

SFY 2023 Medicare-Medicaid Plan Capitation Rate Certification – DRAFT

July 1, 2022 through June 30, 2023

Rhode Island, Executive Office of Health and Human Services

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Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the Rhode Island Executive Office of Health and Human Services (EOHHS) to provide actuarial and consulting services related to the development of capitation rates for Rhode Island's Medicare-Medicaid Plan (MMP), also known as Rhody Health Options (RHO) Integrity. The certified capitation rates are effective July 1, 2022, for state fiscal year (SFY) 2023. MMP is a Medicaid managed care program for dual eligible Medicare and Medicaid beneficiaries.

This letter provides documentation for the development of the certified capitation rates. It also includes the required actuarial certification in Appendix 1. To facilitate review, this document has been organized in the same manner as the 2022-2023 Medicaid Managed Care Rate Development Guide, released by the Center for Medicare and Medicaid Services in April 2022 (CMS guide).

At the time of this report, we acknowledge there is substantial uncertainty regarding the impact of the COVID-19 pandemic on future projections. It is possible that the COVID-19 pandemic could have a material impact on the projected enrollment and capitation rates presented in this report.

Unless otherwise specified, all references to "capitation rates" throughout this document refer to the Medicaid-specific component of the MMP capitation rates. The SFY 2023 composite rates reflect the mandatory 3% Demonstration Year 6 (calendar year 2022) and Demonstration Year 7 (calendar year 2023) savings assumption prescribed by CMS and EOHHS.

FISCAL IMPACT ESTIMATE

The capitation rates for the MMP program are illustrated in Figure 1. These rates are effective from July 1, 2022 through June 30, 2023. Figure 1 provides a comparison of the SFY 2022 rates relative to the SFY 2023 rates for the MMP program. The composite rates illustrated for both SFY 2022 and SFY 2023 were developed based on projected monthly enrollment for SFY 2023.

The Blended LTSS rate change illustrated in Figure 1 below is materially impacted by the change in the membership distribution used to develop the rate. The SFY 2022 blended LTSS rate reflects a membership distribution of 25% / 75% nursing home and community LTSS, respectively, and the SFY 2023 blended rate reflects a 33% / 67% membership distribution. The change in membership distribution reflects emerging MMP enrollment distribution and MMP program passive enrollment initiatives. Using a constant 25% / 75% membership distribution in SFY 2022 and SFY 2023 would result in a rate change of 5.6% for the Blended LTSS rate.

FIGURE 1: COMPARISON WITH STATE FISCAL YEAR 2022 RATES (PMPM)

Rate Cell	Estimated Average Monthly Enrollment	SFY 2022 Capitation Rates	SFY 2023 Capitation Rates	% Change
IC30: MMP - SPMI	1,132	\$ 1,127.26	\$ 1,131.61	0.4%
IC40: MMP - ID	1,411	150.20	146.11	(2.7%)
IC50/IC60: MMP - Blended LTSS	2,457	3,559.74	4,053.69	13.9%
IC70: MMP - Community Non-LTSS	8,427	191.00	209.28	9.6%
Composite	13,427	\$ 882.09	\$ 983.89	11.5%

Notes:

1. Values have been rounded.
2. SFY 2022 and SFY 2023 composite rates were calculated based on projected SFY 2023 enrollment.
3. Illustrated capitation rates reflect the mandatory 3% Demonstration Year 6 and Demonstration Year 7 savings percentage and are prior to application of the withhold.

Figure 2 compares the estimated state and federal expenditures under the SFY 2022 capitation rates relative to the SFY 2023 capitation rates, using the same projected SFY 2023 average monthly enrollment.

FIGURE 2: EXPENDITURE COMPARISON (\$ MILLIONS)

Rate Cell	SFY 2022 Aggregate Expenditures	SFY 2023 Aggregate Expenditures	Expenditure Change
IC30: MMP - SPMI	\$ 15.3	\$ 15.4	\$ 0.1
IC40: MMP - ID	2.5	2.5	0.0
IC50/IC60: MMP - Blended LTSS	105.0	119.5	14.5
IC70: MMP - Community Non-LTSS	19.3	21.2	1.9
Total	\$ 142.1	\$ 158.5	\$ 16.4
Total Federal	\$ 77.0	\$ 85.9	\$ 8.9
Total State	\$ 65.1	\$ 72.6	\$ 7.5

Notes:

1. Values have been rounded.
2. SFY 2022 and SFY 2023 aggregate expenditures were developed based on projected SFY 2023 enrollment.
3. State expenditures for all columns are based on Federal Fiscal Year (FFY) 2022 Federal Medical Assistance Percentage (FMAP) of 54.88% for three months and FFY 2022 FMAP of 53.96% for nine months. No adjustment was made for any applicable enhanced FMAP rates.
4. Illustrated expenditures reflect the mandatory 3% Demonstration Year 6 and Demonstration Year 7 savings percentage and are prior to application of the withhold.

Section I. Medicaid managed care rates

1. General information

This section provides information listed under the General Information section of CMS guide, Section I.

The capitation rates provided under this certification are “actuarially sound” for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care organization (MCO) for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F and CMS-2408-F).
- The 2022-2023 Medicaid Managed Care Rate Development Guide published by CMS.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

“Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes.”¹

The rate methodology was developed in accordance with the three-way contract between EOHHS, CMS, and Neighborhood Health Plan of Rhode Island, which dictates that the capitation rates be set to Medicaid costs incurred absent the demonstration prior to the application of demonstration savings.

The SFY 2023 capitation rate development methodology follows the Joint Rate-Setting Process for the Financial Alignment Initiative’s Capitated Model methodology prescribed by CMS². During the SFY 2021 base data period utilized in developing the SFY 2023 capitation rates, MMP eligible members would have been enrolled in the fee-for-service delivery system absent the demonstration. We utilized Medicaid fee-for-service experience as the base data for purposes of the SFY 2023 MMP capitation rate development. As discussed further in Section I.2, we determined that this was the most appropriate data source available to develop the Medicaid component of the capitation rates assuming the demonstration did not exist.

¹ <http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/>

² <https://www.cms.gov/files/document/capitatedmodelratesettingprocess03192019.pdf>

A. RATE DEVELOPMENT STANDARDS

i. Rate ranges

The SFY 2023 MMP capitation rate development does not utilize rate ranges.

ii. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the twelve-month rate period from July 1, 2022 through June 30, 2023.

iii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Ian McCulla, FSA, is in Appendix 1. Mr. McCulla meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the final rates meet the applicable standards in 42 CFR §438 that are effective for the July 1, 2022 through June 30, 2023 MMP program rating period.

(b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Appendix 5. Member months illustrated in Appendix 5 represent projected enrollment for the July 2022 through June 2023 time period.

(c) Program information

(i) Medicare-Medicaid Plan (MMP) managed care program

EOHHS operates the MMP managed care program for its population dual eligible for Medicaid and Medicare. Under the MMP program, comprehensive services are provided through Neighborhood Health Plan of Rhode Island (NHPRI). Benefits covered under the Medicaid managed program are comprehensive with limited out-of-plan services being covered through the fee-for-service delivery system. A full list of services identified as out-of-plan and excluded from the base data used in the SFY 2023 capitation rate development is included in Appendix 2. The following table outlines the core benefits covered under the MMP capitation rates.

FIGURE 3: MMP BENEFIT PACKAGE

Inpatient and Outpatient Hospital	Services of Other Practitioners
Therapies	Court Ordered Mental Health and Substance Use Services
Physician Services	Podiatry Services
Family Planning Services	Optometry Services
Prescription and Non-Prescription Drugs	Oral Health
Laboratory, Radiology, and Diagnostic Services	Hospice Services
Mental Health and Substance Use Inpatient and Outpatient Services	Durable Medical Equipment
Home Health and Home Care Services	Case Management
Preventive Services	Transplant Services
Emergency Room Services	Rehabilitation services
Emergency Transportation	Home and Community Based (HCBS) Waiver Services ¹
Nursing Home and Skilled Nursing Facility Care	Other Miscellaneous Services

¹Home and community-based services are only covered for eligible members.

Covered services are consistent with the SFY 2022 benefit package. Detailed benefit coverage information for all benefits listed in this table can be found within Appendix A of the three-way contract. In-lieu-of services may also be provided with written approval from EOHHS.

(ii) Rating period

This actuarial certification is effective for the twelve-month rating period of July 1, 2022 through June 30, 2023.

(iii) Covered populations

The MMP program includes dual eligible Medicare-Medicaid beneficiaries in distinct rate cells:

- **Individuals with Intellectual Disabilities:** Individuals enrolled in the Intellectual Disability Waiver.
- **Individuals with Serious and Persistent Mental Illness:** Individuals identified as having severe and persistent mental illness (SPMI).
- **Community long-term services and supports (LTSS):** Individuals living in the community through the assistance of a home and community based (HCBS) waiver program.
- **Community non-LTSS:** Individuals living in the community who are not enrolled in an HCBS waiver program.
- **Nursing Home:** Individuals residing in a nursing home or hospice with long term care nursing home segment.

Figure 4 illustrates the corresponding rate cells and pay levels for the populations covered in this certification.

FIGURE 4: MMP CAPITATION RATE CELLS

Population	Rate Cell	Pay Level
Medicare Medicaid Plan	MMP – SPMI	IC30
	MMP – ID	IC40
	MMP – Community LTSS	IC50
	MMP – Nursing Home	IC60
	MMP – Community Non-LTSS	IC70

Note: The Community LTSS and Nursing Home rate cells are paid a blended rate, as illustrated in Appendix 5.

(iv) Eligibility criteria

Eligible Medicaid beneficiaries may opt into the MMP program. Following the termination of the RHO Phase 1 program effective October 1, 2018, beneficiaries not enrolled in MMP are covered under the state fee-for-service delivery system.

For purposes of developing the SFY 2023 MMP capitation rates, EOHHS provided Milliman an eligibility file corresponding to the SFY 2021 base data that assigned members to the nursing home rate cell consistent with the MMP rate cell assignment logic. This file was reviewed for reasonability, and minor adjustments were made as appropriate after confirmation with EOHHS.

Members will be passively enrolled between July 1, 2022 and June 30, 2023, which is described further in Section II.1.C. Further details on the enrollment processes may be found in the Memorandum of Understanding between the State of Rhode Island and CMS for this program (MOU)³.

(v) Special contract provisions

This rate certification report contains documentation of the following special contract provisions related to payment included within rate development.

- Withhold metrics
- Minimum Medical Loss Ratio

Please see Section I, item 4 for additional detail and documentation.

³ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RIMOU.pdf>

(vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the prior certified capitation rates.

iv. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered populations.

v. Cross-subsidization of rate cell payment

The capitation rates were developed at the rate cell level and neither cross-subsidize nor are cross-subsidized by payments from any other rate cell.

vi. Effective dates

To the best of our knowledge, the effective dates of changes to the MMP program are consistent with the assumptions used in the development of the certified SFY 2023 capitation rates.

vii. Medical loss ratio

Capitation rates were developed in such a way that a medical loss ratio, as calculated under 42 CFR §438.8, is projected to be greater than 85% for the rating year.

viii. Rate ranges

The SFY 2023 MMP capitation rate development does not utilize rate ranges.

ix. Actuarial soundness of rate ranges

The SFY 2023 MMP capitation rate development does not utilize rate ranges.

x. Generally accepted actuarial practices and principles**(a) Reasonable, appropriate, and attainable**

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs that are reflective of financial experience absent the demonstration.

(b) Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process.

(c) Final contracted rates

The SFY 2023 capitation rates certified in this report represent the Medicaid component of the final MMP contracted rates by rate cell. The Medicare component of the rate is excluded from this report.

xi. Rate certification for effective time periods

This actuarial certification is effective for the twelve-month rating period of July 1, 2022 through June 30, 2023.

xii. COVID-19 public health emergency

We considered the direct and indirect impact of COVID-19 on the covered population and services in SFY 2023. The evaluation and rationale for assumptions included in rate development and the risk mitigation strategy are described in Section I.1.B.x.

xiii. Procedures for rate certification and amendment

The SFY 2023 MMP rate development does not utilize rate ranges. In general, a new rate certification will be submitted when the rates change. The following exceptions are allowed per §438.7 of CMS 2390-F:

1. An increase or decrease of up to 1.5% in the capitation rate per rate cell.
2. Risk adjustment, under a methodology described in the initial certification, changes the rates paid to the MCOs. There is only one MCO in the MMP program and risk adjustment is not used.

Under case one above, a contract amendment must still be submitted to CMS. In instances in which the rates are unchanged but a contract amendment could reasonably change the rate development and rates, we will provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound using the joint rate setting process prescribed by CMS. A new rate certification will be provided to account for any costs invalidated by courts of law, or changes in federal statutes, regulations, or approvals.

B. APPROPRIATE DOCUMENTATION

i. Capitation rate certification

The SFY 2023 MMP rate development certifies specific capitation rates for each rate cell.

ii. Documentation of required elements

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

iii. Use of rate ranges

This report certifies specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and §438.7(c).

iv. Rate range boundaries

The SFY 2023 MMP capitation rate development does not utilize rate ranges.

v. Index

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

vi. Compliance with 42 CFR §438.4(b)(1)

The SFY 2023 MMP capitation rate development includes assumptions, methodologies, and/or factors that are based on valid rate development standards and consistent across covered populations in accordance with 42 CFR §438.4(b)(1) and §438.4(b)(6).

vii. Different FMAP

The MMP program receives the regular state FMAP of 54.88% in FFY 2022 and 53.96% in FFY 2023. The enhanced FMAP provided by the Families First Coronavirus Response Act (6.2% increase) is not reflected in the values provided in Figure 2.

viii. Comparison to final certified rates in the previous rate certification.

The previous rate certification applied to SFY 2022 capitation rates. A comparison to SFY 2022 certified rates by rate cell is provided in Figure 1. All material changes to the capitation rate and the rate development process compared to the previous rate certification are described in this report.

ix. Future amendments

The SFY 2023 capitation rates may be amended to reflect material program changes not known or evaluated at the time of this certification, such as legislatively mandated SFY 2023 program changes and/or impacts associated with the termination of the PHE.

x. COVID-19 public health emergency

We considered the impact of COVID-19 on the estimated utilization and service mix for the covered population in SFY 2023. We note that there continues to be material uncertainty related to the impact of COVID-19 on capitation rates. The analysis and estimated impacts are described in detail in Section I.3.B.ii.(a).

For purposes of this report, the public health emergency (PHE) was assumed to continue throughout SFY 2023. The potential termination of the PHE and associated impacts may be evaluated when the PHE termination date is known.

(a) Available data

Rhode Island MMP managed care data and fee-for-service experience through December 2021, inclusive of incurred but not paid (IBNP) expenditures, was evaluated to understand emerging experience during the PHE. Encounter data, fee-for-service data, and corresponding eligibility information provided by EOHHS were utilized in this analysis. Emerging Rhode Island experience was compared to results in other state Medicaid programs to evaluate the consistency of observed pandemic trends.

(b) Direct and indirect impacts

We considered pandemic-related impacts such as COVID-19 infections, suppressed utilization, pent-up demand, and changes in population mix on the observed utilization and service mix. We also considered the effect of increased immunity to COVID-19, the potential impact of COVID-19 variants, and provider capacity. These considerations were evaluated in the development of the emerging experience adjustment and prospective trend adjustments described in section I.3.B.

(c) Non-risk payments

There are no non-risk payments applicable to the Rhode Island MMP program in SFY 2023.

(d) Risk mitigation strategies

There is no change in the risk mitigation strategy specific to the COVID-19 PHE relative to the SFY 2022 contract period.

2. Data

This section provides information regarding the base data used to develop the capitation rates. The base experience data described in this section is illustrated in Appendix 3.

A. RATE DEVELOPMENT STANDARDS

In accordance with 42 CFR §438.5(c), we have followed the rate development standards related to base data. The remainder of Section I, item 2 provides documentation of the data types, sources, validation process, material adjustments and other information relevant to the documentation standards required by CMS.

B. APPROPRIATE DOCUMENTATION

i. Requested data

Milliman receives eligibility, capitation, encounter, and fee-for-service claim files from EOHHS on a monthly basis. SFY 2021 fee-for-service experience was chosen as the base data used in the SFY 2023 capitation rate development.

EOHHS provided supplemental eligibility information for the fee-for-service member base. The supplemental eligibility information identified the MMP capitation rate cell that would have been assigned to the SFY 2021 fee-for-service membership using the SFY 2023 MMP rate cell assignment logic.

The remainder of this section details the base data and validation processes utilized in the SFY 2023 capitation rate development. The SFY 2021 base experience is summarized in Appendix 3.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

We utilized SFY 2021 fee-for-service experience as the base data for purposes of the SFY 2023 MMP capitation rate development, with adjustments for program changes and trends.

The primary data sources used or referenced in the development of the capitation rates are the following:

- Fee-for-service claims data for MMP eligible population incurred July 1, 2020 through June 30, 2021 and paid through April 30, 2022;
- Detailed fee-for-service enrollment data for July 1, 2020 through June 30, 2021; and,
- SFY 2020 Medicaid Expenditure Report.

In addition, MMP claims and enrollment data was reviewed for purposes of developing acuity adjustments described in Section I, item 3, and historical RHO Phase 1 experience was included in the trend analysis described below.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during SFY 2021. The fee-for-service data used in our rate development process reflected claims paid through April 30, 2022.

For the purposes of trend development and analyzing emerging population enrollment patterns and claims experience, we also reviewed RHO Phase 1 experience for July 1, 2016 through September 30, 2018 and dual eligible fee-for-service experience for January 1, 2019 through December 31, 2021. Experience for these sources was provided by EOHHS.

(iii) Data sources

The fee-for-service claims and eligibility data was provided to us by EOHHS for the purposes of developing the SFY 2023 capitation rates. Consistent with the guidance prescribed by CMS in the Joint Rate-Setting Process for the Financial Alignment Initiative's Capitated Model, we developed the baseline costs absent the demonstration utilizing SFY 2021 fee-for-service experience.

(iv) Sub-capitation

The SFY 2021 fee-for-service experience underlying the SFY 2023 capitation rate development does not contain sub-capitated amounts.

(b) Availability and quality of the data**(i) Steps taken to validate the data**

The fee-for-service data was provided by EOHHS. We perform routine reconciliation of EOHHS's financial data as part of the monthly data validation process and provide financial analysis for EOHHS, which involves fee-for-service claim payment reconciliation to other EOHHS data sources.

Completeness

Milliman and EOHHS both play a role in validating the SFY 2021 fee-for-service data for completeness. Milliman summarized the data to look for anomalies in the base data year, which was segmented by rate cell and service category. In addition, a completeness adjustment was applied to reflect claims incurred but not paid in the SFY 2021 base data period, which is summarized in Figure 6 below.

Accuracy

A series of validation checks is applied to the data. For example, all claims must contain a valid Medicaid recipient ID for an individual who was enrolled at the time the service was provided. In addition, fee-for-service claims must pass a series of provider ID and other edits before payment is made.

Consistency of data across data sources

There were no notable inconsistencies between the data sources used in developing the SFY 2023 capitation rates.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by EOHHS and their vendors. The values presented in this letter are dependent upon this reliance.

The capitation rates for the MMP program were developed using fee-for-service experience. Data quality was evaluated at the rate cell and service category level. We found the referenced data to be of appropriate quality for developing the SFY 2023 capitation rates.

(iii) Data concerns

We have not identified any material concerns with the quality or availability of the data that was utilized to develop the Medicaid component of the SFY 2023 MMP program capitation rates. We note that our capitation rate development methodology requires additional assumptions and adjustments to reflect the population mix of the MMP program.

(c) Appropriate data

Fee-for service data was used in the development of the capitation rates. The base data reflects the historical experience and covered services used by the covered populations absent of the demonstration.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all services and populations.

iii. Data adjustments

Capitation rates were developed primarily from SFY 2021 fee-for-service data. Adjustments were made to the base experience for data completion and other program adjustments. The following sections describe the adjustments made to the base data cost models presented in Appendix 2.

(a) Credibility adjustment

We reviewed historical fee-for-service experience and evaluated data quality at the rate cell and service category level. The data was found to be suitable for capitation rate development purposes.

(b) Completion adjustment

The SFY 2023 rate setting process uses one year of fee-for-service experience data with 10 months of runout. Because additional claims are estimated to be paid after the 10 months of claims runout, an incurred but not paid (IBNP) adjustment was applied to the base data period expenditures and is illustrated in Figure 6.

(c) Errors found in the data

We did not find significant errors in the data other than the issues previously described.

(d) Program change adjustments

Changes in the program between the base data and rating period are fully described in Section I.3.B.ii.

(e) Exclusion of payments or services from the data

SFY 2021 fee-for-service experience was limited to members enrolled in the fee-for-service delivery system who were identified by EOHHS as eligible for the MMP program. All services covered out-of-plan from the MMP program were excluded from the base data. Figure 5 illustrates the fee-for-service expenditures excluded from the base data used in rate development. In addition, Appendix 2 provides further description of the excluded out-of-plan services.

