MERCER

Calendar Year 2021 Nevada Medicaid Managed Care Program

Capitation Rate Development and Certification

January 1, 2021–December 31, 2021

State of Nevada
Department of Health and Human Services
Division of Health Care Financing and Policy
February 26, 2021

Mercer Government
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Deputy Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

February 26, 2021

Subject: Nevada Medicaid Managed Care Program Capitation Rate Development and Certification for Calendar Year 2021

Dear Ms. Phinney:

The State of Nevada Department of Health and Human Services (State), Division of Health Care Financing and Policy (DHCFP) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rates for the Nevada Medicaid managed care program. The capitation rates are effective calendar year 2021, January 1, 2021 through December 31, 2021 (CY 2021).

Multiple exhibits are also included as part of this rate certification package (please see the attached file: *CY 2021 Nevada MCO Rate Certification_Appendices_2021.02.26.xlsx*). These attachments include summaries of the capitation rates (including the final and certified capitation rates) and exhibits that provide more detail around various rate development components. The final certified capitation rates by managed care organization (MCO) and rate cell can be found in the attached file.

Additionally, DHCFP has implemented several risk-sharing mechanisms to mitigate some of the uncertainty inherent in the CY 2021 prospective rate development process. There are four risk-sharing mechanisms developed by Mercer and certified in a letter dated
December 23, 2020 (please see the attached document: *CY 2021 Nevada MCO Risk Sharing Mechanisms Certification_2020.12.23.pdf*).

Per Section 4.2 of ASOP 49, capitation rates for the Nevada Medicaid managed care program were developed in accordance with Centers for Medicare & Medicaid Services (CMS) requirements and this

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[1] Actuarially sound/actuarial soundness – Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For the purposes of this definition, other revenue sources include, but are not limited to, governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes. https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

document provides the certification of actuarial soundness required by 42 CFR § 438.4. CMS defines actuarially sound rates as meeting the following criteria:

- Have been developed in accordance with generally accepted actuarial principles and practices. Proposed differences among capitation rates according to covered populations are 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.
- Payments from each rate cell do not cross-subsidize payments for any other rate cell.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

This report provides an overview of the analyses and methodology used in the development of the CY 2021 rates for the purposes of satisfying the requirements of the CMS rate review process. This report follows the general outline for the CMS July 2020 through June 2021 Medicaid Managed Care Rate Development Guide (RDG), which is applicable to contract periods beginning between July 1, 2020 and June 30, 2021. A copy of the RDG with documentation references is also attached with this report.

This document is the result of collaboration between DHCFP and Mercer. It should be read in its entirety and has been prepared under the direction of Katharina Lau, ASA, MAAA, who is a member of the American Academy of Actuaries and meets its US Qualification Standard for issuing the statements of actuarial opinion herein.

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

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Contents

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General Information

This section provides a brief overview of Nevada's Medicaid managed care program and Mercer's rate development process.

Program Background

The Nevada Medicaid managed care program, known as the Nevada Mandatory Health Maintenance Program, has been in existence since 1997. Managed care was first introduced in Nevada through voluntary managed care in Washoe and Clark counties. Through the years, the Nevada Mandatory Health Maintenance Program has expanded and is operating in the two urban geographic areas, referred to for rate development purposes as the Northern (urban Washoe County) and Southern (urban Clark County) regions, covered by mandatory managed care.

MCO Participation

As of the date of this report, there are three distinct MCOs operating in the Nevada Medicaid managed care program: Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem), Health Plan of Nevada (HPN), and SilverSummit Healthplan (SilverSummit).

Covered Populations

The populations served by the MCOs applicable to this certification include the Temporary Assistance for Needy Families/Child Health Assurance Program (TANF/CHAP), Nevada Check Up (Check Up), and Affordable Care Act (ACA) Adult Expansion (Expansion) populations.

The Nevada Medicaid managed care program currently covers children, parents/caretakers, adults without dependent children, and pregnant women. Individuals served through Nevada's Children's Health Insurance Program (CHIP) are covered under the same MCO contract. Generally, managed care enrollment is mandatory in the two urban geographic areas. Notable populations not eligible for managed care include members dually eligible for Medicare, as well as the aged, blind and disabled, residents of nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICF/IDD), children receiving supplemental security income, and those in foster care. Managed care enrollment is voluntary for American Indians/Alaskan Natives, along with adults with serious mental illness and children with severe emotional disturbance.

Covered Services

Services covered by the MCO contract include hospital services (including inpatient, outpatient, and emergency room services), physician services, mental health services, transportation services, laboratory and radiology services, case management, and prescription drugs. Notable services excluded from the MCO contract are dental services, which are provided through a dental prepaid

ambulatory health plan. Refer to the MCO contract for detailed specifications related to program eligibility and covered populations and services.

Rate Structure

The covered populations are segmented into 36 rate cells for capitation rate development. The populations are first broken into 18 category of aid (COA)/demographic cells as follows:

- TANF/CHAP: Nine age/gender demographic cells
- Check Up: Five age/gender demographic cells
- Expansion: Four age/gender demographic cells

Each demographic cell is also segmented into the Northern and Southern regions, creating a total of 36 individual rate cells.

Costs associated with delivery events are separated from the main capitation rate development and included in a single rate cell for a delivery case rate (DCR).

Federal Medical Assistance Percentages

The State receives different Federal Medical Assistance Percentages (FMAP) for certain populations and services that are included in the Nevada Medicaid managed care program. Recognizing this, CMS expects the signing actuary to indicate the proportions or amounts of the costs that are subject to a different FMAP and show this information. Furthermore, if there are proposed differences among the capitation rates to covered populations, CMS requires that valid rate development standards are applied and that differences are not based on the rate of FMAP associated with the covered populations. This subsection addresses these FMAP concerns from CMS.

The rates certified in this report include coverage of several populations that receive higher FMAP than the regular FMAP. These include all Check Up and Expansion populations as well as the CHIP-to-Medicaid population. These populations are included within their applicable rate cell with all adjustments as described in this certification. The estimated baseline CY 2021 FMAP by COA is as follows[2]:

- TANF/CHAP
  - CHIP-to-Medicaid: 74.2% (Enhanced)

[2] Estimated FMAP based on blend of percentages for federal fiscal year (FFY) 2021 (https://www.govinfo.gov/content/pkg/FR-2019-12-03/pdf/FR-2019-12-03.pdf) and FFY 2022 (https://www.federalregister.gov/documents/2020/11/30/2020-26387/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for)

  - All other TANF/CHAP: 63.1% (Standard)

- Check Up: 74.2% (Enhanced)
- Expansion: 90.0% (Enhanced)

In addition, the implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary increase for certain populations, 6.2 percentage point increase to the Standard FMAP for TANF/CHAP and 4.3 percentage point increase to the Enhanced FMAP for Check Up and CHIP-to-Medicaid. The temporary increase is effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the Public Health Emergency (PHE), declared by the Secretary of Health and Human Services for Coronavirus Disease 2019 (COVID-19), including any extensions, terminates. The increased FMAP percentage is not applicable to the Expansion population.

DHCFP uses aid codes in its capitation payment system to identify members qualifying for the higher FMAP. In these instances, the full capitation rate for these members is subject to the higher FMAP.

Rates are developed for each population based on expected cost and homogeneity of risk. The FMAP for each population is not taken into account and is not a consideration. Non-benefit costs are developed using a method that does not consider variations in FMAP for different populations. This includes the provision for underwriting gain and return on capital.

In addition to the populations that receive enhanced FMAP, there are services for which the State receives a different FMAP than the regular FMAP that applies on a population basis. Those services include, but are not limited to, family planning, for which the FMAP is 90.0%, and adult preventive services, which earns an additional 1.0% pursuant to section 4106(b) of the ACA. Mercer and DHCFP prepare separate memoranda that describe and document the process for estimating the proportion of the capitation rate subject to these different FMAPs.

Rate Development

The CY 2021 capitation rates were developed in accordance with rate development guidelines established by CMS and reflect all known benefit changes since those described in the CY 2020 certification revision dated December 23, 2020.

For rate development, Mercer used MCO-reported encounter data from the State's Medicaid management information systems (MMIS), the Supplemental Data Request (SDR) submitted by each MCO, the Division of Welfare and Supportive Services (DWSS) eligibility and DHCFP enrollment information, and other ad hoc data provided by DHCFP and the MCOs. The most recently available financial reports submitted to DHCFP at the time the rates were determined were also considered in the rate development process.

The data used in the development of the rates is collected from each MCO at the level of detail needed for rate development purposes, which includes membership, utilization and cost data, along with various payment arrangements (e.g., incentive payments, subcapitation), and value-added

services for the most recent and complete year of data (CY 2019 for the CY 2021 rates) by COA group and by category of service (COS).

Adjustments were made to the CY 2019 base data to match the covered population risk and the State-approved benefit package for CY 2021. These adjustments are discussed in more detail in subsequent sections of this report. Additional adjustments were then applied to the selected base data to incorporate:

- Trend factors to project the expenditures and utilization to the rating period
- Prospective and historical program changes not reflected (or not fully reflected) in the base data
- Weighting to increase credibility of small rate cells
- Administration, underwriting gain, and premium tax loading

In addition to these adjustments, additional steps are made in the measured matching of payment to risk:

- Application of inpatient hospital stop-loss
- Application of a very low birth weight (VLBW) case rate
- Application of a DCR
- Application of retrospective risk adjustment

Exhibits attached to this report summarize the final and certified rates along with the development of various rate components. This includes the following exhibits:

- Appendix A: CY 2021 Final Certified Rates and Comparison
- Appendix B: Base Data Comparison
- Appendix C: Medical PMPM Build-up
- Appendix D: Below-the-Line Medical Adjustments
- Appendix E: Non-Medical
- Appendix F: Capitation Rate Calculation Sheet (CRCS) (36 exhibits)
- Appendix G: DCR Rate Calculation Sheet
- Appendix H: Delivery System and Provider Payment Initiatives
- Appendix I: CY 2021 Long-Term Institution for Mental Disease (IMD) Add-on Rates and Comparison
- Appendix J: CY 2021 Total Payment Rates and Comparison

Membership Projections

Mercer developed enrollment projections for the period from January 1, 2021 through December 31, 2021 by MCO and rate cell. In developing these projections, Mercer reviewed detailed monthly enrollment by MCO and rate cell through April 2020 as well as summarized monthly enrollment information by MCO and broad COA through October 2020.

Certified Rate Change

Table 1 below illustrates the composite rates effective January 1, 2021 with a comparison to the September 1, 2020 rates on a per member per month (PMPM) basis by major COA. Composite values were calculated using projected member months and DCR and VLBW case counts for the January 1, 2021 through December 31, 2021 rating period.

