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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

Jeffery A. Meyers
Commissioner

Kathleen A. Dunn
Associate Commissioner

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April 18, 2016

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy to exercise a renewal option and amend an existing agreement with the Health Services Advisory Group, Inc. (Vendor #226207) 3133 East Camelback Road, Suite 300, Phoenix, Arizona 85016, by increasing the price limitation by $1,061,286 from $1,924,001 to $2,985,287, and by extending the contract completion date from June 30, 2016 to June 30, 2018 to provide external quality review for New Hampshire's Medicaid Care Management program. The Governor and Executive Council approved the original contract agreement on August 14, 2013 (Item #31), and subsequent amendments on January 14, 2015 (Item #3), April 22, 2015 (Item #10), and November 4, 2015 (Item #10). Funding: 75% Federal Funds, 25% General Funds.

Funds to support this request are available in the following accounts in State Fiscal Year 2016, and 2017, and anticipated to be available in State Fiscal Year 2018 upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust encumbrances between State Fiscal Years through the Budget Office, without further approval from the Governor and Executive Council, if needed and justified.

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$487,350	$0	$487,350
2015	102-500731	Contracts for Program Services	$663,531	$0	$663,531
2016	102-500731	Contracts for Program Services	$495,966	$0	$495,966
2017	102-500731	Contracts for Program Services	$0	$495,966	$495,966
2018	102-500731	Contracts for Program Services	$0	$565,320	$565,320
		Subtotal:	***$1,646,847***	***$1,061,286***	***$2,708,133***

05-095-047-470010-79460000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, AFFORDABLE CARE ACT (ACA)

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$210,217	$0	$210,217
2015	102-500731	Contracts for Program Services	$0	$0	$0
2016	102-500731	Contracts for Program Services	$66,937	$0	$66,937
2017	102-500731	Contracts for Program Services	$0	$0	
2018	102-500731	Contracts for Program Services	$0	$0	
		Subtotal:	***$277,154***	$0	***$277,154***
		Contract Total:	***$1,924,001***	***$1,061,286***	***$2,985,287***

EXPLANATION

This request is to support the continuation of objective and external review activities of the Medicaid Care Management program as required by the Federal Balanced Budget Act of 1997 and 42 CFR 438 Subpart E. These requirements impose an obligation on the Department to assure that its Medicaid Managed Care Organizations are reviewed and evaluated no less than annually and are adherent to the Centers for Medicare and Medicaid Services External Quality Review Organization protocols. In addition to evaluating the Managed Care Organizations, the Department's compliance with the State's Medicaid program quality strategy will also be evaluated. This evaluation must be conducted by an independent and certified External Quality Organization. This agreement will ensure that the Department meets its responsibilities that appropriate care is being provided to NH Medicaid beneficiaries enrolled in managed care.

The External Quality Review Organization is an essential component of the State's Medicaid program quality strategy. EQRO activities related to review of each managed care organization's programs and operations include in part:

- Compliance with federal and state regulations and all contract standards;
- Data validation of encounter data, claims payment information, and performance measures calculations to assure that valid and reliable data is received by the Department;
- Accurate and timely provider claims payments; and
- Oversight for data driven health outcomes performance improvement projects that fill gaps in beneficiary health (e.g., well care visits for children, diabetes screening, preventive care counseling).

HSAG has also provided evaluations of the following Medicaid managed care activities, incorporating the perspectives of external stakeholders and providing independent assessment of:

- Beneficiary access to care and waiting times for medical services through "secret shopper" data collection, analysis and reporting;
- Evaluation of grievances and appeals processes;
- MCO approaches to prior authorization program development, operations, grievances and appeals; and
- Beneficiary experience of care, focused on with early Medicaid Care Management enrollees, mandatory populations and beneficiaries receiving case management.

Additionally, HSAG assists in holding the State accountable to CMS in the state's execution of a Medicaid managed care program in:

- External, impartial Medicaid Care Management program review;
- Review of CMS policy changes with recommendations for New Hampshire Medicaid managed care program improvements; and
- Completion of the CMS required Technical Report;

This contract was competitively bid. The Department is very satisfied with Health Services Advisory Group Inc. high quality and timely scope of work execution and is exercising the option to renew the contract services outlined in Standard Exhibit A paragraph 1.2 of the original contract.

Should the Governor and Executive Council not approve this request, the Department would be out of compliance with the regulations established by the Balanced Budget Act of 1997 and 42 CFR 438 Subpart E and would limit the state's capacity for third-party and statistically rigorous assessment of the Medicaid managed care program.

Area Served: Statewide

Source of Funds:
05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, MEDICAID ADMINISTRATION – 75% Federal Funds, 25% General Funds

05-095-047-470010-79460000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, AFFORDABLE CARE ACT (ACA) - 100% Federal Funds, 0% General Funds

In the event that federal funds become no longer available, general funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:

Jeffrey A. Meyers
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #4 to the Health Services Advisory Group Contract

This 4th Amendment to the Health Services Advisory Group contract (hereinafter referred to as "Amendment #4") dated this 28th day of March, 2016, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Health Services Advisory Group, Inc. (hereinafter referred to as "the Contractor"), a corporation with a place of business at 3133 East Camelback Road, Suite 300, Phoenix, AZ 85016-4501.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 14, 2013 (Item #31), as amended by an agreement (Amendment #1) approved on January 14, 2015 (Item #3), April 22, 2015 (item #10) and again on November 4, 2015 (item #10), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 of the Agreement, and Exhibit A, Paragraph 1.2, the State may renew the contract for two (2) additional years by written agreement of the parties and approval of the Governor and Executive Council; and;

WHEREAS the parties have agreed to add to scope of services and to increase the price limitation; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

To amend as follows:

1. Form P-37, Item 1.7, Completion Date, to read:

   June 30, 2018

2. Form P-37, Item 1.8, Price Limitation, to read:

   $2,965,287

3. Delete Exhibit A, and replace with Exhibit A, Amendment #4

   The term of this agreement shall begin July 25, 2013 through June 30, 2018. The Department reserves the right to offer two (2) additional periods of two (2) years each for a total term of seven (7) years.

4. Delete Exhibit B, Amendment #3 Methods and Conditions Precedent to Payment External Quality Review Organization (EQRO) Services Payment Arrangements and replace with Exhibit B, Amendment #4 Methods and Conditions Precedent to Payment External Quality Review Organization (EQRO) Services Payment Arrangements.

5. Exhibit D, Certification Regarding Drug-Free Workplace Requirements, Period Covered by this Certification to read:

   From: 7/24/13 – To:6/30/2018

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

4/25/16
Date

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Health Services Advisory Group, Inc.

3/29/16
Date

NAME: Mary Ellen Dalton, PhD, MBA, RN
TITLE: Chief Executive Officer

Acknowledgement:
State of Arizona, County of Maricopa on March 29, 2016, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.
Signature of Notary Public or Justice of the Peace

Alexandra Lemmer (Bassanetti) - Notary Public
Name and Title of Notary or Justice of the Peace

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

5/16/16
Date

Name: Megan A. Yaple
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

New Hampshire Department of Health and Human Services
External Quality Review Organization (EQRO) Services Contract

EXHIBIT A

1. Introduction.

1.1. Purpose.

The purpose of this Agreement is to set forth the terms and conditions for the Health Services Advisory Group (HSAG) to provide external quality review services for healthcare systems providing healthcare to New Hampshire Medicaid beneficiaries in order to ensure the quality, timeliness of, and access to care and services provided to beneficiaries who enrolled in an MCO Health Plan and to beneficiaries in the Fee for Service (FFS) programs.

1.2. Agreement Period.

The initial term of this Agreement shall be for three years, from July 25, 2013 through July 30, 2016. The New Hampshire Department of Health and Human Services (DHHS) in its sole discretion may decide to offer two (2) additional periods of two (2) years each, for a total Agreement term of seven (7) years.

2. Acronyms.

2.1. Acronyms.

The following table lists definitions for acronyms used throughout this document:

BBA	Balanced Budget Act of 1997
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CHIP	Children's Health Insurance Program
CSHCN	Children with Special Health Care Needs
DHHS	New Hampshire Department of Health and Human Services
ED	Encounter Data
EDMS	Encounter Data Management System
EQRO	External Quality Review Organization
EQR	External Quality Review
FFP	Federal Financial Participation
FFS	Fee for Service

FFY	Federal Fiscal Year
FTE	Full-Time-Equivalent
G&C	Governor and Executive Council
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HSAG	Health Services Advisory Group
HSH	Health Services Holdings, Inc.
LTC	Long Term Care
MCO	Managed Care Organization
MCIS	Managed Care Information System
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assessment
NH	New Hampshire
NHDHHS	New Hampshire Department of Health and Human Services
OMBP	Office of Medicaid Business and Policy
PCP	Primary Care Physician
PIP	Performance Improvement Project
PRO	Peer Review Organization
QAPI	Quality Assurance and Performance Improvement Program
QIP	Quality Incentive Program
RFP	Request for Proposal
SFY	State Fiscal Year
SURS	Surveillance and Utilization Review Unit (within the Office of Improvement and Integrity)

General Terms and Conditions.

2.1. Agreement elements:

The Agreement between the parties shall consist of the following documents:

- Form P-37 Agreement, General Provisions;
- Exhibit A – Scope of Services - Statement of work for all goods and services to be provided as agreed to by State of New Hampshire DHHS and the EQRO;
- Exhibit B – Methods and Conditions Precedent to Payment;
- Exhibit C – Special Provisions - Provisions and requirements set forth by the State of New Hampshire/DHHS in addition to those outlined in the P-37;
- Exhibit D – Certification Regarding Drug Free Workplace Requirements – EQRO's Agreement to comply with requirements set forth in the Drug-Free Workplace Act of 1988;

- Exhibit E – Certification Regarding Lobbying – EQRO's Agreement to comply with specified lobbying restrictions;
- Exhibit F – Certification Regarding Debarment, Suspension and Other Responsibility Matters - Restrictions and rights of parties who have been disbarred, suspended or ineligible from participating in the Agreement;
- Exhibit G – Certification Regarding Americans With Disabilities Act Compliance – EQRO's Agreement to make reasonable efforts to comply with the Americans with Disabilities Act;
- Exhibit H – Certification Regarding Environmental Tobacco Smoke – EQRO's Agreement to make reasonable efforts to comply with the Pro-Children Act of 1994, which pertains to environmental tobacco smoke in certain facilities;
- Exhibit I – HIPAA Business Associate Agreement - Rights and responsibilities of the EQRO in reference to the Health Insurance Portability and Accountability Act;
- Exhibit J – Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance;
- Attachment 1: DHHS' RFP for EQRO Services (#13-OMBP-EQRO-02); and
- Attachment 2: HSAG's January 17, 2013 Response to RFP for EQRO Services.

2.2. Order and Interpretation of Documents.

In the event of any conflict or contradiction between the Agreement documents, the documents shall control in the above order of precedence. In the event of a dispute regarding the interpretation of Agreement terms, analysis of the these terms shall be informed by reference to DHHS' RFP for EQRO Services (#13-OMBP-EQRO-02) and HSAG's January 17, 2013 Response to RFP for EQRO Services, which shall both be incorporated within this Agreement, for any purpose, by reference hereto.

2.2.1. Delegation of Authority.

Whenever, by any provision of this Agreement, any right, power, or duty is imposed or conferred on DHHS, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner of the New Hampshire Department of Health and Human Services, unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of DHHS.

2.2.2. Errors & Omissions.

The EQRO shall not take advantage of any errors or omissions in the RFP or the resulting Agreement. The EQRO shall promptly notify DHHS of any such errors and/or omissions that are discovered.

2.3. CMS Approval of Agreement & Any Amendments.

This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to review by the Centers for Medicare and Medicaid Services

(CMS) for the purpose of determining that the State is eligible to receive the seventy-five percent EQR match in accordance with 42 C.F.R. 438.370. Prior approval of the Agreement by CMS is not required by federal or state law.

2.4. Cooperation With Other Vendors And Prospective Vendors.

DHHS may award supplemental contracts for work related to the Agreement, or any portion thereof. HSAG shall reasonably cooperate with such other vendors, and shall not commit or permit any act that may interfere with the performance of work by any other vendor, or act in any way that may place members at risk of an emergency medical condition.

2.5. Renegotiation and Reprocurement Rights.

2.5.1. Renegotiation of Agreement terms.

Notwithstanding anything in the Agreement to the contrary, DHHS may at any time during the term of the Agreement exercise its option to notify HSAG that DHHS has elected to renegotiate certain terms of the Agreement. Upon HSAG's receipt of notice pursuant to this Section, HSAG and DHHS will undertake good faith negotiations of the subject terms of the Agreement, and may execute an amendment to the Agreement.

2.5.2. Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected HSAG's Services and/or Deliverables provided during any period of the Agreement, DHHS may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Agreement or Scope of Work similar or comparable to the Scope of Work performed by HSAG under the Agreement. DHHS shall give HSAG ninety (90) calendar days advance notice of intent to replace HSAG with another EQRO or to add an additional EQRO.

2.5.3. Termination rights upon Reprocurement.

If upon procuring the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, DHHS elects to terminate this Agreement, HSAG shall have the rights and responsibilities set forth in Section 15 ("Termination"), Section 16 ("Agreement Closeout"), and Section 18 ("Dispute Resolution Process").

3. Organization.

3.1. Organization Requirements.

Registrations, Licenses, and Certifications. HSAG shall obtain a Certificate of Good Standing from the Corporations Division of the New Hampshire Secretary of State's Office, and provide a copy of this Certificate to DHHS at the time of execution of this agreement. HSAG shall provide to DHHS a Certificate of Insurance from HSAG's insurer. See also the attached contract form P-37 for additional insurance requirements. HSAG shall also provide DHHS with its Certificate of Authority or Vote.

3.2. Articles & Bylaws.

HSAG shall provide by the beginning of each Agreement year, or at the time of any substantive changes, written assurance from HSAG's legal counsel that HSAG is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under this Agreement.

3.3. Relationships.

3.3.1. Ownership and Control

3.3.1.1. HSAG is presently a subsidiary corporation under Health Services Holdings, Inc. HSAG shall notify DHHS of any person or corporation that has, or obtains over the course of this agreement, a five percent (5%) or more ownership or controlling interest in HSAG, a parent organization, subsidiaries, and/or any affiliates, and shall provide financial statements for all owners meeting this criterion [1124(a)(2)(A) 1903(m)(2)(A)(viii); 42 CFR 455.100-104 ; SMM
2087.5(A-D); SMD letter 12/30/97; SMD letter 2/20/98].

3.3.1.2. HSAG shall inform DHHS of intent or plans for mergers, acquisitions, or buy-outs within seven (7) calendar days of key staff learning of such actions.

3.3.1.3. HSAG shall inform its primary contact within DHHS by phone and by email within one business day of HSAG staff learning of any actual or threatened litigation, investigation, complaint, claim, transaction, or event that may reasonably be considered to result in material financial impact on or materially impact or impair the ability of HSAG, or any of its subcontractors, to perform under this Agreement with DHHS.

3.3.2. Prohibited Business Relationships.

HSAG shall not knowingly have a relationship with any of the following:

3.3.2.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No.12549; or

3.3.2.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 3.3.2.1. An individual is described as follows:

3.3.2.2.1. A director, officer, or partner of HSAG;

3.3.2.2.2. A person with beneficial ownership of five percent (5%) or more of HSAG's equity; or

3.3.2.2.3. A person with an employment, consulting, or other arrangement with HSAG's obligations under its Agreement with the State [42 CFR
438.610(a); 42 CFR 438.610(b); SMD letter 2/20/98].

3.3.3. HSAG shall conduct background checks on all employees actively engaged at

HSAG. In particular, those background checks shall screen for exclusions from any federal programs and sanctions from licensing oversight boards, both in-state and out-of-state.

3.3.4. HSAG shall not and shall certify that it does not employ or contract, directly or indirectly, with:

3.3.4.1 Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 or 1128A of the SSA for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

3.3.4.2. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity;

4.3.4.3. Any individual or entity excluded from Medicaid or New Hampshire participation by DHHS;

3.3.4.4. Any individual or entity discharged or suspended from doing business with the State of New Hampshire; or

3.3.4.5. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

4. Sub-Contractors.

4.1. HSAG's Obligations Regarding Subcontractors.

4.1.1. HSAG remains fully responsible for the obligations, services and functions performed by any of its subcontractors, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions had been performed by HSAG employees, and for the purposes of this Agreement, such work will be deemed performed by HSAG. DHHS shall have the right to require the replacement of any subcontractor found by DHHS to be unacceptable or unable to meet the requirements of this Agreement, and to object to the selection of a subcontractor.

4.1.2. HSAG shall have a written agreement with each of its subcontractors whereby the subcontractor agrees to hold harmless DHHS and any DHHS employees and contractors, served under the terms of this Agreement in the event of non- payment by HSAG. The subcontractor further agrees to indemnify and hold harmless DHHS, and any DHHS employees and contractors, against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or DHHS employees and contractors through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

4.2. Notice and Approval.

4.2.1. HSAG shall submit all subcontractor agreements to DHHS for prior approval at least sixty (60) calendar days prior to the anticipated implementation date of each subcontractor agreement, annually for renewals, and whenever there is a substantial change in scope or terms of the subcontractor agreement.
4.2.2. HSAG shall notify DHHS of any change in subcontractors and shall submit a new subcontractor agreement for approval ninety (90) calendar days prior to the start date of the new subcontractor agreement.
4.2.3. Approval by DHHS of a subcontractor agreement does not relieve HSAG from any obligation or responsibility regarding the subcontractor and does not imply any obligation by DHHS regarding the subcontractor or subcontractor agreement.
4.2.4. DHHS may grant a written exception to the notice requirements of 4.2.1 and 4.2.2 if, in DHHS's reasonable determination, HSAG has shown good cause for a shorter notice period.
4.2.5. HSAG shall notify DHHS within one business day of receiving notice from a subcontractor of its intent to terminate a subcontract agreement.
4.2.6. HSAG shall notify DHHS of any material breach of an agreement between the Contractor and the subcontractor within one business day of validation that such breach has occurred.

4.3. HSAG's Oversight.

4.3.1. HSAG shall oversee and be held accountable for any function(s) and responsibilities that it delegates to any subcontractor, including:

4.3.1.1. HSAG shall have a written agreement between HSAG and its subcontractor that specifies the activities and responsibilities delegated to the subcontractor; its transition plan in the event of termination, and provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

4.3.1.2. All subcontracts shall fulfill the requirements of 42 CFR 438 as are applicable to the service or activity delegated under the subcontract agreement.

4.3.1.3. HSAG shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

4.3.1.4. HSAG shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule approved by DHHS, consistent with industry standards, and with State laws and regulations.

4.3.1.5. HSAG shall audit the subcontractor's care systems at least annually to ensure that its subcontractors' performance is consistent with the Agreement between DHHS and HSAG, and whenever there is a substantial change in the scope or terms of the subcontract agreement.

4.3.1.6. HSAG shall identify deficiencies regarding its subcontractors or areas for improvement, if any, for which HSAG and its subcontractor will take corrective action. If HSAG identifies deficiencies regarding its subcontractors or

areas for improvement, HSAG shall so notify DHHS in writing and take corrective action within seven (7) calendar days of identification. HSAG shall provide DHHS with a copy of the Corrective Action Plan for DHHS' review and approval.

4.4. Transition Plan.

4.4.1. In the event of material change, breach, or termination of a subcontractor agreement between HSAG and any of its subcontractors, HSAG's notice to DHHS shall include a transition plan for DHHS's review and approval.

5. Staffing.

5.1. HSAG shall ensure that it has qualified staff to conduct all contracted activities, and shall assign the following key personnel for the duration of this Agreement:

5.1.1. Executive Director to provide leadership and oversee all of the activities required under this agreement, and the activities of the Contract Manager;

5.1.2. Contract Manager to oversee the all of the activities of the EQRO contract with DHHS, and to be the primary point of contact within HSAG for all DHHS inquiries and requests for responsive action;

5.1.3. Project Leads for all External Quality Review activities and required tasks under the EQRO contract;

5.1.4. Chief Technology Officer to provide oversight and expertise with information technology systems and processes;

5.1.5. Reports Director to manage and develop work plans for all reports required under this agreement; and

5.1.6. Technical Writer to write, compile and prepare technical reports for publication in accordance with the terms of this agreement.

5.2. DHHS shall have the right to accept or reject any of the EQRO contractor's employees or subcontractors assigned to this project and to require their replacement at any time and for any reason given.

5.3. HSAG team members, and all other HSAG sub- contractors, shall possess the qualifications, expertise, and experience necessary to perform all of their assigned duties, at the project leadership and coordination level and extending to its subject matter experts, project leads, and assigned staff. HSAG shall ensure and verify that all of its staff and subcontractors have the appropriate training, education, and experience to fulfill the requirements of the positions they hold. HSAG shall keep and maintain documentation of all individuals requiring licenses and/or certifications. HSAG shall keep documentation current, and shall make it available for inspection by DHHS.

5.4. HSAG shall staff the EQRO program, at a minimum, with all proposed staff indicated in the Listing of Personnel on pages 109 – 113 of its January 14, 2013 Response to DHHS' RFP for EQRO Services, and with any additional personnel who are or become necessary to conduct all tasks outlined in sections 8 and 9 of this Agreement on a timely basis.

5.5. HSAG shall provide to DHHS, for its review and approval, a complete listing of key personnel and their qualifications no later than thirty (30) calendar days prior to the start of the program.

5.6. HSAG shall provide and maintain sufficient staff to perform all review activities and tasks specified in this agreement. In the event that HSAG does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS will notify HSAG in writing, which may be by email correspondence, to produce a corrective action plan to remedy insufficient performance.

5.7. HSAG's contract manager shall be available to DHHS during DHHS' hours of operation and available for in-person or video-conference meetings as requested by DHHS. Key personnel, and others as required by DHHS, shall be available for monthly, in-person, or video-conference meetings as requested by DHHS.

5.8. HSAG shall notify DHHS in writing at least thirty (30) calendar days in advance of any plans to change, hire, replace, or reassign designated key personnel. HSAG shall submit the names and qualifications of proposed alternate staff to DHHS for review and approval.

5.9. HSAG shall, within thirty (30) calendar days of implementing this agreement, deliver to DHHS a staffing contingency plan that includes:

5.9.1. The process for replacement of personnel in the event of the loss of personnel before or after execution of this agreement;

5.9.2. Provision of additional staffing resources to this agreement if HSAG is unable to perform the requirements of this agreement on a timely basis;

5.9.3. Replacement of key personnel with personnel who have similar qualifications, education, and experience;

5.9.4. HSAG's ability to provide similarly qualified replacement personnel and timeframes for securing replacement personnel; and

5.9.5. HSAG's method for training and bringing replacement personnel up to date on relevant aspects of this agreement.

6. Representation and Warranties.

6.1. HSAG shall ensure and warrant that all services developed and delivered under this Agreement will meet in all material respects the specifications as described in the Agreement during the Agreement Period, including any subsequently negotiated, and

mutually agreed, specifications.

6.2. HSAG acknowledges that by entering this Agreement, DHHS has relied upon all representations made by HSAG in its Response to RFP #13-OMBP-EQRO-02, including all representation made in its Technical Proposal and Addenda, and its Cost Proposal. HSAG's January 17, 2013 Response to Request for Proposal for External Quality Review Organization (EQRO) Services, RFP #13-OMBP-EQRO-02 is incorporated within this agreement by reference hereto.

6.3 HSAG will work with the State to create timelines for the completion of the activities associated with the Contract. Within 15 business days of execution of the contract, HSAG will propose a Work Plan for approval by the State. If development, implementation, or execution of any activities is delayed due to circumstances outside the control of HSAG (i.e., delayed submission of data to HSAG by DHHS or contractors, or delay in feedback required for the production of HSAG reports, etc.), the parties agree to adjust the timeline to allow HSAG adequate time to conduct the activities.

7. Statement of the Work Beginning in the Pre-Implementation Phase of Medicaid Care Management.

7.1. HSAG will provide analysis and evaluation of aggregated information on the quality, timeliness, and access to healthcare services covered by New Hampshire Medicaid and New Hampshire Medicaid's MCOs. Pursuant to 42 CFR 438.350 and 42 CFR 438.358, HSAG will perform a variety of external quality review (EQR) activities both prior to and upon implementation of New Hampshire Medicaid's Care Management Program. These activities, as outlined below, will generate information for HSAG to use in conducting its EQRs and will serve DHHS' interest in high quality and efficient health service delivery systems within its Medicaid FFS and MCO programs.

7.2. HSAG will assist DHHS, based on its experience with the implementation and monitoring of new statewide Medicaid managed care quality programs, with New Hampshire Medicaid's migration from a Medicaid FFS program to Medicaid Care Management.

7.3. HSAG will collaborate with DHHS and MCO staffs during the development and implementation of the MCOs Performance Improvement Projects (PIPs), and the State's Quality Incentive Program (QIP) submission to provide technical assistance and training on the documentation requirements for PIPs and QIPs and the detail necessary to appropriately address all activities required by the CMS Protocols.

7.4. HSAG will validate the performance of each MCO's Quality Assessment and Performance Improvement (QAPI) program, PIPs, and the State's QIPs as they are developed and implemented, providing a comprehensive assessment of each project, and comparing the

MCO results to similar programs and to metrics for the New Hampshire Medicaid FFS population. In preparation for this comparative analysis, HSAG shall similarly assess and validate New Hampshire Medicaid's quality programs and metrics, and develop a system to facilitate comparison with MCOs' quality programs.

7.5 HSAG will provide DHHS and the MCOs with an orientation to the performance measure validation process that will include a thorough review of the process, the expectations for the MCOs, the roles of the auditors, the timeline for the activities, and measure-specific reviews.

7.6. HSAG, in consultation with DHHS staff, will evaluate, no less than annually, and propose as needed new performance measures to improve New Hampshire Medicaid FFS and MCO performance and meet new Federal and State mandates and objectives, including but not limited to incorporating the National Quality Strategy priorities into the State's FFS and MCO quality programs.

7.7. HSAG will be developing aggregate performance measures and objectives to assess healthcare services delivered and statewide health outcomes, including calculation of administrative measures for the FFS populations comparable to those calculated by the MCOs, and to allow for a comparison of the aggregate managed care population to the residual New Hampshire Medicaid FFS population. In preparation for this comparative analysis, HSAG shall evaluate New Hampshire Medicaid's FFS population measures and develop a system to facilitate comparison of MCO measures to those of New Hampshire Medicaid's FFS program. HSAG will learn about the technical specifications for the measures, identify the data sources necessary to calculate rates, and obtain appropriate data use agreements to acquire data not traditionally housed at DHHS.

7.8. HSAG will recommend to DHHS and, following approval from DHHS, will calculate additional quality of care and access to care measures and performance improvement goals for New Hampshire Medicaid's FFS program. HSAG will also validate the data associated with each measure and objective. Working with DHHS, HSAG will propose detailed quality improvement strategies to DHHS when opportunities for quality of care improvement are identified for a particular FFS program.

7.9. HSAG will be validating MCO performance measures, providing a comprehensive assessment of each measure, and comparing MCO results to similar programs or metrics for the New Hampshire Medicaid FFS population. In preparation for this comparative analysis, HSAG shall develop familiarity with existing New Hampshire Medicaid performance measures, develop and produce new measures, and develop the necessary data analytics strength to compare FFS measures to those of the MCOs.

7.10. Data Systems Development and Management.

7.10.1. HSAG is required to have information systems capable of accepting, cleaning, validating, analyzing, and submitting the required data and reports. Pursuant to 42

CFR438.358 (c)(1) and 42 CFR 438.358 (d), and in order to facilitate the transfer, testing, warehousing, and use of required data that will enable HSAG to perform all functions required under this agreement, HSAG shall, subject to the approval of DHHS, develop and implement a data transfer and management plan, that will ensure that HSAG's information systems:

7.10.1.1. Are ready to accept, test, and analyze all supplied data within a mutually agreed upon timeline from the start of the contract and throughout the life of the contract;

7.10.1.2. Are able to manage historical and ongoing FFS claims MCO encounters, provider data, beneficiary eligibility, MCO-submitted performance and quality data, and other applicable data required to carry out all functions of the EQRO review activities;

7.10.1.3. Will perform quality assurance and validations checks against the data received; will load, warehouse, and analyze data; produce ad hoc reports, and create data files for stakeholders;

7.10.1.4. Will give DHHS remote-access according to a mutually agreed upon timeline to HSAG's systems through a secure portal to allow DHHS staff or contractors to perform ad hoc queries on the data warehoused by HSAG; and

7.10.1.5. Will ensure HSAG's ability to conduct federal-level certification of encounter data for New Hampshire Medicaid and Care Management MCO programs.

7.10.2. HSAG will work closely with DHHS staff and the MCOs to understand the MCOs' capability to submit Encounter Data and DHHS' FFS data submission process and provide useful guidance based on HSAG's experience working with States. HSAG will review and suggest improvements to DHHS's encounter data submission companion guide including identifying any gaps between the guide and CMS's new MSIS process for encounter data, set up a data access protocol and user rights, and finalize a data transfer and validation plan with DHHS according to a mutually agreed upon timeline. HSAG and DHHS will discuss the scope of the validation checks. HSAG will propose critical validation indicators for the weekly validation report.

7.10.3. HSAG will draft a report template for weekly encounter data validation reports, which is subject to DHHS' approval. HSAG will use preliminary flat file data submitted by the MCOs via DHHS' gateway system to test data to generate a mock report in PDF format. Once DHHS approves the mock report, HSAG will move the entire data transfer, validation, and report generation process into production. HSAG will make the PDF version of the weekly report available to DHHS and the MCOs on a specified internet location. DHHS shall also have the capability of viewing various results, e.g. by data field or encounter data type, comparing MCO performance for various time frames, etc., on HSAG's Encounter Data Management System (EDMS).

7.10.4. HSAG shall commence weekly report generation sixty (60) days after Medicaid Care Management program commences.

7.11. HSAG shall develop a system for comparing the MCO enrollee and provider surveys with those of the FFS beneficiary and provider surveys.

