Report to the Centers for Medicare and Medicaid Services

Quarterly Operation Report
Rhode Island Global Consumer Choice Compact
1115 Waiver Demonstration
January 1, 2012 – March 31, 2012

Submitted by the Rhode Island Executive Office of Health and Human Services (EOHHS)

May 2012

This Quarterly Operation Report has been prepared for the Centers for Medicare and Medicaid Services by the State's Executive Office of Health and Human Services pursuant to the requirements outlined in the State's Global Consumer Choice Compact (also known as the "Global Waiver"). The Quarterly Operational Report has been organized as follows:

- Section I provides an overview of Rhode Island's goals for the Global Waiver
- Section II includes key information on eligibility, expenditures and activities
- Section III presents key analytic highlights on the progress of the Global Waiver.

Section I

Goals of the State's Global Waiver: Rhode Island's Global Waiver was approved by the Centers for Medicare and Medicaid Services on January 16th, 2009, under the authority of Section 1115(a)(1) of the Social Security Act. The State sought and received Federal authority to promote the following goals:

- To rebalance the publicly-funded long-term care system in order to increase access to home and community-based services and supports and to decrease reliance on inappropriate institutional stays
- To ensure that all Medicaid beneficiaries have access to a medical home
- To implement payment and purchasing strategies that align with the Waiver's programmatic goals and ensure a sustainable, cost-effective program
- To ensure that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice
- To maximize available service options
- To promote accountability and transparency
- To encourage and reward health outcomes
- To advance efficiencies through interdepartmental cooperation

As Rhode Island articulated in its application to the Centers for Medicare and Medicaid Services (CMS), *the overarching goal of Rhode Island's Global Consumer Choice Waiver is to make the right services available to Medicaid beneficiaries at the right time and in the right setting*. Under the Global Waiver, the State's person-centered approach to service design and delivery has been extended to every Medicaid beneficiary, irrespective of age, care needs, or basis of eligibility.

Rhode Island in Relation to Other States: Prior to July 1st, 2009, the State undertook a judicious and deliberative planning phase to ensure that the Global Waiver's implementation would allow Rhode Island to attain its fundamental goals, by promoting the health and safety of Medicaid beneficiaries in a cost-effective manner. Through this strategic analysis, Rhode Island sought to capitalize upon the positive experience demonstrated by several States which have already achieved a reformation of their system of publicly-financed long-term care (LTC), with a shift from institutional to home and community-based services (HCBS), and a fundamental rebalancing of Medicaid

expenditures. Three States (Oregon, Washington, and New Mexico) have been nationally recognized for having achieved shifts in their LTC expenditures, with more than fifty percent of their Medicaid LTC spending now directed toward home and community-based services. Such shifts were not achieved rapidly, however, and required judicious action plans.

The Public Policy Institute at the American Association of Retired Persons (AARP) has identified twelve factors which have led to States' success in rebalancing LTC services and supports. A brief description is provided for the factors, which were cited[1] by the AARP's Public Policy Institute:

- *Philosophy* – The State's intention to deliver services to people with disabilities in the most independent living situation and expand cost-effective HCBS options guides all other decisions.
- *Array of Services* – States that do not offer a comprehensive array of services designed to meet the particular needs of each individual may channel more people to institutions than will States that provide an array of options.
- *State Organization of Responsibilities* – Assigning responsibility for overseeing the State's long-term services and supports to a single administrator has been a key decision in some of the most successful States.
- *Coordinated Funding Sources* – Coordination of multiple funding sources can maximize a State's ability to meet the needs of people with disabilities.
- *Single Appropriation* – This concept, sometimes called "global budgeting," allows States to transfer funds among programs and, therefore, make more rational decisions to facilitate serving people in their preferred setting.
- *Timely Eligibility* – Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, State Medicaid programs must be able to arrange for HCBS in a timely manner.
- *Standardized Assessment Tool* – Some States use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization.
- *Single Point of Entry* – A considerable body of literature points to the need for a single access point allowing people of all ages with disabilities to access a comprehensive array of LTC services and supports.
- *Consumer Direction* – The growing movement to allow participants a greater role in determining who will provide services, as well as when and how they are delivered, responds to the desire of people with disabilities to maximize their ability to exercise choice and control over their daily lives.
- *Nursing Home Relocation* – Some States have made systematic efforts to regularly assess the possibility of transitioning people out of nursing homes and into their own homes or more home-like community alternatives.

[1] Kassner, E., Reinhard, S., Fox-Grage, W., Houser, A., Accius, J. (2008). *A Balancing Act: State Long-Term Care Reform* (pp. ix – x). Washington, DC: AARP Public Policy Institute.

- *Quality Improvement* – States are beginning to incorporate participant-defined measures of success in their quality improvement plans.
- *Integrating Health and LTC Services* – A few States have developed methods for ensuring that the array of health and LTC services people with disabilities need are coordinated and delivered in a cost-effective manner.

Section II

Key Eligibility and Expenditure Metrics for the reporting period January 1, 2012 – March 31, 2012 are outlined below.

Rhode Island Medicaid Eligibility

Program	December 2011 Counts of Eligibles	March 2012 Counts of Eligibles
Aged	17,392	17,486
Disabled	28,070	28,085
BCCPT	216	240
QMBs, SLMBs, and QI 1s	6,049	6,618
Child and Families	131,709	133,261
Adoptive Subsidy	2,434	2,434
Foster Care	2,278	2,276
Children with Special Health Care Needs	8,837	8,813
Total	196,985	199,213

Care Management Program Enrollment

Program	Enrollment as of 12/31/11	Enrollment as of 03/31/12
RIte Care	124,655	125,598
RIte Share	11,571	11,492
Rhody Health Partners	13,424	13,579
PACE	210	208
Connect Care Choice	1,749	1,755
Connect Care	131	130
RIte Smiles	56,706	57,799
Early Intervention	2,032	2,063
BCCPT	216	240
Extended Family Planning	394	339

Cost Not Otherwise Matchable (CNOM) Program Enrollment

Program	Description	Enrollment as of 12/31/11	Enrollment as of 03/31/12
Budget Population 8	Children and families in managed care enrolled in RIte Care Medicaid parents have behavioral health conditions that result in their children being placed in temporary State custody	**0**	**0**
Budget Population 9	Children with special health care needs who are 21 and under who would otherwise be placed in voluntary State custody-residential diversion	**0**	**0**
Budget Population 10	Elders at risk of LTC	**1,437**	**1,459**
Budget Population 11	217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants Highest need group	**0**	**0**
Budget Population 12	217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants High need group	**0**	**0**
Budget Population 13	217-like, Medically Needy Individuals receiving HCBW-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community	**0**	**0**
Budget Population 14	Women screened for breast or cervical cancer under CDC program and not eligible for Medicaid	**216**	**240**
Budget Population 15	Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid	**2,008**	**2,095**
Budget Population 16	Uninsured adults with mental illness	**8,686**	**9,006**
Budget Population 17	Children at risk for Medicaid and/or institutional care	**2,515**	**2,605**
Budget Population 18	HIV positive individuals who are otherwise not eligible for Medicaid	**338**	**354**

Waiver Category Change Requests

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during this Quarterly Operational Report period January – March 2012

Request Type	Description	Date Submitted	CMS Action	Date
State Plan Amendment	Disproportionate Share Hospital Policy	06/27/11	Pending	
Category II	Elimination of Annual Nursing Facility Rate Adjustment	09/30/11	Pending	
State Plan Amendment	Single State Agency Designation	09/30/11	Pending	
Category II	Pain Management	02/09/12	Pending	
Category II	Nursing Facility Rate Reduction	03/29/12	Pending	

Cost Not Otherwise Matchable (CNOM)

Under the federal authority granted by CMS, the state has claimed $ 5,572,018 million federal dollars in Cost Not Otherwise Claimable (CNOM) during the reporting period.

Budget Neutrality

Under the terms of the Global Waiver, the State is subject to a limit on the amount of Federal Title XIX funding that it may receive on selected Medicaid expenditures during the demonstration period. The budget neutrality cap is for the Federal share of the total computable cost of $12.075 billion for the five-year demonstration period. Rhode Island has achieved Cumulative results of $ 1,932,549,212 million dollars below the cap during this reporting quarter. Attachment A contains the Budget Neutrality Report.

Key activities for the reporting period January 1, 2012 – March 31, 2012 are outlined below.

- Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports by changing the clinical level of care determination process for eligibility for Medicaid-funded long-term care from institutional to needs-based

    - As of March 31, 2012, a total of **1,973 Level of Care (LOC) assessments** had been completed, resulting in the following determinations: **Highest LOC = 1,294**; **High LOC = 556**; and **Preventive LOC = 97**. Twenty-five (26) individuals did not meet a LOC.

- Ensure the appropriate utilization of institutional services and facilitate access to community-based services and supports by designing and implementing a Nursing Facility Transition project to identify individuals who could be safely discharged from the nursing home to a community-based setting

    - **Safely transitioned a total of 1,086 individuals to date to a community setting in the Nursing Facility Transition program and the MFP program**
    - **129 Nursing Home Transition referrals** were made to the Office of Community (OCP) Programs during Q-3 of SFY 2012
    - **39 individuals** were transitioned to a community setting during the reporting quarter. Of the 39 individuals, 4 were enrolled in the MFP demonstration
    - Provided ongoing training of State staff in the EOHHS Office of Community Programs, DHS Long Term Care, and the DEA Home and Community Care
    - Ongoing monitoring of the use of protocols for weekend discharges and inpatient diversion discharges to nursing facilities
    - Tracked Nursing Facility Diversions associated with level of care (LOC) assessments and diversions made by the Connect Care Choice program
    - Aligned planning activities under the *Money Follows the Person* with the Nursing Home Transition Program
    - Convened *Money Follows the Person* Steering Committee and subcommittees in January, February and March 2012

- Expand access to community-based services and supports by implementing a preventive level of care (LOC)

    - During Q-3 of SFY 2012, **97 individuals met the Preventive Level of Care** and received services
    - Explored opportunities for a proposed expansion of Respite Services and transition services with funding available under the *Money Follows the Person* Demonstration Grant

- Expand access to community-based services and supports by providing access to Shared Living for the elderly and adults with physical disabilities

- **Enrolled 72 individuals in the EOHHS Shared Living program** as of March 31, 2012
- Completed the following activities for the enrolled individuals: made home visits, conducted level of care (LOC) assessments, developed and approved service and safety plans, carried out caregiver BCI background checks, and provided training for caregivers
- Reviewed report presented by Caregiver Homes on outcome measurement, data analysis and costs
- Renamed program to "RIte @ Home"

- Expand access to community-based services and supports, focusing upon home health care, assisted living, and adult day services

