

Cardinal Care Managed Care

FY2025 Rate Book

Commonwealth of Virginia

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Section 1

Introduction

In partnership with the Commonwealth (Commonwealth) of Virginia's Department of Medical Assistance Services (DMAS), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, produced the *FY2025 Cardinal Care Managed Care Rate Book Narrative.pdf* and the *FY2025 Cardinal Care Managed Care Procurement Rate Book Exhibits.xlsx* (collectively referred to as the Rate Book) to provide an estimate of the fiscal year (FY) 2025 capitation rates from the Commonwealth's Medicaid managed care program for usage by potential bidders as part of the Cardinal Care Managed Care Request for Proposal (RFP) #13330.

Individuals eligible for Cardinal Care Managed Care fall within one of the following population groups, as further described in this Rate Book: Acute, Family Access to Medical Insurance Security (FAMIS)/FAMIS MOMS, and Managed Long-Term Services and Supports (MLTSS).

In producing this Rate Book, Mercer has relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data, and information supplied by the Commonwealth and its vendors. The Commonwealth and its vendors are solely responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness but did not audit it. In our opinion, the data used for the Rate Book is appropriate for the intended purpose. However, if the data and information are incomplete/inaccurate, the values shown in this Rate Book may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this Rate Book.

The FY2025 rate development is leveraging actuarial and financial analyses that were performed for the purposes of the FY2024 draft rate development as of March, 2023. The FY2025 rate projection has been modified from the FY2024 draft rate projection to reflect additional trend months, revised trend assumptions, and to reflect DMAS's projected enrollment/demographic mix. These rates are estimates only and do not constitute actuarially sound capitation rates.

The user of this Rate Book is cautioned against relying solely on the data contained herein. The Commonwealth and Mercer provide no guarantee, either written or implied, that this Rate Book is 100% accurate or error-free.

This Rate Book was prepared on behalf of the Commonwealth and is intended to be relied upon by the Commonwealth for providing potential bidders, and any other parties the Commonwealth deems appropriate as part of the Cardinal Care Managed Care RFP process, with information related to the capitation rate development process and estimated reimbursement rates for FY2025.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this Rate Book by third parties or the consequences of any unauthorized use or disclosure other than as mutually contemplated when Mercer was first retained to perform this work.

Section 2

General Information

Rate Development Overview

This section provides an overview of the process and the adjustments Mercer applies in the capitation rate development process to ensure capitation rates reflect the State's managed care goals, objectives, and policies for the Cardinal Care Managed Care program. The calendar year (CY) 2021 base data time period was utilized for the preliminary rate development. More recent available enrollment data, encounter data, and managed care organization (MCO) financial reports were also reviewed and utilized for the development of the preliminary FY2025 rates.

Mercer applied the following adjustments to the CY2021 base data:

- Base data adjustments: Adjustments to the base period data that do not reflect changes in MCO requirements (for example, claims completion factors). This is detailed further in the FY2025 Cardinal Care Managed Care Procurement Data Book Narrative.
- Base program changes not reflected in the base data: Adjustments to the base period data that reflect changes in MCO requirements (for example, fee schedule changes).
- Trend: Factors to forecast expenditures and utilization from the base period to the contract period.
- Prospective program changes: Adjustments to the contract period data that reflect changes in MCO requirements (for example, new covered benefits) and other changes expected to occur between the base period and contract period.

The FY2025 contract period is expected to be impacted by the Coronavirus Disease 2019 (COVID-19) pandemic. Additional explicit adjustments are applied to reflect the impact of the COVID-19 pandemic including:

- Testing and treatment
- Public Health Emergency (PHE) enrollment acuity adjustment

Once the preliminary FY2025 projected medical costs are developed, adjustments are applied to reflect various non-benefit cost components of the draft capitation rates. These adjustments are discussed in more detail in subsequent sections of this report and include:

- Administration expense
- Care management
- Underwriting gain

The capitation rates for the MLTSS Nursing Home (NH) and Elderly or Disabled with Consumer Direction (EDCD) waiver populations are blended utilizing a projected FY2025 enrollment mix. ¹

¹ On July 1, 2017, Virginia received approval from the Centers for Medicare and Medicaid Services (CMS) to operate the Commonwealth Coordinated Care Plus (CCC Plus) Home and Community Based Care (HCBS) Waiver. The CCC Plus HCBS waiver replaces the EDCD and Technology Assisted Waivers and has two (2) benefit plans: without private duty nursing (formerly the EDCD Waiver) and with private duty nursing (formerly the Technology Assisted Waiver). The Cardinal Care Managed Care Contract refers to these populations under the CMS approved waiver name and benefits, CCC Plus HCBS Waiver with PDN and without PDN.

