Mercer

Government Human Services Consulting

Capitation Rate Development and Certification

Calendar Year 2022 Nevada Medicaid Managed Care Program

State of Nevada
Department of Health and Human Services
Division of Health Care Financing and Policy

December 21, 2021

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Contents

Section 1

Executive Summary

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 applicable to the managed care organizations (MCOs). The capitation rates are effective for calendar year 2022 (CY 2022), January 1, 2022 through December 31, 2022.

Per Section 4.2 of ASOP 49, capitation rates for the Nevada Medicaid managed care program were developed in accordance with the Centers for Medicare & Medicaid Services (CMS) requirements and this report provides the certification of actuarial soundness, as defined and required in 42 CFR § 438.4. Any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR § 438.4(b)(1), are based on valid rate development standards that represent actual cost differences to the covered populations, and these differences do not vary with the rate of federal financial participation associated with the covered populations in a manner that increases federal costs.

This report provides an overview of the analyses and methodology used in the development of the CY 2022 rates for the purposes of satisfying the requirements of the CMS rate review process. This report follows the general outline for the CMS July 2021 through June 2022 Medicaid Managed Care Rate Development Guide (RDG), which is applicable to contract periods beginning between July 1, 2021 and June 30, 2022. A copy of the RDG, with documentation references, is attached with this report.

Multiple exhibits are also included as part of this rate certification package (please see the attached file: *CY 2022 Nevada MCO Rate Certification_Appendices_2021.12.21.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 rate cell can be found in Appendix A of the attached file.

This report 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.

[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.

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Certified Rate Change

Table 1 illustrates the composite CY 2022 rates with a comparison to the CY 2021 rates on a per member per month (PMPM) basis by major category of aid (COA). Composite values were calculated using projected member months (MMs) and delivery case rate (DCR) and very low birth weight (VLBW) projected case counts for the January 1, 2022 through December 31, 2022 rating period.

Table 1: COA Rate Change Summary

Rate Effective Date	TANF/CHAP Child Capitation	TANF/CHAP Adult Capitation	Check Up Capitation	Expansion Capitation	DCR	VLBW Risk Pool Payment
CY 2021	$144.67	$344.54	$113.66	$501.46	$6,050.61	$82,147.20
CY 2022	$157.33	$346.98	$129.22	$510.50	$5,990.17	$130,510.66
Percent Change	8.75%	0.71%	13.69%	1.80%	-1.00%	58.87%

Appendix A includes the final certified rates effective January 1, 2022 for each rate cell as well as a comparison to the certified rates effective January 1, 2021. The total projected composite change in certified rates is 3.41%.

As shown in Appendix A, there are some rate cells with large or negative changes in rates from the previous rating period, CY 2021. For rate cells with negative rate changes, the drivers of these decreases are the pharmacy benefit manager (PBM) pass-through pricing program change and the population acuity adjustment, both of which are described in Section 4. For the two rate cells with the largest positive rate changes, a significant contributing factor is the residential treatment center (RTC) coverage program change, described in Section 4. The primary drivers of other large positive rate changes are the change in the administrative expense allocation process, described in Section 6, and an additional 12 months of trend application.

Section 2
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 four distinct MCOs anticipated to operate in the Nevada Medicaid managed care program in CY 2022: Community Care Health Plan of Nevada,[2] Health Plan of Nevada, Molina Healthcare of Nevada (Molina), and SilverSummit Healthplan.

During CY 2021, the State went through a reprocurement process to select MCOs to participate in the Nevada Medicaid managed care program, effective January 1, 2022. The three incumbent MCOs were retained through the reprocurement process; Molina was selected as the fourth MCO to enter the market effective January 1, 2022.

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, long-term residents of nursing homes, residents of intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDD), children receiving supplemental security income, and those in foster

[2] Community Care Health Plan of Nevada was referred to as Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) in prior rate certifications.

care. Managed care enrollment is voluntary for American Indians/Alaskan Natives, along with 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, emergency 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, and non-emergency transportation (NET) services, which are provided through the State's NET broker.

In addition, the cost to administer Coronavirus Disease 2019 (COVID-19) vaccines is provided on a non-risk basis by the MCOs. Per the CMS vaccine toolkit, there is no assumed Medicaid liability for the cost of the vaccine itself.

The following are services that are excluded as an MCO-covered benefit and covered under State fee-for-service (FFS) or with current coverage limitations in the prior rating period and continue to be for CY 2022:

- Indian Health Service Facilities and Tribal Clinics
- Non-Emergency Secure Behavioral Health (BH) Transport
- ICF/IDD
- School Health Services
- Adult Day Health Care
- Home and Community Based Waiver Services
- Pre-Admission Screening and Resident Review and Level of Care Assessments
- Hospice
- Swing Bed Stays in Acute Hospitals over 45 Days
- Targeted Case Management
- Adult Chiropractic
- Ground Emergency Medical Transportation
- Orthodontic Services
- Zolgensma®

As part of the aforementioned reprocurement process, effective January 1, 2022, some services previously carved out of managed care and covered through State FFS will be covered by managed care. These include the following:

- RTCs

- Nursing facility (NF) coverage (extended from first 45 days to first 180 days)
- Certified community behavioral health clinic (CCBHC) services

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 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 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.

