

Lori A. Weaver
Commissioner

Henry D. Lipman
Director

158 - 10/21/26

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

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September 29, 2026

Her Excellency, Governor Kelly A. Ayotte
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into a **Sole Source** amendment to an existing contract with Milliman, Inc. (VC #173344), Seattle, WA, to utilize 100% federal Rural Health Transformation Program (RHTP) funding to aid in the development and implementation of a Medicaid Hospital Payment Model and a Medicaid Primary Care Payment and Prevention Model, by increasing the price limitation by \$3,800,000 from \$16,401,991 to \$20,201,991, with no change to the contract Completion Date of June 30, 2028, effective upon Governor and Council approval. 100% Federal Funds.

These federal RHTP funds are available in State Fiscal Year 2027 and are anticipated to be available through September 30, 2031, upon the award of federal RHTP funds from the Centers for Medicare and Medicaid Services, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

The original contract was approved by Governor and Council on May 18, 2022, item #8A, amended on October 4, 2023, item #17, amended on March 27, 2024, item #16, and most recently on June 17, 2026, item #187.

See attached fiscal details.

EXPLANATION

This request is to address federal funding under the RHTP and the federal changes in financing Medicaid under PL 119-021 as well as the expiration of the Medicaid Enhancement Tax (MET) and Disproportionate Share Hospital (DSH) Agreement at the end of State Fiscal Year 2027. Both the compressed timeframe for development of a new payment model and the integral actuarial activity for the subsequent rate filings thereunder make it imperative to streamline the work effort and timing. This request is **Sole Source** because the Department is modifying the scope of services and adding funds.

The purpose of this request is to modify the scope of services for the Department to, in partnership with the Governor's Office of New Opportunities and Rural Transformational Health (GO-NORTH), support the long-term financial sustainability of New Hampshire's rural hospitals, the hospitals they need to refer to, and primary care practices; while advancing rural health access and investments in primary and behavioral health care. New Hampshire's RHTP's Financial Sustainability Initiative includes the design, development, and implementation (including within

the Medicaid Care Management Program and Medicaid's required CMS rate filing) (1) of a Medicaid Hospital Payment Model to reimburse New Hampshire acute care hospitals with a global like budget supported by value and quality metrics; and (2) a Medicaid value-based Primary Care Payment Model to support sustainability of the RHTP investments in team-based care, primary care integrated with behavioral health and substance use treatment, and primary care based integrated care management programs inclusive of nurses, social workers, and community health workers; and (3) of options for multi-payer approaches to adopting both the Hospital Payment Model and Primary Care Payment Model.

The RHTP is a competitive federal funding initiative among states to strengthen rural health care delivery and access, improve health outcomes, advance prevention and population health strategies, enhance care coordination and affordability, and build sustainable rural health system capacity through targeted investments in infrastructure, workforce, and data/technology-enabled improvements.

All Medicaid individuals will be served on a going forward basis.

Rural hospitals and primary care practices are essential healthcare access points for rural communities yet many struggle to remain financially viable due to unique rural characteristics, persistently low volume and fixed costs to maintain essential service lines.

The Department will monitor services through review and assessment of monthly progress reports against the required deliverables and milestones of the Contractor.

Should the Governor and Council not authorize this request, the Department in partnership with GO-NORTH will be unable to support the long-term financial sustainability of New Hampshire's rural hospitals and primary care practices while advancing rural population health and investments in primary care, as required in the RHT Program's Financial Sustainability Initiative, which includes the design and development of a Medicaid Hospital Payment Model.

Area served: Statewide.

Source of Federal Funds: Assistance Listing Number 93.798, FAIN RHTCMS332050.

Respectfully submitted,



For:

Lori A. Weaver
Commissioner

Department of Health and Human Services
FISCAL DETAIL SHEET

Actuarial Services (RFP-2022-DMS-01-ACTUA-01-A04)

05-095-095-950010-63190000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS; HHS: COMMISSIONERS OFFICE; OFFICE OF THE COMMISSIONER; RURAL HEALTH TRANSFORMATION 100% Federal Funds

SFY	Class/Obj	Class Title	Job Number	Current Budget	Increased (Decrease) Amount	Revised Budget
2027	102-500731	Contracts for Program Services	95631912	\$0	\$1,433,000	\$1,433,000
2028	102-500731	Contracts for Program Services	95631912	\$0	\$2,367,000	\$2,367,000
Subtotal				\$0	\$3,800,000	\$3,800,000

05-95-47-470010-79370000 Health and Social Services, Dept of Health and Human Svc, HHS: Division of Medicaid, OFC of Medicaid Services, Medicaid Administration 50% Federal Funds / 50% General Funds

SFY	Class/Obj	Class Title	Job Number	Current Budget	Increased (Decrease) Amount	Revised Budget
2023	102 -500731	Contracts for Program Services	47002901	\$1,824,312	\$0	\$1,824,312
2024	102-500731	Contracts for Program Services	47002901	\$2,178,383	\$0	\$2,178,383
2025	102-500731	Contracts for Program Services	47002901	\$1,923,630	\$0	\$1,923,630
2026	102-500731	Contracts for Program Services	47002901	\$1,681,774	\$0	\$1,681,774
2027	102-500731	Contracts for Program Services	47002901	\$1,691,892	\$0	\$1,691,892
2028	102-500731	Contracts for Program Services	47002901	\$1,925,000	\$0	\$1,925,000
Subtotal				\$11,224,991	\$0	\$11,224,991

05-95-047-470010-23580000 Health and Social Services, Dept of Health and Human Svc, HHS: Division of Medicaid, OFC of Medicaid Services, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND 50% Federal Funds / 50% Other Funds

SFY	Class/Obj	Class Title	Job Number	Current Budget	Increased (Decrease) Amount	Revised Budget
2023	102-500731	Contracts for Program Services	47003330	\$781,848	\$0	\$781,848
2024	102-500731	Contracts for Program Services	47003330	\$945,406	\$0	\$945,406
2025	102-500731	Contracts for Program Services	47003330	\$922,258	\$0	\$922,258
2026	102-500731	Contracts for Program Services	47003330	\$806,303	\$0	\$806,303

Department of Health and Human Services

FISCAL DETAIL SHEET

Actuarial Services (RFP-2022-DMS-01-ACTUA-01-A04)

2027	102-500731	Contracts for Program Services	47003330	\$796,185	\$0	\$796,185
2028	102-500731	Contracts for Program Services	47003330	\$825,000	\$0	\$825,000
			Subtotal	\$5,077,000	\$0	\$5,077,000

**05-95-92-922010-19090000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES,
SAMHSA GRANT 100% Federal Funds**

SFY	Class/Obj	Class Title	Job Number	Current Budget	Increased (Decrease) Amount	Revised Budget
2024	102-500731	Contracts for Program Services		\$100,000	\$0	\$100,000
			Subtotal	\$100,000	\$0	\$100,000
			TOTAL	\$16,401,991	\$3,800,000	\$20,201,991

State of New Hampshire

New Hampshire Department of Health and Human Services

Amendment

Amendment #4

This Amendment to the Actuarial Services contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Milliman, Inc. ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on May 18, 2022 (Item #8A), as amended on October 4, 2023 (Item #17), March 27, 2024 (Item #16), and most recently amended on June 17, 2026 (Item #187), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37, General Provisions, Block 1.8., Price Limitation, to read:
\$20,201,991
2. Add Exhibit B-1, Additional Scope of Services – Amendment #4, which is attached hereto and incorporated by reference herein.
3. Modify Exhibit C, Payment Terms, Section 1, to read:
 1. This Agreement is Funded by:
 - 1.1. 19% Federal funds, Rural Health Transformation Program (RHTP) from the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Assistance Listing Number 93.798, FAIN RHTCMS332050
 - 1.2. 41% Federal funds for Medicaid Entitlement award from the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Assistance Listing Number (ALN) 93.778, FAIN 2605NHADM, FAIN 2405NHADM, FAIN 2205NHADM; and ALN 93.829, FAIN H79SM987622
 - 1.2. 28% General funds.
 - 1.3. 12% Other funds (as defined in RSA 126-AA:3.I).
4. Modify Exhibit C, Payment Terms; Section 3, to read:
 3. Payment shall be made upon the completion of deliverables as specified in Exhibit C-4 – Amendment #3, Activities to Deliverables Mapping and Exhibit C-5 – Amendment #4, Activities to Deliverables Mapping.
5. Add Exhibit C-5 – Amendment #4, Activities to Deliverables Mapping, which is attached hereto and incorporated by reference herein.

