Report to the Centers for Medicare and Medicaid Services

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

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

February 2012

This Quarterly Operation Report has been prepared for the Centers for Medicare and Medicaid Services by the State's Executive Office of Health and Human Services pursuant to the requirements outlined in the State's Global Consumer Choice Compact (also known as the "Global Waiver"). The Quarterly Operational Report has been organized as follows:

- Section I provides an overview of Rhode Island's goals for the Global Waiver
- Section II includes key information on eligibility, expenditures and activities
- Section III presents key analytic highlights on the progress of the Global Waiver.

Section I

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

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

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

Rhode Island in Relation to Other States: Prior to July 1st, 2009, the State undertook a judicious and deliberative planning phase to ensure that the Global Waiver's implementation would allow Rhode Island to attain its fundamental goals, by promoting the health and safety of Medicaid beneficiaries in a cost-effective manner. Through this strategic analysis, Rhode Island sought to capitalize upon the positive experience demonstrated by several States which have already achieved a reformation of their system of publicly-financed long-term care (LTC), with a shift from institutional to home and community-based services (HCBS), and a fundamental rebalancing of Medicaid

expenditures. Three States (Oregon, Washington, and New Mexico) have been nationally recognized for having achieved shifts in their LTC expenditures, with more than fifty percent of their Medicaid LTC spending now directed toward home and community-based services. Such shifts were not achieved rapidly, however, and required judicious action plans.

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

- *Philosophy* – The State's intention to deliver services to people with disabilities in the most independent living situation and expand cost-effective HCBS options guides all other decisions.
- *Array of Services* – States that do not offer a comprehensive array of services designed to meet the particular needs of each individual may channel more people to institutions than will States that provide an array of options.
- *State Organization of Responsibilities* – Assigning responsibility for overseeing the State's long-term services and supports to a single administrator has been a key decision in some of the most successful States.
- *Coordinated Funding Sources* – Coordination of multiple funding sources can maximize a State's ability to meet the needs of people with disabilities.
- *Single Appropriation* – This concept, sometimes called "global budgeting," allows States to transfer funds among programs and, therefore, make more rational decisions to facilitate serving people in their preferred setting.
- *Timely Eligibility* – Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, State Medicaid programs must be able to arrange for HCBS in a timely manner.
- *Standardized Assessment Tool* – Some States use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization.
- *Single Point of Entry* – A considerable body of literature points to the need for a single access point allowing people of all ages with disabilities to access a comprehensive array of LTC services and supports.
- *Consumer Direction* – The growing movement to allow participants a greater role in determining who will provide services, as well as when and how they are delivered, responds to the desire of people with disabilities to maximize their ability to exercise choice and control over their daily lives.
- *Nursing Home Relocation* – Some States have made systematic efforts to regularly assess the possibility of transitioning people out of nursing homes and into their own homes or more home-like community alternatives.

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

- *Quality Improvement* – States are beginning to incorporate participant-defined measures of success in their quality improvement plans.
- *Integrating Health and LTC Services* – A few States have developed methods for ensuring that the array of health and LTC services people with disabilities need are coordinated and delivered in a cost-effective manner.

Section II

Key Eligibility and Expenditure Metrics for the reporting period October 1, 2011 – December 31, 2011 are outlined below.

Rhode Island Medicaid Eligibility

Program	September 2011 Counts of Eligibles	December 2011 Counts of Eligibles
Aged	17,339	17,392
Disabled	28,086	28,070
BCCPT	221	216
QMBs, SLMBs, and QI 1s	5,637	6,049
Child and Families	131,172	131,709
Adoptive Subsidy	2,448	2,434
Foster Care	2,315	2,278
Children with Special Health Care Needs	8,765	8,837
Total	195,983	196,985

Care Management Program Enrollment

Program	Enrollment as of 09/30/11	Enrollment as of 12/31/11
RIte Care	123,698	124,655
RIte Share	11,673	11,571
Rhody Health Partners	13,230	13,424
PACE	209	210
Connect Care Choice	2071	1,749
Connect Care	143	131
RIte Smiles	55,510	56,706
Early Intervention	2,033	2,032
BCCPT	221	216
Extended Family Planning	322	394

Cost Not Otherwise Matchable (CNOM) Program Enrollment

Program	Description	Enrollment as of 09/30/11	Enrollment as of 12/31/11
Budget Population 8	Children and families in managed care enrolled in RIte Care Medicaid parents have behavioral health conditions that result in their children being placed in temporary State custody	**0**	**0**
Budget Population 9	Children with special health care needs who are 21 and under who would otherwise be placed in voluntary State custody-residential diversion	**0**	**0**
Budget Population 10	Elders at risk of LTC	**1,409**	**1,437**
Budget Population 11	217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants Highest need group	**0**	**0**
Budget Population 12	217-like, Categorically Needy Individuals receiving HCBW-like services & PACE-like participants High need group	**0**	**0**
Budget Population 13	217-like, Medically Needy Individuals receiving HCBW-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community	**0**	**0**
Budget Population 14	Women screened for breast or cervical cancer under CDC program and not eligible for Medicaid	**221**	**216**
Budget Population 15	Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid	**1,883**	**2,008**
Budget Population 16	Uninsured adults with mental illness	**8,028**	**8,686**
Budget Population 17	Children at risk for Medicaid and/or institutional care	**2,507**	**2,515**
Budget Population 18	HIV positive individuals who are otherwise not eligible for Medicaid	**363**	**338**

Waiver Category Change Requests

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

Request Type	Description	Date Submitted	CMS Action	Date
State Plan Amendment	Disproportionate Share Hospital Policy	06/27/11	Pending	
Category II	HCBS for Individuals with Developmental Disabilities	06/04/11	Approved	12/20/11
Category I	RIte Care Premium Cost Sharing	8/24/11	Denied	09/09/11
Category I Reconsideration	RIte Care Premium Cost Sharing	9/16/11	Denied	09/30/11
Category II	RIte Share Co-payment	08/24/11	Approved	11/17/11
Category II	Elimination of Annual Nursing Facility Rate Adjustment	09/30/11	Pending	
State Plan Amendment	Single State Agency Designation	09/30/11	Pending	
State Plan Amendment	Health Home for BHDDH SPMI	08/25/11	Approved	11/23/11
State Plan Amendment	Health Home for CEDARR	08/25/11	Approved	11/23/11

Cost Not Otherwise Matchable (CNOM)

Under the federal authority granted by CMS, the state has claimed $ 2,479,669 million federal dollars in Cost Not Otherwise Claimable (CNOM) during the reporting period.

Budget Neutrality

Under the terms of the Global Waiver, the State is subject to a limit on the amount of Federal Title XIX funding that it may receive on selected Medicaid expenditures during the demonstration period. The budget neutrality cap is for the Federal share of the total computable cost of $12.075 billion for the five-year demonstration period. Rhode Island has achieved Cumulative results of $ 1,866,206,914 million dollars below the cap during this reporting quarter. Attachment A contains the Budget Neutrality Report.

Key activities for the reporting period October 1, 2011 – December 31, 2011 are outlined below.

- 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 December 31, 2011, a total of **1,516 Level of Care (LOC) assessments** had been completed, resulting in the following determinations: **Highest LOC = 920**; **High LOC = 486**; and **Preventive LOC = 85**. Twenty-five (25) individuals did not meet a LOC.

