



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

**Designated Medicaid Information
January 1, 2013 – March 31, 2013**

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

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Section I: Introduction

This document has been prepared for the Rhode Island General Assembly's Senate Committee on Health and Human Services by the State's Executive Office of Health and Human Services (EOHHS). 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 on the operation of the State's 1115 Waiver Demonstration, the Global Consumer Choice Compact during the Third Quarter of State Fiscal Year 2013 (January 1, 2013 through March 31, 2013). In the preceding series of quarterly reports submitted to the Committee by EOHHS, an overview of the State's goals for the Section 1115 Waiver were delineated, as well as a description of the factors that have been identified by the Public Policy Institute as instrumental to States' success when launching efforts to rebalance their long-term care services and supports system. This information has been provided again in Section I, as well as bulleted highlights of noteworthy achievements that were realized during the Third Quarter of SFY 2013.

Section II presents the designated Medicaid information covering the period from January 1, 2013 through March 31, 2013. This information has been organized alphabetically, according to the measures delineated in Senate Resolution 10R303.

Goals of the State's Section 1115 Waiver: Rhode Island's Section 1115 Waiver was approved by the Centers for Medicare and Medicaid Services (CMS) 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 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 Section 1115 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 Section 1115 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 on the positive experience demonstrated by several States that 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 comprehensive action plans.

The Public Policy Institute at the American Association of Retired Persons (AARP) has identified twelve factors that have led to States' success in rebalancing LTC services and supports. A brief description is provided for the factors, which were cited¹ by the AARP's Public Policy Institute:

- *Philosophy* – The State's intention to deliver services to people with disabilities in the most independent living situation and expand cost-effective HCBS options guides all other decisions.
- *Array of Services* – States that do not offer a comprehensive array of services designed to meet the particular needs of each individual may channel more people to institutions than will States that provide an array of options.
- *State Organization of Responsibilities* – Assigning responsibility for overseeing the State's long-term services and supports to a single administrator has been a key decision in some of the most successful States.
- *Coordinated Funding Sources* – Coordination of multiple funding sources can maximize a State's ability to meet the needs of people with disabilities.
- *Single Appropriation* – This concept, sometimes called "global budgeting," allows States to transfer funds among programs and, therefore, make more rational decisions to facilitate serving people in their preferred setting.
- *Timely Eligibility* – Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, State Medicaid programs must be able to arrange for HCBS in a timely manner.
- *Standardized Assessment Tool* – Some States use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization.

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.

- *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 the Third Quarter of SFY 2013: In conformance with the Special Terms and Conditions (STCs) established by CMS for the Section 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 EOHHS posts a copy of the quarterly report and a copy of this report on its Web-site.

- Ensure appropriate utilization of institutional services and facilitate access to community-based services and supports by changing the clinical level of care determination process for eligibility for Medicaid-funded long-term care from institutional to needs-based
 - As of March 31, 2013, a total of **1,563 Level of Care (LOC) assessments** had been completed, resulting in the following determinations: **Highest LOC = 1,029; High LOC = 422** and **Preventive LOC = 96**. During Q-3 of SFY 2013, there were 16 assessments that did not meet a LOC determination
- Ensure the appropriate utilization of institutional services and facilitate access to community-based services and supports by designing and implementing a Nursing Facility Transition project to identify individuals who could be safely discharged from the nursing home to a community-based setting
 - **Safely transitioned a total of 1,234 individuals** to date to a community setting in the Nursing Facility Transition program and the *Money Follows the Person* program
 - There were **170 Nursing Home Transition referrals** made to the Office of Community (OCP) Programs during Q-3 of SFY 2013
 - During the reporting quarter, **32 individuals were transitioned to a community setting**, among these individuals, 12 were enrolled in the *Money Follows the Person* Demonstration
 - Ongoing monitoring of the use of protocols for weekend discharges and inpatient diversion discharges to nursing facilities

- Aligned planning activities under *Money Follows the Person* with the Nursing Home Transition Program
 - Produced and distributed marketing materials
 - Refined reporting processes for the MFP initiative
 - Explored MFP reporting changes needed under a Managed Care Organization (MCO) delivery model
 - Convened *Money Follows the Person* Steering Committee in March 2013
 - Monitored contract for Emergency Back-up and reporting of critical incidents
 - Refined failed placement criteria
 - Continued development of housing strategy to increase housing capacity
 - Convened Housing MFP-TA and developed approach for Public Housing outreach
 - Worked with CMS to revise proposed MFP benchmarks and budget
- Expand access to community-based services and supports by implementing a preventive level of care (LOC)
 - During Q-3 of SFY 2013, **96 individuals met the Preventive Level of Care** and received services
 - Explored opportunities for a proposed expansion for Respite Services and Transition Services with funding available under the *Money Follows the Person* Demonstration Grant
- Expand access to community-based services and supports by providing access to Shared Living for the elderly and adults with physical disabilities
 - **Enrolled 79 individuals in Rhode Island Medicaid's Shared Living program, now known as RItE @ Home**, as of March 31, 2013
 - Completed the following activities for the enrolled individuals: made home visits, conducted level of care (LOC) assessments, developed and approved service and safety plans, carried out caregiver BCI background checks, and provided training for caregivers
- Expand access to community-based services and supports, focusing on home health care, assisted living, and adult day services
 - Continued planning efforts and transitions under the *Money Follows the Person* Demonstration Grant
 - Continued transitions under the *Money Follows the Person* Demonstration
 - Participated in regular *Money Follows the Person* Technical Assistance sessions
 - Continued to work with the Assisted Living Trade Organization to identify assisted living facilities that would meet the CMS definition as a "qualified residence" under the *Money Follows the Person* Demonstration Grant
 - Reopened position for the Chief of the Consumer Assistance Program under the *Money Follows the Person* Rebalancing Demonstration (MFP) 2012 Aging and Disability Resource Center (ADRC) Supplemental Funding

- Continued to explore opportunities for Affordable Care Act (ACA) funding to support expanding the Home Care initiatives, including Telehealth and electronic visit verification opportunities
 - Continued to explore acuity-based funding for adult day services, including the array of services provided under adult day services
 - State staff implementing activities to support the MFP demonstration and housing coordinator activities
 - Explored peer navigator services under MFP
 - Included proposals in the 1115 Waiver renewal for expedited eligibility for long term services and housing retention services
- Improve the coordination of all publicly-funding long-term care services and supports through the EOHHS' Assessment and Coordination Organization (ACO)
 - Continued cross-departmental planning for Long Term Care Consolidation under the Integrated Care Initiative and the Unified Health Infrastructure Project (UHIP)
 - Convened cross-departmental planning for state and federal opportunities for Integrated Care for Medicare and Medicaid Beneficiaries and Managed Long Term Care for Medicaid-only beneficiaries
 - Participated in on-going discussions with the CMS CCMI team to discuss progress on the demonstration proposal submitted under the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees
 - Continued to analyze data to support Integrated Care for Medicare-Medicaid Enrollees
 - Continued planning for the MFP activities within the Integrated Care Initiative
 - Continued to explore opportunities under the Affordable Care Act (ACA), including Balancing Incentive Program and Community First Choice for Medicaid Enrollees, 1915(i) and Essential Health Benefit Medicaid Benchmark Plan Habilitation Option
 - Issued procurement documents for the Integrated Care for Medicare and Medicaid Beneficiaries initiative, including model contracts, payment rate methodology and data books
 - Issued responses to questions on the Integrated Care Initiative
 - Participated in the Integrated Care Resource Center (ICRC) Study Hall Call series
 - Convened public input process for the draft 1115 Waiver Demonstration Extension request
 - Drafted 1115 Waiver Demonstration Extension request
 - Awarded State Innovation Models Initiative grant
 - Began planning for the implementation of the CMS for the Adult Medicaid Quality Grant, Measuring and Improving the Quality of Care in Medicaid
 - Provided additional feedback to CMS on the opportunity under the Demonstration Grant for Testing Experience and Functional Tools (TEFT) in Community-Based Long Term Services and Supports
 - Issued RFP for the Enhanced Fraud, Waste and Abuse and Improper Payment Surveillance and Detection Capability
 - Improve the coordination of all publicly-funded long-term care services and supports, by focusing on the needs of beneficiaries whose care results in high costs