  - Continued planning efforts under the *Money Follows the Person* Demonstration Grant
  - Continued transitions under the *Money Follows the Person* Demonstration
  - Participated in regular *Money Follows the Person* Technical Assistance sessions
  - Worked with the Assisted Living Trade Organization to identify assisted living facilities that would meet the CMS definition as a "qualified residence" under the *Money Follows the Person* Demonstration Grant application
  - Commenced planning for the Money Follows the Person Rebalancing Demonstration (MFP) 2012 Aging and Disability Resource Center (ADRC) Supplemental Funding
  - Continued to explore opportunities for Affordable Care Act (ACA) funding to support expanding the Home Care initiatives
  - Continued to explore acuity-based funding for adult day services
  - Completed the development and launched the RIte Resources web-based inventory of long term care services in RI in March 2012

- Improve the coordination of all publicly-funding long-term care services and supports through the EOHHS' Assessment and Coordination Organization (ACO)

  - Continued cross-departmental planning for Long Term Care Consolidation
  - Convened cross-departmental planning for state and federal opportunities for Integrated Care for Medicare and Medicaid Beneficiaries and Managed Long Term Care for Medicaid-only beneficiaries
  - Met bi-monthly with the CMS CCMI team to discuss opportunities under the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees
  - Convened stakeholder meetings on Integrate Care for Medicare-Medicaid Enrollees
  - Analyzed data to support Integrate Care for Medicare-Medicaid Enrollees
  - Explored opportunities under the Affordable Care Act (ACA), including Balancing Incentive Program and Community First Choice for Medicaid Enrollees

- Improve the coordination of all publicly-funded long-term care services and supports, by focusing on the needs of beneficiaries whose care results in high costs

    - Monitored interventions in *Communities of Care* for high utilizers enrolled in the State's managed care health plan delivery system (RIte Care and Rhody Health Partners participating Health Plans and the State's Primary Care Case Management (PCCM) delivery system (Connect Care Choice)
    - Commenced the development of the program evaluation of the *Communities of Care* initiative
    - Commenced the mailing of the brochures for the *Communities of Care* initiative
    - Implemented targeted interventions for high utilizers of pharmacy benefits in the State's Medicaid FFS and managed care delivery systems
    - Submitted the Category II request and promulgated policy changes for the pain management benefit
    - Continued research of the LifeLine cell phone program for Medicaid beneficiaries
    - Explored opportunities for improvement to the care planning assessment tools
    - Implemented regulatory changes to the Personal Choice self-directed program to ensure appropriate levels of service authorization

- Improve the coordination of all publicly funded long-term care services and supports, by revising the Sherlock Plan (Rhode Island's Medicaid buy-in program for adults with disabilities who seek to gain or maintain employment while still retaining health coverage.)

    - Issued regulatory changes to the Sherlock Plan to improve program participation

- Analyze Medicaid Managed Long Term Care models

    - Participated in the CHCS-TA initiative, Implementing Innovations in Long-term Supports and Services (LTSS), funded by SCAN Foundation
    - Submitted the Managed Care Effectiveness Report
    - Continued developing the Integrated Care for Medicare and Medicaid beneficiaries Report
    - Researched best practices and met with key informants

- Promote the adoption of "Medical Homes"

    - Monitoring the implementation of the two *Health Homes for Medicaid Enrollees with Chronic Conditions Initiatives*
    - Participated in the statewide CSI Rhode Island Medical Home Project
    - Exploring opportunities for additional Health Home models of care for additional populations

- Promote the adoption of electronic health records

    - Continued implementing activities under the DRA Medicaid Transformation Grant
    - Continued the voluntary enrollment of Medicaid beneficiaries in Rhode Island Medicaid's **current***care* electronic medical record (EMR)
    - Implemented the process for EMR funding for Medicaid providers
    - Executed MOUs for Nursing Facilities' purchase of computers to support activities under the DRA Medicaid Transformation Grant
    - Implemented activities for P-APD (IT Global Waiver and MITA Planning)
    - Issued RFP for Transition, Enhancement, Operation and Maintenance of the Medicaid Management Information System (MMIS)
    - Completed the planning and implementation for statewide web-based, real-time inventory of LTCSS, RIte Resources

- Participate in Health Insurance Exchange Planning

    - Participated in the Health Insurance Exchange Planning Grant activities
    - Participated in the Regional Health Insurance Exchange Planning Grant activities
    - Continued planning for the United Health Infrastructure, the state's health benefits exchange and integrated eligibility system (HIX/IES)

- Implement competitive selective contracting procurement methodologies to assure that the State obtains the highest value and quality of services for its beneficiaries at the best price

    - Monitored implementation of the new initiatives in the capitated Medicaid managed care program, focusing on selective contracting strategies
    - Analyzed value-based purchasing strategies for the Managed LTC under the Integrated Care for Medicare and Medicaid beneficiaries and Medicaid-only beneficiaries opportunities
    - Exploring opportunities to selectively contract with a Community Health Care Team for under an Enhanced PPCM model for dually eligible and Medicaid-only populations

- Develop and implement procurement strategies that are based on acuity level and the needs of beneficiaries

    - Reviewed opportunities for selective contracting strategies as part of the implementation of the SFY 2012 budget initiatives
    - Developed opportunities for selective contracting for SFY 2013 budget initiatives
    - Continued to refine recommendations for long-term care acuity adjustments to meet budget targets
    - Presented an update on the status of the RI Nursing Facility Payment Methodology refinements included in the Category II request

- Continue to execute the State's comprehensive communications strategy to inform stakeholders (consumers and families, community partners, and State and Federal agencies) about the Global Waiver

    - Convened three meetings with the Global Waiver Task Force on 01/23/2012, 02/27/2012 and 03/26/2012
    - Convened the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 03/07/2012
    - To promote transparency, meeting notes and agenda for the Global Waiver Task Force and the Rhode Island Medicaid Medical Advisory Committee (MCAC) were posted on the EOHHS' Web site
    - Posted on the EOHHS website information on the Integrated Care for Medicare and Medicaid Beneficiaries, the *Rhode to Home* MFP Demonstration, and Veteran's Annual Report
    - Posted EOHHS Notice of Proposed Rulemaking and Policy Changes in January 2012 and February 2012

Section III

Key analytic highlights on the progress of the Global Waiver based on performance during the First Quarter of the SFY 2012 (July 1, 2011 – September 30, 2011).

A. The number of new applicants found eligible for Medicaid funded long-term care services, as well as the basis for the eligibility determination, including level of clinical need and any HIPAA compliant demographic data about such applicants.

There are numerous pathways that lead applicants to Rhode Island Medicaid for long-term care (LTC) eligibility determinations. Major sources of referrals for Medicaid LTC eligibility determinations include hospitals, nursing facilities, and community-based programs. These avenues are discussed further in Item L. In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria.

The following table outlines the number of Medicaid LTC applicants who were deemed to be eligible for Medicaid LTC during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011). The following tables represent a "point-in-time" snapshot of the number of approved applications for Medicaid LTC coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for Q-1 of SFY 2012.

RI MEDICAID: Medicaid Long-term Care Acceptances (Approvals), Q-1, SFY 2012

Month	Long-Term Care Approvals
July 2011	243
August 2011	249
September 2011	258
Total for Q-1, SFY 2012	**750**

Source: InRhodes

B. The number of new applicants found ineligible for Medicaid funded long-term care services, as well as the basis for the determination of ineligibility, including whether ineligibility resulted from failure to meet financial or clinical criteria, and any HIPAA compliant demographic data about such applicants.

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. The following table outlines the number of Medicaid LTC applicants who were found ineligible during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011). InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics. The number of denials documented below represents a "point-in-time" snapshot of activity. This information has been provided by month for Q-1 of SFY 2012.

RI MEDICAID: Medicaid Long-term Care Denials, Q-1, SFY 2012

Month	Long-Term Care Denials
July 2011	49
August 2011	39
September 2011	50
Total for Q-1, SFY 2012	**138**

Source: InRhodes

In comparing the quarterly total to prior intervals, it was noted that the total number of LTC denials for the First Quarter of SFY 2012 (n = 138) was similar to that which was demonstrated in the First Quarter of SFY 2011 (n = 136)[2]. Fewer denials were seen in Q-1 of SFY 2012 in comparison to the Fourth Quarter of SFY 2011 (n = 185)[3].

[2] The Rhode Island Executive Office of Health and Human Services. (June 30, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, July 1, 2010 – September 30, 2010 and October 1, 2010 – December 31, 2010 (p. 10).

[3] The Rhode Island Executive Office of Health and Human Services. (December 15, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information,* April 1, 2011 – June 30, 2011 (p. 10).

C. The number of Medicaid beneficiaries, by age, over and under 65 years, served in institutional and home and community-based long-term care settings, by provider and service type and/or delivery system as applicable, including: nursing facilities, home care, adult day services for elders and persons with disabilities, assisted living, personal attendant and homemaker services, PACE, public and private group homes for persons with developmental disabilities, in-home support services for persons with developmental disabilities, shared living, behavioral health group home, residential facility and institution, and the number of persons in supported employment.

Two data sources have been queried to produce the data pertaining to the number of Medicaid beneficiaries, stratified according to two age groups (less than 65 years of age and greater than or equal to 65 years of age) who were served in institutional and home and community-based long-term care settings, by provider and service type and/or delivery system during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011).

Data Sources: Using the EOHHS Data Warehouse, information was extracted from the Medicaid Management Information System (MMIS) to produce counts of the number of Medicaid beneficiaries who received LTC services that are administered by the RI Division of Elderly Affairs and RI Medicaid. A second database was used to calculate the number of Medicaid beneficiaries who received LTC services that are administered by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH).

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-1, SFY 2012 (RI DEA): The first set of tables quantifies the number (or count) of individuals who received LTC services provided under the auspices of the Rhode Island Division of Elderly Affairs (RI DEA) during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011).

Units of service have been defined as follows for the DEA's set of services:

DEA: LTC Service Type and Corresponding Unit of Service

Service Type	Unit of Service
Assisted Living	Per Diem (Per Day)
Case Management	Per 15-Minute Intervals
Personal Care/Homemaker	Per 15-Minute Intervals

The following set of tables which documents the number of Medicaid beneficiaries has been stratified by participants' age group for the following lines of service which are administered by the RI DEA: Assisted living; case management, and personal care/homemaker. This information has been stratified by month and by age group.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Jul		Aug		Sep		Q-1, SFY 2012	
Reporting Period: Date of Service			2011		2011		2011			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
	Assisted Living	Under 65	50	1,520	47	1,448	45	1,334	142	4,302
		65 and Older	235	7,182	224	6,790	203	5,913	662	19,885
DEA	Assisted Living	Service Type Subtotals:	285	8,702	271	8,238	248	7,247	804	24,187
	Case Management	Under 65	36	196	26	118	40	145	102	459
		65 and Older	434	2,132	431	2,316	406	1,977	1,271	6,425
DEA	Case Management	Service Type Subtotals:	470	2,328	457	2,434	446	2,122	1,373	6,884
	Personal Care/Homemaker	65 and Older	410	111,041	410	113,167	403	108,357	1,223	332,565
DEA	Personal Care/Homemaker	Service Type Subtotals:	410	111,041	410	113,167	403	108,357	1,223	332,565
DEA		Grand Total:		122,071		123,839		117,726		363,636

Please refer to Item G for a discussion about the DEA's Adult Day Care and Home Care Program, which is otherwise known as the "Co-pay" Program.

