Report to the Rhode Island General Assembly
Senate Committee on Health and Human Services

Designated Medicaid Information
April 1, 2010 – June 30, 2010

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

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Section I: Introduction

This document has been prepared for the Rhode Island General Assembly's Senate Committee on Health and Human Services by the State's Executive Office of Health and Human Services. This quarterly report has been prepared in response to Senate Resolution 10R303 (10-S2976, *Senate Resolution Respectfully Requesting the Executive Office of Health and Human Services to Report Designated Medicaid Information to the Rhode Island Senate Committee on Health and Human Services*), which was passed on June 8th, 2010.

The following report focuses upon the operation of the State's Global Consumer Choice Compact (also known as the "Global Waiver") during the Fourth Quarter of State Fiscal Year 2010 (April 1st, 2010 through June 30th, 2010). As was provided in the reports which the EOHHS submitted to the State Senate on 10/01/2010 and 12/15/2010, Section I provides an overview of Rhode Island's goals for the Global Waiver, as well as a description of the factors which have been identified by the Public Policy Institute as instrumental to States' success when launching efforts to rebalance their long-term care (LTC) services and supports system. Section I also includes bulleted highlights of some noteworthy achievements which were realized by Rhode Island during the Fourth Quarter of SFY 2010. The latter information was drawn from Rhode Island's quarterly report to the Centers for Medicare and Medicaid Services (CMS) on the progress of the Global Waiver.

Section II presents the designated Medicaid information covering the period from April 1st, 2010 through June 30th, 2010. This information has been organized alphabetically, according to the measures which were delineated in Senate Resolution 10R303.

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.

[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.

- *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.
- *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.

Highlights from Rhode Island's Quarterly Progress Report to CMS for the Global Consumer Choice Compact 1115 Waiver: In conformance with the Special Terms and Conditions (STCs) which were established by the Centers for Medicare and Medicaid Services (CMS) for the Global Consumer Choice Compact 1115 Waiver, Rhode Island must submit a quarterly progress report to CMS no later than 60 days following the end of each quarter. To promote public transparency, the Executive Office of Health and Human Services posts on its Website a copy of the State's quarterly report to the Centers for Medicare and Medicaid Services. The following bulleted excerpts, organized according to a series of objectives and supporting activities, have been abstracted from Rhode Island's report to CMS for the Fourth Quarter of SFY 2010:

- 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 June 30, 2010, **1,754 Level of Care (LOC) assessments** were completed, resulting in the following determinations: **Highest LOC = 1,156**; **High LOC = 506**; and **Preventive LOC = 92**
    - Care management assessment forms were aligned across Departments

- Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports by designing and implementing a Nursing

Facility Diversion project to identify individuals who could be safely discharged from the hospital to a community-based setting

  - Incorporated a strategy for Nursing Facility Diversions into the State's planning for its Managed Long-term Care procurement
  - Investigated the Safe Transition Program initiatives underway for the CMS Medicare Safe Transition Demonstration project

- 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

  - Nursing home transition services and the Nursing Facility Diversion program resulted in **741 individuals being safely transitioned to community settings**
  - Training was held for State staff in the DHS Office of Community Programs, DHS Long-term Care, and the DEA Home and Community Care
  - Ongoing transition meetings were held with the Alliance for Better Long Term Care, as the responsibilities for the Nursing Home Transition project were shifted from the Alliance to State staff in the Office of Community Programs and the DEA's Home and Community Care

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

  - During Q-4 of SFY 2010, **92 individuals met the Preventive Level of Care** and received services
  - Inter-agency planning was underway to align with the DEA's Lifespan Grant initiative
  - The Affordable Care Act was examined to determine whether there might be opportunities to help support funding for Respite services

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

  - Readiness reviews were completed with both Shared Living contractors prior to the program's implementation
  - Trainings were conducted with Shared Living agency providers and staff
  - The Shared Living program was opened for incoming referrals

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

  - Recommendations were refined for the cross-departmental Managed Long Term Care Request for Information (RFI)

- The Affordable Care Act was examined to determine whether there might be opportunities to help support expanded Home Care initiatives
- Acuity-based payment methodologies were explored for adult day services for beneficiaries with higher needs, such as those with Alzheimer's Disease or in need of wound care or medication management

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

  - Options Counseling materials were refined
  - Workflow matrices were revised for the DHS and DEA
  - A "roll-out" strategy was implemented for new clinical forms

- 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

  - Negotiations were finalized for a specialized unit for ventilator-dependent individuals in a Nursing Facility
  - A targeted intervention, Communities of Care, was incorporated into the State's 2010 Reprocurement for its capitated Medicaid managed care program

- 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.)

