March 31, 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 Dental Program SFY22 Rate Development

Dear Jeremy:

Thank you for the opportunity to assist the Department of Health and Human Services (DHHS) with the development of the Nebraska Dental Program 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 SFY22 capitation rates, effective July 1, 2021 – June 30, 2022. We have also provided our actuarial certification for these rates, compliant with Centers for Medicare & Medicaid Services (CMS) guidelines and requirements. Please send Barry Jordan an e-mail at Barry.Jordan@**Optumas**.com or call at 480.588.2492, or email Chris Dickerson at Chris.Dickerson@**Optumas**.com or call at 480.588.2496 if you have any questions.

Sincerely,

Barry Jordan, FSA, MAAA
Consulting Actuary

Chris Dickerson, ASA, MAAA
Consulting Actuary

CC: Emi Giles, DHHS
Steve Schramm, **Optumas**
Ainsley Ramsey, **Optumas**
Ryan Brancati, **Optumas**

State of Nebraska

Nebraska Dental Program Actuarial Certification

July 1, 2021 – June 30, 2022 Capitation Rates

Table of Contents

1. Executive Summary

This report provides documentation and actuarial certification for the Nebraska Dental Program SFY22 capitation rate development for rates effective July 1, 2021 – June 30, 2022 (SFY22).

The Nebraska Dental Program began operating October 1, 2017, allowing the State of Nebraska (State) to deliver Dental services to Medicaid beneficiaries through a managed care framework, departing from the historical fee-for-service (FFS) framework. Services are provided statewide, via the contracted Dental Benefits Program Manager (DBPM), MCNA Dental.

As the consulting actuaries to the State of Nebraska, **Optumas** ensured that the methodology used to develop the SFY22 Dental rates complied with the CMS guidance for the development of actuarially sound rates.

Optumas worked with the State to identify the necessary components of the rates, accounting for the covered services and populations as described in the Dental 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 necessary to reasonably and appropriately develop SFY22 rates for the Dental program.

The final rates were developed according to actuarially sound principles and reasonably reflect the experience projected for SFY22 of the Nebraska Dental Program.

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

Figure 1. Report Structure

Section	Contents
Background	Provides description of the Dental 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
Appendices	Detailed tables showing compliance with the CMS Consultation Guide, as well as results of data summaries, analyses, and assumptions used within the rate development methodology

2. Background

This report provides documentation and actuarial certification for the Nebraska Dental capitation rate development effective July 1, 2021 – June 30, 2022. The Nebraska Dental Program is a managed care environment where services are provided via a Dental Benefits Program Manager (DBPM), MCNA Dental.

The Dental Program is operated on a Statewide basis, providing all dental services via a managed care delivery system. All Medicaid and CHIP beneficiaries, with the exception of the 599 CHIP population, are eligible for the Nebraska Dental Program. Effective October 1, 2020 Nebraska expanded Medicaid eligibility to higher income populations previously not eligible for services. This results in a group of primarily 19 and 20-year-olds, pregnant women, and individuals qualifying as medically frail being enrolled in the DBPM. This certification letter discusses the development of rates for this new population and cohort structure. At the time of developing the rates described in this certification letter, approval of the 1115 Waiver submitted by the State to allow coverage for additional members within the Expansion population is still pending and therefore has not been directly considered in the development of the rates for the Expansion population. To the extent that eligibility for dental coverage changes during the contract period and that it would require adjustment to the SFY22 capitation rates, an amendment will be provided accordingly to CMS.

As the consulting actuaries to the State for the Dental capitation rates, **Optumas** worked with the State to develop an appropriate rate setting methodology for the Dental rates. The Nebraska Dental Program began operating October 2017 so there were multiple complete years of Nebraska Dental Program experience available at the time of SFY22 rate development. **Optumas** ensured that the rate methodology described in the remainder of this document is compliant with the CMS guidance for the development of actuarially sound rates.

3. Rate Development Process

3.01 Overview

In developing the Dental 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 49 – Medicaid Managed Care Capitation Rate Development and Certification

Optumas specifically applied these criteria in the development of the methodology for calculating the Dental capitation rates for the July 1, 2021 – June 30, 2022 contract period. Appendix I.A contains the 2020-2021 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 Dental capitation rates are compliant with the guidelines.

The base data used for rate setting is comprised of managed care dental claims incurred within CY19 data (January 1, 2019 – December 31, 2019), paid through December 31, 2020, which reflects the most recent complete year of data not impacted by utilization reductions resulting from the COVID-19 pandemic. MCNA's Nebraska Medicaid and CHIP enrollment and capitation data for the same time periods was used for the underlying membership within rate development. A brief description of the rating adjustments applied to transform the base data into projected SFY22 rates is presented below in Figure 2.

Figure 2. Rate Development Process Adjustments

Adjustment	Overview
Base Data Adjustments	IBNR adjustment to account for claim payment lag in the base data
Program Changes	Historical and prospective program (population and benefit) changes not reflected in the raw base data

Adjustment	Overview
Trend	Factors to account for the forecasted change in utilization and unit costs from the base data to the contract period
Non-Medical Loading	Administrative load to account for non-medical expenditures incurred by the DBPM and a profit, risk, and contingency margin
Directed Payment Arrangement	Description of the minimum fee scheduled directed payment arrangement, including development of rating impact

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

3.02 Base Data

Data Reporting

Optumas used CY19 managed care claims data, paid through December 31, 2020, as the base data for rate setting. Monthly, member-level eligibility and capitation files were used to summarize the corresponding membership for the Medicaid and CHIP beneficiaries for the CY19 time period.

To ensure compliance with ASOP 23 – Data Quality, **Optumas** conducted data validation analyses and benchmarked the data used in rate development to other Dental Programs in which **Optumas** develops rates. The data validation analyses included:

1. Referential Integrity Checks – **Optumas** ensured that all managed care claims included in base data were incurred by a member with a valid Medicaid eligibility span that coincided with the incurred date associated with the specific claim.
2. Volume Checks – **Optumas** checked both volume of claims and total dental service expenditures by looking at totals longitudinally. This ensured that any gaps or spikes in the data were identified and addressed before creating the base data.
3. Benchmark Comparison – **Optumas** compared summarized data to other base data summaries used in reference dental programs in other states for benchmarking purposes.

Medicaid Expansion in Nebraska began October 1, 2020. Since very limited data exists on the Medicaid Expansion population's dental utilization in Nebraska, **Optumas** decided to use the existing Medicaid population's encounter data to estimate the Medicaid Expansion cost. Adjustments were made for relative acuity differences, but the same data underlying the traditionally eligible 19-24, 25-54, and 55-64 populations is used as the starting point for the development of Medicaid Expansion rates for the same age bands. The acuity adjustments applied to project the expansion rates are described later in this certification.

Covered Services

The Nebraska Dental Program covers all dental services for the Medicaid population. Covered dental services, identified by claim lines with procedure codes beginning with the letter 'D', or non-'D' codes indicating an Indian Health Service (IHS) dental encounter, are grouped into aggregate categories of service shown below in Figure 3:

Figure 3. Categories of Service (COS)

Categories of Service
Adjunctive General Services
Endodontics
Oral and Maxillofacial Surgery
Orthodontics
Partial Dentures
Periodontics
Preventative
Prosthodontics
Restorative
FQHC
IHS

The units underlying the rate development are units as reported on each claim line for each category of service, with the exception of services provided at an IHS Clinic or a Federally Qualified Health Center (FQHC). The units underlying the IHS and FQHC categories of service are indicative of claim count, as IHS services are reimbursed according to a daily encounter rate and FQHC services will be reimbursed according to a facility-specific daily Alternative Payment Methodology (APM) rate.

Covered Populations

The managed care dental data was summarized into rating categories, distinguished by age bands, that represent distinct levels of risk. Figure 4 shows the rating categories within the Dental Program:

Figure 4. Rating Categories

Age Band
0-1
2-5
6-18
19-24
25-54
55-64
65+
19-24 Expansion
25-54 Expansion
55-64 Expansion

Effective July 1, 2019, all non-expansion populations eligible for dental services in Nebraska Medicaid (inclusive of CHIP beneficiaries) were enrolled in the Dental Program, further described in Section 3.04 under the 'New Populations' subsection. The CY19 managed care base data can be found in Appendix I.B.

October 1, 2020 marked the beginning of Medicaid Expansion in Nebraska, which covers dental benefits primarily for 19-20-year-olds, pregnant women, and individuals qualifying for medical frailty. Because our analyses show age bands to be a sufficient representation of distinct levels of dental risk, the Medicaid Expansion dental rates were split by the same age bands as the traditional population, as shown in Figure 4 above.

3.03 Base Data Adjustments

Incurred but Not Reported (IBNR) Adjustment

Optumas analyzed the claim payment lag by category of service through the incurred but not reported (IBNR) analysis. As previously mentioned, the managed care data was paid through December 31, 2020. IBNR factors were developed and applied to the base data by major category of service. **Optumas** observed that the dental data completes quickly, and our analysis shows that with a full year of runout, the CY19 data is expected to be complete. This analysis is consistent with the financial statements reported by MCNA, which also show 100% completion after 12 months. Consequently, the IBNR factors for all categories of service were assumed to be 1.000, making the aggregate IBNR factor for CY19 1.000. Details surrounding the IBNR factors at the category of service level can be found in Appendix I.C.

