Report to the Centers for Medicare and Medicaid Services

Quarterly Operation Report
Rhode Island Global Consumer Choice Compact
1115 Waiver Demonstration
January 1, 2011 – March 31, 2011

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

December 2011

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 rebalancing
- 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, 2011 – March 31, 2011 are outlined below.

Rhode Island Medicaid Eligibility

	December 2010 Counts of Eligibles	**March 2011 Counts of Eligibles**
Aged	17,199	17,200
Disabled	27,111	27,379
BCCPT	233	230
QMBs, SLMBs, and QI 1s	5,482	5,427
Child and Families	129,623	130,268
Adoptive Subsidy	2,504	2,488
Foster Care	2,702	2,631
Children with Special Health Care Needs	8,637	8,725
Total	193,491	194,348

Care Management Program Enrollment

Program	**Enrollment as of 12/31/10**	**Enrollment as of 03/31/11**
RIte Care	122,885*****	122,605
RIte Share	11,747	11,360
Rhody Health Partners	12,508	12,770
PACE	207	207
Connect Care Choice	2,399	2,399
Connect Care	175	216
RIte Smiles	51,514	51,574
Early Intervention	1,998	2,038
BCCPT	233	230
Extended Family Planning	314	313

*****Previous Quarterly Report Enrollment for RIte Care included Extended Family Planning (EFP). The RIte Care Enrollment numbers have been adjusted by the EFP enrollment figures**.**

Cost Not Otherwise Matchable (CNOM) Program Enrollment

Program	Description	Enrollment as of 03/31/11
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**
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**
Budget Population 10	Elders at risk of LTC	**1,298**
Budget Population 11	217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants Highest need group	**0**
Budget Population 12	217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants High need group	**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**
Budget Population 14	Women screened for breast or cervical cancer under CDC program and not eligible for Medicaid	**230**
Budget Population 15	Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid	**1,872**
Budget Population 16	Uninsured adults with mental illness	**6,944**
Budget Population 17	Children at risk for Medicaid and/or institutional care	**2,470**
Budget Population 18	HIV positive individuals who are otherwise not eligible for Medicaid	**368**

Waiver Category Change Requests

There were no Waiver Category Requests submitted during the reporting quarter.

Cost Not Otherwise Matchable (CNOM)

Under the federal authority granted by CMS, the state has claimed $ 5,225,768 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 $ 1,502,387,134 million dollars below the cap during this reporting quarter. Attachment A contains the Budget Neutrality Report.

Highlights from Rhode Island's Quarterly Progress Report to CMS for the Global Consumer Choice Compact 1115 Waiver: The following bulleted excerpts, organized according to a series of objectives and supporting activities during the reporting period January – March 2011.

- 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, 2011, a total of **1,959 Level of Care (LOC) assessments** had been completed, resulting in the following determinations: **Highest LOC = 1,355**; **High LOC = 406**; and **Preventive LOC = 142**. Two assessments did not meet a LOC determination.

- 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

    - Finalized the production of materials for a discharge planning conference scheduled for April 2011
    - 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 RN Care Managers

- 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 953 individuals to date to a community setting in the Nursing Facility Transition program**
    - **120 Nursing Home Transition referrals** were made to the Office of Community (OCP) Programs during Q-3 of SFY 2011
    - **30 individuals** were transitioned to the community during Q-3 SFY 2011
    - Provided ongoing training of State staff in the DHS Office of Community Programs, DHS Long Term Care, and the DEA Home and Community Care

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

    - During Q-3 of SFY 2011, **142 individuals met the Preventive Level of Care** and received services
    - Included a proposed expansion for Respite 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 36 individuals in the DHS Shared Living program** as of March 31, 2011
    - 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

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

    - Prepared and submitted a *Money Follows the Person* Demonstration Grant application to CMS
    - Awarded a *Money Follows the Person* Demonstration Grant from CMS
    - Participated in weekly *Money Follows the Person* Technical Assistance sessions
    - Prepared revisions to the *Money Follows the Person* Operational Protocol
    - 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
    - Included opportunities for referral to assisted living facilities as a “qualified residence” under the *Money Follows the Person* Demonstration Grant application
    - Included referral to adult day services under the *Money Follows the Person* Demonstration Grant application

- Continued to explore opportunities for Affordable Care Act (ACA) funding to support expanding the Home Care initiatives
- Awaited final rules for the Community First Option
- Continued to explore acuity-based funding for adult day services

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

  - Planned for the Strategic Long Term Care Consolidation Summit
  - Identified analytics and metrics to guide the five-year strategic planning objectives

- 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

  - Implemented 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)
  - Commenced development of the program evaluation of the *Communities of Care* initiative
  - Planned *Communities of Care* interventions for high Emergency Department (ED) utilizers enrolled in the State's Primary Care Case Management (PCCM) delivery system (Connect Care Choice)
  - Implemented targeted interventions for high utilizers of pharmacy benefits in the State's Medicaid FFS and managed care delivery systems
  - Explored opportunities under the Affordable Care Act (ACA), including Money Follows the Person, Health Homes for Medicaid Enrollees with Chronic Conditions, and the Center for Medicare and Medicaid Innovation (CCMI) State Demonstrations to Integrate Care for Dual Eligibles
  - Commenced development of a pain management benefit

- 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.)