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-1, SFY 2012 (RI Medicaid): The second set of tables shows the number (or count) of individuals who received LTC services through Rhode Island Medicaid during the First Quarter of SFY 2012. This information reflects incurred dates of service (July 1, 2011 through September 30, 2011) and has been stratified according to the two age groups (less than 65 years of age and greater than or equal to 65 years of age) as requested.

Units of service have been defined in the following manner.

RI Medicaid: LTC Service Type and Corresponding Unit of Service

Service Type	**Unit of Service**
Adult Day	Per Diem (Per Day)
Assisted Living	Per Diem (Per Day)
Case Management	Per 15 Minute Intervals
Home Health Agency	Mixed*
Hospice	Per Diem (Per Day)
Nursing Facility	Per Diem (Per Day)
Personal Care/Homemaker	Per 15-Minute Intervals
Shared Living	Per Diem (Per Day)
Tavares Pediatric Center	Per Diem (Per Day)

The description of the units of service for home health has been highlighted with an asterisk (*) because of its "mixed" designation. Two types of home health services (home health aide and skilled (registered nurse/RN) nursing care) have different units of services. Depending upon the procedure code used, home health aide services are quantified in 15-minute or 30-minute units of service whereas skilled nursing services provided by a registered nurse are counted on a per visit basis.

Information which documents the number of Medicaid beneficiaries who were served has been stratified by participants' age group for the following lines of service which are administered by RI Medicaid: Adult day care; assisted living; case management; home health agency; hospice; nursing facility; personal care/homemaker; shared living; and Tavares Pediatric Center. This information has been stratified by month and by age

group. Data tables are shown below, with information organized by month for the First Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Jul		Aug		Sep		Q-1, SFY 2012	
Reporting Period: Date of Service			2011		2011		2011			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
EOHHS	Adult Day Care	Under 65	253	3,510	262	3,510	261	3,218	776	10,238
		65 and Older	238	3,307	239	3,523	242	3,404	719	10,234
EOHHS	Adult Day Care	Service Type Subtotals:	491	6,817	501	7,033	503	6,622	1,495	20,472
	Assisted Living	Under 65	12	368	11	340	11	313	34	1,021
		65 and Older	150	4,451	141	4,243	140	4,050	431	12,744
EOHHS	Assisted Living	Service Type Subtotals:	162	4,819	152	4,583	151	4,363	465	13,765
	Case Management	Under 65	270	562	257	408	710	969	1,237	1,939
		65 and Older	106	556	110	582	110	505	326	1,643
EOHHS	Case Management	Service Type Subtotals:	376	1,118	367	990	820	1,474	1,563	3,582
	Hospice	Under 65	47	1,215	46	1,057	33	964	126	3,236
		65 and Older	553	14,525	540	14,170	498	13,096	1,591	41,791
EOHHS	Hospice	Service Type Subtotals:	600	15,740	586	15,227	531	14,060	1,717	45,027
	Nursing Facility	Under 65	560	15,973	557	15,804	539	15,266	1,656	47,043
		65 and Older	5,071	150,438	5,006	148,651	5,014	144,220	15,091	443,309
EOHHS	Nursing Facility	Service Type Subtotals:	5,631	166,411	5,563	164,455	5,553	159,486	16,747	490,352
	Personal Care/Homemaker	Under 65	1,002	278,985	1,005	284,692	1,027	271,961	3,034	835,638
		65 and Older	1,255	352,685	1,261	364,335	1,273	347,998	3,789	1,065,018
EOHHS	Personal Care/Homemaker	Service Type Subtotals:	2,257	631,670	2,266	649,027	2,300	619,959	6,823	1,900,656
	Shared Living Agency	Under 65	14	786	15	886	15	900	44	2,572
		65 and Older	35	2,045	41	2,383	43	2,579	119	7,007
EOHHS	Shared Living Agency	Service Type Subtotals:	49	2,831	56	3,269	58	3,479	163	9,579
	Skilled Nursing	Under 65	204	2,803	215	3,500	212	2,836	631	9,139
		65 and Older	117	1,997	108	2,178	116	1,837	341	6,012
EOHHS	Skilled Nursing	Service Type Subtotals:	321	4,800	323	5,678	328	4,673	972	15,151
	Tavares Pediatric Center	Under 65	18	558	19	566	19	546	56	1,670
EOHHS	Tavares Pediatric Center	Service Type Subtotals:	18	558	19	566	19	546	56	1,670
EOHHS		Grand Total:		834,764		850,828		814,662		2,500,254

<u>The Number of Medicaid Beneficiaries Served by PACE, Q-1, SFY 2012 (RI Medicaid)</u>: Using the EOHHS Data Warehouse, information was extracted from the MMIS to produce counts of the number of individuals who participated in the PACE (Program of All Inclusive Care for the Elderly) program during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011). Please refer to the data table shown on the following page. This information has been stratified by month and by age group.

Source:		EOHHS Data Warehouse/Financial Data Mart		
Reporting Period:		Eligibility Period		
Dept.	**Benefit Period**	**Program Description**	**Age Group**	**Person Count**
EOHHS	7/1/2011	PACE PROGRAM	65 and Over	173
EOHHS		PACE PROGRAM	Under 65	37
	7/1/2011		**Period Totals:**	210
EOHHS	8/1/2011	PACE PROGRAM	65 and Over	171
EOHHS		PACE PROGRAM	Under 65	37
	8/1/2011		**Period Totals:**	208
EOHHS	9/1/2011	PACE PROGRAM	65 and Over	176
EOHHS		PACE PROGRAM	Under 65	37
	9/1/2011		**Period Totals:**	213
			Quarterly Total:	**631**

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-1, SFY 2012 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). As requested, this information has been stratified according to two age groups for participants for the following lines of service which are administered by the RI BHDDH: Day programs; homemaker services; public group homes for persons with developmental disabilities; private group homes for persons with developmental disabilities; family supports; shared living; supported employment; case management; prevocational and job development.

Data for the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011) have been provided on the following page. It should be noted that RI BHDDH implemented a new billing and authorization system on 07/01/2011 and providers now bill for each service based on unique HCPCS coding. An individual may receive both supported employment and day program services in the same reporting period. In the prior system it was coded as only supported employment or a day program. The current system reports present a clearer picture as to the number of individuals receiving actual supported employment, vocational rehab or day programs.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-1, SFY 2012

Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2,774
		Over 65	274
BHDDH	Homemaker	Under 65	126
		Over 65	9
BHDDH	Public Group Homes	Under 65	137
		Over 65	82
BHDDH	Private Group Homes	Under 65	1,140
		Over 65	164
BHDDH	Community Supports	Under 65	1,064
		Over 65	68
BHDDH	Shared Living	Under 65	162
		Over 65	13
BHDDH	Supported Employment	Under 65	405
		Over 65	8
BHDDH	Case Management	Under 65	2,962
		Over 65	266
BHDDH	Transportation	Under 65	2,414
		Over 65	213
BHDDH	Prevocational	Under 65	192
		Over 65	12
BHDDH	Job Development	Under 65	41
		Over 65	1

D. Data on the cost and utilization of service units for Medicaid long-term care beneficiaries.

The following information has been organized by State agency and is based upon incurred (or the actual date when a service was delivered) dates of service for long-term care (LTC) services which were provided during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one that shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

Data Sources: Because this report covers the early phase of the Global Waiver's implementation, two data sources have been used in producing the cost and utilization information which has been requested. The first data source is Rhode Island's Medicaid Management Information System (MMIS). Using the EOHHS Data Warehouse, information was extracted from the MMIS for the LTC services administered by the RI Division of Elderly Affairs and RI Medicaid.

A second data source was queried to produce the cost and utilization data for the LTC services which are administered by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The database which is used by the Division of Developmental Disabilities (RI BHDDH) was queried to prepare the table which outlines LTC cost and utilization by BHDDH service line during the First Quarter of SFY 2012.

Cost and Utilization Data, Q-1, SFY 2012 (RI DEA): The following table provides an average cost per individual, as well as quarterly totals by DEA service line, for the two age groups during the First Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-1, SFY 2012	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
	Assisted Living	Under 65	$ 923	$ 131,033
		65 and Older	$ 836	$ 553,726
DEA	Assisted Living	Service Type Subtotals:	$ 852	$ 684,760
	Case Management	Under 65	$ 68	$ 6,885
		65 and Older	$ 76	$ 96,375
DEA	Case Management	Service Type Subtotals:	$ 75	$ 103,260
	Personal Care/Homemaker	65 and Older	$ 1,372	$ 1,678,487
DEA	Personal Care/Homemaker	Service Type Subtotals:	$ 1,372	$ 1,678,487
DEA		Grand Total:		$ 2,466,506

Cost and Utilization Data, Q-1, SFY 2012 (RI Medicaid): The following table provides an average cost per individual, as well as quarterly totals by RI Medicaid service line, for the two age groups during the First Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-1, SFY 2012	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
EOHHS	Adult Day Care	Under 65	$ 699	$ 542,369
		65 and Older	$ 754	$ 542,194
EOHHS	Adult Day Care	Service Type Subtotals:	$ 725	$ 1,084,562
	Assisted Living	Under 65	$ 1,259	$ 42,805
		65 and Older	$ 1,172	$ 504,935
EOHHS	Assisted Living	Service Type Subtotals:	$ 1,178	$ 547,740
	Case Management	Under 65	$ 85	$ 104,533
		65 and Older	$ 75	$ 24,426
EOHHS	Case Management	Service Type Subtotals:	$ 83	$ 128,959
	Hospice	Under 65	$ 4,557	$ 574,158
		65 and Older	$ 3,885	$ 6,181,727
EOHHS	Hospice	Service Type Subtotals:	$ 3,935	$ 6,755,885
	Nursing Facility	Under 65	$ 4,796	$ 7,942,264
		65 and Older	$ 4,645	$ 70,101,798
EOHHS	Nursing Facility	Service Type Subtotals:	$ 4,660	$ 78,044,062
	Personal Care/Homemaker	Under 65	$ 1,421	$ 4,311,985
		65 and Older	$ 1,444	$ 5,472,336
EOHHS	Personal Care/Homemaker	Service Type Subtotals:	$ 1,434	$ 9,784,320
	Shared Living Agency	Under 65	$ 2,042	$ 89,847
		65 and Older	$ 2,020	$ 240,333
EOHHS	Shared Living Agency	Service Type Subtotals:	$ 2,026	$ 330,180
	Skilled Nursing	Under 65	$ 398	$ 251,006
		65 and Older	$ 548	$ 187,003
EOHHS	Skilled Nursing	Service Type Subtotals:	$ 451	$ 438,009
	Tavares Pediatric Center	Under 65	$ 30,688	$ 1,718,524
EOHHS	Tavares Pediatric Center	Service Type Subtotals:	$ 30,688	$ 1,718,524
EOHHS		Grand Total:		$ 98,832,243

