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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR PROPOSALS (RFP) #RFP-2019-OMS-02-MANAG
for

MEDICAID CARE MANAGEMENT SERVICES

Issued: DATE

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 Pleasant Street
Concord, NH 03301

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). The capitated, risk-based contract period will begin on July 1, 2019 and will continue through June 30, 2024.

DHHS expects to select three Managed Care Organizations (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 proposals (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

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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 [LINK]) 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 Re-Procurement Schedule provided in Section 3 of this RFP, a Mandatory Respondent Conference will be held on [DATE] at [TIME] at [LOCATION]. 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, by [TIME] on [DATE] to pre-register the organization's representative(s) for the conference.

Sincerely,

Jeffrey A. Meyers
Commissioner

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2 Executive Summary

2.1 Medicaid Care Management Program Background

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 128,530 “traditional” Medicaid beneficiaries and 8,800 in the New Adult Group who are medically frail and are ineligible for the current Federal Marketplace program.

Beginning on January 1, 2019, an additional 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.

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.

2.2 Population Overview

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 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**

**Point in time estimate as of 1/1/19*

2.3 Goals of the Medicaid Care Management Program

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.

New Hampshire's objectives in the upcoming re-procurement include the following:

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

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- *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).
- *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.
- *Public Reporting*: Each selected MCO will be responsible for submitting an annual report to the Governor and the legislature that reports: 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.
- *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.

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 five (5)-year contract with selected MCOs to provide Covered Services to Members.

All terms and conditions will be finalized in the MCM Model Contract. MCOs shall adhere to all requirements outlined in the final MCM Model Contract. The contracts and 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.

2.4 Overview of Key MCM Model Contract Components

Figure 2 below provides a summary and description of key MCM program requirements further outlined within the 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

Requirement	MCM Model Contract Section	Description
Care Coordination & Care Management	Section 4.10	• MCOs will implement 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.

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Requirement	MCM Model Contract Section	Description
		• MCOs will conduct an initial Health Risk Assessment of every Member to identify Priority Populations who are most likely to 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. • 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 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.
Coordination and Integration with Social	Section 4.10	• MCOs are required to address social needs for Members including promoting access to stable housing, healthy food, reliable transportation,

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Requirement	MCM Model Contract Section	Description
Services and Community Care		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 Subcontractual relationship.
Mental Health	Section 4.11	• MCOs are required to enter into a Capitated Payment arrangement with State designated CMH Programs/CMH Providers to deliver CMH services, providing for reimbursement on Terms specified by DHHS in guidance, including reimbursement at an enhanced rate for the cost of providing at least fair fidelity Assertive Community Treatment (ACT) services. • MCOs are required to engage in at least one (1) mental health Performance Improvement Project (PIP), and conduct an annual review of the fidelity of ACT teams to the ACT model using Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services (SAMHSA's) ACT Fidelity Scale. • For Members who are homeless or at risk of homelessness, MCOs are required to conduct outreach, employ a housing coordinator to assist with housing, monitor transitions, and work collaboratively with CMH Programs/CMH Providers to promote stable housing among Members who qualify for CMH services. • To reduce psychiatric boarding, MCOs are required to have clinical Providers with admitting privileges at each hospital in the State to work to reduce psychiatric boarding stays in the ED.

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Requirement	MCM Model Contract Section	Description
		• For all Members, MCOs are required to work with DHHS and the New Hampshire Suicide Prevention Council to promote suicide prevention awareness programs. • MCOs are required to work collaboratively and responsively to help implement DHHS's forthcoming Ten (10)-Year Mental Health Plan.
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 Substance Use Disorder service programs and Providers (including Peer Recovery Support Providers 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 PIP designed to improve Substance Use Disorder treatment services.
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; 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.

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Requirement	MCM Model Contract Section	Description
		• 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 re-procurement process will automatically be re-assigned to that same MCO for coverage beginning January 1, 2019; 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 the Member in applying for Marketplace coverage and must maintain Care and Case Management services during the pendency of such application. • DHHS will use the following factors in its auto-

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Requirement	MCM Model Contract Section	Description
		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. • 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

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Requirement	MCM Model Contract Section	Description
		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 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 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.

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Requirement	MCM Model Contract Section	Description
		• MCOs are required to comply with all New Hampshire Health Insurance Department (NHID) statewide network adequacy rules.
Member Cost Transparency and Member Incentives	Sections 4.9.3 and 4.9.4	• MCOs must propose, develop, and implement Member incentive programs, including a reference-based pricing incentive program that rewards and reduces 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.
MCO Withhold & Incentive Program	Section 5.4	• A portion of the MCO's Capitated Payment will be withheld and 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 will include 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.
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,

Requirement	MCM Model Contract Section	Description
		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 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	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.
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.

3 Re-Procurement Schedule

Included in Figure 3 below is an overview of the anticipated re-procurement schedule. DHHS reserves the right to modify these dates and times at its sole discretion; in the event of a

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schedule change, the schedule update will be posted to DHHS's re-procurement website.

Figure 3. Re-Procurement Schedule

Re-Procurement Schedule – *Subject to Change*		
Item	**Action**	**Date**
1	DHHS Releases RFP for Public Comment Period	7/9/18
2	DHHS Issues RFP for Respondent Response	8/10/2018
3	Mandatory Respondent Conference [LOCATION]	[DATE] [TIME] ET
4	Respondent RFP Questions Due	8/24/2018 [TIME] ET
5	DHHS Issues Answers to Respondent Questions	9/07/2018
6	Respondent Proposals Due [ADDRESS for submission]	10/12/2018 2:00PM ET
7	Oral Presentations (to be scheduled with each Respondent, as determined by DHHS) [GENERAL LOCATION INFORMATION]	10/19/2018 – 11/2/2018
8	Contract Negotiations	11/2/2018 – 11/9/2018
9	MCO Contract Execution	11/16/2018
10	Governor and Executive Council Approval of MCO Contract	12/1/2018-12/31/2018
11	Readiness Review Period	1/1/2019 – 7/1/2019

3.1 Request For Proposals and MCM Model Contract Amendment

DHHS reserves the right to amend this RFP and the 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 draft RFP and MCM Model Contract are subject to change based upon a full review for compliance with federal and State law.

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. Any amended language will be posted on DHHS's website at [URL].

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4 Instructions for Responding to the Request For Proposals

4.1 Contact Information: Sole Point of Contact

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
Contracts & Procurement
Brown Building
129 Pleasant Street
Concord New Hampshire 03301
Email: catherine.cormier@dhhs.nh.gov
Phone: 603.271.9076

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. DHHS will not be held responsible for oral responses to Respondents regardless of the source.

4.2 Mandatory Respondent Conference

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. 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 must contact the Procurement Coordinator by [TIME] on [DATE] to pre-register the organization's representative(s) for the conference.

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 Section 4.4 (Respondent RFP Questions and DHHS Response) of this RFP.

4.3 Liability

By attending the Mandatory Respondent Conference, a Respondent agrees that in no event shall DHHS be either responsible for or held liable for any costs incurred by a Respondent in the

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preparation or submittal of or otherwise in connection with a Proposal, or for work performed prior to the Effective Date of a resulting contract.

4.4 Respondent Request For Proposals Questions and DHHS Response

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 Section 4.1 (Contact Information: Sole Point of Contact). 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 the Re-Procurement Schedule. Questions from all other parties will be disregarded. DHHS will not acknowledge receipt of questions.

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 the Re-Procurement Schedule.

