June 28, 2016

RIte Care Data Book

State of Rhode Island

Rates for the period 2/1/2017 through 6/30/2017

Final & Confidential

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INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 2/1/2017 through 6/30/2017 for RIte Care, a Medicaid managed care program authorized under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration.

RIte Care provides eligible children and their families with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE). The health plans are paid capitation rates based on rate cells that are age and gender-driven. The State also pays capitation rates for Extended Family Planning (EFP) for certain qualifying post-partum women not otherwise eligible for full RIte Care benefits for a restricted set of benefits, and it provides lump-sum SOBRA payments for eligible pregnant women for their prenatal care, delivery and post-natal care. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the RIte Care per member per month (PMPM) capitation rates and SOBRA payment rate effective February 1, 2017 through June 30, 2017, for the purpose of attaining rate approval from CMS under 42 CFR 438.6(c). This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using selected trends developed from the claims experience, adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the RIte Care claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected RIte Care rates presented in this data book:

- Patient-Centered Medical Homes for Kids (PCMH-Kids)
- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for RIte Care were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

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CAPITATION RATES & DEMOGRAPHICS

The capitation rates and SOBRA payments (including administrative and premium tax loads) for the rate period 2/1/2017 – 6/30/2017 are as follows:

Table 1
Capitation Rates

RIte Care
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017
Including Reinventing Medicaid Program Initiatives

					Non-Profit Plans		For-Profit Plans		
Capitation Rate Cell	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	2% State Premium Tax: Non-Profit Plans	Proposed Capitation Rates: Non-Profit Plans	2% State Premium Tax: For-Profit Plans	Est. ACA Issuer Fee: For-Profit Plans [2]	Capitation Rates w/ Premium & Issuer Taxes
MF <1	$ 408.65	$ 39.51	$ 6.82	$ -	$ 9.29	**$ 464.27**	$ 9.58	$ 14.37	**$ 478.93**
MF 1-5	$ 128.70	$ 12.72	$ 2.15	$ -	$ 2.93	**$ 146.50**	$ 3.03	$ 4.53	**$ 151.13**
MF 6-14	$ 128.21	$ 12.34	$ 2.14	$ -	$ 2.91	**$ 145.60**	$ 3.00	$ 4.51	**$ 150.20**
Males 15-44	$ 178.23	$ 18.68	$ 3.00	$ 1.18	$ 4.10	**$ 205.19**	$ 4.23	$ 6.35	**$ 211.67**
Females 15-44	$ 268.57	$ 25.58	$ 4.48	$ 1.40	$ 6.12	**$ 306.15**	$ 6.32	$ 9.47	**$ 315.82**
MF 45+	$ 373.32	$ 37.88	$ 6.26	$ 1.66	$ 8.55	**$ 427.67**	$ 8.82	$ 13.24	**$ 441.18**
EFP	$ 8.84	$ 0.86	$ 0.15	$ -	$ 0.20	**$ 10.05**	$ 0.21	$ 0.31	**$ 10.37**
SOBRA (Pmt.)	$ 9,711	$ 949	$ 162	$ -	$ 221	**$ 11,043**	$ 228	$ 342	**$ 11,392**

[1] Risk Margin set at 1.5% of premiums before taxes
[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only
[3] Includes Adult Immunizations

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RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data reports, which were based on encounter data, covered the following State Fiscal Years (SFY)

- 7/1/2012 through 6/30/2013 (SFY 2013), paid through 11/30/2015, estimated at 100%
- 7/1/2013 through 6/30/2014 (SFY 2014), paid through 11/30/2015, estimated at 100%
- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

The claims data was delineated by rate cell and by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail which allowed us to examine historical patterns for unit cost and utilization levels (see Exhibit 1 in the Appendix).

All claims data including SFY 2013, SFY 2014, and SFY 2015 were presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2013, SFY 2014 and SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Exhibit 2 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2013, SFY 2014, and SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '13, SFY '14, and SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services
- CEDARR

BASE PERIOD

The Base Period PMPM was based on the weighted average blend of the participating plans' experience for SFY 2015 – see Table 2 below.

Table 2
Base Period PMPM (excluding SOBRA and EFP):

RIte Care						
For Rate Period 2/1/2017 - 6/30/2017						
Base PMPM						
Excluding SOBRA & EFP						
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Selected Base Period PMPMs (SFY '15)	$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20

TRENDS AND TREND DEVELOPMENT

Trends were developed on the composite experience of the program, by service category, from the claims data including the G/L adjustments. For this rate period, the selected trend was based on the 2-year average unit cost and utilization trends of SFY 2015 over SFY 2013 – see Table 3 below. The selected trends were then adjusted for the impact of **Article 5**, shown in greater detail in exhibits 4a, 4b, 4c, 4d and 4e in the appendix, to derive the final set of trends used to develop the projected benefit costs – see Table 4 below.

Table 3
Selected Trends:

RIte Care								
For Rate Period 2/1/2017 - 6/30/2017								
Incurred SFY, PT 11/15 est. 100%								
Medical Trend Selection								
Util/1000 (Util)	**Non-SOBRA, Non-EFP**				**SOBRA**			
	'14/'13	**'15/'14**	**'15/'13**		**'14/'13**	**'15/'14**	**'15/'13**	
Inpatient	6.8%	1.4%	4.0%					
Outpatient	-2.0%	-1.6%	-1.8%					
Professional	-2.3%	-0.8%	-1.6%					
Pharmacy	-3.8%	-2.4%	-3.1%					
Inst. (NH)	-37.6%	-20.4%	-29.5%					
Cost/Clm-Admt (price)	**Non-SOBRA, Non-EFP**				**SOBRA**			
	'14/'13	**'15/'14**	**'15/'13**		**'14/'13**	**'15/'14**	**'15/'13**	
Inpatient	-3.9%	-6.5%	-5.2%		4.9%	-1.5%	1.7%	
Outpatient	0.3%	4.6%	2.4%		19.5%	9.1%	14.2%	
Professional	2.7%	-0.4%	1.1%		2.8%	2.4%	2.6%	
Pharmacy	6.8%	3.3%	5.0%		n/a	n/a	n/a	
Inst. (NH)	23.8%	22.1%	22.9%		n/a	n/a	n/a	
Composite	**Non-SOBRA, Non-EFP**			**Clm Dist**	**SOBRA**			**Clm Dist**
	'14/'13	**'15/'14**	**'15/'13**	**SFY '15**	**'14/'13**	**'15/'14**	**'15/'13**	**SFY '15**
Inpatient	2.7%	-5.3%	-1.4%	16.4%	4.9%	-1.5%	1.7%	44.9%
Outpatient	-1.8%	2.9%	0.5%	27.3%	19.5%	9.1%	14.2%	28.7%
Professional	0.3%	-1.3%	-0.5%	40.4%	2.8%	2.4%	2.6%	26.4%
Pharmacy	2.8%	0.9%	1.8%	15.8%	n/a	n/a	n/a	n/a
Inst. (NH)	-22.8%	-2.8%	-13.4%	0.1%	n/a	n/a	n/a	n/a
Medical Total			0.0%	100.0%			5.5%	100.0%

Adjustments to Trends

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was estimated on the selected trends, based on the specific language as it applied to Inpatient, Outpatient and Institutional unit cost trends. See the excerpt below for the specific applicable language, and Table 4 for the impact on selected trends.

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Article 5 – The selected trends were adjusted for the impact of **Article 5**, shown in greater detail in exhibits 4a, 4b, 4c, 4d and 4e in the appendix, to derive the final set of trends used to develop the projected benefit costs – see Table 4 below.

Table 4
Impact of Article 5

RIte Care
For Rate Period 2/1/2017 - 6/30/2017
Impact of Article 5 on Selected Trends

	Non-SOBRA	EFP [2]	SOBRA
Selected Trends Based on Experience	0.0%	0.05%	5.5%
Impact of Article 5 on Composite Trends:			
SFY '16 Trends with Article 5 [1] Implementation	-1.3%		-1.2%
7/1/2016 - 1/31/2017 Trends with Article 5 [1] Implementation	1.0%		2.1%
2/1/2017 - 6/30/2017 Trends with Article 5 [1] Implementation	1.0%		2.1%
Average annual trend [3] with Impact of Article 5 [1] Implementation	**0.0%**	**0.05%**	**0.7%**

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans are required to identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to rate period at **1.6%** annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. Since the health service re-class is reported on an aggregate basis, we allocated the re-class amounts based on each rate cell's claims volume to the aggregate. The composite reported re-class for the base period was **$1.82** PMPM, allocated to the Non-SOBRA capitation rates and the SOBRA payment rate, trended to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. EOHHS staff evaluated the RIte Care experience for SFY 2014 and identified 13 average eligible with such diagnoses, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 2 potential surgeries. The cost of surgery, at $52,650 per procedure in 2015, was estimated by EOHHS staff. The cost of surgery was projected to the rate period using the Non-SOBRA, Non-EFP composite inpatient trend as impacted by Article 5.

Table 5
Gender Dysphoria

RIte Care	
For Rate Period 2/1/2017 - 6/30/2017	
Gender Dysphoria	
Non-SOBRA	
	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [4]	$ 55,777
Number of persons estimated seeking surgical benefits [2]	2
Estimated total expenditures for Gender Dysphoria	$ 111,553
Rate Period projected average enrollment [3]	143,915
Estimated impact to Total RIte Care PMPM	$ 0.06
Rate Period projected average enrollment for applicable rate cells (M 15-44, F 15-44, MF 45+)	65,374
Estimated PMPM adjustment for Gender Dysphoria for affected rate cells	$ 0.14

PCMH-Kids – Per EOHHS, this program initiative is defined as follows: *"PCMH-Kids is a multi-payer patient centered medical home initiative. It grew out of the Care Transformation Collaborative (CTC, formerly known as CSI) to spread the transformation of primary care to practices serving children. Currently there are 9 participating primary care practices, serving approximately 30,000 children (approximately 14,000 attributed Medicaid lives). These 9 practices came together with all of the major health plans in Rhode Island (both commercial and Medicaid Managed Care Plans) to design a Common Contract that calls for supplemental payments to the practices to support the transformation. With these payments, practices are required to achieve NCQA PCMH recognition and hire staff for care*

coordination. The onsite care coordinator improves the capacity of the primary care office to manage and coordinate care for the highest needs children and families. Practices are also responsible for reporting and improving upon several measures promoting data-driven quality improvement and population health management. Practices will report clinical quality measures from their electronic health record, participate in a patient experience survey and use utilization data from the all-payers claims data-base to reduce the emergency department utilization of their patients.

Practices will be provided with an onsite practice coach, collaborative learning and best practice sharing opportunities throughout their time in the contract. At the end of the three-year contract, we anticipate that practices will have the foundation to be successful in advanced payment contracts with the health plans, such as shared savings and shared risk arrangements."

The State is allocating **$197,500** for the rate period, pro-rated for the percent of kids under 19 in each rate cell, for the continued development of this program that started in January 2016. It is anticipated that initial efforts by the plans will impact a limited number of enrollees, from which the State is setting a target savings amount of **$49,375**, pro-rated for the percent of kids under 19 in each rate cell. The strategies will include but will not be limited to:

- Expansion of the Chronic Care Sustainability Initiative (CSI) and the implementation of Patient-Centered Medical Home (PCMH) for kids.
- Improved efforts in the area of transitions of care and follow-up after hospital discharge, in particular for mental health hospitalizations
- Alternative contracting, reimbursement and operational arrangements with providers who have a large volume of high utilizing members
- Leveraging of new and existing resources, including Community Health Teams

Health Plans will submit a high utilizer strategy to EOHHS for review and approval. EOHHS will work collaboratively with the health plans to provide all necessary support and technical assistance in the implementation of these efforts.

Table 6
PCMH-Kids

RIte Care						
For Rate Period 2/1/2017 - 6/30/2017						
PCMH-Kids						
	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Rate Period Forecast Average Enrollment	5,231	28,202	45,107	16,818	40,161	8,396
Percent Under 19 (est. from 7/1/15-12/31/15 actual)	100%	100%	100%	29%	16%	0%
PCMH-Kids	5,231	28,202	45,107	4,825	6,410	-
PCMH-Kids Program Development Allowance [1]	$ 0.44	$ 0.44	$ 0.44	$ 0.44	$ 0.44	$ 0.44
Adjustment to Rate Cell for Development Allowance [1]	**$ 0.44**	**$ 0.44**	**$ 0.44**	**$ 0.13**	**$ 0.07**	**$ -**
PCMH-Kids Savings Target [1]	$ (0.11)	$ (0.11)	$ (0.11)	$ (0.11)	$ (0.11)	$ (0.11)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.11)**	**$ (0.11)**	**$ (0.11)**	**$ (0.03)**	**$ (0.02)**	**$ -**

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan*

(Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice, collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. The adjustment for this rate period is estimated by the State at **$(0.60)** PMPM. As applicable, the PMPMs are adjusted based on proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives.

Table 7
Care Transformation Collaborative - CTC

RIte Care						
For Rate Period 2/1/2017 - 6/30/2017						
Care Transformation Collaborative						
	Impact to PMPM					
	MF <1	**MF 1 - 5**	**MF 6 - 14**	**M 15 - 44**	**F 15 - 44**	**MF 45+**
Rate Period Forecast Average Enrollment	5,231	28,202	45,107	16,818	40,161	8,396
Percent 19+ (est. from 7/1/15-12/31/15 actual)	0%	0%	0%	71%	84%	100%
Adults 19+	-	-	-	11,992	33,751	8,396
CTC Program Expenses PMPM - Per Adult 19+ [1]	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)
Adjustment to Rate Cell for CTC Expenses	**$ -**	**$ -**	**$ -**	**$ (0.43)**	**$ (0.50)**	**$ (0.60)**

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 7 for the impact of this initiative.

Comprehensive Evaluation Diagnosis Assessment Referral and Re-evaluation (CEDARR) Services, referred to as Initiative 9A, integrate "out of plan services" for children with special health care needs into Medicaid MCOs:

CEDARR Services as defined by initiative 9A, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to integrate Home Based Therapeutic Services (HBTS), Personal Services and Supports (PASS), and Respite Care into an enrollee's total continuum of care. It is anticipated that the integration of these like services will enable the MCOs with greater flexibility to provide clinically appropriate and evidence-based lower-cost services to children and adolescents. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 7 for the impact of this initiative.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. See Table 7 for the impact of this initiative.

Table 8
Program Initiatives Savings

RIte Care						
For Rate Period 2/1/2017 - 6/30/2017						
Reinventing Medicaid Program Initiatives						
	Non-SOBRA					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Program Initiative Savings [1]						
BH Services	$ -	$ -	$ -	$ (1.71)	$ (1.94)	$ (1.41)
CEDARR Services	$ -	$ (0.29)	$ (1.03)	$ (0.34)	$ (0.08)	$ -
ACO	$ (8.38)	$ (2.13)	$ (2.20)	$ (3.35)	$ (4.88)	$ (6.72)

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. We reviewed the CPI factors for various categories and selected the "Medical Care Services" and "Health Insurance" categories to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The resulting administrative load is on average **9.8%** of projected composite medical PMPM.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to ***$1.66*** *PMPM for adults aged 19 and over.*

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Table 9
Adult Immunization

RIte Care For Rate Period 2/1/2017 - 6/30/2017 *Adult Immunization*	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Enrolled Member Months 7/1/15 - 12/31/15				56,293	101,734	32,938
Enrolled Member Months Aged 19+				40,141	85,496	32,938
% Enrolled Aged 19+				71.3%	84.0%	100.0%
Rate Period Forecast Average Enrollment	5,231	28,202	45,107	16,818	40,161	8,396
Estimated Aged 19+ Forecast Enrollment	**-**	**-**	**-**	**11,992**	**33,751**	**8,396**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ -	$ -	$ -	$ 1.66	$ 1.66	$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ -**	**$ -**	**$ -**	**$ 1.18**	**$ 1.40**	**$ 1.66**

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.

b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**
b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)"*.

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCOs satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. Performance Goal Program

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $1.75 PMPM

2. Provider Incentive Program

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO. These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM

The total maximum pay-out amount for all incentive programs is expected to be no more than **$4.65** PMPM. When measured relative to the proposed capitation rates – estimated composite rates, including EFP and SOBRA, of **$256.10** for non-profit plans and **$264.19** for for-profit plans, the incentive payments plus the capitation rates (& SOBRA payment) are within the 105% threshold for certified rates.

RATE DEVELOPMENT

RIte Care – Non-SOBRA, Non-EFP

Table 10

RIte Care Rate Development (Excluding SOBRA & EFP)

RIte Care							
For Rate Period 2/1/2017 - 6/30/2017							
Excluding SOBRA & EFP							
Rate Period Average Enrollment Forecast		**5,231**	**28,202**	**45,107**	**16,818**	**40,161**	**8,396**
		MF <1	**MF 1 - 5**	**MF 6 - 14**	**M 15 - 44**	**F 15 - 44**	**MF 45+**
Base PMPM Excluding SOBRA & EFP		$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20
Article 5-Adjusted Selected Trend [1]		0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
Projection Period (years)		2.29	2.29	2.29	2.29	2.29	2.29
Projected PMPM Excluding SOBRA & EFP		$ 417.42	$ 131.02	$ 131.34	$ 184.11	$ 276.23	$ 382.55
Adjustments:							
Health Service Reclass [2]		$ 3.41	$ 1.07	$ 1.07	$ 1.51	$ 2.26	$ 3.13
PCMH - Kids Program Development Allowance		$ 0.44	$ 0.44	$ 0.44	$ 0.13	$ 0.07	$ -
PCMH - Kids Savings Target		$ (0.11)	$ (0.11)	$ (0.11)	$ (0.03)	$ (0.02)	$ -
Gender Dysphoria [3]		$ -	$ -	$ -	$ 0.14	$ 0.14	$ 0.14
Care Transformation Collaborative (CTC) [6]		$ -	$ -	$ -	$ (0.43)	$ (0.50)	$ (0.60)
Program Initiative Savings							
BH Services		$ -	$ -	$ -	$ (1.71)	$ (1.94)	$ (1.41)
CEDARR Services		$ -	$ (0.29)	$ (1.03)	$ (0.34)	$ (0.08)	$ -
ACO		$ (8.38)	$ (2.13)	$ (2.20)	$ (3.35)	$ (4.88)	$ (6.72)
Fraud & Abuse (% of Medical)	1.0%	$ (4.13)	$ (1.30)	$ (1.30)	$ (1.80)	$ (2.71)	$ (3.77)
Subtotal Medical PMPM		$ 408.65	$ 128.70	$ 128.21	$ 178.23	$ 268.57	$ 373.32
Projected Administrative Load [4]		$ 39.51	$ 12.72	$ 12.34	$ 18.68	$ 25.58	$ 37.88
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 6.82	$ 2.15	$ 2.14	$ 3.00	$ 4.48	$ 6.26
Premium Before Taxes		$ 454.98	$ 143.57	$ 142.69	$ 199.91	$ 298.63	$ 417.46
Assessments: Adult Immunization		$ -	$ -	$ -	$ 1.18	$ 1.40	$ 1.66
State Premium Tax - Non-Profit Plans	*2.0%*	$ 9.29	$ 2.93	$ 2.91	$ 4.10	$ 6.12	$ 8.55
Projected PMPM For Non-Profit Plans		**$ 464.27**	**$ 146.50**	**$ 145.60**	**$ 205.19**	**$ 306.15**	**$ 427.67**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 9.58*	*$ 3.03*	*$ 3.00*	*$ 4.23*	*$ 6.32*	*$ 8.82*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 14.37	$ 4.53	$ 4.51	$ 6.35	$ 9.47	$ 13.24
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 478.93***	***$ 151.13***	***$ 150.20***	***$ 211.67***	***$ 315.82***	***$ 441.18***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on Plan G/L reports, and projected to rate period.

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff. Rate adjustments for this benefit will be applicable for F 15-44, M 15-44 and MF 45+ rate cells only

[4] Projected administrative load is based on MCO financial reporting of Operating Expenses for RIte Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Extended Family Planning (EFP)

The EFP capitation rate was developed using plan-submitted Encounter data for incurred SFY 2013, SFY 2014, and SFY 2015, paid through November 2015, estimated 100% complete. SFY 2015 was selected as the base period and was projected to the rate period using the Article 5 – adjusted selected trends for EFP (See Exhibits 4a, 4b, 4c, 4d and 4e in the Appendix).

The EFP administrative load, risk margin and taxes were developed from the same source data and in the same manner as the non-SOBRA rates discussed above.

Table 11
EFP Rate Development

RIte Care		
For Rate Period 2/1/2017 - 6/30/2017		
Extended Family Planning (EFP)		
		PMPM
Base EFP PMPM		**$ 8.92**
Article 5-Adjusted Selected Trend [1]		0.05%
Projection Period (years)		2.29
Projected EFP Claims PMPM		$ 8.93
Adjustments:		
Fraud & Abuse	1.0%	$ (0.09)
Subtotal Projected EFP Claims PMPM		$ 8.84
Projected Admin Expense		$ 0.86
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 0.15
Premium Before Taxes		$ 9.85
State Premium Tax - Non-Profit Plans	*2.0%*	$ 0.20
Projected EFP Capitation PMPM - Non-Profit Plans		**$ 10.05**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 0.21*
ACA Issuer Fee - per Plan estimate for 2015 [2]	*3.0%*	$ 0.31
Projected EFP PMPM with ACA Issuer Fee [2]	*0.950*	***$ 10.37***
[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives		
[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only		

SOBRA

The SOBRA payment rate was developed using plan-submitted Encounter data for incurred SFY 2013, SFY 2014, and SFY 2015, paid through November 2015, and estimated 100% complete. SFY 2015 was selected as the base period and was projected to the rate period using the Article 5 – adjusted selected trends for SOBRA (See Tables 3 and 4 above, and Exhibits 4a, 4b, 4c, 4d and 4e in the Appendix).

The SOBRA administrative load, risk margin and taxes were developed from the same source data and in the same manner as the non-SOBRA rates discussed above.

Table 12
SOBRA Rate Development

RIte Care
For Rate Period 2/1/2017 - 6/30/2017
Projected SOBRA Payment Rate

SOBRA Experience					
	SFY 2013		**SFY 2014**		**SFY 2015**
Claims Expense	$ 40,128,699		$ 44,256,516		$ 47,305,893
Number of Births	4,674		4,778		4,987
Net Cost / Birth	$ 8,586		$ 9,263		**$ 9,486**

		PMPMs With Article 5
Base Period Net Cost / Birth		$ 9,486
Article 5-Adjusted Selected Trend [1]		0.67%
Projection Period		2.29
Projected Net Payment Rate		**$ 9,632**
Adjustments:		
Health Service Reclass [2]		$ 79
Subtotal SOBRA Payment		**$ 9,711**
Proposed SOBRA Admin. Load		$ 949
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 162
Premium Before Taxes		$ 10,822
State Premium Tax - Non-Profit Plans	*2.0%*	$ 221
Projected SOBRA Rate with State Premium Tax		**$ 11,043**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 228*
ACA Issuer Fee - per Plan estimate for 2015 [3]	*3.0%*	*$ 342*
Projected SOBRA rate with ACA Issuer Fee [3]	*0.950*	***$ 11,392***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents

[3] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

Actuarial Certification

Certification of the RIte Care capitation rate and the SOBRA payment rates for the rate period 2/1/2017 – 6/30/2017, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

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APPENDIX

RIte Care

For Period 2/1/2017 - 6/30/2017

Aggregate Plan-Submitted Claims Experience

Excluding SOBRA & EFP

Including Off-line Adjustments

SFY 2013 RIte Care PLAN Experience

Type of Service Summary	MF< 1 Year	MF 1-5 Years	MF 6-14 Years	M 15-44 Years	F 15-44 Years	MF > =45 Years	Total
Inpatient	$ 14,680,848	$ 3,531,067	$ 7,554,452	$ 4,412,575	$ 11,812,899	$ 3,875,684	$ 45,867,525
Outpatient	$ 3,581,798	$ 11,346,852	$ 11,733,135	$ 7,118,033	$ 33,249,068	$ 6,137,263	$ 73,166,149
Professional	$ 8,630,225	$ 19,318,513	$ 24,713,518	$ 11,060,862	$ 38,490,904	$ 8,509,615	$ 110,723,638
Pharmacy	$ 1,316,684	$ 3,497,449	$ 8,939,287	$ 5,356,133	$ 16,867,486	$ 5,417,209	$ 41,394,248
Institutional (NH)	$ -	$ -	$ 8,340	$ 46,217	$ 117,133	$ 107,697	$ 279,387
Total	$ 28,209,555	$ 37,693,881	$ 52,948,732	$ 27,993,820	$ 100,537,491	$ 24,047,467	$ 271,430,946
Member Months	65,943	274,243	408,018	150,838	360,260	59,724	1,319,027
Total PMPM	$ 427.79	$ 137.45	$ 129.77	$ 185.59	$ 279.07	$ 402.64	$ 205.78

SFY 2014 RIte Care PLAN Experience

Type of Service Summary	MF< 1 Year	MF 1-5 Years	MF 6-14 Years	M 15-44 Years	F 15-44 Years	MF > =45 Years	Total
Inpatient	$ 14,618,214	$ 3,491,899	$ 8,326,812	$ 5,741,531	$ 13,551,688	$ 4,967,658	$ 50,697,802
Outpatient	$ 3,382,059	$ 10,933,179	$ 12,143,345	$ 8,261,411	$ 34,787,808	$ 7,893,268	$ 77,401,070
Professional	$ 9,367,381	$ 20,704,178	$ 27,260,106	$ 12,073,152	$ 40,755,576	$ 9,466,256	$ 119,626,649
Pharmacy	$ 1,046,017	$ 3,352,443	$ 10,074,672	$ 6,399,186	$ 18,931,962	$ 5,995,802	$ 45,800,082
Institutional (NH)	$ 25,280	$ -	$ 45,731	$ 14,664	$ 65,264	$ 81,369	$ 232,308
Total	$ 28,438,951	$ 38,481,700	$ 57,850,667	$ 32,489,943	$ 108,092,297	$ 28,404,353	$ 293,757,911
Member Months	65,359	282,704	442,576	166,367	391,794	71,464	1,420,264
Total PMPM	$ 435.12	$ 136.12	$ 130.71	$ 195.29	$ 275.89	$ 397.46	$ 206.83

SFY 2015 RIte Care PLAN Experience

Type of Service Summary	MF< 1 Year	MF 1-5 Years	MF 6-14 Years	M 15-44 Years	F 15-44 Years	MF > =45 Years	Total
Inpatient	$ 13,761,848	$ 3,186,490	$ 9,208,462	$ 6,050,747	$ 16,076,101	$ 5,541,566	$ 53,825,214
Outpatient	$ 3,663,794	$ 11,414,632	$ 14,019,918	$ 8,908,663	$ 40,774,989	$ 10,476,239	$ 89,258,235
Professional	$ 9,802,238	$ 21,080,765	$ 28,982,145	$ 13,584,769	$ 46,997,504	$ 11,923,039	$ 132,370,461
Pharmacy	$ 968,045	$ 3,346,557	$ 11,337,338	$ 7,290,371	$ 21,103,645	$ 7,720,900	$ 51,766,857
Institutional (NH)	$ -	$ -	$ -	$ 26,866	$ 81,655	$ 144,518	$ 253,039
Total	$ 28,195,925	$ 39,028,444	$ 63,547,863	$ 35,861,417	$ 125,033,894	$ 35,806,263	$ 327,473,807
Member Months	67,610	298,158	484,274	194,962	453,055	93,686	1,591,744
Total PMPM	$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20	$ 205.73

RIte Care

For Rate Period 2/1/2017 - 6/30/2018

Average Members

Rate Cell	SFY 2013	SFY 2014	SFY 2015
MF <1	5,495	5,447	5,634
MF 1-5	22,854	23,559	24,847
MF 6-14	34,002	36,881	40,356
Males 15-44	12,570	13,864	16,247
Females 15-44	30,022	32,650	37,755
MF >45	4,977	5,955	7,807
EFP	1,307	1,065	352

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Base PMPM

Excluding SOBRA & EFP

	SFY 2013	SFY 2014	SFY 2015
Wtd. Avg. of All Health Plans	$ 205.78	$ 206.83	**$ 205.73**

	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Selected Base Period PMPMs (SFY '15)	$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20
Base Period Average Members	*5,634*	*24,847*	*40,356*	*16,247*	*37,755*	*7,807*

Base Period Weighted Average PMPM	**$ 205.73**

Note: PMPMs include offline adjustments

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Incurred SFY, PT 11/15 est. 100%

Medical Trend Selection

Util/1000 (Util)	Non-SOBRA, Non-EFP			SOBRA		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient	6.8%	1.4%	4.0%			
Outpatient	-2.0%	-1.6%	-1.8%			
Professional	-2.3%	-0.8%	-1.6%			
Pharmacy	-3.8%	-2.4%	-3.1%			
Inst. (NH)	-37.6%	-20.4%	-29.5%			

Cost/Clm-Admt (price)	Non-SOBRA, Non-EFP			SOBRA		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient	-3.9%	-6.5%	-5.2%	4.9%	-1.5%	1.7%
Outpatient	0.3%	4.6%	2.4%	19.5%	9.1%	14.2%
Professional	2.7%	-0.4%	1.1%	2.8%	2.4%	2.6%
Pharmacy	6.8%	3.3%	5.0%	n/a	n/a	n/a
Inst. (NH)	23.8%	22.1%	22.9%	n/a	n/a	n/a

Composite	Non-SOBRA, Non-EFP			Clm Dist	SOBRA			Clm Dist
	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15
Inpatient	2.7%	-5.3%	-1.4%	16.4%	4.9%	-1.5%	1.7%	44.9%
Outpatient	-1.8%	2.9%	0.5%	27.3%	19.5%	9.1%	14.2%	28.7%
Professional	0.3%	-1.3%	-0.5%	40.4%	2.8%	2.4%	2.6%	26.4%
Pharmacy	2.8%	0.9%	1.8%	15.8%	n/a	n/a	n/a	n/a
Inst. (NH)	-22.8%	-2.8%	-13.4%	0.1%	n/a	n/a	n/a	n/a
Medical Total			0.0%	100.0%			5.5%	100.0%

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Impact of Article 5 on Selected Trends

Base Period MidPt *1/1/2015*	Non-SOBRA Selected Trend [3]				% In-State Clms. Dist.	SOBRA Selected Trend			
LOB	SFY '15 Clms. Dist.	Price	Util	comp		SFY '15 Clms. Dist.	Price	Util [2]	comp
Inpatient	16.4%	-5.2%	4.0%	-1.4%	96.0%	44.9%	1.7%	0.0%	1.7%
Outpatient	27.3%	2.4%	-1.8%	0.5%	95.9%	28.7%	14.2%	0.0%	14.2%
Professional	40.4%	1.1%	-1.6%	-0.5%		26.4%	2.6%	0.0%	2.6%
Pharmacy	15.8%	5.0%	-3.1%	1.8%					
Inst. (NH & Hospice)	0.1%	22.9%	-29.5%	-13.4%					
Total	100.0%			**0.0%**		100.0%			**5.5%**

12.00

1/1/2016	Impact of Article 5				Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.		Impact of Article 5				Impact of Trend on Clms. Dist.	
	SFY '15	7/1/15 - 6/30/16						SFY '15	7/1/15 - 6/30/16				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
Inpatient	16.4%	***-5.2%***	4.0%	-1.4%	-1.4%	16.4%	0.16	44.9%	***-2.5%***	0.0%	-2.5%	44.3%	0.44
Outpatient	27.3%	***-2.5%***	-1.8%	-4.3%	-4.1%	26.5%	0.26	28.7%	***-2.5%***	0.0%	-2.5%	28.3%	0.28
Professional	40.4%	1.1%	-1.6%	-0.5%	-0.5%	40.8%	0.40	26.4%	2.6%	0.0%	2.6%	27.4%	0.27
Pharmacy	15.8%	5.0%	-3.1%	1.8%	1.8%	16.3%	0.16					n/a	n/a
Inst. (NH & Hospice)	0.1%	***-2.0%***	-29.5%	-30.9%	-30.9%	0.1%	0.00	-				n/a	n/a
Total	100.0%			**-1.3%**	**-1.3%**	100.0%	0.99	100.0%			**-1.2%**	100.0%	0.99

9.47

10/15/2016	Impact of Article 5				Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.		Impact of Article 5				Impact of Trend on Clms. Dist.	
	SFY '15	7/1/16 - 1/31/17						SFY '15	7/1/16 - 1/31/17				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
Inpatient	16.4%	***1.9%***	4.0%	6.0%	5.7%	17.0%	0.17	44.9%	***1.9%***	0.0%	1.9%	44.2%	0.44
Outpatient	27.3%	***1.9%***	-1.8%	0.0%	0.1%	26.3%	0.26	28.7%	***1.9%***	0.0%	1.9%	28.3%	0.28
Professional	40.4%	1.1%	-1.6%	-0.5%	-0.5%	40.3%	0.40	26.4%	2.6%	0.0%	2.6%	27.5%	0.28
Pharmacy	15.8%	5.0%	-3.1%	1.8%	1.8%	16.4%	0.16					n/a	n/a
Inst. (NH & Hospice)	0.1%	***3.2%***	-29.5%	-27.3%	-27.3%	0.0%	0.00	-				n/a	n/a
Total	100.0%			**1.1%**	**1.0%**	100.0%	1.00	100.0%			**2.1%**	100.0%	1.00

6.00

4/15/2017	Impact of Article 5				Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.		Impact of Article 5				Impact of Trend on Clms. Dist.	
	SFY '15	2/1/17 - 6/30/17						SFY '15	2/1/17 - 6/30/17				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
IP	16.4%	***1.9%***	4.0%	6.0%	5.7%	17.4%	0.17	44.9%	***1.9%***	0.0%	1.9%	44.2%	0.45
OP	27.3%	***1.9%***	-1.8%	0.0%	0.1%	26.1%	0.26	28.7%	***1.9%***	0.0%	1.9%	28.2%	0.29
Prof	40.4%	1.1%	-1.6%	-0.5%	-0.5%	40.0%	0.40	26.4%	2.6%	0.0%	2.6%	27.6%	0.28
Rx	15.8%	5.0%	-3.1%	1.8%	1.8%	16.5%	0.16					n/a	n/a
Inst. (NH & Hospice)	0.1%	***3.2%***	-29.5%	-27.3%	-27.3%	0.0%	0.00	-				n/a	n/a
Total	100.0%			**1.1%**	**1.0%**	100.0%	1.00	100.0%			**2.1%**	100.0%	1.02

Rate Period MidPt *4/15/2017*	**27.47 OK**													
	Impact of Article 5				Adjusted Comp. Trend [1]	Change in Clms. dist. [3]	Adjusted Comp. Trend [1]	Impact of Article 5				Change in Clms. dist. [3]	Adjusted Comp. Trend
	SFY '15	**27.47 -Mo. Avg. Trends**						SFY '15	**27.47 -Mo. Avg. Trends**				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
IP	16.4%	-1.3%	4.0%	2.7%	2.6%	16.9%	2.6%	44.9%	0.0%	0.0%	0.0%	44.5%	0.0%
OP	27.3%	0.0%	-1.8%	-1.9%	-1.8%	26.7%	-1.8%	28.7%	0.0%	0.0%	0.0%	28.5%	0.0%
Prof	40.4%	1.1%	-1.6%	-0.5%	-0.5%	40.2%	-0.5%	26.4%	2.6%	0.0%	2.6%	27.0%	2.6%
Rx	15.8%	5.0%	-3.1%	1.8%	1.8%	16.1%	1.8%					n/a	n/a
Inst. (NH & Hospice)	0.1%	0.9%	-29.5%	-28.9%	-28.9%	0.1%	-28.9%	-				n/a	n/a
	100.0%			**0.01%**	**0.01%**	100.0%	**0.04%**	100.0%			**0.7%**	100.0%	**0.67%**
	27.47 -Mo. Avg. Trend			**0.02%**	**0.02%**		**0.04%**	**Avg. Trend**			**0.66%**		**0.67%**

Note: Article 5 is as per the State's Reinventing Medicaid initiatives

[1] Non-SOBRA trends are adjusted to reflect In-State hospital claims

2 For the SOBRA Trend Impact Analysis, utilization was excluded since the SOBRA payment **rate** is independent of utilization

[3] Change in Claims Distribution reflects the average of the distributions from the base period and the rate period

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Impact of Article 5 on Selected Trends For EFP

Non-EFP, Non-SOBRA			
LOB	Selected Composite Trends	Composite Trends w/Art 5	Art 5 Impact Factor
OP	0.5%	-1.8%	0.977
Prof	-0.5%	-0.5%	-
Rx	1.8%	1.8%	-
Total			

EFP [1]		
SFY '15 Claims Dist	Selected Composite Trends [2]	Composite Trends w/Art 5
43.4%	2.5%	0.12%
18.2%	0.0%	0.00%
38.4%	0.0%	0.00%
100.0%	1.1%	**0.05%**

Selected Trend [3] **0.05%**

[1] The impact of Article 5 on EFP trends is estimated by deriving the impact of Article 5 on Non-EFP composite trends (over the projection period from the base period to the rate period) and applying it to the selected EFP composite trend

[2] EFP benefits do not include hospital inpatient benefits

[3] As applicable, negative trends are disallowed on EFP due to volatility in the underlying data and the impact of ACA on average enrolled

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Impact of Article 5 on Selected Trends

	Non-SOBRA	EFP [2]	SOBRA
Selected Trends Based on Experience	0.0%	0.05%	5.5%
Impact of Article 5 on Composite Trends:			
SFY '16 Trends with Article 5 [1] Implementation	-1.3%		-1.2%
7/1/2016 - 1/31/2017 Trends with Article 5 [1] Implementation	1.0%		2.1%
2/1/2017 - 6/30/2017 Trends with Article 5 [1] Implementation	1.0%		2.1%
Average annual trend [3] with Impact of Article 5[1] Implementation	**0.0%**	**0.05%**	**0.7%**

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Impact of Article 5 on EFP trend is based on the 2-yr average composite effect of Article 5 on the RIte Care hospital OP trend, since EFP does not include hospital IP benefits

[3] Reflects change in TOS claims distribution over time as a result of different trends by TOS (e.g. Inpatient vs. Outpatient, etc.) - see Trend Detail exhibit

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

PCMH-Kids

	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Rate Period Forecast Average Enrollment	5,231	28,202	45,107	16,818	40,161	8,396
Percent Under 19 (est. from 7/1/15-12/31/15 actual)	100%	100%	100%	29%	16%	0%
PCMH-Kids	5,231	28,202	45,107	4,825	6,410	-
PCMH-Kids Program Development Allowance [1]	$ 0.44	$ 0.44	$ 0.44	$ 0.44	$ 0.44	$ 0.44
Adjustment to Rate Cell for Development Allowance [1]	**$ 0.44**	**$ 0.44**	**$ 0.44**	**$ 0.13**	**$ 0.07**	**$ -**
PCMH-Kids Savings Target [1]	$ (0.11)	$ (0.11)	$ (0.11)	$ (0.11)	$ (0.11)	$ (0.11)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.11)**	**$ (0.11)**	**$ (0.11)**	**$ (0.03)**	**$ (0.02)**	**$ -**

[1] Program Development Allowance and Savings Targets as set by the State

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Gender Dysphoria

Non-SOBRA

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [4]	$ 55,777
Number of persons estimated seeking surgical benefits [2]	2
Estimated total expenditures for Gender Dysphoria	$ 111,553
Rate Period projected average enrollment [3]	143,915
Estimated impact to Total RIte Care PMPM	$ 0.06
Rate Period projected average enrollment for applicable rate cells (M 15-44, F 15-44, MF 45+)	65,374
Estimated PMPM adjustment for Gender Dysphoria for affected rate cells	$ 0.14

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person and assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism. Analysis identified 13 average eligibles with such diagnoses; assumed a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[3] Excludes EFP

[4] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Care Transformation Collaborative

	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Rate Period Forecast Average Enrollment	5,231	28,202	45,107	16,818	40,161	8,396
Percent 19+ (est. from 7/1/15-12/31/15 actual)	0%	0%	0%	71%	84%	100%
Adults 19+	-	-	-	11,992	33,751	8,396
CTC Program Expenses PMPM - Per Adult 19+ [1]	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)
Adjustment to Rate Cell for CTC Expenses	**$ -**	**$ -**	**$ -**	**$ (0.43)**	**$ (0.50)**	**$ (0.60)**

[1] CTC PMPM expense adjustment for graduating practice sites, not currently reflected in the base period expenses

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Reinventing Medicaid Program Initiatives

	Non-SOBRA					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Program Initiative Savings [1]						
BH Services	$ -	$ -	$ -	$ (1.71)	$ (1.94)	$ (1.41)
CEDARR Services	$ -	$ (0.29)	$ (1.03)	$ (0.34)	$ (0.08)	$ -
ACO	$ (8.38)	$ (2.13)	$ (2.20)	$ (3.35)	$ (4.88)	$ (6.72)

[1] Please refer to the narrative section of the Data Book for a description of each of the Program Initiatives

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Adult Immunization

	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Enrolled Member Months 7/1/15 - 12/31/15				56,293	101,734	32,938
Enrolled Member Months Aged 19+				40,141	85,496	32,938
% Enrolled Aged 19+				71.3%	84.0%	100.0%
Rate Period Forecast Average Enrollment	5,231	28,202	45,107	16,818	40,161	8,396
Estimated Aged 19+ Forecast Enrollment	**-**	**-**	**-**	**11,992**	**33,751**	**8,396**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ -	$ -	$ -	$ 1.66	$ 1.66	$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ -**	**$ -**	**$ -**	**$ 1.18**	**$ 1.40**	**$ 1.66**

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Excluding SOBRA & EFP

		MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Rate Period Average Enrollment Forecast		**5,231**	**28,202**	**45,107**	**16,818**	**40,161**	**8,396**
Base PMPM Excluding SOBRA & EFP		$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20
Article 5-Adjusted Selected Trend [1]		0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
Projection Period (years)		2.29	2.29	2.29	2.29	2.29	2.29
Projected PMPM Excluding SOBRA & EFP		$ 417.42	$ 131.02	$ 131.34	$ 184.11	$ 276.23	$ 382.55
Adjustments:							
Health Service Reclass [2]		$ 3.41	$ 1.07	$ 1.07	$ 1.51	$ 2.26	$ 3.13
PCMH - Kids Program Development Allowance		$ 0.44	$ 0.44	$ 0.44	$ 0.13	$ 0.07	$ -
PCMH - Kids Savings Target		$ (0.11)	$ (0.11)	$ (0.11)	$ (0.03)	$ (0.02)	$ -
Gender Dysphoria [3]		$ -	$ -	$ -	$ 0.14	$ 0.14	$ 0.14
Care Transformation Collaborative (CTC) [6]		$ -	$ -	$ -	$ (0.43)	$ (0.50)	$ (0.60)
Program Initiative Savings							
BH Services		$ -	$ -	$ -	$ (1.71)	$ (1.94)	$ (1.41)
CEDARR Services		$ -	$ (0.29)	$ (1.03)	$ (0.34)	$ (0.08)	$ -
ACO		$ (8.38)	$ (2.13)	$ (2.20)	$ (3.35)	$ (4.88)	$ (6.72)
Fraud & Abuse (% of Medical)	1.0%	$ (4.13)	$ (1.30)	$ (1.30)	$ (1.80)	$ (2.71)	$ (3.77)
Subtotal Medical PMPM		$ 408.65	$ 128.70	$ 128.21	$ 178.23	$ 268.57	$ 373.32
Projected Administrative Load [4]		$ 39.51	$ 12.72	$ 12.34	$ 18.68	$ 25.58	$ 37.88
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 6.82	$ 2.15	$ 2.14	$ 3.00	$ 4.48	$ 6.26
Premium Before Taxes		$ 454.98	$ 143.57	$ 142.69	$ 199.91	$ 298.63	$ 417.46
Assessments: Adult Immunization		$ -	$ -	$ -	$ 1.18	$ 1.40	$ 1.66
State Premium Tax - Non-Profit Plans	*2.0%*	$ 9.29	$ 2.93	$ 2.91	$ 4.10	$ 6.12	$ 8.55
Projected PMPM For Non-Profit Plans		**$ 464.27**	**$ 146.50**	**$ 145.60**	**$ 205.19**	**$ 306.15**	**$ 427.67**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 9.58*	*$ 3.03*	*$ 3.00*	*$ 4.23*	*$ 6.32*	*$ 8.82*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 14.37	$ 4.53	$ 4.51	$ 6.35	$ 9.47	$ 13.24
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 478.93***	***$ 151.13***	***$ 150.20***	***$ 211.67***	***$ 315.82***	***$ 441.18***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on Plan G/L reports, and projected to rate period.

