



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

**REQUEST FOR PROPOSALS (RFP) # 12-DHHS-CM-01**

**FOR**

**MEDICAID CARE MANAGEMENT SERVICES**

**October 17, 2011**



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# 1. INTRODUCTION

## 1.1. Purpose and Overview

The New Hampshire Medicaid Program is a complex network that provided health care coverage for all or part of more than 166,400<sup>1</sup> people at some point during State Fiscal Year (SFY) 2011 (July 1, 2010 –June 30, 2011). Those covered included low-income children, pregnant women, parents with children, the elderly, and people with disabilities. In an average month during the year, 132,900 people were covered. In addition, to Medicaid, the New Hampshire Department of Health and Human Services also administers a separate Child Health Insurance Program (CHIP) that is in the process of being converted to a Medicaid expansion program. On average 8,500 children were covered by CHIP in SFY 2011.

The Medicaid Program has had a significant impact on the provision of health care coverage to vulnerable populations, particularly low-income children. Approximately 20% of all New Hampshire's children are covered by Medicaid. New Hampshire state government spent a total of \$5.39 Billion in SFY 2011 (state, federal, and other funds combined). Of this amount, \$1.43 Billion, or 26.5% of all state expenditures were accounted for by Medicaid (second only to education at 27.6% of state spending).

The New Hampshire Department of Health and Human Services (DHHS) administers the broad array of Medicaid programs. Fifteen different units within DHHS are involved in this effort. New Hampshire Medicaid spends an average of \$640 per month for each member, with average monthly costs ranging from \$239 for each low-income child (age less than 19) covered up to \$2,771 for beneficiaries covered under Medicaid waiver programs and \$3,406 for long term care for the elderly.

In response to the impact of growing Medicaid expenditures on New Hampshire's State budget, the State Legislature passed SB 147 (Chapter 125, Laws of New Hampshire 2011), that directed DHHS to develop a comprehensive statewide care management program for all Medicaid enrollees which would focus on improving the value, quality, and efficiency of services provided in the Medicaid Program, stimulate innovation, and generate savings for the Medicaid Program. SB 147 called for DHHS to select fully at risk Bidders to provide managed care services and set the target date of July 1, 2012 for the launch of the new Care Management Program.

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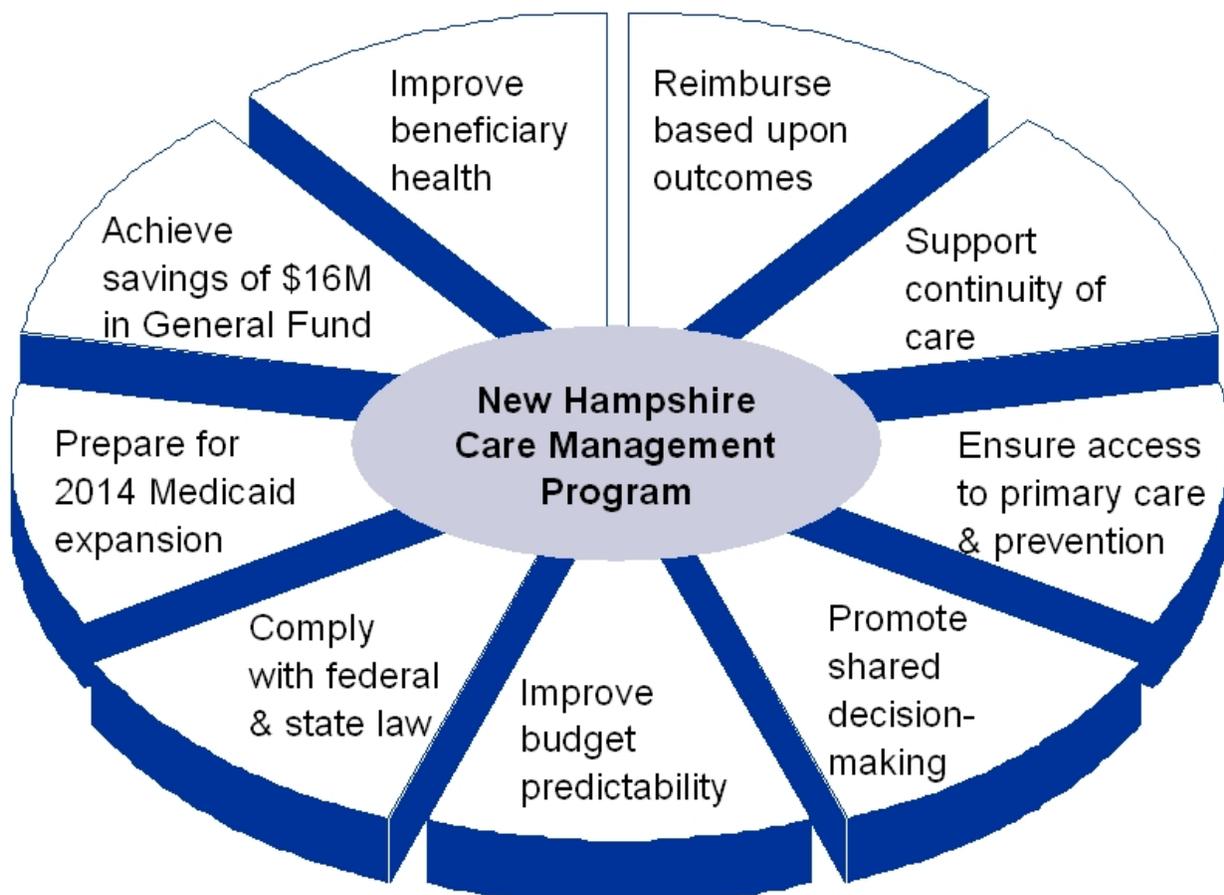
<sup>1</sup> 166,400+ is the unduplicated count of Medicaid members, inclusive of retroactively eligible individuals, individuals with spend down, and others who fall outside of the scope of this RFP. More precise membership statistics are expected to be available with the RFP Data Book.



## New Hampshire Medicaid Care Management Program

In response to SB 147, DHHS, with significant stakeholder involvement, has developed a Care Management Program based on the principles described in the graphic below. Responders to this RFP are expected to demonstrate their understanding of these goals and how their proposal will support them. In addition, responses to the RFP will be evaluated based on:

- 1) The Managed Care Organization's (MCO's) experience and expertise in managing populations with complex physical, behavioral, and social needs.
- 2) The MCO's approach to innovative programs and methods that support transformational change in the health care system.
- 3) The MCO's understanding of the uniqueness of the New Hampshire health care delivery system and New Hampshire's unique geography and culture.
- 4) The MCO's experience and expertise in generating cost savings for state Medicaid programs and the likelihood that the MCO will meet the cost savings goals of the program.
- 5) The MCO's experience and expertise in improving health outcomes in state Medicaid programs and the likelihood that the MCO will achieve similar results in New Hampshire.





## New Hampshire Medicaid Care Management Program

### 1.2. Request For Proposal Terminology

For the purpose of this RFP, the following terms may be used interchangeably:

- Vendor, Contractor, Bidder, Responder, MCO
- Medicaid recipient, beneficiary, member, client, individual, patient, or enrollee
- RFP, Solicitation, or Procurement
- Bid, proposal, or offer
- State of New Hampshire, State, Department, OMBP or DHHS - OMBP
- State Fiscal Year is defined as the State of New Hampshire fiscal year for the period starting July 1 and ending June 30
- Biennium is defined as the two year period beginning July 1 of each odd numbered year through June 30 of the next odd numbered year

ACRONYM	DESCRIPTION
ACA	Affordable Care Act
ACD	Augmentative Communication Device
ADA	Americans with Disabilities Act
AFDC	Aid to Families with Dependent Children
ANB	Aid to the Needy Blind
ANSA	Adult Needs and Strengths
APPLA	Alternative Planned Permanent Living Arrangement
APRN	Advanced Practice Registered Nurse
APTD	Aid to the Permanently and Totally Disabled
ASC	Accredited Standards Committee
ASL	American Sign Language
BA	Business Associate
BAA	Business Associate Agreement
BBH	Bureau of Behavioral Health
BDS	Bureau of Developmental Services
BEAS	Bureau of Elderly and Adult Services
CAD	Coronary Artery Disease
CAHPS	Consumer Assessment of Health Plan Survey
CANS	Child and Adolescent Needs and Strengths Assessment
CDC	Center for Disease Control and Prevention
CFI	Choices for Independence
CFR	Code of Federal Regulations
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CLAS	Cultural and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CQI	Continuous Quality Improvement
CSHCN	Children with Special Health Care Needs



## New Hampshire Medicaid Care Management Program

ACRONYM	DESCRIPTION
DCYF	Division of Children, Youth & Families
DHHS	Department of Health and Human Services (New Hampshire)
DOB	Date of Birth
DME	Direct Medical Education
DME	Durable Medical Equipment
DOB	Date of Birth
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospitals
DUR	Drug Use Review
ED	Emergency Department
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ESRI	Environmental Systems Research Institute
ET	Eastern Time
ETL	Extract Transformation Load
EQRO	External Quality Review
FFS	Fee-for-Service
FPL	Federal Poverty Levels
FQHC	Federally Qualified Health Center
GIS	Geographic Information System
GME	Graduate Medical Education
HCBS	Home and Community Based Services
HC-CSD	Home Care for Children with Severe Disabilities
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
ICF	Intermediate Care Facility
IMD	Institution for Mental Disease
IME	Indirect Medical Education
LTCH	Long Term Care Hospital
MCO	Managed Care Organization
MCIS	Managed Care Information System
MIC	Medicaid Integrity Contractor
MLDAC	M Licensed Drug and Alcohol Counselor
MEAD	Medicaid for Employed Adults with Disabilities
MMIS	Medicaid Management Information System
MR	Mental Retardation
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NHHK	New Hampshire Healthy Kids
NPI	National Provider Identifier
OAA	Old Age Assistance



## New Hampshire Medicaid Care Management Program

ACRONYM	DESCRIPTION
OBRA	Omnibus Budget Reconciliation Act
OMBP	Office of Medicaid Business & Policy
OOS	Out of State
OT	Occupational Therapy
PA	Prior Authorization
PBM	Pharmacy Benefit Management
PCP	Primary Care Physician
PDL	Preferred Drug List
PE	Presumptive Eligibility
PERM	Payment Error Rate Measurement
PIN	Personal Identification Number
POA	Present on Admission
PPACA	Patient Protection and Affordable Care Act
PT	Physical Therapy
QAPI	Quality Assessment and Performance Improvement
QIO	Quality Improvement Organization
QIP	Quality Incentive Program
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
QMP	Quality Management Program
RAC	Recovery Audit Contractors
RBC	Risk-Based Capital
RFP	Request for Proposal
RHC	Rural Health Center
RSA	Revised Statutes Annotated
SAMHSA	Substance Abuse and Mental Health Services Administration
SAU	School Administrative Unit
SB	Senate Bill
SBIRT	Screening, Brief Intervention and Referral to Treatment
SFY	State Fiscal Year
SLMB	Special Low-Income Medicare Beneficiaries
SNF	Skilled Nursing Facility
SSAE	Statement on Standards for Attestation Engagements
ST	Speech Therapy
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
TQM	Total Quality Management
USC	United States Code
VT	Vermont
VA	Veteran's Administration



## New Hampshire Medicaid Care Management Program

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### 1.3. **Contract Period**

The contract resulting from this RFP shall be effective upon approval of Governor & Executive Council and Centers for Medicare and Medicaid Services (CMS). It is the department's intent to award contracts effective July 1, 2012. The initial term of the contract will be 24 months.

The Department may offer contract extension(s) for three additional periods of one year each, for a total contract term of five years. The capitation rates for each year following the first year will be set by the department. As with all State contracts, the duration of the contract is subject to availability of funds. The Department may renegotiate the terms and conditions of the contract in the event applicable local, state, or federal law, regulations, or policy are altered from those existing at the time of the contract in order to be in continuous compliance therewith.



# New Hampshire Medicaid Care Management Program

## 2. BACKGROUND AND REQUIRED SERVICES

### 2.1. New Hampshire DHHS Medicaid Managed Care Program

#### 2.1.1. New Hampshire Medicaid Covered Services

Medicaid may be viewed as four different coverage plans combined into one program. It provides:

- Comprehensive and preventive child health coverage for low-income children up to the age of 21, following federal requirements of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program;
- Acute care coverage for some parents of covered children;
- A complex range of acute and long-term care services for the frail elderly, people with physical and developmental disabilities, and those with mental illness; and
- “Wraparound” coverage that supplements and fills gaps in the Medicare benefit for low-income elders and disabled who are eligible for both Medicaid and Medicare, referred to as the “dually eligible” or “duals”.

The services used and the costs per person vary considerably across these populations. The specific medical services covered by the New Hampshire Medicaid program are included in Table 1 below and are grouped into federally mandated services, state mandated services, and optional services.

Table 1: New Hampshire Medicaid Covered Services

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
<b>Mandatory Services</b>				
Intermediate Care Facility Nursing Home	Federal Mandate (440.60)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Skilled Nursing Facility Nursing Home	Federal Mandate (440.40)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Skilled Nursing Facility Nursing Home Atypical Care	Federal Mandate (440.40)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Intermediate Care Facility Nursing Home Atypical Care	Federal Mandate (440.40)	He-E 802, He-E 806 & He-E 807	Clinical eligibility must be established by BEAS prior to placement.	
Inpatient Hospital Swing Beds, Skilled Nursing Facility	Federal Mandate (440.40)	He-E 802 & He-E 806	Clinical eligibility must be established by BEAS prior to placement.	



## New Hampshire Medicaid Care Management Program

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
Inpatient Hospital Swing Beds, Intermediate Care Facility	Federal Mandate (440.40)	He-E 802 & He-E 806	Clinical eligibility must be established by BEAS prior to placement.	
Outpatient Hospital, General	Federal Mandate (440.20)	He-W 543	Currently 12 visits per SFY ; Transitioning to 4 ED and 8 urgent care visits per SFY.	
Inpatient Hospital, General	Federal Mandate (440.10)	He-W 543	Limited to QIO approved; OOS; inpatient requires PA unless an emergency. Includes LTCH care with PA as of 10/08.	
Physicians Services	Federal Mandate (440.50)	He-W 531	PA not required by rule; some services require PA (transplants, bariatric surgery, potentially cosmetic procedures).	
Rural Health Clinic	Federal Mandate (440.20)	He-W 537		Includes Federally Qualified Health Centers.
Home Health Services	Federal Mandate (440.70)	He-W 553	Selective contracting for incontinence supplies.	DME and Supplies are considered part of home health and are therefore federally mandated.
Dental Service	Federal Mandate (440.50)	He-W 566	No "service limit," but there are other timing/limit criteria in the rule; ortho requires PA-see rule for any other PA's or limits.	Dental in schools falls under dental for state plan
Laboratory (Pathology)	Federal Mandate (440.30)	He-W 577		
Advanced Practice Registered Nurse	Federal Mandate (440.165, 166)	He-W 534	Mental Health APRN visits count toward psychotherapy service limits.	
X-Ray Services	Federal Mandate (440.30)	He-W 569	15 (radiation therapy not counted); PA for certain types of high-tech diagnostic imaging.	
Family Planning Services	Federal Mandate (440.40)	He-W 541		
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services for Persons <Age 21	Federal Mandate (440.40)	He-W 546		All "coverable services" must be covered by Medicaid if medically necessary; these are subject to prior authorization.
<b>Optional Services</b>				
Prescribed Drugs	(440.120)	He-W 570	PBM; PA's, PDL, dose consolidation, maintenance programs, lock in, quantity limits, refill edits, mandatory generic prescribing, new drugs to market restrictions	
Optometric Services Eyeglasses	(440.120)	He-W 565	No "service limit," but 1 exam/12 mo, glasses only if 1/2 Diopter change.	



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Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
Mental Health Center	42 CFR	He-M 401, He-M 426, RSA 135-C	See Service Grid Table 2 for service limits.  In addition, individuals who are determined not eligible for community mental health services are limited to \$1,800 a year in services.  Individuals determined eligible for community mental health services but in the Low Utilizer category have a \$4,000 a year service limitation.	Community Mental Health Services as described in He-M 426 can only be provided by designated community mental health programs.
Ambulance Service	(440.170)	He-W 572		Might be considered mandatory due to requirement to provide transportation to medically necessary services.
Adult Medical Day Care	(440.130)	He-E 803	N/a	
Furnished Medical Supplies & Durable Medical Equipment	(440.120 prosthetics; 440.70 home health)	He-W 571	PA is required for some DME and also for some supplies, i.e., incontinence products. All ACD require PA.	Feds consider this mandatory falling under the home health benefit.
Physical Therapy	(440.110)	He-W 568	80 15-min unit combo of PT/ST/OT.	
Occupational Therapy	(440.110)	He-W 568	80 15-min unit combo of PT/ST/OT.	
Speech Therapy	(440.110)	He-W 568	80 15-min unit combo of PT/ST/OT.	
Private Duty Nursing	(440.80)	He-W 540	PA required.	
Medicaid in the Schools	(440.130)	RSA 186-C:27; I-II He-M 1301	Participation in the medical assistance program is discretionary on the part of school districts and school administrative units.  Medicaid match is paid by the SAUs and not BDS/DHHS.	
Day Habilitation Center	He-W 510			This is Early Supports and Services previously known as Early Intervention
Medical Services Clinic	(440.90)	He-W 536	Subject to the service limits of the provider type doing the service.	Falls under clinic in the state plan, but is not really a clinic as envisioned under federal regulations. Methadone maintenance services fall under medical services clinics.
Psychotherapy	(440.60)	He-W 535	Psychotherapy limits effective 10/14/11 18 visits (adults) ,24 visits (children). Per SFY	
Personal Care Services	(440.167)	RSA 161-E:2 He-W 552		
Wheelchair Van	(440.170)	He-W 573	24 trips/year whether 1 way or round trip, thereafter trips are PA	Might be considered mandatory due to requirement to provide transportation to medically necessary services.



## New Hampshire Medicaid Care Management Program

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
Podiatrist Services	(440.60)	He-W 532	4 visits/sfy	
Nursing Facility Services for Children with Severe Disabilities			Cedarcrest – prior approval is required for all admissions	
Inpatient Psychiatric Facility Services Under Age 22	(440.160)		In-state psych is not PA'd OOS psych is PA'd.	
Audiology Services	(440.110 and 120)	He-W 567		
Outpatient Hospital, Mental			Outpatient services from a mental hospital would require a PA	This service has been billed by one VT provider only
Acquired Brain Disorder Home and Community Based Services (HCBS) Waiver		RSA 137-K:3 He-M 522 He-M 517 He-M 506 He-M 507 He-M 513 He-M 518 He-M 519 He-M 521 He-M 525 He-M 1001 He-M 1201	All services are Prior Authorized by BDS. Clinical eligibility must be determined prior to authorization of services	
Developmentally Disabled HCBS Waiver		RSA 171-A:3; 18, IV He-M 503 He-M 517 He-M 506 He-M 507 He-M 510 He-M 513 He-M 518 He-M 519 He-M 521 He-M 525 He-M 1001 He-M 1201	All services are Prior Authorized by BDS. Clinical eligibility must be determined prior to authorization of services	
Choices for Independence HCBS Waiver		RSA 151-E He-E 801	Clinical eligibility must be established by BEAS prior to initiation of services.	



## New Hampshire Medicaid Care Management Program

Service Category	Authority and CFR	Rule/RSA	Current Utilization Management Strategies	Notes on Included Services
In Home Supports HCBS Waiver		RSA 161-1:7; 171-A:3; 18, IV He-M 524 He-M 503 He-M 510	All services are Prior Authorized by BDS.  Clinical eligibility must be determined prior to authorization of services.  There is a cap of \$30K per year per person for services authorized	
Inpatient hospital, NF, ICF over age 65 in IMD's (440.140)	(440.140)			
Prenatal child/family health care support	(440.130)	He-W 549	Effective. Jan 2012, limits are 12 units for child health support and 16 units for CSHCN nutrition; Units are per 15 minutes	
Early Intervention	20 U.S.C. 1400 et seq.) (440.130)	RSA 171-A:18  He-M 510		
Newborn Home Visit	(440.130)	RSA 167:66-68 He-W 547		
Extended Services for Pregnant Women	(440.220)	He-W 548		
Targeted Case Management (1915g(1) & (g)(2))		HE-E 805	Through He-E 805, this service is limited to individuals eligible for CFI services, under He-E 801.	
Hospice 1905(o)		RSA 126-A:4-e He-W 544		Oversight follows the federal Medicare program.
Private Non-Medical Institution For Children	(440.130)	He-C 6350 and He-C 6420	Prior authorization required.	DCYF Service
Crisis Intervention	(440.130)	He-C 6350 and He-C 6420	Prior authorization required and entered by State Office staff only.	DCYF Service Not Currently in Use.
Intensive Home and Community Services	(440.130)	He-C 6339	Prior authorization required.	DCYF Service
Placement Services	(440.130)	He-C 6355 and He-C 6420	Prior authorization required.	DCYF Service
Home Based Therapy	(440.130)	He-C 6339	Prior authorization required.	DCYF Service
Child Health Support Service	(440.130)	He-C 6339	Prior authorization required.	DCYF Service

\*All services are subject to service limit overrides based on medical need via prior authorization process.



## New Hampshire Medicaid Care Management Program

### 2.1.2. New Hampshire Medicaid Coverage and Service Limits

Medicaid coverage depends on:

- The categories of services that are covered under the State plan;
- The applicable amount, duration, and scope of limitations on otherwise covered benefits (such as visit limits and day limits); and
- The standard of medical necessity that is used to determine whether otherwise covered services are medically appropriate for a particular individual in any specific case.

New Hampshire Medicaid has established service limits on a number of covered services including physician, laboratory, X-ray, and outpatient hospital services. Specific limits on service use are defined in Table 2 below.

<b>Table 2: New Hampshire Limits on Covered Services</b>
Inpatient Hospital Services ( <i>must be medically necessary</i> )
Emergency Room Services ( <i>4 visits per year</i> ) Will be effective by 7/1/12
Diagnostic X-ray ( <i>15 per year</i> )
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for individuals under 21 ( <i>must be medically necessary</i> )
Dental Services ( <i>for persons age 21 and over, limited to treatment of acute pain or infection</i> )
Prescription Drugs ( <i>Pharmacy Benefit Management Limits</i> )
Psychotherapy ( <i>24 visits per year for children less than 21 years, 18 visits per year adults</i> )
Podiatrist Services ( <i>4 visits per year</i> )
Durable Medical Equipment ( <i>some prior authorization required</i> )
Medical supplies ( <i>prior authorization required</i> )
Physical, occupational, speech therapy ( <i>80 15-minute units per year</i> )
Eyeglasses ( <i>examine every year to determine need for glasses, 1 repair per year, replacement with ½ diopter change</i> )

1. This list is not exhaustive. For example, Community Mental Health services are limited to \$1,800 per fiscal year for individuals who do not meet Bureau of Behavioral Health (BBH) eligibility requirements and to \$4,000 per fiscal year for individuals who meet BBH low utilizer eligibility criteria. Chiropractic services are not covered.

