1. Organization and Relevant Experience

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| --- |
| **Section 1 Point Allocation** |
| **Question(s)** | **Points** |
| 1 | 0(Informational Only) |
| 2-3 | 15 |
| 4-6 | 15 |
| 7 | 20 |
| Total | 50 |

* 1. Corporate Overview
		+ - 1. Include in the Proposal a summary of the Respondent’s organization, management history, including how the Respondent’s experience demonstrates the ability to meet the Department’s needs, as described throughout this RFP and MCM Model Contract. At a minimum, the response should include the following information:
				2. A general overview of the Respondent organization;
				3. Information regarding the Respondent organization’s ownership and subsidiaries;
				4. Information regarding the Respondent organization’s background and all health insurer and provider lines of business;
				5. The number of employees employed by the Respondent;
				6. The Respondent organization’s headquarters and satellite locations;
				7. The Respondent’s current project commitments;
				8. The Respondent’s major government and private sector clients; and
				9. The Respondent’s mission statement.
	2. Managed Care Experience and References
		+ - 1. 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:
				2. The Medicaid population(s) served (e.g., children, parents, non-elderly and non-disabled, Aged, Blind, Disabled);
				3. The number of enrollees, by health plan type and population type;
				4. The name, address telephone number and website of the contracted client reference;
				5. The specific start and end dates of the contract;
				6. A brief narrative describing the role of the Respondent organization and the scope of work performed, including covered services;
				7. The use of administrative and/or delegated Subcontractor(s) and their scope of work;
				8. The annual contract amount (payment to the Respondent) and annual claims payment amount;
				9. Whether the contract was/is capitated, fee-for-service, or another payment method (if another payment method, the method should be described);
				10. 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
				11. The accomplishments and achievements the Respondent wishes to highlight.
				12. The webpage listing each plan’s quality performance indicators.
				13. Indicate four (4) prior engagements to be used as references, for which: at least two (2) should be state agencies, preferably state Medicaid agencies, 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 (1) should be a Provider; and at least one (1) should be a community-based organization.

Highlight the response examples that demonstrate the Respondent’s experience with the key priorities indicated by the Department throughout the RFP and MCM Model Contract. The Respondent may not submit a reference that is employed by the State of New Hampshire. The Department intends to contact these references and consider the information obtained as part of the scoring process. By submitting the references, the Respondent is specifically authorizing the Department to contact them regarding this procurement, their Proposal, and any and all information the reference has regarding the Respondent. To the extent a written authorization or release is required by any reference provider, the Respondent agrees to provide one upon request. For each selected reference, include the following information:

* + - * 1. The type of reference (e.g., state Medicaid agency, Provider);
				2. The reference’s name, title, and employer (the reference may not be employed by the State of New Hampshire);
				3. The reference’s contact information, including phone number, email address, and physical address;
				4. The nature of the relationship, including the capacity in which the reference is familiar with the Respondent organization;
				5. The time period of the relationship; and
				6. Activities undertaken during the engagement that establish the Respondent’s qualifications for this RFP.
				7. Identify and describe all instances of non-compliance that the Respondent, its parent organization, and 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 and all details of the sanctions applied against the Respondent as a result of non-compliance.
				8. Identify any and all 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).

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 all other significant compliance concerns.

Q6 For the Respondent’s proposed New Hampshire MCM program:

1) 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 staffing requirements.

2) Will the Respondent agree to contractually bind the CEO, CFO, Medical Director and Director of Quality/UM/Care Management positions for a minimum (3) year period beginning with the MCM program’s Start Date?

3) For Key Personnel as defined in the MCM Model Contract please provide the name, title, qualifications, and resume for each individual currently on staff with the Respondent who are proposed for New Hampshire’s MCM program. 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. The Department reserves the right to accept or reject MCM program dedicated staff individuals.

Q7 New Hampshire reserves the option to require one or more of its MCOs to implement a Medicare Advantage D-SNP. Please describe the Respondent’s D-SNP market experience by State, including program focus (e.g., HIDE, FIDE), membership counts, care management program features, and related results, and Star Ratings for the last 3 years, as applicable.

1. Subcontractors

|  |
| --- |
| **Section 2 Point Allocation** |
| **Question(s)** | **Points** |
| 8 (Items 1-3)  | 5 |
| 8 (Items 4-11) | 45 |
| Total | 50 |

Q8 Please indicate whether the Respondent intends to contract with Subcontractors to perform contractual obligations described in the MCM Model Contract, or otherwise proposed by the Respondent. The Department reserves the right to accept or reject the plan’s Subcontractors. For each function that the Respondent plans to contract with a Subcontractor for, please provide the following information:

* + - * 1. Subcontractor information, including:
1. The portions of the work to be performed by a Subcontractor;
2. Name, address, and location of such Subcontractor; and
3. General terms of the Subcontractor agreement, including the amount, duration and scope of services.
	* + - 1. A description of the Subcontractor’s experience providing those services;
				2. 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 delegated services;
				3. A description of how the Respondent will provide oversight and monitor the performance of its Subcontractors (e.g., NEMT, behavioral health, utilization management, AI technologies) to ensure all MCM Model Contract requirements are met;
				4. Sample performance monitoring reports;
				5. Sample reports showing any actions taken to improve performance and ensure positive results;
				6. A description of the information or data the Respondent will exchange with its Subcontractor(s) and how that information or data will be transferred;
				7. If applicable, a description of how Subcontractors are integrated with Care Management programs;
				8. If applicable, a description of how Subcontractors are integrated with third-party recovery and/or fraud and abuse programs;
				9. A description of any sanctions or penalties that apply if the Subcontractor fails to perform up to the Respondent’s expectations; and
				10. Signed letters of commitment from the Subcontractors, if applicable.
4. Covered Populations and Services

|  |
| --- |
| **Section 3 Point Allocation** |
| **Question(s)** | **Points** |
| 9  | 5 |
| 10 | 100 |
| 11 | 30 |
| 12 | 5 |
| Total | 140 |

* 1. **Early Periodical Screening Diagnostic and Treatment (EPSDT) Services**

Q9Please describe the Respondent’s:

* + - * 1. Process for ensuring coverage of EPSDT 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);
				2. 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;
				3. 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;
				4. Utilization management strategies relative to applied behavioral analysis (ABA) services growth rate; and
				5. EPSDT experience with the Department’s Required Priority Population described in the MCM Model Contract, Section 4.11.2).
	1. **Non-Emergency Medical Transportation (NEMT)**

Q10Reliable, high quality, and safe transportation is key to ensuring Members have access to necessary services.