Table 1: COA Rate Change Summary

Rate Effective Date	TANF/CHAP Child Capitation	TANF/CHAP Adult Capitation	Check Up Capitation	Expansion Capitation	Delivery Case Rate	VLBW Risk Pool Payment
September 1, 2020	$124.60	$323.64	$100.17	$472.16	$5,622.36	$82,082.28
January 1, 2021	$136.52	$334.44	$109.14	$482.36	$5,729.54	$82,147.20
Percent Change	9.6%	3.3%	9.0%	2.2%	1.9%	0.1%

Appendix A includes the final certified rates effective January 1, 2021 by MCO for each rate cell as well as a comparison to the certified rates effective September 1, 2020. The total projected composite change in certified rates is 3.7%.

Long-Term IMD Add-On

The State-funded long-term IMD add-on will be added to every rate cell capitation payment for the TANF/CHAP Adult and Expansion populations. The add-on is not eligible for Federal financial participation pursuant to 42 CFR § 438.6(e). The development of the CY 2021 long-term IMD add-on rates follows a similar methodology to that used in developing the CY 2021 certified capitation rates. The long-term IMD add-on capitation rates are provided in Appendix I and the total contracted rates inclusive of the certified capitation rates and the State-funded long-term IMD add-on rates are provided in Appendix J.

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Data

Data Sources

The primary data sources used for CY 2021 rate development include the following:

- DWSS eligibility and DHCFP enrollment information for January 1, 2017 through March 31, 2020
- MCO-reported encounter data from MMIS (including encounters for subcapitated services) for dates of service ranging from January 1, 2017 through March 31, 2020, paid through April 9, 2020

The encounter, eligibility, and enrollment information was used to develop base period unit cost, utilization and PMPM metrics, to review experience for members eligible on the date of service for the program and to analyze various rating variables such as program changes and trend.

Additional data sources were also relied upon by mercer to supplement various rate development analyses. These include:

- SDR and supplemental information submitted by each MCO for dates of service from January 1, 2018 through March 31, 2020
- MCO-reported financial reports submitted to DHCFP

Data Validations

Encounter data for the enrolled population was evaluated for dates of service from January 1, 2017 through March 31, 2020. Mercer evaluated the encounter data for field validity and the encounter data was determined to be valid. Mercer also compared payment levels to the amounts in the MCO-reported SDRs for completeness by broad COS. Based on this comparison, Mercer did make an adjustment for underreporting as described later in this section.

Mercer relies in part on the State's MMIS processes to review, accept, retain, and update encounters and the State's processes which determine eligibility and enrollment data for eligible members and services. This includes a number of edits to ensure that the encounters submitted comply with minimum business rules associated with a typical encounter adjudication system. The encounter data intake process ensures integrity of the data through a series of edits including, but not limited to, national standard code sets, identification of duplicates, and appropriate provider IDs.

Mercer also completed other reviews and analyses when determining the reasonableness and appropriateness of the data used for rate development purposes. These included data validation for overall monthly encounter volume, consistency in reported enrollment over time, consistency in reported encounters by eligible population and service category, referential integrity between the eligibility and encounter data and review of the eligibility and encounter data for valid values. In

general, Mercer determined the encounter, eligibility, and enrollment data to be reasonable and appropriate to use for rate development purposes.

Base Data

The CY 2019 time period was selected as the base data period for CY 2021 rate development, as it is the most recent and complete year of experience available at the time of this certification and reflects historical member utilization, managed care protocols and provider reimbursement contracted amounts as reported by the MCOs. In accordance with 42 CFR § 438.5(c)(2), the base data time period is no older than the three most recent and complete years prior to the rating period.

The data utilized was managed care data that did not include any disproportionate share hospital payments or include any adjustments for Federally Qualified Health Centers (FQHC) or Rural Health Clinics reimbursements. FQHC costs considered in rate development are the costs incurred by the MCOs, net of any wrap-around payment by the State to reimburse the FQHC at their Prospective Payment System rate.

The encounter, eligibility, and enrollment data served as the primary data source for developing the base data for rate development. Populations not eligible to enroll were excluded from the base data and encounter data was limited to services covered under the MCO contract.

Member Exclusions

Mercer made the following adjustments to ensure that the membership reflected in the base data was representative of the covered populations eligible during CY 2021:

- Missing enrollment: Encounter data with no managed care enrollment segment on the date of service were excluded from the base data.
- Missing demographics: Eligibility records for some members were missing some or all COA information for the member. For members missing essential demographic information, the associated encounter and enrollment data were excluded from the base data.
- Ineligible age/COA: Members with ineligible or incorrectly assigned age or COA were excluded from the base data. This includes Expansion members under age 19 and Check Up members aged 19 and older.
- Removal of members with long-term IMD stays: Mercer identified long-term IMD stays in the base data, identified as more than 15 inpatient days in any calendar month at an IMD by a member aged 21 to 64. In accordance with 42 CFR § 438.6(e), all encounter and enrollment data for these members were removed from the base data.

Excluded and Carved-Out Services

Effective January 1, 2021, day and residential habilitation services were carved out of the MCO-covered benefit and covered under fee-for-service (FFS). Approximately $1,460,000 was removed from the CY 2019 base data for these services.

The following are services that are excluded as an MCO covered benefit and covered under FFS or with current coverage limitations in the prior rating period and continue to be for CY 2021:

- Indian Health Services
- Non-Emergency Transportation
- ICF/IDD
- School Based Child Health Services
- Adult Day Health Care
- Hospice
- Targeted Case Management
- Adult Chiropractic
- Ground Emergency Medical Transportation
- Zolgensma®
- Certified Community Behavioral Health Clinics
- Value-Added Services

Encounters for excluded and carved-out services were identified and excluded from the base data.

In Lieu of Services

DHCFP has authorized the MCOs to cover services delivered in IMDs, to the extent not otherwise authorized under the State Plan, as described in the contract. The vendor may provide access to IMD services in an alternative inpatient setting, such as a hospital or subacute facility that is licensed by the State of Nevada. The hospital or subacute facility must provide psychiatric or substance use disorder inpatient services or crisis residential services. These alternative inpatient settings must be lower cost than traditional inpatient settings, and the length of the stay can be no longer than 15 days during the period of monthly capitation. As noted in the *Member Exclusions* subsection above, in accordance with 42 CFR § 438.6(e), all encounters and enrollment for members aged 21 to 64 with long-term IMD stays were excluded from the base data. Utilization for short-term IMD stays are included in rate development and are repriced as described in the *Short-Term IMD Repricing* subsection of Section 3. *Projected Benefit Costs and Trends*.

The MCO contracts do not currently include provisions for any other in-lieu-of State Plan services.

Retrospective Eligibility Periods

Retrospective eligibility is captured in the member enrollment information provided by the State, which reflect managed care enrollment spans. These spans are linked to the encounter data to appropriately capture the member experience for rate development purposes.

Base Data Adjustments

Once the base data was adjusted to reflect the appropriate services and populations covered under the contract for CY 2021, additional adjustments to the base data were applied as described below. The aggregated PMPM impacts by COA for each base data adjustment described in this Section are provided in Appendix C and summarized in Table 2 below:

Table 2: Base Data Adjustments PMPM Impact by COA

Base Data Adjustment Category	TANF/CHAP Child	TANF/CHAP Adult	Check Up	Expansion	Composite
IBNR	1.51%	0.66%	0.85%	0.65%	0.82%
Underreporting	2.01%	0.99%	2.21%	0.98%	1.20%
Non-Claims Adjustments	0.86%	0.45%	0.48%	0.20%	0.37%

Incurred but Not Reported

Mercer developed monthly completion factors to account for expenditures that are incurred but not reported (IBNR) in the encounter and claims data. The base data used for CY 2021 rate development included paid dates through April 9, 2020 and were inclusive of subcapitated shadow encounters. Mercer analyzed monthly data from January 2017 through March 2020 using claim lag triangles as well as encounters with paid dates in April 2020. Completion factors were developed by payer, major service category, and month. Inpatient factors were developed separately for Child (under age 19) and Adult (aged 19 and greater) populations.

Aggregate completion factors for CY 2019 by major service category are provided in Table 3 below:

Table 3: Annual Completion Factors

Service Category	CY 2019 Estimated Completion
Inpatient – Child	0.9599
Inpatient – Adult	0.9878
Outpatient Facility	0.9868
Pharmacy	1.0000
Other	0.9936

Underreporting

Mercer reviewed the MCO-submitted encounter data from MMIS as compared to the expenses reported in the MCO-submitted SDRs for CY 2019. Mercer observed differences between the data sources and through discussions with the State and the MCOs, identified some instances of underreporting in the encounters for two MCOs. The underreporting was due to encounters not submitted to, or erroneously rejected from, MMIS. Mercer received ad hoc summaries of the missing encounters by rate cell and broad service category and developed an underreporting adjustment to account for the missing CY 2019 experience.

Non-Claims Adjustments

The MCO-submitted SDRs include schedules for the MCOs to describe non-claims adjustments, in addition to providing the amounts for each adjustment by COA. Through a review of this information, it was determined that several of these adjustments reflected appropriate benefit expense adjustments and are indicative of expected future cost levels during CY 2021. Adjustments were made to the base data to add or subtract these non-claims costs as appropriate. These include an addition of approximately $1,600,000 for provider incentive arrangements and $5,400,000 for out-of-system payments as well as a reduction of approximately $1,400,000 for recoveries of provider overpayments not captured in the encounter data. The adjusted base data is therefore net of all known provider overpayments.

Delivery Services

Delivery events and associated services eligible for a DCR payment were identified in the base data and excluded from the development of the PMPM capitation rate to establish a per event supplemental payment. The supplemental payment includes only the costs associated with the delivery event; therefore, costs for the following remain in the data used for PMPM capitation rate development: newborn costs associated with the delivery event, pre-natal care, and post-partum care.

This excluded experience forms the base data for the DCR supplemental payment, as described in Section 3.

3 Projected Benefit Costs and Trends

Trend

Trend is an estimate of the change in the overall unit cost and utilization of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a prospective rating period. Mercer developed unit cost and utilization trend factors by COA and COS. Mercer's selected trends were applied for 24 months from the midpoint of the base period (July 1, 2019) to the midpoint of the contract year (July 1, 2021).

Table 4 shows the aggregate annualized PMPM trends by COA. Annualized trends by rate cell and COS are provided in Appendix F (36 exhibits).