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 2022 FMAP by COA is as follows:[3]

- TANF/CHAP:
  - CHIP-to-Medicaid: 73.8% (Enhanced)
  - All other TANF/CHAP: 62.6% (Standard)
- Check Up: 73.8% (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

[3] Estimated FMAP based on blend of percentages for federal fiscal year (FFY) 2022 (https://www.federalregister.gov/documents/2020/11/30/2020-26387/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for) and FFY 2023 (https://www.govinfo.gov/content/pkg/FR-2021-11-26/pdf/FR-2021-11-26.pdf).

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 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.

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 and demonstration CCBHCs, 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 2022 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 2021 certification amendment dated November 23, 2021. No capitation rate ranges were developed.

For CY 2022 rate development, the capitation rates were updated from the prior year, and no rebasing was undertaken. The rate development process utilizes the same base data and base data adjustments as utilized in the CY 2021 certified rate development process. Mercer used data from the three incumbent MCOs, including MCO-reported encounter data from the State's Medicaid management information systems (MMIS), supplemental data requests (SDRs) 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 incumbent 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 by COA and by category of service (COS).

Adjustments were made to the selected base data period of CY 2019 to match the covered population risk and the State-approved benefit package for CY 2022. Mercer leveraged the base data and adjustments from CY 2021 rate development, confirming the continued appropriateness through review of more recent information and correspondence with DHCFP and the incumbent MCOs. These adjustments are discussed in more detail in subsequent sections of this report. Additional adjustments were then evaluated and 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 an inpatient hospital stop-loss provision
- Application of a VLBW risk pool
- Application of a DCR
- Application of retrospective risk adjustment

Mercer evaluated the direct and indirect impacts of the COVID-19 PHE on capitation rates in various components of the rate development process. These considerations are detailed in the Membership Projections subsection below, and the Trend and Population Acuity subsections of Section 4.

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 2022 Final Certified Rates and Comparison
- Appendix B: Capitated Medical PMPM Build-up
- Appendix C: Below-the-Line Medical Adjustments
- Appendix D: Non-Medical and Total Capitation
- Appendix E: Capitation Annualized Trend Comparison
- Appendix F: Capitation Rate Calculation Sheet (CRCS) (36 exhibits)
- Appendix G: DCR Rate Calculation Sheet
- Appendix H: State Directed Payments (two exhibits)

Membership Projections

Mercer developed enrollment projections for the period from January 1, 2022 through December 31, 2022 by rate cell. In developing these projections, Mercer reviewed detailed monthly enrollment by MCO and rate cell through April 2021, as well as summarized monthly enrollment information by MCO and broad COA through August 2021. Mercer observed significant enrollment increases from March 2020 through August 2021 driven by the PHE and subsequent maintenance of effort (MOE) requirements. Mercer projected further enrollment changes by rate cell through the anticipated end of the PHE. Mercer assumed the PHE will end March 31, 2022, at which point MOE will discontinue. Under guidance from the

State, Mercer assumed redeterminations will span seven months, with resulting disenrollments occurring between June 2022 and December 2022.

Table 2 illustrates the changes in enrollment from the CY 2019 base period to the CY 2022 rating period by major COA.

Table 2: COA Member Month Change Summary

Year	TANF/CHAP Child	TANF/CHAP Adult	Check Up	Expansion	All COAs
CY 2019	2,727,556	614,592	293,799	2,181,744	5,817,692
CY 2022	3,194,908	762,783	266,053	3,232,874	7,456,618
Percent Change	17.13%	24.11%	-9.44%	48.18%	28.17%

Section 3
Data

Data Sources

The primary data sources used for CY 2022 rate development include the following:

- DWSS eligibility and DHCFP enrollment information for January 1, 2017 through March 31, 2021
- Incumbent 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 incumbent MCO for dates of service from January 1, 2018 through February 28, 2021
- Incumbent MCO-reported financial reports submitted to DHCFP
- FFS claims data from MMIS for CY 2019 dates of service, paid through April 9, 2020

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 incumbent 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 rate development base data is unchanged from CY 2021 to CY 2022. The base data continues to be enrollment and encounter data for CY 2019, as reported in the MMIS as of April 9, 2020. Mercer did not undertake a rebasing, as CY 2019 is the most recent and complete year of experience available prior to the start of the PHE and is anticipated to be a more accurate representation of CY 2022 experience as compared to CY 2020. Further, Mercer carried forward the CY 2019 base data from CY 2021 to CY 2022 due to the accelerated rate development timeline for the MCO reprocurement. CY 2019 reflects historical member utilization, managed care protocols, and provider reimbursement contracted amounts as reported by the incumbent MCOs and was determined to be appropriate for CY 2022 rate development. 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 (FQHCs) 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 adjustments to ensure that the membership reflected in the base data was representative of the covered populations eligible during CY 2022. These adjustments are unchanged from CY 2021, and include:

- Missing enrollment: Encounter data with no managed care enrollment segment on the date of service was 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 years and Check Up members aged 19 years and older.
- Removal of members with long-term institution for mental disease (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 years to 64 years. 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

Encounters for excluded and carved out services, as well as value-added services, were identified and excluded from the base data. No changes were made to the base data exclusions from CY 2021 to CY 2022.

Mercer leveraged the base data and adjustments from CY 2021 rate development, which included a carve-out for CCBHC services. Effective January 1, 2022, CCBHC services will be covered under managed care. These services were added through a program change adjustment discussed in Section 4.

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 MCO contract. The contractor 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 years to 64 years 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 4.