DHHS will provide responses to questions submitted in the correct format by the date listed in the Re-Procurement schedule. Written answers to questions asked at Mandatory Respondent Conference will be posted on DHHS's website ([URL]) and sent as an attachment in an e-mail to the contact identified by the Respondent.

4.5 Technical Proposal Submission

Proposals must conform to all instructions, conditions, and requirements included in the RFP. Respondents are expected to examine all documentation and other requirements. 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. Acceptable Proposals must offer all services identified in the Statement of Work and agree to the MCM Model Contract conditions specified throughout the RFP.

4.5.1 Technical Proposal Format

The Respondent must submit the Proposal on standard eight and one-half inch by eleven inch (8 ½" x 11") white paper. The Respondent must use a font size of twelve (12) or larger. The Respondent must submit the Proposal in a separate three-ring binder. The Respondent must provide tabs separating the major sections of the Proposal, and must note the name of the company/organization and RFP number on the front cover. The binder shall include and be organized in the following manner:

- The original, twelve (12) hard copies and two (2) electronic copies of the Proposal and Addenda to the Technical Proposal shall be submitted under sealed cover and labeled on the outside as follows: "New Hampshire Care Management Proposal and Addenda RFP #RFP-2019-OMS-02-MANAG".
- The original copy of the Proposal shall include a cover letter, in the manner described in Section 6.2 (Cover Letter), signed by an official authorized to legally bind the Respondent and shall be marked: "Original." All others shall be marked "Copy".
- The Proposal must be signed in the manner described in Section 6.2 (Cover Letter) to be accepted for consideration.
- Proposal copies sent via fax or email will not be accepted.
- The electronic copies must be divided into folders that correspond to and are labeled identical to the hard copies. Electronic copies may be on CDs or USB/thumb drives.
- In the event of any discrepancy between the copies, the hard copy marked "Original" will control.

4.5.2 Technical Proposal Special Instructions and Page Limits

Figure 4. Special Instructions and Page Limits for Technical Proposal

Special Instructions			
RFP Section Number	**RFP Section Name**	**Page Limit**	**Special Instructions (if applicable)**
6.1	Proposal Table of Contents	*No limit*	
6.2	Cover Letter	3	
6.3	Executive Summary of Proposal	5	
6.4	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.
6.5	Subcontractors	5	
6.6	Covered Populations and Services	5	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.

Special Instructions			
6.7	Pharmacy Management	5	
6.8	Member Enrollment and Disenrollment	5	
6.9	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.
6.10	Member Grievance and Appeals	5	
6.11	Provider Appeals	5	
6.12	Access	5	
6.13	Utilization Management	7	
6.14	Member Education and Incentives	5	
6.15	Care Coordination and Care Management	12	
6.16	Behavioral Health	12	
6.17	Children with Special Health Care Needs	5	
6.18	Quality Management	5	
6.19	Network Management	5	
6.20	MCO Alternative Payment Models	7	
6.21	Provider Payments	7	
6.22	Claims Quality Assurance and Reporting	5	
6.23	Oversight and Accountability	5	
6.24	Third Party Liability	3	

4.5.3 Submission and Acceptance of Proposals

Proposals submitted in response to this RFP must be received no later than the time and date specified in the Re-Procurement Timetable above. Proposals must be addressed for delivery to the Procurement Coordinator and marked with #RFP-2019-OMS-02-MANAG. Late submissions will not be accepted and will remain unopened. Disqualified submissions will be discarded if not re-claimed by the bidding Respondent by the time the contract is awarded. 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.

4.5.3.1 *Validity of Proposal*

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Proposals must be valid for two hundred forty (240) days following the Proposal submission deadline for receipt of Proposals as listed in the Re-Procurement Timetable or until the effective date of any resulting contract, whichever is later. This period may be extended by mutual written Agreement between the Respondent and DHHS.

4.5.3.2 *Property of DHHS*

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.

4.5.4 **Request for Additional Information or Materials**

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.

4.5.5 **Public Disclosure**

A 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 Proposals other than to DHHS will be grounds for disqualification.

The content of each Respondent's Proposal and addenda thereto will become public information once the Governor and Executive Council have approved a contract. Insofar as a 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. 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 New Hampshire Revised Statutes Annotated (RSA) Chapter 91-A. In the event DHHS receives a request for the information identified by a Respondent as confidential, DHHS shall notify the Respondent and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the Respondent's responsibility and at the Respondent's sole expense. If the Respondent fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the Respondent without incurring any liability to the Respondent.

4.5.6 **Proposal Withdrawal**

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 Section 4.1 (Contact Information: Sole Point of Contact).

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4.6 Oral Presentations

Following Proposal submission, DHHS will require some or all Respondents to make oral presentations of their Proposals. Any and all costs associated with an oral presentation shall be borne entirely by the Respondent. 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.

5 Proposal Evaluation Criteria and Respondent Selection

5.1 Technical Proposal Evaluation Criteria

The contents of the Respondent's Technical Proposal, described in Section 6 (Contents of Respondent Technical Proposal) of this RFP, will be worth eight hundred (800) of one thousand (1000) total potential evaluation points. The topic areas included in the Proposal Evaluation Criteria table 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. As noted in Section 5.4 (Contract Negotiations) 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 5. Proposal Evaluation Criteria

Proposal Evaluation Criteria	
RFP Section(s) *Note: in certain instances, multiple sections of the proposed response were grouped*	**Assigned Weight** **(out of 800 possible points)**
Organization Overview, Overview of Relevant Experience, Subcontractors, Covered Populations, and Services	100
Pharmacy Management	70
Member Enrollment and Disenrollment, Member Services, Member Grievances and Appeals	70
Access and Utilization Management	60
Member Incentives and Education	60
Care Coordination and Care Management; including provision of Local Care Management	100
Children with Special Health Care Needs	50
Behavioral Health	100

Proposal Evaluation Criteria	
RFP Section(s) *Note: in certain instances, multiple sections of the proposed response were grouped*	**Assigned Weight (out of 800 possible points)**
Quality Management and Claims Quality Assurance and Reporting, Oversight and Accountability	70
Network Management, Provider Payments, Provider Appeals, and MCO Alternative Payment Models	70
Third Party Liability and Program Integrity	50

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:

- The completeness and quality of the response to each specific prompt included in Section 6 (Contents of the Respondent's Technical Proposal) of this RFP;
- 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;
- 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
- 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.

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 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 1115 Waiver and Medicaid State Plan Amendments.

5.2 Cost Components

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 Cost Components of the RFP will be outlined in a separate attachment, to be released when the RFP and MCM Model Contract are issued for Respondent Response.

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5.3 Contingency

Award of a contract is contingent on the Respondent obtaining a license from the New Hampshire Department of Insurance to operate as an MCO in the State of New Hampshire at the time of MCO contract approval by the Governor and Executive Council.

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

5.4 Contract Negotiations

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

5.5 Respondent Selection

DHHS reserves the right to request a site visit 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.

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

After MCO selection and approval by the Governor and Executive Council and 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. If DHHS determines that any MCO will not be ready to begin services on [DATE], it may, at its sole discretion, withhold enrollment and require corrective action or terminate the Contract.

5.6 Non-Commitment

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

5.7 Protest of Intended Award

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

6 Contents of Respondent Technical Proposal

6.1 Proposal Table of Contents

The required elements of the Technical Proposal shall be:

- Numbered sequentially, in accordance with the order in which the required contents of the Technical Proposal are outlined in this Section 6 (Contents of Respondent Technical Proposal) of this RFP; and
- 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 Section 6.25.1 (Addenda to Technical Proposal) of this RFP.