  - Proposed legislation pertaining to the Sherlock Plan was not passed during the State's 2010 legislative session

- Analyze Medicaid Managed Long Term Care models:

  - Solicited input from national experts as a Managed Long Term Care Request for Information (RFI) was developed
  - Refined the work plan for the Managed Long Term Care Request for Information (RFI)
  - Released the State's Reprocurement Letter of Intent for RIte Care and Rhody Health Partners

- Promote the adoption of "Medical Homes"

  - Participated in the cross-departmental development of the Medicare Advanced Primary Care Practice Demonstration Project

- Promote the adoption of electronic health records

- Procurement was pursued for a *Planning-Advance Planning Document* P-APD vendor
- The adoption of electronic health records was addressed in the State's 2010 Reprocurement for its capitated Medicaid managed care program
- Health information exchange (HIE) activities were integrated under the DRA Medicaid Transformation Grant

- 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

    - Smart purchasing components were integrated into the State's Reprocurement of its capitated Medicaid managed care program

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

    - Recommendations for long-term care acuity adjustments were refined

- 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

    - Met on an on-going basis throughout the Fourth Quarter of SFY 2010 with stakeholders involved in the following collaboratives: Global Waiver Task Force, the Task Force's work groups, and the Medical Care Advisory Committee
    - Updates on the Global Waiver, State Budget initiatives, the MMIS Data Warehouse, and Real Choices Systems Transformation Grant were presented
    - A survey was distributed to solicit inputs from the membership of the Global Waiver Task
    - All of the Global Waiver Task Force's six work groups submitted recommendations to the Secretary of EOHHS
    - Waiver-related updates were posted to the EOHHS Website
    - Four (4) Web-based training tools were developed
    - Planning efforts were coordinated to integrate Community Options trainings with the "roll-out" of RIte Resources, the database of up-to-date community-based resources

SECTION II
Designated Medicaid Information
April 1, 2010 – June 30, 2010 (Q-4, SFY 2010)

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 Fourth Quarter of SFY 2010 (April 1, 2010 – June 30, 2010). 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-4 of SFY 2010.

RI DHS: Medicaid Long-term Care Acceptances (Approvals), Q-4, SFY 2010

Month	Long-Term Care
April 2010	239
May 2010	242
June 2010	392
Total for Q-4, SFY 2010	**873**

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 Fourth Quarter of SFY 2010 (April 1, 2010 – June 30, 2010). 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-4 of SFY 2010.

RI DHS: Medicaid Long-term Care Denials, Q-4, SFY 2010

Month	**Long-term Care Denials**
April 2010	39
May 2010	39
June 2010	56
Total for Q-4, SFY 2010	**134**

Source: InRhodes

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 Fourth Quarter of SFY 2010 (April 1, 2010 through June 30, 2010).

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 Departments of Elderly Affairs and Human Services (RI DEA and RI DHS). 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-4, SFY 2010 (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 Department of Elderly Affairs (RI DEA) during the Fourth Quarter of SFY 2010.

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			April		May		June	
Reporting Period: Date of Service			2010		2010		2010	
	Service Type	Age Group	Count	Units	Count	Units	Count	Units
	Assisted Living	Under 65	30	839	30	919	36	1,076
		65 and Older	254	7,329	239	7,318	241	7,087
DEA	**Assisted Living**	**Service Type Subtotals:**	**284**	**8,168**	**269**	**8,237**	**277**	**8,163**
	Case Management	Under 65	16	93	18	135	14	78
		65 and Older	437	2,273	457	2,221	394	1,848
DEA	**Case Management**	**Service Type Subtotals:**	**453**	**2,366**	**475**	**2,356**	**408**	**1,926**
		65 and Older	418	101,219	414	99,923	419	105,515
DEA	**Personal Care/Homemaker**	**Service Type Subtotals:**	**418**	**101,219**	**414**	**99,923**	**419**	**105,515**
DEA		Grand Total:		**111,753**		**110,516**		**115,604**

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-4, SFY 2010 (RI DHS): The second set of tables shows the number (or count) of individuals who received LTC services through the Rhode Island Department of Human Services (RI DHS) during Q-4, SFY 2010. This information reflects incurred dates of service (April 1st, 2010 through June 30th, 2010) 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.

DHS: 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**
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 the RI DHS: Adult day care; assisted living; case management; home

health agency; hospice; nursing facility; personal care/homemaker; and Tavares Pediatric Center. This information has been stratified by month and by age group.

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 the RI DHS: Adult day care; assisted living; case management; home health agency; hospice; nursing facility; personal care/homemaker; and Tavares Pediatric Center. This information has been stratified by month and by age group.

