STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services
600 New London Avenue
Cranston, RI 02920
Tel: (401) 462-2121
Fax: (401) 462-3677

December 17, 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 quarterly *Designated Medicaid Information* report to the Rhode Island General Assembly's Senate Committee on Health and Human Services. This 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*).

The *Designated Medicaid Information* report focuses upon the implementation of the State's Global Consumer Choice Compact during the Third Quarter of State Fiscal Year 2010 (January 1st, 2010 through March 31st, 2010).

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
January 1, 2010 – March 31, 2010

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

December 15, 2010

Designated Medicaid Information
January 1, 2010 – March 31, 2010
Section I: Introduction

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

The following report focuses upon the Third Quarter of State Fiscal Year 2010 (January 1st, 2010 through March 31st, 2010), during the initial implementation phase of the State's Global Consumer Choice Compact (also known as the "Global Waiver"). As was provided in the initial report which the EOHHS submitted to the State Senate on 10/01/2010, Section I provides an overview of Rhode Island's goals for the Global Waiver, as well as a description of the factors which have been identified by the Public Policy Institute as instrumental to States' success when launching efforts to rebalance their long-term care (LTC) services and supports system. Section I also includes bulleted highlights of some noteworthy achievements which were realized by Rhode Island during the Third Quarter of SFY 2010. The latter information was drawn from Rhode Island's quarterly report to the Centers for Medicare and Medicaid Services (CMS) on the progress of the Global Waiver.

Section II presents the designated Medicaid information covering the period from January 1st, 2010 through March 31st, 2010. This information has been organized alphabetically, according to the measures which were delineated in Senate Resolution 10R303.

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

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

- To advance efficiencies through interdepartmental cooperation

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

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

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

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

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

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

Highlights from Rhode Island's Quarterly Progress Report to CMS for the Global Consumer Choice Compact 1115 Waiver: In conformance with the Special Terms and Conditions (STCs) which were established by the Centers for Medicare and Medicaid Services (CMS) for the Global Consumer Choice Compact 1115 Waiver, Rhode Island must submit a quarterly progress report to CMS no later than 60 days following the end of each quarter. To promote public transparency, the Executive Office of Health and Human Services posts on its Website a copy of the State's quarterly report to the Centers for Medicare and Medicaid Services. The following bulleted excerpts[2], organized according to a series of objectives and supporting activities, have been abstracted from Rhode Island's report to CMS for the Third Quarter of SFY 2010:

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

    - As of March 20, 2010, **1,524 Level of Care (LOC) assessments** were completed, resulting in the following determinations: **Highest LOC = 1,189**; **High LOC = 275**; and **Preventive LOC = 60**
    - Care management assessment forms were aligned across Departments

[2] A full copy of the quarterly report may be accessed on the RI EOHHS Website at the following site: http://www.eohhs.ri.gov/documents/documents10/GW_Quarterly_Report_Jan_Mar_2010.pdf

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

    - Incorporated a strategy for Nursing Facility Diversions into the State's planning for its Managed Long-term Care procurement

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

    - Nursing home transition services and the Nursing Facility Diversion program resulted in **459** individuals being safely transitioned to community settings
    - Planning was ongoing to transition the responsibilities for the Nursing Home Transition project to State staff in the Office of Community Programs and the DEA's Home and Community Care

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

    - During Q-3 of SFY 2010, **60** individuals met the Preventive Level of Care and received services
    - Inter-agency planning was underway to align with the DEA's Lifespan Grant initiative

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

    - Standards were established for the DHS' Shared Living program
    - Two vendors were selected to provide Shared Living services and contracts were executed
    - Fact sheets and training materials were developed
    - Readiness reviews were conducted with both Shared Living contractors prior to program implementation

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

    - Recommendations from the *Value-based Purchasing for Home and Community-based Service Report* were analyzed
    - A tool for home care resource mapping, developed under the State's Real Choices Systems Transformation Grant, was reviewed

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

    - Planned a provider communications strategy for the roll-out of new medical forms
    - A cross-departmental training was convened, focusing on the State's CHOICES Data Warehouse

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

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

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

    - Identified potential eligibility policy changes for the Sherlock Plan to improve participation in the program.
    - Analyzed the guidance issued by CMS in its *State Medicaid Director Letter*[3] regarding the "Ticket to Work" initiative

- Analyze Medicaid Managed Long-Term Care models:

    - Launched a cross-departmental work group to discuss managed long-term care
    - Convened a mini-symposium with national experts to analyze managed long-term care strategies
    - Established a work plan for the development of a Request for Information (RFI) for managed long-term care

- Promote the adoption of "Medical Homes[4]"

    - "Medical Home" principles were incorporated into the State's 2010 Reprocurement for its capitated Medicaid managed care program

- Promote the adoption of electronic health records

---

[3] U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (January 2010). *State Medicaid Director Letter SMD 10-002 (Ticket to Work).* Retrieved from http://www.cms.gov/smdl/downloads/SMD10002.pdf

[4] Subsequent quarterly reports will include information about *The Patient Protection and Affordable Care Act (Public Law 111-148)* and its provisions for "Health Homes."