The Respondent's answers to each of the proposed questions shall be numbered in accordance with the numbering logic assigned throughout this document when provided (for example, Question 1, Question 2, etc.). All appended documents should also reference the relevant section and question number, as applicable.

6.2 Cover Letter

A cover letter must accompany the Proposal on the Respondent organization's letterhead and must be signed by an individual who is authorized to bind the Respondent's organization to all statements, including the first page of the Proposal. The cover letter must also accomplish the following:

- Identify the submitting organization;
- Identify the name, title, mailing address, telephone number and email address of the person authorized by the organization to contractually obligate the organization;
- Identify the name, title, mailing address, telephone number and email address of the fiscal agent of the organization;
- Identify the name, title, telephone number, and e-mail address of the person who will serve as the Respondent's representative for all matters relating to the RFP;

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- Acknowledge that the Respondent has read this RFP, the MCM Model Contract, all Cost Components of the RFP, and all other attachments provided by DHHS on [URL] and that the Respondent understands them, and agrees to be bound by DHHS's requirements;
- Explicitly state acceptance of all MCM Model Contract and RFP terms and conditions;
- Confirm that Appendix [X] Exceptions to terms and conditions is included in the Proposal;
- Explicitly state that the Respondent's submitted Proposal is valid for a minimum of two hundred and forty (240) days from the Proposal submission deadline;
- Identify the date the Proposal was submitted; and
- Include the signature of an authorized person.

The Respondent's required signature on the cover letter 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.

6.3 Executive Summary of Proposal

The Respondent shall submit an executive summary of its Proposal to DHHS. The executive summary of the Proposal should provide DHHS with an overview of the Respondent's organization and what the Respondent intends to provide. This component of the Proposal should concisely demonstrate the Respondent's understanding of the services required under the MCM Model Contract and requested in this RFP, any problems the Respondent anticipates in accomplishing the work, and should highlight 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.

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.

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

6.4 Organization Overview and Overview of Relevant Experience

6.4.1 Corporate Overview

1. Include in the Proposal a summary of the Respondent's organization, management, and history and how the Respondent's experience demonstrates the ability to meet DHHS's needs, as described throughout this RFP and MCM Model Contract. At a minimum, the response should include the following information:
    a. A general overview of the Respondent organization;

b. Information regarding the Respondent organization's ownership and subsidiaries;
c. Information regarding the Respondent organization's background and primary lines of business;
d. The number of employees employed by the Respondent;
e. The Respondent organization's headquarters and satellite locations;
f. The Respondent's current project commitments;
g. The Respondent's major government and private sector clients; and
h. The Respondent's mission statement.

6.4.2 **Managed Care Experience and References**

2. Provide a list of all current and/or recent (within five (5) years of the issue date of this RFP) contracts for managed care services (e.g., medical care, integrated physical and behavioral health services, pharmacy, Early and Periodic Screening, Diagnostic and Treatment services (EPSDT), Care Management and Care Coordination services), including the Respondent's parent, affiliate(s), and subsidiary(ies). Include in a table the following information for each identified contract:
   a. The Medicaid population(s) served (e.g., children, parents, non-elderly and non-disabled, Aged, Blind, Disabled);
   b. The number of enrollees, by health plan type and population type;
   c. The name and address of the client;
   d. The name of the contract;
   e. The specific start and end dates of the contract;
   f. A brief narrative describing the role of the Respondent and the scope of work performed, including covered services;
   g. The use of administrative and/or delegated Subcontractor(s) and their scope of work;
   h. The annual contract amount (payment to the Respondent) and annual claims payment amount;
   i. Whether the contract was/is capitated, FFS, or another payment method (if another payment method, the method should be described);
   j. The scheduled and actual completion dates for contract implementation and – if applicable – any boundaries that hindered implementation and the solutions employed to address those challenges; and
   k. The accomplishments and achievements the Respondent wishes to highlight.
3. Indicate four (4) prior engagements to be used as references, for which: at least two (2) should be state Medicaid agencies (and may not include the State of New Hampshire), including (if applicable) at least one (1) state Medicaid agency with which the Respondent's contract included a "carve-in" of behavioral health services; at least one should be a Provider; and at least one (1) of which should be a community-based organization. Highlight in the response examples that demonstrate the Respondent's experience with the key priorities indicated by DHHS throughout the MCM Model Contract and noted in Section 2.3 (Goals of the MCM Program) in this RFP. DHHS

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intends to contact these references; for each selected reference, the Respondent should include the following information:

a. The type of reference (e.g., state Medicaid agency, Provider);
b. The reference's name, title, and employer;
c. The reference's contact information, including phone number, email address, and physical address;
d. The nature of the relationship, including the capacity in which the reference is familiar with the Respondent organization;
e. The time period of the relationship; and
f. Activities undertaken during the engagement that establish the Respondent's qualifications for this RFP.

4. Identify and describe any instances of non-compliance that the Respondent, its parent organization, or its affiliates have encountered as part of any Medicaid managed care contracts within the past three (3) years. For each non-compliance issued, the Respondent shall indicate the type of non-compliance issued, the date the non-compliance was issued, and the reason the non-compliance was issued, the issuing state(s) in which the Respondent was providing services for which the non-compliance was issued, and any details of the sanctions applied against the Respondent as a result of non-compliance.
5. Respondent shall identify any instances of non-renewal or early termination of contracts with states. The Respondent shall specify the type of contract, why the termination was initiated, and by whom it was initiated (contractor, state, mutual, or federally imposed).
6. For purposes of responding to Question 4 and Question 5, types of non-compliance include: compliance letters (includes Warning Letters, Notices of Non-Compliance, Corrective Action Plans (CAPs) or similar state notices); adverse performance audits (contracts failing more than fifty percent (50%) of audit elements); adverse financial audits (adverse opinions or disclaimed reports); failures to maintain fiscally sound operations (negative net worth or financial loss greater than half of the contractor's total net worth); exclusions enforcement actions (imposed by CMS as an intermediate sanction); and any other significant compliance concerns.

6.4.3 Staff for New Hampshire Operations

7. Submit an organizational chart and a staffing plan for the MCM program. The organizational chart and staffing plan should clearly indicate how the Respondent plans to meet all MCM Model Contract requirements described in Section 3.15 (Staffing) of the MCM Model Contract.
8. Describe the Respondent's intended on-site presence in New Hampshire.
9. For Key Personnel currently on staff with the Respondent, as described in Section 3.15 (Staffing) of the MCM Model Contract, please provide the name, title, qualifications, and resume for each individual. For staff to be hired, please describe the hiring process and the qualifications for the position and include the job description associated with each to-be-hired employee. DHHS reserves the right to accept or reject dedicated staff individuals.