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 reflects 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 MCO contract for CY 2022, additional adjustments to the base data were applied as described below. All rate development base data adjustments are unchanged from CY 2021 rate development. Mercer evaluated more recent available data and information to confirm the continued appropriateness of the adjustments.

The aggregate PMPM impact of each base data adjustment described in this Section is provided by COA in Appendix B.

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 2022 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 years) and Adult (aged 19 years and greater) populations.

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

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

Several program change adjustments leveraged CY 2019 FFS MMs and claims as described in Section 4. Mercer developed monthly completion factors by major service category to account for the applicable expenditures that are IBNR in the FFS claims data. These factors were considered in the development of the program change adjustments as appropriate.

Underreporting

Mercer reviewed the incumbent 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 2022. 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.

Provider Overpayment Recoveries

The base data used in development of the CY 2022 capitation rates is net of all known overpayments, including those overpayments due to third party liability. The majority of overpayment recoveries are netted out of the paid amounts in the encounters submitted to the State's MMIS by the MCOs. In the MCO-reported SDRs collected through March 31, 2020, each MCO reported any additional provider overpayment recoveries for CY 2019 dates of service which were not already captured in the encounter data. Based on this reporting, Mercer applied 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 4.

Section 4

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 36 months, from the midpoint of the base period (July 1, 2019) to the midpoint of the rating period (July 1, 2022).

Annualized trends by rate cell and COS are provided in Appendix F (36 exhibits). A comparison of annualized trends between CY 2021 and CY 2022 by COA are provided in Appendix E.

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, and 26 months of MCO-reported SDR PMPMs (January 2019 through February 2021). 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 three-month, six-month, and 12-month moving average trends 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 the 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. 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.

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 2022, applying a 25.0% annualized utilization trend.

COVID-19 Considerations

Mercer considered the impact of COVID-19 on capitation in the development of trend factors. Significant national uncertainty exists regarding the impact of COVID-19 during CY 2022 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), the availability of a vaccine and vaccine boosters, and shifts in the modalities of care.

There are multiple anticipated impacts due to COVID-19, all with significant uncertainty, expected to have both positive and negative impacts to projected trends for CY 2022. Given the limited experience resulting from COVID-19, Mercer evaluated several data sources in considering impacts to the CY 2022 capitation rates, including internal modeling and national and state data sources, as well as MCO-reported SDR PMPMs through CY 2020 and MCO-reported monthly financial reporting through September 2021. The ultimate impact of COVID-19 is highly dependent on numerous unknown variables.

One significant downward pressure on the benefit cost PMPMs is the impacts of significant enrollment growth due to the PHE and subsequent MOE requirements on the acuity of the enrolled population relative to the CY 2019 base data. These acuity impacts were considered separately from trend and are described in the subsection Population Acuity below.

Based on national evidence that the pandemic has a material impact on BH needs, the CY 2022 utilization trends for outpatient BH includes considerations for anticipated increases in demand. The aggregate PMPM annualized trend across all COAs for outpatient BH is 5.0%.

Mercer considered various COVID-19 impacts in determining non-BH outpatient trends (inclusive of the emergency room, lab and radiology – facility, and other outpatient hospital COS). The aggregate annualized PMPM trend across all COAs for these outpatient categories is -0.1%. These trends include considerations for increases in laboratory services to account for COVID-19 testing absent in the CY 2019 base period and projected decreases in emergency department utilization relative to the CY 2019 base period. MCO-reported SDR and financial reporting indicate continued decreases in outpatient PMPMs relative to the CY 2019 base period. Although these are expected to rebound from pandemic lows, Mercer does not expect them to return to or exceed levels observed in the base, with increased diversion to other modalities, and management of low acuity and non-emergent emergency department events.

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 FDA.

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. In general, fee schedule changes produce corresponding pricing pressures in the managed care delivery system, and managed care provider contracting is often tied to the FFS fee schedule. 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 2022 capitation rates. Several adjustments are carried forward from CY 2021, and are unchanged due to the continuation of the CY 2019 base data from CY 2021 to CY 2022 rate development. Total program change adjustments by rate cell and COS are provided in Appendix F. The aggregate PMPM impact of each individual program change adjustment described in this Section is shown by COA in Appendix B.

Short-Term IMD Repricing

Pursuant to 42 CFR § 438.6(e), short-term IMD stays for members aged 21 years to 64 years 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 years to 64 years 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 BH services at an acute facility as compared to short-term IMD stays. This adjustment is unchanged from CY 2021.

NF Coverage

NF services are a managed care service; however, historically, members were disenrolled from managed care into FFS coverage on day 46 of a continuous NF stay. Effective January 1, 2022, members with a continuous NF admission will remain in managed care for the first 180 days as long as the member is otherwise managed care eligible. Members will be disenrolled from managed care and covered through FFS after 180 days. This policy change applies to new admissions to NFs during CY 2022; members previously disenrolled from managed care for a NF stay will not be reenrolled into managed care. The MCO will be responsible for all covered services for members in a NF for the first 180 days of the admission. Mercer identified FFS MMs and claims for members disenrolled from managed care due to NF residence in the CY 2019 base period. To develop the adjustment, Mercer reviewed the impact to the base data of adding the CY 2019 FFS MMs and claims through day 180 of the admission for members who were otherwise managed care eligible.

