
**Report to the Centers for Medicare and Medicaid Services**

# Quarterly Operation Report
# Rhode Island Global Consumer Choice Compact
# 1115 Waiver Demonstration
# July 1, 2011 – September 30, 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 and expenditures
- 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 July 1, 2011 – September 30, 2011 are outlined below.

**Rhode Island Medicaid Eligibility**

| | June 2011 Counts of Eligibles | September 2011 Counts of Eligibles |
|---|---|---|
| **Aged** | 17,293 | 17,339 |
| **Disabled** | 27,805 | 28,086 |
| **BCCPT** | 225 | 221 |
| **QMBs, SLMBs, and QI 1s** | 5,407 | 5,637 |
| **Child and Families** | 130,861 | 131,172 |
| **Adoptive Subsidy** | 2,478 | 2,448 |
| **Foster Care** | 2,438 | 2,315 |
| **Children with Special Health Care Needs** | 8,785 | 8,765 |
| **Total** | 195,292 | 195,983 |

**Care Management Program Enrollment**

| Program | Enrollment as of 06/30/11 | Enrollment as of 09/30/11 |
|---|---|---|
| **RIte Care** | 123,269 | 123,698 |
| **RIte Share** | 11,727 | 11,673 |
| **Rhody Health Partners** | 13,027 | 13,230 |
| **PACE** | 206 | 209 |
| **Connect Care Choice** | 2,074 | 2071 |
| **Connect Care** | 153 | 143 |
| **RIte Smiles** | 54,627 | 55,510 |
| **Early Intervention** | 2,281 | 2,033 |
| **BCCPT** | 225 | 221 |
| **Extended Family Planning** | 313 | 322 |

**Cost Not Otherwise Matchable (CNOM) Program Enrollment**

| Program | Description | Enrollment as of 06/30/11 | Enrollment as of 09/30/11 |
|---|---|---|---|
| **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** | **0** |
| **Budget Population 9** | Children with special health care needs who are 21 and under who would otherwise be placed in voluntary State custody-residential diversion | **0** | **0** |
| **Budget Population 10** | Elders at risk of LTC | **1,368** | **1,409** |
| **Budget Population 11** | 217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants Highest need group | **0** | **0** |
| **Budget Population 12** | 217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants High need group | **0** | **0** |
| **Budget Population 13** | 217-like, Medically Needy Individuals receiving HCBW-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community | **0** | **0** |
| **Budget Population 14** | Women screened for breast or cervical cancer under CDC program and not eligible for Medicaid | **225** | |
| **Budget Population 15** | Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid | **1,877** | **1,883** |
| **Budget Population 16** | Uninsured adults with mental illness | **7,544** | **8028** |
| **Budget Population 17** | Children at risk for Medicaid and/or institutional care | **2,507** | |
| **Budget Population 18** | HIV positive individuals who are otherwise not eligible for Medicaid | **381** | **363** |

**Waiver Category Change Requests**

The following Waiver Category request changes and or State Plan Amendments have been submitted or are awaiting CMS action during this Quarterly Operational Report period July –September 2011

| *Request Type* | **Description** | **Date Submitted** | **CMS Action** | **Date** |
|---|---|---|---|---|
| State Plan Amendment | Disproportionate Share Hospital Policy | 06/27/11 | Pending | |
| Category II | HCBS for Individuals with Developmental Disabilities | 06/04/11 | Approved | 12/20/11 |
| Category I | RIte Care Premium Cost Sharing | 8/24/11 | Denied | 09/09/11 |
| Category I Reconsideration | RIte Care Premium Cost Sharing | 9/16/11 | Denied | 09/30/11 |
| Category II | RIte Share Co-payment | 08/24/11 | Approved | 11/17/11 |
| Category II | Elimination of Annual Nursing Facility Rate Adjustment | 09/302011 | Pending | |
| State Plan Amendment | Single State Agency Designation | 09/30/11 | Pending | |

**Cost Not Otherwise Matchable (CNOM)**

Under the federal authority granted by CMS, the state has claimed $ 2,676,422 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 $ 1,649,405,376 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 July 1, 2011 – September 30, 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 September 30, 2011, a total of **1,555 Level of Care (LOC) assessments** had been completed, resulting in the following determinations: **Highest LOC = 1,239**; **High LOC = 515**; and **Preventive LOC = 86**. Nineteen (19) individuals did not meet a LOC.

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

    - **Safely transitioned a total of 1,013 individuals to date to a community setting in the Nursing Facility Transition program**
    - **111 Nursing Home Transition referrals** were made to the Office of Community (OCP) Programs during Q-4 of SFY 2011
    - **29 individuals** were transitioned to a community setting during the reporting quarter.
    - Provided ongoing training of State staff in the DHS Office of Community Programs, DHS Long Term Care, and the DEA Home and Community Care
    - Ongoing monitoring of the use of protocols for weekend discharges and inpatient diversion discharges to nursing facilities
    - Tracked Nursing Facility Diversions associated with level of care (LOC) assessments and diversions made by the Connect
    - Aligned planning activities under the *Money Follows the Person* with the Nursing Home Transition Program
    - Convened *Money Follows the Person* Steering Committee on September 28, 2011
    - Submitted *Money Follows the Person* Planning Grant no-cost extension

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

- During Q-4 of SFY 2011, **86 individuals met the Preventive Level of Care** and received services
- Explored opportunities for a proposed expansion of Respite Services and transition services with funding available under the *Money Follows the Person* Demonstration Grant

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

  - **Enrolled 58 individuals in the DHS Shared Living program** as of September 30, 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 revised Operational Protocol for the *Money Follows the Person* Demonstration Grant to CMS
  - Received, on July 26, 2011, final approval from CMS on the Operational Protocol
  - Participated in weekly *Money Follows the Person* Technical Assistance sessions
  - Worked with the Assisted Living Trade Organization to identify assisted living facilities that would meet the CMS definition as a "qualified residence" under the *Money Follows the Person* Demonstration Grant application
  - 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
  - Continued to explore acuity-based funding for adult day services
  - Implemented workgroup recommended enhancements to the Ask Rhody web-based eligibility screening tool
  - Submitted a application to CMS for funding under the Real Choice Systems Change Grant Building Sustainable Partnerships for Housing opportunity on August 15, 2011

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

  - Conducted a Strategic Long Term Care Consolidation Summit follow up meeting
  - Presented analytics and metrics to guide the five-year strategic planning objectives
  - Identified follow up activities for summit participants

- Convened cross-departmental planning for Long Term Care Consolidation
- Convened cross-departmental planning for state and federal opportunities for Integrated Care for Medicare and Medicaid Beneficiaries and managed Long Term Care for Medicaid-only beneficiaries
- Met with the CMS CCMI team to discuss opportunities under the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