* + - * 1. Describe in detail the Respondent’s plan to provide comprehensive oversight of each of the transportation provider types (e.g., sedan, taxi, wheelchair van, ambulance) to ensure on-time delivery of NEMT services in the most appropriate vehicle to meet Member needs. Include in the description:
1. The Respondent’s MCO Transportation Coordinator position qualifications for the position described in the MCM Model Contract (Section 3.11.1.11.3.8);
2. The Respondent’s commitment to oversight of its NEMT program; and
3. Experience with improving NEMT reliability, quality and access, including the approach the Respondent will put in place for New Hampshire’s MCM program.
	* + - 1. Please outline the Respondent’s staffing plan, specifying FTEs dedicated to the NEMT program.
				2. Does the Respondent currently have a contracted broker they anticipate bringing to New Hampshire’s MCM program? If so, please provide the name of the broker.
				3. Please provide a workflow diagram depicting the Respondent’s anticipated NEMT operational strategy—beginning with a Member call to the call center, to documentation of the successful routine or rescue ride completion or wholly failed ride. Within the flow diagram, please include the following details:

a) Responsibilities of both the MCO and the broker;

b) How rescue rides will be managed; and

c) How the Respondent currently utilizes transportation network company (TNC) or rideshare services in its transportation program.

* + - * 1. Describe and submit evidence of the Respondent’s most successful solution(s) to improve safe, high-quality, and on-time NEMT rides completion performance in the most appropriate vehicle, including any Provider incentives and penalties.
				2. Provide an overview of the Respondent’s program integrity requirements within the NEMT program, including:

Specific controls for identifying FWA;

Compliance and program integrity plans;

Screening controls in place for on-boarding of transportation providers and

Process for verifying services for Members submitting claims or other forms for family and friends reimbursement.

**3.3** **Discretionary Services**

Q11Value-added services and In Lieu of Services are not offered under the Medicaid State Plan, the cost for value-added services is excluded from the capitation rate calculations while only the cost effective portion of the cost is included for In Lieu of Services.

1. Describe the Respondent’s experience with In Lieu of Services implementation, monitoring, oversight, and reporting.
2. What community-based prevention programs will the Respondent commit to offer as Value-Added Services for Members (e.g., blood pressure self-monitoring programs, fitness classes, falls prevention classes (e.g., Tai Chi), health coaches), and other established wellness and prevention programs or classes in place in New Hampshire?  Please be specific about the programs and partner organizations, including how the Respondent plans to ensure access to these Value-Added Services in all geographic regions of the State.
3. Indicate any other Value-Added Services the Respondent plan to offer to MCM program Members.
4. Pursuant to 42 CFR 438.3, the Department proposes to authorize diabetes self-management, assistance in finding and keeping housing (not including rent), critical time intervention (CTI), and voluntary family preservation services as In Lieu of Services, subject to CMS approval. Will the Respondent agree to offer these services?
	1. **Clinical Trials**

Q12Describe the Respondent’s experience with clinical trials, including:

* + - * 1. What protocols does the Respondent have in place to ensure a CMS-qualified clinical trial is not inappropriately denied under the Medicaid benefit in accordance with 1905(gg)(2)-(3) of the Social Security Act?
				2. How does the Respondent differentiate between Medicaid covered services incidental to the experimental service and the experimental treatment itself?
1. Pharmacy Management

|  |
| --- |
| **Section 4 Point Allocation** |
| **Question(s)** | **Points** |
| 13 | 0(Informational only) |
| 14 | 50 |
| 15 | 50 |
| 16 | 50 |
| 17 | 50 |
| Total | 200 |

* 1. General

Q13 Who does the Respondent propose to use for its PBM in New Hampshire, and what administrative and clinical responsibilities will be delegated to the PBM?

Q14 New Hampshire Medicaid proposes to introduce three (3) pharmacy program changes under the MCM program. Describe the Respondent’s experience with each of the three changes described below. Will the Respondent agree to each of these arrangements?

 The pharmacy changes are:

* + - * 1. Polypharmacy management by medical providers and community pharmacists as described in the MCM Model Contract (Section 4.2.6);
				2. Introduction of a High-Cost Pharmacy Risk Pool as described in the MCM Model Contract (Section 4.2.2.2); and
				3. Consideration by the Department to introduce a single PBM starting in Year 3 or Year 4 as referenced in the MCM Model Contract (Section 4.2.1.1).

4.2 **Medication Management**

Q15 As described in the MCM Model Contract (Section 4.2.6), the Department proposes to manage medication to ensure appropriate use of pharmacology, a priority for New Hampshire Medicaid. The Department will fund in its Capitation Rates professional claims reimbursement for Polypharmacy management by medical Providers and community pharmacists.

* + - * 1. Describe the Respondent’s plan for providing Medication Management as described in the MCM Model Contract (Section 4.2.6). Cite any relevant experience in other markets.
				2. Has the Respondent provided professional claim reimbursement for Medication Management services previously? If yes, please explain the related payment policy.
				3. Will the Respondent commit to paying Providers for Comprehensive Medication Reviews and medication therapy management services?
				4. Describe the Respondent’s approach to educating Providers about their role in supporting Medication Management and Comprehensive Medication Review programs, including making Providers aware of the availability of reimbursement for related services.
				5. What approaches will the Respondent use to support Provider medication management review for their patients, including Provider education about medication interactions, side effects, and appropriate prescribing? Provide a sample medication management review report.
				6. How will the Respondent share information with Providers and community pharmacists who will perform medication therapy management and comprehensive medication reviews?
				7. Will the Respondent commit to support the medication management review processes based on the Polypharmacy criteria established in the MCM Model Contract (Section 4.2.6)?
				8. In the Respondent’s professional judgment based on the monthly prescription count distribution in Table 1 below:



How will the Respondent enable the Providers to achieve one hundred percent (100%) compliance with Comprehensive Medication Review requirements and related Member counseling in accordance with the Model Contract (Section 4.2.6)?

What are the Respondent’s suggested annual rates of Comprehensive Medication Review completion by Providers and community pharmacists, including Member counseling over five (5) years of the Agreement?

Will the Respondent commit the resources and technology necessary to fully support the Provider’s delivery of Comprehensive Medication Review services, including related Member counseling by a Provider or community pharmacist?

* + - * 1. Describe how the Respondent may achieve higher rates of Provider and Member participation in Comprehensive Medication Management and related Member counseling. Please describe related approaches and results in other markets.
	1. **Prescription Drug and Therapies Cost-Saving Opportunities**

Q16 Describe the Respondent’s utilization review automation (e.g., algorithms, AI technology) for new high-cost therapies that would be utilized in New Hampshire’s MCM program.

Q17 The State's actuary has identified opportunities to improve management of systemic immunomodulators (including but not limited to: Humira, Otezla, Taltz, Skyrizi). What strategies has the Respondent introduced in other markets to improve utilization management and correct prescribing?

1. Has the Respondent participated in a high-risk pharmacy pool? If yes, briefly describe the program.
2. Describe any experience the Respondent has operating within a single pharmacy benefit management environment.
3. Member Enrollment and Disenrollment

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| --- |
| **Section 5 Point Allocation** |
| **Question(s)** | **Points** |
| 18-19 | 20 |
| 20 | 10 |
| Total  | 30 |

5.1 General

Q18 Describe the Respondent’s strategy and experiences with assisting Members in advance of their Medicaid eligibility redetermination.