Source: EOHHS Data Warehouse: MMIS Claim Universe			April		May		June	
Reporting Period: Date of Service			2010		2010		2010	
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units
DHS	Adult Day Care	Under 65	255	3,717	261	3,693	258	3,841
		65 and Older	217	3,155	221	3,108	225	3,331
DHS	Adult Day Care	Service Type Subtotals:	472	6,872	482	6,801	483	7,172
	Assisted Living	Under 65	13	390	13	403	12	356
		65 and Older	155	4,612	155	4,663	157	4,575
DHS	Assisted Living	Service Type Subtotals:	168	5,002	168	5,066	169	4,931
	Case Management	Under 65	781	1,096	276	584	292	528
		65 and Older	170	790	174	799	163	724
DHS	Case Management	Service Type Subtotals:	951	1,886	450	1,383	455	1,252
	Home Health Agencey	Under 65	191	2,138	242	2,363	236	1,907
		65 and Older	114	1,557	113	1,460	118	1,237
DHS	Home Health Agencey	Service Type Subtotals:	305	3,695	355	3,823	354	3,144
	Hospice	Under 65	41	886	35	900	47	964
		65 and Older	539	13,545	545	14,147	530	13,745
DHS	Hospice	Service Type Subtotals:	580	14,431	580	15,047	577	14,709
	Nursing Facility	Under 65	567	15,339	555	15,699	545	15,072
		65 and Older	5,110	145,848	5,096	150,350	5,094	146,212
DHS	Nursing Facility	Service Type Subtotals:	5,677	161,187	5,651	166,049	5,639	161,284
	Personal Care/Homemaker	Under 65	960	252,619	959	257,986	979	266,239
		65 and Older	1,155	290,859	1,165	294,261	1,163	301,195
DHS	Personal Care/Homemaker	Service Type Subtotals:	2,115	543,478	2,124	552,247	2,142	567,434
	Tavares Pediatric Center	Under 65	24	684	24	721	25	731
DHS	Tavares Pediatric Center	Service Type Subtotals:	24	684	24	721	25	731
DHS		Grand Total:		737,235		751,137		760,657

The Number of Medicaid Beneficiaries Served by PACE, Q-4, SFY 2010 (RI DHS): 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 Fourth Quarter of SFY 2010. 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**
DHS	4/1/2010	PACE PROGRAM	65 and Over	157
DHS		PACE PROGRAM	Under 65	29
	4/1/2010		**Period Totals:**	186
DHS	5/1/2010	PACE PROGRAM	65 and Over	162
DHS		PACE PROGRAM	Under 65	33
	5/1/2010		**Period Totals:**	195
DHS	6/1/2010	PACE PROGRAM	65 and Over	166
DHS		PACE PROGRAM	Under 65	33
	6/1/2010		**Period Totals:**	199

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-4, SFY 2010 (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; and behavioral health group home (behavioral health only). Data for the Fourth Quarter of SFY 2010 are shown below.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-4, SFY 2010			
Dept.	**Service Type**	**Age Group**	**# Served**
BHDDH	Day Programs	Under 65	2390
		Over 65	277
BHDDH	Homemaker	Under 65	131
		Over 65	19
BHDDH	Public Group Homes	Under 65	155
		Over 65	77
BHDDH	Private Group Homes	Under 65	1156
		Over 65	155
BHDDH	Family Supports	Under 65	843
		Over 65	57
BHDDH	Shared Living	Under 65	158
		Over 65	12
BHDDH	Supported Employment	Under 65	535
		Over 65	17
BHDDH	Behavioral Health GH	Under 65	*
	(Mental Health Only)	Over 65	*

An asterisk has been flagged in the lower two rows of the previous table to indicate that data validation activities were in process on 03/15/2011 for these two counts.

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 Fourth Quarter of SFY 2010 (April 1st, 2010 through June 30th, 2010). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one which 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 Departments of Elderly Affairs and Human Services (RI DEA and RI DHS).

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 Fourth Quarter of SFY 2010.

Cost and Utilization Data, Q-4, SFY 2010 (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 Fourth Quarter of SFY 2010.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-4, SFY 2010	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
	Assisted Living	Under 65	$ 762	$ 73,120
		65 and Older	$ 648	$ 475,548
DEA	Assisted Living	Service Type Subtotals:	$ 661	$ 548,668
	Case Management	Under 65	$ 96	$ 4,590
		65 and Older	$ 74	$ 95,130
DEA	Case Management	Service Type Subtotals:	$ 75	$ 99,720
		65 and Older	$ 1,232	$ 1,541,431
DEA	Personal Care/Homemaker	Service Type Subtotals:	$ 1,232	$ 1,541,431
DEA		Grand Total:		$ 2,189,819