Section 3

Prospective Rate Development

Base Program Changes

Historical program change adjustments recognize the impact of benefit, reimbursement or eligibility changes occurring prior to the beginning of the contract period. Adjustments for historical base program changes were applied to bring each year of data to a consistent time period. The Base Program Changes listed below were originally developed for the purposes of the rate development for the FY2024 contract period, but have been maintained for the illustration of the FY2025 rate development process. The adjustments listed below are items currently known as of the date of this report and are subject to change at Mercer and DMAS's discretion.

Fee Schedule Changes

- **Freestanding Inpatient Psychiatric Hospital Reimbursement Changes:** Effective July 1, 2021 and July 1, 2023, inflation adjustments were made to reimbursement for freestanding inpatient psychiatric hospital services due to fee-for-service (FFS) fee schedule changes. Effective July 1, 2022, an increase was made to account for inflation and hospital rebasing changes.
- **Inpatient Hospital Reimbursement Changes:** Effective July 1, 2021 and July 1, 2023, inflation adjustments were made to reimbursement for inpatient hospital services due to FFS fee schedule changes. Effective July 1, 2022, an increase was made to account for inflation and hospital rebasing changes.
- **Inpatient Hospital — Children's Hospital of The King's Daughters (CHKD) Reimbursement Changes:** Effective July 1, 2021 and July 1, 2023, inflation adjustments were made to reimbursement for inpatient CHKD services due to FFS fee schedule changes. Effective July 1, 2022, an increase was made to account for inflation and hospital rebasing changes.
- **Outpatient Hospital Reimbursement Changes:** Effective July 1, 2021 and July 1, 2023, inflation adjustments were made to reimbursement for outpatient hospital services due to FFS fee schedule changes. Effective July 1, 2022, an increase was made to account for inflation and hospital rebasing changes.
- **Outpatient Hospital — CHKD Reimbursement Changes:** Effective July 1, 2021 and July 1, 2023, inflation adjustments were made to reimbursement for outpatient CHKD services due to FFS fee schedule changes. Effective July 1, 2022, an increase was made to account for inflation and hospital rebasing changes.
- **Outpatient — Rehab Services:** Effective July 1, 2021, July 1, 2022, and July 1, 2023, increases were made due to inflation.
- **Type One Hospitals** Effective July 1, 2021 and July 1, 2023, inflation adjustments were made to reimbursement for outpatient hospital services due to FFS fee schedule

changes. Effective July 1, 2022, an increase was made to account for inflation and hospital rebasing changes.

- **Critical Access Hospitals (CAH):** Effective July 1, 2021, and July 1, 2023 increases were made due to inflation. Effective July 1, 2022, an increase was made to inpatient services and outpatient services to account for inflation and hospital rebasing changes.
- **Physician — Adult Primary Care:** Effective July 1, 2022, an increase was made for adult primary care services.
- **Physician — Child Primary Care:** Effective July 1, 2022, an increase for child primary care services was applied.
- **Physician — Psychiatric Services:** Effective July 1, 2021, an increase for psychiatric services was applied to increase reimbursement up to 110% of Medicare. Additionally, effective July 1, 2022, an additional increase was applied for psychiatric services.
- **Physician — OBGYN Services:** Effective July 1, 2022, an increase for obstetrics and gynecology services was applied.
- **Physician — Children Vision Services:** Effective July 1, 2022, an increase for vision services for children under 21 years of age was applied.
- **Anesthesiologist Services:** Effective July 1, 2021 Virginia increased Medicaid reimbursement for anesthesiologists to 70% of the equivalent Medicare rate in the fee for service and managed care programs. An increase to anesthesiologist services was applied to reflect the managed care impact of increasing reimbursement for physicians who were reimbursed less than 70% of Medicare rates.
- **Personal Care and Respite Care Adjustment:** Effective May 1, 2021, January 1, 2022, and July 1, 2022, increases were made to reimbursement for personal care and respite care services.
- **Extension of Temporary 12.5% Fee Increase Related to ARPA:** On March 11, 2021, President Biden signed into law the American Rescue Plan Act of 2021 (ARPA). Section 9817 of ARPA Increases the Federal Medical Assistance Percentage for certain Medicaid home- and community-based services (HCBS) services from April 1, 2021 through March 31, 2022.