State of New Hampshire
New Hampshire Department of Health and Human Services
Amendment

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be effective upon Governor and Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by:
Henry D. Lipman
CF5D44D4F70D4E4...

Name: Henry D. Lipman

Title: Medicaid Director

Date Signed: 9/30/2026

Milliman, Inc.

Signed by:
Greg J. Herrle
32A80A38D8AF4F6...

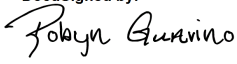
Name: Greg J. Herrle

Title: Principal and Consulting Actuary

Date Signed: 9/30/2026

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

DocuSigned by:

748734844941460...

Name: Robyn Guarino

Title: Attorney

Date Signed: 9/30/2026

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Name:

Title:

Date Signed: _____

**New Hampshire Department of Health and Human Services
Actuarial Services**

Exhibit B-1, Additional Scope of Service – Amendment #4

Medicaid Hospital and Primary Care Payment Model

1. Purpose

- 1.1 WHEREAS, the Centers for Medicare & Medicaid Services (“CMS”) has established the Rural Health Transformation (“RHT”) Program, a competitive federal funding initiative intended to support states and rural communities in strengthening rural health care delivery and access, improving health outcomes, advancing prevention and population health strategies, enhancing care coordination and affordability, and building sustainable rural health system capacity through targeted investments in infrastructure, workforce, and data/technology-enabled improvements.
- 1.2 WHEREAS, CMS approved New Hampshire’s Rural Health Transformation Plan (“RHTP”) and awarded the State funding to implement CMS approved RHTP initiatives.
- 1.3 WHEREAS, through Executive Order 2025-06, Governor Kelly Ayotte established the Governor’s Office of New Opportunities and Rural Transformational Health (“GO-NORTH”) to deliver the transformational initiatives included in New Hampshire’s CMS approved RHTP.
- 1.4 WHEREAS, rural hospitals and primary care practices are essential healthcare access points for rural communities yet many struggle to remain financially viable due to unique rural characteristics, persistently low volume and fixed costs to maintain essential service lines.
- 1.5 WHEREAS, to support the long-term financial sustainability of New Hampshire’s rural hospitals and primary care practices, while advancing rural population health and investments in primary care, New Hampshire’s RHTP’s Financial Sustainability Initiative included the design and development of a (1) Medicaid hospital payment model to reimburse New Hampshire acute care hospitals (each a “Hospital”) and collectively, the “Hospitals”) with a global like budget supported by value and quality metrics (the “Hospital Payment Model”); (2) Medicaid value-based primary care payment model (“Primary Care Payment Model”) to support sustainability of the RHT investments in team-based care, primary care integrated with behavioral health and substance use treatment, and primary care based integrated care management programs inclusive of nurses, social workers, and community health workers; and (3) statewide multi-payer approach to adopting both the Hospital Payment Model and Primary Care Payment Model (collectively, the “Services”).
- 1.6 WHEREAS, in partnership with GO-NORTH the New Hampshire Department of Health and Human Services Division of Medicaid (“Department”) desires to engage the Contractor to provide the Services.

2. Statement of Work - The Contractor’s satisfactory performance of the Services includes completion of two key objectives:

- 2.1 A Hospital Payment Model approved by the Department, actuarially incorporated into the Department’s Medicaid Care Management capitation rates by the Department’s actuary, and ready for implementation, after a testing period in calendar year 2027,

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with participating Hospitals by July 1, 2028. The Hospital Payment Model must incorporate the following four elements:

- 2.1.1 **Expenditure Rate Growth.** Total payments to participating Hospitals will be subject to a controlled rate of expenditures, on a per member per month basis, determined by the Department and subject by CMS approval of the rate filing.
- 2.1.2 **Base Payments.** Payments to participating Hospitals will include a base payment and a global budget-like payment (see Section 2.1.3 below). The Hospital's base payment accounts for the unique fixed costs of the Hospital, regardless of utilization, to ensure a core set of services, determined by the Department, are available in rural communities across New Hampshire.
- 2.1.3 **Global Budget-Like Payments.** The Hospital's global budget-like payment is based on historical utilization and adjustments determined by the Department, including rurality, appropriate changes in service lines, and demographics. Adjustments will be focused on ensuring Hospitals succeed through their own actions and in partnership with other providers in the region, in improving the population health of their communities and reducing preventable hospital utilization.
- 2.1.4 **Additional Risk.** After implementation of the Hospital Payment Model by participating Hospitals the model will support the option to take on additional risk for an attributed population that goes beyond payments to the Hospital, including, for example, hospital-employed physicians.
- 2.2 Implementation of Medicaid Primary Care Payment Model structured to support the long-term sustainability of GO-NORTH RHTP investments in comprehensive primary care including primary care integrated with behavioral health and substance use treatment, and team-based care inclusive of nurses, social workers, and community health workers.
- 2.3 The structure of each of the Hospital Payment Model and Primary Care Payment Model shall support multi-payer alignment and multi-payer adoption.
3. **Performance of Services.** The Contractor's performance of the Services is organized into four phases and includes activities within each phase that must be completed. Activities within each phase may require work to continue simultaneously across phases rather than sequentially. For all four phases, the Contractor must provide dedicated project management personnel, and supporting project management resources, to ensure the timely completion and implementation of the Hospital Payment Model and the Primary Care Payment Model. Contractor shall commence work within seven calendar days of the effective date of this Contract.
 - 3.1 **Hospital Payment Model:**
 - 3.1.1 **Phase 1 – Assessment and Design.** The Contractor must complete a current-state analysis and design of the Hospital Payment Model. Activities include:
 - 3.1.1.1 Facilitate creation of a Hospital working group, including the Department, GO-NORTH, and Hospital representatives.

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Actuarial Services**

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- 3.1.1.2 Hospital Payment Model kickoff meetings with GO-NORTH and the Department and Hospital working group and establishment of recurring meetings to design and develop the Hospital Payment Model.
- 3.1.1.3 Complete baseline analysis, inclusive of an assessment of the role each Hospital plays in its regional system / service area, review and analysis of each hospital's financial, utilization, and population health data.
- 3.1.1.4 Recommend the Hospital services the Department includes in the Hospital Payment Model and identify the Hospital services that may require a separate or unique payment model or phase inclusion to support sustainable access to those Hospital service lines in rural areas.
- 3.1.1.5 Draft payment model framework, inclusive of structure, base period, appropriate standby payments, appropriate cost growth controls, base period, and data sources.
- 3.1.1.6 Recommend appropriate adjustment factors such as case mix, appropriate rural adjustments, population health improvement, access, inflation, cost benchmarks.
- 3.1.1.7 Draft approach to address changes in scope of services provided by participating hospitals.
- 3.1.1.8 Complete Hospital capability assessment to implement the Hospital Payment Model and preliminary recommendations for Hospital resources needed to implement the Hospital Payment Model, and identify appropriate federal authority (SPA, 1115, CMMI demonstration) necessary to implement the Hospital Payment Model.
- 3.1.2 **Phase 2 - Readiness & Implementation.** The Contractor must support Hospital and primary care practice onboarding to the Hospital Payment Model. In addition, the Hospital Payment Model must be operationally ready for implementation by July 1, 2028. Activities include:
 - 3.1.2.1 Complete a shadow period where Medicaid reimbursement under the Hospital Payment Model is modeled but not live and validate results against actual experience.
 - 3.1.2.2 Provide financial impact modeling, by participating Hospital.
 - 3.1.2.3 Refine Hospital Payment Model as needed based on result of shadow period.
 - 3.1.2.4 Adopt final Hospital Payment model parameters, reporting requirements, and oversight mechanisms.
 - 3.1.2.5 Develop Hospital Payment model tool kits for the Department and hospitals adopting the model.
 - 3.1.2.6 Provide technical assistance and training for Hospital CFOs and representatives, Medicaid Care Management plans, and the Department.

