Mercer

Government Human Services Consulting

Capitation Rate Development and Certification

Calendar Year 2023 Nevada Medicaid Managed Care Dental Program

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

December 16, 2022

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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 dental program applicable to the dental benefits administrator (DBA). The capitation rates are effective for calendar year 2023 (CY 2023), January 1, 2023 through December 31, 2023.

Per Section 4.2 of ASOP 49, capitation rates for the Nevada Medicaid managed care dental 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 2023 rates for the purposes of satisfying the requirements of the CMS rate review process. This report follows the general outline for the CMS July 2022 through June 2023 Medicaid Managed Care Rate Development Guide (RDG), which is applicable to contract periods beginning between July 1, 2022 and June 30, 2023. 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 2023 Nevada DBA Rate Certification_Appendices_2022.12.16.xlsx*). This attachment includes 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.

Mercer developed this rate certification package exclusively for DHCFP; subject to this limitation, DHCFP may direct this rate certification package be provided to CMS. It should be read in its entirety and has been prepared under the direction of Katharina Katterman, ASA, MAAA, who is a member of the American Academy of Actuaries and meets its US Qualification Standards for issuing the statements of actuarial opinion herein.

[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.

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

The suppliers of data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

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

Certified Rate Change

Table 1 illustrates the composite CY 2023 rates with a comparison to the CY 2022 rates on a per member per month (PMPM) basis by major category of aid (COA). Composite values were calculated using projected member months for the January 1, 2023 through December 31, 2023 rating period.

Table 1: COA Rate Change Summary

Rate Effective Date	TANF/CHAP Child	TANF/CHAP Adult	Check Up	Expansion	Composite
CY 2022	$17.34	$4.62	$24.92	$5.44	$11.07
CY 2023	$17.38	$5.19	$23.48	$5.70	$11.22
Percent Change	**0.24%**	**12.37%**	**-5.76%**	**4.77%**	**1.31%**

Appendix A includes the final certified rates effective January 1, 2023, for each rate cell as well as a comparison to the certified rates effective January 1, 2022. The total projected composite change in certified rates is an increase of 1.31%.

As shown in Appendix A, there are some rate cells with large or negative changes in rates from the previous rating period, CY 2022. The primary driver of these rate changes is the base data change from CY 2019 to CY 2021, which is shown in Appendix B.

Section 2
General Information

This section provides a brief overview of Nevada's Medicaid managed care dental 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, urban Washoe County and urban Clark County, covered by mandatory managed care.

Effective July 1, 2017, dental services were carved out of the managed care organization contract and were provided through fee-for-service (FFS) for six months. Effective January 1, 2018, dental services for managed care enrollees are provided by a prepaid ambulatory health plan (PAHP).

DBA Participation

As of the date of this report, there is one DBA anticipated to operate in the Nevada Medicaid managed care dental program in CY 2023: Liberty Dental Plan (Liberty). The PAHP has provided dental services to the Nevada Medicaid managed care dental program since January 1, 2018.

The State went through a reprocurement process to select DBA(s) to participate in the Nevada Medicaid managed care dental program, effective January 1, 2023. The incumbent DBA was retained through the reprocurement process.

Covered Populations

The populations served by the DBA 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 Adult Expansion (Expansion) populations.

The Nevada Medicaid managed care dental 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 DBA 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, children receiving supplemental security income, and those in foster care. Managed care enrollment is voluntary for American Indians/Alaskan Natives, along with children with severe emotional disturbance.

There are no changes to the covered populations from the prior rating period.

Covered Services

Services covered by the DBA contract include pediatric dental services for children under age 21 years, in accordance with early and periodic screening, diagnostic, and treatment federal regulations. The DBA provides services for adults aged 21 years and older, limited to medically necessary emergency extractions and palliative care, with additional services for Medicaid-eligible pregnant women. Orthodontia services are covered under FFS and are not covered under the DBA contract. Refer to the DBA contract for detailed specifications related to program eligibility and covered populations and services.

There are no changes to the covered services from the prior rating period.

Rate Structure

The covered populations are segmented into 18 rate cells for capitation rate development. The populations are 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

There are no changes to the rate structure from the prior rating period.

