MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

October 16, 2023

Via Electronic Mail

New Hampshire Department of Health and Human Services
Meredith Telus, Director, Division of Program Quality and Integrity
129 Pleasant Street
Concord, NH 03301

Re: Adjusted Medical Loss Ratio Examination Report Transmittal

This letter is to inform you that Myers and Stauffer LC has completed the examination of New Hampshire Health Families, Inc.'s Adjusted Medical Loss Ratio for the period ended June 30, 2020. As a courtesy to the New Hampshire Department of Health and Human Services and other readers, the health plan management's response letter is included, if provided, in addition to our examination report, as part of this transmittal packet. Myers and Stauffer LC, in no manner, expresses an opinion on the accuracy, truthfulness, or validity of the statements presented within the management's response letter.

Please contact Kevin Buchser at 877.829.7306 if you have questions.

Kind Regards,

Myers and Stauffer LC

Myers and Stauffer LC

700 W 47th Street, Ste. 1100 | Kansas City, MO 64112
PH 816.945.5300 | PH 800.374.6858 | FX 816.945.5301
www.myersandstauffer.com

NEW HAMPSHIRE HEALTHY FAMILIES, INC.

New Hampshire Medicaid Care Management Services

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2020
Paid through December 31, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

The preparation of this report was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

State of New Hampshire
Department of Health and Human Services
Concord, New Hampshire

Independent Accountant's Report

We have examined the New Hampshire Medicaid Care Management Services Medical Loss Ratio (MLR) calculations of the Standard Medicaid (Standard) and the Granite Advantage Health Care Program (GAHCP) populations for New Hampshire Healthy Families, Inc. (health plan) for the state fiscal year ended June 30, 2020. The health plan's management is responsible for presenting the Medical Loss Ratio (MLR) calculations in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal guidance. This criteria was used to prepare the Adjusted Medical Loss Ratios. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratios based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratios are in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratios. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratios, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratios were prepared from information contained in the Medical Loss Ratio Rebate calculation for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the Adjusted Medical Loss Ratios are presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratios exceeds the state's requirement of eighty-five percent (85%) for the Standard and the GAHCP populations for the state fiscal year ended June 30, 2020.

This report is intended solely for the information and use of the Department of Health and Human Services, Milliman, and the health plan and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC

Myers and Stauffer LC
Indianapolis, Indiana
October 4, 2023

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2020 Paid Through December 31, 2020

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2020 Paid Through December 31, 2020 Standard Population					
CMS Line #	**State Line #**	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.		**Medical Loss Ratio Numerator**			
1.1	1.1	Incurred Claims	$ 215,416,286	$ 4,110,728	$ 219,527,014
1.2	1.2	Activities that Improve Health Care Quality	$ 5,339,614	$ (963,691)	$ 4,375,923
1.3	1.3	MLR Numerator	$ 220,755,900	$ 3,147,037	$ 223,902,937
1.4	6.7	Non-Claims Costs (Not Included in Numerator)*	$ 38,592,153	$ 2,964,367	$ 41,556,520
2.		**Medical Loss Ratio Denominator**			
2.1	2.1	Premium Revenue	$ 262,885,779	$ 3,184,252	$ 266,070,031
2.2	2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 4,987,517	$ 1,931,049	$ 6,918,566
2.3	2.3	MLR Denominator	$ 257,898,263	$ 1,253,203	$ 259,151,466
3.		**MLR Calculation**			
3.1	3.1	Member Months	667,838	-	667,838
3.2	4.1	Unadjusted MLR	85.6%	0.8%	86.4%
3.3	4.2	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	4.3	Adjusted MLR	85.6%	0.8%	86.4%
4.		**Remittance**			
4.2	5.2	State Minimum MLR Requirement	85.0%		85.0%
4.6.1	5.5	Remittance dollar amount owed for MLR reporting period	$ -	$ -	$ -

**The Non-Claims Costs line has not been subjected to the procedures applied in the examination, and accordingly, we express no opinion on it. However, any adjustments identified during the course of the examination procedures directly affecting the line, will be properly reflected within the adjustment totals.*

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2020 Paid Through December 31, 2020

