



OFFICIAL RESPONSE TO BIDDERS QUESTIONS

CARE MANAGEMENT RFP # 12-DHHS-CM-01

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| 1 | 1.1, 3.2 Step Two, 3.1 | 7, 33, 31-32 | The first paragraph on page 7 indicates that "responses to the RFP will be based on the Managed Care Organization's (MCO's) experience and expertise in managing populations with complex physical, behavioral, and social needs." Later on in the RFP, on Page 33, in the section titled Step Two, it states "For these reasons, Step Two has not been fully developed to date." On pages 31 to 32, in Section 3.1., a chart indicates which specialized populations will be included in Step Two. Will the State provide detailed requirements for these specialized populations in a second, follow-on RFP or will bidders interested in serving these specialized populations noted in Step 2 respond the RFP as issued on October 15, 2011? How will the state measure the bidder's experience and expertise in managing specialized populations when no guidelines have been put in place by the state in the October 15, 2011 RFP? | DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2. |
| 2 | 1.2 | 8 | Does CAHPS refer to the adult CAHPS survey, the children's CAHPS survey, or both? Which CAHPS survey(s) would the DHHS prefer be utilized for reporting purposes? | Both the complete adult and children's CAHPS must be used in the most recent version approved by NCQA |
| 3 | 1.3 | 11 | The RFP states that "the capitation rates for each year following the first year will be set by the department." Will the contractor have the opportunity to approve the rates before they become effective? In the event that the Contractor does not accept the capitation rates, how much notice will the Contractor be required to provide to DHHS regarding contract termination? | The rate acceptance process and the termination provisions will be defined in the MCO Contract. |
| 4 | 2.1.2 | 17 | Since X-Rays are limited to 15 X-rays per year (routine X-rays, CT scans, MRIs and nuclear medicine studies) 15 X-rays per year do you want to consider requiring pre-service clinical review for the MRI's and CTs? | Selected MCOs may propose whatever utilization management strategy subject to approval of DHHS. |
| 5 | 2.1.1 | 14 | Is the plan required to enforce a PA process for Wheelchair vans trips that exceed the 24 trips per year? | MCOs may apply different utilization management subject to DHHS approval. |
| 6 | 2.1.1 | 13 | Current UM strategies on the grid on page 13 identify that Inpatient Hospital, General is limited to QIO approved. Would you be willing to share the Medical necessity criteria that the Northeast Health Care Quality Foundation utilized for rendering decision and approval on Inpatient Hospital stays? | Admissions are not subject to QIO preapproval; retrospective review is done using Interqual criteria |
| 7 | 2.1.1 | 15 | A. Does this category include the individuals who have a serious mental illness or serious emotional disturbance? B. Which entity is responsible for inpatient psychiatric facility services for Medicaid enrollees <22 years of age? | This category includes individuals who have a serious mental illness or serious emotional disturbance. MCO is financially responsible for inpatient psychiatric services for this population of 22 yrs of age and under. |
| 8 | 2.1.1, 7.12 | 12, 107 | The RFP states that the MCO must provide "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". Can DHHS describe what, if any, "wraparound" coverage is required beyond paying any Medicare coinsurance and/or deductible amounts? | With regard to Community Mental Health services the MCO will be required to pay for the full array of rehab option. Community Mental Health services outlined in He-M 426. |



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| 9 | 2.1.1 | 12-16 | Please provide guidelines for what is required with regards to emergency transportation, non-emergency transportation and wheelchair van transportation. | Current process is reflected in administrative rules, He-M 500s. MCOs may apply different criteria/process subject to DHHS approval. |
| 10 | 2.1.1 | 12-16 | Are the "Current Utilization Management Strategies" described in Table 1 benefit limits? Is an MCO bound by these restrictions or can an MCO impose more or fewer limits? | The bidder may implement and manage its own utilization management policies, procedures, and criteria. However, these policies, procedures, and criteria must be approved by DHHS. |
| 11 | 2.1.1 | 12-16 | Will there be more detail on the covered benefits (e.g., visit/day limits, copayments) provided in the Data Book? If not, can MCOs access this information? | See Data Book and Data Book Appendices issued 11/1/11 |
| 12 | 2.1.1 | 13 | Please provide clarification around the dental benefit (i.e., what constitutes "acute pain" and where is this service delivered, what ortho benefit is included). | Limited orthodontics is available to children, however children's dental coverage is not included in the scope of this RFP. |
| 13 | 2.1.1 | 13 | Who determines if EPSDT services are "medically necessary"? | Currently this is determined by DHHS clinical staff applying state and federal regulatory authorities. MCOs would need to assure compliance with federal regulations in their application of "medically necessary". |
| 14 | 2.1.1 | 14 | Can DHHS provide clarity on the eligibility determination process and criteria for community mental health services? | Refer to New Hampshire Administrative rules He-M 401 |
| 15 | 2.1.1 | 16 | In Table 1, the RFP references a cap of \$30,000 per year per person for in-home support HCBS waiver services. What happens if a member requires services over \$30,000? | The target for the In Home Supports HCBS-Waiver is children who are living at home with their families. If the \$30,000 cap is inadequate, the waiver is not the appropriate option to meet their service needs. In such case, services are arranged under the State Plan and may be in conjunction with the HCBS-DD waiver. |
| 16 | 2.1.1 | 12-16 | Who covers medically necessary covered services when quantity limits are exceeded? (ER, inpatient, etc.) | DHHS will not wrap around payment for services outside the service limits. |
| 17 | 2.1.1 table 1 | 12 | Who will have the responsibility for assessment of eligibility based on clinical guidance once the MCO program is in place and how will the assignment of that member occur? | DHHS retains responsibility for financial and clinical eligibility, and the enrollment function is responsible for assignment. |
| 18 | 2.1.1 table 1 | 13 | X-ray: What services have the 15 limit and what would allow more than the limit other than EPSDT? | DHHS has criteria for service limit overrides outlined in administrative rules, as depicted in table 1 of the RFP; MCOs can apply override criteria subject to DHHS approval. |
| 19 | 2.1.1 table 1 | 16 | Who is financially responsible for inpatient admission on the effective date of the plan? | Admission on day of plan enrollment is covered by the plan. |
| 20 | 2.1.1 table 1 | 12 | Who is financially responsible for transplants? | MCOs are financially responsible; transplants are not carved out of the scope of work |



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| 21 | 2.1.2 | 17 | What happens if a member's utilization exceeds the limits on covered services? Is member, plan, or provider responsible? | The bidder may implement and manage its own utilization management policies, procedures, and criteria. However, these policies, procedures, and criteria must be approved by DHHS. |
| 22 | 2.1.2 | 17 | Does the four emergency room visits/year limitation apply to all patients, regardless of the reason for the visit? What constitutes emergent versus non-emergent diagnosis? | Current strategy is outlined within administrative rules. CFR 438.114 has very specific requirements on maintaining access and coverage to emergency services for any Medicaid recipient and requiring payment to providers for the provision of these services. MCO may limit non emergency visits to an emergency room, subject to DHHS approval. |
| 23 | 2.1.2 | 17 | After a covered service limit listed in Table 2 has been reached, is the member liable for subsequent care and can the member be billed by the provider for this service? | Balance billing is prohibited by federal law; current service limit override criteria are in administrative rules, as depicted in Table 1 of the RFP, MCOs can use different override criteria subject to DHHS approval. |
| 24 | 2.1.2 | 17 | In Table 2, the RFP states "Durable Medical Equipment (some prior authorization required)." For what DME must MCOs obtain prior authorization from DHHS? | Current prior authorization criteria is in administrative rules, as depicted in Table 1 of the RFP; MCOs can apply different criteria subject to DHHS approval |
| 25 | 2.1.2 | 17 | Table 2 in the RFP references limits on dental coverage for members age 21 and over. Can DHHS confirm that dental services are covered for members age 21 and under? If so, can DHHS provide any detail on covered dental benefits for this group? | Dental services, while covered for children, are not included in the RFP scope of work. For more information, see http://www.dhhs.nh.gov/ombp/medicaid/children/documents/dpm.pdf |
| 26 | 2.1.2 table 2 | 17 | Who is responsible for the cost of an ER service after the members 4th visit? Does the member become financially responsible? Will this be tracked to report to a new MCO should the member switch? Is this limitation tracked on a calendar year basis? Who is responsible for tracking this information? | Should the member exceed the limit, the MCO can hold the member financially responsible for non-covered services. |
| 27 | 2.1.2 | 17 | Are the MCO's limited to providing the benefits outlines in section 2.1.2? | No |
| 28 | 2.1.2 | 17 | Has the 4 visit limit on Emergency Room Services been publicly announced to hospitals and physicians? Does the limit apply regardless of whether the visit is classified as emergent or non-emergent? | Yes. No. |
| 29 | 2.1.2 | 17 | On page 17 in the notation under Table 2 : New Hampshire Limits on Covered Services it states: "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..."Question: By what criteria, is the state making the determination that an individual is either a low, moderate or high utilizer of services? | Refer to New Hampshire Administrative rules He-M 401 |
| 30 | 2.1.2 | | New Hampshire Medicaid Coverage and Service Limits. Are the limits proposed in Table 2 applicable exclusively to members remaining in the FFS environment? | Table 2 is the list of current covered services; the MCO can, at its discretion, exceed current coverage limits. |