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

  - Monitored interventions in *Communities of Care* for high utilizers enrolled in the State's managed care health plan delivery system (RIte Care and Rhody Health Partners participating Health Plans and the State's Primary Care Case Management (PCCM) delivery system Connect Care Choice )
  - Commenced the development of the program evaluation of the *Communities of Care* initiative
  - Incorporated feedback resulting from focus groups into the design of brochures for the *Communities of Care* initiative
  - Implemented targeted interventions for high utilizers of pharmacy benefits in the State's Medicaid FFS and managed care delivery systems
  - Explored opportunities under the Affordable Care Act (ACA), including Balancing Incentive Program, Community Choice First, 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

  - Selected for participation in the CHCS initiative, Implementing Innovations in Long-term Supports and Services (LTSS), funded by SCAN Foundation
  - Convened meeting with the Centers for Medicare and Medicaid Services (CMS) CCMI Financial Alignment opportunity for Medicare and Medicaid beneficiaries
  - Submitted Letter of Intent for the CCMI Financial Alignment opportunity for Medicare and Medicaid beneficiaries
  - Commenced planning for Managed Care Effectiveness Report and Integrated Care for Medicare and Medicaid beneficiaries due on December 31, 2011

- 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

    - Continued implementing activities under the DRA Medicaid Transformation Grant
    - Continued the voluntary enrollment of Medicaid beneficiaries in Rhode Island Medicaid's **current***care* electronic medical record (EMR)
    - Implemented 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)
    - Commenced planning design for statewide web-based, real-time inventory of LTCSS

- 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

- 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 under the Integrated Care for Medicare and Medicaid beneficiaries and Medicaid-only beneficiaries opportunities

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

    - Reviewed opportunities for selective contracting strategies as part of the implementation of the SFY 2012 budget initiatives
    - Continued to refine recommendations for long-term care acuity adjustments to meet budget targets

- Implemented acuity adjuster update for Nursing Facilities and implemented a reduction of 1.76% in Nursing Facility rate on July 1, 2011

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

  - Convened three meetings with the Global Waiver Task Force on 07/25/2011 and 09/26/2011
  - Convened the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 09/07/2011
  - 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

**Section III**

Key analytic highlights on the progress of the Global Waiver based on performance during the Third Quarter of the SFY 2011 (January 1, 2011 – March 31, 2011).

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

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

The following table outlines the number of Medicaid LTC applicants who were deemed to be eligible for Medicaid LTC during the Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011). The following tables represent a "point-in-time" snapshot of the number of approved applications for Medicaid LTC coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for Q-3 of SFY 2011.

**RI DHS: Medicaid Long-term Care Acceptances (Approvals), Q-3, SFY 2011**

| Month | Long-Term Care Approvals |
|---|---|
| January 2011 | 221 |
| February 2011 | 266 |
| March 2011 | 306 |
| **Total for Q-3, SFY 2011** | **793** |

Source: InRhodes

In comparing the quarterly total to prior intervals, it was noted that the total number of LTC acceptances for the Third Quarter of SFY 2011 was less than the totals that had been documented during the prior two quarters in SFY 2011 (Q-1, SFY 2011 = 845 and Q-2, SFY 2011 = 827) as well as the final quarter in SFY 2010 (Q-4, SFY 2010 = 873). However, the total number of LTC acceptances for the Third Quarter of SFY 2011 was quite similar to the finding observed during the Third Quarter of SFY 2010 (Q-3, SFY 2010 = 748).

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 Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011). InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics. The number of denials documented below represents a "point-in-time" snapshot of activity. This information has been provided by month for Q-3 of SFY 2011.

**RI DHS: Medicaid Long-term Care Denials, Q-3, SFY 2011**

| Month | Long-Term Care Denials |
|---|---|
| January 2011 | 41 |
| February 2011 | 82 |
| March 2011 | 61 |
| **Total for Q-3, SFY 2011** | **184** |

Source: InRhodes

In comparing the quarterly total to prior intervals, it was noted that the total number of LTC denials for the Third Quarter of SFY 2011 was greater than the observed totals for the prior two quarters in SFY 2011 (Q-1, SFY 2011 = 136 and Q-2, SFY 2011 = 147) as well as the final quarter in SFY 2010 (Q-4, SFY 2010 = 134). However, the total number of LTC denials for the Third Quarter of SFY 2011 was quite similar to the finding that had been documented for the Third Quarter of SFY 2010 (Q-3, SFY 2010 = 181).

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 Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011).

Data Sources: Using the EOHHS Data Warehouse, information was extracted from the Medicaid Management Information System (MMIS) to produce counts of the number of Medicaid beneficiaries who received LTC services that are administered by the RI Division of Elderly Affairs and the Department of 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-3, 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 Division of Elderly Affairs (RI DEA) during the Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011).

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

**DEA: LTC Service Type and Corresponding Unit of Service**

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

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

| Source: EOHHS Data Warehouse: MMIS Claim Universe | | | Jan | | Feb | | Mar | | Q-3, SFY 2011 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Reporting Period: Date of Service | | | 2011 | | 2011 | | 2011 | | | |
| Dept. | Service Type | Age Group | Count | Units | Count | Units | Count | Units | Count | Units |
| | Assisted Living | Under 65 | 41 | 1,268 | 41 | 1,127 | 43 | 1,320 | 125 | 3,715 |
| | | 65 and Older | 260 | 7,809 | 255 | 7,076 | 252 | 7,703 | 767 | 22,588 |
| DEA | Assisted Living | Service Type Subtotals: | 301 | 9,077 | 296 | 8,203 | 295 | 9,023 | 892 | 26,303 |
| | Case Management | Under 65 | 22 | 132 | 31 | 112 | 25 | 126 | 78 | 370 |
| | | 65 and Older | 457 | 1,888 | 417 | 1,913 | 377 | 1,850 | 1,251 | 5,651 |
| DEA | Case Management | Service Type Subtotals: | 479 | 2,020 | 448 | 2,025 | 402 | 1,976 | 1,329 | 6,021 |
| | Personal Care/Homemaker | 65 and Older | 419 | 104,641 | 404 | 96,212 | 402 | 105,441 | 1,225 | 306,294 |
| DEA | Personal Care/Homemaker | Service Type Subtotals: | 419 | 104,641 | 404 | 96,212 | 402 | 105,441 | 1,225 | 306,294 |
| DEA | | Grand Total: | | 115,738 | | 106,440 | | 116,440 | | 338,618 |

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, 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 the Third Quarter of SFY 2011. This information reflects incurred dates of service (January 1st, 2011 through March 31st, 2011) and has been stratified according to the two age groups (less than 65 years of age and greater than or equal to 65 years of age).

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 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.