7.12. HSAG shall assume the performance measurement of and conduct an evaluation of New Hampshire Medicaid's healthcare access monitoring and measurement system, consistent with current DHHS measurement and reporting, on a quarterly basis and recommend strategies to improve access to healthcare for New Hampshire Medicaid beneficiaries. HSAG's evaluation shall be in accordance with the following processes:

7.12.1. DHHS currently examines Medicaid beneficiary access to physician and clinic healthcare services in the FFS programs by monitoring data and trends in three distinct areas: 1) provider and clinic availability, and 2) utilization of healthcare services by Medicaid beneficiaries, and 3) beneficiary needs. New Hampshire Medicaid uses this analysis to systematically evaluate and monitor New Hampshire Medicaid beneficiaries' access to health care, as well as to provide for an early warning system for access disruptions. Evidence of ongoing beneficiary engagement is evaluated as well. Examples of recent DHHS' Access Monitoring reports can be found at: www.dhhs.nh.gov/ombp/publications. HSAG shall produce and maintain all of these quarterly access reports, including after MCO operations begin, by continuing to analyze and validate beneficiary access, modify or enhance monitoring systems as necessary to ensure access to a changing healthcare delivery system, and make recommendations to improve New Hampshire Medicaid beneficiaries' access to healthcare providers.

7.12.2. HSAG shall produce DHHS' quarterly healthcare access report for the State and CMS commencing with the production of the July-September 2013 report by November 15, 2013.

7.13. HSAG shall annually validate adult and child core set measures New Hampshire will submit to CMS as part of CMS's Quality of Care Performance Measurement program. HSAG shall also calculate New Hampshire Medicaid statewide population measures required by the Balancing Incentives Program (BIP), and the New Hampshire State Innovations Grant Measures.

7.14. HSAG shall perform provider-specific or specialty-specific immediate reviews, as requested by New Hampshire Medicaid, in response to beneficiary grievances, concerns regarding access to care, or in response to other concerns from DHHS, Medicaid beneficiaries, or providers.

7.15. Pre-MCM Implementation Additional Services Related to Other EQRO Activities
At the discretion of DHHS, HSAG may be asked to provide additional services related to external quality review activities. These activities may include, but not be limited to, performance measure calculation, CAHPS survey administration, or provider survey administration. All requests for additional services shall be transmitted in writing from DHHS to HSAG and will include, at a minimum, the following:

7.16.1 A description of the major functions, tasks, and activities required;
7.16.2 The requested timeline/due dates for any reports or identified deliverables;
7.16.3 Specifications as to the format of the desired deliverable;
7.16.4 A listing of HSAG's project requirements; and
7.16.5 Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or tasks expected.
7.16.6. HSAG will submit to the DHHS, for approval, its cost proposal for completing the additional service requested according to the scope detailed in the DHHS written request.

8. Statement of the Work Beginning in the Post-Implementation Phase of Medicaid Care Management.

8.1. Evaluation of MCO Programs and Projects.

8.1.1. HSAG shall validate, in accordance with 42 CFR 438.358 (b)(1) and consistent with the most recent federal CMS Protocols for EQR activities, each MCO's Performance Improvement Projects (PIPs) required by DHHS and undertaken by the MCO during the preceding twelve months. DHHS contractually requires the MCOs to have a comprehensive Quality Assurance and Performance Improvement program (QAPI) for their operations and for the services they furnish to their members. The purpose of these QAPI programs is to assess and improve health care delivery processes and health outcomes of care. Within their QAPI programs, the MCO will undertake four (4) PIPs. HSAG will assist in the development and implementation, review, validate, and evaluate these programs and projects in a manner consistent with the most recent federal CMS protocols for EQR activities and the three-stage approach, Design, Implementation, and Outcomes, and will assist with or recommend design improvements to current MCO quality improvement plans.
8.1.2. Section 20.6 of the New Hampshire Medicaid's Care Management contract provides for additional performance improvement projects through its MCO Quality Incentive Program (QIP). The MCOs are eligible for specified monetary incentives for improved performance on four measures chosen by DHHS each contract year. HSAG shall review, validate, and evaluate these programs in a manner consistent with the federal CMS protocols for EQR activities and will assist with or recommend design improvement to the QIPs.
8.1.3. HSAG will assist the MCOs and provide explicit instructions regarding the completion and submission of a PIP and QIP Summary Form for review and validation up until the time of validation by HSAG. HSAG will evaluate and score each of the ten CMS PIP and QIP protocol steps with the three-stage study format using its PIP and QIP evaluation tool. The tool will assess each evaluation element within a given activity and produce and element score of Met, Partially Met, Not Met, Not Applicable, or Not Assessed based on the PIP or QIP documentation and study indicator outcomes submitted by the MCO. HSAG will designate as critical elements some of the evaluation elements deemed pivotal to the PIP and QIP

process. For the PIP or QIP to produce valid and reliable results, all critical elements have to, at minimum, be Met.

8.1.4. HSAG will validate and report on the performance of each MCO's Quality Assessment and Performance Improvement (QAPI) program, Performance Improvement Projects (PIPs) every six months, and the State's Quality Incentive Program (QIP) every six months. At 6 months the EQRO will provide an interim assessment of each of PIPs and QIPs; after 12 months, the EQRO will provide a comprehensive assessment of each PIP project and QIP and compare the MCO results to similar programs or metrics for the New Hampshire Medicaid FFS population and other states' Medicaid managed care programs and the New Hampshire commercial population.

HSAG's six-month interim evaluation will include:

8.1.4.1. An assessment and validation of the first stage of PIP and QIP(Design) to ensure that it is structured in a methodologically sound manner and that it will study what it is intended to study;

8.1.4.2. Background information on the areas evaluated, the methods used to conduct the evaluation, the findings or results, and a scored validation tool for each PIP and QIP;

8.1.4.3. A critical assessment of each PIP and QIP and whether the studies were consistent with the strategy detailed and applied valid statistical data analysis in each MCO's QAPI strategy; and

8.1.4.4. HSAG recommendations to strengthen the design of the PIP and QIP and/or to improve any planned interventions considered by the MCO.

HSAG's twelve-month comprehensive assessment shall include:

8.1.4.5. An evaluation of the MCOs' baseline data collection and analysis (Implementation Stage);

8.1.4.6. A validation of the PIP and QIP through the outcomes stage, once the PIP or QIP has progressed to a point of re-measurement, to determine if changes in indicator rates were statistically significant improvement and capable of being sustained over time; and

8.1.4.7. Recommendations for program improvement.

8.1.5. HSAG shall provide technical assistance to, consult with, and support DHHS and the MCOs prior to PIP and QIP submission with respect to the documentation requirements for PIPs and QIPs, and the level of detail necessary to address all of the activities required by the CMS Protocols.

8.2. Evaluation of MCO Measures and Medicaid Population Measures.

8.2.1. HSAG, pursuant to 42 CFR 438.358(b)(2) and consistent with the most recent CMS protocols, shall validate MCO performance measures that the MCOs report to DHHS to comply with Quality requirements set forth in 42 CFR 438.240, and those quality performance measures that DHHS contractually requires of the MCOs. These performance measures, included as Exhibit O in the NH Medicaid Care Management contract, shall be validated by HSAG including validation of the MCOs' CAHPS

Survey methodology. HSAG activities will incorporate any later revisions of the Medicaid Care Management contract or Quality Strategy made by DHHS including those arising from the inclusion of any additional services and populations into the Care Management Program as well as response to changing situations and the needs of the New Hampshire Medicaid Program and any state or federal laws, regulations, and other policies.

8.2.2. HSAG will validate performance measures calculated and submitted annually by the contracted MCOs using NCQA's HEDIS Compliance audit, standards, policies and procedures.

8.2.3. HSAG shall provide DHHS and the MCOs with an orientation to the performance measure validation process that will include a thorough review of the process, the expectations of the MCOs, the role of the auditors, the timeline of activities, and the measure-specific reviews. HSAG will provide technical assistance to DHHS and the MCOs as needed.

8.2.4. HSAG shall validate the sample frame for MCO and DHHS CAHPS surveys. HSAG will be required to validate MCO sample frames for the annual consumer and/or provider surveys, such as CAHPS, and ensure MCOs include sufficient oversampling to allow each individual MCO to be evaluated, regarding satisfaction with MCOs and the quality of and access to care provided therein, and to compare survey results with the results of surveys of consumer and provider satisfaction with New Hampshire Medicaid FFS programs.

8.2.5. HSAG shall review the MCOs' medical record review and record procurement process, including supervisor and staff qualifications, training of reviewers, hybrid abstraction tools, and quality assurance testing of review results adhering to all of NCQA's medical record review requirements and timelines.

8.2.6. HSAG shall conduct an annual on-site initial audit of the MCOs, which shall include interviews relative to the documentation processes used to collect, store, validate, and report performance measure data, and an information system assessment focusing on the processing of claims and encounter data, enrollment data, and provider data. Year one audit will limited to a review of source code.

8.2.7. Within two weeks of the completion of an initial audit, HSAG shall provide a written report based on the initial audit findings. This report will identify perceived issues of noncompliance, problematic measures, and recommended opportunities for improvement.

8.2.8. HSAG shall validate performance measures no less than annually. HSAG will compare reported rates to national and/or regional benchmarks, including but not limited to other states' managed care and New Hampshire Commercial population data, and will compare the eligible populations to benchmarks for eligible populations. HSAG will alert the MCO and DHHS of any issue or potential problem with a measure and then work with the MCO to correct the issue or minimize its impact on reporting.

8.2.9. Within forty-five calendar days of its receipt of the final rates for the measures, HSAG shall provide DHHS with a report of the final validation findings. This report,

among other things will make conclusions and recommendations for improvement. On an annual basis, HSAG will include the results in the EQR Technical Report and provide a comprehensive assessment of each performance measure. The results will compare the MCO results to the New Hampshire Medicaid FFS populations and other similar programs and metrics, and to NCQA national percentiles and Quality Compass.

8.2.10. Following the annual report, HSAG shall meet with DHHS to discuss and recommend new and/or additional performance measures, and new or updated performance improvement goals. HSAG, in collaboration with DHHS, will develop and produce aggregate performance measures and objectives to assess health care services delivered and statewide health measures and outcomes, and to allow for a comparison of the aggregate managed care population to the residual New Hampshire Medicaid FFS population. Consistent with federal guidelines, the above measures and objectives must be clear, verifiable, and statistically valid.

8.2.11. HSAG will also validate the data associated with each new measure and objective. Working with DHHS, HSAG will propose detailed quality improvement strategies to DHHS when opportunities for quality of care improvement are identified for a particular MCO or program. DHHS has a particular interest in those measures and objectives relating to the health of pregnant women, the elderly, and beneficiaries with special health care needs.

8.3. MCO Contractual Compliance.

8.3.1. HSAG shall conduct a review, pursuant to 42 CFR 438.358 (b)(3) and CMS Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations (revised September 2012), to determine the MCOs' compliance with contract provisions requiring the MCOs to submit performance measurement data relative to the quality, appropriateness, and timeliness of, and access to care and services furnished to all New Hampshire Medicaid enrollees under MCO contracts, and shall conduct a comparative review of health care services furnished to Medicaid beneficiaries, not yet enrolled or waiting to re-enroll in an MCO, and covered under the New Hampshire Medicaid FFS Program. Over the course of the three- year EQRO contract, HSAG will conduct these reviews on an annual basis. HSAG shall validate each MCO's quality program and compliance with New Hampshire's Quality Strategy.

8.3.2. Following review, and in its annual compliance report, HSAG will identify and describe those areas in which the MCOs are less than fully compliant and require corrective action. HSAG will provide compliance review tools with its findings and a template for the MCOs to document their proposed corrective action plans (CAPs) for each requirement that HSAG scored as less than met. HSAG will conduct a review and document its assessment of the CAP's potential for resolving performance areas not fully compliant. If HSAG determines that the CAPs as proposed are insufficient to resolve deficiencies in a timely manner, HSAG will describe the deficiencies and recommend revisions to DHHS. HSAG shall provide technical assistance to the MCO to re-develop its CAP and monitor it to ensure that the MCO makes progress is

resolving any deficiencies.

8.3.3. HSAG's annual review in the second year of the contract and each annual review thereafter will include a review of the previous year's CAPs, an assessment of the degree to which the MCOs' implementation of CAP activities resulted in full compliance.

8.4. Management and Validation of Encounter Data.

8.4.1. Pursuant to 42 CFR 438.358(c)(1), HSAG shall validate encounter data reported by the MCOs to DHHS in accordance with the New Hampshire Medicaid Care Management contract, and issue weekly reports concerning the validity of this encounter data.

8.4.2. In collaboration with DHHS and the MCOs, HSAG shall develop an encounter data transfer and validation process within New Hampshire's Medicaid Management Information System (MMIS). This process would validate encounter data, accept/reject reported encounters, detect data patterns, such as under- or over-reporting of data over time and utilization patterns, and that would validate claims and provider data. HSAG will validate the performance of the MCOs through development of the encounter data exchanged between DHHS and the MCOs, validate the data actively exchanged, and consult with DHHS to improve data validation for DHHS' MMIS.

8.4.3. HSAG shall also conduct additional validation annually by comparing all encounters submitted by the MCOs to DHHS against the encounters residing in the MCOs' data systems. The results of this annual validation will serve as the basis for HSAG's federal-level Encounter Data certification and shall be due to DHHS and CMS on August 1st of each year.

8.4.4. During the validation process, HSAG shall evaluate the extent to which MCOs submit complete and accurate data to DHHS based on their claims processing systems. HSAG shall report results to DHHS using a summary report containing the MCO-specific findings and aggregate-MCO results. HSAG will also prepare a certification letter for each MCO, attesting the level of completeness and accuracy of the Encounter Data submitted by the MCO to DHHS. HSAG will provide technical assistance to DHHS and the MCOs to reach an agreed upon level of consistency and accuracy in the encounter data.

8.4.5. HSAG shall provide ongoing technical assistance to DHHS, to DHHS' MMIS, and to the MCOs as deficiencies are discovered throughout the encounter data validation process to improve data accuracy and completeness.

8.5. Member and Provider Surveys.

Pursuant to 42 CFR 438.358 (c)(2), HSAG shall validate annual consumer and/or provider surveys in Contract Years 2 and 3, such as CAHPS, regarding satisfaction with MCOs and the quality of and access to care provided therein, and allow for subpopulation analysis. In Contract Year 1, HSAG will conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for the DHHS. The 2013 CAHPS Survey Project will include administration of the CAHPS 5.0 Child Medicaid Survey with the Healthcare Effectiveness

Data and Information Set (HEDIS®) supplemental item set and the Children with Chronic Conditions (CCC) measurement set to the Child Medicaid Fee-for-Service (FFS) and Children's Health Insurance Program (CHIP) populations. HSAG will validate MCO CAHPS Surveys to determine network adequacy. HSAG will work with the MCOs to communicate documentation and data needs. Consistent with CMS' current version of the Administering or Validating Surveys Protocol, HSAG shall:

8.5.1. Evaluate DHHS' goals and intended use of the survey results;

8.5.2. Review intended survey audience and determine whether survey is appropriate for the audience and that the most appropriate population is being evaluated to yield meaningful information;

8.5.3. Evaluate the selected beneficiary and provider survey instruments to ensure that they are consistent with the survey purposes, objectives and units of analysis;

8.5.4. Evaluate the study populations, subpopulations, sample frame criteria, sampling strategies, sample sizes, and sample selection;

8.5.5. Identify and recommend strategies to DHHS and the MCOs to maximize survey response rates. HSAG will also assess the effectiveness of the MCO and DHHS sampling strategies and evaluate the extent to which potential sources of nonresponse may have introduced bias into survey findings;

8.5.6. Perform comprehensive analyses of provider and consumer satisfaction (CAHPS) survey data in accordance with NCQA specifications and using an alpha level of 0.05 to determine statistical significance; and

8.5.7. Document the survey process and results with data-driven and aggregate reports for the provider survey and CAHPS validation activities.

8.6. Additional Performance Measures.

Pursuant to 42 CFR 438.358(c)(3), the EQRO will calculate administrative performance measures, in addition to those contractually required and reported by the MCOs, and validated by HSAG in section 8.2. HSAG will evaluate the performance of the MCOs through the development and use of performance measures across MCOs, the development and use of aggregated performance measures to compare MCOs to the FFS program, the provision of appropriate comparison to other Medicaid MCOs and commercial populations, the validation of the performance of DHHS' Adult Medicaid Quality grant and other grants, the measurement of performance of any HSAG-developed projects, and the validation of performance of other Medicaid quality measures as needed. In connection with the development of additional performance measures, HSAG shall:

8.6.1. Review the current set of performance measures employed by DHHS, which are posted and updated on an ongoing basis on the DHHS Medicaid Quality Indicators website, and make recommendations regarding enhancements to current measures;

8.6.2. Calculate aggregated performance measures that will be used to compare the MCO population to the FFS population;

8.6.3. Collaborate with DHHS to select and calculate measures for which comparative information exists, and ensure that the comparison of performance across Medicaid and commercial populations is appropriate based on measure

specifications used to derive the rates independently for each population;

8.6.4. Assist DHHS in validating and measurement of the Adult Medicaid Quality measures;

8.6.5. Collaborate with DHHS to define appropriate measures that evaluate the utility and effectiveness of EQRO-developed projects;

8.6.6. Employ the current CMS protocols for validation of all performance measures, including other Medicaid quality indicators;

8.6.7. Calculate selected Center for Medicaid Services Adult Core Set quality measures that are agreed upon by the DHHS and HSAG.

8.7. EQRO Performance Improvement Projects.

Pursuant to 42 CFR 438.358(c)(4), HSAG shall conduct performance improvement projects in addition to those contractually required of and conducted by the MCOs, and validated by HSAG. These additional performance improvement projects shall include the following:

8.7.1. Access to Healthcare.

8.7.1.1 HSAG shall evaluate the MCOs' and New Hampshire Medicaid's statewide healthcare access monitoring and measurement system on a quarterly basis and recommend strategies to improve access to healthcare for New Hampshire Medicaid beneficiaries.

8.7.1.2. DHHS currently examines Medicaid beneficiary access to physician and clinic healthcare services by monitoring data and trends in three distinct areas: 1) provider and clinic availability, and 2) utilization of healthcare services by Medicaid beneficiaries, and 3) beneficiary needs. New Hampshire Medicaid uses this analysis to systematically evaluate and monitor New Hampshire Medicaid beneficiaries' access to health care, as well as to provide for an early warning system for access disruptions. Evidence of ongoing beneficiary engagement is evaluated as well. Examples of recent DHHS' Access Monitoring reports can be found at: www.dhhs.nh.gov/ombp/publications. HSAG will maintain all of these access reports, by continuing to analyze and validate beneficiary access, modify or enhance monitoring as necessary to ensure access to a changing healthcare delivery system, and make recommendations to improve New Hampshire Medicaid beneficiaries' access to healthcare providers.

8.7.1.3. HSAG will assume the production of quarterly healthcare access report for the State and CMS no later than October 1, 2013 for the November 15, 2013 quarterly report to CMS. This Medicaid beneficiary access analysis and evaluation shall include:

8.7.1.3.1. Analysis of geographic provider availability using the current New Hampshire Medicaid access indicators and New Hampshire Medicaid Care Management Contract standards set forth in the Table 1 below:

Table 1: Provider Access Distance Standards

Provider Type	Number of Providers Available Statewide
PCPs	Two (2) within forty (40) minutes or fifteen (15) miles
Specialists	One (1) within sixty (60) minutes or forty-five (45) miles
Hospitals	One (1) within sixty (60) minutes or forty-five (45) miles
Mental Health Providers	One (1) within forty-five (45) minutes or twenty-five (25) miles
Pharmacies	One (1) within forty-five (45) minutes or fifteen (15) miles
Tertiary or Specialized services (Trauma, Neonatal, etc.)	One within one hundred twenty (120) minutes or eighty (80) miles

8.7.1.3.2. Analysis of provider availability by provider type;

8.7.1.3.3. Analysis of the availability of providers and specialists for children with special health care and mental health and behavioral healthcare needs; and

8.7.1.3.4. Timeliness standards validation taking into consideration the standards set forth in the Table 2 below:

Table 2: Provider Access Timeliness Standards	
Visit Type	Timely Service Delivery (calendar days unless otherwise specified)
Transitional Care after Inpatient Discharge	7 calendar days for physician; 2 calendar days for nurse or counselor
Non-symptomatic and Preventive Care	30 calendar days
Non-urgent, Symptomatic Care	10 calendar days
Urgent, Symptomatic Care	48 hours
Emergency Medical and Psychiatric Care	24 hours, seven days per week
Behavioral Health Care: Routine Care	10 calendar days
Behavioral Health Care: Urgent Care	48 hours
Behavioral Health Care: Non-life Threatening Emergency	6 hours

8.7.1.4. HSAG shall meet with DHHS staff to obtain detailed information regarding the production of the existing quarterly access reports, and its approach to conducting additional access to healthcare analysis and evaluation activities. HSAG will draft a comprehensive methodology document to describe the details of generating the quarterly access reports and to propose the analytic approach in conducting the four evaluation activities.

8.7.1.5. HSAG shall analyze the FFS provider access and availability associated with the four additional analyses of access with Quest Analytics software to conduct the analysis of geographic provider availability for the FFS population. HSAG will:

8.7.1.5.1. Geo-code the FFS beneficiary addresses and provider addresses before performing the time/distance analyses;

8.7.1.5.2. Calculate beneficiary-provider ratios to evaluate the FFS provider availability by provider types;
8.7.1.5.3. Perform time/distance analyses to evaluate spatial accessibility to providers; and
8.7.1.5.4. Conduct an annual access and availability survey, which shall be conducted throughout the year on a list of sampled FFS providers. The scope of the survey will be provided in HSAG's comprehensive methodology, along with the process of sample generation, scripted scenarios based on standards, survey process, and proposed analyses associated with the survey.

8.8. DHHS Grant Support.

HSAG shall, adhering to the periodicity set in its listing of adult quality measures, but no less than annually, validate MCO health plan adult quality measures, validate the New Hampshire Medicaid populations CMS Adult Medicaid Quality Indicators measures and collaborate with DHHS to calculate and/or validate additional quality measures developed through the Adult Medicaid Quality grant-related work. HSAG shall also validate MCO health plan population measures and calculate New Hampshire Medicaid population measures required by the Balancing Incentives Program (BIP), and the New Hampshire State Innovations Grant Measures.

8.9. Other Performance Improvement Projects.

In consultation with DHHS, HSAG shall recommend other quality improvement processes or best practices for New Hampshire MCOs. HSAG shall also recommend and conduct other performance improvement projects and calculate related measures as needed. HSAG shall discuss its recommendations for additional performance improvement projects with DHHS, and conduct two agreed upon additional performance improvement projects per year.

8.10. EQRO Studies on Clinical and Nonclinical Services.

Pursuant to 42 CFR 438.358 (c)(5), HSAG shall conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

8.10.1 Direct Member Feedback through Beneficiary Focus Groups. HSAG or its subcontractor, will conduct a quality study on beneficiary satisfaction with their health and the healthcare services provided through their MCOs and by New Hampshire Medicaid. This will require HSAG to establish, convene, and facilitate Medicaid beneficiary focus groups to discuss health care issues. HSAG shall be required to:

8.10.1.1. Utilize staff, or qualified subcontractors with demonstrable experience with Medicaid populations and with appropriate technical expertise in forming and facilitating focus group discussion and individual participation;
8.10.1.2. Build focus groups comprised solely of Medicaid health plan beneficiaries and families or caregivers for direct beneficiary input (these focus groups are intended to be a forum for beneficiaries rather than a forum for providers or advocacy organizations), including participants representing each of the following Medicaid beneficiary subpopulations: parents of low-income children, low-income adults, and persons with physical and mental

health disabilities;

8.10.1.3. Convene beneficiary focus groups bi-annually on topics of interest approved by DHHS, to Medicaid beneficiaries, and their family members or caregivers, regarding relevant healthcare delivery issues, especially as they pertain to managed care healthcare delivery;

8.10.1.4. Offer incentives, travel reimbursement, food and beverages at group meetings, to beneficiaries to participate in the focus groups;

8.10.1.5. Strive to record each focus group session electronically (only after appropriately notifying participants) and record each focus group by a note taker;

8.10.1.6. Encourage, educate, train and coach participants to freely express their opinions and experiences and provide confidentiality to participants; and

8.10.1.7. Summarize focus groups findings and provide recommendations for improvements for DHHS and the MCOs in response to actionable items within 30 calendar days of the focus group meeting. Each report shall also include an update of any activities on actionable items from the previous meetings.

8.10.2. MCO/DHHS Quarterly Meetings.

HSAG shall convene the MCOs and DHHS on quarterly basis to:

8.10.2.1. Coordinate and standardize the quality work performed by the MCO's and New Hampshire Medicaid's FFS program;

8.10.2.2. Make recommendations to the State and the MCOs on developing a quality strategy to harmonize with the National Quality Strategy with a written report to DHHS of HSAG recommendations no later than three (3) months after the start of each state fiscal year;

8.10.2.3. Plan, organize, and prepare for quarterly MCO meetings and collaborate with DHHS in the running of and reporting out, to include open items, actionable items, person accountable and time frame for completion, from the quarterly meetings; and

8.10.2.4. Conduct local, New Hampshire based, quarterly meetings in collaboration with DHHS, and identify areas of highest importance and interest for DHHS and the MCOs.

8.10.3. "Just in Time" Provider Reviews.

HSAG shall perform provider-specific or specialty-specific immediate reviews, as requested by New Hampshire Medicaid, in response to beneficiary grievances, concerns regarding access to care, or in response to other concerns from DHHS, Medicaid members, or providers. HSAG will function as an independent reviewer and will assist DHHS in investigating and resolving specific medical care complaints, provider complaints, health plan complaints, and broader systemic problems on a timely basis, and in providing ad hoc reviews as requested by DHHS. HSAG will report twice per year on the "just in time" reviews, noting trends, and any corrective action undertaken to resolve substantive concerns. HSAG shall conduct the immediate review according to the following procedure:

8.10.3.1. Upon receipt of a referral from DHHS, HSAG will obtain appropriate records and/or gather other information and/or data pertinent to the review and consult with DHHS to determine the reason for the review;

8.10.3.2. HSAG will collect and review all relevant documentation specific to the case no later than ten (10) calendar days after DHHS referral, including but not limited to beneficiary medical records, and correspondence containing relevant information, claims or other data, regarding the case;

8.10.3.4. HSAG will identify and engage an independent Physician Advisor for the review;

8.10.3.5. HSAG's Physician Advisor will review applicable documentation, and within two (2) calendar days may determine that no concern exists; or the complaint, care concern, or grievance issue is confirmed; or a systemic problem is identified; and HSAG will provide recommendations to DHHS;

8.10.3.6. HSAG will forward the Physician Advisor's determination of an identified concern to its Chief Medical Officer (CMO), who will respond to the DHHS referral by letter within five (5) calendar days on the CMO's determination; and

8.10.3.7. HSAG shall immediately notify DHHS if it identifies a threat to the health and/or safety of a beneficiary, a fraudulent action, or determines that urgent remedial action is required.

8.10.4. Fraud, Waste, and Abuse Monitoring and Reporting.

HSAG shall report promptly all suspected fraud and abuse to DHHS Program Integrity, should HSAG identify potential fraud or abuse while performing the activities listed in the scope of work.

8.10.5. Additional Quality Studies.

DHHS will identify and/or HSAG will recommend additional focused quality studies. HSAG will collaborate with DHHS to plan the detail for the scope of the study topic, and develop a formal statement to address the study question and purpose and submit to DHHS no later than six months after the start of the EQRO contract and annually thereafter. Upon DHHS approval, HSAG will:

8.10.5.1. Develop and draft, using the current CMS protocols for conducting Focused Studies of Health Care Quality as a guideline, the topic study design that defines the goals of the study, the questions to be answered, sampling methodology, the type of data to be collected, and the tools to be used in data collection and the statistical analysis undertaken;

8.10.5.2. Collect data;

8.10.5.3. Conduct statistical analyses in alignment with previously defined analysis plans developed from the study methodology; and

8.10.5.4. Generate and report the analytic results and prepare a summary of conclusions and recommendations. A draft report will be produced within forty-five calendar days after record procurement is complete, and will include

an executive summary, a summary of study methodology and data collection process, a results section and a conclusion and recommendations section for the study.

8.10.6. Education and Training.

Pursuant to 42 CFR 438.358 (d), HSAG shall provide additional technical guidance, at the direction of DHHS, to the staff of the MCOs to assist them in conducting activities related to the review activities outlined above, and to provide other support for new initiatives and review activities. HSAG shall present a calendar of educational training events, including those activities referenced in Section 8.10.6-8.10.8, for the ensuing state fiscal year, no later than 30 calendar days prior to the start of each state fiscal year for DHHS review and approval.

8.10.7. Annual Meeting.

8.10.7.1. HSAG shall conduct annual quality improvement initiative and best practices trainings and conferences for the MCOs and DHHS staff. In collaboration with DHHS, HSAG's Quality Forums, may include such topics as:

8.10.7.1.1. MCO best practices that result from performance improvement goal projects;

8.10.7.1.2. Other States' or commercial payer quality improvement strategies and interventions;

8.10.7.1.3. How to present data and write a good report on that data;

8.10.7.1.4. Statistical methods for non-statisticians;

8.10.7.1.5. How to work with encounter and claims data to improve quality;

and

8.10.7.1.6. Discussion and development of future directions for performance improvement.

8.10.7.2. HSAG will contribute, in collaboration with DHHS, to identifying and defining a conference theme, speakers, and relevant materials. There will be one major conference with the MCOs every calendar year. HSAG will procure a New Hampshire conference site and speakers, and will handle all logistics for the event (refreshments, registration, preparation of conference materials, and evaluation).

8.10.8. Brown Bag Luncheons.

HSAG will conduct focused "Lunch and Learn" informative meetings every four months for all interested DHHS and MCO staff. HSAG may conduct trainings, educational/learning meetings, and presentations by Webinar or on-site with DHHS and the MCOs on topics jointly selected by DHHS with input HSAG. HSAG shall prepare the draft agenda and written materials for each forum. Upon review and approval by DHHS, HSAG will send the final documents to DHHS.

8.11. Additional Services Related to Other EQRO Activities

At the discretion of DHHS, HSAG may be asked to provide additional services related to external quality review activities. These activities may include, but not be limited to, performance measure calculation, CAHPS survey administration, or provider survey administration. All requests for additional services shall be transmitted in writing from DHHS to HSAG and will include, at a minimum, the following:

8.11.1 A description of the major functions, tasks, and activities required;

8.11.2 The requested timeline/due dates for any reports or identified deliverables;

8.11.3 Specifications as to the format of the desired deliverable;

8.11.4 A listing of HSAG's project requirements; and

8.11.5 Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or tasks expected.