  - Continued to explore opportunities for improved participation in the program

- Analyze Medicaid Managed Long Term Care models

  - Reviewed responses to the State's Managed Long Term Care Request for Information (RFI)
  - Interviewed selected entities for additional information regarding responses to the State's Managed Long Term Care Request for Information (RFI)
  - Participated in cross-agency development of the Medicare Advanced Primary Care Practice Demonstration Project

- Submitted an application to the Centers for Medicare and Medicaid Services (CMS) for a *CCMI Innovations State Demonstration to Integrate Care for Dual Eligibles*

- Promote the adoption of "Medical Homes"

  - Commenced the development of a proposal for a *Health Homes for Medicaid Enrollees with Chronic Conditions Initiative* under the Affordable Care Act (ACA)
  - Participated in the statewide CSI Rhode Island Medical Home Project
  - Implemented opportunities to leverage established Medical Home practices under the *Communities of Care* Initiative

- Promote the adoption of electronic health records

  - Secured a no-cost extension for the DRA Medicaid Transformation Grant
  - Continued the voluntary enrollment of Medicaid beneficiaries in Rhode Island Medicaid's **current***care* electronic medical record (EMR)
  - Implemented a plan 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)

- 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
  - Explored opportunities under the proposed CMS rules regarding the adoption of HIE

- 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

  - Implemented new initiatives in the capitated Medicaid managed care program, focusing on selective contracting strategies
  - Analyzed value-based purchasing strategies for the Managed LTC RFI

- 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 development of the SFY 2012 budget process
  - Proposed selective contracting initiatives for the Governor's consideration
  - Continued to refine recommendations for long-term care acuity adjustments to meet budget targets

- 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 two meetings with the Global Waiver Task Force on 01/24/2011 and 03/28/2011
    - Convened the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 03/09/2011
    - 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
    - A consumer-oriented booklet, *You Can Live Safely at Home – Learn More About Options for Home & Community-Based Services,* was published and distributed by the EOHHS
    - Posted a new down-loadable fact sheet, *Transportation Options for Rhode Islanders for Individuals 60 and Older and for Adults with Disabilities,* on the RI DHS Web site
    - Posted a revised down-loadable fact sheet, *Connect Care CHOICE – A Care Management and Wellness Program,* on the RI DHS Web site
    - Posted a revised down-loadable fact sheet, *Rhody Health Partners – Comprehensive Health Care for Adults,* on the RI DHS Web site

Section III

Key analytic highlights on the progress of the Global Waiver based on performance during the First Quarter of the SFY 2011 (July 2010 – September 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 First Quarter of SFY 2011 (July 1, 2010 – September 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-1 of SFY 2011.

RI DHS: Medicaid Long-term Care Acceptances (Approvals) (Q-1, SFY 2011)

Month	Long-Term Care Approvals
July 2010	246
August 2010	240
September 2010	359
Total for Q-1, SFY 2011	**845**

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 2011 (July 1, 2010 – September 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-1 of SFY 2011.

RI DHS: Medicaid Long-term Care Denials (Q-1, SFY 2011)

Month	Long-Term Care Denials
July 2010	44
August 2010	55
September 2010	37
Total for Q-1, SFY 2011	**136**

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 First Quarter of SFY 2011 (July 1, 2010 – September 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-1 SFY 2011 (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 First Quarter of SFY 2011 (July 1, 2010 – September 30, 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.

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.

Source: EOHHS Data Warehouse; MMIS Claim Universe		July		Aug		Sep		Q-1, SFY 2011	
Reporting Period: Date of Service		2010		2010		2010			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
	Assisted Living	Under 65	34	1,032	37	1,135	39	1,154	110	3,321
		65 and Older	250	7,612	256	7,828	261	7,729	767	23,169
DEA	Assisted Living	Service Type Subtotals	284	8,644	293	8,963	300	8,883	877	26,490
	Case Management	Under 65	19	50	26	124	29	121	74	295
		65 and Older	486	2,206	464	2,185	512	2,334	1,462	6,725
DEA	Case Management	Service Type Subtotals	505	2,256	490	2,309	541	2,455	1,536	7,020
	Personal Care/Homemaker	65 and Older	423	108,038	421	108,385	418	105,940	1,262	322,363
DEA	Personal Care/Homemaker	Service Type Subtotals	423	108,038	421	108,385	418	105,940	1,262	322,363
DEA		Grand Total:		118,938		119,657		117,278		355,873

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-1 SFY 2011 (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-1 SFY 2011. This information reflects incurred dates of service (July 1st, 2010 through September 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
Shared Living[2]	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

[2] The DHS Shared Living program became operational during September 2010. A fact sheet which describes the DHS' Shared Living program may be accessed by pasting the following link to a Web browser: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/LTC/SL_fact_sheet.pdf

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; shared living[3]; and Tavares Pediatric Center. This information has been stratified by month and by age group. The data table shows the information organized by month for the First Quarter of SFY 2011.

In reviewing the following table, an increase was observed in DHS case management services, for the under 65 years of age cohort, starting in September of 2010 and continuing throughout the First Quarter of SFY 2011. Based on our preliminary analyses, this increase has been attributed to a vision-screening service for EPSDT-age beneficiaries that is anticipated to be seasonal (i.e., associated with school physicals) in nature. This increase will be monitored in the series of quarterly reports covering the remainder of SFY 2011, to determine whether this change represents a seasonal or an on-going one.

