



Report to the Centers for Medicare and Medicaid Services

Quarterly Operation Report

Rhode Island Global Consumer Choice Compact

1115 Waiver Demonstration

July 1, 2012 – September 30, 2012

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

November 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 cited¹ by the AARP's Public Policy Institute:

- *Philosophy* – The State's intention to deliver services to people with disabilities in the most independent living situation and expand cost-effective HCBS options guides all other decisions.
- *Array of Services* – States that do not offer a comprehensive array of services designed to meet the particular needs of each individual may channel more people to institutions than will States that provide an array of options.
- *State Organization of Responsibilities* – Assigning responsibility for overseeing the State's long-term services and supports to a single administrator has been a key decision in some of the most successful States.
- *Coordinated Funding Sources* – Coordination of multiple funding sources can maximize a State's ability to meet the needs of people with disabilities.
- *Single Appropriation* – This concept, sometimes called “global budgeting,” allows States to transfer funds among programs and, therefore, make more rational decisions to facilitate serving people in their preferred setting.
- *Timely Eligibility* – Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, State Medicaid programs must be able to arrange for HCBS in a timely manner.
- *Standardized Assessment Tool* – Some States use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization.
- *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 July 1, 2012 – September 30, 2012 are outlined below.

Rhode Island Medicaid Eligibility

Program	June 2012 Counts of Eligibles	September 2012 Counts of Eligibles
Aged	17,516	17,612
Disabled	28,004	28,275
BCCPT	246	266
QMBs, SLMBs, and QI 1s	6,593	6,635
Child and Families	133,048	133,567
Adoptive Subsidy	2,433	2,371
Foster Care	2,295	2,273
Children with Special Health Care Needs	8,685	8,668
Total	198,820	199,667

Care Management Program Enrollment

Program	Enrollment as of 06/30/12	Enrollment as of 09/30/12
RItE Care	125,850	125,745
RItE Share	11,498	11,604
Rhody Health Partners	13,309	13,577
PACE	218	227
Connect Care Choice	1,738	1,734
Connect Care	122	0
RItE Smiles	58,696	59,941
Early Intervention	2,096	2,068
BCCPT	246	266
Extended Family Planning	325	346

Cost Not Otherwise Matchable (CNOM) Program Enrollment

Program	Description	Enrollment as of 06/30/12	Enrollment as of 09/30/12
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	1,536	1,519
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	246	266
Budget Population 15	Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid	2,117	2,213
Budget Population 16	Uninsured adults with mental illness	9,780	10,952

Program	Description	Enrollment as of 06/30/12	Enrollment as of 09/30/12
Budget Population 17	Children at risk for Medicaid and/or institutional care	2,676	2,646
Budget Population 18	HIV positive individuals who are otherwise not eligible for Medicaid	341	296
Budget Population 19	Non-working disabled adults ages 19-64 who do not qualify for disability benefits	653	655

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 July 1, 2012 – September 30, 2012

Request Type	Description	Date Submitted	CMS Action	Date
Category II	Elimination of Annual Nursing Facility Rate Adjustment	09/30/11	Pending	
State Plan Amendment	Single State Agency Designation	09/30/11	Approved	08/02/12
Category II	Nursing Facility Rate Reduction	03/29/12 Rescinded	N/A	06/05/12
Category II	Nutrition Services and Individual/Group Education for Individuals with Chronic conditions	05/16/12 Resubmitted 08/24/12	Pending	
Category II	DME	05/21/12	Pending	
State Plan Amendment	Provider Screening and Enrollment	06/12/12	Pending	08/31/12
State Plan Amendment	Payment Adjustment for Provider Preventable Conditions, including Hospital Acquired Conditions	06/20/12	Pending	
State Plan Amendment	Disproportionate Share Hospital Policy	07/10/12	Pending	
State Plan Amendment	Tribal Consultation Requirement	09/16/12	Pending	

Request Type	Description	Date Submitted	CMS Action	Date
State Plan Amendment	Integrated Medical and Behavioral Health Networks in PCCM for Connect Care Choice	09/28/12	Pending	

Cost Not Otherwise Matchable (CNOM)

Under the federal authority granted by CMS, the state has claimed \$ 3,668,871 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 \$ 2,305,609,315 million dollars below the cap during this reporting quarter. Attachment A contains the Budget Neutrality Report.

Key Activities for the reporting period July 1, 2012 – September 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 September 30, 2012, a total of **1620 Level of Care (LOC) assessments** had been completed, resulting in the following determinations: **Highest LOC = 1,048; High LOC = 468; and Preventive LOC = 96.** Eight (8) 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 1,153 individuals to date to a community setting in the Nursing Facility Transition program and the MFP program**
 - **140 Nursing Home Transition referrals** were made to the Office of Community (OCP) Programs during Q-1 of SFY 2013
 - **30 individuals** were transitioned to a community setting during the reporting quarter. Of the 30 individuals, 7 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 September 2012
 - Submitted the marketing materials to CMS for review and granted approval by CMS
 - Sent marketing materials to production
 - Continued development of reporting processes 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, **96 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 77 individuals in the EOHHS Shared Living program** as of September 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
 - Continued 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
 - Approval granted to hire state staff to support the MFP demonstration and housing coordinator activities
 - Drafted scope of work for 24/7 Emergency Back-up Plan coverage
 - Posted job descriptions and interviewed candidates for the positions
- 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
 - Continued 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 Consumer Assistance Office and opportunities to include tenants of the Balancing Incentive Program and ADRC
 - On-going discussions with the CMS CCMi team to discuss progress on demonstration proposal submitted under the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees
 - Continued to analyzed data to support Integrate Care for Medicare-Medicaid Enrollees
 - Continued planning for the MFP activities within the Integrated Care Initiative
 - Continued to explore opportunities under the Affordable Care Act (ACA), including Balancing Incentive Program and Community First Choice for Medicaid Enrollees, 1915(i) and Essential Health Benefit Medicaid Benchmark Plan Habilitation Option
 - Executed 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
 - Commenced Medicaid strategic planning for Health Reform under the ACA and the renewal of the 1115 Demonstration waiver with Technical Assistance from CHCS
 - Hosted a Strategic Planning Summit with representatives from the EOHHS agencies, Governor’s Office, Lt. Governor’s Office, Department of Administration, Office of Health Insurance Commissioner, RI State Senate and House Representatives to identify key focus areas for the Strategic work plan and opportunities for streamlined processes.
 - Participated in the development of the RI’s State Innovation Models Initiative