Cost and Utilization Data, Q-4, SFY 2010 (RI DHS): The following table provides an average cost per individual, as well as quarterly totals by DHS service line, for the two age groups during the Fourth Quarter of SFY 2010.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-4, SFY 2010	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
DHS	Adult Day Care	Under 65	$ 770	$ 596,078
		65 and Older	$ 766	$ 507,731
DHS	Adult Day Care	Service Type Subtotals:	$ 768	$ 1,103,809
	Assisted Living	Under 65	$ 1,085	$ 41,249
		65 and Older	$ 999	$ 466,579
DHS	Assisted Living	Service Type Subtotals:	$ 1,006	$ 507,828
	Case Management	Under 65	$ 85	$ 115,168
		65 and Older	$ 68	$ 34,280
DHS	Case Management	Service Type Subtotals:	$ 81	$ 149,448
	Home Health Agencey	Under 65	$ 673	$ 449,944
		65 and Older	$ 985	$ 339,805
DHS	Home Health Agencey	Service Type Subtotals:	$ 779	$ 789,749
	Hospice	Under 65	$ 4,419	$ 543,511
		65 and Older	$ 3,806	$ 6,143,325
DHS	Hospice	Service Type Subtotals:	$ 3,850	$ 6,686,836
	Nursing Facility	Under 65	$ 4,509	$ 7,516,846
		65 and Older	$ 4,427	$ 67,728,795
DHS	Nursing Facility	Service Type Subtotals:	$ 4,435	$ 75,245,641
	Personal Care/Homemaker	Under 65	$ 1,377	$ 3,990,085
		65 and Older	$ 1,299	$ 4,524,557
DHS	Personal Care/Homemaker	Service Type Subtotals:	$ 1,334	$ 8,514,643
	Tavares Pediatric Center	Under 65	$ 26,227	$ 1,914,570
DHS	Tavares Pediatric Center	Service Type Subtotals:	$ 26,227	$ 1,914,570
DHS		Grand Total:		$ 94,912,524

Cost and Utilization Data, Q-4, SFY 2010 (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 is shown on the following page.

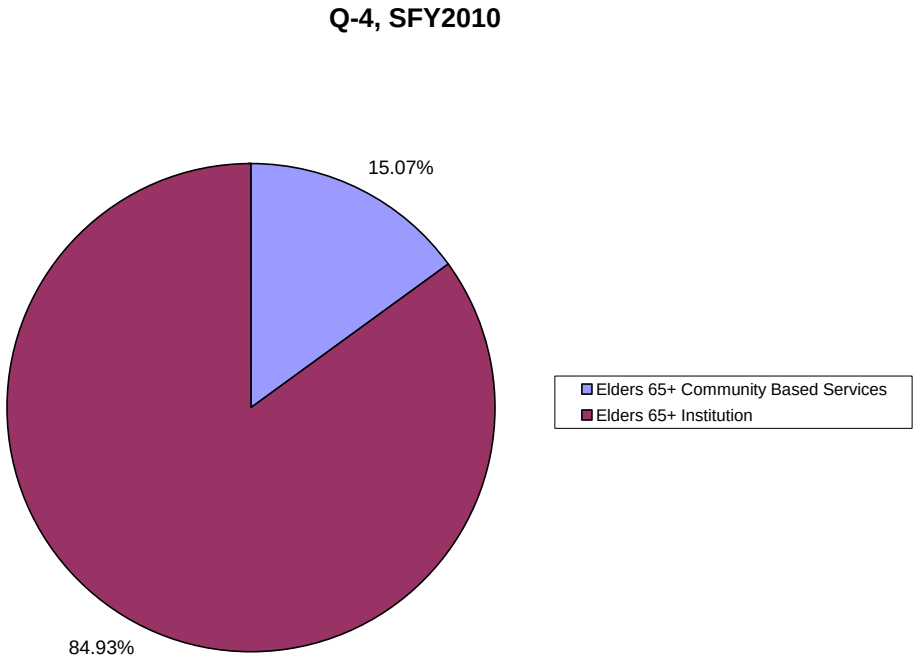
Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-4, SFY 2010				
Dept.	**Service Type**	**Age Group**	**# Served**	**Total Expenditures**
BHDDH	Day Programs	Under 65	2390	10,242,234
		Over 65	277	1,099,744
BHDDH	Homemaker	Under 65	131	833,774
		Over 65	19	73,565
BHDDH	Public Group Homes	Under 65	155	5,536,699
		Over 65	77	2,868,010
BHDDH	Private Group Homes	Under 65	1156	25,757,389
		Over 65	155	3,322,241
BHDDH	Family Supports	Under 65	843	3,979,620
		Over 65	57	300,563
BHDDH	Shared Living	Under 65	158	1,467,058
		Over 65	12	122,162
BHDDH	Supported Employment	Under 65	535	1,961,657
		Over 65	17	51,921
BHDDH	Behavioral Health GH	Under 65	*	*
	(Mental Health Only)	Over 65	*	*

An asterisk has been flagged in the lower two rows of the previous table to indicate that data validation activities were in process on 03/15/2011, specific to the numbers served, by age group, and total expenditures, by age group, for Behavioral Health Group Homes.

