**State Fiscal Year 2023 Medicaid Managed Care Capitation Rate Certification**

**July 1, 2022 through June 30, 2023**

**Rhode Island, Executive Office of Health and Human Services**

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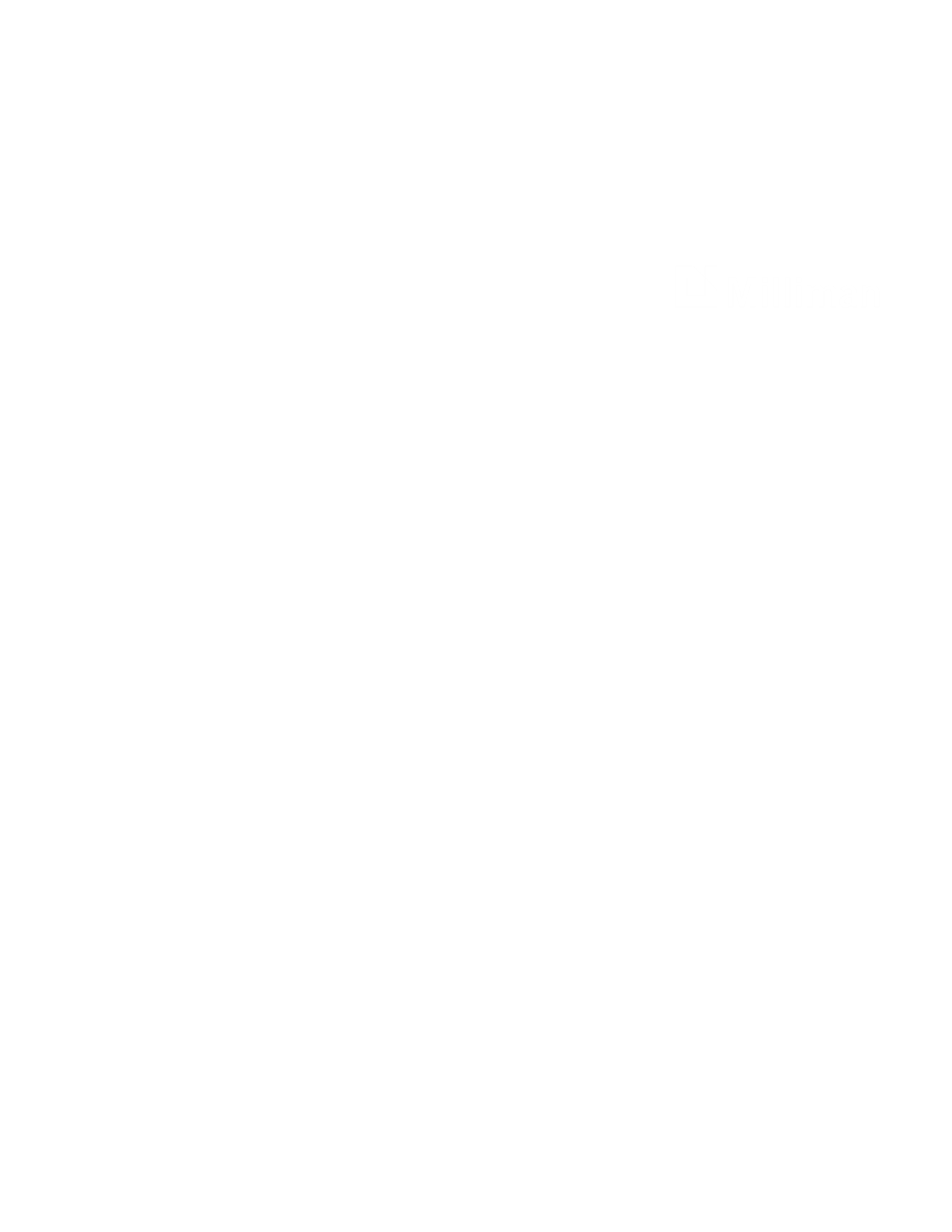


Table of Contents

[Introduction & Executive Summary 1](#_Toc100260669)

[Section I. Medicaid managed care rates 3](#_Toc100260670)

[1. General information 3](#_Toc100260671)

[A. Rate Development Standards 3](#_Toc100260672)

[i. Rate ranges 3](#_Toc100260673)

[ii. Annual basis 3](#_Toc100260674)

[iii. Required elements 3](#_Toc100260675)

[iv. Differences among capitation rates 6](#_Toc100260676)

[v. Cross-subsidization of rate cell payment 6](#_Toc100260677)

[vi. Effective dates 6](#_Toc100260678)

[vii. Medical loss ratio 6](#_Toc100260679)

[viii. Rate ranges 6](#_Toc100260680)

[ix. Actuarial soundness of rate ranges 6](#_Toc100260681)

[x. Generally accepted actuarial practices and principles 6](#_Toc100260682)

[xi. Rate certification for effective time periods 7](#_Toc100260683)

[xii. COVID-19 public health emergency 7](#_Toc100260684)

[xiii. Procedures for rate certification and amendment 7](#_Toc100260685)

[B. Appropriate Documentation 7](#_Toc100260686)

[i. Capitation rate certification 7](#_Toc100260687)

[ii. Documentation of required elements 7](#_Toc100260688)

[iii. Rate ranges 7](#_Toc100260689)

[iv. Rate range boundaries 7](#_Toc100260690)

[v. Index 7](#_Toc100260691)

[vi. Compliance with 42 CFR §438.4(b)(1) 7](#_Toc100260692)

[vii. Different FMAP 8](#_Toc100260693)

[viii. Comparison to final certified rates in the previous rate certification 8](#_Toc100260694)

[ix. Future Amendments 8](#_Toc100260695)

[x. COVID-19 public health emergency 8](#_Toc100260696)

[2. Data 9](#_Toc100260697)

[A. Rate Development Standards 9](#_Toc100260698)

[B. Appropriate Documentation 9](#_Toc100260699)

[i. Requested data 9](#_Toc100260700)

[ii. Data used to develop the capitation rates 9](#_Toc100260701)

[iii. Data adjustments 11](#_Toc100260702)

[3. Projected benefit cost and trends 15](#_Toc100260703)

[A. Rate Development Standards 15](#_Toc100260704)

[i. Final Capitation Rate Compliance 15](#_Toc100260705)

[ii. Benefit Cost Trend Assumptions 15](#_Toc100260706)

[iii. In Lieu Of Services 15](#_Toc100260707)

[iv. IMDs as an in-lieu-of service provider 15](#_Toc100260708)

[B. Appropriate Documentation 15](#_Toc100260709)

[i. Projected Benefit Costs 15](#_Toc100260710)

[ii. Development of Projected Benefit Costs 15](#_Toc100260711)

[iii. Projected Benefit Cost Trends 22](#_Toc100260712)

[iv. Mental Health Parity and Addiction Equity Act Service Adjustment 24](#_Toc100260713)

[v. In Lieu of Services 25](#_Toc100260714)

[vi. Retrospective Eligibility Periods 25](#_Toc100260716)

[vii. Impact of Material Changes 25](#_Toc100260717)

[viii. Documentation of Material Changes 26](#_Toc100260718)

[4. Special Contract Provisions Related to Payment 27](#_Toc100260719)

[A. Incentive Arrangements 27](#_Toc100260720)

[i. Rate Development Standards 27](#_Toc100260721)

[ii. Appropriate Documentation 27](#_Toc100260722)

[B. Withhold Arrangements 27](#_Toc100260723)

[i. Rate Development Standards 27](#_Toc100260724)

[ii. Appropriate Documentation 27](#_Toc100260725)

[C. Risk Sharing Mechanisms 28](#_Toc100260726)

[i. Rate Development Standards 28](#_Toc100260727)

[ii. Appropriate Documentation 28](#_Toc100260728)

[D. Delivery system and provider payment initiatives 30](#_Toc100260729)

[i. Rate Development Standards 30](#_Toc100260730)

[ii. Appropriate Documentation 30](#_Toc100260731)

[E. Pass-Through Payments 33](#_Toc100260732)

[i. Rate Development Standards 33](#_Toc100260733)

[ii. Appropriate Documentation 33](#_Toc100260734)

[5. Projected non-benefit costs 34](#_Toc100260735)

[A. Rate Development Standards 34](#_Toc100260736)

[i. Overview 34](#_Toc100260737)

[ii. PMPM versus percentage 34](#_Toc100260738)

[B. Appropriate Documentation 34](#_Toc100260743)

[i. Development of non-benefit costs 34](#_Toc100260744)

[ii. Non-benefit costs, by cost category 35](#_Toc100260745)

[iii. Historical non-benefit cost 35](#_Toc100260746)

[6. Risk Adjustment and Acuity Adjustments 36](#_Toc100260747)

[A. Rate Development Standards 36](#_Toc100260748)

[i. Overview 36](#_Toc100260749)

[ii. Risk adjustment model 36](#_Toc100260750)

[iii. Acuity adjustments 36](#_Toc100260751)

[B. Appropriate Documentation 36](#_Toc100260752)

[i. Prospective risk adjustment 36](#_Toc100260753)

[ii. Retrospective risk adjustment 37](#_Toc100260754)

[iii. Changes to risk adjustment model since last rating period 37](#_Toc100260755)

[iv. Acuity adjustments 37](#_Toc100260756)

[Section II. Medicaid Managed care rates with long-term services and supports 38](#_Toc100260757)

[Section III. New adult group capitation rates 39](#_Toc100260758)

[1. Data 39](#_Toc100260759)

[A. Data Used in Certification 39](#_Toc100260760)

[B. Description of Emerging Data 39](#_Toc100260761)

[i. New data available for rate setting 39](#_Toc100260762)

[ii. Monitoring of experience 39](#_Toc100260763)

[iii. Comparison to previous rate certifications 39](#_Toc100260764)

[iv. Adjustment to current rates 39](#_Toc100260765)

[2. Projected Benefit Costs 40](#_Toc100260766)

[A. Description of Projected Benefit Cost Issues 40](#_Toc100260767)

[i. For states that covered the new adult group in previous rating periods 40](#_Toc100260768)

[ii. For new adult groups not covered in previous rating periods 40](#_Toc100260769)

[iii. Key assumptions 40](#_Toc100260770)

[B. Other Material Changes or Adjustments to Benefit Costs 41](#_Toc100260771)

[3. Projected Non-Benefit Costs 41](#_Toc100260772)

[A. Description of Issues 41](#_Toc100260773)

[i. Changes in data sources, assumptions, or methodologies 41](#_Toc100260774)

[ii. Assumption changes for previous rating periods 41](#_Toc100260775)

[B. Assumption Differences Relative to Other Medicaid Populations 41](#_Toc100260776)

[4. Final Certified Rates 41](#_Toc100260777)

[A. CMS Requests 41](#_Toc100260778)

[i. Comparison to Previous Certification 41](#_Toc100260779)

[ii. Description of Other Material Changes to the Capitation Rates 41](#_Toc100260780)

[5. Risk Mitigation Strategies 41](#_Toc100260781)

[A. Description of Risk Mitigation Strategy 41](#_Toc100260782)

[B. Changes to Risk Mitigation Strategy Relative to Prior Years 41](#_Toc100260783)

[Limitations 42](#_Toc100260784)

[Appendix 1: Actuarial Certification](#_Toc100260785)

[Appendix 2: CY 2019 Base Data Development](#_Toc100260786)

[Appendix 3: SFY 2023 Projected Benefit Expense Development](#_Toc100260787)

[Appendix 4: SFY 2023 Capitation Rate Development](#_Toc100260788)

# 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 Medicaid managed care program effective July 1, 2022 for state fiscal year (SFY) 2023. This letter provides documentation for the development of the actuarially sound capitation rates. It also includes the required actuarial certification in Appendix 1.

At the time of this report, we acknowledge there continues to be 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.

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). Section II of the CMS guide is not applicable to this certification, as Rhode Island’s Medicaid managed care program does not include long-term services and supports.

Fiscal impact estimate

The actuarially sound capitation rates for the Medicaid Managed Care 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 July 1, 2022 rates relative to the rates effective July 1, 2021 for the Medicaid managed care program. The composite rates illustrated for both SFY 2022 and SFY 2023 were developed based on projected monthly enrollment for SFY 2023 and are illustrated on a per member per month (PMPM) basis.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 1: COMPARISON WITH SFY 2022 RATES (PMPM BASIS)** | | | | |
| **Population** | **Estimated SFY 2023 Average Monthly Enrollment** | **SFY 2022 Composite Rates** | **SFY 2023 Composite Rates** | **% Change** |
| RIte Care | 170,711 | $ 306.21 | $ 313.05 | 2.2% |
| CSHCN | 9,660 | 1,161.06 | 1,208.59 | 4.1% |
| Medicaid Expansion | 107,096 | 663.80 | 647.97 | (2.4%) |
| Rhody Health Partners | 14,545 | 1,929.00 | 1,980.85 | 2.7% |
| SOBRA | 423 | 13,611.28 | 14,552.46 | 6.9% |
| **Composite** | **302,012** | **$ 557.56** | **$ 561.15** | **0.6%** |

**Notes:**

1. SFY 2022 and SFY 2023 composite rates were developed based on projected SFY 2023 average monthly enrollment.
2. SOBRA enrollment reflects the estimated count of monthly deliveries.
3. SFY 2022 capitation rates reflect the capitation rates contained in the “State Fiscal Year 2022 Medicaid Managed Care Capitation Rate Second Amendment” dated June 15, 2022, inclusive of directed payments with separate payment terms.