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- 3.1.2.7 Develop necessary material to support the Department obtaining the appropriate federal authority to implement the Hospital Payment Model (e.g. State Plan Amendment, waiver, etc.).
- 3.1.2.8 Conduct New Hampshire payer landscape assessment and develop strategy
- 3.1.3 **Phase 3 – Actuarial Development and Approval.** The Contractor must ensure actuarial acceptance of the Hospital Payment Model by the Department and CMS actuaries, incorporation into the Department's Medicaid Care Management capitation (as applicable), and the Department and CMS approval of the Hospital Payment Model. Activities include:
 - 3.1.3.1 Complete Hospital Payment Model modeling, including use of Hospital data to simulate payments under different scenarios, assessment of impacts (e.g. no rural hospital faces destabilizing revenue changes) and refinement of Hospital Payment Model parameters based on model feedback.
 - 3.1.3.2 Define actuarial model for incorporation into the Medicaid Care Management capitation and develop actuarial sound rates for incorporation of the Hospital Payment Model in the Medicaid Care Management capitation.
 - 3.1.3.3 Draft technical and actuarial memoranda and the Department fiscal impact of implementing the Hospital Payment Model.
 - 3.1.3.4 Develop necessary actuarial material to support the Department obtaining the appropriate federal authority to implement the Hospital Payment Model (e.g. State Plan Amendment, waiver, etc.).
 - 3.1.3.5 Obtain CMS rate certification approval.
- 3.1.4 **Phase 4 – Monitoring & Sustainment.** The Contractor must ensure ongoing model monitoring, recalibration, and multi-payer expansion support through the end of the period of performance. Activities include:
 - 3.1.4.1 Develop options for participating Hospitals to take on risk.
 - 3.1.4.2 Continued technical assistance activities and support.
 - 3.1.4.3 Creation of clear operational guidance, budget calculation templates, data submission protocol, and tools for the Department and participating Hospitals.
 - 3.1.4.4 Define how the Hospital Payment Model will evolve (e.g. annual budget adjustments, multi-payer alignment, adoption of additional risk, etc.).
 - 3.1.4.5 Support GO-NORTH facilitation of multi-payer workgroups to support adoption of the Hospital Payment Model by multiple payers.
 - 3.1.4.6 Design federally approvable multi-payer alignment mechanisms (e.g., common attribution logic, shared quality measure sets, aligned risk-adjustment methodology, risk corridors, payer compacts, etc.).

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3.2 Primary Care Payment Model

3.2.1 Phase 1 – Assessment and Design: The Contractor must complete a current-state analysis and design of the Primary Care Payment Model. Activities include:

- 3.2.1.1 Facilitate creation of a primary care working group, including the Department, GO-NORTH, and primary care stakeholders.
- 3.2.1.2 Primary Care Payment Model kickoff meeting with GO-NORTH, the Department, and working group and establishment of recurring meetings to design and develop the Primary Care Payment Model.
- 3.2.1.3 Complete baseline analysis of current reimbursement structures for primary in New Hampshire including Medicaid, Medicare, and commercial payers.
- 3.2.1.4 Identify scope of services included in the Primary Care APM.
- 3.2.1.5 Draft payment model framework.
- 3.2.1.6 Recommend appropriate adjustment factors such as case mix, appropriate rural adjustments, population health improvement, access, inflation, cost benchmarks.
- 3.2.1.7 Draft approach to address changes in scope of services.

3.2.2 Phase 2 - Readiness & Implementation. The Contractor must support Hospital and primary care practice onboarding to the Primary Care Payment Model. Activities include:

- 3.2.2.1 Provide financial impact modeling including identification of cost off-sets and actuarially supported cost savings through investments in primary care services through the Primary Care Payment Model.
- 3.2.2.2 Adopt final Primary Care Payment Model parameters, reporting requirements, and oversight mechanisms.
- 3.2.2.3 Develop Primary Care Payment Model tool kits for the Department and primary care providers adopting the model.
- 3.2.2.4 Provide technical assistance and training for primary care organizations and the Department.
- 3.2.2.5 Identify technical assistance, support, workforce, or technology needs of primary care providers to participate in the Primary Care Payment Model.
- 3.2.2.6 Develop necessary material to support the Department obtaining the appropriate federal authority to implement the Primary Care APM (e.g. State Plan Amendment, waiver, etc.).
- 3.2.2.7 Conduct New Hampshire payer landscape assessment and develop strategy for multi-payer alignment of the Primary Care Payment Model.

3.2.3 Phase 3 – Actuarial Development and Approval. The Contractor must ensure actuarial acceptance of the Primary Care Payment Model by the Department and

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CMS actuaries, incorporation into the Department's Medicaid Care Management capitation (as applicable), and the Department and CMS approval of the Primary Care Payment Model. Activities include:

- 3.2.3.1 Complete payment modeling under different scenarios, assessment of impacts and potential cost off-sets or savings, and refinement of Primary Care Payment Model parameters based on model feedback.
- 3.2.3.2 Define actuarial model for incorporation into the Medicaid Care Management capitation and develop actuarial sound rates for incorporation of the Primary Care Payment Model in the Medicaid Care Management capitation.
- 3.2.3.3 Draft technical and actuarial memoranda and the Department fiscal impact of the Department's fiscal impact of implementing the Primary Care Payment Model.
- 3.2.3.4 Develop necessary actuarial material to support the Department in obtaining the appropriate federal authority to implement the Primary Care APM (e.g. State Plan Amendment, waiver, etc.).
- 3.2.3.5 Obtain CMS rate certification approval.
- 3.2.4 **Phase 4 – Monitoring & Sustainment.** The Contractor must ensure ongoing model monitoring, recalibration, and multi-payer expansion support through the end of the period of performance. Activities include:
 - 3.2.4.1 Develop options for participating primary care organizations to take on risk.
 - 3.2.4.2 Continued technical assistance activities and support.
 - 3.2.4.3 Creation of clear operational guidance, budget calculation templates, data submission protocol, and tools for the Department and participating hospitals.
 - 3.2.4.4 Define how the Primary Care Payment Model will evolve (e.g. annual budget adjustments, multi-payer alignment, adoption of additional risk, etc.).
 - 3.2.4.5 Support facilitation of multi-payer workgroups to support adoption of the Primary Care Payment Model by multiple payers.
 - 3.2.4.6 Design federally approvable multi-payer alignment mechanisms (e.g., common attribution logic, shared quality measure sets, aligned risk-adjustment methodology, risk corridors, payer compacts, etc.).
- 3.3 **Activities.** Completion of each activity is subject to the review and approval of the Department.
- 3.4 **Project Plan.** Within thirty (30) days after the Effective Date, the Contractor must submit to the Department for review and approval a detailed project plan (the "Project Plan") to perform the Services. The Project Plan must, in reasonable detail, (a) identify the planned activities within each phase to achieve the tasks; and (b) specify

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the milestones to be achieved, including milestone due dates and measurable completion criteria. The Contractor must maintain and update the Project Plan.

- 3.5 **Stakeholder Collaboration.** The Contractor must work effectively and collaboratively with multiple stakeholder groups, including rural hospitals, primary care providers, GO-NORTH, the New Hampshire Department of Insurance, and commercial payers.

3.6 Staffing.

- 3.6.1 The Contractor must provide qualified personnel at the full-time equivalent (FTE) levels specified below. Proposed personnel changes must be pre-approved by the Department at least fifteen (15) days prior to such changes.

3.6.1.1 **Engagement Director** (0.1 FTE for SFY 27 and 28) - Serves as the primary point of contact for the State, GO-NORTH, and Department leadership. Owns day-to-day client communication, meeting agendas, issue escalation, and decision tracking. Coordinates leadership briefings, status reviews, and client-facing deliverables. Ensures responsiveness, alignment with client priorities, and timely resolution of open items.

3.6.1.2 **Integrated Delivery Lead** (0.4 FTE for SFY 27 and SFY 28) - Has overall responsibility for all workstreams, deliverables, quality control, and PMO performance. Integrates the Hospital Payment Model, Primary Care / APCM, federal strategy, actuarial, multi-payer, and platform work into one delivery structure. Oversees schedule, dependencies, staffing, risk management, and executive review. Approves major deliverables before submission and ensures work remains aligned to SOW requirements and expansion options.