8.11.6. HSAG will submit to the DHHS, for approval, its cost proposal for completing the additional service requested according to the scope detailed in the DHHS written request.

9. EQRO Technical Report

9.1. Pursuant to 42 CFR 438.364(a)(1), HSAG shall produce a detailed Technical Report, based on an annual, external quality review (EQR) conducted pursuant to 42 CFR 438.350 (a) for each MCO participating in New Hampshire Medicaid's Care Management program. The report, which HSAG will prepare in accordance with the current CMS Protocols for technical reports, will describe how data was aggregated and analyzed, and how conclusions were drawn regarding the quality, timeliness, and access to care provided by each of the MCOs and DHHS. With respect to this Technical Report, HSAG shall:

9.1.1. Comply with 42 CFR 438.364 and all relevant federal and State regulations

9.1.2. Collaborate with New Hampshire Medicaid, which will provide its data files to HSAG for each of the MCOs and for its fee-for-service program in accordance with the systems and data transfer plan developed by HSAG and DHHS. As part of its annual reporting on each MCO and related fee-for-service population, HSAG shall prepare one aggregate report to include a sub-section for each of the MCOs, a comparative report across the MCOs, and reporting on the statewide NH Medicaid population, in accordance with 42 CFR 438.364. Specifically, HSAG's Technical Report shall include the following information:

9.1.2.1. A description of the manner in which data from all MCO activities was aggregated and analyzed, and the way in which conclusions were drawn from the data on quality, timeliness, and access to care provided by the MCO. The report shall also include for each activity, analysis and comments regarding the following:

9.1.2.1.1. The objective of the MCO activity and the objective of the EQRO oversight function;

9.1.2.1.2. The technical methods of data collection and analysis;

9.1.2.1.3. A description of the data obtained; and

9.1.2.1.4. The conclusions drawn from the data.

9.1.2.2.An assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients;

9.1.2.3. Recommendations for improving the quality of health care services furnished by each MCO;

9.1.2.4. Information across the State's three MCO programs, including sub-population analysis, provided in a format allowing for comparisons of required activities;

9.1.2.5.New Hampshire Medicaid population-based measurement and analysis; and

9.1.2.6. An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This EQRO activity will commence during the first year of New Hampshire Medicaid Care Management program operations.

9.1.3. HSAG shall submit a draft of the Technical Report to DHHS for review and approval or comment no later than October 15 of each contract year. After DHHS' review, HSAG will discuss the report with DHHS and revise the report as indicated. Once approved, HSAG will prepare the final report, due to DHHS and CMS no later than December 1 of each contract year, and submit it to DHHS in the formats and number of copies requested.

9.1.4. Because the data and documentation available for each of the activities may be incomplete for use in preparing the EQRO first year annual reports, HSAG will collaborate with DHHS to identify any limitations and reservations about the completeness and accuracy of the data HSAG uses, and will document any cautions related to drawing conclusion about the data and findings.

10. Crosswalk between Federal EQRO Regulations, NH Medicaid EQR Scope of Work, and the New Hampshire Care Management Program

10.1. A summary of the federal and State of NH EQRO review activities required are set forth in Table 3 below:

Table 3: EXTERNAL QUALITY REVIEW-RELATED ACTIVITIES	
42 CFR 438.358 Referenced and Summarized Content	**New Hampshire Care Management EQR Strategy**
42 CFR 438.358(b) For each MCO, the EQR must include information from the following activities:	
• Validation of performance improvement projects required by the State	• The EQRO will validate the performance of MCOs' QAPI PIP and QIP

• Validation of MCO performance measures reported	• The EQRO will validate the performance measures included as Exhibit O in the NH Medicaid Care Management contract, including validation of the MCOs' CAHPS Survey methodology
• A review to determine the MCO's compliance with standards established by the State in the Quality Strategy	• The EQRO will validate the MCO's program and contract compliance with the State's Quality Strategy
42 CFR 438.358(c) The EQR may include information derived during the preceding 12 months from the following optional activities:	
(1) Validation of encounter data reported by an MCO	• The EQRO will validate the performance of the MCOs through: • Development of the plan for encounter data exchanged between the MCOs, State, and the EQRO, and • Validation of the data actively exchanged • Consultation on validations that can be implemented in New Hampshire's MMIS
(2) Validation of consumer or provider surveys of quality of care.	• The EQRO will administer or validate the performance of MCO through: • Evaluating network adequacy, • Validating survey data generated by the MCOs
(3) Calculation of performance measures in addition to those reported by an MCO and validated by an EQRO.	• The EQRO will validate the performance of MCO through the calculation of: • Measures to compare across MCOs, • Aggregated measures to compare MCOs to FFS, • Statewide NH Medicaid population measures, • The EQRO will validate the performance of the State's Adult Medicaid Quality Grant, • The EQRO will measure the performance of any EQRO projects, • The EQRO will validate the performance of other Medicaid quality measures as needed.
(4) Conduct of performance improvement projects in addition to those conducted by an MCO and validated by an EQRO.	• Monitoring Access to Care in New Hampshire Medicaid Program • CMS Adult Medicaid Quality Grant measures validation • Balancing Incentives Program Quality Measures • State Innovations Grant Measures • Other measures as needed
(5) Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services	• Beneficiary Focus Groups • Convene and support Medicaid Quality Improvement meetings with the State and the

at a point in time.	health plans • Report on recommendations to the State and the MCOs on developing a statewide quality strategy to harmonize across the MCOs and harmonize with the National Quality Strategy • "Just in Time" grievance reviews • Other projects as needed
(6) *Technical assistance.* The EQRO will provide technical guidance to groups of MCOs and the State to assist them in conducting activities related to the activities that provide information for the EQR.	• The EQRO will conduct the following Quality Forum training activities: • Annual meeting for MCOs and DHHS staff • Three yearly focused "Lunch and Learns" for DHHS staff and MCOs
42 CFR 438.364 (a) The State must ensure that the EQRO produce specified external quality review results.	
(a) *Annual Technical Report.*	• The EQRO will: • Produce a detailed technical report that explains how the data from review activities were aggregated and analyzed, and how conclusions were made relative to quality, timeliness, and beneficiary access to MCO healthcare services • Assess the MCOs strengths and weaknesses relative to quality, timeliness, and access to healthcare furnished to beneficiaries • Recommend improvements to MCO furnished healthcare • Provide comparative information about all MCOs • Assess whether MCOs made previously recommended quality improvements.

10.2. Summary of EQRO Deliverables.

General Topic Area	Description of Deliverable	Periodicity	Report Description
Monitoring of Access to Care	• Beneficiary access to healthcare measuring and monitoring	Quarterly	Maintenance of the DHHS access report with an analysis of risk and opportunities for improvement
Technical Report: MCO and NH Medicaid Statewide Overview	• Assessment of MCO QAPI Plans, MCO strengths and weaknesses; • Recommendations for improving MCO healthcare services • Comparative reporting across all MCOs • Assessment of degree to which MCOs have addressed prior year's EQR recommendations • Comparative analysis of HEDIS and CAHPS for MCOs and FFS	Annually	One aggregate report to include a sub- section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population; annual report must include trends and analysis of opportunities for improvement
Technical Report: Projects	• Evaluation of MCOs' DHHS-QIP and CMS required PIPs • Recommendations for improvement	Bi-Annual, Annually	Mid-year report updating project status; one aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population.

Technical Report: Beneficiary Experience	Validate Medicaid beneficiary experience including satisfaction with MCO provision of care, quality of care, and access to care provide appropriate comparators, including FFS data	Annually	Validation and summary of MCO finding and any additional EQRO beneficiary experience analysis; One aggregate report to include a sub- section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population; annual report must include trends and analysis of opportunities for improvement including HEDIS measures and CAHPS results
Technical Report: Provider Experience	Validate MCO provider surveys	Annually	Validation and summary of MCO finding and any additional EQRO provider experience analysis; One aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population. annual report must include trends and analysis of opportunities for improvement

Technical Report: Contract Compliance	Review of MCOs' compliance with federal, State and Care Management contract	Annually	Assessment of regulatory and operational compliance; One aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population.
Technical Report: MCO Quality Performance Measures	Validation of MCO performance measures required by DHHS Quality Strategy and MCO contract,	No less than annually	Quarterly data file to update the NH Medicaid Quality Indicators website; One aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population; annual report must include trends and analysis of opportunities
EQRO Performance Improvement Projects: Adult Medicaid Quality Grant Measures	Validate MCO adult and pediatric quality measures and EQRO generated aggregate and calculate additional quality measures and assist the State in grant related reporting of the measures	No less than annually	TBD
EQRO Performance Improvement Projects: BIP Reporting Support	Validate MCO population measures required by BIP and NH State Innovations Grant Measures	No less than annually	TBD

EQRO Performance Improvement Projects: SIM Reporting Support	TBD	TBD	TBD
NH Medicaid Beneficiaries	Beneficiary Focus Group Studies regarding satisfaction with MCO and FFS provided healthcare;	Bi-Annual	Minutes and analysis of focus group meeting
NH Medicaid Beneficiaries	Recommend to DHHS and design additional quality studies focused on Medicaid beneficiaries	Annually	2 recommendations per annum
Healthplan Support	Convene MCO/DHHS quarterly meetings. Coordinate, harmonize MCO quality work; support DHHS leadership to plan for and conduct conducting quarterly business meetings	Quarterly	Minutes from meetings
Healthplan Support	Develop Quality Forums to include annual meeting topic related to MCO best practices; healthcare delivery innovation; and quality improvement strategies Organize conference, arrange for conference site, speakers, registration, materials, conference evaluation and other logistics	Annual	1 annual conference
DHHS and Healthplan Support	Conduct informational brown bag lunches for MCO and DHHS staff Collaborate with DHHS staff to develop informative, educational, "lunch and learn" meetings	Tri-annual	3 meetings per annum; Planning document to DHHS 30 calendar days prior to each state fiscal year
MCO Operations and Finance: Encounter Data	• Validation of encounter data per most recent CMS protocols • Recommendations for encounter data improvement	Weekly	Encounter data transfer, warehousing, validation

MCO Operations and Finance: Encounter Data	Process plan development for MMIS encounter data validation and integration	One time	Recommendation for MMIS encounter data validation due to DHHS no later than January 1, 2014
"Just in Time" Reviews	Immediate review of beneficiary grievances or other DHHS requested reviews	Monthly	Summary of reviews, analysis and actions taken; updates on ongoing improvements and outcomes

11. Cultural Considerations.

HSAG's subcontractor shall ensure that its services are provided and its interactions with Medicaid beneficiaries and MCO members, including those with limited English proficiency, occur in a culturally competent manner. The subcontractors will interact with people of all cultures, races, religions, ethnic and economic backgrounds in a manner that recognizes values, and respects the worth and dignity of individual Medicaid beneficiaries. Individuals interacting with Medicaid beneficiaries and MCO members will be highly experienced, trained facilitators who have extensive experience working with the Medicaid population and have specific expertise gathering information from the disadvantaged and individuals and families of individuals with physical, emotional, mental, and developmental issues.

12. Survival.

The following provisions survive expiration, cancellation, or termination of this agreement: section 14. Compliance with State and Federal Laws; section 15. Termination; section 16. Agreement Closeout; section 17. Remedies; section 18. Dispute Resolution Process; section 19. Confidentiality; and section 20. Publicity.

13. Compliance with State and Federal Laws.

13.1. General.

13.1.1. HSAG and its subcontractors shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR438.100(a)(2); 42 CFR 438.100(d)].

13.1.2. HSAG shall ensure that safeguards at a minimum equal to federal safeguards (41 USC 423, section 27) are in place, providing safeguards against conflict of interest [§1923(d)(3) of the SSA; SMD letter 12/30/97].

13.1.3. HSAG shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

13.1.3.1. Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. §1395 et seq.

13.1.3.2. Related rules: Title 42 Chapter IV

13.1.3.3. Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. §1396 et seq. (specific to managed care: §§ 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA)

13.1.3.4. Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR § 438; see also 431 and 435)

13.1.3.5. Children's Health Insurance Program (CHIP): Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397;

13.1.3.6. Regulations promulgated there under: 42 CFR 457

13.1.3.7. Patient Protection and Affordable Care Act of 2010

13.1.3.8. Health Care and Education Reconciliation Act of 2010, amending the Patient Protection and Affordable Care

13.1.3.9. American Recovery and Reinvestment Act

13.1.3.10. 42 CFR 435; XX-YY, Chapter ZZ DHHS Eligibility Manual, NH Laws (RSAs), Regulations, State Plan?

13.1.4. HSAG shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and HSAG, as governed by 45 C.F.R. Section 164.504(e)). Terms of the Agreement shall be considered binding upon execution of this Agreement, shall remain in effect during the term of the Agreement including any extensions, and its obligations shall survive the Agreement.

13.2. Non-Discrimination.

HSAG shall require its subcontractors to comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

13.3. ADA Compliance.

13.3.1. HSAG shall require its subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA).

3.3.2. HSAG shall submit to DHHS a written certification that it is conversant with the requirements of the ADA and that it is in compliance with the law.

13.3.3. HSAG shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, which includes its ongoing compliance monitoring to determine the ADA requirements are being met.

13.4. Non-Discrimination in Employment.

13.4.1. HSAG will not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. HSAG will take affirmative action to ensure that applicants are employed, and that employees are treated during

employment, without regard to their race, color, religion, sex or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. HSAG agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

13.4.2. HSAG will, in all solicitations or advertisements for employees placed by or on behalf of HSAG, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.

13.4.3. HSAG will send to each labor union or representative of workers with which he has a collective bargaining Agreement or other Agreement or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of HSAG's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

13.4.4. HSAG will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

13.4.5. HSAG will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

13.4.6. In the event of HSAG's noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and HSAG may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

13.4.7. HSAG will include the provisions of paragraphs (1) through (7) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. HSAG will take such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event that HSAG becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, HSAG may request the United States to enter into such litigation to protect the interests of the United States.

13.5. Changes in Law.

HSAG shall implement appropriate system changes, as required by changes to federal and state laws or regulations.

14. Termination.

14.1. Transition Assistance.

Upon receipt of notice of termination of this Agreement by DHHS, the Contractor shall provide any transition assistance reasonably necessary to enable DHHS or its designee to effectively close out this Agreement and move the work to another EQRO vendor.

14.1.1. Transition Plan

HSAG shall prepare a Transition Plan, which must be approved by DHHS, to be implemented between notice of termination of the agreement and the termination date. Notice shall be effective as of the date of receipt by DHHS.

14.1.2. Data

14.1.2.1. HSAG shall be responsible for the provision of necessary data, information, and records, whether a part of the HSAG's information systems or compiled and/or stored elsewhere, to DHHS and/or its designee during the closeout period to ensure a smooth transition of responsibility. DHHS and/or its designee shall define the information required during this period and the time frames for submission.

14.1.2.2 All data and information provided by HSAG shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. HSAG shall transmit the information and records required within the time frames specified and required by DHHS. DHHS shall have the right, in its sole discretion, to require updates to these data at regular intervals.

14.2. Termination for Cause.

14.2.1. DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part, if the Contractor:

14.2.1.1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any beneficiary, including behavior of its sub-contractors with respect to beneficiary engagement or beneficiary focus groups;

14.2.1.2. Takes any action that threatens the fiscal integrity of the Medicaid program;

14.2.1.3. Has any of its certifications suspended or revoked by any federal agency and/or is federally debarred or excluded from federal procurement and/or non-procurement Agreement;

14.2.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within thirty (30) calendar days of DHHS' notice of breach and written request for compliance. DHHS'

notice shall be effective the date it is sent to HSAG;

14.2.1.5. Violates state or federal law, policy, or regulation;

14.2.1.6. Fails to carry out the substantive terms of this Agreement that is not cured within thirty (30) calendar days of the date of DHHS's notice and written request for compliance;

14.2.1.7. Becomes insolvent;

14.2.1.8. Fails to meet applicable requirements contained within the provisions of 42 CFR 438.354.

14.2.1.9. Received a "going concern" finding in an annual financial report or indications that creditors are unwilling or unable to continue to provide goods, services or financing or any other indication of insolvency; or

14.2.1.10. Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under the Bankruptcy Act.

14.2.1.11. Fails to correct significant failures in carrying out the substantive terms of this Agreement and this failure to correct is not cured within thirty (30) calendar days of the date of DHHS' notice and written request for compliance.

14.2.2. If DHHS terminates this Agreement for cause, HSAG shall be responsible to DHHS for all reasonable costs incurred by DHHS, the State of New Hampshire, or any of its administrative agencies to replace the Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to the Contractor's failure to perform any service in accordance with the terms of this Agreement.

14.3. Termination for Other Reasons.

Either party may terminate this Agreement upon a breach by a party of any material duty or obligation hereunder which breach continues unremedied for ninety (90) calendar days after written notice thereof by the other party.

14.4. Survival of terms.

Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

14.4.1. The Parties have expressly agreed shall survive any such termination or expiration; or

14.4.2. Arose prior to the effective date of termination and remain to be performed, or by their nature would be intended to be applicable following any such termination or expiration.

15. Agreement Closeout.

15.1. Period.

A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day of HSAG's contract with DHHS. During the closeout period, the Contractor shall work

cooperatively with, and supply program information to, any subsequent Contractor and DHHS. Both the program information and the working relationships between the two Contractors shall be defined by DHHS.

15.2. Data.

15.2.1. The Contractor shall be responsible for the provision of necessary information and records, whether a part of HSAG's information systems or compiled and/or stored elsewhere, to the new Contractor and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new Contractor and/or DHHS shall define the information required during this period and the time frames for submission.

15.2.2. All data and information provided by the Contractor shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The Contractor shall transmit the information and records required under this Article within the time frames required by DHHS. DHHS shall have the right, in its sole discretion, to require updates to these data at regular intervals.

16. Remedies.

16.1. Reservation of Rights and Remedies.

A material default or breach in this Agreement will cause irreparable injury to DHHS. In the event of any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by the State of New Hampshire to any existing or future right or remedy available by law. Failure of the State of New Hampshire to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in the Agreement or by law, or the acceptance of, or payment for, materials, equipment or services, shall not release the Contractor from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State of New Hampshire to insist upon the strict performance of this Agreement. In addition to any other remedies that may be available for default or breach of the Agreement, in equity or otherwise, DHHS may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages. DHHS reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

16.2. Notice of Remedies.

Prior to the imposition of remedies under this Agreement, DHHS will issue written notice of remedies that will include, as applicable, the following:

16.2.1. A citation to the law, regulation or Agreement provision that has been violated;

16.2.2. The remedies to be applied and the date the remedies shall be imposed;

16.2.3. The basis for DHHS's determination that the remedies shall be imposed;

16.2.4. A request for a Corrective Action Plan;

16.2.5. HSAG shall submit a written Corrective Action Plan (CAP) to DHHS within ten (10) calendar days of notification, for review and approval prior to the implementation of corrective action;

16.2.6. The timeframe and procedure for HSAG to dispute DHHS's determination. HSAG's dispute of remedies shall not stay the effective date of the proposed remedies; and

16.2.7. A statement that if the failure is not resolved within the period identified in the Corrective Action Plan, DHHS shall be permitted to impose liquidated damages with written notification and effective date, until the failure is cured, or any resulting dispute is resolved in HSAG's favor.

16.3. Liquidated Damages.

16.3.1. DHHS and HSAG agree that it will be extremely difficult to determine actual damages that DHHS will sustain in the event the Contractor fails to meet the requirements specified in the scope of work detailed in Exhibit A of this Agreement, within the timelines mutually agreed upon by DHHS and HSAG as specified in this Agreement throughout the life of this Agreement. Any breach by the Contractor may delay and disrupt DHHS's operations and obligations and lead to significant damages. Moreover, liquidated damages are intended to be a significant penalty as this assessment may impair HSAG's ability to submit future proposals with existing clients and prevent competitive bidding for new contracts. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable, and imposed as a last resort if corrective actions are insufficient to remedy the breach.

16.3.2. Assessment of liquidated damages may be in addition to, not in lieu of, such other remedies described in Section 16.2 of this Agreement, if HSAG fails to cure within the specified timeframe identified in the Corrective Action Plan. Except and to the extent expressly provided herein, DHHS shall be entitled to recover liquidated damages where due process has been followed, HSAG has been formally notified of the effective date of the damages and the full extent of the damages and the mechanism to cure the damages has been communicated, as applicable.

16.3.3. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify HSAG as specified in Section 16.2 of this Agreement.

16.3.4. HSAG agrees that as determined by DHHS, failure to implement the corrective action within the time period identified may result in liquidated damages in the amount of $1,000.00 per work product or deliverable and shall become effective with written notice to HSAG. HSAG shall have the ability to contact an official at DHHS for explanation of the assessment. HSAG agrees to abide by the remedies and Liquidated Damages as specified herein. DHHS's decision to assess liquidated damages must be reasonable, based in fact and made in good faith, based on the failure of HSAG to comply with the Corrective Action Plan.

16.3.5. The remedies specified in this Section shall apply until the failure is cured or a resulting dispute is resolved in HSAG's favor.

16.3.6. To the extent that HSAG's delay or nonperformance occurs outside the control of HSAG, liquidated damages as specified in this Agreement shall not be assessable against HSAG.

16.4. Suspension of Payment.

16.4.1. Payments shall be suspended when:

16.4.1.1. HSAG fails to cure a default under this Agreement within thirty (30) calendar days of notification.

16.4.1.2. HSAG fails to act on identified Corrective Action Plan.

16.4.2. Upon correction of the deficiency payments to HSAG shall be reinstated.

16. 5. Administrative and Other Remedies.

In addition to other liquidated damages described in Section 16.3, DHHS may impose the following other remedies:

16.5.1. Termination of the Agreement if HSAG fails to carry out the substantive terms of the Agreement or fails to meet the applicable requirements in Section 1903(m) or Section 1932 of the Social Security Act.

17. Dispute Resolution Process.

17.1. Informal Dispute Process.

In connection with any action taken or decision made by DHHS with respect to this Agreement, within ninety (90) calendar days following the written notice of the action or decision, HSAG may protest such action or decision by the delivery of a written notice of protest to DHHS and by which HSAG may protest said action or decision and/or request an informal hearing with the New Hampshire Medicaid Director. HSAG shall provide DHHS with an explanation of its position protesting DHHS's action or decision. The Director will determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s). It is understood that the presentation and discussion of the disputed issue(s) will be informal in nature. The Director will provide written notice by mail and email of the time, format and location of the presentations. At the conclusion of the presentations, the Director shall consider all evidence and issue a written recommendation based on the evidence presented within thirty (30) calendar days of the presentation. The Director may appoint a designee to hear and determine the disputed action or decision.

17.2. No Waiver.

HSAG's exercise of its rights under Section 17.1 shall not limit, be deemed a waiver of, or otherwise affect the parties' rights or remedies otherwise available under law or this Agreement, including HSAG's right to appeal a DHHS decision under RSA chapter 541- A, or any applicable provisions of the New Hampshire Code of Administrative Rules, including Chapter He-C 200 Rules of Practice and Procedure.

18. Confidentiality.

18.1. Confidentiality of Records: All information, reports, data, and records maintained hereunder or collected in connection with the performance of the services performed under this Agreement are confidential. HSAG shall not disclose any confidential information except to public officials requiring such information in connection with their official duties and with the administration of the contracted services and the Agreement pursuant to State law and DHHS regulations regarding the permissible use and disclosure of such information. The use or disclosure of any information by any party about a Medicaid beneficiary for any purpose not directly related to DHHS' or HSAG's responsibilities hereunder is prohibited unless disclosure is specifically permitted by written consent of the beneficiary, the beneficiary's Attorney, or the beneficiary's guardian.

18.2. It is understood that DHHS may, in the course of carrying out its responsibilities under this Agreement, have or gain access to confidential or proprietary data or information owned or maintained by HSAG. If HSAG seeks to maintain the confidentiality of its commercial, financial, personnel, or other information, then HSAG must identify in writing the information it claims to be confidential and provide the basis for its claim of confidentiality. HSAG acknowledges that DHHS is subject to and bound by a New Hampshire Right-to-Know Law, New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of identified confidential information insofar as it is consistent with applicable laws and regulations, including New Hampshire RSA Chapter 91-A. In the event that DHHS receives a proper request for information that HSAG identified as confidential information, DHHS shall so notify HSAG in writing. DHHS shall specify in its notice to HSAG the date it intends to release the requested information. If HSAG maintains that this information is confidential information that cannot be disclosed, it shall be HSAG's responsibility to seek legal protection of its information and to pay all costs associated with this legal process. If HSAG fails to seek legal protection or is unable to obtain a Court Order prohibiting the disclosure of its information, DHHS will be permitted to release HSAG's information, as requested pursuant to RSA 91-A, on the date DHHS specified in its written notice to HSAG. DHHS shall incur no liability to HSAG for any disclosure of HSAG information consistent with the procedure specified above.

19. Publicity.

HSAG shall not release any publicity regarding the subject matter of this Agreement without the prior written consent of DHHS' authorized representative. For the purposes of this provision, publicity includes notices, informational pamphlets, press releases, proposals, research, reports, signs, and other similar public statements prepared by or for the HSAG or its employees or subcontractors, with respect to the program, publications, or services provided as a result of this agreement.

New Hampshire Department of Health and Human Services

Exhibit B - Amendment #4

Methods and Conditions Precedent to Payment
External Quality Review Organization (EQRO) Services Payment Arrangements

This agreement is reimbursed on a monthly basis for a five-year Agreement term, subject to all conditions contained within Exhibit A. Reimbursement for the first year of the Agreement shall commence on July 25, 2013, or the date of approval of the contract by the New Hampshire Governor and Executive Council, whichever is later.

Invoices shall be submitted monthly, on the Contractor's letterhead, to:

Patrick McGowan
NH Medicaid Quality Program
Office of Medicaid Business and Policy
NH Department of Health and Human Services
129 Pleasant Street – Brown Building
Concord, NH 03301-3857

The monthly invoices will include an invoice amount that is equal to $1/12^{th}$ of the total all-inclusive price for the contract year. The following table displays the monthly invoice amounts for Year 1 - Year 5 of the Contract:

Invoicing Schedule

Monthly Invoice Amount for Month Ending	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Contract Year 5
31-Jul	$40,612.50	$41,567.58	$41,330.50	$41,330.50	$47,110.00
31-Aug	$40,612.50	$41,567.58	$41,330.50	$41,330.50	$47,110.00
30-Sep	$40,612.50	$41,567.58	$41,330.50	$41,330.50	$47,110.00
31-Oct	$40,612.50	$41,567.58	$41,330.50	$41,330.50	$47,110.00
30-Nov	$40,612.50	$41,567.58	$41,330.50	$41,330.50	$47,110.00
31-Dec	$40,612.50	$61,528.02	$41,330.50	$41,330.50	$47,110.00
31-Jan	$40,612.50	$61,528.02	$41,330.50	$41,330.50	$47,110.00
28-Feb	$40,612.50	$61,528.02	$41,330.50	$41,330.50	$47,110.00
31-Mar	$40,612.50	$61,528.01	$41,330.50	$41,330.50	$47,110.00
30-Apr	$40,612.50	$61,528.01	$41,330.50	$41,330.50	$47,110.00
31-May	$40,612.50	$61,528.01	$41,330.50	$41,330.50	$47,110.00
30-Jun	$40,612.50	$61,528.01	$41,330.50	$41,330.50	$47,110.00
All-Inclusive Price	**$487,350.00**	**$638,534.00**	**$495,966.00**	**$495,966.00**	**$565,320.00**

Based on DHHS approved cost proposals for additional services related to Exhibit A, Section 8.8, HSAG shall invoice DHHS upon the completion and acceptance of grant support deliverables.

Based on DHHS approved cost proposals for services related Exhibit A-1, HSAG shall invoice the Department as follows:

1. 1/3 of the agreement pricing upon the onset of services related to Exhibit A-1;

Contractor Initials: MEP
Date: 3/29/16

2. 1/3 of the agreement pricing upon Department approval of the services related to Exhibit A-1; and
3. 1/3 of the agreement pricing upon the Center for Medicare and Medicaid Services approval of the services related to Exhibit A-1.

Based on DHHS approved cost proposals for services related Exhibit A, Section 8.6.7, HSAG shall invoice the Department as follows:

1. 1/2 of the agreement pricing upon the onset of services related to Exhibit A Section 8.6.7; and
2. 1/2 of the agreement pricing upon the delivery of services related to Exhibit A Section 8.6.7.

The Contractor agrees to request and receive prior written approval from the State to engage any subcontractors under this Agreement, and further agrees to pay the expenses of any subcontractors awarded under this Agreement in accordance with Exhibit A, Statement of Work.

The Contractor agrees to request and receive prior written approval from the State for any modifications to the project budget, which change any expenditure levels from the levels projected in the budget of this Agreement.

The Contractor agrees to use and apply all payments made by the State for direct and indirect costs and expenses associated with the execution of this Agreement. The Contractor's expenses for administration of any subcontractors shall not exceed the amounts identified in the all-inclusive price for the contract year.

Payments will be made upon receipt of Contractor invoices that identify the contract components delivered and are consistent with the negotiated payment schedule. The total contract payment from DHHS will not exceed the agreed upon contract price.

Pricing Worksheet

Agreement Pricing is as set forth below:

	Agreement Year One	**Agreement Year Two**	**Agreement Year Three**	**Agreement Year Four**	**Agreement Year Five**
	July 25, 2013 - June 30, 2014	July 1, 2014 – June 30, 2015	July 1, 2015 – June 20, 2016	July 1, 2016 – June 20, 2017	July 1, 2017 – June 20, 2018
All Inclusive Price	$487,350	$638,534	$495,966	$495,966	$565,320
Additional Services (Exhibit A, Section 8.8)	$210,217				
Additional Services (Exhibit A, Section 8.6.7)			$66,937		

Contractor Initials: MEA
Date: 3/29/16

Evaluation plan for the NHHPP and Premium Assistance Program 1115 Medicaid Demonstration		$24,997			

Price Limitation. This Agreement is based on a yearly comprehensive pricing proposal from HSAG for SFY 2014 – SFY 2018. Accordingly, the total price limitation is $2,985,287 for the five-year term of this Agreement.

