State of New Hampshire
Department of Health and Human Services
SFY 2019 Capitation Rate Development for the Medically Frail Population Enrolled in the Alternative Benefit Plan

Prepared for:
The State of New Hampshire
Department of Health and Human Services

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I. EXECUTIVE SUMMARY

This report documents the development of the SFY 2019 managed care organization (MCO) capitation rate for New Hampshire's Medically Frail population enrolled in the Alternative Benefit Plan (ABP). The New Hampshire Department of Health and Human Services (DHHS) retained Milliman to calculate, document, and certify its capitation rate development. We developed the capitation rate using the methodology described in this report.

Our role is to certify that the SFY 2019 capitation rate produced by the rating methodology is actuarially sound to comply with Centers for Medicare and Medicaid Services (CMS) regulations. We developed an actuarially sound capitation rate 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.

The Medically Frail population is comprised of individuals who self-identify as being medically frail by having a physical, mental, or emotional condition that causes limitations in daily activities or by residing in a medical facility or nursing home. With the termination of the Bridge Program under the New Hampshire Health Protection Program (NHHPP) on January 1, 2016, individuals that self-identify as Medically Frail cannot enroll in the Qualified Health Plans (QHPs) available through the Premium Assistance Program. Medically Frail individuals have the option to remain in the ABP or enroll in the standard Medicaid program.

The SFY 2019 capitation rate also provides a framework for financial risk protections that safeguard both the MCOs and the state and federal governments from potential overestimation or underestimation of the MCO capitation rates compared to the health care needs of the Medically Frail population. These financial protections are similar to protections that were available for the Bridge Program under NHHPP and for the NHHPP Medically Frail population from January 2016 – June 2018.

SFY 2019 CAPITATION RATE

Table 1 below shows the Medically Frail rate that will be paid to MCOs for each member and the statewide rate change from the SFY 2018 capitation rate to the SFY 2019 capitation rate.

As described in Section II of this report, the capitation rate is based on SFY 2017 MCO encounter data for the Medically Frail population adjusted to reflect the SFY 2019 contract period.

Table 1
New Hampshire Department of Health and Human Services
Medically Frail Population Capitation Rates Per Member Per Month (PMPM)
SFY 2019 Capitation Rate Change

Rate Cell	SFY 2018 Capitation Rate	SFY 2019 Capitation Rate	Percentage Change
Medically Frail	$1,207.45	$1,028.83	-14.8%

A portion of the 14.8% rate decrease from SFY 2018 to SFY 2019 relates to program changes made by DHHS, such as changes in covered benefits and expansion of service availability. The combined impact of these program changes amounts to a 3.7% increase and results in an 18.5% rate decrease excluding the impact of the SFY 2019 program changes. The rate decrease is driven by the reduced acuity of the covered population as observed in the base data.

Table 2 shows the statewide rate change from the SFY 2018 capitation rates to the SFY 2019 Medically Frail capitation rates.

Table 2
New Hampshire Department of Health and Human Services
Medically Frail Population Capitation Rates
Summary of SFY 2019Capitation Rate Change Components

Rate Component	Rate Change	Annualized Dollar Impact
Rate Change Prior to Program Changes	**-18.5%**	**($14,032,000)**
SFY 2019 Program Changes:		
Opioid Addiction Treatment Cost Trend Adjustment	3.3%	2,459,000
CMHC Temporary Fee Schedule Increase	0.4%	333,000
Implementation of Behavioral Health Crisis Treatment Center Services	0.1%	44,000
White Mountain Community Center FQHC Lookalike Status	0.0%	4,000
CMHC Workforce Expansion Directed Payment	0.0%	(34,000)
Total Program Changes	**3.7%**	**2,806,000**
Total SFY 2018 - SFY 2019 Rate Change	**-14.8%**	**($11,226,000)**

The SFY 2019 Medically Frail capitation rates include a directed payment to community mental health centers (CMHCs) that is subject to CMS approval. While this amount is included in the MCO capitation rates, MCOs are not at risk for the amount of the payment.

We project an overall MCO medical loss ratio (MLR) of 89.1% for the Medically Frail rates in SFY 2019, which includes:

- A 7.5% administrative cost allowance and a 1.5% risk margin applied as a percentage of revenue prior to the CMHC directed payment and the premium tax allowance
- A 2.0% allowance for New Hampshire's premium tax

The projected MLR excludes the impact of the CMHC directed payment in both the numerator and denominator of the MLR calculation, which is consistent with the treatment of directed payments in federal MLR calculations.

It should be emphasized that capitation rates are a projection of future costs for an efficient MCO based on a set of assumptions. Actual MCO costs will be dependent on each MCO's situation and the extent to which future experience conforms to the assumptions made in the capitation rate development calculations.

REPORT STRUCTURE

Appendices A – D document the development of the SFY 2019 capitation rate. Appendix E calculates the fiscal impact of the SFY 2019 capitation rate. Appendix F shows the development of the Community Mental Health Agreement Add-On while Appendix G shows the development of the Opioid Addiction Treatment Trend Adjustment. Appendix H lists the NDCs for the excluded drugs. The actuarial certification of the SFY 2019 New Hampshire Medically Frail capitation rate is included as Appendix I.

Section II provides an overview of the methodology, including a summary of changes made to the SFY 2018 methodology. Section III documents the capitation rate base data and medical cost projections. Section IV summarizes final capitation rate adjustments. Section V discusses issues related to the CMS rate setting checklist. Section VI includes comments on items related to the 2018-2019 Medicaid Managed Care Rate Development Guide.

DATA RELIANCE AND IMPORTANT CAVEATS

We used MCO encounter cost and eligibility data for SFY 2017, historical reimbursement information, anticipated fee schedules, and other DHHS information to calculate the New Hampshire Medically Frail capitation rate shown in this report. This data was provided by DHHS and the MCOs. We have not audited 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.

We constructed several projection models to develop the capitation rates shown in this report. Differences between the capitation rate 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 SFY 2019 capitation rate 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 report for the specific purpose of developing the SFY 2019 Medically Frail capitation rate. This report should not be used for any other purpose. This report 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 report 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 report should only be reviewed in its entirety.

The results of this report 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 report 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 report 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 on July 1, 2017 apply to this report and its use.

II. METHODOLOGY OVERVIEW

This section of the report provides an overview of the SFY 2019 New Hampshire Medically Frail capitation rate methodology and highlights program changes effective for SFY 2019.

BASE DATA

The SFY 2019 capitation rate is based on SFY 2017 MCO encounter data. We collected claims data for the Medically Frail population currently enrolled in the ABP from New Hampshire Healthy Families and Well Sense Health Plan. We believe the encounter data is of appropriate quality and completeness to use as the primary basis for developing an actuarially sound rate for the Medically Frail population. We validated the MCO encounter data using the following process:

- We compared the submitted encounter data to quarterly financial data summaries provided by the MCOs. The quarterly financial data summaries included FFS and sub-capitated payments made by the MCOs to providers by rate cell, broad service category, and quarter. The financial data was not audited, but is certified by the MCO as accurate and complete.

- DHHS and Milliman provided an opportunity for MCOs to play a greater role in the base data validation for the SFY 2019 capitation rate development process. As we worked on the development of the SFY 2019 capitation rates, we provided MCOs with a series of detailed data summaries in order to further our understanding of the data, complete the validation process, and offer more transparency on the process leading to the capitation rates.

- Through this detailed review process, Milliman, DHHS, and the MCOs validated the encounter data for use in the capitation rate setting process.

We did not identify any material concerns with the quality or availability of the data with respect to total claims in aggregate or our ability to allocate encounter data to major service categories. Our data reconciliation efforts are consistent with Actuarial Standard of Practice #23.

PROGRAM CHANGES FROM THE SFY 2018 CAPITATION RATE METHODOLOGY

The SFY 2019 capitation rate methodology reflects several program changes from the SFY 2018 capitation rate methodology presented in our November 10, 2017 certification. The changes are as follows:

- Inclusion of a specific trend adjustment to recognize an increase in the number of members treated for opioid addiction and their related treatment costs

- Implementation of a temporary fee schedule increase for CMHC services

- Implementation of a Behavioral Health Crisis Treatment Center effective November 1, 2018

- Implementation of a change for White Mountain Community Center to FQHC Look-Alike (LAL) status

- Inclusion of a CMHC directed payment of $5 million across all programs (MCM and NHHPP) for SFY 2019 to support workforce development

Any subsequent material program changes enacted by the legislature or DHHS would need to be factored into the SFY 2019 capitation rates as a rate adjustment.

METHODOLOGY

The methodology used to develop the New Hampshire Medically Frail capitation rate can be outlined in the following steps:

1. Summarize SFY 2017 encounter data for the Medically Frail population
2. Calculate estimated statewide SFY 2019 Medically Frail medical costs for all covered services
3. Adjust SFY 2019 projected medical costs for administrative expenses, margin, and premium tax

Sections III and IV of this report document the rate setting methodology in detail.

ACA HEALTH INSURER FEE

The ACA places an annual fee on the health insurance industry. The fee is allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (e.g., the 2020 health insurer fee will be based on 2019 premium revenue). There is a moratorium on the health insurer fee for calendar year 2019. Market share is based on commercial, Medicare, and Medicaid revenue. CMS regulations require Medicaid managed care rates to include allowances for taxes like the ACA insurer fee because they are an unavoidable cost of doing business for Medicaid MCOs.

DHHS recognizes the need to fund payments related to the ACA health insurer fee that will be paid by the MCOs. Taxes, such as the ACA health insurer fee and related income tax impacts, are widely recognized as a reasonable and unavoidable cost of doing business for Medicaid MCOs and should be considered by the Medicaid actuary for inclusion in Medicaid managed care payments.

The MCO capitation rates documented in this report are actuarially sound prior to the application of the ACA health insurer fee provision. DHHS will recalculate capitation payments for each MCO based on the actual amount of the health insurer fee for each plan and make gross adjustment payments to the MCOs to appropriately fund the ACA health insurer tax and its related income tax impact. Although paid separately, the allocation for the ACA insurer fee is part of the actuarially sound MCO capitation rates.

