Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Care Financing and Policy
Helping people. It's who we are and what we do.

Suzanne Bierman, JD, MPH
Administrator

November 4, 2020

Julie Sharp
Technical Director
Division of System Reform Demonstrations
State Demonstrations Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
juliana.sharp@cms.hhs.gov

Dear Ms. Sharp:

This letter is in regard to the Nevada Comprehensive Care Waiver and the required report titled "Program Year 4 Quality Measures and Savings Calculations Report" written by Milliman (Actuary). Milliman used the methodology agreed upon in the approved contract between the Nevada Division of Health Care Financing and Policy (DHCFP) and AxisPoint Health (Care Management Organization) and the approved CMS Special Terms and Conditions to determine the pay-for-performance outcomes of the Nevada Comprehensive Care Waiver.

The DHCFP and AxisPoint Health have both agreed to provide their responses in the body of this Program Year 4 Report. Please see attached report.

The DHCFP has completed all required reports of the Nevada Comprehensive Care Waiver. If you have any questions, please contact Erin Lynch at erin.lynch@dhcfp.nv.gov or cell phone at (775) 350-0786.

Sincerely,

DuAne L. Young
DuAne L. Young (Nov 4, 2020 15:06 PST)

DuAne L. Young, MS
Deputy Administrator

Enclosures

Cc: Peter Banks, CMS
Homa Woodrum, Nevada Office of the Attorney General, Deputy Attorney General
Suzanne Bierman, DHCFP, Administrator
Erin Lynch, DHCFP, Chief of Medical Programs Unit
Gladys Cook, DHCFP, Social Services Program Specialist
Tom Sargent, DHCFP, Management Analyst

ATTACHMENT 3

Program Year 4 Quality Measures and Savings Calculations Report
Responses from APH and DHCFP

The following allows both AxisPoint Health (APH) and the Nevada Division of Health Care Financing and Policy (DHCFP) the ability to provide a response regarding the Program Year 4 Quality Measures and Savings Calculations Report published by Milliman on June 25, 2020.

Below is an exact copy of the body of the published report. Please use the response sections below to provide any comment.

Executive Summary

Attachment AA of Nevada's care management organization (CMO) services contract with AxisPoint Health (APH) describes a final calculation of the shared savings bonus conducted with 12 months of claims runout. Due to the transition to a new Medicaid management information system (MMIS), 12 months of claims runout were not available, and this analysis instead uses six months of claims runout. Based on a high-level review of the runout patterns in program year (PY) 3, we expect this would have a small impact (<1%), and that the impact would be similar for the trend and reconciliation populations. This means that the trends would be impacted in approximately the same direction for each population, and the trend comparison would be minimally affected.

The risk-adjusted trend was compared for two populations in order to determine the cost reduction to from the program:

- Reconciliation population: members with chronic conditions enrolled with the CMO
- Trend population: members without chronic conditions who otherwise meet the eligibility criteria for the HCGP. The results of the trend population serve as a benchmark for the results of the reconciliation population.

In PY 4 (June 1, 2017 through May 31, 2018), there is no P4P bonus payment due to APH. The total impact to cost in PY 4, as calculated in Exhibit 3, was a cost reduction of $18,085,990 after accounting for management fees. The overall quality score for PY 4 is 1.8%. While an overall cost reduction for the reconciliation population was achieved in PY 4, the minimum overall quality score threshold of 50% was not met, resulting in a P4P bonus payment of $0.

Program trends, quality measures, and savings calculations are detailed in the following exhibits:

- Exhibit 1 shows the development of the PY 4 risk adjusted cost trends.
- Exhibit 2 shows the P4P quality measures for the baseline and PY 4. It also shows the target PY 4 quality measures, calculated per Attachment AA, and indicates whether or not APH has met these targets.
- Exhibit 3 shows the calculation of the pay-for-performance bonus for PY 4.
- Exhibit 4 shows the membership and cost basis for our trend development.

In January 2014, the State of Nevada DHCFP implemented a policy change reducing coverage for basic skills training (BST), which appears to have contributed to the overall cost reduction. This policy change is discussed in more detail later in this report.

APH Response
APH agrees with the DHCFP observation regarding the 6-months versus 12-month claims runout used in calculating the PY4 results.

APH agrees the PY4 net Cost Reduction results are at least $18,085,990 as indicated by Milliman above.

APH disagrees with the DHCFP assertion that the Cost Savings may be attributed to policy changes while simultaneously disregarding the impact of updating the claims codes to ensure the most accurate accounting for program performance. Clinical outcomes of the program and resulting Cost Savings remain consistently and significantly under-reported due to insufficient regard for claims code updates which inaccurately characterize the efficacy of the program.