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 dental 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 2023 FMAP by COA is as follows:[2]

- TANF/CHAP:
  - CHIP-to-Medicaid: 73.5% (Enhanced)
  - All other TANF/CHAP: 62.2% (Standard)
- Check Up: 73.5% (Enhanced)

[2] Estimated FMAP based on a blend of percentages for federal fiscal year (FFY) 2023 (https://www.govinfo.gov/content/pkg/FR-2021-11-26/pdf/FR-2021-11-26.pdf) and FFY 2024 (https://public-inspection.federalregister.gov/2022-26390.pdf).

- 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, a 6.2 percentage point increase to the Standard FMAP for TANF/CHAP, and a 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 extends 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.

Rate Development

The CY 2023 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 2022 certification dated December 21, 2021. No capitation rate ranges were developed.

For CY 2023 rate development, Mercer used data from the DBA, including DBA-reported encounter data from the State's Medicaid management information systems (MMIS), supplemental data requests (SDRs) submitted by the DBA, the Division of Welfare and Supportive Services (DWSS) eligibility and DHCFP enrollment information, and other ad hoc data provided by DHCFP and the DBA. 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 the DBA 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). The most recent and complete year of data, January 1, 2021 through January 31, 2021 (CY 2021), was selected as the base period for CY 2023 rate development.

Adjustments were made to the selected base data period of CY 2021 to match the covered population risk and the State-approved benefit package for CY 2023. 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

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" subsection 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 2023 Final Certified Rates and Comparison
- Appendix B: Base Data Comparison
- Appendix C: Medical Credibility Adjustment
- Appendix D: Non-Medical
- Appendix E: Annualized Trend Comparison
- Appendix F: Capitation Rate Calculation Sheet (CRCS) (18 exhibits)

Membership Projections

Mercer developed enrollment projections for the period from January 1, 2023 through December 31, 2023 for the program by rate cell. In developing these projections, Mercer reviewed detailed monthly enrollment by rate cell through March 2022, as well as summarized monthly enrollment information by broad COA through August 2022.

Mercer and DHCFP assumed the PHE will close in January 2023, at which point the maintenance of effort (MOE) requirements will discontinue. The State implemented an ex parte process during October 2022, reviewing membership status approximately 75 days prior to the renewal month, which is anticipated to significantly reduce enrollment gaps for eligible members, who, absent the ex parte process, would be disenrolled due to non-response. In addition, the State continued submitting notices to members for redetermination processes throughout the PHE. In this process, if a member's eligibility is confirmed, the next redetermination date is pushed out 12 months. If the member responds and is ineligible, or if there is no response to the notice, the member's next redetermination date is pushed out six months. Based on this guidance from the State and the Unwinding Plan for Operations, Mercer assumed redeterminations will span the 14-month window after the close of the PHE, based on the member's redetermination date (noticing and disenrollment), and disenrollments would begin April 2023.

During 2022, the State underwent an out-of-state eligibility review based on results from a Public Assistance Reporting Information System (PARIS) report that identified members potentially receiving services in Nevada and another state. The State pursued redetermination efforts for the identified members as part of this eligibility review. Mercer removed a portion of the potential out-of-state enrollment spans identified from the DHCFP-provided PARIS data during the CY 2021 base period, and this review is reflected in the CY 2023 enrollment projections below. Mercer also applied a program change adjustment described in the "Program Changes" subsection of Section 4.

Table 2 illustrates the changes in enrollment from the CY 2021 base period to the CY 2023 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 2021	3,317,102	818,385	266,337	3,221,220	7,623,044
CY 2023	3,303,175	818,537	246,491	3,335,616	7,703,818
Percent Change	**-0.42%**	**0.02%**	**-7.45%**	**3.55%**	**1.06%**

Section 3
Data

Data Sources

The primary data sources used for CY 2023 rate development include the following:

- DWSS eligibility and DHCFP enrollment information effective January 1, 2019 through March 31, 2022
- DBA-reported encounter data from MMIS for dates of service ranging from January 1, 2019 through March 31, 2022, processed through MMIS as of April 1, 2022

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 the DBA for dates of service from January 1, 2020 through March 31, 2022
- DBA-reported financial reports submitted to DHCFP
- FFS claims data from MMIS for CY 2021 dates of service, processed through MMIS as of April 1, 2022

Data Validations

Encounter data for the enrolled population was evaluated for dates of service from January 1, 2019 through March 31, 2022. 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 DBA-reported SDR for completeness by broad COS.