FIGURE 5: IMPACT OF DATA ADJUSTMENTS

Rate Cell	AVERAGE SFY 2021 FFS MM	SFY 2021 FFS PMPM	Facility Removals	Professional Removals	Ancillary Removals	SFY 2021 Base Data PMPM
IC30: MMP - SPMI	1,038	\$1,143.88	\$34.77	\$124.74	\$3.03	\$981.34
IC40: MMP - ID	975	4,535.74	207.87	4,152.27	98.38	\$77.22
IC50: MMP - Community LTSS	1,656	2,055.18	7.78	22.74	0.28	\$2,024.38
IC60: MMP - Nursing Home	2,775	5,839.63	37.33	5.51	0.01	\$5,796.78
IC70: MMP - Community Non-LTSS	8,864	127.07	13.29	10.32	0.16	\$103.30
Composite	15,308	\$1,720.74	\$30.90	\$282.35	\$6.60	\$1,400.90

Notes:

1. Non-emergency medical transportation services are capitated and not included in the quantified fee-for-service claim exclusions.
2. Inpatient, Outpatient, Nursing Home, and Hospice services are summarized in the 'Facility Removals' category. Professional, HCBS, and Care Management services are summarized in the 'Prof. Removals' category.

3. Projected benefit cost and trends

This section provides information on the development of projected benefit costs in the capitation rates. The development of the projected benefit costs is illustrated in Appendix 4.

A. RATE DEVELOPMENT STANDARDS

i. Final capitation rate compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e).

ii. Benefit cost trend assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations. In addition, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iii. In lieu of services

In-lieu-of services are not provided in SFY 2021 fee-for-service experience. No adjustment was made to the base data for the provision of in-lieu-of services.

iv. IMDs as an in-lieu-of service provider

IMDs were not used as in-lieu-of service providers in the SFY 2021 fee-for-service experience.

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

This section provides the documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

ii. Development of projected benefit costs

(a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create per member per month (PMPM) cost summaries

The capitation rates were developed from historical claims and enrollment data from the fee-for-service population as described in Section I.2.B.ii of this report.

Step 2: Apply data adjustments

We performed fee-for-service exclusions discussed in Section 2.B.iii.(e).

Step 3: Apply retrospective adjustments

The SFY 2021 base experience was retrospectively adjusted for IBNP claims. Retrospective completion adjustments to the SFY 2021 base experience are contained in Appendix 3 and summarized in Figure 6.

FIGURE 6: RETROSPECTIVE ADJUSTMENTS – COMPLETION

Service Category	IBNP Estimate
Inpatient Hospital	1.6%
Outpatient Hospital	0.0%
Professional	0.2%
Retail Pharmacy	0.0%
Ancillary	0.0%
Nursing Home	1.3%
Other LTSS	0.5%

Notes:

1. The IBNP factors for each category of service were applied to all pay levels.

Step 4: Prospective Program Adjustments

The SFY 2021 base experience was adjusted for program changes effective after SFY 2021 including the HCBS maintenance of needs allowance increase, shared living increase, assisted living tiers, HCBS shift differential increase, behavioral healthcare certification rate enhancement, and LTSS alternative payment methodology (APM). Prospective adjustments to the SFY 2021 base experience are illustrated in Appendix 4, except for the LTSS APM which is included in Appendix 5. Figure 7 summarizes the estimated fiscal impact of the prospective adjustments contained in Appendix 4 by rate cell.

FIGURE 7: PROGRAM CHANGES

SFY 2023 Program Change	IC30: MMP - SPMI	IC40: MMP - ID	IC50: MMP - Community LTSS	IC60: MMP - Nursing Home	IC70: MMP - Community Non-LTSS
HCBS Maintenance of Needs Allowance	0.0%	0.0%	1.2%	0.0%	0.0%
Shared Living Increase	0.0%	0.0%	0.2%	0.0%	0.0%
Assisted Living Tiers	0.0%	2.9%	4.0%	0.0%	0.2%
HCBS Shift Differential Increase	0.0%	0.0%	0.5%	0.0%	0.0%
Behavioral Health Cert Rate Enhancement	0.0%	0.0%	0.5%	0.0%	0.0%

Note: Percentage illustrated represents the percent impact to total costs for the rate cell.

- **HCBS Maintenance of Needs Allowance Increase:** Effective September 1, 2021, the maintenance of need allowance for HCBS was increased from 100% of the Federal Poverty Line (FPL) plus twenty dollars to 300% of the Federal Supplemental Security Income (SSI) standard. This allows individuals living in the community receiving HCBS to keep more of their income for living expenses. Based on discussion with EOHHS, we assumed elimination of HCBS patient share for the SFY 2023 rating period.
- **Shared Living Increase:** Effective July 1, 2021, adult companion care (procedure code S5136) reimbursement in shared living settings was increased by 10%. We estimated the fiscal impact of the reimbursement increase based on historical utilization for this code.
- **Assisted Living Tiers:** Effective November 1, 2021, assisted living services was reimbursed under a tiered rating system. Tiers A and B (Basic and Enhanced, respectively) were effective November 1, 2021, with a third tier (Tier C: Intensive/Highly Specialized) expected to be effective January 1, 2022. The tiered reimbursement replaces the current assisted living reimbursement under procedure code T2031.

The fiscal impact of this program was developed by comparing the estimated composite cost per diem for the tiered rates (approximately \$96) to the current assisted living per diem (\$69.00) for the effective periods. In addition, we estimated a composite reduction of other Medicaid services of approximately \$2.50 attributable to the enhanced services that will be provided in the Tier B and Tier C benefit based on discussions with EOHHS.

- **HCBS Shift Differential Increase:** Effective July 1, 2021, the managed care shift differential rate enhancement for Personal Care and Combined Personal Care/Homemaker services increased by \$0.19. The shift differential applies to services provided on an evening, night, or weekend/holiday (as indicated by procedure code modifiers UH, UJ, or TV). We estimated the fiscal impact of the reimbursement increase based on historical utilization for these codes.
- **Behavioral Healthcare Certification Rate Enhancement:** Effective January 1, 2022, Personal Care, Combined Personal Care/Homemaker, and Homemaker only services performed by providers with 30% of direct care workers certified in behavioral health care training receive a base rate enhancement of \$0.39 per fifteen minutes. We assumed fifteen percent (15%) of providers performing services under procedure codes S5125 or S5130 met this threshold based on discussions with EOHS. We estimated the fiscal impact of the reimbursement increase based on this assumption and historical utilization for these codes.
- **Long-Term Services and Supports Alternative Payment Methodology:** Beginning July 1, 2022, Rhode Island will be piloting a program to provide funding to home care agencies for building capacity to participate in this measurement-based incentive program. The program consists of three phases: Phase 1 readiness period from July 1, 2022 through December 31, 2022, Phase 2 pay for reporting period in calendar year 2023, and Phase 3 pay for performance period in calendar years 2024 through 2027. We utilized home care utilization experience to allocate the defined funding for Phase 1 (\$2.5 million) and the first half of Phase 2 (\$1.875 million) by population. The resulting PMPM adjustments are illustrated in Appendix 5. The operational requirements of the state directed payment are described further in Section 4.D.

Step 5: Adjust for prospective acuity and emerging experience changes

The SFY 2021 base experience was adjusted for population mix differences between the fee-for-service experience and MMP populations. Figure 8 illustrates the estimated impact of the acuity differences between the fee-for-service experience and MMP populations by rate cell and service category.

FIGURE 8: PROSPECTIVE ACUITY AND EMERGING EXPERIENCE ADJUSTMENTS

Adjustment	Service Category	Population	% Impact SPMI	% Impact ID	% Impact Community LTSS	% Impact Nursing Home	% Impact Community Non-LTSS
Nursing Home Cost	Nursing Home	Nursing Home	N/A	N/A	N/A	3.7%	N/A
HCBS Waiver Acuity	HCBS and Case Management	Community LTSS	N/A	N/A	(1.5%)	N/A	N/A
Age/Gender	Non-LTSS Service Categories	All Rate Cells	0.1%	4.7%	1.2%	18.2%	5.5%
Community Non-LTSS Acuity	All Service Categories	Community Non-LTSS	N/A	N/A	N/A	N/A	34.2%
Emerging Experience	HCBS and Nursing Home	All Non-NH Rate Cells	40.2%	116.4%	9.9%	N/A	47.6%

Note: Percentage illustrated represents the percent impact to the affected service categories.

- **Nursing Home Cost:** The nursing home cost adjustment reflects nursing home cost differences between fee-for-service and MMP populations such as facility per diem cost, member acuity, and patient share for the nursing home rate cell. The adjustment was developed by comparing the nursing home cost per day for members in the fee-for-service experience compared to the MMP experience.
- **HCBS Waiver Acuity:** HCBS and case management services were adjusted for population waiver mix differences in the community LTSS rate cell. The cost relativities between waiver types were estimated using fee-for-service experience. The enrollment distribution for the MMP program was estimated using the average of April 2022 and May 2022 enrollment. This enrollment distribution was compared to the SFY 2021 fee-for-service enrollment distribution to estimate the waiver mix acuity difference for HCBS and case management services.

- **Age/Gender:** An age adjustment was developed for all non-LTSS service categories for all rate cells. Non-LTSS service categories were adjusted based on the percentage of members above and below age 65. Similar to the HCBS and case management waiver mix adjustment, the average enrollment distribution for April 2022 and May 2022 for the MMP program was compared to the SFY 2021 fee-for-service membership distribution. The age adjustment was developed using the SFY 2021 fee-for-service experience to develop the age acuity relativities. The material nursing home rate cell age acuity adjustment for non-LTSS service categories is attributable to the MMP program covering a higher proportion of nursing home members under age 65, who are estimated to have a higher acuity for non-LTSS services than those over age 65.
- **Community Non-LTSS Acuity:** While the prior three adjustments reflect acuity differences for specific service categories, the community non-LTSS utilization adjustment reflects differences observed between members in the community non-LTSS rate cell who utilize HCBS services and members who do not utilize HCBS services. The adjustment was developed by comparing the relative morbidity of HCBS-utilizers versus non HCBS-utilizers and the proportion of HCBS utilizers in the fee-for-service and MMP-enrolled members. We observed more HCBS-utilizers in the MMP-enrolled population, resulting in a higher estimated acuity in the MMP program. The adjustment was applied separately to the HCBS service category and all other service categories. We reviewed the relative morbidity by age and determined the adjustment was materially independent of the age adjustment previously described and applied to this rate cell.
- **Emerging Experience:** We observed evidence of dampened levels of HCBS and nursing home service utilization for certain rate cells during the SFY 2021 base data period. SFY 2021 experience was compared to calendar year 2019 pre-pandemic experience and emerging experience through December 31, 2021 to estimate utilization increases in SFY 2023 relative to the SFY 2021 base data period. Based on our review of the pre-pandemic and emerging experience, we did not estimate suppressed utilization in other service categories to materially affect the SFY 2021 base data relative to the SFY 2023 rating period. We note that there continues to be material uncertainty around the potential impact of COVID-19 on service utilization in SFY 2023.

