Rhode Island Comprehensive Section 1115 Demonstration
Project Number: 11-W-00242/1

Category III Change
Change Name: Cortical Integrative Therapy
Change Number: 15-01-CIII

Date of Request:	September 22, 2015
Proposed Implementation Date: *(120 day notice required)*	January 23, 2016

Fiscal Impact

	FFY 2016	**FFY 2017**	**FFY 2018**	**FFY 2019**
State:	$375,000	$500,000	$500,000	$125,000
Federal:	$375,000	$500,000	$500,000	$125,000
Total	$750,000	$1,000,000	$1,000,000	$250,000

Description of Change:
Attachment A

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Attachment A: Description of Change

Summary:

The Rhode Island Executive Office of Health and Human Services (EOHHS) is submitting this change request to the Rhode Island Comprehensive Section 1115 Demonstration to launch a 3-year pilot program to evaluate the clinical and fiscal effectiveness of Cortical Integrative Therapy (CIT). EOHHS requests an effective date of January 9, 2016, to launch this program. The first year of the pilot will thus run from January 2016 to January 2017 with the second year extending from January 2017 to January 2018, and the third year of the pilot running from January 2018 through January 2019.

State statutory authority for this change request was obtained in 2013:

"(i) Cortical Integrative Therapy. The Medicaid single state agency shall seek to create a new service entitled Cortical Integrative Therapy.

Cortical Integrative Therapy (CIT) is a non-invasive diagnostic and treatment program for brain-based disorders. CIT is an innovative approach for detecting and stabilizing abnormal structural and functional brain lesions resulting from acquired brain injury or developmental disabilities, as well identifying the competent stimulus to be an effective treatment for the patient. Specifically, CIT uses objective measures of subtle functional changes across a wide range of domains—sensory systems including pupillary responses, motor systems, the autonomic system and the vestibular system—to diagnose a brain dysfunction. In addition, CIT uses an algorithm-based approach to analyze these data to identify the laterality and longitudinal level of a neurological lesion. CIT algorithms determine how best to stabilize the basic underlying systems of homeostasis so that the patient can benefit from treatment. Finally, CIT delivers a detailed treatment plan including the type, duration, and frequency of noninvasive treatment modalities to enable the patient to quickly recover optimal functionality.

This approach of precise diagnosis and active treatment is a profound departure from present day management practices for acquired brain injury and dysfunction which typically entails passive rest and intermittent monitoring. Rather than managing symptoms, CIT identifies and treats the underlying neurophysiological dysfunction or injury.

This development leads to improved brain function without requiring medication or surgery. The therapy is effective in enhancing level of function, cost effective and may result in beneficial cost avoidance for patients who may not require additional costly therapies due to increased functioning.

Creating this new service may require Category II changes under the terms and conditions of the Global Consumer Choice Waiver and the adoption of new or amended rules, regulations, and procedures;"

2013 H5127 Sub A As Amended - RELATING TO MAKING APPROPRIATIONS FOR THE SUPPORT OF THE STATE FOR THE FISCAL YEAR ENDING JUNE 30, 2014" , Section 6, page 13, lines 20-25.

Rhode Island Medicaid is requesting this approval under the existing 1115 authority for a waiver of Comparability of Eligibility Standards.[1] This request conforms to the Rhode Island Medicaid Reform Act of 2008 which directed the state's Medicaid program to establish a "sustainable cost-effective, person-centered, and opportunity driven program utilizing competitive and value-based purchasing to maximize available service options" and "a results-oriented system of coordinated care."[2] The RI Medicaid Reform Act guided the development and implementation of Rhode Island's initial Global Consumer Choice Compact Section 1115 Demonstration, the precursor to the state's current 1115 waiver.

This change request is submitted as a Category III submission.

Background:

Cortical Integrative Therapy (CIT) is a non-invasive diagnostic and treatment program for brain-based disorders. Cortical Integrative Therapy (CIT) is a non-invasive diagnostic and treatment program for brain-based disorders. CIT is an innovative approach for detecting and stabilizing abnormal structural and functional brain lesions resulting from acquired brain injury or developmental disabilities, as well identifying the competent stimulus to be an effective treatment for the patient. Specifically, CIT uses objective measures of subtle functional changes across a wide range of domains—sensory systems including pupillary responses, motor systems, the autonomic system and the vestibular system—to diagnose a brain dysfunction. In addition, CIT uses an algorithm-based approach to analyze these data to identify the laterality and longitudinal level of a neurological lesion. CIT algorithms determine how best to stabilize the basic underlying systems of homeostasis so that the patient can benefit from treatment. Finally, CIT delivers a detailed treatment plan including the type, duration, and frequency of noninvasive treatment modalities to enable the patient to quickly recover optimal functionality.

This approach of precise diagnosis and active treatment is a profound departure from present day management practices for acquired brain injury and dysfunction which typically entails passive rest and intermittent monitoring. Rather than managing symptoms, CIT identifies and treats the underlying neurophysiological dysfunction or injury.

This development leads to improved brain function without requiring medication or surgery. The therapy is effective in enhancing level of function, cost effective and may result in beneficial cost avoidance for patients who may not require additional costly therapies due to increased functioning.

[1] Section 1902(a)(17) of the Social Security Act.
[2] Rhode Island General Law section 42-12.4.

EOHHS believes this therapy is effective in enhancing the level of function for patients with brain-based disorders. As such, CIT holds the potential to be cost effective and may result in beneficial cost avoidance for patients who, due to increased brain function attributable to the non-invasive and non-pharmaceutical Cortical Integrative Therapy, may not require additional costly therapies, including surgeries, extended costly therapies and long-term pharmaceutical therapy.