Table 4: Annualized PMPM Trends by COA

Medical Rating Adjustment Category	TANF/CHAP Child	TANF/CHAP Adult	Check Up	Expansion	Composite
Non-Pharmacy	3.89%	2.18%	2.48%	1.73%	2.32%
Pharmacy	6.96%	4.27%	4.61%	5.79%	5.72%
Overall	4.37%	2.76%	2.98%	3.07%	3.29%

Medical Trends

The primary data source for trend development was managed care experience data. Mercer reviewed 39 months of encounter data (January 2017 through March 2020), including utilization, unit cost, and PMPM metrics. In developing trend factors, Mercer considered quantitative methods such as regression analysis and monthly moving averages as well as qualitative information in finalizing the ultimate trend projections. Longitudinal reviews of 3-month, 6-month, and 12-month moving average trends are reviewed to ensure that the projected estimates do not result in outlier or unreasonable results compared to historical data. Additionally, Mercer consulted with the State to understand other factors that could influence trends and considered the impact of program changes, adjusted for separately, in order to avoid double counting of the impacts.

Mercer considered other sources of data and information for trend development such as regional and national indicators (e.g., Consumer Price Index), National Health Expenditures from Office of the Actuary, and reporting data for other states with similar Medicaid managed care programs. These sources provide broad perspectives of industry trends in the United States and in the West. Each

source was reviewed for its potential applicability and utilized collectively with other data and information via actuarial judgement in order to inform the final trends.

Unit cost and utilization trends were developed to account for projected changes in medical services for the covered populations reflecting the data sources and considerations outlined above. Trend assumptions vary in direction and magnitude by COA and COS. In some instances, negative unit cost trends were observed. Any negative trend assumptions are supported by observing historical negative trends on a monthly and rolling basis, particularly in the last 12 to 18 months of available data. Unit cost trends reflect changes in the mix of services provided within each service category; negative unit cost trends likely indicate a shift in service utilization to services with lower unit costs. All categories with a negative unit cost trend had an offsetting increase in utilization such that there were no negative PMPM trends applied.

Applied behavior analysis (ABA) services exhibited particularly high historic trends and Mercer developed trends specific to this COS for child COAs. The mix of services within ABA remained relatively stable throughout the historical data; therefore, no unit cost trend was applied. Utilization of ABA services flattened for the Check Up population in CY 2019; therefore, no additional trend was applied for Check Up. However, Mercer observed consistent monthly increases in utilization of ABA services for the TANF/CHAP Child population throughout all available months of data; therefore, Mercer projected a continued increase in utilization through CY 2021, applying a 25.0% annualized utilization trend.

Pharmacy Trends

The overall pharmacy trend consists of projections for specialty and traditional pharmacy trends. Historical program data used in the trend analysis may not fully account for future changes expected to the pharmacy costs due to a variety of factors, including newly diagnosed patients, expanded clinical indications, direct to consumer advertising, anticipated patent expirations and new drugs entering the market faster due to breakthrough therapy approvals granted by the Food and Drug Administration.

Mercer’s trend review is an ongoing process requiring monthly review of newly approved drugs and an annual review of all therapeutic classes. The reviews are handled by a team of Mercer pharmacists with several years of Medicaid experience. Mercer’s Managed Pharmacy Practice reviewed potential blockbusters in the pipeline for approval, highly utilized brand name drugs in the pipeline for generic approval and potential biosimilar medications in the pipeline, leveraging professional experience and industry reviews.

Delivery Trends

Trend development for the DCR followed the same methodology as other medical trends, except that the utilization was reviewed on a per case basis rather than per member month. Therefore, utilization trends reflect slight increases in the volume of services and/or length of stay per delivery event and is irrespective of delivery prevalence within the population. Annualized trend factors for the DCR are provided in Appendix G.

Program Changes

Program change adjustments recognize the impact of changes in covered populations, covered services and payment methodologies, including adjustments for FFS fee schedule changes which impact services covered under the MCO contract. The program changes incorporated in the development of the capitation rates were based on information provided by DHCFP. The program changes detailed below were viewed to have a material impact on capitation rates and effective during or after the base data period. Each was reviewed, analyzed, and evaluated by Mercer with the assistance of DHCFP.

The next few subsections outline the program changes adjustments that were explicitly accounted for within the CY 2021 capitation rates. Total program change adjustments by rate cell and COS are provided in Appendix F. The aggregate PMPM impacts by COA for each individual program change adjustment described in this Section are shown in Table 5 below:

Table 5: Program Changes PMPM Impact by COA

Medical Rating Adjustment Category	TANF/CHAP Child	TANF/CHAP Adult	Check Up	Expansion	Composite
Senate Bill 378	0.00%	-0.01%	-0.01%	-0.01%	-0.01%
Dental ASC Fee Change	0.11%	0.01%	0.13%	0.00%	0.03%
NICU/PICU Fee Change	3.53%	0.00%	0.21%	0.00%	0.73%
Assembly Bill 3	-4.40%	-3.56%	-3.73%	-3.07%	-3.42%
Short-Term IMD Repricing	0.00%	0.02%	0.00%	0.26%	0.17%

Senate Bill 378 Rebates Pass-Through

Effective January 1, 2020, DHCFP implemented a provision pursuant to Senate Bill 378. MCOs are required to pass all pharmacy rebates through to the State, less an administrative fee totaling 1% of rebates. The encounter data utilized for rate development are reported gross of pharmacy rebates. Mercer developed an adjustment to remove 1% of estimated CY 2021 pharmacy rebate payments from the projected pharmacy costs.

Dental Ambulatory Surgical Center Fee Change

Effective April 1, 2019, DHCFP implemented a fee schedule increase of approximately 63% for dental ambulatory surgical center (ASC) services. Encounters for the affected services in the January 2019 through March 2019 portion of the base data were repriced upward by 63% to develop an adjustment.

Newborn Intensive Care Unit and Pediatric Intensive Care Unit Fee Change

Effective January 1, 2020, DHCFP implemented a fee schedule increase of 25% for newborn intensive care unit (NICU) services and 15% for pediatric intensive care unit (PICU) services. Encounters for the affected services in the CY 2019 base data were repriced upward accordingly to develop an adjustment.

Assembly Bill 3

On July 20, 2020, the Nevada Assembly Committee of the Whole enrolled and delivered to the Governor changes relating to State financial administration to reduce certain appropriations and other money budgeted pursuant to Nevada Assembly Bill 3 — Committee of the Whole (Assembly Bill 3). The State reduced as part of this effort. The adjustments reflect the implementation of the changes pursuant to Sections 4 and 31 of Assembly Bill 3, which include two parts.

Effective August 15, 2020, Assembly Bill 3 removed the 2.5% increase for costs related to per diem reimbursement rates for medical, surgical, and intensive care unit services at a general acute inpatient hospital that were effective January 1, 2020. As the CY 2019 base data preceded the original 2.5% fee increase, no adjustment was made for the January 1, 2020 fee increase or the corresponding August 15, 2020 reversal.

Effective August 15, 2020, Assembly Bill 3 reduced the fee schedule reimbursement rates for certain provider types and services and MCOs are expected to effectuate these reductions. The percentage changes to the affected fee schedules vary by provider type and service grouping, and were provided to Mercer by DHCFP. Mercer applied the percentage changes to the paid amounts in the CY 2019 base data encounter data by provider type and service. The adjustment factors reflect the aggregated impact of the various fee schedule reductions by rate cell and COS.

Short-Term IMD Repricing

Pursuant to 42 CFR § 438.6(e), short-term IMD stays for members aged 21 to 64 must be repriced to the State Plan rate, identified for Nevada as the acute inpatient psychiatric/detox per diem. Short-term IMD stays were defined as stays for members aged 21 to 64 with 15 or fewer days in a calendar month at an IMD facility. Mercer repriced CY 2019 base experience for these stays at the State Plan rate. Additionally, Mercer developed a corresponding utilization adjustment which accounted for the difference in the average length of stay for inpatient behavioral health services at an acute facility as compared to short-term IMD stays.

COVID-19 Considerations

The impact of COVID-19 on the CY 2021 capitation rates was considered. Significant national uncertainty exists regarding the impact of COVID-19 during CY 2021 due to the ever-changing situation with regionalized infection rates, responses driven by local governments and new treatment protocols, to name a few factors. Many elements were considered, including infection rate and severity mix of cases, the impact of social distancing, the Federal Government's involvement in COVID-19-related funding (e.g., HHS and FEMA), and the availability of a vaccine.

There are multiple anticipated impacts due to COVID-19, all with significant uncertainty, expected to have both positive and negative impacts to projected cost for CY 2021. Given the limited experience resulting from COVID-19, Mercer evaluated several data sources in considering impacts to the CY 2021 capitation rates, including internal modeling and national and state data sources. Upward pressures include COVID-19 testing, treatment, and vaccine administration as well as potential increase in demand for behavioral health services. Downward pressures include deferred and

canceled care as well as enrollment and population acuity changes. In addition, per the CMS vaccine toolkit, there is no assumed Medicaid liability for the cost of the vaccine itself in CY 2021.

The ultimate impact of COVID-19 is highly dependent on numerous unknown variables. Mercer considered multiple scenarios and as a conservative approach, assumed these impacts are offsetting. Mercer did not make an explicit adjustment to the rates.

Other Medical Rating Adjustments

The capitation rates are calculated as the projected medical cost after applying all base adjustments, trend, and program change adjustments to the base data. Prior to finalizing the CY 2021 capitation rates, Mercer applied several other medical rating adjustments to account for additional provisions to the Nevada Medicaid managed care program, as described in the subsections below. The aggregate PMPM impact by COA for each of the other medical rating adjustments described in this Section are shown in Table 6 below:

Table 6: Other Medical Rating Adjustments COA PMPM Impact

Medical Rating Adjustment Category	TANF/CHAP Child	TANF/CHAP Adult	Check Up	Expansion	Composite
Inpatient Hospital Stop-Loss	-3.18%	-0.27%	-0.40%	-0.51%	-1.04%
VLBW	-3.50%	0.00%	0.00%	0.00%	-0.71%
Credibility	-0.03%	0.02%	0.26%	0.00%	0.00%

The impact by rate cell for each of the other medical rating adjustments can be found in Appendix D.

Inpatient Hospital Stop-Loss

For CY 2021, DHCFP is continuing a member-level stop-loss contract provision for inpatient hospital claims with a $100,000 attachment point. MCOs are responsible for 25% of experience costs above the attachment point. DHCFP reimburses the remaining 75% of inpatient hospital costs in excess of $100,000 per individual member and the expected reimbursement is removed from capitation.

Mercer analyzed member-level inpatient hospital medical costs in the CY 2019 base data and the 30-day period prior to the base period. The encounters were individually adjusted for fee changes and trend to project forward to CY 2021. Mercer then aggregated costs by member and calculated the projected portion of inpatient costs by rate cell expected to be reimbursed by DHCFP in CY 2021. As the base data for rate development is reported gross of any stop-loss reimbursement, the projected CY 2021 reimbursement is netted out of the gross CY 2021 projected medical costs by rate cell.

As computed, the stop-loss provision is expected to be budget neutral to the State in aggregate; however, actual reimbursement may vary from the expected values.