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff. Rate adjustments for this benefit will be applicable for F 15-44, M 15-44 and MF 45+ rate cells only

[4] Projected administrative load is based on MCO financial reporting of Operating Expenses for RIte Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

RIte Care

For Rate Period 2/1/2017 - 6/30/2017

Extended Family Planning (EFP)

		PMPM
Base EFP PMPM		**$ 8.92**
Article 5-Adjusted Selected Trend [1]		0.05%
Projection Period (years)		2.29
Projected EFP Claims PMPM		$ 8.93
Adjustments:		
Fraud & Abuse	1.0%	$ (0.09)
Subtotal Projected EFP Claims PMPM		$ 8.84
Projected Admin Expense		$ 0.86
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 0.15
Premium Before Taxes		$ 9.85
State Premium Tax - Non-Profit Plans	*2.0%*	$ 0.20
Projected EFP Capitation PMPM - Non-Profit Plans		**$ 10.05**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 0.21*
ACA Issuer Fee - per Plan estimate for 2015 [2]	*3.0%*	$ 0.31
Projected EFP PMPM with ACA Issuer Fee [2]	*0.950*	***$ 10.37***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

RIte Care
For Rate Period 2/1/2017 - 6/30/2017
Projected SOBRA Payment Rate

SOBRA Experience	SFY 2013	SFY 2014	SFY 2015
Claims Expense	$ 40,128,699	$ 44,256,516	$ 47,305,893
Number of Births	4,674	4,778	4,987
Net Cost / Birth	$ 8,586	$ 9,263	**$ 9,486**

		PMPMs With Article 5
Base Period Net Cost / Birth		$ 9,486
Article 5-Adjusted Selected Trend [1]		0.67%
Projection Period		2.29
Projected Net Payment Rate		**$ 9,632**
Adjustments:		
Health Service Reclass [2]		$ 79
Subtotal SOBRA Payment		**$ 9,711**
Proposed SOBRA Admin. Load		$ 949
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 162
Premium Before Taxes		$ 10,822
State Premium Tax - Non-Profit Plans	*2.0%*	$ 221
Projected SOBRA Rate with State Premium Tax		**$ 11,043**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 228*
ACA Issuer Fee - per Plan estimate for 2015 [3]	*3.0%*	*$ 342*
Projected SOBRA rate with ACA Issuer Fee [3]	*0.950*	***$ 11,392***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents

[3] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

RIte Care
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	Non-Profit Plans: 2% State Premium Tax: Non-Profit Plans	Non-Profit Plans: Proposed Capitation Rates: Non-Profit Plans	For-Profit Plans: 2% State Premium Tax: For-Profit Plans	For-Profit Plans: Est. ACA Issuer Fee: For-Profit Plans [2]	For-Profit Plans: Capitation Rates w/ Premium & Issuer Taxes
MF <1	$ 408.65	$ 39.51	$ 6.82	$ -	$ 9.29	**$ 464.27**	$ 9.58	$ 14.37	**$ 478.93**
MF 1-5	$ 128.70	$ 12.72	$ 2.15	$ -	$ 2.93	**$ 146.50**	$ 3.03	$ 4.53	**$ 151.13**
MF 6-14	$ 128.21	$ 12.34	$ 2.14	$ -	$ 2.91	**$ 145.60**	$ 3.00	$ 4.51	**$ 150.20**
Males 15-44	$ 178.23	$ 18.68	$ 3.00	$ 1.18	$ 4.10	**$ 205.19**	$ 4.23	$ 6.35	**$ 211.67**
Females 15-44	$ 268.57	$ 25.58	$ 4.48	$ 1.40	$ 6.12	**$ 306.15**	$ 6.32	$ 9.47	**$ 315.82**
MF 45+	$ 373.32	$ 37.88	$ 6.26	$ 1.66	$ 8.55	**$ 427.67**	$ 8.82	$ 13.24	**$ 441.18**
EFP	$ 8.84	$ 0.86	$ 0.15	$ -	$ 0.20	**$ 10.05**	$ 0.21	$ 0.31	**$ 10.37**
SOBRA (Pmt.)	$ 9,711	$ 949	$ 162	$ -	$ 221	**$ 11,043**	$ 228	$ 342	**$ 11,392**

[1] Risk Margin set at 1.5% of premiums before taxes

[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

[3] Includes Adult Immunizations

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the State capitation rates for Rhode Island's State Medicaid program (RIte Care) for the 5-month period February 1, 2017 through June 30, 2017. The 5-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following eligibility categories: males and females under age 1, males and females ages 1 to 5, males and females ages 6 to 14, males ages 15 to 44, females ages 15 to 44, and males and females ages 45 and older. Separate capitation rates were developed for Extended Family Planning (EFP) for certain qualifying post-partum women not otherwise eligible for full RIte Care benefits. This certification also addresses the development of the lump-sum SOBRA payment for eligible pregnant women for their prenatal care, delivery and post-natal care.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Thomas M. Donlon

June 30, 2016
Date

Thomas M. Donlon, FSA, MAAA
Principal
tom.donlon@terrygroup.com

June 28, 2016

RIte Care Data Book

State of Rhode Island

Rates for the period 7/1/2017 through 6/30/2018

Final & Confidential

Prepared by:
HealthCare Analytics
PO Box 41408
Providence, RI 02940-1408

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1

INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 7/1/2017 through 6/30/2018 for RIte Care, a Medicaid managed care program authorized under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration.

RIte Care provides eligible children and their families with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE). The health plans are paid capitation rates based on rate cells that are age and gender-driven. The State also pays capitation rates for Extended Family Planning (EFP) for certain qualifying post-partum women not otherwise eligible for full RIte Care benefits for a restricted set of benefits, and it provides lump-sum SOBRA payments for eligible pregnant women for their prenatal care, delivery and post-natal care. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the RIte Care per member per month (PMPM) capitation rates and SOBRA payment rate effective July 1, 2017 through June 30, 2018, for the purpose of attaining rate approval from CMS under 42 CFR 438.6(c). This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using selected trends developed from the claims experience, adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the RIte Care claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected RIte Care rates presented in this data book:

- Patient-Centered Medical Homes for Kids (PCMH-Kids)
- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for RIte Care were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

2

CAPITATION RATES & DEMOGRAPHICS

The capitation rates and SOBRA payments (including administrative and premium tax loads) for the rate period 7/1/2017 – 6/30/2018 are as follows:

Table 1
Capitation Rates

RIte Care
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018
Including Reinventing Medicaid Program Initiatives

					Non-Profit Plans		For-Profit Plans		
Capitation Rate Cell	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	2% State Premium Tax: Non-Profit Plans	Proposed Capitation Rates: Non-Profit Plans	2% State Premium Tax: For-Profit Plans	Est. ACA Issuer Fee: For-Profit Plans [2]	Capitation Rates w/ Premium & Issuer Taxes
MF <1	$ 412.15	$ 39.95	$ 6.88	$ -	$ 9.37	**$ 468.35**	$ 9.67	$ 14.49	**$ 483.14**
MF 1-5	$ 129.77	$ 12.86	$ 2.17	$ -	$ 2.96	**$ 147.76**	$ 3.05	$ 4.57	**$ 152.42**
MF 6-14	$ 129.30	$ 12.48	$ 2.16	$ -	$ 2.94	**$ 146.88**	$ 3.03	$ 4.55	**$ 151.52**
Males 15-44	$ 179.79	$ 18.88	$ 3.03	$ 1.18	$ 4.14	**$ 207.02**	$ 4.27	$ 6.41	**$ 213.56**
Females 15-44	$ 270.92	$ 25.87	$ 4.52	$ 1.40	$ 6.18	**$ 308.89**	$ 6.37	$ 9.56	**$ 318.64**
MF 45+	$ 376.56	$ 38.30	$ 6.32	$ 1.66	$ 8.63	**$ 431.47**	$ 8.90	$ 13.35	**$ 445.09**
EFP	$ 8.89	$ 0.87	$ 0.15	$ -	$ 0.20	**$ 10.11**	$ 0.21	$ 0.31	**$ 10.43**
SOBRA (Pmt.)	$ 9,854	$ 965	$ 165	$ -	$ 224	**$ 11,208**	$ 231	$ 347	**$ 11,562**

[1] Risk Margin set at 1.5% of premiums before taxes
[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only
[3] Includes Adult Immunizations

3

RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data reports, which were based on encounter data, covered the following State Fiscal Years (SFY)

- 7/1/2012 through 6/30/2013 (SFY 2013), paid through 11/30/2015, estimated at 100%
- 7/1/2013 through 6/30/2014 (SFY 2014), paid through 11/30/2015, estimated at 100%
- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

The claims data was delineated by rate cell and by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail which allowed us to examine historical patterns for unit cost and utilization levels (see Exhibit 1 in the Appendix).

All claims data including SFY 2013, SFY 2014, and SFY 2015 were presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2013, SFY 2014 and SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Exhibit 2 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2013, SFY 2014, and SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '13, SFY '14, and SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services
- CEDARR

BASE PERIOD

The Base Period PMPM was based on the weighted average blend of the participating plans' experience for SFY 2015 – see Table 2 below.

Table 2
Base Period PMPM (excluding SOBRA and EFP):

RIte Care						
For Rate Period 7/1/2017 - 6/30/2018						
Base PMPM						
Excluding SOBRA & EFP						
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Selected Base Period PMPMs (SFY '15)	$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20

TRENDS AND TREND DEVELOPMENT

Trends were developed on the composite experience of the program, by service category, from the claims data including the G/L adjustments. For this rate period, the selected trend was based on the 2-year average unit cost and utilization trends of SFY 2015 over SFY 2013 – see Table 3 below. The selected trends were then adjusted for the impact of **Article 5**, shown in greater detail in exhibits 4a, 4b, 4c, 4d and 4e in the appendix, to derive the final set of trends used to develop the projected benefit costs – see Table 4 below.

Table 3
Selected Trends:

RIte Care								
For Rate Period 7/1/2017 - 6/30/2018								
Incurred SFY, PT 11/15 est. 100%								
Medical Trend Selection								
Util/1000 (Util)	**Non-SOBRA, Non-EFP**				**SOBRA**			
	'14/'13	**'15/'14**	**'15/'13**		**'14/'13**	**'15/'14**	**'15/'13**	
Inpatient	6.8%	1.4%	4.0%					
Outpatient	-2.0%	-1.6%	-1.8%					
Professional	-2.3%	-0.8%	-1.6%					
Pharmacy	-3.8%	-2.4%	-3.1%					
Inst. (NH)	-37.6%	-20.4%	-29.5%					
Cost/Clm-Admt (price)	**Non-SOBRA, Non-EFP**				**SOBRA**			
	'14/'13	**'15/'14**	**'15/'13**		**'14/'13**	**'15/'14**	**'15/'13**	
Inpatient	-3.9%	-6.5%	-5.2%		4.9%	-1.5%	1.7%	
Outpatient	0.3%	4.6%	2.4%		19.5%	9.1%	14.2%	
Professional	2.7%	-0.4%	1.1%		2.8%	2.4%	2.6%	
Pharmacy	6.8%	3.3%	5.0%		n/a	n/a	n/a	
Inst. (NH)	23.8%	22.1%	22.9%		n/a	n/a	n/a	
Composite	**Non-SOBRA, Non-EFP**			**Clm Dist**	**SOBRA**			**Clm Dist**
	'14/'13	**'15/'14**	**'15/'13**	**SFY '15**	**'14/'13**	**'15/'14**	**'15/'13**	**SFY '15**
Inpatient	2.7%	-5.3%	-1.4%	16.4%	4.9%	-1.5%	1.7%	44.9%
Outpatient	-1.8%	2.9%	0.5%	27.3%	19.5%	9.1%	14.2%	28.7%
Professional	0.3%	-1.3%	-0.5%	40.4%	2.8%	2.4%	2.6%	26.4%
Pharmacy	2.8%	0.9%	1.8%	15.8%	n/a	n/a	n/a	n/a
Inst. (NH)	-22.8%	-2.8%	-13.4%	0.1%	n/a	n/a	n/a	n/a
Medical Total			0.0%	100.0%			5.5%	100.0%

Adjustments to Trends

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was estimated on the selected trends, based on the specific language as it applied to Inpatient, Outpatient and Institutional unit cost trends. See the excerpt below for the specific applicable language, and Table 4 for the impact on selected trends.

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Article 5 – The selected trends were adjusted for the impact of **Article 5**, shown in greater detail in exhibits 4a, 4b, 4c, 4d and 4e in the appendix, to derive the final set of trends used to develop the projected benefit costs – see Table 4 below.

Table 4
Impact of Article 5

RIte Care
For Rate Period 7/1/2017 - 6/30/2018
Impact of Article 5 on Selected Trends

	Non-SOBRA	EFP [2]	SOBRA
Selected Trends Based on Experience	0.0%	0.24%	5.5%
Impact of Article 5 on Composite Trends:			
SFY '16 Trends with Article 5 [1] Implementation	-1.3%		-1.2%
SFY '17 Trends with Article 5 [1] Implementation	1.0%		2.1%
SFY '18 Trends with Article 5 [1] Implementation	1.0%		2.1%
Average annual trend [3] with Impact of Article 5[1] Implementation	**0.3%**	**0.24%**	**1.0%**

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans are required to identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to rate period at **1.6%** annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. Since the health service re-class is reported on an aggregate basis, we allocated the re-class amounts based on each rate cell's claims volume to the aggregate. The composite reported re-class for the base period was **$1.82** PMPM, allocated to the Non-SOBRA capitation rates and the SOBRA payment rate, trended to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. EOHHS staff evaluated the RIte Care experience for SFY 2014 and identified 13 average eligible with such diagnoses, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 2 potential surgeries. The cost of surgery, at $52,650 per procedure in 2015, was estimated by EOHHS staff. The cost of surgery was projected to the rate period using the Non-SOBRA, Non-EFP composite inpatient trend as impacted by Article 5.

Table 5
Gender Dysphoria

RIte Care	
For Rate Period 7/1/2017 - 6/30/2018	
Gender Dysphoria	
Non-SOBRA	
	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [4]	$ 58,027
Number of persons estimated seeking surgical benefits [2]	2
Estimated total expenditures for Gender Dysphoria	$ 116,053
Rate Period projected average enrollment [3]	145,949
Estimated impact to Total RIte Care PMPM	$ 0.07
Rate Period projected average enrollment for applicable rate cells (M 15-44, F 15-44, MF 45+)	66,299
Estimated PMPM adjustment for Gender Dysphoria for affected rate cells	$ 0.15

PCMH-Kids – Per EOHHS, this program initiative is defined as follows: *"PCMH-Kids is a multi-payer patient centered medical home initiative. It grew out of the Care Transformation Collaborative (CTC, formerly known as CSI) to spread the transformation of primary care to practices serving children. Currently there are 9 participating primary care practices, serving approximately 30,000 children (approximately 14,000 attributed Medicaid lives). These 9 practices came together with all of the major health plans in Rhode Island (both commercial and Medicaid Managed Care Plans) to design a Common Contract that calls for supplemental payments to the practices to support the transformation. With these payments, practices are required to achieve NCQA PCMH recognition and hire staff for care*

coordination. The onsite care coordinator improves the capacity of the primary care office to manage and coordinate care for the highest needs children and families. Practices are also responsible for reporting and improving upon several measures promoting data-driven quality improvement and population health management. Practices will report clinical quality measures from their electronic health record, participate in a patient experience survey and use utilization data from the all-payers claims data-base to reduce the emergency department utilization of their patients.

Practices will be provided with an onsite practice coach, collaborative learning and best practice sharing opportunities throughout their time in the contract. At the end of the three-year contract, we anticipate that practices will have the foundation to be successful in advanced payment contracts with the health plans, such as shared savings and shared risk arrangements."

The State is allocating **$453,000** for the rate period, pro-rated for the percent of kids under 19 in each rate cell, for the continued development of this program that started in January 2016. It is anticipated that initial efforts by the plans will impact a limited number of enrollees, from which the State is setting a target savings amount of **$113,250**, pro-rated for the percent of kids under 19 in each rate cell. The strategies will include but will not be limited to:

- Expansion of the Chronic Care Sustainability Initiative (CSI) and the implementation of Patient-Centered Medical Home (PCMH) for kids.
- Improved efforts in the area of transitions of care and follow-up after hospital discharge, in particular for mental health hospitalizations
- Alternative contracting, reimbursement and operational arrangements with providers who have a large volume of high utilizing members
- Leveraging of new and existing resources, including Community Health Teams

Health Plans will submit a high utilizer strategy to EOHHS for review and approval. EOHHS will work collaboratively with the health plans to provide all necessary support and technical assistance in the implementation of these efforts.

Table 6
PCMH-Kids

RIte Care						
For Rate Period 7/1/2017 - 6/30/2018						
PCMH-Kids						
	Impact to PMPM					
	MF <1	**MF 1 - 5**	**MF 6 - 14**	**M 15 - 44**	**F 15 - 44**	**MF 45+**
Rate Period Forecast Average Enrollment	5,305	28,601	45,744	17,056	40,729	8,515
Percent Under 19 (est. from 7/1/15-12/31/15 actual)	100%	100%	100%	29%	16%	0%
PCMH-Kids	5,305	28,601	45,744	4,894	6,501	-
PCMH-Kids Program Development Allowance [1]	$ 0.41	$ 0.41	$ 0.41	$ 0.41	$ 0.41	$ 0.41
Adjustment to Rate Cell for Development Allowance [1]	**$ 0.41**	**$ 0.41**	**$ 0.41**	**$ 0.12**	**$ 0.07**	**$ -**
PCMH-Kids Savings Target [1]	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.10)**	**$ (0.10)**	**$ (0.10)**	**$ (0.03)**	**$ (0.02)**	**$ -**

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan*

(Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice, collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. The adjustment for this rate period is estimated by the State at **$(0.59)** PMPM. As applicable, the PMPMs are adjusted based on proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives.

Table 7
Care Transformation Collaborative - CTC

RIte Care						
For Rate Period 7/1/2017 - 6/30/2018						
Care Transformation Collaborative						
	Impact to PMPM					
	MF <1	**MF 1 - 5**	**MF 6 - 14**	**M 15 - 44**	**F 15 - 44**	**MF 45+**
Rate Period Forecast Average Enrollment	5,305	28,601	45,744	17,056	40,729	8,515
Percent 19+ (est. from 7/1/15-12/31/15 actual)	0%	0%	0%	71%	84%	100%
Adults 19+	-	-	-	12,162	34,228	8,515
CTC Program Expenses PMPM - Per Adult 19+ [1]	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)
Adjustment to Rate Cell for CTC Expenses	**$ -**	**$ -**	**$ -**	**$ (0.42)**	**$ (0.50)**	**$ (0.59)**

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 8 for the impact of this initiative.

Comprehensive Evaluation Diagnosis Assessment Referral and Re-evaluation (CEDARR) Services, referred to as Initiative 9A, integrate "out of plan services" for children with special health care needs into Medicaid MCOs:

CEDARR Services as defined by initiative 9A, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to integrate Home Based Therapeutic Services (HBTS), Personal Services and Supports (PASS), and Respite Care into an enrollee's total continuum of care. It is anticipated that the integration of these like services will enable the MCOs with greater flexibility to provide clinically appropriate and evidence-based lower-cost services to children and adolescents. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 8 for the impact of this initiative.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. See Table 8 for the impact of this initiative.

Table 8
Program Initiatives Savings

RIte Care						
For Rate Period 7/1/2017 - 6/30/2018						
Reinventing Medicaid Program Initiatives						
	Non-SOBRA					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Program Initiative Savings [1]						
BH Services	$ -	$ -	$ -	$ (1.69)	$ (1.91)	$ (1.39)
CEDARR Services	$ -	$ (0.29)	$ (1.02)	$ (0.34)	$ (0.08)	$ -
ACO	$ (8.26)	$ (2.10)	$ (2.17)	$ (3.30)	$ (4.81)	$ (6.63)

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. We reviewed the CPI factors for various categories and selected the "Medical Care Services" and "Health Insurance" categories to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The resulting administrative load is on average **9.8%** of projected composite medical PMPM.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to ***$1.66*** *PMPM for adults aged 19 and over.*

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Table 9
Adult Immunization

RIte Care						
For Rate Period 7/1/2017 - 6/30/2018						
Adult Immunization						
	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Enrolled Member Months 7/1/15 - 12/31/15				56,293	101,734	32,938
Enrolled Member Months Aged 19+				40,141	85,496	32,938
% Enrolled Aged 19+				71.3%	84.0%	100.0%
Rate Period Forecast Average Enrollment	5,305	28,601	45,744	17,056	40,729	8,515
Estimated Aged 19+ Forecast Enrollment	**-**	**-**	**-**	**12,162**	**34,228**	**8,515**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ -	$ -	$ -	$ 1.66	$ 1.66	$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ -**	**$ -**	**$ -**	**$ 1.18**	**$ 1.40**	**$ 1.66**

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.

b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**

b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)"*.

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCOs satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. **Health System Transformation Program**

Through its *Health System Transformation Program Rhode Island* and its Medicaid MCOs shall support and incentivize a critical transformation of RI's system of care. The Program will award investments in performance-based infrastructure development by Medicaid Certified Accountable Entities (AE). Medicaid MCOs will be full partners in this transition, as the ultimate intent of this effort is to support the development of value-based contracts between the health plans and AEs.

Accountable Entities that meet state defined certification standards will initially apply for infrastructure funding to develop the governance, technology, skills and capacity to enter into risk-based contracts with Medicaid MCOs; manage enrollees' care across AE providers; and decrease out-year cost trend rates. Qualified AEs must meet one of three levels of readiness demonstrating that they either have or are developing the capacity to integrate and manage the full continuum of health care and to address members' social determinants (e.g., housing, food), in a way that is acceptable to CMS and the State.

The State shall reimburse the health plan for State-approved incentive payments that a health plan makes to providers making infrastructure investments to support this development of Accountable Entities. Up to 10 percent of the incentive payments may be retained by the health plan as an enhanced performance award to accelerate the development of value-based purchasing contracts with Accountable Entities.

Total payments made by all health plans cannot exceed the lesser of the maximum PMPM allocation indicated below or the maximum amount allocated by Rhode Island for the Health Systems Transformation Program within the Contract Period. Payments shall be distributed across the various Products (RIte Care, Substitute Care, Children with Special Healthcare Needs, Rhody Health Partners and Adult Expansion) based on the proportion of the Medicaid MCO's members associated with the AE being awarded the incentive payment.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $6.75 PMPM

2. **Performance Goal Program**

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $1.75 PMPM

3. **Provider Incentive Program**

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO.
These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM

The total maximum pay-out amount for all incentive programs is expected to be no more than **$11.40** PMPM. When measured relative to the proposed capitation rates – estimated composite rates, including EFP and SOBRA, of **$258.08** for non-profit plans and **$266.22** for for-profit plans, the incentive payments plus the capitation rates are within the 105% threshold for certified rates.

RATE DEVELOPMENT

RIte Care – Non-SOBRA, Non-EFP

Table 10

RIte Care Rate Development (Excluding SOBRA & EFP)

RIte Care							
For Rate Period 7/1/2017 - 6/30/2018							
Excluding SOBRA & EFP							
Rate Period Average Enrollment Forecast		**5,305**	**28,601**	**45,744**	**17,056**	**40,729**	**8,515**
		MF <1	**MF 1 - 5**	**MF 6 - 14**	**M 15 - 44**	**F 15 - 44**	**MF 45+**
Base PMPM Excluding SOBRA & EFP		$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20
Article 5-Adjusted Selected Trend [1]		0.30%	0.30%	0.30%	0.30%	0.30%	0.30%
Projection Period (years)		3.00	3.00	3.00	3.00	3.00	3.00
Projected PMPM Excluding SOBRA & EFP		$ 420.80	$ 132.08	$ 132.40	$ 185.60	$ 278.47	$ 385.65
Adjustments:							
Health Service Reclass [2]		$ 3.46	$ 1.08	$ 1.09	$ 1.52	$ 2.29	$ 3.17
PCMH - Kids Program Development Allowance		$ 0.41	$ 0.41	$ 0.41	$ 0.12	$ 0.07	$ -
PCMH - Kids Savings Target		$ (0.10)	$ (0.10)	$ (0.10)	$ (0.03)	$ (0.02)	$ -
Gender Dysphoria [3]		$ -	$ -	$ -	$ 0.15	$ 0.15	$ 0.15
Care Transformation Collaborative (CTC) [6]		$ -	$ -	$ -	$ (0.42)	$ (0.50)	$ (0.59)
Program Initiative Savings							
BH Services		$ -	$ -	$ -	$ (1.69)	$ (1.91)	$ (1.39)
CEDARR Services		$ -	$ (0.29)	$ (1.02)	$ (0.34)	$ (0.08)	$ -
ACO		$ (8.26)	$ (2.10)	$ (2.17)	$ (3.30)	$ (4.81)	$ (6.63)
Fraud & Abuse (% of Medical)	1.0%	$ (4.16)	$ (1.31)	$ (1.31)	$ (1.82)	$ (2.74)	$ (3.80)
Subtotal Medical PMPM		$ 412.15	$ 129.77	$ 129.30	$ 179.79	$ 270.92	$ 376.56
Projected Administrative Load [4]		$ 39.95	$ 12.86	$ 12.48	$ 18.88	$ 25.87	$ 38.30
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 6.88	$ 2.17	$ 2.16	$ 3.03	$ 4.52	$ 6.32
Premium Before Taxes		$ 458.98	$ 144.80	$ 143.94	$ 201.70	$ 301.31	$ 421.18
Assessments: Adult Immunization		$ -	$ -	$ -	$ 1.18	$ 1.40	$ 1.66
State Premium Tax - Non-Profit Plans	*2.0%*	$ 9.37	$ 2.96	$ 2.94	$ 4.14	$ 6.18	$ 8.63
Projected PMPM For Non-Profit Plans		**$ 468.35**	**$ 147.76**	**$ 146.88**	**$ 207.02**	**$ 308.89**	**$ 431.47**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 9.67*	*$ 3.05*	*$ 3.03*	*$ 4.27*	*$ 6.37*	*$ 8.90*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 14.49	$ 4.57	$ 4.55	$ 6.41	$ 9.56	$ 13.35
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 483.14***	***$ 152.42***	***$ 151.52***	***$ 213.56***	***$ 318.64***	***$ 445.09***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on Plan G/L reports, projected to the rate period.

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff. Rate adjustments for this benefit will be applicable for F 15-44, M 15-44 and MF 45+ rate cells only

[4] Projected administrative load is based on the MCO financial reporting of Operating Expenses for RIte Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Extended Family Planning (EFP)

The EFP capitation rate was developed using plan-submitted Encounter data for incurred SFY 2013, SFY 2014, and SFY 2015, paid through November 2015, estimated 100% complete. SFY 2015 was selected as the base period and was projected to the rate period using the Article 5 – adjusted selected trends for EFP (See Exhibits 4a, 4b, 4c, 4d and 4e in the Appendix).

The EFP administrative load, risk margin and taxes were developed from the same source data and in the same manner as the non-SOBRA rates discussed above.

Table 11
EFP Rate Development

RIte Care		
For Rate Period 7/1/2017 - 6/30/2018		
Extended Family Planning (EFP)		
		PMPM
Base EFP PMPM		**$ 8.92**
Article 5-Adjusted Selected Trend [1]		0.24%
Projection Period (years)		3.00
Projected EFP Claims PMPM		$ 8.98
Adjustments:		
Fraud & Abuse	1.0%	$ (0.09)
Subtotal Projected EFP Claims PMPM		$ 8.89
Projected Admin Expense		$ 0.87
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 0.15
Premium Before Taxes		$ 9.91
State Premium Tax - Non-Profit Plans	*2.0%*	$ 0.20
Projected EFP Capitation PMPM - Non-Profit Plans		**$ 10.11**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 0.21*
ACA Issuer Fee - per Plan estimate for 2015 [2]	*3.0%*	$ 0.31
Projected EFP PMPM with ACA Issuer Fee [2]	*0.950*	***$ 10.43***
[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives		
[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only		

SOBRA

The SOBRA payment rate was developed using plan-submitted Encounter data for incurred SFY 2013, SFY 2014, and SFY 2015, paid through November 2015, and estimated 100% complete. SFY 2015 was selected as the base period and was projected to the rate period using the Article 5 – adjusted selected trends for SOBRA (See Tables 3 and 4 above, and Exhibits 4a, 4b, 4c, 4d and 4e in the Appendix).

The SOBRA administrative load, risk margin and taxes were developed from the same source data and in the same manner as the non-SOBRA rates discussed above.

Table 12
SOBRA Rate Development

RIte Care
For Rate Period 7/1/2017 - 6/30/2018
Projected SOBRA Payment Rate

SOBRA Experience			
	SFY 2013	**SFY 2014**	**SFY 2015**
Claims Expense	$ 40,128,699	$ 44,256,516	$ 47,305,893
Number of Births	4,674	4,778	4,987
Net Cost / Birth	$ 8,586	$ 9,263	**$ 9,486**

		PMPMs With Article 5
Base Period Net Cost / Birth		$ 9,486
Article 5-Adjusted Selected Trend [1]		1.00%
Projection Period		3.00
Projected Net Payment Rate		**$ 9,773**
Adjustments:		
Health Service Reclass [2]		$ 81
Subtotal SOBRA Payment		**$ 9,854**
Proposed SOBRA Admin. Load		$ 965
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 165
Premium Before Taxes		$ 10,984
State Premium Tax - Non-Profit Plans	*2.0%*	$ 224
Projected SOBRA Rate with State Premium Tax		**$ 11,208**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 231*
ACA Issuer Fee - per Plan estimate for 2015 [3]	*3.0%*	*$ 347*
Projected SOBRA rate with ACA Issuer Fee [3]	*0.950*	***$ 11,562***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives
[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents
[3] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

Actuarial Certification

Certification of the RIte Care capitation rate and the SOBRA payment rates for the rate period 7/1/2017 – 6/30/2018, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

4

APPENDIX

RIte Care

For Period 7/1/2017 - 6/30/2018

Aggregate Plan-Submitted Claims Experience

Excluding SOBRA & EFP

Including Off-line Adjustments

SFY 2013 RIte Care PLAN Experience

Type of Service Summary	MF< 1 Year	MF 1-5 Years	MF 6-14 Years	M 15-44 Years	F 15-44 Years	MF > =45 Years	Total
Inpatient	$ 14,680,848	$ 3,531,067	$ 7,554,452	$ 4,412,575	$ 11,812,899	$ 3,875,684	$ 45,867,525
Outpatient	$ 3,581,798	$ 11,346,852	$ 11,733,135	$ 7,118,033	$ 33,249,068	$ 6,137,263	$ 73,166,149
Professional	$ 8,630,225	$ 19,318,513	$ 24,713,518	$ 11,060,862	$ 38,490,904	$ 8,509,615	$ 110,723,638
Pharmacy	$ 1,316,684	$ 3,497,449	$ 8,939,287	$ 5,356,133	$ 16,867,486	$ 5,417,209	$ 41,394,248
Institutional (NH)	$ -	$ -	$ 8,340	$ 46,217	$ 117,133	$ 107,697	$ 279,387
Total	$ 28,209,555	$ 37,693,881	$ 52,948,732	$ 27,993,820	$ 100,537,491	$ 24,047,467	$ 271,430,946
Member Months	65,943	274,243	408,018	150,838	360,260	59,724	1,319,027
Total PMPM	$ 427.79	$ 137.45	$ 129.77	$ 185.59	$ 279.07	$ 402.64	$ 205.78

SFY 2014 RIte Care PLAN Experience

Type of Service Summary	MF< 1 Year	MF 1-5 Years	MF 6-14 Years	M 15-44 Years	F 15-44 Years	MF > =45 Years	Total
Inpatient	$ 14,618,214	$ 3,491,899	$ 8,326,812	$ 5,741,531	$ 13,551,688	$ 4,967,658	$ 50,697,802
Outpatient	$ 3,382,059	$ 10,933,179	$ 12,143,345	$ 8,261,411	$ 34,787,808	$ 7,893,268	$ 77,401,070
Professional	$ 9,367,381	$ 20,704,178	$ 27,260,106	$ 12,073,152	$ 40,755,576	$ 9,466,256	$ 119,626,649
Pharmacy	$ 1,046,017	$ 3,352,443	$ 10,074,672	$ 6,399,186	$ 18,931,962	$ 5,995,802	$ 45,800,082
Institutional (NH)	$ 25,280	$ -	$ 45,731	$ 14,664	$ 65,264	$ 81,369	$ 232,308
Total	$ 28,438,951	$ 38,481,700	$ 57,850,667	$ 32,489,943	$ 108,092,297	$ 28,404,353	$ 293,757,911
Member Months	65,359	282,704	442,576	166,367	391,794	71,464	1,420,264
Total PMPM	$ 435.12	$ 136.12	$ 130.71	$ 195.29	$ 275.89	$ 397.46	$ 206.83

SFY 2015 RIte Care PLAN Experience

Type of Service Summary	MF< 1 Year	MF 1-5 Years	MF 6-14 Years	M 15-44 Years	F 15-44 Years	MF > =45 Years	Total
Inpatient	$ 13,761,848	$ 3,186,490	$ 9,208,462	$ 6,050,747	$ 16,076,101	$ 5,541,566	$ 53,825,214
Outpatient	$ 3,663,794	$ 11,414,632	$ 14,019,918	$ 8,908,663	$ 40,774,989	$ 10,476,239	$ 89,258,235
Professional	$ 9,802,238	$ 21,080,765	$ 28,982,145	$ 13,584,769	$ 46,997,504	$ 11,923,039	$ 132,370,461
Pharmacy	$ 968,045	$ 3,346,557	$ 11,337,338	$ 7,290,371	$ 21,103,645	$ 7,720,900	$ 51,766,857
Institutional (NH)	$ -	$ -	$ -	$ 26,866	$ 81,655	$ 144,518	$ 253,039
Total	$ 28,195,925	$ 39,028,444	$ 63,547,863	$ 35,861,417	$ 125,033,894	$ 35,806,263	$ 327,473,807
Member Months	67,610	298,158	484,274	194,962	453,055	93,686	1,591,744
Total PMPM	$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20	$ 205.73

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Average Members

Rate Cell	SFY 2013	SFY 2014	SFY 2015
MF <1	5,495	5,447	5,634
MF 1-5	22,854	23,559	24,847
MF 6-14	34,002	36,881	40,356
Males 15-44	12,570	13,864	16,247
Females 15-44	30,022	32,650	37,755
MF >45	4,977	5,955	7,807
EFP	1,307	1,065	352

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Base PMPM

Excluding SOBRA & EFP

	SFY 2013	SFY 2014	SFY 2015
Wtd. Avg. of All Health Plans	$ 205.78	$ 206.83	$ 205.73

	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Selected Base Period PMPMs (SFY '15)	$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20
Base Period Average Members	*5,634*	*24,847*	*40,356*	*16,247*	*37,755*	*7,807*

Base Period Weighted Average PMPM	**$ 205.73**

Note: PMPMs include offline adjustments

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Incurred SFY, PT 11/15 est. 100%

Medical Trend Selection

Util/1000 (Util)	Non-SOBRA, Non-EFP			SOBRA		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient	6.8%	1.4%	4.0%			
Outpatient	-2.0%	-1.6%	-1.8%			
Professional	-2.3%	-0.8%	-1.6%			
Pharmacy	-3.8%	-2.4%	-3.1%			
Inst. (NH)	-37.6%	-20.4%	-29.5%			

Cost/Clm-Admt (price)	Non-SOBRA, Non-EFP			SOBRA		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient	-3.9%	-6.5%	-5.2%	4.9%	-1.5%	1.7%
Outpatient	0.3%	4.6%	2.4%	19.5%	9.1%	14.2%
Professional	2.7%	-0.4%	1.1%	2.8%	2.4%	2.6%
Pharmacy	6.8%	3.3%	5.0%	n/a	n/a	n/a
Inst. (NH)	23.8%	22.1%	22.9%	n/a	n/a	n/a

Composite	Non-SOBRA, Non-EFP			Clm Dist	SOBRA			Clm Dist
	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15
Inpatient	2.7%	-5.3%	-1.4%	16.4%	4.9%	-1.5%	1.7%	44.9%
Outpatient	-1.8%	2.9%	0.5%	27.3%	19.5%	9.1%	14.2%	28.7%
Professional	0.3%	-1.3%	-0.5%	40.4%	2.8%	2.4%	2.6%	26.4%
Pharmacy	2.8%	0.9%	1.8%	15.8%	n/a	n/a	n/a	n/a
Inst. (NH)	-22.8%	-2.8%	-13.4%	0.1%	n/a	n/a	n/a	n/a
Medical Total			0.0%	100.0%			5.5%	100.0%

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends

Base Period MidPt 1/1/2015	Non-SOBRA Selected Trend [3]				% In-State Clms. Dist.	SOBRA Selected Trend			
LOB	SFY '15 Clms. Dist.	Price	Util	comp		SFY '15 Clms. Dist.	Price	Util [2]	comp
Inpatient	16.4%	-5.2%	4.0%	-1.4%	96.0%	44.9%	1.7%	0.0%	1.7%
Outpatient	27.3%	2.4%	-1.8%	0.5%	95.9%	28.7%	14.2%	0.0%	14.2%
Professional	40.4%	1.1%	-1.6%	-0.5%		26.4%	2.6%	0.0%	2.6%
Pharmacy	15.8%	5.0%	-3.1%	1.8%					
Inst. (NH & Hospice)	0.1%	22.9%	-29.5%	-13.4%					
Total	100.0%			**0.0%**		100.0%			**5.5%**

12.00

1/1/2016	Impact of Article 5				Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.		Impact of Article 5				Impact of Trend on Clms. Dist.	
	SFY '15	7/1/15 - 6/30/16						SFY '15	7/1/15 - 6/30/16				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
Inpatient	16.4%	***-5.2%***	4.0%	-1.4%	-1.4%	16.4%	0.16	44.9%	***-2.5%***	0.0%	-2.5%	44.3%	0.44
Outpatient	27.3%	***-2.5%***	-1.8%	-4.3%	-4.1%	26.5%	0.26	28.7%	***-2.5%***	0.0%	-2.5%	28.3%	0.28
Professional	40.4%	1.1%	-1.6%	-0.5%	-0.5%	40.8%	0.40	26.4%	2.6%	0.0%	2.6%	27.4%	0.27
Pharmacy	15.8%	5.0%	-3.1%	1.8%	1.8%	16.3%	0.16					n/a	n/a
Inst. (NH & Hospice)	0.1%	***-2.0%***	-29.5%	-30.9%	-30.9%	0.1%	0.00	-				n/a	n/a
Total	100.0%			**-1.3%**	**-1.3%**	100.0%	0.99	100.0%			**-1.2%**	100.0%	0.99

12.00

1/1/2017	Impact of Article 5				Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.		Impact of Article 5				Impact of Trend on Clms. Dist.	
	SFY '15	7/1/16 - 6/30/17						SFY '15	7/1/16 - 6/30/17				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
Inpatient	16.4%	***1.9%***	4.0%	6.0%	5.7%	17.2%	0.17	44.9%	***1.9%***	0.0%	1.9%	44.2%	0.45
Outpatient	27.3%	***1.9%***	-1.8%	0.0%	0.1%	26.2%	0.26	28.7%	***1.9%***	0.0%	1.9%	28.2%	0.29
Professional	40.4%	1.1%	-1.6%	-0.5%	-0.5%	40.1%	0.40	26.4%	2.6%	0.0%	2.6%	27.5%	0.28
Pharmacy	15.8%	5.0%	-3.1%	1.8%	1.8%	16.4%	0.16					n/a	n/a
Inst. (NH & Hospice)	0.1%	***3.2%***	-29.5%	-27.3%	-27.3%	0.0%	0.00	-				n/a	n/a
Total	100.0%			**1.1%**	**1.0%**	100.0%	1.00	100.0%			**2.1%**	100.0%	1.01

12.00

1/1/2018	Impact of Article 5				Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.		Impact of Article 5				Impact of Trend on Clms. Dist.	
	SFY '15	7/1/17 - 6/30/18						SFY '15	7/1/17 - 6/30/18				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
IP	16.4%	***1.9%***	4.0%	6.0%	5.7%	18.0%	0.18	44.9%	***1.9%***	0.0%	1.9%	44.1%	0.45
OP	27.3%	***1.9%***	-1.8%	0.0%	0.1%	26.0%	0.26	28.7%	***1.9%***	0.0%	1.9%	28.2%	0.29
Prof	40.4%	1.1%	-1.6%	-0.5%	-0.5%	39.5%	0.40	26.4%	2.6%	0.0%	2.6%	27.7%	0.29
Rx	15.8%	5.0%	-3.1%	1.8%	1.8%	16.5%	0.17					n/a	n/a
Inst. (NH & Hospice)	0.1%	***3.1%***	-29.5%	-27.3%	-27.3%	0.0%	0.00	-				n/a	n/a
Total	100.0%			**1.1%**	**1.0%**	100.0%	1.01	100.0%			**2.1%**	100.0%	1.03

Rate Period MidPt 1/1/2018	**36.00 OK**												
	Impact of Article 5				Adjusted Comp. Trend [1]	Change in Clms. dist. [3]	Adjusted Comp. Trend [1]	Impact of Article 5				Change in Clms. dist. [3]	Adjusted Comp. Trend
	SFY '15	**36 -Mo. Avg. Trends**						SFY '15	**36 -Mo. Avg. Trends**				
LOB	Clms. Dist.	Price	Util	comp				Clms. Dist.	Price	Util [2]	comp		
IP	16.4%	-0.5%	4.0%	3.5%	3.3%	17.2%	3.3%	44.9%	0.4%	0.0%	0.4%	44.5%	0.4%
OP	27.3%	0.4%	-1.8%	-1.4%	-1.3%	26.6%	-1.3%	28.7%	0.4%	0.0%	0.4%	28.4%	0.4%
Prof	40.4%	1.1%	-1.6%	-0.5%	-0.5%	40.0%	-0.5%	26.4%	2.6%	0.0%	2.6%	27.0%	2.6%
Rx	15.8%	5.0%	-3.1%	1.8%	1.8%	16.2%	1.8%					n/a	n/a
Inst. (NH & Hospice)	0.1%	1.4%	-29.5%	-28.5%	-28.5%	0.1%	-28.5%	-				n/a	n/a
	100.0%			**0.26%**	**0.25%**	100.0%	**0.30%**	100.0%			**1.0%**	100.0%	**1.00%**
	36.00 -Mo. Avg. Trend			**0.27%**	**0.26%**		**0.30%**	**Avg. Trend**			**1.00%**		**1.00%**

Note: Article 5 is as per the State's Reinventing Medicaid initiatives

[1] Non-SOBRA trends are adjusted to reflect In-State hospital claims

2 For the SOBRA Trend Impact Analysis, utilization was excluded since the SOBRA payment **rate** is independent of utilization

[3] Change in Claims Distribution reflects the average of the distributions from the base period and the rate period

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends For EFP

Non-EFP, Non-SOBRA			
LOB	Selected Composite Trends	Composite Trends w/Art 5	Art 5 Impact Factor
OP	0.5%	-1.3%	0.981
Prof	-0.5%	-0.5%	-
Rx	1.8%	1.8%	-
Total			

EFP [1]		
SFY '15 Claims Dist	Selected Composite Trends [2]	Composite Trends w/Art 5
43.4%	2.5%	0.56%
18.2%	0.0%	0.00%
38.4%	0.0%	0.00%
100.0%	1.1%	**0.24%**

Selected Trend [3] **0.24%**

[1] The impact of Article 5 on EFP trends is estimated by deriving the impact of Article 5 on Non-EFP composite trends (over the projection period from the base period to the rate period) and applying it to the selected EFP composite trend

[2] EFP benefits do not include hospital inpatient benefits

[3] As applicable, negative trends are disallowed for projection purposes

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends

	Non-SOBRA	EFP [2]	SOBRA
Selected Trends Based on Experience	0.0%	0.24%	5.5%
Impact of Article 5 on Composite Trends:			
SFY '16 Trends with Article 5 [1] Implementation	-1.3%		-1.2%
SFY '17 Trends with Article 5 [1] Implementation	1.0%		2.1%
SFY '18 Trends with Article 5 [1] Implementation	1.0%		2.1%
Average annual trend [3] with Impact of Article 5[1] Implementation	**0.3%**	**0.24%**	**1.0%**

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Impact of Article 5 on EFP trend is based on the average composite effect of Article 5 on the RIte Care hospital OP trend, since EFP does not include hospital IP benefits

[3] Reflects change in TOS claims distribution over time as a result of different trends by TOS (e.g. Inpatient vs. Outpatient, etc.) - see Trend Detail exhibit

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

PCMH-Kids

	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Rate Period Forecast Average Enrollment	5,305	28,601	45,744	17,056	40,729	8,515
Percent Under 19 (est. from 7/1/15-12/31/15 actual)	100%	100%	100%	29%	16%	0%
PCMH-Kids	5,305	28,601	45,744	4,894	6,501	-
PCMH-Kids Program Development Allowance [1]	$ 0.41	$ 0.41	$ 0.41	$ 0.41	$ 0.41	$ 0.41
Adjustment to Rate Cell for Development Allowance [1]	**$ 0.41**	**$ 0.41**	**$ 0.41**	**$ 0.12**	**$ 0.07**	**$ -**
PCMH-Kids Savings Target [1]	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)	$ (0.10)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.10)**	**$ (0.10)**	**$ (0.10)**	**$ (0.03)**	**$ (0.02)**	**$ -**

[1] Program Development Allowance and Savings Targets as set by the State

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Gender Dysphoria

Non-SOBRA

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [4]	$ 58,027
Number of persons estimated seeking surgical benefits [2]	2
Estimated total expenditures for Gender Dysphoria	$ 116,053
Rate Period projected average enrollment [3]	145,949
Estimated impact to Total RIte Care PMPM	$ 0.07
Rate Period projected average enrollment for applicable rate cells (M 15-44, F 15-44, MF 45+)	66,299
Estimated PMPM adjustment for Gender Dysphoria for affected rate cells	$ 0.15

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person and assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism. Analysis identified 13 average eligibles with such diagnoses; assumed a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[3] Excludes EFP

[4] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Care Transformation Collaborative

	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Rate Period Forecast Average Enrollment	5,305	28,601	45,744	17,056	40,729	8,515
Percent 19+ (est. from 7/1/15-12/31/15 actual)	0%	0%	0%	71%	84%	100%
Adults 19+	-	-	-	12,162	34,228	8,515
CTC Program Expenses PMPM - Per Adult 19+ [1]	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)
Adjustment to Rate Cell for CTC Expenses	**$ -**	**$ -**	**$ -**	**$ (0.42)**	**$ (0.50)**	**$ (0.59)**

[1] CTC PMPM expense adjustment for graduating practice sites, not currently reflected in the base period expenses

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Reinventing Medicaid Program Initiatives

	Non-SOBRA					
	MF <1	**MF 1 - 5**	**MF 6 - 14**	**M 15 - 44**	**F 15 - 44**	**MF 45+**
Program Initiative Savings [1]						
BH Services	$ -	$ -	$ -	$ (1.69)	$ (1.91)	$ (1.39)
CEDARR Services	$ -	$ (0.29)	$ (1.02)	$ (0.34)	$ (0.08)	$ -
ACO	$ (8.26)	$ (2.10)	$ (2.17)	$ (3.30)	$ (4.81)	$ (6.63)

[1] Please refer to the narrative section of the Data Book for a description of each of the Program Initiatives

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Adult Immunization

	Impact to PMPM					
	MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Enrolled Member Months 7/1/15 - 12/31/15				56,293	101,734	32,938
Enrolled Member Months Aged 19+				40,141	85,496	32,938
% Enrolled Aged 19+				71.3%	84.0%	100.0%
Rate Period Forecast Average Enrollment	5,305	28,601	45,744	17,056	40,729	8,515
Estimated Aged 19+ Forecast Enrollment	**-**	**-**	**-**	**12,162**	**34,228**	**8,515**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ -	$ -	$ -	$ 1.66	$ 1.66	$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ -**	**$ -**	**$ -**	**$ 1.18**	**$ 1.40**	**$ 1.66**

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Excluding SOBRA & EFP

Rate Period Average Enrollment Forecast		5,305	28,601	45,744	17,056	40,729	8,515
		MF <1	MF 1 - 5	MF 6 - 14	M 15 - 44	F 15 - 44	MF 45+
Base PMPM Excluding SOBRA & EFP		$ 417.04	$ 130.90	$ 131.22	$ 183.94	$ 275.98	$ 382.20
Article 5-Adjusted Selected Trend [1]		0.30%	0.30%	0.30%	0.30%	0.30%	0.30%
Projection Period (years)		3.00	3.00	3.00	3.00	3.00	3.00
Projected PMPM Excluding SOBRA & EFP		$ 420.80	$ 132.08	$ 132.40	$ 185.60	$ 278.47	$ 385.65
Adjustments:							
Health Service Reclass [2]		$ 3.46	$ 1.08	$ 1.09	$ 1.52	$ 2.29	$ 3.17
PCMH - Kids Program Development Allowance		$ 0.41	$ 0.41	$ 0.41	$ 0.12	$ 0.07	$ -
PCMH - Kids Savings Target		$ (0.10)	$ (0.10)	$ (0.10)	$ (0.03)	$ (0.02)	$ -
Gender Dysphoria [3]		$ -	$ -	$ -	$ 0.15	$ 0.15	$ 0.15
Care Transformation Collaborative (CTC) [6]		$ -	$ -	$ -	$ (0.42)	$ (0.50)	$ (0.59)
Program Initiative Savings							
BH Services		$ -	$ -	$ -	$ (1.69)	$ (1.91)	$ (1.39)
CEDARR Services		$ -	$ (0.29)	$ (1.02)	$ (0.34)	$ (0.08)	$ -
ACO		$ (8.26)	$ (2.10)	$ (2.17)	$ (3.30)	$ (4.81)	$ (6.63)
Fraud & Abuse (% of Medical)	1.0%	$ (4.16)	$ (1.31)	$ (1.31)	$ (1.82)	$ (2.74)	$ (3.80)
Subtotal Medical PMPM		$ 412.15	$ 129.77	$ 129.30	$ 179.79	$ 270.92	$ 376.56
Projected Administrative Load [4]		$ 39.95	$ 12.86	$ 12.48	$ 18.88	$ 25.87	$ 38.30
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 6.88	$ 2.17	$ 2.16	$ 3.03	$ 4.52	$ 6.32
Premium Before Taxes		$ 458.98	$ 144.80	$ 143.94	$ 201.70	$ 301.31	$ 421.18
Assessments: Adult Immunization		$ -	$ -	$ -	$ 1.18	$ 1.40	$ 1.66
State Premium Tax - Non-Profit Plans	*2.0%*	$ 9.37	$ 2.96	$ 2.94	$ 4.14	$ 6.18	$ 8.63
Projected PMPM For Non-Profit Plans		**$ 468.35**	**$ 147.76**	**$ 146.88**	**$ 207.02**	**$ 308.89**	**$ 431.47**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 9.67*	*$ 3.05*	*$ 3.03*	*$ 4.27*	*$ 6.37*	*$ 8.90*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 14.49	$ 4.57	$ 4.55	$ 6.41	$ 9.56	$ 13.35
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 483.14***	***$ 152.42***	***$ 151.52***	***$ 213.56***	***$ 318.64***	***$ 445.09***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on Plan G/L reports, projected to the rate period.

