Nevada Medicaid Managed Care:
Calendar Year 2018 Capitation Rate Development

State of Nevada, Division of Health Care Financing and Policy

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M1. EXECUTIVE SUMMARY

INTRODUCTION

Milliman, Inc. (Milliman) has been retained by the State of Nevada, Division of Health Care Financing and Policy (DHCFP) to provide actuarial and consulting services related to the development of actuarially sound medical capitation rates for the Nevada TANF, Check-up and Expansion populations. This report provides the supporting documentation for capitation rates which will be paid to managed care organizations (MCOs) during the calendar year (CY) 2018 contract period.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2017-2018 Medicaid Managed Care Rate Development Guide (CMS Guide), published April 2017:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
- The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS Guide Index [Section I.1.C]

Throughout this report, sub-headings (like the one above) are utilized to identify the page number for items described within the CMS Guide in order to index each section within the table of contents.

CAPITATION RATES

Table 1 illustrates composite capitation rates effective January 1, 2018 through December 31, 2018 by population category. Composite values have been calculated utilizing our projected CY 2018 membership distribution. The values include estimated amounts for SOBRA and LBW case rate payments converted to per member per month (PMPM) spending. The values do not contain provision for any medical cost incurred during a stay of greater than 15 days within a month at institutions for mental disease (IMDs). MCOs will be compensated for these claims through a separate state-funded capitation rate.

Table 1
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed CY 2018 Capitation Rates (Incl Maternity)

Population	July 2017 Rate	Jan 2018 Rate	Rate Change
TANF/CHAP	$ 199.72	$ 212.79	6.5%
Check-up	113.81	115.02	1.1%
Expansion	438.08	490.88	12.1%
Composite	**$ 286.27**	**$ 313.88**	**9.6%**

SUMMARY OF CHANGES

We have implemented several changes in methodology for rate development effective during the CY 2018 contract period. These include:

1. Elimination of MMIS factor: prior to July 1, 2017, the state's administrative system required that the ratios of plan-specific rates for each rate cell be constant. As such, a budget neutral re-balancing factor was applied to develop final payment rates. This is no longer a system requirement.
2. Pro-rated capitation payments for members with partial month MCO enrollment: as eligible members are now directly enrolled with MCOs upon becoming Medicaid eligible, DHCFP has implemented pro-rated payments to reflect partial month experience for the MCOs.
3. Delivery case rate calculation methodology: we have updated the methodology used to project medical cost related to maternity deliveries.
4. Credibility thresholds and manual rate: we have updated the methodology used to adjust partially credible rate cells.
5. Elimination of duration and cohort adjustment: we refreshed duration and cohort analyses for the ACA Expansion population and did not apply an explicit adjustment for these factors this year.
6. Medical cost paid outside claims system to recognize value-based purchasing: The state is encouraging value-based payment initiatives and appropriate provider incentive arrangements, however such arrangements do not have encounter data. We included additional adjustments to our medical cost projection to reflect such payments.
7. Administrative cost load updated with MCO bids: DHCFP conducted a procurement process to engage in new contracts with MCOs effective July 1, 2017. As part of the procurement, each MCO submitted a cost proposal for administrative load, and this served as our rating assumption for administrative cost.
8. Safety net calculation following new CMS regulations: we calculated the prescribed base amount for the remaining eligible safety net provider per the Medicaid managed care final rule.
9. Implementation of a formal pharmacy risk mitigation mechanism: DHCFP is pursuing a risk corridor option for high cost specialty pharmacy treatments to mitigate risk for both the MCOs and the state. The development of specifications for this arrangement are still in discussion, but a report will be provided when specifications have been finalized.
10. Risk adjustment will be retrospective instead of prospective for this rating period: with the entry of a new MCO to the market, we will shift to a concurrent risk adjustment model rather than prospective until enrollment stabilizes among all MCOs.

Several policy, program, or fee changes have been or will be implemented between the base data period and the end of the contract period. We have reflected the following changes for the capitation rate presented herein:

1. Elimination of fee-for-service waiting period for new Medicaid enrollees ("direct enrollment"), as they now enroll directly with MCOs
2. Expansion of ABA service: DHCFP implemented a policy to encourage the utilization of ABA services for members with an autism spectrum disorder diagnosis.
3. Removal of dental services. Note that because this occurred July 1, 2017, we have not quantified a rate change related to this.
4. Fee schedule changes related to several CMS-approved State Plan Amendments.
5. Reduction in safety net provider payments conforming to the Medicaid managed care final rule, as all but one safety net provider has lost eligibility for such payments effective July 1, 2017.
6. Hepatitis C prior authorization policy was updated to expand coverage to additional fibrosis levels.

Tables 2a and 2b illustrate the rating impact of key assumption differences between July through December 2017 capitation rates and CY 2018 proposed capitation rates. Note that these tables do not contain maternity case rates.

Table 2a
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Capitation Rate Change Impact, Excl Maternity (PMPM)

Rate Driver	Children	TANF Adults	Expansion
Base Data Refresh	$ (2.70)	$ 9.90	$ 19.38
Medical Trend	4.59	12.29	19.67
Direct Enrollment	4.87	-	11.77
Remove Duration	-	-	10.07
ABA	(0.42)	-	-
Safety Net	1.43	3.06	2.60
Fee Schedule	(0.11)	(0.94)	(2.08)
Hepatitis C	0.14	-	(8.72)
CY 2018 Capitation	***$ 7.80***	***$ 24.33***	***$ 52.69***
State-funded IMD Add-on	***$ 0.00***	***$ (0.33)***	***$ (1.55)***

Table 2b
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Capitation Rate Change Impact, Excl Maternity (%)

Rate Driver	Children	TANF Adults	Expansion
Base Data Refresh	(1.9%)	3.3%	4.4%
Medical Trend	3.3%	4.0%	4.5%
Direct Enrollment	3.5%	0.0%	2.7%
Durational Impact	0.0%	0.0%	2.3%
ABA	(0.3%)	0.0%	0.0%
Safety Net	1.0%	1.0%	0.6%
Fee Schedule	(0.1%)	(0.3%)	(0.5%)
Hepatitis C	0.1%	0.0%	(2.0%)
CY 2018 Capitation	***5.6%***	***8.0%***	***12.1%***

FISCAL IMPACT

Table 3 illustrates both the estimated State and Federal expenditures and the estimated State-only expenditures by population category for the twelve-month contract period from January to December 2018. We have projected 2018 expenditures using our CY 2018 enrollment projections. State expenditures were estimated using the following FMAP rates: 94.00% Expansion, 99.03% Check-up, 65.75% TANF.

Table 3
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
CY 2018 Fiscal Impact ($ Millions)

Budget Line	Check-up	TANF Children	TANF Adults	Expansion
State and Federal Expenditures				
July 2017 Rates	$ 32.9	$ 426.4	$ 278.9	$ 1,025.9
Proposed CY 2018 Rates	$ 33.3	$ 451.8	$ 299.7	$ 1,149.5
Expenditure Change	1.1%	6.0%	7.4%	12.1%
State-only Expenditures				
July 2017 Rates	$ 0.3	$ 146.0	$ 95.5	$ 61.6
Proposed CY 2018 Rates	$ 0.3	$ 154.7	$ 102.6	$ 69.0
Expenditure Change	1.1%	6.0%	7.4%	12.1%
State-funded IMD Member Exp.	$ 0.0	$ 0.0	$ 0.7	$ 6.5
Total State-only Expenditures	**$ 0.3**	**$ 154.7**	**$ 103.3**	**$ 75.5**

APPENDICES

Appendix A includes exhibits that illustrate the final CY 2018 capitation rates.

- Exhibit A-1 illustrates capitation rates eligible for federal financial participation (i.e., rates excluding costs incurred during IMD stays longer than 15 days in a month). This includes monthly capitated rates as well as case rate payments for SOBRA and VLBW cases.
- Exhibit A-2 illustrates the state-funded IMD “add-on” PMPM rates, which cover the cost of IMD services and any other medical services incurred during an IMD stay that exceeds 15 days within a month.
- Exhibit A-3 illustrates plan-specific capitation rates for rates eligible for federal financial participation. The medical component of these rates is consistent with those presented in Exhibit A-1, however premium tax and administrative load vary by MCO, as contracted. DHCFP currently contracts with three MCOs on a full-risk basis to provide covered Medicaid health care services: Amerigroup, Health Plan of Nevada (HPN), and SilverSummit Health (SilverSummit).
- Exhibit A-4 illustrates plan-specific capitation rates that are paid monthly to the MCOs. These rates are the sum of the rates displayed in Exhibits A-2 and A-3.

Appendix B includes summarized base data, adjustment factors, and projected experience by region and rate cell.

- Exhibit B-1 includes the base data PMPMs for CY 2015 and CY 2016, as well as applicable adjustment factors and projected CY 2018 medical cost by region and rate cell for monthly capitation payments.
- Exhibit B-2 includes the base data cost per delivery experience for CY 2015 and 2016, as well as applicable adjustment factors and projected CY 2018 medical cost for the SOBRA delivery case rate payment.

Appendix C illustrates the capitation rate development using default assumptions of 10.5% administration load and a 3.5% premium tax. Note that the actual assumptions vary by MCO.

Appendix D illustrates the credibility weighting methodology applied to the rates.

Appendix E illustrates the impact of individual rate components on the rate change, as described throughout this report. The default rate of comparison includes 10.5% administrative load and 3.5% premium tax.

Appendix F includes information supporting the development of the Safety Net Enhancement payments.

- Exhibit F-1 illustrates key components of the Safety Net Enhancement payment calculation.
- Exhibit F-2 illustrates a comparison of the Safety Net Enhancement PMPMs included in the 2018 rates to the amount included in past capitation rates.

Appendix G compares the proposed CY 2018 Expansion rates to the prior Expansion rates.

M2. TOPICS OUTSIDE CMS GUIDANCE

MEMBERSHIP PROJECTIONS

We have developed estimates for projected membership by MCO, region, population category, and rate cell for the CY 2018 contract period. Note that because the rate development process separates costs by rate cell, membership projections have no impact on the PMPM rate development. Their use is in the calculation of composite rates and estimated expenditure projections. Because projected expenditures depend on our membership estimates, we have included this section to document the data, assumptions, and methodology utilized to develop membership projections.

Effective July 1, 2017 and terminating August 31, 2017, Aetna Better Health (Aetna) was a contracted MCO in Nevada. While Aetna remained in the market, the new MCOs received 50% of the new enrollment where the enrollee or their family had not been previously or was not currently enrolled in another plan and where the enrollee had not made an explicit choice. Following Aetna's exit from the market, SilverSummit will receive 100% of the subset of new enrollees described.

Member Months

Member months for CY 2018 were projected with the following steps:

1. Historical monthly membership experience was summarized by MCO and population for the period July 2012 through May 2017.
2. Historical growth patterns and trends were calculated and reviewed.
3. Based on our review of historical growth and DHCFP expectations, we assumed monthly membership growth of 0.25% for TANF and Check-up and 0.50% for Expansion.
4. We assumed the following percentages of membership were new enrollees:
    - 1.8% for TANF children
    - 2.5% for TANF adults
    - 1.0% for Check-up
    - 0.35% for HPN Expansion adults
    - 2.5% for Amerigroup Expansion adults
5. We assumed the following monthly disenrollment percentages by duration:
    - 2% within months 1-3, 4-6 and 7-9
    - 10% within months 10-12
    - 2% thereafter
6. We assumed that when Aetna exits the market, their members would enroll equally among the three remaining MCOs.
7. Following Aetna's exit from the market, we assumed that the legacy MCOs would receive 40% of the new enrollment each and SilverSummit would receive 20% of the new enrollment. This is because family connection and historical enrollment rules would favor the legacy MCOs.

Rates are projected on a PMPM basis at the individual rate cell level, but projected 2018 expenditures are calculated using these projected member months. Table 4 illustrates member month counts by population category for CY 2016, March 2017 (March members * 12), and the results of our CY 2018 projection.

Table 4
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Member Month Projections

Population	CY 2016	Annualized March 2017	Projected 2018
TANF/CHAP	3,167,382	3,278,748	3,531,471
Check Up	250,186	269,964	289,113
Expansion	2,007,796	2,117,964	2,341,773
Composite	**5,425,365**	**5,666,676**	**6,162,357**

Deliveries and Low Birth Weight Cases

In order to include the delivery case rate (DCR) and the low birth weight (LBW) kick payment in expenditure projections, we projected the number of births and low birth weight babies in CY 2018.

Birth rates by rate cell were analyzed by population group from 2015 through 2016. As a percentage of women aged 15-34, the assumed birth rates are:

- 0.05% for Check-up
- 2.11% for TANF
- 0.16% for Expansion

Though deliveries are observed outside of the 15-34 age band, the majority of deliveries will are within these rate cells. Historical LBW incidence rates per 1,000 member months in the "<1 year old" rate cell were:

- 0.82 in CY 2014
- 0.73 in CY 2015
- 0.66 in CY 2016.

Because of the structure of the LBW case rate payment, we believe it is most effective as a risk mitigation technique when it is initially funded assuming an incidence rate that is slightly higher than expected. As a result, we chose to use the funding level of 0.85 births per 1,000, the same level as the CY 2017 rates. To project LBW cases in 2018, this incidence rate is multiplied by the projected newborn member months and divided by 1,000.

M3. MEDICAID MANAGED CARE RATES [SECTION I]

GENERAL INFORMATION [SECTION I.1]

Rate Development Standards [Section I.1.A]

Rating Period [Section I.1.A.i]:

This rate certification is for a 12-month rating period effective during CY 2018.

Items included in an acceptable rate certification [Section I.1.A.ii]:

a. A letter from the certifying actuary:

Section M7 contains the signed rate certification.

b. The final and certified capitation rates:

Appendix A includes exhibits that illustrate the final CY 2018 capitation rates.

- Exhibit A-1 illustrates capitation rates eligible for federal financial participation (i.e., rates excluding costs incurred during IMD stays longer than 15 days in a month. This includes monthly capitated rates as well as case rate payments for SOBRA and VLBW cases.
- Exhibit A-2 illustrates the state-funded IMD "add-on" PMPM rates, which cover the cost of IMD services and any other medical services incurred during an IMD stay that exceeds 15 days within a month.
- Exhibit A-3 illustrates plan-specific capitation rates for rates eligible for federal financial participation. The medical component of these rates is consistent with those presented in Exhibit A-1, however premium tax and administrative load vary by MCO, as contracted. DHCFP currently contracts with three MCOs on a full-risk basis to provide covered Medicaid health care services: Amerigroup, Health Plan of Nevada (HPN), and SilverSummit Health (SilverSummit).
- Exhibit A-4 illustrates plan-specific capitation rates that are paid monthly to the MCOs. These rates are the sum of the rates displayed in Exhibits A-2 and A-3.

c. If rate ranges are certified, assurances that rates at any point within the rate range would be actuarially sound and that the capitation rate for each rate cell is within the certified rate range:

Not applicable.

d. Descriptions of the program:

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) *The types and numbers of managed care plans included in the rate development*:

DHCFP contracts with three national for-profit MCOs: Amerigroup, Health Plan of Nevada (owned by UnitedHealth Group), and SilverSummit (owned by Centene Corporation). For a two-month period in 2017, Aetna Better Health was a contracted MCO as well, but they exited the market effective August 31, 2017.

Amerigroup and HPN have a long-standing relationship with DHCFP, having provided health care services for Nevada managed care enrollees for several years.

During 2016 and 2017, DHCFP went through a re-procurement process to select MCOs to participate in the program effective July 1, 2017. The two legacy plans were selected along with two new plans, however one MCO exited the market within two months of entering the contract.

(B) *A general description or list of the benefits that are required to be provided by the managed care plan or plans:*

The MCO contracts cover most medical and pharmacy services under the Nevada State Plan, including acute, primary, specialty, and behavioral health care services.

Prior to July 1, 2017, dental services were also covered under the managed care contracts. Effective July 1, 2017, dental benefits were moved to fee-for-service delivery for managed care enrollees, and effective January 1, 2018 managed care enrollees will have coverage under a separate dental benefits administrator.

(C) *The areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.*

The managed care contracts cover Clark county (Southern region, includes Las Vegas) and Washoe county (Northern region, includes Reno).

Risk-based managed care has been mandatory in Nevada since 1998 for children (including CHIP) and low-income adults, and it was expanded to include the ACA Expansion adult population in 2014.

(ii) Rating period:

The rating period covered by this rate certification is CY 2018.

(iii) Covered populations:

The populations covered under the managed care program documented herein include:

- **TANF/CHAP**: includes Nevada's legacy low-income children and caretaker adults who were eligible for Medicaid prior to the ACA expansion effective January 1, 2014. The Child Health Assurance Program (CHAP) covers children and pregnant women, while Temporary Assistance for Needy Families (TANF) covers caretaker adults at lower income levels. Household income qualifying levels, as a percentage of the federal poverty level (FPL) are:
  - Up to 165% FPL for children under age 6 and pregnant women.
  - Up to 138% FPL for children between ages 6 and 18.
  - Up to 84% FPL for adults.
- **Check-up**: includes children under Nevada's CHIP expansion, covering children in households with income levels between the Medicaid qualifying threshold (138% or 165%, depending on age) and 205% FPL.
- **Expansion**: includes adults with household income up to 138% FPL, excluding those members who would have been eligible for Medicaid prior to January 1, 2014.

(iv) Eligibility and enrollment criteria:

Enrollment in managed care plans is mandatory for the majority of TANF, Check-up and Expansion beneficiaries in Washoe and Clark counties. There are groups for whom managed care is optional, such as American Indian/Alaskan Native beneficiaries. Eligibility criteria are not changing between the base and the rating period.

Children who have been determined as seriously emotionally disturbed (SED) or are severely mentally ill (SMI) are disenrolled from managed care upon determination by authorized entities.

(v) Special contract provisions:

For a discussion of pass-through payments, see section I.4.E. For a discussion of payments to MCOs for Institutions for Mental Disease (IMDs), see section I.3.

Differences between covered populations [Section I.1.A.iii]:

Any observed differences among covered populations are based on valid assumption differences driven primarily by historical experience data.

Cross-subsidization [Section I.1.A.iv]:

Capitation rates were developed such that payments from any rate cell do not cross-subsidize payments from any other rate cell.

Consistency of effective dates [Section I.1.A.v]:

The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) are consistent with the assumptions used to develop the capitation rates. These changes have been summarized in Section M1. Executive Summary, with detail included within the assumption documentation sections.

Considerations for CMS [Section I.1.A.vi]: *As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:*

a. all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.

All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuary.

b. adjustments to the rates or rate ranges that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.

We have not made additional adjustments outside the rate setting process documented herein.

c. consistent with 42 CFR §438.7(c), the final contracted rates in each cell must either match the capitation rates or be within the rate ranges in the rate certification. This is required in total and for each and every rate cell.

It is our understanding that the final contracted rates paid to the MCOs for each rate cell will be consistent with the capitation rates included in Appendix A. However, we have proposed a concurrent risk adjustment method given the entrance of a new MCO to the managed care market. The risk adjustment is intended to be budget neutral to the state and CMS and by its nature must be settled after the completion of the contract period.

Certification period [Section I.1.A.vii]:

Rates are effective and certified for CY 2018.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.viii]:

Not applicable.

Appropriate Documentation [Section I.1.B]

Documentation detail required [Section I.1.B.i]: *States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:*

a. Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.

Base Experience Period Data

Table 5 identifies the types and sources of data and information utilized in developing the CY 2018 capitation rates.

Table 5
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Base Data Sources

Experience type	Data Source	Experience Dates	Date Received
Detailed monthly eligibility	DHCFP	CY 2015-2016	5/9/2017
Fee-for-service claims	DHCFP	CY 2015-2016, Medical claims paid through March 2017, Rx claims paid through May 2017	5/15/2017
MCO-submitted encounters	Amerigroup	CY 2015-2016, paid through April 2017	5/10/2017
MCO-submitted encounters	HPN	CY 2015-2016, paid through March 2017	5/26/2017
MCO financial statements	Amerigroup	CY 2014-2016	5/19/2017
MCO financial statements	HPN	CY 2014-2016	5/19/2017
Rate cell level sub-capitated payments	Amerigroup	CY 2015-2016	7/26/2017
Population, age, and area-level sub-capitated payments	HPN	CY 2015-2016	7/20/2017
Provider incentive payments	Amerigroup	CY 2016	5/19/2017
Historical SOBRA and LBW payments	DHCFP	CY 2015-2016	7/13/2017

MCO Experience

SilverSummit's contract began July 1, 2017, so applicable data was not existent within our base data experience period.

We worked to reconcile the claims loaded into our system to claim summaries reported in financial documents presented by the MCOs to DHCFP. In this process, we confirmed that the difference between the two sources was small enough that it could be reasonably expected to be due to accounting differences, such as in incomplete data estimates (i.e., <1%).

Table 6 illustrates the calendar year credibility weights we selected for each population category. We developed actuarial models on a calendar year basis, with adjustments calculated independently for each year. Then we projected the experience forward to CY 2018 and blended each year's projection with these weights to develop the medical component of the capitation rates. These weights apply to both the monthly capitation rate development and the development of the SOBRA delivery case rate.

Table 6
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Calendar Year Weights for Base Period

Population	CY 2015	CY 2016
TANF/CHAP	45%	55%
Check-up	45%	55%
Expansion	0%	100%

For TANF/CHAP and Check-up populations, we selected a 55% weight for CY 2016. This assumption places somewhat more reliability on the more recent time period while still being informed by the 24-month period. In aggregate, the member month distribution includes approximately 55% of member months in CY 2016, but selecting the single set of calendar year weights allows for consistency across rate cells where this value may fluctuate as a result of small populations. Smaller rate cells gain credibility by utilizing the two-year experience period.

For the Expansion population, we selected CY 2016 as the base experience period because of the significant market fluctuations occurring over CY 2014 and 2015 as new members gained coverage and became familiar with their benefits. Each of the Expansion rate cells were determined to be credible (or mostly credible) using only CY 2016 experience, and explicit adjustments were less likely to be necessary in this more recent time period, as enrollment for this population stabilized. [Additional information is included in Section III.]

Both MCOs operating during CY 2015 and 2016 engaged in sub-capitated arrangements for various services and with provider groups. We evaluated encounters supporting sub-capitated arrangements for each MCO to determine whether they appeared to be reported sufficiently to project future medical cost.