- Rhode Island submitted its *Planning-Advance Planning Document* (P-APD) to CMS and received CMS' approval
- Procurement materials were prepared for a P-APD vendor
- The adoption of electronic health records was addressed in the State's 2010 Reprocurement for its capitated Medicaid managed care program

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

    - As noted previously, during Q-3 of SFY 2010, the State selected two (2) vendors to provide Shared Living services and contracts were executed
    - A draft Model Contract, Request for Information, and Letter of Intent were developed for the State's Reprocurement of its capitated Medicaid managed care program

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

    - EOHHS continued to refine recommendations for long-term care acuity adjustments
    - EOHHS continued to meet with the Hospital Association to refine the proposed All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement methodology for inpatient care
    - EOHHS explored funding sources available through the Long Term Care Service and Finance Reform Act to increase reimbursement for home health services for SFY 2010

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

    - Met on an on-going basis throughout the Third Quarter of SFY 2010 with stakeholders involved in the following collaboratives: Global Waiver Task Force, the Task Force's work groups, and the Medical Care Advisory Committee
    - Waiver-related updates were posted to the EOHHS Website
    - A briefing book and brochure were in development for the Choice Counseling program
    - Planning sessions were held to develop a multi-media Community Options training targeted for the Spring of 2010
    - On 03/29/2010, the EOHHS issued a press release announcing the launch of the State's Data Warehouse for Rhode Island's Medicaid program[5]

[5] Rhode Island Executive Office of Health and Human Services. (March 29, 2010). *RI.gov: Rhode Island Government: EOHHS Launches New Data Warehouse for Rhode Island's Medicaid Program*. Retrieved from http://www.ri.gov/press/view/11059

SECTION II
Designated Medicaid Information
January 1, 2010 – March 31, 2010 (Q-3, 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 Third Quarter of SFY 2010 (January 1, 2010 – March 31, 2010). The following tables represent a "point-in-time" snapshot of the number of approved applications for Medicaid LTC coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for Q-3 of SFY 2010.

RI DHS: Medicaid Long-term Care Acceptances (Approvals), Q-3, SFY 2010

Month	Long-Term Care
January 2010	235
February 2010	206
March 2010	307
Total for Q-3, SFY 2010	**748**

Source: InRhodes

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

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. The following table outlines the number of Medicaid LTC applicants who were found ineligible during the Third Quarter of SFY 2010 (January 1, 2010 – March 31, 2010). InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics. The number of denials documented below represents a "point-in-time" snapshot of activity. This information has been provided by month for Q-3 of SFY 2010.

RI DHS: Medicaid Long-term Care Denials, Q-3, SFY 2010

Month	**Long-term Care Denials**
January 2010	75
February 2010	46
March 2010	60
Total for Q-3, SFY 2010	**181**

Source: InRhodes

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

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

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, 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 Third Quarter of SFY 2010.

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

DEA: LTC Service Type and Corresponding Unit of Service

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

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

Source: EOHHS Data Warehouse: MMIS Claim Universe			January		February		March	
Reporting Period: Date of Service			2010		2010		2010	
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units
DEA	Assisted Living	Under 65	17	517	21	575	23	705
		65 and Over	242	7,330	244	6,732	253	7,671
DEA	Assisted Living	Service Type Subtotals:	259	7,847	265	7,307	276	8,376
	Case Management	Under 65	8	43	10	70	13	45
		65 and Over	500	1,856	460	1,830	474	2,206
DEA	Case Management	Service Type Subtotals:	508	1,899	470	1,900	487	2,251
	Personal Care/Homemaker	65 and Over	431	100,781	423	94,769	422	107,014
DEA	Personal Care/Homemaker	Service Type Subtotals:	431	100,781	423	94,769	422	107,014
DEA		Grand Total:		110,527		103,976		117,641

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, SFY 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 Third Quarter of SFY 2010. This information reflects incurred dates of service (January 1st, 2010 through March 31st, 2010) and has been stratified according to the two age groups (less than 65 years of age and greater than or equal to 65 years of age) as requested.

Units of service have been defined in the following manner.

