STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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October 1, 2010

The Honorable Rhoda E. Perry
Chairperson, Senate Committee on Health and Human Services
Rhode Island General Assembly
82 Smith Street
Providence, RI 02903

Dear Chairperson Perry:

On behalf of the State's Executive Office of Health and Human Services (EOHHS), I am pleased to submit the first quarterly *Designated Medicaid Information* report to the Rhode Island General Assembly's Senate Committee on Health and Human Services. This initial report has been prepared in response to Senate Resolution 10R303 (10-S2976, *Senate Resolution Respectfully Requesting the Executive Office of Health and Human Services to Report Designated Medicaid Information to the Rhode Island Senate Committee on Health and Human Services*).

This report focuses upon the first two quarters of State Fiscal Year 2010 (July 1st, 2009 through December 31st, 2009), during the initial implementation of the State's Global Consumer Choice Compact. Please do not hesitate to contact Ms. Elena Nicolella at 462-3575 if there are any questions about the *Designated Medicaid Information* report.

Sincerely,

Gary D. Alexander
Secretary

cc: The Honorable Leo R. Blais
The Honorable Charles J. Levesque
The Honorable Francis T. Maher, Jr.
The Honorable Joshua Miller
The Honorable Juan Pichardo
The Honorable James C. Sheehan
The Honorable V. Susan Sosnowski
Ms. Elena Nicolella

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

Designated Medicaid Information
July 1, 2009 – December 31, 2009

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

October 1, 2010

Designated Medicaid Information
July 1, 2009 – December 31, 2009
Section I: Introduction

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

The following report focuses upon the first two quarters of State Fiscal Year 2010 (July 1st, 2009 through December 31st, 2009), during the initial implementation phase of the State's Global Consumer Choice Compact (also known as the "Global Waiver"). Section I provides an overview of Rhode Island's goals for the Global Waiver, as well as a description of the factors which have been identified by the Public Policy Institute as instrumental to States' success when launching efforts to rebalance their LTC services and supports system. Section I also includes highlights of some noteworthy achievements which were realized by Rhode Island during the initial implementation of the Global Waiver, as well as several challenges which were addressed during the same time period.

Section II presents the designated Medicaid information covering the period from July 1st, 2009 through December 31st, 2009. This information has been organized alphabetically, according to the measures which were delineated in Senate Resolution 10R303.

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

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

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

Rhode Island in Relation to Other States: Prior to July 1st, 2009, the State undertook a judicious and deliberative planning phase to ensure that the Global Waiver's implementation would allow Rhode Island to attain its fundamental goals, by promoting the health and safety of Medicaid beneficiaries in a cost-effective manner. Through this strategic analysis, Rhode Island sought to capitalize upon the positive experience demonstrated by several States which have already achieved a reformation of their system of publicly-financed long-term care (LTC), with a shift from institutional to home and community-based services (HCBS), and a fundamental rebalancing of Medicaid expenditures. Three States (Oregon, Washington, and New Mexico) have been nationally recognized for having achieved shifts in their LTC expenditures, with more than fifty percent of their Medicaid LTC spending now directed toward home and community-based services. Such shifts were not achieved rapidly, however, and required judicious action plans.

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

- *Philosophy* – The State's intention to deliver services to people with disabilities in the most independent living situation and expand cost-effective HCBS options guides all other decisions.
- *Array of Services* – States that do not offer a comprehensive array of services designed to meet the particular needs of each individual may channel more people to institutions than will States that provide an array of options.
- *State Organization of Responsibilities* – Assigning responsibility for overseeing the State's long-term services and supports to a single administrator has been a key decision in some of the most successful States.
- *Coordinated Funding Sources* – Coordination of multiple funding sources can maximize a State's ability to meet the needs of people with disabilities.
- *Single Appropriation* – This concept, sometimes called "global budgeting," allows States to transfer funds among programs and, therefore, make more rational decisions to facilitate serving people in their preferred setting.
- *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.

[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.

- *Standardized Assessment Tool* – Some States use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization.
- *Single Point of Entry* – A considerable body of literature points to the need for a single access point allowing people of all ages with disabilities to access a comprehensive array of LTC services and supports.
- *Consumer Direction* – The growing movement to allow participants a greater role in determining who will provide services, as well as when and how they are delivered, responds to the desire of people with disabilities to maximize their ability to exercise choice and control over their daily lives.
- *Nursing Home Relocation* – Some States have made systematic efforts to regularly assess the possibility of transitioning people out of nursing homes and into their own homes or more home-like community alternatives.
- *Quality Improvement* – States are beginning to incorporate participant-defined measures of success in their quality improvement plans.
- *Integrating Health and LTC Services* – A few States have developed methods for ensuring that the array of health and LTC services people with disabilities need are coordinated and delivered in a cost-effective manner.

Rhode Island's Achievements During the First Six Months of Implementation: During the first six (6) months of the Global Waiver's implementation, Rhode Island accomplished a series of notable achievements, by expanding statewide capacity for home and community based services, implementing a needs-based system for determining the safest and least restrictive level (or setting) of care for beneficiaries entering the State's Medicaid long-term care program, engaging with key stakeholders, initiating Medicaid claiming for Costs Not Otherwise Matchable (CNOMs), and establishing the Executive Office of Health and Human Services' Inter-agency Assessment and Coordination Organization (ACO) to coordinate Rhode Island's strategic initiatives for publicly-funded long-term care. These achievements have been discussed in greater detail below.

Expanded Statewide Capacity for Home and Community-based Services: The State undertook a thoughtful series of initiatives to enhance Rhode Island's infrastructure for the provision of home and community-based services[2]. To further enhance our State's home and community-based service delivery system's capacity to provide these types of supportive services, which have been documented to assist long-term care beneficiaries to safely reside in either their own home or another community-based setting, Rhode Island also analyzed related reimbursement models.

Outcomes from this work led to the following achievements during the first two quarters of SFY 2010:

[2] For brief examples of these types of home and community-based services, please refer to the brochure entitled *If you or someone you love needs help to stay at home … you have many good choices* (Rhode Island Executive Office of Health and Human Services, April 2010) which has been appended to this report.

- Rhode Island developed criteria to establish a *Preventive Level of Care*, for individuals who are categorically eligible for Medicaid, yet do not meet the highest or high levels of clinical need for long-term care services, but who need a basic level of community-based services so that they may safely remain in their homes. These services (homemaker services, minor environmental modifications, physical therapy (PT) evaluation and services, and respite) have been identified to help avoid or delay a beneficiary's need for institutional care:

    - Phase One of the Preventive Level of Care (LOC) criteria was initially launched during the First Quarter of SFY 2010 for categorically eligible Medicaid beneficiaries who need either limited certified nursing assistant or homemaker services or minor environmental modifications. By providing these services, beneficiaries whose well-being might otherwise severely deteriorate can continue to live safely at home or in a community-based setting.

- To *enhance access to Shared Living services* beyond the State's previous 1915(c) Waiver for Individuals with Developmental Disabilities, Rhode Island issued an initial Request for Information (RFI) and a subsequent Request for Proposals (RFP) for Shared Living.

- To *expand access to Home Health Care services*, the State developed new criteria for Medicaid participating home health agencies. Each agency must:

    - Be enrolled with the Department of Human Services as a Medicaid provider and licensed by the Department of Health as a Home Care Agency
    - Be Medicare certified or else have a formal letter of agreement with a Medicare certified agency
    - Participate in the State's "Enhanced Reimbursement Program"
    - Provide evening, night, weekend, and holiday Certified Nursing Assistance (CNA) coverage and offer "24 hours a day/7 days a week" agency coverage
    - Provide intermittent skilled visits by registered nurses as needed to monitor the status of any beneficiaries with complex medical conditions and bill Medicare for these visits for beneficiaries who have dual (Medicare/Medicaid) health coverage
    - Collaborate with the beneficiaries' care managers in the EOHHS Office of Community Programs and either the Connect Care Choice or Rhody Health Partners programs (depending upon which system of care the individual beneficiary is enrolled)

- To *augment access to Assisted Living*, the State convened an Inter-agency Work Group to analyze system capacity, reimbursement rate reform, and quality of care. The Inter-agency Work Group has:

    - Met with representatives of Rhode Island's Assisted Living industry to discuss reimbursement rate reform

- Implemented streamlined authorization processes and payments through the State's MMIS system
- Investigated potential reimbursement strategies for Assisted Living agencies which might provide care to populations with special needs, such as individuals with cognitive dementia

- To *promote access to Adult Day Services*, representatives of the EOHHS' Assessment and Coordination Organization (ACO) met with representatives of Rhode Island's Adult Day Services industry to fully understand the scope of services rendered. In follow-up, the State:

  - Conducted in-service education on adult day care services for case managers serving LTC beneficiaries
  - Explored acuity-based payment reimbursement methodologies for adult day services which could serve beneficiaries with unique needs, such as individuals with cognitive dementia or those in need of wound care

Implemented a Needs-based Level of Care Process for Long-term Care: Under the Global Waiver, the scope of services available to Medicaid beneficiaries is not based solely on a need for institutional care, but is based on a comprehensive assessment that includes, but is not limited to, an evaluation of the medical, social, physical and behavioral health needs of long-term care (LTC) applicants. To qualify for Medicaid-funded long-term care services under the Global Waiver, an individual must meet Medicaid's general and financial eligibility requirements and, in addition, meet certain clinical eligibility criteria.

