MILLIMAN REPORT

Mountain Health Trust: SFY 2024 Capitation Rate Development

State of West Virginia, Department of Health and Human Resources, Bureau for Medical Services

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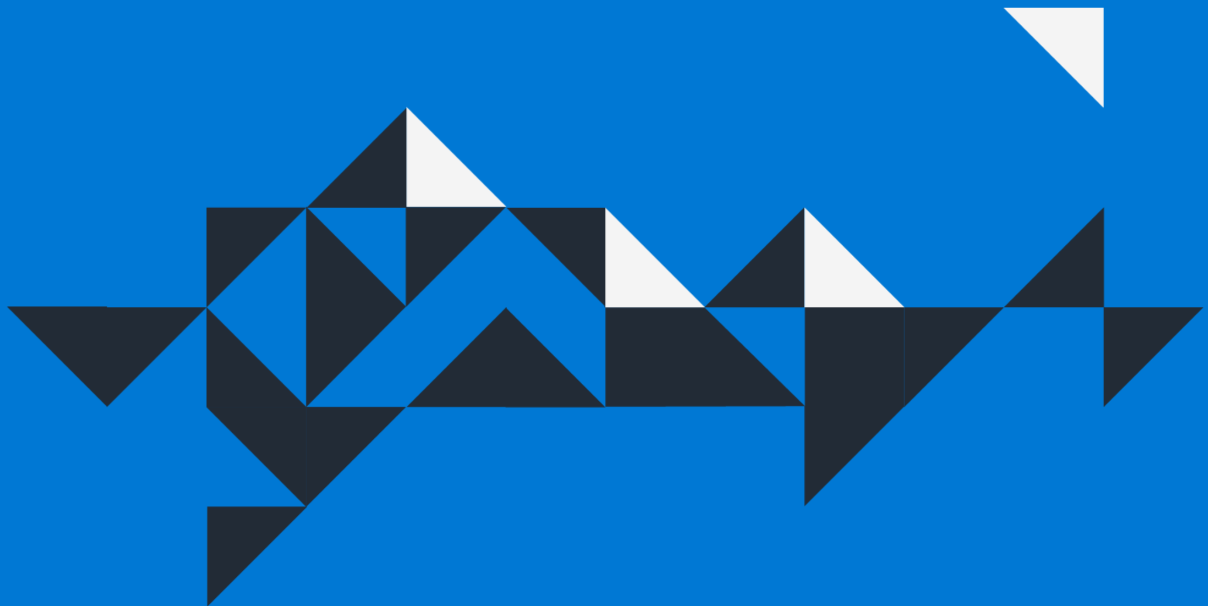

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I. Executive Summary

INTRODUCTION

Milliman, Inc. (Milliman) has been retained by the State of West Virginia, Department of Health and Human Resources, Bureau for Medical Services (BMS) to provide actuarial and consulting services related to the development of actuarially sound capitation rates under its Mountain Health Trust (MHT) contract.

Our role is to calculate and certify actuarially sound state fiscal year (SFY) 2024 capitation rates to comply with the Centers for Medicare & Medicaid Services (CMS) regulations, and the CMS Medicaid Managed Care Rate Development Guide. We developed the capitation rates using published guidance from the American Academy of Actuaries (AAA), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specific Actuarial Standards of Practice (ASOPs) we considered include, but are not limited to, the following:

- ASOP No. 1 – Introductory Actuarial Standard of Practice
- ASOP No. 5 – Incurred Health and Disability Claims
- ASOP No. 12 – Risk Classification
- ASOP No. 23 – Data Quality
- ASOP No. 25 – Credibility Procedures
- ASOP No. 41 – Actuarial Communications
- ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP No. 56 – Modeling

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2022-2023 Medicaid Managed Care Rate Development Guide (CMS Guide), published April 2022[1]:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 C.F.R. §438 and generally accepted actuarial principles and practices.

CAPITATION RATES

Table 1 and Appendix B illustrate aggregated statewide composite monthly capitation rates by category of aid (COA) and by rate cell, respectively, proposed to be effective July 1, 2023 through June 30, 2024 (SFY 2024) for MHT enrollees. All SFY 2024 capitation rates are compared against the most recently amended SFY 2023 capitation rates, which are effective July 1, 2022 to June 30, 2023. SFY 2024 managed care member month projections are used for calculating the composite capitation rates in Table 1 and the Appendices. Please refer to the Enrollment Projections Section for additional information on the development of projected SFY 2024 enrollment.

The primary drivers of the rate changes from SFY 2023 rates are:

- Updated base data from SFY 2021 to SFY 2022,
- Change in fee schedules, especially outpatient behavioral health,
- Increased non-benefit loads resulting from lower projected enrollment, and

[1] https://www.medicaid.gov/medicaid/managed-care/downloads/2022-2023-medicaid-rate-guide-03282022.pdf

- Inclusion of an explicit acuity adjustment for certain rate cells to reflect the end of the COVID-19 public health emergency (PHE) and the expected enrollment changes.

TABLE 1: PROPOSED SFY 2024 CAPITATION RATE CHANGE

CATEGORY OF AID	SFY 2024 RATE	SFY 2023 RATE	RATE CHANGE
TANF (Temporary Aid for Needy Families)	$ 229.08	$ 228.85	0.1%
CSHCN (Children with Special Health Care Needs)	545.72	700.89	(22.1%)
PW (Pregnant Women)	646.42	667.57	(3.2%)
SSI (Social Security Income)	642.50	640.52	0.3%
WVHB (West Virginia Health Bridge)	383.93	411.42	(6.7%)
Composite	**$337.81**	**$349.22**	**(3.3%)**

FISCAL IMPACT

Table 2 illustrates the fiscal impact of the SFY 2024 monthly capitation rate change relative to the SFY 2023 capitation rates using our projected SFY 2024 member months and SFY 2024 federal medical assistance percentages (FMAPs). Table 3 illustrates the FMAPs assumed in the fiscal impact calculations in Table 2. Table 2 and Table 3 assume the State receives the enhanced FMAP available through the Consolidated Appropriations Act of 2022 in addition to the standard FMAP for all populations except WVHB.[2]

TABLE 2: FISCAL IMPACT ($ MILLIONS)

BUDGET LINE	COMPOSITE
STATE AND FEDERAL EXPENDITURES	
SFY 2023 Rates	$ 1,873.6
SFY 2024 Rates	1,812.4
Expenditure Change	(3.3%)
STATE SHARE OF FISCAL IMPACT	
SFY 2023 Rates	$ 333.3
SFY 2024 Rates	327.0
Expenditure Change	(1.9%)

TABLE 1: ASSUMED FMAPS BY QUARTER

CATEGORY OF AID	JUL-SEP 2023	OCT-DEC 2023	JAN-MAR 2024	APR-JUN 2024	COMPOSITE
WVHB	90.00%	90.00%	90.00%	90.00%	90.00%
All Other COAs	76.52%	75.60%	74.10%	74.10%	75.08%

APPENDICES

APPENDIX A crosswalks the main sections of the report to the CMS Guide.

APPENDIX B includes a comparison of the SFY 2024 rates relative to the SFY 2023 rates.

APPENDICES C-G include detailed cost models illustrating the development of the projected benefit cost by rate cell for the listed populations. They also include exhibits illustrating the rate development from the projected benefit costs to the final capitation rates.

[2] West Virginia's standard FMAP is available at: https://public-inspection.federalregister.gov/2022-26390.pdf. The additional enhanced FMAPs by quarter are available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

- Appendix C: TANF
- Appendix D: CSHCN
- Appendix E: PW and DCR (all populations)
- Appendix F: SSI
- Appendix G: WVHB

II. Program Overview

COVERED POPULATIONS

The rates in this certification apply to the following managed care Medicaid populations in West Virginia:

- Traditional TANF,
- Children with Special Healthcare Needs,
- Pregnant Women,
- Supplemental Security Income, and
- Individuals eligible for Medicaid coverage due to West Virginia's Expansion (also known as West Virginia Health Bridge).

West Virginia's Medicaid coverage is available for both children (under 21) and adults. In general, the primary groups covered by West Virginia Medicaid include the aforementioned covered populations, though additional requirements relating to income, size of household, financial resources, etc. may apply.

MANAGED CARE ORGANIZATIONS

These populations have the choice of three (3) managed care organizations (MCOs) that the State has contracted with for the provision of Medicaid medically necessary services. The MCOs are Aetna Better Health of West Virginia (Aetna), The Health Plan of the Upper Ohio Valley (THP), and UniCare. For SFY 2024, the State will contract with two for-profit MCOs (UniCare and Aetna) and one non-for-profit MCO (THP). The three MCOs receive capitation payments from the State for providing health services to the covered population under the terms and conditions of the managed care contracts.

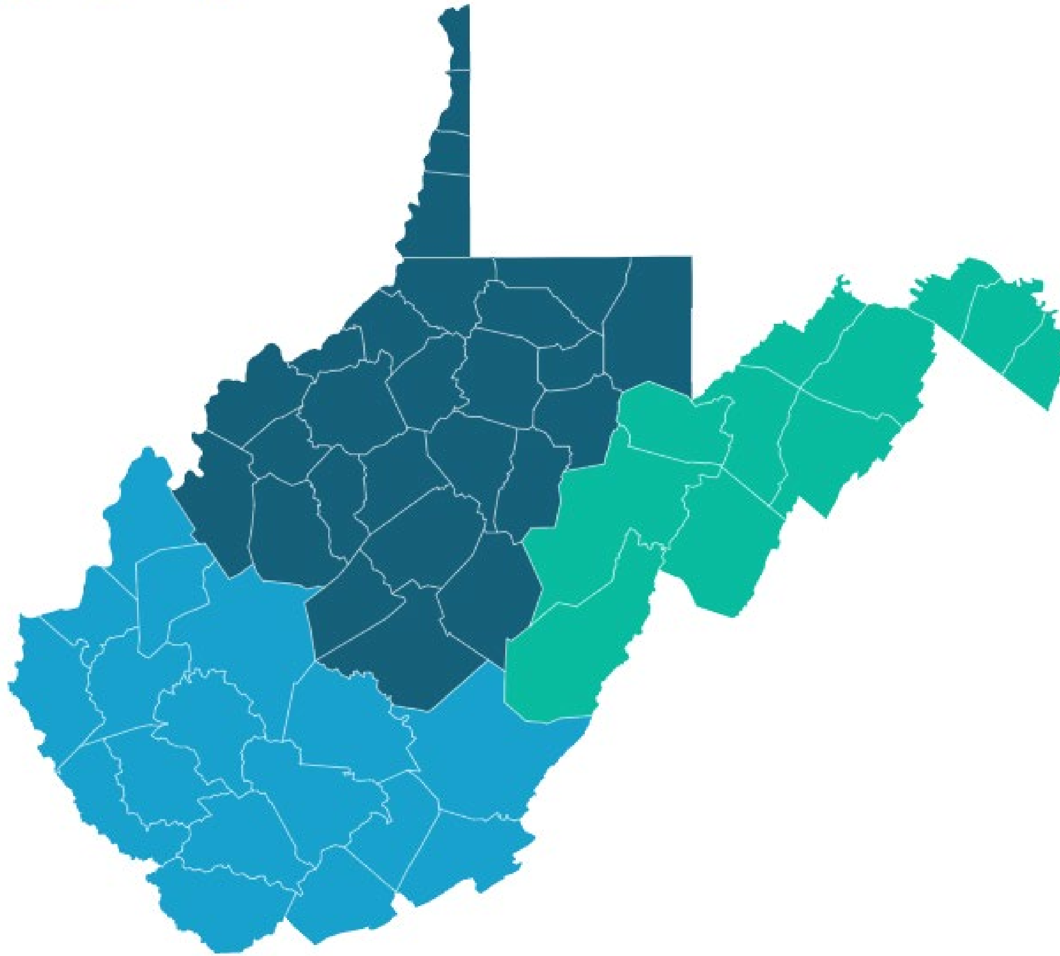
COVERED BENEFITS

The covered benefits in this program include comprehensive physical health services and behavioral health services under the West Virginia State Plan, including acute, primary, and specialty services. Pharmacy services are carved out of the program and are paid on a fee-for-service (FFS) basis. Additionally, there are a handful of select services carved out of the managed care capitation rates, consistent with the SFY 2024 MHT contracts.

REGIONS

The managed care contracts are statewide and the managed care program has been in operation for over a decade. The state is split into three regions and capitation rates are developed in each region for each rate cell. The three regions are North, East, and South. Each region is made up of a mutually exclusive list of counties consistent with Figure 1 below.

FIGURE 1: MHT RATING REGIONS



III. Base Data Development

BASE DATA

Eligibility is based on data received from the State and its vendors as of December 8, 2022 and includes eligibility information through October 2022. The eligibility data received is a member level record dataset. We created monthly membership records based on the eligibility begin and end date. The encounter data is based on data received from the State and its vendors as of December 8, 2022 and includes encounters submitted by the managed care organizations (MCOs) through October 2022.

Data Requested

We requested and received the following from the State and MCOs:

- Managed care encounters from January 2018 through October 2022, paid through October 2022
- Managed care enrollment data and corresponding capitation payments from January 2018 through October 2022
- July 2020 through June 2022 financial report data from each MCOs

The State and MCOs provided all the requested data.

Exclusions

Enrollment records may be excluded for one or more of the following reasons:

- Missing key demographics used in assigning rate cells, such as a region, age, or gender
- Enrollment during an extended mental health stay at an institution for mental disease (IMD)

Encounter data may be excluded for one of the reasons below.

- Demographic exclusions: comprised of encounters matched to eligibility records that are excluded for one or more of the following reasons:
  - claim does not have an associated enrollment record for the member and/or month of service
  - missing key demographics used in assigning rate cells, such as a region, age, or gender
  - enrollment during an extended mental health stay at an IMD
- Value-Added Benefits (VAB): encounter-based services that are not covered by the State Plan and that are not approved as in-lieu of services are identified and excluded from the base experience data. For SFY 2024 the only VAB service included in the encounter data is HCPCS code E0603 – “Electric breast pump”.

Base Period Selection

We reviewed historical data from January 2018 through July 2022 service dates and selected a base period of SFY 2022 for rate development. We believe the selection of this time period represents a credible base for projections, and it limits the development and application of adjustments that would be necessary if a longer or older time period was utilized.

The base data was derived from the West Virginia Medicaid population which will be enrolled in managed care during the contract period.

Data Validation

We received encounters from the State’s data warehouse vendor, Gainwell. Gainwell validates encounters submitted on an ongoing basis as part of its data processes. When receiving claims data, we receive control totals with encounter data totals to ensure the data remain complete and accurate when transferred. We do not have any concerns with the completeness of the data transferred to us. However, the State, the MCOs, and Gainwell are aware of issues with Gainwell’s acceptance of encounters, particularly for claims submitted in early 2021, but continuing into our SFY 2022 base period. This impacts our base data completeness and the consistency with the MCO financial reporting. Due to this issue, we have decided to gross up the available encounter data to the financials provided by the MCOs. We describe this adjustment more under the Adjustments to the Base Data Section below.

After this adjustment, we do not have any concerns with the completeness, accuracy, or consistency of the data. As the certifying actuaries, we have assessed the quality of the encounter data available, as well as supplemental data and information reported by participating MCOs. All data were reviewed at several professional levels by consultants, actuaries, and data analysts who have significant experience with Medicaid data.

ADJUSTMENTS TO THE BASE DATA

Sub-capitated Data Adjustments

The MCOs used varying sub-capitated vendors for certain services of providers. The most significant sub-capitated arrangements are for dental and vision. For these arrangements, we reviewed the encounters available in the base data and compared to the estimated proportion of benefit cost reported by each MCO. We included the estimated benefit cost amount in the base data and the remaining amount in the administrative load.

IMD Data Adjustments

Consistent with federal regulations, we have removed the membership and costs associated with any services delivered during a month where a member aged 21-64 had a mental health IMD stay of more than 15 days. We have also repriced shorter IMD stays for members aged 21 to 64 to the average inpatient mental health per diem costs. West Virginia has an 1115 waiver that allows for federal match for SUD-related IMD stays, so no changes have been made to the base data for such stays.

