Report to the Centers for Medicare and Medicaid Services

Quarterly Operation Report
Rhode Island Global Consumer Choice Compact
1115 Waiver Demonstration
April 1, 2012 – June 30, 2012

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

August 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.

[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 April 1, 2012 – June 30, 2012 are outlined below.

Rhode Island Medicaid Eligibility

Program	March 2012 Counts of Eligibles	June 2012 Counts of Eligibles
Aged	17,486	17,516
Disabled	28,085	28,004
BCCPT	240	246
QMBs, SLMBs, and QI 1s	6,618	6,593
Child and Families	133,261	133,048
Adoptive Subsidy	2,434	2,433
Foster Care	2,276	2,295
Children with Special Health Care Needs	8,813	8,685
Total	199,213	198,820

Care Management Program Enrollment

Program	Enrollment as of 03/31/12	Enrollment as of 06/30/12
RIte Care	125,598	125,850
RIte Share	11,492	11,498
Rhody Health Partners	13,579	13,309
PACE	208	218
Connect Care Choice	1,755	1,738
Connect Care	130	122
RIte Smiles	57,799	58,696
Early Intervention	2,063	2,096
BCCPT	240	246
Extended Family Planning	339	325

Cost Not Otherwise Matchable (CNOM) Program Enrollment

Program	Description	Enrollment as of 03/31/12	Enrollment as of 06/30/12
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	**1,459**	**1,536**
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	**240**	**246**
Budget Population 15	Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid	**2,095**	**2,117**
Budget Population 16	Uninsured adults with mental illness	**9,006**	**9,780**
Budget Population 17	Children at risk for Medicaid and/or institutional care	**2,605**	**2,676**
Budget Population 18	HIV positive individuals who are otherwise not eligible for Medicaid	**354**	**341**
Budget Population 19	Non-working disabled adults ages 19-64 who do not qualify for disability benefits	**655**	**653**

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 April 1, 2012 – June 30, 2012

Request Type	Description	Date Submitted	CMS Action	Date
State Plan Amendment	Disproportionate Share Hospital Policy	06/27/11	Approved	09/23/11
Category II	Elimination of Annual Nursing Facility Rate Adjustment	09/30/11	Pending	
State Plan Amendment	Single State Agency Designation	09/30/11	Pending	
Category II	Pain Management	02/09/12	Approved	04/25/12
Category II	Nursing Facility Rate Reduction	03/29/12	Pending	
Category II	Nutrition Services and Individual/Group Education for Individuals with Chronic conditions	05/16/12	Pending	
Category II	DME	05/21/12	Pending	
State Plan Amendment	SSI Cola	3/23/12	Approved	06/07/12
State Plan Amendment	Medically Needy Income Limit	03/23/12	Approved	06/21/12
State Plan Amendment	Home Equity	03/23/12	Approved	06/21/12
State Plan Amendment	Tobacco Cessation	03/30/12	Approved	06/26/12
State Plan Amendment	Provider Screening and Enrollment	06/12/12	Pending	
State Plan Amendment	Payment Adjustment for Provider Preventable Conditions, including Hospital Acquired Conditions	06/20/12	Pending	

Cost Not Otherwise Matchable (CNOM)

Under the federal authority granted by CMS, the state has claimed $ 5,848,546 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 $ 2,145,520,203 million dollars below the cap during this reporting quarter. Attachment A contains the Budget Neutrality Report.

Key Activities for the reporting period April 1, 2012 – June 30, 2012 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 June 30, 2012, a total of **1682 Level of Care (LOC) assessments** had been completed, resulting in the following determinations: **Highest LOC = 1,092**; **High LOC = 475**; and **Preventive LOC = 104**. Eleven (11) 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 1,123 individuals to date to a community setting in the Nursing Facility Transition program and the MFP program**
    - **185 Nursing Home Transition referrals** were made to the Office of Community (OCP) Programs during Q-4 of SFY 2012
    - **37 individuals** were transitioned to a community setting during the reporting quarter. Of the 37 individuals, 16 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 and subcommittees in April 2012 and May 2012
- Commenced planning for development of marketing materials and reporting for the MFP initiative

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

  - During Q-4 of SFY 2012, **104 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 78 individuals in the EOHHS Shared Living program** as of June 30, 2012
  - 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
  - Continued transitions under the *Money Follows the Person* Demonstration
  - Participated in regular *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
  - Commenced planning for 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

- 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
- Convened cross-departmental overview of the Balancing Incentive Program with Technical Assistance from the Center for Health Care Strategies
- Convened cross-departmental planning for the ADRC Part A and Part B Grant opportunity
- 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
- Submitted a report to the RI General Assembly on the Integrated Care and Financing for Medicare and Medicaid Beneficiaries
- Prepared and posted for Public Comments draft Demonstration Proposal to the Centers for Medicare and Medicaid Services (CMS) for Integrated Care for Medicare and Medicaid Beneficiaries
- Convened two Public Meeting on the Integrate Care for Medicare-Medicaid Enrollees
- Reviewed public comments from the Public Meetings and incorporated comments into the draft Demonstration Proposal to the Centers for Medicare and Medicaid Services (CMS) for Integrated Care for Medicare and Medicaid Beneficiaries
- Submitted a Demonstration Proposal to the Centers for Medicare and Medicaid Services (CMS) for Integrated Care for Medicare and Medicaid Beneficiaries
- Analyzed data to support Integrate Care for Medicare-Medicaid Enrollees
- Explored opportunities under the Affordable Care Act (ACA), including Balancing Incentive Program and Community First Choice for Medicaid Enrollees, 1915(i) and Essential Health Benefit Medicaid Benchmark Plan Habilitation Option
- Planned for Focused Stakeholder sessions for the Integrated Care for Medicare and Medicaid Beneficiaries initiative
- Participated in the Integrated Care Resource Center (ICRC) Study Hall Call series

- 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
  - Continued the mailing of 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
  - Implemented the pain management benefit
  - Implemented streamlined improvements to the care planning assessment tools

- Transitioned Connect Care members into a comprehensive delivery system, either Connect Care Choice or Rhody Health Partners

- 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.)