Invoicing. Invoices shall be submitted to the Finance Unit of DHHS' Office of Medicaid Business and Policy as indicated above for services provided by the Contractor as outlined in Exhibit A. The Contractor shall be notified in writing should this contact information change during the course of the contract.

Remainder of page intentionally left blank

Contractor Initials: MFC
Date: 3/29/16

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Health Services Advisory Group, Inc. doing business in New Hampshire as HSAG of AZ, a(n) Arizona corporation, is authorized to transact business in New Hampshire and qualified on April 16, 2012. I further certify that all fees and annual reports required by the Secretary of State's office have been received.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of April, A.D. 2016

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Joellen Tenison, CPA, MBA, do hereby certify that:
(Name of the elected Officer of the Agency; cannot be contract signatory)

1. I am a duly elected Officer of Health Services Advisory Group, Inc.
(Agency Name)

2. The following is a true copy of the resolution duly adopted at a meeting of the Board of Directors of the Agency duly held on March 1, 2016:
(Date)

RESOLVED: That the Chief Executive Officer
(Title of Contract Signatory)

is hereby authorized on behalf of this Agency to enter into the said contract with the State and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate.

3. The forgoing resolutions have not been amended or revoked, and remain in full force and effect as of the 29th day of March, 2016.
(Date Contract Signed)

4. Mary Ellen Dalton is the duly elected Chief Executive Officer
(Name of Contract Signatory) (Title of Contract Signatory)

of the Agency.

J Tenison
(Signature of the Elected Officer)

STATE OF ARIZONA

County of Maricopa

The forgoing instrument was acknowledged before me this 29th day of March, 2016,

By Joellen Tenison.
(Name of Elected Officer of the Agency)

(Notary Public/Justice of the Peace)

(NOTARY SEAL)

Commission Expires: June 24, 2017

ALEXANDRA BASSANETTI
Notary Public, State of Arizona
Maricopa County
My Commission Expires
June 24, 2017

HEALSER-02 DCOOPER

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 4/6/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 0C36861 Phoenix-Alliant Insurance Services, Inc. 2415 E Camelback Rd Ste 420 Phoenix, AZ 85016	CONTACT NAME: Deborah Cooper PHONE (A/C, No, Ext): (602) 707-1900 FAX (A/C, No): (480) 333-6974 E-MAIL ADDRESS:
INSURED Health Services Holdings, Inc. 3133 East Camelback Rd., Ste 100 Phoenix, AZ 85016	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : National Fire Insurance Co of Hartford — 20478 INSURER B : Transportation Insurance Company — 20494 INSURER C : Continental Casualty Company — 20443 INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	X		6013714190	07/01/2015	07/01/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG STOP GAP	$ 1,000,000 $ 300,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $ 1,000,000
B	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			5095017171	07/01/2015	07/01/2016	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
C	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000	X		6013714206	07/01/2015	07/01/2016	EACH OCCURRENCE AGGREGATE	$ 10,000,000 $ 10,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N N / A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		5095017137	07/01/2015	07/01/2016	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
B	Workers Compensation			5095017087	07/01/2015	07/01/2016	EachAccident/Disease	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Certificate Holder and any entity listed below are included as additional insured per written contract or agreement as respects to General Liability per attached forms. Umbrella policy is follow form excess of all primary policy endorsements.

NH Department of Health & Human Services its officers and employees are included as additional insured.

CERTIFICATE HOLDER

NH Department of Health & Human Services
129 Pleasant St.-Brown Building
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

GENERAL LIABILITY EXTENSION ENDORSEMENT

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

Coverage afforded under this extension of coverage endorsement does not apply to any person or organization covered as an additional insured on any other endorsement now or hereafter attached to this Coverage Part.

1. ADDITIONAL INSURED – BLANKET VENDORS

WHO IS AN INSURED (Section **II**) is amended to include as an additional insured any person or organization (referred to below as vendor) with whom you agreed, because of a written contract or agreement to provide insurance, but only with respect to "bodily injury" or "property damage" arising out of "your products" which are distributed or sold in the regular course of the vendor's business, subject to the following additional exclusions:

1. The insurance afforded the vendor does not apply to:

a. "Bodily injury" or "property damage" for which the vendor is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages that the vendor would have in the absence of the contract or agreement;

b. Any express warranty unauthorized by you;

c. Any physical or chemical change in the product made intentionally by the vendor;

d. Repackaging, except when unpacked solely for the purpose of inspection, demonstration, testing, or the substitution of parts under instructions from the manufacturer, and then repackaged in the original container;

e. Any failure to make such inspections, adjustments, tests or servicing as the vendor has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products;

f. Demonstration, installation, servicing or repair operations, except such operations performed at the vendor's premises in connection with the sale of the product;

g. Products which, after distribution or sale by you, have been labeled or relabeled or used as a container, part or ingredient of any other thing or substance by or for the vendor; or

h. "Bodily injury" or "property damage" arising out of the sole negligence of the vendor for its own acts or omission or those of its employees or anyone else acting on its behalf. However, this exclusion does not apply to:

(1) The exceptions contained in Subparagraphs **d.** or **f.**; or

(2) Such inspections, adjustments, tests or servicing as the vendor has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products.

2. This insurance does not apply to any insured person or organization, from whom you have acquired such products, or any ingredient, part or container, entering into, accompanying or containing such products.

3. This provision **1.** does not apply to any vendor included as an insured by an endorsement issued by us and made a part of this Coverage Part.

4. This provision **1.** does not apply if "bodily injury" or "property damage" included within the "products-completed operations hazard" is excluded either by the provisions of the Coverage Part or by endorsement.

2. MISCELLANEOUS ADDITIONAL INSUREDS

WHO IS AN INSURED (Section **II**) is amended to include as an insured any person or organization (called additional insured) described in paragraphs **2.a.** through **2.g.** below whom you are required to add as an additional insured on this policy under a written contract or agreement but the written contract or agreement must be:

1. Currently in effect or becoming effective during the term of this policy; and

2. Executed prior to the "bodily injury," "property damage" or "personal injury and advertising injury," but

Only the following persons or organizations are additional insureds under this endorsement and

coverage provided to such additional insureds is limited as provided herein:

a. State or Political Subdivisions

A state or political subdivision subject to the following provisions:

(1) This insurance applies only with respect to the following hazards for which the state or political subdivision has issued a permit in connection with premises you own, rent, or control and to which this insurance applies:

(a) The existence, maintenance, repair, construction, erection, or removal of advertising signs, awnings, canopies, cellar entrances, coal holes, driveways, manholes, marquees, hoistaway openings, sidewalk vaults, street banners, or decorations and similar exposures; or

(b) The construction, erection, or removal of elevators; or

(2) This insurance applies only with respect to operations performed by you or on your behalf for which the state or political subdivision has issued a permit.

This insurance does not apply to "bodily injury," "property damage" or "personal and advertising injury" arising out of operations performed for the state or municipality.

b. Controlling Interest

Any persons or organizations with a controlling interest in you but only with respect to their liability arising out of:

(1) Their financial control of you; or

(2) Premises they own, maintain or control while you lease or occupy these premises.

This insurance does not apply to structural alterations, new construction and demolition operations performed by or for such additional insured.

c. Managers or Lessors of Premises

A manager or lessor of premises but only with respect to liability arising out of the ownership, maintenance or use of that specific part of the premises leased to you and subject to the following additional exclusions:

This insurance does not apply to:

(1) Any "occurrence" which takes place after you cease to be a tenant in that premises; or

(2) Structural alterations, new construction or demolition operations performed by or on behalf of such additional insured.

d. Mortgagee, Assignee or Receiver

A mortgagee, assignee or receiver but only with respect to their liability as mortgagee, assignee, or receiver and arising out of the ownership, maintenance, or use of a premises by you.

This insurance does not apply to structural alterations, new construction or demolition operations performed by or for such additional insured.

e. Owners/Other Interests – Land is Leased

An owner or other interest from whom land has been leased by you but only with respect to liability arising out of the ownership, maintenance or use of that specific part of the land leased to you and subject to the following additional exclusions:

This insurance does not apply to:

(1) Any "occurrence" which takes place after you cease to lease that land; or

(2) Structural alterations, new construction or demolition operations performed by or on behalf of such additional insured.

f. Co-owner of Insured Premises

A co-owner of a premises co-owned by you and covered under this insurance but only with respect to the co-owners liability as co-owner of such premises.

g. Lessor of Equipment

Any person or organization from whom you lease equipment. Such person or organization are insureds only with respect to their liability arising out of the maintenance, operation or use by you of equipment leased to you by such person or organization. A person's or organization's status as an insured under this endorsement ends when their written contract or agreement with you for such leased equipment ends.

With respect to the insurance afforded these additional insureds, the following additional exclusions apply:

This insurance does not apply:

(1) To any "occurrence" which takes place after the equipment lease expires; or

(2) To "bodily injury," "property damage," or "personal and advertising injury" arising out of the sole negligence of such additional insured.

Any insurance provided to an additional insured designated under paragraphs **a.** through **g.** above does not apply to "bodily injury" or "property damage" included within the "products-completed operations hazard."

As respects the coverage provided under this endorsement, Paragraph **4.b. SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS** is deleted and replaced with the following:

4. Other Insurance

b. Excess Insurance

This insurance is excess over:

Any other insurance naming the additional insured as an insured whether primary, excess, contingent or on any other basis unless a written contract or agreement specifically requires that this insurance be either primary or primary and noncontributing. Where required by written contract or agreement, we will consider any other insurance maintained by the additional insured for injury or damage covered by this endorsement to be excess and noncontributing with this insurance.

3. NEWLY FORMED OR ACQUIRED ORGANIZATIONS

Paragraph **3.a.** of **Section II – Who Is An Insured** is deleted and replaced by the following:

Coverage under this provision is afforded only until the end of the policy period or the next anniversary of this policy's effective date after you acquire or form the organization, whichever is earlier.

4. JOINT VENTURES / PARTNERSHIP / LIMITED LIABILITY COMPANY COVERAGE

A. The following is added to **Section II – Who Is An Insured:**

4. You are an insured when you had an interest in a joint venture, partnership or limited liability company which terminated or ended prior to or during this policy period but only to the extent of your interest in such joint venture, partnership or limited liability company. This coverage does not apply:

a. Prior to the termination date of any joint venture, partnership or limited liability company; or

b. If there is other valid and collectible insurance purchased specifically to insure the partnership, joint venture or limited liability company.

B. The last paragraph of **Section II – Who Is An Insured** is deleted and replaced by the following:

Except as provided in **4.** above, no person or organization is an insured with respect to the conduct of any current or past partnership, joint venture or limited liability company that is not shown as a Named Insured in the Declarations.

5. PARTNERSHIP OR JOINT VENTURES

Paragraph **1.b.** of **Section II – Who Is An Insured** is deleted and replaced by the following:

b. A partnership (including a limited liability partnership) or joint venture, you are an insured. Your members, your partners, and their spouses are also insureds, but only with respect to the conduct of your business.

6. EMPLOYEES AS INSUREDS – HEALTH CARE SERVICES

For other than a physician, paragraph **2.a(1)(d)** of **Section II – Who Is An Insured** does not apply with respect to professional health care services provided in the course of employment by you.

7. SUPPLEMENTARY PAYMENTS

A. Under **Section I – Supplementary Payments – Coverages A** and **B,** Paragraph **1.b.,** the limit of $250 shown for the cost of bail bonds is replaced by $2,500:

B. In Paragraph **1.d.,** the limit of $250 shown for daily loss of earnings is replaced by $1,000.

8. MEDICAL PAYMENTS

A. Paragraph **7. Medical Expense Limit,** of **Section III – Limits of Insurance** is deleted and replaced by the following:

7. Subject to **5.** above (the Each Occurrence Limit), the Medical Expense Limit is the most we will pay under **Section – I – Coverage C** for all medical expenses because of "bodily injury" sustained by any one person. The Medical Expense Limit is the greater of:

(1) $15,000; or

(2) The amount shown in the Declarations for Medical Expense Limit.

B. This provision **8. (Medical Payments)** does not apply if **Section I – Coverage C Medical Payments** is excluded either by the provisions of the Coverage Part or by endorsement.

C. Paragraph **1.a.(3)(2)** of **Section I – Coverage C – Medical Payments,** is replaced by the following:

The expenses are incurred and reported to us within three years of the date of the accident; and

9. NON-OWNED WATERCRAFT

Under **Section I – Coverage A – Bodily Injury and Property Damage,** Exclusion **2.g.,** subparagraph **(2)** is deleted and replaced by the following.

(2) A watercraft you do not own that is:

(a) Less than 55 feet long; and

(b) Not being used to carry persons or property for a charge.

10. NON-OWNED AIRCRAFT

Exclusion **2.g.** of **Section I – Coverage A – Bodily Injury and Property Damage,** does not apply to an aircraft you do not own, provided that:

1. The pilot in command holds a currently effective certificate issued by the duly constituted authority of the United States of America or Canada, designating that person as a commercial or airline transport pilot;
2. It is rented with a trained, paid crew; and
3. It does not transport persons or cargo for a charge.

11. LEGAL LIABILITY – DAMAGE TO PREMISES

A. Under **Section I – Coverage A – Bodily Injury and Property Damage 2. Exclusions,** Exclusion **j.** is replaced by the following.

"Property damage" to:

(1) Property you own, rent, or occupy, including any costs or expenses incurred by you, or any other person, organization or entity, for repair, replacement, enhancement, restoration or maintenance of such property for any reason, including prevention of injury to a person or damage to another's property;

(2) Premises you sell, give away or abandon, if the "property damage" arises out of any part of those premises;

(3) Property loaned to you;

(4) Personal property in the care, custody or control of the insured;

(5) That particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the "property damage" arises out of those operations; or

(6) That particular part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed on it.

Paragraph **(2)** of this exclusion does not apply if the premises are "your work" and were never occupied, rented or held for rental by you.

Paragraphs **(1), (3)** and **(4)** of this exclusion do not apply to "property damage" (other than damage by fire) to premises:

(1) rented to you;

(2) temporarily occupied by you with the permission of the owner, or

(3) to the contents of premises rented to you for a period of 7 or fewer consecutive days.

A separate limit of insurance applies to Damage To Premises Rented To You as described in **Section III – Limits Of Insurance.**

Paragraphs **(3), (4), (5)** and **(6)** of this exclusion do not apply to liability assumed under a sidetrack agreement.

Paragraph **(6)** of this exclusion does not apply to "property damage" included in the "products-completed operations hazard."

B. Under **Section I – Coverage A – Bodily Injury and Property Damage** the last paragraph of **2. Exclusions** is deleted and replaced by the following.

Exclusions **c.** through **n.** do not apply to damage by fire to premises while rented to you or temporarily occupied by you with permission of the owner or to the contents of premises rented to you for a period of 7 or fewer consecutive days.

A separate limit of insurance applies to this coverage as described in **Section III – Limits Of Insurance.**

C. Paragraph **6. Damage To Premises Rented To You Limit** of **Section III – Limits Of Insurance** is replaced by the following:

6. Subject to **5.** above, (the Each Occurrence Limit), the Damage To Premises Rented To You Limit is the most we will pay under **Section – I – Coverage A** for damages because of "property damage" to any one premises while rented to you or temporarily occupied by you with the permission of the owner, including contents of such premises rented to you for a period of 7 or fewer consecutive days. The Damage To Premises Rented To You Limit is the greater of:

a. $200,000; or

b. The Damage To Premises Rented To You Limit shown in the Declarations.

D. Paragraph **4.b.(1)(b)** of **Section IV – Commercial General Liability Conditions** is deleted and replaced by the following:

(b) That is property insurance for premises rented to you or temporarily occupied by you with the permission of the owner; or

E. This provision **11. (LEGAL LIABILITY – DAMAGE TO PREMISES)** does not apply if Damage To Premises Rented To You Liability under **Section I – Coverage A** is excluded either by the provisions of the Coverage Part or by endorsement.

12. BROAD KNOWLEDGE OF OCCURRENCE

The following is added to paragraph **2.** of **Section IV – Commercial General Liability Conditions – Duties in The Event of Occurrence, Offense, Claim or Suit:**

You must give us or our authorized representative notice of an "occurrence," offense, claim, or "suit" only when the "occurrence," offense, claim or "suit" is known to :

(1) You, if you are an individual;

(2) A partner, if you are a partnership;

(3) An executive officer or the employee designated by you to give such notice, if you are a corporation; or

(4) A manager, if you are a limited liability company.

13. NOTICE OF OCCURRENCE

The following is added to paragraph **2.** of **Section IV – Commercial General Liability Conditions – Duties in The Event of Occurrence, Offense Claim or Suit:**

Your rights under this Coverage Part will not be prejudiced if you fail to give us notice of an "occurrence," offense, claim or "suit" and that failure is solely due to your reasonable belief that the "bodily injury" or "property damage" is not covered under this Coverage Part. However, you shall give written notice of this "occurrence," offense, claim or "suit" to us as soon as you are aware that this insurance may apply to such "occurrence," offense claim or "suit."

14. UNINTENTIONAL FAILURE TO DISCLOSE HAZARDS

Based on our reliance on your representations as to existing hazards, if unintentionally you should fail to disclose all such hazards at the inception date of your policy, we will not deny coverage under this Coverage Part because of such failure.

15. EXPANDED PERSONAL AND ADVERTISING INJURY

A. The following is added to **Section V – Definitions,** the definition of "personal and advertising injury":

h. Discrimination or humiliation that results in injury to the feelings or reputation of a natural person, but only if such discrimination or humiliation is:

(1) Not done intentionally by or at the direction of:

(a) The insured; or

(b) Any "executive officer," director, stockholder, partner, member or manager (if you are a limited liability company) of the insured; and

(2) Not directly or indirectly related to the employment, prospective employment, past employment or termination of employment of any person or persons by any insured.

B. Exclusions of **Section I – Coverage B –Personal and Advertising Injury Liability** is amended to include the following:

p. Discrimination Relating To Room, Dwelling or Premises

Caused by discrimination directly or indirectly related to the sale, rental, lease or sub-lease or prospective sale, rental, lease or sub-lease of any room, dwelling or premises by or at the direction of any insured.

10020009060137141904099

q. Fines Or Penalties

Fines or penalties levied or imposed by a governmental entity because of discrimination.

C. This provision **15. (EXPANDED PERSONAL AND ADVERTISING INJURY COVERAGE)** does not apply to discrimination or humiliation committed in the states of New York or Ohio. Also, **EXPANDED PERSONAL AND ADVERTISING INJURY COVERAGE** does not apply to policies issued in the states of New York or Ohio.

D. This provision **15. (EXPANDED PERSONAL AND ADVERTISING INJURY COVERAGE)** does not apply if **Section I – Coverage B – Personal And Advertising Injury Liability** is excluded either by the provisions of the Coverage Part or by endorsement.

16. BODILY INJURY

Section V – Definitions, the definition of "bodily injury" is changed to read:

"Bodily injury" means bodily injury, sickness or disease sustained by a person, including death, humiliation, shock, mental anguish or mental injury by that person at any time which results as a consequence of the bodily injury, sickness or disease.

17. EXPECTED OR INTENDED INJURY

Exclusion **a.** of **Section I – Coverage A – Bodily Injury and Property Damage Liability** is replaced by the following:

a. "Bodily injury" or "property damage" expected or intended from the standpoint of the insured. This exclusion does not apply to "bodily injury" or "property damage" resulting from the use of reasonable force to protect persons or property.

18. LIBERALIZATION CLAUSE

If we adopt a change in our forms or rules which would broaden coverage under this endorsement without an additional premium charge, your policy will automatically provide the additional coverages as of the date the revision is effective in your state.

19. PROPERTY DAMAGE – ELEVATORS

With respect to Exclusions of **Section I – Coverage A,** paragraphs **(3), (4) and (6)** of Exclusion **j.** and Exclusion **k.** do not apply to the use of elevators.

The insurance afforded by this provision **19.** is excess over any valid and collectible property insurance (including any deductible) available to the insured, and the Other Insurance Condition is changed accordingly.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

September 24, 2015

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy to amend an existing agreement with the Health Services Advisory Group, Inc. (Vendor #226207) 3133 East Camelback Road, Suite 300, Phoenix, Arizona 85016, for the provision of the calculation of Centers for Medicare and Medicaid Services quality measures for the Adult Medicaid Quality grant, by increasing the price limitation by $66,937 from $1,857,064 to $1,924,001 with no change to the contract completion date of July 24, 2016 upon Governor and Executive Council approval. The Governor and Executive Council approved the original contract agreement on August 14, 2013 (Item #31), a subsequent amendment on January 14, 2015 (Item #3), and April 22, 2015 (item #10). 78.6% Federal Funds 21.40% General Funds.

Funds to support this request are anticipated to be available in State Fiscal Year 2016, upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts between fiscal years if needed and justified.

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, MEDICAID ADMINISTRATION 75% Federal Funds, 25% General Funds

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$487,350	$0	$487,350
2015	102-500731	Contracts for Program Services	$663,531	$0	$663,531
2016	102-500731	Contracts for Program Services	$495,966	$0	$495,966
		Subtotal:	***$1,646,847***	***$0***	***$1,646,847***

05-095-047-470010-79460000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, AFFORDABLE CARE ACT (ACA) 100% Federal Funds

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$210,217	$0	$210,217
2015	102-500731	Contracts for Program Services	$0	$0	$0
2016	102-500731	Contracts for Program Services	$0	$66,937	$66,937
		Subtotal:	***$210,217***	***$66,937***	***$277,154***
		Contract Total:	**$1,857,064**	***$66,937***	**$1,924,001**

EXPLANATION

The purpose of this amendment is to calculate the Centers for Medicare and Medicaid Services measures required by the Adult Medicaid Quality grant.

Health Services Advisory Group, Inc. has both timely and accurately calculated these measures in the prior years of the grant. An amendment to the agreement is needed as the Centers for Medicare and Medicaid Services approved a no cost extension for NH to continue the work of the grant for an additional year, which includes the submission of these additional measures in 2015.

Should the Governor and Executive Council not approve this request, the Department would be out of compliance with the Centers for Medicare and Medicaid Services standards terms and conditions for the grant, and potentially be subject to penalties.

Area Served: Statewide

Source of Funds: 78.6% Federal Funds, 21.4% General Funds

In the event that federal funds become no longer available, general funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Health Services Advisory Group Contract

This 3rd Amendment to the Health Services Advisory Group contract (hereinafter referred to as "Amendment #3") dated this 9th day of September, 2015, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Health Services Advisory Group, Inc. (hereinafter referred to as "the Contractor"), a corporation with a place of business at 3133 East Camelback Road, Suite 300, Phoenix, AZ 85016-4501.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 14, 2013 (Item #31), as amended by an agreement (Amendment #1) approved on January 14, 2015 (Item #3) and again on April 22, 2015 (item #10), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 and Exhibit A, Terms and Conditions, Subparagraph 2.5 the State may, make changes to the scope of work, payment schedules and terms and conditions of the contract by written agreement of the parties upon Governor and Council approval; and

WHEREAS the parties have agreed to add to scope of services and to increase the price limitation; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

To amend as follows:

1. Form P-37, Item 1.8, Price Limitation, to read:

   $1,924,001

2. Add Exhibit A, Section 8 Statement of Work Beginning in the Post-Implementation Phase of Medicaid Care Management, Paragraph 8.6 Additional Performance Measures, Sub Paragraph 8.6.7., to read:

   8.6.7. Calculate selected Center for Medicaid Services Adult Core Set quality measures that are agreed upon by the DHHS and HSAG.

3. Delete Exhibit B, Amendment #2 Methods and Conditions Precedent to Payment External Quality Review Organization (EQRO) Services Payment Arrangements and replace with Exhibit B, Amendment #3 Methods and Conditions Precedent to Payment External Quality Review Organization (EQRO) Services Payment Arrangements.

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

9/30/15
Date

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Health Services Advisory Group, Inc.

9/15/15
Date

NAME: Mary Ellen Dalton, PhD, MBA, RN
TITLE: Chief Executive Officer

Acknowledgement:
State of Arizona, County of Maricopa on Sept 15, 2015 before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.
Signature of Notary Public or Justice of the Peace

Notary Public
Name and Title of Notary or Justice of the Peace

ALEXANDRA BASSANETTI
Notary Public, State of Arizona
Maricopa County
My Commission Expires
June 24, 2017

New Hampshire Department of Health and Human Services
Health Services Advisory Group Contract

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

10/14/15
Date

Name: Megan A. Lopez
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

New Hampshire Department of Health and Human Services

Exhibit B - Amendment #3

Methods and Conditions Precedent to Payment
External Quality Review Organization (EQRO) Services Payment Arrangements

This agreement is reimbursed on a monthly basis for a three-year Agreement term, subject to all conditions contained within Exhibit A. Reimbursement for the first year of the Agreement shall commence on July 25, 2013, or the date of approval of the contract by the New Hampshire Governor and Executive Council, whichever is later.

Invoices shall be submitted monthly, on the Contractor's letterhead, to:

Patrick McGowan
NH Medicaid Quality Program
Office of Medicaid Business and Policy
NH Department of Health and Human Services
129 Pleasant Street – Brown Building
Concord, NH 03301-3857

The monthly invoices will include an invoice amount that is equal to 1/12th of the total all-inclusive price for the contract year. The following table displays the monthly invoice amounts for Year 1, Year 2, and Year 3 of the Contract:

Invoicing Schedule

Monthly Invoice Amount for Month Ending	Contract Year 1	Contract Year 2	Contract Year 3
31-Jul	$40,612.50	$41,567.58	$41,330.50
31-Aug	$40,612.50	$41,567.58	$41,330.50
30-Sep	$40,612.50	$41,567.58	$41,330.50
31-Oct	$40,612.50	$41,567.58	$41,330.50
30-Nov	$40,612.50	$41,567.58	$41,330.50
31-Dec	$40,612.50	$61,528.02	$41,330.50
31-Jan	$40,612.50	$61,528.02	$41,330.50
28-Feb	$40,612.50	$61,528.02	$41,330.50
31-Mar	$40,612.50	$61,528.01	$41,330.50
30-Apr	$40,612.50	$61,528.01	$41,330.50
31-May	$40,612.50	$61,528.01	$41,330.50
30-Jun	$40,612.50	$61,528.01	$41,330.50
All-Inclusive Price	**$487,350.00**	**$638,534.00**	**$495,966.00**

Based on DHHS approved cost proposals for additional services related to Exhibit A, Section 8.8, HSAG shall invoice DHHS upon the completion and acceptance of grant support deliverables.

Based on DHHS approved cost proposals for services related Exhibit A-1, HSAG shall invoice the Department as follows:

1. 1/3 of the agreement pricing upon the onset of services related to Exhibit A-1;
2. 1/3 of the agreement pricing upon Department approval of the services related to Exhibit A-1; and

Contractor Initials: [signature]
Date: 9/15/15

3. 1/3 of the agreement pricing upon the Center for Medicare and Medicaid Services approval of the services related to Exhibit A-1.

Based on DHHS approved cost proposals for services related Exhibit A, Section 8.6.7, HSAG shall invoice the Department as follows:

1. 1/2 of the agreement pricing upon the onset of services related to Exhibit A Section 8.6.7; and
2. 1/2 of the agreement pricing upon the delivery of services related to Exhibit A Section 8.6.7.

The Contractor agrees to request and receive prior written approval from the State to engage any subcontractors under this Agreement, and further agrees to pay the expenses of any subcontractors awarded under this Agreement in accordance with Exhibit A, Statement of Work.

The Contractor agrees to request and receive prior written approval from the State for any modifications to the project budget, which change any expenditure levels from the levels projected in the budget of this Agreement.

The Contractor agrees to use and apply all payments made by the State for direct and indirect costs and expenses associated with the execution of this Agreement. The Contractor's expenses for administration of any subcontractors shall not exceed the amounts identified in the all-inclusive price for the contract year.

Payments will be made upon receipt of Contractor invoices that identify the contract components delivered and are consistent with the negotiated payment schedule. The total contract payment from DHHS will not exceed the agreed upon contract price.

Pricing Worksheet

Agreement Pricing is as set forth below:

	Agreement Year One	**Agreement Year Two**	**Agreement Year Three**
	July 25, 2013 - June 30, 2014	July 1, 2014 – June 30, 2015	July 1, 2015 – June 20, 2016
All Inclusive Price	$487,350	$638,534	$495,966
Additional Services (Exhibit A, Section 8.8)	$210,217		
Additional Services (Exhibit A, Section 8.6.7)			$66,937
Evaluation plan for the NHHPP and Premium Assistance Program 1115 Medicaid Demonstration		$24,997	

Contractor Initials: MG
Date: 9/15/15

Price Limitation. This Agreement is based on a yearly comprehensive pricing proposal from HSAG for SFY 2014, SFY 2015, and SFY 2016. Accordingly, the total price limitation is $1,924,001 for the three-year term of this Agreement.

Invoicing. Invoices shall be submitted to the Finance Unit of DHHS' Office of Medicaid Business and Policy as indicated above for services provided by the Contractor as outlined in Exhibit A. The Contractor shall be notified in writing should this contact information change during the course of the contract.

Remainder of page intentionally left blank

Contractor Initials: MES

Date: 9/15/15

G

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

March 30, 2015

G&C Approved
Date 4/22/15
Item # 10

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy to amend an existing agreement with the Health Services Advisory Group, Inc. (Vendor #226207) 3133 East Camelback Road, Suite 300, Phoenix, Arizona 85016, for the provision of a federally required evaluation plan for the Medicaid Premium Assistance Program, by increasing the price limitation by $24,997 from $1,832,067 to $1,857,064, with no change to the contract completion date of July 24, 2016 upon Governor and Executive Council approval. The Governor and Executive Council approved the original contract agreement on August 14, 2013 (Item #31) and a subsequent amendment on January 14, 2015 (Item #3). 75% Federal Funds 25% General Funds.

Funds are available in State Fiscal Year 2015, and are anticipated to be available in State Fiscal Year 2016, upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts between fiscal years if needed and justified.

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$487,350	$0	$487,350
2015	102-500731	Contracts for Program Services	$638,534	$24,997	$663,531
2016	102-500731	Contracts for Program Services	$495,966	$0	$495,966
		Subtotal:	***$1,621,850***	***$24,997***	***$1,646,847***

05-095-047-470010-79460000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, AFFORDABLE CARE ACT (ACA)

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$210,217	$0	$210,217
		Subtotal:	***$210,217***	***$0***	***$210,217***
		Contract Total:	**$1,832,067**	**$24,997**	**$1,857,064**

EXPLANATION

The purpose of this amendment is to add the creation of an evaluation plan to the vendor's Scope of Services in order to identify and measure the effects of the Premium Assistance Program. The evaluation plan must identify and measure the effects of the Premium Assistance Program on member quality of care and member access to care.