Source: EOHHS Data Warehouse: MMIS Claim Universe		July		Aug		Sep		Q-1, SFY 2011	
Reporting Period: Date of Service		2010		2010		2010			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
DHS	Adult Day Care	Under 65	266	3,912	264	4,343	263	4,082	793	12,337
		65 and Older	230	3,356	234	3,585	235	3,252	699	10,193
DHS	Adult Day Care	Service Type Subtotals:	496	7,268	498	7,928	498	7,334	1,492	22,530
	Assisted Living	Under 65	12	343	12	366	14	414	38	1,123
		65 and Older	154	4,587	152	4,531	150	4,374	456	13,492
DHS	Assisted Living	Service Type Subtotals:	166	4,930	164	4,897	164	4,788	494	14,615
	Case Management	Under 65	319	588	268	569	1,890	2,225	2,477	3,382
		65 and Older	158	601	151	658	167	791	476	2,050
DHS	Case Management	Service Type Subtotals:	477	1,189	419	1,227	2,057	3,016	2,953	5,432
	Hospice	Under 65	40	2,065	37	2,020	39	1,865	116	5,950
		65 and Older	555	29,535	535	28,715	538	27,294	1,628	85,544
DHS	Hospice	Service Type Subtotals:	595	31,600	572	30,735	577	29,159	1,744	91,494
	Nursing Facility	Under 65	555	15,753	573	16,128	574	15,450	1,702	47,331
		65 and Older	5,140	152,694	5,170	153,430	5,128	147,567	15,438	453,691
DHS	Nursing Facility	Service Type Subtotals:	5,695	168,447	5,743	169,558	5,702	163,017	17,140	501,022
	Personal Care/Homemaker	Under 65	982	266,905	982	273,344	993	265,034	2,957	805,283
		65 and Older	1,187	304,647	1,210	317,738	1,192	309,741	3,589	932,126
DHS	Personal Care/Homemaker	Service Type Subtotals:	2,169	571,552	2,192	591,082	2,185	574,775	6,546	1,737,409
	Shared Living Agency	Under 65					2	50	2	50
		65 and Older					5	159	5	159
DHS	Shared Living Agency	Service Type Subtotals:					7	209	7	209
	Skilled Nursing	Under 65	244	4,045	224	3,690	256	3,908	724	11,643
		65 and Older	113	2,004	106	2,214	105	2,368	324	6,586
DHS	Skilled Nursing	Service Type Subtotals:	357	6,049	330	5,904	361	6,276	1,048	18,229
	Tavares Pediatric Center	Under 65	25	759	24	718	25	721	74	2,198
DHS	Tavares Pediatric Center	Service Type Subtotals:	25	759	24	718	25	721	74	2,198
DHS		Grand Total:		791,794		812,049		789,295		2,393,138

Source: EOHHS Data Warehouse: MMIS Claim Universe		Oct		Nov		Dec		Q-2, SFY 2011	
Reporting Period: Date of Service		2010		2010		2010			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
DHS	Adult Day Care	Under 65	256	3,979	256	3,727	249	3,707	761	11,413
		65 and Older	232	3,220	238	3,112	231	3,231	701	9,563
DHS	Adult Day Care	Service Type Subtotals:	488	7,190	494	6,849	480	6,937	1,462	20,976
	Assisted Living	Under 65	14	411	12	344	12	355	38	1,110
		65 and Older	154	4,603	149	4,337	149	4,484	456	13,424
DHS	Assisted Living	Service Type Subtotals:	166	5,014	161	4,681	161	4,839	488	14,534
	Case Management	Under 65	2,247	2,562	3,327	3,580	1,659	1,918	7,233	8,060
		65 and Older	150	713	213	722	202	692	565	2,127
DHS	Case Management	Service Type Subtotals:	2,397	3,275	3,540	4,302	1,861	2,610	7,798	10,187
	Hospice	Under 65	43	1,017	37	805	30	825	110	2,647
		65 and Older	548	13,896	532	10,642	502	13,973	1,582	38,511
DHS	Hospice	Service Type Subtotals:	591	14,913	569	11,447	532	14,798	1,692	41,158
	Nursing Facility	Under 65	556	15,770	544	15,102	556	16,038	1,656	46,910
		65 and Older	5,135	152,241	5,112	146,788	5,085	150,907	15,332	449,936
DHS	Nursing Facility	Service Type Subtotals:	5,691	168,011	5,656	161,890	5,641	166,945	16,988	496,846

The Number of Medicaid Beneficiaries Served by PACE, Q-1 SFY 2011 (RI DHS): Using the EOHHS Data Warehouse, information was extracted from the MMIS to

[3] As noted previously, the DHS Shared Living program became operational during September 2010.

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 2011 (July 1, 2010 – September 30, 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	7/1/2010	PACE PROGRAM	65 and Over	175
DHS		PACE PROGRAM	Under 65	35
	7/1/2010		**Period Totals:**	210
DHS	8/1/2010	PACE PROGRAM	65 and Over	178
DHS		PACE PROGRAM	Under 65	35
	8/1/2010		**Period Totals:**	213
DHS	9/1/2010	PACE PROGRAM	65 and Over	180
DHS		PACE PROGRAM	Under 65	34
	9/1/2010		**Period Totals:**	214
			Quarterly Total:	**637**
DHS	10/1/2010	PACE PROGRAM	65 and Over	175
DHS		PACE PROGRAM	Under 65	35
	10/1/2010		**Period Totals:**	210
DHS	11/1/2010	PACE PROGRAM	65 and Over	178
DHS		PACE PROGRAM	Under 65	35
	11/1/2010		**Period Totals:**	213
DHS	12/1/2010	PACE PROGRAM	65 and Over	180
DHS		PACE PROGRAM	Under 65	34
	12/1/2010		**Period Totals:**	214
			Quarterly Total:	**637**

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q1 SFY 2011 (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; and supported employment. Data for the First Quarter of SFY 2011 (July 1, 2010 – September 30, 2010) is shown on the following page.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-1, SFY 2011

Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2,375
		Over 65	295
BHDDH	Homemaker	Under 65	132
		Over 65	19
BHDDH	Public Group Homes	Under 65	149
		Over 65	79
BHDDH	Private Group Homes	Under 65	1,158
		Over 65	163
BHDDH	Family Supports	Under 65	863
		Over 65	64
BHDDH	Shared Living	Under 65	155
		Over 65	13
BHDDH	Supported Employment	Under 65	535
		Over 65	17

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 2011 (July 1, 2010 – September 30, 2010). By organizing the 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 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 that 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 that outlines LTC cost and utilization by BHDDH service line during the First Quarter of SFY 2011.

