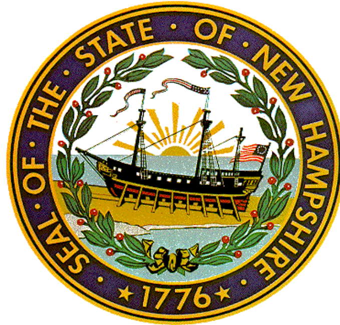
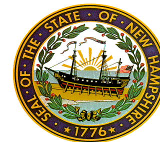


State of New Hampshire

Department of Health and Human Services

REQUEST FOR PROPOSALS RFP-2019-OMS-02-MANAG
FOR
MEDICAID CARE MANAGEMENT SERVICES

August 30, 2018



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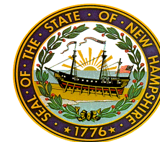

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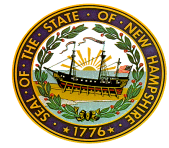


Dear Prospective Respondent:

The New Hampshire Department of Health and Human Services (DHHS) is soliciting proposals from qualified organizations to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program, known as New Hampshire Medicaid Care Management (MCM). Contractual obligations, including readiness review, will become effective on the date the Governor and Executive Council approve the executed MCM Contract. Managed Care Organizations (MCOs) will begin providing services to Members on the Program Start Date, July 1, 2019. The MCM Contract term will continue through June 30, 2024.

DHHS expects to select three MCOs willing to work responsively with the State, Providers, and Members to provide high-quality, integrated health care on a Statewide basis. The Executive Summary contained within this request for proposal (RFP) provides an overview of key provisions of the MCM Model Contract that reflect the priorities of DHHS, and that are described in further detail throughout the RFP, the MCM Model Contract, and other State policy documents.

MCOs will arrange for the provision of services to approximately 180,000 MCM Members determined by DHHS to be eligible for managed care, including pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled, among others, as described in the MCM Model Contract. MCOs will cover the acute care, behavioral health, and pharmacy services for all Members and work with DHHS to address the crucial social determinants of health in accordance with the attached MCM Model Contract.

Respondents are expected to identify the ways in which they will meet or exceed MCM program requirements and are strongly encouraged to propose innovative solutions targeted at meeting New Hampshire MCM Member needs and in alignment with DHHS-specified goals for program improvement.

New Hampshire seeks MCO partners that will advance the goals of the MCM program and offer innovative strategies for addressing the opioid crisis, coordinating and expanding community mental health services for persons presenting in hospital emergency rooms, expanding services for children and families in the child welfare system, and improving population health in every county of the State.

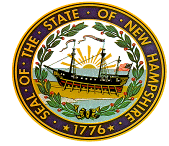
MCOs must have the capability to provide a person-centered, integrated, and comprehensive delivery system that offers the full array of accessible Medicaid services, taking into account each Member's physical wellbeing, behavioral health (mental health and substance use disorders), and social circumstances. DHHS will challenge its MCO partners to work responsively with the provider community and MCM Members to improve access to care and promote healthy behaviors. New Hampshire's MCM program will incentivize value over volume, enhance program efficiency, and hold MCOs accountable for demonstrable improvements in health outcomes.

Specific instructions and details for responding to the RFP and regarding the MCO selection process are enclosed in this RFP. Respondents are expected to review the MCM Model Contract (also available on the DHHS website at https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm) to inform their understanding of the MCM program and requirements for participation. Respondents must routinely check the New Hampshire RFP website for addenda and notices regarding this RFP.

In accordance with the Procurement Schedule in Section 4.2 (Figure 5), a Mandatory Respondent Conference will be held on September 7, 2018 at the State of New Hampshire Department of Health and Human Services, in Concord New Hampshire. The conference will serve as an opportunity for potential Respondents to ask specific questions of DHHS staff concerning the requirements of the RFP, and to express their interest. DHHS will only evaluate Proposals submitted by Respondents who attend the Mandatory Respondent Conference, as evidenced by a signature from a representative of the Respondent's organization. To ensure adequate accommodations, the Respondent must contact the Procurement Coordinator, Catherine Cormier, 603.271.9076, catherine.cormier@dhhs.nh.gov, as soon as possible to pre-register the organization's representative(s) for the conference.

Sincerely,

Jeffrey A. Meyers
Commissioner
Department of Health and Human Services



1. INTRODUCTION

1.1. Terminology

1.1.1. All Definitions included in the Appendix C MCM Model Contract apply to this RFP. In addition, the following definitions apply:

1.1.1.1. Respondent/Responder means an organization submitting a proposal in response to the RFP.

1.1.1.2. Requests for Proposals (RFP) means an invitation to submit a proposal to provide specified goods or services, where the particulars of the goods or services and the price are proposed by the Respondent and, for proposals meeting or exceeding specifications, selection is according to identified criteria as provided by RSA 21-I:22-a and RSA 21-I:22-b.

1.1.1.3. State Fiscal Year (SFY) means the term that begins July 1 and ends the following June 30.

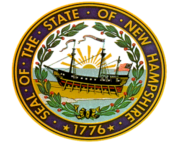
1.1.1.4. Vendor/MCO. The Vendor/MCO means the contractor with whom DHHS will enter into a contract.

1.1.1.5. The Technical Proposal/Technical Components of the RFP means the Respondent's response to questions and other requested information included in Appendix D (Mandatory Responses to Technical Components of the RFP)

1.1.1.6. The Cost Proposal/Cost Components of the RFP means the Respondent's response to questions in response to questions and other requested information included in Appendix E (Mandatory Responses to Cost Components of the RFP)

1.2. Contract Period

1.2.1. Contractual obligations, including readiness review, will become effective on the date the Governor and Executive Council approve the executed MCM Contract or health maintenance organization (HMO) licensure in the State of New Hampshire or whichever is later. The Program Start Date shall begin on July 1, 2019, and the Contract term will continue through June 30, 2024. The MCO's participation in the MCM program is contingent upon the MCO's successful completion of the contract readiness review period, as determined by DHHS. The MCO is solely responsible for the cost of all work during the readiness review and undertakes the work at its sole risk. If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, July 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Contract.



2. BACKGROUND

2.1. Executive Summary

2.1.1. MCM Program Background

2.1.1.1. DHHS first transitioned to Medicaid managed care and began operation of the MCM program in December 2013. Under the MCM program, New Hampshire currently has full-risk, capitated contracts with two MCOs that cover the physical health, behavioral health, and nearly all pharmacy services for approximately 134,330 Medicaid beneficiaries.

2.1.1.2. Beginning on January 1, 2019, 43,970 Medicaid beneficiaries who are currently in the State's New Hampshire Health Protection Program will be enrolled in the MCM program as members of the new Granite Advantage Health Care Program for coverage of the able-bodied New Adult Group.

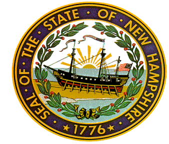
2.1.1.3. Upon Contract approval by the Governor and Executive Council and successful completion of readiness review with DHHS, selected MCOs will begin delivering services on July 1, 2019 and will cover acute care, behavioral health, and pharmacy services for children and adults enrolled in New Hampshire's Medicaid program. The MCM program does not include Long Term Services and Supports (LTSS) (e.g., nursing home and Home and Community Based Services (HCBS) waiver services and supports), Developmental Disability and Acquired Brain Disorder services, or New Hampshire Division of Children, Youth, and Families (DCYF) Medicaid services. All of those services will continue to be offered through fee-for-service (FFS) outside of the MCM program, as will all services for select MCM exempt populations as described in the MCM Model Contract.

2.1.2. Population Overview

2.1.2.1. Coverage in the MCM program is available to individuals who meet specific income thresholds and other eligibility criteria, including: pregnant women, children, parents/caretaker relatives, non-elderly, non-disabled adults under age sixty-five (65), individuals who are Aged, Blind or Disabled, among others, as further outlined in Figure 1 below.

Figure 1. MCM Program Population Overview

Eligibility Category	Projected MCM Members*
Low-Income Children – Children's Health Insurance Program (CHIP) (Age 0-18)	14,100
Low-Income Children - Non-CHIP (Age 0-18)	73,030
Foster Care, Former Foster Care & Adoption Subsidy (Age 0-25)	2,420
Children With Severe Disabilities (Age 0-18)	1,180
Low-Income Non-Disabled Adults (Age 19-64)	12,140
Breast and Cervical Cancer Program (Age 19-64)	150



Eligibility Category	Projected MCM Members*
Adults With Disabilities (Age 19-64)	16,800
Elderly & Elderly With Disabilities (Age 65+)	8,710
NH Health Protection Program (Age 19-64) - Frail	8,880
NH Health Protection Program (Age 19-64) - Non-Frail	43,970
Total Enrollment	**181,380**

2.2. Goals of the MCM Program

2.2.1. DHHS is committed to advancing MCM program performance and will use the RFP process to select MCOs committed to working with DHHS to provide high-quality, high-value care to New Hampshire residents. The MCM Model Contract, attached to this RFP, delineates in detail the specific requirements and expectations of MCOs.