Cost and Utilization Data, Q-1, SFY 2012 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). Currently, as part of its developmental disabilities budget initiative, the Division is engaged in work with Hewlett Packard to develop a new database and claims payment process. The new database will provide functionality to aid in extracting data, leading to greater ease in the development of standardized reports. Please refer to the table that has been provided on the following page.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-1, SFY 2012				
Dept.	**Service Type**	**Age Group**	**# Served**	**Total Expenditures**
BHDDH	Day Programs	Under 65	2,774	$7,638,698.13
		Over 65	274	717,453
BHDDH	Homemaker	Under 65	126	780,878.70
		Over 65	9	58,011.52
BHDDH	Public Group Homes	Under 65	137	5,349,518.51
		Over 65	82	3,197,677.75
BHDDH	Private Group Homes	Under 65	1,140	22,424,612.30
		Over 65	164	3,069,880.34
BHDDH	Family Supports	Under 65	1,064	3,174,971.38
		Over 65	68	255,828.12
BHDDH	Shared Living	Under 65	162	1,308,737.49
		Over 65	13	98,848.05
BHDDH	Supported Employment	Under 65	405	333,598.57
		Over 65	8	2,105.10
BHDDH	Case Management	Under 65	2,962	1,131,722.74
		Over 65	266	108,497.81
BHDDH	Transportation	Under 65	2,414	1,775,262.94
		Over 65	213	151,585.88
BHDDH	Prevocational	Under 65	192	146,012.15
		Over 65	12	8,568.86
BHDDH	Job Development	Under 65	41	17,494.75
		Over 65	1	225.76

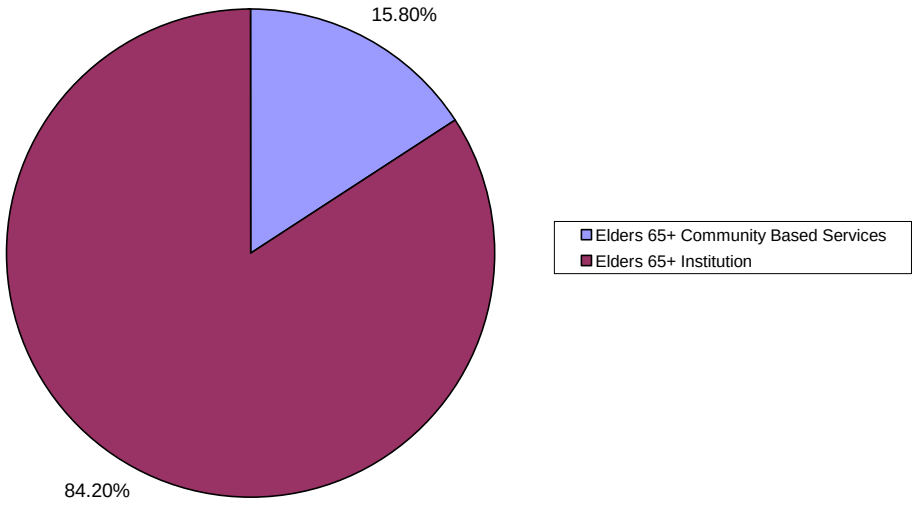
E. Percent distribution of expenditures for Medicaid long-term care institutional services and home and community services (HCBS) by population, including: elders aged 65 and over, persons with disabilities, and children with special health care needs.

Medicaid Long Term Care (LTC) services are available for individuals over age 65 and for individuals with disabilities. The types of services available include institutional and home and community-based services. The following charts show the percent distribution of expenditures for Medicaid long-term care institutional services and home and community-based services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (July 1, 2011 – September 30, 2011).

Elders Aged 65 and Over

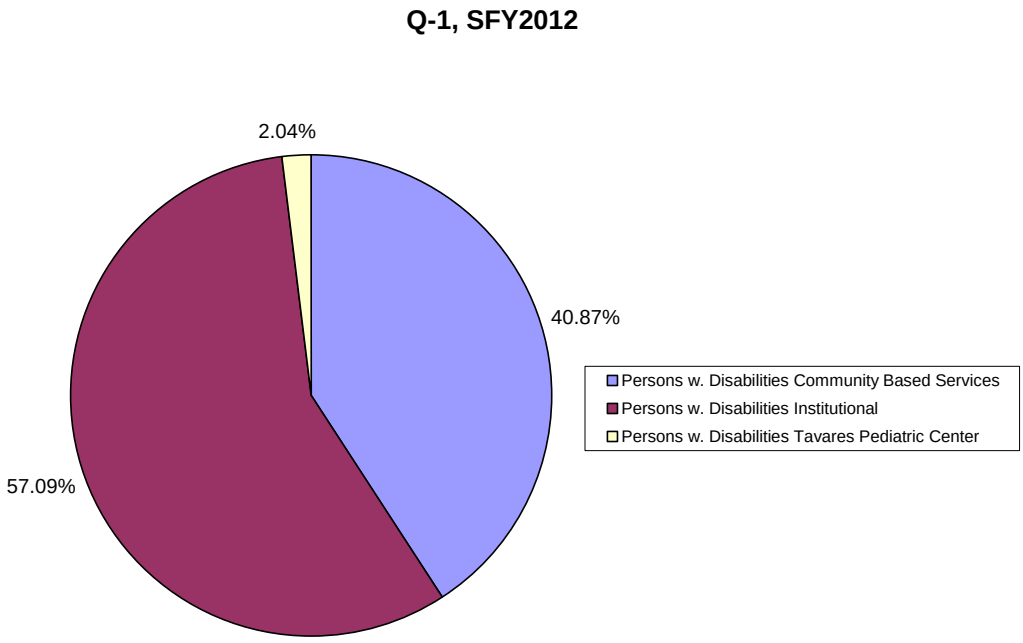
During the First Quarter of SFY 2012, 84.20 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.80 percent were for home and community-based services (HCBS). These findings are similar to those demonstrated during the preceding quarter, Q-4 of SFY 2011, when 84.14 percent of expenditures for elders were for Medicaid long-term care institutional services and 15.86 percent were for home and community-based services.

Q-1, SFY2012



Children with a disability or chronic condition are eligible for the Medical Assistance if they are determined eligible for: Supplemental Security Income (SSI), Katie Beckett or Adoption Subsidy through RI Medicaid.

Persons with Disabilities: Individuals with disabilities are eligible for Medical Assistance if they are 18 years or older, a Rhode Island resident, receive Supplemental Security Income (SSI) or have an income less than 100% of the Federal Poverty Level (FPL) and have resources (savings) of less than $4,000 for an individual or $6,000 for a married couple. The following chart shows the percent distribution of expenditures for Medicaid institutional services and home and community services for persons with disabilities. The utilization data were abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (July 1, 2011 – September 30, 2011).



During the First Quarter of SFY 2012, 57.09 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services, 2.04 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services at the Tavares Pediatric Center, and 40.87 percent were for home and community-based services (HCBS). For purposes of comparison, the following quarterly information has been provided for SFY 2011, specific to the percentage of expenditures for home and community-based services (HCBS): Q-1, SFY 2011 = 41.63 percent; Q-2, SFY 2011 = 41.75 percent; Q-3, SFY 2011 = 40.43 percent; and Q-4, SFY = 42.05 percent.

F. The number of persons on waiting lists for any long-term care services.

Prior to implementation of the Global Waiver, the State's former home and community-based waivers were operated discretely, each having Federal authorization to provide services to an established maximum number of beneficiaries. In addition, each of Rhode Island's former 1915(c) waivers had different "ceilings" or "caps" on the number of Medicaid LTC enrollees who could receive that waiver's stipulated set of home and community-based services. These established limits on the number of participating beneficiaries were sometimes referred to as "slots". When any of the former 1915(c) waivers reached its maximum number of participants, no additional beneficiaries could gain a "slot" for services.

With the implementation of the Global Waiver, Rhode Island received Federal authority to remove any administrative ceilings or caps on the number of Medicaid LTC beneficiaries who could be approved to receive home and community-based services. This change was in accord with the State's goal *to make the right services available to Medicaid beneficiaries at the right time and in the right setting*. Thus, as a result of removing slots for home and community-based services, access has been enhanced for Medicaid LTC beneficiaries since the Global Waiver's implementation.

During the First Quarter of State Fiscal Year 2012, there were no waiting lists for Medicaid LTC services. In addition, the Division of Elderly Affairs and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH) reported that there were no waiting lists for any long-term care services.

G. The number of persons in a non-Medicaid funded long-term care co-pay program by type and units of service utilized and expenditures.

The Division of Elderly Affairs (DEA) administers what has been referred to in the community as the "Co-pay Program". This Program provides adult day and home care services to individuals who are sixty-five (65) years of age and older, who are at risk of long term care, and are at or below 200% of the federal poverty level (FPL). The Program has two service categories, as described in the table below:

Service Category	Income Level
Level D1	0 to 125% FPL
Level D2	126% to 200% FPL

Individuals are assessed for eligibility across several parameters, including functional, medical, social, and financial status. Participant contributions (which have been referred to as "co-pays") are determined through a calculation of community living expense (CLE), which is performed during the assessment process.

The following information, provided by the Division of Elderly Affairs, covers the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011). The tables shown below document the service utilization of the DEA's Adult Day Care and Home Care Program (also referred to as the "Co-pay" Program). This information has been organized for each type of service by quarter.

RI DEA: Adult Day Care (Q-1, SFY 2012)

Service Category: Adult Day Care	**Clients***		**Units (Unit=1 Day)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	148	49	2,056	685
D2 (Income up to 200% FPL):	630	210	9,285	3,095
Total	**778**	**259**	**11,341**	**3,780**
Average utilization= 15 days of adult day care per client per month.				
*Clients are not distinct.				

RI DEA: Case Management (Q-1, SFY 2012)

Service Category: Case Management	**Clients**		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
Case Management	913	304	4,860	1,620
Average utilization = 1.33 Hours of Case management per client per month.				

RI DEA: Home Care (Q-1, SFY 2012)

Service Category: Home Care	**Clients***		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	409	136	41,347	13,782
D2 (Income up to 200% FPL):	1,458	486	165,917	55,306
Total	**1,867**	**622**	**207,264**	**69,088**
Average utilization= 111 units or 28 hours of home care per client per month.				
*Clients are not distinct				

H.	The average and median length of time between submission of a completed long-term care application and Medicaid approval/denial.

There are numerous pathways that lead applicants to Rhode Island Medicaid for long-term care (LTC) eligibility determinations. Major sources of referrals for Medicaid LTC eligibility determinations include hospitals, nursing facilities, and community-based programs. These avenues have been discussed further in Item L.