RTC Coverage

Effective January 1, 2022, members with an admission to a RTC will remain in managed care and with the MCO as long as Medicaid eligible. The MCO will be responsible for all the RTC admission and any ancillary services for the member. The adjustment reflects the implementation of the policy changes for members under both Title XIX and Title XXI of the Social Security Act (SSA). Title XIX members were previously disenrolled from managed care on the first day of the month following admission to the RTC. The MCO was responsible for all member costs until the disenrollment. Title XXI members previously remained in managed care as long as Medicaid eligible; however, the MCO was only responsible for the cost of ancillary services. Mercer identified the CY 2019 FFS MMs and claims for members in an RTC who were otherwise managed care eligible. Mercer evaluated the cost and utilization impact of adding the FFS experience to the base data to develop an adjustment.

Serious Mental Illness Mandatory Enrollment

Effective January 1, 2022, all adult members with a serious mental illness (SMI) diagnosis will be mandatory managed care. Prior to CY 2022, SMI individuals aged 18 years and above within the TANF/CHAP Adult rate cells were able to opt out of managed care through an exemption. SMI individuals in other rate cells were already mandatory managed care. DHCFP provided a list of SMI individuals who had opted out of managed care during the CY 2019 base period. Mercer evaluated the cost and utilization impact of adding the FFS MMs and claims for these members to the base data to develop an adjustment.

CCBHC Services Carve-In

Effective January 1, 2022, CCHBC services will be covered under managed care and subject to a minimum fee schedule State directed payment under 42 CFR §438.6(c), set to the State plan bundled rate. CCBHC services were previously carved out of managed care to FFS on July 1, 2019 and CCBHC services were excluded from the base data development. Mercer reviewed CY 2019 managed care encounters and CY 2019 FFS claims for CCBHC services.

The claims and encounters were repriced to the anticipated State plan bundled rates for each CCBHC effective for CY 2022. Mercer evaluated the cost and utilization impact of adding the repriced CCBHC experience to the base data to develop an adjustment.

Sexually Transmitted Infection and Sexually Transmitted Disease Testing

Effective July 1, 2021, the State approved requirements for providers in outpatient and emergency department settings to conduct sexually transmitted infection (STI) testing for pregnant women and providers in hospitals and primary care to offer sexually transmitted disease (STD) testing to patients aged 15 years and above. Mercer evaluated the impacts 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 years 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 years and above, would now include testing. 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

Effective July 1, 2021, the State approved a newly covered cognitive assessment for persons with suspected cognitive impairment aged 55 years to 64 years. 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 years to 64 years 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 subsequently 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.

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 2022 pharmacy rebate payments from the projected pharmacy costs using MCO-submitted supplemental data, encounters, and industry-wide experience.

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. This adjustment is unchanged from CY 2021.

Acute Inpatient Fee Changes

Effective January 1, 2020, DHCFP implemented general acute inpatient hospital fee schedule increases of 25% for newborn intensive care unit services, 15% for pediatric intensive care unit services, and 2.5% for medical, surgical, and intensive care unit services. Encounters for the affected services in the CY 2019 base data were repriced upward accordingly to develop an adjustment. This adjustment is unchanged from CY 2021.

PBM Pass-Through Pricing

Effective January 1, 2022, MCOs are required to use a pass-through pricing model with contracted PBMs. One incumbent MCO had a spread pricing arrangement during the CY 2019 base period. Mercer received supplemental data from the affected MCO detailing the amount of spread pricing dollars included in the underlying CY 2019 base data, which would not be present if contracted under a pass-through pricing model. Mercer applied an adjustment to remove these dollars from the base data. Mercer assumes a portion of the costs will be replaced by additional administrative expense; these expenses are considered in the administrative expense development as described in Section 6.

Registered Behavior Technician Fee Changes

Effective January 1, 2022, DHCFP will implement an increase of approximately 66% to the ABA fee schedule for services provided by registered behavior technicians (RBTs). Encounters for the affected services in the CY 2019 base data were repriced upward accordingly to develop an adjustment.

Population Acuity

Mercer developed an adjustment to the projected benefit cost to account for the impact of growing enrollment caused by the PHE and MOE requirements that have caused a significant increase in Nevada Medicaid managed care enrollment and an overall change in the expected population acuity relative to the CY 2019 base data upon which the prospective CY 2022 rates were developed. Mercer relied on assumptions provided by DHCFP related to the redeterminations process and timeline to develop the adjustment. DHCFP assumed the PHE will remain in effect through March 2022. Disenrollments resulting from the redetermination process are expected to recommence June 2022 and continue through the end of CY 2022.

As previously described in the subsection Membership Projections in Section 2, MMs increased significantly from the CY 2019 base period. The enrollment growth is attributed to both new entrants and MOE for members who would have otherwise been disenrolled as ineligible or disenrolled for an intermediate period due to non-response in the redetermination process. For purposes of this adjustment, it was assumed that 25% of the

enrollment growth was for new entrants and 75% for MOE. No adjustment was applied to the Check Up COA or any Under 1 rate cells.

As the information and resources needed to perform a Nevada-specific analysis was unavailable, Mercer reviewed Medicaid experience data in seven other states for new entrants and members affected by the MOE for each major COA, which indicated these groups are expected to be lower acuity than the population enrolled in the pre-PHE base period. Mercer also reviewed changes in the raw risk scores for the enrolled population from CY 2019 to CY 2020 in Nevada; although utilization changes in the study period impacted raw risk scores, this review also indicated a decrease in the overall acuity of the enrolled population. As the analyses reviewed were primarily not Nevada-specific, Mercer was conservative in the acuity assumptions for both the new entrants and MOE groups as compared to available observations. Mercer assumed a relative acuity of 0.925 for the MOE group and 0.975 for the TANF/CHAP Adult and Expansion new entrants (1.000 assumed for TANF/CHAP Child). The acuity factors were applied to the incremental enrollment growth assumed for new entrants and MOE between the base period and rating period, by rate cell.