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

|  |  |  |  |
| --- | --- | --- | --- |
| **FIGURE 2: COMPARISON WITH SFY 2022 EXPENDITURES ($ MILLIONS)** | | | |
| **Population** | **SFY 2022 Aggregate Expenditures** | **SFY 2023 Aggregate Expenditures** | **Expenditure Change** |
| RIte Care | $ 627.3 | $ 641.3 | $ 14.0 |
| CSHCN | 134.6 | 140.1 | 5.5 |
| Rhody Health Partners | 336.7 | 345.7 | 9.0 |
|  |  |  |  |
| Subtotal Medicaid | 1,098.6 | 1,127.1 | 28.5 |
| Federal | 595.3 | 610.8 | 15.5 |
| State | 503.3 | 516.3 | 13.0 |
|  |  |  |  |
| Medicaid Expansion | 853.1 | 832.7 | (20.4) |
| Federal | 767.8 | 749.5 | (18.3) |
| State | 85.3 | 83.3 | (2.0) |
|  |  |  |  |
| SOBRA | 69.0 | 73.8 | 4.8 |
| Federal | 41.3 | 44.2 | 2.9 |
| State | 27.7 | 29.6 | 1.9 |
|  |  |  |  |
| **Total** | **$ 2,020.7** | **$ 2,033.7** | **$ 13.0** |
| **Total Federal** | **$ 1,404.4** | **$ 1,404.4** | **$ 0.0** |
| **Total State** | **$ 616.3** | **$ 629.2** | **$ 12.9** |

**Notes:**

1. Values have been rounded.
2. SFY 2022 and SFY 2023 aggregate expenditures were developed based on projected SFY 2023 average monthly enrollment.
3. State expenditures for populations other than Medicaid Expansion are based on Federal Fiscal Year (FFY) 2022 Federal Medical Assistance Percentage (FMAP) of 54.88% for three months and FFY 2023 FMAP of 53.96% for nine months. No adjustment was made for Families First Coronavirus Response Act enhanced FMAP, Children’s Health Insurance Program (CHIP), or other enhanced FMAP rates.
4. State expenditures for the Medicaid Expansion population are based FMAP of 90.00%.
5. The federal and state SOBRA expenditures are allocated based on the portion of SOBRA capitation payments estimated to be associated with RIte Care and Medicaid Expansion members and their corresponding FMAP.

# Section I. Medicaid managed care rates

## 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 most recent 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]](#footnote-2)

### Rate Development Standards

#### Rate ranges

The SFY 2023 Medicaid managed care program capitation rate development does not utilize rate ranges.

#### Annual basis

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

#### Required elements

##### Actuarial certification

The actuarial certification, signed by Jason A. Clarkson, FSA, is in Appendix 1. Mr. Clarkson 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 SFY 2023 managed care program rating period.

##### Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Appendix 4. Member months illustrated in Appendix 4 represent projected values for SFY 2023 under the assumptions outlined in this report. These rates represent the contracted capitation rates prior to risk adjustment.

##### Program information

###### Managed Care program

EOHHS operates the Medicaid managed care program for its population covered by Medicaid who meet the state-defined criteria for enrollment in a risk-based managed care organization (MCO). The managed care populations in this report are composed of low-income children, parents and caretakers, pregnant women, disabled children and adults, adoption subsidy and substitute care, and the Affordable Care Act (ACA) Medicaid expansion population.

Under the managed care program, comprehensive services are provided through the following three MCOs on a statewide basis:

* Neighborhood Health Plan of Rhode Island
* Tufts Health Public Plans
* UnitedHealthcare of New England

Benefits covered under the Medicaid managed program are comprehensive in nature for all populations except for the Extended Family Planning rate cell, which covers a limited set of family planning services. Long-term services and supports are covered on a fee-for-service basis for the Children with Special Healthcare Needs and Rhody Health Partners population. The following figure outlines the core benefits covered under the managed care capitation rate for the covered populations.

|  |  |
| --- | --- |
| **FIGURE 3: MANAGED CARE BENEFIT PACKAGE** | |
| Inpatient and Outpatient Hospital | School-Based Clinic Services |
| Therapies | Services of Other Practitioners |
| Physician Services | Court Ordered Mental Health and Substance Use Services |
| Family Planning Services | Court Ordered Treatment for Children |
| Prescription and Non-Prescription Drugs | Podiatry Services |
| Laboratory, Radiology, and Diagnostic Services | Optometry Services |
| Mental Health and Substance Use Inpatient and Outpatient Services | Oral Health |
| Home Health and Home Care Services | Hospice Services |
| Preventive Services | Durable Medical Equipment |
| EPSDT Services | Case Management |
| Emergency Room Services | Transplant Services |
| Emergency Transportation | Rehabilitation services |
| Nursing Home and Skilled Nursing Facility Care | Other Miscellaneous Services |

Note: COVID-19 vaccine administration professional charges are covered under a non-risk payment from EOHHS to the MCOs.

Covered services are consistent with the SFY 2022 benefit package. Detailed benefit coverage information for all benefits listed in this figure can be found within Attachment A, “Schedule of In-Plan Benefits” in the MCO Medicaid Managed Care Services contracts. In-lieu-of services may also be provided with written approval from EOHHS.

###### Rating period

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

###### Covered populations

The EOHHS Medicaid managed care programs covered in this report includes Medicaid beneficiaries in four distinct populations:

* **RIte Care:** Children, pregnant women, parents, and caretaker populations.
* **Children with Special Healthcare Needs (CSHCN):** Children eligible for Supplemental Security Income (SSI), adoption subsidy, substitute care, and Katie Beckett populations.
* **Medicaid Expansion:** Population eligible for Medicaid under the Affordable Care Act (ACA) Medicaid expansion.
* **Rhody Health Partners (RHP):** Non-dual disabled adults.

Note that the Medicare-Medicaid Plan (MMP) Demonstration / Rhody Health Options Integrity, PACE, and RIte Smiles managed care programs are outside the scope of this certification.

The three MCOs cover all of the above populations with the exception of the CSHCN Substitute Care rate cell, which is solely covered by Neighborhood Health Plan of Rhode Island. Figure 4 illustrates the corresponding rate cells and pay levels for the populations covered in this certification.

| **FIGURE 4: MANAGED CARE CAPITATION RATE CELLS** | | |
| --- | --- | --- |
| **Population** | **Rate Cell** | **Pay Level** |
| **RIte Care** | MF <1 | 001 |
| MF 1-5 | 005 |
| MF 6-14 | 009 |
| M 15-44 | 013 |
| F 15-44 | 017 |
| MF 45+ | 021 |
| EFP | 028 |
| **Children with Special Healthcare Needs** | Adoption Subsidy | 060 – 064 |
| Katie Beckett | 050 – 054 |
| SSI < 15 | 040 – 042 |
| SSI >= 15 | 043 – 044 |
| Substitute Care | 033 – 037 |
| **Medicaid Expansion** | F 19-24 | ME01 |
| F 25-29 | ME02 |
| F 30-39 | ME03 |
| F 40-49 | ME04 |
| F 50-64 | ME05 |
| M 19-24 | ME06 |
| M 25-29 | ME07 |
| M 30-39 | ME08 |
| M 40-49 | ME09 |
| M 50-64 | ME10 |
| **Rhody Health Partners** | RHP – ID | RH40 |
| RHP – SPMI | RH30 |
| RHP – Other Disabled 21-44 | RH10 |
| RHP – Other Disabled 45+ | RH20 |
| **SOBRA** | SOBRA | N/A |

Enrollment values in this report reflect partial months for the RIte Care and Children with Special Healthcare Needs populations. Partial payments are not made for the remaining populations. The SOBRA capitation rate is paid for eligible maternity claims associated with RIte Care and Medicaid Expansion members. The SOBRA capitation rate does not differ between RIte Care and Medicaid Expansion members, and as a result, the composite experience for the SOBRA capitation rate is illustrated in this report.

###### Eligibility criteria

Eligible Medicaid beneficiaries are required to enroll in managed care on a mandatory basis. Beneficiaries are covered under the fee-for-service program for an initial period as the managed care plan enrollment process occurs. Members may be excluded from managed care in certain circumstances, such as the presence of other insurance coverage.

###### Special contract provisions

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

* Withhold metrics
* Incentive payments
* Risk sharing arrangement
* Directed Payments

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

###### Retroactive adjustment to capitation rates

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

#### 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.

#### 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.

#### Effective dates

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

#### 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, which includes provisions for non-benefit costs that are appropriate and attainable.

#### Rate ranges

The SFY 2023 Medicaid managed care program capitation rate development does not utilize rate ranges.

#### Actuarial soundness of rate ranges

The SFY 2023 Medicaid managed care program capitation rate development does not utilize rate ranges.

#### Generally accepted actuarial practices and principles

##### 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. To our knowledge, all reasonable, appropriate, and attainable costs have been included in the certification.

##### Outside the rate setting process

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

##### Final contracted rates

The SFY 2023 capitation rates certified in this report represent the final contracted rates by rate cell prior to risk adjustment.

#### Rate certification for effective time periods

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

#### COVID-19 public health emergency

We considered the direct and indirect impact of COVID-19 on the covered population and services in SFY 2023. This 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.

#### Procedures for rate certification and amendment

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.

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. A new rate certification will be provided to account for any costs invalidated by courts of law, or changes in federal statues, regulations, or approvals.

Any update to the payment terms by application of this risk adjustment methodology will be provided to CMS consistent with 42 CFR §438.3(c).

### Appropriate Documentation

#### Capitation rate certification

The SFY 2023 Medicaid managed care rate development specifies capitation rates for each rate cell.

#### 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.

#### 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).

#### Rate range boundaries

The SFY 2023 Medicaid managed care program capitation rate development does not utilize rate ranges.

#### 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.

#### Compliance with 42 CFR §438.4(b)(1)

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

#### Different FMAP

Capitated payments for CSHCN, RHP, and RIte Care populations receive the standard state FMAP of 54.88% in FFY 2022 and 53.96% in FFY 2023. The Medicaid Expansion population receives an enhanced 90% FMAP.

The enhanced FMAP of 68.42% in FFY 2022 and 67.77% in FFY 2023 for children who are eligible for Title XXI benefits, the enhanced FMAP provided by the Families First Coronavirus Response Act (6.2% increase), and 90% enhanced FMAP for family planning services are not reflected in the values provided in Figure 2.

#### 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 Appendix 4. All material changes to the capitation rates and rate development process compared to the previous rate certification are described in this report.

#### Future Amendments

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

#### 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. This analysis and estimated impacts are described in detail in Section I.3.B.ii.(a).

As previously stated, the 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.

##### Available data

Rhode Island Medicaid managed care data through December 31, 2021,inclusive of incurred but not paid (IBNP) expenditures, was evaluated to understand emerging experience during the PHE. Encounter data, program enrollment, and MCO submitted Financial Data Cost Reports (FDCRs) 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.

##### 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, prospective trends, and COVID-19 testing adjustment described in section I.3.B.

##### Non-risk payments

In SFY 2023, COVID-19 vaccines will be paid for and provided by the federal government, and professional administration fees paid by the MCOs will be fully reimbursed through a non-risk payment for COVID-19 vaccine administration. As a result, no adjustment is made for the cost of COVID-19 vaccinations in SFY 2023.

##### 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. The risk sharing mechanism that was established prior to the PHE is unchanged, as described in Section I.4.C.

## 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 2.

### 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.

### Appropriate Documentation

#### Requested data

Milliman receives eligibility, capitation, encounter, and fee-for-service claim files from EOHHS on a monthly basis. In addition, Milliman receives quarterly cost reports from the MCOs. Milliman reviewed January 1, 2019 through December 31, 2021 experience with claims runout through December 31, 2021 for the SFY 2022 rate setting process.

The base data used in the SFY 2023 capitation rate development includes calendar year (CY) 2019 experience and is summarized in Appendix 2. CY 2019 was chosen as a base data period due to it not being impacted by the COVID-19 pandemic. As described in Section I, item 3 “Projected benefit cost and trends”, the capitation rates are adjusted to reflect emerging experience observed in the PHE environment.

The remainder of this section details the base data and validation processes utilized in the SFY 2023 capitation rate development.

#### Data used to develop the capitation rates

##### Description of the data

###### Types of data

The primary data sources for the SFY 2023 capitation rate development include the following:

* Encounter data submitted by the MCOs;
* Eligibility and capitation payment data provided by EOHHS;
* Calendar Year 2021 Quarter 3 (CY 2021 Q3) Financial Data Cost Reports (FDCRs) submitted by the MCOs;
* Calendar Year 2021 Quarter 4 (CY 2021 Q4) FDCRs submitted by the MCOs; and,
* MCO Survey responses provided by the MCOs.

###### Age of the data

The data serving as the base experience in the capitation rate development process was incurred during CY 2019. The CY 2021 Q3 FDCR submissions used in the base data development reflect claims paid through September 30, 2021. The encounter data used in the base data development reflects encounters paid through September 30, 2021, consistent with the CY 2021 Q3 FDCR submissions. These data sources were utilized in the base data adjustments described in Section I, item 2.B.iii, “Data adjustments”.

For the purposes of analyzing prospective program adjustments, we reviewed encounter data submissions included in the EOHHS encounter data transferred to Milliman on March 15, 2022, and financial experience included in the CY 2021 Q4 FDCR through December 31, 2021.

###### Data sources

The historical encounter data used for this certification was submitted by Neighborhood Health Plan of Rhode Island, Tufts Health Public Plans, and UnitedHealthcare of New England. The encounter data, eligibility, and capitation payment data was provided to Milliman by EOHHS.

The FDCRs and MCO Surveys were submitted by the MCOs to EOHHS, and EOHHS transferred this information to Milliman.

###### Sub-capitation

The CY 2019 base encounter data reflects sub-capitated federally qualified health center (FQHC) experience for one MCO. As described later in this report, FQHC prospective payment system (PPS) services were adjusted to the PPS rate since the MCOs are responsible for the full PPS amount effective July 1, 2019. In addition, encounter experience reflects sub-capitated behavioral health experience for one MCO. The behavioral health sub-capitated encounters are utilized for purposes of the SFY 2023 rate development.