- Monitored interventions in *Communities of Care* for high utilizers enrolled in the State's managed care health plan delivery system (RIte Care and Rhody Health Partners participating Health Plans and the State's Primary Care Case Management (PCCM) delivery system, Connect Care Choice)
 - Continued the program evaluation of the *Communities of Care* initiative for the Connect Care Choice program
 - Continued the mailing of brochures for the *Communities of Care* initiative
 - Monitored the targeted interventions for high utilizers of pharmacy benefits in the State's Medicaid FFS and managed care delivery systems
 - Monitored the implementation of the pain management benefit
 - Monitored the implementation of improvements to the care planning assessment tools
 - Continued participation in the development of the Alzheimer's State Plan
 - Received approval of co-located Behavioral Health for Connect Care Choice PCCM 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)
 - Continued to explore opportunities to align efforts under a recent Health Care Innovation grant award "Living RIte – A Disruptive Solution for Management of Chronic Care Disease" (This grant focuses on adults with disabilities: intellectual and developmental diagnoses and dementia patients with two (2) or more chronic conditions.)
 - Continued to explore opportunities to align the Sherlock Plan with the Integrated Care Initiative
- Analyze Medicaid Managed Long Term Care models
 - Participated in the CHCS-TA initiative, *Implementing Innovations in Long-term Supports and Services (LTSS)*, funded by the SCAN Foundation
 - Continued developing the long-term services and supports (LTSS) models for Integrated Care for Medicare and Medicaid beneficiaries
 - Incorporated the Quality Monitoring and Oversight measures across six domains for the Integrated Care Initiative procurement
 - Incorporated quality measures and process measures for the Integrated Care Initiative
 - Commenced development of an analytic framework for program monitoring for the Integrated Care Initiative
 - Commenced development of Balancing Incentive Payment Program application to promote Medicaid Managed LTSS
 - Explored Managed LTSS models that connect the federal funding opportunities available under the ACA
 - Promote the adoption of "Medical Homes"

- Monitored the implementation of the two (2) *Health Homes for Medicaid Enrollees with Chronic Conditions Initiatives*
 - Continued to participate in the statewide CSI/Beacon Rhode Island Medical Home Project
 - Developed opportunities for additional Health Home models of care for additional populations
 - Included Medical Home model requirements for the Integrated Care Initiative
 - Included promotion of Medical Home models in the CMS State Innovation Models Demonstration proposal and the Integrated Care Initiative
 - Monitored the Federally Qualified Health Center (FQHC) quality reporting initiative for FQHCs qualified as NCQA or JCAHO Patient Centered Medical Homes
 - Submitted Primary Care Provider payment increase State Plan Amendment (SPA)
 - Participated in the development of a Health Home for Opioid Treatment
- Promote the adoption of electronic health records
 - Drafted final report under the DRA Medicaid Transformation II Grant
 - Continued the voluntary enrollment of Medicaid beneficiaries in Rhode Island's **currentcare** electronic medical record (EMR)
 - Included adoption of **currentcare** in the program design for the Integrated Care Initiative and with the RI State Employees health insurance carrier
 - Monitored the EMR funding for Medicaid providers
 - Participated in the 13-state collaborative Medicaid Assistance Provider Incentive Repository (MAPIR) program management tool to support Meaningful Use
 - Monitored activities for P-APD (IT Global Waiver and MITA Planning)
 - Monitored the contract with selected vendor for the RFP for Transition, Enhancement, Operation and Maintenance of the Medicaid Management Information System (MMIS)
 - Explored opportunity to utilize care management tool, Atlantes
 - Explored opportunities for Telehealth, including a vendor product demonstration
- Participate in Health Insurance Exchange Planning
 - Participated in the Health Insurance Exchange Planning Grant activities
 - Participated in the design and implementation of the United Health Infrastructure Project (UHIP), the state's health benefits exchange and integrated eligibility system (HIX/IES)
 - Participated in the planning of the Essential Health Benefits benchmark plan development
 - Continued to analyze options for an Essential Health Benefits Medicaid Benchmark Plan, Medicaid Expansion and a Basic Health Plan Option
- 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
 - Monitored implementation of the initiatives in the capitated Medicaid managed care program, focusing on selective contracting strategies

- Analyzed value-based purchasing strategies for the Managed LTC RFI under the Integrated Care for Medicare and Medicaid beneficiaries and Medicaid-only beneficiaries opportunities
- Planned for the Medicare DMEPOS Selective Contracting round two initiative
- Develop and implement procurement strategies that are based on acuity level and the needs of beneficiaries
 - Continued to refine recommendations for long-term care acuity adjustments to meet budget targets
 - Submitted the State Plan Amendment for the implementation of the RI Nursing Facility Payment Methodology refinements
- Continue to execute the State's comprehensive communications strategy to inform stakeholders (consumers and families, community partners, and State and Federal agencies) about the Section 1115 Waiver
 - Convened three (3) meetings with the Section 1115 Waiver Task Force on 01/28/2013, 02/25/2013, and 03/25/2013
 - Convened the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 03/06/2013
 - To promote transparency, meeting notes and agenda for the Global Waiver Task Force and the Rhode Island Medicaid Medical Advisory Committee (MCAC) were posted on the EOHHS' Web-site
 - Developed and posted the draft 1115 Waiver Extension
 - Convened Public Process on the 1115 Demonstration Waiver extension request
 - Presented overview and solicited public input of the 1115 Demonstration Waiver extension request
 - Convened three (3) Community Forums on the Rhode Island Section 1115 Research and Demonstration Waiver Extension Request on 01/28/2013, 02/11/2013, and 02/19/2013
 - Posted responses to public comments on 1115 Waiver Extension request
 - Submitted Rhode Island's Section 1115 Waiver Extension Request to CMS (March 2013)
 - Received CMS' response that the 1115 Waiver Extension request was incomplete
 - Updated the EOHHS Web-site information on the Integrated Care for Medicare and Medicaid Beneficiaries
 - Continued efforts to re-design the EOHHS Web-site to improve communications and transparency
 - Posted EOHHS Notice of Proposed Rulemaking and Policy Changes in February and March
 - Posted the following information on the EOHHS Web-site:
 - Draft Section 1115 Waiver Extension Request (January 2013)
 - Review of the Basic Health Program Option for Rhode Island (January 2013)
 - Funding the Children's Health Account and Immunization Programs for Adults and Children through Claims Assessment (January 2013)
 - Medicaid Report to the Rhode Island Senate, April – June 2012 (January 2013)

- Global Waiver Quarterly Report, October – December 2012 (February 2013)
- Integrated Care Initiative/Category II Change Request to CMS (02/11/2013)
- Integrated Care Initiative (ICI) “Interested Parties” Letter (02/11/2013)
- Responses to Frequently Asked Questions (FAQs) regarding the Medicaid Primary Care Fee Increase (02/21/2013)
- Responses to Public Comments regarding the draft Waiver Extension (March 2013)
- Section 1115 Waiver Extension Request (March 2013)
- Primary Care Rate Increase “Interested Parties” Letter (03/18/2013)

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 2013 (January 1, 2013 – March 31, 2013). 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 2013.

RI MEDICAID: Medicaid Long-term Care Acceptances (Approvals), Q-3, SFY 2013

Month	Long-Term Care Approvals
January 2013	266
February 2013	223
March 2013	269
Total for Q-3, SFY 2013	758

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 2013 (January 1, 2013 – March 31, 2013). 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 2013.

RI MEDICAID: Medicaid Long-term Care Denials, Q-3, SFY 2013

Month	Long-Term Care Denials
January 2013	47
February 2013	42
March 2013	47
Total for Q-3, SFY 2013	136

Source: InRhodes

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

Two data sources have been queried to produce the data pertaining to the number of Medicaid beneficiaries, stratified according to two age groups (less than 65 years of age and greater than or equal to 65 years of age) who were served in institutional and home and community-based long-term care settings, by provider and service type and/or delivery system during the Third Quarter of SFY 2013 (January 1, 2013 – March 31, 2013).

Data Sources: Using the EOHHS Data Warehouse, information was extracted from the Medicaid Management Information System (MMIS) to produce counts of the number of Medicaid beneficiaries who received LTC services that are administered by the RI Division of Elderly Affairs and RI Medicaid. 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 2013 (RI Division of Elderly Affairs (DEA): The first set of tables quantifies the number (or count) of individuals who received LTC services provided under the auspices of the Rhode Island Division of Elderly Affairs (RI DEA) during the Third Quarter of SFY 2013 (January 1, 2013 – March 31, 2013).

