November 4, 2021

Mr. Jeremy Brunssen
Deputy Director of Finance & Program Integrity
Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

PROPRIETARY AND CONFIDENTIAL

Subject: Nebraska Heritage Health January 1, 2022 - December 31, 2022 Rate Development

Dear Jeremy:

Thank you for the opportunity to assist the Department of Health and Human Services (DHHS) with the development of the Heritage Health capitation rates. It was a pleasure to work with your team throughout this project. The following report summarizes the methodology for the development of the capitation rates, effective January 1, 2022 – December 31, 2022. We have also provided our actuarial certification for these rates, compliant with CMS guidelines and requirements. Please send me an e-mail at Barry.Jordan@Optumas.com or call at 480.588.2492 if you have any questions.

Sincerely,

Barry Jordan, FSA, MAAA
Consulting Actuary

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State of Nebraska

Heritage Health Actuarial Certification

January 1, 2022 – December 31, 2022 Capitation Rates

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1. Executive Summary

This report provides documentation and actuarial certification for the Nebraska Heritage Health capitation rate development for rates effective January 1, 2022 – December 31, 2022 (CY22). The capitation rates for the newly eligible Heritage Health Adult (HHA) population effective with Medicaid Expansion beginning October 1, 2020 are also provided in a section within this certification letter.

The Nebraska Heritage Health Managed Care program was implemented on January 1, 2017, to allow the State of Nebraska (State) to deliver Physical Health and Behavioral Health Medicaid services to eligible members through an integrated, mandatory, managed care framework. Services are provided via managed care entities, known as Managed Care Organizations (MCOs). Currently there are three contracted MCOs: Nebraska Total Care (NTC), United Health Care – Midlands (UHC), and Healthy Blue of Nebraska (HBN).

As the consulting actuaries to the State of Nebraska, **Optumas** ensured that the methodology used to develop the CY22 Heritage Health rates complied with the Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rates.

Optumas worked with the State to identify and develop the components of the rates, accounting for the covered services and populations as described in the Heritage Health contract. With that understanding, a reasonable base data set was identified that could then be adjusted for any anticipated program (population and benefits), health care system, and economic changes to reasonably and appropriately develop the 12-month rates for the Heritage Health program. This was an iterative process informed by the analysis of the effect of various adjustments upon the base data and the experience of **Optumas'** actuaries.

The final results were developed according to actuarially sound principles and reasonably reflect the experience projected for the January to December 2022 contract period for the Heritage Health program.

This report presents the capitation rate development process and its results in three sections, as described in Figure 1 below.

Figure 1. Report Structure

Section	Contents
Background	Provides a description of the Heritage Health program and context for rate development
Rate Development Process	Overview of methodology used when developing the capitation rates, including applicable data, adjustments, analyses, and assumptions
Rate Certification	**Optumas'** actuarial certification that the calculated rates comply with guidelines set forth by CMS

2. Background

This report provides documentation and actuarial certification for the Heritage Health capitation rate development, effective January to December 2022 (CY22). Heritage Health represents the integration of previous Behavioral Health and Physical Health managed care programs, as well as the incorporation of populations and services provided via Fee-for-Service (FFS) prior to January 1, 2017.

Effective October 1, 2020, individuals eligible under Medicaid Expansion are eligible for Nebraska Medicaid under the Heritage Health Adult (HHA) program, which includes the same benefit package as the non-HHA population. In addition to the remainder of the Heritage Health population, this report includes documentation and actuarial certification for the newly eligible HHA population's capitation rate development for rates effective CY22. These two programs are both referred to as "Heritage Health" throughout the remainder of this document.

2.01 Previous Managed Care Programs

Prior to September 2013, the State of Nebraska implemented a partial-risk Behavioral Health program in which services were delivered through an Administrative Service Organization (ASO). The full-risk Behavioral Health program was implemented in September 2013 to allow the State to deliver Behavioral Health Medicaid services to eligible recipients under a mandatory managed care framework. For the duration of the program, Magellan Behavioral Health was paid according to actuarially sound capitation rates.

The Physical Health Service Area 1 managed care program was implemented in August 2010 to allow eligible recipients in the 10-county region in the State of Nebraska to receive Medicaid services under a mandatory managed care framework. The Physical Health Service Area 2 managed care program was implemented in July 2012, expanding the managed care framework to include the remaining 83 counties in the State of Nebraska and to deliver Medicaid services to eligible recipients under a mandatory managed care framework. Historically, eligible members have received acute care services through a managed care organization as opposed to a FFS environment.

The State collaborated with actuaries to develop the actuarially sound rates for the Behavioral Health and Physical Health programs each year. The methodology evolved over time, but the foundation continued to be based on historical Nebraska-specific base data experience.

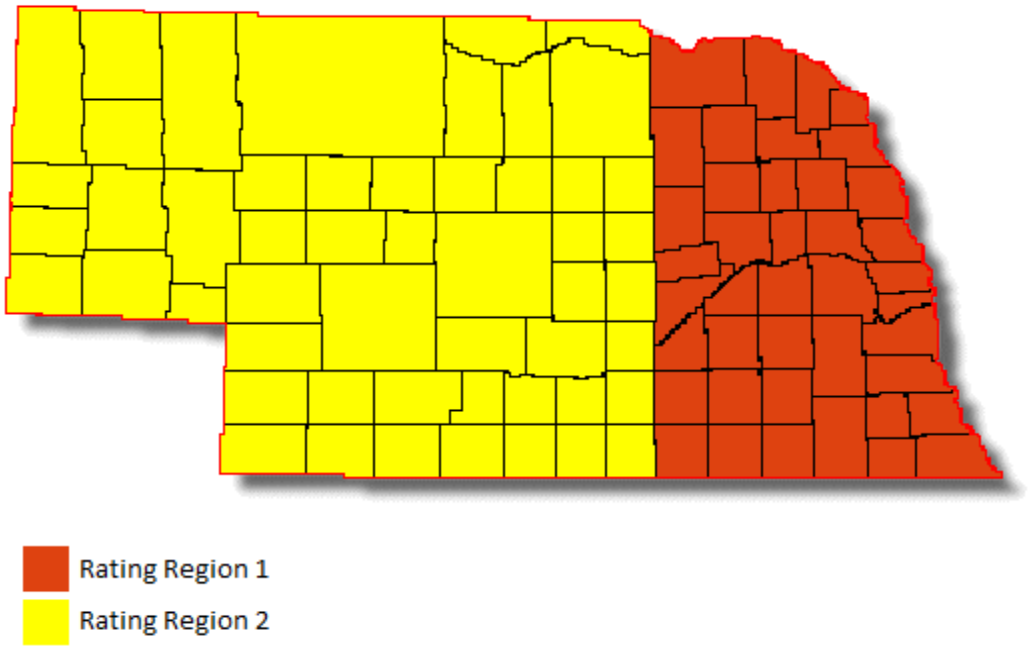
2.02 Heritage Health Changes

The Heritage Health program integrates the delivery of Physical Health and Behavioral Health services for a Medicaid recipient under a single MCO. The program also brings new services, populations, and periods of coverage into the managed care delivery system. The primary populations and services new to managed care under Heritage Health as of 1/1/2017 are pharmacy services for all populations, periods of retroactive eligibility for all populations, and acute care services for long term services and support (LTSS) recipients and dually-eligible members. Additional services and populations that transitioned to managed care under Heritage Health are described later in this report.

As the consulting actuaries to the State for the Heritage Health capitation rates, **Optumas** worked with the State to refine the existing rate setting methodology to be appropriate for the CY22 Heritage Health capitation rates. The Heritage Health rate setting process analyzes MCO encounter data and supplemental data provided by the State and MCOs to inform actuarial adjustments.

The Heritage Health program utilizes the same geographic Rating Regions as were used in the CY17-CY21 rate development to group similar cost areas together and minimize MCO geographic enrollment mix risk. The Rating Regions differ from the Physical Health managed care program's Service Areas due to the new populations and services covered under the Heritage Health program. Rating Regions were developed by reviewing the historical FFS, encounter, and supplemental data that contain the entire medical experience for the Heritage Health populations. Operational logistics were also considered to ensure rating regions represented both reasonable geographical groupings and similar cost counties were grouped together.

Upon conclusion of the regional analysis, it was determined that Rating Region 1 would consist of 41 counties: Antelope, Boone, Burt, Butler, Cass, Cedar, Clay, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Gage, Hamilton, Jefferson, Johnson, Knox, Lancaster, Madison, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Pierce, Platte, Polk, Richardson, Saline, Sarpy, Saunders, Seward, Stanton, Thayer, Thurston, Washington, Wayne, and York. Rating Region 2 consists of the remaining 52 counties: Adams, Arthur, Banner, Blaine, Box Butte, Boyd, Brown, Buffalo, Chase, Cherry, Cheyenne, Custer, Dawes, Dawson, Deuel, Dundy, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Kearney, Keith, Keya Paha, Kimball, Lincoln, Logan, Loup, McPherson, Morrill, Perkins, Phelps, Red Willow, Rock, Scotts Bluff, Sheridan, Sherman, Sioux, Thomas, Valley, Webster, and Wheeler. A map showing the two Rating Regions is below:



Optumas also ensured that the rate methodology complied with the CMS guidance for the development of actuarially sound rates.

3. Rate Development Process

3.01 Overview

In developing the Heritage Health rate methodology, **Optumas** adhered to guidance provided by CMS in accordance with 42 CFR 438.4 and 438.5, the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Additionally, **Optumas** ensured that all applicable ASOPs were followed during the rate development process. This includes, but is not limited to:

- ASOP 5 – Incurred Health and Disability Claims
- ASOP 23 – Data Quality
- ASOP 41 – Actuarial Communications
- ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 49 – Medicaid Managed Care Capitation Rate Development and Certification

Optumas specifically applied these criteria in the development of the methodology for calculating Heritage Health capitation rates for the CY22 contract period. Appendix I contains the 2021-2022 Medicaid Managed Care Rate Development Guide published by CMS. The appendix shows each section of the rate guidance along with a reference indicating how the Heritage Health rates comply.

The CY22 Heritage Health rates are based on January 2018 – December 2019 (CY18 and CY19) Heritage Health data paid as of May 2021, and reflect all known policy related to the Heritage Health program. The base data set is predominantly comprised of Heritage Health encounters, as well as FFS claims data for Non-Emergency Medical Transportation (NEMT) Non-Ambulance services carved into managed care July 1, 2019. Additionally, a small component of rate setting data includes non-encounterable medical expenditures. This component has been itemized via a rating adjustment. The remainder of this document briefly describes each of the components of the rate development.

While typically the most recent complete year of data (in this case CY20) would be included within the rate development base data, upon review of this year of data, **Optumas** believes that the COVID-19 pandemic renders the CY20 data unusable for rate setting without considerable adjustments and normalization for the variety of externalities present within the experience. As a result, the normal incrementation of the base data was not conducted for this rate cycle. **Optumas** instead decided to use the same base data time period as last cycle, ensuring more consistency in the rate development process.

As previously mentioned, the base data are comprised of CY18 and CY19 encounter data and any applicable supplemental data and estimates that are not included in the reported encounter data, as well as FFS data for applicable NEMT Non-Ambulance services. Additionally, financial reports submitted by the Heritage Health plans supplemented the encounter data. Once the base data were compiled, the State and **Optumas** met with each health plan to ensure the summarization of their encounter data accurately reflected their expenditures in CY18 and CY19. Every health plan indicated complete data were submitted and the data were aggregated and summarized appropriately. Once the base data were validated, the State and **Optumas** worked in partnership to determine all adjustments needed to ensure that the adjusted base data set was an appropriate proxy for the expected contract year experience. The adjustment categories are presented below in Figure 2.

Figure 2. Rate Development Process Adjustments

Adjustment	Overview
Base Adjustments	Adjustments necessary to complete the CY18 and CY19 data so the total cost of care for covered services and populations is reflected in the base data (e.g. IBNR, non-claim payments, etc.)
Program Changes and Policy Adherence	Historical and prospective program (population and benefit) changes not reflected in the adjusted base data, and other adjustments to ensure the rates adhere to State Policy
Trend	Factors to account for the forecasted change in utilization and unit costs from the base to the contract period
Non-Medical Loading	Administrative load to account for non-medical expenditures incurred by an MCO and a profit, risk, and contingency margin

The remainder of this report provides further detail on each of the adjustment categories above.

3.02 Base Data

Data Reporting

The base data set is comprised of detailed encounter data and supplemental data extracts containing information not included in the detailed CY18 and CY19 encounter data, in addition to FFS data for NEMT Non-Ambulance services that have been carved into managed care effective July 2019. The Rating Regions and Categories of Aid (COA) used within rate development are consistent with those used in the CY21 rate development.

In addition to encounter data, **Optumas** also received the following supplemental financial information, outlined below:

- Heritage Health MCO supplemental financial reports for dates of service 1/1/2018 – 6/30/2021
- Critical Access Hospital settlement estimates
- Supplemental payments related to: Case Management Capitation Payment, Uninet Withhold, Risk Share Paid, Capitation Variance, and Other Medical Expenses
- Supplemental data related to the impact of changes in MCO contracting pertaining to Pharmacy Benefit Manager (PBM) arrangements

Optumas utilized a monthly, member-level eligibility file to identify members enrolled with a Heritage Health MCO in CY18 and CY19.

Covered Services

The Heritage Health Managed Care Program covers a range of acute care, mental health, and substance abuse services to eligible members. Covered services are summarized below in Figure 3:

Figure 3. Heritage Health Covered Services

Covered Services
Dialysis
DME/Supplies
Emergency Room
Emergency Transportation
EPSDT
Family Planning
FQHC/RHC
Home Health
Hospice
IHS
Inpatient Hospital
Lab and Radiology
Non-Emergency Transportation - Ambulance
Non-Emergency Transportation - Non-Ambulance
Other Care
Other Professional
Outpatient Hospital
PCP
Specialist
Vision
Rx
Behavioral Health - IP
Behavioral Health - OP
Behavioral Health - Other
Behavioral Health - Residential

Covered Services Notes:

- Home and Community Based Services, Nursing Facility, Dental, and School-based services are excluded from Heritage Health.
- Effective July 1, 2019, NEMT Non-Ambulance services are covered by the Heritage Health MCOs.

Covered Populations

The encounter data were summarized into rating cohorts that represent different levels of risk, referred to as the following COAs:

- Aged, Blind, and Disabled (AABD)
- Children's Health Insurance Program (CHIP)
- Family – Adults and Children (Family)
- Foster Care/Wards (Foster Care)
- Katie Beckett
- Healthy Dual
- Dual LTC
- Non-Dual LTC
- Dual Waiver
- Non-Dual Waiver
- Refugee Resettlement Population

Effective July 1, 2019, a few new populations enrolled into Heritage Health. These populations include the Refugee Resettlement and State Disability populations, as well as the Share of Cost Clients in certain living arrangements who had previously not been enrolled in managed care. Consistent with the CY21 rate development cycle, the State Disability population is a part of the AABD cohort depending on a member's age. Based on the historical experience, the Share of Cost Clients in certain living arrangements will continue to be classified under the AABD, Family, or Healthy Dual cohorts. The Refugee Resettlement population will remain a separate cohort.

Effective October 1, 2020, members are also newly eligible for Medicaid in Nebraska via Medicaid Expansion. This population is referred to as the HHA population; the CY22 capitation rates for the HHA population are described further in this certification letter.

Some COAs are further split by age and/or gender, when appropriate, to group similar risk profiles together and insulate the MCOs, the State, and CMS from mix risk as much as possible. Due to the size of the Katie Beckett and 599 CHIP populations, a single statewide rate is set for each cohort. In the accompanying Excel exhibits included as Appendix II of the document, all Katie Beckett and 599 CHIP membership and experience have been grouped in Rating Region 1 for display purposes. The same rate will be paid to Rating Region 1 and Rating Region 2 for these populations.

While the Refugee Resettlement population is eligible for federal medical assistance through the Refugee Medical Assistance Program (RMAP) and is not Medicaid-eligible, the population will be enrolled in Heritage Health, and therefore the January – December 2022 capitation rate has been included in this submission. The capitation rate has been developed on a statewide basis and is shown in tab |3. Plan Rates| of the accompanying Excel file, titled "Appendix II. Heritage Health CY22 Capitation Rate Certification Exhibits."

Nebraska's Heritage Health program does not currently cover the following population groups:

- Aliens who are eligible for Medicaid for an emergency condition only
- Clients who have excess income or who are designated to have a premium due
- Clients participating in an approved DHHS PACE program
- Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles
- Clients who reside in a correctional facility

- Clients who have manually entered a waiver of managed care

Heritage Health covers periods of retroactive eligibility up to 90 days prior to a member's enrollment in a health plan. **Optumas** incorporated expenses and member months for retroactive periods in the capitation rate development as part of the base data. Analysis of capitation payments was used to determine retroactive coverage periods. For example, if a capitation payment was paid in July for May eligibility, that is indicative of retroactive eligibility. Retroactive enrollment volume was reviewed across plans and determined to be reasonably and evenly distributed in the more recent snapshot months, making a combined retroactive and prospective capitation rate appropriate.