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| 31 | 2.1.2 | 17 | Refer to the chart on page 17 – effective 10/14/11, psychotherapy visit caps were limited to 18 for adults and 24 for children. Is this for private practitioners only? Is there an impact to the \$1800 cap for non-eligible adults served by CMHC's? | This is a list of currently covered medicaid service and utilization limits. Psychotherapy visit caps outlined in this table do not apply to CMHC's. The \$1800 limit for non-eligible BBH clients remains in place. |
| 32 | 2.1.3 | 17 | For individuals who are Medicaid pending and not eligible on day one of the month, will they be reimbursed at current Fee for Service rates for services that are provided prior to their inclusion in Medicaid Care Management? | Refer to section 3.1 of the RFP Covered Populations and Services. |
| 33 | 2.1.3 | 18 | Are there different benefits for the different Medicaid eligibility categories outlined in Table 3? | The benefit package is the same for adults and children; however children can receive services unavailable to adults via EPSDT. Children also have dental services (excluded from scope of work in RFP). Limited difference applies for pregnant women (e.g. smoking cessation group counseling) For persons seeking behavioral health services authorization, some services may be based on an eligibility determination associated with the medical need for those services. |
| 34 | 2.1.3 | 18 | How will New Hampshire identify newborns who do not yet have a social security number? | Newborns will be auto enrolled into their mother's MCO. |
| 35 | 2.1.3 | 19 | Has the state plan amendment been submitted? | No |
| 36 | 2.1.3 | 19 | On page 19 of RFP Section 2.1.3, please describe how CHIP beneficiaries will transition to managed care, and the continuing role, if any, of New Hampshire Healthy Kids. | CHIP enrollees will transition the same way as Medicaid members. Details of this plan remain under development. |
| 37 | 2.4 | 21 | We have heard that DHHS may be implementing MMIS system changes. How, if at all, would that system implementation affect the State's data exchange and other functions with MCOs for this program? | A new MMIS system will be supporting this Care Management program. |
| 38 | 2.4.2 | 22 | Please define more specifically what the DHHS means by access to MCO systems? | The State's access requirements to the MCOs systems are described in section 2.4.2. Bidders should document their assumptions regarding web access in their responses. |
| 39 | 2.4.3 | 22 | Please clarify what source code is being referenced in the first sentence -- The state's source code or the MCO's? | MCO |
| 40 | 2.4.4 | 23 | Please define subcontractor. | A subcontractor is an individual or entity that signs a contract with bidder to perform part or all of the obligations of the Bidders contract with DHHS. Also see Sections 3.20 and 6.11 |
| 41 | 2.4.4.2 | 24 | Please clarify : is DHHS requesting web access to the awardee's MCIS? What exactly will DHHS be accessing in the awardee's MCIS? | The State's access requirements to MCIS are described in section 2.4.4.4 on page 25. Vendors should document their assumptions regarding web access in their responses. |
| 42 | 2.4.4.3 | 25 | Third Party Coverage Data - Is DHHS requiring that only other health insurance information (basically COB information) be submitted? | Refer to sections 3.18.j, 3.18.k, 3.18.l of the RFP |



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| 43 | 2.4.4.3 | 24 | Will the data files transmitted from DHHS to the MCO be in a standard HIPPA ANSI transaction format? If not, what format will DHHS use? | This issue will be addressed in the MCO contract. |
| 44 | 2.4.4.5 | 26 | Please specify the functionality required for a member portal | The member portal requirements are described on page 26. Vendors should document their assumptions regarding member portal in their responses. |
| 45 | 2.4.4.6 | 27 | Please consider amending the language to the following in RFP Section 2.4.4.6, which will enable MCOs using shared systems to manage multiple markets to participate: "The MCO shall ensure the New Hampshire data is able to be accessed and reported separately from data for any other markets processed in the MCIS. And, system and application security will be in place such that only those with a need to access New Hampshire data will have access to this data." | The State's security requirements for the MCIS are described in section 2.4.4.6 on page 27. Vendors should document in their responses any alternative approaches to security they believe are equivalent and meet the intention of the requirement stated in the RFP. |
| 46 | 2.4.4.8, fifth bullet | 28 | Does contracting with a new subcontractor, or terminating an existing contractor, constitute a "major systems change"? Does revising a subcontract constitute a "major systems change"? | Major system change will be further defined in the MCO contract |
| 47 | 2.4.4.9 | 29 | Please provide clarification on the ownership of data. | All data existing or collected during contract period is owned by State |
| 48 | 2.4.4.10 | 29 | When will DHHS make available its detailed and comprehensive reporting manual? | Contract time |
| 49 | 2.4.4.10 | | Reporting. Can the Department provide more information about the number of reports, report formats and report frequency and due dates? | Specific reporting requirements to be part of contract; to comply with State and Federal requirements |
| 50 | 3 | 31 | In the Statement of Work, on page 31, it states "For each component, the RFP outlines requirements and lists key questions for the MCO." Requirements for Step Two are not outlined and a list of key questions is not noted. Will the State do so in a separate RFP for Step Two for the second year of operation to include all waived services and long term care services? | DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2. |
| 51 | 3.1 | 31 | How does the RFP intend to address dually eligible consumers with spend-down requirements? According to the RFP, dually eligible consumers are included but have the option (per CMS) to opt out until/unless the state gets a waiver. | See section 3.1 Covered Populations and Services. |
| 52 | 3.1 | 31 | What is the opt out option for Medicare duals? How will these services be paid and will they be paid directly by DHHS or by the MCO? | Medicare duals will be auto enrolled with the choice to opt out of the MCO and remain in FFS Medicaid in step 1. |
| 53 | 3.1 | 32 - 33 | The RFP states that "DHHS reserves the right to alter this list [of covered services] at any time by informing the MCO." Will the Contractor have the opportunity to approve the expanded scope of services, or the modified rates to compensate the expanded scope, before this obligation becomes effective? In the event that the Contractor does not accept the capitation rates, how much notice will the Contractor be required to provide to DHHS regarding contract termination? | No, there are no MCO approval rights. MCO termination provisions will be described in the MCO contract. |



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| 54 | 3.1 | | Covered Population and Services; Regarding Step 1 Members, can the Department provide approximate numbers by each category of members? Under services, will the MCO be at financial risk for the Community Mental Health Services? Please clarify. Related to duals, are the duals full benefit duals? Regarding Step 2, when does the Department expect to receive approval for its approach to mandatory enrollment of duals? On page 32, the chart is misaligned. Is the lower section of Services related to Step 2? Under step 2, will the MCO be financially liable for the listed Services and will this be included in an adjusted capitation rate? | See the databook for population information. The MCO is at financial risk for all covered services. |
| 55 | 3.2 | 33 | Readiness Review is defined In two phases. Will complete instructions for the readiness review be defined and what is the consequence for a MCO that does not pass either review phase? | The readiness review requirements will be provided in the MCO Contract. DHHS reserves the right to not allow a bidder failing either readiness review from enrolling members. |
| 56 | 3.2 | 33 | When does the state anticipate fully developing Step Two. | The timeline for Step Two planning is still under development. |
| 57 | 3.2 | 34 | Please confirm that for the purposes of responding to RFP questions related to the Bidder's experience (i.e. Q1, Q3, and Q4), a bidder may offer the experience and contracts held by Affiliates of the bidding entity. For example, a new entrant may be in the process of establishing a newly licensed entity in New Hampshire with experience in other states through its parent and affiliate health plans. For the purposes of demonstrating experience and meeting the qualifications of being contracted in another state to provide Medicaid managed care services, such an organization would offer the experience of one of the affiliate health plans currently contracted and operating in other states. Please confirm that this meets the requirements of the bidder's minimum qualifications. | For questions related to the bidder's experience, the bidder should respond with experience related to the bidder, its parent company, and its subsidiaries. Experience of subcontractors should not be included in experience for the bidder. |
| 58 | 3.2 | 33 | RFP Section 3.2 indicates that Step Two will be developed; how will DHHS ensure that the MCOs initially selected have the requisite capability to be successful in implementing Step Two? Will DHHS provide more concrete operational steps, information on the current delivery system relative to these services, proposed service and quality measurement data, and timelines to ensure that Step Two launches one year after Sept 1, as indicated in the RFP? | The process and timeline for Step Two implementation is still under development |
| 59 | 3.2 | 33 | What Federal authority is DHHS seeking to implement the Care Management program, and what is the status of discussion with CMS? Also, what plans are underway to expand any authorities to implement Step Two? | DHHS will be working with CMS to define its strategy and will execute on this strategy in time for each of the programs to go live. |
| 60 | 3.2 | 33 | On page 33, the second paragraph under Step One, it states "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." Is this readiness review for all populations, including Step 2 special populations? Please define the term "Program Start Date." | The readiness reviews referenced are just for Step One. The Step Two implementation process is not yet developed. |
| 61 | 3.2 | 33 | Step Two, outlined on page 33 of the RFP, states "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." Will a second RFP be issued after this process? Or, will the contracted MCOs, from the October 15, 2011 RFP, be leading this process in cooperation with DHHS? | DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2. |
| 62 | 3.3 | 34 | Will there be updates to the formulary PDL in conjunction with the pharmacy rebate program? If yes, what will be the process for updating the MCOs? | Yes, the process will be defined in the MCO Contract. |



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| 63 | 3.3 | 34 | Will the State of New Hampshire provide member's pharmacy claim history? If so, how far back will the history be available? | DHHS will work with the selected bidders to develop a process for historical claims data transfers. |
| 64 | 3.3 | 35 | If pharmacy claims are paid through a different claims platform than medical claims, please describe how third-party liability information is coordinated and shared. Is DHHS looking for other health insurance only (basically COB information)? | DHHS requests bidders to explain how they coordinate data between their various claims payment platforms. |
| 65 | 3.3 | 34 | Please further explain the statement that MCO formulary will "Align" with FFS PDL. Must it match exactly or can the MCO's current PDL be used? | Must match exactly |
| 66 | 3.3 | 34 | If the MCO's PDL can vary from the FFS PDL what degree of variance is acceptable to the state? | None |
| 67 | 3.3 | 34 | Are there specific therapeutic categories of drugs that have mandated coverage rules? e.g. all HIV drugs must be on the PDL and may not require prior auth. | MCOs can propose coverage rules subject to DHHS approval and consistent with federal regulation |
| 68 | 3.3 | 34 | Are there specific therapeutic categories of drugs that will be carved out to FFS, e.g. HIV or behavioral health medications? | No, there are not any specific therapeutic categories of drugs that will be carved out to FFS. |
| 69 | 3.3 | 34 | The RFP states each MCO is invited to participate in the state DUR Board, please elaborate on the degree and level of participation a MCO may expect. | DUR board meets 2-3 times per year and MCO participant would be expected to attend. |
| 70 | 3.3 | 34 | If MCO must implement the state's FFS PDL, will the MCO be given a seat(s) on the DUR Committee with voting rights? | DUR composition is in set by Chapter 19, Laws of NH (2009) |
| 71 | 3.3 | 34 | Are the pharmacies that process prescription drug claims for NH Medicaid recipients required to have any additional or specific Medicaid registration with the state or are their usual state-issued license acceptable? | No, pharmacies that process prescription drug claims for NH Medicaid recipients will not be required to have any additional or specific Medicaid registration with the State. |
| 72 | 3.3 | 34 | Are there Medicaid recipients who reside out-side the state where they may need to receive pharmacy services, such as but not limited to foster children in homes outside NH? | There are individuals who are temporarily in out of state placements or who are temporarily out of state who will require access to pharmacy. |
| 73 | 3.3 | 34 | What is the required turn-around times for coverage decisions related to prescription drugs that require prior authorization? | This is dictated by federal regulation |
| 74 | 3.3 | 34 | Will MCO be able to determine the prescription drug benefit design, such as days supply per fill, maintenance quantities, copays? | Yes; copays must comport with limitation in Deficit Reduction Act; MCOs must follow the existing PDL, subject to DHHS approval |
| 75 | 3.3 | 34 | Are adult vaccinations permitted or required to accessible as a prescription drug benefit, i.e. can pharmacists be permit to administer and bill for a vaccination via the rx claims adjudication system? | Adult vaccinations are a covered service. DHHS does not currently enroll pharmacists as providers, only pharmacies |
| 76 | 3.3 | 34 | Are MCO permitted to utilize a preferred specialty pharmacy for designated pharmaceuticals? | Yes, the bidder is permitted to utilize a preferred specialty pharmacy for designated pharmaceuticals. |
| 77 | 3.3 | 34 | May the MCO define/determine what constitutes a specialty pharmacy product and must this definition be approved by the state? | Yes, with DHHS approval the bidder may define/determine what constitutes a specialty pharmacy product. |
| 78 | 3.3 | 34 | Are all recipients entitled to the same prescription drug coverage benefit? Or does it vary based on MA category? | Yes |