As additional support for the adjustment made, Mercer also reviewed emerging experience in the Nevada managed care program through the third quarter of 2021 as reported in the monthly MCO-reported financials. Reported experience continues to show lower PMPMs for the affected COAs compared to pre-PHE.

The PMPM impact is shown by rate cell in Appendix F (36 exhibits). The aggregate PMPM impact is shown by COA in Appendix B.

Other Medical Rating Adjustments

To finalize the CY 2022 projected benefit costs, Mercer applied further medical rating adjustments to account for additional provisions to the Nevada Medicaid managed care program, as described in the subsections below. The PMPM impact of each medical rating adjustment described in this Section is shown by rate cell in Appendix C.

Inpatient Hospital Stop-Loss

DHCFP is continuing a member-level stop-loss contract provision for inpatient hospital claims. The attachment point increased from $100,000 in the prior MCO contract to $500,000 for CY 2022. MCOs are responsible for 25% of experience costs above the attachment point. DHCFP reimburses the remaining 75% of inpatient hospital costs in excess of $500,000 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 2022. 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 2022. As the base data for rate development is reported gross of any stop-loss reimbursement, the projected CY 2022 reimbursement is netted out of the gross CY 2022 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 C. For more detail regarding the inpatient hospital stop-loss provision, please refer to Section 5.

VLBW Risk Pool Payment

For CY 2022 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 year members. The value of the VLBW supplemental case rate benefit cost increased from the CY 2021 VLBW risk pool benefit amount of $71,000 to $115,000 for CY 2022. Mercer reviewed encounters for VLBW babies in CY 2018 and CY 2019 in conjunction with the increase to the inpatient hospital stop-loss attachment point to determine an appropriate benefit cost for CY 2022. 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–CY 2020 experience data. Mercer then selected a conservative prevalence rate for the CY 2022 prospective rating period as a percentage of expected CY 2022 under age 1 year MMs by COA to ensure adequate funding for the risk pool. The projected prevalence rate for CY 2022 is 0.95 per 1,000 MMs 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 year MMs and the VLBW case rate benefit cost of $115,000. The resulting PMPM is deducted from the projected benefit cost for capitation rates for applicable rate cells as shown in Appendix C. 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 5.

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 MMs. 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 MMs.

- 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 year and ages 1 year to 18 years.

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

Delivery Case Rate

For CY 2022, 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 2022 capitation rates as described in the Base Data and Base Data Adjustments subsections of Section 3. 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.

Effective January 1, 2022, the State approved use of doulas as managed care covered services. Mercer does not expect the new benefit to have a material impact to the DCR in the first year, but will monitor for future rating periods.

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 childbearing aged female rate cell in the CY 2017–CY 2020 experience data.

The development of the DCR is shown in Appendix G.

Section 5

Special Contract Provisions Related to Payment

Incentive Arrangements

There continues to be no incentive arrangements applicable to the program during CY 2022.

Withhold Arrangements

There are no withhold arrangements applicable to the program during CY 2022.

Risk-Sharing Mechanisms

There are three risk-sharing mechanisms effective for CY 2022:

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

Inpatient Hospital Stop-Loss

For CY 2022, DHCFP will continue an MCO stop-loss contract provision for inpatient hospital claims. The prior MCO contract included an inpatient stop-loss provision and the risk-mitigation mechanism was 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.

The DHCFP will assume partial risk for member-level inpatient hospital medical costs that exceed $500,000 during CY 2022. This attachment point increased from $100,000 in the prior MCO contract. The DHCFP will reimburse the MCO at 75% of the vendor's paid amount for a member’s inpatient hospital medical costs above the $500,000 attachment point, inclusive of a 30-day period prior to the commencement of CY 2022. 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 MCO contract.

A description of the effect of inpatient hospital stop-loss on the development of capitation rates is provided in Section 4. This risk-mitigation program has been developed in accordance with generally accepted actuarial principles and practices.

VLBW Risk Pool

For CY 2022, DHCFP will continue an MCO contract provision for a risk pool to fund supplemental payments for VLBW members. This risk mitigation program was in place for the entirety of the prior MCO 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 year 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 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 4. The VLBW case rate benefit cost is $115,000. The case rate is loaded for administration, underwriting gain, and premium tax for a total of $130,510.66.

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

Remittance on Minimum MLR

For CY 2022, DHCFP will continue an MCO contract provision for remittance to the State if an MCO's MLR falls below 85%. An MLR remittance was in place for the Medicaid population for the entirety of the prior MCO 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%, the State will collect a remittance from that MCO. New for CY 2022, the MLR remittance will be calculated separately for TANF/CHAP and Expansion within Title XIX of the SSA; the MLR remittance will continue to be calculated separately for Title XXI of the SSA.

Although capitation rates are not directly affected by the minimum MLR requirement, the rates have been developed in such a way that the MCOs are reasonably expected to achieve an MLR of at least 85% for CY 2022.