3.03 Base Data Adjustments

Additional details around the Base Data Adjustments, including the impact by COA and Rating Region, can be found in tab |1a. Rate Summary - HH| of the accompanying Excel file titled "Appendix II. Heritage Health CY22 Capitation Rate Certification Exhibits."

Incurred but not reported (IBNR)

Optumas analyzed the claim payment lag by category of service (COS) through the incurred but not reported (IBNR) analysis. Upon review of historical payment patterns and consideration of the amount of runout (17 months) from the CY18-19 base data period, it was determined that no IBNR adjustment was necessary for the CY18-19 period.

Part D Copay Adjustment

The capitation rates must be developed consistent with State Plan authority with regards to all enrollee cost share policies. The State does not pay cost-sharing amounts associated with Medicare Part D covered drugs per its State Plan. There were instances where Medicare Part D copays were paid by the MCOs in the encounter data, so **Optumas** removed them from the base data. Supplemental data extracts and/or data flags identifying all Part D copayments were provided by each MCO and used to remove the appropriate expenditures. This adjustment results in a reduction of 0.29% for Rating Region 1 and a reduction of 0.33% for Rating Region 2 in CY18. This adjustment results in a reduction of 0.02% for both Rating Region 1 and Rating Region 2 in CY19.

HRC/LRC Adjustment

Optumas calculated and applied an adjustment to account for cost settlements made outside of the detailed data to the Hastings Regional Center (HRC) and Lincoln Regional Center (LRC) Psychiatric Residential Treatment Facilities (PRTFs). **Optumas** relied upon estimates provided by the MCOs to account for the incremental cost differences between the PRTF paid amounts inherent in the encounter data and the ultimate payment amount to these providers after all cost settlements.

Critical Access Hospital Settlements

MCOs are required to pay Critical Access Hospital (CAH) settlements, which were estimated based on MCO-provided estimates and validated using previous settlement data. **Optumas** added these additional payments into the base data used in the development of the Heritage Health rates.

Supplemental Payments

The CY18 and CY19 financial information provided by the Heritage Health MCOs included additional expenditures that are processed outside of the encounter data, such as incentive payment arrangements with contracted providers as well as CY19 expenditures for NEMT services reported by one MCO that was not included within the original detailed claims data extract. **Optumas** added these additional payments into the base data used in the development of the Heritage Health rates.

3.04 Program Changes and Policy Adherence

The State has implemented several program changes and policy adherence adjustments that impacted the service costs and were not reflected in the base data. **Optumas** considered any prospective program change adjustments necessary to project the base to the contract period. **Optumas** and the State worked in partnership to determine the impact of the program changes on the projected capitation rates, and to make any other necessary adjustments to align the capitation rates with state policy. Additional details around the program changes and policy adherence, including the impact by COA and Rating Region, can be found in tab |1a. Rate Summary - HH| of the accompanying Excel file titled "Appendix II. Heritage Health CY22 Capitation Rate Certification Exhibits."

Note that, unless otherwise stated, the aggregate impacts noted within this section refer to the impact to the non-HHA population. This is because the majority of the program changes have been developed prior to the blend of the Family and Disabled experience used as the starting point for the HHA population rates, discussed in more detail later in this document.

Pharmacy Benefit Manager Contracting Impact

By the end of CY19, all Heritage Health MCOs transitioned from a PBM spread pricing arrangement to a pass-through model arrangement per contractual requirements. One MCO has historically operated under a pass-through model with its contracted PBM. The other two MCOs provided supplemental information related to the expected change in pharmacy medical expenditures moving from spread pricing reimbursement to the contracted pass-through arrangement in place for CY22. **Optumas** relied upon this information to make an adjustment to the base data to reflect the estimated impact of these contracting changes. Consistent with the CY21 rate development, consideration was made in the development of the non-medical load (NML) to account for reasonable additional administrative expenditures related to the change in PBM contracting arrangement. The impact of the adjustment to CY18 medical expenditures results in a reduction of 1.53% to Rating Region 1 and a reduction of 1.42% to Rating Region 2. The impact of the adjustment to CY19 medical expenditures results in a reduction of 0.57% to Rating Region 1 and a reduction of 0.53% to Rating Region 2.

Base Data Blend

After accounting for the PBM contracting impact, the two years of data (CY18 and CY19) were aggregated together to develop a blended two-year base. All adjustments and impacts described below are applicable to the combined CY18-19 two-year base.

HIPP Population Adjustment

Effective January 1, 2022, Medicaid members enrolled in the Health Insurance Premium Payment (HIPP) program will no longer be part of, nor subsequently have paid on their behalf, a capitation rate for one of the current Heritage Health rating cohorts; instead, separate capitation rates will be paid to the MCOs for members enrolled in HIPP. The HIPP-specific rate development will be described further in this document, however the first step in this process requires that HIPP individuals enrolled in CY18-19 be excluded from the non-HIPP rate development process. **Optumas** worked with the State to identify individuals and corresponding member months for individuals enrolled in HIPP in the CY18-19 base data. Once these individuals were identified, all enrollment, expenditures, and utilization were removed from the development of the Heritage Health capitation rates.

The impact to the blended CY18-19 base data as a result of excluding the HIPP members' experience, normalized based on the updated membership after the omission of HIPP members, is an increase of 0.13% to the aggregate Rating Region 1 experience and an increase of 0.03% for Rating Region 2.

Reinsurance Recoveries

The Heritage Health rates are built in a manner that reflects reinsurance recoveries as a reduction to medical expenditures and considers reinsurance premiums in the development of the administrative load. **Optumas** has observed changes in MCO reinsurance arrangements in recent years as reported in the quarterly MCO financial templates, which include adjustments to the underlying deductible and payout formulas since the CY18-19 base period. Upon review of the revised reinsurance arrangements, the adjustment this cycle has been revised to reflect expectations under the new MCO reinsurance thresholds and therefore, this adjustment is considerably less impactful for CY22 than it was in CY21. This adjustment has no impact for Rating Region 1 and reduces the experience by 0.15% for Rating Region 2.

FQHC and RHC Repricing

Optumas applied an adjustment to account for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rate changes.

Optumas adjusted the RHC rates inherent in the encounter data to be commensurate with the RHC rates effective July 2021. Since RHC rates are updated every July, it is expected that there will be an increase in RHC rates effective July 2022. As a result, the July 2021 rates were compounded for a half year of growth at the historical encounter growth rate of 1.7%, for an approximate increase of 0.85% to reflect the expected increase half-way through the contract period.

Optumas adjusted the FQHC rates inherent in the encounter data to be commensurate with the CY21 FQHC APM rates for applicable facilities. The CY22 rates have not been released yet, however it is expected there will be an increase in FQHC rates that will be effective January 2022. As a result, the CY21 APM rates were adjusted for a projected year of growth at the historical growth rate of 2.2%. For those facilities not operating under an APM, the data was adjusted for the CY21 PPS rate, grown at an expected market basket increase of 2.2% to CY22.

The impact of the FQHC and RHC adjustments is a 0.20% increase to Rating Region 1 and a 0.16% increase to Rating Region 2.

IHS Repricing

Optumas calculated and applied an adjustment to account for Indian Health Service (IHS) encounter rate changes. The IHS providers are paid a per-encounter rate of $519 in CY21 for non-inpatient services rendered at traditional IHS clinics, as well as for prescriptions filled at an IHS pharmacy. The CY22 encounter rate is not known, so **Optumas** estimated it as $554 by applying the average growth in the encounter rate over the last six years. No IHS inpatient hospital services were identified in the base data, so no inpatient per-diem repricing was conducted. The repricing of IHS services to the latest encounter rate increases Rating Region 1 by 0.24% and increases Rating Region 2 by less than 0.01%.

Hospice Rate Change

Optumas applied an adjustment to reflect the fee schedule change for hospice services. The services were repriced at the rates effective October 2020 – September 2021, projected forward to CY22 using a case-mix assumption of 0.5%. The impact of this fee schedule change was an increase of less than 0.01% to Rating Region 1 and Rating Region 2.

APR DRG Changes

Effective January 1st, 2020, MCOs were expected to migrate to APR-DRG grouper version 36. Version 36 of the APR-DRG grouper includes many intentional payment changes, such as increasing funding for neonate services and decreasing funding for other hospital services. In order to determine the correct COA-level impact of APR-DRG version 36, **Optumas** priced the data at v34/v35 and then repriced it at v36. For this analysis the hospital base rates were held constant to isolate the impact of the grouper version change. This analysis showed an increase of 1.0% to APR-DRG services, concentrated in COAs that have newborns (Family Under 1, Foster Care, etc.). **Optumas** then priced the data again at v36 with the FY22 hospital base rates and cost-to-charge ratios in addition to half of the expected 2% increase effective July 1st, 2022, to reflect the rates covering the entire CY22 contract period. The updated hospital rates resulted in an additional 3.6% increase, which is slightly less than the expected change using solely base rates due to the fluctuating changes in cost-to-charge ratios. Taken together, the full change from the APR-DRG reimbursement structure in place during the base period to the v36 grouper with FY22 base rates, plus the approximate 1% to account for the mid-year 2% fee increase, was a 4.7% increase to all APR-DRG reimbursed services. Last cycle's adjustment was a 3.0% increase, so this outcome is consistent with the expected change when the base rates increase by 2%. When added to the full rates inclusive of all other services, the impact of the APR-DRG change is a 0.65% increase to Rating Region 1 and a 0.53% increase to Rating Region 2.

DME Reimbursement Change

Effective July 1st, 2018, the State's reimbursement for durable medical equipment (DME) services that are covered by both Medicaid and Medicare was changed to pay, at a maximum, the Medicare reimbursement rate. This represents a reduction in reimbursement for 49 procedure code/modifier combinations and an increase for one combination. **Optumas** repriced the MCO encounter data by applying the percent change in the procedure code/modifier combination between the Medicaid fee schedule effective prior to July 1st, 2018 and the revised DME fee schedule, to the first half of the CY18 encounter data.

There were also fee schedule changes that went into effect through July 1st, 2021. **Optumas** applied the percent change from the fee schedules in place at the time of each service up to the fee schedule effective July 1st, 2021, for the entire base data to account for the changes in the fee schedules through July 1st, 2021. An additional 1% increase has also been applied to these services to reflect the 2% provider fee change effective July 1st, 2022 that will be effective for half of the contract period. The DME repricing results in a reduction of 0.04% to Rating Region 1 and a reduction of 0.05% to Rating Region 2.

General Provider Fee Change

In the spring of 2019, the Nebraska State Legislature passed a 2% across-the-board fee change for most physical health services and a 4% across-the-board fee change for most behavior health services, effective July 1st, 2019 and July 1st, 2020. Select services and providers are excluded from this fee change including pharmacy services, FQHCs, RHCs, IHS providers, CAH outpatient services, and enhanced primary care services. **Optumas** identified the excluded providers and services and applied the appropriate 2% or 4% fee change to the non-excluded providers and services for the change effective July 1st, 2019 and July 1st, 2020.

Additionally, in 2021 a 2% across-the-board fee change for most physical health and behavioral health services was approved effective July 1st, 2021 and July 1st, 2022. Consistent with the approach above, applicable providers and services were identified and then the appropriate 2% increase was applied for the increase effective July 1st, 2021, and 1% was applied for the increase effective July 1st, 2022 to reflect the fact that this is effective for only half of the CY22 contract period.

Note that the impact of the provider fee increases for inpatient services reimbursed via APR-DRG are included within the APR-DRG adjustment described above. Likewise, outpatient services impacted by the EAPG program change (described in more detail below) are all captured within the EAPG program change impact. Additional services priced separately and exempted from the 2% across-the-board fee change include HRC/LRC services, clinical lab services, and DME repriced services. The impact of this across-the-board fee schedule change is an increase of 3.12% to Rating Region 1 and an increase of 2.76% to Rating Region 2.

EAPG Program Change

Effective January 1st, 2020, Nebraska implemented the Enhanced Ambulatory Payment Grouping (EAPG) system (version 3.14) for payment of most outpatient hospital services (bill type codes 13X or 14X). Navigant Consulting worked with various stakeholders, including DHHS, the MCOs, and hospitals, to develop hospital base rates and peer groups for January 1st, 2020 - June 30th, 2020. Base rates were developed by Navigant to account for growth at the CMS Market Basket inflation factor from the CY17 analysis period to the January 1st, 2020 – June 30th, 2020 projection period. Because of this, Nebraska's transition to EAPG is not anticipated to be budget neutral to base expenditures, since it includes a measure of anticipated unit cost growth.

To calculate the rating adjustment, **Optumas** first validated the CY17 work performed by Navigant and then priced the CY18 and CY19 base data underlying the Heritage Health rate development at the national EAPG v3.14 weights developed by Navigant. **Optumas** compared this pricing to emerging CY20 data to validate the pricing impact, and it showed actual CY20 paid amounts consistent with the repriced values. **Optumas** also benchmarked this data against the rating adjustment applied last cycle and found it was a very similar impact to what was applied to the CY21 rates.

In addition to the baseline EAPG change, there is an additional program change exempting revenue code 510 from EAPG reimbursement. After validating that the previous application of EAPG was producing consistent and expected results, **Optumas** re-ran the grouper excluding revenue code 510. The output from this run of EAPG was also priced at the FY22 hospital base rates plus an additional 1%, accounting for the 2% provider fee change effective July 1st, 2022.

The combined impact of the EAPG pricing, the revenue code 510 exclusion, and the FY22 hospital base rates plus the additional 1% for the July 1st, 2022 fee change, is an 8.2% increase to CY18 and a 7.9% increase to CY19. These increases are relative to the services that will be reimbursed via EAPG. When added to the full rates inclusive of all services, the final impact of converting the base data from the historical cost-to-charge reimbursement to EAPG v3.14 reimbursement represents a 1.23% increase to Rating Region 1 and a 0.03% decrease to Rating Region 2.

Copay Adjustment

Capitation rates are required to be developed assuming the collection of copays consistent with State Plan authority. The Heritage Health MCOs frequently do not require members to pay copays as a value-added benefit. Using State Plan design information, **Optumas** identified all services and populations with a copay requirement and reviewed the data for any copay collections. If a copay was not collected, **Optumas** removed the copay amount from the base data paid amount. The impact of reducing the base data to reflect full copay collection is a 0.28% reduction to Rating Region 1 and a 0.27% reduction to Rating Region 2.

Benefit Limit

Similar to the copay adjustment, capitation rates must be developed enforcing all applicable benefit limits. Effective January 1st, 2020, the previous chiropractic visit limit was removed. However, the limits for rehab visits, hearing aids, and eyeglasses for certain Medicaid populations will still be enforced by the State. MCOs can choose whether to enforce benefit limits, but the State reimburses assuming limits are enforced. The impact of this adjustment was calculated by removing any services from the base data that exceeded the utilization limits required by the Medicaid State Plan. This adjustment results in a reduction of 0.01% to Rating Region 1 and a reduction of 0.02% to Rating Region 2.

Chiropractor Services Adjustment

Effective January 1st, 2020, Nebraska changed three policy elements pertaining to chiropractic services:

1. The 12 visit-per-year cap in place for adults will be removed.
2. Chiropractors will be allowed to bill Evaluation and Management (E&M) codes.
3. Chiropractors will be allowed to bill select physical therapy codes.

Optumas evaluated the impact of these policy changes in the order listed above. First, the visit limit removal was modeled by reviewing adults receiving 10-12 visits a year and comparing the distribution of visits to that of the child population, which did not previously have a visit limit. Changing the adult visit distribution for those approaching or meeting the visit limit to reflect the limitless distribution of the child population results in 8,715 new chiropractic visits on a 2-year basis. At the previous per-visit cost, this is worth $0.3M in additional expenditures on a 2-year basis (relative to CY18-19 base). Next, **Optumas** analyzed emerging CY20 experience to evaluate the frequency of chiropractic visits with a billed E&M or physical therapy code. This analysis has driven **Optumas** to reduce the previous CY20

assumptions for total chiropractic visits with a billed E&M or physical therapy code to reflect emerging experience. Pricing these visits at the base data reimbursement level when they occurred bundled with a chiropractic service results in $1.23M in additional funding for the new E&M codes and $0.94M in additional funding for the new physical therapy codes on a 2-year basis.

Overall, the policy changes to chiropractic services results in a 0.10% increase to Rating Region 1 and a 0.17% increase to Rating Region 2.