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| 79 | 3.3 | 34 | Are there prescription program benefits that limit number and/or type of prescriptions that can be filled per month? | Not under the existing FFS program |
| 80 | 3.3 | | Pharmacy Management. Who is the current PBM? Can the State provide a copy of the Preferred Drug List (PDL)? If the MCO is at full-risk and the DHHS is required to collect the rebates from drug manufacturers, will the rebate dollars be distributed back to the MCO? | Magellan is the current PBM. PDL is on the DHHS website and on Magellan NH website. Federal law requires the state to be the collector of CMS rebates. Any supplemental rebate, if collected, would be retained by the state. |
| 81 | 3.4 | 36 | In terms of "open enrollment", section 3.4, much of this section appears geared toward the TANF population in terms of PCP selection, etc. There are a number of issues presented by this process for the SPMI and SMI populations that will require work on the part of CMHC case managers and benefit specialists. Will there be training for this activity, and who will bear the costs for this additional work? | Section 3.4 addresses Member Enrollment. |
| 82 | 3.4 | 36 | There is a provision that allows an MCO to make changes to covered services with 30 day's notice. Does this exclude services that are mandated by this RFP and subsequently by contract between the MCO and DHHS including those outlined under He-M 426? | 3.5.1 Requires the MCO to notify members of changes made to covered services by DHHS 30 days prior to the change. |
| 83 | 3.4.2. | 36 | Information contained in the MCO's member handbook (specified in Section 3.D of this RFP)We are unable to find the referenced Section 3.D. Can DHHS please clarify? | Information related to the member handbook can be found in Section 3.5, Member Services. |
| 84 | 3.4.3 and 3.4.4 | 36 | Please clarify if the state will be selecting two or three MCO's for participation under this contract. | DHHS will determine whether to select two or three MCOs based on the responses to this RFP. DHHS will at least select two MCOs. |
| 85 | 3.4.3 | 36 | Can the state be more specific about how many MCOs it will contract with (2 or 3) and what will drive that decision? | DHHS will determine whether to select two or three MCOs based on the responses to this RFP. DHHS will at least select two MCOs. |
| 86 | 3.4.3 | 36 | Are members enrolled for a period of one year generally with the exception of a qualifying event? (otherwise known as enrollment lock-in) | Members will be able to change MCOs during an annual enrollment period. The reasons that members will be able to change plans off-cycle will be outlined in the MCO Contract. |
| 87 | 3.4.3 | 36 | On page 36, section 3.4.3, it states "Members shall have a choice between two or three MCO's operating in the state." Can a member choose one MCO for Step 1 services and a different MCO for Step 2 services? | Step Two will be defined as part of the Step Two planning process. |
| 88 | 3.4.4 | 36-37 | As described in section 3.4.4, does the "technical score" refer to the total points (technical plus cost) or the technical score only (70 points)? | In section 3.4.4 the "technical score" refers to the Technical Score only (70 points). |
| 89 | 3.4.4 | 36 | Can members be assigned to an FQHC or RHC directly? | A member can self select a FQHC or RHC for primary care if they are part of the MCO network |
| 90 | 3.4.4 | 37 | What methodology will be used for the auto-assignment algorithm after year one? | DHHS will determine the auto assignment algorithm for Step Two 90 days prior to the beginning of Step Two. |
| 91 | 3.4.4 | 37 | What is the methodology for the auto-assignment algorithm if there are only two MCOs? | If the State selects two MCOs then it will develop a new auto assignment algorithm. |
| 92 | 3.4.4 | 37 | This algorithm has the potential to auto-assign members of the same family to different plans. How will that be addressed? | Families will be auto assigned as a single "unit" in the algorithm. |



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| 93 | 3.4.4 | 37 | Will there be a defined period of time after auto-assignment for the member to voluntarily change plans? | Yes, DHHS will define the period in the MCO contract. |
| 94 | 3.4.4 | 37 | Will there be a defined period of time after a member selects a plan either during open enrollment or initial enrollment to voluntarily change plans? | DHHS will outline the parameters around voluntarily changing plans after open enrollment or initial enrollment in the MCO Contract. |
| 95 | 3.4.4 | 36-37 | How will families be assigned. Will they be kept in the same MCO if they have PCP's in different MCO's? | Families will be auto assigned as a single "unit" in the algorithm. |
| 96 | 3.4.4 | 36 | Please provide details on the components of the technical score that is used to determine the auto-assignment algorithm | DHHS is not releasing detailed information on scoring criteria. |
| 97 | 3.4.4 | | Auto-assignment. This section assumes that the highest technical score will be correlated with MCO performance. The results of the two readiness reviews may be a better early predictor of MCO performance, and after the first year HEDIS scores, satisfaction scores, or a combination of ratings may better serve consumers. Would DHHS consider acknowledging other potential ways to determine auto-assignment prior to receiving proposals? | The algorithm for auto-assignment identified in the RFP is a sample algorithm. DHHS reserves the right to modify the auto-assignment at its discretion. |
| 98 | 3.4.5. | 37 | Will DHHS consider changing the 60 days to 90 days as this time frame is more efficient, meets specifications from the other states where we provide Medicaid managed care and avoids member confusion? | DHHS intends to provide automatic re-enrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less. |
| 99 | 3.4.5 | 36-38 | Does the auto-assignment algorithm apply for the entire length of the contract or the initial 24 month period? | The initial algorithm will be used for the first year of the program |
| 100 | 3.4.5 | 37 | Is the member automatically reassigned to the plan they were last located in when losing eligibility for 2 months? | If a member loses eligibility for two months or less, the member will be automatically re-enrolled in the MCO in which the individual was enrolled prior to losing eligibility. |
| 101 | 3.5 | 38 | Please advise if it is required to have the PCP's address printed on the ID card or if the PCP's name and phone number is acceptable? | The Member ID card must include the PCP's name, address, and telephone number (in addition to the other minimum requirements identified in the RFP). |
| 102 | 3.5.1 | 37 | Is there a dollar limit to promotional items for members? | Bidder to propose their approach; department reserves right to adjust dollar limit. Ref. 42 CFR 417.538 |
| 103 | 3.5.1 | 37 | It is our standard operating procedure to offer incentive programs to encourage members to complete preventive/wellness programs. Will DHHS permit the Bidder to offer incentive programs to members? | Yes, but the incentives programs must be approved by DHHS. |
| 104 | 3.5.1 | 38 | It is our standard operating procedure to have the name of the assigned PCP on the ID card, but not the PCP's effective date. Would DHHS permit that only the PCP name be on the ID card (not the effective date), to avoid member and provider confusion? | DHHS will take the question under advisement and finalize the approach in the MCO Contract. |
| 105 | 3.5.1 | 38 | The required elements include the provider's name, address and telephone number. Would DHHS consider allowing just the provider's name and telephone number to avoid potential member confusion over multiple office locations attributed to the same provider | The Member ID card must include the PCP's name, address, and telephone number (in addition to the other minimum requirements identified in the RFP). |
| 106 | 3.5.1 | 38 | When will DHHS have the minimum requirements of the member handbook available? | Minimum requirements for the Member Handbook will be outlined in the MCO Contract. |



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| 107 | 3.5.1 | 38 | What is the time frame for re-issuing Member ID Cards? | The MCO should cite its usual and customary process |
| 108 | 3.5.1 | 38 | Does this have to be given in paper form or can members be told of their opportunity to access online and request a paper copy at time of enrollment? | The handbook can be in both paper and electronic formats. |
| 109 | 3.5.1 | 37 | Will there be any additional time consideration for welcome calls to be made within 30 days for the initial population assigned to a MCO? | No |
| 110 | 3.5.1 | 37 | For the purposes of conducting welcome calls identified in RFP Section 3.5.1, are plans permitted to an automated call system with the option for the member to speak with a live agent? | Yes |
| 111 | 3.5.1 | 37-38 | Member Outreach includes, within 30 days of enrollment with the MCO, that the MCO call and take a "health risk assessment" and "screen for special needs and/or services for the member." Please clarify and define what the health risk assessment will include and what the State defines as "special needs." | Bidders should define their proposed health risk assessment approach and its definition of special needs in their RFP response |
| 112 | 3.5.2 | 38 | It is our standard operating procedure to provide audio CD's rather than audiotapes for the visually impaired because cassette tape players and tapes are no longer readily available. Would this standard operating procedure be acceptable to DHHS? | The reference to audiotapes in the RFP is an example format. Audio CDs would be considered an appropriate format for visually impaired members. |
| 113 | 3.5.2 | 38 | Member materials are required in English and Spanish and other major population group. Please provide verification of what measurement will be used to determine other languages needed for member materials. The website requirements reflect 10% threshold | A Major Population Group for member materials is defined at ten percent. |
| 114 | 3.5.2 | | Please identify the Major Population Groups to be accommodated and the threshold languages. [Note: the Cultural Competency section is very detailed with a lot of requirements] | A Major Population Group for member materials is defined at ten percent. |
| 115 | 3.5.3 | 39 | What is the timeframe for submitting documents to DHHS? For example, 30 days prior to use? Also, if we don't receive a response within 30 days (as an example), are we permitted to distribute the material? | DHHS approval is required prior to distribution. MCOs to allow a reasonable amount of time for DHHS to perform the review. |
| 116 | 3.5.3 | 39 | What does DHHS consider a substantive revision to the Provider Directory? Does the requirement for DHHS prior review and approval of updates apply to print directory, online directory, or both? This requirement seems to be in contrast with the statement on page 47 where DHHS wants immediate updates:Pg 47: 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 | Detailed requirements for updating the provider directory will be outlined in the MCO Contract. |
| 117 | 3.5.4 | 39 | When will DHHS provide the requirements and standards as referenced in this section? It is our standard operation procedure to have these standards available prior to the beginning the initial design of the system to make sure we are responsive to DHHS' n | Detailed requirements for updating the provider directory will be outlined in the MCO Contract, prior to implementation. |
| 118 | 3.5.4 | 39 | Regarding the Program Website, is translation of Program Content in the Provider Section required or is it specific to Member sections of the website? | Translation of Program Content is just in reference to the Member Section of the website. |
| 119 | 3.5.5 | 39 | Can this be accomplished through a NH dedicated team/management within our stand-alone Medicaid customer service/claims center? Employees will be trained and work specifically on NH Medicaid matters. Will bidders who provide in-person service center get more points/preference in scoring the RFP? | Bidders should propose their approach to member service operations. |