DHS: LTC Service Type and Corresponding Unit of Service

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

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

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

Source: EOHHS Data Warehouse: MMIS Claim Universe			January		February		March	
Reporting Period: Date of Service			2010		2010		2010	
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units
DHS	Adult Day Care	Under 65	246	3,269	244	3,207	247	3,658
		65 and Over	179	2,409	176	2,267	192	2,798
DHS	Adult Day Care	Service Type Subtotals:	425	5,678	420	5,474	439	6,456
	Assisted Living	Under 65	13	366	14	375	15	437
		65 and Over	155	4,635	151	4,048	150	4,529
DHS	Assisted Living	Service Type Subtotals:	168	5,001	165	4,423	165	4,966
	Case Management	Under 65	161	410	174	334	113	289
		65 and Over	154	736	160	668	156	794
DHS	Case Management	Service Type Subtotals:	315	1,146	334	1,002	269	1,083
	Home Health Agency	Under 65	175	2,518	155	1,937	151	1,959
		65 and Over	127	1,484	126	1,253	119	1,383
DHS	Home Health Agency	Service Type Subtotals:	302	4,002	281	3,190	270	3,342
	Hospice	Under 65	29	683	29	687	32	924
		65 and Over	514	13,096	480	11,440	510	12,972
DHS	Hospice	Service Type Subtotals:	543	13,779	509	12,127	542	13,896
	Nursing Facility	Under 65	559	15,789	559	14,196	555	15,632
		65 and Over	5,162	152,659	5,106	137,246	5,079	150,050
DHS	Nursing Facility	Service Type Subtotals:	5,721	168,448	5,665	151,442	5,634	165,682
	Personal Care/Homemaker	Under 65	895	232,866	906	218,813	931	261,544
		65 and Over	1,129	276,027	1,120	259,111	1,139	301,596
DHS	Personal Care/Homemaker	Service Type Subtotals:	2,024	508,893	2,026	477,924	2,070	563,140
	Tavares Pediatric Center	Under 65	22	654	22	598	21	651
DHS	Tavares Pediatric Center	Service Type Subtotals:	22	654	22	598	21	651
DHS	0	Grand Total:		707,601		656,180		759,216

The Number of Medicaid Beneficiaries Served by PACE, Q-3, 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	1/1/2010	PACE PROGRAM	65+	156
DHS		PACE PROGRAM	Under 65	31
	1/1/2010		**Period Totals:**	**187**
DHS	2/1/2010	PACE PROGRAM	65+	158
DHS		PACE PROGRAM	Under 65	29
	2/1/2010		**Period Totals:**	**187**
DHS	3/1/2010	PACE PROGRAM	65+	158
DHS		PACE PROGRAM	Under 65	30
	3/1/2010		**Period Totals:**	**188**

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, SFY 2010 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). As requested, this information has been stratified according to two age groups for participants for the following lines of service which are administered by the RI BHDDH: Day programs; homemaker services; public group homes for persons with developmental disabilities; private group homes for persons with developmental disabilities; family supports; shared living; supported employment; and behavioral health group home (behavioral health only). Data for the Third Quarter of SFY 2010 are shown below.

Source: RI BHDDH, Medicaid LTC Beneficiaries Served, Q-3, SFY 2010

Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2366
		Over 65	272
BHDDH	Homemaker	Under 65	142
		Over 65	20
BHDDH	Public Group Homes	Under 65	157
		Over 65	78
BHDDH	Private Group Homes	Under 65	1176
		Over 65	154
BHDDH	Family Supports	Under 65	843
		Over 65	56
BHDDH	Shared Living	Under 65	147
		Over 65	11
BHDDH	Supported Employment	Under 65	519
		Over 65	12
BHDDH	Behavioral Health GH	Under 65	444
	(Mental Health Only)	Over 65	34

As part of its developmental disabilities budget initiative, the RI BHDDH is currently 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 Third Quarter of SFY 2010 (January 1st, 2010 through March 31st, 2010). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one which shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

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

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

Cost and Utilization Data, Q-3, 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 Third Quarter of SFY 2010.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-3, SFY 2010	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
DEA	Assisted Living	Under 65	$ 776	$ 47,319
		65 and Over	$ 640	$ 472,933
DEA	Assisted Living	Service Type Subtotals:	$ 650	$ 520,252
	Case Management	Under 65	$ 76	$ 2,370
		65 and Over	$ 62	$ 88,335
DEA	Case Management	Service Type Subtotals:	$ 62	$ 90,705
	Personal Care/Homemaker	65 and Over	$ 1,195	$ 1,524,924
DEA	Personal Care/Homemaker	Service Type Subtotals:	$ 1,195	$ 1,524,924
DEA		Grand Total:		$ 2,135,881