To fully evaluate the clinical and financial effectiveness of CIT, EOHHS will launch a 3-year evaluation with up to 100 patients enrolled in each year of the pilot program. The 3-year time frame will allow for patient recruitment, treatment, and enable the state to conduct quality evaluation along a 36-month continuum. A patient sample of up to 100 beneficiaries per year will minimize the logistical and administrative burdens of initiating the program and will facilitate rapid, detailed analysis of patient outcomes by EOHHS. Furthermore, the relatively small annual size of the patient pool will enable the state to conduct a detailed analysis of the costs and costs avoided through the pilot treatment modality.

Patients Eligible to Enroll in the Pilot Program:

Only Medicaid-eligible individuals with the following diagnoses will be able to request enrollment in the CIT pilot:

Diagnosis:	ICD 9:	ICD 10:
Peripheral Vertigo Unspecified	386.10	H81.39
Benign Paroxsymal Positional Vertigo	386.11	H81.1
Other Peripheral Vertigo	386.19	H81.3
Vertigo of Central Origin	386.2	H81.4
Dizziness	780.4	R42
Migraine Headaches	780.4	G43
Dysautonomia	742.8	G90.1
Post-Concussion Syndrome	310.2	S06.0
Other Brain Disorder Unspecified	348.96	G93.9
Ataxia	438.84	R27.0
Apraxia of Movement	784.69	R48
Apraxia of Speech	784.69	R48.2
Aphasia	784.3	R47.01
Pots Syndrome	458.0	I95.9

A request for CIT will be reviewed by Rhode Island Medicaid to confirm that an eligible diagnosis is present.

Services Included in CIT Pilot:

Beneficiaries participating in the CIT pilot will receive services in the following areas:
Evaluation and management

Chiropractic manipulation
Video Nystagmography—Oculomotor testing

The Pilot is capitated for the population of patients enrolled on an annual basis and utilizes a bundled payment for each patient in order to better facilitate the demonstration of potential cost avoidance in the independent evaluation. RI EOHHS intends to demonstrate both improved function for the patients enrolled and cost effectiveness for this bundled payment that will provide access to this effective, non-invasive and non pharmaceutical treatment modality.

The specific codes associated with each service are identified below:

Evaluation and Management:

New Patient
99201 Self-limited/Minor evaluation
99202 Low to Moderate evaluation
99203 Moderate evaluation
99204 Moderate to High evaluation
99205 Moderate to High evaluation

Established Patient
99212 Self-limited/Minor evaluation
99213 Low to moderate evaluation
99214 Moderate to high evaluation
99215 Moderate to high evaluation

Chiropractic Manipulation:

CMT—manual treatment to influence joint and neurophysiological function.
The 5 spinal regions are cervical, thoracic, lumbar, sacral, and pelvic.
The 5 extra-spinal regions are head, lower extremities, upper extremities, rib cage, and abdomen.

98940 CMT: Spinal (1-2 regions)
98941 CMT: Spinal (3-4 regions)
98942 CMT: Spinal (5 regions)
98943 CMT: Extraspinal (1 or more regions)

Physical Medicine and Rehabilitation
97001 Physical therapy evaluation
97002 Physical therapy re-evaluation
97003 Occupational therapy re-evaluation
97004 Occupational therapy re-evaluation

Supervised Modalities

97010 Hot or cold packs
97012 Tractions, mechanical
97014 Electrical stimulation

Constant Attendance
97032 Electrical stimulation
97033 Electrical current therapy
97034 Contrast bath therapy
97035 Ultrasound therapy
97036 Contrast bath therapy
97039 Physical therapy treatment

Therapeutic Procedures
97110 Therapeutic exercises
97112 MM
97116 Gait training therapy
97139 Physical medicine procedure
97150 Group therapeutic procedures
97140 Myofascial release
97140 Manual traction
97124 Massage therapy
97530 Therapeutic activities
97532 Cognitive skills development
97533 Sensory Integration
97535 Self-care management training

Tests and measurements
97750 Physical performance test

Video Nystagmography:

Vestibular Function Tests
92541 Spontaneous nystagmus test
92542 Positional nystagmus test
92543 Caloric vestibular tests
92544 Optokinetic nystagmus test
92545 Oscillating tracking test
92546 Sinusoidal rotational test
92547 Electrical

Special Ophthalmological Services
92081 Blind spot map

Attachment B: Evaluation Plan

Upon CMS's approval of the Cortical Integrative Therapy pilot, EOHHS will contract with an independent evaluator to develop the clinical and financial evaluation measures for this program. Those measures will be incorporated into an overall evaluation strategy and will serve as the basis for the cumulative CIT evaluation report which will be produced at the conclusion of the 3-year period.

EOHHS will submit these evaluation measures to CMS for review during the year one implementation in the pilot.

This evaluation plan will articulate quantifiable measures in the following areas:

1. Patient Outcomes
2. Financial Measures

Patient outcomes will be defined when the evaluation plan is promulgated. As patients are enrolled in the pilot, they will be screened in accordance with these measures to establish a treatment baseline. EOHHS will oversee chart audits and medical reviews at 12-month intervals after the CIT program launches. In addition, patient outcomes will be compared to those of the patients randomly selected for the financial control group described below. This comparison will also be based on chart audits and medical reviews.

Financial evaluation measures will be recorded semi-annually. At the beginning of each pilot year, EOHHS will randomly select 100 beneficiaries with similar diagnoses and functional limitations to the patients enrolled in CIT. Those 100 non-CIT enrolled patients will serve as a financial control group for the study. EOHHS will then track the costs associated with the control group alongside those of the CIT beneficiaries to register cost-avoidance trends associated with this new treatment.