The impact of the IMD repricing and the IMD long-stay removal on a PMPM basis by category of aid is included in Table 4 below. The composite impact of both adjustments is a decrease of $0.6 million to base medical claims. We also removed 152 member months from the base period membership.

TABLE 4: IMD ADJUSTMENT IMPACT (PMPM)

ADJUSTMENT DESCRIPTION	TANF	CSHCN	SSI	PREG	WVHB	COMPOSITE
Long-stay removal	($ 0.01)	$ 0.00	($ 1.89)	($ 0.31)	($ 0.25)	($ 0.27)
ILoS repricing	0.04	0.00	0.64	0.00	0.23	0.17

Completion Adjustment

As discussed in the Data Validation Section, data issues were identified that required reconciling the encounter data to the MCO financials. Additionally, MCOs reported other non-system payments and benefit cost adjustments within the financials that we include in our completion factor adjustment. Table 5a-5c summarizes the completion factors applied. Please refer to Appendices C through G for illustrations of how these factors were applied to the base data.

TABLE 5A: COMPLETION ADJUSTMENT IMPACT – AETNA

SERVICE CATEGORY	TANF & CSHCN	PW	SSI	WVHB
Medical	1.030	1.020	1.034	1.024
Dental	1.539	1.573	1.637	1.602
Vision	0.961	0.961	0.961	0.961

TABLE 5B: COMPLETION ADJUSTMENT IMPACT – THP

SERVICE CATEGORY	TANF & CSHCN	PW	SSI	WVHB
Medical	1.150	1.110	1.131	1.127
Dental	1.001	1.003	0.994	0.995
Vision	1.325	1.325	1.325	1.325

TABLE 5C: COMPLETION ADJUSTMENT IMPACT – UNICARE

SERVICE CATEGORY	TANF & CSHCN	PW	SSI	WVHB
Medical	1.111	1.088	1.031	1.049
Dental	1.161	1.161	1.161	1.161
Vision	0.508	0.544	0.487	0.457

Note that our completion factor includes the impact of reconciliation and run-out, which was developed by comparing the MCO encounter payments paid through October 2022 by COA, incurred month, and claim type (medical, dental, or vision) for the SFY 2022 base data period to the MCO-reported benefit payments. However, the MCO-reported payments also include:

- Encounter payments,
- Estimated incurred but not paid amounts,
- Estimated benefit costs for sub-capitated services,
- Provider quality incentive and settlement payments not reported in the encounter data to the State,
- Fraud, provider overpayment recoveries, and subrogation recoveries not reported in the encounter data to the State,
- Rebates for physician-administered drugs, and
- Expected changes in sub-capitated vendor costs from the SFY 2022 base period to the SFY 2024 rating period.

Therefore, the "completion" adjustments are often larger than we would generally expect if the completion factors only represented incurred but not paid amounts.

COVID-19 DATA

We have reviewed multiple additional data sources in developing capitation rates specific to the COVID-19 PHE, including but not limited to:

- West Virginia Mountain Health Trust experience data pre-PHE and during the PHE,
- West Virginia Department of Health COVID-19 dashboard[3] which includes case counts, tests, positive test rate, vaccination rates, hospitalizations, and deaths,
- West Virginia's unemployment rate during the PHE, and
- The COVID-19 Medicaid data snapshot with data through July 31, 2022, as published by CMS.[4]

[3] https://dhhr.wv.gov/COVID-19/Pages/default.aspx

[4] https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-07312022.pdf

IV. Program Changes

Historical experience has been adjusted to reflect program changes and fee schedule changes implemented between the base period and the rating period. Adjustments documented in this section are represented in the appendices as either a utilization or cost-based adjustment unless noted otherwise.

PROGRAM CHANGES

Table 6 illustrates the impact to the SFY 2022 base experience for program changes occurring between the SFY 2022 base data and the SFY 2024 rating period.

TABLE 6: PROGRAM CHANGES - PMPM IMPACT

ADJUSTMENT DESCRIPTION	TANF	CSHCN	SSI	PREG	WVHB	COMPOSITE
COVID-19 Vaccine Costs	$ 0.87	$ 0.30	$ 0.98	$ 0.28	$ 0.55	$ 0.74
Gender Affirming Care	0.01	0.00	0.12	0.00	0.23	0.11

COVID-19 VACCINE COSTS

Effective with the end of the PHE May 11, 2023, the federal government is no longer expected to cover the full cost of the COVID-19 vaccine. In SFY 2024 we do not expect a significant number of MHT members to get the full vaccine for the first time. Instead, we expected some already-vaccinated members will get an annual booster. We have removed the historical COVID-19 vaccine costs embedded in the SFY 2022 base data and replaced them with estimated costs using the following assumptions:

- The cost of administration for the annual booster will be $30
- The cost of the annual booster will be $120
- For populations under 50, we estimate that half the proportion of people who have historically received the flu vaccine will receive the COVID-19 vaccine, or approximately:
  - 10% of members age 19 and under
  - 3% of members age 20 through 49
- For populations 50 and older, we estimate that a similar proportion of people who have historically received the flu vaccine will receive the COVID-19 vaccine, or approximately:
  - WVHB 50+ & SSI 50-59 females: 15%
  - WVHB 50+ & SSI 50-59 males: 10%
  - SSI 60+: 15%

This is an increase of approximately $4.0 million to the base medical claims.

GENDER AFFIRMING CARE

Effective September 1, 2022, the MCOs are responsible for providing gender affirming surgeries to eligible individuals as a result of Fain v. Crouch. We have developed an estimate of the potential cost of this service by reviewing the costs for gender affirming care surgeries for members in other state Medicaid programs as a proportion of Medicaid members. We applied this cost estimate to the percentage of SFY 2022 MHT members by category of aid and age band. The impact is an increase of approximately $0.6 million to the base medical claims.

POSTPARTUM EXPANSION

Effective April 1, 2022, West Virginia expanded Medicaid coverage for pregnant women from two months after delivery to twelve months after delivery. Due to the PHE maintenance of effort requirements, West Virginia has maintained coverage for these women in our SFY 2022 base data. Prior to April 1, 2022, these women were shifted out of the pregnant women population into other aid categories (generally to TANF). Starting April 1, 2022, women who were eligible for other aid categories continued to be shifted out of the pregnant women aid category at two months post-

delivery. Women who were not otherwise eligible remained in the pregnant women population, leading to an increase in membership in this population.

We expect that the pregnant women population will continue to grow for ten months, at which point the population will stabilize as women shift out of this aid category and into others, or disenroll from Medicaid entirely, after twelve months of post-delivery care. The PMPM cost of services between 3 and 12 months post-delivery is lower than that of the pre-natal, delivery, and 1-2 month post-natal periods, so this change is expected to cause a decrease in the average acuity of the pregnant women population.

We determined the average PMPM during each of the four periods (pre-natal, delivery month, 1-2 months post-natal, and 3-12 months post-natal) for women in the pregnant women aid category in SFY 2021 (runout impacts this categorization significantly, so we did not use SFY 2022 data). We projected the total number of months by period for SFY 2024, then assumed that the cost relativities between periods would be consistent with the SFY 2021 period. This results in a 3.6% decrease in the expected acuity of the full pregnant women population. Note that this adjustment is applied in the member acuity column in the cost model in Appendix E.

IMMATERIAL PROGRAM CHANGES

In addition to the changes above, there were program changes that we identified as having an immaterial impact on rates. These are:

- COVID-19 Vaccine Counseling: We have not built an explicit adjustment into the capitation rates to account for COVID-19 vaccination counseling visits which became the responsibility of MCOs effective January 1, 2022. Vaccine counseling has been an existing covered service and is not expected to extend E&M visit intensity materially. Therefore, we have not made any changes to the SFY 2024 rates for this service.
- Maternal Opioid Misuse (MOM) Model: Effective in June 2022, the State received approval from CMS to amend its state plan to include maternity opioid misuse (MOM) model services. Emerging data suggests the costs of encounters for these services are not material. Therefore, we have not made any changes to the SFY 2024 rates for this service.

FEE SCHEDULE CHANGES

The State made both regularly recurring and one-time fee schedule adjustments since the start of our base data period. Because the MCOs leverage the State's fee schedule in their contracts, we have evaluated and adjusted the base data for significant fee schedules changed occurring from July 1, 2021 through April 1, 2023. Many of the fee schedule changes are regularly recurring and have been accounted for during trend.

We have accounted for the fee schedule changes explicitly via fee schedule adjustments illustrated directly in the cost models included as Appendices C through G. Table 7 illustrates the impact to the SFY 2022 base experience for fee schedule updates. To develop each adjustment, we repriced the SFY 2022 base claims data to the most recently available Medicaid fee schedule and to the fee schedule in effect at the time of service. The fee schedule impact is calculated as the ratio of the most recent fee schedule to the fee schedule in effect at the time of service, multiplied by the MCO paid amount.

TABLE 7: FEE SCHEDULE CHANGES - PMPM IMPACT

FEE SCHEDULE	TANF	CSHCN	SSI	PREG	WVHB	COMPOSITE
Ambulance (4/1/2023)	$ 0.23	$ 0.43	$ 2.51	$ 0.65	$ 0.99	$ 0.76
Anesthesia (1/1/2023)	0.00	-	0.00	-	0.00	0.00
ASP / Drugs (1/1/2023)	0.07	(1.74)	(0.30)	(0.08)	(0.33)	(0.13)
Clinical Laboratory (4/1/2023)	(0.17)	(0.27)	0.07	0.26	(0.01)	(0.07)
Dental (1/1/2023)	(0.05)	(0.06)	(0.01)	(0.00)	(0.00)	(0.03)
DME (4/1/2023)	0.14	3.40	2.18	0.04	0.55	0.50
FQHC / RHC (1/1/2023)	3.29	4.43	3.73	2.43	3.05	3.22

FEE SCHEDULE	TANF	CSHCN	SSI	PREG	WVHB	COMPOSITE
Inpatient DRG (10/1/2022)	0.39	1.63	5.59	4.87	3.76	2.32
LBHC (4/1/2023)	(2.38)	(3.89)	(10.10)	(2.78)	(8.51)	(5.58)
OP Surgery Max Units (1/1/2023)	-	-	-	-	-	-
RBRVS (4/1/2022)	1.37	3.23	3.58	4.81	2.38	2.05

Please note that the fee schedule changes above do not reflect expected mid-year fee schedule changes. We have accounted for our projection of mid-year fee schedule updates within the unit cost trend, except for the inpatient DRG change which will be effective October 1, 2023 and we expect to consider during a mid-year rate change after more information is known. We added the following adjustments to our unit cost assumptions for each of the following fee schedules:

- Ambulance: 5% fee schedule increase effective April 1, 2024
- Clinical laboratory: 3% fee schedule increase effective April 1, 2024
- DME: 5% fee schedule increase effective April 1, 2024
- FQHC / RHC: 4% fee schedule increase effective January 1, 2024 and an additional 1% annual fee schedule increase for change in scope events
- RBRVS: 3% fee schedule increase effective April 1, 2024

Note that the above assumptions are applied as annual unit cost trends and are dampened accordingly. Please refer to the Projected Benefit Costs Section for more information on unit cost trends.

The fee schedule changes above do not include the impacts of known provider contracting changes reported by the MCOs. We have included an additional $0.5 million in known contracting changes due to hospital mergers and acquisitions.

MANAGED CARE SAVINGS

We have capped payments from the MCOs that exceed 102.5% of the Medicaid fee schedule in aggregate for a provider consistent with the terms in the MHT contract. The estimated impact is an $11.1 million reduction to projected SFY 2024 benefit costs when we repriced the SFY 2022 base data to the fee schedules in effect at the time of service. The impact by rate cell and category of service is illustrated in the cost models in Appendices C through G.

V. Trend Assumptions

ENROLLMENT PROJECTIONS

SFY 2024 membership projections have been developed under the assumption that West Virginia will begin disenrolling ineligible recipients from Medicaid effective May 1, 2023 and will take twelve months to complete the redetermination process. After the redetermination process is complete, we are assuming that MHT enrollment in aggregate will be approximately 10% higher than CY 2019 levels.

We have modeled the enrollment for SFY 2023 assuming membership continues its current trajectory through April 2023. Beginning in May 2023, membership will then change by one twelfth of the difference between the April 2023 enrollment and 10% higher than the March 2020 enrollment. Note that there is variation by category of aid and rate cell in the assumptions as some rate cells and categories of aid have showed declined enrollment since the beginning of the PHE.

Table 8 shows the historical and projected enrollment by rate cell.

TABLE 8: SFY 2022 ACTUAL AND SFY 2024 PROJECTED ENROLLMENT

	CSHCN	PREG	SSI	TANF	WVHB	COMPOSITE
SFY 2022	6,242	73,532	476,406	2,713,606	2,471,427	5,741,213
SFY 2024	5,038	101,992	488,868	2,592,399	2,176,736	5,365,033
Annualized Growth	(19.3%)	38.7%	2.6%	(4.5%)	(11.9%)	(6.6%)

PROJECTED BENEFIT COSTS

Projected benefit costs for monthly capitation rates are developed using the following general methodology. See the listed columns in Appendices C through G for cost model application.

1. Summarize historical base experience data into actuarial models by service category and rate cell, including stratification by region, category of aid, and age/gender groups. See columns A through G.
2. Apply completion factors described in the Completion Adjustment Section to reflect estimated ultimate incurred experience for the base period. See column I.
3. Apply program change impacts described in the Program Changes Section. See columns J-K.
4. Apply fee schedule adjustments described in the Fee Schedule Changes Section. See column L.
5. Apply managed care savings adjustments described in the Managed Care Savings Section. See column M.
6. Apply adjustments for utilization and unit cost trends described below. See columns N-O.
7. Apply adjustments for acuity described in the Acuity Adjustment Section. See column P.

The primary data source used to develop medical trends was encounter data from the state's data warehouse. We compiled regression time series on encounter data incurred in January 2018 through June 2022, paid through October 2022. Experience was adjusted to account for completion, normalize for changes in age/gender mix over time, program adjustments, changes to the FFS fee schedule, and other disruptions observed in the time series data. For most categories, we relied on pre-PHE experience to develop trend adjustments.

Trends were developed separately for unit cost and utilization by service category. Trends are based on a regression of normalized historical experience and reflect actuarial judgement where necessary and appropriate. Trends were selected separately for:

- TANF children
- TANF adults
- Pregnant women

- Disabled children (incl. SSI children and CSHCN)
- Disabled adults
- WVHB

Experience trends were reviewed in detail by service category and population. We relied on historical experience from the covered population and services, where available, to inform prospective trend selections. In cases where a regression of normalized historical experience resulted in unreasonable trends due to volatility, actuarial judgement was used to select reasonable assumptions for projection. We have also considered future fee schedule changes in the unit cost trend selection. Selected trend rates have been developed in accordance with 42 CFR §438.5(d) and generally accepted actuarial principles and practices. We have assessed them to be reasonable for the Medicaid program covered by this certification.

Trends were developed by and vary by the following categories of service. In some cases, notably the categories in the "Other" grouping, professional lab, and OP SUD, populations were combined to select trend rates.

TABLE 9: TREND SERVICE CATEGORIES

INPATIENT	OUTPATIENT	PROFESSIONAL	ANCILLARY	OTHER
IP Physical Health	Emergency Room	Hospital Visits	Home Health/ Hospice/DME	COVID-19 Testing
IP Behavioral Health	Lab	Maternity	Ambulance	COVID-19 Vaccines
IP Deliveries	Drugs	Office Visits		Case Management
	Mental Health	Drugs		
	SUD	Well Visits/Other		
	Clinic	Dental		
	Other	Lab		

Tables 10 and 11, respectively, summarize the selected annual utilization and unit cost trends by major category of service. Additional detail on the final annual utilization and unit cost trends selected by detailed category of service is included in the cost models in Appendices C through G.