- Developed and submitted a proposal to the Administration on Aging under the Affordable Care Act-Aging and Disability Resource Center Part A grant, RI Enhanced ADRC Options Counseling System. The proposal was not selected by AoA.
- Developed and submitted a proposal to CMS for the Adult Medicaid Quality Grant, Measuring and Improving the Quality of Care in Medicaid
- Examined opportunity under the Demonstration Grant for Testing Experience and Functional Tools (TEFT) in Community-Based Long Term Services and Supports
- 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)
 - Finalizing the program evaluation of the *Communities of Care* initiative for the RIte Care and Rhody Health Partners programs
 - Commenced the program evaluation of the *Communities of Care* initiative for the Connect Care Choice program
 - 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
 - Monitored the implementation of 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.)
 - Continued to explore 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)
 - Continued to explore opportunities to align the Sherlock Plan with the Integrated Care Initiative
- Analyze Medicaid Managed Long Term Care models
 - Participated in the CHCS-TA initiative, Implementing Innovations in Long-term Supports and Services (LTSS), funded by SCAN Foundation
 - Continued developing the LTSS models for the Integrated Care for Medicare and Medicaid beneficiaries
 - Researched best practices and met with key informants

- Convened stakeholder meeting focused on Services and Supports, Outreach and Information and Oversight, Monitoring and Continuous Improvement
- Researched Quality Monitoring and Oversight metrics and prepared a inventory of measures across six domains
- 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
 - Examining Medical Home models for the Integrated Care Initiative
 - Included promotion of Medical Home models in the CMS State Innovation Models Demonstration proposal
- Promote the adoption of electronic health records
 - Finalized activities under the DRA Medicaid Transformation Grant
 - Continued the voluntary enrollment of Medicaid beneficiaries in Rhode Island Medicaid’s **currentcare** electronic medical record (EMR)
 - Monitoring the EMR funding for Medicaid providers
 - Monitored activities for P-APD (IT Global Waiver and MITA Planning)
 - Commenced negotiations with selected vendor for 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
 - Reviewed responses to the 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
 - Continued to analyze options for Essential Health Benefits Medicaid Benchmark plan, Medicaid Expansion and the Basic Health Plan Option
- Implement competitive selective contracting procurement methodologies to assure that the State obtains the highest value and quality of services for its beneficiaries at the best price
 - Monitored implementation of the initiatives in the capitated Medicaid managed care program, focusing on selective contracting strategies

- Analyzed value-based purchasing strategies for the Managed LTC under the Integrated Care for Medicare and Medicaid beneficiaries and Medicaid-only beneficiaries opportunities
- Develop and implement procurement strategies that are based on acuity level and the needs of beneficiaries
 - Reviewed opportunities for selective contracting strategies as part of the development of the SFY 2014 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 07/23/2012 and 09/24/2012
 - Convened the quarterly meeting of the Rhode Island Medicaid Medical Advisory Committee (MCAC) on 09/05/2012
 - 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 and Statutory Changes to Medicaid Intercept and Estate Recoveries
 - Posted EOHHS Notice of Proposed Rulemaking and Policy Changes in August 2012 relating to Personal Choice Program and Post-Eligibility Treatment of Income
 - Commenced efforts to re-design the EOHHS website to improve communications and transparency

Section III

Key analytic highlights on the progress of the Global Waiver based on performance during the Third Quarter of the SFY 2012 (January 1, 2012 – March 31, 2012).

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

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

The following table outlines the number of Medicaid LTC applicants who were deemed to be eligible for Medicaid LTC during the Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012). The following table represents a “point-in-time” snapshot of the number of approved applications for Medicaid LTC coverage. InRhodes, the State’s Medicaid eligibility system, is the source of the following statistics. This information has been provided by month for Q-3 of SFY 2012.

RI MEDICAID: Medicaid Long-term Care Acceptances (Approvals), Q-3, SFY 2012

Month	Long-Term Care Approvals
January 2012	246
February 2012	289
March 2012	288
Total for Q-3, SFY 2012	823

Source: InRhodes

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

In order to be approved for Medicaid LTC coverage, applicants must meet an explicit set of financial and clinical eligibility criteria. The following table outlines the number of Medicaid LTC applicants who were found ineligible during the Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012). InRhodes, the State’s Medicaid eligibility system, is the source of the following denial statistics. The number of denials documented below represents a “point-in-time” snapshot of activity. This information has been provided by month for Q-3 of SFY 2012.

RI MEDICAID: Medicaid Long-term Care Denials, Q-3, SFY 2012

Month	Long-Term Care Denials
January 2012	40
February 2012	51
March 2012	50
Total for Q-3, SFY 2012	141

Source: InRhodes

In comparing this finding to that which was documented during the Second Quarter of SFY 2012, there were 137 LTC denials during that interval².

² The Rhode Island Executive Office of Health and Human Services. (June 26, 2012). *Report to the Rhode Island General Assembly, Senate Committee on Health and Human Services, Designated Medicaid Information*, October 1, 2011 – December 31, 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 Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012).

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, SFY 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 Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012).

