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April 22, 2020

Mr. Henry Lipman, FACHE
Medicaid Director
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

[Sent via email: henry.lipman@dhhs.nh.gov]

Re: September 2019 to June 2020 MCM Program Rate Update

Dear Henry:

This letter provides the Hampshire Department of Health and Human Services (DHHS) with updated September 2019 to June 2020 managed care organization (MCO) capitation rates for the Medicaid Care Management (MCM) program. DHHS retained Milliman to calculate, document, and certify its capitation rate development. We developed the capitation rates using the methodology described in this letter.

Our role is to certify that the September 2019 to June 2020 MCO capitation rates produced by the rating methodology are actuarially sound to comply with Centers for Medicare and Medicaid Services (CMS) regulations. We developed actuarially sound capitation rates using published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements.

We developed the updated September 2019 to June 2020 MCO capitation rates using the same base claims data and methodology as the original September 2019 to June 2020 capitation rates certified in our January 14, 2020 report. The updated rates include a few adjustments described in detail below. All other assumptions remain the same. Please refer to the January 14, 2020 report for a full description of the September 2019 to June 2020 rate setting methodology.

The attachments to this letter include responses to the CMS Rate Setting Checklist and the 2019-2020 Medicaid Managed Care Rate Development Guide, as well as a new actuarial certification for the September 2019 to June 2020 MCM capitation rates.

DIRECTED PAYMENT FUNDING POOL

Subject to CMS approval, the New Hampshire Department of Health and Human Services (DHHS) will require each MCO to pay a percentage add-on for specific qualifying services provided by the following six safety net provider classes for the September 2019 to June 2020 rating period.

- FQHCs and RHCs
  - Procedure code T1015 for physician encounters
  - Revenue code 0521 for physician encounters
- Critical Access Hospitals
  - All DRGs for inpatient admissions
  - All procedures related to outpatient emergency room services
- SUD Residential Treatment Providers
  - Procedure code H0018: High intensity adult behavioral health; short-term residential
  - Procedure code H0018-U4: Medium intensity adolescent behavioral health; short-term residential
  - Procedure code T1006: Specialty residential services for pregnant and parenting women
  - Procedure code H0010: Medically monitored residential withdrawal management
- Home Health Providers
  - Procedure code G0156: Services of home health / hospice aide in home health or hospice settings
- Private Duty Nursing Providers
  - Procedure code S9123: Nursing care, in the home; by registered nurse
  - Procedure code S9124: Nursing care, in the home; by licensed practical nurse
- Personal Care Providers
  - Procedure code T1019: Personal care services

An identified portion of the actuarially sound per member per month (PMPM) capitation payment to the MCOs multiplied by the member months the plan is paid for the month will form a pool to be used every month to make percentage add-on payments to the defined safety net provider classes. The pool will be about 1.5% of the capitation payments made to the MCOs, or approximately $11.7 million for the September 2019 to June 2020 contract year. Actual pool funding will be determined by actual MCM program enrollment multiplied by the PMPM directed payment funding for each rate cell in the September 2019 to June 2020 MCM program capitation rates.

DHHS will establish the percentage of the pool that will be allocated to a separate sub-pool for each of the six safety net provider classes based on historical MCO payments to these providers (i.e., if FQHC and RHC payments represent 32% of historical payments for the defined safety net provider classes, the FQHC and RHC sub-pool would be funded with 32% of the total pool). Table 1 shows the initial allocation of the separate sub-pools based on January 2019 to June 2019 MCO encounter payments.

Table 1
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
Initial Allocation of Directed Payment Sub-Pools

Safety Net Provider Class	Percentage Distribution of January to June 2019 MCO Payments for Selected Services Only	Approximate September 2019 to June 2020 Direct Payment (Total)[1]	Approximate September 2019 to June 2020 Direct Payment (Monthly)[1]
FQHCs and RHCs	32.0%	$3,744,000	$374,400
Critical Access Hospitals	29.8%	3,486,600	348,660
SUD Residential Treatment	16.8%	1,965,600	196,560
Home Health	4.9%	573,300	57,330
Private Duty Nursing	8.8%	1,029,600	102,960
Personal Care	7.7%	900,900	90,090
Total Pool	**100.0%**	**$11,700,000**	**$1,170,000**

[1]Approximate values of the direct payment pool are based on the initial enrollment projections in the January 14, 2020 rate setting report. Actual monthly pool funding will be determined by actual MCM program enrollment multiplied by the PMPM directed payment funding for each rate cell in the September 2019 to June 2020 MCM program capitation rates.

At the end of the month, the amount in each sub-pool will be divided by the payments made by the MCOs to the defined safety net provider class for qualifying services adjudicated in the month. This calculation will determine the amount of the uniform percentage add-on for the month. The additional payments will be sent to the safety net providers on the following schedule:

- May 2020 directed payments: Based on September 2019 to March 2020 paid encounters
- June 2020 directed payments: Based on April 2020 paid encounters
- July 2020 directed payments: Based on May 2020 paid encounters
- August 2020 directed payments: Based on June 2020 paid encounters

CHANGES TO MCM PROGRAM CAPITATION RATES

DHHS will make the following changes to components of the capitation rates in order to fund the proposed directed payment funding pool. These changes are illustrated in Exhibit 1.