TABLE 10: ANNUAL TREND FACTORS - UTILIZATION

SERVICE CATEGORY	TANF KIDS	TANF ADULTS	PREG	DIS KIDS (INCL. CSHCN)	DIS ADULTS	WVHB
Inpatient	1.1%	(0.2%)	2.6%	0.9%	(2.4%)	(0.7%)
Outpatient	2.4%	1.0%	1.3%	4.6%	2.0%	2.8%
Physician	1.5%	(0.4%)	0.0%	2.4%	(0.1%)	(1.3%)

TABLE 11: ANNUAL TREND FACTORS – UNIT COST

SERVICE CATEGORY	TANF KIDS	TANF ADULTS	PREG	DIS KIDS (INCL. CSHCN)	DIS ADULTS	WVHB
Inpatient	1.3%	2.0%	0.9%	1.8%	3.5%	3.0%
Outpatient	2.3%	1.7%	1.7%	(2.0%)	0.1%	0.3%
Physician	2.4%	2.6%	2.3%	3.6%	1.6%	2.1%

COVID-19 ADJUSTMENTS

The PHE ended May 11, 2023. We have considered the following impacts of the COVID-19 PHE in developing trend assumptions:

- COVID-19 vaccine administration costs: The SFY 2022 experience includes costs for administering the COVID-19 vaccines and boosters to the extent they were approved, and members were eligible. However, in SFY 2024 we do not expect a significant number of new vaccines to be administered. Instead, we expect people will receive boosters to the extent they choose to be vaccinated. Additionally, in SFY 2024 MCOs will be responsible for the drug cost after federal supplies run out. We have removed the historical utilization and replaced it with an assumption for future utilization and costs. We have developed a separate program adjustment described in the Program Changes Section to reflect these changes.
- COVID-19 vaccine counseling: covered at-risk under MCO contracts; We assumed these costs are immaterial and embedded in base professional costs. We have not assumed any change in costs beyond normal professional office visit trends.
- Clinical pathology/laboratory testing for COVID-19 pathogens: These costs are covered at-risk under MCO contracts; SFY 2022 experience is adjusted for utilization and unit cost trend.
- Monoclonal antibody infusions: These costs are covered at-risk under MCO contracts for mild to moderate COVID-19 at high risk for severe illness or hospitalization, hospitalized adults and pediatric children, and post-exposure prophylaxis (PEP). However, recommendations of their coverage for emerging COVID-19 variants is currently restricted.[5] Therefore, we have assumed the cost impact is immaterial.
- Inpatient hospital treatment: These costs are covered at-risk under MCO contracts to the extent the federal government did not provide the treatments free of charge to hospitals. We reviewed inpatient utilization and unit cost levels within the trend assumption to reflect our best estimate of ongoing inpatient hospital treatment costs, inclusive of COVID-19 vaccine treatments.
- Increased use of telehealth: Telehealth is covered at-risk under MCO contracts with payment parity to in-person visits. We reviewed experience in the MHT program and nationwide and believe the treatments have generally been a replacement for in-person services rather than expansion of total services. Therefore, we have not made any adjustments.
- Deferred and returning care: We are assuming that deferred care had largely returned during our base period of SFY 2022 and have not applied any explicit adjustment to trends.
- Cost sharing: During the PHE, West Virginia suspended copay collection. However, the SFY 2022 payments to providers continue to reflect the reduced payment amounts assuming copays were collected. Additionally, total cost sharing reported did not change significantly from pre-PHE to our base period. Therefore, we did not make any changes to the base data for the resumption of copay collection in SFY 2024. Any impact of change in member behavior from knowing that copays were suspended is included in the acuity adjustment.
- Enrollment: Please refer to the Enrollment Projections Section.
- Acuity: Please refer to the Acuity Adjustments Section.

[5] https://www.cms.gov/monoclonal#:~:text=Monoclonal%20Antibodies%20to%20Treat%20Mild%2Dto%2DModerate%20COVID%2D19&text=ACTEMRA%C2%AE%20(tocilizumab)%20(EUA,with%20severe%20COVID%2D19%20illness.

VI. Acuity Adjustments

The end of the PHE and subsequent disenrolling of members who remained on Medicaid due to the suspension of disenrollment is likely to lead to a different average member acuity level in the projection period than the base period. Due to the difference in acuity profile for physical and behavioral health services, we analyzed physical and behavioral health service costs separately and determined that we would only apply an acuity adjustment to physical health service costs.

We developed acuity adjustment factors by reviewing historical utilization, costs, and risk scores for members prior to and during the PHE. We repriced claims data from August 2019 through July 2022 to the fee schedules in place as of March 1, 2023, and reviewed rolling historical costs and utilizers over time. For every month, we reviewed members' costs from the most recent six-month period and categorized members as non-, low-, medium-, high-, or very high utilizers. We reviewed the distribution of members among these cohorts over time for each rate cell. Due to the initial repricing, shifts in cost over time should be predominantly due to changes in utilization patterns and acuity and not the result of increased unit cost.

We considered the distribution of utilizers from the six-month period of August 2019 - January 2020 to be the "normal" utilization profile, unaffected by COVID utilization changes or membership distribution changes. The August 2021 – January 2022 period was used as the "base period" profile, as it is a recent time period covering the same months of the base year as the "normal" period and is less impacted by shorter runout or deferred utilization. We then calculated the change in average cost due to shifting between utilizer cohorts from the January 2020 normal period to the January 2022 base period.

For physical health services, we assumed that a reduction in cost of 8.7% was expected due to permanent PHE-related changes in utilization habits, based on the change in average cost of the SSI population (which was relatively unaffected by PHE-related disenrollment suspension). For behavioral health services, we assumed the equivalent cost change was an increase of 1.2%. The remaining change in average cost for each rate cell is then considered to be caused by acuity changes from PHE-related disenrollment suspension. Membership is not expected to fully return to pre-PHE levels, and disenrollment is happening throughout SFY 2024, so we dampened our acuity adjustment factors to account for projected enrollment remaining above January 2020 levels. Only positive acuity adjustments were considered, with the exception of the pregnant women rate cell factor described in the postpartum expansion program change in Section IV Program Changes.

A sample calculation follows (physical health services, using the expansion 50-59 year-old male rate cell):

Normalized PMPM (Aug 19 – Jan 20) **(a)**	$ 352.46
Normalized PMPM (Aug 21 – Jan 22), based on Jan 2020 costs and Jan 22 utilizer distribution **(b)**	$ 300.87
% Change from Jan 2020 to Jan 2022 **(c) = b/a - 1**	(14.6%)
Permanent PHE-related utilization changes **(d)**	(8.7%)
Projected acuity change if membership returned to Jan 2020 levels **(e) = (1+d)/(1+c) - 1**	7.0%
Membership growth from the January 2020 acuity base to SFY 2022 **(f)**[6]	39.7%
Projected SFY 2022 to SFY 2024 membership change **(g)**	(12.8%)
Projected acuity change from SFY 2022 to SFY 2024 **(h) = -e*g/f**	**2.2%**

Table 12 summarizes the acuity adjustments applied to physical health service categories by rate cell. No adjustments were applied to the SSI or CSHCN populations.

[6] Note that we have used CY 2019 member months as a proxy for the base member months used in this calculation.

TABLE 12: PHYSICAL HEALTH ACUITY ADJUSTMENT FACTORS

TANF RATE CELL	ACUITY FACTOR	WVHB RATE CELL	ACUITY FACTOR
Age <1	1.000	Age 15 - 29 Female	1.023
Age 1	1.000	Age 15 - 29 Male	1.079
Age 2 - 14	1.020	Age 30 - 39 Female	1.006
Age 15 - 19 Female	1.029	Age 30 -39 Male	1.059
Age 15 - 19 Male	1.020	Age 40 - 49 Female	1.002
Age 20 - 29 Female	1.000	Age 40 - 49 Male	1.055
Age 20 - 29 Male	1.000	Age 50 - 59 Female	1.003
Age 30 - 39 Female	1.007	Age 50 - 59 Male	1.022
Age 30 - 39 Male	1.009	Age 60+ Female	1.000
Age 40+	1.018	Age 60+ Male	1.000

Table 13 summarizes the acuity adjustments applied to behavioral health service categories by rate cell. No adjustments were applied to the SSI populations.

TABLE 13: BEHAVIORAL HEALTH ACUITY ADJUSTMENT FACTORS

TANF RATE CELL	ACUITY FACTOR	WVHB RATE CELL	ACUITY FACTOR
Age <1	1.000	Age 15 - 29 Female	1.056
Age 1	1.000	Age 15 - 29 Male	1.026
Age 2 - 14	1.044	Age 30 - 39 Female	1.006
Age 15 - 19 Female	1.018	Age 30 -39 Male	1.057
Age 15 - 19 Male	1.077	Age 40 - 49 Female	1.001
Age 20 - 29 Female	1.004	Age 40 - 49 Male	1.055
Age 20 - 29 Male	1.000	Age 50 - 59 Female	1.007
Age 30 - 39 Female	1.007	Age 50 - 59 Male	1.018
Age 30 - 39 Male	1.013	Age 60+ Female	1.058
Age 40+	1.055	Age 60+ Male	1.091
CSHCN	1.139		

VII. Non-Benefit Expenses

We relied primarily on non-benefit cost information submitted by the MCOs in their July 2020 through June 2022 financial report data to develop the non-benefit expense projections. We reviewed the reported MCO data for reasonableness and appropriateness and adjusted it as needed to project future costs. Non-benefit costs were explicitly developed by the following components:

- General administration
- Quality improvement
- Risk margin
- Premium tax

Different approaches were used to develop each of the four components to reflect their distinct cost nature and relationship to the rest of the capitation rate components. There is no material change to the data used or approach for non-benefit expenses relative to prior rate certification other than the use of more recent data.

GENERAL ADMINISTRATION

We relied on the SFY 2022 general administrative cost expenses reported by the MCOs by category of aid to determine the projected general administrative cost expenses. We adjusted the historical administrative expenses for:

- Removal of value-added benefits reported as general administrative costs
- Removal of certain reported administrative costs associated with elective business activities not required by MCO contract such as corporate sponsorship and donations

In aggregate, 3.3% of total reported general administrative cost was removed from the reported base. The adjusted base general administrative cost as a percentage of the adjusted base SFY 2022 benefit cost was 7.6% across the entire MHT program.

In projecting the SFY 2024 general administrative cost, we assumed that 50% of the cost was fixed regardless of enrollment and benefit costs and 50% would vary with projected aggregate benefit costs. We assumed the fixed component will grow with inflation for an 8.9% increase from the base period to the contract period. The projected total fixed component of general administrative cost was then allocated across all COAs on a uniform PMPM basis. The resulting uniform PMPM was converted into a projected percentage of benefit cost specific to each COA by dividing the uniform PMPM by the COA-specific projected benefit cost PMPM.

The variable component is assumed to increase or decrease at the same rate as the benefit cost changes and therefore stay constant on a percentage of benefit cost basis at category of aid level. The projected variable component as a percentage of benefit cost was assumed to be the same across all COAs.

We combined the two components as a percentage of projected benefit costs to determine the final admin load by COA. Table 14 includes the final admin assumptions by COA.

QUALITY IMPROVEMENT

We relied on the SFY 2022 quality improvement expenses reported by the MCOs by category of aid to determine the SFY 2024 quality improvement assumption. We adjusted the historical quality improvement expenses for removal of value-added benefits reported as quality improvement expenses. In aggregate, 3.0% of total reported quality improvement cost was removed from the reported base.

The adjusted base quality improvement cost as a percentage of the adjusted base SFY 2022 benefit cost was 2.6% across the entire MHT program. In projecting the SFY 2024 quality improvement cost, we applied an approach similar to the projection of general administrative cost. We assumed that 50% of the cost (fixed component) will grow in aggregate at the expected general inflation rate of 8.9% in total from SFY 2022 to SFY 2024. The projected total fixed component of quality improvement cost was then allocated across all COAs on a uniform PMPM basis. The resulting uniform PMPM was then converted into a projected percentage of benefit cost specific to each COA by dividing the uniform PMPM by the COA specific projected benefit cost PMPM.

The remaining 50% (variable component) is assumed to grow at the same rate as the benefit cost changes and therefore stay constant on a percentage of benefit cost basis at category of aid level. The projected variable component as a percentage of benefit cost was assumed to be the same across all COAs.

We combined the two components as a percentage of projected benefit costs to determine the final quality improvement expense percentage assumption by COA. Table 14 includes the final quality improvement percentage assumptions by COA.

RISK MARGIN

Risk margin was developed as a percentage of the capitated rate and does not vary by COA. For SFY 2024, we continue to use a 1.50% risk margin.

PREMIUM TAX

Premium tax will be assessed at MCO level based on the MCO's actual total Medicaid enrollment as follows:

- The first 249,999 member months will be taxed at a base rate of $36.27 PMPM for SFY 2024.
- The next 250,001 member months will be taxed at a base rate of $20.73 PMPM for SFY 2024.
- The remaining member months will be taxed at a base rate of $1.04 PMPM for SFY 2024.

The premium tax PMPM assumption for SFY 2024 capitation rates was first estimated on a PMPM basis for each individual MCO using MCO specific projected enrollment for SFY 2024. The estimated MCO specific premium tax was then weighted using each MCO's projected enrollment to calculate the program average. The calculated program average of the premium tax was included uniformly into all applicable certified capitation rates. Note that the premium tax component of the capitation rate payments to each individual MCO will be trued up to the actual premium tax paid by the MCO following the contract period.

COMPARISON TO SFY 2023 ASSUMPTIONS

Table 14 summarizes the non-benefit cost assumptions for SFY 2024.

TABLE 14: SFY 2024 NON-BENEFIT COST ASSUMPTIONS

	TANF	CSHCN	PW	DCR	SSI	WVHB
General Admin (% of Bene. Cost)	10.1%	6.2%	8.6%	3.8%	5.9%	7.4%
Quality Improvement (% of Bene. Cost)	3.5%	2.1%	2.9%	1.3%	2.0%	2.5%
Margin (% of Rate before Tax)	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Premium Tax (PMPM)	$ 8.37	$ 8.37	$ 8.37	n/a	$ 8.37	$ 8.37

VIII. Development of Capitation Rates

Capitation rates are developed using the following steps:

1. Project benefit costs for SFY 2024 as discussed in the Projected Benefit Cost Section and as provided in each cost model in Appendices C through G.
2. Adjust for credibility.
3. Add projected general administrative expenses as a percent of projected benefit costs.
4. Add the projected quality incentive expenses as a percent of projected benefit costs.
5. Add the margin as a percent of the total costs less premium tax.
6. Add the premium tax.

During or after the end of the SFY 2024 period, the following additional adjustments will occur:

1. Risk adjustment
2. Premium tax settlement
3. Risk mitigation
4. Directed payments through separate payment terms

Table 15 summarizes the rates using projected SFY 2024 member months by category of aid and includes the projected MLR if all QI expenses are considered in the numerator of the calculation and premium taxes are excluded from the denominator.

TABLE 15: COMPOSITE RATE BREAK-DOWN (INCL. DCR)

RATE COMPONENT	CSHCN	PREG	SSI	TANF	WVHB
Credibility Adj. Benefit Cost	$ 488.73	$ 734.38	$ 578.94	$ 191.58	$ 336.75
General Admin	30.30	39.85	34.11	19.18	24.80
Quality Improvement	10.26	13.53	11.56	6.65	8.38
Margin	8.06	12.00	9.51	3.31	5.63
Premium Tax	8.37	8.37	8.37	8.37	8.37
Projected MLR	**92.9%**	**93.5%**	**93.1%**	**89.8%**	**91.9%**

CREDIBILITY ADJUSTMENTS

Due to limited membership in certain categories of aid and rate cell, we made the following credibility adjustments:

- CSHCN and PW: We developed rates on a statewide basis, combining all regions and age bands. Given the limited membership in these COAs and volatility of the costs within each rate cell over time, we decided the statewide average was the most reliable projection for all rate cells for these COAs.
- Within WVHB and SSI, we combined a few low enrollment rate cells for rate setting purposes:
  - SSI: females 60+ and males 60+ were combined
  - WVHB: members aged 15 to 19 and 20 to 29 were combined, separately for males and females
- SSI, TANF, and WVHB: We relied on a publicly available Medicaid credibility analysis to determine whether Medicaid membership within each rate cell was credible for rate setting purposes. The analysis suggested the following credibility formulas and limits are appropriate for Medicaid populations:
  - Formula: experience credibility equals the square root of the experience member months divided by the credibility threshold

- Credibility threshold: 45,000 for TANF and WVHB; 21,000 for SSI

The manual rate which gets blended with the experience data is the statewide projected benefit cost for the same rate cell. The adjustments are applied in columns G and H in the summary tabs of Appendix C, F, and G.