The PMPM impact of inpatient hospital stop-loss by rate cell is provided in Appendix D. For more detail regarding the inpatient hospital stop-loss provision, please refer to Section 4, *Special Contract Provisions Related to Payments* of this report.

VLBW Risk Pool Payment

For CY 2021 rate development, DHCFP is continuing a VLBW risk pool contract provision for eligible birth events. For infants with a birth weight at or below 1,500 grams, the State will pay the MCO a supplemental payment to offset a portion of the medical costs attributed to covering a VLBW newborn during its first 90 days of life.

The VLBW risk pool is funded by a reduction to the respective capitation rates for under age 1 members. The value of the VLBW supplemental case rate benefit cost is unchanged from the CY 2020 VLBW risk pool benefit amount of $71,000. The supplemental payment is not expected to fully offset expenses for these members, but to offset a portion of the costs.

Mercer analyzed the prevalence associated with VLBW events in the CY 2017–2019 experience data. Mercer then selected a conservative prevalence rate for the CY 2021 prospective rating period as a percentage of expected CY 2021 under age 1 member months by COA to ensure adequate funding for the risk pool. The projected prevalence rate for CY 2021 is 0.95 per 1,000 member months for TANF/CHAP Under 1 rate cells and 0.00 projected prevalence rate for Check Up Under 1 rate cells.

As the VLBW risk pool is funded by an offset to the capitated rate, the projected PMPM value of the VLBW case rate benefit cost was calculated using the expected prevalence rate associated with projected under age 1 member months and the VLBW case rate benefit cost of $71,000. The resulting PMPM is deducted from the projected benefit cost for capitation rates for applicable rate cells as shown in Appendix D. The value of the VLBW risk pool is not a fixed amount; rather, the risk pool is funded by the reduction to the capitation rates and will vary with actual enrollment. As such, the VLBW risk pool is budget neutral to the DHCFP.

For more detail regarding the VLBW risk pool payment, please refer to Section 4, *Special Contract Provisions Related to Payments* of this report.

Credibility Adjustments

In order to increase the stability and statistical credibility of small rate cells, credibility weighting is applied to rate cells with partial credibility using the classical credibility formula. Rate cells are considered fully credible at a threshold of 36,000 base member months. For rate cells determined to have partial credibility, projected medical cost PMPMs were blended with manual rates.

The manual rates were calculated by blending projected medical costs for other rate cells. A summary of the development of manual rates for applicable rate cells are as follows:

- TANF/CHAP Northern region: Manual rates leverage the projected medical cost of the respective TANF/CHAP age/gender rate cell in the Southern region. A region factor is applied based on the relative composite projected medical cost for TANF/CHAP Child and TANF/CHAP Adult between

the Northern and Southern regions with composites based on the TANF/CHAP Northern region projected member months.

- Check Up: Manual rates are a blend of three components, the projected medical cost of the respective age/gender cell in TANF/CHAP Child for both Northern and Southern regions as well as the respective age/gender cell in Check Up for the opposing region. Region factors are applied similarly as described above when leveraging a rate cell in an opposing region. A COA differential factor is also applied when leveraging the TANF/CHAP Child rate cells based on the relative composite projected medical cost for TANF/CHAP Child and Check Up, separated into under age 1 and ages 1 to 18.

The credibility weighting, manual rate PMPMs, and blended final medical PMPMs are provided in Appendix D.

Delivery Case Rate

For CY 2021, DHCFP will continue the MCO DCR contract provision to provide a supplemental delivery payment associated with members delivering a child. The supplemental payment amount is based on services incurred during inpatient hospital admissions for delivery and does not reflect costs for any of the following: newborn costs associated with the delivery event, pre-natal care, or post-partum care. These costs are instead reflected in the monthly capitation rates for their respective rate cell. Where there are multiple live births, the event will be treated as a single delivery event and only one supplemental payment will be paid.

The average delivery event costs are significantly higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. Due to the variance in cost, the DCR supplemental payment allows payment to better match risk by mitigating variation in the prevalence of delivery events.

The development of the projected benefit cost for the supplemental payment uses the same data sources and follows the same methodology to that used in developing the CY 2021 capitation rates as described in the *Base Data* and *Base Data Adjustments* subsections of Section 2. The delivery data is identified by filtering the base data to identify facility claims with Diagnosis Related Group codes and/or diagnosis codes indicating the delivery event. All costs incurred during the dates of such a hospital stay are excluded from the main capitation rate development and included in the development of the DCR.

The DCR is developed on a per delivery event basis and is irrespective of delivery prevalence within the population. Projected delivery counts were developed based on a review of the prevalence of delivery events per child-bearing aged female rate cell in the CY 2017–2019 experience data.

The development of the DCR is shown in Appendix G.

4

Special Contract Provisions Related to Payment

Incentive Arrangements

There continues to be no incentive arrangements applicable to the program during CY 2021.

Withhold Arrangements

There are no withhold arrangements applicable to the program during CY 2021.

Risk-Sharing Mechanisms

There continues to be four risk-sharing mechanisms effective for CY 2021. Mercer developed and certified the following provisions in a letter dated December 23, 2020:

- Inpatient hospital stop-loss
- VLBW risk pool
- Remittance on minimum Medical Loss Ratio (MLR)
- Risk corridor

Inpatient Hospital Stop-Loss

For CY 2021, DHCFP will continue the MCO stop-loss contract provision for inpatient hospital claims. This risk mitigation mechanism has been in place for the entirety of the contract and approved by CMS for prior rating periods. This inpatient hospital stop-loss provision applies to all of the MCOs.

Inpatient hospital stop-loss is intended to mitigate catastrophic hospital costs for high cost members. Inpatient is the largest medical service category covered by the risk-based MCOs for catastrophic claims. Providing stop-loss on high cost members is a relatively common tool used by states and their actuaries across the country to enable the DHCFP to assume partial risk for these members.

Consistent with prior years, the DHCFP will assume partial risk for member-level inpatient hospital medical costs that exceed $100,000 during a SFY. The DHCFP will reimburse the MCO at 75% of the vendor's paid amount for a member’s inpatient hospital medical costs above the $100,000 attachment point, inclusive of a 30-day period prior to the commencement of the SFY. The MCO will be responsible for the remaining 25% of the costs and shall continue to care for the member under the terms of the contract.

A description of the effect of inpatient hospital stop-loss on the development of capitation rates is provided in Section 3, *Projected Benefit Costs and Trends* of this report. This risk mitigation program has been developed in accordance with generally accepted actuarial principles and practices.

VLBW Risk Pool

For CY 2021, DHCFP will continue the MCO contract provision for a risk pool to fund supplemental payments for VLBW members. This risk mitigation program has been in place for the entirety of the contract and approved by CMS for prior rating periods. This risk pool applies to all of the MCOs.

VLBW babies are typically very high-cost members with long inpatient hospital stays within the first 90 days of life and have significantly higher costs than the average under age 1 member. Due to the variance in cost within this rate cell, the VLBW risk pool is intended to mitigate the risk of a disproportionate share of VLBW babies among MCOs.

When a qualifying VLBW event is reported, DHCFP will issue the VLBW payment to the applicable MCO. If the number of actual VLBW events exceed the funds available in the VLBW risk pool, the MCOs will receive $0 for any VLBW event that exceeds the funding amount available in the risk pool. Conversely, if at the end of the contract rating period there are any funds remaining in the VLBW risk pool, DHCFP will redistribute those remaining funds to the MCOs based on a distribution of infant member months during the period.

A description of the effect of the VLBW risk pool on the development of capitation rates can be found in Section 3, *Projected Benefit Costs and Trends* of this report. The VLBW case rate benefit cost is $71,000 and is loaded for administration and underwriting gain as described in Section 5, *Projected Non-Benefit Costs* of this report.

This risk mitigation program has been developed in accordance with generally accepted actuarial principles and practices.

Risk Corridor

Effective CY 2021, DHCFP will continue to use a symmetrical, two-sided MLR-based risk corridor on all populations and all medical costs. The risk corridor is being implemented as a response to the COVID-19 PHE. This risk corridor applies to all of the MCOs.

The CY 2021 rating period remains a period of uncertainty due to the COVID-19 PHE and corresponding economic and enrollment impacts. This is causing dramatic shifts in utilization across the healthcare industry and causing financial uncertainty for managed care plans. There remains a great deal of uncertainty in the utilization of services in the CY 2021 period. The risk corridor is intended to mitigate excess managed care gains or losses due to uncertainty in rate development for CY 2021, limiting financial risks to both State and local governments and managed care plans.

This risk corridor applies to all populations, services, and rating regions included in the Medicaid/CHIP managed care program. The risk corridor is a two-sided, symmetrical risk corridor based on a target MLR. The parameters of the CY 2021 risk corridor are as follows:

- The target MLR for CY 2021 is 91.25%. The MLR for purposes of this risk corridor will be computed consistent with CMS regulations as outlined in 42 CFR § 438.8 and related policy guidance. This target MLR was set consistent with CY 2021 capitation rate development assumptions, including the assumptions for the non-medical expense load, consideration for the portion attributable to MLR-allowable health care quality improvement expenses and other nuances of the CMS MLR definitions. The State and Mercer are proposing one uniform risk corridor for all three MCOs; the selection of a 91.25% target MLR was considered reasonable and appropriate for the program and consistent with rate development.

- Risk corridor bands and sharing levels are shown in Table 7 below. In developing the risk corridor bands and sharing levels, considerations included the parameters used in Nevada's historical risk corridors, parameters utilized in other states with similar Medicaid managed care programs and a review of guidance provided by CMS. The parameters selected for the CY 2021 risk corridor are structured similarly to the example provided in the May 14, 2020 CMS informational bulletin.[3] The DHCFP will limit MCO gains and losses in CY 2021 if the actual MLR is different from the target MLR within a specific margin, as laid out in Table 7 below:

Table 7: Risk Corridor Sharing Margins

CY 2021 MLR Risk Corridor Bands	MCO Share of Gain/Loss	DHCFP/Federal Share of Gain/Loss
MLR of less than 87.25%	25%	75%
MLR of 87.25% to less than 89.25%	50%	50%
MLR of 89.25% to 93.25%	100%	0%
MLR of 93.25% to less than 95.25%	50%	50%
MLR greater than or equal to 95.25%	25%	75%

DHCFP will provide MCOs with a reporting tool, along with an instructional guide, for the CY 2021 risk corridor. The reporting tool and the MLR calculation will be consistent with the regulations set forth in 42 CFR § 438.8. DHCFP will allow for reasonable claims run-out as well as reflection of any other adjustments applicable to CY 2021 revenues, such as risk adjustment and payment of all supplemental per event payments, before computing the risk corridor settlement.

There is no impact on the CY 2021 capitation rates for the provision of a risk corridor. The CY 2021 capitation rates reflect Mercer's best estimate projection of reasonable, appropriate, and attainable costs.