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6.5 Subcontractors

10. Please indicate whether the Respondent intends to Subcontract with any Subcontractors to perform portions of the obligations described in the MCM Model Contract, or otherwise proposed by the Respondent. For each function that the Respondent plans to contract with a Subcontractor for, please provide the following information:
    a. (i) The portions of the work to be performed by a Subcontractor; (ii) the name, address, and location of such Subcontractor; (iii) the general terms of the Subcontractor agreement, including the amount, duration and scope of services; and (iv) how the Respondent intends to provide oversight of Subcontractor;
    b. A description of the Subcontractor's experience providing those services;
    c. If applicable, a description and actual copies of the relevant licenses, certifications or permits the Subcontractor has and maintains that are necessary for it to perform the services;
    d. A description of how the Respondent will monitor the performance of its Subcontractors to ensure all MCM Model Contract requirements are met;
    e. Sample performance monitoring reports;
    f. Sample reports showing any actions taken to improve performance and ensure positive results;
    g. A description of the information or data the Respondent will exchange with its Subcontractor(s) and how that information or data will be transferred;
    h. If applicable, a description of how Subcontractors are integrated with Care Management programs;
    i. If applicable, a description of how Subcontractors are integrated with third-party recovery and/or fraud and abuse programs; and
    j. A description of any sanctions or penalties that apply if the Subcontractor fails to perform up to the Respondent's expectations.

6.6 Covered Populations and Services

11. Describe how the Respondent plans to integrate and ensure access to comprehensive primary care, specialty care, pharmacy, and Behavioral Health Services for all Members.
12. Describe the Respondent's process and procedures for providing Post-Stabilization Services.
13. Describe the Respondent's process and procedures for coordinating and facilitating Non-Emergency Medical Transportation (NEMT) for Members.
14. EPSDT provisions are a core requirement for the provision of services to children. Please describe the Respondent's:
    a. Process for ensuring coverage of services that are Medically Necessary to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination for Members younger than twenty-one (21);

b. Outreach and communication strategies that enhance Member education on EPSDT requirements and improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening; and
c. Monitoring approach to ensure compliance with EPSDT requirements described in Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) of the MCM Model Contract throughout all relevant departments within the managed care plan and with Subcontractors.

15. Indicate the Value-Added Services that are not offered under the Medicaid State Plan and for which the cost of services would not be included in Capitation Payment calculations. The Respondent should indicate which Value-Added Services it plans to offer to all Members, and, in particular, whether the Respondent will include the following:
    a. Mental health and/or Substance Use Disorder-related treatment services beyond what is required by the MCM Model Contract (e.g., Peer Recovery Support Services (PRSS) in excess of those required under the MCM Model Contract); and/or
    b. Social supports for Members identified as having high unmet resource needs (as described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of the MCM Model Contract) beyond those required under the MCM Model Contract.
16. Describe the Respondent's experience providing In Lieu of Services, pursuant to 42 CFR 438.3, which In Lieu of Services listed in the MCM Model Contract that the Respondent will provide to MCM Members in New Hampshire if selected; and which additional services the Respondent would like to provide subject to DHHS approval.

6.7 <u>Pharmacy Management</u>

17. Describe the Respondent's plans for providing pharmacy benefits management and the processes that will be employed for oversight, monitoring, and analysis of pharmacy benefits management performance. Please also describe in detail how the Respondent will ensure that all MCM Model Contract requirements, including those related to data reporting and exchange with DHHS, Providers, and Members, will be completed.
18. Describe the Respondent's plan for providing Medication Management (as described in Section 4.2.5 (Medication Management) of the MCM Model Contract) to all Members. The description should include:
    a. How the Respondent would identify Members at greatest need for medication management, including how the medication review will incorporate use of pharmacy claims, Provider reports, comprehensive assessments and care plans, contact with the Member's Provider(s) (including DCYF and residential or other treatment entities), current diagnoses, current behavioral health functioning, and information from the Member and the Member's family;
    b. The Respondent's proposed approach to conducting medication review and counseling, particularly for Members at risk of harm due to polypharmacy; and

c. The Respondent's approach to providing active and comprehensive medication management for Children with Special Health Care Needs.

19. On the basis of the Respondent's experience to date, please include a description of improvements made by the Respondent as a result of implementing medication management initiatives, amongst similar populations as those covered in the MCM program. The description should include statistically valid results.

6.8 Member Enrollment and Disenrollment

20. The Respondent shall describe how it will accept and process the State-supplied enrollment files, including policies and procedures for enrollment transactions. The policies and procedures should address initial connectivity to State systems, ability to capture enrollments, timing of accepting the transactions, successful acceptance of the transaction into the system (including downstream systems such as Care Management). Provide a flow chart and/or detailed diagrams for the pathways described.
21. Describe procedures for processing and monitoring enrollment/disenrollment files to ensure Members are enrolled/disenrolled within the designated timeframe after receiving notification from the State.
22. Describe how the Respondent will monitor the enrollment process including the processing of enrollment files, timely issuing of Member identification cards, and mailing initial Member materials.
23. Describe the Respondent's strategy and experiences with assisting Members in retaining their Medicaid eligibility at redetermination.
24. Describe the support and strategies the Respondent will employ to assist Members who transition in and out of the MCO due to loss of Medicaid eligibility.

6.8.1 MCO Role in Work and Community Engagement Requirements for Granite Advantage Members

25. Describe how the Respondent will work collaboratively with DHHS to support the ongoing operations of Work and Community Engagement requirements for Granite Advantage Members, as described in Section 4.3.1.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members) of the MCM Model Contract. Describe in detail:
    a. The methods and modalities the MCO will use to conduct General Outreach and Member Education Activities;
    b. The specific Member Support Services the Respondent will provide, particularly assistance related to supporting State processes for reporting compliance; and
    c. The Respondent's plan for conducting targeted outreach activities for "mandatory non-compliant" Granite Advantage Members, including the overall approach and specific modalities it will employ.
26. DHHS is in the process of developing and defining the parameters by which the MCO will be required to use claims and Encounter Data to identify exempt and potentially exempt Members, as described in the MCM Model Contract. The Respondent should

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provide innovative ideas for best identifying the indicated Members and how the MCO's capabilities will best support this need.

6.8.2 Auto-Assignment

To the extent an MCO or MCOs that currently participate in the MCM program are selected in the re-procurement, DHHS is committed to maintaining continuity of coverage for Members, while identifying a pathway to ensuring that incoming MCO(s) receive an equitable share of Member enrollment. DHHS will institute an auto-assignment process that ensures Members are able to remain in their existing MCO, while providing a pathway for incoming MCO(s) to gain an equitable share of Members. In future years, DHHS plans to use the auto-assignment methodology to prioritize the assignment of Members based on each MCO's relative performance against State priorities including but not limited to quality and APM performance.

27. In light of these DHHS priorities, please provide:
    a. The minimum number of Members the Respondent would expect to cover within six (6), twelve (12), and eighteen (18) months of the contract effective date; and
    b. Whether there is a maximum number of Members the Respondent would expect to cover within six (6), twelve (12), and eighteen (18) months of the contract effective date.

6.9 Member Services

28. Provide an organizational chart of the Member Services Department, showing the placement of Member Services within the Respondent's organization and the key staff within the Member Services Department.
29. Describe the Respondent's call center management experience in other states and anticipated approach for the MCM program, including:
    a. The location of operations (if out-of-state, describe how the Respondent will accommodate services for New Hampshire);
    b. The call center performance metrics that will be implemented including how the Respondent will meet minimum abandonment and speed of answer requirements indicated in Section 4.4.4.1 (Member Call Center) of the MCM Model Contract;
    c. The processes used for conducting the Welcome Call and early rates of success in reaching Members for such calls;
    d. The way in which the Respondent will determine staffing levels;
    e. The process that will be used to conduct warm transfers (including any training to be provided); and
    f. The plan to ensure a single, integrated Member service line for physical and behavioral health.
30. In a scenario where a Member who is hard of hearing calls the Member Services Department due to trouble scheduling an appointment with a Participating Provider,

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describe the steps and mechanisms that the Respondent will use to identify the caller's concern and document, track, and resolve the issue.