  - Issued regulatory changes to the Sherlock Plan to improve program participation
  - Included the Sherlock Plan in the Demonstration Proposal to the Centers for Medicare and Medicaid Services (CMS) for Integrated Care for Medicare and medicaid Beneficiaries
  - Exploring opportunities to aligning efforts under a recently Health Care Innovation grant award "Living Rite-A Disruptive Solution for Management of Chronic Care Disease (a focus on adults with disabilities: intellectual and developmental diagnoses and dementia patients with 2 or more chronic conditions)

- 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 developing the LTSS models for the Integrated Care for Medicare and Medicaid beneficiaries
  - Researched best practices and met with key informants

- Promote the adoption of "Medical Homes"

  - Monitoring the implementation of the two *Health Homes for Medicaid Enrollees with Chronic Conditions Initiatives*
  - Participated in the statewide CSI Rhode Island Medical Home Project
  - Exploring opportunities for additional Health Home models of care for additional populations

- 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
  - Implemented activities for P-APD (IT Global Waiver and MITA Planning)
  - Reviewed responses to the RFP for Transition, Enhancement, Operation and Maintenance of the Medicaid Management Information System (MMIS)
  - Monitored the utilization of the 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
    - Issued RFP for the United Health Infrastructure, the state's health benefits exchange and integrated eligibility system (HIX/IES)
    - Participated in the planning of the Essential Health Benefits benchmark plan development
    - Analyzed options for Essential Health Benefits Medicaid Benchmark plan and Basic Health Plan Option

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

    - Monitored implementation of the 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
    - Continued development of selective contracts with a Community Health Care Team for under an Enhanced PPCM model for dually eligible and Medicaid-only populations

- 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
    - Developed opportunities for selective contracting for SFY 2013 budget initiatives
    - Continued to refine recommendations for long-term care acuity adjustments to meet budget targets
    - Continued planning of the implementation of the RI Nursing Facility Payment Methodology refinements

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

    - Convened three meetings with the Global Waiver Task Force on 04/23/2012, 05/21/2012 and 06/25/2012
    - Convened the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 06/06/2012

- 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
- Posted on the EOHHS website information on the Integrated Care for Medicare and Medicaid Beneficiaries, the Medicaid Senate Report and press releases related to the closure of a Nursing Facility
- Posted EOHHS Notice of Proposed Rulemaking and Policy Changes in April 2012 and May 2012

Section III

Key analytic highlights on the progress of the Global Waiver based on performance during the Second Quarter of the SFY 2012 (October 1, 2011 – December 31, 2011).

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

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

The following table outlines the number of Medicaid LTC applicants who were deemed to be eligible for Medicaid LTC during the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011). The following tables represent a "point-in-time" snapshot of the number of approved applications for Medicaid LTC coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for Q-2 of SFY 2012.

RI MEDICAID: Medicaid Long-term Care Acceptances (Approvals), Q-2, SFY 2012

Month	Long-Term Care Approvals
October 2011	235
November 2011	207
December 2011	208
Total for Q-2, SFY 2012	**650**

Source: InRhodes

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

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. The following table outlines the number of Medicaid LTC applicants who were found ineligible during the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011). InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics. The number of denials documented below represents a "point-in-time" snapshot of activity. This information has been provided by month for Q-2 of SFY 2012.

RI MEDICAID: Medicaid Long-term Care Denials, Q-2, SFY 2012

Month	Long-Term Care Denials
October 2011	50
November 2011	45
December 2011	42
Total for Q-2, SFY 2012	**137**

Source: InRhodes

In comparing this finding to that which was documented during the First Quarter of SFY 2012, there were 138 LTC denials during that interval[2].

[2] The Rhode Island Executive Office of Health and Human Services. (April 2, 2012). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, July 1, 2011 – September 30, 2011 (p. 10).

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 Second Quarter of SFY 2011 (October 1, 2011 – December 31, 2011).

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-2, SFY 2012 (RI Division of Elderly Affairs (DEA): The first set of tables quantifies the number (or count) of individuals who received LTC services provided under the auspices of the Rhode Island Division of Elderly Affairs (RI DEA) during the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011).

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

DEA: LTC Service Type and Corresponding Unit of Service

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

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

Source: EOHHS Data Warehouse: MMIS Claim Universe			Oct		Nov		Dec		Q-2, SFY 2012	
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	55	1,678	58	1,728	55	1,705	168	5,111
		65 and Older	251	7,566	246	7,267	246	7,443	743	22,276
DEA	Assisted Living	Service Type Subtotals:	306	9,244	304	8,995	301	9,148	911	27,387
	Case Management	Under 65	37	151	34	147	47	177	118	475
		65 and Older	424	2,190	429	2,097	383	1,931	1,236	6,218
DEA	Case Management	Service Type Subtotals:	461	2,341	463	2,244	430	2,108	1,354	6,693
	Personal Care/Homemaker	65 and Older	396	105,632	399	106,969	396	104,566	1,191	317,167
DEA	Personal Care/Homemaker	Service Type Subtotals:	396	105,632	399	106,969	396	104,566	1,191	317,167
DEA		Grand Total:		117,217		118,208		115,822		351,247

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-2, SFY 2012 (RI Medicaid): The second set of tables shows the number (or count) of individuals who received LTC services through Rhode Island Medicaid during the Second Quarter of SFY 2012. This information reflects incurred dates of service (October 1, 2011 through December 31, 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.

RI Medicaid: LTC Service Type and Corresponding Unit of Service

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

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

Information which documents the number of Medicaid beneficiaries who were served has been stratified by participants' age group for the following lines of service which are administered by the RI 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.

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 that 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 RI Medicaid: 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 Second Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Oct		Nov		Dec		Q-2, SFY 2012	
Reporting Period: Date of Service			2011		2011		2011			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
EOHHS	Adult Day Care	Under 65	264	3,499	260	3,250	253	3,430	777	10,179
		65 and Older	252	3,474	260	3,508	254	3,510	766	10,492
EOHHS	Adult Day Care	Service Type Subtotals:	516	6,973	520	6,758	507	6,940	1,543	20,671
	Assisted Living	Under 65	11	331	10	298	11	328	32	957
		65 and Older	141	4,248	136	3,919	136	4,034	413	12,201
EOHHS	Assisted Living	Service Type Subtotals:	152	4,579	146	4,217	147	4,362	445	13,158
	Case Management	Under 65	2,573	2,779	632	855	284	491	3,489	4,125
		65 and Older	148	779	171	686	168	864	487	2,329
EOHHS	Case Management	Service Type Subtotals:	2,721	3,558	803	1,541	452	1,355	3,976	6,454
	Hospice	Under 65	35	950	32	845	31	920	98	2,715
		65 and Older	503	13,661	501	12,617	502	13,386	1,506	39,664
EOHHS	Hospice	Service Type Subtotals:	538	14,611	533	13,462	533	14,306	1,604	42,379
	Nursing Facility	Under 65	566	16,295	567	15,601	563	16,391	1,696	48,287
		65 and Older	5,165	152,651	5,118	147,100	5,110	151,696	15,393	451,447
EOHHS	Nursing Facility	Service Type Subtotals:	5,731	168,946	5,685	162,701	5,673	168,087	17,089	499,734
	Personal Care/Homemaker	Under 65	1,030	282,645	1,035	277,523	1,024	289,928	3,089	850,096
		65 and Older	1,272	353,052	1,271	354,993	1,274	362,618	3,817	1,070,663
EOHHS	Personal Care/Homemaker	Service Type Subtotals:	2,302	635,697	2,306	632,516	2,298	652,546	6,906	1,920,759
	Shared Living Agency	Under 65	17	956	17	1,021	18	1,006	52	2,983
		65 and Older	43	2,707	48	2,621	49	2,938	140	8,266
EOHHS	Shared Living Agency	Service Type Subtotals:	60	3,663	65	3,642	67	3,944	192	11,249
	Skilled Nursing	Under 65	243	3,088	235	3,356	215	3,131	693	9,575
		65 and Older	116	2,129	108	1,882	107	1,551	331	5,562
EOHHS	Skilled Nursing	Service Type Subtotals:	359	5,217	343	5,238	322	4,682	1,024	15,137
	Tavares Pediatric Center	Under 65	19	576	19	570	19	589	57	1,735
EOHHS	Tavares Pediatric Center	Service Type Subtotals:	19	576	19	570	19	589	57	1,735
EOHHS		Grand Total:		843,820		830,645		856,811		2,531,276