[3] CMS. *Medicaid Managed Care Options in Responding to COVID-19*. May 2020. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf.

This risk mitigation program has been developed in accordance with generally accepted actuarial principles and practices. Additional details specific to the risk corridor requirements can be found in the MCO contract.

Remittance on Minimum MLR

For CY 2021, DHCFP will continue the MCO contract provision for remittance to the State if an MCO's MLR falls below 85.0%. This is separate from the aforementioned risk corridor. The MLR remittance has been in place for the Medicaid population for the entirety of the contract and for the CHIP population since CY 2019, and has been approved by CMS for prior rating periods. The minimum MLR remittance applies to all of the MCOs.

CMS regulations offer states the option to require a remittance from plans if their reported MLR per 42 CFR §438.8 is less than the State's minimum MLR. DHCFP has opted to incorporate this optional requirement in the program to provide the State some protection against excess gains in the Nevada Medicaid managed care program.

The MCOs provide an MLR report to DHCFP within 12 months of the end of the rating period in accordance with CMS regulation and guidance. If the calculated MLR for an MCO falls below the State's minimum MLR of 85.0%, the State will collect a remittance from that MCO.

Capitation rates are not directly affected by the minimum MLR requirement. As noted in the *Risk Corridor* subsection of Section 4, the target MLR set consistent with rate development assumptions is 91.25%; therefore, the rates have been developed in such a way that the MCOs are reasonably expected to achieve an MLR of at least 85.0% for CY 2021.

This risk mitigation program has been developed in accordance with generally accepted actuarial principles and practices.

Delivery System and Provider Payment Initiatives

There are two provider payment initiatives, Proposal A (OP) and Proposal B (IP), under 42 CFR § 438.6(c) proposed for the program in CY 2021. Pre-prints for the proposed payment arrangements were submitted to CMS on February 4, 2021. The payments are accounted for in this rate certification in a manner that is consistent with the pre-prints submitted for CMS review.

Proposal A is in alignment with the State plan rate for practitioner services delivered in a teaching environment as detailed in State Plan Attachment 4.19-B, pages 8, 9, and 9a. The directed payment is a uniform percentage increase for services provided by designated practitioners through an eligible public teaching entity. The directed payment will increase payments by the difference between payments under the average commercial rates (ACR) and Medicaid base reimbursement for this provider class; therefore, total Medicaid reimbursement will not exceed estimated payments under ACR.

Proposal B is for inpatient services provided by public hospitals in counties whose population is 700,000 or more. The inpatient reimbursement will be consistent with the supplemental payment for

non-state governmentally owned or operated hospitals as detailed in State Plan Attachment 4.19-A, pages 32, 32a, and 32a.i. The directed payment is a uniform dollar increase for inpatient services provided by eligible public hospitals. The directed payment will increase payments by the difference between payments under the Medicare upper payment limit (UPL) and Medicaid base reimbursement for this provider class; therefore, total Medicaid reimbursement will not exceed estimated payments under the Medicare UPL.

Both directed payments are incorporated as a separate payment term. The aggregate estimated payments under Proposal A is $10,293,136 and the aggregate estimated payments under Proposal B is $92,469,711. The distribution methodology is similar for both directed payments. Payments will be issued quarterly. The first three payments for each will be 25% of the projected aggregate estimated payment amount under the proposal. After the final quarter of the year, the final reimbursement total will be reconciled using actual service utilization or applicable services for the year under the proposal. The fourth and final payment of the year for each proposal will be the difference between the final reconciled reimbursement total and the first three quarterly payments.

All services that meet the eligibility criteria under Proposal A will be subject to the same percentage increase. All services that meet the eligibility criteria under Proposal B will be eligible for the same enhanced reimbursement.

Appendix H illustrates the estimated magnitude of the payments on a PMPM basis for each rate cell. These amounts are developed based on the CY 2021 projected aggregate estimated payments provided by DHCFP. The estimated payments are then grossed up for the 3.5% Nevada State premium tax. The estimated payments are distributed by rate cell based on the estimated CY 2021 utilization mix by rate cell, estimated using utilization for applicable services by rate cell identified in the CY 2019 base data, reweighted on CY 2021 projected enrollment.

Final payments made will vary from these estimates based on actual utilization for applicable services in CY 2021. After the rating period is complete, the State will submit documentation to CMS that incorporates the total amounts for each directed payment into the rate certification’s rate cells, distributed consistent with the distribution methodology noted above.

There are no additional directed payments in the program for CY 2021 that are not addressed in this rate certification. There are no requirements regarding the reimbursement rates the MCOs must pay to any providers unless specified in the certification as a directed payment or authorized under applicable law, regulation, or waiver.

Pass-Through Payments

There continues to be no pass-through payments applicable to the program during CY 2021.

5

Projected Non-Benefit Costs

Administration and Underwriting Gain Load

The CY 2021 rates include provisions for MCO administrative expense and underwriting gain. Administration and underwriting gain loads continue to be, as in the prior years of the contract, taken directly from each MCO's bid, submitted as part of the process to award contracts for Nevada's Medicaid managed care program. The bid load amounts are 10.5% for HPN and Anthem and 10.0% for SilverSummit, inclusive of both administration and underwriting gain. While not explicitly separated in the bid process, Mercer assumes an appropriate portion attributable to underwriting gain within the bid amounts of 1.5%, which implicitly and broadly considers the cost of capital and level of risk in the program including the various risk mitigation strategies employed in CY 2021.

Mercer analyzed the changes in the projected medical PMPMs from prior years in conjunction with projected enrollment in the program to evaluate the change in both administration PMPM and projected dollars within the capitation using the MCO's bids year-over-year. Mercer also reviewed administrative costs and gains/losses as reported in the SDRs and available financial reports by participating MCOs as well as non-medical loads across other similar Medicaid managed care programs. Based on these comparisons, Mercer determined that the administration/underwriting gain loads bid by the MCOs continue to be reasonable and appropriate.

No changes were made to the application of the administrative/underwriting gain loads compared to prior rating periods. They are applied to the final projected benefit costs and are loaded equally on each rate component. The same load is applied for each rate cell capitation, the DCR, and the VLBW case rate.

The PMPM impacts by rate cell for the administration and underwriting gain on the capitation rates are provided in both Appendix E and Appendix F. The impact of administration and underwriting gain on the DCR is provided in Appendix G. The impact on the VLBW case rate is $8,329.61 for HPN and Anthem and $7,888.89 for SilverSummit.

Premium Tax

All MCOs are subject to Nevada State premium tax of 3.5% for CY 2021. Each rate component includes an additional 3.5% load for premium tax.

The PMPM impacts by rate cell for the premium tax on the capitation rates is provided in both Appendix E and Appendix F. The impact on the DCR is provided in Appendix G. The impact on the VLBW case rate is $2,877.24 for HPN and Anthem and $2,861.26 for SilverSummit.

Health Insurance Providers Fee

The ACA imposed a fee on health insurers, including most Medicaid managed care plans. In prior years the Health Insurance Providers Fee (HIPF) adjustment to the Nevada Medicaid managed care program was accounted for as a retrospective payment after the actual fee amounts were finalized by the IRS. This approach allowed the HIPF expense to match directly with the increase in capitation rates. For CY 2021, the HIPF is no longer applicable due to the discontinuation after the 2019 premium year; therefore, no adjustment is required for CY 2021 rates.

6

Risk Adjustment and Acuity Adjustments

Risk Adjustment

There is no prospective risk adjustment applied to the CY 2021 rates. There will be a retrospective application of risk adjustment applied to CY 2021 capitation rates, performed once annually following the end of the rating period. Under age 1 rate cells will not be risk adjusted nor will per event supplemental case rates; capitation rates will be risk adjusted net of directed payments paid under separate payment terms. The risk adjustment will be performed by Mercer.

The data used for risk adjustment will include MCO-submitted encounter data and FFS claims data with CY 2021 dates of service for all members who were enrolled with an MCO within CY 2021. The data utilized for the retrospective risk adjustment will include at least three months of runout and include only those encounters and claims recorded in the Nevada data warehouse; therefore, MCO denied or State rejected encounters and claims will not be used. Only members with six or more months of experience within the 12-month contract period will be included in risk scoring, and claims/encounters that do not involve an encounter with a physician and are diagnostic in nature, such as professional laboratory and diagnostic radiology claims, will be excluded.

Mercer intends to utilize the most recent Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model with national concurrent risk weights. The model is a combination of two models developed by the University of California, San Diego: the Chronic Illness and Disability Payment System model is a diagnosis-based risk adjustment model that uses diagnosis codes to asses risk and the Medicaid Rx is a pharmacy-based model that uses National Drug Codes to assess risk. Mercer will not include the CDPS+Rx maternity categories as the DCR is not risk adjusted.

Mercer does not anticipate making any substantive changes to the risk adjustment model compared to CY 2019 or CY 2020 beyond using the most up-to-date version of the CDPS+Rx model. Risk adjustment will be normalized on the capitation rates net of the non-medical components and will be budget neutral to the State on a benefit cost basis by region and COA. The risk adjusted rates will then be re-loaded for non-medical rate components. As the administration and underwriting gain load components of the premium rates vary among the MCOs, there may be slight net impacts to the State.

Acuity Adjustments

There are no acuity adjustments applied in the CY 2021 rate development.

7

Certification of Final Rates

This certification assumes items in the Medicaid State Plan, including any proposed State Plan Amendments, as well as the MCO contract, have been, or will be approved by CMS.

In preparing the capitation rates and directed payment separate payment term estimates for CY 2021, found in Appendix A and Appendix H respectively, for the Nevada Medicaid managed care program, Mercer has used and relied upon enrollment, eligibility, encounter, claims, revenue and other information supplied by DHCFP and its vendors. DHCFP and its vendors are responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness, but did not audit it. In Mercer's opinion, the data used for the rate development process is appropriate for the intended purposes. If the data and information is incomplete or inaccurate, the values shown in this certification may need to be revised accordingly.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate or unattainable when they were made.

Mercer certifies that the Nevada Medicaid managed care program capitation rates and the directed payment separate payment term estimates were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCFP to demonstrate compliance with CMS requirements under 42 CFR § 438.4 and in accordance with applicable laws and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCOs for any purpose. Mercer recommends that any MCO considering contracting with DHCFP should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rates before deciding whether to contract with DHCFP.

DHCFP understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that DHCFP secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification assumes the reader is familiar with the Nevada Medicaid managed care program, Medicaid eligibility rules, and actuarial rating techniques. It has been prepared exclusively for DHCFP and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. This report should only be reviewed in its entirety and Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

Sincerely,

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November 23, 2021

Subject: Revised Nevada Medicaid Managed Care Program Capitation Rate Development and Certification for Calendar Year 2021

Dear Ms. Ruybalid:

The State of Nevada Department of Health and Human Services (State), Division of Health Care Financing and Policy (DHCFP) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rates for the Nevada Medicaid managed care program. The capitation rates are effective for calendar year (CY) 2021, January 1, 2021 through December 31, 2021 (CY 2021).