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		Q-3, SFY 2013	
Reporting Period: Date of Service			2013		2013		2013			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
	Assisted Living	Under 65	59	1,776	58	1,597	61	1,864	178	5,237
		65 and Older	275	8,243	275	7,416	272	8,172	822	23,831
DEA	Assisted Living	Service Type Subtotals:	334	10,019	333	9,013	333	10,036	1,000	29,068
	Case Management	Under 65	39	160	36	89	44	169	119	418
		65 and Older	564	2,819	555	2,445	574	2,731	1,693	7,995
DEA	Case Management	Service Type Subtotals:	603	2,979	591	2,534	618	2,900	1,812	8,413
	Personal Care/Homemaker	65 and Older	414	114,236	410	101,045	411	117,731	1,235	333,012
DEA	Personal Care/Homemaker	Service Type Subtotals:	414	114,236	410	101,045	411	117,731	1,235	333,012
DEA		Grand Total:		127,234		112,592		130,667		370,493

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 2013 (RI Medicaid): The second set of tables shows the number (or count) of individuals who received LTC services through Rhode Island Medicaid during the Third Quarter of SFY 2013. This information reflects incurred dates of service (January 1, 2013 through March 31, 2013) 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.

RI Medicaid: LTC Service Type and Corresponding Unit of Service

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

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

service whereas skilled nursing services provided by a registered nurse are counted on a per visit basis.

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 EOHHS: Adult day care; assisted living; case management; home health agency; hospice; nursing facility; personal care/homemaker; shared living and Tavares Pediatric Center.

This information has been stratified by month and by age group. Data tables are shown below, with information organized by month for the Third Quarter of SFY 2013.

Source: EOHHS Data Warehouse: MMIS Claim Universe			January		February		March		Q-3, SFY 2013	
Reporting Period:	Date of Service		2013		2013		2013			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
EOHHS	Adult Day Care	Under 65	268	3,944	264	3,352	264	3,866	796	11,162
		65 and Older	275	3,825	280	3,459	304	4,061	859	11,345
		Service Type Subtotals:	543	7,769	544	6,811	568	7,927	1,655	22,507
EOHHS	Assisted Living	Under 65	16	496	14	392	15	447	45	1,335
		65 and Older	132	3,976	129	3,507	127	3,747	388	11,230
		Service Type Subtotals:	148	4,472	143	3,899	142	4,194	433	12,565
EOHHS	Case Management	Under 65	392	902	324	1,100	291	740	1,007	2,742
		65 and Older	212	898	130	562	111	522	453	1,982
		Service Type Subtotals:	604	1,800	454	1,662	402	1,262	1,460	4,724
EOHHS	Hospice	Under 65	22	483	21	479	24	581	67	1,543
		65 and Older	512	12,376	471	10,819	461	11,200	1,444	34,395
		Service Type Subtotals:	534	12,859	492	11,298	485	11,781	1,511	35,938
EOHHS	Nursing Facility	Under 65	585	16,566	575	14,956	571	16,431	1,731	47,953
		65 and Older	5,184	153,284	5,119	136,700	5,100	151,431	15,403	441,415
		Service Type Subtotals:	5,769	169,850	5,694	151,656	5,671	167,862	17,134	489,368
EOHHS	Personal Care/Homemaker	Under 65	1,080	310,077	1,072	276,082	1,071	308,444	3,223	894,603
		65 and Older	1,414	425,988	1,412	375,741	1,405	420,137	4,231	1,221,866
		Service Type Subtotals:	2,494	736,065	2,484	651,823	2,476	728,581	7,454	2,116,469
EOHHS	Shared Living Agency	Under 65	17	3,279	19	2,116	21	2,903	57	8,298
		65 and Older	58	6,515	57	5,474	58	5,083	173	17,072
		Service Type Subtotals:	75	9,794	76	7,590	79	7,986	230	25,370
EOHHS	Skilled Nursing	Under 65	211	3,109	199	2,671	200	2,669	610	8,449
		65 and Older	133	2,499	127	1,887	121	2,082	381	6,468
		Service Type Subtotals:	344	5,608	326	4,558	321	4,751	991	14,917
EOHHS	Tavares Pediatric Center	Under 65	20	620	20	560	20	620	60	1,800
		Service Type Subtotals:	20	620	20	560	20	620	60	1,800
EOHHS		Grand Total:		948,837		839,857		934,964		2,723,658

The Number of Medicaid Beneficiaries Served by PACE, Q-3, SFY 2013 (RI Medicaid): Using the EOHHS Data Warehouse, information was extracted from the MMIS to produce counts of the number of individuals who participated in the PACE (Program of All Inclusive Care for the Elderly) program during the Third Quarter of SFY 2013 (January 1, 2013 – March 31, 2013). Please refer to the data table shown on the following page. This information has been stratified by month and by age group.

Source: EOHHS Data Warehouse/Financial Data Mart				
Reporting Period:		Eligibility Period		
Dept.	Benefit Period	Program Description	Age Group	Person Count
EOHHS	1/1/2013	PACE PROGRAM	65 and Over	202
EOHHS		PACE PROGRAM	Under 65	39
	1/1/2013		Period Totals:	241
EOHHS	2/1/2013	PACE PROGRAM	65 and Over	201
EOHHS		PACE PROGRAM	Under 65	39
	2/1/2013		Period Totals:	240
EOHHS	3/1/2013	PACE PROGRAM	65 and Over	206
EOHHS		PACE PROGRAM	Under 65	40
	3/1/2013		Period Totals:	246
			Quarterly Total:	727

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, SFY 2013 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). As requested, this information has been stratified according to two age groups for participants for the following lines of service which are administered by the RI BHDDH: Day programs; homemaker services; public group homes for persons with developmental disabilities; private group homes for persons with developmental disabilities; family supports; shared living; and supported employment. Data for the Third Quarter of SFY 2013 (January 1, 2012 – March 31, 2013) are shown on the following page.

Source: RI, BHDDH, Medicaid LTC Beneficiaries, Q-3, SFY 2013			
Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2,686
		Over 65	264
BHDDH	Homemaker	Under 65	119
		Over 65	5
BHDDH	Public Group Homes	Under 65	145
		Over 65	77
BHDDH	Private Group Homes	Under 65	1,067
		Over 65	171
BHDDH	Community Supports	Under 65	1,035
		Over 65	68
BHDDH	Shared Living	Under 65	209
		Over 65	17
BHDDH	Supported Employment	Under 65	285
		Over 65	6
BHDDH	Case Management	Under 65	2,862
		Over 65	272
BHDDH	Transportation	Under 65	2,269
		Over 65	188
BHDDH	Prevocational	Under 65	155
		Over 65	11
BHDDH	Job Development	Under 65	58
		Over 65	0

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 2013 (January 1, 2013 – March 31, 2013). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one that shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

Data Sources: Two data sources have been used in producing the cost and utilization information which has been requested. The first data source is Rhode Island's Medicaid Management Information System (MMIS). Using the EOHHS Data Warehouse, information was extracted from the MMIS for the LTC services administered by the RI Division of Elderly Affairs and RI Medicaid.

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 2013.