3.6.1.3 **Project Manager** (0.3 FTE for SFY 27 and SFY 28) - Runs the master workplan, milestone tracking, RAID log, governance calendar, and reporting package. Supports the Project Plan and performance reporting requirements in the SOW.

3.6.1.4 **Hospital Workstream Lead** (0.5 FTE for SFY 27 and 0.4 FTE for SFY 28) - Lead model design, readiness, implementation support, and stakeholder-facing workgroups. Anchor work in the payment model phases and deliverables. Own financial modeling, scenario testing, rate development support, fiscal impact analysis, and actuarial memoranda. Ensure fit of the SOW's primary design, technical assistance, toolkit, and other provisions.

3.6.1.5 **Primary Care Workstream Lead** (0.3 FTE for SFY 27 and 0.5 FTE for SFY 28) - Provide senior-level expertise across areas including Medicaid financing, federal approval pathways, value-based payment design, actuarial rate development, multi-payer strategy, technology, data integration, and total cost of care. Assess receptivity of federal agencies and peer states to potential approaches for establishing New Hampshire's hospital payment base and growth factor. Interpret implications for model design and approvability. Translate insights into

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practical recommendations for the State. Ensure that policy, actuarial, operational, and federal strategy considerations are integrated throughout the engagement.

3.7 Performance Metrics.

- 3.7.1 Quarterly Progress Reporting. The Contractor must submit quarterly progress reports to the Department for submission to GO-NORTH detailing the progress made during the applicable reporting period. See the table below for quarterly progress report time periods and due dates.

Report	Reporting period start date	Reporting period end date	Due date
Quarterly Report #1	August 1	October 30	November 7
Quarterly Report #2	October 31	January 30	February 7
Quarterly Report #3	January 31	April 30	May 7

If the reporting due date falls on a weekend or State recognized holiday, the report shall be due the next business day following the reporting date.

*Note: To reduce reporting burden on the Contractor, and the timing of the annual report, there is no quarterly report due for the time period of May 1 to July 31.

- 3.7.2 Annual Progress Reporting. The Contractor must submit annual progress reports to the Department for submission to GO-NORTH detailing the progress made during the applicable reporting period. Annual progress report time periods and due dates are as follows:

- 3.7.2.1 Annual progress report #1: Effective Date through July 30, 2027, and due August 7, 2027.
- 3.7.2.2 Annual progress report #2: August 1, 2027 through July 30, 2028, and due August 7, 2028.
- 3.7.2.3 Annual progress report #3: August 1, 2028 through July 30, 2029, and due August 7, 2029.
- 3.7.2.4 Annual progress report #4: August 1, 2029 through July 30, 2030, and due August 7, 2030.
- 3.7.2.5 Final report: Effective Date through October 30, 2030 and due December 15, 2030.

*If the reporting due date falls on a weekend or State recognized holiday the report shall be due the next business day following the reporting date.

- 3.8 The Contractor must submit annual and quarterly reports in a format as determined by GO-NORTH and communicated to the Contractor by the Department.

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- 3.9 The Contractor must participate in Hospital Payment Model forums and Primary Care APM forums as requested by either the Department or by GO-NORTH.
- 3.10 The Contractor must participate and cooperate in evaluation and implementation science activities led by GO-NORTH and GO-NORTH's Evaluation Contractor to support evaluation, learning, performance monitoring, and CMS reporting requirements.
- 3.11 Credits and Copyright Ownership
 - 3.11.1 When issuing public statements resulting from activities supported by this Contract the Contractor must include the following statement, "This GO-NORTH [project/publication/program/website, etc.] [is/was] supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$XX with 100 percent funded by CMS/HHS [or as part of a financial assistance award totaling \$XX with XX percentage funded by CMS/HHS and \$XX amount and XX percentage funded by non-government source(s)]. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government."
 - 3.11.2 The Contractor must submit the following to the Department for CMS review and comment at least forty-five (45) days prior to release:
 - 3.11.2.1 Publications that report results from or describe information obtained through the Contractor's use of funds under this Contract.
 - 3.11.2.2 Any external formal presentation of any report or statistical or analytical material based on information obtained through the Contractor's use of funds under this Contract. Formal presentation includes papers, articles, professional publication, speeches, and testimony.
 - 3.11.2.3 External presentation-related material, such as abstracts, power point presentations or other slide decks, posters, and videos.
 - 3.11.2.4 All public materials specific to the program including but not limited to, brochures, recruitment materials, informational materials, advertisements, website copy, website pages, videos, and op-ed articles.
 - 3.11.3 At least fourteen (14) days prior to release, the Contractor must submit to the Department for CMS's review and comment:
 - 3.11.3.1 Any press release or media advisory concerning the outcome of activities supported through the Contractor's use of funds under this Contract.
 - 3.11.3.2 All media interviews, media requests, releases of information, filming, and broadcasts.
 - 3.11.4 For 1 year after completion of the project, the recipient must continue to submit for review and comment all publications, presentations, and communications

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Actuarial Services**

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resulting from this award or based on information obtained through the Contractor's use of funds under this Contract, including papers, articles, professional publications, power point presentations, posters, speeches, announcements, and testimony in any format, including digital technology.

- 3.11.5 Specifically excluded from the review and comment process are internal presentations, information discussions, in general, class lectures, and informal meetings and conversations with community leaders. However, if such a presentation or slide deck is later re-purposed for a public event, it will need to be submitted in advance for review and comment.
- 3.11.6 One copy of each publication, that requires prior review and comment under this Contract, must accompany the final progress report.
- 3.11.7 The Department will retain all intellectual property rights, including but not limited to copyright ownership, for any and all original materials produced, including, but not limited to reports, protocols, guidelines, brochures, posters, and resource directories under this Agreement. The Contractor must not reproduce any materials produced under the Agreement without prior written approval from the Department.

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
A. Hospital Payment Model							
A.1	Hospital stakeholder governance and workgroup facilitation.	3.1.1–3.1.2; 3.2.6; 3.2.8; 3.4.2; 3.4.5–3.4.6; and 3.7.					
A.1.1	Organize and facilitate a Hospital Payment Model workgroup and dedicated subgroups (e.g. Critical Access Hospital, PPS Hospitals, or other subgroups, as directed) to inform, review, and support decisions across assessment, design, implementation, and sustainment. • Develop charters defining purpose, membership, cadence, roles, decision rights, escalation, and participation expectations. • Create engagement plan covering rural hospitals, hospital systems, GO-NORTH, the Department, Medicaid Care Management plans, the Department of Insurance, commercial payers, and other relevant participants.		1	\$ 9,000	\$ 9,000	\$ 9,000	\$ -
A.1.2	Complete analyses and research findings in response to ad hoc requests in any given calendar month, as deemed necessary. Such activities may include, but not necessarily be limited to: • Kickoff and recurring-meeting agendas, pre-reads, presentations, summaries, action items, and decision logs. • Structured Critical Access Hospital input on low-volume economics, fixed-cost and standby capacity, essential service lines, regional access, and implementation feasibility. • Stakeholder findings and disposition log documenting how input was incorporated, deferred, or otherwise addressed. • Financial analysis and research in support of hospital payment model deliverables. • Ad hoc support, as requested. • Training and technical assistance for hospital CFOs and representatives, Medicaid Care Management plans, and Department staff. • GO-NORTH multi-payer workgroup support plan and materials		20	\$ 30,000	\$ 600,000	\$ 240,000	\$ 360,000
A.2	Hospital current-state quantitative assessment.	3.1.3–3.1.4 and 3.1.8; informs 3.1.5–3.1.7 and 3.2.2.					\$ -
A.2.1	Deliver a provider-level and provider-class assessment that quantifies the current state of Medicaid hospital financing and establishes the analytical baseline for payment model design.		1	\$ 25,000	\$ 25,000	\$ 25,000	\$ -
A.2.2	Establish hospital-specific levels of "reasonable performance" for purposes of setting threshold levels for adjustment eligibility, taking into account a range of factors (e.g., workforce capacity constraints, rurality, minimum operating requirements, etc.)		1	\$ 35,000	\$ 35,000	\$ 35,000	\$ -
A.2.3	Identify minimum funding requirements for sustaining essential services		1	\$ 36,000	\$ 36,000	\$ 36,000	\$ -
A.2.4	Quantify current Medicaid payments as a percentage of Medicare by provider and provider class, with documented methods and limitations.		1	\$ 30,000	\$ 30,000	\$ 30,000	\$ -
A.2.5	Evaluate current Medicaid provider payments, supplemental payments, and the relationship between payments and provider taxes or other financing arrangements, as applicable.		1	\$ 30,000	\$ 30,000	\$ 30,000	\$ -
A.2.6	Evaluate hospital and health-system ownership and affiliation structures and implications for payment design, financial reporting, and participation.		1	\$ 20,000	\$ 20,000	\$ 20,000	\$ -
A.2.7	Assess financial condition, utilization, service mix, volume, population health indicators, regional role, and service area by hospital.		1	\$ 25,000	\$ 25,000	\$ 25,000	\$ -
A.2.8	Identify essential, low-volume, standby, or distinct services that may require separate treatment or phased inclusion.		1	\$ 17,000	\$ 17,000	\$ 17,000	\$ -
A.2.9	Produce a baseline data book, methodology memorandum, provider classification framework, and executive findings.		1	\$ 25,000	\$ 25,000	\$ 25,000	\$ -
A.3	Hospital payment options assessment and recommended strategy.	Builds on 3.1.4–3.1.8; supports 3.2.1–3.2.4, 3.2.7–3.2.8, 3.3.1–3.3.5, and 3.4.1–3.4.6.					Initial