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| 120 | 3.5.5 | 40 | Please confirm if it is meant to state that the member hotline should only operate between the hours of 8am and 5pm Monday through Friday in addition to weekends and holidays? | The member call center should operate no less than standard business hours (8 am - 5 pm). The member hotline should be available 24/7. |
| 121 | 3.5.5 | 39 | RFP Section 3.5.5 appears to have two conflicting requirements regarding the hours of operation for a member call center. One reference identifies that plans must match the current DHHS call center hours of 8:00 am to 5:00 pm EST two days per week and 8:00 am to 8:00 pm EST three days per week. However, RFP Section 3.5.5 states that "the call center shall be operational Monday through Friday for the hours that the DHHS current member call center is operational." Which requirement is correct? If it is the former, is the requirement that these hours be available Monday through Friday? | The member call center should operate no less than standard business hours (8 am - 5 pm). The member hotline should be available 24/7. |
| 122 | 3.5.5 | 39 | RFP Section 3.5.5. states 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 percent of calls will be abandoned • Average Speed of Answer: 90 percent of calls will be answered with live voice within 30 seconds. Most call centers utilize an interactive voice response (IVR) system for all incoming member customer service calls, which offer self-service options to members (e.g., order an ID card, confirm eligibility, change address or telephone number, find a doctor or PCP, etc.) and often do not require the member to speak with a live agent. It is important to note that such systems give callers the option of selecting a live agent for assistance. Will DHHS consider amending the Average Speed of Answer requirement to state "90 percent of calls will be answered within 30 seconds or less by a live voice and/or an interactive voice response system," as this is a better offer of true service levels to report Average Speed of Answer as a blended rate of live agent and IVR? | MCOs to provide detail to current response times as part of their proposal. |
| 123 | 3.5.6 | 40 | Will DHHS permit the Bidder to advertise/market using billboards, radio, TV, bus transit etc.? | The MCO shall consult with DHHS and the Medical Advisory Committee when reviewing/approving marketing material. |
| 124 | 3.5.7 | 40 | What defines a region for the regional member meetings? Is there a standard process for notification (email, mail, phone) to which the MCO should adhere? | The bidders should describe their approach to regions and the notification process in their response. |
| 125 | 3.5.7 | 41 | Is there a required frequency for the ongoing in-person regional member meetings? | Regional meetings should be held on a quarterly basis. |
| 126 | 3.5.7 | 41 | Please clarify which Medicaid CAHPS surveys are to be administered by the MCO. | Both the complete adult and children's CAHPS must be used in the most recent version approved by NCQA |
| 127 | 3.5.7 | 40-41 | The RFP states that "each MCO shall develop and facilitate an active member advisory board that is composed of members who represent the member population." Since Step One includes all populations for designated care types and Step Two includes long term care services and support, will the advisory board immediately include members, and their families, of the developmental disability and acquired brain disorder population? Or will the state require that these members be wrapped in a year later? Will this advisory board influence and help define Steps Two and Three? Will the State provide leadership in the advisory board or will this be MCO-driven? | The bidders should describe their proposed approach to the member advisory board composition in their response. |
| 128 | 3.6 | | Cultural Considerations. Can the State provide a definition of the regions (a map or list of counties) as well as information on the current language prevalence by region? | Not at this time. |
| 129 | 3.7 | 44 | What exactly is expected of MCO's and their network of PCP's in terms of coordinating care with CMHC's? | The MCOs must address this in their proposal. |



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| 130 | 3.7 | 44 | Are there implications to a CMHC or an MCO if a CMHC must close an office and thereby increases the travel and wait time for consumers? If the travel and wait time requirements are not possible, is the MCO accountable? | Refer to section 3.7.1 of the RFP |
| 131 | 3.7 | 44 | Section 3.7 – requires an MCO to guarantee patient contact with a CMHC within 48 hours of discharge from New Hampshire Hospital. Given that some discharges are to shelters or other access points, how can the MCO guarantee this? | See Section 3.7.2 Timely Access to Service Delivery |
| 132 | 3.7.1 | 44 | What physician specialties are defined as PCP's? Family Practice? Internal Medicine? Are NP's and PA's considered PCP's? | The PCP and Provider Specialty requirements for the MCO Network are outlined in the RFP under the Provider Network Section. |
| 133 | 3.7.1 | 44 | What physician specialties are required for the network? | The PCP and Provider Specialty requirements for the MCO Network are outlined in the RFP under the Provider Network Section. |
| 134 | 3.7.1 | 44 | What physician specialties are defined as Mental Health Providers? | The PCP and Provider Specialty requirements for the MCO Network are outlined in the RFP under the Provider Network Section. |
| 135 | 3.7.1 | 44 | Requires 2 PCPs within 8 miles for urban. Most require 1 for 30 miles in urban. What is the reasoning for this? | Bidders should provide a proposed ratio for DHHS consideration |
| 136 | 3.7.1 | 44 | How frequently are the plans required to update GeoAccess maps to the state? | Plans are required to update GeoAccess maps to the state on a monthly basis. |
| 137 | 3.7.1 | 44 | Geographic distance is clearly defined for Step 1 providers, but there is no clarification for Step Two providers in the chart? Will this be defined in a follow on RFP? | Language Step 2 |
| 138 | 3.7.1 | 44 | MCO must meet certain geographic provider access standards for Members based in whether the Member's location is considered "Urban" or "Rural". The standards are clearly laid out (e.g. 2 PCPs within 8 miles for Urban members), however, the RFP does not articulate what criteria is being used to define the location as "urban" or "rural". Question: Can DHHS please provide criteria used to define "urban" and rural"? | There is no current definition. Bidders should propose their own definition for DHHS consideration. |
| 139 | 3.7.1 | 44 | Our health plan recognizes the following specialty types as primary care (upon execution of Primary Care participation agreement): Family Practice, General Practice, Internal Medicine, Pediatrics, Ob/Gyn and Nurse Practitioners. Question: Can DHHS confirm they recognize the specialty types listed above as primary care providers? Can DHHS please define the list of Specialists that are included in the Geographic Distance Access Standards? | The PCP and Provider Specialty requirements for the MCO Network are outlined in the RFP under the Provider Network Section. |
| 140 | 3.7.2 | 45 | DHHS states it is concerned about access to maternity services in Coos County and that Bidders should specifically describe in their proposal how they intend to assure access to maternity services in Coos County. 1. Would it be acceptable for the Bidder to include a response to this in question 31? 2. Can DHHS please provide their experience in developing a responsive hospital network for maternity care in Coos county? | 1. Bidders choice 2. We are supporting a network of OB/GYN providers shared among the three Coos County hospitals. In addition to the PMPM payment, DHHS intends to continue to financially support maternity services at Androscoggin Valley Hospital outside the scope of the RFP. |



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| 141 | 3.7.2 | 45 | Can the state please provide more information to bidders about the state's concerns about maternity access in Coos County. | Access is currently limited for maternity care in this region due to the fact that Huggins (Wolfeboro), Upper Connecticut Valley (Colebrook) and Weeks (Lancaster) Hospitals no longer provide labor/delivery services. |
| 142 | 3.7.2 | 45 | Waiting time for provider appointment is clearly defined in the chart in subpart 3.7.2. There are no requirements for Step Two providers. Will the state define this in a second RFP or will the MCO define this as part of its Step Two implementation and delivery? | Step Two provider access requirements will be defined as part of the Step Two planning process. |
| 143 | 3.7.2 | 44 | Regarding Timely Access to Service Delivery: Does the State consider Psychiatrists to be Specialists or Mental Health Providers when determining appointment wait times? | Regarding Timely Access to Service Delivery, the State considers Psychiatrists to be Mental Health Providers when determining appointment wait times. |
| 144 | 3.7.2 | | Post Discharge from New Hampshire Hospitals. The RFP indicates that DHHS is concerned about access to maternity services in Coos County and currently provides enhanced inpatient maternity payments to a local hospital. Is access to other services (e.g., OB/GYN) also an issue or are your concerns limited to hospital care? Will the Department adjust the MCO premium to reflect the special reimbursement for these services to this provider? | No other immediate concerns; and no, DHHS does not intend to adjust the premium payment |
| 145 | 3.7.3 | 45 | What is the definition of a women's health specialist? | A women's health specialist is defined as an OB, GYN Physician, APRN with OB specialty and certified mid-wives |
| 146 | 3.7.4 | 45-46 | How are providers to be paid by the MCO when the member is admitted as an inpatient as a result of an emergency room episode to a hospital that is not in network. Neither of the two examples provided specifically address this scenario. Can the MCO's be protected to only have to pay the NH Medicaid rate? | No, the MCOs will be responsible for negotiating payments to non participating providers. |
| 147 | 3.7.4 | 45 | Language states that payment amount is a matter between the MCO and the out-of-network provider. Is there a default mandate to encourage participation? 100%, 90%.? | No |
| 148 | 3.7.4 | 46 | Does the state have default language for contracts for Non-Par and out-of-network providers? | No, the state does not have default language for contracts for Non-Par and out-of-network providers. |
| 149 | 3.7.4 | 45 | What is DHHS policy for MCO payment amounts to out of network provider (but participating in DHHS Medicaid) for true emergency services? Are providers required to accept DHHS Medicaid reimbursement? | No, providers are not required to accept DHHS Medicaid reimbursement. |
| 150 | 3.7.5. | 46 | Does the Bidder receive additional points depending on their level of agreement (contract, letter of agreement, letter of intent or in negotiations)? | Bidders will be evaluated on the progress of their network development activities at the time of RFP submission (as documented in their RFP response). |
| 151 | 3.7.5 | 46 | What specialties are deemed to be knowledgeable about genetic or chromosomal conditions and related health risks? | Any licensed provider with specialized training and experience in serving individuals with developmental and intellectual disabilities and acquired brain disorders may qualify to provide services to this population |