Q19 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.

5.2 Membership Auto-Assignment

 To the extent one or more incumbent MCOs are selected in the re-procurement, the Department is committed to maintaining continuity of health plan coverage for Members with their existing MCO at each Member’s option, while identifying a pathway to ensure the incoming MCO(s) receives an equitable share of Member enrollment. To achieve these objectives, the Department will institute an auto-assignment process that ensures Members are able to remain in their existing MCO, while providing a pathway for the incoming MCO(s) to gain an equitable share of Members. The Department may 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 as described in the MCM Model Contract (Section 4.3.4).

Q20 Relative to membership auto-assignment processes, please provide:

* + - * 1. 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
				2. 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.
1. Member Services

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| --- |
| **Section 6 Point Allocation** |
| **Question(s)** | **Points** |
| 21 | 10 |
| 22 | 10 |
| Total  | 20 |

Q21 Describe the Respondent’s mechanisms in place to support its Members, 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.

Q22 Describe how the Respondent will ensure cultural competency throughout the Respondent’s Participating Provider network.

1. Access

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| --- |
| **Section 7 Point Allocation** |
| **Question(s)** | **Points** |
| 23 | 15 |
| 24 | 10 |
| 25 | 5 |
| Total | 30 |

Q23 Describe the Respondent’s existing relationships with relevant Providers and stakeholders in New Hampshire, as applicable. Which relationships does the Respondent anticipate forming? If new to the New Hampshire market, describe in detail how the Respondent will build a sufficient and effective network of Medicaid Participating Providers that promotes person-centered care and choice of Providers; engages each Member’s informal support system (e.g., family caregivers), and provides care in the most integrated setting for Members.

Q24 Explain how the Respondent has contributed to improving the limited supply of Providers in rural areas. Provide a detailed example of the Respondent’s rural network approach in another state’s Medicaid managed care market.

Q25 Please provide a detailed example of the Respondent’s recent experience with timely and appropriate Provider enrollment and terminations, including:

* + - * 1. How many Providers the Respondent declined to enroll in the last 24 months? Please list the number by provider type; and
				2. How many Providers the Respondent terminated for cause other than fraud in the last 24 months.
1. Utilization Management (UM)

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| --- |
| **Section 8 Point Allocation** |
| **Question(s)** | **Points** |
| 26 | 15 |
| 27 | 15 |
| 28 | 20 |
| Total | 50 |

Q26 What Utilization Management (UM) strategies has the Respondent employed in other state Medicaid markets to contain health care spending while ensuring Members maintain access to high-quality health care services? Respondents should include all markets with at least 100 covered lives.

* + - * 1. Describe processes the Respondent will implement for emergency department (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 visits. What strategies will the Respondent implement to reduce high ED utilization? Provide statistically relevant results of initiatives employed in a program similar to the MCM program wherever possible.
				2. Describe the Respondent’s UM techniques or initiatives in place or that will be in place by New Hampshire’s 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.

Q27 In alignment with MCM Model Contract requirements (Section 4.8), describe the Respondent’s approach to UM and how the approach would be modified for New Hampshire, including the Respondent’s process to ensure its UM program includes criteria that:

1) Are practicable, objective, and based on evidence-based criteria, to the extent possible;

2) 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);

* + - * 1. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (the Department shall approve any changes to the clinical criteria before the criteria are utilized);
				2. Are applied based on individual needs and circumstances (including social determinant of health needs);
				3. Are applied based on an assessment of the local delivery system;
				4. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and
				5. Conform to the standards of NCQA Health Plan Accreditation.

Q28 For each Category and Covered Service in Table 2 below, please provide the following information:

1. 1) Across the Respondent’s Medicaid Managed Care Organizations, provide the highest percentage of prior authorizations denied in calendar years 2019 and 2022 per 10,000 Members for each service category and service in Table A of the provided template (Appendix D-1). Please also identify within each service category whether the service and/or coverage determination are evaluated by the MCO or delegated to a Subcontractor. For all denied services, please specify reason for the initial denial separately as a percent of denial reason (e.g., Not medically necessary, Not a covered benefit, Administrative denial (i.e., inconsistent, inaccurate, or missing information), Out-Of-Network or non-participating facility). For pharmacy services, please consider industry standard denial reasons (e.g., step therapy, age limits, quantity limits, non-formulary).

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| --- |
| Table 2List of Covered Services Commonly Subject to Prior Authorization |
| Category | **Service** | **Examples** |
| Outpatient or Ambulatory Care Services  | Behavioral Health | Key Areas: intensive day or partial hospitalization programs |
| Physical Health  | Key areas include cardiology, oncology, radiology, gastroenterology Examples: outpatient and office-based diagnostic catheterizations, stress echocardiograms, electrophysiology implants, nuclear cardiology, and stress echocardiograms, endoscopy, colonoscopy, radiation therapy, sleep apnea studies, pain management, spinal cord stimulators, vein ablation, infertility evaluation and treatment |
| Inpatient Acute, Subacute or Rehabilitative Services  | Behavioral Health | Extended stays following an emergent admission |
| Physical Health  | Key areas include cardiology, orthopedic, and some specialized surgicalExamples: arthroscopy, arthroplasty, joint replacement, surgical procedures on the foot; bariatric surgery, non-mastectomy breast reconstruction, inpatient cerebral seizure monitoring, hysterectomy, maxillofacial functional impairment, rhinoplasty/sinuplasty, sleep apnea procedures and surgeries, spinal surgery, and organ or tissue transplant |
| Home Care Services | Private Duty Nursing | Full or partial denials for supervision, custodial or respite care |
| Home Health Aid | Full or partial denials for supervision, custodial or respite care, needs assessment |
| Durable Medical Equipment, Prosthetics, Orthotics and Supplies | Diabetes Care | Continuous glucose monitoring and insulin pumps |
| Disposable Supplies | Incontinence and wound care |
| Powered or higher cost items | Mobility devices like wheelchairs and scooters, lymphedema pumps and specialty pressurized bed mattresses |
| Higher cost prosthetics  |   |
| Vision/Hearing | Hearing aids and cochlear implants |   |
| Complex Imaging | Higher cost imaging  | CT of head, chest, abdominal, cervical spine, and lower joint |
| MRIs of lumbar spine  |
| Laboratory | Genetic/Molecular Testing for BRCA |   |
| Experimental/Investigational | Participation in clinical trials |   |
| Formulary | Typically requires step therapy and/or may limit supplies | Examples include: injectables and/or specialty pharmacy including bone-modifiers, colony-stimulating factors, anti-emetics, chemotherapies, blood modifiers, asthma, dermatology, endocrine, enzyme deficiencies or replacement, radiopharmaceuticals, autoimmune including multiple sclerosis |

2) How many and what UM edits does the Respondent have in place to trigger prior authorization review?