31. Describe the mechanisms in place, including specific language assistance capabilities, services and supports, to help potential Members and Members with Limited English Proficiency (LEP), disabilities, special health care needs, and diverse cultural and ethnic backgrounds. Indicate how the Respondent will identify, monitor and address cultural and linguistic disparities among Members.
32. Describe how the Respondent will ensure cultural competency throughout the Respondent's Participating Provider network.
33. Describe how the Respondent will approach the composition and processes of the Member Advisory Board (described in Section 4.4.6.1 (Member Advisory Board) of the MCM Model Contract, including:
    a. How the Respondent will determine and ensure that there is sufficient representation of populations covered under the MCM program; and
    b. How the Respondent will accommodate Members with disabilities to ensure their full participation on the Member Advisory Board.

6.10 Member Grievances and Appeals

34. Describe the Grievances Process the Respondent will use. Describe the process and timing for addressing a Member's dissatisfaction with any aspect of their care, including which staff will be involved.
35. Describe the process and timing for reviewing an appeals request, including the process and timing for addressing standard and expedited appeals requests.
36. Provide a flowchart that depicts the process the Respondent will employ, from the receipt of the appeals request through each phase of the review to notification of disposition, including providing notice to the State Hearing Process.
37. Describe how data resulting from the Member Grievance and Appeals Processes will be tracked and used to improve the operational performance of the MCO.

6.11 Provider Appeals

38. Describe the Provider Appeals Process the Respondent will employ, in compliance with NH standards and requirements outlined in the MCM Model Contract.
39. Specify the supports and management efficiencies employed by the Respondent to ensure that Provider administrative burden is kept to a minimum, processes are clearly communicated, and inquiries are readily responded to in a timely manner resulting in a demonstrated low volume of Provider Appeals.

6.12 Access

40. Describe existing relationships the Respondent has with relevant Providers and stakeholders in New Hampshire, if any. Which relationships does the Respondent anticipate forming?

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41. Describe in detail how the Respondent will build a sufficient and effective network of Participating Providers that promotes Member-centered care, promotes choice of Provider, engages Member's informal support system (e.g., family caregivers), and provides care in the most integrated setting for Members. Provide a detailed example of the Respondent's approach in another state's Medicaid managed care market, addressing, if possible, how the Respondent has overcome a limited supply of Providers in rural areas.
42. In building the Respondent's Participating Provider network and contracting with Providers, describe how the Respondent will ensure the ability of Participating Providers to provide physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Members with physical or mental disabilities, as required by 42 CFR 438.206(c)(3).

6.13 Utilization Management

43. What strategies has the Respondent employed or does the Respondent currently employ in other state Medicaid markets to contain health care spending while ensuring Members maintain access to high-quality health care services? Describe how the Respondent plans to apply these strategies and any additional or new strategies in New Hampshire.
44. In alignment with MCM Model Contract requirements, describe the Respondent's approach to Utilization Management and how the approach would be modified for New Hampshire, including the Respondent's process to ensure the MCO Utilization Management Program includes criteria that:
    a. Are practicable, objective and based on evidence-based criteria, to the extent possible;
    b. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);
    c. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (DHHS shall approve any changes to the clinical criteria before the criteria are utilized);
    d. Are applied based on individual needs and circumstances (including social determinant of health needs);
    e. Are applied based on an assessment of the local delivery system;
    f. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and
    g. Conform to the standards of NCQA Health Plan Accreditation.
45. Describe the processes the Respondent will implement for ED utilization review and identification of Members with high utilization, including use of Admission, Discharge and Transfers (ADT) feeds to identify Members with one (1) or more ED visit. What strategies will the Respondent implement to reduce high ED utilization? Provide

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statistically relevant results of initiatives employed in a program similar to the MCM program wherever possible.

46. Describe the Respondent's management techniques, policies, procedures or initiatives in place or that will be place by the Program Start Date to effectively and appropriately control avoidable hospitalizations and readmissions. Provide statistically relevant results of initiatives employed in a program similar to the MCM program if possible.

6.14 Member Education and Incentives

MCOs participating in the MCM program will be expected to develop a Member health education program that promotes and supports the overall wellness of Members, with the goal of empowering Members to actively participate in their care. In alignment with this goal, the MCO is required (as described in Section 4.9.4 (Member Incentive Programs) of the MCM Model Contract) to develop Member Incentive Programs designed to achieve these goals.

47. Describe the Respondent's plan for implementing at least one (1) Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as described in the MCM Model Contract. For each program proposed, describe:
    a. How Members eligible for the program will be identified and enrolled in the program;
    b. The target number of Members for the program;
    c. How preferred Providers and services will be identified and communicated to Members;
    d. The types of incentives that will be offered to Members (including the dollar value of cash incentives and any other incentives that will be provided); and
    e. How Members will earn and lose points based on changes in behavior over a period of time.
    f. The Contractor shall describe processes for capturing and storing the data necessary for qualifying activities and programs.
48. If applicable, the MCO should provide an example of its experience administering a Member Incentive Program for a similar population and/or with similar objectives, and include:
    a. The target population for the Member incentive program;
    b. How individuals were identified for participation in the Member incentive program;
    c. The number of individuals that ultimately enrolled in the program, and received incentives for participation; and
    d. Any statistically relevant program results, particularly those that demonstrate a change in Member behavior and/or improved health outcomes.

6.15 Care Coordination and Care Management

High-performing Care Coordination and Care Management are fundamental to the added value DHHS seeks through its relationship with Medicaid MCOs. DHHS is seeking responses that will

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clearly describe Care Coordination and Care Management strategies that are targeted at improving Member care and health outcomes, reducing inappropriate hospitalizations and utilization of Emergency Services, addressing unmet resource needs, better integrating primary and behavioral health, providing Local Care Management, and decreasing the total cost of care.

49. Provide a description of the Respondent's structure and plan for Care Coordination and Care Management inclusive of key components of each program, type of service provided, roles and responsibilities of staff involved in the provision of each service and how Members will be identified for Care Coordination versus Care Management.
    a. Describe the plan for Care Coordination, including: a description of Care Coordination functions; and key activities and performance expectations.
    b. Describe the plan for Care Management, including:
        i. A description of the process and timing for conducting a Health Risk Assessment of every Member within ninety (90) days of the effective date of MCO enrollment; the identification, Risk Scoring and Stratification process, tools and methods that the Respondent will use for identifying the Priority Populations as required in the MCM Model Contract;
        ii. A description of the plan and methodology for conducting Risk Scoring and Stratification;
        iii. A description of the process and timing for conducting a Comprehensive Assessment for high-risk, high-need Members identified, including how such Members will be identified, the content that will be included in the Comprehensive Assessment and how frequently re-assessments will be conducted;
        iv. A description of the Care Management that will be provided to high risk high-need individuals identified as Priority Populations including, at a minimum, the coordination of physical, behavioral health and social services, regular medication reconciliation, referral follow-up, peer support, training on self-management, assistance with meeting unmet resource needs, and the convening of local community based care teams, including the frequency of such convenings. The description should include the projected share of Members that will be classified as high risk high and engaged in active Care Management based on the Respondent's current Medicaid managed care experience and proposed approach in New Hampshire. The description should include identification for the percent and/or number of Members engaged in active Care Management, either by direct MCO staff or contracted agencies or in known identified relationships with the MCO;
        v. A description of the qualifications and competencies of the Respondent's care managers;
        vi. A description of all the components of the Respondent's Care Plan as described in Section 4.10.6 (Care Management for High Risk and High Need Members) of the MCM Model Contract, including how frequently it will be updated;