2.2.2. New Hampshire's objectives in the upcoming procurement include the following:

2.2.2.1. Beneficiary Choice and Competition: DHHS is committed to providing MCM Members with three (3) high-quality MCOs from which to choose. DHHS recognizes there are challenges for new plans entering an existing market. DHHS plans to utilize a program structure to allow new entrant(s) the ability to achieve an equitable share of MCM Members within twelve (12) to eighteen (18) months of the beginning of the new contract.

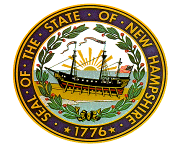
2.2.2.2. Continuity of Care: A Member's decision to continue to be served by an existing MCO, if selected in the procurement, will be honored.

2.2.2.3. Integrated Care: MCOs are expected to provide person-centered care that is accessible and takes into account each Member's physical health, behavioral health (mental health and substance use disorders), and social and economic needs. DHHS expects MCOs to work with Members, Providers, Integrated Delivery Networks (IDNs), and Community Mental Health Programs (CMHPs) to integrate physical health and behavioral health and address social determinants of health that affect health outcomes and the cost-effectiveness of care.

2.2.2.4. Increase Access to Care and Healthy Behaviors: DHHS expects MCOs to provide Members with access to health care Providers and incentives and opportunities to participate in healthy behaviors.

2.2.2.5. Provider Friendly Environment: DHHS is increasing its commitment to Medicaid Providers by expecting MCOs to coordinate enrollment and payment efforts to better align with State processes.

2.2.2.6. Incentivize Value Over Volume: Increasingly, DHHS will expect MCOs to pay Providers based on the outcomes that they achieve rather than the volume of care that they deliver through use of Alternative Payment Models (APMs).



2.2.2.7. Accountability for Results: A share of payment to MCOs will be directly linked to their performance, ensuring accountability for results, particularly in high priority areas such as addressing Substance Use Disorders, integrating physical and behavioral health, providing robust Care Management, and reducing unnecessary use of high-cost services.

2.2.2.8. Public Reporting: Each selected MCO will be responsible for submitting and presenting an annual report to the Governor and the legislature that provides information regarding: how the MCO has helped address DHHS's priority issues, what innovative programs it has established, how it is addressing social determinants of health of its Members, how it is improving the population health of the State, and other key metrics of the program.

2.2.2.9. Heighten Program Efficiency: DHHS will leverage the MCM Model Contract to implement programmatic changes that increase standardization of administrative practices and simplify processes that are burdensome to the State, Providers, and MCOs alike.

2.2.3. DHHS is soliciting Proposals from qualified Respondents to enter into fully capitated, risk-based contracts to administer the MCM program. DHHS plans to enter into a contract with selected MCOs to provide Covered Services to Members from July 1, 2019 through June 30, 2024.

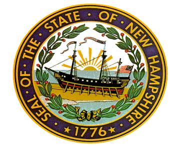
2.2.4. All terms and conditions will be finalized in the MCM Model Contract. MCOs shall be required to adhere to all requirements outlined in the final MCM Model Contract. The rates will be reestablished annually and as needed, subject to CMS approval pursuant to 42 CFR 438.6. Modifications will be issued on an as needed basis.

2.3. Overview of Key MCM Model Contract Components

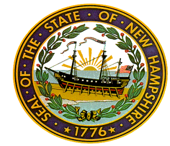
2.3.1. Figure 2 below provides a summary and description of key MCM program requirements further outlined within Appendix C MCM Model Contract. Respondents are required to demonstrate capabilities to perform all requirements included in the MCM Model Contract and not just those listed in Figure 2 below.

Figure 2. Overview of Key MCM Model Contract Components

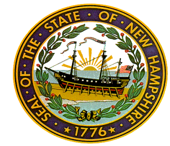
Component	MCM Model Contract Section	Description
Care Coordination & Care Management	Section 4.10	• MCOs will implement Care Coordination and Care Management strategies to improve Member care and health outcomes, reduce inappropriate hospitalizations and utilization of Emergency Services, address unmet resource needs, better integrate primary and behavioral health, and decrease total costs of care. • MCOs will conduct an initial Health Risk Assessment of every Member to identify Priority Populations who are most likely to



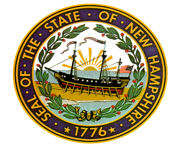
Component	MCM Model Contract Section	Description
		require Care Management. • Priority Populations will be given a Comprehensive Assessment to determine the level of Care Management needed. • Care Management for high-risk/high-need Members must be provided to at least fifteen percent (15%) of an MCO's Members or the MCO must provide to DHHS documentation of why fewer Members require such services, which will be subject to DHHS approval. • MCOs will be responsible for managing transitions of care for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department (ED) visits or adverse outcomes. • Designated Local Care Management, meaning Care Management that is performed at the site of care (or otherwise in the community) where face-to-face interaction is possible, is the preferred modality for Care Management. As such, the MCO will be required to conduct Local Care Management or contract with a Designated Care Management Entity. • MCOs are expected to use Local Care Management Entities to deliver Care Management to at least fifty percent (50%) of high-risk/high-need Members enrolled in Care Management. • Designated Local Care Management Entities can include Integrated Delivery Networks (IDNS) that have been certified as Care Management entities by DHHS or other Local Care Management Entities. During the period when contracting is not required with IDNs, MCOs shall enter into Memorandums of Understanding (MOUs) with IDNs to identify roles and responsibilities with respect to common Members and timely exchange of data, to the extent permissible by state and federal law. • MCOs are required to provide Member-level data on a monthly basis to Local Care Management Entities including IDNs related to Member's diagnoses, utilization of services and total costs of care; MCOs shall collaborate with IDNs to utilize the event notification and shared care plan system employed by IDNs, as applicable, for exchanging Member information necessary to provide care management.



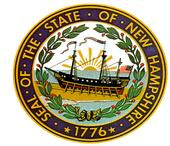
Component	MCM Model Contract Section	Description
Coordination and Integration with Social Services and Community Care	Section 4.10	• MCOs are required to address social needs for Members including promoting access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. • MCOs are required to develop relationships that actively link Members with other State, local, and community programs that may provide or assist with related health and social services.
Behavioral Health	Section 4.11	• MCOs are required to screen Members for behavioral health needs, maximize use of integrated and co-located care, develop and maintain care plans for Members with significant behavioral health needs, support Care Management during transitions in care, and offer an integrated Member service line. • MCOs are permitted to Subcontract with behavioral health vendors, provided DHHS reviews and approves the sub-contractual relationship.
Substance Use Disorder Treatment	Section 4.11	• MCOs are required to cover the full continuum of care required for Members with Substance Use Disorders. • MCOs are required to contract with all willing Peer Recovery Programs and methadone clinics to deliver Substance Use Disorder services for eligible Members. • MCOs are required to offer enhanced reimbursement to qualified physicians who are SAMHSA certified to provide Medication Assisted Treatment (MAT), and must develop MCO APMs for both MAT and Neonatal Abstinence Syndrome (NAS). • For infants at risk of NAS and their mothers, MCOs are required to establish a screening and treatment protocol. MCOs will also provide training to Providers regarding families with infants with NAS. • MCOs are required to annually conduct at least one (1) PIP designed to improve Substance Use Disorder treatment services. • MCOs are required to assist Substance Use Disorder Providers with proper billing and reimbursement for Medicaid services. Within the first one hundred and eighty (180) days of the Program Start Date, and on a case-by-case basis, DHHS has the discretion to direct MCOs to extend the one hundred and twenty (120) day timeframe for submission of a timely claim.
Pharmacy Management	Section 4.2	• MCOs are required to design formularies consistent with a single, State-designated Preferred Drug List (PDL) that: prioritizes Member care and access to necessary medications;