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

    - **Safely transitioned a total of 1,047 individuals to date to a community setting in the Nursing Facility Transition program and the MFP program**
    - **102 Nursing Home Transition referrals** were made to the Office of Community (OCP) Programs during Q-2 of SFY 2012
    - **34 individuals** were transitioned to a community setting during the reporting quarter. Of the 34 individuals, 6 were enrolled in the MFP demonstration
    - Provided ongoing training of State staff in the EOHHS Office of Community Programs, DHS Long Term Care, and the DEA Home and Community Care
    - Ongoing monitoring of the use of protocols for weekend discharges and inpatient diversion discharges to nursing facilities
    - Tracked Nursing Facility Diversions associated with level of care (LOC) assessments and diversions made by the Connect Care Choice program
    - Aligned planning activities under the *Money Follows the Person* with the Nursing Home Transition Program
    - Convened *Money Follows the Person* Steering Committee in October and November 2011

- Received approval of the *Money Follows the Person* Planning Grant no-cost extension

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

  - During Q-2 of SFY 2012, **85 individuals met the Preventive Level of Care** and received services
  - Explored opportunities for a proposed expansion of Respite Services and transition services with funding available under the *Money Follows the Person* Demonstration Grant

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

  - **Enrolled 67 individuals in the EOHHS Shared Living program** as of December 31, 2011
  - Completed the following activities for the enrolled individuals: made home visits, conducted level of care (LOC) assessments, developed and approved service and safety plans, carried out caregiver BCI background checks, and provided training for caregivers

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

  - Continued planning efforts under the *Money Follows the Person* Demonstration Grant
  - Began transitions under the *Money Follows the Person* Demonstration
  - Participated in weekly *Money Follows the Person* Technical Assistance sessions
  - Worked with the Assisted Living Trade Organization to identify assisted living facilities that would meet the CMS definition as a "qualified residence" under the *Money Follows the Person* Demonstration Grant application
  - Applied for and was awarded 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
  - Continued to explore acuity-based funding for adult day services
  - Implemented workgroup for the development of the RIte Resources web-based inventory of long term care services in RI to be operational in March 2012

- 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

- Convened cross-departmental planning for state and federal opportunities for Integrated Care for Medicare and Medicaid Beneficiaries and Managed Long Term Care for Medicaid-only beneficiaries
- Met bi-monthly with the CMS CCMI team to discuss opportunities under the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees
- Convened stakeholder meetings on Integrate Care for Medicare-Medicaid Enrollees
- Analyzed data to support Integrate Care for Medicare-Medicaid Enrollees
- Explored opportunities under the Affordable Care Act (ACA), including Balancing Incentive Program and Community Choice First for Medicaid Enrollees

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

  - Monitored interventions in *Communities of Care* for high utilizers enrolled in the State's managed care health plan delivery system (RIte Care and Rhody Health Partners participating Health Plans and the State's Primary Care Case Management (PCCM) delivery system Connect Care Choice)
  - Commenced the development of the program evaluation of the *Communities of Care* initiative
  - Finalized the brochures for the *Communities of Care* initiative
  - Implemented targeted interventions for high utilizers of pharmacy benefits in the State's Medicaid FFS and managed care delivery systems
  - Commenced development of a pain management benefit
  - Explored opportunities for the LifeLine cell phone program for Medicaid beneficiaries
  - Explored opportunities for improvement to the care planning assessment tools
  - Proposed regulatory changes to the Personal Choice self-directed program to ensure appropriate levels of service authorization

- 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.)

  - Proposed regulatory changes to the Sherlock Plan to improve program participation

- Analyze Medicaid Managed Long Term Care models

  - Participated in the CHCS-TA initiative, Implementing Innovations in Long-term Supports and Services (LTSS), funded by SCAN Foundation
  - Continued planning for Managed Care Effectiveness Report and Integrated Care for Medicare and Medicaid beneficiaries due on December 31, 2011

- Researched best practices and met with key informants

- Promote the adoption of "Medical Homes"

  - Received approval on the two State Plan Amendments for *Health Homes for Medicaid Enrollees with Chronic Conditions Initiative* under the Affordable Care Act (ACA)
  - Commenced implementation of the two Health Homes for Medicaid Enrollees with Chronic Conditions
  - Participated in the statewide CSI Rhode Island Medical Home Project

- Promote the adoption of electronic health records

  - Continued implementing activities under the DRA Medicaid Transformation Grant
  - Continued the voluntary enrollment of Medicaid beneficiaries in Rhode Island Medicaid's **current***care* electronic medical record (EMR)
  - Implemented the process for EMR funding for Medicaid providers
  - Executed MOUs for Nursing Facilities' purchase of computers to support activities under the DRA Medicaid Transformation Grant
  - Implemented activities for P-APD (IT Global Waiver and MITA Planning)
  - Commenced planning design for statewide web-based, real-time inventory of LTCSS, RIte Resources

- Participate in Health Insurance Exchange Planning

  - Participated in the Health Insurance Exchange Planning Grant activities
  - Participated in the Regional Health Insurance Exchange Planning Grant activities

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

  - Monitored implementation of the new initiatives in the capitated Medicaid managed care program, focusing on selective contracting strategies
  - Analyzed value-based purchasing strategies for the Managed LTC under the Integrated Care for Medicare and Medicaid beneficiaries and Medicaid-only beneficiaries opportunities

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

  - Reviewed opportunities for selective contracting strategies as part of the implementation of the SFY 2012 budget initiatives
  - Explored opportunities for selective contracting for SFY 2013 budget initiatives

- Continued to refine recommendations for long-term care acuity adjustments to meet budget targets

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

  - Convened three meetings with the Global Waiver Task Force on 10/24/2011, 11/28/2011 and 12/19/2011
  - Convened the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 12/07/2011
  - To promote transparency, meeting notes and agenda for the Global Waiver Task Force and the Rhode Island Medicaid Medical Advisory Committee (MCAC) were posted on the EOHHS' Web site
  - Commissioned the Lewin Group to prepare an Independent Evaluation of the RI Global Waiver and posted the report on the EOHHS web site
  - Posted on the EOHHS website information on the Integrated Care for Medicare and Medicaid Beneficiaries, the *Rhode to Home* MFP Demonstration, and Monitoring Quality and Access in RIte Care and Rhody Health Partners managed care programs

Section III

Key analytic highlights on the progress of the Global Waiver based on performance during the Fourth Quarter of the SFY 2011 (April 1, 2011 – June 30, 2011).

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

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

The following table outlines the number of Medicaid LTC applicants who were deemed to be eligible for Medicaid LTC during the Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011). The following tables represent a "point-in-time" snapshot of the number of approved applications for Medicaid LTC coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for Q-4 of SFY 2011.

RI EOHHS/DHS: Medicaid Long-term Care Acceptances (Approvals), Q-4, SFY 2011

Month	Long-Term Care Approvals
April 2011	286
May 2011	283
June 2011	268
Total for Q-4, SFY 2011	**837**

Source: InRhodes

The finding (837 approvals) for Q-4 of SFY 2011 was comparable to the acceptances which were observed in Q-1 of SFY 2011 (845) and Q-2 of SFY 2011 (827). As noted in the EOHHS report which has submitted to the State Senate on 09/15/2011, the acceptances in Q-3 of SFY 2011 (793) were less than those observed during the first two quarters of SFY 2011.

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 Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011). InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics. The number of denials documented below represents a "point-in-time" snapshot of activity. This information has been provided by month for Q-4 of SFY 2011.

RI EOHHS/DHS: Medicaid Long-term Care Denials, Q-4, SFY 2011

Month	Long-Term Care Denials
April 2011	53
May 2011	79
June 2011	53
Total for Q-4, SFY 2011	**185**

Source: InRhodes

The finding (185 denials) for Q-4 of SFY 2011 was comparable to the prior quarter, when there were 184 denials.

