Request to Extend the Rhode Island 1115 Research and Demonstration Waiver Project No. 11-W-00242/1

Addendum to Rhode Island's March 12, 2013 Submission
August 15, 2013

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APPENDIX

1. Background to this Submission

In June 2008, Rhode Island submitted to the Centers for Medicare and Medicaid Services (CMS) a proposal for an 1115 Waiver Demonstration entitled the "Global Consumer Choice Compact." The Demonstration is scheduled to end on December 31, 2013.

January 18, 2013: Rhode Island initiated a public comment period for the extension request. Pursuant to that process, the State posted for public comment a draft extension request (www.eohhs.ri.gov/ri1115waiver/updates/). That January posting was the primary document for the State's public comment period. The public comment period ended on March 1, 2013.

March 12, 2013: Rhode Island submitted to the Centers for Medicare and Medicaid (CMS) its request to extend the State's 1115 waiver, included as *Appendix A*. The request reflected the input received from the public (www.eohhs.ri.gov/ri1115waiver/updates/).

March 27, 2013: Rhode Island received a letter from CMS indicating that CMS had determined that the State's extension request did not meet the requirements for a complete extension request as specified under section 42 CFR 431.412(c). The CMS letter is attached as *Appendix B*. Below is a list of the requests included in the letter and the State's response.

(1) Additional information on the State's plan for evaluation activities during the extension period including research hypotheses and an evaluation design regarding the State's proposed revisions to the demonstration;

The State's Plan for Evaluation Activities is included in Section 4 of this document.

(2) A copy of the notice that the State published in the newspaper of widest circulation;

A copy of that notice is included as Appendix C.

(3) A description of any additional mechanisms, such as electronic mailing lists, the State used to notify interested parties of the extension application.

The State has sent notices via email to the following groups:

- *the RI Health and Human Services Policy Interested Parties email list,*
- *the RI 1115 Waiver Taskforce Interested Parties and*
- *the RIte Care Consumer Advisory Committee*

See Section 5 of this document for more information.

(4) A determination that the State's process for tribal consultation was not fully in compliance with 42 CFR 431.408 (a)(1).

The State has notified the Narragansett Indian Tribe of the submission of this updated extension request.

The Public Process to be followed for this submission is described in Section 5 of this document.

(5) A determination that the draft extension request posted in January did not include sufficient detail regarding budget neutrality. Specifically, CMS indicates that the notice should have provided additional information regarding projected expenditures for the extension period, cumulative expenditures, projected enrollment and a financial analysis of the requested changes to the demonstration. For these reasons, CMS directed Rhode Island to make this information available for public comment pursuant to the public notice requirements in 42 CFR 431.408(a)(1).

While we concur with CMS as to the level of detail regarding budget neutrality in the January draft, we note that the State's March 2013 submission to CMS was posted on the Rhode Island Executive Office of Health and Human Services website on March 13, 2013. That submission included considerably more detail on projected expenditures, cumulative expenditures, projected enrollment and financial forecasts.

In order to address the various concerns raised by CMS the State is initiating a new public notice period beginning July 10, 2013. The extension request posted for public notice is composed of two linked documents. The first is the March 12, 2013 submission, the second is this Addendum.

This Addendum addresses specific issues raised by CMS not otherwise included in the March document. Rhode Island will also take the opportunity of this submission to incorporate several changes to the Medicaid Program that were enacted in the legislative session that ended on July 3, 2013.

Those changes include:

1. **Enrollment of newly eligible adults and former foster care children up to age 26 in managed care delivery systems.**
   The March 12, 2013 submission to CMS reflected the expectation that the Rhode Island General Assembly would approve Governor Chafee's proposal to expand the Medicaid program to include eligible adults without dependent children with income at or below 133% FPL, based on modified adjusted gross income and former foster care children up to age 26. The General Assembly has approved both coverage expansions. The State will use the authority under the State Plan to implement eligibility for the new coverage groups, but is seeking the authority of the 1115 Waiver to mandatorily enroll these individuals in a managed care delivery system. Newly eligible adults and former foster care children up to age 26 will have the option of enrolling in one of the managed care organizations through the Rhody Health Partners Program or with our primary care case management program, Connect Care Choice.

2. **Reduction in Parent/Caretaker Relative Eligibility from 175% FPL to 133% FPL**
   Through this submission, Rhode Island seeks federal approval to decrease eligibility levels for parents/caretaker relatives from 175% FPL to 133% FPL, based on modified adjusted gross income, effective January 1, 2014. This is a group that could be covered

under the State Plan, but that the State has opted to cover through §1115 Waiver authority. It is the State's expectation that these individuals will be able to access health insurance coverage with a qualified health plan through the State's Insurance Exchange. We have documented the expected impact this change will have on Budget Neutrality in Section 3 of this submission.

3. Affordable Coverage and Personal Responsibility

Currently, all children and parent/caretaker relatives eligible for Medicaid with household incomes at 150% FPL and above are required to share in the cost of care. If these cost-sharing requirements remain, the parents/caretaker relatives from 150% -175% FPL who will lose Medicaid coverage effective January 1, 2014 and take-up commercial coverage will be required to pay both the Medicaid premium as well as the premium for their own health care coverage. In considering how to treat the existing Medicaid premiums in the context of the eligibility change, the State needs to balance two goals: the first is to ensure that overall health care coverage is affordable and the second is to continue to require households at certain income levels to participate in the cost of care.