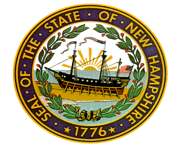
Component	MCM Model Contract Section	Description
		provides easy access to the right information for Members, prescribers, and pharmacies; and minimizes, wherever possible, Member and Provider burden. • DHHS retains the option of annually establishing a select list of drugs that will be carved out of the MCM program and covered by DHHS in order to ensure Member access. Additional information regarding the list of drugs currently excluded from the MCO Capitation Payment will be made available in the cost proposal elements of this RFP. • MCOs are required to provide medication management for all Members, including an annual medication review and counseling by a pharmacist for Members at risk of harm due to polypharmacy. MCOs are additionally required to complete specific activities intended to address the medication needs of special populations (e.g., Children with Special Health Care Needs, Members with Substance Use Disorder).
Member Enrollment & Disenrollment	Section 4.3	• Members enrolled in a current MCO that is selected in the procurement process will automatically be re-assigned to that same MCO; those Members will have the option to select a different MCO within ninety (90) days of their MCO assignment. • New Members who do not select an MCO as part of the Medicaid application process will be enrolled in an MCO and given ninety (90) calendar days to either remain in the assigned MCO or select another MCO. • A Member can change from one MCO to another outside the ninety (90) day MCO-selection period for a number of reasons, including if the Member was auto-assigned but has an established relationship with a PCP who is only in the network of a non-assigned MCO, or if the Member needs available services but not all services are available from the assigned MCO, and at annual redetermination. • The MCO shall support the implementation and ongoing operations of the work and community engagement eligibility requirements for certain Granite Advantage Members. MCOs will provide targeted outreach to Members who are subject to community engagement/work requirements to assist them in reporting compliance with, or exemption from, the requirements. In the event the Member becomes ineligible for Medicaid coverage due to the work requirement, the MCO is required to support DHHS in determining eligibility for other health insurance programs.



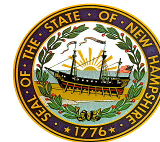
Component	MCM Model Contract Section	Description
		• DHHS will use the following factors in its auto-assignment methodology in the first contract year: preference to an MCO with which there is already a family affiliation; previous MCO enrollment, when applicable; Provider-Member relationship, to the extent obtainable; and equal assignment among the MCOs, taking into account new MCO entrants. In future years (once quality performance data is available and Members have been equally distributed across MCOs), DHHS will adjust the auto-assignment methodology to incorporate consideration of the MCO's quality performance.
Alternative Payment Models	Section 4.14	• In alignment with the Special Terms and Conditions of the Section 1115 *Building Capacity for Transformation* waiver, MCOs are required to develop a strategy for moving fifty percent (50%) of their medical expenditures into Qualifying APMs, as will be further defined via a DHHS Medicaid APM Strategy. • "Qualifying APMs" are defined by DHHS and must be in alignment with the Health Care Payment Learning & Action Network (HCP-LAN) APM framework Category 2C or above. "Qualifying APMs" also include Capitated CMHP Payments made in accordance with DHHS requirements. • In developing their APM strategies, MCOs are expected to predominantly rely on total cost of care models with shared savings for large Providers; to ensure that appropriate APM strategies are available for smaller Providers; and to maximize alignment with the APM models in use in the Medicare and the commercial markets. All APM models are subject to DHHS review and approval. • MCOs must provide to DHHS and Providers the methodology they will employ, including with respect to Member attribution, any attachment points, quality performance targets, and risk adjustment methodology, and are required to comply with data-sharing and reporting requirements, both to Providers participating in APMs and to DHHS. • MCOs are required to use their APM strategy to promote New Hampshire priorities, including priorities established in Senate Bill (SB) 313 or otherwise specified in the forthcoming DHHS Medicaid APM Strategy, including: management of pharmacy utilization, decreasing unnecessary service utilization including addressing use of the emergency department for non-emergency visits and reducing preventable admissions and all-cause readmissions, increasing timeliness of prenatal care and other efforts to reduce NAS births, integrating physical and behavioral



Component	MCM Model Contract Section	Description
		health including addressing the timeliness of follow-up after a mental illness or Substance Use Disorder admission, and enhancing access to Substance Use Disorder treatment and addressing social determinants of health.
Quality Management	Section 4.12	• MCOs are required to develop comprehensive Quality Assessment and Performance Improvement (QAPI) programs that reflect New Hampshire's priorities, including projects focused on behavioral health, and areas where clinical quality performance in the prior year was relatively poor; adopt mechanisms to address disparities in the quality of and access to health care; and use quality strategies aligned to Centers for Medicare & Medicaid Services (CMS) standards, National Committee for Quality Assurance (NCQA) standards, and DHHS-specified metrics. • MCOs are required to achieve Health Plan Accreditation from NCQA.
In Lieu Of Services and Value-Added Services (Optional)	Sections 4.1.3 and 4.1.7	• At the MCO's discretion and expense, the MCO may elect to purchase and provide services to Members to improve health, the quality of care, and reduce costs. • MCOs, with DHHS approval, may provide Members with services or settings that are "in lieu of" services or settings included in the Medicaid State Plan that are more medically appropriate, cost-effective substitutes for the Medicaid State Plan Services.
Access	Section 4.7	• MCOs are required to meet Statewide standards in federally-required areas (e.g., time and distance standards for Primary Care Providers (PCPs), specialists, obstetrics and gynecology) and additional areas identified by New Hampshire, including for Substance Use Disorder treatment services and for Children with Special Health Care Needs. • MCOs are required to comply with all New Hampshire Health Insurance Department (NHID) statewide network adequacy rules
Member Education and Incentives, Cost Transparency, Price Transparency, and Reference-Based Pricing	Section 4.9	• MCOs must publish on their website and incorporate in their Care Coordination programs cost transparency and price transparency information that identifies the most cost-effective providers and settings for select services. • MCOs must also propose, develop, and implement Member incentive programs, including a healthy behavior incentive program and a reference-based pricing incentive program. The reference-based pricing incentive program must be designed to



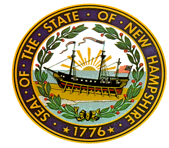
Component	MCM Model Contract Section	Description
		reward and reduce points (that are used to determine if the Member is eligible for an incentive) based on Member selection of services provided in low-cost, high-quality settings.
Withhold & Incentive Program	Section 5.4	• A portion of the MCO's Capitated Payment will be used to fund a Withhold and Incentive Program, designed to advance MCO accountability against a select set of priority interventions. Details regarding the Withhold and Incentive Program will be made available to MCOs in guidance separate from the MCM Model Contract. Generally, the design includes that MCOs meet certain performance improvement targets that will serve as "gating" criteria. MCOs – upon meeting the gating criteria – will be eligible to earn all, or a portion of, the withhold amount for meeting performance targets in each of the following three (3) areas: o Quality Improvement on Priority Metrics; o Behavioral Health; and o Care Management. • Any unearned portion of the withhold will be used to fund an incentive pool, from which MCOs may earn incentives based on their performance relative to other MCOs in the MCM program. • DHHS will issue guidance prior to the start of each MCM withhold measurement year that details the program requirements and targets for the forthcoming year and that further describes the mechanics of the program.
Children with Special Health Care Needs	Multiple Sections	• MCOs must meet DHHS standards for the treatment of Children with Special Health Care Needs, including children in foster care. These requirements include strengthening network adequacy requirements, ensuring access to Providers during transitions of care, improving Care Coordination and Care Management, and providing targeted Provider training. • In the future, DHHS is considering developing a specialized MCO that will serve children within DCYF's system and other Children with Special Health Care Needs.
Program Integrity	Section 5.3	• MCOs must comply with policies and procedures that guide and require the MCO and the MCO's officers, employees, agents, and Subcontractors to comply with federal and State program integrity requirements. • MCOs are expected to identify and investigate fraud, waste and abuse (FWA) of Providers and to refer fraud to DHHS Program



Component	MCM Model Contract Section	Description
		Integrity. • MCOs are required to identify and recover Overpayments and will report on FWA activities.
Remedies and Sanctions	Section 5.5	• DHHS is strengthening its remedies and sanctions requirements, including its use of liquidated damages, suspension of payments and intermediate sanctions, to ensure MCO compliance and accountability.
Third Party Liability/ Coordination of Benefits	Section 6.11	• MCOs are expected to pursue Third Party Liability (TPL) claims on behalf of DHHS, and Capitation Payments will be set at a level that reflects expected MCO recoupments; if an MCO is more effective than assumed, the MCO can retain the additional dollars that it has recouped. • MCOs are required to coordinate benefits to ensure that Medicaid is always the payor of last resort.
Minimum Medical Loss Ratio	Section 6.3	• MCOs are required to meet a minimum eighty-five percent (85%) Medical Loss Ratio (MLR); in the event the MCO's MLR is below eighty-five percent (85%) , the MCO is required to refund DHHS and/or the federal government the difference between the actual MLR and the dollar amount corresponding to an eighty-five percent (85%) MLR.