Cost and Utilization Data, Q-1 SFY 2011 (RI DEA): The following table provides an average cost per individual, as well as quarterly totals by RI DEA service line, for the two age groups during the First Quarter of SFY 2011.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-1, SFY 2011		Q-2, SFY 2011	
Reporting Period: Date of Service						
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals	Avg/Person/Mo	3 Month Totals
	Assisted Living	Under 65	$ 941	$ 103,524	$ 934	$ 101,805
		65 and Older	$ 824	$ 631,983	$ 824	$ 641,949
DEA	Assisted Living	Service Type Subtotals:	$ 839	$ 735,506	$ 838	$ 743,754
	Case Management	Under 65	$ 60	$ 4,425	$ 44	$ 2,730
		65 and Older	$ 69	$ 100,875	$ 67	$ 85,545
DEA	Case Management	Service Type Subtotals:	$ 69	$ 105,300	$ 66	$ 88,275
	Personal Care/Homemaker	65 and Older	$ 1,285	$ 1,621,789	$ 1,299	$ 1,632,152
DEA	Personal Care/Homemaker	Service Type Subtotals:	$ 1,285	$ 1,621,789	$ 1,299	$ 1,632,152
DEA		Grand Total:		$ 2,462,595		$ 2,495,251

Cost and Utilization Data, Q-1 SFY 2011 (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 First Quarter of SFY 2011.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-1, SFY 2011		Q-2, SFY 2011	
Reporting Period: Date of Service						
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals	Avg/Person/Mo	3 Month Totals
DHS	Adult Day Care	Under 65	$ 824	$ 653,614	$ 795	$ 604,661
		65 and Older	$ 772	$ 539,466	$ 722	$ 506,088
DHS	Adult Day Care	Service Type Subtotals:	$ 800	$ 1,193,080	$ 760	$ 1,110,749
	Assisted Living	Under 65	$ 1,235	$ 46,930	$ 1,225	$ 46,558
		65 and Older	$ 1,169	$ 532,935	$ 1,184	$ 532,754
DHS	Assisted Living	Service Type Subtotals:	$ 1,174	$ 579,865	$ 1,187	$ 579,312
	Case Management	Under 65	$ 61	$ 151,394	$ 40	$ 290,552
		65 and Older	$ 64	$ 30,500	$ 56	$ 31,442
DHS	Case Management	Service Type Subtotals:	$ 62	$ 181,894	$ 41	$ 321,994
	Hospice	Under 65	$ 4,339	$ 503,352	$ 4,329	$ 476,188
		65 and Older	$ 3,885	$ 6,324,240	$ 3,582	$ 5,666,201
DHS	Hospice	Service Type Subtotals:	$ 3,915	$ 6,827,592	$ 3,630	$ 6,142,389
	Nursing Facility	Under 65	$ 4,533	$ 7,715,796	$ 4,720	$ 7,816,790
		65 and Older	$ 4,525	$ 69,854,676	$ 4,557	$ 69,866,736
DHS	Nursing Facility	Service Type Subtotals:	$ 4,526	$ 77,570,471	$ 4,573	$ 77,683,526
	Personal Care/Homemaker	Under 65	$ 1,399	$ 4,135,653	$ 1,403	$ 4,175,583
		65 and Older	$ 1,328	$ 4,767,151	$ 1,339	$ 4,843,704
DHS	Personal Care/Homemaker	Service Type Subtotals:	$ 1,360	$ 8,902,804	$ 1,368	$ 9,019,288
	Shared Living Agency	Under 65	$ 1,068	$ 2,137	$ 1,674	$ 25,117
		65 and Older	$ 1,341	$ 6,707	$ 1,752	$ 73,577
DHS	Shared Living Agency	Service Type Subtotals:	$ 1,263	$ 8,844	$ 1,731	$ 98,693
	Skilled Nursing	Under 65	$ 386	$ 279,589	$ 340	$ 270,344
		65 and Older	$ 533	$ 172,668	$ 528	$ 180,000
DHS	Skilled Nursing	Service Type Subtotals:	$ 432	$ 452,257	$ 396	$ 450,344
	Tavares Pediatric Center	Under 65	$ 26,159	$ 1,935,734	$ 26,641	$ 1,838,248
DHS	Tavares Pediatric Center	Service Type Subtotals:	$ 26,159	$ 1,935,734	$ 26,641	$ 1,838,248
DHS		Grand Total:		$ 97,652,542		$ 97,244,543

As previously noted in Item C, the RI DHS Shared Living program became operational in September 2010. Thus, the table shown above reflects the initial expenditures for this service line starting in Q-1 of SFY 2011.