- Reduce service costs by 1.5% for all services to recognize the expected net impact of reductions in non-emergency and elective service costs due to COVID-19 pandemic preparedness and social distancing guidelines, increased COVID-19 treatment costs, the impact of waiving certain prior authorization requirements, and reduced population acuity due to projected enrollment increases related to the recession.
  - DHHS will require the MCOs to continue their capitation arrangement with the community mental health centers (CMHCs) at current payment levels and waive any related maintenance of effort (MOE) provisions for state fiscal year (SFY) 2020.
- Reduce the PMPM administrative allowance for all rate cells by 1.5% to recognize that significantly fewer MCM program members are enrolled in care management programs compared to the 15% expectation in the MCM contract.
- Further reduce the administrative allowance for the GAHCP Non-Medically Frail population by $0.45 PMPM to remove costs related to the GAHCP work and community engagement requirement that was prohibited by the US District Court for the District of Columbia. This reduction was made at the direction of CMS. The related funding is repurposed for the directed payment pool.

- Recalculate the gain / loss margin to reflect the shifting of revenue from at-risk services to the new non-risk directed payments. The gain / loss margin still represents 1.5% of at-risk revenue.

- Calculate the amount available for the new directed payment funding pool, which is approximately $11.7 million assuming the original projected enrollment level (i.e., not incorporating likely enrollment growth resulting from the recession).

- The original CMHC directed payment remains unchanged.

- The PMPM premium tax allowance remains unchanged because the capitation rates by rate cell are unchanged after the reallocation by component.

IMPLEMENT RISK CORRIDOR PROGRAM

Subject to CMS approval, DHHS will implement a risk corridor for the September 2019 to June 2020 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

The MCO capitation rates reflect a target medical loss ratio (MLR), which measures the projected medical service costs as a percentage of the total at-risk MCO capitation rates. The risk corridor will limit MCO gains and losses if the actual MLR is different than the target MLR. The target MLR for at-risk services is 89.6% for Standard Medicaid and 88.7% for GAHCP based on the September 2019 to June 2020 projected enrollment distribution, as shown in Exhibit 1.

Table 2 summarizes the share of gains and losses relative to the target MLR for each party.

Table 2
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
Proposed MCM Program Risk Corridor Parameters

MLR Claims Corridor	MCO Share of Gain / Loss in Corridor	DHHS Share of Gain / Loss in Corridor
Less than Target MLR - 3.5%	0%	100%
Target MLR - 3.5% to Target MLR - 2.0%	75%	25%
Target MLR - 2.0% to Target MLR + 1.5%	100%	0%
Target MLR + 1.5% to Target MLR + 3.5%	75%	25%
Greater than Target MLR + 3.5%	0%	100%

There are several operational requirements to administering the risk corridor:

- The settlement will be done separately for the Standard Medicaid and GAHCP populations.

- Target MLRs will be calculated separately for each MCO based on their actual enrollment mix by rate cell.

- Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment).

- The numerator of each MCO's actual MLR will include all payments made to providers, such as fee-for-service payments, subcapitation payments, incentive payments, and settlement payments.

- Payments and revenue related to directed payments and premium taxes will be excluded from the numerator and denominator of each MCO's actual MLR, which is consistent with the treatment of directed payments and premium taxes in federal MLR calculations.

- The risk corridor applies to the Standard Medicaid and GAHCP population, so it replaces the current GAHCP downside risk protection provision for September 2019 to June 2020.

- The 85% minimum MLR provision in the MCM contract will apply after the risk corridor settlement calculation. The 85% minimum MLR provision is adjudicated using federal MLR reporting rules, which produce a different MLR than the MLR calculated for risk corridor settlement purposes.

- The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

OTHER ADMINISTRATIVE ITEMS

DHHS is making two additional administrative changes:

- DHHS will waive the quality withhold provisions of the MCM contract for the September 2019 to June 2020 contract year due to the impact of the COVID-19 pandemic. All MCOs will receive 100% of the quality withhold.

- DHHS will modify the auto-assignment algorithm for the May 1, 2020 to June 30, 2020 time period to incorporate equal auto-assignment among the three MCOs.

CAVEATS AND LIMITATIONS ON USE

We used fee-for-service (FFS) and MCO encounter cost and eligibility data for July 2016 through December 2018, MCO financial data, historical reimbursement information, TPL recoveries, current fee schedules, and other DHHS and MCO information to calculate the New Hampshire MCM program capitation rates shown in this letter. This data was provided by DHHS and participating MCOs. We did not audit 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 did not find material defects in the data. If there are material defects in the data, it is possible 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.

We constructed several projection models to develop the capitation rates shown in this letter. 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 in the September 2019 to June 2020 capitation rates due to differences in health care trend, managed care efficiency, provider reimbursement levels, and many other factors. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.

Milliman prepared this letter for the specific purpose of developing September 2019 to June 2020 MCM program capitation rates. This letter should not be used for any other purpose. This letter has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHHS. We understand this letter may be shared with participating MCOs, CMS, and other interested parties. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. This letter should only be reviewed in its entirety.

The results of this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

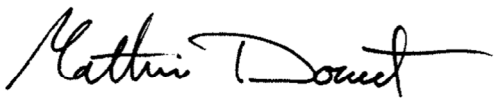
The authors of this letter are consulting actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this letter is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The terms of Milliman's contract with the New Hampshire Department of Health and Human Services effective July 1, 2017, apply to this letter and its use.

❖ ❖ ❖ ❖ ❖

Please call John Meerschaert, Greg Herrle, or me at 262 796 2250 if you have any questions.