[2] The DHS Shared Living program became operational during September 2011. 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

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; and Tavares Pediatric Center. This information has been stratified by month and by age group. Data tables are shown on the following page, with information organized by month for the Third Quarter of SFY 2011.

| Source: EOHHS Data Warehouse: MMIS Claim Universe | | | Jan | | Feb | | Mar | | Q-3, SFY 2011 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Reporting Period: Date of Service | | | 2011 | | 2011 | | 2011 | | | |
| Dept. | Service Type | Age Group | Count | Units | Count | Units | Count | Units | Count | Units |
| DHS | Adult Day Care | Under 65 | 248 | 3,295 | 246 | 3,405 | 247 | 4,000 | 741 | 10,700 |
| | | 65 and Older | 228 | 2,700 | 222 | 2,865 | 228 | 3,584 | 678 | 9,149 |
| DHS | Adult Day Care | Service Type Subtotals: | 476 | 5,995 | 468 | 6,270 | 475 | 7,584 | 1,419 | 19,849 |
| | Assisted Living | Under 65 | 12 | 367 | 12 | 333 | 13 | 380 | 37 | 1,080 |
| | | 65 and Older | 152 | 4,556 | 156 | 4,178 | 156 | 4,685 | 464 | 13,419 |
| DHS | Assisted Living | Service Type Subtotals: | 164 | 4,923 | 168 | 4,511 | 169 | 5,065 | 501 | 14,499 |
| | Case Management | Under 65 | 1,280 | 1,592 | 1,291 | 2,111 | 1,242 | 1,711 | 3,813 | 5,414 |
| | | 65 and Older | 175 | 817 | 149 | 982 | 124 | 630 | 448 | 2,429 |
| DHS | Case Management | Service Type Subtotals: | 1,455 | 2,409 | 1,440 | 3,093 | 1,366 | 2,341 | 4,261 | 7,843 |
| | Hospice | Under 65 | 32 | 814 | 35 | 905 | 47 | 1,039 | 114 | 2,758 |
| | | 65 and Older | 512 | 13,423 | 538 | 12,268 | 573 | 14,402 | 1,623 | 40,093 |
| DHS | Hospice | Service Type Subtotals: | 544 | 14,237 | 573 | 13,173 | 620 | 15,441 | 1,737 | 42,851 |
| | Nursing Facility | Under 65 | 561 | 16,002 | 555 | 14,481 | 559 | 15,726 | 1,675 | 46,209 |
| | | 65 and Older | 5,228 | 153,936 | 5,133 | 136,917 | 5,118 | 150,548 | 15,479 | 441,401 |
| DHS | Nursing Facility | Service Type Subtotals: | 5,789 | 169,938 | 5,688 | 151,398 | 5,677 | 166,274 | 17,154 | 487,610 |
| | Personal Care/Homemaker | Under 65 | 980 | 264,534 | 972 | 245,967 | 990 | 278,654 | 2,942 | 789,155 |
| | | 65 and Older | 1,191 | 305,801 | 1,206 | 293,469 | 1,231 | 339,859 | 3,628 | 939,129 |
| DHS | Personal Care/Homemaker | Service Type Subtotals: | 2,171 | 570,335 | 2,178 | 539,436 | 2,221 | 618,513 | 6,570 | 1,728,284 |
| | Shared Living Agency | Under 65 | 7 | 410 | 9 | 407 | 10 | 581 | 26 | 1,398 |
| | | 65 and Older | 24 | 1,217 | 27 | 1,290 | 27 | 1,625 | 78 | 4,132 |
| DHS | Shared Living Agency | Service Type Subtotals: | 31 | 1,627 | 36 | 1,697 | 37 | 2,206 | 104 | 5,530 |
| | Skilled Nursing | Under 65 | 237 | 1,792 | 224 | 1,402 | 222 | 1,518 | 683 | 4,712 |
| | | 65 and Older | 104 | 1,213 | 109 | 969 | 122 | 1,223 | 335 | 3,405 |
| DHS | Skilled Nursing | Service Type Subtotals: | 341 | 3,005 | 333 | 2,371 | 344 | 2,741 | 1,018 | 8,117 |
| | Tavares Pediatric Center | Under 65 | 23 | 676 | 21 | 570 | 21 | 623 | 65 | 1,869 |
| DHS | Tavares Pediatric Center | Service Type Subtotals: | 23 | 676 | 21 | 570 | 21 | 623 | 65 | 1,869 |
| DHS | | Grand Total: | | 773,145 | | 722,519 | | 820,788 | | 2,316,452 |

The Number of Medicaid Beneficiaries Served by PACE, Q-3, SFY 2011 (RI DHS): Using the EOHHS Data Warehouse, information was extracted from the MMIS to produce counts of the number of individuals who participated in the PACE (Program of All Inclusive Care for the Elderly) program during the Third Quarter of SFY 2011 (January 1st, 2011 – March 31st, 2011). Please refer to the data table shown on the following page. This information has been stratified by month and by age group.

| Source: | | EOHHS Data Warehouse/Financial Data Mart | | |
|---|---|---|---|---|
| Reporting Period: | | Eligibility Period | | |
| **Dept.** | **Benefit Period** | **Program Description** | **Age Group** | **Person Count** |
| DHS | 1/1/2011 | PACE PROGRAM | 65 and Over | 179 |
| DHS | | PACE PROGRAM | Under 65 | 34 |
| | **1/1/2011** | | **Period Totals:** | 213 |
| DHS | 2/1/2011 | PACE PROGRAM | 65 and Over | 180 |
| DHS | | PACE PROGRAM | Under 65 | 35 |
| | **2/1/2011** | | **Period Totals:** | 215 |
| DHS | 3/1/2011 | PACE PROGRAM | 65 and Over | 178 |
| DHS | | PACE PROGRAM | Under 65 | 36 |
| | **3/1/2011** | | **Period Totals:** | 214 |
| | | | **Quarterly Total:** | **642** |

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, 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 Third Quarter of SFY 2011 (January 1st, 2011 – March 31st, 2011) are shown below.

| **Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-3, SFY 2011** | | | |
|---|---|---|---|
| **Dept.** | **Service Type** | **Age Group** | **# Served** |
| BHDDH | Day Programs | Under 65 | 2,370 |
| | | Over 65 | 288 |
| BHDDH | Homemaker | Under 65 | 131 |
| | | Over 65 | 19 |
| BHDDH | Public Group Homes | Under 65 | 142 |
| | | Over 65 | 81 |
| BHDDH | Private Group Homes | Under 65 | 1,164 |
| | | Over 65 | 163 |
| BHDDH | Family Supports | Under 65 | 857 |
| | | Over 65 | 63 |
| BHDDH | Shared Living | Under 65 | 160 |
| | | Over 65 | 13 |
| BHDDH | Supported Employment | Under 65 | 542 |
| | | Over 65 | 21 |

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 Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one that shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

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

A second data source was queried to produce the cost and utilization data for the LTC services which are administered by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The database which is used by the Division of Developmental Disabilities (RI BHDDH) was queried to prepare the table which outlines LTC cost and utilization by BHDDH service line during the Third Quarter of SFY 2011.