The Centers for Medicare and Medicaid Services Special Terms and Conditions of the New Hampshire Medicaid Demonstration Waiver, Section 1115(a), requires an evaluation plan for the Premium Assistance Program, which is an alternative to traditional Medicaid for low-income adults where members receive their benefits from a commercial Qualified Health Plan provider who is authorized to offer services on the insurance marketplace. The Centers for Medicare and Medicaid Services approved the Demonstration Waiver on March 3, 2015, which requires the creation of a plan that evaluates the Premium Assistance Program within ninety (90) days from the approval date.

The Health Services Advisory Group, Inc. is currently New Hampshire's External Quality Review Organization for the Medicaid Care Management program. By authorizing this amendment with the vendor, a certified External Quality Review Organization, the Department is eligible for an enhanced federal match for funding of the services included in this amendment. The vendor has the ability to create the evaluation plan within the ninety (90) day timeframe established by the Centers for Medicare and Medicaid Services.

The vendor must create an evaluation plan that includes the background on the NH Health Protection Program and Premium Assistance Program. The plan must include research design, questions and hypotheses, as well as a description of the study population and comparison groups along with any needed standardization between the groups. The vendor must provide a description of data availability and collection processes. The vendor's plan must identify actual measures that will be used for each question and hypotheses, including the measure source, data source and analysis that will be performed. The plan must identify and measure the effects of the premium assistance program on member insurance coverage (uptake); coverage gaps and loss of coverage. Finally, the plan must identify the effects that co-payments have on members.

Due to the compressed time frames of submitting a plan by June 3, 2015, and the technical expertise required, the Health Services Advisory Group, Inc. is best equipped for creating the evaluation plan required by the Centers for Medicare and Medicaid Services. Since assuming operations in SFY 2014, the vendor has exceeded the Department's expectations by producing high quality work that is similar in scope to the evaluation plan outlined in this amendment. Based on this past performance and the vendor's experience, technical expertise, and knowledge of the New Hampshire market and operations, the Department is confident in this organization's ability to successfully produce an appropriate evaluation plan within the short timeline allotted by the Centers for Medicare and Medicaid Services.

Should the Governor and Executive Council not approve this request, the Department would not be able to meet the Centers for Medicare and Medicaid Services required time frames which would put at risk the continued approval of the Premium Assistance Waiver.

Area Served: Statewide

Source of Funds: 75% Federal Funds
25% General Funds

In the event that federal funds become no longer available, general funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:

Nicholas A. Toumpas
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #2 to the Health Services Advisory Group Contract

This 2nd Amendment to the Health Services Advisory Group contract (hereinafter referred to as "Amendment #2") dated this 6th day of March, 2015, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Health Services Advisory Group, Inc. (hereinafter referred to as "the Contractor"), a corporation with a place of business at 3133 East Camelback Road, Suite 300, Phoenix, AZ 85016-4501.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 14, 2013 (Item #31), as amended by an agreement (Amendment #1) approved on January 14, 2015 (Item #3), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 and Exhibit A, Terms and Conditions, Subparagraph 2.5 the State may, make changes to the scope of work, payment schedules and terms and conditions of the contract by written agreement of the parties upon Governor and Council approval; and

WHEREAS the parties have agreed to add to scope of services and to increase the price limitation; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

To amend as follows:

1. Form P-37, Item 1.8, Price Limitation, to read:

   $1,857,064

2. Add Exhibit A-1 – Amendment #2.
3. Delete Exhibit B – Amendment #1, Methods and Conditions Precedent to Payment, External Quality Review Organization (EQRO) Services Payment Arrangement, and replace with Exhibit B – Amendment #2, Methods and Conditions Precedent to Payment, External Quality Review Organization (EQRO) Services Payment Arrangements.

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

4-1-15
Date

Kathleen A. Dunn
Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Health Services Advisory Group, Inc.

3-31-15
Date

Mary Ellen Dalton
NAME:
TITLE:

Acknowledgement:
State of Arizona, County of Maricopa on 03/31/2015, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.
Signature of Notary Public or Justice of the Peace

Name and Title of Notary or Justice of the Peace

BRETT MCGILLEN
Notary Public, State of Arizona
Maricopa County
My Commission Expires
May 08, 2018

New Hampshire Department of Health and Human Services
Health Services Advisory Group Contract

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

4/6/15
Date

Name: Megan A. Tegu
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. NHHPP and PAP 1115 Medicaid Demonstration Waiver

1.1. The Contractor shall develop an evaluation plan for the New Hampshire Health Protection Program (NHHPP) and Premium Assistance Program (PAP) 1115 Medicaid Demonstration Waiver. The Contractor shall:

1.1.1. Ensure the evaluation plain meets all Centers for Medicare and Medicaid Services (CMS) requirements.

1.1.2. Ensure plan designs include, but are not limited to:

1.1.2.1. Background on NHHPP and PAP.

1.1.2.2. Research design.

1.1.2.3. Research questions and hypothesis.

1.1.2.4. Description of study populations and comparison groups.

1.1.2.5. A data analysis plan that includes needed standardization of the study population and comparison group, such as age, gender, or risk factors.

1.1.2.6. Actual measures to be used for each question and hypotheses, including the measure source, data source and analysis to be performed.

1.2. The Contractor shall incorporate, at minimum, the following Department-approved questions and hypothesis in the evaluation plan design:

1.2.1. **Table I**

Question	Hypothesis
What are the effects of the QHP premium assistance plan on member quality of care?	QHP premium assistance enrollees will have equal or better quality of care (e.g., preventative visits, primary care, etc.)
	QHP premium assistance enrollees will report equal or greater satisfaction with their health care.
	QHP premium assistance enrollees will report equal or greater satisfaction with their personal doctor.
	QHP premium assistance enrollees will report equal or greater satisfaction with their health plan.

Contractor Initials MH
Date: 3-31-15

What are the effects of the QHP premium assistance plan on member access to care?	QHP premium assistance enrollees will have equal or lower use of emergency department services.
	QHP premium assistance enrollees will have equal or greater timely access to primary specialty and behavioral health care services.
	QHP premium assistance enrollees will have equal or lower rates of potentially avoidable ambulatory care sensitive hospital admissions.
	QHP premium assistance enrollees will have equal or greater access to needed non-emergency transportation whether delivered by the QHP or delivered through a Medicaid FFS wraparound.
	19-20 year old QHP premium assistance enrollees will have equal or greater access to EPSDT services whether delivered by the QHP or delivered through a Medicaid FFS wraparound.
What are the effects of the QHP premium assistance plan on member insurance coverage (uptake) and coverage gaps and loss of coverage?	QHP premium assistance enrollees will experience equal or less coverage gaps and loss of coverage (regardless of source of coverage).
	QHP premium assistance enrollees will maintain continuous access to a regular source of health care.
	Potentially eligible NHHPP Medicaid enrollees will be equal or more likely to enroll in NHHPP into QHP premium assistance than HPP-Bridge MCM.
What are the effects of the QHP premium assistance plan copayments on members?	The copayments will not pose a barrier to accessing care.

1.3. The Contractor shall submit the Department-approved evaluation plan to CMS no later than ninety (90) days after the CMS approval of the Demonstration Waiver. The Contractor shall ensure the evaluation plan:

Contractor Initials MCL
Date: 3-31-15

1.3.1. Describes the evaluation analysis, including but not limited to, research design, measures and data sources.

1.3.2. Is revised in collaboration with the Department, in accordance with CMS requests, as necessary.

1.3.3. Has the level of detail necessary to procure an evaluation vendor who will complete the evaluation.

1.3.4. Applies a statistical rigor using statistically sound measurement and analysis.

1.3.5. Uses national and industry standard quality measures that have been vetted through a consensus process with input from a wide variety of stakeholders.

1.3.6. Uses meaningful comparison data for each quality measure.

1.3.7. Is reviewed and approved by the Department.

Contractor Initials MCD
Date: 3-31-15

New Hampshire Department of Health and Human Services

Exhibit B - Amendment #2

Methods and Conditions Precedent to Payment
External Quality Review Organization (EQRO) Services Payment Arrangements

This agreement is reimbursed on a monthly basis for a three-year Agreement term, subject to all conditions contained within Exhibit A. Reimbursement for the first year of the Agreement shall commence on July 25, 2013, or the date of approval of the contract by the New Hampshire Governor and Executive Council, whichever is later.

Invoices shall be submitted monthly, on the Contractor's letterhead, to:

Patrick McGowan
NH Medicaid Quality Program
Office of Medicaid Business and Policy
NH Department of Health and Human Services
129 Pleasant Street – Brown Building
Concord, NH 03301-3857

The monthly invoices will include an invoice amount that is equal to 1/12th of the total all-inclusive price for the contract year. The following table displays the monthly invoice amounts for Year 1, Year 2, and Year 3 of the Contract:

Invoicing Schedule

Monthly Invoice Amount for Month Ending	Contract Year 1	Contract Year 2	Contract Year 3
31-Jul	$40,612.50	$41,567.58	$41,330.50
31-Aug	$40,612.50	$41,567.58	$41,330.50
30-Sep	$40,612.50	$41,567.58	$41,330.50
31-Oct	$40,612.50	$41,567.58	$41,330.50
30-Nov	$40,612.50	$41,567.58	$41,330.50
31-Dec	$40,612.50	$61,528.02	$41,330.50
31-Jan	$40,612.50	$61,528.02	$41,330.50
28-Feb	$40,612.50	$61,528.02	$41,330.50
31-Mar	$40,612.50	$61,528.01	$41,330.50
30-Apr	$40,612.50	$61,528.01	$41,330.50
31-May	$40,612.50	$61,528.01	$41,330.50
30-Jun	$40,612.50	$61,528.01	$41,330.50
All-Inclusive Price	**$487,350.00**	**$638,534.00**	**$495,966.00**

Based on DHHS approved cost proposals for additional services related to Exhibit A, Section 8.8, HSAG shall invoice DHHS upon the completion and acceptance of grant support deliverables.

Based on DHHS approved cost proposals for services related Exhibit A-1, HSAG shall invoice the Department as follows:

1. 1/3 of the agreement pricing upon the onset of services related to Exhibit A-1;
2. 1/3 of the agreement pricing upon Department approval of the services related to Exhibit A-1; and

Contractor Initials: MSD
Date: 3-31-15

3. 1/3 of the agreement pricing upon the Center for Medicare and Medicaid Services approval of the services related to Exhibit A-1.

The Contractor agrees to request and receive prior written approval from the State to engage any subcontractors under this Agreement, and further agrees to pay the expenses of any subcontractors awarded under this Agreement in accordance with Exhibit A, Statement of Work.

The Contractor agrees to request and receive prior written approval from the State for any modifications to the project budget, which change any expenditure levels from the levels projected in the budget of this Agreement.

The Contractor agrees to use and apply all payments made by the State for direct and indirect costs and expenses associated with the execution of this Agreement. The Contractor's expenses for administration of any subcontractors shall not exceed the amounts identified in the all-inclusive price for the contract year.

Payments will be made upon receipt of Contractor invoices that identify the contract components delivered and are consistent with the negotiated payment schedule. The total contract payment from DHHS will not exceed the agreed upon contract price.

Pricing Worksheet

Agreement Pricing is as set forth below:

	Agreement Year One	**Agreement Year Two**	**Agreement Year Three**
	July 25, 2013 - June 30, 2014	July 1, 2014 – June 30, 2015	July 1, 2015 – June 20, 2016
All Inclusive Price	$487,350	$638,534	$495,966
Additional Services (Exhibit A, Section 8.8)	$210,217		
Evaluation plan for the NHHPP and Premium Assistance Program 1115 Medicaid Demonstration		$24,997	

Price Limitation. This Agreement is based on a yearly comprehensive pricing proposal from HSAG for SFY 2014, SFY 2015, and SFY 2016. Accordingly, the total price limitation is $1,857,064 for the three-year term of this Agreement.

Invoicing. Invoices shall be submitted to the Finance Unit of DHHS' Office of Medicaid Business and Policy as indicated above for services provided by the Contractor as outlined in Exhibit A. The Contractor shall be notified in writing should this contact information change during the course of the contract.

Remainder of page intentionally left blank

Contractor Initials: MED

Date: 3-31-15

03

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MEDICAID BUSINESS AND POLICY

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

December 17, 2014

G&C Approved

Date 1/14/15

Item # 3

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy to amend an existing agreement with the Health Services Advisory Group, Inc. (HSAG) (Vendor #226207) 3133 East Camelback Road, Suite 300, Phoenix, Arizona 85016, for the provision of an external quality review for New Hampshire's Medicaid Care Management program beneficiaries, by increasing the price limitation by $139,723, from $1,692,344 to $1,832,067, with no change to the completion date of July 24, 2016, effective December 23, 2014 or upon Governor and Executive Council approval, whichever is later. The Governor and Executive Council approved the original contract agreement on August 14, 2013, Item #31. 75% Federal 25% General.

Funds are available in State Fiscal Year 2015, and are anticipated to be available in State Fiscal Year 2016, upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts between fiscal years if needed and justified.

05-095-047-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, MEDICAID ADMINISTRATION

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$487,350	$ 0	$487,350
2015	102-500731	Contracts for Program Services	$498,811	$139,723	$638,534
2016	102-500731	Contracts for Program Services	$495,966	$ 0	$495,966
		Contract Subtotal:	***$1,482,127***	***$139,723***	***$1,621,850***

05-095-047-470010-79460000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: OFC OF MEDICAID & BUS PLCY, OFF OF MEDICAID & BUS POLICY, AFFORDABLE CARE ACT (ACA)

State Fiscal Year	Class/ Object	Class Title	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2014	102-500731	Contracts for Program Services	$210,217	$ 0	$210,217
		Contract Subtotal:	***$210,217***	***$ 0***	***$210,217***
		Contract Total:	**$1,692,344**	**$139,723**	**$1,832,067**

EXPLANATION

The purpose of this amendment is to add a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to the Contractors 2015 scope of work. CAHPS measures the Medicaid Care Management (MCM) member experience of care and satisfaction with Medicaid managed care benefits, providers and services received during the past year. Understanding members' perspectives is critical in ensuring member participation with the MCM program and in identifying and addressing any MCM program liabilities as identified by the member's experience of care. CAHPS is the most recognized and vetted industry tool. This survey and an evaluation of its results must be conducted by an independent and certified External Quality Review Organization. This amendment safeguards the Department in meeting its responsibility for ensuring the appropriateness and quality of care provided to New Hampshire Medicaid beneficiaries enrolled in managed care and that the Department meets the requirements in 42 CFR 438, Subpart E regarding its obligation in ensuring that surveys conducted adhere to the Centers for Medicare and Medicaid Services (CMS) protocols.

The original agreement with the contractor provided for the impartial and expert external review of the Medicaid fee-for-service programs and management care organizations, including conducting surveys and adherence to CMS protocols as required by CMS.

Should the Governor and Executive Council withhold its approval of this request, the Department would be out of compliance with federal regulations regarding impartial managed care external quality review administration and validation of consumer or provider surveys of quality of care.

Area Served: Statewide

Source of Funds: 75% Federal Funds

25% General Funds

In the event that federal funds become no longer available, general funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:
Nicholas A. Toumpas
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the Health Services Advisory Group Contract

This 1st Amendment to the Health Services Advisory Group contract (hereinafter referred to as "Amendment #1") dated this 22nd day of October, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Health Services Advisory Group, Inc. (hereinafter referred to as "the Contractor"), a corporation with a place of business at 3133 East Camelback Road, Suite 300, Phoenix, AZ 85016-4501.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 14, 2013 (Item #31), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18 and Exhibit A, Terms and Conditions, Subparagraph 2.5 the State may, make changes to the scope of work, payment schedules and terms and conditions of the contract by written agreement of the parties upon Governor and Council approval; and

WHEREAS the parties have agreed to change the date on which the provider must complete satisfaction surveys and to increase the price limitation; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree as follows:

To amend as follows:

1. Form P-37, Item 1.8, Price Limitation, to read:

   $1,832,067

2. Delete Section 8.5, Member and Provider Surveys, in its entirety, and replace with:

   8.5. Member and Provider Surveys.

   Pursuant to 42 CFR 438.358 (c)(2), HSAG shall validate annual consumer and/or provider surveys in Contract Year 3, such as CAHPS, regarding satisfaction with MCOs and the quality of and access to care provided therein, and allow for subpopulation analysis. In Contract Year 1, HSAG will conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for the DHHS. The 2013 and 2014 CAHPS Survey Project will include administration of the CAHPS 5.0 Child Medicaid Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set. HSAG will validate MCO CAHPS Surveys to determine network adequacy. HSAG will work with the MCOs to communicate documentation and data needs.

Consistent with CMS' current version of the Administering or Validating Surveys Protocol, HSAG shall:

8.5.1. Evaluate DHHS' goals and intended use of the survey results;

8.5.2. Review intended survey audience and determine whether survey is appropriate for the audience and that the most appropriate population is being evaluated to yield meaningful information;

8.5.3. Evaluate the selected beneficiary and provider survey instruments to ensure that they are consistent with the survey purposes, objectives and units of analysis;

8.5.4. Evaluate the study populations, subpopulations, sample frame criteria, sampling strategies, sample sizes, and sample selection;

8.5.5. Identify and recommend strategies to DHHS and the MCOs to maximize survey response rates. HSAG will also assess the effectiveness of the MCO and DHHS sampling strategies and evaluate the extent to which potential sources of nonresponse may have introduced bias into survey findings;

8.5.6. Perform comprehensive analyses of provider and consumer satisfaction (CAHPS) survey data in accordance with NCQA specifications and using an alpha level of 0.05 to determine statistical significance; and

8.5.7. Document the survey process and results with data-driven and aggregate reports for the provider survey and CAHPS validation activities.

3. Delete Exhibit B, Methods and Conditions Precedent to Payment, External Quality Review Organization (EQRO) Services Payment Arrangement, and replace with:

Exhibit B – Amendment #1, Methods and Conditions Precedent to Payment, External Quality Review Organization (EQRO) Services Payment Arrangements.

New Hampshire Department of Health and Human Services
Health Services Advisory Group Contract

This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12-17-14
Date

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Health Services Advisory Group, Inc.

11-21-14
Date

Mary Ellen Dalton, PhD, MBA, RN
Chief Executive Officer

Acknowledgement:
State of Arizona, County of Maricopa on Nov 21, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.
Signature of Notary Public or Justice of the Peace

Alexandra Lemmon, Notary Public
Name and Title of Notary or Justice of the Peace

ALEXANDRA BASSANETTI
Notary Public, State of Arizona
Maricopa County
My Commission Expires
June 24, 2017

New Hampshire Department of Health and Human Services
Health Services Advisory Group Contract

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/24/14
Date

Name: Megan A. Pace
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

_____
Date

_____
Name:
Title:

New Hampshire Department of Health and Human Services

Exhibit B - Amendment #1

Methods and Conditions Precedent to Payment
External Quality Review Organization (EQRO) Services Payment Arrangements

This agreement is reimbursed on a monthly basis for a three-year Agreement term, subject to all conditions contained within Exhibit A. Reimbursement for the first year of the Agreement shall commence on July 25, 2013, or the date of approval of the contract by the New Hampshire Governor and Executive Council, whichever is later.

Invoices shall be submitted monthly, on the Contractor's letterhead, to:

Patrick McGowan
NH Medicaid Quality Program
Office of Medicaid Business and Policy
NH Department of Health and Human Services
129 Pleasant Street – Brown Building
Concord, NH 03301-3857

The monthly invoices will include an invoice amount that is equal to **1/12th** of the total all-inclusive price for the contract year. The following table displays the monthly invoice amounts for Year 1, Year 2, and Year 3 of the Contract:

Invoicing Schedule

Monthly Invoice Amount for Month Ending	Contract Year 1	Contract Year 2	Contract Year 3
31-Jul	$40,612.50	$41,567.58	$41,330.50
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31-May	$40,612.50	$61,528.01	$41,330.50
30-Jun	$40,612.50	$61,528.01	$41,330.50
All-Inclusive Price	**$487,350.00**	**$638,534.00**	**$495,966.00**

Based on DHHS approved cost proposals for additional services related to Exhibit A, Section 8.8, HSAG shall invoice DHHS upon the completion and acceptance of grant support deliverables.

The Contractor agrees to request and receive prior written approval from the State to engage any subcontractors under this Agreement, and further agrees to pay the expenses of any subcontractors awarded under this Agreement in accordance with Exhibit A, Statement of Work.

Contractor Initials: MED

Date: 11/21/14

The Contractor agrees to request and receive prior written approval from the State for any modifications to the project budget, which change any expenditure levels from the levels projected in the budget of this Agreement.

The Contractor agrees to use and apply all payments made by the State for direct and indirect costs and expenses associated with the execution of this Agreement. The Contractor's expenses for administration of any subcontractors shall not exceed the amounts identified in the all-inclusive price for the contract year.

Payments will be made upon receipt of Contractor invoices that identify the contract components delivered and are consistent with the negotiated payment schedule. The total contract payment from DHHS will not exceed the agreed upon contract price.

Pricing Worksheet

Agreement Pricing is as set forth below:

	Agreement Year One	Agreement Year Two	Agreement Year Three
	July 25, 2013 - June 30, 2014	July 1, 2014 – June 30, 2015	July 1, 2015 – June 20, 2016
All Inclusive Price	$487,350.00	$638,534.00	$495,966.00
Additional Services (Exhibit A, Section 8.8)	$210,217.00		

Price Limitation. This Agreement is based on a yearly comprehensive pricing proposal from HSAG for SFY 2014, SFY 2015, and SFY 2016. Accordingly, the total price limitation is $1,832,067.00 for the three-year term of this Agreement.

Invoicing. Invoices shall be submitted to the Finance Unit of DHHS' Office of Medicaid Business and Policy as indicated above for services provided by the Contractor as outlined in Exhibit A. The Contractor shall be notified in writing should this contact information change during the course of the contract.

Remainder of page intentionally left blank

Contractor Initials: MED

Date: 11-21-14

31

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner
Medicaid Director

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

G&C Approved

July 15, 2013

Date 8/14/13

Item # 31

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy to enter into an agreement with Health Services Advisory Group, Inc., Vendor # 226207, Phoenix, Arizona, to provide external quality review for New Hampshire's Medicaid Fee-For-Service and Care Management programs in an amount not to exceed $1,692,344.00, effective August 1, 2013, or date of Governor and Executive Council approval, whichever is later, through July 24, 2016.

Funds are available in State Fiscal Year 2014, and are anticipated to be available in State Fiscal Years 2015 and 2016 upon the availability and continued appropriation of funds in the future operating budgets, with authority to adjust amounts between fiscal years if needed and justified.

75% Fed. 25% General

05-00095-047-470010-7937 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: OFC OF MEDICAID & BUS PLCY, OFF. OF MEDICAID & BUS. POLICY, MEDICAID ADMINISTRATION

Fiscal Year	Class/Object	Class Title	Amounts
2014	102-500731	Contracts for Program	$487,350.00
2015	102-500731	Contracts for Program	$498,811.00
2016	102-500731	Contracts for Program	$495,966.00
		Subtotal	$1,482,127.00

05-00095-047-470010-7946 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: OFC OF MEDICAID & BUS PLCY, OFF. OF MEDICAID & BUS. POLICY, AFFORDABLE CARE ACT (ACA)

Fiscal Year	Class/Object	Class Title	Amounts
2014	102-500731	Contracts for Program	$210,217.00
		Subtotal	$210,217.00
		Grand Total	$1,692,344.00

EXPLANATION

The purpose of this agreement is to provide impartial and expert external review of the Medicaid Fee-For-Service and Care Management programs in order to be fully compliant with Federal and State regulations governing Medicaid Program quality. The Balanced Budget Act of 1997 established a mandatory requirement for states to establish a quality monitoring and reporting system for Medicaid managed care. In response to the Balanced Budget Act the Centers for Medicare and Medicaid Services published detailed protocols for the external review of Medicaid managed care organization compliance with state and federal regulations, validation of quality performance projects, and validation of encounter data. The Centers for Medicare and Medicaid Services has also recently published rules requiring the reporting of specific health outcome measures for pediatric and adult Medicaid beneficiaries for both managed care and fee-for-service programs for the purpose of publishing comparative and trend analysis of individual state results in their annual quality report.

The External Quality Review Organization will be capable of meeting all the requirements of 42 CFR 438, Subpart E (sections 438.310 through 438.370 inclusive) and all other applicable Federal and State regulations. These requirements impose an obligation on the New Hampshire Department of Health and Human Services to ensure that its Medicaid Care Management Program's Managed Care Organizations are reviewed and evaluated no less than annually to assure adherence to the Centers for Medicare and Medicaid Services External Quality Review Organization protocols. The evaluation must be conducted by an independent and certified External Quality Review Organization. This agreement will ensure that the Department meets its responsibility for ensuring the appropriateness and quality of care provided to New Hampshire Medicaid beneficiaries enrolled in managed care.

In addition to the federally mandated quality improvement activities and consistent with the Request for Proposals and each bidder's response, the External Quality Review Organization will support the Department in fulfilling the requirements of the Adult Quality Measurement grant award. To support states in building the internal infrastructure needed for effectively monitoring and evaluating Medicaid programs, the Centers for Medicare and Medicaid Services awarded funds to states through a competitive process. New Hampshire was one of twenty-seven states to receive a grant award. Those grant funds were approved as part of the Department's SFY 2014 and SFY 2015 budgets.

The External Quality Review Organization is an essential component of the State's quality strategy for the Medicaid program. Specifically work required of the Medicaid External Quality Review Organization will include:

- Evaluation of Managed Care Organization quality programs and projects: The External Quality Review Organization will assist in the development, review and evaluation of each Managed Care Organization's Quality Assurance and Performance Improvement program which includes four Managed Care Organization contractually required Performance Improvement Projects, and the Managed Care Organization's response to the Quality Incentive Program design, activities, and results;
- Evaluation of Managed Care Organization compliance with the federally mandated Consumer Assessment of Healthcare Providers and Systems survey: The External Quality Review Organization will validate that each Managed Care Organization conducted the survey consistent with federal and contractual requirements and that any required corrective action plans are completed to the Department's satisfaction;
- Ensure Managed Care Organization compliance with administrative and operational quality standards: The External Quality Review Organization will monitor and review Managed Care Organization activities to determine Managed Care Organization compliance with State standards for access to care,

administrative structure and operations, and quality measurement and improvement as articulated in the Medicaid Care Management contract and the State's Quality Strategy;

- Encounter data validation: The External Quality Review Organization will ensure accurate encounter data exchange through:
  - Review of the plan for encounter data exchanged between the Managed Care Organizations, and the State,
  - Validation of the accuracy and timeliness of the data actively exchanged, and
  - Consultation on validations that could be automated and implemented within New Hampshire's Medicaid Management Information System;
- External Quality Review Organization evaluation of the generated quality measures: The External Quality Review Organization will calculate performance measures in addition to those reported by a Managed Care Organization. Specifically, the External Quality Review Organization will calculate:
  - Measures to compare performance and outcomes across Managed Care Organizations Aggregated measures to compare Managed Care Organization performance to Fee-For-Service,
  - Statewide New Hampshire Medicaid population measures,
  - Performance measurement for the State's Adult Medicaid Quality Grant,
  - Performance measurement for other Medicaid quality measures as developed as part of the Adult Medicaid Quality Grant;
- New Hampshire Medicaid Performance Improvement Projects: The External Quality Review Organization will review Medicaid data and recommend for Department approval two Performance Improvement Projects annually that the External Quality Review Organization will complete in addition to those conducted by the Managed Care Organizations. As part of this work, the External Review Organization will perform additional quality activities as determined by the Department. Those studies will focus on particular aspects of clinical or nonclinical services at a point in time, including at this time:
  - Two beneficiary focus groups,
  - Convene and support Medicaid Quality Improvement meetings between the State and the Managed Care Organizations,
  - Report on recommendations to the State and the Managed Care Organizations on developing a statewide quality strategy to harmonize across the Managed Care Organizations and harmonize with the National Quality Strategy, and
  - Grievance and appeal reviews;
- Provide Technical Assistance: The External Quality Review Organization will provide technical guidance to the Managed Care Organizations and the Department to assist them in conducting activities related to quality oversight and improvement, in part through Quality Forum training activities, including at this time:
  - Annual meeting for Managed Care Organizations and Department of Health and Human Services staff, and
  - Three yearly subject focused "Lunch and Learns" for Department of Health and Human Services staff and Managed Care Organizations;
- Annual Technical Report: As required by federal regulation, the External Quality Review Organization will produce a detailed technical report, to be publically available including:
  - An explanation on how the data from review activities were aggregated and analyzed, and how conclusions were made relative to quality, timeliness, and beneficiary access to Managed Care Organization healthcare services,
  - An assessment of the Managed Care Organizations' strengths and weaknesses relative to quality, timeliness, and access to healthcare furnished to beneficiaries,
  - Recommended improvements to Managed Care Organization furnished healthcare,
  - Provide comparative information about all Managed Care Organizations, and

Source of Funds

The source of funds for State Fiscal Year 2014 and State Fiscal Year 2015 is 75% Federal Funds and 25% General Funds. Federal matching funds are available at a seventy-five/twenty-five percent match for external quality reviews, for External Quality Review results, and for External Quality Review -related activities that are conducted by the External Quality Review Organization. Additional funding related to grant activities is funded at 100% Federal Funds.

In the event that federal funds become no longer available, general funds will not be requested to support this program.