Sincerely,



Mathieu Doucet, FSA, MAAA
Consulting Actuary

MD/bl

Attachments

EXHIBIT 1

Provided in Excel Only

ATTACHMENTS

ATTACHMENT A

CMS RATE SETTING CHECKLIST ISSUES

This section of the report lists each item in the November 10, 2014 CMS checklist and discusses how DHHS addresses each issue and / or directs the reader to other parts of our January 14, 2020 report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

AA.1.0 – Overview of Rates Being Paid Under the Contract

The September 2019 to June 2020 managed care organization (MCO) capitation rates for the Medicaid Care Management program are developed using SFY 2017 and SFY 2018 MCO encounter data and FFS data for the MCO eligible population, and CY 2017 and CY 2018 claims data from the CHIS for the GAHCP Non-Medically Frail population, along with other information. DHHS sets rates by rate cell for all MCOs.

Please refer to this report for background on the program and more details around the rate development.

AA.1.1 – Actuarial Certification

The Actuarial Certification of the September 2019 to June 2020 MCM capitation rates is shown in Attachment C. The September 2019 to June 2020 MCM capitation rates have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

AA.1.2 – Projection of Expenditures

Exhibit B from our January 14, 2020 rate report includes a projection of total expenditures based on estimated enrollment and September 2019 to June 2020 capitation rates.

AA.1.3 – Risk Contracts

The MCM program contract meets the criteria of a risk contract.

AA.1.4 – Modifications

The September 2019 to June 2020 rates documented in the attached letter are updated capitation rates for the MCM population for the September 2019 to June 2020 MCM contract period. The original certification is dated March 4, 2019, a second iteration is dated August 14, 2019, and a third iteration is dated January 14, 2020.

Note: There is no AA.1.5 on the Rate Setting Checklist

AA.1.6 – Limit on Payment to Other Providers

It is our understanding no payment is made to a provider other than the participating MCOs for services available under the contract.

AA.1.7 – Risk and Profit

The September 2019 to June 2020 MCM capitation rates include a targeted margin of 1.5% for risk, profit, and contribution to reserves. We believe that this margin is appropriate given the variability of expenses under the program.

AA.1.8 – Family Planning Enhanced Match

DHHS claims enhanced match for family planning services for the population covered under this program. Separate estimates for the portion of each capitation rates related to family planning services will be provided at a later date.

AA.1.9 – Indian Health Service (IHS) Facility Enhanced Match

DHHS does not claim enhanced match for Indian Health Services for the population covered under this program.

AA.1.10 – Newly Eligible Enhanced Match

The GAHCP population is part of the newly eligible Medicaid population. Therefore, the rates for those rate cells are eligible for the enhanced Federal match under Section 1905(y). Capitation rates for the Medically Frail and Non-Medically Frail populations are developed separately from the Standard Medicaid populations.

ATTACHMENT A

AA.1.11 – Retroactive Adjustments

The September 2019 to June 2020 rates documented in the attached letter are an update to the capitation rates documented in the January 14, 2020 report and contain the retroactive adjustments described in the attached letter. The changes are applied within the two year limit for retroactive adjustments.

AA.2.0 – Based Only Upon Services Covered Under the State Plan

The SFY 2017 and SFY 2018 MCO encounter and CY 2017 and CY 2018 CHIS base experience data includes a cost effective non-covered service that qualifies as an in-lieu of service and meets cost effectiveness requirements. Please see Section III of our January 14, 2020 report for more details.

AA.2.1 – Provided Under the Contract to Medicaid-Eligible Individuals

The September 2019 to June 2020 capitation rate development methodology primarily relies on MCO encounter data for all MCM eligible populations. FFS data is used for the MCM eligible populations during their plan selection period. This enrollment period will now be covered by MCOs under the Next Day passive enrollment process.

AA.2.2 – Data Sources

The September 2019 to June 2020 capitation rates are developed using SFY 2017 and SFY 2018 MCO encounter and FFS claims and eligibility data, as well as CY 2017 and CY 2018 CHIS data.

Please refer to Sections II and III of our January 14, 2020 report for more details.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in our January 14, 2020 report. In addition, each item in the checklist is addressed in items AA.3.1 through AA.3.17 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rates includes the services covered under the MCM contract.

Section IV of this our January 14, 2020 documents the development of PMPM add-ons for substance use disorder treatment in an IMD for adolescents, Applied Behavioral Analysis (ABA) services, gender dysphoria surgery, and other services that were not offered under the MCM contract in the base period but are part of the MCM contract for September 2019 to June 2020. We also document several services provided to the Non-Medically Frail population that are not include in the base experience data from CHIS.

Please refer to Section IV of our January 14, 2020 report for more details.

AA.3.2 – Administrative Cost Allowance Calculations

The capitation rates include explicit administrative allowances by rate cell. Please see Section IV in our January 14, 2020 report for more details regarding the administrative allowance calculation. The attached letter describes further adjustments to the administrative allowances by rate cell.

AA.3.3 – Special Populations' Adjustments

The September 2019 to June 2020 capitation rates methodology does not include an adjustment for special populations as the base FFS and encounter data used to calculate the capitation rates is consistent with the eligible population.

AA.3.4 – Eligibility Adjustments

The base data only reflects experience for time periods where members were eligible to enroll in a MCO.

AA.3.5 – Third Party Liability (TPL)

The managed care organizations are responsible for the collection of any TPL recoveries. The capitation rates include an adjustment to reflect additional TPL recoveries that are not reflected in the base year FFS data portion.

AA.3.6 – Indian Health Care Provider Payments

The MCOs are responsible for the entirety of any IHC payments, which are fully reflected in the claims data.

AA.3.7 – DSH Payments

DSH payments are not included in the capitation rates.

AA.3.8 – FQHC and RHC Reimbursement

The MCOs are responsible for the entirety of the FQHC and RHC encounter payments, which are fully reflected in the claims data.

AA.3.9 – Graduate Medical Education (GME)

GME payments are not included as part of the capitation rates.