2.4. Culturally and Linguistically Appropriate Standards

2.4.1. The New Hampshire Department of Health and Human Services (DHHS) is committed to reducing health disparities in New Hampshire. DHHS recognizes that culture and language can have a considerable impact on how individuals access and respond to health and human services. Culturally and linguistically diverse populations experience barriers in their efforts to access services. As a result, DHHS is strongly committed to providing culturally and linguistically competent programs and services for its clients, and as a means of ensuring access to quality care for all. As part of that commitment DHHS continuously strives to improve existing programs and services, and to bring them in line with current best practices.



2.4.2. DHHS requires all contractors and subcontractors to provide culturally and linguistically appropriate programs and services in compliance with all applicable federal civil rights laws, which may include: Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Rehabilitation Act of 1973. Collectively, these laws prohibit discrimination on the grounds of race, color, national origin, disability, age, sex, and religion.

2.4.3. There are numerous resources available to help recipients increase their ability to meet the needs of culturally, racially and linguistically diverse clients. Some of the main information sources are listed in the Bidder's Reference Guide for Completing the Culturally and Linguistically Appropriate Services Section of the RFP, and, in the Vendor/RFP section of the DHHS website.

2.4.4. A key Title VI guidance is the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), developed by the U.S. Department of Health and Human Services in 2000. The CLAS Standards provide specific steps that organizations may take to make their services more culturally and linguistically appropriate. The enhanced CLAS standards, released in 2013, promote effective communication not only with persons with Limited English Proficiency, but also with persons who have other communication needs. The enhanced Standards provide a framework for organizations to best serve the nation's increasingly diverse communities.

2.4.5. Bidders are expected to consider the need for language services for individuals with Limited English Proficiency (LEP) as well as other communication needs, served or likely to be encountered in the eligible service population, both in developing their budgets and in conducting their programs and activities.

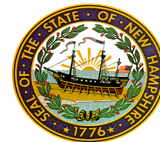
2.4.6. Successful applicants will be:

2.4.6.1. Required to submit a detailed description of the language assistance services they will provide to LEP persons to ensure meaningful access to their programs and/or services, and prior to the Program Start Date, as part of the readiness review.

2.4.6.2. Monitored on their Federal civil rights compliance using the Federal Civil Rights Compliance Checklist, which can be found in the Vendor/RFP section of the DHHS website.

2.4.7. The guidance that accompanies Title VI of the Civil Rights Act of 1964 requires recipients to take reasonable steps to ensure meaningful access to their programs and services by persons with Limited English Proficiency (LEP persons). The extent of an organization's obligation to provide LEP services is based on an individualized assessment involving the balancing of four factors:

2.4.7.1. The number or proportion of LEP persons served or likely to be encountered in the population that is eligible for the program or services (this includes minor children served by the program who have LEP parent(s) or guardian(s) in need of language assistance);



2.4.7.2. The frequency with which LEP individuals come in contact with the program, activity or service;

2.4.7.3. The importance or impact of the contact upon the lives of the person(s) served by the program, activity or service;

2.4.7.4. The resources available to the organization to provide language assistance.

2.4.8. Bidders are required to complete the two (2) steps listed in the Appendix G CLAS Requirements to this RFP, as part of their Proposal. Completion of these two items is required not only because the provision of language and/or communication assistance is a longstanding requirement under the Federal civil rights laws, but also because consideration of all the required factors will help inform Bidders' program design, which in turn, will allow Bidders to put forth the best possible Proposal.

2.4.9. For guidance on completing the two steps in Appendix G CLAS Requirements, please refer to Bidder's Reference Guide for Completing the Culturally and Linguistically Appropriate Services Addendum of the RFP, which is posted on the DHHS website at http://www.dhhs.nh.gov/business/forms.htm.

2.5. Contract Monitoring Provisions

2.5.1. All Respondents must complete Appendix F, Contract Monitoring Provisions.

2.5.2. The Department will determine if enhanced monitoring is necessary for any contracted Vendor.

3. PROPOSAL EVALUATION CRITERIA

3.1. Technical Proposal/Components Evaluation Criteria

3.1.1. The contents of the Respondent's Technical Proposal will be worth eight hundred (800) of one thousand (1000) total potential evaluation points. The topic areas included in Figure 3 (Technical Proposal Evaluation Criteria) below will be scored as part of the Respondent's Technical Proposal and the weights indicated will be applied to DHHS's assessment of the Technical Proposal.

3.1.2. The weights are further broken down in Appendix D (Mandatory Responses to Technical Proposal of the RFP), in line with the questions posed to the Respondent.

3.1.3. As noted in Contract Negotiations (Section 4.18) of this RFP, DHHS will negotiate the Terms of the Agreement; until DHHS successfully completes negotiations with the selected Respondent(s), all submitted Proposals will remain eligible for selection by DHHS.

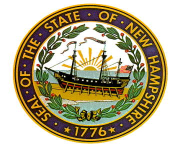


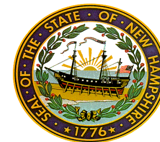
Figure 3. Technical Proposal Evaluation Criteria

Technical Proposal Evaluation Criteria	
RFP Section(s)	**Assigned Weight** (out of 800 possible points)
1. Organization Overview and Overview of Relevant Experience	50
2. Subcontractors	25
3. Covered Populations and Services	25
4. Pharmacy Management	70
5. Member Enrollment and Disenrollment	30
6. Member Services	20
7. Member Grievances and Appeals	20
8. Provider Appeals	10
9. Access	30
10. Utilization Management	30
11. Member Education and Incentives	60
12. Care Coordination and Care Management	100
13. Behavioral Health	100
14. Heath Homes and Children with Special Health Care Needs	50
15. Quality Management	30
16. Network Management	10
17. Alternative Payment Models	40
18. Provider Payments	10
19. Claims Quality Assurance and Reporting	10
20. Oversight and Accountability	30
21. Third Party Liability/Coordination of Benefits	50

3.1.4. The Respondent's Technical Proposal must address the Respondent's relevant experience, where applicable, and how that experience is to be applied in the covered areas. Generally speaking, scoring will be awarded based on:

3.1.4.1. The completeness and quality of the response to each specific prompt included in Contents of the Respondent's Technical Proposal (Section 5) of this RFP;

3.1.4.2. The degree to which the response demonstrates an ability to meet or exceed the requirements of the program, including those requirements set forth in the MCM Model Contract;



3.1.4.3. The degree to which the response demonstrates a thorough and thoughtful understanding of the specific needs of the Members described and included in the scope of this RFP and MCM Model Contract; and

3.1.4.4. The level of innovation and types of innovative approaches to service delivery described in the response; and the alignment of the response with DHHS's priority areas.

3.1.4.5. The Respondent's Technical Proposal shall reflect an understanding of the MCM Model Contract, which contains the DHHS's detailed requirements of the new MCM program. The Respondent must respond to the questions in a manner that addresses and supports the requirements of the MCM Model Contract. A simple restatement of the RFP or the MCM Model Contract language shall not be considered an acceptable response. The MCM Model Contract is subject to revision by DHHS during the course of the procurement and negotiations, which will result in the final MCM contracts with the Contracted Vendors.

3.1.5. The Respondent's response to the RFP questions shall reflect an understanding of all other Appendices to the RFP and MCM Model Contract as well as the DHHS's delivery system reform efforts including, but not limited to, DHHS's section 1115 waivers[1] and Medicaid State Plan Amendments.[2]

3.2. Cost Components of the Proposal

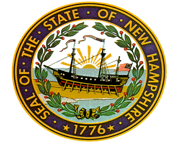
3.2.1. The contents of the Respondent's responses to the Cost Components of the RFP will be worth two hundred (200) of one thousand (1000) potential evaluation points. The topic areas included in Figure 4 (Cost Components Evaluation Criteria) below will be scored and the weights indicated will be applied to DHHS's assessment of the Cost Components of the Respondent's Proposal.

3.2.2. The Respondent should use the SFY 2019 MCM program and NHHPP capitation rate reports provided by DHHS in formulating its responses to the questions posed in the Cost Components of the RFP (Appendix E).