Cost and Utilization Data, Q-3, 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 Third Quarter of SFY 2010.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-3, SFY 2010	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
DHS	Adult Day Care	Under 65	$ 728	$ 536,899
		65 and Over	$ 723	$ 395,311
DHS	Adult Day Care	Service Type Subtotals:	$ 726	$ 932,210
	Assisted Living	Under 65	$ 1,007	$ 42,302
		65 and Over	$ 978	$ 445,874
DHS	Assisted Living	Service Type Subtotals:	$ 980	$ 488,176
	Case Management	Under 65	$ 47	$ 21,216
		65 and Over	$ 69	$ 32,472
DHS	Case Management	Service Type Subtotals:	$ 58	$ 53,688
	Home Health Agency	Under 65	$ 1,079	$ 518,877
		65 and Over	$ 1,200	$ 446,440
DHS	Home Health Agency	Service Type Subtotals:	$ 1,132	$ 965,316
	Hospice	Under 65	$ 5,009	$ 450,781
		65 and Over	$ 3,696	$ 5,558,689
DHS	Hospice	Service Type Subtotals:	$ 3,770	$ 6,009,470
	Nursing Facility	Under 65	$ 4,434	$ 7,418,307
		65 and Over	$ 4,389	$ 67,355,344
DHS	Nursing Facility	Service Type Subtotals:	$ 4,393	$ 74,773,652
	Personal Care/Homemaker	Under 65	$ 1,340	$ 3,660,807
		65 and Over	$ 1,261	$ 4,271,052
DHS	Personal Care/Homemaker	Service Type Subtotals:	$ 1,296	$ 7,931,859
	Tavares Pediatric Center	Under 65	$ 26,215	$ 1,704,002
DHS	Tavares Pediatric Center	Service Type Subtotals:	$ 26,215	$ 1,704,002
DHS		Grand Total:		$ 92,858,373

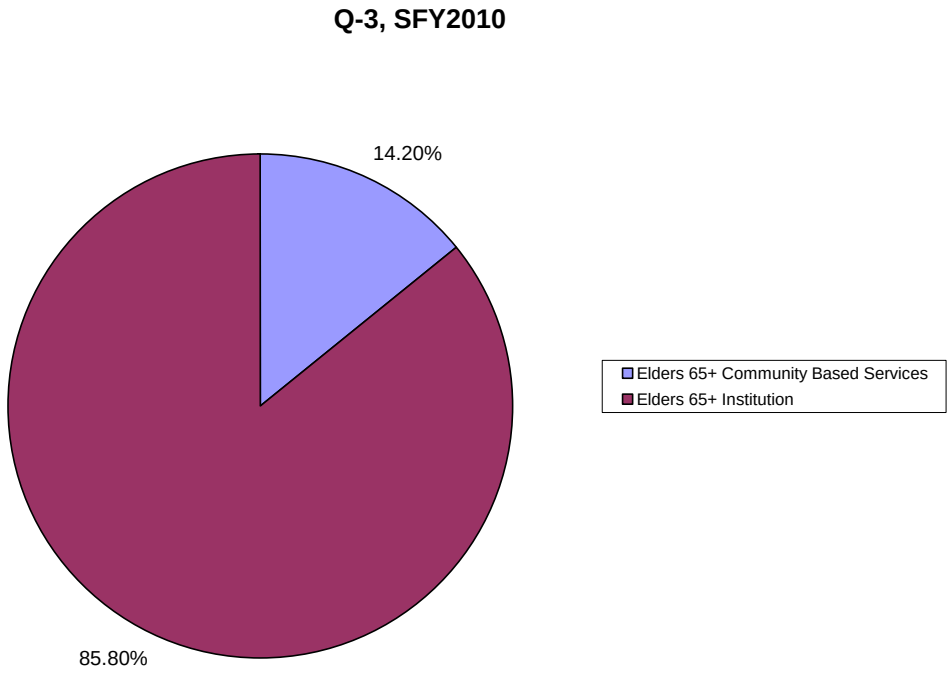
Cost and Utilization Data, Q-3, SFY 2010 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). Currently, as part of its developmental disabilities budget initiative, the Division is engaged in work with Hewlett Packard to develop a new database and claims payment process. The new database will provide functionality to aid in extracting data, leading to greater ease in the development of standardized reports. Please refer to the table that is shown on p. 17.