Cost and Utilization Data, Q-3, SFY 2011 (RI DEA): The following table provides an average cost per individual, as well as quarterly totals by DEA service line, for the two age groups during the Third Quarter of SFY 2011.

| Source: EOHHS Data Warehouse: MMIS Claim Universe | | | Q-3, SFY 2011 | |
|---|---|---|---|---|
| Reporting Period: Date of Service | | | | |
| Dept. | Service Type | Age Group | Avg/Person/Mo | 3 Month Totals |
| | Assisted Living | Under 65 | $ 920 | $ 114,996 |
| | | 65 and Older | $ 781 | $ 598,959 |
| DEA | Assisted Living | Service Type Subtotals: | $ 800 | $ 713,955 |
| | Case Management | Under 65 | $ 71 | $ 5,550 |
| | | 65 and Older | $ 68 | $ 84,765 |
| DEA | Case Management | Service Type Subtotals: | $ 68 | $ 90,315 |
| | Personal Care/Homemaker | 65 and Older | $ 1,255 | $ 1,537,345 |
| DEA | Personal Care/Homemaker | Service Type Subtotals: | $ 1,255 | $ 1,537,345 |
| DEA | | Grand Total: | | $ 2,341,615 |

Cost and Utilization Data, Q-3, 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 Third Quarter of SFY 2011.

| Source: EOHHS Data Warehouse: MMIS Claim Universe | | | Q-3, SFY 2011 | |
|---|---|---|---|---|
| Reporting Period: Date of Service | | | | |
| Dept. | Service Type | Age Group | Avg/Person/Mo | 3 Month Totals |
| DHS | Adult Day Care | Under 65 | $ 765 | $ 566,886 |
| | | 65 and Older | $ 714 | $ 484,341 |
| DHS | Adult Day Care | Service Type Subtotals: | $ 741 | $ 1,051,227 |
| | Assisted Living | Under 65 | $ 1,224 | $ 45,293 |
| | | 65 and Older | $ 1,149 | $ 533,214 |
| DHS | Assisted Living | Service Type Subtotals: | $ 1,155 | $ 578,506 |
| | Case Management | Under 65 | $ 43 | $ 163,495 |
| | | 65 and Older | $ 81 | $ 36,122 |
| DHS | Case Management | Service Type Subtotals: | $ 47 | $ 199,617 |
| | Hospice | Under 65 | $ 4,183 | $ 476,890 |
| | | 65 and Older | $ 3,692 | $ 5,992,435 |
| DHS | Hospice | Service Type Subtotals: | $ 3,724 | $ 6,469,324 |
| | Nursing Facility | Under 65 | $ 4,562 | $ 7,640,924 |
| | | 65 and Older | $ 4,366 | $ 67,574,653 |
| DHS | Nursing Facility | Service Type Subtotals: | $ 4,385 | $ 75,215,578 |
| | Personal Care/Homemaker | Under 65 | $ 1,380 | $ 4,059,071 |
| | | 65 and Older | $ 1,323 | $ 4,798,497 |
| DHS | Personal Care/Homemaker | Service Type Subtotals: | $ 1,348 | $ 8,857,567 |
| | Shared Living Agency | Under 65 | $ 1,983 | $ 51,553 |
| | | 65 and Older | $ 1,830 | $ 142,708 |
| DHS | Shared Living Agency | Service Type Subtotals: | $ 1,868 | $ 194,261 |
| | Skilled Nursing | Under 65 | $ 412 | $ 281,298 |
| | | 65 and Older | $ 621 | $ 208,171 |
| DHS | Skilled Nursing | Service Type Subtotals: | $ 481 | $ 489,470 |
| | Tavares Pediatric Center | Under 65 | $ 27,067 | $ 1,759,337 |
| DHS | Tavares Pediatric Center | Service Type Subtotals: | $ 27,067 | $ 1,759,337 |
| DHS | | Grand Total: | | $ 94,814,887 |

Cost and Utilization Data, Q-3, 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 has been provided on the following page.

**Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-3, SFY 2011**

| Dept. | Service Type | Age Group | # Served | Total Expenditures |
|---|---|---|---|---|
| BHDDH | Day Programs | Under 65 | 2,356 | $10,088,653.38 |
| | | Over 65 | 295 | $1,126,734.22 |
| BHDDH | Homemaker | Under 65 | 134 | $818,096.80 |
| | | Over 65 | 17 | $69,358.50 |
| BHDDH | Public Group Homes | Under 65 | 144 | $5,471,257.37 |
| | | Over 65 | 80 | $3,066,632.00 |
| BHDDH | Private Group Homes | Under 65 | 1,158 | $25,429,151.24 |
| | | Over 65 | 163 | $3,392,666.51 |
| BHDDH | Family Supports | Under 65 | 850 | $3,849,958.29 |
| | | Over 65 | 61 | $331,200.29 |
| BHDDH | Shared Living | Under 65 | 156 | $1,560,214,14 |
| | | Over 65 | 12 | $117,650.86 |
| BHDDH | Supported Employment | Under 65 | 554 | $1,935,769.23 |
| | | Over 65 | 17 | $61,586.26 |

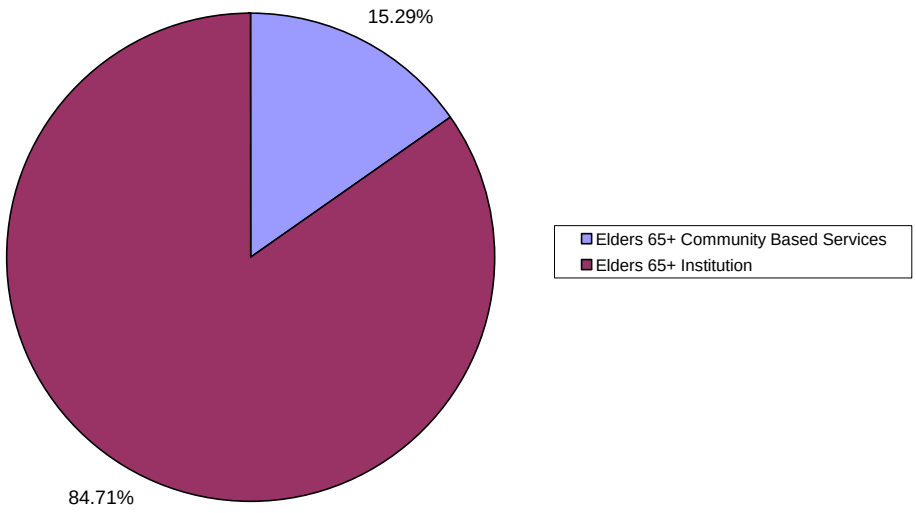
E. Percent distribution of expenditures for Medicaid long-term care institutional services and home and community services (HCBS) by population, including: elders aged 65 and over, persons with disabilities, and children with special health care needs.

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 (January 1, 2011 – March 31, 2011).

Elders Aged 65 and Over

During the Third Quarter of SFY 2011, 84.71 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.29 percent were for home and community-based services (HCBS). The latter finding (15.29 percent for HCBS in Q-3, SFY 2011) reflects a trend increase for HCBS for elders, in comparison to the first two quarters of State Fiscal Year of 2011 (13.87 percent in the First Quarter and 14.48 percent in the Second Quarter).