Clinical Lab Fee Change

The fee schedule for clinical lab services generally changes effective dates every six months. The impact of these fee schedule changes is applied to the historical data by taking the percent change in reimbursement from the fee at the time of service to the most recent known fee (effective July 1st, 2021), for each procedure code/modifier combination, and applying it to the base data paid amount. The impact of this fee schedule change is a reduction of 0.03% to Rating Region 1 and a reduction of 0.02% to Rating Region 2.

PDN LPN Rate Change

Private Duty Nurse (PDN) and Licensed Practical Nurse (LPN) services received a targeted rate increase effective January 1st, 2020. The historical spend for the two procedure codes used to bill this service, S9124 and S9124-TG, were priced at the new fee in place effective January 2020. The impact of repricing these services to the latest known fee schedule results in an increase of 0.10% to Rating Region 1 and an increase of 0.01% to Rating Region 2.

Targeted Behavioral Health Rates

Per Nebraska LB1008, effective July 1, 2020, certain behavioral health-related services have been targeted for increased rates. These include certain psychotherapy, substance abuse assessment, and day rehabilitation services. These services were identified within the CY18-19 base data and adjustments have been made commensurate with the targeted rate increase applicable for each applicable service.

The impact of this targeted rate increase is a 0.81% increase in Rating Region 1 and a 0.92% increase in Rating Region 2.

PRTF Bedhold

PRTF leave days are reimbursed at 50% of the PRTF per-diem rate. **Optumas** calculated the impact of this program change by looking within PRTF utilization for therapeutic leave bedhold revenue codes and procedure code modifiers and pricing those services at the most recent fee schedule, which reflects the 50% reimbursement policy. Reducing the reimbursement for PRTF days where the member was on therapeutic leave results in a reduction of 0.06% to Rating Region 1 and a reduction of 0.03% to Rating Region 2.

Medication Assisted Treatment (MAT) and Medically Monitored Withdrawal (MMW) Adjustment

Nebraska pursued a Substance Use Disorder (SUD) Institute for Mental Disease (IMD) Section 1115 waiver. As part of CMS's approval of that waiver, Nebraska must cover medication assisted treatment

(MAT) and medically monitored withdrawal (MMW) services. **Optumas** determined the cost for these new services based on a combined review of other state experience and the prevalence of SUD in Nebraska Medicaid.

For MAT, **Optumas** identified the number of people in Nebraska Medicaid diagnosed with an opioid dependence. This was 1,172 individuals in CY18 and 1,195 individuals in CY19. Based on discussions with DHHS on the availability for providers to serve individuals with a need and the national treatment rate for opioid disorders, **Optumas** assumed 20% of these individuals will receive MAT treatment. The treatment distribution is assumed to be approximately 53% methadone, 46.5% buprenorphine (including implants and injectables), and 0.5% naltrexone. The most recent Nebraska Medicaid fee schedule was used to price out treatment costs, inclusive of intake fees, counseling, naloxone, and dosage checks. Annual treatment costs for the projected mix of drugs ranges from $8,000 to $8,500 for new patients and $6,000 to $6,700 for established patients. Effective January 1, 2020, methadone services are being covered under Medicare. To account for the change for these services, **Optumas** reduced the Dual cohorts' costs by 80% to account for an estimate of cost share which would be Medicaid's responsibility.

To determine the MMW costs, **Optumas** looked at individuals with a SUD diagnosis who received inpatient detox services during CY18 and CY19. This showed 3.3% of individuals with a SUD requiring detox. Potential individuals with a SUD were increased by 50% to reflect the expected prevalence of undiagnosed individuals. **Optumas** assumed these individuals will receive an average of 14 days of MMW, consistent with national averages. The days were priced at a per-diem rate of $453.56, consistent with the most recent fee schedule.

Overall, the combined impact of MAT and MMW results in an increase of 0.29% to Rating Region 1 and an increase of 0.24% to Rating Region 2.

Halfway House Adjustment

Effective July 1st, 2020, DHHS has increased its halfway house rates to a $117.59 per-diem to match what the Division of Behavioral Health (DBH) pays for the service. While the historical experience for halfway house utilization for the non-HHA population within Medicaid had historically been de minimis, there has been a moderate increase in the utilization of halfway house utilization for non-Expansion members after the implementation of the July 1st, 2020 reimbursement change. **Optumas** reviewed the emerging non-Expansion PMPM experience from September 2020 – January 2021 to estimate the level of expected halfway house utilization for the non-Expansion population in the CY22 contract period.

The overall impact of this adjustment is an increase of 0.02% to Rating Region 1 and a 0.01% increase to Rating Region 2.

Disenrollment Freeze

As part of the CY21 mid-year rate adjustment, **Optumas** incorporated an acuity adjustment for the Family/CHIP Children (excluding newborns) and Family 21+ populations. As discussed during the mid-year rate development process, this included an estimate of continued enrollment increase throughout the duration of CY21.

With the combination of the churn rate and acuity changes during the March 2020 – December 2021 timeframe, a disenrollment freeze impact estimate was developed for the July-December 2021 mid-year

rate adjustment. The underlying enrollment growth for this adjustment reflected a blend of projected enrollment growth over the course of the July – December 2021 experience period. Since the CY22 rates would presumably begin with enrollment volume at the level of growth through December 2021, the adjustment inherent in the CY22 rates reflects the estimated acuity differential for December 2021 as presented during the CY21 mid-year rate presentations. While the general process is the same as that of the mid-year rate adjustment, the use of the December 2021 projected acuity differential results in a slightly more material adjustment, with a -4.1% impact for the Family/CHIP Children cohorts and -3.1% for the Family 21+ population.

At this point, it is uncertain whether the Public Health Emergency (PHE) and subsequent disenrollment freeze will end December 31, 2021 or be extended beyond this period. Additionally, it is uncertain how long the redetermination efforts will last, particularly given CMS's recent guidance indicating that states have up to 12 months to complete the redetermination processes. As a result, there is currently no explicit assumption that the excess enrollment will either continue to grow beyond CY21, nor that members will disenroll during the course of CY22. With this understanding, **Optumas** and the State will continue to monitor policy changes at the federal level as well as expectations as to the speed of disenrollment once further guidance and processes are implemented. To the extent that these changes result in an expected reduction in utilization during CY22, **Optumas** anticipates that an adjustment will be made to the acuity adjustment via a mid-year amendment to the rates if deemed necessary.

The impact of this change across all populations is a decrease of 1.52% in Rating Region 1 and a decrease of 1.65% in Rating Region 2.

COVID-19 Testing

The cost of COVID-19 testing was estimated based on historical experience and an estimation of the range of possible outcomes in the CY22 contract period. **Optumas** identified COVID-19 testing expenses incurred from February 2020 through April 2021 in the detailed claims data using the State's Medicaid fee schedule. The expenses identified in CY20 benchmarked consistently with the supplemental data extract provided by the MCOs in the Spring of 2021, indicating a full and complete identification of services. **Optumas** then considered what COVID-19 testing experience might look like in CY22 and developed a lower bound and upper bound estimate. The thought process underlying the lower bound is best characterized as an elevated baseline, where testing is not anywhere near the peaks that have been experienced during COVID-19 case spikes, but also is not as low as it has been for parts of CY20 and CY21. This could occur if negative test results are required for certain societal functions (school, sporting events, concerts, etc.). The upper bound scenario imagines that another few COVID-19 spikes occur every four to five months during CY22, but that none of them is as severe as the winter of late CY20 to early CY21 due to the increased vaccination rates of Nebraskans. This range estimate was created by selecting months from the base data that reflect a level of utilization consistent with the scenario described. The primary thought process underlying the scenario has been described above, but **Optumas** recognizes many possible scenarios can occur and the funding provided via this adjustment can cover alternative scenarios (e.g., the lower bound funding sufficiently covers a scenario of one spike followed by reduced testing, or the upper bound could cover fewer, larger spikes in COVID-19 cases, etc.).

The impact of this at the payment rate is an increase of 0.33% in Rating Region 1 and an increase of 0.32% in Rating Region 2.

3.05 Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major COS (e.g., inpatient, outpatient, etc.) and COA (e.g., AABD, Family, etc.). Prospective trends were applied from the midpoint of the CY18 and CY19 base (December 31st, 2018) to the midpoint of the contract period (July 2nd, 2022).

Prior to reviewing historical experience, **Optumas** first normalized the base data for programmatic and reimbursement changes to ensure that the impact of these changes was not duplicated as both a rating adjustment and as trend. Once this was done, the Heritage Health data were arrayed by COA, COS, and month of service so that historical utilization/1,000, unit cost, and PMPMs could be reviewed. These data were arrayed so that 3-month moving averages (MMAs), 6 MMAs, and 12 MMAs could be calculated. In general, a combination of these three metrics was used to determine prospective trend, but there is not a pre-determined algorithm in place, and varies based on nuances within a specific population or COS; given that prospective trend is a projection of future experience, it is necessary to make adjustments to consider that historical trend experience may differ from what will materialize in the future. For example, certain populations and services experienced large reductions in spend, but these negative trends were not projected into the contract period.

In addition to the review of emerging Heritage Health experience, trends were also reviewed for programs in other states in which **Optumas** develops rates and adjusted for programmatic differences. **Optumas** also reviewed recently published Medicare unit cost trends for certain services to ensure consistency for Dual-eligible populations.

Note that the underlying trends for the CY22 rate development have not changed from the trends utilized within the CY21 rate development process. Minor aggregate differences may be present to the extent that there are shifts in COS utilization mix and/or cohort mix underlying the updated CY18-19 base data used for the CY22 rates as compared with CY21.

3.06 HHA Methodology

In the development of the CY22 HHA capitation rates, **Optumas** has relied on historical experience for the currently eligible Family and AABD rating cohorts. Specifically, the experience underlying the rate development consists of Family 21+ M&F and AABD 21+ M&F CY18 and CY19 experience adjusted for all applicable base data and program changes up to the application of trend, which includes all changes up to and including the PRTF bedhold adjustment described above. A blend of the experience for these two cohorts is used to approximate the acuity differential between the HHA population and the currently eligible Heritage Health individuals. The following describes the steps taken to adjust the Family and AABD experience to estimate the PMPMs for the HHA population, in addition to laying out the impact of program changes that were developed with specific Expansion-related considerations.

Age Factors

Age and gender factors were developed and applied to the Family 21+ M&F and AABD 21+ M&F experience to better reflect the expected age/gender mix of the HHA population. Age/gender factors have been developed in two steps, and are described below:

1. Step 1 – Development of 'vertical' age/gender factors. This portion of the age/gender factor stratifies the current AABD and Family populations into separate 19-44 M, 19-44 F, and 45-64 M&F age/gender bands based on the PMPM difference for those age bands relative to the current AABD 21+ M&F and Family 21+ M&F populations. The 19 and 20-year-olds from the AABD 0-20, Family 6-20 M, and Family 6-20 F populations were also included.
2. Step 2 – Development of 'horizontal' age/gender factors, which adjust for the difference of the underlying age mix within 19-44 M, 19-44 F, and 45-64 M&F subpopulations in the base data for the current populations with the expected mix of the HHA population. In other words, this addresses the fact that the average age for the HHA population is expected to vary from the average age within the current Medicaid cohorts, even after stratifying into the 19-44 M, 19-44 F, and 45-64 M&F age/gender bands. This component of the adjustment is based on re-aggregating the PMPMs by discrete age using the underlying age/gender mix present in the 2017 ACS census data for populations expected to enroll in HHA and comparing the resulting PMPM to the PMPM by age/gender band for the current populations.

The combination of the 'vertical' and 'horizontal' age/gender factors results in an aggregate age/gender factor that is applied to transform the current populations' experience into an appropriate starting point for the HHA rating cohort structure. The impact by COA is shown in tab |1b. Rate Summary - HHA| within Appendix II.

AABD/Family Blend

After the application of the age/gender factors described above, blend assumptions were applied to capture the expected acuity differences between HHA enrollees and the current Family and Disabled populations, outside of the already captured demographic adjustments (i.e., age/gender factors) noted above. To approximate an acuity difference between HHA and Family beneficiaries, a blend of the Family and AABD experience was applied. The blend varies by age band to reflect the different acuities in different expansion subpopulations. The blend assumptions have been developed based on a review of implied acuity differences between the age adjusted TANF and Expansion populations in other Medicaid programs. The blend is heavily weighted towards the AABD experience for the populations designated as Medically Frail (this designation was used until October 1, 2021 and is not used in the contract period) due to the expected higher acuity of this population. The following blend assumptions have been applied to the HHA cohorts:

1. 19-44 M (Non-Medically Frail): 5% AABD, 95% Family
2. 19-44 F (Non-Medically Frail): 0% AABD, 100% Family
3. 45-64 M&F (Non-Medically Frail): 10% AABD, 90% Family
4. Medically Frail Cohorts: 95% AABD, 5% Family

The final AABD/Family blend utilizes the most recent emerging data on the portion of Non-Medically Frail and Medically Frail individuals by cohort to create an aggregate rate that reflects the current rating structure and no longer differentiates between Medically Frail and Non-Medically Frail.

The resulting impact of the AABD/Family blend is illustrated in tab |1b. Rate Summary - HHA| within Appendix II.

MAT/MMW Adjustment (HHA)

As noted in section 3.04 of this document, the CY22 Heritage Health capitation rate development includes an adjustment to reflect the expected increase in expenditures as a result of covering MAT and MMW services.

As a result of the expected differences in behavioral health needs between the TANF/Family and HHA populations, consideration was made to incorporate separate adjustments for the HHA population. For the non-Medically Frail portion of the population, **Optumas** increased the MAT/MMW PMPM incorporated into the Family 21+ M&F rates by 50%. This increase is based on review of a recent Kaiser Family Foundation report (published November 15, 2019) on the prevalence of opioid use disorder between Medicaid Expansion adults (6.9%) compared to non-disabled adults (4.7%).

In the development of the estimate for the Medically Frail portion of the HHA population, **Optumas** relied on the adjustment that was applied to the AABD 21+ M&F rate for CY22, given the assumption that the acuity of this population is more in line with a disabled population.

To develop an aggregate impact for the HHA capitation rates, given that there is no longer a distinction between Medically Frail individuals for capitation rate purposes, the emerging distribution of Medically Frail and non-Medically Frail individuals by HHA age/gender band was used to blend the PMPMs described above.

The overall impact of this adjustment is approximately a 0.71% increase to the HHA population.
The impact by COA is shown in tab |1b. Rate Summary - HHA| within Appendix II.

Halfway House Adjustment (HHA)

As discussed in section 3.04 of this document, the halfway house utilization for non-HHA populations has historically been very minimal. However, as expected and adjusted for within the CY21 rates, the utilization for the HHA population is materially higher. **Optumas** reviewed the emerging data from December 2020 – March 2021 for the HHA population and relied upon this PMPM experience to develop an adjustment to account for halfway house utilization for the CY22 contract period.

The overall impact of this adjustment is approximately a 0.32% increase to the HHA population.

The impact by COA is shown in tab |1b. Rate Summary - HHA| within Appendix II.

COVID-19 Testing

The process utilized to develop the COVID-19 testing adjustment for the non-HHA Heritage Health population, as described in section 3.04, is consistent with that used for the HHA population and relies on the specific utilization distribution of the HHA population.

The overall impact of this adjustment is approximately a 0.30% increase to the HHA population.

The impact by COA is shown in tab |1b. Rate Summary - HHA| within Appendix II.

3.07 Non-Medical Loading

The non-medical load (NML) measures the dollars associated with components such as administration, profit, and quality improvement (QI) expenses and are expressed as a percentage of the capitation rate. **Optumas** utilized reported administrative and profit levels in the financials submitted by the Heritage Health MCOs, and reviewed information provided by MCOs related to administrative cost changes resulting from changes in PBM contracting to develop the NML. Experience in other states and similar programs on both a PMPM and percentage basis were also reviewed to ensure reasonableness. Components of NML are determined based on reviewing Heritage Health MCO financial statements and allocating the total developed NML into each component using a similar percentage. This results in approximately 15% of non-medical loading being allocated to care management and care coordination services.

The emerging administrative expenditures through the first half of CY21 show a continued reduction in expenditures as a percentage of premium. This is attributed predominately to changes in MCO reinsurance arrangements and changes in managed care entities, and also correlates to a continual increase in enrollment as a result of the disenrollment freeze and continual ramp-in of the HHA population. As a result of these observations, the overall NML target in the CY22 capitation rates has been reduced from CY21 and is approximately 11.5% (9.5% admin, 2.0% profit/risk/contingency) across the entire Heritage Health population, inclusive of the HHA enrollment.