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 Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011).

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-4, SFY 2011 (RI DEA): The first set of tables quantifies the number (or count) of individuals who received LTC services provided under the auspices of the Rhode Island Division of Elderly Affairs (RI DEA) during the Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011).

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

DEA: LTC Service Type and Corresponding Unit of Service

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

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

Source: EOHHS Data Warehouse: MMIS Claim Universe			Apr		May		Jun		Q-4, SFY 2011	
Reporting Period: Date of Service			2011		2011		2011			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
	Assisted Living	Under 65	45	1,410	48	1,488	47	1,392	140	4,290
		65 and Older	253	7,449	238	7,255	242	7,010	733	21,714
DEA	Assisted Living	Service Type Subtotals:	298	8,859	286	8,743	289	8,402	873	26,004
	Case Management	Under 65	35	181	37	176	34	162	106	519
		65 and Older	471	2,286	462	2,165	459	2,458	1,392	6,909
DEA	Case Management	Service Type Subtotals:	506	2,467	499	2,341	493	2,620	1,498	7,428
	Personal Care/Homemaker	65 and Older	397	102,648	394	104,741	408	107,564	1,199	314,953
DEA	Personal Care/Homemaker	Service Type Subtotals:	397	102,648	394	104,741	408	107,564	1,199	314,953
DEA		Grand Total:		113,974		115,825		118,586		348,385

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-4, SFY 2011 (RI EOHHS/DHS): The second set of tables shows the number (or count) of individuals who received LTC services through the Rhode Island Department of Human Services (RI EOHHS/DHS) during the Fourth Quarter of SFY 2011. This information reflects incurred dates of service (April 1, 2011 through June 30, 2011) and has been stratified according to the two age groups (less than 65 years of age and greater than or equal to 65 years of age) as requested.

Units of service have been defined in the following manner.

EOHHS/DHS: LTC Service Type and Corresponding Unit of Service

Service Type	Unit of Service
Adult Day	Per Diem (Per Day)
Assisted Living	Per Diem (Per Day)
Case Management	Per 15 Minute Intervals
Home Health Agency	Mixed*
Hospice	Per Diem (Per Day)
Nursing Facility	Per Diem (Per Day)
Personal Care/Homemaker	Per 15-Minute Intervals
Shared Living[2]	Per Diem (Per Day)
Tavares Pediatric Center	Per Diem (Per Day)

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

[2] The DHS Shared Living program became operational during September 2011. A fact sheet which describes the DHS' Shared Living program may be accessed by pasting the following link to a Web browser: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/LTC/SL_fact_sheet.pdf

Information which documents the number of Medicaid beneficiaries who were served has been stratified by participants' age group for the following lines of service which are administered by the RI EOHHS/DHS: Adult day care; assisted living; case management; home health agency; hospice; nursing facility; personal care/homemaker; shared living[3]and Tavares Pediatric Center. This information has been stratified by month and by age group.

The 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/DHS: Adult day care; assisted living; case management; home health agency; hospice; nursing facility; personal care/homemaker; shared living; and Tavares Pediatric Center. This information has been stratified by month and by age group. Data tables are shown below, with information organized by month for the Fourth Quarter of SFY 2011.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Apr		May		Jun		Q-4, SFY 2011	
Reporting Period: Date of Service			2011		2011		2011			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
EOHHS DHS	Adult Day Care	Under 65	256	3,899	264	3,779	262	3,591	782	11,269
		65 and Older	220	3,195	220	3,235	231	3,418	671	9,848
EOHHS DHS	Adult Day Care	Service Type Subtotals:	476	7,094	484	7,014	493	7,009	1,453	21,117
	Assisted Living	Under 65	11	328	12	366	12	358	35	1,052
		65 and Older	155	4,491	157	4,616	155	4,445	467	13,552
EOHHS DHS	Assisted Living	Service Type Subtotals:	166	4,819	169	4,982	167	4,803	502	14,604
	Case Management	Under 65	566	1,019	318	808	287	554	1,171	2,381
		65 and Older	96	524	122	667	127	726	345	1,917
EOHHS DHS	Case Management	Service Type Subtotals:	662	1,543	440	1,475	414	1,280	1,516	4,298
	Hospice	Under 65	57	1,202	49	1,380	46	1,103	152	3,685
		65 and Older	523	13,318	534	13,984	545	13,777	1,602	41,079
EOHHS DHS	Hospice	Service Type Subtotals:	580	14,520	583	15,364	591	14,880	1,754	44,764
	Nursing Facility	Under 65	561	15,456	550	15,642	557	15,290	1,668	46,388
		65 and Older	5,091	147,348	5,056	149,739	5,015	144,243	15,162	441,330
EOHHS DHS	Nursing Facility	Service Type Subtotals:	5,652	162,804	5,606	165,381	5,572	159,533	16,830	487,718
	Personal Care/Homemaker	Under 65	993	263,840	998	273,618	1,001	274,613	2,992	812,071
		65 and Older	1,225	324,229	1,235	341,777	1,254	347,354	3,714	1,013,360
EOHHS DHS	Personal Care/Homemaker	Service Type Subtotals:	2,218	588,069	2,233	615,395	2,255	621,967	6,706	1,825,431
	Shared Living Agency	Under 65	11	598	13	728	13	779	37	2,105
		65 and Older	29	1,609	33	1,954	35	1,981	97	5,544
EOHHS DHS	Shared Living Agency	Service Type Subtotals:	40	2,207	46	2,682	48	2,760	134	7,649
	Skilled Nursing	Under 65	233	1,476	240	1,442	208	1,250	681	4,168
		65 and Older	117	1,182	119	1,215	116	1,135	352	3,532
EOHHS DHS	Skilled Nursing	Service Type Subtotals:	350	2,658	359	2,657	324	2,385	1,033	7,700
	Tavares Pediatric Center	Under 65	21	606	20	575	19	543	60	1,724
EOHHS DHS	Tavares Pediatric Center	Service Type Subtotals:	21	606	20	575	19	543	60	1,724
		Grand Total:		784,320		815,525		815,160		2,415,005

[3] As noted previously, the DHS Shared Living program became operational during September 2011.

The Number of Medicaid Beneficiaries Served by PACE, Q-4, SFY 2011 (RI EOHHS/DHS): Using the EOHHS Data Warehouse, information was extracted from the MMIS to produce counts of the number of individuals who participated in the PACE (Program of All Inclusive Care for the Elderly) program during the Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011). Please refer to the data table shown below. This information has been stratified by month and by age group.

