MILLIMAN REPORT

West Virginia CHIP: SFY 2024 Capitation Rate Development

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

June 29, 2023

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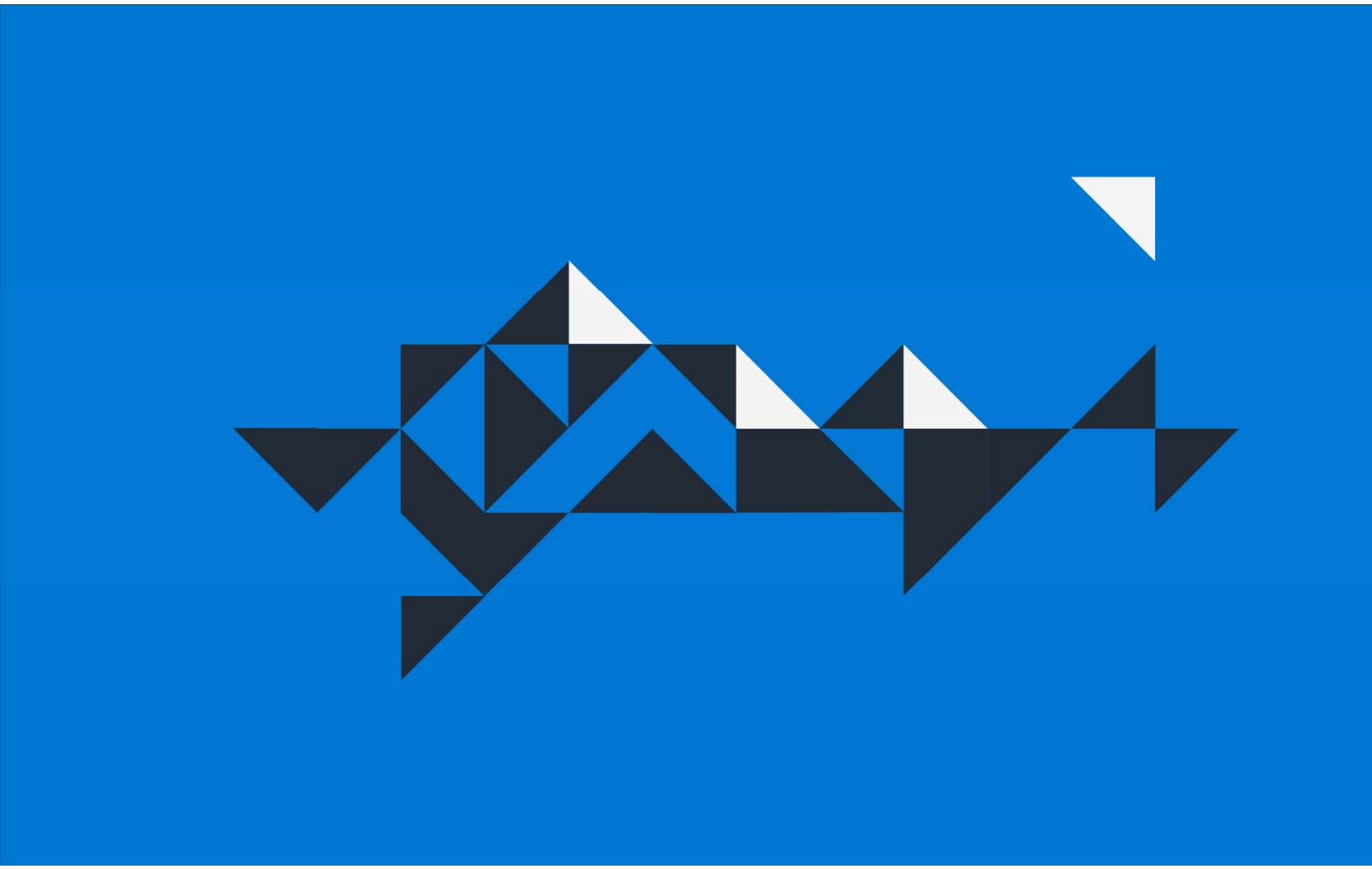


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I. Executive Summary

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 West Virginia CHIP (WVCHIP) program.