##### Availability and quality of the data

###### Steps taken to validate the data

The base experience used in the capitation rates relies on encounter data and CY 2021 Q3 FDCRs submitted to EOHHS by participating MCOs. Managed care eligibility is maintained by EOHHS. The actuary, the MCOs, and EOHHS all play a role in validating the quality of encounter data used in the development of the capitation rates. The MCOs play the initial role, collecting and summarizing data sent to the state. EOHHS focuses on encounter data quality and MCO performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. In addition, we perform independent analysis of encounter data and FDCRs to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area.

**Completeness**

The EOHHS Data Quality Team routinely reviews the completeness of the submitted encounter data:

* The MCOs are contractually required to submit claims for all billable services provided to Medicaid members.
* Plans submit a monthly Financial Summary Report that is stratified by fiscal year and population. This report is required to reconcile to the MCO’s financials. The submitted encounter data is then compared to the Financial Summary Report for completeness.
* MCO’s are contractually required to maintain their files with less than a 2% error rate in any submission cycle.

In addition, Milliman applies several measures to the MCO-submitted encounter data used in rate setting to evaluate the completeness of the data. A sample of measures focused on the completeness of the data include:

* Encounter data volume measures by population and service category;
* Comparison against the FDCRs by population and service category; and,
* Comparison against the File Submission Reports by population and service category.

We also summarize the encounter data to assess month to month completeness of the encounter data. These measures are applied to identify any months where encounter data volume is unusually large or small, indicating a potential issue with the submitted encounter data.

In addition, we reviewed each submission of the FDCRs to identify large data variances, incomplete data, and other reporting issues. Any identified issues were provided to each MCO by EOHHS and the FDCRs were re-submitted to EOHHS as necessary.

**Accuracy**

The EOHHS Data Quality Team performs multiple edits to ensure the accuracy of the submitted encounter data:

* MCO encounters are required to pass all the edit and load criteria set out in the encounter companion guide, which are similar to the edits required for fee-for-service claims.
* EOHHS maintains a monthly utilization tracking report that illustrates services provided to Medicaid beneficiaries and tracks trends by utilization category and line of business. This report is used to identify any gaps in MCO submissions.
* The Data Quality Team meets on a bi-weekly basis to identify more nuanced errors in the data, such as encounter submission issues with specific services or for fields not specifically addressed by the automated edits.

We review the accuracy of the encounter data by comparing expenditures to outside data sources including the File Submission Reports (FSR) and FDCR submissions. We summarize the encounter data into an actuarial cost model format that is consistent with the format of the base experience illustrated in Appendix 2. The MCOs were provided with their specific experience contributing to the base data in Appendix 2 to verify its accuracy.

Annual base period data summaries are created to ensure that the data for each service is consistent across the MCOs and with prior historical periods. Stratification by rate cell facilitates this review, as it minimizes the impact of changes in population mix. This process is used to review MCO and service category combinations that may have unreasonable reported data.

**Consistency of data across data sources**

We performed a detailed review of the encounter data used in the development of capitation rates effective July 1, 2022. Assessing the encounter data for consistency with the FDCR was a critical part of the rate development process. We also reviewed the FDCR against the FSR for consistency of expenditures across various data sources.

We reviewed enrollment records against capitation payment records and EOHHS internal summaries. The enrollment records were determined to be consistent across various data sources.

###### 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.

We found the encounter data to be of appropriate quality for developing the SFY 2023 capitation rates, with adjustment for data missing from the EOHHS encounter data warehouse as described in Section I, item 2.B.iii.a.

###### Data concerns

We compared the encounter data against the FDCR submissions and did not have material concerns regarding the availability or quality of the base data utilized for the capitation rate development.

##### Appropriate data

Managed care encounter data was the primary data source used in the development of the capitation rates.

##### 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 covered services and populations.

#### Data adjustments

Capitation rates utilize CY 2019 encounter data as the base experience. Adjustments were made to the base experience for data quality, completion, payments not captured in the MCOs’ claim systems, recoveries, and other program adjustments. The following sections describe the adjustments made to the base data cost models presented in Appendix 2.

##### Credibility adjustment

Data Quality Adjustment

We reviewed MCO encounter data and FDCR information for consistency of reported benefit expense across data sources. Data quality was evaluated at the rate cell and service category level. The data was found to be suitable for capitation rate development purposes, with adjustment for encounter data quality issues. A data quality adjustment was applied at the population and service category level (with professional, ancillary, and LTSS combined) to the base encounter data to account for encounter data quality issues, such as services that were provided by the MCOs but were not reported as an encounter at the time of data extraction.

Certain rate cells and service categories were adjusted at a more granular level to reflect observed issues in the encounter data reporting:

**Rate Cells Adjusted Separately**

RIte Care Children <1

RIte Care SOBRA and Medicaid Expansion SOBRA

The data quality adjustment was applied separately to the RIte Care and Medicaid Expansion SOBRA payments, which were then composited into a single rate cell.

**Service Categories Adjusted Separately**

Outpatient Pharmacy

Professional Office Administered Drugs

Non-state plan expenditures were removed as a component of the data quality adjustment. In addition, inpatient expenditures for the RIte Care Extended Family Planning rate cell were excluded in this adjustment. These expenditures were removed to reflect that they are not covered under the Medicaid managed care program.

Figure 5 illustrates the PMPM impact of data quality adjustments for each population in CY 2019.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 5: CALENDAR YEAR 2019 DATA QUALITY ADJUSTMENT** | | | | |
| **Population** | **Member Months / Deliveries** | **Base Encounter Data PMPM** | **Adjusted for Data Quality** | **Percent Difference** |
| **CY 2019** |  |  |  |  |
| RIte Care | 1,831,343 | $ 216.06 | $ 224.40 | 3.9% |
| Children with Special Healthcare Needs | 114,092 | 891.84 | 943.32 | 5.8% |
| Medicaid Expansion | 840,364 | 493.72 | 513.61 | 4.0% |
| Rhody Health Partners | 175,342 | 1,536.15 | 1,594.00 | 3.8% |
| SOBRA | 4,671 | 11,434.22 | 11,986.58 | 4.8% |

Note: Values have been rounded.

##### Completion adjustment

Completion Adjustment

The data submitted by the MCOs was adjusted to reflect claims completion. IBNP adjustments were applied at the population and service category level (with professional, ancillary, and LTSS combined).

MCO-reported IBNP in the FDCR was reviewed and determined to be reasonable for purposes of the SFY 2023 capitation rate development, and as a result, the MCO reported amounts were utilized for the completion adjustment. Provision for adverse deviation (PAD) was removed from the MCO reported IBNP to the extent it was reported.

Figure 6 illustrates the PMPM impact of completion adjustment for each population in CY 2019.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 6: CALENDAR YEAR 2019 COMPLETION ADJUSTMENT** | | | | |
| **Population** | **Member Months / Deliveries** | **Adjusted for Data Quality** | **Adjusted for Completion** | **Percent Difference** |
| **CY 2019** |  |  |  |  |
| RIte Care | 1,831,343 | $ 224.40 | $ 224.56 | 0.1% |
| Children with Special Healthcare Needs | 114,092 | 943.32 | 943.56 | 0.0% |
| Medicaid Expansion | 840,364 | 513.61 | 513.83 | 0.0% |
| Rhody Health Partners | 175,342 | 1,594.00 | 1,595.08 | 0.1% |
| SOBRA | 4,671 | 11,986.58 | 11,994.09 | 0.1% |

Note: Values have been rounded.

sub-capitated and Non-Encounterable services Adjustment

**Sub-capitated Services**

The CY 2019 base encounter data reflects sub-capitated federally qualified health center (FQHC) experience for one MCO. The base experience was adjusted to reflect the actual capitated payments made to the FQHCs, as reported in the FDCR.

**Non-Encounterable Services**

The base data was adjusted to include benefit expense that is unable to be submitted to the EOHHS encounter data warehouse. These non-encounterable expenses are reported in the FDCR and include (but are not limited to) the following:

Services paid outside the MCO’s claims payment system

Subrogation expenses

Provider settlements

FQHC Prospective Payment System (PPS) wrap payments reported under non-encounterable expenses were excluded from this adjustment using information submitted in the FDCRs and MCO surveys. The value of PPS wrap payments (adjusted to a SFY 2023 basis) is fully reflected in the prospective program adjustments. Therefore, the base experience reflects the fee-for-service and capitation payments to FQHCs, while the PPS adjustment (described in Section I, item 3.B.ii) reflects the additional amount of funding included in the managed care program attributable to covering the full FQHC PPS reimbursement in the managed care program.

Figure 7 illustrates the PMPM impact of the sub-capitated and non-encounterable services for each population in CY 2019.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 7: CALENDAR YEAR 2019 NON-ENCOUNTERABLE ADJUSTMENT** | | | | |
| **Population** | **Member Months / Deliveries** | **Adjusted for Completion** | **Adjusted for Sub-cap / Non-Encounterable** | **Percent Difference** |
| **CY 2019** |  |  |  |  |
| RIte Care | 1,831,343 | $ 224.56 | $ 229.44 | 2.2% |
| Children with Special Healthcare Needs | 114,092 | 943.56 | 950.69 | 0.8% |
| Medicaid Expansion | 840,364 | 513.83 | 515.34 | 0.3% |
| Rhody Health Partners | 175,342 | 1,595.08 | 1,600.77 | 0.4% |
| SOBRA | 4,671 | 11,994.09 | 12,068.50 | 0.6% |

Note: Values have been rounded.

Recoveries Adjustment

The base experience was adjusted for recoupments made outside the MCO claims payment system. Individual adjustment items are described below:

**Reinsurance Premiums Paid and Reinsurance Recoveries:** MCOs participating in the managed care program are required to carry reinsurance for high-cost claimants. We adjusted encounter data expenses in the base data period for the net cost of coverage (premiums less recoveries) as reported in the CY 2021 Q3 FDCR.

**Other Overpayments:** An adjustment was made for provider overpayments recouped outside the MCO’s claims payment system as reported in the CY 2021 Q3 FDCR.

No adjustments were made for the early intervention, skilled nursing facility, hepatitis C, and transplant stop loss programs. The early intervention and skilled nursing facility stop loss programs were sunset on July 1, 2018, and the hepatitis C and transplant stop loss programs were sunset effective July 1, 2021.

Figure 8 illustrates the PMPM impact of the recoveries adjustment for each population in CY 2019.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 8: CALENDAR YEAR 2019 RECOVERIES ADJUSTMENT** | | | | |
| **Population** | **Member Months / Deliveries** | **Adjusted for Sub-cap / Non-Encounterable** | **Adjusted for Recoveries** | **Percent Difference** |
| **CY 2019** |  |  |  |  |
| RIte Care | 1,831,343 | $ 229.44 | $ 230.08 | 0.3% |
| Children with Special Healthcare Needs | 114,092 | 950.69 | 951.76 | 0.1% |
| Medicaid Expansion | 840,364 | 515.34 | 516.53 | 0.2% |
| Rhody Health Partners | 175,342 | 1,600.77 | 1,603.09 | 0.1% |
| SOBRA | 4,671 | 12,068.50 | 12,064.73 | (0.0%) |

Note: Values have been rounded.

##### Errors found in the data

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

##### Program change adjustments

Retrospective Program Adjustments

Due to the nature of the data adjustments described thus far, the adjustments were applied directly to the base data and not illustrated as separate adjustments. The CY 2019 data included in Appendix 2 illustrate the base data after the application of the above-described adjustments. The remainder of the certification describes the adjustments applied to the base data.

Adjustments in this section represent program changes that occurred during the CY 2019 base data period that were considered when developing the SFY 2023 adjusted base data. Figure 9 illustrates the fiscal impact of the retrospective program changes and is followed by a description the adjustment.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FIGURE 9: CALENDAR YEAR 2019 RETROSPECTIVE PROGRAM ADJUSTMENTS** | | | | | | |
| **Program Change** | **Category of Service Impacted** | **% Impact RIte Care** | **% Impact CSHCN** | **% Impact Medicaid Expansion** | **% Impact Rhody Health Partners** | **% Impact SOBRA** | |
| Recoveries Adjustment | All | (1.3%) | (0.6%) | (1.7%) | (1.5%) | (0.5%) | |

Note: The percentages illustrated are specific to the category of service impacted.

* **Recoveries Adjustment:** The CY 2019 base data was reduced for third-party liability recoveries and pharmacy rebate recoveries. These recovery types were developed as targeted amounts and therefore not removed during the base data development process. These adjustments were developed with consideration of historical experience as well as the interaction with related adjustments, such as managed care efficiencies and targeted pharmacy reimbursement adjustments.

Further detail of the impact of the recoveries adjustments on the CY 2019 experience is illustrated in Appendix 2.

##### Exclusion of payments or services from the data

Non-state plan services were excluded from the base data. The MCOs report non-state plan expenditures separately from state plan services in the FDCR submissions.

## 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 3.

### Rate Development Standards

#### 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). Non-state plan services provided by the MCOs have been excluded from the capitation rate development process.

#### Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions were developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends was 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.

#### In Lieu Of Services

The projected benefit costs include costs for in-lieu-of services defined at 42 CFR § 438.3(e)(2) using the utilization and unit costs of the in-lieu-of services. Further information on in-lieu-of services is provided in Section I, item 3.B.v.

#### IMDs as an in-lieu-of service provider

The Rhode Island Medicaid managed care program primarily uses institutions of mental disease (IMDs) as an in-lieu-of service provider of substance use disorder services. EOHHS obtained an 1115 waiver of the IMD exclusion in section 1905(a)(29)(B) of the Social Security Act to allow Medicaid coverage and federal financial participation for residential treatment services for Medicaid-eligible individuals who have substance use disorders (SUD) and are participating in residential treatment programs with a census of 16 or more beds that are considered IMDs. Since these services are covered under the 1115 waiver, the amount paid to the IMDs for substance use disorder services in the base period was utilized for the SFY 2023 capitation rate development.