In comparison to the experience demonstrated in Q-4 of SFY 2010, an increase was seen in the three-month total for DHS case management services for the under 65 years of age cohort during the First Quarter of SFY 2011. As noted in Item C, an increase was observed in DHS case management services, for the under 65 years of age cohort, starting in September of 2010 and continuing throughout the First Quarter of 2011. Based on our preliminary analyses, this increase has been attributed to a vision-screening service for EPSDT-age beneficiaries that is anticipated to be seasonal (i.e., associated with school physicals) in nature. This increase will be monitored in the series of quarterly reports covering the remainder of SFY 2011, to determine whether this change represents a seasonal or an on-going one.

Cost and Utilization Data, Q-1 SFY 2011 (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-1, SFY 2011

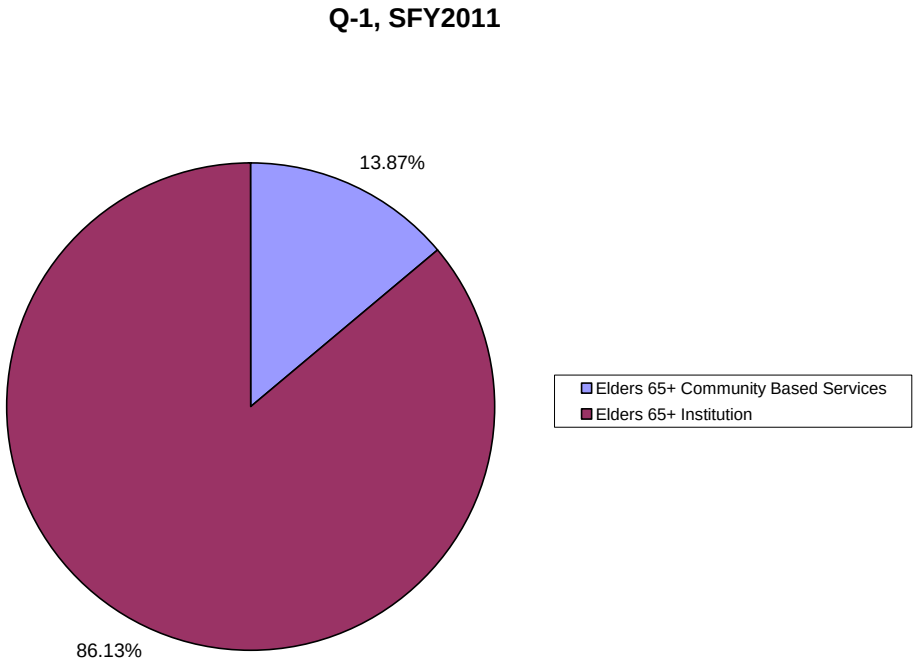
Dept.	Service Type	Age Group	# Served	Total Expenditures
BHDDH	Day Programs	Under 65	2,375	$10,203,432.58
		Over 65	295	$1,135,552.00
BHDDH	Homemaker	Under 65	132	$847,812.02
		Over 65	19	$76,541.19
BHDDH	Public Group Homes	Under 65	149	$5,814,049.07
		Over 65	79	$3,142,954.50
BHDDH	Private Group Homes	Under 65	1,158	$25,773,284.51
		Over 65	163	$3,381,416.35
BHDDH	Family Supports	Under 65	863	$4,072,336.81
		Over 65	64	$326,943.33
BHDDH	Shared Living	Under 65	155	$1,517,896.14
		Over 65	13	$133,060.89
BHDDH	Supported Employment	Under 65	535	$1,947,976.25
		Over 65	17	$52,149.70

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, 2010 – September 30, 2010).

During the First Quarter of SFY 2011, 86.13 percent of expenditures for elders aged 65 and over were for Medicaid LTC institutional services and 13.87 percent were for home and community-based services. The latter finding (13.87 percent for HCBS) represented a decrease of approximately (1) percent in comparison to the finding that was demonstrated in the prior quarter (15.07 percent for HCBS for elders during Q-4 of SFY 2010)[4].

Elders Aged 65 and Over

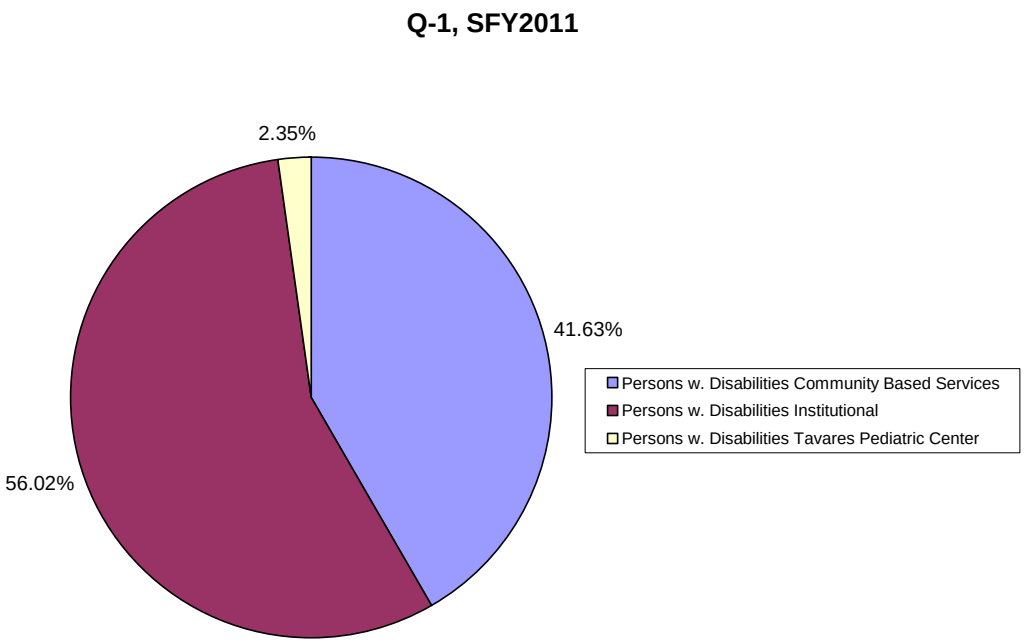


[4] The Rhode Island Executive Office of Health and Human Services. (March 15, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information, April 1, 2010 – June 30, 2010* (p. 18).

