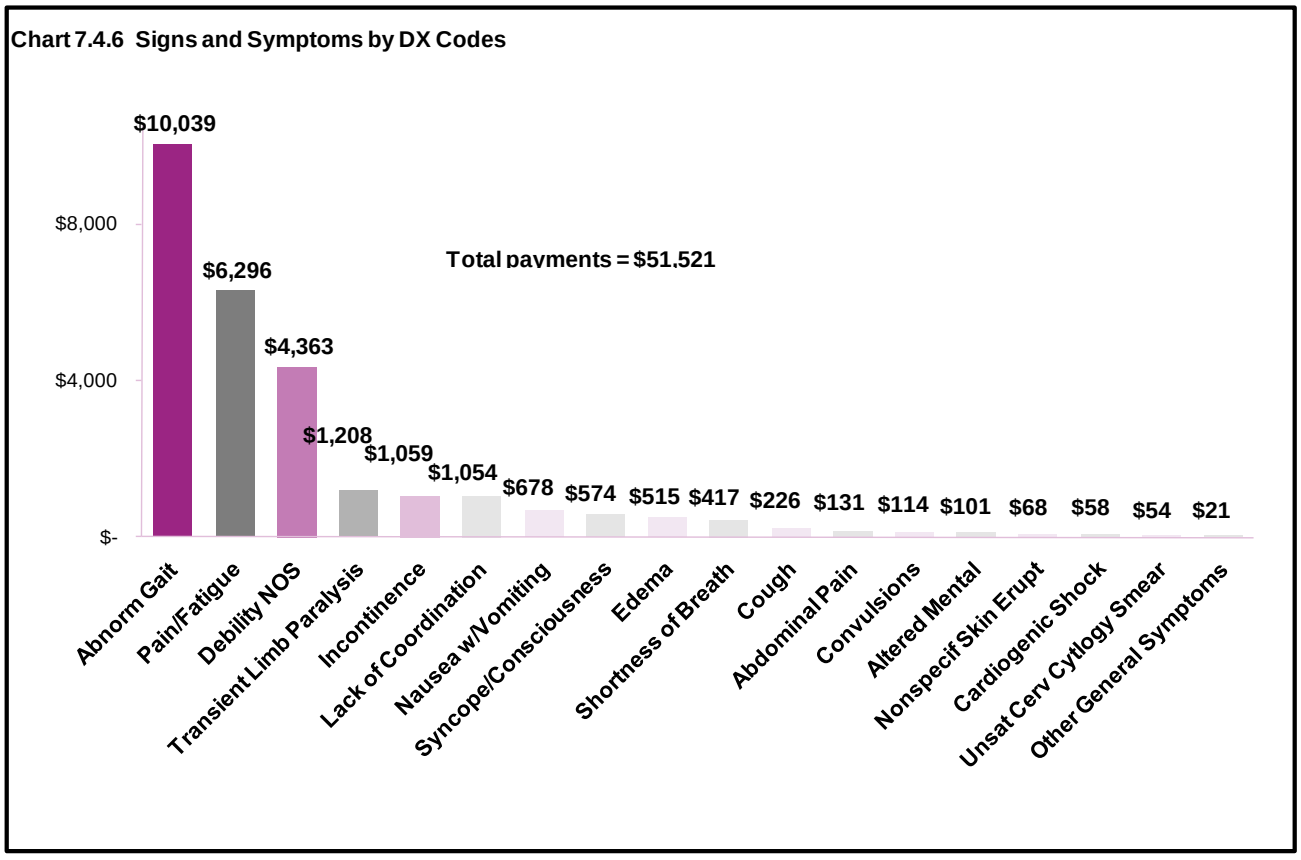


Chart 7.4.6 Signs and Symptoms by DX Codes
$10,039
$6,296
$4,363
$1,208
$1,059
$1,054
$678
$574
$515
$417
$226
$131
$114
$101
$68
$58
$54
$21
$8,000
$4,000
$-
Total payments = $51,521
Abnorm Gait
Pain/Fatigue
Debility NOS
Transient Limb Paralysis
Incontinence
Lack of Coordination
Nausea w/Vomiting
Syncope/Consciousness
Edema
Shortness of Breath
Cough
Abdominal Pain
Convulsions
Altered Mental
Nonspecif Skin Erupt
Cardiogenic Shock
Unsat Cerv Cytlogy Smear
Other General Symptoms