EOHHS identified a limited number of psychiatric services provided to members ages 21 through 64 at an IMD. IMD psychiatric stays for these members up to 15 days per month were repriced to an estimated per diem rate through the use of the Rhode Island Medicaid APR-DRG Pricing Calculator[[2]](#footnote-3). Member months and services incurred during psychiatric IMD stays exceeding 15 days in a month (including non-IMD expenditures) were removed from the capitation rate development process. The estimated impact of the repricing psychiatric IMD stays less than 15 days and removing expenditures and exposures for stays over 15 days is illustrated in Figure 10 and applied in Appendix 3.

### Appropriate Documentation

#### 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.

#### Development of Projected Benefit Costs

##### 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 cost summaries**

The capitation rates were developed from historical claims and enrollment data from the enrolled populations as described in Section I.2.B.ii of this report.

**Step 2: Apply data adjustments**

We applied data adjustments to the CY 2019 incurred encounter data as described in Section I.2.B.iii of this report. This includes historical program adjustments and data exclusions.

**Step 3: Adjust for prospective program and policy changes**

The CY 2019 base experience was adjusted for known policy and program changes that were implemented and are expected to be implemented between the base data period and the rating period.

**Step 4: Adjust for managed care efficiencies**

We targeted improvements in managed care efficiency when developing projected SFY 2023 benefit expense.

**Step 5: Trend to SFY 2020**

The adjusted PMPM values from the base experience period were trended forward to the midpoint of the contract period (January 1, 2023). The resulting PMPMs establish the adjusted claim cost by population rate cell for the contract period.

The remainder of this section outlines the adjustments described in Step 3 through Step 5.

Prospective Program and Policy Adjustments

Figure 10 illustrates the fiscal impact of the prospective program changes applied in Appendix 3 of the rate development and is followed by a description of each adjustment. The rate adjustments for the personal care shift differential and personal care behavioral health certification state directed payments are illustrated in Appendix 4.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FIGURE 10: PROSPECTIVE PROGRAM ADJUSTMENTS** | | | | | | |
| **Program Change** | **Category of Service Impacted** | **% Impact RIte Care** | **% Impact CSHCN** | **% Impact Medicaid Expansion** | **% Impact Rhody Health Partners** | **% Impact SOBRA** |
| Respite Care | LTSS | 1.1% | 2.0% | 0.0% | 0.0% | 0.0% |
| COVID Testing | Outpatient Hospital / Professional | 1.6% | 0.6% | 0.9% | 0.3% | 0.0% |
| Doula Service Addition | Professional | 0.0% | 0.0% | 0.0% | 0.0% | 6.1% |
| Psychiatric IMD | All Service Categories | 0.0% | (0.0%) | (0.0%) | (0.3%) | 0.0% |
| Pharmacy Repricing | Retail Pharmacy | (6.3%) | (2.8%) | (2.8%) | (1.8%) | 0.0% |
| FQHC Adjustment | Professional / LTSS | 16.7% | 3.6% | 13.7% | 7.8% | 13.2% |
| Level IV Detoxification | Inpatient Hospital | 0.1% | 0.0% | 0.8% | 0.4% | 0.0% |

Note: The percentages illustrated are specific to the category of service impacted.

* **Respite Care:** EOHHS doubled the number of hours of respite care available to the CSHCN and RIte Care populations. This change was made in response to COVID-19 and will continue in the SFY 2023 rating period. We developed the adjustment based on the additional respite care cost estimate provided by EOHHS. This resulted in a LTSS service cost increase of 2.0% for the CSHCN population and an increase of 1.1% for the RIte Care population.
* **COVID-19 Testing Adjustment:** An adjustment was included to reflect the additional cost of COVID-19 testing incurred by the MCOs in SFY 2023. We considered historical and emerging COVID-19 testing levels, the impact of COVID-19 vaccines and prevalence rates, and the impact of over-the-counter testing utilization to estimate the SFY 2023 COVID-19 testing cost. Additional consideration of COVID-19 impacts is discussed in Section I.3.B.iii, Projected Benefit Cost Trends.
* **Doula Service Addition:** EOHHS submitted a state plan amendment to add coverage for doula services to the managed care benefit package effective July 1, 2021.

Doula services will be reimbursed on a fee-for-service basis at an amount not to exceed $1,500 per pregnancy. We estimated 10% of maternity deliveries would include the use of doula services.

* **Psychiatric IMD:** Psychiatric IMD stays for members ages 21 through 64 up to 15 days per month were repriced to the EOHHS inpatient hospital APR-DRG estimated per diem rate. Member months and services incurred during psychiatric IMD stays exceeding 15 days in a month (including non-IMD expenditures) were removed. The psychiatric IMD adjustment reflects the net impact of these two items.
* **Pharmacy Spread and Targeted Reimbursement:** Pharmacy experience was re-priced to benchmarks relative to average wholesale price (AWP). The target was based on our review of the AWP discounts in the Rhode Island Medicaid managed care and other state markets. Figure 11 illustrates the targeted AWP discount utilized for brand and generic drugs. Pharmacy experience was categorized as brand or generic based on national drug code (NDC) level definitions contained in Medi-span reference data sets, with trademarked single-source and multi-source brand drugs being classified as brand. Targets were developed separately for children and adults, which was determined at the rate cell level (RIte Care children in the age 15-44 rate cells were included with the adult group).

|  |  |  |
| --- | --- | --- |
| **FIGURE 11: AWP Discount Target** | | |
| **Population** | **Generic** | **Brand** |
| Child | 75.00% | 18.50% |
| Adult | 85.00% | 18.50% |

No provision for pharmacy administrative spread was included in the AWP targets illustrated above. Administrative amounts attributable to spread pricing were excluded from pharmacy claims cost and considered in the administrative load development. Supplemental rebate targets as described in Section I, item 2.B.iii.d were considered in the factors illustrated in Figure 11. These targets are generally consistent with historical supplemental rebate experience of the MCOs reported in the FDCR submissions and were developed with consideration for the AWP discount target assumptions.

* **Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) In-Plan:** Effective July 1, 2019, MCOs are required to pay the PPS rate to FQHCs. Prior to July 1, 2019, the MCOs paid FQHCs according to their negotiated rates (or sub-capitation arrangements), and EOHHS paid the FQHCs a wrap-around payment for the difference between the PPS rate and the MCO reimbursement rate. As previously described, the CY 2019 base experience does not include the PPS wrap payments paid for services incurred between July 1, 2019 and December 31, 2019.

To estimate the additional cost of the PPS reimbursement in SFY 2023, the CY 2019 base encounter experience was repriced to the SFY 2023 PPS rate. An adjustment was applied to the base FQHC service utilization consistent with the encounter data quality and IBNP adjustments described in Section I.2.B.iii. In addition, a 10% utilization increase adjustment factor was estimated and applied to reflect observed FQHC utilization growth beyond the estimated non-FQHC professional utilization trends.

* **Level IV Detoxification Services:** EOHHS is continuing the directed payment to increase the per diem reimbursement for Level IV alcohol and drug detoxification programs in SFY 2023. This adjustment reflects an increase in the per diem reimbursement rate to a minimum fee schedule amount of $1,621.80 in SFY 2023 consistent with the preprint previously submitted with control name Preprint\_RI\_Fee\_IPH\_New\_20210701-20220630.
* **Personal Care Shift Differential:** Effective July 1, 2021, reimbursement for personal care and combined personal care/homemaker services (procedure code S5125) with a shift differential modifier was increased by $0.19 per fifteen minutes via a state directed payment. The shift differential applies to services provided on an evening, night, or weekend/holiday (indicated by procedure code modifier values of UH, UJ, and TV).

We estimated the impact of the shift differential directed payment based on the utilization of personal care and combined personal care/homemaker services in the SFY 2021 data period to reflect emerging experience since the beginning of the COVID-19 pandemic. Utilization was trended to a SFY 2023 basis using the prospective HCBS utilization trends used in the SFY 2023 capitation rate development. The PMPM adjustment by rate cell is illustrated in Appendix 4.

* **Personal Care Behavioral Health Certification Enhancement:** Effective January 1, 2022, a new behavioral health certification enhancement of $0.39 per fifteen minutes of personal care, combined personal care/homemaker, and homemaker only services (procedure codes S5125 and S5130) was implemented for providers who have at least 30% of their direct-care workers certified in behavioral health training via a state directed payment. We assumed that 15% of these services would be performed by providers who qualify for the behavioral health enhancement based on communication with EOHHS.

The impact of the behavioral health certification enhancement directed payment was estimated using consistent data and methodology as the shift differential directed payment. The PMPM adjustment by rate cell is illustrated in Appendix 4.

Acuity and Emerging Experience Adjustments

We observed evidence of changing levels of acuity and service utilization in the Medicaid program between the CY 2019 base data period and emerging experience since the onset of the COVID-19 pandemic. The pandemic and increasing Medicaid program enrollment associated with the Families First Coronavirus Response Act continuous coverage requirement are estimated to contribute to the acuity shifts and service utilization changes. An acuity and emerging experience adjustment was estimated to account for these changes to the extent they are expected to continue into the SFY 2023 rating period. As previously stated, the PHE was assumed to continue throughout SFY 2023 in this certification.

We considered the following items when estimating the acuity and emerging experience adjustment:

* **Trended calendar year 2019 experience:** We trended the CY 2019 experience utilizing the estimated prospective trends illustrated in Section I, item 3.B.iii to the emerging experience period. For purposes of this analysis, we reviewed the trended calendar year 2019 experience compared to the experience in the emerging experience period. The CY 2019 experience was adjusted to facilitate a consistent comparison with the emerging experience for program changes such as the estimated enhanced respite care benefit expenditures.
* **Emerging experience:** We reviewed the emerging experience from July 1, 2020, to December 31, 2021, reported in the CY 2021 Q4 FDCR. Adjustments were made to facilitate a consistent comparison with the trended CY 2019 experience, such as removing COVID-19 vaccine administration expenditures and adjusting for rate cell mix changes.
* **Direct COVID-19 costs:** We reviewed the percentage of claims directly attributable to COVID-19 infections. We reviewed this data to understand the magnitude of direct COVID-19 costs in the emerging experience.
* **Elective procedures:** We reviewed the percentage of claims attributed to elective procedures. We reviewed this data to understand the potential for service deferral, especially during COVID-19 outbreaks, in the emerging experience.
* **Changes relative to the rating period:** We considered potential changes in member behavior and acuity between the emerging experience reviewed and the rating period. We assume that a subset of utilization in the emerging experience period that was potentially suppressed may emerge in the SFY 2023 rating period. In addition, increases in member enrollment between the emerging experience period and the rating period may lead to further acuity changes. Finally, we recognize that future COVID-19 variants or outbreaks may affect member utilization in the rating period.

The adjusted emerging experience was compared to the trended CY 2019 experience to understand the impact of changes in acuity and service utilization. This analysis was performed at a population and service category detail level. When selecting the acuity and emerging experience adjustment, we considered the stability of the emerging experience and the items outlined above. We note that there continues to be material uncertainty around the potential impact of COVID-19 on service utilization in SFY 2023.

Figure 12 illustrates the impact of the acuity and emerging experience adjustment by population and service category.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FIGURE 12: CALENDAR YEAR 2019 ACUITY AND EMERGING EXPERIENCE ADJUSTMENT** | | | | | | | |
| **Category of Service Impacted** | **% Impact RIte Care <15** | **% Impact RIte Care 15+** | **% Impact EFP** | **% Impact CSHCN** | **% Impact Medicaid Expansion** | **% Impact Rhody Health Partners** | **% Impact SOBRA** |
| Inpatient Hospital | (7.5%) | 5.0% | (7.5%) | 15.0% | 0.0% | 7.5% | 0.0% |
| Outpatient Hospital | (2.5%) | (5.0%) | (7.5%) | 7.5% | (2.5%) | 10.0% | 0.0% |
| Professional | (2.5%) | 2.5% | (7.5%) | (2.5%) | (5.0%) | (5.0%) | 0.0% |
| Emergency Room | (12.5%) | (10.0%) | (7.5%) | (5.0%) | (10.0%) | 0.0% | 0.0% |
| Behavioral Health | 10.0% | 0.0% | (7.5%) | 0.0% | (5.0%) | 2.5% | 0.0% |
| Retail Pharmacy | (5.0%) | (5.0%) | (7.5%) | 0.0% | (10.0%) | (10.0%) | 0.0% |
| Ancillary | (2.5%) | 2.5% | (7.5%) | (2.5%) | (5.0%) | (5.0%) | 0.0% |
| LTSS | (2.5%) | 2.5% | (7.5%) | (2.5%) | (5.0%) | (5.0%) | 0.0% |

Managed Care Adjustments

We calculated percentage adjustments to the experience data to reflect the utilization and cost per unit differential between the managed care experience and the levels targeted for the projection period managed care environment. To reflect that the interaction between the managed care adjustments and the acuity and emerging experience adjustment, the managed care efficiency adjustments were developed using SFY 2021 data, with the exception of the vaginal and cesarean section deliveries adjustment. CY 2019 managed care efficiency metrics were reviewed for consistency and to understand the potential impact of the PHE but were not directly used in the managed care efficiency adjustment development. In addition, the target reduction in the percentage of potentially avoidable emergency room visits was reduced relative to prior rating periods to reflect the overall reduction in emergency room visits.