In order to meet both those goals, the State seeks approval to change how the State applies the requirement to pay the Medicaid premium. The State also seeks expenditure authority approval for financial help it may provide to assist in ensuring coverage is affordable. The following describes how the State envisions the application of the Medicaid premium beginning January 1, 2014.

<u>3a. Households at 150% - 250% FPL: Children are Medicaid eligible and enrolled in RIte Care, Parent/Caretaker Relative(s) enrolled in commercial coverage</u>

The State proposes to eliminate cost-sharing requirements for these households. The request to remove the cost-sharing requirement is grounded on the notion that the parent/caretaker relatives of children in households with incomes above 150% FPL will be enrolled in commercial coverage and will be required to pay premiums and cost-sharing for their own health care. Elimination of the Medicaid premium for these households will require cost-sharing related only to the parent/caretaker relatives' commercial health care coverage.

<u>3b. Households at 150% - 250% FPL: Children are Medicaid eligible and enrolled in RIte Share and covered through Parent/Caretaker Relative's commercial coverage</u>

The RIte Share Premium Assistance Program was established to subsidize the costs of enrolling Medicaid eligible households in commercial coverage that meets certain cost and coverage requirements. The State intends to include any Qualified Health Plans offered through the new Exchange in the RIte Share program, if those plans meet the RIte Share requirements.

The RIte Share Program has always allowed for the payment of a premium for family coverage even if the parent/caretaker relative or other members of the household are ineligible for Medicaid. If that family coverage meets the cost-effective and benefit requirements, the State will pay the full premium. Today, the households are required to pay the Medicaid Premium.

The State proposes to maintain that Medicaid premium for children enrolled in RIte Share in households at 150% and above. The rationale for this request is to ensure equity with households described in 3a.

We are proposing the elimination of the Medicaid premium for the households described in 3a. because they will face premium requirements associated with the coverage for the parent/caretaker relative. If Medicaid premiums were also eliminated for households described in 3b, households enrolled in RIte Share, those households would face no premium. The rationale for maintaining the Medicaid premium for these households is to ensure households at 150% FPL and above continue to share in the cost of their coverage.

3c. Households up to 175% FPL: Children are Medicaid eligible and enrolled in RIte Care; Parent/Caretaker Relative(s) are enrolled in coverage through the Health Insurance Exchange and coverage does not meet RIte Share requirements

To address the potential that coverage available through the State's new Insurance Exchange may still be difficult for certain households to afford, the State is seeking approval to use expenditure authority to develop a health insurance financial assistance program. This program would be targeted to adults who are not otherwise Medicaid eligible but who are parent/caretaker relatives of current Medicaid-eligible children and whose incomes are at or below 175% FPL. The financial assistance would be available for the purchase of insurance coverage through the State's new Insurance Exchange. The current legislation envisions the financial assistance would be equal to one-half of the cost of the premium of a qualified health plan, after subtracting the federal tax credits available as well as a state established cost-sharing amount – equal to the Medicaid premium.

The State believes that these three tools:

a. elimination of the Medicaid premium for households above 150% FPL with parent/caretaker relatives enrolled in commercial coverage;
b. maintenance of the Medicaid premium for households above 150% FPL enrolled in RIte Share; and
c. assistance with the premium costs of coverage through the new Insurance Exchange for households up to 175% FPL with Medicaid –eligible children

will enable the State to balance efforts to ensure health insurance is affordable with the requirement that households at certain income levels continue to share in the cost of care.

4. Requirement to apply for health insurance prior to receipt of services provided under the Costs Not Otherwise Matchable (CNOM) expenditure authority

Any individual, for whom a claim for CNOM services is submitted, must document that he or she has applied for any health insurance for which he or she may be eligible, including health insurance available through the new Insurance Exchange. Implementation of this requirement will be developed in coordination with providers, individuals receiving the services, and the community to ensure there is no undue disruption of access to necessary services.

The following sections provide additional information related to these changes and updates to the March 12 submission.

- **Section 2**: Updates to requested changes to the waiver.
- **Section 3**: Impact of requested changes on budget neutrality, including some technical corrections to the budget neutrality calculations.
- **Section 4**: Additional information on the State's plan for evaluation activities.
- **Section 5**: Updated description of the State's public notice process.

2. Requested Changes to the Waiver

As described in its initial waiver submission in 2008 and the March 2013 Waiver Extension Request, Rhode Island seeks to build a Medicaid program that is highly responsive to the needs of the beneficiaries we serve and contributes to the improvement of the State's overall health care system in a cost effective manner. The established goals of the demonstration remain in place. The waiver changes requested here represent strategies to further the State's ability to achieve the goals of the demonstration.