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| 152 | 3.7.5 | 46 | What specialties are deemed to be knowledgeable about individuals with intellectual/developmental disabilities? | Any licensed provider with specialized training and experience in serving individuals with developmental and intellectual disabilities and acquired brain disorders may qualify to provide services to this population |
| 153 | 3.7.5 | 46 | Please confirm that "Include an indication of the level of agreement that has been reached at the time of the RFP response." means that having obtained a Letter of Intent from a provider is sufficient for a provider to be included in the bidder's provider network list and GIS reports. | A Letter of Agreement is sufficient. |
| 154 | 3.7.5 | 46 | RFP Section 3.7.5: Please confirm that providers who have entered into a Letter of Intent with a bidder and providers who the plan is actively recruiting may be included within responses to Q33 and Q34. | A Letter of Agreement is sufficient. |
| 155 | 3.7.5 | 46 | In the RFP, Q33, on page 46, asks that all bidders provide a list of providers by type and specialty in New Hampshire that are included in their network, or are expected to be in their network. "Include an indication of the level of agreement that has been reached at the time of the RFP response." Does this list need to include developmental disabilities and acquired brain disorder long term care providers as part of Step Two implementation? Will a second provider listing be asked for/required for submission at the time of Step Two implementation and if so, when? | A separate provider list will need to be provided for Step Two. |
| 156 | 3.7.5 | 46 | Can DHHS confirm that a signed Letter of Intent from a provider is an acceptable level of agreement? | A Letter of Agreement is sufficient. |
| 157 | 3.7.5 | | Second Opinion. What percentage of primary care and specialty care providers currently do not accept Medicaid? | The percentage is not known. |
| 158 | 3.8 | 47 | The RFP states that "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." It is our standard operating procedure to do daily online updates. Will this practice satisfy DHHS' requirement? | Yes |
| 159 | 3.8 | 47 | What is the preferred method for an MCO to notify DHHS of planned or unplanned disenrollment/termination of or by a provider? Phone, Fax, Mail, Email, Other? | The method of notification will be defined in the MCO contract. |
| 160 | 3.8 | | Provider Network Management and Requirements. Please clarify the provider termination process. If the plan for replacement is required within 72 hours, what does that plan include? Can the Department provide a listing of current New Hampshire physicians who are providing services to Medicaid members, by specialty? Is the MCO bidder expected to have contact with New Hampshire providers prior to bid submittal, i.e. Letters of intent to contract or is it sufficient to describe our approach to contracting the provider network to meet the Department's requirements? | Bidders should propose their provider termination replacement plan in their RFP response. Letters of intent are sufficient, however bidders will be evaluated on the progress of their network development activities as described in their RFP response, taking into consideration the most vulnerable population and the need for transition. |
| 161 | 3.8 | 47 | Will MCO's be prevented from excluding non-licensed Masters and Bachelors level staff from the provision of services? Given the extensive mandated supervision required in the community mental health system of care, RSA 415:18 has required the coverage of services provided regardless of the credentials of the staff providing the service. A change to this staffing requirement would have a significant negative impact on the cost and availability of services in the community mental health system. | See 3.8.1 designated and approved providers will be recognized in accordance with the RFP |



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| 162 | 3.8.1 | 49 | The RFP states that FQHCs and RHCs will be paid the current encounter rate paid by DHHS. Does this mean the current rate as of the date of service? | Yes |
| 163 | 3.8.1 | 50 | The RFP states that notice of termination must be provided by the earlier of 15 days after the receipt of issuance of the term notice, or 15 days prior to the effective date of termination. Would the Contractor be able to terminate immediately in certain exigent circumstances (e.g., if the provider lost its license or there was reason to believe members might be in harm's way) provided the Contractor notifies DHHS upon submission of the termination notice? | Immediate termination for exigent circumstances will be allowed upon prior approval of DHHS |
| 164 | 3.8.1 | 48 - 49 | The RFP states the MCO must submit model Provider Contracts to DHHS for review "during the Readiness Review process." Section 3.2 refers to two different readiness reviews -- by which date must the templates be submitted (the first or second readiness review)? | The MCO must submit model Provider Contracts to DHHS for review during the first readiness review. |
| 165 | 3.8.1 | 48 - 49 | By what date must executed copies of the Provider Contracts and subcontracts be submitted to the Department? | By the time the MCO Contract is signed executed copies of the Provider Contracts and subcontractors must be submitted to DHHS. |
| 166 | 3.8.1 | 48 - 49 | The RFP states the MCO must resubmit the model Provider contracts "any time it makes substantive modifications" to such agreements. Aetna regularly negotiates specific terms with individual hospitals and other providers. Can DHHS offer guidance regarding what constitutes the type of substantive modification that DHHS would like to receive? (E.g., does this apply only to those terms specific to the New Hampshire Medicaid program?) | Details regarding substantive modifications will be outlined in the MCO Contract. |
| 167 | 3.8.1 | 48-49 | Where are the NH DHHS requirements listed? Will an HMO that is only writing Medicaid business (no commercial business) need to also comply with any NH DOI provider contract requirements, or have the NH DOI approve the provider contract templates? Can Letters of Agreement or Letters of Intent be used in general, and will they be able to be used to determine network adequacy? Can a provider decide to maintain an exclusive relationship with an MCO as long as the MCO did not require provider to do so as a condition of contracting? | Bidder should contact the NHID directly with HMO licensure questions. |
| 168 | 3.8.1 | 48 | FQHCs and RHCs are paid at the encounter rate – does this vary from year to year based on cost reports and how does the new rate get communicated? | DHHS will inform the MCOs of annual rate changes. RHC/FQHCs are reimbursed per federal regulations |
| 169 | 3.8.1 | 49 | Can DHHS please describe its intent regarding provider relations presence in the state of New Hampshire as referenced in this section? | Bidders should describe their provider relations approach in their RFP response. |
| 170 | 3.8.1 | 49 | It is our standard operating procedure to make Provider Manuals available only through our website. Will this procedure be permitted by DHHS? | Yes |
| 171 | 3.8.1 | 48 | What authority is used for the designation of Level I and Level II trauma- the American College of Surgeons, or the State of New Hampshire? | See RSA 153-A:20 Emergency Medical and Trauma Services, Rulemaking and rules promulgated thereunder. |
| 172 | 3.8.1 | 48 | How is adequate number of participating providers having admitting privileges defined? Is this PCPs, specialists or both? | Adequacy is determined by the number of members served and the bidder's ability to meet the member service needs. This includes admitting privileges for both PCPs and specialists. |
| 173 | 3.8.1 | 48 | What date does DHHS consider inclusion in network? Credentialing date or contract effective date? | Time of second readiness review. |



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| 174 | 3.8.1 | 48 | What form of communication is required to notify DHHS within 2 business days of any significant changes to the provider network? Phone, Fax, Mail, Email, Other? | Written notification and a phone call is required to notify DHHS within 2 business days of any significant changes to the provider network. |
| 175 | 3.8.1 | 49 | Does the provider manual have to be distributed in paper format? Can this be distributed to providers via email, CD or other electronic format? | The provider manual can be distributed in paper or electronic format. |
| 176 | 3.8.1 | 49 | Is there a specific Encounter CPT code? | No, there is not a specific Encounter CPT code. |
| 177 | 3.8.1 | 48 | Are LOI's acceptable to use for purposes of the RFP response and until contract award? | Yes, Letters of Intent are acceptable to use for purpose of this RFP response and until contract award. |
| 178 | 3.8.1 | 48 | Are exclusive arrangements acceptable if agreed to by the providers? | No |
| 179 | 3.8.1 | 48 | Will the state please provide a copy of the New Hampshire DHHS requirements for provider contracts referenced in RFP Section 3.8.1? Bidders who are in the process of developing their networks will need to ensure that these provisions are incorporated into model agreements. If these requirements are not received until after contract award, it may delay or prolong network development activities. | 3.8.1 addresses DHHS' contract requirements. |
| 180 | 3.8.1 | 48 | RFP Section 3.8.1: Do all network providers have to be enrolled as a New Hampshire Medicaid provider prior to being eligible for entering into contract with a MCO? What actions are expected/required from a MCO to assist providers? | Yes, all network providers are expected to be enrolled as a NH Medicaid provider prior to being eligible for entering into contract with a MCO. The MCOs to describe exceptions to this requirement for DHHS to consider. |
| 181 | 3.8.1 | 48 | RFP Section 3.8.1: Will DHHS provide a data file containing current Medicaid providers with demographic data? | A list of providers is included in the databook |
| 182 | 3.8.1 | 48 | RFP Section 3.8.1: Per Network Requirements, 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. Please clarify and define "substantive." | Details regarding substantive modifications will be outlined in the MCO Contract. |
| 183 | 3.8.1 | 48 | Under the title "All Providers" on page 48, it indicates that "providers must be licensed or designated and approved in the State of New Hampshire to provide covered services for which the MCO is contracting with the provider, and not be under sanction or exclusion from the Medicaid program." It also notes that "DHHS will continue to be responsible for enrolling providers" as approved NH Medicaid providers. Will DHHS furnish an approved provider list to the MCO? Please define the DHHS provider approval process moving forward. | Enrolled providers were included in the databook appendices. Providers must be licensed or designated and approved to be enrolled. |
| 184 | 3.8.1 | 48 | The RFP states all providers in the MCOs 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. Question: Can DHHS elaborate on the extent of assistance that is expected from the MCO in assisting providers with Medicaid enrollment? Can the MCO enroll members and pay claims to a provider prior to enrollment in NH Medicaid if contracted with the MCO? | Yes, all network providers are expected to be enrolled as a NH Medicaid provider prior to being eligible for entering into contract with a MCO. The MCOs to describe exceptions to this requirement for DHHS to consider. |