RISK PROTECTION STRUCTURE

Given the uncertainty of estimating the future cost of the Medically Frail population due to upcoming changes in Medically Frail attestation and implementation of work requirements, DHHS will implement a framework for financial risk protections that safeguard both the MCOs and the state and federal governments from potential overestimation or underestimation of the MCO capitation rate compared to the health care needs of the population. The risk mitigation provision for the SFY 2019 contract period includes the following items:

1. ***Risk adjustment*** – Similar to the risk adjustment process for the current Medicaid population under the MCM program, risk adjustment will shift revenue from MCOs with lower acuity populations to MCOs with higher acuity populations. This portion of the risk adjustment process is revenue neutral.
2. ***Risk corridors*** – The risk corridor provision protects against uncertainty in annual profit or loss results for the MCOs serving NHHPP Medically Frail members in the SFY 2019 contract period. DHHS and the each MCO will share the financial risk of actual results that are above or below the 89.1% medical loss ratio (MLR) target as shown in Table 3:

Table 3
New Hampshire Department of Health and Human Services
New Hampshire Health Protection Program Medically Frail Population
Risk Corridor Program

Actual MLR Compared to Target MLR	MCO Share	DHHS Share
>3% below	10%	90%
1% - 3% below	50%	50%
1% below - 1% above	100%	0%
1% - 3% above	50%	50%
>3% above	10%	90%

III. MEDICAL COST PROJECTIONS

This section of the report describes the projection of the MCO encounter data for Medically Frail population enrolled in the ABP during the base period.

We used the following methodology to project the encounter data used in the calculation of the medical component of the capitation rate:

1. Summarize SFY 2017 encounter base experience data for the Medically Frail population for the services covered by the Alternative Benefit Plan

2. Apply adjustments to the base data to project SFY 2019 medical costs

Each of the above steps is described in detail below.

STEP 1: SUMMARIZE ENCOUNTER BASE EXPERIENCE DATA

In this step, we summarize the encounter data for SFY 2017 by broad service category for the Medically Frail population enrolled in the ABP.

Appendix A shows the summarized SFY 2017 encounter base experience data.

Base Data

We received detailed encounter claims data from each MCO with dates of service between July 2016 and June 2017 and payments through December 2017. The SFY 2019 capitation rate includes sub-capitated expenditures for services not capitated through an affiliated organization. For related entities, the SFY 2019 rate includes actual encounter payments to providers for those services, when available. We removed administrative payments made by the MCOs to related parties from the encounter data. The MCOs also provided summarized provider incentive payments and settlements made outside of the claims data and these items were included in the base data.

Non-Covered Services Adjustment

MCOs are allowed to provide services not explicitly covered under the NHHPP Medically Frail program to beneficiaries in lieu of a covered service. As part of the capitation rate development process, the encounter data must be adjusted to remove the portion of the cost of in-lieu-of services that exceeds the cost of the corresponding covered service.

MCOs currently provide Medical Nutrition & Diabetes Self-Management services defined by procedure codes 97802, 97803 and G0108 with average unit cost of $26.05 per unit using staff nutritionists under the SFY 2017 NHHPP fee schedule. With the change to the Medicaid fee-for-service fee schedule, these services are repriced at $15.70 per unit. Alternatively, these services would be provided as a covered service by a physician in an office setting at the cost of $20.16 per unit (based on the Medicaid fee for 99201 office visit). This comparison shows that Medical Nutrition & Diabetes Self-Management services are cost effective. Therefore, we did not make any adjustment to the base period data for non-covered services.

Eligibility Category Assignment

The Medically Frail population is identified through the MGIM eligibility category code found on an individual's enrollment record. Within the total Medically Frail population, those with a special eligibility code of MA are enrolled in the ABP. The population identification is done on a first of the month basis, consistent with capitation rate payment from MMIS.

STEP 2: APPLY ADJUSTMENTS TO THE BASE EXPERIENCE DATA TO PROJECT SFY 2019 MEDICAL COSTS

In this step, we apply adjustment factors to reflect differences between the base period Medically Frail encounter data and the projected SFY 2019 Medically Frail medical costs. We explain each adjustment factor in detail below.

Appendix B shows adjusted and trended values.

IBNR Adjustment

We developed a completion factor (CF) for the base period data provided in the data book.

We used Milliman's *Claim Reserve Estimation Workbook (CREW)* to calculate completion factors by month and in aggregate for the SFY 2017 base period. CREW calculates incurred but not reported (IBNR) reserve estimates by blending two different estimation methods: the lag completion method and the projection method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. In order to measure this average lag, claims are separated by month of incurral and month of payment. Using this data, historical lag relationships are used to estimate ultimate incurred claims (i.e., total claims for a given incurral month after all claims are paid) for a specific incurral month based on cumulative paid claims for each month.

The projection method develops estimates for incurred claims in recent incurral months by trending an average base period incurred cost per unit to the midpoint of the incurred month at an assumed annual trend rate, and applying an additional factor to account for the seasonality of claim costs and the differing number of working days between months. The base period is chosen by selecting a group (usually 12) of recent consecutive months for which the lag completion method provides reasonable results.

The lag completion and projection methods are combined to produce the final incurred claim estimate. Final incurred claim estimates are calculated as a weighted average of these two methods.

We applied a 1.05 underreporting adjustment to the SFY 2017 MCO encounter base experience data for CMHC services only. We applied the same adjustment used in the SFY 2019 capitation rate development for the Medicaid Care Management (MCM) program. We developed the underreporting adjustment in order to correct for data reporting issues between the CMHCs and MCOs as we understand there is not an actual reduction in services provided by the CMHCs.

Table 4 below shows the IBNR adjustment factor applied to the SFY 2017 experience data.

Table 4 New Hampshire Department of Health and Human Services Medically Fail Population Capitation Rate IBNR Adjustment Factors	
Service Category	**Adjustment Factor**
Hospital Inpatient	1.0146
Hospital Outpatient	1.0071
Professional and Other State Plan Services	1.0062
Prescription Drugs	1.0000
Community Mental Health Centers	1.0509

Reimbursement Adjustment

On December 19, 2016, CMS issued a Corrective Action Plan for DHHS to develop capitation rates with underlying reimbursement levels that are not based on the rate of federal financial participation. In order to comply with 42 CFR §438.4(b)(1), starting in SFY 2018 the capitation rate for the Medically Frail population is based on the current Medicaid fee schedule rather than the NHHPP fee schedule.

Our adjustment factors are based on a repricing of the encounter base experience data. We used the most recent Medicaid fee schedule to reprice the SFY 2017 claim experience and determine the overall change by service category. Table 5 shows a summary of the impact of the repricing.

Table 5 New Hampshire Department of Health and Human Services Medically Fail Population Capitation Rate Reimbursement Adjustment Factors	
Service Category	**Adjustment Factor**
Hospital Inpatient	0.5114
Hospital Outpatient	0.5424
Professional and Other State Plan Services	0.8222
Prescription Drugs	1.0000
Community Mental Health Centers	0.9894

To determine the inpatient reimbursement change, we first summarized the historical paid claims by DRG and applied a factor reflecting the cost difference between the current Medicaid fee schedule and the SFY 2017 NHHPP fee schedule for each DRG.

Outpatient hospital services were reimbursed under the SFY 2017 NHHPP fee schedule at cost, which is represented by a percent of billed charges specific to each facility. DHHS provided us with updated cost-to-charge ratios (CCRs) and the current Medicaid payment rates as a percent of billed charges. Using this information and the base period paid claims for each facility, we estimated the net change of -45.8%.

We estimated the reimbursement change for non-facility services (professional, community mental health center, and other services combined) by summarizing all paid claims by procedure code and modifier. For each combination, we then calculated the actual change in fee from the SFY 2017 NHHPP fee schedule to the current Medicaid fee schedule. We also incorporated known fee changes not included in the current fee schedules.

Manchester Community Health Center (MCHC) recently filed a request for rate change due to two separate changes in their scope in services. Following approval by DHHS, the per encounter rate was increased to $195.08 for SFY 2019. The impact of the change in per encounter rate for MCHC is reflected in the reimbursement adjustment factors.

No adjustments were necessary for prescription drugs.

Medical Trend from SFY 2017 to SFY 2019

We developed trend rates from SFY 2017 to SFY 2019 by rate category and type of service using our experience with similar populations in other states and CMS projected trends. Table 6 below summarizes the trend rate assumptions by major service category. The annual trends are generally consistent with the annual trends used for the SFY 2019 MCM capitation rates.

Table 6
New Hampshire Department of Health and Human Services
Annual Trends from SFY 2017 to SFY 2019

Service Category	Utilization Trend	Unit Cost Trend
Hospital Inpatient Services	0.00%	0.64%[1]
Hospital Outpatient Services	2.00%	1.20%
Professional	1.00%	0.00%
Mental Health Center Services	1.00%	0.00%
Other Services	1.00%	0.00%

[1] Unit cost trend for hospital inpatient services is applied as a one-time allowance for the expected 0.85% increase in DRG reimbursement on October 1, 2018 (not as an annual trend rate).

Although hospital inpatient, professional, and other services are repriced using the October 2017 DRG rate table and the 2018 fee schedule, we also made a trend adjustment to account for expected changes in reimbursement levels in SFY 2019. For hospital inpatient services, we estimated the expected October 2018 DRG weight update to be an increase of 0.85% based on our review of historical DRG weights. We applied the 0.85% DRG weight increase as a 0.64% adjustment since it impacts only the last nine months of SFY 2019. For professional and other services, we assumed no fee schedule changes would be implemented during SFY 2019. DHHS does not anticipate making mid-year capitation rate changes if mid-year FFS reimbursement changes do not vary materially from our assumptions.

Hospital outpatient reimbursement changes are tied to changes in each hospital's operating cost. We developed the 1.2% annual trend for hospital outpatient services by reviewing the average annual change in the Bureau of Labor Statistics (BLS) Producer Price Index (PPI) for hospital services from CY 2015 to CY 2017 (Series ID PCU622---622---). The Hospital PPI is a measure of hospital revenue changes that can also be used as a proxy for operating cost changes because the national average operating margins for hospitals are relatively stable from year to year.

Note that the utilization and unit cost trends in Table 6 exclude trends related to the opioid addiction treatment population, which are shown as a separate adjustment and are described later in this report.

Prescription Drug Trend from SFY 2017 to SFY 2019

Pharmacy trend assumptions are based on a combination of historical New Hampshire Medicaid data analysis, Milliman research on utilization and cost trends, and publicly available trend reports and forecasts.

Our prescription drug trend model uses the most recent 12 months of available Medically Frail population data with sufficient run out (December 2016 – November 2017) as the base period for our projections. Given the constantly changing prescription drug, it is critical to project trends using the most current available data.