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vii. A description of an end-to-end description of the process and timing for conducting Transitional Care Management for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits or other adverse outcomes;

viii. A description of the process and approach for providing Local Care Management, to the maximum extent possible, and in compliance with the MCM Model Contract. The description should include in the proposal for providing face-to-face Care Management support and how the MCO will coordinate with Designated Care Management Entities. Responses must include a description of the Designated Care Management Entities that will be leveraged, if applicable, including whether they are IDNS or other contracted entities capable of performing Local Care Management for a designated cohort of MCO Members. Propose a projected percentage of high-need Members who will be provided local face-to-face Care Management in the community in alignment with the MCM Model Contract

ix. Provision of an end-to-end description of the process the Respondent will employ to provide Care Management for a Child With Special Health Care Needs, from the initial care needs screening through each phase of the Care Management process. Description should include the process for initially and periodically assessing Children with Special Health Care Needs and identify the staff performing the assessments and their credentials; and

x. A description of whether the Respondent will include contractual relationships, if any, that support the Respondent's ability to coordinate care, including information sharing and care planning, for a Member among multiple Providers. Include a description of the contractor(s) and role.

c. Describe the Respondent's experiences and the approaches it will use to coordinate comprehensive services, including primary, acute, and behavioral health. A description of the Care Management-to-Member staffing ratios and how they may vary based on acuity of the Member should be included.

d. Provide concrete examples of working with entities similar to IDNs to support the implementation of Local Care Management. What challenges did the Respondent face and how were they mitigated?

e. To address New Hampshire's key priorities, describe how the Respondent will work with IDNs in alignment with the goals and requirements set forth by DHHS in the MCM Model Contract, including:

   i. What the Respondent envisions to be the delineation of roles and responsibilities between the MCO and IDNs, addressing specific provisions described in the MCM Model Contract; and

   ii. How the Respondent will coordinate data collection and ensure data sharing with IDNs that is consistent with DHHS's goals.

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6.15.1 Coordination and Integration with Social Services and Community Care

50. Describe the Respondent’s competencies and approach to addressing social needs for Members, including promoting access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support.
51. Describe the Respondent’s competencies and approach in addressing social determinants of health as part of the initial Health Risk Assessment Screening and Risk Scoring and Stratification processes. Describe how the Respondent will identify whether the Member is in need of services that address social determinants of health and, in particular, how the Respondent will identify homeless individuals and assist with housing as described in the MCM Model Contract, as well as provide supports for Members facing multiple barriers to food and transportation.
52. Describe the Respondent’s experience addressing social determinants of health in Comprehensive Health Assessments and how “warm handoffs,” closed loop referrals, or other approaches to helping Members secure needed services are integrated into the Respondent’s Care Management strategy or related policies and protocols.
53. For the three (3) preceding questions, provide specific examples of how the Respondent has supported these functions in other Medicaid markets, and all results, measurable outcomes, achieved from the Respondent’s applied interventions.
54. Describe the local relationships and processes that the Respondent will use in New Hampshire to make referrals to local social services and community care and follow up to ensure that Members are successful in addressing unmet resource needs.

6.16 Behavioral Health

55. Describe the strategies the Respondent will implement in the delivery and coordination of Behavioral Health Services and supports, including:
    a. Whether the Respondent intends to use a Subcontractor for the delivery of Behavioral Health Services;
    b. A description of the way in which the Respondent will promote integrated physical and behavioral health (including the strategies the Respondent will use to promote the integration of Behavioral Health Services in physical health settings and the provision of physical health services in behavioral health settings consistent with the SAMHSA model for Integrated Care). If the Respondent is using a Subcontractor, please describe the processes that will be deployed to maximize use of fully Integrated Care;
    c. How the Respondent will comply with all Behavioral Health staffing requirements (including training and education) as required under the MCM Model Contract, taking into account the limited supply of behavioral health Providers in New Hampshire; and
    d. The Respondent’s plan to use incentive payments or MCO APMs to advance behavioral health goals.

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6.16.1 Mental Health

56. Describe the Respondent's capacity to provide the required mental health services as outlined in the MCM Model Contract.
57. Describe the strategies and actions the Respondent will take to reduce psychiatric boarding stays in the ED and in medical wards, including a description of the following:
    a. The Respondent's approach to providing a sufficient number of qualified and licensed clinical staff with the authority to provide on-site psychiatric assessments, treatment, prescribing, Care Coordination and discharge planning for Members who are subject to or at risk for psychiatric boarding; and
    b. To the degree applicable, any statistically relevant results of intervention(s) implemented by the Respondent in other states.
58. As indicated in Section 4.11.1 (General Coordination Requirements) and Section 4.11.5.1 (Contracting for Community Mental Health Services) of the MCM Model Contract, MCOs will be required to enter into capitated payment arrangements with CMH Programs/CMH Providers, providing for reimbursement on Terms specified by DHHS in guidance. Describe the Respondent's ability to support these types of arrangements and experience supporting them in other states, including:
    a. Processing timely prospective payment from a Member eligibility list provided by the CMH Program/CMH Provider;
    b. Determining whether Members are eligible for DHHS-required Capitation Payments, or should be paid on a FFS basis to the CMH Program/CMH Provider;
    c. Providing detailed MCO data submissions to DHHS and the CMHP for purposes of reconciling payments and performance (e.g., 835 file); and
    d. Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs/CMH Provides (by region).
59. Describe the Respondent's strategies and actions it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire.

6.16.2 Substance Use Disorder

60. Describe the Respondent's capacity to provide the required Substance Use Disorder services as outlined in the MCM Model Contract.
61. Describe how the Respondent will ensure and monitor that the full continuum of care is available to Members with a Substance Use Disorder and the Respondent's experience in other states addressing Provider shortages or other gaps in Substance Use Disorder treatment services.
62. Describe the Respondent's plans to promote use of MAT in New Hampshire and the Respondent's experiences in other states increasing use of MAT, providing statistically-relevant data if possible.
63. Describe the Respondent's plans to screen for and treat babies born with NAS and their families, providing specific examples of the Respondent's work in other states and any statistically-relevant results.
64. Describe the steps the Respondent will take to contract with and have in its network all willing Peer Recovery Providers and methadone clinics in New Hampshire. The

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response should include examples of the Respondent's experiences in other states integrating such Providers into its delivery network and how the Respondent has worked with such Providers in the past. This response should also include how the Respondent would work with existing and new Provider organizations to ensure proper Medicaid reimbursement practices are in place.

65. Describe how the Respondent will safely reduce the rate of opioid prescribing without increasing use of illicit opioids, including, but not limited to:
    a. Strategies for working with Providers to reduce opioid prescribing;
    b. Supporting Providers in alternative strategies for addressing pain;
    c. Providing assistance to Members who are chronic or high users of opioids;
    d. Using the New Hampshire Prescription Drug Monitoring Program (PDMP) and/or opioid prescribing data to monitor and change prescribing patterns; and
    e. Any additional strategies that the Respondent has found effective in other states for safely reducing use of prescription opioids.
66. Describe how the Respondent will track and ensure timely treatment for and follow up with Members who have an ED visit or are hospitalized due to an overdose.