3.04 Program Changes

Optumas worked with the State to identify any prospective program or policy changes implemented after the base data time period. Note that the approach used for the three Expansion age-band cohorts (19-24, 25-54, 55-64) is identical to that of the non-Expansion 19-24, 25-54, and 55-64 age bands with the exception of the Expansion Population Acuity Adjustment noted in this section.

IHS Repricing

Each calendar year, all dental services provided at an IHS clinic are to be reimbursed at a different encounter rate. The most recent available encounter rate was $519 per visit for CY21. **Optumas** worked with the State to identify all IHS providers within the managed care data and to reprice the dental services at the most recent encounter rate. The average annual percentage increase in encounter rates from CY15 to CY21 (6.8%) was applied to the CY21 encounter rate to project a CY22 encounter rate. To reflect the fact that the IHS encounter rate is expected to increase mid-contract period, IHS claims were repriced such that the contract period reflects the CY21 encounter rate, increased by half of the percent change between the CY21 and estimated CY22 encounter rates (approximately 3.4%, which is half of the historical 6.8% average). The impact of repricing IHS services to the latest encounter rate is an aggregate increase of 0.49% to the base data for the non-expansion population. The impact by Age Band and COS for the non-expansion populations can be found in Appendix I.D.

The impact of repricing IHS services for the expansion population is an aggregate increase of 0.35% to the base data. The impact by Age Band and COS for the expansion population can be found in Appendix I.D.

FQHC Repricing

Effective July 1, 2020, all dental services provided at an FQHC facility are to be reimbursed at per claim per day APM rate corresponding to the facility name. **Optumas** worked with the State to identify the FQHC facilities within the managed care data and to reprice the dental services at the corresponding APM rates. FQHC claims in the base data were first repriced to the CY21 APM rates (2020 rates increased by the market-basket increase of 1.7% for 2021), and then increased by half of the most recent market-basket increase (half of 1.7%, or approximately 0.85%) to estimate the growth in rates that will occur mid-contract period. The impact of repricing FQHC claims at the latest APM rate is an aggregate increase of 5.83% to the base data for the non-expansion population. The impact by Age Band and COS for the non-expansion populations can be found in Appendix I.E.

The impact of repricing FQHC claims for the expansion population is an aggregate increase of 7.65% to the base data. The impact by age band and COS for the expansion populations can be found in Appendix I.E.

Provider Fee Change

Effective July 1, 2019 (SFY20) and July 1, 2020 (SFY21) the State implemented 2.0% provider fee changes for dental services, excluding dental services provided in an IHS clinic or an FQHC facility. Another 2.0% provider fee increase will be implemented effective July 1, 2021. **Optumas** repriced the applicable services within the base data to be consistent with the latest provider reimbursement changes, inclusive of half of the 2.0% increase effective July 1, 2019 due to its being reflected in half of the CY19 base period already, as well as the two subsequent 2.0% increases (July 1, 2020 and July 1, 2021). The impact of repricing the dental services to the latest Medicaid reimbursement is an aggregate increase of 4.30% for the non-expansion population and an aggregate increase of 4.15% for the expansion population. Additional details on the provider fee change adjustment values, by rating cohort and COS, can be found in Appendix I.F.

Expansion Population Acuity Adjustment

Coverage of Medicaid Expansion members began in Nebraska on October 1, 2020. As part of converting the traditional dental rates to expansion-appropriate rates, **Optumas** created acuity factors based upon a reference state in which expansion has already taken effect. As part of the rate development process, the ratio of the cost of the reference state's expansion members to the cost of its traditional members was applied to the MCNA data to arrive at rates appropriate for the expansion context. Expansion acuity factors were applied by age band. The same acuity factors developed for the 10/1/20 – 6/30/21 rates were applied to the SFY22 rates. The impact of this expansion population acuity adjustment is an aggregate decrease of 0.09%. Further details on the impact of this expansion population acuity adjustment, by rating cohort and COS, can be found in Appendix I.H.

New Populations

Certain populations were not enrolled into the Managed Care Dental program during initial implementation, and they instead received services via FFS. Effective July 1, 2019, the following populations started enrolling into the Managed Care program for the provision of dental services:

1. State Wards out of state population
2. State Disability population
3. Refugee Resettlement population
4. Share of Cost Clients in certain living arrangements, that had previously not been enrolled in managed care

Optumas reviewed the historical dental experience for these populations, in conjunction with the overall enrollment volume of these populations, as compared with the members already enrolled with the DBPM and inherent in the Managed Care base data. This review determined that the expected impact to the capitation rates with the inclusion of these population is de minimis. Therefore, no explicit rating adjustment has been applied for the inclusion of these populations, and they will receive the applicable age-band based capitation rate corresponding to their age consistent with the already enrolled population. This methodology is consistent with that of the previous rate cycle and is further supported by the fact that half of the CY19 base data already includes experience for these populations.

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 category of service (COS) (e.g., Preventative, Orthodontics, etc.) and rating category (e.g., 0-1, 2-5, etc.). Prospective trends were applied from the midpoint of the adjusted CY19 base (7/2/2019) to the midpoint of the SFY22 contract period (12/30/2021) for the expansion and non-expansion cohorts. The same trend factors were applied to both the non-expansion and expansion populations.

Prior to reviewing historical experience, **Optumas** first normalized the CY19 base data for programmatic and reimbursement changes described above, to ensure that the impact of these changes were not duplicated as both a rating adjustment and as trend. Once this was done, the historical base data was arrayed by rating category, COS, and month of service, so that historical utilization/1,000, unit cost, and PMPMs could be reviewed. There is not a pre-determined algorithm in place to convert historical trend to prospective trend, and trend assumptions vary based on nuances with a specific population or COS; given that prospective trend is a projection of future experience, it is necessary to make adjustments considering that historical trend experience may differ from what will materialize in the future.

The annualized prospective utilization, unit cost, and PMPM trend assumptions by rating category and COS are included within Appendix I.G.

3.06 Non-Medical Load

The non-medical load measures the dollars associated with components such as administration, profit, risk, and contingency and is expressed as a percentage of the capitation rate. **Optumas** reviewed emerging reported administrative cost experience for the DBPM, as well as experience in other states and similar programs, on both a PMPM and percentage basis, to develop a reasonable non-medical load for the dental rates. The non-medical load developed for the Nebraska Dental Program consists of a 10%

administrative load and 1% profit for all rating categories, and for both non-expansion and expansion populations.

The detailed non-medical loading assumptions by each rating category is included in Appendix I.I.

3.07 Directed Payment Arrangement

Description of Arrangement

Effective July 1, 2021 the State is seeking approval of the Percentage Increase directed payment arrangement methodology for applicable providers. The payment arrangement has not yet been approved for the July 1, 2021 – June 30, 2022 contract period but is consistent with the Percentage Increase pre-print that was approved by CMS for July 1, 2020 – June 30, 2021, and the anticipated pre-print that will be submitted to CMS for review. Under this mechanism, in accordance with CFR 438.6(c)(2)(i)(B), a supplemental payment for covered dental services will be made for the services provided or supervised by a faculty or staff member of an academic dentistry institution of a public university. Providers who participate in this payment arrangement are dental service providers who are acting in the capacity of an employee or contractor of the public academic dentistry institution under a network provider agreement with the Nebraska Medicaid Dental Managed Care Plan. Practitioners shall be identified by the reported federal tax ID for the public academic dentistry institution. The qualifying faculty or staff member shall be providing or supervising treatment as part of an approved program of the public academic dental institution to Medicaid enrollees covered under the Dental Managed Care Plan.

This payment arrangement will apply to all qualified providers of the specific class identified above and will establish payment for dental services covered under the Medicaid Dental Managed Care Plan. Through a contract amendment, the DBPM will be required to adopt the State-directed minimum fee schedule payment arrangement for the providers identified as members of this specific class. Please refer to NE Medicaid State Plan, Attachment 4.19-B Item 10, Pages 2-3.

Payment Distribution

Under the arrangement described above, the DBPM will pay the customary rate when adjudicating claims. The payment arrangement is based upon the actual utilization by CDT code paid by the DBPM to the specified group of qualified providers, for services to Medicaid enrollees of the DBPM. The basis for the supplemental payments is the difference between the average commercial rate for each CDT code (for the academic dentistry institutions top three commercial payers) and the actual Medicaid and third-party liability payment for each code. The differential is multiplied by the Medicaid volume for each code paid at the customary rate to this class of providers. These calculations are incorporated into the actuarially determined difference between the dental capitation payments calculated with the supplemental payment arrangement change and without the supplemental payment arrangement change. The DBPM is responsible for paying the academic dentistry institution the calculated differential payment arrangement amounts based on actual utilization.

Please see NE Medicaid State Plan, Attachment 4.19-B Item 10, Pages 2-3 for a description of the payment methodology.

Rating Adjustment

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

Optumas worked with the State to identify claims and services attributed to UNMC providers within the CY19 managed care base data. The State provided the most recent UNMC commercial-level fee schedules to be used to reprice these claims. The difference between the average of the commercial rates and Medicaid customary rate (Medicaid fee schedule) for each CDT underlying the data for UNMC providers was then calculated. This difference was calculated to arrive at a supplemental PMPM amount by category of aid, which is the amount in excess of what would be paid at the Medicaid fee schedule up to a soft cap in growth of 2%, in line with the provider fee increase effective for SFY22, from the directed payment amount in place for SFY22; non-medical load has not been applied to this incremental PMPM amount. The resulting PMPM by category of aid, is the amount built into the capitation rates to reflect the impact of implementing the directed payment arrangement.