- Amerigroup reported reasonable and complete encounters for their sub-capitated arrangements in CY 2015, however we were not comfortable using the encounters for CY 2016. CY 2016 reflects sub-capitation payments made to providers, assuming the payments are entirely attributable to medical cost.
- HPN was not able to provide encounter data supporting their sub-capitated arrangements which would be sufficient for use in rate development. As such, we have included sub-capitation payments made to providers, assuming global capitation arrangements shift some level of administrative cost to contracted provider groups, but that payments for all other arrangements are entirely attributable to medical cost.
    - Note that HPN was unable to provide a level of administrative cost embedded within their global capitation arrangements, so we applied a default 10.5% reduction to payments estimating 89.5% of the payments are attributable to medical cost.

Table 7 illustrates aggregate sub-capitation payment PMPMs included in the rate development by service type. Note that the "Other" row included in our actuarial models reflects services provided by specialists, including neonatal/perinatal medicine and urologists, among others. We have only included payment information in the table that was used in the rate development.

Table 7
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Capitation PMPMs by Category of Service

Category of Service	Sub-cap PMPM
Office/Home Visits	$ 4.42
Radiology/Pathology/Lab	1.67
DME/Prosthetics/Orthotics	2.04
Vision	0.21
MH/SUD	1.92
Specialist Services	6.85

Amerigroup provided documentation supporting expenses related to their provider quality incentive program (PQIP). This program rewards providers for achieving cost savings and quality score improvements. Benchmarks for achievement are based on medical loss ratio and HEDIS-like quality measures. We received payments associated with PQIP by incurred month during CY 2015-2016. Upon our review of the information and expenditure levels, and in conjunction with CMS's efforts to incorporate value-based payment initiatives in Medicaid, we included the cost as medical cost because these payments are associated with the provision of medical services.

Provider incentive payments contributed $0.26 PMPM and $0.46 PMPM to Amerigroup's total projected costs in 2015 and 2016 respectively. Dollars were added on a PMPM basis to each rate cell and did not receive any additional adjustments for trend, completion, etc.

Fee-for-service Experience

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 March 2017 for all eligible beneficiaries. We utilized fee-for-service waiting period experience data during CY 2015 and 2016 to estimate the experience of this expansion in managed care coverage.

DHCFP provided a list of services which are not covered under the managed care contracts. We excluded claims for these benefits from our base data as they will remain covered under fee-for-service. The following services were identified within our claims data set and removed prior to populating base data in the cost models.

- Targeted case management (procedure code T1017)
- School-based services (provider type 60)
- Residential treatment centers (provider type 63)

The following services were identified but had no material impact:

- Adult group care waiver (provider type 57)
- Hospice, long term care (provider type 65)
- Indian health services (provider type 78)
- Physically disabled waiver (provider type 58)
- Intermediate care facility for individuals with intellectual disabilities (provider type 68)

We used the waiting period experience to develop PMPM medical cost by region and rate cell consistent with the MCO base data projections. We applied completion factors, trends, fee schedule adjustments, and other experience adjustments consistent with those documented as applying to managed care experience. The CY 2018 projected medical cost included in the capitation rates is a blend of the managed care and fee-for-service PMPM projections, blended using member months from each cohort.

Table 8 illustrates projected CY 2018 medical cost for managed care experience separate from fee-for-service waiting period experience by population category. Note that the rate cells with the largest experience differentials are TANF/CHAP infants and Expansion adults. The fee-for-service waiting period experience was used as a proxy for the impact of direct enrollment to future managed care experience.

Table 8
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
CY 2018 Projected PMPM Medical Cost Comparison

Population/Rate Cell	Managed Care	FFS Waiting Period
TANF/CHAP Infants (<1)	$ 546.56	$ 1,799.74
TANF/CHAP Children (1-18)	87.05	108.85
TANF/CHAP Adults (19+)	267.01	257.40
Check-up Children (<19)	92.21	120.57
Expansion 19-34 Females	229.30	371.71
Expansion 19-34 Males	256.21	548.51
Expansion 35-64 Females	503.65	699.70
Expansion 35-64 Males	545.46	1,154.97

Longer-Term Analysis Data

We utilized additional historical experience from the managed care plans, submitted and verified during previous rate development processes, in order to develop historical trend and completion estimates for the base data used in CY 2018 rate development.

In addition to historical medical trend experience, we reviewed and considered national health expenditures[1] (NHE) data and CMS OACT projections[2] to help inform our trend rate selection.

In our selection of pharmacy trends and adjustments for brands going generic and high-cost specialty drugs, we utilized several sources in addition to historical experience:

- Internal Milliman research
- National average drug acquisition cost (NADAC) files [3]
- Publicly available industry reports [4]

b. Assumptions made:

Details supporting all assumptions are provided throughout this document. The following assumptions have been addressed during rate development:

- Medical and pharmacy trend
- Supplemental pharmacy rebates
- Pent-up demand and anti-selection for the Expansion population
- Adjustment for claims completion
- Adjustments for fee schedule and policy changes
- Credibility
- In lieu of services
- IMD exclusion requirements
- Safety net provider payments

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf
[3] https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html
[4] http://lab.express-scripts.com/lab/drug-trend-report; https://www1.magellanrx.com/magellan-rx/publications/medicaid-trend-report.aspx; https://www.primetherapeutics.com/content/dam/corporate/Documents/Newsroom/PrimeInsights/2017/document-medicaid-trend-report-040507.pdf

- Non-benefit expenses

c. Methods for analyzing data and developing assumptions and adjustments:

Methodology applied in developing assumptions and adjustments are described throughout this document where assumptions are identified.

Rate certification index [Section I.1.B.ii]

The table of contents of this document serves as the rate certification index.

Differences in FMAP [Section I.1.B.iii]

Costs for TANF/CHAP, Check-up, and Expansion populations are all subject to different federal medical assistance percentage (FMAP) rates. Capitation rates and assumptions are stratified throughout this document for reference. Table 9 summarizes expenditures by population as well as effective FMAP rates for FFY 2018.

Table 9
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
CY 2018 Expenditures by Population ($ Millions)

Budget Line	Check-up	TANF	Expansion
State and Federal Expenditures			
Proposed CY 2018 PMPM Rates	$ 115.02	$ 212.79	$ 490.88
Proposed CY 2018 Expenditures	$ 33.3	$ 751.5	$ 1,149.5
Federal-Only Expenditures			
Proposed CY 2018 PMPM Rates	$ 113.91	$ 139.91	$ 461.43
Proposed CY 2018 Expenditures	$ 32.9	$ 494.1	$ 1,080.6
FFY 2018 FMAP	99.03%	65.75%	94.00%

The only services covered under managed care which are eligible for enhanced federal funding are family planning services, which receive a 90% FMAP. We will prepare a separate report which identifies these services, but historically they have made up approximately 0.7% of the capitation rates for the TANF population.

Rate range documentation requirements [Section I.1.B.iv]

Not applicable

Rate range development [Section I.1.B.v]

Not applicable

DATA [SECTION I.2]

Rate Development Standards [Section I.2.A]

Base data standards [Section I.2.A.i]:

a. Validated data and audited financial reports

The state and MCOs provided validated data for use in rate development. Section I.2.B discusses the provided data in detail.

b. Appropriate base data period

We reviewed historical data from January 2014 through December 2016 and selected a base period of CY 2015 and 2016 for TANF and Check-up populations, and CY 2016 for the Expansion population. We believe selection of these time periods represents a credible base for projections, and it limits the development and application of adjustments that would be necessary if utilizing the entire three-year period.

c. Appropriate base data population

The base data was derived from the Medicaid population which will be enrolled in managed care during the contract period.

d. Alternative data sources

Not applicable.

Appropriate Documentation [Section I.2.B]

Description of data requested [Section I.2.B.i]: *In accordance with 42 CFR §438.7(b)(1), the rate certification must include:*

e. A description of base data requested by the actuary for the rate setting process, including:

(i) A summary of the base data that was requested by the actuary.

Data requests were sent to the DHCFP, HPN, and Amerigroup.

Specifically, we requested the following information from DHCFP:

- Historical case rate payment counts for SOBRA and LBW case rates, incurred between January 2016 and the most recent available
- All approved program changes inforce between January 2015 and December 2017, including:
  - Changes to safety net providers
  - Legislative changes approved during the June 2017 session
- A list of value-added benefits for provided by each MCO
- A list of known "in lieu of" services provided under managed care
- Administrative and premium tax assumptions loads for each MCO
- A copy of the state's eligibility summary report
- Monthly eligibility data
- Fee-for-service (FFS) claims incurred during CY 2015 and 2016, paid through at least March 31, 2017
- Details regarding the cost sharing and treatment limitations for all services

All items were received from DHCFP.

We requested the following information from each of the MCOs, specific to the January 2015 through December 2016 timeframe, paid through at least March 2017, unless otherwise noted:

- Detailed sub-capitation payments
- Encounter data associated with sub-capitation payments
- Out-of-system payments
- Control totals for reconciliation:
  - Claim lag triangles
  - MCO-estimates for incurred but not reported claims
  - Sub-capitation payment control totals
  - Member month control totals
- A reconciliation of control totals to the company financial statements
- An attestation of accuracy by a company officer
- Plan-financials specific to Nevada Medicaid
- Pharmacy rebates by quarter, split by population if feasible
- A summary of all PCP enhancement payments that were not included as part of original claim payments to providers
- Historical administrative costs, split by detailed category and population
- Estimate of medical management costs for members who generate a case payment
- Provider taxonomy codes, either by claim or provider ID for all providers active during the base period
- Approximate percentage of provider contracts directly or indirectly related to the Medicaid FFS fee schedule, and the percentage of FFS paid on average by major category of service
- A list of value-added services
- Expectations for LBW births as a percentage of newborn member months in 2017 and beyond
- The administrative cost built into all sub-capitation amounts

All items were provided to the best of each plan's ability. We requested the following information from the MCO's subsequent to the initial data request:

- Claims logic for identifying members receiving a case payment. This information was received from HPN but not Amerigroup.
- Analysis supporting each MCO's compliance with Mental Health Parity. Through discussions with DHCFP, it is our understanding that the MCO benefit plans were compliant with MHP during the historical base data period. We did not receive this analysis from any MCO.
- An attestation that any sub-capitation agreements with related parties are set at rates comparable to agreements with non-related parties. This was requested of HPN only and it was provided. Amerigroup did not identify any sub-capitation arrangements with related parties.

(ii) A summary of the base data that was provided by the state.

DHCFP has ongoing initiatives to improve its encounter data warehouse, however we were unable to receive data directly from the state during rate development. Both MCOs which operated during the CY 2015 and 2016 base data period provided detailed claims data. We reconciled the information provided with financial statements summaries from each MCO.

(iii) An explanation of why any base data requested was not provided by the state.

Although the state has begun to maintain encounter data from the MCOs, we were unable to assess that it was sufficiently accurate to be appropriate for rate development at this time. There is a significant volume of encounter data which the state's MMIS has rejected because of differences between FFS and encounter data submission requirements. Like many states, Nevada's MMIS was developed for processing FFS data, and they continue to work through known system issues in order to be comfortable with using state data in the future. We are working with the state to create a transition plan from using data directly submitted to us by the MCOs to using state-provided encounter data.

Description of data used to develop rates [Section I.2.B.ii]:

The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:

a. Description of the data

(i) the types of data used, which may include, but is not limited to: fee-for-service claims data; managed care encounter data; health plan financial data; information from program integrity audits; or other Medicaid program data.

We utilized fee-for-service claims, managed care encounters, health plan financials, and state eligibility data in the development of capitation rates. Table 5 identifies additional details related to all data received.

(ii) the age or time periods of all data used.

CY 2015 and 2016 eligibility and claims data served as the base data underlying the capitation rates presented herein. Additionally, we utilized claims incurred between July 2013 and March 2017 for development of trends and completion factor assumptions.

(iii) the sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).

Table 5 identifies the source of each individual data component utilized during rate development. All data was received from either DHCFP or the MCOs.

(iv) if a significant portion of the benefits under the contract with the managed care entity are provided through arrangements with subcontractors that are also paid on a capitated basis (or subcapitated arrangements), a description of the data received from the subcapitated plans or providers; or, if data is not received from the subcapitated plans or providers, a description of how the historical costs related to subcapitated arrangements were developed or verified.

Both MCOs operating during CY 2015 and 2016 engaged in sub-capitated arrangements for various services and provider groups. We evaluated encounters supporting sub-capitated arrangements for each MCO to determine whether they appeared to be reported sufficiently to project future medical cost.

- Amerigroup reported reasonable and complete encounters for their sub-capitated arrangements in CY 2015, however we were not comfortable using the encounters for CY 2016. CY 2016 reflects sub-capitation payments made to providers, assuming the payments are entirely attributable to medical cost.
- We could not verify the reasonability or completeness of HPN's reported encounters for their sub-capitated arrangements in either calendar year period. We have included sub-capitation payments

made to providers, assuming global capitation arrangements shift some level of administrative cost to contracted provider groups, but that payments for all other arrangements are entirely attributable to medical cost.
  - Note that HPN was unable to provide a level of administrative cost embedded within their global capitation arrangements, so we applied a default 10.5% reduction to payments estimating 89.5% of the payments are attributable to medical cost.

Table 7 illustrates aggregate sub-capitation payment PMPMs included in the rate development by service type.

b. Data quality and validation:

(i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data.
(B) accuracy of the data.
(C) consistency of the data across data sources.

DHCFP contracts, to the extent required by federal law, with an External Quality Review Organization (EQRO) to conduct independent, external reviews of the quality of services, outcomes, timeliness of, and access to the services provided by contracted vendors.

DHCFP validates fee-for-service claims on a regular basis as part of its processes for federal reporting and provider oversight. When receiving claims data from DHCFP, we receive control total reports to ensure the data remain complete and accurate when transferred.

Per the MCO contracts with DHCFP, each MCO is required to certify encounter data, payment data, and all other information submitted to the state. Data is required to comply with the applicable certification requirements for data and documents specified by DHCFP pursuant to 42 C.F.R. § 438.604, 438.606 and 457.950(a)(2). A certification, which attests, based on best knowledge, information, and belief that the data are accurate, complete and truthful as required by the State for participation in the Medicaid program and constrained in contracts, proposals and related documents. Each MCO provided the following information which we used in validating the data sources:

- Control totals for reconciliation:
  - Claim lag triangles
  - MCO-estimates for incurred but not reported claims
  - Sub-capitation payment control totals
  - Member month control totals
- A reconciliation of control totals to the company financial statements
- An attestation of accuracy by a company officer
- Plan-financials specific to Nevada Medicaid

We have a series of internal data validation processes which were conducted upon receipt of each set of data from DHCFP and the MCOs. We use a series of reconciliation workbooks to fully reconcile costs and member month counts with the control totals from separate reports. We also perform reasonableness checks throughout the rate development as we review data and information at various levels to develop assumptions such as trend and completion factors. We compare medical cost PMPMs and utilization rates over time, across MCOs, and against FFS data for the Nevada Medicaid program as well as other states' experience. We maintain a collaborative relationship with the state and its contractors, such that we are able to discuss data review questions and concerns throughout the rate development process.

(ii) a summary of the actuary's assessment of the data.

As the certifying actuary, I have assessed the quality of available data to be sufficient for the purpose of developing projected medical cost for capitation rates effective during the CY 2018 contract period. All data were reviewed at several professional levels by consultants, actuaries, and data analysts who have significant experience with Medicaid data. We have 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.

(iii) any other concerns that the actuary has over the availability or quality of the data.

We do not have concerns about the availability or quality of the data used for our analysis.

c. Data appropriateness: a description of how the actuary determined what data was appropriate to use for the rating period, including:

(i) if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.

We utilized both fee-for-service claims and managed care encounter data in the development of CY 2018 capitation rates.

(ii) if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.

Managed care encounter data was used in the development of CY 2018 capitation rates. The data used in our analysis is considered appropriate because it is historical experience data for the population and benefits covered under managed care in the contract period.

d. Reliance on a data book:

We developed a data book using detailed claims information from DHCFP and its vendors. We prepared actuarial models for each region and rate cell, which we relied upon in the development of medical cost projections. This information has been truncated for inclusion as Appendix B in this report such that only PMPMs are provided in order to preserve potentially proprietary unit cost information during the historical period, as only two MCOs were operating during the base data period. Our analysis included consideration for utilization and unit cost separately where appropriate.

Description of data adjustments [Section I.2.B.iii]:

a. Credibility:

We conducted a detailed review of the variance in historical medical cost by population to assess credibility. As a result of this analysis, we have defined our full credibility threshold as 80,000 member months during the experience period. For TANF and Check-up populations, we utilized two years of base data in order to maximize the credibility of the data used directly in rate development, however there were still rate cells which were not fully credible, based on our definition of full credibility. As such, we applied a classical credibility methodology at the age/gender cell level in order to reduce the potential for significant variations in the age/gender relativities from year to year. Partial credibility was assigned using the square root of (experience period member months / 80,000), with a maximum of 100%.

For cells with partial credibility, the projected medical cost PMPM was blended with other experience (the “manual rate”). We calculated manual rates separately by population to maintain comparability with each partially credible cell. A summary of the application of credibility follows:

- TANF and Expansion South region: All rate cells are fully credible, so no adjustments were made.
- TANF and Expansion North region: Manual rates were based on Southern region data for the same population, age, and gender cells. A regional factor was applied based on the relativity of aggregate claims between north and south separately by population and stratified by adults versus children.
- Check-up all regions: The manual rate for Check-up has three components:
    - TANF South data with an area factor applied based on the relativity of aggregate claims between TANF North and TANF South children.
    - TANF North data with an area factor applied based on the relativity of aggregate claims between TANF North and South children.
    - Check-up data from the other region (i.e., Check-up North’s manual rate contains Check-up South data with an area factor applied based on the relativity of aggregate claims between Check-up North and South.

For Check-up infants, the TANF infants experience was used as the manual rate. However, historical data suggests that TANF and Check-up newborn costs are materially different. The primary driver for this difference is the distribution of monthly age. (i.e., TANF infants have a higher prevalence of birth month than Check-up infants).

We developed a factor to convert the TANF experience for infants to be consistent with the monthly age distribution of Check-up experience.

Table 10 illustrates the partial credibility percentage for all rate cells that did not exceed the full credibility threshold of 80,000 member months in the experience period.

Table 10
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Partially Credible Rate Cells

Population	Region	Rate Cell	Experience MMs	Credibility Factor
TANF	North	Males & Females; < 1yr old	59,073	86%
TANF	North	Females; 15 - 18 yrs old	47,462	77%
TANF	North	Males; 15 - 18 yrs old	47,405	77%
TANF	North	Males; 19 - 34 yrs old	16,130	45%
TANF	North	Females; 35+ yrs old	35,957	67%
TANF	North	Males; 35+ yrs old	15,235	44%
Check-Up	South	Males & Females; < 1yr old	3,410	21%
Check-Up	South	Males & Females; 1 - 2 yrs old	22,906	54%
Check-Up	South	Females; 15 - 18 yrs old	39,766	71%
Check-Up	South	Males; 15 - 18 yrs old	40,281	71%
Check-Up	North	Males & Females; < 1yr old	874	10%
Check-Up	North	Males & Females; 1 - 2 yrs old	5,756	27%
Check-Up	North	Males & Females; 3 - 14 yrs old	66,630	91%
Check-Up	North	Females; 15 - 18 yrs old	9,804	35%
Check-Up	North	Males; 15 - 18 yrs old	9,781	35%
Expansion	North	Females; 19 - 34 yrs old	69,661	93%
Expansion	North	Males; 19 - 34 yrs old	57,543	85%

Appendix D includes additional details supporting the credibility adjustment calculations.

b. Completion factors:

Claim lag triangles were evaluated separately by major service category, population, and MCO with completion factors applied to raw data by quarter. We did not apply completion factors to subcapitation payments paid by MCOs to medical providers. Completion factors were developed and applied to claims data using aggregated data for both the monthly capitation rates and delivery case rate claims. For fee-for-service claims, we applied completion factors which were developed using HPN claim lags because both sets of data were paid through March 31, 2017, and the fee-for-service population data were not sufficient to establish estimates because of a lack of credibility.

Table 11 illustrates the impact of completion to encounters and claims paid on a fee-for-service basis. Note that factors are calculated and applied separately by plan, quarter, and category of service, though they are aggregated here for presentation purposes.

Table 11
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Completion Impact

Service Category	TANF/CHAP	Check-up	Expansion
Inpatient	2.4%	2.9%	1.1%
Outpatient	0.4%	0.5%	1.0%
Physician	0.3%	0.3%	0.8%
Pharmacy	0.0%	0.0%	0.0%
Composite	**0.8%**	**0.4%**	**0.7%**

c. Data errors:

We did not identify any errors in the data. 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.

d. Program changes:

Several fee schedule and program changes have been implemented by DHCFP to take effect between the start of the experience period and the end of the rating period. These include the following:

- Effective January 1, 2015
  - DHCFP began covering institutions for mental disease (IMDs) as an in-lieu of service
  - The rate for NICU Level II claims is paid at the Level III rate
- Effective July 1, 2015
  - Increase to acute inpatient hospital per diems
  - Discontinuation of the primary care physician (PCP) enhancement
  - Changes made to many CPT and HCPCS codes for certified physicians, nurse practitioners, and physicians assistants (Nevada provider types 20, 24, and 77 respectively)
- Effective January 1, 2016
  - Increase to transplant reimbursement
  - Applied behavioral analysis (ABA) services covered under managed care
- Effective March 1, 2016
  - Removal of restrictions by fibrosis level for access to Hepatitis C drugs
- Effective July 1, 2016
  - Increase to home health reimbursement
  - Increased coverage for community paramedicine
- Effective July 1, 2017
  - Change to fee schedule for durable medical equipment
  - Reimbursement realignment for several provider types
  - Converted reimbursement from ASCs to APCs
  - Increase to skilled nursing facility reimbursement
  - Increase to surgical pediatric codes
  - Expansion of medication-assisted treatment (MAT) services

Each of these changes is described below in more detail.

Effective January 1, 2015

These changes are fully reflected in our experience period, so no adjustment was needed to adjust the experience period for these program changes. These changes are included here for context as the period we used for our trend analysis extended back prior to January 2015.

More information about IMDs is covered in sections I.3.A.(iv)-(vi).

Effective July 1, 2015
DHCFP made changes to fee schedules for several provider types:

- Acute inpatient hospitals, excluding NICU and behavioral health days
- Physicians
- Advanced registered nurse practitioners (ARNP)
- Nurse midwives, and
- Physician assistants (PA).