Source:		EOHHS Data Warehouse/Financial Data Mart		
Reporting Period:		Eligibility Period		
Dept.	**Benefit Perio**	**Program Descriptio**	**Age Group**	**Person Cour**
EOHHS	DHS 4/1/2011	PACE PROGRAM	65 and Over	178
EOHHS	DHS	PACE PROGRAM	Under 65	36
	4/1/2011		**Period Totals:**	214
EOHHS	DHS 5/1/2011	PACE PROGRAM	65 and Over	177
EOHHS	DHS	PACE PROGRAM	Under 65	37
	5/1/2011		**Period Totals:**	214
EOHHS	DHS 6/1/2011	PACE PROGRAM	65 and Over	176
EOHHS	DHS	PACE PROGRAM	Under 65	36
	6/1/2011		**Period Totals:**	212
			Quarterly Total:	**640**

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-4, SFY 2011 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). As requested, this information has been stratified according to two age groups for participants for the following lines of service which are administered by the RI BHDDH: Day programs; homemaker services; public group homes for persons with developmental disabilities; private group homes for persons with developmental disabilities; family supports; shared living; and supported employment. Data for the Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011) are shown below.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-4, SFY 2011

Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2,361
		Over 65	288
BHDDH	Homemaker	Under 65	132
		Over 65	18
BHDDH	Public Group Homes	Under 65	138
		Over 65	82
BHDDH	Private Group Homes	Under 65	1,157
		Over 65	164
BHDDH	Family Supports	Under 65	847
		Over 65	63
BHDDH	Shared Living	Under 65	159
		Over 65	13
BHDDH	Supported Employment	Under 65	546
		Over 65	22

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 Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one that shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

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

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

Cost and Utilization Data, Q-4, SFY 2011 (RI DEA): The following table provides an average cost per individual, as well as quarterly totals by DEA service line, for the two age groups during the Fourth Quarter of SFY 2011.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Apr		May		Jun		Q-4, SFY 2011	
Reporting Period: Date of Service			2011		2011		2011			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
	Assisted Living	Under 65	45	1,410	48	1,488	47	1,392	140	4,290
		65 and Older	253	7,449	238	7,255	242	7,010	733	21,714
DEA	Assisted Living	Service Type Subtotals:	298	8,859	286	8,743	289	8,402	873	26,004
	Case Management	Under 65	35	181	37	176	34	162	106	519
		65 and Older	471	2,286	462	2,165	459	2,458	1,392	6,909
DEA	Case Management	Service Type Subtotals:	506	2,467	499	2,341	493	2,620	1,498	7,428
	Personal Care/Homemaker	65 and Older	397	102,648	394	104,741	408	107,564	1,199	314,953
DEA	Personal Care/Homemaker	Service Type Subtotals:	397	102,648	394	104,741	408	107,564	1,199	314,953
DEA		Grand Total:		113,974		115,825		118,586		348,385

Cost and Utilization Data, Q-4, SFY 2011 (RI EOHHS/DHS): The following table provides an average cost per individual, as well as quarterly totals by EOHHS/DHS service line, for the two age groups during the Fourth Quarter of SFY 2011.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Apr		May		Jun		Q-4, SFY 2011	
Reporting Period: Date of Service			2011		2011		2011			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
EOHHS/DHS	Adult Day Care	Under 65	256	3,899	264	3,779	262	3,591	782	11,269
		65 and Older	220	3,195	220	3,235	231	3,418	671	9,848
EOHHS/DHS	Adult Day Care	Service Type Subtotals:	476	7,094	484	7,014	493	7,009	1,453	21,117
	Assisted Living	Under 65	11	328	12	366	12	358	35	1,052
		65 and Older	155	4,491	157	4,616	155	4,445	467	13,552
EOHHS/DHS	Assisted Living	Service Type Subtotals:	166	4,819	169	4,982	167	4,803	502	14,604
	Case Management	Under 65	566	1,019	318	808	287	554	1,171	2,381
		65 and Older	96	524	122	667	127	726	345	1,917
EOHHS/DHS	Case Management	Service Type Subtotals:	662	1,543	440	1,475	414	1,280	1,516	4,298
	Hospice	Under 65	57	1,202	49	1,380	46	1,103	152	3,685
		65 and Older	523	13,318	534	13,984	545	13,777	1,602	41,079
EOHHS/DHS	Hospice	Service Type Subtotals:	580	14,520	583	15,364	591	14,880	1,754	44,764
	Nursing Facility	Under 65	561	15,456	550	15,642	557	15,290	1,668	46,388
		65 and Older	5,091	147,348	5,056	149,739	5,015	144,243	15,162	441,330
EOHHS/DHS	Nursing Facility	Service Type Subtotals:	5,652	162,804	5,606	165,381	5,572	159,533	16,830	487,718
	Personal Care/Homemaker	Under 65	993	263,840	998	273,618	1,001	274,613	2,992	812,071
		65 and Older	1,225	324,229	1,235	341,777	1,254	347,354	3,714	1,013,360
EOHHS/DHS	Personal Care/Homemaker	Service Type Subtotals:	2,218	588,069	2,233	615,395	2,255	621,967	6,706	1,825,431
	Shared Living Agency	Under 65	11	598	13	728	13	779	37	2,105
		65 and Older	29	1,609	33	1,954	35	1,981	97	5,544
EOHHS/DHS	Shared Living Agency	Service Type Subtotals:	40	2,207	46	2,682	48	2,760	134	7,649
	Skilled Nursing	Under 65	233	1,476	240	1,442	208	1,250	681	4,168
		65 and Older	117	1,182	119	1,215	116	1,135	352	3,532
EOHHS/DHS	Skilled Nursing	Service Type Subtotals:	350	2,658	359	2,657	324	2,385	1,033	7,700
	Tavares Pediatric Center	Under 65	21	606	20	575	19	543	60	1,724
EOHHS/DHS	Tavares Pediatric Center	Service Type Subtotals:	21	606	20	575	19	543	60	1,724
		Grand Total:		784,320		815,525		815,160		2,415,005

Cost and Utilization Data, Q-4, SFY 2011 (RI BHDDH): The following data have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). Currently, as part of its developmental disabilities budget initiative, the Division is engaged in work with Hewlett Packard to develop a new database and claims payment process. The new database will provide functionality to aid in extracting data, leading to greater ease in the development of standardized reports. Please refer to the table that has been provided on the following page.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-4, SFY 2011				
Dept.	**Service Type**	**Age Group**	**# Served**	**Total Expenditures**
BHDDH	Day Programs	Under 65	2,361	$9,231,836.18
		Over 65	288	$1,053,685.16
BHDDH	Homemaker	Under 65	132	840,410.67
		Over 65	18	75,369.24
BHDDH	Public Group Homes	Under 65	138	5,360,782.64
		Over 65	82	3,214,661.25
BHDDH	Private Group Homes	Under 65	1,157	23,520,884.34
		Over 65	164	3,120,777.14
BHDDH	Family Supports	Under 65	847	3,678,636.77
		Over 65	63	311,673.96
BHDDH	Shared Living	Under 65	159	1,567,400.58
		Over 65	13	129,218.94
BHDDH	Supported Employment	Under 65	546	1,767,040.63
		Over 65	22	65,342.01

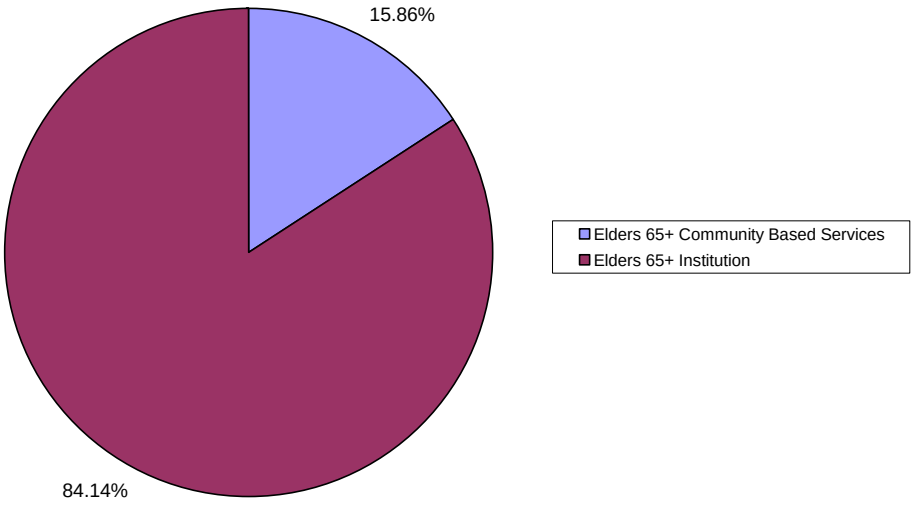
E. Percent distribution of expenditures for Medicaid long-term care institutional services and home and community services (HCBS) by population, including: elders aged 65 and over, persons with disabilities, and children with special health care needs.