Step 6: Trend to rating period

The adjusted PMPM values from the base experience period were trended forward to the midpoint of the contract period. The resulting PMPMs establish the adjusted claim cost by population rate cell for the contract period. The projected benefit cost trend is discussed further below.

(b) Material changes to the data, assumptions, and methodologies

The data sources and methodology utilized in the development of the projected benefit costs for the SFY 2023 capitation rate setting are generally consistent with the SFY 2022 capitation rate development. Any changes relative to the SFY 2022 rate certification are described in this document.

(c) Overpayments to providers

We did not observe nor are we aware of any overpayments to providers.

iii. Projected benefit cost trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (SFY 2021) to the SFY 2023 rating period of this certification. We evaluated prospective trend rates using historical experience for the RHO Phase 1 program, experience for the fee-for-service population, and external data sources.

(a) Required elements

(i) Data

RHO Phase 1 encounter data used for trend development included cost and utilization experience from July 1, 2016 through the end of the RHO Phase 1 program, September 30, 2018. In addition to this historical trend information, we also reviewed fee-for-service experience between January 1, 2019 and December 31, 2021.

External data sources that were referenced for evaluating trend rates developed from the base data include:

- National Health Expenditure (NHE) projections developed by the CMS office of the actuary⁴, specifically those related to Medicaid.
- Other sources: We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

(ii) Methodology

The adjusted PMPM values from the base experience period were trended forward to the midpoint of the contract period (January 1, 2023). Historical utilization and per member per month cost data was stratified by month, rate cell, and category of service for purposes of trend development.

We reviewed multiple regression models, month-over-month, and year-over year trends when developing the prospective trend estimates. The resulting utilization per 1,000 and PMPM data points were compared to historical experience, internal sources from other managed care programs, and federal Medicaid cost projections. We used the resulting analysis, along with actuarial judgment, to estimate the prospective trend rates for the period from the midpoint of the base period to the midpoint of the rating period. Consideration was given to the nature of the coordination of benefits with Medicare for the covered populations.

Prospective trend adjustments include consideration for legislatively mandated provider reimbursement trends for the fee-for-service program. Hospital inpatient facility, hospital outpatient facility, home care, and nursing home reimbursement trends are legislatively mandated in the State of Rhode Island General Assembly Budget Article Relating to Human Services. Additional increases of 0.5% effective October 1, 2021, and 1.0% effective October 1, 2022, for the legislatively mandated nursing home staffing adjustments were also applied to the nursing home and hospice service categories. Appendix 4 illustrates the prospective trend adjustment impact of these legislatively mandated trends by service category.

(iii) Comparisons

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not solely rely on the historical trend experience due to anomalies observed in the historical trend data. We referred to the sources listed in the prior section as well as considered changing practice patterns and the impact of reimbursement changes on utilization.

(iv) Chosen trend rates

The trend rates selected are illustrated below in Section I.3.B.iii.(b). There were no outlier trends or negative trends.

(b) Benefit cost trend components

Figure 9 illustrates the utilization and unit cost components of the trend by category of service.

FIGURE 9: ANNUALIZED PROSPECTIVE UTILIZATION AND UNIT COST TREND ASSUMPTIONS

Service Category	Utilization Trend	Unit Cost Trend
Inpatient	1.5%	2.5%
Outpatient	1.5%	2.5%
Emergency Room	0.5%	2.5%
Professional	2.0%	2.0%
Retail Pharmacy	2.0%	4.0%
Ancillary (Non-Hospice)	1.0%	2.5%
Nursing Home and Hospice	0.5%	2.8%
HCBS	2.0%	2.0%

Notes:

- Unit cost trends for the inpatient, outpatient, emergency room, and nursing home and hospice service categories reflects legislatively mandated reimbursement increases for the fee-for-service program.
- The inpatient, outpatient, and emergency room increases are 2.4% and 2.7% effective July 1, 2021 and July 1, 2022, respectively.
- The nursing home and hospice increases are 2.4% effective October 1, 2020, 2.2% effective October 1, 2021, and 2.0% effective October 1, 2022, respectively. The nursing home and hospice increase also includes a 0.5% increase for staffing effective October 1, 2021 and 1.0% effective October 1, 2022.

⁴ <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html>

(c) Variation**(i) Medicaid populations**

Trend was developed consistently across the MMP population for credibility purposes.

(ii) Rate cells

Trend was developed consistently across the MMP rate cells for credibility purposes.

(iii) Subsets of benefits within a category of services

Service categories where Medicaid is the primary payer were stratified into more detailed service categories. For example, LTSS services were stratified into nursing home services and HCBS categories, and trend assumptions were developed separately for these services.

(d) Material adjustments

We made adjustments to the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable or were not within consensus parameters derived from other sources. For many rate cells and categories of services, raw model output was outside of a range of reasonable results. In these situations, we relied on the sources identified to develop prospective trend.

As noted previously, the cost trend for the Inpatient Hospital, Outpatient Hospital, Emergency Room, and Nursing Home service categories were prescribed by legislatively mandated reimbursement increases.

(e) Any other adjustments**(i) Impact of managed care**

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the demonstration savings assumed in the MOU. The demonstration savings adjustment is illustrated in Appendix 5.

(ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

iv. Mental health parity and addiction equity act service adjustment

The projected benefit costs do not include any services deemed by the state to be necessary to accommodate parity compliance.

v. In lieu of services

As discussed in Section I.3.A.iv, the projected benefit costs do not include costs for in-lieu-of services defined at 42 CFR 438.3(e)(2).

vi. Retrospective eligibility periods**(a) MCO responsibility**

The MCO is not responsible for retrospective eligibility periods. Coverage in MMP does not begin until a member is enrolled with the MCO.

(b) Claims treatment

The MCO is not responsible for claims incurred before enrollment in MMP. The base data experience is consistent with this requirement.

(c) Enrollment treatment

Enrollment is treated consistently with claims. We have not included retrospective eligibility in the base experience period.

(d) Adjustments

No explicit retrospective eligibility adjustment was applied for the SFY 2023 rate setting.

vii. Impact of material changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the July 1, 2021 through June 30, 2022 rating period.

(a) Change to covered benefits

There were no material changes to covered benefits compared to the previous certification.

(b) Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries is reflected in the base period fee-for-service data.

(c) Change to payment requirements

There were no material changes to requirements for provider payment compared to the previous certification.

(d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of material changes**(a) Non-material changes****(i) List of all non-material adjustments**

Adjustment factors were developed for policy and program changes estimated to materially affect the MMP program during SFY 2023 that are not fully reflected in the base experience. Program adjustments were made in the rate development process to the extent a policy or reimbursement change is deemed to have a material cost impact. We defined a program adjustment to be material if the total benefit expense for any individual rate cell is impacted by more than 0.1%. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change:

- Redetermination freeze
- Section 210 of Consolidated Appropriations Act, 2021
- Independent Provider Program

(ii) Description of adjustments

Redetermination Freeze: Beginning in March 2020, EOHHS paused the member redetermination process to ensure members do not lose coverage during the COVID-19 pandemic. We evaluated the actual MMP enrollment changes since the onset of the PHE and did not observe a material change in aggregate membership. As a result, we did not estimate an acuity adjustment associated with the redetermination freeze.

Section 210 of Consolidated Appropriations Act, 2021: Effective January 1, 2022, routine patient costs provided to Medicaid members participating in qualified clinical trials, not including the item or service that is the subject of the trial, must be covered by Medicaid programs. Any incremental cost associated with the coverage of such services is estimated to be immaterial for purposes of the SFY 2023 capitation rate development.

Independent Provider Program: The Independent Provider (IP) Program is a self-directed option for people living in their homes who meet the clinical and/or functional criteria for Medicaid LTSS but might need fewer services. People in IP receive homemaker and personal care services. The IP program allows consumers to select their specially trained personal care aides (PCAs), control their service schedules, and receive case management and assistance with PCA coordination. To participate in the program, the Medicaid LTSS consumer must be 65 or over or 18 or over and have a disability. This program is estimated to be budget neutral since it replaces home care services the member would otherwise be receiving.

(iii) Application of the adjustments

A composite non-material adjustment was not applied.

(iv) Aggregate cost impact of all non-material adjustments.

A composite non-material adjustment was not applied.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate development standards

There are no incentive arrangements reflected in the SFY 2023 capitation rates.

ii. Appropriate documentation

There are no incentive arrangements reflected in the SFY 2023 capitation rates.

B. WITHHOLD ARRANGEMENTS

i. Rate development standards

This section provides documentation of the withhold arrangement in the MMP program.

ii. Appropriate documentation

(a) Description of the withhold arrangement

(i) Time period

The withhold is effective for the SFY 2023 rating period.

(ii) Enrollees, services, and providers covered by the withhold arrangement

All rate cells are covered by the withhold arrangement, which is applied to the total capitation rate.

(iii) Purpose

The quality withhold ensures that dually eligible individuals receive high quality care and incentivizes quality improvement. The participating MCO is eligible for repayment of the withheld amounts subject to performance on a combination of CMS Core and State-Specific quality withhold measures.

(iv) Description of total percentage withheld

The withhold is 4.0% in both Demonstration Year 6 (calendar year 2022) Demonstration Year 7 (calendar year 2023). The withhold may be earned upon meeting certain quality measures as specified in the three-way contract.

(v) Estimate of percent to be returned

We reviewed the withhold return for Demonstration Year 1⁵, Demonstration Year 2⁶, Demonstration Year 3⁷, Demonstration Year 4⁸, and information provided by EOHHS on the expectation of withhold return in Demonstration Year 6 and Demonstration Year 7. Based on this review and discussions with EOHHS, we believe that a full withhold return is attainable in Demonstration Year 6 and Demonstration Year 7.

(vi) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 4.0% of capitation revenue indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the MCO's financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cash flow needs for the MCO to pay claims and administer benefits. We evaluated the reasonableness of the withhold within this context by reviewing cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by EOHHS.

⁵ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReportRIDY1.pdf>. Accessed 6/28/2022

⁶ <https://www.cms.gov/files/document/qualitywithholdresultsreportridy2.pdf>. Accessed 6/28/2022

⁷ <https://www.cms.gov/files/document/qualitywithholdresultsreportridy3.pdf> Accessed 6/28/2022

⁸ <https://www.cms.gov/files/document/qualitywithholdresultsreportridy4.pdf> Accessed 6/28/2022

(vii) Effect on the capitation rates

No explicit adjustment was made to the capitation rates to reflect the impact of the withhold.

(b) Rate certification consideration of withhold

The actuarial rate certification includes consideration for the withhold and is included in Appendix 1.