Respectfully submitted,

Kathleen A. Dunn, MPH
Associate Commissioner
Medicaid Director

Approved by:

Nicholas A. Toumpas
Commissioner

Vendor Qualifications and Experience (Total 150 Points)	Maximum Score	IPRO	HSAG	Delmarva Foundation
Qualifications	50	50	47	43
Experience	100	75	98	50
Sub-Total Qualifications and Experience	150	125	145	93
Methodology Proposed/Technical Approach (Total 550 Points)	Maximum Score	IPRO	HSAG	Delmarva Foundation
Validation of MANAGED CARE ORGANIZATION Quality Programs and Projects	25	14	24	20
Performance Measures	100	62	94	72
Compliance with Contract and DHHS Quality Strategy	25	15	25	16
Encounter Data Management and Validation	100	64	90	82
Surveys	50	34	48	39
EQRO Performance Improvement Projects	100	69	90	73
EQRO Studies	75	56	67.5	60.5
Training and Education	25	23	25	20
EQRO Technical Report	25	23	25	20
Staffing Model	25	18	20	23
Sub-Total	550	378	508.5	425.5
Technical Proposal Total	700	503	653.5	518.5
Cost Proposal (Total 300) Points	Maximum Score	IPRO	HSAG	Delmarva Foundation
Scope of Work	300	187	300	140
Total Technical and Cost Proposal Points				
Total	1000	690	953.5	658.5

AGREEMENT
GENERAL PROVISIONS

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

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy		1.2 State Agency Address NHDHHS Brown Bldg., 129 Pleasant Street, Concord, NH 03301	
1.3 Contractor Name Health Services Advisory Group, Inc. (HSAG)		1.4 Contractor Address 3133 East Camelback Road, Suite 300 Phoenix, AZ 85016-4501	
1.5 Contractor Phone Number (602) 264-6382	1.6 Account Number	1.7 Completion Date July 24, 2016	1.8 Price Limitation $1,692,344.00
1.9 Contracting Officer for State Agency Kathleen Dunn, New Hampshire Medicaid Director and Associate Commissioner of NH DHHS		1.10 State Agency Telephone Number (603) 271-9421	
1.11 Contractor Signature Mary Ellen Dalton		1.12 Name and Title of Contractor Signatory Mary Ellen Dalton, PhD, MBA, RN Chief Executive Officer	

1.13 Acknowledgement: State of Arizona, County of Maricopa

On, July 8, 2013 before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

OFFICIAL SEAL
REBA H. PALMATIER
Notary Public - State of Arizona
MARICOPA COUNTY
My Comm. Expires Nov. 5, 2014

[Seal]

Reba Palmatier, Notary Public

1.13.2 Name and Title of Notary or Justice of the Peace

Reba Palmatier, Notary Public

1.14 State Agency Signature Kathleen A. Dunn	1.15 Name and Title of State Agency Signatory Kathleen A. Dunn, Associate Commissioner

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: Joanne P. Herrick, Attorney On: 15 Jul. 2013

1.18 Approval by the Governor and Executive Council

By: On:

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, this Agreement, and all obligations of the parties hereunder, shall not become effective until the date the Governor and Executive Council approve this Agreement ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

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

5. CONTRACT PRICE/PRICE LIMITATION/PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to

permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

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

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

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

8. EVENT OF DEFAULT/REMEDIES.

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

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

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

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/PRESERVATION.

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

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

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

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

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

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

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

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $250,000 per claim and $2,000,000 per occurrence; and
14.1.2 fire and extended coverage insurance covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.
14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than fifteen (15) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to endeavor to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than ten (10) days prior written notice of cancellation or modification of the policy.

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

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

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

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

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

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

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

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

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

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

Remainder of page intentionally left blank

EXHIBIT A

1. Introduction.

1.1. Purpose.

The purpose of this Agreement is to set forth the terms and conditions for the Health Services Advisory Group (HSAG) to provide external quality review services for healthcare systems providing healthcare to New Hampshire Medicaid beneficiaries in order to ensure the quality, timeliness of, and access to care and services provided to beneficiaries who enrolled in an MCO Health Plan and to beneficiaries in the Fee for Service (FFS) programs.

1.2. Agreement Period.

The initial term of this Agreement shall be for three years, from July 25, 2013 through July 30, 2016. The New Hampshire Department of Health and Human Services (DHHS) in its sole discretion may decide to offer two (2) additional periods of two (2) years each, for a total Agreement term of seven (7) years.

2. Acronyms.

2.1. Acronyms.

The following table lists definitions for acronyms used throughout this document:

BBA	Balanced Budget Act of 1997
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CHIP	Children's Health Insurance Program
CSHCN	Children with Special Health Care Needs
DHHS	New Hampshire Department of Health and Human Services
ED	Encounter Data
EDMS	Encounter Data Management System
EQRO	External Quality Review Organization
EQR	External Quality Review
FFP	Federal Financial Participation
FFS	Fee for Service

FFY	Federal Fiscal Year
FTE	Full-Time-Equivalent
G&C	Governor and Executive Council
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HSAG	Health Services Advisory Group
HSH	Health Services Holdings, Inc.
LTC	Long Term Care
MCO	Managed Care Organization
MCIS	Managed Care Information System
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assessment
NH	New Hampshire
NHDHHS	New Hampshire Department of Health and Human Services
OMBP	Office of Medicaid Business and Policy
PCP	Primary Care Physician
PIP	Performance Improvement Project
PRO	Peer Review Organization
QAPI	Quality Assurance and Performance Improvement Program
QIP	Quality Incentive Program
RFP	Request for Proposal
SFY	State Fiscal Year
SURS	Surveillance and Utilization Review Unit (within the Office of Improvement and Integrity)

General Terms and Conditions.

2.1. Agreement elements:

The Agreement between the parties shall consist of the following documents:

- Form P-37 Agreement, General Provisions;
- Exhibit A – Scope of Services - Statement of work for all goods and services to be provided as agreed to by State of New Hampshire DHHS and the EQRO;
- Exhibit B – Methods and Conditions Precedent to Payment;
- Exhibit C – Special Provisions - Provisions and requirements set forth by the State of New Hampshire/DHHS in addition to those outlined in the P-37;
- Exhibit D – Certification Regarding Drug Free Workplace Requirements – EQRO's Agreement to comply with requirements set forth in the Drug-Free Workplace Act of 1988;

- Exhibit E – Certification Regarding Lobbying – EQRO's Agreement to comply with specified lobbying restrictions;
- Exhibit F – Certification Regarding Debarment, Suspension and Other Responsibility Matters - Restrictions and rights of parties who have been disbarred, suspended or ineligible from participating in the Agreement;
- Exhibit G – Certification Regarding Americans With Disabilities Act Compliance – EQRO's Agreement to make reasonable efforts to comply with the Americans with Disabilities Act;
- Exhibit H – Certification Regarding Environmental Tobacco Smoke – EQRO's Agreement to make reasonable efforts to comply with the Pro-Children Act of 1994, which pertains to environmental tobacco smoke in certain facilities;
- Exhibit I – HIPAA Business Associate Agreement - Rights and responsibilities of the EQRO in reference to the Health Insurance Portability and Accountability Act;
- Exhibit J – Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance;
- Attachment 1: DHHS' RFP for EQRO Services (#13-OMBP-EQRO-02); and
- Attachment 2: HSAG's January 17, 2013 Response to RFP for EQRO Services.

2.2. Order and Interpretation of Documents.

In the event of any conflict or contradiction between the Agreement documents, the documents shall control in the above order of precedence. In the event of a dispute regarding the interpretation of Agreement terms, analysis of the these terms shall be informed by reference to DHHS' RFP for EQRO Services (#13-OMBP-EQRO-02) and HSAG's January 17, 2013 Response to RFP for EQRO Services, which shall both be incorporated within this Agreement, for any purpose, by reference hereto.

2.2.1. Delegation of Authority.

Whenever, by any provision of this Agreement, any right, power, or duty is imposed or conferred on DHHS, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner of the New Hampshire Department of Health and Human Services, unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of DHHS.

2.2.2. Errors & Omissions.

The EQRO shall not take advantage of any errors or omissions in the RFP or the resulting Agreement. The EQRO shall promptly notify DHHS of any such errors and/or omissions that are discovered.

2.3. CMS Approval of Agreement & Any Amendments.

This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to review by the Centers for Medicare and Medicaid Services

(CMS) for the purpose of determining that the State is eligible to receive the seventy-five percent EQR match in accordance with 42 C.F.R. 438.370. Prior approval of the Agreement by CMS is not required by federal or state law.

2.4. Cooperation With Other Vendors And Prospective Vendors.

DHHS may award supplemental contracts for work related to the Agreement, or any portion thereof. HSAG shall reasonably cooperate with such other vendors, and shall not commit or permit any act that may interfere with the performance of work by any other vendor, or act in any way that may place members at risk of an emergency medical condition.

2.5. Renegotiation and Reprocurement Rights.

2.5.1. Renegotiation of Agreement terms.

Notwithstanding anything in the Agreement to the contrary, DHHS may at any time during the term of the Agreement exercise its option to notify HSAG that DHHS has elected to renegotiate certain terms of the Agreement. Upon HSAG's receipt of notice pursuant to this Section, HSAG and DHHS will undertake good faith negotiations of the subject terms of the Agreement, and may execute an amendment to the Agreement.

2.5.2. Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected HSAG's Services and/or Deliverables provided during any period of the Agreement, DHHS may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Agreement or Scope of Work similar or comparable to the Scope of Work performed by HSAG under the Agreement. DHHS shall give HSAG ninety (90) calendar days advance notice of intent to replace HSAG with another EQRO or to add an additional EQRO.

2.5.3. Termination rights upon Reprocurement.

If upon procuring the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, DHHS elects to terminate this Agreement, HSAG shall have the rights and responsibilities set forth in Section 15 ("Termination"), Section 16 ("Agreement Closeout"), and Section 18 ("Dispute Resolution Process").

3. Organization.

3.1. Organization Requirements.

Registrations, Licenses, and Certifications. HSAG shall obtain a Certificate of Good Standing from the Corporations Division of the New Hampshire Secretary of State's Office, and provide a copy of this Certificate to DHHS at the time of execution of this agreement. HSAG shall provide to DHHS a Certificate of Insurance from HSAG's insurer. See also the attached contract form P-37 for additional insurance requirements. HSAG shall also provide DHHS with its Certificate of Authority or Vote.

3.2. Articles & Bylaws.

HSAG shall provide by the beginning of each Agreement year, or at the time of any substantive changes, written assurance from HSAG's legal counsel that HSAG is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under this Agreement.

3.3. Relationships.

3.3.1. Ownership and Control

3.3.1.1. HSAG is presently a subsidiary corporation under Health Services Holdings, Inc. HSAG shall notify DHHS of any person or corporation that has, or obtains over the course of this agreement, a five percent (5%) or more ownership or controlling interest in HSAG, a parent organization, subsidiaries, and/or any affiliates, and shall provide financial statements for all owners meeting this criterion [1124(a)(2)(A) 1903(m)(2)(A)(viii); 42 CFR 455.100-104 ; SMM
2087.5(A-D); SMD letter 12/30/97; SMD letter 2/20/98].

3.3.1.2. HSAG shall inform DHHS of intent or plans for mergers, acquisitions, or buy-outs within seven (7) calendar days of key staff learning of such actions.

3.3.1.3. HSAG shall inform its primary contact within DHHS by phone and by email within one business day of HSAG staff learning of any actual or threatened litigation, investigation, complaint, claim, transaction, or event that may reasonably be considered to result in material financial impact on or materially impact or impair the ability of HSAG, or any of its subcontractors, to perform under this Agreement with DHHS.

3.3.2. Prohibited Business Relationships.

HSAG shall not knowingly have a relationship with any of the following:

3.3.2.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No.12549; or

3.3.2.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 3.3.2.1. An individual is described as follows:

3.3.2.2.1. A director, officer, or partner of HSAG;

3.3.2.2.2. A person with beneficial ownership of five percent (5%) or more of HSAG's equity; or

3.3.2.2.3. A person with an employment, consulting, or other arrangement with HSAG's obligations under its Agreement with the State [42 CFR
438.610(a); 42 CFR 438.610(b); SMD letter 2/20/98].

3.3.3. HSAG shall conduct background checks on all employees actively engaged at

HSAG. In particular, those background checks shall screen for exclusions from any federal programs and sanctions from licensing oversight boards, both in-state and out-of-state.

3.3.4. HSAG shall not and shall certify that it does not employ or contract, directly or indirectly, with:

3.3.4.1 Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 or 1128A of the SSA for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

3.3.4.2. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity;

4.3.4.3. Any individual or entity excluded from Medicaid or New Hampshire participation by DHHS;

3.3.4.4. Any individual or entity discharged or suspended from doing business with the State of New Hampshire; or

3.3.4.5. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

4. Sub-Contractors.

4.1. HSAG's Obligations Regarding Subcontractors.

4.1.1. HSAG remains fully responsible for the obligations, services and functions performed by any of its subcontractors, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions had been performed by HSAG employees, and for the purposes of this Agreement, such work will be deemed performed by HSAG. DHHS shall have the right to require the replacement of any subcontractor found by DHHS to be unacceptable or unable to meet the requirements of this Agreement, and to object to the selection of a subcontractor.

4.1.2. HSAG shall have a written agreement with each of its subcontractors whereby the subcontractor agrees to hold harmless DHHS and any DHHS employees and contractors, served under the terms of this Agreement in the event of non- payment by HSAG. The subcontractor further agrees to indemnify and hold harmless DHHS, and any DHHS employees and contractors, against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or DHHS employees and contractors through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

4.2. Notice and Approval.

4.2.1. HSAG shall submit all subcontractor agreements to DHHS for prior approval at least sixty (60) calendar days prior to the anticipated implementation date of each subcontractor agreement, annually for renewals, and whenever there is a substantial change in scope or terms of the subcontractor agreement.

4.2.2. HSAG shall notify DHHS of any change in subcontractors and shall submit a new subcontractor agreement for approval ninety (90) calendar days prior to the start date of the new subcontractor agreement.

4.2.3. Approval by DHHS of a subcontractor agreement does not relieve HSAG from any obligation or responsibility regarding the subcontractor and does not imply any obligation by DHHS regarding the subcontractor or subcontractor agreement.

4.2.4. DHHS may grant a written exception to the notice requirements of 4.2.1 and 4.2.2 if, in DHHS's reasonable determination, HSAG has shown good cause for a shorter notice period.

4.2.5. HSAG shall notify DHHS within one business day of receiving notice from a subcontractor of its intent to terminate a subcontract agreement.

4.2.6. HSAG shall notify DHHS of any material breach of an agreement between the Contractor and the subcontractor within one business day of validation that such breach has occurred.

4.3. HSAG's Oversight.

4.3.1. HSAG shall oversee and be held accountable for any function(s) and responsibilities that it delegates to any subcontractor, including:

4.3.1.1. HSAG shall have a written agreement between HSAG and its subcontractor that specifies the activities and responsibilities delegated to the subcontractor; its transition plan in the event of termination, and provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

4.3.1.2. All subcontracts shall fulfill the requirements of 42 CFR 438 as are applicable to the service or activity delegated under the subcontract agreement.

4.3.1.3. HSAG shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

4.3.1.4. HSAG shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule approved by DHHS, consistent with industry standards, and with State laws and regulations.

4.3.1.5. HSAG shall audit the subcontractor's care systems at least annually to ensure that its subcontractors' performance is consistent with the Agreement between DHHS and HSAG, and whenever there is a substantial change in the scope or terms of the subcontract agreement.

4.3.1.6. HSAG shall identify deficiencies regarding its subcontractors or areas for improvement, if any, for which HSAG and its subcontractor will take corrective action. If HSAG identifies deficiencies regarding its subcontractors, or

areas for improvement, HSAG shall so notify DHHS in writing and take corrective action within seven (7) calendar days of identification. HSAG shall provide DHHS with a copy of the Corrective Action Plan for DHHS' review and approval.

4.4. Transition Plan.

4.4.1. In the event of material change, breach, or termination of a subcontractor agreement between HSAG and any of its subcontractors, HSAG's notice to DHHS shall include a transition plan for DHHS's review and approval.

5. Staffing.

5.1. HSAG shall ensure that it has qualified staff to conduct all contracted activities, and shall assign the following key personnel for the duration of this Agreement:

5.1.1. Executive Director to provide leadership and oversee all of the activities required under this agreement, and the activities of the Contract Manager;

5.1.2. Contract Manager to oversee the all of the activities of the EQRO contract with DHHS, and to be the primary point of contact within HSAG for all DHHS inquiries and requests for responsive action;

5.1.3. Project Leads for all External Quality Review activities and required tasks under the EQRO contract;

5.1.4. Chief Technology Officer to provide oversight and expertise with information technology systems and processes;

5.1.5. Reports Director to manage and develop work plans for all reports required under this agreement; and

5.1.6. Technical Writer to write, compile and prepare technical reports for publication in accordance with the terms of this agreement.

5.2. DHHS shall have the right to accept or reject any of the EQRO contractor's employees or subcontractors assigned to this project and to require their replacement at any time and for any reason given.

5.3. HSAG team members, including Horn Research, LLC, and all other HSAG sub-contractors, shall possess the qualifications, expertise, and experience necessary to perform all of their assigned duties, at the project leadership and coordination level and extending to its subject matter experts, project leads, and assigned staff. HSAG shall ensure and verify that all of its staff and subcontractors have the appropriate training, education, and experience to fulfill the requirements of the positions they hold. HSAG shall keep and maintain documentation of all individuals requiring licenses and/or certifications. HSAG shall keep documentation current, and shall make it available for inspection by DHHS.

5.4. HSAG shall staff the EQRO program, at a minimum, with all proposed staff indicated in the Listing of Personnel on pages 109 – 113 of its January 14, 2013 Response to DHHS' RFP for EQRO Services, and with any additional personnel who are or become necessary to conduct all tasks outlined in sections 8 and 9 of this Agreement on a timely basis.

5.5. HSAG shall provide to DHHS, for its review and approval, a complete listing of key personnel and their qualifications no later than thirty (30) calendar days prior to the start of the program.

5.6. HSAG shall provide and maintain sufficient staff to perform all review activities and tasks specified in this agreement. In the event that HSAG does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS will notify HSAG in writing, which may be by email correspondence, to produce a corrective action plan to remedy insufficient performance.

5.7. HSAG's contract manager shall be available to DHHS during DHHS' hours of operation and available for in-person or video-conference meetings as requested by DHHS. Key personnel, and others as required by DHHS, shall be available for monthly, in-person, or video-conference meetings as requested by DHHS.

5.8. HSAG shall notify DHHS in writing at least thirty (30) calendar days in advance of any plans to change, hire, replace, or reassign designated key personnel. HSAG shall submit the names and qualifications of proposed alternate staff to DHHS for review and approval.

5.9. HSAG shall, within thirty (30) calendar days of implementing this agreement, deliver to DHHS a staffing contingency plan that includes:

5.9.1. The process for replacement of personnel in the event of the loss of personnel before or after execution of this agreement;

5.9.2. Provision of additional staffing resources to this agreement if HSAG is unable to perform the requirements of this agreement on a timely basis;

5.9.3. Replacement of key personnel with personnel who have similar qualifications, education, and experience;

5.9.4. HSAG's ability to provide similarly qualified replacement personnel and timeframes for securing replacement personnel; and

5.9.5. HSAG's method for training and bringing replacement personnel up to date on relevant aspects of this agreement.

6. Representation and Warranties.

6.1. HSAG shall ensure and warrant that all services developed and delivered under this Agreement will meet in all material respects the specifications as described in the Agreement during the Agreement Period, including any subsequently negotiated, and

mutually agreed, specifications.

6.2. HSAG acknowledges that by entering this Agreement, DHHS has relied upon all representations made by HSAG in its Response to RFP #13-OMBP-EQRO-02, including all representation made in its Technical Proposal and Addenda, and its Cost Proposal. HSAG's January 17, 2013 Response to Request for Proposal for External Quality Review Organization (EQRO) Services, RFP #13-OMBP-EQRO-02 is incorporated within this agreement by reference hereto.

6.3 HSAG will work with the State to create timelines for the completion of the activities associated with the Contract. Within 15 business days of execution of the contract, HSAG will propose a Work Plan for approval by the State. If development, implementation, or execution of any activities is delayed due to circumstances outside the control of HSAG (i.e., delayed submission of data to HSAG by DHHS or contractors, or delay in feedback required for the production of HSAG reports, etc.), the parties agree to adjust the timeline to allow HSAG adequate time to conduct the activities.

7. Statement of the Work Beginning in the Pre-Implementation Phase of Medicaid Care Management.

7.1. HSAG will provide analysis and evaluation of aggregated information on the quality, timeliness, and access to healthcare services covered by New Hampshire Medicaid and New Hampshire Medicaid's MCOs. Pursuant to 42 CFR 438.350 and 42 CFR 438.358, HSAG will perform a variety of external quality review (EQR) activities both prior to and upon implementation of New Hampshire Medicaid's Care Management Program. These activities, as outlined below, will generate information for HSAG to use in conducting its EQRs and will serve DHHS' interest in high quality and efficient health service delivery systems within its Medicaid FFS and MCO programs.

7.2. HSAG will assist DHHS, based on its experience with the implementation and monitoring of new statewide Medicaid managed care quality programs, with New Hampshire Medicaid's migration from a Medicaid FFS program to Medicaid Care Management.

7.3. HSAG will collaborate with DHHS and MCO staffs during the development and implementation of the MCOs Performance Improvement Projects (PIPs), and the State's Quality Incentive Program (QIP) submission to provide technical assistance and training on the documentation requirements for PIPs and QIPs and the detail necessary to appropriately address all activities required by the CMS Protocols.

7.4. HSAG will validate the performance of each MCO's Quality Assessment and Performance Improvement (QAPI) program, PIPs, and the State's QIPs as they are developed and implemented, providing a comprehensive assessment of each project, and comparing the

MCO results to similar programs and to metrics for the New Hampshire Medicaid FFS population. In preparation for this comparative analysis, HSAG shall similarly assess and validate New Hampshire Medicaid's quality programs and metrics, and develop a system to facilitate comparison with MCOs' quality programs.

7.5 HSAG will provide DHHS and the MCOs with an orientation to the performance measure validation process that will include a thorough review of the process, the expectations for the MCOs, the roles of the auditors, the timeline for the activities, and measure-specific reviews.

7.6. HSAG, in consultation with DHHS staff, will evaluate, no less than annually, and propose as needed new performance measures to improve New Hampshire Medicaid FFS and MCO performance and meet new Federal and State mandates and objectives, including but not limited to incorporating the National Quality Strategy priorities into the State's FFS and MCO quality programs.

7.7. HSAG will be developing aggregate performance measures and objectives to assess healthcare services delivered and statewide health outcomes, including calculation of administrative measures for the FFS populations comparable to those calculated by the MCOs, and to allow for a comparison of the aggregate managed care population to the residual New Hampshire Medicaid FFS population. In preparation for this comparative analysis, HSAG shall evaluate New Hampshire Medicaid's FFS population measures and develop a system to facilitate comparison of MCO measures to those of New Hampshire Medicaid's FFS program. HSAG will learn about the technical specifications for the measures, identify the data sources necessary to calculate rates, and obtain appropriate data use agreements to acquire data not traditionally housed at DHHS.

7.8. HSAG will recommend to DHHS and, following approval from DHHS, will calculate additional quality of care and access to care measures and performance improvement goals for New Hampshire Medicaid's FFS program. HSAG will also validate the data associated with each measure and objective. Working with DHHS, HSAG will propose detailed quality improvement strategies to DHHS when opportunities for quality of care improvement are identified for a particular FFS program.

7.9. HSAG will be validating MCO performance measures, providing a comprehensive assessment of each measure, and comparing MCO results to similar programs or metrics for the New Hampshire Medicaid FFS population. In preparation for this comparative analysis, HSAG shall develop familiarity with existing New Hampshire Medicaid performance measures, develop and produce new measures, and develop the necessary data analytics strength to compare FFS measures to those of the MCOs.

7.10. Data Systems Development and Management.

7.10.1. HSAG is required to have information systems capable of accepting, cleaning, validating, analyzing, and submitting the required data and reports. Pursuant to 42

CFR438.358 (c)(1) and 42 CFR 438.358 (d), and in order to facilitate the transfer, testing, warehousing, and use of required data that will enable HSAG to perform all functions required under this agreement, HSAG shall, subject to the approval of DHHS, develop and implement a data transfer and management plan, that will ensure that HSAG's information systems:

7.10.1.1. Are ready to accept, test, and analyze all supplied data within a mutually agreed upon timeline from the start of the contract and throughout the life of the contract;

7.10.1.2. Are able to manage historical and ongoing FFS claims MCO encounters, provider data, beneficiary eligibility, MCO-submitted performance and quality data, and other applicable data required to carry out all functions of the EQRO review activities;

7.10.1.3. Will perform quality assurance and validations checks against the data received; will load, warehouse, and analyze data; produce ad hoc reports, and create data files for stakeholders;

7.10.1.4. Will give DHHS remote-access according to a mutually agreed upon timeline to HSAG's systems through a secure portal to allow DHHS staff or contractors to perform ad hoc queries on the data warehoused by HSAG; and

7.10.1.5. Will ensure HSAG's ability to conduct federal-level certification of encounter data for New Hampshire Medicaid and Care Management MCO programs.

7.10.2. HSAG will work closely with DHHS staff and the MCOs to understand the MCOs' capability to submit Encounter Data and DHHS' FFS data submission process and provide useful guidance based on HSAG's experience working with States. HSAG will review and suggest improvements to DHHS's encounter data submission companion guide including identifying any gaps between the guide and CMS's new MSIS process for encounter data, set up a data access protocol and user rights, and finalize a data transfer and validation plan with DHHS according to a mutually agreed upon timeline. HSAG and DHHS will discuss the scope of the validation checks. HSAG will propose critical validation indicators for the weekly validation report.

7.10.3. HSAG will draft a report template for weekly encounter data validation reports, which is subject to DHHS' approval. HSAG will use preliminary flat file data submitted by the MCOs via DHHS' gateway system to test data to generate a mock report in PDF format. Once DHHS approves the mock report, HSAG will move the entire data transfer, validation, and report generation process into production. HSAG will make the PDF version of the weekly report available to DHHS and the MCOs on a specified internet location. DHHS shall also have the capability of viewing various results, e.g. by data field or encounter data type, comparing MCO performance for various time frames, etc., on HSAG's Encounter Data Management System (EDMS).

7.10.4. HSAG shall commence weekly report generation sixty (60) days after Medicaid Care Management program commences.

7.11. HSAG shall develop a system for comparing the MCO enrollee and provider surveys with those of the FFS beneficiary and provider surveys.

7.12. HSAG shall assume the performance measurement of and conduct an evaluation of New Hampshire Medicaid's healthcare access monitoring and measurement system, consistent with current DHHS measurement and reporting, on a quarterly basis and recommend strategies to improve access to healthcare for New Hampshire Medicaid beneficiaries. HSAG's evaluation shall be in accordance with the following processes:

7.12.1. DHHS currently examines Medicaid beneficiary access to physician and clinic healthcare services in the FFS programs by monitoring data and trends in three distinct areas: 1) provider and clinic availability, and 2) utilization of healthcare services by Medicaid beneficiaries, and 3) beneficiary needs. New Hampshire Medicaid uses this analysis to systematically evaluate and monitor New Hampshire Medicaid beneficiaries' access to health care, as well as to provide for an early warning system for access disruptions. Evidence of ongoing beneficiary engagement is evaluated as well. Examples of recent DHHS' Access Monitoring reports can be found at: www.dhhs.nh.gov/ombp/publications. HSAG shall produce and maintain all of these quarterly access reports, including after MCO operations begin, by continuing to analyze and validate beneficiary access, modify or enhance monitoring systems as necessary to ensure access to a changing healthcare delivery system, and make recommendations to improve New Hampshire Medicaid beneficiaries' access to healthcare providers.

7.12.2. HSAG shall produce DHHS' quarterly healthcare access report for the State and CMS commencing with the production of the July-September 2013 report by November 15, 2013.

7.13. HSAG shall annually validate adult and child core set measures New Hampshire will submit to CMS as part of CMS's Quality of Care Performance Measurement program. HSAG shall also calculate New Hampshire Medicaid statewide population measures required by the Balancing Incentives Program (BIP), and the New Hampshire State Innovations Grant Measures.

7.14. HSAG shall perform provider-specific or specialty-specific immediate reviews, as requested by New Hampshire Medicaid, in response to beneficiary grievances, concerns regarding access to care, or in response to other concerns from DHHS, Medicaid beneficiaries, or providers.

7.15. Pre-MCM Implementation Additional Services Related to Other EQRO Activities
At the discretion of DHHS, HSAG may be asked to provide additional services related to external quality review activities. These activities may include, but not be limited to, performance measure calculation, CAHPS survey administration, or provider survey administration. All requests for additional services shall be transmitted in writing from DHHS to HSAG and will include, at a minimum, the following:

7.16.1 A description of the major functions, tasks, and activities required;
7.16.2 The requested timeline/due dates for any reports or identified deliverables;
7.16.3 Specifications as to the format of the desired deliverable;
7.16.4 A listing of HSAG's project requirements; and
7.16.5 Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or tasks expected.
7.16.6. HSAG will submit to the DHHS, for approval, its cost proposal for completing the additional service requested according to the scope detailed in the DHHS written request.

8. Statement of the Work Beginning in the Post-Implementation Phase of Medicaid Care Management.

8.1. Evaluation of MCO Programs and Projects.

8.1.1. HSAG shall validate, in accordance with 42 CFR 438.358 (b)(1) and consistent with the most recent federal CMS Protocols for EQR activities, each MCO's Performance Improvement Projects (PIPs) required by DHHS and undertaken by the MCO during the preceding twelve months. DHHS contractually requires the MCOs to have a comprehensive Quality Assurance and Performance Improvement program (QAPI) for their operations and for the services they furnish to their members. The purpose of these QAPI programs is to assess and improve health care delivery processes and health outcomes of care. Within their QAPI programs, the MCO will undertake four (4) PIPs. HSAG will assist in the development and implementation, review, validate, and evaluate these programs and projects in a manner consistent with the most recent federal CMS protocols for EQR activities and the three-stage approach, Design, Implementation, and Outcomes, and will assist with or recommend design improvements to current MCO quality improvement plans.
8.1.2. Section 20.6 of the New Hampshire Medicaid's Care Management contract provides for additional performance improvement projects through its MCO Quality Incentive Program (QIP). The MCOs are eligible for specified monetary incentives for improved performance on four measures chosen by DHHS each contract year. HSAG shall review, validate, and evaluate these programs in a manner consistent with the federal CMS protocols for EQR activities and will assist with or recommend design improvement to the QIPs.
8.1.3. HSAG will assist the MCOs and provide explicit instructions regarding the completion and submission of a PIP and QIP Summary Form for review and validation up until the time of validation by HSAG. HSAG will evaluate and score each of the ten CMS PIP and QIP protocol steps with the three-stage study format using its PIP and QIP evaluation tool. The tool will assess each evaluation element within a given activity and produce and element score of Met, Partially Met, Not Met, Not Applicable, or Not Assessed based on the PIP or QIP documentation and study indicator outcomes submitted by the MCO. HSAG will designate as critical elements some of the evaluation elements deemed pivotal to the PIP and QIP

process. For the PIP or QIP to produce valid and reliable results, all critical elements have to, at minimum, be Met.

