Mercer

Government Human Services Consulting

Cardinal Care Managed Care

CY2021 Data Book

Commonwealth of Virginia

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Mercer Government

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Section 1
Introduction

In partnership with the Commonwealth (Commonwealth) of Virginia's Department of Medical Assistance Services (DMAS), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, produced the *Cardinal Care Managed Care Data Book Narrative.pdf* and the *Cardinal Care Managed Care Data Book Exhibits.xlsx* (collectively referred to as the Data Book) to provide historical encounter and eligibility data summaries from the Commonwealth's Medicaid managed care program for usage by potential bidders as part of the Cardinal Care Managed Care Request for Proposal (RFP) #13330.

Individuals eligible for Cardinal Care Managed Care fall within one of the following population groups, as further described in this Data Book: Acute, Family Access to Medical Insurance Security (FAMIS)/FAMIS MOMS, and Managed Long-Term Services and Supports (MLTSS).

The Data Book does not include claims experience or eligibility for members in the Commonwealth's fee-for-service (FFS) program. The Data Book summarizes historical claim-level encounter data submitted through the Commonwealth's Enterprise Data Warehouse Solution (EDWS) system with run-out through June 30, 2022, and provided by the Commonwealth for the following calendar year (CY) time-period:

- January 1, 2021, through December 31, 2021 (CY2021)

The enrollment data summarized in the Data Book is sourced from the Commonwealth's capitation payment enrollment data for CY2021 as of June 30, 2022. The Data Book also provides general information on the capitation rate development process, including adjustments that will be considered for the July 1, 2023, through June 30, 2024 (fiscal year [FY] 2024) capitation rates. Aspects of the Cardinal Care Managed Care program will be described in more detail in subsequent sections of this Data Book.

In producing this Data Book, Mercer has relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data, and information supplied by the Commonwealth and its vendors. The Commonwealth and its vendors are solely responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness but did not audit it. In our opinion, the data used for the Data Book is appropriate for the intended purpose. However, if the data and information are incomplete/inaccurate, the values shown in this Data Book may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this Data Book.

The Commonwealth and Mercer regularly review the Cardinal Care Managed Care MCO-reported encounter and financial data for completeness and accuracy for use in analyses and program management. The Commonwealth places a high level of importance and value in the collection and submission of complete and accurate encounter and financial data for program management and monitoring purposes. All data used for the Data Book is assessed for quality and completeness per Actuarial Standards of Practice (ASOP) 23 (Data Quality) in order to deem the data sufficient to support rate setting. The MCOs are provided with data summaries and have the opportunity to provide feedback on any reconciliation to reported financial statements. Additional validation efforts include reviews of the data for

changes year-over-year, errors in reporting including missing or duplicated data, and overall reasonableness/consistency across data sources to ensure it is reasonable to develop the rates. As partners with the Commonwealth, bidders who are selected to participate in the Medicaid managed care program are expected to put forth the necessary efforts to submit complete and accurate encounter and financial data.

The user of this Data Book is cautioned against relying solely on the data contained herein. The Commonwealth and Mercer provide no guarantee, either written or implied, that this Data Book is 100% accurate or error-free.

This Data Book was prepared on behalf of the Commonwealth and is intended to be relied upon by the Commonwealth for providing potential bidders, and any other parties the Commonwealth deems appropriate as part of the Cardinal Care Managed Care RFP process, with information related to Medicaid managed care experience and general information on the capitation rate development process.

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

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

Section 2
General Information

The Cardinal Care Managed Care program consists of individuals in the following population groups: Acute, FAMIS/FAMIS MOMS, and MLTSS, as described in greater detail below.

Program Background

DMAS currently operates two statewide, fully capitated, risk-based Medicaid managed care programs. Participation is mandatory for eligible populations.

1. The Commonwealth Coordinated Care Plus Managed Care Program serves vulnerable populations, including older adults, disabled children, disabled adults, medically complex Medicaid Expansion adults, and members who receive Medicaid long-term services and supports (LTSS) in a facility or through home and community-based care (HCBS) waivers. CCC Plus also includes dual eligible individuals enrolled in both Medicare and Medicaid.