Incorrect data inputs combined with inaccurate, incomplete, and irrelevant service billing codes achieves misleading results. Therefore, APH does not agree with the Quality Score reported by DHCFP for PY4 or any prior year for the program.

DHCFP Response
The DHCFP agrees with the findings by Milliman in regard to cost savings. Cost savings from a change in BST policy cannot be fully attributed to the efforts of the HCGP. Additionally, APH is stating that additional claim codes should have been included in the analysis for the pay for performance measures. While the DHCFP does not disagree with this statement, the DHCFP and Milliman only used billing codes from the claims data as outlined in the approved contract between APH and the DHCFP (Attachment AA), CMS approved Special Terms and Conditions, and official letters between the DHCFP and APH. It was agreed upon that Baseline and PY1 – PY4 Reports would use reconciliation data to calculate the pay-for-performance measures outlined in Attachment GG. Milliman utilized reconciliation data and all approved methodologies as outlined in the approved Attachment GG and not the unapproved Attachment HH.

In PY2, the DHCFP did run the Quality Measures and Savings Calculations Report with the specifications outlined in the unapproved Attachment HH. The outcomes utilizing Attachment HH had the same results as the approved Attachment GG – no targets were achieved to receive a pay-for-performance payment and the quality score was at 0%.

Program Background

The HCGP was created by an 1115 waiver, approved by CMS in 2013. The five-year demonstration began June 2013 and continued through May 2018.

Under this statewide demonstration waiver, Nevada enrolled individuals in a care management program who are eligible under the state Medicaid plan, who have certain qualifying conditions, and who are not eligible for the state's existing care management options. A detailed description of the eligibility criteria and exclusions can be found in Attachment AA of Nevada's CMO services contract. The care management services were provided by the CMO AxisPoint Health.

The demonstration will assist the state to:

- Provide care management to high-cost, high-need Medicaid beneficiaries who receive services on a fee-for-service (FFS) basis;
- Improve the quality of care that high-cost, high-need Nevada Medicaid beneficiaries in FFS receive through care management and financial incentives such as pay for performance (quality and outcomes); and
- Establish long-lasting reforms that sustain the improvements in the quality of health and wellness for Nevada Medicaid beneficiaries and provide care in a more cost-efficient manner.

APH Response
APH agrees with the Program Background information provided above.

DHCFP Response
No response.

Impact of Policy Changes

Direct Enrollment

Beginning in October of 2016, DHCFP began enrolling a subset of eligible beneficiaries directly into managed care rather than enrolling them into fee-for-service during an initial choice period. This initiative was completed in May 2017 for all eligible beneficiaries.

DHCFP has implemented direct enrollment into managed care plans in phases:

- Phase 1 – effective October 17, 2016, members who regain eligibility after having lost eligibility for less than the current month are re-enrolled in their previous plan with no gap in enrollment. Members who regain eligibility after having lost eligibility for more than the current month are re-enrolled with their previous plan as of the effective the date MMIS receives the new eligibility record.
- Phase 2 – effective May 1, 2017, newly eligible members will be enrolled into managed care effective the date MMIS receives the eligibility record.
- Newborns can be retroactively enrolled into managed care for up to three months if the mother is in managed care at the time of birth.

Prior to October 17, 2016, members were enrolled with FFS until the next administratively possible month (6-40 days). Following this waiting period in FFS they would enroll in a managed care organization (MCO).

This transition to direct enrollment immediately prior to PY 4 impacted our calculation due to the introduction of partial member months, whereas, before direct enrollment, member months were integer values. We reviewed the calculation of quality metrics with this change in mind, particularly as it relates to continuous enrollment for a certain number of days. We updated our logic to use the data field enrol_disp_date to assign the end date for partial member months.

Basic Skills Training

The calculation described in this report and presented in the attached exhibits is intended to follow the terms of the contract approved by CMS in 2013. The trend-based nature of the contract implicitly accounts for policy and fee schedule changes that occur proportionately in both the trend population and the reconciliation population. To the extent that a policy or fee schedule change disproportionately impacts one population over the other, these changes may impact the calculation of the trend differential.

In January 2014, the service limitations changed for basic skills training (BST) to a maximum of 2 hours per day for all service limitation levels (previously the limitation only applied to levels I, II and III), and to require more stringent validation of whether or not these services are "reasonable and necessary."1 This change in BST service levels would have been fully effective in PY 2, but only effective for 5 months of the 12 month baseline. BST services are more widely used for enrollees with behavioral health diagnoses, who are more likely to be enrolled in the reconciliation population than the trend population.

As a percentage of total claims, BST claims decreased more for the reconciliation population than the trend population between the baseline and PY 4, as seen in Table 1.