### 2.1.3. Eligibility for the Medicaid Program

Medicaid serves five main groups of low-income individuals: children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly. There are two parts to Medicaid eligibility:

#### *Categorical Eligibility*

Federal law establishes many eligibility “categories,” and an individual will be determined eligible only if the detailed criteria are met for one of those categories. States are required to include certain “mandatory” eligibility groups; for example, all states must cover children and pregnant women with family incomes up to specified



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levels. Other eligibility pathways are optional and available only in those states that choose to cover them. Table 3 below describes the eligibility groups covered by New Hampshire Medicaid.

<b>Table 3: NH Medicaid Eligibility Categories</b>
<i>Mandatory Eligibility Groups (all State Medicaid programs must cover)</i> <sup>2</sup>
<ul style="list-style-type: none"> <li>• Low-income Medicare beneficiaries</li> </ul>
<ul style="list-style-type: none"> <li>• Individuals who would qualify for Temporary Assistance to Needy Families (TANF) today under the state’s 1996 AFDC eligibility requirements<sup>3</sup></li> </ul>
<ul style="list-style-type: none"> <li>• Children under age six and pregnant women with family income at or below 133% of federal poverty level (FPL) guidelines</li> </ul>
<ul style="list-style-type: none"> <li>• Children born after September 30, 1983, who are at least age five and live in families with income up to the FPL</li> </ul>
<ul style="list-style-type: none"> <li>• Infants born to Medicaid-enrolled pregnant women</li> </ul>
<ul style="list-style-type: none"> <li>• Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program</li> </ul>
<ul style="list-style-type: none"> <li>• Low-income aged, blind, and disabled receiving state supplemental assistance</li> </ul>
<i>Optional Eligibility Groups (NH Medicaid has chosen to cover)</i> <sup>4</sup>
<ul style="list-style-type: none"> <li>• Children and pregnant women up to 185% of the FPL</li> </ul>
<ul style="list-style-type: none"> <li>• Individuals determined to be “medically needy” due to large medical expenses<sup>5</sup></li> </ul>
<ul style="list-style-type: none"> <li>• Home Care for Children with Severe Disabilities (HC-CSD), commonly known as “Katie Beckett”; for severely disabled children up to age 19 whose medical disability qualifies them for institutional care but are cared for at home</li> </ul>
<ul style="list-style-type: none"> <li>• Medicaid for Employed Adults with Disabilities (MEAD) allows Medicaid-eligible disabled individuals between the ages of 18 and 64 who want to save money or work to increase their earnings while maintaining Medicaid coverage (up to 450% FPL)</li> </ul>

2 In 1974, New Hampshire, like over thirty other states at the time, elected for the “209(b)” status provided in the federal law that created the Supplemental Security Income (SSI) program (the federal income assistance program for disabled, blind, or aged individuals). When creating the SSI program, Congress hoped that SSI beneficiaries would also receive Medicaid. However, Congress was mindful of the increased expense for states to automatically cover all SSI beneficiaries. To provide states some financial flexibility, the 209(b) option was crafted which allowed a state to be more restrictive in its Medicaid eligibility than the SSI program eligibility guidelines, so long as those methodologies were no more restrictive than methodologies in place on January 1, 1972. Accordingly, New Hampshire does not automatically grant Medicaid to SSI beneficiaries. SSI beneficiaries who desire Medicaid must qualify for a state defined category of assistance.

3 In 1996, federal policymakers severed the tie between medical and cash assistance when the AFDC program was replaced. The AFDC standard was retained in Title XIX to prevent the states from using the more restrictive eligibility requirements and time limits of AFDC’s successor—Temporary Assistance for Needy Families or TANF—when providing Medicaid coverage to needy children and families.

4 The ACA extended ARRA eligibility maintenance of effort (MOE) requirements for adults until 2014 and for children until 2019.

5 While Medically Needy is an optional category, as a 209(b) State, if New Hampshire does not elect to provide medically needy coverage, we must allow adult category individuals whose income exceeds the categorically needy income limit to spend down to the categorically needy income limit. Additionally, once a State opts to provide medically needy coverage, there are certain groups that must be covered as medically needy (e.g., pregnant women).



## New Hampshire Medicaid Care Management Program

### Financial Eligibility

Medicaid is a means-tested program. To qualify for Medicaid, a person must have a low-income typically expressed as a percentage of the Federal Poverty Level (FPL). CMS sets a minimum financial requirement; however, states have some flexibility in extending eligibility beyond the minimum for each categorical group. In New Hampshire Medicaid, income levels vary from 450% of FPL for Medicaid for Employed Adults with Disabilities (MEAD) to 40% FPL for parents as shown below in Figure 1.

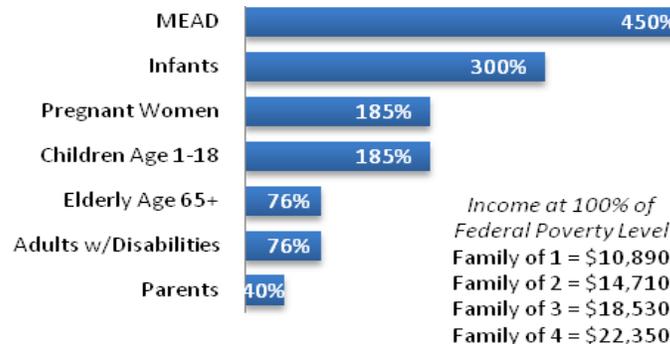


Figure 1: New Hampshire Medicaid Eligibility by Percent of Poverty Level

### Children’s Health Insurance Program Transition to Medicaid

Chapter Law 224:43, Laws of 2011 (HB 2), requires the Department to submit a Title XXI state plan amendment, subject to approval by the Fiscal Committee of the General Court and the Oversight Committee of Health and Human Services, to administer the Children’s Health Insurance Program (CHIP) with the Department commencing upon implementation of Medicaid Managed Care.

The New Hampshire Healthy Kids (NHHK) Corporation continues to administer the program and is expected to do so until the Managed Care Program is implemented. NHHK directly administers the premium-based CHIP program through insurance subcontractors. New Hampshire CHIP serves children ages 1 – 19 from 186% to 300% of FPL.

## 2.2. General and Audit Requirements

MCOs are responsible for providing a risk based, capitated program for providing health care services to members enrolled in the New Hampshire Medicaid Program and for all aspects of managing such program, including claims processing and operational reports. MCOs are responsible for establishing and demonstrating audit trails for all claims processing and financial reporting carried out by the MCO’s staff, system, or designated agents.



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Within 4 months following the end of the MCO's fiscal year, the MCO shall provide the Department a copy of its audited financial statements. Financial statements may be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

No later than forty (40) working days after the end of the State Fiscal Year on June 30, the MCO shall provide the Department of Health and Human Services a "SOC 1" Type 2 report in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report will assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period. The Department will share the report with internal and external auditors of the State of New Hampshire and federal oversight agencies.

The SSAE 16 type 2 report shall include:

1. Description by the service organization's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the specified period of time;
2. Written assertion by the service organization's management about whether:
  - A. the aforementioned description fairly presents the system in all material respects,
  - B. the controls were suitably designed to achieve the control objectives stated in that description, and
  - C. the controls operated effectively throughout the specified period to achieve those control objectives; and
3. Report of the service organization's auditor, which:
  - A. Expresses an opinion on the matters covered in management's written assertion, and
  - B. Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

The State shall make available to the service auditor, upon request, data and information pertaining to services being contracted and/or controls that are necessary for the completion of the Service Auditor's Report.

The price of the SSAE attestation during the term of the Contract shall be identified as a separate line item in the Cost Proposal.

MCO's are responsible for responding to and providing resolution of auditor inquiries and findings relative to the MCO Managed Care activities.



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### 2.3. **Health Insurance Portability & Accountability Act of 1996 Compliance**

The State intends to protect the privacy and provide for the security of any protected health information disclosed to the Bidder in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”) and any other applicable laws or regulations. To the extent HIPAA applies, the Bidder shall, at no additional cost to the State, enter into contractual agreements with the State required to comply with HIPAA, as applicable and deemed necessary by the State, including but not limited to a Business Associate (BA) Agreement (see Appendix C: Contract Minimum Requirements, which includes the HIPAA Standards for Privacy-Business Associate Agreement). If the parties are not able to reach agreement on the BA Agreement, the State may reject the Bidder at the State’s sole discretion, and proceed with Bidder selection.

### 2.4. **Managed Care Information System**

#### 2.4.1. **System Functionality**

The MCO Managed Care Information System (MCIS) shall include, but not be limited to:

- Management of Recipient Demographic Eligibility and Enrollment and History
- Management of Provider Enrollment and Credentialing
- Benefit Plan Coverage Management, History and Reporting
- Eligibility Verification
- Encounter data
- Weekly Reference File Updates
- Service Authorization Tracking, Support and Management
- Third Party Coverage and Cost Avoidance Management
- Financial Transactions Management and Reporting
- Payment Management (Checks, EFT, Remittance Advices, Banking)
- Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)
- Call Center Management

#### 2.4.2. **Data Transfer**

Effective communication between the MCO and DHHS will require seamless transfer of data to/from the MCO and DHHS management information systems. This shall include, but not be limited to:

- DHHS access to all data, which includes all tools required to access the data at no additional cost to the State.
- Exchanges of data between the MCO and the State in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target.



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- Effective communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to identify and resolve issues according to the timelines set forth by the state.
- State on-line secure access to all components prescribed by the State that comprise and support the MCO's system for New Hampshire.
- Collaborative relationships among the Department, its MMIS fiscal agent, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this RFP.
- MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure the effective transfer of data
- Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the extract, transformation and load processes, and that provide for source to target or source to specification mappings.
- Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts.

### 2.4.3. **Ownership and Access to Systems and Data**

Source code developed for the New Hampshire Medicaid program shall remain the property of the State.

All data accumulated as part of this program shall remain the property of the State and upon termination of the contract the data will be electronically transmitted to the State in the media format and schedule prescribed by the State.

Bidders shall provide a description, as to how the proposed system solution meets or exceeds the technical and system processing requirements and capabilities as summarized above.

Bidders must provide a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between the State and MCO, including any MCO/subcontractor locations supporting the New Hampshire project.

### 2.4.4. **Requirements**

The MCO must have a comprehensive, automated and integrated managed care information system (MCIS) that is capable of meeting the requirements listed below and throughout this Agreement and for providing all of the data and information necessary for the Department to meet federal Medicaid reporting and information regulations. The MCIS used for New Hampshire shall include, but not be limited to:

- Management of Recipient Demographic Eligibility and Enrollment and History
- Management of Provider Enrollment and Credentialing
- Benefit Plan Coverage Management, History, and Reporting



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- Eligibility Verification
- Encounter Data
- Weekly Reference File Updates
- Service Authorization Tracking, Support and Management
- Third Party Coverage and Cost Avoidance Management
- Financial Transactions Management and Reporting
- Payment Management (Checks, Electronic Funds Transfer (EFT), Remittance Advices, Banking)
- Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand)
- Call Center Management

Subcontractors must meet the same MCIS requirements as the MCO. The MCO will be held responsible for errors or noncompliance resulting from the action of a subcontractor.

### **2.4.4.1. Functionality**

Specific functionality related to the above includes, but is not limited to, the following:

- The MCIS membership management system must have the capability to receive, update, and maintain the New Hampshire's membership files consistent with information provided by the Department.
- The MCIS must have the capability to provide daily updates of membership information to subcontractors or Providers with responsibility for processing Claims or authorizing services based on membership information.
- The MCIS's Provider file must be maintained with detailed information on each Provider sufficient to support Provider enrollment and payment and also meet the Department's reporting and Encounter Data requirements.
- The MCIS's Claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements of a federal MMIS system.
- The MCIS's Services Authorization system must be integrated with the Claims processing component.
- The MCIS must be able to maintain its Claims history with sufficient detail to meet all Department reporting and Encounter requirements.
- The MCIS's credentialing system must have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements, Quality Management and Utilization Management Program Requirements.
- The MCIS must be bi-directionally linked to the other operational systems maintained by the State, in order to ensure that data captured in Encounter records accurately matches data in Member, Provider, Claims and Authorization files, and in order to enable Encounter Data to be utilized for Member profiling, Provider profiling, Claims validation, Fraud and Abuse monitoring activities, and any other research and reporting purposes defined by the Department.



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- The Encounter Data system must have a mechanism in place to receive, process and store the required data
- The MCO system must be compliant with the requirements of HIPAA, including privacy, security, National Provider Identifier (NPI), and transaction processing, including being able to process electronic data interchange transactions in the Accredited Standards Committee (ASC) 5010 format.

### **2.4.4.2. MCIS Capability, Performance and Support**

MCIS capability will include, but not be limited to the following:

- 24x7x365, except for scheduled maintenance
- Provider Network Connectivity
- Documented scheduled down time and maintenance windows as agreed upon with the State
- DHHS on-line access to all components comprising and supporting the system
- DHHS access to user acceptance test environment
- Documented instructions and user manuals for each component
- Secure Access

Systems operations and support will include, but not be limited to the following:

- 24x7x365 operating support, except for scheduled maintenance
- On-Call procedures and contacts
- Job Scheduling and failure notification documentation
- Secure data transmission methodology
- Interface acknowledgements and error reporting
- Technical Issue Escalation Procedures
- Business and Customer Notification
- Change Control Management
- Assistance with User Acceptance testing and implementation coordination
- Documented data interface specifications – data imported and extracts exported including database mapping specifications.
- Disaster Recovery and Business Continuity Plan

MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and will provide:

- Network diagram
- State/MCO connectivity
- Any MCO/subcontractor locations requiring MCIS access/support
- Web access for State staff, providers and recipients

### **2.4.4.3. Automated Data Files and Interfaces**

Data transmissions from the Department to the MCO will include, but not be limited to the following:



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- Provider Extract (Bi-weekly)
- Recipient Eligibility Extract (Daily)
- Recipient Refresh Data Extract (Monthly)
- Premium payment data

Data transmissions from the MCO to the Department shall include but not be limited to:

- Member Benefit Plan Enrollment Data (Daily)
- Beneficiary encounter Data including paid, denied, adjustment transactions by pay period (Weekly/Monthly)
- Financial Transaction data
- Third Party Coverage Data

### **2.4.4.4. Department Access and Availability**

The MCO is responsible for providing Department staff with access to timely and complete data:

- All exchanges of data between the MCO and the State shall be in a format, file record layout, and scheduled as prescribed by the State.
- The MCO shall provide the State with secure, on-line access to any and all components that comprise and support the New Hampshire system.
- The MCO shall work collaboratively with the Department, its MMIS fiscal agent, the New Hampshire Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this RFP.
- The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide the State with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between the State and MCO, including any MCO/subcontractor locations supporting the New Hampshire project.
- The MCO shall utilize data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling, that, to the maximum extent possible, automate the ETL processes, and that provide for source to target or source to specification mappings, all business rules and transformations where applied, summary and detailed counts, and any data that cannot be loaded.
- The MCO shall provide support to the Department and its fiscal agent to prove the validity, integrity and reconciliation of its data, including encounter data.
- The MCO shall be responsible for correcting data extract errors in a timeline set forth by the State.
- The MCO shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and State staff to project plans, documentation, issues tracking, deliverables, and other project related artifacts.
- Access will be secure and data will be encrypted while being transmitted and at rest for the MCIS in accordance with HIPPA regulations and any other applicable state and federal law.



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- Secure access will be managed via passwords/pins/and any operational methods used to gain access.

### **2.4.4.5. Web Access For Providers and Enrollees**

MCIS will include web access for use by and support to enrolled providers and member enrollees. The services shall be provided at no cost to the provider or member enrollees. All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO and should be incorporated into the bid price.

- The MCO will create secure web access for Medicaid providers and member enrollees and authorized State staff to access case-specific information.
- The MCO shall manage provider and enrollee access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist providers and enrollees with gaining access and utilizing the web portal.
- Providers will have the ability to electronically submit service authorization requests and access and utilize other utilization management tools.
- Providers and enrollees will have the ability to download and print any needed Medicaid MCO program forms and other information.
- Providers will have an option to e-prescribe as an option without electronic medical records or hand held devices.
- MCO will support provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es).
- Providers will have access to drug information.
- The website shall provide an e-mail link to the MCO to allow providers and enrollees or other interested parties to e-mail inquiries or comments. This website shall provide a link to the State's Medicaid website.
- The website shall be secure and HIPAA compliant in order to ensure the protection of protected health information and Medicaid recipient confidentiality. Access should be limited to verified users via passwords and any other available industry standards.
- The MCO will have this system available no later than July 1, 2012.
- Support Performance Standards will include:
  - Email inquiries – 1 business day response
  - New information posted within 1 business day of receipt
  - Monthly maintenance
  - Standard reports regarding portal usage such as hits per month by providers/members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports
  - Website User interfaces will be ADA compliant



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### 2.4.4.6. Security

The MCIS supports the delivery of critical medical services to enrollees and reimbursement to providers, and as such contingency plans must be developed and tested to ensure continuous operation of the MCIS.

- The MCO is responsible for hosting the MCIS at the MCO's data center, and providing for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to New Hampshire within 24 hours of incident onset.
- The MCO shall ensure that the hardware and software supporting the MCIS, and New Hampshire data, data processing, and data repositories are securely segregated from any other account or project, and are under configuration management and change management governed through and in support of the New Hampshire project.
- MCO will manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files. Archiving processes should not modify the data composition of the State's records, and archived data must be retrievable at the request of the State. Archiving shall be conducted at intervals agreed upon between the MCO and the State.
- The MCIS must be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between Providers, provider billing agents/clearing houses, or the Department and the MCO.
- At the beginning of each State Fiscal Year, the MCO must submit the following documents and corresponding checklists for the State's review and approval:
  - Disaster Recovery Plan;
  - Business Continuity Plan;
  - Security Plan
- The MCO must provide the following documents. If after the original documents are submitted, the MCO modifies any of them, the revised documents and corresponding checklists must be submitted to the State for review and approval:
  - Joint Interface Plan
  - Risk Management Plan
  - Systems Quality Assurance Plan
  - Confirmation of 5010 compliance and Companion Guides
  - Approach to implementation of ICD-10

### 2.4.4.7. Change Management

Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements will be part of the change management process:

- Complete system must have proper configuration management/change management in place (to be reviewed and approved by the State). The MCO system must be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.



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- Prior to any major modifications to the MCIS, including upgrades and/or new purchases, the MCO must inform the State in writing of the potential changes. A work plan detailing the recovery effort and use of parallel system testing must be included.
- The MCO must implement a formal change request and change management process with the Department to allow for the tracking of documented requests or requirements to modify benefit coverage, reports, or any other component of the system. This tracking system shall be accessible to the Department.
- A New Hampshire project centralized electronic repository will be provided that will allow full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and ANY project artifacts. All items will be turned over to the State upon request.
- MCO must provide appropriate testing environments to allow New Hampshire to discretely test all system and interfacing functionality in a safe and secure manner with no potential risk of data exposure.
- The MCO must make timely changes or defect fixes to data interfaces and execute testing with the State and other applicable entities to validate the integrity of the interface changes.

### **2.4.4.8. System Readiness and Subsequent Changes**

The Department, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MCIS requirements.

- The System Readiness Review may include a desk review and/or an onsite review.
- If the Department determines that it is necessary to conduct an onsite review, the MCO is responsible for all reasonable travel costs associated with such onsite reviews for at least 2 staff from the Department. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by the State or its authorized agent in connection with the onsite reviews.
- If for any reason an MCO does not fully meet the MCIS requirements, the MCO must, upon request by the Department, either correct such deficiency or submit to the State a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, the Department may impose contractual remedies according to the severity of the deficiency
- The MCO must have a system that can be adapted to changes in Business Practices/Policies within the timeframes negotiated by the Parties. The MCO is expected to cover the cost of such systems modifications over the life of the Contract.
- The MCO must provide the Department with written notice of major systems changes and implementations no later than 180 days prior to the planned change or implementation, including any changes relating to subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and the Department and/or the fiscal



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agent. The Department retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

- The MCO must provide the State with updates to the MCIS organizational chart and the description of MIS responsibilities at least 30 days prior to the effective date of the change. The MCO must provide the Department official points of contact for MCIS issues on an ongoing basis.

### **2.4.4.9. Ownership and Access to Systems and Data**

Systems enhancements and data accumulated as part of the New Hampshire Medicaid Managed Care program remain the property of the State of New Hampshire.

- Source code developed for the New Hampshire Medicaid program shall remain the property of the State.
- All data accumulated as part of this program shall remain the property of the State and upon termination of the contract the data will be electronically transmitted to the State in a format and schedule prescribed by the State.
- The MCO shall not destroy or purge the State's data unless directed to or agreed to in writing by the state. The MCO shall archive data only on a schedule agreed upon by the State and the data archive process shall not modify the data composition of the source records. All State archived data shall be retrievable for review and or reporting by the State in the timeframe set forth by the state.

### **2.4.4.10. Reporting**

The MCO shall provide the Department with system reporting capabilities that shall include access to pre-designed and agreed upon scheduled reports, as well as the ability to execute queries to support the Department data and information needs.

## **2.5. Ownership and Control Statement**

MCOs must include in their Proposal a summary of their company's organization, management and history and how the organization's experience demonstrates the ability to meet the needs of requirements in this RFP. This shall include, but not be limited to the following information:

1. General Company Overview including ownership and subsidiaries, company background and primary lines of business, Number of Employees, headquarters and satellite locations, and major government and private sector clients.
2. Confirmation that MCO has the capacity and commitment to meet the stated activities in this section.
3. Confirmation that the MCO holds all necessary registrations and licensures to provide the managed care services in the State of New Hampshire.
4. Confirmation that no individual with an ownership interest of five (5) percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere



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to, any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts

5. Confirmation that MCO does not and will not knowingly employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities.
6. MCO must provide written assurance from contractor's legal counsel that the contractor is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract.



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### 3. STATEMENT OF WORK

The Statement of Work outlined in this RFP describes the necessary components of the New Hampshire Care Management Program. For each component, the RFP outlines requirements and lists key questions for the MCO. The MCO's response shall address all requirements and answer specific questions posed by the RFP.