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 (April 1, 2011 – June 30, 2011).

Elders Aged 65 and Over

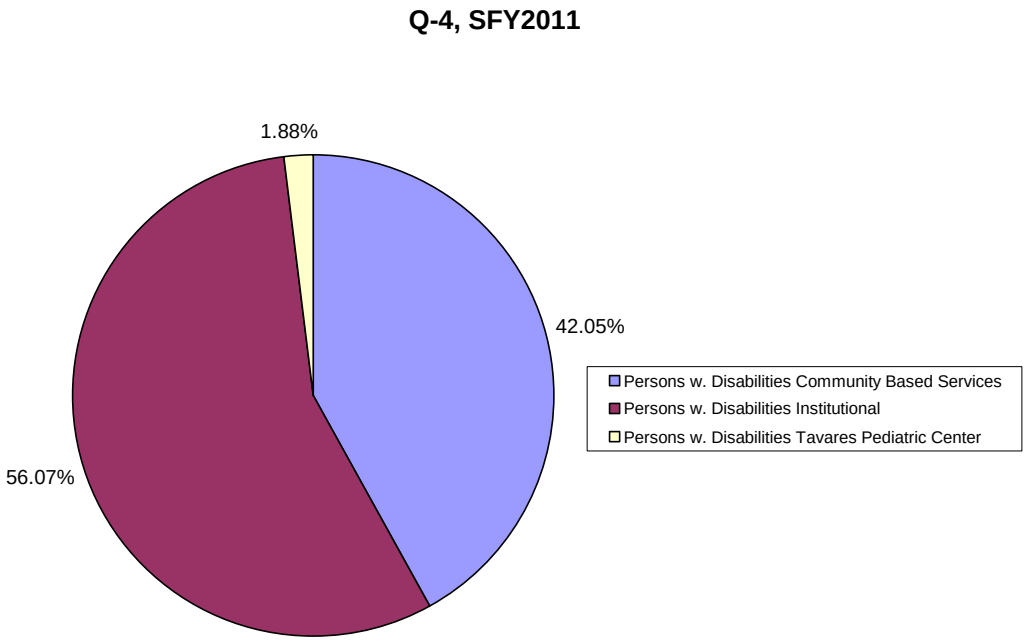
During the Fourth Quarter of SFY 2011, 84.14 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.86 percent were for home and community-based services (HCBS). The latter finding (15.86 percent for HCBS in Q-4, SFY 2011) reflects a trend increase for HCBS for elders, in comparison to the first three quarters of State Fiscal Year of 2011 (Q-1, SFY 2011 = 13.87 percent; Q-2, SFY 2011 = 14.48 percent; and Q-3, SFY 2011 = 15.29 percent).

Q-4, SFY2011



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

Persons with Disabilities: Individuals with disabilities are eligible for Medical Assistance if they are 18 years or older, a Rhode Island resident, receive Supplemental Security Income (SSI) or have an income less than 100% of the Federal Poverty Level (FPL) and have resources (savings) of less than $4,000 for an individual or $6,000 for a married couple. The following chart shows the percent distribution of expenditures for Medicaid institutional services and home and community services for persons with disabilities. The utilization data were abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (April 1, 2011 – June 30, 2011).



During the Fourth Quarter of SFY 2011, 56.07 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services, 1.88 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services at the Tavares Pediatric Center, and 42.05 percent were for home and community-based services (HCBS). For purposes of comparison, the following information has been provided for the first three quarters of SFY 2011, specific to the percentage of expenditures for HCSB for persons with disabilities. Findings from the first three quarters of SFY 2011 were: 41.63 percent in Q-1; 41.75 percent in Q-2; and 40.43 percent in Q-3.

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

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

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

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

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

The following information, provided by the Division of Elder Affairs, covers the Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011). The tables shown below document the service utilization of the DEA's Adult Day Care and Home Care Program (also referred to as the "Co-pay" Program). This information has been organized for each type of service by quarter.

RI DEA: Adult Day Care (Q-4, SFY 2011)

Service Category: Adult Day Care	**Clients***		**Units (Unit=1 Day)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	129	43	1,905	635
D2 (Income up to 200% FPL):	615	205	9,238	3,079
Total	**744**	**248**	**11,143**	**3,714**
Average utilization= 15 days of adult day care per client per month.				
*Clients are not distinct				

RI DEA: Case Management (Q-4, SFY 2011)

Service Category: Case Management	**Clients**		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
Case Management	1,102	367	6,189	2,063
Average utilization = 1.40 Hours of Case management per client per month.				

RI DEA: Home Care (Q-4, SFY 2011)

Service Category: Home Care	**Clients***		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	397	132	40,410	13,470
D2 (Income up to 200% FPL):	1,431	477	156,946	52,315
Total	**1,828**	**609**	**197,356**	**65,785**
Average utilization= 108 units or 27 hours of home care per client per month.				
*Clients are not distinct				

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

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

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

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

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

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

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

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

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

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

RI EOHHS/DHS: Turn-around Times for New LTC Applications (Q-4, SFY 2011)

Month	< 30 Days		30 – 90 Days		> 90 Days		Monthly Total	
April 2011	104	27.66%	214	56.91%	58	15.43%	**376**	**100%**
May 2011	127	32.73%	215	55.41%	46	11.86%	**388**	**100%**
June 2011	139	35.92%	205	52.97%	43	11.11%	**387**	**100%**
Total for Q-4, SFY 2011	**370**	**32.15%**	**634**	**55.08%**	**147**	**12.77%**	**1,151**	**100%**

Source: InRhodes

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

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

2011, 30.93% of the new LTC applications that were processed had turn-around times of < 30 days[11].

For this reporting period, InRhodes data have been further analyzed in order to quantify the average number of days for approving or denying new applications for Medicaid LTC coverage. The following table shows the average turn-around time in days for Medicaid LTC approvals during the Fourth Quarter of SFY 2011 and the average TAT for Medicaid LTC denials during the same interval. The calculated averages for TATs have been provided and in addition these figures have been rounded up to whole integers.

RI EOHHS/DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-4, SFY 2011)

Number of Approvals for Medicaid LTC	Average TAT in Days
837	41.8 (~ 42 Days)*

Source: InRhodes

RI EOHHS/DHS: Average Turn-around Time (TAT) in Days for Medicaid LTC Denials (Q-4 SFY 2011)

Number of Denials for Medicaid LTC	Average TAT in Days
185	11.12 (~ 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. These outlier cases pertained to SSI and their inclusion would otherwise inflate the TAT statistic. 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.

On average, Medicaid LTC approvals and denials were processed below a 90-day threshold throughout SFY 2011. In the EOHHS report[12] which covered the first two

[11] The Rhode Island Executive Office of Health and Human Services. (June 30, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, January 1, 2011 – March 31, 2011 (p. 25).

quarters of SFY 2011, the average TAT for approvals of Medicaid LTC applications was 65 days and the corresponding TAT for denials was 11 days. During the Third Quarter of SFY 2011, the average TAT for approvals of Medicaid LTC applications was 59 days and the corresponding TAT for denials was 16 days[13].

[12] Ibid, p. 29.