The Number of Medicaid Beneficiaries Served by PACE, Q-2, SFY 2012 (RI Medicaid): Using the EOHHS Data Warehouse, information was extracted from the MMIS to produce counts of the number of individuals who participated in the PACE (Program of All Inclusive Care for the Elderly) program during the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011). Please refer to the data table shown on the following page. This information has been stratified by month and by age group.

Source:		EOHHS Data Warehouse/Financial Data Mart		
Reporting Period:		Eligibility Period		
Dept.	**Benefit Period**	**Program Description**	**Age Group**	**Person Count**
EOHHS	10/1/2011	PACE PROGRAM	65 and Over	179
EOHHS		PACE PROGRAM	Under 65	37
	10/1/2011		**Period Totals:**	216
EOHHS	11/1/2011	PACE PROGRAM	65 and Over	178
EOHHS		PACE PROGRAM	Under 65	38
	11/1/2011		**Period Totals:**	216
EOHHS	12/1/2011	PACE PROGRAM	65 and Over	177
EOHHS		PACE PROGRAM	Under 65	38
	12/1/2011		**Period Totals:**	215
			Quarterly Total:	**647**

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-2, SFY 2012 (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; community supports; shared living; supported employment; case management; transportation; prevocational services; and job development. Data for the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011) are displayed on the following page.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-2, SFY 2012

Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2,797
		Over 65	278
BHDDH	Homemaker	Under 65	125
		Over 65	9
BHDDH	Public Group Homes	Under 65	134
		Over 65	80
BHDDH	Private Group Homes	Under 65	1,133
		Over 65	170
BHDDH	Community Supports	Under 65	1,005
		Over 65	73
BHDDH	Shared Living	Under 65	177
		Over 65	14
BHDDH	Supported Employment	Under 65	364
		Over 65	4
BHDDH	Case Management	Under 65	3,022
		Over 65	334
BHDDH	Transportation	Under 65	2,431
		Over 65	216
BHDDH	Prevocational	Under 65	188
		Over 65	13
BHDDH	Job Development	Under 65	59
		Over 65	1

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 Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one that shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

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

A second data source was queried to produce the cost and utilization data for the LTC services which are administered by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The database which is used by the Division of Developmental Disabilities (RI BHDDH) was queried to prepare the table which outlines LTC cost and utilization by BHDDH service line during the Second Quarter of SFY 2012.

Cost and Utilization Data, Q-2, SFY 2012 (RI Division of Elderly Affairs (DEA)): The following table provides an average cost per individual, as well as quarterly totals by DEA service line, for the two age groups during the Second Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-2, SFY 2012	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
	Assisted Living	Under 65	$ 1,068	$ 179,373
		65 and Older	$ 916	$ 680,755
DEA	Assisted Living	Service Type Subtotals:	$ 944	$ 860,128
	Case Management	Under 65	$ 60	$ 7,125
		65 and Older	$ 75	$ 93,270
DEA	Case Management	Service Type Subtotals:	$ 74	$ 100,395
	Personal Care/Homemaker	65 and Older	$ 1,347	$ 1,604,412
DEA	Personal Care/Homemaker	Service Type Subtotals:	$ 1,347	$ 1,604,412
DEA		Grand Total:		$ 2,564,935

Cost and Utilization Data, Q-2, SFY 2012 (RI Medicaid): The following table provides an average cost per individual, as well as quarterly totals by RI Medicaid service line, for the two age groups during the Second Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-2, SFY 2012	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
EOHHS	Adult Day Care	Under 65	$ 694	$ 539,243
		65 and Older	$ 725	$ 555,587
EOHHS	Adult Day Care	Service Type Subtotals:	$ 710	$ 1,094,830
	Assisted Living	Under 65	$ 1,253	$ 40,107
		65 and Older	$ 1,174	$ 485,022
EOHHS	Assisted Living	Service Type Subtotals:	$ 1,180	$ 525,129
	Case Management	Under 65	$ 48	$ 168,153
		65 and Older	$ 71	$ 34,634
EOHHS	Case Management	Service Type Subtotals:	$ 51	$ 202,787
	Hospice	Under 65	$ 4,208	$ 412,388
		65 and Older	$ 3,803	$ 5,727,373
EOHHS	Hospice	Service Type Subtotals:	$ 3,828	$ 6,139,761
	Nursing Facility	Under 65	$ 4,843	$ 8,213,977
		65 and Older	$ 4,686	$ 72,131,962
EOHHS	Nursing Facility	Service Type Subtotals:	$ 4,702	$ 80,345,939
	Personal Care/Homemaker	Under 65	$ 1,417	$ 4,377,111
		65 and Older	$ 1,441	$ 5,498,584
EOHHS	Personal Care/Homemaker	Service Type Subtotals:	$ 1,430	$ 9,875,694
	Shared Living Agency	Under 65	$ 1,987	$ 103,310
		65 and Older	$ 1,993	$ 279,053
EOHHS	Shared Living Agency	Service Type Subtotals:	$ 1,991	$ 382,363
	Skilled Nursing	Under 65	$ 349	$ 241,550
		65 and Older	$ 510	$ 168,739
EOHHS	Skilled Nursing	Service Type Subtotals:	$ 401	$ 410,289
	Tavares Pediatric Center	Under 65	$ 31,303	$ 1,784,266
EOHHS	Tavares Pediatric Center	Service Type Subtotals:	$ 31,303	$ 1,784,266
EOHHS		Grand Total:		$ 100,761,058

Cost and Utilization Data, Q-2, SFY 2012 (RI BHDDH): The following data[3] have been provided by the Division of Developmental Disabilities on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). Please refer to the table that has been provided on the following page.

[3] Several variances in expenditures have been noted by RI BHDDH for Q-2 of SFY 2012. Subsequent to the implementation of *Project Sustainability* on 07/01/2011, some lags in billing have been noted each month. In the transition to the new system, providers have needed to learn how to use the new system and the associated billing codes.