3.08 UNMC Directed Payment Arrangement

Description of Arrangement

Effective January 1, 2020 the State received CMS approval of the Percentage Increase directed payment arrangement methodology for applicable providers. The State is seeking approval for a renewal of this directed payment for January 1, 2022 – December 31, 2022; the payment arrangement has not yet been submitted or approved for the January 1, 2022 – December 31, 2022 contract period, but is consistent with the Uniform Percentage Increase pre-print that is expected to be submitted to CMS for review prior to the start of the CY22 contract period. Under this mechanism, in accordance with CFR 438.6(c)(2)(i)(B), a directed payment will be made for covered services provided by practitioners who are acting in the capacity of an employee or contractor of the public academic medical institutions. All services eligible for directed payments are billed under the federal employer number for the public entity. A directed payment will be made for the covered services provided or supervised by a faculty or staff member of an academic medical institution of a public university. For practitioners qualifying under this section, a

directed payment will be made. The payment amount will be the difference between payments otherwise made to these practitioners. The qualifying faculty or staff member shall be providing or supervising treatment as part of an approved program of the public academic medical institution to Medicaid enrollees covered under the Heritage Health Managed Care Plan.

This payment arrangement will apply to all qualified providers of the specific class identified above and will establish payment for Medicaid services covered under the Heritage Health Managed Care Plans. The Heritage Health Managed Care Plan will be required to adopt the State-directed uniform percentage increase directed payment arrangement for the providers identified as members of this specific class. Please refer to NE Medicaid State Plan, Attachment 4.19-B Item 5, Pages 3-4.

Payment Distribution

Under the arrangement described above, the Heritage Health Managed Care Plans will pay directed payments for services provided by practitioners who are acting in the capacity of an employee or contractor of the Public Academic Medical Institutions. These payments are made in addition to payments otherwise provided under the state plan to practitioners that qualify for such payments. Please see NE Medicaid State Plan, Attachment 4.19-B Item 5, Pages 3-4 for a description of the payment methodology, including information around applicable practitioners.

Rating Adjustment

As part of the rate development process, historical utilization of services provided by practitioners that meet the requirements of this arrangement has been identified within the base data. Currently, only providers affiliated with University of Nebraska Medical Center (UNMC) meet the requirement for this arrangement.

Optumas received a list of UNMC provider IDs from the State, which was used to identify claims and services attributed to UNMC providers within the CY18 and CY19 base data. The State also provided the most recent UNMC commercial-level fee schedules for the academic institution's top five commercial payers. The difference between the commercial rate and Medicaid customary rate (Medicaid fee schedule) for each procedure code underlying the data for UNMC providers was then calculated. This difference was calculated to arrive at a directed payment PMPM amount by COA, and it is the amount in excess of what would be paid at the Medicaid fee schedule up to the cap implemented by the State of $15.1M in total expenditures for the non-HHA population based on annualized CY18-19 enrollment; in addition, the 2% profit/risk/contingency load has been applied to this incremental PMPM amount. The resulting PMPM by COA is the amount built into the capitation rates to reflect the impact of implementing the uniform percentage increase directed payment.

The tables in tabs |1a. Rate Summary - HH| and |1b. Rate Summary - HHA| of the accompanying Excel file titled "Appendix II. Heritage Health CY22 Capitation Rate Certification Exhibits" show the statewide value of the PMPM adjustment described above, by rating cohort, for the addition of the uniform percentage increase directed payment adjustment. The directed payment PMPMs are subject to the same risk adjustment as the remainder of the CY22 rates; the application of risk adjustment is shown in column "RAR - UNMC" in tab |3. Plan Rates| of Appendix II. This reflects the directed payment portion of the capitation rates that are paid to each MCO for CY22.

This resulting UNMC adjustment is a 1.24% increase to Rating Region 1 and a 0.58% increase to Rating Region 2 for the non-HHA population.

For implementation into the HHA rates, this adjustment has been developed by starting with the UNMC directed payment PMPM developed for the Family 21+ M&F and AABD 21+ M&F cohorts. These PMPMs are converted for the HHA population by applying the same age/gender and acuity-related adjustments used within the development of the remainder of the HHA rates to arrive at HHA-specific directed payment amounts. The impact is a 0.85% increase to Rating Region 1 and a 0.26% increase to Rating Region 2 for the HHA population.

Additional Documentation

Additionally, per direction from the 2021-2022 Medicaid Managed Care Rate Development Guide, the following pertinent information should be referenced:

Control name of the state directed payment	**Type of payment**	**Brief Description**	**Is the payment included as a rate adjustment or separate payment term?**
This information is not yet available, as the pre-print has not yet been submitted to CMS.	Uniform Percentage Increase	Please reference the preceding subsection of Section 3.08, titled "Description of Arrangement".	Rate adjustment to the base capitation rates.

Control name of the state directed payment	Rate cells affected	Impact	Description of the adjustment	Confirmation on the rates are consistent with the preprint	For maximum fee schedules, provide the information requested in Section I 4.D.ii(a)(ii)E of 2021-2022 MC Rate Development Guide
This information is not yet available, as the pre-print has not yet been submitted to CMS.	All rate cells, with the exception of Duals (Healthy Dual, Dual LTC, Dual Waiver), HIPP populations, and Refugee population	See "UNMC Directed Payment Arrangement" section of tab |1a. Rate Summary – HH| and "UNMC Adj." section of tab |1b. Rate Summary – HHA| of Appendix II for impacts by COA and rating region.	Detail regarding how the directed payment is reflected within the certified capitation rates is included in the preceding subsection of Section 3.08, titled "Rating Adjustment".	Please reference the preceding subsection of Section 3.08, titled "Description of Arrangement".	N/A

3.09 HIPP Rates

Effective January 1, 2022, Medicaid members enrolled in HIPP will no longer be part of, nor subsequently have paid on their behalf, a capitation rate for one of the current Heritage Health rating cohorts; instead, separate capitation rates will be paid to the MCOs for members enrolled in HIPP. As a result, a separate development process for the HIPP cohorts is necessary this cycle.

As previously described in this narrative, **Optumas** worked with the State to identify individuals and corresponding member months for individuals enrolled in HIPP in the CY18-19 base data. Once these individuals were identified, all enrollment, expenditures, and utilization were removed from the development of the non-HIPP Heritage Health capitation rates. This data was then segmented such that the PMPM experience for the HIPP population compared to the non-HIPP population for each rating cohort could be reviewed (e.g., HIPP non-Dual Waiver PMPM could be compared to non-HIPP non-Dual Waiver PMPM, etc.).

Optumas reviewed the cost relativity between HIPP and non-HIPP individuals, based on a comparison of the CY18-19 base data from the HIPP populations to the subsequent non-HIPP populations, and mix-adjusted by cohort based on HIPP enrollment volume for CY18-19. The overall differential is 0.699, such that the Medicaid claims costs for the HIPP population on average are roughly 30% lower than those of

the corresponding non-HIPP population.

Once this cost relativity factor was calculated, it was applied to the CY22 capitation rate net of UNMC (aggregated at a statewide level) for each Heritage Health cohort to develop a COA-level HIPP PMPM estimate. Once these COA-level PMPMs were determined, specific cohorts were aggregated to arrive at a blended HIPP rate for CY22. The following are the proposed HIPP cohorts:

1. Disabled/Non-Dual Waiver – this consists of the AABD 00-20, AABD 21+, and Non-Dual Waiver cohorts. As a result of the relative similarity in costs, as well as relatively consistent HIPP year-to-year enrollment pattern, these cohorts have been aggregated for HIPP rate purposes.
2. Katie Beckett – Due to the large cost differential for this population relative to other HIPP populations, the Katie Beckett population will be a standalone HIPP rate cohort.
3. All other non-HHA – This category is a default category for all other non-HHA populations not contained in one of the groupings noted above.
4. HHA – All HHA populations have been aggregated, using the projected enrollment mix between the three age/gender bands, to form one HHA HIPP rate.

Once the groupings above were determined, the corresponding COA-level PMPMs were blended based on the underlying HIPP enrollment by COA in CY18-19, with the exception of HHA which relies upon the assumed blend between the HHA age/gender bands, to determine the CY22 HIPP rates.

The HIPP rates are shown in tab |7. HIPP Rate Exhibit| within Appendix II.

Additionally, the HIPP population will be subject to a two-sided MLR risk corridor, as is discussed further in this report.

3.10 Risk Adjustment

In order to help assess the risk of the Heritage Health population across the three Heritage Health MCOs**, Optumas** ran January 1, 2018 – December 31, 2019 (CY18 and CY19) data through the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx). Consistent with the CY21 rates, the CY19 time frame has been used as the study period, as a result of concerns related to the use of an experience period that reflects suppressed utilization as a result of COVID-19. This approach maintains consistency with the relative risk scores used in the CY21 rates.

The University of California, San Diego (UCSD) risk model (Version 6.4) was used to develop the risk factors discussed throughout this narrative. Given that risk adjustment for Heritage Health is prospective in nature, **Optumas** used prospective national acute care weights. For the CDPS+Rx analysis, members were attributed to respective rating regions, COAs, and Heritage Health MCOs based on their December 2019 snapshot enrollment. **Optumas** ran multiple iterations of the risk score tool using different snapshot months, but ultimately decided that December 2019 was most appropriate, as it provides a recent snapshot month prior to the impact of COVID-19, while ensuring a similar distribution of unscored members across MCOs. The resulting normalized risk scores were renormalized using January – March 2021 enrollment to capture a more recent mix between cohorts by MCO.

Correlation Analyses

To validate the appropriateness of the CDPS+Rx tool for the Heritage Health program, **Optumas** conducted a correlation analysis to understand the relationship between risk score and service costs. In this analysis, **Optumas** grouped members into percentile cost bands within a given Rating Region and COA. These percentile bands were determined based on each member's CY18 and CY19 PMPM. **Optumas** then calculated the PMPM and raw risk score associated with each percentile. The risk scores were normalized across all percentiles, such that the aggregate Rating Region/COA combination across all percentile bands weighted to a 1.0. After reviewing the results of this correlation analysis for each COA and rating region, **Optumas** and the State felt comfortable proceeding with CDPS+Rx with a study period of CY19 and snapshot month of December 2019 as the risk adjustment parameters for the CY22 rate development.

The correlation analysis was also used to assist in determining which cohorts would be appropriate to risk adjust. After reviewing the results of this analysis and the correlation between average PMPM and normalized risk score, the same COAs were chosen to be risk adjusted for CY22 as were chosen in CY21, as shown below:

- AABD 00-20 M&F
- AABD 21+ M&F
- CHIP M&F
- Family 01-05 M&F
- Family 06-20 F
- Family 06-20 M
- Family 21+ M&F
- Foster Care M&F
- Non-Dual Waiver
- Non-Dual LTC

Service Exclusions

In the development of CY21 risk scores, **Optumas** included all populations and services eligible for Heritage Health, with the exception of the following services to the extent they could be identified within the data:

- Delivery-Related Services
- Hospice
- Freestanding Ambulatory Surgical Centers
- Home Health Care
- Dialysis
- Laboratory Services
- Ambulances and Other Transportation
- Radiology Services
- DME/Supplies

The delivery-related services and risk score weights were removed since delivery-related expenditures are reimbursed to the MCOs via the maternity supplemental rate. The remainder of the service exclusions are consistent with industry standards, including Medicare Advantage risk score practices.

Duration Checks

Scenario tests were performed to determine the impact of member duration on the risk score calculation for both raw and normalized risk scores. In assessing the appropriate threshold for member duration, **Optumas** evaluated the change in risk scores, as well as the number of scored members versus non-scored members, under various durational scenarios. Consistent with the approach used within the CY21 rate development, a durational threshold of 3+ months was used within the risk score calculation for the CY22 rates.

Handling of Non-Scored Members

Members that have fewer than 3 months of duration within the study period are considered non-scored members. Although the disease component of these members' risk scores is not used, their age and gender information is still valid, so the demographic component of their risk score was used. Non-scored members are assumed to have a similar disease profile as the scored members within their region and COA. Therefore, all non-scored members are assigned the disease component of the regional average risk score for the Rating Region and COA in which they are attributed.

Credibility

The specific COAs within each MCO and Rating Region that have fewer than 300 unique scored members are adjusted for credibility by using the classical credibility formula below:

$$\sqrt{\frac{Member\ Count}{300}} = \text{weight given to the MCO-specific risk score}$$

The complementary percentage is given to the regional average risk score for a given rating cohort. The result is a credibility-adjusted risk score that mitigates bias due to rate cell sample size.

Once members have been attributed to an MCO, risk scores are summarized by Rating Region, COA, and MCO. Credibility is applied as needed to the summarized values, resulting in MCO-specific scores for each COA and Rating Region. These credibility-adjusted, MCO-specific risk scores are then aggregated into regional risk scores by COA. This allows each MCO-specific risk score by COA and Rating Region to be normalized by dividing by the regional risk score for that same COA and rating region. Normalized risk scores will be applied in a budget neutral manner, ensuring that costs are not removed or added by applying the risk score factors to the PMPMs for each Rating Region and COA.

Risk scores for each MCO, COA, and Rating Region can be found in tab |4. Risk Score Budget Neutrality| within Appendix II.

3.11 Duals Relativity Factor

A review of the CY18 and CY19 base data made it clear that a difference in underlying risk/acuity still existed between the Dual members assigned to the three Heritage Health MCOs. Consistent with the CY20 and CY21 rate development, **Optumas** developed relativity factors for each of the Dual cohorts. Development of the CY22 Duals relativity factors used CY19 data to determine the cost relativity amongst MCOs. CY19 data was used to remain consistent with CDPS+Rx and to produce a more recent summary of Duals' cost relativities to be projected to the CY22 contract period. After removing the value of Part D copays and adjusting for PBM contracting changes, **Optumas** compared the PMPM for each MCO by Rating Region for the Healthy Dual, Dual LTC, and Dual Waiver cohorts individually. Each MCO's Dual cohort PMPM was divided by the regional average to produce an initial relativity factor. Smaller-sized COAs within each MCO and Rating Region that have less than 3,600 member months (300 members times 12 month enrollment duration, consistent with the approach to credibility for CDPS+Rx risk adjustment) are adjusted for credibility by using the classical credibility formula below:

$$\sqrt{\frac{Member\ Months}{3{,}600}} = \text{weight given to the MCO-specific relativity factor}$$

The complementary percentage is given to the regional average relativity factor of 1.0 for that rating cohort. The result is a credibility-adjusted relativity factor that mitigates bias due to rate cell sample size. For this cycle, all COA, MCO, and Rating Region combinations exceeded the threshold of 3,600 member months, so the credibility adjustment did not have any practical impacts.

In addition to the credibility adjustment, a maximum weight of 75% was given to any MCO's specific experience. The 75% maximum weight was included to account for the impact that enrollment churn due to changes in eligibility may have on any given MCO's Dual population relative to the regional average, and to provide incentives for MCOs to manage the care of their Dual enrollees. The resulting factors were renormalized using January – March 2021 enrollment, consistent with the membership used in developing normalized CDPS+Rx weights for risk-adjusted COAs.

Duals relativity factors by MCO, COA, and Rating Region can be found in tab |4. Risk Score Budget Neutrality| within Appendix II.

3.12 HHA Relativity Factor

Optumas has observed a disparate distribution of enrollees in the previously-existing medically frail category amongst the MCOs, consistent with observations noted within the October – December 2021 HHA rate amendment. If unadjusted this would have resulted in MCOs with higher-than-average proportions of expansion enrollment in the previous medically frail category being disadvantaged and lower-than-average proportions advantaged. MCO-specific mixes of historical medically frail and non-medically frail enrollment through September 2021, were used to create an MCO-specific blended rate. This blended rate was then used to create a risk factor that accounts for the different risk of medically frail enrollment proportions amongst the MCOs. The risk factors by rating region and COA are shown in tab |1b. Rate Summary - HHA| within Appendix II.

3.13 High-Cost Drug Pool

The State implemented a high-cost drug pool as part of the Heritage Health program, beginning with the CY19 contract period. The purpose of this pool is to develop a mechanism that will retrospectively re-allocate funding between MCOs should there be a disproportionate share of high-cost drug experience for any MCO(s). The CY22 high-cost drug pool will be operationalized like that of CY21, such that there will be a risk corridor around the high-cost drug pool. **Optumas** has included additional detail surrounding the high-cost drug risk corridor below.

Drug Identification Criteria

High-cost drug experience has been identified within the CY18 and CY19 base data using a cost-based approach. Ten-digit Generic Product Indicators (GPIs), as well as injectable codes on the CY18 and CY19 fee schedules that have an average cost of $10,000 PMPM, have been classified as high-cost. This high-cost drug pool will only be applicable to the non-Dual populations. The following Heritage Health rating cohorts will be exempt: Healthy Dual, Dual LTC, and Dual Waiver. Additionally, the HHA and HIPP populations are exempt from the high-cost drug pool as a result of having their own population-specific risk corridors in place.

