Mercer

Government Human Services Consulting

Capitation Rate Development and Certification

Calendar Year 2023 Nevada Medicaid Managed Care Program

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

December 22, 2022

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A business of Marsh McLennan

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 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 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 MCO Rate Certification_Appendices_2022.12.22.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, and Roger Figueroa, FSA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standards for issuing the statements of actuarial opinion herein.

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

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 and delivery case rate (DCR) and very low birth weight (VLBW) projected case counts for the January 1, 2023 through December 31, 2023 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 2022	$155.73	$348.64	$130.50	$509.95	$5,990.17	$130,510.66
CY 2023	$149.12	$343.96	$114.49	$467.41	$6,186.68	$138,070.15
Percent Change	**-4.24%**	**-1.34%**	**-12.27%**	**-8.34%**	**3.28%**	**5.79%**

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 a decrease of 6.36%.

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. The base data change is driven, in large part, by changes in acuity of the underlying population, as further discussed in the "COVID-19 Considerations" subsection of Section 4.

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 2023: Community Care Health Plan of Nevada, Health Plan of Nevada, Molina Healthcare of Nevada (Molina), and SilverSummit Healthplan.

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, and entered 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 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 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 and provide counseling for COVID-19 vaccinations 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 2023:

- Indian health service facilities and Tribal clinics
- Non-emergency secure behavioral health 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
- Nursing facility stays over 180 days
- Targeted case management
- Adult chiropractic
- Ground emergency medical transportation
- Orthodontic services
- Zolgensma®

Refer to the MCO 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 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.

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 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)
- 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

[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).

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 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 certified community behavioral health services (CCBHCs), for which the FMAP is 90.0%; substance use disorder services, for which the FMAP is 80.0%; 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 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 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 for all four MCOs submitted to DHCFP at the time the rates were determined were also considered in the rate development process.

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

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

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 "COVID-19 Considerations" 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: Capitated Medical PMPM Build-up
- Appendix D: Below-the-Line Medical Adjustments
- Appendix E: Non-Medical and Total Capitation
- Appendix F: Capitation Annualized Trend Comparison
- Appendix G: Capitation Rate Calculation Sheet (CRCS) (36 exhibits)
- Appendix H: DCR Rate Calculation Sheet
- Appendix I: State Directed Payments (two 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 observed significant enrollment increases from March 2020 through August 2022 driven by the PHE and subsequent maintenance of effort (MOE) requirements. Mercer and DHCFP assumed the PHE will close in January 2023, at which point the 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
- MCO-reported encounter data from MMIS (including encounters for subcapitated services) 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 each MCO for dates of service from January 1, 2020 through March 31, 2022
- MCO-reported financial reports submitted to DHCFP, through September 2022
- 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 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 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 incumbent MCOs 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 MCOs, net of any wraparound 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 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 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, such as Expansion members under age 19 years.
- 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, services covered under non-risk arrangements, as well as value-added services, were identified and excluded from the base data.

Effective January 1, 2022, CCBHC services were carved into managed care from FFS. These services were excluded from the CY 2021 base period and added through a program change adjustment discussed in the “Program Changes” subsection of Section 4.

In Lieu of Services

DHCFP 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 2023, additional adjustments to the base data were applied as described below.

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

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 dates processed through MMIS as of April 1, 2022, and were

inclusive of subcapitated shadow encounters. 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 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. The aggregate impact to the CY 2021 base data for the IBNR adjustment is an increase of 1.25%.

Aggregate completion factors for CY 2021 by major service category are provided in Table 3.

Table 3: Annual Completion Factors

Service Category	CY 2021 Estimated Completion
Inpatient – Child	0.9531
Inpatient – Adult	0.9799
Outpatient Facility	0.9814
Pharmacy	1.0001
Other	0.9897

Several program change adjustments leveraged CY 2021 FFS member months 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.

Under- and Over-Reporting

Mercer reviewed the incumbent MCO-submitted encounter data from MMIS as compared to the expenses reported in the MCO-submitted SDRs for CY 2021. Mercer observed differences between the data sources. Through discussions with the State and the MCOs, Mercer 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. Overpayments were also identified for one MCO. This MCO reported instances of overpayments to some providers in which the overpayment recoveries were not reflected in the encounters. The base data was adjusted for these instances of both under- and over-reporting; the aggregate impact to the CY 2021 base data was an increase of 1.49%.

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 MCOs. In the MCO-reported SDRs collected through March 31, 2022, each MCO reported any additional provider overpayment recoveries for CY 2021 dates of service that were not already captured in the encounter data. This reporting was the basis of the over-reporting adjusted noted above. The adjusted base data is, therefore, net of all known provider overpayments.