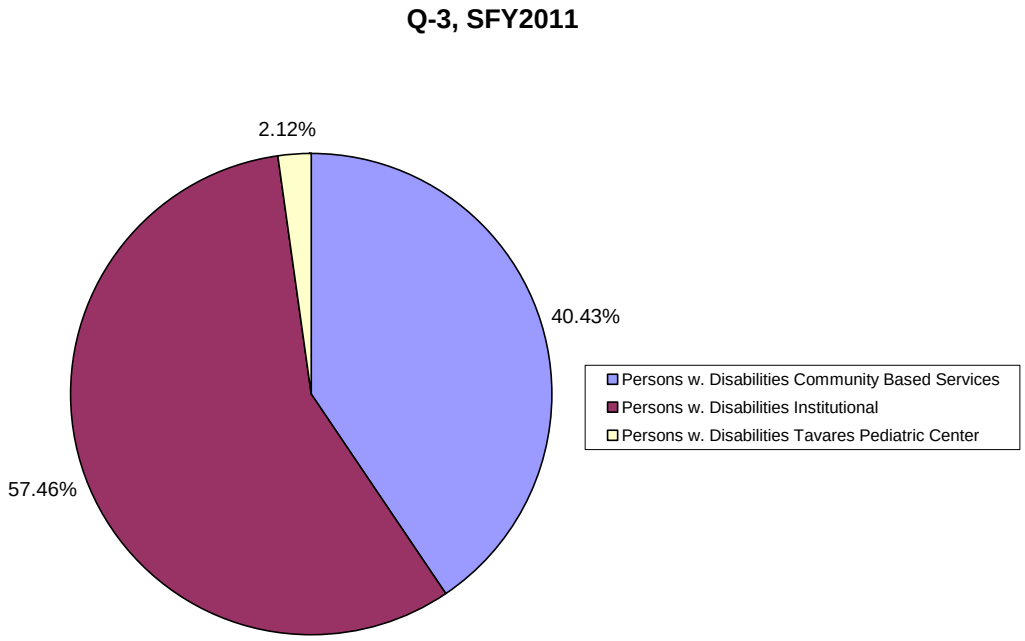
**Q-3, SFY2011**



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 (January 1, 2011 – March 31, 2011). As in prior quarterly reports, the following chart does not include expenditures for the State's MR/DD population that is served by the RI BHDDH.




During the Third Quarter of SFY 2011, 57.46 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services, 2.12 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services at the Tavares Pediatric Center, and 40.43 percent were for home and community-based services (HCBS).

The latter finding (40.43 percent for HCBS for persons with disabilities) is comparable to those for the first two quarters of State Fiscal Year of 2011. In Q-1 of SFY 2011, 41.63

percent of expenditures for persons with disabilities were for HCBS[3] and in Q-2 of SFY 2011 the corresponding finding was 41.75 percent.

[3] Please not that in the report submitted on 6/30/2011, the accompanying pie charts for Item E correctly displayed that the percent of expenditures for persons with disabilities that were for HCBS were 41.63 percent in Q-1 and 41.75 percentage in Q-2 of SFY 2011. In the discussion section, however, the Tavares expenditures had been combined with the HCBS expenditures for persons with disabilities.

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

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

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

During the Third Quarter of State Fiscal Year 2011, there were no waiting lists for Medicaid LTC services. In addition, the Division of Elderly Affairs and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH) reported that there were no waiting lists for any long-term care services.

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

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

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

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

The following information, provided by the RI DEA, covers the Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011). The tables shown below document the service utilization of the DEA's Adult Day Care and Home Care Program (also referred to as the "Co-pay" Program). This information has been organized for each type of service by quarter.

**RI DEA: Adult Day Care (Q-3, SFY 2011)**

| **Service Category:** Adult Day Care | **Clients*** | | **Units (Unit=1 Day)** | |
|---|---|---|---|---|
| | **Total** | **Avg/Mo.** | **Total** | **Avg/Mo.** |
| D1 (Income up to 125% FPL): | 127 | 42 | 1,651 | 550 |
| D2 (Income up to 200% FPL): | 566 | 189 | 7,660 | 2,553 |
| **Total** | **693** | **231** | **9,311** | **3,104** |
| *Average utilization= 13.4 days of adult day care per client per month.* | | | | |
| *Clients are not distinct | | | | |

**RI DEA: Case Management (Q-3, SFY 2011)**

| **Service Category:** Case Management | **Clients** | | **Units (Unit=1/4 Hour)** | |
|---|---|---|---|---|
| | **Total** | **Avg/Mo.** | **Total** | **Avg/Mo.** |
| Case Management | 1,103 | 338 | 5,793 | 1,931 |
| *Average utilization= 1.43 Hours of Case management per client per month.* | | | | |

**RI DEA: Home Care (Q-3, SFY 2011)**

| **Service Category:** Home Care | **Clients*** | | **Units (Unit=1/4 Hour)** | |
|---|---|---|---|---|
| | **Total** | **Avg/Mo.** | **Total** | **Avg/Mo.** |
| D1 (Income up to 125% FPL): | 348 | 116 | 35,450 | 11,817 |
| D2 (Income up to 200% FPL): | 1,344 | 448 | 138,115 | 46,038 |
| Total | **1,692** | **564** | **173,565** | **57,855** |

| | | | | |
|---|---|---|---|---|
| *Average utilization= 103 units or 25.7 hours of home care per client per month.* | | | | |
| *Clients are not distinct | | | | |

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

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

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

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

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

[4] The Rhode Island Department of Human Services. *Code of Rules, Medical Assistance,* Section 0302.15 (*Decision on Eligibility*), https://www.policy.dhs.ri.gov/.
[5] Ibid, Section 0382.15.20.05 (*Negotiability of Instruments*), https://www.policy.dhs.ri.gov/.
[6] Op cit, Section 0382.15.20.15 (*Salability*), https://www.policy.dhs.ri.gov/.
3 Op cit, Section 0382.10.10.10 (*Docu Non-Avail of Real Est*), https://www.policy.dhs.ri.gov/.

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

Information has been drawn from InRhodes, the State's Medicaid eligibility system, to produce the following cohort analysis for LTC processing turn-around times during the Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011). Turn-around times (TAT) for processing new LTC applications have been organized according to three timeframes: a) less than thirty (30) days; b) thirty (30) to ninety (90) days; and greater than ninety (90) days.