Toward this end, Rhode Island's initial waiver period provided some important lessons learned. Rhode Island's resulting guiding principles for reform are summarized below:

Guiding Principles
o Ensure information about services and how to access them is readily available and consistent.
o Ensure Medicaid financed services are responsive and appropriate to a person's medical, functional, and social needs.
o Ensure the Medicaid program is coordinated and integrated with other publicly-financed health care.
o Ensure the Medicaid program is coordinated with other insurance systems.
o Utilize information technology systems more efficiently

Rhode Island has translated these guiding principles into four primary strategic areas, to be implemented over the waiver extension period. Additionally, over the course of the waiver period much has changed in the health care environment, most notably the passage of the Affordable Care Act. Rhode Island's strategies have evolved and will continue to evolve as the impacts of this landmark legislation unfold. Rhode Island's four primary strategic areas are:

1. Improve coverage and eligibility policies and procedures to achieve timely appropriate coverage and interventions to prevent higher cost care and forestall the need for Medicaid coverage.
2. Expand covered benefits to incorporate a broader definition of health enabling programs to better improve and maintain health status, avoid more costly services and address key factors leading to poor health outcomes.
3. Reform payment and delivery systems to change the way services are delivered and paid for to improve integration of care and align incentives.
4. Continue to strengthen coordination of the Medicaid program with other public programs – (e.g. Medicare, other state health services within EOHHS) to achieve maximum impact.

These four strategies will be implemented over the waiver extension period through a combination of initiatives. The following figure summarizes the requested waiver changes in the context of these strategies.

	TABLE 1	Refer to Page # in March 2013 Submission	Improved coverage and eligibility policies & procedures	Expansion of benefits to include a broader definition of Health	Reform delivery system	Coordination with other public programs
Eligibility	Expanded eligiblity for persons transitioning between Medicaid/HIP QHP in HIX	18	x			
	Extend MAGI renewals betw 1/1/2013 and 3/31/2014	19	x			
	Expedited LTC eligibility	19	x			
	Post eligibility Treatment of income	20	x			
	Process for collecting patient liability	21	x			
	Expand Budg Pop 10 (elders 65+)	22	x			x
	New Budg Pop 20 Adults 19-64 with alzheimers disaease or dementia	22	x			x
	Modification to Budg Pop 16 - (incl underinsured; incl adults w/ MH/SA needs in families w/ child at risk of out-of-home placement to DCYF	23	x			x
	Clarific of Budg Pop 17; Coverage of detection and intervention services for at-risk children not elig for Medicaid up to 330% SSI	23	x			
	Outstationing eligibility workers	24	x			
	Increase FPL for EFP from 200% to 250% (Budg Pop 5)	25	x			
	Budg Pop 21: Young adults aging out of Katie Beckett	25	x			
	Coverage for people incarcerated pending disposition of charges	26	x			x
	Reduction in Parent/Caregiver Eligibility from 175% FPL to 133% FPL	New				x
	Requirement to apply for health insurance prior to receipt of services provided under the Costs Not Otherwise Matchable authority	New	x			x
Benefits	Wellness Benefit - Rhode to Home (incentive for participation)	27		x		
	Alternative Benefits for specific populations	28		x		
	STOP - Sobering Treatment opportunity Program	30		x		x
	Telemedicine Services	31		x	x	
	Peer supports/peer mentoring	32		x		
	In home Behavioral Health services (Functional Family Therapy; MST)	33		x		
	Habilitative services (remove hospital LOC requirement)	33		x		
	Housing Stabilization Services	34		x		
	Healthy Works Initiative	36		x		
	Healthy Works I	37		x		
	Healthy Works II	38		x		
	Recategorization of Family Planning codes to Service Categories	43	x	x		
	State to no longer seek to utilize co-pays (except for EFP)	45	x			
	Financial Help Program Strategies to ensure affordable coverage and maintain personal responsibility	New	x			x
Service Delivery and Payment Reform	Mandatory enrollment in managed care for Medicaid expansion group	49			x	
	Dental services for older children and adults - mandatory managed care	49			x	
	Amendment to Institute for Mental Disease exclusion	50	x			
	Delivery system reform incentive payments	51			x	
	Community Health Team	54			x	

Together, the continuation of existing program authorities and the combination of strategies described above seek to enable the Rhode Island Medicaid program to "bend the cost curve," by targeting four primary objectives:

- *Strengthen primary care and community based services*
- *Achieve acute care hospital cost trend reductions*
- *Achieve long term care cost trend reductions*
- *Prevent/forestall the need for Medicaid services among at-risk, vulnerable populations*

3. Requested Changes to the Waiver: Budget Neutrality

This section of the Addendum addresses issues related to budget neutrality. The March 12, 2013 submission includes a detailed review of the State's budget neutrality forecasts (see Section VII).

This section of the Addendum supplements that discussion in two respects. The first (Section 3.1) notes certain adjustments are made to the source data for the forecasts, modifying the results. The second (Section 3.2) is to provide a financial analysis of the requested changes to the demonstration, viewing their impact through the four areas shown above. The end of this section summarizes the difference between these analyses and the prior submission.

3.1 Adjustments to the March 12, 2013 Submission

Adjustments are made to the March 12, 2013 submission to reflect three revisions made to the source data used.