Milliman, Inc.

Initials:

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
A.3.1	Assess feasible hospital payment strategies and recommend a sequenced approach that advances financial sustainability, access, accountability, and federal approvability, starting with potential participation in a form of CMS's AHEAD program, CMMI models, or other permissible CMS payment methodologies.		1	\$ 21,000	\$ 21,000	\$ 21,000	\$ -
A.3.2	Assess minimum Medicaid fee schedules, including assessment of moving applicable payments up to 100 percent of Medicare alignment and identifying services or classes needing a different benchmark.		1	\$ 21,000	\$ 21,000	\$ 21,000	\$ -
A.3.3	Explore graduate medical education, indirect medical education payment approaches, and other permissible CMS payment approaches (wage index, capital and outlier adjustments and quality and incentive adjustments used in Medicare) including objectives, eligible providers or costs, allocation, financing, and interaction with other payments.		1	\$ 9,000	\$ 9,000	\$ 9,000	\$ -
A.3.4	Assess movement toward value-based payment through a Medicaid global-like budget or global budget-like model using Medicare unit price levels as an analytical reference point.		1	\$ 7,000	\$ 7,000	\$ 7,000	\$ -
A.3.5	Compare options for provider impact, rural and Critical Access Hospital implications, access, budget, financing, operational complexity, data readiness, managed care, multi-payer alignment, and federal authority.		1	\$ 19,000	\$ 19,000	\$ 19,000	\$ -
A.3.6	Recommend near-term and longer-term sequencing, transition protections, decisions needed, and rationale for options not recommended.		1	\$ 9,000	\$ 9,000	\$ 9,000	\$ -
A.4	Federal receptivity and precedent assessment for Hospital Payment Model.	3.1.5–3.1.8; 3.2.7; 3.3.1–3.3.5; 3.4.4–3.4.6					
A.4.1	Conduct targeted informal outreach and information-gathering with relevant federal entities and peer states to assess receptivity to potential approaches for establishing New Hampshire’s model parameters. This work may include engagement with CMCS, CMMI, the Office of the Actuary, the Rural Health Transformation team, the Demonstration Group, and selected states with similar policy interests or model features. Summarize feedback, implications, risks, and recommended design considerations for incorporation into New Hampshire’s hospital payment model development, federal strategy, and rate approval approach.		1	\$ 70,000	\$ 70,000	\$ -	\$ 70,000
A.5	Hospital payment model design specification.	3.1.5–3.1.7; 3.2.3–3.2.4; 3.4.1 and 3.4.3–3.4.4.					
A.5.1	Translate the selected strategy option(s) into a complete Hospital Payment Model design specification suitable for modeling, federal review, implementation planning, and managed care documentation.		1	\$ 33,000	\$ 31,000	\$ 31,000	\$ -
A.5.2	Define participating providers, covered services, excluded or separately paid services, and services that may be phased in.		1	\$ 11,000	\$ 11,000	\$ 11,000	\$ -
A.5.3	Specify payment structure, base period, Medicare benchmark treatment, base and global budget-like components, standby payments, and expenditure growth limits.		1	\$ 15,000	\$ 15,000	\$ 15,000	\$ -
A.5.4	Specify case mix, rural, service mix, population health, access, inflation, cost benchmark, and scope-change adjustments.		1	\$ 14,000	\$ 14,000	\$ 14,000	\$ -
A.5.5	Define quality, access, attribution, reporting, reconciliation, oversight, governance, and dispute requirements.		1	\$ 22,000	\$ 22,000	\$ 22,000	\$ -
A.6	Hospital financial and actuarial modeling and approval package.	3.2.2 and 3.2.7; 3.3.1–3.3.5.					
A.6.1	Quantify the financial, actuarial, and fiscal effects of the proposed Hospital Payment Model and prepare materials needed for managed care rate development and federal approval.		1	\$ 27,000	\$ 27,000	\$ -	\$ 27,000
A.6.2	Provider-level scenario modeling, impact assessment, transition analysis, and tests for destabilizing revenue changes.		1	\$ 35,000	\$ 31,000	\$ -	\$ 31,000
A.6.3	Medicaid fiscal impact, provider financing interactions, managed care capitation impact, and sensitivity analyses.		1	\$ 29,000	\$ 28,000	\$ -	\$ 28,000
A.6.4	Actuarial methodology and actuarially sound rates for incorporation into Medicaid Care Management capitation.		1	\$ 38,000	\$ 31,000	\$ -	\$ 31,000

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
A.6.5	Technical and actuarial memoranda documenting assumptions, methods, results, limitations, and policy decisions.		1	\$ 15,000	\$ 15,000	\$ -	\$ 15,000
A.6.6	Authority assessment covering State Plan Amendment, Section 1115 demonstration, CMMI pathway, or a coordinated combination, with recommended sequence.		1	\$ 8,000	\$ 8,000	\$ -	\$ 8,000
A.6.7	Federal submission and rate-certification support materials, including responses to reviewer questions within the contracted scope.		1	\$ 7,000	\$ 7,000	\$ -	\$ 7,000
A.7	Hospital implementation readiness and shadow period package.	3.1.8; 3.2.1 and 3.2.3–3.2.6; 3.4.2–3.4.3.					
A.7.1	Test the Hospital Payment Model against actual experience, assess readiness, and provide the operational materials and supports required for implementation.		1	\$ 14,000	\$ 14,000	\$ -	\$ 14,000
A.7.2	Hospital and Department capability assessment covering data, systems, staffing, governance, reporting, contracting, and change management.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000
A.7.3	Shadow-period plan, calculation files, modeled-to-actual comparison, validation results, issue log, and parameter refinements.		1	\$ 14,000	\$ 14,000	\$ -	\$ 14,000
A.7.4	Final model parameters, reporting requirements, oversight mechanisms, implementation schedule, and readiness criteria.		1	\$ 20,000	\$ 16,000	\$ -	\$ 16,000
A.7.5	Operational toolkit with guidance, budget templates, data specifications, reporting templates, frequently asked questions, and worked examples.		1	\$ 26,000	\$ 24,000	\$ -	\$ 24,000
A.8	Hospital sustainment, risk, and evaluation of options for multi-payer alignment opportunities	3.2.8; 3.4.1–3.4.6.					
A.8.1	Provide a roadmap for ongoing operation, annual model evolution, additional risk, and alignment with Medicare.		1	\$ 20,000	\$ 20,000	\$ -	\$ 20,000
A.8.2	New Hampshire payer landscape assessment and prioritized alignment opportunities.		1	\$ 9,000	\$ 9,000	\$ -	\$ 9,000
A.8.3	Options and readiness gates for hospitals to assume additional financial or performance risk, including potential alignment with commercial payers.		1	\$ 17,000	\$ 17,000	\$ -	\$ 17,000
A.8.4	Annual budget update, growth factor, service and scope change, quality update, reconciliation, and oversight methodology.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000
A.8.5	Alignment design for attribution, quality, risk adjustment approaches, payer compacts, coordinated milestones,		1	\$ 11,000	\$ 11,000	\$ -	\$ 11,000
A.8.6	Identification and quantification of risk factors associated with payment model and mitigation strategies.		1	\$ 15,000	\$ 15,000	\$ -	\$ 15,000
A.8.7	Operational readiness plan for evaluating plan performance and identifying opportunities to improve operational processes related to data management, program oversight, and technical support.		1	\$ 18,000	\$ 18,000	\$ -	\$ 18,000
B. Primary Care and Prevention Payment Model							
B.1	Primary care stakeholder governance and workgroup facilitation.	7					
B.1.1	Organize a Primary Care Payment Model workgroup to inform, review, and support decisions across assessment, design, implementation, and sustainment. • Establish workgroup charter defining purpose, membership, cadence, roles, decision rights, escalation, and participation expectations. • Create engagement plan representing independent and health-system practices, federally qualified health centers, rural health clinics, other rural providers, GO-NORTH, the Department, health plans, the Department of Insurance, and commercial payers.		1	\$ 9,000	\$ 9,000	\$ 9,000	\$ -