Appendix B

Table 8.1.1

Table 8.1.1 Total Payments Inside and Outside of the MMIS FY 2010				
Provider Name	Inside the MMIS	Outside the MMIS	Total	% of Total
Bristol	$ 621,326	$ 3,215	$ 624,542	14%
Saint Elizabeth	$ 437,438		$ 437,438	10%
Summer Villa	$ 270,807	$ 77,075	$ 347,882	8%
Autumn Villa	$ 271,827	$ 68,188	$ 340,014	8%
Forest Farm	$ 309,083		$ 309,083	7%
Darlington Assisted	$ 151,382	$ 91,151	$ 242,533	6%
Blackstone	$ 203,683	$ 37,790	$ 241,472	6%
Cortland	$ 165,946	$ 68,662	$ 234,608	5%
West Bay Manor	$ 165,365	$ 50,545	$ 215,910	5%
Horizon Bay	$ 147,677	$ 54,924	$ 202,601	5%
Oes Home	$ 137,340	$ 51,088	$ 188,428	4%
United Methodist	$ 133,185	$ 32,301	$ 165,486	4%
Darlington Assisted Liv Cntr	$ 119,275		$ 119,275	3%
B-VII New Eng	$ 88,875	$ 21,623	$ 110,498	3%
Willows	$ 81,284	$ 26,925	$ 108,209	3%
St Joseph	$ 72,749	$ 30,250	$ 102,999	2%
Manchester Manor	$ 63,306	$ 26,935	$ 90,241	2%
East Bay Manor	$ 40,319	$ 10,616	$ 50,935	1%
Senior Lifestyle Eme	$ 45,545		$ 45,545	1%
Senior Lifestyle Nor	$ 12,894	$ 28,945	$ 41,838	1%
Frassati	$ 39,589		$ 39,589	1%
The Bridge At Cherry	$ 19,831	$ 1,464	$ 21,295	0%
Tockwotton Home		$ 18,995	$ 18,995	0%
Pocasset Bay		$ 18,859	$ 18,859	0%
Village At Waterman Lake - Chalet	$ 6,683		$ 6,683	0%
South Bay Manor	$ 6,283		$ 6,283	0%
Total	**$3,605,408**	**$ 719,551**	**$ 4,324,959**	**100%**
*Data Collection Period is 10 months, July 2009 to April 2010				

Table 8.1.2

Table 8.1.2 Assisted Living Homes							
Provider Name	Claims	Units	Charges	Allowed	Allowed Per Unit	Avg Allowed Per Claim	Avg Units Per Claim
Bristol	580	17,107	$ 621,326	$ 621,326	$ 36	$ 1,071	29
Saint Elizabeth A	420	12,044	$ 437,438	$ 437,438	$ 36	$ 1,042	29
Forest Farm	304	8,510	$ 309,083	$ 309,083	$ 36	$ 1,017	28
Autumn Villa	254	7,508	$ 271,827	$ 271,827	$ 36	$ 1,070	30
Summer Villa	259	7,536	$ 270,807	$ 270,807	$ 36	$ 1,046	29
Blackstone Valley	186	5,608	$ 203,683	$ 203,683	$ 36	$ 1,095	30
Cortland Place	167	4,569	$ 165,946	$ 165,946	$ 36	$ 994	27
West Bay Manor	151	4,553	$ 165,365	$ 165,365	$ 36	$ 1,095	30
Darlington	139	4,168	$ 151,382	$ 151,382	$ 36	$ 1,089	30
Horizon Bay	139	4,066	$ 147,677	$ 147,677	$ 36	$ 1,062	29
Oes Home	126	3,782	$ 137,340	$ 137,340	$ 36	$ 1,090	30
United Methodist	128	3,667	$ 134,258	$ 133,185	$ 36	$ 1,041	29
Darlington Assisted Liv Cntrs	110	3,284	$ 119,275	$ 119,275	$ 36	$ 1,084	30
B-VII New Eng	92	2,447	$ 88,875	$ 88,875	$ 36	$ 966	27
The Willows	74	2,238	$ 81,284	$ 81,284	$ 36	$ 1,098	30
St Joseph Living	67	2,003	$ 72,749	$ 72,749	$ 36	$ 1,086	30
Manchester	59	1,743	$ 63,306	$ 63,306	$ 36	$ 1,073	30
Senior Lifestyle Eme	41	1,254	$ 45,545	$ 45,545	$ 36	$ 1,111	31
East Bay Manor	37	1,119	$ 40,319	$ 40,319	$ 36	$ 1,090	30
Frassati	36	1,090	$ 39,589	$ 39,589	$ 36	$ 1,100	30
The Bridge At Cherry	18	546	$ 19,831	$ 19,831	$ 36	$ 1,102	30
Senior Lifestyle Nor	12	355	$ 12,894	$ 12,894	$ 36	$ 1,074	30
Village	6	184	$ 6,683	$ 6,683	$ 36	$ 1,114	31
South Bay	7	173	$ 6,283	$ 6,283	$ 36	$ 898	25
Totals	**3,412**	**99,554**	**$3,612,764**	**$3,611,691**	**$ 36**	**$ 1,059**	**29**
**Allowed Amount does not include $719,551 in payments made outside the MMIS from July and August of 2009.							
*Data Collection Period is 10 months, July 2009 to April 2010							