Source: RI BHDDH, Utilization and Cost Data, Q-3, SFY 2010				
Dept.	Service Type	Age Group	# Served	Total Expenditures
BHDDH	Day Programs	Under 65	2366	10,009,484
		Over 65	272	1,065,541
BHDDH	Homemaker	Under 65	142	828,749
		Over 65	20	74,448
BHDDH	Public Group Homes	Under 65	157	5,752,601
		Over 65	78	2,875,563
BHDDH	Private Group Homes	Under 65	1176	25,766,474
		Over 65	154	3,232,752
BHDDH	Family Supports	Under 65	843	3,879,596
		Over 65	56	291,065
BHDDH	Shared Living	Under 65	147	1,379,419
		Over 65	11	116,373
BHDDH	Supported Employment	Under 65	519	1,890,651
		Over 65	12	38,793
BHDDH	Behavioral Health GH	Under 65	444	4,160,940
	(Mental Health Only)	Over 65	34	355,375

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 services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (January 1st, 2010 through March 31st, 2010).

Elders Aged 65 and Over



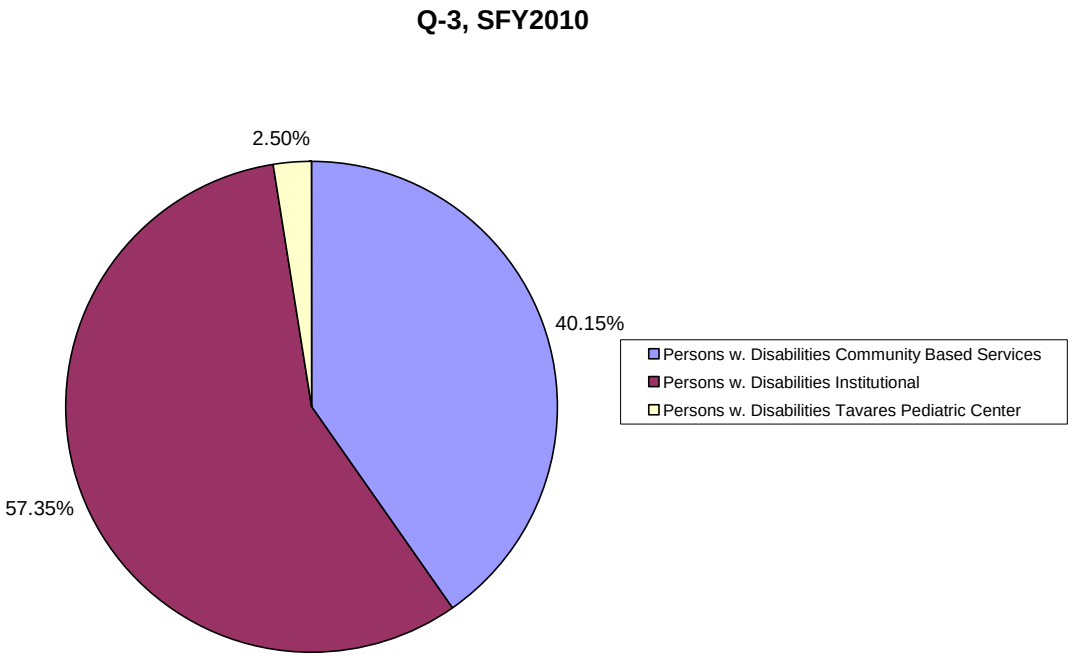
During the Third Quarter of SFY 2010, 85.8 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services.

Children with Special Health Care Needs

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

Persons with Disabilities: Individuals with disabilities are eligible for Medical Assistance if they are 18 years or older, a Rhode Island resident, receive Supplemental Security Income (SSI) or have an income less than 100% of the Federal Poverty Level (FPL) and have resources (savings) of less than $4,000 for an individual or $6,000 for a married couple. The following charts show the percent distribution of expenditures for Medicaid institutional services and home and community services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (January 1st, 2010 through March 31st, 2010).

Persons with Disabilities



During the Third Quarter of SFY 2010, 59.85 percent[6] of expenditures for persons with disabilities were for Medicaid long-term care institutional services.

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

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

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

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

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

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

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

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

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

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

RI DEA: Adult Day Care (01/01/2010 – 03/31/2010)

Service Category: Adult Day Care	**Clients***		**Units (Unit=1 Day)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	117	39	1,696	566
D2 (Income between 126% to 200% FPL):	650	217	8,639	2,880
Total	**767**	**256**	**10,335**	**3,446**
Average utilization=13 days of adult day care per client per month.				

*Clients are not distinct.

RI DEA: Case Management (01/01/2010 – 03/31/2010)

Service Category: Case Management	**Clients**		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
Case Management	889	297	4,196	1,399
Average utilization=1.18 Hours of Case management per client per month.				