Please note: The needs-based level of care determination system, which has been outlined below, does not apply to beneficiaries who were eligible to received Medicaid-funded long-term care services and who were living in institutions on or before June 30th, 2009. The State's previous institutional level of care criteria still continues to be applied to this group of beneficiaries (who are considered "grandfathered" for institutional LTC services).

- Rhode Island implemented its new assessment process for *needs-based clinical level of care (LOC) determinations Medicaid for long-term care services*, through the Department of Human Services' Office of Medical Review:

  - The supporting materials which were developed for Rhode Island's needs-based clinical level of care determination process were based upon the recommendations from in-State level of care stakeholders and Perry-Sullivan work groups, and, in addition, incorporated key elements that were abstracted from Vermont's successful long-term care (LTC) program
  - A Web-based software (OMAR) was developed and installed on secure laptops which are used by the Office of Medical Review's registered nurses who conduct the clinical level of care determinations in off-site locations, such as hospitals

- The State convened training about the new clinical long-term care determination process for discharge planners at all in-State hospitals

- Rhode Island designed and launched its *Nursing Home Diversion* project, to identify any individuals who might safely be transitioned from a nursing home to a community-based setting:

  - Educational materials about home and community-based services were developed for consumers and health care providers, including physicians and nursing homes

Engaged with Key Stakeholders: During the first two quarters of SFY 2010, the State engaged with key stakeholders and developed a comprehensive communication strategy to inform all parties about the Global Waiver: consumers and families, community partners, and State and Federal partners. As previously described, during this period the State hosted a wide variety of meetings and training sessions with representatives from Rhode Island's hospitals, nursing facilities, as well as home care agencies and other community-based care delivery systems. The inputs from key stakeholders, including consumers, advocates, clinicians, and other service providers, were also solicited in an ongoing manner through the following forums:

- The State's Global Waiver Task Force and related Workgroups
- The State's Medical Care Advisory Committee (MCAC)

The State also developed a *Choice Counseling* program to provide beneficiaries and/or their representatives with information concerning the range of options that are available in Rhode Island to address an individual's long-term care needs.

During the Global Waiver's initial implementation phase, the State updated the EOHHS and DHS Websites with user-friendly information pertaining to the Global Waiver. To further encourage public transparency, a wide variety of Waiver-related documents have been posted to the EOHHS Website, including but not limited to: agenda, membership rosters, minutes, and presentations from the meetings of the Global Waiver's Task Force and the Medical Care Advisory Committee; quarterly reports and other Global Waiver-related documents which have been submitted to the Centers for Medicare and Medicaid Services; and a series of reports focusing upon the State's home and community-based service system, which were developed on behalf of the State's *Real Choices System Transformation Grant*. In addition to the posting of a wide variety of written materials, videotaped presentations about the Global Waiver are available to the public on the EOHHS Website for viewing.

Initiated Medicaid Claiming for Costs Not Otherwise Matchable (CNOMs): The Global Waiver granted Federal authority to Rhode Island so that the State could provide a specified set of Medicaid-funded services to non-Medicaid eligible individuals, thereby preventing or delaying these individuals' need for full Medicaid coverage. The Center for Medicare and Medicaid Services authorized the State's Medicaid Agency (the

Department of Human Services) to lead the effort in claiming specific health-related services in order to qualify for matching Federal funds.

The following State Agencies manage programs that have been identified as CNOM eligible:

- The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
- The Department of Children, Youth, and Families (DCYF)
- The Department of Elderly Affairs (DEA)
- The Department of Human Services (DHS)
- The Department of Health (DOH)
- The Office of Rehabilitative Services (ORS within the RI DHS)

CNOM Eligibility and Service Groups

CNOM Eligibility Group	Demonstration Budget Population Group
Children and families in managed care enrolled in RIte Care (children under 19 and parents) when the parents have behavioral health conditions that result in their children being placed in temporary State custody	Budget Population 8
Children with special health care needs who are 21 and under who would otherwise be placed in voluntary State custody-residential diversion	Budget Population 9 & Budget Services Group 4
Elders at risk of LTC	Budget Population 10
Adults with disabilities at risk for LTC who would otherwise not be eligible for Medicaid	Budget Population 15
Uninsured adults with mental illness	Budget Population 16
Children at risk for Medicaid and/or institutional care	Budget Population 17
HIV positive individuals who are otherwise not eligible for Medicaid	Budget Population 18

During the Global Waiver's pre-implementation period (January through June of 2009), the Department of Human Services provided technical assistance about CNOMs to each of the EOHHS Agencies. These collective planning efforts included but were not limited to the following:

- Development of policies and procedures necessary to support the implementation of each of the budget populations and the budget services group listed in the table shown above
- Preparation of an overall claiming manual for the CNOM programs
- Inter-Agency collaboration with the State's data system Contractors to develop the modifications necessary for several of the State's information technology systems, including InRhodes, MMIS, and RICST (the operating system used by the RI DCYF), for the implementation of final claiming methods

Information specific to State and Federal Expenditures for the CNOM provision of the Global Waiver has been provided in Section T of this report.

Establishment of the EOHHS' Inter-agency Assessment and Coordination Organization (ACO): The Executive Office of Health and Human Services established its Assessment and Coordination Organization (ACO) during the Global Waiver's planning phase. The mission of the ACO is to provide a central, inter-agency fulcrum for the EOHHS' coordination of Rhode Island's strategic initiatives for publicly-funded long-term care.

In addition to the inter-agency initiatives which have been previously described, the ACO coordinated the development of a series of key deliverables, interventions, and systems modifications which were necessary to ensure the efficient and effective implementation of the Global Waiver. The following inter-agency achievements were realized by the ACO during the first two quarters of SFY 2010:

- A special work group was established to assist dual-eligible (Medicare/Medicaid) beneficiaries who were transitioning from Medicare Special Needs Plans (SNPs) which were closing
- An inter-agency work group developed and implemented a cohesive Information and Referral strategy which included:

    - Collaboration with the Department of Elderly Affairs in the development of new activities for the State's Aging and Disability Resource Center (ADRC), *The Point*

- The Office of Medical Review's infrastructure was increased with the hiring of additional registered nursing (RN) staff
- Recommendations from the State's High-cost Case Review Work Group led to the establishment of a specialized unit for ventilator-dependent beneficiaries
- A work group was established to analyze and determine whether the ARRA might offer any opportunities for the State's Medicaid Buy-in program (the Sherlock Plan) for adults with disabilities who seek to gain or maintain employment while still maintaining health coverage
- Systems modifications were made to the State's Medicaid eligibility system (InRhodes) and its Medicaid Management Information System (MMIS)

Challenges Experienced During the Initial Implementation Phase: In undertaking to fundamentally restructure the State's Medicaid program, challenges would be anticipated due to the complex nature of Federal Medicaid regulations and the need to substantially modify a number of the State's long-standing policies, reimbursement models, and information technology systems for Medicaid eligibility and program management. Challenges which have been experienced to date have been highlighted in the following narrative summary and have also been addressed in the EOHHS' discussion of the metrics which were delineated in Senate Resolution 10R303.

Data Integration Challenges: The EOHHS recognized that the Global Waiver would call for integrated Information Technology (IT) to support the changes outlined in the Global Waiver. In July of 2009, Rhode Island received a $3.6 million planning grant awarded by the Centers for Medicare and Medicaid Services, funded with 90 percent Federal funds and 10 percent State funds, to streamline the State's Medicaid Information Technology Architecture (MITA) through the CHOICES Project. As noted by the Secretary of the Executive Office of Health and Human Services at the time of the State's receipt of its Federal MITA award, Rhode Island has many data systems but they are not integrated and not readily accessible. The State's CHOICES Project has two components: a Data Warehouse system for comprehensive reporting and a Community Systems Management (CSM) system for managing long-term care applications processing and care management functions[3].

Implementation of the Global Waiver has necessitated modifications to the State's automated operating systems which are used for Medicaid eligibility determination and redetermination processes (InRhodes) and for Medicaid management information and claims processing (MMIS). These modifications were fully expected due to significant changes brought about by the Global Waiver, such as the following:

- The need to develop acuity-based reimbursement rates for nursing facilities
- The establishment of new payment rates for home health agencies which were approved to participate in the State's Enhanced Reimbursement Program
- The incorporation of the State's series of discrete former 1915(c) waivers into the Global Waiver allowed Rhode Island to increase access to home and community-based services above the prior "ceiling" limits on the number of beneficiaries who could receive such services
- The development of new clinical level of care (LOC) categories (highest, high, and preventive) for LTC beneficiaries, which impact authorization systems for institutional and home and community-based care

The Global Waiver also necessitated the development of new databases to meet the needs of the registered nurses who work on behalf of the EOHHS Office of Community Programs (OCP). Because the State's processes and workflows for completing clinical, needs-based LTC determinations and redeterminations were transformed with the Global Waiver's implementation, additional databases (OMAR and Tracker) were developed to

[3] *EOHHS Launches New Data Warehouse for Rhode Island's Medicaid Program* (RI.gov, 03/29/2010) http://www.r.gov/press/view/11059

store this beneficiary-level information in a fully HIPAA-compliant manner. It was not possible to integrate the clinical databases used by the OCP's RNs with other data systems during earliest phase of the Global Waiver's implementation (the first two quarters of SFY 2010). On a "go forward basis", however, the implementation of CHOICES' Community Supports Management (CSM) system will be used to manage long-term care applications processing and care management functions. The CSM will transition LTC information to a more easily accessible Web-based system.