C. RISK SHARING MECHANISMS**i. Rate development standards**

This section provides documentation of the risk-sharing mechanisms in the MMP program.

ii. Appropriate documentation**(a) Description of risk-sharing mechanism**

The MMP program does not include a risk corridor in Demonstration Year 6 or Demonstration Year 7.

(b) Medical loss ratio**(i) Methodology**

The medical loss ratio will be calculated as set forth in section 4.3.2 of the three-way contract.

(ii) Formula for Remittance/Payment

The MMP program has a minimum target medical loss ratio (MLR) in Demonstration Year 6 and Demonstration Year 7.

- **Demonstration Year 6.** If the MLR is between 85% and 87%, the MCO shall refund EOHHS and CMS an amount equal to 50% of the difference between the calculated MLR and 87%, multiplied by the coverage year revenue. If the MLR is less than 85%, the MCO shall refund EOHHS and CMS an amount equal to the difference between the calculated MLR and 85%, plus 1.0%, multiplied by the coverage year revenue.
- **Demonstration Year 7.** If the MLR is between 85% and 88%, the MCO shall refund EOHHS and CMS an amount equal to 50% of the difference between the calculated MLR and 88%, multiplied by the coverage year revenue. If the MLR is less than 85%, the MCO shall refund EOHHS and CMS an amount equal to the difference between the calculated MLR and 85%, plus 1.5%, multiplied by the coverage year revenue.

(iii) Financial consequences

As described above, a remittance will be due to EOHHS and CMS if the MLR is less than the minimum threshold.

(c) Reinsurance requirements and effect on capitation rates

There are no reinsurance requirements in the three-way contract between EOHHS, CMS, and Neighborhood Health Plan of Rhode Island.

D. STATE DIRECTED PAYMENTS**i. Rate Development Standards****(a) Description of managed care plan requirement**

Consistent with guidance in 42 CFR §438.6(c), the capitation rates effective July 1, 2022, reflect the following delivery and provider payment initiatives:

- Inpatient hospital state directed uniform percentage increase
- Outpatient hospital state directed uniform percentage increase

- Nursing home state directed uniform percentage increase
- Personal Care Shift Differential
- Personal Care Behavioral Health Certification Enhancement
- Shared living state directed uniform percentage increase
- Assisted living facility tiered rates state directed fee schedule
- Home care agencies state directed uniform percentage increase

(b) CMS approval

At the time of certification, EOHHS has not yet submitted the directed payment preprints except for the home care agencies state directed payment. We anticipate that EOHHS will submit the required preprints to CMS, and that the payment arrangement reflected in these certified rates is consistent with what we understand will be submitted to CMS.

(c) Generally accepted actuarial standards

The arrangements outlined in the state directed payment documentation are developed in accordance with 42 CFR §438.4 and §438.5 and follow generally accepted actuarial principles and practices.

(d) How payment arrangement is reflected in managed care rates

The fee-for-service program follows similar legislatively mandated reimbursement increases that were included in the rate development and are described in Section 3.B.ii and Section 3.B.iii. The state directed payment adjustments described below are consistent with the legislatively mandated reimbursement increase for the fee-for-service programs. In addition, consistent with EOHHS discussions with CMS, we included the home care agencies state directed payment which does not have a corresponding fee-for-service reimbursement mechanism, as this program would exist absent the MMP demonstration.

ii. Appropriate Documentation

(a) Delivery system and provider payment initiatives

(i) Description delivery system and provider payment initiatives

Figure 10 describes the directed payments for the MMP program.

FIGURE 10: STATE DIRECTED PAYMENTS

CONTROL NAME OF STATE DIRECTED PAYMENT	TYPE OF PAYMENT	BRIEF DESCRIPTION	IS THE PAYMENT INCLUDED AS A RATE ADJUSTMENT OR SEPARATE PAYMENT TERM
TBD: Inpatient Hospital	Uniform Percentage Increase	Uniform increase for inpatient hospital services	Rate Adjustment
TBD: Outpatient Hospital	Uniform Percentage Increase	Uniform increase for outpatient hospital services	Rate Adjustment
TBD: Nursing Facility	Uniform Percentage Increase	Uniform increase for nursing home services	Rate Adjustment
TBD: Shared Living	Uniform Percentage Increase	Uniform increase for shared living services	Rate Adjustment
N/A: Assisted Living	Minimum fee schedule	Minimum fee schedule for assisted living services approved in Medicaid state plan	Rate Adjustment
TBD: Personal Care Shift Differential	Minimum fee schedule	Minimum fee schedule per fifteen minutes for personal care and combined personal care/homemaker services with a shift modifier for nights, weekends, and holidays	Rate Adjustment
N/A: Personal Care Behavioral Health Certification Enhancement	Minimum fee schedule	Implement a base rate enhancement approved in Medicaid state plan for personal care, combined personal care/homemaker, and homemaker only services for providers with at least 30% of direct care workers certified in behavioral healthcare training	Rate Adjustment
RI_Fee_HCBS_New_20220701-20230630: Home Care Agencies	Uniform Dollar Increase	Uniform increase to home care agencies to build capacity and sustainability	Separate Payment Term

Note: The assisted living and personal care behavioral health certification enhancement directed payments are based on a state plan approved fee schedule and no preprint will be submitted.

(ii) State directed payments incorporated as a rate adjustment

Consistent with 42 CFR §438.7(b)(6) and 438.6(d), state directed payments are to be incorporated into the rate certification as a rate adjustment consistent with the anticipated preprints. The effect of each state directed payment on the SFY 2023 capitation rates is outlined in the figure below.

FIGURE 11: EFFECT OF STATE DIRECTED PAYMENTS – RATE ADJUSTMENT

CONTROL NAME OF STATE DIRECTED PAYMENT	RATE CELLS AFFECTED	IMPACT	DESCRIPTION OF THE ADJUSTMENT	CONFIRMATION THE RATES ARE CONSISTENT WITH THE PREPRINT
TBD: Inpatient Hospital	All Rate Cells	2.7% increase effective July 1, 2022	Uniform increase applied to inpatient hospital services	Consistent with anticipated preprint
TBD: Outpatient Hospital	All Rate Cells	2.7% increase effective July 1, 2022	Uniform increase applied to outpatient hospital services	Consistent with anticipated preprint
TBD: Nursing Facility	All Rate Cells	3.0% increase effective October 1, 2022	Uniform increase applied to nursing home services	Consistent with anticipated preprint
TBD: Shared Living	All Rate Cells	See Figure 7	See Section 3.B.ii	Consistent with anticipated preprint
N/A: Assisted Living	All Rate Cells	See Figure 7	See Section 3.B.ii	No preprint will be submitted; directed payment is based on the state plan approved fee schedule
TBD: Personal Care Shift Differential	All Rate Cells	See Figure 7	See Section 3.B.ii	Consistent with anticipated preprint
N/A: Personal Care Behavioral Health Certification Enhancement	All Rate Cells	See Figure 7	See Section 3.B.ii	No preprint will be submitted; directed payment is based on the state plan approved fee schedule

Note: The assisted living and personal care behavioral health certification enhancement directed payments are based on a state plan approved fee schedule. No preprint is required.

(iii) State directed payments incorporated as a separate payment term

Consistent with 42 CFR §438.7(b)(6) and 438.6(d), the state directed payment is incorporated into the rate certification consistent with the approved preprint. The effect of the state directed payment incorporated as a separate payment term in the SFY 2023 capitation rates is outlined in the figure below.

FIGURE 12: EFFECT OF STATE DIRECTED PAYMENTS – SEPARATE PAYMENT TERM

CONTROL NAME OF THE STATE DIRECTED PAYMENT	AGGREGATE AMOUNT INCLUDED IN CERTIFICATION	CERTIFIED AMOUNT	PMPM MAGNITUDE	CONFIRMATION THE RATES ARE CONSISTENT WITH THE PREPRINT	DOCUMENTATION WILL BE SUBMITTED AT END OF THE RATING PERIOD
RI_Fee_HCBS_ New_20220701- 20230630	\$4,375,000	We certify that the amount of the separate payment term disclosed in this certification is a reasonable estimate for the ultimately reconciled retrospective amounts.	The estimated magnitude of this state directed payment is illustrated in Appendix 5, in the "LTSS APM" column.	The payment arrangement reflected in these certified rates is consistent with the preprint submitted to CMS.	When the rating period is complete, EOHHS will submit to CMS documentation that incorporates the total amount of the state directed payment into each rate cell consistent with the distribution methodology included in the approved state directed payment preprint, as if the payment information had been fully known when the rates were initially developed.

(b) Additional directed payments

There are no additional directed payment arrangements.

(c) Required reimbursement rates outside the certification

There are no requirements regarding reimbursement rates the plans must pay to any providers unless specified in the certification as a directed payment or authorized under applicable law, regulation, or waiver.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

There are no pass-through payments reflected in the SFY 2023 capitation rates.

ii. Appropriate Documentation

There are no pass-through payments reflected in the SFY 2023 capitation rates.

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5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

The non-benefit component of the capitation rate includes reasonable, appropriate, and attainable expenses related to the MMP population absent the demonstration.

The remainder of Section I, item 5 provides documentation of the data, assumptions and methodology that were utilized to develop the non-benefit cost component of the capitation rate illustrated in Appendix 5.

ii. PMPM versus percentage

The administrative cost allowance was developed as a percentage of the base benefit costs and converted to a per member per month basis.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

DATA

The primary data source used in the development of the SFY 2023 non-benefit costs is the SFY 2020 Medicaid Expenditures report. The Medicaid Expenditure report was used to identify the central administrative costs related to managing the Medicaid program incurred by EOHHS.

ASSUMPTIONS AND METHODOLOGY

- **Administrative Cost:** Administrative loads included in the capitation rate development reflect EOHHS administrative expenditures estimated to have occurred absent the demonstration for a full benefit fee-for-service Medicaid member. We reviewed EOHHS administrative costs reported in the annual Medicaid Expenditure Report, administrative costs estimated for similar covered populations in Rhode Island managed care programs, and administrative costs included in other dual demonstration programs. This review, in combination with actuarial judgment, was used to validate the reasonableness of the composite non-benefit expense load and develop the rate cell administrative load relativities.
- **Demonstration Savings:** The Medicaid capitation rates were established with the application of the 3.0% Demonstration Year 6 and Demonstration Year 7 savings percentage as documented in the MOU.

(b) Material changes

The data, assumptions, and methodology used to develop the projected non-benefit cost are generally consistent with the SFY 2022 rate development.

(c) Other material adjustments

There are no other material non-benefit cost adjustments.

ii. Non-benefit costs, by cost category

The non-benefit expense components are illustrated in Figure 13 are illustrated as a PMPM amount prior to demonstration savings.