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 hHome and community-based services. The following charts show the percent distribution of expenditures for Medicaid long-term care institutional services and home and community services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (April 1st, 2010 through June 30th, 2010).

Elders Aged 65 and Over



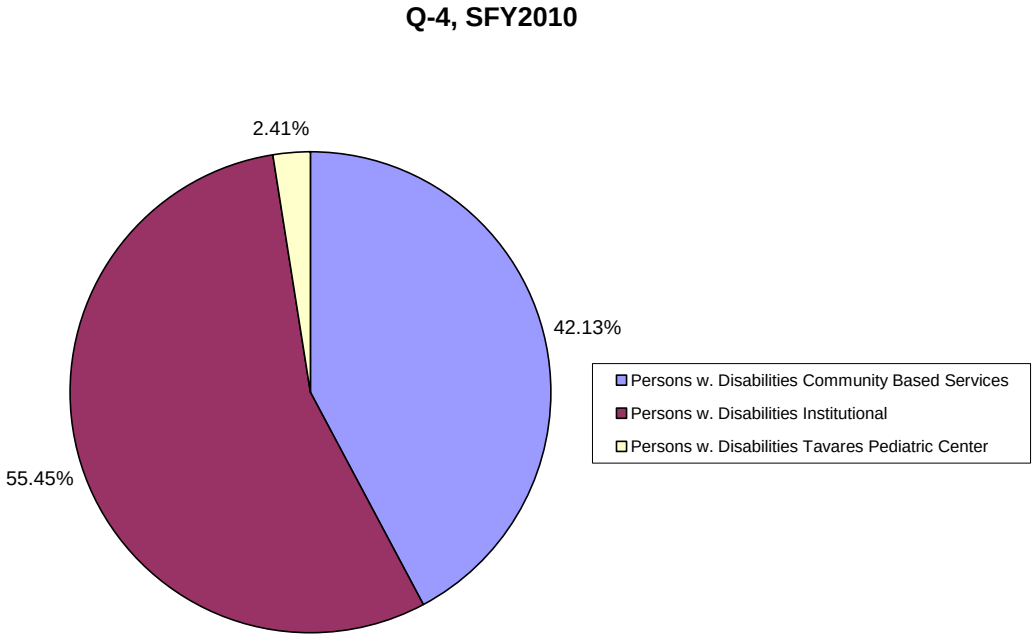
During the Fourth Quarter of SFY 2010, 84.93 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.07 percent were for home and community based services. The latter finding (15.07 percent for HCBS in Q-4, SFY 2010) represents an increase of almost one percent from the prior quarter (14.20 percent for HCBS in Q-3, SFY 2010[2]).

[2] The Rhode Island Executive Office of Health and Human Services. (December 15, 2010). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, January 1, 2010 – March 31, 2010 (p. 18).

Children with Special Health Care Needs

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 the RI Department of Human Services.

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 charts show the percent distribution of expenditures for Medicaid institutional services and home and community services. The utilization data were abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (April 1st, 2010 through June 30th, 2010).



During the Fourth Quarter of SFY 2010, 57.86 percent[3] of expenditures for persons with disabilities were for Medicaid long-term care institutional services and 42.13 percent were for home and community based services. The latter finding (42.13 percent for HCBS in Q-4, SFY 2010) represents an increase of almost two percent from the prior quarter (40.15 percent for HCBS in Q-3, SFY 2010[4]).

[3] This total percentage is inclusive of expenditures for the Tavares Pediatric Center.
[4] Ibid., p. 19.

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 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 Fourth Quarter of State Fiscal Year 2010, there were no waiting lists for Medicaid LTC services. In addition, the Department of Elderly Affairs (RI DEA) 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 Department 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 RI DEA, covers the Fourth Quarter of SFY 2010. 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).

RI DEA: Adult Day Care (04/1/2010 – 06/30/2010)

Service Category: Adult Day Care	**Clients***		**Units (Unit=1 Day)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	114	38	1,726	575
D2 (Income between 126% to 200% FPL):	658	9,498	9,498	3,166
Total	**772**	**11,224**	**11,224**	**3,741**
Average utilization=14.5 days of adult day care per client per month.				