- *CNOM (Charges Not Otherwise Matchable)*
  CNOM expense was not included in the original submission of historical data that examined Medicaid expenditures. However, because the CNOM expense is part of the waiver and is included in the budget neutrality limits, this expense should have been included in the baseline historical data. CNOM expense in SFY2012 was approximately $33 million.
- *Department of Children, Youth, and Families (DCYF) refinements*
  DCYF expense estimates have been updated, including additional payments that were not included in the MMIS experience, totaling $10 million that had not been captured in the original submission.
- *Parents over 133% FPL*
  The Rhode Island legislature has recently lowered the eligibility for Parents/Caretaker Relatives, from up to 175% FPL to up to 133% FPL effective January 1, 2014. As such, historical expenses and average eligibles relating to these populations have been excluded.
- *Updated Enrollment Projections*
  The March submission estimated an increase in take-up of eligible but not enrolled Rhode Islanders, adding 12,700 enrollees over the course of 2014-16 due to changes implemented in accordance with the ACA. This estimate has been increased from 12,700 to 15,500, predominantly due to updated (and lower) estimates of undocumented Rhode Islanders. Reducing the estimated number of undocumented Rhode Islanders correspondingly increases the number of Rhode Islanders eligible for Medicaid.[1]

The source data used in the original waiver request had a baseline historical expense trend for Rhode Island Medicaid of 1.8%, which incorporates a 1.3% enrollment trend and a 0.5% PMPM trend, as shown below:

[1] Updated estimates are based on the ACS 2011 data set -- prior estimates had been developed by Jon Gruber (MIT economist) based on older data sets and regional (rather than Rhode Island specific) survey information.

Original Table 7.9: Baseline Projected With Waiver (WW) Expenditures
(prior to adjustments)

		Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total	1.8%	1,621	1,692	1,696	1,785	1,802	1,773	1,822	1,856	1,890	1,926	1,962	1,999
ABD	2.6%	1,002	1,046	1,103	1,151	1,166	1,138	1,183	1,213	1,244	1,277	1,310	1,343
C+F	0.5%	619	645	592	634	636	635	639	642	646	649	652	655
Enrollment													
Total	1.3%	180,662	176,760	175,179	182,977	189,131	193,030	196,904	199,529	202,191	204,887	207,621	210,390
ABD	1.1%	45,652	45,328	45,748	46,576	47,429	48,329	49,162	49,726	50,296	50,872	51,456	52,045
C+F	1.4%	135,011	131,432	129,431	136,402	141,702	144,701	147,741	149,804	151,895	154,015	156,165	158,345
PMPM													
Total	0.5%	748	798	807	813	794	765	771	775	779	783	787	792
ABD	1.4%	1,829	1,924	2,010	2,059	2,049	1,963	2,005	2,033	2,062	2,091	2,121	2,151
C+F	-0.9%	382	409	381	388	374	365	361	357	354	351	348	345

After the revisions described above, the historical baseline projected WW expenditure trend increased to 2.3%, comprised of a 0.8% PMPM trend and a 1.5% enrollment trend.

Revised Table 7.9: Baseline Projected With Waiver (WW) Expenditures
(prior to adjustments)

	2014-18	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total	**2.3%**	1,601	1,671	1,691	1,784	1,814	1,797	**1,860**	1,905	1,950	1,996	2,044	2,093
ABD	3.0%	1,002	1,046	1,110	1,163	1,189	1,162	**1,215**	1,252	1,289	1,328	1,368	1,409
C+F	1.2%	599	625	580	620	625	634	**645**	653	660	668	676	684
Enrollment													
Total	**1.5%**	173,327	170,004	169,785	177,468	183,072	186,871	**191,141**	194,043	196,990	199,982	203,021	206,107
ABD	1.1%	45,652	45,328	45,748	46,576	47,429	48,329	**49,162**	49,726	50,296	50,873	51,456	52,046
C+F	1.6%	127,676	124,676	124,037	130,893	135,643	138,542	**141,978**	144,317	146,694	149,110	151,565	154,062
PMPM													
Total	**0.8%**	770	819	830	838	826	801	**811**	818	825	832	839	846
ABD	1.8%	1,829	1,924	2,023	2,082	2,088	2,004	**2,060**	2,098	2,136	2,176	2,216	2,257
C+F	-0.5%	391	418	390	395	384	382	**379**	377	375	373	372	370

As shown above, using this revised historical data as a baseline, the With Waiver scenario was then adjusted for non-recurring anticipated events over the historical and proposed waiver period. These adjustments were described in the original waiver demonstration document and the source data for those adjustments has not changed, with the exception of the estimate of increased enrollment due to enhanced ACA outreach.

The resulting With Waiver expenditure trend rate using revised historical data and revised increased enrollment estimates, after adjusting for non-recurring events, is 7.1%, comprised of an enrollment trend of 2.7% and a PMPM trend of 4.3%, as shown below.

Revised With Waiver (WW) Forecast

after non-recurring adjustments

	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total*	**7.1%**	1,397	1,512	1,604	1,731	1,795	1,797	**1,960**	2,140	2,320	2,480	2,642	2,819
ABD	5.1%	969	1,024	1,096	1,149	1,183	1,162	1,245	1,311	1,376	1,446	1,522	1,603
C+F	10.1%	429	487	507	582	612	634	716	828	944	1,033	1,121	1,217
							Year over year projected total expense trend:		9.1%	8.4%	6.9%	6.6%	6.7%
Enrollment													
Total	**2.7%**	173,327	170,004	169,785	177,468	183,072	186,871	**191,586**	201,008	212,037	216,908	220,282	223,712
ABD	1.8%	45,652	45,328	45,748	46,576	47,429	48,329	**49,608**	50,479	51,365	52,267	53,185	54,119
C+F	3.0%	127,676	124,676	124,037	130,893	135,643	138,542	**141,978**	150,529	160,672	164,641	167,097	169,593
PMPM													
Total	**4.3%**	672	741	787	813	817	801	**853**	887	912	953	1,000	1,050
ABD	3.3%	1,768	1,883	1,997	2,056	2,078	2,004	**2,091**	2,165	2,233	2,306	2,384	2,468
C+F	6.9%	280	326	341	370	376	382	**420**	458	490	523	559	598