8.1.4. HSAG will validate and report on the performance of each MCO's Quality Assessment and Performance Improvement (QAPI) program, Performance Improvement Projects (PIPs) every six months, and the State's Quality Incentive Program (QIP) every six months. At 6 months the EQRO will provide an interim assessment of each of PIPs and QIPs; after 12 months, the EQRO will provide a comprehensive assessment of each PIP project and QIP and compare the MCO results to similar programs or metrics for the New Hampshire Medicaid FFS population and other states' Medicaid managed care programs and the New Hampshire commercial population.

HSAG's six-month interim evaluation will include:

8.1.4.1. An assessment and validation of the first stage of PIP and QIP(Design) to ensure that it is structured in a methodologically sound manner and that it will study what it is intended to study;

8.1.4.2. Background information on the areas evaluated, the methods used to conduct the evaluation, the findings or results, and a scored validation tool for each PIP and QIP;

8.1.4.3. A critical assessment of each PIP and QIP and whether the studies were consistent with the strategy detailed and applied valid statistical data analysis in each MCO's QAPI strategy; and

8.1.4.4. HSAG recommendations to strengthen the design of the PIP and QIP and/or to improve any planned interventions considered by the MCO.

HSAG's twelve-month comprehensive assessment shall include:

8.1.4.5. An evaluation of the MCOs' baseline data collection and analysis (Implementation Stage);

8.1.4.6. A validation of the PIP and QIP through the outcomes stage, once the PIP or QIP has progressed to a point of re-measurement, to determine if changes in indicator rates were statistically significant improvement and capable of being sustained over time; and

8.1.4.7. Recommendations for program improvement.

8.1.5. HSAG shall provide technical assistance to, consult with, and support DHHS and the MCOs prior to PIP and QIP submission with respect to the documentation requirements for PIPs and QIPs, and the level of detail necessary to address all of the activities required by the CMS Protocols.

8.2. Evaluation of MCO Measures and Medicaid Population Measures.

8.2.1. HSAG, pursuant to 42 CFR 438.358(b)(2) and consistent with the most recent CMS protocols, shall validate MCO performance measures that the MCOs report to DHHS to comply with Quality requirements set forth in 42 CFR 438.240, and those quality performance measures that DHHS contractually requires of the MCOs. These performance measures, included as Exhibit O in the NH Medicaid Care Management contract, shall be validated by HSAG including validation of the MCOs' CAHPS

Survey methodology. HSAG activities will incorporate any later revisions of the Medicaid Care Management contract or Quality Strategy made by DHHS including those arising from the inclusion of any additional services and populations into the Care Management Program as well as response to changing situations and the needs of the New Hampshire Medicaid Program and any state or federal laws, regulations, and other policies.

8.2.2. HSAG will validate performance measures calculated and submitted annually by the contracted MCOs using NCQA's HEDIS Compliance audit, standards, policies and procedures.

8.2.3. HSAG shall provide DHHS and the MCOs with an orientation to the performance measure validation process that will include a thorough review of the process, the expectations of the MCOs, the role of the auditors, the timeline of activities, and the measure-specific reviews. HSAG will provide technical assistance to DHHS and the MCOs as needed.

8.2.4. HSAG shall validate the sample frame for MCO and DHHS CAHPS surveys. HSAG will be required to validate MCO sample frames for the annual consumer and/or provider surveys, such as CAHPS, and ensure MCOs include sufficient oversampling to allow each individual MCO to be evaluated, regarding satisfaction with MCOs and the quality of and access to care provided therein, and to compare survey results with the results of surveys of consumer and provider satisfaction with New Hampshire Medicaid FFS programs.

8.2.5. HSAG shall review the MCOs' medical record review and record procurement process, including supervisor and staff qualifications, training of reviewers, hybrid abstraction tools, and quality assurance testing of review results adhering to all of NCQA's medical record review requirements and timelines.

8.2.6. HSAG shall conduct an annual on-site initial audit of the MCOs, which shall include interviews relative to the documentation processes used to collect, store, validate, and report performance measure data, and an information system assessment focusing on the processing of claims and encounter data, enrollment data, and provider data. Year one audit will limited to a review of source code.

8.2.7. Within two weeks of the completion of an initial audit, HSAG shall provide a written report based on the initial audit findings. This report will identify perceived issues of noncompliance, problematic measures, and recommended opportunities for improvement.

8.2.8. HSAG shall validate performance measures no less than annually. HSAG will compare reported rates to national and/or regional benchmarks, including but not limited to other states' managed care and New Hampshire Commercial population data, and will compare the eligible populations to benchmarks for eligible populations. HSAG will alert the MCO and DHHS of any issue or potential problem with a measure and then work with the MCO to correct the issue or minimize its impact on reporting.

8.2.9. Within forty-five calendar days of its receipt of the final rates for the measures, HSAG shall provide DHHS with a report of the final validation findings. This report,

among other things will make conclusions and recommendations for improvement. On an annual basis, HSAG will include the results in the EQR Technical Report and provide a comprehensive assessment of each performance measure. The results will compare the MCO results to the New Hampshire Medicaid FFS populations and other similar programs and metrics, and to NCQA national percentiles and Quality Compass.

8.2.10. Following the annual report, HSAG shall meet with DHHS to discuss and recommend new and/or additional performance measures, and new or updated performance improvement goals. HSAG, in collaboration with DHHS, will develop and produce aggregate performance measures and objectives to assess health care services delivered and statewide health measures and outcomes, and to allow for a comparison of the aggregate managed care population to the residual New Hampshire Medicaid FFS population. Consistent with federal guidelines, the above measures and objectives must be clear, verifiable, and statistically valid.

8.2.11. HSAG will also validate the data associated with each new measure and objective. Working with DHHS, HSAG will propose detailed quality improvement strategies to DHHS when opportunities for quality of care improvement are identified for a particular MCO or program. DHHS has a particular interest in those measures and objectives relating to the health of pregnant women, the elderly, and beneficiaries with special health care needs.

8.3. MCO Contractual Compliance.

8.3.1. HSAG shall conduct a review, pursuant to 42 CFR 438.358 (b)(3) and CMS Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations (revised September 2012), to determine the MCOs' compliance with contract provisions requiring the MCOs to submit performance measurement data relative to the quality, appropriateness, and timeliness of, and access to care and services furnished to all New Hampshire Medicaid enrollees under MCO contracts, and shall conduct a comparative review of health care services furnished to Medicaid beneficiaries, not yet enrolled or waiting to re-enroll in an MCO, and covered under the New Hampshire Medicaid FFS Program. Over the course of the three- year EQRO contract, HSAG will conduct these reviews on an annual basis. HSAG shall validate each MCO's quality program and compliance with New Hampshire's Quality Strategy.

8.3.2. Following review, and in its annual compliance report, HSAG will identify and describe those areas in which the MCOs are less than fully compliant and require corrective action. HSAG will provide compliance review tools with its findings and a template for the MCOs to document their proposed corrective action plans (CAPs) for each requirement that HSAG scored as less than met. HSAG will conduct a review and document its assessment of the CAP's potential for resolving performance areas not fully compliant. If HSAG determines that the CAPs as proposed are insufficient to resolve deficiencies in a timely manner, HSAG will describe the deficiencies and recommend revisions to DHHS. HSAG shall provide technical assistance to the MCO to re-develop its CAP and monitor it to ensure that the MCO makes progress is

resolving any deficiencies.

8.3.3. HSAG's annual review in the second year of the contract and each annual review thereafter will include a review of the previous year's CAPs, an assessment of the degree to which the MCOs' implementation of CAP activities resulted in full compliance.

8.4. Management and Validation of Encounter Data.

8.4.1. Pursuant to 42 CFR 438.358(c)(1), HSAG shall validate encounter data reported by the MCOs to DHHS in accordance with the New Hampshire Medicaid Care Management contract, and issue weekly reports concerning the validity of this encounter data.

8.4.2. In collaboration with DHHS and the MCOs, HSAG shall develop an encounter data transfer and validation process within New Hampshire's Medicaid Management Information System (MMIS). This process would validate encounter data, accept/reject reported encounters, detect data patterns, such as under- or over-reporting of data over time and utilization patterns, and that would validate claims and provider data. HSAG will validate the performance of the MCOs through development of the encounter data exchanged between DHHS and the MCOs, validate the data actively exchanged, and consult with DHHS to improve data validation for DHHS' MMIS.

8.4.3. HSAG shall also conduct additional validation annually by comparing all encounters submitted by the MCOs to DHHS against the encounters residing in the MCOs' data systems. The results of this annual validation will serve as the basis for HSAG's federal-level Encounter Data certification and shall be due to DHHS and CMS on August 1st of each year.

8.4.4. During the validation process, HSAG shall evaluate the extent to which MCOs submit complete and accurate data to DHHS based on their claims processing systems. HSAG shall report results to DHHS using a summary report containing the MCO-specific findings and aggregate-MCO results. HSAG will also prepare a certification letter for each MCO, attesting the level of completeness and accuracy of the Encounter Data submitted by the MCO to DHHS. HSAG will provide technical assistance to DHHS and the MCOs to reach an agreed upon level of consistency and accuracy in the encounter data.

8.4.5. HSAG shall provide ongoing technical assistance to DHHS, to DHHS' MMIS, and to the MCOs as deficiencies are discovered throughout the encounter data validation process to improve data accuracy and completeness.

8.5. Member and Provider Surveys.

Pursuant to 42 CFR 438.358 (c)(2), HSAG shall validate annual consumer and/or provider surveys in Contract Years 2 and 3, such as CAHPS, regarding satisfaction with MCOs and the quality of and access to care provided therein, and allow for subpopulation analysis. In Contract Year 1, HSAG will conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for the DHHS. The 2013 CAHPS Survey Project will include administration of the CAHPS 5.0 Child Medicaid Survey with the Healthcare Effectiveness

Data and Information Set (HEDIS®) supplemental item set and the Children with Chronic Conditions (CCC) measurement set to the Child Medicaid Fee-for-Service (FFS) and Children's Health Insurance Program (CHIP) populations. HSAG will validate MCO CAHPS Surveys to determine network adequacy. HSAG will work with the MCOs to communicate documentation and data needs. Consistent with CMS' current version of the Administering or Validating Surveys Protocol, HSAG shall:

8.5.1. Evaluate DHHS' goals and intended use of the survey results;

8.5.2. Review intended survey audience and determine whether survey is appropriate for the audience and that the most appropriate population is being evaluated to yield meaningful information;

8.5.3. Evaluate the selected beneficiary and provider survey instruments to ensure that they are consistent with the survey purposes, objectives and units of analysis;

8.5.4. Evaluate the study populations, subpopulations, sample frame criteria, sampling strategies, sample sizes, and sample selection;

8.5.5. Identify and recommend strategies to DHHS and the MCOs to maximize survey response rates. HSAG will also assess the effectiveness of the MCO and DHHS sampling strategies and evaluate the extent to which potential sources of nonresponse may have introduced bias into survey findings;

8.5.6. Perform comprehensive analyses of provider and consumer satisfaction (CAHPS) survey data in accordance with NCQA specifications and using an alpha level of 0.05 to determine statistical significance; and

8.5.7. Document the survey process and results with data-driven and aggregate reports for the provider survey and CAHPS validation activities.

8.6. Additional Performance Measures.

Pursuant to 42 CFR 438.358(c)(3), the EQRO will calculate administrative performance measures, in addition to those contractually required and reported by the MCOs, and validated by HSAG in section 8.2. HSAG will evaluate the performance of the MCOs through the development and use of performance measures across MCOs, the development and use of aggregated performance measures to compare MCOs to the FFS program, the provision of appropriate comparison to other Medicaid MCOs and commercial populations, the validation of the performance of DHHS' Adult Medicaid Quality grant and other grants, the measurement of performance of any HSAG-developed projects, and the validation of performance of other Medicaid quality measures as needed. In connection with the development of additional performance measures, HSAG shall:

8.6.1. Review the current set of performance measures employed by DHHS, which are posted and updated on an ongoing basis on the DHHS Medicaid Quality Indicators website, and make recommendations regarding enhancements to current measures;

8.6.2. Calculate aggregated performance measures that will be used to compare the MCO population to the FFS population;

8.6.3. Collaborate with DHHS to select and calculate measures for which comparative information exists, and ensure that the comparison of performance across Medicaid and commercial populations is appropriate based on measure

specifications used to derive the rates independently for each population;

8.6.4. Assist DHHS in validating and measurement of the Adult Medicaid Quality measures;

8.6.5. Collaborate with DHHS to define appropriate measures that evaluate the utility and effectiveness of EQRO-developed projects; and

8.6.6. Employ the current CMS protocols for validation of all performance measures, including other Medicaid quality indicators.

8.7. EQRO Performance Improvement Projects.

Pursuant to 42 CFR 438.358(c)(4), HSAG shall conduct performance improvement projects in addition to those contractually required of and conducted by the MCOs, and validated by HSAG. These additional performance improvement projects shall include the following:

8.7.1. Access to Healthcare.

8.7.1.1 HSAG shall evaluate the MCOs' and New Hampshire Medicaid's statewide healthcare access monitoring and measurement system on a quarterly basis and recommend strategies to improve access to healthcare for New Hampshire Medicaid beneficiaries.

8.7.1.2. DHHS currently examines Medicaid beneficiary access to physician and clinic healthcare services by monitoring data and trends in three distinct areas: 1) provider and clinic availability, and 2) utilization of healthcare services by Medicaid beneficiaries, and 3) beneficiary needs. New Hampshire Medicaid uses this analysis to systematically evaluate and monitor New Hampshire Medicaid beneficiaries' access to health care, as well as to provide for an early warning system for access disruptions. Evidence of ongoing beneficiary engagement is evaluated as well. Examples of recent DHHS' Access Monitoring reports can be found at: www.dhhs.nh.gov/ombp/publications. HSAG will maintain all of these access reports, by continuing to analyze and validate beneficiary access, modify or enhance monitoring as necessary to ensure access to a changing healthcare delivery system, and make recommendations to improve New Hampshire Medicaid beneficiaries' access to healthcare providers.

8.7.1.3. HSAG will assume the production of quarterly healthcare access report for the State and CMS no later than October 1, 2013 for the November 15, 2013 quarterly report to CMS. This Medicaid beneficiary access analysis and evaluation shall include:

8.7.1.3.1. Analysis of geographic provider availability using the current New Hampshire Medicaid access indicators and New Hampshire Medicaid Care Management Contract standards set forth in the Table 1 below:

Table 1: Provider Access Distance Standards

Provider Type	Number of Providers Available Statewide
PCPs	Two (2) within forty (40) minutes or fifteen (15) miles

Specialists	One (1) within sixty (60) minutes or forty-five (45) miles
Hospitals	One (1) within sixty (60) minutes or forty-five (45) miles
Mental Health Providers	One (1) within forty-five (45) minutes or twenty-five (25) miles
Pharmacies	One (1) within forty-five (45) minutes or fifteen (15) miles
Tertiary or Specialized services (Trauma, Neonatal, etc.)	One within one hundred twenty (120) minutes or eighty (80) miles

8.7.1.3.2. Analysis of provider availability by provider type;

8.7.1.3.3. Analysis of the availability of providers and specialists for children with special health care and mental health and behavioral healthcare needs; and

8.7.1.3.4. Timeliness standards validation taking into consideration the standards set forth in the Table 2 below:

Table 2: Provider Access Timeliness Standards

Visit Type	Timely Service Delivery (calendar days unless otherwise specified)
Transitional Care after Inpatient Discharge	7 calendar days for physician; 2 calendar days for nurse or counselor
Non-symptomatic and Preventive Care	30 calendar days
Non-urgent, Symptomatic Care	10 calendar days
Urgent, Symptomatic Care	48 hours
Emergency Medical and Psychiatric Care	24 hours, seven days per week
Behavioral Health Care: Routine Care	10 calendar days
Behavioral Health Care: Urgent Care	48 hours
Behavioral Health Care: Non-life Threatening Emergency	6 hours

8.7.1.4. HSAG shall meet with DHHS staff to obtain detailed information regarding the production of the existing quarterly access reports, and its approach to conducting additional access to healthcare analysis and evaluation activities. HSAG will draft a comprehensive methodology document to describe the details of generating the quarterly access reports and to propose the analytic approach in conducting the four evaluation activities.

8.7.1.5. HSAG shall analyze the FFS provider access and availability associated with the four additional analyses of access with Quest Analytics software to conduct the analysis of geographic provider availability for the FFS population. HSAG will:

8.7.1.5.1. Geo-code the FFS beneficiary addresses and provider addresses before performing the time/distance analyses;

8.7.1.5.2. Calculate beneficiary-provider ratios to evaluate the FFS provider availability by provider types;

8.7.1.5.3. Perform time/distance analyses to evaluate spatial accessibility to providers; and

8.7.1.5.4. Conduct an annual access and availability survey, which shall be conducted throughout the year on a list of sampled FFS providers. The scope of the survey will be provided in HSAG's comprehensive methodology, along with the process of sample generation, scripted scenarios based on standards, survey process, and proposed analyses associated with the survey.

8.8. DHHS Grant Support.

HSAG shall, adhering to the periodicity set in its listing of adult quality measures, but no less than annually, validate MCO health plan adult quality measures, validate the New Hampshire Medicaid populations CMS Adult Medicaid Quality Indicators measures and collaborate with DHHS to calculate and/or validate additional quality measures developed through the Adult Medicaid Quality grant-related work. HSAG shall also validate MCO health plan population measures and calculate New Hampshire Medicaid population measures required by the Balancing Incentives Program (BIP), and the New Hampshire State Innovations Grant Measures.

8.9. Other Performance Improvement Projects.

In consultation with DHHS, HSAG shall recommend other quality improvement processes or best practices for New Hampshire MCOs. HSAG shall also recommend and conduct other performance improvement projects and calculate related measures as needed. HSAG shall discuss its recommendations for additional performance improvement projects with DHHS, and conduct two agreed upon additional performance improvement projects per year.

8.10. EQRO Studies on Clinical and Nonclinical Services.

Pursuant to 42 CFR 438.358 (c)(5), HSAG shall conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

8.10.1 Direct Member Feedback through Beneficiary Focus Groups. HSAG, through its subcontractor, Horn Research, will conduct a quality study on beneficiary satisfaction with their health and the healthcare services provided through their MCOs and by New Hampshire Medicaid. This will require HSAG to establish, convene, and facilitate Medicaid beneficiary focus groups to discuss health care issues. HSAG shall be required to:

8.10.1.1. Utilize staff, Horn Research, or other qualified subcontractors with demonstrable experience with Medicaid populations and with appropriate technical expertise in forming and facilitating focus group discussion and individual participation;

8.10.1.2. Build focus groups comprised solely of Medicaid health plan beneficiaries and families or caregivers for direct beneficiary input (these focus groups are intended to be a forum for beneficiaries rather than a forum for providers or advocacy organizations), including participants representing each of the following Medicaid beneficiary subpopulations: parents of low-income children, low-income adults, and persons with physical and mental health disabilities;

8.10.1.3. Convene beneficiary focus groups bi-annually on topics of interest approved by DHHS, to Medicaid beneficiaries, and their family members or caregivers, regarding relevant healthcare delivery issues, especially as they pertain to managed care healthcare delivery;

8.10.1.4. Offer incentives, travel reimbursement, food and beverages at group meetings, to beneficiaries to participate in the focus groups;

8.10.1.5. Strive to record each focus group session electronically (only after appropriately notifying participants) and record each focus group by a note taker;

8.10.1.6. Encourage, educate, train and coach participants to freely express their opinions and experiences and provide confidentiality to participants; and

8.10.1.7. Summarize focus groups findings and provide recommendations for improvements for DHHS and the MCOs in response to actionable items within 30 calendar days of the focus group meeting. Each report shall also include an update of any activities on actionable items from the previous meetings.

8.10.2. MCO/DHHS Quarterly Meetings.

HSAG shall convene the MCOs and DHHS on quarterly basis to:

8.10.2.1. Coordinate and standardize the quality work performed by the MCO's and New Hampshire Medicaid's FFS program;

8.10.2.2. Make recommendations to the State and the MCOs on developing a quality strategy to harmonize with the National Quality Strategy with a written report to DHHS of HSAG recommendations no later than three (3) months after the start of each state fiscal year;

8.10.2.3. Plan, organize, and prepare for quarterly MCO meetings and collaborate with DHHS in the running of and reporting out, to include open items, actionable items, person accountable and time frame for completion, from the quarterly meetings; and

8.10.2.4. Conduct local, New Hampshire based, quarterly meetings in collaboration with DHHS, and identify areas of highest importance and interest for DHHS and the MCOs.

8.10.3. "Just in Time" Provider Reviews.

HSAG shall perform provider-specific or specialty-specific immediate reviews, as requested by New Hampshire Medicaid, in response to beneficiary grievances, concerns regarding access to care, or in response to other concerns from DHHS, Medicaid members, or providers. HSAG will function as an independent reviewer and will assist DHHS in investigating and resolving specific medical care complaints, provider complaints, health plan complaints, and broader systemic problems on a timely basis, and in providing ad hoc reviews as requested by DHHS. HSAG will report twice per year on the "just in time" reviews, noting trends, and any corrective action undertaken to resolve substantive concerns. HSAG shall conduct the immediate review according to the following procedure:

8.10.3.1. Upon receipt of a referral from DHHS, HSAG will obtain

appropriate records and/or gather other information and/or data pertinent to the review and consult with DHHS to determine the reason for the review;

8.10.3.2. HSAG will collect and review all relevant documentation specific to the case no later than ten (10) calendar days after DHHS referral, including but not limited to beneficiary medical records, and correspondence containing relevant information, claims or other data, regarding the case;

8.10.3.4. HSAG will identify and engage an independent Physician Advisor for the review;

8.10.3.5. HSAG's Physician Advisor will review applicable documentation, and within two (2) calendar days may determine that no concern exists; or the complaint, care concern, or grievance issue is confirmed; or a systemic problem is identified; and HSAG will provide recommendations to DHHS;

8.10.3.6. HSAG will forward the Physician Advisor's determination of an identified concern to its Chief Medical Officer (CMO), who will respond to the DHHS referral by letter within five (5) calendar days on the CMO's determination; and

8.10.3.7. HSAG shall immediately notify DHHS if it identifies a threat to the health and/or safety of a beneficiary, a fraudulent action, or determines that urgent remedial action is required.

8.10.4. Fraud, Waste, and Abuse Monitoring and Reporting.

HSAG shall report promptly all suspected fraud and abuse to DHHS Program Integrity, should HSAG identify potential fraud or abuse while performing the activities listed in the scope of work.

8.10.5. Additional Quality Studies.

DHHS will identify and/or HSAG will recommend additional focused quality studies. HSAG will collaborate with DHHS to plan the detail for the scope of the study topic, and develop a formal statement to address the study question and purpose and submit to DHHS no later than six months after the start of the EQRO contract and annually thereafter. Upon DHHS approval, HSAG will:

8.10.5.1. Develop and draft, using the current CMS protocols for conducting Focused Studies of Health Care Quality as a guideline, the topic study design that defines the goals of the study, the questions to be answered, sampling methodology, the type of data to be collected, and the tools to be used in data collection and the statistical analysis undertaken;

8.10.5.2. Collect data;

8.10.5.3. Conduct statistical analyses in alignment with previously defined analysis plans developed from the study methodology; and

8.10.5.4. Generate and report the analytic results and prepare a summary of conclusions and recommendations. A draft report will be produced within forty-five calendar days after record procurement is complete, and will include an executive summary, a summary of study methodology and data collection

process, a results section and a conclusion and recommendations section for the study.

8.10.6. Education and Training.

Pursuant to 42 CFR 438.358 (d), HSAG shall provide additional technical guidance, at the direction of DHHS, to the staff of the MCOs to assist them in conducting activities related to the review activities outlined above, and to provide other support for new initiatives and review activities. HSAG shall present a calendar of educational training events, including those activities referenced in Section 8.10.6-8.10.8, for the ensuing state fiscal year, no later than 30 calendar days prior to the start of each state fiscal year for DHHS review and approval.

8.10.7. Annual Meeting.

8.10.7.1. HSAG shall conduct annual quality improvement initiative and best practices trainings and conferences for the MCOs and DHHS staff. In collaboration with DHHS, HSAG's Quality Forums, may include such topics as:

8.10.7.1.1. MCO best practices that result from performance improvement goal projects;

8.10.7.1.2. Other States' or commercial payer quality improvement strategies and interventions;

8.10.7.1.3. How to present data and write a good report on that data;

8.10.7.1.4. Statistical methods for non-statisticians;

8.10.7.1.5. How to work with encounter and claims data to improve quality;

and

8.10.7.1.6. Discussion and development of future directions for performance improvement.

8.10.7.2. HSAG will contribute, in collaboration with DHHS, to identifying and defining a conference theme, speakers, and relevant materials. There will be one major conference with the MCOs every calendar year. HSAG will procure a New Hampshire conference site and speakers, and will handle all logistics for the event (refreshments, registration, preparation of conference materials, and evaluation).

8.10.8. Brown Bag Luncheons.

HSAG will conduct focused "Lunch and Learn" informative meetings every four months for all interested DHHS and MCO staff. HSAG may conduct trainings, educational/learning meetings, and presentations by Webinar or on-site with DHHS and the MCOs on topics jointly selected by DHHS with input HSAG. HSAG shall prepare the draft agenda and written materials for each forum. Upon review and approval by DHHS, HSAG will send the final documents to DHHS.

8.11. Additional Services Related to Other EQRO Activities

At the discretion of DHHS, HSAG may be asked to provide additional services related to

external quality review activities. These activities may include, but not be limited to, performance measure calculation, CAHPS survey administration, or provider survey administration. All requests for additional services shall be transmitted in writing from DHHS to HSAG and will include, at a minimum, the following:

8.11.1 A description of the major functions, tasks, and activities required;

8.11.2 The requested timeline/due dates for any reports or identified deliverables;

8.11.3 Specifications as to the format of the desired deliverable;

8.11.4 A listing of HSAG's project requirements; and

8.11.5 Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or tasks expected.

8.11.6. HSAG will submit to the DHHS, for approval, its cost proposal for completing the additional service requested according to the scope detailed in the DHHS written request.

9. EQRO Technical Report

9.1. Pursuant to 42 CFR 438.364(a)(1), HSAG shall produce a detailed Technical Report, based on an annual, external quality review (EQR) conducted pursuant to 42 CFR 438.350 (a) for each MCO participating in New Hampshire Medicaid's Care Management program. The report, which HSAG will prepare in accordance with the current CMS Protocols for technical reports, will describe how data was aggregated and analyzed, and how conclusions were drawn regarding the quality, timeliness, and access to care provided by each of the MCOs and DHHS. With respect to this Technical Report, HSAG shall:

9.1.1. Comply with 42 CFR 438.364 and all relevant federal and State regulations

9.1.2. Collaborate with New Hampshire Medicaid, which will provide its data files to HSAG for each of the MCOs and for its fee-for-service program in accordance with the systems and data transfer plan developed by HSAG and DHHS. As part of its annual reporting on each MCO and related fee-for-service population, HSAG shall prepare one aggregate report to include a sub-section for each of the MCOs, a comparative report across the MCOs, and reporting on the statewide NH Medicaid population, in accordance with 42 CFR 438.364. Specifically, HSAG's Technical Report shall include the following information:

9.1.2.1. A description of the manner in which data from all MCO activities was aggregated and analyzed, and the way in which conclusions were drawn from the data on quality, timeliness, and access to care provided by the MCO. The report shall also include for each activity, analysis and comments regarding the following:

9.1.2.1.1. The objective of the MCO activity and the objective of the EQRO oversight function;

9.1.2.1.2. The technical methods of data collection and analysis;

9.1.2.1.3. A description of the data obtained; and

9.1.2.1.4. The conclusions drawn from the data.

9.1.2.2.An assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients;

9.1.2.3. Recommendations for improving the quality of health care services furnished by each MCO;

9.1.2.4. Information across the State's three MCO programs, including sub-population analysis, provided in a format allowing for comparisons of required activities;

9.1.2.5.New Hampshire Medicaid population-based measurement and analysis; and

9.1.2.6. An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This EQRO activity will commence during the first year of New Hampshire Medicaid Care Management program operations.

9.1.3. HSAG shall submit a draft of the Technical Report to DHHS for review and approval or comment no later than October 15 of each contract year. After DHHS' review, HSAG will discuss the report with DHHS and revise the report as indicated. Once approved, HSAG will prepare the final report, due to DHHS and CMS no later than December 1 of each contract year, and submit it to DHHS in the formats and number of copies requested.

9.1.4. Because the data and documentation available for each of the activities may be incomplete for use in preparing the EQRO first year annual reports, HSAG will collaborate with DHHS to identify any limitations and reservations about the completeness and accuracy of the data HSAG uses, and will document any cautions related to drawing conclusion about the data and findings.