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

State Directed Payments

There are four State directed payments under 42 CFR § 438.6(c) proposed for the program in CY 2022. Preprints for applicable proposed payment arrangements were submitted to CMS on December 15, 2021 and December 17, 2021. The payments are accounted for in this rate certification in a manner that is consistent with the preprints submitted for CMS review. A summary of the State-directed payments described in this Section are provided in Table 4.

Table 4: State Directed Payment Overview

Control name	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term
NV_Fee_OPH.AMC_Renewal_20220101-20221231	Uniform percentage increase	Uniform percentage increase for services provided by designated practitioners through an eligible public teaching entity set as difference between average commercial rates and Medicaid base reimbursement	Separate payment term
NV_Fee_IPH_Renewal_20220101-20221231	Uniform dollar increase	Uniform dollar increase for inpatient services provided by eligible public hospitals set as difference between Medicare upper payment limit and Medicaid base reimbursement	Separate payment term
NV_VBP_BHO.Oth_New_20220101-20221231	Performance improvement initiative	Quality bonus/incentive payments for CCBHCs at a maximum of 15% of total bundled rate payments, dependent on meeting specified performance measures	Separate payment term
CCBHC Bundled Rate (no preprint required)	Minimum fee schedule	Minimum fee schedule set at Medicaid State plan rate	Rate adjustment

Additional detail related to the State-directed payment that was incorporated into this rate certification in the base capitation rates as a rate adjustment is provided in Table 5.

Table 5: Rate Adjustment State Directed Payments

Control name	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint

Additional detail related to the State-directed payments that will be incorporated as separate payment terms described in this Section are provided in Table 6.

Table 6: Separate Payment Term State Directed Payments

Control name	Aggregate amount included in the certification	Statement that the actuary is certifying the separate payment term	The magnitude on a PMPM basis	Confirmation the rate development is consistent with the preprint	Confirmation that the state and actuary will submit required documentation at the end of the rating period
NV_Fee_ OPH.AMC_ Renewal_ 20220101-20221231	$8.0 million	The signing actuary certifies the separate payment term	Refer to Appendix H	The State directed payment is accounted for consistent with the submitted preprint. The preprint is under CMS review.	DHCFP will submit documentation to incorporate the total amount of the State directed payment
NV_Fee_ IPH_ Renewal_ 20220101-20221231	$122.9 million	The signing actuary certifies the separate payment term	Refer to Appendix H	The State directed payment is accounted for consistent with the submitted preprint. The preprint is under CMS review.	DHCFP will submit documentation to incorporate the total amount of the State directed payment
NV_VBP_ BHO.Oth_ New_ 20220101-20221231	$1.7 million	The signing actuary certifies the separate payment term	Refer to Appendix H	The State directed payment is accounted for consistent with the submitted preprint. The preprint is under CMS review.	DHCFP will submit documentation to incorporate the total amount of the State directed payment

Appendix H, Separate Payment Term exhibit, illustrates the estimated magnitude of each separate payment term State directed payment on a PMPM basis for each rate cell. These amounts are developed based on the CY 2022 projected aggregate estimated payments provided by DHCFP. The estimated payments are then grossed up for the 3.5% Nevada State premium tax to produce the estimated impact to managed care capitation. The estimated dollar impacts are distributed by rate cell based on the projected CY 2022 utilization mix by rate cell, estimated using utilization for applicable services by rate cell identified in the CY 2019 base data, reweighted on CY 2022 projected enrollment.

Final payments made will vary from these estimates based on actual utilization for applicable services in CY 2022. 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 below.

There are no additional directed payments in the program for CY 2022 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.

Outpatient Practitioner Services in a Teaching Environment

The State directed payment for outpatient practitioner services provided in a teaching environment (CMS control name NV_Fee_OPH.AMC_Renewal_20220101-20221231) 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 and Medicaid base reimbursement for this provider class; therefore, total Medicaid reimbursement will not exceed estimated payments under average commercial rates.

This directed payment is incorporated as a separate payment term. The aggregate estimated impact to managed care capitation under this State directed payment is $8,064,989. 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 the preprint will be subject to the same percentage increase.

Inpatient Services Provided by Public Hospitals

The State directed payment for inpatient services provided by public hospitals (CMS control name NV_Fee_IPH_Renewal_20220101-20221231) 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 and Medicaid base reimbursement for this provider class; therefore, total Medicaid reimbursement will not exceed estimated payments under the Medicare upper payment limit.

This directed payment is incorporated as a separate payment term. The aggregate estimated impact to managed care capitation under this State directed payment is $122,884,710. 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 the preprint will be eligible for the same enhanced reimbursement.

CCBHC Quality Payments

The State directed payment for CCBHC quality payments (CMS control name NV_VBP_BHO.Oth_New_20220101-20221231) is for quality bonus payments/quality incentive payments for CCBHCs achieving established performance metrics. Nine CCBHCs provide services under two cohorts within the State. Cohort 1 includes three CCBHCs that operate under an 1115 demonstration waiver and are eligible to receive quality bonus payments. Cohort 2 includes six CCBHCs that operate under the State Plan Amendment 19-010 and eligible to receive quality incentive payments. The performance period is based on each entity's fiscal year. The payments are up to 15% of the total facility-specific bundled rate payments made to the CCBHC in the performance period on a statewide basis. Payments will be issue annually and the managed care portion of the quality payments will be attributed to the rating period in which the entity's fiscal year ends.