MCOs chosen to contract with DHHS as an MCO shall perform the services described in the RFP in compliance with the provisions of the Contract Terms and Conditions (which will be released to the selected MCO, and all pertinent state and federal statutes, regulations, and rules. The following requirements shall be met, in their entirety, by any MCO that contracts with DHHS as a result of the RFP process.

DHHS will provide a comprehensive contract to MCOs selected as a result of the RFP evaluation process.

#### 3.1. Covered Populations and Services

The following matrix depicts the steps in which populations will transition from Fee For Service (FFS) to managed care. By 2014, most New Hampshire Medicaid member population groups are mandatorily enrolled in managed care.

Members	Step 1	Step 2	Step 3	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty/Foster Care - Non-Duals	X			
HC-CSD (Katie Becket) - With Member Opt Out	X			
CHIP (transition to Medicaid expansion)	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
ACA Expansion Group			X	
Members with VA Benefits				X
Family Planning Only Benefit (in development)				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X



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Services	Step 1	Step 2	Step 3	Excluded/ FFS
Maturity & Newborn Kick Payment	X			
Inpatient Hospital	X			
Outpatient Hospital	X			
Inpatient Psychiatric Facility Services Under Age 22	X			
Physicians Services	X			
Advanced Practice Registered Nurse	X			
Rural Health Clinic & FQHC	X			
Prescribed Drugs	X			
Community Mental Health Center Services	X			
Psychology	X			
Ambulatory Surgical Center	X			
Laboratory (Pathology)	X			
X-Ray Services	X			
Family Planning Services	X			
Medical Services Clinic (mostly methadone clinic)	X			
Physical Therapy	X			
Occupational Therapy	X			
Speech Therapy	X			
Audiology Services	X			
Podiatrist Services	X			
Home Health Services	X			
Private Duty Nursing	X			
Adult Medical Day Care	X			
Personal Care Services	X			
Hospice	X			
Optometric Services Eyeglasses	X			
Furnished Medical Supplies & Durable Medical Equipment	X			
Non-Emergency Medical Transportation (current admin. expense)	X			
Ambulance Service	X			
Wheelchair Van	X			
Acquired Brain Disorder Waiver Services			X	
Developmentally Disabled Waiver Services			X	
Choices for Independence Waiver Services			X	
In Home Supports Waiver Services			X	
Skilled Nursing Facility			X	
Skilled Nursing Facility Atypical Care			X	
Inpatient Hospital Swing Beds, SNF			X	
Intermediate Care Facility Nursing Home			X	
Intermediate Care Facility Atypical Care			X	
Inpatient Hospital Swing Beds, ICF			X	
Glenciff Home			X	
Developmental Services Early Supports and Services			X	
New Substance Abuse Benefit Allowing MLDACs			X	
Home Based Therapy - DCYF			X	
Child Health Support Service - DCYF			X	
Intensive Home and Community Services - DCYF			X	
Placement Services - DCYF			X	
Private Non-Medical Institutional For Children - DCYF			X	
Crisis Intervention - DCYF			X	
Intermediate Care Facility MR				X
Medicaid to Schools Services				X
Dental Benefit Services				X

The previous matrix depicts the planned steps for transitioning services from FFS to managed care. While the MCO is permitted to provide a higher level of service and cover additional services, the MCO shall, at a minimum, cover the services identified at



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least up to the limits described in New Hampshire's State Plan. DHHS reserves the right to alter this list at any time by informing the MCO.

### 3.2. Transitioning to the Care Management Program

#### *Step One*

As described in the above charts, DHHS plans to move most of its covered populations into the program in year one, along with many of the services provided to those individuals. Step one will be implemented July 1, 2012.

DHHS will describe its approach to MCO implementation oversight and the MCO's implementation responsibilities in the proposed contract. As part of its implementation oversight responsibilities DHHS will conduct two readiness reviews – the first review will take place 90 days prior to the Program start date, the second review will take place 30 days before the Program start date.

#### *Step Two*

As described above, DHHS plans to expand the Care Management Program in its second year of operation to include all waived services and long term care services. Furthermore, DHHS intends to approach CMS to develop a shared savings program for the dual eligible population which would better integrate and align Medicare and Medicaid services for that population.

DHHS recognizes that there are many challenges around coordinating services for waived services, both for non-dual and dual eligible members and that moving to a capitated managed care model for these services and populations will require significant planning, stakeholder involvement, and provider and service re-alignment. For these reasons, Step Two has not been fully developed to date.

DHHS will actively engage the selected MCOs along with stakeholders, members, and providers to design and develop the Step Two model. Step Two will be twelve months after the implementation of Step One.

#### *Step Three*

Step Three will commence on January 1, 2014. Assuming that Patient Protection and Affordable Care Act (PPACA) is still in place, DHHS intends to enroll all new populations eligible for Medicaid in January 2014, as a result of the Affordable Care Act (ACA), into its Care Management Program.

DHHS reserves the right to remove one or more of the selected MCOs from the program if it determines that those MCOs do not have a satisfactory approach to the Step Three population and/or fails a readiness review prior to implementing Step Three.



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Provide responses to the following:

- Q1. Describe your experience with initiating similar programs for such a broad array of populations and service in an expedited manner.*
- Q2. Describe your proposed implementation approach for Step One*
- Q3. Describe your experience in managing care for dually eligible populations. What are the greatest challenges to meeting the needs of these groups?*
- Q4. Describe your experience in managing the full range of long-term services and supports, including in-home supports, residential care and nursing home services.*
- Q5. In 2014, if PPACA is still in place, a great number of consumers will routinely move between Medicaid and subsidized coverage available on a health benefits exchange. DHHS is interested in minimizing the impact of these transitions on consumers. Please describe your current interest in potentially offering a product on the Health Benefits Exchange to allow members to maintain continuity of access to services as they transition from one program to another.*

### 3.3. Pharmacy Management

Pharmacy management will be a service carved into managed care; however, it will operate jointly with the present FFS program. DHHS and the current Pharmacy Benefits Manager (PBM) will continue to operate the statewide Preferred Drug List (PDL) and administer both the Omnibus Budget Reconciliation Act (OBRA) 90 rebate and supplemental rebate program. The State's Drug Utilization Board (DUR), continue to review the PDL. Each selected MCO will be invited to participate on the DUR as established in PART He-C 5010 DRUG USE REVIEW BOARD.

The MCO shall administer benefits on its own (i.e., pay pharmacy claims, conduct prior authorizations, and operate its own medication adherence programs). However, the MCO's formulary and pharmacy prior authorization criteria will be subject to DHHS approval. Pharmacy prior authorizations in place at the time a member transitions from FFS to an MCO will be honored for a maximum of 90 days. Additionally, the MCO shall adjudicate pharmacy claims for its members utilizing a point of service system where appropriate.

In accordance with changes to rebate collection processes in the Patient Protection and Affordable Care Act (PPACA), DHHS will be responsible for collecting OBRA 90 rebates from drug manufacturers on MCO pharmacy claims. The MCO shall provide all necessary pharmacy encounter data to the State to support the rebate billing process.

It is DHHS' intention to align each MCO's formulary to the PDL and continue to operate its supplemental rebate program with drug manufacturers. This rebate program will also combine FFS and managed care pharmacy claims.



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Provide responses to the following:

- Q6.** *Recognizing DHHS' PDL/Formulary approach, describe your general approach to pharmacy management. Provide specific details in the following areas:*
- *Describe your Medication Adherence programs and how they are coordinated with your care management programs.*
  - *Describe your specialty pharmacy program and how it is coordinated with your care management programs.*
  - *Describe your approach to pharmacy utilization management.*
  - *Describe your approach to pharmacy lock in programs.*
  - *Describe your approach to making pharmacy services information, such as claims history, drug information, etc) accessible to members.*
- Q7.** *Describe your academic detailing program or other programs that support evidenced-based physician prescribing.*
- Q8.** *Describe your strategy to create a robust network of pharmacies across the State.*
- Q9.** *Describe what role, if any, the pharmacies play in your disease and care management programs.*
- Q10.** *Describe your strategies to promote the use of e-prescribing.*
- Q11.** *Describe strategies you employ to make your formulary and prior authorization accessible to your provider network.*
- Q12.** *In regards to pharmacy claims adjudication:*
- *Who adjudicates your pharmacy claims?*
  - *Describe how you ensure adequate oversight and monitoring of the pharmacy claims processor.*
  - *If pharmacy claims are paid through a different claims platform than medical claims, describe how third-party liability information is coordinated and shared.*
  - *If pharmacy claims are paid through a different claims platform than medical claims, describe how encounter data are aggregated.*
  - *If pharmacy claims are paid through a different claims platform than medical claims, describe how pharmacy utilization data are used in your disease and care management programs. Describe how pharmacy data are linked with Medical claims data at the member level in these programs.*



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### 3.4. **Member Enrollment**

#### 3.4.1. **Eligibility**

Qualifications for New Hampshire's Medicaid program are based on three types of eligibility requirements—general (Citizenship Status/Immigration, Residency, Age, Social Security Number), financial (Household income, Household Resources, Potential Income), and some New Hampshire Medicaid categories also have medical eligibility requirements.

The State has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether/when he/she will be enrolled in the Care Management Initiative. The State shall maintain its current responsibility and processes for determining member eligibility.

#### 3.4.2. **Relationship with Enrollment Services**

DHHS intends to provide MCO Enrollment Services to facilitate member enrollment into the managed care plans. The MCO shall exchange information with DHHS or its designee, including but not limited to:

- Plan benefit descriptions
- Accurate provider network information updated no less than every 30 days
- Information contained in the MCO's member handbook (specified in Section 3.D of this RFP)

#### 3.4.3. **MCO Choice**

Members shall have a choice between two or three MCOs operating in the State. Members will have an opportunity to choose an MCO during the initial enrollment period and then will have an annual enrollment period to either maintain plans or change plans. Beyond the annual enrollment period, members will be able to change plans off-cycle for the reasons specified in MCO Contract.

#### 3.4.4. **Auto-Assignment**

Despite the best efforts of DHHS or its designee to engage all members in choosing a plan during the initial enrollment and/or when an individual becomes eligible for Medicaid, not all individuals will make an active decision. For this population, DHHS will use the following auto-assignment methodology in the first year of the program. DHHS will review fee for service claims data to determine if the member had a usual provider of primary care services. If that provider is only under contract with a single MCO, the member will be assigned to that MCO. If the provider is under contract with more than one MCO or no usual source of primary care can be determined the following algorithm will be used, and the MCO with the highest technical score will be assigned 50% of the auto-assigned members. The sample algorithm is outlined below:

- The MCO with the highest technical score will be assigned the first member



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- The MCO with the second highest technical score will be assigned the next member
- The MCO with the highest technical score will be assigned the next member
- The MCO with the third highest technical score will be assigned the next member

The algorithm will be used until all members are assigned. DHHS reserves the right to change the auto assignment process at its discretion.

### 3.4.5. **Automatic Re-enrollment**

DHHS (or its agent) will provide for automatic re-enrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less.

Provide responses to the following:

- Q13. Describe your strategy and experiences with assisting members in retaining their Medicaid eligibility.*
- Q14. Describe the support and strategies you will employ to assist members who transition in and out of your plan, due to loss of Medicaid eligibility.*
- Q15. Describe your experience collaborating with a State's enrollment assistance function and your strategies and processes to assist members in plan choice and enrollment.*
- Q16. Describe your policies toward enrolling a newborn*

### 3.5. **Member Services**

The MCO must maintain a Member Services Department to assist members and their family members or guardians in obtaining Covered Services under the Care Management Program. The MCO shall have a robust member services operation to respond to and provide up to date information to members, respond to inquiries, engage and support members. The MCO's member services function shall align with all applicable Cultural Considerations requirements in Section 3.5 of this RFP, including accommodating members whose primary language is not English and members with special needs.

#### 3.5.1. **Member Information**

##### *Member Outreach*

The MCO is required to make a welcome call to each new member within 30 days of the member's enrollment in the MCO. A minimum of three attempts should be made. The welcome call shall at a minimum:

- Confirm the member's Primary Care Provider (PCP) selection
- Include a brief health risk assessment



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- Screen for special needs and /or services of the member
- Answer any other member questions about the MCO

### *Member Identification Card*

All Member ID cards must, at a minimum, include the following information:

- The Member's name
- The Member's date of birth (DOB)
- The Member's Medicaid Program number
- The effective date of the PCP assignment
- The PCP's name, address and telephone number
- The name of the MCO

The ID card should include the 24-hour, seven (7) day a week toll-free Member services telephone/hotline number operated by the MCO. The MCO must reissue the Member ID card if: a Member reports a lost card, has a name change, requests a new PCP, or for any other reason that results in a change to the information disclosed on the ID card.

### *Member Handbook*

The MCO is required to provide members with a Member Handbook. DHHS must approve the Member Handbook, and any substantive revisions, prior to publication and distribution. The MCO must develop and submit to DHHS the draft Member Handbook for approval during the Readiness Review and must submit a final Member Handbook, incorporating changes required by DHHS prior to the operational start date.

The MCO must produce a revised Member Handbook, or an insert informing Members of changes to Covered Services, upon DHHS notification and at least 30 days prior to the effective date of such change in Covered Services. In addition to modifying the Member Materials for new Members, the MCO must notify all existing Members of the Covered Services change during the specified timeframe.

### 3.5.2. **Language and Format of Member Information**

Member Materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch reading ease test. Member Materials must be available in English, Spanish, and the languages of other Major Population Groups. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and audiotapes.

The MCO must submit member materials to DHHS for approval prior to use or mailing. DHHS will identify any required changes to the Member materials within 15 Business Days. If DHHS has not responded to a request for review by the fifteenth Business Day, the MCO may proceed to use the submitted materials. DHHS reserves the right to require discontinuation of any Member materials that are not produced in accordance with Department policies.



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### 3.5.3. Provider Directory

The Provider Directory for each MCO Program, and any substantive revisions, must be approved by DHHS prior to publication and distribution. The MCO is responsible for submitting draft Provider Directory updates to DHHS for prior review and approval.

During the Readiness Review process, the MCO must develop and submit the draft Provider Directory template to DHHS for approval and must submit a final Provider Directory, incorporating changes required by DHHS prior to the operational start date.

### 3.5.4. Program Website

The MCO must develop and maintain, consistent with DHHS standards and other applicable State laws, a website to provide general information about the MCO's Program(s), its Provider Network, its customer services, and its Complaints and Appeals process.

The MCO Program content included on the website must be:

- Written in English, Spanish, and the languages of any other Major Population Groups in the Service Area. DHHS will provide the MCO with reasonable notice when the population reaches the 10 percent threshold for a Major Population Group;
- Culturally appropriate;
- Written for understanding at the 6th grade reading level; and
- Be geared to the health needs of the enrolled MCO Program population.

### 3.5.5. Member Call Center

The MCO shall operate a New Hampshire plan specific call center to handle member inquiries during normal business hours. While the call center must be dedicated to the plan operating in New Hampshire, it is not required to be physically located within the State. Additionally, the MCO can operate an in-person member services center, where members can have questions answered in-person, rather than on the phone; however, this is not required.

At a minimum, the call center shall be operational Monday through Friday for the hours that the DHHS current member call center is operational, but the MCO is free to operate longer hours:

- Two days per week: 8:00 am EST to 5:00 pm EST
- Three days per week: 8:00 am EST to 8:00 pm EST

The member call center shall be held to the following minimum standards, but DHHS reserves the right to modify/add/subtract standards.

- **Call Abandonment Rate:** Fewer than 5% of calls will be abandoned
- **Average Speed of Answer:** 90% of calls will be answered with live voice within 30 seconds



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The MCO shall develop a means of coordinating its call center with the current DHHS member services call center that will continue to operate for the FFS program. Members are used to calling the current number and may be uncertain as to the appropriate contact number. To respond to situations where a member calls the DHHS call center or the MCO's call center, looking for the other's services, the MCO shall develop transfer protocols so that members speak to the correct representatives.

### *Member Hotline*

The MCO must operate a toll-free hotline that members can call 24 hours a day, seven (7) days a week. The Member Hotline is an automated system that should operate between the hours of 8:00 a.m. to 5:00 p.m. Monday through Friday, and at all hours on weekends and holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages. A MCO's Representative shall return messages on the next business day.

### 3.5.6. **Marketing**

- The MCO(s) shall not, directly or indirectly, conduct door-to-door, telephonic, or other cold call marketing.
- The MCO(s) shall consult with DHHS and the Medical Care Advisory Committee when reviewing/approving marketing material.
- The MCO(s) shall comply with federal requirements for provision of information that ensures the potential enrollee is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.
- The MCO(s) marketing materials may not contain false or materially misleading information.
- The MCO(s) shall market to entire service areas under contract.
- The MCO(s) shall not offer other insurance products as inducement to enroll.

### 3.5.7. **Member Engagement Strategy**

One of the primary objectives of the Managed Care Program is to facilitate constructive engagement among members, providers, and the MCO.

The MCO is also responsible for making sure that its programs are meeting the needs of its members and are reducing barriers to needed care. To support that requirement, each MCO shall develop and facilitate an active member advisory board that is composed of members who represent its member population. The advisory board should meet quarterly, and regional forums should be convened twice a year during Step One. This advisory board should meet in-person and provide a member perspective to influence program changes and decisions.



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The MCO shall also hold ongoing in-person regional member meetings for two-way communication where members can provide input and ask questions and the MCO can ask questions and obtain feedback from members.

Each MCO shall conduct an annual member survey in accordance with National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plan Survey (CAHPS) requirements.

Provide responses to the following:

- Q17.** *Describe how you will accommodate non-English speaking members in member services.*
- Q18.** *Describe how you will accommodate members with special needs, including those who are deaf, visually impaired, persons with mental illness, or persons with cognitive impairments in need of additional assistance to understand information, in member services.*
- Q19.** *Provide an organizational chart of the Member Services Department, showing the placement of Member Services within the MCO's organization and showing the key staff within the Member Services Department.*
- Q20.** *Describe the curriculum for training to be provided to Member Services representatives, including when the training is conducted and how the training addresses:*
- Covered Services, including Behavioral Health Services and Community-based Long Term Services and Supports
  - MCO Program requirements
  - Special Populations, including those who are deaf, visually impaired, persons with mental illness, or persons with cognitive impairments
  - Cultural Competency
  - Providing assistance to Members with limited English proficiency.
- Q21.** *Describe how you would coordinate the current New Hampshire call center operations with your call center. Describe your proposed transfer protocols.*
- Q22.** *Describe your experience operating member call centers. Provide details with regards to the following metrics from your other operations:*
- Average call answer time
  - Call abandonment rate
  - Representative to member ratio
  - Average call length
  - Interpretation services you are currently providing
- Q23.** *Describe your anticipated call center operation for the New Hampshire plan, including: location of operations (if out of state, describe how it will accommodate services for New Hampshire)*
- Q24.** *Describe the process in place to ensure that member calls pertaining to immediate medical needs are properly handled.*
- Q25.** *Describe your plan for in-person member services availability, if any.*
- Location(s)
  - Services provided



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- *Accommodations for special needs populations*
- Q26. *Describe how you will develop, engage, and utilize a consumer advisory board.*
- Q27. *Describe your approach for ongoing member communication and outreach.*
- Q28. *Describe your strategy for use of internet member services and other social media programs.*

### 3.6. Cultural Considerations

The MCO shall participate in efforts to promote the delivery of services in a culturally competent manner to all members and their families. The MCO shall develop appropriate methods of communicating and working with its members who do not speak English as a first language, as well as members who are visually and hearing impaired, and accommodating members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities. In addition, the MCO shall respect members whose lifestyle or customs may differ from those of the majority of members.

The MCO shall ensure in-person or telephonic interpreter services are available to any member who requests them, regardless of the prevalence of the member's language within the overall program. The MCO shall bear the cost of these services, as well as the costs associated with making American Sign Language (ASL) interpreters and Braille materials available to hearing- and vision-impaired members. The *Member Handbook* shall include information on the availability of oral and interpretive services.

The MCO shall communicate in ways that can be understood by persons who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the member's health and health care.

MCOs shall comply with National Standards on Cultural and Linguistically Appropriate Services (CLAS) as described below:

- The MCO shall ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- The MCO shall implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- The MCO shall ensure that staff, at all levels and across all disciplines, receive ongoing education and training in culturally and linguistically appropriate service delivery.
- The MCO shall offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with



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limited English proficiency at all points of contact, in a timely manner, during all hours of operation.

- The MCO shall provide to patients/consumers, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.
- The MCO shall assure the competence of language assistance provided by interpreters and bilingual staff to patients/consumers who have limited English proficiency. Family and friends should not be used to provide interpretation services (except upon request by the member).
- The MCO shall make available easily understood member-related materials and post signage in the most prevalent languages in New Hampshire.
- The MCO shall develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- The MCO shall conduct initial and ongoing organizational self-assessments of CLAS-related activities and is encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
- The MCO shall ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
- The MCO shall maintain a current demographic, cultural, and epidemiological profile of the community, as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
- The MCO shall develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
- The MCO shall ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by members.
- The MCO is encouraged to regularly make available to the public information about the MCO's progress and successful innovations in implementing the CLAS standards and to provide to the public notice in a communities about the availability of this information.

Provide responses to the following:

- Q29.** *Describe how you will assure cultural competency throughout your network. What training programs and support do you offer staff and providers regarding cultural competency?*



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**Q30.** Describe how you will ensure that your provider network is ethnically diverse and similar to the demographic profile of your members.

### 3.7. Access

The MCO's Network must have PCPs in sufficient numbers, and with sufficient capacity, to provide timely access to regular and preventive care services to all Members in the Medicaid Program. The MCO is required to systematically and regularly verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in Sections 3.5, and for Covered Services furnished by PCPs, the standards described in Section 3.1.

#### 3.7.1. Geographic Distance

In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the MCO shall meet the following geographic access standards for all Members:

	<b>Urban</b>	<b>Rural</b>
PCPs	Two (2) within eight (8) miles	Two (2) within forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One, seven (7) days a week, within thirty (30) minutes or thirty (30) miles

MCOs may request exceptions from these standards after demonstrating its efforts to create a sufficient network of providers to meet these standards. DHHS reserves the right at its discretion to approve or disapprove these requests.

#### 3.7.2. Timely Access to Service Delivery

The MCO shall require that all network Providers offer hours of operation that are no less than the hours of operation offered to commercial and fee-for-service patients. The MCO shall encourage its PCPs to offer after-hours office care in the evenings and on weekends.