Figure 4. Cost Components Evaluation Criteria

Cost Components Evaluation Criteria	
RFP Section(s)	**Assigned Weight** (out of 200 possible points)
Managed Care Savings Opportunities (Questions 105 through 120)	120
Third Party Liability, Coordination of Benefits, and Cost Avoidance (Questions 121 through 123)	20

[1] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
[2] https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html



Cost Components Evaluation Criteria	
RFP Section(s)	**Assigned Weight** (out of 200 possible points)
Program Integrity – Fraud, Waste, and Abuse (Questions 124 through 125)	20
MCO Administrative Expenses and Efficiencies (Questions 126 through 130)	40

4. PROPOSAL PROCESS

4.1. Contact Information – Sole Point of Contact

4.1.1. Effective upon the RFP issue date and until the selection of a Respondent and approval of the resulting Contract by the Governor and Executive Council, the sole point of contact for this RFP relative to the bid or bidding process for this RFP is the Procurement Coordinator, whose contact information is as follows:

State of New Hampshire
Department of Health and Human Services
Catherine Cormier
Administrator I
Brown Building
129 Pleasant St.
Concord, New Hampshire 03301
Email: Catherine.cormier@dhhs.nh.gov
Phone: 603-271-9076

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

4.2. Procurement Timetable

4.2.1. Included in Figure 5 below is an overview of the procurement timetable. DHHS reserves the right to modify these dates and times at its sole discretion; in the event of a schedule change, the schedule update will be posted to DHHS's procurement website. All times are according to Eastern Time.

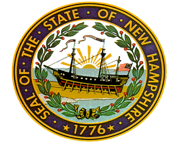
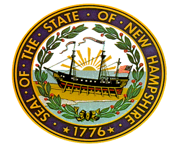


Figure 5. Procurement Schedule

Procurement Schedule *DHHS reserves the right to modify these dates at is sole discretion.*		
	Action	**Date**
1.	DHHS Issues RFP for Respondent Response	8/30/18
2.	Mandatory Respondent Conference	9/7/2018 1:00pm EST
3.	Respondent RFP Questions Due	9/12/2018
4.	DHHS Issues Answers to Respondent Questions	9/21/18
5.	Respondent Proposals Due	10/30/2018 2:00pm EST
6.	Oral Presentations *(to be scheduled as determined by DHHS)*	11/8/2018– 11/9/2018
7.	Contract Negotiations	11/19/2018– 12/3/2018
8.	MCO Contract Execution	12/5/2018
9.	Governor and Executive Council Approval of MCO Contract	12/7/2018-1/14/19
10.	Contract Effective Date and Readiness Review Period	Effective Upon Governor and Executive Council Approval of MCO Contract
11.	MCM Program Start Date	7/1/19



4.3. Mandatory Respondent Conference

4.3.1. The Mandatory Respondent Conference will serve as an opportunity for potential Respondents to ask specific questions of DHHS staff concerning the requirements of the RFP, and for Respondents to indicate their interest to DHHS.

4.3.2. In-person attendance at the Mandatory Respondent Conference is a requirement to submit a Proposal. DHHS will only evaluate Proposals submitted by Respondents who attend the Mandatory Respondent Conference, as evidenced by a signature from a representative of the Respondent's organization. To ensure adequate accommodations, the Respondent should contact the Procurement Coordinator as soon as possible to pre-register the organization's representative(s) for the conference.

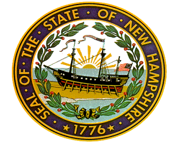
4.3.3. Oral answers given at the conference are non-binding; all Respondents will be provided the opportunity to submit formal questions for which DHHS will provide written responses, as described in Respondent RFP Questions and DHHS Response (Section 4.4) of this RFP.

4.3.4. The Mandatory Respondent Conference will be held on the date specified in the Procurement Schedule (Figure 5), in the Auditorium in the Brown Building, 129 Pleasant Street, Concord, New Hampshire. The Mandatory Respondent Conference is not open to the public. Respondents, good faith potential Respondents, and their representatives interested in attending the Mandatory Respondents Conference should contact the Procurement Coordinator specified in Contact Information – Sole Point of Contact (Section 4.1) to preregister for the Mandatory Respondent's Conference. However, same-day registration is allowed. All attendees will be required to register and disclose their affiliation.

4.4. Respondent RFP Questions and DHHS Response

4.4.1. All questions about this RFP that are raised outside of the Mandatory Respondent Conference, including but not limited to requests for clarification, additional information, or any changes to the RFP, must be made in writing, and reference the RFP and/or MCM Model Contract page number and part or subpart, and be submitted to the Procurement Coordinator identified in Contact Information – Sole Point of Contact (Section 4.1). DHHS may consolidate or paraphrase questions for efficiency and clarity. Questions that are not understood by DHHS will not be answered. Statements that are not questions will not receive a response. Questions will only be accepted from those Respondents who have attended the Mandatory Respondent Conference by the deadline given in Procurement Schedule Section 4.2 (Figure 5). Questions from all other parties will be disregarded. DHHS will not acknowledge receipt of questions.

4.4.2. Questions may be submitted by e-mail; however, DHHS assumes no liability for assuring accurate and complete e-mail transmissions. Questions must be received by the deadline given in Procurement Schedule Section 4.2 (Figure 5).



4.4.3. DHHS will provide responses to questions submitted in the correct format by the date listed in -Procurement Schedule Section 4.2 (Figure 5). Written answers to formal questions submitted at the Mandatory Respondent Conference will be posted on DHHS's procurement website (https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm). The Department will e-mail notification of the posting to the contact identified by the Respondent. This date may be subject to change at DHHS discretion.

4.5. RFP and MCM Contract Amendment

4.5.1. DHHS reserves the right to amend the RFP and MCM Model Contract, as it deems appropriate, prior to the Proposal Submission Deadline on its own initiative or in response to issues raised through Respondent questions. The MCM Model Contract is subject to revision by DHHS during the course of the procurement and negotiations, which will result in the final MCM contracts with the Contracted Vendors.

4.5.2. The draft RFP and MCM Model Contract are subject to change based upon a full review for compliance with federal and State law.

4.5.3. In the event of significant amendment to the RFP and/or MCM model Contract, DHHS, at its sole discretion, may extend the Proposal Submission Deadline. Respondents who attended the Mandatory Respondent Conference will receive notification of the amendment, and the amended language will be posted on the DHHS procurement website: (https://www.dhhs.nh.gov/business/rfp/rfp-2019-oms-02-manag.htm).

4.6. Submission and Acceptance of Proposals

4.6.1. In the event the Department receives a nonconforming Proposal, the following process shall apply:

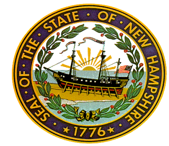
4.6.1.1. The Department shall, in writing, notify Respondents submitting timely proposals which, on initial review, do not appear to conform to the requirements of the bid of:

4.6.1.1.1. Nonconformities which are subject to correction and cure;

4.6.1.1.2. What, if any, additional or corrected information may be submitted to bring the proposal into conformity; and

4.6.1.1.3. The deadline by which such information must be received, which deadline shall, unless otherwise specified in the notice, be by the close of business on the third (3rd) business day after the date of the notice.

4.6.1.2. If, by the deadline established above, the Respondent notified submits materials or corrections that bring a proposal into conformity with the requirements of the RFP as specified, the Department shall, unless the process is cancelled by the Department, process the proposal as if the proposal had originally been in conformity therewith.



4.6.1.3. If, by the deadline established above, the Respondent notified does not submit materials or corrections as specified that bring the proposal into conformity with the requirements of the RFP, the Department shall finally disqualify the proposal and, unless the process is cancelled by the Department, process the matter as if the proposal had not been submitted.

4.6.1.4. For the purposes of this RFP, all nonconforming items are subject to correction and cure, except the following:

4.6.1.4.1. Appendix A Exceptions to Terms and Conditions

4.6.1.4.2. Signed Transmittal Cover Letter (Section 5.3.1.2)

4.6.1.4.3. Appendix D Mandatory Responses to Technical Components of the RFP

4.6.1.4.4. Appendix E Mandatory Responses to Cost Components of the RFP and Appendix E-1 RFP Cost Component Questions Excel Template

4.6.2. Proposals submitted in response to this RFP must be received no later than the time and date specified in procurement Schedule (Figure 5). Proposals must be addressed for delivery to the Procurement Coordinator in Section 4.1 and marked with **#RFP-2019-OMS-02-MANAG**.

4.6.3. Late submissions will not be accepted and will remain unopened.

4.6.4. Non-conforming submissions will be discarded if not re-claimed by the bidding Respondent by the time the contract is awarded.

4.6.5. Delivery of the Proposals shall be at the Respondent's expense. The time of receipt shall be considered when a Proposal has been officially documented by DHHS, in accordance with its established policies, as having been received at the location designated above. DHHS accepts no responsibility for mislabeled mail. Any and all damage that may occur due to shipping shall be the Respondent's responsibility.