The final trends are calculated as the ratio of the average drug costs in the projection period (SFY 2019) compared to the average drug costs in the rate setting base period (SFY 2017). Trends were calculated for brand, generic, and specialty drugs, separately for utilization and unit cost. Projected values are estimated using the prescription drug base period data (December 2016 – November 2017) as a starting point and applying anticipated shifts and trends. Each component of pharmacy trend is documented below.

Since hepatitis C, hemophilia, and other high cost drugs (Carbaglu and Ravicti) are carved out for the Medically Frail population for SFY 2019, we excluded these drugs from our prescription drug trend development. Appendix F contains a list of NDCs for the excluded drugs.

Brand Patent Loss

When a brand drug loses patent, utilization shifts from the brand drug to new generic alternatives. In our analysis, we shifted utilization for brand drugs that recently lost patent or are expected to lose patent in the projection period. We included known patent expirations through the end of 2018 (later expirations were excluded due to the uncertainty of the timing of patent expirations further out in the future). Our utilization shift assumptions are based on Milliman research of how quickly historic brand utilization converts to generic in each month after a patent expires. Similarly, we used assumptions for what the cost of the new generic drug would be relative to the current brand drug price. Major brand drugs that have already lost or are expected to lose patent between the base period and the projection period include the following drugs:

- Adcirca
- Byetta
- Lexiva
- Remicade
- Remodulin
- Rituxan
- Sensipar
- Treximet
- Viagra
- Viread
- Xolair

Cost per Script Trends

Projected costs per script in December 2017 (the first month of the projection) are generally based on the average costs per script in the most recent three months of the experience data (September 2017 - November 2017), adjusted for any anomalies in the data. These costs are trended forward using separate cost trend assumptions for brand, generic, and specialty products, including class-specific trend assumptions for classes with demonstrably different trend patterns in recent months, based on AWP price history in New Hampshire claims experience data.

The cost per script trends are based on an analysis of historical average wholesale price (AWP) data. We mapped AWPs from Medi-Span by NDC and analyzed the annual trends over the past several quarters, using a fixed market basket of drugs from the Medically Frail population's pharmacy claims experience. We also used public industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", to validate these unit cost trends.

Note that the overall average unit cost trend factor resulting from our trend analysis for certain drug classes is above (or below) the targeted prospective unit cost trend used in our trend analysis to the extent that the September 2017 to November 2017 experience that we used as the starting point for the unit cost projections is above (or below) the SFY 2017 base period unit cost experience.

Brand Cost Trends

We analyzed AWP trends for the brand drugs used by Medically Frail members. Based on a combination of Milliman research, industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", and the historical AWP trends using MCM program data, we assumed a default brand annual unit cost trend of 8.0%. We varied trends from this default for several classes though, based on variations for classes with typically higher or lower than average trends. Table 7 shows the classes for which we used a unique trend value:

Table 7
New Hampshire Department of Health and Human Services
Annual Brand Unit Cost Trends for Specific Therapeutic Classes

Therapeutic Class	Annual Brand Unit Cost Trend
Acne Products	3.0%
Anaphylaxis Therapy Agents	12.0%
Anticonvulsants - Benzodiazepines	12.0%
Antipsychotics - Misc.	18.0%
Diagnostic Tests	3.0%
Insulin - Long Acting	2.0%
Insulin - Short / Intermediate Acting	12.0%
Opioid Partial Agonists	6.0%
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	15.0%
Combination Contraceptives - Oral	5.0%
Sympathomimetics	5.0%
Stimulants - Misc.	12.0%
Antidementia Agents	15.0%
Anticonvulsants - Misc.	12.0%
Scabicides & Pediculicides	20.0%

Generic Cost Trends

Generic drugs typically have only modest price increases. While generic trend increases were higher than usual during much of 2014 to 2016 due to ingredient shortages, changes to legislation, and consolidation of generic manufacturers resulting in reduced competition, this pattern has slowed, and generic trends have been returning to more typical levels in recent quarters. We expect this slowing of generic trends to continue in the near future.

Based on a combination of Milliman research, industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", and the historical AWP trends using MCM program data, we assumed a default generic annual unit cost trend of 1.5%. Similar to brand unit cost trends, we varied trends from this default for several classes, based on variations in the data for classes with typically higher or lower than average trends. Table 8 shows the classes for which we used a unique trend value:

Table 8 New Hampshire Department of Health and Human Services Annual Generic Unit Cost Trends for Specific Therapeutic Classes	
Therapeutic Class	**Annual Generic Unit Cost Trend**
Acne Products	3.0%
HMG CoA Reductase Inhibitors	0.0%
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	0.0%
Soluble Tumor Necrosis Factor Receptor Agents - Monoclonoal Antibodies	3.5%
Stimulants - Misc.	10.0%
Phenothiazines	8.0%
Scabicides & Pediculicides	20.0%

Specialty Cost Trends

Specialty drugs continue to be a major contributor to overall pharmacy trends. There is an increase in overall average pharmacy costs due to an increased mix of specialty treatments—specialty drugs tend to be much higher cost than non-specialty medications, so as utilization of specialty products increases, the average price of all drugs increases. AWP trends for specialty drugs are also significant, and are currently expected to be somewhat higher than non-specialty brand cost trends.

Based on a combination of Milliman research, industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", and the historical AWP trends using New Hampshire data, we assumed a default specialty unit cost trend of 9.5%. While historical unit cost trends, including high-cost pipeline drugs for the specialty category, have been below 9.5%, this assumption includes an allowance for additional high-cost pipeline drugs above those reflected in the historical claims data used in the trend analysis. We varied unit cost trends from this default for several classes, based on variations in the data for classes with typically higher or lower than average trends. Table 9 shows the classes for which we used a unique trend value:

Table 9 New Hampshire Department of Health and Human Services Annual Specialty Unit Cost Trends for Specific Therapeutic Classes	
Therapeutic Class	**Annual Specialty Unit Cost Trend**
Cystic Fibrosis Agents	35.0%
Soluble Tumor Necrosis Factor Receptor Agents / Anti-TNF-alpha - Monoclonoal Antibodies	17.0%

Changes in Utilization

Utilization levels for each month in the projection period was based on the utilization level for the same month in our base period projected forward based on the utilization trend assigned to the therapeutic class. For example, December 2017 utilization was projected by trending December 2016 utilization using the applicable utilization trend assumptions, January 2018 utilization was projected by trending January 2017 utilization using the applicable utilization trend assumptions, and so on. This method accounts for seasonality differences in each month.

Additionally, the most recent three to six months of the experience data were used to determine the appropriate brand / generic mix of utilization for each therapeutic class, adjusted for anomalies as needed. By using the most recent three to six months of data to set the brand / generic mix, the projection reflects the impact of the MCO management of the PDL.

Generally, we have observed very flat utilization trends among Medicaid populations. As such, we generally used 0% utilization trends for both brands and generics. There are a few specialty classes, however, that have been growing significantly and are expected to grow in the future based on our analysis. Therefore, we applied non-zero utilization trends to a few specialty classes, as seen in Table 10 below:

Table 10
New Hampshire Department of Health and Human Services
Specialty Utilization Trends for Specific Therapeutic Classes

Therapeutic Class	Specialty Trend
Antineoplastic Enzyme Inhibitors	10.0%
Antiretrovirals	-5.0%
Growth Hormones	5.0%
Hematopoietic Growth Factors	5.0%
Multiple Sclerosis Agents	3.0%
Soluble Tumor Necrosis Factor Receptor Agents / Anti-TNF-alpha - Monoclonoal Antibodies	15.0%
Pulmonary Hypertension – Endothelin Receptor Agonists	5.0%

Note that while flat or positive prospective utilization trends are used in our trend analysis in nearly all cases, the overall utilization trend factor resulting from our trend analysis for certain drug classes is above (or below) the targeted prospective trend to the extent that the December 2016 – November 2017 utilization is above (or below) the SFY 2017 base data utilization.

Summary of Drug Trends by Eligibility Category

Table 11 shows a summary of the drugs trends.

Table 11
New Hampshire Department of Health and Human Services
Annual Prescription Drug Trends from SFY 2017 to SFY 2019

Script Category	Utilization	Unit Cost	PMPM
Generic	-4.8%	7.7%	2.6%
Brand	-4.4%	2.1%	-2.4%
Specialty	-2.1%	-1.6%	-3.6%
Total	-3.7%	2.1%	-1.7%

Aggregate pharmacy trends are lower than the trends included in recent rate development years. This largely results from utilization levels that decreased 15.2% between SFY 2016 and SFY 2017 with these negative trends continuing through November 2017. The persistent negative trends in the recent data partially explains the current projected pharmacy trend levels since our projections start from a lower point than what is included in the base experience period underlying the capitation rates.

It is also important to note that the shift to generic drugs further reduces the projected PMPM drug trends by 1.0%.

Comparison to CMS Office of the Actuary Trends

We did not rely on a strict trend calculation based on observed Medically Frail program encounter data trends when developing trend assumptions for the SFY 2019 rate development. Instead, we developed the trend based on forward-looking considerations as described above.

In general, we compared our overall trend assumptions to the national Medicaid benefit expenditures per enrollee estimates included in Table 19 of the 2016 Actuarial Report on the Financial Outlook for Medicaid published by the CMS Office of the Actuary. Table 12 summarizes federal fiscal year (FFY) 2017 - FFY 2019 expenditure projections and trends for the Child, Adult, Aged, and Disabled eligibility categories. This time period is generally consistent with the base data period and rate period used to calculate the SFY 2019 Medically Frail population capitation rate. Note that the Aged and Disabled eligibility categories include a significant amount of costs related to long term services and supports (LTSS); therefore, the services included may not be as representative compared to current Medically Frail population covered services that exclude LTSS.