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The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

PCPs (routine visits)	Not to exceed 14 calendar days
PCP (adult sick visit)	Not to exceed 24 hours
PCP (pediatric sick visit)	Not to exceed 24 hours
Specialists	Not to exceed 30 calendar days
Elective Hospitalizations	30 calendar days
Mental health Providers	14 calendar days
Urgent Care Providers	Not to exceed 24 hours
Emergency Providers	Immediately (24 hours a day, 7 days a week) and without prior authorization

### Post Discharge from New Hampshire Hospitals

The MCO will ensure that members have contact with the community mental health center within 48 hours of psychiatric discharge from New Hampshire Hospital and a follow-up appointment will occur within 7 calendar days. The MCO will ensure that members will have a follow-up appointment within 7 calendar days from a private hospital psychiatric discharge.

DHHS is concerned about access to maternity services in Coos County. DHHS has provided financial support through enhanced inpatient maternity payments to a Coos County Hospital to ensure continued access. Bidders should specifically describe in their proposal how they intend to assure access to maternity services in Coos County.

#### 3.7.3. Women's Health

The MCO shall provide female members with direct in-network access to a women's health specialist for covered care necessary to provide her routine and preventive health care services. This is in addition to the member's designated source of primary care if that provider is not a women's health specialist.

#### 3.7.4. Out-of-Network Providers

If the MCO's network is unable to provide Medically Necessary Covered Services to a particular member, the MCO shall adequately and in a timely manner cover these services out-of-network for the member. The MCO must inform the out-of network provider that the member cannot be balance billed.

The MCO shall coordinate with out-of-network providers regarding payment. For payment to out-of-network, or non-participating providers, the following guidelines apply:



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- If the MCO offers the service through an in-network provider(s), and the member chooses to access non-emergent services from an out-of-network provider, the MCO is not responsible for payment.
- If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the MCO and the out-of-network provider.

### 3.7.5. **Second Opinion**

The MCO shall provide for a second opinion from a qualified health care professional within the provider network, or arrange for the member to obtain one outside the network, at no charge to the member. The MCO shall clearly state its procedure for obtaining a second opinion in the *Member Handbook*.

Provide responses to the following:

- Q31.** *Describe your approach to building a viable network of services in the rural areas of New Hampshire and how you will ensure access to primary and specialty care in these areas.*
- Q32.** *Describe your strategies for provider recruitment for providers who currently do not accept Medicaid.*
- Q33.** *Submit a list of all providers, by provider type/specialty, in New Hampshire in your network, or who are expected to be in your network. Include an indication of the level of agreement that has been reached at the time of the RFP response. (Refer to the GIS Instructions - Appendix A).*
- Q34.** *Identify the projected ratio of primary care and specialty providers to members by county and the rationale you have used to determine that the network is sufficient.*
- Q35.** *Describe how you will ensure that members have access to providers who are knowledgeable about genetic or chromosomal condition(s) and related health risks, and understand the issues of health disparities for individuals with intellectual/developmental disabilities and the prevention and management of secondary disability(ies).*



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### 3.8. Provider Network Management and Requirements

The MCO shall be responsible for developing and maintaining a statewide provider network that adequately meets all covered physical and behavioral health needs of the covered population in a manner that provides for coordination and collaboration among multiple providers and disciplines. In developing its network, the MCO shall consider the following:

- Current and anticipated New Hampshire Medicaid enrollment
- The expected utilization of services, taking into consideration the characteristics and health care needs of the covered New Hampshire population
- The number and type (in terms of training and experience and specialization) of providers required to furnish the contracted services
- The number of network providers not accepting new New Hampshire Medicaid patients
- The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by New Hampshire members
- Accessibility of provider practices for members with disabilities
- Required access standards identified in Sections 3.7.1 and 3.7.2 of this RFP

In developing its network, the MCO's provider selection policies and procedures shall not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment. The MCO also may not employ or contract with providers excluded from participation in federal health care programs.

The MCO shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its provider network to meet the needs of all members including those with limited English proficiency and those with unique cultural needs (see Cultural Consideration standards). The MCO shall notify DHHS (or its agent) within 24 hours upon knowledge of a planned or unplanned dis-enrollment/termination of or by a provider. Within 72 hours, the MCO shall have a plan for replacement of coverage for members served by that provider.

The MCO shall maintain an updated list of participating providers on its website in a *Provider Directory*. This directory shall be updated immediately, as new providers are added or removed from the network. The *Provider Directory* shall identify all providers, including primary care, specialty care, behavioral health, substance abuse, home health, home care, rehabilitation, hospital, pharmacy and other providers and include the following information for each provider:

- Address of all practice/facility locations
- Hospital affiliations, if applicable
- Open/closed status for MCO members
- Languages spoken in each provider location



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### 3.8.1. Network Requirements

The MCO must enter into written contracts with properly credentialed providers as described in this section. The provider contracts must comply with the New Hampshire DHHS requirements.

The MCO must maintain a provider network sufficient to provide all members with access to the full range of covered services required under the contract. The MCO must ensure that its providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the contract.

**All Providers:** All providers must be licensed or designated and approved in the State of New Hampshire to provide the covered services for which the MCO is contracting with the provider, and not be under sanction or exclusion from the Medicaid program. Providers must also have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

All providers in the MCO's network shall be enrolled as a New Hampshire Medicaid provider. DHHS will continue to be responsible for enrolling providers; however, the MCO should assist providers with this process.

**Trauma:** The MCO must ensure members access to New Hampshire-designated Level I and Level II trauma centers within the State, or Hospitals meeting the equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO must make written out-of-network reimbursement arrangements with the New Hampshire-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its network.

**Hemophilia centers:** The MCO must ensure member access to hemophilia centers supported by the Centers for Disease Control and Prevention (CDC). A list of these hemophilia centers can be found at <http://www.cdc.gov/ncbddd/hemophilia/HTC.html>. If the MCO's network does not include CDC-supported hemophilia centers in proximity to the member's residence, the MCO must make written arrangements with out-of-network providers for such care.

**Physician services:** The MCO must ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the provider network to ensure that necessary admissions are made.

#### *Provider Contract Requirements*

The MCO is prohibited from requiring a provider or provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.



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The MCO's contract with health care Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include the minimum requirements that will be specified in the MCO's contract with DHHS.

The MCO must submit model Provider Contracts to DHHS for review during the Readiness Review process. The MCO must resubmit the model Provider contracts any time it makes substantive modifications to such agreements. DHHS retains the right to reject or require changes to any Provider contract that does not comply with DHHS Medicaid Care Management Program requirements.

### *Provider Reimbursement*

Except in the following circumstances, MCOs may negotiate provider reimbursement rates and methodologies.

- FQHCs and RHCs will be paid the current encounter rate paid by DHHS
- Hospice services will be reimbursed at the current Medicare rates

### *Provider Relations*

The MCO must maintain a provider relations presence in New Hampshire as approved by DHHS.

### *Provider Manuals and Training Material*

The MCO must prepare and issue a provider manual(s) to all network providers, including any necessary specialty manuals (e.g., behavioral health). For newly contracted providers, the MCO must issue copies of the provider manual(s) no later than five (5) business days after inclusion in the network. The provider manual must contain sections relating to special requirements of the MCO program(s) and the enrolled populations in compliance with the DHHS requirements.

DHHS must approve the Provider Manual, and any substantive revisions to the Provider Manual, prior to publication and distribution to providers. DHHS's initial review of the Provider Manual will be part of the readiness review process.

The MCO must provide training to all providers and their staff regarding the requirements of the contract. The MCO's provider training must be completed within 30 days of placing a newly contracted provider on active status. The MCO must provide ongoing training to new and existing providers as required by the MCO, or as required by DHHS to comply with the contract. Upon request by DHHS, enrollment or attendance rosters dated and signed by each attendee, or other written evidence of training of each provider and his or her staff, must be provided.

The MCO(s) shall be responsible for tracking, monitoring, and reporting specific reasons for claim adjustments and denials, by error type and by provider. As the MCO(s) discover incorrect billing trends with a particular provider/provider type, specific billing



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issue trends, or quality trends, it is the MCO(s) responsibility to reach out to the provider(s) and provide individualized or group training regarding the issues at hand. The MCO(s) shall notify DHHS as this occurs and discuss the most effective means of accomplishing this.

Provider materials must comply with state and federal laws and DHHS requirements. The MCO must make available any provider training materials to DHHS upon request.

### *Provider Hotline*

The MCO must operate a toll-free telephone line for provider inquiries from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday, except for State-approved holidays. The Provider Hotline must be staffed with personnel who are knowledgeable about the New Hampshire Medicaid Care Management Program.

The MCO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a member with an urgent condition or an emergency medical condition. The MCO must have a process in place to handle after-hours inquiries from providers seeking to verify enrollment for a member with an urgent condition or an emergency medical condition, provided, however, that the MCO and its providers do not require such verification prior to providing emergency services.

### *Termination of Provider Contracts or Network Changes*

The MCO must notify the DHHS and notify affected current members in writing of a provider termination, unless prohibited or limited by applicable law. The notice must be provided by the earlier of: (1) 15 days after the receipt or issuance of the termination notice, or (2) 15 days prior to the effective date of the termination. Affected members include all members in a PCP's panel and all members who have been receiving ongoing care from the terminated provider, where ongoing care is defined as two (2) or more visits for home-based or office-based care in the past 12 months.

If a member is in a prior authorized ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services, the MCO shall notify the member in writing within ten (10) Calendar Days from the date the MCO becomes aware of such unavailability.

A continuity of Care Plan is required to be submitted to DHHS 60 days prior to anticipated mass Network changes that will impact membership.

The MCO shall notify DHHS within two (2) business days of any significant changes to the provider network or, if applicable, to any subcontractors' provider network. A significant change is defined as:

- A decrease in the total number of PCPs by more than five percent (5%);



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- A loss of all providers in a specific specialty where another provider in that specialty is not available within thirty (30) minutes or thirty (30) miles;
- A loss of a hospital in an area where another contracted hospital of equal service ability is not available within thirty (30) minutes or thirty (30) miles; or
- Other adverse changes to the composition of the network, which impair or deny members' adequate access to in-network providers.

The MCO shall have procedures to address changes in the health plan provider network that negatively affect the ability of members to access services, including access to a culturally diverse provider network. Significant changes in network composition that negatively impact member access to services may be grounds for contract termination or State determined remedies.

### 3.8.2. **Provider Credentialing and Re-Credentialing**

The MCO must review, approve, and periodically recertify the credentials of all participating physician providers and all other licensed providers who participate in the MCO's network. The MCO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by DHHS.

For the initial first year of the Care Management Program, the MCO shall deem all current Medicaid eligible providers as enrolled and credentialed. MCO's may re-visit these credentialing standards in the second year of the program. All providers must be licensed or designated and approved in accordance with New Hampshire laws and regulations.

At a minimum, the scope and structure of a MCO's credentialing and re-credentialing processes must be consistent with recognized MCO industry standards, such as those provided by NCQA, and relevant state and federal regulations relating to provider credentialing and notice. Medicaid MCOs must also comply with 42 C.F.R. §438.12 and 42 C.F.R. §438.214(b). A provider's first original credentialing, including application and verification of information, must be completed before the effective date of the provider's initial network provider agreement. Re-credentialing must occur at least every three (3) years.

The MCO may not discriminate in terms of the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her designation, license or certification under applicable State law, solely on the basis of that designation, license or certification. Additionally, if the MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision.



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The re-credentialing process must take into consideration provider performance data including, but not be limited to, member complaints and appeals, quality of care, and utilization management.

- a) The MCO(s) shall make payments only to providers enrolled in the New Hampshire Title XIX Program.
- b) DHHS shall retain the authority to enroll providers in the New Hampshire Title XIX Program and shall notify the MCO(s) of any provider enrollment status changes. The MCO(s) shall notify DHHS of any provider enrollment status changes.
- c) If an enrolled provider is excluded from participation by the MCO(s), DHHS will be notified of such exclusion and provided with an explanation as to why the provider is being excluded from participation.
- d) When DHHS receives exclusion notification of a currently enrolled provider, OHSURS shall notify the MCO(s) accordingly.

### *Board Certification Status*

The MCO must maintain a policy with respect to board certification status that mandates participation of greater than ninety eight (98) percent board certification among participating PCPs and specialty physicians in the provider network. The MCO must make information on the percentage of board-certified PCPs in the provider network and the percentage of board-certified specialty physicians, by specialty, available to DHHS upon request.

### 3.8.3. **Provider Engagement**

To achieve a collaborative network between the MCO and providers who promote patient health and reduce the growth of spending, the MCO shall actively engage providers in two-way communication.

To support this level of engagement, the MCO shall, at a minimum, develop and facilitate an active provider advisory board that is composed of a broad spectrum of provider types. This advisory board should meet face-to-face on a quarterly basis and provide a provider perspective to influence program changes and decisions. The MCO shall also conduct a provider satisfaction survey at least once a year to gain a broader perspective of provider opinions. The results of these surveys shall be made available to DHHS in writing. The MCO, as part of its provider relations/network management function, will operate a provider call center to assist providers with questions about the operations and policies and procedures of the MCO.



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Provide responses to the following:

- Q36. Describe your strategy for ongoing provider communication and outreach. Include a description of the mechanisms you currently use and will use to communicate with providers and the content you anticipate including in communications.*
- Q37. Describe how you will develop, engage, and utilize a provider advisory board. Describe the approach you currently take and will take to assess provider satisfaction, including tools you plan to use, frequency of assessment, and responsible parties.*
- Q38. Describe your experience with conducting provider surveys and your provider survey methodology. Also summarize the results of the provider surveys for other state's managed care programs you administered.*
- Q39. Describe your process for using input derived from the advisory board and surveys to inform possible changes in program design and/or administration.*
- Q40. Describe your experience in other state's managed care programs you administer – the percentage of providers who you have credentialed compared with the provider population and how many providers were added or terminated during the first 3 years of the programs' implementation date.*

### 3.9. **Payment Reform**

One of DHHS' goals for the Managed Care Initiative is to transform New Hampshire's Medicaid program from an FFS system that rewards the volume of services to one that rewards improved outcomes and reduced costs for episodes of care. DHHS believes that such a transformation will require the MCOs and providers to work together to create new approaches and partnerships.

Each MCO shall describe in detail its plan to promote new methods of value-based payment and other innovative partnerships with providers. The MCO shall take advantage of current New Hampshire based as well as Federal initiatives to improve the health care delivery system. This plan shall contain measurable goals and outcomes. DHHS will approve each plan and negotiate an incentive program equal to 1% of capitation revenue received that will reward or penalize the MCO based on its performance against its approved plan.

As part of this plan, each MCO should also demonstrate how it will provide incentive to providers to improve outcomes and, where appropriate, share in the savings resulting from the initiatives in the MCO's plan.



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### 3.10. Behavioral Health Services

The New Hampshire Bureau of Behavioral Health (New Hampshire BBH) is responsible for planning and overseeing behavioral health services for individuals who have a serious mental illness or serious emotional disturbance. New Hampshire BBH contracts with 10 Community Mental Health Centers who provide community mental health rehabilitation option and targeted case management services and who oversee referrals to the State's psychiatric hospital.

New Hampshire BBH has prioritized the use of community-based services and SAMHSA approved evidence based practices, as outlined below:

1. Community Mental Health Centers located within the MCO service region shall be offered participation in the MCO provider network. Should a CMHC decline participation in the MCO in that service area, or if the MCO fails to meet access or any other terms and conditions of the contract, the MCO may meet its network requirements by offering participation to other qualified providers. In the event that the CMHC in the MCO service region declines to participate or fails to meet participation requirements, the MCO shall notify BBH, which will implement action steps to designate a community mental health provider in that region.
2. State Administrative Rule He-M 426, Community Mental Health Services, details the services available to adults with a severe mental illness and children with serious emotional disturbance. The MCO will, at a minimum, make these services available to all adults and children determined eligible for community mental health services under State Administrative Rule He-M 401. Priority shall be given to the continued implementation of evidence based practices across the entire service delivery system. Services shall be recovery and resiliency oriented. The MCO shall ensure that community mental health services are delivered in the least restrictive community based environment, based on a person-centered approach, where the consumer and family's personal goals and needs are considered central in the development of the individualized service plans. The MCO shall ensure that services to individuals who are homeless or at risk for homelessness continue to be prioritized.
3. The MCO shall utilize the New Hampshire approved Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths (ANSA) as the statewide client level outcomes measurement tools and for the purpose of determining eligibility for community mental health services.
4. The MCO shall ensure that the provider network for community mental health services adheres to all applicable State and Federal requirements governing New Hampshire community mental health services.
5. The MCO shall ensure that the community mental health services system adheres to Americans with Disabilities Act (ADA) regulations and the Olmstead Act.
6. The MCO shall continue the implementation of New Hampshire's 10-year Olmstead Plan, *Addressing the Critical Mental Health Needs of New Hampshire's*



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*Citizens: A Strategy for Restoration*, through the reinvestment of savings into the 10-year plan. An online copy of this plan can be found at the following link:

<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>

7. The MCO shall require a local regional planning process to ensure that services and programs offered are tailored to the unique needs of each New Hampshire community. This process shall occur no less than annually and shall include the BBH.
8. The MCO shall allocate resources to support the New Hampshire community mental health service system to hire and retain well trained staff. The MCO shall promote provider competence and opportunities for skill-enhancement through training opportunities and consultation.
9. The MCO shall be responsible for complying with State and Federal reporting requirements. As part of these requirements the MCO shall ensure that data are collected and submitted to the BBH for monitoring access, outcomes, and meeting the National Outcomes Measures reporting requirements specified by the Substance Abuse and Mental Health Services Administration (SAMHSA). The MCO shall respond to any BBH request for data or information, including utilization, quality, and enrollment reports for adults and children served through the community mental health provider network.
10. The MCO shall ensure that regionally based crisis lines are in place 24 hours a day/ 7 days a week for individuals in crisis. These crisis lines shall employ clinicians trained in managing crisis intervention calls, and who have access to a clinician available to evaluate the client on a face-to-face basis in the community to address the crisis and evaluate for the need for hospitalization if needed.
11. The MCO shall develop policies governing the coordination of care with primary care providers and community mental health programs
12. In regions where the State of New Hampshire has established a mental health court, which is supported in whole or in part with staff from a community mental health center, the MCO shall continue to provide that support.
13. The MCO shall enter into a collaborative agreement with New Hampshire Hospital, the State of New Hampshire's state operated inpatient psychiatric facility. This collaborative agreement, subject to the approval of the BBH, shall at a minimum address federal Olmstead Law, include the responsibilities of the community mental health provider network in order to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital.
14. The MCO shall ensure that a designated liaison is established for New Hampshire Hospital to coordinate the discharge planning process for adults and children admitted to New Hampshire Hospital. The liaison shall actively participate in treatment team meetings and discharge planning meetings to ensure compliance with Olmstead and other applicable regulations.
15. The MCO shall continue to support and ensure that services for the deaf population continue to be made available such as those made available through the Deaf Services Team at Greater Nashua Mental Health Center.



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16. The MCO shall facilitate the exchange of information among community mental health programs and other health care providers to facilitate a best practice model to reduce the use of polypharmacy for antipsychotic medications and reduce the incidences of adverse drug reactions.

Provide responses to the following:

- Q41. Describe your plan for implementing delivery system and payment reform. Describe your approach to creating partnerships with providers to support health care reform.*
- Q42. Describe your experience with creating value-based payment arrangements, episodes of care payments, sub-capitation arrangements, and Incentive programs and their impact on improved quality and reduced cost.*
- Q43. Describe your approach to Behavioral Health delivery system and payment reform in other states.*
- Q44. Describe your direct experience in developing partnerships with Community Mental Health Centers. Separately describe your past and present subcontracting arrangements for individuals experiencing serious mental illness or serious emotional disturbance.*
- Q45. Describe your direct experience in service delivery and payment for services for persons with serious mental illness and serious emotional disturbance requiring long-term care services and supports.*



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### 3.11. Care Management Overall Approach

One of the key goals of DHHS is to achieve cost reductions through improvement in care coordination, the quality of services provided, and the improvement of the long-term health status of New Hampshire's Medicaid members. DHHS is interested in selecting MCOs that have a strong focus on assisting their members in maintaining and improving their health and in assisting members in effectively managing acute health care events.

Each MCO will be required to implement a comprehensive care management program that has at a minimum the following components:

- 1) Care coordination
- 2) Support of patient centered medical homes and health homes
- 3) Non-emergency medical transportation
- 4) Wellness and prevention programs
- 5) The management of chronic diseases
- 6) High-cost/ high risk member management programs
- 7) A special needs program
- 8) Social services support coordination

#### 3.11.1. Care Coordination: Role of the MCO

Each MCO shall develop a strategy for coordinating care for all members. Care coordination shall be designed to coordinate primary care and all other covered services to its members and promote and assure service accessibility; attention to individual needs; continuity of care; comprehensive; coordinated and integrated service delivery; and culturally appropriate care.

The MCO shall maintain a written plan providing for continuity of care in the event of contract termination between the MCO and any of its contracted providers, or in the event of site closings involving a primary care provider with more than one location of service. The written plan shall describe how members will be identified and how continuity of care will be provided.

The MCO shall ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements (to the extent that they are applicable).

#### 3.11.2. Care Coordination: Role of the Primary Care Provider

*Supporting Patient Centered Medical Homes and Health Homes*



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DHHS believes that a key strategy for improving member health and controlling Medicaid costs is to encourage members to build a strong relationship with their primary care providers for enhanced care coordination. The MCO shall implement procedures that ensure that each member has access to an ongoing source of primary care appropriate to his or her needs.

The MCO must develop programs to support, wherever possible, primary care providers wishing to qualify as a patient centered medical home. The MCO must develop systems and processes that provide information to primary care providers who promote coordination of the services furnished by the MCO to the member outside of that member's primary care practice.

In addition, it is DHHS' intention to vigorously pursue the development of health homes throughout New Hampshire. It is the expectation of DHHS that each MCO will actively support the creation of health homes for its medically complex members.

### 3.11.3. **Non-Emergency Transportation**

Each MCO will be required to arrange for the non-emergency transportation of its members.

### 3.11.4. **Wellness and Prevention**

DHHS believes that it is essential to encourage members to actively pursue healthy lifestyles in order to improve overall member health and reduce Medicaid costs. To support this strategy, the MCO shall develop and implement wellness and prevention programs for its members.

MCOs are expected, at a minimum, to develop and implement programs designed to address childhood obesity, smoking cessation, and other programs in consultation with DHHS.

MCOs are also expected to provide members with general health information and provide services to help members make informed decisions about their health care needs.