*Clients are not distinct.

RI DEA: Case Management (04/01/2010 – 06/30/2010)

Service Category: Case Management	**Clients**		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
Case Management	823	274	3,984	1,328
Average utilization= 1.21 Hours of Case management per client per month.				

RI DEA: Home Care (04/01/2010 – 06/30/2010)

Service Category: Home Care	**Clients***		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	325	108	35,664	11,888
D2 (Income between 126% to 200% FPL):	1,319	440	137,429	45,810
Total	**1,644**	**548**	**173,093**	**57,698**
Average utilization=105 units or 26 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. Necessary components 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.

The following information has been drawn from InRhodes, the State's Medicaid eligibility system. At this time, InRhodes cannot produce the median turn-around time (TAT) statistics for completed LTC applications as outlined in Item H. As described in our prior quarterly report, enhanced reporting capability will be realized through Rhode Island's CHOICES Project, which will streamline the State's Medicaid Information Technology Architecture.

InRhodes was used to produce the following cohort analysis for LTC processing turn-around times during the Fourth Quarter of SFY 2010. 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.

RI DHS: Turn-around Times for New LTC Applications (Q-4, SFY 2010)

Month	**< 30 Days**		**30 – 90 Days**		**> 90 Days**		**Monthly Total**	
April 2010	121	29.95%	214	52.97%	69	17.08%	404	100%
May 2010	87	20.91%	234	56.25%	95	22.84%	416	100%
June 2010	129	29.32%	226	51.36%	85	19.32%	440	100%
Total for Q-4, SFY 2010	**337**	**26.75%**	**674**	**53.49%**	**249**	**19.76%**	**1,260**	**100%**

Source: InRhodes

During Q-4 of SFY 2010, there were 1,011 new LTC applications processed within less than 90 days (337 in < 30 days + 674 within 30 – 90 days = 1,011). Thus, 80.24% of the applications (1,011/1,260 = 80.24%) were processed within less than 90 days during Q-4 of SFY 2010. This statistic represents a decline of approximately four percentage points

in comparison to Q-3 of SFY 2010 (408 in < 30 days + 594 within 30 – 90 days = 1,002/1,185 = 84.56%).

In this quarter's report, InRhodes data have been further analyzed in order to quantify the average number of days for approving or denying applications for Medicaid LTC coverage. The following two tables show the average turn-around time in days for Medicaid LTC approvals during Q-4 of 2010 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 DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-4, SFY 2010)

Quarter	Number of Approvals for Medicaid LTC	Average TAT in Days
April 2010	239	43.69 (~ 44 Days)
May 2010	242	35.17 (~ 36 Days)
June 2010	254	85.92 (~ 86 Days)
Total	**735**	**54.93 (~ 55 Days)**

Source: InRhodes

RI DHS: Average Turn-around Time in Days for Medicaid LTC Denials (Q-4, SFY 2010)

Month	Number of Denials for Medicaid LTC	Average TAT in Days
April 2010	39	7.09 (~ 8 Days)
May 2010	39	15.06 (~ 16 Days)
June 2010	56	10.27 (~ 11 Days)
Total	**134**	**10.81 (~ 11 Days)**

Source: InRhodes

Thus, on average, Medicaid LTC approvals and denials were processed well below a 90-day threshold during Q-4 of SFY 2010. In the EOHHS' previous report[5] which covered the Third Quarter of SFY 2010, the average TAT for approvals was 46 days and the corresponding TAT for denials was 16 days.

[5] The Rhode Island Executive Office of Health and Human Services. (December 15, 2010). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information,* January 1, 2010 – March 31, 2010 (p. 23).

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) which have been enumerated in Item I 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[6] waiver community-based services	Access to ICFMR, and section 1915(c) HCBS Waivers MR/DD community-based services.

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Human Services (RI DHS): Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI DHS), using three clinical levels of care: Highest, High, and Preventive. The following data have been provided by the Office of Medical Review, based upon the clinical eligibility determinations which were performed during the Fourth Quarter of SFY 2010.

DHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-4, SFY 2010)

Clinical Eligibility Level of Care Criteria	Q-4, SFY 2010
Nursing Facility	847
Hospital (HAB applicants)*	4

Data Source: Office of Medical Review (OMR), Long-term Care Tracker

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.

[6] 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.

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 Fourth Quarter of SFY 2010, there were 91 applications made by individuals with developmental disabilities. There were also six (6) applications for hospital care during the same time period.

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

Turnaround Times for Clinical Eligibility Determinations Conducted by the Rhode Island Department of Human Services (RI DHS): Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI DHS) since implementation of the Global Waiver. The following data have been provided by the Office of Medical Review, based upon the clinical eligibility determinations which were performed during the Fourth Quarter of SFY 2010. 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.