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. 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

While CHIP is separate from Medicaid, we have worked to comply with all regulations for Medicaid given the volume of guidance provided for Medicaid. 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 most recent version available when we developed the rates:

- 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 A illustrate aggregated program-wide composite monthly capitation rates proposed to be effective July 1, 2023 through June 30, 2024 (SFY 2024) for WVCHIP enrollees. All SFY 2024 capitation rates are compared against the most recent 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.

The primary drivers of the overall rate changes for Children rate group from SFY 2023 rates are:

- An increase of 11.3% to the base PMPM from SFY 2021 to SFY 2022,

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

- An increase of 6.3% to the overall non-benefit load assumptions from 8.0% to 14.3% including an explicit inclusion of 2.0% risk margin
- A net decrease of 0.69% to the overall benefit cost projection factor from 15.85% to 15.16% due to the combined effects of the following changes:
    - Alignment of WVCHIP covered benefits with Medicaid covered benefits,
    - Reduction of WVCHIP fee schedules to align with Medicaid fee schedules for certain services,
    - Increases of trend assumptions, and
    - Decrease of PHE unwinding assumptions

TABLE 1: PROPOSED SFY 2024 CAPITATION RATE CHANGE

WVCHIP RATE GROUP	SFY 2024 Projected Enrollment	SFY 2024 RATE	SFY 2023 RATE	RATE CHANGE
CHILDREN (Under Age 19)	219,186	$ 208.80	$ 178.36	17.1%
PW (Pregnant Women Age 19 and older)	3,327	313.72	325.59	(3.6%)
DCR (Delivery Case Rate)	185	7,774.67	6,751.60	15.2%
Composite	**222,512**	**$ 216.83**	**$ 186.17**	**16.5%**

APPENDICES

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

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

- Appendix B: Development of final capitation rates for CHILDREN, PW and DCR
- Appendix B-1: Development of projected benefit cost for CHILDREN
- Appendix B-2: Development of projected benefit cost for PW and DCR

II. Program Overview

COVERED POPULATIONS

WVCHIP covers children from birth through the end of the month of their 19th birthday who have family income above the Medicaid income limit but less than or equal to 300% FPL. Starting July 1, 2019, WVCHIP also covers pregnant women 19 years of age and older with income up to 300% FPL who do not qualify for Medicaid.

COVERED BENEFITS

WVCHIP covers a full range of health care services for children, including doctor visits, check-ups, vision and dental visits, immunizations, prescriptions, hospital stays, mental health, and special needs services. Benefits are the same for both children and pregnant women. Effective July 1, 2023, the WVCHIP covered benefits will be modified to align with Medicaid covered benefits for eligible children and pregnant women.

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 Mountain Health Trust (MHT) contracts which include WVCHIP members.

MANAGED CARE ORGANIZATIONS

Effective January 1, 2021, WVCHIP transitioned its service delivery system from Fee-For-Service (FFS) to managed care. The covered populations have the choice of three (3) managed care organizations (MCOs) that BMS has contracted with for the provision of WVCHIP covered 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 the period of July 1, 2023 through June 30, 2024 (SFY 2024), the State will continue to 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.

III. Base Data Development

BASE DATA

Eligibility is based on data received from BMS and its vendors as of February 8, 2023 and includes eligibility information through December 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 BMS and its vendors as of February 8, 2023 and includes encounters submitted by the managed care organizations (MCOs) through December 2022.

Data Requested

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

- Managed care encounters from January 2021 through December 2022, paid through February 2023
- Managed care enrollment data and corresponding capitation payments from January 2021 through December 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
- Ineligible population such as male adults who are age 19 and older

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 age, or gender
  - Ineligible population such as male adults who are age 19 and older

Base Period Selection

We reviewed historical data from January 2021 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 WVCHIP population which will be enrolled in managed care during the contract period.

Data Validation

We received encounters from BMS' 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, BMS, 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 relevant experience.

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.

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. In aggregate, the encounter data was adjusted with a completion factor of 1.03 to better reconcile to the MCO financials.

IV. Program Changes

There are three major program changes anticipated to occur between the base period and the rating period.

- COVID-19 vaccine costs after the end of PHE
- Full benefit alignment between WVCHIP and Medicaid effective July 1, 2023
- Partial fee schedule alignment between WVCHIP and Medicaid effective July 1, 2023

The following section describes each change and its estimated impact to the base period cost.