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff. Rate adjustments for this benefit will be applicable for F 15-44, M 15-44 and MF 45+ rate cells only

[4] Projected administrative load is based on the MCO financial reporting of Operating Expenses for RIte Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

RIte Care

For Rate Period 7/1/2017 - 6/30/2018

Extended Family Planning (EFP)

		PMPM
Base EFP PMPM		**$ 8.92**
Article 5-Adjusted Selected Trend [1]		0.24%
Projection Period (years)		3.00
Projected EFP Claims PMPM		$ 8.98
Adjustments:		
Fraud & Abuse	1.0%	$ (0.09)
Subtotal Projected EFP Claims PMPM		$ 8.89
Projected Admin Expense		$ 0.87
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 0.15
Premium Before Taxes		$ 9.91
State Premium Tax - Non-Profit Plans	*2.0%*	$ 0.20
Projected EFP Capitation PMPM - Non-Profit Plans		**$ 10.11**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 0.21*
ACA Issuer Fee - per Plan estimate for 2015 [2]	*3.0%*	$ 0.31
Projected EFP PMPM with ACA Issuer Fee [2]	*0.950*	***$ 10.43***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

RIte Care
For Rate Period 7/1/2017 - 6/30/2018
Projected SOBRA Payment Rate

SOBRA Experience	SFY 2013	SFY 2014	SFY 2015
Claims Expense	$ 40,128,699	$ 44,256,516	$ 47,305,893
Number of Births	4,674	4,778	4,987
Net Cost / Birth	$ 8,586	$ 9,263	**$ 9,486**

		PMPMs With Article 5
Base Period Net Cost / Birth		$ 9,486
Article 5-Adjusted Selected Trend [1]		1.00%
Projection Period		3.00
Projected Net Payment Rate		**$ 9,773**
Adjustments:		
Health Service Reclass [2]		$ 81
Subtotal SOBRA Payment		**$ 9,854**
Proposed SOBRA Admin. Load		$ 965
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 165
Premium Before Taxes		$ 10,984
State Premium Tax - Non-Profit Plans	*2.0%*	$ 224
Projected SOBRA Rate with State Premium Tax		**$ 11,208**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 231*
ACA Issuer Fee - per Plan estimate for 2015 [3]	*3.0%*	*$ 347*
Projected SOBRA rate with ACA Issuer Fee [3]	*0.950*	***$ 11,562***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents

[3] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

RIte Care
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	Non-Profit Plans: 2% State Premium Tax: Non-Profit Plans	Non-Profit Plans: Proposed Capitation Rates: Non-Profit Plans	For-Profit Plans: 2% State Premium Tax: For-Profit Plans	For-Profit Plans: Est. ACA Issuer Fee: For-Profit Plans [2]	For-Profit Plans: Capitation Rates w/ Premium & Issuer Taxes
MF <1	$ 412.15	$ 39.95	$ 6.88	$ -	$ 9.37	**$ 468.35**	$ 9.67	$ 14.49	**$ 483.14**
MF 1-5	$ 129.77	$ 12.86	$ 2.17	$ -	$ 2.96	**$ 147.76**	$ 3.05	$ 4.57	**$ 152.42**
MF 6-14	$ 129.30	$ 12.48	$ 2.16	$ -	$ 2.94	**$ 146.88**	$ 3.03	$ 4.55	**$ 151.52**
Males 15-44	$ 179.79	$ 18.88	$ 3.03	$ 1.18	$ 4.14	**$ 207.02**	$ 4.27	$ 6.41	**$ 213.56**
Females 15-44	$ 270.92	$ 25.87	$ 4.52	$ 1.40	$ 6.18	**$ 308.89**	$ 6.37	$ 9.56	**$ 318.64**
MF 45+	$ 376.56	$ 38.30	$ 6.32	$ 1.66	$ 8.63	**$ 431.47**	$ 8.90	$ 13.35	**$ 445.09**
EFP	$ 8.89	$ 0.87	$ 0.15	$ -	$ 0.20	**$ 10.11**	$ 0.21	$ 0.31	**$ 10.43**
SOBRA (Pmt.)	$ 9,854	$ 965	$ 165	$ -	$ 224	**$ 11,208**	$ 231	$ 347	**$ 11,562**

[1] Risk Margin set at 1.5% of premiums before taxes

[2] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit plans only

[3] Includes Adult Immunizations

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the State capitation rates for Rhode Island's State Medicaid program (RIte Care) for the 12-month period July 1, 2017 through June 30, 2018. The 12-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following eligibility categories: males and females under age 1, males and females ages 1 to 5, males and females ages 6 to 14, males ages 15 to 44, females ages 15 to 44, and males and females ages 45 and older. Separate capitation rates were developed for Extended Family Planning (EFP) for certain qualifying post-partum women not otherwise eligible for full RIte Care benefits. This certification also addresses the development of the lump-sum SOBRA payment for eligible pregnant women for their prenatal care, delivery and post-natal care.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Thomas M. Donlon

June 30, 2016
Date

Thomas M. Donlon, FSA, MAAA
Principal
tom.donlon@terrygroup.com

June 28, 2016

Children with Special Health Care Needs (CSHCN) and Substitute Care Data Book

State of Rhode Island

Rates for the period 2/1/2017 through 6/30/2017

Final & Confidential

Prepared by:
HealthCare Analytics
PO Box 41408
Providence, RI 02940-1408

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INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 2/1/2017 through 6/30/2017 for Children with Special Health Care Needs (CSHCN) and Children in Substitute Care Arrangements (Substitute Care), who are eligible for enrollment into the State's RIte Care program, a Medicaid managed care program authorized under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration.

CSHCN and Substitute Care provides eligible children with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE). The health plans are paid capitation rates based on population cohorts. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the CSHCN and Substitute Care per member per month (PMPM) capitation rates effective February 1, 2017 through June 30, 2017, for the purpose of attaining rate approval from CMS under 42 CFR 438.6(c). This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using selected trends developed from the claims experience, adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the CSHCN and Substitute Care claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected CSHCN and Substitute Care rates presented in this data book:

- Patient-Centered Medical Homes for Kids (PCMH-Kids)
- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for CSHCN and Substitute Care were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

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CAPITATION RATES & DEMOGRAPHICS

The capitation rates including assessments, taxes and fees for the rate period 2/1/2017 – 6/30/2017 are as follows:

Table 1
Capitation Rates

CSHCN and Substitute Care
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017

					Non-Profit Plans		For-Profit Plans		
Population Cohort	**Medical Component of Capitation Rates**	**Admin Component of Capitation Rates**	**Risk Margin [1]**	**Assess-ments [5]**	**State Premium Tax [2]: Non-Profit Plans**	**Capitation Rates: Non-Profit Plans [3]**	**State Premium Tax [2]: For-Profit Plans**	**ACA Issuer Fee For-Profit Plans [4]**	**Capitation Rates: For-Profit Plans**
Adoption Subsidy	$ 471.73	$ 48.78	$ 7.93	$ 0.06	$ 10.79	**$ 539.29**	$ 11.13	$ 16.69	**$ 556.32**
Katie Beckett	$ 2,293.02	$ 232.48	$ 38.46	$ -	$ 52.33	**$ 2,616.29**	$ 53.98	$ 80.97	**$ 2,698.91**
SSI < 15	$ 1,031.76	$ 107.59	$ 17.35	$ -	$ 23.61	**$ 1,180.31**	$ 24.35	$ 36.53	**$ 1,217.58**
SSI >= 15	$ 906.88	$ 91.17	$ 15.20	$ 0.56	$ 20.69	**$ 1,034.50**	$ 21.34	$ 32.02	**$ 1,067.17**
Substitute Care [3]	$ 637.53	$ 85.38	$ 11.01	$ 0.22	$ 14.98	**$ 749.12**	$ 15.46	$ 23.18	**$ 772.78**

[1] Risk Margin set at 1.5% of premium before taxes
[2] State Premium Tax is set at 2% of Permiums
[3] Substitute Care is only available under NHPRI, a Non-Profit Plan
[4] ACA Issuer Fee, per UHC estimate for 2015, is applicable to For-Profit health plans only
[5] Includes Adult Immunization

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RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data reports, which were based on encounter data, covered the following State Fiscal Years (SFY)

- 7/1/2012 through 6/30/2013 (SFY 2013), paid through 11/30/2015, estimated at 100%
- 7/1/2013 through 6/30/2014 (SFY 2014), paid through 11/30/2015, estimated at 100%
- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

The claims data was delineated by rate cell and by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail which allowed us to examine historical patterns for unit cost and utilization levels.

All claims data including SFY 2013, SFY 2014, and SFY 2015 were presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2013, SFY 2014 and SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Exhibit 1 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2013, SFY 2014, and SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '13, SFY '14, and SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services
- CEDARR

BASE PERIOD

The base period PMPMs are credibility weighted averages from SFY 2013, SFY 2014 and SFY 2015. SFY 2013 and SFY 2014 were trended to SFY 2015 using the 2-year average trend for the composite experience of all the rate cells. Adoptions Subsidy and Katie Beckett reflect a blend of SFY 2013, SFY 2014 and SFY 2015 at 33%, 33% and 34% respectively, while both SSI rate cells and Substitute Care rate cells reflect a blend of SFY 2014 and SFY 2015 at 30% and 70%. This methodology is intended to smooth out the year-over-year variability in the experience so that they are not magnified in the projected benefit costs. (see Table 2 below and Exhibits 2 & 3 in the appendix).

Table 2
Base Period PMPM:

CSHCN and Substitute Care
For Rate Period 2/1/2017 - 6/30/2017
Base Period Selection

2-yr. Average Composite Trend: *2.1%*

Population Cohorts	wt.	Prior Period SFY '13 Proj to SFY '15 [1]	wt.	Prior Period SFY '14 Proj to SFY '15 [1]	wt.	Current Period SFY 2015	Base Period PMPM [2]
Adoption Subsidy	33%	$ 513.87	33%	$ 453.41	34%	$ 394.24	$ 453.24
Katie Beckett	33%	$ 2,438.83	33%	$ 2,211.34	34%	$ 2,210.45	$ 2,286.11
SSI < 15	0%	$ 988.48	30%	$ 1,052.31	70%	$ 992.31	$ 1,010.31
SSI >= 15	0%	$ 835.10	30%	$ 860.61	70%	$ 900.00	$ 888.18
Substitute Care	0%	$ 574.19	30%	$ 552.96	70%	$ 635.77	$ 610.93

TRENDS AND TREND DEVELOPMENT

Trends were developed on the composite experience of the program due to the relatively small size of the populations in each rate cell and the volatility exhibited in the year-to-year experience. The trends were developed by service category, from the claims data including the G/L adjustments, based on the 2-year average unit cost and utilization trends of SFY 2015 over SFY 2013. The trends were further adjusted to exclude non-recurring events impacting inpatient utilization trends as described below.

Adjustments to Trends

The Selected 2-year average trends for SFY '15 over SFY '13 (composite all rate cells) were adjusted to exclude NHPRI's inpatient experience for Substitute Care and SSI 15-20, for the following reason as described by the State to the actuaries. The State became aware of care coordination-related issues for Substitute Care enrollees at the State agency level, which resulted in the inappropriate use of the inpatient setting for Substitute Care and older SSI enrollees at NHPRI. The State has implemented process improvements to address the inappropriate use of the Inpatient setting for these members. Accordingly, it is assumed that the observed inpatient trends for these population cohorts will not continue into the rate period, and that their inpatient trend will track more closely with the composite inpatient trends exclusive of Substitute Care and SSI 15-20.

Table 3
Selected Trends:

CSHCN and Substitute Care
For Rate Period 2/1/2017 - 6/30/2017
Trend Selection

	PMPM			Price per Unit			Utilization/1k		
Category	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**
Inpatient [1]	20.5%	-9.4%	4.5%	-3.3%	-6.1%	-4.7%	24.6%	-3.5%	9.7%
Outpatient	-5.4%	-4.8%	-5.1%	-0.5%	-4.6%	-2.6%	-4.9%	-0.2%	-2.6%
Professional	1.2%	-3.0%	-1.0%	-1.1%	-4.2%	-2.7%	2.3%	1.2%	1.7%
Rx	-0.9%	3.7%	1.4%	3.4%	2.9%	3.2%	-4.2%	0.8%	-1.7%
Inst./NH	16.2%	-36.4%	-14.1%	-1.6%	-20.6%	-11.6%	18.0%	-19.9%	-2.8%

	Selected Trends [1,2]			Dist%
Category	**Price**	**Util.**	**PMPM**	**SFY14**
Inpatient [1]	-4.7%	9.7%	4.5%	28%
Outpatient	0.0%	0.0%	0.0%	12%
Professional	0.0%	1.7%	1.7%	46%
Rx	3.2%	-1.7%	1.4%	13%
Inst./NH	0.0%	0.0%	0.0%	1%
Total			**2.2%**	100%

Continued on next page

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was estimated on the selected trends, based on the specific language as it applied to Inpatient, Outpatient and Institutional unit cost trends. See the excerpt below for the specific applicable language, and Table 4 for the impact on selected trends.

ARTICLE 5 (Excerpt)		
Page	**Line**	**Inpatient**
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.
Page	**Line**	**Outpatient**
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Table 4
Impact of Article 5

CSHCN and Substitute Care
For Rate Period 2/1/2017 - 6/30/2017
Impact of Article 5 on Selected Trends

	Impact to Trends				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Selected Trends Based on Experience	2.2%	2.2%	2.2%	2.2%	2.2%
Impact of Article 5 on Composite Trends:					
SFY '16 Trends with Article 5 [1] Implementation	1.9%	1.9%	1.9%	1.9%	1.9%
7/1/2016 - 1/31/2017 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
2/1/2017 - 6/30/2017 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
Average annual trend [2] with Impact of Article 5 [1] Implementation	**3.4%**	**3.4%**	**3.4%**	**3.4%**	**3.4%**

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans are required to identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to rate period at **1.6%** annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. Since the health service re-class is reported on an aggregate basis, we allocated the re-class amounts based on each rate cell's claims volume to the aggregate. The composite reported re-class for the base period was **$7.50** PMPM for CSHCN and **$6.08** PMPM for Substitute Care, projected to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. EOHHS staff evaluated the CSHCN and Substitute Care experience for SFY 2014 and identified 8 average eligible with such diagnoses, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 1 potential surgeries. The cost of surgery, at $52,650 per procedure in 2015, was estimated by EOHHS staff. The cost of surgery was projected to the rate period using the composite inpatient trend as impacted by Article 5. The estimated cost for surgery was allocated to each rate cell based on number of enrollees over 15 years of age in the applicable rate cells.

Table 5
Gender Dysphoria

CSHCN & Substitute Care		
For Rate Period 2/1/2017 - 6/30/2017		
Gender Dysphoria		
		Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]		$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [5]		$ 63,109
Number of persons estimated seeking surgical benefits [2]		1
Estimated total expenditures for Gender Dysphoria		$ 63,109
Rate Period forecasted average enrollment (excluding SSI <15) [3]		6,107
Estimated impact to Total CSHCN & Substitute Care PMPM [3]		$ 0.86
Rate Adjustment Allocation [3]:	Est. Aged 15+ for Rate Period	PMPM Adjustment [4]
Adoption Subsidy	536	$ 0.45
Katie Beckett	30	$ 0.45
SSI >=15	1,930	$ 1.61
Substitute Care	768	$ 0.58

PCMH-Kids – Per EOHHS, this program initiative is defined as follows: *"PCMH-Kids is a multi-payer patient centered medical home initiative. It grew out of the Care Transformation Collaborative (CTC, formerly known as CSI) to spread the transformation of primary care to practices serving children. Currently there are 9 participating primary care practices, serving approximately 30,000 children*

(approximately 14,000 attributed Medicaid lives). These 9 practices came together with all of the major health plans in Rhode Island (both commercial and Medicaid Managed Care Plans) to design a Common Contract that calls for supplemental payments to the practices to support the transformation. With these payments, practices are required to achieve NCQA PCMH recognition and hire staff for care coordination. The onsite care coordinator improves the capacity of the primary care office to manage and coordinate care for the highest needs children and families. Practices are also responsible for reporting and improving upon several measures promoting data-driven quality improvement and population health management. Practices will report clinical quality measures from their electronic health record, participate in a patient experience survey and use utilization data from the all-payers claims data-base to reduce the emergency department utilization of their patients.

Practices will be provided with an onsite practice coach, collaborative learning and best practice sharing opportunities throughout their time in the contract. At the end of the three-year contract, we anticipate that practices will have the foundation to be successful in advanced payment contracts with the health plans, such as shared savings and shared risk arrangements."

The State is allocating **$152,500** for the rate period, pro-rated for the percent of kids under 19 in each rate cell, for the continued development of this program that started in January 2016. It is anticipated that initial efforts by the plans will impact a limited number of enrollees, from which the State is setting a target savings amount of $**38,125**, pro-rated for the percent of kids under 19 in each rate cell. The strategies will include but will not be limited to:

- Expansion of the Chronic Care Sustainability Initiative (CSI) and the implementation of Patient-Centered Medical Home (PCMH) for kids.
- Improved efforts in the area of transitions of care and follow-up after hospital discharge, in particular for mental health hospitalizations
- Alternative contracting, reimbursement and operational arrangements with providers who have a large volume of high utilizing members
- Leveraging of new and existing resources, including Community Health Teams

Health Plans will submit a high utilizer strategy to EOHHS for review and approval. EOHHS will work collaboratively with the health plans to provide all necessary support and technical assistance in the implementation of these efforts.

Table 6
PCMH-Kids

CSHCN and Substitute Care						
For Rate Period 2/1/2017 - 6/30/2017						
PCMH-Kids						
	Impact to PMPM					
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15		Substitute Care
Rate Period Forecast Average Enrollment	1,918	109	3,344	1,930		2,151
Percent Kids	96.7%	100.0%	100.0%	66.4%		86.8%
PCMH-Kids	1,855	109	3,344	1,282		1,866
PCMH-Kids Program Development Allowance [1]	$ 3.61	$ 3.61	$ 3.61	$ 3.61		$ 3.61
Adjustment to Rate Cell for Development Allowance [1]	**$ 3.49**	**$ 3.61**	**$ 3.61**	**$ 2.40**		**$ 3.13**
PCMH-Kids Savings Target [1]	$ (0.90)	$ (0.90)	$ (0.90)	$ (0.90)		$ (0.90)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.87)**	**$ (0.90)**	**$ (0.90)**	**$ (0.60)**		**$ (0.78)**

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by*

the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan (Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice, collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. The adjustment for this rate period is estimated by the State at **$(0.60)** PMPM. As applicable, the PMPMs are adjusted based on proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives.

Table 7
Care Transformation Collaborative - CTC

CSHCN and Substitute Care						
For Rate Period 2/1/2017 - 6/30/2017						
Care Transformation Collaborative						
	Impact to PMPM					
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15		Substitute Care
Rate Period Forecast Average Enrollment	1,918	109	3,344	1,930		2,151
Percent 19+ (est. from 7/1/15-12/31/15 actual)	3.3%	0.0%	0.0%	33.6%		13.2%
Adults	64	-	-	648		285
CTC Program Expenses PMPM - Per Adult [1]	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)		$ (0.60)
Adjustment to Rate Cell for CTC Expenses	**$ (0.02)**	**$ -**	**$ -**	**$ (0.20)**		**$ (0.08)**

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the

product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 8 for the impact of this initiative.

Comprehensive Evaluation Diagnosis Assessment Referral and Re-evaluation (CEDARR) Services, referred to as Initiative 9A, integrate "out of plan services" for children with special health care needs into Medicaid MCOs:

CEDARR Services as defined by initiative 9A, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to integrate Home Based Therapeutic Services (HBTS), Personal Services and Supports (PASS), and Respite Care into an enrollee's total continuum of care. It is anticipated that the integration of these like services will enable the MCOs with greater flexibility to provide clinically appropriate and evidence-based lower-cost services to children and adolescents. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 8 for the impact of this initiative.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. See Table 8 for the impact of this initiative.

Table 8
Program Initiatives Savings

CSHCN and Substitute Care					
For Rate Period 2/1/2017 - 6/30/2017					
Reinventing Medicaid Program Initiatives					
	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Program Initiative Savings [1]					
BH Services	$ (4.32)	$ (1.85)	$ (9.68)	$ (12.77)	$ (10.75)
CEDARR	$ (10.59)	$ (143.05)	$ (33.52)	$ (26.92)	$ (2.19)
ACO	$ (5.09)	$ (30.99)	$ (17.26)	$ (14.46)	$ (11.76)

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. We reviewed the CPI factors for various categories and selected the "Medical Care Services" and "Health Insurance" categories to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The resulting administrative load is on average **10.8%** of projected composite medical PMPM.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to ***$1.66*** *PMPM for adults aged 19 and over.*

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Table 9
Adult Immunization

CSHCN and Substitute Care						
For Rate Period 2/1/2017 - 6/30/2017						
Adult Immunization						
	Impact to PMPM					
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15		Substitute Care
Enrolled Member Months 7/1/15 - 12/31/15	8,674			9,937		12,202
Enrolled Member Months Aged 19+	288			3,336		1,615
% Enrolled Aged 19+	3.3%			33.6%		13.2%
Rate Period Forecast Average Enrollment	1,918	109	3,344	1,930		2,151
Estimated Aged 19+ Forecast Enrollment	**64**	**-**	**-**	**648**		**285**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ 1.66	$ 1.66	$ 1.66	$ 1.66		$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ 0.06**	**$ -**	**$ -**	**$ 0.56**		**$ 0.22**

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.

b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**
b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)"*.

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCOs satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. Performance Goal Program

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $3.00 PMPM for both CSHCN and Substitute Care

2. Provider Incentive Program

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO. These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM for both CSHCN and Substitute Care

The total maximum pay-out amount for all incentive programs is expected to be no more than **$5.90** PMPM for CSHCN, and **$5.90** PMPM for Substitute Care. When measured relative to the proposed capitation rates – estimated non-profit composite rates of **$994.79** for CSHCN and **$749.12** for Substitute Care, the incentive payments plus the capitation rates are within the 105% threshold for certified rates.

RATE DEVELOPMENT

Table 10
CSHCN & Substitute Care Rate Development

CSHCN and Substitute Care
For Rate Period 2/1/2017 - 6/30/2017

		Adoption Subsidy	Katie Beckett	SSI <15	SSI 15-20	Substitute Care
Rate Period Average Enrollment Forecast		**1,918**	**109**	**3,344**	**1,930**	**2,151**
Base Medical PMPM		$ 453.24	$ 2,286.11	$ 1,010.31	$ 888.18	$ 610.93
Article 5-Adjusted Selected Trend [1]		3.40%	3.40%	3.40%	3.40%	3.40%
Projection Period (years)		2.29	2.29	2.29	2.29	2.29
Projected Medical PMPM		**$ 489.31**	**$ 2,468.02**	**$ 1,090.70**	**$ 958.86**	**$ 659.54**
Adjustments To Total PMPM:						
Health Service Reclass [2]		$ 4.14	$ 20.89	$ 9.23	$ 8.12	$ 6.31
PCMH - Kids Program Development Allowance		$ 3.49	$ 3.61	$ 3.61	$ 2.40	$ 3.13
PCMH - Kids Savings Target		$ (0.87)	$ (0.90)	$ (0.90)	$ (0.60)	$ (0.81)
Gender Dysphoria [3]		$ 0.45	$ 0.45	$ -	$ 1.61	$ 0.58
Care Transformation Collaborative (CTC) [6]		$ (0.02)	$ -	$ -	$ (0.20)	$ (0.08)
Program Initiative Savings:						
BH Services		$ (4.32)	$ (1.85)	$ (9.68)	$ (12.77)	$ (10.75)
CEDARR		$ (10.59)	$ (143.05)	$ (33.52)	$ (26.92)	$ (2.19)
ACO		$ (5.09)	$ (30.99)	$ (17.26)	$ (14.46)	$ (11.76)
Subtotal Adjustments		$ (12.81)	$ (151.84)	$ (48.52)	$ (42.82)	$ (15.57)
Fraud & Abuse (% of Medical)	1.0%	$ (4.77)	$ (23.16)	$ (10.42)	$ (9.16)	$ (6.44)
Subtotal Net Medical PMPM		**$ 471.73**	**$ 2,293.02**	**$ 1,031.76**	**$ 906.88**	**$ 637.53**
Projected Administrative Load [4]		$ 48.78	$ 232.48	$ 107.59	$ 91.17	$ 85.38
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 7.93	$ 38.46	$ 17.35	$ 15.20	$ 11.01
Premium Before Taxes		$ 528.44	$ 2,563.96	$ 1,156.70	$ 1,013.25	$ 733.92
Assessments: Adult Immunization		***$ 0.06***	***$ -***	***$ -***	***$ 0.56***	***$ 0.22***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 10.79	$ 52.33	$ 23.61	$ 20.69	$ 14.98
Projected PMPM For Non-Profit Plans		**$ 539.29**	**$ 2,616.29**	**$ 1,180.31**	**$ 1,034.50**	**$ 749.12**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 11.13*	*$ 53.98*	*$ 24.35*	*$ 21.34*	*$ 15.46*
ACA Issuer Fee - est. per Plan submission for 2015 [5]	*3.0%*	$ 16.69	$ 80.97	$ 36.53	$ 32.02	$ 23.18
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 556.32***	***$ 2,698.91***	***$ 1,217.58***	***$ 1,067.17***	***$ 772.78***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[4] Projected administrative load is based on MCO financial reporting of Operating Expenses for CSHCN and Substitute Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services" . Substitute Care admin reflects an adjustment to the BH Services sub-capitation admin, to bring it to parity with the BH Services admin in non-Substitute Care CSHCN

[5] Projected PMPM with ACA Issuer Fee applicable to For-Profit plans only. Issuer Fee estimate as provided by UHC for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Actuarial Certification

Certification of the CSHCN and Substitute Care capitation rates for the rate period 2/1/2017 – 6/30/2017, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

4

APPENDIX

CSHCN and Substitute Care

For Rate Year 2/1/2017 - 6/30/2017

Average Eligible Members

Population Cohorts	SFY 2013	SFY 2014	SFY 2015
Adoption Subsidy	1,375	1,377	1,485
Katie Beckett	96	95	92
SSI < 15	3,452	3,414	3,489
SSI >= 15	1,780	1,820	1,859
Substitute Care	2,033	2,059	2,168

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Incurred SFY, PT November 2015, est. 100% complete

PMPM with Offline Adjustments [1]

Population Cohorts	Adjusted SFY 2013 Total	Adjusted SFY 2014 Total	Adjusted SFY 2015 Total
Adoption Subsidy	$ 493.17	$ 444.19	$ 394.24
Katie Beckett	$ 2,340.59	$ 2,166.35	$ 2,210.45
SSI < 15	$ 948.66	$ 1,030.90	$ 992.31
SSI >= 15	$ 801.46	$ 843.10	$ 900.00
Subtotal	$ 836.14	$ 875.47	$ 855.39
Substitute Care	$ 551.06	$ 541.70	$ 635.77
Grand Total	$ 768.44	$ 794.92	$ 800.69

Population Cohorts	SFY 2014 over SFY 2013 Total	SFY 2015 over SFY 2014 Total	SFY 2015 over SFY 2013 (Avg.) Total
Adoption Subsidy	-9.9%	-11.2%	-10.6%
Katie Beckett	-7.4%	2.0%	-2.8%
SSI < 15	8.7%	-3.7%	2.3%
SSI >= 15	5.2%	6.7%	6.0%
Subtotal	4.7%	-2.3%	1.1%
Substitute Care	-1.7%	17.4%	7.4%
Grand Total	3.4%	0.7%	2.1%

[1] PMPMs include offline adjustments, which are identified through the reconciliation efforts between EOHHS and the health plans for claims and expenses not reflected in the encounter data.

CSHCN and Substitute Care
For Rate Period 2/1/2017 - 6/30/2017
Base Period Selection

2-yr. Average Composite Trend: *2.1%*

Population Cohorts	wt.	Prior Period SFY '13 Proj to SFY '15 [1]	wt.	Prior Period SFY '14 Proj to SFY '15 [1]	wt.	Current Period SFY 2015	Base Period PMPM [2]
Adoption Subsidy	33%	$ 513.87	33%	$ 453.41	34%	$ 394.24	$ 453.24
Katie Beckett	33%	$ 2,438.83	33%	$ 2,211.34	34%	$ 2,210.45	$ 2,286.11
SSI < 15	0%	$ 988.48	30%	$ 1,052.31	70%	$ 992.31	$ 1,010.31
SSI >= 15	0%	$ 835.10	30%	$ 860.61	70%	$ 900.00	$ 888.18
Substitute Care	0%	$ 574.19	30%	$ 552.96	70%	$ 635.77	$ 610.93

[1] Prior Period is projected using indicated trends

[2] Base Period PMPMs represent SFY '13 projected to SFY '15, SFY '14 projected to SFY '15 and actual SFY '15 at credibility weights of 33%, 33% and 34% respectively for Adoptions Subsidy and Katie Beckett to smooth out the high variability in year-over-year experience for these two rate cells, and 0%, 30% and 70% respectively for SSI <15, SSI >=15, and Substitute Care

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Trend Selection

	PMPM			Price per Unit			Utilization/1k		
Category	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**
Inpatient [1]	20.5%	-9.4%	4.5%	-3.3%	-6.1%	-4.7%	24.6%	-3.5%	9.7%
Outpatient	-5.4%	-4.8%	-5.1%	-0.5%	-4.6%	-2.6%	-4.9%	-0.2%	-2.6%
Professional	1.2%	-3.0%	-1.0%	-1.1%	-4.2%	-2.7%	2.3%	1.2%	1.7%
Rx	-0.9%	3.7%	1.4%	3.4%	2.9%	3.2%	-4.2%	0.8%	-1.7%
Inst./NH	16.2%	-36.4%	-14.1%	-1.6%	-20.6%	-11.6%	18.0%	-19.9%	-2.8%

	Selected Trends [1,2]			Dist%
Category	**Price**	**Util.**	**PMPM**	**SFY14**
Inpatient [1]	-4.7%	9.7%	4.5%	28%
Outpatient	0.0%	0.0%	0.0%	12%
Professional	0.0%	1.7%	1.7%	46%
Rx	3.2%	-1.7%	1.4%	13%
Inst./NH	0.0%	0.0%	0.0%	1%
Total			**2.2%**	100%

[1] Selected trends are based off the 2-year average trends for SFY '15 over SFY '13 (composite all rate cells), except for Inpatient trends, which excludes NHPRI experience for Substitute Care and SSI 15-20. The State became aware of care coordination-related issues for Substitute Care enrollees at the State agency level, which resulted in the inappropriate use of the inpatient setting for Substitute Care and older SSI enrollees at NHPRI. The State has implemented process improvements to address the inappropriate use of the Inpatient setting for these members. Accordingly, it is assumed that the observed inpatient trends for these population cohorts will not continue into the rate period, and that their inpatient trend will track more closely with the composite inpatient trends exclusive of Substitute Care and SSI 15-20

[2] Where the indicated composite PMPM trend is negative and the price x utilization trends do not appear to offset each other, the indicated negative component trend was set to 0%, else negative trends were carried through

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Impact of Article 5 on Selected Trends

Base Period MidPt					
1/1/2015	**Selected Trends**				% In-State
LOB	SFY '15 Clms. Dist.	Price	Util	comp	Clms. Dist.
Inpatient	28.0%	-4.7%	9.7%	4.5%	93.7%
Outpatient	12.2%	0.0%	0.0%	0.0%	96.0%
Professional	46.3%	0.0%	1.7%	1.7%	
Pharmacy	12.9%	3.2%	-1.7%	1.4%	
Institutional	0.5%	0.0%	0.0%	0.0%	
Total	100.0%			**2.2%**	

12.00

1/1/2016	Impact of Article 5				**Adjusted**	Impact of Trend on	
	SFY '15	7/1/15 - 6/30/16			**Comp.**	Clms. Dist.	
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**		
Inpatient	28.0%	-4.7%	9.7%	4.5%	4.5%	28.7%	0.29
Outpatient	12.2%	-2.5%	0.0%	-2.5%	-2.4%	11.7%	0.12
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	46.2%	0.47
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.9%	0.13
Institutional	0.5%	-2.0%	0.0%	-2.0%	-2.0%	0.5%	0.00
Total	100.0%			**1.9%**	**1.9%**	100.0%	1.02

9.47

10/15/2016	Impact of Article 5				**Adjusted**	Impact of Trend on	
	SFY '15	7/1/16 - 1/31/17			**Comp.**	Clms. Dist.	
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**		
Inpatient	28.0%	1.9%	9.7%	11.7%	11.3%	30.2%	0.32
Outpatient	12.2%	1.9%	0.0%	1.9%	1.8%	11.5%	0.12
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	45.3%	0.48
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.6%	0.13
Institutional	0.5%	3.2%	0.0%	3.2%	3.2%	0.5%	0.01
Total	100.0%			**4.5%**	**4.4%**	100.0%	1.05

6.00

4/15/2017	Impact of Article 5				**Adjusted**	Impact of Trend on	
	SFY '15	2/1/17 - 6/30/17			**Comp.**	Clms. Dist.	
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**		
Inpatient	28.0%	1.9%	9.7%	11.7%	11.3%	31.2%	0.34
Outpatient	12.2%	1.9%	0.0%	1.9%	1.8%	11.3%	0.12
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	44.7%	0.48
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.4%	0.13
Institutional	0.5%	3.2%	0.0%	3.2%	3.2%	0.5%	0.01
Total	100.0%			**4.5%**	**4.4%**	100.0%	1.08

Rate Period MidPt	**27.47 OK**						
4/15/2017	Impact of Article 5				**Adjusted**	**Change in**	**Adjusted**
	SFY '15	**27.47 -Mo. Avg. Trends**			**Comp.**	**Clms. dist.**	**Comp.**
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**	**over time**	**Trend [1]**
Inpatient	28.0%	-1.1%	9.7%	8.5%	8.2%	29.6%	8.2%
Outpatient	12.2%	0.0%	0.0%	0.0%	0.0%	11.8%	0.0%
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	45.5%	1.7%
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.6%	1.4%
Institutional	0.5%	0.9%	0.0%	0.9%	0.9%	0.5%	0.9%
Total	100.0%			**3.4%**	**3.3%**	100.0%	**3.4%**
		average trend		**3.4%**	**3.3%**		**3.4%**

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Impact of Article 5 on Selected Trends

	Impact to Trends				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Selected Trends Based on Experience	2.2%	2.2%	2.2%	2.2%	2.2%
Impact of Article 5 on Composite Trends:					
SFY '16 Trends with Article 5 [1] Implementation	1.9%	1.9%	1.9%	1.9%	1.9%
7/1/2016 - 1/31/2017 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
2/1/2017 - 6/30/2017 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
Average annual trend [2] with Impact of Article 5[1] Implementation	**3.4%**	**3.4%**	**3.4%**	**3.4%**	**3.4%**

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

PCMH-Kids

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Rate Period Forecast Average Enrollment	1,918	109	3,344	1,930	2,151
Percent Kids	96.7%	100.0%	100.0%	66.4%	86.8%
PCMH-Kids	1,855	109	3,344	1,282	1,866
PCMH-Kids Program Development Allowance [1]	$ 3.61	$ 3.61	$ 3.61	$ 3.61	$ 3.61
Adjustment to Rate Cell for Development Allowance [1]	**$ 3.49**	**$ 3.61**	**$ 3.61**	**$ 2.40**	**$ 3.13**
PCMH-Kids Savings Target [1]	$ (0.90)	$ (0.90)	$ (0.90)	$ (0.90)	$ (0.90)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.87)**	**$ (0.90)**	**$ (0.90)**	**$ (0.60)**	**$ (0.78)**

[1] Program Development Allowance and Savings Targets as set by the State

CSHCN & Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Gender Dysphoria

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [5]	$ 63,109
Number of persons estimated seeking surgical benefits [2]	1
Estimated total expenditures for Gender Dysphoria	$ 63,109
Rate Period forecasted average enrollment (excluding SSI <15) [3]	6,107
Estimated impact to Total CSHCN & Substitute Care PMPM [3]	$ 0.86

Rate Adjustment Allocation [3]:	Est. Aged 15+ for Rate Period	PMPM Adjustment [4]
Adoption Subsidy	536	$ 0.45
Katie Beckett	30	$ 0.45
SSI >=15	1,930	$ 1.61
Substitute Care	768	$ 0.58

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person for SFY 2015, and is assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism. Analysis identified 8 average eligibles with such diagnoses; assumed a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[3] Allocation of the adjustment for Gender Dysphoria is based on the ratio of members aged 15+ in each rate cell as at SFY '15 average enrollment. Excludes SSI <15 enrollees

[4] PMPM Adjustment is based on allocation of expenses to 15+ year-olds in each rate cell stated over all members in that rate cell

[5] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Care Transformation Collaborative

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Rate Period Forecast Average Enrollment	1,918	109	3,344	1,930	2,151
Percent 19+ (est. from 7/1/15-12/31/15 actual)	3.3%	0.0%	0.0%	33.6%	13.2%
Adults	64	-	-	648	285
CTC Program Expenses PMPM - Per Adult [1]	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)
Adjustment to Rate Cell for CTC Expenses	**$ (0.02)**	**$ -**	**$ -**	**$ (0.20)**	**$ (0.08)**

[1] CTC PMPM expense adjustment for graduating practice sites, not currently reflected in the base period expenses

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Reinventing Medicaid Program Initiatives

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Program Initiative Savings [1]					
BH Services	$ (4.32)	$ (1.85)	$ (9.68)	$ (12.77)	$ (10.75)
CEDARR	$ (10.59)	$ (143.05)	$ (33.52)	$ (26.92)	$ (2.19)
ACO	$ (5.09)	$ (30.99)	$ (17.26)	$ (14.46)	$ (11.76)

[1] Please refer to the narrative section of the Data Book for a description of the Program Savings Initiatives

CSHCN and Substitute Care

For Rate Period 2/1/2017 - 6/30/2017

Adult Immunization

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Enrolled Member Months 7/1/15 - 12/31/15	8,674			9,937	12,202
Enrolled Member Months Aged 19+	288			3,336	1,615
% Enrolled Aged 19+	3.3%			33.6%	13.2%
Rate Period Forecast Average Enrollment	1,918	109	3,344	1,930	2,151
Estimated Aged 19+ Forecast Enrollment	**64**	**-**	**-**	**648**	**285**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ 1.66	$ 1.66	$ 1.66	$ 1.66	$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ 0.06**	**$ -**	**$ -**	**$ 0.56**	**$ 0.22**

CSHCN and Substitute Care
For Rate Period 2/1/2017 - 6/30/2017

Rate Period Average Enrollment Forecast		1,918	109	3,344	1,930	2,151
		Adoption Subsidy	Katie Beckett	SSI <15	SSI 15-20	Substitute Care
Base Medical PMPM		$ 453.24	$ 2,286.11	$ 1,010.31	$ 888.18	$ 610.93
Article 5-Adjusted Selected Trend [1]		3.40%	3.40%	3.40%	3.40%	3.40%
Projection Period (years)		2.29	2.29	2.29	2.29	2.29
Projected Medical PMPM		**$ 489.31**	**$ 2,468.02**	**$ 1,090.70**	**$ 958.86**	**$ 659.54**
Adjustments To Total PMPM:						
Health Service Reclass [2]		$ 4.14	$ 20.89	$ 9.23	$ 8.12	$ 6.31
PCMH - Kids Program Development Allowance		$ 3.49	$ 3.61	$ 3.61	$ 2.40	$ 3.13
PCMH - Kids Savings Target		$ (0.87)	$ (0.90)	$ (0.90)	$ (0.60)	$ (0.81)
Gender Dysphoria [3]		$ 0.45	$ 0.45	$ -	$ 1.61	$ 0.58
Care Transformation Collaborative (CTC) [6]		$ (0.02)	$ -	$ -	$ (0.20)	$ (0.08)
Program Initiative Savings:						
BH Services		$ (4.32)	$ (1.85)	$ (9.68)	$ (12.77)	$ (10.75)
CEDARR		$ (10.59)	$ (143.05)	$ (33.52)	$ (26.92)	$ (2.19)
ACO		$ (5.09)	$ (30.99)	$ (17.26)	$ (14.46)	$ (11.76)
Subtotal Adjustments		$ (12.81)	$ (151.84)	$ (48.52)	$ (42.82)	$ (15.57)
Fraud & Abuse (% of Medical)	1.0%	$ (4.77)	$ (23.16)	$ (10.42)	$ (9.16)	$ (6.44)
Subtotal Net Medical PMPM		**$ 471.73**	**$ 2,293.02**	**$ 1,031.76**	**$ 906.88**	**$ 637.53**
Projected Administrative Load [4]		$ 48.78	$ 232.48	$ 107.59	$ 91.17	$ 85.38
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 7.93	$ 38.46	$ 17.35	$ 15.20	$ 11.01
Premium Before Taxes		$ 528.44	$ 2,563.96	$ 1,156.70	$ 1,013.25	$ 733.92
Assessments: Adult Immunization		***$ 0.06***	***$ -***	***$ -***	***$ 0.56***	***$ 0.22***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 10.79	$ 52.33	$ 23.61	$ 20.69	$ 14.98
Projected PMPM For Non-Profit Plans		**$ 539.29**	**$ 2,616.29**	**$ 1,180.31**	**$ 1,034.50**	**$ 749.12**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 11.13*	*$ 53.98*	*$ 24.35*	*$ 21.34*	*$ 15.46*
ACA Issuer Fee - est. per Plan submission for 2015 [5]	*3.0%*	$ 16.69	$ 80.97	$ 36.53	$ 32.02	$ 23.18
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 556.32***	***$ 2,698.91***	***$ 1,217.58***	***$ 1,067.17***	***$ 772.78***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[4] Projected administrative load is based on MCO financial reporting of Operating Expenses for CSHCN and Substitute Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services" . Substitute Care admin reflects an adjustment to the BH Services sub-capitation admin, to bring it to parity with the BH Services admin in non-Substitute Care CSHCN

[5] Projected PMPM with ACA Issuer Fee applicable to For-Profit plans only. Issuer Fee estimate as provided by UHC for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

CSHCN and Substitute Care
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017

Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [5]	Non-Profit Plans		For-Profit Plans		
					State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans [3]	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee For-Profit Plans [4]	Capitation Rates: For-Profit Plans
Adoption Subsidy	$ 471.73	$ 48.78	$ 7.93	$ 0.06	$ 10.79	**$ 539.29**	$ 11.13	$ 16.69	**$ 556.32**
Katie Beckett	$ 2,293.02	$ 232.48	$ 38.46	$ -	$ 52.33	**$ 2,616.29**	$ 53.98	$ 80.97	**$ 2,698.91**
SSI < 15	$ 1,031.76	$ 107.59	$ 17.35	$ -	$ 23.61	**$ 1,180.31**	$ 24.35	$ 36.53	**$ 1,217.58**
SSI >= 15	$ 906.88	$ 91.17	$ 15.20	$ 0.56	$ 20.69	**$ 1,034.50**	$ 21.34	$ 32.02	**$ 1,067.17**
Substitute Care [3]	$ 637.53	$ 85.38	$ 11.01	$ 0.22	$ 14.98	**$ 749.12**	$ 15.46	$ 23.18	**$ 772.78**

[1] Risk Margin set at 1.5% of premium before taxes

[2] State Premium Tax is set at 2% of Permiums

[3] Substitute Care is only available under NHPRI, a Non-Profit Plan

[4] ACA Issuer Fee, per UHC estimate for 2015, is applicable to For-Profit health plans only

[5] Includes Adult Immunization

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the Rhode Island State capitation rates for the 5-month period February 1, 2017 through June 30, 2017 for Children with Special Health Care Needs (CHSCN) and Children in Substitute Care Arrangements (Substitute Care) who are eligible for enrollment into the State's RIte Care program, a Medicaid managed care program implemented under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration. The 5-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following eligibility categories: Substitute Care, Adoption Subsidy, Katie Beckett, SSI under age 15, and SSI age 15 and older.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Thomas M. Donlon, FSA, MAAA
Principal
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June 30, 2016
Date

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June 28, 2016

Children with Special Health Care Needs (CSHCN) and Substitute Care Data Book

State of Rhode Island

Rates for the period 7/1/2017 through 6/30/2018

Final & Confidential

Prepared by:
HealthCare Analytics
PO Box 41408
Providence, RI 02940-1408

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INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 7/1/2017 through 6/30/2018 for Children with Special Health Care Needs (CSHCN) and Children in Substitute Care Arrangements (Substitute Care), who are eligible for enrollment into the State's RIte Care program, a Medicaid managed care program authorized under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration.