Cost and Utilization Data, Q-3, SFY 2013 (RI Division of Elderly Affairs (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 2013.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-3, SFY 2013	
Reporting Period:	Date of Service			
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
	Assisted Living	Under 65	\$ 964	\$ 171,524
		65 and Older	\$ 856	\$ 703,970
DEA	Assisted Living	Service Type Subtotals:	\$ 875	\$ 875,494
	Case Management	Under 65	\$ 53	\$ 6,270
		65 and Older	\$ 71	\$ 119,925
DEA	Case Management	Service Type Subtotals:	\$ 70	\$ 126,195
	Personal Care/Homemaker	65 and Older	\$ 1,357	\$ 1,676,174
DEA	Personal Care/Homemaker	Service Type Subtotals:	\$ 1,357	\$ 1,676,174
DEA		Grand Total:		\$ 2,677,863

Cost and Utilization Data, Q-3, SFY 2013 (RI Medicaid): The following table provides an average cost per individual, as well as quarterly totals by RI Medicaid service line, for the two age groups during the Third Quarter of SFY 2013.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-3, SFY 2013	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
EOHHS	Adult Day Care	Under 65	\$ 743	\$ 591,363
		65 and Older	\$ 700	\$ 601,059
EOHHS	Adult Day Care	Service Type Subtotals:	\$ 720	\$ 1,192,422
	Assisted Living	Under 65	\$ 1,250	\$ 56,252
		65 and Older	\$ 1,140	\$ 442,361
EOHHS	Assisted Living	Service Type Subtotals:	\$ 1,152	\$ 498,613
	Case Management	Under 65	\$ 103	\$ 104,031
		65 and Older	\$ 65	\$ 29,386
EOHHS	Case Management	Service Type Subtotals:	\$ 91	\$ 133,417
	Hospice	Under 65	\$ 4,315	\$ 289,131
		65 and Older	\$ 3,650	\$ 5,270,024
EOHHS	Hospice	Service Type Subtotals:	\$ 3,679	\$ 5,559,155
	Nursing Facility	Under 65	\$ 4,795	\$ 8,299,840
		65 and Older	\$ 4,650	\$ 71,630,143
EOHHS	Nursing Facility	Service Type Subtotals:	\$ 4,665	\$ 79,929,983
	Personal Care/Homemaker	Under 65	\$ 1,422	\$ 4,581,783
		65 and Older	\$ 1,473	\$ 6,233,479
EOHHS	Personal Care/Homemaker	Service Type Subtotals:	\$ 1,451	\$ 10,815,262
	Shared Living Agency	Under 65	\$ 2,315	\$ 131,962
		65 and Older	\$ 2,074	\$ 358,716
EOHHS	Shared Living Agency	Service Type Subtotals:	\$ 2,133	\$ 490,678
	Skilled Nursing	Under 65	\$ 409	\$ 249,699
		65 and Older	\$ 552	\$ 210,356
EOHHS	Skilled Nursing	Service Type Subtotals:	\$ 464	\$ 460,055
	Tavares Pediatric Center	Under 65	\$ 21,931	\$ 1,315,840
EOHHS	Tavares Pediatric Center	Service Type Subtotals:	\$ 21,931	\$ 1,315,840
EOHHS		Grand Total:		\$ 100,395,425

Cost and Utilization Data, Q-3, SFY 2013 (RI BHDDH): Cost and utilization 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). Please refer to the table shown on the following page.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-3, SFY 2013				
Dept.	Service Type	Age Group	# Served	Total Expenditures
BHDDH	Day Programs	Under 65	2,686	\$7,657,023.94
		Over 65	264	701,765.17
BHDDH	Homemaker	Under 65	119	784,959.53
		Over 65	5	42,423.32
BHDDH	Public Group Homes	Under 65	145	5,650,390.02
		Over 65	77	2,989,862.19
BHDDH	Private Group Homes	Under 65	1,067	19,858,508.75
		Over 65	171	3,043,916.42
BHDDH	Community Supports	Under 65	1,035	2,841,264.94
		Over 65	68	256,869.82
BHDDH	Shared Living	Under 65	209	2,112,268.27
		Over 65	17	173,782.18
BHDDH	Supported Employment	Under 65	285	338,736.56
		Over 65	6	3,850.30
BHDDH	Case Management	Under 65	2,862	1,228,447.44
		Over 65	272	121,698.61
BHDDH	Transportation	Under 65	2,269	2,004,246.15
		Over 65	188	166,100.66
BHDDH	Prevocational	Under 65	155	138,933.95
		Over 65	11	12,763.76
BHDDH	Job Development	Under 65	58	28,873.04
		Over 65	0	0

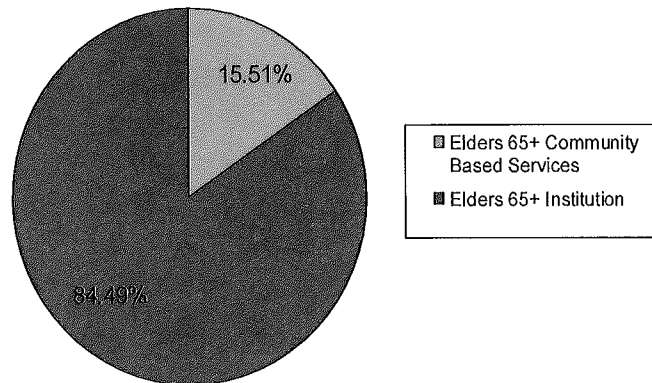
E. Percent distribution of expenditures for Medicaid long-term care institutional services and home and community services (HCBS) by population, including: elders aged 65 and over, persons with disabilities, and children with special health care needs.

Medicaid Long Term Care (LTC) services are available for individuals over age 65 and for individuals with disabilities. The types of services available include institutional and home and community-based services. The following charts show the percent distribution of expenditures for Medicaid long-term care institutional services and home and community-based services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (January 1, 2013 – March 31, 2013).

Elders Aged 65 and Over

During the Third Quarter of SFY 2013, 84.49 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.51 percent were for home and community-based services (HCBS).

Q-3, SFY 2013



Findings for the Third Quarter were comparable to those observed during the two preceding quarters in SFY 2013. Expenditures for Medicaid LTC institutional services for elders aged 65 and older = 84.02 percent during the First Quarter and 83.98 percent during the Second Quarter of SFY 2013. Expenditures for community-based services for this age cohort = 15.98 percent during the First Quarter and 16.02 percent during the Second Quarter of SFY 2013.

The experience during the first three quarters of SFY 2013 has been similar to the preceding State Fiscal Year. Please refer to the following table, which depicts this information for State Fiscal Year 2012.

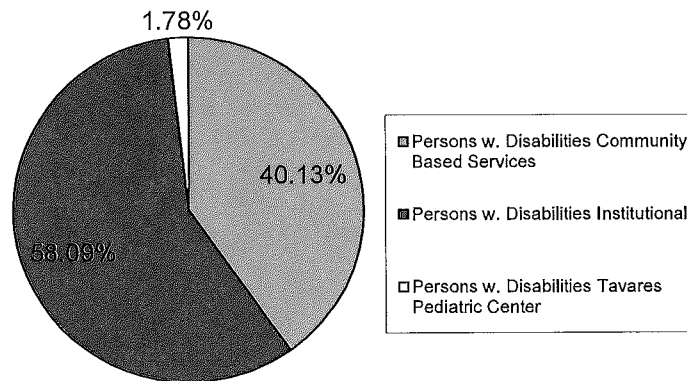
RI Medicaid: LTC Expenditures for Elders, 65 Years of Age and Older (SFY 2012)

Quarter	Institutional Services	Home & Community-based Services
Q-4, SFY 2102	84.03%	15.97%
Q-3, SFY 2012	84.56%	15.44%
Q-2, SFY 2012	84.98%	15.02%
Q-1, SFY 2012	84.20%	15.80%

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 chart shown below depicts the percent distribution of expenditures for Medicaid institutional services and home and community services for persons with disabilities. The utilization data were abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (January 1, 2013 – March 31, 2013).

Q-3, SFY 2013



During the Third Quarter of SFY 2013, 58.09 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services, 1.78 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services at the Tavares Pediatric Center, and 40.13 percent were for home and community-based services (HCBS).

Findings for the Third Quarter were comparable to those observed during the two preceding quarters in SFY 2013. Expenditures for Medicaid LTC institutional services for persons with disabilities = 57.31 percent during the First Quarter and 57.80 percent during the Second Quarter of SFY 2013. Expenditures for community-based services for persons with disabilities = 40.55 percent during the First Quarter and 40.31 percent during the Second Quarter of SFY 2013. The corresponding findings for the percentage of expenditures for persons with disabilities at the Tavares Pediatric Center = 2.14 percent during the First Quarter and 1.90 percent during the Second Quarter of SFY 2013.

The experience during the first three quarters of SFY 2013 has been similar to the preceding State Fiscal Year. The following table depicts this information for State Fiscal Year 2012.

RI Medicaid: LTC Expenditures for Persons with Disabilities (SFY 2012)

Quarter	Institutional Services	Tavares Pediatric Center	Home & Community-based Services
Q-4, SFY 2012	56.96%	2.49%	40.54%
Q-3, SFY 2012	56.98%	2.49%	40.53%
Q-2, SFY 2012	57.04%	2.53%	40.43%
Q-1, SFY 2012	57.09%	2.04%	40.87%

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

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

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

During the Third Quarter of State Fiscal Year 2013, there were no waiting lists for Medicaid LTC services. In addition, the Division of Elderly Affairs and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH) reported that there were no waiting lists for any long-term care services.