The original capitation rates were developed by Mercer and certified in a report dated February 26, 2021 (please see the attached document: *CY 2021 Nevada MCO Rate Certification_2021.02.26.pdf*). This certification revision accounts for legislation determined to have a material impact to Medicaid managed care from the 81st (2021) Session of the Nevada Legislature that adjourned June 1, 2021, including the repeal of the provisions pursuant to Nevada Assembly Bill 3 — Committee of the Whole (Assembly Bill 3), which was originally enrolled and delivered to the Governor on July 20, 2020.

The adjustments result in revised capitation rates for the entirety of CY 2021. Revisions were limited to adjustments and assumptions directly impacted by the recent legislative session and the repeal of

[1] Actuarially sound/actuarial soundness – Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For the purposes of this definition, other revenue sources include, but are not limited to, governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes. https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

Assembly Bill 3. No other assumptions were revised compared to the original certification dated February 26, 2021.

Multiple exhibits are included as part of this rate certification package and have been updated from the original certification to reflect these changes (please see the attached file: *CY 2021 Nevada MCO Rate Certification Amendment_Appendices_2021.11.23.xlsx*). These attachments include summaries of the capitation rates (including the final and certified capitation rates) and exhibits that provide more detail regarding various rate-development components. The final certified rates by managed care organization (MCO) and rate cell can be found in Appendix A of the attached file.

Additionally, DHCFP has implemented several risk-sharing mechanisms applicable to the MCOs in CY 2021, certified by Mercer in a letter dated December 23, 2020 (please see the attached document: *CY 2021 Nevada MCO Risk Sharing Mechanisms Certification_2020.12.23.pdf*). No revisions have been made to the development of the risk-sharing mechanisms.

Per Section 4.2 of ASOP 49, the revised capitation rates for the Nevada Medicaid managed care program were developed in accordance with Centers for Medicare & Medicaid Services (CMS) requirements and this document provides the certification of actuarial soundness required by 42 CFR § 438.4. CMS defines actuarially sound rates as meeting the following criteria:

- Have been developed in accordance with generally accepted actuarial principles and practices. Proposed differences among capitation rates according to covered populations are 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.
- Payments from each rate cell do not cross-subsidize payments for any other rate cell.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

This report provides an overview of the analyses and methodology used in the development of the CY 2021 rate revision for the purposes of satisfying the requirements of the CMS rate review process. This report follows the general outline for the CMS July 2020 through June 2021 Medicaid Managed Care Rate Development Guide (RDG), which is applicable to contract periods beginning between July 1, 2020 and June 30, 2021. A copy of the RDG with documentation references is attached with this report.

This document is the result of collaboration between DHCFP and Mercer. It should be read in its entirety and has been prepared under the direction of Katharina Lau, ASA, MAAA, who is a member of the

American Academy of Actuaries and meets its US Qualification Standard for issuing the statements of actuarial opinion herein.

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

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Aggregated across all rate cells, the revised CY 2021 capitation rates represent a 4.0% increase when compared to the original certified CY 2021 capitation rates for the managed care program.

General Information

Please refer to the original February 26, 2021 certification for general information related to the Nevada Medicaid managed care program, including the following elements:

- Program background
- MCO participation
- Covered populations
- Covered services
- Rate structure
- Rate development
- Membership projections

The information provided in this section should be supplemented with the MCO contract information for additional detail.

Federal Medical Assistance Percentages

There have been no changes made to the estimated baseline CY 2021 Federal Medical Assistance Percentages (FMAP) by major category of aid (COA) due to the revised CY 2021 capitation rates. Please refer to the original February 26, 2021 certification for additional details related to the standard and enhanced FMAP percentages.

The revised CY 2021 capitation rates result in changes to the proportion of the capitation rate subject to the enhanced FMAP for family planning services. Mercer and DHCFP will update the separate

memorandum to document the process for revising the estimated portion of the capitation rate subject to the different FMAP.

Certified Rate Change

Table 1 below illustrates the composite revised rates effective January 1, 2021 with a comparison to the original rates effective January 1, 2021 on a per member per month (PMPM) basis by major COA. Composite values were calculated using projected member months and delivery case rate (DCR) and very low birth weight (VLBW) case counts for the January 1, 2021 through December 31, 2021 rating period.

Table 1: COA Rate Change Summary

Certified Rate	TANF/CHAP Child Capitation	TANF/CHAP Adult Capitation	Check Up Capitation	Expansion Capitation	Delivery Case Rate	VLBW Risk Pool Payment
CY 2021 – Original	$136.52	$334.44	$109.14	$482.36	$5,729.54	$82,147.20
CY 2021 – Revised	$142.90	$348.06	$113.52	$500.24	$6,050.63	$82,147.20
Percent Change	4.67%	4.07%	4.01%	3.71%	5.60%	0.00%

Long-Term IMD Add-On

There have been no changes made to the methodology used to develop the State-funded long-term Institution for Mental Disease (IMD) rates for CY 2021. The add-on is not eligible for Federal financial participation pursuant to 42 CFR § 438.6(e). The add-on was revised similarly to the CY 2021 certified capitation rates. The revised long-term IMD add-on capitation rates are provided in Appendix I, and the total revised contracted rates, inclusive of the certified capitation rates and the State-funded long-term IMD add-on rates, are provided in Appendix J.

Data

There have been no changes made to the following data elements in the development of the revised CY 2021 capitation rates:

- Data sources
- Data validations
- Base data
- In lieu of services

- Retrospective eligibility periods
- Base data adjustments
- Delivery services

For more detail related to these components, please refer to the original February 26, 2021 certification.

Projected Benefit Costs and Trends

Trend

There have been no changes made to the annualized trend percentages used to develop the projected benefit costs for CY 2021. Please see the original February 26, 2021 certification for more detail related to the development of these assumptions.

Program Changes

The revision of the CY 2021 capitation rates accounts for bills determined to have a material impact to Medicaid managed care from the 81st (2021) Session of the Nevada Legislature. The revision includes the removal of one program change, revision of two program changes, and application of two new program changes as described below.

Program changes that were not impacted by the 81st (2021) Session of the Nevada Legislature were not revised. No changes were made to the following program changes:

- Senate Bill 378 Rebates Pass-Through
- Dental Ambulatory Surgical Center Fee Change

For information related to the development of these non-impacted program changes, please refer to the original February 26, 2021 certification.

Total program change adjustments by rate cell and category of service are provided in Appendix F. The aggregate PMPM impacts by COA for individual program change adjustments are shown in Appendix C.

Assembly Bill 3

The original CY 2021 capitation rates incorporated fee schedule reductions for certain provider types and services pursuant to Assembly Bill 3 effective August 15, 2020. The percentage changes to the affected fee schedules varied by provider type and service grouping, and were provided to Mercer by DHCFP. Mercer applied the percentage changes to the paid amounts in the CY 2019 base data encounter data by provider type and service. The 81st (2021) Session of the Nevada Legislature approved the repeal of

the Assembly Bill 3 provisions, retroactive to the initial effective date. Due to the repeal, an adjustment for Assembly Bill 3 reductions in fee-schedule reimbursement rates is no longer applicable; therefore, Mercer removed the adjustment.

Please see the original February 26, 2021 certification for further detail on the prior Assembly Bill 3 program change adjustment.

Acute Inpatient Fee Changes

The original CY 2021 capitation rates included adjustments for fee schedule increases to newborn intensive care unit (NICU) services and pediatric intensive care unit (PICU) services at a general acute inpatient hospital effective January 1, 2020. However, the original CY 2021 capitation rates did not include an adjustment for the corresponding 2.5% per diem fee schedule increase for medical, surgical, and intensive care unit (ICU) services at a general acute inpatient hospital, as Assembly Bill 3 had removed this increase. The removal of the 2.5% increase to medical, surgical, and ICU services at a general acute inpatient hospital was not included as an explicit adjustment in the development of the original CY 2021 capitation rates as the CY 2019 base data preceded the rate change.

With the repeal of the Assembly Bill 3 provisions, retroactive to the initial effective date, the 2.5% fee schedule increase for medical, surgical, and ICU services at a general acute inpatient hospital was restored. Encounters for the affected services in the CY 2019 base data were repriced upward accordingly. Mercer combined the impact to the medical, surgical, and ICU services with the prior impact for the fee schedule increases to NICU services and PICU services effective January 1, 2020. The revised program change accounts for the combined impact of all three January 1, 2020 acute inpatient fee schedule changes.

Please see the original February 26, 2021 certification for further detail on the prior Assembly Bill 3 and NICU/PICU fee change program change adjustments.

Short-Term IMD Repricing

As described in the original February 26, 2021 certification, pursuant to 42 CFR § 438.6(e), Mercer repriced CY 2019 base experience for short-term IMD stays at the State Plan rate, identified for Nevada as the acute inpatient psychiatric/detox per diem. The elimination of the Assembly Bill 3 fee schedule reductions increased the corresponding State Plan rate, and the adjustment was revised accordingly. Please see the original February 26, 2021 certification for more detail on the short-term IMD repricing adjustment.

Sexually Transmitted Infection and Sexually Transmitted Disease Testing

On June 4, 2021, the Governor approved the provisions pursuant to Assembly Bill 192 and Senate Bill 211 from the 81st (2021) Session of the Nevada Legislature with provisions effective July 1, 2021. This newly applied program change reflects the requirement from Assembly Bill 192 for providers in outpatient and emergency department settings to conduct sexually transmitted infection (STI) testing for pregnant women and the requirement from Senate Bill 211 for providers in hospitals and primary care to offer sexually transmitted disease (STD) testing to patients aged 15 and above. Mercer reviewed the impacts related to both bills in conjunction to ensure no duplication in the adjustment for testing efforts among pregnant women.

Mercer reviewed applicable visits in the CY 2019 base data for pregnant women and non-pregnant patients aged 15 and above and identified the portion of those visits that did not have associated STI or STD testing. Based on clinical review and professional judgment, Mercer assumed that following these initiatives, the testing rate would increase such that 40% of visits identified without testing for pregnant women, and 20% for non-pregnant patients aged 15 and above, would now include testing. Mercer prorated the adjustment for the July 1, 2021 effective date and additionally assumed that testing would ramp up over the first six months. Mercer evaluated actual STI and STD testing services cost and utilization in the CY 2019 base data to determine the number of tests and overall cost per STI and STD testing event.

Cognitive Assessments

On June 4, 2021, the Governor approved the provisions pursuant to Assembly Bill 216 from the 81st (2021) Session of the Nevada Legislature. This newly applied program change reflects the State's newly covered cognitive assessment for persons with suspected cognitive impairment aged 55 to 64 as part of this provision, effective July 1, 2021. These assessments have previously not been available to managed care members, and were not included in the CY 2019 base data.