CSHCN and Substitute Care provides eligible children with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE). The health plans are paid capitation rates based on population cohorts. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the CSHCN and Substitute Care per member per month (PMPM) capitation rates effective July 1, 2017 through June 30, 2018, for the purpose of attaining rate approval from CMS under 42 CFR 438.6(c). This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using selected trends developed from the claims experience, adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the CSHCN and Substitute Care claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected CSHCN and Substitute Care rates presented in this data book:

- Patient-Centered Medical Homes for Kids (PCMH-Kids)
- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for CSHCN and Substitute Care were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

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CAPITATION RATES & DEMOGRAPHICS

The capitation rates including assessments, taxes and fees for the rate period 7/1/2017 – 6/30/2018 are as follows:

Table 1
Capitation Rates

CSHCN and Substitute Care
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018

					Non-Profit Plans		For-Profit Plans		
Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [5]	State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans [3]	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee For-Profit Plans [4]	Capitation Rates: For-Profit Plans
Adoption Subsidy	$ 489.56	$ 49.72	$ 8.21	$ 0.06	$ 11.17	**$ 558.72**	$ 11.53	$ 17.29	**$ 576.37**
Katie Beckett	$ 2,375.38	$ 236.99	$ 39.78	$ -	$ 54.13	**$ 2,706.28**	$ 55.84	$ 83.75	**$ 2,791.74**
SSI < 15	$ 1,068.91	$ 109.67	$ 17.95	$ -	$ 24.42	**$ 1,220.95**	$ 25.19	$ 37.79	**$ 1,259.51**
SSI >= 15	$ 939.48	$ 92.94	$ 15.72	$ 0.56	$ 21.40	**$ 1,070.10**	$ 22.07	$ 33.12	**$ 1,103.89**
Substitute Care [3]	$ 659.75	$ 86.30	$ 11.36	$ 0.22	$ 15.46	**$ 773.09**	$ 15.95	$ 23.93	**$ 797.51**

[1] Risk Margin set at 1.5% of premium before taxes
[2] State Premium Tax is set at 2% of Premiums
[3] Substitute Care is only available under NHPRI, a Non-Profit Plan
[4] ACA Issuer Fee, per UHC estimate for 2015, is applicable to For-Profit health plans only
[5] Includes Adult Immunization

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RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data reports, which were based on encounter data, covered the following State Fiscal Years (SFY)

- 7/1/2012 through 6/30/2013 (SFY 2013), paid through 11/30/2015, estimated at 100%
- 7/1/2013 through 6/30/2014 (SFY 2014), paid through 11/30/2015, estimated at 100%
- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

The claims data was delineated by rate cell and by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail which allowed us to examine historical patterns for unit cost and utilization levels.

All claims data including SFY 2013, SFY 2014, and SFY 2015 were presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2013, SFY 2014 and SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Exhibit 1 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2013, SFY 2014, and SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '13, SFY '14, and SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services
- CEDARR

BASE PERIOD

The base period PMPMs are credibility weighted averages from SFY 2013, SFY 2014 and SFY 2015. SFY 2013 and SFY 2014 were trended to SFY 2015 using the 2-year average trend for the composite experience of all the rate cells. Adoptions Subsidy and Katie Beckett reflect a blend of SFY 2013, SFY 2014 and SFY 2015 at 33%, 33% and 34% respectively, while both SSI rate cells and Substitute Care rate cells reflect a blend of SFY 2014 and SFY 2015 at 30% and 70%. This methodology is intended to smooth out the year-over-year variability in the experience so that they are not magnified in the projected benefit costs. (see Table 2 below and Exhibits 2 & 3 in the appendix).

Table 2
Base Period PMPM:

CSHCN and Substitute Care
For Rate Period 7/1/2017 - 6/30/2018
Base Period Selection

2-yr. Average Composite Trend: *2.1%*

Population Cohorts	wt.	Prior Period SFY '13 Proj to SFY '15 [1]	wt.	Prior Period SFY '14 Proj to SFY '15 [1]	wt.	Current Period SFY 2015	Base Period PMPM [2]
Adoption Subsidy	33%	$ 513.87	33%	$ 453.41	34%	$ 394.24	$ 453.24
Katie Beckett	33%	$ 2,438.83	33%	$ 2,211.34	34%	$ 2,210.45	$ 2,286.11
SSI < 15	0%	$ 988.48	30%	$ 1,052.31	70%	$ 992.31	$ 1,010.31
SSI >= 15	0%	$ 835.10	30%	$ 860.61	70%	$ 900.00	$ 888.18
Substitute Care	0%	$ 574.19	30%	$ 552.96	70%	$ 635.77	$ 610.93

TRENDS AND TREND DEVELOPMENT

Trends were developed on the composite experience of the program due to the relatively small size of the populations in each rate cell and the volatility exhibited in the year-to-year experience. The trends were developed by service category, from the claims data including the G/L adjustments, based on the 2-year average unit cost and utilization trends of SFY 2015 over SFY 2013. The trends were further adjusted to exclude non-recurring events impacting inpatient utilization trends as described below.

Adjustments to Trends

The Selected 2-year average trends for SFY '15 over SFY '13 (composite all rate cells) were adjusted to exclude NHPRI's inpatient experience for Substitute Care and SSI 15-20, for the following reason as described by the State to the actuaries. The State became aware of care coordination-related issues for Substitute Care enrollees at the State agency level, which resulted in the inappropriate use of the inpatient setting for Substitute Care and older SSI enrollees at NHPRI. The State has implemented process improvements to address the inappropriate use of the Inpatient setting for these members. Accordingly, it is assumed that the observed inpatient trends for these population cohorts will not continue into the rate period, and that their inpatient trend will track more closely with the composite inpatient trends exclusive of Substitute Care and SSI 15-20.

Table 3
Selected Trends:

CSHCN and Substitute Care
For Rate Period 7/1/2017 - 6/30/2018
Trend Selection

	PMPM			Price per Unit			Utilization/1k		
Category	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**
Inpatient [1]	20.5%	-9.4%	4.5%	-3.3%	-6.1%	-4.7%	24.6%	-3.5%	9.7%
Outpatient	-5.4%	-4.8%	-5.1%	-0.5%	-4.6%	-2.6%	-4.9%	-0.2%	-2.6%
Professional	1.2%	-3.0%	-1.0%	-1.1%	-4.2%	-2.7%	2.3%	1.2%	1.7%
Rx	-0.9%	3.7%	1.4%	3.4%	2.9%	3.2%	-4.2%	0.8%	-1.7%
Inst./NH	16.2%	-36.4%	-14.1%	-1.6%	-20.6%	-11.6%	18.0%	-19.9%	-2.8%

	Selected Trends [1,2]			Dist%
Category	**Price**	**Util.**	**PMPM**	**SFY14**
Inpatient [1]	-4.7%	9.7%	4.5%	28%
Outpatient	0.0%	0.0%	0.0%	12%
Professional	0.0%	1.7%	1.7%	46%
Rx	3.2%	-1.7%	1.4%	13%
Inst./NH	0.0%	0.0%	0.0%	1%
Total			**2.2%**	100%

Continued on next page

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was estimated on the selected trends, based on the specific language as it applied to Inpatient, Outpatient and Institutional unit cost trends. See the excerpt below for the specific applicable language, and Table 4 for the impact on selected trends.

ARTICLE 5 (Excerpt)		
Page	**Line**	**Inpatient**
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.
Page	**Line**	**Outpatient**
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Table 4
Impact of Article 5

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends

	Impact to Trends				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Selected Trends Based on Experience	2.2%	2.2%	2.2%	2.2%	2.2%
Impact of Article 5 on Composite Trends:					
SFY '16 Trends with Article 5 [1] Implementation	1.9%	1.9%	1.9%	1.9%	1.9%
SFY '17 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
SFY '18 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
Average annual trend [2] with Impact of Article 5 [1] Implementation	**3.7%**	**3.7%**	**3.7%**	**3.7%**	**3.7%**

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans are required to identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to rate period at **1.6%** annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. Since the health service re-class is reported on an aggregate basis, we allocated the re-class amounts based on each rate cell's claims volume to the aggregate. The composite reported re-class for the base period was **$7.50** PMPM for CSHCN and **$6.08** PMPM for Substitute Care, projected to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. EOHHS staff evaluated the CSHCN and Substitute Care experience for SFY 2014 and identified 8 average eligible with such diagnoses, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 1 potential surgeries. The cost of surgery, at $52,650 per procedure in 2015, was estimated by EOHHS staff. The cost of surgery was projected to the rate period using the composite inpatient trend as impacted by Article 5. The estimated cost for surgery was allocated to each rate cell based on number of enrollees over 15 years of age in the applicable rate cells.

Table 5
Gender Dysphoria

CSHCN & Substitute Care		
For Rate Period 7/1/2017 - 6/30/2018		
Gender Dysphoria		
		Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]		$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [5]		$ 68,088
Number of persons estimated seeking surgical benefits [2]		1
Estimated total expenditures for Gender Dysphoria		$ 68,088
Rate Period forecasted average enrollment (excluding SSI <15) [3]		6,315
Estimated impact to Total CSHCN & Substitute Care PMPM [3]		$ 0.90
Rate Adjustment Allocation [3]:	Est. Aged 15+ for Rate Period	PMPM Adjustment [4]
Adoption Subsidy	582	$ 0.48
Katie Beckett	30	$ 0.48
SSI >=15	1,950	$ 1.70
Substitute Care	776	$ 0.61

PCMH-Kids – Per EOHHS, this program initiative is defined as follows: *"PCMH-Kids is a multi-payer patient centered medical home initiative. It grew out of the Care Transformation Collaborative (CTC, formerly known as CSI) to spread the transformation of primary care to practices serving children. Currently there are 9 participating primary care practices, serving approximately 30,000 children*

(approximately 14,000 attributed Medicaid lives). These 9 practices came together with all of the major health plans in Rhode Island (both commercial and Medicaid Managed Care Plans) to design a Common Contract that calls for supplemental payments to the practices to support the transformation. With these payments, practices are required to achieve NCQA PCMH recognition and hire staff for care coordination. The onsite care coordinator improves the capacity of the primary care office to manage and coordinate care for the highest needs children and families. Practices are also responsible for reporting and improving upon several measures promoting data-driven quality improvement and population health management. Practices will report clinical quality measures from their electronic health record, participate in a patient experience survey and use utilization data from the all-payers claims data-base to reduce the emergency department utilization of their patients.

Practices will be provided with an onsite practice coach, collaborative learning and best practice sharing opportunities throughout their time in the contract. At the end of the three-year contract, we anticipate that practices will have the foundation to be successful in advanced payment contracts with the health plans, such as shared savings and shared risk arrangements."

The State is allocating **$363,000** for the rate period, pro-rated for the percent of kids under 19 in each rate cell, for the continued development of this program that started in January 2016. It is anticipated that initial efforts by the plans will impact a limited number of enrollees, from which the State is setting a target savings amount of **$90,750**, pro-rated for the percent of kids under 19 in each rate cell. The strategies will include but will not be limited to:

- Expansion of the Chronic Care Sustainability Initiative (CSI) and the implementation of Patient-Centered Medical Home (PCMH) for kids.
- Improved efforts in the area of transitions of care and follow-up after hospital discharge, in particular for mental health hospitalizations
- Alternative contracting, reimbursement and operational arrangements with providers who have a large volume of high utilizing members
- Leveraging of new and existing resources, including Community Health Teams

Health Plans will submit a high utilizer strategy to EOHHS for review and approval. EOHHS will work collaboratively with the health plans to provide all necessary support and technical assistance in the implementation of these efforts.

Table 6
PCMH-Kids

CSHCN and Substitute Care						
For Rate Period 7/1/2017 - 6/30/2018						
PCMH-Kids						
	Impact to PMPM					
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15		Substitute Care
Rate Period Forecast Average Enrollment	2,082	109	3,390	1,950		2,174
Percent Kids	96.7%	100.0%	100.0%	66.4%		86.8%
PCMH-Kids	2,013	109	3,390	1,295		1,886
PCMH-Kids Program Development Allowance [1]	$ 3.48	$ 3.48	$ 3.48	$ 3.48		$ 3.48
Adjustment to Rate Cell for Development Allowance [1]	**$ 3.36**	**$ 3.48**	**$ 3.48**	**$ 2.31**		**$ 3.02**
PCMH-Kids Savings Target [1]	$ (0.87)	$ (0.87)	$ (0.87)	$ (0.87)		$ (0.87)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.84)**	**$ (0.87)**	**$ (0.87)**	**$ (0.58)**		**$ (0.75)**

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by*

the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan (Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice, collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. The adjustment for this rate period is estimated by the State at **$(0.59)** PMPM. As applicable, the PMPMs are adjusted based on proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives.

Table 7
Care Transformation Collaborative - CTC

CSHCN and Substitute Care						
For Rate Period 7/1/2017 - 6/30/2018						
Care Transformation Collaborative						
	Impact to PMPM					
	Adoption Subsidy	**Katie Beckett**	**SSI < 15**	**SSI >= 15**		**Substitute Care**
Rate Period Forecast Average Enrollment	2,082	109	3,390	1,950		2,174
Percent 19+ (est. from 7/1/15-12/31/15 actual)	3.3%	0.0%	0.0%	33.6%		13.2%
Adults	69	-	-	655		288
CTC Program Expenses PMPM - Per Adult [1]	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)		$ (0.59)
Adjustment to Rate Cell for CTC Expenses	**$ (0.02)**	**$ -**	**$ -**	**$ (0.20)**		**$ (0.08)**

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the

product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 8 for the impact of this initiative.

Comprehensive Evaluation Diagnosis Assessment Referral and Re-evaluation (CEDARR) Services, referred to as Initiative 9A, integrate "out of plan services" for children with special health care needs into Medicaid MCOs:

CEDARR Services as defined by initiative 9A, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to integrate Home Based Therapeutic Services (HBTS), Personal Services and Supports (PASS), and Respite Care into an enrollee's total continuum of care. It is anticipated that the integration of these like services will enable the MCOs with greater flexibility to provide clinically appropriate and evidence-based lower-cost services to children and adolescents. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 8 for the impact of this initiative.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. See Table 8 for the impact of this initiative.

Table 8
Program Initiatives Savings

CSHCN and Substitute Care					
For Rate Period 7/1/2017 - 6/30/2018					
Reinventing Medicaid Program Initiatives					
	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Program Initiative Savings [1]					
BH Services	$ (3.98)	$ (1.85)	$ (9.55)	$ (12.64)	$ (10.64)
CEDARR	$ (9.76)	$ (143.05)	$ (33.06)	$ (26.63)	$ (2.17)
ACO	$ (4.69)	$ (30.99)	$ (17.02)	$ (14.30)	$ (11.64)

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. We reviewed the CPI factors for various categories and selected the "Medical Care Services" and "Health Insurance" categories to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The resulting administrative load is on **10.7%** of projected composite medical PMPM.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to ***$1.66*** *PMPM for adults aged 19 and over.*

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Table 9
Adult Immunization

CSHCN and Substitute Care						
For Rate Period 7/1/2017 - 6/30/2018						
Adult Immunization						
	Impact to PMPM					
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15		Substitute Care
Enrolled Member Months 7/1/15 - 12/31/15	8,674			9,937		12,202
Enrolled Member Months Aged 19+	288			3,336		1,615
% Enrolled Aged 19+	3.3%			33.6%		13.2%
Rate Period Forecast Average Enrollment	2,082	109	3,390	1,950		2,174
Estimated Aged 19+ Forecast Enrollment	**69**	**-**	**-**	**655**		**288**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ 1.66	$ 1.66	$ 1.66	$ 1.66		$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ 0.06**	**$ -**	**$ -**	**$ 0.56**		**$ 0.22**

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.

b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**
b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)".*

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCOs satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. **Health System Transformation Program**

Through its *Health System Transformation Program Rhode Island* and its Medicaid MCOs shall support and incentivize a critical transformation of RI's system of care. The Program will award investments in performance-based infrastructure development by Medicaid Certified Accountable Entities (AE). Medicaid MCOs will be full partners in this transition, as the ultimate intent of this effort is to support the development of value-based contracts between the health plans and AEs.

Accountable Entities that meet state defined certification standards will initially apply for infrastructure funding to develop the governance, technology, skills and capacity to enter into risk-based contracts with Medicaid MCOs; manage enrollees' care across AE providers; and decrease out-year cost trend rates. Qualified AEs must meet one of three levels of readiness demonstrating that they either have or are developing the capacity to integrate and

manage the full continuum of health care and to address members' social determinants (e.g., housing, food), in a way that is acceptable to CMS and the State.

The State shall reimburse the health plan for State-approved incentive payments that a health plan makes to providers making infrastructure investments to support this development of Accountable Entities. Up to 10 percent of the incentive payments may be retained by the health plan as an enhanced performance award to accelerate the development of value-based purchasing contracts with Accountable Entities.

Total payments made by all health plans cannot exceed the lesser of the maximum PMPM allocation indicated below or the maximum amount allocated by Rhode Island for the Health Systems Transformation Program within the Contract Period. Payments shall be distributed across the various Products (RIte Care, Substitute Care, Children with Special Healthcare Needs, Rhody Health Partners and Adult Expansion) based on the proportion of the Medicaid MCO's members associated with the AE being awarded the incentive payment.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $45.00 PMPM for CSHCN, and $30.00 PMPM for Substitute Care

2. Performance Goal Program

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $3.00 PMPM for both CSHCN and Substitute Care

3. Provider Incentive Program

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO.
These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM for both CSHCN and Substitute Care

The total maximum pay-out amount for all incentive programs is expected to be no more than **$50.90** PMPM for CSHCN, and **$35.90** for Substitute Care. When measured relative to the proposed capitation rates – estimated non-profit composite rates of **$1,020.31** for CSHCN and **$773.09** for Substitute Care, the incentive payments plus the capitation rates are within the 105% threshold for certified rates.

RATE DEVELOPMENT

Table 10
CSHCN & Substitute Care Rate Development

CSHCN and Substitute Care
For Rate Period 7/1/2017 - 6/30/2018

		Adoption Subsidy	Katie Beckett	SSI <15	SSI 15-20	Substitute Care
Rate Period Average Enrollment Forecast		**2,082**	**109**	**3,390**	**1,950**	**2,174**
Base Medical PMPM		$ 453.24	$ 2,286.11	$ 1,010.31	$ 888.18	$ 610.93
Article 5-Adjusted Selected Trend [1]		3.72%	3.72%	3.72%	3.72%	3.72%
Projection Period (years)		3.00	3.00	3.00	3.00	3.00
Projected Medical PMPM		**$ 505.73**	**$ 2,550.85**	**$ 1,127.31**	**$ 991.03**	**$ 681.68**
Adjustments To Total PMPM:						
Health Service Reclass [2]		$ 4.23	$ 21.32	$ 9.42	$ 8.28	$ 6.38
PCMH - Kids Program Development Allowance		$ 3.36	$ 3.48	$ 3.48	$ 2.31	$ 3.02
PCMH - Kids Savings Target		$ (0.84)	$ (0.87)	$ (0.87)	$ (0.58)	$ (0.75)
Gender Dysphoria [3]		$ 0.48	$ 0.48	$ -	$ 1.70	$ 0.61
Care Transformation Collaborative (CTC) [6]		$ (0.02)	$ -	$ -	$ (0.20)	$ (0.08)
Program Initiative Savings:						
BH Services		$ (3.98)	$ (1.85)	$ (9.55)	$ (12.64)	$ (10.64)
CEDARR		$ (9.76)	$ (143.05)	$ (33.06)	$ (26.63)	$ (2.17)
ACO		$ (4.69)	$ (30.99)	$ (17.02)	$ (14.30)	$ (11.64)
Subtotal Adjustments		$ (11.22)	$ (151.48)	$ (47.60)	$ (42.06)	$ (15.27)
Fraud & Abuse (% of Medical)	1.0%	$ (4.95)	$ (23.99)	$ (10.80)	$ (9.49)	$ (6.66)
Subtotal Net Medical PMPM		**$ 489.56**	**$ 2,375.38**	**$ 1,068.91**	**$ 939.48**	**$ 659.75**
Projected Administrative Load [4]		$ 49.72	$ 236.99	$ 109.67	$ 92.94	$ 86.30
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 8.21	$ 39.78	$ 17.95	$ 15.72	$ 11.36
Premium Before Taxes		$ 547.49	$ 2,652.15	$ 1,196.53	$ 1,048.14	$ 757.41
Assessments: Adult Immunization		***$ 0.06***	***$ -***	***$ -***	***$ 0.56***	***$ 0.22***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 11.17	$ 54.13	$ 24.42	$ 21.40	$ 15.46
Projected PMPM For Non-Profit Plans		**$ 558.72**	**$ 2,706.28**	**$ 1,220.95**	**$ 1,070.10**	**$ 773.09**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 11.53*	*$ 55.84*	*$ 25.19*	*$ 22.07*	*$ 15.95*
ACA Issuer Fee - est. per Plan submission for 2015 [5]	*3.0%*	$ 17.29	$ 83.75	$ 37.79	$ 33.12	$ 23.93
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 576.37***	***$ 2,791.74***	***$ 1,259.51***	***$ 1,103.89***	***$ 797.51***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[4] Projected administrative load is based on the MCO financial reporting of Operating Expenses for CSHCN and Substitute Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services" - per State budget initiative. Substitute Care admin reflects an adjustment to the BH Services sub-capitation admin, to bring it to parity with the BH Services admin in non-Substitute Care CSHCN

[5] Projected PMPM with ACA Issuer Fee applicable to For-Profit plans only. Issuer Fee estimate as provided by UHC for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Actuarial Certification

Certification of the CSHCN and Substitute Care capitation rates for the rate period 7/1/2017 – 6/30/2018, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

4

APPENDIX

CSHCN and Substitute Care

For Rate Year 7/1/2017 - 6/30/2018

Average Eligible Members

Population Cohorts	SFY 2013	SFY 2014	SFY 2015
Adoption Subsidy	1,375	1,377	1,485
Katie Beckett	96	95	92
SSI < 15	3,452	3,414	3,489
SSI >= 15	1,780	1,820	1,859
Substitute Care	2,033	2,059	2,168

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Incurred SFY, PT November 2015, est. 100% complete

PMPM with Offline Adjustments [1]

Population Cohorts	Adjusted SFY 2013 Total	Adjusted SFY 2014 Total	Adjusted SFY 2015 Total
Adoption Subsidy	$ 493.17	$ 444.19	$ 394.24
Katie Beckett	$ 2,340.59	$ 2,166.35	$ 2,210.45
SSI < 15	$ 948.66	$ 1,030.90	$ 992.31
SSI >= 15	$ 801.46	$ 843.10	$ 900.00
Subtotal	$ 836.14	$ 875.47	$ 855.39
Substitute Care	$ 551.06	$ 541.70	$ 635.77
Grand Total	$ 768.44	$ 794.92	$ 800.69

Population Cohorts	SFY 2014 over SFY 2013 Total	SFY 2015 over SFY 2014 Total	SFY 2015 over SFY 2013 (Avg.) Total
Adoption Subsidy	-9.9%	-11.2%	-10.6%
Katie Beckett	-7.4%	2.0%	-2.8%
SSI < 15	8.7%	-3.7%	2.3%
SSI >= 15	5.2%	6.7%	6.0%
Subtotal	4.7%	-2.3%	1.1%
Substitute Care	-1.7%	17.4%	7.4%
Grand Total	3.4%	0.7%	2.1%

[1] PMPMs include offline adjustments, which are identified through the reconciliation efforts between EOHHS and the health plans for claims and expenses not reflected in the encounter data.

CSHCN and Substitute Care
For Rate Period 7/1/2017 - 6/30/2018
Base Period Selection

2-yr. Average Composite Trend: *2.1%*

Population Cohorts	wt.	Prior Period SFY '13 Proj to SFY '15 [1]	wt.	Prior Period SFY '14 Proj to SFY '15 [1]	wt.	Current Period SFY 2015	Base Period PMPM [2]
Adoption Subsidy	33%	$ 513.87	33%	$ 453.41	34%	$ 394.24	$ 453.24
Katie Beckett	33%	$ 2,438.83	33%	$ 2,211.34	34%	$ 2,210.45	$ 2,286.11
SSI < 15	0%	$ 988.48	30%	$ 1,052.31	70%	$ 992.31	$ 1,010.31
SSI >= 15	0%	$ 835.10	30%	$ 860.61	70%	$ 900.00	$ 888.18
Substitute Care	0%	$ 574.19	30%	$ 552.96	70%	$ 635.77	$ 610.93

[1] Prior Period is projected using indicated trends

[2] Base Period PMPMs represent SFY '13 projected to SFY '15, SFY '14 projected to SFY '15 and actual SFY '15 at credibility weights of 33%, 33% and 34% respectively for Adoptions Subsidy and Katie Beckett to smooth out the high variability in year-over-year experience for these two rate cells, and 0%, 30% and 70% respectively for SSI <15, SSI >=15, and Substitute Care

CSHCN and Substitute Care
For Rate Period 7/1/2017 - 6/30/2018
Trend Selection

	PMPM			Price per Unit			Utilization/1k		
Category	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**	**'14/'13**	**'15/'14**	**'15/'13**
Inpatient [1]	20.5%	-9.4%	4.5%	-3.3%	-6.1%	-4.7%	24.6%	-3.5%	9.7%
Outpatient	-5.4%	-4.8%	-5.1%	-0.5%	-4.6%	-2.6%	-4.9%	-0.2%	-2.6%
Professional	1.2%	-3.0%	-1.0%	-1.1%	-4.2%	-2.7%	2.3%	1.2%	1.7%
Rx	-0.9%	3.7%	1.4%	3.4%	2.9%	3.2%	-4.2%	0.8%	-1.7%
Inst./NH	16.2%	-36.4%	-14.1%	-1.6%	-20.6%	-11.6%	18.0%	-19.9%	-2.8%

	Selected Trends [1,2]			Dist%
Category	**Price**	**Util.**	**PMPM**	**SFY14**
Inpatient [1]	-4.7%	9.7%	4.5%	28%
Outpatient	0.0%	0.0%	0.0%	12%
Professional	0.0%	1.7%	1.7%	46%
Rx	3.2%	-1.7%	1.4%	13%
Inst./NH	0.0%	0.0%	0.0%	1%
Total			**2.2%**	100%

[1] Selected trends are based off the 2-year average trends for SFY '15 over SFY '13 (composite all rate cells), except for Inpatient trends, which excludes NHPRI experience for Substitute Care and SSI 15-20. The State became aware of care coordination-related issues for Substitute Care enrollees at the State agency level, which resulted in the inappropriate use of the inpatient setting for Substitute Care and older SSI enrollees at NHPRI. The State has implemented process improvements to address the inappropriate use of the Inpatient setting for these members. Accordingly, it is assumed that the observed inpatient trends for these population cohorts will not continue into the rate period, and that their inpatient trend will track more closely with the composite inpatient trends exclusive of Substitute Care and SSI 15-20

[2] Where the indicated composite PMPM trend is negative and the price x utilization trends do not appear to offset each other, the indicated negative component trend was set to 0%, else negative trends were carried through

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends

Base Period MidPt					
1/1/2015	**Selected Trends**				% In-State
LOB	SFY '15 Clms. Dist.	Price	Util	comp	Clms. Dist.
Inpatient	28.0%	-4.7%	9.7%	4.5%	93.7%
Outpatient	12.2%	0.0%	0.0%	0.0%	96.0%
Professional	46.3%	0.0%	1.7%	1.7%	
Pharmacy	12.9%	3.2%	-1.7%	1.4%	
Institutional	0.5%	0.0%	0.0%	0.0%	
Total	100.0%			**2.2%**	

12.00

1/1/2016	Impact of Article 5				**Adjusted**	Impact of Trend on	
	SFY '15	7/1/15 - 6/30/16			**Comp.**	Clms. Dist.	
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**		
Inpatient	28.0%	-4.7%	9.7%	4.5%	4.5%	28.7%	0.29
Outpatient	12.2%	-2.5%	0.0%	-2.5%	-2.4%	11.7%	0.12
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	46.2%	0.47
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.9%	0.13
Institutional	0.5%	-2.0%	0.0%	-2.0%	-2.0%	0.5%	0.00
Total	100.0%			**1.9%**	**1.9%**	100.0%	1.02

12.00

1/1/2017	Impact of Article 5				**Adjusted**	Impact of Trend on	
	SFY '15	7/1/16 - 6/30/17			**Comp.**	Clms. Dist.	
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**		
Inpatient	28.0%	1.9%	9.7%	11.7%	11.3%	30.6%	0.33
Outpatient	12.2%	1.9%	0.0%	1.9%	1.8%	11.4%	0.12
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	45.0%	0.48
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.5%	0.13
Institutional	0.5%	3.2%	0.0%	3.2%	3.2%	0.5%	0.01
Total	100.0%			**4.5%**	**4.4%**	100.0%	1.06

12.00

1/1/2018	Impact of Article 5				**Adjusted**	Impact of Trend on	
	SFY '15	7/1/17 - 6/30/18			**Comp.**	Clms. Dist.	
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**		
Inpatient	28.0%	1.9%	9.7%	11.7%	11.3%	32.6%	0.36
Outpatient	12.2%	1.9%	0.0%	1.9%	1.8%	11.1%	0.12
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	43.8%	0.49
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.1%	0.13
Institutional	0.5%	3.1%	0.0%	3.1%	3.1%	0.5%	0.01
Total	100.0%			**4.5%**	**4.4%**	100.0%	1.11

Rate Period MidPt	**36.00 OK**						
1/1/2018	Impact of Article 5				**Adjusted**	**Change in**	**Adjusted**
	SFY '15	**36.00 -Mo. Avg. Trends**			**Comp.**	**Clms. dist.**	**Comp.**
LOB	Clms. Dist.	Price	Util	comp	**Trend [1]**	**over time**	**Trend [1]**
Inpatient	28.0%	-0.4%	9.7%	9.3%	8.9%	30.3%	8.9%
Outpatient	12.2%	0.4%	0.0%	0.4%	0.4%	11.7%	0.4%
Professional	46.3%	0.0%	1.7%	1.7%	1.7%	45.0%	1.7%
Pharmacy	12.9%	3.2%	-1.7%	1.4%	1.4%	12.5%	1.4%
Institutional	0.5%	1.4%	0.0%	1.4%	1.4%	0.5%	1.4%
Total	100.0%			**3.6%**	**3.5%**	100.0%	**3.7%**
		average trend		**3.6%**	**3.6%**		**3.7%**

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends

	Impact to Trends				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Selected Trends Based on Experience	2.2%	2.2%	2.2%	2.2%	2.2%
Impact of Article 5 on Composite Trends:					
SFY '16 Trends with Article 5 [1] Implementation	1.9%	1.9%	1.9%	1.9%	1.9%
SFY '17 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
SFY '18 Trends with Article 5 [1] Implementation	4.4%	4.4%	4.4%	4.4%	4.4%
Average annual trend [2] with Impact of Article 5[1] Implementation	**3.7%**	**3.7%**	**3.7%**	**3.7%**	**3.7%**

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

PCMH-Kids

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Rate Period Forecast Average Enrollment	2,082	109	3,390	1,950	2,174
Percent Kids	96.7%	100.0%	100.0%	66.4%	86.8%
PCMH-Kids	2,013	109	3,390	1,295	1,886
PCMH-Kids Program Development Allowance [1]	$ 3.48	$ 3.48	$ 3.48	$ 3.48	$ 3.48
Adjustment to Rate Cell for Development Allowance [1]	**$ 3.36**	**$ 3.48**	**$ 3.48**	**$ 2.31**	**$ 3.02**
PCMH-Kids Savings Target [1]	$ (0.87)	$ (0.87)	$ (0.87)	$ (0.87)	$ (0.87)
Adjustment to Rate Cells for Savings Target [1]	**$ (0.84)**	**$ (0.87)**	**$ (0.87)**	**$ (0.58)**	**$ (0.75)**

[1] Program Development Allowance and Savings Targets as set by the State

CSHCN & Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Gender Dysphoria

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [5]	$ 68,088
Number of persons estimated seeking surgical benefits [2]	1
Estimated total expenditures for Gender Dysphoria	$ 68,088
Rate Period forecasted average enrollment (excluding SSI <15) [3]	6,315
Estimated impact to Total CSHCN & Substitute Care PMPM [3]	$ 0.90

Rate Adjustment Allocation [3]:	Est. Aged 15+ for Rate Period	PMPM Adjustment [4]
Adoption Subsidy	582	$ 0.48
Katie Beckett	30	$ 0.48
SSI >=15	1,950	$ 1.70
Substitute Care	776	$ 0.61

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person for SFY 2015, and is assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism. Analysis identified 8 average eligibles with such diagnoses; assumed a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[3] Allocation of the adjustment for Gender Dysphoria is based on the ratio of members aged 15+ in each rate cell as at SFY '15 average enrollment. Excludes SSI <15 enrollees

[4] PMPM Adjustment is based on allocation of expenses to 15+ year-olds in each rate cell stated over all members in that rate cell

[5] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Care Transformation Collaborative

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Rate Period Forecast Average Enrollment	2,082	109	3,390	1,950	2,174
Percent 19+ (est. from 7/1/15-12/31/15 actual)	3.3%	0.0%	0.0%	33.6%	13.2%
Adults	69	-	-	655	288
CTC Program Expenses PMPM - Per Adult [1]	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)
Adjustment to Rate Cell for CTC Expenses	**$ (0.02)**	**$ -**	**$ -**	**$ (0.20)**	**$ (0.08)**

[1] CTC PMPM expense adjustment for graduating practice sites, not currently reflected in the base period expenses

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Reinventing Medicaid Program Initiatives

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Program Initiative Savings [1]					
BH Services	$ (3.98)	$ (1.85)	$ (9.55)	$ (12.64)	$ (10.64)
CEDARR	$ (9.76)	$ (143.05)	$ (33.06)	$ (26.63)	$ (2.17)
ACO	$ (4.69)	$ (30.99)	$ (17.02)	$ (14.30)	$ (11.64)

[1] Please refer to the narrative section of the Data Book for a description of the Program Savings Initiatives

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Adult Immunization

	Impact to PMPM				
	Adoption Subsidy	Katie Beckett	SSI < 15	SSI >= 15	Substitute Care
Enrolled Member Months 7/1/15 - 12/31/15	8,674			9,937	12,202
Enrolled Member Months Aged 19+	288			3,336	1,615
% Enrolled Aged 19+	3.3%			33.6%	13.2%
Rate Period Forecast Average Enrollment	2,082	109	3,390	1,950	2,174
Estimated Aged 19+ Forecast Enrollment	**69**	**-**	**-**	**655**	**288**
Adult Immunization PMPM Allowance for Aged 19+ [1]	$ 1.66	$ 1.66	$ 1.66	$ 1.66	$ 1.66
PMPM Adjustment to Rate Cell For Adult Immunization	**$ 0.06**	**$ -**	**$ -**	**$ 0.56**	**$ 0.22**

CSHCN and Substitute Care

For Rate Period 7/1/2017 - 6/30/2018

Rate Period Average Enrollment Forecast		2,082	109	3,390	1,950	2,174
		Adoption Subsidy	Katie Beckett	SSI <15	SSI 15-20	Substitute Care
Base Medical PMPM		$ 453.24	$ 2,286.11	$ 1,010.31	$ 888.18	$ 610.93
Article 5-Adjusted Selected Trend [1]		3.72%	3.72%	3.72%	3.72%	3.72%
Projection Period (years)		3.00	3.00	3.00	3.00	3.00
Projected Medical PMPM		**$ 505.73**	**$ 2,550.85**	**$ 1,127.31**	**$ 991.03**	**$ 681.68**
Adjustments To Total PMPM:						
Health Service Reclass [2]		$ 4.23	$ 21.32	$ 9.42	$ 8.28	$ 6.38
PCMH - Kids Program Development Allowance		$ 3.36	$ 3.48	$ 3.48	$ 2.31	$ 3.02
PCMH - Kids Savings Target		$ (0.84)	$ (0.87)	$ (0.87)	$ (0.58)	$ (0.75)
Gender Dysphoria [3]		$ 0.48	$ 0.48	$ -	$ 1.70	$ 0.61
Care Transformation Collaborative (CTC) [6]		$ (0.02)	$ -	$ -	$ (0.20)	$ (0.08)
Program Initiative Savings:						
BH Services		$ (3.98)	$ (1.85)	$ (9.55)	$ (12.64)	$ (10.64)
CEDARR		$ (9.76)	$ (143.05)	$ (33.06)	$ (26.63)	$ (2.17)
ACO		$ (4.69)	$ (30.99)	$ (17.02)	$ (14.30)	$ (11.64)
Subtotal Adjustments		$ (11.22)	$ (151.48)	$ (47.60)	$ (42.06)	$ (15.27)
Fraud & Abuse (% of Medical)	1.0%	$ (4.95)	$ (23.99)	$ (10.80)	$ (9.49)	$ (6.66)
Subtotal Net Medical PMPM		**$ 489.56**	**$ 2,375.38**	**$ 1,068.91**	**$ 939.48**	**$ 659.75**
Projected Administrative Load [4]		$ 49.72	$ 236.99	$ 109.67	$ 92.94	$ 86.30
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 8.21	$ 39.78	$ 17.95	$ 15.72	$ 11.36
Premium Before Taxes		$ 547.49	$ 2,652.15	$ 1,196.53	$ 1,048.14	$ 757.41
Assessments: Adult Immunization		***$ 0.06***	***$ -***	***$ -***	***$ 0.56***	***$ 0.22***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 11.17	$ 54.13	$ 24.42	$ 21.40	$ 15.46
Projected PMPM For Non-Profit Plans		**$ 558.72**	**$ 2,706.28**	**$ 1,220.95**	**$ 1,070.10**	**$ 773.09**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 11.53*	*$ 55.84*	*$ 25.19*	*$ 22.07*	*$ 15.95*
ACA Issuer Fee - est. per Plan submission for 2015 [5]	*3.0%*	$ 17.29	$ 83.75	$ 37.79	$ 33.12	$ 23.93
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 576.37***	***$ 2,791.74***	***$ 1,259.51***	***$ 1,103.89***	***$ 797.51***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[4] Projected administrative load is based on the MCO financial reporting of Operating Expenses for CSHCN and Substitute Care, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services" - per State budget initiative. Substitute Care admin reflects an adjustment to the BH Services sub-capitation admin, to bring it to parity with the BH Services admin in non-Substitute Care CSHCN

[5] Projected PMPM with ACA Issuer Fee applicable to For-Profit plans only. Issuer Fee estimate as provided by UHC for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

CSHCN and Substitute Care
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018

Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [5]	Non-Profit Plans		For-Profit Plans		
					State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans [3]	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee For-Profit Plans [4]	Capitation Rates: For-Profit Plans
Adoption Subsidy	$ 489.56	$ 49.72	$ 8.21	$ 0.06	$ 11.17	**$ 558.72**	$ 11.53	$ 17.29	**$ 576.37**
Katie Beckett	$ 2,375.38	$ 236.99	$ 39.78	$ -	$ 54.13	**$ 2,706.28**	$ 55.84	$ 83.75	**$ 2,791.74**
SSI < 15	$ 1,068.91	$ 109.67	$ 17.95	$ -	$ 24.42	**$ 1,220.95**	$ 25.19	$ 37.79	**$ 1,259.51**
SSI >= 15	$ 939.48	$ 92.94	$ 15.72	$ 0.56	$ 21.40	**$ 1,070.10**	$ 22.07	$ 33.12	**$ 1,103.89**
Substitute Care [3]	$ 659.75	$ 86.30	$ 11.36	$ 0.22	$ 15.46	**$ 773.09**	$ 15.95	$ 23.93	**$ 797.51**

[1] Risk Margin set at 1.5% of premium before taxes

[2] State Premium Tax is set at 2% of Premiums

[3] Substitute Care is only available under NHPRI, a Non-Profit Plan

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the Rhode Island State capitation rates for the 12-month period July 1, 2017 through June 30, 2018 for Children with Special Health Care Needs (CHSCN) and Children in Substitute Care Arrangements (Substitute Care) who are eligible for enrollment into the State's RIte Care program, a Medicaid managed care program implemented under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration. The 12-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following eligibility categories: Substitute Care, Adoption Subsidy, Katie Beckett, SSI under age 15, and SSI age 15 and older.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Thomas M. Donlon, FSA, MAAA
Principal
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June 30, 2016
Date

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June 28, 2016

Rhody Health Partners Data Book

State of Rhode Island

Rates for the period 2/1/2017 through 6/30/2017

Final & Confidential

Prepared by:
HealthCare Analytics
PO Box 41408
Providence, RI 02940-1408

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1

INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 2/1/2017 through 6/30/2017 for Rhody Health Partners (RHP), a Medicaid managed care program authorized under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration.

Rhody Health Partners provides certain segments of the Aged, Blind and Disabled Adult population with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE). The health plans are paid capitation rates based on rate cells that are based on the population cohorts' health care needs. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the Rhody Health Partners per member per month (PMPM) capitation rates effective February 1, 2017 through June 30, 2017, for the purpose of attaining rate approval from CMS under 42 CFR 438.6(c). This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using selected trends developed from the claims experience, adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the Rhody Health Partners claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected Rhody Health Partners rates presented in this data book:

- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for Rhody Health Partners were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

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CAPITATION RATES & DEMOGRAPHICS

The capitation rates, including assessments, taxes and fees for the rate period 2/1/2017 – 6/30/2017 are as follows:

Table 1
Capitation Rates

Rhody Health Partners
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017

RHP Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee: For-Profit Plans [4]	Capitation Rates: For-Profit Plans
ID	$ 983.78	$ 77.96	$ 16.17	$ 1.66	$ 22.03	**$ 1,101.60**	$ 22.73	$ 34.09	**$ 1,136.39**
SPMI	$ 2,036.41	$ 181.22	$ 33.77	$ 1.66	$ 45.98	**$ 2,299.04**	$ 47.43	$ 71.15	**$ 2,371.64**
Other Disabled 21-44	$ 804.88	$ 70.32	$ 13.33	$ 1.66	$ 18.17	**$ 908.36**	$ 18.74	$ 28.11	**$ 937.04**
Other Disabled 45+	$ 1,151.80	$ 101.99	$ 19.09	$ 1.66	$ 26.01	**$ 1,300.55**	$ 26.83	$ 40.25	**$ 1,341.62**

[1] Risk margin set at 1.5% of premium before taxes
[2] State Premium Tax is set at 2% of Premiums
[3] Includes Adult Immunization
[4] ACA Issuer Tax, per estimate by UHC for 2015, is applicable to For-Profit health plans only

3

RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data reports, which were based on encounter data, covered the following State Fiscal Years (SFY)

- 7/1/2012 through 6/30/2013 (SFY 2013), paid through 11/30/2015, estimated at 100%
- 7/1/2013 through 6/30/2014 (SFY 2014), paid through 11/30/2015, estimated at 100%
- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

The claims data was delineated by rate cell and by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail which allowed us to examine historical patterns for unit cost and utilization levels.