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
B.1.2	Complete analyses and research findings in response to ad hoc requests in any given calendar month, as deemed necessary. Such activities may include, but not necessarily be limited to: • Kickoff and recurring-meeting agendas, pre-reads, presentations, summaries, action items, and decision logs. • Targeted sessions to test implications for different practice types, sizes, regions, and capability levels. • Stakeholder findings and disposition log documenting how input was incorporated, deferred, or otherwise addressed. • Training and technical assistance for providers, health plans, and Department staff. • Financial analysis and research in support of primary care payment model deliverables. • Ad hoc support, as requested. • GO-NORTH multi-payer workgroup support plan and materials		20	\$ 32,000	\$ 640,000	\$ 256,000	\$ 384,000
B.2	Primary care current-state quantitative assessment	3.1.11–3.1.12; 3.2.13; informs 3.1.13–3.1.15 and 3.2.9.					
B.2.1	Deliver a statewide assessment of current primary care reimbursement, delivery capacity, and readiness that establishes the analytical baseline for payment model design.		1	\$ 25,000	\$ 25,000	\$ 25,000	\$ -
B.2.2	Quantify reimbursement across Medicaid, Medicare, and available commercial benchmarks, including fee-for-service, prospective, supplemental, care-management, and performance-based payments.		1	\$ 36,000	\$ 36,000	\$ 36,000	\$ -
B.2.3	Classify providers by practice type, ownership, rurality, size, and delivery arrangement.		1	\$ 19,000	\$ 19,000	\$ -	\$ 19,000
B.2.4	Assess service scope, utilization, access, panel characteristics, workforce, technology, data, care-management capability, and existing APM participation.		1	\$ 28,000	\$ 28,000	\$ -	\$ 28,000
B.2.5	Identify technical assistance, workforce, infrastructure, reporting, and capability gaps affecting participation.		1	\$ 18,000	\$ 18,000	\$ -	\$ 18,000
B.2.6	Produce a baseline data book, methodology memorandum, provider classification framework, and executive findings.		1	\$ 24,000	\$ 24,000	\$ -	\$ 24,000
B.3	Primary care payment options assessment and recommended strategy.	Builds on 3.1.11–3.1.15; supports 3.2.9–3.2.15, 3.3.6–3.3.10, and 3.4.7–3.4.12.					
B.3.1	Assess feasible primary care payment strategies, including a uniform approach versus reasonable adjustments to address practice characteristics, and recommend a sequenced model that increases investment, strengthens capabilities, supports access, and creates a practical path toward value-based payment.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000
B.3.2	Assess applicable minimum Medicaid fee schedules, including movement toward Medicare benchmarks where appropriate.		1	\$ 20,000	\$ 20,000	\$ -	\$ 20,000
B.3.3	Assess prospective or capitated payments for defined primary care services, including attribution, included services, reconciliation, and protections.		1	\$ 15,000	\$ 15,000	\$ -	\$ 15,000
B.3.4	Assess payments for provider capabilities such as care management, access, team-based care, data and technology, and population health.		1	\$ 25,000	\$ 25,000	\$ -	\$ 25,000
B.3.5	Assess quality or value-based components, including measures, improvement methodology, risk adjustment, and progression toward accountability.		1	\$ 20,000	\$ 20,000	\$ -	\$ 20,000
B.3.6	Compare options for provider impacts, rural access, budget and offsets, operational complexity, readiness, managed care, equity, multi-payer alignment, and authority.		1	\$ 18,000	\$ 18,000	\$ -	\$ 18,000
B.3.7	Recommend near-term and longer-term sequencing, transition protections, decisions, and rationale.		1	\$ 11,000	\$ 11,000	\$ -	\$ 11,000
B.3.8	Define recruitment priorities and roll-out considerations		1	\$ 12,000	\$ 12,000	\$ -	\$ 12,000
B.4	Primary care payment model design specification.	3.1.12–3.1.15; 3.2.10; 3.4.7 and 3.4.9–3.4.10.					

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
B.4.1	Translate the selected strategy into a complete Primary Care Payment Model design specification suitable for modeling, federal review, implementation planning, and managed care documentation.		1	\$ 25,000	\$ 25,000	\$ -	\$ 25,000
B.4.2	Define eligible practices and practitioners, included and excluded services, and participation requirements.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000
B.4.3	Specify fee schedule, prospective or capitated, capability investment, and performance-based components, as applicable.		1	\$ 13,000	\$ 13,000	\$ -	\$ 13,000
B.4.4	Specify attribution, risk adjustment, rural adjustment, case mix, access, population health, inflation, cost benchmark, quality, and scope-change methodologies.		1	\$ 17,000	\$ 17,000	\$ -	\$ 17,000
B.4.5	Define reporting, reconciliation, oversight, governance, dispute, and data requirements.		1	\$ 12,000	\$ 12,000	\$ -	\$ 12,000
B.4.6	Define transition methodology and protections for differences in practice size and capability.		1	\$ 19,000	\$ 19,000	\$ -	\$ 19,000
B.4.7	Provide calculation rules, worked examples, policy decisions, and unresolved issues.		1	\$ 10,000	\$ 10,000	\$ -	\$ 10,000
B.5	Primary care financial and actuarial modeling and approval package.	3.2.9 and 3.2.14; 3.3.6–3.3.10.					
B.5.1	Quantify provider, program, and actuarial impacts and prepare materials needed for managed care rate development and federal approval.		1	\$ 24,000	\$ 24,000	\$ -	\$ 24,000
B.5.2	Provider-level and provider-class scenario modeling, including investment, distributional impacts, transition, and sensitivity. Including assessment of potential cost offsets or savings, timing, uncertainty, and distinction between gross investment and assumed offsets.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000
B.5.3	Assessment of potential cost offsets or savings, timing, uncertainty, and distinction between gross investment and assumed offsets.		1	\$ 12,000	\$ 12,000	\$ -	\$ 12,000
B.5.4	Medicaid fiscal impact and managed care capitation impact.		1	\$ 21,000	\$ 21,000	\$ -	\$ 21,000
B.5.5	Actuarial methodology and actuarially sound rates for Medicaid Care Management capitation.		1	\$ 25,000	\$ 25,000	\$ -	\$ 25,000
B.5.6	Technical and actuarial memoranda documenting assumptions, methods, results, limitations, and decisions.		1	\$ 21,000	\$ 21,000	\$ -	\$ 21,000
B.5.7	Authority assessment covering State Plan Amendment, Section 1115 demonstration, CMMI pathway, or a combination, with submission and certification materials.		1	\$ 9,000	\$ 9,000	\$ -	\$ 9,000
B.6	Primary care implementation readiness and adoption package.	3.2.10–3.2.13; 3.4.8–3.4.9.					
B.6.1	Assess provider and Department readiness and provide the materials, training, and supports required for adoption.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000
B.6.2	Provider readiness assessment covering data, technology, workforce, care management, contracting, quality improvement, reporting, and change management.		1	\$ 23,000	\$ 23,000	\$ -	\$ 23,000
B.6.3	Final parameters, reporting requirements, oversight, implementation schedule, participation criteria, and readiness gates.		1	\$ 22,000	\$ 22,000	\$ -	\$ 22,000
B.6.4	Toolkit with operational guidance, payment templates, attribution and roster protocols, data specifications, reporting templates, FAQs, and examples.		1	\$ 21,000	\$ 21,000	\$ -	\$ 21,000
B.6.5	Segmented technical assistance plan based on provider type, capability, region, and implementation risk register with remediation plan.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000
B.7	Primary care sustainment, risk, and evaluation of options for multi-payer alignment opportunities	3.2.15; 3.4.7–3.4.12.					
B.7.1	Provide a roadmap for ongoing operation, annual model evolution, additional accountability, and alignment with Medicare and commercial payers.		1	\$ 12,000	\$ 12,000	\$ -	\$ 12,000
B.7.2	New Hampshire payer landscape assessment and prioritized alignment opportunities.		1	\$ 10,000	\$ 10,000	\$ -	\$ 10,000
B.7.3	Options and readiness gates for primary care providers to assume additional financial or performance risk, including potential alignment with commercial payers.		1	\$ 15,000	\$ 15,000	\$ -	\$ 15,000
B.7.4	Annual methodology for payment updates, service and scope changes, quality updates, reconciliation, and oversight.		1	\$ 12,000	\$ 12,000	\$ -	\$ 12,000
B.7.5	Alignment design for attribution, quality, risk adjustment, risk corridors, payer compacts, and coordinated milestones.		1	\$ 13,000	\$ 13,000	\$ -	\$ 13,000
B.7.6	Identification and quantification of risk factors associated with payment model and mitigation strategies.		1	\$ 16,000	\$ 16,000	\$ -	\$ 16,000