Table 12
Summary of National Medicaid Benefit Expenditures per Enrollee Estimates
Table 19 of the 2016 Actuarial Report on the Financial Outlook for Medicaid
Published by the CMS Office of the Actuary

Federal Fiscal Year	Non-Disabled Children	Non-Disabled Adults	Aged[1]	Disabled[1]
2017	$3,579	$5,475	$14,939	$20,934
2019	$3,939	$6,067	$16,294	$22,899
Average Annual Trend	**4.9%**	**5.3%**	**4.4%**	**4.6%**

[1] *Note that the Aged and Disabled eligibility categories include a significant amount of costs related to long term services and supports (LTSS); therefore, the services included may not be as representative compared to current covered services that exclude LTSS.*

The combined annual trend rate applied from the SFY 2017 base period to the SFY 2019 rate period for all rate cells and services was 2.6%. This trend includes utilization and unit cost trend across all services. The trend projections included in the report by CMS' Office of the Actuary have not been updated since 2016 and are based on historical data through FFY 2015. Given the significant decrease in prescription drug trends in recent years, we believe that at a high level, the overall average annual trend rate we applied is consistent with CMS projections.

MCO Reimbursement Adjustment

We expect MCO provider reimbursement arrangements for the Medically Frail population in SFY 2019 to be consistent with provider reimbursement arrangements in the MCM program because the NHHPP fee schedule was retired on August 15, 2018.

We adjusted the repriced MCO encounter data (which was repriced to Medicaid FFS rates) to reflect typical contractual arrangements between MCOs and providers. Based on our review of the MCM encounter data, MCOs contract with providers at a rate greater than the FFS reimbursement for medical services to establish networks that provide adequate access to medical services for the Medicaid enrollees.

Table 13 shows the MCO reimbursement adjustment by type of service.

Table 13
New Hampshire Department of Health and Human Services
MCO Reimbursement Adjustment

Service Category	Reimbursement Adjustment (% FFS)
Hospital Inpatient	102%
Hospital Outpatient Services	102%
Professional Services	101%
Federally Qualified Health Center Services	100%
Mental Health Center	100%
Prescription Drugs	100%
Other Services	101%

Managed Care Savings Adjustment

The managed care savings adjustment reflects the medical cost savings generated through MCO care management activities. The managed care savings adjustment reflects targeted initiatives for the Medically Frail population in SFY 2019. DHHS identified two priorities for MCO medical cost reductions in SFY 2019 compared to the SFY 2017 base period:

1. ***Hospital unit cost reductions:*** We observed that, on average, the MCOs contract with hospitals at approximately 102% of the New Hampshire Medicaid fee schedule for the MCM program. We compared the observed hospital contracting level of each MCO and concluded it was attainable for the MCOs to reduce the average hospital contracting factor by 0.5%. Therefore, we applied a 0.5% managed care savings factor to all hospital inpatient and hospital outpatient costs in the MCO encounter data.

2. ***Medical cost savings from the integration of acute care and behavioral health care:*** The coordination of acute care and behavioral health care management has been fostered by the capitated arrangements between the CMHCs and the MCOs that were implemented in SFY 2017, the expansion of service capacity through the Community Mental Health Agreement, the expansion of SUD services through the Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Waiver, and the delivery system reform activities that are part of New Hampshire's Building Capacity for Transformation 1115 waiver. The expected impact of behavioral health integration is described in case studies cited in the Building Capacity for Transformation 1115 waiver application that show significant cost savings related to the integration of acute care and behavioral health care:

   > *"A variety of approaches to integrated medical-behavioral healthcare have been the focus of cost effectiveness research over the past three decades, with most studies finding that integrated care can lead to reductions in total healthcare costs. Typical cost savings estimates range from 5% to 10% of total healthcare costs over a two to four year period for patients receiving collaborative care, although the most robust evidence is in the care of depression in older adults."*

   The SFY 2019 capitation rates include the same level of targeted savings included in the SFY 2018 capitation rates. For the Medically Frail population, we applied a medical cost reduction of 0.5% to only non-CMHC services.

Pharmacy Rebate Adjustment

The pharmacy rebate adjustment reflects a cost adjustment for prescription drugs to account for rebates the MCOs collect. The SFY 2017 encounter data does not reflect rebates the MCOs will collect outside of the claims payment system. As such, we include a reduction of 3.25% to estimate the amount of gross drug costs that will be collected in post-sale rebates. We based this estimate on a review of recent MCO prescription drug rebates after the MCOs started managing the PDL, as reported in quarterly financial data.

Non-Emergency Transportation Adjustment

We made a 1.0000 adjustment to non-emergency transportation services in the encounter data to reflect flat utilization levels for the non-opioid addiction treatment population in the Medically Frail program. Adjustment for the NEMT costs for the opioid addiction treatment population are discussed later in this report.

We developed the adjustment by reviewing cost experience and determined the impact on the base period experience had the vendor been in place during SFY 2017. The NEMT cost adjustment related to the opioid addiction treatment population is discussed in the “Opioid Addiction Treatment Trend Adjustment” section later in this report.

Opioid Addiction Treatment Trend Adjustment

We made a trend adjustment to the base experience data underlying the Medically Frail capitation rates to account for the estimated increase in both prevalence and cost of treatment for the opioid addiction treatment population.

The proposed adjustments result in increased opioid addiction funding of roughly $2.1 million the Medically Frail population in SFY 2019 compared to using the SFY 2017 base experience data without any adjustment beyond standard trends. The base experience data underlying the SFY 2019 Medically Frail capitation rates includes an average annual amount of about $7.9 million in SFY 2017 for opioid related addiction treatment services, which brings the total funding to $10.0M for the SFY 2019 contract period, before application of the normal utilization and cost trends. We believe the proposed adjustment factor of 1.041 properly addresses the funding of opioid addiction treatment in the SFY 2019 capitation rates based on available information.

IV. FINAL CAPITATION RATE ADJUSTMENTS

This section of the report describes the final adjustments to calculate the New Hampshire Medically Frail capitation rate from the projected SFY 2019 medical costs developed in Section III of this report.

CALCULATE FINAL PROJECTED MEDICAL COSTS

In this step, we use PMPM add-on adjustments for benefits not included in the base experience data. These benefits include:

- Expanded mental health services under the Community Mental Health Agreement
- Temporary CMHC fee schedule increase
- Gender dysphoria surgery benefit
- Facility specific FQHC adjustments
- Behavioral Health Crisis Treatment Center

Appendix C shows the details of our calculations.

Expanded Mental Health Services

DHHS is continuing its expansion of mental health service capacity consistent with the Community Mental Health Agreement (CMHA). New Hampshire's SFY 2019 Medicaid budget includes approximately $18.0 million for additional Medicaid-funded services related to mobile crisis teams, crisis apartments, adult ACT teams, and supported employment. The SFY 2019 Medically Frail capitation rates include an $850,000 funding allowance to incorporate the expanded services expected to be delivered to the Medically Frail population during the contract period.

The CMHA services are intended for all Medicaid beneficiaries in the adult behavioral health population (i.e., people identified as being in the Severe / Persistent Mental Illness, Serious Mental Illness, and Low Utilizer population). Accounting for the implementation of mandatory MCM enrollment under the 1915(b) waiver, approximately 25.6% of the CMHC expenditures for the adult behavioral health population will remain in the FFS program because they are not eligible to enroll in the MCM program due to retroactive eligibility, spenddown status, or Veteran's Administration eligibility. Therefore, we allocated 74.4% of the $18.0 million in CMHA funding ($13.4 million) to the managed care populations (MCM and NHHPP).

We developed the PMPM add-on by rate cell using the CMHC expenditures to allocate the CMHA funding. Note that some funding is allocated to members in the waiver population rate cells because there are some SPMI, SMI, and low utilizer members in the waiver rate cells. Appendix F shows the calculation of the PMPM add-on for expanded services under the CMHA.

Temporary CMHC Fee Schedule Increase

DHHS is temporarily increasing service rates by 8.5% for select services provided by CMHCs during SFY 2019 through a $3 million general fund investment. This investment will increase total CMHC revenue by approximately $5.6 million when matched with Federal funds across all Medicaid populations and programs. The fee schedule increase applies to following twelve codes when the 'HW' modifier is present:

- T1016 - Case management
- H2019 - Therapeutic behavioral services, per 15 minutes
- H2015 - Comprehensive community support services, per 15 minutes
- H2020 - Therapeutic behavioral services, per diem

- 90847 - Family psychotherapy (conjoint psychotherapy) (with patient present)
- H2023 - Supported employment, per 15 minutes
- T1027 - Family training and counseling for child development, per 15 minutes
- H2018 - Psychosocial rehabilitation services, per diem
- S9485 - Crisis intervention mental health services, per diem
- 90846 - Family psychotherapy (without the patient present)
- H0034 - Medication training and support, per 15 minutes
- 90832 - Psychotherapy, 30 minutes with patient and / or family member

These codes, when paired with the 'HW' modifier, account for over 80% of all CMHC payments during SFY 2016 and SFY 2017.

Implementation of Gender Dysphoria Surgery Benefit

Effective July 1, 2017, DHHS implemented a gender dysphoria surgery benefit that covers male to female and female to male gender reassignment surgery.

We developed the expected cost of the gender dysphoria benefit using an estimated surgery cost of $50,000. We identified individuals with a gender dysphoria diagnosis in the MCO encounter data and assumed 10% would proceed with the surgery during SFY 2019.

Based on the assumptions listed above, we estimate the cost of the gender dysphoria surgery benefit is $0.72 PMPM.

Facility Specific FQHC Adjustments

As of April 1, 2018, White Mountain Community Center is classified as a Federally Qualified Health Center Look-Alike (LAL) with a per encounter rate of $152.87 for SFY 2019. We estimated the impact of the change in classification by repricing all encounters at this facility at the per encounter rate. We only repriced services subject to the per encounter rate payment as defined in the FQHC provider manual, Volume II dated January 1, 2018.

We estimate the impact of this change to $0.06 PMPM.

Behavioral Health Crisis Treatment Center

On November 1, 2018, DHHS is implementing a Behavioral Health Crisis Treatment Center to serve any individuals in need of acute psychiatric treatment. The Behavioral Health Crisis Treatment Center is expected to provide services to adults ranging from crisis intervention to individual and group psychotherapy to psychoeducational services.

We used information provided by DHHS to estimate the cost of those services to the Medically Frail population at $39,000 or 0.63 PMPM.

CALCULATE FINAL CAPITATION RATE

In this step, we apply adjustment factors to reflect an allowance for MCO administration / margin and an allowance for state premium tax.

Appendix D shows the details of our calculations.