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| 185 | 3.8.2(a) | 52 | What if a member ends up at a hospital on an emergency basis (either in state or out of state) or because member needs services that MCO does not have available in-network, and the provider is not enrolled in NH Title XIX program - does this mean the MCO cannot pay those claims? | No |
| 186 | 3.8.2 | 51 | Please confirm that deeming providers for the initial first year is not in conflict with NCQA credentialing Standards or 42 CFR 438.12 and 42.438.214 (b). | It is up to the bidder to determine its compliance with NCQA standards. DHHS' intent is to prevent a large-scale disruption of New Hampshire providers as they attempt to meet potentially multiple MCO credentialing standards. DHHS is also concerned with the MCOs' ability to credential their network providers in sufficient time to meet the program start date. Bidders are encouraged to propose alternative approaches. |
| 187 | 3.8.2 | 51 | RFP Section 3.8.2 identifies that "for the initial first year of the program, the MCOs shall deem all current Medicaid eligible providers as enrolled and credentialed." However, the following paragraph states that 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." These two statements appear to conflict; please confirm which statement is correct. Are MCOs permitted to deem providers credentialed based on current Medicaid enrollment, or must MCOs obtain credentialing applications and verify information? | The credentialing referenced in this RFP section is the MCO internal credentialing process. |
| 188 | 3.8.2 | 52 | The RFP states that the MCO must maintain a policy with respect to board certification status that mandates participation of greater than 98% board certification among participating PCPs and specialty physicians in the provider network. Question: 98% board certification is a high percentage and may impact our ability to fill gaps in the network. Would the DHHS consider a lower percentage rate such as 92% What percentage of current NH Medicaid PCPs and Specialists are board certified? Does DHHS allow the MCO to consider a PCP or Specialist in their 5 year post training board-eligible period to be considered/counted as board certified? | MCOs may include in their proposal an alternative recommended standard. |
| 189 | 3.8.2 | 51 | The RFP states for the first year of the Care Management Program, the MCO shall deem all current Medicaid eligible providers as enrolled and credentialed. MCOs may re-visit these credentialing standards in the second year of the program. Question: Must credentialing by the MCO be completed by the end of the first year of the program or at what point in the second year? When will the DHHS share a file of currently enrolled Medicaid providers with the MCO's for verification purposes? | Credentialing must be completed by the end of year one of the program. DHHS will provide a file of Medicaid providers to selected bidders. |
| 190 | 3.8.3 | 52 | Please clarify what type of influence providers will have on program changes and decisions. | Providers will serve on the MCOs Advisory Board. |
| 191 | 3.8.3 | 52 | RFP Section 3.8.3: Will DHHS conduct outreach to providers to encourage their participation? | DHHS expects the MCO to reach out to the provider's in New Hampshire to encourage participation. |
| 192 | 3.9 | 53 | Will any negotiated incentive program be subject to mutual written agreement of DHHS and the Contractor? | The incentive program will be defined in the MCO Contract. |
| 193 | 3.9 | 53 & 56 | Can DHHS please define its intent regarding the payment reform plan and the Bidder's measurable goals and outcomes; specifically regarding the reward or penalty provisions related to the Bidder's performance against the goals and outcomes? Would it be possible for the Bidder to receive partial credit of the 1% withhold if some but not all of the measurable outcomes were achieved? Can DHHS please define the measurement period for determining the Bidder's compliance with the measurable goals and outcomes for the payment reform plan? | The incentive program will be defined in the MCO Contract. |



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| 194 | 3.9 | 53 | When is the 1% incentive payout reconciled? 1 year of data with 90 days to reconcile as an example? | The incentive program will be defined in the MCO Contract. |
| 195 | 3.9 | 53 | In the section titled Payment Reform, it states that the "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." Will the State provide a detailed outline or template for this portion of the RFP? | No |
| 196 | 3.9 | | Payment Reform. Please provide additional detail about current New Hampshire initiatives as mentioned in the RFP. | The MCOs should be aware of community and state reform initiatives i.e. include in your proposal how you intend to implement and maintain payment reform initiatives, such as the NH Citizen's Health Initiative. |
| 197 | 3.10 | 54 | Is this assessment to determine level of placement or does it only determine eligibility for services? Also, what is the frequency that it needs to be initially done and revisited? Are there reporting requirements on the CANS and ANSA assessment? | The MCO is responsible for assuring the CANS and/or ANSA functional assessment has been completed and the eligibility requirements for community mental health long term care supports and services have been met. The assessment will be done at intake and quarterly. DHHS will establish reporting requirements in the contract with the MCO. |
| 198 | 3.10 | 54 | Is it DHHS' information that CMHCs are currently in compliance with all relevant State and Federal requirements, including but not limited to those requirements as reference in the RFP? Could DHHS please provide a listing of all current State requirements for CMHCs that the Bidder would be responsible for administering? | USC, CFR, New Hampshire Revised Statutes and New Hampshire Administrative Rules. |
| 199 | 3.10 | 54 | What is DHHS' definition of "reinvestment of savings" and what is the MCO's role? | As the system becomes more efficient and effective through the continued use of Evidence Based Practices and other strategies to reduce the need for services, it is the expectation of DHHS that those savings be reinvested in the continued implementation of the 10-year Olmstead Plan, including an expansion of programs and services outlined in the 10-year Olmstead Plan. |
| 200 | 3.10 | 54 | A. Are services for this specific population "carved out" from the MCOs scope of services? B. Please define the behavioral health and/or substance abuse services the | A. No B. See description of covered populations and services in the RFP. |
| 201 | 3.10 | 54 | Can the MCO use other qualified behavioral health providers, even if the CMHC has agreed to provide services within the MCO's service region? | The MCO may only use designated and approved Community Mental Health Providers for Community Mental Health Services. The MCO may use other enrolled providers such as LICSW, psychiatry, psychology or APRN to provide the psychotherapy benefit, as outlined in Section 3.10 sub 1. |
| 202 | 3.10 | 54 | What is the definition of a "qualified provider"? | Refer to NH Administrative Rules for Community Mental Health Services which define provider qualifications for specific CMH services. |



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| 203 | 3.10 | 54 | Page 54 #1 – Who defines “participation requirements”? | NH DHHS |
| 204 | 3.10 | 55 | Is the regional planning process already in place? How will the MCO provide oversight to ensure that services and programs offered are tailored to the New Hampshire community? What is the role of the New Hampshire BBH in the planning process? | New Hampshire has a behavioral health planning and advisory council responsible for providing a review of the federal block grant submission and performance measures that are tied to the national outcomes measures as well as New Hampshire specific measures. BBH has a full time state planner assigned to these responsibilities. The development of regional plans is currently recommended but not required in administrative rule or contract. He-M 403.05 requires “(a) A CMHP shall plan, establish, and maintain a comprehensive and coordinated array of programs and services for persons with mental illness who are residing in the region or are moving to the region from New Hampshire hospital (NHH) pursuant to He-M 426.” It is our expectation that this process will continue and that BBH will continue to have an active role in the development of statewide as well as regionally tailored programs and services. |
| 205 | 3.10 | 55 | Can DHHS please define the role of the Bidder in supporting the CMHCs hiring and retaining trained staff? Can DHHS please describe the Bidder's responsibilities for promoting provider competence and opportunities for skill enhancement through training op | The MCO will be expected to participate in and implement national initiatives that support the most effective and efficient delivery of services. DHHS expects the bidders to propose their approach supporting the CMHCs. |
| 206 | 3.10 | 55 | Can DHHS please describe the Bidder's role in supporting the "mental health court" through the CMCHs? Will DHHS please also describe if the cost related to this effort will be part of the Databook? | The MCO is expected to allow and pay for covered services recommended and/or required through the mental health court. |
| 207 | 3.10 | 54-56 | Pages 54-56 outline specific requirements for serving individuals who have a serious mental illness or serious emotional disturbance. Will a second RFP be issued by the state for Step Two outlining requirements for serving individuals who have a developmental disability or acquired brain disorder? Or will the MCO selected in Phase I be responsible for developing a service plan for Step Two populations? | DHHS will be developing information, guidelines and criteria regarding the specialized services included in Step 2. |
| 208 | 3.10 | 55 | Section reads: “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. ” Question: What is the current “support” they are getting? Is it expected that the MCO will provide this service? Or, Is this a billable service for which the MCO should pay the CMHC for its participation? | The MCO is expected to allow and pay for covered services recommended and/or required through the mental health court. |
| 209 | 3.10 | 55 | Section reads: “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” Question: Is it the State's expectation that this be performed on-site at the Hospital? | Either on site or utilizing existing videoconferencing capacity at NHH and the 10 Community Mental Health Centers or by telephone conference call. |



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| 210 | 3.10 | 55 | Will the financial responsibility for care given by the New Hampshire Hospital (state hospital) be retained by the state and the MCO's role is coordination of care into and out of the state hospital? | No. The MCO will not coordinate access to New Hampshire Hospital. |
| 211 | 3.10 | | Behavioral Health Services. Can the Department clarify whether that MCO will be at risk for payments to the CMHCs and other behavioral health providers or will the Department continue to maintain its current process for reimbursing BH providers? | The MCO will be at full risk for all Community Mental Health and Behavioral Health services for individuals covered under the RFP. |
| 212 | 3.10.7 | 55 | #10 – Will the MCO be required to have crisis intervention 24/7, or will they be required to contract with existing resources to have crisis intervention 24/7? NHCBA is trying to clarify if duplication of services will result? Could DHHS better define “regionally based crisis lines”? | The MCOs should address this in their proposals. |
| 213 | 3.10.8 | | Behavioral Health Services. Please clarify the requirement “The MCO shall allocate resources to support the New Hampshire community mental health service system to hire and retain well trained staff.” | The MCO will be at full risk for all Community Mental Health and Behavioral Health services for individuals covered under the RFP. |
| 214 | 3.10.12 | | Behavioral Health Services. Please clarify. Is the plan required to staff the court or is it required to pay CMHC staff to support that. | The bidder should outline in their responses their approach to addressing this issue. |
| 215 | 3.11.2, 3.11.7, 3.11.8 | 61 | Has the state filed a State Plan Amendment with CMS for consideration of a Health Home demonstration under the Affordable Care Act? If so, is there an anticipated time for approval and for beginning the demonstration? | No, the State has not filed a SPA with CMS for consideration of a Health Home demonstration under the ACA. |
| 216 | 3.11.2, 3.11.7, 3.11.8 | 61 | Can a CMHC or specialist serve as a PCMH if they demonstrate the capability to provide comprehensive primary care services consistent with a recognized PCMH care model? | Yes, a CMHC or specialist can serve as a PCMH if they demonstrate the capability to provide comprehensive primary care services consistent with a recognized PCMH care model. |
| 217 | 3.11.2, 3.11.7, 3.11.8 | 57-58, 60,61 | On page 58, the RFP states that “It is the expectation of DHHS that each MCO will actively support the creation of health homes for its medically complex members.” Can DHHS provide further details on the expectation for health homes? How does DHHS differentiate a health home from a medical home? On page 60 of the RFP, it states that “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.” Will DHHS take leadership in defining the health home model? Will the MCO(s) define the health home model? On page 61, Q58 asks bidders to “describe your experience, approach, and time needed to supporting Health Homes as defined by SAMSHA.” Is this the Health Home definition the State of New Hampshire will adhere to? | DHHS will work with the selected bidders to develop the Health Home model. The definition of Health Home will be finalized in the model development process. |
| 218 | 3.11.2 | | Care Coordination. The RFP requires the MCO to develop programs to support primary care providers wishing to qualify as a patient-centered medical home. Does DHHS mean certification by NCQA as a Patient-centered Medical Home or some other qualification? | NCQA certification as a patient centered medical home. |
| 219 | 3.11.2 | | Care Coordination. RFP indicates that DHHS considers enhanced care coordination by primary care providers to be a key strategy to improve health and control Medicaid costs while Section 3.11.6 states that the MCO is the best provider of support to improve care coordination. Please elaborate on the MCO and provider roles in care coordination. | DHHS is looking for the bidders to propose their approach to care coordination. |