Modifications were needed to the State's MMIS, InRhodes, and RICHST in order to implement the State's Costs Not Otherwise Matchable (CNOM) initiative. Due to the complexity involved, an interim claiming solution was initially developed and used for SFY 2009. As implementation of the CHOICES Project unfolds, enhanced data integration will simplify the flow of information across the EOHHS agencies which participate in the Global Waiver.

Housing Challenges for LTC Beneficiaries: One of the Work Groups convened by the State's Global Waiver Task Force focused on the unique housing needs of Rhode Island's LTC beneficiaries. The Housing Work Group summarized the nature of this need in a compelling manner:

> *Housing is the foundation on which an effective and cost-efficient long-term care system can be developed. It is a critical need for those transitioning out of institutions, those seeking to remain safely in the community, and those seeking the necessary stability to address the necessary stability to address their immediate health and well-being.*[4]

The Global Waiver Task Force's Housing Work Group identified a series of housing-related challenges, based on its comprehensive review of the State's housing programs and services geared toward those receiving publicly-funded long-term care services. The following series of issues and recommendations were abstracted from the Housing Work Group's Initial Report to the Global Waiver Task Force (GWTF):

Issues Identified by the GWTF's Housing Work Group:	**Recommendations Put Forward for Consideration by the GWTF's Housing Work Group:**
1. There is a lack of affordable housing options in the community; many subsidized housing programs have lengthy waiting lists, which creates a significant barrier to transitioning individuals from institutions to the	1. Rhode Island should be encouraged to pursue flexibility for individuals diverting out of nursing homes to access subsidized housing programs such as Section 202 Senior Housing, Section 811 Housing for Adults with

[4] Rhode Island Medicaid Global Waiver Task Force, Housing Work Group. (2009) *Initial Report, Housing Work Group* (p. 1).

community.	Disabilities, and Public Housing on a priority basis.[5]
2. Assisted Living: Capacity to serve Medicaid clients is limited.	2. Review the daily rate for Medicaid services in Assisted Living; address room and board rates; develop service standards and reimbursement for individuals with cognitive limitations; provide more flexibility for new residents to enter Assisted Living while receiving some skilled services on a temporary basis; review the level of care needs of individuals on the Enhanced Assisted Living benefit to provide services and service reimbursement under Medicaid, thus maximizing the FMAP; improve the correlation between reimbursement for Assisted Living services and those provided in similar housing models across state departments.
3. There is a wide range of housing programs and services available to various populations, which can be confusing and difficult to navigate.	3. A training curriculum and a centralized, Web-based source of information would help provide a more unified and coordinated approach to assist in identification of the most appropriate housing.
4. There are limited housing options for Severe and Persistently Mentally Ill (SPMI) populations, who may end up being institutionalized at Eleanor Slater Hospital.	4. Explore the expansion of Mental Health Psychiatric Rehabilitation Residences (MHPRR) programs as a way to reduce the use of Eleanor Slater Hospital and offer a diversionary path. Explore whether MHPRRs may be appropriate for DCYF youth aging out of the DCYF system.
5. Certain individuals have limited or no housing options and regularly access high intensity, high cost services such as ER or detox visits, as well as incarceration.	5. Explore new models such as Housing First (which provides housing with social services). Another approach for consideration would be to use the capacity available through "Sober Houses" that might be appropriate to convert into specialized homes for "wet housing" or elderly-specific housing, or other specific populations of homeless persons.

[5] Ibid., p. 1.

Due to the importance of housing, significant work was undertaken under the auspices of the Executive Office of Health and Human Services during the first two quarters of SFY 2010, specific to Shared Living, Assisted Living, and Adult Day. Please refer to pages 3 and 4 of this report for discussion about these housing-related initiatives.

The next section of this initial quarterly report to the Senate provides the designated Medicaid information covering the period from July 1st, 2009 through December 31st, 2009. This information has been organized alphabetically, according to the measures which were delineated in Senate Resolution 10R303.

The information which has been provided in Section II of this report covers the first two quarters of SFY 2010 and unless otherwise noted, reflects *incurred (or actual) dates of service* rather than paid dates. Organizing the data by incurred dates of service rather than by paid dates provides a much clearer picture of actual utilization, by *showing how many beneficiaries received services and when the services were actually provided*. From a program management standpoint (as well as the standpoint of beneficiaries who receive LTC services in Rhode Island), the date of service provides a much more tangible metric of "what actually occurred" during the two quarters which have been the area of focus of this initial quarterly report. Unless otherwise noted, the principal source of data is Rhode Island's Medicaid Management Information System (MMIS).

Please note that because incurred dates of service, rather than paid dates have been reported here for Q-1 and Q-2 of SFY 2010, the utilization statistics provided within this report will not match the expenditure reports which have been submitted to the General Assembly regularly for this time interval.

SECTION II
Designated Medicaid Information
July 1, 2009 – December 31, 2009 (Q-1 & Q-2, SFY 2010)

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

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

The following table outlines the number of Medicaid LTC applicants who were deemed to be eligible for Medicaid LTC during the first two quarters of SFY 2010 (July 1, 2009 – December 31, 2009). 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 the first two quarters of SFY 2010.

RI DHS: Medicaid Long-term Care Acceptances (Approvals), Q-1, SFY 2010

Month	Long-term Care
July 2009	298
August 2009	269
September 2009	230
Total for Q-1, SFY 2010	**797**

Source: InRhodes

RI DHS: Medicaid Long-term Care Acceptances (Approvals), Q-2, SFY 2010

Month	Long-Term Care
October 2009	232
November 2009	205
December 2009	197
Total for Q-2, SFY 2010	**634**

Source: InRhodes

During the first two quarters of SFY 2010, there were 1,431 approved applications documented in InRhodes for Medicaid LTC.

Noting a statistical decline of approximately twenty percent (20%) in Medicaid LTC approvals when comparing Q-2 (634 approvals) to Q-1 (797 approvals) in SFY 2010, the EOHHS also analyzed the number of clinical eligibility approvals for LTC during the same time period. This analysis was performed to determine whether there was a similar pattern emerging in the outcome of Medicaid LTC clinical eligibility determinations that were conducted by the RI DHS Office of Medical Review. A similar trend was not demonstrated, however. Less than a six percent (6%) decline was seen in the number of clinical eligibility approvals for the two quarters (with 845 clinical approvals during Q-2,

compared to 896 during Q-1 of SFY 2010)[6]. This trend will continue to be monitored to determine whether there may be any impacts of seasonality affecting the approval statistics, particularly during the months of November and December.

[6] Please refer to Item I, which addresses the number of applicants for Medicaid funded long-term care who met the clinical eligibility criteria for each of the following: (1) Nursing facility care; (2) Intermediate care facility for persons with developmental disabilities or mental retardation; and (3) Hospital care.

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

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. The following table outlines the number of Medicaid LTC applicants who were found ineligible during the first two quarters of SFY 2010 (July 1, 2009 – December 31, 2009). 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 the first two quarters of SFY 2010.

RI DHS: Medicaid Long-term Care Denials, Q-1, SFY 2010

Month	**Long-term Care Denials**
July 2009	56
August 2009	42
September 2009	50
Total for Q-1, SFY 2010	**148**

Source: InRhodes

RI DHS: Medicaid Long-term Care Denials, Q-2, SFY 2010

Month	**Long-term Care Denials**
October 2009	50
November 2009	29
December 2009	32
Total for Q-2, SFY 2010	**111**

Source: InRhodes

During the first two quarters of SFY 2010, there were 259 denied applications documented in InRhodes for Medicaid LTC. A decline of approximately twenty-five percent (25%) was seen when comparing the number of Medicaid LTC denials which occurred during Q-2 (111 denials) and Q-1 (148 denials) in SFY 2010.

As described previously in Item A, a statistical decline of approximately twenty percent (20%) was seen in the number of Medicaid LTC eligibility approvals when the first and second quarters of SFY 2010 were compared.

These statistics will continue to be monitored to ascertain whether there may be any seasonal trends impacting approvals and denials for Medicaid LTC.

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

Two data sources have been queried to produce the data pertaining to the number of Medicaid beneficiaries, stratified according to two age groups (less than 65 years of age and greater than or equal to 65 years of age) who were served in institutional and home and community-based long-term care settings, by provider and service type and/or delivery system during the first two quarters of SFY 2010 (July 1, 2009 through December 31, 2009).

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-1 & Q-2, SFY 2010 (RI DEA): The first set of tables quantifies the number (or count) of individuals who received LTC services provided under the auspices of the Rhode Island Department of Elderly Affairs (RI DEA) during the first two quarters of SFY 2010.