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. Thus, the EOHHS has interpreted that a completed LTC application would be inclusive of all of the requisite components needed in order to execute a LTC eligibility determination. Most new LTC applications, however, are not submitted in a fully complete manner. As noted in the Rhode Island Department of Human Services' *Codes of Rules, Medical Assistance*, eligibility decisions for disabled applicants are to be made within ninety (90) days, except in unusual circumstances when good cause for delay exists.[4] Good cause exists when the DHS cannot reach a decision because the applicant or examining physician delays or fails to take a required action or when there is an administrative or other emergency beyond the agency's control.

Necessary components of a long-term care application include the findings from the medical evaluations that substantiate a clinical need for LTC, as well as the State's Medicaid LTC clinical eligibility screening. (Please refer to Item J for a presentation of the average and median turn-around times for Medicaid LTC Clinical Eligibility Determinations, which are conducted by the Office of Medical Review.) In addition to the necessary clinical information, the LTC application must include the *Statement of Need* form (Rhode Island Department of Human Services, DHS-2, Rev. 5-06), which has been completed by or on behalf of the applicant. In addition, the processing of long-term care applications must undergo review by the Office of Legal Counsel if any of the following circumstances exist, per the Rhode Island Department of Human Services, Codes of Rules, Medical Assistance:

- If there are any questions about the negotiability of promissory notes, mortgages, and loans[5]
- If a resource cannot be sold or liquidated and a determination regarding availability cannot be made by the LTC Administrator[6]
- If an individual claims that a real property resource cannot be liquidated and documentation has been submitted from a competent authority (e.g., real estate broker or attorney)[7]

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[4] The Rhode Island Department of Human Services. *Code of Rules, Medical Assistance,* Section 0302.15 (*Decision on Eligibility*), https://www.policy.dhs.ri.gov/.

[5] Ibid, Section 0382.15.20.05 (*Negotiability of Instruments*), https://www.policy.dhs.ri.gov/.

[6] Op cit, Section 0382.15.20.15 (*Salability*), https://www.policy.dhs.ri.gov/.

7 Op cit, Section 0382.10.10.10 (*Docu Non-Avail of Real Est*), https://www.policy.dhs.ri.gov/.

- If there is a claim of undue hardship, the LTC Administrator, in consultation with the Office of Legal Counsel, makes a determination[8]
- If consultation is needed by the LTC Administrator to aid in the determination of the amount of countable income and/or resources from a trust (and the date and amount of any prohibited transfer of assets)[9]

Information has been drawn from InRhodes, the State's Medicaid eligibility system, to produce the following cohort analysis for LTC processing turn-around times during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011). Turn-around times (TAT) for processing new LTC applications have been organized according to three timeframes: a) less than thirty (30) days; b) thirty (30) to ninety (90) days; and greater than ninety (90) days.

On average, approximately thirty (30) percent of all new LTC applications that are processed by RI Medicaid are those that have been submitted by current Medicaid enrollees. This subset of LTC applications (i.e., those filed by current Medicaid beneficiaries) tends to be adjudicated very quickly.

The following statistics, however, reflect the processing of <u>new</u> applications for long-term care (LTC) coverage for individuals who are not already enrolled in Medicaid. Thus, the following information addresses a specific subset of the LTC applications that are processed by RI Medicaid.

RI MEDICAID: Turn-around Times for New LTC Applications (Q-1, SFY 2012)

Month	**< 30 Days**		**30 – 90 Days**		**> 90 Days**		**Monthly Total**	
July 2011	110	31.79%	198	57.23%	38	10.98%	**346**	**100%**
Aug. 2011	112	28.35%	241	61.01%	42	10.63%	**395**	**100%**
Sept. 2011	122	33.33%	196	53.55%	48	13.11%	**366**	**100%**
Total for Q-1, SFY 2012	**344**	**31.07%**	**635**	**57.36%**	**128**	**11.56%**	**1,107**	**100%**

Source: InRhodes

A decline in the percentage of new LTC applications processed in more than ninety (90) days was demonstrated in Q-1 of SFY 2012, in comparison to Q-4 of SFY 2011. This decline represents a positive trend and it builds on that which was seen throughout SFY 2011. For purposes of comparison, please refer to the table that documents the turn-around times by quarter during SFY 2011, which has been provided on the following page.

[8] Op cit, Section 0382.50.25 (*Claims of Undue Hardship*), https://www.policy.dhs.ri.gov/.
[9] Op cit, Section 0382.50.15 (*Trust Evaluation Process*), https://www.policy.dhs.ri.gov/.

RI MEDICAID: Turn-around Times for New LTC Applications by Quarter (SFY 2011)

Quarter	< 30 Days		30 – 90 Days		> 90 Days		Quarterly Total	
Q-1, SFY 2011	355	28.22%	600	47.69%	303	24.09%	1,258	100%
Q-2, SFY 2011	341	28.53%	616	51.55%	238	19.92%	1,195	100%
Q-3, SFY 2011	391	30.93%	628	49.68%	245	19.38%	1,264	100%
Q-4, SFY 2011	370	32.15%	634	55.08%	147	12.77%	1,151	100%
Total for SFY 2011	**1,457**	**29.93%**	**2,478**	**50.90%**	**933**	**19.17%**	**4,868**	**100%**

For this reporting period, InRhodes data have been further analyzed in order to quantify the average number of days for approving or denying new applications for Medicaid LTC coverage. The following table shows the average turn-around time in days for Medicaid LTC approvals during the First Quarter of SFY 2012 and the average TAT for Medicaid LTC denials during the same interval. The calculated averages for TATs have been provided and in addition these figures have been rounded up to whole integers.

RI MEDICAID: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-1, SFY 2012)

Number of Approvals for Medicaid LTC	Average TAT in Days
735	48.6 (~ 49 Days)*

Source: InRhodes

RI MEDICAID: Average Turn-around Time (TAT) in Days for Medicaid LTC Denials (Q-1 SFY 2012)

Number of Denials for Medicaid LTC	Average TAT in Days
138	16.79 (~ 17 Days)

Source: InRhodes

An asterisk has been flagged above to highlight that the InRhodes turn-around time (TAT) statistic for Medicaid LTC approvals during Q-1 of SFY 2012 had several outliers excluded. If the outliers were not excluded from this calculation, however, then the average turn-around time in calendar days would equal 84.7 days (or 85 days as a result of rounding up to a whole integer). Thus, even with the inclusion of the outliers, Medicaid LTC approvals fell within the 90-day threshold during Q-1 of SFY 2012.

During the prior quarterly report, an explanation had been provided specific to outliers pertaining to SSI. For the SSI cohort, one of two dates has been recorded as the application date, depending upon whether: a) the individual has been newly added to SSI; or b) has already been SSI-eligible but has moved to Rhode Island from another state. The application date for individuals who are newly approved for SSI is recorded as the "Onset of Disability" date, which Rhode Island receives from the Social Security Administration (SSA).

However, for SSI-eligible individuals who relocate to Rhode Island from another state, the application date is set as the first day of the following month, based on the "Residency Begin Date", which is sent by the Social Security Administration (SSA). For those individuals who relocate to Rhode Island from another state, the SSA does not always indicate the relocation status on the clients' records. Therefore, the individual is viewed as a new SSI beneficiary and the "Onset of Disability" date is recorded rather than the "Residency Begin Date", resulting in an inflated turn-around time.

For purposes of comparison, the following table has been provided to demonstrate the average turn-around times in calendar days for Medicaid LTC approvals and denials by quarter during SFY 2011. The figures shown below have been rounded up to whole numbers.

RI MEDICAID: Average Turn-around Times for Medicaid LTC Approvals and Denials by Quarter (SFY 2011)

Quarter	Average TAT in Calendar Days for Medicaid LTC Approvals	Average TAT in Calendar Days for Medicaid LTC Denials
Q-1, SFY 2011	65 Days	11 Days
Q-2, SFY 2011	65 Days	11 Days
Q-3, SFY 2011	59 Days	16 Days
Q-4, SFY 2011	42 Days*	12 Days

On average, Medicaid LTC approvals and denials were processed below a 90-day threshold throughout SFY 2011.

I. Number of applicants for Medicaid funded long-term care meeting the clinical eligibility criteria for each level of: (1) Nursing facility care; (2) Intermediate care facility for persons with developmental disabilities or mental retardation; and (3) Hospital care.

The clinical levels of care (nursing facility care, intermediate care facility for persons with developmental disabilities or mental retardation, and hospital care) that have been enumerated above were those used by the State prior to CMS' approval of the Global Waiver. Level of care determinations were categorized as follows, prior to the Global Waiver:

Nursing Home Level of Care	Hospital Level of Care	ICFMR Level of Care
Access to Nursing Facilities and section 1915(c) HCBS Waivers (the scope of community-based services varied, depending on the waiver)	Access to LTC, Hospital, Residential Treatment Centers and the 1915(c) HAB[10] waiver community-based services	Access to ICFMR, and section 1915(c) HCBS Waivers MR/DD community-based services.

Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI Medicaid), using three clinical levels of care: Highest, High, and Preventive. The following data have been extracted from the RI EOHHS Data Warehouse and are based upon the clinical eligibility determinations that were performed during the First Quarter of SFY 2012.

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-1, SFY 2012)

Clinical Eligibility Level of Care Criteria	Q-1, SFY 2012
Nursing Facility	1,075
Hospital (HAB applicants)*	0

Data Source: RI EOHHS Data Warehouse

An asterisk has been flagged to note that the Medicaid LTC applicants who met the clinical eligibility criteria for a hospital (or habilitation) level of care required intensive daily rehabilitation and/or ongoing skilled nursing services, comparable to those offered

[10] Rhode Island's former section 1915(c) Habilitation Waiver provided home and community-based services to Medicaid eligible individuals age 18 and older with disabilities who met a hospital level of care and who did not qualify for services through the State's Developmental Disability Waiver. Services which were provided under the Habilitation Waiver (also referred to as the "HAB Waiver") included intensive daily rehabilitation and/or ongoing skilled nursing services comparable to those offered in a hospital setting, which could not be provided adequately or appropriately in a nursing facility.

in a hospital setting, as would have been the case under the State's former section 1915(c) Habilitation Waiver.

For purposes of comparison, the following table documents the number of applicants for Medicaid LTC who met the clinical eligibility criteria for nursing facility or hospital (habilitation) services on a quarterly basis during SFY 2011.

EOHHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services, by Quarter (SFY 2011)

Clinical Eligibility Level of Care Criteria	Q-1, SFY 2011	Q-2, SFY 2011	Q-3, SFY 2011	Q-4, SFY 2011
Nursing Facility	858	841	939	791
Hospital (HAB applicants)*	3	0	0	0

As noted previously, an asterisk has been flagged to note that the Medicaid LTC applicants who met the clinical eligibility criteria for a hospital (or habilitation) level of care required intensive daily rehabilitation and/or ongoing skilled nursing services, comparable to those offered in a hospital setting, as would have been the case under the State's former section 1915(c) Habilitation Waiver.

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. During the First Quarter of SFY 2012, there were twenty-six (26) applications made by individuals with developmental disabilities. There were also seventeen (17) applications made for hospital care during Q-1 of SFY 2012.