Due to provider staffing issues that occurred during the Third Quarter of SFY 2013, the Personal Choice program began to experience a delay in assessing beneficiaries who were receiving home and community-based services and wished to switch to the Personal Choice program. Beneficiaries who are newly-eligible with no home and community-based services have been prioritized for Personal Choice assessments and enrollment into that program.

The State has recently begun to collect data in a different and more precise way from the provider of the State's Home-delivered Meals program and has identified a very limited waiting list for a service that is relevant to a cohort of Medicaid LTC beneficiaries who receive Waiver services, reside in their homes, and qualify for *home-delivered meals*. The delivery of home-based meals is based on need: those individuals who are most frail and have no other resources for meal preparation are given priority access to this service and are not obliged to wait for this service. Those who qualify but may have temporary options may be subject to a limited delay, in large part due to the lack of available drivers for all of the routes. The Division of Elderly Affairs administers the program and they are working with the provider, on an ongoing basis, to monitor the limited waiting list for any variation.

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

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

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

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

The following information, provided by the Division of Elderly Affairs, covers the Third Quarter of SFY 2013 (January 1, 2013 – March 31, 2013). The tables shown below document the service utilization of the DEA’s Adult Day Care and Home Care Program (also referred to as the “Co-pay” Program). This information has been organized for each type of service by quarter.

RI DEA: Adult Day Care (Q-3, SFY 2013)

Service Category: Adult Day Care	Clients*		Units (Unit=1 Day)	
	Total	Avg/Mo.	Total	Avg/Mo.
D1 (Income up to 125% FPL):	119	40	1,634	545
D2 (Income up to 200% FPL):	576	192	7,856	2,619
Total	695	232	9,490	3,164

Average utilization = 13.65 days of adult day care per client per month.
 *Clients are not distinct.

RI DEA: Case Management (Q-3, SFY 2013)

Service Category: Case Management	Clients		Units (Unit=1/4 Hour)	
	Total	Avg/Mo.	Total	Avg/Mo.
Case Management	1,069	356	6,483	2,161

Average utilization = 1.52 Hours of Case management per client per month.

RI DEA: Home Care (Q-3, SFY 2013)

Service Category: Home Care	Clients*		Units (Unit=1/4 Hour)	
	Total	Avg/Mo.	Total	Avg/Mo.
D1 (Income up to 125% FPL):	433	144	48,539	16,180
D2 (Income up to 200% FPL):	1,551	517	178,371	59,457
Total	1,984	661	226,910	75,637

Average utilization = 114.37 units or 28.59 hours of home care per client per month.
 *Clients are not distinct.

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

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

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. Thus, the EOHHS has interpreted that a completed LTC application would be inclusive of all of the requisite components needed in order to execute a LTC eligibility determination. Most new LTC applications, however, are not submitted in a fully complete manner. As noted in the Rhode Island Department of Human Services' *Codes of Rules, Medical Assistance*, eligibility decisions for disabled applicants are to be made within ninety (90) days, except in unusual circumstances when good cause for delay exists.² Good cause exists when the DHS cannot reach a decision because the applicant or examining physician delays or fails to take a required action or when there is an administrative or other emergency beyond the agency's control.

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

- If there are any questions about the negotiability of promissory notes, mortgages, and loans³
- If a resource cannot be sold or liquidated and a determination regarding availability cannot be made by the LTC Administrator⁴
- If an individual claims that a real property resource cannot be liquidated and documentation has been submitted from a competent authority (e.g., real estate broker or attorney)⁵
- If there is a claim of undue hardship, the LTC Administrator, in consultation with the Office of Legal Counsel, makes a determination⁶

²² The Rhode Island Department of Human Services. *Code of Rules, Medical Assistance*, Section 0302.15 (*Decision on Eligibility*), <https://www.policy.dhs.ri.gov/>.

³ Ibid, Section 0382.15.20.05 (*Negotiability of Instruments*), <https://www.policy.dhs.ri.gov/>.

⁴ Op cit, Section 0382.15.20.15 (*Salability*), <https://www.policy.dhs.ri.gov/>.

⁵ Op cit, Section 0382.10.10.10 (*Docu Non-Avail of Real Est*), <https://www.policy.dhs.ri.gov/>.

⁶ Op cit, Section 0382.50.25 (*Claims of Undue Hardship*), <https://www.policy.dhs.ri.gov/>.

- If consultation is needed by the LTC Administrator to aid in the determination of the amount of countable income and/or resources from a trust (and the date and amount of any prohibited transfer of assets)⁷

Information has been drawn from InRhodes, the State's Medicaid eligibility system, to produce the following cohort analysis for LTC processing turn-around times during the Third Quarter of SFY 2013 (January 1, 2013 – March 31, 2013). Turn-around times (TAT) for processing new LTC applications have been organized according to three timeframes: a) less than thirty (30) days; b) thirty (30) to ninety (90) days; and greater than ninety (90) days.

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

The following statistics, however, reflect the processing of new applications for long-term care (LTC) coverage for individuals who are not already enrolled in Medicaid. Thus, the following information, which focuses on the Third Quarter of SFY 2013, addresses a specific subset of the LTC applications that are processed by RI Medicaid.

RI MEDICAID: Turn-around Times for New LTC Applications (Q-3, SFY 2013)

Month	< 30 Days		30 – 90 Days		> 90 Days		Monthly Total	
Jan. 2013	116	26%	219	48%	119	26%	454	100%
Feb. 2013	145	30%	222	45%	123	25%	490	100%
March 2013	148	32%	214	46%	106	23%	468	100%
Total for Q-3, SFY 2013	409	29%	655	46%	348	25%	1412	100%

Source: InRhodes

For purposes of comparison, the quarterly information from the preceding State Fiscal Year has been shown on the following page. As noted previously, the statistics presented for SFY 2012 reflect the processing of new applications for LTC coverage for individuals who were not already enrolled in Medicaid.

⁷ Op cit, Section 0382.50.15 (*Trust Evaluation Process*), <https://www.policy.dhs.ri.gov/>.

RI MEDICAID: Turn-around Times for New LTC Applications (SFY 2012)

Quarter	< 30 Days		30 – 90 Days		> 90 Days		Quarterly Total	
Q-4, SFY 2012	392	29.81%	683	51.94%	240	18.25%	1,315	100%
Q-3, SFY 2012	440	33.38%	632	47.95%	246	18.66%	1,318	100%
Q-2, SFY 2012	414	33.17%	649	52.0%	185	14.82%	1,248	100%
Q-1, SFY 2012	344	31.07%	635	57.36%	128	11.56%	1,107	100%

Source: InRhodes

For the Third Quarter of SFY 2013, InRhodes data have been further analyzed in order to quantify the average number of days for approving or denying new applications for Medicaid LTC coverage. The following table shows the average turn-around time (TAT) in days for Medicaid LTC approvals during the Third Quarter of SFY 2013 and the average TAT for Medicaid LTC denials during the same interval. The calculated averages for TATs have been provided and in addition these figures have been rounded up to whole integers.

RI MEDICAID: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-3, SFY 2013)

Number of Approvals for Medicaid LTC	Average TAT in Days
758	56.28 (~ 57 Days)

Source: InRhodes

RI MEDICAID: Average Turn-around Time (TAT) in Days for Medicaid LTC Denials (Q-3, SFY 2013)

Number of Denials for Medicaid LTC	Average TAT in Days
136	22.38 (~ 23 Days)

Source: InRhodes

The average turn-around times for Medicaid LTC approvals and denials shown in the preceding tables were comparable to those observed during the Second Quarter of SFY 2013, when approvals occurred on average at ~ 52 days and denials at ~ 17 days. The findings from Q-3, SFY 2013 demonstrate that new Medicaid LTC approvals and denials continue to be processed in less than 90 days.

As discussed in prior reporting periods, SSI-related outliers can artificially increase the turn-around time statistic for LTC approvals. For the SSI cohort, one of two dates has been recorded as the application date, depending upon whether: a) the individual has been newly added to SSI; or b) has already been SSI-eligible but has moved to Rhode Island from another state. The application date for individuals who are newly approved for SSI is recorded as the “Onset of Disability” date, which Rhode Island receives from the Social Security Administration (SSA). However, for SSI-eligible individuals who relocate to Rhode Island from another state, the application date is set as the first day of the following month, based on the “Residency Begin Date”, which is sent by the Social Security Administration (SSA). For those individuals who relocate to Rhode Island from another state, the SSA does not always indicate the relocation status on the clients’ records. Therefore, the individual is viewed as a new SSI beneficiary and the “Onset of Disability” date is recorded rather than the “Residency Begin Date”, resulting in an inflated turn-around time.