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 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, 2010 – September 30, 2010).



During the First Quarter of SFY 2011, 56.02 percent[5] of expenditures for persons with disabilities were for Medicaid long-term care institutional services and 43.98 percent were for home and community-based services. The latter finding (43.98 percent for HCBS in Q-1, SFY 2011) represents an increase of close to two percent in comparison to the prior quarter (42.13 percent for HCBS in Q-4, SFY 2010) [6].

[5] This total percentage is inclusive of expenditures for the Tavares Pediatric Center.

[6] The Rhode Island Executive Office of Health and Human Services. (March 15, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information, April 1, 2010 – June 30, 2010* (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 First Quarter of SFY 2011 (July 1, 2010 – September 30, 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 First Quarter of SFY 2011 (July 1, 2010 – September 30, 2010). The table shown below documents 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 2011)

Service Category: Adult Day Care	**Clients***		**Units (Unit=1 Day)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	135	44	1,930	634
D2 (Income up to 200% FPL):	674	225	9,717	3,239
Total	**809**	**269**	**11,647**	**3,873**
Average utilization=14.4 days of adult day care per client per month.				
*Clients are not distinct				

RI DEA: Case Management (Q-1, SFY 2011)

Service Category: Case Management	**Clients**		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
Case Management	878	293	4,355	1,452
Average utilization=1.24 Hours of Case management per client per month.				

RI DEA: Home Care (Q-1, SFY 2011)

Service Category: Home Care	**Clients***		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	354	116	36,684	12,027
D2 (Income up to 200% FPL):	1,404	468	148,251	49,417
Total	**1,758**	**584**	**184,935**	**61,444**
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. 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.[7] 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[8]
- If a resource cannot be sold or liquidated and a determination regarding availability cannot be made by the LTC Administrator[9]
- 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)[10]

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

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

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

[10] 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[11]
- 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)[12]

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 2011 (July 1, 2010 – September 30, 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.

On average, approximately thirty (30) percent of all new LTC applications that are processed by the Department of Human Services (DHS) are those which 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 the Department of Human Services.

RI DHS: Turn-around Times for New LTC Applications (Q-1, SFY 2011)

Month	**< 30 Days**		**30 – 90 Days**		**> 90 Days**		**Monthly Total**	
July 2010	130	27.72%	189	52.97%	150	31.98%	469	100%
August 2010	101	24.94%	228	56.25%	76	18.77%	405	100%
September 2010	124	32.29%	183	51.36%	77	20.05%	384	100%
Total for Q-1, SFY 2011	**355**	**28.22%**	**600**	**47.69%**	**303**	**24.09%**	**1,258**	**100%**

Source: InRhodes

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 two tables show the average turn-around time in days for Medicaid LTC approvals during the First Quarter of SFY 2011 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.

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

RI DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-1 SFY 2011)

Quarter	Number of Approvals for Medicaid LTC	Average TAT in Days
Q-1, SFY 2011	733	64.59 (65 Days)

Source: InRhodes

RI DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Denials (Q-1 SFY 2011)

Quarter	Number of Denials for Medicaid LTC	Average TAT in Days
Q-1, SFY 2011	131	10.83 (~ 11 Days)

Source: InRhodes

On average, Medicaid LTC approvals and denials were processed well below a 90-day threshold during the first quarter of SFY 2011. In the EOHHS report[13] which covered the Fourth Quarter of SFY 2010, the average TAT for approvals of Medicaid LTC applications was 55 days and the corresponding TAT for denials was 11 days.

[13] The Rhode Island Executive Office of Health and Human Services. (March 15, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information,* April 1, 2010 – June 30, 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) 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[14] 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 First Quarter of SFY 2011.

DHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-1 SFY 2011)

Clinical Eligibility Level of Care Criteria	Q-1, SFY 2011
Nursing Facility	858
Hospital (HAB applicants)*	3

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.

[14] 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 First Quarter of SFY 2011, there were fifty-five (55) applications made by individuals with developmental disabilities. There were also 12 applications for hospital care during Q-1 of SFY 2011.

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 First Quarter of SFY 2011. 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-1 SFY 2011)

	Q-1, SFY 2011	
Nursing Facility Care	Average	Median
	26	26
Hospital/(HAB applicants)	25	28

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 First Quarter of SFY 2011, 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[15] 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 First Quarter of SFY 2011.

DHS: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care (Q-1 SFY 2011)

Appeals of LTC Clinical Eligibility Determinations by Level of Care	**Q-1, SFY 2011**
Nursing Facility	0
Hospital/Habilitation	0

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 filed during the first quarter of SFY 2011.

[15] 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.

Prior to the start of SFY 2011, The Alliance for Better Long Term Care partnered with Qualidigm[16] 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 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 the Rhode Island Department of Human Services.