J. The average and median turnaround time for such clinical eligibility determinations across populations.

Turnaround Times for Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI Medicaid) since implementation of the Global Waiver. The following data have been extracted from the RI EOHHS Data Warehouse, based upon the clinical eligibility determinations that were performed during the First Quarter of SFY 2012. The calculations of average and median turnaround times have been based on calendar days (not business days).

As noted previously, in order to meet a hospital (or habilitation) level of care, a Medicaid LTC applicant must have a demonstrable need for intensive daily rehabilitation and/or ongoing skilled nursing services, comparable to those offered in a hospital setting, as would have been the case under the State's former section 1915(c) Habilitation Waiver.

RI Medicaid: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations (Q-1, SFY 2012)

	Q-1, SFY 2012	
Nursing Facility Care	**Average**	**Median**
	17	15
Hospital/(HAB applicants)	N/A*	N/A*

Data Source: RI EOHHS Data Warehouse

During the First Quarter of SFY 2012, there were no applicants for Medicaid LTC who met the clinical eligibility criteria for a hospital (or habilitation) level of care. Therefore, the average and median TAT cells were marked with "N/A*" in the preceding table.

For purposes of comparison, the following table documents the average and median turnaround time in calendar days for Medicaid LTC clinical eligibility determinations on a quarterly basis during SFY 2011.

RI Medicaid: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations, by Quarter (SFY 2011)

	Q-1, SFY 2011		**Q-2, SFY 2011**		**Q-3, SFY 2011**		**Q-4, SFY 2011**	
Nursing Facility Care	26	26	24	21	7	6	12	7
Hospital/HAB Applicants	25	28	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*

In the event that there were not any applicants for Medicaid LTC who met the clinical eligibility criteria for a hospital (or habilitation) level of care, then the average and median TAT cells in the preceding table were flagged with "N/A*".

Turnaround Times for Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The following information was provided by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The Division of Developmental Disabilities conducts clinical eligibility determinations for individuals with developmental disabilities.

During the First Quarter of SFY 2012, the Division was unable to track the time between a completed application for services and clinical eligibility approval. However, as a result of *Project Sustainability*, the Division developed a new internal database that began to track this information on a go-forward basis beginning in October 2011.

K. The number of appeals of clinical eligibility determinations across populations.

Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews for nursing facility care and hospital/habilitation[11] care have been conducted by the Office of Medical Review at Rhode Island Medicaid. In the event that a LTC clinical eligibility determination has not been approved, the individual has the right to file an appeal, seeking to overturn the outcome of that determination.

Appeals Based on Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: The following data have been provided by RI Medicaid's Office of Medical Review to document the number of appeals which had been filed as a result of non-approved clinical eligibility determinations for nursing facility care and hospital/habilitation care during the First Quarter of SFY 2012.

RI Medicaid: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-1, SFY 2012

Appeals of LTC Clinical Eligibility Determinations by Level of Care	Q-1, SFY 2012
Nursing Facility	0
Hospital/Habilitation	0

Source: Office of Medical Review, RI Medicaid

Appeals Based on Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The following information was provided by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. As previously described, any applicant whose clinical eligibility determination has not been approved has the right to file appeal, seeking to overturn the outcome of that determination. The BHDDH's Division of Developmental Disabilities reported that there was one (1) appeal filed during the First Quarter of SFY 2012.

[11] To meet a hospital (or habilitation) level of care, an applicant must require intensive daily rehabilitation and/or ongoing skilled nursing services comparable to those offered in a hospital setting, which could not be provided adequately or appropriately in a nursing facility. This level of care requirement is analogous to that which had been established by Rhode Island's former 1915(c) Habilitation Waiver.

L. Average and median length of time after an applicant is approved for Medicaid long-term care until placement in the community or an institutional setting.

As noted previously, there are several pathways to Medicaid for LTC eligibility determinations. The majority of applicants for Medicaid long-term care (LTC) coverage file their application in order to secure a new payer so that they may continue to receive ongoing services. The following examples are provided, based upon whether the applicant is seeking LTC coverage for institutionally-based or home- or community-based services.

Institutional LTC services: New applications for institutionally-based LTC services generally come in to Rhode Island Medicaid from individuals who have already been admitted to an inpatient institution or a nursing facility. This group of applicants may have exhausted the benefit package covered by their primary source of health insurance coverage or, if they are without primary health insurance, may have depleted their personal financial resources. Therefore, these individuals have applied for Medicaid coverage in order to continue to receive an ongoing course of LTC services, which was initiated prior to Medicaid's involvement with the applicant. As such, these applicants have not sought *placement* in an institutional setting. Instead, they have sought Medicaid coverage in order to *remain* within an institutional LTC setting. For this group of new applicants, the Medicaid application approval date would not precede the applicant's date of admission to an inpatient institution or a nursing facility.

Community-based LTC services: New applications for Medicaid's community-based LTC services frequently come in to Rhode Island Medicaid from individuals who are nearing discharge from a hospital or nursing facility. These individuals, who were not covered by Medicaid at the time of their admission, have improved or stabilized clinically, and no longer require an institutional level of care. Based upon the discharge needs of this cohort of LTC applicants, Medicaid coverage would be sought so that they may receive community-based long-term care services post-discharge. For this group of applicants, therefore, the date of admission to the discharging institution would precede the Medicaid application approval date.

In an additional scenario, new applications for Medicaid LTC community services come directly from individuals who reside at home or in a community-based setting. Because this category of new applicant who is seeking Medicaid LTC coverage is already residing in a home- or community-based setting, their Medicaid application approval date would not precede the applicant's placement in the home- or community-based setting.

M. For persons transitioned from nursing homes, the average length of stay prior to transfer and type of living arrangement or setting and services upon transfer.

Through the Nursing Home Transitions Program, within the Office of Community Programs at Rhode Island Medicaid, assistance is provided to beneficiaries before, during, and following a transition from nursing facilities. These functions are undertaken to ensure the provision of timely and appropriate services that enable these individuals to move safely and successfully to either a home-based or a community-based setting. Each person transferred from a nursing home has a unique discharge plan that identifies the individual's needs and family supports. This discharge plan includes the arrangement of services and equipment, and home modifications. The length of stay prior to transfer and type of living arrangements or setting and services upon transfer is unique to each individual.

The following table documents the number of nursing home transitions that took place during the First Quarter of State Fiscal Year 2012. As was the case in prior reporting periods, the average length of stay (ALOS) has been measured in calendar days.

RI Medicaid: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-1, SFY 2012)

	Q-1, SFY 2012
Number of Nursing Home Transitions	31
Average Length of Stay (ALOS) Prior to Transfer in Calendar Days	196

Source: Office of Community Programs, Nursing Home Transition Referral Tracker database

The following table documents the type of living arrangement (or setting) that LTC beneficiaries who were transitioned from a nursing facility went to subsequent to their discharge.

RI Medicaid: The Type of Living Arrangement or Setting and Services upon Transfer for Persons Transitioned from Nursing Homes (Q-1, SFY 2012)

	Q-1, SFY 2012	
Existing Home	28	90.32%
Assisted Living	1	3.23%
New Housing	0	0.00%
Group Home	0	0.00%
Other	2	6.45%
Total	**31**	**100%**

Source: Office of Community Programs, Nursing Home Transition Referral Tracker database

N. Data on diversions and transitions from nursing homes to community care, including information on unsuccessful transitions and their cause.

An important component of the State's Nursing Home Transition and Diversion Program focuses upon the process for conducting a root cause analysis in the event of any unsuccessful diversions or transitions. Reporting criteria have been established to determine the cause(s) or factors that may have contributed to any unsuccessful outcomes.

Prior to the start of SFY 2011, The Alliance for Better Long Term Care partnered with Qualidigm[12] and Rhode Island Medicaid on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of RI Medicaid and the Division of Elderly Affairs in the identification of residents who could be transitioned safely. In collaboration with representatives of the RI EOHHS, the Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting. As of July of 2010, the functions that had been conducted by the Alliance were transferred to the Nursing Home Transitions Program, within the Office of Community Programs at Rhode Island Medicaid.

As noted in Item M, there were 31 LTC beneficiaries who were transitioned from nursing facilities during the First Quarter of SFY 2012 (July 1, 2011 through September 30, 2011). The Office of Community Programs at Rhode Island Medicaid reported that there were no (0) failed placements during the First Quarter of SFY 2012.

[12] Qualidigm is the Peer Review Organization (PRO) that is under contract to the RI EOHHS to conduct utilization review for admissions to inpatient and skilled nursing facilities for Medicaid beneficiaries who are not enrolled in either of the State's capitated Medicaid managed care programs.

O. Data on the number of RIte Care and RIte Share applications per month and the outcome of the eligibility determination by income level (acceptance or denial, including the basis for denial).

RIte Care is the State's health insurance program for eligible uninsured pregnant women, children, and parents and for families enrolled in the Rhode Island Works program. Applicants who seek RIte Care coverage only must complete either the *RIte Care/RIte Share Application* form (RI Department of Human Services Medical Assistance Program, MARC-1, Rev. 2/07) or else the State's *Statement of Need* form (Rhode Island Department of Human Services, DHS-2, Rev. 5-06). All applicants who seek to apply for other additional benefits (in addition to RIte Care) must complete the DHS-2 *Statement of Need* form.

Based on the information given by the applicant, Rhode Island Medicaid determines whether the applicant qualifies for RIte Care or RIte Share. RIte Share is the State's health insurance premium assistance program that helps families afford health insurance through their employer by paying for some or all of the employee's cost.

Processed Applications: InRhodes, the State's Medicaid eligibility system, is the source of the following application statistics. The number of applications documented below represents a "point-in-time" snapshot of activity, which warrants some explanation of several factors that impact eligibility determinations. For example, new applications that came in at any time during the month of August would have application processing start dates ranging from the 1st to the 31st day of that month. However, any completed applications which were received on August 1st would have an anticipated eligibility processing determination date occurring on August 31st whereas completed eligibility applications which were received on August 31st would have an anticipated eligibility processing determination at the close of September. (Please note: the timing of eligibility determinations has been described here, not the date when coverage would become effective for an approved applicant.) Also, the receipt of incomplete applications would affect the timing of eligibility determinations. For these reasons, the sum of approved and denied applications within a given month will not equal the number of applications received during the same month.

Cohort Analysis for RIte Care/RIte Share Applicants: For the purpose of the following cohort analysis, two major groups comprised the RIte Care/RIte Share applicant population and information has been provided for each group during the First Quarter of SFY 2012 (July 1, 2011 through September 30, 2011). These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[13] and b) several additional categories of applicants. Statistics for the latter grouping are aggregated (or added) within the InRhodes system and are classified as "Other" [14].

[13] Rhode Island Works (RIW) provides financial and employment assistance to eligible pregnant women and parents with children. The scope of the RIW program includes Medical Assistance (RIte Care) if the applicant's income and resources are within program limits.