COVID-19 VACCINE COSTS

Effective with the end of the PHE May 11, 2022, 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 WVCHIP 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
- The overall participation rate of 5%

This is an increase of approximately $0.1 million to the base medical claims for WVCHIP children rate group.

FULL BENEFIT ALIGNMENT WITH MEDICAID COVERAGE

Effective July 1, 2023, WVCHIP covered benefits will be modified to align with Medicaid covered benefits. While the benefit covered by WVCHIP prior to this alignment is already materially similar to the benefit covered by Medicaid for children, this benefit alignment is expected to have a material impact on WVCHIP members' utilization of outpatient behavioral health services as this benefit alignment extends to provider qualifications for covered outpatient behavioral health services. Specifically, WVCHIP will allow lower-level credentialed providers who work towards their licensure to provide outpatient behavioral health services to covered members like Medicaid does. As a result, we expect WVCHIP children's outpatient behavioral health services utilization to increase to the current level of comparable Medicaid children.

To quantify this expected impact, we calculated the PMPM cost differential of this service between WVCHIP children group and Medicaid TANF children group as observed in SFY 2022 after the normalization of the fee schedule difference. The resulting factor was then applied to this service category in the benefit cost projection during the rate development.

This is an increase of approximately $0.6 million to the base medical claims for WVCHIP children rate group.

FEE SCHEDULE ALIGNMENT WITH MEDICAID

Effective July 1, 2023, WVCHIP fee schedules for services other than the following categories will be aligned with their corresponding Medicaid fee schedules:

- IPPS/DRG rates for acute care hospitals
- RBRVS
- Anesthesia
- OPPS/APC
- FQHC/RHC
- Vision

To quantify the rate impact of these one-time fee schedule changes, we calculated the difference between the repriced amount using the most recently available Medicaid fee schedules and the repriced amount using the effective CHIP fee schedules in SFY 2022. The differences were then converted into fee schedule adjustment factors at applicable service category level by dividing the differences by the MCO paid amounts. The factors were then applied to the applicable service categories in the benefit cost projection during the rate development.

This is a decrease of approximately $0.1 million to the base medical claims for WVCHIP children rate group.

V. Projection of Benefit Costs

OVERALL APPROACH

Consistent to prior year's rate structure, the approach used for the projection of benefit cost varies by the three WVCHIP rate groups:

- Children (under age 19)
- Pregnant Women (PW) (age 19 and older)
- Delivery Case Rate (DCR)

For children rate group, the projection of its benefit cost was based on its own combined experience across all three MCOs. For the other two rate groups, their own experience data is not credible to support experience-based cost projection due to their small enrollment size and case count. Therefore, we have projected their benefit cost based on WVCHIP children's benefit cost using the observed cost ratios between each of these two rate groups and the children group in the Medicaid program under the assumption that the cost ratios between each of these two rate groups and children rate group would be comparable between WVCHIP and Medicaid. Using projected statewide SFY 2024 benefit cost PMPM for Medicaid TANF Children, PMPM cost for Medicaid Pregnant Women, and per case cost for Medicaid DCR, we have calculated their cost relativity factors as below:

- 1.50:1 between Pregnant Women's benefit cost PMPM and Children's benefit cost PMPM
- 39.28 :1 between DCR's per case benefit cost and Children's benefit cost PMPM

We then applied these factors to the projected PMPM cost of WVCHIP children rate group to derive the projected benefit cost PMPM for WVCHIP pregnant women and the benefit cost component of the case rate for WVCHIP DCR. Note that the resulting projected PMPM or per case costs for WVCHIP PW and WVCHIP DCR are approximately 10.4% higher than the comparable Medicaid rate groups, primarily due to the overall fee schedule differences.

The following sections describe the projection of benefit cost PMPM for WVCHIP children rate group in detail.

GENERAL METHODOLOGY

For WVCHIP children rate group, projected benefit costs for monthly capitation rates are developed using the following general methodology. See the listed columns in Appendix B for cost model application.

1. Apply completion factors described in the Completion Adjustment Section to the historical base experience data and then summarize them into actuarial cost models by service category for WVCHIP children. See column A-G.
2. Apply program change impacts related to COVID vaccine costs and benefit alignment with Medicaid described in the Program Changes Section. See columns I.
3. Apply program change impacts related to fee schedule alignment with Medicaid adjustments described in the Fee Schedule Changes Section. See column J.
4. Apply adjustments for PMPM trends described below. See columns K.
5. Apply adjustments for PHE unwinding related utilization recovery described below. See column L.