[13] The Rhode Island Executive Office of Health and Human Services. (June 30, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, January 1, 2011 – March 31, 2011 (p. 26).

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

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

Nursing Home Level of Care	Hospital Level of Care	ICFMR Level of Care
Access to Nursing Facilities and section 1915(c) HCBS Waivers (the scope of community-based services varied, depending on the waiver)	Access to LTC, Hospital, Residential Treatment Centers and the 1915(c) HAB[14] waiver community-based services	Access to ICFMR, and section 1915(c) HCBS Waivers MR/DD community-based services.

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Human Services (RI DHS): Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI EOHHS/DHS), using three clinical levels of care: Highest, High, and Preventive. The following data have been provided by the Office of Medical Review, based upon the clinical eligibility determinations which were performed during the Fourth Quarter of SFY 2011.

EOHHS/DHS: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-4, SFY 2011)

Clinical Eligibility Level of Care Criteria	Q-4, SFY 2011
Nursing Facility	791
Hospital (HAB applicants)*	0

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

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

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

in a hospital setting, as would have been the case under the State's former section 1915(c) Habilitation Waiver.
For purposes of comparison, the following table documents the number of applicants for Medicaid LTC who met the clinical eligibility criteria for nursing facility or hospital (habilitation) services during the first three quarters of SFY 2011.

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

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

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

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. During the Fourth Quarter of SFY 2011, there were thirty-nine (39) applications made by individuals with developmental disabilities. There were also twelve (12) applications made for hospital care during Q-4 of SFY 2011.

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

Turnaround Times for Clinical Eligibility Determinations Conducted by the Rhode Island Department of Human Services (RI DHS): Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI EOHHS/DHS) since implementation of the Global Waiver. The following data have been provided by the Office of Medical Review, based upon the clinical eligibility determinations that were performed during the Fourth Quarter of SFY 2011. The calculations of average and median turnaround times have been based on calendar days (not business days).

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

EOHHS/DHS: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations (Q-4, SFY 2011)

	Q-4, SFY 2011	
Nursing Facility Care	**Average**	**Median**
	12	7
Hospital/(HAB applicants)	N/A*	N/A*

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

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

For purposes of comparison, the following table documents the average and median turnaround time in calendar days for Medicaid LTC clinical eligibility determinations during the first three quarters of SFY 2011.

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

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

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

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

During SFY 2011, the Division was unable to track the time between a completed application for services and clinical eligibility approval. As a result of *Project Sustainability*, the Division is developing a new internal database that will track these data. It is anticipated that this information will be available for new applications beginning in October 2011.

K. The number of appeals of clinical eligibility determinations across populations.

Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews for nursing facility care and hospital/habilitation[15] care have been conducted by the Office of Medical Review at the Rhode Island Department of Human Services (RI EOHHS/DHS). In the event that a LTC clinical eligibility determination has not been approved, the individual has the right to file an appeal, seeking to overturn the outcome of that determination.

Appeals Based on Clinical Eligibility Determinations Conducted by the Rhode Island Department of Human Services (RI DHS): The following data have been provided by the DHS' Office of Medical Review to document the number of appeals which had been filed as a result of non-approved clinical eligibility determinations for nursing facility care and hospital/habilitation care during the Fourth Quarter of SFY 2011.

EOHHS/DHS: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-4, SFY 2011

Appeals of LTC Clinical Eligibility Determinations by Level of Care	**Q-4, SFY 2011**
Nursing Facility	1
Hospital/Habilitation	0

Source: Office of Medical Review, RI DHS

Appeals Based on Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The following information was provided by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. As previously described, any applicant whose clinical eligibility determination has not been approved has the right to file appeal, seeking to overturn the outcome of that determination. The BHDDH's Division of Developmental Disabilities reported that there were (2) appeals filed during the Fourth Quarter of SFY 2011.

[15] To meet a hospital (or habilitation) level of care, an applicant must require intensive daily rehabilitation and/or ongoing skilled nursing services comparable to those offered in a hospital setting, which could not be provided adequately or appropriately in a nursing facility. This level of care requirement is analogous to that which had been established by Rhode Island's former 1915(c) Habilitation Waiver.

L. Average and median length of time after an applicant is approved for Medicaid long-term care until placement in the community or an institutional setting.

As noted previously, there are several pathways to Medicaid for LTC eligibility determinations. The majority of applicants for Medicaid long-term care (LTC) coverage file their application in order to secure a new payer so that they may continue to receive ongoing services. The following examples are provided, based upon whether the applicant is seeking LTC coverage for institutionally-based or home- or community-based services.

Institutional LTC services: New applications for institutionally-based LTC services generally come in to EOHHS/DHS from individuals who have already been admitted to an inpatient institution or a nursing facility. This group of applicants may have exhausted the benefit package covered by their primary source of health insurance coverage or, if they are without primary health insurance, may have depleted their personal financial resources. Therefore, these individuals have applied for Medicaid coverage in order to continue to receive an ongoing course of LTC services, which was initiated prior to Medicaid's involvement with the applicant. As such, these applicants have not sought *placement* in an institutional setting. Instead, they have sought Medicaid coverage in order to *remain* within an institutional LTC setting. For this group of new applicants, the Medicaid application approval date would not precede the applicant's date of admission to an inpatient institution or a nursing facility.

Community-based LTC services: New applications for Medicaid's community-based LTC services frequently come in to EOHHS/DHS from individuals who are nearing discharge from a hospital or nursing facility. These individuals, who were not covered by Medicaid at the time of their admission, have improved or stabilized clinically, and no longer require an institutional level of care. Based upon the discharge needs of this cohort of LTC applicants, Medicaid coverage would be sought so that they may receive community-based long-term care services post-discharge. For this group of applicants, therefore, the date of admission to the discharging institution would precede the Medicaid application approval date.

In an additional scenario, new applications for Medicaid LTC community services come directly from individuals who reside at home or in a community-based setting. Because this category of new applicant who is seeking Medicaid LTC coverage is already residing in a home- or community-based setting, their Medicaid application approval date would not precede the applicant's placement in the home- or community-based setting.

M. For persons transitioned from nursing homes, the average length of stay prior to transfer and type of living arrangement or setting and services upon transfer.

Each person transferred from a nursing home has a unique discharge plan that identifies the individual's needs and family supports. This discharge plan includes the arrangement of services and equipment, and home modifications. The length of stay prior to transfer and type of living arrangements or setting and services upon transfer is unique to each individual.

Prior to the start of SFY 2011, The Alliance for Better Long Term Care partnered with Qualidigm[16] and the Rhode Island Department of Human Services on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of the RI EOHHS/DHS and DEA in the identification of residents who could be transitioned safely. In collaboration with representatives of the two EOHHS agencies (EOHHS/DHS and DEA), the Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting. As of July of 2010, the functions that had been conducted by the Alliance were transferred to the Nursing Home Transitions Program, within the Office of Community Programs at Rhode Island Medicaid.

RI Medicaid: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-4, SFY 2011)

	Q-4, SFY 2011
Number of Nursing Home Transitions	31
Average Length of Stay (ALOS) Prior to Transfer in Calendar Days	425

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

As was the case in prior reporting periods, the average length of stay (ALOS) was measured in calendar days. For those beneficiaries who were transitioned from a nursing facility, their ALOS prior to transfer was 425 days in Q-4 of SFY 2011. During this quarter, the average length of stay prior to transfer increased significantly from 193 days in Q-3 of SFY. The increase in this statistic was demonstrated because two (2) of the 31 Medicaid LTC beneficiaries who were successfully transferred to home-based settings during Q-4 of SFY 2011 had been in a Nursing Facility for more than two years. Because of these outliers, the ALOS prior to transfer was greater than in any prior reporting periods.