[14] "Other" applicants for Medicaid include several groups: Those who are applying for RIte Care coverage only (that is, uninsured or under-insured pregnant women, children up to age 19

RI MEDICAID: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-1, SFY 2012

Month	Rhode Island Works	"Other"
July 2011	3,023	272
Aug. 2011	3,378	332
Sept. 2011	3,541	308
Total for Q-1 of SFY 2012	**9,942**	**912**

For purposes of comparison, the following table documents the number of applications that were made by quarter during SFY 2011.

RI MEDICAID: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, by Quarter (SFY 2011)

Quarter	Rhode Island Works	"Other"
Q-1, SFY 2011	9,405	1,813
Q-2, SFY 2011	8,418	1,845
Q-3, SFY 2011	9,586	1,272
Q-4, SFY 2011	9,158	1,413
Total for SFY 2011	**36,567**	**6,343**

Approved Applications: The following tables outline the number of Rhode Island Works and "Other" applicants who were deemed to be eligible for Medicaid during the First Quarter of SFY 2012 (July 1, 2011 through September 30, 2011). The following table represents a "point-in-time" snapshot of the number of approved applications for Medicaid coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics.

RI MEDICAID: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-1, SFY 2012

Month	Rhode Island Works	"Other"
July 2011	2,158	251
Aug. 2011	2,498	346
Sept. 2011	2,533	283
Total for Q-1 of SFY 2012	**7189**	**880**

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whose family income is < 250% FPL, and parents with children under age 18 whose family income is less than 175 percent of the FPL who are applying for health care coverage but no cash assistance benefits); those who are seeking benefits for other means-tested programs, such as the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp program) and RIte Care coverage; and childless, non-pregnant adults who are seeking Community Medicaid coverage. Thus, the "Other" category includes some individuals who are not seeking RIte Care.

For purposes of comparison, the following table documents the number of applications that were approved by quarter during SFY 2011.

RI MEDICAID: Approved Applications for Rhode Island Works and "Other" Category of Applicants, by Quarter (SFY 2011)

Quarter	Rhode Island Works	"Other"
Q-1, SFY 2011	6,612	1,459
Q-2, SFY 2011	6,633	1,437
Q-3, SFY 2011	6,852	1,183
Q-4, SFY 2011	6,996	1,018
Total for SFY 2011	**27,093**	**5,097**

Denied Applications: InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics for the Rhode Island Works (RIW) and the "Other" category of applicants during the First Quarter of SFY 2012 (July 1, 2011 through September 30, 2011). The number of denials documented below represents a "point-in-time" snapshot of activity.

RI MEDICAID: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-1, SFY 2012

Month	Rhode Island Works	"Other"
July 2011	213	11
Aug. 2011	245	9
Sept. 2011	236	5
Total for Q-1 of SFY 2012	**694**	**25**

Currently, InRhodes cannot produce a report showing denial code types stratified by income levels, as outlined in Item O. However, enhanced reporting capability will be realized through the EOHHS Data Warehouse.

For purposes of comparison, the following table documents the number of applications that were denied by quarter during SFY 2011.

RI MEDICAID: Denied Applications for Rhode Island Works and "Other" Category of Applicants, by Quarter (SFY 2011)

Quarter	Rhode Island Works	"Other"
Q-1, SFY 2011	632	64
Q-2, SFY 2011	591	61
Q-3, SFY 2011	671	46
Q-4, SFY 2011	709	29
Total for SFY 2011	**2,603**	**200**

P. For New RIte Care and RIte Share applicants, the number of applications pending more than 30 days.

RIte Care is the State's health insurance program for eligible uninsured pregnant women, children, and parents and for families enrolled in the Rhode Island Works program. Applicants who seek RIte Care coverage only must complete either the *RIte Care/RIte Share Application* form (RI Department of Human Services Medical Assistance Program, MARC-1, Rev. 2/07) or else the State's *Statement of Need* form (Rhode Island Department of Human Services, DHS-2, Rev. 5-06). All applicants who seek to apply for other additional benefits (in addition to RIte Care) must complete the DHS-2 *Statement of Need* form. Based on the information that is provided by the applicant, the Department of Human Services determines whether the applicant qualifies for RIte Care or RIte Share. RIte Share is the State's health insurance premium assistance program that helps families afford health insurance through their employer by paying for some or all of the employee's cost.

In Item O, information was provided specific to the processing of applications for RIte Care. As noted in the discussion of Item O, the receipt of an incomplete application would affect the timing of the applicant's eligibility determination. Assuming that a fully complete application is submitted, an eligibility determination for RIte Care would be anticipated within thirty (30) days, based on the information submitted on the application. In every instance, information regarding the applicant's income is verified. Other information is verified as required. Any information on the application that is questionable must be confirmed before eligibility can be certified.

Item O provided tables that documented the number of applications received from RIte Care applicants during the First Quarter of SFY 2012 (July 1, 2011 through September 30, 2011). For the purpose of that cohort analysis, there were two major groups comprising the RIte Care/RIte Share applicant population. In the response to Item O, information was stratified for these two groups of applicants: a) those who were seeking enrollment in Rhode Island Works[15] and b) several additional categories of applicants. As previously noted, statistics for the latter grouping are aggregated (or combined) within the InRhodes system and are classified as "Other" [16].

[15] Rhode Island Works (RIW) provides financial and employment assistance to eligible pregnant women and parents with children. The scope of the RIW program includes Medical Assistance (RIte Care) if the applicant's income and resources are within program limits.

[16] "Other" applicants for Medicaid include several groups: Those who are applying for RIte Care coverage only (that is, uninsured or under-insured pregnant women, children up to age 19 whose family income is < 250% FPL, and parents with children under age 18 whose family income is less than 175 percent of the FPL who are applying for health care coverage but no cash assistance benefits); those who are seeking benefits for other means-tested programs, such as the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp program) and RIte Care coverage; and childless, non-pregnant adults who are seeking Community Medicaid coverage. Thus, the "Other" category includes some individuals who are not seeking RIte Care.

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and addresses the monthly average number of RIte Care/RIte Share applications pending for more than thirty (30) days. Pending cases are defined as those that have not yet had either an acceptance (approval) or denial determination. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the pending applications for the Rhode Island Works/RIte Care applicant cohort during the First Quarter of State Fiscal Year 2012.

RI MEDICAID: The Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort (Q-1, SFY 2012)

Quarter	Average Number of Applications Pending More than 30 Days for Rhode Island Works Applicants
Q-1, SFY 2012	491

Source: InRhodes

The average number of applications pending for more than thirty (30) days for Rhode Island applicants during Q-1 of SFY 2012 (mean = 491) was similar to that which was demonstrated during the Fourth Quarter of SFY 2011 (mean = 479). For purposes of comparison, the following table documents the average number of new applications pending more than thirty days for this enrollment cohort by quarter during SFY 2011.

RI MEDICAID: The Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort, by Quarter (SFY 2011)

Quarter	Average Number of Applications Pending More than 30 Days for Rhode Island Works Applicants
Q-1, SFY 2011	507*
Q-2, SFY 2011	345
Q-3, SFY 2011	321
Q-4, SFY 2011	479

As had been described in the quarterly report[17] that was submitted to the State Senate on 09/30/2011, the average number of applications pending more than 30 days during the First Quarter of SFY 2011 was flagged with an asterisk because the finding for the first

[17] The Rhode Island Executive Office of Health and Human Services. (June 30, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information,* July 1, 2010 – September 30, 2010 and October 1, 2010 – December 31, 2010 (p. 42).

month (July of 2010) in that quarter represented an outlier. If July 2010 were to be excluded from the calculation, then the average number of new applications pending more than 30 days during the First Quarter of SFY 2011 would equal 430.

Q. Data on the number of RIte Care and RIte Share beneficiaries losing coverage per month including the basis for the loss of coverage and whether the coverage was terminated at recertification or at another time.

In Item O, the number of new applications for RIte Care/RIte Share was quantified for the First Quarter of SFY 2012 (July 1, 2011 through September 30, 2011). That prior discussion also gave an overview of the eligibility determination processes specific to new applications. Information was provided about the number of eligibility approvals (also referred to as "acceptances") and denials for new RIte Care/RIte Share applicants during the same time frame.

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and focuses on RIte Care/RIte Share redeterminations and closures. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the redeterminations and closures which were processed for the Rhode Island Works/RIte Care enrollment cohort during the First Quarter of SFY 2012. At this time, a detailed analysis of the reasons for closures is not available. However, enhanced reporting capability will be realized through Rhode Island's CHOICES Project, which will streamline the State's Medicaid Information Technology Architecture.

RI Medicaid: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort (Q-1, SFY 2012)

Month	RIW Redeterminations	RIW Closures	Percentage
July 2011	52,099	2,524	4.84%
Aug. 2011	52,371	2,137	4.08%
Sept. 2011	52,812	1,899	~3.6%
Total for Q-1, SFY 2012	**157,282**	**6,560**	**4.17%**

Source: InRhodes

For purposes of comparison, the following table provides the findings on a quarterly basis during SFY 2011.

RI Medicaid: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort, by Quarter (SFY 2011)

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-1, SFY 2011	133,586	5,810	4.35%
Q-2, SFY 2011	137,123	5,136	3.74%
Q-3, SFY 2011	148,708	6,039	4.1%
Q-4, SFY 2011	157,322	6,280	~ 4.0%
Total	**576,739**	**23,265**	**4.08%**

R. Number of families enrolled in RIte Care and RIte Share required to pay premiums by income level (150 - 184% FPL, 185 – 199% FPL, and 200 – 250% FPL).

Some RIte Care- or RIte Share[18]-enrolled families pay for a portion of the cost of their health care coverage by paying a monthly premium. The purpose of cost sharing is to encourage program participants to assume some financial responsibility for their own health care.

The following table provides information about monthly premium payment requirements for families enrolled in either RIte Care or RIte Share. Family income levels have been stratified according to Federal Poverty Levels (FPL), which are established annually by the U.S. Department of Health and Human Services (US DHHS). The State has established premium payment requirements for three income bands, based on FPLs.

RI Medicaid: Monthly Premiums for Families, By Income Level

Family Income Level[19]	Monthly Premium for a Family
> 150% FPL and not > 185% FPL	$61.00/month
> 185% FPL and not > 200% FPL	$77.00/ month
> 200% FPL and not > 250% FPL	$92.00/month

The following quarterly data were obtained from InRhodes, RI Medicaid's Eligibility System, and document the number of RIte Care- or RIte Share-enrolled families who must pay premiums for coverage.

RI Medicaid: The Average Number of RIte Care- or RIte Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-1, SFY 2012)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2012	
> 150 - 185% FPL	3,118	59.2%
> 185 - 200% FPL	710	13.5%
> 200 - 250% FPL	1,438	27.3%
Total	**5,264**	**100.0%**

[18] RIte Share is Rhode Island's Premium Assistance Program that helps Rhode Island families afford health insurance through their employer by paying for some or all of the employee's cost. Eligibility is based on income and family size and is the same as eligibility requirements for the RIte Care program.