1. Primary Care and Prevention Focused Model of Care

|  |
| --- |
| **Section 9 Point Allocation** |
| **Question(s)** | **Points** |
| 29 | 40 |
| 30 | 40 |
| 31 | 25 |
| 32-35 | 25 |
| 36 | 25 |
| 37 | 20 |
| 38-41 | 25 |
| Total | 200 |

**9.1 General**

New Hampshire Medicaid will adopt a Primary Care and Prevention Focused Model of Care as described in the MCM Model Contract (Section 4.10) in recognition that routine Member visits with their PCP are important to establish authentic, meaningful relationships as evidenced by claim encounters. These authentic and meaningful relationships between a Member and his or her PCP are defined by the Member’s regular engagement with their PCP, including formally documented PCP attribution to reflect the Member’s primary health care source.

This model is connected to the State’s overall aim of promoting whole-person health, optimal health, wellness and independence to avoid or slow the progression of illness. New Hampshire Medicaid cares about more than just avoiding illness--we care about making beneficiaries as healthy as possible while at the same time promoting integrated and bi-directional physical health with behavioral health care.

Under the Primary Care and Prevention Focused Model of Care, the PCP (and other Providers who share responsibility of the Member) shall be responsible for Provider-Delivered Care Coordination and primary care services as described at Section 4.11.7 of the MCM Model Contract, including facilitating health risk assessment (HRA) screenings, care coordination, and referrals for their patients consistent with Practice Guidelines and Standards.

Q29 Please explain:

* + - * 1. How the Respondent will support authentic primary care engagement between the PCP and Member as evidenced by preventive service, HRA, and Comprehensive Medication Review encounters;
				2. How the Respondent will support Providers in increasing the number of appropriate wellness and preventive care visits based on HRA information;
				3. How the Respondent will incentivize the Provider and Member to increase preventive care appointments;
				4. Provide an example of the Respondent’s experience administering a Member Incentive Program with similar objectives, including:
1. The target population for the Member incentive program;
2. How individuals were identified for participation in the Member incentive program(s);
3. The number of individuals that ultimately enrolled in the program, and received incentives for participation; and
4. Any statistically relevant program results, particularly those that demonstrate a change in Member behavior and/or improved health outcomes.
	* + - 1. The Respondent’s primary care experience in its markets (e.g., Medicaid, Medicare, commercial markets);
				2. Primary care strategies the Respondent has employed in other markets; and
				3. What implementation challenges the Respondent anticipates, and how they will be mitigated.
	1. **Member Assessment, Screening, and Referral**

The Health Risk Assessment (HRA) screening tool is important to help identify areas of opportunity to improve patient health and equitable access to care for all Members. Under the new Model of Care, PCPs are expected to facilitate HRA screenings with Members. In New Hampshire, utilization of HRA screenings to determine care needs and health-related social needs averages less than twenty percent (20%). Assessment and identification of patient engagement readiness, barriers and opportunities is necessary to effectively establish a Member Care Plan.

Q30 Please describe:

1. How the Respondent will transition HRA screenings to PCPs.
2. How the Respondent will archive and utilize HRA information facilitated by Member PCPs to support MCO-Delivered Care Management.
3. What practices the Respondent will put in place for the transfer of information to and from the Provider for purposes of supporting concurrent Provider-Delivered Care Coordination and MCO-Delivered Care Management.
4. How the Respondent will incentivize the Provider and Member to increase HRA completion rates, and follow through with referrals identified care gaps.

Q31 Based on the expected enrollment distribution in Table 3 below, what percentage rate by eligibility category would the Respondent hold themselves accountable to achieving PCP-facilitated HRA completions?

*Intentionally left blank*

| **Table 3** |
| --- |
| **New Hampshire Department of Health and Human Services** |
| **Medicaid Care Management Program** |
| **Rate Cell Membership Distribution - Rate Year (RY) 2024** |
| **Eligibility Category** | **Average Monthly Projected RY24 Membership** | **Distribution** |
| *Standard* |   |   |
| Low Income Children - Age 0-11 mos. | 3,408 | 1.90% |
| Low Income Children - Age 1-18 yrs. | 54,174 | 30.30% |
| Low Income Adults | 12,316 | 6.90% |
| CHIP | 15,292 | 8.60% |
| Foster Care / Adoption | 2,706 | 1.50% |
| Severely Disabled Children | 831 | 0.50% |
| Elderly and Disabled Adults-Age 19-64 | 5,715 | 3.20% |
| Elderly and Disabled Adults-Age 65+ | 1,278 | 0.70% |
| Dual Eligibles | 14,195 | 8.00% |
|   |   |   |
| Severe/Persistent Mental Illness-Non-Dual | 1,264 | 0.70% |
| Severe/Persistent Mental Illness-Dual | 1,753 | 1.00% |
| Severe Mental Illness-Non-Dual | 449 | 0.30% |
| Severe Mental Illness-Dual | 224 | 0.10% |
| Low Utilizer-Non-Dual | 207 | 0.10% |
| Low Utilizer-Dual | 250 | 0.10% |
| Serious Emotionally Disturbed Child | 5,633 | 3.20% |
|   |   |   |
| *Granite Advantage* |   | 0.00% |
| Granite Advantage-Medically Frail | 6,981 | 3.90% |
| Granite Advantage-Non-Medically Frail | 49,263 | 27.60% |
|
| Severe/Persistent Mental Illness-Non-Dual | 1,160 | 0.60% |
|
| Severe Mental Illness-Non-Dual | 1,163 | 0.70% |
| Low Utilizer-Non-Dual | 194 | 0.10% |
| Serious Emotionally Disturbed Child | 83 | 0.00% |

* + 1. **USPSTF Level A and B Screenings**

New Hampshire Medicaid prioritizes preventive Level A and B screenings recognized by the United States Preventive Screening Task Force (USPSTF) as described in the MCM Model Contract (Section 4.11.1.4.8), as well as State specific preventive lead screening priorities statutorily prescribed under RSA 130-A:5-a.

Q32 In accordance with the membership distribution in Table 3 above, what completion rates does the Respondent expect to achieve for each recommended age and risk appropriate preventive screening below?

* 1. Colorectal cancer screening
	2. Lung cancer screening
	3. Breast cancer screening
	4. Cervical cancer screening
	5. Abdominal aortic aneurysm screening
	6. STI screening (HIV, Hepatitis B and C, chlamydia and gonorrhea)
	7. Osteoporosis screening

Q33 What Member and Provider incentives will the Respondent adopt to accomplish the statutory completion of Level A and Level B USPSTF preventive screenings?

Q34 The MCO will be expected to reimburse Providers for USPSTF recommended screenings that utilize a standardized screening tool (i.e., for obesity, anxiety, depression and suicide risk, unhealthy alcohol and drug use, and falls prevention), even when delivered outside of a Wellness Visit. What is the Respondent’s plan to meet the MCM program’s Provider payment objective?