The table in Appendix I.J shows the value of the PMPM adjustment described above, by rating cohort, for the addition of the directed payment amounts. Based on the CY19 membership underlying the base data for the non-expansion cohorts, in addition to projected expansion enrollment, this amounts to a total supplemental dollar amount of $4.1M for the non-expansion and expansion populations combined.

3.08 Additional Considerations

Profit Cap

Effective beginning with the SFY22 contract period, the Dental program is subject to a state-manded 3% profit cap. The parameters for this calculation are as follows:

A. The expenditures for the profit cap calculation will be comprised of the following components:

1. Incurred claims (net of directed payment amounts described in Section 3.07)
2. IBNR estimate for claims incurred in contract period
3. Non-claim service-related payments (incentive and bonus payments)
4. Reinsurance premiums less recoveries
5. Administrative expenditures, subject to maximum of 12% (12% of capitation rates gross withhold, and net of directed payment amount described in Section 3.07)
6. Less related-party medical margin

This will result in the sum of items 1-5, minus item 6.

B. The revenue for the profit cap calculation will be comprised of the following components:

1. Capitation payments net of withhold and net of amount related to the directed payment described in Section 3.07
2. Earned withhold amount

3. Less HIPF
4. Less other applicable federal/state taxes

This will result in the sum of items 1-2, minus items 3-4.

The profit cap calculation will then be conducted to review whether the implied amount of profit relative to revenue (B – A)/(B), is greater than 3%. If the amount is less than 3%, then no remittance is required. However, if the amount is greater than 3%, then a payment will be triggered from the DBPM to the State. The payment amount will be the amount that results in a 3% profit relative to the effective net revenue. In other words, the payment amount X will be such that (B – A – X)/(B – X) = 3%.

MLR Calculation

The State will use a minimum Medical Loss Ratio (MLR) for the Dental Program. The minimum MLR is established as 85%. If the MLR is less than 85%, the DBPM must refund the State the difference. Plan submitted encounters and the reported financials will be reconciled to the assumed experience included in the developed rates to evaluate any MLR payments necessary from the DBPM to the State.

The methodology that will be used to calculate the MLR under the DBM contract is as follows:

A. The numerator for the MLR calculation will be comprised of the following components:

1. Incurred claims (net of directed payment amounts described in Section 3.07)
2. IBNR estimate for claims incurred in contract period
3. Non-claim service-related payments (incentive and bonus payments)
4. Costs for Activities that Improve Health Care Quality (per 42 CFR §438.8 (e)(3))
5. Fraud prevention costs (per 42 CFR 438.8 (e)(4))
6. Reinsurance premiums less recoveries
7. Less related-party medical margin

This will result in the sum of items 1-6, minus item 7.

B. The denominator for the MLR calculation will be comprised of the following components:

1. Capitation payments net of withhold and net of the amount related to the directed payment described in Section 3.07
2. Earned withhold amount
3. Less HIPF
4. Less other applicable federal/state taxes
5. Less any remittances required as a result of the 3% profit cap described above

This will result in the sum of items 1-2, minus items 3-5.

The MLR calculation will then be conducted as the numerator (A) divided by the denominator (B). To the extent that A/B is below 85%, a payment will be triggered from the DBM to the State. The payment amount will be the amount that results in an 85% MLR relative to the effective net revenue. In other words, the payment amount X will be such that A/(B – X) = 85%.

Withhold

Per the Dental Program contract, 1.5% of premium (net of the Directed Payment Arrangement PMPM described in Section 3.07) is withheld and deposited into the Holding Account. The DBPM 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 capitation rate net of the Directed Payment Arrangement amount. To the extent that the DBPM does not earn back the withhold, the payment rate would still be reasonable and appropriate for the covered services and populations. The full withhold was earned back by the DBPM for SFY20, and it is anticipated that the DBPM will continue to earn the majority or entirety of the withhold.

4. Rate Certification

We, Barry Jordan, Consulting Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA) and a Fellow of the Society of Actuaries (FSA), and Chris Dickerson, Consulting Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA) and an Associate of the Society of Actuaries (ASA), are certifying the calculation of the payment rates, which are shown in Appendix II.A. We 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 payment rates that are associated with this certification are effective July 1, 2021 through June 30, 2022 for the Nebraska Dental Program.

The actuarially sound capitation rates are based on a projection of future events. Actual experience will likely vary from the assumed experience underlying these rates. The capitation rates offered may not be appropriate for any specific DBPM. An individual DBPM should review the rates in relation to the benefits that it is obligated to provide to the covered population. The DBPM 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 DBPM may require rates above, within, or below the actuarially sound rates associated with this certification.

Please feel free to contact Barry Jordan at 480.588.2492 or Chris Dickerson at 480.588.2496 for any additional information.

Sincerely,

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

Chris Dickerson, ASA, MAAA
Consulting Actuary, **Optumas**

5. Appendices

Appendix I. Rate Development

Appendix I.A: Medicaid Managed Care Rate Guidance

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
Section I. Medicaid Managed Care Rates			
General Information			
1.A.i	Rate certifications must be done for a 12-month rating period. CMS will consider a time period other than 12 months to address unusual circumstances.	Section 1	
1.A.ii.a	Letter from Certifying Actuary	Section 4	
1.A.ii.b	Certified Capitation Rates	Appendix II	
1.A.ii.c.i	Managed Care Programs Summary	Section 1	
1.A.ii.c.ii	Rating Period Covered	Section 1	
1.A.ii.c.iii	Medicaid Populations Covered	Sections 3.02, 3.04	
1.A.ii.c.iv	Eligibility/Enrollment Criteria	Sections 3.02, 3.04	
1.A.ii.c.v	Special Contract Provisions per 42 CFR §438.6	Section 3.08	
1.A.ii.c.vi	Retroactive Adjustments	N/A	
1.A.iii	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.iv	No Cross-Subsidization Between Rate Cells	Section 3	Confirmed
1.A.v	Effective Dates of Program Changes Consistent with Development of Rating Adjustments	Section 3.04	
1.A.vi	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 should clearly be outlined in	Confirmed, see Section 3.08	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	rate certification and demonstrate compliance with 42 CFR 438.8(c).		
1.A.vii.a	All Rating Adjustments Reflect Reasonable, Appropriate, and Attainable Costs	Section 3	Confirmed
1.A.vii.b	No Adjustments Outside of Rate Setting Process	Section 3	Confirmed
1.A.vii.c	Contracted Rates Match Rates in Certification Letter	Confirmed	
1.A.viii	Certification Provided for All Effective Dates	Section 4	Confirmed
1.A.ix	Procedures for Rate Certification for Rate and Contract Amendments	Section 4	
1.B.i.a-c	Document Data, Assumptions, and Methodology	Section 3	
1.B.ii	Actuary Must Certify Specific Rates and not Rate Ranges	Section 4	Confirmed
1.B.iii	Rate Development Guide Index	Appendix I.A	This Document
1.B.iv	Different FMAP Components for Applicable Services, Populations, or Programs	Appendix II.C	
1.B.v.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.	Appendix II.B	The only cohort with a negative rate change is the 55-64 age band (non-expansion and expansion), which is a result of reductions in base data from the prior rate cycle. This is attributed primarily to reductions in Partial Denture and Restorative services.
1.B.v.b	Description of any material changes to rate development methodology not otherwise	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	addressed in the other sections of the other sections of the guidance		
1.B.vi	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.	N/A	No amendments for the SFY22 contract period are known at this time.
Data			
2.A.i.a	State Must Provide Three Most Recent Years of Complete Data	Confirmed	**Optumas** requested, and the State provided more than three years of historical dental FFS data, in addition to managed care experience from October 2017 – December 2020.
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	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	**Optumas** requested, and the State provided more than three years of historical dental FFS data, in addition to managed care experience from October 2017 – December 2020.

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
2.B.i.a.ii	Description of Base Data Provided by State	Section 3.02	**Optumas** requested, and the State provided more than three years of historical dental FFS data, in addition to managed care experience from October 2017 – December 2020.
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	N/A	
2.B.ii.b.i.A-C	Steps Taken to Validate Completeness, Accuracy, and Consistency of Data	Section 3.02	
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	N/A	
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	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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	Variations in the assumptions used to develop the projected benefit costs for covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations	Section 3	Confirmed
3.A.iii	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	Section 3.05	Confirmed
3.A.iv	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	
3.A.v.a	Exclusion of costs associated with an IMD stay of more than 15 days	N/A	
3.A.v.b	Exclusion of any other costs for any services delivered during the time an enrollee is in an IMD for more than 15 days	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
3.B.i	The rate certification must clearly document the final projected benefit costs by relevant level of detail	Appendix I.G and I.H	
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	Any amount 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	
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	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
3.B.iii.a.iii	Any comparisons to historical or other programs' benefit cost trends	N/A	
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	Appendix I.G	
3.B.iii.b.i.B	Projected utilization trend	Appendix I.G	
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	N/A	
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	Section 3.05	
3.B.iii.d.ii	Cost impact of each material adjustment to projected trends	N/A	
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		No explicit adjustment was made to reflect additional managed care efficiencies; however, utilization reductions were observed moving from