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 2023. Adjustments were made to the base data to add these non-claims costs as appropriate. These include an addition of approximately $7.6 million for provider incentive arrangements and $1.3 million for out-of-system payments. The combined aggregate impact to the CY 2021 base data was an increase of 0.52%.

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

COVID-19 Considerations

Mercer considered the impact of COVID-19 in the development of the projected benefit cost. Significant uncertainty continues to exist regarding the impact of COVID-19 during CY 2023 due to the ever-changing situation with federal requirements, regionalized infection rates, responses driven by local governments, and new treatment protocols, to name a few factors. Many elements were considered when reviewing the program experience over time and projecting into CY 2023, including MOE requirements and subsequent changes to the enrolled population acuity, 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, Federal Emergency Management Agency), the availability of a vaccine and vaccine boosters, and shifts in the modalities of care.

Population Acuity

One significant downward pressure on the benefit cost PMPMs since the onset of the COVID-19 PHE is the impact of significant enrollment growth, due to the MOE requirements, on the acuity of the enrolled population. Total managed care member months increased by 31.0% from the prior base period of CY 2019 to the CY 2023 base period of CY 2021; the largest increases in enrollment were observed in the Expansion COA. The Check Up COA has experienced decreases in enrollment due to the MOE requirements, as many children are retained in the TANF/CHAP population. The enrollment changes from CY 2019 to CY 2021 by rate cell and aggregate COA are provided in Appendix B.

Additional membership increases continued after the CY 2021 base period, and additional increases are expected through the duration of the PHE. As previously described in the "Membership Projections" subsection of Section 2, member month volume in CY 2023 is expected to be similar to CY 2021 due to the assumed close of the PHE in January 2023 and the subsequent redetermination process.

Mercer reviewed raw program risk scores from CY 2019 through CY 2021, performed various benefit PMPM regression analyses on five years of Nevada managed care experience (2017–2021) against enrollment volume by COA, and reviewed Medicaid experience data in other state Medicaid programs. Although utilization suppression after the onset of the PHE impacted raw risk scores and benefit PMPMs, these reviews indicated a significant decrease in the overall acuity of the enrolled population for all COAs, correlated with enrollment volume. This acuity change is a significant driver of the base data PMPM decreases displayed in Appendix B.

As CY 2023 enrollment projections are expected to be very similar to CY 2021 enrollment, Mercer projected that the acuity of the enrolled population in CY 2023 would be equivalent to

the base period of CY 2021. Therefore, no additional population acuity adjustments were applied for CY 2023. However, in reviewing benefit PMPMs over time for the medical trend developed, as described below, the benefit PMPMs were normalized for the acuity impact of enrollment changes over time, to develop annualized trend assumptions that were independent of underlying population acuity.

Direct COVID-19 Services

The MCOs are not at risk for the direct COVID-19 costs for vaccines and vaccine administration; therefore, these services were excluded from the base data and there were no considerations for these costs in the rate development. In addition, 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 aforementioned MOE requirements; accordingly, there were no additional adjustments required.

The CY 2021 base period includes COVID-19 testing and treatment experience, and direct and indirect impacts of the COVID-19 PHE. Although the COVID-19 direct services ebbed and flowed through the observable experience after the onset of the COVID-19 PHE, the aggregate inpatient and outpatient utilization was smoother. In the development of trends, data was reviewed for both COVID-19 direct services in isolation and for total medical experience, net and gross of these services. CY 2023 trends were developed for each COS in aggregate. No explicit adjustment was applied specific to COVID-19 services, as the services are embedded in the base data and reflected in the aggregated trends by COA and COS described below.

Service Utilization

Mercer observed some suppression of utilization in the CY 2021 base period, relative to experience prior to the PHE, in addition to the aforementioned population acuity impacts. This was likely due to foregone and/or delayed care and service delivery changes throughout the COVID-19 PHE. Through a review of managed care encounters through February 2022 and MCO-reported financials through September 2022, Mercer observed a recovery of utilization throughout CY 2021 and into CY 2022 to varying extents by COA and COS. As Mercer expects utilization levels to largely return to historical levels observed in the periods prior to the COVID-19 PHE, higher than normal utilization trends were applied for CY 2023 rate development to offset the lower utilization levels present in the CY 2021 base period.

Based on national evidence that the pandemic has had a material impact on behavioral health needs, the CY 2023 utilization trends for outpatient behavioral health includes considerations for anticipated increases in demand. The aggregate PMPM annualized trend across all COAs for outpatient behavioral health is 5.4%.

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).

Annualized trends by rate cell and COS are provided in Appendix G (36 exhibits). A comparison of annualized trends between CY 2022 and CY 2023 by COA is provided in Appendix F.