The following steps have been taken to identify the GPIs or Physician-Administered Drugs (PAD) that meet the high-cost criteria:

1. Utilizers of each GPI or injectable/PAD were identified, along with all associated member months for these utilizers across the entire calendar year
2. The total paid dollars and total member months for drug utilizers were summarized to determine an average “utilizer” PMPM for each GPI and injectable within the CY18 and CY19 data
3. Each GPI or injectable with an average “utilizer” PMPM of $10,000 or greater meets the criteria for the high-cost pharmacy risk pool within the base data

For example, there are 10 members who utilize a particular GPI in CY18. These 10 members have a combined count of 90 member months through CY18. The total expenditures for this GPI are $900,000, resulting in an average PMPM of $10,000. All expenditures associated with this GPI would now be included in the development of the high-cost drug pool.

Establish Benchmarks

Upon identification of the relevant GPIs and injectables, the total spend associated with these drugs was summarized to arrive at a specific high-cost drug PMPM by COA and Rating Region. These amounts were then projected forward to the CY22 contract period. A sample of the high-cost drug pool cost projection is shown below:

COA	Total COA MMs	High Cost GPI PMPM	High Cost PAD PMPM	Total High Cost PMPM (GPI+PAD)	Illustrative Projection Factor	Projected to CY22
1	50,000	*$0.00*	*$0.00*	$0.00	-	$0.00
2	150,000	*$8.00*	*$2.00*	$10.00	1.15	$11.50
3	250,000	*$15.00*	*$5.00*	$20.00	1.15	$23.00

Once COA and Regional PMPM projections were established, these PMPMs were converted to MCO-specific PMPMs. MCO-specific PMPMs were calculated using the CDPS+Rx prospective risk score applicable to the CY21 Heritage Health capitation rates.

	Statewide	MCO A		MCO B	
COA	**Projected to CY22**	**Risk Score**	**MCO-Specific PMPM**	**Risk Score**	**MCO-Specific PMPM**
1	$0.00	1.00	$0.00	1.00	$0.00
2	$11.50	1.10	$12.65	0.90	$10.35
3	$23.00	0.95	$21.85	1.05	$24.15

Experience Period Reconciliation

Once the CY22 contract period ends, a reconciliation will occur between MCOs to the extent that the distribution of high-cost drugs between MCOs is different than the distribution projected by the rate development process.

A total pool of dollars will be calculated after the end of the CY22 contract period. This pool will be calculated based on the total CY22 member months and the MCO-specific PMPMs described in the "Establish Benchmarks" section above. Once this pool is established, dollars may be added to or subtracted from the pool as a result of the risk corridor that is in place for CY22.

To determine the CY22 actual expenditures that will be compared to the high-cost drug pool, high-cost GPIs and PADs relevant to CY22 are yet to be identified. Due to the nature of new drugs coming onto the market over time, it is possible that drugs that exist in CY22 were not present in the CY18 or CY19 base data period. Therefore, a separate identification of drugs with an average PMPM of $10,000 in the CY22 contract period will be completed. This will be completed in a manner consistent with the approach described in the "High-Cost Drug Identification Criteria" section above, with the exception that the membership and claims data will be based on CY22 experience and a standardized unit cost will be applied to NDCs underlying each GPI identified. Once this identification process is completed, the total experience for the GPIs and injectables meeting the criteria in CY22 will comprise the experience to be compared to the high-cost drug pool.

Prior to the determination of dollar transfers between MCOs, the CY22 experience for drugs that meet the high-cost criteria will be evaluated against the risk corridor. The risk corridor bands are noted below:

Corridor Bands		State/Fed and MCO Share	
Low	High	State/Fed Share	MCO Share
<=85%	85%	100%	0%
85%	90%	75%	25%
90%	95%	50%	50%
95%	100%	0%	100%
100%	105%	0%	100%
105%	110%	50%	50%
110%	115%	75%	25%
115%	>=115%	100%	0%

If the program-wide experience for high-cost drugs exceeds the original pool enough to warrant a State/Fed share of the excess expenditures, new dollars will be added to the pool in addition to the capitation rates. Likewise, if the experience is far enough below the original pool to warrant State/Fed savings, then dollars will be removed and MCOs will collectively pay dollars back to the State/Fed.

Once the risk corridor is calculated, any additions or reductions to the pool will be made as necessary. A dollar transfer will then occur to the extent that an MCO's total contribution to the statewide pool is proportionally different than its actual CY22 experience, as compared to the statewide CY22 actual experience. For example, an MCO's CY22 member month count, multiplied by its MCO-Specific PMPMs, contributes 30% of the high-cost drug pool, but its CY22 expenditures for high-cost drugs reflects 35% of the statewide CY22 expenditures. In this scenario, the MCO would receive a payment of 5% (35% - 30%) of the total high-cost drug pool. Conversely, either one or two of the other MCOs would have to pay out the equivalent of the 5%.

Additional details around the high-cost drug pool (including the list of GPIs and PADs meeting the high-cost criteria, CY18 and CY19 high-cost drug spend by MCO, and CY22 high-cost drug benchmark) can be found in tab |8. High Cost Drug Pool| within Appendix II. Additionally, tab |9. High Cost Drug Risk Corridor| within Appendix II includes hypothetical examples illustrating how the high-cost drug pool and associated risk corridor interact.

3.14 Risk Corridor and Minimum Medical Loss Ratio

HHA-Specific Risk Corridor

The CY22 HHA-specific risk corridor will be an MLR-based risk corridor applicable only to the HHA population, including any HIPP HHA enrollees, such that the target MLR will be calculated as 100% minus the rating administrative load (exclusive of margin for profit/risk/contingency). Specifically, this would result in a target of 100% - 10.25%, or 89.75%. The risk corridor recoupments/payouts will be calculated based on an adjustment to revenue, similar to the method used for the current Heritage Health MLR calculations. This means the calculation will be conducted in a way that the Medical PMPM experience relative to the adjusted revenue (after risk corridor payments/recoupments) will be no more than 91.75%, and no less than 87.75%.

The numerator for the MLR calculation for the HHA risk corridor will consist of medical expenditures only and will not include the additional expenditures allowable within the federal MLR guidelines (such as Quality Improvement expenditures). Any payouts or recoupments under the HHA-specific risk corridor will be incorporated into the MCO revenue prior to the calculation of the program-wide risk corridor and MLR.

HIPP-Specific Risk Corridor

As a result of the uncertainty between the prospective mix of populations and overall volume of the HIPP population, the CY22 contract period will include a HIPP-specific risk corridor. This risk corridor will be an MLR-based risk corridor applicable only to the non-HHA HIPP population, since the HHA HIPP members are part of the broader HHA risk corridor. This corridor is developed such that the target MLR will be calculated as 100% minus the rating administrative load (exclusive of margin for profit/risk/contingency). Since the non-HHA HIPP population is comprised of three different rating cohorts with differing NML amounts built into the capitation rates, a blended MLR target will be determined. Based on each MCOs' enrollment distribution between the Disabled/Non-Dual Waiver, Katie Beckett, and All Other non-HHA HIPP cohorts, an aggregate MLR target will be determined for each MCO. The Katie Beckett population will carry a target of 98.75% (1 – 1.25% admin target) while the other two cohorts will carry a target of 91.75% (1 – 8.25% admin target). Once the aggregate MLR target is determined based on actual enrollment experience, the risk corridor recoupments/payouts will be calculated based on an adjustment to revenue, consistent with the method used for the HHA risk corridor.

The numerator for the MLR calculation for the HIPP risk corridor will consist of medical expenditures only and will not include the additional expenditures allowable within the federal MLR guidelines (such as Quality Improvement expenditures), nor any expenditures related to HIPP premiums. Any payouts or recoupments under the HIPP-specific risk corridor will be incorporated into the MCO revenue prior to the calculation of the program-wide risk corridor and MLR.

Program-wide Risk Corridor and Medical Loss Ratio

The State will use a minimum Medical Loss Ratio (MLR) and a risk corridor for the Heritage Health program. The minimum MLR is established as 85%. If the MLR is less than 85%, the MCO must refund the State the difference. The State proposes using a risk corridor for CY22 Heritage Health rates since the program is relatively new and the risk profile is still emerging. The risk corridor will protect the State in case the estimated capitation rate does not match the true risk of the program. The risk corridor will apply to all populations and services currently eligible. It will be an asymmetric risk corridor and will cap MCO profits at 2% of premium. The risk corridor does not provide any downside or loss protection for MCOs.

The program-wide risk corridor will be calculated after incorporating the impact of the high-cost drug pool, as well as the Heritage Health Adult (HHA) risk corridor and HIPP risk corridor described within this certification letter. These will all be calculated prior to the MLR, and any payments under the risk corridor will be incorporated in the MLR calculation. Payments made under either the risk corridor or MLR rebate are considered changes to revenue.

MCO-submitted encounters and reported financials will be reconciled to the assumed experience included in the developed rates to evaluate risk corridor payments between the State and MCOs.

3.15 Additional Considerations

Withhold

Per the Heritage Health contract, 1.5% of premium is withheld and deposited into the reinvestment fund. Each MCO has the ability to earn back the withhold to the extent that specific quality and performance measures are met, as stated in the contract. The 1.5% withhold is not a component of the non-medical load since it is removed from the final developed capitation rate. The capitation rates net of the 1.5% withhold are shown in tab |3. Plan Rates| within Appendix II. The State is in the process of finalizing the measures that will be in place in CY22. To the extent that an MCO does not earn back the withhold, the payment rate would still be reasonable and attainable for the covered services and populations.

4. Rate Certification

I, Barry Jordan, Consulting Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA) and a Fellow of the Society of Actuaries (FSA), am certifying the calculation of capitation payment rates described within this certification narrative. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time to time by the Actuarial Standards Board.

The capitation rates provided with this certification are considered actuarially sound for purposes of the 42 CFR 438.4 and 438.5.

The actuarially sound rates that are associated with this certification are effective January 1, 2022 through December 31, 2022 for the Nebraska Heritage Health program and are shown in tabs |3. Plan Rates| of the supplemental Excel file titled "Appendix II. Heritage Health CY22 Capitation Rate Certification Exhibits."

The actuarially sound capitation rates are based on a projection of future events. Actual experience may vary from the experience assumed within the rate development. The capitation rates offered may not be appropriate for any specific MCO. An individual MCO should review the rates in relation to the benefits that it is obligated to provide to the covered population. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with the State. The MCO may require rates above or below the actuarially sound rate developed within this certification.

Please feel free to contact me at 480.588.2492 for any additional information.

Sincerely,

Barry Jordan, FSA, MAAA
Consulting Actuary, **Optumas**

5. Appendix I – Managed Care Guidance

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
Section I. Medicaid Managed Care Rates			
General Information			
1.A.i	Unless otherwise stated, all standards and documentation expectations for capitation rates also apply for the development of the upper and lower bounds of rate ranges, in accordance with 42 C.F.R. § 438.4(c).		Acknowledged
1.A.ii	Rate certifications must be done for a 12-month rating period	Section 1	
1.A.iii.a	Letter from Certifying Actuary	Section 4	
1.A.iii.b	Certified Capitation Rates or Rate Ranges for all rate cells	Tab |3. Plan Rates| of the accompanying Excel file	
1.A.iii.c.i	Managed Care Programs Summary	Section 2	
1.A.iii.c.ii	Rating Period Covered	Section 1	
1.A.iii.c.iii	Medicaid Populations Covered	Section 3	
1.A.iii.c.iv	Eligibility/Enrollment Criteria	Section 3.02	
1.A.iii.c.v	Special Contract Provisions per 42 CFR §438.6	Sections 3.08 & 3.13-3.15	
1.A.iii.c.vi	Retroactive Adjustments must be certified in a revised rate certification or amendment. In addition to describing rationale, data, assumptions, and methodologies for the adjustment, revisions must describe whether the rates were adjusted by a de minimis amount per 42 C.F.R. § 438.7(c)(3) prior to the submission of the rate amendment and	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	must address all differences from most recent certified rates.		
1.A.iv	Proposed differences among capitation rates for different covered populations must be based on valid rate development standards and not FFP.	Section 3	Confirmed
1.A.v	No Cross-Subsidization Between Rate Cells	Section 3	Confirmed
1.A.vi	Effective Dates of Program Changes Consistent with Development of Rating Adjustments	Section 3.04	
1.A.vii	Capitation rates must be developed to reasonably achieve an MLR of at least 85% per 42 CFR 438.8. Terms and conditions of any remittance must clearly be outlined in rate certification and demonstrate compliance with 42 CFR 438.8(c).	Confirmed, Section 3.14	
1.A.viii.a	Rate Certification Identifies and Justifies the Assumptions, Data, and Methodologies Specific to Upper and Lower Bounds of Rate Range	N/A	Rate ranges are not being certified
1.A.viii.b	Upper and Lower Bounds of Rate Range must be Certified as Actuarially Sound consistent with the requirements of 42 C.F.R. § 438.4	N/A	
1.A.viii.c	Upper Bound of Rate Range Does Not Exceed Lower Bound Multiplied by 1.05	N/A	
1.A.viii.d	Rate Certification Documents the State's Criteria for paying MCOs, PIHPs, and PAHPs at different points within the rate range	N/A	
1.A.viii.e.i	State does not use the willingness of the MCOs, PIHPs, or PAHPs or their network	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	providers to enter into or adhere to intergovernmental transfer (IGT) agreements as criterion for paying them at different points within the rate range.		
1.A.viii.e.ii	State does not use the amount of funding the MCOs, PIHPs, or PAHPs or their network providers provide through IGT agreements as criterion for paying them at different points within the rate range.	N/A	
1.A.ix.a	State must document the Capitation Rates, prior to the start of the rating period, for the MCOs, PIHPs, and PAHPs at points within the Rate Range consistent with 42 C.F.R. § 438.4(c)(1)(iv)	N/A	
1.A.ix.b	State must not modify the Capitation Rates after Certifying the Rate Range as Actuarially Sound under 42 C.F.R. § 438.7(c)(3)	N/A	
1.A.ix.c	The State can modify the capitation rates per rate cell within the rate range up to 1 percent during the rating period. Any modification is subject to 42 C.F.R. § 438.4(b)(1). Modifications greater than 1 percent require a revised rate certification which demonstrates of the following:	N/A	
1.A.ix.c.i.	The criteria in 42 C.F.R. § 438.4(c)(1)(iv), as described in the initial rate certification, were not applied accurately.	N/A	
1.A.ix.c.ii	The modification is necessary to fix a material error in data, assumptions, or methodologies initially used.	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
1.A.ix.c.iii	Other adjustments are appropriate and reasonable to account for programmatic changes.	N/A	
1.A.ix.d	Per 42 C.F.R. §438.10(c)(3), the following must be posted on the website before executing MC contract or amendment that includes or modifies a rate range:	N/A	
1.A.ix.d.i	Upper and lower bounds of each rate cell	N/A	
1.A.ix.d.ii	Description of all varying assumptions between upper and lower bounds of each rate cell	N/A	
1.A.ix.d.iii	Description of the data and methodologies varying between the upper and lower bounds of each rate cell	N/A	
1.A.x.a	All Rating Adjustments Reflect Reasonable, Appropriate, and Attainable Costs	Section 3	Confirmed
1.A.x.b	No Adjustments Outside of Rate Setting Process	Section 3	Confirmed
1.A.x.c	Final Contracted Rates Match Rates in Certification Letter. For Rate Ranges approvable under § 438.4(c) the final contracted rates must be within the rate ranges in the rate certification.	Tab |3. Plan Rates| of the accompanying Excel file	Confirmed
1.A.xi	Certification Provided for all Effective Dates	Section 4	
1.A.xii	Evaluate how the capitation rates should account for direct and indirect impacts of the COVID-19 public health emergency (PHE).	Section 3.04	Explicit adjustments have been made related to the disenrollment freeze and COVID testing costs
1.A.xiii	Procedures for Rate Certifications for Rate and Contract Amendments	Section 4	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
1.A.xiii.a	If a state intends to claim FFP for capitation rates, the state must comply with the time limit for filing claims for FFP specified in section 1132 of the Act and implementing regulations at 45 CFR part 95.		Acknowledged
1.A.xiii.b	If the actuary is certifying rates, the state must submit a revised rate certification when the rates change, except for changes permitted in 42 CFR § 438.4(c) or § 438.7(c)(3). States that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3).		Acknowledged
1.A.xiii.c	For contract amendments that do not affect the rates and for rate changes permitted as specified in 42 C.F.R. §§ 438.4(c) or 438.7(c)(3), CMS does not require a rate amendment from the state. However, if the contract amendment revises the covered populations, services furnished under the contract or other changes that could reasonably change the rate development and rates, the state and its actuary must provide supporting documentation indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 C.F.R. § 438.4.		Acknowledged
1.A.xiii.d	New or revised rate certifications are not required for limited payment changes:		
1.A.xiii.d.i	If the actuary certified rates, the state may increase or decrease the most recently certified rate up to 1.5 percent during the		Acknowledged