TABLE 1: PERCENTAGE OF BST CLAIMS RELATIVE TO TOTAL

YEAR	RECONCILIATION	TREND
Baseline	12.0%	1.0%
PY 4	0.5%	0.0%
Difference	11.5%	1.0%

Table 1 indicates that the reduction in BST claims would have had a disproportionate impact on the reconciliation population. Between the baseline period and PY 4, the proportion of BST claims in the reconciliation population decreased by about 11.5%, while proportion of BST claims in the trend population changed by 1.0%.

Please note that we have not performed an analysis that would allow us to estimate the precise impact of the BST policy change in isolation. As such, we are not able to validate whether the decrease in cost shown in Exhibit 3 was solely a function of APH's medical management activities. Even if we had performed such an analysis, separating the impact of policy changes and medical management activities would be extremely difficult, so any estimate would be imprecise.

APH Response

As inferred by Milliman and previously stated by APH, accurately quantifying the impact of policy changes would be extremely difficult, making any ***estimate*** imprecise. Multiple variables are impacted as the result of a policy change. Any ***estimate*** would be misleading because it is difficult to discern the implications of such a change, making the resulting conclusion inaccurate.

APH acknowledges Milliman's effort to reconcile the perceived disconnect between the cost savings achievements in prior years with the purportedly low achievement on clinical quality. Furthermore, APH agrees with and logic dictates these metrics should complement one another sharing similar trajectory. In this instance, APH maintains that the difference cannot be explained by focusing on policy changes. The lower quality metric results are a direct reflection of having used the wrong data set based upon fundamental flaws in the methodology of its determination of claims-based clinical quality measurements and in the corresponding production of the quality metrics.

APH respectfully disagrees with continuing to ascribe a significant portion of the $82.5M in Cost Savings over the four years of this program to a policy change made by the State of Nevada in the final 5 months of PY2. The impact of which cannot possibly be accurately calculated.

DHCFP Response

The DHCFP agrees with Milliman in that it would be extremely difficult and almost impossible to claim that changes in behavioral health outcomes were due to efforts of the HCGP versus the change in the BST policy. In January 2014, the DHCFP implemented policy change for BST. The change in policy included a reduction in allowable BST hours. Therefore, a lack of billable BST hours would impact the use of this service and create a reduction in costs that was not attributed to the HCGP and would have the same effect from PY2 to PY4 Reports.

The reason that BST policy change impact was investigated by Milliman was to explain how the HCGP could have such large cost savings (aka - Return on Investment), especially the change in Return on Investment when there was a 1.8% quality metric met.

The data sets utilized for the calculations of the PY4 Report are from the approved contract between APH and the DHCFP (Attachment AA), CMS approved Special Terms and Conditions, and official letters between the DHCFP and APH, it was agreed upon that Baseline and PY1 – PY4 Reports would use reconciliation data to calculate the pay-for-performance measures outlined in Attachment GG. Therefore, the same methodologies and data sets that were used in the Baseline to the PY1, PY2, and PY3 Reports, were also used in the PY4 Report. Therefore, the Baseline to the PY4 Quality Measures and Savings Calculation Reports all use the same methodologies for calculating cost savings, quality score, and performance measures. The only difference in these reports would be different outcomes.

Data

The Nevada FFS data used in this calculation was provided by DHCFP. This includes claims incurred from June 1, 2011 through May 31, 2018 and paid through November 30, 2018.

Attachment AA stipulates that this data includes 12 months of runout. However, the transition to a new MMIS presented difficulties for the validation of post-transition data. With approval from the state on June 11, 2020, we developed this analysis with six months of runout instead. It is our expectation that less runout would have similar, small impacts on the trend and reconciliation populations, so no adjustment was applied for potential additional claims runout.

Trend Calculation

Membership and risk adjusted cost trends are shown in Exhibit 1. Total combined trends were calculated in addition to the separate trends for the reconciliation and trend populations, as defined in Attachment AA. The membership and cost basis for these can be seen in Exhibit 4.

Risk Adjustment

Risk scores for the population were calculated using concurrent weights from the CDPS + Rx v6.4 risk adjustment model.

Because CDPS uses separate risk models for adults vs. children and disabled vs. non-disabled, it was necessary to normalize risk scores to a common basis. An average PMPM cost was calculated for each year for each CDPS classification (Adult Disabled, Adult non-Disabled, Child Disabled, Child non-Disabled). Costs for each classification were averaged across the five-year period, resulting in a single PMPM cost for each classification. This approach was taken, rather than calculating a single overall average, to ensure that the combination of trend and any shift in population distribution by classification did not impact the classification relativities.

Using Adult non-disabled as the base (i.e. 1.00), relativities were calculated for each classification. The relativities are shown in Table 2 below.