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

DEA: LTC Service Type and Corresponding Unit of Service

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

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

Source: EOHHS Data Warehouse: MMIS Claim Universe			January	February	March	Q-3, SFY 2012				
Reporting Period: Date of Service			2012		2012		2012			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
	Assisted Living	Under 65	61	1865	60	1739	61	1844	182	5448
		65 and Older	232	6986	226	6427	228	6951	686	20364
DEA	Assisted Living	Service Type Subtotals:	293	8851	286	8166	289	8795	868	25812
	Case Management	Under 65	45	192	43	170	47	243	135	605
		65 and Older	392	1853	370	1886	365	1752	1127	5491
DEA	Case Management	Service Type Subtotals:	437	2045	413	2056	412	1995	1262	6096
	Personal Care/Homemaker	65 and Older	393	106393	378	97614	372	99698	1143	303705
DEA	Personal Care/Homemaker	Service Type Subtotals:	393	106393	378	97614	372	99698	1143	303705
DEA		Grand Total:		117,289		107,836		110,488		335,613

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

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, SFY 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 Third Quarter of SFY 2012. This information reflects incurred dates of service (January 1, 2011 through March 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 EOHHS: Adult day care; assisted living; case management; home health agency; hospice; nursing facility; personal care/homemaker; shared living and Tavares Pediatric Center. This information has been stratified by month and by age group.

Data tables are shown below, with information organized by month for the Third Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			January		February		March		Q-3, SFY 2012	
Reporting Period: Date of Service			2012		2012		2012			
Dept.	Service Type	Age Group	Count	Units	Count	Units	Count	Units	Count	Units
EOHHS	Adult Day Care	Under 65	243	3117	259	3275	264	3564	766	9956
		65 and Older	245	3148	248	3285	267	3855	760	10288
EOHHS	Adult Day Care	Service Type Subtotals:	488	6265	507	6560	531	7419	1526	20244
	Assisted Living	Under 65	13	389	11	319	14	415	38	1123
		65 and Older	134	4032	133	3692	128	3787	395	11511
EOHHS	Assisted Living	Service Type Subtotals:	147	4421	144	4011	142	4202	433	12634
	Case Management	Under 65	530	955	687	1346	904	1523	2121	3824
		65 and Older	147	784	152	920	125	717	424	2421
EOHHS	Case Management	Service Type Subtotals:	677	1739	839	2266	1029	2240	2545	6245
	Hospice	Under 65	30	791	29	754	25	577	84	2122
		65 and Older	500	13162	483	11891	497	12972	1480	38025
EOHHS	Hospice	Service Type Subtotals:	530	13953	512	12645	522	13549	1564	40147
	Nursing Facility	Under 65	567	16221	554	15160	562	16174	1683	47555
		65 and Older	5201	153587	5163	142787	5124	151749	15488	448123
EOHHS	Nursing Facility	Service Type Subtotals:	5768	169808	5717	157947	5686	167923	17171	495678
	Personal Care/Homemaker	Under 65	1034	296366	1052	283412	1059	298037	3145	877815
		65 and Older	1289	372480	1301	355872	1310	381141	3900	1109493
EOHHS	Personal Care/Homemaker	Service Type Subtotals:	2323	668846	2353	639284	2369	679178	7045	1987308
	Shared Living Agency	Under 65	16	954	17	915	18	982	51	2851
		65 and Older	48	2749	51	2815	52	3067	151	8631
EOHHS	Shared Living Agency	Service Type Subtotals:	64	3703	68	3730	70	4049	202	11482
	Skilled Nursing	Under 65	239	4172	219	3908	252	4883	710	12963
		65 and Older	119	2413	124	2406	128	2410	371	7229
EOHHS	Skilled Nursing	Service Type Subtotals:	358	6585	343	6314	380	7293	1081	20192
	Tavares Pediatric Center	Under 65	19	589	20	565	20	601	59	1755
EOHHS	Tavares Pediatric Center	Service Type Subtotals:	19	589	20	565	20	601	59	1755
EOHHS		Grand Total:		875,909		833,322		886,454		2,595,685

The Number of Medicaid Beneficiaries Served by PACE, Q-3, 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 Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012). Please refer to the data table shown below. This information has been stratified by month and by age group.

Source:	EOHHS Data Warehouse/Financial Data Mart			
Reporting Period:	Eligibility Period			
Dept.	Benefit Period	Program Description	Age Group	Person Count
EOHHS	1/1/2012	PACE PROGRAM	65 and Over	178
EOHHS		PACE PROGRAM	Under 65	39
	1/1/2012		Period Totals:	217
EOHHS	2/1/2012	PACE PROGRAM	65 and Over	181
EOHHS		PACE PROGRAM	Under 65	36
	2/1/2012		Period Totals:	217
EOHHS	3/1/2012	PACE PROGRAM	65 and Over	181
EOHHS		PACE PROGRAM	Under 65	35
	3/1/2012		Period Totals:	216
			Quarterly Total:	650

The Number of Medicaid Beneficiaries Served in Institutional and Home and Community-based Long-term Care Settings, Q-3, 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; family supports; shared living; and supported employment. Data for the Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012) are shown below.