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 2021 time period was selected as the base data period for CY 2023 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 DBA and was determined to be appropriate for CY 2023 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 used was managed care data that did not include any disproportionate share hospital payments nor did it include any adjustments for federally qualified health centers (FQHCs) or rural health clinic reimbursements. FQHC costs considered in rate development are the costs incurred by the DBA, net of any wrap-around payment by the State to reimburse the FQHC at its 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 DBA 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 2023:

- 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.

In Lieu of Services

The DBA contract does not currently include provisions for any 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 DBA contract for CY 2023, additional adjustments to the base data were applied as described below.

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 2023 rate development included encounters processed through MMIS as of April 1, 2022. Mercer analyzed monthly data from January 2020 through March 2022, using claim lag triangles as well as encounters with paid dates of April 1, 2022. Completion factors were developed by month for the program, separated for dental prostheses and all other services. The aggregate impact to the CY 2021 base data for the IBNR adjustment is an increase of 0.82%.

Underreporting

Mercer reviewed the DBA-submitted encounter data from MMIS as compared to the expenses reported in the DBA-submitted SDRs for CY 2021. Mercer observed differences between the data sources, and through discussions with the State and the DBA, identified some instances of underreporting. The underreporting was due to encounters not submitted to, or erroneously rejected from, MMIS. The aggregate impact to the CY 2021 base data for the underreporting adjustment is an increase of 2.03%.

Financial Adjustments

The DBA-submitted SDR includes schedules for the DBA to describe financial adjustments, in addition to providing the amounts for each adjustment by COA. Through a review of this information, it was determined that one of these adjustments reflected appropriate benefit expense adjustments and is indicative of expected future cost levels during CY 2023.

Provider Overpayment Recoveries

The base data used in development of the CY 2023 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 DBA. In the DBA-reported SDRs collected through March 31, 2022, the DBA reported any additional provider overpayment recoveries for CY 2021 dates of service which were not already captured in the encounter data. Based on this reporting, Mercer applied a reduction of approximately $11,400 for recoveries of provider overpayments not captured in the encounter data. The adjusted base data is, therefore, net of all known provider overpayments.

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 24 months, from the midpoint of the base period (July 1, 2021) to the midpoint of the rating period (July 1, 2023).

The primary data source for trend development was managed care experience data. Mercer reviewed 38 months of encounter data (January 2019 through February 2022), including utilization, unit cost, and PMPM metrics, and 20 months of DBA-reported PMPMs in the financial reports (January 2021 through August 2022). 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, 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 dental 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 was utilized collectively with other data and information via actuarial judgement to inform the final trends.

Unit cost and utilization trends were developed to account for projected changes in dental services for the covered populations, reflecting the data sources and considerations outlined above. Trend assumptions vary in direction and magnitude by COA and COS. Mercer did not select any negative trends for CY 2023.

Unit cost trends ranged from 0.50% to 3.00% depending on the COA and COS. Unit cost trends may reflect inflationary pressures as well as changes in the mix of services provided within each service category. Utilization trends ranged from 1.00% to 5.00%, depending on the COA and COS.

The aggregate annualized PMPM trend for CY 2023 is 2.70%. Annualized trends by rate cell and COS are provided in Appendix F (18 exhibits).

COVID-19 Considerations

Mercer considered the impact of COVID-19 in the development of trend factors. Significant uncertainty exists regarding the impact of COVID-19 during CY 2023 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., Health and Human Services, and Federal Emergency Management Agency), and the availability of a vaccine and vaccine boosters.

The encounter data and DBA-reported SDR through March 2022, and financial reporting through August 2022 indicate utilization continuing to return to pre-PHE levels relative to the CY 2021 base period. No explicit adjustment was applied related to COVID-19. The annualized trend factors are adjusted as compared to CY 2022 to reflect that the CY 2021 base period reflects some suppressed utilization and slower growth from the onset of the PHE and into the base period, but a consistent return to normal is expected into the CY 2023 rating period. Appendix E provides a comparison of annualized trends between CY 2022 and CY 2023 by COA.

The DBA is not at risk for any direct COVID-19 costs, as the program scope is limited to dental services; therefore, there were no considerations for these costs in the rate development. DHCFP did not implement any material policy changes to covered populations, covered services, and payment methodologies specific to COVID-19 PHE requirements aside from the MOE requirements, which were incorporated in the CY 2023 membership projections; accordingly, there were no additional adjustments required.