We developed the targeted managed care efficiency adjustments through a review and analysis of the following:

* Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQI) for inpatient admissions
* Inpatient hospital readmissions with the same DRG
* Potentially avoidable emergency room utilization
* Mix of vaginal and cesarean section deliveries
* Polypharmacy savings for script reduction
* Fraud, Waste, and Abuse savings

Inpatient Hospital

We estimated managed care efficiency adjustments to reflect higher levels of care management in the rating period relative to the base and emerging experience period. We identified potentially avoidable admissions using the AHRQ prevention quality indicators (PQI). We also analyzed the frequency of re-admissions for the same DRG. Inpatient hospital managed care adjustments were developed by applying assumed reductions to potentially avoidable inpatient admissions and same-DRG readmissions. This analysis was completed at the rate cell level.

Our analysis was completed by reducing readmissions within 30 days and reducing non-readmissions for select PQIs. Inpatient hospital managed care adjustments were developed by applying a 10% reduction to same-DRG readmissions and a 5% reduction to potentially avoidable inpatient admissions. In completing our analysis, we estimated inpatient hospital unit cost changes based on the utilization reductions outlined above. No adjustments were made to corresponding inpatient physician charges to account for the potential shift of these services to an ambulatory setting. Nursing facility claims were excluded from this analysis. The figure below outlines the PQIs included in the analysis.

|  |  |
| --- | --- |
| **FIGURE 13: AHRQ PREVENTION QUALITY INDICATORS** | |
| **PQI NUMBER** | **DESCRIPTION** |
| PQI #01 | Diabetes Short-term Complications Admission Rate |
| PQI #02 | Perforated Appendix Admission Rate |
| PQI #03 | Diabetes Long-term Complications Admission Rate |
| PQI #05 | Chronic Obstructive Pulmonary Disease (COPD) Admission Rate |
| PQI #07 | Hypertension Admission Rate |
| PQI #08 | Congestive Heart Failure (CHF) Admission Rate |
| PQI #10 | Dehydration Admission Rate |
| PQI #11 | Bacterial Pneumonia Admission Rate |
| PQI #12 | Urinary Tract Infection Admission Rate |
| PQI #13 | Angina without Procedure Admission Rate |
| PQI #14 | Uncontrolled Diabetes Admission Rate |
| PQI #15 | Adult Asthma Admission Rate |
| PQI #16 | Rate of Lower-extremity Amputation among Patients with Diabetes |

Emergency Room

For the outpatient hospital emergency room service category, multiple potentially avoidable diagnosis groups were clinically developed using the primary diagnosis of each claim. The potentially avoidable diagnosis groups were stratified by severity to target potentially avoidable emergency room visits, starting with the lowest severity group. In addition, potentially avoidable outpatient hospital emergency room visits were summarized by rate cell. Target utilization levels were developed by assuming a 10% decrease in potentially avoidable services using SFY 2021 experience.

When applying these adjustments, reductions were taken from level 1 emergency room claims first, followed by level 2, and level 3 claims up to an assumed cap for each level. We assumed that 95% of emergency room visits reduced would be replaced with an office visit. This process was completed at a rate cell level.

In addition, we reviewed historical Rhode Island experience, along with data from other Medicaid states, to develop assumptions for additional services that may also be included with an office visit. Based on this review, additional services related to pathology/lab and radiology were included with the replacement office visit.

Delivery Services

We reviewed the mix of vaginal and cesarean section deliveries by MCO to determine appropriate efficiency adjustments for SOBRA payments. Delivery managed care efficiency adjustments were developed by analyzing the percent ofcesarean and vaginal deliveries by MCO in the CY 2019 base period.

We targeted a mix of approximately 71.0% / 29.0% of vaginal/cesarean section deliveries in the rating period. Managed care savings were estimated by evaluating the cost per delivery difference between cesarean and vaginal deliveries. No adjustment was made to the total number of deliveries.

Pharmacy Services

We reviewed historical pharmacy experience for the number of monthly prescriptions that each member was taking during the SFY 2021 emerging experience period. The goal of this efficiency adjustment is to identify users with excessive prescriptions and identify opportunities for reduction. We separated the experience into two categories: 10-14 scripts per month and 15+ scripts per month. Based on clinical evaluation of this adjustment, we established thresholds of reduction of 2 scripts per month for those over 15 scripts per month and removal of 1 script for those in the 10-14 category. We developed pharmacy managed care efficiency adjustments by rate cell to reflect mix differences by therapeutic class due to the age, gender, and morbidity of the applicable rate cell. We assumed a reduction of scripts based on the median cost per script.

The composite impact of these adjustments by population and category of service is listed in Figure 14.

| **FIGURE 14: MANAGED CARE EFFICIENCIES** | | | |
| --- | --- | --- | --- |
| **MCE Adjustment Category** | **Managed Care Utilization** | **Managed Care Cost** | **Managed Care Total** |
| **RIte Care** |  |  |  |
| Inpatient | 0.9924 | 1.0017 | 0.9941 |
| Emergency Room | 0.9684 | 1.0185 | 0.9863 |
| Office Visits | 1.0029 | 1.0000 | 1.0029 |
| Rad/Path/Lab | 1.0014 | 1.0000 | 1.0014 |
| Pharmacy | 0.9989 | 1.0000 | 0.9989 |
| **CSHCN** |  |  |  |
| Inpatient | 0.9900 | 0.9996 | 0.9896 |
| Emergency Room | 0.9781 | 1.0138 | 0.9916 |
| Office Visits | 1.0023 | 1.0000 | 1.0023 |
| Rad/Path/Lab | 1.0015 | 1.0000 | 1.0015 |
| Pharmacy | 0.9989 | 1.0000 | 0.9989 |
| **Medicaid Expansion** |  |  |  |
| Inpatient | 0.9868 | 1.0036 | 0.9904 |
| Emergency Room | 0.9767 | 1.0141 | 0.9905 |
| Office Visits | 1.0020 | 1.0000 | 1.0020 |
| Rad/Path/Lab | 1.0015 | 1.0000 | 1.0015 |
| Pharmacy | 0.9983 | 1.0000 | 0.9983 |
| **Rhody Health Partners** |  |  |  |
| Inpatient | 0.9862 | 1.0015 | 0.9877 |
| Emergency Room | 0.9777 | 1.0143 | 0.9917 |
| Office Visits | 1.0024 | 1.0000 | 1.0024 |
| Rad/Path/Lab | 1.0016 | 1.0000 | 1.0016 |
| Pharmacy | 0.9961 | 1.0000 | 0.9961 |
| **SOBRA** |  |  |  |
| Inpatient | 1.0000 | 0.9983 | 0.9983 |
| Emergency Room | 1.0000 | 1.0000 | 1.0000 |
| Office Visits | 1.0000 | 1.0000 | 1.0000 |
| Rad/Path/Lab | 1.0000 | 1.0000 | 1.0000 |

Fraud, Waste, and ABuse Savings

In addition to the managed care efficiency savings identified by the processes outlined above, we estimated that savings could be generated by identifying opportunities to reduce fraud, waste, and abuse. This adjustment is reflective of opportunities for cost reductions available to the MCOs outside of the managed care efficiencies explicitly measured and described above. Total medical expenses across all rate cells were reduced by 0.5% to account for potential Fraud, Waste, and Abuse savings, consistent with the SFY 2022 capitation rate development. The fraud, waste, and abuse reduction is not included in the values in Figure 14.

##### Material changes to the data, assumptions, and methodologies

The data, assumptions, and methodologies utilized in the developing the projected benefit costs for the SFY 2023 capitation rate setting is generally consistent with the SFY 2022 capitation rate development. Any changes relative to the SFY 2022 rate certification, such as the application of an explicit acuity and emerging experience adjustment, are described this document.

##### Overpayments to providers

Overpayments to providers recouped outside the MCOs’ claims system were removed from the base experience as previously described.

#### 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 CY 2019 base period to the SFY 2023 rating period of this certification. We evaluated prospective trend rates using historical experience for the Medicaid managed care program, as well as external data sources.

##### Required elements

###### Data

The primary data used to develop benefit cost trends is historical claims and encounters from the covered populations. Data used for trend development included over three years of cost and utilization experience, from July 1, 2018 through December 31, 2021. Data was stratified between pre- and post-pandemic experience to review trends prior to the pandemic and emerging experience.

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 Actuary[[3]](#footnote-4), specifically those related to Medicaid.

*Magellan Rx Medicaid Pharmacy Trend Report*[[4]](#footnote-5).

*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.

###### Methodology

The adjusted PMPM values from the base experience period were trended forward to the midpoint of the contract period (January 1, 2023).

Medical Trends

For medical trends, historical utilization and PMPM cost data was stratified by month, rate cell, and category of service. The data was adjusted for completion and the program adjustments previously described. The effect of the COVID-19 pandemic was estimated to be accounted for in the acuity and emerging experience adjustment. Therefore, the estimated utilization and cost per unit trends represent inflationary trends that are unrelated to the estimated emerging experience impacts.

We reviewed multiple regression models, month-over-month, and year-over year trends when analyzing the prospective trend estimates using pre-pandemic experience. 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 prospective trend rates. Prospective medical trend rates are consistent with assumptions underlying the SFY 2022 capitation rates, which is primarily attributable to the consistency in pre-pandemic data sources used in both rate setting activities.

Prospective trend adjustments include consideration for legislatively mandated provider reimbursement trends. Hospital inpatient facility, hospital outpatient facility, and nursing home reimbursement trends are legislatively mandated in the State of Rhode Island General Assembly Budget Article Relating to Human Services. Figure 15 illustrates the legislatively mandated trends. The factors illustrated in Figure 15 are the basis of the prospective trends illustrated in Figure 16.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 15: Annual legislatively mandated Price Trend Factors** | | | | |
| **Service Category** | **CY 2019** | **SFY 2020** | **SFY 2021** | **SFY 2022** |
| Inpatient Hospital | 1.0347 | 1.0260 | 1.0240 | 1.0200 |
| Outpatient Hospital | 1.0347 | 1.0260 | 1.0240 | 1.0200 |
| Nursing Home | 1.0050 | 1.0205 | 1.0263 | 1.0293 |
| Hospice | 1.0050 | 1.0205 | 1.0263 | 1.0293 |

Notes:

1. CY 2019 factors represent adjusting the base data period from a CY 2019 to SFY 2020 basis.

2. Nursing Home and Hospice trends include the inflation and staffing adjustment.

The State of Rhode Island General Assembly Budget Article Relating to Human Services either provides a specific rate change as determined by the General Assembly or is linked to CMS market basket updates. Note, the nursing home and hospice reimbursement changes are effective October 1st of each year, while Figure 15 illustrates the impact of the legislatively mandated reimbursement changes on a state fiscal year basis. The legislatively mandated reimbursement changes are discussed further in Section I, item 4.D.

Pharmacy Trends

We utilized a Medicaid pharmacy projection model (trend model) for the purposes of reviewing and estimating detailed pharmacy trend information. The trend model summarizes pharmacy claims data by month, covered population, and therapeutic class. Generic and brand pharmacy experience was repriced to a consistent percentage of AWP to isolate changes in PBM contracting from inflationary trends. Projected values were estimated using the base period data as a starting point and applying anticipated shifts and trends.

The utilization and cost per script trends are based on a review of historical data and the estimated prospective impact of market changes, such as new drugs coming to market. We analyzed the historical trends using data from CY 2019 through CY 2021. We used public industry trend reports and experience in other state Medicaid programs to validate these unit cost trends. Our trends accounted for a combination of anticipated utilization and price changes on existing products as well as the impact of new pipeline products entering the market up through the rating period.

###### 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 referred to the sources listed in the prior section as well as considered changing practice patterns and the impact of COVID-19 as previously described.

###### Chosen trend rates

The trend rates chosen are illustrated below in Section I, item 3.B.iii.(b), by population and service category. There were no outlier trends or negative trends.

##### Benefit cost trend components

This section includes the projected benefit cost trends by population and category of service. Figure 16 illustrates the price change component of the trend by population and category of service.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FIGURE 16: ANNUALIZED UNIT COST TREND ASSUMPTIONS** | | | | | | | | |
| **Population** | **Inpatient** | **Outpatient** | **Emergency Room** | **Professional** | **Ancillary (Non-Hospice)** | **Nursing Home and Hospice** | **HCBS** | **Retail Pharmacy** |
| RIte Care <15 | 3.0% | 3.0% | 3.0% | 1.0% | 1.0% | 2.3% | 1.5% | 3.5% |
| RIte Care 15+ | 3.0% | 3.0% | 3.0% | 1.0% | 1.0% | 2.3% | 1.5% | 5.5% |
| EFP | 3.0% | 3.0% | 3.0% | 1.0% | 1.0% | 2.3% | 1.5% | 2.0% |
| CSHCN | 3.0% | 3.0% | 3.0% | 1.0% | 1.0% | 2.3% | 1.0% | 3.5% |
| Medicaid Expansion | 3.0% | 3.0% | 3.0% | 1.5% | 1.0% | 2.3% | 1.5% | 5.5% |
| Rhody Health Partners | 3.0% | 3.0% | 3.0% | 0.5% | 1.5% | 2.3% | 1.5% | 6.0% |
| SOBRA | 3.0% | 3.0% | 3.0% | 0.5% | 2.0% | 2.3% | 1.5% | 0.0% |

Note: The professional unit cost trend adjustment is not applied to services reimbursed under an FQHC PPS reimbursement methodology. These services were separately repriced to the SFY 2023 PPS rate.