Medical Trends

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 21 months of MCO-reported PMPMs in the financial reports (January 2021 through September 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 adjusted and reviewed the underlying trend data for the COVID-19 considerations as described above.

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 was used 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 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. Mercer did not select any negative trends for CY 2023.

Unit cost trends ranged from 0.00% to 4.00% 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.

Applied behavior analysis (ABA) services exhibited particularly high historic trends, and Mercer developed trends specific to this COS for child COAs. 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 2023, applying a 25.0% annualized utilization trend.

Utilization trends for other medical COS ranged from 1.00% to 8.00% depending on the COA and COS.

The aggregate annualized PMPM trend for medical services for CY 2023 is 5.43%.

Pharmacy Trends

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

Mercer's trend review is an ongoing process requiring monthly review of newly approved drugs and an annual review of all therapeutic classes. The reviews are handled by a team of Mercer pharmacists with several years of Medicaid experience. Mercer's Managed Pharmacy Practice reviewed potential blockbuster drugs 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.

The aggregate annualized PMPM trend for pharmacy COS's for CY 2023 is 9.32%.

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 H.

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 change adjustments that were explicitly accounted for within the CY 2023 capitation rates. Total program change adjustments by rate cell and COS are provided in Appendix G (36 exhibits). The aggregate PMPM impact of each individual program change adjustment described in this section is shown by COA in Appendix C.

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 2021 base experience for these stays at the State plan rate. Additionally, Mercer developed a corresponding utilization adjustment, which accounted for the difference in the average length of stay for inpatient behavioral health services at an acute facility as compared to short-term IMD stays.

Nursing Facility Coverage

Nursing facility services are a managed care service; however, historically, members were disenrolled from managed care into FFS coverage on day 46 of a continuous nursing facility stay. Effective January 1, 2022, members with a continuous nursing facility admission remain in managed care for the first 180 days, as long as the member is otherwise managed care eligible. Members are disenrolled from managed care and covered through FFS after 180 days. The MCO is responsible for all covered services for members in a nursing facility for the first 180 days of the admission. Mercer identified FFS member months and claims for members disenrolled from managed care due to the prior nursing facility coverage limit in the CY 2021 base period. To develop the adjustment, Mercer reviewed the impact to the base data of adding the CY 2021 FFS member months and claims from day 46 through day 180 of the admission for members who were otherwise managed care eligible.

Residential Treatment Center Coverage

Effective January 1, 2022, members with an admission to a residential treatment center (RTC) remain in managed care and with the MCO, as long as Medicaid eligible. The MCO is 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 2021 FFS member months 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 are 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 2021 base period. Mercer evaluated the cost and utilization impact of adding the FFS member months and claims for these members to the base data to develop an adjustment.

Certified Community Behavioral Health Center Services Carve-In

Effective January 1, 2022, CCBHC services are 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 2021 FFS claims for CCBHC services. The claims were repriced to the anticipated State plan bundled rates for each CCBHC, effective for CY 2023. Mercer evaluated the cost and utilization impact of adding the repriced CCBHC experience to the base data to develop an adjustment.

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 2023 pharmacy rebate payments from the projected pharmacy costs using MCO-submitted supplemental data, encounters, and industry-wide experience.

Pharmacy Benefit Manager Pass-Through Pricing

Effective January 1, 2022, MCOs are required to use a pass-through pricing model with contracted pharmacy benefit managers. One incumbent MCO had a spread pricing arrangement during the CY 2021 base period. Mercer received supplemental data from the affected MCO detailing the amount of spread pricing dollars included in the underlying CY 2021 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 implemented an increase of approximately 66% to the ABA fee schedule for services provided by registered behavior technicians. Encounters for the affected services in the CY 2021 base data were repriced upward, accordingly, to develop an adjustment.

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.

Other Medical Rating Adjustments

To finalize the CY 2023 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 D.

Inpatient Hospital Stop-Loss

DHCFP is continuing a member-level stop-loss contract provision for inpatient hospital claims with an attachment point of $500,000 for CY 2023. 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 2021 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 2023. 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 2023. As the base data for rate development is reported gross of any stop-loss reimbursement, the projected CY 2023 reimbursement is netted out of the gross CY 2023 projected medical costs by rate cell.

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

The PMPM impact of inpatient hospital stop-loss by rate cell is provided in Appendix D. For more detail regarding the inpatient hospital stop-loss provision, please refer to Section 5.

VLBW Risk Pool Payment

For CY 2023 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 members under the age of one year. The value of the VLBW supplemental case rate benefit cost is $115,000 for CY 2023. 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 2019–CY 2022 experience data. Mercer then selected a conservative prevalence rate for the CY 2023

prospective rating period as a percentage of expected CY 2023 under age one year member months by COA to ensure adequate funding for the risk pool. The projected prevalence rate for CY 2023 is 0.95 per 1,000 member months for TANF/CHAP Under 1 rate cells and 0.00 projected prevalence rate for Check Up Under 1 rate cells.