[16] Qualidigm is the Peer Review Organization (PRO) that is under contract to RI Medicaid 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.

The following table documents the type of living arrangement (or setting) that LTC beneficiaries who were transitioned from a nursing facility went to subsequent to their discharge.

RI Medicaid: The Type of Living Arrangement or Setting and Services upon Transfer for Persons Transitioned from Nursing Homes (Q-4, SFY 2011)

	Q-4, SFY 2011	
Existing Home	23	74.19%
Assisted Living	8	25.81%
New Housing	0	0%
Group Home	0	0%
Other	0	0%
Total	**31**	**100%**

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

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

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

Prior to the start of SFY 2011, The Alliance for Better Long Term Care partnered with Qualidigm[17] and the Rhode Island Department of Human Services on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of the RI EOHHS/DHS and DEA in the identification of residents who could be transitioned safely. In collaboration with representatives of the two EOHHS agencies (EOHHS/DHS and DEA), the Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting. As of July of 2010, the functions that had been conducted by the Alliance were transferred to the Nursing Home Transitions Program, within the Office of Community Programs at Rhode Island Medicaid.

As noted in Item M, there were 31 LTC beneficiaries who were transitioned from nursing facilities during the Fourth Quarter of SFY 2011 (April 1, 2011 through June 30, 2011). The Office of Community Programs at Rhode Island Medicaid reported that there were no (0) failed placements during the Fourth Quarter of SFY 2011.

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

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

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

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

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

Cohort Analysis for RIte Care/RIte Share Applicants: For the purpose of the following cohort analysis, two major groups comprised the RIte Care/RIte Share applicant population and information has been provided for each group during the Fourth Quarter of SFY 2011 (April 1, 2011 through June, 2011). These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[18] and b) several additional

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

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

RI EOHHS/DHS: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-4 SFY 2011

Month	Rhode Island Works	"Other"
April 2011	3,219	330
May 2011	3,116	391
June 2011	2,823	692
Total for Q-4 of SFY 2011	**9,158**	**1,413**

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

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

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

Approved Applications: The following tables outline the number of Rhode Island Works and "Other" applicants who were deemed to be eligible for Medicaid during the Fourth Quarter of SFY 2011 (April 1, 2011 through June 30, 2011). The following table represents a "point-in-time" snapshot of the number of approved applications for Medicaid coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics.

RI EOHHS/DHS: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-4 SFY 2011

Month	Rhode Island Works	"Other"
April 2011	2,474	322
May 2011	2,320	388
June 2011	2,202	308
Total for Q-4 of SFY 2011	**6,996**	**1,018**

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

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

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

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

Denied Applications: InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics for the Rhode Island Works (RIW) and the "Other" category of applicants during the Fourth Quarter of SFY 2011 (April 1, 2011 through June 30, 2011). The number of denials documented below represents a "point-in-time" snapshot of activity.

RI EOHHS/DHS: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-4 SFY 2011

Month	Rhode Island Works	"Other"
April 2011	227	10
May 2011	256	6
June 2011	226	13
Total for Q-4 of SFY 2011	**709**	**29**

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

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

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

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

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

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

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

Item O provided tables that documented the number of applications received from RIte Care applicants during the Fourth Quarter of SFY 2011 (April 1, 2011 through June 30, 2011). For the purpose of that cohort analysis, there were two major groups comprising the RIte Care/RIte Share applicant population. In the response to Item O, information was stratified for these two groups of applicants: a) those who were seeking enrollment in Rhode Island Works[20] and b) several additional categories of applicants. As previously noted, statistics for the latter grouping are aggregated (or combined) within the InRhodes system and are classified as "Other"[21].

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

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

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and addresses the monthly average number of RIte Care/RIte Share applications pending for more than thirty (30) days. Pending cases are defined as those which have not yet had either an acceptance (approval) or denial determination. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the pending applications for the Rhode Island Works/RIte Care applicant cohort during the Fourth Quarter of State Fiscal Year 2011.

RI EOHHS/DHS: The Monthly Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort (Q-4, SFY 2011)

Quarter	Average Number of Applications Pending More than 30 Days for Rhode Island Works Applicants
Q-4, SFY 2011	479

Source: InRhodes

For purposes of comparison, the following table documents the monthly average number of new applications pending more than thirty days for this enrollment cohort during the first three quarters of SFY 2011.

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

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

As had been described in the quarterly report[22] that was submitted to the State Senate on 09/30/2011, the average number of applications pending more than 30 days during the First Quarter of SFY 2011 was flagged with an asterisk because the finding for the first month (July of 2010) in that quarter represented an outlier. If July 2010 were to be excluded from the calculation of this statistic, then the average number of new applications pending more than 30 days during the First Quarter of SFY 2011 would equal 430.

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

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 Fourth Quarter of SFY 2011 (April 1, 2011 through June 30, 2011). That prior discussion also gave an overview of the eligibility determination processes specific to new applications. Information was provided about the number of eligibility approvals (also referred to as "acceptances") and denials for new RIte Care/RIte Share applicants during the same time frame.

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and focuses on RIte Care/RIte Share redeterminations and closures. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the redeterminations and closures which were processed for the Rhode Island Works/RIte Care enrollment cohort during the Fourth Quarter of SFY 2011. At this time, a detailed analysis of the reasons for closures is not available. However, enhanced reporting capability will be realized through Rhode Island's CHOICES Project, which will streamline the State's Medicaid Information Technology Architecture.

RI EOHHS/DHS: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort (Q-4, SFY 2011)

Month	RIW Redeterminations	RIW Closures	Percentage
April 2011	52,367	2,393	4.66%
May 2011	52,307	2,174	4.16%
June 2011	52,648	1,713	3.25%
Total for Q-4, SFY 2011	**157,322**	**6,280**	**~4.0%**

Source: InRhodes

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

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

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

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

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

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

Source: InRhodes

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

Some RIte Care- or RIte Share[23]-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.

EOHHS/DHS: Monthly Premiums for Families, By Income Level

Family Income Level[24]	Monthly Premium for a Family
> 150% FPL and not > 185% FPL	$61.00/month
> 185% FPL and not > 200% FPL	$77.00/ month
> 200% FPL and not > 250% FPL	$92.00/month

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

EOHHS/DHS: The Number of RIte Care- or RIte Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-4, SFY 2011)

Percentage of the Federal Poverty Level (FPL)	Q-4, SFY 2011	
> 150 - 185% FPL	10,383	60.2%
> 185 - 200% FPL	2,343	13.6%
> 200 - 250% FPL	4,524	26.2%
Total	**17,250**	**100.0%**

These findings were similar to those noted throughout SFY 2011, based on the EOHHS' previous reports[25] to the State Senate.

[23] 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.

[24] For a family of four, the following FPLs were updated by the US DHHS and published in the *Federal Register* on 08/03/201: 150% FPL = $33,075.00; 185% FPL = $40,792.50; 200% FPL = $44,100.00; 250% FPL = $55,125.00.

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

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

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

If full payment is not received by the twelfth (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 month[26]. For example, if a premium payment which is due on January 1st has not been not 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.

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[25] The Rhode Island Executive Office of Health and Human Services. (September 15, 2011). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, July 1, 2010 – December 30, 2010 (pg. 45).

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

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

The following sanction data were obtained from InRhodes, the EOHHS/DHS Eligibility System, and document the number of RIte Care- or RIte Share-enrolled families who were sanctioned during the Fourth Quarter of SFY 2011 (April 1, 2011 – June 30, 2011. For purposes of comparison, data from the First, Second, and Third Quarters of SFY 2011 have also been provided.