Program Changes

Program change adjustments recognize the impact of changes in covered populations, covered services, and payment methodologies. The next few subsections outline the program changes that were considered for CY 2023. Each of these program changes was reviewed, analyzed, and evaluated by Mercer, with the assistance of DHCFP.

Population Changes

Effective January 1, 2022, some populations previously carved out of managed care and covered through State FFS are covered by managed care. These include the following:

- All members admitted to residential treatment centers remain in managed care
- Change to extend managed care coverage of members in nursing facilities from the first 45 days to the first 180 days
- Serious mental illness population are mandatory managed care for TANF/CHAP Adult members

Mercer determined the population coverage changes will slightly increase the member months covered under the contract; however, the PMPM impact is expected to be

immaterial, as these members have similar utilization and costs as their respective rate cells. Therefore, no explicit adjustment for the population changes was applied.

Out-of-State Eligibility Review

During 2022, the State underwent an out-of-state eligibility review based on results from a PARIS report that identified members potentially receiving services in Nevada and another state. The potential out-of-state spans identified from the PARIS report were provided to Mercer. The PARIS data system is not verified, but provides a list of members who are potentially out-of-state, subject to additional verification.

Mercer applied an adjustment to reflect the potential disenrollments due to the ongoing Medicaid eligibility review. This adjustment reflects the impact of removing member months from the CY 2021 base data time period for those members that may have been out-of-state during the period. As the PARIS data system is not verified, Mercer reviewed encounters for the flagged members. If a flagged member had any Medicaid services incurred in Nevada during the flagged span in CY 2021, that member was assumed to still reside in Nevada. All flagged potential out-of-state members were removed if a Nevada Medicaid encounter was not incurred during the potential out-of-state span. Members and associated costs were retained if a Nevada Medicaid encounter was incurred during the potential out-of-state span.

This adjustment results in an increase to the CY 2023 rates due to the removal of member months with no associated spend from the CY 2021 base data time period. The aggregate impact to the CY 2023 rates for the out-of-state eligibility review is an increase of 0.46%. The impacts by rate cell are provided in Appendix F.

Credibility Adjustments

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.

There were four rate cells with partial credibility, all within the Check Up COA. Manual rates were developed based on the projected medical cost of the respective age/gender cell in TANF/CHAP Child. A COA differential factor was applied when leveraging the TANF/CHAP Child rate cells based on the relative composite projected medical cost for TANF/CHAP Child and Check Up, with composites based on the Check Up projected member months.

The aggregate impact to the CY 2023 rates for the credibility adjustments is 0.00%. The credibility weighting, manual rate PMPMs, and blended final medical PMPMs are provided in Appendix C.

Section 5

Special Contract Provisions Related to Payment

Incentive Arrangements

There continues to be no incentive arrangements applicable to the program during CY 2023.

Withhold Arrangements

There are no withhold arrangements applicable to the program during CY 2023.

Risk-Sharing Mechanisms

Remittance on Minimum Medical Loss Ratio

For CY 2023, DHCFP will continue the DBA contract provision for remittance to the State if the DBA's medical loss ratio (MLR) falls below 85%. The MLR remittance has been in place since CY 2019 and has been approved by CMS for prior rating periods.

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 dental program.

The DBA provides 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 the DBA falls below the State's minimum MLR of 85%, the State will collect a remittance from the DBA.

Although capitation rates are not directly affected by the minimum MLR requirement, the rates have been developed in such a way that the DBA is reasonably expected to achieve an MLR of at least 85% for CY 2023.

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

State Directed Payments

There continues to be no State directed payments applicable to the program for CY 2023. There are no requirements regarding the reimbursement rates the DBA 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 2023.

Section 6

Projected Non-Benefit Costs

Administrative Expense

The CY 2023 rates include provisions for DBA administrative expense. Administrative expense was developed leveraging multiple data sources, including DBA-reported non-benefit expenses in the SDRs from January 2020 through March 2022, ad hoc information from DHCFP and the DBA, along with regional and national administrative expense benchmarks for similar Medicaid dental programs. Mercer also reviewed changes to contract requirements in the DBA contract starting January 1, 2023.

The administrative expense was developed and applied as a percentage load. Mercer set the administrative expense percentage load for CY 2023 to 13.00%. Mercer considers 13.00% to be reasonable, appropriate, and attainable.

No changes were made to the application of the percentage loads as compared to prior rating periods. The percentage loads are applied to the final projected benefit costs on a fixed basis and are loaded equally on each rate cell.