Mercer reviewed Nevada-specific Centers for Disease Control and Prevention statistics on people experiencing subjective cognitive decline to project the portion of members aged 55 to 64 expected to pursue and receive the newly covered cognitive assessment. Based on clinical review and professional judgment, Mercer anticipated a portion of the members receiving this cognitive assessment will be diagnosed with cognitive impairment, a portion of which may subsequently utilize other medical services. Early identification may also prevent a small number of emergency events or hospitalizations. The adjustment includes the cost of the assessment and the consideration for subsequent utilization of other medical services. Mercer prorated the adjustment for the July 1, 2021 effective date.

COVID-19 Considerations

There have been no changes made to the Coronavirus Disease 2019 (COVID-19) assumptions used to develop the projected benefit costs and trends for CY 2021. Please see the original February 26, 2021 certification for more detail related to these considerations.

Other Medical Rating Adjustments

Other medical rating adjustments were revised for the aforementioned program changes where appropriate as described below. The aggregate PMPM and percentage impacts by COA for each of the other medical rating adjustments described in this Section are shown in Appendix D and the PMPM impacts by rate cell are shown in both Appendix D and Appendix F.

Inpatient Hospital Stop-Loss

There have been no changes made to the methodology used to develop the inpatient hospital stop-loss adjustment for CY 2021. In the development of the stop-loss adjustment, Mercer analyzes member-level inpatient medical costs in the base data and adjusts for relevant fee changes and trend to project forward to CY 2021. Due to the repeal of the Assembly Bill 3 provisions, the adjustments for fee changes were revised to remove the approximately 6% reduction for affected provider types and include the 2.5% fee increase for medical, surgical, and ICU services at a general acute inpatient hospital for applicable encounters. The projected CY 2021 stop-loss reimbursement was revised accordingly, and netted out of the gross CY 2021 projected medical costs by rate cell. For more detail related to the development of the inpatient hospital stop-loss adjustment, please see the original February 26, 2021 certification.

VLBW Risk Pool Payment

There have been no changes made to the VLBW risk pool payment and rating adjustment. Please see the original February 26, 2021 certification for more detail related to the development and application of the adjustment to capitation for the VLBW risk pool payment.

Credibility Adjustments

There have been no changes made to the methodology used to develop the credibility adjustments for CY 2021. The methodology was applied to the revised projected medical cost. Updated manual rates and blended final medical PMPMs, consistent with this methodology, are provided in Appendix D. Please see the original February 26, 2021 certification for more detail related to the methodology and development of these adjustments.

Delivery Case Rate

There have been no changes made to the methodology used to develop the DCR for CY 2021; the development of the DCR continues to follow the same methodology used in development of the CY 2021 capitation rates. The projected delivery medical cost was revised consistently with the projected capitated medical costs for the repeal of the Assembly Bill 3 provisions, as described above. Revisions were limited to the removal of the Assembly Bill 3 adjustment and the revision of the acute inpatient fee changes effective January 1, 2020.

The development of the updated DCR is shown in Appendix G. For more detail related to the development of the DCR, please see the original February 26, 2021 certification.

Special Contract Provisions Related to Payment

There have been no changes made to special contract provisions related to payment in the development of the revised capitation rates. For more detail associated with special contract provisions related to payment, please refer to the original February 26, 2021 certification and the risk-sharing mechanisms certification dated December 23, 2020.

Projected Non-Benefit Costs

Administration and Underwriting Gain Load

There have been no changes made to the administrative/underwriting gain percentage loads; the percentage loads continue to be taken directly from each MCO's bid. The administrative/underwriting gain percentage loads were applied to the revised projected medical costs, which resulted in updated PMPM impacts. PMPM impacts by rate cell are provided in Appendix E and Appendix F. The impact of administration and underwriting gain on the updated DCR is provided in Appendix G. The impact on the VLBW case rate is unchanged.

Please see the original February 26, 2021 certification for more detail related to the methodology and application of the administration and underwriting gain on the capitation rates.

Premium Tax

There have been no changes made to the premium tax percentage load for each rate cell; the MCOs continue to be subject to the Nevada State premium tax of 3.5% for CY 2021. The premium tax load was applied to the revised rates. The resulting PMPMs are provided in both Appendix E and Appendix F. The impact on the DCR is provided in Appendix G. The impact on the VLBW case rate is unchanged.

Please refer to the original February 26, 2021 certification for additional details related to the application of the premium tax.

Health Insurance Providers Fee

The Health Insurance Providers Fee is not applicable to the CY 2021 rates, as described in the original February 26, 2021 certification.

Risk Adjustment and Acuity Adjustments

Risk Adjustment

There have been no changes made to the methodology of the retrospective risk adjustment. Risk adjustment will be applied to the revised CY 2021 capitation rates. For more detail associated with the methodology and application of risk adjustment, please refer to the original February 26, 2021 certification.

Acuity Adjustments

There continues to be no acuity adjustments applied in the CY 2021 rate development, consistent with the original February 26, 2021 certification.

Certification of Final Rates

This certification assumes items in the Medicaid State Plan, including any proposed State Plan Amendments, as well as the MCO contract, have been, or will be approved by CMS.

In preparing the capitation rates for CY 2021, found in Appendix A, for the Nevada Medicaid managed care program, Mercer has used and relied upon enrollment, eligibility, encounter, claims, revenue and other information supplied by DHCFP and its vendors. DHCFP and its contracted vendors are responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness, but did not audit it. In Mercer's opinion, the data used for the rate-development process is appropriate for the intended purposes. If the data and information is incomplete or inaccurate, the values shown in this certification may need to be revised accordingly.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the Nevada Medicaid managed care program revised capitation rates were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCFP to demonstrate compliance with CMS requirements under 42 CFR § 438.4 and in accordance with applicable laws and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCOs for any purpose. Mercer recommends that any MCO considering contracting with DHCFP should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rates before deciding whether to contract with DHCFP.

DHCFP understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that DHCFP secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification assumes the reader is familiar with the Nevada Medicaid managed care program, Medicaid eligibility rules, and actuarial rating techniques. It has been prepared exclusively for DHCFP and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. This report should only be reviewed in its entirety and Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

Sincerely,

BLANK FOR PUBLIC POSTING

Katharina Lau, ASA, MAAA
Principal

CY 2021 NEVADA MCO RATE CERTIFICATION AMENDMENT APPENDICES

Appendix J: CY 2021 Total Payment Rates and Comparison

Total Rates[1]