Effective July 1, 2021, through June 30, 2022, DMAS temporarily increased the rates for all HCBS, except that for agency and consumer directed personal care, respite, and companion services in the HCBS waivers and Early Periodic Screening, Diagnosis and Treatment program.

Effective July 1, 2022, DMAS temporarily extended the increase rates in effect prior to July 1, 2021 for certain HCBS including Adult Day Health Care, Crisis Supervision/Support, Mental Health and Early Intervention Case Management, and Community Behavioral Health and Habilitation services.

- **Resource-Based Relative Value Scale (RBRVS) Adjustment:** Effective July 1, 2021, an RBRVS rebasing change was made.

- **NF Adjustment:** Applicable to the Cardinal Care Managed Care - MLTSS population group only. Effective July 1, 2022 and July 1, 2023, increases were made to reimbursement for nursing facility (NF) services due to FFS fee schedule changes. Additionally, effective July 1, 2021, regional increases to NF services were made.
- **Skilled and Private Duty Nursing:** Applicable to the Cardinal Care Managed Care - MLTSS population group only. Effective July 1, 2021, Virginia will increase Medicaid reimbursement for skilled and private duty nursing to 80% of the benchmark rate developed by DMAS. Additionally, effective July 1, 2022, an increase was made to reimbursement due to FFS fee schedule changes.
- **Home Health Adjustment:** Applicable to Cardinal Care Managed Care - MLTSS population group only. Effective July 1, 2021, July 1, 2022, and July 1, 2023, increases were made to reimbursement for home health services due to FFS fee schedule changes.
- **Durable Medical Equipment (DME):** Effective July 1, 2021 Virginia will require MCOs to reimburse at no less than 90% of the state Medicaid fee schedule for durable medical equipment. An increase to the DME category of service (COS) was applied to reflect the impact of this minimum reimbursement requirement.

Applied Behavior Analysis

Effective December 1, 2021, the Commonwealth implemented American Medical Association coding logic for use in reporting applied behavior analysis (ABA) services. Mercer subsequently applied an adjustment that reflects the fee schedule developed in accordance with the revised coding logic.

Behavioral Health Redesign

Beginning July 1, 2021 Virginia's behavioral health system underwent a multiple-phase realignment of services to ensure that the system supports evidence-based, trauma-informed, prevention focused, and cost-effective services for individuals. The first phase-in began on July 1, 2021 with the implementation of Assertive Community Treatment (ACT), Intensive Outpatient Program (IOP), and Partial Hospitalization Program (PHP), followed by Multi-system Treatment (MST), Functional Family Therapy (FFT), and Crisis enhancement effective December 1, 2021.

COVID-19 Testing and Treatment

As a result of the COVID-19 pandemic, additional costs are projected to occur in the FY2025 contract period related to the testing and treatment of COVID-19. The final adjustment applied to the FY2025 rates represents the difference in COVID-19 testing and treatment levels in the base period and the projection period.

Trend

Trend is an estimate of the change in overall cost of providing health care benefits over a finite period of time and is necessary to estimate the cost of providing health care services in a future period. Mercer has utilized information from the Cardinal Care Managed Care FY2024 rate development process and maintained certain assumptions for the purposes of estimating FY2025 capitation rates.

As part of Mercer's trend development process, Mercer reviewed detailed historical encounter data summarized by month of service and grouped by major COS and population type. The historical experience for the populations and services that are covered under the Cardinal Care Managed Care - Acute, FAMIS, and MLTSS population groups were the primary data sources used for the trend analysis, as it reflects the Commonwealth's specific Medicaid environment, including medical management practices, network construction, and population risk.