IX. Risk Mitigation

The MHT contracts include a gain share whereby MCOs agree to reimburse the State for payments below an MLR of 85%. Additionally, 50% of payments between 85% and 88% of MLR are owed to the State. There are no other risk-sharing mechanisms in place. The gain share is used to protect the State against excessive profits earned by the MCOs. At the end of the rating period, the MCOs submit MLR reports to the state reporting the SFY medical costs, quality improvement incentives, revenue, and taxes. As defined in the contract, the MLR is calculated as the medical costs plus quality improvement incentives divided by the revenue less taxes. If the MCO's MLR is below 85%, the MCO must return funds until the MLR hits 85.0%. If the MCO's MLR is between 85% and 88%, the MCO returns half of the funds requires to hit an 88.0% MLR. Please refer to the contract for additional details on the calculation. There is no effect on rates since the projected MLR is above the threshold where recoupments would begin. There are no other applicable risk-sharing mechanisms in place other than the gain share.

The MCO may obtain adequate reinsurance or establish a restricted fund balance for the purpose of self-insurance for financial risks accepted as part of this contract. Reinsurance arrangements are subject to approval by the State.

X. Risk Adjustment

We intend to use the CDPS+Rx model for risk adjustment with the default set of pharmacy carve-out prospective risk weights from CDPS+Rx for all regions to reflect the benefits these risk adjustment factors apply to, which include acute care benefits only. However, we will review the model to determine if any adjustments to coefficients, area factors, or other changes are warranted.

Disabled weights are utilized for the SSI and CSHCN categories of aid. Non-disabled weights are utilized for all other categories of aid. Members with less than six months of exposure in the experience period are not scored and are instead given a risk score equal to the population and age-gender-specific average risk score of scored members.

We will make the following adjustments to the standard CDPS+Rx model:

- Complete and incomplete pregnancy risk weights are excluded because maternity care is covered under a separate delivery case rate.
- Diagnoses associated with claims with a CPT or revenue code which we identified as diagnostic in nature (i.e., radiology, laboratory, pathology) are excluded.

We select the risk adjustment models and assumptions based on our understanding of the State's managed care program. We anticipate applying the following methodology to develop relative risk adjustment factors:

1. Summarize average raw risk scores by aid category, region, and MCO from the risk scoring analysis for scored members.
2. Blend in average attributed risk scores by aid category, region, and MCO for non-scored members. Non-scored attributed risk scores are calculated as average aid category and age-gender-specific risk scores for scored members, applied to non-scored enrollment.
3. Adjust raw risk scores to normalize out the impact of paying capitation rates by age/gender to avoid duplication of case mix differences among MCOs.
4. Apply credibility to the risk scores based on the number of scored members within a cohort. We will review the number of scored members within a rate cell, region, and MCO to determine if applying a credibility threshold is warranted for risk score development.
5. Calculate budget-neutral risk adjustment relativities using plan-specific scores divided by regional composites scores.

A full description of the methodology will be included in the risk adjustment report that will accompany final risk adjustment factor exhibits.

XI. Data Reliance and Caveats

The terms of the contract with BMS effective on February 15, 2022 and the MSLC subcontract signed February 10, 2022 apply to this email and attachments and its use.

We relied on certain models in the preparation of these exhibits. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

This analysis is intended for the use of the State of West Virginia, Bureau for Medical Services (BMS) in support of the Medicaid managed care programs. We understand that this information may be shared with BMS's contracted MCO and the Centers for Medicaid and Medicare Services (CMS). This report may not be distributed to any third parties without the prior consent of Milliman. To the extent that the information contained in this report is provided to third parties, the document, including all appendices, should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for BMS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any MCO to make an independent determination as to the adequacy of the proposed capitation rates for their organization.

Actual costs for the program will vary from our projections for many reasons. Differences between the results of our analysis and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis, with modifications to rates or to the program as necessary.

This analysis has relied extensively on data provided by BMS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

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

XII. Actuarial Certification

We, Annie Hallum and Justin Birrell, are Principals and Consulting Actuaries with the firm of Milliman, Inc. We are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. We meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. We have been retained by the State of West Virginia, Bureau for Medical Services (BMS) and we are familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. We have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the period of July 2023 to June 2024 (SFY 2024).

To the best of our information, knowledge and belief, for the SFY 2024 period, the capitation rates offered by BMS are actuarially sound and comply with the requirements of 42 CFR § 438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in 42 CFR § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in42 CFR § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under 42 CFR § 438.8, of at least 85 percent for the rate year.

We have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

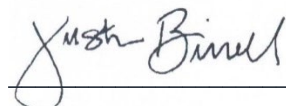
This certification is intended for the State of West Virginia and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

The capitation rates developed herein may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with BMS. The health plan may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

May 17, 2023

Annie P. Hallum, FSA, MAAA — Date



May 17, 2023

Justin C. Birrell, FSA, MAAA — Date

Appendix A – Medicaid Managed Care Rate Development Guide

Medicaid Managed Care Rate Development [Section I]

GENERAL INFORMATION [SECTION I.1]

General – Rate Development Standards [Section I.1.A]

Upper and lower bound rate ranges [Section I.1.A.i]:

The rate certification discloses and supports specific assumptions that underlie the certified rates for each rate cell and no rate ranges are certified by the actuaries.

Rating Period [Section I.1.A.ii]:

This rate certification is for a 12-month rating period effective July 1, 2023.

Items included in an acceptable rate certification [Section I.1.A.iii]:

(a) a letter from the certifying actuary

This report concludes with a rate certification signed by the certifying actuaries.

(b) final and certified capitation rates

Appendix B presents final and certified rates eligible for federal financial participation (FFP).

(c) description of the program

Please refer to the Program Background section of this report.

(i) special contract provisions under 42 C.F.R. §438.6

The following special contract provisions are included in the SFY 2024 MHT contract:

- Risk Sharing Mechanism [Section I.4.C]: The State has a gain share with a minimum loss ratio of 85.0%. 100% of payments that drive the medical loss ratio (MLR) below 85% are reimbursable to the State. Additionally, 50% of payments causing the MLR to be between 85% and 88% are also reimbursable to the State.
- State-directed payments approved under 42 C.F.R. §438.6(c) [Section I.4.D]: The State has several directed payment programs which are outlined in Section I.4.D.
- Institutions for mental disease (IMD) treatment [Section I.3.B.vii(h)]: Calendar months where a member exceeds 15 mental health-related days in an IMD are not included in the capitation rate and are instead paid using state funds.

(ii) retroactive adjustments to capitation rates

At this time there are no known retroactive changes to the capitation rates documented herein. If a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments we will issue a revised rate certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2).

Differences among covered populations [Section I.1.A.iv]:

Any observed differences among covered populations are based on valid assumption differences driven primarily by historical experience data or substantiated adjustment differences.

Cross-subsidization [Section I.1.A.v]:

Capitation rates were developed such that payments from any rate cell do not cross-subsidize payments from any other rate cell.

Consistency of effective dates [Section I.1.A.vi]:

The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, and program initiatives) are consistent with the assumptions used to develop the capitation rates.

Minimum medical loss ratio [Section I.1.A.vii]:

Capitation rates have been developed in such a way that MCOs are expected to reasonably achieve a medical loss ratio of at least 85% for the contract period, as calculated per 42 CFR §438.8. Please refer to Section VIII Development of Capitation Rates for projected loss ratios.

Capitation rate range [Section I.1.A.viii]:

Not applicable. The rate certification discloses and supports specific assumptions that underlie the certified rates for each rate cell and no rate ranges are certified by the actuaries.

Certification of a range of capitation rates [Section I.1.A.ix]:

Not applicable. The rate certification discloses and supports specific assumptions that underlie the certified rates for each rate cell and no rate ranges are certified by the actuaries.

Considerations for CMS approval [Section I.1.A.x]:

(a) *all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.*

All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuaries.

(b) *adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 C.F.R. § 438.4.*

Additional adjustments to the capitation rates outside the rate setting process have not been made. If additional adjustments are made to the capitation rates prior to the end of the contract period, appropriate documentation will be submitted outlining any data, assumptions, methodology, and impact to the capitation rates.

(c) *final contract rates in each cell must match the capitation rates in the rate certification*

It is our understanding that the final contracted rates paid to the MCOs for each rate cell will be consistent with the capitation rates included in Appendix B.

Certification period [Section I.1.A.xi]:

We have developed new contracted rates for SFY 2024, which are documented in this rate certification.

COVID-19 public health emergency [Section I.1.A.xii]:

Please refer to the COVID-19 Data Section.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.xiii]:

(a) *Federal financial participation (FFP) for capitation rates*

The state intends to claim FFP for capitation rates included in this certification and will comply with the time limit for filing claims for FFP specified in Section 1132 of the Social Security Act and implementing regulations at 45 CFR § 95.

(b) *requirement for a new rate certification when rates change*

If capitation rates change within SFY 2024 for reasons other than those outlined below in Section I.1.A.xiii(d), the state will submit a rate certification amendment outlining the data, assumptions, methodologies, and adjusted capitation rates as appropriate.

(c) *supporting documentation for contract changes that revise covered populations or services under the contract*

For contract amendments that do not affect rates, a new rate certification will not be developed. However, if a contract amendment changes the covered populations or services under the contract, the certifying actuaries will review the potential for a material capitation rate impact and provide an actuarial report documenting the data, assumptions, and methodologies used to evaluate the contract provisions.

(d) *circumstances not requiring a new rate certification*

(i) *increase or decrease within 1.5% corridor*

In the event of a de minimis rate increase or decrease within 1.5% of originally certified rates, we will document such rate changes through an actuarial memorandum rather than full rate certification.

(ii) increase or decrease capitation rates up to 1 percent

No rate ranges are certified by the actuaries.

(iii) application of risk scores under an approved methodology

We will provide an actuarial report documenting the development of risk adjustment factors, including the data, assumptions, and methodologies used to develop the factors.

(e) contract amendment for rate changes other than already approved payment terms

The state will submit a contract amendment for any change that is made to the program other than what is defined within this report.

(f) invalidated program features

The state will submit a rate amendment adjusting capitation rates to remove costs that are specific to any program or activity that become invalidated by law. The amendment will take into account the effective date of the loss of program authority.

General – Appropriate Documentation [Section I.1.B]

Capitation rates certified [Section I.1.B.i]:

The actuaries are certifying capitation rates. No rate ranges are certified by the actuaries.

Documentation detail required [Section I.1.B.ii]:

(a) data used

Please refer to Section III Base Data Development.

(b) assumptions made

Details supporting all assumptions are provided throughout this document. Please refer to the following sections for further information:

- Section III Base Data Development
- Section IV Program Changes
- Section V Trend Assumptions
- Section VI Acuity Adjustments
- Section VII Non-Benefit Expenses
- Section VIII Development of Capitation Rates

(c) methods for analyzing data and developing assumptions and adjustments

Methodology applied in developing assumptions and adjustments are described throughout this document where assumptions are identified.

Ranges for Assumptions and Adjustments [Section I.1.B.iii]

The rate certification discloses and supports specific assumptions that underlie the certified rates for each rate cell and no rate ranges are certified by the actuaries.

Capitation rate ranges [Section I.1.B.iv]

No rate ranges are certified by the actuaries.

Rate certification index [Section I.1.B.v]

The table of contents in this document serves as the rate certification index.

Differences in assumptions, methodologies, or factors [Section I.1.B.vi]

All assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards. The FFP associated with the covered populations does not factor into our assumption development.

Enhanced FMAP [Section I.1.B.vii]

West Virginia receives a higher FMAP for WVHB than its other MHT populations, as documented in Table 3. Throughout this document we have provided WVHB rates and assumptions separately, to the extent possible. There are no other services identified in this report for which the State currently claims at a different federal match rate.

Comparison to prior rating periods [Section I.1.B.viii]

(a) comparison to previous certified rates

Please refer to Table 1 and Appendix B.

(b) description of material changes to the rates or rate development process

Please refer to Section I Executive Summary.

(c) description of any adjustment to the capitation rates in the previous period

Our understanding is that all adjustments in the previous rate period were over 1.5% and required a rate amendment.

List of known future amendments [Section I.1.B.ix]

There are no known future amendments at the time of the rate certification submission. However, there are several program changes that may be implemented during SFY 2024 that could require a capitation rate change. Potential known changes include:

- Approval of West Virginia's pending renewal application for its 1115 waiver entitled "Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders,"
- Implementation of a change in the State's prior authorization law that will go into effect January 1, 2024,
- New requirements regarding value-based purchasing for substance use disorder (SUD) providers,
- Implementation of Certified Community Behavioral Health Clinic (CCBHC) payment models, and
- Coverage of mobile crisis services.

Additionally, the State intends to monitor emerging experience related to the COVID-19 PHE unwind and will consider a mid-year capitation rate adjustment if circumstances suggest a material change in underlying assumptions.

Approach to address COVID-19 [Section I.1.B.x]

(a) available and applicable data

Please refer to the COVID-19 Data Section.

(b) capitation rates account for direct and indirect effects

Please refer to the COVID-19 Adjustments Section.

(c) risk mitigation strategies

The state is using a gain share to reflect increased risk to the State that the costs continue to come in below expectations.

DATA [SECTION I.2]

Data – Rate Development Standards [Section I.2.A]

Base data standards under 42 C.F.R. § 438.5(c) [Section I.2.A.i]:

Please refer to the Base Data Development Section.

Data – Appropriate Documentation [Section I.2.B]

Base data under 42 C.F.R. § 438.7(b)(1) [Section I.2.B.i]:

Please refer to Base Data Development Section.

Description of data used to develop rates [Section I.2.B.ii]:

Please refer to Base Data Development Section.

Description of data adjustments [Section I.2.B.iii]:

(a) credibility adjustments

Please refer to the Credibility Adjustments Section.

(b) completion factors

Please refer to the Completion Adjustments Section.

(c) data errors

We did not observe any material data errors outside of the data reconciliation issues described in the Data Validation Section.

(d) program changes

Please refer to Program Changes Section.

(e) exclusions of certain payments or services from the data

Please refer to the Adjustments to the Base Data Section. We have not made any other exclusions from the base data that are not described elsewhere in this report.

PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Projected Benefit Cost – Rate Development Standards [Section I.3.A]

Allowed services [Section I.3.A.i]:

Final capitation rates are based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

Development of benefit cost trends [Section I.3.A.ii]:

Please refer to Trend Assumptions Section.

In-lieu-of services under 42 C.F.R. § 438.3(e)(2) [Section I.3.A.iii]:

The MCO contract does not include provision for services in-lieu of State Plan services.

IMD treatment as in-lieu-of service [Section I.3.A.iv]:

Please refer to the IMD Data Adjustments Section for more information.

Projected Benefit Cost – Appropriate Documentation [Section I.3.B]

Final projected benefit cost [Section I.3.B.i]:

Final projected benefit costs are illustrated in Appendices C through G for each rate cell.

Development of projected benefit cost [Section I.3.B.ii]:

(a) description of the data, assumptions, and methodologies used to develop the projected benefit costs and, all significant and material items in developing the projected benefit costs

Please refer to Trend Assumptions Section.

(b) material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.

Material changes to data, assumptions, and methodologies are discussed in the Executive Summary.

(c) amount of overpayments to providers and a description of how the state accounted for this in rate development

We have accounted for overpayments to providers in rate development through the completion adjustment which includes estimated claim recoveries.