These reports will serve as the basis for the overall CIT evaluation that EOHHS will finalize at the conclusion of this 3-year period.

Attachment C: State Notice Procedures

The Executive Office of Health and Human Services provided numerous opportunities for public input during the development of this category change request. These opportunities conformed to state's administrative procedures act.

Initially, the state conducted a 30-day public comment period. Public notice of the proposed category change was posted on the agency's website and distributed electronically through an interested parties mailing list. The state's tribal partners were contacted via email and through regular mail.

While preparing the Category III change request, the state held a public hearing. The hearing was open to the public; furthermore, the hearing was noticed and conducted in accordance with the state's administrative procedures act. The hearing took place on September 8, 2015, at 10am at the Executive Office of Health and Human Services' offices, 57 Howard Ave, Cranston, RI, 02920.

Attachment D: Assurances

The State assures the following:

- This change is consistent with the protections to health and welfare as appropriate to title XIX of the Social Security Act (the Act).
- The change results in appropriate efficient and effective operation of the program, including justification and response to Funding Questions.
- This change would be permissible as a State Plan or Section 1915 Waiver Amendment and is otherwise consistent with sections 1902, 1903, 1905, and 1906, Current Federal Regulations, and CMS Policy.

Attachment E: Standard Funding Questions

1. Section 1903(a)(I) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   Providers keep all of the Medicaid payments made by the state.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not to the Medicaid agency, the source of the state share would necessarily be derived through either through an I GT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the nonfederal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations)

   The state's share of the payments comes from annual legislative appropriations to the designated Medicaid Single State agency.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   The state will not be making enhanced or supplemental payments for this pilot.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

   Not applicable

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   Payments do not exceed the cost of services. If, in some instance, payment did exceed the cost of service, the state would recoup that money and return the federal share to CMS.

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA (From previously approved BN agreement)**						
2							
3	**CY 2009 (HY 1) - CY 2013 (HY 5)**						
4							
5	**ABD Adults No TPL**	**HY 1 (CY 2009)**	**HY 2 (CY 2010)**	**HY 3 (CY 2011)**	**HY 4 (CY 2012)**	**HY 5 (CY 2013)**	**5-YEARS**
6	**TOTAL EXPENDITURES**	$ 380,836,025	$ 410,246,445	$ 441,928,112	$ 476,056,426	$ 512,820,331	$ 2,221,887,338
7	**ELIGIBLE MEMBER MONTHS**	191,779	193,908	196,060	198,237	200,437	
8	**PMPM COST**	$ 1,986	$ 2,116	$ 2,254	$ 2,401	$ 2,559	
9	**TREND RATES**						**5-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE		7.72%	7.72%	7.72%	7.72%	7.72%
12	ELIGIBLE MEMBER MONTHS		1.11%	1.11%	1.11%	1.11%	1.11%
13	PMPM COST		6.54%	6.54%	6.54%	6.54%	6.54%
14							
15	**ABD Adults TPL**	**HY 1 (CY 2009)**	**HY 2 (CY 2010)**	**HY 3 (CY 2011)**	**HY 4 (CY 2012)**	**HY 5 (CY 2013)**	**5-YEARS**
16	**TOTAL EXPENDITURES**	$ 891,605,274	$ 960,460,330	$ 1,034,632,782	$ 1,114,533,271	$ 1,200,604,150	$ 5,201,835,807
17	**ELIGIBLE MEMBER MONTHS**	368,171	372,258	376,390	380,568	384,792	
18	**PMPM COST**	$ 2,422	$ 2,580	$ 2,749	$ 2,929	$ 3,120	
19	**TREND RATES**						**5-YEAR**
20				**ANNUAL CHANGE**			**AVERAGE**
21	TOTAL EXPENDITURE		7.72%	7.72%	7.72%	7.72%	7.72%
22	ELIGIBLE MEMBER MONTHS		1.11%	1.11%	1.11%	1.11%	1.11%
23	PMPM COST		6.54%	6.54%	6.54%	6.54%	6.54%
24							
25	**RIte Care**	**HY 1 (CY 2009)**	**HY 2 (CY 2010)**	**HY 3 (CY 2011)**	**HY 4 (CY 2012)**	**HY 5 (CY 2013)**	**5-YEARS**
26	**TOTAL EXPENDITURES**	$ 459,894,583	$ 499,297,624	$ 542,076,655	$ 588,520,927	$ 638,944,470	$ 2,728,734,258
27	**ELIGIBLE MEMBER MONTHS**	1,397,894	1,417,185	1,436,742	1,456,569	1,476,669	
28	**PMPM COST**	$ 329	$ 352	$ 377	$ 404	$ 433	
29	**TREND RATES**						**5-YEAR**
30				**ANNUAL CHANGE**			**AVERAGE**
31	TOTAL EXPENDITURE		8.57%	8.57%	8.57%	8.57%	8.57%
32	ELIGIBLE MEMBER MONTHS		1.38%	1.38%	1.38%	1.38%	1.38%
33	PMPM COST		7.09%	7.09%	7.09%	7.09%	7.09%
34							
35							
36	**CSHCN**	**HY 1 (CY 2009)**	**HY 2 (CY 2010)**	**HY 3 (CY 2011)**	**HY 4 (CY 2012)**	**HY 5 (CY 2013)**	**5-YEARS**
37	**TOTAL EXPENDITURES**	$ 311,088,286	$ 338,120,296	$ 367,501,252	$ 399,435,266	$ 434,144,186	$ 1,850,289,286
38	**ELIGIBLE MEMBER MONTHS**	160,521	162,736	164,982	167,259	169,567	
39	**PMPM COST**	$ 1,938	$ 2,078	$ 2,228	$ 2,388	$ 2,560	
40	**TREND RATES**						**5-YEAR**
41				**ANNUAL CHANGE**			**AVERAGE**
42	TOTAL EXPENDITURE		8.69%	8.69%	8.69%	8.69%	8.69%
43	ELIGIBLE MEMBER MONTHS		1.38%	1.38%	1.38%	1.38%	1.38%
44	PMPM COST		7.21%	7.21%	7.21%	7.21%	7.21%