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2020 Paid Through December 31, 2020 GAHCP Population					
CMS Line #	**State Line #**	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.		**Medical Loss Ratio Numerator**			
1.1	1.1	Incurred Claims	$ 118,438,401	$ 39,970	$ 118,478,371
1.2	1.2	Activities that Improve Health Care Quality	$ 3,105,747	$ (538,491)	$ 2,567,256
1.3	1.3	MLR Numerator	$ 121,544,148	$ (498,521)	$ 121,045,627
1.4	6.7	Non-Claims Costs (Not Included in Numerator)*	$ 24,357,008	$ (238,829)	$ 24,118,179
2.		**Medical Loss Ratio Denominator**			
2.1	2.1	Premium Revenue	$ 142,058,271	$ 2,043,247	$ 144,101,518
2.2	2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 2,757,650	$ 1,309,075	$ 4,066,725
2.3	2.3	MLR Denominator	$ 139,300,621	$ 734,172	$ 140,034,793
3.		**MLR Calculation**			
3.1	3.1	Member Months	257,794	-	257,794
3.2	4.1	Unadjusted MLR	87.3%	-0.9%	86.4%
3.3	4.2	Credibility Adjustment	1.3%	0.0%	1.3%
3.4	4.3	Adjusted MLR	88.6%	-0.8%	87.8%
4.		**Remittance**			
4.2	5.2	State Minimum MLR Requirement	85.0%		85.0%
4.6.1	5.5	Remittance dollar amount owed for MLR reporting period	$ -	$ -	$ -

**The Non-Claims Costs line has not been subjected to the procedures applied in the examination, and accordingly, we express no opinion on it. However, any adjustments identified during the course of the examination procedures directly affecting the line, will be properly reflected within the adjustment totals.*

Schedule of Adjustments and Comments for State Fiscal Year Ended June 30, 2020

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust National Imaging Associates' (NIA) claims to the verified certification statement amounts.

The health plan provided a report discrepancy file that confirmed the health plan's exclusion of NIA claim amounts from the reported as-filed amounts. The NIA vendor provided a certification statement, but was unable to allocate the certification statement further between Standard and GAHCP. Therefore, Myers and Stauffer performed an allocation of the certification statement amount between Standard and GAHCP utilizing the claims detail percentages recorded by the health plan. An adjustment was proposed to adjust NIA claims to the verified amount in Line 1.1. The Incurred Claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$1,901,980	$5,370

Adjustment #2 – To adjust Coordinated Transportation Solutions' (CTS) claims to the verified certification statement amounts.

The health plan provided claims detail for their CTS claims support which differed slightly from the CTS vendor provided certification statement. However CTS was unable to separate the certification statement amounts between the Standard and GAHCP populations. Therefore, Myers and Stauffer performed an allocation of the certification statement amount between Standard and GAHCP utilizing the claims detail percentages recorded by the health plan. An adjustment was proposed to reclassify these variances between incurred claims and non-claims costs since the health plan pays the vendor utilizing capitation payments. The Incurred Claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$58,822	$37,585
1.4	Non-Claims Costs (Not Included in Numerator)	$(58,822)	$(37,585)

Adjustment #3 – To reclassify the administrative portion of the payment amounts to CTS from Incurred Claims to Non-Claims costs.

The health plan provided support for CTS transportation capitation amounts reported in Line 1.1. Based on the support provided, Myers and Stauffer determined that the administrative portion of the CTS transportation capitation amounts was included in incurred claims in the Other Payments line of the MLR report. As these amounts do not represent incurred claims, these amounts should be categorized as non-claims costs. An adjustment was proposed to reclassify these amounts to non-claims costs. The Incurred Claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$(1,250,006)	$(476,995)
1.4	Non-Claims Costs (Not Included in Numerator)	$1,250,006	$476,995

Adjustment #4 – To adjust pharmacy paid claims to the verified amount reported on the certification statement and reclassify the amounts between Medicaid populations.

The health plan provided claims detail for their pharmacy claims support. The pharmacy vendor provided a certification statement that allocated incurred claims between Standard and GAHCP. The variances between the net pharmacy claims amount reported on the MLR and the vendor certification statement was proposed as a reclassification between populations. Overall there was small variance of $8,931 in the total amount of claims incurred per the vendor certification statement that was added to the Standard population. The Incurred Claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$1,320,456	$(1,311,525)

Adjustment #5 – To reclassify Pharmacy Network Access Fees from Incurred Claims to Non-Claims Costs.