Table 8.1.3

Table 8.1.3 Facility Payments by Waiver Category Facility Payments by Waiver Type						
Facility	DEA Allowed	DHS Allowed	Total Allowed	DEA Census	DHS Census	Total Census 10 Months
Bristol Assisted	$ 3,160	$ 618,166	$ 621,326	1	70	71
Saint Elizabeth		$ 437,438	$ 437,438		51	51
Forest Farm		$ 309,083	$ 309,083		40	40
Autumn Villa	$ 257,444	$ 14,383	$ 271,827	36	2	38
Summer Villa, Inc	$ 270,807		$ 270,807	39		39
Blackstone	$ 121,999	$ 81,684	$ 203,683	16	8	24
Cortland Place	$ 146,297	$ 19,649	$ 165,946	23	4	27
West Bay Manor	$ 114,517	$ 50,848	$ 165,365	21	6	27
Darlington	$ 151,381		$ 151,381	23		23
Horizon Bay	$ 106,381	$ 41,296	$ 147,677	20	5	25
Oes Home	$ 98,936	$ 38,404	$ 137,340	15	4	19
United Methodist	$ 108,633	$ 24,552	$ 133,185	15	3	18
Darlington Assisted Liv Cntr	$ 119,275		$ 119,275	17		17
B-Vii New England	$ 78,996	$ 9,879	$ 88,875	12	2	14
The Willows	$ 59,202	$ 22,083	$ 81,284	8	2	10
St Joseph Living	$ 72,749		$ 72,749	12		12
Manchester Manor	$ 63,306		$ 63,306	12		12
Senior Lifestyle Eme	$ 45,545		$ 45,545	9		9
East Bay	$ 30,367	$ 9,952	$ 40,319	4	1	5
The Frassati Residence	$ 19,758	$ 19,831	$ 39,589	3	2	5
The Bridge At Cherry		$ 19,831	$ 19,831		3	3
Senior Lifestyle	$ 12,894		$ 12,894	8		8
Village At Waterman Lake		$ 6,683	$ 6,683		1	1
South Bay Manor	$ 6,283		$ 6,283	2		2
Totals	**$1,887,929**	**$1,723,761**	**$3,611,690**	**296**	**204**	**500**
**Does not include $719,555 in payments made outside the MMIS from July 1, 2009 to August 31, 2009.						
*Data Collection Period is 10 months, July 2009 to April 2010						

Table 8.1.4

Table 8.1.4 Assisted Living Census						
Provider Name	Unique Resident Count	Avg Daily Census	Avg Monthly Census	Avg Age	Min Age	Max Age
Bristol	71	56	58	82	47	100
Saint Elizabeth	51	40	41	84	53	100
Forest Farm	40	28	30	84	59	99
Summer Villa	39	25	26	73	57	91
Autumn Villa	38	25	25	77	52	90
Cortland Place	27	15	16	87	75	98
West Bay	27	15	19	82	50	102
Horizon Bay	25	13	17	83	62	97
Blackstone	24	18	19	72	55	88
Darlington	23	14	17	79	66	92
Oes Home Of Rhode Is	19	12	13	82	65	98
United Methodist Ret	18	12	13	88	68	99
Darlington Assisted Liv Cntr	17	11	12	75	65	97
B-VIIi New Eng	14	8	9	84	68	95
Manchester Manor Inc	12	6	8	74	49	93
St Joseph	12	7	8	85	75	95
The Willows	10	7	7	86	72	96
Senior Lifestyle Eme	9	4	8	77	64	83
Senior Lifestyle Nor	8	1	4	84	70	99
East Bay	5	4	4	93	89	100
Frassati	5	4	4	85	66	96
The Bridge At Cherry	3	2	3	92	90	95
South Bay	2	1	1	64	62	66
Village	1	1	1	100	100	100
Totals	**500**	**327**	**363**	**82**	**47**	**102**
*Data Collection Period is 10 months, July 2009 to April 2010						