Mercer's trend analysis takes into account the impact of other rating adjustments that may be addressed elsewhere in the rate development, so as to prevent any duplication of its impact in trend development. To further supplement the trend analysis, Mercer reviewed information from proprietary work with other states' Medicaid programs, publicly available reports on general health expenditure trend and Medicaid trends, and Bureau of Labor Statistics Consumer Price Index medical trend information.

Prospective Program Changes

The Commonwealth and Mercer reviewed and applied program changes that would have a material impact on the cost and utilization that occur during the FY2025 contract period. The Prospective Program Changes listed below were originally developed for the purposes of the rate development for the FY2024 contract period. All adjustments have been maintained for the illustration of the FY2025 rate development process, with the exception of COVID-19 PHE Enrollment Acuity Adjustment (for both Acute and MLTSS population groups) and Third Party Liability Mix Adjustment for Cardinal Care Managed Care – Acute only, which were updated to reflect DMAS's projected enrollment/demographic mix for the FY2025 contract period. The adjustments listed below are items currently known as of the date of this report and are subject to change at Mercer and DMAS' discretion.

Pharmacy Rebates Adjustment

Mercer applies adjustments to projected pharmacy expenditures to reflect the rebates retained by the Cardinal Care Managed Care MCOs with their respective pharmacy benefit manager (PBM). The rebate assumptions applied to the FY2025 rates were based on industry intelligence and professional assessment of marketplace competition and rebating activity.

Common Core Formulary

Effective January 1, 2022, the Common Core Formulary underwent changes to reflect drugs and treatments to be included in closed and open classes as approved by the Pharmacy and Therapeutics Committee. An analysis was completed by reviewing potential shifts in utilization to determine the impact of these changes.

Maternity Kick Population Adjustment

One statewide Maternity Kick per-member-per-delivery (PMPD) payment rate is developed for the Cardinal Care Managed Care - Acute, FAMIS, FAMIS MOMS and MLTSS population groups and applied to both the Non-Expansion and Expansion populations. Previously, only the Non-Expansion Maternity Kick encounter data was used in the calculation due to limited experience for the Expansion population. Given the Expansion population now has multiple

years of experience, Mercer has included an adjustment to reflect the slightly higher observed PMPD experience for Expansion.

COVID-19 PHE Enrollment Acuity Adjustment

To account for the impact of the unwinding Maintenance of Effort (MOE) requirements, Mercer has applied a rating adjustment to reflect changes in the underlying population acuity between the base and projection periods that are expected as a result of increased terminations of lower acuity members.

High Cost Drug Adjustment

Additional adjustments were necessary to account for additional potential utilization above and beyond what is accounted for in pharmacy trend and historical experience for gene therapies anticipated to be available in FY2025. These high cost drugs are less likely to be billed and paid through the pharmacy benefit and additional adjustments beyond pharmacy trend were considered to capture the full potential cost.

NH Per Diem Add-On

Applicable to the Cardinal Care Managed Care - MLTSS population group only. DMAS will increase provider payment rates for NFs and specialized care providers by \$6.41 per person per day.

Third Party Liability Mix Adjustment

Applicable to the Cardinal Care Managed Care - Acute and FAMIS/FAMIS MOMS population groups only. The Cardinal Care Managed Care program covers members with comprehensive private insurance as the primary payer. These members are referred to as "Major TPL" and typically have lower claim costs relative to members without any third party insurance. As such, an explicit program change is necessary to reflect the anticipated changes in the non-third-party liability (TPL) and TPL enrollment distribution that may occur between the base and contract period. To develop the adjustment, Mercer calculated historical PMPM relativities between non-TPL and TPL using incurred experience. Mercer compared the non-TPL and TPL historical enrollment distribution to projected distribution to develop the adjustment.