Figure 17 illustrates the utilization component of the trend.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FIGURE 17: ANNUALIZED UTILIZATION TREND ASSUMPTIONS** | | | | | | | | |
| **Population** | **Inpatient** | **Outpatient** | **Emergency Room** | **Professional** | **Ancillary (Non-Hospice)** | **Nursing Home and Hospice** | **HCBS** | **Retail Pharmacy** |
| RIte Care <15 | 0.5% | 1.0% | 0.5% | 1.5% | 1.0% | 0.5% | 1.0% | 0.5% |
| RIte Care 15+ | 1.0% | 1.0% | 1.0% | 1.5% | 1.0% | 0.5% | 1.0% | 1.0% |
| EFP | 0.0% | 0.5% | 0.5% | 1.0% | 1.0% | 0.5% | 1.0% | 1.0% |
| CSHCN | 0.5% | 1.5% | 0.5% | 1.5% | 1.0% | 0.5% | 1.0% | 1.0% |
| Medicaid Expansion | 0.5% | 1.0% | 0.5% | 1.0% | 1.0% | 0.5% | 1.0% | 1.0% |
| Rhody Health Partners | 0.5% | 0.5% | 0.5% | 0.5% | 0.5% | 0.5% | 1.0% | 1.0% |
| SOBRA | 0.0% | 0.5% | 0.5% | 1.0% | 0.5% | 0.5% | 1.0% | 0.0% |

##### Variation

###### Medicaid populations

To limit the variation in benefit cost that is present across the Medicaid population as a whole, we developed trends by population category and major category of service. Trend variations between populations and service categories reflect observed variation in the underlying historical experience and actuarial judgement based on the sources listed in the section above.

###### Rate cells

We split out several populations by rate cell, to appropriately reflect the material difference in rate cell morbidity. The Rite Care population was split into RIte Care Children (up to age 15), RIte Care Adults (over age 15), and EFP.

###### Subsets of benefits within a category of services

For the pharmacy trend assumption development, we further reviewed experience by therapeutic class. The variation that occurs between the therapeutic class prescription drug stratifications and further within each major population category contributes to the variation in the pharmacy trend assumptions applied across the managed care program in the SFY 2023 capitation rate development.

##### Material adjustments

We adjusted 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, Nursing Home and Hospice service categories were prescribed by legislatively mandated reimbursement changes.

##### Any other adjustments

###### 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 managed care efficiencies.

###### Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than regular utilization or unit cost. Adjustments for prospective program adjustments described in Section I.3.B.ii.

#### Mental Health Parity and Addiction Equity Act Service Adjustment

The projected benefit cost does not include any additional services deemed by the state necessary to accommodate parity compliance.

#### In Lieu of Services

As discussed in Section I.3.A.iv, the reported benefit costs for in-lieu-of-services are described in this section.

##### Categories of covered service

MCOs reported offering in-lieu-of services for facility and professional service categories. The services approved by EOHHS to be utilized this way include acupuncture, chiropractic services, and massage therapy.

##### Percentage of cost

The reported cost for in-lieu-of services were approximately $5.1 million in CY 2019. The following figure illustrates that in-lieu-of services represent approximately 0.4% of the base benefit cost in CY 2019.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 18: In-Lieu-Of Services as a Percentage of CY 2019 Benefit Cost** | | | | |
| **Population** | **Facility** | **Professional** | **All Other** | **Composite** |
| RIte Care | 0.1% | 0.2% | 0.0% | **0.1%** |
| CSHCN | 0.3% | 0.9% | 0.0% | **0.4%** |
| Medicaid Expansion | 0.4% | 1.4% | 0.0% | **0.5%** |
| Rhody Health Partners | 0.2% | 0.5% | 0.0% | **0.2%** |
| **Composite** | **0.3%** | **0.9%** | **0.0%** | **0.4%** |

Note: The values in this exhibit reflect the percent of in-lieu-of expenditures relative to the specific category of service and population illustrated.

##### Development of projected benefit costs

In-lieu-of services were included in the base data and are treated consistently with other service expenditures. The development of the projected benefit costs did not vary for in-lieu-of services.

##### IMDs as an in-lieu-of-service

The rate development complies with the requirements of 42 CFR 438.6(e). See Section I, item 3.A.v for explanation of the treatment of IMD service costs in rate development.

#### Retrospective Eligibility Periods

##### MCO responsibility

The MCOs are not responsible for retrospective eligibility periods. Coverage in the managed care program does not begin until a member is enrolled in an MCO.

##### Claims treatment

MCOs are not responsible for claims incurred before enrollment in the managed care program. The base data experience is consistent with this requirement.

##### Enrollment treatment

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

##### Adjustments

No explicit retroactive enrollment adjustment was applied for the SFY 2023 rate setting.

#### 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 2021 through June 2022 (SFY 2022) rating period.

##### Change to covered benefits

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

##### Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the MCOs in their FDCR responses, and an adjustment was applied to reflect any such recoveries.

##### Change to payment requirements

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

##### Change to waiver requirements

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

##### Change due to litigation

There were no material changes due to litigation.

#### Documentation of Material Changes

All material changes to covered benefits and services compared to the previous certification are described in this report.

##### Non-material changes

Adjustment factors were developed for policy and program changes estimated to materially affect the managed care program during SFY 2023 that are not fully reflected in the base experience. 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 outlines program adjustments deemed immaterial based on our review of the experience data and policy change. No adjustment was applied for these non-material changes.

* **COVID-19 Vaccinations:** COVID-19 vaccines are paid for and provided by the federal government, and professional administration fees paid by the MCOs are fully reimbursed through a non-risk payment for COVID-19 vaccine administration.
* **Department of Children, Youth, & Families Custody Eligibility Pathway:** A limited number of children were enrolled in the substitute care rate cell through a new Medicaid eligibility pathway allowing children to obtain Medicaid eligibility without the parents relinquishing custody. We reviewed emerging experience for this population and determined any cost differential for members to be immaterial.
* **Category 1 Terminations:** EOHHSsuspended the termination of member eligibility as part of the Category 1 enrollment cleanup until the end of the COVID emergency period. This affects approximately 1,700 members that were originally expected to be terminated in April 2020. We reviewed the estimated acuity of this population relative to the remainder of the Medicaid population and determined the acuity differential to be immaterial.
* **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.

## Special Contract Provisions Related to Payment

### Incentive Arrangements

#### Rate Development Standards

This section provides documentation of the incentive payment structure in the Medicaid managed care program.

#### Appropriate Documentation

Incentive payments under this plan are below 105% of the certified capitation rates paid under the contract. EOHHS operates the following incentive program for its MCOs.

**Health System Transformation Program**: The Health System Transformation Program invests in the development of certified accountable entities through the approval of the Rhode Island 1115 waiver Special Terms and Conditions. Incentive payments for the development of accountable entities are funded via an incentive payment to the MCOs with EOHHS approval. MCOs may be eligible for incentive payment under this program up to the PMPM illustrated in the figure below.

|  |  |  |  |
| --- | --- | --- | --- |
| **FIGURE 19: MAXIMUM INCENTIVE PAYMENT (PMPM)** | | | |
| **Population** | **SFY 2023 Composite Rates** | **105% of Capitation Rates** | **Maximum Incentive Payment** |
| RIte Care | $ 315.20 | $ 330.96 | $ 15.76 |
| CSHCN | 1,208.59 | 1,269.02 | 60.43 |
| Medicaid Expansion | 647.97 | 680.37 | 32.40 |
| Rhody Health Partners | 1,980.85 | 2,079.89 | 99.04 |
| SOBRA | 14,552.46 | 15,280.08 | N/A |

Note: Health System Transformation Program incentive payments do not include the SOBRA or extended family planning rate cells.

The sum of the incentive payments does not exceed 105% of the certified capitation rates. There is no explicit adjustment to the capitation rates for the incentive arrangement.

### Withhold Arrangements

#### Rate Development Standards

This section provides documentation of the withhold arrangement in the Medicaid managed care program.

#### Appropriate Documentation

##### Description of the Withhold Arrangement

###### Time period

The Alternative Payment Methodology (APM) withhold will continue in SFY 2023. Withhold metrics will be reviewed and paid annually.

###### Enrollees, services, and providers covered

All rate cells are covered by the withhold arrangement, with the exception of the RIte Care Extended Family Planning or SOBRA capitation rates. No withhold is applied to the Extended Family Planning or SOBRA capitation rates.

###### Purpose

The goals of Rhode Island’s Medicaid Quality Strategy are based on a commitment to the following principles: consumer empowerment and choice, community-based solutions, prevention/wellness, value-based purchasing, integration of physical and behavioral health, care coordination/care management, attention to social determinants of health, and improved technology. The withhold promotes the transition from fee-for-service towards a population health model, thereby encouraging greater coordination of care and rewarding both cost efficiency and quality of care outcomes.

###### Description of total percentage withheld

The withhold will remain at 0.5% in SFY 2023 and be returned in accordance to the “Alternative Payment Methodology Requirements for Each Contract Period” of the MCO contract.

###### Estimate of percent to be returned

Based on discussion with EOHHS, we believe that a full withhold return is attainable by the MCOs.

###### Reasonableness of withhold arrangement

Our review of the total withhold percentage of 0.5% 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 for its covered population.

###### Effect on the capitation rates

The effect of the withhold was considered when developing and reviewing the overall adequacy of the capitation rates. No explicit adjustment was made to the capitation rates to reflect the impact of the withhold.

##### Rate certification consideration of withhold

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

### Risk Sharing Mechanisms

#### Rate Development Standards

This section provides documentation of the risk-sharing mechanisms in the Medicaid managed care program.

#### Appropriate Documentation

##### Description of Risk-sharing Mechanism

The Rhode Island Medicaid managed care program includes a risk-sharing arrangement in SFY 2023.

###### Risk sharing rationale

The risk sharing mechanisms in the Rhode Island Medicaid managed care program address potential claims volatility and other risk for MCOs participating in the managed care program.

###### Risk sharing implementation

The risk-sharing arrangement will be maintained in SFY 2023. The risk corridors parameters for the SFY 2023 contract year are included in the figure below.

|  |  |  |
| --- | --- | --- |
| **FIGURE 20: RISK CORRIDOR PARAMETERS** | | |
| **Risk Sharing Provisions** | **Plan Share of Expenses** | **EOHHS Share of Expenses** |
| For Medical Expenses between 100% and 103% of Baseline | 100% | 0% |
| For Medical Expenses between 103% and 105% of Baseline | 40% | 60% |
| For Medical Expenses greater than 105% of Baseline | 10% | 90% |
| **Gain Sharing Provisions** | **Plan Share of Gains** | **EOHHS Share of gains** |
| For Medical Expenses between 97% and 100% of Baseline | 100% | 0% |
| For Medical Expenses between 97% and 95% of Baseline | 40% | 60% |
| For Medical Expenses less than 95% of Baseline | 10% | 90% |

The baseline medical expenses consist of the base benefit expense, Care Transformation Collaborative adjustment, and care coordination. Care coordination expenditures reported by the MCOs for purposes of the risk sharing calculation are limited to the care coordination capitation revenue received by the MCO.

###### Impact on capitation rate development

The risk corridor incorporated in the Rhode Island Medicaid managed care program reduces the overall MCO financial volatility and risk. The impact of the risk corridor was considered when developing the non-benefit expense load as discussed in Section I.5.B.ii.

###### Attestation of the use of generally accepted actuarial principles and practices

The SFY 2023 risk sharing mechanism was developed in accordance with generally accepted actuarial principles and practices.

###### Consistency with pricing assumptions

The SFY 2023 risk sharing mechanism was developed consistently with pricing assumptions used in capitation rate development.

###### Remittance/payment based on pricing assumptions

The SFY 2023 risk sharing mechanism will not result in a remittance/payment if SFY 2023 experience is consistent with the pricing assumptions used in capitation rate development.

##### Medical Loss Ratio

###### Methodology

The medical loss ratio for SFY 2023 will be reported to CMS in accordance with 42 CFR 438.8*.*

###### Formula for Remittance/Payment

A remittance is not required for having a medical loss ratio above or below any pre-defined thresholds.

###### Financial consequences

There are no financial consequences associated with MLR requirements.

##### Reinsurance Requirements and Effect on Capitation Rates

###### Description of reinsurance requirements

EOHHS requires the MCOs to obtain reinsurance coverage from a source other than EOHHS. The level at which the MCO establishes reinsurance must be consistent with sound business practices under the financial condition of the MCO. EOHHS reserves the right to review the reinsurance coverage and to require changes to that coverage in the form of lower thresholds if considered necessary based on the MCO’s overall financial condition.

###### Effect on capitation rates

The SFY 2023 capitation rates were adjusted for the effect of reinsurance. Reinsurance premiums reported by the MCOs via the FDCRs were included in the capitation rate development base data, and the base data was likewise reduced for reinsurance recoveries.

###### Attestation of the use of generally accepted actuarial principles and practices

The reinsurance arrangement was reflected in the capitation rate development in accordance with generally accepted actuarial principles and practices.

###### Reinsurance premium development

The reinsurance coverage is purchased by the MCOs from a source other than EOHHS. EOHHS is not responsible for the premium development.

### Delivery system and provider payment initiatives

#### Rate Development Standards

##### Description of Managed Care Plan Requirement

Consistent with guidance in 42 CFR §438.6(c), the capitation rates effective July 1, 2023, 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
* Care Transformation Collaborative of Rhode Island state directed value-based purchasing
* Accountable Entity (AE) program state directed value-based purchasing

##### State directed payments

EOHHS has submitted SFY 2023 directed payment preprints for each provider payment initiative except the personal care shift differential and personal care behavioral health certification enhancement. A preprint for personal care shift differential is anticipated to be submitted to CMS. The behavioral health certification enhancement is based on a state plan approved fee schedule and does not have a corresponding preprint. The state directed payment arrangements reflected in these certified rates is consistent with what has been submitted or is anticipated to be submitted to CMS.

##### Generally accepted actuarial principles

The contract arrangements that direct MCO expenditures were developed in accordance with guidance in 42 CFR §438.4, the standards in §438.5, and generally accepted actuarial principles and practices.

##### How state directed payment arrangements are reflected in managed care rates

All the initiatives described above are considered in the capitation rates paid to the plans. None are implemented via a separate payment term.