3.2 Impact of Waiver Adjustments

In Section VII. C. of Rhode Island's March 2013 1115 Research and Demonstration Waiver Extension Request, Rhode Island developed a With Waiver and Without Waiver scenario for expenditures over the waiver period. In response to this budget neutrality proposal, CMS has requested that Rhode Island amend these forecasts to include *"a financial analysis of the requested changes to the demonstration."*

Many of the proposed initiatives are intended to increase access to critical and cost effective primary care and professional services in order to reduce and/or contain utilization of costly acute care and institutional services. As such, the With Waiver forecast has been revised to reflect the combined impact of the strategies and requested changes in the waiver on the four key objectives described in Section 2 above. In sum, Rhode Island anticipates the following impact:

- *Strengthen primary care and community based services*
  Rhode Island anticipates a 10% higher annual PMPM trend for professional services from CY 2013-14 and an ongoing 5% higher annual PMPM trend for CY 2015-18, resulting in a 0.3 percentage point increase in the professional care services trend for Aged, Blind, and Disabled (ABD) populations and a 0.5 percentage point increase for children and families.
- *Achieve acute care hospital cost trend reductions*
  Rhode Island anticipates that these above strategies will together decrease hospital care annual cost trends by 15% for CY 2015-18, resulting in a 1.3 percentage point reduction in acute care hospital average cost trends for ABD populations, and a 0.6 percentage point reduction for children and families.
- *Achieve long term care cost trend reductions*
  Rhode Island anticipates that these strategies shall together decrease long term care annual cost trends by 15% for CY 2015-18, resulting in a 0.1 percentage point reduction in long-term care cost trends for ABD populations, and a 0.1 percentage point trend reduction for children & families.

- *Prevent/forestall the need for Medicaid services among at-risk, vulnerable populations*
  Many of these strategies are designed to increase access to critical professional and ancillary services in order to prevent or forestall the need for more costly long-term care services. Rhode Island anticipates a 10% lower enrollment trend, resulting in a 0.2 percentage point reduction in ABD enrollment trend, and 0.2 percentage point reduction in children and families enrollment trend, as the need for Medicaid services is prevented or forestalled.

The impact of the initiatives is modeled by adjusting the PMPM and enrollment trends by provider type by population segment based on the framework shown in the table below.

Impact of Initiatives

PMPM Trend	Long Term Care	No impact CY2014, 15% reduction in annual trend CY 2015-18
	Hospital	No impact CY2014, 15% reduction in annual trend CY 2015-18
	Professional	10% increase in annual trend CY 2014, 5% increase in annual trend CY 2015-18
Enrollment Trend	ABD	10% reduction in annual trend CY 2014-18
	Children and Families	10% reduction in annual trend CY 2014-18

The trend rates in the following table isolate the difference in trend due to the waiver initiative impact[2].

Detailed Impact of Initiatives

Annual Trend Rates - after non-recurring cost reductions

PMPM	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY14-18 CAGR
ABD: Long Term Care	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
ABD: Hospital	8.9%	8.9%	8.9%	8.9%	8.9%	8.9%
ABD: Professional	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
ABD TOTAL	**3.0%**	**3.1%**	**3.2%**	**3.4%**	**3.5%**	**3.3%**
CF Long Term Care	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
CF: Hospital	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
CF: Professional	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
CF TOTAL	**6.7%**	**6.8%**	**6.8%**	**6.9%**	**7.0%**	**6.9%**
Medicaid Total	**4.4%**	**4.5%**	**4.7%**	**4.8%**	**4.9%**	**4.7%**

Eligibles	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY14-18 CAGR
ABD	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
CF	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%
Medicaid Total	**1.7%**	**1.7%**	**1.7%**	**1.7%**	**1.7%**	**1.7%**

Annual Trend Rates - adjusted for impact of waiver initiatives

PMPM	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY14-18 CAGR	*Change in Trend*
ABD: Long Term Care	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%	*-0.1%*
ABD: Hospital	8.9%	7.6%	7.6%	7.6%	7.6%	7.6%	*-1.3%*
ABD: Professional	6.2%	5.9%	5.9%	5.9%	5.9%	5.9%	*0.3%*
ABD TOTAL	**3.1%**	**2.9%**	**3.0%**	**3.1%**	**3.2%**	**3.0%**	***-0.3%***
CF Long Term Care	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%	*-0.1%*
CF: Hospital	3.9%	3.3%	3.3%	3.3%	3.3%	3.3%	*-0.6%*
CF: Professional	9.9%	9.5%	9.5%	9.5%	9.5%	9.5%	*0.5%*
CF TOTAL	**7.2%**	**6.8%**	**6.9%**	**7.0%**	**7.1%**	**6.9%**	***0.1%***
Medicaid Total	**4.7%**	**4.4%**	**4.5%**	**4.6%**	**4.8%**	**4.6%**	***-0.1%***

Eligibles	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY14-18 CAGR	*Change in Trend*
ABD	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	*-0.2%*
CF	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	*-0.2%*
Medicaid Total	**1.5%**	**1.5%**	**1.5%**	**1.5%**	**1.5%**	**1.5%**	***-0.2%***

[2] These changes in trend rates are modeled after the non-recurring adjustments in historical expenditure but before the anticipated non-recurring adjustments in future expenditures.