Medicaid Eligibility during Hospitalization

Applicable to the Cardinal Care Managed Care - Acute and FAMIS/FAMIS MOMS population groups only. For the Cardinal Care Managed Care - Acute population group, individuals with FFS coverage, who were hospitalized at the time of managed care assignment, were maintained as FFS until date of discharge. Under Cardinal Care Managed Care, these individuals will be assigned to the appropriate managed care rate cell and all professional and ancillary expenditures will be the responsibility of the MCO. The full hospital claim will continue to be paid through FFS including all diagnosis related group outlier claims. To determine the impact of this provision, DMAS provided a listing of individuals who had previously been reverted to FFS coverage at the time of hospitalization. Mercer summarized historic professional and ancillary expense along with the impact to member months. This adjustment reflects the cost differences of members impacted by this policy change.

Newborns of MLTSS Mothers Enrolling in Acute Care

Applicable to the Cardinal Care Managed Care - Acute population group only. Under Cardinal Care Managed Care, MCOs will be required to cover the cost for newborns of mothers who are enrolled in Cardinal Care Managed Care - MLTSS population groups back to their date of birth. Previously, the cost for these newborns were covered in FFS until an application for Medicaid enrollment was received. To inform the adjustment, Mercer summarized historic claims for the impacted population and developed an adjustment to the 'LIFC Under 1' rate cell for the IP – Newborn and Physician – Evaluation & Management categories of service.

FAMIS MOMS Post-Partum Extension

Applicable to the Cardinal Care Managed Care - FAMIS and FAMIS MOMS population groups only. Effective November 2021, the postpartum coverage for members in FAMIS MOMS was extended from two months postpartum to 12 months postpartum. Mercer applied an adjustment that accounts for the extension of postpartum coverage for the FY2024 rating period. Because the PMPMs during the extended period are lower than the prior coverage period, the addition of these coverage months results in a downward impact to the average rate for FAMIS MOMS.

Non-Benefit Expenses

The actuarially sound capitation rates developed include a provision for MCO non-benefit expenses, which include administration expenses, care management, and underwriting gain. These expenses are essential to ensure proper functioning of the MCO business operations during the course of administering care to the Cardinal Care Managed Care populations. The Non-Benefit Expenses developed were originally developed for the purposes of the rate development for the FY2024 contract period but have been maintained for the illustration of the FY2025 rate development process.

Administration

Mercer utilizes the historical administrative expense incurred in the Cardinal Care Managed Care - Acute, FAMIS and MLTSS population groups as the starting point for administrative expense development and projects an estimate for reasonable administrative expenses expected to be incurred in future periods. Mercer considers items such as staffing changes due to contractual requirements, wage inflation, and other market factors that may impact MCO overhead costs when developing the prospective administrative expenses.

Care Management

Applicable to the Cardinal Care Managed Care MLTSS population group only. Mercer includes additional non-benefit expenses related to care management, which allows MCOs to eliminate unnecessary medical expenses. Mercer utilizes the care management expenses reported by the MCOs and considers items such as wage inflation, population growth and changing contractual requirements for developing prospective care management expenses.

Underwriting Gain

Actuarial soundness requires that capitation rates consider all necessary and reasonable costs the MCO incurs to satisfy the terms of the contract. Mercer develops an underwriting

gain component expressed as a percentage of the premium rate that provides for the cost of capital and a margin for risk appropriate for the covered populations under the Cardinal Care Managed Care program.

Section 4

Risk Mitigation, Risk Sharing and Withholds

This sections below describes the risk adjustment process, risk-sharing mechanism, and incentive arrangements the Commonwealth currently employs for Cardinal Care Managed Care populations. DMAS and Mercer intend to review each risk-sharing provision to ensure that the programs align with DMAS' goals and objectives for the Cardinal Care Managed Care program and are subject to change at DMAS's discretion.

Risk Adjustment

Risk adjustment is not applied to FAMIS or FAMIS MOMS.

Within the Cardinal Care Managed Care - Acute and MLTSS population groups, capitation rates for the LIFC Adult, LIFC Child, Non-Medically Complex Expansion, Medically-Complex Expansion and 'Community Non-Dual >1' rate cells are currently subject to risk adjustment utilizing the combined Chronic Illness and Disability Payment System and Medicaid Rx (CDPS+Rx) risk adjustment model. The CDPS+Rx model utilizes demographic, diagnostic, and pharmacy data to classify individuals into demographic and disease categories that are used to predict the health care expenditures for each individual.