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Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
B.7.7	Operational readiness plan for evaluating plan performance and identifying opportunities to improve operational processes related to data management, program oversight, and technical support.		1	\$ 11,000	\$ 11,000	\$ -	\$ 11,000
B.8	Advanced Primary Care Management (APCM) Opportunity Assessment and Coordination	3.2.13–3.2.15; 3.3.6; and 3.4.7–3.4.12.					
B.8.1	Prepare analysis of current and projected primary care revenue generated by PCPs through APCM (or similar services) and longitudinal care add-on services within the fee-for-service Medicare population.		1	\$ 18,000	\$ 18,000	\$ 18,000	\$ -
B.8.2	Quantify incremental revenue available to PCPs for each medical practice in New Hampshire and summarize by geographic area and practice type.		1	\$ 25,000	\$ 25,000	\$ 25,000	\$ -
B.8.3	Evaluate models for leveraging RHTP funds to enable primary care providers across New Hampshire to meet the operational, service-delivery, data, staffing, and care-management requirements of APCM that elevate primary care access and capabilities.		1	\$ 33,000	\$ 50,000	\$ 20,000	\$ 30,000
B.8.4	Complete analyses and research findings in response to ad hoc requests in any given calendar month, as deemed necessary. Such activities may include, but not necessarily be limited to: • Share services implementation roadmap, • Project management plan, • Governance and communication plan, • Mobilization and startup considerations, • Staffing and vendor on-boarding, • Technology stack requirements • Provider engagement and intake infrastructure, • Service delivery and participation framework, • Program operating procedures, • Integration with value-based payment models, • Interoperability and practice transformation, • Payer engagement, • Sustainability planning, • Material risks, issues, dependencies, corrective actions, and decisions requiring State direction, • Planned activities for the upcoming reporting period		20	\$ 22,000	\$ 440,000	\$ 176,000	\$ 264,000
B.9	Advanced Primary Care Management (APCM) and Longitudinal Care Platform Development (The State may request additional services from the Contractor and require rates if additional services are required, upon future Governor and Executive Council approval of any revisions to the price limitation.)						
B.9.1	Care Management and Care Coordination Model documenting: • Service scope, • Staffing, • Patient identification and stratification, • Workflows, • Documentation, • Coordination, • Escalation, and • Performance expectations.		1	\$ 75,000	\$ 75,000	\$ -	\$ 75,000

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
B.9.2	Shared-Service Portfolio and Operating Plan defining: • Core, optional, tiered, and phased services, • Eligibility, • Service levels, • Delivery methods, • Provider responsibilities, • Responsible entities, and • Implementation sequencing.		1	\$ 105,000	\$ 105,000	\$ -	\$ 105,000
B.9.3	Shared-Services Financial Model projecting: • Startup and mobilization costs, • Ongoing operating costs, • CONTRACTOR administrative compensation, • CONTRACTOR-delivered service costs, • Subcontractor and vendor costs, • Provider Support Funds, • Revenues, • Staffing, • Service utilization, • Provider participation, • Patient volume, • Cash-flow requirements, and • Financing requirements under multiple implementation scenarios.		1	\$ 65,000	\$ 65,000	\$ -	\$ 65,000
B.9.4	Provider Economic Impact and Affordability Analysis assessing: • Provider-focused fees and other participation costs, • Administrative burden, • Technology and implementation expenses, • Anticipated revenues and financial benefits, • Costs funded through RHTP, payer contributions, subsidies, or other sources, • Financial risks, and • Expected return on investment.		1	\$ 60,000	\$ 60,000	\$ -	\$ 60,000
B.9.5	Create shared services implementation plan and roadmap including: • Operating model, • Implementation phases, • Startup and mobilization activities, • Deliverables, payment milestones, and State acceptance points, • Dependencies, • Decision points, • Responsible parties, • Staffing and direct provider staffing supports, and • Timelines.		1	\$ 85,000	\$ 85,000	\$ -	\$ 85,000
B.9.6	Participation Support and Provider Value Proposition describing: • Available technology and infrastructure, • Shared-services and implementation support • Financial and nonfinancial Participation Support, • Participation obligations, • Allocation criteria, and • Processes for providing and coordinating nonfinancial Participation Support; and, where applicable, administering Provider Support Funds for financial Participation Support.		1	\$ 60,000	\$ 60,000	\$ -	\$ 60,000

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
B.9.7	Provider Education and Capacity-Building Plan describing: • Training, • Technical assistance, • Feedback, • Peer learning, • Retention, and • Knowledge-transfer activities.		1	\$ 65,000	\$ 65,000	\$ -	\$ 65,000
B.9.8	Service Delivery and Participation Framework documenting: • Organizational roles, • Provider participation pathways, • Core and optional services, • Intake and onboarding processes, • Provider-focused services and Participation Support Conditions associated with access to State-approved services and Participation Support • Distinctions among delivered services, services delivered through the State-approved subcontractors • Communications, and • Issue-resolution procedures.		1	\$ 95,000	\$ 95,000	\$ -	\$ 95,000
B.9.9	Technology Deployment and Support Plan addressing: • Procurement, • Licensing, • Implementation, • Data migration, • Testing, • Training, • Go-live, • Technical assistance, • Help desk functions, and • Ongoing support.		1	\$ 155,000	\$ 155,000	\$ -	\$ 155,000
B.9.10	Provider-Focused Analytics and Reporting Plan identifying: • Priority use cases, • Data sources, • Reports, • Dashboards, • Registries, • Users, • Implementation requirements, and • Processes for refinement.		1	\$ 75,000	\$ 80,000	\$ -	\$ 80,000
B.9.11	APCM Readiness and Implementation Framework including: • Standardized workflows, • Staffing, • Documentation, • Patient engagement, • Billing, • Training, • Compliance, and • Performance-monitoring processes.		1	\$ 105,000	\$ 105,000	\$ -	\$ 105,000