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	rating period (in accordance with 42 CFR § 438.7(c)(3))		
1.A.xiii.d.ii	If the actuary certified rate ranges, the state may increase or decrease the capitation rates within the certified rate range up to 1 percent during the rating period (in accordance with 42 CFR § 438.4(c)(2)).	N/A	
1.A.xiii.d.iii	If the contract and rate certification specify an approved risk adjustment methodology, the state may apply that specified methodology to increase or decrease payment to the managed care plan(s) (in accordance with 42 CFR § 438.7(b)(5)(iii)). State must provide CMS with the payment terms updated by the application of the risk adjustment methodology.		Acknowledged
1.A.xiii.e	Any time a rate changes for any reason other than application of an approved payment term, the state must submit a contract amendment to CMS (even if no rate amendment is needed).		Acknowledged
1.A.xiii.f	State must submit a contract amendment and rate amendment to adjust capitation rates to address changes in applicable law or losses of program authority (must take into account the effective date).		Acknowledged
1.B.i	Certification Indicates Whether Actuary is Either Certifying Capitation Rates or Rate Ranges	Section 4	Capitation rates are being certified

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
1.B.ii	States and their actuaries must ensure that the following elements are properly documented:		
1.B.ii.a	Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources	Section 3	
1.B.ii.b	Assumptions made, including any basis or justification for the assumption	Section 3	
1.B.ii.c	Methods for analyzing data and developing assumptions and adjustments		
1.B.iii	Certification Must Disclose and Support Specific Assumptions for Each Rate Cell if Developing Capitation Rates per Rate Cell (and not Rate Ranges)	Section 3	
1.B.iv	If the state and actuary develop and certify rate ranges the certification must include:	N/A	
1.B.iv.a	Statement that Upper and Lower Bounds are Actuarially Sound consistent with the requirements in 42 C.F.R. §§ 438.4 through 438.7.	N/A	
1.B.iv.b	A table of the certified rate ranges clearly showing that the upper bound of the rate range does not exceed the lower bound of the rate range multiplied by 1.05 for each rate cell.	N/A	
1.B.iv.c.i-iii	Documentation for Data, Assumptions, and Methodologies Used to Develop Upper and Lower Bounds	N/A	
1.B.iv.d	The State's Criteria for Paying Managed Care Plans at different points within the rate range.	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
1.B.iv.e	Information on Development in Relevant Sections or Separate Section Directly Related to Rate Range	N/A	
1.B.v	Rate Development Guide Index	Section 5	This document
1.B.vi	CMS may require a state to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations. The state must have documentation to provide to CMS upon request, which may include the following information:	Confirmed	
1.B.vi.a	A description of each assumption, methodology, or factor used to develop capitation rates that varies by the rate of FFP associated with all covered populations		Acknowledged
1.B.vi.b	A justification of how each difference in the assumptions, methodologies, or factors used to develop capitation rates for the covered population represents actual cost differences based on the characteristics and mix of the covered services or the covered populations		Acknowledged
1.B.vi.c	The financial impact on federal costs of the difference in each of the assumptions, methodologies, or factors used to develop capitation rates for covered populations		Acknowledged

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	that varies by the rate of FFP associated with all covered populations		
1.B.vii	Different FMAP Components for Applicable Services, Populations, or Programs	Tab |5. FMAP Breakout| of the accompanying Excel file	
1.B.viii.a	Rate Change Comparison. If there are large, or negative changes in rates from the previous year, the actuary should describe what is leading to these differences.		From a statewide basis, the most material rate increase is for the Katie Beckett population, which is driven by the removal of the lower cost HIPP enrollees due to the separate HIPP rate development.
1.B.viii.b	Description of any material changes to rate development methodology not otherwise addressed in the other sections of the other sections of the guidance	N/A	
1.B.viii.c	A description of whether the state adjusted the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 C.F.R. § 438.7(c)(3).	N/A	
1.B.ix	The rate certification should include a list of known amendments that will be provided to CMS in the future, when the state expects the amendments will be submitted to CMS, and why the current certification cannot account for changes that are anticipated to be made to the rates.		The state has no planned amendments to the rates at this time. However, if changes to the PHE occur during the CY22 period, there may be updates necessary as part of a mid-year amendment.
1.B.x.a	Description of state specific, and applicable national or regional data for determining	Sections 3.01, 3.04, & 3.06	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	how to address the COVID-19 PHE in rate setting		
1.B.x.b	Description of how the rates account for direct and indirect impacts of the COVID-19 PHE	Sections 3.04 & 3.06	
1.B.x.c	Description of any risk mitigation strategies	Sections 3.13 & 3.14	
Data			
2.A.i.a	State Must Provide Three Most Recent Years of Complete Data	Section 3.02	
2.A.i.b	State and Actuary's Use of Appropriate Base Data	Section 3.02	
2.A.i.c	Base Data Must be Derived From Medicaid, or Similar, Population	Section 3.02	Confirmed
2.A.i.d	Exception for Use of Data Prior to Last Three Most Recent Complete Years	N/A	
2.B.i.a.i	Description of Base Data Requested by Actuary	Section 3.02	
2.B.i.a.ii	Description of Base Data Provided by State	Section 3.02	
2.B.i.a.iii	Explanation of Data Requested but not Provided	N/A	
2.B.ii.a.i	Types of Data Used	Section 3.02	
2.B.ii.a.ii	Time Period of Data	Section 3.02	
2.B.ii.a.iii	Data Source(s)	Section 3.02	
2.B.ii.a.iv	Description of Subcapitated Data	Section 3.02	
2.B.ii.b.i.A-C	Steps Taken to Validate Completeness, Accuracy, and Consistency of Data	Section 3.03	
2.B.ii.b.ii	Summary of Actuary's Assessment of Data	Section 3.02	
2.B.ii.b.iii	Any Other Concerns Over Availability or Quality of Data	Section 3.02	

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2.B.ii.c.i	Explanation of why Encounter or FFS Data was not used	N/A	
2.B.ii.c.ii	Explanation of why Managed Care Data was not used in rate development	N/A	
2.B.ii.d	Data Reliance or Use of Data Book	N/A	
2.B.iii.a	Adjustments for Credibility of Data	N/A	
2.B.iii.b	Adjustments for Completion Factors	Section 3.03	
2.B.iii.c	Adjustments for Errors Found in Data	N/A	
2.B.iii.d	Adjustments for Program Changes	Section 3.04	
2.B.iii.e	Adjustments for Exclusions of Certain Payments or Services from Data	Sections 3.03 & 3.04	
Projected Benefit Cost and Trends			
3.A.i	Final capitation rates must be based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e)	Section 3.02	Confirmed
3.A.ii	Trend assumptions must be developed primarily from actual experience of the Medicaid population or from a similar population, and including consideration of other factors that may affect projected benefit cost trends through the rating period (in accordance with 42 CFR § 438.5(d)).	Section 3.05	
3.A.iii	Utilization and unit costs of any in-lieu-of services must be taken into account in developing the projected benefit costs of the covered services, unless a statute or regulation explicitly requires otherwise.	N/A	See responses to 3.A.iv.a below
3.A.iv.a	The data used for development the projected benefit costs must not include	N/A	Cost of an IMD in excess of 15 days per month were only identified for the SUD IMD

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	costs associated with an IMD stay of more than 15 days.		stays, which have been included in the base per the SUD 1115 waiver.
3.A.iv.b	The data used for development the projected benefit costs must not include any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days.	N/A	See responses to 3.A.iv.a above
3.B.i	The rate certification must clearly document the final projected benefit costs by relevant level of detail	See |1a. Rate Summary - HH| and |1b. Rate Summary – HHA| of accompanying Excel file	
3.B.ii.a	A description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs	Section 3	
3.B.ii.b	Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described	Section 3	
3.B.ii.c	The amount of recoveries of overpayments to providers and a description of how the state accounted for this in rate development.	N/A	
3.B.iii.a.i.A	Citations for the data and sources used to develop the assumptions should be included whenever possible, particularly when published articles, reports, and sources other than actual experience from the Medicaid population are used.	Section 3.05	

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3.B.iii.a.i.B	The description of data and assumptions should state whether the trend is developed primarily with actual experience from the Medicaid population or provide rationale for the experience from a similar population that is utilized	Section 3.05	
3.B.iii.a.ii	Methodologies used to develop projected benefit trends	Section 3.05	
3.B.iii.a.iii	Any comparisons to historical or other programs' benefit cost trends	Section 3.05	
3.B.iii.a.iv	Documentation supporting the chosen trend rates and explanation of outlier and negative trends.	Section 3.05	
3.B.iii.b.i.A	Projected price trend	Section 3.05	
3.B.iii.b.i.B	Projected utilization trend	Section 3.05	
3.B.iii.b.ii	If the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s) used	N/A	
3.B.iii.b.iii	The projected benefit cost trends may include other components as applicable and used by the actuary in developing rates	Section 3.05	
3.B.iii.c	Variations in projected benefit cost trend must be explained	Section 3.05	
3.B.iii.d.i	A description of the data, assumptions, and methodologies used to determine each material adjustment to projected trends	N/A	
3.B.iii.d.ii	Cost impact of each material adjustment to projected trends	N/A	

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3.B.iii.d.iii	Where in the rate setting process the material adjustment was applied	N/A	
3.B.iii.e.i	The impact of managed care on the utilization and the unit costs of health care services	N/A	The base data comes from the managed care environment.
3.B.iii.e.ii	Changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services	N/A	
3.B.iv.a	Mental Health Parity and Addiction Equity Act: the categories of service that contain additional services necessary for parity	N/A	The base data meets Mental Health Parity Standards
3.B.iv.b	Mental Health Parity and Addiction Equity Act: the percentage of cost that these additional services represent in each category of service	N/A	
3.B.iv.c	Mental Health Parity and Addiction Equity Act: how these services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service	N/A	
3.B.iv.d	Mental Health Parity and Addiction Equity Act: an assurance that the payment represents a payment amount that is adequate to allow the MCO, PIHP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.	N/A	

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3.B.v.a	The categories of covered service that contain in-lieu-of-services	N/A	
3.B.v.b	The percentage of cost that in-lieu-of services represent in each category of service	N/A	
3.B.v.c	How the in-lieu-of services were taken into account in the development of the projected benefit costs	N/A	
3.B.v.d	For inpatient psychiatric or substance use disorder services provided in an IMD setting, rate development must comply with the requirements of 42 CFR §438.6(e) and the data and assumptions utilized should be described in the rate certification. The costs of an IMD as an in-lieu-of-service must not be used in rate development. See Section I, item 3.A.v of this guide.		See response to 3.A.iv.a
3.B.vi.a	Retrospective Eligibility Periods: the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period	Section 3.02	
3.B.vi.b	Retrospective Eligibility Periods: how the claims information are included in the base data	Section 3.02	
3.B.vi.c	Retrospective Eligibility Periods: how the enrollment or exposure information is included in the base data	Section 3.02	
3.B.vi.d	Retrospective Eligibility Periods: how the capitation rates are adjusted to reflect the retroactive eligibility period, and the	Section 3.02	

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	assumptions and methodologies used to develop those adjustments		
3.B.vii.a	Impact of more or fewer state plan benefits covered by Medicaid managed care	Section 3	
3.B.vii.b	Impact of any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d)	N/A	
3.B.vii.c	Impact of requirements related to payments from health plans to any providers or class of providers	Section 3.03, 3.04 and 3.08	
3.B.vii.d	Impact of requirements or conditions of any applicable waivers	Tab |6. (b)(3) Summary| of the accompanying Excel file	
3.B.vii.e	Impact of requirements or conditions of any litigation to which the state is subjected	N/A	
3.B.viii	For each change related to covered benefits or services, the rate certification must include an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies to develop the adjustment	Section 3.04	
Special Contract Provisions Related to Payment			
4.A.i.a	The rate certification and supporting documentation must describe any incentives included in the contract between the state and the managed care plans	N/A	
4.A.i.a.i	The rate certification must include documentation that the incentive	N/A	

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	arrangement will not exceed 105% of the approved capitation payments under the contract		
4.A.ii.a.i	Time period of the incentive arrangement	N/A	
4.A.ii.a.ii	Enrollees, services, and providers covered by the incentive arrangement	N/A	
4.A.ii.a.iii	Purpose of the incentive arrangement	N/A	
4.A.ii.a.iv	Confirmation that incentive payments will not exceed 105% of the capitation payments	N/A	
4.A.ii.a.v	Description of any effect that each incentive arrangement has on the development of the capitation rates	N/A	
4.B.i.a	The rate certification and supporting documentation must describe any withhold arrangements in the contract between the state and the managed care plans	Section 3.15	
4.B.i.b	In accordance with 42 C.F.R. § 438.6(b)(3), the capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound	Section 3.15	
4.B.ii.a.i	Time period of the withhold arrangement	Section 3.15	
4.B.ii.a.ii	Enrollees, services, and providers covered by the withhold arrangement	Section 3.15	
4.B.ii.a.iii	Purpose of the withhold arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.)	Section 3.15	

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4.B.ii.a.iv	Description of the total percentage of the certified capitation rates being withheld through withhold arrangements	Section 3.15	
4.B.ii.a.v	Estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable	Section 3.15	
4.B.ii.a.vi	Description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the managed care plan's financial operating needs	Section 3.15	
4.B.ii.a.vii	Description of any effect that the withhold arrangements have on the development of the capitation rates	Section 3.15	
4.B.ii.b	Actuary must certify capitation payments minus any portion of the withhold that is not reasonably achievable as actuarially sound	Section 3.15	
4.C.i.a	If the state utilizes risk-sharing mechanisms with its managed care plan(s) these arrangements must be described in the contract(s) and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.	Sections 3.13 & 3.14	

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4.C.i.b	The rate certification and supporting documentation must describe any risk mitigation that may affect the rates or final net payments to the managed care plan(s).	Sections 3.13 & 3.14	
4.C.ii.a.i	Rationale for the use of the risk sharing arrangement	Sections 3.13 & 3.14	
4.C.ii.a.ii	Detailed description of how the risk-sharing arrangement is implemented	Sections 3.13 & 3.14	
4.C.ii.a.iii	Description of any effect that the risk-sharing arrangements have on the development of the capitation rates	Sections 3.13 & 3.14	
4.C.ii.a.iv	Documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices	Sections 3.13 & 3.14	
4.C.ii.b	If the contract includes a remittance/payment for being below/above a specified MLR, the rate certification and supporting documentation must include a description of this MLR arrangement:	Sections 3.13 & 3.14	
4.C.ii.b.i	The methodology used to calculate the MLR	Sections 3.13 & 3.14	
4.C.ii.b.ii	The formula for calculating a remittance/payment for having a MLR below/above the minimum requirements	Sections 3.13 & 3.14	
4.C.ii.b.iii	Any other consequences for a remittance/payment for a MLR below/above the minimum requirements	Sections 3.13 & 3.14	
4.C.ii.c	If the contract has reinsurance requirements, the rate certification and	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	supporting document must include a description of the requirements:		
4.C.ii.c.i	Detailed description of any reinsurance requirements under the contract associated with the rate certification, including the reinsurance premiums and any relevant historical reinsurance experience	N/A	
4.C.ii.c.ii	Identification of any effect that the reinsurance requirements have on the development of the capitation rates	N/A	
4.C.ii.c.iii	Documentation that the reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices	N/A	
4.C.ii.c.iv	If the actuary develops the reinsurance premiums, a description of how the reinsurance premiums were developed	N/A	
4.D.i.a.i	State Directed Payments: implement value-based purchasing models for provider reimbursement	N/A	
4.D.i.a.ii	State Directed Payments: participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative	N/A	
4.D.i.a.iii	State Directed Payments: adopt a minimum fee schedule for network providers that provide a particular service under the contract using Medicaid State plan approved rates	N/A	

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4.D.i.a.iv	State Directed Payments: adopt a minimum fee schedule for network providers that provide a particular service under the contract using rates other than the Medicaid State plan approved rates	N/A	
4.D.i.a.v	State Directed Payments: provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract	Section 3.08	
4.D.i.a.vi	State Directed Payments: adopt a maximum fee schedule for network providers that provide a particular service under the contract	N/A	
4.D.i.b	All state directed payments, except for minimum fee schedules using Medicaid State plan approved rates, must receive written prior approval from CMS and be consistent with the information in the approved preprint and related preprint review documents.	Section 3.08	
4.D.i.c	All contract arrangements that direct MCO's, PIHP's, or PAHP's expenditures must be developed in accordance with 42 C.F.R. § 438.4, the standards specified in § 438.5, and generally accepted actuarial principles and practices	Section 3.08	
4.D.i.d	The state's rate certification for the applicable period must address how each payment arrangement approved by CMS under 42 CFR § 438.6(c) is reflected in the payments to the managed care plan from	Section 3.08	