The overall change in trend from this modeling, after future non-recurring adjustments are taken into account, is a lower forecasted With Waiver (WW) expenditure trend for 2014-18 from 7.1% to 6.8%. PMPM trend decreases from 4.3% to 4.2%, a reduction of 0.1%. Enrollment trend decreases from 2.7% to 2.6%, a reduction of 0.1%.

Revised Detailed With Waiver (WW) Forecast

after non-recurring adjustments & waiver initiative impact

	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total*	**6.8%**	1,397	1,512	1,604	1,731	1,795	1,797	**1,960**	2,141	2,316	2,468	2,623	2,791
ABD	4.7%	969	1,024	1,096	1,149	1,183	1,162	1,245	1,311	1,370	1,434	1,502	1,575
C+F	10.0%	429	487	507	582	612	634	716	831	946	1,034	1,121	1,216
								Year over year projected total expense trend:	9.2%	8.1%	6.6%	6.3%	6.4%
Enrollment													
Total	**2.6%**	173,327	170,004	169,785	177,468	183,072	186,871	**191,586**	200,687	211,385	215,914	218,936	222,002
ABD	1.6%	45,652	45,328	45,748	46,576	47,429	48,329	**49,608**	50,392	51,188	51,997	52,819	53,654
C+F	2.9%	127,676	124,676	124,037	130,893	135,643	138,542	**141,978**	150,295	160,197	163,917	166,117	168,349
PMPM													
Total	**4.2%**	672	741	787	813	817	801	**853**	889	913	953	998	1,048
ABD	3.1%	1,768	1,883	1,997	2,056	2,078	2,004	**2,091**	2,168	2,231	2,298	2,370	2,446
C+F	6.9%	280	326	341	370	376	382	**420**	461	492	526	562	602

3.3 Summary of Revised Budget Neutrality Submission

Table 7.5 in the March 12 submission summarized the With Waiver Forecast of the aggregate ten-year projected expenditure under the extension estimated at $20,872 million, which was composed of the $8,813 million from the initial period plus an additional $12,059 million for the five-year extension period. This forecast was based on a total expense trend of 6.6%, an enrollment trend of 2.3% and a PMPM trend of 4.2%, as shown below.

Table 7.5 With Waiver (WW) Forecast Summary

from March 12 submission

	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total*	**6.6%**	1,421	1,534	1,595	1,730	1,784	1,773	**1,932**	2,103	2,270	2,414	2,559	2,713
ABD	5.0%	971	1,027	1,092	1,139	1,161	1,138	1,222	1,301	1,372	1,440	1,509	1,582
C+F	9.0%	450	507	503	591	622	635	711	801	897	974	1,050	1,131
								Year over year projected total expense trend:	8.8%	8.0%	6.4%	6.0%	6.0%
Enrollment													
Total	**2.3%**	180,662	176,760	175,179	182,977	189,131	193,030	**197,322**	205,275	214,597	218,925	221,972	225,065
ABD	1.9%	45,652	45,328	45,748	46,576	47,429	48,329	**49,581**	50,693	51,889	52,839	53,736	54,649
C+F	2.5%	135,011	131,432	129,431	136,402	141,702	144,701	**147,741**	154,582	162,709	166,086	168,236	170,416
PMPM													
Total	**4.2%**	655	723	759	788	786	765	**816**	854	881	919	961	1,004
ABD	3.1%	1,773	1,888	1,989	2,038	2,040	1,963	**2,053**	2,139	2,204	2,271	2,341	2,412
C+F	6.4%	278	322	324	361	366	365	**401**	432	460	489	520	553

Waiver Fcst Years 1-10		**DY 1-10**	**CY 2009-18**	**20,872**
Waiver Fcst Years 6-10		**DY 6-10**	**CY 2014-18**	**12,059**

After the adjustments described above, the revised With Waiver forecast results in an aggregate ten-year projected expenditure under the extension estimated at $21,226 million, which is composed of $8,886 million from the initial period plus an additional $12,340 Million for the five-year extension period. This revised forecast is based on a 6.8% aggregate expense trend, a 2.6% enrollment trend and a 4.2% PMPM trend as shown below.