This directed payment is incorporated as a separate payment term and the aggregate estimated impact to managed care capitation under this directed payment is $1,698,864.

Pass-Through Payments

There continues to be no pass-through payments applicable to the program during CY 2022.

Section 6
Projected Non-Benefit Costs

Administration Expense

The CY 2022 rates include provisions for MCO administrative expense. Administrative expenses were developed on a PMPM basis leveraging multiple data sources, including incumbent MCO-reported non-benefit expenses in the SDR, ad hoc information from DHCFP and the MCOs, along with regional and national administrative expense benchmarks for similar Medicaid populations. Administration expenses by rate cell and in aggregate are provided on a PMPM basis and as a percentage load in Appendix D.

Non-Pharmacy Administration

To develop the non-pharmacy-related portion of the administrative expense, Mercer reviewed historical MCO administrative expenses reported in the SDR by quarter from CY 2019Q1 to CY 2021Q1. Through discussion with each MCO on their reported expenses, Mercer adjusted the reported administrative expenses to remove one-time expenses. The administrative expenses for CY 2019 and CY 2020 were projected forward to CY 2022 for cost trends based on a review of the Consumer Price Index; CY 2019 was projected forward at an annualized rate of 2.58% and CY 2020 was projected forward at an annualized rate of 2.87%.

An adjustment was also made to reflect the changes in enrollment from the experience periods to the rating period. Mercer considered the impact of one new MCO joining the Nevada Medicaid managed care program in CY 2022. At the start of CY 2022, membership is anticipated to be redistributed evenly across the four MCOs. Mercer modeled the enrollment impacts to each of the historical MCOs of the combination of increased overall projected enrollment (from the study periods to the rating period) and the redistribution of enrollment by MCO; this is anticipated to result in enrollment decreases for two of the incumbent MCOs and an enrollment increase for the third.

Mercer reviewed changes to contract requirements in the MCO contract starting January 1, 2022. The MCO contract includes some new administrative and care management requirements, clarifies expectations for existing requirements, and stipulates location and/or contract exclusivity for certain key staff. In aggregate, an additional 2.5% adjustment was applied to the administrative expense to reflect the updated contract requirements.

Pharmacy Administration

Pharmacy administration expense was developed separately from non-pharmacy related administration expenses. Mercer reviewed MCO-reported pharmacy administration expenses in CY 2019 and CY 2020 for two of the incumbent MCOs. The third MCO historically had minimal pharmacy administration expense due to a spread pricing arrangement; Mercer relied on direct feedback and input from the affected MCO to model pharmacy administration costs after the transition to a pass-through pricing model. Pharmacy administration expense for CY 2022 was priced at 2.5% of projected pharmacy benefit expenses.

Administrative Expense Allocation

Administrative expense was projected across all MCO-covered members, and was then allocated by major COA and converted to a percentage load.

For the non-pharmacy portion of the administrative expense, one-third of the PMPM was allocated to capitation for each major COA and two-thirds was variable as a function of the final projected benefit costs. As the fixed cost for members are captured through the allocation to capitation rates, the case rates are loaded for the variable portion only. The pharmacy administration expense was allocated to each major COA on a 100% variable basis by projected pharmacy scripts. The resulting combined administrative expense PMPM for each major COA and the case rates were converted to a percentage load. The resulting percentage loads were applied uniformly to the underlying rate cells.

Underwriting Gain

The CY 2022 rates include provisions for underwriting gain, 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 2022. The analysis utilized MCO audited financial statements, premium and expense information, and enrollment data to determine underwriting gain assumptions that are sufficient to cover at least minimum costs of capital needs. Underwriting gain is determined as a percentage of the capitation prior to the loading of State premium tax. An underwriting gain percentage load of 1.5% is applied to each rate cell.

Underwriting gain by rate cell and in aggregate are provided on a PMPM basis and as a percentage load in Appendix D.

Premium Tax

All MCOs are subject to Nevada State premium tax of 3.5% for CY 2022. Each rate component includes an additional 3.5% load for premium tax.

The PMPM impact of the premium tax is provided by rate cell in Appendix D.

Section 7

Risk Adjustment and Acuity Adjustments

Risk Adjustment

There is no prospective risk adjustment applied to the CY 2022 rates. There will be a retrospective application of risk adjustment applied to CY 2022 capitation rates, performed once annually following the end of the rating period. Under age 1 year 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. Mercer will perform the risk adjustment.

The data used for risk adjustment will include MCO-submitted encounter data and FFS claims data with CY 2022 dates of service for all members who were enrolled with an MCO within CY 2022. 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. 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 Disability Payment System and Medicaid Rx (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 2020 or CY 2021 beyond using the most up-to-date version of the CDPS+Rx model. Risk adjustment will be normalized on the capitation rates and will be budget neutral to the State by region and COA.