TREND ASSUMPTIONS

Because the WVCHIP managed care program was recently implemented, there were not sufficient years of completed managed care data available for historical trend analysis under a managed care environment. We have instead relied on the PMPM trend assumptions developed for Medicaid TANF Children in the development of SFY 2024 capitation rates for the MHT program as our best estimate of the trend assumptions for SFY 2024 WVCHIP rate development. Please see the actuarial cost model for the detailed annualized PMPM trend assumptions by applicable service categories.

Note that we adjusted the TANF Children trend assumptions to adjust specific fee schedule impacts included for the following service categories which will not be aligned with Medicaid fee schedule for SFY 2024:

- IPPS/DRG rates for acute care hospitals
- RBRVS
- Anesthesia
- OPPS/APC
- FQHC/RHC
- Vision

We also reviewed the WVCHIP fee schedules to consider adjustments to the trend assumptions for WVCHIP-specific fee schedule changes. Our review did not indicate a need to adjust the currently selected WVCHIP unit cost trend assumptions to account for the known WVCHIP fee schedule changes between the base period and the rate period. The annualized PMPM trend was calculated to be around 4.2% in aggregate across all service categories for WVCHIP children rate group.

PHE UNWINDING RELATED UTILIZATION RECOVERY

The PHE ended May 11, 2023. We have considered and developed explicit COVID-19 PHE unwinding related utilization recovery factor to account for the anticipated service utilization changes for WVCHIP population from the base period to the post-PHE rating period.

While we believe that any deferred care during the initial PHE period has been largely returned during our base period, a WVCHIP specific non-user percentage analysis indicates that the percentage of non-users in SFY 2022 is materially larger than the percentage of non-users in CY 2019, the most recent pre-PHE period. This indicates that there might be temporary or permanent member behavior related service utilization changes during the PHE. After the PHE ends, we expect the percentage of non-users and the associated service utilization pattern to partially recover towards the pre-PHE level. We assumed that the increased non-user percentage will decrease by half during SFY 2024. This results in an estimated utilization increase of 4.1% for covered WVCHIP children rate group.

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.

GENERAL ADMINISTRATION

We relied on the SFY 2022 general administrative cost expenses reported by the MCOs for WVCHIP 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 8.8% across the entire 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 applicable rate groups on a uniform PMPM basis based on projected enrollment. The resulting uniform PMPM was converted into a projected percentage of benefit cost by dividing the uniform PMPM by the projected benefit cost PMPM for all applicable rate groups.

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 applicable rate group level. The projected variable component as a percentage of benefit cost was assumed to be the same across all applicable rate groups.

We combined the two components as a percentage of projected benefit costs to determine the final administrative load by applicable rate group. Table 2 includes the final administrative assumptions by each rate group.

QUALITY IMPROVEMENT

We relied on the SFY 2022 quality improvement expenses reported by the MCOs for WVCHIP 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, 4.6% 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 3.5% across the entire 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 applicable rate groups on a uniform PMPM basis based on projected enrollment. The resulting uniform PMPM was then converted into a projected percentage of benefit cost by dividing the uniform PMPM by the projected benefit cost PMPM for all applicable rate groups.

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 applicable rate group level. The projected variable component as a percentage of benefit cost was assumed to be the same across all applicable rate groups.

We combined the two components as a percentage of projected benefit costs to determine the final quality improvement expense percentage assumption by applicable rate group. Table 2 includes the final quality improvement percentage assumptions by each rate group.

RISK MARGIN

Risk margin was developed as a percentage of the capitated rate and does not vary by rate group. For SFY 2024, we use a 2.0% risk margin.

PREMIUM TAX

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

- The first 149,999 member months will be taxed at a base rate of $0.26 PMPM for SFY 2024.
- The remaining member months will be taxed at a base rate of $0.10 PMPM for SFY 2024.

Since all three MCOs are projected to have less than 149,999 member months for SFY 2024, the premium tax PMPM was projected to be $0.26 for all applicable rate groups for SFY 2024.

Table 2 summarizes the non-benefit cost assumptions for SFY 2024.