TABLE 2: **CDPS CLAIM COST RELATIVITIES**

CLASSIFICATION	RELATIVITY
Child non-Disabled	0.606
Adult non-Disabled	1.000
Child Disabled	2.563
Adult Disabled	2.982

The risk score for each sub-population (aid category, calendar year, county, adult child status) was multiplied by the appropriate relativity. With this adjustment, the new risk scores were expected to represent accurate relativities to the overall population rather than the individual classifications.

Using these normalized risk scores, annual risk-adjusted PMPMs were calculated separately for each combination of

- Aid category (ABD, non-ABD)
- Program year
- County (Clark, Washoe, Other)

Overall risk-adjusted PMPMs for each program year were calculated as the weighted average of each county group's risk-adjusted PMPM for that year. The weights used were the county's total member months during the study period (June 1, 2017 through May 31, 2018). By using the same weights in each year, we eliminate any impact geographic population shifts might have on trend.

Total risk-adjusted PMPMs for each calendar year were calculated as the weighted average of each aid category's (ABD and non-ABD) risk-adjusted PMPM for that year. The weights used were each aid category's total member months during the study period. By using the same weights in the baseline and study years, we eliminate any impact on trend due to shifts in each aid category's relative population counts. These total risk-adjusted PMPMs were used to calculate annual trends.

In Exhibit 3, the PY 4 gross cost reduction is calculated using the following steps:

1. The baseline reweighted paid PMPM from the reconciliation population is trended to PY 4 using the risk adjusted trend from the trend population. This result is the expected PY 4 paid PMPM for the reconciliation population absent any care management or change in population morbidity (as measure by the risk score).
2. The PY 4 reweighted paid PMPM is adjusted to be on the same morbidity basis as the baseline reweighted paid PMPM by removing the risk score trend. A risk score trend value less than one indicates that the risk score decreased between the baseline and PY 4.
3. The results of step 1 and step 2 above are then compared to determine the gross cost reduction. If the trended baseline paid PMPM from step 1 is greater than the adjusted PY 4 paid PMPM from step 2, then the gross cost reduction is positive.

This approach to calculating trend was developed in late 2015 in conjunction with CMS in order to obtain their approval to include a bonus payment in the program.

APH Response
APH does not have a specific response to the information in this section.

DHCFP Response
No response.

Quality Measures

Quality Measure Calculation

As per Attachment AA of the contract, an annual pay-for-performance payment will be made based on a net reduction in costs, if the CMO meets the criteria outlined in the contract. These criteria require both a reduction in cost as well as a demonstration of quality of care improvements based on the use of specified quality measures.

Attachment FF and GG of the contract list and define these quality measures. Actual achieved measure values for the baseline and PY 4 are shown in Exhibit 2.

The quality measures provided in Exhibit 2 were calculated for the reconciliation population using a process reviewed and approved by the Health Services Advisory Group (HSAG). P4P measures presented in Exhibit 2 use SAS code reviewed by HSAG in August 2017, with additional comments and feedback in May 2018.

PY 4 reflects the impact of ICD-9 to ICD-10 diagnosis code conversion. We updated our methodology to include ICD-10 diagnosis and procedure codes, using a mapping reviewed by HSAG in September 2017. This update impacts claims incurred after October 1, 2015.

Consistent with the last version of our PY 3 calculation dated May 28, 2020, we have relied on the national drug codes (NDCs) listed in Attachment GG to calculate quality measures. Between PY 1 and 2, an Attachment HH was created with an updated list of NDCs based on the reference HEDIS NDC lists, with the intention of using these new NDC codes for the quality measure calculations. However, because this change was not approved by CMS, we have relied on the NDC lists in the original Attachment GG.

Quality Improvement Target Calculation

Exhibit 2 shows quality improvement targets for PY 4 along with an indication whether that target was achieved. For each year of the program, per Attachment AA, the quality improvement target for each quality measure is calculated as 10 percent of the difference between the optimal quality level (either 100% or 0%, depending on the measure) and the value of the measurement during the baseline period for the eligible population. In subsequent years, the quality measurement score must sustain or exceed the prior year's improvement in order to qualify for a pay-for-performance bonus. Some measures, such as those measuring emergency room visits post-discharge, were targeted to decrease, but most were targeted to increase. Targets were only calculated for measures impacting the P4P calculation.

APH Response

Much like PY3, APH was not involved in the review processes leading up to the generation of Milliman's PY4 report. That said, APH does not know if the application billing codes have been updated to align with the performance year being evaluated. To accurately measure the delivery of quality-related services, the relevant, accurate, complete, and timely service billing codes used by providers (CPT, HCPCS, UB40, POS, ICD10 and NDC) during the measurement/study period must be included in the relevant associated metric analysis.

Logic dictates that the Cost Savings and Quality Score calculation metrics should complement one another sharing similar trajectory. The lower quality metric results are a direct reflection of having used the wrong data set based upon fundamental flaws in the methodology of its determination of claims-based clinical quality measurements and in the corresponding production of the quality metrics.