2. The Medallion 4.0 program serves Medicaid pregnant women, infants, children, parents/caregivers, and Medicaid Expansion adults. Medallion 4.0 also includes individuals enrolled in Virginia's State Children's Health Insurance Program (S-CHIP), called FAMIS, which provides coverage for pregnant women and children in families whose earnings are too high to qualify for Medicaid but cannot afford private insurance. FAMIS MOMS provides the same coverage to pregnant women as available under the Medicaid program.

Cardinal Care Managed Care Program (Anticipated October 2023)

In June 2021, the Virginia General Assembly mandated that DMAS combine the CCC Plus and Medallion 4.0 managed care programs under a single contract and name, the Cardinal Care Managed Care program. When implemented, Cardinal Care Managed Care will also operate as a fully capitated, risk-based Medicaid managed care program with statewide, mandatory participation. Cardinal Care Managed Care will include coverage for acute and long-term services and supports (LTSS) population groups as further defined in the Cardinal Care Managed Care contract between the Commonwealth and the MCOs.

Covered Populations

The Medallion 4.0 populations listed above are referred to as the Cardinal Care Managed Care Acute population group in this Data Book, and include the following populations:

- Low-Income Families and Children (LIFC)
- Non-Medically Complex Expansion
  - Includes adults with income levels up to 138% of the federal poverty level (FPL)
- Members with comprehensive private insurance or third-party liability (TPL) as a primary payer (Major TPL)

- FAMIS and FAMIS MOMS members.
- Individuals in psychiatric residential treatment facilities are currently excluded.

The CCC Plus managed care populations listed above are referred to as the Cardinal Care Managed Care MLTSS population group in this Data Book, and include the following Dual and non-Dual eligible populations:

- Are eligible in the aged, blind, or disabled (ABD) Medicaid coverage groups.
- Receive Medicare benefits and full Medicaid benefits (Dual-eligible).
- Receive Medicaid long-term services and supports (LTSS) in a facility or through one of the following home and community based (HCBS) waivers: Commonwealth Coordinated Care Plus HCBS Waiver (formerly known as the Elderly or Disabled with Consumer Direction (EDCD) and Technology Assisted Waivers)[1], or one of the Department's three Developmental Disabilities (DD) HCBS Waivers: Building Independence, Community Living, and Family and Individual Supports. Populations in intermediate care facilities for the intellectually disabled and government-owned nursing homes (NHs) are currently excluded.
- Medically Complex Expansion
  - Includes adults with income levels up to 138% of the federal poverty level (FPL)
- Any of the populations listed above with private insurance are also included.
- Individuals in psychiatric residential treatment facilities are currently excluded.

Rate Structure

The rate structure for Cardinal Care Managed Care members is consolidated based on age and aid category for purposes of monthly capitation payment. The rate structure may be reevaluated in the future and is subject to change. DMAS is exploring changes to the rate structure which may include but is not limited to: consolidation of existing rate cells, and/or modifications to risk adjustment.

The anticipated configuration of the Cardinal Care Managed Care rate cells for FY2025 is shown below. This configuration is subject to review and change.

Cardinal Care Managed Care Acute Rate Cell Structure

Rate Cell	TPL Category	Age	Geography
LIFC	Non-TPL/Major TPL Combined	Under 1, Child (age 1–20), Adult (age 21+)	Regional Capitation

[1] On July 1, 2017, Virginia received approval from the Centers for Medicare and Medicaid Services (CMS) to operate the Commonwealth Coordinated Care Plus (CCC Plus) Home and Community Based Care (HCBS) Waiver. The CCC Plus HCBS waiver replaces the EDCD and Technology Assisted Waivers and has two (2) benefit plans: without private duty nursing (PDN) and with private duty nursing. Individuals who are enrolled in the private duty nursing benefit plan are eligible to receive all CCC Plus HCBS waiver services as well as private duty nursing services. Individuals receiving the private duty nursing benefit are technology dependent and have experienced loss of a vital body function and require substantial and ongoing skilled nursing care.