	A	B	C	D	E	F	G	H	I	J
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**									
2	**CY 2014 (DY 6) - CY 2018 (DY 10)**									
3										
4	**ELIGIBILITY**		**BASE YEAR**	**WOW**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
5	**GROUP**		**DY 05 (2013)**	**TREND**	**DY 06 (2014)**	**DY 07 (2015)**	**DY 08 (2016)**	**DY 09 (2017)**	**DY 10 (2018)**	**WOW**
6										
7	**ABD Adults No TPL**									
8	**Pop Type:**	**Medicaid**								
9	Eligible Member Months		203,451	1.6%	206,706	210,014	213,374	216,788	220,256	
10	PMPM Cost		$ 2,559	4.3%	$ 2,667	$ 2,781	$ 2,899	$ 3,023	$ 3,152	
11	Total Expenditure				$ 551,374,362	$ 584,045,486	$ 618,651,530	$ 655,308,062	$ 694,137,776	$ 3,103,517,216
12										
13	**ABD Adults TPL**									
14	**Pop Type:**	**Medicaid**								
15	Eligible Member Months		353,433	1.6%	359,088	364,833	370,671	376,601	382,627	
16	PMPM Cost		$ 2,893	4.3%	$ 3,015.67	$ 3,144.05	$ 3,277.90	$ 3,417.44	$ 3,562.93	
17	Total Expenditure				$ 1,082,890,692	$ 1,147,054,246	$ 1,215,021,383	$ 1,287,012,685	$ 1,363,273,293	$ 6,095,252,299
18										
19	**RIte Care**									
20	**Pop Type:**	**Medicaid**								
21	Eligible Member Months		1,553,835	2.9%	1,595,896.22	1,642,228	1,689,905	1,738,977	1,789,461	
22	PMPM Cost		$ 432.69	5.2%	$ 455	$ 479	$ 504	$ 530	$ 558	
23	Total Expenditure				$ 726,531,752	$ 786,594,466	$ 851,627,558	$ 922,040,489	$ 998,268,891	$ 4,285,063,156
24										
25	**CSHCN**									
26	**Pop Type:**	**Medicaid**								
27	Eligible Member Months		149,906	2.9%	154,253	158,727	163,330	168,066	172,940	
28	PMPM Cost		$ 2,560	5.0%	$ 2,689	$ 2,825	$ 2,967	$ 3,116	$ 3,273	
29	Total Expenditure				$ 414,820,990	$ 448,342,382	$ 484,571,427	$ 523,728,054	$ 566,048,752	$ 2,437,511,605
30										
38	**217-like Group**									
39	**Pop Type:**	**Hypothetical**								
40	Eligible Member Months		38,407	1.6%	39,014	39,631	40,257	40,894	41,540	
41	PMPM Cost		n/a	3.1%	$ 3,629.00	$ 3,735.00	$ 3,848.00	$ 3,968.00	$ 4,095.00	
42	Total Expenditure				$ 141,581,806	$ 148,021,785	$ 154,908,936	$ 162,267,392	$ 170,106,300	$ 776,886,219
43										
44	**Low-Income Adult Group**									
45	**Pop Type:**	**Hypothetical**								
46	Eligible Member Months		n/a	5.2%	350,107	368,313	387,465	407,613	428,809	
47	PMPM Cost		n/a	5.1%	773	813	855	899	945	
48	Total Expenditure				$ 270,772,754	$ 299,482,312	$ 331,235,923	$ 366,354,401	$ 405,198,647	$ 1,673,044,037
49										
50	**Family Planning Group**									
51	**Pop Type:**	**Hypothetical**								
52	Eligible Member Months		3,720	1.0%	3,000	3,036	3,072	3,096	3,132	
53	PMPM Cost		18.27	5.3%	$ 19.23	$ 20.24	$ 21.31	$ 22.43	$ 23.61	
54	Total Expenditure				$ 57,690	$ 61,449	$ 65,464	$ 69,443	$ 73,947	$ 327,993

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS
CY 2014 (DY 6) - CY 2018 (DY 10)