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
			FFS to the first two plus years of managed care experience.
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	
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	
3.B.v.a	The categories of covered service that contain in-lieu-of-services	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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.	N/A	
3.B.vi.a	Retrospective Eligibility Periods: the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period		The DBPM is responsible for paying claims incurred during the retroactive eligibility period.
3.B.vi.b	Retrospective Eligibility Periods: how the claims information are included in the base data		The claims data underlying the base contains claims information for retroactive eligibility.
3.B.vi.c	Retrospective Eligibility Periods: how the enrollment or exposure information is included in the base data		The enrollment data underlying the base contains enrollment information for retroactive eligibility.
3.B.vi.d	Retrospective Eligibility Periods: how the capitation rates are adjusted to reflect the	N/A	The data underlying the base contains experience reflective

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments		of retroactive eligibility, and therefore the impact is inherent in the base data.
3.B.vii.a	Impact of more or fewer state plan benefits covered by Medicaid managed care	N/A	
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	Sections 3.04 and 3.07	
3.B.vii.d	Impact of requirements or conditions of any applicable waivers	N/A	
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 health plans	N/A	
4.A.i.a.i	The rate certification must include documentation that the incentive	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	arrangement will not exceed 105% of the approved capitation payments under the contract		
4.A.i.a.ii.a.i	Time period of the incentive arrangement	N/A	
4.A.i.a.ii.a.ii	Enrollees, services, and providers covered by the incentive program	N/A	
4.A.i.a.ii.a.iii	Purpose of the incentive arrangement	N/A	
4.A.i.a.ii.a.iv	Confirmation that incentive payments will not exceed 105% of the capitation payments	N/A	
4.A.i.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 health plans	Section 3.08	
4.B.i.b	The capitation payment(s) minus any portion of the withhold that is not reasonably achievable must be actuarially sound	Section 3.08	
4.B.ii.a.i	Time period of the withhold arrangement	Section 3.08	
4.B.ii.a.ii	Enrollees, services, and providers covered by the withhold arrangement	Section 3.08	
4.B.ii.a.iii	Purpose of the withhold arrangement (e.g. specified activities, targets, performance measures, or quality-based outcomes, etc.)	Section 3.08	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
4.B.ii.a.iv	Description of the total percentage of the certified capitation rates being withheld through withhold arrangements	Section 3.08	
4.B.ii.a.v	Estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable	Section 3.08	
4.B.ii.a.vi	Description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs	Section 3.08	
4.B.ii.a.vii	Description of any effect that the withhold arrangements have on the development of the capitation rates	Section 3.08	
4.B.ii.b	Actuary must certify capitation payments minus any portion of the withhold that is not reasonably achievable as actuarially sound	Section 3.08	
4.C.i.a	If the state utilizes risk-sharing mechanisms with its health plan(s), such as reinsurance, risk corridors, or stop-loss limits, these arrangements must be described in the contract(s) and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices	Section 3.08	
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 health plan(s)	Section 3.08	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
4.C.ii.a.i	Rationale for the use of the risk sharing arrangement	Section 3.08	
4.C.ii.a.ii	Detailed description of how the risk-sharing arrangement is implemented	Section 3.08	
4.C.ii.a.iii	Description of any effect that the risk-sharing arrangements have on the development of the capitation rates	Section 3.08	
4.C.ii.a.iv	Documentation demonstrating that the risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices	Section 3.08	
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:	Section 3.08	
4.C.ii.b.i	The methodology used to calculate the MLR	Section 3.08	
4.C.ii.b.ii	The formula for calculating a remittance/payment for having a MLR below/above the minimum requirements	Section 3.08	
4.C.ii.b.iii	any other consequences for a remittance/payment for a MLR below/above the minimum requirements	Section 3.08	
4.C.ii.c	If the contract has reinsurance requirements, the rate certification and supporting document must include a description of the requirements:	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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	Delivery System and Provider Payment Initiatives: implement value-based purchasing models for provider reimbursement	N/A	
4.D.i.a.ii	Delivery System and Provider Payment Initiatives: participate in a multi-payer or Medicaid-specific delivery system reform	N/A	
4.D.i.a.iii	Delivery System and Provider Payment Initiatives: adopt a minimum fee schedule for network providers that provide a particular service under the contract	N/A	
4.D.i.a.iv	Delivery System and Provider Payment Initiatives: provide a uniform dollar or percentage increase for network providers	Section 3.07	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	that provide a particular service under the contract		
4.D.i.a.v	Delivery System and Provider Payment Initiatives: adopt a maximum fee schedule for network providers that provide a particular service under the contract	N/A	
4.D.i.b	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 the state. 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:	Section 3.07	
4.D.i.b.i	Documentation related to the payment term will 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.b.ii	When a material portion of the total capitation payment to the managed care plan for any rate cell is for directed payments addressed through separate payment terms, 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	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	the state will provide the final figures after the payment has been made).		
4.D.i.b.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 must 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, enrollees seen, etc.) had been known when the rates were initially developed.	N/A	
4.D.i.b.iv	Please note, if the total amount of the payment or distribution methodology is changed from the initial base 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 any delivery system and provider payment initiatives. The documentation needed depends on which approach the state has used to incorporate the payment into its rate certification. Please provide the	Section 3.07	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	following information for each delivery system and provider payment initiative:		
4.D.ii.a.i	Brief description of the delivery system and provider payment initiative(s) included in the rates for this rating period, including:	Section 3.07	
4.D.ii.a.i.A	The type of directed payment arrangement (minimum fee schedule, maximum fee schedule, bundled payment, etc.).	Section 3.07	
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 3.07	
4.D.ii.a.ii	If a 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 3.07	
4.D.ii.a.ii.A	Indication of which rate cells were affected by the directed payment arrangement.	Section 3.07	
4.D.ii.a.ii.B	The impact the directed payment has on the rates, for each rate cell.	Section 3.07	
4.D.ii.a.ii.C	Description of how the payment arrangement is reflected in the certified capitation rates. To the extent an adjustment is applied to account for the impact of the payment arrangement or	Section 3.07	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	changes to the payment arrangement from the base data period, the actuary should provide a description of the data, assumptions, and methodologies used to develop the adjustment.		
4.D.ii.a.ii.D	An indication that the payment is being made under an approved §438.6(c) payment arrangement in a manner that is consistent with the pre-print (including any correspondence between the state and CMS regarding the pre-print) reviewed by CMS. To the extent the payment arrangement has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the payment arrangement that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the payment arrangement is accounted for in a manner consistent with the pre-print that is under CMS review. If the preprint has not yet been submitted to CMS for review, the certification should indicate when the preprint will be submitted to CMS.	Section 3.07	
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 plans paid above the maximum fee schedule and	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	how the actuary determined that it was reasonable to assume that the plans 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 schedule which allow for plans 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 should be included in the state's rate certification (please include this information for each separate directed payment arrangement):	N/A	
4.D.ii.a.iii.A	Aggregate amount of the payment applicable to the rate certification.	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	Provider types that will be receiving the payment.	N/A	
4.D.ii.a.iii.D	Distribution methodology.	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
4.D.ii.a.iii.E	An estimate of the magnitude 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.ii.a.iii.F	Indication that the payment is being made under an approved §438.6(c) payment arrangement in a manner that is consistent with the pre-print (including correspondence between the state and CMS regarding the pre-print) reviewed by CMS. To the extent the payment arrangement has not been approved by CMS before the actuary certifies the capitation rates, this should be noted in the certification and the payment arrangement that is under review should still be accounted for in rate development. In this case, the actuary should also provide an indication that the payment arrangement 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 indicate when the preprint will be submitted to CMS	N/A	
4.D.ii.a.iii.G	Statement that after the rating period is complete the state will submit (to CMS) documentation that incorporates the total amount of the payment into the rate	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	certification's rate cells consistent with the distribution methodology described in the initial rate certification, 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		
4.D.ii.b	The rate certification and supporting documentation must confirm that there are not any additional directed payments in the program that are not addressed in the certification.	Confirmed	
4.D.ii.c	The rate certification and supporting documentation must confirm that there are not any requirements regarding the reimbursement rates the plans must pay to any providers unless specifically specified in the certification as a directed payment or authorized under applicable law, regulation, or waiver.	Confirmed	
Pass-Through Payments			
4.E.i.a A pass-through payment, as defined in 42 CFR §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: i. a specific service or benefit provided to a specific enrollee covered under the contract; ii. a provider payment methodology permitted under 42 CFR §438.6(c)(1)(i) through (iii) for services and enrollees covered under the contract; iii. a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; iv. Graduate Medical Education (GME) payments; or v. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) wrap around payments.			
4.E.i.b	Pass-through payments are allowed for transition periods as outlined in 42 CFR	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	§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:		
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) 80 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	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	meet the requirement of 42 CFR §438.6(d)(1)(i).		
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 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).	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 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:	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	(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 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:	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	(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	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-month period immediately 2 years prior to the rating period should be included when calculating amounts in Section I, Item 4.E.i.d.i.B of the guide.	N/A	
4.E.i.g	In accordance with 42 CFR §438.6(d)(2)(iv), states may calculate reasonable estimates of the aggregate differences in paragraph	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	(d) in accordance with the upper payment limit requirements in 42 CFR part 447.		
4.E.i.g.i	If the state chooses to utilize a trend adjustment when calculating reasonable estimates of the aggregate differences in paragraph (d), 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 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.	N/A	
4.E.i.h	Capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities in accordance with 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 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	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	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 plans		
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	The amount of the pass-through payments, both in total and on a per member per month basis (if applicable)	N/A	
4.E.ii.a.iii	The program(s) that includes the pass-through payment	N/A	
4.E.ii.a.iv	The providers receiving the pass-through payment	N/A	
4.E.ii.a.v	The financing mechanism for the pass-through payment	N/A	
4.E.ii.a.vi	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	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	for the pass-through payments by provider type:		
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 §438.6(d)(1)(i)): (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. (B) if the managed care contract(s) and rate certification(s) for the rating period that	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	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 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.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 assumptions for any reasonable estimate(s) utilized. 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,	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	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.		
4.E.ii.c.ii	The aggregate amounts calculated 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 this guide.	N/A	
4.E.ii.c.iii	if the state chooses to utilize trend adjustments when calculating the amounts identified in 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, the state must ensure clear documentation, including: (i) explanation of the purpose of the trend adjustment (e.g. cost inflation, utilization, etc.) and justification of why an adjustment is reasonable and appropriate. (ii) the trend adjustment applied to amounts, as applicable, in 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. (iii) a description of the data source, assumptions, and methodology	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	used to determine each adjustment. (iv) the fiscal impact of each trend adjustment. (v) 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.		
4.E.ii.c.iv	The calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in Section I, Item 4.E.i.c. of the guide.	N/A	
4.E.ii.c.v	The amount of any §438.6(c) directed payment arrangements 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	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	the calculations of amounts in Section I, Item 4.E.i.d.i.B of the guide.		
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 3.06	
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 3.06	
5.A.iii	Variations in the assumptions used to develop the projected non-benefit costs for covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.	Section 3.06	
5.A.iv	States have the flexibility to account for the Health Insurance Providers Fee on a prospective or retrospective basis into rate development for either the data year or fee year. Any payment for the fee must be incorporated in the health plan capitation rates.	N/A	HIPF is not applicable for this contract period