DHS: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-1 SFY 2011)

	Q-1, SFY 2011
Number of Nursing Home Transitions	29
Average Length of Stay (ALOS) Prior to Transfer in Calendar Days	144

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

As was the case in prior reporting periods, the average length of stay (ALOS) was measured in calendar days. For those beneficiaries who were transitioned from a nursing facility, their ALOS prior to transfer was 144 days (or approximately 4.8 months) in Q-1 of SFY 2011. In comparison, during the Fourth Quarter of SFY 2010, the ALOS in a nursing facility prior to transfer was 215 days (or approximately 7.2 months).

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.

[16] Qualidigm is the Peer Review Organization (PRO) that 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.

DHS: The Type of Living Arrangement or Setting and Services upon Transfer for Persons Transitioned from Nursing Homes (Q-1 SFY 2011)

	Q-1, SFY 2011	
Existing Home	27	93.10%
Assisted Living	2	6.90%
New Housing	0	0.00%
Group Home	0	0.00%
Other	0	0.00%
Total	**29**	**100.00%**

Source: DHS, 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 which may have contributed to any unsuccessful outcomes.

Prior to the start of SFY 2011, The Alliance for Better Long Term Care partnered with Qualidigm[17] 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 (RI DHS and RI 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 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 the Rhode Island Department of Human Services.

As noted in Item M, there were 29 LTC beneficiaries who were transitioned from nursing facilities during the First Quarter of SFY 2011 (July 1, 2010 through September 30, 2010). The Office of Community Programs at the RI DHS reported that there were no (0) failed placements during the first quarter of SFY 2011.

[17] Qualidigm is the Peer Review Organization (PRO) that 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 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 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 during the First Quarter of SFY 2011. These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[18] and b) several additional categories of applicants. Statistics for the

[18] 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.

latter grouping are aggregated (or added) within the InRhodes system and are classified as "Other" [19].

RI DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants (Q-1, SFY 2011)

Month	Rhode Island Works	"Other"
July 2010	3,009	597
August 2010	3,136	591
September 2010	3,260	625
Total for Q-1 of SFY 2011	**9,405**	**1,813**

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 2011 (July 1, 2010 through September 30, 2010). The following table 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.

RI DHS: Approved Applications for Rhode Island Works and "Other" Category of Applicants (Q-1, SFY 2011)

Month	Rhode Island Works	"Other"
July 2010	2,132	511
August 2010	2,130	492
September 2010	2,350	456
Total for Q-1 of SFY 2011	**6,612**	**1,459**

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 2011 (July 1, 2010 through September 30, 2010). The number of denials documented below represents a "point-in-time" snapshot of activity.

[19] "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-1, SFY 2011)

Month	Rhode Island Works	"Other"
July 2010	195	17
August 2010	214	24
September 2010	223	23
Total for Q-1 of SFY 2011	**632**	**64**

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 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 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 which is questionable must be confirmed before eligibility can be certified.

Item O provided tables which documented the number of applications received from RIte Care applicants during the First Quarter of SFY 2011 (July 1, 2010 through September 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[20] 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" [21].

[20] 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.

[21] "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 First Quarter of State Fiscal Year 2011.

RI DHS: The Monthly Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort (Q-1 & Q-2, SFY 2011)

Quarter	**Average Number of Applications Pending More than 30 Days for Rhode Island Works Applicants**
Q-1, SFY 2011	507*

Source: InRhodes

* The average number of applications pending more than 30 days during the First Quarter of SFY 2011 has been flagged with an asterisk (*) because the finding for the first month (July of 2010) in this three-month period represented an outlier. If July 2010 were to be excluded from the calculation of this statistic, then the average number of new applications pending more than 30 days during the First Quarter of SFY 2011 would equal 430. In comparison, the average number of pending applications during Q-4 of SFY 2010 was 368.

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 2011 (July 1, 2010 through September 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 First Quarter of SFY 2011. 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-1, SFY 2011)

Month	RIW Redeterminations	RIW Closures	Percentage
July 2010	44,294	2,036	~ 4.6%
August 2010	44,379	1,911	4.31%
September 2010	44,913	1,863	4.15%
Total for Q-1, SFY 2011	**133,586**	**5,810**	**4.35%**

Source: InRhodes

When comparing the percentage of closures to redeterminations on a quarterly basis during SFY 2011, these statistics were noted to be similar to those from the final two quarters in SFY 2010. Please refer to the following table. Information for Q-3 and Q-4 of SFY 2010 has been organized below in reverse chronological order.

RI DHS: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort (Q-4 & Q-3, SFY 2010)

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-4, SFY 2010	145,505	6,208	4.26%
Q-3, SFY 2010	143,935	6,107	4.24%

Source: InRhodes

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[22]-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[23]	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 for the First Quarter of SFY 2011 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-1, SFY 2011)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2011	
> 150 - 185% FPL	9,956	60.8%
> 185 - 200% FPL	2,169	13.2%
> 200 - 250% FPL	4,257	26.0%
Total	**16,382**	**100.0%**

[22] 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.

[23] The US Department of Health and Human Services (US DHHS) issued updated poverty guidelines on 08/03/2010, which were to remain in effect for the remainder of 2010. The poverty guidelines are frequently referred to as "federal poverty levels" (FPL). Based upon the updated guidelines issued by the US DHHS in August of 2010, for a family of four, 100 percent of the FPL = $22,050. More information about the poverty guidelines may be obtained by pasting the following link on a Web browser: http://aspe.hhs.gov/poverty/10poverty.shtml

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[24]. 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.