TABLE 2: SFY 2024 NON-BENEFIT COST ASSUMPTIONS

	AGE <19	PW	DCR
General Admin (% of Bene. Cost)	8.46%	8.46%	4.41%
Quality Improvement (% of Bene. Cost)	3.40%	3.40%	1.77%
Margin (% of Rate before Tax)	2.0%	2.0%	2.0%
Premium Tax (PMPM)	$ 0.26	$ 0.26	$ 0.00

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 the cost model in Appendix B.
2. Add projected general administrative expenses as a percent of projected benefit costs.
3. Add the projected quality improvement expenses as a percent of projected benefit costs.
4. Add the margin as a percent of the total costs less premium tax.
5. Add the premium tax.

After the end of the SFY 2024 period, there will be a risk sharing settlement. Please refer to the Risk Mitigation Section of this report for additional information.

Table 3 summarizes the rates using projected SFY 2024 member months by rate group 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 3: COMPOSITE RATE BREAK-DOWN

RATE COMPONENT	CHILDREN	PREG	DCR	WVCHIP TOTAL
Benefit Cost	$ 182.70	$ 274.62	$ 7,175.72	$ 190.03
General Admin	15.46	23.23	316.45	15.84
Quality Improvement	6.21	9.34	127.01	6.36
Margin	4.17	6.27	155.49	4.33
Premium Tax	0.26	0.26	0.00	0.26
Projected MLR	**90.6%**	**90.6%**	**93.9%**	**90.7%**

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 for the MHT program, including WVCHIP. As defined in the contract, the MLR is calculated across all MHT populations 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 BMS.

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 WVCHIP managed care program. 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 WVCHIP program, eligibility rules, and benefit provisions for the state's WVCHIP managed care program. We have experience in the examination of financial calculations for CHIP 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 in 42 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.

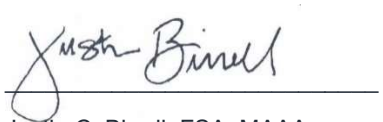
This certification is intended for the State of West Virginia and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. 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.

Annie P. Hallum, FSA, MAAA — June 29, 2023

Date



Justin C. Birrell, FSA, MAAA — June 29, 2023

Date

Appendix A – Capitation Rate Development

West Virginia Bureau for Medical Services

WVCHIP Rate Development

SFY 2024 Rate Development

COA / Rate Cell	Projected. SFY 2024 MMs/Cases	SFY 2024 Rate	SFY 2023 Rate	% Change
CHIP				
Children	219,186	$ 208.80	$ 178.36	17.1%
PW	3,327	$ 313.72	$ 325.59	(3.6%)
DCR	185	$ 7,774.67	$ 6,751.60	15.2%
Composite	**222,512**	**$ 216.83**	**$ 186.17**	**16.5%**

Appendix B – Projected Benefit Cost Development

West Virginia Bureau for Medical Services
WVCHIP Rate Development
SFY 2024 Rate Development

WVCHIP Rate Cells	SFY 2022 MMs/Cases	SFY 2024 Proj. MMs/Cases	SFY 2024 Benefit Cost PMPM	Non-Benefit Costs QI PMPM	Admin PMPM	Margin PMPM	HMO Tax	SFY 2024 Proposed Rate	SFY 2023 Capitation Rate	SFY 2024 / SFY 2023 % Change
Composite										
Children	210,525	219,186	$ 182.70	$ 6.21	$ 15.46	$ 4.17	$ 0.26	$ 208.80	$ 178.36	17.1%
PW	1,541	3,327	$ 274.62	$ 9.34	$ 23.23	$ 6.27	$ 0.26	$ 313.72	$ 325.59	(3.6%)
DCR	131	185	$ 7,175.72	$ 127.01	$ 316.45	$ 155.49	$ 0.00	$ 7,774.67	$ 6,751.60	15.2%
Composite	212,066	222,512	$ 190.03	$ 6.36	$ 15.84	$ 4.33	$ 0.26	$ 216.83	$ 186.17	16.5%

