DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

May 9, 2023

Ms. Kristin Sousa
Medicaid Director
Rhode Island Executive Office of Health and Human Services
3 West Road, Virks Building
Cranston, RI 02920

Dear Ms. Sousa:

The Centers for Medicare & Medicaid Services (CMS) has approved the Evaluation Design for Rhode Island's Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Rhode Island Comprehensive Demonstration" (Project Number 11-W-00242/1).We sincerely appreciate the state's commitment to efficiently meeting the requirement for an Evaluation Design stated in the demonstration's Special Terms and Conditions (STCs) for this amendment, especially under these extraordinary circumstances.

The approved Evaluation Design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved Evaluation Design on Medicaid.gov.

Please note that, consistent with the approved Evaluation Design, the draft Final Report will be due to CMS 18 months after either the expiration of the demonstration approval period or the end of the latest rating period covered under the state's approved expenditure authority, whichever comes later.

We look forward to our continued partnership with you and your staff on the "Rhode Island Comprehensive" demonstration. If you have any questions, please contact your CMS project officer, Kathleen O'Malley, at Kathleen.OMalley@cms.hhs.gov.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2023.05.09 13:49:33 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Robert Townes, State Monitoring Lead, Medicaid and CHIP Operations Group

MCO Risk Mitigation COVID-19 PHE 1115 Waiver: Rhode Island Evaluation Plan

General Background Information

Effective retroactively to March 1, 2020, Rhode Island was given authority to operate its Medicaid program exempt from the regulatory prohibition in 42 C.F.R. 438.6(b)(1) in order to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

Through the provision of this demonstration opportunity, which provides an exemption allowing states to enter or modify a risk mitigation arrangement with a Medicaid managed care plan after the applicable rating period has begun, CMS aims to better understand the impact of retroactive risk sharing agreements on payments to plans. The rating periods that will be covered by this demonstration are July 1, 2020-June 30, 2021, July 1, 2021-June 30, 2022, July 1, 2022-June 30, 2023, and any future rating periods during which the PHE is in effect.

Historically, Rhode Island has used risk corridors to limit the gains and losses of its managed care organizations (MCOs) if actual medical expenses differ by more than a certain percentage from the baseline estimate of what medical expenses would be for the rating period in question. The State intends to continue this approach under 1115 Demonstration authority through the end of the Public Health Emergency (PHE). Before the regulatory prohibition in 42 C.F.R. 438.6(b)(1) was in place, Rhode Island's risk corridors were in some cases imposed "retroactively," in the sense that contacts between the state and MCOs, which define the risk corridors, were not formally executed before the start of the rating period and therefore would be applied retroactively to cover the arrangement from the first day of the rating period. Rhode Island understands that this is considered a retroactive risk corridor even in the case that the same risk corridor is applied for successive rating periods and is fully expected by all parties in advance of the new rating period and before the contacts are formally executed.

Rhode Island believes that the flexibility afforded by this demonstration during the PHE will help the state furnish medical assistance in a manner intended to protect individuals and providers affected by COVID-19, and it will also support learning by the state and CMS about the impact of these arrangements. For example, Rhode Island anticipates that, had the demonstration authority not been in place for the rating period ending June 30, 2021, the impact of COVID-19 on healthcare utilization would have led to greatly overstated payments to MCOs.

Research Questions

Like CMS, Rhode Island is interested in understanding the impact of the exemption on appropriate and equitable payments to Managed Care Organizations during a PHE. As such, Rhode Island seeks to answer the following research questions:

1. What problems does the state anticipate would have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems?
2. What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?
3. To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to managed care plans?

4. What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?

Methodology

Given the research questions' focus on more accurate payments to managed care plans, Rhode Island will utilize available data sets and reports to analyze the associated financial outcomes of the retroactive risk sharing agreements.

Rhode Island will utilize data from the relevant fiscal years to examine predicted medical expenditures assumed in the capitation rates versus actual spending subject to the shared risk agreement during the PHE. The differences between predicted and actual spending will be further analyzed to determine if that difference demonstrates that managed care plans were paid more accurately under the exemption than would have been paid without retroactive risk sharing.

Rhode Island anticipates that the outcomes of risk sharing will be shown to have resulted in overall savings in the state's Medicaid program.

Evaluation Design

This evaluation will assess the performance of the demonstration goals using a two-sided risk corridor arrangement based on the following:

State Fiscal Year 2021 (July 1, 2020-June 30, 2021)- RI Medicaid and CHIP Programs

The MCO capitation rates reflect a Baseline Medical Expenses (Baseline) estimate which measures the projected medical service costs. The risk corridor would limit MCO gains and losses if the Actual Medical Expenses differs by more than 3% from the Baseline estimate. The timeframe for this risk corridor shall be the period of July 2020 through June 2021.