Table 8.1.5

Table 8.1.5 Aid Category/Assisted Living Residents Only										
Aid Code	AidCtgDesc	Claims	Charges	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Total Allowed	% of Total	Allowed Per Claim
AA	Cat Needy Cash Assist / Aged	1602	$ 1,695,840	$ 843,591	45%	$ 851,559	49%	$ 1,695,150	47%	$ 1,058
WA	Cat Needy Home Comm Base Svc / Aged	841	$ 891,098	$ 406,167	22%	$ 484,813	28%	$ 890,980	25%	$ 1,059
AD	Cat Needy Cash Assist / Disabled	626	$ 668,441	$ 359,430	19%	$ 309,011	18%	$ 668,441	19%	$ 1,068
MA	Med Needy Individual / Aged	223	$ 231,015	$ 183,852	10%	$ 46,962	3%	$ 230,814	6%	$ 1,035
WD	Cat Needy Home Comm Base Svc / Disabled	36	$ 39,189	$ 20,920	1%	$ 18,269	1%	$ 39,189	1%	$ 1,089
LA	Cat Needy Medical Asst Eligible / Aged	28	$ 27,552	$ 16,620	1%	$ 10,932	1%	$ 27,552	1%	$ 984
BA	Cat Needy No Cash Assist / Aged	18	$ 19,822	$ 19,758	1%		0%	$ 19,758	1%	$ 1,098
AB	Cat Needy Cash Assist / Blind	15	$ 16,489	$ 16,489	1%		0%	$ 16,489	0%	$ 1,099
LD	Cat Needy Medical Asst Eligible / Disabled	16	$ 15,545	$ 15,545	1%		0%	$ 15,545	0%	$ 972
BD	Cat Needy No Cash Assist / Disabled Adult	5	$ 5,557	$ 5,557	0%		0%	$ 5,557	0%	$ 1,111
MD	Med Needy Individual / Disabled	2	$ 2,216		0%	$ 2,216	0%	$ 2,216	0%	$ 1,108
Total		**3,412**	**$3,612,764**	**$1,887,929**	**100%**	**$1,723,762**	**100%**	**$3,611,691**	**100%**	**$ 1,059**
**Allowed Amount does not include $719,551 in payments made outside the MMIS from July and August of 2009										
*Data Collection Period is 10 months, July 2009 to April 2010										