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
5.A.iv.a	Due to the HIPF moratorium established by the Consolidated Appropriations Act of 2016 and continuing resolution legislation, Pub. Law. 115-120 (H.R. 195), Division D – Suspension of Certain Health- Related Taxes, § 4003, CMS does not expect any HIPF amounts to be paid for calendar year 2017 and 2019 by managed care plans that are subject to that fee. Therefore, no amounts should be included in Medicaid managed care capitation rates for fees that would have been paid by plans to the IRS for 2017 or 2019	N/A	
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 3.06	
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 3.06	
5.B.i.c	Any other material adjustments must be described in accordance with 42 CFR §438.7(b)(4), including:	Section 3.06	
5.B.i.c.i	A description of the data, assumptions, and methodologies used to determine each adjustment	Section 3.06	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
5.B.i.c.ii	Where in the rating setting process each adjustment was applied	Section 3.06	
5.B.i.c.iii	The cost impact of each material adjustment	Section 3.06	
5.B.ii.a	Administrative costs	Section 3.06	
5.B.ii.b	Taxes, licensing and regulatory fees, and other assessments and fees	Section 3.06	
5.B.ii.c	Contribution to reserves, risk margin, and cost of capital	Section 3.06	
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 3.06	
5.B.iii	Actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the plans, and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in rate development.	Section 3.06	
5.B.iv.a	HIPF: specifically address how this fee is incorporated into capitation rates if the managed care plan is required to pay the fee for 2020	Section 3.06	
5.B.iv.b	HIPF: if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period	N/A	HIPF is not applicable for this contract period

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
5.B.iv.c	HIPF: a description of how the amount of the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known	N/A	HIPF is not applicable for this contract period
5.B.iv.d	HIPF: if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee	N/A	HIPF is not applicable for this contract period
5.B.iv.e	HIPF: if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix) (e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed	N/A	HIPF is not applicable for this contract period
5.B.iv.f	For managed care plans that were required to pay the fee in 2014, 2015, 2016, and/or 2018, a description as to whether or not the fee has been included in the capitation rates for those years (either prospectively in the rates or through amendments to the initially certified rates).		The fee for MCNA's expected HIPF liability for 2018 was built into the capitation rates for October 1, 2017 – June 30, 2018 as a rate amendment dated June 5, 2018.

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
Risk Adjustment and Acuity Adjustments			
6.A	Rate Development Standards for Risk Adjustment and Acuity Adjustments	Section 3.04	An adjustment has been made to reflect the anticipated acuity of the Expansion population relative to the current Medicaid populations which form the basis for rate development and is described in Section 3.04.
6.B.i	The rate certification must describe all prospective risk adjustment methodologies, including:	N/A	
6.B.i.a	The data, and any adjustments to that data, to be used to calculate the adjustment	N/A	
6.B.i.b	The model, and any adjustments to that model, to be used to calculate the adjustment	N/A	
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	N/A	
6.B.i.d	the magnitude of the adjustment on the capitation rate per MCO, PIHP, or PAHP	N/A	
6.B.i.e	An assessment of the predictive value of the methodology compared to prior rating periods	N/A	
6.B.i.f	Any concerns the actuary has with the risk adjustment process	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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	N/A	
6.B.iii.b	Documentation that the risk adjustment model is budget neutral in accordance with 42 CFR §438.5(g)	N/A	
6.B.iv	If an acuity adjustment is being used, the rate certification must include a description of the acuity adjustment and its basis that is adequate to evaluate its reasonableness and whether it is consistent with generally accepted actuarial principles and practices:	Section 3.04	An adjustment has been made to reflect the anticipated acuity of the Expansion population relative to the current Medicaid populations which form the basis for rate development and is described in Section 3.04.
6.B.iv.a	The reason that there is significant uncertainty about the health status of the	Section 3.04	The Expansion population is newly eligible as a result of

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	population and the need for an acuity adjustment		Medicaid Expansion, and therefore 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	There is not a specific model implemented for this adjustment, rather it is a calculation to adjust for the expected acuity between the Expansion and non-Expansion cohorts for dental services, based on experience observed in other Medicaid programs.
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	There is not a specific model implemented for this adjustment, rather it is a calculation to adjust for the expected acuity between the Expansion and non-Expansion cohorts for dental services, based on experience observed in other Medicaid programs.
6.B.iv.d	The relationship and potential interactions between the acuity adjustment	Section 3.04	
6.B.iv.e	How frequently the acuity adjustment scores are calculated	Section 3.04	
6.B.iv.f	A description of how the acuity adjustment scores are being used to adjust the capitation rates	Section 3.04	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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	The acuity adjustment is a calculation to adjust for the expected acuity between the Expansion and non-Expansion cohorts for dental services, based on experience observed in other Medicaid programs.
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 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	
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	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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 developed for populations receiving these services	N/A	
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			

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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, the rate certification must describe any data used to develop new adult group rates, particularly where different or additional data were used.	Section 3.02	
1.B	For states that have covered the new adult group in Medicaid managed care plans in previous rating periods (i.e. starting in 2014, 2015, 2016, 2017, 2018, 2019 and/or January through June 2020), CMS expects the rate certification, as supported by assurances from the state, to describe:	Section 3.02	Sufficient data is not available to revise assumptions since the prior rate cycle, since the Expansion population became eligible October 1, 2020. As a result of limited runout and the presumed impact that the COVID-19 pandemic had on the early utilization for this population, the Expansion rates continue to rely on the experience for the non-Expansion populations using comparable age bands.
1.B.i	Any new data that is available for use in this rate setting	Section 3.02	See comment to reference 1.B above. Sufficient data is unavailable for the Expansion population due to its effective date of October 1, 2020.
1.B.ii	How the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults	Section 3.02	See comment to reference 1.B above. Sufficient data is unavailable for the Expansion

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
			population due to its effective date of October 1, 2020.
1.B.iii	How actual experience and costs in previous rating periods have differed from assumptions and expectations in previous rate certifications	Section 3.02	See comment to reference 1.B above. Sufficient data is unavailable for the Expansion population due to its effective date of October 1, 2020.
1.B.iv	How differences between projected and actual experience in previous rating periods have been used to adjust these rates	Section 3.02	See comment to reference 1.B above. Sufficient data is unavailable for the Expansion population due to its effective date of October 1, 2020.
Projected Benefit Costs			
2.A.i	For states that covered the new adult group in previous rating periods:	Section 3.02	
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	Section 3.02	See comment to reference 1.B above. Sufficient data is unavailable for the Expansion population due to its effective date of October 1, 2020.
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	N/A	See comment to reference 1.B above. Sufficient data is unavailable for the Expansion population due to its effective date of October 1, 2020.
2.A.i.c	How assumptions changed from the rate certification(s) for previous rating periods on the following issues:	N/A	
2.A.i.c.i	Change in acuity or health status adjustments	Section 3.04	No changes have been made to the approach used within