The MCOs will be expected to coordinate their wellness and prevention programs with New Hampshire's Wellness Incentive Program. The Program has a number of key components directed at improving participation and compliance with lifestyle related mitigators of health outcomes such as exercise classes, nutrition counseling and smoking cessation through the use of mentors and coaches. This program will be offered to nearly 4,500 Medicaid recipients at New Hampshire's ten community mental health centers. The program will be overseen by the Centers for Health and Aging and the Prevention Research Center at The Dartmouth Institute, the Bureau of Behavioral Health, and the Office of Medicaid and Business Policy (OMBP) Medical Director's Office.



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### 3.11.5. **Member Health Education**

Part of improving the health of New Hampshire Medicaid members is to help them help themselves, by educating them on healthy lifestyles and practices. The MCO shall develop and initiate a member health education program that supports the overall wellness, prevention, and care management programs, with the goal of improving the health of members.

DHHS expects its MCOs to actively engage members in the effort to improve the program and their health status. As part of this strategy, the MCO shall provide outreach to members who are difficult to engage. This strategy shall align with all applicable Cultural Considerations requirements.

### 3.11.6. **Chronic Disease and High Risk/High Cost Member Management**

A significant number of New Hampshire's Medicaid consumers suffer from one or more chronic diseases that impact their well being and health status. A key goal of DHHS' managed care initiative is to assist consumers to better manage their chronic conditions and, where possible, prevent the onset and/or worsening of their conditions.

The MCO shall develop effective disease management programs that assist members in the management of their chronic diseases. These programs shall incorporate a "whole person" approach to ensure that a member with multiple co-morbidities has a care plan that recognizes the importance of coordinating services for all of the member's physical and behavioral health as well as social services needs.

It is DHHS' expectation that disease management programs be focused on supporting providers and members in improving care coordination and removing barriers to care. DHHS also believes that this support is best provided by the MCO, having its care managers/coordinators engaging members and providers face to face when appropriate and economically feasible.

It is also DHHS' expectation that the MCO will operate specific programs focused on effective management and coordination of its most costly and highest risk members.

The MCO shall at a minimum provide disease management services for the following disease states:

- Diabetes
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Coronary artery disease (CAD)



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### 3.11.7. Special Needs Program

Services provided to members need to be coordinated, comprehensive, collaborative, and continuous with the goal of having the delivery system organize itself around the member's complex array of needs. The MCO must create an organizational structure to ensure that each member with special needs receives access to PCPs and specialists trained and skilled in the special needs of the member; information about and access to a specialist, as appropriate; and information about and access to all covered services appropriate to the recipient's condition or circumstance. Identification of special needs members should be based on the member's physical, developmental, emotional, and/or behavioral conditions.

DHHS also expects that each MCO will work collaboratively with each other and DHHS to develop a statewide health home model to serve members with special needs.

### 3.11.8. System Coordination and Integration

The MCO shall develop relationships with other state, local, and community programs that provide related health and social services to members, including:

- Juvenile Justice and Adult Community Corrections
- Locally administered programs including Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.
- Family organizations, youth organizations, consumer organizations, and faith based organizations
- Other state programs
- The court system, specific to services related to children and youth involved with the child protection agency and juvenile justice systems
- Schools
- Children and youth in foster home/group home/residential placement

#### **Provide responses to the following:**

- Q46.** *Describe your overall approach to care management and how you integrate wellness, prevention, and chronic care management into one seamless program.*
- Q47.** *Describe how your member education program supports your overall wellness and chronic care management programs.*
- Q48.** *Describe your approach to wellness and prevention services. What strategies are you proposing to encourage member use of wellness and prevention services? Describe your experience with these approaches and document the outcomes of those strategies.*
- Q49.** *Describe your proposed smoking cessation program, particularly smoking cessation for pregnant women. Provide information on the outcomes of similar programs you have deployed.*
- Q50.** *Describe your strategy to reduce childhood obesity. Provide information on the outcomes of similar programs you have deployed.*



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- Q51.** *Describe what web based and/or telephonic tools you provide to assist members with their health care choices.*
- Q52.** *Describe how you identify new and existing members who have the greatest need for care coordination and how you provide this coordination.*
- Q53.** *Describe how you will assist members in identifying and gaining access to community resources that may provide services that the managed care program does not cover, but which support the member's overall healthcare needs and goals.*
- Q54.** *Members who require care management are more often transient, difficult to locate, homeless, and difficult to engage. Describe the strategies that you will utilize to address these barriers to care management.*
- Q55.** *Describe how members are engaged with the development of their care plan and how they are encouraged to follow that plan.*
- Q56.** *Describe your process for communicating with members about their primary care provider assignment, ensuring/encouraging members to use their assigned provider, and ensuring/encouraging members to keep their scheduled appointments.*
- Q57.** *Describe your programs and time needed to support practices to attain NCQA patient centered medical home certification.*
- Q58.** *Describe your experience, approach, and time needed to supporting Health Homes as defined by SAMSHA.*
- Q59.** *Describe your process and procedures for coordinating and facilitating non-emergency transportation for your members.*
- Q60.** *Describe your direct experience in managing substance abuse benefits provided through Medicaid programs, including Screening, Brief Intervention and Referral to Treatment (SBIRT).*
- Q61.** *Describe your organizational approach to the following: data sharing and integration to promote care coordination for members with special needs, such as mental illness, substance use disorders, and Human Immunodeficiency Virus (HIV).*
- Q62.** *Describe your experience managing the listed disease states. Include empirical evidence of health outcomes your members have experienced through your chronic care management programs.*
- Q63.** *Describe how you provide care management to children and youth involved in the child protection and/or juvenile justice systems as well as children in foster home/group home/residential placements.*
- Q64.** *Describe your proposed chronic care management program, including:*
- Any additional diseases you will target.*
  - Your risk stratification methodology.*
  - Your outreach strategies to members requiring disease management services.*
  - The interventions you will implement for members of each risk level.*
  - Your approach to telephonic interventions and face-to-face interventions.*



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- *How you engage the member's primary care physician and other providers in developing and implementing a care plan.*
  - *Your approach for managing members with multiple co-morbidities.*
  - *How you will integrate your disease management programs with the member's primary care provider's care management responsibilities?*
  - *Your approach to coordinating community resources for members in the disease management program.*
  - *Describe you proposed approach to transitioning members who were receiving care management support from DHHS prior to enrollment in the MCO.*
  - *Describe your approach for handling high-cost/high-risk individuals.*
  - *Describe your organizational approach to the following: Aligning systems and management practices, including provider contracts, credentialing, training, and reimbursement policies; practice protocols; services authorization policies; benefit and non-MCO service coordination policies and protocols; and your quality assurance mechanisms, to promote care coordination of members with special needs, such as substance use disorders and HIV.*
  - *Children and youth in foster home/group home/residential placements*
- Q65.** *Describe your organization's experience with managing the care of children in the child protection systems and/or juvenile justice system (e.g., foster care).*
- Q66.** *Describe your approach to providing care management to children and youth involved in the child protection and/or juvenile justice systems as well as children in foster home/group home/residential placement.*
- *Identify children in the child welfare and child protection system.*
  - *Initiate services and conduct a comprehensive health assessment.*
  - *Develop and monitor a care management plan in consultation with the child's primary DHHS case manager based on the health assessment and including all disease management or behavioral health needs.*
  - *Assure continuation of care when the child/family leaves the child welfare/child protection system.*
- Q67.** *Describe your approach to assuring the coordination with supporting community resources for children and families in child welfare and child protection system.*



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### 3.12. Quality Management

The MCO must provide for the delivery of quality care with the primary goal of improving the health status of members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO must work in collaboration with providers to actively improve the quality of care provided to members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The MCO must provide mechanisms for members and providers to offer input into the MCO's quality improvement activities.

The MCO shall support and comply with New Hampshire DHHS's Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to New Hampshire Medicaid members (as defined in Title 42 of the Code of Federal Regulations 42 C.F.R. §431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 C.F.R. §438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 C.F.R. §164 (HIPAA Privacy Requirements).

The New Hampshire DHHS Quality Strategic Plan promotes improvement in the quality of care provided to enrolled members through established processes. DHHS Managed Care & Quality staff' oversight of the MCO includes:

- Monitoring and evaluating the MCO's service delivery system and provider network, as well as its own processes for quality management and performance improvement;
- Implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members,
- Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.;
- Monitoring compliance with Federal and State requirements;
- Ensuring the MCO's coordination with State registries;
- Ensuring MCO executive and management staff participation in the quality management and performance improvement processes;
- Ensuring that the development and implementation of quality management and performance improvement activities include contracted provider participation and information provided by members, their families and guardians
- Recommendations for new quality improvement activities

#### *Quality Assessment and Performance Improvement Program Overview*

The MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the contract requirements. MCOs must also meet the requirements of 42 C.F.R. §438.240 for the QAPI Program.



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The MCO must have on file with DHHS an approved plan describing its QAPI Program, including how the MCO will accomplish the activities required by this section. The MCO must submit a QAPI Program Annual Summary in a format and timeframe specified by DHHS or its designee. The MCO must keep participating physicians and other Network providers informed about the QAPI Program and related activities. The MCO must include in provider contracts a requirement securing cooperation with the QAPI.

The MCO must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

- Evaluate performance using objective quality indicators;
- Promote data-driven decision-making;
- Recognize that opportunities for improvement are unlimited;
- Solicit member and provider input on performance and QAPI activities;
- Support continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction;
- Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and
- Support re-measurement of effectiveness and member satisfaction, and continued development and implementation of improvement interventions as appropriate.

The MCO must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO must designate a senior executive responsible for the QAPI Program and the Medical Director must have substantial involvement in QAPI Program activities. At a minimum, the MCO must ensure that the QAPI Program structure is:

- Organization-wide, with clear lines of accountability within the organization
- Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians
- Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities
- Evaluates the effectiveness of clinical and non-clinical initiatives.

### *QAPI Program Subcontracting*

If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO must maintain detailed files documenting work performed by the Subcontractor. The file must be available for review by DHHS or its designee upon request.

### *Behavioral Health Integration into QAPI Program*

The MCO must integrate behavioral health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality



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and appropriateness of Behavioral Health Services provided to members. The MCO must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the member's overall care.

### 3.12.1. Practice Guidelines and Standards

The MCO must adopt evidence-based clinical practice guidelines. Such practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the MCO's members, be adopted in consultation with network providers, and be reviewed and updated periodically, as appropriate. The MCO must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

The MCO must make practice guidelines to all affected providers and, upon request, to members and potential members.

The MCO's decisions regarding utilization management, member education, coverage of services, and other areas included in the practice guidelines must be consistent with the MCO's clinical practice guidelines.

### 3.12.2. External Quality Review Organization

DHHS will contract with an External Quality Review Organization (EQRO) to conduct annual, external, independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in the MCO Contract. The MCO shall collaborate with DHHS's EQRO to develop studies, surveys and other analytic activities to assess the Quality of care and services provided to members and to identify opportunities for MCO plan improvement. To facilitate this process the MCO shall supply data, including but not limited to Claims data and Medical Records, to the EQRO.

### 3.12.3. Evaluation

Annually, the MCO shall prepare a written report on the QMP that describes: (a) completed and ongoing QM activities, including all delegated functions; (b) a trending of measures to assess performance in quality of care and quality of service; (c) an analysis of whether there have been any demonstrated improvements in the quality of care or service; (d) an evaluation of the overall effectiveness of the QMP, including an analysis of barriers to improvement, and (e) recommendations for new quality improvement activities. The annual evaluation report shall be reviewed and approved by the MCO's governing body and submitted to the DHHS Quality Oversight Committee for review.

The MCO shall establish a mechanism for periodic reporting of QMP activities to the governing body, practitioners, members, and appropriate MCO staff. The MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of



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QM activity are documented and reported to appropriate individuals within the organization and through established QM channels.

### 3.12.4. Performance Incentives

Each year DHHS will select four measures to be included in the Quality Incentive Program (QIP).

For each measure selected by DHHS for the QIP, the MCO will be eligible to receive a bonus payment equal to up to one-quarter of one percent of the total capitation payment received by the MCO in the contract year for which the measure was selected.

For each measure, DHHS will establish an improvement goal for which achievement of that goal will qualify the MCO for the incentive payment. When DHHS is able to determine a MCO-specific baseline and measure and MCO-specific improvement, the MCO will be eligible for a partial incentive payment for improved performance on that measure that does not fully meet the improvement goal. Partial payment will be determined by calculating the percentage improvement in the chosen measure and multiplying that percentage by one-half of one percent of the total capitation payment received by the MCO in the contract year for which the measure was selected.

If the MCO's performance on a measure chosen for the QIP declines below the MCO's specific baseline, the MCO will be penalized one-quarter of one percent of the total capitation payment received by the MCO in the year for which the measure was selected.

Provide a response to the following:

- Q68.** *Describe your proposed Quality Management Program for your New Hampshire offering.*
- Q69.** *While DHHS will be choosing measures, describe how you would select measures to include in the QIP and offer recommendations of measures to include.*
- Q70.** *Describe how you recommend DHHS establish improvement goals.*
- Q71.** *Please provide your strategy for improving the following measures in the first year of the contract and over the longer term. Four of the below measures will be chosen by DHHS prior to contract finalization as part of the quality incentive payment program for year 1. It is the intent of the Department to require member Satisfaction to be one of the four.*
  - *Member Satisfaction (overall plan, call abandonment/timeliness) from CAHPS*
  - *Smoking Cessation Among Pregnant Women*
  - *Coordination of Care for Children With Chronic Conditions Composite from CAHPS*
  - *Shared Decision Making Composite from CAHPS*
  - *Adolescent Well Care Visits*



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- *Follow up after Hospitalization for mental illness (7 days and 30 days)*
- *Cholesterol Management for Patients with Cardiovascular Conditions*
- *Reduction in child & adult BMI*

### 3.13. **Early Periodic Screening, Diagnosis and Treatment**

The MCO shall provide Early Periodic Screening, Diagnosis and Treatment (EPSDT) services to Medicaid children less than twenty-one (21) years of age, in compliance with all requirements found below.

The MCO shall comply with sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and federal regulations at 42 C.F.R. §441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The MCO shall comply with all EPSDT requirements.

The MCO shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the periodicity schedules. The EPSDT Plan shall emphasize outreach and compliance monitoring for children and adolescents (young adults), taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population. The plan shall include procedures for follow-up of missed appointments, including missed Referral appointments for problems identified through screens and exams. The plan shall also include procedures for referral, tracking and follow up for annual dental examinations and visits. The MCO shall submit its EPSDT Plan to DHHS for review and approval as updated.

The MCO shall ensure providers perform a full EPSDT (Early and Periodic Screening Diagnostic and Treatment) visit according to the periodic schedule approved by DHHS. The visit must include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements, and health education/anticipatory guidance. All five (5) components must be performed for the visit to be considered an EPSDT visit.

Provide a response to the following:

*Q72. Describe your plan to meet the EPSDT requirements of this RFP.*



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### 3.14. Utilization Management

The MCO has the flexibility to implement and manage its own utilization management policies, procedures, and criteria. However, its utilization management policies, procedures, and criteria must be approved by DHHS.

Because some cases and authorizations will be open/in progress at the time a member transitions from FFS to an MCO, there will be a 90-day grace period where the current authorization will remain valid, while the MCO evaluates the case and incorporates it into its own Utilization Management program.

Provide responses to the following:

- Q73.** *Describe your approach to utilization management, including:*
- *Lines of accountability for utilization policies and procedures and for individual medical necessity determinations;*
  - *Data sources and processes used to determine which services require prior authorization and how often these requirements will be re-evaluated;*
  - *Process and resources to develop utilization review criteria, as well as specifically address how you use clinical evidence and comparative effectiveness research in the management of utilization and your approach when such evidence or research is insufficient or absent in the medial literature;*
  - *Prior authorization processes for members requiring services from non-participating providers;*
  - *Prior authorization processes for members who require expedited prior authorization review and determination due to conditions that threaten the member's life or health; and*
  - *Processes to ensure consistent application of criteria by individual clinical reviewers.*
- Q74.** *Describe how you identify provider utilization patterns to improve care and reduce costs.*
- Q75.** *Describe how under-utilization, over-utilization, and inappropriate utilization of services are detected and monitored, as well as processes to address opportunities for improvement.*
- Q76.** *Describe the type of personnel responsible for each level of utilization management, including prior authorization and decision-making. Provide a narrative description of your prior authorization processes.*
- Q77.** *Describe your process for emergency department utilization review and identification of members with high utilization. What strategies to reduce high emergency department utilization will you implement?*
- Q78.** *Describe your methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with utilization management policies and procedures.*



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*Q79. Describe your management techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable hospitalization and hospital readmissions. Describe your strategy moving forward to improve performance in this area.*

### 3.15. Data Reporting Requirements

#### 3.15.1. Encounter Data

The MCO shall ensure that Encounter Records are consistent with the DHHS requirements and all applicable state and federal laws. The MCO shall have a computer and data processing system sufficient to accurately produce the data, reports, and Encounter record set in formats and timelines prescribed by DHHS as defined in the Contract. The system shall be capable of following or tracing an Encounter within its system using a unique Encounter Record identification number for each Encounter. At a minimum, the MCO shall be required to electronically provide Encounter Record as specified by DHHS. Encounter Record shall follow the format, data elements and method of transmission specified by DHHS. The MCO shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounter Records in accordance with guidelines defined by DHHS in writing. The MCO shall also use appropriate provider numbers for Encounter Records as directed by DHHS.

All subcontracts with providers or other Bidders of service shall have provisions requiring that Encounter Records are reported or submitted in an accurate and timely fashion.

*Q80. Provide relevant reports from at least two other states describing accuracy and timely submission of encounters.*

### 3.16. Grievance and Appeals

The MCO must develop, implement and maintain a system for tracking, resolving, and reporting member Complaints regarding its services, processes, procedures, and staff. The MCO shall also have a Grievance and Appeal system in place that includes a Grievance process, an Appeal of Adverse Action process, and an escalation process to the DHHS Administrative Appeals Unit. The full details of the requirements for grievance and appeals, as well as complaints will be provided in the MCO Contract.

- a) The MCO(s) shall have protocol for a provider to appeal a decision on any component of a claim or retrospective review, which results in the denial of a claim, and the ability to carry out said appeal process.
- b) All providers shall receive denial notices sent by the Contractor, which shall include information specifying the reason for the denial, along with a description of the process for a provider to request a reconsideration of the determination. The reconsideration review shall be conducted by a (physician) reviewer who was not



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involved with the initial determination. If the initial decision is upheld, the MCO(s) shall issue a final denial notice, which shall include information regarding their rights to request an administrative fair hearing through the New Hampshire Medicaid Administrative Appeals Unit.

- c) The MCO(s) shall provide copies of any/all medical records reviewed for decisions made, reviewers' notations, case summaries, and any other documentation deemed necessary by the Department's hearing staff to justify the decision made by the MCO(s) and/or its physician reviewer(s) to support the Department in hearings or appeals, which shall include witness testimony, if requested by DHHS, for any investigation, appeal, or court proceedings emanating from a review of a Medicaid provider by the MCO(s)
- d) Any and all additional or associated costs incurred by the MCO(s), shall be the sole responsibility of the MCO(s).

### Member Appeal

- a) The MCO(s) shall provide each member with written instructions regarding their rights to an appeal within a timeframe established by DHHS.
- b) The MCO(s) shall respond to each appeal request within a timeframe, which shall be determined between DHHS and the MCO(s).
- c) The MCO(s) final decision of all member appeals shall be made by a (physician) reviewer who was not involved with the initial coverage determination.
- d) The MCO(s) shall provide each member with a decision outcome, along with information for each member, regarding the DHHS appeal process in the event of an adverse outcome within a timeframe established by DHHS and the MCO(s).

Provide a response to the following:

**Q81.** *Describe your complaint and grievance process specifically addressing:*

- *Compliance with State requirements*
- *Levels of review and timing*
- *Process for expedited review*
- *How complaints and grievances are tracked and trended and how you use the data to make changes to procedures and processes*



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### 3.17. **Fraud and Abuse**

DHHS is committed to program integrity and detecting/preventing fraud and abuse among providers and members affiliated with the program. The MCO shall have a program integrity plan in place, that has been approved by DHHS, which shall include at a minimum, the establishment of internal controls, policies, and procedures as a means of preventing, detecting, and deterring fraud, waste, and abuse, as required in accordance with 42 C.F.R. §455, 42 C.F.R. §456, and 42 C.F.R. §438.

#### *Communication*

The MCO shall have in place:

- a) Written policies, procedures, and standards of conduct that articulate the organization's adherence to comply with all applicable federal and state, rules and regulations.
- b) A compliance officer and a compliance committee that is accountable to senior management.
- c) A process to report physical/sexual/emotional abuse of enrollees by providers to appropriate State agency

#### *Affiliations*

- a) The MCO must provide full and complete information on the identity of each person or corporation with an ownership or controlling interest (5%+) in the MCO, or any subcontractor in which the MCO has a 5% or more ownership interest.
- b) The MCO may not knowingly have an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other agreement with debarred individual for the provision of items and services that are significant to the entity's contractual obligation with the State
- c) The MCO may not knowingly have an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities, as a director, officer, partner, or person with beneficial ownership of more than 5% of the MCO's equity.

#### *Encounter/Claims*

- a) As an integral part of the Program Integrity function, and in accordance with 42 C.F.R. §455, 42 C.F.R. §456, and 42 C.F.R. §438, DHHS shall have access to all of the MCO electronic claims data as is available from the MCO current claims system. DHHS shall have the capability of accessing clean, live claim data, along with the ability to download and run their own reports as needed.
- b) The encounter data shall be made available to DHHS (and other State staff) using a reporting system that is compatible with the State's system.



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- c) The MCO and subcontractors will cooperate fully with federal and State agencies in any investigations and subsequent legal actions.
- d) The program integrity program of the MCO shall include a process for Recipient Explanation of Medicaid Benefits.
- e) The MCO shall regularly run algorithms to detect fraud, waste, and abuse.