All claims data including SFY 2013, SFY 2014, and SFY 2015 were presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2013, SFY 2014 and SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Exhibit 1 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2013, SFY 2014, and SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '13, SFY '14, and SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services

BASE PERIOD

The base period PMPMs are credibility weighted averages from the 2 most recent periods, SFY 2014 (projected to SFY 2015) and SFY 2015. SFY 2014 was trended to SFY 2015 using the 2-year average trends for medical and pharmacy, where the variability in the indicated pharmacy trends between the rate cells were smoothed via a blending of the indicated trend for ID and SPMI rate cells with that of the combined Other Disabled rate cells. This methodology is intended to smooth out the year-over-year variability in the experience so that they are not magnified in the projected benefit costs. Credibility weights of 30% and 70% were applied for SFY 2014 and SFY 2015 PMPMs respectively, for both the medical and pharmacy expenses, to give more weight to the more recent experience (see Table 2 below and Exhibit 2 in the appendix).

Table 2
Base Period PMPMs:

Rhody Health Partners															
For Rate Period 2/1/2017 - 6/30/2017															
Encounter Claims Experience PMPM & Trends															
Incurred State Fiscal Year (SFY), Paid through November 2015, estimated 100%															
SFY '15 Average. Members		847			2,227			3,910			6,845			10,755	
		ID			SPMI			Other Disabled 21-44			Other Disabled 45+			Total Other Disabled	
Incurred Periods		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy
7/1/12 - 6/30/13 (SFY '13)		$ 656.65	$ 246.63		$ 1,630.34	$ 395.02		$ 600.82	$ 157.62		$ 850.79	$ 274.02		$ 758.71	$ 231.14
7/1/13 - 6/30/14 (SFY '14)		$ 664.90	$ 277.33		$ 1,638.51	$ 427.08		$ 666.58	$ 167.67		$ 882.82	$ 292.90		$ 804.79	$ 247.71
7/1/14 - 6/30/15 (SFY '15)		$ 653.91	$ 297.31		$ 1,582.00	$ 420.13		$ 612.64	$ 159.43		$ 814.56	$ 300.37		$ 741.16	$ 249.14
SFY '14 over SFY '13		1.3%	12.4%		0.5%	8.1%		10.9%	6.4%		3.8%	6.9%		6.1%	7.2%
SFY '15 over SFY '14		-1.7%	7.2%		-3.4%	-1.6%		-8.1%	-4.9%		-7.7%	2.6%		-7.9%	0.6%
SFY '15 over SFY '13		**-0.2%**	9.8%		**-1.5%**	3.1%		**1.0%**	0.6%		**-2.2%**	4.7%		-1.2%	**3.8%**
Selected Rx Trend [1,2]	*25%*		**5.3%**	*75%*		**3.3%**			**3.8%**			**3.8%**			
SFY '14 --> SFY '15	*30%*	$ 663.51	$ 292.07	*30%*	$ 1,614.04	$ 441.19	*30%*	$ 673.10	$ 174.08	*30%*	$ 863.82	$ 304.10			
Selected Base Period [3]		**$ 656.79**	**$ 295.73**		**$ 1,591.61**	**$ 426.45**		**$ 630.78**	**$ 163.83**		**$ 829.34**	**$ 301.49**			

TRENDS AND TREND DEVELOPMENT

Medical (non-pharmacy) unit cost and utilization trend rates were calculated from the claims data including the G/L adjustments, by service category, for each cohort /rate cell. The two "Other Disabled" rate cells (21-44 and 45+) were combined to calculate aggregate trends, to be applied to each of the "Other Disabled" rate cells. To smooth out the wide variability in the cohort-specific indicated trends, we set a ceiling of 12% and a floor of 0% to the 2-year average cost and utilization trends of SFY 2015 over SFY 2013 (see Table 3 below). The assumption for the floor and ceiling is that any indicated negative trends would likely not be sustainable in future years, and any trends higher than 12% present additional care management opportunities for the MCOs. Pharmacy trends exhibited a wide variability in the year-over-year and multiyear trends within and between the rate cells. To smooth out the variability in the pharmacy trends between the rate cells, the combined "Other Disabled" rate cells' aggregate 2-year average pharmacy trend of SFY 2015 over SFY 2013 was blended with each of the cohort's own 2-year average trend. For ID, this blend was 25%/75%, giving lower credibility to ID because of its relatively low membership; for SPMI, this blend was 75%/25%, giving higher credibility to the SPMI trend. For Other Disabled 21-44 and Other Disabled 45+, their aggregate trend was selected for each "Other Disabled" rate cell.

Table 3
Selected Trends:

Rhody Health Partners
For Rate Period 2/1/2017 - 6/30/2017
Incurred SFY, PT 11/15 est. 100%
Medical Trend Selection

Util/1000 (Util)	ID			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	9.2%	-12.9%	-2.5%	6.1%	-5.4%	0.2%	10.3%	-8.3%	0.6%
Outpatient Total	7.5%	-3.1%	2.1%	2.7%	-4.0%	-0.7%	3.5%	-3.1%	0.1%
Professional Total	-5.3%	-2.0%	-3.7%	-3.5%	1.9%	-0.8%	0.0%	0.2%	0.1%
Inst. (NH)	43.7%	30.6%	37.0%	40.5%	9.9%	24.3%	10.0%	16.5%	13.2%

Cost/Clm-Admt (price)	MRDD/DD			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	-15.9%	0.1%	-8.2%	-3.4%	-1.6%	-2.5%	-0.3%	-1.9%	-1.1%
Outpatient Total	-7.5%	-5.2%	-6.4%	7.7%	3.5%	5.6%	-2.8%	-8.5%	-5.7%
Professional Total	13.8%	9.7%	11.8%	-0.8%	-4.2%	-2.5%	8.1%	-3.0%	2.4%
Inst. (NH)	16.8%	-25.0%	-6.4%	-5.5%	-3.9%	-4.7%	-6.9%	-2.7%	-4.8%

Composite	MRDD/DD			Clm Dist	SPMI			Clm Dist	Other Disabled Total			Clm Dist
	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15
Inpatient Total	-8.2%	-12.8%	-10.5%	27.4%	2.5%	-6.9%	-2.3%	31.4%	10.0%	-10.1%	-0.5%	34.6%
Outpatient Total	-0.6%	-8.2%	-4.4%	16.5%	10.6%	-0.6%	4.9%	17.6%	0.6%	-11.3%	-5.5%	31.3%
Professional Total	7.7%	7.5%	7.6%	54.9%	-4.2%	-2.4%	-3.3%	49.9%	8.1%	-2.8%	2.5%	32.3%
Inst. (NH)	67.8%	-2.0%	28.2%	1.2%	32.8%	5.6%	18.5%	1.0%	2.3%	13.4%	7.7%	1.8%
Medical Total			0.9%	100.0%			-1.3%	100.0%			-1.0%	100.0%

Trend Ceiling [1]:	**12.0%**
Trend Floor [1]:	**0.0%**

Adjusted Trends [1]	MRDD/DD			SPMI			Other Disabled Total		
	price	Util	comp[1]	price	Util	comp	price	Util	comp
Inpatient	2.6%	-2.5%	0.0%	-0.2%	0.2%	0.0%	-0.6%	0.6%	0.0%
Outpatient	-2.0%	2.1%	0.0%	5.6%	-0.7%	4.9%	-0.1%	0.1%	0.0%
Professional	11.8%	-3.7%	7.6%	0.8%	-0.8%	0.0%	2.4%	0.1%	2.5%
Inst. (NH)	-18.2%	37.0%	12.0%	-9.9%	24.3%	12.0%	-4.8%	13.2%	7.7%
Total			**4.3%**			**1.0%**			**0.9%**

Adjustments to Trends

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was estimated on the selected trends, based on the specific language as it applied to Inpatient, Outpatient and Institutional unit cost trends. See the excerpt below for the specific applicable language, and Table 4 below for the impact of Article 5 on the selected trends.

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Article 5 – The selected trends were adjusted for the impact of **Article 5**, shown in greater detail in exhibits 4a, 4b and 4c in the appendix, to derive the final set of trends used to develop the projected benefit costs – see Table 4 below.

Table 4
Impact of Article 5

Rhody Health Partners
For Rate Period 2/1/2017 - 6/30/2017
Impact of Article 5 on Selected Trends

	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Selected Trends Based on Experience	4.3%	1.0%	0.9%	0.9%
Impact of Article 5 on Composite Trends:				
SFY '16 Trends with Article 5 [1] Implementation	2.9%	-1.1%	-0.4%	-0.4%
7/1/2016 - 1/31/2017 Trends with Article 5 [1] Implementation	5.2%	1.2%	2.6%	2.6%
2/1/2017 - 6/30/2017 Trends with Article 5 [1] Implementation	5.2%	1.1%	2.6%	2.6%
Average annual trend [2] with Impact of Article 5[1] Implementation	**4.5%**	**0.2%**	**1.3%**	**1.3%**

Trend Smoothing – The resulting trends were further normalized to reduce year-to-year projection volatility, by compositing the results of all the rate cells as a single trend rate to be applied to all rate cells – see Table 5 below.

Table 5
Trend Smoothing

Rhody Health Partners					
For Rate Period 2/1/2017 - 6/30/2017					
Medical Trend Selection & Smoothing					
Including Impact of Article 5 on Selected Trends					
	ID	**SPMI**	**Other Disabled 21-44**	**Other Disabled 45+**	**Total RHP**
Rate Period Forecast Average Enrollment	926	2,654	3,864	7,230	14,674
Selected Base Medical (Non-Rx) PMPM	$ 656.79	$ 1,591.61	$ 630.78	$ 829.34	
Rate Cell Cohort Weight (to Composite)	4.6%	31.8%	18.4%	45.2%	100.0%
Average annual trend with Impact of Article 5[1] Implementation	**4.5%**	**0.2%**	**1.3%**	**1.3%**	
Composite Trend					**1.08%**
Selected (Smoothed) Trend For Rating	**1.08%**	**1.08%**	**1.08%**	**1.08%**	

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans are required to identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to the rate period at **1.6%** annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. Since the health service re-class is reported on an aggregate basis, we allocated the re-class amounts based on each rate cell's claims volume to the aggregate. The composite reported re-class for the base period was **$8.61** PMPM trended to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. EOHHS staff evaluated the RHP experience for SFY 2014 and identified 3 average eligible with such diagnoses, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 1 potential surgeries. The cost of surgery, at $52,650 per procedure in 2015, was estimated by EOHHS staff. The cost of surgery was projected to the rate period using the Other Disabled composite inpatient trend as impacted by Article 5.

Table 7
Gender Dysphoria

Rhody Health Partners	
For Rate Period 2/1/2017 - 6/30/2017	
Gender Dysphoria	
	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]	$ 53,264
Number of persons estimated seeking surgical benefits [2]	1
Estimated total expenditures for Gender Dysphoria surgical treatment	$ 53,264
Rate Period projected average enrollment	14,674
Estimated impact to total Rhody Health Partners PMPM	$ 0.30

	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Estimated Expenses PMPM for Gender Dysphoria coverage	$ 0.30	$ 0.30	$ 0.30	$ 0.30

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan (Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice,*

collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. The adjustment for this rate period is estimated by the State at **$(0.60)** PMPM. As applicable, the PMPMs are adjusted based on proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives.

Table 8
Care Transformation Collaborative - CTC

Rhody Health Partners				
For Rate Period 2/1/2017 - 6/30/2017				
Care Transformation Collaborative				
	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Rate Period Forecast Average Enrollment	926	2,654	3,864	7,230
CTC Program Expenses PMPM [1]	**$ (0.60)**	**$ (0.60)**	**$ (0.60)**	**$ (0.60)**

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 9 for the impact of this initiative.

Adult Day, referred to as Initiative 8B – Adult Day Health:

Beginning 1/1/2016, the State instituted Medicaid provider certification standards, established minimum levels of care requirements; instituted acuity-based payments which incorporate minimum functional requirements, and instituted

program oversight and monitoring for Adult Day Health, in order to provide a "variety of health, social, and related support services to individuals in a protective setting". The State anticipates that the Adult Day Health program will affect adults with disabilities, and such intervention and support services will result in reduced total care costs for the beneficiaries Please refer to the contract for additional details on this program initiative

The savings estimate for this initiative was based on a savings target estimate set by the State for rate period as part of its Reinventing Medicaid Initiatives, and was allocated to the Rhody Health Partners and Rhody Health Options product lines based on the State's assessment of the target clients and the anticipated savings from this initiative.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative. See Table 9 for the impact of this initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. See Table 9 for the impact of this initiative.

Table 9
Program Initiatives Savings

Rhody Health Partners				
For Rate Period 2/1/2017 - 6/30/2017				
Reinventing Medicaid Program Initiatives				
	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Program Initiative Savings [1]				
BH Services	$ (1.71)	$ (14.54)	$ (1.84)	$ (1.85)
Adult Day	$ (1.38)	$ (2.66)	$ (1.23)	$ (1.67)
ACO	$ (16.15)	$ (31.20)	$ (14.50)	$ (19.60)

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. We reviewed the CPI factors for various categories and selected the "Medical Care Services" and "Health Insurance" categories to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The resulting administrative load is on average **8.8%** of claims.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to $1.66 PMPM for adults aged 19 and over.

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Since Rhody Health Partners serves adult beneficiaries, **$1.66** PMPM will be assessed in each rate cell.

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.
b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**
b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)".*

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCOs satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. Performance Goal Program

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $3.00 PMPM

2. Provider Incentive Program

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO.
These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM

The total maximum pay-out amount for all incentive programs is expected to be no more than **$5.90** PMPM. When measured relative to the proposed capitation rates – estimated composite rates of **$1,365.29** for non-profit plans and **$1,408.40** for for-profit plans, the incentive payments plus the capitation rates are within the 105% threshold for certified rates.

RATE DEVELOPMENT

Table 10
Rhody Health Partners Rate Development

Rhody Health Partners					
For Rate Period 2/1/2017 - 6/30/2017					
Including Reinventing Medicaid Program Initiatives					
Rate Period Average Enrollment Forecast		**926**	**2,654**	**3,864**	**7,230**
		ID	**SPMI**	**Other Disabled 21-44**	**Other Disabled 45+**
Base Medical (Non-Rx) PMPM		$ 656.79	$ 1,591.61	$ 630.78	$ 829.34
Article 5-Adjusted Selected Trend [1]		1.08%	1.08%	1.08%	1.08%
Projection Period (years)		2.29	2.29	2.29	2.29
Projected Medical PMPM		**$ 673.15**	**$ 1,631.25**	**$ 646.49**	**$ 849.99**
Base Rx PMPM		$ 295.73	$ 426.45	$ 163.83	$ 301.49
Selected Trend		5.3%	3.3%	3.8%	3.8%
Projection Period (years)		2.29	2.29	2.29	2.29
Projected Rx PMPM		**$ 332.86**	**$ 459.36**	**$ 178.44**	**$ 328.37**
Projected Total Medical & Rx PMPM		**$ 1,006.01**	**$ 2,090.61**	**$ 824.93**	**$ 1,178.36**
Adjustments To Total PMPM:					
Health Service Reclass [2]		$ 7.25	$ 15.07	$ 5.95	$ 8.49
Gender Dysphoria [3]		$ 0.30	$ 0.30	$ 0.30	$ 0.30
Care Transformation Collaborative (CTC) [6]		$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)
Program Initiative Savings:					
BH Services		$ (1.71)	$ (14.54)	$ (1.84)	$ (1.85)
Adult Day		$ (1.38)	$ (2.66)	$ (1.23)	$ (1.67)
ACO		$ (16.15)	$ (31.20)	$ (14.50)	$ (19.60)
Subtotal Adjustments		$ (12.29)	$ (33.63)	$ (11.92)	$ (14.93)
Fraud & Abuse (% of Medical)	1.0%	$ (9.94)	$ (20.57)	$ (8.13)	$ (11.63)
Subtotal Net Medical PMPM		**$ 983.78**	**$ 2,036.41**	**$ 804.88**	**$ 1,151.80**
Projected Administrative Load [4]		$ 77.96	$ 181.22	$ 70.32	$ 101.99
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 16.17	$ 33.77	$ 13.33	$ 19.09
Premium Before Taxes		$ 1,077.91	$ 2,251.40	$ 888.53	$ 1,272.88
Assessments: Adult Immunization		***$ 1.66***	***$ 1.66***	***$ 1.66***	***$ 1.66***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 22.03	$ 45.98	$ 18.17	$ 26.01
Projected PMPM For Non-Profit Plans		**$ 1,101.60**	**$ 2,299.04**	**$ 908.36**	**$ 1,300.55**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 22.73*	*$ 47.43*	*$ 18.74*	*$ 26.83*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 34.09	$ 71.15	$ 28.11	$ 40.25
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 1,136.39***	***$ 2,371.64***	***$ 937.04***	***$ 1,341.62***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage mandated by State law. Surgical costs estimated by OHHS staff at $52,650 per eligible person

[4] Projected administrative load is based on MCO financial reporting of Operating Expenses, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit health plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Actuarial Certification

Certification of the Rhody Health Partners capitation rates for the rate period 2/1/2017 – 6/30/2017, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

4

APPENDIX

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Average Eligible Members

Program Population	SFY 2013	SFY 2014	SFY 2015
ID	777	804	847
SPMI	1,929	2,082	2,227
Other Disabled 21-44	3,853	3,880	3,910
Other Disabled 45+	6,607	6,873	6,845

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Encounter Claims Experience PMPM & Trends

Incurred State Fiscal Year (SFY), Paid through November 2015, estimated 100%

SFY '15 Average. Members		847			2,227			3,910			6,845			10,755	
		ID			SPMI			Other Disabled 21-44			Other Disabled 45+			Total Other Disabled	
Incurred Periods		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy
7/1/12 - 6/30/13 (SFY '13)		$ 656.65	$ 246.63		$ 1,630.34	$ 395.02		$ 600.82	$ 157.62		$ 850.79	$ 274.02		$ 758.71	$ 231.14
7/1/13 - 6/30/14 (SFY '14)		$ 664.90	$ 277.33		$ 1,638.51	$ 427.08		$ 666.58	$ 167.67		$ 882.82	$ 292.90		$ 804.79	$ 247.71
7/1/14 - 6/30/15 (SFY '15)		$ 653.91	$ 297.31		$ 1,582.00	$ 420.13		$ 612.64	$ 159.43		$ 814.56	$ 300.37		$ 741.16	$ 249.14
SFY '14 over SFY '13		1.3%	12.4%		0.5%	8.1%		10.9%	6.4%		3.8%	6.9%		6.1%	7.2%
SFY '15 over SFY '14		-1.7%	7.2%		-3.4%	-1.6%		-8.1%	-4.9%		-7.7%	2.6%		-7.9%	0.6%
SFY '15 over SFY '13		**-0.2%**	9.8%		**-1.5%**	3.1%		**1.0%**	0.6%		**-2.2%**	4.7%		-1.2%	**3.8%**
Selected Rx Trend [1,2]	*25%*		**5.3%**	*75%*		**3.3%**			**3.8%**			**3.8%**			
SFY '14 --> SFY '15	*30%*	$ 663.51	$ 292.07	*30%*	$ 1,614.04	$ 441.19	*30%*	$ 673.10	$ 174.08	*30%*	$ 863.82	$ 304.10			
Selected Base Period [3]		**$ 656.79**	**$ 295.73**		**$ 1,591.61**	**$ 426.45**		**$ 630.78**	**$ 163.83**		**$ 829.34**	**$ 301.49**			

[1] Selected Rx trends for "Other Disabled 21-44" and "Other Disabled 45+" rate cells are based on the composite trends of the Other Disabled rate cells

[2] Selected Rx trends for ID and SPMI are weighted averages as follows: ID/DD & Composite Other Disabled at 25% / 75%, respectively; SPMI & Composite Other Disabled at 75% / 25%,

[3] The selected Base Period PMPMs are as follows:

Medical: Credibility wtd. average of SFY '14 projected to SFY '15 & actual SFY '15 at 30% & 70% respectively

Pharmacy: Credibility wtd. average of SFY '14 projected to SFY '15 & actual SFY '15 at 30% & 70% respectively

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Incurred SFY, PT 11/15 est. 100%

Medical Trend Selection

Util/1000 (Util)	ID			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	9.2%	-12.9%	-2.5%	6.1%	-5.4%	0.2%	10.3%	-8.3%	0.6%
Outpatient Total	7.5%	-3.1%	2.1%	2.7%	-4.0%	-0.7%	3.5%	-3.1%	0.1%
Professional Total	-5.3%	-2.0%	-3.7%	-3.5%	1.9%	-0.8%	0.0%	0.2%	0.1%
Inst. (NH)	43.7%	30.6%	37.0%	40.5%	9.9%	24.3%	10.0%	16.5%	13.2%

Cost/Clm-Admt (price)	MRDD/DD			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	-15.9%	0.1%	-8.2%	-3.4%	-1.6%	-2.5%	-0.3%	-1.9%	-1.1%
Outpatient Total	-7.5%	-5.2%	-6.4%	7.7%	3.5%	5.6%	-2.8%	-8.5%	-5.7%
Professional Total	13.8%	9.7%	11.8%	-0.8%	-4.2%	-2.5%	8.1%	-3.0%	2.4%
Inst. (NH)	16.8%	-25.0%	-6.4%	-5.5%	-3.9%	-4.7%	-6.9%	-2.7%	-4.8%

Composite	MRDD/DD			Clm Dist	SPMI			Clm Dist	Other Disabled Total			Clm Dist
	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15
Inpatient Total	-8.2%	-12.8%	-10.5%	27.4%	2.5%	-6.9%	-2.3%	31.4%	10.0%	-10.1%	-0.5%	34.6%
Outpatient Total	-0.6%	-8.2%	-4.4%	16.5%	10.6%	-0.6%	4.9%	17.6%	0.6%	-11.3%	-5.5%	31.3%
Professional Total	7.7%	7.5%	7.6%	54.9%	-4.2%	-2.4%	-3.3%	49.9%	8.1%	-2.8%	2.5%	32.3%
Inst. (NH)	67.8%	-2.0%	28.2%	1.2%	32.8%	5.6%	18.5%	1.0%	2.3%	13.4%	7.7%	1.8%
Medical Total			0.9%	100.0%			-1.3%	100.0%			-1.0%	100.0%

Trend Ceiling [1]:	**12.0%**
Trend Floor [1]:	**0.0%**

Adjusted Trends [1]	MRDD/DD			SPMI			Other Disabled Total		
	price	Util	comp[1]	price	Util	comp	price	Util	comp
Inpatient	2.6%	-2.5%	0.0%	-0.2%	0.2%	0.0%	-0.6%	0.6%	0.0%
Outpatient	-2.0%	2.1%	0.0%	5.6%	-0.7%	4.9%	-0.1%	0.1%	0.0%
Professional	11.8%	-3.7%	7.6%	0.8%	-0.8%	0.0%	2.4%	0.1%	2.5%
Inst. (NH)	-18.2%	37.0%	12.0%	-9.9%	24.3%	12.0%	-4.8%	13.2%	7.7%
Total			**4.3%**			**1.0%**			**0.9%**

[1] Variability in short-term indicated trends were smoothed for forecasting purposes by setting a ceiling of 12% and a floor of 0%. The resulting upper limit also indicates care management opportunities for the MCOs

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Impact of Article 5 on Selected Trends

Medical (Non-Rx) Trends

Base Period MidPt
1/1/2015

LOB	ID Selected Trends '15 Clms. Dist.	Price	Util	comp	% In-State Clms. Dist.
Inpatient	27.4%	2.6%	-2.5%	0.0%	99.7%
Outpatient	16.5%	-2.0%	2.1%	0.0%	99.0%
Professional	54.9%	11.8%	-3.7%	7.6%	
Inst. (NH & Hospice)	1.2%	-18.2%	37.0%	12.0%	
Total	100%			**4.3%**	

LOB	SPMI Selected Trends '15 Clms. Dist.	Price	Util	comp	% In-State Clms. Dist.
Inpatient	31.4%	-0.2%	0.2%	0.0%	99.1%
Outpatient	17.6%	5.6%	-0.7%	4.9%	99.0%
Professional	49.9%	0.8%	-0.8%	0.0%	
Inst. (NH & Hospice)	1.0%	-9.9%	24.3%	12.0%	
Total	100%			**1.0%**	

LOB	Other Disabled Selected Trends '15 Clms. Dist.	Price	Util	comp	% In-State Clms. Dist.
Inpatient	34.6%	-0.6%	0.6%	0.0%	96.6%
Outpatient	31.3%	-0.1%	0.1%	0.0%	98.1%
Professional	32.3%	2.4%	0.1%	2.5%	
Inst. (NH & Hospice)	1.8%	-4.8%	13.2%	7.7%	
Total	100%			**0.9%**	

12.00
1/1/2016

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/15 - 6/30/16 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	27.4%	***-2.5%***	-2.5%	-4.9%	-4.9%	25.3%	0.26
Outpatient	16.5%	***-2.5%***	2.1%	-0.5%	-0.5%	15.9%	0.16
Professional	54.9%	11.8%	-3.7%	7.6%	7.6%	57.5%	0.59
Inst. (NH & Hospice)	1.2%	***-18.2%***	37.0%	12.0%	12.0%	1.3%	0.01
Total	100%			**2.9%**	**2.9%**	100.0%	1.03

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/15 - 6/30/16 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	31.4%	***-2.5%***	0.2%	-2.3%	-2.3%	31.0%	0.31
Outpatient	17.6%	***-2.5%***	-0.7%	-3.2%	-3.1%	17.3%	0.17
Professional	49.9%	0.8%	-0.8%	0.0%	0.0%	50.5%	0.50
Inst. (NH & Hospice)	1.0%	***-9.9%***	24.3%	12.0%	12.0%	1.2%	0.01
Total	100%			**-1.2%**	**-1.1%**	100.0%	0.99

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/15 - 6/30/16 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	34.6%	***-2.5%***	0.6%	-1.9%	-1.9%	34.1%	0.34
Outpatient	31.3%	***-2.5%***	0.1%	-2.4%	-2.3%	30.7%	0.31
Professional	32.3%	2.4%	0.1%	2.5%	2.5%	33.3%	0.33
Inst. (NH & Hospice)	1.8%	***-4.8%***	13.2%	7.7%	7.7%	1.9%	0.02
Total	100%			**-0.5%**	**-0.4%**	100.0%	1.00

9.47
10/15/2016

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/16 - 1/31/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	27.4%	***1.9%***	-2.5%	-0.6%	-0.6%	24.1%	0.26
Outpatient	16.5%	***1.9%***	2.1%	4.0%	4.0%	15.8%	0.17
Professional	54.9%	11.8%	-3.7%	7.6%	7.6%	58.4%	0.63
Inst. (NH & Hospice)	1.2%	***3.2%***	37.0%	41.4%	41.4%	1.7%	0.02
Total	100%			**5.2%**	**5.2%**	100.0%	1.07

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/16 - 1/31/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	31.4%	***1.9%***	0.2%	2.1%	2.1%	31.3%	0.31
Outpatient	17.6%	***1.9%***	-0.7%	1.2%	1.2%	17.3%	0.17
Professional	49.9%	0.8%	-0.8%	0.0%	0.0%	50.0%	0.50
Inst. (NH & Hospice)	1.0%	***3.2%***	24.3%	28.3%	28.3%	1.4%	0.01
Total	100%			**1.2%**	**1.2%**	100.0%	1.00

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/16 - 1/31/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	34.6%	***1.9%***	0.6%	2.5%	2.4%	34.0%	0.35
Outpatient	31.3%	***1.9%***	0.1%	2.0%	2.0%	30.6%	0.31
Professional	32.3%	2.4%	0.1%	2.5%	2.5%	33.2%	0.34
Inst. (NH & Hospice)	1.8%	***3.2%***	13.2%	16.9%	16.9%	2.1%	0.02
Total	100%			**2.6%**	**2.6%**	100.0%	1.02

6.00
4/15/2017

LOB	Impact of Article 5 '15 Clms. Dist.	2/1/17 - 6/30/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	27.4%	***1.9%***	-2.5%	-0.6%	-0.6%	23.4%	0.26
Outpatient	16.5%	***1.9%***	2.1%	4.0%	4.0%	15.7%	0.17
Professional	54.9%	11.8%	-3.7%	7.6%	7.6%	59.0%	0.65
Inst. (NH & Hospice)	1.2%	***3.2%***	37.0%	41.4%	41.4%	1.9%	0.02
Total	100%			**5.2%**	**5.2%**	100.0%	1.10

LOB	Impact of Article 5 '15 Clms. Dist.	2/1/17 - 6/30/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	31.4%	***1.9%***	0.2%	2.1%	2.1%	31.4%	0.32
Outpatient	17.6%	***1.9%***	-0.7%	1.2%	1.1%	17.3%	0.17
Professional	49.9%	0.8%	-0.8%	0.0%	0.0%	49.7%	0.50
Inst. (NH & Hospice)	1.0%	***3.2%***	24.3%	28.3%	28.3%	1.6%	0.02
Total	100%			**1.2%**	**1.1%**	100.0%	1.00

LOB	Impact of Article 5 '15 Clms. Dist.	2/1/17 - 6/30/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	34.6%	***1.9%***	0.6%	2.5%	2.4%	34.0%	0.35
Outpatient	31.3%	***1.9%***	0.1%	2.0%	2.0%	30.5%	0.31
Professional	32.3%	2.4%	0.1%	2.5%	2.5%	33.2%	0.34
Inst. (NH & Hospice)	1.8%	***3.2%***	13.2%	16.9%	16.9%	2.3%	0.02
Total	100%			**2.6%**	**2.6%**	100.0%	1.03

Rate Period MidPt
4/15/2017

27.47 OK

LOB	Impact of Article 5 '15 Clms. Dist.	**27.47 -Mo. Avg. Trends** Price	Util	comp	Adjusted Comp. Trend [1]	Change in Clms. dist.	Adjusted Comp. Trend [1]
IP	27.4%	0.0%	-2.5%	-2.5%	-2.5%	25.4%	-2.5%
OP	16.5%	0.0%	2.1%	2.0%	2.0%	16.1%	2.0%
Prof	54.9%	11.8%	-3.7%	7.6%	7.6%	57.0%	7.6%
Inst. (NH & Hospice)	1.2%	-6.8%	37.0%	27.7%	27.7%	1.6%	27.7%
Total	100.0%			**4.2%**	**4.2%**	100.0%	**4.5%**
	27.47 -Mo. Avg. Trends			**4.2%**	**4.2%**		**4.5%**

27.47 OK

LOB	Impact of Article 5 '15 Clms. Dist.	**27.47 -Mo. Avg. Trends** Price	Util	comp	Adjusted Comp. Trend [1]	Change in Clms. dist.	Adjusted Comp. Trend [1]
IP	31.4%	0.0%	0.2%	0.2%	0.2%	31.4%	0.2%
OP	17.6%	0.0%	-0.7%	-0.7%	-0.7%	17.4%	-0.7%
Prof	49.9%	0.8%	-0.8%	0.0%	0.0%	49.8%	0.0%
Inst. (NH & Hospice)	1.0%	-2.7%	24.3%	20.9%	20.9%	1.3%	20.9%
Total	100.0%			**0.1%**	**0.1%**	100.0%	**0.2%**
	27.47 -Mo. Avg. Trends			**0.1%**	**0.2%**		**0.2%**

27.47 OK

LOB	Impact of Article 5 '15 Clms. Dist.	**27.47 -Mo. Avg. Trends** Price	Util	comp	Adjusted Comp. Trend [1]	Change in Clms. dist.	Adjusted Comp. Trend [1]
IP	34.6%	0.0%	0.6%	0.5%	0.5%	34.3%	0.5%
OP	31.3%	0.0%	0.1%	0.1%	0.1%	30.9%	0.1%
Prof	32.3%	2.4%	0.1%	2.5%	2.5%	32.8%	2.5%
Inst. (NH & Hospice)	1.8%	-0.4%	13.2%	12.8%	12.8%	2.0%	12.8%
Total	100.0%			**1.2%**	**1.2%**	100.0%	**1.3%**
	27.47 -Mo. Avg. Trends			**1.2%**	**1.2%**		**1.3%**

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Impact of Article 5 on Selected Trends

	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Selected Trends Based on Experience	4.3%	1.0%	0.9%	0.9%
Impact of Article 5 on Composite Trends:				
SFY '16 Trends with Article 5 [1] Implementation	2.9%	-1.1%	-0.4%	-0.4%
7/1/2016 - 1/31/2017 Trends with Article 5 [1] Implementation	5.2%	1.2%	2.6%	2.6%
2/1/2017 - 6/30/2017 Trends with Article 5 [1] Implementation	5.2%	1.1%	2.6%	2.6%
Average annual trend [2] with Impact of Article 5[1] Implementation	**4.5%**	**0.2%**	**1.3%**	**1.3%**

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Reflects change in TOS claims distribution over time as a result of different trends by TOS (e.g. Inpatient vs. Outpatient, etc.) - see Trend Detail exhibit

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Medical Trend Selection & Smoothing

Including Impact of Article 5 on Selected Trends

	ID	SPMI	Other Disabled 21-44	Other Disabled 45+	Total RHP
Rate Period Forecast Average Enrollment	926	2,654	3,864	7,230	14,674
Selected Base Medical (Non-Rx) PMPM	$ 656.79	$ 1,591.61	$ 630.78	$ 829.34	
Rate Cell Cohort Weight (to Composite)	4.6%	31.8%	18.4%	45.2%	100.0%
Average annual trend with Impact of Article 5[1] Implementation	**4.5%**	**0.2%**	**1.3%**	**1.3%**	
Composite Trend					**1.08%**
Selected (Smoothed) Trend For Rating	**1.08%**	**1.08%**	**1.08%**	**1.08%**	

[1] As referenced in the State's Reinventing Medicaid initiatives

Rhody Health Partners
For Rate Period 2/1/2017 - 6/30/2017
Gender Dysphoria

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]	$ 53,264
Number of persons estimated seeking surgical benefits [2]	1
Estimated total expenditures for Gender Dysphoria surgical treatment	$ 53,264
Rate Period projected average enrollment	14,674
Estimated impact to total Rhody Health Partners PMPM	$ 0.30

	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Estimated Expenses PMPM for Gender Dysphoria coverage	$ 0.30	$ 0.30	$ 0.30	$ 0.30

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person for SFY 2015, and is assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism. Analysis identified 3 average eligibles with such diagnoses; State assumed a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[5] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend for Other Disabled

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Care Transformation Collaborative

	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Rate Period Forecast Average Enrollment	926	2,654	3,864	7,230
CTC Program Expenses PMPM [1]	**$ (0.60)**	**$ (0.60)**	**$ (0.60)**	**$ (0.60)**

[1] CTC PMPM expense adjustment for graduating practice sites, not currently reflected in the base period expenses

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Reinventing Medicaid Program Initiatives

	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Program Initiative Savings [1]				
BH Services	$ (1.71)	$ (14.54)	$ (1.84)	$ (1.85)
Adult Day	$ (1.38)	$ (2.66)	$ (1.23)	$ (1.67)
ACO	$ (16.15)	$ (31.20)	$ (14.50)	$ (19.60)

[1] Please refer to the narrative section of the Data Book for a description of each of the Program Initiatives

Rhody Health Partners

For Rate Period 2/1/2017 - 6/30/2017

Including Reinventing Medicaid Program Initiatives

		ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Rate Period Average Enrollment Forecast		**926**	**2,654**	**3,864**	**7,230**
Base Medical (Non-Rx) PMPM		$ 656.79	$ 1,591.61	$ 630.78	$ 829.34
Article 5-Adjusted Selected Trend [1]		1.08%	1.08%	1.08%	1.08%
Projection Period (years)		2.29	2.29	2.29	2.29
Projected Medical PMPM		**$ 673.15**	**$ 1,631.25**	**$ 646.49**	**$ 849.99**
Base Rx PMPM		$ 295.73	$ 426.45	$ 163.83	$ 301.49
Selected Trend		5.3%	3.3%	3.8%	3.8%
Projection Period (years)		2.29	2.29	2.29	2.29
Projected Rx PMPM		**$ 332.86**	**$ 459.36**	**$ 178.44**	**$ 328.37**
Projected Total Medical & Rx PMPM		**$ 1,006.01**	**$ 2,090.61**	**$ 824.93**	**$ 1,178.36**
Adjustments To Total PMPM:					
Health Service Reclass [2]		$ 7.25	$ 15.07	$ 5.95	$ 8.49
Gender Dysphoria [3]		$ 0.30	$ 0.30	$ 0.30	$ 0.30
Care Transformation Collaborative (CTC) [6]		$ (0.60)	$ (0.60)	$ (0.60)	$ (0.60)
Program Initiative Savings:					
BH Services		$ (1.71)	$ (14.54)	$ (1.84)	$ (1.85)
Adult Day		$ (1.38)	$ (2.66)	$ (1.23)	$ (1.67)
ACO		$ (16.15)	$ (31.20)	$ (14.50)	$ (19.60)
Subtotal Adjustments		$ (12.29)	$ (33.63)	$ (11.92)	$ (14.93)
Fraud & Abuse (% of Medical)	1.0%	$ (9.94)	$ (20.57)	$ (8.13)	$ (11.63)
Subtotal Net Medical PMPM		**$ 983.78**	**$ 2,036.41**	**$ 804.88**	**$ 1,151.80**
Projected Administrative Load [4]		$ 77.96	$ 181.22	$ 70.32	$ 101.99
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 16.17	$ 33.77	$ 13.33	$ 19.09
Premium Before Taxes		$ 1,077.91	$ 2,251.40	$ 888.53	$ 1,272.88
Assessments: Adult Immunization		***$ 1.66***	***$ 1.66***	***$ 1.66***	***$ 1.66***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 22.03	$ 45.98	$ 18.17	$ 26.01
Projected PMPM For Non-Profit Plans		**$ 1,101.60**	**$ 2,299.04**	**$ 908.36**	**$ 1,300.55**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 22.73*	*$ 47.43*	*$ 18.74*	*$ 26.83*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 34.09	$ 71.15	$ 28.11	$ 40.25
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 1,136.39***	***$ 2,371.64***	***$ 937.04***	***$ 1,341.62***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage mandated by State law. Surgical costs estimated by OHHS staff at $52,650 per eligible person

[4] Projected administrative load is based on MCO financial reporting of Operating Expenses, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit health plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Rhody Health Partners

Proposed Capitation Rates

Rate Period 2/1/2017 - 6/30/2017

RHP Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee: For-Profit Plans [4]	Capitation Rates: For-Profit Plans
ID	$ 983.78	$ 77.96	$ 16.17	$ 1.66	$ 22.03	**$ 1,101.60**	$ 22.73	$ 34.09	**$ 1,136.39**
SPMI	$ 2,036.41	$ 181.22	$ 33.77	$ 1.66	$ 45.98	**$ 2,299.04**	$ 47.43	$ 71.15	**$ 2,371.64**
Other Disabled 21-44	$ 804.88	$ 70.32	$ 13.33	$ 1.66	$ 18.17	**$ 908.36**	$ 18.74	$ 28.11	**$ 937.04**
Other Disabled 45+	$ 1,151.80	$ 101.99	$ 19.09	$ 1.66	$ 26.01	**$ 1,300.55**	$ 26.83	$ 40.25	**$ 1,341.62**

[1] Risk margin set at 1.5% of premium before taxes

[2] State Premium Tax is set at 2% of Premiums

[3] Includes Adult Immunization

[4] ACA Issuer Tax, per estimate by UHC for 2015, is applicable to For-Profit health plans only

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the State capitation rates for specific segments of the SSI population under Rhode Island's Medicaid program called Rhody Health Partners (RHP) for the 5-month period February 1, 2017 through June 30, 2017. The 5-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following eligibility categories: MR Waiver, SPMI, Other Disabled ages 21 to 44, and Other Disabled ages 45 and older.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Thomas M. Donlon

Thomas M. Donlon, FSA, MAAA
Principal
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June 30, 2016
Date

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June 28, 2016

Rhody Health Partners Data Book

State of Rhode Island

Rates for the period 7/1/2017 through 6/30/2018

Final & Confidential

Prepared by:
HealthCare Analytics
PO Box 41408
Providence, RI 02940-1408

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1

INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 7/1/2017 through 6/30/2018 for Rhody Health Partners (RHP), a Medicaid managed care program authorized under the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration.

Rhody Health Partners provides certain segments of the Aged, Blind and Disabled Adult population with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE). The health plans are paid capitation rates based on rate cells that are based on the population cohorts' health care needs. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the Rhody Health Partners per member per month (PMPM) capitation rates effective July 1, 2017 through June 30, 2018, for the purpose of attaining rate approval from CMS under 42 CFR 438.6(c). This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using selected trends developed from the claims experience, adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the Rhody Health Partners claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected Rhody Health Partners rates presented in this data book:

- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for Rhody Health Partners were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

2

CAPITATION RATES & DEMOGRAPHICS

The capitation rates, including assessments, taxes and fees for the rate period 7/1/2017 – 6/30/2018 are as follows:

Table 1
Capitation Rates

Rhody Health Partners
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018

RHP Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee: For-Profit Plans [4]	Capitation Rates: For-Profit Plans
ID	$ 1,007.65	$ 78.79	$ 16.54	$ 1.66	$ 22.54	**$ 1,127.18**	$ 23.26	$ 34.88	**$ 1,162.78**
SPMI	$ 2,074.91	$ 183.14	$ 34.39	$ 1.66	$ 46.82	**$ 2,340.92**	$ 48.29	$ 72.45	**$ 2,414.84**
Other Disabled 21-44	$ 820.66	$ 71.06	$ 13.58	$ 1.66	$ 18.51	**$ 925.47**	$ 19.09	$ 28.64	**$ 954.69**
Other Disabled 45+	$ 1,175.07	$ 103.07	$ 19.46	$ 1.66	$ 26.52	**$ 1,325.78**	$ 27.35	$ 41.03	**$ 1,367.64**

[1] Risk margin set at 1.5% of premium before taxes
[2] State Premium Tax is set at 2% of Premiums
[3] Includes Adult Immunization
[4] ACA Issuer Tax, per estimate by UHC for 2015, is applicable to For-Profit health plans only

3

RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data reports, which were based on encounter data, covered the following State Fiscal Years (SFY)

- 7/1/2012 through 6/30/2013 (SFY 2013), paid through 11/30/2015, estimated at 100%
- 7/1/2013 through 6/30/2014 (SFY 2014), paid through 11/30/2015, estimated at 100%
- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

The claims data was delineated by rate cell and by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail which allowed us to examine historical patterns for unit cost and utilization levels.

All claims data including SFY 2013, SFY 2014, and SFY 2015 were presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2013, SFY 2014 and SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Exhibit 1 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2013, SFY 2014, and SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '13, SFY '14, and SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services

BASE PERIOD

The base period PMPMs are credibility weighted averages from the 2 most recent periods, SFY 2014 (projected to SFY 2015) and SFY 2015. SFY 2014 was trended to SFY 2015 using the 2-year average trends for medical and pharmacy, where the variability in the indicated pharmacy trends between the rate cells were smoothed via a blending of the indicated trend for ID and SPMI rate cells with that of the combined Other Disabled rate cells. This methodology is intended to smooth out the year-over-year variability in the experience so that they are not magnified in the projected benefit costs. Credibility weights of 30% and 70% were applied for SFY 2014 and SFY 2015 PMPMs respectively, for both the medical and pharmacy expenses, to give more weight to the more recent experience (see Table 2 below and Exhibit 2 in the appendix).

Table 2
Base Period PMPMs:

Rhody Health Partners															
For Rate Period 7/1/2017 - 6/30/2018															
Encounter Claims Experience PMPM & Trends															
Incurred State Fiscal Year (SFY), Paid through November 2015, estimated 100%															
SFY '15 Average. Members		847			2,227			3,910			6,845			10,755	
		ID			SPMI			Other Disabled 21-44			Other Disabled 45+			Total Other Disabled	
Incurred Periods		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy
7/1/12 - 6/30/13 (SFY '13)		$ 656.65	$ 246.63		$ 1,630.34	$ 395.02		$ 600.82	$ 157.62		$ 850.79	$ 274.02		$ 758.71	$ 231.14
7/1/13 - 6/30/14 (SFY '14)		$ 664.90	$ 277.33		$ 1,638.51	$ 427.08		$ 666.58	$ 167.67		$ 882.82	$ 292.90		$ 804.79	$ 247.71
7/1/14 - 6/30/15 (SFY '15)		$ 653.91	$ 297.31		$ 1,582.00	$ 420.13		$ 612.64	$ 159.43		$ 814.56	$ 300.37		$ 741.16	$ 249.14
SFY '14 over SFY '13		1.3%	12.4%		0.5%	8.1%		10.9%	6.4%		3.8%	6.9%		6.1%	7.2%
SFY '15 over SFY '14		-1.7%	7.2%		-3.4%	-1.6%		-8.1%	-4.9%		-7.7%	2.6%		-7.9%	0.6%
SFY '15 over SFY '13		**-0.2%**	9.8%		**-1.5%**	3.1%		**1.0%**	0.6%		**-2.2%**	4.7%		-1.2%	**3.8%**
Selected Rx Trend [1,2]	*25%*		**5.3%**	*75%*		**3.3%**			**3.8%**			**3.8%**			
SFY '14 --> SFY '15	*30%*	$ 663.51	$ 292.07	*30%*	$ 1,614.04	$ 441.19	*30%*	$ 673.10	$ 174.08	*30%*	$ 863.82	$ 304.10			
Selected Base Period [3]		**$ 656.79**	**$ 295.73**		**$ 1,591.61**	**$ 426.45**		**$ 630.78**	**$ 163.83**		**$ 829.34**	**$ 301.49**			

TRENDS AND TREND DEVELOPMENT

Medical (non-pharmacy) unit cost and utilization trend rates were calculated from the claims data including the G/L adjustments, by service category, for each cohort /rate cell. The two "Other Disabled" rate cells (21-44 and 45+) were combined to calculate aggregate trends, to be applied to each of the "Other Disabled" rate cells. To smooth out the wide variability in the cohort-specific indicated trends, we set a ceiling of 12% and a floor of 0% to the 2-year average cost and utilization trends of SFY 2015 over SFY 2013 (see Table 3 below). The assumption for the floor and ceiling is that any indicated negative trends would likely not be sustainable in future years, and any trends higher than 12% present additional care management opportunities for the MCOs. Pharmacy trends exhibited a wide variability in the year-over-year and multiyear trends within and between the rate cells. To smooth out the variability in the pharmacy trends between the rate cells, the combined "Other Disabled" rate cells' aggregate 2-year average pharmacy trend of SFY 2015 over SFY 2013 was blended with each of the cohort's own 2-year average trend. For ID, this blend was 25%/75%, giving lower credibility to ID because of its relatively low membership; for SPMI, this blend was 75%/25%, giving higher credibility to the SPMI trend. For Other Disabled 21-44 and Other Disabled 45+, their aggregate trend was selected for each "Other Disabled" rate cell.