FIGURE 13: NON-BENEFIT EXPENSE LOADS

Rate Cell	Administrative Cost PMPM
IC30: MMP - SPMI	\$ 70.00
IC40: MMP - ID	27.00
IC50: MMP - Community LTSS	240.00
IC60: MMP - Nursing Home	240.00
IC70: MMP - Community Non-LTSS	16.00

iii. Historical non-benefit cost

Because the non-benefit component of the capitation rate reflects the estimated non-benefit costs for MMP-eligible members while in the fee-for-service program (i.e., “absent the demonstration”), we did not request historical non-benefit cost data from the MCO.

6. Risk Adjustment and Acuity Adjustments

This section of the CMS Guide is not applicable to the populations covered under this rate certification. Risk adjustment and acuity adjustments are not applicable as there is only one MCO operating in the MMP program.

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Section II. Medicaid Managed care rates with long-term services and supports

This section provides additional information on the base data and methodologies used to develop the capitation rates for the managed long-term services and supports (LTSS) provided to the MMP population.

1. Managed Long-Term Services and Supports

A. APPLICABILITY

The LTSS portion of the MMP capitation rates were developed consistently with the required standards for rate development described in Section 1 of this report.

B. RATE DEVELOPMENT STANDARDS

i. Rate cell structure

The community LTSS and nursing home rate cell members have a nursing home level of care and are blended into a single payment rate. The remaining rate cells are not blended.

C. APPROPRIATE DOCUMENTATION

i. Covered benefits

(a) Structure of rate cells

The community LTSS and nursing home rate cells are blended into a single payment rate.

(b) Data, assumptions, and methodology

Baseline costs for the community LTSS and nursing home rate cells are developed based on SFY 2021 fee-for-service experience. Assumptions utilized in the development of the rate-cell specific costs are outlined in Section I. The SFY 2023 enrollment estimates, which were used to blend the community LTSS and nursing home rate cell into a single payment rate, were developed with the following methodology.

- **Step 1:** MMP enrollment as of June 1, 2022 was utilized as the baseline rate cell distribution.
- **Step 2:** Total enrollment was adjusted to the average monthly enrollment for the July 1, 2022 through June 30, 2023 period estimates from the May 2022 EOHHS Caseload estimates.
- **Step 3:** The final SFY 2023 estimated monthly enrollment distribution reflects passive enrollment estimates impacting all rate cells and is based on data provided by EOHHS. In addition, the final community non-LTSS / nursing home blend of 67%/33% was based on a review of the emerging MMP enrollment distribution and historical enrollment changes. The 67%/33% blend was estimated as an appropriate “absent the demonstration” distribution used to develop the blended LTSS rate.

Figure 14 illustrates the development of the SFY 2023 projected enrollment.

FIGURE 14: PROJECTED ENROLLMENT DEVELOPMENT

Rate Cell	Step 1: June 2022 Enrollment	Step 2: Adjusted for SFY 2023 Caseload Estimate	Step 3: Average Monthly Projected Enrollment SFY 2023
IC30: MMP - SPMI	1,083	1,118	1,132
IC40: MMP - ID	1,386	1,432	1,411
IC50: MMP - Community LTSS	1,653	1,707	1,646
IC60: MMP - Nursing Home	684	707	811
IC70: MMP - Community Non-LTSS	8,194	8,463	8,427
Total MMP	13,000	13,427	13,427

(c) Payment structure

There are not any other payment structures, incentives, or disincentives used to pay the MCO for transitioning the setting of care for the members.

(d) LTSS management

The rate cell structure encourages the MCO to manage the population towards lower cost settings by way of the blended LTSS rate.

(e) Effects of managed care

The MCO is expected to deliver care in the most efficient setting of care, often transitioning service utilization from nursing homes to home and community-based services. In addition, certain opportunities may be available to reduce or postpone the use of certain home and community-based services.

ii. Projected non-benefit costs

The projected non-benefit costs included in the rate development are fully described in Section I.5.

iii. Assumptions

Section I details the experience and assumptions employed for the development of the LTSS service costs included in the MMP capitation rates.

Section III. New adult group capitation rates

Section III of the CMS Guide is not applicable to the populations covered under this rate certification. The state operates a new adult group program for Medicaid Expansion that is outlined in a separate capitation rate certification document.

DRAFT

Limitations

The information contained in this report has been prepared for the Rhode Island Executive Office of Health and Human Services (EOHHS) to provide documentation of the methodology and data sources used for developing the certified Medicaid component of the July 1, 2022 through June 30, 2023 capitation rates for the Rhode Island Medicare-Medicaid Plan (MMP) program. The data and information presented may not be appropriate for any other purpose.

The information contained in this report, including the enclosures, has been prepared for EOHHS and their consultants and advisors. It is our understanding that the information contained in this report may be shared with the Center for Medicare and Medicaid Services (CMS) and the managed care organization (MCO) operating in the MMP program. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for EOHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this correspondence. The intent of the models was to develop the SFY 2023 Medicare-Medicaid Plan capitation rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The methodology for these models follows the guidance prescribed by CMS in the Joint Rate-Setting Process for the Financial Alignment Initiative's Capitated Model. The models rely on data and information as input to the models. We have relied upon certain data and information provided by EOHHS and the MCO for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. Milliman's data and information reliance includes the data sources outlined in the body of this report. The models, including all input, calculations, and output may not be appropriate for any other purpose.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

At the time of this report, we acknowledge there is substantial uncertainty regarding the impact of the COVID-19 pandemic on future projections. It is possible that the COVID-19 pandemic could have a material impact on the projected enrollment and capitation rates presented in this report.

The services provided by Milliman to EOHHS were performed under the signed contract agreement between Milliman and EOHHS dated March 10, 2022.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Appendix 1: Actuarial Certification

State of Rhode Island
Executive Office of Health and Human Services
State Fiscal Year 2023 Capitation Rates
Medicare-Medicaid Plan Actuarial Certification

I, Ian M. McCulla, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been contracted by the State of Rhode Island, Executive Office of Health and Human Services to perform an actuarial review and certification regarding the development of capitation rates for the Medicare-Medicaid Plan (MMP) effective July 1, 2022. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

Assessment of actuarial soundness, in the context of the Medicare-Medicaid Alignment Initiative program, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. The Center for Medicare and Medicaid Services (CMS) considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. The capitation rates provided with this certification are considered actuarially sound for purposes of 42 CFR 438.4(a), according to the following criteria:

- the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), actuarial soundness is defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

The assumptions used in the development of the actuarially sound capitation rates have been documented in my correspondence with the State of Rhode Island. The actuarially sound capitation rates that are associated with this certification are effective July 1, 2022 through June 30, 2023. The capitation rates are considered actuarially sound after adjustment for the amount of the withhold not expected to be earned. The actuarially sound capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

I acknowledge that the state may elect to amend the capitation rates in accordance with 42 CFR 438.7(c)(3), which indicates that a capitation rate certification is not required for adjustments that increase or decrease capitation rates by 1.5% or less. The capitation rates developed may not be appropriate for any specific managed care plan. An individual managed care plan will need to review the rates in relation to the benefits that it will be obligated to provide. The managed care plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The managed care plan may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

As allowed by ASOP 49 and ASOP 1, I relied upon a capitation rate setting methodology selected by another party. Specifically, I followed guidance prescribed by CMS in the Joint Rate-Setting Process for the Financial Alignment Initiative's Capitated Model (Joint Rate-Setting Process), updated March 19, 2019, for Medicare-Medicaid plans participating in the demonstration.

Ian M. McCulla, FSA
Member, American Academy of Actuaries

July 22, 2022
Date

Appendix 2: Out-of-Plan Services

State of Rhode Island Executive Office of Health and Human Services State Fiscal Year (SFY) 2023 Capitation Rate Development Medicare-Medicaid Plan Out-of-Plan Service Criteria	
Out-of-Plan Services	Definition
BHDDH services (except MR Waiver - Private)	Funding Sources 20, 21, 23, 24, 25, 27, 28, 29, 30, 31, 78, 89, A2, A3, B1, B2, B3, B4, B5, and B6 (Funding Source 22 is included)
DHS services	Funding Sources 07, 14, 15, 19, 48, 50, 58, 65, 69, 72, 75, 77, 79, 88, 91, 92, 93, 96, 97, 98, 99, and A1
DCYF services	Funding Sources 38, 39, 40, 41, and 42
Ryan White services	Funding Sources 52 and 76
Special Education services	Funding Source 13
Eleanor Slater Hospital	Provider Types 022 and 028
ICF - MR Private Facility (Tavares)	Provider Type 029
Dental	Provider Type 004
RICLASS Facilities	Provider Type 026
BHDDH DD Agencies	Provider Type 088
Cortical Integrated Therapy	Provider Type 106
Personal Care Aide/Assistant claims under Department of Elderly Affairs	HCPCS S5125 and Provider Type 072 and Funding Source 60 for Intellectual Disability Waiver members
FQHC Dental	Provider Type 024 and Dental HCPCS
Fatima Hospital	NPI 1871918870 and FEIN 464661337 and Provider Type 001 for Inpatient MH/SA claims

Appendix 3: Retrospective Benefit Expense Development

State of Rhode Island Executive Office of Health and Human Services State Fiscal Year (SFY) 2023 Capitation Rate Development Medicare-Medicaid Plan Retrospective Rate Development Model - SFY 2021				
Rate Cell: IC30: MMP - SPMI	SFY 2021 Base Experience	Incomplete Data Adjustments		Adjusted Base Experience
Average Monthly Enrollment: 1,038				
Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital				
Inpatient Hospital	\$ 85.36	\$ 1.40	\$ 0.00	\$ 86.76
Subtotal Inpatient Hospital	\$ 85.36			\$ 86.76
Outpatient Hospital				
Outpatient Emergency Room	\$ 2.82	\$ 0.00	\$ 0.00	\$ 2.82
Outpatient Surgery	2.11	-	-	2.11
Other Outpatient	3.40	-	-	3.40
Subtotal Outpatient Hospital	\$ 8.33			\$ 8.33
Professional				
MH/SA	\$ 581.52	\$ 0.87	\$ 0.00	\$ 582.39
Other Professional	26.39	0.04	-	26.43
Subtotal Professional	\$ 607.91			\$ 608.82
Retail Pharmacy				
Retail Pharmacy	\$ 1.94	\$ 0.00	\$ 0.00	\$ 1.94
Subtotal Retail Pharmacy	\$ 1.94			\$ 1.94
Ancillary				
Transportation	\$ 0.09	\$ 0.00	\$ 0.00	\$ 0.09
DME/Prosthetics	2.20	-	-	2.20
Subtotal Ancillary	\$ 2.29			\$ 2.29
LTSS				
Hospice	\$ 0.18	\$ 0.00	\$ 0.00	\$ 0.18
Nursing Home	11.95	0.16	-	12.11
HCBS	32.83	0.18	-	33.01
Case Management	230.55	1.27	-	231.82
Subtotal LTSS	\$ 275.51			\$ 277.12
Total Medical Costs	\$ 981.34			\$ 985.26