Rate Cell	TPL Category	Age	Geography
Non-Medically Complex Expansion	Non-TPL/Major TPL Combined	All Ages	Regional Capitation
Maternity Kick	Non-TPL/Major TPL Combined	All Ages	Statewide Delivery Payment

Cardinal Care Managed Care FAMIS Rate Cell Structure

Rate Cell	TPL Category	Age	Geography
FAMIS <= 150% FPL	Non-TPL/Major TPL Combined	Under 1, 1–5, 6–14, 15–18 Female, 15–18 Male	Statewide Capitation
FAMIS > 150% FPL	Non-TPL/Major TPL Combined	Under 1, 1–5, 6–14, 15–18 Female, 15–18 Male	Statewide Capitation
FAMIS MOMS	Non-TPL/Major TPL Combined	Pregnant women of any age	Statewide Capitation
Maternity Kick	Non-TPL/Major TPL Combined	All Ages	Statewide Delivery Payment

Cardinal Care Managed Care MLTSS Rate Cell Structure

Rate Cell	Description	TPL Category	Age	Geography
Blended NH/Elderly or Disabled with Consumer Direction (EDCD) waiver[2]	Nursing facility (NF) and CCC Plus waiver EDCD subpopulation (Meet nursing facility level of care [NF LOC])	Dual (includes Medicare Part A or B)	All Ages	Regional Capitation
		Non-Dual (includes Major, Minor or No TPL)		
DD waiver	DD waiver population	Dual (includes Medicare Part A or B)	All Ages	Statewide Capitation
		Non-Dual (includes Major, Minor or No TPL)		

[2] Documented as CCC Plus HCBS Waiver without private duty nursing benefit plan in the Cardinal Care Managed Care Contract.

Rate Cell	Description	TPL Category	Age	Geography
Technology Assisted waiver[3]	CCC Plus waiver Technology Assisted Subpopulation (Meet Specialized NF LOC for Technology Dependent)	Dual and Non-Dual	All Ages	Statewide Capitation
Community No LTSS	ABD population	Dual (includes Medicare Part A or B)	Age Under 65 Age 65 and Over	Regional Risk-Adjusted Capitation
		Non-Dual (includes Major, Minor or No TPL)	Age Under 1	Statewide Capitation
			Age 1 and Over	Regional Risk-Adjusted Capitation
Medically Complex Expansion	Medically Complex Expansion No LTSS population	Non-TPL/Major TPL blended	All Ages	Regional Capitation
Maternity Kick		All	All Ages	Statewide Delivery Payment

Due to the small population size of Medically Complex Expansion LTSS rate cells, Mercer has relied on equivalent non-Expansion LTSS rate cells as a proxy. This methodology is subject to change at Mercer and DMAS's discretion.

Regional Groups

The Cardinal Care Managed Care program includes six separate regions. Counties and cities that make up the rate regions for the Cardinal Care Managed Care Acute and MLTSS population groups are displayed below and represent region mappings anticipated to be in effect for FY2025.

Region/County Mapping

Region	Counties
Central Virginia	Amelia, Brunswick, Caroline, Charles City, Chesterfield, Colonial Heights, Cumberland, Dinwiddie, Emporia, Essex, Franklin City, Fredericksburg, Goochland, Greensville, Hanover, Henrico, Hopewell, King and Queen, King George, King William, Lancaster,

[3] Documented as CCC Plus HCBS Waiver with Private Duty Nursing Waiver in the Cardinal Care Managed Care Contract.

Region	Counties
	Lunenburg, Matthews, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Powhatan, Prince Edward, Prince George, Richmond City, Richmond County, Southampton, Spotsylvania, Stafford, Surry, Sussex, Westmoreland
Charlottesville/Western	Albemarle, Amherst, Appomattox, Augusta, Buckingham, Campbell, Charlotte, Charlottesville, Danville, Fluvanna, Greene, Halifax, Harrisonburg, Louisa, Lynchburg, Madison, Nelson, Orange, Pittsylvania, Rockingham, Staunton, Waynesboro
Northern/Winchester	Alexandria, Arlington, Clarke, Culpeper, Fairfax City, Fairfax County, Falls Church, Fauquier, Frederick, Loudoun, Manassas City, Manassas Park City, Page, Prince William, Rappahannock, Shenandoah, Warren, Winchester
Roanoke/Alleghany	Alleghany, Bath, Bedford County, Botetourt, Buena Vista, Covington, Craig, Floyd, Franklin County, Giles, Henry, Highland, Lexington, Martinsville, Montgomery, Patrick, Pulaski, Radford, Roanoke City, Roanoke County, Rockbridge, Salem, Wythe
Southwest	Bland, Bristol, Buchanan, Carroll, Dickenson, Galax, Grayson, Lee, Norton, Russell, Scott, Smyth, Tazewell, Washington, Wise
Tidewater	Accomack, Chesapeake, Gloucester, Hampton, Isle of Wight, James City County, Newport News, Norfolk, Northampton, Poquoson, Portsmouth, Suffolk, Virginia Beach, Williamsburg, York