Source: RI BHDDH, Medicaid LTC Beneficiaries, Q-2, SFY 2012				
Dept.	**Service Type**	**Age Group**	**# Served**	**Total Expenditures**
BHDDH	Day Programs	Under 65	2,797	$6,981,603.02
		Over 65	278	656,518
BHDDH	Homemaker	Under 65	125	823,922.83
		Over 65	9	43,408.02
BHDDH	Public Group Homes	Under 65	134	5,202,396.48
		Over 65	80	3,131,028.75
BHDDH	Private Group Homes	Under 65	1,133	19,864,145.37
		Over 65	170	2,794,258.07
BHDDH	Community Supports	Under 65	1,005	3,146,672.67
		Over 65	73	239,153.47
BHDDH	Shared Living	Under 65	177	1,600,401.04
		Over 65	14	126,072.66
BHDDH	Supported Employment	Under 65	364	279,506.82
		Over 65	4	2,174.64
BHDDH	Case Management	Under 65	3,022	1,048,470.20
		Over 65	334	115,916.81
BHDDH	Transportation	Under 65	2,431	1,693,282.25
		Over 65	216	145,539.44
BHDDH	Prevocational	Under 65	188	153,767.34
		Over 65	13	12,083.63
BHDDH	Job Development	Under 65	59	19,792.28
		Over 65	1	204.16

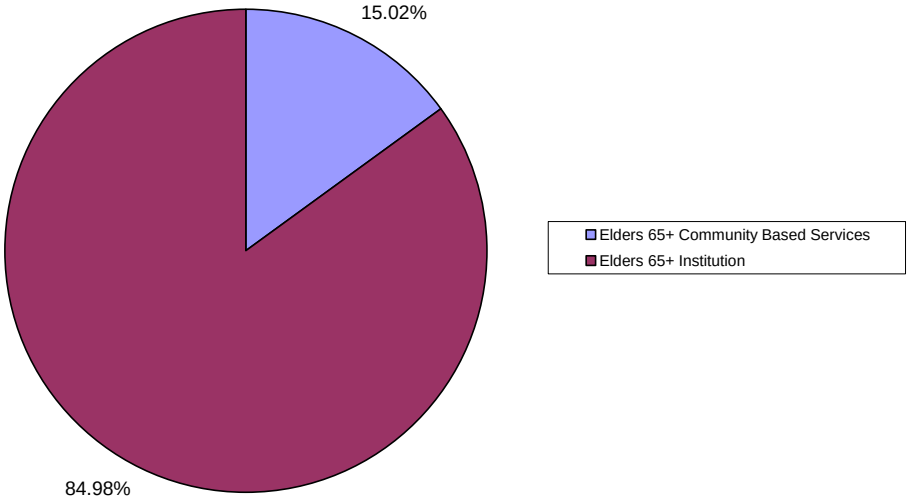
E. Percent distribution of expenditures for Medicaid long-term care institutional services and home and community services (HCBS) by population, including: elders aged 65 and over, persons with disabilities, and children with special health care needs.

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 (October 1, 2011 – December 31, 2011).

Elders Aged 65 and Over

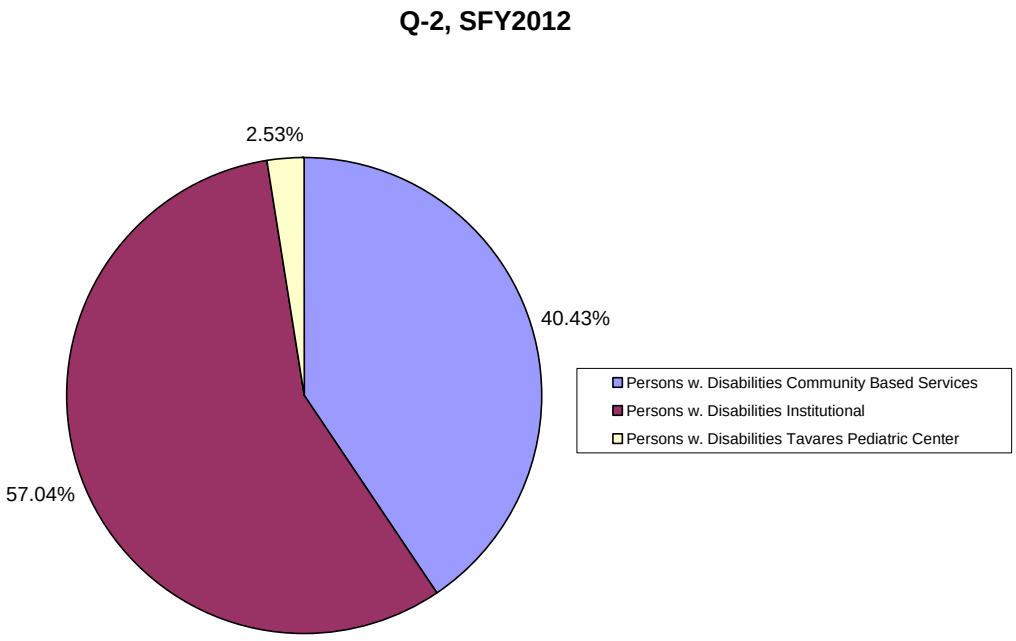
During the Second Quarter of SFY 2012, 84.98 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.02 percent were for home and community-based services (HCBS). These findings were similar to those which had been documented during the preceding quarter, Q-1 of SFY 2012, when 84.20 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.80 percent were for home and community-based services (HCBS).

Q-2, SFY2012



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 Executive Office of Health and 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 (October 1, 2011 – December 31, 2011).



During the Second Quarter of SFY 2012, 57.04 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services, 2.53 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services at the Tavares Pediatric Center, and 40.43 percent were for home and community-based services (HCBS). These findings were similar to those which had been documented during the preceding quarter, Q-1 of SFY 2012, when 57.09 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services, 2.04 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services at the Tavares Pediatric Center, and 40.87 percent were for home and community-based services (HCBS).

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 Second Quarter of State Fiscal Year 2012, 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 Elderly Affairs, covers the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011). The tables shown below document the service utilization of the DEA's Adult Day Care and Home Care Program (also referred to as the "Co-pay" Program). This information has been organized for each type of service by quarter.

RI DEA: Adult Day Care (Q-2, SFY 2012)

Service Category: Adult Day Care	**Clients***		**Units (Unit=1 Day)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	137	46	1,894	631
D2 (Income up to 200% FPL):	608	203	8,558	2,853
Total	**745**	**248**	**10,452**	**3,484**

Average utilization= 14 days of adult day care per client per month.
*Clients are not distinct.

RI DEA: Case Management (Q-2, SFY 2012)

Service Category: Case Management	**Clients**		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
Case Management	1,021	340	5,937	1,979

Average utilization = 1.45 Hours of Case management per client per month.