The Pharmacy Benefit Administrator (PBM) charged servicing pharmacy providers Network Access Fees by reducing the amounts remitted to the pharmacy providers. These fees are a reduction to the reportable incurred claims totals paid to the pharmacies. However, since these transaction did not result in any payment amount differences between the health plan and the PBM, this adjustment is to be considered an imputed administrative cost amount by the health plan to account for the additional amounts retained by the PBM from the pharmacy providers. An adjustment was proposed to reclassify these administrative costs from Incurred Claims to Non-Claims Costs. The Incurred Claims reporting requirement are addressed in Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$(81,465)	$(55,697)
1.4	Non-Claims Costs (Not Included in Numerator)	$81,465	$55,697

Adjustment #6 – To adjust Incurred But Not Reported (IBNR) expenses to the verified amounts.

The health plan reported IBNR of $804,665 for the Standard population and $534,353 for the GAHCP population. The plan's documentation supported IBNR of $738,756 for Standard and $454,649 for GAHCP. An adjustment was proposed to remove the difference between the as-filed amount and the verified amount. The Incurred Claims reporting requirement are addressed in Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$(65,909)	$(79,704)

Adjustment #7 – To adjust Contingent Benefit and Lawsuit Reserves Settlement expenses to the verified amounts.

The health plan reported contingent benefit and lawsuit reserve settlement expenses of $4,044,147 for the Standard population and $19,231 for the GAHCP population. The plan's documentation supported settlement expenses of $3,860,595 for the Standard population and $183,552 for GAHCP population. The variances between the as-filed amount and the verified amount results in a proposed reclassification between populations and a slight overall adjustment to the reported expenses. The Incurred Claims reporting requirement are addressed in Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$(183,552)	$164,321

Adjustment #8 – To adjust incurred claims to reflect verified pharmacy recovery amounts.

The health plan provided a report discrepancy file that confirmed the understatement of pharmacy recovery deposits reported on the as-filed MLR, which resulted in an overstatement of incurred claims. The variances between the as-filed amounts and the verified amounts was adjusted from incurred claims. The Incurred Claims reporting requirement are addressed in Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$(327,275)	$(329,481)

Adjustment #9 – To remove the health plan's reported discrepancy amount from Line 1.1 (Other Payments) and reclassify these amounts from Incurred Claims to Non-Claims costs.

The health plan provided a report discrepancy file that confirms the overstatement of Line 1.1 expenses included in the Other Payment's category of the MLR report. The health plan confirmed that the self-reported adjustment amounts were based on a review of their own documentation where they noted general ledger and transaction descriptions that did not meet the definition of what should be included in Line 1.1 for the Other Payments subcategory. An adjustment was proposed to remove the self-reported discrepancy amount from Line 1.1 and to reclassify these amounts from Incurred Claims to

Non-Claims Costs. The Incurred Claims reporting requirement are addressed in Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$(2,796,353)	$(117,783)
1.4	Non-Claims Costs (Not Included in Numerator)	$2,796,353	$117,783

Adjustment #10 – To reclassify non-qualifying costs claimed as Health Care Quality Improvement (HCQI) expenses from HCQI to Non-Claims Costs.

Based on the job descriptions and allocation amounts provided by the health plan for the positions that were included in the HCQI amount filed for each population, Myers and Stauffer determined the job descriptions contained items that are not allowable for HCQI based on the federal guidance. Additionally, based on review of other healthcare quality improvement expenses claimed, Myers and Stauffer determined further non-qualifying HCQI expenses. The total variance between the as-filed amounts and the verified amounts are noted below along with the reclassification of these amounts to non-claims costs. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(e)(3).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.2	Activities that Improve Health Care Quality	$(963,691)	$(538,491)
1.4	Non-Claims Costs (Not Included in Numerator)[1]	$973,635	$542,285

[1]EPC E-Connect amounts were excluded entirely from the as-filed MLR; therefore, EPC E-Connect amounts are not factored in the non-claims costs reclassification. See the additional subcategory table below for an itemized detail of the total HCQI adjustment.

HCQI: Detail of Adjustment Items (Line 1.2)		
Expense Detail	Amount	
	Standard	GAHCP
Non-Qualifying HCQI salaries and benefits	$(820,241)	$(470,863)
Envolve People Care Disease Management vendor allocated overhead	$(8,997)	$(2,943)
Envolve People Care Nursewise vendor allocated overhead	$(60,427)	$(23,237)

HCQI: Detail of Adjustment Items (Line 1.2)		
Envolve People Care Nursewise vendor profit	$(40,117)	$(15,445)
Non-Qualifying Community Outreach vendor expenses	$(28,298)	$(19,602)
Bi-State Association Dues	$(15,555)	$(10,195)
EPC E-Connect amounts	$9,944	$3,794
Total HCQI Adjustment to Line 1.2	$(963,691)	$(538,491)

Adjustment #11 – To adjust Incurred Claims to the verified CMHC and COVID-19 directed payment expense amounts.