Table 7.5 With Waiver (WW) Forecast Summary

REVISED Summary

	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total*	**6.8%**	**1,397**	**1,512**	**1,604**	**1,731**	**1,795**	**1,797**	**1,960**	**2,141**	**2,316**	**2,468**	**2,623**	**2,791**
ABD	4.7%	969	1,024	1,096	1,149	1,183	1,162	1,245	1,311	1,370	1,434	1,502	1,575
C+F	10.0%	429	487	507	582	612	634	716	831	946	1,034	1,121	1,216
							Year over year projected total expense trend:		9.2%	8.1%	6.6%	6.3%	6.4%
Enrollment													
Total	**2.6%**	**173,327**	**170,004**	**169,785**	**177,468**	**183,072**	**186,871**	**191,586**	**200,687**	**211,385**	**215,914**	**218,936**	**222,002**
ABD	1.6%	45,652	45,328	45,748	46,576	47,429	48,329	49,608	50,392	51,188	51,997	52,819	53,654
C+F	2.9%	127,676	124,676	124,037	130,893	135,643	138,542	141,978	150,295	160,197	163,917	166,117	168,349
PMPM													
Total	**4.2%**	672	741	787	813	817	801	**853**	889	913	953	998	1,048
ABD	3.1%	1,768	1,883	1,997	2,056	2,078	2,004	**2,091**	2,168	2,231	2,298	2,370	2,446
C+F	6.9%	280	326	341	370	376	382	**420**	461	492	526	562	602

Waiver Fcst Years 1-10		**DY 1-10**	**CY 2009-18**	**21,226**
Waiver Fcst Years 6-10		**DY 6-10**	**CY 2014-18**	**12,340**

This can be compared to an anticipated without waiver (WOW) trend over this same period of 7.4%, as detailed in the initial waiver request, with an aggregate ten-year projected expenditure estimated at $27,244 million[3].

Table 7.4 from March 12 submission: Without Waiver Forecast/Budget Neutrality Cap (WOW)

		Historical CY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
				DY 1	DY 2	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	DY 9	DY 10
Expenses $ Millions													
Total	**7.4%**			2,600	2,400	2,300	2,400	2,375	2,601	2,831	3,035	3,241	3,462
							Year over year projected total expense trend:		*9.5%*	*8.8%*	*7.2%*	*6.8%*	*6.8%*
Enrollment													
Total	**2.2%**							196,948	204,613	213,639	217,662	220,396	223,167
PMPM													
Total	**5.1%**							1,005	1,059	1,104	1,162	1,225	1,293

Waiver Cap Years 1-10		**DY 1-10**	**CY 2009-18**	**27,244**
Waiver Cap Years 6-10		**DY 6-10**	**CY 2014-18**	**15,169**

[3] Offsetting changes to enrollment projections may be warranted due to downward adjustments to the number of undocumented adults in Rhode Island (and consequent upward adjustments of eligible but not enrolled) and impacts of changes in eligibility for parents.

4. Plan for Evaluation Activities

CMS' March 27 letter to Rhode Island requests additional information on the State's plan for evaluation activities during the extension period including research hypotheses and an evaluation design regarding the State's proposed revisions to the demonstration.

The revisions or additional authorities requested by Rhode Island represent strategies to continue to pursue the core goals of our initial submission. In this respect, the evaluation design and measures continue to be effectively targeted.

The initial effective date for Rhode Island's 1115 waiver was January 1, 2009. The Special Terms and Conditions (STCs) for the Waiver issued upon approval stipulated that the State submit a draft evaluation design to CMS not later than July 2009. On July 17, 2009, Rhode Island submitted to CMS its comprehensive evaluation design for the Waiver. In Attachment G of the March 12, 2013, submission to CMS, Rhode Island provided an overview of the status of the evaluation of the current Waiver and key findings to date, based on that evaluation design.

Based on approval of Rhode Island's extension request, the State anticipates that CMS would seek updates, where appropriate, to the evaluation design to incorporate waiver changes.

Regarding the current evaluation design, Paragraph 94 of the current STCs sets forth specific components of the Demonstration that must be included in the evaluation:

> **Comprehensive Evaluation -- Waiver Demonstration:** A discussion of the goals, objectives, evaluation questions, and outcome measures used to assess the entire Demonstration as well as the adequacy and appropriateness of the benefit coverage, safety and outcome of the LTC reform and expansion groups, especially the Extended Family Planning, HIV Services, Elders 65 and Over, and Parents pursuing behavioral health services.
>
> **Focused Evaluation:** The separate components of the Demonstration identified for evaluation in the STCs included:
>
> a) LTC Reform, including the HCBS-like and PACE-like programs;
> b) RIte Care;
> c) RIte Share;
> d) The 1115 Expansion Programs (Limited Benefit Programs), including but limited to:
>
> (1) Children and Families in Managed Care and Continued eligibility for RIte Care parents when children are in temporary state custody;
> (2) Children with Special Health Care Needs;
> (3) Elders 65 and Over;
> (4) HCBS for Frail Elders, adults with disabilities, children in residential diversion and at risk/Medicaid eligible youth;
> (5) Uninsured adults with behavioral health and substance abuse problems;
> (6) Coverage of detection and intervention services for at risk young children;
> (7) HIV Services;

(8) Administrative process flexibility; and
(9) Extended Family Planning

The July 2009 evaluation design sets forth a comprehensive description of goals, objectives and measures for the waiver addressing each of these components. For reference, Appendix D to this Addendum excerpts a table from that submission identifying goals, objectives, evaluation questions, measures and data sources for the evaluation. Since the start of the Waiver, there have been changes, for example, in the structure of delivery systems; additional changes are anticipated (e.g. implementation of the Integrated Care Initiative). Although such changes alter the specific form of the program, the core goals and objectives remain intact.