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

DEA: LTC Service Type and Corresponding Unit of Service

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

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

Source: EOHHS Data Warehouse: MMIS Claim Universe			Jul		Aug		Sep		Oct		Nov		Dec	
Reporting Period: Date of Service			2009		2009		2009		2009		2009		2009	
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units	Count	Units	Count	Units
DEA	Assisted Living	Under 65					14	420	15	465	16	463	15	444
		65 and Over	4	73	9	236	218	6,322	235	7,106	235	6,941	235	7,098
DEA	Assisted Living	Service Subtotals:	**4**	**73**	**9**	**236**	**232**	**6,742**	**250**	**7,571**	**251**	**7,404**	**250**	**7,542**
	Case Management	Under 65					3	26	7	20	9	22	7	7
		65 and Over	343	1,607	358	1,478	407	1,941	495	2,428	505	2,286	496	2,351
DEA	Case Management	Service Subtotals:	**343**	**1,607**	**358**	**1,478**	**410**	**1,967**	**502**	**2,448**	**514**	**2,308**	**503**	**2,358**
	Personal Care/Homemaker	65 and Over	424	104,668	422	101,993	431	102,762	427	103,306	426	99,024	429	103,541
DEA	Personal Care/Homemaker	Service Subtotals:	**424**	**104,668**	**422**	**101,993**	**431**	**102,762**	**427**	**103,306**	**426**	**99,024**	**429**	**103,541**
DEA		Grand Total:		**106,348**		**103,707**		**111,471**		**113,325**		**108,736**		**113,441**

In reviewing the table shown above, please note that during the first quarter of SFY 2010, data for several LTC services were being migrated from other databases to the MMIS system. During that period, the following two DEA LTC service lines were not processed through the State's MMIS: Assisted Living and Case Management. Because the data system migration occurred during Q-1 of SFY 2010, figures shown for the months of July 2009 and August 2009 represent under-counts of service units and well as the number of beneficiaries served. Therefore, the sharp increase in the number (or count) of beneficiaries who received DEA Assisted Living services during the month of September 2009 (n=218) and the corresponding rise in the number of service units (n=6,322) during that month are due to the integration of these data within the MMIS, not because of a significant change in utilization in comparison to the preceding months of July and August.

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-1 & Q-2, SFY 2010 (RI DHS): The second set of tables shows the number (or count) of individuals who received LTC services through the Rhode Island Department of Human Services (RI DHS) during the first two quarters of SFY 2010. This information reflects incurred dates of service (July 1st, 2009 through December 31st, 2009) and has been stratified according to the two age groups (less than 65 years of age and greater than or equal to 65 years of age) as requested.

Units of service have been defined in the following manner.

DHS: LTC Service Type and Corresponding Unit of Service

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

Tavares Pediatric Center	Per Diem (Per Day)

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

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

Source: EOHHS Data Warehouse: MMIS Claim Universe			Jul		Aug		Sep		Oct		Nov		Dec	
Reporting Period: Date of Service			2009		2009		2009		2009		2009		2009	
Dept.	**Service Type**	**Age Group**	**Count**	**Units**	**Count**	**Units**	**Count**	**Units**	**Count**	**Units**	**Count**	**Units**	**Count**	**Units**
DHS	Adult Day Care	Under 65	239	3,346	231	3,243	227	3,180	237	3,454	247	3,215	251	3,626
		65 and Over	177	2,616	175	2,483	180	2,597	173	2,550	175	2,317	176	2,560
DHS	Adult Day Care	Service Subtotals:	**416**	**5,962**	**406**	**5,726**	**407**	**5,777**	**410**	**6,004**	**422**	**5,532**	**427**	**6,186**
	Assisted Living	Under 65	14	412	13	399	14	393	13	401	13	366	13	389
		65 and Over	154	4,592	153	4,595	158	4,585	153	4,597	155	4,591	155	4,637
DHS	Assisted Living	Service Subtotals:	**168**	**5,004**	**166**	**4,994**	**172**	**4,978**	**166**	**4,998**	**168**	**4,957**	**168**	**5,026**
	Case Management	Under 65	53	153	52	148	121	299	138	350	185	284	162	338
		65 and Over	154	717	164	648	168	890	167	843	200	691	219	930
DHS	Case Management	Service Subtotals:	**207**	**870**	**216**	**796**	**289**	**1,189**	**305**	**1,193**	**385**	**975**	**381**	**1,268**
	Home Health Agency	Under 65	194	2,186	193	2,199	189	2,162	183	2,104	180	1,989	176	2,045
		65 and Over	128	1,237	131	1,289	126	1,599	126	1,428	123	1,658	124	1,546
DHS	Home Health Agency	Service Subtotals:	**322**	**3,423**	**324**	**3,488**	**315**	**3,761**	**309**	**3,532**	**303**	**3,647**	**300**	**3,591**
	Hospice	Under 65	27	572	31	627	28	624	33	766	29	631	27	620
		65 and Over	597	15,786	604	16,107	597	15,661	582	15,507	549	14,245	532	14,107
DHS	Hospice	Service Subtotals:	**624**	**16,358**	**635**	**16,734**	**625**	**16,285**	**615**	**16,273**	**578**	**14,876**	**559**	**14,727**
	Nursing Facility	Under 65	562	15,619	555	15,733	544	15,008	535	15,122	529	14,688	545	15,563
		65 and Over	5,124	151,108	5,129	152,034	5,112	146,949	5,131	151,831	5,082	146,433	5,084	151,708
DHS	Nursing Facility	Service Subtotals:	**5,686**	**166,727**	**5,684**	**167,767**	**5,656**	**161,957**	**5,666**	**166,953**	**5,611**	**161,121**	**5,629**	**167,271**
	Personal Care/Homemaker	Under 65	661	203,090	681	205,003	847	214,005	888	235,490	887	223,515	883	238,889
		65 and Over	899	260,224	938	267,200	1,099	260,537	1,130	281,440	1,138	272,515	1,136	288,001
DHS	Personal Care/Homemaker	Service Subtotals:	**1,560**	**463,314**	**1,619**	**472,203**	**1,946**	**474,542**	**2,018**	**516,930**	**2,025**	**496,030**	**2,019**	**526,890**
	Tavares Pediatric Center	Under 65	21	635	22	659	22	637	22	667	22	635	22	655
DHS	Tavares Pediatric Center	Service Subtotals:	**21**	**635**	**22**	**659**	**22**	**637**	**22**	**667**	**22**	**635**	**22**	**655**
DHS		Grand Total:		**662,293**		**672,367**		**669,126**		**716,550**		**687,773**		**725,614**

The Number of Medicaid Beneficiaries Served by PACE, Q-1 & Q-2, SFY 2010 (RI DHS): Using the EOHHS Data Warehouse, information was extracted from the MMIS to produce counts of the number of individuals who participated in the PACE (Program of All Inclusive Care for the Elderly) program during the first two quarters of SFY 2010. This information has been stratified by month and by age group.

Source:	EOHHS Data Warehouse/Financial Data Mart			
Report Period:	**Eligibility Period**			
Dept.	Benefit Period	Program Description	Age Group	Person Count
DHS	7/1/2009	PACE PROGRAM	65+	149
DHS		PACE PROGRAM	Under 65	27
	7/1/2009		**Period Totals:**	**176**
DHS	8/1/2009	PACE PROGRAM	65+	148
DHS		PACE PROGRAM	Under 65	32
	8/1/2009		**Period Totals:**	**180**
DHS	9/1/2009	PACE PROGRAM	65+	150
DHS		PACE PROGRAM	Under 65	31
	9/1/2009		**Period Totals:**	**181**
DHS	10/1/2009	PACE PROGRAM	65+	154
DHS		PACE PROGRAM	Under 65	32
	10/1/2009		**Period Totals:**	**186**
DHS	11/1/2009	PACE PROGRAM	65+	154
DHS		PACE PROGRAM	Under 65	32
	11/1/2009		**Period Totals:**	**186**
DHS	12/1/2009	PACE PROGRAM	65+	152
DHS		PACE PROGRAM	Under 65	32
	12/1/2009		**Period Totals:**	**184**

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-1 & Q-2, SFY 2010 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). As requested, this information has been stratified according to two age groups for participants for the following lines of service which are administered by the RI BHDDH: Day programs; homemaker services; public group homes for persons with developmental disabilities; private group homes for persons with developmental disabilities; family supports; shared living; supported employment; and behavioral health group home (behavioral health only). Data for Quarters 1 and 2 of SFY 2010 have been summed and are shown below.

Source: RI BHDDH, Medicaid LTC Beneficiaries Served, Q-1 & Q-2, SFY 2010

Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2327
		Over 65	276
BHDDH	Homemaker	Under 65	147
		Over 65	22

BHDDH	Public Group Homes	Under 65	165
		Over 65	79
BHDDH	Private Group Homes	Under 65	1158
		Over 65	151
BHDDH	Family Supports	Under 65	832
		Over 65	55
BHDDH	Shared Living	Under 65	141
		Over 65	11
BHDDH	Supported Employment	Under 65	540
		Over 65	15
BHDDH	Behavioral Health GH	Under 65	444
	(Mental Health Only)	Over 65	34

Currently, as part of its developmental disabilities budget initiative, the Division of Developmental Disabilities 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.

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

The following information has been organized by State agency and is based upon incurred (or the actual date when a service was delivered) dates of service for long-term care (LTC) services which were provided during the first two quarters of SFY 2010 (July 1, 2009 through December 31, 2009). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one which shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

Data Sources: Because this initial report covers the early phase of the Global Waiver's implementation, two data sources have been used in producing the cost and utilization information which has been requested. The first data source is Rhode Island's Medicaid Management Information System (MMIS). Using the EOHHS Data Warehouse, information was extracted from the MMIS for the LTC services administered by the RI Departments of Elderly Affairs and Human Services (RI DEA and RI DHS). It should be noted that during the first quarter of SFY 2010, the utilization and payment data for several LTC services were migrating to the MMIS system. Therefore, the cost information shown below for the first quarter represents an undercounting of these service lines. The following LTC service lines were not processed through the State's MMIS during Q-1 of SFY 2010: Assisted Living and Case Management for the RI DEA[7].