### *Data and Information the MCO Shall Supply to DHHS*

- a) The MCO shall have a demonstrated and proven effective, overpayment recovery and tracking process, which shall include a means of confirming overpayment estimations, a method regarding how providers will be contacted, and a system it will use for case management and tracking of audit findings, recoveries, and underpayments.
- b) The MCO shall provide DHHS with a quarterly report of all audits in process and completed during the quarter. The timing, format, and mode of transmission will be mutually agreed upon between DHHS and the MCO.
- c) All reports submitted to DHHS shall be developed and submitted in a format and mode of delivery, mutually agreed upon between DHHS and the MCO. The report format at a minimum, shall:
  - 1) Summarize all written and verbal communications with providers;
  - 2) Identify the number of claims targeted for recovery;
  - 3) Identify the number of records requested from each provider;
  - 4) Identify the number of cases with and without overpayments/underpayments;
  - 5) Identify the number and type of letters sent to providers;
  - 6) Identify the number of new appeals;
  - 7) Identify the number of hearings held, determinations and monetary reconciliations;
  - 8) Identify the number of providers audited with identified results;
  - 9) Identify the ICD-9-CM diagnosis and procedure codes billed, (or ICD-10-CM when implemented), for identified recoveries, from high to low;
  - 10) Identify CPT/HCPS codes billed from high to low ; and
  - 11) Identify the dollar amount identified and the dollar amount recovered from the provider or owed the provider.
- d) Ad hoc reports shall be provided, and/or DHHS shall have the capability to download ad hoc reports, as requested by DHHS, at no additional cost to DHHS. DHHS reserves the right to conduct peer reviews of final audits completed by the MCO. The MCO may also be required to meet with DHHS periodically to discuss audit results and make recommendations for program improvements.
- e) The MCO shall provide DHHS with an annual report of all audits in process and completed during the previous year. The report shall consist of an aggregate of all of the quarterly reports, as well as any recommendations by the MCO for future reviews, changes in the review process, or any other findings related to the review of claims for fraud, waste and abuse.
- f) The MCO shall provide DHHS with a final report within thirty (30) days following the termination of the resulting contract. The final report format shall be



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developed jointly by DHHS and the MCOs, and shall consist of an aggregate compilation of the data received in the quarterly reports; as well as a narrative describing:

- 1) Recommended changes to internal controls to minimize erroneous payments;
  - 2) Monies recovered to date and MCO share of those recoveries.
- g) The MCO shall refer all suspected Medicaid fraud and abuse cases to DHHS immediately upon discovery, for referral to the Attorney General's Office, Medicaid Fraud Control Unit.

### *Lock-In Programs*

- a) The MCO shall institute a Pharmacy Lock-In Program for members in accordance with the criteria established and approved by DHHS and the State of New Hampshire DUR Board.
- b) The MCO shall be responsible for performing a minimum of 6 months of claims review on any enrolled members who meet the criteria established by the DUR Board and approved by DHHS.
- c) If following the review, the MCO determines that a member meets the criteria as established and approved in (a) above, the MCO shall refer the case to DHHS for Lock-In status determination.
- d) DHHS shall send the MCO their determination in writing within a time period established between DHHS and the MCO, along with a written explanation (justification).
- e) The MCO shall be responsible for all communication to the member regarding the determination.
- f) MCO's may, with prior approval from the DHHS, implement Lock-In Programs for other medical services.
- g) The MCO shall notify DHHS of any changes to members subject to lock-in programs.
- h) The MCO shall provide DHHS with a monthly report regarding the Pharmacy Lock-In Program. Report format, design, and mode of transmission shall be mutually agreed upon between DHHS and the MCO.

### *Fraud, Waste & Abuse*

- a) The MCO will have in place internal controls, policies, and procedures to prevent and detect fraud and abuse in accordance with 42 C.F.R. §438.
- b) The MCO must report fraud and abuse information to DHHS within 15 days from the date of detection.
- c) The MCO shall provide a quarterly report to include: number of complaints of fraud and abuse made to DHHS that warrant preliminary investigation. For each instance, which warrants investigation, supply: name/ID number, source of complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of case



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- d) DHHS retains the right to determine disposition and retain settlements on cases investigated by the Medicaid Fraud Control Unit.
- e) The MCO will allow access to all medical records and claims information to any State and Federal MCOs (i.e. Recovery Audit MCOs (RAC) or the Medicaid Integrity MCO (MIC)).

### *MCO Responsibility*

- a) The MCO shall have specific processes and internal controls in place, including, but not limited to the following areas:
  - 1) Claims edits;
  - 2) Post-processing review of claims;
  - 3) Prior authorization;
  - 4) Utilization management; and
  - 5) Provider profiling, credentialing, and re-credentialing, including a review process for claims and encounters for providers who are suspected of potential fraud and abuse activities.
- b) The MCO shall post and maintain DHHS approved information on its website, including provider notices, updates, policies, provider resources, contact information, upcoming educational sessions/webinars, etc.
- c) The MCO shall provide follow-up with providers who receive specific training, and include a summary of the outcomes in the annual report that the MCO provide to DHHS.

### *DHHS Responsibility*

- a) The MCO shall be subject to on-site review by DHHS, and shall comply with any and all DHHS documentation and records requests.
- b) DHHS shall conduct investigations related to suspected fraud, waste, and abuse cases, and reserves the right to pursue and retain recoveries for the following types of claims older than six months for which the MCO do not have an active investigation
- c) DHHS and MCO designees shall meet monthly, or more frequently as needed, to discuss areas of interest for past, current, and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities.
- d) DHHS shall validate the MCO performance on the program integrity scope of services via a mutually agreeable process, as set forth in 42 C.F.R. §456 – Utilization Control.
- e) DHHS shall establish performance measures to monitor the MCO compliance with the contract.
- f) DHHS shall attend meetings with the MCO at a frequency determined by the Department and the MCO.
- g) DHHS shall notify the MCO of any policy changes that impact the function and responsibilities required under this section of the contract.
- h) DHHS shall notify the MCO of any changes with its fiscal agent that may impact this section of the contract as soon as reasonably possible.



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Provide responses to the following:

- Q82. *Describe any front-end claims editing/auditing functionality that you are proposing.*
- Q83. *Describe how you propose communicating suspected incidents of fraud to DHHS.*
- Q84. *Describe, in detail, the fraud and abuse program that you will implement including:*
  - *Fraud detection methods that will be used*
  - *Plan for compliance with the Exclusion Program of the United States Department of Health and Human Services Office of the Inspector General or any provider restrictions imposed by the State*
- Q85. *Describe your experience with fraud recovery collection. Provide any empirical evidence of your collection success rate when fraud is identified.*
- Q86. *Describe your experience administering provider and pharmacy lock-in programs. Include any empirical evidence on their effectiveness.*
- Q87. *Besides lock-in programs, describe other fraud and abuse prevention programs that you would propose to operate across the FFS program and the MMI.*
- Q88. *Describe any internal training programs that your MCO uses to train employees to recognize and report patterns of fraud and abuse.*
- Q89. *Describe how you engage members in preventing fraud and abuse.*

### 3.18. **Third-Party Liability**

By law, Medicaid is the payer of last resort and shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. If a Member has Third Party resources available for payment of expenses associated with the provision of Covered Services, such resources are primary to the coverage provided by the MCO and must be exhausted prior to payment by the MCO. The MCO must establish a file transfer protocol between the Medicaid MMIS and their system to receive Medicare and private insurance information. The MCO shall develop a third-party cost avoidance and pay and chase plan to ensure payers have been held responsible for payment of services. The plan will include, but not be limited to the following:

- a) The MCO shall be responsible for cost avoiding claims covered by third party and retroactive billing pursuant to 42 C.F.R. §433.138. Such activity will include, but not be limited to;
  - 1) Actively pursue, collect and retain all monies available from all available resources for services to members under this Contract except where the amount of reimbursement the MCO can reasonably expect to receive is less than estimated cost of recovery.
  - 2) Cost effectiveness of recovery is determined by, but not limited to, time, effort, and capital outlay required in performing the activity. The MCO shall specify the threshold amount or other guidelines used in determining



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whether to seek reimbursement from a liable third party, or describe the process by which the MCO determines seeking reimbursement would not be cost effective. The MCO shall provide the guidelines to DHHS for review and approval. DHHS may pursue any reimbursements below the approved threshold.

- 3) COB collections are the responsibility of the MCO or its Subcontractors.
  - 4) Subcontractors must report COB information to the MCO.
  - 5) MCO and Subcontractors shall not pursue collection from the member but rather directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to COB collection.
  - 6) Reviewing claims for accident and trauma codes as required under 42 C.F.R. §433.138 (e). The MCO shall specify the guideline used in determining accident and trauma claims and establish a procedure to send letters to Medicaid members to follow up on claims. Return of these letters is to be sent to DHHS for determination of an accident and trauma case. The MCO shall provide the guidelines and procedures to DHHS for review and approval.
  - 7) Defending or assisting in the defense of the State in matters appealed to the Administrative Appeals Unit or judicial process.
- b) DHHS shall be responsible for:
- 1) Medicare and Insurance verification and submitting this information to the MCO
  - 2) Cost avoidance and pay and chase of those services that are excluded from MCO
  - 3) Accident and trauma settlements
  - 4) Mail order pharmacy program
  - 5) Veterans Administration benefit determination
  - 6) Health Insurance Premium Payment Program
  - 7) Audits of MCO collection efforts and recovery
- c) All funds recovered by the MCO from Third Party Resources shall be treated as income to the MCO to be used for eligible expenses under the Contract.
- d) The MCO and all providers in the MCO's network are prohibited from directly receiving payment or any type of compensation from the member, except for member co-pays or deductibles from members for providing Covered Services. Member co-pay, co-insurance or deductible amounts cannot exceed amounts specified in federal and state law.
- e) DHHS shall have access to information related to private insurance, amounts billed, amounts not collected, and denials.
- f) The MCO must establish an electronic exchange of detail claim history on a request basis for specific Medicaid members with specific dates of service date range for accident and trauma cases and any legal action that may require claim data.



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- g) DHHS reserves the right to pursue and retain recoveries for the following types of claims:
  - 1) Claims older than six months for which the MCO has not already initiated third party liability recovery efforts
  - 2) Any reimbursement below the approved specified threshold 1. (b) above
  - 3) Settlements related to accident and trauma cases when Medicaid recipients are injured in a car or work place accident, or other incident such as a fall and where a third party liability can be determined
- h) The MCO shall be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. DHHS has the right to review all billing histories and other data related to COB activities for members.
- i) The MCO shall maintain records of all COB collection efforts and results and report such information either through electronic data transfers monthly or access rights by State OII staff to MCOs data files. The data extract shall be in a delimited text format. Data elements may be subject to change during the course of the contract. The MCO will make every effort to accommodate changes required.
- j) DHHS will require a detailed claim history of all paid claims based on a specific service date parameter requested and this data shall be in a delimited text format. The claim history needs to have the following data elements:
  - 1) Medicaid member name
  - 2) Medicaid member ID
  - 3) Dates of service
  - 4) Claim unique identifier (transaction code number)
  - 5) National Diagnosis code
  - 6) Diagnosis code description
  - 7) National Drug code
  - 8) Drug code description
  - 9) Amount billed by the provider
  - 10) Amount paid by Medicaid
  - 11) Amount of other insurance recovery
  - 12) Date claim paid
  - 13) Performing provider
- k) DHHS will require a monthly file of COB collection effort and results. This data shall be in a delimited text format. The file should contain the following data elements:
  - 1) Medicaid member name
  - 2) Medicaid member ID
  - 3) Insurance Carrier, PBM, or benefit administrator ID
  - 4) Insurance Carrier, PBM, or benefit administrator Name
  - 5) Date of Service
  - 6) Claim unique identifier (transaction code number)
  - 7) Date billed to the insurance carrier, PBM, or benefit administrator
  - 8) Amount billed
  - 9) Amount recovered



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- 10) Denial reason code
  - 11) Denial reason description
  - 12) Performing provider
- l) DHHS will require a monthly file of detail claims data. This data shall be in a delimited text format. The file should contain the following data elements:
- 1) Medicaid member name
  - 2) Medicaid member ID
  - 3) Medicaid member date of birth
  - 4) Medicaid member address
  - 5) Referring provider name
  - 6) Referring provider NPI
  - 7) Rendering (attending) provider name
  - 8) Rendering (attending) provider NPI
  - 9) Rendering provider address
  - 10) Dates of service
  - 11) Place of service code
  - 12) Type of bill code (hospital only claims)
  - 13) Revenue code (hospital only claims)
  - 14) Admission date and time (hospital only claims)
  - 15) Occurrence codes (hospital only claims)
  - 16) Occurrence date (hospital only claims)
  - 17) Admission national diagnosis code (hospital only claims)
  - 18) Source of admission code (hospital only claims)
  - 19) Discharge hour (hospital only claims)
  - 20) Patient discharge status code (hospital only claims)
  - 21) National Procedure code
  - 22) Procedure code description
  - 23) National diagnosis code
  - 24) Diagnosis code description
  - 25) Amount provider charged
  - 26) Amount Medicaid paid

### Records

- m) Records - Retention – The MCO(s) shall retain records in accordance with 45 C.F.R. §74 (3 years after final payment is made and all pending matters closed, or if an audit, litigation, or other legal action involving the records is started before or during the original 3-year period until all litigation, claims, or audit findings involving the records have been resolved and final action taken). 42 C.F.R. §434.6(a)(7) 45 C.F.R. §74.53, §92.36(i)(11)
- n) The MCO(s) shall maintain appropriate record systems for services to members pursuant to 42 C.F.R. §434.6(a)(7) and shall provide such information either through electronic data transfers or access rights by DHHS staff to MCO(s) data files. Such information shall include, but not be limited to:
- 1) Recipient – First Name, Last Name, DOB and identifying number
  - 2) Provider Name and number (Performing and Referring)



## New Hampshire Medicaid Care Management Program

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- 3) Date of Service(s) Begin/End
- 4) Place Of Service
- 5) Billed amount/Paid amount
- 6) Paid date
- 7) Standard diagnosis codes (ICD-9), procedure codes (CPT/HCPCS), revenue codes and DRG codes, billing modifiers (include ALL that are listed on the claim)
- 8) Paid and denied claims
- 9) Recouped claims
- 10) Discharge status
- 11) Present on Admission (POA)
- 12) Length of Stay
- 13) Claim Type
- 14) Prior Authorization Information
- 15) Detail claim information vs. Summary information
- 16) Provider type
- 17) Category of Service
- 18) Admit time
- 19) Admit code
- 20) Admit source
- 21) Covered days
- 22) TPL information
- 23) Units of service
- 24) EOB

\*\*Data must be clean, not scrubbed. Any other data deemed necessary by DHHS

Provide responses to the following:

- Q90. Describe your TPL recovery experience. Provide empirical evidence of your collection percentage against TPL identification.*
- Q91. Describe how you will maximize the identification and recovery of TPL.*
- Q92. Describe your method and process for capturing third-party resource and payment information from your claims system.*
- Q93. Describe the process you use for retrospective post-payment recoveries of health-related insurance, as well as your process for adjudicating a claim involving an auto accident.*
- Q94. Describe your collection rate of TPL when a third-party payer is identified.*
- Q95. Describe your process for sharing TPL information with DHHS.*

Because some cases will still be open when managed care begins, DHHS will continue to collect on cases that were filed prior to the “go-live” date. The MCO shall collect on cases filed after the “go-live” date.



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### 3.19. Administrative Quality Assurance Standards

New Hampshire DHHS is committed to continuous quality improvement and expects its MCOs to routinely monitor the accuracy of claims processing against quality assurance benchmarks.

Within its current operations, DHHS's claims quality unit conducts monthly reviews of statistically valid samples of claims to measure dollar financial accuracy, payment accuracy, and processing accuracy. In addition, as required by CMS, New Hampshire DHHS participates in the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs to identify improper payments.

#### 3.19.1. Claims Payment Standards

New Hampshire DHHS expects MCOs to process and pay claims submitted by contracted and non-contracted providers on a timely basis, pursuant to 42 USC 1396a(a)(37) and regulations promulgated thereunder. To support this objective and minimize the potential to adversely impact members and providers, DHHS has established the following requirements:

- The MCO shall pay or deny 95% of clean claims within 30 days of receipt
- The MCO shall pay interest on any clean claims that are not paid within 30 days at the interest rate published in the *Federal Register* in January of each year for the Medicare program
- The MCO shall pay or deny all claims within 60 days of receipt

For purposes of this requirement, New Hampshire DHHS has adopted the "clean" claim definition established by CMS under the Medicare program, which is as follows: "a clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment."

Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom or an electronic claim is submitted. The paid date is the date a payment check or electronic funds transfer is issued to the service provider. The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

#### 3.19.2. Quality Assurance Program

The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MMIS and report results to DHHS on a monthly basis. Monthly reporting shall be based on a review of a statistically valid sample of paid and denied claims determined with a 95% confidence level, +/- 3%, assuming an error rate of 3% in the population of managed care claims.



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DHHS will review and approve the MCO's quality assurance program, including sampling methodology, definitions of errors, and performance measure calculation methodology.

The MCO shall implement corrective action plans to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

### 3.19.3. **Claims Financial Accuracy**

Claims financial accuracy measures the accuracy of dollars paid to providers. It is generally measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims. The MCO shall pay 99% of dollars accurately.

### 3.19.4. **Claims Payment Accuracy**

Claims payment accuracy measures the percentage of claims paid or denied correctly. It is generally measured by dividing the number of claims paid/denied correctly by the total claims reviewed. The MCO shall pay 97% of claims accurately.

### 3.19.5. **Claims Processing Accuracy**

Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is generally measured by dividing the total number of claims processed correctly by the total number of claims reviewed. The MCO shall process 95% of all claims correctly.

Provide responses to the following:

- Q96.** *Describe your internal claims quality review program, including staffing, type and frequency of reviews, sampling methodologies, definitions of errors, performance measure calculations, and performance standards.*
- Q97.** *Provide the results of your internal claims quality review program for the past 12 months.*
- Q98.** *Describe any failures to meet claims accuracy standards for any of your contracts over the last two years that resulted in not meeting your service level agreements with your customers. Describe the steps you took to correct these situations.*
- Q99.** *Describe any other administrative quality assurance monitoring conducted by your organization.*
- Q100.** *Describe your processes and procedures to monitor claims payment timeliness, including operational monitoring reports and business practices employed to monitor and address aging claims.*
- Q101.** *Describe the current claims payment timeliness standards used within your organization.*



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*Q102. Provide your organization's actual performance for the last 12 months in relation to your claims payment timeliness standard.*

*Q103. Describe the system you use to process claims.*

### 3.20. Delegation and Subcontractors

DHHS recognizes that the MCO may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the MCO shall retain the responsibility and accountability for the function(s). The MCO shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual and RFP requirements as the MCO and the MCO is responsible to ensure subcontractor compliance with those requirements.

When the MCO delegates a function to another organization, the MCO shall do the following:

- Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
- Have a written agreement with the delegate that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the delegate's performance is not adequate
- Monitor the delegates' performance on an ongoing basis
- Provide to DHHS an annual schedule identifying subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
- Audit their care systems annually

DHHS shall review and approve all subcontractors.

If the MCO identifies deficiencies or areas for improvement are identified, the MCO shall take corrective action.

Provide responses to the following:

*Q104. Describe your subcontracting plan, in detail, if you intend to subcontract with other entities to perform portions of the Scope of Work.*

*Q105. List the names and addresses of the Subcontractors to be used, as well as their location(s).*

*Q106. Describe the services that the Subcontractor will provide and provide evidence of their experience providing those services.*



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- Q107. Describe how you will monitor the performance of your subcontractors to ensure all RFP and Sample Contract requirements are met. Provide sample reports showing any actions taken to improve performance and ensure positive results.*
- Q108. Describe data you will transfer with your subcontractor(s) and how that data will be transferred.*
- Q109. Describe how subcontractors are integrated with your care management programs.*
- Q110. Describe how subcontractors are integrated with your TPL and fraud and abuse programs.*
- Q111. Describe any sanctions or penalties that apply if the subcontractor fails to perform up to the expectations of your organization. Attach sample performance monitoring reports.*

### 3.21. **Privacy and Security of Member Information**

DHHS is the designated owner of all data and shall approve all access to that data. The MCO shall not have ownership of State data at any time. The MCO shall be in compliance with privacy policies established by governmental agencies or by state or federal law. Privacy policy statements may be developed and amended from time to time by the State and will be appropriately displayed on the State portal. The MCO shall provide sufficient security to protect the State and DHHS data in network, transit, storage and cache.



### 4. RFP EVALUATION

#### 4.1. **Technical Proposal**

The Technical Proposal will be worth 70 of the 100 potential evaluation points.

The Following topic areas of the RFP will be scored as part of the Technical response:

1. Services and Populations
2. Pharmacy Management
3. Member Enrollment, member Services and Cultural Considerations
4. Access and network Management
5. Payment Reform
6. Behavioral Health
7. Care Management
8. Quality Management
9. EPSDT
10. Utilization Management
11. Administrative Functions

#### 4.2. **Cost Proposal**

The Cost proposal will be worth 30 of the 100 potential evaluation points. More description of the cost proposal scoring process will be provided when the data book is released.



### 5. PROPOSAL PROCESS

#### 5.1. **Contact Information: - Sole Point of Contact**

The sole point of contact, the Procurement Coordinator, for this RFP relative to the bid or bidding process for this RFP, from the RFP issue date until the selection of a Bidder, and approval of the resulting Contract by the Governor and Executive Council is:

State of New Hampshire  
Department of Health and Human Services  
Walter Faasen  
Director of Contracts & Procurement  
Brown Building  
129 Pleasant St.  
Concord, New Hampshire 03301  
Email: [wfaasen@dhhs.state.nh.us](mailto:wfaasen@dhhs.state.nh.us)  
Fax: 603-271-4232  
Phone: 603-271-7367 (until 10/31/2011)  
603-271-9405 (from 11/01/2011)

Other personnel are NOT authorized to discuss this RFP with Bidders before the proposal Submission deadline. Contact regarding this RFP with any State personnel not listed above could result in disqualification. The State will not be held responsible for oral responses to Bidders regardless of the source.

#### 5.2. **Letter of Intent**

A letter of intent to submit a proposal in response to this RFP must be received by the date and time identified in Section 5.5: Procurement Timetable.

Receipt of the Letter of Intent by DHHS will be required in order to receive any correspondence regarding this RFP, any RFP amendments in the event such are produced, or any further materials on this project, including electronic files containing tables required for response to this RFP, any addenda, corrections, schedule modifications, or notifications regarding any informational meetings for bidders, or responses to comments or questions.

The Letter of Intent may be transmitted by e-mail to [wfaasen@dhhs.state.nh.us](mailto:wfaasen@dhhs.state.nh.us), but must be followed by delivery of a paper copy within two (2) business days to the procurement coordinator identified in 5.1.

The potential bidder is responsible for successful e-mail transmission. DHHS will provide confirmation if the name and e-mail address or fax number of the person to receive such confirmation is provided.

The Letter of Intent must include the name, telephone number, mailing address and e-mail address of the Bidder's designated contact to which DHHS will direct correspondence.



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Proposals submitted by entities that did not submit a Letter of Intent shall not be considered.