6.16.3 **Health Homes**

DHHS is committed to ensuring that evidence-based treatment models to address the State's opioid epidemic and to improve access to behavioral/mental health services are considered. DHHS plans to implement Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act within twenty four (24) months of the beginning of the Agreement Term. The State's intent is to allow as much innovation as possible with all MCOs in the adoption, design, and implementation of Health Homes.

67. Please detail:
    a. The Respondent's capabilities and proposed approach for coordinating with Health Homes, taking into consideration the current MCM Model Contract requirements for behavioral health, mental health, and Substance Use Disorder.
    b. DHHS intends for Health Homes to incorporate a Member's current community based Provider wherever possible and leverage, when practicable, the IDNs construct and capacity. Indicate how the Respondent will incorporate existing service structures Members currently access into Health Homes.
    c. Explain how the Respondent would support the implementation of Health Homes in New Hampshire and describe your experience is providing such services in another Medicaid market.

6.17 Children with Special Health Care Needs

DHHS is committed to ensuring the unique needs of Children with Special Health Care Needs are met through the Medicaid managed care delivery system. DHHS is currently exploring whether to develop a separate Medicaid managed care product, with adjusted capitation rates and tailored contractual requirements that would be exclusively offered to children with complex physical and behavioral health care needs.

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68. In light of this information, please describe:
    a. The Respondent's capabilities and approach for addressing the current MCM Model contract requirements designed for Children with Special Health Care Needs including medication management, network adequacy, access to Providers during transitions of care and Provider supports; and
    b. The Respondent's interest in offering a separate product for Children with Special Health Care Needs at a future date. If this is of interest, please describe your experience with providing such tailored services in another Medicaid market.

6.18 Quality Management

6.18.1 Health Plan Accreditation

69. The Respondent shall specify its current health plan accreditation status for all markets in which it is currently participating. This shall include:
    a. The name of the accrediting entity (e.g., NCQA, Utilization Review Accreditation Commission (URAC));
    b. The most recent date of certification;
    c. The effective date of the accreditation;
    d. The type(s) and corresponding level(s) of accreditation achieved; and
    e. The status of the accreditation (e.g., provisional, conditional, etc.).

6.18.2 Quality Assessment and Performance Improvement Program

70. Describe the Respondent's plan for establishing and implementing an ongoing QAPI Program inclusive of all elements specified in the MCM Model Contract.
71. Provide an organizational chart that indicates what the relationship of the QAPI program would be to Respondent leadership, and how the Respondent's QAPI program relates to the Respondent's processes for Utilization Management, the development and implementation of clinical Practice Guidelines, Provider relations, etc.
72. Provide one or more detailed examples of how, in another Medicaid managed care market, the Respondent's QAPI program was utilized to identify a necessary improvement, implement an initiative designed to address the challenge, modify the initiative based on ongoing assessment. Describe statistically relevant outcomes achieved as result of implementing the improvement.
73. Describe the Respondent's experience in achieving quality standards with populations similar to the populations covered under the MCM program. Include, in table format, the following information:
    a. A description of the population reflected in the results;
    b. The Respondent's most recent two (2) years of results for all available quality measures required by DHHS, as described in Exhibit O of the MCM Model Contract; and
    c. The Respondent's most recent two (2) years of results for all Consumer Assessment of Healthcare Providers and Systems (CAHPS®) items/composites

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specified for Medicaid Managed Care Organizations and required by NCQA for Health Plan Accreditation.

74. If, in response to the previous question, the MCO is unable to provide Healthcare Effectiveness Data and Information Set (HEDIS) results for at least three (3) Medicaid contracts, the Respondent should provide commercial HEDIS measures for the Respondent's largest (in number of lives) contracts. If the Respondent is located in New Hampshire, New Hampshire-based results should be prioritized for inclusion in the Respondent's Proposal over larger, out-of-state contracts.

6.19 Network Management

DHHS is committed to improving the Provider credentialing process and exploring opportunities to centralize Provider credentialing in the near future.

75. Ongoing Provider support is important to ensuring Members' access to and the delivery of high-quality care. Please describe the Respondent's proposed approach for:
    a. Conducting Provider outreach and communications when programmatic changes are made;
    b. Meeting the Provider training requirements as required in the MCM Model Contract;
    c. Implementing a prompt and accessible credentialing and re-credentialing process that will be used to conduct outreach and supports to Providers (note: DHHS's requirement is that all PCP Providers be credentialed within thirty (30) days and all specialty Providers be credentialed within forty-five (45) days);
    d. Standardizing work processes between DHHS and Participating Providers ensure efficient implementation of the MCM program and minimal Provider burden relative to claims billing processes, reporting, prior authorizations, etc.; and
    e. Providing technical assistance to Participating Providers, especially for Participating Providers with which the Respondent would be implementing high-priority interventions (e.g., with Substance Use Disorder Providers, with Behavioral Health Providers and PCPs on the integration of physical behavioral health, with Provider participants in MCO Alternative Payment Models, etc.)

6.20 Alternative Payment Models

DHHS is committed to implementing clinically and actuarially sound incentives designed to improve care quality and utilization, and also recognizes that there is not a "one size fits all" approach to implementing APMs for the many types of Providers that serve MCM Members. As indicated in Section 4.14 (Alternative Payment Models) of the MCM Model Contract, DHHS will issue a Medicaid APM Strategy that may include supporting guidance, worksheets, and templates that will build upon the parameters set forth in the MCM Model Contract. In the interim, DHHS is interested in understanding how the Respondent would propose to implement APMs that meet DHHS's goals and requirements as described broadly and as specifically related

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to APMs, as described in Section 4.14 (Alternative Payment Models) of the MCM Model Contract.

76. Submit to DHHS an initial proposed APM Implementation Plan, including all components described within the MCM Model Contract. DHHS recognizes that this Implementation Plan may require further iteration based upon DHHS's issuance of the DHHS Medicaid APM Strategy. The APM Implementation Plan shall clearly describe what steps the MCO will take by the time of execution of the MCM Agreement, and within the first 6 and 12 months of implementation of the MCM Agreement, including:
    a. The Respondent's approach to implementing a total cost of care model with upside only shared savings for large Provider systems to the maximum extent feasible;
    b. The Respondent's approach for making accommodations for small Providers;
    c. How the Respondent will align its approach with existing APM models, including those that are aligned to "Other Payer Advanced Alternative Payment Model" under the requirements of the Quality Payment Program as set forth by MACRA;
    d. How the Respondent will adhere to all APM model transparency requirements outlined within the MCM Model Contract;
    e. The Respondent's approach, consistent with the requirements outlined in the MCM Model Contract, to Provider engagement and data sharing.
77. For all proposed APM models included in the Respondent's APM Implementation Plan, clearly articulate how the Respondent will be transparent both in contracting with Providers and with DHHS on all elements of the Respondent's APM offerings, including:
    a. How Member attribution will be determined, the frequency at which attribution will be re-assessed, and how Providers will be proactively made aware of the Members attributed to the Provider on a timely and actionable basis;
    b. The risk adjustment methodology that will be applied;
    c. The methodology for developing cost targets and the frequency at which participating Providers will receive that information;
    d. The methodology for developing quality targets and the frequency at which participating Providers will receive that information; and
    e. How Provider performance against the cost target will be assessed.
78. To the extent the Respondent has prior experience implementing APMs (or similarly defined payment models) among its Provider network(s) the Respondent should include a table indicating all of its current APM arrangements across all lines of business and states. The table should include:
    a. Name of the APM program;
    b. Line(s) of business to which the program applies (e.g., Medicaid, Medicare Advantage, etc.);
    c. State(s) in which the program applies;
    d. Description of the APM program;
    e. Whether the arrangement was required by the state;
    f. The applicable HCP-LAN APM category/sub-category (e.g., Category 2C) in which the arrangement best fits;
    g. Provider types governed under the arrangement;

h. Service types governed under the arrangement;
i. Quality requirements included as part of the arrangement;
j. Percent of total Medicaid spending (including drug spending) governed under the arrangement for the relevant line of business in the most recent 12-month measurement period; and
k. Percent of total Medicaid spending (including drug spending) projected to be governed under the relevant line of business in the next 12-month measurement period.