RI DEA: Home Care (Q-2, SFY 2012)

Service Category: Home Care	**Clients***		**Units (Unit=1/4 Hour)**	
	Total	**Avg/Mo.**	**Total**	**Avg/Mo.**
D1 (Income up to 125% FPL):	388	129	44,168	14,723
D2 (Income up to 200% FPL):	1,528	509	172,373	57,458
Total	**1,916**	**639**	**216,541**	**72,180**

Average utilization= 113 units or 28.25 hours of home care per client per month.
*Clients are not distinct.

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

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

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

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

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

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

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

Information has been drawn from InRhodes, the State's Medicaid eligibility system, to produce the following cohort analysis for LTC processing turn-around times during the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011). Turn-around times (TAT) for processing new LTC applications have been organized according to three timeframes: a) less than thirty (30) days; b) thirty (30) to ninety (90) days; and greater than ninety (90) days.

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

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

RI MEDICAID: Turn-around Times for New LTC Applications (Q-2, SFY 2012)

Month	**< 30 Days**		**30 – 90 Days**		**> 90 Days**		**Monthly Total**	
Oct. 2011	117	32.5%	187	51.94%	56	15.56%	**360**	**100%**
Nov. 2011	145	33.8%	225	52.45%	59	13.75%	**429**	**100%**
Dec. 2011	152	33.12%	237	51.63%	70	15.25%	**459**	**100%**
Total for Q-2, SFY 2012	**414**	**33.17%**	**649**	**52.0%**	**185**	**14.82%**	**1,248**	**100%**

Source: InRhodes

An increase in the percentage of new LTC applications processed in less than thirty (30) days was demonstrated in Q-2 of SFY 2012. This finding was similar to that which was observed during the prior quarter, when 31.07 percent of the new LTC applications were processed in less than 30 days. This finding represents a positive trend and it builds on that which was seen throughout SFY 2011. For purposes of comparison, please refer to the table that documents the turn-around times by quarter during SFY 2011, which has been provided on the following page.

[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/.

RI MEDICAID: Turn-around Times for New LTC Applications by Quarter (SFY 2011)

Quarter	< 30 Days		30 – 90 Days		> 90 Days		Quarterly Total	
Q-1, SFY 2011	355	28.22%	600	47.69%	303	24.09%	1,258	100%
Q-2, SFY 2011	341	28.53%	616	51.55%	238	19.92%	1,195	100%
Q-3, SFY 2011	391	30.93%	628	49.68%	245	19.38%	1,264	100%
Q-4, SFY 2011	370	32.15%	634	55.08%	147	12.77%	1,151	100%
Total for SFY 2011	**1,457**	**29.93%**	**2,478**	**50.90%**	**933**	**19.17%**	**4,868**	**100%**

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 Second Quarter of SFY 2012 and the average TAT for Medicaid LTC denials during the same interval. The calculated averages for TATs have been provided and in addition these figures have been rounded up to whole integers.

RI MEDICAID: Average Turn-around Time (TAT) in Days for Medicaid LTC Approvals (Q-2, SFY 2012)

Number of Approvals for Medicaid LTC	Average TAT in Days
650	53.2 (~ 54 Days)*

Source: InRhodes

RI MEDICAID: Average Turn-around Time (TAT) in Days for Medicaid LTC Denials (Q-2 SFY 2012)

Number of Denials for Medicaid LTC	Average TAT in Days
137	9.05 (~ 10 Days)

Source: InRhodes

These findings were similar to those observed during the First Quarter of SFY 2012, when the average turn-around time for approvals was 49 days and 17 days for denials. An asterisk has been flagged above to highlight that the InRhodes turn-around time (TAT) statistic for Medicaid LTC approvals during Q-2 of SFY 2012 had several significant outliers excluded. As noted in the prior two quarterly reports, SSI-related outliers can artificially increase the turn-around time statistic for LTC approvals.

For the SSI cohort, one of two dates has been recorded as the application date, depending upon whether: a) the individual has been newly added to SSI; or b) has already been SSI-eligible but has moved to Rhode Island from another state. The application date for individuals who are newly approved for SSI is recorded as the "Onset of Disability" date, which Rhode Island receives from the Social Security Administration (SSA).

However, for SSI-eligible individuals who relocate to Rhode Island from another state, the application date is set as the first day of the following month, based on the "Residency Begin Date", which is sent by the Social Security Administration (SSA). For those individuals who relocate to Rhode Island from another state, the SSA does not always indicate the relocation status on the clients' records. Therefore, the individual is viewed as a new SSI beneficiary and the "Onset of Disability" date is recorded rather than the "Residency Begin Date", resulting in an inflated turn-around time.

For purposes of comparison, the following table has been provided to demonstrate the average turn-around times in calendar days for Medicaid LTC approvals and denials by quarter during SFY 2011. The figures shown below have been rounded up to whole numbers.

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

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

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. On average, Medicaid LTC approvals and denials were processed below a 90-day threshold throughout SFY 2011.

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

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

Nursing Home Level of Care	Hospital Level of Care	ICFMR Level of Care
Access to Nursing Facilities and section 1915(c) HCBS Waivers (the scope of community-based services varied, depending on the waiver)	Access to LTC, Hospital, Residential Treatment Centers and the 1915(c) HAB[10] waiver community-based services	Access to ICFMR, and section 1915(c) HCBS Waivers MR/DD community-based services.

Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI Medicaid), using three clinical levels of care: Highest, High, and Preventive. The following data have been extracted from the RI EOHHS Data Warehouse and are based upon the clinical eligibility determinations that were performed during the Second Quarter of SFY 2012.

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-2, SFY 2012)

Clinical Eligibility Level of Care Criteria	Q-2, SFY 2012
Nursing Facility	785
Hospital (HAB applicants)*	0

Data Source: RI EOHHS Data Warehouse

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

[10] 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 on a quarterly basis during SFY 2011.

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

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

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

Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. During the Second Quarter of SFY 2012, there were ten (10) applications made.

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

Turnaround Times for Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: Medicaid LTC clinical eligibility reviews have been conducted by the Office of Medical Review (RI Medicaid) since implementation of the Global Waiver. The following data have been extracted from the RI EOHHS Data Warehouse, based upon the clinical eligibility determinations that were performed during the Second Quarter of SFY 2012. The calculations of average and median turnaround times have been based on calendar days (not business days).

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

RI Medicaid: Average and Median Turnaround Time in Calendar Days for Medicaid LTC Clinical Eligibility Determinations (Q-2, SFY 2012)

	Q-2, SFY 2012	
Nursing Facility Care	**Average**	**Median**
	16	12
Hospital/(HAB applicants)	N/A	N/A

Data Source: RI EOHHS Data Warehouse

During the Second Quarter of SFY 2012, 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.