Projected benefit cost trends [Section I.3.B.iii]:

(a) in accordance with 42 CFR §438.7(b)(2), this section must include:

(i) data and assumptions used to select trends

Please refer to the Trend Assumptions Section.

(ii) methodologies used to select trends

Trends are based primarily on regression results for normalized historical time series experience, as described above. Regressions were performed separately for pre-PHE and post-PHE time periods. Generally, pre-PHE regressions were used to select trends.

(iii) comparisons to historical trends or alternative sources used in selecting trends

We did not analyze any other trends as part of the trend development.

(iv) documentation supporting selected trends and explanation of outlier and negative trends

All negative trends are a direct result of costs or utilization in our experience period.

(b) components of trend

(i) projected benefit cost trends should be separated into:

(A) changes in price

(B) changes in utilization

We reviewed historical experience in the following components to inform separate assumptions for unit cost and utilization trends:

- admissions / encounters per 1,000 member months
- procedure counts per 1,000 member months
- reported units per 1,000 member months
- recipient counts per 1,000 member months
- cost per admission
- cost per procedure
- cost per unit
- cost per recipient

(ii) justification for selecting trends in aggregate rather than split into price and utilization components

Not applicable.

(iii) other components of trend

Not applicable.

(c) variations in trend

Please refer to Trend Assumptions Section.

(d) other material adjustments to trend

Not applicable.

(e) Other non-material adjustments to trend:

We did not make any non-material adjustments to historical experience used in evaluating trends.

Adjustments due to MHPAEA [Section I.3.B.iv]:

Historical experience does not require adjustment for compliance with the Mental Health Parity and Addiction Equity Act.

In-lieu-of services [Section I.3.B.v]:

(a) categories of covered service that contain in-lieu of services

West Virginia Medicaid allows for mental health-related IMD stays of less than 15 days in one calendar month for members aged 21-64 to be used as 'in lieu of' services. These costs are included in the base data under the inpatient behavioral health claim lines.

(b) the percentage of cost that in-lieu-of services represent in each category of service

In-lieu of services represent approximately 28% of IP Psych for adult rate cells.

(c) how in-lieu-of services were taken into account

We repriced in-lieu-of IMD services to the State's average per diem cost for inpatient behavioral health services. No other adjustment was made to the development of projected benefit costs specific to IMDs.

(d) data and assumptions utilization should be described in the rate certification

Please refer to Table 4.

Retrospective eligibility periods [Section I.3.B.vi]:

(a) MCOs' responsibility to pay for claims incurred during the retroactive eligibility period

MCOs are not responsible for retroactive eligibility periods prior to application approval.

(b) how claims information are included in the base data

All claims or encounters incurred for a month that have not been identified as a covered MCO month are excluded.

(c) how enrollment or exposure information is included in the base data

Detailed enrollment files are provided by the state, and only months where members are identified as assigned to an MCO are included in our base experience.

(d) how capitation rates are adjusted to reflect retroactive eligibility period

Capitation rates are not explicitly adjusted to reflect retroactive eligibility periods.

Impact of changes to covered benefits or services since the last rate certification [Section I.3.B.vii]:

(a) more or fewer State Plan benefits covered by Medicaid managed care

Please refer to the Program Changes Section of this report.

(b) recoveries of overpayments made to providers by health plans

We have accounted for overpayments to providers in rate development through the completion adjustment which includes estimated claim recoveries.

(c) requirements related to payments from health plans to any providers or class of providers

There are no material changes to the requirements related to payments from managed care plans to any providers or class of providers since the last rate certification that would impact the projected benefit costs included in the capitation rates.

(d) requirements or conditions of any applicable waivers

There have not been any changes in applicable waivers since the last rate certification.

(e) requirements or conditions of any litigation to which the state is subjected

Please refer to the gender affirming care section within the Program Changes Section. We are not aware of any other requirements or conditions of any other litigation to which the state is subjected.

Impact of non-material changes to covered benefits or services [Section I.3.B.viii]:

(a) aggregate adjustment for changes determined by the actuary to be non-material

(i) list of all non-material adjustments used in the rate development process

All adjustments for changes related to covered benefits or services have been described elsewhere in this report. We have not aggregated multiple changes together in the development of adjustment factors.

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Not applicable.

Withhold Arrangements [Section I.4.B]

Not applicable.

Risk-Sharing Mechanisms [Section I.4.C]

Please refer to the Risk Mitigation Section of this report.

Delivery System and Provider Payment Initiatives [Section I.4.D]

State-Directed Payments – Rate Development Standards [Section I.4.D.i]

(a) *state-directed delivery system and provider payment initiatives under 42 CFR §438.6(c)*

(i) *value-based purchasing models for provider reimbursement - pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services*

Not applicable.

(ii) *multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives*

Not applicable.

(iii) *minimum fee schedule for network providers providing a particular contract service using Medicaid state plan approved rates*

The state directs MCOs to pay a minimum fee schedule to providers based on State Plan approved rates for the following services:

- Durable medical equipment (DME)
- Family planning
- Behavioral health
- Emergency transportation

(iv) *minimum fee schedule for network providers providing a particular contract service using rates other than the Medicaid state plan approved rates*

Not applicable.

(v) *uniform dollar or percentage increase for network providers that provide a particular service under the contract.*

The state directs MCOs to pay a uniform dollar or percentage increase to eligible network providers for the following two directed payments:

- Hospital Directed Payment (Hospital DPP)
- Physician Directed Payment (Physician DPP)

(vi) *maximum fee schedule for network providers providing a particular contract service, allowing health plans to retain ability to reasonably manage risk*

Not applicable.

(b) *State-directed payments are consistent with the information in the approved preprint*

For the Hospital DPP and Physician DPP, the rate development is consistent with the expected terms of the preprints which we expect will be submitted to CMS in June 2023 for review and approval. However, we will amend the certification as needed to confirm consistency with the final preprints.

(c) *Contract arrangements must be developed in accordance with 42 C.F.R. § 438.4, the standards specified in § 438.5, and generally accepted actuarial principles and practices*

All contract arrangements that direct the MCOs' expenditures are developed in accordance with the C.F.R. and generally accepted actuarial principles and practices.

(d) *how each approved state-directed payment is reflected in the payments to the managed care plan from the state*

Each of the following state-directed payments which do not require preprints was incorporated into the capitation rates as an adjustment:

- Durable medical equipment (DME)
- Family planning
- Behavioral health
- Emergency transportation

Each of the following two state-directed payments which require preprints was incorporated into the capitation rates as a separate payment term:

- Hospital Directed Payment (Hospital DPP)
- Physician Directed Payment (Physician DPP)

(i) *documentation related to the payment term in the initial, base rate certification*

See the required documentation in Section I.4.D.ii.a.iii.

(ii) *material directed payments addressed through separate payment terms*

See the estimated magnitude of the portion of the rates on a PMPM basis in Section I.4.D.ii.a.iii.

(iii) *subsequent documentation of directed payments made*

Once the state has made payments consistent with the contract and as reflected in this initial, base rate certification, the state will submit additional documentation to CMS that incorporates the total amount of the final payments into the rate certification's rate cells consistent with the distribution methodology described herein.

(iv) *capitation rate amendment*

To the extent that the total amount of the payment or the distribution methodology changes from this initial base rate certification, the state will submit a capitation rate amendment for the rating period describing the magnitude of and reason for the change.

State-Directed Payments – Appropriate Documentation [Section I.4.D.ii]

(a) *description of each delivery system and provider payment initiative*

The table below provides a summary of all state-directed payments as applicable to this program for SFY 2024.

CONTROL NAME OF THE STATE DIRECTED PAYMENT	TYPE OF PAYMENT [SEE (I) (A) BELOW]	BRIEF DESCRIPTION [SEE (I) (B)]	IS THE PAYMENT INCLUDED AS A RATE ADJUSTMENT OR A SEPARATE PAYMENT TERM [SEE (II) (III) BELOW]
Durable Medical Equipment	Minimum fee schedule	At least 100% of FFS Medicaid fee schedule	Rate adjustment
Family Planning	Minimum fee schedule	At least 100% of FFS Medicaid fee schedule	Rate adjustment
Behavioral Health	Minimum fee schedule	At least 100% of FFS Medicaid fee schedule	Rate adjustment
Emergency Transportation	Minimum fee schedule	At least 100% of FFS Medicaid fee schedule	Rate adjustment
Hospital DPP	Uniform dollar or percentage increase	Supplemental payment	Separate payment term
Physician DPP	Uniform dollar or percentage increase	Supplemental payment	Separate payment term

(i) a brief description of each state directed payment

(A) type(s) of directed payment arrangement

Please refer to table above in Section I.4.D.ii.(a).

(B) brief description of each directed payment arrangement

DURABLE MEDICAL EQUIPMENT

The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network durable medical equipment (DME) providers unless such provider agreed to an alternative payment schedule.

FAMILY PLANNING

The reimbursement must be provided at least at the applicable West Virginia Medicaid FFS rate appropriate to the provider type (current family planning services fee schedule available from BMS).

BEHAVIORAL HEALTH

The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network behavioral health provider unless such provider agreed to an alternative payment schedule.

EMERGENCY TRANSPORTATION

The MCO must reimburse for emergency transportation at a rate of at least one hundred percent (100%) of the Medicaid fee schedule for emergency ground transportation and emergency air transportation.

HOSPITAL DPP

The Hospital DPP provides supplemental payments to the following six groups of qualifying providers.

- Urban non-safety net providers
- Rural non-safety net providers
- Urban safety net providers
- Rural safety net providers
- Public safety net
- Academic physician groups

The size of the supplemental payment for SFY 2024 has yet to be determined and will be included as an amendment to this certification. The supplemental payments will be paid to each group of qualifying providers under their own sub-pool on a quarterly basis. Each quarterly payment will be distributed across qualifying providers within their own group based on MHT enrolled members' actual utilization of any of the following services: inpatient admissions, outpatient visits, or physician visits to the extent applicable. No payments are made related to delivery case rate payments, dental, or behavioral health services.

PHYSICIAN DPP

Physician DPP provides supplemental payments to qualifying physicians employed by eligible acute care hospitals. The size of the supplemental payment for SFY 2024 has yet to be determined and will be included as an amendment to this certification. The supplemental payments will be paid under a single set pool to qualifying providers on a quarterly basis. Each quarterly payment will be distributed across qualifying providers based on MHT enrolled members' actual utilization of eligible physician services. Please refer to the preprint for additional details about this payment.

(ii) state-directed payments incorporated into the base capitation rates as a rate adjustment

The provider payment initiatives listed below were included as rate adjustments to the historical base experience data used to develop SFY 2024 capitation rates.

- Durable Medical Equipment (DME)
- Family planning
- Behavioral Health
- Emergency Transportation

The table below provides a summary of the required information in the prescribed table format for each of the above state-directed payments:

CONTROL NAME OF THE STATE DIRECTED PAYMENT	RATE CELLS AFFECTED [SEE (A) BELOW]	IMPACT [SEE (B) BELOW]	DESCRIPTION OF THE ADJUSTMENT [SEE (C) BELOW]	CONFIRMATION THE RATES ARE CONSISTENT WITH THE PREPRINT [SEE (D) BELOW]	FOR MAXIMUM FEE SCHEDULES, PROVIDE THE INFORMATION IN (E) BELOW
Durable Medical Equipment	All	None. Please see B below.	Included in the base and adjusted for in fee schedule changes and trend	No preprint required; confirmed the rates are consistent with the applicable state plan fee schedule	Not applicable
Family Planning	All	None. Please see B below.	Included in the base and adjusted for in fee schedule changes and trend	No preprint required; confirmed the rates are consistent with the applicable state plan fee schedule	Not applicable
Behavioral Health	All	None. Please see B below.	Included in the base and adjusted for in fee schedule changes and trend	No preprint required; confirmed the rates are consistent with the applicable state plan fee schedule	Not applicable
Emergency Transportation	All	None. Please see B below.	Included in the base and adjusted for in fee schedule changes and trend	No preprint required; confirmed the rates are consistent with the applicable state plan fee schedule	Not applicable

(A) indication of which rate cells were affected by the directed payment arrangement

All rate cells are affected by each of the above directed payments to the extent members within the rate cell utilize the services.

(B) impact the directed payment has on the rates

There is no explicit impact of the directed payments above. The directed payments above are already reflected in the base data. We have adjusted the base payments for fee schedule changes and unit cost trends consistent with all other services.

(C) description of how each payment arrangement is reflected in the certified capitation rates

For each of the above directed payments, the MCO paid amounts included in the base encounters used for rate development reflected the state plan fee schedule effective in the base period. We adjusted the base payments for fee schedule changes and unit cost trends consistent with all other services.

(D) CMS approval of included payment arrangements under §438.6(c)

These four directed payments do not require preprints as they set minimum fee schedule at the state plan fee schedule level.

(E) implementation of a maximum fee schedule

Not applicable.

(iii) state-directed payments incorporated into the base capitation rates as a rate adjustment

Each of the following state-directed payments are included in the rates as a separate payment term consistent with the preprints expected to be submitted to CMS for review and approval:

- Hospital DPP
- Physician DPP

The table below provides a summary of the required information in the prescribed table format for each of the above state-directed payments:

CONTROL NAME OF THE STATE DIRECTED PAYMENT	AGGREGATE AMOUNT INCLUDED IN THE CERTIFICATION [SEE (A) BELOW]	STATEMENT THAT THE ACTUARY IS CERTIFYING THE SEPARATE PAYMENT TERM [SEE(B) BELOW]	THE MAGNITUDE ON A PMPM BASIS [SEE (C) BELOW]	CONFIRMATION THE RATE DEVELOPMENT IS CONSISTENT WITH THE PREPRINT [SEE (D) BELOW]	CONFIRMATION THAT THE STATE AND ACTUARY WILL SUBMIT REQUIRED DOCUMENTATION AT THE END OF THE RATING PERIOD [AS APPLICABLE; SEE (E) BELOW]
Hospital DPP	TBD	None. Please see B below.	The actuaries will certify the separate payment term once the amount is known.	We will confirm when the preprint is finalized.	Confirmed
Physician DPP	TBD	None. Please see B below.	The actuaries will certify the separate payment term once the amount is known.	We will confirm when the preprint is finalized.	Confirmed

(A) aggregate amount of the payment applicable to the rate certification

To be determined. We will submit a rate amendment once the final payment size is known.

(B) certification of amount of the separate payment term disclosed

The signing actuaries will certify the amount of the separate payment term disclosed in the SFY 2024 rate certification for Hospital DPP and Physician DPP once the preprints are finalized.

(C) clear reference to the exhibit that shows the magnitude of the payment on a PMPM basis

None of the two separated payment terms is paid and certified as a part of the capitation rates on a PMPM basis. The aggregated amounts will be paid on a quarterly basis and distributed across eligible providers based on MHT enrolled members' actual utilization of eligible services. Table 16 shows an estimate of the magnitude of each of the two payments on a PMPM basis by category of aid for informational purpose only using expected SFY 2023 payment amounts. We will amend this table as part of an amendment to the rate certification once the preprints are finalized.

TABLE 16: DPP PMPM ESTIMATE BY COA FROM SFY 2023

COA	HOSPITAL DPP	PHYSICIAN DPP
TANF & CSHCN	$ 27.24	$ 2.97
WVHB	69.47	7.53
SSI	148.04	12.32
Pregnant Women	251.27	25.62

(D) *indication that the state directed payment is consistent with the preprint*

The Hospital and Physician preprints will be submitted to CMS in June 2023 for review. For each of the two, the state-directed payment has been accounted for in a manner consistent with the SFY 2023 preprints. We will review the preprints and amend our certification as necessary once the preprints are finalized.

(E) *subsequent documentation of directed payments made*

After the rating period is complete, the state will submit to CMS documentation that incorporates the total amount of the Hospital and Physician payments into the applicable rate cells consistent with the distribution methodology included in the approved state directed payment preprints. The Hospital and Physician payments are included in the rate certification as a separate pool that is certified in addition to the base PMPM capitation rates.