6.21 Provider Payments

79. Describe the Respondent's process for meeting the prompt payment requirements described within the MCM Model Contract.
80. Describe the Respondent's process for paying claims based on the effective date of the Current Procedural Terminology (CPT) code.

6.22 Claims Quality Assurance and Reporting

81. Please submit a flow chart and narrative of the Encounter Data submission process the Respondent will employ in NH, including but not limited to, how accuracy, timeliness, and completeness of data will be ensured.
82. Completeness of Encounter Data submissions requires that key fields are populated accurately for every encounter submission; describe the quality control processes that will ensure key fields are accurately populated when encounters are submitted.
83. Indicate what quality control procedures the Respondent will use to ensure documentation and coding of encounters are consistent throughout all records and data sources and across Providers and Provider types. The description should include tracking, trending, reporting, provides improvement, and monitoring of encounter submissions, encounter revisions, and its methodology for eliminating duplicate data.
84. Indicate any feedback mechanisms that the Respondent will use to improve Encounter Data accuracy, timeliness, and completeness, and the tools and methodologies that will be used to determine compliance with Encounter Data submission requirements.
85. Include documentation of the Respondent's most recent three (3) years of Encounter Data submission compliance ratings for at least one Medicaid managed care contract arrangement. The documentation should be an assessment completed either by DHHS (the Medicaid Agency or the Agency with which the Respondent was contracted) or the External Quality Review Organization.
86. Describe how the Respondent will work with Providers – particularly subcapitated Providers, Subcontractors, and Non-Participating Providers – to ensure the accuracy, timeliness, and completeness of Encounter Data.
87. Provide a table listing all instances in the last five (5) years and for all Medicaid managed care contracts in which the Respondent was: (1) delayed in submitting Encounter Data; (2) unable to submit Encounter Data; and/or 3) otherwise out of compliance with a state's requirement to provide Encounter Data.

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6.23 Oversight and Accountability

6.23.1 General

88. Please indicate the number of times, over the past five (5) years, that punitive action has been taken against the Respondent (i.e. required to submit CAPs, monetary or non-monetary penalties imposed, Capitation Payments withheld, etc.) by state Medicaid agencies. Describe the reason each action was taken and what the Respondent did to improve performance in response to the action.

6.23.2 Program Integrity

89. Provide a copy of the following:
    a. Policies and procedures demonstrating compliance with 42 CFR Section 438.608.
    b. Policies and procedures regarding recovery, reporting and tracking of Overpayments.
    c. Policies and procedures on collection and maintenance of information on ownership and control to demonstrate compliance with Sections 3.10.3 (Ownership and Control Disclosures) and 5.3.7 (Access to Records, On-Site Inspections, and Periodic Audits) of the MCM Model Contract.
    d. Policies and procedures demonstrating compliance with False Claims Act, and other federal and state laws described in Section 1902(a)(68) of the Social Security Act.
90. Describe how background and exclusion screenings, and the frequency of which, are conducted on:
    a. Board Members
    b. Employees
    c. Vendors
    d. Contractors
    e. Subcontractors

6.23.3 Fraud Waste and Abuse

91. Describe data analytic algorithms that will be used by the Respondent for purposes of fraud detection.
92. Describe the Respondent's specific controls to detect and prevent potential FWA including, without limitation:
    a. A list of automated pre-payment claims edits, including National Correct Coding Initiative edits;
    b. A list of automated post-payment claims edits;
    c. A list of audits of post-processing review of claims planned;
    d. A list of reports on Participating Providers and Non-Participating Providers profiling used to aid program and payment integrity reviews;
    e. The methods MCO will use to identify high-risk claims and MCO's definition of "high-risk claims";

f. Visit verification procedures and practices, including sample sizes and targeted Provider types or locations;
g. A list of surveillance and/or Utilization Management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
h. A method to ensure that services represented as delivered by Participating Providers were received by Members;
i. A list of references in Provider and Member material identifying fraud and abuse reporting hotline number;
j. Work plans for conducting both announced and unannounced site visits and field audits of Providers determined to be at high risk to ensure services are rendered and billed correctly;
k. The process for putting a Provider on and taking a Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate; and
l. The ability to suspend Provider's payment due to credible allegation of fraud if directed by DHHS Program Integrity.

93. Describe the resources for FWA including the organization and reporting structure, and the number of full time equivalents (FTEs).
94. Provide the Respondent's policy regarding how credible allegations of fraud or abuse shall be referred to DHHS Program Integrity and fraud to the Medicaid Fraud Control Unit (MFCU).
95. Describe the Respondent's experience with Provider recovery collection. Provide any empirical evidence of the Respondent's collection success rate.
96. Describe any training programs that the Respondent's organization uses to train employees to recognize and report patterns of fraud and abuse.
97. Describe how the Respondent engages Members in preventing fraud and abuse.

6.24 <u>Third Party Liability</u>

98. Describe how the Respondent will:
    a. Query data sources to identify potential sources of TPL; and
    b. Identify other potential TPL when adjudicating Members' claims.
99. Provide the number of FTE dedicated to TPL identification and recovery and to whom they report.
100. Describe how the Respondent will maximize the identification and recovery of TPL.
101. Describe the Respondent's method and process for capturing third-party resource and payment information from the Respondent's claims system.
102. Describe the process the Respondent uses for retrospective post-payment recoveries of health-related insurance, as well as the Respondent's process for adjudicating a claim involving an auto accident.
103. Describe the Respondent's TPL collection rate broken down by category when a third-party payer is identified for each of the organizations provided in response to Question 2 (in Section 6.4.2) of this RFP.
104. Describe the Respondent's process for sharing TPL information with DHHS.

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105. Describe the Respondent’s process for recovering funds related to other TPL coverage.

6.25 Additional Required Information

6.25.1 Performance Bond and Insurance

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.

6.25.2 Subcontractor Letters of Commitment (if applicable)

If Subcontractors are part of this Proposal, signed letters of commitment from the Subcontractor are required as part of the RFP. The 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 or not 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 DHHS. DHHS reserves the right to approve or reject Subcontractors for this project and to require the Respondent to replace Subcontractors found to be unacceptable.

6.25.3 License, Certificates and Permits

Selected Respondents must be licensed by the New Hampshire Department of Insurance to operate as an MCO in the State as required by New Hampshire RSA 420-B, and any other relevant laws and regulations, or acquire such license prior to MCO selection by the Governor and Executive Council.

6.25.4 Affiliations – Conflict of Interest Statement.

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

6.25.5 Attachments

The following attachments are required statements 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. Respondent Information and Declarations will include:

- Geographic information system (GIS) Reports
- Exceptions to Terms and Conditions

6.25.1 Addenda to Technical Proposal

The Respondent may submit any additional material not requested in this RFP that the Respondent believes to be germane to understanding its qualifications, capabilities, and successes in a separate document entitled “Addenda to Proposal.” No material in this segment

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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.

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