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

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

**RI DHS: Turn-around Times for New LTC Applications (Q-3, SFY 2011)**

| **Month** | **< 30 Days** | | **30 – 90 Days** | | **> 90 Days** | | **Monthly Total** | |
|---|---|---|---|---|---|---|---|---|
| Jan. 2011 | 107 | 25.48% | 215 | 51.19% | 98 | 23.33% | 420 | 100% |
| Feb. 2011 | 127 | 30.38% | 208 | 49.76% | 83 | 19.86% | 418 | 100% |
| March 2011 | 157 | 36.85% | 205 | 48.12% | 64 | 15.02% | 426 | 100% |
| **Total for Q-3, SFY 2011** | **391** | **30.93%** | **628** | **49.68%** | **245** | **19.38%** | **1,264** | **100%** |

Source: InRhodes

The percentage of new LTC applications that were processed in less than thirty (30) days has increased throughout the course of SFY 2011. As documented in the EOHHS' report[10] that covered the first two quarters of SFY 2011, 28.22 percent of the new LTC applications that were processed in Q-1 of SFY 2011 had turn-around times of < 30 days. In Q-2 of SFY 2011, this percentage increased to 28.53%.

[8] Op cit, Section 0382.50.25 (*Claims of Undue Hardship*), https://www.policy.dhs.ri.gov/.
[9] Op cit, Section 0382.50.15 (*Trust Evaluation Process*), https://www.policy.dhs.ri.gov/.
[10] The Rhode Island Executive Office of Health and Human Services. (June 30, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, July 1, 2010 – September 30, 2010 and October 1, 2010 – December 31, 2010 (p. 28).

For this reporting period, InRhodes data have been further analyzed in order to quantify the average number of days for approving or denying new applications for Medicaid LTC coverage. The following table shows the average turn-around time in days for Medicaid LTC approvals during the Third 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.

**RI DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-3, SFY 2011)**

| Number of Approvals for Medicaid LTC | Average TAT in Days |
|---|---|
| 793 | 58.1 (~ 59 Days) |

Source: InRhodes

**RI DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Denials (Q-3 SFY 2011)**

| Number of Denials for Medicaid LTC | Average TAT in Days |
|---|---|
| 184 | 16.0 (~ 16 Days) |

Source: InRhodes

On average, Medicaid LTC approvals and denials were processed well below a 90-day threshold across the first three quarters during SFY 2011. In the EOHHS report[11] which covered the first two quarters of SFY 2011, the average TAT for approvals of Medicaid LTC applications was 65 days and the corresponding TAT for denials was 11 days.

[11] Ibid, p. 29.

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[12] 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 Third Quarter of SFY 2011.

**DHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-3, SFY 2011)**

| Clinical Eligibility Level of Care Criteria | Q-3, SFY 2011 |
|---|---|
| Nursing Facility | 939 |
| Hospital (HAB applicants)* | 0 |

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

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

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

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

**DHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services, by Quarter (Q-1 – Q-3, SFY 2011)**

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

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

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. During the Third Quarter of SFY 2011, there were 57 applications made by individuals with developmental disabilities. There were also 8 applications made for hospital care during Q-3 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 that were performed during the Third 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-3, SFY 2011)**

| | **Q-3, SFY 2011** | |
|---|---|---|
| Nursing Facility Care | **Average** | **Median** |
| | 7 | 6 |
| Hospital/(HAB applicants) | N/A* | N/A* |

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

During the Third Quarter of SFY 2011, there were no applicants for Medicaid LTC who met the clinical eligibility criteria for a hospital (or habilitation) level of care. Therefore, the average and median TAT cells were marked with "N/A*" in the preceding table.

A decline was noted in the turnaround time for clinical eligibility determinations for nursing facility care during the Third Quarter of SFY 2011. This decrease represents a positive change. For purposes of comparison, the following table documents the average and median turnaround time in calendar days for Medicaid LTC clinical eligibility determinations during the first three quarters of SFY 2011.

**DHS: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations, by Quarter (Q-1 – Q-3, SFY 2011)**

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

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

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

During the First and Second Quarters 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[13] 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 Third Quarter of SFY 2011.

**DHS: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-3, SFY 2011**

| Appeals of LTC Clinical Eligibility Determinations by Level of Care | Q-3, 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 Third Quarter of SFY 2011.

[13] 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[14] 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-3, SFY 2011)**

| | **Q-3, SFY 2011** |
|---|---|
| Number of Nursing Home Transitions | 30 |
| Average Length of Stay (ALOS) Prior to Transfer in Calendar Days | 193 |

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 193 days (or approximately 6.4 months) in Q-3 of SFY 2011.

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.

[14] 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-3, SFY 2011)**

| | Q-3, SFY 2011 | |
|---|---|---|
| Existing Home | 22 | 73.33% |
| Assisted Living | 6 | 20.00% |
| New Housing | 0 | 0.00% |
| Group Home | 0 | 0.00% |
| Other | 2 | 6.67% |
| **Total** | 30 | 100% |

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 that may have contributed to any unsuccessful outcomes.

Prior to the start of SFY 2011, The Alliance for Better Long Term Care partnered with Qualidigm[15] 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.

As noted in Item M, there were 30 LTC beneficiaries who were transitioned from nursing facilities during the Third Quarter of SFY 2011 (January 1, 2011 through March 31, 2011). The Office of Community Programs at the RI DHS reported that there were no (0) failed placements during the Third Quarter of SFY 2011.

[15] 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 Third Quarter of SFY 2011 (January 1, 2011 through March 31, 2011). These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[16] and b) several

[16] 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.

additional categories of applicants. Statistics for the latter grouping are aggregated (or added) within the InRhodes system and are classified as "Other" [17].

**RI DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-3 SFY 2011**

| Month | Rhode Island Works | "Other" |
|---|---|---|
| January 2011 | 2,536 | 493 |
| February 2011 | 3,242 | 375 |
| March 2011 | 3,808 | 404 |
| **Total for Q-3 of SFY 2011** | **9,586** | **1,272** |

For purposes of comparison, the following table documents the number of applications that were made during the first three quarters of SFY 2011.

**RI DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, by Quarter (Q-1 – Q-3, SFY 2011)**

| Quarter | Rhode Island Works | "Other" |
|---|---|---|
| Q-1, SFY 2011 | 9,405 | 1,813 |
| Q-2, SFY 2011 | 8,418 | 1,845 |
| Q-3, SFY 2011 | 9,586 | 1,272 |
| **Total** | **27,409** | **4,930** |

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 Third Quarter of SFY 2011 (January 1, 2011 through March 31, 2011). The following table represents a "point-in-time" snapshot of the number of approved applications for Medicaid coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics.

[17] "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: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-3 SFY 2011**

| Month | Rhode Island Works | "Other" |
|---|---|---|
| January 2011 | 1,787 | 430 |
| February 2011 | 2,280 | 347 |
| March 2011 | 2,785 | 406 |
| **Total for Q-3 of SFY 2011** | **6,852** | **1,183** |

For purposes of comparison, the following table documents the number of applications that were approved during the first three quarters of SFY 2011.