Table 8.2.1

Table 8.2.1
Fee-For-Service Category of Service

Category	Units	Claims	Residents	Charges	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Allowed	% of Total	Allowed Per Resident	Allowed Per Claim	Allowed Per Unit
MH Clinic	17,512	1,620	74	$ 492,452	$ 295,019	20%	$ 123,217	17%	$ 418,236	19%	$ 5,652	$ 258	$ 24
Ambulance	83,896	4,139	255	$ 970,425	$ 233,014	16%	$ 131,593	19%	$ 364,607	17%	$ 1,430	$ 88	$ 4
Inpatient	9,268	38	13	$ 628,697	$ 254,043	18%	$ 83,594	12%	$ 337,637	16%	$ 25,972	$ 8,885	$ 36
Prescribed Drugs	920,225	13,128	448	$ 501,777	$ 166,178	12%	$ 88,823	13%	$ 255,001	12%	$ 569	$ 19	$ 0
DME Other	269,103	1,418	208	$ 362,621	$ 206,322	14%	$ 45,804	6%	$ 252,126	12%	$ 1,212	$ 178	$ 1
TCM--MH	8,230	1,781	435	$ 123,399	$ 44,786	3%	$ 78,530	11%	$ 123,316	6%	$ 283	$ 69	$ 15
Hospice	552	30	12	$ 105,995	$ 10,747	1%	$ 95,582	14%	$ 106,329	5%	$ 8,861	$ 3,544	$ 193
Outpatient	5,851	222	21	$ 286,623	$ 52,494	4%	$ 13,152	2%	$ 65,646	3%	$ 3,126	$ 296	$ 11
Day Care	949	111	14	$ 517,106	$ 45,457	3%	$ 4,821	1%	$ 50,278	2%	$ 3,591	$ 453	$ 53
Physician	796	583	50	$ 114,763	$ 23,200	2%	$ 5,860	1%	$ 29,060	1%	$ 581	$ 50	$ 37
Dental Adult	533	207	75	$ 43,184	$ 17,041	1%	$ 4,005	1%	$ 21,046	1%	$ 281	$ 102	$ 39
HCBS Aged/Disabled Waiver	3,688	83	3	$ 306,977	$ 17,081	1%	$ 1,771	0%	$ 18,852	1%	$ 6,284	$ 227	$ 5
Home Health Private	247	45	12	$ 30,498	$ 11,538	1%	$ 4,635	1%	$ 16,173	1%	$ 1,348	$ 359	$ 65
FQHC Dentistry	224	118	36	$ 15,736	$ 9,229	1%	$ 6,495	1%	$ 15,724	1%	$ 437	$ 133	$ 70
HCBS DEA Waiver	2,967	106	7	$ 304,154	$ 14,705	1%	$ 525	0%	$ 15,230	1%	$ 2,176	$ 144	$ 5
MR Rehab	10	10	1	$ 14,539		0%	$ 11,631	2%	$ 11,631	1%	$ 11,631	$ 1,163	$ 1,163
Dentures, Adult	33	22	20	$ 21,637	$ 9,461	1%	$ 542	0%	$ 10,003	0%	$ 500	$ 455	$ 303
Independent Lab	902	318	32	$ 31,487	$ 5,035	0%	$ 837	0%	$ 5,872	0%	$ 184	$ 18	$ 7
FQHC Family Practice	74	40	8	$ 5,354	$ 4,226	0%	$ 1,108	0%	$ 5,334	0%	$ 667	$ 133	$ 72
Durable Medical Equip	35	26	6	$ 9,903	$ 5,133	0%	$ 154	0%	$ 5,287	0%	$ 881	$ 203	$ 151
Personal Care Attend	829	25	3	$ 243,515	$ 3,966	0%		0%	$ 3,966	0%	$ 1,322	$ 159	$ 5
Prosthetic/Orthotic	32	2	1	$ 5,020	$ 3,692	0%		0%	$ 3,692	0%	$ 3,692	$ 1,846	$ 115
Optometrist Supplies	119	43	43	$ 8,500	$ 2,981	0%	$ 595	0%	$ 3,576	0%	$ 83	$ 83	$ 30
Physician X-Ray	156	131	21	$ 16,384	$ 2,097	0%	$ 814	0%	$ 2,911	0%	$ 139	$ 22	$ 19
Optometrist Services	112	92	67	$ 7,304	$ 2,046	0%	$ 419	0%	$ 2,465	0%	$ 37	$ 27	$ 22
Podiatrist Services	114	98	26	$ 7,094	$ 1,558	0%	$ 611	0%	$ 2,169	0%	$ 83	$ 22	$ 19
Optician Supplies	53	18	17	$ 9,298	$ 1,064	0%	$ 396	0%	$ 1,460	0%	$ 86	$ 81	$ 28
Dme A&D Waiver	32	30	4	$ 1,150	$ 925	0%	$ 225	0%	$ 1,150	0%	$ 288	$ 38	$ 36
Substance Abuse	41	9	2	$ 991	$ 815	0%		0%	$ 815	0%	$ 407	$ 91	$ 20
Dme Dea Waiver	14	13	3	$ 584	$ 546	0%		0%	$ 546	0%	$ 182	$ 42	$ 39
Optician Services	12	12	12	$ 294	$ 180	0%	$ 60	0%	$ 240	0%	$ 20	$ 20	$ 20
Physician Lab Services	16	12	6	$ 1,442	$ 147	0%	$ 79	0%	$ 226	0%	$ 38	$ 19	$ 14
Outpatient Psych Facility	2	2	1	$ 268	$ 151	0%		0%	$ 151	0%	$ 151	$ 76	$ 76
Optician Services Despensing	5	5	5	$ 111	$ 72	0%	$ 18	0%	$ 90	0%	$ 18	$ 18	$ 18
Unknown - Default	10	1	1	$ 45	$ 45	0%		0%	$ 45	0%	$ 45	$ 45	$ 5
Totals	**1,326,642**	**24,538**	**1,942**	**$ 5,189,324**	**$ 1,444,994**	**100%**	**$ 705,896**	**100%**	**$ 2,150,890**	**100%**	**$ 1,108**	**$ 88**	**$ 2**

*Data Collection Period is 10 months, July 2009 to April 2010

**The data indicates that in 2010 DHS residents had higher utilization for Hospice services. In 2010 the age range of residents is 47 to 102. The average age is 82. The data indicates that a higher percentage of DHS residents needed Hospice services thereby increasing total expenditures.