Excluded Populations and Carved Out Services

Any State Plan populations and services that are not included in the Cardinal Care Managed Care program benefit package and are provided to enrollees on a FFS basis are excluded from the Cardinal Care Managed Care program. Excluded services, also referred to as carved-out services are primarily dental services, school-based services, DD Waiver Services, DD case management services, and treatment foster care targeted case management services. These services are described in the Cardinal Care Managed Care Model Contract.

Cardinal Care Managed Care MLTSS individuals enrolled in the DD waivers are enrolled for their non-waiver services only. At this time, their DD waiver services will continue to be covered through Medicaid FFS.

Coordination with Medicare

Dual eligible members classified under the Cardinal Care Managed Care MLTSS population group may receive their Medicare benefits from the Contractor’s companion Dual Eligible Special Needs Plan, Medicare FFS, or through another Medicare Advantage Plan. The

providers for the Cardinal Care Managed Care program are required to submit claims directly to Medicare for services that are covered by Medicare FFS, otherwise these claims are submitted to the Medicare managed care plan. Costs for services that are covered by Medicare are included in the plans' separate Medicare premium and are not reflected in this data book. The Cardinal Care Managed Care MLTSS rates do reflect costs for any member cost sharing related to these Medicare-covered services, as applicable.

Covered Services

The selected vendors will have the ability to develop creative and innovative solutions to deliver the contractually required Medicaid and FAMIS services. The summarized encounter data in this Data Book includes historical experience reflecting the eligible Medicaid and FAMIS services that the Cardinal Care Managed Care MCOs were responsible for covering for CY2021.

The following table lists the historical medical services for which members are eligible. Users of this Data Book seeking more information on services, including more detailed categories of service should refer to the listing of covered services included in the Cardinal Care Managed Care Request for Proposal (RFP) #13330.

Cardinal Care Managed Care Acute, FAMIS and MLTSS Categories of Service
Addiction and Recovery Treatment Services (ARTS)
Case Management Services
Child Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Community Behavioral Health
Durable Medical Equipment (DME)/Supplies
Early Intervention Services
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)
Home Health Services
Inpatient-Maternity Kick Payment
Inpatient-Newborn
Inpatient-Other
Inpatient-Psych
Lab/Radiology
Outpatient-ER
Outpatient-Maternity
Outpatient-Other
Pharmacy
Physician-Anesthesia
Physician-Dental
Physician-Evaluation & Management
Physician-Maternity
Physician-Other
Physician-Psych
Physician-Specialist
Physician-Vision
Transportation/Emergency
Transportation/Non-emergency

Cardinal Care Managed Care MLTSS Only Categories of Service
Adult Day Care
Consumer Directed-Personal Care
Consumer Directed-Respite Care
Medicare Crossover-Inpatient (IP)
Medicare Crossover-NF
Medicare Crossover-Outpatient (OP)
Medicare Crossover-Other
Medicare Crossover-Physician
Nursing Facility
Other Waiver Services
Personal Care Agency-Personal Care
Personal Care Agency-Respite Care

Section 3

Adjustments Reflected in this Data Book

This section describes the adjustments Mercer has applied to the historical data for the purposes of this Data Book.

Encounter Base Data Source

Mercer received and validated actual encounter data submitted through the EDWS system for claims paid through June 2022. Mercer validated the data and selected the CY2021 time period as the base for the FY2024 rate development. The CY2021 time period will serve as the basis for the preliminary FY2025 rate development and is subject to change.

Base Data Adjustments

Mercer reviewed the encounter data to ensure they were appropriate for the populations and services covered in Cardinal Care Managed Care. This review included comparisons of the encounter data results at a rate cell and category of service (COS) level to the previous base data utilized in prior rate developments and to the MCO-reported financials for CY2021. Additionally, Mercer provided summaries to each of the MCOs to allow them an opportunity to review and validate the data used for rate setting. The following items were not included in the encounter data costs; therefore, no adjustment was necessary:

- Graduate Medical Education payments.
- Disproportionate Share Hospital payments.
- Wrap around payments made to FQHCs/RHCs such that total reimbursement is at the level authorized in the State Plan.
- Payments from TPL recoveries.