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
			the October 1, 2020 – June 30, 2021 capitation rates for this adjustment.
2.A.i.c.ii	Change in adjustments for pent-up demand	N/A	
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 newly eligible adults	Section 3.04	No changes have been made to the approach used within the October 1, 2020 – June 30, 2021 capitation rates for this adjustment.
2.A.i.c.v	Change in differences in provider reimbursement rates or provider networks	Section 3.04	No changes have been made to the approach used within the October 1, 2020 – June 30, 2021 capitation rates for this adjustment.
2.A.i.c.vi	Other material changes or adjustments to the new adult group projected benefit costs	Section 3.04	No changes have been made to the approach used within the October 1, 2020 – June 30, 2021 capitation rates for this adjustment.
2.A.i.c.vii	Any changes to the benefit plan offered to the new adult group	N/A	No changes have been made since the last rate cycle.
2.A.ii	For states that did not cover the new adult group in previous rating periods: 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	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
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:	Section 3	
2.A.iii.a	Acuity or health status adjustments	Section 3.04	Specifically, the "Expansion Population Acuity Adjustment" subsection.
2.A.iii.b	Adjustments for pent-up demand	N/A	No explicit adjustment has been made for pent-up demand.
2.A.iii.c	Adjustments for adverse selection	N/A	No explicit adjustment has been made for adverse selection.
2.A.iii.d	Adjustments for the demographics of the new adult group	Section 3.02	No explicit adjustments have been made, as the rating cohorts are structured by age bands which we believe to appropriately capture the differences in demographics.
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 Expansion and non-Expansion populations.
2.A.iii.f	Other material adjustments	N/A	

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
2.B	The rate certification and supporting documentation must describe any other material changes or adjustments to projected benefit costs	Section 3	
Projected Non-Benefit Costs			
3.A.i	For states that covered the new adult group in Medicaid managed care plans in previous rating periods, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs since the last rate certification	N/A	No changes have been made since last cycle.
3.A.ii.a	Change in administrative cost assumptions	N/A	No changes have been made since last cycle.
3.A.ii.b	Change in care coordination and care management assumptions	N/A	No changes have been made since last cycle.
3.A.ii.c	Change in provision for operating or profit margin	N/A	No changes have been made since last cycle.
3.A.ii.d	Change in taxes, fees, and assessments	N/A	No changes have been made since last cycle.
3.A.ii.e	Change in other material non-benefit costs	N/A	No changes have been made since last cycle.
3.B.i	Administrative costs	Section 3.06	
3.B.ii	Care coordination and care management	Section 3.06	
3.B.iii	Provision for operating or profit margin	Section 3.06	
3.B.iv	Taxes, fees, and assessments	Section 3.06	
3.B.v	Other material non-benefit costs	Section 3.06	
Final Certified Rates			

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
4.A.i	A comparison to the final certified rates in the previous rate certification	Appendix II.B	
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 CFR §438.7(d) that states describe the risk mitigation strategy specific to the new adult group rates	N/A	No risk mitigation strategy specific to the Expansion population has been implemented. The program-wide profit cap and minimum MLR described in Section 3.08 applies to Expansion and non-Expansion cohorts.
5.B.i	Any changes in the risk mitigation strategy from those used during previous rating periods	Section 3.08	The only change is related to the inclusion of the program-wide profit cap, which is described in Section 3.08.
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:	N/A	The only change is related to the inclusion of the program-wide profit cap, which is described in Section 3.08.

Section of 2020-2021 Rate Guidance	Section Description	Certification Reference	Comments
	(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.		
5.B.iii	Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during previous rating periods	N/A	

Appendix I.B: Base Data

	Base Data - CY2019					
Age Band	**MMs**	**Dollars**	**Units**	**Util/K**	**Unit Cost**	**PMPM**
0-1	264,809	$533,574	16,935	767	$31.51	$2.01
2-5	459,337	$7,430,498	214,249	5,597	$34.68	$16.18
6-18	1,263,017	$20,919,346	595,373	5,657	$35.14	$16.56
19-24	108,857	$997,508	20,265	2,234	$49.22	$9.16
25-54	499,250	$6,255,640	117,803	2,832	$53.10	$12.53
55-64	141,694	$1,745,079	27,610	2,338	$63.20	$12.32
65+	225,697	$2,136,515	36,096	1,919	$59.19	$9.47
Total	**2,962,661**	**$40,018,160**	**1,028,331**	**4,165**	**$38.92**	**$13.51**

	Base Data - CY2019			
COS	**MMs**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	2,962,661	110	$46.20	$0.42
Endodontics	2,962,661	28	$149.71	$0.35
Oral and Maxillofacial Surgery	2,962,661	144	$84.16	$1.01
Orthodontics	2,962,661	6	$1,160.49	$0.60
Partial Dentures	2,962,661	14	$149.99	$0.18
Periodontics	2,962,661	22	$69.15	$0.13
Preventative	2,962,661	3,178	$21.38	$5.66
Prosthodontics	2,962,661	8	$626.92	$0.40
Restorative	2,962,661	500	$81.72	$3.41
FQHC	2,962,661	146	$80.67	$0.98
IHS	2,962,661	10	$462.73	$0.37
Total	**2,962,661**	**4,165**	**$38.92**	**$13.51**

	Base Data - CY2019 Expansion					
Age Band	**SFY22 Expansion MMs Estimate**	**Dollars**	**Units**	**Util/K**	**Unit Cost**	**PMPM**
19-24 Exp.	47,376	$434,130	8,820	2,234	$49.22	$9.16
25-54 Exp.	50,372	$631,168	11,886	2,832	$53.10	$12.53
55-64 Exp.	14,137	$174,109	2,755	2,338	$63.20	$12.32
Total	**111,885**	**$1,239,407**	**23,460**	**2,516**	**$52.83**	**$11.08**

	Base Data - CY2019 Expansion			
COS	**SFY22 Expansion MMs Estimate**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	111,885	62	$69.39	$0.36
Endodontics	111,885	28	$266.37	$0.62
Oral and Maxillofacial Surgery	111,885	217	$86.07	$1.56
Orthodontics	111,885	0	$359.27	$0.01
Partial Dentures	111,885	20	$175.71	$0.30
Periodontics	111,885	61	$69.65	$0.36
Preventative	111,885	1,491	$22.01	$2.73
Prosthodontics	111,885	12	$617.94	$0.64
Restorative	111,885	496	$77.32	$3.20
FQHC	111,885	122	$107.89	$1.10
IHS	111,885	6	$451.46	$0.21
Total	**111,885**	**2,516**	**$52.83**	**$11.08**

Appendix I.C: IBNR Adjustment

	IBNR Adjustment - CY2019			
Age Band	**IBNR Factor**	**Util/K**	**Unit Cost**	**PMPM**
0-1	1.00	767	$31.51	$2.01
2-5	1.00	5,597	$34.68	$16.18
6-18	1.00	5,657	$35.14	$16.56
19-24	1.00	2,234	$49.22	$9.16
25-54	1.00	2,832	$53.10	$12.53
55-64	1.00	2,338	$63.20	$12.32
65+	1.00	1,919	$59.19	$9.47
Total	**1.00**	**4,165**	**$38.92**	**$13.51**

	IBNR Adjustment - CY2019			
COS	**IBNR Factor**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	1.00	110	$46.20	$0.42
Endodontics	1.00	28	$149.71	$0.35
Oral and Maxillofacial Surgery	1.00	144	$84.16	$1.01
Orthodontics	1.00	6	$1,160.49	$0.60
Partial Dentures	1.00	14	$149.99	$0.18
Periodontics	1.00	22	$69.15	$0.13
Preventative	1.00	3,178	$21.38	$5.66
Prosthodontics	1.00	8	$626.92	$0.40
Restorative	1.00	500	$81.72	$3.41
FQHC	1.00	146	$80.67	$0.98
IHS	1.00	10	$462.73	$0.37
Total	**1.00**	**4,165**	**$38.92**	**$13.51**

	IBNR Adjustment - CY2019 Expansion			
Age Band	**IBNR Factor**	**Util/K**	**Unit Cost**	**PMPM**
19-24 Exp.	1.00	2,234	$49.22	$9.16
25-54 Exp.	1.00	2,832	$53.10	$12.53
55-64 Exp.	1.00	2,338	$63.20	$12.32
Total	**1.00**	**2,516**	**$52.83**	**$11.08**

	IBNR Adjustment - CY2019 Expansion			
COS	**IBNR Factor**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	1.00	62	$69.39	$0.36
Endodontics	1.00	28	$266.37	$0.62
Oral and Maxillofacial Surgery	1.00	217	$86.07	$1.56
Orthodontics	1.00	0	$359.27	$0.01
Partial Dentures	1.00	20	$175.71	$0.30
Periodontics	1.00	61	$69.65	$0.36
Preventative	1.00	1,491	$22.01	$2.73
Prosthodontics	1.00	12	$617.94	$0.64
Restorative	1.00	496	$77.32	$3.20
FQHC	1.00	122	$107.89	$1.10
IHS	1.00	6	$451.46	$0.21
Total	**1.00**	**2,516**	**$52.83**	**$11.08**

Appendix I.D: IHS Repricing

	IHS Repricing - CY2019			
Age Band	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
0-1	0.95%	767	$31.81	$2.03
2-5	0.65%	5,597	$34.91	$16.28
6-18	0.48%	5,657	$35.31	$16.64
19-24	0.28%	2,234	$49.36	$9.19
25-54	0.36%	2,832	$53.29	$12.57
55-64	0.47%	2,338	$63.50	$12.37
65+	0.38%	1,919	$59.41	$9.50
Total	**0.49%**	**4,165**	**$39.11**	**$13.57**

	IHS Repricing - CY2019			
COS	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	0.00%	110	$46.20	$0.42
Endodontics	0.00%	28	$149.71	$0.35
Oral and Maxillofacial Surgery	0.00%	144	$84.16	$1.01
Orthodontics	0.00%	6	$1,160.49	$0.60
Partial Dentures	0.00%	14	$149.99	$0.18
Periodontics	0.00%	22	$69.15	$0.13
Preventative	0.00%	3,178	$21.38	$5.66
Prosthodontics	0.00%	8	$626.92	$0.40
Restorative	0.00%	500	$81.72	$3.41
FQHC	0.00%	146	$80.67	$0.98
IHS	17.94%	10	$545.73	$0.43
Total	**0.49%**	**4,165**	**$39.11**	**$13.57**