**RI DHS: Approved Applications for Rhode Island Works and "Other" Category of Applicants, by Quarter, (Q-1 – Q-3 SFY 2011)**

| Quarter | Rhode Island Works | "Other" |
|---|---|---|
| Q-1, SFY 2011 | 6,612 | 1,459 |
| Q-2, SFY 2011 | 6,633 | 1,437 |
| Q-3, SFY 2011 | 6,852 | 1,183 |
| Total | **20,097** | **4,079** |

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 Third Quarter of SFY 2011 (January 1, 2011 through March 31, 2011). The number of denials documented below represents a "point-in-time" snapshot of activity.

**RI DHS: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-3 SFY 2011**

| Month | Rhode Island Works | "Other" |
|---|---|---|
| January 2011 | 181 | 21 |
| February 2011 | 196 | 13 |
| March 2011 | 294 | 12 |
| **Total for Q-3 of SFY 2011** | **671** | **46** |

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.

For purposes of comparison, the following table documents the number of applications that were denied during the first three quarters of SFY 2011.

**RI DHS: Denied Applications for Rhode Island Works and "Other" Category of Applicants, by Quarter (Q-1 – Q- 3, SFY 2011)**

| Quarter | Rhode Island Works | "Other" |
|---|---|---|
| Q-1, SFY 2011 | 632 | 64 |
| Q-2, SFY 2011 | 591 | 61 |
| Q-3, SFY 2011 | 671 | 46 |
| **Total** | **1,894** | **171** |

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

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

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

Item O provided tables that documented the number of applications received from RIte Care applicants during the Third Quarter of SFY 2011 (January 1, 2011 through March 31, 2011). For the purpose of that cohort analysis, there were two major groups comprising the RIte Care/RIte Share applicant population. In the response to Item O, information was stratified for these two groups of applicants: a) those who were seeking enrollment in Rhode Island Works[18] 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" [19].

[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.

[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.

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 Third 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-3, SFY 2011)**

| Quarter | Average Number of Applications Pending More than 30 Days for Rhode Island Works Applicants |
|---|---|
| Q-3, SFY 2011 | 321 |

Source: InRhodes

In comparison to the first two quarters of SFY 2011, a decline was noted in the monthly average number of new applications pending more than thirty days for the Rhode Island Works/RIte Care applicant cohort during the Third Quarter of SFY 2011. This decrease reflects a positive trend that began during the Second Quarter of SFY 2011. For purposes of comparison, the following table documents the monthly average number of new applications pending more than thirty days for this enrollment cohort during the first three quarters of SFY 2011.

**RI DHS: The Monthly Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort, by Quarter (Q-1 – Q-3, SFY 2011)**

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

As had been described in the quarterly report[20] that was submitted to the State Senate on 09/30/2011, the average number of applications pending more than 30 days during the First Quarter of SFY 2011 was flagged with an asterisk because the finding for the first month (July of 2010) in that quarter 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

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

equal 430. As shown above, the average number of applications pending more than 30 days declined to 345 days during Q-2 of SFY 2011 and 321 days during the following quarter (Q-3, SFY 2011). This decrease represents a favorable finding. 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 Third Quarter of SFY 2011 (January 1, 2011 through March 31, 2011). That prior discussion also gave an overview of the eligibility determination processes specific to new applications. Information was provided about the number of eligibility approvals (also referred to as "acceptances") and denials for new RIte Care/RIte Share applicants during the same time frame.

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and focuses on RIte Care/RIte Share redeterminations and closures. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the redeterminations and closures which were processed for the Rhode Island Works/RIte Care enrollment cohort during the Third Quarters 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-3, SFY 2011)**

| Month | RIW Redeterminations | RIW Closures | Percentage |
|---|---|---|---|
| January 2011 | 45,867 | 1,926 | 4.2% |
| February 2011 | 50,556 | 2,227 | 4.4% |
| March 2011 | 52,285 | 1,886 | 3.6% |
| **Total for Q-3, SFY 2011** | **148,708** | **6,039** | **4.1%** |

Source: InRhodes

For purposes of comparison, the following table provides the findings for the first three quarters of SFY 2011.

**RI DHS: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort, by Quarter (Q-1 – Q-3, SFY 2011)**

| Quarter | RIW Redeterminations | RIW Closures | Percentage |
|---|---|---|---|
| Q-1, SFY 2011 | 133,586 | 5,810 | 4.35% |
| Q-2, SFY 2011 | 137,123 | 5,136 | 3.74% |
| Q-3, SFY 2011 | 148,708 | 6,039 | 4.1% |
| **Total** | **419,417** | **16,985** | **4.05%** |

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[21]-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[22] | 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 data for the Third Quarter of SFY 2011 (January 1, 2011 through March 31, 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-3, SFY 2011)**

| Percentage of the Federal Poverty Level (FPL) | Q-3, SFY 2011 | |
|---|---|---|
| > 150 - 185% FPL | 9,823 | 60.3% |
| > 185 - 200% FPL | 2,107 | 12.9% |
| > 200 - 250% FPL | 4,371 | 26.8% |
| **Total** | **16,301** | **100.0%** |

These findings were similar to those noted during the First and Second Quarters of SFY 2011 in the EOHHS' previous report to the State Senate[23].

[21] 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.

[22] The US Department of Health and Human Services (US DHHS) issued updated poverty guidelines on 01/20/2011. The poverty guidelines are frequently referred to as "federal poverty levels" (FPL). Based upon the updated guidelines issued by the US DHHS in January of 2011, for a family of four, 100 percent of the FPL = $22,350. More information about the poverty guidelines may be obtained by pasting the following link on a Web browser: **http://aspe.hhs.gov/poverty/11poverty.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.

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[23] The Rhode Island Executive Office of Health and Human Services. (June 30, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information, July 1, 2010 – December 30, 2010* (pgs. 45 & 46).

[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.

- Good cause does not include choosing to pay other household expenses instead of the premium.

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 Third Quarter of SFY 2011 (January 1, 2011 – March 31, 2011. For purposes of comparison, data from the First and Second Quarters of SFY 2011 (July 1, 2010 – September 30, 2010 and October 1, 2010 – December 31, 2010) have also been provided.