Table 3
Selected Trends:

Rhody Health Partners
For Rate Period 7/1/2017 - 6/30/2018
Incurred SFY, PT 11/15 est. 100%
Medical Trend Selection

Util/1000 (Util)	ID			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	9.2%	-12.9%	-2.5%	6.1%	-5.4%	0.2%	10.3%	-8.3%	0.6%
Outpatient Total	7.5%	-3.1%	2.1%	2.7%	-4.0%	-0.7%	3.5%	-3.1%	0.1%
Professional Total	-5.3%	-2.0%	-3.7%	-3.5%	1.9%	-0.8%	0.0%	0.2%	0.1%
Inst. (NH)	43.7%	30.6%	37.0%	40.5%	9.9%	24.3%	10.0%	16.5%	13.2%

Cost/Clm-Admt (price)	MRDD/DD			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	-15.9%	0.1%	-8.2%	-3.4%	-1.6%	-2.5%	-0.3%	-1.9%	-1.1%
Outpatient Total	-7.5%	-5.2%	-6.4%	7.7%	3.5%	5.6%	-2.8%	-8.5%	-5.7%
Professional Total	13.8%	9.7%	11.8%	-0.8%	-4.2%	-2.5%	8.1%	-3.0%	2.4%
Inst. (NH)	16.8%	-25.0%	-6.4%	-5.5%	-3.9%	-4.7%	-6.9%	-2.7%	-4.8%

Composite	MRDD/DD			Clm Dist	SPMI			Clm Dist	Other Disabled Total			Clm Dist
	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15
Inpatient Total	-8.2%	-12.8%	-10.5%	27.4%	2.5%	-6.9%	-2.3%	31.4%	10.0%	-10.1%	-0.5%	34.6%
Outpatient Total	-0.6%	-8.2%	-4.4%	16.5%	10.6%	-0.6%	4.9%	17.6%	0.6%	-11.3%	-5.5%	31.3%
Professional Total	7.7%	7.5%	7.6%	54.9%	-4.2%	-2.4%	-3.3%	49.9%	8.1%	-2.8%	2.5%	32.3%
Inst. (NH)	67.8%	-2.0%	28.2%	1.2%	32.8%	5.6%	18.5%	1.0%	2.3%	13.4%	7.7%	1.8%
Medical Total			0.9%	100.0%			-1.3%	100.0%			-1.0%	100.0%

Trend Ceiling [1]:	**12.0%**
Trend Floor [1]:	**0.0%**

Adjusted Trends [1]	MRDD/DD			SPMI			Other Disabled Total		
	price	Util	comp[1]	price	Util	comp	price	Util	comp
Inpatient	2.6%	-2.5%	0.0%	-0.2%	0.2%	0.0%	-0.6%	0.6%	0.0%
Outpatient	-2.0%	2.1%	0.0%	5.6%	-0.7%	4.9%	-0.1%	0.1%	0.0%
Professional	11.8%	-3.7%	7.6%	0.8%	-0.8%	0.0%	2.4%	0.1%	2.5%
Inst. (NH)	-18.2%	37.0%	12.0%	-9.9%	24.3%	12.0%	-4.8%	13.2%	7.7%
Total			**4.3%**			**1.0%**			**0.9%**

Adjustments to Trends

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was estimated on the selected trends, based on the specific language as it applied to Inpatient, Outpatient and Institutional unit cost trends. See the excerpt below for the specific applicable language, and Table 4 below for the impact of Article 5 on the selected trends.

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Article 5 – The selected trends were adjusted for the impact of **Article 5**, shown in greater detail in exhibits 4a, 4b and 4c in the appendix, to derive the final set of trends used to develop the projected benefit costs – see Table 4 below.

Table 4
Impact of Article 5

Rhody Health Partners
For Rate Period 7/1/2017 - 6/30/2018
Impact of Article 5 on Selected Trends

	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Selected Trends Based on Experience	4.3%	1.0%	0.9%	0.9%
Impact of Article 5 on Composite Trends:				
SFY '16 Trends with Article 5 [1] Implementation	2.9%	-1.1%	-0.4%	-0.4%
SFY '17 Trends with Article 5 [1] Implementation	5.2%	1.2%	2.6%	2.6%
SFY '18 Trends with Article 5 [1] Implementation	5.2%	1.1%	2.6%	2.6%
Average annual trend [2] with Impact of Article 5[1] Implementation	**4.8%**	**0.5%**	**1.6%**	**1.6%**

Trend Smoothing – The resulting trends were further normalized to reduce year-to-year projection volatility, by compositing the results of all the rate cells as a single trend rate to be applied to all rate cells – see Table 5 below.

Table 5
Trend Smoothing

Rhody Health Partners					
For Rate Period 7/1/2017 - 6/30/2018					
Medical Trend Selection & Smoothing					
Including Impact of Article 5 on Selected Trends					
	ID	**SPMI**	**Other Disabled 21-44**	**Other Disabled 45+**	**Total RHP**
Rate Period Forecast Average Enrollment	932	2,672	3,891	7,282	14,778
Selected Base Medical (Non-Rx) PMPM	$ 656.79	$ 1,591.61	$ 630.78	$ 829.34	
Rate Cell Cohort Weight (to Composite)	4.6%	31.8%	18.4%	45.2%	100.0%
Average annual trend with Impact of Article 5[1] Implementation	**4.8%**	**0.5%**	**1.6%**	**1.6%**	
Composite Trend					**1.39%**
Selected (Smoothed) Trend For Rating	**1.39%**	**1.39%**	**1.39%**	**1.39%**	

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans are required to identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to the rate period at 1.6% annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. Since the health service re-class is reported on an aggregate basis, we allocated the re-class amounts based on each rate cell's claims volume to the aggregate. The composite reported re-class for the base period was **$8.61** PMPM trended to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. EOHHS staff evaluated the RHP experience for SFY 2014 and identified 3 average eligible with such diagnoses, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 1 potential surgeries. The cost of surgery, at $52,650 per procedure, was estimated by EOHHS staff. The cost of surgery was projected to the rate period using the Other Disabled composite inpatient trend as impacted by Article 5.

Table 7
Gender Dysphoria

Rhody Health Partners							
For Rate Period 7/1/2017 - 6/30/2018							
Gender Dysphoria							
							Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]							$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]							$ 54,169
Number of persons estimated seeking surgical benefits [2]							1
Estimated total expenditures for Gender Dysphoria surgical treatment							$ 54,169
Rate Period projected average enrollment							14,778
Estimated impact to total Rhody Health Partners PMPM							$ 0.31
		Impact to PMPM					
		ID		SPMI		Other Disabled 21-44	Other Disabled 45+
Estimated Expenses PMPM for Gender Dysphoria coverage		$ 0.31		$ 0.31		$ 0.31	$ 0.31

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan (Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice,*

collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. The adjustment for this rate period is estimated by the State at **$(0.59)** PMPM. As applicable, the PMPMs are adjusted based on proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives.

Table 8
Care Transformation Collaborative - CTC

Rhody Health Partners				
For Rate Period 7/1/2017 - 6/30/2018				
Care Transformation Collaborative				
	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Rate Period Forecast Average Enrollment	932	2,672	3,891	7,282
CTC Program Expenses PMPM [1]	**$ (0.59)**	**$ (0.59)**	**$ (0.59)**	**$ (0.59)**

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. See Table 9 for the impact of this initiative.

Adult Day, referred to as Initiative 8B – Adult Day Health:

Beginning 1/1/2016, the State instituted Medicaid provider certification standards, established minimum levels of care requirements; instituted acuity-based payments which incorporate minimum functional requirements, and instituted

program oversight and monitoring for Adult Day Health, in order to provide a "variety of health, social, and related support services to individuals in a protective setting". The State anticipates that the Adult Day Health program will affect adults with disabilities, and such intervention and support services will result in reduced total care costs for the beneficiaries Please refer to the contract for additional details on this program initiative

The savings estimate for this initiative was based on a savings target estimate set by the State for rate period as part of its Reinventing Medicaid Initiatives, and was allocated to the Rhody Health Partners and Rhody Health Options product lines based on the State's assessment of the target clients and the anticipated savings from this initiative. See Table 9 for the impact of this initiative.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. See Table 9 for the impact of this initiative.

Table 9
Program Initiatives Savings

Rhody Health Partners				
For Rate Period 7/1/2017 - 6/30/2018				
Reinventing Medicaid Program Initiatives				
	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Program Initiative Savings [1]				
BH Services	$ (1.69)	$ (14.44)	$ (1.83)	$ (1.84)
Adult Day	$ (1.37)	$ (2.64)	$ (1.23)	$ (1.66)
ACO	$ (16.04)	$ (30.98)	$ (14.40)	$ (19.46)

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. We reviewed the CPI factors for various categories and selected the "Medical Care Services" and "Health Insurance" categories to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The resulting administrative load is on average **8.7%** of projected composite medical PMPM.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to $1.66 PMPM for adults aged 19 and over.

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Since Rhody Health Partners serves adult beneficiaries, **$1.66** PMPM will be assessed in each rate cell.

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.
b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**
b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)".*

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCOs satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. **Health System Transformation Program**

Through its *Health System Transformation Program Rhode Island* and its Medicaid MCOs shall support and incentivize a critical transformation of RI's system of care. The Program will award investments in performance-based infrastructure development by Medicaid Certified Accountable Entities (AE). Medicaid MCOs will be full partners in this transition, as the ultimate intent of this effort is to support the development of value-based contracts between the health plans and AEs.

Accountable Entities that meet state defined certification standards will initially apply for infrastructure funding to develop the governance, technology, skills and capacity to enter into risk-based contracts with Medicaid MCOs; manage enrollees' care across AE providers; and decrease out-year cost trend rates. Qualified AEs must meet one of three levels of readiness demonstrating that they either have or are developing the capacity to integrate and manage the full continuum of health care and to address members' social determinants (e.g., housing, food), in a way that is acceptable to CMS and the State.

The State shall reimburse the health plan for State-approved incentive payments that a health plan makes to providers making infrastructure investments to support this development of Accountable Entities. Up to 10 percent of the incentive payments may be retained by the health plan as an enhanced performance award to accelerate the development of value-based purchasing contracts with Accountable Entities.

Total payments made by all health plans cannot exceed the lesser of the maximum PMPM allocation indicated below or the maximum amount allocated by Rhode Island for the Health Systems Transformation Program within the Contract Period. Payments shall be distributed across the various Products (RIte Care, Substitute Care, Children with Special Healthcare Needs, Rhody Health Partners and Adult Expansion) based on the proportion of the Medicaid MCO's members associated with the AE being awarded the incentive payment.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $60.00 PMPM

2. Performance Goal Program

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $3.00 PMPM

3. Provider Incentive Program

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO.
These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM

The total maximum pay-out amount for all incentive programs is expected to be no more than **$65.90** PMPM. When measured relative to the proposed capitation rates – estimated composite rates of **$1,391.41** for non-profit plans and **$1,435.35** for for-profit plans, the incentive payments plus the capitation rates are within the 105% threshold for certified rates.

RATE DEVELOPMENT

Table 10
Rhody Health Partners Rate Development

Rhody Health Partners					
For Rate Period 7/1/2017 - 6/30/2018					
Including Reinventing Medicaid Program Initiatives					
Rate Period Average Enrollment Forecast		**932**	**2,672**	**3,891**	**7,282**
		ID	**SPMI**	**Other Disabled 21-44**	**Other Disabled 45+**
Base Medical (Non-Rx) PMPM		$ 656.79	$ 1,591.61	$ 630.78	$ 829.34
Article 5-Adjusted Selected Trend [1]		1.39%	1.39%	1.39%	1.39%
Projection Period (years)		3.00	3.00	3.00	3.00
Projected Medical PMPM		**$ 684.56**	**$ 1,658.91**	**$ 657.45**	**$ 864.41**
Base Rx PMPM		$ 295.73	$ 426.45	$ 163.83	$ 301.49
Selected Trend		5.3%	3.3%	3.8%	3.8%
Projection Period (years)		3.00	3.00	3.00	3.00
Projected Rx PMPM		**$ 345.29**	**$ 470.08**	**$ 183.23**	**$ 337.18**
Projected Total Medical & Rx PMPM		**$ 1,029.85**	**$ 2,128.99**	**$ 840.68**	**$ 1,201.59**
Adjustments To Total PMPM:					
Health Service Reclass [2]		$ 7.36	$ 15.22	$ 6.01	$ 8.59
Gender Dysphoria [3]		$ 0.31	$ 0.31	$ 0.31	$ 0.31
Care Transformation Collaborative (CTC) [6]		$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)
Program Initiative Savings:					
BH Services		$ (1.69)	$ (14.44)	$ (1.83)	$ (1.84)
Adult Day		$ (1.37)	$ (2.64)	$ (1.23)	$ (1.66)
ACO		$ (16.04)	$ (30.98)	$ (14.40)	$ (19.46)
Subtotal Adjustments		$ (12.02)	$ (33.12)	$ (11.73)	$ (14.65)
Fraud & Abuse (% of Medical)	1.0%	$ (10.18)	$ (20.96)	$ (8.29)	$ (11.87)
Subtotal Net Medical PMPM		**$ 1,007.65**	**$ 2,074.91**	**$ 820.66**	**$ 1,175.07**
Projected Administrative Load [4]		$ 78.79	$ 183.14	$ 71.06	$ 103.07
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 16.54	$ 34.39	$ 13.58	$ 19.46
Premium Before Taxes		$ 1,102.98	$ 2,292.44	$ 905.30	$ 1,297.60
Assessments: Adult Immunization		***$ 1.66***	***$ 1.66***	***$ 1.66***	***$ 1.66***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 22.54	$ 46.82	$ 18.51	$ 26.52
Projected PMPM For Non-Profit Plans		**$ 1,127.18**	**$ 2,340.92**	**$ 925.47**	**$ 1,325.78**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 23.26*	*$ 48.29*	*$ 19.09*	*$ 27.35*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 34.88	$ 72.45	$ 28.64	$ 41.03
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 1,162.78***	***$ 2,414.84***	***$ 954.69***	***$ 1,367.64***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs estimated by OHHS staff at $52,650 per eligible person

[4] Projected administrative load is based on the MCO financial reporting of Operating Expenses for total RHP, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit health plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Actuarial Certification

Certification of the Rhody Health Partners capitation rates for the rate period 7/1/2017 – 6/30/2018, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

4

APPENDIX

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Average Eligible Members

Program Population	SFY 2013	SFY 2014	SFY 2015
ID	777	804	847
SPMI	1,929	2,082	2,227
Other Disabled 21-44	3,853	3,880	3,910
Other Disabled 45+	6,607	6,873	6,845

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Encounter Claims Experience PMPM & Trends

Incurred State Fiscal Year (SFY), Paid through November 2015, estimated 100%

SFY '15 Average. Members		847			2,227			3,910			6,845			10,755	
		ID			SPMI			Other Disabled 21-44			Other Disabled 45+			Total Other Disabled	
Incurred Periods		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy		Medical	Pharmacy
7/1/12 - 6/30/13 (SFY '13)		$ 656.65	$ 246.63		$ 1,630.34	$ 395.02		$ 600.82	$ 157.62		$ 850.79	$ 274.02		$ 758.71	$ 231.14
7/1/13 - 6/30/14 (SFY '14)		$ 664.90	$ 277.33		$ 1,638.51	$ 427.08		$ 666.58	$ 167.67		$ 882.82	$ 292.90		$ 804.79	$ 247.71
7/1/14 - 6/30/15 (SFY '15)		$ 653.91	$ 297.31		$ 1,582.00	$ 420.13		$ 612.64	$ 159.43		$ 814.56	$ 300.37		$ 741.16	$ 249.14
SFY '14 over SFY '13		1.3%	12.4%		0.5%	8.1%		10.9%	6.4%		3.8%	6.9%		6.1%	7.2%
SFY '15 over SFY '14		-1.7%	7.2%		-3.4%	-1.6%		-8.1%	-4.9%		-7.7%	2.6%		-7.9%	0.6%
SFY '15 over SFY '13		**-0.2%**	9.8%		**-1.5%**	3.1%		**1.0%**	0.6%		**-2.2%**	4.7%		-1.2%	**3.8%**
Selected Rx Trend [1,2]	*25%*		**5.3%**	*75%*		**3.3%**			**3.8%**			**3.8%**			
SFY '14 --> SFY '15	*30%*	$ 663.51	$ 292.07	*30%*	$ 1,614.04	$ 441.19	*30%*	$ 673.10	$ 174.08	*30%*	$ 863.82	$ 304.10			
Selected Base Period [3]		**$ 656.79**	**$ 295.73**		**$ 1,591.61**	**$ 426.45**		**$ 630.78**	**$ 163.83**		**$ 829.34**	**$ 301.49**			

[1] Selected Rx trends for "Other Disabled 21-44" and "Other Disabled 45+" rate cells are based on the composite trends of the Other Disabled rate cells

[2] Selected Rx trends for ID and SPMI are weighted averages as follows: ID/DD & Composite Other Disabled at 25% / 75%, respectively; SPMI & Composite Other Disabled at 75% / 25%, respectively

[3] The selected Base Period PMPMs are as follows:

Medical: Credibility wtd. average of SFY '14 projected to SFY '15 & actual SFY '15 at 30% & 70% respectively

Pharmacy: Credibility wtd. average of SFY '14 projected to SFY '15 & actual SFY '15 at 30% & 70% respectively

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Incurred SFY, PT 11/15 est. 100%

Medical Trend Selection

Util/1000 (Util)	ID			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	9.2%	-12.9%	-2.5%	6.1%	-5.4%	0.2%	10.3%	-8.3%	0.6%
Outpatient Total	7.5%	-3.1%	2.1%	2.7%	-4.0%	-0.7%	3.5%	-3.1%	0.1%
Professional Total	-5.3%	-2.0%	-3.7%	-3.5%	1.9%	-0.8%	0.0%	0.2%	0.1%
Inst. (NH)	43.7%	30.6%	37.0%	40.5%	9.9%	24.3%	10.0%	16.5%	13.2%

Cost/Clm-Admt (price)	MRDD/DD			SPMI			Other Disabled Total		
	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13	'14/'13	'15/'14	'15/'13
Inpatient Total	-15.9%	0.1%	-8.2%	-3.4%	-1.6%	-2.5%	-0.3%	-1.9%	-1.1%
Outpatient Total	-7.5%	-5.2%	-6.4%	7.7%	3.5%	5.6%	-2.8%	-8.5%	-5.7%
Professional Total	13.8%	9.7%	11.8%	-0.8%	-4.2%	-2.5%	8.1%	-3.0%	2.4%
Inst. (NH)	16.8%	-25.0%	-6.4%	-5.5%	-3.9%	-4.7%	-6.9%	-2.7%	-4.8%

Composite	MRDD/DD			Clm Dist	SPMI			Clm Dist	Other Disabled Total			Clm Dist
	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15	'14/'13	'15/'14	'15/'13	SFY '15
Inpatient Total	-8.2%	-12.8%	-10.5%	27.4%	2.5%	-6.9%	-2.3%	31.4%	10.0%	-10.1%	-0.5%	34.6%
Outpatient Total	-0.6%	-8.2%	-4.4%	16.5%	10.6%	-0.6%	4.9%	17.6%	0.6%	-11.3%	-5.5%	31.3%
Professional Total	7.7%	7.5%	7.6%	54.9%	-4.2%	-2.4%	-3.3%	49.9%	8.1%	-2.8%	2.5%	32.3%
Inst. (NH)	67.8%	-2.0%	28.2%	1.2%	32.8%	5.6%	18.5%	1.0%	2.3%	13.4%	7.7%	1.8%
Medical Total			0.9%	100.0%			-1.3%	100.0%			-1.0%	100.0%

Trend Ceiling [1]:	**12.0%**
Trend Floor [1]:	**0.0%**

Adjusted Trends [1]	MRDD/DD			SPMI			Other Disabled Total		
	price	Util	comp[1]	price	Util	comp	price	Util	comp
Inpatient	2.6%	-2.5%	0.0%	-0.2%	0.2%	0.0%	-0.6%	0.6%	0.0%
Outpatient	-2.0%	2.1%	0.0%	5.6%	-0.7%	4.9%	-0.1%	0.1%	0.0%
Professional	11.8%	-3.7%	7.6%	0.8%	-0.8%	0.0%	2.4%	0.1%	2.5%
Inst. (NH)	-18.2%	37.0%	12.0%	-9.9%	24.3%	12.0%	-4.8%	13.2%	7.7%
Total			**4.3%**			**1.0%**			**0.9%**

[1] Variability in short-term indicated trends were smoothed for forecasting purposes by setting a ceiling of 12% and a floor of 0%. The resulting upper limit also indicates care management opportunities for the MCOs

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends

Medical (Non-Rx) Trends

Base Period MidPt
1/1/2015

LOB	ID Selected Trends '15 Clms. Dist.	Price	Util	comp	% In-State Clms. Dist.
Inpatient	27.4%	2.6%	-2.5%	0.0%	99.7%
Outpatient	16.5%	-2.0%	2.1%	0.0%	99.0%
Professional	54.9%	11.8%	-3.7%	7.6%	
Inst. (NH & Hospice)	1.2%	-18.2%	37.0%	12.0%	
Total	100%			**4.3%**	

LOB	SPMI Selected Trends '15 Clms. Dist.	Price	Util	comp	% In-State Clms. Dist.
Inpatient	31.4%	-0.2%	0.2%	0.0%	99.1%
Outpatient	17.6%	5.6%	-0.7%	4.9%	99.0%
Professional	49.9%	0.8%	-0.8%	0.0%	
Inst. (NH & Hospice)	1.0%	-9.9%	24.3%	12.0%	
Total	100%			**1.0%**	

LOB	Other Disabled Selected Trends '15 Clms. Dist.	Price	Util	comp	% In-State Clms. Dist.
Inpatient	34.6%	-0.6%	0.6%	0.0%	96.6%
Outpatient	31.3%	-0.1%	0.1%	0.0%	98.1%
Professional	32.3%	2.4%	0.1%	2.5%	
Inst. (NH & Hospice)	1.8%	-4.8%	13.2%	7.7%	
Total	100%			**0.9%**	

12.00
1/1/2016

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/15 - 6/30/16 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	27.4%	***-2.5%***	-2.5%	-4.9%	-4.9%	25.3%	0.26
Outpatient	16.5%	***-2.5%***	2.1%	-0.5%	-0.5%	15.9%	0.16
Professional	54.9%	11.8%	-3.7%	7.6%	7.6%	57.5%	0.59
Inst. (NH & Hospice)	1.2%	***-18.2%***	37.0%	12.0%	12.0%	1.3%	0.01
Total	100%			**2.9%**	**2.9%**	100.0%	1.03

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/15 - 6/30/16 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	31.4%	***-2.5%***	0.2%	-2.3%	-2.3%	31.0%	0.31
Outpatient	17.6%	***-2.5%***	-0.7%	-3.2%	-3.1%	17.3%	0.17
Professional	49.9%	0.8%	-0.8%	0.0%	0.0%	50.5%	0.50
Inst. (NH & Hospice)	1.0%	***-9.9%***	24.3%	12.0%	12.0%	1.2%	0.01
Total	100%			**-1.2%**	**-1.1%**	100.0%	0.99

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/15 - 6/30/16 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	34.6%	***-2.5%***	0.6%	-1.9%	-1.9%	34.1%	0.34
Outpatient	31.3%	***-2.5%***	0.1%	-2.4%	-2.3%	30.7%	0.31
Professional	32.3%	2.4%	0.1%	2.5%	2.5%	33.3%	0.33
Inst. (NH & Hospice)	1.8%	***-4.8%***	13.2%	7.7%	7.7%	1.9%	0.02
Total	100%			**-0.5%**	**-0.4%**	100.0%	1.00

12.00
1/1/2017

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/16 - 6/30/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	27.4%	***1.9%***	-2.5%	-0.6%	-0.6%	23.8%	0.26
Outpatient	16.5%	***1.9%***	2.1%	4.0%	4.0%	15.7%	0.17
Professional	54.9%	11.8%	-3.7%	7.6%	7.6%	58.7%	0.64
Inst. (NH & Hospice)	1.2%	***3.2%***	37.0%	41.4%	41.4%	1.8%	0.02
Total	100%			**5.2%**	**5.2%**	100.0%	1.08

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/16 - 6/30/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	31.4%	***1.9%***	0.2%	2.1%	2.1%	31.3%	0.31
Outpatient	17.6%	***1.9%***	-0.7%	1.2%	1.2%	17.3%	0.17
Professional	49.9%	0.8%	-0.8%	0.0%	0.0%	49.9%	0.50
Inst. (NH & Hospice)	1.0%	***3.2%***	24.3%	28.3%	28.3%	1.5%	0.02
Total	100%			**1.2%**	**1.2%**	100.0%	1.00

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/16 - 6/30/17 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	34.6%	***1.9%***	0.6%	2.5%	2.4%	34.0%	0.35
Outpatient	31.3%	***1.9%***	0.1%	2.0%	2.0%	30.6%	0.31
Professional	32.3%	2.4%	0.1%	2.5%	2.5%	33.2%	0.34
Inst. (NH & Hospice)	1.8%	***3.2%***	13.2%	16.9%	16.9%	2.2%	0.02
Total	100%			**2.6%**	**2.6%**	100.0%	1.02

12.00
1/1/2018

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/17 - 6/30/18 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	27.4%	***1.9%***	-2.5%	-0.6%	-0.6%	22.4%	0.26
Outpatient	16.5%	***1.9%***	2.1%	4.0%	4.0%	15.5%	0.18
Professional	54.9%	11.8%	-3.7%	7.6%	7.6%	59.7%	0.68
Inst. (NH & Hospice)	1.2%	***3.1%***	37.0%	41.3%	41.3%	2.4%	0.03
Total	100%			**5.2%**	**5.2%**	100.0%	1.15

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/17 - 6/30/18 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	31.4%	***1.9%***	0.2%	2.1%	2.1%	31.6%	0.32
Outpatient	17.6%	***1.9%***	-0.7%	1.2%	1.1%	17.3%	0.17
Professional	49.9%	0.8%	-0.8%	0.0%	0.0%	49.3%	0.50
Inst. (NH & Hospice)	1.0%	***3.1%***	24.3%	28.2%	28.2%	1.9%	0.02
Total	100%			**1.2%**	**1.1%**	100.0%	1.01

LOB	Impact of Article 5 '15 Clms. Dist.	7/1/17 - 6/30/18 Price	Util	comp	Adjusted Comp. Trend [1]	Impact of Trend on Clms. Dist.	
Inpatient	34.6%	***1.9%***	0.6%	2.5%	2.4%	34.0%	0.36
Outpatient	31.3%	***1.9%***	0.1%	2.0%	2.0%	30.4%	0.32
Professional	32.3%	2.4%	0.1%	2.5%	2.5%	33.2%	0.35
Inst. (NH & Hospice)	1.8%	***3.1%***	13.2%	16.8%	16.8%	2.5%	0.03
Total	100%			**2.6%**	**2.6%**	100.0%	1.05

Rate Period MidPt
1/1/2018

36.00 OK

LOB	Impact of Article 5 '15 Clms. Dist.	36.00 -Mo. Avg. Trends Price	Util	comp	Adjusted Comp. Trend [1]	Change in Clms. dist.	Adjusted Comp. Trend [1]
IP	27.4%	0.4%	-2.5%	-2.1%	-2.1%	24.9%	-2.1%
OP	16.5%	0.4%	2.1%	2.5%	2.5%	16.0%	2.5%
Prof	54.9%	11.8%	-3.7%	7.6%	7.6%	57.3%	7.6%
Inst. (NH & Hospice)	1.2%	-4.5%	37.0%	30.8%	30.8%	1.8%	30.8%
Total	100.0%			**4.4%**	**4.4%**	100.0%	**4.8%**
	36.00 -Mo. Avg. Trends			**4.4%**	**4.4%**		**4.8%**

36.00 OK

LOB	Impact of Article 5 '15 Clms. Dist.	36.00 -Mo. Avg. Trends Price	Util	comp	Adjusted Comp. Trend [1]	Change in Clms. dist.	Adjusted Comp. Trend [1]
IP	31.4%	0.4%	0.2%	0.6%	0.6%	31.5%	0.6%
OP	17.6%	0.4%	-0.7%	-0.3%	-0.2%	17.4%	-0.2%
Prof	49.9%	0.8%	-0.8%	0.0%	0.0%	49.6%	0.0%
Inst. (NH & Hospice)	1.0%	-1.4%	24.3%	22.6%	22.6%	1.5%	22.6%
Total	100.0%			**0.4%**	**0.4%**	100.0%	**0.5%**
	36.00 -Mo. Avg. Trends			**0.4%**	**0.4%**		**0.5%**

36.00 OK

LOB	Impact of Article 5 '15 Clms. Dist.	36.00 -Mo. Avg. Trends Price	Util	comp	Adjusted Comp. Trend [1]	Change in Clms. dist.	Adjusted Comp. Trend [1]
IP	34.6%	0.4%	0.6%	1.0%	1.0%	34.3%	1.0%
OP	31.3%	0.4%	0.1%	0.5%	0.5%	30.9%	0.5%
Prof	32.3%	2.4%	0.1%	2.5%	2.5%	32.8%	2.5%
Inst. (NH & Hospice)	1.8%	0.4%	13.2%	13.7%	13.7%	2.1%	13.7%
Total	100.0%			**1.6%**	**1.5%**	100.0%	**1.6%**
	36.00 -Mo. Avg. Trends			**1.6%**	**1.5%**		**1.6%**

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Impact of Article 5 on Selected Trends

	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Selected Trends Based on Experience	4.3%	1.0%	0.9%	0.9%
Impact of Article 5 on Composite Trends:				
SFY '16 Trends with Article 5 [1] Implementation	2.9%	-1.1%	-0.4%	-0.4%
SFY '17 Trends with Article 5 [1] Implementation	5.2%	1.2%	2.6%	2.6%
SFY '18 Trends with Article 5 [1] Implementation	5.2%	1.1%	2.6%	2.6%
Average annual trend [2] with Impact of Article 5[1] Implementation	**4.8%**	**0.5%**	**1.6%**	**1.6%**

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Reflects change in TOS claims distribution over time as a result of different trends by TOS (e.g. Inpatient vs. Outpatient, etc.) - see Trend Detail exhibit

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Medical Trend Selection & Smoothing

Including Impact of Article 5 on Selected Trends

	ID	SPMI	Other Disabled 21-44	Other Disabled 45+	Total RHP
Rate Period Forecast Average Enrollment	932	2,672	3,891	7,282	14,778
Selected Base Medical (Non-Rx) PMPM	$ 656.79	$ 1,591.61	$ 630.78	$ 829.34	
Rate Cell Cohort Weight (to Composite)	4.6%	31.8%	18.4%	45.2%	100.0%
Average annual trend with Impact of Article 5[1] Implementation	**4.8%**	**0.5%**	**1.6%**	**1.6%**	
Composite Trend					**1.39%**
Selected (Smoothed) Trend For Rating	**1.39%**	**1.39%**	**1.39%**	**1.39%**	

[1] As referenced in the State's Reinventing Medicaid initiatives

Rhody Health Partners
For Rate Period 7/1/2017 - 6/30/2018
Gender Dysphoria

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]	$ 54,169
Number of persons estimated seeking surgical benefits [2]	1
Estimated total expenditures for Gender Dysphoria surgical treatment	$ 54,169
Rate Period projected average enrollment	14,778
Estimated impact to total Rhody Health Partners PMPM	$ 0.31

	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Estimated Expenses PMPM for Gender Dysphoria coverage	$ 0.31	$ 0.31	$ 0.31	$ 0.31

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person for SFY 2015, and is assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism. Analysis identified 3 average eligibles with such diagnoses; State assumed a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[5] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend for Other Disabled

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Care Transformation Collaborative

	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Rate Period Forecast Average Enrollment	932	2,672	3,891	7,282
CTC Program Expenses PMPM [1]	**$ (0.59)**	**$ (0.59)**	**$ (0.59)**	**$ (0.59)**

[1] CTC PMPM expense adjustment for graduating practice sites, not currently reflected in the base period expenses

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Reinventing Medicaid Program Initiatives

	Impact to PMPM			
	ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Program Initiative Savings [1]				
BH Services	$ (1.69)	$ (14.44)	$ (1.83)	$ (1.84)
Adult Day	$ (1.37)	$ (2.64)	$ (1.23)	$ (1.66)
ACO	$ (16.04)	$ (30.98)	$ (14.40)	$ (19.46)

[1] Please refer to the narrative section of the Data Book for a description of each of the Program Initiatives

Rhody Health Partners

For Rate Period 7/1/2017 - 6/30/2018

Including Reinventing Medicaid Program Initiatives

		ID	SPMI	Other Disabled 21-44	Other Disabled 45+
Rate Period Average Enrollment Forecast		**932**	**2,672**	**3,891**	**7,282**
Base Medical (Non-Rx) PMPM		$ 656.79	$ 1,591.61	$ 630.78	$ 829.34
Article 5-Adjusted Selected Trend [1]		1.39%	1.39%	1.39%	1.39%
Projection Period (years)		3.00	3.00	3.00	3.00
Projected Medical PMPM		**$ 684.56**	**$ 1,658.91**	**$ 657.45**	**$ 864.41**
Base Rx PMPM		$ 295.73	$ 426.45	$ 163.83	$ 301.49
Selected Trend		5.3%	3.3%	3.8%	3.8%
Projection Period (years)		3.00	3.00	3.00	3.00
Projected Rx PMPM		**$ 345.29**	**$ 470.08**	**$ 183.23**	**$ 337.18**
Projected Total Medical & Rx PMPM		**$ 1,029.85**	**$ 2,128.99**	**$ 840.68**	**$ 1,201.59**
Adjustments To Total PMPM:					
Health Service Reclass [2]		$ 7.36	$ 15.22	$ 6.01	$ 8.59
Gender Dysphoria [3]		$ 0.31	$ 0.31	$ 0.31	$ 0.31
Care Transformation Collaborative (CTC) [6]		$ (0.59)	$ (0.59)	$ (0.59)	$ (0.59)
Program Initiative Savings:					
BH Services		$ (1.69)	$ (14.44)	$ (1.83)	$ (1.84)
Adult Day		$ (1.37)	$ (2.64)	$ (1.23)	$ (1.66)
ACO		$ (16.04)	$ (30.98)	$ (14.40)	$ (19.46)
Subtotal Adjustments		$ (12.02)	$ (33.12)	$ (11.73)	$ (14.65)
Fraud & Abuse (% of Medical)	1.0%	$ (10.18)	$ (20.96)	$ (8.29)	$ (11.87)
Subtotal Net Medical PMPM		**$ 1,007.65**	**$ 2,074.91**	**$ 820.66**	**$ 1,175.07**
Projected Administrative Load [4]		$ 78.79	$ 183.14	$ 71.06	$ 103.07
Risk Margin (% of Premium Before Taxes)	*1.5%*	$ 16.54	$ 34.39	$ 13.58	$ 19.46
Premium Before Taxes		$ 1,102.98	$ 2,292.44	$ 905.30	$ 1,297.60
Assessments: Adult Immunization		***$ 1.66***	***$ 1.66***	***$ 1.66***	***$ 1.66***
State Premium Tax - Non-Profit Plans	*2.0%*	$ 22.54	$ 46.82	$ 18.51	$ 26.52
Projected PMPM For Non-Profit Plans		**$ 1,127.18**	**$ 2,340.92**	**$ 925.47**	**$ 1,325.78**
State Premium Tax - For-Profit Plans	*2.0%*	*$ 23.26*	*$ 48.29*	*$ 19.09*	*$ 27.35*
ACA Issuer Fee - per Plan estimate for 2015 [5]	*3.0%*	$ 34.88	$ 72.45	$ 28.64	$ 41.03
Projected PMPM with ACA Issuer Fee [5]	*0.950*	***$ 1,162.78***	***$ 2,414.84***	***$ 954.69***	***$ 1,367.64***

[1] Article 5 as referenced in the State's Reinventing Medicaid initiatives

[2] Health Service Reclass adjustment to recognize Care Coordination activities as medical rather than administrative expenses - as per Section 2.06 of plan documents. Estimates based on MCO G/L reports, projected at 1.6% annually as a proxy for wage increase

[3] Gender Dysphoria coverage is a Medicaid benefit. Surgical costs estimated by OHHS staff at $52,650 per eligible person

[4] Projected administrative load is based on the MCO financial reporting of Operating Expenses for total RHP, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[5] ACA Issuer Fee, per estimate by UHC for 2015, is applicable to For-Profit health plans only

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Rhody Health Partners

Proposed Capitation Rates

Rate Period 7/1/2017 - 6/30/2018

RHP Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee: For-Profit Plans [4]	Capitation Rates: For-Profit Plans
ID	$ 1,007.65	$ 78.79	$ 16.54	$ 1.66	$ 22.54	**$ 1,127.18**	$ 23.26	$ 34.88	**$ 1,162.78**
SPMI	$ 2,074.91	$ 183.14	$ 34.39	$ 1.66	$ 46.82	**$ 2,340.92**	$ 48.29	$ 72.45	**$ 2,414.84**
Other Disabled 21-44	$ 820.66	$ 71.06	$ 13.58	$ 1.66	$ 18.51	**$ 925.47**	$ 19.09	$ 28.64	**$ 954.69**
Other Disabled 45+	$ 1,175.07	$ 103.07	$ 19.46	$ 1.66	$ 26.52	**$ 1,325.78**	$ 27.35	$ 41.03	**$ 1,367.64**

[1] Risk margin set at 1.5% of premium before taxes

[2] State Premium Tax is set at 2% of Premiums

[3] Includes Adult Immunization

[4] ACA Issuer Tax, per estimate by UHC for 2015, is applicable to For-Profit health plans only

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the State capitation rates for specific segments of the SSI population under Rhode Island's Medicaid program called Rhody Health Partners (RHP) for the 12-month period July 1, 2017 through June 30, 2018. The 12-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following eligibility categories: MR Waiver, SPMI, Other Disabled ages 21 to 44, and Other Disabled ages 45 and older.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Thomas M. Donlon

Thomas M. Donlon, FSA, MAAA
Principal
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June 30, 2016
Date

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June 28, 2016

Medicaid Expansion Data Book

State of Rhode Island

Rates for the period 2/1/2017 through 6/30/2017

Final & Confidential

Prepared by:
HealthCare Analytics
PO Box 41408
Providence, RI 02940-1408

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1

INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 2/1/2017 through 6/30/2017 for Medicaid Expansion, a Medicaid managed care program authorized under the Affordable Care Act (ACA).

Medicaid Expansion provides eligible uninsured adults without dependent children with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE or UHC). The health plans are paid capitation rates based on rate cells that are age and gender-driven. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the Medicaid Expansion per member per month (PMPM) capitation rates effective February 1, 2017 through June 30, 2017, for the purpose of attaining rate approval from CMS under 42 CFR 438.6 and 438.60. This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to the historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using trends that were adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the Medicaid Expansion claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected Medicaid Expansion rates presented in this data book:

- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for Medicaid Expansion were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

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CAPITATION RATES & DEMOGRAPHICS

The capitation rates (including administrative and premium tax loads) for the rate period 2/1/2017 – 6/30/2017 are as follows:

Table 1
Capitation Rates

Medicaid Expansion
Rate Period 2/1/2017 - 6/30/2017
Including Implementation of Reinventing Medicaid Program Initiatives

	Non-Profit Plans					For-Profit Plans					
Rate Cell	Medical	Admin + Risk Margin	Assess-ments [2]	State Prem. Tax	Non-Profit Capitation Rates	Medical	Admin + Risk	Assess-ments [2]	State Prem. Tax	Est. ACA Issuer Tax	For-Profit Capitation Rates
RHE F 19-24	$ 294.75	$ 31.52	$ 1.13	$ 6.68	**$ 334.09**	$ 294.75	$ 31.52	$ 1.13	$ 6.89	$ 10.34	**$ 344.64**
RHE F 25-29	$ 384.26	$ 41.09	$ 1.47	$ 8.71	**$ 435.54**	$ 384.26	$ 41.09	$ 1.47	$ 8.99	$ 13.48	**$ 449.29**
RHE F 30-39	$ 464.35	$ 49.66	$ 1.78	$ 10.53	**$ 526.31**	$ 464.35	$ 49.66	$ 1.78	$ 10.86	$ 16.28	**$ 542.93**
RHE F 40-49	$ 556.08	$ 59.47	$ 2.13	$ 12.61	**$ 630.29**	$ 556.08	$ 59.47	$ 2.13	$ 13.01	$ 19.50	**$ 650.19**
RHE F 50-64	$ 588.98	$ 62.99	$ 2.26	$ 13.35	**$ 667.58**	$ 588.98	$ 62.99	$ 2.26	$ 13.78	$ 20.66	**$ 688.66**
RHE M 19-24	$ 219.62	$ 23.49	$ 0.84	$ 4.98	**$ 248.93**	$ 219.62	$ 23.49	$ 0.84	$ 5.14	$ 7.70	**$ 256.79**
RHE M 25-29	$ 263.13	$ 28.14	$ 1.01	$ 5.97	**$ 298.25**	$ 263.13	$ 28.14	$ 1.01	$ 6.15	$ 9.23	**$ 307.66**
RHE M 30-39	$ 346.53	$ 37.06	$ 1.33	$ 7.86	**$ 392.77**	$ 346.53	$ 37.06	$ 1.33	$ 8.10	$ 12.15	**$ 405.17**
RHE M 40-49	$ 484.64	$ 51.83	$ 1.86	$ 10.99	**$ 549.31**	$ 484.64	$ 51.83	$ 1.86	$ 11.33	$ 17.00	**$ 566.66**
RHE M 50-64	$ 631.03	$ 67.48	$ 2.42	$ 14.31	**$ 715.24**	$ 631.03	$ 67.48	$ 2.42	$ 14.76	$ 22.13	**$ 737.83**

[1] A/G factors reflect the midpoint of the factors used in SFY '16 rate setting and the implied A/G factor from SFY '15 experience, normalized to achieve a risk factor of 1.0
[2] Includes Adult Immunizations

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RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data report was based on encounter data, and it covered the following State Fiscal Years (SFY)

- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

Since Medicaid Expansion became effective January 1, 2014 as a new program for a previously uninsured adult population, the startup period of January 1, 2014 through June 30, 2014 were excluded from the base period. The claims data was delineated by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail (see Table 1 below and Exhibit 1 in the Appendix).

The claims data for SFY 2015 was presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Table 1 below and Exhibit 1 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services

BASE PERIOD

The Base Period PMPM was based on the weighted average blend of the participating plans' experience for SFY 2015. As the program is still relatively new and only one year of experience is available for review, the composite PMPM of all the rate cells was selected as the base period PMPM for this period's rate setting (see Table 1 below and Exhibit 1 in the Appendix). Individual rate cell PMPMs will be considered in future rating as more experience and history is accumulated for each rate cell.

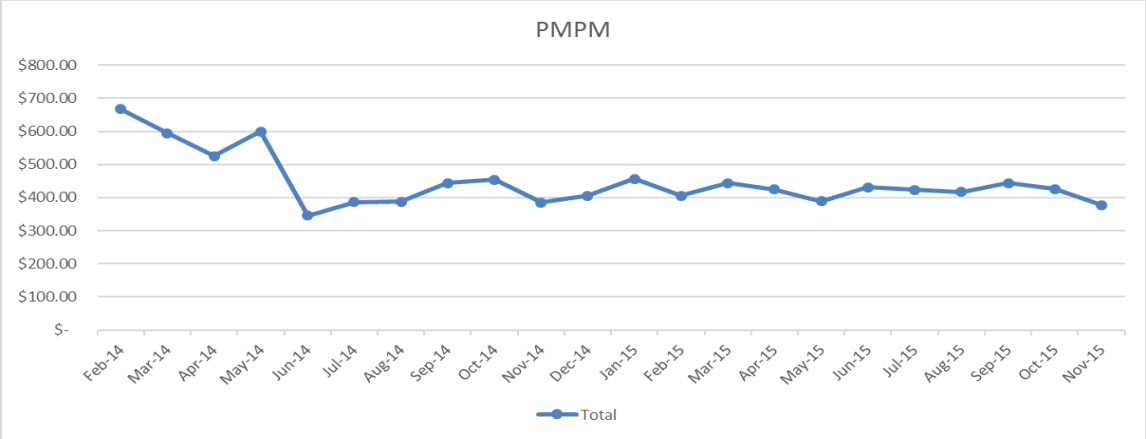
Table 1
Claims, Enrollment and Base Period PMPM:

Medicaid Expansion												
Rate Period 2/1/2017 - 6/30/2017												
Aggregate Encounter Data Claims Experience												
	Incurred SFY 2015, Paid Through November, 2015, est. 100%											
Type of Service Summary	RHE F 19-24 ME01	RHE F 25-29 ME02	RHE F 30-39 ME03	RHE F 40-49 ME04	RHE F 50-64 ME05	RHE M 19-24 ME06	RHE M 25-29 ME07	RHE M 30-39 ME08	RHE M 40-49 ME09	RHE M 50-64 ME10	Total
Inpatient	$ 2,495,504	$ 2,203,030	$ 3,622,612	$ 4,661,468	$ 12,291,351	$ 2,884,971	$ 4,556,528	$ 8,143,773	$ 9,986,905	$ 16,050,230	$ 66,896,372
Outpatient	$ 4,979,524	$ 3,426,322	$ 4,931,173	$ 8,640,192	$ 17,583,579	$ 3,292,465	$ 4,598,700	$ 6,684,895	$ 8,075,675	$ 13,086,002	$ 75,298,527
Professional	$ 5,206,851	$ 4,543,668	$ 5,887,664	$ 8,836,948	$ 18,329,775	$ 4,111,431	$ 5,697,403	$ 9,746,170	$ 10,500,302	$ 13,995,251	$ 86,855,461
Pharmacy	$ 2,353,999	$ 2,143,155	$ 2,780,918	$ 4,633,524	$ 11,189,497	$ 1,687,987	$ 2,643,442	$ 4,985,445	$ 6,219,246	$ 10,138,575	$ 48,775,787
Institutional	$ 13,197	$ 16,062	$ 8,875	$ 70,024	$ 576,171	$ 23,385	$ 18,698	$ 127,708	$ 355,741	$ 764,533	$ 1,974,394
Total	$ 15,049,073	$ 12,332,237	$ 17,231,243	$ 26,842,157	$ 59,970,373	$ 12,000,238	$ 17,514,771	$ 29,687,991	$ 35,137,868	$ 54,034,590	$ 279,800,541
Member Months	66,832	39,447	34,914	49,113	112,837	71,584	58,587	72,209	62,515	90,444	658,481
PMPM	$ 225.18	$ 312.63	$ 493.53	$ 546.54	$ 531.48	$ 167.64	$ 298.95	$ 411.14	$ 562.07	$ 597.44	$ 424.92
Plan Reported G/L Adjustments [1]											$ (3.93)
Net Base Period PMPM											**$ 420.99**

Adjustments to Base Period

Reverse Pent-Up Demand and Adverse Selection – Analysis of the MCO-reported monthly claims experience PMPM indicated a relatively stable enrollment and experience through SFY '15 and into SFY '16. Based on this data, it is assumed that pent-up demand and adverse risk was presented early in the program and that the experience leveled off by SFY '15, with no apparent pent-up demand reflected in that experience – see Table 2 below and Exhibit 2 in the Appendix for further details.