[24] 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 First Quarter of SFY 2011 (July 1, 2010 – September 30, 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, SFY 2011)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2011	
>150 - 185% FPL	230	50.8%
>185 - 200% FPL	78	17.2%
>200 - 250% FPL	145	32.0%
Total	**453**	**100.0%**

Thus, the average number of families sanctioned across the first quarter of SFY 2011 (SFY 2011, Year to Date) = 453. Across the four quarters in SFY 2010, the average number of families sanctioned = 338. The following table provides quarterly comparative data about sanctions by percentage of the Federal Poverty Level (FPL) 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.

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 2011 through March of 2011. 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 2011, YTD Through 03/31/2011)

State	$10,345,942
Federal	$11,601,920
Total	**$21,947,861**

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 Rhode Island Department of Human Services Third Party Liability (TPL) Unit and document the total recoveries which were paid to the DHS during the First Quarter of SFY 2011. This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

RI DHS: Estate and Casualty Recoveries (Q-1 SFY 2011)

Recoveries by Type	**Amount Recovered**	
	Q-1, SFY 2011	
Estate Recoveries: TPL and Legal	$1,246,060	
Casualty Recoveries: TPL and Legal	$666,226	
Total	**$1,912,286**	

Rhode Island Global Consumer Choice Compact 11 W-00242/1 Section 1115 Demonstration

Budget Neutrality Summary	Calendar Year 2009 Total DY 1	Calendar Year 2010 Total DY 2	Calendar Year 2011 Q/E 3/31/11
Section I: Total Expenditures Subject to Budget Neutrality			
Budget Population 1: (ABD no TPL)	$ 418,731,831	$ 486,505,287	$ 130,556,772
Budget Population 2 (ABD TPL)	$ 715,844,300	$ 659,668,554	$ 148,524,007
Budget Population 3 (RIte Care)	$ 362,611,218	$ 405,517,339	$ 79,544,666
Budget Population 4 (CSHCNs)	$ 188,895,404	$ 184,738,525	$ 35,963,022
Budget Population 5 (EFP)	$ 198,808	$ 134,380	$ 14,060
Budget Population 6 (Pregnant Expansion)	$ 1,489,534	$ 1,820,522	$ 390,517
Budget Population 7 (SCHIP Children)	$ -	$ -	$ -
Budget Population 8 (CNOM: Substitute Care)	$ -	$ -	$ -
Budget Population 9 (CNOM: CSHCNs otherwise in voluntaary state custody)	$ 3,364,541	$ -	$ -
Budget Population 10 (CNOM: 65, <200%, at risk for LTC)	$ 2,943,524	$ 4,492,554	$ 967,582
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	$ 833,860
Budget Population 15 (CNOM: Adults w/ disabilities at risk for LTC, <300% FPL)	$ 255,250	$ 897,633	$ 163,586
Budget Population 16 (CNOM: Uninsured Adults w/ mental illness)	$ 6,595,169	$ 6,989,503	$ 1,883,322
Budget Population 17 (CNOM: Youth at risk for Medicaid; at risk children < 300% FPL)	$ 3,775,172	$ 3,696,607	$ 826,479
Budget Population 18 (HIV)	$ -	$ 752,914	$ -
Budget Population 19 (CNOM: Non-working disabled adults 19-64, GPA)	$ 1,743,740	$ 1,790,059	$ 377,301
Budget Services 1 (Windows)	$ 4,504	$ -	$ -
Budget Services 2 (RIte Share and collections)	$ 5,369,938	$ 6,772,712	$ 1,572,816
Budget Service 3 (Other payments - e.g.FQHC suppl., stop loss)	$ 10,194,423	$ 33,205,530	$ 1,865,220
Budget Services 4 (CNOM: core and preventive svcs, Medicaid eligible at risk youth)	$ -	$ -	$ -

Budget Neutrality Summary	Calendar Year 2009 Total DY 1	Calendar Year 2010 Total DY 2	Calendar Year 2011 Q/E 3/31/11
Budget Services 5 (CNOM: Services by FQHCs to uninsured individuals)	$ 600,000	$ 1,200,000	$ -
Base Expenses [1]	$ 33,090,955	$ 91,516,977	$ 13,079,459
TOTAL Expenditures for Period as reported on the CMS-64*	**$ 1,762,261,653**	**$ 1,893,513,074**	**$ 416,562,669**
Section II: Expenditure Target			
Quarterly	$ 2,600,000,000	$ 2,400,000,000	$ 575,000,000
Cumulative	$ 2,600,000,000	$ 5,000,000,000	$ 575,000,000
Section III: Actual Expenditures w/Waiver			
Quarterly			$ 416,562,669
Cumulative	$ 1,762,261,653	$ 1,893,513,074	$ 416,562,669
Section IV: Surplus / (Deficit)			
Quarterly	$ 837,738,347	$ 506,486,926	$ 158,437,331
Cumulative	**$ 837,738,347**	**$ 1,344,225,273**	**$ 1,502,662,604**

* 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	*$ 416,562,669*
LEA	*$ 3,392,487*
SCHIP (RIteShare Premiums & Collections)	*$ (202,187)*
SCHIP	*$ 3,372,960*
DSH	*$ -*
Prior Period Adjustments	*($513,897)*
Current Period Adjustments	*$ 2,109,978*
CMS 64 Summary Sheet: 6. Expenses this Quarter)	*$ 424,722,010*

[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 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.

	Calendar Year 2009	Calendar Year 2010	Calendar Year 2011
Budget Neutrality Summary	**Total DY 1**	**Total DY 2**	**Q/E 3/31/11**