As the VLBW risk pool is funded by an offset to the capitated rate, the projected PMPM value of the VLBW case rate benefit cost was calculated using the expected prevalence rate associated with projected under age one year member months 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 D. The value of the VLBW risk pool is not a fixed amount; rather, the risk pool is funded by the reduction to the capitation rates and will vary with actual enrollment. As such, the VLBW risk pool is budget neutral to the DHCFP.

For more detail regarding the VLBW risk pool payment, please refer to Section 5.

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. A summary of the development of manual rates for applicable rate cells are as follows:

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

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

Delivery Case Rate

For CY 2023, 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 2023 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 claims with Diagnosis Related Group codes and/or diagnosis codes indicating the delivery event. All costs incurred during the dates of such a delivery event are excluded from the main capitation rate development and included in the development of the DCR.

Effective CY 2023, the DCR development methodology was updated to include a case-mix adjustment based on review of delivery counts for Cesarean versus vaginal deliveries over time. The projected mix selected for CY 2023 is 32.9% Cesarean births and 67.1% vaginal births, approximately a 0.5% reduction in Cesarean births as compared to the CY 2021 base period.

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 experience data (January 2019 through March 2022).

The development of the DCR is shown in Appendix H.

Section 5
Special Contract Provisions Related to Payment

Incentive Arrangements

There are two incentive arrangements effective for CY 2023:

- Primary care investment
- Value-based purchasing (VBP) enhancement

There is no impact on the CY 2023 capitation rates for the provision of the incentive arrangements. The CY 2023 capitation rates reflect Mercer's best estimate projection of reasonable, appropriate, and attainable costs.

In the event that the maximum amounts under either incentive arrangement are not earned at the end of the rating period, DHCFP may use unused funds to provide high-performing MCO(s) during CY 2023 an additional incentive payment, not to exceed a total of five percent of capitation for each MCO across all incentive arrangements. The total payments under the incentive arrangements applicable to CY 2023, and described below, have been designed in such a manner as to not exceed 105% of the capitation payments for each MCO.

Additional details specific to the incentive arrangements requirements can be found in the MCO contract.

Primary Care Investment

For CY 2023, DHCFP will implement an incentive arrangement for primary care investment under which an MCO may receive up to 3% over and above the capitation rate for meeting targets specified in the MCO contract, effective for the entirety of the CY 2023 contract period (January 1, 2023 through December 31, 2023). The incentive arrangement provision for primary care investment is intended as a bonus payment for increasing primary care medical expenditures as a portion of total medical expenditures, and applies to all of the MCOs.

The CY 2023 incentive arrangement aligns with the State's quality strategy to increase access to, and use of, primary care and preventive services and to reduce and/or eliminate health care disparities for Medicaid members. The State established a three-tiered approach to evaluate MCO performance under the incentive arrangement. CY 2022 primary care and total medical expenditures serve as the baseline for performance comparison.

Value-Based Purchasing Enhancement

For CY 2023, DHCFP will implement an incentive arrangement for VBP enhancement under which an MCO may receive up to 1% over and above the capitation rate for meeting targets

specified in the MCO contract, effective for the entirety of the CY 2023 contract period (January 1, 2023 through December 31, 2023). The incentive arrangement provision for VBP enhancement is intended as a bonus payment to increase/expand the use of VBP in the Medicaid managed care program, and applies to all of the MCOs.

The CY 2023 incentive arrangement aligns with the State's quality strategy to drive improvement in healthcare outcomes for Medicaid members through the use of alternative payment methods. The State established three goals for which MCOs must meet at least two goals under the incentive arrangement. The State will work with each MCO to determine the baseline for performance comparison.

Withhold Arrangements

For CY 2023, DHCFP will implement a withhold arrangement under which 1.5% of the capitation rate will be withheld from an MCO, and a portion, or all, of the withheld amount will be paid to the MCO for meeting the targets outlined in the MCO contract, effective for the entirety of the CY 2023 contract period (January 1, 2023 through December 31, 2023). The MCO contract included a withhold arrangement provision for the prior rating period but was not implemented; therefore, the parameters are new for CY 2023. The 1.5% will be withheld from each capitation rate cell, and this withhold arrangement provision applies to all of the MCOs. Earned withhold will be evaluated and processed for payment no later than twelve months after the closing of the contract period.

The CY 2023 withhold arrangement aligns with the State's quality strategy to increase access to, and use of, primary care and preventive services and improve the quality of, and access to, behavioral health services available to members.