### 5.3. **Bidders' Questions and Answers**

#### 5.3.1. **Bidders' Questions**

All questions about this RFP, including but not limited to requests for clarification, additional information or any changes to the RFP must be made in writing, citing the RFP page number and part or subpart, and submitted to the Procurement Coordinator identified in Section 5.1.

DHHS may consolidate or paraphrase questions for efficiency and clarity. Questions that are not understood will not be answered. Statements that are not questions will not receive a response.

Questions will only be accepted from those Bidders who have submitted a Letter of Intent by the deadline given in Section 5.5, Procurement Timetable. Questions from all other parties will be disregarded. DHHS will not acknowledge receipt of questions.

The questions may be submitted by fax or e-mail; however, DHHS assumes no liability for assuring accurate and complete fax and e-mail transmissions.

Questions must be received by the deadline given in Section 5.5 Procurement Timetable.

#### 5.3.2. **Vendors' Conferences**

##### **5.3.2.1. *Technical Proposal Conference***

The Vendors' Technical Proposal Conference will be held on the date specified in Section 5.5 Procurement Timetable, in the Auditorium in the Brown Building, 129 Pleasant Street, Concord, New Hampshire. The conference will serve as an opportunity for Vendors to ask specific questions of State staff concerning the technical requirements of the RFP.

Attendance at the Vendors' Technical Conference is not mandatory, but highly recommended. Contact the Procurement Coordinator to register for the Technical Proposal Conference.



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### **5.3.2.2. Cost Proposal Conference**

The Vendors' Cost Proposal Conference will be held on the date specified in Section 5.5 Procurement Timetable, in the Auditorium 29 Hazen Drive, Concord, New Hampshire. The conference will serve as an opportunity for Vendors to ask specific questions of State staff concerning the cost requirements of the RFP.

Attendance at the Vendors' Cost Conference is not mandatory, but highly recommended. Contact the Procurement Coordinator to register for the Cost Proposal Conference.

Vendors may attend the Cost Proposal Conference via webinar. Contact the Procurement Coordinator, specified in 5.1, for information about attending this webinar.

### **5.3.3. DHHS Answers**

DHHS intends to issue responses to properly submitted questions one week after the respective conferences (Technical and Cost). Oral answers given at the conference are non-binding. Written answers to questions asked at the respective conferences will be posted on the DHHS Public website (<http://www.dhhs.nh.gov/business/rfp/index.htm>) and sent as an attachment in an e-mail to the contact identified in accepted Letters of Intent. This date may be subject to change at DHHS's discretion.

### **5.4. RFP Amendment**

DHHS reserves the right to amend this RFP, as it deems appropriate prior to the proposal submission deadline on its own initiative or in response to issues raised through Vendor questions. In the event of an amendment to the RFP, DHHS, at its sole discretion, may extend the proposal submission deadline. Vendors who submitted a Letter of Intent will receive notification of the amendment, and the amended language will be posted on the DHHS Internet site.



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### 5.5. Procurement Timetable

Procurement Timetable		
Item	Action	Date
1.	Release RFP	10/15/2011
2.	Mandatory Letter of Intent	10/26/2011
3.	RFP Technical questions due	10/26/2011
4.	Release databook	11/01/2011
5.	RFP Technical Proposal Conference	1:00-5:00pm 11/03/2011
6.	DHHS answers to Technical questions posted	11/10/2011
7.	RFP Cost questions due	11/14/2011
8.	RFP Cost Proposal Conference	1:30-4:30pm 11/17/2011
9.	DHHS answers to Cost questions posted	11/23/2011
10.	Technical and Cost Bids due at DHHS	by 4:00pm 12/16/2011
11.	Tentative Oral Presentations and Interviews	1/3/2012-1/6/2012
12.	Anticipated selection of successful Bidder	1/15/2012
13.	Contract execution	3/08/2012
14.	Anticipated start of contract	7/01/2012

All times are according to Eastern Time.

DHHS reserves the right to modify these dates at its sole discretion.

### 5.6. Proposal Submission

Proposals submitted in response to this RFP must be received no later than the time and date specified in Section 5.5: Procurement Timetable. Proposals must be addressed for delivery to the Procurement Coordinator, as specified in 5.1, and marked with RFP # 12-DHHS-CM-01.

Late submissions will not be accepted and will remain unopened. Disqualified submissions will be discarded if not re-claimed by the bidding Bidder by the time the contract is awarded. Delivery of the Proposals shall be at the Bidder's expense. The time of receipt shall be considered when a Proposal has been officially documented by DHHS, in accordance with its established policies, as having been received at the location designated above. The State accepts no responsibility for mislabeled mail. Any and all damage that may occur due to shipping shall be the Bidder's responsibility.

### 5.7. Non-Collusion

The Bidder's required signature on the Transmittal Cover Letter for a proposal submitted in response to this RFP guarantees that the prices, terms and conditions, and



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services quoted have been established without collusion with other Bidders and without effort to preclude DHHS from obtaining the best possible competitive proposal.

### 5.8. **Validity of Proposal**

Proposals must be valid for two hundred forty (240) days following the Closing Date for receipt of proposals as listed in Part 5.5, Procurement Timetable or until the effective date of any resulting contract, whichever is later. This period may be extended by mutual written agreement between the Bidder and DHHS.

### 5.9. **Property of Department**

All material property submitted and received in response to this RFP will become the property of DHHS and will not be returned to the Bidder. DHHS reserves the right to use any information presented in any proposal provided that its' use does not violate any copyrights or other provisions of law.

### 5.10. **Proposal Withdrawal**

Prior to the Closing Date for receipt of proposals, a submitted Letter of Intent or proposal may be withdrawn by submitting a written request for its withdrawal to Procurement Coordinator identified in Section 5.1.

### 5.11. **Public Disclosure**

A Proposal must remain confidential until the Governor and Executive Council have approved a contract as a result of this RFP. A Bidder's disclosure or distribution of Proposals other than to the State will be grounds for disqualification.

The content of each Bidder's proposal and addenda thereto will become public information once the Governor and Executive Council have approved a contract. Insofar as a Bidder seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the Bidder must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. Each Bidder acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by a Bidder as confidential, DHHS shall notify the Bidder and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the Bidder's responsibility and at the Bidder's sole expense. If the Bidder fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the Bidder without incurring any liability to the Bidder.



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### 5.12. **Non-Commitment**

Notwithstanding any other provision of this RFP, this RFP does not commit DHHS to award a Contract. DHHS reserves the right to reject any and all proposals or any portions thereof, at any time and to cancel this RFP and to solicit new proposals under a new bid process.

### 5.13. **Liability**

By submitting a Letter of Intent to submit a proposal in response to this RFP, a Bidder agrees that in no event shall the State be either responsible for or held liable for any costs incurred by a Bidder in the preparation or submittal of or otherwise in connection with a proposal, or for work performed prior to the Effective Date of a resulting contract.

### 5.14. **Request for Additional Information or Materials**

During the period from date of proposal submission to the date of Contractor selection, DHHS may request of any Bidder additional information or materials needed to clarify information presented in the proposal. Such a request will be issued in writing and will not provide a Bidder with an opportunity to change, extend, or otherwise amend its proposal in intent or substance. Key personnel shall be available for interviews.

### 5.15. **Oral Presentations and Discussions**

DHHS reserves the right to require some or all Bidders to make oral presentations of their proposal. Any and all costs associated with an oral presentation shall be borne entirely by the Bidder. Bidders may be requested to provide demonstrations of any proposed automated systems. Such a request will be in writing and will not provide a Bidder with an opportunity to change, extend, or otherwise amend its proposal in intent or substance.

### 5.16. **Contract Negotiations and Unsuccessful Bidder Notice**

If a Bidder(s) is selected, the State will notify the Successful Bidder(s) in writing of their selection and the State's desire to enter into contract negotiations. Until the State successfully completes negotiations with the selected Bidder(s), all submitted Proposals remain eligible for selection by the State. In the event contract negotiations are unsuccessful with the selected Bidder(s), the evaluation team may recommend another Bidder(s).

### 5.17. **Scope of Award and Contract Award Notice**

DHHS reserves the right to award a service, part of a service, group of services, or total proposal and to reject any and all proposals in whole or in part. The notice of the intended contract award will be sent by certified mail or overnight mail to the selected Bidder. A contract award is contingent on approval by the Governor and Executive Council.



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If a Contract is awarded, the Bidder must obtain written consent from the State before any public announcement or news release is issued pertaining to any Contract award.

### 5.18. **Site Visits**

DHHS reserves the right to request a site visit for DHHS Staff to review Vendor's organization structure, subcontractors, policy and procedures, and any other aspect of the proposal that directly affects the provisions of the RFP and the delivery of services. Any and all costs associated with the site visits incurred by the bidder shall be borne by the bidder.

Prior to implementation, DHHS reserves the right to make a pre-delegation audit by DHHS staff to the bidders site to determine that the bidder is prepared to initiate required activities. Any and all costs associated with this pre-delegation visit shall be borne by the bidder.

After executing the contract resulting from this Procurement, but prior to the contractors providing any services to enrollees, DHHS will review the contractors' readiness to begin providing services. The review will be to determine whether the contractors are carrying-out their implementation plans as submitted in response to this procurement. If DHHS determines that any contractor will not be ready to begin services on July 1, 2012, it may, at its sole discretion, withhold enrollment and require corrective action or terminate the Contract.

### 5.19. **Protest of Intended Award**

Any protests of intended award or otherwise related to the RFP, shall be governed by the appropriate State requirements and procedures and the terms of this RFP. In the event that a legal action is brought challenging the RFP and selection process, and in the event that the State of New Hampshire prevails, the Bidder agrees to pay all expenses of such action, including attorney's fees and costs at all stages of litigations. Legal action shall include administrative proceedings.

### 5.20. **Contingency**

Award of contract is contingent on Bidder having a license from the New Hampshire Department of Insurance to operate as an HMO in the State of New Hampshire. Aspects of the award may be contingent upon changes to State or federal laws and regulations.



## 6. PROPOSAL OUTLINE AND REQUIREMENTS

### 6.1. Overview

Proposals must conform to all instructions, conditions, and requirements included in the RFP.

Bidders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal are at the Bidder's risk and may, at the discretion of the State, result in disqualification of the Proposal for nonresponsiveness. Acceptable Proposals must offer all services identified in Section 3 - Statement of Work and agree to the contract conditions specified throughout the RFP.

Bidders must provide an overview of their understanding of the Medicaid Care Management requirements as specifically identified or implied in this RFP. A statement must be included specifying the Bidder's acceptance of the contractual specifications set forth in Part 2, Background and Required Services and Part 3, Statement of Work.

### 6.2. Presentation and Identification

The Bidder must submit Proposals on standard eight and one-half by eleven inch (8 ½" x 11") white paper. The Bidder must use a font size of 12 or larger. The Bidder must Submit Proposals in separate three-ring binders as specified in the RFP. The Bidder must provide tabs separating the major sections of the Proposal, and must note the name of the company/organization and RFP # on the front cover.

#### Contents of Binders

- The original, eight (8) hard copies and two (2) electronic copies of the Technical Proposal and Addenda to the Technical Proposal shall be submitted under sealed cover and labeled on the outside as follows:  
"New Hampshire Care Management Technical Proposal and Addenda  
RFP # 12-DHHS-CM-01."
- The original, eight (8) copies and two (2) electronic copies of the Cost Proposal under sealed cover and labeled on the outside as follows:  
"New Hampshire Care Management Cost Proposal and Addenda  
RFP # 12-DHHS-CM-01."
- Proposals should be received by December 16, 2011 and delivered to Procurement Coordinator identified in Section 5.1
- The original copy of each proposal shall include a Transmittal Cover Letter, in the manner described in Section 6.4., signed by an official authorized to legally bind the Bidder and shall be marked: "Original." All others shall be marked "Copy." Signature: the proposal must be signed in the manner described on the Transmittal Cover Letter in order to be accepted for consideration.



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- Fax or email copies will not be accepted
- The electronic copy must be divided into folders that correspond to and are labeled the same as the hard copies
- In the event of any discrepancy between the copies, the hard copy marked "Original" will control.

### 6.3. **Outline**

The Proposal shall follow the outline described below and is required to contain all listed components as follows:

- Transmittal Cover Letter
- Table of Contents
- Executive Summary
- Proposal Narrative, Project Approach, and Technical Response (not to exceed one hundred (100) pages)
- Description of Organization
- Bidder's References
- Statement of Bidder's Financial Condition
- Performance Bond and Insurance
- Bidder's Staff and Resumes
- Subcontractor Letters of Commitment (if applicable)
- Addenda to Technical Proposal
- License, Certificates and Permits as Required
- Required Attachments
- Affiliations – Conflict of Interest statement
- Cost Proposal (in separate binder; information on format of the cost proposal will be provided when the data book is released.

### 6.4. **Content Description**

Responses to this RFP must consist of all of the following components. (See the following sections for more detail on each component.) Each of these components must be separate from the others and uniquely identified with labeled tabs.

#### **Transmittal Cover Letter**

A Transmittal Cover Letter must accompany the technical proposal and the cost proposal on the Bidding Company's letterhead and each must be signed by an individual who is authorized to bind the Bidding Company to all statements, including



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services and prices contained in the proposal. The Transmittal Cover Letter must be the first page of the Proposal and must also accomplish the following:

- Identify the submitting organization
- Identify the name, title, mailing address, telephone number and email address of the person authorized by the organization to contractually obligate the organization
- Identify the name, title, mailing address, telephone number and email address of the fiscal agent of the organization
- Identify the name, title, telephone number, and e-mail address of the person who will serve as the Bidder's representative for all matters relating to the RFP
- Acknowledge that the Bidder has read this RFP, understands it, and agrees to be bound by its requirements
- Explicitly state acceptance of terms, conditions, and general instructions stated in Part 9 Mandatory Business Specifications, Contract Terms and Conditions
- Confirm that Appendix XXXXX Exceptions to Terms and Conditions is included in the proposal
- Explicitly state that the *Bidder's* submitted Proposal is valid for a minimum of two hundred forty (240) days from the Closing Date for receipt of proposals
- Date proposal was submitted
- Signature of authorized person

### **Table of Contents**

The required elements of the Proposal shall be numbered sequentially and represented in the Table of Contents.

### **Executive Summary**

The Bidder shall submit an executive summary to provide DHHS with an overview of the bidder's organization and what is intended to be provided by the Bidder. This component of the proposal should demonstrate the Bidder's understanding of the services requested in this RFP and any problems anticipated in accomplishing the work. The Executive Summary should also show the Bidder's overall design of the project in response to achieving the deliverables as defined in this RFP. Specifically, the proposal should demonstrate the Bidder's familiarity with the project elements, its solutions to the problems presented and knowledge of the requested services.

## 6.5. **Proposal Narrative, Project Approach, and Technical Response**

The Bidder must answer all questions and must include all items requested for the proposal to be considered. The Bidder must address every section of Section 3 Statement of Work, even though certain sections may not be scored.

Responses must be in the same sequence and format as listed in Section 3 Statement of Work and must, at a minimum, cite the relevant section, subsection, and paragraph number, as appropriate.



## New Hampshire Medicaid Care Management Program

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### 6.6. Description of Organization

Bidders must include in their Proposal a summary of their company's organization, management and history and how the organization's experience demonstrates the ability to meet the needs of requirements in this RFP.

- At a minimum respond to:
  - General Company Overview
  - Ownership and Subsidiaries
  - Company Background and Primary Lines of Business
  - Number of Employees
  - Headquarters and Satellite Locations
  - Current Project commitments
  - Major Government and Private Sector Clients
  - Mission Statement
  
- This section must include information on:
  - the programs and activities of the organization,
  - the number of people served,
  - programmatic accomplishments.
  
- And also include:
  - reasons why the organization is capable to effectively complete the services outlined in the RFP;
  - all strengths that are considered an asset to the program.
  
- The Bidder should demonstrate:
  - the length, depth, and applicability of all prior experience in providing the requested services;
  - the skill and experience of staff and the length, depth and applicability of all prior experience in providing the requested services.

### 6.7. Bidder's References

The Proposal must include relevant information about at least three (3) similar or related contracts or subcontracts awarded to the Bidder and must also include provider network references and client testimonials. Particular emphasis should be placed on previous contractual experience with government agencies and administrative data sets. DHHS reserves the right to contact any reference so identified. The information must contain the following:

- Name, address, telephone number, and website of the customer
- A description of the work performed under each contract
- A description of the nature of the relationship between the Bidder and the customer



## New Hampshire Medicaid Care Management Program

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- Name, telephone number, and e-mail address of the person whom DHHS can contact as a reference
- Dates of performance

### 6.8. **Statement of Bidder's Financial Condition**

The organization's financial solvency will be evaluated. The Bidder's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered.

Each Bidder must submit audited financial statements for the four (4) most recently completed fiscal years that demonstrate the Bidder's organization is in sound financial condition. Statements must include a report by an independent auditor that expresses an unqualified or qualified opinion as to whether or not the accompanying financial statements are presented fairly in accordance with generally accepted accounting principles. A disclaimer of opinion, an adverse opinion, a special report, a review report, or a compilation report will be grounds for rejection of the proposal.

Complete financial statements must include the following:

- Opinion of Certified Public Accountant
- Balance Sheet;
- Income Statement
- Statement of Cash Flow
- Statement of Stockholder's Equity of Fund Balance; and
- Complete Financial Notes
- Consolidating and Supplemental Financial Schedules.

A Bidder, which is part of a consolidated financial statement, may file the audited consolidated financial statements if it includes the consolidating schedules as supplemental information. A Bidder, which is part of a consolidated financial statement, but whose certified consolidated financial statements do not contain the consolidating schedules as supplemental information, shall, in addition to the audited consolidated financial statements, file unaudited financial statements for the Bidder alone accompanied by a certificate of authenticity signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification which attests that the financial statements are correct in all material respects.

The Bidder shall provide all results of any state, federal, or other independent monitoring for the last three years, 2008, 2009, and 2010 of the Bidder's QAPI programs in managed care serving low income populations in other states.



## **New Hampshire Medicaid Care Management Program**

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### **6.9. Performance Bond and Insurance**

Bidder shall, at time of Contract award, meet all New Hampshire Department of Insurance requirements to operate as an HMO in the State of New Hampshire as required by RSA 420-B and any other relevant New Hampshire laws and regulations.

### **6.10. Staffing and Resumes**

Each Bidder shall submit an Organizational Chart and a staffing plan for the program. For persons currently on staff with the Bidder, it shall provide names, title, qualifications and resumes. For staff to be hired, Bidder shall describe the hiring process and the qualifications for the position and the job description. The State reserves the right to accept or reject dedicated staff individuals.

### **6.11. Subcontractor Letters of Commitment (If Applicable)**

If subcontractors are part of this proposal, signed letters of commitment from the subcontractor are required as part of the RFP. The Bidder shall be solely responsible for meeting all requirements and terms and conditions specified in this RFP, its Proposal, and any resulting contract, regardless of whether or not it proposes to use any subcontractors. The Bidder and any subcontractors shall commit to the entire contract period stated within the RFP, unless a change of subcontractors is specifically agreed to by the State. The State reserves the right to approve or reject subcontractors for this project and to require the Bidder to replace subcontractors found to be unacceptable.

### **6.12. Addenda to Technical Proposal**

The Bidder may submit any additional material that it believes to be germane to understanding its qualifications, capabilities, and successes in a separate document entitled "Addenda to Proposal." No material in this segment will be considered by DHHS as meeting any of the required conditions of this RFP. This material should be bound or contained as a single discrete unit with its own Table of Contents.

### **6.13. License, Certificates and Permits as Required**

This includes: a Certificate of Good Standing or assurance of obtaining registration with the New Hampshire Office of the Secretary of State; a license to operate as an HMO in New Hampshire, or other state(s); or assurance of obtaining a license to operate as an HMO from the New Hampshire Department of Insurance. Selected Bidders must be licensed by the New Hampshire Department of Insurance to operate as an HMO in the State as required by New Hampshire RSA 420-B, and any other relevant laws and regulations, or acquire such license prior to award of Contract.



## New Hampshire Medicaid Care Management Program

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### 6.14. **Cost Bid Requirements**

Cost proposals will be submitted separately and may be adjusted based on the final negotiations of the scope of work.

Cost proposals shall be submitted per instructions to be published with the databook, release date as specified in the Procurement Timetable. The budget should reflect the costs for State Fiscal Years 2013 and 2014. The cost proposal includes the capitation rates and populations for the program and the administrative costs of operating the program based on the proposed staffing pattern and other direct and indirect costs.

### 6.15. **Affiliations – Conflict of Interest**

The Bidder must include a statement regarding any and all affiliations that might result in a conflict of interest. Examples of such affiliations would include hospitals and physician organizations. Explain the relationship and how the affiliation would not represent a conflict of interest.

### 6.16. **Required Attachments**

The following are required statements that must be included with the Proposal. The Bidder must complete the correlating forms found in the RFP Appendices and submit them as the “Required Attachments” section of the Proposal.

Bidder Information and Declarations will include:

- GIS Reports (see Appendix A for instructions)
- Exceptions to Terms and Conditions Appendix B



### 7. FINANCE

#### 7.1. **Financial Standards**

DHHS has established financial standards to protect its members, the State, and its provider network from financial hardships incurred by the MCO.

#### 7.2. **Risk Protection Reinsurance for High Cost Cases**

Reinsurance is not required.

#### 7.3. **Equity Requirements and Solvency Protection**

In compliance with C.F.R. §438.116, the MCO shall maintain a minimum capital determined in accordance with New Hampshire Insurance Department Regulations, and any other relevant laws and regulations.

#### 7.4. **Risk-Based Capital**

The MCO shall maintain a risk-based capital (RBC) ratio to meet or exceed the New Hampshire Insurance Department Regulations, and any other relevant laws and regulations.

#### 7.5. **Prior Approval of Payments to Affiliates**

With the exception of payment of a claim for a medical product or service that was provided to a member, and that is in accordance with a written agreement with the provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

- RBC ratio was less than 2.0 for the most recent year filing
- MCO was not in compliance with the solvency requirement

#### 7.6. **Change in Independent Actuary or Independent Auditor**

The MCO shall notify DHHS within 10 calendar days when its contract with an independent auditor or actuary has ended, and seek approval of the replacement auditor or actuary, if any from DHHS.



## New Hampshire Medicaid Care Management Program

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### 7.7. **Modified Current Ratio**

The MCO shall maintain current assets, plus long-term investments that can be converted to cash within five Business Days without incurring a penalty of more than 20 percent that equal or exceed current liabilities.

### 7.8. **Limitation of Liability**

The MCO shall assure that members shall not be liable for the MCO's debts if the MCO becomes insolvent.