(a) *Additional directed payments*

There are no additional directed payments in the program that are not addressed in the certification.

(b) *Requirements regarding the reimbursement rates the plans must pay to providers*

There are not any requirements regarding the reimbursement rates the plans must pay to any providers unless specified in the certification.

Pass-Through Payments [Section I.4.E]

Not applicable. The state does not have any pass-through payments in effect for the rating period.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Non-Benefit Cost – Rate Development Standards [Section I.5.A]

Please refer to the Projected Non-Benefit Costs Section.

Non-Benefit Cost – Appropriate Documentation [Section I.5.B]

Please refer to the Projected Non-Benefit Costs Section.

Categories of non-benefit costs [Section I.5.B.ii]:

(a) *administrative costs*

The resulting general administrative load assumptions can be seen in Appendix A and Table 14.

(b) *taxes, licensing and regulatory fees, and other assessments and fees*

The resulting state premium tax PMPM can be seen in Appendix A and Table 14.

(c) *contribution to reserves, risk margin, and cost of capital*

The risk margin assumption was set at 1.5% of capitation rate net of premium tax and state-directed payment.

(d) *other operational costs*

Not applicable.

Historical Non-Benefit Cost Data [Section 1.5.B.iii]:

Table 17 summarizes SFY 2022 adjusted non-benefit costs across the entire MHT program by each individual component as explicitly modeled for SFY 2024 rates.

TABLE 17: SFY 2022 NON-BENEFIT COSTS

NON-BENEFIT COST COMPONENT	MHT
General administrative cost as % of benefit cost	7.6%
Quality improvement cost as % of benefit cost	2.6%
Premium tax PMPM	$7.59

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Risk Adjustment & Acuity – Rate Development Standards [Section I.6.A]

Please refer to the Acuity Adjustments Section and Risk Adjustment Section.

Risk Adjustment & Acuity – Appropriate Documentation [Section I.6.B]

Prospective risk adjustment methodologies [Section I.6.B.i]

We will develop budget neutral prospective risk adjustment factors which will be documented with a separate report. Risk adjustment will not be applied to the under 1 rate cells, pregnant women rate cells, or the delivery case rate.

(a) *the data, and any adjustments to that data, to be used to calculate the adjustment.*

We will utilize twelve months of encounter and FFS data from the State to calculate risk scores.

(b) *the model, and any adjustments to that model, to be used to calculate the adjustment.*

Please refer to the Risk Adjustment Section.

(c) *the method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations.*

Please refer to the Risk Adjustment Section.

(d) *the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP.*

Adjustment factors vary by aid category and region for each MCO and are not known at this time.

(e) *an assessment of the predictive value of the methodology compared to prior rating periods.*

We may use West Virginia specific data to refine the default CDPS+Rx coefficients. This should allow the predictive value of the model to be at least as good as the prior rating periods.

(f) *any concerns the actuary has with the risk adjustment process.*

We do not have material concerns with the proposed risk adjustment process.

Retrospective risk adjustment methodologies [Section I.6.B.ii]

Not applicable.

Risk adjustment assurances [Section I.6.B.iii]

(a) *any changes that are made to risk adjustment models since the last rating period*

We will update the risk adjustment model to the most recently available CDPS+Rx model and are considering the use of state-specific factors to calibrate the model and/or add geographic variables to the risk adjustment process.

(b) *documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g)*

Risk adjustment factors are calculated using a method that is budget neutral to the state at the aid category and region level, as well as in aggregate across the program statewide.

Acuity adjustment [Section I.6.B.iv]

Please refer to the Acuity Adjustments Section.

Medicaid Managed Care Rates with LTSS [Section II]

Not applicable, these services are not covered under the West Virginia Managed Care contracts.

New Adult Group Capitation Rates [Section III]

DATA [SECTION III.1]

Description of Additional Data Used [Section III.1.A]

We did not use any different data sources for the development of capitation rates for new adult group rates relative to other covered populations.

Prior Rates for Newly Eligible Adults [Section III.1.B]

New data available [Section III.1.B.i]

We have relied on the most recently available data as our base for rate setting. Please refer to the Base Data Development Section for a discussion of the data.

Monitoring cost and experience [Section III.1.B.ii]

We continue to rely on the most recent and complete experience specific to the new adult group for rate development.

Actual to expected experience [Section III.1.B.iii]

Given the significant impact of the PHE, we do not think actual to expected experience is a relevant metric for setting the SFY 2024 capitation rates.

Adjustments based on actual-to-expected analysis [Section III.1.B.iv]

We have not adjusted based on actual-to-expected experience.

PROJECTED BENEFIT COSTS [SECTION III.2]

Description of Issues for New Adult Group [Section III.2.A]

For states with prior managed care coverage [Section III.2.A.i]

(a) *data and experience specific to newly eligible adults covered in previous rating periods that was used to develop projected benefit costs for capitation rates*

Data and experience used in capitation rate development was reviewed and applied separately for the new adult group. Additional information is described throughout this report.

(b) *changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last rate certification*

There are no material changes in data sources, assumptions, or methodologies relative to the prior rate certification specific to the new adult group.

(c) *how assumptions changed from rate certification(s) for previous rating periods on the following issues:*

(i) *acuity or health status adjustments*

We have added an acuity adjustment to reflect changes in the acuity of the new adult population given the resumption of redeterminations. Please refer to the Acuity Adjustments Section for more detail.

(ii) *adjustments for pent-up demand:*

No adjustment

(iii) *adjustments for adverse selection:*

No adjustment

(iv) *adjustments for demographics of newly eligible adults*

No adjustment

(v) *differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates*

There are no differences in provider reimbursement rates or provider networks specific to the newly eligible adult group.

(vi) *other material adjustments to newly eligible adults projected benefit cost*

There are no other adjustments applied specifically to the newly eligible adult group.

(vii) *any changes to the benefit plan offered to the new adult group*

There are no other changes specific to the newly eligible adult group. Benefit plan changes which apply to the entire program are documented in the Program Changes Section.

Key Assumptions for Newly Eligible Adults [Section III.2.B]

See Section III.2.A.

PROJECTED NON-BENEFIT COSTS [SECTION III.3]

Description of Non-Benefit Cost for Newly Eligible Adults [Section III.3.A]

Please refer to the Projected Non-Benefit Expenses Section of this report.

Comparison to other populations [Section III.3.B]

See Section I.5.

FINAL CERTIFIED RATES [SECTION III.4]

Description of Final Rates for Newly Eligible Adults [Section III.4.A]

Comparison to prior rates [Section III.4.A.i]

Please refer to Appendices B and G.

Description of other material changes [Section III.4.A.ii]

All material changes are described elsewhere in this report.

RISK MITIGATION STRATEGIES [SECTION III.5]

Description of Risk Mitigation Strategy for the New Adult Group [Section III.5.A]

All risk mitigation used under the MCO contract is applied consistently across all populations, including the New Adult Group.

Additional Risk Mitigation Information [Section III.5.B]

There is no change to the risk mitigation strategy for the New Adult Group relative to prior period capitation rates.

Appendix B – Capitation Rate Development

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: All

	Projected. SFY 2024 MMs				SFY 2024 Rate by Region				SFY 2023 Rate by Region				% Change			
COA / Rate Cell	North	East	South	Composite	North	East	South	Composite	North	East	South	Composite	North	East	South	Composite
TANF																
Age <1	41,994	20,389	58,990	121,373	$ 581.55	$ 601.02	$ 589.29	$ 588.58	$ 497.35	$ 460.32	$ 520.90	$ 502.58	16.9%	30.6%	13.1%	17.1%
Age 1	39,408	19,519	52,058	110,985	161.47	158.90	178.68	169.09	163.93	146.13	154.93	156.58	(1.5%)	8.7%	15.3%	8.0%
Age 2 - 14	500,522	239,351	664,520	1,404,393	163.08	154.38	168.15	163.99	159.42	149.01	165.30	160.43	2.3%	3.6%	1.7%	2.2%
Age 15 - 19 Female	70,830	33,667	96,431	200,928	259.16	234.41	249.78	250.51	296.48	272.26	282.32	285.63	(12.6%)	(13.9%)	(11.5%)	(12.3%)
Age 15 - 19 Male	73,616	33,517	98,834	205,967	176.43	161.29	180.97	176.14	181.75	192.57	194.62	189.69	(2.9%)	(16.2%)	(7.0%)	(7.1%)
Age 20 - 29 Female	55,418	23,666	72,408	151,492	282.07	273.99	271.78	275.89	281.15	291.80	301.45	292.52	0.3%	(6.1%)	(9.8%)	(5.7%)
Age 20 - 29 Male	9,665	3,821	12,394	25,880	202.60	199.65	181.51	192.07	219.81	206.85	205.84	211.21	(7.8%)	(3.5%)	(11.8%)	(9.1%)
Age 30 - 39 Female	67,589	29,074	83,250	179,913	315.77	319.22	364.69	338.96	335.51	347.73	380.12	358.13	(5.9%)	(8.2%)	(4.1%)	(5.4%)
Age 30 - 39 Male	19,800	7,740	23,587	51,127	258.16	266.35	283.87	271.26	290.18	289.18	313.92	300.98	(11.0%)	(7.9%)	(9.6%)	(9.9%)
Age 40+	50,777	21,749	67,815	140,341	425.96	388.93	407.42	411.26	384.14	384.76	420.33	401.72	10.9%	1.1%	(3.1%)	2.4%
Delivery Case Rate	387	149	533	1,069	6,829.75	7,041.93	6,976.53	6,932.50	6,437.37	7,272.86	6,718.31	6,693.90	6.1%	(3.2%)	3.8%	3.6%
Composite	**929,619**	**432,493**	**1,230,287**	**2,592,399**	**$ 228.13**	**$ 216.66**	**$ 234.18**	**$ 229.08**	**$ 225.51**	**$ 215.08**	**$ 236.21**	**$ 228.85**	**1.2%**	**0.7%**	**(0.9%)**	**0.1%**
CSHCN																
All Ages	2,354	708	1,976	5,038	$ 545.72	$ 545.72	$ 545.72	$ 545.72	$ 700.89	$ 700.89	$ 700.89	$ 700.89	(22.1%)	(22.1%)	(22.1%)	(22.1%)
Composite	**2,354**	**708**	**1,976**	**5,038**	**$ 545.72**	**$ 545.72**	**$ 545.72**	**$ 545.72**	**$ 700.89**	**$ 700.89**	**$ 700.89**	**$ 700.89**	**(22.1%)**	**(22.1%)**	**(22.1%)**	**(22.1%)**
PW																
All Ages	36,720	17,606	47,666	101,992	$ 289.93	$ 289.93	$ 289.93	$ 289.93	$ 322.52	$ 322.52	$ 322.52	$ 322.52	(10.1%)	(10.1%)	(10.1%)	(10.1%)
Delivery Case Rate[1]	1,838	886	2,518	5,242	6,829.75	7,041.93	6,976.53	6,936.12	6,437.37	7,272.86	6,718.31	6,713.54	6.1%	(3.2%)	3.8%	3.3%
Composite	**36,720**	**17,606**	**47,666**	**101,992**	**$ 631.79**	**$ 644.31**	**$ 658.48**	**$ 646.42**	**$ 644.74**	**$ 688.52**	**$ 677.42**	**$ 667.57**	**(2.0%)**	**(6.4%)**	**(2.8%)**	**(3.2%)**
SSI																
Age <20	29,898	12,933	38,410	81,241	$ 471.44	$ 373.85	$ 354.97	$ 400.84	$ 438.87	$ 370.54	$ 328.69	$ 375.90	7.4%	0.9%	8.0%	6.6%
Age 20 - 29 Female	7,006	2,503	9,145	18,654	442.23	422.00	405.88	421.69	528.88	478.74	519.31	517.46	(16.4%)	(11.9%)	(21.8%)	(18.5%)
Age 20 - 29 Male	10,431	3,905	14,927	29,263	256.24	272.51	328.93	295.49	289.99	308.79	383.75	340.32	(11.6%)	(11.7%)	(14.3%)	(13.2%)
Age 30 - 39 Female	11,726	2,784	15,119	29,629	543.38	530.74	600.37	571.27	557.50	527.84	607.03	579.99	(2.5%)	0.5%	(1.1%)	(1.5%)
Age 30 - 39 Male	11,188	3,129	16,995	31,312	430.56	403.68	466.90	447.60	511.74	441.17	486.85	491.18	(15.9%)	(8.5%)	(4.1%)	(8.9%)
Age 40 - 49 Female	16,150	3,961	26,754	46,865	789.85	758.47	795.05	790.16	755.64	768.34	787.99	775.18	4.5%	(1.3%)	0.9%	1.9%
Age 40 - 49 Male	11,663	2,223	19,851	33,737	658.56	582.89	565.08	598.57	652.22	635.10	629.12	637.50	1.0%	(8.2%)	(10.2%)	(6.1%)
Age 50 - 59 Female	26,653	7,348	45,950	79,951	924.25	818.62	804.96	845.98	906.95	863.46	776.39	827.91	1.9%	(5.2%)	3.7%	2.2%
Age 50 - 59 Male	20,843	5,766	36,277	62,886	757.23	753.39	697.82	722.61	749.94	728.25	701.24	719.86	1.0%	3.5%	(0.5%)	0.4%
Age 60+	25,821	7,664	41,845	75,330	866.66	787.81	816.69	830.88	825.10	821.97	773.78	796.28	5.0%	(4.2%)	5.5%	4.3%
Delivery Case Rate	69	11	91	171	6,829.75	7,041.93	6,976.53	6,921.51	6,437.37	7,272.86	6,718.31	6,640.62	6.1%	(3.2%)	3.8%	4.2%
Composite	**171,379**	**52,216**	**265,273**	**488,868**	**$ 669.62**	**$ 583.55**	**$ 636.58**	**$ 642.50**	**$ 662.14**	**$ 601.82**	**$ 634.17**	**$ 640.52**	**1.1%**	**(3.0%)**	**0.4%**	**0.3%**
WVHB																
Age 15 - 29 Female	116,291	48,642	160,243	325,176	$ 267.43	$ 228.85	$ 264.78	$ 260.35	$ 292.29	$ 263.01	$ 301.88	$ 292.63	(8.5%)	(13.0%)	(12.3%)	(11.0%)
Age 15 - 29 Male	97,059	36,532	144,383	277,974	230.34	211.06	230.36	227.81	268.93	256.60	282.46	274.33	(14.3%)	(17.7%)	(18.4%)	(17.0%)
Age 30 - 39 Female	103,513	43,277	140,631	287,421	345.32	309.83	368.55	351.35	379.26	340.92	420.07	393.45	(8.9%)	(9.1%)	(12.3%)	(10.7%)
Age 30 -39 Male	94,740	34,638	133,181	262,559	354.82	304.92	406.64	374.52	418.74	382.14	452.69	431.13	(15.3%)	(20.2%)	(10.2%)	(13.1%)
Age 40 - 49 Female	91,603	35,632	134,001	261,236	412.57	396.97	416.64	412.53	429.30	411.19	438.56	431.58	(3.9%)	(3.5%)	(5.0%)	(4.4%)
Age 40 - 49 Male	78,263	27,073	117,343	222,679	422.29	375.38	450.99	431.71	423.60	394.54	485.73	452.81	(0.3%)	(4.9%)	(7.2%)	(4.7%)
Age 50 - 59 Female	79,843	33,205	98,066	211,114	519.42	495.15	492.70	503.19	512.18	511.10	487.52	500.55	1.4%	(3.1%)	1.1%	0.5%
Age 50 - 59 Male	66,763	27,750	88,434	182,947	504.35	465.38	485.71	489.43	488.90	516.51	520.36	508.30	3.2%	(9.9%)	(6.7%)	(3.7%)
Age 60+ Female	32,350	13,961	36,916	83,227	575.44	559.81	556.15	564.26	539.76	539.44	509.71	526.38	6.6%	3.8%	9.1%	7.2%
Age 60+ Male	25,511	10,663	26,229	62,403	535.35	508.15	564.39	542.91	536.54	548.77	557.66	547.51	(0.2%)	(7.4%)	1.2%	(0.8%)
Delivery Case Rate	406	160	573	1,139	6,829.75	7,041.93	6,976.53	6,933.39	6,437.37	7,272.86	6,718.31	6,696.07	6.1%	(3.2%)	3.8%	3.5%
Composite	**785,936**	**311,373**	**1,079,427**	**2,176,736**	**$ 386.61**	**$ 355.96**	**$ 390.05**	**$ 383.93**	**$ 405.63**	**$ 389.70**	**$ 421.89**	**$ 411.42**	**(4.7%)**	**(8.7%)**	**(7.5%)**	**(6.7%)**
Composite																
TANF	929,619	432,493	1,230,287	2,592,399	$ 228.13	$ 216.66	$ 234.18	$ 229.08	$ 225.51	$ 215.08	$ 236.21	$ 228.85	1.2%	0.7%	(0.9%)	0.1%
CSHCN	2,354	708	1,976	5,038	545.72	545.72	545.72	545.72	700.89	700.89	700.89	700.89	(22.1%)	(22.1%)	(22.1%)	(22.1%)
PW	36,720	17,606	47,666	101,992	631.79	644.31	658.48	646.42	644.74	688.52	677.42	667.57	(2.0%)	(6.4%)	(2.8%)	(3.2%)
SSI	171,379	52,216	265,273	488,868	669.62	583.55	636.58	642.50	662.14	601.82	634.17	640.52	1.1%	(3.0%)	0.4%	0.3%
WVHB	785,936	311,373	1,079,427	2,176,736	386.61	355.96	390.05	383.93	405.63	389.70	421.89	411.42	(4.7%)	(8.7%)	(7.5%)	(6.7%)
Composite	**1,926,008**	**814,396**	**2,624,629**	**5,365,033**	**$ 340.17**	**$ 302.97**	**$ 346.89**	**$ 337.81**	**$ 346.44**	**$ 317.30**	**$ 361.16**	**$ 349.22**	**(1.8%)**	**(4.5%)**	**(4.0%)**	**(3.3%)**
Composite Non-Expansion	**1,140,072**	**503,023**	**1,545,202**	**3,188,297**	**$ 308.15**	**$ 270.17**	**$ 316.75**	**$ 306.32**	**$ 305.63**	**$ 272.48**	**$ 318.74**	**$ 306.75**	**0.8%**	**(0.8%)**	**(0.6%)**	**(0.1%)**