The health plan did not report amounts for the Community Mental Health Centers (CMHC) and COVID-19 directed payment expenses on Line 1.1, Incurred Claims for Standard and GAHCP based on previous guidance received. However, CMS has confirmed that payments developed under 42 CFR §438.6(c) and included in the rate certification should be included within both the numerator and denominator for the MLR calculation. Based on the supporting documentation provided by the state, an adjustment was proposed to adjust incurred claims to the verified amount in Line 1.1, while the proposed respective adjustment to the premium revenue was made as part of Adjustment #12. The Incurred Claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(e)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
1.1	Incurred Claims	$5,534,030	$2,203,879

Adjustment #12 – To adjust Premium Revenue to the verified State data.

The health plan reported premium revenue of $262,885,779 for the Standard population and $142,058,271 for the GAHCP population. The state's documentation supported premium revenue of $266,070,031 for Standard and $144,101,518 for GAHCP, which is inclusive of the directed payment revenues described in Adjustment #11. An adjustment was proposed to adjust to the state's verified amounts. The Premium Revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(f)(2).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
2.1	Premium Revenue	$3,184,252	$2,043,247

Adjustment #13 – To adjust tax amounts to the verified amounts.

The health plan reported federal income taxes and state premium taxes for the Standard population GAHCP populations which required adjustments to account for changes made to deferred tax assets, removal of taxes associated with investment income, and revised premium tax calculations resulting from revised revenue totals. The proposed adjustments to the tax amounts are summarized below. Taxes reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(f)(3).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees.	$(147,221)	$(84,929)

[1]See the additional subcategory table below for an itemized detail of the total tax adjustment.

Tax: Detail of Adjustment Items (Line 2.2)		
Expense Detail	Amount	
	Standard	GAHCP
Federal Income Taxes	$(210,906)	$(125,794)
State Premium taxes	$63,685	$40,865
Total Tax Adjustment to Line 2.2	$(147,221)	$(84,929)

Adjustment #14 – To reclassify HIPF expense amounts from Non-Claims costs to Taxes.

The health plan reported amounts for the Health Insurance Provider Fee (HIPF) expense on Line 1.4, Non-Claims Costs for the Standard and GAHCP populations. Based on the supporting documentation provided by the state, Myers and Stauffer determined that HIPF expenses should be reported on Line 2.2. An adjustment was proposed to reclassify these amounts from non-claims costs to taxes. The Taxes reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(f)(3).

Proposed Adjustment			
Line #	Line Description	Amount	
		Standard	GAHCP
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees.	$2,078,270	$1,394,004
1.4	Non-Claims Costs (Not Included in Numerator)[1]	$(2,078,270)	$(1,394,004)

Appendix A: Health Plan Responses

The health plan responses are attached below. The responses have been reviewed by Myers and Stauffer prior to finalization of the examination report, and have been incorporated into the adjustments if deemed necessary by Myers and Stauffer.

nh healthy families

2 Executive Park Drive
Bedford, NH 03110
1-866-769-3085
1-855-742-0123
(TDD/TTY)
NHhealthyfamilies.com

Myers and Stauffer LC
800 East 96th Street, Suite 200
Indianapolis, IN 46240

We are providing the following management responses in connection with your examination of New Hampshire Healthy Families, Inc.'s Medical Loss Ratio (MLR) Report for the period ended June 30, 2020.

Adjustment #1 – To adjust National Imaging Associates' (NIA) claims to the verified certification statement amounts. $1,901,980 Standard, $5,370 GAHCP
Management Response – A significant portion of this adjustment ($1,876,640 Standard and $5,298 GAHCP) was self-reported by NH Healthy Families (the "health plan") and was previously corrected in subsequent Medical Loss Ratio filings. The health plan accepts the remaining portion of the adjustment to align with the certification statement amounts ($25,340 Standard and $72 GAHCP).

Adjustment #2 – To adjust Coordinated Transportation Solutions' (CTS) claims to the verified certification statement amounts. ($58,822 Standard and $37,585 GAHCP).
Management Response – The health plan accepts this adjustment to align with the certification statement amounts.