AA.3.10 – Copayments, Coinsurance, and Deductibles in Capitated Rates

The MCM population with an income over 100% of FPL must pay a $1 / $2 preferred / non-preferred copay for prescription drugs. The FFS and MCO encounter data reflect the copayment collection.

AA.3.11 – Medical Cost / Trend Inflation

Section III of our January 14, 2020 report documents the trend assumptions used to project the base period costs to September 2019 to June 2020.

The attached letter describes further adjustments to service costs to reflect the expected net impact of reductions in non-emergency and elective service costs due to the COVID-19 pandemic preparedness and social distancing guidelines, increased COVID-19 treatment costs, the impact of waiving certain prior authorization requirements, and reduced population acuity due to projected enrollment increases related to the recession

AA.3.12 – Utilization Adjustments

Utilization trend is included in AA.3.11.

AA.3.13 – Utilization and Cost Assumptions

The utilization and cost assumptions are appropriate for the population to be covered.

AA.3.14 – Post-Eligibility Treatment of Income (PETI)

Long-term care services that are subject to patient liability are excluded from the MCM population capitation rates.

AA.3.15 – Incomplete Data Adjustment

The capitation rates include an adjustment to reflect IBNR claims and underreported CMHC claims. Please refer to Section III of our January 14, 2020 report for more information on the development of these adjustment factors.

AA.3.16 – Primary Care Rate Enhancement

The September 2019 to June 2020 capitation rates are priced at levels consistent with current MCO reimbursement levels with considerations for expected MCM fee schedule changes.

AA.3.17 – Health Homes

Not Applicable.

AA.4.0 – Establish Rate Category Groupings

The September 2019 to June 2020 capitation rates use several rate cells developed from Medicaid eligibility categories to designate the eligible population. Please see Section II of our January 14, 2020 report and Exhibit F for more details.

There are also separate maternity and newborn kick payments.

ATTACHMENT A

AA.4.1 – Eligibility Categories

The eligibility categories included in the September 2019 to June 2020 capitation rates are defined in Section II of our January 14, 2020 report.

AA.4.2 – Age

Age is used for certain rate category groupings.

AA.4.3 – Gender

Gender is not used for rate category groupings.

AA.4.4 – Locality / Region

Region is not used as a rating variable.

AA.4.5 – Risk Adjustments

The MCM population capitation rates will use an actuarially sound risk adjustment model to adjust the rates for each participating MCO. Section II of our January 14, 2020 report includes an overview of the risk adjustment methodology.

We will provide a separate report documenting the development of the MCO Adjusted Risk Factors that will be applied to the September 2019 to June 2020 capitation rates.

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.2 – Data Distortion Assessment

Our review of the base FFS and MCO encounter data did not detect any material distortions or outliers.

AA.5.3 – Data Smoothing Techniques

We determined that a data smoothing mechanism resulting from data distortions was not required.

AA.5.4 – Risk Adjustments

The MCM population capitation rates will use an actuarially sound risk adjustment model to adjust the rates for each participating MCO. Section II of our January 14, 2020 report includes an overview of the risk adjustment methodology.

We will provide a separate report documenting the development of the MCO Adjusted Risk Factors that will be applied to the September 2019 to June 2020 capitation rates.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

DHHS administers a stop-loss arrangement for high cost patients where DHHS will share 50% of the cost above $500,000 for member that have total expenses for capitated services valued at Medicaid fee levels above that threshold. The stop-loss provision will exclude claims incurred at Boston Children's Hospital due to the creation of a separate risk pool for those services.

The adjustment factors reduce the base experience data by about 0.05% to reflect the MCO liability under the stop-loss agreement. This change is intended to be budget neutral to DHHS and the MCOs, since it is a program change. It helps to reduce the variability of MCO financial results due to large cases.

The September 2019 to June 2020 MCM capitation rates also feature a risk pool for Boston Children's Hospital services described in Section II of our January 14, 2020 report.

AA.6.1 – Commercial Reinsurance

DHHS does not require entities to purchase commercial reinsurance.

AA.6.2 – Stop-Loss Program

DHHS administers a stop-loss arrangement for high cost patients where DHHS will share 50% of the cost above $500,000 for member that have total expenses for capitated services valued at Medicaid fee levels above that threshold. The stop-loss provision will exclude claims incurred at Boston Children's Hospital due to the creation of a separate risk pool for those services.

The adjustment factors reduce the base experience data by about 0.05% to reflect the MCO liability under the stop-loss agreement. This change is intended to be budget neutral to DHHS and the MCOs, since it is a program change. It helps to reduce the variability of MCO financial results due to large cases.

AA.6.3 – Risk Corridor Program

The September 2019 to June 2020 MCM capitation rates also feature a risk mitigation corridor as described in the attached letter.

AA.7.0 – Incentive Arrangements

The MCO contract includes a withhold and incentive program in which unearned withheld dollars will be used to finance an incentive pool that is available for additional incentive payments to be made to high-performing MCOs. The amount of an incentive pool awarded to a particular MCO will not exceed 5.0% of the MCO's qualifying capitation revenue.

Please refer to the Withhold and Incentive Program policy included in the MCO contract for more details.

DHHS will waive the quality withhold provisions of the MCM contract for the September 2019 to June 2020 contract year due to the impact of the COVID-19 pandemic. All MCOs will receive 100% of the quality withhold.

AA.7.1 – Electronic Health Records (EHR) Incentive Payments

DHHS has not implemented incentive payments related to EHRs for the September 2019 to June 2020 contract period.