The State set MCO-specific performance targets for four measures. The performance targets represent incremental improvement over performance from the 2020 measurement year baseline. Through a review of measure results from the 2020 baseline period and the prior two periods by plan, the targets for CY 2023 were determined to be reasonable achievable for each target for each MCO. For additional support, the State's external quality review vendor confirmed no concerns with the CY 2023 measures under the withhold arrangement. The incremental improvements needed to achieve the CY 2023 targets relative to the baseline period were consistent with rate-development assumptions for the CY 2023 projected benefit cost for returning utilization across relevant service categories.

The MCOs are therefore reasonably expected to achieve 100% of the 1.5% withhold for CY 2023. As no portion of the withhold was determined to not be reasonably achievable, the capitation rates gross of the withhold are considered actuarially sound.

There is no impact on the CY 2023 projected benefit or administrative cost for the provision of a withhold arrangement. The CY 2023 capitation rates reflect Mercer's best estimate projection of reasonable, appropriate, and attainable costs. The 1.5% withhold was determined to be reasonable given the MCOs' financial operating needs, the size and characteristics of the populations covered under the contract, and the MCOs' capital reserves. The withhold arrangement was taken into consideration in evaluating the cost of capital requirements when developing the CY 2023 underwriting gain assumption described in the "Underwriting Gain" subsection of Section 6.

Additional details specific to the withhold arrangement requirements can be found in the MCO contract.

Risk-Sharing Mechanisms

There are four risk-sharing mechanisms effective for CY 2023:

- Inpatient hospital stop-loss
- VLBW risk pool
- Remittance on minimum medical loss ratio (MLR)
- Risk corridor

Inpatient Hospital Stop-Loss

For CY 2023, 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 DHCFP to assume partial risk for these members.

DHCFP will assume partial risk for member-level inpatient hospital medical costs that exceed $500,000 during CY 2023. 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 2023. 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 2023, 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 one 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 $138,070.15.

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

Remittance on Minimum MLR

For CY 2023, 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 into 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. 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 2023.

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

Risk Corridor

For CY 2023, DHCFP will implement a symmetrical, two-sided MLR-based risk corridor on all populations and all medical costs. The risk corridor is being implemented as a response to the COVID-19 PHE. This risk corridor applies to all of the MCOs.

The CY 2023 rating period remains a period of uncertainty due to the COVID-19 PHE and corresponding economic and enrollment impacts. This is causing dramatic shifts in utilization across the healthcare industry and is causing financial uncertainty for managed care plans.

There remains a great deal of uncertainty in the utilization of services and acuity of the enrolled population in the CY 2023 period. The risk corridor is intended to mitigate excess managed care gains or losses due to uncertainty in rate development for CY 2023, limiting financial risks to both State and local governments and managed care plans.

This risk corridor applies to all populations, services, and rating regions included in the Medicaid/CHIP managed care program. The parameters of the CY 2023 risk corridor are as follows:

- The target MLR for CY 2023 is 89.50%. For purposes of the risk corridor, the MLR will be computed consistent with CMS regulations as outlined in 42 CFR § 438.8 and related policy guidance. This target MLR was set consistent with CY 2023 capitation rate development assumptions, including the assumptions for the non-medical expense load, consideration for the portion attributable to MLR-allowable health care quality improvement expenses, and other nuances of the CMS MLR definitions. The State and Mercer are proposing one uniform risk corridor for all four MCOs. The selection of an 89.50% target MLR was considered reasonable and appropriate for the program and is consistent with rate development.
- Risk corridor bands and sharing levels are shown in Table 4 below. In developing the risk corridor bands and sharing levels, considerations included the parameters used in Nevada's historical risk corridors, parameters used in other states with similar Medicaid managed care programs, and a review of guidance provided by CMS. The parameters selected for the CY 2023 risk corridor are structured similarly to the example provided in the May 14, 2020, CMS informational bulletin.[3] The DHCFP will limit MCO gains and losses in CY 2023 if the actual MLR is different from the target MLR within a specific margin, as laid out in Table 4 below:

Table 4: Risk Corridor Sharing Parameters

MLR Corridor	MCO Share of Gain/Loss	DHCFP/Federal Share of Gain/Loss
MLR of less than 85.50%	25%	75%
MLR of 85.50% to less than 87.50%	50%	50%
MLR of 87.50% to 91.50%	100%	0%
MLR of 91.50% to less than 93.50%	50%	50%
MLR greater than or equal to 93.50%	25%	75%

DHCFP will provide MCOs with a reporting tool, along with an instructional guide, for the CY 2023 risk corridor. The reporting tool and the MLR calculation will be consistent with the regulations set forth in 42 CFR § 438.8. DHCFP will allow for reasonable claims run-out as well as reflection of any other adjustments applicable to CY 2023 revenues, such as risk

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

adjustment and payment of all supplemental per event payments, before computing the risk corridor settlement.