Q35 When would it be appropriate to require prior authorizations for Covered Services identified through preventive screenings? Under what specific conditions would the Respondent recommend or require a prior authorization?

Q36 What incentives will the Respondent offer to Member incentivize and encourage Member follow-through with diagnostic and treatment referrals prompted by adverse preventive screenings? Please describe what incentives the Respondent would propose and for which preventive screenings, if they vary?

* + 1. **Blood Lead Screening for Children**

Based on the 2021 HEDIS blood lead screening measure, New Hampshire Medicaid had a lead screening rate of seventy-five percent (75%) for children. The measure captures the percent of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

In accordance with NH RSA 130-A, all Medicaid-eligible children regardless of whether coverage is funded through title XIX or XXI, are required to receive blood lead screening tests at ages 12 months and 24 months. Any children between ages 24-72 months with no record of a previous blood lead screen test must receive one. (Medicaid Manual Section 5123.2.D.1) In 2022, the State’s testing rates for Medicaid insured children under the age of 6, were 50% for 1-year olds and 39% for 2-year olds. Rates for all children in NH in 2021 were 60% for one-year olds and 51% for two-year olds. Under the MCM Model Contract, New Hampshire will measure lead testing based on the HEDIS and title XIX/XXI designations and impose financial penalties for failure to improve testing rates.

NH expects improvement in testing rates based on the State requirements of blood lead screening tests at ages 12 months and 24 months. Goals will begin at fifty-five percent (55%) for 12-month olds and forty-four percent (44%) for 24-month olds, with incremental increases of five percent (5%) for each category annually. At the end of the 5-year contract period, the expectation for successful testing rates will be seventy-five percent (75%) for 12-month olds and sixty-four percent (64%) for 24-month olds.

Q37 The MCM program does not meet the statutory lead screening requirement today. What is the Respondent’s plan to achieve related compliance?

* + 1. What is the Respondent’s understanding of the Exhibit N (Liquidated Damages Matrix) remedies regarding lead test screening rates?
		2. What actions will the Respondent undertake to minimize Exhibit N (Liquidated Damages Matrix) financial exposures for failure to achieve acceptable lead testing rates as described in the MCM Model Contract (Section 4.8.2.3.2)?

3) How will the Respondent increase incentives to Providers and parents/guardians to improve lead testing completion rates?

* 1. **Diabetes Management**

In New Hampshire, HEDIS data shows diabetes control has been worsening for the past five years across all Medicaid MCOs. The data shows poor control of A1c above nine percent (9%) was 32.4% in 2017. In 2021, the rates worsened to forty-three (43%). The Department has authorized the extension of diabetes self-management as an In Lieu of Service anticipated for approval under new CMS rules.

Q38 What is the Respondent’s competency in offering the diabetes self-management In Lieu of Service (ILOS)?

Q39 Describe how the Respondent will partner with the State’s Department of Public Health to improve diabetes control rates.

Q40 How will the Respondent engage key stakeholders in developing the diabetes management pathway, including but not limited to engagement with CMHCs, FQHCs, RHC/rural primary care, other health systems, accredited diabetes self-management education programs, as well as Members presenting with a diabetes diagnosis.

Q41 What strategies does the Respondent plan for increasing enrollment in a Centers for Disease Control (CDC) recognized diabetes self-management program for Members with a pre-diabetes diagnosis?

1. Care Coordination and Care Management

|  |
| --- |
| **Section 10 Point Allocation** |
| **Question(s)** | **Points** |
| 42-44 | 75 |
| 45 | 125 |
| 46-48 | 50 |
| 49 | 15 |
| 50 | 10 |
| 51 | 25 |
| Total | 300 |

**10.1** **General**

Care Management and Care Coordination services are fundamental to the added value the Department seeks through its MCO partnerships. In this section, the Department seeks responses that clearly describe the Respondent’s strategies for Provider-Delivered Care Coordination and MCO-Delivered Care Management programs targeted to improve Member care and health outcomes.

Under the MCM program’s Primary Care and Prevention Focused Model of Care, the MCO is responsible for ensuring effective management, coordination, and Continuity of Care for all Members, including oversight of Provider-Delivered Care Coordination responsibilities for the PCPs’ attributed Members. The MCO is responsible for MCO-Delivered Care Management Services for Required Priority Populations as described in the MCM Model Contract (Section 4.11.2.2).

New Hampshire Medicaid has identified the following high-risk groups as Required Priority Populations in need of MCO-Delivered Care Management

* Individuals who have required an inpatient admission for a behavioral health diagnosis within the previous 12 months;
* Infants, children and youth who are involved in the State’s child welfare system, Division for Children Youth and Families (DCYF), including those in foster care and whose families have elected voluntary family preservation services and other voluntary services;
* Babies experiencing low birth weight and/or neonatal abstinence syndrome (NAS); and
* Individuals who are incarcerated and eligible for participation in the Department’s Community Reentry demonstration program, pending CMS approval.

While the MCO may identify other Members who may benefit from the MCO’s Care Management services at the plan’s option, MCO-Delivered Care Management requirements specified in the MCM Model Contract apply only to the identified Required Priority Populations which may be expanded from time to time with advance notification by the Department to the MCO.

**10.2** **MCO-Delivered Care Management**

Q42 New Hampshire Medicaid requires enhanced focus on the above-referenced Required Priority Populations. The MCO’s focus shall include assessment of barriers and opportunities to help manage/coordinate Member care as described in the MCM Model Contract (Section 4.11.2).

1) Per 10,000 Members, provide the FTE staffing ratio and staff positions for the Respondent’s MCO-Delivered Care Management program.

2) Describe outreach activities the Respondent will undertake in New Hampshire to encourage and incentivize Required Priority Populations Members to engage in MCO-Delivered Care Management.

Q43 Describe the Respondent’s plan for operationalizing MCO-Delivered Care Management, including:

* 1. The process and timing for conducting a Comprehensive Assessment for the Required Priority Populations;

2) Description of processes, services, and activities the Respondent will undertake to support Care Management for Required Priority Populations including, at a minimum, the coordination of physical, behavioral health and social services, medication management review, referral follow-up, peer support, training on self-management, assistance with meeting unmet resource needs, and the convening of Care Teams, including the frequency of such meetings as well as integration with Provider-Delivered Care Coordination;

3) The Respondent’s plan to ensure that the MCO-Delivered Care Management approach effectively integrates with waiver-based Providers who support the Department’s programs (e.g., targeted case management under Choices for Independence (HCBS) and Acquired Brain Disorder, Special Medical Services for children, the Doorways), and targeted case management provided by the Community Mental Health Centers (CMHCs);

4) Description of the qualifications and competencies of the Respondent’s care managers;

5) Attestation that the Respondent will employ sufficient staffing, processes and systems to support the State’s continuously evolving Care Management model in future years of the Contract; and

6) What percent of each Required Priority Population group does the Respondent anticipate they will have enrolled into MCO-Delivered Care Management, during the following contract measurement periods:

a) By the end of Year 2 (June 30, 2026); and

b) By the end of Year 3 (June 30, 2027)?