Source: RI, BHDDH, Medicaid LTC Beneficiaries, Q-3, SFY 2012			
Dept.	Service Type	Age Group	# Served
BHDDH	Day Programs	Under 65	2,821
		Over 65	273
BHDDH	Homemaker	Under 65	121
		Over 65	7
BHDDH	Public Group Homes	Under 65	136
		Over 65	81
BHDDH	Private Group Homes	Under 65	1,117
		Over 65	167
BHDDH	Community Supports	Under 65	1,016
		Over 65	69
BHDDH	Shared Living	Under 65	188
		Over 65	14
BHDDH	Supported Employment	Under 65	310
		Over 65	6
BHDDH	Case Management	Under 65	3,035
		Over 65	316
BHDDH	Transportation	Under 65	2,448
		Over 65	221
BHDDH	Prevocational	Under 65	211
		Over 65	13
BHDDH	Job Development	Under 65	64
		Over 65	0

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

The following information has been organized by State agency and is based upon incurred (or the actual date when a service was delivered) dates of service for long-term care (LTC) services which were provided during the Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012). By organizing these data by incurred dates of service rather than by paid dates, a much clearer picture of actual utilization is produced, one that shows how many beneficiaries received services and when the services were actually provided. This information has been stratified, as requested, according to two age groups (less than 65 years of age and greater than or equal to 65 years of age).

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

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

Cost and Utilization Data, Q-3, 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 Third Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-3, SFY 2012	
Reporting Period:	Date of Service			
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
	Assisted Living	Under 65	\$ 1,007	\$ 183,285
		65 and Older	\$ 873	\$ 598,650
DEA	Assisted Living	Service Type Subtotals:	\$ 901	\$ 781,935
	Case Management	Under 65	\$ 67	\$ 9,075
		65 and Older	\$ 73	\$ 82,365
DEA	Case Management	Service Type Subtotals:	\$ 72	\$ 91,440
	Personal Care/Homemaker	65 and Older	\$ 1,337	\$ 1,527,738
DEA	Personal Care/Homemaker	Service Type Subtotals:	\$ 1,337	\$ 1,527,738
DEA		Grand Total:		\$ 2,401,113

Cost and Utilization Data, Q-3, 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 Third Quarter of SFY 2012.

Source: EOHHS Data Warehouse: MMIS Claim Universe			Q-3, SFY 2012	
Reporting Period: Date of Service				
Dept.	Service Type	Age Group	Avg/Person/Mo	3 Month Totals
EOHHS	Adult Day Care	Under 65	\$ 689	\$ 527,428
		65 and Older	\$ 717	\$ 544,805
EOHHS	Adult Day Care	Service Type Subtotals:	\$ 703	\$ 1,072,234
	Assisted Living	Under 65	\$ 1,221	\$ 46,387
		65 and Older	\$ 1,148	\$ 453,419
EOHHS	Assisted Living	Service Type Subtotals:	\$ 1,154	\$ 499,806
	Case Management	Under 65	\$ 55	\$ 117,547
		65 and Older	\$ 85	\$ 35,878
EOHHS	Case Management	Service Type Subtotals:	\$ 60	\$ 153,425
	Hospice	Under 65	\$ 3,802	\$ 319,395
		65 and Older	\$ 3,833	\$ 5,672,643
EOHHS	Hospice	Service Type Subtotals:	\$ 3,831	\$ 5,992,038
	Nursing Facility	Under 65	\$ 4,766	\$ 8,020,640
		65 and Older	\$ 4,562	\$ 70,649,392
EOHHS	Nursing Facility	Service Type Subtotals:	\$ 4,582	\$ 78,670,032
	Personal Care/Homemaker	Under 65	\$ 1,428	\$ 4,491,226
		65 and Older	\$ 1,455	\$ 5,675,107
EOHHS	Personal Care/Homemaker	Service Type Subtotals:	\$ 1,443	\$ 10,166,333
	Shared Living Agency	Under 65	\$ 1,953	\$ 99,598
		65 and Older	\$ 1,932	\$ 291,668
EOHHS	Shared Living Agency	Service Type Subtotals:	\$ 1,937	\$ 391,266
	Skilled Nursing	Under 65	\$ 504	\$ 357,516
		65 and Older	\$ 606	\$ 224,850
EOHHS	Skilled Nursing	Service Type Subtotals:	\$ 539	\$ 582,366
	Tavares Pediatric Center	Under 65	\$ 28,782	\$ 1,698,110
EOHHS	Tavares Pediatric Center	Service Type Subtotals:	\$ 28,782	\$ 1,698,110
EOHHS		Grand Total:		\$ 99,225,609

Cost and Utilization Data, Q-3, 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). Please refer to the table that has been provided on the following page.

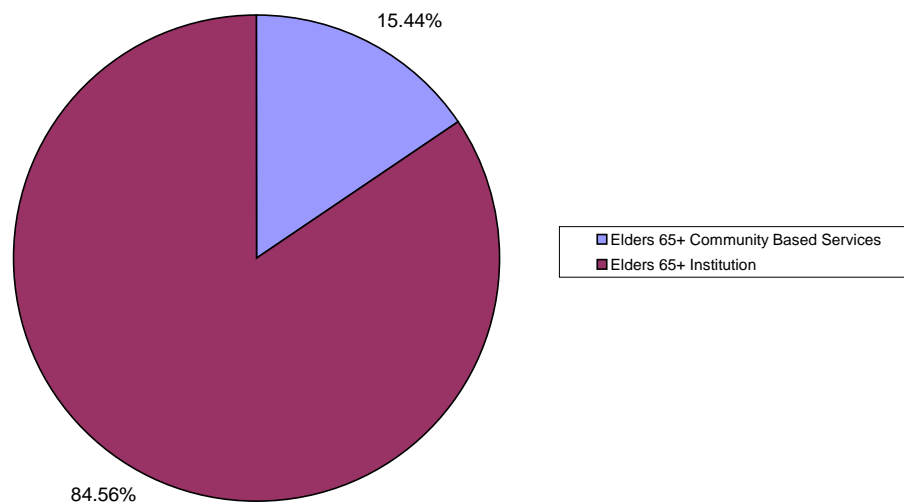
Source: RI, BHDDH, Medicaid LTC Beneficiaries, Q-3, SFY 2012				
Dept.	Service Type	Age Group	# Served	Total Expenditures
BHDDH	Day Programs	Under 65	2,821	\$7,550,988.50
		Over 65	273	688,991.01
BHDDH	Homemaker	Under 65	121	862,817.94
		Over 65	7	54,270.34
BHDDH	Public Group Homes	Under 65	136	3,600,828.34
		Over 65	81	2,082,896.06
BHDDH	Private Group Homes	Under 65	1,117	20,050,696.70
		Over 65	167	2,852,405.40
BHDDH	Community Supports	Under 65	1,016	3,584,692.51
		Over 65	69	282,474.84
BHDDH	Shared Living	Under 65	188	1,737,430.69
		Over 65	14	118,868.26
BHDDH	Supported Employment	Under 65	310	266,810.34
		Over 65	6	1,764.50
BHDDH	Case Management	Under 65	3,035	1,105,549.97
		Over 65	316	114,017.70
BHDDH	Transportation	Under 65	2,448	2,246,138.88
		Over 65	221	198,385.52
BHDDH	Prevocational	Under 65	211	174,119.28
		Over 65	13	11,972.58
BHDDH	Job Development	Under 65	64	20,640.97
		Over 65	0	0.00