State of Rhode Island Executive Office of Health and Human Services State Fiscal Year (SFY) 2023 Capitation Rate Development Medicare-Medicaid Plan Retrospective Rate Development Model - SFY 2021				
Rate Cell: IC40: MMP - ID	SFY 2021 Base Experience	Incomplete Data Adjustments		Adjusted Base Experience
Average Monthly Enrollment: 975 Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital				
Inpatient Hospital	\$ 5.34	\$ 0.09	\$ 0.00	\$ 5.43
Subtotal Inpatient Hospital	\$ 5.34			\$ 5.43
Outpatient Hospital				
Outpatient Emergency Room	\$ 1.45	\$ 0.00	\$ 0.00	\$ 1.45
Outpatient Surgery	1.43	-	-	1.43
Other Outpatient	2.43	-	-	2.43
Subtotal Outpatient Hospital	\$ 5.31			\$ 5.31
Professional				
MH/SA	\$ 13.08	\$ 0.02	\$ 0.00	\$ 13.10
Other Professional	6.45	0.01	-	6.46
Subtotal Professional	\$ 19.53			\$ 19.56
Retail Pharmacy				
Retail Pharmacy	\$ 1.77	\$ 0.00	\$ 0.00	\$ 1.77
Subtotal Retail Pharmacy	\$ 1.77			\$ 1.77
Ancillary				
Transportation	\$ 0.02	\$ 0.00	\$ 0.00	\$ 0.02
DME/Prosthetics	24.05	-	-	24.05
Subtotal Ancillary	\$ 24.07			\$ 24.07
LTSS				
Hospice	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Nursing Home	1.17	0.02	-	1.19
HCBS	20.01	0.11	-	20.12
Case Management	0.02	-	-	0.02
Subtotal LTSS	\$ 21.20			\$ 21.33
Total Medical Costs	\$ 77.22			\$ 77.47

State of Rhode Island Executive Office of Health and Human Services State Fiscal Year (SFY) 2023 Capitation Rate Development Medicare-Medicaid Plan Retrospective Rate Development Model - SFY 2021				
Rate Cell: IC50: MMP - Community LTSS	SFY 2021 Base Experience	Incomplete Data Adjustments		Adjusted Base Experience
Average Monthly Enrollment: 1,656				
Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital				
Inpatient Hospital	\$ 23.88	\$ 0.38	\$ 0.00	\$ 24.26
Subtotal Inpatient Hospital	\$ 23.88			\$ 24.26
Outpatient Hospital				
Outpatient Emergency Room	\$ 2.00	\$ 0.00	\$ 0.00	\$ 2.00
Outpatient Surgery	2.45	-	-	2.45
Other Outpatient	14.93	-	-	14.93
Subtotal Outpatient Hospital	\$ 19.38			\$ 19.38
Professional				
MH/SA	\$ 43.51	\$ 0.07	\$ 0.00	\$ 43.58
Other Professional	21.13	0.03	-	21.16
Subtotal Professional	\$ 64.64			\$ 64.74
Retail Pharmacy				
Retail Pharmacy	\$ 2.78	\$ 0.00	\$ 0.00	\$ 2.78
Subtotal Retail Pharmacy	\$ 2.78			\$ 2.78
Ancillary				
Transportation	\$ 0.06	\$ 0.00	\$ 0.00	\$ 0.06
DME/Prosthetics	29.72	-	-	29.72
Subtotal Ancillary	\$ 29.78			\$ 29.78
LTSS				
Hospice	\$ 0.72	\$ 0.00	\$ 0.00	\$ 0.72
Nursing Home	17.33	0.23	-	17.56
HCBS	1,824.48	10.03	-	1,834.51
Case Management	41.39	0.23	-	41.62
Subtotal LTSS	\$ 1,883.92			\$ 1,894.41
Total Medical Costs	\$ 2,024.38			\$ 2,035.35

State of Rhode Island Executive Office of Health and Human Services State Fiscal Year (SFY) 2023 Capitation Rate Development Medicare-Medicaid Plan Retrospective Rate Development Model - SFY 2021				
Rate Cell: IC60: MMP - Nursing Home	SFY 2021 Base Experience	Incomplete Data Adjustments		Adjusted Base Experience
Average Monthly Enrollment: 2,775 Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital				
Inpatient Hospital	\$ 8.10	\$ 0.14	\$ 0.00	\$ 8.24
Subtotal Inpatient Hospital	\$ 8.10			\$ 8.24
Outpatient Hospital				
Outpatient Emergency Room	\$ 0.90	\$ 0.00	\$ 0.00	\$ 0.90
Outpatient Surgery	0.50	-	-	0.50
Other Outpatient	3.33	-	-	3.33
Subtotal Outpatient Hospital	\$ 4.73			\$ 4.73
Professional				
MH/SA	\$ 1.38	\$ 0.00	\$ 0.00	\$ 1.38
Other Professional	3.84	0.01	-	3.85
Subtotal Professional	\$ 5.22			\$ 5.23
Retail Pharmacy				
Retail Pharmacy	\$ 1.13	\$ 0.00	\$ 0.00	\$ 1.13
Subtotal Retail Pharmacy	\$ 1.13			\$ 1.13
Ancillary				
Transportation	\$ 0.04	\$ 0.00	\$ 0.00	\$ 0.04
DME/Prosthetics	0.24	-	-	0.24
Subtotal Ancillary	\$ 0.28			\$ 0.28
LTSS				
Hospice	\$ 422.10	\$ 2.32	\$ 0.00	\$ 424.42
Nursing Home	5,352.92	71.73	-	5,424.65
HCBS	1.40	0.01	-	1.41
Case Management	0.90	-	-	0.90
Subtotal LTSS	\$ 5,777.32			\$ 5,851.38
Total Medical Costs	\$ 5,796.78			\$ 5,870.99

State of Rhode Island Executive Office of Health and Human Services State Fiscal Year (SFY) 2023 Capitation Rate Development Medicare-Medicaid Plan Retrospective Rate Development Model - SFY 2021				
Rate Cell: IC70: MMP - Community Non-LTSS	SFY 2021 Base Experience	Incomplete Data Adjustments		Adjusted Base Experience
Average Monthly Enrollment: 8,864 Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital				
Inpatient Hospital	\$ 14.74	\$ 0.24	\$ 0.00	\$ 14.98
Subtotal Inpatient Hospital	\$ 14.74			\$ 14.98
Outpatient Hospital				
Outpatient Emergency Room	\$ 1.39	\$ 0.00	\$ 0.00	\$ 1.39
Outpatient Surgery	2.07	-	-	2.07
Other Outpatient	5.18	-	-	5.18
Subtotal Outpatient Hospital	\$ 8.64			\$ 8.64
Professional				
MH/SA	\$ 22.61	\$ 0.03	\$ 0.00	\$ 22.64
Other Professional	10.92	0.02	-	10.94
Subtotal Professional	\$ 33.53			\$ 33.58
Retail Pharmacy				
Retail Pharmacy	\$ 0.89	\$ 0.00	\$ 0.00	\$ 0.89
Subtotal Retail Pharmacy	\$ 0.89			\$ 0.89
Ancillary				
Transportation	\$ 0.04	\$ 0.00	\$ 0.00	\$ 0.04
DME/Prosthetics	2.41	-	-	2.41
Subtotal Ancillary	\$ 2.45			\$ 2.45
LTSS				
Hospice	\$ 1.15	\$ 0.01	\$ 0.00	\$ 1.16
Nursing Home	24.98	0.33	-	25.31
HCBS	7.96	0.04	-	8.00
Case Management	8.96	0.05	-	9.01
Subtotal LTSS	\$ 43.05			\$ 43.48
Total Medical Costs	\$ 103.30			\$ 104.02

Appendix 4: SFY 2023 Prospective Benefit Expense Development

State of Rhode Island
Executive Office of Health and Human Services
State Fiscal Year (SFY) 2023 Capitation Rate Development
Medicare-Medicaid Plan
Prospective Rate Development Model

Rate Cell: IC30: MMP - SPMI	Adjusted Base Experience	Program Change Adjustments		Acuity Adjustments		Trend Adjustments		Projected Experience
Average Monthly Enrollment: 1,132 Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital								
Inpatient Hospital	\$ 86.76	\$ 0.00	\$ 0.00	\$ 0.07	\$ 0.00	\$ 2.63	\$ 4.62	\$ 94.08
Subtotal Inpatient Hospital	\$ 86.76							\$ 94.08
Outpatient Hospital								
Outpatient Emergency Room	\$ 2.82	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.03	\$ 0.15	\$ 3.00
Outpatient Surgery	2.11	-	-	-	-	0.07	0.11	2.29
Other Outpatient	3.40	-	-	-	-	0.11	0.18	3.69
Subtotal Outpatient Hospital	\$ 8.33							\$ 8.98
Professional								
MH/SA	\$ 582.39	\$ 0.00	\$ 0.00	\$ 0.47	\$ 0.00	\$ 23.54	\$ 24.50	\$ 630.90
Other Professional	26.43	-	-	0.02	-	1.07	1.11	28.63
Subtotal Professional	\$ 608.82							\$ 659.53
Retail Pharmacy								
Retail Pharmacy	\$ 1.94	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.08	\$ 0.16	\$ 2.18
Subtotal Retail Pharmacy	\$ 1.94							\$ 2.18
Ancillary								
Transportation	\$ 0.09	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.01	\$ 0.10
DME/Prosthetics	2.20	-	-	-	-	0.05	0.11	2.36
Subtotal Ancillary	\$ 2.29							\$ 2.46
LTSS								
Hospice	\$ 0.18	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.01	\$ 0.19
Nursing Home	12.11	-	-	-	-	0.12	0.69	12.92
HCBS	33.01	-	-	18.16	-	2.06	2.15	55.38
Case Management	231.82	-	-	-	-	9.37	9.74	250.93
Subtotal LTSS	\$ 277.12							\$ 319.42
Total Medical Costs	\$ 985.26							\$ 1,086.65

State of Rhode Island
Executive Office of Health and Human Services
State Fiscal Year (SFY) 2023 Capitation Rate Development
Medicare-Medicaid Plan
Prospective Rate Development Model