Table 2
Monthly Base Period PMPM:



TRENDS AND TREND DEVELOPMENT

Since there was only one year of historical claims experience for Medicaid Expansion, trends for this population were developed from three sources. The latest available OHIC-approved small group utilization trends by service category, the average of the RIte Care and Rhody Health Partners unit cost trends by service category (as affected by Article 5), and SFY '15 Medicaid Expansion distribution of claims by service category. It was assumed that until Medicaid Expansion is managed by the MCOs for two to three years, small group trends may be a better proxy for utilization trends than established managed Medicaid programs such as RIte Care and Rhody Health Partners. It was also assumed that unit cost trends would follow more closely with established managed Medicaid product lines because of MCOs' contracting with providers, for which an equally weighted blend of RIte Care and Rhody Health Partners was selected to be the proxy for this population's unit cost trends.

Table 3
Selected Trends:

Medicaid Expansion Rate Setting
Rate Period 2/1/2017 - 6/30/2017
Trend Assumption
Including the Impact of Article 5 on Selected Trends

Analysis of Encounter Data Including Offline & G/L Adjustments								Composite Trend Including Impact of Article 5				
7/1/14 - 6/30/15			**Small Group CY '16 from OHIC [1,2]**				**Avg. unit cost "price" trend for Rate Period [3]**			**Utilization - Small Group [2,4]**	**Composite Trend**
TOS	PMPM	Pct. Total	Price	Util	Composite		RHP [3]	RIte Care	Wtd. Avg		
Inpatient	$105.90	24.6%	*2.8%*	*-1.7%*	*1.1%*		0.0%	-1.3%	-0.7%	-1.7%	**-2.3%**
Outpatient	$117.55	27.3%	*2.9%*	*2.1%*	*5.1%*		0.0%	0.0%	0.0%	2.1%	**2.1%**
Professional	$134.64	31.3%	*2.1%*	*0.3%*	*2.4%*		2.4%	1.1%	1.8%	0.3%	**2.1%**
Pharmacy	$ 68.99	16.0%	*4.2%*	*5.1%*	*9.5%*	1	5.7%	5.0%	5.4%	5.1%	**10.8%**
Inst. (NH & Hospice)	$ 2.96	0.7%	*2.8%*	*-1.7%*	*1.1%*	1	-0.4%	0.9%	0.3%	-1.7%	**-1.4%**
Total	$430.04	100.0%	**2.9%**	**1.1%**	**4.0%**	2					**2.4%**
						Wt.	*0.5*	*0.5*	*1.0*		

Adjustments to Trends

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was reflected in the selected unit cost trends from RIte Care and Rhody Health Partners. See the excerpt below for the specific applicable language, and Table 2 above as they were applied to the trend development for those product lines for the applicable rate period.

Continued on next page

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)		
Page	**Line**	**Nursing Facilities**
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Pent-Up Demand and Adverse Selection – Analysis of the MCO-reported monthly claims experience PMPM indicated a relatively stable enrollment and experience through SFY '15 and into SFY '16. Based on this data, it is assumed that pent-up demand and adverse risk was presented early in the program and that the experience leveled off by SFY '15, with no apparent pent-up demand reflected in that experience – see Table 2 above and Exhibit 2 in the Appendix for further details.

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to rate period at 1.6% annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. NHPRI did not report the health service re-class amount in their G/L report, and was therefore assumed to be in their reported operating expense amounts. UHC's reported re-class amount was used as a proxy PMPM for the rate development, as well as the amount used to exclude it from NHPRI's reported operating expenses. The re-class amount for the base period was **$3.69** PMPM, trended to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. Pending an evaluation of the Medicaid

Expansion historical claims data by the State, prior rate development's assumptions were carried forward to this rate development – that of using RIte Care experience as proxy for potential gender dysphoria surgical expenses in Medicaid Expansion. EOHHS staff evaluated the RIte Care experience for SFY 2014 and identified 13 average eligible with such diagnoses in their adult population, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 2 potential surgeries. The incidence rate of 13 eligible in the RIte Care adult population was applied to the Medicaid Expansion population to derive the number of eligible, and to calculate the potential surgeries. Since the projected rate period enrollment for the Medicaid Expansion population is similar in size to the RIte Care adult population, the estimation yielded 2 potential surgeries for Medicaid Expansion. The cost of surgery, at $52,650 per procedure in 2015 as estimated by EOHHS staff, was projected to the rate period using the Article 5-impacted composite inpatient trend.

Table 3
Gender Dysphoria

Medicaid Expansion		
Rate Period 2/1/2017 - 6/30/2017		
Gender Dysphoria		
		Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]		$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]		$ 49,862
Number of persons estimated seeking surgical benefits [2]		2
Estimated total expenditures for Gender Dysphoria		$ 99,724
Rate Period estimated projected average enrollment		63,964
Estimated impact to Total Medicaid Expansion PMPM		$ 0.13

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan (Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice, collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."*

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. As applicable, the PMPMs are adjusted based on proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives. The adjustment for this rate period is estimated by the State at **$(0.60)** PMPM.

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. The composite estimated adjustment for this rate period for Medicaid Expansion is **$(2.05)** PMPM.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. The composite estimated adjustment for this rate period for Medicaid Expansion is **$(8.29)** PMPM.

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. The CPI factors for various categories were reviewed and the "Medical Care Services" and "Health Insurance" categories were selected to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

NHPRI did not delineate health service re-class in their G/L reports, and was assumed to be reflected in their reported operating expenses, as it was in their previous year's financial statements. UHC's reported health service re-class PMPM was used as a proxy to adjust the NHPRI operating expenses to exclude a re-class amount for admin load development – see the discussion above under Projected Benefit Costs for the inclusion of health service re-class as medical.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The administrative load for this rate period is **9.0%** of projected medical PMPM.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to ***$1.66*** *PMPM for adults aged 19 and over.*

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.
b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	**Plan Share of Expenses**	**State Share of Expenses**
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**
b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)".*

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCO's satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. Performance Goal Program

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $3.00 PMPM

2. Provider Incentive Program

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO.
These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM

The total maximum pay-out amount for all incentive programs is expected to be no more than **$5.90 PMPM**. When measured relative to the proposed capitation rates – estimated composite rates of **$490.93 PMPM** for non-profit plans and **$506.43 PMPM** for for-profit plans, the incentive payments plus the capitation rates are within the 105% threshold for certified rates.

RATE DEVELOPMENT

Table 4
Medicaid Expansion Rate Development

Medicaid Expansion		
Rate Period 2/1/2017 - 6/30/2017		
		PMPM
Encounter Data for claims incurred 7/1/2014 - 6/30/2015 (SFY '15), Paid through 11/30/2015, estimated @100%. Including Offline & G/L Adjustments		$ 420.99
Trend Assumptions - OHIC small group adjusted for medicaid mgd. care price trends		2.4%
Projection Period (years)		2.29
Projected PMPM		$ 444.49
Adjustments to Total PMPM		
Health Service Reclass [1]		$ 3.83
Gender Dysphoria [2]		$ 0.13
Care Transformation Collaborative (CTC) [6]		$ (0.60)
Program Initiative Savings:		
BH Services		$ (2.05)
ACO		$ (8.29)
Subtotal Adjustments		$ (6.98)
Subtotal Medical PMPM		$ 437.51
Fraud & Abuse (% of Medical)	1.0%	$ (4.38)
Net Medical PMPM		**$ 433.13**
Projected Admin Load PMPM for Rate Period [3]		**$ 39.13**
Risk Margin	*1.5%*	**$ 7.19**
Projected Premium Before Taxes & Fees		**$ 479.45**
Assessments: Adult Immunization		***$ 1.66***
Projected Premium Before Taxes & Fees		**$ 481.11**
Non-Profit Capitation Rate:		
State Premium Tax for Non-Profit Plans	*2.0%*	$ 9.82
Estimated Rate Period Composite Capitation Rate for Non-Profit Plans		**$ 490.93**
For-Profit Capitation Rate:		
State Premium Tax for For-Profit Plans	*2.0%*	$ 10.13
Estimated ACA Issuer Fee [4]	*3.0%*	$ 15.19
Estimated Rate Preiod Composite Capitation Rate for For-Profit Plans	*0.950*	**$ 506.43**

[1] Based on UHC reporting. NHPRI did not report on Health Service Reclass, and is therefore assumed to be included in their reported administrative expense figures. Used UHC's reported reclass PMPM to include in the development of the Medical PMPM and to adjust NHPRI's reported administrative expense amount for the reclass amount accordingly. Reported admin re-class projected to rate period at 1.6% annualy as a proxy for wage increase

[2] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[3] Projected administrative load is based on MCO financial reporting of Operating Expenses, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services" - per State budget initiative

[4] ACA Issuer Fee estimate based on UHC estimate for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Rate Cells

Aggregate premium PMPM, including administration, assessments, fees and taxes were converted into capitation rates on a rate cell-basis with the use of age/gender factors. In a move to recognize the age/gender differences inherent in the experience, and in an effort to mitigate variances in the capitation rates from previous period's capitation rates and between rate cells, a blend of the age/gender factors was used. The blend was the average of the age/gender factors used in the SFY '16 rate development and the age/gender factors from the SFY 2015 experience reported by the plans – see Exhibit 6 in the Appendix. Future rate-setting will transition to developing the rates on a rate-cell basis.

Actuarial Certification

Certification of the Medicaid Expansion capitation rates for the rate period 2/1/2017 – 6/30/2017, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

4

APPENDIX

Medicaid Expansion

Rate Period 2/1/2017 - 6/30/2017

Aggregate Encounter Data Claims Experience

Incurred SFY 2015, Paid Through November, 2015, est. 100%

Type of Service Summary	RHE F 19-24 ME01	RHE F 25-29 ME02	RHE F 30-39 ME03	RHE F 40-49 ME04	RHE F 50-64 ME05	RHE M 19-24 ME06	RHE M 25-29 ME07	RHE M 30-39 ME08	RHE M 40-49 ME09	RHE M 50-64 ME10	Total
Inpatient	$ 2,495,504	$ 2,203,030	$ 3,622,612	$ 4,661,468	$ 12,291,351	$ 2,884,971	$ 4,556,528	$ 8,143,773	$ 9,986,905	$ 16,050,230	$ 66,896,372
Outpatient	$ 4,979,524	$ 3,426,322	$ 4,931,173	$ 8,640,192	$ 17,583,579	$ 3,292,465	$ 4,598,700	$ 6,684,895	$ 8,075,675	$ 13,086,002	$ 75,298,527
Professional	$ 5,206,851	$ 4,543,668	$ 5,887,664	$ 8,836,948	$ 18,329,775	$ 4,111,431	$ 5,697,403	$ 9,746,170	$ 10,500,302	$ 13,995,251	$ 86,855,461
Pharmacy	$ 2,353,999	$ 2,143,155	$ 2,780,918	$ 4,633,524	$ 11,189,497	$ 1,687,987	$ 2,643,442	$ 4,985,445	$ 6,219,246	$ 10,138,575	$ 48,775,787
Institutional	$ 13,197	$ 16,062	$ 8,875	$ 70,024	$ 576,171	$ 23,385	$ 18,698	$ 127,708	$ 355,741	$ 764,533	$ 1,974,394
Total	$ 15,049,073	$ 12,332,237	$ 17,231,243	$ 26,842,157	$ 59,970,373	$ 12,000,238	$ 17,514,771	$ 29,687,991	$ 35,137,868	$ 54,034,590	$ 279,800,541
Member Months	66,832	39,447	34,914	49,113	112,837	71,584	58,587	72,209	62,515	90,444	658,481
PMPM	$ 225.18	$ 312.63	$ 493.53	$ 546.54	$ 531.48	$ 167.64	$ 298.95	$ 411.14	$ 562.07	$ 597.44	$ 424.92
Plan Reported G/L Adjustments [1]											$ (3.93)
Net Base Period PMPM											**$ 420.99**

[1] Plan reported G/L adjustments include reinsurance expense and recoveries, pharmacy rebates, medical portion of subcapitation payments not reflected in claims experience; excludes administrative portion of behavioral health, pharmacy and DME subcapitations

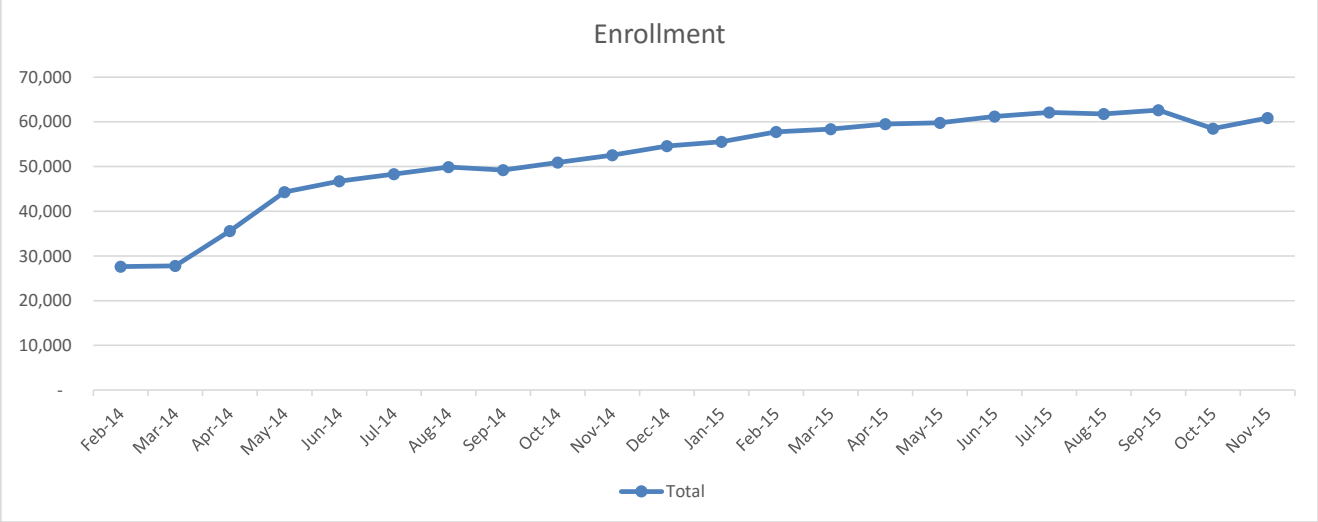
Medicaid Expansion
MCO-Reported Experience

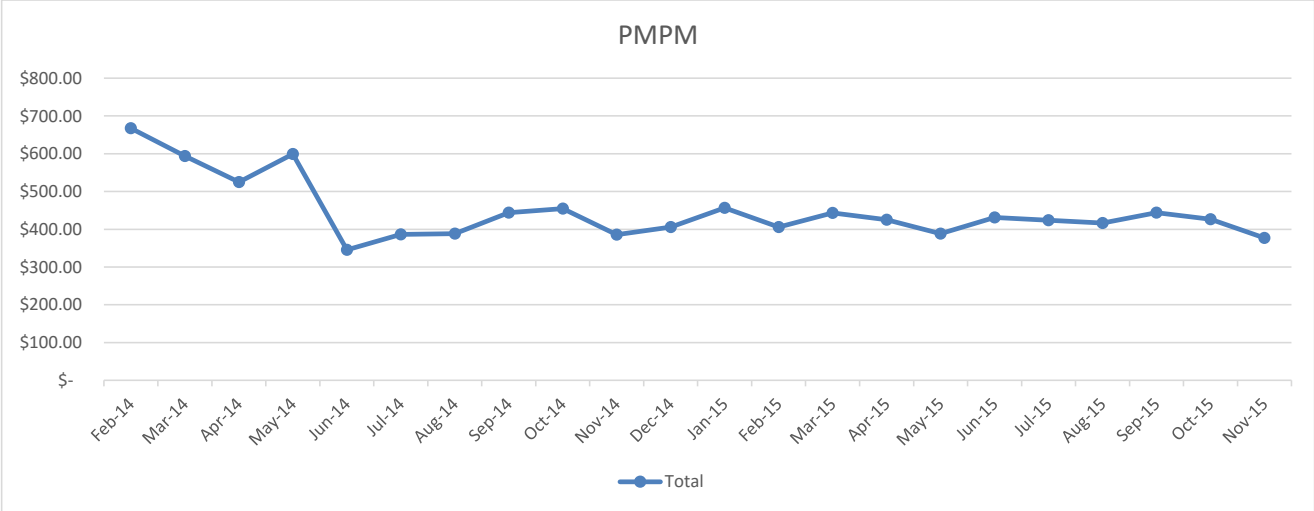
	Enrollment				PMPM*				Percent Diff./ Wtd. Avg. PMPM			
Month	MCO 1	MCO 2	Total	Month	MCO 1	MCO 2	Total		1/14-6/14	7/14-6/15	1/14-6/15	7/15-11/15
Feb-14			27,622	Feb-14			$ 667.33		26%		51%	
Mar-14			27,789	Mar-14			$ 593.84		12%		34%	
Apr-14			35,602	Apr-14			$ 525.07		-1%		19%	
May-14			44,312	May-14			$ 599.30		13%		36%	
Jun-14			46,711	Jun-14			$ 345.40		-35%		-22%	
Jul-14			48,289	Jul-14			$ 385.99			-8%	-13%	
Aug-14			49,893	Aug-14			$ 388.15			-7%	-12%	
Sep-14			49,231	Sep-14			$ 443.75			6%	0%	
Oct-14			50,933	Oct-14			$ 454.42			9%	3%	
Nov-14			52,560	Nov-14			$ 385.54			-8%	-13%	
Dec-14			54,601	Dec-14			$ 405.62			-3%	-8%	
Jan-15			55,560	Jan-15			$ 456.67			9%	3%	
Feb-15			57,763	Feb-15			$ 405.60			-3%	-8%	
Mar-15			58,390	Mar-15			$ 443.46			6%	0%	
Apr-15			59,485	Apr-15			$ 425.13			2%	-4%	
May-15			59,823	May-15			$ 388.37			-7%	-12%	
Jun-15			61,209	Jun-15			$ 431.31			3%	-2%	
Jul-15			62,139	Jul-15			$ 423.75					1%
Aug-15			61,765	Aug-15			$ 416.61					0%
Sep-15			62,630	Sep-15			$ 444.16					6%
Oct-15			58,474	Oct-15			$ 426.15					2%
Nov-15			60,896	Nov-15			$ 376.94					-10%
									$ 529.12	$ 418.14	$ 442.20	$ 417.63

Not Disclosed For Confidentiality Reasons

Not Disclosed For Confidentiality Reasons

* Monthly PMPMs were calculated from the **cumulative** monthly risk share reports including IBNR, and thus the derived monthly PMPMs may be distorted by preceding periods' IBNR





ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Medicaid Expansion Rate Setting

Rate Period 2/1/2017 - 6/30/2017

Trend Assumption

Including the Impact of Article 5 on Selected Trends

Analysis of Encounter Data Including Offline & G/L Adjustments

7/1/14 - 6/30/15			Small Group CY '16 from OHIC [1,2]				Composite Trend Including Impact of Article 5				
							Avg. unit cost "price" trend for Rate Period [3]			Utilization - Small Group [2,4]	Composite Trend
TOS	PMPM	Pct. Total	Price	Util	Composite		RHP [3]	RIte Care	Wtd. Avg		
Inpatient	$ 105.90	24.6%	*2.8%*	*-1.7%*	*1.1%*		0.0%	-1.3%	-0.7%	-1.7%	**-2.3%**
Outpatient	$ 117.55	27.3%	*2.9%*	*2.1%*	*5.1%*		0.0%	0.0%	0.0%	2.1%	**2.1%**
Professional	$ 134.64	31.3%	*2.1%*	*0.3%*	*2.4%*		2.4%	1.1%	1.8%	0.3%	**2.1%**
Pharmacy	$ 68.99	16.0%	*4.2%*	*5.1%*	*9.5%*	[1]	5.7%	5.0%	5.4%	5.1%	**10.8%**
Inst. (NH & Hospice)	$ 2.96	0.7%	*2.8%*	*-1.7%*	*1.1%*	[1]	-0.4%	0.9%	0.3%	-1.7%	**-1.4%**
Total	$ 430.04	100.0%	**2.9%**	**1.1%**	**4.0%**	[2]					**2.4%**
						Wt.	*0.5*	*0.5*	*1.0*		

[1] Rx Trend was presented as a composite only, assumed previously presented CY '15 price trend and backed into implied utilization trend. Institutional trends were not presented, therefore assumed same trends as inpatient.

[2] Small Group Trend estimate for CY '16 provided by OHIC, adjusted to reflect MA Expansion claims distribution

[3] Reference price trends are from RIte Care and RHP rate setting for same rate period, including impact of Article 5. RHP reference trends based on "Other Disabled" rate cells

[4] Trends to be applied to MA Expansion rating. Assumes that utilization for this population will be similar to commercial/small group while price will be subject to price controls set by the State for managed medicaid plans.

Medicaid Expansion
Rate Period 2/1/2017 - 6/30/2017
Gender Dysphoria

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]	$ 49,861
Number of persons estimated seeking surgical benefits [2]	2
Estimated total expenditures for Gender Dysphoria	$ 99,721
Rate Period estimated projected average enrollment	63,964
Estimated impact to Total Medicaid Expansion PMPM	$ 0.13

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person for SFY 2015, and is assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism for RIte Care, the incidence rate for which is assumed indicative for the Medicaid Expansion population for potential Gender Dysphoria surgical benefits. Analysis identified 13 average eligibles with such diagnoses, and potential surgeries were estimated at a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[5] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend

Medicaid Expansion
Rate Period 2/1/2017 - 6/30/2017

		PMPM
Encounter Data for claims incurred 7/1/2014 - 6/30/2015 (SFY '15), Paid through 11/30/2015, estimated @100%. Including Offline & G/L Adjustments		$ 420.99
Trend Assumptions - OHIC small group adjusted for medicaid mgd. care price trends		2.4%
Projection Period (years)		2.29
Projected PMPM		$ 444.49
Adjustments to Total PMPM		
Health Service Reclass [1]		$ 3.83
Gender Dysphoria [2]		$ 0.13
Care Transformation Collaborative (CTC) [6]		$ (0.60)
Program Initiative Savings:		
BH Services		$ (2.05)
ACO		$ (8.29)
Subtotal Adjustments		$ (6.98)
Subtotal Medical PMPM		$ 437.51
Fraud & Abuse (% of Medical)	1.0%	$ (4.38)
Net Medical PMPM		**$ 433.13**
Projected Admin Load PMPM for Rate Period [3]		**$ 39.13**
Risk Margin	*1.5%*	**$ 7.19**
Projected Premium Before Taxes & Fees		**$ 479.45**
Assessments: Adult Immunization		***$ 1.66***
Projected Premium Before Taxes & Fees		**$ 481.11**
Non-Profit Capitation Rate:		
State Premium Tax for Non-Profit Plans	*2.0%*	$ 9.82
Estimated Rate Period Composite Capitation Rate for Non-Profit Plans		**$ 490.93**
For-Profit Capitation Rate:		
State Premium Tax for For-Profit Plans	*2.0%*	$ 10.13
Estimated ACA Issuer Fee [4]	*3.0%*	$ 15.19
Estimated Rate Preiod Composite Capitation Rate for For-Profit Plans	*0.950*	**$ 506.43**

[1] Based on UHC reporting. NHPRI did not report on Health Service Reclass, and is therefore assumed to be included in their reported administrative expense figures. Used UHC's reported reclass PMPM to include in the development of the Medical PMPM and to adjust NHPRI's reported administrative expense amount for the reclass amount accordingly. Reported admin re-class projected to rate period at 1.6% annualy as a proxy for wage increase

[2] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[3] Projected administrative load is based on MCO financial reporting of Operating Expenses, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services" - per State budget initiative

[4] ACA Issuer Fee estimate based on UHC estimate for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Medicaid Expansion

Rate Period 2/1/2017 - 6/30/2017

Including Implementation of Reinventing Medicaid Program Initiatives

Rate Cell		A/G Factor Used in SFY '16 Rates	A/G Factor Implied in Experience	**Average / Midpoint A/G Factor**
RHE F 19-24	ME01	0.7543	0.6972	**0.7258**
RHE F 25-29	ME02	1.0469	0.8454	**0.9461**
RHE F 30-39	ME03	1.2317	1.0550	**1.1433**
RHE F 40-49	ME04	1.4861	1.2523	**1.3692**
RHE F 50-64	ME05	1.6219	1.2786	**1.4502**
RHE M 19-24	ME06	0.5543	0.5272	**0.5408**
RHE M 25-29	ME07	0.6060	0.6898	**0.6479**
RHE M 30-39	ME08	0.9051	0.8014	**0.8532**
RHE M 40-49	ME09	1.2336	1.1530	**1.1933**
RHE M 50-64	ME10	1.6948	1.4128	**1.5538**

Rate Cell		A/G Factor [1]	Rate Period Forecast Enrollment	**Normalized A/G Factor [1]**	Non-Profit Plans: Medical	Non-Profit Plans: Admin + Risk Margin	Non-Profit Plans: Assess-ments [2]	Non-Profit Plans: State Prem. Tax	**Non-Profit Capitation Rates**	For-Profit Plans: Medical	For-Profit Plans: Admin + Risk	For-Profit Plans: Assess-ments [2]	For-Profit Plans: State Prem. Tax	For-Profit Plans: Est. ACA Issuer Tax	**For-Profit Capitation Rates**
RHE F 19-24	ME01	0.7258	6,611	**0.6805**	$ 294.75	$ 31.52	$ 1.13	$ 6.68	**$ 334.09**	$ 294.75	$ 31.52	$ 1.13	$ 6.89	$ 10.34	**$ 344.64**
RHE F 25-29	ME02	0.9461	3,950	**0.8872**	$ 384.26	$ 41.09	$ 1.47	$ 8.71	**$ 435.54**	$ 384.26	$ 41.09	$ 1.47	$ 8.99	$ 13.48	**$ 449.29**
RHE F 30-39	ME03	1.1433	3,358	**1.0721**	$ 464.35	$ 49.66	$ 1.78	$ 10.53	**$ 526.31**	$ 464.35	$ 49.66	$ 1.78	$ 10.86	$ 16.28	**$ 542.93**
RHE F 40-49	ME04	1.3692	4,303	**1.2839**	$ 556.08	$ 59.47	$ 2.13	$ 12.61	**$ 630.29**	$ 556.08	$ 59.47	$ 2.13	$ 13.01	$ 19.50	**$ 650.19**
RHE F 50-64	ME05	1.4502	10,408	**1.3598**	$ 588.98	$ 62.99	$ 2.26	$ 13.35	**$ 667.58**	$ 588.98	$ 62.99	$ 2.26	$ 13.78	$ 20.66	**$ 688.66**
RHE M 19-24	ME06	0.5408	7,191	**0.5071**	$ 219.62	$ 23.49	$ 0.84	$ 4.98	**$ 248.93**	$ 219.62	$ 23.49	$ 0.84	$ 5.14	$ 7.70	**$ 256.79**
RHE M 25-29	ME07	0.6479	5,961	**0.6075**	$ 263.13	$ 28.14	$ 1.01	$ 5.97	**$ 298.25**	$ 263.13	$ 28.14	$ 1.01	$ 6.15	$ 9.23	**$ 307.66**
RHE M 30-39	ME08	0.8532	7,457	**0.8001**	$ 346.53	$ 37.06	$ 1.33	$ 7.86	**$ 392.77**	$ 346.53	$ 37.06	$ 1.33	$ 8.10	$ 12.15	**$ 405.17**
RHE M 40-49	ME09	1.1933	5,926	**1.1189**	$ 484.64	$ 51.83	$ 1.86	$ 10.99	**$ 549.31**	$ 484.64	$ 51.83	$ 1.86	$ 11.33	$ 17.00	**$ 566.66**
RHE M 50-64	ME10	1.5538	8,798	**1.4569**	$ 631.03	$ 67.48	$ 2.42	$ 14.31	**$ 715.24**	$ 631.03	$ 67.48	$ 2.42	$ 14.76	$ 22.13	**$ 737.83**
Composite		1.0665	63,964	**1.0000**	$ 433.13	$ 46.32	$ 1.66	$ 9.82	**$ 490.93**	$ 433.13	$ 46.32	$ 1.66	$ 10.13	$ 15.19	**$ 506.43**
					check $ 433.13	$ 46.32	$ 1.66	$ 9.82	$ 490.93	$ 433.13	$ 46.32	$ 1.66	$ 10.13	$ 15.19	$ 506.43
					OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK

[1] A/G factors reflect the midpoint of the factors used in SFY '16 rate setting and the implied A/G factor from SFY '15 experience, normalized to achieve a risk factor of 1.0

[2] Includes Adult Immunizations

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the State capitation rates for Rhode Island's State Medicaid Expansion Program for the 5-month period February 1, 2017 through June 30, 2017. The 5-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following age-gender eligibility categories: Ages 19-24, 25-29, 30-39, 40-49, and 50-64, for both males and females.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

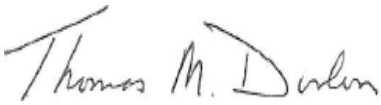
In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.



June 30, 2016
Date

Thomas M. Donlon, FSA, MAAA
Principal
tom.donlon@terrygroup.com

June 28, 2016

Medicaid Expansion Data Book

State of Rhode Island

Rates for the period 7/1/2017 through 6/30/2018

Final & Confidential

Prepared by:
HealthCare Analytics
PO Box 41408
Providence, RI 02940-1408

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1

INTRODUCTION & SUMMARY

The Executive Office of Health and Human Services of Rhode Island (EOHHS, the State) requested that HealthCare Analytics assist it with developing actuarially sound capitation rates for the rate period 7/1/2017 through 6/30/2018 for Medicaid Expansion, a Medicaid managed care program authorized under the Affordable Care Act (ACA).

Medicaid Expansion provides eligible uninsured adults without dependent children with comprehensive health coverage through managed care health plans, including Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England (UHCNE or UHC). The health plans are paid capitation rates based on rate cells that are age and gender-driven. A summary of the benefits can be found in the Appendix as Attachment A.

This document presents the approach and calculation of the Medicaid Expansion per member per month (PMPM) capitation rates effective July 1, 2017 through June 30, 2018, for the purpose of attaining rate approval from CMS under 42 CFR 438.6 and 438.60. This document was made consistent with the guidance provided in the Centers for Medicare and Medicaid Services (CMS) Rate Checklist.

The rates were developed from existing claims data for the target populations. Adjustments were made to the historical experience to account for off-line expenses (represented in MCO general ledger reports) not reflected in the claims data, as reconciled between EOHHS and the health plans. Adjustments were also made to projected benefit costs for programmatic changes and initiatives that will impact future claims costs and is not currently reflected in the base period data. Such programmatic changes include the impact of Article 5 legislation on hospital and institutional unit cost trends, and program initiatives stemming from the State's Reinventing Medicaid Initiatives. Additional discussion on the program initiatives are presented in various sections of this data book. The claims were trended forward to the rate period using trends that were adjusted for the impact of Article 5 legislation. The resulting projected claims costs were loaded for administrative expenses, risk margin, assessments, fees, taxes and the ACA Issuer tax (as applicable to for-profit plans) to set actuarially sound capitation rates. Exhibits supporting the calculations for the rate development and adjustments related to programmatic changes are shown in tables throughout this document and in the appendix.

HealthCare Analytics relied on data and analysis produced by EOHHS and its subcontractors for the Medicaid Expansion claims experience (encounter data), data related to programmatic changes such as listed above, and the following program initiatives and program changes to develop the projected Medicaid Expansion rates presented in this data book:

- Gender Dysphoria surgery and treatment
- Care Transformation Collaborative
- Fraud & Abuse

Base period claims data review and selection, trend development, program initiative impact calculations, assumptions, methodologies, observations of the underlying data in support of the rate development and proposed capitation rates for Medicaid Expansion were performed in consultation with the actuarial firm of The Terry Group, which also provided the certification letter required by CMS.

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CAPITATION RATES & DEMOGRAPHICS

The capitation rates (including administrative and premium tax loads) for the rate period 7/1/2017 – 6/30/2018 are as follows:

Table 1
Capitation Rates

Medicaid Expansion
Rate Period 7/1/2017 - 6/30/2018
Including Implementation of Reinventing Medicaid Program Initiatives

	Non-Profit Plans					For-Profit Plans					
Rate Cell	Medical	Admin + Risk Margin	Assess-ments [2]	State Prem. Tax	Non-Profit Capitation Rates	Medical	Admin + Risk	Assess-ments [2]	State Prem. Tax	Est. ACA Issuer Tax	For-Profit Capitation Rates
RHE F 19-24	$ 301.78	$ 31.92	$ 1.13	$ 6.83	**$ 341.67**	$ 301.78	$ 31.92	$ 1.13	$ 7.05	$ 10.58	**$ 352.46**
RHE F 25-29	$ 393.42	$ 41.62	$ 1.47	$ 8.91	**$ 445.42**	$ 393.42	$ 41.62	$ 1.47	$ 9.19	$ 13.79	**$ 459.49**
RHE F 30-39	$ 475.42	$ 50.29	$ 1.78	$ 10.76	**$ 538.25**	$ 475.42	$ 50.29	$ 1.78	$ 11.11	$ 16.66	**$ 555.26**
RHE F 40-49	$ 569.34	$ 60.23	$ 2.13	$ 12.89	**$ 644.59**	$ 569.34	$ 60.23	$ 2.13	$ 13.30	$ 19.95	**$ 664.95**
RHE F 50-64	$ 603.03	$ 63.79	$ 2.26	$ 13.65	**$ 682.73**	$ 603.03	$ 63.79	$ 2.26	$ 14.09	$ 21.13	**$ 704.30**
RHE M 19-24	$ 224.86	$ 23.79	$ 0.84	$ 5.09	**$ 254.58**	$ 224.86	$ 23.79	$ 0.84	$ 5.25	$ 7.88	**$ 262.62**
RHE M 25-29	$ 269.41	$ 28.50	$ 1.01	$ 6.10	**$ 305.01**	$ 269.41	$ 28.50	$ 1.01	$ 6.29	$ 9.44	**$ 314.65**
RHE M 30-39	$ 354.79	$ 37.53	$ 1.33	$ 8.03	**$ 401.69**	$ 354.79	$ 37.53	$ 1.33	$ 8.29	$ 12.43	**$ 414.37**
RHE M 40-49	$ 496.20	$ 52.49	$ 1.86	$ 11.23	**$ 561.78**	$ 496.20	$ 52.49	$ 1.86	$ 11.59	$ 17.39	**$ 579.53**
RHE M 50-64	$ 646.08	$ 68.34	$ 2.42	$ 14.63	**$ 731.47**	$ 646.08	$ 68.34	$ 2.42	$ 15.09	$ 22.64	**$ 754.58**

[1] A/G factors reflect the midpoint of the factors used in SFY '16 rate setting and the implied A/G factor from SFY '15 experience, normalized to achieve a risk factor of 1.0
[2] Includes Adult Immunizations

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RATE DEVELOPMENT METHODOLOGY

CLAIMS & ENROLLMENT DATA

Claims data was provided by EOHHS and its subcontractors on behalf of the State, which we used to develop the capitation rates exhibited in the above table. The data report was based on encounter data, and it covered the following State Fiscal Years (SFY)

- 7/1/2014 through 6/30/2015 (SFY 2015), paid through 11/30/2015, estimated at 100%

Since Medicaid Expansion became effective January 1, 2014 as a new program for a previously uninsured adult population, the startup period of January 1, 2014 through June 30, 2014 were excluded from the base period. The claims data was delineated by service categories that included inpatient, outpatient, professional, institutional and pharmacy detail (see Table 1 below and Exhibit 1 in the Appendix).

The claims data for SFY 2015 was presented on an incurred basis paid through November 2015 and estimated complete at 100%. HealthCare Analytics relied on the completed claims experience developed by EOHHS and its subcontractors on behalf of the State.

EOHHS staff also provided enrollment data for SFY 2015 for each of the rate cells under consideration. The enrollment was based on the payments made to the health plans during the stated periods (see Table 1 below and Exhibit 1 in the Appendix).

Adjustments to Historical Claims

General Ledger (G/L) Adjustments - EOHHS staff provided additional information with which adjustments were made to the claims data for SFY 2015. The G/L adjustments, as reported by the MCOs and reconciled between EOHHS staff and the MCOs, are for expenses and adjustments to expenses not available in the claims (encounter data) system. Such adjustments include pharmacy rebates, re-insurance recoveries, the medical portion of sub-capitation arrangements.

Reinventing Medicaid Initiatives – As part of the State's Reinventing Medicaid Initiatives, several previously out-of-plan (OOP) benefits were rolled into the managed Medicaid contracts and thus became In-Plan benefits. As these expenses are not reflected in the managed care claims experience (encounter data), the fee-for-service (FFS) expenses associated with these services are included in the historical base period data for SFY '15. The additional In-Plan benefits are:

- HIV Case Management
- BH Services

BASE PERIOD

The Base Period PMPM was based on the weighted average blend of the participating plans' experience for SFY 2015. As the program is still relatively new and only one year of experience is available for review, the composite PMPM of all the rate cells was selected as the base period PMPM for this period's rate setting (see Table 1 below and Exhibit 1 in the Appendix). Individual rate cell PMPMs will be considered in future rating as more experience and history is accumulated for each rate cell.

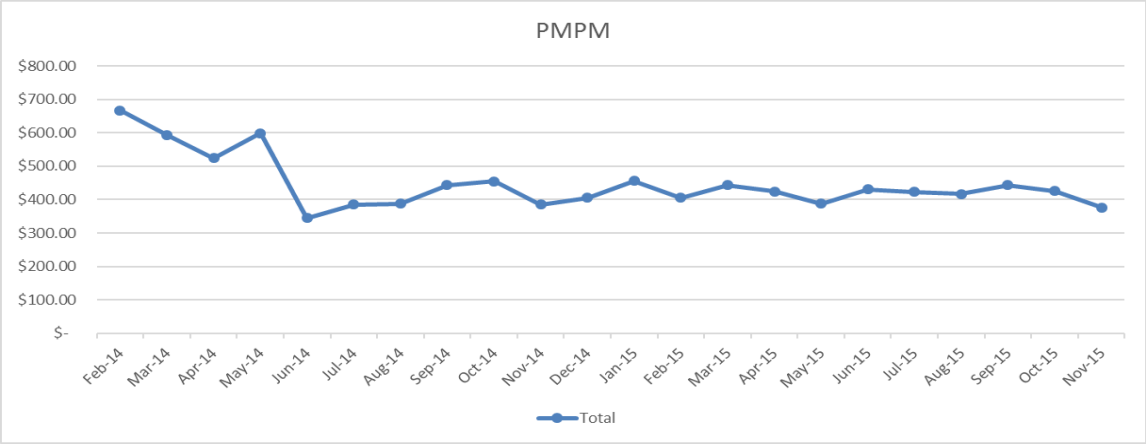
Table 1
Claims, Enrollment and Base Period PMPM:

Medicaid Expansion											
Rate Period 7/1/2017 - 6/30/2018											
Aggregate Encounter Data Claims Experience											
	Incurred SFY 2015, Paid Through November, 2015, est. 100%										
Type of Service Summary	RHE F 19-24 ME01	RHE F 25-29 ME02	RHE F 30-39 ME03	RHE F 40-49 ME04	RHE F 50-64 ME05	RHE M 19-24 ME06	RHE M 25-29 ME07	RHE M 30-39 ME08	RHE M 40-49 ME09	RHE M 50-64 ME10	Total
Inpatient	$ 2,495,504	$ 2,203,030	$ 3,622,612	$ 4,661,468	$ 12,291,351	$ 2,884,971	$ 4,556,528	$ 8,143,773	$ 9,986,905	$ 16,050,230	$ 66,896,372
Outpatient	$ 4,979,524	$ 3,426,322	$ 4,931,173	$ 8,640,192	$ 17,583,579	$ 3,292,465	$ 4,598,700	$ 6,684,895	$ 8,075,675	$ 13,086,002	$ 75,298,527
Professional	$ 5,206,851	$ 4,543,668	$ 5,887,664	$ 8,836,948	$ 18,329,775	$ 4,111,431	$ 5,697,403	$ 9,746,170	$ 10,500,302	$ 13,995,251	$ 86,855,461
Pharmacy	$ 2,353,999	$ 2,143,155	$ 2,780,918	$ 4,633,524	$ 11,189,497	$ 1,687,987	$ 2,643,442	$ 4,985,445	$ 6,219,246	$ 10,138,575	$ 48,775,787
Institutional	$ 13,197	$ 16,062	$ 8,875	$ 70,024	$ 576,171	$ 23,385	$ 18,698	$ 127,708	$ 355,741	$ 764,533	$ 1,974,394
Total	$ 15,049,073	$ 12,332,237	$ 17,231,243	$ 26,842,157	$ 59,970,373	$ 12,000,238	$ 17,514,771	$ 29,687,991	$ 35,137,868	$ 54,034,590	$ 279,800,541
Member Months	66,832	39,447	34,914	49,113	112,837	71,584	58,587	72,209	62,515	90,444	658,481
PMPM	$ 225.18	$ 312.63	$ 493.53	$ 546.54	$ 531.48	$ 167.64	$ 298.95	$ 411.14	$ 562.07	$ 597.44	$ 424.92
Plan Reported G/L Adjustments [1]											$ (3.93)
Net Base Period PMPM											**$ 420.99**

Adjustments to Base Period

Reverse Pent-Up Demand and Adverse Selection – Analysis of the MCO-reported monthly claims experience PMPM indicated a relatively stable enrollment and experience through SFY '15 and into SFY '16. Based on this data, it is assumed that pent-up demand and adverse risk was presented early in the program and that the experience leveled off by SFY '15, with no apparent pent-up demand reflected in that experience – see Table 2 below and Exhibit 2 in the Appendix for further details.

Table 2
Monthly Base Period PMPM:



TRENDS AND TREND DEVELOPMENT

Since there was only one year of historical claims experience for Medicaid Expansion, trends for this population were developed from three sources. The latest available OHIC-approved small group utilization trends by service category, the average of the RIte Care and Rhody Health Partners unit cost trends by service category (as affected by Article 5), and SFY '15 Medicaid Expansion distribution of claims by service category. It was assumed that until Medicaid Expansion is managed by the MCOs for two to three years, small group trends may be a better proxy for utilization trends than established managed Medicaid programs such as RIte Care and Rhody Health Partners. It was also assumed that unit cost trends would follow more closely with established managed Medicaid product lines because of MCOs' contracting with providers, for which an equally weighted blend of RIte Care and Rhody Health Partners was selected to be the proxy for this population's unit cost trends.

Table 2
Selected Trends:

Medicaid Expansion Rate Setting
Rate Period 7/1/2017 - 6/30/2018
Trend Assumption
Including the Impact of Article 5 on Selected Trends

Analysis of Encounter Data Including Offline & G/L Adjustments								Composite Trend Including Impact of Article 5				
7/1/14 - 6/30/15			**Small Group CY '16 from OHIC [1,2]**				**Avg. unit cost "price" trend for Rate Period [3]**			**Utilization - Small Group [2,4]**	**Composite Trend**
TOS	PMPM	Pct. Total	Price	Util	Composite		RHP [3]	RIte Care	Wtd. Avg		
Inpatient	$105.90	24.6%	*2.8%*	*-1.7%*	*1.1%*		0.4%	-0.5%	-0.1%	-1.7%	**-1.8%**
Outpatient	$117.55	27.3%	*2.9%*	*2.1%*	*5.1%*		0.4%	0.4%	0.4%	2.1%	**2.5%**
Professional	$134.64	31.3%	*2.1%*	*0.3%*	*2.4%*		2.4%	1.1%	1.8%	0.3%	**2.1%**
Pharmacy	$ 68.99	16.0%	*4.2%*	*5.1%*	*9.5%*	1	5.7%	5.0%	5.4%	5.1%	**10.8%**
Inst. (NH & Hospice)	$ 2.96	0.7%	*2.8%*	*-1.7%*	*1.1%*	1	0.4%	1.4%	0.9%	-1.7%	**-0.8%**
Total	$430.04	100.0%	**2.9%**	**1.1%**	**4.0%**	2					**2.6%**
						Wt.	*0.5*	*0.5*	*1.0*		

Adjustments to Trends

Article 5 of the State's Reinventing Medicaid initiatives – The impact of Article 5 legislation was reflected in the selected unit cost trends from RIte Care and Rhody Health Partners. See the excerpt below for the specific applicable language, and Table 2 above as they were applied to the trend development for those product lines for the applicable rate period.