There is no impact on the CY 2023 capitation rates for the provision of a risk corridor. The CY 2023 capitation rates reflect Mercer's best estimate projection of reasonable, appropriate, and attainable costs.

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

State Directed Payments

There are four State directed payments under 42 CFR § 438.6(c) proposed for the program in CY 2023. Preprints for applicable proposed payment arrangements were submitted to CMS on December 5, 2022, and the remainder are anticipated to be submitted by December 31, 2022. The payments are accounted for in this rate certification in a manner that is consistent with the preprints submitted, or anticipated to be submitted, for CMS review. A summary of the State directed payments described in this Section are provided in Table 5.

Table 5: 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_AMC_ Renewal_20230101-20231231	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

Control Name	Type of Payment	Brief Description	Is the Payment included as a Rate Adjustment or Separate Payment Term?
NV_Fee_IPH.OPH_Renewal_20230101-20231231	Uniform percentage increase	Uniform percentage increase for inpatient and outpatient services provided by eligible public hospitals set as difference between Medicare upper payment limit and average Medicare base reimbursement or between average commercial rates and Medicaid base reimbursement	Separate payment term
Control Name TBD – CCBHC Quality Payments	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 6.

Table 6: Rate Adjustment State Directed Payments

Control Name	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint
CCBHC Bundled Rate (no preprint required)	All capitation rate cells	Refer to Appendix I	See Section 4, subsection “CCBHC Services Carve-In”	Not applicable

Additional detail related to the State directed payments that will be incorporated as separate payment terms described in this section are provided in Table 7.

Table 7: 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_AMC_Renewal_20230101-20231231	$26.2 million	The signing actuaries certify the separate payment term	Refer to Appendix I	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.OPH_Renewal_20230101-20231231	$134.9 million	The signing actuaries certify the separate payment term	Refer to Appendix I	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

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
Control Name TBD – CCBHC Quality Payments	$1.4 million	The signing actuaries certify the separate payment term	Refer to Appendix I	The State-directed payment is accounted for consistent with the preprint anticipated to be submitted to CMS	DHCFP will submit documentation to incorporate the total amount of the State directed payment

Appendix I, 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 2023 projected aggregate estimated payments provided by DHCFP. The estimated payments are then grossed up for the 3.50% 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 2023 utilization mix by rate cell, estimated using utilization for applicable services by rate cell identified in the CY 2021 base data, reweighted on CY 2023 projected enrollment.

Final payments made will vary from these estimates based on actual utilization or performance measures for applicable services in CY 2023. 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 2023 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.

Services in a Teaching Environment

The State directed payment for professional services provided in a teaching environment (CMS control name NV_Fee_AMC_Renewal_20230101-20231231) is in alignment with the State plan rate for professional 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. New for CY 2023, an additional entity was added to the provider class. This directed payment was approved by CMS for prior rating periods.

This directed payment is incorporated as a separate payment term. The aggregate estimated impact to managed care capitation under this State directed payment is $26,217,617. Payments will be issued quarterly. The first three payments for each will be 25% of the projected aggregate estimated payment amount under the directed payment. 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 directed payment. The fourth and final payment of the year for each directed payment 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.

Services Provided by Public Hospitals

The State directed payment for inpatient and outpatient services provided by public hospitals (CMS control name NV_Fee_IPH.OPH_Renewal_20230101-20231231) is for inpatient and outpatient 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, and the outpatient reimbursement will be consistent with the supplemental payment for non-state governmentally owned or operated hospitals as detailed in State Plan Attachment 4.19-B, pages 20 and 20 (Continued). The directed payment is a uniform percentage increase for inpatient and outpatient services provided by eligible public hospitals. The directed payment will increase payments by the difference between payments under the Medicare upper payment limit and average Medicare base reimbursement for outpatient services in this provider class and will increase payments by the difference between payments under the average commercial rates and Medicaid base reimbursement for inpatient services in this provider class; therefore, total Medicaid reimbursement will not exceed estimated payments under average commercial rates. New for CY 2023, the payment type changed from a uniform dollar increase to a uniform percentage increase, and the eligible services expanded to include outpatient services. This directed payment was approved by CMS for prior rating periods.

This directed payment is incorporated as a separate payment term. The aggregate estimated impact to managed care capitation under this State directed payment is $134,944,743. Payments will be issued quarterly. The first three payments for each will be 25% of the projected aggregate estimated payment amount under the directed payment. 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 directed payment. The fourth and final payment of the year for each directed payment 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 TBD) is for quality bonus payments/quality incentive payments for CCBHCs achieving established performance metrics. Eight CCBHCs are anticipated to provide services under two cohorts within the State for CY 2023. Cohort 1 includes three CCBHCs that operate under an 1115 demonstration waiver and are eligible to receive quality bonus payments. Cohort 2 includes five CCBHCs that operate under the State Plan Amendment 19-010 and are 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 issued 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 was approved by CMS for prior rating periods.