Notes:

1) DCR cases for other COAs are not included here, so composites do not tie to those in Appendix E. Please refer to Appendix E for the development of the DCR.

Appendix C – TANF Projected Benefit Cost Development

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: TANF

Region/Rate Cell	SFY 2022 MMs	SFY 2024 Proj. MMs	SFY 2024 Benefit Cost PMPM	Credibility[1]	Adj. SFY 2024 Benefit Cost PMPM[2]	Non-Benefit Costs QI PMPM	Admin PMPM[3]	Margin PMPM	HMO Tax	SFY 2024 Proposed Rate	SFY 2023 Capitation Rate	SFY 2024 / SFY 2023 % Change
North												
Age <1	42,971	41,994	$ 496.83	97.7%	$ 496.99	$ 17.39	$ 50.20	$ 8.60	$ 8.37	$ 581.55	$ 497.35	16.9%
Age 1	41,940	39,408	132.54	96.5%	132.75	4.65	13.41	2.30	8.37	161.47	163.93	(1.5%)
Age 2 - 14	521,767	500,522	134.15	100.0%	134.15	4.70	13.55	2.32	8.37	163.08	159.42	2.3%
Age 15 - 19 Female	74,370	70,830	217.45	100.0%	217.45	7.61	21.96	3.76	8.37	259.16	296.48	(12.6%)
Age 15 - 19 Male	77,893	73,616	145.73	100.0%	145.73	5.10	14.72	2.52	8.37	176.43	181.75	(2.9%)
Age 20 - 29 Female	57,630	55,418	237.32	100.0%	237.32	8.31	23.97	4.11	8.37	282.07	281.15	0.3%
Age 20 - 29 Male	8,849	9,665	178.48	44.3%	168.41	5.89	17.01	2.91	8.37	202.60	219.81	(7.8%)
Age 30 - 39 Female	71,003	67,589	266.54	100.0%	266.54	9.33	26.92	4.61	8.37	315.77	335.51	(5.9%)
Age 30 - 39 Male	21,096	19,800	211.71	68.5%	216.59	7.58	21.88	3.75	8.37	258.16	290.18	(11.0%)
Age 40+	58,677	50,777	362.08	100.0%	362.08	12.67	36.57	6.26	8.37	425.96	384.14	10.9%
Delivery Case Rate[4]	387	387	6,400.86		6,400.86	83.21	243.23	102.45	-	6,829.75	6,437.37	6.1%
Composite	976,196	929,619	$ 190.73		$ 190.75	$ 6.62	$ 19.10	$ 3.30	$ 8.37	$ 228.13	$ 225.51	1.2%
East												
Age <1	19,903	20,389	$ 518.91	66.5%	$ 513.88	$ 17.99	$ 51.90	$ 8.89	$ 8.37	$ 601.02	$ 460.32	30.6%
Age 1	20,793	19,519	126.70	68.0%	130.52	4.57	13.18	2.26	8.37	158.90	146.13	8.7%
Age 2 - 14	246,145	239,351	126.60	100.0%	126.60	4.43	12.79	2.19	8.37	154.38	149.01	3.6%
Age 15 - 19 Female	34,941	33,667	194.16	88.1%	196.00	6.86	19.80	3.39	8.37	234.41	272.26	(13.9%)
Age 15 - 19 Male	35,235	33,517	130.96	88.5%	132.60	4.64	13.39	2.29	8.37	161.29	192.57	(16.2%)
Age 20 - 29 Female	24,269	23,666	229.74	73.4%	230.31	8.06	23.26	3.98	8.37	273.99	291.80	(6.1%)
Age 20 - 29 Male	3,390	3,821	180.29	27.4%	165.85	5.80	16.75	2.87	8.37	199.65	206.85	(3.5%)
Age 30 - 39 Female	30,421	29,074	265.96	82.2%	269.53	9.43	27.22	4.66	8.37	319.22	347.73	(8.2%)
Age 30 - 39 Male	8,001	7,740	218.89	42.2%	223.69	7.83	22.59	3.87	8.37	266.35	289.18	(7.9%)
Age 40+	24,900	21,749	323.65	74.4%	329.98	11.55	33.33	5.71	8.37	388.93	384.76	1.1%
Delivery Case Rate[4]	149	149	6,599.71		6,599.71	85.80	250.79	105.63	-	7,041.93	7,272.86	(3.2%)
Composite	447,998	432,493	$ 180.02		$ 180.77	$ 6.28	$ 18.11	$ 3.12	$ 8.37	$ 216.66	$ 215.08	0.7%
South												
Age <1	57,306	58,990	$ 503.70	100.0%	$ 503.70	$ 17.63	$ 50.87	$ 8.71	$ 8.37	$ 589.29	$ 520.90	13.1%
Age 1	56,560	52,058	147.67	100.0%	147.67	5.17	14.92	2.55	8.37	178.68	$ 154.93	15.3%
Age 2 - 14	691,374	664,520	138.54	100.0%	138.54	4.85	13.99	2.40	8.37	168.15	$ 165.30	1.7%
Age 15 - 19 Female	101,140	96,431	209.32	100.0%	209.32	7.33	21.14	3.62	8.37	249.78	$ 282.32	(11.5%)
Age 15 - 19 Male	105,050	98,834	149.65	100.0%	149.65	5.24	15.12	2.59	8.37	180.97	$ 194.62	(7.0%)
Age 20 - 29 Female	74,375	72,408	228.40	100.0%	228.40	7.99	23.07	3.95	8.37	271.78	$ 301.45	(9.8%)
Age 20 - 29 Male	11,560	12,394	140.15	50.7%	150.13	5.25	15.16	2.60	8.37	181.51	$ 205.84	(11.8%)
Age 30 - 39 Female	87,658	83,250	308.95	100.0%	308.95	10.81	31.20	5.34	8.37	364.69	$ 380.12	(4.1%)
Age 30 - 39 Male	24,947	23,587	242.90	74.5%	238.88	8.36	24.13	4.13	8.37	283.87	$ 313.92	(9.6%)
Age 40+	79,442	67,815	346.01	100.0%	346.01	12.11	34.95	5.99	8.37	407.42	$ 420.33	(3.1%)
Delivery Case Rate[4]	533	533	6,538.42		6,538.42	85.00	248.46	104.65	-	6,976.53	6,718.31	3.8%
Composite	1,289,412	1,230,287	$ 195.98		$ 196.00	$ 6.80	$ 19.62	$ 3.39	$ 8.37	$ 234.18	$ 236.21	(0.9%)
Composite												
Age <1	120,180	121,373	$ 503.88		$ 503.09	$ 17.61	$ 50.81	$ 8.70	$ 8.37	$ 588.58	$ 502.58	17.1%
Age 1	119,293	110,985	138.61		139.36	4.88	14.08	2.41	8.37	169.09	156.58	8.0%
Age 2 - 14	1,459,286	1,404,393	134.94		134.94	4.72	13.63	2.33	8.37	163.99	160.43	2.2%
Age 15 - 19 Female	210,451	200,928	209.64		209.95	7.35	21.21	3.63	8.37	250.51	285.63	(12.3%)

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: TANF

			SFY 2024		Adj. SFY 2024	Non-Benefit Costs				SFY 2024	SFY 2023	SFY 2024 /
	SFY 2022	SFY 2024	Benefit Cost		Benefit Cost	QI	Admin	Margin	HMO	Proposed	Capitation	SFY 2023
Region/Rate Cell	**MMs**	**Proj. MMs**	**PMPM**	**Credibility[1]**	**PMPM[2]**	**PMPM**	**PMPM[3]**	**PMPM**	**Tax**	**Rate**	**Rate**	**% Change**
Age 15 - 19 Male	218,178	205,967	145.21		145.47	5.09	14.69	2.52	8.37	176.14	189.69	(7.1%)
Age 20 - 29 Female	156,274	151,492	231.87		231.96	8.12	23.43	4.01	8.37	275.89	292.52	(5.7%)
Age 20 - 29 Male	23,799	25,880	160.39		159.28	5.57	16.09	2.76	8.37	192.07	211.21	(9.1%)
Age 30 - 39 Female	189,082	179,913	286.07		286.65	10.03	28.95	4.96	8.37	338.96	358.13	(5.4%)
Age 30 - 39 Male	54,044	51,127	227.18		227.95	7.98	23.02	3.94	8.37	271.26	300.98	(9.9%)
Age 40+	163,019	140,341	348.36		349.34	12.23	35.28	6.04	8.37	411.26	401.72	2.4%
Delivery Case Rate[4]	1,069	1,069	6,497.16		6,497.16	84.46	246.89	103.99	-	6,932.50	6,693.90	3.6%
Composite	2,713,606	2,592,399	$ 191.43		$ 191.58	$ 6.65	$ 19.18	$ 3.31	$ 8.37	$ 229.08	$ 228.85	0.1%

Notes:

1) Credibility is defined as the minimum of 1 and the square root of the SFY 2022 MMs divided by 45,000.

2) The manual rate used in the credibility adjustment is the statewide average by age band.

3) The admin load is applied as a percent of the adjusted SFY 2024 benefit costs.

4) Please refer to the Pregnant Women exhibit worksheet for DCR development.

Appendix D – CSHCN Projected Benefit Cost Development

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: CSHCN

Region/Rate Cell	SFY 2022 MMs	SFY 2024 Proj. MMs	SFY 2024 Benefit Cost PMPM	Non-Benefit Costs QI PMPM	Admin PMPM[1]	Margin PMPM	HMO Tax	SFY 2024 Proposed Rate	SFY 2023 Capitation Rate	SFY 2024 / SFY 2023 % Change
Composite										
All Ages	6,242	5,038	$ 488.73	$ 10.26	$ 30.30	$ 8.06	$ 8.37	$ 545.72	$ 700.89	(22.1%)
Composite	6,242	5,038	$ 488.73	$ 10.26	$ 30.30	$ 8.06	$ 8.37	$ 545.72	$ 700.89	(22.1%)

Notes:

1) The admin load is applied as a percent of the adjusted SFY 2024 benefit costs.

Appendix E – Pregnant Women Projected Benefit Cost Development

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: Pregnant Women

Region/Rate Cell	SFY 2022 MMs[1]	SFY 2024 Proj. MMs[1]	SFY 2024 Benefit Cost PMPM	Non-Benefit Costs: QI PMPM	Non-Benefit Costs: Admin PMPM[2]	Non-Benefit Costs: Margin PMPM	Non-Benefit Costs: HMO Tax	SFY 2024 Proposed Rate	SFY 2023 Capitation Rate	SFY 2024 / SFY 2023 % Change
Composite										
All Ages	73,532	101,992	$ 248.74	$ 7.21	$ 21.39	$ 4.22	$ 8.37	289.93	$ 322.52	(10.1%)
Delivery Case Rate - North	2,700	2,700	6,400.86	83.21	243.23	102.45	-	6,829.75	6,437.37	6.1%
Delivery Case Rate - East	1,206	1,206	6,599.71	85.80	250.79	105.63	-	7,041.93	7,272.86	(3.2%)
Delivery Case Rate - South	3,715	3,715	6,538.42	85.00	248.46	104.65	-	6,976.53	6,718.31	3.8%
Composite	73,532	101,992	$ 734.38	$ 13.53	$ 39.85	$ 12.00	$ 8.37	$ 808.12	$ 823.64	(1.9%)

Notes:

1) Historical SFY 2022 and projected SFY 2024 MMs for the Delivery Case Rate include deliveries from women in all rate cells.

2) The admin load is applied as a percent of the adjusted SFY 2024 benefit costs.