ELIGIBILITY GROUP	BASE YEAR (DY 05/ CY 2013)	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 06 (2014)	DY 07 (2015)	DY 08 (2016)	DY 09 (2017)	DY 10 (2018)	TOTAL WW
ABD Adults No TPL								
Pop Type: Medicaid								
Eligible Member Months	203,451	1.6%	206,667	209,933	213,251	216,622	220,046	
PMPM Cost	$ 1,961.00	3.1%	$ 2,032.00	$ 2,092.00	$ 2,155.00	$ 2,222.00	$ 2,293.00	
Total Expenditure			$ 419,947,344	$ 439,179,836	$ 459,555,905	$ 481,334,084	$ 504,565,478	$ 2,304,582,647
ABD Adults TPL								
Pop Type: Medicaid								
Eligible Member Months	353,433	1.6%	359,019	364,693	370,457	376,312	382,260	
PMPM Cost	$ 1,942.00	3.1%	$ 2,013.00	$ 2,072.00	$ 2,134.00	$ 2,201.00	$ 2,271.00	
Total Expenditure			$ 722,705,247	$ 755,643,896	$ 790,555,238	$ 828,262,712	$ 868,112,460	$ 3,965,279,553
RIte Care								
Pop Type: Medicaid								
Eligible Member Months	1,553,835	2.9%	1,595,896	1,642,228	1,689,905	1,738,977	1,789,461	
PMPM Cost	330	6.9%	$ 362.00	$ 387.00	$ 413.00	$ 442.00	$ 473.00	
Total Expenditure			$ 577,714,430	$ 635,542,315	$ 697,930,710	$ 768,627,921	$ 846,415,204	$ 3,526,230,580
CSHCN								
Pop Type: Medicaid								
Eligible Member Months	149,906	2.9%	158,688	169,142	173,070	175,392	177,749	
PMPM Cost	1,281	6.9%	$ 1,405.00	$ 1,501.00	$ 1,604.00	$ 1,716.00	$ 1,837.00	
Total Expenditure			$ 222,956,640	$ 253,882,142	$ 277,604,280	$ 300,972,672	$ 326,524,913	$ 1,381,940,647
217-like Group								
Pop Type: Hypothetical								
Eligible Member Months	38,407	1.6%	39,014	39,631	40,257	40,894	41,540	
PMPM Cost	3501	3.1%	$ 3,629.00	$ 3,735.00	$ 3,848.00	$ 3,968.00	$ 4,095.00	
Total Expenditure			$ 141,581,806	$ 148,021,785	$ 154,908,936	$ 162,267,392	$ 170,106,300	$ 776,886,219
Low-Income Adult Group								
Pop Type: Hypothetical								
Eligible Member Months	n/a	5.2%	350,107	368,313	387,465	407,613	428,809	
PMPM Cost		5.1%	$773.40	$ 813.12	$ 854.88	$ 898.78	$ 944.94	
Total Expenditure			$ 270,772,754	$ 299,482,312	$ 331,235,923	$ 366,354,401	$ 405,198,647	$ 1,673,044,037
Family Planning Group								
Pop Type: Hypothetical								
Eligible Member Months	n/a	1.0%	3,000	3,036	3,072	3,096	3,132	
PMPM Cost		5.3%	$19.23	$20.24	$21.31	$22.43	$23.61	
Total Expenditure			$ 57,690	$ 61,449	$ 65,464	$ 69,443	$ 73,947	$ 327,993

Hypo 1							
Pop Type:	**Hypothetical**						
Eligible Member Months		#REF!	#REF!	#REF!	#REF!	#REF!	
PMPM Cost		#REF!	#REF!	#REF!	#REF!	#REF!	
Total Expenditure		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

Hypo 2							
Pop Type:	**Hypothetical**						
Eligible Member Months		#REF!	#REF!	#REF!	#REF!	#REF!	
PMPM Cost		#REF!	#REF!	#REF!	#REF!	#REF!	
Total Expenditure		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

Exp Pop 1							
Pop Type:	**Expansion**						
Eligible Member Months							
PMPM Cost							
Total Expenditure		$ -	$ -	$ -	$ -	$ -	$ -

Exp Pop 2							
Pop Type:	**Expansion**						
Eligible Member Months							
PMPM Cost							
Total Expenditure		$ -	$ -	$ -	$ -	$ -	$ -

NOTES
For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 06 (CY 2014)	DY 07 (CY 2015)	DY 08 (CY 2016)	DY 09 (CY 2017)	DY 10 (CY 2018)	
Medicaid Populations						
ABD Adults No TPL	$ 551,374,362	$ 584,045,486	$ 618,651,530	$ 655,308,062	$ 694,137,776	$ 3,103,517,216
ABD Adults TPL	$ 1,082,890,692	$ 1,147,054,246	$ 1,215,021,383	$ 1,287,012,685	$ 1,363,273,293	$ 6,095,252,299
RIte Care	$ 726,531,752	$ 786,594,466	$ 851,627,558	$ 922,040,489	$ 998,268,891	$ 4,285,063,156
CSHCN	$ 414,820,990	$ 448,342,382	$ 484,571,427	$ 523,728,054	$ 566,048,752	$ 2,437,511,605
TOTAL	$ 2,775,617,795	$ 2,966,036,581	$ 3,169,871,898	$ 3,388,089,290	$ 3,621,728,712	$ 15,921,344,276

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 06 (CY 2014)	DY 07 (CY 2015)	DY 08 (CY 2016)	DY 09 (CY 2017)	DY 10 (CY 2018)	
Medicaid Populations						
ABD Adults No TPL	$ 419,947,344	$ 439,179,836	$ 459,555,905	$ 481,334,084	$ 504,565,478	$ 2,304,582,647
ABD Adults TPL	$ 722,705,247	$ 755,643,896	$ 790,555,238	$ 828,262,712	$ 868,112,460	$ 3,965,279,553
RIte Care	$ 577,714,430	$ 635,542,315	$ 697,930,710	$ 768,627,921	$ 846,415,204	$ 3,526,230,580
CSHCN	$ 222,956,640	$ 253,882,142	$ 277,604,280	$ 300,972,672	$ 326,524,913	$ 1,381,940,647
Excess Spending From Hypotheticals	$ -	$ -	$ -	$ -	$ -	$ -
Other WW Categories - CNOM						
CNOM services	$ 49,921,728	$ 53,166,640	$ 56,622,472	$ 60,302,933	$ 64,222,623	$ 284,236,396
Marketplace Subsidy	$ 3,298,154	$ 3,021,190	$ 3,270,462	$ 3,540,302	$ 3,540,302	$ 16,670,410
Cortical Integrative Therapy Pilot	$ -	$ 1,000,000	$ 1,050,000	$ 1,102,500	$ 1,157,625	$ 4,310,125
TOTAL	$ 1,996,543,543	$ 2,141,436,020	$ 2,286,589,067	$ 2,444,143,123	$ 2,614,538,605	$ 11,483,250,359