Table 8.2.2

Table 8.2.2

Diagnosis Categories for Fee-For-Service Stays

Dx Category	Claims	Residents	Charges	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Allowed	% of Total	Allowed Per Resident	Allowed Per Claim
Mental Disorders	2,140	114	$ 1,469,713	$ 474,116	41%	$ 204,483.00	35%	$ 678,599	32%	$ 5,953	$ 317
Signs & Symptoms	2,072	182	$ 529,971	$ 222,476	19%	$ 71,701.00	12%	$ 294,177	14%	$ 1,616	$ 142
Visit (V) Codes	3,542	472	$ 1,174,022	$ 163,782	14%	$ 126,923.00	21%	$ 290,705	14%	$ 616	$ 82
Neoplasms	54	9	$ 145,046	$ 51,687	4%	$ 58,986.00	10%	$ 110,673	5%	$ 12,297	$ 2,050
Musculoskeletal	705	77	$ 173,927	$ 40,230	3%	$ 28,729.00	5%	$ 68,959	3%	$ 896	$ 98
Circulatory	438	60	$ 198,219	$ 49,021	4%	$ 17,025.00	3%	$ 66,046	3%	$ 1,101	$ 151
Nervous Sys & Sensory	309	139	$ 200,188	$ 45,692	4%	$ 16,624.00	3%	$ 62,316	3%	$ 448	$ 202
Respiratory	270	28	$ 139,100	$ 28,969	2%	$ 21,570.00	4%	$ 50,539	2%	$ 1,805	$ 187
Genitourinary	284	22	$ 186,670	$ 13,549	1%	$ 32,847.00	6%	$ 46,396	2%	$ 2,109	$ 163
Digestive	108	17	$ 105,291	$ 28,776	2%	$ 4,077.00	1%	$ 32,853	2%	$ 1,932	$ 304
Skin Diseases	124	21	$ 72,354	$ 17,849	2%	$ 2,819.00	0%	$ 20,668	1%	$ 984	$ 167
Endocrine,Nutrit,Metabolic	174	34	$ 32,244	$ 8,039	1%	$ 2,957.00	1%	$ 10,996	1%	$ 323	$ 63
Injury & Poisoning	80	33	$ 34,374	$ 7,343	1%	$ 1,215.00	0%	$ 8,558	0%	$ 259	$ 107
Congenital Anomalies	23	5	$ 19,567	$ 6,915	1%		0%	$ 6,915	0%	$ 1,383	$ 301
Blood	76	10	$ 19,111	$ 4,193	0%	$ 45.00	0%	$ 4,238	0%	$ 424	$ 56
Infectious Disease	45	13	$ 10,622	$ 2,889	0%	$ 400.00	0%	$ 3,289	0%	$ 253	$ 73
Totals	**24,486**	**1,705**	**$ 5,189,324**	**$1,165,526**	**100%**	**$590,401.00**	**100%**	**$ 1,755,927**	**100%**	**$ 1,262**	**$ 88**

*Does not include pharmacy claim data because those claims do not have PDX codes. Total expenditure was $394,970.

**Data Collection Period is 10 months, July 2009 to April 2010

***There was a significant decrease in the total DHS allowed in 2010 in the respiratory disorder category. The primary reason for this decrease is a decline in DHS case mix for respiratory disorders in 2010. In 2009, the top five inpatient stays ranged from $1,397 to $108,059 in terms of total allowed. In 2010, the top five inpatient stays ranged from $573 to $5,290 in terms of total allowed amount. Essentially, residents suffered significantly less from respiratory disorders in 2010.

Table 8.2.3

Table 8.2.3 FFS Aid Category													
Aid Ctg Code	Aid Ctg Desc	Claims	Residents	Charges	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Allowed	% of Total	Allowed Per Recipient	Allowed Per Claim
AD	Cat Needy Cash Assist / Disabled	9,688	98	$ 2,819,572	$ 833,838	58%	$ 379,333	54%	$ 1,213,171	56%	$ 12,379	$ 125
AA	Cat Needy Cash Assist / Aged	8,745	251	$ 1,115,946	$ 336,460	23%	$ 135,573	19%	$ 472,033	22%	$ 1,881	$ 54
WA	Cat Needy Home Comm Base Svc / Aged	2,651	153	$ 494,755	$ 60,516	4%	$ 76,373	11%	$ 136,889	6%	$ 895	$ 52
LA	Cat Needy Medical Asst Eligible / Aged	761	63	$ 122,486	$ 9,613	1%	$ 82,621	12%	$ 92,234	4%	$ 1,464	$ 121
BD	Cat Needy No Cash Assist / Disabled Adult	329	7	$ 103,845	$ 56,836	4%	$ 122	0%	$ 56,958	3%	$ 8,137	$ 173
MA	Med Needy Individual / Aged	1,083	66	$ 79,609	$ 27,004	2%	$ 13,003	2%	$ 40,007	2%	$ 606	$ 37
LD	Cat Needy Medical Asst Eligible / Disabled	292	10	$ 57,953	$ 31,467	2%	$ 395	0%	$ 31,863	1%	$ 3,186	$ 109
WD	Cat Needy Home Comm Base Svc / Disabled	306	8	$ 42,014	$ 10,567	1%	$ 16,313	2%	$ 26,879	1%	$ 3,360	$ 88
BA	Cat Needy No Cash Assist / Aged	354	18	$ 49,863	$ 24,225	2%	$ 799	0%	$ 25,024	1%	$ 1,390	$ 71
MD	Med Needy Individual / Disabled	59	5	$ 30,393	$ 23,917	2%	$ 831	0%	$ 24,748	1%	$ 4,950	$ 419
D2	DEA Copay Level Two - State Only - Not Eligible Medical Assistance	99	4	$ 259,736	$ 21,285	1%	$ -	0%	$ 21,285	1%	$ 5,321	$ 215
XS	Specified Low Income Beneficiary	21	2	$ 8,584	$ 6,930	0%	$ 525	0%	$ 7,456	0%	$ 3,728	$ 355
AB	Cat Needy Cash Assist / Blind	76	3	$ 4,566	$ 2,337	0%	$ 10	0%	$ 2,347	0%	$ 782	$ 31
Totals		**24,464**	**688**	**$5,189,324**	**$ 1,444,995**	**100%**	**$ 705,898**	**100%**	**$2,150,893**	**100%**	**$ 3,126**	**$ 88**
*Data Collection Period is 10 months, July 2009 to April 2010												