4.7. Compliance

4.7.1. Respondents must be in compliance with applicable federal and State laws, rules and regulations, and applicable policies and procedures adopted by the Department of Health and Human Services currently in effect, and as they may be adopted or amended during the contract period.

4.8. Non-Collusion

4.8.1. The Respondent's required signature on the Transmittal Cover Letter (described in Section 5.3.1.2) for a Proposal submitted in response to this RFP guarantees that the prices, terms and conditions, and services quoted have been established without collusion with other Respondents and without effort to preclude DHHS from obtaining the best possible competitive proposal.

4.9. Collaborative Proposals

4.9.1. Proposals must be submitted by one Respondent. Any organization collaborating with the Respondent must be designated as Subcontractor subject to the terms of Appendix B Contract Minimum Requirements and the standards applied to the MCO if it was rendering services as described in Appendix C MCM Model Contract.

4.10. Validity of Proposals

4.10.1. Proposals submitted in response to this RFP must be valid for two hundred and forty (240) days following the Proposal Submission Deadline for receipt of Proposals specified in procurement Schedule (Figure 5) or until the effective date of any resulting contract, whichever is later. This period may be extended by mutual written agreement between the Respondent and DHHS.

4.11. Property of Department

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

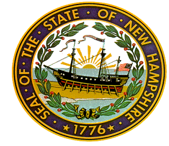
4.12. Proposal Withdrawal

4.12.1. Prior to the Proposal submission deadline for receipt of Proposals, a Proposal may be withdrawn by submitting a written request for its withdrawal to the Procurement Coordinator identified in Contact Information: Sole Point of Contact (Section 4.1).

4.13. Public Disclosure

4.13.1. The content of a Respondent's Proposal must remain confidential until the Governor and Executive Council have approved a contract as a result of this RFP. A Respondent's disclosure or distribution of the contents of its Proposal, other than to the State, will be grounds for disqualification at the State's sole discretion.

4.13.2. The content of each Respondent's Proposal and addenda thereto, will become public information once the Governor and Executive Council have approved a contract. Any information submitted as part of a bid in response to this RFP may be subject to public disclosure under RSA 91-A. In addition, in accordance with RSA 9-F:1, any contract entered into as a result of this RFP will be made accessible to the public online via the website Transparent NH (www.nh.gov/transparentnh/). Business financial information and proprietary information such as trade secrets, business and financials models and forecasts, and proprietary formulas may be exempt from public disclosure under RSA 91-A:5, IV.



4.13.3. Insofar as the Respondent seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the Respondent must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. This should be done by separate letter identifying by page number and proposal section number the specific information the Respondent claims to be exempt from public disclosure pursuant to RSA 91-A:4, I or RSA 91-A:5.

4.13.4. Each Respondent acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to NH RSA 91-A. DHHS is obligated to conduct an independent analysis of the confidentiality of the information submitted in an RFP. In the event DHHS receives a request identified by a respondent as confidential, and the information is deemed not confidential through independent analysis, DHHS shall notify the Respondent and specify the date DHHS intends to release the requested information. To halt the release of information by DHHS, the Respondent must obtain and provide to DHHS, prior to the date specified in the notice, a court order valid and enforceable in the State of New Hampshire, at its sole expense, enjoining the release of the requested information. If the Respondent fails to obtain a court order before the date specified in the notice, DHHS may release the information on the date DHHS specifies in its notice without incurring any liability to the Respondent.

4.14. Non-Commitment

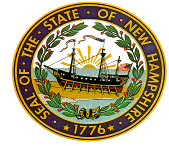
4.14.1. Notwithstanding any other provision of this RFP, this RFP does not commit DHHS to award a contract. DHHS reserves the right to reject any and all Proposals or any portions thereof, at any time and to cancel this RFP and to solicit new Proposals under a new bid process.

4.15. Liability

4.15.1. By attending the Mandatory Respondent Conference in response to this RFP, a Respondent agrees that in no event shall the State be either responsible for or held liable for any costs incurred by a Respondent in the preparation or submittal of or otherwise in connection with a Proposal, or for work performed prior to the effective date of a resulting contract.

4.16. Request for Additional Information or Materials

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



4.17. Oral Presentations and Discussions

4.17.1. Following Proposal submission, DHHS may require some or all Respondents to make oral presentations of their Proposal. Respondents are advised that any and all invitations to oral presentations are at the State's sole discretion. The purpose of oral presentations is to clarify and expand upon information provided in the written Proposal. Respondents are prohibited from altering the basic substance of their Proposals during the oral presentations. The Oral Presentations will be used to refine scores assigned to the RFP Responses.

4.17.2. Any and all costs associated with an oral presentation shall be borne entirely by the Respondent.

4.17.3. Respondents may be requested to provide demonstrations of any proposed automated systems. Such a request will be in writing and will not provide a Respondent with an opportunity to change, extend, or otherwise amend its proposal in intent or substance.

4.18. Contract Negotiations and Unsuccessful Respondent Notice

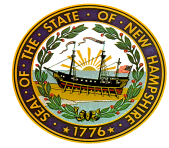
4.18.1. If a Respondent(s) is selected, the State will notify the successful Respondent(s) in writing of their selection and the State's desire to enter into contract negotiations. Until the State successfully completes negotiations with the selected Respondent(s), all submitted Proposals remain eligible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

4.18.2. In order to protect the integrity of the bidding process, notwithstanding RSA 91-A:4, no information shall be available to the public, or to the members of the general court or its staff, concerning specific responses to requests for bids (RFBs), requests for proposals (RFPs), requests for applications (RFAs), or similar requests for submission for the purpose of procuring goods or services or awarding contracts from the time the request is made public until the closing date for responses except that information specifically allowed by RSA 21-G:37.

4.19. Site Visits

4.19.1. DHHS reserves the right to request a site visit, at any time prior to for DHHS Staff to review the Respondent's organizational structure, Subcontractors' structure, policies and procedures, and any other aspect of the Proposal that directly affects the provisions of the RFP and the delivery of services. Any and all costs associated with the site visits incurred by the Respondent shall be borne by the Respondent.

4.19.2. The Department may also require the Respondent to produce additional documents, records, or materials relevant to determining the Respondent's capacity to satisfy the terms of this RFP. Any and all costs associated with any site visit or requests for documents shall be borne entirely by the Respondent.



4.20. Scope of Award and Contract Award Notice

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

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

4.21. Respondent Readiness

4.21.1. Prior to the MCO providing any services to Members, DHHS will review the MCO's readiness to begin providing services. The review will be to determine whether the MCO is carrying out its implementation plan as submitted in response to the RFP and agreed upon with DHHS. The Vendor is solely responsible for the cost of all work during the readiness review and undertakes the work at its sole risk. If DHHS determines that any MCO will not be ready to begin providing services on the Program Start Date of July 1, 2019, it may, at its sole discretion, withhold enrollment and require corrective action or terminate the Contract.

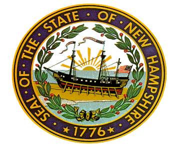
4.22. Protest of Intended Award

4.22.1. Any challenge of an award made or otherwise related to this RFP shall be governed by RSA 21-G:37, and the procedures and terms of this RFP. The procedure set forth in RSA 21-G:37, IV, shall be the sole remedy available to challenge any award resulting from this RFP. In the event that any legal action is brought challenging this RFP and selection process, outside of the review process identified in RSA 21-G:37,IV, and in the event that the State of New Hampshire prevails, the challenger agrees to pay all expenses of such action, including attorney's fees and costs at all stages of litigation.

4.23. Contingency

4.23.1. In addition to being contingent upon approval by the Governor and Executive Council, any contract awarded is contingent on the Respondent having a license from the New Hampshire Department of Insurance to operate as a health maintenance organization (HMO) in the State of New Hampshire which must occur no later than thirty (30) days following Contract approval by the Governor and Executive Council. Failure to satisfy this contingency will result in immediate termination of the contract without liability to DHHS. Any Respondent that executes a contract prior to having the required license to operate as an HMO does so at its sole risk and expense.

4.23.2. Aspects of the award may be contingent upon changes to State or federal laws and regulations.



5. PROPOSAL REQUIREMENTS

5.1. Presentation and Identification

5.1.1. Overview

5.1.1.1. Respondents are expected to examine all documentation and other requirements provided and/or referenced by DHHS. Failure to observe the terms and conditions in completion of the Proposal are at the Respondent's risk and may, at the discretion of the State, result in disqualification of the Proposal for non-responsiveness.

