

**New Hampshire 438.6(c) Proposal C- 2019-2020 - COVID  
Questions for the State  
April 23, 2020**

**New Hampshire Responses in Red  
4/24/2020**

**Approval Period**

1. CMS would like to note that prior approval for payment arrangements under 438.6(c) are for a specific period of time and cannot be automatically renewed. Generally, CMS has interpreted this to be an annual period for these proposals.<sup>1</sup> Therefore, any approvals granted for this proposal would be for a 1 year period; if the state intends to continue this payment arrangement in future years, it would need to obtain approval for this payment arrangement for each successive year. **The State understands this condition; this pre-print would end with the MCM contract year that ends on June 30, 2020.**

**Reimbursement Level**

2. The regulations at 42 CFR 438.6(c) require that payment arrangements be developed in accordance with 42 CFR 438.4, the standards specified in 42 CFR 438.5 and generally accepted actuarial principles and practices. Generally, CMS asks states to provide an analysis that would demonstrate that the payment arrangement is appropriate, reasonable and attainable. However, CMS recognizes such an analysis can take time to develop. Given that this payment arrangement is intended to respond to the COVID-19 pandemic, can the state and its actuaries please provide the following attestation:

“This payment arrangement has been developed in accordance with 42 CFR 438.4, the standards specified in 42 CFR 438.5 and generally accepted actuarial principles and practices. Specifically, the state and its actuaries attest that the payments are reasonable compared to the total funds the provider would have received absent the public health emergency and that the addition of the state directed payment arrangement does not result in total payments that would exceed what was or would have been assumed in the capitation rate certification absent the public health emergency.” **Please see the attached letter from our actuary, Milliman.**

**Funding Question**

1. For the payment arrangement the state is proposing to incorporate into their contracts and rates, can the state describe the non-federal share of the payment arrangement, including the

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<sup>1</sup> In the CMCS Information Bulletin on state directed payments published November 2, 2017, CMCS indicated that payment arrangements intended to pursue delivery system reform over a fixed period of time could be eligible for multi-year approvals under 42 CFR 438.6(c) provided they meet select criteria identified in the CIB. Generally, multi-year approvals would not apply to fee schedules. For more information, please refer to the following CIB: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf>.

source for the non-federal share? For example, are the funds for the non-federal share from state legislative appropriations to the Medicaid agency, intergovernmental transfers (from a state or local government entity), provider taxes or some other mechanism? **The funding follows the same method for the Mental Health Directed Payments submission noted in our January 7, 2020 response to CMS's questions, and approved by CMS on April 6, 2020. The funding is as follows: the non-federal share of the payment arrangement is General Funds for the Standard Medicaid population. The non-federal share of the payment for the Granite Advantage (expansion) population is from the Health Care Trust Fund, which is funded by the health insurance premium tax on MCO's, health insurance assessments and revenue from the Alcohol Abuse Prevention Fund.**

**There are no payments funded by IGT's.**

- a. For any payment funded by IGTs, please provide the following:
  - i. A complete list of the names of entities transferring funds
  - ii. The operational nature of the entity (state, county, city, other)
  - iii. The total amounts transferred by each entity
  - iv. Clarify whether the transferring entity has general taxing authority
  - v. Whether the transferring entity received appropriations (identify level of appropriations)
  - vi. Can the state provide information or documentation regarding any written agreements that exist between the state and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement? Is the state aware of any additional written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement?

### **Standard Rate Certification Questions**

3. CMS would like to note for the state that the impact of payment arrangements approved under 42 CFR 438.6(c) must be incorporated into the state's rate certification for the applicable period. CMS would appreciate if the state could elaborate on how the impact of this payment arrangement will be included in the applicable rate certification. For example, will the impact of this payment arrangement be included in the base capitation rates as a rate adjustment, or in some other manner? **Please see the attached letter from our actuary, Milliman.**

CMS has recently published guidance on the documentation expected in the state's rate certification for directed payments in the [2019-2020 Medicaid Managed Care Rate Development Guide](#). Please note that the actuary's certification must contain all of the information outlined in the Rate Guide. If this is not included, the rate review will be delayed. Please note that CMS can provide technical assistance if the state has questions or concerns about how to include the impact of the payment arrangement in their rate certification.

4. Please indicate the total dollars (federal and non-federal) the state plans to add to the rate certification for this directed payment. **Please see the attached letter from our actuary, Milliman.**

## **Quality Questions**

5. The state has not provided evaluation metrics as specified in §438.6(c)(2)(v) and in section 14 of the preprint. These necessary metrics are for the specified activities, targets, performance measures, and include baseline year and data of quality-based outcomes that support program initiatives as specified in the state's quality strategy §438.340. **At the time of the state's next preprint submission**, please include quality metrics.

The state may use this table for ease of reporting:

Please see our response in the table below.

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Measure Name	Description	Baseline Year	Baseline Statistic	Performance Target
NH Counties Meeting Provider Network Adequacy	Percentage of counties where MCO provider networks meet 90% of travel time or travel distance standards. NOTE: Network adequacy in a county can also be met when DHHS approves an exception request for specific provider types, when the request includes plans to assure members have access to services.	Calendar Year 2019	100%	100%