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	the state in accordance with § 438.6(b)(6). Such payment arrangements can be incorporated into the base capitation rates as an adjustment to the rate or addressed through a separate payment term. When the payment arrangement is addressed through a separate payment term, CMS's expectations are as follows:		
4.D.i.d.i	Documentation related to the payment term must be included in the initial rate certification as outlined in Section I, Item 4.D.ii.a.iii of the guide.	N/A	
4.D.i.d.ii	An estimate of the magnitude of that portion of the payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate, and that the state will provide the final figures after the payment has been made).	N/A	
4.D.i.d.iii	After the rating period is complete and the state makes the payment consistent with the contract and as reflected in the initial rate certification, the state should submit documentation to CMS that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred,	N/A	

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	enrollees seen, etc.) had been known when the rates were initially developed.		
4.D.i.b.iv	Please note, if the total amount of the payment or distribution methodology is changed from the initial rate certification, CMS expects the state to submit a rate amendment for the rating period, and clearly describe the magnitude of and the reason for the change.	N/A	
4.D.ii.a	The rate certification and supporting documentation must include a description of each state directed payment utilized by the state within the applicable Medicaid managed care program(s). The documentation needed depends on which approach the state has used to incorporate the payment into its rate certification. Please provide the following information for each state directed payment in the body of the certification and table format outlined in the guide:	Section 3.08	
4.D.ii.a.i	Brief description of the state directed state directed payment including:	Section 3.08	
4.D.ii.a.i.A	The type of state directed payment (minimum fee schedule, maximum fee schedule, bundled payment, etc.).	Section 3.08	
4.D.ii.a.i.B	A brief description (e.g. minimum fee schedule is set at $x as approved in the Medicaid state plan, minimum fee schedule is set at y% of Medicare, etc.).	Section 3.08	

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4.D.ii.a.ii	If the state directed payment will be incorporated into the rate certification in the base capitation rates as a rate adjustment, then the following information should be included in the state's rate certification (please include this information for each separate directed payment arrangement):	Section 3.08	
4.D.ii.a.ii.A	Indication of each rate cell affected by the state directed payment.	Section 3.08	
4.D.ii.a.ii.B	The impact the state directed payment has on the rates, for each rate cell. Each state directed payment rate adjustment must be separately identified in the exhibit, the exhibit cannot combine the impacts of state directed payments.	Section 3.08	
4.D.ii.a.ii.C	Description of how the state directed payment is reflected in the certified capitation rates. To the extent an adjustment is applied to account for the impact of the state directed payment, or changes to the state directed payment from the base data period, the actuary should provide a description of the data, assumptions, and methodologies used to develop the adjustment.	Section 3.08	
4.D.ii.a.ii.D	An indication that the state directed payment is consistent with the pre-print (including any correspondence between the state and CMS regarding the pre-print) reviewed and approved by CMS, when	Section 3.08	

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	prior approval is required per 42 C.F.R. § 438.6(c)(2)(ii). To the extent the state directed payment preprint has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification, and the state directed payment that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the state directed payment is accounted for in a manner consistent with the pre-print that is under CMS review. If the state directed payment preprint has not yet been submitted to CMS for review, the certification should provide a specific timeline for when the preprint will be submitted to CMS.		
4.D.ii.a.ii.E	If implementing a maximum fee schedule, the actuary should explain if there are any instances in the base data where the managed care plan(s) paid above the maximum fee schedule and how the actuary determined that it was reasonable to assume that the managed care plan(s) that currently pay above the maximum fee schedule will be able to lower their reimbursement rates consistent with the maximum fee schedule requirement. The actuary should also explain whether there are any exemptions to the maximum fee	N/A	

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	schedule which allow for managed care plan(s) to pay above the maximum fee schedule during the rating period and how these exemptions were considered in rate development.		
4.D.ii.a.iii	If the payment will be incorporated into the initial rate certification as a separate payment term, then the following information must be included in the state's rate certification (please include this information for each applicable state directed payment in a separate row):	N/A	
4.D.ii.a.iii.A	Aggregate amount of the payment applicable to the rate certification. If the separate payment term directed payment is paid and certified as a part of the capitation rate on a PMPM basis, provide the estimates aggregate amount of the payment.	N/A	
4.D.ii.a.iii.B	An explicit statement from the actuary that he or she certifies the amount of the separate payment term disclosed in the certification (i.e. the amount in Section I, Item 4.D.ii.a.iii.A).	N/A	
4.D.ii.a.iii.C	An estimate of the magnitude of the state directed payment on a PMPM basis for each rate cell (CMS recognizes that this is an estimate for separate payment terms that are incorporated as pools). If the state directed payments, addressed as a separate payment term, is paid and	N/A	

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	certified as part of the capitation rates on a PMPM basis, provide the amount of the payment of a PMPM basis. Each separate payment term must be separately identified in the exhibit; the exhibit cannot combine the impacts of state directed payments.		
4.D.ii.a.iii.D	An indication that the state directed payment is consistent with the preprint (including correspondence between the state and CMS regarding the pre-print) reviewed and approved by CMS, when prior approval is required per 42 C.F.R. § 438.6(c)(2)(ii). To the extent the state directed payment preprint has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the state directed payment that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the state directed payment is accounted for in a manner consistent with the pre-print that is under CMS review. If the preprint has not been submitted to CMS for review, the certification should provide a specific timeline for when the preprint will be submitted to CMS.	N/A	
4.D.ii.a.iii.E	Statement that after the rating period is complete, the state will submit to CMS	N/A	

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	documentation that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been fully known when the rates were initially developed. Note this is only applicable to separate payment terms that are included in the certification as separate pools that are certified in addition to the base PMPM capitation rates.		
4.D.ii.b	The rate certification and supporting documentation must confirm that there are no additional directed payments in the program that are not addressed in the certification.	Confirmed	No additional directed payments are in place for CY22 at this time. If this changes for CY22, the State will be in communication with CMS to provide appropriate documentation.
4.D.ii.c	The rate certification and supporting documentation must confirm that there are no requirements regarding the reimbursement rates the managed care plan(s) must pay to any providers unless specifically specified in the certification as a state directed payment or authorized under applicable law, regulation, or waiver.	Confirmed	

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4.E.i.a	A pass-through payment, as defined in 42 C.F.R. § 438.6(a), is any amount required by the state to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between MCOs, PIHPs, or PAHPs and hospitals, physicians, or nursing facilities that is not for one of the following purposes:	N/A	
4.E.i.a.i	A specific service or benefit provided to a specific enrollee covered under the contract;	N/A	
4.E.i.a.ii	A provider payment methodology permitted under 42 C.F.R. §§ 438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract;	N/A	
4.E.i.a.iii	A subcapitated payment arrangement for a specific set of services and enrollees covered under the contract;	N/A	
4.E.i.a.iv	Graduate Medical Education (GME) payments; or	N/A	
4.E.i.a.v	Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments	N/A	
4.E.i.b	Pass-through payments are allowed for transition periods as outlined in 42 CFR §438.6(d). In order to use a transition period, a state must demonstrate that it had pass-through payments for hospitals, physicians, or nursing facilities, as defined in 42 CFR §438.6(d)(1)(i), in:	N/A	

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4.E.i.b.i	Managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016, and were submitted for CMS review and approval on or before July 5, 2016; or	N/A	
4.E.i.b.ii	If the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, the managed care contract(s) and rate certification(s) for a rating period before July 5, 2016 that had been most recently submitted for CMS review and approval as of July 5, 2016	N/A	
4.E.i.c	Pass-through payments to hospitals must comply with the requirements of 42 CFR §438.6(d).	N/A	
4.E.i.c.i	In accordance with 42 CFR §438.6(d)(3), the aggregate pass-through payments to hospitals may not exceed the lesser of: (1) 70 percent of the base amount; or (2) the total dollar amount of pass-through payments to hospitals identified in the managed care contract(s) and rate certification(s) used to meet the requirement of 42 CFR §438.6(d)(1)(i).	N/A	
4.E.i.c.ii	In accordance with 42 CFR §438.6(d)(5), the aggregate pass-through payments to physicians or nursing facilities may be no more than the total	N/A	

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	dollar amount of pass-through payments to physicians or nursing facilities, respectively, identified in the managed care contract(s) and rate certification(s) used to meet the requirements of 42 CFR 438.6(d)(1)(i).		
4.E.c.iii	In accordance with 42 C.F.R. § 438.6(d)(6), for states transitioning services or populations from a FFS delivery system to a managed care delivery system, the aggregate amount of the pass-through payments the State requires the MCO, PIHP or PAHP to make to hospitals, nursing facilities or physicians is less than or equal to the amounts calculated in 42 C.F.R. § 438.6(d)(iii)(A), (B), or (C).	N/A	
4.E.c.iii.A	In determining the amount of each component for the calculations contained in 42 C.F.R. § 438.6(e)(iii)(A) through (C), the State must use the amounts paid for services during the 12-month period immediately 2 years prior to the first rating period of the transition period.	N/A	
4.E.i.d	Hospital Pass-Through Base Amount Payment Calculation. The base amount, as defined in 42 CFR §438.6(d)(2), is determined as the sum of (i) and (ii) below:	N/A	
4.E.i.d.i	For inpatient and outpatient hospital services that will be provided to eligible	N/A	

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	populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between: (A) the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and (B) the amount the MCOs, PIHPs, or PAHPs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.		
4.E.i.d.ii	For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or	N/A	

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	PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the state must determine reasonable estimates of the aggregate difference between: (A) the amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and (B) the amount the state paid under Medicaid FFS (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12- month period immediately 2 years prior to the rating period that will include pass-through payments.		
4.E.i.e	In accordance with 42 C.F.R. §438.6(d)(2)(iii), the base amount must be calculated on an annual basis and is recalculated annually.	N/A	
4.E.i.f	The impact of any §438.6(c) directed payments made to hospitals during the 12-	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	month period immediately 2 years prior to the rating period should be included when calculating amounts in accordance with 42 C.F.R. § 438.6(d)(2)(i)(B).		
4.E.i.g	In accordance with 42 CFR §438.6(d)(2)(iv), states may calculate reasonable estimates of the aggregate differences § 438.6(d)(2)(i) and (ii) in accordance with the upper payment limit requirements in 42 CFR part 447.	N/A	
4.E.i.g.i	If the state chooses to utilize a trend adjustment when calculating reasonable estimates of the aggregate differences in § 438.6(d)(2)(i) and (ii), it must provide a justification of why an adjustment is reasonable and appropriate, and the state should utilize the same data source for the trend adjustments when calculating amounts in § 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B).	N/A	
4.E.i.h	Capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities when permitted by 42 CFR §438.6(d); states may not include pass-through payments to providers other than hospitals, physicians, and nursing facilities in the capitation rates.	N/A	
4.E.i.i	If a state chooses to include a pass-through payment as a per member per month (PMPM) amount, tied to enrollment, the state must monitor the actual pass-through	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	payment amounts paid during the rating period to ensure it does not exceed the amount permitted under 42 CFR 438.6(d) to ensure compliance with the regulation. If the actual enrollment were to vary in a way that increases the pass-through payments beyond the allowable amount, the state must amend the rates to comply with Federal requirements. Additionally, the state must include the maximum dollar amount of pass-through payment amounts permitted under 42 CFR 438.6(d) within its contracts with managed care plan(s)		
4.E.ii.a	The rate certification and supporting documentation must include a description of each existing pass-through payment incorporated into the rates for this rating period. An adequate description includes at least the following for each pass-through payment:	N/A	
4.E.ii.a.i	A description of the pass-through payment, including the provider type (e.g. hospital, nursing facility, or physician).	N/A	
4.E.ii.a.ii	A description of how the pass-through payment will be paid (e.g. an aggregate payment or a PMPM amount where the final aggregate payment varies based on actual enrollment)	N/A	
4.E.ii.a.iii	The amount of the pass-through payment, both in total and on a per member per month basis (if applicable)	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
4.E.ii.a.iv	The program(s) that includes the pass-through payment	N/A	
4.E.ii.a.v	The providers receiving the pass-through payment	N/A	
4.E.ii.a.vi	The financing mechanism for the pass-through payment including the following:	N/A	
4.E.ii.a.vi.A	A description of the non-federal share of the pass-through payment, including the source of the non-Federal share and the amount of the nonfederal share financing. For example, the funds for the non-federal share may be from state legislative appropriations to the Medicaid agency, intergovernmental transfers (from a state or local government entity), provider taxes, or some other mechanism used by the state to provide the non-Federal share.	N/A	
4.E.ii.a.vi.B	For any payment funded by intergovernmental transfers, the description should include the following: 1. A complete list of the names of entities transferring funds. 2. The operational nature of the entity (state, county, city, other). 3. The total amounts transferred by each entity. 4. Clarification on whether the transferring entity has general taxing authority. 5. Clarification on whether the transferring entity received appropriations (identify level of appropriations).	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	6. Additional information or documentation regarding any written agreements that exist between the state and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement, including a description of any additional written agreements the state is aware may exist with healthcare providers to support and finance the non-federal share of the payment arrangement.		
4.E.ii.a.vi.C	Identification of any §438.6(c) directed payment arrangement(s) which target the same providers receiving the pass-through payment.	N/A	
4.E.ii.b	The rate certification and supporting documentation must include a description of the aggregate pass-through payments incorporated into the rates for this rating period by provider type. An adequate description includes at least the following for the pass-through payments by provider type:	N/A	
4.E.ii.b.i	The amount of pass-through payments by provider type both in total and on a per member per month basis (if applicable).	N/A	
4.E.ii.b.ii	Documentation of historical pass-through payments by provider type that are a prerequisite for authorization to use a transition period (as outlined in 42 CFR	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	§438.6(d)(1)(i)), unless permissible in accordance with § 438.6(d)(6):		
4.E.ii.b.ii.A	If the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 were submitted to CMS on or before July 5, 2016, please provide: 1. the total aggregate amount of pass-through payments per provider type (i.e. hospital, physician and nursing facility) incorporated into capitation rates for the rating period in effect on July 5, 2016. 2. the date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.	N/A	
4.E.ii.b.ii.B	If the managed care contract(s) and rate certification(s) for the rating period that includes July 5, 2016 had not been submitted to CMS on or before July 5, 2016, please provide: 1. The total aggregate amount of pass-through payments by provider type incorporated into capitation rates for the rating period before July 5, 2016 that had been most recently submitted for	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	CMS review and approval as of July 5, 2016. 2. The date(s) the managed care contract(s) and rate certification(s) were submitted to CMS for review and approval.		
4.E.ii.b.iv	In accordance with 42 C.F.R. § 438.6(d)(6), for states transitioning services or populations from a FFS delivery system to a managed care delivery system, please provide:	N/A	
4.E.ii.b.iv.A	Confirmation that services will be covered for the first time under a managed care contract and were previously provided in a FFS delivery system prior to the first rating period of the transition period.	N/A	
4.E.ii.b.iv.B	Confirmation that the state made supplemental payments, as defined in 42 C.F.R. § 438.6 (a), to hospitals, nursing facilities, or physicians during the 12-month period immediately 2 years prior to the first year of the transition period.	N/A	
4.E.ii.c	In accordance with 42 CFR §438.6(d)(4), the certification must document the following information about the base amount for hospital pass-through payments:	N/A	
4.E.ii.c.i	The data, methodologies, and assumptions used to calculate the base amount, including the data, methodologies and	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	assumptions for any reasonable estimate(s) utilized.		
4.E.ii.c.i.A	The description must include a summary of any adjustment made to the base data used to calculate amounts for Section I, Item 4.E.i.d.i.A, Section I, 4.E.i.d.i.B, Section I, Item 4.E.i.d.ii.A, and Section I, 4.E.i.d.ii.B of the guide, including a rationale and fiscal impact of each adjustment.	N/A	
4.E.ii.c.i.B	An explanation of any changes to the methodology utilized for the base amount calculation from the previous years' calculations including a rationale and the fiscal impact of the proposed methodology changes.	N/A	
4.E.ii.c.ii	The aggregate amounts calculated for each amount in accordance with 42 C.F.R. § 438.6(d)(2)(i)(a), (i)(b), (ii)(a) and (ii)(b).	N/A	
4.E.ii.c.iii	If the state chooses to utilize trend adjustments when calculating the amounts identified in accordance with 42 C.F.R. § 438.6(d)(2)(i)(a), (i)(b), (ii)(a) and (ii)(b), the state must ensure clear documentation, including:	N/A	
4.E.ii.c.iii.A	Explanation of the purpose of the trend adjustment (e.g. cost inflation, utilization, etc.) and justification of why an adjustment is reasonable and appropriate.	N/A	
4.E.ii.c.iii.B	The trend adjustment applied to amounts, as applicable, in accordance with 42 C.F.R. § 438.6(d)(2)(i)(a), (i)(b), (ii)(a) and (ii)(b).	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
4.E.ii.c.iii.C	A description of the data source, assumptions, and methodology used to determine each adjustment.	N/A	
4.E.ii.c.iii.D	The fiscal impact of each trend adjustment.	N/A	
4.E.ii.c.iii.E	If the state does not utilize a consistent data source for the trend adjustment used in the base amount calculation and demonstrations of upper payment limits requirements for inpatient and outpatient hospital services in accordance with 42 CFR 447, the state must provide a clear rationale of why a different data source is reasonable and appropriate for the trend adjustments used in the base amount calculation.	N/A	
4.E.ii.c.iv	The calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in accordance with 42 C.F.R. § 438.6(d)(3).	N/A	
4.E.ii.c.v	The amount of any §438.6(c) state directed payment(s) made to hospitals during the 12-month period immediately 2 years prior to the rating period, and an explanation of how these were included in the calculations of amounts in accordance with 42 C.F.R. § 438.6(d)(2)(i)(B).	N/A	
4.E.ii.d	In accordance with 42 C.F.R. § 438.6(d)(6), the certification must document the calculations in 42 C.F.R. § 438.6(d)(iii)(A), (B), or (C) for states transitioning services	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	or populations from a FFS delivery system to a managed care delivery system, including the data, methodologies and assumptions used to develop these calculations		
Projected Non-Benefit Costs			
5.A.i	The development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital.	Section 3.07	
5.A.ii	Non-benefit costs may be developed as per member per month (PMPM) costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs.	Section 3.07	
5.B.i.a	Description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all significant and material items in developing the projected non-benefit costs	Section 3.07	
5.B.i.b	Any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification	Section 3.07	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
5.B.i.c	Any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including:		
5.B.i.c.i	A description of the data, assumptions, and methodologies used to determine each adjustment	Section 3.07	
5.B.i.c.ii	Where in the rating setting process each adjustment was applied	Section 3.07	
5.B.i.c.iii	The cost impact of each material adjustment	Section 3.07	
5.B.ii.a	Administrative costs	Section 3.07	
5.B.ii.b	Taxes, licensing and regulatory fees, and other assessments and fees	Section 3.07	
5.B.ii.c	Contribution to reserves, risk margin, and cost of capital	Section 3.07	
5.B.ii.d	Other operational costs associated with the provision of services identified in 438.3(c)(1)(ii) to the populations covered under the contract	Section 3.07	
5.B.iii	Actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the managed care plan(s), and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in rate development.	Section 3.07	
Risk Adjustment and Acuity Adjustments			
6.A	Rate Development Standards for Risk Adjustment and Acuity Adjustments		