RI DEA: Home Care (01/01/2010 – 03/31/2010)

Service Category: Home Care	**Clients***		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	323	108	33,447	11,149
D2 (Income between 126% to 200% FPL):	1,259	420	129,876	43,292
Total	**1,582**	**528**	**163,323**	**54,441**
Average utilization=103 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 the time when the EOHHS submitted its initial *Designated Medicaid Information* report, InRhodes data could not be used to produce the mean and median turn-around time (TAT) statistics for completed LTC applications as outlined in Item H. Therefore, for its initial report to the State Senate, EOHHS conducted a cohort analysis to determine LTC processing turn-around times during one month from each of the first two quarters of SFY 2010. Replicating the same methodology, InRhodes has been used to produce the table shown below. For the Third Quarter of SFY 2010, turn-around times (TAT) for processing new LTC applications have been organized according to three timeframes: a) less than thirty (30) days; b) thirty (30) to ninety (90) days; and greater than ninety (90) days

RI DHS: Turn-around Times for New LTC Applications (Q-3, SFY 2010)

Month	**< 30 Days**		**30 – 90 Days**		**> 90 Days**		**Monthly Total**	
Jan. 2010	137	34.42%	191	47.99%	70	17.59%	398	100%
Feb. 2010	149	36.61%	202	49.63%	56	13.76%	407	100%
March 2010	122	32.11%	201	52.89%	57	15.00%	380	100%
Total for Q-3, SFY 2010	**408**	**34.43%**	**594**	**50.13%**	**183**	**15.44%**	**1,185**	**100%**

Source: InRhodes

Based on the prior analysis[7] for August and December of 2009, the percentage of new LTC applications which were processed within less than 30 days increased by four

[7] The Rhode Island Executive Office of Health and Human Services. (October 1, 2010). *Report to the Rhode Island General Assembly Senate Committee on Health and Human Services, Designated Medicaid Information, July 1, 2009 – December 31, 2009* (p. 33).

percentage points (34.43% for Q-3 of SFY 2010 in comparison to 30.2% for August and December of 2009). This finding represents a positive one. An additional positive trend was demonstrated by the decline shown in the number of new LTC applications which were processed in more than ninety (90) days. A decline of slightly less than four percentage points was demonstrated in comparison to the findings which were reported[8] in the initial report (15.44% for Q-3 of SFY 2010 in comparison to 19.3% for August and December of 2009).

In this quarter's report, InRhodes data have been further analyzed in order to quantify the average number of days for approving or denying applications for Medicaid LTC coverage. The following two tables show the average turn-around time in days for Medicaid LTC approvals during the Third Quarter of SFY 2010 and the average TAT for Medicaid LTC denials during the same period. The calculated averages for TATs have been provided and in addition these figures have been rounded up to whole integers.

RI DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-3, SFY 2010)

Month	**Number of Approvals for Medicaid LTC**	**Average TAT in Days**
January 2010	235	44.92 (~ 45 Days)
February 2010	206	45.57 (~ 46 Days)
March 2010	307	Data for 03/2010 currently unavailable
Total	**748**	**Average ~ 46 Days (for activity in January and February 2010)**

Source: InRhodes

RI DHS: Average Turn-around Time in Days for Medicaid LTC Denials (Q-3, SFY 2010)

Month	**Number of Denials for Medicaid LTC**	**Average TAT in Days**
January 2010	75	20.79 (~ 21 Days)
February 2010	46	10.50 (~ 11 Days)
March 2010	60	Data for 03/2010 currently unavailable
Total	**181**	**Average ~ 16 Days (for activity in January and February 2010)**

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.

[8] Ibid., p. 33.

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[9] waiver community-based services	Access to ICFMR, and section 1915(c) HCBS Waivers MR/DD community-based services.

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

DHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-3, SFY 2010)

Clinical Eligibility Level of Care Criteria	Q-3, SFY 2010
Nursing Facility	885
Hospital (HAB applicants)*	2

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

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

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

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. During the Third Quarter of SFY 2010, there were fifty-seven (57) applications made by individuals with developmental disabilities. There were also twelve (12) 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 Third Quarter of SFY 2010. The calculations of average and median turnaround times have been based on calendar days (not business days).

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

DHS: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations (Q-3, SFY 2010)

	Q-3, SFY 2010	
	Average	**Median**
Nursing Facility Care	18	18
Hospital/(HAB applicants)	62	75

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

Turnaround Times for Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The following information was provided by the 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 Third Quarter of SFY 2010.

The Division of Developmental Disabilities will begin to track these data. As previously described in the responses to Items C and D, the Division of Developmental Disabilities is currently engaged in work with Hewlett Packard (HP) 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[10] care have been conducted by the Office of Medical Review at the Rhode Island Department of Human Services (RI DHS). In the event that a LTC clinical eligibility determination has not been approved, the individual has the right to file an appeal, seeking to overturn the outcome of that determination.