Table 8.3.1

Table 8.3.1 Procedure Detail for COS Mental Health Clinics							
PX Code	HCPC CPT Code Desc.	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Allowed	% of Total
H0040	Assertive Community Treatment Program, Per Diem	$ 173,375	59%	$ 77,356	63%	$ 250,731	60%
H0036	Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	$ 74,788	25%	$ 5,759	5%	$ 80,547	19%
X0341	Local Code	$ 10,750	4%	$ 36,750	30%	$ 47,500	11%
H2017	Psychosocial Rehabilitation Services, Per 15 Minutes	$ 18,194	6%	$ -	0%	$ 18,194	4%
H2011	Crisis Intervention Service, Per 15 Minutes	$ 7,238	2%	$ 846	1%	$ 8,084	2%
H0004	Behavioral Health Counseling And Therapy, Per 15 Minutes	$ 5,219	2%	$ 2,096	2%	$ 7,315	2%
H0032	Mental Health Service Plan Development By Non-Physician	$ 2,354	1%	$ 196	0%	$ 2,550	1%
X0136	Local Code	$ 1,502	1%	$ 215	0%	$ 1,717	0%
H0031	Mental Health Assessment, By Non-Physician	$ 1,012	0%	$ -	0%	$ 1,012	0%
X0134	Local Code	$ 587	0%	$ -	0%	$ 587	0%
Totals		**$ 295,019**	**100%**	**$123,218**	**100%**	**$418,237**	**100%**
*Data Collection Period is 10 months, July 2009 to April 2010							

Table 8.3.2

Table 8.3.2 Procedure Detail for COS Ambulance								
PX Code	HCPC CPT Code Description	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Allowed	% of Total
A0130	Non-Emergency Transportation: Wheel-Chair Van	$ 148,153	64%	$ 75,539	57%	$ 223,692	61%
A0425	Ground Mileage, Per Statute Mile	$ 77,762	33%	$ 53,501	41%	$ 131,263	36%
A0428	Ambulance Service, Basic Life Support, Non-Emergency Transport, (Bls)	$ 2,798	1%	$ 1,469	1%	$ 4,267	1%
A0429	Ambulance Service, Basic Life Support, Emergency Transport (Bls-Emergency)	$ 2,308	1%	$ 280	0%	$ 2,588	1%
A0427	Ambulance Service, Advanced Life Support, Emergency Transport, Level 1 (Als1-Emergency)	$ 1,609	1%	$ 769	1%	$ 2,378	1%
A0422	Ambulance (Als Or Bls) Oxygen And Oxygen Supplies, Life Sustaining Situation	$ 233	0%	$ 35	0%	$ 268	0%
A0420	Ambulance Waiting Time (Als Or Bls), One Half (1/2) Hour Increments	$ 150	0%	$ -	0%	$ 150	0%
Totals		**$ 233,013**	**100%**	**$ 131,593**	**100%**	**$ 364,607**	**100%**
*Data Collection Period is 10 months, July 2009 to April 2010							