Incorrect data input combined with inaccurate, incomplete, and irrelevant service billing codes achieves meaningless results. Therefore, APH cannot agree to the values reported.

DHCFP Response

The DHCFP only used billing codes from the claims data as outlined in the approved contract between APH and the DHCFP (Attachment AA), CMS approved Special Terms and Conditions, and official letters between the DHCFP and APH, it was agreed upon that Baseline and PY1 – PY4 Reports would use reconciliation data to calculate the pay-for-performance measures outlined in Attachment GG. Milliman utilized reconciliation data and all approved methodologies as outlined in the approved Attachment GG and not the unapproved Attachment HH.

APH has been involved in the review process and this Settlement Agreement gives APH the ability to provide their responses to Milliman's report. The process/methodologies that Milliman used is the same for each program year report.

Pay-for-Performance Bonus Calculation

The trend calculation and the P4P quality measure calculations combine to calculate the P4P bonus payment. Per Attachment AA, the bonus is calculated using this equation:

Bonus = Reduction in Costs x [50% - (100% - Overall Quality Score)]

Where this formula results in a negative number due to an overall quality score less than 50%, a maximum of zero was applied. This calculation is shown in Exhibit 3. Each component of this calculation is defined as follows.

Reduction in Costs

The reduction in costs is calculated assuming the difference in trend between the trend and reconciliation populations is due to management by APH. After risk adjustment, the reconciliation population's baseline PMPM is trended forward using the trend population's annual cost trend. This result is then compared to the reconciliation population's actual risk adjusted program year PMPM. After removing care management fees paid to APH, the difference is the calculated reduction in costs.

Overall Quality Score

Each condition receives a condition specific quality score, calculated as the number of "achieved" quality improvement targets divided by the total number of quality improvement measures for that condition. The condition specific quality scores are shown in Exhibit 2.

The overall quality score is the weighted average of each condition specific quality score, based on the number of member months with that condition. Members with multiple conditions are counted multiple times in this calculation.

Caveats & Limitations

The information contained in this letter, including the enclosures, has been prepared for the State of Nevada Division of Health Care Finance and Policy (DHCFP) and their consultants and advisors, subject to the terms of Milliman's contract with DHCFP, as amended December 10, 2019. This report may not be distributed to other parties without Milliman's prior written consent. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter

prepared for DHCFP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In performing our analysis, we relied on data and other information provided to us by DHCFP and its data vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries, and we meet the qualification standards for performing the analysis in this letter.

APH Response
APH disputes the 1.8% quality score reported by Milliman and the State of Nevada in the "Program Year 4 Quality Measures and Savings Calculations". The quality score conclusions are inherently flawed due to the use of incorrect data and improper, inaccurate, and untimely service billing codes. The quality determination should be recalculated consistent with the requirements of the Contract.

DHCFP Response
The DHCFP agrees with Milliman's 1.8% quality score. Milliman utilized all reconciliation data and approved methodologies as outlined in the approved Attachment GG, approved contract between APH and the DHCFP (Attachment AA), CMS approved Special Terms and Conditions, and official letters between the DHCFP and APH. It was agreed upon that Baseline and PY1 – PY4 Reports would use reconciliation data to calculate the pay-for-performance measures.

End of Report

Summary - Any last statements may be provided by APH or the DHCFP

APH Response
The absence of a collaborative and constructive process, once again for PY4, resulted in quality score (clinical outcomes) findings which continue to highlight that the use of inaccurate, incomplete, and irrelevant service billing codes continues to yield meaningless results.

The lower quality metric results are a direct reflection of having used the wrong data set based upon fundamental flaws in the methodology of its determination of claims-based clinical quality measurements and in the corresponding production of the quality metrics.

The total absence of collaboration on the performance calculations is prone to methodological misalignment as demonstrated in the PY1, PY2, and PY3 calculations.

While APH firmly believes the net Cost Savings achievements for the Health Care Guidance Program, totaling more than $82.5M over the four years of the program, are moderately understated these cost savings are a far more accurate a reflection of the performance of this program on behalf of the State of Nevada.

DHCFP Response

It is the intent of the DHCFP to continue to uphold all components of the approved contract between APH and the DHCFP, CMS approved Special Terms and Conditions, and official letters of agreement between the DHCFP and APH for all of the Quality Measures and Savings Calculations Reports. The DHCFP worked extensively with APH for almost 2.5 years on the PY2 Report. The baseline report and all four program year reports followed the same methodologies. The DHCFP agrees with Milliman's assessments on this PY4 Report.