ATTACHMENT B

RESPONSE TO 2019 TO 2020 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (MARCH 2019)

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

i. The rate certification included herein is for the ten-month September 2019 to June 2020 contract period. It is an update to the September 2019 to June 2020 rate certification dated January 14, 2020.

ii. This rate certification submission was prepared in accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7.

a. The actuarial certification letter signed by John Meerschaert, FSA, MAAA certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7. The certification can be found in Attachment C.

b. The final and certified capitation rates for all rate cells can be found in Exhibit 1.

c. The items requested can be found in Sections I through IV of our January 14, 2020 report and the attached letter.

iii. Differences in capitation rates for covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered population.

iv. Each rate cell is developed independently to be actuarially sound and does not cross-subsidize payments for another rate cell.

v. The effective dates of changes to the Medicaid program are consistent with the assumptions used to develop the capitation rates.

vi. The capitation rates are developed in a way that the MCO can reasonably achieve a medical loss ratio of at least 85% for the rate year.

vii. The rate certification submission demonstrates that the capitation rates were developed using generally accepted actuarial practices and principles.

a. All adjustment to the capitation rates reflect reasonable, appropriate, and attainable costs.

b. No adjustments to the rates are performed outside of the rate setting process beyond those outlined in Section III of our January 14, 2020 report and the attached letter.

c. The final contracted rates in each cell match the capitation rates in the certification.

viii. The capitation rates included in this submission are certified for all time periods in which they are effective. No rates for a previous time period are used for a future time period.

ix. This rate certification conforms to the procedure for rate certifications for rate and contract amendments. The September 2019 to June 2020 rates documented in the attached letter are updated capitation rates for the September 2019 to June 2020 Medicaid Care Management program contracts. The prior certification is dated January 14, 2020.

B. Appropriate Documentation

i. We believe the January 14, 2020 report and the attached letter properly documents all the elements included in the rate certification and provides CMS enough detail to determine that regulation standards are met.

Please see Sections I through IV of our January 14, 2020 report and the attached letter for the following details:

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

b. Assumptions made, including any basis or justification for the assumption.

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

ii. We detail within our responses in this guide the section of our report where each item described in the 2019 to 2020 Medicaid Managed Care Rate Development Guide can be found.

iii. DHHS claims enhanced match for family planning services for the population covered under this program. All other services and populations included in this rate certification are subject to the regular state FMAP except for the newly eligible population as described in Section III of our January 14, 2020 report.

iv. Please see Sections I and II of our January 14, 2020 report and the attached letter for the requested documentation.

2. Data

A. Rate Development Standards

i. Our report includes a thorough description of the data used and shows compliance with 42 CFR §438.5(c).

a. DHHS provided Milliman with validated encounter data and financial reports for at least the three most recent and complete years prior to the rating period.

b. The rate development methodology uses current MCO encounter data.

c. The data used is derived from the Medicaid population served under the Medicaid Care Management program.

d. The rate development methodology uses recent MCO encounter data.

B. Appropriate Documentation

i. Milliman requested and received a full claims and enrollment database from DHHS and the MCOs. This information is summarized in Appendices A1-A4 of our January 14, 2020 report.

ii. A detailed description of the data used in the rate development methodology can be found in Section III of our January 14, 2020 report. Section III also includes comments on the availability and quality of the data used for rate development.

iii. The January 14, 2020 report thoroughly describes any material adjustments, and the basis for the adjustments, that are made to the data. Please see Section III and IV of our January 14, 2020 report for more details.

ATTACHMENT B

RESPONSE TO 2019 TO 2020 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (MARCH 2019)

3. Projected Benefit Costs

A. Rate Development Standards

i. The final capitation rates shown in Exhibit 1 are based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).

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

iii. Each projected benefit cost trend assumption is reasonable and developed in accordance with generally accepted actuarial principles and practices using actual experience of the Medicaid population and consideration of other factors that may affect projected benefit cost trends through the rating period.

iv. Please refer to Section III of our January 14, 2020 report for the details related to the treatment of in lieu of services.

v. The September 2019 to June 2020 capitation rates do not allow an institution for mental disease (IMD) to be used as an in lieu of service provider, therefore the cost of all psychiatric services provided in IMDs is excluded from the capitation rates. In addition, the September 2019 to June 2020 capitation rate methodology excludes all claims and eligibility data for the portion of any month when an individual age 21 through 64 had a psychiatric stay longer than 15 days in an IMD.

However, note that New Hampshire's Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Waiver allows for the coverage of substance use disorder (SUD) services provided in an IMD.

B. Appropriate Documentation

i. The various Exhibits included in our January 14, 2020 report and the attached letter document the final projected benefit costs by relevant level of detail and is consistent with how the State makes payments to the plans.

ii. Please refer to Section III of our January 14, 2020 report and the attached letter for the methodology and assumptions used to project contract period benefit costs. Section II of our January 14, 2020 report highlights key methodological changes since the previous rate development.

iii. The rate certification includes a section on projected benefit cost trends in compliance with 42 CFR §438.7(b)(2). See Step 2 of Section III of our January 14, 2020 report for details related to the development of projected benefit cost trends.

iv. This certification does not include additional services deemed by the state to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act.

v. Please refer to Section III of our January 14, 2020 report for the details related to the treatment of in lieu of services.

vi. Section III of our January 14, 2020 report includes a description of how retrospective eligibility periods are accounted for in rate development.

vii. Section I of our January 14, 2020 report documents the impact on projected costs for all material changes to covered benefits or services since the last rate certification.

viii. The rate certification includes an estimated impact of each covered benefit or service change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment for each change related to covered benefits or services.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

The revised September 2019 to June 2020 capitation rate methodology does not include an incentive arrangement. DHHS will waive the quality withhold and incentive provisions of the MCM contract for the September 2019 to June 2020 contract year. All MCOs will receive 100% of the quality withhold.

ii. Appropriate Documentation

The revised September 2019 to June 2020 capitation rate methodology does not include an incentive arrangement. DHHS will waive the quality withhold and incentive provisions of the MCM contract for the September 2019 to June 2020 contract year. All MCOs will receive 100% of the quality withhold.