Table 8.3.2.A

Table 8.3.2A 2009 Procedure Detail for Ambulance			
PX Code	HCPCS CPT Code Description	Allowed	% of Total
A0130	Wheel-chair Van	$ 54,788	56%
A0425	Ground Mileage	$ 40,796	42%
A0428	BLS, Non-emergency	$ 1,049	1%
A0427	ALS-Emergency, Level 1	$ 350	0%
A0429	BLS, Emergency	$ 140	0%
A0420	AMB Waiting Time (ALS or BLS)	$ 50	0%
A0422	ALS or BLS Oxygen	$ 12	0%
Total		**$ 97,185**	**100%**

Table 8.3.3

Table 8.3.3 Detail Payments by DME Procedure Code Categories to Include Waiver Type					
Category	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Total
Disposable Diapers/Under pads	$ 195,118	95%	$ 37,940	83%	$ 233,058
Hearing Aid Device	$ 6,290	3%	$ 5,385	12%	$ 11,675
Medical and Surgical Supplies	$ 4,705	2%	$ 2,479	5%	$ 7,184
Durable Medical Equipment	$ 76	0%		0%	$ 76
Enternal and Parenteral Therapy	$ 68	0%		0%	$ 68
Specialized Medical Equipment	$ 65	0%		0%	$ 65
Totals	**$ 206,322**	**100%**	**$45,804**	**100%**	**$ 252,126**
*Data Collection Period is 10 months, July 2009 to April 2010					

Table 8.3.4

Table 8.3.4 Diagnosis Detail for Mental Disorders								
Category		DEA Allowed	DEA % of Total		DHS Allowed	DHS % of Total		Total
Schizophrenic disorders	$	130,958	28%	$	131,782	64%	$	262,740
Episodic mood disorders	$	173,078	37%	$	37,739	18%	$	210,817
Anxiety	$	43,198	9%	$	4,184	2%	$	47,383
Nonorganic psychoses	$	37,184	8%	$	6,494	3%	$	43,678
Dementia	$	22,873	5%	$	9,083	4%	$	31,957
Alcohol-induced mental disorders	$	22,833	5%			0%	$	22,833
Psychotic Conditions	$	15,795	3%	$	1,765	1%	$	17,560
Transient mental disorders	$	12,340	3%	$	358	0%	$	12,698
Mental Retardation	$	939	0%	$	11,631	6%	$	12,571
Depression	$	7,023	1%	$	1,184	1%	$	8,207
Nondependent abuse of drugs	$	5,026	1%	$	73	0%	$	5,099
Alcohol dependence syndrome	$	1,473	0%	$	188	0%	$	1,661
Adjustment reaction	$	765	0%			0%	$	765
Acute reaction to stress	$	409	0%			0%	$	409
Personality disorders	$	221	0%			0%	$	221
Totals	**$**	**474,116**	**100%**	**$**	**204,483**	**100%**	**$**	**678,599**
*Data Collection Period is 10 months, July 2009 to April 2010								

Table 8.3.5

Table 8.3.5 Payments by Waiver Type for Signs and Symptoms, Diagnosis Detail					
Category	DEA Allowed	DEA % of Total	DHS Allowed	DHS % of Total	Total
Urinary System	$ 165,952	75%	$ 27,346	38%	$ 193,298
Musculoskeletal Systems	$ 35,197	16%	$ 9,741	14%	$ 44,938
Unknown Causes Of Morbidity And Mortality	$ 1,469	1%	$ 23,164	32%	$ 24,633
Respiratory System	$ 4,115	2%	$ 4,219	6%	$ 8,334
General Symptoms	$ 7,963	4%	$ 94	0%	$ 8,057
Digestive System	$ 1,165	1%	$ 5,661	8%	$ 6,826
Skin Disorders	$ 3,109	1%	$ 263	0%	$ 3,373
Abdomen And Pelvis	$ 2,036	1%	$ 1,192	2%	$ 3,228
Head And Neck	$ 1,180	1%		0%	$ 1,180
Nonspecific Abnormal Findings	$ 149	0%	$ 20	0%	$ 169
Examination Of Blood	$ 96	0%		0%	$ 96
Cardiovascular Study	$ 45	0%		0%	$ 45
Totals	**$ 222,476**	**100%**	**$ 71,701**	**100%**	**$ 294,177**
*Data Collection Period is 10 months, July 2009 to April 2010					

Notes

1 National Center for Assisted Living, Issue Brief, Assisted Living-A Critical Option for American's Seniors, (05.25.10).

2 The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs (October 2009).

3 Robert L. Mollica, Ed.D., "State Medicaid Reimbursement Policies and Practices in Assisted Living," prepared for the National Center for Assisted Living American Health Care Association (Sept 2009).

4 The pharmacy data received show that $20,823 was paid for 67 prescriptions with 109 lines of service for 5 recipients.