Exhibit 1
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
Comparison of Trends
Chronic Condition vs Non Chronic Condition Population

	Total Eligible Population		
	PY2014 (3)	PY2018 (3)	2014-18 (3)
Member Months	672,990	726,866	8.0%
Average Risk Score	1.77	1.99	12.4%
Reweighted Paid PMPM (1)	$629.44	$714.47	13.5%
Risk Adjusted PMPM	$355.26	$358.70	1.0%

	Reconciliation Population		
	PY2014 (3)	PY2018 (3)	2014-18 (3)
Member Months	268,343	371,825	38.6%
Average Risk Score	3.39	3.24	-4.5%
Reweighted Paid PMPM (1)	$1,342.98	$1,246.40	-7.2%
Risk Adjusted PMPM	$396.11	$385.05	-2.8%

	Trend Population		
	PY2014 (3)	PY2018 (3)	2014-18 (3)
Member Months	404,647	355,041	-12.3%
Average Risk Score	0.70	0.69	-1.5%
Reweighted Paid PMPM (1)	$156.26	$157.39	0.7%
Risk Adjusted PMPM	$223.74	228.86	2.3%

Difference in Risk Adjusted Trends (2)	-5.1%

Notes:
(1) PMPM is capped at $500,000 per individual per program year.
(2) Positive number indicates target population > benchmark population
(3) PY14 and PY18 represent the Baseline (Jun 1, 2013 - May 31, 2014) and Program Year 4 (Jun 1, 2017 - May 31, 2018) respectively.

Exhibit 2
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
P4P Bonus Calculations
Program Year 4 - Measurement Period Ending May 31, 2018

Asthma Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure ASM.1	5 - 64	Members with persistent asthma that received preferred prescription	Members with persistent asthma	369	543	68.0%	320	478	66.9%	296	426	69.5%	342	456	75.0%	338	488	69.3%	INCREASE	75.0%	NO
Measure ASM.2	All Ages	Members with persistent asthma that received a flu shot	Members with persistent asthma	66	568	11.6%	30	498	6.0%	50	448	11.2%	48	482	10.0%	20	513	3.9%	INCREASE	20.5%	NO
Measure ASM.3	All Ages	Members with persistent asthma with an ED or Urgent Care visit	Members with persistent asthma	105	568	18.5%	125	498	25.1%	116	448	25.9%	112	482	23.2%	98	513	19.1%	DECREASE	16.6%	NO
Measure ASM.4	All Ages	IP asthma discharges with an ambulatory follow up visit	IP asthma discharges	76	259	29.3%	77	268	28.7%	61	212	28.8%	53	235	22.6%	51	207	24.6%	INCREASE	36.4%	NO

Coronary Artery Disease Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure CAD.1	All Ages	Members with CAD who were prescribed lipid lowering medications	Members with CAD	227	1,263	18.0%	185	1,302	14.2%	162	1,338	12.1%	147	1,360	10.8%	174	1,656	10.5%	INCREASE	26.2%	NO
Measure CAD.2	All Ages	Members with CAD with an LDL-C screening	Members with CAD	941	1,446	65.1%	1,010	1,505	67.1%	967	1,533	63.1%	995	1,541	64.6%	1,159	1,850	62.6%	INCREASE	68.6%	NO
Measure CAD.3	All Ages	IP CAD discharges with an ambulatory follow up visit	IP CAD discharges	54	177	30.5%	67	180	37.2%	65	188	34.6%	61	174	35.1%	67	227	29.5%	INCREASE	37.5%	NO

Chronic Obstructive Pulmonary Disease Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure SPR.1	40 +	Members with a COPD index episode start date receiving a spirometry test	Members with a COPD index episode start date	83	272	30.5%	97	294	33.0%	54	153	35.3%	58	138	42.0%	37	118	31.4%	INCREASE	42.0%	NO
Measure SPR.2	18 +	Members with COPD that received a flu shot	Members with COPD	279	2,209	12.6%	251	2,351	10.7%	371	2,109	17.6%	314	1,992	15.8%	156	2,162	7.2%	INCREASE	21.4%	NO
Measure SPR.3	All Ages	IP COPD discharges with an ambulatory follow up visit	IP COPD discharges	99	312	31.7%	91	302	30.1%	105	319	32.9%	110	317	34.7%	119	390	30.5%	INCREASE	38.6%	NO