The findings for the Second Quarter of SFY 2012 were similar to those documented during the preceding quarter, when a seventeen (17) calendar day mean was demonstrated for clinical eligibility determination turn-around times for nursing facility care. The median for clinical eligibility determinations for nursing facility care was fifteen (15) calendar days during the First Quarter. As was the case in Q-2 of SFY 2012, there were no applicants for Medicaid LTC who met the clinical eligibility criteria for a hospital (or habilitation) level of care during the First Quarter of SFY 2012.

To provide additional comparative information, the table shown on the following page documents the average and median turnaround time in calendar days for Medicaid LTC clinical eligibility determinations on a quarterly basis during SFY 2011.

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

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

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

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

During the Second Quarter of SFY 2012, the Division reported that eligibility determinations were processed on average within seventy (70) days from the time of application. This timeframe reflects that not all applications are fully completed when submitted for eligibility determination. Incomplete applications necessitate seeking additional documentation that is necessary in order to make an eligibility determination.

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

Since implementation of the Global Waiver, Medicaid LTC clinical eligibility reviews for nursing facility care and hospital/habilitation[11] care have been conducted by the Office of Medical Review at Rhode Island Medicaid. In the event that a LTC clinical eligibility determination has not been approved, the individual has the right to file an appeal, seeking to overturn the outcome of that determination.

Appeals Based on Clinical Eligibility Determinations Conducted by Rhode Island Medicaid: The following data have been provided by RI Medicaid's Office of Medical Review to document the number of appeals which had been filed as a result of non-approved clinical eligibility determinations for nursing facility care and hospital/habilitation care during the Second Quarter of SFY 2012.

RI Medicaid: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-2, SFY 2012

Appeals of LTC Clinical Eligibility Determinations by Level of Care	Q-2, SFY 2012
Nursing Facility	8
Hospital/Habilitation	0

Source: Office of Medical Review, RI Medicaid

Appeals Based on Clinical Eligibility Determinations Conducted by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH): The following information was provided by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (RI BHDDH). The Division of Developmental Disabilities at the RI BHDDH conducts clinical eligibility determinations for individuals with developmental disabilities. As previously described, any applicant whose clinical eligibility determination has not been approved has the right to file appeal, seeking to overturn the outcome of that determination. The BHDDH's Division of Developmental Disabilities reported that there were no (0) appeals filed during the Second Quarter of SFY 2012.

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

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

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

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

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

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

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

Through the Nursing Home Transition Program, within the Office of Community Programs at Rhode Island Medicaid, assistance is provided to beneficiaries before, during, and following a transition from nursing facilities. These functions are undertaken to ensure the provision of timely and appropriate services that enable these individuals to move safely and successfully to either a home-based or a community-based setting. Each person transferred from a nursing home has a unique discharge plan that identifies the individual's needs and family supports. This discharge plan includes the arrangement of services and equipment, and home modifications. The length of stay prior to transfer and type of living arrangements or setting and services upon transfer is unique to each individual.

The following table documents the number of nursing home transitions that took place during the Second Quarter of State Fiscal Year 2012. As was the case in prior reporting periods, the average length of stay (ALOS) has been measured in calendar days.

RI Medicaid: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-2, SFY 2012)

	Q-2, SFY 2012
Number of Nursing Home Transitions	36
Average Length of Stay (ALOS) Prior to Transfer in Calendar Days	240

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

The average length of stay (ALOS) in Q-2 of SFY 2012 (240 days) was greater than that which had been observed in the First Quarter (196 days). The finding for the Second Quarter was skewed statistically because of a "success story". One of the Medicaid LTC enrollees who had been transitioned to home and community-based supports during Q-2 of SFY 2012 had been residing in a nursing home for over four (4) years prior to discharge from the facility.

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

RI Medicaid: The Type of Living Arrangement or Setting and Services upon Transfer for Persons Transitioned from Nursing Homes (Q-2, SFY 2012)

	Q-2, SFY 2012	
Existing Home	30	83.33%
Assisted Living	4	11.11%
New Housing	0	0.00%
Group Home	0	0.00%
Other	2	5.56%
Total	**36**	**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[12] and Rhode Island Medicaid on behalf of the Nursing Home Transition Project. The Alliance worked with residents of nursing facilities, their families, and representatives of RI Medicaid and the Division of Elderly Affairs in the identification of residents who could be transitioned safely. In collaboration with representatives of the RI EOHHS, the Alliance assisted the State before, during, and following the transition of beneficiaries from nursing facilities to ensure the provision of timely and appropriate services that would enable these individuals to move safely and successfully to either a home-based or a community-based setting. As of July of 2010, the functions that had been conducted by the Alliance were transferred to the Nursing Home Transition Program, within the Office of Community Programs at Rhode Island Medicaid.

As noted in Item M, there were thirty-six (36) LTC beneficiaries who were transitioned from nursing facilities during the Second Quarter of SFY 2012 (October 1, 2011 through December 31, 2011). The Office of Community Programs at Rhode Island Medicaid reported that there were no (0) failed placements during the Second Quarter of SFY 2012.

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

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

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

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

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

Cohort Analysis for RIte Care/RIte Share Applicants: For the purpose of the following cohort analysis, two major groups comprised the RIte Care/RIte Share applicant population and information has been provided for each group during the Second Quarter of SFY 2012 (October 1, 2011 through December 31, 2011). These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works[13] and b) several additional categories of applicants. Statistics for the latter grouping are aggregated (or added) within the InRhodes system and are classified as "Other" [14].

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

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

RI MEDICAID: Applications for Rhode Island Works/RIte Care and "Other" Category of Applicants, Q-2, SFY 2012

Month	Rhode Island Works	"Other"
October 2011	2,897	289
November 2011	3,623	244
December 2011	3,392	331
Total for Q-2 of SFY 2012	**9,912**	**864**

The findings shown in the table above for Q-2 of SFY 2012 were similar to those reported for Q-1 of SFY 2012. There were 9,942 applications for Rhode Island Works and 912 "Other" applications during the First Quarter of SFY 2012. For purposes of comparison, the following table documents the number of applications that were made by quarter during SFY 2011.

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

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

Approved Applications: The following tables outline the number of Rhode Island Works and "Other" applicants who were deemed to be eligible for Medicaid during the Second Quarter of SFY 2012 (October 1, 2011 through December 31, 2011). The following table represents a "point-in-time" snapshot of the number of approved applications for Medicaid coverage. InRhodes, the State's Medicaid eligibility system, is the source of the following statistics.

RI MEDICAID: Approved Applications for Rhode Island Works and "Other" Category of Applicants, Q-2, SFY 2012

Month	Rhode Island Works	"Other"
October 2011	2,328	275
November 2011	2,520	243
December 2011	2,466	320

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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.

Total for Q-2 of SFY 2012	**7,314**	**838**

The findings shown in the table above for Q-2 of SFY 2012 were similar to those reported for Q-1 of SFY 2012. There were 7,189 approved applications for Rhode Island Works and 880 approved applications for the "Other" cohort during the First Quarter of SFY 2012. For purposes of comparison, the following table documents the number of applications that were approved by quarter during SFY 2011.