### 7.9. **DSH/GME Payment**

The MCO will not make direct payments of DSH/GME (IME/DME) to hospitals. DSH and GME amounts are not included in capitation payments.

### 7.10. **Recoupments from Other Insurance**

Recoupments from other insurance are addressed in section YY.

### 7.11. **Capitation Payments**

#### 7.11.1. **Development of Capitation Rates**

Capitation rates for the first year shall be proposed by bidders in accordance with the Cost Proposal Template (see section X to be released separate from this RFP) and in consideration of the information supplied in the Data Book (to be released separate from this RFP see Appendix YY). Final rates will be determined as part of contract negotiations, any best and final offer process, and the DHHS actuary's soundness certification. For subsequent years of the contract actuarially sound per member, per month capitated rates will be calculated and certified by the DHHS actuary. When developing proposed rates for each rate cell, bidders should also consider the information presented below.

#### 7.11.2. **Risk Adjustment of Capitation Payments**

The capitation rates for non-dual eligible rate cells will be risk adjusted as explained in the cost proposal template.

#### 7.11.3. **Maternity Kick Payment**

For each live birth, DHHS will make a one-time maternity payment to the MCO with whom the mother is enrolled on the date of birth. This payment is a global fee to cover



## New Hampshire Medicaid Care Management Program

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all maternity expenses, including prenatal care, delivery fees, and post-partum care. In the event of multiple births, DHHS will make only one maternity payment. Maternity payments include prenatal care and two months of postnatal care for the mother. A live birth will be defined in accordance with New Hampshire Vital Records reporting requirements for live births as specified in RSA 5-C.

The MCO shall submit information on maternity events to DHHS. The MCO shall follow written policies and procedures for receiving, processing and reconciling maternity payments.

The Data Book contains details of the services included and the estimates of the kick payment based on prior experience. Bidders may accept these estimates or provide their own alternative as specified in the Cost Proposal Template.

A supplemental maternity kick payment shall be made to all Coos hospital maternity cases. The amount of the kick enhancement shall be described in the databook and be passed in full to the Coos hospitals.

### 7.11.4. **Capitation Payment Settlements**

Capitation payment settlements will be made:

- Settlements will be made at six month intervals.
- DHHS will recover capitation payments made for deceased members, or members who were later determined to be ineligible for New Hampshire Medicaid or New Hampshire Medicaid Managed Care.
- Capitation payments for members who became ineligible for services in the middle of the month will be prorated based on the number of days eligible in the month.

Capitation payments for members whose change in edibility status or age lead to a change in the rate cell the member belongs to will be settled based on the first date of the month following the change.

### 7.11.5. **Incentive Payments**

As specified in the Quality section of this RFP, 1% of the capitation rate will be withheld annually based on the MCO's performance in meeting DHHS' quality performance benchmarks. Incentives will be measured annually (first measurement period July 2012 – June 2013) and incentive payments will be distributed by the end of the following contract year. Further details of the quality incentive program are outlined in Section 3.12.5.

### 7.11.6. **Schedule of Capitation Payments**

DHHS will make a monthly payment to each MCO for each member enrolled in the MCO's plan. The capitation payment will be made retrospectively with a two month



## **New Hampshire Medicaid Care Management Program**

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delay. For example, a payment will be made within five working days of the first day in October, 2012 for services provided in July, 2012.

### **7.11.7. Program Changes**

DHHS will inform the MCO of any required program revisions or additions in a timely manner that will impact capitated rates. DHHS may adjust the contracted rates to reflect these changes as necessary to maintain actuarial soundness.

### **7.12. Financial Responsibility of Dual Eligibles**

The MCO shall pay any Medicare coinsurance and deductible amount up to what New Hampshire Medicaid would have paid for that service, whether or not the Medicare provider is included in the MCO's provider network. These payments are included in services presented in the Data Book and are included in the calculated capitation payment.

### **7.13. Premium Payments**

DHHS is responsible for collection of any premium payments from members. If the MCO inadvertently receives premium payments from members, it shall inform the member and forward the payment to DHHS.



## 8. MANDATORY BUSINESS SPECIFICATIONS

### 8.1. **Contract Terms, Conditions and Penalties, Forms**

The State of New Hampshire has not yet developed a sample contract; bidder to agree to minimum requirement as set forth in the Appendix C.

The Department and the Contractor agree that the actual damages that the Department will sustain in the event the Vendor fails to maintain the required performance standards throughout the life of the contract will be uncertain in amount and difficult and impracticable to determine. The Contractor acknowledges and agrees that any failure to achieve required performance levels by the Contractor will more than likely substantially delay and disrupt the Department's operations. Therefore the parties agree that liquidated damages shall be determined as part of the contract specifications.

Assessment of liquidated damages shall be in addition to, and not in lieu of, such other remedies as may be available to the Department. Except and to the extent expressly provided herein, the Department shall be entitled to recover liquidated damages applicable to any given incident.

The Department will determine compliance and assessment of liquidated damages as often as it deems reasonable necessary to ensure required performance standards are met. Amounts due the State as liquidated damages may be deducted by the State from any fees payable to the Contractor and any amount outstanding over and above the amounts deducted from the invoice will be promptly tendered by check from the Contractor to the State.

The State intends to negotiate with the awarded vendor to include liquidated damages in the Contract in the event any deliverables are not met.



## **9. ADDITIONAL INFORMATION**

- 9.1. **Appendix A – GIS Instructions**
- 9.2. **Appendix B - Exceptions to Terms and Conditions**
- 9.3. **Appendix C – Contract minimum requirements**

## APPENDIX A

### Geographic Information Systems (GIS) - Reporting Instructions

The submitted GIS reports (mapping and accessibility analysis) must demonstrate provider availability for each provider type/specialty managed by the Managed Care Organization (MCO). In production of the GIS reports, please note the following:

1. The Bidder must utilize either an ESRI based solution or one with demonstrated compatibility with ESRI when producing required reports and be capable of federating data across geographic regions.
2. The GIS reports must be produced based on all MCO members as indicated in the MCO member census file, including out-of-state members.
3. Each GIS report must indicate those members with access and those without access in accordance with the network access standards. In addition, each GIS report must indicate the average distance from the Member's resident zip code to the contracted provider.
4. GIS reporting is required for all services supported within an MCO by client by type/specialty. If the Bidder has a different network for any of the services provided, separate GIS reports must be produced for each product network. If using the same network for all products, only produce one report indicating for "all services" on the report.
5. Bidder shall indicate whether the GIS reports include physician practices that are closed to new patients.
6. Bidder shall provide separate GIS reports based on:
  - a) All zip codes located in within New Hampshire:
    - i. Rural GIS report for each provider type listed in the network access standard table
    - ii. Suburban GIS report for each provider type listed in the network access standard table
    - iii. Urban GIS report for each provider type listed in the network access standard table
  - b) All zip codes located outside New Hampshire:
    - i. For members residing in out-of-state zip codes, the GIS reports must be labeled accordingly with the specific state, membership, and access analysis based on the network access standards. The Bidder may use the Rural, Suburban and Urban designations provided by GIS for out-of-state members.
  - c) Regional reports (based on the zip code listing provided with regional designation):
    - i. Rural report for each provider type (listed in the network access standard table) for each region
    - ii. Suburban report for each provider type (listed in the network access standard table) for each region
    - iii. Urban report for each provider type (listed in the network access standard table) for each region
    - iv. Out-of-state members may be excluded from the regional reports.

# APPENDIX B

## EXCEPTIONS TO TERMS AND CONDITIONS

A Responder shall be presumed to be in agreement with the terms and conditions of the RFP unless the Responder takes specific exception to one or more of the conditions on this form.

**RESPONDERS ARE CAUTIONED THAT BY TAKING ANY EXCEPTION THEY MAY BE MATERIALLY DEVIATING FROM THE RFP SPECIFICATIONS. IF A RESPONDER MATERIALLY DEVIATES FROM A RFP SPECIFICATION, ITS PROPOSAL MAY BE REJECTED.**

A material deviation is an exception to a specification which 1) affords the Responder taking the exception a competitive advantage over other Responders, or 2) gives the State something significantly different than the State requested.

**INSTRUCTIONS:** Responders must explicitly list all exceptions to State of NH minimum terms and conditions. Reference the actual number of the State's term and condition and Exhibit number for which an exception(s) is being taken. If no exceptions exist, state "NONE" specifically on the form below. Whether or not exceptions are taken, the Responder must sign and date this form and submit it as part of their Proposal. (*Add additional pages if necessary.*)

<b>Responder Name:</b>	
<b><u>Term &amp; Condition Number/Provision</u></b>	<b><u>Explanation of Exception</u></b>

*By signing this form, I acknowledge that the above named Responder accepts, without qualification, all terms and conditions stated in this RFP Section 9- Mandatory Business Specifications, Contract Terms and Conditions except those clearly outlined as exceptions above.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

# Appendix C

**FORM NUMBER P-37 (version 1/09)**

Subject: \_\_\_\_\_

## AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

### GENERAL PROVISIONS

#### 1. IDENTIFICATION.

<b>1.1 State Agency Name</b>		<b>1.2 State Agency Address</b>  129 Pleasant Street, Brown Building Concord, New Hampshire 03301-3857	
<b>1.3 Contractor Name</b>		<b>1.4 Contractor Address</b>	
<b>1.5 Contractor Phone Number</b>  )	<b>1.6 Account Number</b>	<b>1.7 Completion Date</b>	<b>1.8 Price Limitation</b>
<b>1.9 Contracting Officer for State Agency</b>		<b>1.10 State Agency Telephone Number</b>	
<b>1.11 Contractor Signature</b>		<b>1.12 Name and Title of Contractor Signatory</b>	
<b>1.13 Acknowledgement:</b> State of _____, County of _____  On _____, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
<b>1.13.1 Signature of Notary Public or Justice of the Peace</b>  [Seal]			
<b>1.13.2 Name and Title of Notary or Justice of the Peace</b>			
<b>1.14 State Agency Signature</b>		<b>1.15 Name and Title of State Agency Signatory</b>	
<b>1.16 Approval by the N.H. Department of Administration, Division of Personnel (if applicable)</b>  By: _____ Director, On: _____			
<b>1.17 Approval by the Attorney General (Form, Substance and Execution)</b>  By: _____ On: _____			
<b>1.18 Approval by the Governor and Executive Council</b>  By: _____ On: _____			

# Appendix C

**2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED.** The State of New Hampshire, acting through the agency identified in block 1.1 (“State”), engages contractor identified in block 1.3 (“Contractor”) to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference (“Services”).

**3. EFFECTIVE DATE/COMPLETION OF SERVICES.**

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, this Agreement, and all obligations of the parties hereunder, shall not become effective until the date the Governor and Executive Council approve this Agreement (“Effective Date”).

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

**4. CONDITIONAL NATURE OF AGREEMENT.**

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

**5. CONTRACT PRICE/PRICE LIMITATION/PAYMENT.**

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

**6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.**

6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. In addition, the Contractor shall comply with all applicable copyright laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 (“Equal Employment Opportunity”), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor’s books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

**7. PERSONNEL.**

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State’s representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer’s decision shall be final for the State.

# Appendix C

## 8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder (“Event of Default”):

- 8.1.1 failure to perform the Services satisfactorily or on schedule;
- 8.1.2 failure to submit any report required hereunder; and/or
- 8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

- 8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
- 8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
- 8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
- 8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

## 9. DATA/ACCESS/CONFIDENTIALITY/PRESERVATION.

9.1 As used in this Agreement, the word “data” shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

**10. TERMINATION.** In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report (“Termination Report”) describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination

Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

**11. CONTRACTOR’S RELATION TO THE STATE.** In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers’ compensation or other emoluments provided by the State to its employees.

**12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.** The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written consent of the N.H. Department of Administrative Services. None of the Services shall be subcontracted by the Contractor without the prior written consent of the State.

**13. INDEMNIFICATION.** The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

## 14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than \$250,000 per claim and \$2,000,000 per occurrence; and

14.1.2 fire and extended coverage insurance covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than fifteen (15) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each

## Appendix C

certificate(s) of insurance shall contain a clause requiring the insurer to endeavor to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than ten (10) days prior written notice of cancellation or modification of the policy.

### **15. WORKERS' COMPENSATION.**

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A ("Workers' Compensation").

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

**16. WAIVER OF BREACH.** No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

**17. NOTICE.** Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

**18. AMENDMENT.** This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire.

### **19. CONSTRUCTION OF AGREEMENT AND TERMS.**

This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

**20. THIRD PARTIES.** The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

**21. HEADINGS.** The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

**22. SPECIAL PROVISIONS.** Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

**23. SEVERABILITY.** In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

**24. ENTIRE AGREEMENT.** This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

## NH Department of Health and Human Services

## STANDARD EXHIBIT C

SPECIAL PROVISIONS

**1. Contractors Obligations:** The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

**2. Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

**3. Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

**4. Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

**5. Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

**6. Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

**7. Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

**8. Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party fundors for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than

such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:

**8.1** Renegotiate the rates for payment hereunder, in which event new rates shall be established;

**8.2** Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

**8.3** Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

## **RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:**

**9. Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:

**9.1 Fiscal Records:** books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

**9.2 Statistical Records:** Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

**9.3 Medical Records:** Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

**10. Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.

**10.1 Audit and Review:** During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.

**10.2 Audit Liabilities:** In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

**11. Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be

disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

**12. Reports: Fiscal and Statistical:** The Contractor agrees to submit the following reports at the following times if requested by the Department.

**12.1 Interim Financial Reports:** Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.

**12.2 Final Report:** A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

**13. Completion of Services: Disallowance of Costs:** Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

**14. Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:

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

**15. Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

**SPECIAL PROVISIONS – DEFINITIONS**

As used in the Contract, the following terms shall have the following meanings:

**COSTS:** Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

**DEPARTMENT:** NH Department of Health and Human Services.

**FINANCIAL MANAGEMENT GUIDELINES:** Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

**PROPOSAL:** If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

**UNIT:** For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

**FEDERAL/STATE LAW:** Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

**CONTRACTOR MANUAL:** Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

**SUPPLANTING OTHER FEDERAL FUNDS:** The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

# Appendix C

## NH Department of Health and Human Services

### STANDARD EXHIBIT C-1

#### ADDITIONAL SPECIAL PROVISIONS

1. **Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:**

#### **4. CONDITIONAL NATURE OF AGREEMENT.**

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. **Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;**

10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

## Appendix C

10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

**3. Subparagraph 14.1.1 of the General Provisions of this contract is deleted and the following subparagraph is added:**

14.1.1 comprehensive general liability against all claims of bodily injury, death or property damage, in amounts of not less than \$250,000 per claim and \$1,000,000 per occurrence and excess/umbrella liability coverage in the amount of \$1,000,000 per occurrence; and

**NH Department of Health and Human Services**

**STANDARD EXHIBIT D**

**CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS**

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

**ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS**

- US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS**
- US DEPARTMENT OF EDUCATION - CONTRACTORS**
- US DEPARTMENT OF AGRICULTURE - CONTRACTORS**

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner  
NH Department of Health and Human Services  
129 Pleasant Street,  
Concord, NH 03301-6505

- (A) The grantee certifies that it will or will continue to provide a drug-free workplace by:
  - (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
  - (b) Establishing an ongoing drug-free awareness program to inform employees about—
    - (1) The dangers of drug abuse in the workplace;
    - (2) The grantee's policy of maintaining a drug-free workplace;
    - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
    - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

# Appendix C

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- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
- (d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will—
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted—
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

(B) The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check  if there are workplaces on file that are not identified here.

From: 7/1/2011 To: 6/30/2013

\_\_\_\_\_  
(Contractor Name)

\_\_\_\_\_  
(Period Covered by this Certification)

\_\_\_\_\_  
(Name & Title of Authorized Contractor Representative)

\_\_\_\_\_  
(Contractor Representative Signature)

\_\_\_\_\_  
(Date)

Contractor Initials: \_\_\_\_\_

Date: \_\_\_\_\_

NH Department of Health and Human Services

STANDARD EXHIBIT E

CERTIFICATION REGARDING LOBBYING

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor’s representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

**US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS**  
**US DEPARTMENT OF EDUCATION - CONTRACTORS**  
**US DEPARTMENT OF AGRICULTURE - CONTRACTORS**

- Programs (indicate applicable program covered):
- \*Temporary Assistance to Needy Families under Title IV-A
- \*Child Support Enforcement Program under Title IV-D
- \*Social Services Block Grant Program under Title XX
- \*Medicaid Program under Title XIX
- \*Community Services Block Grant under Title VI
- \*Child Care Development Block Grant under Title IV

Contract Period: July 1, 2011 through June 30, 2013

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The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)
- (3) The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

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(Contractor Representative Signature)

(Authorized Contractor Representative Name & Title)

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(Contractor Name)

(Date)

**NH Department of Health and Human Services**

**STANDARD EXHIBIT F**

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION  
AND OTHER RESPONSIBILITY MATTERS**

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

**INSTRUCTIONS FOR CERTIFICATION**

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.
2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.
3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.
4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.
6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

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7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).
9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

## **PRIMARY COVERED TRANSACTIONS**

- (1) The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
  - (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
  - (b) have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
  - (c) are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
  - (d) have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.
- (2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

Contractor Initials: \_\_\_\_\_

Date: \_\_\_\_\_

# Appendix C

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## LOWER TIER COVERED TRANSACTIONS

By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- (b) where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

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(Contractor Representative Signature)

(Authorized Contractor Representative Name & Title)

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(Contractor Name)

(Date)

Contractor Initials: \_\_\_\_\_

Date: \_\_\_\_\_

**NH Department of Health and Human Services**

**STANDARD EXHIBIT G**

**CERTIFICATION REGARDING  
THE AMERICANS WITH DISABILITIES ACT COMPLIANCE**

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to make reasonable efforts to comply with all applicable provisions of the Americans with Disabilities Act of 1990.

\_\_\_\_\_  
(Contractor Representative Signature)

\_\_\_\_\_  
(Authorized Contractor Representative Name & Title)

\_\_\_\_\_  
(Contractor Name)

\_\_\_\_\_  
(Date)

NH Department of Health and Human Services

STANDARD EXHIBIT H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children’s services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor’s representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

- 1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

\_\_\_\_\_  
(Contractor Representative Signature)

\_\_\_\_\_  
(Authorized Contractor Representative Name & Title)

\_\_\_\_\_  
(Contractor Name)

\_\_\_\_\_  
(Date)

NH Department of Health and Human Services

**STANDARD EXHIBIT I**  
**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**  
**BUSINESS ASSOCIATE AGREEMENT**

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and those parts of the HITECH Act applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

**BUSINESS ASSOCIATE AGREEMENT**

(1) **Definitions.**

- a. "Breach" shall have the same meaning as the term "Breach" in Title XXX, Subtitle D. Sec. 13400.
- b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
- c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
- d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.
- e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.
- f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.
- g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, Title XIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.
- h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164.
- i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).
- j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

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- k. “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 CFR Section 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- l. “Required by Law” shall have the same meaning as the term “required by law” in 45 CFR Section 164.501.
- m. “Secretary” shall mean the Secretary of the Department of Health and Human Services or his/her designee.
- n. “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.
- o. “Unsecured Protected Health Information” means protected health information that is not secured by a technology standard that renders protected health information unusable, unreasonable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.
- p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH Act.

## (2) Use and Disclosure of Protected Health Information.

- a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, the Business Associate shall not, and shall ensure that its directors, officers, employees and agents, do not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
- b. Business Associate may use or disclose PHI:
  - I. For the proper management and administration of the Business Associate;
  - II. As required by law, pursuant to the terms set forth in paragraph d. below; or
  - III. For data aggregation purposes for the health care operations of Covered Entity.
- c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402 of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
- d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

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- e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

**(3) Obligations and Activities of Business Associate.**

- a. Business Associate shall report to the designated Privacy Officer of Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement, including any security incident involving Covered Entity data, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402.
- b. The Business Associate shall comply with all sections of the Privacy and Security Rule as set forth in, the HITECH Act, Subtitle D, Part 1, Sec. 13401 and Sec.13404.
- c. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.
- d. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section (3)b and (3)k herein. The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard provision #13 of this Agreement for the purpose of use and disclosure of protected health information.
- e. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.
- f. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.
- g. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

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- h. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.
- i. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.
- j. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.
- k. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

**(4) Obligations of Covered Entity**

- a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.
- b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.
- c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

**(5) Termination for Cause**

In addition to standard provision #10 of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

**(6) Miscellaneous**

- a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, and the HITECH Act as amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.
- b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.
- c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.
- d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule and the HITECH Act.
- e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.
- f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section 3 k, the defense and indemnification provisions of section 3 d and standard contract provision #13, shall survive the termination of the Agreement.

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IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

DHHS/DCBCS/BEAS

\_\_\_\_\_  
The State Agency Name

\_\_\_\_\_  
Name of the Contractor

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Signature of Authorized Representative

Nancy L. Rollins

\_\_\_\_\_  
Name of Authorized Representative

\_\_\_\_\_  
Name of Authorized Representative

Associate Commissioner

\_\_\_\_\_  
Title of Authorized Representative

\_\_\_\_\_  
Title of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

# Appendix C

NH Department of Health and Human Services

## STANDARD EXHIBIT J

### CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than \$25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of \$25,000 or more. If the initial award is below \$25,000 but subsequent grant modifications result in a total award equal to or over \$25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (*Reporting Subaward and Executive Compensation Information*), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

- 1) Name of entity
- 2) Amount of award
- 3) Funding agency
- 4) NAICS code for contracts / CFDA program number for grants
- 5) Program source
- 6) Award title descriptive of the purpose of the funding action
- 7) Location of the entity
- 8) Principle place of performance
- 9) Unique identifier of the entity (DUNS #)
- 10) Total compensation and names of the top five executives if:
  - a. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than \$25M annually and
  - b. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (*Reporting Subaward and Executive Compensation Information*), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

---

(Contractor Representative Signature)

(Authorized Contractor Representative Name & Title)

---

(Contractor Name)

(Date)

Contractor initials: \_\_\_\_\_  
Date: \_\_\_\_\_  
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# Appendix C

NH Department of Health and Human Services

## STANDARD EXHIBIT J

### FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: \_\_\_\_\_

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) \$25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

\_\_\_\_\_ NO

\_\_\_\_\_ YES

**If the answer to #2 above is NO, stop here**

**If the answer to #2 above is YES, please answer the following:**

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

\_\_\_\_\_ NO

\_\_\_\_\_ YES

**If the answer to #3 above is YES, stop here**

**If the answer to #3 above is NO, please answer the following:**

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

Name: \_\_\_\_\_

Amount: \_\_\_\_\_

Contractor initials: \_\_\_\_\_

Date: \_\_\_\_\_

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