Diabetes Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure CDC.1	18 - 75	Members with diabetes who had an HbA1c test	Members with diabetes	1,806	2,597	69.5%	1,975	2,793	70.7%	1,793	2,566	69.9%	1,768	2,440	72.5%	1,978	2,816	70.2%	INCREASE	72.6%	NO
Measure CDC.2	18 - 75	Members with diabetes who had an LDL-C screening	Members with diabetes	1,770	2,597	68.2%	1,909	2,793	68.3%	1,683	2,566	65.6%	1,636	2,440	67.0%	1,883	2,816	66.9%	INCREASE	71.3%	NO
Measure CDC.3	18 - 75	Members with diabetes who underwent nephropathy screening	Members with diabetes	1,916	2,597	73.8%	1,989	2,793	71.2%	1,788	2,566	69.7%	1,665	2,440	68.2%	1,715	2,816	60.9%	INCREASE	76.4%	NO
Measure CDC.4	18 - 75	Members with diabetes who underwent diabetic retinal screening	Members with diabetes	738	2,597	28.4%	831	2,793	29.8%	725	2,566	28.3%	713	2,440	29.2%	769	2,816	27.3%	INCREASE	35.6%	NO
Measure CDC.5	18 - 75	Members with diabetes who received a flu shot	Members with diabetes	296	2,597	11.4%	314	2,793	11.2%	407	2,566	15.9%	381	2,440	15.6%	177	2,816	6.3%	INCREASE	20.3%	NO
Measure CDC.6	5 - 17	Members with diabetes who had an HbA1c test	Members with diabetes	60	84	71.4%	55	94	58.5%	69	106	65.1%	81	112	72.3%	88	116	75.9%	INCREASE	74.3%	YES

Heart Failure Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure HF.1	18 +	Members with an IP visit for HF and were dispensed beta blockers	Members with an IP visit for HF	26	77	33.8%	34	84	40.5%	17	91	18.7%	28	104	26.9%	25	100	25.0%	INCREASE	40.5%	NO
Measure HF.2	All Ages	Members with HF who had at least one ED visit	Members with HF	668	936	71.4%	725	1,035	70.0%	690	935	73.8%	662	939	70.5%	829	1,117	74.2%	DECREASE	64.2%	NO
Measure HF.3	18 +	Members prescribed ACE inhibitors who received annual monitoring	Members prescribed ACE inhibitors	1,693	1,985	85.3%	1,288	1,482	86.9%	1,084	1,274	85.1%	1,070	1,240	86.3%	625	725	86.2%	INCREASE	86.9%	NO
Measure HF.4	All Ages	IP discharges for HF with an ambulatory follow up visit	IP discharges for HF	85	245	34.7%	98	279	35.1%	107	318	33.6%	121	324	37.3%	126	404	31.2%	INCREASE	41.2%	NO

HIV / AIDS Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure HIV.1	All Ages	Members with HIV/AIDS and two ambulatory visits 60 days apart	Members with HIV/AIDS	166	270	61.5%	164	286	57.3%	122	263	46.4%	99	231	42.9%	120	257	46.7%	INCREASE	65.3%	NO

Hypertension Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure HPTN.1	All Ages	Members with 3 or more hypertension OP visits who received a thiazide diuretic	Members with 3 or more hypertension OP visits	500	2,903	17.2%	430	3,041	14.1%	364	2,806	13.0%	278	2,540	10.9%	242	2,855	8.5%	INCREASE	25.5%	NO

Mental Health and Substance Abuse Measures				Baseline (PY14)			Program Year 1 (PY15)			Program Year 2 (PY16)			Program Year 3 (PY17)			Program Year 4 (PY18)			Target for Program Year 4 (PY18)		Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Increase or Decrease?	Percent	
Measure MH.1	All Ages	Bipolar members who were prescribed mood stabilizers	Bipolar members	107	536	20.0%	97	559	17.4%	99	637	15.5%	73	616	11.9%	52	675	7.7%	INCREASE	28.0%	NO
Measure MH.2	All Ages	Members with a new episode of major depression with anti-depression meds	Members with a new episode of major depression	100	195	51.3%	114	234	48.7%	99	184	53.8%	70	157	44.6%	79	172	45.9%	INCREASE	56.2%	NO
Measure MH.3.1	6 +	Schizophrenic members with at least 5 months of anti-psychotic medication	Schizophrenic members	380	968	39.3%	382	1,029	37.1%	333	992	33.6%	263	1,041	25.3%	219	1,298	16.9%	INCREASE	45.3%	NO
Measure MH.3.2	6 +	Schizophrenic members with at least 11 months of anti-psychotic medication	Schizophrenic members	69	968	7.1%	69	1,029	6.7%	72	992	7.3%	48	1,041	4.6%	32	1,298	2.5%	INCREASE	16.4%	NO
Measure MH.4.1	6 +	MH IP discharges who went to a MH practitioner within 30 days	MH IP discharges	383	847	45.2%	381	986	38.6%	491	1,360	36.1%	430	1,260	34.1%	711	1,543	46.1%	INCREASE	50.7%	NO
Measure MH.4.2	6 +	MH IP discharges who went to a MH practitioner within 7 days	MH IP discharges	254	847	30.0%	234	986	23.7%	286	1,360	21.0%	250	1,260	19.8%	481	1,543	31.2%	INCREASE	37.0%	NO
Measure SA.1.1	13+	Members with a new episode of AOD who initiated AOD treatment	Members with a new episode of AOD	331	1,731	19.1%	341	1,834	18.6%	392	1,653	23.7%	385	1,671	23.0%	454	1,783	25.5%	INCREASE	27.2%	NO
Measure SA.1.2	13+	Members with a new episode of AOD who engaged in AOD treatment	Members with a new episode of AOD	131	1,731	7.6%	128	1,834	7.0%	178	1,653	10.8%	169	1,671	10.1%	219	1,783	12.3%	INCREASE	16.8%	NO