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

5.1.1.3. Acceptable Proposals must offer all services identified in Appendix C MCM Model Contract and the conditions specified throughout the RFP.

5.1.1.4. Proposals should be received by the Proposal Submission Deadline specified in Procurement Schedule Section 4.2 (Figure 5) and delivered, under sealed cover, to the Procurement Coordinator specified in Section 4.1.

5.1.1.5. Fax or email copies will not be accepted.

5.1.1.6. The Proposal must be signed in the manner described in Section 5.3.3.2 to be accepted for consideration.

5.1.2. Presentation of Submissions

5.1.2.1. Original copy of the Technical and Cost Components of the RFP shall be provided in separate three-ring binders.

5.1.2.2. Copies should be provided in a bound format (e.g., wire bound, coil bound, saddle stitch, perfect bound etc. at minimum stapled). Loose proposals will not be accepted.

5.1.2.3. Major sections of the Technical and Cost Components of the RFP shall be separated by tabs.

5.1.2.4. The Respondent shall use standard eight and one-half by eleven inch (8 ½" x 11") white paper.

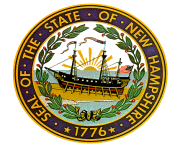
5.1.2.5. The Respondent shall use Arial font size 12 or larger for all narrative responses. Text included as part of a graphic, table, chart, or otherwise identified by DHHS as permissible to append to the Respondent's Proposal may be in size 10 font.

5.1.3. Technical and Cost Proposal

5.1.3.1. The original of the Technical Proposal and Cost Components of the RFP shall each be provided in a three-ring binder marked as "Original."

5.1.3.2. The original Transmittal Cover Letter (described in Section 5.3.1.2) must be the first page of the Technical Proposal and marked as "Original."

5.1.3.3. 12 copies of the Technical Proposal and Cost Components of the RFP shall be provided in bound format marked as "Copy."



5.1.3.4. 1 electronic copy (divided into folders that correspond to and are labeled the same as the hard copies) on CD or Memory Card/Thumb Drive. NOTE: In the event of any discrepancy between the copies, the hard copy marked “Original” will control.

5.1.3.5. Front cover labeled with:

5.1.3.5.1. Name of company / organization;

5.1.3.5.2. RFP#; and

5.1.3.5.3. Technical Proposal.

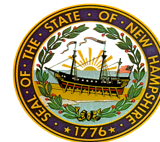
5.2. Technical Proposal Special Instructions and Page Limits

5.2.1. The Respondent shall comply with the Page Limits and Special Instructions provided in Figure 6 below in its Technical Proposal (in response to questions included in Appendix D).

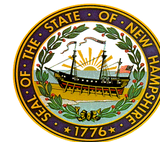
5.2.2. The Respondent may append any requested tables, flow charts, diagrams, and graphics. If the Respondent chooses to append these materials, the materials must be clearly labeled and cross-referenced in the Respondent’s proposal, and displayed in the Proposal Table of Contents (described in Section 5.3.1.1 of this RFP). Appropriately appended materials will not count toward the assigned Page Limit, including but not limited to, those indicated under “Special Instructions” in Figure 6 below.

Figure 6. Special Instructions and Page Limits for Technical Proposal

Special Instructions and Page Limits for Technical Proposal			
Section	**RFP Section Name**	**Page Limit**	**Special Instructions (if applicable)**
RFP Section 5.3.1.1.	Proposal Table of Contents	No limit	
RFP Section 5.3.1.2.	Transmittal Cover Letter	3	
RFP Section 5.3.1.3.	Executive Summary of Proposal	5	
Appendix D; Section 1	Organization Overview and Overview of Relevant Experience	7	The requested organizational chart and staffing plan may be appended to the Response and will, in that case, not count toward the indicated page limit.
Appendix D; Section 2	Subcontractors	8	Sample reports and signed letters of commitment referenced in this



Special Instructions and Page Limits for Technical Proposal			
Section	**RFP Section Name**	**Page Limit**	**Special Instructions (if applicable)**
			Section may be appended to the Response and will not, in that case, count toward the indicated page limit
Appendix D; Section 3	Covered Populations and Services	10	Procedural codes or other identifying information related to any Respondent-offered Value-Added Services may be appended to the Response and will, in that case, not count toward the page limit.
Appendix D; Section 4	Pharmacy Management	5	
Appendix D; Section 5	Member Enrollment and Disenrollment	10	
Appendix D; Section 6	Member Services	6	The Member Services organizational chart may be appended to the Response and will, in that case, not count toward the indicated page limit.
Appendix D; Section 7	Member Grievance and Appeals	8	
Appendix D; Section 8	Provider Appeals	6	
Appendix D; Section 9	Access	5	
Appendix D; Section 10	Utilization Management	10	
Appendix D; Section 11	Member Education and Incentives	6	



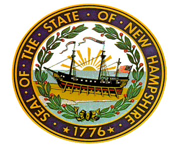
Special Instructions and Page Limits for Technical Proposal			
Section	**RFP Section Name**	**Page Limit**	**Special Instructions (if applicable)**
Appendix D; Section 12	Care Coordination and Care Management	20	
Appendix D; Section 13	Behavioral Health (Mental Health and Substance Use Disorder)	20	
Appendix D; Section 14	Health Homes and Children with Special Health Care Needs	5	
Appendix D; Section 15	Quality Management	12	
Appendix D; Section 16	Network Management	12	
Appendix D; Section 17	MCO Alternative Payment Models	10	To meet the requirements outlined in Question 78, the Respondent may append a table that will not count toward the page limit.
Appendix D; Section 18	Provider Payments	7	
Appendix D; Section 19	Claims Quality Assurance and Reporting	5	
Appendix D; Section 20	Oversight and Accountability	5	
Appendix D; Section 21	Third Party Liability	3	

5.3. Outline and Detail

5.3.1. Each Proposal shall contain the following, in the order described in this Section of the RFP. Each of these components must be separate from the others and uniquely identified with labeled tabs.

5.3.1.1. Proposal Table of Contents

5.3.1.1.1. The required elements of the Technical Proposal shall be:



5.3.1.1.1.1. Numbered sequentially, in accordance with the order in which the required contents of the Technical Proposal are outlined in this RFP; and

5.3.1.1.1.2. Represented in a clear Table of Contents that also incorporates an overview of any and all appended materials, including delineation between materials appended in accordance with the requirements of the Technical Proposal Response and those that are included on the basis of Addenda, as described in Addenda to Technical Proposal (Section 5.6) of this RFP.

5.3.1.2. Transmittal Cover Letter

5.3.1.2.1. The Transmittal Cover Letter must be on the Bidding company's letterhead, signed by an individual who is authorized to bind the Bidding Company to all statements, including services and prices contained in the Proposal; and contain the following:

5.3.1.2.1.1. Identify the submitting organization;

5.3.1.2.1.2. Identify the name, title, mailing address, telephone number and email address of the person authorized by the organization to contractually obligate the organization;

5.3.1.2.1.3. Identify the name, title, mailing address, telephone number and email address of the fiscal agent of the organization;

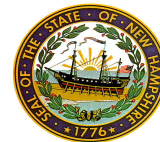
5.3.1.2.1.4. Identify the name, title, telephone number, and e-mail address of the person who will serve as the Respondent's representative for all matters relating to the RFP;

5.3.1.2.1.5. Acknowledge that the Respondent has read this RFP, understands it, and agrees to be bound by its requirements;

5.3.1.2.1.6. Explicitly state acceptance of terms, conditions, and general instructions stated in Mandatory Business Specifications (Section 5.7) and Contract Terms and Conditions.

5.3.1.2.1.7. Confirm that Appendix A Exceptions to Terms and Conditions is included in the proposal;

5.3.1.2.1.8. Explicitly state that the Respondent's submitted Proposal is valid for a minimum of two hundred forty (240) days from the Proposal Submission Deadline (specified in Section 4.2, Figure 5 of this RFP);



5.3.1.2.1.9. Date Proposal was submitted; and

5.3.1.2.1.10. Signature of authorized person.

5.3.1.2.2. The Respondent's required signature on the Transmittal Cover Letter (described in Section 5.3.1.2 of this RFP) for a Proposal submitted in response to this RFP guarantees that the prices, terms and conditions, and services quoted have been established without collusion with other Respondents and without effort to preclude DHHS from obtaining the best possible competitive Proposal.