For acute inpatient hospitals, per diem rates increased 5%. Therefore, we applied a 5% increase to all paid claims at an acute inpatient facility, as identified by specialty codes provided by the health plans, for services prior to 7/1/2015. The only exceptions to this increase were for payments for NICU bed days and inpatient behavioral health claims which did not receive a 5% increase.

Table 12 illustrates the impact of applying this change to base period experience data prior to July 2015. Note that the impact for the Expansion population is 0% because the change was fully reflected within the CY 2016 experience used as the basis of Expansion rates.

Table 12
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Inpatient Hospital Fee Schedule Impact

Service Category	Check-up	TANF Kids	TANF Adults	Expansion	Composite
Medical/Surgical	0.9%	0.9%	0.9%	0.0%	0.4%
Vaginal delivery	1.7%	1.1%	1.0%	0.0%	1.0%
C-Section delivery	2.2%	0.9%	1.0%	0.0%	1.0%
Maternity Delivery	1.9%	1.1%	1.0%	0.0%	1.0%
Maternity Non-Delivery	0.0%	0.9%	1.0%	0.0%	0.9%
Well Newborn	0.0%	1.0%	1.6%	0.0%	1.0%
Other Newborn	0.0%	0.5%	0.2%	0.0%	0.5%
All Inpatient	0.8%	0.6%	0.9%	0.0%	0.4%
Overall Adjustment	0.1%	0.2%	0.3%	0.0%	0.1%

To evaluate the impact of the rate adjustments for non-hospital providers listed, we relied on specialty code within managed care encounters and Nevada Medicaid provider type within fee-for-service claims to identify qualifying providers and claims. Changes to the fee schedule varied by specific CPT/HCPCS procedure codes. Therefore, rate changes were applied as a percentage change to the paid amounts at the detailed claim-level, with distinct percentages calculated for each unique combination of HCPCS, modifier, provider type, and adult/child status. For claims missing specialty code, we attributed specialty code by assuming these claims would follow the same distribution by provider type as those claims with specialty code populated within the same category of service. This “percent of paid” approach was taken based on our understanding that most MCO provider contracts in the Nevada Medicaid market reimburse providers based on a percentage of the Medicaid fee-for-service fee schedule.

Changes to the physician, ARNP, and PA fee schedules also occurred in May 2015, December 2015, January 2016, and July 2016, though the vast majority of changes (>97% of unique HCPCS codes) occurred effective July 2015. We have made changes using the methodology described for the other dates where rate changes occurred, though we have not mentioned them separately in this report.

Tables 13 through 15 illustrate the impact of all fee change adjustments (effective at all dates) for provider types 20, 24, and 77.

Table 13
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Fee Schedule Adjustment Impact- Physician (20)

Service Category	Check-up	TANF Kids	TANF Adults	Expansion	Composite
Hospital Visits	7.2%	6.9%	6.9%	1.8%	4.8%
ED/Urgent Care Visits	6.1%	6.7%	6.2%	1.8%	4.8%
Office Visits	6.6%	6.7%	6.8%	1.5%	4.9%
Well Baby/Physical Exams	1.3%	1.7%	6.9%	0.8%	1.8%
Allergy/Immunizations	10.2%	12.8%	4.7%	0.0%	11.1%
Other Physician	(0.4%)	(0.6%)	0.4%	0.0%	0.0%
All Physician	4.0%	4.6%	2.4%	0.8%	2.7%
Overall Adjustment	1.8%	1.9%	1.0%	0.2%	1.0%

Table 14
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Fee Schedule Adjustment Impact - Advanced Practice Registered Nurse (24)

Service Category	Check-up	TANF Kids	TANF Adults	Expansion	Composite
Allergy/Immunizations	1.0%	1.3%	0.2%	0.0%	1.1%
Other Physician	0.1%	0.1%	0.0%	0.0%	0.0%
All Physician	0.2%	0.2%	0.0%	0.0%	0.1%
Overall Adjustment	0.1%	0.1%	0.0%	0.0%	0.0%

Table 15
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Adjustments due to Fee Schedule - Physician Assistant (77)

Service Category	Check-up	TANF Kids	TANF Adults	Expansion	Composite
Allergy/Immunizations	0.4%	0.5%	0.0%	0.0%	0.4%
Other Physician	0.1%	0.0%	0.0%	0.0%	0.0%
All Physician	0.1%	0.1%	0.0%	0.0%	0.0%
Overall Adjustment	0.1%	0.0%	0.0%	0.0%	0.0%

In calendar years 2013 and 2014, each MCO was required by federal law to make enhancement payments for primary care services provided by individuals classified as PCPs. The State of Nevada initially extended enhanced payments through June 30, 2015, and then discontinued the program beyond that date. We removed the enhancements from the base data as discussed below.

According to DHCFP and the health plans, each MCO dealt with the PCP enhancement differently in their claims data.

- Amerigroup paid the enhancement outside of the claims system.
- HPN paid the enhancement as part of the original claim.

We removed the enhancements paid by HPN in their claims data by identifying PCPs through taxonomy codes and adjusting the average cost of services performed by these providers. We considered the following taxonomy categories to be PCPs: general practitioner, internal medicine, pediatrician, and family planning.

Claim adjustments were developed using the change in the average unit cost for HPN's PCP services from 2012 (before the enhancement payment became effective) through June 30, 2015. Adjustments were made at the HCPCS and category of service level. When the average cost per service increased by at least 5%, and enough credible experience existed in the base period (defined here as at least $5,000 total for that particular HCPCS and category of service combination), we reduced the unit cost in the base period claims data. This calculation was performed by quarter, separately for TANF/Check-up and Expansion populations.

Finally, we modified the adjustment by a multiplicative factor to ensure that the total impact of the adjustment was consistent with HPN's enhancement payments (as reported to us by HPN).

Effective January 1, 2016

Effective January 1, 2016, DHCFP increased rates for liver, kidney, bone marrow, and corneal transplants. This rate increase was immaterial to these rates.

Beginning January 1, 2016, applied behavioral analysis (ABA) services were added to MCO contracts as covered benefits under managed care. These services are available to individuals under age 21 based on medical necessity. To be considered for this program, a diagnosis of autism spectrum disorder (ASD) must be present.

Table 16 identifies the procedure codes associated with ABA services.

Table 16
State of Nevada
Division of Healthcare Financing and Policy
CY 2018 Capitation Rate Development
ABA HCPCS Codes

ABA HCPCS Code	Code Description
S5110	Family homecare training, per 15 minutes
0359T	Behavior identification assessment
0360T	Observational behavioral assessment
0361T	Observational behavioral assessment, additional
0362T	Exposure behavioral assessment
0363T	Exposure behavioral assessment, additional
0364T	Adaptive behavior treatment
0365T	Adaptive behavior treatment, additional
0366T	Group behavior treatment
0367T	Group behavior treatment, additional
0368T	Behavior treatment modified
0369T	Behavior treatment modified, additional
0370T	Family behavior treatment guidance
0372T	Social skills training group
0373T	Exposure behavior treatment
0374T	Exposure behavior treatment, additional

The costs associated with ABA services in the rates come from two components:

1. The ABA experience already in the base data, which has not been removed, and is trended forward.
2. An ABA add-on amount to account for an increase in use of ABA services relative to the experience, and the fact that ABA was not covered in 2015.

To calculate the ABA service cost add-on, we analyzed historical MCO claims data for children under age 21 with diagnoses of autistic disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS), or Asperger's syndrome. We then assumed that 5% of these members would use ABA services at a cost of $35 per hour, and 40 hours a month.

The assumed cost per hour was calculated based on the hourly rate for a registered behavior technician (RBT) and their supervising behavior analyst (BCBA). Based on the fee schedule provided by the state, the hourly rate for a RBT is $31.31, and the BCBA's hourly rate is $72.24 for the services they perform most frequently. We blended these rates together assuming a ratio of 12 RBTs for every 1 BCBA supported by documents released by DHCFP. The resulting hourly rate is $34.46, which we rounded to $35.

Table17 illustrates the calculation of the ABA add-on (before administration and tax):

Table 17
State of Nevada
Division of Healthcare Financing and Policy
CY 2018 Capitation Rate Development
ABA Assumption Development

	TANF Kids	Check-up Kids
ASD Prevalence	0.7%	0.9%
Unit Cost	$35/hour	$35/hour
# of hours	40	40
Take-up rate	5.0%	5.0%
Total ABA add-on PMPM	$ 0.50	$ 0.62

Table 18 illustrates the PMPM cost from the underlying base data, the PMPM cost which was included in July 2017 capitation rates, and the PMPM amount which was added to the medical cost projection for CY 2018.

Table 18
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
ABA Services In Rates (Not Incl. Admin and Tax)

Population	2016 (Not Trended)	2017 H2 Add-On Amount	2018 Add-On Amount
TANF Adults	$ 0.00	$ 0.01	$ 0.01
TANF Children	0.01	0.98	0.50
Check Up	0.01	1.19	0.62
Expansion	0.00	0.02	0.02

Effective March 1, 2016

Effective March 1, 2016, Nevada Medicaid MCOs were no longer able to restrict access to Hepatitis C drugs based on fibrosis level. Prior to March 1, 2016, members with fibrosis levels 0, 1 and 2 were only prescribed a Hepatitis C drug if it was deemed medically necessary. Prescriptions are still based on medical necessity, but increased access and decreased restrictions have increased utilization of Hepatitis C drugs.

We analyzed scripts per 1,000 lives and unit cost since 2014. Our goal was to identify a level at which we could expect utilization to continue in the future. We compared CY 2015 and CY 2016 to the periods of October 2016 through February 2017 and July 2016 through February 2017, then averaged the results. We performed the same calculation for unit cost.

Table 19 illustrates the development of the adjustment factors applied to Hepatitis C experience. No other adjustments, including trend, were applied to Hepatitis C experience.

Table 19
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Hepatitis C Adjustment Factors

	Util/1000		Unit Cost	
Period	**TANF adult**	**Expansion**	**Composite**	**Note**
Experience Data				
CY 2015	0.8	3.4	$ 25,824.26	(1)
CY 2016	1.9	6.9	23,681.37	(2)
Stable Period experience est.				
October 2016 - February 2017	2.3	6.6	$ 21,368.35	(3)
July 2016 - February 2017	2.6	7.5	22,087.70	(4)
CY 2015 Base Exp.				
Factor 1	2.660	1.940	0.827	(5)=(3)/(1)
Factor 2	3.019	2.190	0.855	(6)=(4)/(1)
CY 2016 Base Exp.				
Factor 1	1.184	0.962	0.902	(7)=(3)/(2)
Factor 2	1.343	1.086	0.933	(8)=(4)/(2)
Final Adj. Factor *				
CY 2015	2.840	N/A	0.841	(9)=avg[(5),(6)]
CY 2016	1.263	1.024	0.918	(10)=avg[(7),(8)]

**Note: TANF/CHAP Adults and Expansion population use the same composite unit cost adjustment factors, but they use different utilization adjustment factors.*

Effective July 1, 2016

DHCFP has made an additional change to the home health fee schedule effective July 1, 2016. The rate changes would increase reimbursement by 25% for home health claims. We have applied this increase to the experience period data. The impact of this change is shown in Table 21.

Also on July 1, 2016, DHCFP expanded coverage to community paramedicine providers. DHCFP projected this change to be cost neutral due to savings generated by better access to care. Additionally, DHCFP has stated that utilization of these services has been negligible since the program became effective. As a result we have not explicitly modeled an impact because of this change.

Effective July 1, 2017

In June 2017 Nevada was awarded a grant to address the opioid crisis by increasing mediation-assisted treatment (MAT) services[5]. The purpose of this grant is to increase access to treatment, reduce unmet need, and reduce opioid overdose-related deaths. We did not explicitly adjust for this expansion, since very little information is available about what actions will be taken and the impacts of those actions. However, we did consider this when selecting behavioral health trends, which is discussed in section I.3.

On July 1, 2017, DHCFP revised the reimbursement for surgical services provided in hospital-based and freestanding ambulatory surgical centers (ASC). The revised payment methodology uses ambulatory payment classification (APC) payment methodology for outpatient surgery and ambulatory surgical center provider types (Nevada provider types 10 and 46). We repriced applicable claims incurred between 2012 and 2017 to APCs using an internal Milliman tool that applies ASC and APC payment logic to detailed claim records. The repriced claims were 26% less than the original allowed amounts, so a 26% reduction was applied to all ASC claims in the base experience, where the HCPCS for these claims was in the fee schedule provided by DHCFP.

[5] http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/MCAC/2017/MCAC_07_18_17_Opioid_STR.pdf

Table 20 illustrates the impact of the outpatient surgical fee change by service category.

Table 20
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
ASC to APC fee schedule change impact

Service Category	Check-up	TANF Kids	TANF Adults	Expansion	Composite
Outpatient Surgery	(16.1%)	(17.1%)	(9.3%)	(11.2%)	(13.2%)
Outpatient Other	0.0%	(0.0%)	(0.7%)	(1.6%)	(1.1%)
All Outpatient	(6.3%)	(5.7%)	(1.9%)	(2.6%)	(3.3%)
Overall Rate Adjustment	(0.6%)	(0.5%)	(0.2%)	(0.3%)	(0.3%)

Also on July 1, 2017, DHCFP approved the following changes:

- 10% increase to skilled nursing facilities
- 15% increase to surgical codes (HCPCS 10000-58999, 60000-69999 and 93000 – 93350) for pediatric cases (ages 0 -20).
- DMEPOS fee schedule was updated to use the July 2016 Medicare fee schedule

These changes were applied to the base data at the claim level. Tables 21 and 22 illustrate the impacts of these changes to costs for each service category.

Table 21
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
DME, Home Health, and SNF fee schedule impacts

Service Category	Check-up	TANF Kids	TANF Adults	Expansion	Composite
Durable Medical Equipment	(0.5%)	(1.7%)	(11.7%)	(13.9%)	(7.6%)
Home Health	18.3%	16.0%	15.5%	10.6%	12.7%
Skilled Nursing Facility	9.1%	8.9%	8.8%	9.5%	9.4%

Table 22
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Adjustments due to pediatric surgery fee schedule change

Service Category	Check-up	TANF Kids	TANF Adults	Expansion	Composite
Outpatient Surgery	1.9%	1.8%	0.0%	0.0%	0.7%
Surgery - Physician	5.6%	5.1%	0.1%	0.1%	1.7%
All Outpatient	1.0%	0.8%	0.0%	0.0%	0.2%
All Physician	0.4%	0.3%	0.0%	0.0%	0.1%
Overall Rate Adjustment	0.3%	0.2%	0.0%	0.0%	0.1%

Additionally, there were fee schedule changes effective July 1, 2017 for several other provider types, including outpatient hospitals, optometrists, podiatrists, and therapists. The latter changes were referred to using the general term “rate realignment.” DHCFP supplied fee schedules before and after these changes, and the percentage change was applied at the HCPCS-level. Table 23 illustrates the net impact of this change by service category.

Table 23 State of Nevada Division of Health Care Financing and Policy CY 2018 Capitation Rate Development Adjustments due to rate realignment					
Service Category	**Check-up**	**TANF Kids**	**TANF Adults**	**Expansion**	**Composite**
Outpatient Observation	(1.2%)	(1.0%)	(3.1%)	(2.7%)	(2.7%)
Outpatient Radiology/Pathology/Lab	(40.7%)	(39.3%)	(8.4%)	(15.5%)	(19.7%)
Other Outpatient	0.7%	1.9%	0.2%	(1.0%)	0.1%
All Outpatient	(0.8%)	0.9%	(0.6%)	(1.7%)	(0.7%)
Physician Radiology/Pathology/Lab	(2.2%)	(1.8%)	(1.6%)	(2.7%)	(2.2%)
Vision	9.0%	7.8%	7.4%	8.4%	8.0%
PT/ST/OT	1.1%	0.7%	3.2%	2.1%	1.5%
Chiropractic Services	27.9%	20.9%	22.7%	18.4%	22.1%
All Other Ancillary	0.1%	0.2%	(0.0%)	(0.0%)	0.0%
All Ancillary	3.6%	2.5%	1.9%	1.3%	1.9%
Overall Adjustment	0.3%	0.2%	(0.1%)	(0.2%)	(0.1%)

e. Exclusions:

Only services that will be covered under the managed care contract were included in our analysis. The following is a list of excluded services:

- Dental claims, including dental procedure codes D1206 and D1208, which are sometimes covered under medical service contracts as preventive medical services
- All claims incurred by a member during a stay in an IMD of greater than 15 days within a month
- Targeted case management (procedure code T1017)
- School-based services (provider type 60)
- Residential treatment centers (provider type 63)
- Adult group care waiver (provider type 57)
- Hospice, long term care (provider type 65)
- Indian health services (provider type 78)
- Physically disabled waiver (provider type 58)
- Intermediate care facility for individuals with intellectual disabilities (provider type 68)

We excluded some members based on demographic information:

- Expansion members who were not between the ages of 19 and 64
- Check-up members who were over age 19
- Members without known demographics, such as region, age, or gender.

FEE-FOR-SERVICE PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Rate Development Standards [Section I.3.A]

Services in final rates [Section I.3.A.i]:

Final capitation rates are based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

Variations in assumptions [Section I.3.A.ii]:

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Development of benefit cost trends [Section I.3.A.iii]:

See section I.3.B.iii

In-lieu-of services [Section I.3.A.iv]:

See section I.3.B.v

Costs associated with IMDs [Section I.3.A.v]:

We repriced IMD claims which meet the CMS requirements to qualify as in-lieu of services to the average state plan service rate for FFS inpatient psychiatric per diem rates. This repricing is done at the claim-level, replacing the reported cost of each IMD claim equal to the covered days on the claim multiplied by the per diem FFS fee schedule rates for acute facility behavioral health claims. The impact is a 1.9% increase to claims for Expansion and a 0.2% increase to claims for TANF and Check-up. Note that this repricing has not been applied to the IMD add-on rates (described below) because these rates are not subject to federal financial participation.

Table 24 includes national provider identifiers (NPI) for facilities identified by DHCFP as IMDs.

Table 24
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Provider IDs Identified as IMDs

NPI	Provider Name
1174890487	Montevista Hospital
1144498643	Seven Hills Hospital
1871934877	Desert Parkway Behavioral Healthcare Hospital
1730287319	West Hills Hospital
1417947490	Valley Hospital Medical Center
1790883205	Willow Springs Center
1457306359	Southern Hills Medical Center
1154317964	Desert Springs Hospital
1275801532	Red Rock Behavioral Health Hospital
1477543171	Sparks Family Hospital
1255306270	Spring Mountain Treatment Center
1972501021	Northern Nevada Adult Mental Health Services
1891756920	Southern Nevada Adult Mental Health Services
1669408928	Spring Mountain Sahara

The percentage of each category of service that are in-lieu of services is shown in Table 25.

Table 25
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
In-Lieu of Services Summary by Category of Service

Inpatient Hospital COS	TANF Adults	Expansion
Medical/Surgical	3.7%	9.8%
Maternity Non-Delivery	4.5%	9.8%
Well Newborn	0.0%	0.0%
Inpatient MH/SUD	49.1%	82.3%
Vaginal delivery	3.4%	2.9%
C-Section delivery	3.8%	1.4%

According to the new regulations, IMD stays longer than 15 days within a month for patients age 21 to 64 are not eligible for federal funding. For the capitation rates that will be reported to CMS for federal match, we have excluded these long stays, the corresponding member months, and any other (non-IMD) services incurred during the IMD long stay. Claims

and member months incurred during a month of an IMD long-stay are used to develop "IMD add-on" rates which cover the additional cost to MCOs of patients who reside within an IMD for more than 15 days in a single month.

- These add-on rates will be paid to the MCOs in order to assure continuity of care, but they will be entirely state funded.
- The add-on rates are determined by isolating claims paid during months with an IMD stay greater than 15 days.
- Any fee schedule changes applicable to these claims are added, as well as completion factors, consistent with sections I.2.B.(ii).(b).(i).(A) and I.2.B.(iii).(d) in this report. Administration and premium tax are loaded for each MCO consistent with section I.5 of this report.
- The IMD add-on rates can be seen in Attachment A-2.

Additional IMD information [Section I.3.A.vi]:

a. The number of enrollees who received treatment in an IMD through managed care organizations or plans in the base data period;

b. The range of and the average number of months and of length of stay during those months that enrollees received care in an IMD;

c. The impact that providing treatment through IMDs has had on the capitation rates or rate ranges.

Table 26 addresses the requested additional IMD information. This includes experience only for members between the ages of 22 and 64 years old based on CY 2016 experience for Expansion and CY 2015 and 2016 for TANF adults. We have quantified the impact of IMD costs that are included in the capitation rates eligible for federal financial participation. This table does not include claims incurred during IMD long stays.

Table 26
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Statistics for Institutions for Mental Disease, Members Aged 21-64

IMD Statistics	TANF Adults (22+)	Expansion	Total
Number of Distinct Users	2,015	5,375	7,390
Month Range	1 - 2	1 - 2	1 - 2
Month Average	1.12	1.17	1.16
LOS Range	1 - 27	1 - 25	1 - 27
LOS Average	4.9	6.3	6.0
Utils/1000	107.7	285.2	221.5
PMPM (raw)	$ 8.08	$ 19.04	$ 15.10
PMPM (repriced)	$ 10.40	$ 26.22	$ 20.53

Appropriate Documentation [Section I.3.B]

Projected benefit costs [Section I.3.B.i]: Detailed projection models are included in Appendix B and C.

Development of projected benefit costs [Section I.3.B.ii]:

Section I.1.B.i.(a) includes a description of data used. Assumptions and methodologies are identified below, and elsewhere in this report in the applicable section.

Delivery Case Rate:

Since the last rate certification, there has been a material change in the method used to project DCR costs. Beginning in the 2018 rates, maternity claims will be carved out of the MCO base data, and these claims are projected separately as the DCR amount. Delivery exposure units are defined using an assigned DRG and HCPCS present in the MCO encounter data. Please see Appendix B-2 for more information.

Low Birth Weight Kick Payment:

Though it is similar to the SOBRA rate in that payments are made per case, the LBW payment is intended to cover a portion of the costs associated with the LBW infants, whereas SOBRA payments are meant to cover average costs associated with the mother. The number of LBW payments to be made in a calendar year is limited by the following formula:

Funded Births = 0.85 births per 1,000 member months in the "< 1 year old" rate cell

Under the LBW fund structure, the actual funded birth count will be updated periodically based on actual enrollment. Calculating the LBW fund in this way will protect plans from risk associated with growing or shrinking membership. As with previous years, if the final number of LBW births in CY 2018 is below the final number of funded births in CY 2018, the remaining dollars will be distributed to the health plans in direct proportion to the percent of "< 1 year old" members covered by each plan. Deliveries in excess of the final funded count will receive no additional payment.