A second data source was queried to produce the cost and utilization data for the LTC services which are administered by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The database which is used by the Division of Developmental Disabilities (RI BHDDH) was queried to prepare the table which outlines LTC cost and utilization by BHDDH service line during the first two quarters of SFY 2010.

Cost and Utilization Data, Q-1 & Q-2, SFY 2010 (RI DEA): The following table provides an average cost per individual, as well as quarterly totals by DEA service line, for the two age groups during the first two quarters of SFY 2010.

[7] Prior to their migration to MMIS, payments for this subset of LTC services were processed through the State's Integrated Financial Management system, RI-FANS.

Source: EOHHS Data Warehouse: MMIS Claim Universe Reporting Period: Date of Service			Q-1, SFY 2010	Q-1, SFY 2010	Q-2, SFY 2010	Q-2, SFY 2010	% Difference	% Difference
Dept.	Service Type	Age Group	Avg/Person	3 Month Total	Avg/Person	3 Month Total	Avg/Person	3 Month Total
DEA	Assisted Living	Under 65	$733	$10,257	$729	$33,515	-0.45%	226.76%
		65 and Over	$580	$147,047	$665	$469,037	14.66%	218.97%
DEA	Assisted Living	Service Subtotals:	$582	$157,303	$669	$502,552	14.96%	219.48%
	Case Management	Under 65	$130	$390	$32	$735	-75.76%	88.46%
		65 and Over	$68	$75,390	$70	$104,880	3.26%	39.12%
DEA	Case Management	Service Subtotals:	$68	$75,780	$70	$105,615	2.20%	39.37%
	Personal Care/Homemaker	65 and Over	$1,228	$1,567,501	$1,200	$1,538,292	-2.26%	-1.86%
DEA	Personal Care/Homemaker	Service Subtotals:	$1,228	$1,567,501	$1,200	$1,538,292	-2.26%	-1.86%
DEA		Grand Total:		$1,800,584		$2,146,459		19.21%

As noted previously, because the cost and utilization data for DEA's Assisted Living service line were not processed through MMIS during Q-1 of SFY 2010, the cost and utilization data for that service line have been under-reported for that quarter. As a result, the percentage differences between Q-2 of SFY 2010 and Q-1 of SFY 2010 appear inflated when comparing the average cost per individual per month and the three-month totals.

Cost and Utilization Data, Q-1 & Q-2, SFY 2010 (RI DHS): The following table provides an average cost per individual, as well as quarterly totals by DHS service line, for the two age groups during the first two quarters of SFY 2010.

Source: EOHHS Data Warehouse: MMIS Claim Universe Reporting Period: Date of Service			Q-1, SFY 2010	Q-1, SFY 2010	Q-2, SFY 2010	Q-2, SFY 2010	% Difference	% Difference
Dept.	Service Type	Age Group	Avg/Person	3 Month Total	Avg/Person	3 Month Total	Avg/Person	3 Month Total
DHS	Adult Day Care	Under 65	$743	$517,562	$742	$545,429	-0.03%	5.38%
		65 and Over	$765	$407,218	$750	$392,863	-2.04%	-3.53%
DHS	Adult Day Care	Service Subtotals:	$752	$924,779	$745	$938,292	-0.92%	1.46%
	Assisted Living	Under 65	$1,044	$42,750	$1,050	$40,943	0.53%	-4.23%
		65 and Over	$1,003	$466,393	$1,011	$468,046	0.77%	0.35%
DHS	Assisted Living	Service Subtotals:	$1,007	$509,144	$1,014	$508,989	0.74%	-0.03%
	Case Management	Under 65	$62	$13,634	$46	$21,882	-26.28%	60.50%
		65 and Over	$68	$33,238	$63	$36,245	-8.52%	9.05%
DHS	Case Management	Service Subtotals:	$66	$46,872	$55	$58,127	-16.05%	24.01%
	Home Health Agency	Under 65	$1,338	$770,995	$1,016	$547,806	-24.05%	-28.95%
		65 and Over	$1,603	$618,804	$1,588	$592,561	-0.95%	-4.24%
DHS	Home Health Agency	Service Subtotals:	$1,444	$1,389,799	$1,249	$1,140,367	-13.52%	-17.95%
	Hospice	Under 65	$3,862	$332,904	$4,182	$373,232	8.29%	12.11%
		65 and Over	$3,758	$6,756,979	$3,930	$6,535,456	4.58%	-3.28%
DHS	Hospice	Service Subtotals:	$3,763	$7,089,883	$3,943	$6,908,688	4.79%	-2.56%
	Nursing Facility	Under 65	$4,379	$7,273,537	$4,674	$7,521,567	6.74%	3.41%
		65 and Over	$4,376	$67,246,022	$4,625	$70,746,140	5.67%	5.20%
DHS	Nursing Facility	Service Subtotals:	$4,377	$74,519,559	$4,629	$78,267,707	5.78%	5.03%
	Personal Care/Homemaker	Under 65	$1,487	$3,221,670	$1,349	$3,585,972	-9.25%	11.31%
		65 and Over	$1,396	$4,066,579	$1,267	$4,313,672	-9.23%	6.08%
DHS	Personal Care/Homemaker	Service Subtotals:	$1,435	$7,288,249	$1,303	$7,899,645	-9.17%	8.39%
	Tavares Pediatric Center	Under 65	$27,547	$1,790,099	$27,489	$1,814,284	-0.21%	1.35%
DHS	Tavares Pediatric Center	Service Subtotals:	$27,547	$1,790,099	$27,489	$1,814,284	-0.21%	1.35%
DHS		Grand Total:		$93,558,384		$97,536,098		4.25%

Cost and Utilization Data, Q-1 & Q-2, SFY 2010 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). Currently, as part of its developmental disabilities budget initiative, the Division is engaged in work with Hewlett Packard to develop a new database and claims

payment process. The new database will provide functionality to aid in extracting data, leading to greater ease in the development of standardized reports.

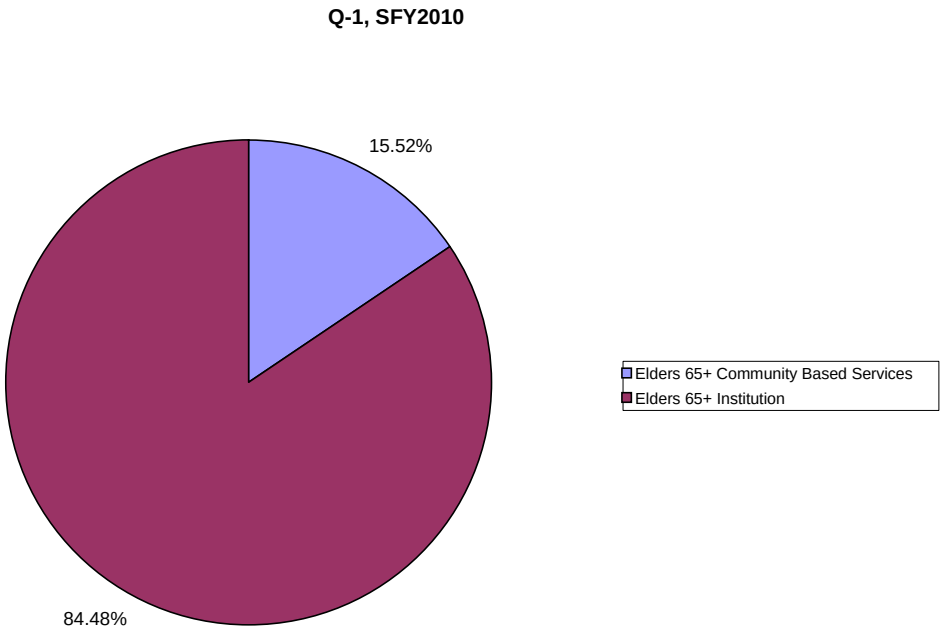
Source: RI BHDDH, Utilization and Cost Data, Q-1 & Q-2, SFY 2010

Dept.	Service Type	Age Group	# Served	Total Expenditures
BHDDH	Day Programs	Under 65	2327	19,987,942
		Over 65	276	2,114,248
BHDDH	Homemaker	Under 65	147	1,714,025
		Over 65	22	157,492
BHDDH	Public Group Homes	Under 65	165	12,118,453
		Over 65	79	5,921,587
BHDDH	Private Group Homes	Under 65	1158	52,418,309
		Over 65	151	6,497,654
BHDDH	Family Supports	Under 65	832	7,888,124
		Over 65	55	572,169
BHDDH	Shared Living	Under 65	141	2,487,670
		Over 65	11	190,945
BHDDH	Supported Employment	Under 65	540	3,899,825
		Over 65	15	92,490
BHDDH	Behavioral Health GH	Under 65	444	8,415,949
	(Mental Health Only)	Over 65	34	685,750