5.3.1.3. Executive Summary of Proposal

5.3.1.3.1. The Respondent shall submit an executive summary of the Proposal that:

5.3.1.3.1.1. Provides DHHS with an overview of the Respondent's organization and what is intended to be provided by the Respondent;

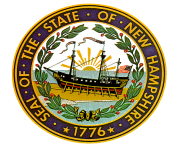
5.3.1.3.1.2. Demonstrates the Respondent's understanding of the services requested in this RFP and MCM contract any problems anticipated in accomplishing the work;

5.3.1.3.1.3. Highlights areas of the Respondent's Proposal that the Respondent wishes to note as particularly innovative and demonstrative of the Respondent's commitment to meaningfully participating in the MCM program and in partnering with DHHS to accomplish the stated goals.

5.3.1.3.1.4. Shows the Respondent's overall design of the project in response to achieving the deliverables as defined in this RFP; and

5.3.1.3.1.5. Specifically demonstrates the Respondent's familiarity with the project elements, its solutions to the problems presented and knowledge of the requested services.

5.3.1.3.1.6. The executive summary should demonstrate the Respondent's capabilities with meeting or exceeding the requirements in the MCM Model Contract, the Respondent's proposed solutions to the questions presented in the RFP, and knowledge of the included populations and services.



5.3.1.3.1.7. A statement must be included specifying the Respondent's acceptance of the contractual specifications set forth in the MCM Model Contract.

5.3.1.4. Proposal Narrative, Project Approach, and Technical Response

5.3.1.4.1. The Respondent shall provide in their Proposal mandatory responses to all RFP questions included in Appendix D Mandatory Responses to Technical Proposal of the RFP and Appendix E Mandatory Responses to Cost Components of the RFP, including completion of required template document(s).

5.3.1.4.2. The Respondent's answers to each of the proposed questions shall be in the same sequence as, and numbered in accordance with, the numbering logic provided by DHHS in Appendix D and Appendix E (for example, Question 1, Question 2, etc.), and should restate the question prior to providing the narrative response. Restatement of the question will not count toward the page limits assigned to the Respondent's response.

5.4. Subcontractors

5.4.1. The Respondent shall be solely responsible for meeting all requirements and terms and conditions specified in this RFP, its Proposal, and any resulting contract regardless of whether it proposes to use any Subcontractors. The Respondent and any Subcontractors shall commit to the entire contract period stated within the RFP, unless a change of subcontractors is specifically agreed to by the State. The State reserves the right to approve or reject subcontractors for this project and to require the Respondent to replace subcontractors found to be unacceptable.

5.4.2. All Subcontractor requirements established in Appendix C MCM Model Contract apply to this RFP.

5.5. License, Certificates and Permits as Required

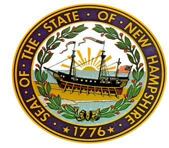
5.5.1. The Respondent is responsible for obtaining all requires licenses, certificates, and permits set forth herein below, as well as those required and described in Section 4.23 (Contingency) of this RFP. This includes:

5.5.1.1. A Certificate of Good Standing with the New Hampshire Office of the Secretary of State, in accordance with Revised Statues Annotated (RSA) 5:18-a, by the effective date of the Agreement.

5.5.1.2. Performance Bond and Insurance

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

5.5.1.3. Affiliations – Conflict of Interest



5.5.1.3.1. The Respondent must include a statement regarding any and all affiliations that might result in a conflict of interest. Explain the relationship and how the affiliation would not represent a conflict of interest.

5.5.1.4. Required Attachments

5.5.1.4.1. The following are required attachments that must be included with the Proposal. The Respondent must complete the correlating forms found in the RFP Appendices and submit them as the "Required Attachments" section of the Proposal.

5.5.1.4.1.1. Respondents Information and Declarations: Exceptions to Terms and Conditions (Appendix A)

5.5.1.4.1.2. Contract Monitoring Provisions (Appendix F; pages 3 and 4)

5.5.1.4.1.3. CLAS Requirements (Appendix G)

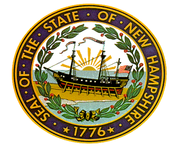
5.5.2. **Assessment of Respondent Finances**

5.5.2.1. The cost of the services covered under this RFP may be adjusted based on final negotiations of the scope of work.

5.5.2.2. The following are required statements that must be included with the Proposal:

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

5.5.2.2.2. Each Respondent must submit audited financial statements for the four (4) most recently completed fiscal years that demonstrate the Respondent's organization is in sound financial condition. Statements must include a report by an independent auditor that expresses an unqualified or qualified opinion as to whether the accompanying financial statements are presented fairly in accordance with generally accepted accounting principles. A disclaimer of opinion, an adverse opinion, a special report, a review report, or a compilation report will be grounds for rejection of the proposal



5.5.2.2.2.1. Complete financial statements must include the following: Opinion of Certified Public Accountant; Balance Sheet; Income Statement; Statement of Cash Flow; Statement of Stockholder's Equity of Fund Balance; Complete Financial Notes; and Consolidating and Supplemental Financial Schedules

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

5.5.2.2.4. If a Respondent is not otherwise required by either state or federal statute to obtain a certification of audit of its financial statements, and thereby elects not to obtain such certification of audit, the Respondent shall submit as part of its proposal:

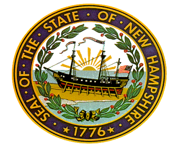
5.5.2.2.4.1. Uncertified financial statements; and

5.5.2.2.4.2. A certificate of authenticity which attests that the financial statements are correct in all material respects and is signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification.

5.6. Addenda to Technical Proposal

5.6.1.1. The Respondent may submit any additional material not requested in the RFP that the Respondent believes to be germane to understanding its qualifications, capabilities, and successes in a separate document entitled "Addenda to Technical Proposal." No material in this segment will be considered by DHHS as meeting any of the required conditions of this RFP. This material should be bound or contained as a single discrete unit with its own Table of Contents.

5.6.1.2. If the Respondent submits Addenda to the Technical Proposal, as described in this Section 5.6 of the RFP, the Respondent shall submit an original copy marked "Original" and 12 copies of the Addenda to the Technical Proposal.



5.7. Contract Terms, Conditions and Liquidated Damages, Forms

5.7.1. Contract Terms and Conditions

5.7.1.1.1. The State of New Hampshire MCM Model Contract is included as Appendix C to this RFP; the Respondent shall agree to all contractual requirements as set forth in the Appendix B Contract Minimum Requirements and Appendix C MCM Model Contract.

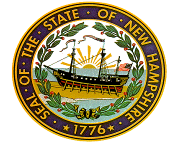
5.7.2. Liquidated Damages

5.7.2.1.1. The State intends to implement liquidated damages as described in the MCM Model Contract and its appendices in the event any deliverables are not met.

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

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

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



6. ADDITIONAL INFORMATION

Please see the online Document Library for additional information.

6.1 Appendix A – Exceptions to Terms & Conditions

6.2 Appendix B – Contract Minimum Requirements

General Provisions, Form Number P-37

Exhibit C:	Special Provisions
Exhibit C-1:	Revisions to General Provisions
Exhibit D:	Certification Regarding Drug Free Workplace Requirements,
Exhibit E:	Certification Regarding Lobbying
Exhibit F:	Certification Regarding Debarment, Suspension, and Other Responsibility Matters
Exhibit G:	Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower
Exhibit H:	Certification Regarding Environmental Tobacco Smoke,
Exhibit I:	Health Insurance Portability Act Business Associate Agreement
Exhibit J:	Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance
Exhibit K:	DHHS Information Security Requirements

6.3 Appendix C – MCM Model Contract

Exhibit A:	Scope of Services
Exhibit B:	Methods and Conditions Precedent to Payment
Exhibit L:	MCO's Implementation Plan
Exhibit M:	Reserved
Exhibit N:	Liquidated Damages Matrix
Exhibit O:	Quality and Oversight Reporting Requirements
Exhibit P:	MCOs Program Management Plan

6.4 Appendix D – Mandatory Responses to Technical Components of the RFP

6.5 Appendix E – Mandatory Responses to Cost Components for the RFP

6.6 Appendix E-1 – RFP Cost Component Questions Excel Template

(Please use the four (4) tabs/spreadsheets in this Excel Workbook to complete Appendix E-1)

6.7 Appendix F – Contract Monitoring Provisions

6.8 Appendix G – CLAS

6.9 Note: In addition to the Appendices of this RFP, DHHS provides the following guidance documents:

6.9.1 State Fiscal Year 2019 MCM program and NHHPP capitation rate reports, for Respondent reference and use in completion of Appendix E.

6.9.2 Year 1 Withhold and Incentive Guidance.