Related costs are removed from the monthly capitation rates. The amount of the payment prior to application of premium tax will remain the same as the 2017 payment, which was $60,000 prior to administration.

We analyzed the historical costs for LBW births using data from the January 2017 rate setting and found that these enrollees typically cost between $65K and $70K within 90 days of birth. Based on this analysis, we concluded that the historical cost payment amount of $60,000 remained appropriate.

Table 27 shows the results of this analysis. We have not removed stop loss recoveries from this analysis.

Table 27
State of Nevada
Division of Healthcare Financing and Policy
CY 2018 Capitation Rate Development
LBW Costs Incurred within 90 Days of Birth

	Member Count	Average IP Cost
With Paid > 0	312	$66,054.95
With Paid > $1000	311	$66,267.34
With Paid > $5,000	300	$68,670.38

Trends [Section I.3.B.iii]:

a. This section must include:

(i) Data and assumptions used to develop trends:

(A) Descriptions of data and assumptions.

Medical Trends

The data used to develop medical trends included managed care claims incurred between July 2013 and March 2017, paid through at least the end of March 2017. The data was grouped according to major service category and population (TANF and Check-up children, TANF adults, and Expansion). The data was adjusted for completion and fee schedule changes. Maternity and non-maternity claims were analyzed separately.

To develop utilization trends, we processed historical experience through Milliman's *Global RVU* (GRVU) tool. This tool converts utilization for different services to a relative value unit (RVU) in order to be more directly comparable in terms of intensity, and resources required.

We summarized experience by utilization (RVUs), cost per RVU, and PMPM amounts.

Additionally, we considered national health (NHE) expenditure data and projections when selecting trend assumptions. Table 28 shows summarized NHE data.

Table 28 State of Nevada Division of Health Care Financing and Policy CY 2018 Capitation Rate Development National Health Care Expenditure Trends	
Service category	**Per capita trend**
Hospital	2.2%
Physician	4.0%
Home Health	4.7%
DME	4.1%
Other	3.2%

Pharmacy Trends

Note that the discussion of pharmacy trend in this section excludes Hepatitis C. Hepatitis C trends are covered in section 1.2.B.(iii).(d).

The data used to develop pharmacy trends was managed care data from January 2014 through March 2017. The data were summarized by utilization, unit cost and PMPM amounts.

We also considered the following additional information to assist with informing our trend rate selection.

- National average drug acquisition cost (NADAC) files available on Medicaid.gov to reprice MCO pharmacy claims.
- Internal Milliman research on high-cost pipeline drugs
- Internal Milliman research on brand to generic drug conversion
- Additionally, patent expiration information for drugs modeled as a brand converting to generic was corroborated with an online source.[6]

(B) Reliance on experience

Trend rates were selected primarily based on actual experience from the Medicaid population, with actuarial judgement.

(ii) Methodologies used to develop trends:

Medical Trends

The historical data described in section I.3.B.iii.(a).(i) was reviewed, and trends were selected based on judgement, and emerging utilization and claims patterns.

To investigate emerging and historical patterns in the data, we applied a regression model to PMPMs, costs per service, and utilizations per 1000 lives. The default regression period was January 2014 – June 2016 with the following exceptions:

- TANF adults:
  - Inpatient BH – started January 2015 (IMDs)
  - Outpatient BH – started July 2015 (disruption)

[6] Abilify: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm444862.htm
Gleevec: http://www.medscape.com/viewarticle/867272
Epzicom: https://www.drugs.com/availability/generic-epzicom.html
Seroquel: http://www.prnewswire.com/news-releases/endo-begins-shipment-of-generic-seroquel-xr-300354795.html
Lantus: http://www.businessinsider.com/insulin-cheaper-generic-2016-12
Epipen: https://www.goodrx.com/blog/epipen-generic-is-finally-in-pharmacies/
Norvir: https://www.drugs.com/availability/generic-norvir.html
Strattera: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm561096.htm
Viread: http://www.pmlive.com/pharma_news/gilead_settles_patent_dispute_with_teva_over_viread_generic_464432
Novolog: https://www.drugs.com/availability/generic-novolog.html
Reyataz: https://www.drugs.com/availability/generic-reyataz.html
Advair Diskus: https://www.drugs.com/availability/generic-advair-diskus.html
Xolair: http://gabionline.net/Biosimilars/General/Biosimilars-of-omalizumab
Latuda: https://www.drugs.com/availability/generic-latuda.html
Lyrica: https://www.drugs.com/availability/generic-lyrica.html

- Expansion:
  - Excluded CY 2014
- Children:
  - Inpatient hospital – exclude newborns due to fee schedule disruption
  - Start regression for maternity categories in July 2014

Where regression values appeared volatile or overly large, we tempered selected trends, assuming that outlier historical trends would regress to the mean over time.

Tables 29 and 30 show the regression results compared to our selected trends for 2018 rates and July 2017 rates.

Table 29
State of Nevada
Division of Health Care Financing and Policy
Managed Care CY 2018 Capitation Rates
Util/1000 Trend

Service Category	TANF/Check-up Children			TANF Adults			Expansion Adults		
	Prior	Raw Regression	Selected	Prior	Raw Regression	Selected	Prior	Raw Regression	Selected
Inpatient - Other	2.0%	9.2%	4.0%	2.0%	9.4%	4.0%	1.0%	4.3%	4.0%
Inpatient - Psych	2.0%	5.1%	5.0%	2.0%	15.4%	10.0%	1.0%	15.7%	10.0%
OP- Other	0.0%	4.0%	4.0%	0.0%	6.1%	6.0%	0.0%	9.5%	6.0%
OP - ER	2.0%	5.4%	2.0%	2.0%	10.3%	3.0%	1.0%	9.4%	3.0%
OP- Psych	0.0%	32.5%	10.0%	0.0%	51.2%	12.5%	0.0%	65.1%	10.0%
Prof - Other	0.5%	4.4%	2.0%	0.5%	6.9%	4.0%	0.0%	3.9%	4.0%
Prof - Psych	0.0%	12.8%	10.0%	0.0%	23.3%	12.5%	0.0%	37.2%	10.0%
Other	2.0%	7.7%	5.0%	2.0%	8.2%	4.0%	2.0%	13.4%	7.0%
Total (net Mat)	**0.8%**	**6.0%**	**3.3%**	**0.9%**	**8.5%**	**4.7%**	**0.5%**	**8.4%**	**5.2%**
Maternity Total	**1.4%**	**(1.3%)**	**0.7%**	**1.3%**	**0.8%**	**0.7%**	**0.6%**	**6.7%**	**0.7%**

Table 30
State of Nevada
Division of Health Care Financing and Policy
Managed Care CY 2018 Capitation Rates
Unit Cost Trend

Service Category	TANF/Check-Up Children			TANF Adults			Expansion Adults		
	Prior	Raw Regression	Selected	Prior	Raw Regression	Selected	Prior	Raw Regression	Selected
Inpatient - Other	0.5%	0.3%	0.5%	0.5%	(1.0%)	(1.0%)	0.5%	1.0%	1.0%
Inpatient - Psych	0.5%	(0.5%)	(0.5%)	0.5%	(1.2%)	(1.0%)	0.5%	(5.3%)	(1.0%)
OP- Other	2.0%	(4.5%)	(2.0%)	2.0%	2.4%	2.5%	2.0%	2.9%	3.0%
OP– ER	2.0%	(2.3%)	(2.0%)	2.0%	(1.3%)	(1.5%)	2.0%	(2.0%)	(1.0%)
OP - Psych	0.0%	(0.8%)	(1.0%)	0.0%	(4.5%)	(0.5%)	0.0%	(2.8%)	(2.0%)
Prof – Other	1.0%	3.7%	1.5%	1.0%	3.1%	1.5%	1.0%	0.2%	0.5%
Prof– Psych	0.0%	(0.3%)	(0.5%)	0.0%	(0.5%)	(0.5%)	0.0%	1.0%	(2.0%)
Other	1.0%	0.9%	1.0%	1.0%	0.8%	1.0%	1.0%	1.0%	1.0%
Total (net Mat)	**1.0%**	**1.7%**	**0.7%**	**1.0%**	**1.6%**	**0.9%**	**0.9%**	**0.3%**	**0.7%**
Maternity Total	**0.7%**	**1.9%**	**0.8%**	**0.7%**	**0.4%**	**0.8%**	**0.7%**	**2.5%**	**0.8%**

Pharmacy Trends

Pharmacy trends were calculated in several components:

- Utilization: Historical utilization trends were analyzed by population (TANF adults, children (TANF and Check-up), and Expansion), and drug class (generic, brand, and specialty). Trends were selected based on reviewing this historical experience.
- Unit cost: Unit cost in the base data is adjusted for several components of trend:
  - Base unit cost: Historical unit cost trends were analyzed by population (TANF adults, children (TANF and Check-up), and Expansion), and drug class (generic, brand, and specialty). MCO data was repriced using the NADAC in order to provide a trend that was independent of pharmacy benefit manager (PBM) arrangements. Table 31 shows certain classes of drug that were modeled separately. Trends were selected based on reviewing this historical experience.

Table 31
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Cost Trends for Specific Therapeutic Classes

Therapeutic Class	Class	% of Class Costs	Trend
Acne Products	Generic	3.2%	4.0%
Amphetamines	Generic	1.6%	0.0%
Anaphylaxis Therapy Agents	Brand	5.3%	26.0%
Diagnostic Tests	Brand	5.5%	6.0%
Dibenzapines / Quinolinone Derivatives / Benzisoxazoles	Brand	4.6%	0.0%
Antineoplastic Enzyme Inhibitors	Specialty	6.5%	14.0%
Antiretrovirals	Specialty	37.7%	8.0%
Soluble Tumor Necrosis Factor Receptor Agents	Specialty	14.1%	15.0%

- **Brand patent loss**: Brand drugs in the base experience were identified as losing patents before the end of CY 2018. Internal Milliman research was used to project the utilization and cost shift for each drug, with the exception of Abilify. Historical experience was used to project the generic shift of from Abilify to aripiprazole. The adjustment was calculated by population: (TANF adults, children (TANF and Check-up), and Expansion). Tables 32 and 33 show the adjustment for brand patent loss. Table 33 shows the contribution of each drug to the total brand-to-generic cost factor.

Table 32
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Impact of Brand-to-Generic Shift on Brand Drugs

Year	TANF Adults	Children	Expansion
2015	(3.6%)	(6.3%)	n/a
2016	(2.3%)	(7.4%)	(3.4%)

Table 33 State of Nevada Division of Health Care Financing and Policy CY 2018 Capitation Rate Development % of Impact to Brand-to-Generic Factor				
Brand Name	**Launch Date**	**TANF Adults**	**Children**	**Expansion**
ABILIFY	4/28/2015	7.6%	2.0%	0.0%
GLEEVEC	2/1/2016	0.0%	0.0%	13.8%
EPZICOM	9/28/2016	1.7%	0.0%	7.7%
SEROQUEL XR	11/1/2016	34.3%	1.3%	33.1%
LANTUS	12/15/2016	0.9%	0.0%	0.6%
EPIPEN 2-PAK	12/19/2016	19.4%	38.1%	8.7%
EPIPEN-JR 2-PAK	12/19/2016	0.1%	38.5%	0.1%
STRATTERA	5/26/2017	7.1%	17.4%	4.1%
VIREAD	12/15/2017	4.2%	0.0%	4.2%
NOVOLOG	12/20/2017	0.3%	0.1%	0.2%
REYATAZ	12/27/2017	8.1%	0.1%	10.5%
ADVAIR DISKUS	6/1/2018	2.3%	0.6%	1.4%
XOLAIR	6/1/2018	2.6%	1.6%	2.0%
LATUDA	7/2/2018	4.7%	0.1%	2.8%
LYRICA	12/15/2018	0.0%	0.0%	0.0%
NORVIR	12/26/2016	6.8%	0.1%	11.0%

- New specialty drugs: In order to account for the costs of new specialty drugs we reviewed claims data to determine the population-wide prevalence of conditions that would lead to use of newly available specialty drugs. We also reviewed public information regarding expected sales and alternative treatments. This analysis was performed separately for TANF (children and adults individually), Check-up, and Expansion.

  Our estimated costs were developed based on the prevalence of the conditions treated, projected unit cost, and projected take-up rates. For drugs that had already launched before the end of the experience period, including Entresto, Orkambi, Praluent, and Repatha, we used experience after the launch date to inform our projection of future claims.

The high-level assumptions underlying our calculation of the new specialty drug impact are shown in Table 34.

Table 34
State of Nevada
Division of Health Care Financing and Policy
Managed Care CY 2018 Capitation Rates
High Cost Specialty Drugs

Product	Approval Date	Condition	Estimated Cost per Patient	Age Restricted
Orkambi	7/2/2015	Cystic Fibrosis	$15K-$30K/month	Ages 12+
Kalydeco	5/17/2017	Cystic Fibrosis	$15K-$30K/month	Ages 2+
Entresto	7/7/2015	Heart Failure	$168-208/month	Ages 45+
Praluent	7/24/2015	Hyperlipidemia	$471-850/month	Ages 18+
Repatha	8/31/2015	Hyperlipidemia	$471-850/month	Ages 18+
Tagrisso	11/13/2015	Non-small cell lung cancer	$156K/year	All Ages
Darzalex	11/16/2015	Multiple Myeloma	$121K/year	Ages 18+
Uptravi	12/22/2015	Pulmonary Arterial Hypertension (PAH)	$178K/year	All Ages
Idelvion	3/4/2016	Hemophilia B	$470K/year	All Ages
Kovaltry	3/17/2016	Hemophilia A	$380K/year	All Ages
Spinraza	12/23/2016	Spinal Muscular Atrophy	$765K/year	All Ages
Kisqali	4/1/2017	Breast cancer	$130K/year	Female 55+
Imfinzi	4/1/2017	Non-small cell lung cancer	$125K-175K/year	Ages 12+
Brineura	4/27/2017	Neuronal ceroid lipofuscinosis	$200K-320K/year	Ages 3+
AGS-003	Q2 2018	Renal cell cancer	$80K-$100K/year	Adults 18+
Exondys	9/19/2016	Duchennes Muscular Dystrophy	up to $1M/year	All Ages
Rubraca	12/19/2016	Ovarian Cancer	$170K/year	Female 55-64
Radicava	6/16/2017	Amyotrophic lateral sclerosis	$500K/year	Adults 18+
Bavencio	3/23/2017	MERKEL CELL CARCINOMA	$150K/year	Age 12+

We computed PMPM adjustments for these drugs, and incorporated those adjustments into the final specialty pharmacy unit cost trend assumption.

Table 35 illustrates the PMPMs added to the specialty drugs for high-cost specialty drugs for each product that had a material rate impact. All other products which were identified in Table 34 but are not listed in Table 35 are grouped in the "Other" row.

Table 35
State of Nevada
Division of Health Care Financing and Policy
Managed Care CY 2018 Capitation Rates
High Cost Specialty Drug PMPM

Product	Check-up	TANF Kids	TANF Adults	Expansion
Orkambi	$ 0.03	$ 0.02	$ 0.00	$ 0.19
Kalydeco	0.49	0.23	-	-
Tagrisso	-	-	0.02	0.08
Uptravi	-	0.02	0.09	0.30
Idelvion	0.01	0.00	0.19	0.22
Kovaltry	0.01	0.01	0.05	0.05
Spinraza	0.07	0.09	0.02	0.04
Kisqali	-	-	0.21	0.45
Imfinzi	-	-	0.02	0.08
Exondys	0.69	0.37	-	-
Rubraca	-	-	0.01	0.02
Radicava	-	-	0.02	0.02
Other	-	-	0.01	0.03
Composite	**$ 1.29**	**$ 0.73**	**$ 0.63**	**$ 1.49**

Table 36 illustrates the total impact of trend for medical and pharmacy (excluding maternity).

Table 36
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Aggregate Annual Trend Impact

Population	Util/1,000	Unit cost	PMPM
TANF/Check-Up Children	2.9%	1.5%	4.4%
TANF Adults	3.8%	1.6%	5.4%
Expansion	4.0%	1.9%	6.1%
Composite	**3.7%**	**1.8%**	**5.5%**

(iii) Comparisons to historical trends:

Tables 29 and 30 illustrate results of our regression analysis relative to our selected trends.

b. *Components of trend:*

Tables 37 and 38 illustrate selected pharmacy trends, and Tables 29 and 308 illustrate selected medical trends. Note that the pharmacy trends in Tables 37 and 38 do not include the adjustment for new specialty drugs, or Hepatitis C.

Table 37
State of Nevada
Division of Health Care Financing and Policy
Managed Care CY 2018 Capitation Rates
Annual Pharmacy Utilization Factors

Service Line	TANF Adults	TANF Children	Check-up	Expansion
Generic	(0.5%)	(1.5%)	(1.5%)	0.5%
Brand	0.5%	(1.0%)	(1.0%)	1.0%
Specialty	5.0%	5.5%	5.5%	1.0%
Composite	**(0.4%)**	**(1.4%)**	**(1.4%)**	**0.6%**

Table 38
State of Nevada
Division of Health Care Financing and Policy
Managed Care CY 2018 Capitation Rates
Annual Pharmacy Unit Cost Trends

Service Line	TANF Adults	TANF Children	Check-Up	Expansion
Generic	2.0%	1.9%	1.9%	3.5%
Brand	6.0%	6.4%	6.4%	7.1%
Specialty	15.0%	11.3%	11.3%	9.1%
Composite	**6.5%**	**5.4%**	**5.7%**	**6.8%**
Previous	**11.7%**	**11.7%**	**12.6%**	**11.2%**

c. Variations in trend:

Selected trends vary by category of service and population, in the following way:

- Populations receiving different trend: TANF adults, children (TANF and Check-up), Expansion
- Categories of service receiving different trend: inpatient, inpatient maternity, inpatient behavioral health, outpatient, outpatient behavioral health, emergency room, physician, physician maternity, physician behavioral health, other, generic drugs, brand drugs, and specialty drugs.

These variations in trend were due to meaningful differences observed between populations in historical experience, and not because of differences in federal financial participation.

d. Other material adjustments to trend:

We did not make any other material adjustments to trend that have not been described in the section above.

e. Other non-material adjustments to trend:

There were no non-material adjustments made to trend.

Adjustments due to MHPAEA [Section I.3.B.iv]:

DHCFP has stated that there are no additional services required to comply with the standards of the Mental Health Parity and Addiction Equity Act.

In-lieu-of services [Section I.3.B.v]:

See section I.3.A.(v)-(vi) for a discussion around IMD data and assumptions. IMDs are the only in-lieu-of service in this rate certification.

Retrospective eligibility periods [Section I.3.B.vi]:

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 March 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 fee-for-service (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).

To account for this change, we summarized claims and membership from FFS waiting periods from January 1, 2015 through December 31, 2016. We excluded claims for targeted case management, school-based services, and residential treatment centers because these services will continue to be covered under fee-for-service arrangements. Other services that are carved out of managed care did not have a material impact.

We have appended these claims and member months to the base data used to project rates. After this initial adjustment, the FFS waiting period data is treated with the same adjustments as the managed care data. For example, the same trends that are applied to MCO data are applied to the FFS waiting period data. We have assumed that the MCOs will not be able to manage costs in the FFS waiting period to a lower level. You can see the impact of this data in the row labeled "Direct enrollment claims" in the Appendix B cost models.

Changes to covered benefits or services [Section I.3.B.vii]: See section I.2.B.(iii).(d)

Impact of changes to covered benefits or services [Section I.3.B.viii]: See section I.2.B.(iii).(d)

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Rate Development Standards [Section I.4.A.i]

There are no incentive arrangements between the MCOs and DHCFP.

Appropriate Documentation [Section I.4.A.ii]

Not applicable.

Withhold Arrangements [Section I.4.B]

Rate Development Standards [Section I.4.B.i]

There are no withhold arrangements effective during CY 2018.

Appropriate Documentation [Section I.4.B.ii]

Not applicable.

Risk-Sharing Mechanisms [Section I.4.C]

Rate Development Standards [Section I.4.C.i]

See section I.4.C.ii.

Appropriate Documentation [Section I.4.C.ii]

a. Description of risk-sharing mechanisms: The rate certification and supporting documentation must include a description of any other risk-sharing arrangements, such as a risk corridor or a large claims pool. An adequate description of these includes at least the following:

The delivery case rate and the low birth weight kick payment are programs through which the state and MCOs better distribute risk for high-cost events. These programs are discussed throughout this report as part of the rate setting process.

Additionally, DHCFP is currently developing a risk corridor for high-cost drugs to apply to the rating period CY 2018. The parameters of this risk corridor are not known at this time, though it is not expected to impact the rates in this certification.

(i) Rationale:

The rationale for the high-cost drug risk corridor is to mitigate the risk of any plan bearing a disproportionate cost burden for high-cost pharmacy costs.

(ii) Implementation:

This is not known at this time.

(iii) Effect on rates:

The high-cost drug risk corridor is not expected to have any impact on the rates certified herein.

(iv) Documentation of compliance:

This is not known at this time, though documentation will be provided once the risk corridor is fully developed.

b. MLR risk-sharing arrangement:

MCOs are required to provide periodic reports of Medical Loss Ratio (MLR), in a time and manner established by the State, and in accordance with CMS' methodology [Id. § 438.8(e)]. Reports must be no later than within 12 months of the end of a year for which the MLR pertains. All third party vendors providing claims adjudications activities are required to provide all underlying data associated with MLR reporting to the vendor within 180 days of the end of the MLR reporting year, or within 30 days of a request by the vendor (whichever comes sooner) to calculate and validate the accuracy of MLR reporting. The state will collect a remittance for the applicable years in which the vendor's MLR falls below 85%.

c. Reinsurance requirements:

Under the current MCO contract, the state reimburses plans for 75% of inpatient hospital costs above $100,000 for any individual member. The terms of this stop loss provision are not changing in the contract effective January 1, 2018.

Because reinsurance recoveries are included in the encounter information provided by the health plans, the initial cost models are on a gross claims basis. Using the claims information provided, expected stop loss recoveries were calculated by individual, then summarized and removed as a bottom line adjustment to each cost model. This bottom line adjustment ensures that the calculated capitation rates do not include the expected cost of claims that are to be reimbursed by the state under the stop loss provision. As a result, the stop loss adjustment is revenue neutral to the state on an aggregate expected basis.