Q44 Using Table 3 above, based on the Respondent’s current Medicaid managed care experience and proposed MCO-Delivered Care Management approach, estimate the projected share of Members actively engaged in MCO-Delivered Care Management.

**10.3 Provider-Delivered Care Coordination**

Q45 Describe the Respondent’s strategy for Provider-Delivered Care Coordination that is Member and family-centered as well as assessment-driven, including:

1) Description of what readiness approach the Respondent will undertake to prepare PCPs for their Provider-Delivered Care Coordination role;

* 1. The process and timing for enabling the PCP to conduct a HRA for every Member within ninety (90) days of the effective date of PCP assignment as specified in the MCM Model Contract (Section 4.11.2); and
	2. Description of all the components of the Respondent’s integrated care planning approach for the Member Care Plan maintained by the PCP as described in the MCM Model Contract (Section 4.11.4.8), including how frequently it will be updated a roadmap and accountability system for integrating care based on individual/family needs and priorities identified in the assessment and used in coordinating care.

**10.4 Integrated Model of Care**

Q46 Provide a description of the Respondent’s structure and plan for Provider-Delivered Care Coordination and MCO-Delivered Care Management inclusive of key components of each program, type of services provided, roles and responsibilities of staff involved in the provision of each service and how the Respondent proposes Members will be identified for Provider-Delivered Care Coordination versus MCO-Delivered Care Management, including a description of the Respondent’s proposed contractual approach to secure the PCP’s accountability for delivery of Member Care Coordination services required and be reimbursed for related services.

Q47 Describe the Respondent’s Provider technical assistance strategy for supporting the Provider-Delivered Care Coordination and the MCO-Delivered Care Management initiatives.

Q48 Describe the Respondent’s Member Service strategies for supporting Provider-Delivered Care Coordination and the MCO-Delivered Care Management initiatives.

**10.5** **Priority Population Specialty Services and Programs**

Q49 Understanding New Hampshire’s priorities described throughout the RFP, please describe:

* + - * 1. Value-Added Services, In Lieu of Services, or other initiatives the Respondent proposes for introduction to effectively address health-related social needs;
				2. The Respondent’s experience with addressing health-related social needs identified in Comprehensive Health Assessments and how “warm handoffs,” closed-loop referrals, or other approaches to help Members secure needed services are integrated into Provider-Delivered Care Coordination strategies;
				3. Specific examples of how the Respondent has supported these functions in other Medicaid markets, including results and measurable outcomes achieved from the Respondent’s applied interventions; and
				4. The community-based relationships and processes the Respondent will utilize for Member referrals and follow-up to community-based social services in order to ensure Members are successful in securing unmet resource needs.

*Q50* The Department proposes to adopt preventive measures to improve Member and family welfare outcomes. One area of interest is identification of at-risk Members who would benefit from voluntary family preservation services and supports to prevent the need for future Division for Children Youth and Families (DCYF) intervention. Please describe:

1. The Respondent’s experience and interest offering home-based family preservation services as a means to prevent child welfare involvement for at-risk populations under Medicaid.
2. If available, a summary of the Respondent’s results that demonstrate the effectiveness of such programs.

Q51 New Hampshire is seeking CMS demonstration authority benefitting Medicaid-eligible incarcerated individuals of the State’s prisons (initially State Department of Corrections facilities and later County jails and youth correctional facilities) who are scheduled for release from correctional facilities within 45 days. Eligible individuals under the demonstration would have behavioral health needs, including Substance Use Disorder, mental health or mental illness diagnoses. Demonstration services are proposed to include managed care enrollment, provision of ongoing medication assisted treatment (MAT), behavioral health, enhanced case management, care coordination and initial pre-release visits with community-based providers, case management transition meetings prior to reentry, and 30-day prescription drug supplies provided upon release. The Demonstration population, services and other elements are subject to future demonstration amendments.[[1]](#footnote-1)

* + - * 1. Describe the Respondent’s Care Management approach managing this Required Priority Population, including the Respondent’s collaboration and integration with State Department of Corrections Care Managers?
				2. How will the Respondent incentivize the availability of timely appointment slots with Providers to meet Member needs?
1. Behavioral Health (including Mental Health, Substance Use Disorder, and Integration with Physical Health Services)

| **Section 11 Point Allocation** |
| --- |
| **Question(s)** | **Points** |
| 52 | 20 |
| 53 | 20 |
| 54 | 20 |
| 55 | 20 |
| 56 | 30 |
| 57 | 30 |
| 58 | 30 |
| 59 | 30 |
| Total | 200 |

Q52 Describe the strategies the Respondent will implement in the delivery and coordination of Behavioral Health Services and supports as described in the MCM Model Contract (Section 4.1.2), including:

* + - * 1. Whether the Respondent intends to use a Subcontractor for the delivery of Behavioral Health Services. If so, describe the provisions within the MCO Model Contract that would be subcontracted and how the Respondent will ensure a seamless care experience for Members and a reduction of administrative burden for the Department and Behavioral Health network service Providers under the Department’s MCM program; and
				2. How the Respondent will effectively support Member access to all Behavioral Health services required under the MCM Model Contract, including New Hampshire public and private behavioral health providers, practitioners, professionals, and paraprofessionals to meet Member needs at different levels of care and different provider types, such that waitlists for services are increasingly reduced or eliminated altogether.

Q53 Describe the Respondent’s capacity to recruit mental health Providers for service delivery to meet network adequacy requirements outlined in the MCM Model Contract (Section 4.12.1.6).

Q54 Describe strategies and actions the Respondent will take to reduce Member psychiatric boarding stays in the emergency department (ED) and in other hospital settings (regardless of whether Medicaid is the primary payer), and to the degree applicable, any statistically relevant results of intervention(s) implemented by the Respondent in other states, including a description of the following:

* + - * 1. The Respondent’s approach to reduce the frequency of and rate of Members experiencing psychiatric boarding stays;
				2. The Respondent’s plans to track and ensure timely treatment for and follow-up with Members who experience an ED visit or are hospitalized due to an overdose or for psychiatric reasons; and
				3. The Respondent’s plan for establishing Provider reimbursement methodologies that create appropriate financial incentives to reduce psychiatric boarding and increase timely discharges from hospitals for Members no longer in need of acute inpatient psychiatric care.

Q55 As described in the MCM Model Contract (Section 4.20.2.1), the MCO will be required to enter into Capitated Payment arrangements with (Community Mental Health Centers)[[2]](#footnote-2),[[3]](#footnote-3) providing reimbursement on terms specified by the Department in forthcoming guidance. Will the Respondent agree to such an arrangement? If so, describe the Respondent’s ability to support capitated contract arrangements with Community Mental Health Centers (CMHCs), including experience supporting these or similar arrangements in other states, including functions such as:

* + - * 1. Conducting administrative service organization type functions in such arrangements, given bifurcated CMHC targeted case management, Provider-Delivered Care Coordination, and MCO-Delivered Care Management as described in the MCM Model Contract, based on terms described in Appendix E-1 (Table G)), and specified by the Department in forthcoming guidance; and
				2. Establishing a coordinated effort for CMHC program treatment in collaboration with Substance Use Disorder Providers, and other Mental Health and private Community Mental Health Providers.