[19] For a family of four, the following FPLs were established by the US DHHS on January 20, 2011: 150% FPL = $33,525.00; 185% FPL = $41,347.50; 200% FPL = $44,700.00; and 250% FPL = $55,875.00.

S. Information on sanctions due to nonpayment of premiums by income level (150 - 184% FPL, 185 – 199% FPL, and 200 – 250% FPL).

RIte Care- or RIte Share-enrolled families whose incomes range between > 150% - 250% of the Federal Poverty Level (FPL) must pay for a portion of the cost of their healthy care coverage by paying a monthly premium.

Payment of the initial premium is due on the first of the month following the date of the initial bill. The initial bill is sent during the first regular billing cycle following Medical Assistance (MA) acceptance, and depending on the date of MA approval, is due for one (1) or more months of premiums. Ongoing monthly bills are then sent to the family approximately fifteen (15) days prior to the due date. Premium payments are due by the first day of the coverage month.

If full payment is not received by the twelfth (12^{th}) of the month following the coverage month, then a notice of MA discontinuance is sent to the family. MA eligibility is discontinued for all family members subject to cost sharing at the end of the month following the coverage month[20]. For example, if a premium payment which is due on January 1^{st} has not been received by February 12^{th}, then MA eligibility would be discontinued, effective on February 28^{th}. Dishonored checks and incomplete electronic fund transfers are treated as non-payments.

A restricted eligibility period, or "sanction period", would begin on the first of the month after MA coverage ends and this period would continue for four (4) full months. Once the balance is paid in full, the sanction will be lifted and eligibility will be reinstated effective the first of the month following the month of payment. If payment is made more than thirty (30) days after the close of the family's case, then a new application will be required, in addition to the payment.

An exemption from sanctions may be granted in cases of good cause. Good cause is defined as circumstances beyond a family's control or circumstances not reasonably foreseen which resulted in the family being unable or failing to pay the premium. Good cause circumstances include but are not limited to the following:

- Serious physical or mental illness.
- Loss or delayed receipt of a regular source of income that the family needed to pay the premium.
- Good cause does not include choosing to pay other household expenses instead of the premium.

[20] MA coverage is reinstated without penalty for otherwise eligible family members if all due and overdue premiums are received by Rhode Island Medicaid's fiscal agent on or before the effective date of MA discontinuance.

The following sanction data were obtained from InRhodes, the State's Eligibility System, and document the number of RIte Care- or RIte Share-enrolled families who were sanctioned during the First Quarter of SFY 2012 (July 1, 2011 – September 30, 2011.

RI Medicaid: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-1, SFY 2012)

Percentage of the Federal Poverty Level (FPL)	**Q-1, SFY 2012**	
>150 - 185% FPL	283	54.1%
>185 - 200% FPL	93	17.8%
>200 - 250% FPL	147	28.1%
Total	**523**	**100.0%**

For purposes of comparison, quarterly data pertaining to sanctions that occurred during SFY 2011 have been provided in the following table.

RI Medicaid: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (SFY 2011)

Percentage of the Federal Poverty Level (FPL)	**Q-1, SFY 2011**		**Q-2, SFY 2011**		**Q-3, SFY 2011**		**Q-4, SFY 2011***	
>150 - 185% FPL	230	50.8%	203	50.6%	223	52.0%	178	51.0%
>185 - 200% FPL	78	17.2%	65	16.2%	66	15.4%	59	16.9%
>200 - 250% FPL	145	32.0%	133	33.2%	140	32.6%	112	32.1%
Total	**453**	**100%**	**401**	**100%**	**429**	**100%**	**349**	**100%**

As had been noted previously in the EOHHS report that was submitted to the State Senate on 12/15/2011, the preceding table was flagged with an asterisk (*) to note that the number of cases sanctioned for the month of April 2011 was zero due to an error in the transmission of the cost share file between MMIS and InRhodes. However, the number of cases sanctioned for the month of May 2011 was unusually high because it included many of those cases that had not been sanctioned in the prior month.

T. On an annual basis, State and Federal Expenditures under the "Cost Not Otherwise Matchable" provision of Section 1115(a)(2) of the Social Security Act.

The following table documents the total of State and Federal expenditures for the Cost Not Otherwise Matchable (CNOM) provision of Section 1115(a)(2) of the Social Security Act on a Year-to-Date (YTD) basis for SFY 2012 through September 30, 2011. These data were obtained from RI EOHHS Financial Management and are based upon paid dates, not incurred dates of service.

State and Federal Expenditures Under the CNOM Provision of Section 1115(a)(2) of the Social Security Act (SFY 2012, YTD Through 09/30/2011)

State	$2,357,460
Federal	$2,676,422
Total	**$5,033,882**

U. On an annual basis, data on Medicaid spending recoveries, including estate recoveries as provided in section 40-8-15.

The following data were obtained from the DHS TPL Unit and document the total recoveries that were paid to the DHS during the First Quarter of SFY 2012 (July 1, 2011 through September 30, 2011). This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: Q-1, SFY 2012

Recoveries by Type	**Amount Recovered**
Estate Recoveries: TPL and Legal	$928,105
Casualty Recoveries: TPL and Legal	$102,542
Total	**$1,030,647**

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Budget Neutrality Summary	Total DY 1	Total DY 2	Total DY 3	DY 4 Q/E 3/31/12
Section I: Total Expenditures Subject to Budget Neutrality				
Budget Population 1: (ABD no TPL)	$ 418,731,831	$ 486,505,287	$ 522,293,881	$ 129,621,525
Budget Population 2 (ABD TPL)	$ 715,844,300	$ 659,668,554	$ 602,777,488	$ 163,046,184
Budget Population 3 (RIte Care)	$ 362,611,218	$ 405,517,339	$ 440,197,089	$ 86,380,753
Budget Population 4 (CSHCNs)	$ 188,895,404	$ 184,738,525	$ 168,271,992	$ 41,880,598
Budget Population 5 (EFP)	$ 198,808	$ 134,380	$ 94,294	$ 28,336
Budget Population 6 (Pregnant Expansion)	$ 1,489,534	$ 1,820,522	$ 1,740,579	$ 572,618
Budget Population 7 (SCHIP Children)	$ -	$ -	$ -	$ -
Budget Population 8 (CNOM: Substitute Care)	$ -	$ -	$ -	$ -
Budget Population 9 (CNOM: CSHCNs otherwise in voluntaary state custody)	$ 3,364,541	$ -	$ 4,744,703	$ -
Budget Population 10 (CNOM: 65, <200%, at risk for LTC)	$ 2,943,524	$ 4,492,554	$ 4,941,055	$ 1,311,765
Budget Population 11 (217-like, CatNeedy HCBW like svcs, Highest Need)	$ -	$ -	$ -	$ -
Budget Population 12 (217-like CatNeedy HCBW like svcs, High need)	$ -	$ -	$ -	$ -
Budget Population 13 (217-like Medically Needy, HCBW like svcs (high and highest). Medically Needy PACE-like partricipnts in community	$ -	$ -	$ -	$ -
Budget Population 14 (BCCTP)	$ 6,553,342	$ 3,813,979	$ 3,957,712	$ 1,210,304
Budget Population 15 (CNOM: Adults w/ disabilities at risk for LTC, <300% FPL)	$ 255,250	$ 897,633	$ 764,713	$ 288,707
Budget Population 16 (CNOM: Uninsured Adults w/ mental illness)	$ 6,595,169	$ 6,989,503	$ 12,099,917	$ 3,070,467
Budget Population 17 (CNOM: Youth at risk for Medicaid; at risk children < 300% FPL)	$ 3,775,172	$ 3,696,607	$ 3,253,287	$ 999,174
Budget Population 18 (HIV)	$ -	$ 752,914	$ 1,059,261	$ -
Budget Population 19 (CNOM: Non-working disabled adults 19-64, GPA)	$ 1,743,740	$ 1,790,059	$ 1,823,738	$ 389,477
Budget Services 1 (Windows)	$ 4,504	$ -	$ -	$ -
Budget Services 2 (RIte Share and collections)	$ 5,369,938	$ 6,772,712	$ 6,437,643	$ 1,349,571
Budget Service 3 (Other payments - e.g.FQHC suppl., stop loss)	$ 10,194,423	$ 33,205,530	$ 14,600,045	$ 2,638,991
Budget Services 4 (CNOM: core and preventive svcs, Medicaid eligible at risk youth)	$ -	$ -	$ -	$ 4,076,296

Budget Services 5 (CNOM: Services by FQHCs to uninsured individuals)	$ 600,000	$ 1,200,000	$ 1,208,689	$ 914,811
Base Expenses [1]	$ 33,090,955	$ 91,516,977	$ 75,940,829	$ 7,689,570
TOTAL Expenditures for Period as reported on the CMS-64*	**$ 1,762,261,653**	**$ 1,893,513,074**	**$ 1,866,206,914**	**$ 445,469,147**
Section II: Expenditure Target				
Quarterly	$ 2,600,000,000	$ 2,400,000,000	$ 2,300,000,000	$ 600,000,000
Cumulative	$ 2,600,000,000	$ 5,000,000,000	$ 7,300,000,000	$ 600,000,000
Section III: Actual Expenditures w/Waiver				
Quarterly				$ 445,469,147
Cumulative	$ 1,762,261,653	$ 1,893,513,074	$ 1,866,206,914	$ 445,469,147
Section IV: Surplus / (Deficit)				
Quarterly	$ 837,738,347	$ 506,486,926	**$ 433,793,086**	$ 154,530,853
Cumulative	**$ 837,738,347**	**$ 1,344,225,273**	**$ 1,778,018,359**	**$ 1,932,549,212**

* Reported Medical Assistance payments correspond with CMS-64 for each quarter as adjusted through the exclusion of LEA, SCHIP and DSH related expenditures as shown below:

Total Global Waiver Expenditures	*$ 445,469,147*
LEA	*$ 4,442,816*
SCHIP (RIteShare Premiums & Collections)	*$ (122,903)*
SCHIP	*$ 6,280,879*
DSH	*$ -*
Prior Period Adjustments	*$ -*
Current Period Adjustments	*$ -*
CMS 64 Summary Sheet: 6. Expenses this Quarter)	*$ 456,069,939*

[1] **Base Expense(** Other Expenses unallocated by Budget Population or Budget Service) Expenditures included in "Other" category are payments that are non-recipient specific and therefore, cannot be allocated to a specific recipient/waiver population. Due to the nature of the transactions and reimbursement of the payment the amount reported could include negative reportable amounts, as : 1) System payouts, e.g.: single cycle payment made to a provider as an interim payment until claim specific payment is made. The single payment is reimbursed wth the claim specific payment is made. 2) Manual payments: same as system payout but paid off cycle. 3) Managed Care system and manual payments including risk share, stoploss, pay-for-preformance, FQHC prospective payments, and other similar transactions: 4) Non-MMIS payments. These payments include such transactions as supplied in the Non-EDS Paid backup documents.