Reinsurance recoveries are projected using the hospital inpatient medical/surgical trend, with a leveraging factor of 1.50 applied to trend.

Table 39 shows the impact of reinsurance recoveries on the rates, including direct enrollment membership and claims:

Table 39
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Impact of Stop-Loss
CY 15-16 for TANF and Check-up, CY 16 for Expansion

Population	Claim Count	Un-trended Stop-Loss PMPM	Percent of IP PMPM
TANF	266	$ 2.00	6.2%
Check-Up	1	0.16	2.0%
Expansion	112	2.60	5.1%

The reinsurance mechanism has been developed in accordance with generally accepted actuarial principles and practices.

An adjustment is made to the projected medical cost which serves as the basis of capitation rates. The PMPM amount for each rate cell can be found in Appendix B.

Delivery System and Provider Payment Initiatives [Section I.4.D]

Rate Development Standards [Section I.4.D.i]

Not applicable

Appropriate Documentation [Section I.4.D.ii]

Not applicable.

Pass-Through Payments [Section I.4.E]

Rate Development Standards [Section I.4.E.i]

See section I.4.E.ii

Appropriate Documentation [Section I.4.E.ii]

a. Description of pass-through payments:

(i) Description of the pass-through payment:

Effective January 2014, capitation rates include an amount intended to ensure access to safety net providers. In CY 2018, the only provider receiving a safety net payment will be University Medical Center (UMC), a hospital in Clark County.

(ii) Amount of pass-through payment:

Safety net payments are shown in Appendix G. Note that the payments with a 3.50% premium tax apply to Amerigroup and SilverSummit, and the payments with a 3.33% premium tax apply to HPN.

(iii) Providers receiving the pass-through payment:

UMC is the only provider receiving a pass-through payment in CY 2018.

(iv) Financing mechanism:

The safety net is financed through intergovernmental transfers.

(v) Pass-through payments in previous rating periods (v)-(vi):

See Appendix G-2.

b. Hospital pass-through payments: The certification must document the following information about the base amount for hospital pass-through payments:

(i) Calculation of the base amount:

The base amount was determined by taking the difference between:

- The amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO contracts for the 12-month period immediately two years prior to the rating period (CY 2016) and
- The amount the MCOs paid (not including pass-through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO contracts for the 12-month period immediately 2 years prior to the rating period (CY 2016).

The base amount was not trended forward. This calculation is shown in Table 40 and Appendix G.

Table 40
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Development of Pass-through Payment - UMC

	TANF/Check-up	Expansion	Note
Experience Claims			
CY2016 Member Months	3,299,220	2,126,307	(1)
CY2016 Paid Claims	$ 22,066,083	$ 23,878,489	(2)
CY2016 PMPM	$ 6.69	$ 11.23	(3)=(2)/(1)
Annual PMPM Trend [(1)]	3.5%	5.5%	(4)
Projected CY2018 PMPM	$ 7.17	$ 12.50	(5)=(3)*[1+(4)]^2
Medicare Repriced			
CY 2016 Repriced Paid Claims	$ 57,873,972	$ 54,656,579	(6)
CY2016 Repriced PMPM	$ 17.54	$ 25.70	(7)=(6)/(1)
Annual PMPM Trend [(2)]	6.4%	7.1%	(8)
Projected CY2018 Repriced PMPM	$ 19.88	$ 29.50	(9)=(7)*[1+(8)]^2
Initial Enhancement Payment	**$ 12.71**	**$ 17.00**	**(10)=(9)-(5)**
Base Amount Calculation			
Base Amount in Dollars	$ 35,807,889	$ 30,778,091	(11)=(6)-(2)
Base Amount PMPM (Max Enhancement)	$ 10.85	$ 14.47	(12)=(11)/(1)
Final Enhancement Payment	**$ 10.85**	**$ 14.47**	**(13)=min[(10),(12)]**

Note: (1) Utilization and cost trend applied to experience claims are from CY2018 capitation rate development.
(2) Utilization trend applied to Medicare repriced claims is from CY2018 capitation rate development, and cost trend is from 2018 Milliman Standard Part C Trend.

(ii) Aggregate amounts:

The aggregate amounts calculated for Section I, Item 4.E.i.c.i.A, and Section I, Item 4.E.i.c.i.B are shown in Appendix F. Amounts described in Section I, Item 4.E.i.c.ii.A, and Section I, Item 4.E.i.c.ii.B do not apply.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Rate Development Standards [Section I.5.A]

See Section I.5.B.

Appropriate Documentation [Section I.5.B]

Description of non-benefit cost projection [Section I.5.B.i]:

Administration loads are taken directly from the bids submitted as part of the bidding process to award contracts for Nevada's MCOs. Amerigroup and HPN bid a load equal to 10.5% of premium, and SilverSummit bid 10.0% to cover administration and risk margin. Though it is not specified in the contract, nor does it impact rate development, we consider these loads as being comprised of 9.0% administrative cost, with the remainder representing risk margin. The administrative load is added as a percentage of premium.

This administrative load is applicable to the total of DCR, LBW, and medical costs (excluding the Safety Net and PCP enhancements), and is loaded equally on each component. This is a change from our prior rate settings where the administrative load was disproportionately loaded on to the medical costs. The same load is applied to each population.

We have compared this load to actual administrative costs as filed by participating MCOs as well as loads added to capitation rates in other state Medicaid programs. Both of these comparisons lead us to believe that the 10.5% and 10.0% loads are reasonable.

Amerigroup and SilverSummit rates include an additional 3.5% load for premium tax. HPN rates include a lower premium tax rate of 3.33%. This lower rate is based on HPN's estimate of a tax credit they will receive as a Nevada-domiciled company. We have accepted HPN's estimate for use in our rate development for CY18, with the understanding that any difference will be reconciled with the state.

Categories of non-benefit costs [Section I.5.B.ii]:

In Table 41, we have estimated the projected non-benefit costs by category of costs. Administration varies by MCO according to their amount bid during re-procurement. Note that premium tax is applied on top of the administration load.

Table 41
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Non-Benefit Costs as a % of Premium

Component of Non-Benefit Cost	Amerigroup	HPN	SilverSummit
Administrative Costs	9.0%	9.0%	9.0%
Contribution to reserves/risk margin	1.5%	1.5%	1.0%
Sum of components	**10.5%**	**10.5%**	**10.0%**
Premium Tax	3.5%	3.33%	3.5%

Health Insurance Providers Fee [Section I.5.B.iii]:

The Health Insurance Providers Fee (HIPF) is not included in these rates. An updated certification for these rates in the fall of 2019 will include the HIPF. The following describes the assumptions that will be used in the development of the HIPF adjustment amounts as well as the methods to apply these changes.

- Each health plan will provide its final notice of the fee amount as reported by the United States Internal Revenue Service.
- We will review each health plan's allocation of the final notice fee amount to the Nevada Medicaid programs.
- We will use health plan nationwide premiums and Nevada Medicaid premiums as well as the total HIPF reported by the IRS to estimate the impact of the HIPF on Nevada Medicaid Calendar Year 2015 rates. We will then multiply this value by a factor of 1 / (1 – 35%) to account for the fee amount for federal income tax. A similar adjustment will be made to account for the appropriate state premium tax.
- A required rate increase will be calculated by comparing the resulting HIPF reimbursement to capitation paid in 2018. The calculated increase due to HIPF will be applied to the 2018 capitation rates.

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Rate Development Standards [Section I.6.A]

See Section 1.6.B.

Appropriate Documentation [Section I.6.B]

Not applicable. These rates do not contain any risk adjustment or acuity adjustment factors. It is our intention to perform a retrospective risk adjustment calculation at the end of the rating period and we will issue an updated certification at that time.

M4. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS [SECTION II]

Not applicable, these services are not covered under the Nevada Managed Care contracts.

M5. NEW ADULT GROUP CAPITATION RATES [SECTION III]

DATA [SECTION III.1]

Description of data used [Section III.1.A]:

See sections I.1.B.i.(a) and I.2.B.iii.

Prior Expansion rates [Section III.1.B]:

New data [Section III.1.B.i]:

There is no new data available for this rate setting except for more months of available historical experience.

Cost monitoring [Section III.1.B.ii]:

We have rebased the rates using the most recent data available, and we have updated our duration and cohort analyses in order to monitor costs.

Retrospective analysis [Section III.1.B.iii]:

Table 42 illustrates age-gender adjusted PMPMs from the July 2017 rate development compared to age-gender adjusted PMPMs from the CY 2018 rate development.

Table 42
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Comparison of Expansion Rate Components

Service Category	2017 H2 Rates	2018 Rates	% Difference
Inpatient	$ 80.74	$ 104.01	28.8%
Outpatient	38.61	43.83	13.5%
Professional/Other	134.72	121.17	(10.1%)
Pharmacy	108.74	100.37	(7.7%)
Total	362.81	369.38	1.8%

** Rates include trend and fee schedule adjustments and exclude safety net, ABA adjustments, and duration adjustments.*
2018 rates include Direct Enrollment.

Adjustments due to retrospective analysis [Section III.1.B.iv]:

No actual-to-expected adjustment was made.

PROJECTED BENEFIT COSTS [SECTION III.2]

Summary of assumptions [Section III.2.A]:

[Section III.2.A.i]:

a. Data used:

See section I.1.B.i.(a).

b. Changes in data sources:

There are no changes in data sources that specifically apply to Expansion rates.

c. Changes to assumptions:

(i) Acuity or health status adjustments

There are no acuity or health status adjustments that apply specifically to the Expansion rates. This has not changed from the prior rate setting period.

(ii) Pent-up demand:

To evaluate the impact of duration, we conducted a study reviewing cost during our experience period for Expansion membership, separated by months since enrollment. Due to credibility concerns, we averaged monthly cost factors into durational quarters. Furthermore, because of the limited data available for membership with enrollment of more than three years, we assumed that costs stabilized after three years. To estimate the impact of duration into our projection period, we did the following:

- Disenrollment rates were calculated based on historical data by duration, and were averaged together for every duration quarter year.
- New membership each month was determined in order to match our enrollment projections, and was held steady between April, 2017 and December, 2018.
- We adjusted the claims for age/gender mix, and monthly trend.

The estimated impact of duration for rates effective January 1, 2018 was calculated to be a reduction of less than 0.5%, which is within an interval of potential estimation error. As such, we did not apply an explicit adjustment.

(iii) Adverse selection:

To evaluate the impact of adverse selection, we conducted a cohort study by grouping members into month of initial enrollment and calculating their average costs. Due to credibility concerns, we averaged monthly cost factors into six-month enrollment cohorts. Furthermore, because of the limited data available for membership with initial enrollment in 2017, we assumed that all cohorts beginning in 2017 would have average costs consistent with the average spending for both six-month cohorts enrolling in 2016. To estimate the impact of the unwinding of anti-selection in our projection period, we made the same lapse and enrollment assumptions described earlier for the duration analysis. Additionally, we adjusted the claims for age/gender mix, and monthly trend.

The expected impact of this cohort analysis for rates effective January 1, 2018 was a reduction of 1%. When combined with the estimated duration adjustment described above, the estimated impact was within an interval of potential estimation error. As such, we did not apply an explicit adjustment.

(iv) Demographics:

There are no demographic adjustments that apply specifically to the Expansion rates. This has not changed from the prior rate setting period.

(v) Delivery system differences:

There are no delivery system adjustments that apply specifically to the Expansion rates. This has not changed from the prior rate setting period.

(vi) Other:

There are no other adjustments that apply specifically to the Expansion rates. This has not changed from the prior rate setting period.

Key assumptions to include [Section III.2.B]: See section II.2.A

Benefit plan changes [Section III.2.C]:

There are no changes to the benefit plan that apply specifically to the Expansion rates.

Other material changes [Section III.2.D]:

There are no other material changes that apply specifically to the Expansion rates.

PROJECTED NON-BENEFIT COSTS [SECTION III.3]

New adult non-benefit costs [Section III.3.A] See section I.5

Comparison to other populations [Section III.3.B]: See section I.5

FINAL CERTIFIED RATES OR RATE RANGES [SECTION III.4]

[Section III.4.A]

Comparison to prior rates [Section III.4.A.i]:

See Appendix G.

Description of other material changes [Section III.4.A.ii]:

All material changes are described elsewhere in this report.

RISK MITIGATION STRATEGIES [SECTION III.5]

Description of risk mitigation strategy [Section III.5.A.i]:

Not applicable

Additional risk mitigation information [Section III.5.B]:

There is no change to the risk mitigation strategy relative to the 2017 rates.

M6. DATA RELIANCE AND CAVEATS

We have modeled total costs in a managed care environment based on prior managed care data. The managed care assumptions implicit in these rates may not be realized.

This analysis is intended for the use of the State of Nevada DHCFP in support of the Medicaid managed care programs. We understand that this information will be shared with other parties. To the extent that the information contained in this report is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report 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. It is the responsibility of any MCO to make an independent determination as to the adequacy of the proposed capitation rates for their organization.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual MCO experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

This analysis has relied extensively on data provided by DHCFP and its 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. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

The terms of Milliman's contract with the Nevada Division of Health Care Financing and Policy, as amended April 12, 2016, apply to this report and its use.

M7. ACTUARIAL CERTIFICATION

I, Jennifer L. Gerstorff, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Nevada Division of Health Care Financing and Policy (DHCFP) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the twelve-month period of calendar year (CY) 2018. At the end of this period, the capitation rates will be updated for calendar year 2019.

To the best of my information, knowledge and belief, for the CY 2018 period, the capitation rates offered by DHCFP are actuarially sound and comply with the requirements of 42 CFR § 438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to 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.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the State of Nevada and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

The capitation rates developed herein may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHCFP. The health plan may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

September 29, 2017

Jennifer L. Gerstorff, FSA, MAAA
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Date

APPENDIX A

Appendix A-1
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed State & Federal Rates - Excluding IMD long-stay, Composite

TANF/CHAP	**Proj. 2018**	**Capitation Rates***		**%**	**Cap. Rates Net Pass-through**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**	**CY 2018**	**Jul-Dec 2017**	**Rate Change**
Males & Females; < 1yr old	189,650	$ 657.25	$ 564.39	16.5%	$ 616.54	$ 535.01	15.2%
Males & Females; 1 - 2 yrs old	323,863	136.16	130.59	4.3%	127.76	123.35	3.6%
Males & Females; 3 - 14 yrs old	1,577,262	101.26	99.44	1.8%	95.03	93.95	1.2%
Females; 15 - 18 yrs old	176,843	141.09	144.78	(2.5%)	132.36	136.68	(3.2%)
Males; 15 - 18 yrs old	170,546	118.19	112.34	5.2%	110.91	106.10	4.5%
Females; 19 - 34 yrs old	350,085	275.38	270.29	1.9%	258.32	255.15	1.2%
Males; 19 - 34 yrs old	63,263	193.02	157.62	22.5%	181.07	148.79	21.7%
Females; 35+ yrs old	171,788	456.25	423.07	7.8%	427.98	399.38	7.2%
Males; 35+ yrs old	63,586	442.06	347.78	27.1%	414.67	328.30	26.3%
Composite Southern Region	3,086,885	$ 190.70	$ 178.28	7.0%	$ 178.92	$ 168.48	6.2%
Northern Region							
Males & Females; < 1yr old	30,070	$ 542.72	$ 510.72	6.3%	$ 509.10	$ 485.58	4.8%
Males & Females; 1 - 2 yrs old	49,256	116.40	111.21	4.7%	109.21	105.05	4.0%
Males & Females; 3 - 14 yrs old	227,069	80.31	80.99	(0.8%)	75.37	76.52	(1.5%)
Females; 15 - 18 yrs old	24,146	129.06	127.11	1.5%	121.07	120.01	0.9%
Males; 15 - 18 yrs old	24,124	99.96	102.22	(2.2%)	93.80	96.53	(2.8%)
Females; 19 - 34 yrs old	50,363	242.77	245.58	(1.1%)	227.73	231.83	(1.8%)
Males; 19 - 34 yrs old	9,439	182.88	120.75	51.5%	171.56	114.00	50.5%
Females; 35+ yrs old	21,179	456.86	396.97	15.1%	428.56	374.74	14.4%
Males; 35+ yrs old	8,942	392.54	332.60	18.0%	368.22	313.98	17.3%
Composite Northern Region	444,587	$ 164.10	$ 156.66	4.7%	$ 153.95	$ 148.17	3.9%
SOBRA Case Rate	14,170	$ 5,425.72	$ 5,163.51	5.1%	$ 5,425.72	$ 5,163.51	5.1%
LBW Case Rate	187	$ 69,384.67	$ 65,198.43	6.4%	$ 69,384.67	$ 65,198.43	6.4%
TANF/CHAP Composite PMPM	3,531,471	$ 212.79	$ 199.72	6.5%	$ 201.22	$ 190.09	5.9%
Check-up							
Southern Region							
Males & Females; < 1yr old	2,090	$ 240.04	$ 182.51	31.5%	$ 225.17	$ 172.31	30.7%
Males & Females; 1 - 2 yrs old	14,251	132.06	125.28	5.4%	123.91	118.32	4.7%
Males & Females; 3 - 14 yrs old	171,129	112.60	112.37	0.2%	105.68	106.17	(0.5%)
Females; 15 - 18 yrs old	24,682	146.14	143.35	1.9%	137.09	135.35	1.3%
Males; 15 - 18 yrs old	24,984	122.57	121.75	0.7%	115.02	115.04	(0.0%)
Composite Southern Region	237,136	$ 119.43	$ 117.98	1.2%	$ 112.08	$ 111.45	0.6%
Northern Region							
Males & Females; < 1yr old	480	$ 225.93	$ 155.81	45.0%	$ 211.94	$ 147.09	44.1%
Males & Females; 1 - 2 yrs old	3,219	113.38	108.73	4.3%	106.41	102.64	3.7%
Males & Females; 3 - 14 yrs old	37,316	83.73	78.50	6.7%	78.59	74.19	5.9%
Females; 15 - 18 yrs old	5,467	124.18	140.75	(11.8%)	116.49	132.88	(12.3%)
Males; 15 - 18 yrs old	5,496	103.78	131.43	(21.0%)	97.36	124.10	(21.6%)
Composite Northern Region	51,977	$ 93.25	$ 93.23	0.0%	$ 87.51	$ 88.08	(0.6%)
SOBRA Case Rate	16	$ 5,425.76	$ 5,162.55	5.1%	$ 5,425.76	$ 5,162.55	5.1%
LBW Case Rate	-	$ 0.00	$ 0.00	0.0%	$ 0.00	$ 0.00	0.0%
Check-up Composite PMPM	289,113	$ 115.02	$ 113.81	1.1%	$ 107.96	$ 107.54	0.4%
Expansion							
Southern Region							
Females; 19 - 34 yrs old	467,432	$ 281.38	$ 247.41	13.7%	$ 272.75	$ 240.57	13.4%
Males; 19 - 34 yrs old	414,875	328.68	268.23	22.5%	318.61	260.82	22.2%
Females; 35+ yrs old	586,526	603.64	555.14	8.7%	585.12	539.78	8.4%
Males; 35+ yrs old	551,583	673.43	615.75	9.4%	652.78	598.72	9.0%
Composite Southern Region	2,020,416	$ 491.68	$ 441.58	11.3%	$ 476.60	$ 429.36	11.0%
Northern Region							
Females; 19 - 34 yrs old	74,218	$ 253.26	$ 210.88	20.1%	$ 245.49	$ 205.05	19.7%
Males; 19 - 34 yrs old	61,219	266.98	191.14	39.7%	258.79	185.86	39.2%
Females; 35+ yrs old	95,677	599.64	522.76	14.7%	581.25	508.30	14.4%
Males; 35+ yrs old	90,243	644.61	566.83	13.7%	624.84	551.16	13.4%
Composite Northern Region	321,357	$ 468.90	$ 399.93	17.2%	$ 454.52	$ 388.87	16.9%
SOBRA Case Rate	1,005	$ 5,425.98	$ 5,162.97	5.1%	$ 5,425.98	$ 5,162.97	5.1%
LBW Case Rate	-	$ 0.00	$ 0.00	0.0%	$ 0.00	$ 0.00	0.0%
Expansion Composite PMPM	2,341,773	$ 490.88	$ 438.08	12.1%	$ 475.89	$ 426.02	11.7%
Overall Composite PMPM	**6,162,357**	**$ 313.88**	**$ 286.27**	**9.6%**	**$ 301.22**	**$ 275.88**	**9.2%**

*Note: Each MCO has unique payment rates because of varying contracted rates for administrative cost and premium tax. This exhibit illustrates the estimated composite rates across MCOs

Appendix A-2
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed IMD Add-On Rates