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

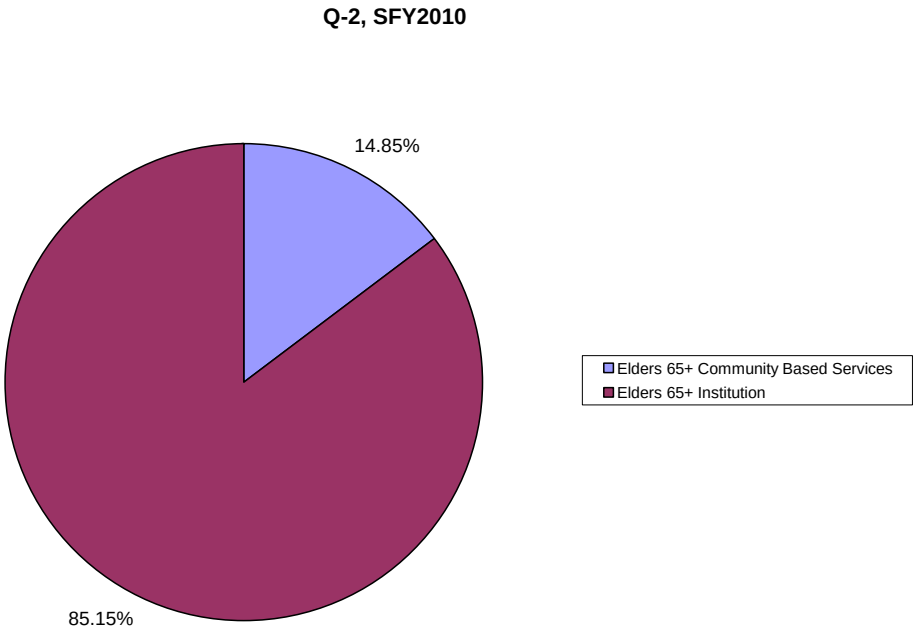
Medicaid long-term care (LTC) services are available for individuals over age 65 and for individuals with disabilities. The types of services available include institutional and home and community-based services. The following charts show the percent distribution of expenditures for Medicaid long-term care institutional services and home and community-based services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (July 1, 2009 through December 31, 2009).

Elders Aged 65 and Over



During Quarter One of SFY 2010, 84.48% of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services.

Elders Aged 65 and Over

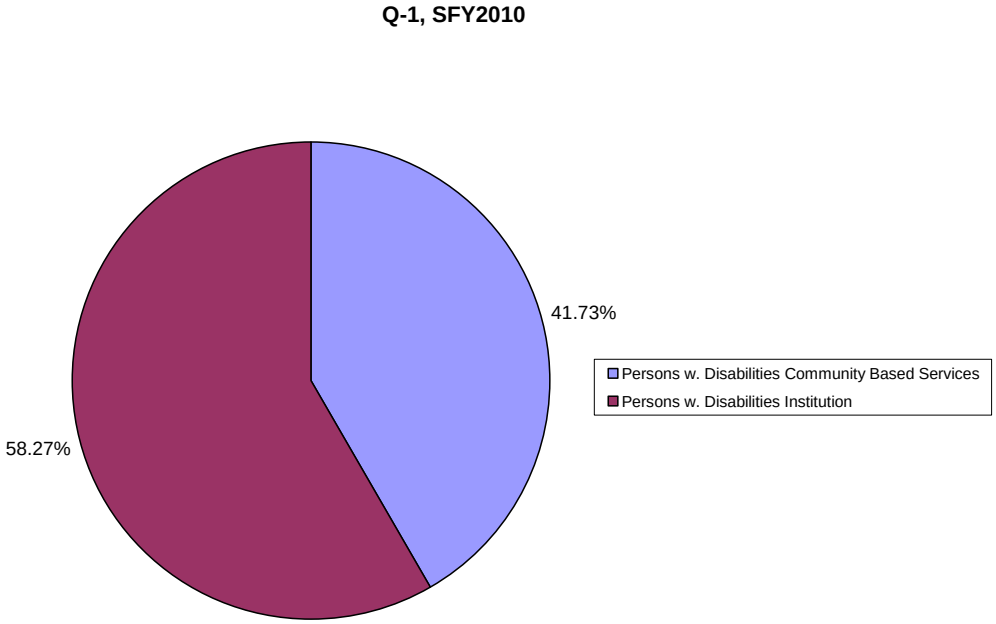


During Quarter Two of SFY 2010, 85.15% of expenditures for elders aged 65 and over where for Medicaid long-term care institutional services. This is an increase of less than 1% from Quarter One.

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.

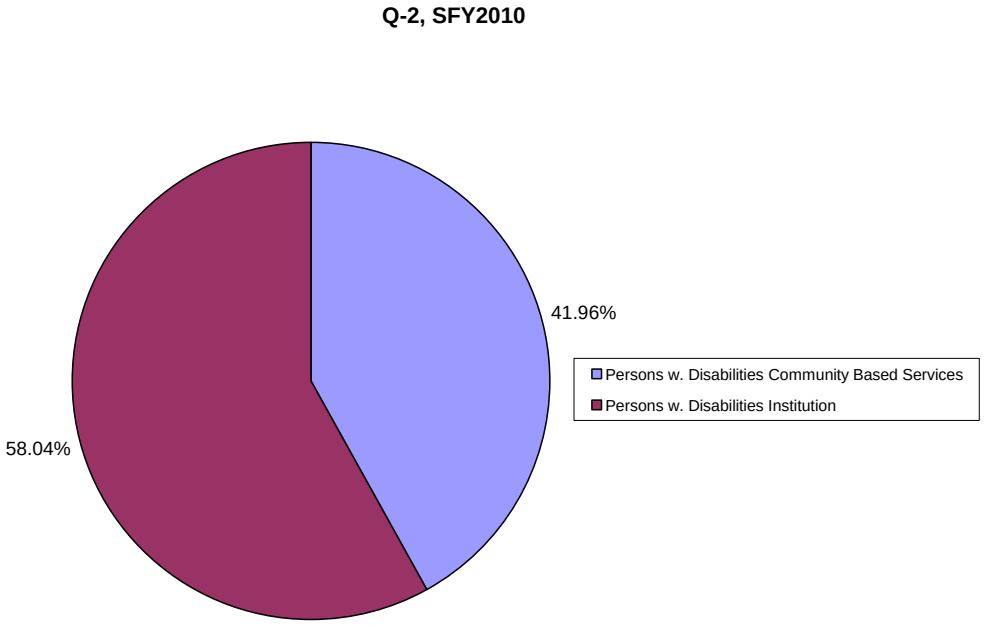
Individuals with disabilities are eligible for Medical Assistance if they are 18 years or older, a Rhode Island resident, receive Supplemental Security Income (SSI) or have income less than 100% of the Federal Poverty Level (FPL) and have resources (savings) of less than $4,000 for an individual or $6,000 for a married couple. The following charts show the percent distribution of expenditures for Medicaid institutional services and home and community services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (July 1st, 2009 through December 31st, 2009).

Persons with Disabilities



During Quarter One of SFY 2010, 58.27% of expenditures for persons with disabilities were for Medicaid long-term care institutional services.

Persons with Disabilities



During Quarter Two of SFY 2010, 58.04% of expenditures for persons with disabilities were for Medicaid long-term care institutional services.

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

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

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

During the first two quarters of State Fiscal Year 2010, there were no waiting lists for Medicaid LTC services. In addition, the Department of Elderly Affairs (RI DEA) and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH) reported that there were no waiting lists for any long-term care services.

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

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

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

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

The following information, provided by the RI DEA, covers the first two quarters of SFY 2010. The tables shown below document the service utilization of the DEA's Adult Day Care and Home Care Program (also referred to as the "Co-pay" Program).

RI DEA: Adult Day Care (07/01/2009 – 12/31/2009)

Service Category: Adult Day Care	**Clients***		**Units (Unit=1 Day)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	215	36	3,146	524
D2 (Income between 126% to 200% FPL):	1,300	217	17,968	2,995
Total	**1,515**	**253**	**21,114**	**3,519**
Average utilization=14 days of adult day care per client per month.				

*Clients are not distinct.

RI DEA: Case Management (07/01/2009 – 12/31/2009)

Service Category: Case Management	**Clients**		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
Case Management	1,862	310	9,231	1,539
Average utilization=1.24 Hours of Case management per client per month.				

RI DEA: Home Care (07/01/2009 – 12/31/2009)

Service Category: Home Care	**Clients***		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	581	97	54,192	9,032
D2 (Income between 126% to 200% FPL):	2,598	433	271,684	45,281
Total	**3,179**	**530**	**325,876**	**54,313**
Average utilization=102.5 units or 26 hours of home care per client per month.				

*Clients are not distinct.

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

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

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. Thus, the EOHHS has interpreted that a completed LTC application would be inclusive of all of the requisite components needed in order to execute a LTC eligibility determination. Necessary components include the findings from the medical evaluations that substantiate a clinical need for LTC, as well as the State's Medicaid LTC clinical eligibility screening. (Please refer to Item J for a presentation of the average and median turn-around times for Medicaid LTC Clinical Eligibility Determinations which are conducted by the Office of Medical Review.) In addition to the necessary clinical information, the LTC application must include the *Statement of Need* form (Rhode Island Department of Human Services, DHS-2, Rev. 5-06), which has been completed by or on behalf of the applicant.

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

InRhodes was used to produce the following cohort analysis for LTC processing turn-around times during one month in each of the first two quarters in SFY 2010. The months of August and December of 2009 were randomly selected for this analysis. Turn-around times (TAT) for processing new LTC applications have been organized according to three timeframes: a) less than thirty (30) days; b) thirty (30) to ninety (90) days; and greater than ninety (90) days.