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
6.A.i	Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the state.	Sections 3.10 -3.12	
6.A.ii	As required by 42 C.F.R. § 438.5(g), if risk adjustment is applied prospectively or retrospectively, states and their actuaries must select a risk adjustment methodology that uses generally accepted models and must apply it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs, PIHPs or PAHPs in the program to calculate adjustments to the payments as necessary.	Sections 3.10-3.12	
6.A.iii	An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment (permissible under 42 C.F.R. § 438.5(f))	Section 3.04 (disenrollment freeze) and Section 3.06	
6.A.iii.a	Acuity adjustments may be used prospectively or retrospectively	Section 3.04 (disenrollment freeze) and Section 3.06	
6.A.iii.b	While retrospective acuity adjustments may be permissible, they are intended solely as a mechanism to account for differences between assumed and actual	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	health status when there is significant uncertainty about the health status or risk of a population, such as: (1) new populations coming into the Medicaid program; or (2) a Medicaid population that is moving from FFS to managed care when enrollment is voluntary and there may be concerns about adverse selection. In the latter case, there may be significant uncertainty about the health status of which individuals would remain in FFS versus move to managed care; although this uncertainty is expected to decrease as the program matures.		
6.B.i	The rate certification must describe all prospective risk adjustment methodologies, including:	Sections 3.10-3.12	
6.B.i.a	The data, and any adjustments to that data, to be used to calculate the adjustment	Sections 3.10-3.12	
6.B.i.b	The model, and any adjustments to that model, to be used to calculate the adjustment	Sections 3.10-3.12	
6.B.i.c	The method for calculating the relative risk factors and the reasonableness and appropriateness of the method in measuring the risk factors of the respective populations	Sections 3.10-3.12	
6.B.i.d	The magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP	Sections 3.10-3.12	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
6.B.i.e	An assessment of the predictive value of the methodology compared to prior rating periods	Sections 3.10-3.12	
6.B.i.f	Any concerns the actuary has with the risk adjustment process	Sections 3.10-3.12	
6.B.ii	The rate certification must describe all retrospective risk adjustment methodologies, including:	N/A	
6.B.ii.a	The party calculating the risk adjustment	N/A	
6.B.ii.b	The data, and any adjustments to that data, to be used to calculate the adjustment	N/A	
6.B.ii.c	The model, and any adjustments to that model, to be used to calculate the adjustment	N/A	
6.B.ii.d	The timing and frequency of the application of the risk adjustment	N/A	
6.B.ii.e	Any concerns the actuary has with the risk adjustment process	N/A	
6.B.iii.a	Any changes that are made to risk adjustment models since the last rating period	Sections 3.10-3.12	
6.B.iii.b	Documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g)	Sections 3.10-3.12 as well as tab |1b. Rate Summary - HHA| for the HHA relativity factor and tab |4. Risk Score Budget Neutrality| for non-HHA risk adjustment, of the accompanying Excel file	
6.B.iv	If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its	Section 3.04 (disenrollment freeze) and Section 3.06	An adjustment has been made to estimate the acuity difference resulting from the

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices:		PHE-related disenrollment freeze. Additionally, an adjustment has been made to reflect the anticipated acuity of the HHA population relative to the current Heritage Health populations which form the basis for rate development and is described in Section 3.06.
6.B.iv.a	The reason that there is significant uncertainty about the health status of the population and the need for an acuity adjustment	Section 3.04 (disenrollment freeze) and Section 3.06	Details related to the rationale for the disenrollment freeze acuity adjustment are provided in Section 3.04. The HHA population is newly eligible as a result of Medicaid Expansion, and therefore reliable historical data specific to this population does not exist.
6.B.iv.b	The acuity adjustment model(s) being used to calculate acuity adjustment scores	Section 3.04 (disenrollment freeze) and Section 3.06	Details related to the rationale for the disenrollment freeze acuity adjustment are provided in Section 3.04. For the HHA population, there is not a specific model in use for this adjustment, it reflects an assumed mix of TANF (Family) and AABD (Disabled) acuity for the HHA population.

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
6.B.iv.c	The specific data, including the source(s) of the data, being used by the acuity adjustment model(s)	Section 3.04 (disenrollment freeze) and Section 3.06	
6.B.iv.d	The relationship and potential interactions between the acuity adjustment	Section 3.04 (disenrollment freeze) and Section 3.06	
6.B.iv.e	How frequently the acuity adjustment scores are calculated	Section 3.04 (disenrollment freeze) and Section 3.06	
6.B.iv.f	A description of how the acuity adjustment scores are being used to adjust the capitation rates	Section 3.04 (disenrollment freeze) and Section 3.06	
6.B.iv.g	Documentation that the acuity adjustment mechanism has been developed in accordance with generally accepted actuarial principles and practices	Section 3.04 (disenrollment freeze) and Section 3.06	
Section II. Medicaid Managed Care Rates with Long-Term Services and Supports			
Managed Long-Term Services and Supports			
1.A	For managed long-term services and supports (MLTSS) programs, or for programs that include MLTSS as part of the covered benefits, the guidance above in Section I of the guide regarding the required standards for rate development and CMS's expectations for appropriate documentation required in the rate certification is also applicable for rates for provision of MLTSS	N/A	
1.B.i.a	Structure the rate cells by health care status and the level of need of the beneficiaries ("blended")	N/A	

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1.B.i.b	Structure the rate cells by the long-term care setting that the beneficiary uses ("non-blended")	N/A	
1.C.i	The rate certification and supporting documentation for MLTSS programs, or for programs that include MLTSS as part of the covered benefits must also specifically address the following considerations:	N/A	
1.C.i.a	The structure of the capitation rates and rate cells or rating categories (e.g. blended, non-blended, etc.)	N/A	
1.C.i.b	The structure of the rates and the rate cells, and the data, assumptions, and methodology used to develop the rates in light of the overall rate setting approach	N/A	
1.C.i.c	Any other payment structures, incentives, or disincentives used to pay the MCOs, PIHPs or PAHPs	N/A	
1.C.i.d	The expected effect that managing LTSS has on the utilization and unit costs of services	N/A	
1.C.i.e	Any effect that the management of this care is expected to have within each care setting and any effect in managing the level of care that the beneficiary receives	N/A	
1.C.ii	The projected non-benefit costs, such as administrative costs and care coordination costs, may differ for populations receiving MLTSS from other managed care programs, and the rate certification should describe how the projected non-benefit costs were	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
	developed for populations receiving these services		
1.C.iii	The rate certification should provide information on historical experience, analysis, and other sources (e.g., studies or research) used to develop the assumptions used for rate setting	N/A	
Section III. New Adult Group Capitation Rates			
Data			
1.A	In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the state, described in Section I of the guide, the rate certification must describe the data used to develop new adult group rates, particularly where different or additional data was used	Sections 3.02, 3.03, & 3.06	
1.B	For states that have covered the new adult group in Medicaid managed care plan(s) in previous rating periods (i.e. starting in 2014, 2015, 2016, 2017, 2018, 2019, 2020 and/or January through June 2021), CMS expects the rate certification, as supported by assurances from the state, to describe:	Section 3.06 & 3.12	The HHA population go-live was October 1, 2020. Data was provided from October 2020 – May 2021, with runout through May 2021. As a result of this timing and the implications of the COVID-19 pandemic, we generally do not believe that the emerging utilization experience for the HHA population is reliable to use as the base for rate development at this point. Emerging utilization

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
			information has been used to inform specific adjustments related to half-way house and COVID testing utilization. Emerging enrollment experience has been used to estimate the overall and MCO-specific mix of Medically Frail individuals for rate blending and relativity purposes.
1.B.i	Any new data that is available for use in this rate setting	Section 3.06 & 3.12	See response to 1.B above.
1.B.ii	How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults	N/A	
1.B.iii	How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications		We do not believe that the overall emerging experience is substantive or reliable enough to use for meaningful comparisons at this point.
1.B.iv	How differences between projected and actual experience in previous rating periods have been used to adjust these rates		See response to 1.B.iii above.
Projected Benefit Costs			
2.A.i	For states that covered the new adult group in previous rating periods:		
2.A.i.a	Any data and experience specific to the new adult group covered in previous rating periods that was used to develop projected benefits costs for capitation rates	N/A	The HHA population go-live was October 1, 2020. Data was provided from October 2020 – May 2021, with runout

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
			through May 2021. As a result of this timing and the implications of the COVID-19 pandemic, we generally do not believe that the emerging utilization experience for the HHA population is reliable to use as the base for rate development at this point. Emerging utilization information has been used to inform specific adjustments related to half-way house and COVID testing utilization. Emerging enrollment experience has been used to estimate the overall and MCO-specific mix of Medically Frail individuals for rate blending and relativity purposes
2.A.i.b	Any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last rate certification	Section 3.06	See response to 2.A.i.b related to the half-way house and COVID testing adjustments, as well as the use of emerging Medically Frail member mix.
2.A.i.c	How assumptions changed from the rate certification(s) for previous rating periods on the following issues:	Section 3.06	
2.A.i.c.i	Change in acuity or health status adjustments	N/A	There has not been a change in the approach used to estimate acuity/health status,

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
			however more recent emerging data has been used to estimate the portion of the population that is Medically Frail.
2.A.i.c.ii	Change in adjustments for pent-up demand		The CY22 contract period reflects a period of time that is between 15-27 months after the go-live of the HHA program. As a result, we believe that the majority of the impact due to both pent-up demand and durational implications that were reflected in prior cycles, should have begun to stabilize. Therefore, these adjustments are no longer being applied for CY22.
2.A.i.c.iii	Change in adjustments for adverse selection	N/A	
2.A.i.c.iv	Change in adjustments for the demographics of the new adult group	N/A	
2.A.i.c.v	Change in differences in provider reimbursement rates or provider networks	N/A	
2.A.i.c.vi	Other material changes or adjustments to the new adult group projected benefit costs	N/A	
2.A.i.c.vii	Any changes to the benefit plan offered to the new adult group	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
2.A.ii	For states that did not cover the new adult group in previous rating periods: (a) descriptions of any differences of the benefit plan offered to the new adult group population and other covered populations (i.e., the non-new adult group population).	N/A	
2.A.iii	For any state that is covering the new adult group, regardless if they have been covered in previous rating periods, the following key assumptions related to the new adult group must be identified and described in the rate certification and supporting documentation:		
2.A.iii.a	Acuity or health status adjustments	Sections 3.06 & 3.12	
2.A.iii.b	Adjustments for pent-up demand	N/A	The CY22 contract period reflects a period of time that is between 15-27 months after the go-live of the HHA program. As a result, we believe that the majority of the impact due to both pent-up demand and durational implications that were reflected in prior cycles, should have begun to stabilize. Therefore, these adjustments are no longer being applied for CY22.
2.A.iii.c	Adjustments for adverse selection	N/A	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
2.A.iii.d	Adjustments for the demographics of the new adult group	Sections 3.06 & 3.12	
2.A.iii.e	Differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for the new adult group rates and other Medicaid population rates	N/A	Provider reimbursement rates do not vary between the HHA and non-HHA populations.
2.A.iii.f	Other material adjustments	Section 3.06	
2.B	The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs	Section 3.06	
Projected Non-Benefit Costs			
3.A.i	For states that covered the new adult group in Medicaid managed care plan(s) in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification	Section 3.07	
3.A.ii.a	Change in administrative cost assumptions	Section 3.07	
3.A.ii.b	Change in care coordination and care management assumptions	Section 3.07	
3.A.ii.c	Change in provision for operating or profit margin	N/A	
3.A.ii.d	Change in taxes, fees, and assessments	N/A	
3.A.ii.e	Change in other material non-benefit costs	N/A	
3.B.i	Administrative costs	Section 3.07	
3.B.ii	Care coordination and care management	Section 3.07	
3.B.iii	Provision for operating or profit margin	Section 3.07	

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
3.B.iv	Taxes, fees, and assessments	Section 3.07	
3.B.v	Other material non-benefit costs	Section 3.07	
Final Certified Rates			
4.A.i	A comparison to the final certified rates in the previous rate certification	Rate change comparison is shown in Tab |1b. Rate Summary – HHA| of accompanying Excel file	
4.A.ii	A description of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance	N/A	
Risk Mitigation Strategies			
5.A	CMS requests under 42 C.F.R. § 438.7(d) that states describe any risk mitigation strategy that is specific to the new adult group. In accordance with 42 C.F.R. § 438.6(b), if the state utilizes risk-sharing mechanisms with its managed care plan(s) these arrangements must be documented in the contract(s) and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period.	Section 3.14	
5.B.i	Any changes in the risk mitigation strategy from those used during previous rating periods	N/A	The risk mitigation strategy for the HHA population is

Section of 2021-2022 Rate Guidance	Section Description	Certification Reference	Comments
			unchanged from the prior contract period.
5.B.ii	The rationale for making the change in the risk mitigation strategy or removing the risk mitigation used during previous rating periods. For states that utilize a risk mitigation strategy specific to the new adult group for the initial rating period that included this population, CMS believes this risk mitigation strategy should continue to be utilized until the following three criteria are met: (a) the state uses data only from the new adult group's experience to develop capitation rates; (b) the state has settled or reconciled previous risk mitigation terms in their contract (e.g., MLR, risk corridor) to assess the appropriateness of their previous rate development; and (c) the state can demonstrate that capitation rates are stable, or that rates have been adjusted consistent with differences in early experience.	N/A	
5.B.iii	Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods	N/A	

6. Appendix II – Heritage Health CY22 Rate Certification Exhibits

See the accompanying Excel file titled "Appendix II. Heritage Health CY22 Capitation Rate Certification Exhibits.xlsx"

This file contains the following tabs:

- 1a. Rate Summary - HH
- 1b. Rate Summary - HHA
- 2. Trend
- 3. Plan Rates
- 4. Risk Score Budget Neutrality
- 5. FMAP Breakout
- 6. (b)(3) Summary
- 7. HIPP Rate Exhibit
- 8. High Cost Drug Pool
- 9. High Cost Drug Risk Corridor
- 10. Historical Admin Experience