MCO Administration / Margin Allowance

The overall MCO administration / margin allowance is $90.52 PMPM for the Medically Frail population, which represents 9.0% of MCO revenue prior to the CMHC directed payment and premium tax allowance. The administration / margin allowance provides for a 7.5% load for administrative expenses ($75.48 PMPM) and 1.5% for profit and risk margin ($15.04 PMPM). The MCO administration / margin allowance percentage is consistent with the allowance applied to the Elderly and Disabled Adults rate cell in the SFY 2019 MCM capitation rate. The acuity of the Medically Frail ABP population is expected to be similar in to the acuity of the Elderly and Disabled Adults population.

CMHC Directed Payment

The SFY 2019 MCM and CMHC capitation rates include a directed payment of $5 million to the CMHCs across all programs and populations (MCM and NHHPP), pending approval by CMS. MCOs are required to pay these amounts directly to CMHCs according to criteria approved by CMS. The CMHC directed payment is new to NHHPP for SFY 2019.

The directed payment is targeted to all Medicaid beneficiaries in the behavioral health population (members identified as SPMI, SMI, low utilizer, and SED children). We developed the PMPM directed payment for the Medically Frail population using the CMHC expenditures to allocate the total directed payment amount. Since these amounts are to be paid directly to the providers by the MCOs, we did not include an additional allowance for administrative expense or risk margin.

This adjustment is shown in Appendix C.

Premium Tax Allowance

The capitation rate includes an allowance for the 2.0% premium tax collected by the New Hampshire Insurance Department.

V. SERVICE CATEGORY ASSIGNMENT

This section of the report provides information about the service category assignment used to create the cost models included in the New Hampshire MCM program capitation rate development. This information can be used by participating MCOs to monitor their experience in a format and detail similar to the rate development process.

To prepare the attached cost models, we grouped claims into service categories. The service category assignment described below does not account for excluded or limited services. The next few paragraphs detail how the claim level detail is assigned to the service categories shown in Appendices A and B.

HOSPITAL INPATIENT

Hospital inpatient services are those items and services, provided under the direction of a physician, furnished to a patient who is admitted to a general acute care or psychiatric medical facility for facility and professional services on a continuous basis that is expected to last for a period greater than 24 hours. An admission occurs when the Severity of Illness / Intensity of Services criteria set forth by the review contractor and approved by DHHS is met. Among other services, hospital inpatient services encompass a full range of necessary diagnostic, therapeutic care including surgical, medical, general nursing, radiological, and rehabilitative services in emergency or non-emergency conditions. Additional hospital inpatient services would include miscellaneous hospital services, medical supplies, and equipment.

The hospital inpatient claims are assigned a service category based on Diagnostic Related Group (DRG) codes. Milliman's algorithm classifies hospital inpatient claims using the following groupings of CMS v24 DRG codes.

Table 14
New Hampshire Department of Health and Human Services
Hospital Inpatient Service Groupings by DRG Code

Service Category	Diagnosis Related Group
Medical	'052'-'103','121'-'125','146'-'159','175'-'208','280'-'316','368'-'395','432'-'446','533'-'566','592'-'607','637'-'645','682'-'700','722'-'730','754'-'761','789'-'794','808'-'816','834'-'849','862'-'872','913'-'923','933'-'935','945'-'951','963'-'965','974'-'977'
Surgical	'001'-'042','113'-'117','129'-'139','163'-'168','215'-'265','326'-'358','405'-'425','453'-'517','573'-'585','614'-'630','652'-'675','707'-'718','734'-'750','799'-'804','820'-'830','853'-'858','876'-'876','901'-'909','927'-'929','939'-'941','955'-'959','969'-'970','981'-'989'
Maternity Delivery	'765'-'768', '774'-'775'
Maternity Non-Delivery	'769'-'770', '776'-'782'
Newborn	'795'
Psychiatric	'880'-'887'
Alcohol and Drug Abuse	'894'-'897'
Other	'998'-'999'

HOSPITAL OUTPATIENT

Hospital outpatient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, and emergency services received by a patient through an outpatient / ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours. Outpatient / ambulatory care facilities include hospital outpatient departments, diagnostic / treatment centers, ambulatory surgical centers, emergency rooms, end stage renal disease (ESRD) clinics, and outpatient pediatric AIDS clinics (OPAC). Costs include facility charges only and do not include professional charges unless performed by staff of the facility and billed on a UB-92 (hospital) claims form. All facility-billed items not part of an inpatient admission are considered hospital outpatient services.

The hospital outpatient claims are assigned a service category based on revenue codes. Milliman's algorithm classifies hospital outpatient claims using the following groupings of revenue codes.

Table 15
New Hampshire Department of Health and Human Services
Hospital Outpatient Service Groupings by Revenue Code

Service Category	Revenue Code
Emergency Room	'0450'-'0459'
Surgery	'0360'-'0369','0481','0490'-'0499','0750'-'0759','0790'-'0799'
Radiology	'0320'-'0330','0333','0339'-'0349','0350'-'0359','0400'-'0403','0404','0409','0610'-'0619'
Pathology / Lab	'0300'-'0319','0923','0925'
Pharmacy	'0250'-'0269','0331'-'0332','0335','0630'-'0637'
Cardiovascular	'0480','0482'-'0489','0730'-'0739'
PT / OT / ST	'0420'-'0449','0470'-'0479','0530'-'0539','0930'-'0932','0951'-'0952'
Psychiatric	'0513','0900'-'0905','0907'-'0919'
Alcohol and Drug Abuse	'0906', '0944'-'0945'
Other	'0001','0220'-'0249','0270'-'0279','0280'-'0289','0290'-'0299','0370'-'0379','0380'-'0399','0410'-'0419','0460'-'0469','0500'-'0509','0510'-'0512','0514'-'0521','0523','0526','0528','0529','0550'-'0569','0600'-'0609','0621'-'0624','0650','0655'-'0659','0670'-'0729','0740'-'0749','0760'-'0769','0770'-'0789','0800'-'0809','0810'-'0819','0820'-'0859','0860'-'0861','0880'-'0889','0920'-'0922','0924','0929','0940'-'0943','0946'-'0947','0948','0949','0990'-'0999','2100'-'3109'

PROFESSIONAL

Professional services are assigned to a service category using a condensed version of Milliman's *Health Cost Guidelines (HCGs)* grouping logic and other categories defined by DHHS. Professional services include the full range of preventive care services, primary care medical services, and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care, and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics, and skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service.

COMMUNITY MENTAL HEALTH CENTER

Community Mental Health Center services are split into detailed service categories in order to provide more comprehensive medical cost information for the populations eligible for enhanced mental health services through the CMHCs. We reviewed the CMHC expenditures for those eligible for enhanced mental health services and developed the following service categories with the help of DHHS staff.

Table 16
New Hampshire Department of Health and Human Services
Community Mental Health Center Service Groupings by CPT Code

Service Category	CPT Code
Case Management	T1016
Long Term Support Service	H0034, H2011, H2015, H2019, H2020, T1027
Partial Hospital	H2001, H2018
Psychotherapy	90875, 90801, 90804, 90806, 90808, 90816, 90818, 90821, 90832, 90833, 90834, 90836, 90837, 90839, 90840, 90846, 90847, 90853
Evidence Based Practice	H2027
Medication Management	90805, 90807, 90809, 90817, 90819, 90862, H2010, M0064, T1001
Emergency Service 24/7	S9484
APRTP	S9485
Supported Employment	H2023
Harbor Homes	Provider NPI = 1699705079

PHARMACY

The pharmacy category includes pharmaceuticals as ordered by licensed prescribers and obtained at an outpatient pharmacy. Prescription drugs are identified by the presence of a National Drug Code (NDC) in the claims file. We used Medi-Span information to separate prescription drug expenditures into generic, single source brand, multi-source brand, specialty, and other scripts. We used a definition of specialty drugs consistent with Milliman's *HCGs*.

OTHER

The other service category includes the following services:

- Home health services including intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies
- Emergency transportation or acute care situation where normal transportation would potentially endanger the life of the patient
- Durable medical equipment that provides therapeutic benefits or enables a recipient to perform certain tasks that he or she would be unable to undertake otherwise due to certain medical conditions and / or illnesses

Other services are also assigned a service category using CPT codes. Other unidentifiable services are assigned an "unknown" category of service.

VI. 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 this 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 SFY 2019 managed care organization (MCO) capitation rate for the New Hampshire Health Protection Program (NHHPP) Medically Frail population is developed using SFY 2017 MCO encounter data for the MCO eligible population, along with other information. DHHS sets one rate 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 SFY 2019 Medically Frail capitation rate is shown in Appendix I. The SFY 2019 Medically Frail capitation rate has 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

Appendix E includes a projection of total expenditures based on estimated enrollment and SFY 2019 capitation rate.

AA.1.3 – Risk Contracts

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

AA.1.4 – Modifications

The SFY 2019 rate documented in this report is the initial capitation rate for the Medically Frail population for the SFY 2019 NHHPP contract period.

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 SFY 2019 Medically Frail capitation rate includes 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 does not claim enhanced match for family planning services for the population covered under this program at this time.

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 Medically Frail population is part of the newly eligible Medicaid population. Therefore, the rate is eligible for the enhanced Federal match under Section 1905(y).

AA.1.11 – Retroactive Adjustments

The SFY 2019 rate documented in this report is the initial capitation rate for the SFY 2019 NHHPP contracts and does not contain any retroactive adjustments.

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

The SFY 2017 MCO encounter 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 this report for more details.

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

The SFY 2019 capitation rate development methodology primarily relies on MCO encounter data for the Medically Frail eligible population.

AA.2.2 – Data Sources

The SFY 2019 capitation rate is developed using SFY 2017 MCO encounter claims and eligibility data.

Please refer to Sections II and III of this report for more details.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in this report. In addition, each item in the checklist is addressed in items AA.3.1 – AA.3.17 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rate includes the services covered under the NHHPP contract.

Section IV of this report documents the development of PMPM add-ons for gender dysphoria surgery services that were not offered to Medicaid eligibles in the base period but are part of the NHHPP contract for SFY 2019.

AA.3.2 – Administrative Cost Allowance Calculations

The capitation rate includes explicit administrative allowances. Please see Section IV in the report for more details regarding the administrative allowance calculation.

AA.3.3 – Special Populations' Adjustments

The SFY 2019 capitation rate methodology does not include an adjustment for special populations as the base encounter data used to calculate the capitation rate 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. MCO recoveries are already reflected in the encounter data, therefore, no adjustment is necessary.

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 rate.

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 rate.

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

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

AA.3.11 – Medical Cost / Trend Inflation

Section III of this report documents the trend assumptions used to project the SFY 2017 base period costs to SFY 2019.

