17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

Mathieu Doucet, FSA, MAAA
Senior Consulting Actuary

mathieu.doucet@milliman.com

October 27, 2022

Henry Lipman, FACHE
Medicaid Director
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
Sent via email: henry.lipman@dhhs.nh.gov

Re: Adult Dental 1915(b) Cost Effectiveness Limit Projections

Dear Henry:

At your request, we prepared this letter to document the development of the April 2023 through March 2025 cost effectiveness targets for the 1915(b) waiver renewal submission.

The cost projections included in the 1915(b) cost effectiveness calculations are consistent with the April 2023 to June 2024 adult dental capitation rate report dated October 19, 2022.

All adult dental state plan services are included in the 1915(b) cost effectiveness calculations. We excluded all adult dental services covered under a separate 1915(c) waiver or 1115 waiver (i.e., dentures) for individuals that are eligible for those services.

RESULTS

Table 1 shows the cost effectiveness limits by Medicaid Eligibility Group (MEG).

Table 1
New Hampshire Department of Health and Human Services
Initial Adult Dental 1915(b) Waiver
April 2023 to June 2025 Cost Effectiveness Limits PMPM

MEG	P1	P2
Qualified Waiver Recipients	$27.44	$28.81
Non-Qualified Waiver Population	27.44	28.81
Non-Qualified Waiver Population NF	27.44	28.81
Expansion Non-Qualified Waiver Population	25.61	26.89

The attached CMS cost effectiveness Excel template provides the detailed development of the cost effectiveness limits. Please refer to the CMS preprint in Attachment A for a description of the methodology and assumptions used to develop the cost effectiveness limits.

CAVEATS AND LIMITATIONS ON USE

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to project expenditures for the 1915(b) cost effectiveness calculations. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. We used fee-for-service (FFS) and MCO encounter cost and eligibility data, historical reimbursement information, TPL recoveries, current fee schedules, and other DHHS and MCO information to develop the expenditure projections shown in this letter. This data was provided by DHHS and participating MCOs. We did not audit this data and other information. If the underlying data or information

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

We constructed several projection models to develop the projections shown in this letter. Differences between the projected expenditures and actual experience will depend on the extent to which future experience conforms to the assumptions made in the development of the projections. It is certain that actual experience will not conform exactly to the assumptions used in the expenditure projections 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.

This letter is designed to assist DHHS with documenting the development of the 1915(b) Waiver renewal cost effectiveness targets for April 2023 through March 2025. This information may not be appropriate, and should not be used for other purposes.

The information contained in this letter has been prepared for DHHS. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of this information must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

The terms of Milliman's contract with the New Hampshire Department of Health and Human Services effective July 1, 2022, apply to this letter and its use.

❖ ❖ ❖ ❖ ❖

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

Sincerely,

Mathieu Doucet, FSA, MAAA
Senior Consulting Actuary

MD/bl

Attachments (Provided in Excel)

APPENDIX A

ATTACHMENT A

Section D – Cost Effectiveness

PART I: STATE COMPLETION SECTION

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: Athena Gagnon

c. Telephone Number: (603) 271-9420

d. E-mail: athena.gagnon@dhhs.nh.gov

e. The State is choosing to report waiver expenditures based on

_X_ date of payment.

___ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. Expedited or Comprehensive Test

a. ___ The State provides additional services under 1915(b)(3) authority.

b. ___ The State makes enhanced payments to contractors or providers.

c. ___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d. ___ The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that have overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

ATTACHMENT A

Section D – Cost Effectiveness

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete Appendix D3
- Your waiver will not be reviewed by OMB at the discretion of CMS and OMB

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated Portion of the Waiver Only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a. ___ MCO
b. ___ PIHP
c. _X_ PAHP
d. ___ PCCM
e. ___ Other (please explain):

D. PCCM Portion of the Waiver Only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ___ **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.

1.___ First Year: $_____ per member per month fee
2.___ Second Year: $_____ per member per month fee
3.___ Third Year: $_____ per member per month fee
4.___ Fourth Year: $_____ per member per month fee

b. ___ **Enhanced fee for primary care services.**
Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ___ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.**

Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives / bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ___ **Other reimbursement method / amount.**

$_____

Please explain the State's rationale for determining this method or amount.

ATTACHMENT A

Section D – Cost Effectiveness

E. Member Months

Please mark all that apply.

a. _X_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ___ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. _X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: The cost effectiveness projections include an enrollment decrease beginning June 2023 for a period of 9 months following the expected end of the PHE. DHHS expects that enrollment will return to March 2022 levels at the end of the unwind process.

Enrollment then slowly increases at an annual rate of 2% through the end of the waiver period.

d. _X_ [Required] Explain any other variance in eligible member months from BY/R1 to P2: The only variance in member months from R1 to P2 is the annual enrollment trend described above.

e. _X_ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: Since the program is new, there is no actual base period data. For the purpose of the cost effectiveness calculations, BY and P1 are both April 2023 through March 2024 and P2 is April 2024 through March 2025.