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

Medicaid Long Term Care (LTC) services are available for individuals over age 65 and for individuals with disabilities. The types of services available include institutional and home and community-based services. The following charts show the percent distribution of expenditures for Medicaid long-term care institutional services and home and community-based services. The utilization data was abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (January 1, 2012 – March 31, 2012).
Elders Aged 65 and Over

During the Third Quarter of SFY 2012, 84.56 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.44 percent were for home and community-based services (HCBS).

Q-3, SFY2012



These findings were similar to those that had been documented during the first two quarters of State Fiscal Year 2012. For purposes of comparison, information from the first two quarters of SFY 2012 has been depicted in the following table.

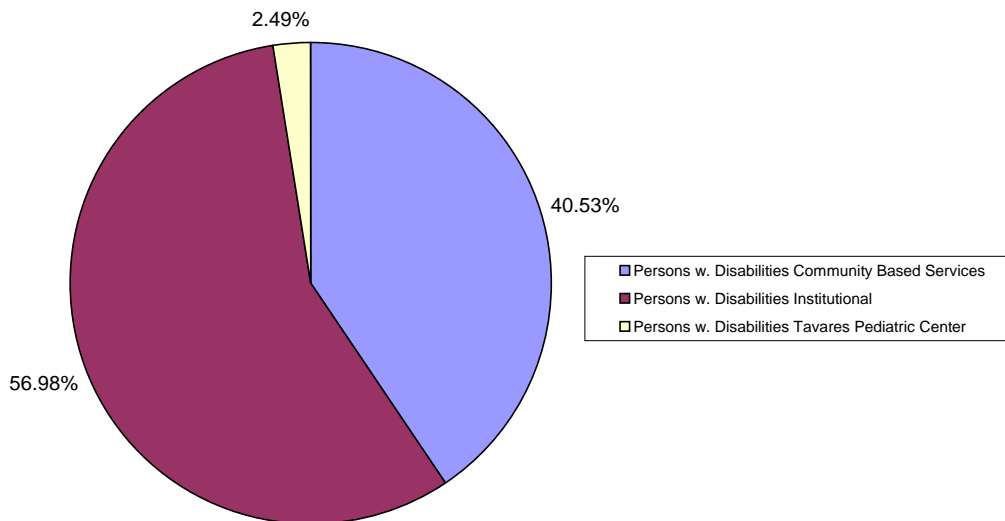
RI Medicaid: LTC Expenditures for Elders, 65 Years of Age and Older (Q-1 & Q-2, SFY 2012)

Quarter	Institutional Services	Home & Community-based Services
Q-2, SFY 2012	84.98%	15.02%
Q-1, SFY 2012	84.20%	15.80%

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

Persons with Disabilities: Individuals with disabilities are eligible for Medical Assistance if they are 18 years or older, a Rhode Island resident, receive Supplemental Security Income (SSI) or have an income less than 100% of the Federal Poverty Level (FPL) and have resources (savings) of less than \$4,000 for an individual or \$6,000 for a married couple. The following chart shows the percent distribution of expenditures for Medicaid institutional services and home and community services for persons with disabilities. The utilization data were abstracted from the MMIS Claims Universe, EOHHS Data Warehouse, based upon incurred dates of service (January 1, 2012 – March 31, 2012).

Q-3, SFY2012



During the Third Quarter of SFY 2012, 56.98 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services, 2.49 percent of expenditures for persons with disabilities were for Medicaid long-term care institutional services at the Tavares Pediatric Center, and 40.53 percent were for home and community-based services (HCBS).

These findings were comparable to those that had been documented in the first two quarters of State Fiscal Year 2012. For purposes of comparison, information from those intervals has been depicted in the following table.

RI Medicaid: LTC Expenditures for Persons with Disabilities (Q-1 & Q-2, SFY 2012)

Quarter	Institutional	Tavares Pediatric	Home & Community-based
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		Center	Services
Q-2, SFY 2012	57.04%	2.53%	40.43%
Q-1, SFY 2012	57.09%	2.04%	40.87%

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

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

During the Third Quarter of State Fiscal Year 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 Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012). The tables shown below document the service utilization of the DEA’s Adult Day Care and Home Care Program (also referred to as the “Co-pay” Program). This information has been organized for each type of service by quarter.

RI DEA: Adult Day Care (Q-3, SFY 2012)

Service Category: Adult Day Care	Clients*		Units (Unit=1 Day)	
	Total	Avg/Mo.	Total	Avg/Mo.
D1 (Income up to 125% FPL):	144	48	2,053	684
D2 (Income up to 200% FPL):	611	204	8,850	2,950
Total	755	252	10,903	3,634

Average utilization = 14.42 days of adult day care per client per month.