Rate Cell: IC40: MMP - ID	Adjusted Base Experience	Program Change Adjustments		Acuity Adjustments		Trend Adjustments		Projected Experience
Average Monthly Enrollment: 1,411 Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital								
Inpatient Hospital	\$ 5.43	\$ 0.00	\$ 0.00	\$ 0.25	\$ 0.00	\$ 0.18	\$ 0.30	\$ 6.16
Subtotal Inpatient Hospital	\$ 5.43							\$ 6.16
Outpatient Hospital								
Outpatient Emergency Room	\$ 1.45	\$ 0.00	\$ 0.00	\$ 0.07	\$ 0.00	\$ 0.01	\$ 0.08	\$ 1.61
Outpatient Surgery	1.43	-	-	0.07	-	0.04	0.08	1.62
Other Outpatient	2.43	-	-	0.11	-	0.08	0.14	2.76
Subtotal Outpatient Hospital	\$ 5.31							\$ 5.99
Professional								
MH/SA	\$ 13.10	\$ 0.00	\$ 0.00	\$ 0.61	\$ 0.00	\$ 0.56	\$ 0.57	\$ 14.84
Other Professional	6.46	-	-	0.30	-	0.28	0.28	7.32
Subtotal Professional	\$ 19.56							\$ 22.16
Retail Pharmacy								
Retail Pharmacy	\$ 1.77	\$ 0.00	\$ 0.00	\$ 0.08	\$ 0.00	\$ 0.08	\$ 0.16	\$ 2.09
Subtotal Retail Pharmacy	\$ 1.77							\$ 2.09
Ancillary								
Transportation	\$ 0.02	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.02
DME/Prosthetics	24.05	-	-	1.13	-	0.50	1.30	26.98
Subtotal Ancillary	\$ 24.07							\$ 27.00
LTSS								
Hospice	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Nursing Home	1.19	-	-	-	-	0.01	0.07	1.27
HCBS	20.12	-	2.29	27.46	-	2.01	2.10	53.98
Case Management	0.02	-	-	-	-	-	-	0.02
Subtotal LTSS	\$ 21.33							\$ 55.27
Total Medical Costs	\$ 77.47							\$ 118.67

State of Rhode Island
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Prospective Rate Development Model

Rate Cell: IC50: MMP - Community LTSS	Adjusted Base Experience	Program Change Adjustments		Acuity Adjustments		Trend Adjustments		Projected Experience
Average Monthly Enrollment: 1,646								
Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital								
Inpatient Hospital	\$ 24.26	\$ 0.00	\$ 0.00	\$ 0.30	\$ 0.00	\$ 0.75	\$ 1.30	\$ 26.61
Subtotal Inpatient Hospital	\$ 24.26							\$ 26.61
Outpatient Hospital								
Outpatient Emergency Room	\$ 2.00	\$ 0.00	\$ 0.00	\$ 0.02	\$ 0.00	\$ 0.03	\$ 0.10	\$ 2.15
Outpatient Surgery	2.45	-	-	0.03	-	0.08	0.13	2.69
Other Outpatient	14.93	-	-	0.19	-	0.45	0.81	16.38
Subtotal Outpatient Hospital	\$ 19.38							\$ 21.22
Professional								
MH/SA	\$ 43.58	\$ 0.00	\$ 0.00	\$ 0.54	\$ 0.00	\$ 1.79	\$ 1.85	\$ 47.76
Other Professional	21.16	-	-	0.26	-	0.87	0.90	23.19
Subtotal Professional	\$ 64.74							\$ 70.95
Retail Pharmacy								
Retail Pharmacy	\$ 2.78	\$ 0.00	\$ 0.00	\$ 0.03	\$ 0.00	\$ 0.12	\$ 0.24	\$ 3.17
Subtotal Retail Pharmacy	\$ 2.78							\$ 3.17
Ancillary								
Transportation	\$ 0.06	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.01	\$ 0.07
DME/Prosthetics	29.72	-	-	0.37	-	0.61	1.55	32.25
Subtotal Ancillary	\$ 29.78							\$ 32.32
LTSS								
Hospice	\$ 0.72	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.01	\$ 0.04	\$ 0.77
Nursing Home	17.56	-	-	0.44	-	0.18	1.02	19.20
HCBS	1,834.51	-	131.32	164.58	-	86.07	89.54	2,306.02
Case Management	41.62	-	-	(0.62)	-	1.66	1.72	44.38
Subtotal LTSS	\$ 1,894.41							\$ 2,370.37
Total Medical Costs	\$ 2,035.35							\$ 2,524.64

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Rate Cell: IC60: MMP - Nursing Home	Adjusted Base Experience	Program Change Adjustments		Acuity Adjustments		Trend Adjustments		Projected Experience
Average Monthly Enrollment: 811		Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	
Category of Service	PMPM							PMPM
Inpatient Hospital								
Inpatient Hospital	\$ 8.24	\$ 0.00	\$ 0.00	\$ 1.50	\$ 0.00	\$ 0.30	\$ 0.52	\$ 10.56
Subtotal Inpatient Hospital	\$ 8.24							\$ 10.56
Outpatient Hospital								
Outpatient Emergency Room	\$ 0.90	\$ 0.00	\$ 0.00	\$ 0.16	\$ 0.00	\$ 0.02	\$ 0.05	\$ 1.13
Outpatient Surgery	0.50	-	-	0.09	-	0.02	0.03	0.64
Other Outpatient	3.33	-	-	0.61	-	0.12	0.21	4.27
Subtotal Outpatient Hospital	\$ 4.73							\$ 6.04
Professional								
MH/SA	\$ 1.38	\$ 0.00	\$ 0.00	\$ 0.25	\$ 0.00	\$ 0.07	\$ 0.07	\$ 1.77
Other Professional	3.85	-	-	0.70	-	0.19	0.19	4.93
Subtotal Professional	\$ 5.23							\$ 6.70
Retail Pharmacy								
Retail Pharmacy	\$ 1.13	\$ 0.00	\$ 0.00	\$ 0.21	\$ 0.00	\$ 0.05	\$ 0.11	\$ 1.50
Subtotal Retail Pharmacy	\$ 1.13							\$ 1.50
Ancillary								
Transportation	\$ 0.04	\$ 0.00	\$ 0.00	\$ 0.01	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.05
DME/Prosthetics	0.24	-	-	0.04	-	0.01	0.01	0.30
Subtotal Ancillary	\$ 0.28							\$ 0.35
LTSS								
Hospice	\$ 424.42	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 4.24	\$ 24.14	\$ 452.80
Nursing Home	5,424.65	-	-	-	202.34	56.27	319.97	6,003.23
HCBS	1.41	-	0.23	-	-	0.06	0.07	1.77
Case Management	0.90	-	-	-	-	0.04	0.03	0.97
Subtotal LTSS	\$ 5,851.38							\$ 6,458.77
Total Medical Costs	\$ 5,870.99							\$ 6,483.92

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Rate Cell: IC70: MMP - Community Non-LTSS	Adjusted Base Experience	Program Change Adjustments		Acuity Adjustments		Trend Adjustments		Projected Experience
Average Monthly Enrollment: 8,427 Category of Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	PMPM
Inpatient Hospital								
Inpatient Hospital	\$ 14.98	\$ 0.00	\$ 0.00	\$ 1.74	\$ 0.00	\$ 0.49	\$ 0.90	\$ 18.11
Subtotal Inpatient Hospital	\$ 14.98							\$ 18.11
Outpatient Hospital								
Outpatient Emergency Room	\$ 1.39	\$ 0.00	\$ 0.00	\$ 0.16	\$ 0.00	\$ 0.02	\$ 0.08	\$ 1.65
Outpatient Surgery	2.07	-	-	0.24	-	0.07	0.12	2.50
Other Outpatient	5.18	-	-	0.60	-	0.17	0.31	6.26
Subtotal Outpatient Hospital	\$ 8.64							\$ 10.41
Professional								
MH/SA	\$ 22.64	\$ 0.00	\$ 0.00	\$ 2.62	\$ 0.00	\$ 1.02	\$ 1.06	\$ 27.34
Other Professional	10.94	-	-	1.27	-	0.49	0.51	13.21
Subtotal Professional	\$ 33.58							\$ 40.55
Retail Pharmacy								
Retail Pharmacy	\$ 0.89	\$ 0.00	\$ 0.00	\$ 0.10	\$ 0.00	\$ 0.04	\$ 0.09	\$ 1.12
Subtotal Retail Pharmacy	\$ 0.89							\$ 1.12
Ancillary								
Transportation	\$ 0.04	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.01	\$ 0.00	\$ 0.05
DME/Prosthetics	2.41	-	-	0.28	-	0.05	0.14	2.88
Subtotal Ancillary	\$ 2.45							\$ 2.93
LTSS								
Hospice	\$ 1.16	\$ 0.00	\$ 0.00	\$ 0.07	\$ 0.00	\$ 0.01	\$ 0.07	\$ 1.31
Nursing Home	25.31	-	-	1.47	-	0.27	1.52	28.57
HCBS	8.00	-	0.28	62.57	-	2.86	2.98	76.69
Case Management	9.01	-	-	0.52	-	0.39	0.40	10.32
Subtotal LTSS	\$ 43.48							\$ 116.89
Total Medical Costs	\$ 104.02							\$ 190.01

Appendix 5: SFY 2023 Capitation Rate Development

State of Rhode Island
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Medicare-Medicaid Plan
Rate Change Summary

Region: Statewide	Average Monthly Enrollment	Base Benefit Expense	LTSS APM	Subtotal Benefit Expense	Administrative Cost Allowance	Benefit Expense with Admin	Demonstration Savings	SFY 2023 Capitation Rate	SFY 2022 Capitation Rate	% Change	Withhold	SFY 2023 Capitation Rate Less Withhold
MMP Demonstration												
MMP - SPMI	1,132	\$ 1,086.65	\$ 9.96	\$ 1,096.61	\$ 70.00	\$ 1,166.61	\$ (35.00)	\$ 1,131.61	\$ 1,127.26	0.4%	\$ (45.26)	\$ 1,086.35
MMP - ID	1,411	118.67	4.96	123.63	27.00	150.63	(4.52)	146.11	150.20	(2.7%)	(5.84)	140.27
MMP - Community LTSS	1,646	2,524.64	160.19	2,684.83	240.00	2,924.83	N/A	N/A	N/A	N/A	N/A	N/A
MMP - Nursing Home	811	6,483.92	0.73	6,484.65	240.00	6,724.65	N/A	N/A	N/A	N/A	N/A	N/A
MMP - Blended LTSS	2,457	3,831.51	107.56	3,939.06	240.00	4,179.06	(125.37)	4,053.69	3,559.74	13.9%	(162.15)	3,891.54
MMP - Community Non-LTSS	8,427	190.01	9.74	199.75	16.00	215.75	(6.47)	209.28	191.00	9.6%	(8.37)	200.91
Total MMP Demonstration	13,427	\$ 924.46	\$ 27.16	\$ 951.62	\$ 62.70	\$ 1,014.32	\$ (30.43)	\$ 983.89	\$ 882.09	11.5%	\$ (39.35)	\$ 944.53



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