Q56 Describe how the Respondent plans to promote use of the State’s 988-Mobile Crisis Response System for Members experiencing a Behavioral Health related crisis, as well as plans to educate the Respondent’s Behavioral Health Providers on the 988 system, and encourage the development of workflows with the system to ensure rapid access to care for Members.

Q57 Describe the Respondent’s capacity to provide the required Substance Use Disorder services as outlined in the MCM Model Contract (Section 4.13.26), including:

1) The Respondent’s capacity and strategies to provide effective monitoring, technical assistance, and training for Opioid Treatment Programs and all other Substance Use Disorder treatment programs; and

2) The Respondent’s plans to promote use of medication assisted treatment (MAT) services in New Hampshire, and the Respondent’s experiences in other states increasing use of MAT, providing statistically relevant data if possible, including but not limited to promotional approaches that differ by provider type (e.g., PCP practices, Substance Use Disorder treatment programs).

Q58 Describe the Respondent’s experience and capacity to support a sustained and expanded Maternal Opioid Misuse (MOM) Grant Program funded by the Centers for Medicare and Medicaid Services (CMS).[[4]](#footnote-4),[[5]](#footnote-5)

Q59 Describe how the Respondent will safely reduce the rate of opioid prescribing without increasing use of illicit opioids, including, but not limited to:

* + - * 1. Strategies for working with Providers to reduce opioid prescribing;
				2. Supporting Providers on alternative strategies for addressing pain management;
				3. Providing assistance to Members who are chronic or high users of opioids;
				4. The Respondent’s policies requiring Providers and pharmacists to review New Hampshire Prescription Drug Monitoring Program (PDMP) data prior to prescribing or dispensing opioids to Members; and
				5. Any additional strategies that the Respondent has found effective in other states for safely reducing use of prescription opioids.
1. Quality Management

|  |
| --- |
| **Section 12 Point Allocation** |
| **Question(s)** | **Points** |
| 60-61 | 10 |
| 62-63 | 20 |
| 64-65 | 20 |
| Total | 50 |

* 1. Health Plan Accreditation

Q60 The Respondent shall specify its current health plan and any affiliate accreditation status for all products in which it is currently participating. This shall include:

* + - * 1. The name of the accrediting entity(ies) (e.g., NCQA, Utilization Review Accreditation Commission (URAC));
				2. The most recent date of certification;
				3. The effective date of the accreditation;
				4. The type(s) and corresponding level(s) of accreditation achieved; and
				5. The status of the accreditation (e.g., provisional, conditional).

Q61 Based on the health plan accreditation information provided immediately above, identify and provide the Respondent’s rank order from a) highest performing to b) lowest performing accredited health plans, including:

1. Health plan category (e.g., HMO, Medicare);
2. State(s); and

3) Rating details.

* 1. Quality Assessment and Performance Improvement Program (QAPI)

Q62 Provide an organizational chart that depicts the relationship between the QAPI and Respondent leadership, including how the Respondent’s QAPI program relates to the Respondent’s processes for Utilization Management, as well as the development and implementation of clinical Practice Guidelines, provider relations, etc.

Q63 Provide one or more detailed examples of how, in another Medicaid managed care market, the Respondent utilized its QAPI program to identify necessary improvement in the market, implement an initiative designed to address the challenge in the same market, and/or modified the initiative based on ongoing assessment. Describe statistically relevant outcomes achieved as result of implementing the improvement(s).

Q64 Provide the Respondent’s most recent two (2) years of Medicaid managed care results for all available Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures. This information should be conveyed in a table by Medicaid managed care plan. In the table, include the following information:

* + - * 1. The name and location of the plan;
				2. The total membership of the plan; and
				3. A description of the population reflected in the results.

Q65 If, in response to the previous question, the Respondent is unable to provide 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.

1. Alternative Payment Model (APM)

|  |
| --- |
| **Section 13 Point Allocation** |
| **Question(s)** | **Points** |
| 66 | 20 |
| 67 | 15 |
| 68 | 15 |
| Total | 50 |

The Department is committed to implementing clinically and actuarially sound incentives designed to improve care quality and utilization. As indicated in the MCM Model Contract (Section 4.16), the Department will define a Medicaid APM Strategy proposed to include supporting guidance, worksheets, and templates that build upon parameters set forth in the MCM Model Contract. The Department is interested in understanding how the Respondent would propose to implement APMs that meet the Department’s goals and requirements.

Q66 Submit to the Department an initial proposed APM Implementation Plan, including all required components described within the MCM Model Contract. The Department recognizes that this Implementation Plan may require further iteration based upon issuance of the Department’s Medicaid APM Strategy. In the Respondent’s plan, clearly describe steps the Respondent will take at Program Start, and within the first 6, 12, and 18 months of implementation of the MCM program, including:

* + - * 1. The Respondent’s approach to ensuring that fifty percent (50%) of all MCO medical expenditures are in qualifying HCP-LAN APMs specified by the Department within the timeline prescribed by the MCM Model Contract, and consistent with the Department’s overall objective to promote the goals of the MCM program;
				2. The Respondent’s approach to implementing a total cost of care (TCOC) model with upside only shared savings for large Provider systems to the maximum extent feasible;
				3. The Respondent’s approach for designing APM arrangements and implementation plans that support the participation of small Providers (e.g., FQHCs, SUD); and
				4. How the Respondent will align its approach with the HCP-LAN APM framework and any existing APM models in the New Hampshire market, including those that are aligned to “Other Payer Advanced Alternative Payment Models” under the requirements of the Quality Payment Program as set forth by MACRA.

Q67 Clearly describe how the Respondent will be transparent both in contracting with the Department and Providers on all elements of the Respondent’s APM offerings, including how Member attribution will be determined and what actions may trigger Member re-attribution, the frequency at which attribution will be re-assessed, suggested efforts to adjust and maintain Member attribution, and how Providers will be proactively made aware of the Members attributed to the Provider on a timely and actionable basis.