*Clients are not distinct.

RI DEA: Case Management (Q-3, SFY 2012)

Service Category: Case Management	Clients		Units (Unit=1/4 Hour)	
	Total	Avg/Mo.	Total	Avg/Mo.
Case Management	999	333	5,814	1,938

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

RI DEA: Home Care (Q-3, SFY 2012)

Service Category: Home Care	Clients*		Units (Unit=1/4 Hour)	
	Total	Avg/Mo.	Total	Avg/Mo.
D1 (Income up to 125% FPL):	396	132	46,251	15,417
D2 (Income up to 200% FPL):	1,542	514	181,618	60,539
Total	1,938	646	227,869	79,956

Average utilization = 123.8 units or 30.94 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.³ 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 loans⁴
- If a resource cannot be sold or liquidated and a determination regarding availability cannot be made by the LTC Administrator⁵
- 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)⁶
- If there is a claim of undue hardship, the LTC Administrator, in consultation with the Office of Legal Counsel, makes a determination⁷

³ The Rhode Island Department of Human Services. *Code of Rules, Medical Assistance*, Section 0302.15 (*Decision on Eligibility*), <https://www.policy.dhs.ri.gov/>.

⁴ Ibid, Section 0382.15.20.05 (*Negotiability of Instruments*), <https://www.policy.dhs.ri.gov/>.

⁵ Op cit, Section 0382.15.20.15 (*Salability*), <https://www.policy.dhs.ri.gov/>.

⁴ Op cit, Section 0382.10.10.10 (*Docu Non-Avail of Real Est*), <https://www.policy.dhs.ri.gov/>.

⁷ Op cit, Section 0382.50.25 (*Claims of Undue Hardship*), <https://www.policy.dhs.ri.gov/>.

- If consultation is needed by the LTC Administrator to aid in the determination of the amount of countable income and/or resources from a trust (and the date and amount of any prohibited transfer of assets)⁸

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

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

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

RI MEDICAID: Turn-around Times for New LTC Applications (Q-3, SFY 2012)

Month	< 30 Days		30 – 90 Days		> 90 Days		Monthly Total	
Jan. 2012	132	28.51%	241	52.05%	90	19.44%	463	100%
Feb. 2012	144	33.18%	205	47.24%	85	19.59%	434	100%
Mar. 2012	164	38.95%	186	44.18%	71	16.86%	421	100%
Total for Q-3, SFY 2012	440	33.38%	632	47.95%	246	18.66%	1,318	100%

Source: InRhodes

The experience during the first two quarters of SFY 2012 has been shown below. As noted previously, these statistics reflect the processing of new applications for LTC coverage for individuals who were not already enrolled in Medicaid.

RI MEDICAID: Turn-around Times for New LTC Applications (Q-1 & Q-2, SFY 2012)

Quarter	< 30 Days		30 – 90 Days		> 90 Days		Quarterly Total	
Q-2, SFY 2012	414	33.17%	649	52.0%	185	14.82%	1,248	100%
Q-1, SFY 2012	344	31.07%	635	57.36%	128	11.56%	1,107	100%

Source: InRhodes

⁸ Op cit, Section 0382.50.15 (*Trust Evaluation Process*), <https://www.policy.dhs.ri.gov/>.

For purposes of comparison, the quarterly findings from SFY 2011 have been provided in the following table.

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 (TAT) in days for Medicaid LTC approvals during the Third 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-3, SFY 2012)

Number of Approvals for Medicaid LTC	Average TAT in Days
823	48.02 (~ 49 Days)*

Source: InRhodes

RI MEDICAID: Average Turn-around Time (TAT) in Days for Medicaid LTC Denials (Q-3 SFY 2012)

Number of Denials for Medicaid LTC	Average TAT in Days
141	18.29 (~ 19 Days)

Source: InRhodes

An asterisk (*) has been flagged above to highlight that the InRhodes turn-around time (TAT) statistic for Medicaid LTC approvals during Q-3 of SFY 2012 had several significant outliers excluded. These findings demonstrate that new Medicaid LTC approvals and denials continue to be processed below a 90-day metric, as has been the case throughout SFY 2012.

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

RI MEDICAID: Average Turn-around Times for Medicaid LTC Approvals and Denials by Quarter (Q-1 & Q-2, SFY 2012)

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

The asterisk (*) shown above indicates that several outliers were excluded. As discussed in the prior two reports that focused on Q-1 and Q-2 of SFY 2012, 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 ⁹ waiver community-based services	Access to ICFMR, and section 1915(c) HCBS Waivers MR/DD community-based services.

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

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-3, SFY 2012)

Clinical Eligibility Level of Care Criteria	Q-3, SFY 2012
Nursing Facility	1,168
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 in a hospital setting, as would have been the case under the State’s former section 1915(c) Habilitation Waiver.

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

Findings from Q-3 of SFY 2012 were similar to those demonstrated in the First Quarter of SFY 2012. The following table documents the findings from the first two quarters of SFY 2012.

RI Medicaid: Applicants for Medicaid LTC Who Met the Clinical Eligibility Criteria For Nursing Facility or Hospital (Habilitation) Services (Q-1 & Q-2, SFY 2012)

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

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 Third Quarter of SFY 2012, there were thirteen (13) 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 Third 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-3, SFY 2012)

	Q-3, SFY 2012	
	Average	Median
Nursing Facility Care	17 days	13 Days
Hospital/(HAB applicants)	N/A*	N/A*

Data Source: RI EOHHS Data Warehouse

During the Third 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 Third Quarter of SFY 2012 were similar to those documented during the first two quarters in SFY 2012, which have been depicted below.