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 Medically Frail population capitation rate.

AA.3.15 – Incomplete Data Adjustment

The capitation rate includes an adjustment to reflect IBNR claims and underreported CMHC claims. Please refer to Section III of this report for more information on the development of these adjustment factors.

AA.3.16 – Primary Care Rate Enhancement

The SFY 2019 capitation rate is priced at levels consistent with current MCO reimbursement levels with considerations for expected NHHPP fee schedule changes.

AA.3.17 – Health Homes

Not Applicable.

AA.4.0 – Establish Rate Category Groupings

The SFY 2019 capitation rate uses only one rate cell to designate the eligible population.

AA.4.1 – Eligibility Categories

The eligibility categories included in the SFY 2019 capitation rate are defined in Section II of this report.

AA.4.2 – Age

Age is not 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 Medically Frail population capitation rate will use an actuarially sound risk adjustment model to adjust the rate for each participating MCO. Section II of this report includes an overview of the risk protection features.

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 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 Medically Frail population capitation rate will use an actuarially sound risk adjustment model to adjust the rate for each participating MCO as part of the risk mitigation process. Section II of this report includes an overview of the risk protection features.

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

DHHS will implement risk corridors for the Medically Frail population as part of the risk mitigation process. Section II of this report includes an overview of the risk protection features.

AA.6.1 – Commercial Reinsurance

DHHS does not require entities to purchase commercial reinsurance.

AA.6.2 – Stop-Loss Program

None.

AA.6.3 – Risk Corridor Program

DHHS will implement risk corridors for the Medically Frail population as part of the risk mitigation process. Section II of this report includes an overview of the risk protection features.

AA.7.0 – Incentive Arrangements

None.

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

DHHS has not implemented incentive payments related to EHRs for the SFY 2019 contract period.

VII. RESPONSE TO 2018-2019 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (MAY 2018)

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

i. The rate certification included herein is for the twelve-month SFY 2019 contract period. The previous certification was for the SFY 2018 contract period.

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 (excluding paragraphs (b)(9)), 438.5, 438.6, and 438.7. The certification can be found in Appendix I.

b. The final and certified capitation rate can be found in Appendix D.

c. The items requested can be found in Sections I through IV of this report.

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. The SFY 2019 capitation rate uses only one rate cell to designate the eligible population and is developed to be actuarially sound.

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

vi. The rate certification submission demonstrates that the capitation rate was developed using generally accepted actuarial practices and principles.

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

b. No adjustments to the rate are performed outside of the initial rate setting process beyond those outlined in Section III of the report.

c. The final contracted rate match the capitation rate in the certification

vii. The capitation rate included in this submission is certified for all time periods in which it is effective. No rates for a previous time period are used for a future time period.

viii. This rate certification conforms to the procedure for rate certifications for rate and contract amendments. The SFY 2019 rate documented in this report is the initial capitation rate for the SFY 2019 Medically Frail population as part of the NHHPP contract.

B. Appropriate Documentation

i. We believe the attached report 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 this report 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; and

   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 2018-2019 Medicaid Managed Care Rate Development Guide can be found.

iii. All services and populations included in this rate certification are subject to the enhanced Federal match under Section 1905(y).

iv. Please see Sections I and II of this report 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 NHHPP 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 Appendix A.

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

iii. The rate certification and attached report thoroughly describe any material adjustments, and the basis for the adjustments, that are made to the data. Please see Section III and IV of this report for more details.

3. Projected Benefit Costs

A. Rate Development Standards

i. The final capitation rate shown in Appendix D is 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 this report for the details related to the treatment of in-lieu of services.

v. The SFY 2019 capitation rate does 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 SFY 2019 capitation rate methodology excludes all claims and eligibility data for the portion of any month when an individual age 21-64 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.

vi. The SFY 2019 capitation rates do not allow an IMD to be used as an in-lieu of service provider.

B. Appropriate Documentation

i. The various Exhibits included in this report 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 this report for the methodology and assumptions used to project contract period benefit costs. Section II of the 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 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 this report for the details related to the treatment of in-lieu of services.

vi. Section III includes a description of how retrospective eligibility periods are accounted for in rate development.

vii. Section I 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 SFY 2019 capitation rate methodology does not include any incentive arrangements.

ii. Appropriate Documentation

The SFY 2019 capitation rate methodology does not include any incentive arrangements.

B. Withhold Arrangements

i. Rate Development Standards

The SFY 2019 capitation rate methodology does not include any withhold arrangements.

ii. Appropriate Documentation

The SFY 2019 capitation rate methodology does not include any withhold arrangements.

C. Risk Sharing Mechanism

i. Rate Development Standards

The SFY 2019 Medically Frail population capitation rate will use the risk adjustment and risk corridor arrangement described in Section II of this report.

ii. Appropriate Documentation

The SFY 2019 Medically Frail population capitation rate will use the risk adjustment and risk corridor arrangement described in Section II of this report.

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

Section IV of the report documents the CMHC directed payment that is new for SFY 2019 and is pending CMS approval.

ii. Appropriate Documentation

Section IV of the report documents the CMHC directed payment that is new for SFY 2019 and is pending CMS approval.

E. Pass-Through Payments

i. Rate Development Standards

The SFY 2019 capitation rate methodology does not include any pass-through payments.

ii. Appropriate Documentation

The SFY 2019 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 SFY 2019 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 SFY 2019 capitation rate are developed as a percentage of projected benefit costs.

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 rate documented in this report. 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 this report 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 this report. 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 this report 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 SFY 2019 capitation rate will use a risk adjustment arrangement as part of the retrospective risk protection structure described in Section II of this 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 this report documents the trend adjustment for opioid addiction population treatment costs to reflect the increased acuity of the covered population.

B. Appropriate Documentation

i. The SFY 2019 capitation rate will use a risk adjustment arrangement as part of the retrospective risk protection structure described in Section II of this report.

ii. The retrospective risk protection structure in the SFY 2019 capitation rate methodology uses a retrospective risk adjustment component, as described in Section II of this report.

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 this report for the requested documentation regarding the trend adjustment for opioid addiction population treatment costs to reflect the increased acuity of the covered 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 certification only includes 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 this report.

B. The Medically Frail population was covered starting in September 2014. The SFY 2019 rate is based on SFY 2017 encounter data, which is the most recent data available for the Medically Frail population. Actual experience costs in previous rating periods were lower than originally projected, and have continued to trend downward due to the acuity mix of the growing membership. As a result, the most recent full year of data is used to accurately capture this historical acuity change.

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 population is available. The rate is based on SFY 2017 encounter data.

ii. The base data and methodology used to calculate the SFY 2019 Medically Frail capitation rate is similar to the methodology used to calculate the SFY 2018 Medically Frail capitation rate.

iii. Our rate setting assumptions are generally consistent between the SFY 2018 rate period and the SFY 2019 rate period.

B. We did not make any adjustments for acuity, pent-up demand, adverse selection, and demographic differences since the base experience data reflects the Medically Frail population and the base data reflects the third year of enrollment.

C. Table 2 in Section I of the report quantifies the impact of program changes implemented for SFY 2019.

D. Table 2 in Section I of the report quantifies the impact of program changes implemented for SFY 2019.

3. Projected Non-Benefit Costs

A. The assumptions used to develop the SFY 2019 non-benefit costs are consistent with those used to develop the SFY 2018 non-benefits costs.

B. Please refer to Section IV of this report for more details on the development of the non-benefit costs for the Medically Frail population and how these assumptions compare to the MCM population.

4. Final Certified Rates

A. Please refer to Tables 1 and 2 in Section I of the report for a comparison of the SFY 2018 capitation rate to the SFY 2019 capitation rate.

5. Risk Mitigation Strategy

A. The SFY 2019 Medically Frail population capitation rate will use the risk adjustment and risk corridor arrangement described in Section II of this report.

B. The SFY 2019 risk mitigation strategy is the same as the SFY 2018 risk mitigation strategy.

APPENDIX A – H
State of New Hampshire
Department of Health and Human Services
SFY 2019 Capitation Rate Development for Medically Frail Population Enrolled in the Alternative Benefit Plan

Appendix A
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
SFY 2017 MCO Encounter Base Experience Data