Table 1 summarizes the share of gains and losses relative to the Baseline estimate for each party.

Table 1
Rhode Island Medicaid
Proposed risk Corridor Parameters

Risk Sharing Provisions	Plan Share of Risk	EOHHS Share of Risk
For Actual Medical Expenses between 100% and 103% of Baseline	100%	0%
For Actual Medical Expenses between 103% and 105% of Baseline	40%	60%
For Actual Medical Expenses greater than 105% of Baseline	10%	90%

The risk corridor will be implemented using the following provisions:

- The Baseline estimate includes Base Benefit Expenses plus Care Transformation Collaborative Expenses plus Care Coordination Expenses. The Baseline estimate does not include Administrative Cost Allowance, Risk Margin, Vaccine Assessment, or Premium Tax. The baseline medical amount is not reduced for the withhold amount. See MCO contract for additional detail.

- Actual Medical Expenses mean those benefits and services that the Contractor is obligated to provide and pay for during the Contract Period. Services that are not contractual requirements are not to be included in Medical Expenses. See MCO contract for additional detail.

State Fiscal Year 2022 (July 1, 2021-June 30, 2022)- RI Medicaid and CHIP Programs

The MCO capitation rates reflect a Baseline estimate which measures the projected medical service costs. The risk corridor would limit MCO gains and losses if the Actual Medical Expenses differs by more than 3% from the Baseline estimate. The timeframe for this risk corridor shall be the period of July 2021 through June 2022.

Table 2 summarizes the share of gains and losses relative to the Baseline estimate for each party.

Table 2
Rhode Island Medicaid
Proposed risk Corridor Parameters

Risk Sharing Provisions	Plan Share of Risk	EOHHS Share of Risk
For Actual Medical Expenses between 100% and 103% of Baseline	100%	0%
For Actual Medical Expenses between 103% and 105% of Baseline	40%	60%
For Actual Medical Expenses greater than 105% of Baseline	10%	90%

The risk corridor will be implemented using the following provisions:

- The Baseline estimate includes Base Benefit Expenses plus Care Transformation Collaborative Expenses plus Care Coordination Expenses. The Baseline estimate does not include Administrative Cost Allowance, Risk Margin, Vaccine Assessment, or Premium Tax. The baseline medical amount is not reduced for the withhold amount. See MCO contract for additional detail.

- Actual Medical Expenses mean those benefits and services that the Contractor is obligated to provide and pay for during the Contract Period. Services that are not contractual requirements are not to be included in the Actual Medical Expenses. See MCO contract for additional detail.

State Fiscal Year 2023 (July 1, 2022-June 30, 2023)- RI Medicaid and CHIP Programs

The MCO capitation rates reflect a Baseline Medical Expenses (Baseline) estimate which measures the projected medical service costs. The risk corridor would limit MCO gains and losses if the Actual Medical Expenses differs by more than 3% from the Baseline estimate. The timeframe for this risk corridor shall be the period of July 2022 through June 2023.

Table 3 summarizes the share of gains and losses relative to the Baseline estimate for each party.

Table 3 Rhode Island Medicaid Proposed risk Corridor Parameters		
Risk Sharing Provisions	**Plan Share of Risk**	**EOHHS Share of Risk**
For Actual Medical Expenses between 100% and 103% of Baseline	100%	0%
For Actual Medical Expenses between 103% and 105% of Baseline	40%	60%
For Actual Medical Expenses greater than 105% of Baseline	10%	90%

The risk corridor will be implemented using the following provisions:

- The Baseline estimate includes Base Benefit Expenses plus Care Transformation Collaborative Expenses plus Care Coordination Expenses. The Baseline estimate does not include Administrative Cost Allowance, Risk Margin, Vaccine Assessment, or Premium Tax. The baseline medical amount is not reduced for the withhold amount. See MCO contract for additional detail.

- Actual Medical Expenses mean those benefits and services that the Contractor is obligated to provide and pay for during the Contract Period. Services that are not contractual requirements are not to be included in Medical Expenses. See MCO contract for additional detail.

Evaluation Period

The evaluation will be conducted for the demonstration period of July 1, 2020 through June 30, 2023. Rhode Island Medicaid will monitor the progress of the demonstration for the risk corridor calculations.