	Q-1, SFY 2012		Q-2, SFY 2012	
	Average	Median	Average	Median
Nursing Facility Care	17 Days	15 Days	16 Days	12 Days
Hospital/(HAB Applicants)	N/A	N/A	N/A	N/A

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 Third Quarter of SFY 2012, the Division reported that eligibility determinations were processed on average within twenty-nine (29) 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/habilitation¹⁰ care have been conducted by the Office of Medical Review at Rhode Island Medicaid. In the event that a LTC clinical eligibility determination has not been approved, the individual has the right to file an appeal, seeking to overturn the outcome of that determination.

Appeals Based on Clinical Eligibility Determinations Conducted by Rhode Island Medicaid:

The following data have been provided by RI Medicaid's Office of Medical Review to document the number of appeals which had been filed as a result of non-approved clinical eligibility determinations for nursing facility care and hospital/habilitation care during the Third Quarter of SFY 2012.

RI Medicaid: Appeals of LTC Clinical Eligibility Determinations for Nursing Facility and Hospital/Habilitation Care, Q-3, SFY 2012

Appeals of LTC Clinical Eligibility Determinations by Level of Care	Q-3, 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 three (3) appeals filed during the Third Quarter of SFY 2012.

¹⁰ To meet a hospital (or habilitation) level of care, an applicant must require intensive daily rehabilitation and/or ongoing skilled nursing services comparable to those offered in a hospital setting, which could not be provided adequately or appropriately in a nursing facility. This level of care requirement is analogous to that which had been established by Rhode Island's former 1915(c) Habilitation Waiver.

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

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

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

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

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

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

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

The following table documents the number of nursing home transitions that took place during the Third Quarter of State Fiscal Year 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-3, SFY 2012)

	Q-3, SFY 2012
Number of Nursing Home Transitions	40
Average Length of Stay (ALOS) Prior to Transfer in Calendar Days	259

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

The average length of stay (ALOS) in Q-3 of SFY 2012 (259 days) was greater than that which had been documented in the preceding quarter, when an ALOS of 240 was observed. During the Third Quarter, approximately one-fourth of the transitions that occurred were for individuals who had been in nursing facilities for more than one (1) year. In fact, one of the individuals had been in a nursing facility for three (3) years prior to transitioning to a home-based setting in Q-3 of SFY 2012.

The table shown on the following page documents the type of living arrangement (or setting) that LTC beneficiaries who were transitioned from a nursing facility went to subsequent to their discharge during the Third Quarter of SFY 2012.

RI Medicaid: The Type of Living Arrangement or Setting and Services upon Transfer for Persons Transitioned from Nursing Homes (Q-3, SFY 2012)

	Q-3, SFY 2012	
Existing Home	29	72.50%
Assisted Living	6	15.00%
New Housing	0	0.00%
Group Home	0	0.00%
Other	5	12.50%
Total	40	100.00%

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

Throughout SFY 2012, an increase in the number of nursing home transitions has been demonstrated. The following table documents these findings for the first two quarters of SFY 2012.

RI Medicaid: The Average Length of Stay Prior to Discharge for Persons Transitioned from Nursing Homes (Q-1 & Q-2, SFY 2012)

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

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 Qualidigm¹¹ 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 forty (40) LTC beneficiaries who were transitioned from nursing facilities during the Third Quarter of SFY 2012 (January 1, 2012 through March 31, 2012). The Office of Community Programs at Rhode Island Medicaid reported that there were no (0) failed placements during the Third Quarter of SFY 2012.

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

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

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

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

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

Cohort Analysis for RItE Care/RItE Share Applicants: For the purpose of the following cohort analysis, two major groups comprised the RItE Care/RItE Share applicant population and information has been provided for each group during the Third Quarter of SFY 2012 (January 1, 2012 through March 31, 2012). These two groups of applicants are: a) those who are seeking enrollment in Rhode Island Works¹² and b) several additional categories of applicants.

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

Statistics for the latter grouping are aggregated (or added) within the InRhodes system and are classified as “Other”¹³.

RI MEDICAID: Applications for Rhode Island Works/Rite Care and “Other” Category of Applicants, Q-3, SFY 2012

Month	Rhode Island Works	“Other”
January 2012	3,524	290
February 2012	3,790	279
March 2012	3,566	309
Total for Q-3 of SFY 2012	10,880	878

The findings shown in the table above for Q-3 of SFY 2012 represented an increase of approximately nine (9) percent for this combined (Rhode Island Works and “Other”) cohort, in comparison to Q-2 of SFY 2012, when there were 9,912 applications for Rhode Island Works and 864 “Other” applications. 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 Third Quarter of SFY 2012 (January 1, 2012 through March 31, 2012). 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.

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

RI MEDICAID: Approved Applications for Rhode Island Works and “Other” Category of Applicants, Q-3, SFY 2012

Month	Rhode Island Works	“Other”
January 2012	2,590	282
February 2012	2,625	279
March 2012	2,703	300
Total for Q-3 of SFY 2012	7,918	861

The findings shown in the table above for Q-3 of SFY 2012 represented an increase of approximately seven (7) percent for this combined (Rhode Island Works and “Other”) cohort, in comparison to Q-2 of SFY 2012, when there were 7,314 approved applications for Rhode Island Works and 838 approved applications for the “Other” group. 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 Third Quarter of SFY 2012 (January 1, 2012 through March 31, 2012). 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-3, SFY 2012

Month	Rhode Island Works	“Other”
January 2012	243	8
February 2012	197	5
March 2012	219	11
Total for Q-3 of SFY 2012	659	24

The findings shown in the table above for Q-3 of SFY 2012 represented a decrease of approximately thirteen (13) percent for this combined (Rhode Island Works and “Other”) cohort, in comparison to the Second Quarter of SFY 2012, when there were 760 denied applications for Rhode Island Works and 24 denied applications for the “Other” cohort. 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.