B. Withhold Arrangements

i. Rate Development Standards

The revised September 2019 to June 2020 capitation rate methodology does not include a withhold arrangement. DHHS will waive the quality withhold and incentive provisions of the MCM contract for the September 2019 to June 2020 contract year. All MCOs will receive 100% of the quality withhold.

ii. Appropriate Documentation

The revised September 2019 to June 2020 capitation rate methodology does not include a withhold arrangement. DHHS will waive the quality withhold and incentive provisions of the MCM contract for the September 2019 to June 2020 contract year. All MCOs will receive 100% of the quality withhold.

C. Risk Sharing Mechanism

i. Rate Development Standards

Section III of our January 14, 2020 report documents the High Cost Patient Stop-Loss Adjustment, and the Boston Children's Hospital risk pool. The attached letter documents the risk corridor in place for all populations enrolled in the MCM program.

ii. Appropriate Documentation

Section III of our January 14, 2020 report documents the High Cost Patient Stop-Loss Adjustment, and the Boston Children's Hospital risk pool. The attached letter documents the risk corridor in place for all populations enrolled in the MCM program.

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

Section IV of our January 14, 2020 report documents the CMHC directed payment and minimum DME fee schedule that have been approved by CMS. The attached letter documents the COVID-19 related directed payment to specific safety net provider classes and is pending CMS approval.

ii. Appropriate Documentation

Section IV of our January 14, 2020 report documents the CMHC directed payment and minimum DME fee schedule that have been approved by CMS. The attached letter documents the COVID-19 related directed payment to specific safety net provider classes and is pending CMS approval.

E. Pass-Through Payments

i. Rate Development Standards

The September 2019 to June 2020 capitation rate methodology does not include any pass-through payments.

ii. Appropriate Documentation

The September 2019 to June 2020 capitation rate methodology does not include any pass-through payments.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. The development of the non-benefit component of the September 2019 to June 2020 rates is compliant with 42 CFR §438.5(e) and includes reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital.

ii. The non-benefit costs included in the September 2019 to June 2020 capitation rates are developed as a percentage of projected benefit costs. The attached letter describes a 1.5% reduction to the PMPM administrative allowances by rate cell. We also reduced the original administrative allowance for the GAHCP Non-Medically Frail population by $0.45 PMPM to remove costs related to the GAHCP work and community engagement requirement that was prohibited by the US District Court for the District of Columbia. This reduction was made at the direction of CMS. The related funding is repurposed for the directed payment pool.

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

iv. The Health Insurance Providers Fee (HIPF) is not included in the capitation rates documented in our January 14, 2020 report and the attached letter. DHHS will recalculate capitation payments for each MCO based on the actual amount of the HIPF for each plan and make gross adjustment payments to the MCOs to appropriately fund the HIPF and its related income tax impact, once appropriate documentation can be provided.

B. Appropriate Documentation

i. Please refer to Section IV of our January 14, 2020 report and the attached letter for a detailed description of the data and methodology used to develop of the projected non-benefit costs included in the capitation rates. The report includes a description of changes made since the last rate development.

ii. The projected non-benefit costs include appropriate consideration for administrative costs, taxes, licensing and regulatory fees, other assessments and fees, contribution to reserves, risk margin, and cost of capital.

iii. The Health Insurance Providers Fee (HIPF) is not included in the capitation rates documented in our January 14, 2020 report and the attached letter. DHHS will recalculate capitation payments for each MCO based on the actual amount of the HIPF for each plan and make gross adjustment payments to the MCOs to appropriately fund the HIPF and its related income tax impact once appropriate documentation can be provided. The MCO capitation rates documented in our January 14, 2020 report and the attached letter are actuarially sound prior to the application of the ACA health insurer fee provision.

6. Risk Adjustment and Acuity Adjustment

A. Rate Development Standards

i. The September 2019 to June 2020 capitation rates will use the risk adjustment arrangement described in Section II of our January 14, 2020 report.

ii. The risk adjustment arrangement described in Section II has been developed in accordance with generally accepted actuarial principles and practices and is budget neutral to the state in total.

iii. Section III of our January 14, 2020 report documents the trend adjustment for opioid addiction population treatment costs to reflect the increased acuity of the covered population Section III also documents the acuity adjustment applied for the Medically Frail population.

B. Appropriate Documentation

i. The September 2019 to June 2020 capitation rates will use the risk adjustment arrangement described in Section II of our January 14, 2020 report.

ii. The September 2019 to June 2020 capitation rate methodology does not include any retrospective risk adjustment components.

iii. Proposed changes to the risk adjustment methodology will be documented in a separate correspondence. The risk adjustment process is and will remain budget neutral to the state in total.

iv. Please see Section III of our January 14, 2020 report for the requested documentation regarding the trend adjustment for opioid addiction population treatment costs to reflect the increased acuity of the covered population, as well as the acuity adjustment for the Medically Frail population.

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

This certification does not include rates for managed long-term services and supports (MLTSS).