Rate Cell: Children

SFY 2022 MMs: 210,525

Projected SFY 2024 MMs: 219,186

Service Category	SFY 2022 Base Data[1] Admits Per 1,000	Avg Length of Stay	Utilization Per 1,000	Cost Per Service	Completed PMPM	Program Change Benefit Change[2]	Program Change Fee Sched Change[3]	Annual PMPM Trend	PHE Unwinding Utilization Recovery	SFY 2024 Medical Cost PMPM
Hospital Inpatient										
IP Medical	6.0	4.7	27.9	$ 1,729.38	$ 4.02	1.000	1.000	1.041	1.041	$ 4.53
IP Surgical	1.5	6.1	9.1	3,826.27	2.89	1.000	1.000	1.041	1.041	3.25
IP Psych Hospital	4.7	7.7	36.4	1,255.90	3.81	1.000	1.000	0.994	1.041	3.92
IP Psych Residential	0.1	128.0	13.5	640.12	0.72	1.000	1.000	0.994	1.041	0.74
IP SUD Hospital	-	-	-	-	-	1.000	1.000	0.994	1.041	-
IP SUD Residential	-	-	-	-	-	1.000	1.000	0.994	1.041	-
IP Normal Delivery	-	-	-	-	-	1.000	1.000	1.041	1.041	-
IP C-Section Delivery	-	-	-	-	-	1.000	1.000	1.041	1.041	-
IP Well Newborn	0.9	2.3	1.9	352.85	0.06	1.000	1.000	1.041	1.041	0.06
IP Other Newborn	1.0	7.4	7.5	768.15	0.48	1.000	1.000	1.041	1.041	0.54
IP SNF	-	-	-	-	-	1.000	1.000	1.041	1.041	-
Subtotal	**14.2**	**6.8**	**96.2**	**$ 1,492.62**	**$ 11.97**					**$ 13.05**
Hospital Outpatient										
OP Observation			7.1	$ 3,106.64	$ 1.84	1.000	1.000	1.056	1.041	$ 2.13
OP Emergency Department			358.9	392.14	11.73	1.000	1.000	1.056	1.041	13.61
OP Surgery			47.0	2,168.47	8.50	1.000	1.000	1.045	1.041	9.66
OP Radiology			163.9	145.21	1.98	1.000	1.000	1.045	1.041	2.25
OP Lab/Pathology			275.1	101.40	2.32	1.000	0.967	1.051	1.041	2.58
OP Pharmacy			29.7	1,986.28	4.92	1.000	0.971	1.050	1.041	5.48
OP Chemotherapy			3.9	2,861.46	0.92	1.000	1.008	1.050	1.041	1.06
OP Cardiovascular			29.5	235.61	0.58	1.000	1.000	1.045	1.041	0.66
OP PT/OT/ST			101.4	97.34	0.82	1.000	1.000	1.045	1.041	0.93
OP Psych PHP & IOP			22.6	121.08	0.23	1.000	1.000	1.032	1.041	0.25
OP SUD PHP & IOP			0.2	77.02	0.00	1.000	1.000	1.085	1.041	0.00
OP Other			107.6	147.01	1.32	1.000	1.000	1.045	1.041	1.50
OP Clinic			1,474.2	124.02	15.24	1.000	1.000	1.038	1.041	17.10
OP Dialysis			0.3	290.17	0.01	1.000	1.000	1.045	1.041	0.01
OP Preventive			67.2	59.65	0.33	1.000	0.997	1.045	1.041	0.38
Subtotal			**2,688.5**	**$ 226.46**	**$ 50.74**					**$ 57.62**
Physician										
PROF IP Surgery			14.0	$ 549.68	$ 0.64	1.000	1.000	1.013	1.041	$ 0.68
PROF OP Surgery			185.2	208.13	3.21	1.000	1.000	1.013	1.041	3.43
PROF Maternity - Normal Deliveries			-	-	-	1.000	1.000	1.013	1.041	-
PROF Maternity - Cesarean Deliveries			-	-	-	1.000	1.000	1.013	1.041	-
PROF Maternity - Other			0.2	376.68	0.01	1.000	1.000	1.013	1.041	0.01
PROF Maternity - Anesthesia			-	-	-	1.000	1.000	1.009	1.041	-
PROF IP Visits			-	-	-	1.000	1.000	1.013	1.041	-
PROF IP Medical			72.4	181.57	1.09	1.000	1.000	1.013	1.041	1.17
PROF IP Psych/SUD			28.6	71.10	0.17	1.000	1.000	1.013	1.041	0.18
PROF PCP			552.9	103.91	4.79	1.000	1.000	1.054	1.041	5.54
PROF Specialist			1,143.2	114.32	10.89	1.000	1.000	1.054	1.041	12.59