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

DHS: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-3, SFY 2010

Appeals of LTC Clinical Eligibility Determinations by Level of Care	Q-3, SFY 2010
Nursing Facility	0
Hospital/Habilitation	1

Source: Office of Medical Review, RI DHS

Appeals Based on Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The following information was provided by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. As previously described, any applicant whose clinical eligibility determination has not been approved has the right to file appeal, seeking to overturn the outcome of that determination. The BHDDH's Division of Developmental Disabilities reported that there were two (2) appeals during the Third Quarter of SFY 2010.

[10] 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 SFY 2010, 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 (DHA and DEA), The Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting. The following statistics were prepared for the RI DHS by The Alliance for Better Long Term Care.

DHS: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-3, SFY 2010)

	Q-3, SFY 2010
Number of Nursing Home Transitions	21
Average length of stay (ALOS) prior to transfer (days)	154

Data Source: The Alliance for Better Long Term Care

The average length of stay (ALOS) was measured in calendar days. During the Third Quarter of SFY 2010, for those beneficiaries who were transitioned from a nursing facility, their ALOS in a nursing home prior to transfer was 154 days (or approximately 5.1 months).

DHS: The Type of Living Arrangement or Setting and Services Upon Transfer for Persons Transitioned from Nursing Homes (Q-3, SFY 2010)

	Q-3, SFY 2010	
Existing Home	13	61.9%
Assisted Living	5	23.8%
New Housing	3	14.3%
Group Home	0	0.0%
Other	0	0.0%
Total	**21**	**100%**

[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.

Data Source: The Alliance for Better Long Term Care

During the Third Quarter of SFY 2010, approximately sixty-two (62) 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 SFY 2010, The Alliance for Better Long Term Care partnered with Qualidigm[12] and the Rhode Island Department of Human Services on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of the RI DHS and DEA in the identification of residents who could be transitioned safely. In collaboration with representatives of the two EOHHS agencies (DHA and DEA), The Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting.

As noted in Item M, there were 21 LTC beneficiaries who were transitioned from nursing facilities during the period from January 1, 2010 through March 31, 2010. The Alliance for Better Long Term Care reported that during this time period there were no (n=0) failed placements.

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

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

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

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

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

Cohort Analysis for RIte Care/RIte Share Applicants: For the purpose of the following cohort analysis, two major groups comprised the RIte Care/RIte Share applicant population and information has been provided for each group by month for the Third Quarter of SFY 2010. These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[13] and b) several additional categories of applicants

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

which for the purposes of this report have been referred to as "Other"[14]. Statistics for the latter grouping are aggregated (or added) within the InRhodes system.

RI DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-3, SFY 2010

Month	Rhode Island Works	"Other"
January 2010	2,831	252
February 2010	2,942	292
March 2010	3,373	349
Total for Q-3 of SFY 2010	**9,146**	**893**

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 Third Quarter of SFY 2010 (January 1, 2010 – March 31, 2010). The following tables represent a "point-in-time" snapshot of the number of approved applications for Medicaid coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for the Third Quarter of SFY 2010.

RI DHS: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-3, SFY 2010

Month	Rhode Island Works	"Other"
January 2010	1,802	231
February 2010	2,312	260
March 2010	2,447	337
Total for Q-3 of SFY 2010	**6,561**	**828**

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 Third Quarter of SFY 2010.

RI DHS: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-3, SFY 2010

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

Month	Rhode Island Works	"Other"
January 2010	178	7
February 2010	200	10
March 2010	198	9
Total for Q-3 of SFY 2010	**576**	**26**

Source: InRhodes

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

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

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

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

Item O provided a count of the number of applications received from RIte Care applicants during the Third Quarter of SFY 2010 (January 1, 2010 through March 31, 2010). For the purpose of that cohort analysis, there were two major groups comprising the RIte Care/RIte Share applicant population. In the response to Item O, information was stratified for these two groups of applicants: a) those who were seeking enrollment in Rhode Island Works[15] and b) several additional categories of applicants. As previously noted, statistics for the latter grouping are aggregated (or combined) within the InRhodes system and are classified as "Other" [16].

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

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

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and addresses the number of RIte Care/RIte Share applications pending for more than thirty (30) days. Pending cases are defined as those which have not yet had either an acceptance (approval) or denial determination. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the pending applications for the Rhode Island Works/RIte Care applicant cohort during the Third Quarter of State Fiscal Year 2010.

RI DHS: The Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort (Q-3, SFY 2010)

Quarter	Number of Applications Pending for Rhode Island Works Applicants
Q-3, SFY 2010	391

Source: InRhodes

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

In Item O, the number of new applications for RIte Care/RIte Share was quantified for the Third Quarter of SFY 2010 (January 1, 2010 through March 31, 2010). That prior discussion also gave an overview of the eligibility determination processes specific to new applications. Information was provided about the number of eligibility approvals (also referred to as "acceptances") and denials for new RIte Care/RIte Share applicants during the same time frame.