RI DHS: Turn-around Times for New LTC Applications (Aug. & Dec. 2009)

Month	**< 30 Days**		**30 – 90 Days**		**> 90 Days**		**Monthly Total**	
August 2009	120	33.4%	181	50.4%	58	16.2%	363	100%
December 2009	98	27%	184	50.4%	81	22.3%	359	100%
Total for Aug. and Dec. 2009	**218**	**30.2%**	**365**	**50.5%**	**139**	**19.3%**	**722**	**100%**

Source: InRhodes

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

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

Nursing Home Level of Care	Hospital Level of Care	ICFMR Level of Care
Access to Nursing Facilities and section 1915(c) HCBS Waivers (the scope of community-based services varied, depending on the waiver)	Access to LTC, Hospital, Residential Treatment Centers and the 1915(c) HAB[8] waiver community-based services	Access to ICFMR, and section 1915(c) HCBS Waivers MR/DD community-based services.

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

DHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-1 & Q-2, SFY 2010)

	Q-1, SFY 2010	Q-2, SFY 2010	Quarters 1 & 2, SFY 2010
Nursing Facility	896	841	1737
Hospital (HAB applicants)*	0	4	4

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

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

[8] 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.

The number of applicants for Medicaid funded long-term care who met the clinical eligibility criteria for Nursing Home placement decreased by six (6) percent from Quarter Ending September 2009 to December 2009. During the same period applicants for Medicaid funded long-term care that met the clinical eligibility criteria for community placement increased by eleven (11) percent.

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. During the first two quarters of SFY 2010, there were 115 applications made by individuals with developmental disabilities. There were also 23 applications for hospital care during the same time period.

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

Turnaround Times for Clinical Eligibility Determinations Conducted by the Rhode Island Department of Human Services (RI DHS): Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI DHS) since implementation of the Global Waiver. The following data have been provided by the Office of Medical Review, based upon the clinical eligibility determinations which were performed during the first two quarters of SFY 2010. The calculations of average and median turnaround times have been based on calendar days (not business days).

As noted previously, in order to meet a hospital (or habilitation) level of care, a Medicaid LTC applicant must have a demonstrable need for intensive daily rehabilitation and/or ongoing skilled nursing services, comparable to those offered in a hospital setting, as would have been the case under the State's former section 1915(c) Habilitation Waiver. In the table that was provided for Item I, it had been noted that there were no applicants who met the clinical eligibility criteria for a hospital (or habilitation) level of care during Q-1 of SFY 2010.

DHS: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations (Q-1 & Q-2, SFY 2010)

	Q-1, SFY 2010		**Q-2 SFY 2010**	
	Average	***Median***	***Average***	***Median***
Nursing Facility Care	25	21	21	20
Hospital/(HAB applicants)	85*	85*	58	32

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

An asterisk (*) has been flagged in the table shown above to note that during Q-1 of SFY 2010, there was one (1) Medicaid LTC applicant for whom a clinical eligibility determination was conducted, specific to a hospital (or habilitation) level of care. For this applicant, who had complex needs, the Office of Medical Review (OMR) sought to obtain all sources of relevant clinical data. Because the clinical eligibility determination process is dependent upon the OMR's receipt of the requisite medical documentation, the outcome of this applicant's clinical determination was extended. Despite these ongoing efforts to seek the necessary clinical information on behalf of this applicant, however, it was not possible for the OMR to substantiate that a hospital (or habilitation) level of care had been met. Therefore, this application was closed after 85 days.

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 Division of Developmental Disabilities on behalf of 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. The number of calendar days that elapsed between the date of an applicant's completed application and the subsequent date of a clinical eligibility determination could not be tracked during the first two quarters of SFY 2010. The Division reported that it will begin to track these data. 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 (including turnaround times for clinical eligibility determinations).

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[9] care have been conducted by the Office of Medical Review at the Rhode Island Department of Human Services (RI DHS). In the event that a LTC clinical eligibility determination has not been approved, the individual has the right to file an appeal, seeking to overturn the outcome of that determination.

Appeals Based on Clinical Eligibility Determinations Conducted by the Rhode Island Department of Human Services (RI DHS): The following data have been provided by the DHS' Office of Medical Review to document the number of appeals which had been filed as a result of non-approved clinical eligibility determinations for nursing facility care and hospital/habilitation care during the first two quarters of SFY 2010.

DHS: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care

	Q-1, SFY 2010	Q-2, SFY 2010	Quarters 1 & 2, SFY 2010
Nursing Facility	1	1	2
Hospital/Habilitation	1	0	1

Appeals Based on Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The following information was provided by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. As previously described, any applicant whose clinical eligibility determination has not been approved has the right to file appeal, seeking to overturn the outcome of that determination. The BHDDH's Division of Developmental Disabilities reported that there was one (1) appeal during the first two quarters of SFY 2010.

[9] 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.

During 2009, The Alliance for Better Long Term Care partnered with Qualidigm[10] 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 (DHS and DEA), the Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting. The following statistics were prepared for the RI DHS by The Alliance for Better Long Term Care.

DHS: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-1 & Q-2, SFY 2010)

	Q-1, SFY 2010	Q-2, SFY 2010	Q-1 & Q-2, SFY 2010
Number of Nursing Home Transitions	59	34	93
Average length of stay (ALOS) prior to transfer (days)	126	194	160

Source: The Alliance for Better Long Term Care

The average length of stay (ALOS) was measured in calendar days. During the first two quarters of SFY 2010, for those beneficiaries who were transitioned from a nursing facility, their ALOS in a nursing home prior to transfer was 160 days (or approximately 5.3 months).

DHS: The Type of Living Arrangement or Setting and Services Upon Transfer for Persons Transitioned from Nursing Homes (Q-1 & Q-2, SFY 2010)

	Q-1, SFY 2010		Q-2, SFY 2010		Q-1 & Q-2, SFY 2010	
Existing Home	40	67.8%	24	70.6%	64	68.8%
Assisted Living	8	13.6%	3	8.8%	11	11.8%
New Housing	6	10.2%	4	11.8%	10	10.8%
Group Home	2	3.4%	1	2.9%	3	3.2%

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

Other	3	5.0%	2	5.9%	5	5.4%
Total	**59**	**100%**	**34**	**100%**	**93**	**100%**

Source: The Alliance for Better Long Term Care

During the first two quarters of SFY 2010, approximately 69 percent of the beneficiaries who were transitioned from a nursing facility were transferred to their existing home.

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

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

During 2009, The Alliance for Better Long Term Care partnered with Qualidigm[11] 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 (DHS and DEA), the Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting.

As noted in Item M, there were 93 LTC beneficiaries who were transitioned from nursing facilities during the period from July 2009 to December 2009. The Alliance for Better Long Term Care reported that during this time period there was one (1) failed placement, which represented one (1) percent of the total number of individuals who were transitioned. In this case, the individual returned to the nursing facility because the co-share payment, which the beneficiary was expected to pay for community services, was not affordable.

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

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

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

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

Processed Applications: InRhodes, the State's Medicaid eligibility system, is the source of the following application statistics. The number of applications documented below represents a "point-in-time" snapshot of activity, which warrants some further explanation. Using a point-in-time methodology means that the sum of approved and denied applications within a given month will not equal the number of applications received during the same month. Some examples of why this is the case have been provided below.

On a daily basis, new applications that are received for processing are reviewed to determine their completeness. Any incomplete application would be pended for further information, which in effect would temporarily "stop the processing clock". Therefore, for the subset of new applications which are incomplete, their anticipated determination date would differ from that of the fully completed applications which had been received for administrative processing on the same day.

Because applications are coming in throughout the course of a given month, complete applications which are received at the beginning of a calendar month (for example, the month of August) could have an eligibility determination by the close of that same month. However, completed applications which are received at the close of August would not be anticipated to have an eligibility determination until the end of September. (Please note: the turn-around time of eligibility determinations has been described here, not the effective date of coverage. The effective data of coverage is the first day of the month in which the application was received.)

Cohort Analysis for RIte Care/RIte Share Applicants: For the purpose of the following cohort analysis, two major groups comprised the RIte Care/RIte Share applicant population and information has been provided for each group by month for the first two quarters of SFY 2010. These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[12] and b) several additional categories of applicants. Statistics for the latter grouping are aggregated (or added) within the InRhodes system and are classified as "Other" [13].

RI DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-1, SFY 2010

Month	Rhode Island Works	"Other"
July 2009	2,683	659
August 2009	2,450	296
September 2009	3,461	305
Total for Q-1 of SFY 2010	**8,594**	**1260**

Source: InRhodes

RI DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-2, SFY 2010

Month	Rhode Island Works	"Other"
October 2009	2,916	365
November 2009	2,352	204
December 2009	2,669	273
Total for Q-2 of SFY 2010	**7,937**	**842**

Source: InRhodes

Approved Applications: The following table outlines the number of Rhode Island Works and "Other" applicants who were deemed to be eligible for Medicaid during the first two quarters of SFY 2010 (July 1, 2009 – December 31, 2009). The following tables represent a "point-in-time" snapshot of the number of approved applications for Medicaid coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for the first two quarters of SFY 2010.