Member Months: 53,532

Benefits	Total Paid Dollars	Total Paid Admits	Total Paid Services	Admits Per 1,000	Utilization Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient							
Medical	$4,396,251	585	2,922	131.1	655.0	$7,514.96	$82.12
Surgical	3,779,989	223	1,479	50.0	331.5	16,950.63	70.61
Maternity Delivery	121,268	26	82	5.8	18.4	4,664.13	2.27
Maternity Non-Delivery	8,336	2	8	0.4	1.8	4,168.14	0.16
Well Newborn	0	0	0	0.0	0.0	0.00	0.00
Psychiatric	1,071,819	196	1,446	43.9	324.1	5,468.47	20.02
Alcohol and Drug Abuse	1,015,736	267	3,239	59.9	726.1	3,804.26	18.97
Other	452	5	11	1.1	2.5	90.35	0.01
	$10,393,852	1,304	9,187	292.3	2,059.4	$7,970.75	$194.16
Hospital Outpatient							
Emergency Room	$5,306,572		5,967		1,337.6	$889.32	$99.13
Surgery	1,276,626		1,246		279.3	1,024.58	23.85
Radiology	2,396,819		5,443		1,220.1	440.35	44.77
Pathology	647,772		33,217		7,446.0	19.50	12.10
Pharmacy	1,705,835		169,728		38,046.7	10.05	31.87
Cardiovascular	262,178		719		161.2	364.64	4.90
PT/OT/ST	443,414		10,118		2,268.1	43.82	8.28
Psychiatric	44,628		228		51.1	195.74	0.83
Substance Abuse	61,410		545		122.2	112.68	1.15
Other	1,883,009		42,854		9,606.3	43.94	35.18
	$14,028,264		270,065		60,538.6	$51.94	$262.05
Professional and Other State Plan Services							
Ambulatory Surgery Center	$245,863		374		83.8	$657.39	$4.59
Office Visits	2,476,760		24,940		5,590.6	99.31	46.27
Preventive Medicine	242,499		5,342		1,197.5	45.39	4.53
Maternity	43,867		127		28.5	345.41	0.82
Certified Midwife	118		2		0.4	58.93	0.00
PT/OT/ST	299,086		9,265		2,076.9	32.28	5.59
Psychiatric and Substance Abuse	2,075,902		20,563		4,609.5	100.95	38.78
Radiology and Pathology	1,427,371		34,542		7,743.0	41.32	26.66
Home Health and Private Duty Nursing	535,159		19,384		4,345.2	27.61	10.00
Ambulance	532,318		14,628		3,279.1	36.39	9.94
Non-Emergency Transportation	2,968,066		151,481		33,956.4	19.59	55.44
Opioid Treatment Program	1,421,000		139,041		31,167.9	10.22	26.54
Federally Qualified and Rural Health Clinics	1,087,460		7,428		1,665.1	146.40	20.31
Adult Medical Day Care	295		20		4.5	14.77	0.01
Personal Care	899		170		38.1	5.29	0.02
Durable Medical Equipment	633,519		100,619		22,555.1	6.30	11.83
Other	3,722,299		158,300		35,485.0	23.51	69.53
	$17,712,483		686,226		153,826.5	$25.81	$330.87
Prescription Drugs							
Generic Scripts	$2,669,068		124,878		27,993.0	$21.37	$49.86
Single-Source Brand	5,821,912		22,094		4,952.7	263.51	108.75
Multi-Source Brand	287,907		876		196.4	328.66	5.38
Specialty	4,031,312		917		205.6	4,396.20	75.31
Other	227		10		2.2	22.70	0.00
	$12,810,426		148,775		33,349.9	$86.11	$239.30
Mental Health Center							
Case Management	$2,319,673		6,477		1,451.9	$358.14	$43.33
Long Term Support Service	814,416		30,853		6,916.1	26.40	15.21
Partial Hospital	369		4		0.9	92.24	0.01
Psychotherapy	907,725		16,407		3,677.8	55.33	16.96
Evidence Based Practice	37,543		1,899		425.7	19.77	0.70
Medication Management	22,739		842		188.7	27.01	0.42
Emergency Service 24/7	9,642		411		92.1	23.46	0.18
APRTP	137,799		251		56.3	549.00	2.57
Supported Employment Services	234,799		8,847		1,983.2	26.54	4.39
Harbor Homes	2,714		18		4.0	150.78	0.05
Other	471,522		5,438		1,219.0	86.71	8.81
	$4,958,942		71,447		16,015.8	$69.41	$92.63
All Services	$59,903,966	1,304	1,185,700	292.3	265,790.1	$50.52	$1,119.02

Appendix B
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
SFY 2019 Projected Medical Costs
Data Adjustments for SFY 2017 MCO Encounter Base Experience Data

Benefits	Per Capita Monthly Paid Cost	IBNR Adjustment	Reimbursement Adjustment	Utilization Trend Factors	Unit Cost Trend Factors	MCO Reimbursement Adjustment	Managed Care Savings Adjustment	Pharmacy Rebate Adjustment	NEMT Adjustment	Opiod Adjustment	Projected Per Capita Monthly Paid Cost
Hospital Inpatient											
Medical	$82.12	1.0146	0.4801	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	$42.32
Surgical	70.61	1.0146	0.4652	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	35.25
Maternity Delivery	2.27	1.0146	0.5314	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	1.29
Maternity Non-Delivery	0.16	1.0146	0.5006	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	0.08
Well Newborn	0.00	1.0146	1.0000	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	0.00
Psychiatric	20.02	1.0146	0.7990	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	17.17
Alcohol and Drug Abuse	18.97	1.0146	0.5128	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	10.44
Other	0.01	1.0146	1.0000	1.0000	1.0064	1.0200	0.9900	1.0000	1.0000	1.0408	0.01
	$194.16										$106.57
Hospital Outpatient											
Emergency Room	$99.13	1.0071	0.5526	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	$61.77
Surgery	23.85	1.0071	0.5309	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	14.28
Radiology	44.77	1.0071	0.5195	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	26.23
Pathology	12.10	1.0071	0.5365	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	7.32
Pharmacy	31.87	1.0071	0.5535	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	19.89
Cardiovascular	4.90	1.0071	0.5665	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	3.13
PT/OT/ST	8.28	1.0071	0.5592	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	5.22
Psychiatric	0.83	1.0071	0.4601	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	0.43
Substance Abuse	1.15	1.0071	1.0000	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	1.29
Other	35.18	1.0071	0.5224	1.0404	1.0241	1.0200	0.9900	1.0000	1.0000	1.0408	20.73
	$262.05										$160.31
Professional and Other State Plan Services											
Ambulatory Surgery Center	$4.59	1.0062	0.4215	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	$2.08
Office Visits	46.27	1.0062	0.5665	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	28.14
Preventive Medicine	4.53	1.0062	0.6258	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	3.04
Maternity	0.82	1.0062	0.5776	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	0.51
Certified Midwife	0.00	1.0062	0.7249	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	0.00
PT/OT/ST	5.59	1.0062	0.7155	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	4.29
Psychiatric and Substance Abuse	38.78	1.0062	0.9160	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	38.14
Radiology and Pathology	26.66	1.0062	0.7298	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	20.89
Home Health and Private Duty Nursing	10.00	1.0062	0.7650	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	8.21
Ambulance	9.94	1.0062	0.6056	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	6.47
Non-Emergency Transportation	55.44	1.0062	1.0000	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	59.52
Opioid Treatment Program	26.54	1.0062	1.0000	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	28.50
Federally Qualified and Rural Health Clinics	20.31	1.0062	1.0175	1.0201	1.0000	1.0000	0.9950	1.0000	1.0000	1.0408	21.97
Adult Medical Day Care	0.01	1.0062	1.0000	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	0.01
Personal Care	0.02	1.0062	0.9999	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	0.02
Durable Medical Equipment	11.83	1.0062	1.1159	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	14.18
Other	69.53	1.0062	0.7487	1.0201	1.0000	1.0100	0.9950	1.0000	1.0000	1.0408	55.89
	$330.87										$291.85
Prescription Drugs											
Generic Scripts	$49.86	1.0000	1.0000	0.9070	1.1606	1.0000	0.9950	0.9675	1.0000	1.0408	$52.59
Single-Source Brand	108.75	1.0000	1.0000	0.9141	1.0417	1.0000	0.9950	0.9675	1.0000	1.0408	103.77
Multi-Source Brand	5.38	1.0000	1.0000	0.9141	1.0417	1.0000	0.9950	0.9675	1.0000	1.0408	5.13
Specialty	75.31	1.0000	1.0000	0.9589	0.9692	1.0000	0.9950	0.9675	1.0000	1.0408	70.12
Other	0.00	1.0000	1.0000	0.9070	1.1606	1.0000	0.9950	0.9675	1.0000	1.0408	0.00
	$239.30										$231.62
Mental Health Center											
Case Management	$43.33	1.0509	1.0032	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	$48.50
Long Term Support Service	15.21	1.0509	1.0126	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	17.19
Partial Hospital	0.01	1.0509	1.0000	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	0.01
Psychotherapy	16.96	1.0509	0.9171	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	17.35
Evidence Based Practice	0.70	1.0509	1.1710	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	0.92
Medication Management	0.42	1.0509	1.0000	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	0.47
Emergency Service 24/7	0.18	1.0509	0.9928	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	0.20
APRTP	2.57	1.0509	1.0000	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	2.87
Supported Employment Services	4.39	1.0509	1.0023	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	4.91
Harbor Homes	0.05	1.0509	0.9774	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	0.06
Other	8.81	1.0509	0.9962	1.0201	1.0000	1.0000	1.0000	1.0000	1.0000	1.0408	9.79
	$92.63										$102.26
All Services	$1,119.02										$892.60

Appendix C
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
SFY 2019 Capitation Rates
Medicaid Care Management Benefit Add-Ons

Projected Per Capita Monthly Paid Cost	$892.60
PMPM Add-On for Expanded Mental Health Services	13.59
CMHC Fee Schedule Increase	4.73
White Mountain Community Center	0.72
Behavioral Health Crisis Treatment Center	0.06
Gender Dysphoria Adjustment	0.63
Final Base Capitation Rate	$912.32

Appendix D
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
SFY 2019 Capitation Rates
Final Base Capitation Rate Development

Projected Per Capita Monthly Paid Cost	$912.32
Administration Load	7.5%
Administration Expense Allocation	$75.48
Risk/Profit Margin	1.5%
Risk/Profit Margin Allocation	$15.04
CMHC Directed Payment	$5.41
Premium Tax Adjustment	2.0%
Premium Tax Amount	$20.58
Final Base Capitation Rate	$1,028.83

Appendix E
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
SFY 2019 Capitation Rates
Estimated Fiscal Impact of Medicaly Frail Capitation Rate

Rate Cell	Est. SFY 2019 Member Months	Capitation Rate	Total Capitation Liability
Medically Frail Population	62,659	$1,028.83	$64,465,053

Appendix F1
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
CMHC Services
Community Mental Health Agreement Add-on Development

CMHA Services	SFY 2019 Budgeted for Medicaid Services	Portion Allocated to MFPopulation	Portion Allocated to Step 1 Services	SFY 2019 MF Population Funding
Mobile Crisis Teams	$1,467,300	6.4%	74.4%	$69,493
Community Crisis Apartments	657,000	6.4%	74.4%	31,116
Assertive Community Treatment Teams	10,605,100	6.4%	74.4%	502,271
Supported Employment	5,250,000	6.4%	74.4%	248,646
Total CMHA Funding	$17,979,400			$851,526

Appendix F2
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
CMHC Services
Community Mental Health Agreement Add-on Development

Total SFY 2019 Allocated CMHA Funding	SFY 2019 Projected Member Months	PMPM Add-On
$851,526	62,659	$13.59

Exhibit G
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
Opioid Addiction Treatment Trend Adjustment Development

	Base Year Member Months				Projected SFY 2019 Member Months			Base Year PMPM Cost				Projected SFY 2019	
Base Data Year	Opioid Addiction Population	Non-Opioid Addiction Population	Total Population	Opioid Addiction Enrollment Trend	Opioid Addiction Population	Non-Opioid Addiction Population	Total Population	Opioid Treatment Cost	Other Cost For Opioid Addiction	Non-Opioid Addiction Population	Total	Projected Enrollment Mix PMPM	Rate Adjustment
SFY 2017	11,006	43,334	54,340	16.9%	15,047	47,612	62,659	$716.84	$956.22	$967.07	$1,110.07	$1,155.36	1.0408

Appendix H
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
National Drug Codes for Carved-Out Prescription Drugs

* A Hepatitis C supplemental drug is carved out if there's an accompanying treatment drug in the same month.