**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-3, SFY 2011)**

| **Percentage of the Federal Poverty Level** | **Q-1, SFY 2011** | | **Q-2, SFY 2011** | | **Q-3, SFY 2011** | |
|---|---|---|---|---|---|---|
| | | | | | | |
| >150 - 185% FPL | 230 | 50.8% | 203 | 50.6% | 223 | 52.0% |
| >185 - 200% FPL | 78 | 17.2% | 65 | 16.2% | 66 | 15.4% |
| >200 - 250% FPL | 145 | 32.0% | 133 | 33.2% | 140 | 32.6% |
| **Total** | **453** | **100.0%** | **401** | **100.0%** | **429** | **100.0%** |

Thus, the average number of families sanctioned across the first three quarters of SFY 2011 (SFY 2011, Year to Date) = 427. 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 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 DHS TPL Unit and document the total recoveries which were paid to the DHS during the Third Quarter of SFY 2011 (January 1, 2011 through March 31, 2011). This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

**Estate and Casualty Recoveries: Q-3, SFY 2011**

| **Recoveries by Type** | **Amount Recovered** |
|---|---|
| Estate Recoveries: TPL and Legal | $823,323 |
| Casualty Recoveries: TPL and Legal | $169,866 |
| **Total** | **$993,189** |

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

| Budget Neutrality Summary | Total DY 1 | Total DY 2 | Q/E 3/31/11 | Q/E 6/30/11 | Q/E 9/30/11 | Q/E 12/31/11 |
|---|---|---|---|---|---|---|
| **Section I: Total Expenditures Subject to Budget Neutrality** | | | | | | |
| **Budget Population 1**: (ABD no TPL) | $ 418,731,831 | $ 486,505,287 | $ 130,556,772 | $ 140,982,161 | $ 123,918,206 | |
| **Budget Population 2** (ABD TPL) | $ 715,844,300 | $ 659,668,554 | $ 148,524,007 | $ 159,367,720 | $ 142,689,875 | |
| **Budget Population 3** (RIte Care) | $ 362,611,218 | $ 405,517,339 | $ 79,831,400 | $ 140,533,523 | $ 107,517,852 | |
| **Budget Population 4** (CSHCNs) | $ 188,895,404 | $ 184,738,525 | $ 35,963,022 | $ 55,517,524 | $ 36,358,822 | |
| **Budget Population 5** (EFP) | $ 198,808 | $ 134,380 | $ 14,060 | $ 35,781 | $ 21,180 | |
| **Budget Population 6** (Pregnant Expansion) | $ 1,489,534 | $ 1,820,522 | $ 390,517 | $ 540,786 | $ 526,355 | |
| **Budget Population 7** (SCHIP Children) | $ - | $ - | $ - | $ - | $ - | |
| **Budget Population 8** ( CNOM: Substitute Care) | $ - | $ - | $ - | $ - | $ - | |
| **Budget Population 9** ( CNOM: CSHCNs otherwise in voluntaary state custody) | $ 3,364,541 | $ - | $ - | $ 4,744,703 | $ - | |
| **Budget Population 10** (CNOM: 65, <200%, at risk for LTC) | $ 2,943,524 | $ 4,492,554 | $ 967,582 | $ 1,375,070 | $ 1,281,497 | |
| **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 | $ 1,123,274 | $ 1,031,739 | |
| **Budget Population 15** (CNOM: Adults w/ disabilities at risk for LTC, <300% FPL) | $ 255,250 | $ 897,633 | $ 163,586 | $ 283,098 | $ 144,853 | |
| **Budget Population 16 (**CNOM: Uninsured Adults w/ mental illness) | $ 6,595,169 | $ 6,989,503 | $ 1,883,322 | $ 4,926,523 | $ 2,118,455 | |
| **Budget Population 17** (CNOM: Youth at risk for Medicaid; at risk children < 300% FPL) | $ 3,775,172 | $ 3,696,607 | $ 826,479 | $ 1,231,669 | $ 566,502 | |
| **Budget Population 18** (HIV) | $ - | $ 752,914 | $ - | $ 1,059,261 | $ - | |
| **Budget Population 19** (CNOM: Non-working disabled adults 19-64, GPA) | $ 1,743,740 | $ 1,790,059 | $ 377,301 | $ 536,238 | $ 465,926 | |
| **Budget Services 1** (Windows) | $ 4,504 | $ - | $ - | $ - | $ - | |
| **Budget Services 2** (RIte Share and collections) | $ 5,369,938 | $ 6,772,712 | $ 1,572,816 | $ 1,640,782 | $ 1,709,458 | |
| **Budget Service 3** (Other payments - e.g.FQHC suppl., stop loss) | $ 10,194,423 | $ 33,205,530 | $ 1,865,220 | $ 12,742,529 | $ 2,768,640 | |

| **Budget Neutrality Summary** | **Total DY 1** | **Total DY 2** | **Q/E 3/31/11** | **Q/E 6/30/11** | **Q/E 9/30/11** | **Q/E 12/31/11** |
|---|---|---|---|---|---|---|
| **Budget Services 4** (CNOM: core and preventive svcs, Medicaid eligible at risk youth) | $ - | $ - | $ - | $ - | $ - | |
| **Budget Services 5** (CNOM: Services by FQHCs to uninsured individuals) | $ 600,000 | $ 1,200,000 | $ - | $ 1,200,000 | $ - | |
| **Base Expenses** [1] | $ 33,090,955 | $ 91,516,977 | $ 13,068,195 | $ 61,571,413 | $ (7,549,657) | |
| **TOTAL Expenditures for Period as reported on the CMS-64*** | **$ 1,762,261,653** | **$ 1,893,513,074** | **$ 416,838,139** | **$ 589,412,055** | **$ 413,569,703** | |
| **Section II: Expenditure Target** | | | | | | |
| **Quarterly** | $ 2,600,000,000 | $ 2,400,000,000 | $ 575,000,000 | $ 575,000,000 | $ 575,000,000 | $ 575,000,000 |
| **Cumulative** | $ 2,600,000,000 | $ 5,000,000,000 | $ 575,000,000 | $ 1,150,000,000 | $ 1,725,000,000 | $ 2,300,000,000 |
| **Section III: Actual Expenditures w/Waiver** | | | | | | |
| **Quarterly** | | | $ 416,838,139 | $ 589,412,055 | $ 413,569,703 | |
| **Cumulative** | $ 1,762,261,653 | $ 1,893,513,074 | $ 416,838,139 | $ 1,006,250,194 | $ 1,419,819,897 | |
| **Section IV: Surplus / (Deficit)** | | | | | | |
| **Quarterly** | $ 837,738,347 | $ 506,486,926 | $ 158,161,861 | $ (14,412,055) | $ 161,430,297 | |
| **Cumulative** | **$ 837,738,347** | **$ 1,344,225,273** | **$ 1,502,387,134** | **$ 1,487,975,079** | **$ 1,649,405,376** | |

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

| | | | |
|---|---|---|---|
| Total Global Waiver Expenditures | *$ 416,838,139* | *$ 589,412,055* | *$ 413,569,703* |
| *LEA* | *$ 3,403,751* | *$ 4,958,741* | *$ 2,964,665* |
| *SCHIP* (RIteShare Premiums & Collections) | *$ (202,187)* | *$ (150,510)* | *$ (96,849)* |
| *SCHIP* | *$ 3,086,226* | *$ (369,555)* | *$ 8,332,495* |
| *DSH* | *$ -* | *$ -* | *$ 118,266,255* |
| *Prior Period Adjustments* | *$ (513,897)* | *$ 667,285* | *$ -* |
| *Current Period Adjustments* | *$ 2,109,978* | *$ 863,795* | *$ 10,052,786* |
| *CMS 64 Summary Sheet: 6. Expenses this Quarter )* | *$ 424,722,010* | *$ 595,381,811* | *$ 553,089,055* |

[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. 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, i.e. transactions as supplied in the Non-EDS Paid backup documents.