DHS: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations (Q-4, SFY 2010)

	Q-4, SFY 2010	
	Average	**Median**
Nursing Facility Care	25	26
Hospital/(HAB applicants)	27	15

Data Source: Office of Medical Review (OMR), Long-term Care Tracker

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 Fourth Quarter of SFY 2010, the Division was unable to track the time between a completed application for services and clinical eligibility approval. As a result of *Project Sustainability*, the Division is developing a new internal database that will track these data. It is anticipated that this information will be available for new applications 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[7] care have been conducted by the Office of Medical Review at the Rhode Island Department of Human Services (RI DHS). 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 the Rhode Island Department of Human Services (RI DHS): The following data have been provided by the DHS' 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 Fourth Quarter of SFY 2010.

DHS: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-4, SFY 2010

Appeals of LTC Clinical Eligibility Determinations by Level of Care	Q-4, SFY 2010
Nursing Facility	1
Hospital/Habilitation	2

Source: Office of Medical Review, RI DHS

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 during the Fourth Quarter of SFY 2010.

[7] 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 DHS 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 DHS 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.

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.

Starting in 2009, The Alliance for Better Long Term Care partnered with Qualidigm[8] and the Rhode Island Department of Human Services on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of the RI DHS and DEA in the identification of residents who could be transitioned safely. In collaboration with representatives of the two EOHHS agencies (DHA and DEA), 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. The following statistics were prepared for the RI DHS by The Alliance for Better Long Term Care.

DHS: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-4, SFY 2010)

	Q-4, SFY 2010
Number of Nursing Home Transitions*	19
Average length of stay (ALOS) prior to transfer (days)*	215

*Data Source: The Alliance for Better Long Term Care

The average length of stay (ALOS) was measured in calendar days. During the Fourth Quarter of SFY 2010, for those beneficiaries who were transitioned from a nursing facility, their ALOS in a nursing home prior to transfer was 215 days (or approximately 7.2 months).

DHS: The Type of Living Arrangement or Setting and Services Upon Transfer for Persons Transitioned from Nursing Homes (Q-4, SFY 2010)

	Q-4, SFY 2010	
Existing Home	14	73.68%
Assisted Living	5	26.32%
New Housing	0	0.0%
Group Home	0	0.0%
Other	0	0.0%
Total	**19**	**100%**

*Data Source: The Alliance for Better Long Term Care

[8] Qualidigm is the Peer Review Organization (PRO) which is under contract to the RI DHS 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.

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 which may have contributed to any unsuccessful outcomes.

During SFY 2010, The Alliance for Better Long Term Care partnered with Qualidigm[9] and the Rhode Island Department of Human Services on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of the RI DHS and DEA in the identification of residents who could be transitioned safely. In collaboration with representatives of the two EOHHS agencies (DHA and DEA), 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 noted in Item M, there were 19 LTC beneficiaries who were transitioned from nursing facilities during the period from April 1, 2010 through June 30, 2010. The Alliance for Better Long Term Care reported that during this time period there were no (0) failed placements.

[9] Qualidigm is the Peer Review Organization (PRO) which is under contract to the RI DHS 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 families enrolled in the Rhode Island Works program and for eligible uninsured pregnant women, children, and parents. 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 which is given 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.

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 which impact eligibility determinations. For example, new applications which 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 by month for the Fourth Quarter of SFY 2010. These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[10] and b) several additional categories of applicants.

[10] 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.

Statistics for the latter grouping are aggregated (or added) within the InRhodes system and are classified as "Other" [11].

RI DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-4, SFY 2010

Month	Rhode Island Works	"Other"
April 2010	3,337	313
May 2010	3,154	264
June 2010	3,336	356
Total for Q-4 of SFY 2010	**9,827**	**933**

Source: InRhodes

Approved Applications: The following table outlines the number of Rhode Island Works and "Other" applicants who were deemed to be eligible for Medicaid during the Fourth Quarter of SFY 2010 (April 1, 2010 – June 30, 2010). The following tables represent 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. This information has been provided by month for the Fourth Quarter of SFY 2010.

RI DHS: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-4, SFY 2010

Month	Rhode Island Works	"Other"
April 2010	2,445	308
May 2010	2,479	256
June 2010	2,388	197
Total for Q-4 of SFY 2010	**7,312**	**761**

Source: InRhodes

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. The number of denials documented below represents a "point-in-time" snapshot of activity. This information has been provided by month for the Fourth Quarter of SFY 2010.

[11] "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.