SECTION III. NEW ADULT GROUP CAPITATION RATES

This section includes the documentation for the rates for the new adult group under 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

1. Data

A. A detailed description of the data can be found in Sections II and III of our January 14, 2020 report.

B. The Medically Frail and Non-Medically Frail populations were covered starting in September 2014. The September 2019 to June 2020 rates are based on SFY 2017 and SFY 2018 encounter data for the Medically Frail population and the CY 2017 and CY 2018 CHIS encounter data for the Non-Medically Frail population, which is the most recent data available for these populations.

ATTACHMENT B

RESPONSE TO 2019 TO 2020 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (MARCH 2019)

2. Projected Benefit Costs

A. Our report includes a thorough discussion of issues related to the projected benefit costs for the new adult group:

i. Data for the Medically Frail and Non-Medically Frail populations is available. The rates are based on SFY 2017 and SFY 2018 encounter data for the Medically Frail population and the CY 2017 and CY 2018 CHIS encounter data for the Non-Medically Frail population.

ii. The base data and methodology used to calculate the September 2019 to June 2020 capitation rates is similar to the methodology used to calculate the July 2019 to August 2019 capitation rates.

iii. Our rate setting assumptions are generally consistent between the July 2019 to August 2019 rate period and the September 2019 to June 2020 rate period.

B. We made an adjustment for acuity to reflect observed acuity differences between the base period data and emerging experience for the Medically Frail population. We did not make any adjustments for pent-up demand, adverse selection, and demographic differences to either Medically Frail or Non-Medically Frail populations.

C. Table 2 in Section I of our January 14, 2020 report quantifies the impact of program changes implemented for September 2019 to June 2020.

D. Table 2 in Section I of our January 14, 2020 report quantifies the impact of program changes implemented for September 2019 to June 2020.

3. Projected Non-Benefit Costs

A. The methodology used to develop the September 2019 to June 2020 non-benefit costs is consistent with those used to develop the July 2019 to August 2019 non-benefits costs. We increased the non-benefit cost allowance for all rate cells to reflect new MCO contract requirement.

B. Please refer to Section IV of our January 14, 2020 report and the attached letter for more details on the development of the non-benefit costs for the Medically Frail and Non-Medically Frail populations and how these assumptions compare to the Standard Medicaid population. The attached letter describes a 1.5% reduction to the PMPM administrative allowances by rate cell. We also reduced the original administrative allowance for the GAHCP Non-Medically Frail population by $0.45 PMPM to remove costs related to the GAHCP work and community engagement requirement that was prohibited by the US District Court for the District of Columbia. This reduction was made at the direction of CMS. The related funding is repurposed for the directed payment pool.

4. Final Certified Rates

A. Please refer to Tables 1 and 2 in Section I of our January 14, 2020 report for a comparison of the original September 2019 to June 2020 capitation rates to the revised September 2019 to June 2020 capitation rates. The updated September 2019 to June 2020 capitation rates in the attached letter are equal to the capitation rates in the January 14, 2020 report, although funds were reallocated to directed payments for safety net providers as documented in the attached letter.

ATTACHMENT B

RESPONSE TO 2019 TO 2020 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (MARCH 2019)

5. Risk Mitigation Strategy

A. The September 2019 to June 2020 capitation rate for the new adult group will use the same risk adjustment, minimum loss ratio requirement with remittance, High Cost Patient Stop-Loss arrangement, and Boston Children's Hospital risk pool as the Standard Medicaid population as described in Section II of our January 14, 2020 report. The attached letter documents the risk corridor in place for all populations enrolled in the MCM program.

B. The September 2019 to June 2020 risk mitigation strategy is different than previous rating period. Refer to the attached letter for the detailed provisions of the risk corridor in place for all populations enrolled in the MCM program.

April 22, 2020

New Hampshire Department of Health and Human Services
Capitated Contracts Ratesetting
Actuarial Certification
September 2019 to June 2020 Medicaid Care Management Program Capitation Rates

I, John D. Meerschaert, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I was retained by the New Hampshire Department of Health and Human Services (DHHS) to perform an actuarial certification of the Medicaid care management program capitation rates for September 2019 to June 2020 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the calculated capitation rates and am familiar with the relevant requirements of 42 CFR 438; the CMS "Attachment A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting;" the 2019 to 2020 Medicaid Managed Care Rate Development Guide and Actuarial Standard of Practice (ASOP) 49.

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for September 2019 to June 2020. To the best of my information, knowledge and belief, the capitation rates offered by DHHS are in compliance with the relevant requirements of 42 § CFR 438.3(c), 438.3(e), 438.4 (excluding paragraph (b)(9)), 438.5, 438.6, and 438.7. The attached actuarial report describes the capitation rate setting methodology.

In my opinion, the capitation rates are actuarially sound, as defined in Actuarial Standard of Practice (ASOP) 49, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I relied upon the accuracy of the underlying claims and eligibility data records prepared by DHHS, as well as encounter data, financial data summaries, and other information prepared by the participating MCOs. A copy of the reliance letter received from DHHS is attached and constitutes part of this opinion. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

The capitation rates developed may not be appropriate for any specific MCO. Any MCO will need to review the rates in relation to the benefits provided. Each MCO should compare the rates with its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHHS. The MCO may require rates above, equal to, or below the actuarially sound capitation rates.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

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 MCO's situation and experience.

This Opinion assumes the reader is familiar with the New Hampshire Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. The Opinion is intended for the State of New Hampshire and the Centers for Medicare and Medicaid Services 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 rate projections of the type in this Opinion, so as to properly interpret the projection results.