Appendix F – SSI Projected Benefit Cost Development

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: SSI

			SFY 2024		Adj. SFY 2024	Non-Benefit Costs				SFY 2024	SFY 2023	SFY 2024 /
	SFY 2022	SFY 2024	Benefit Cost		Benefit Cost	QI	Admin	Margin	HMO	Proposed	Capitation	SFY 2023
Region/Rate Cell	MMs	Proj. MMs	PMPM	Credibility[1]	PMPM[2]	PMPM	PMPM[3]	PMPM	Tax	Rate	Rate	% Change
North												
Age <20	28,849	29,898	$ 422.73	100.0%	$ 422.73	$ 8.45	$ 24.94	$ 6.95	$ 8.37	$ 471.44	$ 438.87	7.4%
Age 20 - 29 Female	6,683	7,006	409.83	56.4%	396.06	7.92	23.37	6.51	8.37	442.23	528.88	(16.4%)
Age 20 - 29 Male	9,580	10,431	211.22	67.5%	226.28	4.53	13.35	3.72	8.37	256.24	289.99	(11.6%)
Age 30 - 39 Female	11,331	11,726	481.06	73.5%	488.40	9.77	28.82	8.03	8.37	543.38	557.50	(2.5%)
Age 30 - 39 Male	10,682	11,188	381.35	71.3%	385.41	7.71	22.74	6.33	8.37	430.56	511.74	(15.9%)
Age 40 - 49 Female	15,390	16,150	713.82	85.6%	713.40	14.27	42.09	11.72	8.37	789.85	755.64	4.5%
Age 40 - 49 Male	11,449	11,663	611.83	73.8%	593.55	11.87	35.02	9.75	8.37	658.56	652.22	1.0%
Age 50 - 59 Female	25,563	26,653	836.09	100.0%	836.09	16.72	49.33	13.74	8.37	924.25	906.95	1.9%
Age 50 - 59 Male	20,418	20,843	684.04	98.6%	683.63	13.67	40.33	11.23	8.37	757.23	749.94	1.0%
Age 60+	26,796	25,821	783.52	100.0%	783.52	15.67	46.23	12.87	8.37	866.66	825.10	5.0%
Delivery Case Rate[4]	69	69	6,400.86		6,400.86	83.21	243.23	102.45	-	6,829.75	6,437.37	6.1%
Composite	166,741	171,379	$ 603.92		$ 603.71	$ 12.06	$ 35.56	$ 9.92	$ 8.37	$ 669.62	$ 662.14	1.1%
East												
Age <20	12,415	12,933	$ 326.58	76.9%	$ 333.64	$ 6.67	$ 19.68	$ 5.48	$ 8.37	$ 373.85	$ 370.54	0.9%
Age 20 - 29 Female	2,385	2,503	376.33	33.7%	377.60	7.55	22.28	6.20	8.37	422.00	478.74	(11.9%)
Age 20 - 29 Male	3,567	3,905	217.59	41.2%	241.13	4.82	14.23	3.96	8.37	272.51	308.79	(11.7%)
Age 30 - 39 Female	2,587	2,784	417.97	35.1%	476.86	9.54	28.13	7.84	8.37	530.74	527.84	0.5%
Age 30 - 39 Male	2,885	3,129	302.09	37.1%	360.88	7.22	21.29	5.93	8.37	403.68	441.17	(8.5%)
Age 40 - 49 Female	3,865	3,961	649.97	42.9%	684.75	13.70	40.40	11.25	8.37	758.47	768.34	(1.3%)
Age 40 - 49 Male	2,223	2,223	488.21	32.5%	524.47	10.49	30.94	8.62	8.37	582.89	635.10	(8.2%)
Age 50 - 59 Female	6,960	7,348	722.43	57.6%	739.67	14.79	43.64	12.15	8.37	818.62	863.46	(5.2%)
Age 50 - 59 Male	5,627	5,766	704.12	51.8%	680.12	13.60	40.13	11.18	8.37	753.39	728.25	3.5%
Age 60+	7,851	7,664	688.07	61.1%	711.54	14.23	41.98	11.69	8.37	787.81	821.97	(4.2%)
Delivery Case Rate[4]	11	11	6,599.71		6,599.71	85.80	250.79	105.63	-	7,041.93	7,272.86	(3.2%)
Composite	50,365	52,216	$ 507.48		$ 525.11	$ 10.49	$ 30.95	$ 8.63	$ 8.37	$ 583.55	$ 601.82	(3.0%)
South												
Age <20	37,051	38,410	$ 316.40	100.0%	$ 316.40	$ 6.33	$ 18.67	$ 5.20	$ 8.37	$ 354.97	$ 328.69	8.0%
Age 20 - 29 Female	8,828	9,145	354.55	64.8%	362.88	7.26	21.41	5.96	8.37	405.88	519.31	(21.8%)
Age 20 - 29 Male	13,991	14,927	300.52	81.6%	292.64	5.85	17.27	4.81	8.37	328.93	383.75	(14.3%)
Age 30 - 39 Female	14,517	15,119	546.86	83.1%	540.43	10.81	31.89	8.88	8.37	600.37	607.03	(1.1%)
Age 30 - 39 Male	15,918	16,995	422.01	87.1%	418.58	8.37	24.70	6.88	8.37	466.90	486.85	(4.1%)
Age 40 - 49 Female	26,103	26,754	718.14	100.0%	718.14	14.36	42.37	11.80	8.37	795.05	787.99	0.9%
Age 40 - 49 Male	19,477	19,851	506.92	96.3%	508.21	10.16	29.98	8.35	8.37	565.08	629.12	(10.2%)
Age 50 - 59 Female	44,259	45,950	727.19	100.0%	727.19	14.54	42.90	11.95	8.37	804.96	776.39	3.7%
Age 50 - 59 Male	35,590	36,277	629.39	100.0%	629.39	12.59	37.13	10.34	8.37	697.82	701.24	(0.5%)
Age 60+	43,566	41,845	737.90	100.0%	737.90	14.76	43.54	12.12	8.37	816.69	773.78	5.5%
Delivery Case Rate[4]	91	91	6,538.42		6,538.42	85.00	248.46	104.65	-	6,976.53	6,718.31	3.8%
Composite	259,300	265,273	$ 574.19		$ 573.54	$ 11.46	$ 33.79	$ 9.42	$ 8.37	$ 636.58	$ 634.17	0.4%
Composite												
Age <20	78,315	81,241	$ 357.15		$ 358.28	$ 7.17	$ 21.14	$ 5.89	$ 8.37	$ 400.84	$ 375.90	6.6%
Age 20 - 29 Female	17,896	18,654	378.24		377.32	7.55	22.26	6.20	8.37	421.69	517.46	(18.5%)
Age 20 - 29 Male	27,138	29,263	257.62		262.11	5.24	15.46	4.31	8.37	295.49	340.32	(13.2%)
Age 30 - 39 Female	28,435	29,629	508.71		513.86	10.28	30.32	8.44	8.37	571.27	579.99	(1.5%)
Age 30 - 39 Male	29,485	31,312	395.50		400.96	8.02	23.66	6.59	8.37	447.60	491.18	(8.9%)
Age 40 - 49 Female	45,358	46,865	710.89		713.69	14.27	42.11	11.73	8.37	790.16	775.18	1.9%

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: SSI

Region/Rate Cell	SFY 2022 MMs	SFY 2024 Proj. MMs	SFY 2024 Benefit Cost PMPM	Credibility[1]	Adj. SFY 2024 Benefit Cost PMPM[2]	Non-Benefit Costs QI PMPM	Non-Benefit Costs Admin PMPM[3]	Non-Benefit Costs Margin PMPM	Non-Benefit Costs HMO Tax	SFY 2024 Proposed Rate	SFY 2023 Capitation Rate	SFY 2024 / SFY 2023 % Change
Age 40 - 49 Male	33,149	33,737	541.96		538.79	10.78	31.79	8.85	8.37	598.57	637.50	(6.1%)
Age 50 - 59 Female	76,782	79,951	763.06		764.64	15.29	45.11	12.56	8.37	845.98	827.91	2.2%
Age 50 - 59 Male	61,635	62,886	654.35		652.02	13.04	38.47	10.71	8.37	722.61	719.86	0.4%
Age 60+	78,213	75,330	748.47		750.86	15.02	44.30	12.34	8.37	830.88	796.28	4.3%
Delivery Case Rate[4]	171	171	6,486.85		6,486.85	84.33	246.50	103.82	-	6,921.51	6,640.62	4.2%
Composite	476,406	488,868	$ 577.49		$ 578.94	$ 11.56	$ 34.11	$ 9.51	$ 8.37	$ 642.50	$ 640.52	0.3%

Notes:

1) Credibility is defined as the minimum of 1 and the square root of the SFY 2022 MMs divided by 21,000.
2) The manual rate used in the credibility adjustment is the statewide average by age band.
3) The admin load is applied as a percent of the adjusted SFY 2024 benefit costs.
4) Please refer to the Pregnant Women exhibit worksheet for DCR development.
5) Male and female 60+ age bands have been combined for SFY 2024.

Appendix G – WVHB Projected Benefit Cost Development

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: WVHB

			SFY 2024		Adj. SFY 2024	Non-Benefit Costs				SFY 2024	SFY 2023	SFY 2024 /
	SFY 2022	SFY 2024	Benefit Cost		Benefit Cost	QI	Admin	Margin	HMO	Proposed	Capitation	SFY 2023
Region/Rate Cell	MMs	Proj. MMs	PMPM	Credibility[1]	PMPM[2]	PMPM	PMPM[3]	PMPM	Tax	Rate	Rate	% Change
North												
Age 15 - 29 Female	128,034	116,291	$ 232.19	100.0%	$ 232.19	$ 5.80	$ 17.18	$ 3.89	$ 8.37	$ 267.43	$ 292.29	(8.5%)
Age 15 - 29 Male	114,892	97,059	198.94	100.0%	198.94	4.97	14.72	3.33	8.37	230.34	268.93	(14.3%)
Age 30 - 39 Female	113,806	103,513	302.00	100.0%	302.00	7.55	22.35	5.05	8.37	345.32	379.26	(8.9%)
Age 30 -39 Male	115,168	94,740	310.51	100.0%	310.51	7.76	22.98	5.20	8.37	354.82	418.74	(15.3%)
Age 40 - 49 Female	99,554	91,603	362.27	100.0%	362.27	9.06	26.81	6.06	8.37	412.57	429.30	(3.9%)
Age 40 - 49 Male	94,166	78,263	370.98	100.0%	370.98	9.27	27.45	6.21	8.37	422.29	423.60	(0.3%)
Age 50 - 59 Female	87,387	79,843	458.04	100.0%	458.04	11.45	33.89	7.67	8.37	519.42	512.18	1.4%
Age 50 - 59 Male	73,589	66,763	444.53	100.0%	444.53	11.11	32.90	7.44	8.37	504.35	488.90	3.2%
Age 60+ Female	35,106	32,350	509.58	88.3%	508.25	12.71	37.61	8.51	8.37	575.44	539.76	6.6%
Age 60+ Male	29,460	25,511	471.37	80.9%	472.32	11.81	34.95	7.90	8.37	535.35	536.54	(0.2%)
Delivery Case Rate[4]	406	406	6,400.86		6,400.86	83.21	243.23	102.45	-	6,829.75	6,437.37	6.1%
Composite	891,162	785,936	$ 339.17		$ 339.15	$ 8.44	$ 24.98	$ 5.67	$ 8.37	$ 386.61	$ 405.63	(4.7%)
East												
Age 15 - 29 Female	52,985	48,642	$ 197.61	100.0%	$ 197.61	$ 4.94	$ 14.62	$ 3.31	$ 8.37	$ 228.85	$ 263.01	(13.0%)
Age 15 - 29 Male	42,588	36,532	181.24	97.3%	181.66	4.54	13.44	3.04	8.37	211.06	256.60	(17.7%)
Age 30 - 39 Female	47,437	43,277	270.19	100.0%	270.19	6.75	19.99	4.52	8.37	309.83	340.92	(9.1%)
Age 30 -39 Male	41,761	34,638	263.43	96.3%	265.79	6.64	19.67	4.45	8.37	304.92	382.14	(20.2%)
Age 40 - 49 Female	38,588	35,632	347.19	92.6%	348.29	8.71	25.77	5.83	8.37	396.97	411.19	(3.5%)
Age 40 - 49 Male	32,411	27,073	320.12	84.9%	328.94	8.22	24.34	5.51	8.37	375.38	394.54	(4.9%)
Age 50 - 59 Female	36,399	33,205	435.49	89.9%	436.29	10.91	32.29	7.30	8.37	495.15	511.10	(3.1%)
Age 50 - 59 Male	30,627	27,750	405.17	82.5%	409.60	10.24	30.31	6.86	8.37	465.38	516.51	(9.9%)
Age 60+ Female	15,277	13,961	491.47	58.3%	494.24	12.36	36.57	8.27	8.37	559.81	539.44	3.8%
Age 60+ Male	12,441	10,663	422.33	52.6%	447.93	11.20	33.15	7.50	8.37	508.15	548.77	(7.4%)
Delivery Case Rate[4]	160	160	6,599.71		6,599.71	85.80	250.79	105.63	-	7,041.93	7,272.86	(3.2%)
Composite	350,514	311,373	$ 309.00		$ 311.68	$ 7.75	$ 22.94	$ 5.21	$ 8.37	$ 355.96	$ 389.70	(8.7%)
South												
Age 15 - 29 Female	177,799	160,243	$ 229.81	100.0%	$ 229.81	$ 5.75	$ 17.01	$ 3.85	$ 8.37	$ 264.78	$ 301.88	(12.3%)
Age 15 - 29 Male	170,407	144,383	198.96	100.0%	198.96	4.97	14.72	3.33	8.37	230.36	282.46	(18.4%)
Age 30 - 39 Female	155,252	140,631	322.82	100.0%	322.82	8.07	23.89	5.40	8.37	368.55	420.07	(12.3%)
Age 30 -39 Male	162,320	133,181	356.96	100.0%	356.96	8.92	26.41	5.97	8.37	406.64	452.69	(10.2%)
Age 40 - 49 Female	145,849	134,001	365.92	100.0%	365.92	9.15	27.08	6.12	8.37	416.64	438.56	(5.0%)
Age 40 - 49 Male	142,810	117,343	396.70	100.0%	396.70	9.92	29.36	6.64	8.37	450.99	485.73	(7.2%)
Age 50 - 59 Female	107,240	98,066	434.09	100.0%	434.09	10.85	32.12	7.26	8.37	492.70	487.52	1.1%
Age 50 - 59 Male	97,153	88,434	427.82	100.0%	427.82	10.70	31.66	7.16	8.37	485.71	520.36	(6.7%)
Age 60+ Female	40,450	36,916	490.57	94.8%	490.96	12.27	36.33	8.22	8.37	556.15	509.71	9.1%
Age 60+ Male	30,471	26,229	503.08	82.3%	498.34	12.46	36.88	8.34	8.37	564.39	557.66	1.2%
Delivery Case Rate[4]	573	573	6,538.42		6,538.42	85.00	248.46	104.65	-	6,976.53	6,718.31	3.8%
Composite	1,229,751	1,079,427	$ 342.34		$ 342.24	$ 8.51	$ 25.20	$ 5.73	$ 8.37	$ 390.05	$ 421.89	(7.5%)
Composite												
Age 15 - 29 Female	358,818	325,176	$ 225.84		$ 225.84	$ 5.65	$ 16.71	$ 3.78	$ 8.37	$ 260.35	$ 292.63	(11.0%)
Age 15 - 29 Male	327,887	277,974	196.63		196.68	4.92	14.55	3.29	8.37	227.81	274.33	(17.0%)
Age 30 - 39 Female	316,495	287,421	307.40		307.40	7.68	22.75	5.14	8.37	351.35	393.45	(10.7%)
Age 30 -39 Male	319,249	262,559	327.86		328.17	8.20	24.28	5.49	8.37	374.52	431.13	(13.1%)
Age 40 - 49 Female	283,991	261,236	362.08		362.24	9.06	26.81	6.06	8.37	412.53	431.58	(4.4%)
Age 40 - 49 Male	269,387	222,679	378.35		379.42	9.49	28.08	6.35	8.37	431.71	452.81	(4.7%)

West Virginia Bureau for Medical Services
Mountain Health Trust (MHT) Rate Development
SFY 2024 Rate Development
Category of Aid: WVHB

Region/Rate Cell	SFY 2022 MMs	SFY 2024 Proj. MMs	SFY 2024 Benefit Cost PMPM	Credibility[1]	Adj. SFY 2024 Benefit Cost PMPM[2]	Non-Benefit Costs QI PMPM	Admin PMPM[3]	Margin PMPM	HMO Tax	SFY 2024 Proposed Rate	SFY 2023 Capitation Rate	SFY 2024 / SFY 2023 % Change
Age 50 - 59 Female	231,026	211,114	443.37		443.49	11.09	32.82	7.42	8.37	503.19	500.55	0.5%
Age 50 - 59 Male	201,369	182,947	430.48		431.16	10.78	31.91	7.22	8.37	489.43	508.30	(3.7%)
Age 60+ Female	90,833	83,227	498.11		498.23	12.46	36.87	8.34	8.37	564.26	526.38	7.2%
Age 60+ Male	72,372	62,403	476.32		479.09	11.98	35.45	8.02	8.37	542.91	547.51	(0.8%)
Delivery Case Rate[4]	1,139	1,139	6,497.99		6,497.99	84.47	246.92	104.00	-	6,933.39	6,696.07	3.5%
Composite	2,471,427	2,176,736	$ 336.43		$ 336.75	$ 8.38	$ 24.80	$ 5.63	$ 8.37	$ 383.93	$ 411.42	(6.7%)

Notes:

1) Credibility is defined as the minimum of 1 and the square root of the SFY 2022 MMs divided by 45,000.

2) The manual rate used in the credibility adjustment is the statewide average by age band.

3) The admin load is applied as a percent of the adjusted SFY 2024 benefit costs.

4) Please refer to the Pregnant Women exhibit worksheet for DCR development.

5) Age bands 15-19 and 20-29 have been combined for males and females for SFY 2024.

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