For purposes of comparison, the following table has been provided to demonstrate the average turn-around times in calendar days for Medicaid LTC approvals and denials during SFY 2012. In the following table, the turn-around time statistics have been rounded up to whole numbers and the quarterly data have been presented in descending order.

RI MEDICAID: Average Turn-around Times for Medicaid LTC Approvals and Denials by Quarter (SFY 2012)

Quarter	Average TAT in Calendar Days for Medicaid LTC Approvals	Average TAT in Calendar Days for Medicaid LTC Denials
Q-4, SFY 2012	49 Days	15 Days
Q-3, SFY 2012	49 Days*	19 Days*
Q-2, SFY 2012	54 Days*	10 Days
Q-1, SFY 2012	49 Days*	17 Days

Source: InRhodes

The asterisk (*) shown above indicates that several outliers were excluded.

Additional comparative information, from State Fiscal Year 2011, has been provided below. The figures shown below have been rounded up to whole numbers.

RI MEDICAID: Average Turn-around Times for Medicaid LTC Approvals and Denials by Quarter (SFY 2011)

Quarter	Average TAT in Calendar Days for Medicaid LTC Approvals	Average TAT in Calendar Days for Medicaid LTC Denials
Q-1, SFY 2011	65 Days	11 Days
Q-2, SFY 2011	65 Days	11 Days
Q-3, SFY 2011	59 Days	16 Days
Q-4, SFY 2011	42 Days*	12 Days

Source: InRhodes

An asterisk has been flagged to highlight that the InRhodes turn-around time (TAT) statistic, which has been presented for Q-4 of SFY 2011, had several outliers excluded. As was the case in SFY 2012, Medicaid LTC approvals and denials were processed on average below a 90-day threshold throughout SFY 2011.

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

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

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

Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI Medicaid), using three clinical levels of care: Highest, High, and Preventive. The following data have been extracted from the RI EOHHS Data Warehouse and are based upon the clinical eligibility determinations that were performed during the Third Quarter of SFY 2013.

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria for Nursing Facility or Hospital (Habilitation) Services (Q-3, SFY 2013)

Clinical Eligibility Level of Care Criteria	Q-3, SFY 2013
Nursing Facility	903
Hospital (HAB applicants)*	N/A*

Data Source: RI EOHHS Data Warehouse

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. The findings for the Third Quarter of SFY 2013 are comparable to those observed during the two preceding quarters. Information from the first two quarters of SFY 2013 has been documented below.

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria for Nursing Facility or Hospital (Habilitation) Services (Q-1 and Q-2, SFY 2013)

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.

Clinical Eligibility Level of Care Criteria	Q-1, SFY 2013	Q-2, SFY 2013
Nursing Facility	918	809
Hospital (HAB applicants)*	N/A*	N/A*

To provide additional baseline information, the following table documents the quarterly findings from State Fiscal Year 2012.

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria for Nursing Facility or Hospital (Habilitation) Services (SFY 2012)

Clinical Eligibility Level of Care Criteria	Q-1, SFY 2012	Q-2, SFY 2012	Q-3, SFY 2012	Q-4, SFY 2012
Nursing Facility	1,075	785	1,168	974
Hospital (HAB applicants)*	0	0	0	0

For further purposes of comparison, the following table documents the number of applicants for Medicaid LTC who met the clinical eligibility criteria for nursing facility or hospital (habilitation) services on a quarterly basis during SFY 2011.

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria for Nursing Facility or Hospital (Habilitation) Services, by Quarter (SFY 2011)

Clinical Eligibility Level of Care Criteria	Q-1, SFY 2011	Q-2, SFY 2011	Q-3, SFY 2011	Q-4, SFY 2011
Nursing Facility	858	841	939	791
Hospital (HAB applicants)*	3	0	0	0

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

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. During the Third Quarter of SFY 2013, seventy-nine (79) eligibility applications were received and twenty (20) individuals were determined to have met the eligibility criteria. Twenty (20) cases were reopened and sixteen (16) were determined not to be eligible. Also during Q-3 of SFY 2013, eleven (11) hospital applications were made to the RI BHDDH.

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

Turnaround Times for Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI Medicaid) since implementation of the Global Waiver. The following data have been extracted from the RI EOHHS Data Warehouse, based upon the clinical eligibility determinations that were performed during the Third Quarter of SFY 2013. 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.

RI Medicaid: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations (Q-3, SFY 2013)

	Q-3, SFY 2013	
	Average	Median
Nursing Facility Care	11.186 Days (~ 12 Days)	6.00 Days
Hospital/(HAB applicants)	N/A*	N/A*

Data Source: RI EOHHS Data Warehouse

There were no applicants for Medicaid LTC who met the clinical eligibility criteria for a hospital (or habilitation) level of care during the Third Quarter of SFY 2013. Therefore, the average and median TAT cells were marked with "N/A*" in the preceding table.

The findings from the Third Quarter of SFY 2013 were similar to those observed during the first two quarters of State Fiscal Year 2013. For Nursing Facility Care, the average (mean) TAT for Medicaid LTC clinical eligibility determinations was thirteen (13) calendar days during Q-1 of SFY 2013 and nine (9) calendar days during Q-2 of SFY 2013. The median TAT for Nursing Facility Care was seven (7) calendar days during Q-1 of SFY 2013 and five (5) calendar days during Q-2 of SFY 2013.

To provide further comparative information, the quarterly mean (average) and median turnaround time statistics for SFY 2012 have been depicted below.

RI Medicaid: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations, by Quarter (SFY 2012)

	Q-1, SFY 2012		Q-2, SFY 2012		Q-3, SFY 2012		Q-4, SFY 2012	
Nursing Facility Care	17 days	15 days	16 days	12 days	17 days	13 days	9 days	6 days
Hospital/HAB Applicants	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*

The table shown below documents the average and median turnaround time in calendar days for Medicaid LTC clinical eligibility determinations on a quarterly basis during SFY 2011.

RI Medicaid: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations, by Quarter (SFY 2011)

	Q-1, SFY 2011		Q-2, SFY 2011		Q-3, SFY 2011		Q-4, SFY 2011	
Nursing Facility Care	26 days	26 days	24 days	21 days	7 days	6 days	12 days	7 days
Hospital/HAB Applicants	25	28	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*

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

Turnaround Times for Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH):

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

During the Third Quarter of SFY 2013, the Division reported that eligibility determinations were processed on average within one hundred (100) days from the time of application. This timeframe reflects that not all applications are fully completed when submitted for eligibility determination. Incomplete applications necessitate seeking additional documentation that is necessary in order to make an eligibility determination.

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/habilitation⁹ care have been conducted by the Office of Medical Review at Rhode Island Medicaid. 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 Rhode Island Medicaid: The following data have been provided by RI Medicaid's 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 2013.

RI Medicaid: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-3 (SFY 2013)

Appeals of LTC Clinical Eligibility Determinations by Level of Care	Q-3, SFY 2013
Nursing Facility	2
Hospital/Habilitation	0

Source: Office of Medical Review, RI Medicaid

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 filed during the Third Quarter of SFY 2013.

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 Rhode Island Medicaid 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 Rhode Island Medicaid 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.

Through the Nursing Home Transition Program, within the Office of Community Programs at Rhode Island Medicaid, assistance is provided to beneficiaries before, during, and following a transition from nursing facilities. These functions are undertaken to ensure the provision of timely and appropriate services that enable these individuals to move safely and successfully to either a home-based or a community-based setting. 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.

The following table documents the number of nursing home transitions that took place during the Third Quarter of State Fiscal Year 2013. As was the case in prior reporting periods, the average length of stay (ALOS) has been measured in calendar days, with rounding up to the next integer.

RI Medicaid: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-3, SFY 2013)

	Q-3, SFY 2013
Number of Nursing Home Transitions	32
Average Length of Stay (ALOS) Prior to Transfer in Calendar Days	237.22 Days (~ 238 Days)

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

The total number of nursing home transitions that occurred during the Third Quarter of SFY 2013 (n = 32) was similar to the experience during the two preceding quarters. There had been 31 nursing transitions during both of the preceding quarters in SFY 2013.