	IHS Repricing - CY2019 Expansion			
Age Band	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
19-24 Exp.	0.28%	2,234	$49.36	$9.19
25-54 Exp.	0.36%	2,832	$53.29	$12.57
55-64 Exp.	0.47%	2,338	$63.50	$12.37
Total	**0.35%**	**2,516**	**$53.01**	**$11.12**

	IHS Repricing - CY2019 Expansion			
COS	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	0.00%	62	$69.39	$0.36
Endodontics	0.00%	28	$266.37	$0.62
Oral and Maxillofacial Surgery	0.00%	217	$86.07	$1.56
Orthodontics	0.00%	0	$359.27	$0.01
Partial Dentures	0.00%	20	$175.71	$0.30
Periodontics	0.00%	61	$69.65	$0.36
Preventative	0.00%	1,491	$22.01	$2.73
Prosthodontics	0.00%	12	$617.94	$0.64
Restorative	0.00%	496	$77.32	$3.20
FQHC	0.00%	122	$107.89	$1.10
IHS	17.94%	6	$532.43	$0.25
Total	**0.35%**	**2,516**	**$53.01**	**$11.12**

Appendix I.E: FQHC Repricing

	FQHC Repricing - CY2019			
Age Band	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
0-1	16.87%	767	$37.17	$2.38
2-5	5.26%	5,597	$36.74	$17.14
6-18	5.39%	5,657	$37.21	$17.54
19-24	8.95%	2,234	$53.78	$10.01
25-54	7.80%	2,832	$57.45	$13.56
55-64	3.88%	2,338	$65.97	$12.85
65+	3.62%	1,919	$61.56	$9.85
Total	**5.83%**	**4,165**	**$41.38**	**$14.36**

	FQHC Repricing - CY2019			
COS	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	0.00%	110	$46.20	$0.42
Endodontics	0.00%	28	$149.71	$0.35
Oral and Maxillofacial Surgery	0.00%	144	$84.16	$1.01
Orthodontics	0.00%	6	$1,160.49	$0.60
Partial Dentures	0.00%	14	$149.99	$0.18
Periodontics	0.00%	22	$69.15	$0.13
Preventative	0.00%	3,178	$21.38	$5.66
Prosthodontics	0.00%	8	$626.92	$0.40
Restorative	0.00%	500	$81.72	$3.41
FQHC	80.42%	146	$145.54	$1.77
IHS	0.00%	10	$545.73	$0.43
Total	**5.83%**	**4,165**	**$41.38**	**$14.36**

	FQHC Repricing - CY2019 Expansion			
Age Band	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
19-24 Exp.	8.95%	2,234	$53.78	$10.01
25-54 Exp.	7.80%	2,832	$57.45	$13.56
55-64 Exp.	3.88%	2,338	$65.97	$12.85
Total	**7.65%**	**2,516**	**$57.07**	**$11.97**

	FQHC Repricing - CY2019 Expansion			
COS	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	0.00%	62	$69.39	$0.36
Endodontics	0.00%	28	$266.37	$0.62
Oral and Maxillofacial Surgery	0.00%	217	$86.07	$1.56
Orthodontics	0.00%	0	$359.27	$0.01
Partial Dentures	0.00%	20	$175.71	$0.30
Periodontics	0.00%	61	$69.65	$0.36
Preventative	0.00%	1,491	$22.01	$2.73
Prosthodontics	0.00%	12	$617.94	$0.64
Restorative	0.00%	496	$77.32	$3.20
FQHC	77.39%	122	$191.39	$1.95
IHS	0.00%	6	$532.43	$0.25
Total	**7.65%**	**2,516**	**$57.07**	**$11.97**

Appendix I.F: Provider Fee Change

	Provider Fee Change - CY2019			
Age Band	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
0-1	3.70%	767	$38.55	$2.47
2-5	4.43%	5,597	$38.37	$17.90
6-18	4.35%	5,657	$38.83	$18.30
19-24	4.19%	2,234	$56.04	$10.43
25-54	4.11%	2,832	$59.81	$14.11
55-64	4.14%	2,338	$68.70	$13.39
65+	4.28%	1,919	$64.20	$10.27
Total	**4.30%**	**4,165**	**$43.16**	**$14.98**

	Provider Fee Change - CY2019			
COS	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	5.08%	110	$48.55	$0.44
Endodontics	5.08%	28	$157.31	$0.37
Oral and Maxillofacial Surgery	5.08%	144	$88.44	$1.06
Orthodontics	5.08%	6	$1,219.45	$0.63
Partial Dentures	5.08%	14	$157.61	$0.18
Periodontics	5.08%	22	$72.66	$0.13
Preventative	5.08%	3,178	$22.47	$5.95
Prosthodontics	5.08%	8	$658.77	$0.42
Restorative	5.08%	500	$85.88	$3.58
FQHC	0.00%	146	$145.54	$1.77
IHS	0.00%	10	$545.73	$0.43
Total	**4.30%**	**4,165**	**$43.16**	**$14.98**

	Provider Fee Change - CY2019 Expansion			
Age Band	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
19-24 Exp.	4.19%	2,234	$56.04	$10.43
25-54 Exp.	4.11%	2,832	$59.81	$14.11
55-64 Exp.	4.14%	2,338	$68.70	$13.39
Total	**4.15%**	**2,516**	**$59.44**	**$12.46**

	Provider Fee Change - CY2019 Expansion			
COS	**% Adj**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	5.08%	62	$72.91	$0.37
Endodontics	5.08%	28	$279.90	$0.65
Oral and Maxillofacial Surgery	5.08%	217	$90.44	$1.64
Orthodontics	5.08%	0	$377.52	$0.01
Partial Dentures	5.08%	20	$184.63	$0.31
Periodontics	5.08%	61	$73.18	$0.37
Preventative	5.08%	1,491	$23.13	$2.87
Prosthodontics	5.08%	12	$649.33	$0.67
Restorative	5.08%	496	$81.25	$3.36
FQHC	0.00%	122	$191.39	$1.95
IHS	0.00%	6	$532.43	$0.25
Total	**4.15%**	**2,516**	**$59.44**	**$12.46**

Appendix I.G: Prospective Trend

	Prospective Trend – CY2019 -> SFY2022			
Age Band	**Util/K %**	**UC %**	**PMPM %**	**PMPM**
0-1	3.4%	0.6%	4.0%	$2.72
2-5	2.9%	-0.1%	2.9%	$19.21
6-18	3.0%	0.0%	3.0%	$19.71
19-24	1.0%	1.2%	2.2%	$11.03
25-54	1.2%	1.5%	2.7%	$15.07
55-64	1.2%	1.8%	3.1%	$14.44
65+	1.1%	1.8%	2.9%	$11.03
Total	**2.7%**	**0.3%**	**2.9%**	**$16.10**

	Prospective Trend – CY2019 -> SFY2022			
COS	**Util/K %**	**UC %**	**PMPM %**	**PMPM**
Adjunctive General Services	0.6%	0.5%	1.1%	$0.46
Endodontics	0.5%	0.5%	1.0%	$0.37
Oral and Maxillofacial Surgery	1.0%	0.5%	1.5%	$1.10
Orthodontics	0.5%	0.5%	1.0%	$0.65
Partial Dentures	0.5%	0.5%	1.0%	$0.19
Periodontics	9.5%	0.6%	10.2%	$0.17
Preventative	3.1%	0.5%	3.6%	$6.49
Prosthodontics	4.0%	0.5%	4.5%	$0.47
Restorative	0.5%	0.5%	1.0%	$3.67
FQHC	3.6%	0.7%	4.3%	$1.97
IHS	10.0%	0.0%	10.0%	$0.55
Total	**2.7%**	**0.3%**	**2.9%**	**$16.10**

	Prospective Trend – CY2019 -> SFY2022 Expansion			
Age Band	**Util/K %**	**UC %**	**PMPM %**	**PMPM**
19-24 Exp.	1.0%	1.2%	2.2%	$11.03
25-54 Exp.	1.2%	1.5%	2.7%	$15.07
55-64 Exp.	1.2%	1.8%	3.1%	$14.44
Total	**1.1%**	**1.4%**	**2.6%**	**$13.28**

	Prospective Trend – CY2019 -> SFY2022 Expansion			
COS	**Util/K %**	**UC %**	**PMPM %**	**PMPM**
Adjunctive General Services	1.0%	0.5%	1.5%	$0.39
Endodontics	0.5%	0.5%	1.0%	$0.66
Oral and Maxillofacial Surgery	1.5%	0.5%	2.0%	$1.72
Orthodontics	0.5%	0.5%	1.0%	$0.02
Partial Dentures	0.5%	0.5%	1.0%	$0.32
Periodontics	10.0%	0.5%	10.6%	$0.48
Preventative	0.5%	0.5%	1.0%	$2.95
Prosthodontics	4.0%	0.5%	4.5%	$0.75
Restorative	0.5%	0.5%	1.0%	$3.44
FQHC	5.0%	0.5%	5.5%	$2.23
IHS	10.0%	0.0%	10.0%	$0.32
Total	**1.1%**	**1.4%**	**2.6%**	**$13.28**