Exhibit 3
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
Quality Score Bonus Calculations
Program Year 4 - Measurement Period Ending May 31, 2018

Step 1: Calculate Reduction in Cost (from page 4 of contract):

Reweighted Base Year Recon (PY14) Population PMPM	$1,342.98	(a) - From Exh 1
Trend this PMPM forward to the appropriate period using the Trend Population's trend		
Trend Factor from Trend Population. This is the risk-adjusted Program Year 4 (PY18) PMPM / risk-adjusted Base Year (PY14) PMPM	1.023	(b)
Trended Baseline PMPM	$1,373.69	(c) = (a) * (b)
Reconciliation Population Program Year 4 (PY18) PMPM costs	$1,246.40	(d) - From Exh 1
Risk Score Trend for Reconciliation Population	0.955	(e)
Trended Program Year 4 (PY18) PMPM	$1,305.48	(f) = (d) / (e)
Program Year 4 (PY18) PMPM Gross Cost Reduction. A positive amount here implies savings	$68.21	(g) = (c) - (f)
Calculate Total Gross Cost Reduction		
Program Year 4 (PY18) Member Months in Target Population	371,825	(h)
Total Gross Cost Reduction	$25,362,028	(i) = (g) * (h)
Calculate Program Period Care Management Fees		
Program Year 4 (PY18) Member Months for Program Eligible Population	474,009	(j)
Program Year 4 (PY18) Program Care Management Fees PMPM, from page 12 of contract	$15.35	(k)
Total Program Year 4 (PY18) Program Care Management Fees	$7,276,038	(l) = (j) * (k)
Total Reduction in Cost. A positive amount here implies savings	**$18,085,990**	(m) = (i) - (l)

Step 2: Overall Quality Score Calculations (from page 10 of contract):

Category	Condition Specific Quality Score	Program Year 4 (PY18) Member Months
Asthma Measures	0%	55,612
Coronary Artery Disease Measures	0%	15,306
Chronic Obstructive Pulmonary Disease Measures	0%	30,923
Diabetes Measures	17%	51,486
Heart Failure Measures	0%	13,897
HIV / AIDS Measures	0%	5,221
Hypertension Measures	0%	42,055
Mental Health and Substance Abuse Measures	0%	269,591
Overall Quality Score	**1.8%**	

Step 3: Final Bonus Calculation

Bonus = Reduction in Costs x [50% - (100% - Overall Quality Score)]	**$ -**	Both Components must be positive

Exhibit 4
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
Trend and Recon Population PMPM Buildup for PY14 and PY18

	PY14[(1)] Recon Population Basis			PY18[(1)] Recon Population Basis		
ABD Clark	46%	116,360	$371.75	46%	169,752	$407.38
ABD Washoe	8%	21,545	$255.67	8%	28,431	$284.01
ABD Other	10%	28,493	$310.82	10%	37,606	$324.85
TANF Clark	10%	39,459	$619.37	10%	36,581	$510.76
TANF Washoe	3%	9,207	$457.69	3%	10,986	$388.55
TANF Other	24%	53,279	$424.27	24%	88,469	$347.82
Total	100%	268,343	**$396.11**	100%	371,825	**$385.05**

	PY14[(1)] Trend Population Basis			PY18[(1)] Trend Population Basis		
	Weight	MM	PMPM[(2)]	Weight	MM	PMPM[(2)]
ABD Clark	18%	71,916	$238.42	18%	65,462	$282.68
ABD Washoe	3%	11,389	$191.08	3%	9,196	$195.26
ABD Other	4%	15,371	$221.69	4%	12,623	$197.26
TANF Clark	10%	80,473	$284.40	10%	34,175	$193.90
TANF Washoe	4%	25,738	$336.78	4%	13,903	$335.01
TANF Other	62%	199,760	$204.27	62%	219,682	$214.77
Total	100%	404,647	**$223.74**	100%	355,041	**$228.86**

(1) PY14 and PY18 represent the Baseline (Jun 1, 2013 - May 31, 2014) and Program Year 4 (Jun 1, 2017 - May 31, 2018) respectively.
(2) Risk adjusted PMPMs