Within the Cardinal Care Managed Care - MLTSS population group, the behavioral health portion of the capitation rates for the 'Community Duals < 65' and 'Community Duals 65+' rate cells are currently risk-adjusted. The behavioral health portion of the capitation rates is risk-adjusted leveraging the Clinical Classifications Software Refined diagnostic grouper. For the purposes of the behavioral health risk adjustment process, behavioral health services are defined as the Community behavioral health, Addiction and Recovery Treatment Services, Case Management Services, and Early intervention COS lines. The model utilizes demographic and diagnostic data from behavioral health records to classify individuals into model categories to predict behavioral health care expenditures for each individual.

Note that both risk adjustment processes described in this document are budget neutral, such that total projected dollars are the same both prior to and after the application of the risk adjustment processes.

Risk-Sharing Mechanisms

The Cardinal Care Managed Care contract currently includes a pharmacy reinsurance pool that is intended to mitigate risk associated with excessive pharmacy claims between MCOs. This reinsurance pool is budget-neutral overall and funds will be redistributed between MCOs after the rating period based on actual pharmacy claims exceeding the \$200,000 attachment point are known.

The MCOs are subject to both a minimum medical loss ratio (MLR) and a limit on underwriting gain. These provisions will apply on a combined basis across the Expansion and Non-Expansion populations in the Cardinal Care Managed Care - Acute and MLTSS

population groups and will only include revenue and expense experience applicable to enrolled members included under the Cardinal Care Managed Care contract. The MLR is calculated first followed by the calculation of the underwriting gain limit.

The MCOs are required to report MLR calculations to DMAS subsequent to the end of the contract period, using a formula and methodology in accordance with 42 CFR §438.8. As further directed by DMAS, the MCOs shall maintain a minimum MLR of 85% in aggregate for the MCO's enrollee population. If the MCO does not maintain such minimum, the MCO is required to remit an amount equal to the deficiency percentage applied to the amount of adjusted premium revenue.

Finally, the MCOs are subject to a maximum underwriting gain for the contract period. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income earned for each respective contract period. If the underwriting gain percentage for the applicable contract period exceeds 3% then the Contractor shall make payment to the Department equal to one-half of the underwriting gain in excess of 3% of Medicaid premium income up to 10%. The Contractor shall return 100% of the underwriting gain above 10%. Such amount will be remitted to DMAS as a refund of an overpayment. DMAS has implemented the underwriting gain limit as a cost-control strategy. The underwriting gain limit has been developed in accordance with generally accepted actuarial principles and practices. The underwriting gain limit does not have an effect on the development of the capitation rates.

Incentive Arrangements

Incentive arrangements are defined under 42 CFR §438.6(a) as “any payment mechanism under which an MCO may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.” Payments under these arrangements must not exceed 105% of the approved capitation payment. The Commonwealth implemented the MLTSS Discrete Incentive Transition program on July 1, 2019 and is still in effect. The MLTSS Discrete Incentive Transition Program provides financial rewards for MCOs that successfully transition complex members residing in a NF to a home- and community-based setting for a sustained period. DMAS will reward MCOs when these transitions result in better care outcomes and quality of life for members. MCOs will receive a one-time payment of \$7,500 for each successful transition accomplished under the program.

Withhold Arrangements

Withhold arrangements are defined under 42 CFR §438.6(a) as “any payment mechanism under which a portion of a capitation rate is withheld from an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract.” The Cardinal Care Managed Care program has historically included provisions for the Performance Withhold Program (PWP) and the Clinical Efficiency (CE) Performance Withhold during the prior contract periods and will evaluate any changes to withhold arrangements applicable to the new contracts.

PWP

The PWP is established using a 1.0% withhold applied to the capitation payments made to the MCOs to incentivize health outcomes and quality of care. For the FY2024 PWP, MCO

performance will be evaluated on seven National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures (14 measure indicators), one Agency for Healthcare Research and Quality and Pediatric Quality Indicator (AHRQ PDI) measure (one measure indicator), and two CMS Core Set of Adult Health Care Quality Measures for Medicaid (CMS Adult Core Set) measures (two measure indicators). The measures will be evaluated across the Cardinal Care Managed Care programs. The MCOs will earn back withheld funds based on performance in accordance with the methodology established by the DMAS External Quality Review Organization.