VARIANCE	$ 779,074,252	$ 824,600,561	$ 883,282,831	$ 943,946,166	$ 1,007,190,107	$ 4,438,093,918
Excess BN savings (DY 1 - 5)	$ 3,189,000,000					
CUMULATIVE BN VARIANCE	$ 3,968,074,252	$ 4,792,674,813	$ 5,675,957,644	$ 6,619,903,811	$ 7,627,093,918	$ 7,627,093,918

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 06 (CY 2014)	DY 07 (CY 2015)	DY 08 (CY 2016)	DY 09 (CY 2017)	DY 10 (CY 2018)	
217-like Group	$141,581,806	$148,021,785	$154,908,936	$162,267,392	$170,106,300	$776,886,219
Low-Income Adult Group	$270,772,754	$299,482,312	$331,235,923	$366,354,401	$405,198,647	$1,673,044,037
Family Planning Group	$57,690	$61,449	$65,464	$69,443	$73,947	$327,993
TOTAL	**$412,412,250**	**$447,565,546**	**$486,210,323**	**$528,691,236**	**$575,378,894**	**$2,450,258,249**

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 06 (CY 2014)	DY 07 (CY 2015)	DY 08 (CY 2016)	DY 09 (CY 2017)	DY 10 (CY 2018)	
217-like Group	$ 141,581,806	$ 148,021,785	$ 154,908,936	$ 162,267,392	$ 170,106,300	$ 776,886,219
Low-Income Adult Group	$ 270,772,754	$ 299,482,312	$ 331,235,923	$ 366,354,401	$ 405,198,647	$ 1,673,044,037
Family Planning Group	$ 57,690	$ 61,449	$ 65,464	$ 69,443	$ 73,947	$ 327,993
TOTAL	**$ 412,412,250**	**$ 447,565,546**	**$ 486,210,323**	**$ 528,691,236**	**$ 575,378,894**	**$ 2,450,258,249**

Excess Spending

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 06 (CY 2014)	DY 07 (CY 2015)	DY 08 (CY 2016)	DY 09 (CY 2017)	DY 10 (CY 2018)	
217-like Group	$ -	$ -	$ -	$ -	$ -	$ -
Low-Income Adult Group	$ -	$ -	$ -	$ -	$ -	$ -
Family Planning Group	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -

Trend Analysis

Eligibility Group	Historical (from 2009 appro	PB14	Lower of	PB Group Used
ABD No TPL	6.5%	4.3%	4.3%	Aged and Disabled
ABD TPL	6.5%	4.3%	4.3%	Aged and Disabled
RIte Care	7.1%	5.2%	5.2%	Current Adults and Children
CSHCN	7.2%	5.0%	5.0%	Current Children
217-like	3.1%	4.3%	3.1%	Aged and Disabled
VIII Group	NA	5.1%	5.1%	Expansion adults
Family Planning	NA	5.3%	5.3%	Current Adults

Historical - PMPMs from Previously Approved BN

Without Waiver		Total FFY07 (2)	Applied Trends (3)	CY 08	CY 09	CY 10	CY 11	CY 12	CY 13
ABD Adults	Expenses	$322,142,271.57		$353,534,027	$380,836,025	$410,246,445	$441,928,112	$476,056,426	$512,820,331
(NoTPL)	Avg Elig	15,589.54	1.11%	15,806	15,982	16,159	16,338	16,520	16,703
	PMPM	$1,722.00	6.54%	1,864	$1,986	$2,116	$2,254	$2,401	$2,559
ABD Adults	Expenses	$754,192,696.71		$827,686,413	$891,605,274	$960,460,330	$1,034,632,782	$1,114,533,271	$1,200,604,150
(TPLDuals)	Avg Elig	29,928.28	1.11%	30,344	30,681	31,021	31,366	31,714	32,066
	PMPM	$2,100.00	6.54%	2,273	$2,422	$2,580	$2,749	$2,929	$3,120
RIteCare	Expenses	$382,235,114.41		$423,601,109	$459,894,583	$499,297,624	$542,076,655	$588,520,927	$638,944,470
	Avg Elig	112,953.64	1.38%	114,905	116,491	118,099	119,728	121,381	123,056
	PMPM	$282.00	7.09%	307	$329	$352	$377	$404	$433
CSHCNFC	Expenses	$257,906,089.28		$286,217,428	$311,088,286	$338,120,296	$367,501,252	$399,435,266	$434,144,186
	Avg Elig	12,970.53	1.38%	13,195	13,377	13,561	13,748	13,938	14,131
	PMPM	$1,657.00	7.21%	1,808	$1,938	$2,078	$2,228	$2,388	$2,560
Total	Expenses	$640,141,203.69		$709,818,537	$770,982,868	$837,417,920	$909,577,908	$987,956,193	$1,073,088,656
Ch/Fam	Avg Elig	125,924.17		128,100	129,868	131,660	133,477	135,319	137,186
	PMPM	$423.63		$462	$495	$530	$568	$608	$652
Total	Expenses	$1,716,476,171.97		$1,891,038,977	$2,043,424,167	$2,208,124,694	$2,386,138,801	$2,578,545,890	$2,786,513,137
	Avg Elig	171,442.00		174,250	176,530	178,841	181,181	183,553	185,955
	PMPM	$834.33		$904	$965	$1,029	$1,097	$1,171	$1,249
		Unemployment Impact on RC		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
								5 Year Cap	**$12,002,746,689**

Assumptions

Net of Parents 175-185% FPL, Window Replacements and EFP. Negative SCHIP Offset reallocated according to hierarchy, with average eligibles reduced for SC

1. SFY07: Prorated $26.2 M in "Other Costs" not otherwise claimed, respective to appropriate MEGs, ie. $0 allocated to RIteCare.