Continued on next page

ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)		
Page	**Line**	**Nursing Facilities**
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

PROJECTED BENEFIT COSTS

Adjustments to Projected Benefit Costs

Pent-Up Demand and Adverse Selection – Analysis of the MCO-reported monthly claims experience PMPM indicated a relatively stable enrollment and experience through SFY '15 and into SFY '16. Based on this data, it is assumed that pent-up demand and adverse risk was presented early in the program and that the experience leveled off by SFY '15, with no apparent pent-up demand reflected in that experience – see Table 2 above and Exhibit 2 in the Appendix for further details.

Health Service Re-class / Coordination of Care – Per Section 2.06 of the plan documents the State allows for the reclassification of certain administrative expenses related to care management activities designed to reduce medical expenses and improve members' health, as medical. The plans identify, reclassify and report such expenses separately in their General Ledger expense reports. Reported health service re-class expenses for the base were reviewed for reasonableness, trended forward to rate period at **1.6%** annual trend (from an analysis of BLS's RI survey for "professional", "health services" and "other" data series), and included as an adjustment to the medical portion of the rates. NHPRI did not report the health service re-class amount in their G/L report, and was therefore assumed to be in their reported operating expense amounts. UHC's reported re-class amount was used as a proxy PMPM for the rate development, as well as the amount used to exclude it from NHPRI's reported operating expenses. The re-class amount for the base period was **$3.69** PMPM, trended to the rate period.

Gender Dysphoria – Gender Dysphoria is a covered Medicaid benefit and most services related to it and with diagnosis codes for Gender Incongruence and/or Transsexualism are presently paid for and included in the experience. The State is including an adjustment to the rates to cover for potential surgical procedures related to Gender Dysphoria not currently in the experience, particularly in light of the recent social awareness. Pending an evaluation of the Medicaid

Expansion historical claims data by the State, prior rate development's assumptions were carried forward to this rate development – that of using RIte Care experience as proxy for potential gender dysphoria surgical expenses in Medicaid Expansion. EOHHS staff evaluated the RIte Care experience for SFY 2014 and identified 13 average eligible with such diagnoses in their adult population, and assumed a conservative estimate of 1 in 10 for the election of surgery. The estimate was rounded up to the nearest whole number, yielding 2 potential surgeries. The incidence rate of 13 eligible in the RIte Care adult population was applied to the Medicaid Expansion population to derive the number of eligible, and to calculate the potential surgeries. Since the projected rate period enrollment for the Medicaid Expansion population is similar in size to the RIte Care adult population, the estimation yielded 2 potential surgeries for Medicaid Expansion. The cost of surgery, at $52,650 per procedure in 2015 as estimated by EOHHS staff, was projected to the rate period using the Article 5-impacted composite inpatient trend.

Table 3
Gender Dysphoria

Medicaid Expansion		
Rate Period 7/1/2017 - 6/30/2018		
Gender Dysphoria		
		Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]		$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]		$ 49,921
Number of persons estimated seeking surgical benefits [2]		2
Estimated total expenditures for Gender Dysphoria		$ 99,841
Rate Period estimated projected average enrollment		65,094
Estimated impact to Total Medicaid Expansion PMPM		$ 0.13

Care Transformation Collaborative (CTC) – Per EOHHS, this program initiative is defined as follows: *"The Care Transformation Collaborative (CTC, formerly known as CSI) is a multi-payer patient centered medical home initiative that began in 2008 under the auspices of the Health Insurance Commissioner and EOHHS. CTC is now a 501c3 non-profit organization supported directly by the participating health plans and governed by a Board of Directors. It is committed to working with all major health plans to transform the way we pay for and deliver primary care. The participating primary care practices are paid the same PMPM from each health plan (Commercial and Medicaid Managed Care Plans) to transform their practice over the course of a four-year developmental contract. Additionally, CTC provides project management support for the initiative, direct on-site practice coaching for each participating practice, collaborative learning opportunities for all members of the care team, data aggregation and analysis, and community health teams. Community Health Teams serve as an extension of the primary care office to meet patients in their home or communities and help them address the social, environmental, and/or behavioral health needs that complicate their physical health care and drive high costs."*

The State estimates a reduction in the number of members attributed to a CTC site during the rating period when compared to the average CTC membership during state fiscal year 2015. Specifically, in June 2016 the State anticipates that 21 practice sites will "graduate" from CTC, with another 15 practices graduating in December 2016. Together, these practices have nearly 50,000 attributed Medicaid members.

The State anticipates a reduction in costs during the Rating Period that is associated with CTC as a result of this reduction in participating sties and members for whom the Health Plans will no longer be expected to make monthly CTC payments. These "savings" are partially offset by (a) an increase in the average PMPM cost across all remaining participants in the current rating period compared to the base period, and; (b) increased administrative costs and funding of the Community Health Teams.

The overall reduction in CTC-related costs is distributed across all products and according to the number covered adults in the Product as a share of total adult Medicaid membership. As applicable, the PMPMs are adjusted based on

proportion of adults aged 19 or older in the rate cell. No savings are assumed as it relates to the Health Plan's continued CTC costs in the rating period beyond what is already reflected in the base experience or captured by the State's *Reinventing Medicaid* initiatives. The adjustment for the rate period is estimated by the State at **$(0.59)** PMPM.

Reinventing Medicaid Initiatives -

BH Services, referred to as Initiative 6B – Coordinated Care Management for SPMI:

Behavioral Health (BH) Services as defined by initiative 6B, was previously paid on a Fee-For-Service (FFS) basis and became an In-Plan benefit included in the managed care contracts effective 1/1/2016. This program initiative is intended to create a health home-based model of care delivery and coordination for persons with severe mental illness. Please refer to contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the product line's contribution of expenses related to this initiative to the total forecasted expense associated with this initiative. The composite estimated adjustment for this rate period for Medicaid Expansion is **$(2.01)** PMPM.

ACO, referred to as Initiative 5 – Pilot Coordinated Care Program:

The State is facilitating the enrollment of Medicaid Managed Care beneficiaries into State-certified Accountable Entity Coordinated Care Pilot Programs in partnerships with the MCOs, which offer care coordination and integration through integrated delivery networks that include physicians, hospitals and other providers. It is anticipated that these pilot programs will achieve better patient outcomes, higher patient satisfaction, and reduced overall cost of care. Please refer to the contract for additional details on this program initiative.

The savings estimate for this initiative was based on a savings target estimate set by the State for the rate period as part of its Reinventing Medicaid Initiatives, and was allocated to each product line based on the relative weight of the contribution of this product line's State-forecasted managed care claims expenses for SFY 2016, to the total State-forecasted managed care claims expense for all product lines for SFY 2016. The composite estimated adjustment for this rate period for Medicaid Expansion is **$(8.15)** PMPM.

Fraud & Abuse – The additional provisions for healthcare compliance as contained in the model contract, and the healthcare compliance programs as mandated by the Healthcare Reform Law of the Patient Protection and Affordable Care Act (PPACA) of 2010 are expected to produce additional savings in the healthcare system. In anticipation, an adjustment was applied to recognize such savings at 1.0% of net projected claims. As Fraud & Abuse prevention and recovery programs are newly introduced or existing ones better implemented the benefits will accrue to the State over time through the claims experience. To the extent that MCOs achieve higher levels of savings than that assumed in the rate development in any given year, they are rewarded for their efforts.

PROJECTED NON-BENEFIT COSTS

Administrative Load – Development

The administrative load was developed from a review of operating expenses as reported in the plan financial statements for 2015, adjusted to also include administrative expenses related to sub-capitated arrangements for behavioral health, DME and pharmacy, as reported in the plans' General Ledger expense reports. The resultant net administrative expense was projected to the rate period using a combination of CPI factors for January 2016. The CPI factors for various categories were reviewed and the "Medical Care Services" and "Health Insurance" categories were selected to develop an appropriate factor for MCO operating expenses. The "Health Insurance" CPI factor indicated a rate of 4.8%, while the "Medical Care Services" factor indicated a rate of 3.3%. It was assumed that "Health Insurance" represents the total cost of health insurance and is inclusive of the medical and administrative components of insurance. Thus, the difference of "Health Insurance" and "Medical Care Services" was assumed to represent the administrative portion of health insurance, at 1.50%.

NHPRI did not delineate health service re-class in their G/L reports, and was assumed to be reflected in their reported operating expenses, as it was in their previous year's financial statements. UHC's reported health service re-class PMPM was used as a proxy to adjust the NHPRI operating expenses to exclude a re-class amount for admin load development – see the discussion above under Projected Benefit Costs for the inclusion of health service re-class as medical.

Note: Since United Healthcare of NE (UHC) reports administrative expenses as an aggregate across all managed Medicaid, and does not delineate between various managed Medicaid products (e.g. RIte Care, Rhody Health Partners, etc.), we relied upon Neighborhood Health Plans of RI's (NHPRI) reports to produce product-specific administrative rate loads. The State has requested that UHC provide more detailed reporting of their administrative expenses that better reflect the true costs of administration on each of the product lines in which they participate. When such information is presented, it will be included in the development of the administrative loads.

The administrative load for this rate period is **8.9%** of projected medical PMPM.

Risk Margin

A risk margin of 1.5% of premium before taxes is included in the capitation rates.

Assessments

Adult Immunization – Per EOHHS: *Effective January 1, 2016, the Rhode Island State-supplied Vaccine (SSV) program will be funded through an assessment against health care insurers, health benefit plans, and third-party administrators. These payers are being assessed their proportionate share of the state's overall vaccine costs based on their number of enrollees. Previously this assessment was based on a percentage of their premium receipts and Medicaid MCOs were exempt from any liability.*

The assessment rate for the Rhode Island State-supplied vaccine program at January 1, 2016, is $3.70 PMPM for adult contribution enrollees. The Rhode Island Department of Health (DOH) estimates that by July 1, 2016, once the state enrollees and the non-profit organizations are added as insurers subject to assessment, the costs of the SSV assessment is expected to drop to ***$1.66*** *PMPM for adults aged 19 and over.*

Medicaid MCOs are required to fund the purchase of vaccines for insured adults. The federally-funded Vaccines for Children (VFC) program that pays for vaccines for Medicaid-insured children under 19 years of age is not affected by this change in the vaccine assessment program.

Taxes & Fees

The capitation rates include a 2% premium tax imposed by the State, and, for for-profit plans, the ACA-related Issuer Fee. The issuer fee was estimated at 3.0% of premium by UHC and EOHHS staff.

Risk Mitigation

The State uses risk corridors with risk-sharing arrangements around the rates to limit the plans' exposure and to mitigate the risk of over-adequacy or under- adequacy in the rates. The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where Medical Expenses are between Baseline and 101.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 101.5% of Baseline and 105.0% of Baseline	40%	60%
For portion of Medical Expenses that are greater than 105.0% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where Medical Expenses are between Baseline and 98.5% of Baseline	100%	0%
For portion of Medical Expenses that are between 98.5% of Baseline and 95.0% of Baseline	40%	60%
For portion of Medical Expenses that are less than 95.0% of Baseline	10%	90%

Notes:

a. Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group, **less the portion of the medical premium attributed to the Integrated Health Home baseline revenue described below under "Risk Mitigation on Specified Behavioral Health Initiatives"**.
b. Risk Share/Gain share calculations are on an aggregate basis for all Premium Rating Groups combined.

Risk Mitigation on Specified Behavioral Healthcare Initiatives

For the rating periods through 6/30/2018, the State is implementing a separate 100% risk share/gain share arrangement for specified behavioral healthcare expenditures for the treatment of enrollees in an integrated health home, a subset of the BH services first brought In-Plan effective 1/1/2016. This separate risk share/gain share arrangement is intended to allay both Health Plans and the State's concerns over the potential volatility of the specified expenditures because the State has implemented a new assessment tool for identifying enrollees eligible for treatment and has also made changes to the payment rates for certain procedure provided to these enrollees. The new assessment tool introduced 1/1/2016 is used to determine whether an SPMI/SMI member eligible for Medicaid should be enrolled in either an Integrated Health Home (IHH) or in Assertive Community Treatment (ACT). As well, the State has retained responsibility for establishing the payment rates that the Health Plans must pay for the specified procedures provided to IHH enrollees.

The risk-sharing arrangement will be structured as follows:

Risk Sharing Provisions	Plan Share of Expenses	State Share of Expenses
Where IHH Expenses are greater than 100% of Baseline	0%	100%
Gain Sharing Provisions	**Plan Share of Gain**	**State Share of Gain**
Where IHH Expenses are less than 100% of Baseline	0%	100%

Notes:

a. Baseline means one hundred percent (100%) of the **portion of the medical premium attributed to the Integrated Health Home (IHH) baseline revenue described "*Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)*".**
b. Risk Share/Gain share calculations are on an aggregate basis for all applicable Premium Rating Groups combined.

Additional details, definitions, methodology, calculation example, and **Baseline IHH Revenue PMPM** can be found in the document titled *"Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health (IHH)".*

Incentives

The State is implementing the following incentive programs, payments for which will be paid directly by Rhode Island Medicaid to the Medicaid MCO, upon MCO's satisfactory compliance with the performance measurements as described in the incentive programs. These payments will be made in addition to the capitation rates presented in this data book.

1. **Health System Transformation Program**

Through its *Health System Transformation Program Rhode Island* and its Medicaid MCOs shall support and incentivize a critical transformation of RI's system of care. The Program will award investments in performance-based infrastructure development by Medicaid Certified Accountable Entities (AE). Medicaid MCOs will be full partners in this transition, as the ultimate intent of this effort is to support the development of value-based contracts between the health plans and AEs.

Accountable Entities that meet state defined certification standards will initially apply for infrastructure funding to develop the governance, technology, skills and capacity to enter into risk-based contracts with Medicaid MCOs; manage enrollees' care across AE providers; and decrease out-year cost trend rates. Qualified AEs must meet one of three levels of readiness demonstrating that they either have or are developing the capacity to integrate and manage the full continuum of health care and to address members' social determinants (e.g., housing, food), in a way that is acceptable to CMS and the State.

The State shall reimburse the health plan for State-approved incentive payments that a health plan makes to providers making infrastructure investments to support this development of Accountable Entities. Up to 10 percent of the incentive payments may be retained by the health plan as an enhanced performance award to accelerate the development of value-based purchasing contracts with Accountable Entities.

Total payments made by all health plans cannot exceed the lesser of the maximum PMPM allocation indicated below or the maximum amount allocated by Rhode Island for the Health Systems Transformation Program within the Contract Period. Payments shall be distributed across the various Products (RIte Care, Substitute Care, Children with Special Healthcare Needs, Rhody Health Partners and Adult Expansion) based on the proportion of the Medicaid MCO's members associated with the AE being awarded the incentive payment.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $15.00 PMPM

2. Performance Goal Program

The *Performance Goal Program* establishes benchmark standards for quality and access performance measures. The Program advances quality improvement initiatives that focus on access to preventive care, access to care, chronic disease management, and behavioral health services for enrollees. The State awards incentive payments to the health plans based on their achievement against both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures).

Payments will be awarded in or around June of each year and based largely on prior Calendar Year performance; although some measurements may utilize other reporting periods as necessary. The Maximum award will be calculated as the product of total member months in contract period × indicated PMPM.

The maximum amount to be paid out on this program for this rate period will be $3.00 PMPM

3. Provider Incentive Program

The Provider Incentive Program awards providers who are actively building and strengthening their capacity to manage total cost of care and support value-based purchasing arrangement with the Medicaid MCO.
These State-approved incentive payments shall be awarded exclusively to support providers seeking to become a Certified Accountable Entity (AE).

The maximum available award across all products shall not exceed $4,000,000 within a fiscal year, pro-rated for the specified Contract Period. Any payment made to a Medicaid MCO under the *Provider Incentive Program* shall be allocated to product lines based on the ratio of product-specific capitation to total capitation paid to the Medicaid MCO.

Payment may be made by the State to the health plans throughout the Contract Period.

The maximum amount to be paid out on this program for this rate period will be $2.90 PMPM

The total maximum pay-out amount for all incentive programs is expected to be no more than **$20.90 PMPM**. When measured relative to the proposed capitation rates – estimated composite rates of **$502.07 PMPM** for non-profit plans and **$517.93 PMPM** for for-profit plans, the incentive payments plus the capitation rates are within the 105% threshold for certified rates.

RATE DEVELOPMENT

Table 4
Medicaid Expansion Rate Development

Medicaid Expansion Rate Period 7/1/2017 - 6/30/2018		
		PMPM
Encounter Data for claims incurred 7/1/2014 - 6/30/2015 (SFY '15), Paid through 11/30/2015, estimated @100%. Including Offline & G/L Adjustments		$ 420.99
Trend Assumptions - OHIC small group adjusted for medicaid mgd. care price trends		2.6%
Projection Period (years)		3.00
Projected PMPM		$ 454.69
Adjustments to Total PMPM		
Health Service Reclass [1]		$ 3.87
Gender Dysphoria [2]		$ 0.13
Care Transformation Collaborative (CTC) [6]		$ (0.59)
Program Initiative Savings:		
BH Services		$ (2.01)
ACO		$ (8.15)
Subtotal Adjustments		$ (6.75)
Subtotal Medical PMPM		$ 447.94
Fraud & Abuse (% of Medical)	1.0%	$ (4.48)
Net Medical PMPM		**$ 443.46**
Projected Admin Load PMPM for Rate Period		**$ 39.55**
Risk Margin	*1.5%*	**$ 7.36**
Projected Premium Before Taxes & Fees		**$ 490.37**
Assessment: Adult Immunization		***$ 1.66***
Projected Premium Before Taxes & Fees		**$ 492.03**
Non-Profit Capitation Rate:		
State Premium Tax for Non-Profit Plans	*2.0%*	$ 10.04
Estimated Rate Period Composite Capitation Rate for Non-Profit Plans		**$ 502.07**
For-Profit Capitation Rate:		
State Premium Tax for For-Profit Plans	*2.0%*	$ 10.36
Estimated ACA Issuer Fee [4]	*3.0%*	$ 15.54
Estimated Rate Preiod Composite Capitation Rate for For-Profit Plans	*0.950*	**$ 517.93**

[1] Based on UHC reporting. NHPRI did not report on Health Service Reclass, and is therefore assumed to be included in their reported administrative expense figures. Used UHC's reported reclass PMPM to include in the development of the Medical PMPM and to adjust NHPRI's reported administrative expense amount for the reclass amount accordingly. Reported admin re-class projected to rate period at 1.6% annualy as a proxy for wage increase

[2] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[3] Projected administrative load is on the MCO financial reporting of Operating Expenses for total RHP, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[4] ACA Issuer Fee estimate based on UHC estimate for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Rate Cells

Aggregate premium PMPM, including administration, assessments, fees and taxes were converted into capitation rates on a rate cell-basis with the use of age/gender factors. In a move to recognize the age/gender differences inherent in the experience, and in an effort to mitigate variances in the capitation rates from previous period's capitation rates and between rate cells, a blend of the age/gender factors was used. The blend was the average of the age/gender factors used in the SFY '16 rate development and the age/gender factors from the SFY 2015 experience reported by the plans – see Exhibit 6 in the Appendix. Future rate-setting will transition to developing the rates on a rate-cell basis.

Actuarial Certification

Certification of the Medicaid Expansion capitation rates for the rate period 7/1/2017 – 6/30/2018, and the certification for the incentive payments meeting the threshold of 105% of capitation rates, is provided under a separate cover by the actuarial firm of The Terry Group, in support of this data book.

4

APPENDIX

Medicaid Expansion

Rate Period 7/1/2017 - 6/30/2018

Aggregate Encounter Data Claims Experience

Incurred SFY 2015, Paid Through November, 2015, est. 100%

Type of Service Summary	RHE F 19-24 ME01	RHE F 25-29 ME02	RHE F 30-39 ME03	RHE F 40-49 ME04	RHE F 50-64 ME05	RHE M 19-24 ME06	RHE M 25-29 ME07	RHE M 30-39 ME08	RHE M 40-49 ME09	RHE M 50-64 ME10	Total
Inpatient	$ 2,495,504	$ 2,203,030	$ 3,622,612	$ 4,661,468	$ 12,291,351	$ 2,884,971	$ 4,556,528	$ 8,143,773	$ 9,986,905	$ 16,050,230	$ 66,896,372
Outpatient	$ 4,979,524	$ 3,426,322	$ 4,931,173	$ 8,640,192	$ 17,583,579	$ 3,292,465	$ 4,598,700	$ 6,684,895	$ 8,075,675	$ 13,086,002	$ 75,298,527
Professional	$ 5,206,851	$ 4,543,668	$ 5,887,664	$ 8,836,948	$ 18,329,775	$ 4,111,431	$ 5,697,403	$ 9,746,170	$ 10,500,302	$ 13,995,251	$ 86,855,461
Pharmacy	$ 2,353,999	$ 2,143,155	$ 2,780,918	$ 4,633,524	$ 11,189,497	$ 1,687,987	$ 2,643,442	$ 4,985,445	$ 6,219,246	$ 10,138,575	$ 48,775,787
Institutional	$ 13,197	$ 16,062	$ 8,875	$ 70,024	$ 576,171	$ 23,385	$ 18,698	$ 127,708	$ 355,741	$ 764,533	$ 1,974,394
Total	$ 15,049,073	$ 12,332,237	$ 17,231,243	$ 26,842,157	$ 59,970,373	$ 12,000,238	$ 17,514,771	$ 29,687,991	$ 35,137,868	$ 54,034,590	$ 279,800,541
Member Months	66,832	39,447	34,914	49,113	112,837	71,584	58,587	72,209	62,515	90,444	658,481
PMPM	$ 225.18	$ 312.63	$ 493.53	$ 546.54	$ 531.48	$ 167.64	$ 298.95	$ 411.14	$ 562.07	$ 597.44	$ 424.92
Plan Reported G/L Adjustments [1]											$ (3.93)
Net Base Period PMPM											**$ 420.99**

[1] Plan reported G/L adjustments include reinsurance expense and recoveries, pharmacy rebates, medical portion of subcapitation payments not reflected in claims experience; excludes administrative portion of behavioral health, pharmacy and DME subcapitations

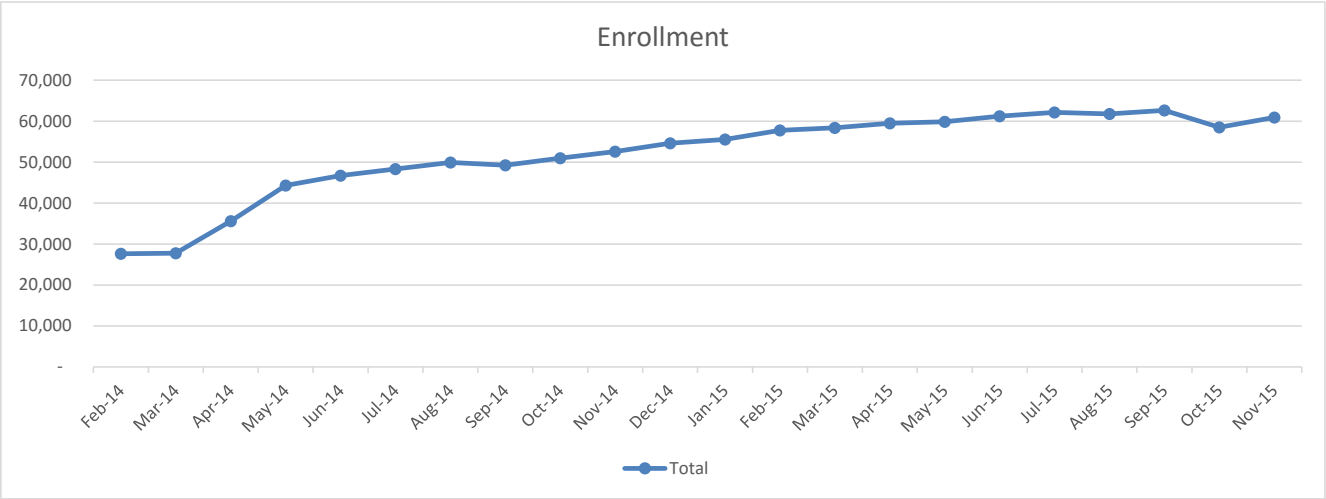
Medicaid Expansion
MCO-Reported Experience

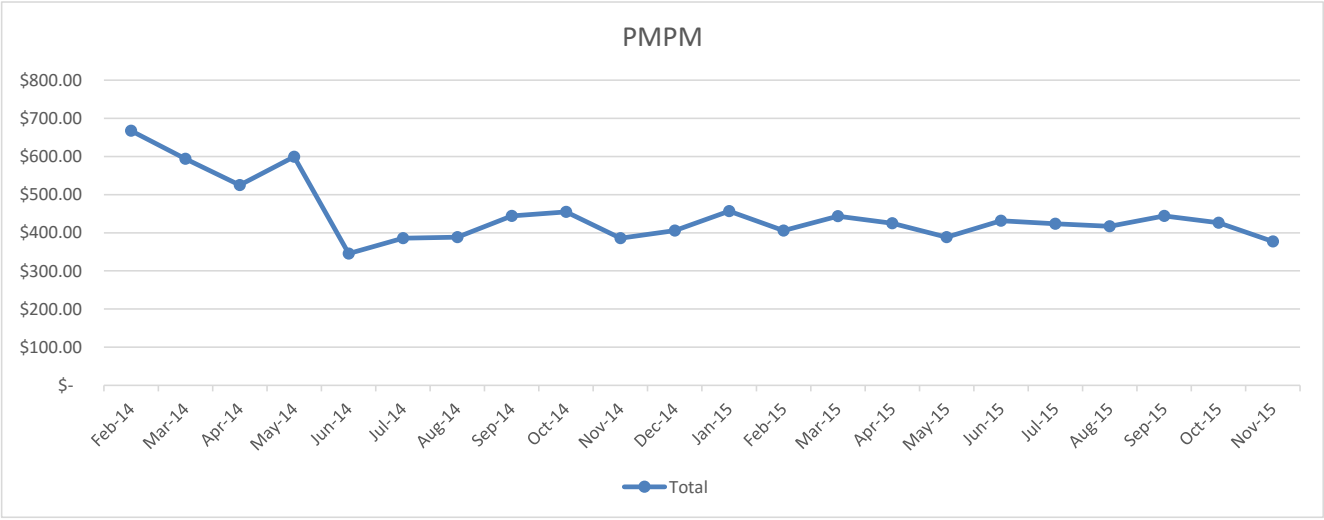
	Enrollment				PMPM*				Percent Diff./ Wtd. Avg. PMPM			
Month	MCO 1	MCO 2	Total	Month	MCO 1	MCO 2	Total		1/14-6/14	7/14-6/15	1/14-6/15	7/15-11/15
Feb-14			27,622	Feb-14			$ 667.33		26%		51%	
Mar-14			27,789	Mar-14			$ 593.84		12%		34%	
Apr-14			35,602	Apr-14			$ 525.07		-1%		19%	
May-14			44,312	May-14			$ 599.30		13%		36%	
Jun-14			46,711	Jun-14			$ 345.40		-35%		-22%	
Jul-14			48,289	Jul-14			$ 385.99			-8%	-13%	
Aug-14			49,893	Aug-14			$ 388.15			-7%	-12%	
Sep-14			49,231	Sep-14			$ 443.75			6%	0%	
Oct-14			50,933	Oct-14			$ 454.42			9%	3%	
Nov-14			52,560	Nov-14			$ 385.54			-8%	-13%	
Dec-14			54,601	Dec-14			$ 405.62			-3%	-8%	
Jan-15			55,560	Jan-15			$ 456.67			9%	3%	
Feb-15			57,763	Feb-15			$ 405.60			-3%	-8%	
Mar-15			58,390	Mar-15			$ 443.46			6%	0%	
Apr-15			59,485	Apr-15			$ 425.13			2%	-4%	
May-15			59,823	May-15			$ 388.37			-7%	-12%	
Jun-15			61,209	Jun-15			$ 431.31			3%	-2%	
Jul-15			62,139	Jul-15			$ 423.75					1%
Aug-15			61,765	Aug-15			$ 416.61					0%
Sep-15			62,630	Sep-15			$ 444.16					6%
Oct-15			58,474	Oct-15			$ 426.15					2%
Nov-15			60,896	Nov-15			$ 376.94					-10%
									$ 529.12	$ 418.14	$ 442.20	$ 417.63

Not Disclosed For Confidentiality Reasons

Not Disclosed For Confidentiality Reasons

* Monthly PMPMs were calculated from the **cumulative** monthly risk share reports including IBNR, and thus the derived monthly PMPMs may be distorted by preceding periods' IBNR





ARTICLE 5 (Excerpt)

Page	Line	Inpatient
15	1	(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until
	2	December 31, 2011, that the Medicaid managed care payment rates between each hospital and
	3	health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June
	4	30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month
	5	period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid
	6	Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the
	7	applicable period; (ii) provided, however, for the twenty-four (24) month period beginning July 1,
	8	2013 the Medicaid managed care payment rates between each hospital and health plan shall not
	9	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	10	**beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each**
	11	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	12	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital**
	13	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	14	**the Centers for Medicare and Medicaid Services national CMS Prospective Payment System**
	15	**(IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv)**
	16	The Rhode Island executive office of health and human services will develop an audit
	17	methodology and process to assure that savings associated with the payment reductions will
	18	accrue directly to the Rhode Island Medicaid program through reduced managed care plan
	19	payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode
	20	Island shall accept such payment rates as payment in full; and (vi) for all such hospitals,
	21	compliance with the provisions of this section shall be a condition of participation in the Rhode
	22	Island Medicaid program.

Page	Line	Outpatient
15	33	year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31,
	34	2011, that the Medicaid managed care payment rates between each hospital and health plan shall
16	1	not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
	2	increases in hospital outpatient payments for each annual twelve (12) month period beginning
	3	January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS
	4	Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period;
	5	(ii) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the
	6	Medicaid managed care outpatient payment rates between each hospital and health plan shall not
	7	exceed the payment rates in effect as of January 1, 2013 **and for the twelve (12) month period**
	8	**beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each**
	9	**hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the**
	10	**payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital**
	11	**payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 2016 may not exceed**
	12	**the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment**
	13	**System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable**
	14	**period.**

ARTICLE 5 (Excerpt)

Page	Line	Nursing Facilities
18	18	(vi) Adjustment of rates by the change in a recognized national nursing home inflation
	19	index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will
	20	not occur on October 1, 2013 **or October 1, 2015** but will ~~resume~~ **occur** on April 1, 2015. Said
	21	inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.
	22	(b) Transition to full implementation of rate reform. For no less than four (4) years after
	23	the initial application of the price-based methodology described in subdivision (a)(2) to payment
	24	rates, the executive office of health and human services shall implement a transition plan to
	25	moderate the impact of the rate reform on individual nursing facilities. Said transition shall
	26	include the following components:
	27	(1) No nursing facility shall receive reimbursement for direct care costs that is less than
	28	the rate of reimbursement for direct care costs received under the methodology in effect at the
	29	time of passage of this act; and
	30	(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate
	31	the first year of the transition. ~~The~~ An adjustment to the per diem loss or gain may be phased out
	32	by twenty-five percent (25%) each year; **except, however, for the year beginning October 1, 2015,**
	33	**there shall be no adjustment to the per diem gain or loss,** ~~gain during state fiscal year 2016~~, **but** ~~it~~
	34	~~may resume~~ **the phase out shall resume thereafter;** and
19	1	(3) The transition plan and/or period may be modified upon full implementation of
	2	facility per diem rate increases for quality of care related measures. Said modifications shall be
	3	submitted in a report to the general assembly at least six (6) months prior to implementation.
	4	**(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning**
	5	**July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section**
	6	**shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.**

Medicaid Expansion Rate Setting

Rate Period 7/1/2017 - 6/30/2018

Trend Assumption

Including the Impact of Article 5 on Selected Trends

Analysis of Encounter Data Including Offline & G/L Adjustments

7/1/14 - 6/30/15			Small Group CY '16 from OHIC [1,2]				Composite Trend Including Impact of Article 5				
							Avg. unit cost "price" trend for Rate Period [3]			Utilization - Small Group [2,4]	Composite Trend
TOS	PMPM	Pct. Total	Price	Util	Composite		RHP [3]	RIte Care	Wtd. Avg		
Inpatient	$ 105.90	24.6%	*2.8%*	*-1.7%*	*1.1%*		0.4%	-0.5%	-0.1%	-1.7%	**-1.8%**
Outpatient	$ 117.55	27.3%	*2.9%*	*2.1%*	*5.1%*		0.4%	0.4%	0.4%	2.1%	**2.5%**
Professional	$ 134.64	31.3%	*2.1%*	*0.3%*	*2.4%*		2.4%	1.1%	1.8%	0.3%	**2.1%**
Pharmacy	$ 68.99	16.0%	*4.2%*	*5.1%*	*9.5%*	1	5.7%	5.0%	5.4%	5.1%	**10.8%**
Inst. (NH & Hospice)	$ 2.96	0.7%	*2.8%*	*-1.7%*	*1.1%*	1	0.4%	1.4%	0.9%	-1.7%	**-0.8%**
Total	$ 430.04	100.0%	**2.9%**	**1.1%**	**4.0%**	2					**2.6%**
						Wt.	*0.5*	*0.5*	*1.0*		

[1] Rx Trend was presented as a composite only, assumed previously presented CY '15 price trend and backed into implied utilization trend. Institutional trends were not presented, therefore assumed same trends as inpatient.

[2] Small Group Trend estimate for CY '16 provided by OHIC, adjusted to reflect MA Expansion claims distribution

[3] Reference price trends are from RIte Care and RHP rate setting for same rate period, including impact of Article 5. RHP reference trends based on "Other Disabled" rate cells

[4] Trends to be applied to MA Expansion rating. Assumes that utilization for this population will be similar to commercial/small group while price will be subject to price controls set by the State for managed medicaid plans.

Medicaid Expansion
Rate Period 7/1/2017 - 6/30/2018
Gender Dysphoria

	Impact to PMPM
Estimated expenses per person for Gender Dysphoria surgical treatment [1]	$ 52,650
Projected per-person Gender Dysphoria surgical treatment for rate period [3]	$ 49,921
Number of persons estimated seeking surgical benefits [2]	2
Estimated total expenditures for Gender Dysphoria	$ 99,841
Rate Period estimated projected average enrollment	65,094
Estimated impact to Total Medicaid Expansion PMPM	$ 0.13

[1] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs are estimated by OHHS staff at $52,650 per person for SFY 2015, and is assumed not yet reflected in the base period experience. Related services, i.e. hormone and psycho-social therapies are assumed to be included in the current experience and in the base PMPM

[2] Based on EOHHS analysis of persons diagnosed with Gender Incongruence and/or Transsexualism for RIte Care, the incidence rate for which is assumed indicative for the Medicaid Expansion population for potential Gender Dysphoria surgical benefits. Analysis identified 13 average eligibles with such diagnoses, and potential surgeries were estimated at a conservative election for surgery of 1 in 10, rounded up to a whole number. Estimates are stated on an annualized basis

[5] Surgical treatment projected to rate period at the Article 5-impacted composite inpatient trend

Medicaid Expansion
Rate Period 7/1/2017 - 6/30/2018

		PMPM
Encounter Data for claims incurred 7/1/2014 - 6/30/2015 (SFY '15), Paid through 11/30/2015, estimated @100%. Including Offline & G/L Adjustments		$ 420.99
Trend Assumptions - OHIC small group adjusted for medicaid mgd. care price trends		2.6%
Projection Period (years)		3.00
Projected PMPM		$ 454.69
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Subtotal Medical PMPM		$ 447.94
Fraud & Abuse (% of Medical)	1.0%	$ (4.48)
Net Medical PMPM		**$ 443.46**
Projected Admin Load PMPM for Rate Period		**$ 39.55**
Risk Margin	*1.5%*	**$ 7.36**
Projected Premium Before Taxes & Fees		**$ 490.37**
Assessment: Adult Immunization		***$ 1.66***
Projected Premium Before Taxes & Fees		**$ 492.03**
Non-Profit Capitation Rate:		
State Premium Tax for Non-Profit Plans	*2.0%*	$ 10.04
Estimated Rate Period Composite Capitation Rate for Non-Profit Plans		**$ 502.07**
For-Profit Capitation Rate:		
State Premium Tax for For-Profit Plans	*2.0%*	$ 10.36
Estimated ACA Issuer Fee [4]	*3.0%*	$ 15.54
Estimated Rate Preiod Composite Capitation Rate for For-Profit Plans	*0.950*	**$ 517.93**

[1] Based on UHC reporting. NHPRI did not report on Health Service Reclass, and is therefore assumed to be included in their reported administrative expense figures. Used UHC's reported reclass PMPM to include in the development of the Medical PMPM and to adjust NHPRI's reported administrative expense amount for the reclass amount accordingly. Reported admin re-class projected to rate period at 1.6% annualy as a proxy for wage increase

[2] Gender Dysphoria treatment coverage is a Medicaid benefit. Surgical costs based on estimates from OHHS staff

[3] Projected administrative load is on the MCO financial reporting of Operating Expenses for total RHP, projected at Jan '16 CPI report for "Health Insurance" less "Medical Care Services"

[4] ACA Issuer Fee estimate based on UHC estimate for 2015

[6] CTC PMPM adjustment is associated with the graduation of the practice sites expected in the rate period, expressed as a reduction to what is currently reflected in the base period expenses

Medicaid Expansion

Rate Period 7/1/2017 - 6/30/2018

Including Implementation of Reinventing Medicaid Program Initiatives

Rate Cell		A/G Factor Used in SFY '16 Rates	A/G Factor Implied in Experience	**Average / Midpoint A/G Factor**
RHE F 19-24	ME01	0.7543	0.6972	**0.7258**
RHE F 25-29	ME02	1.0469	0.8454	**0.9461**
RHE F 30-39	ME03	1.2317	1.0550	**1.1433**
RHE F 40-49	ME04	1.4861	1.2523	**1.3692**
RHE F 50-64	ME05	1.6219	1.2786	**1.4502**
RHE M 19-24	ME06	0.5543	0.5272	**0.5408**
RHE M 25-29	ME07	0.6060	0.6898	**0.6479**
RHE M 30-39	ME08	0.9051	0.8014	**0.8532**
RHE M 40-49	ME09	1.2336	1.1530	**1.1933**
RHE M 50-64	ME10	1.6948	1.4128	**1.5538**

Rate Cell		A/G Factor [1]	Rate Period Forecast Enrollment	**Normalized A/G Factor [1]**	Non-Profit Plans: Medical	Non-Profit Plans: Admin + Risk Margin	Non-Profit Plans: Assess-ments [2]	Non-Profit Plans: State Prem. Tax	**Non-Profit Capitation Rates**	For-Profit Plans: Medical	For-Profit Plans: Admin + Risk	For-Profit Plans: Assess-ments [2]	For-Profit Plans: State Prem. Tax	For-Profit Plans: Est. ACA Issuer Tax	**For-Profit Capitation Rates**
RHE F 19-24	ME01	0.7258	6,728	**0.6805**	$ 301.78	$ 31.92	$ 1.13	$ 6.83	**$ 341.67**	$ 301.78	$ 31.92	$ 1.13	$ 7.05	$ 10.58	**$ 352.46**
RHE F 25-29	ME02	0.9461	4,020	**0.8872**	$ 393.42	$ 41.62	$ 1.47	$ 8.91	**$ 445.42**	$ 393.42	$ 41.62	$ 1.47	$ 9.19	$ 13.79	**$ 459.49**
RHE F 30-39	ME03	1.1433	3,418	**1.0721**	$ 475.42	$ 50.29	$ 1.78	$ 10.76	**$ 538.25**	$ 475.42	$ 50.29	$ 1.78	$ 11.11	$ 16.66	**$ 555.26**
RHE F 40-49	ME04	1.3692	4,379	**1.2839**	$ 569.34	$ 60.23	$ 2.13	$ 12.89	**$ 644.59**	$ 569.34	$ 60.23	$ 2.13	$ 13.30	$ 19.95	**$ 664.95**
RHE F 50-64	ME05	1.4502	10,591	**1.3598**	$ 603.03	$ 63.79	$ 2.26	$ 13.65	**$ 682.73**	$ 603.03	$ 63.79	$ 2.26	$ 14.09	$ 21.13	**$ 704.30**
RHE M 19-24	ME06	0.5408	7,318	**0.5071**	$ 224.86	$ 23.79	$ 0.84	$ 5.09	**$ 254.58**	$ 224.86	$ 23.79	$ 0.84	$ 5.25	$ 7.88	**$ 262.62**
RHE M 25-29	ME07	0.6479	6,067	**0.6075**	$ 269.41	$ 28.50	$ 1.01	$ 6.10	**$ 305.01**	$ 269.41	$ 28.50	$ 1.01	$ 6.29	$ 9.44	**$ 314.65**
RHE M 30-39	ME08	0.8532	7,589	**0.8001**	$ 354.79	$ 37.53	$ 1.33	$ 8.03	**$ 401.69**	$ 354.79	$ 37.53	$ 1.33	$ 8.29	$ 12.43	**$ 414.37**
RHE M 40-49	ME09	1.1933	6,031	**1.1189**	$ 496.20	$ 52.49	$ 1.86	$ 11.23	**$ 561.78**	$ 496.20	$ 52.49	$ 1.86	$ 11.59	$ 17.39	**$ 579.53**
RHE M 50-64	ME10	1.5538	8,953	**1.4569**	$ 646.08	$ 68.34	$ 2.42	$ 14.63	**$ 731.47**	$ 646.08	$ 68.34	$ 2.42	$ 15.09	$ 22.64	**$ 754.58**
Composite		1.0665	65,094	**1.0000**	$ 443.46	$ 46.91	$ 1.66	$ 10.04	**$ 502.07**	$ 443.46	$ 46.91	$ 1.66	$ 10.36	$ 15.54	**$ 517.93**
					check $ 443.46	$ 46.91	$ 1.66	$ 10.04	$ 502.07	$ 443.46	$ 46.91	$ 1.66	$ 10.36	$ 15.54	$ 517.93
					OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK

[1] A/G factors reflect the midpoint of the factors used in SFY '16 rate setting and the implied A/G factor from SFY '15 experience, normalized to achieve a risk factor of 1.0

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Yes, except for neonatal intensive care unit (NICU) services at Women and Infants Hospitals. Contractor shall be responsible for all clinical arrangements and support services required by the newborn following discharge from the NICU at Women and Infants Hospital.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Therapies	Covered as needed, based on medical necessity, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes
Family Planning Services	Enrolled female Members have freedom of choice of providers of family planning services.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Use – Outpatient& Inpatient	Covered as needed for all members including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community, or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations. Also includes, DCYF ordered administratively necessary days or hospital-based detox, MH/SUD residential treatment, Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.	Yes
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.	Yes
Preventive Services	Covered when ordered by a health plan physician. Services include: homemaker, minor environmental modifications, physical therapy evaluation and services, and respite	Yes
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered.	Yes, for Rite care subject to Stop-Loss provisions.
School-Based Clinic Services	Covered as Medically Necessary at all designate sites	Yes, For Rite Care
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.	Yes, except as defined in the contract.

Court-ordered mental health and substance use treatment – civil court	All Civil (Mental Health Court) Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-5, Mental Health Law, Section 40.1-5.5 must be followed. Note the following facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Court ordered treatment is exempt from the 30 day prior authorization requirement for residential treatment. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification	Yes, except as defined in the contract.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Podia try	Covered as ordered by Health Plan physician	Yes
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Yes
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Yes
Hosp ice Servi ces	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary, with the exception of Emergency Response Systems (ERS) and home modifications for Rhody Health Partners members	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Yes
Children's' Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	Yes
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes, subject to Stop-Loss limitations
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required "steps" such that all clients are provided with an Intake, Assessment, and Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.	
AIDS Medical Case Management	Medical Case Management services are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.	
Treatment for Gender Dysphoria	Comprehensive benefit package	Yes
Early Intervention	Covered for Rite care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.	Yes, for RIte Care Members, subject to Stop-Loss limitations
Habilitative Services	Covered as ordered by a health plan physician. Services include: Residential habilitation and day habilitation	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Rehabilitation Services	Physical, Occupational and Speech Therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.	Yes

THETERRYGROUP

STATEMENT OF ACTUARIAL OPINION

I, Thomas M. Donlon, am associated with the firm of The Terry Group, LLC. I am a Member of the American Academy of Actuaries and meet its General Qualification Standards to issue public statements of actuarial opinions, which include the development of capitated rates for state Medicaid programs. I have been involved in developing the State capitation rates for Rhode Island's State Medicaid Expansion Program for the 12-month period July 1, 2017 through June 30, 2018. The 12-month rates incorporate the implementation of Article 5 of The Reinventing Medicaid Act of 2015 effective July 1, 2015.

Capitation rates were developed for the following age-gender eligibility categories: Ages 19-24, 25-29, 30-39, 40-49, and 50-64, for both males and females.

I have examined the actuarial assumptions and actuarial methods used in determining the capitated payment rates as developed in the attached HealthCare Analytics report dated June 28, 2016. In my review of the capitation rate development, I have relied upon the following data provided by EOHHS and their contractors: Medicaid managed care encounter data, Medicaid eligibility data, estimated savings rates for the State's Reinventing Medicaid initiatives, operating expenses as reported by the participating managed care plans, risk sharing results as reported by the participating managed care plans, and other program documentation describing incentive programs, budget initiatives, and care management initiatives. I performed no audit as to the accuracy of these data. In other respects, my determination included such review of the actuarial calculations as I considered necessary in the circumstances.

In my opinion, the capitation rates developed in the report dated June 28, 2016:

1) Are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

2) Are based on actuarial assumptions which reflect historical program experience, and

3) Are in compliance with the regulations found at 42 CFR 438.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Thomas M. Donlon, FSA, MAAA
Principal
tom.donlon@terrygroup.com

June 30, 2016
Date

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