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

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

Denied Applications: InRhodes, the State's Medicaid eligibility system, is the source of the following denial statistics for the Rhode Island Works (RIW) and the "Other" category of applicants during the Second Quarter of SFY 2012 (October 1, 2011 through December 31, 2011). The number of denials documented below represents a "point-in-time" snapshot of activity.

RI MEDICAID: Denied Applications for Rhode Island Works and "Other" Category of Applicants, Q-2, SFY 2012

Month	Rhode Island Works	"Other"
October 2011	323	7
November 2011	199	11
December 2011	238	6
Total for Q-2 of SFY 2012	**760**	**24**

The findings shown in the table above for Q-2 of SFY 2012 were similar to those reported for Q-1 of SFY 2012. There were 694 denied applications for Rhode Island Works and 25 denied applications for the "Other" cohort during the First Quarter of SFY 2012. 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 table provided on the following page documents the number of applications that were denied by quarter during SFY 2011.

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

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

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

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

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

Item O provided tables that documented the number of applications received from RIte Care applicants during the Second Quarter of SFY 2012 (October 1, 2011 through December 31, 2011). For the purpose of that cohort analysis, there were two major groups comprising the RIte Care/RIte Share applicant population. In the response to Item O, information was stratified for these two groups of applicants: a) those who were seeking enrollment in Rhode Island Works[15] and b) several additional categories of applicants. As previously noted, statistics for the latter grouping are aggregated (or combined) within the InRhodes system and are classified as "Other" [16].

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

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

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and addresses the monthly average number of RIte Care/RIte Share applications pending for more than thirty (30) days. Pending cases are defined as those that have not yet had either an acceptance (approval) or denial determination.

RI MEDICAID: The Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort (Q-2, SFY 2012)

Quarter	Average Number of Applications Pending More than 30 Days for Rhode Island Works Applicants
Q-2, SFY 2012	619*

Source: InRhodes

The statistic shown above has been flagged with an asterisk (*) to note that it should be considered a provisional finding. Further analyses are being conducted because the finding for Q-2 of SFY 2012 represents an outlier in comparison to prior quarters. For example, during Q-1 of SFY 2012, the average number of applications pending for more than thirty (30) days for the Rhode Island Works applicant cohort was 491. The following table documents the average number of new applications pending more than thirty days for this enrollment cohort by quarter during SFY 2011.

RI MEDICAID: The Average Number of New Applications Pending More than Thirty Days for the Rhode Island Works/RIte Care Cohort, by Quarter (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
Q-4, SFY 2011	479

As had been described in the quarterly report[17] 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, then the average number of new applications pending more than 30 days during the First Quarter of SFY 2011 would equal 430.

[17] 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 Second Quarter of SFY 2012 (October 1, 2011 through December 31, 2011). That prior discussion also gave an overview of the eligibility determination processes specific to new applications. Information was provided about the number of eligibility approvals (also referred to as "acceptances") and denials for new RIte Care/RIte Share applicants during the same time frame.

The following information has been drawn from InRhodes, the State's Medicaid eligibility system, and focuses on RIte Care/RIte Share redeterminations and closures. Because information could not be easily accessed for the "Other" applicant category, the analysis shown below focuses exclusively on the redeterminations and closures which were processed for the Rhode Island Works/RIte Care enrollment cohort during the Second Quarter of SFY 2012. 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 Medicaid: Redeterminations and Closures, Rhode Island Works/RIte Care Cohort (Q-2, SFY 2012)

Month	RIW Redeterminations	RIW Closures	Percentage
Oct. 2011	53,213	1,924	3.62%
Nov. 2011	53,330	2,457	4.61%
Dec. 2011	53,680	2,070	~ 3.9%
Total for Q-2, SFY 2012	**160,223**	**6,451**	**4.04%**

Source: InRhodes

These findings were similar to those documented for the First Quarter of SFY 2012, when there were 157,282 Rhode Island Works redeterminations and 6,560 closures processed. For further background reference, the following table delineates the quarterly findings during SFY 2011.

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

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-1, SFY 2011	133,586	5,810	4.35%
Q-2, SFY 2011	137,123	5,136	3.74%
Q-3, SFY 2011	148,708	6,039	4.1%
Q-4, SFY 2011	157,322	6,280	~ 4.0%
Total	**576,739**	**23,265**	**4.08%**

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[18]-enrolled families pay for a portion of the cost of their health care coverage by paying a monthly premium. The purpose of cost sharing is to encourage program participants to assume some financial responsibility for their own health care.

The following table provides information about monthly premium payment requirements for families enrolled in either RIte Care or RIte Share. Family income levels have been stratified according to Federal Poverty Levels (FPL), which are established annually by the U.S. Department of Health and Human Services (US DHHS). The State has established premium payment requirements for three income bands, based on FPLs.

RI Medicaid: Monthly Premiums for Families, By Income Level

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

The following quarterly data were obtained from InRhodes, RI Medicaid's Eligibility System, and document the number of RIte Care- or RIte Share-enrolled families who must pay premiums for coverage.

RI Medicaid: The Average Number of RIte Care- or RIte Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-2, SFY 2012)

Percentage of the Federal Poverty Level (FPL)	Q-2, SFY 2012	
> 150 - 185% FPL	6,404	59.7%
> 185 - 200% FPL	1,373	12.8%
> 200 - 250% FPL	2,945	27.5%
Total	**10,722**	**100.0%**

[18] 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.

[19] For a family of four, the following FPLs were established by the US DHHS on January 20, 2011: 150% FPL = $33,525.00; 185% FPL = $41,347.50; 200% FPL = $44,700.00; and 250% FPL = $55,875.00.

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

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

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

If full payment is not received by the twelfth (12^{th}) of the month following the coverage month, then a notice of MA discontinuance is sent to the family. MA eligibility is discontinued for all family members subject to cost sharing at the end of the month following the coverage month[20]. For example, if a premium payment which is due on January 1^{st} has not been received by February 12^{th}, then MA eligibility would be discontinued, effective on February 28^{th}. Dishonored checks and incomplete electronic fund transfers are treated as non-payments.

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

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

- Serious physical or mental illness.
- Loss or delayed receipt of a regular source of income that the family needed to pay the premium.
- Good cause does not include choosing to pay other household expenses instead of the premium.

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

The following sanction data were obtained from InRhodes, the State's Eligibility System, and document the number of RIte Care- or RIte Share-enrolled families who were sanctioned during the Second Quarter of SFY 2012 (October 1, 2011 – December 31, 2011).