Appendix I.H: Expansion Acuity Adjustment

	Expansion Acuity Adjustment – SFY2022			
Age Band	**Expansion Acuity**	**Util/K**	**Unit Cost**	**PMPM**
19-24 Exp.	-5.6%	2,162	$57.80	$10.41
25-54 Exp.	-2.1%	2,856	$62.03	$14.76
55-64 Exp.	21.2%	2,924	$71.84	$17.51
Total	**-0.1%**	**2,571**	**$61.93**	**$13.27**

	Expansion Acuity Adjustment – SFY2022			
COS	**Expansion Acuity**	**Util/K**	**Unit Cost**	**PMPM**
Adjunctive General Services	-2.5%	62	$73.74	$0.38
Endodontics	-2.1%	28	$283.22	$0.65
Oral and Maxillofacial Surgery	-0.3%	227	$90.83	$1.72
Orthodontics	-5.6%	0	$382.33	$0.01
Partial Dentures	6.5%	22	$184.28	$0.34
Periodontics	-0.1%	78	$74.01	$0.48
Preventative	-0.8%	1,499	$23.40	$2.92
Prosthodontics	9.7%	15	$658.43	$0.82
Restorative	-1.5%	494	$82.34	$3.39
FQHC	-0.2%	138	$193.90	$2.23
IHS	1.4%	7	$532.51	$0.32
Total	**-0.1%**	**2,571**	**$61.93**	**$13.27**

Appendix I.I: Non-Medical Load

	Non-Medical Load	
Age Band	**Load %**	**Loaded PMPM**
0-1	11.0%	$3.05
2-5	11.0%	$21.59
6-18	11.0%	$22.14
19-24	11.0%	$12.39
25-54	11.0%	$16.93
55-64	11.0%	$16.22
65+	11.0%	$12.40
Total	**11.0%**	**$18.09**

	Non-Medical Load - Expansion	
Age Band	**Load %**	**Loaded PMPM**
19-24 Exp.	11.0%	$11.70
25-54 Exp.	11.0%	$16.59
55-64 Exp.	11.0%	$19.67
Total	**11.0%**	**$14.91**

Appendix I.J: Directed Payment Arrangement

	SFY22 UNMC Supplemental Payment		
Age Band	**CY19 MMs**	**Add. PMPM**	**Add. Dollars**
0-1	264,809	$0.21	$54,966
2-5	459,337	$2.44	$1,121,626
6-18	1,263,017	$1.59	$2,005,645
19-24	108,857	$0.74	$80,262
25-54	499,250	$0.97	$483,433
55-64	141,694	$0.90	$128,108
65+	225,697	$0.74	$166,665
Total	**2,962,661**	**$1.36**	**$4,040,704**

	SFY22 Expansion - UNMC Supplemental Payment		
Age Band	**Proj. MMs**	**Add. PMPM**	**Add. Dollars**
19-24 Exp.	47,376	$0.70	$33,280
25-54 Exp.	50,372	$0.96	$48,206
55-64 Exp.	14,137	$1.11	$15,637
Total	**111,885**	**$0.87**	**$97,123**

Appendix II. July 1, 2021 – June 30, 2022 Rates

Appendix II.A: Payment Rates

	SFY22 Rates (Net UNMC)	
Age Band	**CY19 MMs**	**Payment Rate**
0-1	264,809	$3.05
2-5	459,337	$21.59
6-18	1,263,017	$22.14
19-24	108,857	$12.39
25-54	499,250	$16.93
55-64	141,694	$16.23
65+	225,697	$12.39
Total	**2,962,661**	**$18.09**

	SFY22 Rates (Gross UNMC)	
Age Band	**CY19 MMs**	**Payment Rate**
0-1	264,809	$3.26
2-5	459,337	$24.03
6-18	1,263,017	$23.73
19-24	108,857	$13.13
25-54	499,250	$17.90
55-64	141,694	$17.13
65+	225,697	$13.13
Total	**2,962,661**	**$19.45**

	SFY22 Expansion Rates (Net UNMC)	
Age Band	**Proj. MMs**	**Payment Rate**
19-24 Exp.	47,376	$11.70
25-54 Exp.	50,372	$16.58
55-64 Exp.	14,137	$19.67
Total	**111,885**	**$14.90**

	SFY22 Expansion Rates (Gross UNMC)	
Age Band	**Proj. MMs**	**Payment Rate**
19-24 Exp.	47,376	$12.40
25-54 Exp.	50,372	$17.54
55-64 Exp.	14,137	$20.78
Total	**111,885**	**$15.77**

Appendix II.B: Payment Rate Comparison

	Nebraska Dental Program Payment Rates (Net UNMC)			
Age Band	**CY19 MMs**	**SFY21 Rate**	**SFY22 Rate**	**% Change**
0-1	264,809	$2.83	$3.05	7.9%
2-5	459,337	$21.12	$21.59	2.2%
6-18	1,263,017	$21.76	$22.14	1.8%
19-24	108,857	$11.92	$12.39	4.0%
25-54	499,250	$16.55	$16.93	2.3%
55-64	141,694	$16.31	$16.23	-0.5%
65+	225,697	$12.33	$12.39	0.5%
Total	**2,962,661**	**$17.75**	**$18.09**	**1.9%**

	Nebraska Dental Program Payment Rates (Gross UNMC)			
Age Band	**CY19 MMs**	**SFY21 Rate**	**SFY22 Rate**	**% Change**
0-1	264,809	$3.06	$3.26	6.6%
2-5	459,337	$23.52	$24.03	2.2%
6-18	1,263,017	$23.29	$23.73	1.9%
19-24	108,857	$12.60	$13.13	4.2%
25-54	499,250	$17.52	$17.90	2.2%
55-64	141,694	$17.27	$17.13	-0.8%
65+	225,697	$13.04	$13.13	0.7%
Total	**2,962,661**	**$19.08**	**$19.45**	**1.9%**

	Nebraska Dental Program Payment Rates (Net UNMC) - Expansion			
Age Band	**Proj. MMs**	**SFY21 Rate**	**SFY22 Rate**	**% Change**
19-24 Exp.	47,376	$11.30	$11.70	3.5%
25-54 Exp.	50,372	$16.29	$16.58	1.8%
55-64 Exp.	14,137	$19.88	$19.67	-1.0%
Total	**111,885**	**$14.63**	**$14.90**	**1.9%**

	Nebraska Dental Program Payment Rates (Gross UNMC) - Expansion			
Age Band	**Proj. MMs**	**SFY21 Rate**	**SFY22 Rate**	**% Change**
19-24 Exp.	47,376	$11.95	$12.40	3.8%
25-54 Exp.	50,372	$17.25	$17.54	1.7%
55-64 Exp.	14,137	$21.05	$20.78	-1.3%
Total	**111,885**	**$15.48**	**$15.77**	**1.9%**

Appendix II.C: IHS Component of SFY22 Rates

	SFY22 Rates - IHS Component		
Age Band	**CY19 MMs**	**SFY22 Rate, Net UNMC**	**IHS Component**
0-1	264,809	$3.05	$0.18
2-5	459,337	$21.59	$0.98
6-18	1,263,017	$22.14	$0.75
19-24	108,857	$12.39	$0.24
25-54	499,250	$16.93	$0.42
55-64	141,694	$16.23	$0.54
65+	225,697	$12.39	$0.34
Total	**2,962,661**	**$18.09**	**$0.62**

	SFY22 Expansion Rates - IHS Component		
Age Band	**Proj. MMs**	**SFY22 Rate, Net UNMC**	**IHS Component**
19-24 Exp.	47,376	$11.70	$0.23
25-54 Exp.	50,372	$16.58	$0.41
55-64 Exp.	14,137	$19.67	$0.66
Total	**111,885**	**$14.90**	**$0.36**

Appendix II.D: SFY22 Payment Rates Net Withhold

	SFY22 Payment Rates & Withhold Amount					
Age Band	**CY19 MMs**	**Payment Rate, Net UNMC**	**Withhold**	**Rate Net UNMC, Net Withhold**	**UNMC PMPM**	**Final Rate Net Withhold, Gross UNMC**
0-1	264,809	$3.05	$0.05	$3.00	$0.21	$3.21
2-5	459,337	$21.59	$0.32	$21.27	$2.44	$23.71
6-18	1,263,017	$22.14	$0.33	$21.81	$1.59	$23.40
19-24	108,857	$12.39	$0.19	$12.20	$0.74	$12.94
25-54	499,250	$16.93	$0.25	$16.68	$0.97	$17.65
55-64	141,694	$16.23	$0.24	$15.99	$0.90	$16.89
65+	225,697	$12.39	$0.19	$12.20	$0.74	$12.94
Total	**2,962,661**	**$18.09**	**$0.27**	**$17.82**	**$1.36**	**$19.18**

	SFY22 Expansion Payment Rates & Withhold Amount					
Age Band	**Proj. MMs**	**Payment Rate, Net UNMC**	**Withhold**	**Rate Net UNMC, Net Withhold**	**UNMC PMPM**	**Final Rate Net Withhold, Gross UNMC**
19-24 Exp.	47,376	$11.70	$0.18	$11.52	$0.70	$12.22
25-54 Exp.	50,372	$16.58	$0.25	$16.33	$0.96	$17.29
55-64 Exp.	14,137	$19.67	$0.30	$19.37	$1.11	$20.48
Total	**111,885**	**$14.90**	**$0.22**	**$14.68**	**$0.87**	**$15.55**