For purposes of the evaluation, Rhode Island Medicaid will leverage the Financial Data Cost Report (FDCR) submitted by each plan as of 2022 Q3, which includes summaries of benefit expenditures by service category and premium rating group. This report includes an attestation as its accuracy and completeness. Additionally, on an annual basis, the managed care organizations include a reconciliation between benefit expenses as included in the FDCR to those reported on annual NAIC statements. EOHHS will supplement this information with detailed medical encounters submitted by the health plans and accepted into the State's MMIS, as noted below.

Sources of Data

The following sources of quantitative data will be used to calculate the Baseline and Medical Expenses:

1. Capitation payments, specifically the medical component of the rates
2. Medical encounters submitted by the health plans (and stored in the MMIS)
3. Financial Data Cost Reports submitted by the health plans
4. National Association of Insurance Commissioners (NAIC) Annual Statement
5. Risk Share Settlement Template

Analytic Methods

The state will calculate both the Baseline Medical and Actual Medical Expenditures for the MCOs participating in the Medicaid program. Utilizing those calculations and the distribution of costs for each MCO, of the state will compare those figures to the Baseline medical component of the capitation rates. The State will capture this data using the template found in Attachment A.

Anticipated Limitations

One of the limitations of the proposed evaluation is that differences between the actuarially certified medical baseline and the actual experience of each plan can be influenced by many factors. The base capitation rates are subject to actuarial judgement regarding what claims experience during the rating period will look like; this involves assumptions around changes in utilization, both underlying and due to the PHE, program changes, enrollment changes to the extent to which the actuary feels it will have an impact on overall acuity, among many others. Further, when creating the risk adjusted capitation rates, EOHHS's actuaries utilize a membership snapshot combined with claims experience from a prior period to assign risk scores to members in each plan using the CDPS +MRx model. In addition to the changes in utilization of services due to the PHE, utilization of services and member acuity can differ from the base period for many reasons; further, beneficiaries can choose to enroll in a different plan throughout the course of a fiscal year which does not result in a rebasing of the overall risk scores used to create rates for each plan.

Timeline for Submission

Evaluation Design
This Evaluation Design template is required to be submitted to CMS for review and approval no later than 180 days after the receipt of the demonstration approval letter, or by July 17, 2022.

Final Report
The draft of the Final Report for this demonstration project must be submitted to CMS for review and approval no later than 18 months after either the expiration of the demonstration approval period or the end of the latest rating period covered under the state's approved expenditure authority, whichever comes later. Assuming the PHE is not extended past April 11, 2023, the expected timeframe for this submission is on or before October 11, 2024.

ATTACHMENT A

FY 2021 Risk Share Settlement - FINAL Status:

Summary

MCO: PLAN NAME

SFY 2021

Plan Reporting

Reporting through: **Paid Through Q3 2022 FDCR - September 30, 2022**

	2021	2021	2021	2021	
MCO	**UHC**	**UHC**	**UHC**	**UHC**	
PRODUCT	**Core**	**CSHCN**	**RHP**	**Expansion**	**TOTAL**
Medical Premium					
Medical Expense (FDCR)					
Adjustments:					
[1] Less Claims Paid > 365 Days (Excluding Inpatient/Outpatient)					
[2] Less Reserves (end of 12 month run-out)					
[3] Less Accrued Provider Settlements (end of 12 month run-out)					
[4] Less CC Expenditures Above Funded Amt					
[5] Plus FQHC Subcapitated (Subcap - Proxy Paid)					
Net Medical Expense Recognized (Risk Share)					
Medical Premium Above / (Below) Medical Expense	$ -	$ -	$ -	$ -	$ -
Gain / (Loss) on Medical Premium	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	*#DIV/0!*	
Calculation of Risk Share Payment					
105.0%	$ -	$ -	$ -	$ -	
103.0%	$ -	$ -	$ -	$ -	
97.0%	$ -	$ -	$ -	$ -	
95.0%	$ -	$ -	$ -	$ -	
Risk Share Pool					
Excess of 105%	-	-	-	-	
Between 103%-105%	-	-	-	-	
Baseline and 103%	-	-	-	-	
Baseline and 97%	-	-	-	-	
Between 95% and 97%	-	-	-	-	
Under 95%	-	-	-	-	
	$ -	$ -	$ -	$ -	
	TRUE	*TRUE*	*TRUE*	*TRUE*	
EOHHS Share of Risk Pool					
Excess of 105%	90%	90%	90%	90%	
Between 103%-105%	60%	60%	60%	60%	
Baseline and 103%	0%	0%	0%	0%	
Baseline and 97%	0%	0%	0%	0%	
Between 95% and 97%	60%	60%	60%	60%	
Under 95%	90%	90%	90%	90%	
EOHHS Payment/ (EOHHS Recoupment)	$ -	$ -	$ -	$ -	$ -