RI Medicaid: The Number of RIte Care or RIte Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-2, SFY 2012)

Percentage of the Federal Poverty Level (FPL)	**Q-2, SFY 2012**	
>150 - 185% FPL	265	56.4%
>185 - 200% FPL	68	14.5%
>200 - 250% FPL	137	29.1%
Total	**470**	**100.0%**

In comparing these findings to those demonstrated during the First Quarter of SFY 2012, when there had been a total of 523 families sanctioned, it should be noted that the sanction process did not run during October and November 2011. Sanctions had not been levied during the first two months of the Second Quarter of SFY 2012 because information had been sent to families stating that premiums would increase and that decision was subsequently retracted. Therefore, a grace period was provided for premiums in order to alleviate any confusion for families as to the exact amount owed.

For purposes of comparison, quarterly data pertaining to sanctions that occurred during SFY 2011 have been provided in the following table.

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

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

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

The following table documents the total of State and Federal expenditures for the Cost Not Otherwise Matchable (CNOM) provision of Section 1115(a)(2) of the Social Security Act on a Year-to-Date (YTD) basis for SFY 2012 through December 31, 2011. These data were obtained from RI EOHHS Financial Management and are based upon paid dates, not incurred dates of service.

State and Federal Expenditures Under the CNOM Provision of Section 1115(a)(2) of the Social Security Act (SFY 2012, YTD Through 12/31/2011)

State	$4,744,872
Federal	$5,156,091
Total	**$9,900,863**

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 DHS during the Second Quarter of SFY 2012 (October 1, 2011 through December 31, 2011). This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: Q-2, SFY 2012

Recoveries by Type	**Amount Recovered**
Estate Recoveries: TPL and Legal	$1,047,220
Casualty Recoveries: TPL and Legal	$181,732
Total	**$1,228,952**

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Budget Neutrality Summary	Total DY 1	Total DY 2	Total DY 3	DY 4 Q/E 3/31/12	Q/E 6/30/12
Section I: Total Expenditures Subject to Budget Neutrality					
Budget Population 1: (ABD no TPL)	$ 418,731,831	$ 486,505,287	$ 522,293,881	$ 129,621,525	$ 113,759,881
Budget Population 2 (ABD TPL)	$ 715,844,300	$ 659,668,554	$ 602,777,488	$ 163,046,184	$ 167,301,136
Budget Population 3 (RIte Care)	$ 362,611,218	$ 405,517,339	$ 440,197,089	$ 86,380,753	$ 46,396,373
Budget Population 4 (CSHCNs)	$ 188,895,404	$ 184,738,525	$ 168,271,992	$ 41,880,598	$ 35,723,590
Budget Population 5 (EFP)	$ 198,808	$ 134,380	$ 94,294	$ 28,336	$ 56,637
Budget Population 6 (Pregnant Expansion)	$ 1,489,534	$ 1,820,522	$ 1,740,579	$ 572,618	$ 468,060
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	$ 4,941,055	$ 1,311,765	$ 1,463,268
Budget Population 11 (217-like, CatNeedy HCBW like svcs, Highest Need)	$ -	$ -	$ -	$ -	$ -
Budget Population 12 (217-like CatNeedy HCBW like svcs, High need)	$ -	$ -	$ -	$ -	$ -
Needy, HCBW like svcs (high and highest). Medically Needy PACE-like partricipnts in community	$ -	$ -	$ -	$ -	$ -
Budget Population 14 (BCCTP)	$ 6,553,342	$ 3,813,979	$ 3,957,712	$ 1,210,304	$ 923,685
Budget Population 15 (CNOM: Adults w/ disabilities at risk for LTC, <300% FPL)	$ 255,250	$ 897,633	$ 764,713	$ 288,707	$ 184,864
Budget Population 16 (CNOM: Uninsured Adults w/ mental illness)	$ 6,595,169	$ 6,989,503	$ 12,099,917	$ 3,070,467	$ 4,353,332
Budget Population 17 (CNOM: Youth at risk for Medicaid; at risk children < 300% FPL)	$ 3,775,172	$ 3,696,607	$ 3,253,287	$ 999,174	$ 1,208,872
Budget Population 18 (HIV)	$ -	$ 752,914	$ 1,059,261	$ -	$ 1,760,529
Budget Population 19 (CNOM: Non-working disabled adults 19-64, GPA)	$ 1,743,740	$ 1,790,059	$ 1,823,738	$ 389,477	$ 246,328
Budget Services 1 (Windows)	$ 4,504	$ -	$ -	$ -	$ -
Budget Services 2 (RIte Share and collections)	$ 5,369,938	$ 6,772,712	$ 6,437,643	$ 1,349,571	$ 1,508,146
Budget Service 3 (Other payments - e.g.FQHC suppl., stop loss)	$ 10,194,423	$ 33,205,530	$ 14,600,045	$ 2,638,991	$ (7,840,791)

Budget Services 4 (CNOM: core and preventive svcs, Medicaid eligible at risk youth)	$ -	$ -	$ -	$ 4,076,296	$ 1,974,474
Budget Services 5 (CNOM: Services by FQHCs to uninsured individuals)	$ 600,000	$ 1,200,000	$ 1,208,689	$ 914,811	$ 317,970
Base Expenses [1]	$ 33,090,955	$ 91,516,977	$ 71,486,093	$ 7,689,570	$ 21,677,390
TOTAL Expenditures for Period as reported on the CMS-64*	**$ 1,762,261,653**	**$ 1,893,513,074**	**$ 1,861,752,178**	**$ 445,469,147**	**$ 391,483,744**
Section II: Expenditure Target					
Quarterly	$ 2,600,000,000	$ 2,400,000,000	$ 2,300,000,000	$ 600,000,000	$ 600,000,000
Cumulative	$ 2,600,000,000	$ 5,000,000,000	$ 7,300,000,000	$ 600,000,000	$ 1,200,000,000
Section III: Actual Expenditures w/Waiver					
Quarterly			$ 1,861,752,178	$ 445,469,147	$ 391,483,744
Cumulative	$ 1,762,261,653	$ 1,893,513,074	$ 1,861,752,178	$ 445,469,147	$ 836,952,892
Section IV: Surplus / (Deficit)					
Quarterly	**$ 837,738,347**	**$ 506,486,926**	**$ 438,247,822**	**$ 154,530,853**	**$ 208,516,256**
Cumulative	**$ 837,738,347**	**$ 1,344,225,273**	**$ 1,782,473,095**	**$ 1,937,003,948**	**$ 2,145,520,203**

* 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	*$ 445,469,147*	*$ 391,483,744*
LEA	*$ 4,442,816*	*$ 6,110,842*
SCHIP (RIteShare Premiums & Collections)	*$ (122,903)*	*$ (55,866)*
SCHIP	*$ 6,280,879*	*$ 13,389,670*
DSH	*$ -*	*$ 1,548,841*
Prior Period Adjustments	*$ -*	*$ -*
Current Period Adjustments	*$ -*	*$ 789,266*
CMS 64 Summary Sheet: 6. Expenses this Quarter)	*$ 456,069,939*	*$ 413,266,497*

[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.