After processing the data, Mercer identified and applied the following adjustments within the Data Book and are as follows:

- Removal of duplicated claims.
- Removal of claims not matched to individuals in the enrollment roster.
- Removal of services typically covered through waivers such as NF, Adult Day Care and Respite Care for the Cardinal Care Managed Care – Acute, FAMIS and FAMIS MOMS population groups only.
- Removal of certain COS that were identified as frequently paid for through sub-capitated arrangements, including vision and non-emergency medical transportation (NEMT) services. In order to reflect the actual costs for these services under sub-capitation,

Mercer relied on financial data and known contract arrangements to price in the costs for these arrangements.

Mercer subsequently considered the following adjustments when forming the Base Data Book:

Incurred but Not Reported Claims

The base period includes encounter data from the historical Acute and MLTSS populations for the period of January 2021–December 2021, paid through June 2022. To account for any outstanding claim liabilities that would not have been reflected in the base encounter data, Mercer developed completion factors to apply to the base data. Claims payment triangles using monthly EDWS data from January 2021–June 2022 were analyzed to estimate the amount of outstanding claim liabilities due to claim payment lags for the EDWS data.

NH Per Diem Add-On Removal

Per the FY2021 Supplemental Rate Certification dated June 20, 2020, in response to the Coronavirus Disease 2019 (COVID-19) pandemic, DMAS increased payment rates for NFs and specialized care providers by $20.00 per person per day in FY2021. This amount was reduced to $15.00 in FY2022 per the rate report dated May 25, 2021. Mercer developed a base data adjustment to calculate the removal of the increased unit cost for base period NF COS utilization that is reflected ONLY for the MLTSS population.

Provider Incentives

The Cardinal Care Managed Care MCOs continue to provide incentive payments to providers for coordinating care, ensuring access, and improving quality. These payments were not included in the encounter data. Mercer relied on financial data submitted by the MCOs and worked with the MCOs to gain feedback on the populations and services affected by these arrangements in order to account for the impact of these payments.

Pharmacy Efficiency Adjustments

After the base data was adjusted to reflect the populations and benefits expected to be covered for FY2025, Mercer applied various efficiency adjustments based on a review of the base period encounter claims. These adjustments are intended to reflect efficient provision of services in the pharmacy settings and are consistent with the Commonwealth's goals, Joint Legislative Audit Review Commission recommendations and requirements included in the biennial budget that the Virginia Medicaid managed care program be operated in an efficient, high-quality matter.

Pharmacy Clinical Edits

Mercer performed a retrospective analysis of the CY2021 pharmacy encounter data to identify potentially inappropriate prescribing and/or dispensing patterns using a customized series of clinical rules-based pharmacy utilization management edits. These edits were developed by Mercer's Managed Pharmacy Practice based on published literature, industry standard practices, clinical appropriateness review, professional expertise, and information gathered during the review of several MCO pharmacy programs across the country.

Drug-Disease Matching

Mercer also reviewed the pharmacy claims for select medications to determine if clinically appropriate diagnosis codes appeared in the medical claims data. The select list of medications included those medications for which off-label use is associated with the potential for misuse/abuse, are relatively high cost and/or carry safety concerns. Mercer clinicians developed a list of clinically appropriate diagnosis codes based on peer-reviewed literature, FDA-approved indications and clinically accepted off-label use.

Mercer reviewed CY2021 pharmacy and medical claims data and looked back 24 months and looked forward six months from the pharmacy claim date of service to identify pharmacy claims that did not have a corresponding, clinically appropriate diagnosis present in the medical claims (ICD-10 diagnosis code). Each pharmacy claim that did not have an appropriate diagnosis in the medical data was considered potentially inappropriate (or avoidable).

Maximum Allowable Cost

Mercer performed an evaluation of CY2021 pharmacy encounter data to evaluate efficient payment for generic products in addition to identifying potential for generic substitution when brands drugs were dispensed. This analysis is performed by benchmarking MCO payment for drugs against a Medicaid industry standard maximum allowable cost (MAC).