Q68 To the extent the Respondent has prior experience implementing APMs (or similarly defined payment models) among its Provider network(s), complete Table B of the provided template (Appendix D-1) indicating all current APM arrangements across all lines of business and states during the past three (3) calendar years. The table includes:

* + - * 1. Name of the APM program;
				2. Line(s) of business to which the program applies (e.g., Medicaid, Medicare Advantage, Marketplace, Medicaid expansion);
				3. State(s) in which the program applies;
				4. Whether the arrangement was required by the state and, if so, under what state program;
				5. Description of the APM program, including any payments or funding sources made available to provider organizations in preparation for APM participation;
				6. The method of attributing and adjusting Members, as applicable;
				7. The total Member lives and Member months attributed to the APM;
				8. The applicable HCP-LAN APM category/sub-category (e.g., Category 2C) in which the arrangement best fits;
				9. Provider types governed under the arrangement, and the percentage of APM expenditures each provider type represents;
				10. Service types governed under the arrangement;
				11. Quality requirements included as part of the arrangement;
				12. 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;
				13. 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;
				14. Total incentive payments (excluding regular payments or negative payments) made to provider participants based on their performance in the APM; and
				15. Key cost-related performance milestones, population health improvements, or quality outcomes achieved through the APM.
1. Claims Quality Assurance and Reporting

|  |
| --- |
| **Section 14 Point Allocation** |
| **Question(s)** | **Points** |
| 69 | 10 |
| 70 | 20 |
| 71 | 10 |
| 72 | 10 |
| Total | 50 |

Q69 Please submit a flow chart and detailed narrative explaining how the Encounter Data submission process will be deployed in New Hampshire, including but not limited to, demonstration of quality controls for accuracy, timeliness, and completeness of data will be ensured.

Q70 Completeness of Encounter Data submissions requires that key fields are populated accurately for every encounter submission. Please describe:

1. The quality control processes that will ensure key fields are accurately populated when encounters are submitted;
2. 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, process improvement, and monitoring of encounter submissions, encounter revisions, and the methodology for eliminating duplicate data;
3. Any feedback mechanisms 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; and
4. 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.
	1. Outside of claims edits and billing manuals, what methods does the Respondent employ to ensure correct claims submission? Please describe any work directly with Providers to ensure correct claims submission.
	2. How does the Respondent ensure that all Providers identify the correct procedure code across identical or nearly-identical services? Please highlight any post-adjudication claims reviews or audits.

Q71 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 the Department (the Medicaid Agency or the Agency with which the Respondent was contracted) or the External Quality Review Organization (EQRO).

Q72 Provide a table listing all instances in the last three (3) years 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 Encounter Data requirements.

1. Oversight and Accountability

|  |
| --- |
| **Section 15 Point Allocation** |
| **Question(s)** | **Points** |
| 73-74 | 5 |
| 75 | 15 |
| 76 | 15 |
| 77-79 | 5 |
| Total | 40 |

Q73 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) by a state Medicaid agency. Describe the reason each action was taken, and what the Respondent did to improve related performance.

Q74 Provide a copy of the following:

* + - * 1. Policies and procedures demonstrating compliance with 42 CFR Section 438.608; and
				2. Policies and procedures regarding recovery, reporting and tracking of overpayments.

These policies and procedures will not count toward page limits.

Q75 How does the Respondent categorize the plan’s Providers by risk level for suspicions of fraud in accordance with 42 CFR 455.450? Does the Respondent use any other Provider profiling for risk levels? How does this impact the Respondent’s Provider oversight?

1. How many investigative staff does the Respondent have in other contracted states? Describe and provide the number of fraud, waste and abuse (FWA) FTE staff resources by position and reporting structure by State Medicaid Agency contract. If preferred, an organizational chart may be included as an attachment (with a summary table), and will not count toward page limits.
2. Provide the number of FTE(s) by position title that will be dedicated to New Hampshire’s FWA resources for identification and Recovery processes, and to whom they will report. Include responses in Table C of the provided template (Appendix D-1).
3. Provide at least five (5) examples of data analytic algorithms that the Respondent typically uses for purposes of fraud detection.

Q76 Describe how the Respondent prevents potential FWA including without limitation:

1. The types of claims editing the Respondent utilizes, the software, and frequency of edit updates;
2. Methods the Respondent will use in New Hampshire to identify high-risk claims and its definition of high-risk claims;
3. List of surveillance and/or Utilization Management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
4. Method to ensure services represented as delivered by Participating Providers were received by Members; and
5. 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;
6. Description of training programs the Respondent uses to train employees to recognize and report patterns of fraud and abuse; and
7. Interactions between FWA staff, quality and clinical management staff, and other utilization review staff, including internal referral processes.

Q77 Describe methods used to engage Members in preventing fraud and abuse. Please distinguish methods that utilize EOB communications from methods that do not utilize EOBs.

Q78 What percentage of claims were paid to out-of-network Providers in the last 24 months? (Please include any claims paid by Subcontractors, and identify the total number of claims used in the denominator to respond to this question.)

Q79 How many single case agreements (include by Respondent and Subcontractors) has the Respondent issued in the past 24 months? (Please identify the total number of states.)

1. Third Party Liability/Coordination of Benefits

|  |
| --- |
| **Section 16 Point Allocation** |
| **Question(s)** | **Points** |
| 80 | 10 |
| 81 | 5 |
| 82 | 5 |
| 83 | 10 |
| 84 | 5 |
| 85 | 10 |
| 86 | 5 |
| Total | 50 |

Q80 Describe how the Respondent:

* + - * 1. Performs data matching with other third-party liability (TPL) insurance and the match frequency, including how the Respondent’s system maintains other insurance information, and how the information is used to Cost Avoid claims;
				2. Ensures Subcontractors delegated claims processing gain information about other insurance; and
				3. Monitors Subcontractor utilization of TPL information to Cost Avoid claims covered by other insurance.

Q81 Provide the number of FTE(s) by position title that will be dedicated to New Hampshire’s TPL and coordination of benefits (COB) identification and Recovery processes per 10,000 Members, and to whom they will report. Include responses in Table D of the provided template (Appendix D-1).

Q82 Provide the number of FTE(s) by position title that will be dedicated to New Hampshire’s Subrogation efforts, including the number of attorneys. Is the Subrogation work performed by vendor or Respondent staff? Include responses in Table E of the provided template (Appendix D-1).

Q83 How does the Respondent define a successful TPL program? What are the priority processes? How is success measured? What percent of claims should be Cost Avoided or recovered? What metrics does the Respondent use and what are considered successful benchmarks? Please distinguish between metrics related to TPL versus Subrogation.

Q84 Does the Respondent’s claim system capture other insurance payments and denials from Providers? What does the Respondent’s system capture (e.g., payments, denials, co-pays, and deductible information from the Provider)?

Q85 Summarize the process the Respondent uses for retrospective post-payment recoveries of health-related insurance, whether done by the MCO or a Subcontractor, including the process for reporting Recovery amounts to the state.

Q86 Describe how the Respondent’s system processes pharmacy claims with a Member’s Medicare Part A and Part B.

1. New Hampshire Department of Health and Human Services, *Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request* (September 2022), available on June 30, 2023 at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/sed-extention-request.pdf. [↑](#footnote-ref-1)
2. <https://www.dhhs.nh.gov/dcbcs/bbh/centers.htm> [↑](#footnote-ref-2)
3. <http://www.gencourt.state.nh.us/rules/state_agencies/he-m400.html> [↑](#footnote-ref-3)
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