	Amerigroup 10.5% Admin, 3.50% Tax				Health Plan of Nevada 10.5% Admin, 3.33% Tax in CY2018, 3.27% Tax in 2017H2				SilverSummit 10.0% Admin, 3.50% Tax			
TANF/CHAP	**Proj. 2018**	**Capitation Rates**		**%**	**Proj. 2018**	**Capitation Rates**		**%**	**Proj. 2018**	**Capitation Rates**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**
Males & Females; < 1yr old	86,709	$ 0.00	$ 0.00	0.0%	96,083	$ 0.00	$ 0.00	0.0%	6,858	$ 0.00	$ 0.00	0.0%
Males & Females; 1 - 2 yrs old	149,645	-	-	0.0%	162,504	-	-	0.0%	11,713	-	-	0.0%
Males & Females; 3 - 14 yrs old	659,844	-	-	0.0%	860,484	-	-	0.0%	56,933	-	-	0.0%
Females; 15 - 18 yrs old	66,978	-	-	0.0%	103,493	-	-	0.0%	6,372	-	-	0.0%
Males; 15 - 18 yrs old	63,307	-	-	0.0%	101,096	-	-	0.0%	6,143	-	-	0.0%
Females; 19 - 34 yrs old	150,346	0.48	1.31	(63.5%)	182,364	0.48	1.20	(60.2%)	17,375	0.48	1.26	(62.3%)
Males; 19 - 34 yrs old	25,109	-	0.15	(100.0%)	35,024	-	0.13	(100.0%)	3,130	-	0.14	(100.0%)
Females; 35+ yrs old	62,384	2.18	2.48	(12.2%)	100,930	2.17	2.21	(1.6%)	8,473	2.17	2.32	(6.7%)
Males; 35+ yrs old	23,066	1.91	0.93	105.1%	37,384	1.90	0.80	138.0%	3,136	1.90	0.85	123.1%
Composite Southern Region	1,287,388	$ 0.20	$ 0.29	(33.2%)	1,679,362	$ 0.22	$ 0.28	(20.7%)	120,134	$ 0.27	$ 0.37	(27.1%)
Northern Region												
Males & Females; < 1yr old	12,198	$ 0.00	$ 0.00	0.0%	16,787	$ 0.00	$ 0.00	0.0%	1,085	$ 0.00	$ 0.00	0.0%
Males & Females; 1 - 2 yrs old	20,236	-	-	0.0%	27,242	-	-	0.0%	1,777	-	-	0.0%
Males & Females; 3 - 14 yrs old	80,630	-	-	0.0%	138,243	-	-	0.0%	8,195	-	-	0.0%
Females; 15 - 18 yrs old	8,514	-	-	0.0%	14,760	-	-	0.0%	871	-	-	0.0%
Males; 15 - 18 yrs old	8,421	-	-	0.0%	14,833	-	-	0.0%	871	-	-	0.0%
Females; 19 - 34 yrs old	19,188	0.04	0.22	(81.5%)	28,684	0.04	0.19	(78.6%)	2,491	0.04	0.21	(80.7%)
Males; 19 - 34 yrs old	3,787	-	0.03	(100.0%)	5,184	-	0.02	(100.0%)	467	-	0.02	(100.0%)
Females; 35+ yrs old	7,461	-	0.18	(100.0%)	12,672	-	0.06	(100.0%)	1,046	-	0.12	(100.0%)
Males; 35+ yrs old	3,579	-	0.08	(100.0%)	4,920	-	0.04	(100.0%)	443	-	0.05	(100.0%)
Composite Northern Region	164,014	$ 0.00	$ 0.04	(86.9%)	263,327	$ 0.00	$ 0.02	(82.1%)	17,246	$ 0.01	$ 0.04	(85.1%)
TANF/CHAP Composite PMPM	1,451,403	$ 0.17	$ 0.26	(34.0%)	1,942,689	$ 0.19	$ 0.25	(21.6%)	137,380	$ 0.24	$ 0.33	(28.0%)
Check-up												
Southern Region												
Males & Females; < 1yr old	950	$ 0.00	$ 0.00	0.0%	1,097	$ 0.00	$ 0.00	0.0%	42	$ 0.00	$ 0.00	0.0%
Males & Females; 1 - 2 yrs old	6,789	-	-	0.0%	7,172	-	-	0.0%	290	-	-	0.0%
Males & Females; 3 - 14 yrs old	66,863	-	-	0.0%	100,788	-	-	0.0%	3,478	-	-	0.0%
Females; 15 - 18 yrs old	8,537	-	-	0.0%	15,643	-	-	0.0%	502	-	-	0.0%
Males; 15 - 18 yrs old	8,480	-	-	0.0%	15,996	-	-	0.0%	508	-	-	0.0%
Composite Southern Region	91,620	$ 0.00	$ 0.00	0.0%	140,696	$ 0.00	$ 0.00	0.0%	4,820	$ 0.00	$ 0.00	0.0%
Northern Region												
Males & Females; < 1yr old	177	$ 0.00	$ 0.00	0.0%	293	$ 0.00	$ 0.00	0.0%	10	$ 0.00	$ 0.00	0.0%
Males & Females; 1 - 2 yrs old	1,198	-	-	0.0%	1,956	-	-	0.0%	65	-	-	0.0%
Males & Females; 3 - 14 yrs old	12,448	-	-	0.0%	24,113	-	-	0.0%	754	-	-	0.0%
Females; 15 - 18 yrs old	1,842	-	-	0.0%	3,514	-	-	0.0%	111	-	-	0.0%
Males; 15 - 18 yrs old	1,846	-	-	0.0%	3,539	-	-	0.0%	111	-	-	0.0%
Composite Northern Region	17,512	$ 0.00	$ 0.00	0.0%	33,415	$ 0.00	$ 0.00	0.0%	1,051	$ 0.00	$ 0.00	0.0%
Check-up Composite PMPM	109,131	$ 0.00	$ 0.00	0.0%	174,111	$ 0.00	$ 0.00	0.0%	5,871	$ 0.00	$ 0.00	0.0%
Expansion												
Southern Region												
Females; 19 - 34 yrs old	186,865	$ 1.04	$ 1.61	(35.2%)	269,572	$ 1.04	$ 1.53	(31.9%)	10,995	$ 1.04	$ 1.55	(33.1%)
Males; 19 - 34 yrs old	155,359	1.25	2.86	(56.2%)	249,766	1.25	2.74	(54.3%)	9,750	1.25	2.78	(55.2%)
Females; 35+ yrs old	204,711	3.47	5.40	(35.8%)	368,043	3.46	5.18	(33.1%)	13,772	3.45	5.26	(34.4%)
Males; 35+ yrs old	199,371	5.56	8.49	(34.5%)	339,255	5.55	8.17	(32.0%)	12,957	5.53	8.27	(33.1%)
Composite Southern Region	746,306	$ 2.96	$ 4.75	(37.6%)	1,226,636	$ 3.06	$ 4.71	(35.0%)	47,474	$ 3.01	$ 4.71	(36.2%)
Northern Region												
Females; 19 - 34 yrs old	29,074	$ 1.52	$ 1.90	(19.9%)	43,234	$ 1.52	$ 1.82	(16.6%)	1,909	$ 1.51	$ 1.84	(17.8%)
Males; 19 - 34 yrs old	26,847	0.80	1.54	(48.3%)	32,795	0.79	1.49	(46.7%)	1,577	0.79	1.50	(47.3%)
Females; 35+ yrs old	38,410	0.68	1.70	(59.9%)	54,806	0.68	1.60	(57.4%)	2,462	0.68	1.63	(58.4%)
Males; 35+ yrs old	40,715	1.88	2.38	(21.2%)	47,202	1.87	2.25	(16.8%)	2,326	1.87	2.29	(18.5%)
Composite Northern Region	135,046	$ 1.25	$ 1.92	(35.0%)	178,037	$ 1.22	$ 1.81	(32.4%)	8,275	$ 1.23	$ 1.84	(33.3%)
Expansion Composite PMPM	881,352	$ 2.70	$ 4.31	(37.5%)	1,404,672	$ 2.83	$ 4.34	(34.9%)	55,749	$ 2.74	$ 4.29	(36.0%)
Overall Composite PMPM	**2,441,885**	**$ 1.08**	**$ 1.71**	**(37.2%)**	**3,521,472**	**$ 1.23**	**$ 1.87**	**(33.9%)**	**199,000**	**$ 0.93**	**$ 1.43**	**(34.7%)**

Appendix A-3
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed State & Federal Rates - Excluding IMD long-stay, by MCO
Amerigroup
10.5% Admin, 3.50% Tax

TANF/CHAP	**Proj. 2018**	**Capitation Rates**		**%**	**Cap. Rates Net Pass-through**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**	**CY 2018**	**Jul-Dec 2017**	**Rate Change**
Males & Females; < 1yr old	86,709	$ 657.96	$ 573.97	14.6%	$ 617.21	$ 544.10	13.4%
Males & Females; 1 - 2 yrs old	149,645	136.31	132.78	2.7%	127.90	125.42	2.0%
Males & Females; 3 - 14 yrs old	659,844	101.38	101.25	0.1%	95.15	95.66	(0.5%)
Females; 15 - 18 yrs old	66,978	141.26	147.60	(4.3%)	132.53	139.35	(4.9%)
Males; 15 - 18 yrs old	63,307	118.34	114.56	3.3%	111.04	108.20	2.6%
Females; 19 - 34 yrs old	150,346	275.71	275.12	0.2%	258.63	259.72	(0.4%)
Males; 19 - 34 yrs old	25,109	193.26	160.58	20.4%	181.30	151.59	19.6%
Females; 35+ yrs old	62,384	456.84	431.49	5.9%	428.54	407.34	5.2%
Males; 35+ yrs old	23,066	442.63	354.70	24.8%	415.21	334.84	24.0%
Composite Southern Region	1,287,388	$ 191.33	$ 181.83	5.2%	$ 179.51	$ 171.85	4.5%
Northern Region							
Males & Females; < 1yr old	12,198	$ 543.35	$ 520.24	4.4%	$ 509.70	$ 494.64	3.0%
Males & Females; 1 - 2 yrs old	20,236	116.53	113.27	2.9%	109.34	107.00	2.2%
Males & Females; 3 - 14 yrs old	80,630	80.41	82.63	(2.7%)	75.47	78.07	(3.3%)
Females; 15 - 18 yrs old	8,514	129.22	129.70	(0.4%)	121.22	122.45	(1.0%)
Males; 15 - 18 yrs old	8,421	100.08	104.32	(4.1%)	93.92	98.51	(4.7%)
Females; 19 - 34 yrs old	19,188	243.07	250.35	(2.9%)	228.02	236.34	(3.5%)
Males; 19 - 34 yrs old	3,787	183.11	123.00	48.9%	171.78	116.13	47.9%
Females; 35+ yrs old	7,461	457.46	405.01	12.9%	429.12	382.34	12.2%
Males; 35+ yrs old	3,579	393.02	338.82	16.0%	368.68	319.85	15.3%
Composite Northern Region	164,014	$ 168.22	$ 163.32	3.0%	$ 157.82	$ 154.48	2.2%
SOBRA Case Rate	5,616	$ 5,432.44	$ 5,170.36	5.1%	$ 5,432.44	$ 5,170.36	5.1%
LBW Case Rate	74	$ 69,470.58	$ 65,284.97	6.4%	$ 69,470.58	$ 65,284.97	6.4%
TANF/CHAP Composite PMPM	1,451,403	$ 213.28	$ 203.07	5.0%	$ 201.62	$ 193.23	4.3%
Check-up							
Southern Region							
Males & Females; < 1yr old	950	$ 240.29	$ 185.64	29.4%	$ 225.40	$ 175.27	28.6%
Males & Females; 1 - 2 yrs old	6,789	132.19	127.34	3.8%	124.03	120.27	3.1%
Males & Females; 3 - 14 yrs old	66,863	112.73	114.54	(1.6%)	105.80	108.22	(2.2%)
Females; 15 - 18 yrs old	8,537	146.31	146.32	(0.0%)	137.26	138.15	(0.6%)
Males; 15 - 18 yrs old	8,480	122.72	124.30	(1.3%)	115.16	117.45	(1.9%)
Composite Southern Region	91,620	$ 119.55	$ 120.09	(0.5%)	$ 112.19	$ 113.45	(1.1%)
Northern Region							
Males & Females; < 1yr old	177	$ 226.20	$ 158.92	42.3%	$ 212.19	$ 150.02	41.4%
Males & Females; 1 - 2 yrs old	1,198	113.51	110.89	2.4%	106.54	104.68	1.8%
Males & Females; 3 - 14 yrs old	12,448	83.83	80.16	4.6%	78.68	75.76	3.9%
Females; 15 - 18 yrs old	1,842	124.33	143.71	(13.5%)	116.64	135.67	(14.0%)
Males; 15 - 18 yrs old	1,846	103.91	134.19	(22.6%)	97.48	126.71	(23.1%)
Composite Northern Region	17,512	$ 93.68	$ 95.44	(1.8%)	$ 87.92	$ 90.16	(2.5%)
SOBRA Case Rate	5	$ 5,432.44	$ 5,170.36	5.1%	$ 5,432.44	$ 5,170.36	5.1%
LBW Case Rate	-	$ 69,470.58	$ 65,284.97	6.4%	$ 69,470.58	$ 65,284.97	6.4%
Check-up Composite PMPM	109,131	$ 115.67	$ 116.39	(0.6%)	$ 108.57	$ 109.97	(1.3%)
Expansion							
Southern Region							
Females; 19 - 34 yrs old	186,865	$ 281.70	$ 252.09	11.7%	$ 273.06	$ 245.12	11.4%
Males; 19 - 34 yrs old	155,359	329.07	273.53	20.3%	318.98	265.97	19.9%
Females; 35+ yrs old	204,711	604.38	566.57	6.7%	585.85	550.90	6.3%
Males; 35+ yrs old	199,371	674.24	628.18	7.3%	653.57	610.81	7.0%
Composite Southern Region	746,306	$ 484.94	$ 443.28	9.4%	$ 470.07	$ 431.03	9.1%
Northern Region							
Females; 19 - 34 yrs old	29,074	$ 253.55	$ 214.92	18.0%	$ 245.78	$ 208.98	17.6%
Males; 19 - 34 yrs old	26,847	267.27	194.52	37.4%	259.08	189.14	37.0%
Females; 35+ yrs old	38,410	600.33	532.62	12.7%	581.92	517.89	12.4%
Males; 35+ yrs old	40,715	645.29	576.61	11.9%	625.50	560.66	11.6%
Composite Northern Region	135,046	$ 473.01	$ 410.27	15.3%	$ 458.51	$ 398.93	14.9%
SOBRA Case Rate	377	$ 5,432.44	$ 5,170.36	5.1%	$ 5,432.44	$ 5,170.36	5.1%
LBW Case Rate	-	$ 69,470.58	$ 65,284.97	6.4%	$ 69,470.58	$ 65,284.97	6.4%
Expansion Composite PMPM	881,352	$ 485.43	$ 440.44	10.2%	$ 470.62	$ 428.32	9.9%
Overall Composite PMPM	**2,441,885**	**$ 307.15**	**$ 284.87**	**7.8%**	**$ 294.55**	**$ 274.36**	**7.4%**

Appendix A-3
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed State & Federal Rates - Excluding IMD long-stay, by MCO
Health Plan of Nevada
10.5% Admin, 3.33% Tax in CY2018, 3.27% Tax in 2017H2

TANF/CHAP	**Proj. 2018**	**Capitation Rates**		**%**	**Cap. Rates Net Pass-through**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**	**CY 2018**	**Jul-Dec 2017**	**Rate Change**
Males & Females; < 1yr old	96,083	$ 656.81	$ 555.99	18.1%	$ 616.13	$ 527.06	16.9%
Males & Females; 1 - 2 yrs old	162,504	136.07	128.63	5.8%	127.68	121.50	5.1%
Males & Females; 3 - 14 yrs old	860,484	101.20	98.08	3.2%	94.98	92.67	2.5%
Females; 15 - 18 yrs old	103,493	141.02	142.98	(1.4%)	132.29	134.98	(2.0%)
Males; 15 - 18 yrs old	101,096	118.13	110.97	6.5%	110.85	104.81	5.8%
Females; 19 - 34 yrs old	182,364	275.22	266.50	3.3%	258.18	251.58	2.6%
Males; 19 - 34 yrs old	35,024	192.92	155.55	24.0%	180.98	146.84	23.2%
Females; 35+ yrs old	100,930	456.03	417.97	9.1%	427.79	394.57	8.4%
Males; 35+ yrs old	37,384	441.85	343.59	28.6%	414.48	324.36	27.8%
Composite Southern Region	1,679,362	$ 189.55	$ 174.96	8.3%	$ 177.84	$ 165.34	7.6%
Northern Region							
Males & Females; < 1yr old	16,787	$ 542.40	$ 503.95	7.6%	$ 508.81	$ 479.15	6.2%
Males & Females; 1 - 2 yrs old	27,242	116.33	109.72	6.0%	109.14	103.64	5.3%
Males & Females; 3 - 14 yrs old	138,243	80.27	80.04	0.3%	75.33	75.62	(0.4%)
Females; 15 - 18 yrs old	14,760	128.99	125.64	2.7%	121.01	118.62	2.0%
Males; 15 - 18 yrs old	14,833	99.91	101.05	(1.1%)	93.75	95.43	(1.8%)
Females; 19 - 34 yrs old	28,684	242.65	242.51	0.1%	227.62	228.93	(0.6%)
Males; 19 - 34 yrs old	5,184	182.79	119.15	53.4%	171.48	112.50	52.4%
Females; 35+ yrs old	12,672	456.65	392.33	16.4%	428.37	370.37	15.7%
Males; 35+ yrs old	4,920	392.33	328.21	19.5%	368.03	309.84	18.8%
Composite Northern Region	263,327	$ 160.95	$ 152.01	5.9%	$ 151.00	$ 143.76	5.0%
SOBRA Case Rate	7,900	$ 5,422.89	$ 5,158.07	5.1%	$ 5,422.89	$ 5,158.07	5.1%
LBW Case Rate	104	$ 69,348.41	$ 65,129.74	6.5%	$ 69,348.41	$ 65,129.74	6.5%
TANF/CHAP Composite PMPM	1,942,689	$ 211.45	$ 196.31	7.7%	$ 199.98	$ 186.88	7.0%
Check-up							
Southern Region							
Males & Females; < 1yr old	1,097	$ 239.86	$ 179.83	33.4%	$ 225.01	$ 169.78	32.5%
Males & Females; 1 - 2 yrs old	7,172	131.96	123.35	7.0%	123.82	116.51	6.3%
Males & Females; 3 - 14 yrs old	100,788	112.53	110.95	1.4%	105.61	104.82	0.8%
Females; 15 - 18 yrs old	15,643	146.06	141.74	3.0%	137.02	133.83	2.4%
Males; 15 - 18 yrs old	15,996	122.50	120.40	1.7%	114.96	113.77	1.0%
Composite Southern Region	140,696	$ 119.37	$ 116.62	2.4%	$ 112.03	$ 110.17	1.7%
Northern Region							
Males & Females; < 1yr old	293	$ 225.80	$ 153.94	46.7%	$ 211.82	$ 145.32	45.8%
Males & Females; 1 - 2 yrs old	1,956	113.31	107.42	5.5%	106.35	101.41	4.9%
Males & Females; 3 - 14 yrs old	24,113	83.68	77.65	7.8%	78.55	73.39	7.0%
Females; 15 - 18 yrs old	3,514	124.11	139.21	(10.8%)	116.43	131.42	(11.4%)
Males; 15 - 18 yrs old	3,539	103.72	129.99	(20.2%)	97.31	122.75	(20.7%)
Composite Northern Region	33,415	$ 93.04	$ 92.08	1.0%	$ 87.31	$ 86.99	0.4%
SOBRA Case Rate	10	$ 5,422.89	$ 5,158.07	5.1%	$ 5,422.89	$ 5,158.07	5.1%
LBW Case Rate	-	$ 69,348.41	$ 65,129.74	6.5%	$ 69,348.41	$ 65,129.74	6.5%
Check-up Composite PMPM	174,111	$ 114.63	$ 112.21	2.2%	$ 107.60	$ 106.02	1.5%
Expansion							
Southern Region							
Females; 19 - 34 yrs old	269,572	$ 281.21	$ 244.20	15.2%	$ 272.58	$ 237.45	14.8%
Males; 19 - 34 yrs old	249,766	328.50	264.97	24.0%	318.42	257.65	23.6%
Females; 35+ yrs old	368,043	603.32	548.82	9.9%	584.82	533.64	9.6%
Males; 35+ yrs old	339,255	673.06	608.50	10.6%	652.42	591.67	10.3%
Composite Southern Region	1,226,636	$ 495.86	$ 440.58	12.5%	$ 480.65	$ 428.40	12.2%
Northern Region							
Females; 19 - 34 yrs old	43,234	$ 253.10	$ 208.19	21.6%	$ 245.34	$ 202.43	21.2%
Males; 19 - 34 yrs old	32,795	266.80	188.42	41.6%	258.62	183.21	41.2%
Females; 35+ yrs old	54,806	599.28	515.93	16.2%	580.90	501.66	15.8%
Males; 35+ yrs old	47,202	644.16	558.55	15.3%	624.40	543.10	15.0%
Composite Northern Region	178,037	$ 465.87	$ 392.17	18.8%	$ 451.58	$ 381.33	18.4%
SOBRA Case Rate	604	$ 5,422.89	$ 5,158.07	5.1%	$ 5,422.89	$ 5,158.07	5.1%
LBW Case Rate	-	$ 69,348.41	$ 65,129.74	6.5%	$ 69,348.41	$ 65,129.74	6.5%
Expansion Composite PMPM	1,404,672	$ 494.39	$ 436.67	13.2%	$ 479.30	$ 424.65	12.9%
Overall Composite PMPM	**3,521,472**	**$ 319.52**	**$ 288.03**	**10.9%**	**$ 306.83**	**$ 277.73**	**10.5%**

Appendix A-3
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed State & Federal Rates - Excluding IMD long-stay, by MCO
SilverSummit
10.5% Admin, 3.33% Tax in CY2018, 3.27% Tax in 2017H2