Hemophilia	Hepatitis C (Treatment)	Hepatitis C (Supplemental)*	Hyperammonemia (Carbaglu & Ravicti)
00026037220	00003001101	00004008694	52276031260
00026037230	00003021301	00004035009	52276031205
00026037250	00003021501	00004035239	75987005006
00026037920	00006307401	00004035730	76325010004
00026037930	00006307402	00004036030	76325010025
00026037950	00074006328	00004036530	
00026378220	00074308228	00074319716	
00026378225	00074309328	00074322456	
00026378330	59676022528	00074323956	
00026378335	61958150101	00074327156	
00026378550	61958180101	00074328256	
00026378555	61958220101	00085031402	
00026378660		00085119403	
00026378665		00085127901	
00026378770		00085129101	
00026378775		00085129701	
00026379220		00085129702	
00026379330		00085130401	
00026379550		00085131601	
00026379660		00085131602	
00026379770		00085131801	
00026382125		00085132301	
00026382225		00085132302	
00026382425		00085132704	
00026382650		00085135105	
00026382850		00085136801	
00053623302		00085137001	
00053761505		00085137002	
00053761510		00085138507	
00053761520		00085435301	
00053762005		00085435401	
00053762010		00085435501	
00053762020		00085435601	
00053763302		00093722758	
00053763402		00093722763	
00053765601		00093722772	
00053765602		00093722777	
00053765604		00093723281	
00053765605		00187200601	
00053766801		00187200605	
00053766802		00187200702	
00053766804		00187200706	
00053813001		00406204616	
00053813002		00406226042	
00053813004		00406226056	
00053813005		00406226070	
00053813102		00406226084	
00053813202		00781204304	
00053813302		00781204316	
00053813402		00781204342	
00053813502		00781204367	
00169701001		00781517728	
00169701301		16241006956	
00169702001		16241006976	
00169704001		16241007056	
00169705001		16241007076	
00169706001		16241033776	
00169706101		23490014105	
00169706201		38779025608	
00169720101		38779025609	
00169720201		42291071818	

Appendix H
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
National Drug Codes for Carved-Out Prescription Drugs

Hemophilia	Hepatitis C (Supplemental)*
00169720501	42291071856
00169720801	42291071870
00169781001	42291071884
00169781501	49452622101
00169782001	49452622102
00169782501	49452622103
00169783001	49452622104
00169785001	49884004532
00944058101	49884007176
00944130110	49884033876
00944130210	49884034076
00944130310	49884085656
00944130410	49884085692
00944283110	49884085693
00944283210	49884085694
00944283310	51167010001
00944283401	51167010003
00944283410	51552081304
00944283501	51552081305
00944283510	51927167100
00944284110	54738095016
00944284210	54738095156
00944284310	54738095256
00944284410	54738095318
00944284510	54738095342
00944292102	54738095356
00944292202	54738095370
00944292302	54738095384
00944292402	54868452100
00944293001	54868452101
00944293101	54868452102
00944293201	54868452103
00944293301	54868488700
00944293501	54868488800
00944293502	54868503500
00944293503	54868503600
00944293504	54868503601
00944293801	59930152301
00944293802	59930152302
00944293803	59930152303
00944294001	59930152304
00944294002	62991207701
00944294003	62991207702
00944294004	62991207703
00944294010	63370021935
00944294110	63370021945
00944294210	63370021950
00944294310	63370021955
00944294410	64116003101
00944294510	64116003106
00944294610	64116003124
00944294810	64116003901
00944296010	64116003906
00944296110	64116003924
00944296210	65862020768
00944296310	65862029018
00944296410	65862029042
00944296510	65862029056
00944302602	65862029070
00944302802	65862029084
00944303002	66435010118
00944303202	66435010142

Appendix H
New Hampshire Department of Health and Human Services
Medically Frail Capitation Rate Development
National Drug Codes for Carved-Out Prescription Drugs

Hemophilia	Hepatitis C (Supplemental)*
00944303402	66435010156
00944304510	66435010170
00944304610	66435010184
00944304710	66435010216
00944305102	66435010356
00944305202	66435010456
00944305302	66435010556
00944305402	66435010599
00944394002	66435010656
00944394202	66435010699
00944394402	66435010756
00944394602	66435010799
00944425202	66435010856
00944425402	66435010899
00944425602	66435020115
00944425802	66435020195
00944462201	66435020196
00944462301	66435020199
00944462401	66435020209
00944462501	66435020295
00944500101	68084015011
00944500105	68084015065
00944500110	68084017911
00944755102	68084017965
00944755302	68382004603
13533066520	68382004610
13533066530	68382004628
13533066550	68382026004
50242092001	68382026007
50242092101	68382026009
50242092201	68382026010
50242092301	68382026012
52769046001	68382026028
53270027005	
53270027105	
53270027106	
53270027205	
53270027206	
58394000101	
58394000105	
58394000106	
58394000201	
58394000205	
58394000206	
58394000301	
58394000305	
58394000306	
58394000502	
58394000504	
58394000602	
58394000604	
58394000702	
58394000704	
58394000802	
58394000803	
58394001102	
58394001104	
58394001201	
58394001202	
58394001301	
58394001302	
58394001401	

Hemophilia

58394001402
58394001501
58394001502
58394001603
58394002203
58394002303
58394002403
58394002503
58394063303
58394063403
58394063503
58394063603
58394063703
63833038602
63833038702
63833051802
63833061502
63833061602
63833061702
63833089151
63833891501
64193022203
64193022204
64193022205
64193022302
64193022402
64193022502
64193024402
64193042302
64193042402
64193042502
64193044502
64208775201
64208775301
64406048308
64406048408
64406048508
64406048608
64406048708
64406048808
64406048908
64406080101
64406080201
64406080301
64406080401
64406080501
64406080601
64406080701
64406091101
64406092201
64406093301
64406094401
64406096601
64406097701
67467018101
67467018102
67467018201
67467018202
68516320002
68516320003
68516320004

Hemophilia

68516320005
68516320101
68516320202
68516320302
68516320401
68516320502
68516320602
68516360002
68516360004
68516360005
68516360006
68516360102
68516360202
68516360302
68516360402
68516360502
68516360602
68516460001
68516460002
68516460101
68516460201
68516460302
68516460402
68516460501
68516460601
68516460702
68516460802
68516460902
68516461002
68982013901
68982014001
68982014101
68982014201
68982014301
68982014401
68982014501
68982014601
68982018201
68982018202
69911047402
69911047502
69911047602
69911047702
69911047802
69911086402
69911086502
69911086602
69911086702
70504028205
70504028305
70504028405
70504028506
70504028606
70504028705
70504028805
70504028905
76125025020
76125050030
76125066730
76125066750
76125067250
76125067351

APPENDIX I
State of New Hampshire
Department of Health and Human Services
SFY 2019 Actuarial Certification for Medically Frail Population Enrolled in the Alternative Benefit Plan

June 12, 2018

New Hampshire Department of Health and Human Services
Capitated Contracts Ratesetting
Actuarial Certification
SFY 2019 Capitation Rate for Medically Frail Population Enrolled in the Alternative Benefit Plan

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 New Hampshire Health Protection Program Medically Frail population capitation rate for SFY 2019 for filing with the Centers for Medicare and Medicaid Services (CMS). The rate in this certification applies to the Medically Frail population enrolled in the Alternative Benefit Plan (ABP). I reviewed the calculated capitation rate 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 2018-2019 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 rate for SFY 2019. To the best of my information, knowledge and belief, the capitation rate 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 rate is 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 rate developed may not be appropriate for any specific MCO. Any MCO will need to review the rate in relation to the benefits provided. Each MCO should compare the rate with its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHHS. The MCO may require a rate above, equal to, or below the actuarially sound capitation rate.

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

June 12, 2018

RELIANCE LETTER

This report assumes that the reader is familiar with the State of New Hampshire's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to DHHS to set the SFY 2019 capitation rate for Medically Frail individuals enrolled in the ABP. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

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

Jeffrey A. Meyers
Commissioner

Henry D. Lipman
Director

129 PLEASANT STREET, CONCORD, NH 03301
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www.dhhs.nh.gov

May 29, 2018

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

Re: Actuarial Certification of SFY 2019 Capitation Rates for New Hampshire Medicaid Care Management and New Hampshire Health Protection Program Capitation Rates

Dear Mr. Meerschaert:

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 SFY 2019 New Hampshire Medicaid Care Management (MCM) program and New Hampshire Health Protection Program (NHHPP) 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 SFY 2019 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) CHB Enhanced Report for Milliman SFY 2017.xlsx
    17) Fiscal Impact Change of Scope & LAL SFY19.xlsx
    18) tblNHHLinked_to_MedicaidSFY2017v2.xlsx

2. Fee schedule files:

   1) CY/SFY/FFY 2016 fee schedules:
      - 2016 DRG Rate Sheet.xls
      - 2016 Outpatient Reimbursement Rates.xlsx
      - 100% CCR.xlsx
      - 2016 NH Fee Schedule - Covered Procedures.xlsx
      - 2016 NH Fee Schedule – Manually Priced Procedures.xlsx
      - Copy of Active ASC Codes Fee Schedule 2016- Update.xlsx
      - FQHC Annual Update FY2016.docx
      - 26/TC split: ATTFJV4Y.xlsx

   2) 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

   3) 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

   4) NHHPP fees schedules (from www.dhhs.nh.gov)
      - NHCSR-OMBP-1-Rate-Attachment-20150226.xlsx
      - NH-HPP+Fee+Schedule+Distribution+Revised+Effective+11-01-2016.xlsx
      - NHHPP+Fee+Schedule-08152017.xlsx

3. January 2010 – December 2017 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
   - NEMT (Bridges) Detail for Milliman 2015.xlsx
   - CTS Encounter data- Milliman.xlsx
6) BCH Settlement:
   - CHB Figures for Milliman - SFY 2016.xlsx
7) Additional BDAS claims:
   - BDAS Likely Medicaid SFY2016-2017.accdb

4. Other supporting documentation, including:
   1) MCO contract
   2) Other computer files
   3) Conversations concerning supplied data

Signature

Henry D. Lipman
Name

Medicaid Director
Title

May 29, 2018
Date