RI Medicaid: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-1 - Q-4, SFY 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%**

The following table provides quarterly comparative data about sanctions by percentage of the Federal Poverty Level throughout SFY 2010.

RI Medicaid: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-1 – Q-4, SFY 2010)

Percentage of the Federal Poverty Level (FPL)	**Q-1, SFY 2010**		**Q-2, SFY 2010**		**Q-3, SFY 2010**		**Q-4, SFY 2010**	
> 150 - 185% FPL	183	58.1%	136	47.7%	206	52.8%	188	52.1%
> 185 - 200% FPL	48	15.2%	65	22.8%	60	15.4%	62	17.2%
> 200 - 250% FPL	84	26.7%	84	29.5%	124	31.8%	111	30.7%
Total	**315**	**100%**	**285**	**100%**	**390**	**100%**	**361**	**100%**

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

The following table documents the total of State and Federal expenditures for the Cost Not Otherwise Matchable (CNOM) provision of Section 1115(a)(2) of the Social Security Act for SFY 2011. These data were obtained from DHS Financial Management and are based upon paid dates, not incurred dates of service.

State and Federal Expenditures Under the CNOM Provision of Section 1115(a)(2) of the Social Security Act (SFY 2011)

State	$17,335,506
Federal	$19,502,121
Total	**$36,837,627**

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

The following data were obtained from the DHS TPL Unit and document the total recoveries that were paid to the EOHHS/DHS during the Fourth Quarter of SFY 2011 (April 1, 2011 through June 30, 2011). This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: Q-4, SFY 2011

Recoveries by Type	**Amount Recovered**
Estate Recoveries: TPL and Legal	$952,330
Casualty Recoveries: TPL and Legal	$336,211
Total	**$1,288,541**

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Budget Neutrality Summary	Total DY 1	Total DY 2	Q/E 12/31/11	Total DY 3
Section I: Total Expenditures Subject to Budget Neutrality				
Budget Population 1: (ABD no TPL)	$ 418,731,831	$ 486,505,287	$ 126,836,742	$ 522,293,881
Budget Population 2 (ABD TPL)	$ 715,844,300	$ 659,668,554	$ 152,195,886	$ 602,777,488
Budget Population 3 (RIte Care)	$ 362,611,218	$ 405,517,339	$ 112,314,314	$ 440,197,089
Budget Population 4 (CSHCNs)	$ 188,895,404	$ 184,738,525	$ 40,432,624	$ 168,271,992
Budget Population 5 (EFP)	$ 198,808	$ 134,380	$ 23,273	$ 94,294
Budget Population 6 (Pregnant Expansion)	$ 1,489,534	$ 1,820,522	$ 282,921	$ 1,740,579
Budget Population 7 (SCHIP Children)	$ -	$ -	$ -	$ -
Budget Population 8 (CNOM: Substitute Care)	$ -	$ -	$ -	$ -
Budget Population 9 (CNOM: CSHCNs otherwise in voluntaary state custody)	$ 3,364,541	$ -	$ -	$ 4,744,703
Budget Population 10 (CNOM: 65, <200%, at risk for LTC)	$ 2,943,524	$ 4,492,554	$ 1,316,906	$ 4,941,055
Budget Population 11 (217-like, CatNeedy HCBW like svcs, Highest Need)	$ -	$ -	$ -	$ -
Budget Population 12 (217-like CatNeedy HCBW like svcs, High need)	$ -	$ -	$ -	$ -
Budget Population 13 (217-like Medically Needy, HCBW like svcs (high and highest). Medically Needy PACE-like partricipnts in community	$ -	$ -	$ -	$ -
Budget Population 14 (BCCTP)	$ 6,553,342	$ 3,813,979	$ 968,839	$ 3,957,712
Budget Population 15 (CNOM: Adults w/ disabilities at risk for LTC, <300% FPL)	$ 255,250	$ 897,633	$ 173,176	$ 764,713
Budget Population 16 (CNOM: Uninsured Adults w/ mental illness)	$ 6,595,169	$ 6,989,503	$ 3,171,617	$ 12,099,917
Budget Population 17 (CNOM: Youth at risk for Medicaid; at risk children < 300% FPL)	$ 3,775,172	$ 3,696,607	$ 628,637	$ 3,253,287
Budget Population 18 (HIV)	$ -	$ 752,914	$ -	$ 1,059,261
Budget Population 19 (CNOM: Non-working disabled adults 19-64, GPA)	$ 1,743,740	$ 1,790,059	$ 444,273	$ 1,823,738
Budget Services 1 (Windows)	$ 4,504	$ -	$ -	$ -
Budget Services 2 (RIte Share and collections)	$ 5,369,938	$ 6,772,712	$ 1,514,587	$ 6,437,643
Budget Service 3 (Other payments - e.g.FQHC suppl., stop loss)	$ 10,194,423	$ 33,205,530	$ (2,776,344)	$ 14,600,045
Budget Services 4 (CNOM: core and preventive svcs, Medicaid eligible at risk youth)	$ -	$ -	$ -	$ -

Budget Services 5 (CNOM: Services by FQHCs to uninsured individuals)	$ 600,000	$ 1,200,000	$ 8,689	$ 1,208,689
Base Expenses [1]	$ 33,090,955	$ 91,516,977	$ 8,850,877	$ 75,940,829
TOTAL Expenditures for Period as reported on the CMS-64*	**$ 1,762,261,653**	**$ 1,893,513,074**	**$ 446,387,017**	**$ 1,866,206,914**
Section II: Expenditure Target				
Quarterly	$ 2,600,000,000	$ 2,400,000,000	$ 575,000,000	$ 2,300,000,000
Cumulative	$ 2,600,000,000	$ 5,000,000,000	$ 2,300,000,000	$ 7,300,000,000
Section III: Actual Expenditures w/Waiver				
Quarterly			$ 446,387,017	
Cumulative	$ 1,762,261,653	$ 1,893,513,074	$ 1,866,206,914	$ 1,866,206,914
Section IV: Surplus / (Deficit)				
Quarterly	$ 837,738,347	$ 506,486,926	$ 128,612,983	**$ 433,793,086**
Cumulative	**$ 837,738,347**	**$ 1,344,225,273**	**$ 1,778,018,359**	**$ 1,778,018,359**

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

Total Global Waiver Expenditures	*$*	*446,387,017*
LEA	*$*	*4,370,597*
SCHIP (RIteShare Premiums & Collections)	*$*	*(241,811)*
SCHIP	*$*	*3,053,801*
DSH	*$*	-
Prior Period Adjustments	*$*	-
Current Period Adjustments	*$*	-
CMS 64 Summary Sheet: 6. Expenses this Quarter)	*$*	*453,569,604*

[1] **Base Expense(** Other Expenses unallocated by Budget Population or Budget Service) Expenditures included in "Other" category are payments that are non-recipient specific and therefore, cannot be allocated to a specific recipient/waiver population. Due to the nature of the transactions and reimbursement of the payment the amount reported could include negative reportable amounts, as : 1) System payouts, e.g.: single cycle payment made to a provider as an interim payment until claim specific payment is made. The single payment is reimbursed wth the claim specific payment is made. 2) Manual payments: same as system payout but paid off cycle. 3) Managed Care system and manual payments including risk share, stoploss, pay-for-preformance, FQHC prospective payments, and other similar transactions: 4) Non-MMIS payments. These payments include such transactions as supplied in the Non-EDS Paid backup documents.