PROF Pharmacy			44.5	813.43	3.02	1.000	1.023	1.080	1.041	3.75
PROF Chemotherapy			3.2	70.25	0.02	1.000	1.000	1.080	1.041	0.02
PROF Dialysis			0.2	750.29	0.01	1.000	1.000	1.056	1.041	0.02
PROF Immunizations			374.9	17.11	0.53	1.000	1.002	1.056	1.041	0.62
PROF Well Baby Exams			73.8	106.97	0.66	1.000	1.000	1.056	1.041	0.76
PROF Preventive Exams			396.2	112.34	3.71	1.000	1.000	1.056	1.041	4.30
PROF Vision Exams			187.2	92.94	1.45	1.000	1.000	1.056	1.041	1.68
PROF Other			1,929.8	63.45	10.20	1.000	1.000	1.056	1.041	11.83
PROF PT			792.4	62.88	4.15	1.000	1.000	1.056	1.041	4.82
PROF Radiology			582.1	28.25	1.37	1.000	1.000	1.056	1.041	1.59
PROF Pathology/Lab			1,040.2	19.21	1.67	1.000	0.944	1.035	1.041	1.75
PROF Chiropractor			37.8	35.10	0.11	1.000	1.000	1.056	1.041	0.13
PROF OP Psych			598.0	131.47	6.55	1.449	1.000	1.032	1.041	10.52
PROF OP SUD			0.5	62.47	0.00	1.000	1.000	1.085	1.041	0.00
Subtotal			**8,057.2**	**$ 80.81**	**$ 54.26**					**$ 65.40**
Ancillary										
OTH Home Health			1.7	$ 152.09	$ 0.02	1.000	1.000	1.006	1.041	$ 0.02
OTH Hospice			0.1	236.01	0.00	1.000	1.000	1.006	1.041	0.00
OTH Other Services			14.7	50.66	0.06	1.000	1.000	1.052	1.041	0.07
OTH Ambulance			51.3	305.75	1.31	1.000	0.840	1.032	1.041	1.22
OTH DME/Prosthetics			155.0	229.63	2.97	1.000	1.027	1.013	1.041	3.25
OTH Glasses/Contacts			274.0	53.71	1.23	1.000	0.996	1.052	1.041	1.41
OTH Dental			5,625.3	65.70	30.80	1.000	1.002	1.045	1.041	35.08
COVID Testing			885.9	71.01	5.24	1.000	0.944	0.975	1.041	4.90
COVID Vaccines			26.9	28.47	0.06	10.809	1.000	1.000	1.000	0.69
PROF Case Management			-	-	-	1.000	1.000	1.025	1.041	-
Subtotal			**7,034.9**	**$ 71.12**	**$ 41.69**					**$ 46.63**
Medical Encounter Subtotal			**17,876.9**	**$ 106.50**	**$ 158.66**					**$ 182.70**

Notes:

1) SFY 2022 base costs are derived from Blue Box data incurred through January 2022 and EDI data beginning February 1, 2022 with data submitted through February 2023.
The completion factor was applied to reconcile the SFY 2022 base paid encounters to the reported SFY 2022 expenditures and IBNP by MCO.
2) This program change includes benefit changes related to COVID vaccine cost and WVCHIP's full benefit alignment with Medicaid coverage as described in the rate certification.
3) This program change includes fee schedule change related to WVCHIP's partial fee schedule alignment with Medicaid as described in the rate certification.

West Virginia Bureau for Medical Services
WVCHIP Rate Development
SFY 2024 Rate Development

Rate Cell	SFY 2022 MMs/Cases	SFY 2024 Proj. MMs/Cases	SFY 2024 Benefit Cost PMPM - Children	Adj. Factor[1]	SFY 2024 Benefit Cost PMPM
Composite					
PW	1,541	3,327	$ 182.70	1.50	$ 274.62
DCR	131	185	$ 182.70	39.28	$ 7,175.72

Notes:

1) The adjustment factors were developed based on the projected SFY 2024 benefit cost relativities between MHT PW/DCR and MHT TANF ChidIr

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