#### Appropriate Documentation

##### Delivery system and provider payment initiatives

###### Description delivery system and provider payment initiatives

**Inpatient Hospital (RI\_Fee\_IPH\_Renewal\_20220701-20230630).** The inpatient hospital directed payment is a uniform percentage increase to hospital reimbursement. Reimbursement for inpatient hospital services is mandated to be increased by a uniform 2.0% effective July 1, 2022.

**Outpatient Hospital (RI\_Fee\_OPH\_Renewal\_20220701-20230630).** The outpatient hospital directed payment is a uniform percentage increase to hospital reimbursement. Reimbursement for outpatient hospital services is mandated to be increased by a uniform 2.0% effective July 1, 2022.

**Nursing Home (RI\_Fee\_NF\_Renewal\_20220701-20230630).** The nursing home directed payment is a uniform percentage increase to nursing home reimbursement, inclusive of hospice services incurred in the nursing home. Reimbursement for nursing home services is mandated to be increased by a uniform 2.0% effective October 1, 2022. Please note that the SFY 2023 nursing home trend factor illustrated in Figure 16 reflects a combination of 2.2% reimbursement increase effective October 1, 2021 and a 2.0% increase effective October 1, 2022.

**Personal Care Shift Differential (TBD).** Effective July 1, 2021, reimbursement for personal care and combined personal care/homemaker services (procedure code S5125) with a shift differential modifier was increased by $0.19 per fifteen minutes. The shift differential applies to services provided on an evening, night, or weekend/holiday (indicated by procedure code modifier values of UH, UJ, and TV).

**Personal Care Behavioral Health Certification Enhancement (N/A).** Effective January 1, 2022, a new behavioral health certification enhancement of $0.39 per fifteen minutes of personal care, combined personal care/homemaker, and homemaker only services (procedure codes S5125 and S5130) will be implemented for providers who have at least 30% of their direct-care workers certified in behavioral health training. We assumed that 15% of these services would be performed by providers who qualify for the behavioral health enhancement based on communication with EOHHS.

**Care Transformation Collaborative of Rhode Island (RI\_VBP\_PC\_Renewal\_20220701-20230630).** MCOs are required to participate in the Care Transformation Collaborative of Rhode Island to promote accessible, comprehensive, coordinated care.

Payments are made to Care Transformation Collaborative based on managed care member enrollment in pediatric primary care practices participating in the Care Transformation Collaborative. In SFY 2023, qualifying providers receive a uniform $3.00 PMPM once meeting certification requirements established by the Office of the Health Insurance Commissioner as a Patient Centered Medical Home.

**Accountable Entity Program (RI\_VBP\_Oth\_Renewal\_20220701-20230630).** Accountable entities are responsible for the cost and quality of an attributed population and participate in shared savings and losses under the program. Shared savings or losses are determined by comparing the total cost of care of an accountable entities’ attributed population to cost thresholds derived using a methodology generally consistent with the MCO capitation rate development. Specified quality targets must also be met for accountable entities to qualify for shared savings payments. In addition, all certified AEs are eligible for performance-based incentive payments, established by the Total Incentive Pool for each MCO-AE relationship. The Total Incentive Pool is determined by EOHHS and is subject to the incentive payment maximum described earlier in this section.

The specific description for each state directed payment is outlined in the figure below.

|  |  |  |  |
| --- | --- | --- | --- |
| **FIGURE 21: DESCRIPTION OF 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?** |
| RI\_Fee\_IPH\_Renewal\_20220701-20230630 | Uniform percentage increase | Uniform increase to inpatient hospital reimbursement | Rate Adjustment |
| RI\_Fee\_OPH\_Renewal\_20220701-20230630 | Uniform percentage increase | Uniform increase to outpatient hospital reimbursement | Rate Adjustment |
| RI\_Fee\_NF\_Renewal\_20220701-20230630 | Uniform percentage increase | Uniform increase to nursing home reimbursement | 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 | Rate Adjustment |
| N/A: Personal Care Behavioral Health Certification Enhancement | Minimum fee schedule | Minimum fee schedule per fifteen minutes for personal care, combined personal care/homemaker, and homemaker only services | Rate Adjustment |
| RI\_VBP\_PC\_Renewal\_20220701-20230630 | Performance-based incentive payments | Incentive payment to qualifying providers | Rate Adjustment |
| RI\_VBP\_Oth\_Renewal\_20220701-20230630 | Performance-based incentive payments | Shared savings or losses for certified AEs | Rate Adjustment |

###### Effect on capitation rates

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 22: EFFECT OF STATE DIRECTED PAYMENTS** | | | | |
| **Control Name of the State Directed Payment** | **Rate Cells Affected** | **Impact** | **Description of the Adjustment** | **Confirmation the Rates are Consistent with the Preprint** |
| RI\_Fee\_IPH\_Renewal\_20220701-20230630 | All Rate Cells | 2.0% increase effective July 1, 2022 | Uniform increase to hospital reimbursement | Consistent with anticipated preprint |
| RI\_Fee\_OPH\_Renewal\_20220701-20230630 | All Rate Cells | 2.0% increase effective July 1, 2022 | Uniform increase to hospital reimbursement | Consistent with anticipated preprint |
| RI\_Fee\_NF\_Renewal\_20220701-20230630 | All Rate Cells | 2.0% increase effective October 1, 2022 | Uniform increase to nursing home reimbursement | Consistent with anticipated preprint |
| TBD: Personal Care Shift Differential | All Rate Cells utilizing personal care services | The state directed payment rate impact is illustrated in Appendix 4, in the “Personal Care Shift Differential” column. | Estimated reimbursement increase based on SFY 2021 utilization and HCBS utilization trends | Consistent with anticipated preprint |
| N/A: Personal Care Behavioral Health Certification Enhancement | All Rate Cells utilizing personal care and homemaker services | The state directed payment rate impact is illustrated in Appendix 4, in the “Behavioral Health Certification Enhancement” column. | Estimated reimbursement increase based on SFY 2021 utilization and HCBS utilization trends | N/A |
| RI\_VBP\_PC\_Renewal\_20220701-20230630 | All Rate Cells with members below age 18 | Up to $3.50 PMPM for qualifying providers | Incentive payment to qualifying providers | Consistent with anticipated preprint |
| RI\_VBP\_Oth\_Renewal\_20220701-20230630 | No explicit rate adjustment | Based on total cost of care thresholds | Shared savings or losses for certified AEs | Consistent with anticipated preprint |

Additional information for the state directed payments is provided below.

**Inpatient Hospital (RI\_Fee\_IPH\_Renewal\_20220701-20230630).** The inpatient hospital reimbursement increase was reflected in the capitation rate development through the cost trend as described in Section I, item 3.B.iii.

Reimbursement for inpatient hospital services is increased by a uniform 2.0% effective July 1, 2022. The magnitude of the payment increase for each rate cell is illustrated in Appendix 3.

**Outpatient Hospital (RI\_Fee\_OPH\_Renewal\_20220701-20230630).** The outpatient hospital reimbursement increase was reflected in the capitation rate development through the cost trend as described in Section I, item 3.B.iii. Reimbursement for outpatient hospital services is increased by a uniform 2.0% effective July 1, 2022. The magnitude of the payment increase for each rate cell is illustrated in Appendix 3.

**Nursing Home (RI\_Fee\_NF\_Renewal\_20220701-20230630).** The nursing home reimbursement increase was reflected in the capitation rate development through the cost trend as described in Section I, item 3.B.iii. Reimbursement for nursing home services is mandated to be increased by a uniform 2.0% effective October 1, 2022. Please note that the SFY 2021 nursing home trend factor illustrated in Figure 16 reflects a combination of 2.2% trend effective October 1, 2021 and 2.0% trend effective October 1, 2022. The magnitude of the payment increase for each rate cell is illustrated in Appendix 3.

**Personal Care Shift Differential (TBD).** The personal care shift differential directed payment was reflected in the capitation rate development through a PMPM add-on described in Section I, item 3.B.ii of this report, and magnitude of the payment increase for each rate cell is illustrated in Appendix 4.

**Personal Care Behavioral Health Certification Enhancement (N/A).** The personal care behavioral health certification enhancement directed payment was reflected in the capitation rate development through a PMPM add-on described in Section I, item 3.B.ii of this report, and magnitude of the payment increase for each rate cell is illustrated in Appendix 4.

**Care Transformation Collaborative of Rhode Island (RI\_VBP\_PC\_Renewal\_20220701-20230630).** The Care Transformation Collaborative directed payment was reflected in the capitation rate development through a PMPM add-on described in Section I, item 5.B.i.(a) of this report, and magnitude of the payment increase for each rate cell is illustrated in Appendix 4.

**Accountable Entity Program (RI\_VBP\_Oth\_Renewal\_20220701-20230630).** No explicit upward or downward adjustment is made to the capitation rates for the Accountable Entity program. Historical program experience and SFY 2023 program parameters are considered when evaluating the reasonableness, appropriateness, and attainability of the capitation rates.

###### Separate payment term

The directed payments are not incorporated as a separate payment term.

##### Additional directed payments

There are no additional directed payment arrangements.

##### 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.

### Pass-Through Payments

#### Rate Development Standards

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

#### Appropriate Documentation

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

## Projected non-benefit costs

### Rate Development Standards

#### Overview

In accordance with 42 CFR §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCO operation of the Medicaid managed care program. Section I, item 5 provides documentation of the data, assumptions, and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

#### PMPM versus percentage

The non-benefit costs were developed as both a PMPM and a percentage of the capitation rate. The Care Transformation Collaborative adjustment and the State-Supplied Vaccine Program (vaccine assessment) were developed as PMPM amounts. The care coordination, administrative cost allowance, risk margin, and premium tax amounts were developed as a percentage of the capitation rate.

### Appropriate Documentation

#### Development of non-benefit costs

##### Description of the data, assumptions, and methodologies

Data

The following items were considered in determining the appropriate administrative payment to the MCOs:

MCO administrative requirements as specified in the contract;

MCO financial information contained in NAIC financial statement data;

MCO administrative costs and financial considerations reported in the FDCR and MCO Survey;

MCO historical administrative efficiency in relation to industry norms by expense category;

Average administrative costs from the financial statements of Medicaid health plans nationally; and,

Base claims cost.

We used historical program costs and projections provided by EOHHS to develop the PMPM amounts for Care Transformation Collaborative and vaccine assessment.

Assumptions and methodology

In developing the administrative cost allowances, we reviewed historical administrative expenses for the program along with national Medicaid health plan administrative expenses. We considered the size of the health plans and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the population. The final assumptions were based on our actuarial judgement and not formulaically derived.

We did not develop administrative expenses from the ground up (based on individual components). However, individual components were reviewed within financial statement data. We considered the pharmacy benefit target AWP discount values described in Section I, item 3.B.ii and related PBM administrative load in this development. Care coordination expense was separately allocated from the general administrative cost allowance and is considered as a component of the baseline medical expense for purposes of risk share reporting.

In addition to care coordination and administrative costs, the development of actuarially sound capitation rates considers the following other program components:

**Care Transformation Collaborative of Rhode Island:** The SFY 2023 PMPM add-on for Care Transformation Collaborative is based on SFY 2023 projections provided by EOHHS. The projections were reviewed for reasonability in their development and in total magnitude. The Care Transformation Collaborative amounts are included as a component of the baseline medical expense for purposes of risk share reporting.

**State-Supplied Vaccine Program (vaccine assessment):** Amounts for vaccine assessment are included in the rate development as a PMPM add-on amount. The SFY 2023 assessment is $3.56 for adults ages 19 and over.

**Premium Tax:** MCOs operating in the Rhode Island are subject to a 2.0% premium tax, which is included in the rate development.

Figure 23 illustrates the PMPM add-on amounts for Care Transformation Collaborative and vaccine assessment.

|  |  |  |  |
| --- | --- | --- | --- |
| **FIGURE 23: PMPM ADD-ONS** | | | |
| **Population** | **Care Transformation Collaborative** | **Vaccine Assessment** |
| RIte Care | $ 1.31 | $ 1.28 |
| CSHCN | 1.71 | 0.59 |
| Medicaid Expansion | 0.00 | 3.56 |
| Rhody Health Partners | 0.00 | 3.56 |
| SOBRA | 0.00 | 0.00 |

Note: Amounts are composited based on estimated SFY 2023 enrollment.

##### Material changes

The data, assumptions, and methodology used to develop the projected non-benefit cost are generally consistent with the SFY 2022 rate development. Based on this review, the care coordination and administrative cost load assumptions are unchanged from the SFY 2022 percentage loads. Prior non-benefit expense assumptions are fully described within the SFY 2022 rate certification report.

##### Other material adjustments

There are no other material non-benefit expense adjustments not described within this section.

#### Non-benefit costs, by cost category

The care coordination, administrative cost, and risk margin are illustrated as a percentage of the capitation effective rate (less the Care Transformation Collaborative PMPM add-on). Premium tax is applied as a percentage of the total capitation. The SFY 2023 non-benefit expense percentages are illustrated in Figure 24 below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIGURE 24: NON-BENEFIT EXPENSE LOADS** | | | | |
| **Population** | **Care Coordination** | **Administrative Cost** | **Risk Margin** | **Premium Tax** |
| RIte Care <15 | 1.50% | 7.50% | 1.50% | 2.00% |
| RIte Care 15+ | 1.50% | 6.75% | 1.50% | 2.00% |
| EFP | 1.50% | 10.00% | 1.50% | 2.00% |
| CSHCN - Adoption/Sub Care | 1.50% | 9.00% | 1.50% | 2.00% |
| CSHCN - Other | 1.50% | 7.00% | 1.50% | 2.00% |
| Medicaid Expansion | 1.50% | 6.75% | 1.50% | 2.00% |
| Rhody Health Partners | 1.50% | 6.00% | 1.50% | 2.00% |
| SOBRA | 1.00% | 2.00% | 1.50% | 2.00% |

#### Historical non-benefit cost

Historical non-benefit costs were reported through MCO FDCR submissions and financial statement data. We evaluated the historical program costs along with nationwide administrative cost benchmarks and trends when establishing the non-benefit expense loads. In addition, we considered the potential impact of items such as PBM administrative costs and MCO reporting allocation methodologies in this analysis.