			Anthem				Health Plan of Nevada				SilverSummit				All MCOs			
Region	COA	Rating Group	Projected MMs / Counts	CY 2021 – Revised	CY 2021 – Prior[2]	% Change	Projected MMs / Counts	CY 2021 – Revised	CY 2021 – Prior[2]	% Change	Projected MMs / Counts	CY 2021 – Revised	CY 2021 – Prior[2]	% Change	Projected MMs / Counts	CY 2021 – Revised	CY 2021 – Prior[2]	% Change
			Capitation Rates				Capitation Rates				Capitation Rates				Capitation Rates			
Northern	TANF/CHAP Child	Under 1	11,747	$ 520.91	$ 488.99	6.5%	12,460	$ 520.91	$ 488.99	6.5%	3,952	$ 518.02	$ 486.28	6.5%	28,159	$ 520.50	$ 488.61	6.5%
Northern	TANF/CHAP Child	Child 1-2	20,413	$ 106.66	$ 101.54	5.0%	25,771	$ 106.66	$ 101.54	5.0%	6,789	$ 106.07	$ 100.98	5.0%	52,973	$ 106.58	$ 101.47	5.0%
Northern	TANF/CHAP Child	Child 3-14	98,835	$ 88.16	$ 84.81	4.0%	134,786	$ 88.16	$ 84.81	4.0%	21,615	$ 87.67	$ 84.34	3.9%	255,236	$ 88.12	$ 84.77	3.9%
Northern	TANF/CHAP Child	Female 15-18	11,144	$ 143.47	$ 138.38	3.7%	18,070	$ 143.47	$ 138.38	3.7%	2,789	$ 142.67	$ 137.61	3.7%	32,003	$ 143.40	$ 138.31	3.7%
Northern	TANF/CHAP Child	Male 15-18	11,202	$ 114.38	$ 110.40	3.6%	17,262	$ 114.38	$ 110.40	3.6%	2,906	$ 113.74	$ 109.79	3.6%	31,370	$ 114.32	$ 110.34	3.6%
Northern	TANF/CHAP Adult	Female 19-34	22,448	$ 272.47	$ 260.45	4.6%	25,240	$ 272.47	$ 260.45	4.6%	5,596	$ 270.96	$ 259.00	4.6%	53,283	$ 272.31	$ 260.30	4.6%
Northern	TANF/CHAP Adult	Male 19-34	4,141	$ 187.20	$ 179.81	4.1%	4,114	$ 187.20	$ 179.81	4.1%	1,307	$ 186.16	$ 178.82	4.1%	9,563	$ 187.06	$ 179.67	4.1%
Northern	TANF/CHAP Adult	Female 35 and Over	11,987	$ 451.55	$ 434.54	3.9%	14,352	$ 451.55	$ 434.54	3.9%	2,740	$ 449.03	$ 432.12	3.9%	29,079	$ 451.31	$ 434.31	3.9%
Northern	TANF/CHAP Adult	Male 35 and Over	5,082	$ 418.66	$ 402.92	3.9%	5,371	$ 418.66	$ 402.92	3.9%	1,418	$ 416.34	$ 400.68	3.9%	11,871	$ 418.38	$ 402.65	3.9%
Northern	Check Up	Under 1	126	$ 210.96	$ 199.24	5.9%	115	$ 210.96	$ 199.24	5.9%	27	$ 209.79	$ 198.13	5.9%	268	$ 210.84	$ 199.13	5.9%
Northern	Check Up	Child 1-2	1,249	$ 112.02	$ 106.86	4.8%	2,013	$ 112.02	$ 106.86	4.8%	366	$ 111.40	$ 106.27	4.8%	3,627	$ 111.96	$ 106.80	4.8%
Northern	Check Up	Child 3-14	13,487	$ 85.33	$ 82.34	3.6%	21,713	$ 85.33	$ 82.34	3.6%	2,672	$ 84.86	$ 81.88	3.6%	37,873	$ 85.30	$ 82.31	3.6%
Northern	Check Up	Female 15-18	1,804	$ 131.38	$ 126.93	3.5%	3,301	$ 131.38	$ 126.93	3.5%	495	$ 130.65	$ 126.22	3.5%	5,600	$ 131.32	$ 126.87	3.5%
Northern	Check Up	Male 15-18	1,925	$ 102.81	$ 99.39	3.4%	3,624	$ 102.81	$ 99.39	3.4%	404	$ 102.24	$ 98.84	3.4%	5,953	$ 102.77	$ 99.35	3.4%
Northern	Expansion	Female 19-34	40,257	$ 317.40	$ 304.76	4.1%	39,112	$ 317.40	$ 304.76	4.1%	13,064	$ 315.63	$ 303.07	4.1%	92,434	$ 317.15	$ 304.52	4.1%
Northern	Expansion	Male 19-34	36,248	$ 403.53	$ 390.18	3.4%	27,272	$ 403.53	$ 390.18	3.4%	11,566	$ 401.29	$ 388.01	3.4%	75,087	$ 403.18	$ 389.85	3.4%
Northern	Expansion	Female 35 and Over	48,577	$ 662.18	$ 638.65	3.7%	48,867	$ 662.18	$ 638.65	3.7%	12,485	$ 658.50	$ 635.10	3.7%	109,929	$ 661.76	$ 638.25	3.7%
Northern	Expansion	Male 35 and Over	54,720	$ 708.13	$ 679.53	4.2%	41,551	$ 708.13	$ 679.53	4.2%	15,323	$ 704.19	$ 675.75	4.2%	111,594	$ 707.59	$ 679.01	4.2%
Southern	TANF/CHAP Child	Under 1	80,929	$ 652.01	$ 615.17	6.0%	86,545	$ 652.01	$ 615.17	6.0%	24,844	$ 648.39	$ 611.75	6.0%	192,317	$ 651.54	$ 614.73	6.0%
Southern	TANF/CHAP Child	Child 1-2	154,617	$ 128.58	$ 122.38	5.1%	177,447	$ 128.58	$ 122.38	5.1%	43,615	$ 127.87	$ 121.70	5.1%	375,679	$ 128.50	$ 122.30	5.1%
Southern	TANF/CHAP Child	Child 3-14	839,180	$ 102.85	$ 98.89	4.0%	980,495	$ 102.85	$ 98.89	4.0%	166,250	$ 102.28	$ 98.34	4.0%	1,985,926	$ 102.80	$ 98.84	4.0%
Southern	TANF/CHAP Child	Female 15-18	96,623	$ 147.24	$ 141.64	4.0%	138,202	$ 147.24	$ 141.64	4.0%	22,735	$ 146.42	$ 140.85	4.0%	257,560	$ 147.17	$ 141.57	4.0%
Southern	TANF/CHAP Child	Male 15-18	97,002	$ 113.21	$ 108.99	3.9%	139,766	$ 113.21	$ 108.99	3.9%	23,463	$ 112.58	$ 108.38	3.9%	260,230	$ 113.15	$ 108.94	3.9%
Southern	TANF/CHAP Adult	Female 19-34	170,893	$ 276.47	$ 264.43	4.6%	186,773	$ 276.47	$ 264.43	4.6%	42,675	$ 274.93	$ 262.96	4.6%	400,341	$ 276.31	$ 264.27	4.6%
Southern	TANF/CHAP Adult	Male 19-34	30,287	$ 169.22	$ 162.77	4.0%	34,502	$ 169.22	$ 162.77	4.0%	8,998	$ 168.28	$ 161.86	4.0%	73,788	$ 169.11	$ 162.66	4.0%
Southern	TANF/CHAP Adult	Female 35 and Over	99,178	$ 485.93	$ 467.97	3.8%	125,121	$ 485.93	$ 467.97	3.8%	26,050	$ 483.23	$ 465.37	3.8%	250,349	$ 485.65	$ 467.70	3.8%
Southern	TANF/CHAP Adult	Male 35 and Over	37,349	$ 447.61	$ 432.82	3.4%	47,098	$ 447.61	$ 432.82	3.4%	10,410	$ 445.13	$ 430.41	3.4%	94,856	$ 447.34	$ 432.56	3.4%
Southern	Check Up	Under 1	400	$ 239.75	$ 226.42	5.9%	652	$ 239.75	$ 226.42	5.9%	322	$ 238.41	$ 225.17	5.9%	1,374	$ 239.44	$ 226.13	5.9%
Southern	Check Up	Child 1-2	5,927	$ 137.49	$ 130.79	5.1%	7,045	$ 137.49	$ 130.79	5.1%	1,906	$ 136.73	$ 130.06	5.1%	14,878	$ 137.39	$ 130.70	5.1%
Southern	Check Up	Child 3-14	66,959	$ 106.15	$ 101.97	4.1%	90,110	$ 106.15	$ 101.97	4.1%	13,230	$ 105.56	$ 101.41	4.1%	170,300	$ 106.10	$ 101.93	4.1%
Southern	Check Up	Female 15-18	9,345	$ 160.60	$ 155.08	3.6%	15,374	$ 160.60	$ 155.08	3.6%	2,316	$ 159.71	$ 154.22	3.6%	27,035	$ 160.52	$ 155.01	3.6%
Southern	Check Up	Male 15-18	8,849	$ 131.71	$ 126.99	3.7%	15,237	$ 131.71	$ 126.99	3.7%	2,182	$ 130.97	$ 126.29	3.7%	26,269	$ 131.65	$ 126.93	3.7%
Southern	Expansion	Female 19-34	277,582	$ 280.71	$ 270.17	3.9%	321,647	$ 280.71	$ 270.17	3.9%	89,910	$ 279.14	$ 268.67	3.9%	689,139	$ 280.51	$ 269.97	3.9%
Southern	Expansion	Male 19-34	244,128	$ 303.98	$ 293.36	3.6%	273,642	$ 303.98	$ 293.36	3.6%	97,628	$ 302.29	$ 291.74	3.6%	615,398	$ 303.71	$ 293.10	3.6%
Southern	Expansion	Female 35 and Over	301,117	$ 647.85	$ 625.75	3.5%	412,584	$ 647.85	$ 625.75	3.5%	99,866	$ 644.25	$ 622.28	3.5%	813,566	$ 647.41	$ 625.32	3.5%
Southern	Expansion	Male 35 and Over	296,416	$ 695.36	$ 670.53	3.7%	362,460	$ 695.36	$ 670.53	3.7%	112,105	$ 691.50	$ 666.80	3.7%	770,981	$ 694.80	$ 669.99	3.7%
			Delivery Case Rate				Delivery Case Rate				Delivery Case Rate				Delivery Case Rate			
All Regions	TANF/CHAP Child	All	269	$ 6,054.21	$ 5,732.93	5.6%	391	$ 6,054.21	$ 5,732.93	5.6%	64	$ 6,020.58	$ 5,701.08	5.6%	724	$ 6,051.25	$ 5,730.12	5.6%
All Regions	TANF/CHAP Adult	All	6,142	$ 6,054.21	$ 5,732.93	5.6%	6,856	$ 6,054.21	$ 5,732.93	5.6%	1,541	$ 6,020.58	$ 5,701.08	5.6%	14,539	$ 6,050.65	$ 5,729.56	5.6%
All Regions	Check Up	All	4	$ 6,054.21	$ 5,732.93	5.6%	7	$ 6,054.21	$ 5,732.93	5.6%	1	$ 6,020.58	$ 5,701.08	5.6%	13	$ 6,051.31	$ 5,730.19	5.6%
All Regions	Expansion	All	321	$ 6,054.21	$ 5,732.93	5.6%	371	$ 6,054.21	$ 5,732.93	5.6%	104	$ 6,020.58	$ 5,701.08	5.6%	796	$ 6,049.82	$ 5,728.77	5.6%
			VLBW Case Rate				VLBW Case Rate				VLBW Case Rate				VLBW Case Rate			
All Regions	TANF/CHAP Child	All	88	$ 82,206.85	$ 82,206.85	0.0%	94	$ 82,206.85	$ 82,206.85	0.0%	27	$ 81,750.14	$ 81,750.14	0.0%	209	$ 82,147.20	$ 82,147.20	0.0%
All Regions	TANF/CHAP Adult	All	-	$ 82,206.85	$ 82,206.85	0.0%	-	$ 82,206.85	$ 82,206.85	0.0%	-	$ 81,750.14	$ 81,750.14	0.0%	-	$ -	$ -	0.0%
All Regions	Check Up	All	-	$ 82,206.85	$ 82,206.85	0.0%	-	$ 82,206.85	$ 82,206.85	0.0%	-	$ 81,750.14	$ 81,750.14	0.0%	-	$ -	$ -	0.0%
All Regions	Expansion	All	-	$ 82,206.85	$ 82,206.85	0.0%	-	$ 82,206.85	$ 82,206.85	0.0%	-	$ 81,750.14	$ 81,750.14	0.0%	-	$ -	$ -	0.0%
			Composite PMPM				Composite PMPM				Composite PMPM				Composite PMPM			
All Regions	TANF/CHAP Child	All	1,421,692	$ 149.77	$ 143.29	4.5%	1,730,805	$ 145.62	$ 139.38	4.5%	318,958	$ 165.13	$ 157.81	4.6%	3,471,454	$ 149.11	$ 142.67	4.5%
All Regions	TANF/CHAP Adult	All	381,365	$ 442.88	$ 424.15	4.4%	442,571	$ 445.68	$ 426.97	4.4%	99,194	$ 436.76	$ 418.37	4.4%	923,131	$ 443.56	$ 424.88	4.4%
All Regions	*All TANF/CHAP*	*All*	*1,803,056*	*$ 211.76*	*$ 202.69*	*4.5%*	*2,173,376*	*$ 206.72*	*$ 197.94*	*4.4%*	*418,153*	*$ 229.57*	*$ 219.62*	*4.5%*	*4,394,585*	*$ 210.97*	*$ 201.95*	*4.5%*
All Regions	Check Up	All	110,071	$ 113.24	$ 108.85	4.0%	159,185	$ 113.83	$ 109.46	4.0%	23,920	$ 116.03	$ 111.48	4.1%	293,176	$ 113.79	$ 109.40	4.0%
All Regions	Expansion	All	1,299,046	$ 503.13	$ 485.16	3.7%	1,527,135	$ 510.92	$ 492.77	3.7%	451,948	$ 497.56	$ 479.83	3.7%	3,278,128	$ 505.99	$ 487.97	3.7%
All Regions	**All COAs**	**All**	**3,212,173**	**$ 326.22**	**$ 313.71**	**4.0%**	**3,859,696**	**$ 323.25**	**$ 310.94**	**4.0%**	**894,021**	**$ 362.01**	**$ 348.27**	**3.9%**	**7,965,890**	**$ 328.80**	**$ 316.25**	**4.0%**

General Notes:

- Totals may differ due to rounding.
- All composites are weighted on CY 2021 projected member months.

Footnotes:

1. Capitation rates are the combined total of the rates eligible for federal financial participation and the long-term IMD State-funded add-on.
2. CY 2021 – Prior reflects the payment rates in the CY 2021 rate certification dated February 26, 2021.