RI DHS: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-4, SFY 2010

Month	Rhode Island Works	"Other"
April 2010	233	14
May 2010	210	5
June 2010	255	15
Total for Q-4 of SFY 2010	**698**	**34**

Source: InRhodes

Currently, InRhodes cannot produce a report showing denial code types stratified by income levels, as outlined in Item O. As described in Section I of this report, enhanced reporting capability will be realized through Rhode Island's CHOICES Project, which will streamline the State's Medicaid Information Technology Architecture.

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 families enrolled in the Rhode Island Works program and for eligible uninsured pregnant women, children, and parents. 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 which is given 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 which is questionable must be confirmed before eligibility can be certified.

Item O provided a count of the number of applications received from RIte Care applicants during the Fourth Quarter of SFY 2010 (April 1, 2010 through June 30, 2010). 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[12] 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" [13].

[12] 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.

[13] "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 which 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 Fourth Quarter of State Fiscal Year 2010.

RI DHS: The Monthly Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort (Q-4, SFY 2010)

Quarter	**Number of Applications Pending More than 30 Days for Rhode Island Works Applicants**
Q-4, SFY 2010	368

Source: InRhodes

This finding represents an improvement from Q-3 of SFY 2010, when the monthly average number of new Rhode Island Works applications pending for more than 30 days was 391.

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 Fourth Quarter of SFY 2010 (April 1, 2010 through June 30, 2010). 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 Fourth Quarter of SFY 2010. 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 DHS: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort (Q-4, SFY 2010)

Month	RIW Redeterminations	RIW Closures	Percentage
April 2010	48,231	2,090	4.33%
May 2010	48,624	2,036	4.19%
June 2010	48,650	2,082	4.28%
Total for Q-4, SFY 2010	**145,505**	**6,208**	**4.26%**

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[14]-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.

DHS: Monthly Premiums for Families, By Income Level

Family Income Level[15]	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, the DHS Eligibility System, and document the number of RI Care- or RIte Share-enrolled families who must pay premiums for coverage on a monthly basis.

DHS: The Number of RIte Care- or RIte Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-4, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	Q-4, SFY 2010	
> 150 - 185% FPL	9,922	61.2%
> 185 - 200% FPL	2,151	13.3%
> 200 - 250% FPL	4,124	25.5%
Total	**16,197**	**100%**

[14] 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.

[15] For a family of four, the following FPLs were established by the US DHHS on January 23, 2009: 150% FPL = $33,075.00; 185% FPL = $40,792.50; 200% FPL = $44,100.00; 250% FPL = $55,125.00.

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[16]. For example, if a premium payment which is due on January 1^{st} has not been not 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.

[16] MA coverage is reinstated without penalty for otherwise eligible family members if all due and overdue premiums are received by the Department of Human Services' fiscal agent on or before the effective date of MA discontinuance.

The following sanction data were obtained from InRhodes, the DHS Eligibility System, and document the number of RIte Care- or RIte Share-enrolled families who were sanctioned during the Fourth Quarter of SFY 2010.

DHS: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-4, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	Q-4, SFY 2010	
> 150 - 185% FPL	188	52.1%
> 185 - 200% FPL	62	17.2%
> 200 - 250% FPL	111	30.7%
Total	**361**	**100%**

Source: InRhodes

This quarter's finding represents a decrease of approximately eight (8) percent in the total number of sanctions in comparison to the Third Quarter of SFY 2010. The following table provides quarterly comparative data about sanctions by percentage of the Federal Poverty Level throughout SFY 2010.

DHS: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-1 – Q-4, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2010		Q-2, SFY 2010		Q-3, SFY 2010		Q-4, SFY 2010	
> 150 - 185% FPL	183	58.1%	136	47.7%	206	52.8%	188	52.1%
> 185 - 200% FPL	48	15.2%	65	22.8%	60	15.4%	62	17.2%
> 200 - 250% FPL	84	26.7%	84	29.5%	124	31.8%	111	30.7%
Total	**315**	**100%**	**285**	**100%**	**390**	**100%**	**361**	**100%**

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.

During SFY 2010, 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 = $32,249,453.

The following table provides disaggregated data for SFY 2010 for State and Federal Expenditures under the Cost Not Otherwise Matchable (CNOM) provision of Section 1115(a)(2) of the Social Security Act. These data were obtained from DHS 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 2010)

State	$15,414,550
Federal	$16,834,903
Total	**$32,249,453**

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 which were paid to the DHS during the period from 04/01/2010 – 06/30/2010. This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: 04/01/2010 – 06/30/2010

Recoveries by Type:	**Amount Recovered:**
Estate Recoveries: TPL and Legal	$868,582
Casualty Recoveries: TPL and Legal	$361,877
Total	**$1,230,459**

Source: TPL Unit, RI DHS