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| 220 | 3.11.3 | 58 | What are the current arrangements for non-emergency transportation? How is that handled today? | Under current FFS system, all recipient volunteer drivers must be enrolled the program. All reimbursements are based on paid Medicaid service via the shortest route. Wheelchair van is a distinct service. |
| 221 | 3.11.3 | | Non-Emergency Transportation. Are there service limits or specific requirements around the needs for which non-emergency transportation is required to be arranged? Please clarify that you mean non-emergency medical transportation. | No service limits; but see He-W 574 General Medical Transportation and 573 Wheelchair Van Services |
| 222 | 3.11.4 | 58 | Will MCOs be allowed to have transportation sub -contracts in place for these services? | The bidder will be allowed to have subcontracts in place for non-emergency transportation, so long as the subcontractor(s) align with any subcontracting requirements in this RFP or MCO Contract. |
| 223 | 3.11.4 | 58 | RFP Section 3.11.4: Will DHHS provide additional information on the New Hampshire Wellness Incentive Program and interface with MCOs? Also, if the MCO is not contracted with participating CMHCs, how will that affect the MCO's participation in this initiative? | Information is available on the NH DHHS website. |
| 224 | 3.11.4 | | Wellness and Prevention. Can the State expand on the requirement that we coordinate with New Hampshire's Wellness Incentive Program? What are the State's expectations? Can you please tell us more about the program? | The MCO should outline their approach in the proposal. |
| 225 | 3.11.6 | | Chronic Disease. Will the data book allow prospective bidders to identify members with multiple, co-morbid chronic diseases and evaluate their total healthcare costs on a recent annual basis? | No |
| 226 | 3.11.8 | | System Coordination and Integration. Q62 requires the bidder to describe experience in managing chronic diseases that are listed in the RFP. Given that the Care Management program emphasizes a holistic approach, should the bidder also describe experience and outcomes with care management in the context of "whole person" approaches? | Yes |
| 227 | 3.12 | 63 | Where can the Bidder obtain a copy of DHHS' Quality Strategic Plan as referenced in the RFP? | The strategic plan is under development |
| 228 | 3.12. | 63 | Will the New Hampshire DHHS's Quality Strategic Plan be provided to the MCO? | The strategic plan is under development |
| 229 | 3.12 | 63 | Will the state detail: 1. How the MCO can access a registry? 2. The level of access the MCO will have to registries? 3. What registries will be accessible? | State law governs the operation of the registries |
| 230 | 3.12 | 63 | Will DHHS consider deeming of Quality Management requirements (including but not limited to External Quality Review) if the awardee is NCQA accredited? | Yes, DHHS will consider deeming of QM requirements if the awardee is NCQA accredited. |
| 231 | 3.12 | 64 | On page 64, the RFP calls for the MCO to "integrate behavioral health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to members." There is no mention of the developmental disabilities and acquired brain disorder populations being included in QAPI. Will a second RFP at a later date be issued for Step Two or further definition in this RFP be given by NH DHHS and if so when? | No |
| 232 | 3.12.2 | 65 | The RFP states that "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." When will this EQRO be engaged and available to work with the selected MCO(s) so that the MCO can fulfill its requirements outlined per this RFP? | The EQRO scope of services is not yet defined. |



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| 233 | 3.12.4 | 66 | Are the Performance Incentives unique for each MCO or will they be unique for each program? | Performance incentives will be the same for each MCO. |
| 234 | 3.12.4 | 66 | If not set forth in the model contract prior to execution, will any performance measures be subject to mutual written agreement of DHHS and the Contractor? | The process for selecting performance measures will be defined in the final contract. |
| 235 | 3.12.4 | 66 | Will the State provide specifications for the performance measures: 1. Smoking Cessation among Pregnant Women; 2. Reduction in Child and Adult BMI? | To be provided with MCO Contract |
| 236 | 3.12.4 | 66 | What is the methodology for establishing the improvement goal? | The methodology will be defined in the MCO Contract. |
| 237 | 3.12.4 | 66 | Will each health plan have the same quality incentives? | Yes, each bidder will have the same quality incentives. |
| 238 | 3.12.4 | 66-67 | If DHHS is not able to establish baseline and performance data, is there any opportunity for an MCO to earn or lose the 1% of capitation incentive? | The methodology will be defined in the MCO Contract. |
| 239 | 3.12.4 | 66-67 | Will the measures be industry standard measures (i.e. HEDIS) where possible? If not, will the awardee be involved in the process of drafting specifications? | The methodology will be defined in the MCO Contract. |
| 240 | 3.12.4 | 66-67 | The requirements do not mention achievement of benchmark performance. What would occur if the awardee's performance decreases slightly from the baseline, but maintains, for example, the 90th percentile national performance? Would the awardee still incur a penalty? | The methodology will be defined in the MCO Contract. |
| 241 | 3.12.4 | Pg. 66 Q71 | Are the measures "Adolescent Well Care Visits", "Follow up after Hospitalization for mental illness" and other measures listed in Q71 based on the NCQA HEDIS Technical Specifications? | The methodology will be defined in the MCO Contract. |
| 242 | 3.12.4 | Pg. 66 Q71 | Is it the intent of DHHS to implement the performance incentives based on outcomes from CAHPS 2013 and HEDIS 2014? | The methodology will be defined in the MCO Contract. |
| 243 | 3.12.4 | | Performance Incentives. What is the baseline data for the Performance Incentives? Q71 indicates that member satisfaction as measured by the CAHPS survey is to be one of four measures used during year one (and a number of other measures also rely on CAHPS data). Please clarify the timeframes for the quality payment in the context of the timeframes for conducting and reporting CAHPS data – e.g., CAHPS data relative to year one would be available by mid-year 2013. Are those scores the baseline for the purpose of determining an improvement goal, and if so, would year one quality payments then be made in 2014 when year two results could be compared to the year one baseline/improvement goal? | The methodology will be defined in the MCO Contract. |
| 244 | 3.13 | 67 | Is there a state wide specific EPSDT form that can be used for all plans | No |



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| 245 | 3.14 | | <p>Utilization Management. Q73 requires the bidder to describe its approach to utilization management. Please indicate the criteria currently used to make medical necessity determinations for prior authorization; are criteria based on national standard criteria sets such as Milliman Care Guidelines or McKesson InterQual? Also related to Q78, how is the appropriateness of inpatient care currently assured? Will we receive Medicare claims data for dual members in the Data Book or once the program is implemented?</p> <p>Please provide the following utilization data if available: Population in FFS appropriate for Utilization Review Number of reviews by setting Number and percent referred to 2nd level review; # and % denied Number and percent appealed and results of appeals Annual # of deliveries Estimate of women with high risk pregnancies Estimated number of people with special needs Waivers and current waiver enrollees by type of waiver; expenditures for waiver services</p> | DHHS uses McKesson InterQual Guidelines. DHHS does not have access to Medicare claims data on dual eligibles at this time. |
| 246 | 3.14 | | <p>Utilization Management. Q79 asks bidders to describe their approaches to control avoidable hospitalizations and readmissions. We have several questions. How does DHHS define an "avoidable hospitalization?" Are readmissions defined as admissions to another inpatient facility within 30 days of discharge from an inpatient facility? Will the data book assist bidders to identify current levels of avoidable hospitalizations and readmissions?</p> | Bidders should propose their approach to avoidable admissions and re-admissions in their RFP response. |
| 247 | 3.15.1 | 69 | When will DHHS make available it's detailed and comprehensive encounter manual? | Details regarding encounter data will be available in the MCO Contract. |
| 248 | 3.16 | | Grievance and Appeals. What metrics do you plan on using to establish appeal timeframes, e.g., NCQA? | Metrics will be established in the MCO contract |
| 249 | 3.16 | 69-70 | Please confirm that members must first exhaust all internal MCO appeal processes before seeking state fair hearing through DHHS. What are the time frames that apply to the appeal/grievance process? Can MCOs follow federal regulations? Is the reference to provider "reconsideration" in 3.16(b) the same as a provider appeal? If not, what is the difference? Does MCO's Medical Director and nurses conducting UM work need to be NH-licensed? | A member must exhaust all internal MCO grievance and appeals options before the case is referred to DHHS. DHHS has not yet determined the timeframe for appeals. Provider reconsideration in 3.16(b) is the same as a provider appeal. Refer question to DHHS about Medical Director and Utilization Management Nurses being NH licensed. |
| 250 | | 72 | Will DHHS please define the meaning of "Recipient Explanation of Medicaid Benefits"? | Recipient Explanation Of Medicaid Benefits as per federal requirement. |
| 251 | 3.17 | 73 | Can DHHS please provide a copy of the "established and approved criteria" for the Lock-in program? | See addendum #1 |
| 252 | 3.17. | 73 | For the monthly report regarding the Pharmacy Lock-in Program, what is the established report format, design, and mode of transmission? | The Pharmacy Lock-In Program report format, design, and mode of transmission will be decided between DHHS and the selected bidders during the implementation phase. |
| 253 | 3.17 | 73 | What are the criteria for the Pharmacy Lock-in Program? Are there requirements for a Physician Lock-In Program? Do all Lock-In requests require DHHS approval? | See addendum #1 |