On a quarterly basis, some differences have been observed in the average length of stay (ALOS) statistic. This fluctuation is attributed to the presence of any outlier cases within a quarter. The ALOS prior to nursing home transitions during Q-3 of SFY 2013 was 238 days, which exceeded the corresponding statistic (ALOS = 197 days) during Q-1 of SFY 2013, but was less than that observed in Q-2 of SFY 2013 (ALOS = 287 days).

The table shown on the following page documents the type of living arrangement (or setting) that LTC beneficiaries who were transitioned from a nursing facility went to subsequent to their discharge during the Third Quarter of SFY 2013.

RI Medicaid: The Type of Living Arrangement or Setting and Services upon Transfer for Persons Transitioned from Nursing Homes (Q-3, SFY 2013)

	Q-3, SFY 2013	
Existing Home	25	78%
Assisted Living	3	9%
New Housing	4	13%
Group Home	0	0%
Other	0	0%
Total	32	100%

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

The following table documents quarterly findings throughout SFY 2012.

RI Medicaid: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (SFY 2012)

	Q-1, SFY 2012	Q-2, SFY 2012	Q-3, SFY 2012	Q-4, SFY 2012
Number of Nursing Home Transitions	31	36	40	42
Average Length of Stay (ALOS) Prior to Transfer in Calendar Days	196	240	259	212

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

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

Prior to the start of SFY 2011, The Alliance for Better Long Term Care partnered with Qualidigm¹⁰ and Rhode Island Medicaid on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of RI Medicaid and the Division of Elderly Affairs in the identification of residents who could be transitioned safely. In collaboration with representatives of the RI EOHHS, the Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting. As of July of 2010, the functions that had been conducted by the Alliance were transferred to the Nursing Home Transition Program, within the Office of Community Programs at Rhode Island Medicaid.

As noted in Item M, there were thirty-two (32) LTC beneficiaries who were transitioned from nursing facilities during the Third Quarter of SFY 2013 (January 1, 2013 through March 31, 2013). The Office of Community Programs at Rhode Island Medicaid reported that there were no (0) failed placements during the Third Quarter of SFY 2013.

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

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

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

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

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

Cohort Analysis for RItE Care/RItE Share Applicants: For the purpose of the following cohort analysis, two major groups comprised the RItE Care/RItE Share applicant population and information has been provided for each group during the Third Quarter of SFY 2013 (January 1, 2013 through March 31, 2013). These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works¹¹ 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”¹².

RI MEDICAID: Applications for Rhode Island Works/RItE Care and “Other” Category of Applicants, Q-3, SFY 2013

Month	Rhode Island Works	“Other”
January 2013	3,825	270
February 2013	3,128	248
March 2013	3,447	265
Total for Q-3 of SFY 2013	10,400	783

Source: InRhodes

Please refer to the following table, which documents the number of applications for the Rhode Island Works and the “Other” cohorts during the first two quarters in SFY 2013.

RI MEDICAID: Applications for Rhode Island Works/RItE Care and “Other” Category of Applicants, Q-1 and Q-2, SFY 2013

Quarter	Rhode Island Works	“Other”
Q-2, SFY 2013	9,331	906
Q-1, SFY 2013	10,065	849

The findings from the first three quarters of SFY 2013 are comparable to the experience that was demonstrated during the preceding State Fiscal Year. The quarterly findings from SFY 2012 have been presented below in reverse chronological order.

¹¹ 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.

¹² “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 MEDICAID: Applications for Rhode Island Works/Rite Care and “Other” Category of Applicants, by Quarter (SFY 2012)

Quarter	Rhode Island Works	“Other”
Q-4, SFY 2012	10,200	852
Q-3, SFY 2012	10,880	878
Q-2, SFY 2012	9,912	864
Q-1, SFY 2012	9,942	912
Total for SFY 2012	40,934	3,506

To provide additional comparative information, the following table shown on the following page documents the number of applications that were made by quarter during SFY 2011.

RI MEDICAID: Applications for Rhode Island Works/Rite Care and “Other” Category of Applicants, by Quarter (SFY 2011)

Quarter	Rhode Island Works	“Other”
Q-1, SFY 2011	9,405	1,813
Q-2, SFY 2011	8,418	1,845
Q-3, SFY 2011	9,586	1,272
Q-4, SFY 2011	9,158	1,413
Total for SFY 2011	36,567	6,343

Approved Applications: The following tables outline the number of Rhode Island Works and “Other” applicants who were deemed to be eligible for Medicaid during the Third Quarter of SFY 2013 (January 1, 2013 through March 31, 2013). The following table represents a “point-in-time” snapshot of the number of approved applications, which may also be referred to as “entitlements”, for Medicaid coverage. InRhodes, the State’s Medicaid eligibility system, is the source of the following statistics.

RI MEDICAID: Approved Applications for Rhode Island Works and “Other” Category of Applicants, Q-3, SFY 2013

Month	Rhode Island Works	“Other”
January 2013	2,511	243
February 2013	2,336	242
March 2013	2,566	262
Total for Q-3 of SFY 2013	7,413	747

Source: InRhodes

Please refer to the following table, which displays the number of approved applications for the Rhode Island Works and “Other” cohorts during the first two quarters in SFY 2013.

RI MEDICAID: Approved Applications for Rhode Island Works and “Other” Category of Applicants, Q-1 and Q-2, SFY 2013

Quarter	Rhode Island Works	“Other”
Q-2, SFY 2013	6,973	843
Q-1, SFY 2013	7,342	829

The following table documents the number of application approvals that occurred on a quarterly basis during SFY 2012. The information for SFY 2012 has been presented in reverse chronological order.

RI MEDICAID: Approved Applications for Rhode Island Works and “Other” Category of Applicants, by Quarter (SFY 2012)

Quarter	Rhode Island Works	“Other”
Q-4, SFY 2012	7,654	824
Q-3, SFY 2012	7,918	861
Q-2, SFY 2012	7,314	838
Q-1, SFY 2012	7,189	880
Total for SFY 2012	30,075	3,403

To provide additional comparative information, the following table documents the number of approvals that were made by quarter during SFY 2011.

RI MEDICAID: Approved Applications for Rhode Island Works and “Other” Category of Applicants, by Quarter (SFY 2011)

Quarter	Rhode Island Works	“Other”
Q-1, SFY 2011	6,612	1,459
Q-2, SFY 2011	6,633	1,437
Q-3, SFY 2011	6,852	1,183
Q-4, SFY 2011	6,996	1,018
Total for SFY 2011	27,093	5,097

Denied Applications: InRhodes, the State’s Medicaid eligibility system, is the source of the following denial statistics for the Rhode Island Works (RIW) and the “Other” category of applicants during the Third Quarter of SFY 2013 (January 1, 2013 through March 31, 2013). The number of denials documented below represents a “point-in-time” snapshot of activity. Currently, InRhodes cannot produce a report showing denial code types stratified by income levels, as outlined in Item O.

RI MEDICAID: Denied Applications for Rhode Island Works and “Other” Category of Applicants, Q-3, SFY 2013

Month	Rhode Island Works	“Other”
January 2013	171	13
February 2013	162	5
March 2013	211	9
Total for Q-3 of SFY 2013	544	27

Source: InRhodes

The number of denied applications during the first two quarters of SFY 2013 has been provided in the table shown below.

RI MEDICAID: Denied Applications for Rhode Island Works and “Other” Category of Applicants, Q-1 and Q-2, SFY 2013

Quarter	Rhode Island Works	“Other”
Q-2, SFY 2013	590	26
Q-1, SFY 2013	590	28

To provide further baseline information, the table on the following page documents the number of application denials that occurred on a quarterly basis in SFY 2012. This information has been presented in reverse chronological order.

RI MEDICAID: Denied Applications for Rhode Island Works/Rite Care and “Other” Category of Applicants, by Quarter (SFY 2012)

Quarter	Rhode Island Works	“Other”
Q-4, SFY 2012	697	17
Q-3, SFY 2012	659	24
Q-2, SFY 2012	760	24
Q-1, SFY 2012	694	25
Total for SFY 2012	2,810	90

For purposes of comparison, quarterly information about denied applications has been documented in the following table for SFY 2011.