2. FFY07: Trended Total SFY07 (including "Other Costs") 3 months based on 02:07 trends (excluding "other costs", since "other costs" were only available for S super-meg.

3. Trends: a suggested scenario of 7.1% for PMPMs and 1.3% for caseload.

Anticipated Trends (3) FFY07:13
7.7%
1.1%
6.5%
7.7%
1.1%
6.5%
8.6%
1.4%
7.1%
8.7%
1.4%
7.2%
8.6%
1.4%
7.1%
8.1%
1.3%
6.7%

FFY and CMS trends

CHIP.

SFY07) by

Table 1a

Enrollment Forecast from August 15, 2013 Submission

	2014-2018 Trend	Historical SFY 2007	2008	2009	2010	2011	20
Expenses $ Millions							
Total*	**6.8%**	**1,397**	**1,512**	**1,604**	**1,731**	**1,795**	**1**
ABD	4.7%	969	1,024	1,096	1,149	1,183	1
C+F	10.0%	429	487	507	582	612	
						Year over year projected	
Enrollment							
Total	**2.6%**	**173,327**	**170,004**	**169,785**	**177,468**	**183,072**	**186**
ABD	1.6%	45,652	45,328	45,748	46,576	47,429	48
C+F	2.9%	127,676	124,676	124,037	130,893	135,643	138
PMPM							
Total	**4.2%**	672	741	787	813	817	
ABD	3.1%	1,768	1,883	1,997	2,056	2,078	2
C+F	6.9%	280	326	341	370	376	

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**

With Enrollment Detail by 4 MEGs

Table 1b

	2014-2018 Trend	Historical SFY 2007	2008	2009	2010	2011	20
Enrollment							
Total	**2.6%**	**173,328**	**170,004**	**169,785**	**177,469**	**183,072**	**186**
ABD Total	**1.6%**	**45,652**	**45,329**	**45,748**	**46,576**	**47,429**	**48**
ABD NonDual	1.6%	15,616	15,338	15,455	15,874	16,361	16
ABD Duals	1.6%	30,035	29,991	30,293	30,702	31,068	31
CF Total	**2.9%**	**127,676**	**124,676**	**124,037**	**130,893**	**135,643**	**138**
RIteCare	3.0%	114,759	111,855	111,668	118,455	123,063	126
CSHCNSC	1.5%	12,917	12,821	12,370	12,437	12,580	12

2014 HYPOTHETICALS	Avg Member M	Annual MM	PMPM	PMPM Trer
New Adults	29,176	350,107	$773.40	5.1%
217-like group	3,498	41,976		3.1%
Family Planning	3,000	250	$18.27	5.3%

217-like

	SFY12	SFY13	CY14	CY15	CY16
MMs		3,501	39,012	39636	40,260
Family Planning	3,984	3,720	3,000	3,036	3,072

	Base Yr CY	Waiver Period CY				
)12	2013	2014	2015	2016	2017	2018
L,797	**1,960**	**2,141**	**2,316**	**2,468**	**2,623**	**2,791**
L,162	1,245	1,311	1,370	1,434	1,502	1,575
634	716	831	946	1,034	1,121	1,216
total expense trend:		9.2%	8.1%	6.6%	6.3%	6.4%
5,871	**191,586**	**200,687**	**211,385**	**215,914**	**218,936**	**222,002**
3,329	49,608	50,392	51,188	51,997	52,819	53,654
3,542	141,978	150,295	160,197	163,917	166,117	168,349
801	**853**	889	913	953	998	1,048
2,004	**2,091**	2,168	2,231	2,298	2,370	2,446
382	**420**	461	492	526	562	602

	Base Yr CY	Waiver Period CY				
)12	2013	2014	2015	2016	2017	2018
5,871	**191,586**	**200,687**	**211,385**	**215,914**	**218,936**	**222,002**
3,329	**49,608**	**50,392**	**51,188**	**51,997**	**52,819**	**53,654**
5,612	17,052	17,321	17,595	17,873	18,155	18,442
L,717	32,556	33,071	33,593	34,124	34,664	35,212
3,542	**141,978**	**150,295**	**160,197**	**163,917**	**166,117**	**168,349**
5,352	129,486	137,618	147,331	150,861	152,867	154,903
2,190	12,492	12,677	12,865	13,056	13,250	13,446

nd

CY17	CY18	2013
40,896	41,544	
3,096	3,132	

WITH DETAIL BY ADDITIONAL MEG BREAKDOWN:

	2014-2018 Trend	Hist SFY 2012	Base Yr CY 2013	Waiver Period CY 2014	2015	2016	2017	2018
Expenses $ Millions								
Total*	**6.8%**	**1,797**	**1,960**	**2,141**	**2,316**	**2,468**	**2,623**	**2,791**
CNOM	**6.5%**	**33**	**36**	**39**	**42**	**44**	**47**	**50**
ABD Total	**4.7%**	**1,139**	**1,220**	**1,284**	**1,343**	**1,405**	**1,472**	**1,543**
ABD NonDual	4.7%	372	399	420	439	459	481	505
ABD Duals	4.7%	641	686	723	756	791	828	868
ABD Waiver	4.7%	126	134	142	148	155	162	170
CF Total	**10.0%**	**625**	**705**	**818**	**932**	**1,019**	**1,104**	**1,198**
RiteCare	10.0%	455	513	595	678	741	804	872
CSHCNSC	10.0%	170	192	223	254	278	301	326
		Year over year projected total expense trend:		9.2%	8.1%	6.6%	6.3%	6.4%
Enrollment - Average Eligibles								
Total	**2.6%**	**186,871**	**191,586**	**200,687**	**211,385**	**215,914**	**218,936**	**222,002**
CNOM	**NA**							
ABD Total	**1.6%**	**48,329**	**49,608**	**50,392**	**51,188**	**51,997**	**52,819**	**53,654**
ABD NonDual	1.6%	16,517	16,954	17,222	17,494	17,771	18,052	18,337
ABD Duals	1.6%	28,694	29,453	29,918	30,391	30,871	31,359	31,855
ABD Waiver	1.6%	3,118	3,201	3,251	3,303	3,355	3,408	3,462
CF Total	**2.9%**	**138,542**	**141,978**	**150,295**	**160,197**	**163,917**	**166,117**	**168,349**
RiteCare	2.9%	126,352	129,486	137,071	146,101	149,495	151,501	153,536
CSHCNSC	2.9%	12,190	12,492	13,224	14,095	14,423	14,616	14,812
PMPM								
Total	**4.2%**	**786**	**837**	**873**	**897**	**935**	**981**	**1,029**
CNOM	**NA**							
ABD Total	**3.1%**	**1,964**	**2,049**	**2,124**	**2,186**	**2,252**	**2,322**	**2,397**
ABD NonDual	3.1%	1,879	1,961	2,032	2,092	2,155	2,222	2,293
ABD Duals	3.1%	1,861	1,942	2,013	2,072	2,134	2,201	2,271
ABD Waiver	3.1%	3,356	3,501	3,629	3,735	3,848	3,968	4,095
CF Total	**6.9%**	**376**	**414**	**454**	**485**	**518**	**554**	**593**
RiteCare	6.9%	300	330	362	387	413	442	473
CSHCNSC	6.9%	1,164	1,281	1,405	1,501	1,604	1,716	1,837

Enrollment - Member Months								
Total	**2.6%**	**2,242,450**	**2,299,033**	**2,408,245**	**2,536,617**	**2,590,971**	**2,627,227**	**2,664,030**
CNOM	**NA**							
ABD Total	**1.6%**	**579,948**	**595,292**	**604,700**	**614,258**	**623,966**	**633,828**	**643,846**
ABD NonDual	1.6%	198,208	203,451	206,667	209,933	213,251	216,622	220,046
ABD Duals	1.6%	344,323	353,433	359,019	364,693	370,457	376,312	382,260
ABD Waiver	1.6%	37,417	38,407	39,014	39,631	40,257	40,894	41,540
CF Total	**2.9%**	**1,662,502**	**1,703,742**	**1,803,545**	**1,922,359**	**1,967,005**	**1,993,399**	**2,020,184**
RiteCare	2.9%	1,516,224	1,553,835	1,644,857	1,753,218	1,793,935	1,818,007	1,842,435
CSHCNSC	2.9%	146,278	149,906	158,688	169,142	173,070	175,392	177,749

[redacted]

CNOM FQHC Change:

Old Estimate	New Estimate	Subtract the following from 2014 CNOM:
$2,400,000	$1,300,000	$1,100,000

	DY6
Marketplace Subsidy Program:	$2,911,443
Premium Holiday	$386,711
	$3,298,154

Table 3			
ABD no TPL	Medicaid only, non-duals	Budg Pop 1 Budget Pop 11, 12, 13, 14 sorted by tpl	
ABD TPL	duals	BudgPop2 Budget Pop 11, 12, 13, 14 sorted by tpl	
Rite Care	*includes CHIP children, Pregnant Expansion, Rite Share payments and collections*		
	Pregnant Expansion	BudgPop6	
	RiteCare	BudPop3	
	RiteShare&Collctns	BudgSvc 1,2, 3	
	SCHIP Children	BudgPop 7	
	Other payments P4P, Risk share, stop loss, FQHC supplemental	BudgSvc3	
	EFP	BudgPop5	
CSHCN	CSHCNFC	BudgPop4	
	Substitute Care	BudgPop8	
Additional Population Groups/CNOMs			Eligibles SFY 2012
	Core preventive services - CSHCNs <21 <300% SSI otherwise in state custody	BudgPop9 Budg Svcs 4	735
	Elders 65 and over	Budg Pop10	1,701
	FQHCs	BudgSvcs5	n.a
	HIV	BudgPop 18	993
	AD Non-working	BudgPop19	916
	AD Risk for LTC	BudgPop15	2,509
	Adult Mental Unins	BudgPop16	12,311
	Window /Replacement	Budg Svcs 1	n.a.
	Youth Risk Medic	BudgPop17	3,919

Comments	SFY 2012
Avg BCCTP eligibles no TPL (BudgPop14)	226
Avg BCCCTP eligibles tpl (BudgPop 14)	4
Avg Pregnant Expansion Eligibles 185-250	
200-250	114
185-200 cat 58	49
EFP	
<185	300
>185	79
Avg BCCCTP eligibles (BudgPop 14)	1

Adjustment of ABD PMPM to account for removal of 217-like group

$ 3,120	Historical 2013 PMPM (including 217-like group)
384792	Historical 2013 Enrollment (including 217-like group)
353,433	WW Enrollment for ABD Dual (2013 state estimate)
38407	WW Enrollment for 217-like group (2013 state estimate)
1942	WW PMPM for ABD Dual (2013 state estimate)
3501	WW PMPM for 217-like group (2013 state estimate)
2094.8086	Blended WW PMPM for ABD duals and 217-like group
0.9270537	ABD Dual PMPM as a percentage of blended PMPM
$ 2,892.53	Adjusted WOW PMPM for ABD Duals - 2013 (Paul's method)