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| 254 | 3.17. | 73 | Does the state currently have other existing lock-in programs for other service - i.e. medical, emergency room ? If so will it follow same process? | There are no other lock-in programs at this time. |
| 255 | 3.17 | | Fraud and Abuse, Pharmacy Lock-In Program. We have several questions about this section. Is a Lock-In Program currently in operation? If so, how many individuals are currently in the program, and what is the average tenure in the program? Our experience is that members who are eligible for Pharmacy or medical Lock-In are almost by definition part of a high risk/high cost cohort and may also be eligible for chronic care/disease management programs. Will the MCO be able to engage the member in one or both programs as indicated? | Bidders are allowed to propose their own lock-in programs, subject to DHHS review. DHHS will approve each MCOs lock-in criteria |
| 256 | 3.17 | | Fraud and Abuse, DHHS Responsibility. Item b) says "DHHS shall conduct investigations related to suspected fraud, waste, and abuse cases, and reserved the right to pursue and retain recoveries for the following types of claims older than six months for which the MCO does not have an active investigation." Are there types other than older than six months not under active investigation? | The intent is that for first six months after a claim is paid, the MCO retains full jurisdiction over the validity of the claim. After six months, DHHS will be allowed to review, audit, and potentially recover the claim, as it deems appropriate. The reference is to any and all claims older than 6 months |
| 257 | 3.18.f | 76 | How will DHHS ask for detailed claim history on members for a specific date? Will it be a file, an email, etc.? What will be the turn around requirement for the response? | The requirements for the detailed claims history related to TPL will be outlined in the MCO Contract. |
| 258 | 3.18.a.6 | 76 | Please describe how DHHS wants the member letter responses forwarded for accident and trauma cases? | This will be specified in the MCO Contract. |
| 259 | 3.18.f | 77 | Please describe how DHHS wants attorney and casualty information forwarded if the MCO is not allowed to pursue? | This will be specified in the MCO Contract. |
| 260 | 3.18.l | 78 | DHHS will require a monthly file of detail claim data. Is this for Encounters or TPL? If it is for TPL, please explain how the TPL file will be different from the specific claim histories DHHS will be requesting and the Encounter files that will be sent? When will the file format specification for the TPL file be available? | The requirements around detailed claims history in 3.18(f) is specifically related to TPL. Specific requirements for this claims history data will be outlined in the MCO Contract. |
| 261 | 3.18 | 75-77 | Please clarify what TPL monies the MCO is allowed to pursue, collect and retain? Section 3.18.a.1 states the MCO is to actively pursue ALL monies available from ALL resources. But, Section 3.18.b.3 says that DHHS is responsible for accident and trauma settlements and Section 3.18.b.g.1-3 says DHHS retains the right to pursue and retain recoveries for claims older than 6 months and accident, trauma and workers compensation. | The MCO is allowed to pursue, collect, and retain all TPL except for those specifically designated to DHHS in 3.18 (b) and 3.18 (g). |
| 262 | 3.18 | 76 | This section states that 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 of determination of an accident and trauma case". Please confirm if the DHHS asking for the MCO to define the claims population that could be accident or injury but the member is to return the questionnaire to DHHS and that DHHS will determine if this was accident or trauma related. If so will DHHS pursue and retain all cases. How will DHHS notify the MCO when the member has responded to the questionnaire so that any follow up letters were not sent. | This will be specified in the MCO Contract. |



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| 263 | 3.18 | 76 | What does the state define as Third Party Resources if under a a6 and a7 it appears the state retains rights to accident and trauma settlements, as the source of these are often third parties. | A third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a recipient under the approved state Medicaid plan. Third parties may include: Private health insurance · Employment-related health insurance · Medical support from absent parents · Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance) · Court judgments or settlements from a liability insurer · State workers' compensation · First party probate-estate recoveries; and/or · Other federal programs (e.g., Indian Health, Community Health, and Migrant Health programs), unless excluded by statute. MCO is required to pursue collection from private health insurance, employment-related health insurance, medical support from absent parents, and other federal programs, such as Medicare, that were required to pay a claim as part of a private insurance benefit of the member. |
| 264 | 3.18 | 77 | What is the state using to define claims that are older than six months for which the state then has right to pursue and retain recoveries for TPL? Is this date of service, date of accident driven, date of payment? | Date of payment. |
| 265 | 3.18 | 77-78 | Please provide the differences between these reports. For example is J looking into third party liability, or TPL and COB. Is report I provided to allow the state to evaluate and pursue settlements based on the questionnaire process noted under a 6? | 3.18.j is the information required for claim history to pursue accident and trauma cases. 3.18.k is the information required to review MCO third party billing and collections. 3.18.l is the information required as encounter data that may be requested in other sections of the RFP. This information is encounter data needed specific for DHHS TPL. |
| 266 | 3.18 | | General Question: What is the state defining as TPL, COB and settlement of accident and trauma cases. | TPL is a third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a recipient under the approved state Medicaid plan. COB is coordination of benefits between private or federal payor and Medicaid for individual claims processed. Accident and trauma claims are defined by 42 CFR 433.138 as claims with diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) The agency may exclude code 994.6, Motion Sickness. Settlement of accident and trauma case relates to the pursuit of these claims under a accident insurance or lawsuit |



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| 267 | 3.18 | | Third Party Liability. Item a) 6). When they refer to the return of letters to Medicaid members to follow up on claims, are they referring to information submitted by members in response to the letter to determine accident/trauma or letters that are undeliverable? | Responses submitted by members in response to the letters sent. An accident and trauma questionnaire will be sent with these letters that must be completed and returned by the Medicaid member. |
| 268 | 3.18 | | Third Party Liability. Item b) 3). Indicates that DHHS is responsible for accident and trauma settlements. Does that mean the MCO does not receive the recovered monies? 3.1.8.g) states that DHHS reserves the right to pursue and retain recoveries for settlements related to accident and trauma cases, does that mean that MCO is not to pursue these cases? Q93 asks how we'll adjudicate a claim involving an auto accident. | MCO is not to pursue accident and trauma cases. Funds collected by DHHS for accident and trauma cases will be retained by DHHS. |
| 269 | 3.18 | | Third Party Liability. Item b) 4). Can the MCO use their own mail order pharmacy vendor or must it contract with the DHHS mail order vendor? | The mail order pharmacy program noted in 3.18.b.4 relates to a Medicaid member with private insurance that requires the Medicaid member to use the private insurance mail order to pay for their medications. DHHS has established a program that allows DHHS to reimburse Medicaid members for their private insurance co-pays and deductibles when using their private insurance mail order for prescriptions. This does not relate to how the vendor chooses to handle pharmacy claims to be paid by Medicaid |
| 270 | 3.18 | | Third Party Liability. Item c). Please define eligible expenses. | Eligible expenses are expenses to operate and manage the MCO contract. |
| 271 | 3.19 | 80 | Will the MCO pay CMHC's directly or will it authorize payment through the MMIS? | Directly |
| 272 | 3.19.1 | 80 | It is our standard operating procedure to adhere to Federal prompt payment standards. Will this practice be allowed under this RFP? | Yes |
| 273 | 3.20 | 82 | Page 82 of the RFP notes that "DHHS shall review and approve all subcontractors." What process will DHHS put in place for approval and disapproval? | This will be specified in the MCO Contract. |
| 274 | 5.2 | 85 | May the Bidder assign this contract to an affiliate, provided the affiliate meets the requirements set forth in the RFP? | Yes |
| 275 | 5.2 | 91 | RFP Section 5.20: Please clarify if DHHS will consider a MCO who obtains a HMO license by the contract execution date to the equivalent of being licensed by the contract award? | An HMO license from the NH Department of Insurance must be acquired prior to award of contract – i.e. Contract execution (RFP Section 5.5 Item 13 3/08/2012) |
| 276 | 5.3 | 86 | If questions arise after the bidder's conference and Q&A's are submitted will there be any opportunity for further questions. | DHHS will post answers 11/23/2011 to questions received as of the close of the Cost Proposal Conference held on 11/17/2011 |
| 277 | 5.11 | 89 | Will the Department, for the reasons described below, please consider an alternative formulation of section 5.11. | RFP Section 5.11 is consistent with New Hampshire RSA Chapter 91-A |
| 278 | 5.17 | 90 | The RFP states on page 90 that "DHHS reserves the right to award a service, group of services, or total proposal and to reject any and all proposals in whole or in part." Can a bidder submit a proposal for Step Two exclusively? | No |



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| 279 | 6.2 | 92 | In RFP Section 6.2, it states that Bidders "must use a font size of 12 or larger." Does this apply to all text, including tables and graphics, or may we use smaller font sizes for tables and graphics in order to conserve space? | Text must be readable but font size 12 is not required for all materials. |
| 280 | 6.2 | | Presentation and Identification – Please provide instructions for including confidential information. | See RFP Section 5.11. |
| 281 | 6.13 | 97 | Need clarification on the "must be licensed by the New Hampshire Department of Insurance to operate as an HMO in the state or acquire such license prior to the award of the contract." Is it required before the award can be made or at the effective date | An HMO license from the NH Department of Insurance must be acquired prior to award of contract – i.e. Contract execution (RFP Section 5.5 Item 13 3/08/2012) |
| 282 | 6.4 | | Content Description. Table of Contents. The RFP states "required elements of the Proposal shall be numbered sequentially and represented in the Table of Contents." 6.12 Addenda to Technical Proposal is a required element (and not the last one). It says that it should be "in a separate document...bound or contained as a single discrete unit with its own Table of Contents". Do we have to consider everything in 6.3 as a required element or can we use separate numbering for some, perhaps starting with Statement of Bidder's Financial Condition? Also, do all pages need to be numbered sequentially from start to finish including attachments/exhibits? | Addenda to Proposal should be bound or contained as a single discrete unit with its own Table of Contents. |
| 283 | 6.6 | 95 | We understand this information to be required of the Bidder only, is that correct? | Yes |
| 284 | 6.7 | 95 | Does DHHS want provider network references and client testimonials for each of the three client references? | Yes |
| 285 | 6.8 | 96 | If the MCO is a start-up, newly licensed HMO in NH, what information do we provide for financials? That of the parent company that operates Medicaid MCOs in other states? | Yes |
| 286 | 6.9 | 97 | Will a Performance Bond be required? If yes, what is bond amount and how will it be calculated? Is use of an annual bond form extended by continuation certificate acceptable by the State? | Refer to New Hampshire Department of Insurance requirements |
| 287 | 6.11 | 97 | Are intercompany agreements between MCO and affiliates (common parent) considered subcontracts? | Subcontracts include agreements between related and unrelated organizations, including affiliates. |
| 288 | 6.14 | 98 | Will adjustments to cost proposals and scope of work be subject to mutual written agreement of DHHS and Bidder? | Yes |
| 289 | 6.16 | 98 | DHHS lists required statements that must be included with the proposal as GIS reports (Appendix A) and Exceptions to Terms and Conditions (Appendix B) Question: Is the Bidder also required to complete and submit Appendix C as part of the Attachments? | Exhibit B requires the Responder to indicate any exceptions (or "none") to the terms and conditions of the RFP, which includes the terms and conditions of Exhibit C. |
| 290 | Appendix A | | Will the MCO be provided the member locations by DHHS in order to demonstrate accessibility in the GIS reports? | See Addendum #1 Appendix E |
| 291 | | | If a CPT Code is not priced in the NH Medicaid Fee Schedule and it is a covered service, how is the fee calculated to pay providers? | Manually priced. |
| 292 | | | Which version of the CMS DRG payment methodology is DHHS currently using? | The most current CMS MS DRG schedule with state specific modifications for neonatal rates and usage of lower price points |



New Hampshire Medicaid Care Management Program

| Nr. | Section | Page | Question | Answer |
|-----|---------|------|--|--|
| 293 | | | What are the current Disease Management programs provided by DHHC? Methods – telephonic or face-to-face? Engagement rates? | DHHS does not currently have any Disease Management programs |