RI MEDICAID: Denied Applications for Rhode Island Works and “Other” Category of Applicants, by Quarter (SFY 2011)

Quarter	Rhode Island Works	“Other”
Q-1, SFY 2011	632	64
Q-2, SFY 2011	591	61
Q-3, SFY 2011	671	46
Q-4, SFY 2011	709	29
Total for SFY 2011	2,603	200

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

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

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

Subsequent to the EOHHS’ production of its report that focused on the Second Quarter of SFY 2012, the Department of Human Services determined that a quarterly operational report, which is produced from InRhodes, Medicaid’s eligibility system, would serve as a more complete source of information about the average number of new applications for RItE Care that have been pending for further action. The quarterly InRhodes operational report (*Pending MA Applications/Cases Over 45 Days – Summary Report*) provides information about all new Family Medical applications and does not focus exclusively on the Rhode Island Works cohort.

The following result, which was drawn from the quarterly InRhodes operational report (*Pending MA Applications/Cases Over 45 Days – Summary Report*), focuses on the average number of Family Medical applications pending over forty-five (45) days.

RI MEDICAID: The Average Number of New Applications Pending More than Forty-five Days for Family Medical Coverage (Q-3, SFY 2013)

Quarter	Average Number of New Applications Pending More Than 45 Days for Family Medical Coverage
Q-3, SFY 2013	203

Source: InRhodes

The finding for Q-3 of SFY 2013 was comparable to that which had been observed during the Third Quarter of SFY 2012, when the average number of new applications pending for more than forty-five (45) days for family medical coverage was 196.

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 2013 (January 1, 2013 through March 31, 2013). 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 2013. At this time, a detailed analysis of the reasons for closures is not available.

RI Medicaid: Redeterminations and Closures, Rhode Island Works/RItE Care Cohort (Q-3, SFY 2013)

Month	RIW Redeterminations	RIW Closures	Percentage
Jan. 2013	55,181	2,126	3.85%
Feb. 2013	55,568	1,933	3.48%
March 2013	55,889	2,236	4.00%
Total for Q-3, SFY 2013	166,638	6,295	3.78%

Source: InRhodes

Please refer to the following table, which displays the findings from the preceding two quarters in SFY 2013.

RI Medicaid: Redeterminations and Closures, Rhode Island Works/RItE Care Cohort, Q-1 and Q-2, SFY 2013

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-2, SFY 2013	164,864	6,625	4.02%
Q-1, SFY 2013	165,168	6,780	4.10%

Source: InRhodes

The findings from the first three quarters of SFY 2013 are comparable to the experience that was demonstrated during the preceding State Fiscal Year. The quarterly findings from SFY 2012 have been presented in reverse chronological order on the following page.

**RI Medicaid: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort
(SFY 2012)**

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-4, SFY 2012	164,735	7,100	~4.31%
Q-3, SFY 2012	163,455	6,480	3.96%
Q-2, SFY 2012	160,223	6,451	4.04%
Q-1, SFY 2012	157,282	6,560	4.17%
Total	645,695	26,591	4.12%

For further background reference, the table shown below delineates the quarterly findings from SFY 2011.

**RI Medicaid: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort, by
Quarter (SFY 2011)**

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-1, SFY 2011	133,586	5,810	4.35%
Q-2, SFY 2011	137,123	5,136	3.74%
Q-3, SFY 2011	148,708	6,039	4.06%
Q-4, SFY 2011	157,322	6,280	~ 4.00%
Total	576,739	23,265	4.04%

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 Share¹³ 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.

RI Medicaid: Monthly Premiums for Families, By Income Level

Family Income Level ¹⁴	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, RI Medicaid’s Eligibility System, and document the number of RItE Care- or RItE Share-enrolled families who must pay premiums for coverage.

RI Medicaid: The Average Number of RItE Care- or RItE Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-3, SFY 2013)

Percentage of the Federal Poverty Level (FPL)	Q-3, SFY 2013	
> 150 - 185% FPL	9,657	59.7%
> 185 - 200% FPL	2,181	13.5%
> 200 - 250% FPL	4,347	26.9%
Total	16,185	100.0%

¹³ 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.

¹⁴ For a family of four, the following FPLs were established by the US DHHS on January 24, 2013: 150% FPL = \$35,325.00; 185% FPL = \$43,567.50; 200% FPL = \$47,100.00; and 250% FPL = \$58,875.00. For further information, please refer to: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2013-Federal-Poverty-level-charts.pdf>

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 health 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 (12th) 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 month¹⁵. For example, if a premium payment which is due on January 1st has not been received by February 12th, then MA eligibility would be discontinued, effective on February 28th. 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.

The following sanction data were obtained from InRhodes, the State’s Eligibility System, and document the number of RIte Care- or RIte Share-enrolled families who were sanctioned during the Third Quarter of SFY 2013 (January 1, 2013 – March 31, 2013).

¹⁵ MA coverage is reinstated without penalty for otherwise eligible family members if all due and overdue premiums are received by Rhode Island Medicaid’s fiscal agent on or before the effective date of MA discontinuance.

RI Medicaid: The Number of Rite Care or Rite Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-3, SFY 2013)

Percentage of the Federal Poverty Level (FPL)	Q-3, SFY 2013	
	>150 - 185% FPL	235
>185 - 200% FPL	72	16.1%
>200 - 250% FPL	139	31.2%
Total	446	100.0%

A modest decline in the number of families who were sanctioned due to non-payment of premiums was observed during Q-3 of SFY 2013, when the findings were compared to those from the first two quarters of the State Fiscal Year. The following table provides this information for the first half of SFY 2013.

Percentage of the Federal Poverty Level (FPL)	Q-2, SFY 2013		Q-1, SFY 2013	
	>150 - 185% FPL	313	60.8%	274
>185 - 200% FPL	52	10.1%	92	18.2%
>200 - 250% FPL	150	29.1%	139	27.5%
Total	515	100.0%	505	100.0%

For further comparison, information about sanctions that occurred on a quarterly basis during SFY 2012 has been provided in the following table.

RI Medicaid: The Number of Rite Care or Rite Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (SFY 2012)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2012		Q-2, SFY 2012		Q-3, SFY 2012		Q-4, SFY 2012	
	>150 - 185% FPL	283	54.1%	265	56.4%	210	50.48%	163
>185 - 200% FPL	93	17.8%	68	14.5%	71	17.07%	49	16.0%
>200 - 250% FPL	147	28.1%	137	29.1%	135	32.45%	94	30.7%
Total	523	100.0%	470	100.0%	416	100.0%	306	100.0%

Comparative information about sanctions during State Fiscal Year 2011 has been outlined on the next page.

RI Medicaid: The Number of Rite Care or Rite Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (SFY 2011)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2011		Q-2, SFY 2011		Q-3, SFY 2011		Q-4, SFY 2011*	
>150 - 185% FPL	230	50.8%	203	50.6%	223	52.0%	178	51.0%
>185 - 200% FPL	78	17.2%	65	16.2%	66	15.4%	59	16.9%
>200 - 250% FPL	145	32.0%	133	33.2%	140	32.6%	112	32.1%
Total	453	100%	401	100%	429	100%	349	100.0%

As had been noted previously in the EOHHS report that was submitted to the State Senate on 12/15/2011, the preceding table was flagged with an asterisk (*) to note that the number of cases sanctioned for the month of April 2011 was zero due to an error in the transmission of the cost share file between MMIS and InRhodes. However, the number of cases sanctioned for the month of May 2011 was unusually high because it included many of those cases that had not been sanctioned in the prior month.

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

The following table documents the total of State and Federal expenditures for the Cost Not Otherwise Matchable (CNOM) provision of Section 1115(a)(2) of the Social Security Act for on a Year-to-Date (YTD) basis for SFY 2013 through March 31, 2013. These data were obtained from RI EOHHS 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 2013, YTD Through 03/31/2013)

State	\$13,552,435
Federal	\$14,368,173
Total	\$27,920,608

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 TPL Unit and document the total recoveries that were paid to the EOHHS during the Third Quarter of SFY 2013 (January 1, 2013 through March 31, 2013). This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: Q-3, SFY 2013

Recoveries by Type	Amount Recovered
Estate Recoveries: TPL and Legal	\$55,189
Casualty Recoveries: TPL and Legal	\$164,295
Total	\$219,484