Adjustment #3 – To reclassify the administrative portion of the payment amounts to CTS from Incurred Claims to Non-Claims costs. (($1,250,006 Standard) and ($476,995) GAHCP)
Management Response – The health plan accepts this adjustment and has adjusted subsequent Medical Loss Ratio filings accordingly.

Adjustment #4 – To adjust pharmacy paid claims to the verified amount reported on the certification statement and reclassify the amounts between Medicaid populations. ($1,320,456 Standard, ($1,311,525) GAHCP)
Management Response – The health plan accepts this adjustment, noting this is a population reclass adjustment associated with member attribution changes that are not expected to impact future Medical Loss Ratio filings.

Adjustment #5 – To reclassify Pharmacy Network Access Fees from Incurred Claims to Non-Claims Costs. (($81,465) Standard and ($55,697) GAHCP)

Management Response – The health plan respectfully disagrees with Myers and Stauffer's finding that transaction fees paid by network pharmacies to CVS ("PBM transaction fees") should be deducted from incurred claims or treated as an imputed administrative cost for purposes of MLR reporting. In summary, it is clear from the relevant regulation (42 C.F.R. § 438.8) that PBM transaction fees are neither deductions nor exclusions from incurred claims. The May 2019 CMCS Informational Bulletin ("2019 CIB") provided guidance on MLR requirements related to third-party vendors, but CMS is not permitted to expand the scope of regulatory text without notice and comment rulemaking. Similarly,

nh healthy families

2 Executive Park Drive
Bedford, NH 03110
1-866-769-3085
1-855-742-0123
(TDD/TTY)
NHhealthyfamilies.com

Myers and Stauffer must not apply the CMS-issued regulation in a manner that is unsupported by the regulatory text.

42 C.F.R. § 438.8 dictates how the MLR numerator is to be calculated by Medicaid managed care organizations, including unambiguously defining "incurred claims." Specifically, 42 C.F.R. § 438.8(e)(2)(ii) identifies what needs to be deducted from incurred claims (thus lowering the incurred claims amount), including: (i) overpayment recoveries received from network providers; and (ii) prescription drug rebates received and accrued. Furthermore, 42 C.F.R. § 438.8(e)(2)(v) identifies expenses that must be excluded from incurred claims, including expenses for administrative costs, which include the following: (i) amounts paid to third party vendors for secondary network savings; (ii) amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; and (iii) amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee. The transaction fees charged by CVS are for bona fide services that CVS renders to each pharmacy and are not prescription drug rebates or any amounts paid by the health plan to qualify as an exclusion.

Additionally, 42 C.F.R. § 438.8(e)(2)(ii) states that prescription drug rebates received and accrued need to be deducted from incurred claims, thus lowering the incurred claims amount. The 2019 CIB states that "CMS interprets this regulation to require that any time a managed care plan receives something of value for the provision of a Medicaid covered outpatient drug (e.g., manufacturer rebates, incentive payments, direct or indirect remuneration, goods in kind, etc.) regardless from whom the item of value is received (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, etc.) the value of that rebate must be deduced from the amount of incurred claims . . . . CMS also interprets this requirement to apply equally regardless of whether the prescription drug rebate is received by the managed care plan (i.e., directly) or by a subcontractor (i.e., indirectly)." However, the transaction fees are not rebates as they are not paid by the manufacturer, do not reduce the cost to the health plan, and do not provide anything of value to the health plan. To the extent that CMS wants to expand the definition of rebate beyond the definition in the present regulation, it is required to undertake notice and comment rulemaking.

Lastly, 42 C.F.R. § 438.8(e)(2)(v) identifies expenses that must be excluded from incurred claims, including "non-claims costs" which include the following: (i) amounts paid to third party vendors for secondary network savings; (ii) amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; and (iii) amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee. On its face, this is limited to "non-claims costs," which is defined as those expenses of the health plan for administrative services that are not incurred claims, expenditures on activities that improve health care quality, licensing and regulatory fees, or Federal and State taxes. 42 C.F.R. § 438.8(b). Thus, based upon the plain language of the regulation, the exclusion applies only to expenses paid by the health plan and not amounts paid by third parties for bona fide services. This is consistent with the 2019 CIB, which states that expenditures and profits on administrative functions

nh healthy families

2 Executive Park Drive
Bedford, NH 03110
1-866-769-3085
1-855-742-0123
(TDD/TTY)
NHhealthyfamilies.com

performed by the PBM shall not be counted as an incurred claim. The transaction fees are neither expenditures by the health plan nor profits by the PBM, but rather fees charged for bona fide services. To the extent that CMS believes the amounts paid by the third-party pharmacies should be excluded as non-claims costs, then it would need to engage in notice and comment rulemaking to modify the rule.