This directed payment is incorporated as a separate payment term, and the aggregate estimated impact to managed care capitation under this directed payment is $1,363,743.

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 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 E.

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 2020 Q1 to CY 2022 Q1. Through discussion with each MCO on its reported expenses, Mercer adjusted the reported administrative expenses to remove one-time expenses. The administrative expenses for CY 2020 and CY 2021 were projected forward to CY 2023 for cost trends, based on a review of the Consumer Price Index and Employment Cost Index; CY 2020 was projected forward at an annualized rate of 4.4%, and CY 2021 was projected forward at an annualized rate of 4.7%.

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 that joined the Nevada Medicaid managed care program in CY 2022. At the start of CY 2022, membership was redistributed across the four MCOs. Mercer modeled the enrollment impacts to each of the historical MCOs of the combination of overall enrollment changes (from the study periods to the rating period) and the redistribution of enrollment by MCO, based on the distribution of members by MCO in mid-2022. Enrollment in CY 2023 is anticipated to be lower than the study periods for two of the incumbent MCOs and higher for the third.

Mercer reviewed changes to contract requirements in the MCO contract that were effective January 1, 2022. The MCO contract included some new administrative and care management requirements, clarified expectations for existing requirements, and stipulated location and/or contract exclusivity for certain key staff. Each of the incumbent MCOs provided information regarding additional FTEs and salaries needed to meet the updated MCO contract requirements that were above and beyond staffing included in the historical administrative expense data. Consistent with CY 2022 administrative expense development, Mercer reviewed and compared each plan’s provided information against the current and new contract requirements to develop the adjustment with an impact of 2.2%.

Mercer also considered the interaction between the MCOs and CCBHCs related to care management requirements. Mercer verified by having each MCO attest that there is no duplication of services between internal MCO activities and the targeted care management services performed by CCBHCs.

Pharmacy Administration

Pharmacy administration expense was developed separately from non-pharmacy-related administration expenses. Mercer reviewed MCO-reported pharmacy administration expenses in CY 2020 and CY 2021 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 2023 was priced at 2.1% 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, 10% of the PMPM was allocated to capitation for each major COA and 90% was variable as a function of the final projected benefit costs. As the fixed cost for members is 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 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 various risk-mitigation strategies and the quality withhold employed in CY 2023. The analysis used 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. 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 3.00% 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 E.

Premium Tax

All MCOs are 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 in Appendix E.

Section 7

Risk Adjustment and Acuity Adjustments

Risk Adjustment

There is currently no prospective risk adjustment applied to the CY 2023 rates. The State reserves the right to implement prospective risk adjustment. If implemented, appropriate documentation would be provided at that time.

There will be a final retrospective application of risk adjustment applied to CY 2023 capitation rates, performed once annually following the end of the rating period. Under age one 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 and net of the quality withhold. Mercer will perform the risk adjustment.

The data used for risk adjustment will include MCO-submitted encounter data and FFS claims data with CY 2023 dates of service for all members who were enrolled with an MCO within CY 2023. The data utilized for the final 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 currently intends to use 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 assess 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 currently anticipate making any substantive changes to the risk-adjustment model compared to CY 2022 beyond using the most up-to-date version of the CDPS+Rx model; however, the State reserves the right to update the approach per the MCO contract. In the event changes are made to the risk adjustment model, appropriate documentation would be provided at that time. 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 I for CY 2023 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 actuaries are members of the American Academy of Actuaries and meet 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 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 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 2023 NEVADA MCO RATE CERTIFICATION APPENDICES