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

Underwriting Gain

The CY 2023 rates include provisions for underwriting gain, which implicitly and broadly considers the cost of capital and level of risk in the program, including the risk-mitigation strategy employed in CY 2023. The analysis used DBA-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. Mercer verified that the underwriting gain percentage load was no less than the output from the Society of Actuaries Medicaid Managed Care Underwriting Margin Model.

Underwriting gain is determined as a percentage of the capitation prior to the loading of State premium tax. An underwriting gain percentage load of 1.50% 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

The DBA is subject to Nevada State premium tax of 3.50% for CY 2023. Each rate cell includes an additional 3.50% load for premium tax.

The PMPM impacts of the premium tax by rate cell and in aggregate are provided by rate cell in Appendix D.

Section 7

Risk Adjustment and Acuity Adjustments

There is no prospective or retrospective risk adjustment nor acuity adjustments applied in the CY 2023 rate development.

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 DBA contract, have been or will be approved by CMS.

In preparing the capitation rates found in Appendix A for CY 2023 for the Nevada Medicaid managed care dental program, Mercer 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 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 dental program 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 US 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 DBA 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.

DBAs 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 DBAs for

any purpose. Mercer recommends that any DBA 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 dental 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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Principal

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CY 2023 NEVADA DBA RATE CERTIFICATION APPENDICES

Appendix A: CY 2023 Final Certified Rates and Comparison

Region	COA	Rating Group	Projected MMs	CY 2023	CY 2022[1]	% Change
			Capitation Rates			
All Regions	TANF/CHAP Child	Under 1	209,928	$ 0.42	$ 0.41	2.4%
All Regions	TANF/CHAP Child	Child 1-2	388,017	$ 6.77	$ 7.16	-5.4%
All Regions	TANF/CHAP Child	Child 3-14	2,109,136	$ 20.82	$ 21.02	-1.0%
All Regions	TANF/CHAP Child	Female 15-18	301,157	$ 19.08	$ 18.00	6.0%
All Regions	TANF/CHAP Child	Male 15-18	294,937	$ 17.04	$ 15.74	8.3%
All Regions	TANF/CHAP Adult	Female 19-34	403,677	$ 5.11	$ 4.26	20.0%
All Regions	TANF/CHAP Adult	Male 19-34	78,259	$ 3.87	$ 3.82	1.3%
All Regions	TANF/CHAP Adult	Female 35 and Over	247,164	$ 5.76	$ 5.28	9.1%
All Regions	TANF/CHAP Adult	Male 35 and Over	89,438	$ 5.12	$ 5.10	0.4%
All Regions	Check Up	Under 1	1,705	$ 0.45	$ 0.58	-22.4%
All Regions	Check Up	Child 1-2	10,489	$ 8.28	$ 9.31	-11.1%
All Regions	Check Up	Child 3-14	169,624	$ 25.28	$ 27.15	-6.9%
All Regions	Check Up	Female 15-18	31,952	$ 22.63	$ 22.89	-1.1%
All Regions	Check Up	Male 15-18	32,719	$ 21.07	$ 21.59	-2.4%
All Regions	Expansion	Female 19-34	786,517	$ 5.43	$ 5.04	7.7%
All Regions	Expansion	Male 19-34	708,968	$ 4.18	$ 3.94	6.1%
All Regions	Expansion	Female 35 and Over	929,037	$ 6.75	$ 6.45	4.7%
All Regions	Expansion	Male 35 and Over	911,093	$ 6.03	$ 5.91	2.0%
			Composite PMPM			
All Regions	TANF/CHAP Child	All RGs	3,303,175	$ 17.38	$ 17.34	0.2%
All Regions	TANF/CHAP Adult	All RGs	818,537	$ 5.19	$ 4.62	12.4%
All Regions	*TANF/CHAP*	*All RGs*	*4,121,712*	*$ 14.96*	*$ 14.81*	*1.0%*
All Regions	Check Up	All RGs	246,491	$ 23.48	$ 24.92	-5.8%
All Regions	Expansion	All RGs	3,335,616	$ 5.70	$ 5.44	4.8%
All Regions	**All Populations**	**All RGs**	**7,703,818**	**$ 11.22**	**$ 11.07**	**1.3%**

General Notes:

- Totals may differ due to rounding.
- All composites are weighted on CY 2023 projected member months.

Footnote:

1. CY 2022 rates reflect the rates certified on December 21, 2021.