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

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

RI DHS: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-1, SFY 2010

Month	Rhode Island Works	"Other"
July 2009	1,532	698
August 2009	2,032	276
September 2009	2,612	187
Total for Q-1 of SFY 2010	**6,176**	**1161**

Source: InRhodes

RI DHS: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-2, SFY 2010

Month	Rhode Island Works	"Other"
October 2009	2,255	374
November 2009	2,022	120
December 2009	2,008	263
Total for Q-2 of SFY 2010	**6,285**	**757**

Source: InRhodes

Denied Applications: InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics for the Rhode Island Works (RIW) and the "Other" category of applicants. The number of denials documented below represents a "point-in-time" snapshot of activity. This information has been provided by month for the first two quarters of SFY 2010.

RI DHS: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-1, SFY 2010

Month	Rhode Island Works	"Other"
July 2009	166	14
August 2009	228	9
September 2009	253	10
Total for Q-1 of SFY 2010	**647**	**33**

Source: InRhodes

RI DHS: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-2, SFY 2010

Month	Rhode Island Works	"Other"
October 2009	247	8
November 2009	155	3
December 2009	157	1
Total for Q-2 of SFY 2010	**559**	**12**

Source: InRhodes

Currently, InRhodes cannot produce a report showing denial code types stratified by income levels, as outlined in Item O. As described in Section I of this report, enhanced

reporting capability will be realized through Rhode Island's CHOICES Project, which will streamline the State's Medicaid Information Technology Architecture.

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

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

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

Item O provided a count of the number of applications received from RIte Care applicants during the first two quarters of SFY 2010 (July 1, 2009 through December 31, 2009). 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[14] 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". [15]

[14] 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.

[15] "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 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. A snapshot report was run for one month from each of the first two quarters in SFY 2010. The months of August and December of 2009 were selected for this query because activity occurring during these two months had been analyzed in Item H (which addressed processing turn-around times for new LTC applications). 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 months of August and December of 2009.

RI DHS: The Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort (Aug. & Dec. 2009)

Month	**Number of Applications Pending for Rhode Island Works Applicants**
August 2009	296
December 2009	40

Source: InRhodes

As described in Section I of this report, enhanced reporting capability will be realized through Rhode Island's CHOICES Project, which will streamline the State's Medicaid Information Technology Architecture.

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

In Item O, the number of new applications for RIte Care/RIte Share was quantified for the first two quarters of SFY 2010 (July 1, 2009 through December 31, 2009). 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. A snapshot report was run for one month from each of the first two quarters in SFY 2010. The months of August and December of 2009 were selected for this query because activity that occurred during these two months had been analyzed previously in Item P (which addressed new applications for RIte Care/RIte Share which were pending for more than 30 days).

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 months of August and December of 2009. 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 (Aug. & Dec. 2009)

Month	RIW Redeterminations	RIW Closures
Aug. 2009	44,969	1,917
Dec. 2009	47,833	1,819
Total for Aug. & Dec. 2009	**92,802**	**3,726**

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[16]-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[17]	Monthly Premium for a Family
> 150% FPL and not > 185% FPL	$61.00/month
> 185% FPL and not > 200% FPL	$77.00/ month
> 200% FPL and not > 250% FPL	$92.00/month

The following quarterly data were obtained from InRhodes, the DHS Eligibility System, and document the number of RI Care- or RIte Share-enrolled families who must pay premiums for coverage on a monthly basis.

DHS: The Number of RIte Care- or RIte Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-1 & Q-2, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2010		Q-2, SFY 2010	
> 150 - 185% FPL	8,760	61.1%	9,242	61.1%
> 185 - 200% FPL	2,032	14.2%	2,144	14.2%
> 200 - 250% FPL	3,551	24.7%	3,747	24.7%
Total	**14,343**	**100%**	**15,133**	**100%**

Source: InRhodes

[16] 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.

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

As shown in the previous table, the percentage distribution across the State's three premium bands was unchanged from Q-1, SFY 2010 to Q-2, SFY 2010.

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[18]. For example, if a premium payment which is due on January 1^{st} has not been not received by February 12^{th}, then MA eligibility would be discontinued, effective on February 28^{th}. Dishonored checks and incomplete electronic fund transfers are treated as non-payments.

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

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

- Serious physical or mental illness.

- Loss or delayed receipt of a regular source of income that the family needed to pay the premium.

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

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

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

DHS: The Number of RIte Care- or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-1 & Q-2, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2010		Q-2, SFY 2010	
> 150 - 185% FPL	183	58.1%	136	47.7%
> 185 - 200% FPL	48	15.2%	65	22.8%
> 200 - 250% FPL	84	26.7%	84	29.5%
Total	**315**	**100%**	**285**	**100%**

Source: InRhodes

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

During SFY 2010, the total of State and Federal expenditures for the Cost Not Otherwise Matchable (CNOM) provision of Section 1115(a)(2) of the Social Security Act = $32,249,453.

The following table provides disaggregated data for SFY 2010 for State and Federal Expenditures under the Cost Not Otherwise Matchable (CNOM) provision of Section 1115(a)(2) of the Social Security Act. These data were obtained from DHS Financial Management and are based upon paid dates, not incurred dates of service.

State and Federal Expenditures Under the CNOM Provision of Section 1115(a)(2) of the Social Security Act (SFY 2010)

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

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

The following data were obtained from the DHS TPL Unit and document the total recoveries which were paid to the DHS during the period from 07/01/2009 – 12/31/2009. This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: 07/01/2009 – 12/31/2009

Recoveries by Type:	**Amount Recovered:**
Estate Recoveries	$975,428.89
Casualty Recoveries	$472,887.35
Total	**$1,448,316.24**

Do you need extra help with...

...daily tasks such as bathing, dressing and personal care?

...other activities you have trouble doing on your own?

We may be able to help.

You may be able to get in-home care or services in your community.

Whether you are living at home, in assisted living or in shared living, you may be able to get services and support so you can continue to live independently and safely.

Call **The POINT** at (401) 462-4444
or (401) 462-4445 TTY
for information and referrals.

Am I eligible?

You may qualify for services depending on:

- your level of need and
- your income and other assets/resources.

For veterans

Are you a veteran or the spouse of a veteran? Do you need home care, adult day services or assisted living?

You and your spouse may qualify for the Aid and Attendance benefit available through the U.S. Veterans Administration. Find out more by calling **(800) 827-1000**.

For help solving a problem

If you are having a problem with the nursing home or assisted living facility you live in, or with the home care you are receiving, call the Alliance for Better Long Term Care at **(401) 785-3340** or go to **www.LtcOmbudsman.org**.

For elders and adults with disabilities

Do you need information on what your options are for home and community-based care? If so, call **The POINT** at **(401) 462-4444**.

You can also go to:

- Department of Human Services website at www.dhs.ri.gov under Elders or Adults with Disabilities
- Department of Elderly Affairs website at www.dea.ri.gov
- Rhodes to Independence website at www.RhodesToIndependence.org

Call **The POINT** at (401) 462-4444
or (401) 462-4445 TTY
for information and referrals.

Donald L. Carcieri,
Governor of Rhode Island

Gary D. Alexander, *Secretary*
Executive Office of Health and Human Services

Some of these programs are funded by the Administration on Aging.

If you or someone you love needs help to stay at home...

...you have many good choices

Services for Elders & Adults with Disabilities
RI Executive Office of Health and Human Services

Services available to you in your home and in your community

Adult Day Services

You can go to a safe place during the day for meals, help with medication, health and personal care services, and to participate in recreational activities. There are also special programs for people with dementia.

Assisted Living

Live in apartment-like housing with 24-hour support services, supervision, meals, housekeeping services and personal care.

Companions

Volunteers provide companionship and can visit you at your home, adult day center or other places in the community.

Employment Assistance

Get help finding or keeping a job.

Food Assistance

Receive extra money each month to buy food through SNAP.

Home Health Aide

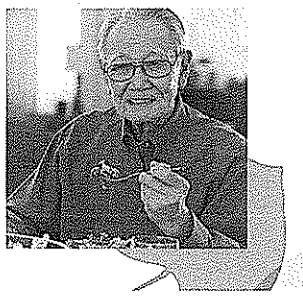
Get help with eating, getting in and out of bed, bathing, dressing and grooming – for a few hours per week or every day.

Homemaker Services

Get help with household tasks such as laundry, grocery shopping, meal preparation and light housekeeping.

Meals at Senior Centers

Get a nutritious lunch at one of the many centers throughout Rhode Island. Transportation to the nearest center may be available.



Meals on Wheels

If you can't leave your home or prepare your own meals, lunch can be delivered.

Personal Emergency Response System

If you have an emergency, such as a bad fall, a medical alert lifeline connects you to a trained professional who can send help quickly – 24 hours a day, seven days a week.

Prescription Drug Assistance

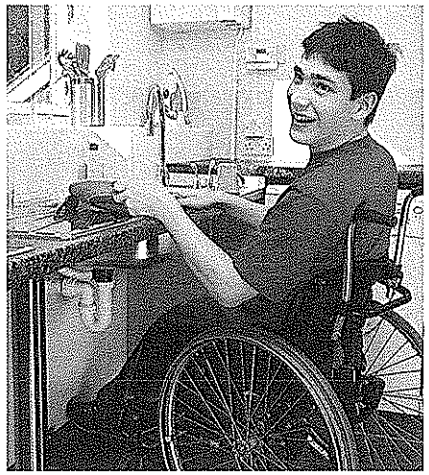
Get help paying for part of the cost of some prescription drugs.

Respite Care

Help may be available for the person who takes care of you if he or she needs time off or becomes sick.

Shared Living

Live in a home-like environment and have a caretaker of your choice provide personal care, meals, transportation and other services. You can still participate in adult day services.



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