TANF/CHAP	**Proj. 2018**	**Capitation Rates**		**%**	**Cap. Rates Net Pass-through**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**	**CY 2018**	**Jul-Dec 2017**	**Rate Change**
Males & Females; < 1yr old	6,858	$ 654.54	$ 561.01	16.7%	$ 613.79	$ 531.64	15.5%
Males & Females; 1 - 2 yrs old	11,713	135.60	129.86	4.4%	127.19	122.62	3.7%
Males & Females; 3 - 14 yrs old	56,933	100.85	99.02	1.8%	94.62	93.53	1.2%
Females; 15 - 18 yrs old	6,372	140.53	144.25	(2.6%)	131.79	136.13	(3.2%)
Males; 15 - 18 yrs old	6,143	117.72	112.02	5.1%	110.43	105.77	4.4%
Females; 19 - 34 yrs old	17,375	274.27	268.21	2.3%	257.19	253.07	1.6%
Males; 19 - 34 yrs old	3,130	192.25	156.99	22.5%	180.29	148.15	21.7%
Females; 35+ yrs old	8,473	454.45	421.79	7.7%	426.16	398.04	7.1%
Males; 35+ yrs old	3,136	440.32	346.77	27.0%	412.91	327.25	26.2%
Composite Southern Region	120,134	$ 200.08	$ 186.68	7.2%	$ 187.65	$ 176.34	6.4%
Northern Region							
Males & Females; < 1yr old	1,085	$ 540.52	$ 508.35	6.3%	$ 506.87	$ 483.18	4.9%
Males & Females; 1 - 2 yrs old	1,777	115.92	110.71	4.7%	108.73	104.54	4.0%
Males & Females; 3 - 14 yrs old	8,195	80.00	80.79	(1.0%)	75.05	76.31	(1.7%)
Females; 15 - 18 yrs old	871	128.55	126.71	1.4%	120.55	119.59	0.8%
Males; 15 - 18 yrs old	871	99.56	101.95	(2.3%)	93.40	96.24	(3.0%)
Females; 19 - 34 yrs old	2,491	241.81	244.28	(1.0%)	226.75	230.50	(1.6%)
Males; 19 - 34 yrs old	467	182.15	120.20	51.5%	170.82	113.45	50.6%
Females; 35+ yrs old	1,046	455.07	395.75	15.0%	426.74	373.46	14.3%
Males; 35+ yrs old	443	390.97	331.10	18.1%	366.63	312.45	17.3%
Composite Northern Region	17,246	$ 172.99	$ 164.37	5.2%	$ 162.24	$ 155.37	4.4%
SOBRA Case Rate	653	$ 5,402.26	$ 5,170.36	4.5%	$ 5,402.26	$ 5,170.36	4.5%
LBW Case Rate	9	$ 69,084.63	$ 65,284.97	5.8%	$ 69,084.63	$ 65,284.97	5.8%
TANF/CHAP Composite PMPM	137,380	$ 226.70	$ 212.56	6.7%	$ 214.48	$ 202.39	6.0%
Check-up							
Southern Region							
Males & Females; < 1yr old	42	$ 239.03	$ 181.55	31.7%	$ 224.15	$ 171.35	30.8%
Males & Females; 1 - 2 yrs old	290	131.50	124.54	5.6%	123.35	117.59	4.9%
Males & Females; 3 - 14 yrs old	3,478	112.14	112.01	0.1%	105.21	105.79	(0.5%)
Females; 15 - 18 yrs old	502	145.55	143.09	1.7%	136.49	135.06	1.1%
Males; 15 - 18 yrs old	508	122.08	121.56	0.4%	114.52	114.83	(0.3%)
Composite Southern Region	4,820	$ 118.95	$ 117.62	1.1%	$ 111.59	$ 111.08	0.5%
Northern Region							
Males & Females; < 1yr old	10	$ 225.02	$ 155.42	44.8%	$ 211.01	$ 146.67	43.9%
Males & Females; 1 - 2 yrs old	65	112.92	108.45	4.1%	105.95	102.35	3.5%
Males & Females; 3 - 14 yrs old	754	83.39	78.39	6.4%	78.25	74.06	5.6%
Females; 15 - 18 yrs old	111	123.69	140.53	(12.0%)	115.99	132.63	(12.5%)
Males; 15 - 18 yrs old	111	103.37	131.24	(21.2%)	96.94	123.89	(21.8%)
Composite Northern Region	1,051	$ 92.88	$ 93.09	(0.2%)	$ 87.14	$ 87.92	(0.9%)
SOBRA Case Rate	0	$ 5,402.26	$ 5,170.36	4.5%	$ 5,402.26	$ 5,170.36	4.5%
LBW Case Rate	-	$ 69,084.63	$ 65,284.97	5.8%	$ 69,084.63	$ 65,284.97	5.8%
Check-up Composite PMPM	5,871	$ 114.58	$ 113.51	0.9%	$ 107.51	$ 107.22	0.3%
Expansion							
Southern Region							
Females; 19 - 34 yrs old	10,995	$ 280.19	$ 246.48	13.7%	$ 271.55	$ 239.63	13.3%
Males; 19 - 34 yrs old	9,750	327.30	267.47	22.4%	317.21	260.04	22.0%
Females; 35+ yrs old	13,772	601.13	553.99	8.5%	582.59	538.59	8.2%
Males; 35+ yrs old	12,957	670.61	614.24	9.2%	649.94	597.16	8.8%
Composite Southern Region	47,474	$ 489.53	$ 440.37	11.2%	$ 474.43	$ 428.13	10.8%
Northern Region							
Females; 19 - 34 yrs old	1,909	$ 252.18	$ 210.16	20.0%	$ 244.41	$ 204.32	19.6%
Males; 19 - 34 yrs old	1,577	265.83	190.20	39.8%	257.64	184.92	39.3%
Females; 35+ yrs old	2,462	597.10	520.80	14.7%	578.69	506.32	14.3%
Males; 35+ yrs old	2,326	641.82	563.82	13.8%	622.03	548.14	13.5%
Composite Northern Region	8,275	$ 466.94	$ 398.20	17.3%	$ 452.54	$ 387.13	16.9%
SOBRA Case Rate	24	$ 5,402.26	$ 5,170.36	4.5%	$ 5,402.26	$ 5,170.36	4.5%
LBW Case Rate	-	$ 69,084.63	$ 65,284.97	5.8%	$ 69,084.63	$ 65,284.97	5.8%
Expansion Composite PMPM	55,749	$ 488.49	$ 436.33	12.0%	$ 473.50	$ 424.26	11.6%
Overall Composite PMPM	**199,000**	**$ 296.73**	**$ 272.33**	**9.0%**	**$ 283.89**	**$ 261.74**	**8.5%**

Appendix A-4
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed Total MCO Rates
Amerigroup
10.5% Admin, 3.50% Tax

TANF/CHAP	**Proj. 2018**	**Capitation Rates**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**
Males & Females; < 1yr old	86,709	$ 657.96	$ 573.97	14.6%
Males & Females; 1 - 2 yrs old	149,645	136.31	132.78	2.7%
Males & Females; 3 - 14 yrs old	659,844	101.38	101.25	0.1%
Females; 15 - 18 yrs old	66,978	141.26	147.60	(4.3%)
Males; 15 - 18 yrs old	63,307	118.34	114.56	3.3%
Females; 19 - 34 yrs old	150,346	276.19	276.43	(0.1%)
Males; 19 - 34 yrs old	25,109	193.26	160.73	20.2%
Females; 35+ yrs old	62,384	459.01	433.97	5.8%
Males; 35+ yrs old	23,066	444.54	355.63	25.0%
Composite Southern Region	1,287,388	$ 191.52	$ 182.12	5.2%
Northern Region				
Males & Females; < 1yr old	12,198	$ 543.35	$ 520.24	4.4%
Males & Females; 1 - 2 yrs old	20,236	116.53	113.27	2.9%
Males & Females; 3 - 14 yrs old	80,630	80.41	82.63	(2.7%)
Females; 15 - 18 yrs old	8,514	129.22	129.70	(0.4%)
Males; 15 - 18 yrs old	8,421	100.08	104.32	(4.1%)
Females; 19 - 34 yrs old	19,188	243.11	250.57	(3.0%)
Males; 19 - 34 yrs old	3,787	183.11	123.03	48.8%
Females; 35+ yrs old	7,461	457.46	405.19	12.9%
Males; 35+ yrs old	3,579	393.02	338.90	16.0%
Composite Northern Region	164,014	$ 168.22	$ 163.36	3.0%
SOBRA Case Rate	5,616	$ 5,432.44	$ 5,170.36	5.1%
LBW Case Rate	74	$ 69,470.58	$ 65,284.97	6.4%
TANF/CHAP Composite PMPM	1,451,403	$ 213.45	$ 203.34	5.0%
Check-up				
Southern Region				
Males & Females; < 1yr old	950	$ 240.29	$ 185.64	29.4%
Males & Females; 1 - 2 yrs old	6,789	132.19	127.34	3.8%
Males & Females; 3 - 14 yrs old	66,863	112.73	114.54	(1.6%)
Females; 15 - 18 yrs old	8,537	146.31	146.32	(0.0%)
Males; 15 - 18 yrs old	8,480	122.72	124.30	(1.3%)
Composite Southern Region	91,620	$ 119.55	$ 120.09	(0.5%)
Northern Region				
Males & Females; < 1yr old	177	$ 226.20	$ 158.92	42.3%
Males & Females; 1 - 2 yrs old	1,198	113.51	110.89	2.4%
Males & Females; 3 - 14 yrs old	12,448	83.83	80.16	4.6%
Females; 15 - 18 yrs old	1,842	124.33	143.71	(13.5%)
Males; 15 - 18 yrs old	1,846	103.91	134.19	(22.6%)
Composite Northern Region	17,512	$ 93.68	$ 95.44	(1.8%)
SOBRA Case Rate	5	$ 5,432.44	$ 5,170.36	5.1%
LBW Case Rate	-	$ 69,470.58	$ 65,284.97	6.4%
Check-up Composite PMPM	109,131	$ 115.67	$ 116.39	(0.6%)
Expansion				
Southern Region				
Females; 19 - 34 yrs old	186,865	$ 282.75	$ 253.70	11.4%
Males; 19 - 34 yrs old	155,359	330.33	276.39	19.5%
Females; 35+ yrs old	204,711	607.85	571.97	6.3%
Males; 35+ yrs old	199,371	679.81	636.67	6.8%
Composite Southern Region	746,306	$ 487.90	$ 448.03	8.9%
Northern Region				
Females; 19 - 34 yrs old	29,074	$ 255.07	$ 216.82	17.6%
Males; 19 - 34 yrs old	26,847	268.07	196.06	36.7%
Females; 35+ yrs old	38,410	601.01	534.32	12.5%
Males; 35+ yrs old	40,715	647.17	578.99	11.8%
Composite Northern Region	135,046	$ 474.26	$ 412.19	15.1%
SOBRA Case Rate	377	$ 5,432.44	$ 5,170.36	5.1%
LBW Case Rate	-	$ 69,470.58	$ 65,284.97	6.4%
Expansion Composite PMPM	881,352	$ 488.13	$ 444.75	9.8%
Overall Composite PMPM	**2,441,885**	**$ 308.22**	**$ 286.58**	**7.6%**

Appendix A-4
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed Total MCO Rates
Health Plan of Nevada
10.5% Admin, 3.33% Tax in CY2018, 3.27% Tax in 2017H2

TANF/CHAP	**Proj. 2018**	**Capitation Rates**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**
Males & Females; < 1yr old	96,083	$ 656.81	$ 555.99	18.1%
Males & Females; 1 - 2 yrs old	162,504	136.07	128.63	5.8%
Males & Females; 3 - 14 yrs old	860,484	101.20	98.08	3.2%
Females; 15 - 18 yrs old	103,493	141.02	142.98	(1.4%)
Males; 15 - 18 yrs old	101,096	118.13	110.97	6.5%
Females; 19 - 34 yrs old	182,364	275.70	267.70	3.0%
Males; 19 - 34 yrs old	35,024	192.92	155.68	23.9%
Females; 35+ yrs old	100,930	458.21	420.18	9.0%
Males; 35+ yrs old	37,384	443.75	344.39	28.9%
Composite Southern Region	1,679,362	$ 189.78	$ 175.24	8.3%
Northern Region				
Males & Females; < 1yr old	16,787	$ 542.40	$ 503.95	7.6%
Males & Females; 1 - 2 yrs old	27,242	116.33	109.72	6.0%
Males & Females; 3 - 14 yrs old	138,243	80.27	80.04	0.3%
Females; 15 - 18 yrs old	14,760	128.99	125.64	2.7%
Males; 15 - 18 yrs old	14,833	99.91	101.05	(1.1%)
Females; 19 - 34 yrs old	28,684	242.69	242.70	(0.0%)
Males; 19 - 34 yrs old	5,184	182.79	119.17	53.4%
Females; 35+ yrs old	12,672	456.65	392.39	16.4%
Males; 35+ yrs old	4,920	392.33	328.25	19.5%
Composite Northern Region	263,327	$ 160.95	$ 152.03	5.9%
SOBRA Case Rate	7,900	$ 5,422.89	$ 5,158.07	5.1%
LBW Case Rate	104	$ 69,348.41	$ 65,129.74	6.5%
TANF/CHAP Composite PMPM	1,942,689	$ 211.64	$ 196.56	7.7%
Check-up				
Southern Region				
Males & Females; < 1yr old	1,097	$ 239.86	$ 179.83	33.4%
Males & Females; 1 - 2 yrs old	7,172	131.96	123.35	7.0%
Males & Females; 3 - 14 yrs old	100,788	112.53	110.95	1.4%
Females; 15 - 18 yrs old	15,643	146.06	141.74	3.0%
Males; 15 - 18 yrs old	15,996	122.50	120.40	1.7%
Composite Southern Region	140,696	$ 119.37	$ 116.62	2.4%
Northern Region				
Males & Females; < 1yr old	293	$ 225.80	$ 153.94	46.7%
Males & Females; 1 - 2 yrs old	1,956	113.31	107.42	5.5%
Males & Females; 3 - 14 yrs old	24,113	83.68	77.65	7.8%
Females; 15 - 18 yrs old	3,514	124.11	139.21	(10.8%)
Males; 15 - 18 yrs old	3,539	103.72	129.99	(20.2%)
Composite Northern Region	33,415	$ 93.04	$ 92.08	1.0%
SOBRA Case Rate	10	$ 5,422.89	$ 5,158.07	5.1%
LBW Case Rate	-	$ 69,348.41	$ 65,129.74	6.5%
Check-up Composite PMPM	174,111	$ 114.63	$ 112.21	2.2%
Expansion				
Southern Region				
Females; 19 - 34 yrs old	269,572	$ 282.25	$ 245.73	14.9%
Males; 19 - 34 yrs old	249,766	329.75	267.71	23.2%
Females; 35+ yrs old	368,043	606.78	554.00	9.5%
Males; 35+ yrs old	339,255	678.61	616.67	10.0%
Composite Southern Region	1,226,636	$ 498.92	$ 445.29	12.0%
Northern Region				
Females; 19 - 34 yrs old	43,234	$ 254.62	$ 210.01	21.2%
Males; 19 - 34 yrs old	32,795	267.59	189.91	40.9%
Females; 35+ yrs old	54,806	599.96	517.53	15.9%
Males; 35+ yrs old	47,202	646.03	560.80	15.2%
Composite Northern Region	178,037	$ 467.09	$ 393.98	18.6%
SOBRA Case Rate	604	$ 5,422.89	$ 5,158.07	5.1%
LBW Case Rate	-	$ 69,348.41	$ 65,129.74	6.5%
Expansion Composite PMPM	1,404,672	$ 497.22	$ 441.01	12.7%
Overall Composite PMPM	**3,521,472**	**$ 320.76**	**$ 289.90**	**10.6%**

Appendix A-4
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Proposed Total MCO Rates
SilverSummit
10.0% Admin, 3.50% Tax

TANF/CHAP	**Proj. 2018**	**Capitation Rates**		**%**
Southern Region	**Mem. Months**	**CY 2018**	**Jul-Dec 2017**	**Change**
Males & Females; < 1yr old	6,858	$ 654.54	$ 561.01	16.7%
Males & Females; 1 - 2 yrs old	11,713	135.60	129.86	4.4%
Males & Females; 3 - 14 yrs old	56,933	100.85	99.02	1.8%
Females; 15 - 18 yrs old	6,372	140.53	144.25	(2.6%)
Males; 15 - 18 yrs old	6,143	117.72	112.02	5.1%
Females; 19 - 34 yrs old	17,375	274.75	269.47	2.0%
Males; 19 - 34 yrs old	3,130	192.25	157.13	22.4%
Females; 35+ yrs old	8,473	456.62	424.11	7.7%
Males; 35+ yrs old	3,136	442.22	347.62	27.2%
Composite Southern Region	120,134	$ 200.35	$ 187.05	7.1%
Northern Region				
Males & Females; < 1yr old	1,085	$ 540.52	$ 508.35	6.3%
Males & Females; 1 - 2 yrs old	1,777	115.92	110.71	4.7%
Males & Females; 3 - 14 yrs old	8,195	80.00	80.79	(1.0%)
Females; 15 - 18 yrs old	871	128.55	126.71	1.4%
Males; 15 - 18 yrs old	871	99.56	101.95	(2.3%)
Females; 19 - 34 yrs old	2,491	241.85	244.49	(1.1%)
Males; 19 - 34 yrs old	467	182.15	120.22	51.5%
Females; 35+ yrs old	1,046	455.07	395.87	15.0%
Males; 35+ yrs old	443	390.97	331.15	18.1%
Composite Northern Region	17,246	$ 172.99	$ 164.41	5.2%
SOBRA Case Rate	653	$ 5,402.26	$ 5,170.36	4.5%
LBW Case Rate	9	$ 69,084.63	$ 65,284.97	5.8%
TANF/CHAP Composite PMPM	137,380	$ 226.94	$ 212.89	6.6%
Check-up				
Southern Region				
Males & Females; < 1yr old	42	$ 239.03	$ 181.55	31.7%
Males & Females; 1 - 2 yrs old	290	131.50	124.54	5.6%
Males & Females; 3 - 14 yrs old	3,478	112.14	112.01	0.1%
Females; 15 - 18 yrs old	502	145.55	143.09	1.7%
Males; 15 - 18 yrs old	508	122.08	121.56	0.4%
Composite Southern Region	4,820	$ 118.95	$ 117.62	1.1%
Northern Region				
Males & Females; < 1yr old	10	$ 225.02	$ 155.42	44.8%
Males & Females; 1 - 2 yrs old	65	112.92	108.45	4.1%
Males & Females; 3 - 14 yrs old	754	83.39	78.39	6.4%
Females; 15 - 18 yrs old	111	123.69	140.53	(12.0%)
Males; 15 - 18 yrs old	111	103.37	131.24	(21.2%)
Composite Northern Region	1,051	$ 92.88	$ 93.09	(0.2%)
SOBRA Case Rate	0	$ 5,402.26	$ 5,170.36	4.5%
LBW Case Rate	-	$ 69,084.63	$ 65,284.97	5.8%
Check-up Composite PMPM	5,871	$ 114.58	$ 113.51	0.9%
Expansion				
Southern Region				
Females; 19 - 34 yrs old	10,995	$ 281.22	$ 248.03	13.4%
Males; 19 - 34 yrs old	9,750	328.55	270.25	21.6%
Females; 35+ yrs old	13,772	604.58	559.25	8.1%
Males; 35+ yrs old	12,957	676.15	622.51	8.6%
Composite Southern Region	47,474	$ 492.53	$ 445.08	10.7%
Northern Region				
Females; 19 - 34 yrs old	1,909	$ 253.70	$ 212.00	19.7%
Males; 19 - 34 yrs old	1,577	266.62	191.70	39.1%
Females; 35+ yrs old	2,462	597.78	522.43	14.4%
Males; 35+ yrs old	2,326	643.68	566.11	13.7%
Composite Northern Region	8,275	$ 468.16	$ 400.04	17.0%
SOBRA Case Rate	24	$ 5,402.26	$ 5,170.36	4.5%
LBW Case Rate	-	$ 69,084.63	$ 65,284.97	5.8%
Expansion Composite PMPM	55,749	$ 491.23	$ 440.62	11.5%
Overall Composite PMPM	**199,000**	**$ 297.66**	**$ 273.75**	**8.7%**

APPENDIX B

(See attached Excel file *20170929 Appendix B CY 2018 Nevada Rates.xlsx*)

APPENDIX C

Appendix C
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Rates for 1/1/2018 - Assuming 3.5% Premium Tax and 10.5% Admin, Excluding Safet Net

	Projected 2018 Member Months	Member Months Distribution	Assumed Deliveries	Medical Cost Net Mat	Medical Cost Net Mat/LBW	Admin Composite	Tax	Prior Managed Care Rates Effective 7/1/2017	Prior Based on Rates Effective 7/1/2017	Proposed, Pre-Credibility Managed Care Rates Effective 1/1/2018	Proposed, Pre-Credibility Based on Rates Effective 1/1/2018
TANF/CHAP											
Southern Region Medical Rates											
Males & Females; < 1yr old	189,650	6.1%	0	$ 585.01	$ 533.04	$ 62.54	$ 21.60	$ 488.24	$ 92,595,281	$ 617.18	$ 117,048,041
Males & Females; 1 - 2 yrs old	323,863	10.5%	0	110.00	110.00	12.91	4.46	121.76	39,432,470	127.36	41,247,152
Males & Females; 3 - 14 yrs old	1,577,262	51.1%	0	81.54	81.54	9.57	3.30	92.38	145,713,969	94.41	148,909,267
Females; 15 - 18 yrs old	176,843	5.7%	3,154	114.31	114.31	13.41	4.63	137.18	24,259,722	132.35	23,405,151
Males; 15 - 18 yrs old	170,546	5.5%	0	95.42	95.42	11.19	3.87	106.52	18,166,176	110.48	18,841,922
Females; 19 - 34 yrs old	350,085	11.3%	6,245	223.37	223.37	26.21	9.05	254.66	89,152,088	258.63	90,542,528
Males; 19 - 34 yrs old	63,263	2.0%	0	156.54	156.54	18.37	6.34	156.76	9,917,191	181.25	11,466,485
Females; 35+ yrs old	171,788	5.6%	3,064	370.12	370.12	43.42	15.00	401.84	69,031,079	428.54	73,617,861
Males; 35+ yrs old	63,586	2.1%	0	358.61	358.61	42.07	14.53	350.62	22,294,594	415.21	26,401,344
Composite	3,086,885	100.0%	12,463	$ 151.10	$ 147.90	$ 17.35	$ 5.99	$ 162.79	$ 510,562,570	$ 178.65	$ 551,479,750
			4								
								Impact of Rate Change - TANF/CHAP Southern Region Monthly Medical Capitation Rates			**8.0%**
Northern Region Medical Rates											
Males & Females; < 1yr old	30,070	6.8%	0	$ 485.17	$ 440.28	$ 51.65	$ 17.84	$ 397.37	$ 11,948,721	$ 509.78	$ 15,328,974
Males & Females; 1 - 2 yrs old	49,256	11.1%	0	94.13	94.13	11.04	3.81	104.37	5,140,745	108.99	5,368,376
Males & Females; 3 - 14 yrs old	227,069	51.1%	0	64.73	64.73	7.59	2.62	75.31	17,100,724	74.95	17,018,787
Females; 15 - 18 yrs old	24,146	5.4%	431	107.72	107.72	12.64	4.37	123.41	2,979,768	124.72	3,011,485
Males; 15 - 18 yrs old	24,124	5.4%	0	81.22	81.22	9.53	3.29	95.65	2,307,489	94.04	2,268,607
Females; 19 - 34 yrs old	50,363	11.3%	898	196.93	196.93	23.10	7.98	230.61	11,614,355	228.01	11,483,265
Males; 19 - 34 yrs old	9,439	2.1%	0	151.27	151.27	17.75	6.13	130.35	1,230,330	175.15	1,653,198
Females; 35+ yrs old	21,179	4.8%	378	383.41	383.41	44.98	15.54	404.23	8,561,349	443.93	9,402,068
Males; 35+ yrs old	8,942	2.0%	0	298.42	298.42	35.01	12.09	345.92	3,093,321	345.52	3,089,708
Composite	444,587	100.0%	1,707	$ 130.78	$ 127.74	$ 14.99	$ 5.18	$ 141.68	$ 63,976,801	$ 154.35	$ 68,624,469
								Impact of Rate Change - TANF/CHAP Northern Region Monthly Medical Capitation Rates			**7.3%**
			Count								
SOBRA Rate			14,170	$ 5,432.44	$ 5,432.44			$ 5,170	$ 73,263,673	$ 5,432	$ 76,977,289
Low Birth Weight Baby Kick Payment (0.85 per 1,000 MMs < 1 year old)			187	$ 60,000.00	$ 60,000.00			$ 65,285	$ 12,192,727	$ 69,471	$ 12,974,437
Estimated Expenditures								$ 70,760	$ 659,995,771	$ 75,236	$ 710,055,945
									Impact of Rate Change - TANF/CHAP Total Medical		**7.6%**