Mercer reviewed the PWP design specifications and terms that dictate how the MCOs can earn back the withhold. Based on review of available data that showed historical MCO performance on the HEDIS measures, improvement bonus criteria and the report only requirement for the AHRQ PDI and CMS Adult Core Set, Mercer determined the PWP metrics provide the MCOs the opportunity to earn back the full withhold during the contract period. As a result, no adjustments to the capitation rates have been made for a portion of the withhold that is not reasonably attainable.

CE Performance Withhold

An additional CE performance withhold is established using a 0.25% withhold applied to the capitation payments made to the MCOs to address performance improvements in potentially preventable ER visits, acute inpatient 30-day readmissions, and potentially preventable admissions. The goal of the CE policy is to incentivize MCOs to direct resources and care support efforts to avoid these events and reduce associated utilization and costs. The withhold for FY2025 will be evaluated based on actual FY2025 performance as compared to a baseline year across both the Cardinal Care Managed Care - Acute and MLTSS population groups, as determined by DMAS.

Mercer worked with DMAS on the withhold design specifications and terms that dictate how the MCOs earn back the withhold. Mercer reviewed the targets established by DMAS with consideration for historical MCO experience, impact of Expansion enrollment and attainable readmission rates in other state programs. After review, Mercer determined the FY2025 targets established by DMAS were reasonable and achievable for an effectively managed MCO. As a result, no adjustments to the capitation rates have been made for a portion of the withhold that is not reasonably achievable.

Section 5

Exhibit Descriptions

The exhibits included in this Rate Book provide an illustration of the capitation rate development for the populations included in the Cardinal Care Managed Care program. The exhibits included within this Rate Book, as well as a brief description of the information included, are described below.

Users of this Rate Book are advised to review the information in the FY2025 Cardinal Care Managed Care Procurement Data Book Narrative and this report's Section 1 – 3 regarding the sources of data, methodology, and adjustments made to the data within this Rate Book.

Demographic information, including region, rate cell, and population, is provided at the top of the page. Additional key data elements contained in the exhibits include:

- *FY2025 Projected Member Months (MMs)* – Number of MMs projected for the FY2025 contract period
- *Base Midpoint* – Midpoint of the CY2021 base period.
- *Contract Midpoint* – Midpoint of the FY2025 contract period.
- *Trend Months* – Number of months between the base and contract midpoint that represents the amount of time that the annualized medical trends are applied over.
- *Category of Services (COS)* – Services that fall under the responsibility of the Cardinal Care Managed Care Model Contract, as defined in the FY2025 Cardinal Care Managed Care Procurement Data Book Narrative.
- *Final Base Data*
 - *Utilization per 1,000 (Util/1000)* – Represents the base-adjusted units divided by MMs multiplied by 12,000. See file labeled *FY2025 Cardinal Care Managed Care Procurement Data Book Exhibits.xlsx* for additional detail.
 - *Unit Cost* – Computed as the total base-adjusted PMPM divided by (Util/1,000 x 12,000). See file labeled *FY2025 Cardinal Care Managed Care Procurement Data Book Exhibits.xlsx* for additional detail.
 - *Per Member Per Month (PMPM)* – Computed as the total base-adjusted paid amount divided by MMs. See file labeled *FY2025 Cardinal Care Managed Care Procurement Data Book Exhibits.xlsx* for additional detail.
- *Base Program Changes* – PMPM percentage impact attributed to the impacts detailed in Section 3 (Base Program Changes).

- *Annual Medical Trends* – Annualized trend assumptions by COS. Trend factors will be applied over 42 months from the base midpoint to the contract midpoint.
- *Prospective Program Changes* – PMPM percentage impact attributed to the impacts detailed in Section 3 (Prospective Program Changes).
- *Projected Medical Expenses:*
 - *Util/1000* – Computed as the projected units divided by projected MMs multiplied by 12,000.
 - *Unit Cost* – Computed as the total projected PMPM divided by (Util/1,000 x 12,000).
 - *PMPM* – Computed as the total projected paid amount divided by MMs.



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