Section 8

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 found in Appendix A and directed payment separate payment term estimates found in Appendix H for CY 2022 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 its judgment. Use of such simplifying techniques does not, in Mercer's 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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CY 2022 NEVADA MCO RATE CERTIFICATION APPENDICES

Appendix A: CY 2022 Final Certified Rates and Comparison

Region	COA	Rating Group	Projected MMs/Counts	Certified Rates		
				CY 2022	CY 2021[1]	% Change
				Capitation Rates		
Northern	TANF/CHAP Child	Under 1	26,892	$ 571.30	$ 520.50	9.8%
Northern	TANF/CHAP Child	Child 1-2	48,946	$ 112.81	$ 106.58	5.8%
Northern	TANF/CHAP Child	Child 3-14	235,944	$ 97.14	$ 88.12	10.2%
Northern	TANF/CHAP Child	Female 15-18	28,919	$ 155.79	$ 143.40	8.6%
Northern	TANF/CHAP Child	Male 15-18	29,684	$ 127.31	$ 114.32	11.4%
Northern	TANF/CHAP Adult	Female 19-34	46,420	$ 276.26	$ 272.31	1.5%
Northern	TANF/CHAP Adult	Male 19-34	8,457	$ 190.36	$ 186.85	1.9%
Northern	TANF/CHAP Adult	Female 35 and Over	23,094	$ 442.84	$ 450.66	-1.7%
Northern	TANF/CHAP Adult	Male 35 and Over	9,981	$ 409.95	$ 418.38	-2.0%
Northern	Check Up	Under 1	256	$ 237.48	$ 210.84	12.6%
Northern	Check Up	Child 1-2	1,909	$ 128.02	$ 111.96	14.3%
Northern	Check Up	Child 3-14	32,843	$ 108.50	$ 85.30	27.2%
Northern	Check Up	Female 15-18	5,858	$ 156.02	$ 131.32	18.8%
Northern	Check Up	Male 15-18	6,276	$ 116.39	$ 102.77	13.3%
Northern	Expansion	Female 19-34	82,718	$ 318.38	$ 309.59	2.8%
Northern	Expansion	Male 19-34	68,816	$ 393.19	$ 390.59	0.7%
Northern	Expansion	Female 35 and Over	108,416	$ 664.84	$ 657.23	1.2%
Northern	Expansion	Male 35 and Over	107,656	$ 704.33	$ 695.02	1.3%
Southern	TANF/CHAP Child	Under 1	185,499	$ 710.26	$ 651.54	9.0%
Southern	TANF/CHAP Child	Child 1-2	356,521	$ 138.52	$ 128.50	7.8%
Southern	TANF/CHAP Child	Child 3-14	1,795,673	$ 112.46	$ 102.80	9.4%
Southern	TANF/CHAP Child	Female 15-18	244,517	$ 157.06	$ 147.17	6.7%
Southern	TANF/CHAP Child	Male 15-18	242,313	$ 120.08	$ 113.15	6.1%
Southern	TANF/CHAP Adult	Female 19-34	343,296	$ 279.75	$ 275.94	1.4%
Southern	TANF/CHAP Adult	Male 19-34	59,953	$ 174.41	$ 168.80	3.3%
Southern	TANF/CHAP Adult	Female 35 and Over	200,234	$ 488.18	$ 485.65	0.5%
Southern	TANF/CHAP Adult	Male 35 and Over	71,348	$ 443.89	$ 447.34	-0.8%
Southern	Check Up	Under 1	1,332	$ 264.41	$ 239.44	10.4%
Southern	Check Up	Child 1-2	8,213	$ 153.65	$ 137.39	11.8%
Southern	Check Up	Child 3-14	156,864	$ 118.76	$ 106.10	11.9%
Southern	Check Up	Female 15-18	26,096	$ 181.11	$ 160.52	12.8%
Southern	Check Up	Male 15-18	26,408	$ 147.53	$ 131.65	12.1%
Southern	Expansion	Female 19-34	712,619	$ 280.99	$ 278.29	1.0%
Southern	Expansion	Male 19-34	570,057	$ 306.87	$ 297.82	3.0%
Southern	Expansion	Female 35 and Over	840,738	$ 654.25	$ 645.60	1.3%
Southern	Expansion	Male 35 and Over	741,853	$ 706.15	$ 689.79	2.4%
				Delivery Case Rate		
All Regions	TANF/CHAP Child	All	684	$ 5,990.17	$ 6,051.25	-1.0%
All Regions	TANF/CHAP Adult	All	12,152	$ 5,990.17	$ 6,050.65	-1.0%
All Regions	Check Up	All	10	$ 5,990.17	$ 6,051.31	-1.0%
All Regions	Expansion	All	1,065	$ 5,990.17	$ 6,049.82	-1.0%
				VLBW Case Rate		
All Regions	TANF/CHAP Child	All	202	$ 130,510.66	$ 82,147.20	58.9%
All Regions	TANF/CHAP Adult	All	-	$ -	$ -	0.0%
All Regions	Check Up	All	-	$ 130,510.66	$ 82,147.20	58.9%
All Regions	Expansion	All	-	$ -	$ -	0.0%
				Composite PMPM		
All Regions	TANF/CHAP Child	All	3,194,908	$ 166.86	$ 151.16	10.4%
All Regions	TANF/CHAP Adult	All	762,783	$ 442.41	$ 440.94	0.3%
All Regions	*All TANF/CHAP*	*All*	*3,957,691*	*$ 219.97*	*$ 207.01*	*6.3%*
All Regions	Check Up	All	266,053	$ 129.43	$ 113.88	13.7%
All Regions	Expansion	All	3,232,874	$ 512.47	$ 503.45	1.8%
All Regions	**All COAs**	**All**	**7,456,618**	**$ 343.55**	**$ 332.21**	**3.41%**

General Notes:

- Totals may differ due to rounding.
- All composites are weighted on CY 2022 projected member months.

Footnotes:

1. CY 2021 rates reflect all-MCO composite amended rates certified on November 23, 2021.