10. Crosswalk between Federal EQRO Regulations, NH Medicaid EQR Scope of Work, and the New Hampshire Care Management Program

10.1. A summary of the federal and State of NH EQRO review activities required are set forth in Table 3 below:

Table 3: EXTERNAL QUALITY REVIEW-RELATED ACTIVITIES	
42 CFR 438.358 Referenced and Summarized Content	**New Hampshire Care Management EQR Strategy**
42 CFR 438.358(b) For each MCO, the EQR must include information from the following activities:	
• Validation of performance improvement projects required by the State	• The EQRO will validate the performance of MCOs' QAPI PIP and QIP
• Validation of MCO performance measures	• The EQRO will validate the performance

reported	measures included as Exhibit O in the NH Medicaid Care Management contract, including validation of the MCOs' CAHPS Survey methodology
• A review to determine the MCO's compliance with standards established by the State in the Quality Strategy	• The EQRO will validate the MCO's program and contract compliance with the State's Quality Strategy
42 CFR 438.358(c) The EQR may include information derived during the preceding 12 months from the following optional activities:	
(1) Validation of encounter data reported by an MCO	• The EQRO will validate the performance of the MCOs through: • Development of the plan for encounter data exchanged between the MCOs, State, and the EQRO, and • Validation of the data actively exchanged • Consultation on validations that can be implemented in New Hampshire's MMIS
(2) Validation of consumer or provider surveys of quality of care.	• The EQRO will administer or validate the performance of MCO through: • Evaluating network adequacy, • Validating survey data generated by the MCOs
(3) Calculation of performance measures in addition to those reported by an MCO and validated by an EQRO.	• The EQRO will validate the performance of MCO through the calculation of: • Measures to compare across MCOs, • Aggregated measures to compare MCOs to FFS, • Statewide NH Medicaid population measures, • The EQRO will validate the performance of the State's Adult Medicaid Quality Grant, • The EQRO will measure the performance of any EQRO projects, • The EQRO will validate the performance of other Medicaid quality measures as needed.
(4) Conduct of performance improvement projects in addition to those conducted by an MCO and validated by an EQRO.	• Monitoring Access to Care in New Hampshire Medicaid Program • CMS Adult Medicaid Quality Grant measures validation • Balancing Incentives Program Quality Measures • State Innovations Grant Measures • Other measures as needed
(5) Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.	• Beneficiary Focus Groups • Convene and support Medicaid Quality Improvement meetings with the State and the health plans

	• Report on recommendations to the State and the MCOs on developing a statewide quality strategy to harmonize across the MCOs and harmonize with the National Quality Strategy • "Just in Time" grievance reviews • Other projects as needed

(6) *Technical assistance.* The EQRO will provide technical guidance to groups of MCOs and the State to assist them in conducting activities related to the activities that provide information for the EQR.	• The EQRO will conduct the following Quality Forum training activities:
	  • Annual meeting for MCOs and DHHS staff
	  • Three yearly focused "Lunch and Learns" for DHHS staff and MCOs

42 CFR 438.364 (a) The State must ensure that the EQRO produce specified external quality review results.	

(a) *Annual Technical Report.*	• The EQRO will:
	  • Produce a detailed technical report that explains how the data from review activities were aggregated and analyzed, and how conclusions were made relative to quality, timeliness, and beneficiary access to MCO healthcare services
	  • Assess the MCOs strengths and weaknesses relative to quality, timeliness, and access to healthcare furnished to beneficiaries
	  • Recommend improvements to MCO furnished healthcare
	  • Provide comparative information about all MCOs
	  • Assess whether MCOs made previously recommended quality improvements.

10.2. Summary of EQRO Deliverables.

General Topic Area	Description of Deliverable	Periodicity	Report Description
Monitoring of Access to Care	• Beneficiary access to healthcare measuring and monitoring	Quarterly	Maintenance of the DHHS access report with an analysis of risk and opportunities for improvement
Technical Report: MCO and NH Medicaid Statewide Overview	• Assessment of MCO QAPI Plans, MCO strengths and weaknesses; • Recommendations for improving MCO healthcare services • Comparative reporting across all MCOs • Assessment of degree to which MCOs have addressed prior year's EQR recommendations • Comparative analysis of HEDIS and CAHPS for MCOs and FFS	Annually	One aggregate report to include a sub- section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population; annual report must include trends and analysis of opportunities for improvement
Technical Report: Projects	• Evaluation of MCOs' DHHS-QIP and CMS required PIPs • Recommendations for improvement	Bi-Annual, Annually	Mid-year report updating project status; one aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population.

Technical Report: Beneficiary Experience	Validate Medicaid beneficiary experience including satisfaction with MCO provision of care, quality of care, and access to care provide appropriate comparators, including FFS data	Annually	Validation and summary of MCO finding and any additional EQRO beneficiary experience analysis; One aggregate report to include a sub- section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population; annual report must include trends and analysis of opportunities for improvement including HEDIS measures and CAHPS results
Technical Report: Provider Experience	Validate MCO provider surveys	Annually	Validation and summary of MCO finding and any additional EQRO provider experience analysis; One aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population. annual report must include trends and analysis of opportunities for improvement

Technical Report: Contract Compliance	Review of MCOs' compliance with federal, State and Care Management contract	Annually	Assessment of regulatory and operational compliance; One aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population.
Technical Report: MCO Quality Performance Measures	Validation of MCO performance measures required by DHHS Quality Strategy and MCO contract,	No less than annually	Quarterly data file to update the NH Medicaid Quality Indicators website; One aggregate report to include a sub-section for each the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population; annual report must include trends and analysis of opportunities
EQRO Performance Improvement Projects: Adult Medicaid Quality Grant Measures	Validate MCO adult and pediatric quality measures and EQRO generated aggregate and calculate additional quality measures and assist the State in grant related reporting of the measures	No less than annually	TBD
EQRO Performance Improvement Projects: BIP Reporting Support	Validate MCO population measures required by BIP and NH State Innovations Grant Measures	No less than annually	TBD

EQRO Performance Improvement Projects: SIM Reporting Support	TBD	TBD	TBD
NH Medicaid Beneficiaries	Beneficiary Focus Group Studies regarding satisfaction with MCO and FFS provided healthcare;	Bi-Annual	Minutes and analysis of focus group meeting
NH Medicaid Beneficiaries	Recommend to DHHS and design additional quality studies focused on Medicaid beneficiaries	Annually	2 recommendations per annum
Healthplan Support	Convene MCO/DHHS quarterly meetings. Coordinate, harmonize MCO quality work; support DHHS leadership to plan for and conduct conducting quarterly business meetings	Quarterly	Minutes from meetings
Healthplan Support	Develop Quality Forums to include annual meeting topic related to MCO best practices; healthcare delivery innovation; and quality improvement strategies Organize conference, arrange for conference site, speakers, registration, materials, conference evaluation and other logistics	Annual	1 annual conference
DHHS and Healthplan Support	Conduct informational brown bag lunches for MCO and DHHS staff Collaborate with DHHS staff to develop informative, educational, "lunch and learn" meetings	Tri-annual	3 meetings per annum; Planning document to DHHS 30 calendar days prior to each state fiscal year
MCO Operations and Finance: Encounter Data	• Validation of encounter data per most recent CMS protocols • Recommendations for encounter data improvement	Weekly	Encounter data transfer, warehousing, validation

MCO Operations and Finance: Encounter Data	Process plan development for MMIS encounter data validation and integration	One time	Recommendation for MMIS encounter data validation due to DHHS no later than January 1, 2014
"Just in Time" Reviews	Immediate review of beneficiary grievances or other DHHS requested reviews	Monthly	Summary of reviews, analysis and actions taken; updates on ongoing improvements and outcomes

11. Cultural Considerations.

HSAG's subcontractor shall ensure that its services are provided and its interactions with Medicaid beneficiaries and MCO members, including those with limited English proficiency, occur in a culturally competent manner. The subcontractors will interact with people of all cultures, races, religions, ethnic and economic backgrounds in a manner that recognizes values, and respects the worth and dignity of individual Medicaid beneficiaries. Individuals interacting with Medicaid beneficiaries and MCO members will be highly experienced, trained facilitators who have extensive experience working with the Medicaid population and have specific expertise gathering information from the disadvantaged and individuals and families of individuals with physical, emotional, mental, and developmental issues.

12. Survival.

The following provisions survive expiration, cancellation, or termination of this agreement: section 14. Compliance with State and Federal Laws; section 15. Termination; section 16. Agreement Closeout; section 17. Remedies; section 18. Dispute Resolution Process; section 19. Confidentiality; and section 20. Publicity.

13. Compliance with State and Federal Laws.

13.1. General.

13.1.1. HSAG and its subcontractors shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR438.100(a)(2); 42 CFR 438.100(d)].

13.1.2. HSAG shall ensure that safeguards at a minimum equal to federal safeguards (41 USC 423, section 27) are in place, providing safeguards against conflict of interest [§1923(d)(3) of the SSA; SMD letter 12/30/97].

13.1.3. HSAG shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

13.1.3.1. Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. §1395 et seq.

13.1.3.2. Related rules: Title 42 Chapter IV

13.1.3.3. Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. §1396 et seq. (specific to managed care: §§ 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA)

13.1.3.4. Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR § 438; see also 431 and 435)

13.1.3.5. Children's Health Insurance Program (CHIP): Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397;

13.1.3.6. Regulations promulgated there under: 42 CFR 457

13.1.3.7. Patient Protection and Affordable Care Act of 2010

13.1.3.8. Health Care and Education Reconciliation Act of 2010, amending the Patient Protection and Affordable Care

13.1.3.9. American Recovery and Reinvestment Act

13.1.3.10. 42 CFR 435; XX-YY, Chapter ZZ DHHS Eligibility Manual, NH Laws (RSAs), Regulations, State Plan?

13.1.4. HSAG shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and HSAG, as governed by 45 C.F.R. Section 164.504(e)). Terms of the Agreement shall be considered binding upon execution of this Agreement, shall remain in effect during the term of the Agreement including any extensions, and its obligations shall survive the Agreement.

13.2. Non-Discrimination.

HSAG shall require its subcontractors to comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

13.3. ADA Compliance.

13.3.1. HSAG shall require its subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA).

3.3.2. HSAG shall submit to DHHS a written certification that it is conversant with the requirements of the ADA and that it is in compliance with the law.

13.3.3. HSAG shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, which includes its ongoing compliance monitoring to determine the ADA requirements are being met.

13.4. Non-Discrimination in Employment.

13.4.1. HSAG will not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. HSAG will take affirmative action to ensure that applicants are employed, and that employees are treated during

employment, without regard to their race, color, religion, sex or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. HSAG agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

13.4.2. HSAG will, in all solicitations or advertisements for employees placed by or on behalf of HSAG, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.

13.4.3. HSAG will send to each labor union or representative of workers with which he has a collective bargaining Agreement or other Agreement or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of HSAG's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

13.4.4. HSAG will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

13.4.5. HSAG will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

13.4.6. In the event of HSAG's noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and HSAG may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

13.4.7. HSAG will include the provisions of paragraphs (1) through (7) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. HSAG will take such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event that HSAG becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, HSAG may request the United States to enter into such litigation to protect the interests of the United States.

13.5. Changes in Law.
HSAG shall implement appropriate system changes, as required by changes to federal and state laws or regulations.

14. Termination.

14.1. Transition Assistance.

Upon receipt of notice of termination of this Agreement by DHHS, the Contractor shall provide any transition assistance reasonably necessary to enable DHHS or its designee to effectively close out this Agreement and move the work to another EQRO vendor.

14.1.1. Transition Plan

HSAG shall prepare a Transition Plan, which must be approved by DHHS, to be implemented between notice of termination of the agreement and the termination date. Notice shall be effective as of the date of receipt by DHHS.

14.1.2. Data

14.1.2.1. HSAG shall be responsible for the provision of necessary data, information, and records, whether a part of the HSAG's information systems or compiled and/or stored elsewhere, to DHHS and/or its designee during the closeout period to ensure a smooth transition of responsibility. DHHS and/or its designee shall define the information required during this period and the time frames for submission.

14.1.2.2 All data and information provided by HSAG shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. HSAG shall transmit the information and records required within the time frames specified and required by DHHS. DHHS shall have the right, in its sole discretion, to require updates to these data at regular intervals.

14.2. Termination for Cause.

14.2.1. DHHS shall have the right to terminate this Agreement, without liability to the State, in whole or in part, if the Contractor:

14.2.1.1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any beneficiary, including behavior of its sub-contractors with respect to beneficiary engagement or beneficiary focus groups;

14.2.1.2. Takes any action that threatens the fiscal integrity of the Medicaid program;

14.2.1.3. Has any of its certifications suspended or revoked by any federal agency and/or is federally debarred or excluded from federal procurement and/or non-procurement Agreement;

14.2.1.4. Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within thirty (30) calendar days of DHHS' notice of breach and written request for compliance. DHHS'

notice shall be effective the date it is sent to HSAG;

14.2.1.5. Violates state or federal law, policy, or regulation;

14.2.1.6. Fails to carry out the substantive terms of this Agreement that is not cured within thirty (30) calendar days of the date of DHHS's notice and written request for compliance;

14.2.1.7. Becomes insolvent;

14.2.1.8. Fails to meet applicable requirements contained within the provisions of 42 CFR 438.354.

14.2.1.9. Received a "going concern" finding in an annual financial report or indications that creditors are unwilling or unable to continue to provide goods, services or financing or any other indication of insolvency; or

14.2.1.10. Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under the Bankruptcy Act.

14.2.1.11. Fails to correct significant failures in carrying out the substantive terms of this Agreement and this failure to correct is not cured within thirty (30) calendar days of the date of DHHS' notice and written request for compliance.

14.2.2. If DHHS terminates this Agreement for cause, HSAG shall be responsible to DHHS for all reasonable costs incurred by DHHS, the State of New Hampshire, or any of its administrative agencies to replace the Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to the Contractor's failure to perform any service in accordance with the terms of this Agreement.

14.3. Termination for Other Reasons.

Either party may terminate this Agreement upon a breach by a party of any material duty or obligation hereunder which breach continues unremedied for ninety (90) calendar days after written notice thereof by the other party.

14.4. Survival of terms.

Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

14.4.1. The Parties have expressly agreed shall survive any such termination or expiration; or

14.4.2. Arose prior to the effective date of termination and remain to be performed, or by their nature would be intended to be applicable following any such termination or expiration.

15. Agreement Closeout.

15.1. Period.

A closeout period shall begin one-hundred twenty (120) calendar days prior to the last day of HSAG's contract with DHHS. During the closeout period, the Contractor shall work

cooperatively with, and supply program information to, any subsequent Contractor and DHHS. Both the program information and the working relationships between the two Contractors shall be defined by DHHS.

15.2. Data.

15.2.1. The Contractor shall be responsible for the provision of necessary information and records, whether a part of HSAG's information systems or compiled and/or stored elsewhere, to the new Contractor and/or DHHS during the closeout period to ensure a smooth transition of responsibility. The new Contractor and/or DHHS shall define the information required during this period and the time frames for submission.

15.2.2. All data and information provided by the Contractor shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The Contractor shall transmit the information and records required under this Article within the time frames required by DHHS. DHHS shall have the right, in its sole discretion, to require updates to these data at regular intervals.

16. Remedies.

16.1. Reservation of Rights and Remedies.

A material default or breach in this Agreement will cause irreparable injury to DHHS. In the event of any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by the State of New Hampshire to any existing or future right or remedy available by law. Failure of the State of New Hampshire to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in the Agreement or by law, or the acceptance of, or payment for, materials, equipment or services, shall not release the Contractor from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State of New Hampshire to insist upon the strict performance of this Agreement. In addition to any other remedies that may be available for default or breach of the Agreement, in equity or otherwise, DHHS may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages. DHHS reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

16.2. Notice of Remedies.

Prior to the imposition of remedies under this Agreement, DHHS will issue written notice of remedies that will include, as applicable, the following:

16.2.1. A citation to the law, regulation or Agreement provision that has been violated;

16.2.2. The remedies to be applied and the date the remedies shall be imposed;

16.2.3. The basis for DHHS's determination that the remedies shall be imposed;

16.2.4. A request for a Corrective Action Plan.

16.2.5. HSAG shall submit a written Corrective Action Plan (CAP) to DHHS within ten (10) calendar days of notification, for review and approval prior to the implementation of corrective action;

16.2.6. The timeframe and procedure for HSAG to dispute DHHS's determination. HSAG's dispute of remedies shall not stay the effective date of the proposed remedies; and

16.2.7. A statement that if the failure is not resolved within the period identified in the Corrective Action Plan, DHHS shall be permitted to impose liquidated damages with written notification and effective date, until the failure is cured, or any resulting dispute is resolved in HSAG's favor.

16.3. Liquidated Damages.

16.3.1. DHHS and HSAG agree that it will be extremely difficult to determine actual damages that DHHS will sustain in the event the Contractor fails to meet the requirements specified in the scope of work detailed in Exhibit A of this Agreement, within the timelines mutually agreed upon by DHHS and HSAG as specified in this Agreement throughout the life of this Agreement. Any breach by the Contractor may delay and disrupt DHHS's operations and obligations and lead to significant damages. Moreover, liquidated damages are intended to be a significant penalty as this assessment may impair HSAG's ability to submit future proposals with existing clients and prevent competitive bidding for new contracts. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable, and imposed as a last resort if corrective actions are insufficient to remedy the breach.

16.3.2. Assessment of liquidated damages may be in addition to, not in lieu of, such other remedies described in Section 16.2 of this Agreement, if HSAG fails to cure within the specified timeframe identified in the Corrective Action Plan. Except and to the extent expressly provided herein, DHHS shall be entitled to recover liquidated damages where due process has been followed, HSAG has been formally notified of the effective date of the damages and the full extent of the damages and the mechanism to cure the damages has been communicated, as applicable.

16.3.3. Should DHHS determine that liquidated damages may, or will be assessed, DHHS shall notify HSAG as specified in Section 16.2 of this Agreement.

16.3.4. HSAG agrees that as determined by DHHS, failure to implement the corrective action within the time period identified may result in liquidated damages in the amount of $1,000.00 per work product or deliverable and shall become effective with written notice to HSAG. HSAG shall have the ability to contact an official at DHHS for explanation of the assessment. HSAG agrees to abide by the remedies and Liquidated Damages as specified herein. DHHS's decision to assess liquidated damages must be reasonable, based in fact and made in good faith, based on the failure of HSAG to comply with the Corrective Action Plan.

16.3.5. The remedies specified in this Section shall apply until the failure is cured or a resulting dispute is resolved in HSAG's favor.

16.3.6. To the extent that HSAG's delay or nonperformance occurs outside the control of HSAG, liquidated damages as specified in this Agreement shall not be assessable against HSAG.

16.4. Suspension of Payment.

16.4.1. Payments shall be suspended when:

16.4.1.1. HSAG fails to cure a default under this Agreement within thirty (30) calendar days of notification.

16.4.1.2. HSAG fails to act on identified Corrective Action Plan.

16.4.2. Upon correction of the deficiency payments to HSAG shall be reinstated.

16. 5. Administrative and Other Remedies.

In addition to other liquidated damages described in Section 16.3, DHHS may impose the following other remedies:

16.5.1. Termination of the Agreement if HSAG fails to carry out the substantive terms of the Agreement or fails to meet the applicable requirements in Section 1903(m) or Section 1932 of the Social Security Act.

17. Dispute Resolution Process.

17.1. Informal Dispute Process.

In connection with any action taken or decision made by DHHS with respect to this Agreement, within ninety (90) calendar days following the written notice of the action or decision, HSAG may protest such action or decision by the delivery of a written notice of protest to DHHS and by which HSAG may protest said action or decision and/or request an informal hearing with the New Hampshire Medicaid Director. HSAG shall provide DHHS with an explanation of its position protesting DHHS's action or decision. The Director will determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s). It is understood that the presentation and discussion of the disputed issue(s) will be informal in nature. The Director will provide written notice by mail and email of the time, format and location of the presentations. At the conclusion of the presentations, the Director shall consider all evidence and issue a written recommendation based on the evidence presented within thirty (30) calendar days of the presentation. The Director may appoint a designee to hear and determine the disputed action or decision.

17.2. No Waiver.

HSAG's exercise of its rights under Section 17.1 shall not limit, be deemed a waiver of, or otherwise affect the parties' rights or remedies otherwise available under law or this Agreement, including HSAG's right to appeal a DHHS decision under RSA chapter 541- A, or any applicable provisions of the New Hampshire Code of Administrative Rules, including Chapter He-C 200 Rules of Practice and Procedure.

18. Confidentiality.

18.1. Confidentiality of Records: All information, reports, data, and records maintained hereunder or collected in connection with the performance of the services performed under this Agreement are confidential. HSAG shall not disclose any confidential information except to public officials requiring such information in connection with their official duties and with the administration of the contracted services and the Agreement pursuant to State law and DHHS regulations regarding the permissible use and disclosure of such information. The use or disclosure of any information by any party about a Medicaid beneficiary for any purpose not directly related to DHHS' or HSAG's responsibilities hereunder is prohibited unless disclosure is specifically permitted by written consent of the beneficiary, the beneficiary's Attorney, or the beneficiary's guardian.

18.2. It is understood that DHHS may, in the course of carrying out its responsibilities under this Agreement, have or gain access to confidential or proprietary data or information owned or maintained by HSAG. If HSAG seeks to maintain the confidentiality of its commercial, financial, personnel, or other information, then HSAG must identify in writing the information it claims to be confidential and provide the basis for its claim of confidentiality. HSAG acknowledges that DHHS is subject to and bound by a New Hampshire Right-to-Know Law, New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of identified confidential information insofar as it is consistent with applicable laws and regulations, including New Hampshire RSA Chapter 91-A. In the event that DHHS receives a proper request for information that HSAG identified as confidential information, DHHS shall so notify HSAG in writing. DHHS shall specify in its notice to HSAG the date it intends to release the requested information. If HSAG maintains that this information is confidential information that cannot be disclosed, it shall be HSAG's responsibility to seek legal protection of its information and to pay all costs associated with this legal process. If HSAG fails to seek legal protection or is unable to obtain a Court Order prohibiting the disclosure of its information, DHHS will be permitted to release HSAG's information, as requested pursuant to RSA 91-A, on the date DHHS specified in its written notice to HSAG. DHHS shall incur no liability to HSAG for any disclosure of HSAG information consistent with the procedure specified above.

19. Publicity.

HSAG shall not release any publicity regarding the subject matter of this Agreement without the prior written consent of DHHS' authorized representative. For the purposes of this provision, publicity includes notices, informational pamphlets, press releases, proposals, research, reports, signs, and other similar public statements prepared by or for the HSAG or its employees or subcontractors, with respect to the program, publications, or services provided as a result of this agreement.

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New Hampshire Department of Health and Human Services

Exhibit B

Methods and Conditions Precedent to Payment
External Quality Review Organization (EQRO) Services Payment Arrangements

This agreement is reimbursed on a monthly basis for a three-year Agreement term, subject to all conditions contained within Exhibit A. Reimbursement for the first year of the Agreement shall commence on July 25, 2013, or the date of approval of the contract by the New Hampshire Governor and Executive Council, whichever is later.

Invoices shall be submitted monthly, on the Contractor's letterhead, to:

Andrew Chalsma,
Bureau of Data and Systems Management
Office of Medicaid Business and Policy
NH Department of Health and Human Services
129 Pleasant Street – Brown Building
Concord, NH 03301-3857

The monthly invoices will include an invoice amount that is equal to $1/12^{th}$ of the total all-inclusive price for the contract year. The following table displays the monthly invoice amounts for Year 1, Year 2, and Year 3 of the Contract:

Invoicing Schedule

Monthly Invoice Amount for Month Ending	Contract Year 1	Contract Year 2	Contract Year 3
31-Jul	$40,612.50	$41,567.58	$41,330.50
31-Aug	$40,612.50	$41,567.58	$41,330.50
30-Sep	$40,612.50	$41,567.58	$41,330.50
31-Oct	$40,612.50	$41,567.58	$41,330.50
30-Nov	$40,612.50	$41,567.58	$41,330.50
31-Dec	$40,612.50	$41,567.58	$41,330.50
31-Jan	$40,612.50	$41,567.58	$41,330.50
28-Feb	$40,612.50	$41,567.58	$41,330.50
31-Mar	$40,612.50	$41,567.58	$41,330.50
30-Apr	$40,612.50	$41,567.58	$41,330.50
31-May	$40,612.50	$41,567.58	$41,330.50
30-Jun	$40,612.50	$41,567.58	$41,330.50
All-Inclusive Price	**$487,350.00**	**$498,811.00**	**$495,966.00**

Based on DHHS approved cost proposals for additional services related to Exhibit A, Section 8.8, HSAG shall invoice DHHS upon the completion and acceptance of grant support deliverables.

The Contractor agrees to request and receive prior written approval from the State to engage any subcontractors under this Agreement, and further agrees to pay the expenses of any subcontractors awarded under this Agreement in accordance with Exhibit A, Statement of Work.

The Contractor agrees to request and receive prior written approval from the State for any modifications to the project budget, which change any expenditure levels from the levels projected in the budget of this Agreement.

The Contractor agrees to use and apply all payments made by the State for direct and indirect costs and expenses associated with the execution of this Agreement. The Contractor's expenses for administration of any subcontractors shall not exceed the amounts identified in the all-inclusive price for the contract year.

Payments will be made upon receipt of Contractor invoices that identify the contract components delivered and are consistent with the negotiated payment schedule. The total contract payment from DHHS will not exceed the agreed upon contract price.

Pricing Worksheet

Agreement Pricing is as set forth below:

	Agreement Year One	Agreement Year Two	Agreement Year Three
	July 25, 2013 - June 30, 2014	July 1, 2014 – June 30, 2015	July 1, 2015 – June 20, 2016
All Inclusive Price	$487,350.00	$498,811.00	$495,966.00
Additional Services (Exhibit A, Section 8.8)	$210,217.00		

Price Limitation. This Agreement is based on a yearly comprehensive pricing proposal from HSAG for SFY 2014, SFY 2015, and SFY 2016. Accordingly, the total price limitation is $1,692,344.00 for the three-year term of this Agreement.

Invoicing. Invoices shall be submitted to the Finance Unit of DHHS' Office of Medicaid Business and Policy as indicated above for services provided by the Contractor as outlined in Exhibit A. The Contractor shall be notified in writing should this contact information change during the course of the contract.

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NH Department of Health and Human Services

STANDARD EXHIBIT C

SPECIAL PROVISIONS

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

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

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

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

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

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

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

8. Conditions of Purchase: Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractor's costs, at a rate which

exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:

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

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

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

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

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

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

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

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

10. Audit: Contractor shall submit an annual audit to the Department within 120 days after the close of the Contractor fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.

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

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

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

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

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

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

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

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

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

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

15. Prior Approval and Copyright Ownership:
All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

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

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

When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:

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

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

SPECIAL PROVISIONS – DEFINITIONS

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

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

DEPARTMENT: NH Department of Health and Human Services.

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

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

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

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

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STANDARD EXHIBIT D

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I -FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

(A) The grantee certifies that it will or will continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about

(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will

(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

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

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

Health Services Advisory Group - Arizona	From: 7/24/2013	To: 7/24/2016
(Contractor Name)	(Period Covered by this Certification)	

Mary Ellen Dalton, PhD, MBA, RN – Chief Executive Officer
(Name & Title of Authorized Contractor Representative)

Mary Ellen Dalton 7-8-13
(Contractor Representative Signature) (Date)

NH Department of Health and Human Services

STANDARD EXHIBIT E

CERTIFICATION REGARDING LOBBYING

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

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

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

Contract Period: July 24, 2013 through July 24, 2016

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

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or subcontractor).

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or subcontractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

(3) The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

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

Mary Ellen Dalton

(Contractor Representative Signature)

Mary Ellen Dalton, PhD, MBA, RN - CEO

(Authorized Contractor Representative Name & Title)

Health Services Advisory Group -- Arizona

(Contractor Name)

7-8-13

(Date)

NH Department of Health and Human Services

STANDARD EXHIBIT F

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without

modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

(1) The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and

(d) have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

(2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

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

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

(b) where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

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

Mary Ellen Dalton — Mary Ellen Dalton, PhD, MBA, RN - CEO

(Contractor Representative Signature) — (Authorized Contractor Representative Name & Title)

Health Services Advisory Group - Arizona — Jul 8, 2013

(Contractor Name) — (Date)

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NH Department of Health and Human Services

STANDARD EXHIBIT G

CERTIFICATION REGARDING
THE AMERICANS WITH DISABILITIES ACT (ADA) COMPLIANCE

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

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

Mary Ellen Dalton	Mary Ellen Dalton, PhD, MBA, RN - CEO
(Contractor Representative Signature)	(Authorized Contractor Representative Name & Title)
Health Services Advisory Group - Arizona	7-8-13
(Contractor Name)	(Date)

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NH Department of Health and Human Services

STANDARD EXHIBIT H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

Mary Ellen Dalton — Mary Ellen Dalton, PhD, MBA, RN - CEO
(Contractor Representative Signature) (Authorized Contractor Representative Name & Title)

Health Services Advisory Group - Arizona — 7-8-13
(Contractor Name) (Date)

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STANDARD EXHIBIT I

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILTY ACT BUSINESS ASSOCIATE AGREEMENT

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

BUSINESS ASSOCIATE AGREEMENT

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in Title XXX, Subtitle D. Sec. 13400.

b. "Business Associate" has the meaning given such term in section 160.103 of Tile 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, Title XIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.501.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreasonable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH Act.

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

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, the Business Associate shall not, and shall ensure that its directors, officers, employees and agents, do not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402 of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

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

(3) Obligations and Activities of Business Associate.

a. Business Associate shall report to the designated Privacy Officer of Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement, including any security incident involving Covered Entity data, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402.

b. The Business Associate shall comply with all sections of the Privacy and Security Rule as set forth in, the HITECH Act, Subtitle D, Part 1, Sec. 13401 and Sec.13404.

c. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

d. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section (3)b and (3)k herein. The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard provision #13 of this Agreement for the purpose of use and disclosure of protected health information.

e. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

f. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

g. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

h. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

i. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

j. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

k. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) **Obligations of Covered Entity**

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) **Termination for Cause**

In addition to standard provision #10 of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines

that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary

(6) **Miscellaneous**

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, and the HITECH Act as amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule and the HITECH Act.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or indemnification provisions of section 3 d and standard contract provision #13, shall survive the termination of the Agreement.

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

N.H. Department of Health & Human Services	Health Services Advisory Group - Arizona
The State Agency Name	Name of the Contractor
Kathleen A. Dunn	Mary Ellen Dalton
Signature of Authorized Representative	Signature of Authorized Representative
Kathleen A. Dunn	Mary Ellen Dalton, PhD, MBA, RN
Name of Authorized Representative	Name of Authorized Representative
Associate Commissioner	Chief Executive Officer
Title of Authorized Representative	Title of Authorized Representative
7/15/13	7-8-13
Date	Date

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STANDARD EXHIBIT J

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

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

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

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

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

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

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

Mary Ellen Dalton — Mary Ellen Dalton, PhD, MBA, RN - CEO

(Contractor Representative Signature) (Authorized Contractor Representative Name & Title)

Health Services Advisory Group-Arizona — 7-8-13

(Contractor Name) (Date)

STANDARD EXHIBIT J
FORM A

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

1. The DUNS number for your entity is: 114443260

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

_x_ NO _____YES

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

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

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

_____ NO _____YES

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

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

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

Name: _____ Amount: _____

Name: _____ Amount: _____

Name: _____ Amount: _____

Name: _____ Amount: _____

Name: _____ Amount: _____