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and focuses on RIte Care/RIte Share redeterminations and closures. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the redeterminations and closures which were processed for the Rhode Island Works/RIte Care enrollment cohort during the Third Quarter of SFY 2010. At this time, a detailed analysis of the reasons for closures is not available. However, enhanced reporting capability will be realized through Rhode Island's CHOICES Project, which will streamline the State's Medicaid Information Technology Architecture.

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

Month	**RIW Redeterminations**	**RIW Closures**	**Percentage**
January 2010	47,863	1,665	3.48%
February 2010	47,944	2,303	4.80%
March 2010	48,128	2,139	4.44%
Total for Q-3, SFY 2010	**143,935**	**6,107**	**4.24%**

Source: InRhodes

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

Some RIte Care- or RIte Share[17]-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 individuals/groups must pay a monthly premium to maintain coverage[18]:

1. Medical Assistance (MA) waiver families with income equal to or greater than one hundred fifty percent (150%) of the federal poverty income guidelines (FPL) and not exceeding one hundred seventy-five percent (175%) of the FPL

2. Children age one (1) to nineteen (19) with family income equal to or greater than one hundred fifty percent (150%) of FPL, and not exceeding two hundred fifty percent (250%) of the FPL

3. Pregnant women with family income above two hundred fifty percent (250%) of the FPL and not exceeding three hundred fifty percent (350%) of the FPL

4. Extended Family Planning (EFP) recipients with family income above two hundred fifty percent (250%) of the FPL and not exceeding three hundred fifty percent (350%) of the FPL.

The premium amount is determined as follows:

- Pregnant women whose countable family income is above two hundred fifty percent (250%) but not exceeding three hundred fifty percent (350%) of the FPL

- Extended Family Planning recipients whose countable family income is above two hundred fifty percent (250%) but not exceeding three hundred fifty percent (350%) of the FPL

- There is no premium charged for an individual whose MA eligibility is based on the federal poverty level income standard for a family size of one (such as when an aunt applies for MA for her nephew only, or when an SSI parent with one child applies for MA for the child only)

[17] 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.

[18] Rhode Island Department of Human Services. *RI DHS Policy Manual, Section 0348.40.05 (Premium Share Requirements*). Retrieved from https://www.policy.dhs.ri.gov/0300.htm#_Toc279989626.

- There is no premium charged for Rhode Island Works (RIW) recipients, Extended MA recipients, IV-E and non IV-E foster children, or IV-E and non IV-E adoption assistance children

- For all others, the amount of the premium is determined by countable family income as shown in the following table

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

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

DHS: The Number of RIte Care- or RIte Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-3, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	**Q-3, SFY 2010**	
> 150 - 185% FPL	9,787	61.4%
> 185 - 200% FPL	2,146	13.5%
> 200 - 250% FPL	3,998	25.1%
Total	**15,931**	**100%**

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

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

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

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

If full payment is not received by the twelfth (12^{th}) of the month following the coverage month, then a notice of MA discontinuance is sent to the family. MA eligibility is discontinued for all family members subject to cost sharing at the end of the month following the coverage month[20]. 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.

[20] 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 Third Quarter of SFY 2010.

DHS: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-3, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	Q-3, SFY 2010	
> 150 - 185% FPL	206	52.8%
> 185 - 200% FPL	60	15.4%
> 200 - 250% FPL	124	31.8%
Total	**390**	**100%**

Source: InRhodes

This quarter's finding represents an increase in the total number of sanctions in comparison to the first two quarters in SFY 2010. The following table provides comparative data about sanctions by percentage of the Federal Poverty Level for the first three 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-3, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2010		Q-2, SFY 2010		Q-3, SFY 2010		Total Q-1 – Q-3, SFY 2010	
> 150 - 185% FPL	183	58.1%	136	47.7%	206	52.8%	525	53.0%
> 185 - 200% FPL	48	15.2%	65	22.8%	60	15.4%	173	17.5%
> 200 - 250% FPL	84	26.7%	84	29.5%	124	31.8%	292	29.5%
Total	**315**	**100%**	**285**	**100%**	**390**	**100%**	**990**	**100%**

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

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

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

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

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

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

The following data were obtained from the DHS TPL Unit and document the total recoveries which were paid to the DHS during the Third Quarter of SFY 2010 (01/01/2010 – 03/31/2010). This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: 01/01/2010 – 03/31/2020

Recoveries by Type:	**Amount Recovered:**
Estate Recoveries: TPL and Legal	$540,443
Casualty Recoveries: TPL and Legal	$901,453
Total	**$1,441,896**

Source: TPL Unit, RI DHS