Physician-Administered Drugs

The final pharmacy-related adjustment Mercer completed was to identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications. Mercer reviewed the MCO CY2021 professional encounter data to identify the drug-related health care common procedure coding system (HCPCS) codes with the highest reimbursement expense. To identify the potentially avoidable costs, Mercer compared the MCO per unit reimbursement rate to an industry benchmark. For the industry benchmark, Mercer used the Centers for Medicare & Medicaid Services (CMS) average sales price (ASP) plus 6% per unit reimbursement rate for a similar time period.

Institution for Mental Disease

CMS published the Managed Care Final Rule on May 6, 2016, that included provisions regarding the treatment of utilization at Institution for Mental Diseases (IMDs) in capitation payment and rate setting. Specifically, the Final Rule outlines that states, “[…] may make a monthly capitation payment to an MCO or PIHP [prepaid inpatient health plan] for an enrollee ages 21–64 receiving inpatient treatment in an Institution for Mental Diseases, as defined in §435.1010 of this chapter, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment.” As a result of this provision, Mercer incorporated an adjustment to the Data Book that reflects the appropriate cost and utilization of allowable stays in an IMD facility.

The IMD adjustment only impacts the Cardinal Care Managed Care Acute and MLTSS population groups and did not impact the FAMIS and FAMIS MOMS populations.

Non-State Plan Services Removal

Mercer included an adjustment to remove services provided to members beyond those identified in the Cardinal Care Managed Care contract. The costs associated with these services were excluded from the base data for the applicable populations. The excluded services include home delivered meals, adult dental, adult vision, adult hearing, environment modifications, and NEMT.

COVID-19 Vaccine Cost Removal

Mercer included an adjustment to remove costs related to the COVID-19 vaccine administration from the CY2021 base period. During the CY2021 time period, the costs directly associated with the COVID-19 vaccine administration were paid directly to the MCOs on a non-risk basis, and that payment was separate from the monthly capitation payments during that time period.

Out-of-State Removal

For the preliminary FY2025 rate development, Mercer included an adjustment reflecting the removal of the claims and eligibility for members that DMAS has determined were residing out-of-state during the base period. DMAS provided the list of out-of-state members that was used to develop the adjustment.

Section 4

Exhibit Descriptions

The exhibits included in this Data Book provide historical data on the populations included in the Cardinal Care Managed Care program. These exhibits reflect managed care data only. The exhibits included within this Data Book, as well as a brief description of the information included, are described below.

Users of this Data Book are advised to review the information in Section 1 and Section 2 regarding the sources of data and program information and Section 3 regarding exclusions and adjustments made to the data within this Data Book.

Demographic information, including region, rate cell, and population, is provided at the top of the page. Additional key data elements contained in the exhibits include:

- *Member Months (MMs)* – Number of MMs for the CY2021 period.
- COS – Services that fall under the responsibility of the Cardinal Care Managed Care Model Contract, as defined in Section 2.
- Raw Base Data:
  - *Dollars* – Total, unadjusted paid dollars for each COS, incurred in CY2021 and paid thru June 30, 2022.
  - *Units* – Total, unadjusted service units for each COS, incurred in CY2021 and paid thru June 30, 2022.
  - *Utilization per 1,000 (Util/1000)* – Computed as the total units divided by MMs and multiplied by 12,000.
  - *Unit Cost* – Computed as the total paid dollars divided by the total number of units.
  - *Per Member Per Month (PMPM)* – Computed as the total paid amount divided by the MMs.
- Base Adjustments:
  - Incurred but not Reported (IBNR) – Please see Section 3.
  - NH Per Diem Add-On Removal (MLTSS only) – Please see Section 3.
  - Provider Incentives – Please see Section 3.
  - Pharmacy Efficiencies – Please see Section 3.

  - IMD – Please see Section 3.
  - Non-State Plan Services Removal – Please see Section 3.
  - COVID-19 Vaccine Cost Removal – Please see Section 3.
  - Out-of-State Removal – Please see Section 3.
- Final Base Data:
  - *Util/1000* – Computed as the total base-adjusted units divided by MMs multiplied by 12,000.
  - *Unit Cost* – Computed as the total base-adjusted PMPM divided by (Util/1,000 x 12,000).
  - *PMPM* – Computed as the total base-adjusted paid amount divided by MMs.

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com