Exhibit C-5 - Amendment 4, Activities to Deliverables Mapping

Activity #	Deliverable	Mapping to Activities	Instances	Cost per Instance	TOTAL CONTRACT COST	SFY 2027 Cost	SFY 2028 Cost
C. Project Management							
C.1	Cross-model project management plan, governance support, and ongoing project management resources.	Supports 3.1.1–3.1.15, 3.2.1–3.2.15, 3.3.1–3.3.10, and 3.4.1–3.4.12. Builds on 3.2.6–3.2.8, 3.2.11–3.2.15, and 3.4.1–3.4.12.					
C.1.1	Establish a cross-model project management plan		1	\$ 10,000	\$ 10,000	\$ 10,000	\$ -
C.1.2	Identify milestones, due dates, measurable completion criteria, and schedule for ongoing updates.		1	\$ 7,000	\$ 7,000	\$ 7,000	\$ -
C.1.3	Establish measurable completion criteria and schedule for ongoing updates.		1	\$ 6,000	\$ 6,000	\$ 6,000	\$ -
C.1.4	Identify planned activities within each phase, milestones, due dates, and measurable completion criteria;		1	\$ 8,000	\$ 8,000	\$ 8,000	\$ -
C.1.5	Complete analyses and research findings in response to ad hoc requests in any given calendar month, as deemed necessary. Such activities may include, but not necessarily be limited to: • Project plan updates. • Management of process for 45-day and 14-day advance submission requirements for publications, formal presentations, slide decks, posters, videos, brochures, website copy/pages, press releases, media requests, filming, broadcasts, etc., • 1-year post-project review period for certain materials. • Prepare materials and participate in hospital and primary care payment model forums. • Prepare materials and participate in GO-NORTH evaluation / implementation science activities. • Cooperate in evaluation, learning, performance monitoring, and CMS reporting support activities for each forum and activity.		20	\$ 17,000	\$ 340,000	\$ 136,000	\$ 204,000
C.1.6	Prepare contract end-of-life transition deliverables, including Data Transition Plan, transition support, tools inventory/inventory document, and data destruction completion. Contract End-of-Life Transition Services: begin DTP 90 days prior to contract end if applicable; assist secure transfer of records/data; inventory and return tools with inventory document; provide internal transition planning; destroy data within 30 days after migration is complete, subject to requirements.		1	\$ 30,000	\$ 30,000	\$ -	\$ 30,000
C.2	Quarterly progress reports.	Summarizes 3.1.1–3.1.15, 3.2.1–3.2.15, 3.3.1–3.3.10, and 3.4.1–3.4.12.				\$ -	\$ -
C.2.1	Establish quarterly performance metrics		1	\$ 10,000	\$ 10,000	\$ 10,000	\$ -
C.2.2	Create a standard format for a quarterly progress report in a format acceptable to GO-NORTH		1	\$ 5,000	\$ 5,000	\$ 5,000	\$ -
C.3	Annual progress reports.	Summarizes 3.1.1–3.1.15, 3.2.1–3.2.15, 3.3.1–3.3.10, and 3.4.1–3.4.12.					
C.3.1	Establish annual performance metrics		1	\$ 10,000	\$ 10,000	\$ 10,000	\$ -
C.3.2	Create a standard format for a annual progress report in a format acceptable to GO-NORTH		1	\$ 5,000	\$ 5,000	\$ 5,000	\$ -
C.4	Final report	Summarizes 3.1.1–3.1.15, 3.2.1–3.2.15, 3.3.1–3.3.10, and 3.4.1–3.4.12.					
C.4.1	Prepare draft of final report, including copy of each publication requiring prior review and comment.		1	\$ 25,000	\$ 25,000	\$ -	\$ 25,000
C.4.2	Deliver final report by May 31, 2028; one copy of each publication requiring prior review/comment must accompany final progress report.		1	\$ 10,000	\$ 10,000	\$ -	\$ 10,000
Subtotal for A					\$ 1,438,000	\$ 671,000	\$ 767,000
Subtotal for B (excl. B.9)					\$ 1,896,000	\$ 565,000	\$ 1,331,000
Subtotal for C					\$ 466,000	\$ 197,000	\$ 269,000
Combined for SFYs 2027 & 2028					\$ 3,800,000	\$ 1,433,000	\$ 2,367,000

State of New Hampshire

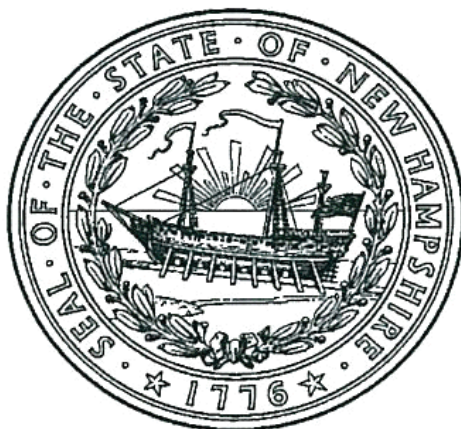
Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that MILLIMAN, INC. is a Washington Profit Corporation registered to transact business in New Hampshire on September 15, 1988. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **134216**

Certificate Number: **0007921297**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 1st day of May A.D. 2026.

A handwritten signature in black ink, appearing to read "David M. Scanlan", is written over a faint circular outline.

David M. Scanlan
Secretary of State



Certification of Corporate Secretary

I, Mary C. Clare, hereby certify that I am the duly qualified and acting Corporate Secretary of Milliman, Inc. and I hereby affirm that:

1. On December 3, 2002, the following resolution was duly adopted by the Board of Directors of the corporation, and it has not been amended or repealed and remains in full force and effect.

BE IT HEREBY RESOLVED, that each Principal of the firm and any consultant meeting requirements established by the Board of Directors are hereby granted the authority to individually negotiate and enter into proposals, engagement letters, contracts, letters of intent, and other documents on behalf of the corporation for the purpose of providing consulting, actuarial, and other professional services.

2. Gregory J. Herrle

☒ is a duly elected and acting Principal of the firm.

☐ is a consultant of the firm who meets the requirements established by the Board of Directors.

3. This authority was valid thirty (30) days prior to and remains valid for thirty (30) days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

DATED this 30th day of September 2026.



A handwritten signature in black ink, appearing to read 'Mary C. Clare', written over a horizontal line.

Mary C. Clare
Chief Legal Officer, Corporate Secretary,
Senior Vice President



CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
06/23/2026

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Northeast, Inc. New York NY Office One Liberty Plaza 165 Broadway, Suite 3201 New York NY 10006 USA	CONTACT NAME:	
	PHONE (A/C. No. Ext): (312) 381-1000	FAX (A/C. No.): (312) 381-7007
INSURED Milliman, Inc. 1301 Fifth Avenue Ste. 3800 Seattle WA 98101 USA	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	
	NAIC #	
	INSURER A: Great Northern Insurance Co.	
	INSURER B: ACE American Insurance Company	
	INSURER C:	
	INSURER D:	
INSURER E:		
INSURER F:		

Holder Identifier :

COVERAGES**CERTIFICATE NUMBER:** 570121077007**REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	☒ COMMERCIAL GENERAL LIABILITY			30040837 General Liability	06/30/2026	06/30/2027	EACH OCCURRENCE
	☐ CLAIMS-MADE ☒ OCCUR		\$1,000,000				
	GEN'L AGGREGATE LIMIT APPLIES PER:		DAMAGE TO RENTED PREMISES (Ea occurrence)				
	☐ POLICY ☒ PRO-JECT ☒ LOC		\$1,000,000				
	OTHER:						MED EXP (Any one person)
							\$15,000
							PERSONAL & ADV INJURY
							\$1,000,000
							GENERAL AGGREGATE
							\$2,000,000
							PRODUCTS - COMP/OP AGG
							Included
A	AUTOMOBILE LIABILITY			7363-49-03 Auto Liability	06/30/2026	06/30/2027	COMBINED SINGLE LIMIT (Ea accident)
	☒ ANY AUTO		\$1,000,000				
	☐ OWNED AUTOS ONLY	☐ SCHEDULED AUTOS					
	☐ HIRED AUTOS ONLY	☐ NON-OWNED AUTOS ONLY					
	☒ Deductible \$1,000						BODILY INJURY (Per person)
							BODILY INJURY (Per accident)
							PROPERTY DAMAGE (Per accident)
	UMBRELLA LIAB						EACH OCCURRENCE
	EXCESS LIAB		AGGREGATE				
	☐ DED ☐ RETENTION						
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			2771839056 Workers Compensation	06/30/2026	06/30/2027	☒ PER STATUTE ☐ OTHER
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	☐ Y ☒ N	N/A				E.L. EACH ACCIDENT
	If yes, describe under DESCRIPTION OF OPERATIONS below						\$1,000,000
							E.L. DISEASE-EA EMPLOYEE
							\$1,000,000
							E.L. DISEASE-POLICY LIMIT
							\$1,000,000

Certificate No : 570121077007

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER**CANCELLATION**

State of NH Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857 USA	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE <i>Aon Risk Services Northeast, Inc.</i>