Rhode Island's extension request seeks new federal authorities to continue to pursue the goals and objectives of the initial waiver period. As noted in the above section on budget neutrality, the State anticipates that these initiatives will serve to:

- *Strengthen primary care and community based services*
- *Achieve acute care hospital cost trend reductions*
- *Achieve long term care cost trend reductions*
- *Prevent/forestall the need for Medicaid services among at-risk, vulnerable populations*

The outcomes to be achieved will be assessed both comprehensively and through focused evaluations. Modifications to the areas of focused evaluations can be made to better reflect changes in the structures of delivery systems. The specific programmatic context for certain measures change as the structure of delivery systems change but the measures remain relevant.

The actual implementation of the new initiatives, which focus on eligibility, benefits, and reform of service delivery systems and payment methodologies, will occur in a staged manner as the initiatives become fully developed and gain the necessary Federal and/or State authorizations. Accordingly, proposed refinements or additions to evaluation measures will be identified incrementally, based on the various initiatives' final component elements.

As the State undertakes the implementation of new initiatives, the RI EOHHS will affirm the following basic strategies for concurrent quality monitoring and program evaluation:

- Articulate clear research hypotheses, to guide the development of measurable goals, objectives, and evaluation questions.
- When possible, require the use of established quality metrics developed by external experts, such as the National Quality Forum (NQF), the Agency for Health Care Research and Quality (AHRQ), and the National Committee for Quality Assurance (NCQA).
- Compare the State's performance to relevant internal and/or external benchmarks.
- Ensure that the design of any focused evaluations contains all of the requisite elements that have been stipulated in the Waiver's revised STCs.
- Continue to involve key stakeholders, such as the Waiver's Quality and Evaluation Work Group, in the development of updates to the Waiver's Evaluation Design, as proposed initiatives are formulated and evaluation components are determined.

5. PUBLIC NOTICE PROCESS

In addition to the initial public notice process that the State Medicaid agency implemented in January 2013, there has been additional engagement with stakeholders over the past five (5) months. There have been 1115 Waiver Taskforce meetings held on the following dates: February 25, March 25, April 22, May 20 and June 24, 2013.

Tribal Notification

Tribal Notification was sent to the Narragansett Indian Chief Sachem Matthew Thomas on April 1, 2013 via certified letter. The State has sent a second certified letter to Chief Thomas and the Narragansett Indian Health Center informing the tribe of the additional information posted on the website. This correspondence was sent on July 10, 2013 and is attached to this document. A copy of the entire Waiver submission including the additional documentation on evaluation activities and budget neutrality, is included in the correspondence to the Narragansett Indian Tribe. The March 12, 2013 submission to CMS was posted on the EI EOHHS website and has been continuously available for review.

The state held three (3) additional public hearings during the current 30-day public notice and review period which began on July 10, 2013 and ended on August 10, 2013.

Public Notice of the application was:

- **Published in the Providence Journal**, the daily newspaper with the widest circulation in the state, on July 10, 2013.

- **Posted on the EOHHS Website.** The application, descriptions of the public notice process, public input on the waiver, and the public hearing schedule were posted on the state's website at: http://www.eohhs.ri.gov/ri1115waiver/updates
  The state will be launching a new website for EOHHS. This information can be found at the new website in August 2013 at
  http://www.eohhs.ri.gov/ReferenceCenter/GlobalWaiver.aspx under "Updates."

- **Sent to Email Lists.** In addition to the newspaper announcement and the public hearings, a notice regarding the application and supplemental resubmission information has been sent via electronic mail to the following mailing lists:

  - Rhode Island Health and Human Services Policy Interested Parties
  - Rhode Island 1115 Waiver Taskforce Interested Parties
  - RIte Care Consumer Advisory Committee

Public Hearings:

The state held three (3) public hearings in separate parts of the state. They included:

Public Hearing #1:
July 17, 2013 from 4- 6 pm at the University of Rhode Island, Kingston, RI.
There were three (6) people that attended this hearing. The public was able to participate by conference call at this hearing. There was testimony from one (1) person at this hearing.

Public Hearing #2:
July 22, 2013 from 1-3 pm at the Medicaid 1115 Waiver Taskforce meeting at the RI Dept. of Labor and Training, Cranston, RI. There were 24 people that attended this meeting. There were no public comments at the meeting.

Public Hearing #3:
July 25, 2013 from 4-6 pm at the Woonsocket City Hall, Woonsocket, RI. There were (3) people that attended this public hearing. There was one (1) person that gave oral testimony but did not submit comments in writing.

Public Comments

All public comments from the public hearings are included in the Public Comments section of the website listed below:
http://www.ohhs.ri.gov/ri1115waiver/publiccomments/
The state will be launching a new website for EOHHS. This information can be found at the new website in August 2013 at:
http://www.eohhs.ri.gov/ReferenceCenter/GlobalWaiver/PublicComments.aspx
An additional eight (8) comments were received by email. The comments are posted on the website in the Public Comments section and are summarized and responded to in a document that is included on the website at the email listed above. There were no comments received by mail.

Public comments could have been submitted at public hearings, by email or by regular mail.

March 12, 2013 Submission

Please note that in March 12, 2013 submission described the public notice process pursuant to the draft extension request. Although CMS determined that the public notice process was not fully compliant with federal regulations, those public meetings and comments were part of our public process and are referenced here.