Appendix A: CY 2023 Final Certified Rates and Comparison

Region	COA	Rating Group	Projected MMs/Counts	CY 2023	CY 2022[1]	% Change
				Capitation Rates		
Northern	TANF/CHAP Child	Under 1	25,483	$ 705.72	$ 571.30	23.5%
Northern	TANF/CHAP Child	Child 1-2	48,658	$ 107.41	$ 112.81	-4.8%
Northern	TANF/CHAP Child	Child 3-14	245,699	$ 94.23	$ 97.14	-3.0%
Northern	TANF/CHAP Child	Female 15-18	33,578	$ 179.79	$ 155.79	15.4%
Northern	TANF/CHAP Child	Male 15-18	33,047	$ 123.09	$ 127.31	-3.3%
Northern	TANF/CHAP Adult	Female 19-34	48,198	$ 268.32	$ 276.26	-2.9%
Northern	TANF/CHAP Adult	Male 19-34	9,441	$ 146.94	$ 190.36	-22.8%
Northern	TANF/CHAP Adult	Female 35 and Over	26,219	$ 434.50	$ 442.84	-1.9%
Northern	TANF/CHAP Adult	Male 35 and Over	10,430	$ 346.62	$ 409.95	-15.4%
Northern	Check Up	Under 1	213	$ 325.70	$ 237.48	37.1%
Northern	Check Up	Child 1-2	1,706	$ 111.67	$ 128.02	-12.8%
Northern	Check Up	Child 3-14	28,609	$ 89.77	$ 108.50	-17.3%
Northern	Check Up	Female 15-18	5,385	$ 160.13	$ 156.02	2.6%
Northern	Check Up	Male 15-18	5,625	$ 113.47	$ 116.39	-2.5%
Northern	Expansion	Female 19-34	90,920	$ 284.79	$ 318.38	-10.6%
Northern	Expansion	Male 19-34	79,569	$ 313.71	$ 393.19	-20.2%
Northern	Expansion	Female 35 and Over	111,540	$ 577.97	$ 664.84	-13.1%
Northern	Expansion	Male 35 and Over	115,632	$ 658.94	$ 704.33	-6.4%
Southern	TANF/CHAP Child	Under 1	184,445	$ 728.52	$ 710.26	2.6%
Southern	TANF/CHAP Child	Child 1-2	339,358	$ 116.74	$ 138.52	-15.7%
Southern	TANF/CHAP Child	Child 3-14	1,863,437	$ 98.83	$ 112.46	-12.1%
Southern	TANF/CHAP Child	Female 15-18	267,580	$ 160.63	$ 157.06	2.3%
Southern	TANF/CHAP Child	Male 15-18	261,890	$ 133.54	$ 120.08	11.2%
Southern	TANF/CHAP Adult	Female 19-34	355,478	$ 282.84	$ 279.75	1.1%
Southern	TANF/CHAP Adult	Male 19-34	68,817	$ 157.54	$ 174.41	-9.7%
Southern	TANF/CHAP Adult	Female 35 and Over	220,946	$ 488.76	$ 488.18	0.1%
Southern	TANF/CHAP Adult	Male 35 and Over	79,008	$ 415.66	$ 443.89	-6.4%
Southern	Check Up	Under 1	1,492	$ 300.40	$ 264.41	13.6%
Southern	Check Up	Child 1-2	8,783	$ 106.67	$ 153.65	-30.6%
Southern	Check Up	Child 3-14	141,015	$ 108.04	$ 118.76	-9.0%
Southern	Check Up	Female 15-18	26,567	$ 157.66	$ 181.11	-12.9%
Southern	Check Up	Male 15-18	27,095	$ 113.83	$ 147.53	-22.8%
Southern	Expansion	Female 19-34	695,598	$ 261.13	$ 280.99	-7.1%
Southern	Expansion	Male 19-34	629,399	$ 278.68	$ 306.87	-9.2%
Southern	Expansion	Female 35 and Over	817,497	$ 605.10	$ 654.25	-7.5%
Southern	Expansion	Male 35 and Over	795,461	$ 648.52	$ 706.15	-8.2%
				Delivery Case Rate		
All Regions	TANF/CHAP Child	All	419	$ 6,186.68	$ 5,990.17	3.3%
All Regions	TANF/CHAP Adult	All	10,505	$ 6,186.68	$ 5,990.17	3.3%
All Regions	Check Up	All	9	$ 6,186.68	$ 5,990.17	3.3%
All Regions	Expansion	All	1,567	$ 6,186.68	$ 5,990.17	3.3%
				VLBW Case Rate		
All Regions	TANF/CHAP Child	All	199	$ 138,070.15	$ 130,510.66	5.8%
All Regions	TANF/CHAP Adult	All	-	$ -	$ -	0.0%
All Regions	Check Up	All	-	$ 138,070.15	$ 130,510.66	5.8%
All Regions	Expansion	All	-	$ -	$ -	0.0%
				Composite PMPM		
All Regions	TANF/CHAP Child	All	3,303,175	$ 158.24	$ 164.37	-3.7%
All Regions	TANF/CHAP Adult	All	818,537	$ 423.36	$ 425.52	-0.5%
All Regions	*All TANF/CHAP*	*All*	*4,121,712*	*$ 210.89*	*$ 216.23*	*-2.5%*
All Regions	Check Up	All	246,491	$ 114.72	$ 130.72	-12.2%
All Regions	Expansion	All	3,335,616	$ 470.32	$ 512.76	-8.3%
All Regions	**All COAs**	**All**	**7,703,818**	**$ 320.14**	**$ 341.89**	**-6.4%**

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.