Appendix C
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Rates for 1/1/2018 - Assuming 3.5% Premium Tax and 10.5% Admin, Excluding Safet Net

	Projected 2018 Member Months	Member Months Distribution	Assumed Deliveries	Medical Cost Net Mat	Medical Cost Net Mat/LBW	Admin Composite	Tax	Prior Managed Care Rates Effective 7/1/2017	Prior Based on Rates Effective 7/1/2017	Proposed, Pre-Credibility Managed Care Rates Effective 1/1/2018	Proposed, Pre-Credibility Based on Rates Effective 1/1/2018
Check-up											
Southern Region Medical Rate											
Males & Females; < 1yr old	2,090	0.9%	0	$ 179.60	$ 179.60	$ 21.07	$ 7.28	$ 175.57	$ 366,927	$ 207.95	$ 434,590
Males & Females; 1 - 2 yrs old	14,251	6.0%	0	103.34	103.34	12.12	4.19	117.52	1,674,722	119.65	1,705,102
Males & Females; 3 - 14 yrs old	171,129	72.2%	0	90.62	90.62	10.63	3.67	104.89	17,949,824	104.92	17,954,884
Females; 15 - 18 yrs old	24,682	10.4%	13	119.16	119.16	13.98	4.83	133.35	3,291,437	137.97	3,405,372
Males; 15 - 18 yrs old	24,984	10.5%	0	99.83	99.83	11.71	4.05	114.70	2,865,664	115.59	2,887,895
Composite	237,136	100.0%	13	$ 94.15	$ 94.15	$ 11.05	$ 3.82	$ 110.23	$26,148,574	111.28	26,387,843
								Impact of Rate Change - CHECK UP Southern Region Monthly Medical Capitation Rates			**0.9%**
Northern Region Medical Rate											
Males & Females; < 1yr old	480	0.9%	0	$ 353.31	$ 353.31	$ 41.45	$ 14.32	$ 171.89	$ 82,453	$ 409.08	$ 196,233
Males & Females; 1 - 2 yrs old	3,219	6.2%	0	91.76	91.76	10.77	3.72	108.87	350,468	106.24	342,007
Males & Females; 3 - 14 yrs old	37,316	71.8%	0	67.30	67.30	7.90	2.73	74.20	2,768,843	77.92	2,907,645
Females; 15 - 18 yrs old	5,467	10.5%	3	108.89	108.89	12.77	4.41	129.52	708,059	126.08	689,231
Males; 15 - 18 yrs old	5,496	10.6%	0	92.92	92.92	10.90	3.77	113.80	625,413	107.59	591,306
Composite	51,977	100.0%	3	$ 76.82	$ 76.82	$ 9.01	$ 3.11	$ 87.18	$ 4,535,237	$ 90.93	$ 4,726,422
								Impact of Rate Change - CHECK UP Northern Region Monthly Medical Capitation Rates			**4.2%**
			Count								
SOBRA Rate			16	$ 5,432.44	$ 5,432.44			$ 5,170	$ 82,166	$ 5,432	$ 86,331
Low Birth Weight Baby Kick Payment			0	$ 60,000.00	$ 60,000.00			$ 65,285	$ 0	$ 69,471	$ 0
Estimated Expenditures								$ 70,653	$ 30,765,977	$ 75,105	$ 31,200,596
									Impact of Rate Change - Check-up Total Medical		**1.4%**

Appendix C
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Rates for 1/1/2018 - Assuming 3.5% Premium Tax and 10.5% Admin, Excluding Safet Net

	Projected 2018 Member Months	Member Months Distribution	Assumed Deliveries	Medical Cost Net Mat	Medical Cost Net Mat/LBW	Admin Composite	Tax	Prior Managed Care Rates Effective 7/1/2017	Prior Based on Rates Effective 7/1/2017	Proposed, Pre-Credibility Managed Care Rates Effective 1/1/2018	Proposed, Pre-Credibility Based on Rates Effective 1/1/2018
Expansion											
Southern Region Medical Rate											
Females; 19 - 34 yrs old	467,432	23.1%	384	$ 235.82	$ 235.82	$ 27.67	$ 9.56	$ 246.87	$ 115,396,816	$ 273.04	$ 127,627,602
Males; 19 - 34 yrs old	414,875	20.5%	0	275.44	275.44	32.31	11.16	267.80	111,103,136	318.92	132,312,027
Females; 35+ yrs old	586,526	29.0%	481	505.98	505.98	59.36	20.50	554.89	325,456,605	585.85	343,615,975
Males; 35+ yrs old	551,583	27.3%	0	564.47	564.47	66.22	22.87	615.23	339,350,694	653.57	360,498,215
Composite	2,020,416	100.0%	865	$ 402.17	$ 402.17	$ 47.18	$ 16.30	$ 442.08	$ 891,307,251	$ 477.15	$ 964,053,819
								Impact of Rate Change - Expansion Southern Region Monthly Medical Capitation Rates			**8.2%**
Northern Region Medical Rate											
Females; 19 - 34 yrs old	74,218	23.1%	61	$ 211.55	$ 211.55	$ 24.82	$ 8.57	$ 214.03	$ 15,884,435	$ 244.94	$ 18,178,855
Males; 19 - 34 yrs old	61,219	19.1%	0	217.34	217.34	25.50	8.81	189.43	11,596,760	251.65	15,405,750
Females; 35+ yrs old	95,677	29.8%	79	502.59	502.59	58.96	20.37	518.27	49,586,967	581.92	55,676,599
Males; 35+ yrs old	90,243	28.1%	0	540.23	540.23	63.38	21.89	566.01	51,078,432	625.50	56,447,045
Composite	321,357	100.0%	139	$ 381.06	$ 381.06	$ 44.71	$ 15.44	$ 399.64	$ 128,146,594	$ 453.42	$ 145,708,249
								Impact of Rate Change - Expansion Northern Region Monthly Medical Capitation Rates			**13.7%**
			Count								
SOBRA Rate			1,005	$ 5,432.44	$ 5,432.44			$ 5,170	$ 5,194,386	$ 5,629	$ 5,655,627
Low Birth Weight Baby Kick Payment			0	$ 60,000.00	$ 60,000.00			$ 65,285	$ 0	$ 69,471	$ 0
Estimated Expenditures								$ 71,297	$ 1,024,648,231	$ 76,031	$ 1,115,417,696
									Impact of Rate Change - Expansion Total Medical		**8.9%**

APPENDIX D

Appendix D
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Rates for 1/1/2018 - Assuming 3.5% Premium Tax and 10.5% Admin, Excluding Safet Net

	Experience Member Months	Projected Member Months	Pre-Credibility Managed Care Rates Effective 1/1/2018	Credibility Threshold	Credibility Weight	Composite Manual PMPM	Final Credibility Adjusted PMPM	Credibility Impact
TANF/CHAP								
Southern Region Medical Rates								
Males & Females; < 1yr old	346,422	189,650	$ 617.18	80,000	100%		$ 617.18	0.0%
Males & Females; 1 - 2 yrs old	591,102	323,863	127.36	80,000	100%		127.36	0.0%
Males & Females; 3 - 14 yrs old	2,873,224	1,577,262	94.41	80,000	100%		94.41	0.0%
Females; 15 - 18 yrs old	321,109	176,843	132.35	80,000	100%		132.35	0.0%
Males; 15 - 18 yrs old	309,493	170,546	110.48	80,000	100%		110.48	0.0%
Females; 19 - 34 yrs old	546,984	350,085	258.63	80,000	100%		258.63	0.0%
Males; 19 - 34 yrs old	98,837	63,263	181.25	80,000	100%		181.25	0.0%
Females; 35+ yrs old	266,575	171,788	428.54	80,000	100%		428.54	0.0%
Males; 35+ yrs old	98,916	63,586	415.21	80,000	100%		415.21	0.0%
Composite	5,452,661	3,086,885	$ 178.65				$ 178.65	0.0%
Northern Region Medical Rates								
Males & Females; < 1yr old	59,073	30,070	$ 509.78	80,000	86%	$ 509.03	$ 509.67	(0.0%)
Males & Females; 1 - 2 yrs old	96,799	49,256	108.99	80,000	100%		108.99	0.0%
Males & Females; 3 - 14 yrs old	446,313	227,069	74.95	80,000	100%		74.95	0.0%
Females; 15 - 18 yrs old	47,462	24,146	124.72	80,000	77%	109.16	121.15	(2.9%)
Males; 15 - 18 yrs old	47,405	24,124	94.04	80,000	77%	91.12	93.37	(0.7%)
Females; 19 - 34 yrs old	85,648	50,363	228.01	80,000	100%		228.01	0.0%
Males; 19 - 34 yrs old	16,130	9,439	175.15	80,000	45%	168.76	171.63	(2.0%)
Females; 35+ yrs old	35,957	21,179	443.93	80,000	67%	399.01	429.12	(3.3%)
Males; 35+ yrs old	15,235	8,942	345.52	80,000	44%	386.60	368.68	6.7%
Composite	850,021	444,587	$ 154.35			$ 285.34	$ 153.80	(0.4%)
CHECK UP								
Southern Region Medical Rate								
Males & Females; < 1yr old	3,410	2,090	$ 207.95	80,000	21%	$ 229.94	$ 225.40	8.4%
Males & Females; 1 - 2 yrs old	22,906	14,251	119.65	80,000	54%	128.04	123.55	3.3%
Males & Females; 3 - 14 yrs old	276,125	171,129	104.92	80,000	100%		104.92	0.0%
Females; 15 - 18 yrs old	39,766	24,682	137.97	80,000	71%	135.29	137.18	(0.6%)
Males; 15 - 18 yrs old	40,281	24,984	115.59	80,000	71%	111.50	114.40	(1.0%)
Composite	382,486	237,136	$ 111.28			$ 127.72	$ 111.46	0.2%
Northern Region Medical Rate								
Males & Females; < 1yr old	874	480	$ 409.08	80,000	10%	$ 189.21	$ 212.19	(48.1%)
Males & Females; 1 - 2 yrs old	5,756	3,219	106.24	80,000	27%	105.44	105.66	(0.6%)
Males & Females; 3 - 14 yrs old	66,630	37,316	77.92	80,000	91%	78.17	77.94	0.0%
Females; 15 - 18 yrs old	9,804	5,467	126.08	80,000	35%	111.41	116.54	(7.6%)
Males; 15 - 18 yrs old	9,781	5,496	107.59	80,000	35%	91.88	97.37	(9.5%)
Composite	92,845	51,977	$ 90.93			$ 85.83	$ 87.01	(4.3%)
Expansion								
Southern Region Medical Rate								
Females; 19 - 34 yrs old	411,108	467,432	$ 273.04	80,000	100%		$ 273.04	0.0%
Males; 19 - 34 yrs old	364,569	414,875	318.92	80,000	100%		318.92	0.0%
Females; 35+ yrs old	514,959	586,526	585.85	80,000	100%		585.85	0.0%
Males; 35+ yrs old	484,498	551,583	653.57	80,000	100%		653.57	0.0%
Composite	1,775,132	2,020,416	$ 477.15				$ 477.15	0.0%
Northern Region Medical Rate								
Females; 19 - 34 yrs old	69,661	74,218	$ 244.94	80,000	93%	$ 256.97	$ 245.75	0.3%
Males; 19 - 34 yrs old	57,543	61,219	251.65	80,000	85%	300.15	259.01	2.9%
Females; 35+ yrs old	89,830	95,677	581.92	80,000	100%		581.92	0.0%
Males; 35+ yrs old	84,855	90,243	625.50	80,000	100%		625.50	0.0%
Composite	301,890	321,357	$ 453.42				$ 455.00	0.4%

APPENDIX E

Appendix E
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Rates for 1/1/2018 - Assuming 3.5% Premium Tax and 10.5% Admin, Excluding Safet Net

	Rebalanced Rates Effective 1/1/2018	Rate Impacts of		Final Proposed Managed Care Rates Effective 1/1/2018
		Safety Net	ABA/Autism	
TANF/CHAP				
Southern Region Medical Rates				
Males & Females; < 1yr old	$ 617.18	$ 40.75	$ 0.04	$ 657.96
Males & Females; 1 - 2 yrs old	127.36	8.41	0.54	136.31
Males & Females; 3 - 14 yrs old	94.41	6.23	0.73	101.38
Females; 15 - 18 yrs old	132.35	8.74	0.17	141.26
Males; 15 - 18 yrs old	110.48	7.29	0.56	118.34
Females; 19 - 34 yrs old	258.63	17.08	0.00	275.71
Males; 19 - 34 yrs old	181.25	11.97	0.05	193.26
Females; 35+ yrs old	428.54	28.29	0.00	456.84
Males; 35+ yrs old	415.21	27.41	0.00	442.63
	$ 178.65	$ 11.80	$ 0.48	$ 190.93
Northern Region Medical Rates				
Males & Females; < 1yr old	$ 509.67	$ 33.65	$ 0.03	$ 543.35
Males & Females; 1 - 2 yrs old	108.99	7.20	0.35	116.53
Males & Females; 3 - 14 yrs old	74.95	4.95	0.52	80.41
Females; 15 - 18 yrs old	121.15	8.00	0.07	129.22
Males; 15 - 18 yrs old	93.37	6.16	0.55	100.08
Females; 19 - 34 yrs old	228.01	15.05	0.00	243.07
Males; 19 - 34 yrs old	171.63	11.33	0.15	183.11
Females; 35+ yrs old	429.12	28.33	0.00	457.46
Males; 35+ yrs old	368.68	24.34	0.00	393.02
	$ 153.80	$ 10.15	$ 0.34	$ 164.30
Check-up				
Southern Region Medical Rate				
Males & Females; < 1yr old	$ 225.40	$ 14.88	$ 0.00	$ 240.29
Males & Females; 1 - 2 yrs old	123.55	8.16	0.48	132.19
Males & Females; 3 - 14 yrs old	104.92	6.93	0.88	112.73
Females; 15 - 18 yrs old	137.18	9.06	0.08	146.31
Males; 15 - 18 yrs old	114.40	7.55	0.76	122.72
	$ 111.46	$ 7.36	$ 0.75	$ 119.57
Northern Region Medical Rate				
Males & Females; < 1yr old	$ 212.19	$ 14.01	$ 0.00	$ 226.20
Males & Females; 1 - 2 yrs old	105.66	6.98	0.88	113.51
Males & Females; 3 - 14 yrs old	77.94	5.15	0.74	83.83
Females; 15 - 18 yrs old	116.54	7.69	0.10	124.33
Males; 15 - 18 yrs old	97.37	6.43	0.11	103.91
	$ 87.01	$ 5.75	$ 0.61	$ 93.37
Expansion				
Southern Region Medical Rates				
Females; 19 - 34 yrs old	$ 273.04	$ 8.64	$ 0.02	$ 281.70
Males; 19 - 34 yrs old	318.92	10.09	0.07	329.07
Females; 35+ yrs old	585.85	18.53	0.00	604.38
Males; 35+ yrs old	653.57	20.68	0.00	674.24
	$ 477.15	$ 15.10	$ 0.02	$ 492.27
Northern Region Medical Rates				
Females; 19 - 34 yrs old	$ 245.75	$ 7.77	$ 0.03	$ 253.55
Males; 19 - 34 yrs old	259.01	8.19	0.06	267.27
Females; 35+ yrs old	581.92	18.41	0.00	600.33
Males; 35+ yrs old	625.50	19.79	0.00	645.29
	$ 455.00	$ 14.40	$ 0.02	$ 469.42

APPENDIX F

Appendix F-1
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Estimation of Maximum Allowed Enhancement for University Medical Center

Projected MMs	3,820,585	2,341,773	6,162,357	from CY2018 rate development
Inpatient Claims	**TANF/Check-up**	**Expansion**	**Total**	
Included in CY2018 Rates	$ 5.29	$ 8.65	$ 6.56	From Exhibits 2 and 3
UPL PMPM	15.17	21.22	17.47	From Exhibits 2 and 3
Differential	9.88	12.57	10.90	
Outpatient Claims				
Included in CY2018 Rates	$ 1.88	$ 3.85	$ 2.63	From Exhibits 2 and 3
UPL PMPM	4.71	8.28	6.07	From Exhibits 2 and 3
Differential	2.83	4.43	3.44	
All Claims				
Included in CY2018 Rates	$ 7.17	$ 12.50	$ 9.19	(1)
UPL PMPM	19.88	29.50	23.53	(2)
Initial Enhancement Payment	12.71	17.00	14.34	(3) = (2) - (1)
Base Amount Calculation				
2016 MMs	3,299,220	2,126,307	5,425,527	(4)
Claims Paid in CY2016 (Section I, 4.E.i.c.i.B)	$ 22,066,083	$ 23,878,489	$ 45,944,571	(5)
Medicare Repriced Claims (Section I, 4.E.i.c.i.A)	57,873,972	54,656,579	112,530,551	(6)
Base Amount in Dollars	35,807,889	30,778,091	66,585,980	(7) = (6) - (5)
Base Amount PMPM (Max Enhancement)	10.85	14.47	12.27	(8) = (7) / (4)
Final Enhancement Payment	**$ 10.85**	**$ 14.47**		**(9)=min[(3),(8)]**

Appendix F-2
State of Nevada
Division of Health Care Financing and Policy
CY 2018 Capitation Rate Development
Historical Provider Pass-Through Payments (Includes Premium Tax)

Total Safety Net PMPM

TANF/Check-Up	2016	Jan-Jun 2017	Jul-Dec 2017	2018 (Proposed)
University Med Center	$ 8.20	$ 9.08	$ 9.05	$ 11.24
Behavioral Health	2.22	2.28	n/a	n/a
Las Vegas Fire	0.08	0.11	n/a	n/a
Henderson Fire	0.02	0.03	n/a	n/a

Expansion	2016	Jan-Jun 2017	Jul-Dec 2017	2018 (Proposed)
UMC	$ 12.90	$ 10.64	$ 10.72	$ 14.98
Behavioral Health	2.23	2.04	n/a	n/a
Las Vegas Fire	0.33	0.40	n/a	n/a
Henderson Fire	0.09	0.11	n/a	n/a

Composite	2016	Jan-Jun 2017	Jul-Dec 2017	2018 (Proposed)
UMC	$ 9.94	$ 9.67	$ 9.68	$ 12.66
Behavioral Health	2.22	2.19	n/a	n/a
Las Vegas Fire	0.17	0.22	n/a	n/a
Henderson Fire	0.04	0.06	n/a	n/a

Total Safety Net (Annualized)

TANF/Check-Up	2016	Jan-Jun 2017	Jul-Dec 2017	2018 (Proposed)
University Med Center	$ 28,004,945	$ 16,158,180	$ 33,513,294	$ 42,928,586
Behavioral Health	7,584,549	4,054,621	n/a	n/a
Las Vegas Fire	272,788	195,873	n/a	n/a
Henderson Fire	61,464	56,672	n/a	n/a

Expansion	2016	Jan-Jun 2017	Jul-Dec 2017	2018 (Proposed)
UMC	$ 25,905,862	$ 11,294,387	$ 24,118,889	$ 35,089,309
Behavioral Health	4,468,839	2,165,602	n/a	n/a
Las Vegas Fire	670,640	424,080	n/a	n/a
Henderson Fire	177,158	118,916	n/a	n/a

Composite	2016	Jan-Jun 2017	Jul-Dec 2017	2018 (Proposed)
UMC	$ 53,910,806	$ 27,452,567	$ 57,632,183	$ 78,017,895
Behavioral Health	12,053,388	6,220,222	n/a	n/a
Las Vegas Fire	943,428	619,953	n/a	n/a
Henderson Fire	238,622	175,588	n/a	n/a

APPENDIX G

Appendix G
Nevada Division of Health Care Financing and Policy
Rates Change from 2017H2 to CY2018 for Expansion Population
Rates Do NOT Include IMD Long Stays

	Amerigroup	HPN	SilverSummit
Section 1: Rates Effective January 1, 2018 - December 31, 2018			
Expansion Southern Region			
Females; 19 - 34 yrs old	$ 281.70	$ 281.21	$ 280.19
Males; 19 - 34 yrs old	329.07	328.50	327.30
Females; 35+ yrs old	604.38	603.32	601.13
Males; 35+ yrs old	674.24	673.06	670.61
Expansion Northern Region Rate			
Females; 19 - 34 yrs old	$ 253.55	$ 253.10	$ 252.18
Males; 19 - 34 yrs old	267.27	266.80	265.83
Females; 35+ yrs old	600.33	599.28	597.10
Males; 35+ yrs old	645.29	644.16	641.82
Section 2: Rates Effective July 1, 2017 - December 31, 2017			
Expansion Southern Region			
Females; 19 - 34 yrs old	$ 252.09	$ 244.20	$ 246.48
Males; 19 - 34 yrs old	273.53	264.97	267.47
Females; 35+ yrs old	566.57	548.82	553.99
Males; 35+ yrs old	628.18	608.50	614.24
Expansion Northern Region Rate			
Females; 19 - 34 yrs old	$ 214.92	$ 208.19	$ 210.16
Males; 19 - 34 yrs old	194.52	188.42	190.20
Females; 35+ yrs old	532.62	515.93	520.80
Males; 35+ yrs old	576.61	558.55	563.82
Section 3: Rates Change from 2017H2 to CY2018			
Expansion Southern Region			
Females; 19 - 34 yrs old	11.7%	15.2%	13.7%
Males; 19 - 34 yrs old	20.3%	24.0%	22.4%
Females; 35+ yrs old	6.7%	9.9%	8.5%
Males; 35+ yrs old	7.3%	10.6%	9.2%
Expansion Northern Region Rate			
Females; 19 - 34 yrs old	18.0%	21.6%	20.0%
Males; 19 - 34 yrs old	37.4%	41.6%	39.8%
Females; 35+ yrs old	12.7%	16.2%	14.7%
Males; 35+ yrs old	11.9%	15.3%	13.8%

*Rate changes vary by MCO due to premium tax changes (HPN) and the removal of risk adjustment in the CY 2018 rates