F. Appendix D2.S – Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. __X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.

The same services are included in Appendix B3 and Appendix B5.

b._X_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

The cost effectiveness analysis only includes adult dental state plan services for the listed MEGs, and all state plan services are capitated by DHHS. We excluded all adult dental services covered by a separate 1915(c) waiver or 1115 waiver (i.e., dentures) for individuals that are eligible for those services. New Hampshire currently has several 1915(c) waivers covering home and community based services as follows:

- Choices For Independence (CFI)
- Developmentally Disabled (DD)
- Acquired Brain Disorder (ABD)
- In-Home Supports Services (IHS)

All adult dental state plan services are included in the cost effectiveness calculations.

G. Appendix D2.A – Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

ATTACHMENT A

Section D – Cost Effectiveness

The allocation method for either initial or renewal waivers is explained below:

a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO / PCCM programs.*

b. _X_ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP / PAHP programs.*

Administrative costs are allocated based on the percentage of Medicaid expenditures under the proposed waiver compared to all Medicaid expenditures in the waiver.

The administrative costs have been trended to P1 and P2 at the same rate as the state plan service costs.

c. ___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a. ___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

b. __ **The State is including voluntary populations in the waiver.**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. _X_ **Capitated portion of the waiver only -- Reinsurance or Stop / Loss Coverage:** Please note, how the State will be providing or requiring reinsurance or stop / loss coverage as required under the regulation. States may require MCOs / PIHPs / PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs / PIHPs / PAHPs when MCOs / PIHPs / PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO / PIHP / PAHP will be responsible. If the State plans to provide stop / loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop / loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stop / loss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop / loss protection for MCOs / PIHPs / PAHPs, but requires MCOs / PIHPs / PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop / loss protection (please describe):

d. ___ **Incentive / bonus / enhanced Payments for both Capitated and fee-for-service Programs:**

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives / bonuses.
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs / PIHPs / PAHPs do not exceed the Waiver Cost Projection.

2.____ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives / bonuses.
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs / PIHPs / PAHPs / PCCMs do not exceed the Waiver Cost Projection.

I. Appendix D4 – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

This section is only applicable to Initial waivers.

J. Appendix D4 – Conversion or Renewal Waiver Cost Projection and Adjustments

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic / policy / pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic / policy / pricing changes.**

1. __ [Required, if the State's BY or R2 is more than three months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present).*
The actual trend rate used is:

Please document how that trend was calculated:

2._X_ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and / or units of service PMPM.

ii. _X_ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase, such as changes in technology, practice patterns, and / or units of service PMPM.

The trends from BY to P1 is 0.0% since these two time periods are the same.

We used a 5.0% PMPM trends for P1 to P2 since the dental capitation rates have not yet been calculated for July 2024 to March 2025.

3.___ The State estimated the PMPM cost changes in units of service, technology and / or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

a. **State Plan Services Programmatic / Policy / Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan, then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1._X_ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is (are) listed and described below:

i. ___ The State projects an externally driven State Medicaid managed care rate increases / decreases between the base and rate periods.

For each change, please report the following:

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ___ ***Determine adjustment for Medicare Part D dual eligibles.***
E. ___ Other (please describe):

ii. ___ The State has projected no externally driven managed care rate increases / decreases in the managed care rates.

iii.___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv. __ Changes brought about by legal action (please describe):

For each change, please report the following:

A.___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.__ Other (please describe):

v. ___ Changes in legislation (please describe):

For each change, please report the following:

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ___ Other (please describe):

vi. ___ Other (please describe):

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ___ Other (please describe):

b. **Administrative Cost Adjustment***: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2._X_ An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii._X_ Cost increases were accounted for.

A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. _X_ Other (please describe):

DHHS' administrative expenses are trended to P1 and P2 at the same annual trend rate as the state plan service costs.

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based:

Base years_____

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

c. **1915(b)(3) Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than three months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).*

The actual documented trend is: _____.

Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a**.
2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**
3. Explain any differences:

f. Other Adjustments including but not limited to federal government changes:

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only) ***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

  Basis and method:

  1. __ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5**.

  2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.

  3. ___ Other

     1._X_ No adjustment was made.

     2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

ATTACHMENT A

Section D – Cost Effectiveness

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

   The cost effectiveness projections include an enrollment decrease beginning June 2023 for a period of 9 months following the expected end of the PHE. DHHS expects that enrollment will return to March 2022 levels at the end of the unwind process.

   Enrollment then slowly increases at an annual rate of 2% through the end of the waiver period.

   The only variance in member months from R1 to P2 is the annual enrollment trend described above.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

   The trends from BY to P1 is 0.0% since these two time periods are the same.

   We used a 5.0% PMPM trends for P1 to P2 since the dental capitation rates have not yet been calculated for July 2024 to March 2025.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

   Please see our comment above.

   Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

   All principal factors contributing to the overall annualized rate of change are described in the above sections.