In the prior quarterly report, it was noted that further analyses would be conducted because the finding represented an outlier (an average of 619 applications pending for more than thirty (30) days for new applicants for the Rhode Island Works cohort of RItE Care applicants). Subsequent to EOHHS’ production of the report for Q-2 of SFY 2012, the Department of Human Services determined that a quarterly operational report, which is produced from InRhodes, Medicaid’s eligibility system, would serve as a more complete source of information for addressing the TAT metric. The quarterly operational report (*Pending MA Applications/Cases Over 45 Days – Summary Report*) provides information about all new Family Medical applications and does not focus exclusively on the Rhode Island Works cohort.

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

RI MEDICAID: The Average Number of New Applications Pending More than Forty-five Days for Family Medical Coverage (Q-3, SFY 2012)

Quarter	Average Number of Applications Pending More Than 45 Days for Family Medical Coverage
Q-3, SFY 2012	195.66 (~ 196)

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

In Item O, the number of new applications for RItE Care/RItE Share was quantified for the 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 Third 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-3, SFY 2012)

Month	RIW Redeterminations	RIW Closures	Percentage
Jan. 2012	53,995	2,079	3.85%
Feb. 2012	54,477	2,216	~4.07%
March 2012	54,983	2,185	3.97%
Total for Q-3, SFY 2012	163,455	6,480	3.96%

Source: InRhodes

The findings from the Third Quarter of SFY 2012 are comparable to those that were demonstrated during the prior two quarters. The following table documents the experience from these intervals.

RI Medicaid: Redeterminations and Closures, Rhode Island Works/RItE Care Cohort (Q-1 & Q-2, SFY 2012)

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-2, SFY 2012	160,223	6,451	4.04%
Q-1, SFY 2012	157,282	6,560	4.17%

For further background reference, the table shown on the following page delineates the quarterly findings from SFY 2011.

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

Quarter	RIW Redeterminations	RIW Closures	Percentage
Q-1, SFY 2011	133,586	5,810	4.35%
Q-2, SFY 2011	137,123	5,136	3.74%
Q-3, SFY 2011	148,708	6,039	4.1%
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 Share¹⁴-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 ¹⁵	Monthly Premium for a Family
> 150% FPL and not > 185% FPL	\$61.00/month
> 185% FPL and not > 200% FPL	\$77.00/ month
> 200% FPL and not > 250% FPL	\$92.00/month

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

RI Medicaid: The Average Number of RItE Care- or RItE Share-enrolled Families Who Were Required to Pay Premiums by Income Level (Q-3, SFY 2012)

Percentage of the Federal Poverty Level (FPL)	Q-3, SFY 2012	
> 150 - 185% FPL	9,811	60.46%
> 185 - 200% FPL	2,104	12.97%
> 200 - 250% FPL	4,311	26.57%
Total	16,226	100.00%

¹⁴ 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.

¹⁵ For a family of four, the following FPLs were established by the US DHHS on January 26, 2012: 150% FPL = \$34,575.00; 185% FPL = \$42,642.50; 200% FPL = \$46,100.00; and 250% FPL = \$57,625. For further information, please refer to <http://www.gpo.gov/fdsys/pkg/FR-2012-01-26/html/2012-1603.htm>

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

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

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

If full payment is not received by the twelfth (12th) of the month following the coverage month, then a notice of MA discontinuance is sent to the family. MA eligibility is discontinued for all family members subject to cost sharing at the end of the month following the coverage month¹⁶. For example, if a premium payment which is due on January 1st has not been received by February 12th, then MA eligibility would be discontinued, effective on February 28th. Dishonored checks and incomplete electronic fund transfers are treated as non-payments.

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

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

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

The following sanction data were obtained from InRhodes, the State’s Eligibility System, and document the number of RItE Care- or RItE Share-enrolled families who were sanctioned during the Third Quarter of SFY 2012 (January 1, 2012 – March 31, 2012).

¹⁶ MA coverage is reinstated without penalty for otherwise eligible family members if all due and overdue premiums are received by Rhode Island Medicaid’s fiscal agent on or before the effective date of MA discontinuance.

RI Medicaid: The Number of RItE Care or RItE Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-3, SFY 2012)

Percentage of the Federal Poverty Level (FPL)	Q-3, SFY 2012	
>150 - 185% FPL	210	50.48%
>185 - 200% FPL	71	17.07%
>200 - 250% FPL	135	32.45%
Total	416	100.00%

Information about sanctions that occurred during the first two quarters of SFY 2012 has been provided in the following table.

RI Medicaid: The Number of RItE Care or RItE Share Families Who Were Sanctioned Due to Non-payment of Premiums by Income Level (Q-3, SFY 2012)

Percentage of the Federal Poverty Level (FPL)	Q-1, SFY 2012		Q-2, SFY 2012	
>150 - 185% FPL	283	54.1%	265	56.4%
>185 - 200% FPL	93	17.8%	68	14.5%
>200 - 250% FPL	147	28.1%	137	29.1%
Total	523	100.0%	470	100.0%

In comparing the findings from Q-3 of SFY 2012 (sanctions = 416) to those from the Second Quarter of SFY 2012, when there had been a total of 470 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.

Comparative information about sanctions has been provided in the following table, which documents the quarterly findings from State Fiscal Year 2011.

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 March 31, 2012. 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 03/31/2012)

State	\$10,671,837
Federal	\$11,729,562
Total	\$22,401,399

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 Third Quarter of SFY 2012 (January 1, 2012 through March 31, 2012). This information has been disaggregated according to two sources (or types) of recovery: estate or casualty.

Estate and Casualty Recoveries: Q-3, SFY 2012

Recoveries by Type	Amount Recovered
Estate Recoveries: TPL and Legal	\$766,172
Casualty Recoveries: TPL and Legal	\$501,084
Total	\$1,267,256