John D. Meerschaert
Member, American Academy of Actuaries
April 22, 2020

DATA RELIANCE LETTER

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

Jeffrey A. Meyers
Commissioner

Henry D. Lipman
Director

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November 6, 2019

Mr. John D. Meerschaert, F.S.A.
Milliman, Inc.
15800 Bluemound Road, Suite 100
Brookfield, WI 53005

Re: Actuarial Certification of September 2019 to June 2020 Capitation Rates for New Hampshire Medicaid Care Management Program Capitation Rates

Dear John:

I, Henry Lipman, Medicaid Director for the New Hampshire Department of Health and Human Services, hereby affirm that the data prepared and submitted to Milliman, Inc. (Milliman) for the purpose of certifying the September 2019 to June 2020 New Hampshire Medicaid Care Management (MCM) program capitation rates were prepared under my direction, and to the best of my knowledge and belief are accurate and complete. This data includes:

1. Computer files supporting the September 2019 to June 2020 capitation rate calculation, including, but not limited to:

    1) Technical Definition for NH MCM Data Book Services Scope V3.doc
    2) Reference Files.xls
    3) NH Provider Type Codes and Descriptions.xls
    4) Eligibility Category Detail.xlsx
    5) Medicaid CAHs.xls
    6) OP-RHC-FQHC Reimbursement Process as of 2-5-13.doc
    7) Provider Payment Algorithms2011.docx
    8) QA LOG Care management 111412012 w corrected date at top.xlsx
    9) Medicaid Extract and Claims Information.doc
    10) NH+Medicaid+rebranded+detailed+FQHC+Provider+Manual+2-1-18.pdf
    11) Newborn Reporting Procedures Guidance Statement 20121130.doc
    12) NH Care Management Contract Exhibit A 031612.pdf
    13) Executed Children's Hospital Agreement.pdf
    14) NH MCM Rate Cells Definition 2014-02-20.xls
    15) Community Mental Health Agreement 1.22.15.pdf
    16) Fiscal Impact Change of Scope & LAL SFY19.xlsx
    17) ABA Calculations for Milliman-20190508.xlsx
    18) FY20_21 Provider Rate Increases by Senate Bill and Milliman Exh 1.xlsx

2. Fee schedule files:

1) CY/SFY/FFY 2017 fee schedules:
   - 2017 DRG Rate Sheet.xls
   - Estimated 2018 DRG Rate Sheet.xls
   - Hospital OP 2018 Estimate.xls
   - ADH-REF-101 2017-01-05.xlsx
   - ADH-REF-102 2017-01-05.xlsx
   - Copy of NHCSR-OMBP-1-ASC+Fee+Schedule-Attachment1-20160105.xlsx
   - NHCSR-BBH-1-2017 Annual CPT Family Psychotherapy-Attachment1-20170106.xlsx

2) CY/SFY/FFY 2018 fee schedules:
   - 2018 DRG Rate Sheet.xls
   - SFY 18 Hosp IP & OP.xls
   - 2018 NH Fee Schedule Covered Procedures 02232018.xlsx
   - 2018 NH Fee Schedule Manually Priced Procedures 02232018.xlsx
   - 2018 ASC Fee Schedule.xls
   - 2018 Hospice Rates worksheet-Final.xlsx
   - FQHC Based Rate SFY 2018.xls
   - SFY18 RATE CHANGE LOG.xlsx
   - 2019 FISCAL IMPACT - Hospice Rates FINAL.xlsx

3) CY/SFY/FFY 2019 fee schedules:
   - 2019 DRG Rate Sheet.xls
   - Fee Schedule 1-8-19.xlsx
   - 2018 Medicaid Rates for Diagnostic and Physician Rates-20190108.xlsx
   - Report of Covered Procedures - 20190110.xlsx
   - Report of Manually Priced Procedures - 20190110.xlsx

4) FFY2020 fee schedules:
   - 2020 DRG rates (from www.dhhs.nh.gov)
   - FQHC.xlsx

3. January 2010 – December 2018 Medicaid eligibility data and claims from MMIS, including:

1) Biweekly claims data (facility, professional and drug).
2) Biweekly enrollment data
3) Provider reference files.
4) Supplemental eligibility/ineligibility files
5) Additional Hospice and NEMT claims:
   - Copy of SFY 16 Hospice Claims Data for Milliman.xlsx
   - SFY 2017 claims data for Milliman.xlsx
   - SFY 2018 Hospice data for Milliman.xlsx
   - CTS 2017 Data.xlsx
   - SFY 2018 NEMT Claim Data for Milliman.xlsx
   - CTS Encounter data- Milliman.xlsx

6) BCH Settlement:
   - Childrens Hospital of Boston Enhanced Amounts SFY17_SFY18.xlsx
   - CHB Enhanced Data for Milliman Actuarial Analysis 03-15-2019v2.xlsx
7) Additional BDAS claims:
   - BDAS Likely Medicaid SFY2016-2017.accdb
   - tblWITS_SFY18_SvcInMedicaidSpan.xlsx
8) Plan Selection Period info:
   - Fee for Service Spans for Andrew 1-1-2018 to current.xls
9) IMD Claims:
   - tblNHHLinkedtoMC 4-25-17.xlsx
   - tblNHHLinked_to_MedicaidSFY2017v2.xlsx
   - tblNHHAdmitsJuly2015thruNov2018.xlsx

4. Other supporting documentation, including:

1) MCO contract
2) State PDL as of May 31, 2019
3) ATECH services details
4) Sununu Youth Center ramp up schedule and per diem rates
5) Behavioral Health Crisis Treatment Center implementation schedule
6) Anticipated fee schedule changes for SUD residential services
7) DRF identification process
8) Fiscal impact and appropriation amounts for various legislative provisions
9) Other computer files
10) Conversations concerning supplied data

Sincerely,

Henry D. Lipman, FACHE
Medicaid Director