## Risk Adjustment and Acuity Adjustments

This section provides information on the risk adjustment included in the contract.

### Rate Development Standards

#### Overview

In accordance with 42 CFR §438.5(g), we will follow the rate development standards related to budget-neutral risk adjustment for the Medicaid managed care program. The capitation rates will be prospectively risk adjusted by MCO to reflect estimated prospective morbidity differences in the underlying population enrolling with each MCO.

To the extent that material items are observed such as data quality concerns, MCO enrollment, or risk differences not quantified by the approach outlined below, we may consider adjustments to the proposed risk adjustment methodology. All adjustments will be in accordance with our review of the risk adjustment data, results, and methodology and will be developed in accordance with generally accepted actuarial principles and practices. These adjustments may include, but are not limited to, risk-adjustment rebasing during SFY 2023, using concurrent risk score mechanisms, or non-budget-neutral risk adjustment.

The remainder of this section outlines the intended approach to risk adjusting the SFY 2023 capitation rates.

#### Risk adjustment model

Risk adjustment will be performed using CDPS + Rx version 6.4. We developed custom condition weights based on Rhode Island Medicaid experience. Risk adjustment will be performed on a basis estimated to be budget neutral at the rate cell level. Children less than one year old, the extended family planning population, delivery kick payments, and the CSHCN substitute care rate cell will be excluded from the risk adjustment process.

#### Acuity adjustments

All acuity adjustments are applied on a prospective basis and are described in Section I, item 3.B.ii. These acuity adjustments are included in the certified capitation rates documented in this report.

### Appropriate Documentation

#### Prospective risk adjustment

##### Data and adjustments

The SFY 2023 rate period is anticipated to be risk adjusted based on a diagnosis and prescription drug collection period including incurred (dispensed) dates in SFY 2021. The risk adjustment diagnosis base data will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes. Prospective risk scores will be applied to the SFY 2023 capitation rates in total. We will calculate normalized rates on a budget neutral basis for each MCO.

##### Risk adjustment model

The capitation rates will be risk-adjusted using CDPS+Rx risk scoring models with custom weights. We will provide full documentation of the results and methodology for the risk adjustment analysis in a separate correspondence.

##### Risk adjustment methodology

Risk adjustment is designed to be cost neutral for each population. Relative risk scores will be normalized to result in a composite risk score of 1.000 for each population group. The risk adjustment methodology uses generally accepted actuarial principles and practices.

##### Magnitude of the adjustment

We will provide full documentation of the results and methodology for the risk adjustment analysis in a separate correspondence.

##### Assessment of predictive value

We will provide full documentation of the results and methodology for the risk adjustment analysis in a separate correspondence.

##### Any concerns the actuary has with the risk adjustment process

The SFY 2021 base data for risk adjustment will include claims experience affected by the COVID-19 pandemic. We previously evaluated the SFY 2020 diagnostic and pharmacy script data for purposes of SFY 2022 risk adjustment and concluded that the budget-neutral risk adjustment results were not materially impacted by the pandemic. We will continue to evaluate this conclusion when reviewing the SFY 2021 base data for risk adjustment.

#### Retrospective risk adjustment

Not applicable. The risk adjustment analysis will utilize a prospective methodology.

#### Changes to risk adjustment model since last rating period

##### Changes made since the last rating period

Risk adjustment was performed on the SFY 2022 capitation rates using the CDPS+Rx risk adjustment model with standard weights. We developed custom weights based on Rhode Island Medicaid experience for the SFY 2023 risk adjustment process. We utilized a member duration adjustment and modified the treatment of unscored members to account for recent pandemic-related enrollment changes.

##### Budget neutrality

Risk adjustment is designed to be cost neutral for each population.

#### Acuity adjustments

A retrospective acuity adjustment is not planned for the SFY 2023 rating year. As previously stated, we will consider changes to the risk adjustment methodology in the event of material program enrollment changes.

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

Section II of the CMS Guide is not applicable to the populations covered under this rate certification. Managed long-term services and supports (MLTSS) populations are generally excluded from the program. EOHHS operates the Rhody Health Options Medicare-Medicaid Plan (MMP) which is outlined in a separate capitation rate certification document. Long-term services and supports for the Rhody Health Partners population are reimbursed by EOHHS on a fee-for-service basis.

# Section III. New adult group capitation rates

EOHHS implemented the Affordable Care Act’s Medicaid expansion on January 1, 2014. As of December 2021, approximately 100,000 individuals receive Medicaid benefits through MCOs in Rhode Island’s Medicaid Expansion population.

## Data

### Data Used in Certification

The source of data used to develop the Medicaid Expansion capitation rates for SFY 2023 is the same source of data used in the development of rates for the Rite Care, CSHCN, and Rhody Health Partners populations, as outlined in Section I.2.B.ii.

### Description of Emerging Data

#### New data available for rate setting

No new data sources were available for purposes of the SFY 2023 capitation rate development. Emerging Medicaid Expansion data was used in the SFY 2023 capitation rate development.

#### Monitoring of experience

EOHHS has monitored enrollment and costs in the Medicaid Expansion population on an on-going basis. MCOs routinely submit financial experience via the FDCR reporting process.

#### Comparison to previous rate certifications

Figure 25 provides a comparison of actual SFY 2021 experience by rate cell used relative to SFY 2021 projections in the SFY 2021 Medicaid Expansion capitation rates.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FIGURE 25: RECONCILIATION OF SFY 2021 ASSUMED BENEFIT EXPENSE TO ACTUAL BENEFIT EXPENSE** | | | | | | | |
| **Rate Cell** | **Estimated Member Months** | **Actual Member Months** | **Difference** |  | **Estimated Benefit Expense PMPM** | **Actual Benefit Expense PMPM** | **Difference** |
| ME - F 19-24 | 115,701 | 114,812 | (0.8%) |  | $ 282.63 | $ 277.61 | (1.8%) |
| ME - F 25-29 | 62,683 | 65,569 | 4.6% |  | 404.80 | 376.74 | (6.9%) |
| ME - F 30-39 | 59,801 | 66,056 | 10.5% |  | 604.82 | 588.61 | (2.7%) |
| ME - F 40-49 | 62,066 | 63,371 | 2.1% |  | 789.18 | 684.82 | (13.2%) |
| ME - F 50-64 | 164,125 | 175,317 | 6.8% |  | 733.54 | 696.24 | (5.1%) |
| ME - M 19-24 | 118,837 | 119,491 | 0.6% |  | 192.72 | 187.37 | (2.8%) |
| ME - M 25-29 | 90,701 | 91,220 | 0.6% |  | 359.65 | 330.91 | (8.0%) |
| ME - M 30-39 | 125,904 | 133,956 | 6.4% |  | 530.45 | 521.65 | (1.7%) |
| ME - M 40-49 | 81,498 | 83,924 | 3.0% |  | 693.61 | 686.59 | (1.0%) |
| ME - M 50-64 | 139,263 | 146,532 | 5.2% |  | 778.72 | 773.90 | (0.6%) |
| **Composite** | **1,020,579** | **1,060,248** | **3.9%** |  | **$ 539.79** | **$ 522.89** | **(3.1%)** |

Note: Actual benefit expense PMPMs are derived from the CY 2021 Q4 FDCR submission. Adjustments were made to the actual benefit expense to exclude vaccine administration expenditures, consistent with the estimated benefit expense PMPM.

As Figure 25 illustrates, actual MCO-covered member months were approximately 3.9% above values estimated in the development of the SFY 2021 capitation rates. On an aggregate basis, actual benefit expense PMPM was approximately 3.1% lower than estimated benefit expense assumed in the capitation rate development.

#### Adjustment to current rates

An explicit adjustment was not made for differences between projected and actual experience in previous rating periods; emerging experience was utilized when developing the Medicaid Expansion SFY 2023 capitation rates.

## Projected Benefit Costs

### Description of Projected Benefit Cost Issues

CY 2019 Medicaid Expansion population experience, in the form of adjusted encounter data, is used as the underlying data source for the development of the SFY 2023 capitation rates. Discussion of other assumption changes is provided in the next section.

#### For states that covered the new adult group in previous rating periods

##### Data specific to newly eligible adults

There was no data that was only available for newly eligible adults utilized in the capitation rate development.

##### Changes in data sources, assumptions, or methodologies

There were no changes to the data sources, assumptions, or methodologies used to develop projected benefit costs that was specific to the Medicaid Expansion population that was not previously outlined in this report.

##### Assumption changes from previous rating periods

###### Acuity adjustments

An adjustment was made for changes in acuity and emerging experience for the Medicaid Expansion population as described in Section I, item 3.B.ii. The methodology to develop the acuity adjustment was consistent for all populations, and the acuity adjustment impact is illustrated separately by population. The acuity adjustment is included in the certified capitation rates documented in this report.

###### Adjustments for pent-up demand

Consistent with the SFY 2022 rate setting, an explicit pent-up demand adjustment was not made for the Medicaid Expansion population.

###### Adjustment for adverse selection

Consistent with the SFY 2022 rate setting, an explicit adverse selection adjustment was not made for the Medicaid Expansion population.

###### Adjustment for demographics

Consistent with the SFY 2022 rate setting, an explicit demographic adjustment was not made for the Medicaid Expansion population. The current rate cell structure of the Medicaid Expansion population adjusts capitation payments to the MCOs to the extent the demographic mix of the population changes significantly during the SFY 2023 rate period.

###### Differences in provider reimbursement rates or provider networks

Consistent with the SFY 2022 rate setting, differences in provider reimbursement were not assumed or observed for the Medicaid Expansion population.

###### Other material adjustments

Consistent with the SFY 2022 rate setting, there are no other material adjustments.

###### Changes to the benefit plan

There were no changes to the benefit plan offered to the new adult group.

#### For new adult groups not covered in previous rating periods

This section does not apply as the new adult group was previously covered.

#### Key assumptions

The key assumptions related to the new adult group are identified and described in Section III.2.A.i.

### Other Material Changes or Adjustments to Benefit Costs

We did not make any other adjustments in the Medicaid Expansion rate development process other than those previously outlined in the report.

## Projected Non-Benefit Costs

### Description of Issues

#### Changes in data sources, assumptions, or methodologies

The data sources, assumptions, and methodologies utilized in the development of the non-benefit expense component of the capitation rates is outlined in Section I.5.B.

#### Assumption changes for previous rating periods

Figure 26 illustrates the non-benefit expense assumptions for the SFY 2023 capitation rates relative to the SFY 2022 capitation rate development.

|  |  |  |
| --- | --- | --- |
| **FIGURE 26: MEDICAID EXPANSION NON-BENEFIT EXPENSE ASSUMPTIONS** | | |
| **Non-Benefit Expenses** | **SFY 2022** | **SFY 2023** |
| Admin | 6.75% | 6.75% |
| Care Coordination | 1.50% | 1.50% |
| **Subtotal Non-Benefit Expense** | **8.25%** | **8.25%** |
|  |  |  |
| Risk Margin | 1.50% | 1.50% |
| **Total Non-Benefit Expense (Excluding Fees and Taxes)** | **9.75%** | **9.75%** |

The SFY 2023 non-benefit expense load assumptions are consistent with the SFY 2022 non-benefit expense load assumptions.

### Assumption Differences Relative to Other Medicaid Populations

Figure 26 provides the non-benefit expense assumptions for the Medicaid Expansion population and other populations administered by EOHHS. Any differences among assumptions 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.

## Final Certified Rates

### CMS Requests

#### Comparison to Previous Certification

Appendix 4 illustrates a comparison of the SFY 2022 and SFY 2023 capitation rates.

#### Description of Other Material Changes to the Capitation Rates

All material changes to the Medicaid Expansion rate development methodology are outlined in this report.

## Risk Mitigation Strategies

### Description of Risk Mitigation Strategy

The Medicaid expansion population is included in the risk mitigation programs consistent with all other populations as outlined in Section I.4 and Section I.6. There are no risk mitigation strategies specific to the Medicaid Expansion population.

### Changes to Risk Mitigation Strategy Relative to Prior Years

There are no risk mitigation strategies specific to the Medicaid Expansion population.

# 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 anticipated to be used for developing the certified state fiscal year (SFY) 2023 capitation rates for the Rhode Island Medicaid managed care 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 managed care organizations (MCO) participating in the managed care program and the Centers for Medicare and Medicaid Services (CMS). 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 Medicaid managed care 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 models rely on data and information as input to the models. We have relied upon certain data and information provided by EOHHS and the MCOs 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**

**Medicaid Managed Care**

**Actuarial Certification**

I, Jason A. Clarkson, 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 Medicaid Managed Care program effective July 1, 2022. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

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 for State Fiscal Year 2022.

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.

At the time of this rate certification, there is uncertainty regarding the impact of the COVID-19 pandemic, including whether the pandemic will increase or decrease costs in SFY 2023. We acknowledge that the COVID-19 pandemic could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this rate certification.



Jason A. Clarkson, FSA

Member, American Academy of Actuaries

June 22, 2022

Date

# Appendix 2: CY 2019 Base Data Development

# Appendix 3: SFY 2023 Projected Benefit Expense Development

# Appendix 4: SFY 2023 Capitation Rate Development



Milliman is among the world’s largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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1. <http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/> [↑](#footnote-ref-2)
2. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-06/DRG\_calculator\_2021.xlsx [↑](#footnote-ref-3)
3. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html> [↑](#footnote-ref-4)
4. <https://www1.magellanrx.com/read-watch-listen/read/our-publications/medicaid-pharmacy-trend-report/> [↑](#footnote-ref-5)