Adjustment #6 – To adjust Incurred But Not Reported (IBNR) expenses to the verified amounts. (($65,909) Standard and ($79,704) GAHCP)
Management Response – The health plan accepts this adjustment and has adjusted subsequent Medical Loss Ratio filings accordingly.

Adjustment #7 – To adjust Contingent Benefit and Lawsuit Reserves Settlement expenses to the verified amounts. (($183,552) Standard and $164,321 GAHCP)
Management Response – A portion of this adjustment ($19,230 GAHCP) was self-reported by the health plan. The health plan accepts the remaining portion of the adjustment, noting it is a population reclass adjustment only.

Adjustment #8 – To adjust incurred claims to reflect verified pharmacy recovery amounts.
(($327,275) Standard and ($329,481) GAHCP)
Management Response – The health plan self-reported this adjustment to adjust pharmacy recovery amounts from a reported basis to a restated basis. Subsequent Medical Loss Ratio filings have been adjusted accordingly.

Adjustment #9 – To remove the health plan's reported discrepancy amounts from Line 1.1 (Other Payments) and reclassify these amounts from Incurred Claims to Non-Claims costs. ($2,796,353 Standard, ($117,783) GAHCP)
Management Response – The health plan self-reported this adjustment and subsequent Medical Loss Ratio filings have been adjusted accordingly.

Adjustment #10 – To reclassify non-qualifying costs claimed as Health Care Quality Improvement (HCQI) expenses from HCQI to Non-Claims Costs. (($963,691) Standard and ($538,491) GAHCP)
Management Response – A portion of this adjustment (($5,611) Standard and ($6,401) GAHCP) was self-reported by the health plan. The health plan accepts the portion of this adjustment (($137,839) Standard and ($61,227) GAHCP) to remove Envolve People Care vendor allocated overhead and profit as well as to remove non-qualifying community outreach expenses. Please see responses below regarding the remaining portion of the adjustment for non-qualifying HCQI salaries and benefits (($820,241) Standard and ($470,863) GAHCP).

The Quality Improvement Activities (QIA) survey process provides information to split roles between HCQI and non HCQI functions and report expenses in accordance with Medicaid Managed Care Final

nh healthy families

2 Executive Park Drive
Bedford, NH 03110
1-866-769-3085
1-855-742-0123
(TDD/TTY)
NHhealthyfamilies.com

Rule 42 CFR § 438.8(e)(3); therefore, we disagree with the reduction or disallowing 100% of HCQI expenses based on the following:

- **Parts or entire job functions that were removed are specifically in place to improve health quality at the corporate and health plan levels, which has been reflected in the job description.**
- **Reducing or disallowing HCQI activities based on just job titles or departments will understate allowable HCQI. The written support included within the surveys should be used to determine the allowable HCQI percentage for each position.**

Adjustment #11 – To adjust Incurred Claims to the verified CMHC and COVID-19 directed payment expense amounts. ($5,534,030 Standard and $2,203,879 GAHCP)
Management Response – The health plan accepts this adjustment, noting an offsetting adjustment will also be made to include directed payment amounts within premium revenue.

Adjustment #12 – To adjust Premium Revenue to the verified State data. ($3,184,252 Standard and $2,043,247 GAHCP).
Management Response – The health plan accepts this adjustment, noting a portion of this adjustment relates to directed payments, for which an offsetting adjustment will also be made to include directed payment amounts within incurred claims. The health plan also notes that a portion of this adjustment (($2,534,121) Standard, ($375,242) GAHCP) relates to retro risk score adjustments and true ups to risk corridor settlements, both items that occurred subsequent to the Medical Loss Ratio filing date.

Adjustment #13 – To adjust tax amounts to the verified amounts. (($147,221) Standard, ($84,929) GAHCP)
Management Response – The health plan accepts this adjustment.

Adjustment #14 – To reclassify HIPF expense amounts from Non-Claims costs to Taxes. ($2,078,270 Standard, $1,394,004 GAHCP)
Management Response – The health plan accepts this adjustment, noting an offsetting adjustment will also be made to include HIPF revenue amounts within premium revenue.